PRIMARY CARE COVID-19 EMERGENCY RESPONSE PLAN

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Background to this Plan

In Canterbury the whole of health coordinated and managed response utilised the organisational structure of the Coordinated Incident Management System (CIMS) with the CDHB leading from the Emergency Coordination Centre (ECC) through to a range of Emergency Operations Centres, including the CPRG Primary Emergency Operations Centre (EOC).

This document captures some of the work to date in context to the event, as well as provides a framework for short, medium and long term planning as the health system continues to maintain surveillance and readiness to respond to any elevated risk.

This Plan focuses on the processes, structures, and roles to support and coordinate General Practice, Community Pharmacies and other Primary Health Care Providers in the readiness for, response to, reduction of, and recovery from the COVID-19 pandemic.

This Plan is a subset of the overarching generic CPRG Pandemic Plan and any response should be managed within the context of that plan and the CPRG Emergency Plan as well as any overarching plans such as those of the CDHB and Ministry of Health (MoH).

Assumptions

The following assumptions underpin this plan:

- The Ministry of Health is the agency leading pandemic planning, including national planning, risk management and coordination of health service delivery.
- That this plan supports and recognises the health sector's pandemic plans and other planning by the Ministry of Health (MoH), the Canterbury DHB and Community and Public Health (C & PH) in relation to pandemics.
- That the CPRG, in partnership with CDHB (as funder and provider), will lead and coordinate local readiness, capability and response amongst General Practice, Community Pharmacies, and other Primary Health Care Providers as required within the CDHB region.
- That this plan requires acceptance of Primary Health Organisations (PHO), Community Pharmacies and other Primary Health Care Providers to support the CPRG role and the activation of an Emergency Operations Centre during a pandemic.
- That the rights of all primary and community health providers to continue providing their services for their patients is recognised and it is acknowledged that they will be supported to meet increased demand and, where necessary, to reshape services to meet changes in demand and funding.

Planning Structure

The New Zealand emergency planning structure outlining the health response perspective from the Ministry of Health (MoH) (Influenza Pandemic Plan – also applicable to COVID-19). As this plan is the only pandemic plan in existence at this time the principles included are used as a basis for COVID-19 planning.

New Zealand pandemic planning is based around a six-phase strategy:[1]

1. Plan for it (planning and preparedness)
2. Keep it out (border management)
3. Stamp it out (cluster control)
4. Manage it (pandemic management)
5. Manage it: Post-Peak
6. Recover from it (recovery).

The responsibilities of the MoH, District Health Boards, Public Health Units and the Ambulance services are contained in the above plan. The MoH may at times alter the stages above to meet the requirements of the response to COVID-19. Such changes will be notified and included as they occur.

The Primary EOC plan fits within the Canterbury DHB plan structure, which fits within the MoH's plan.

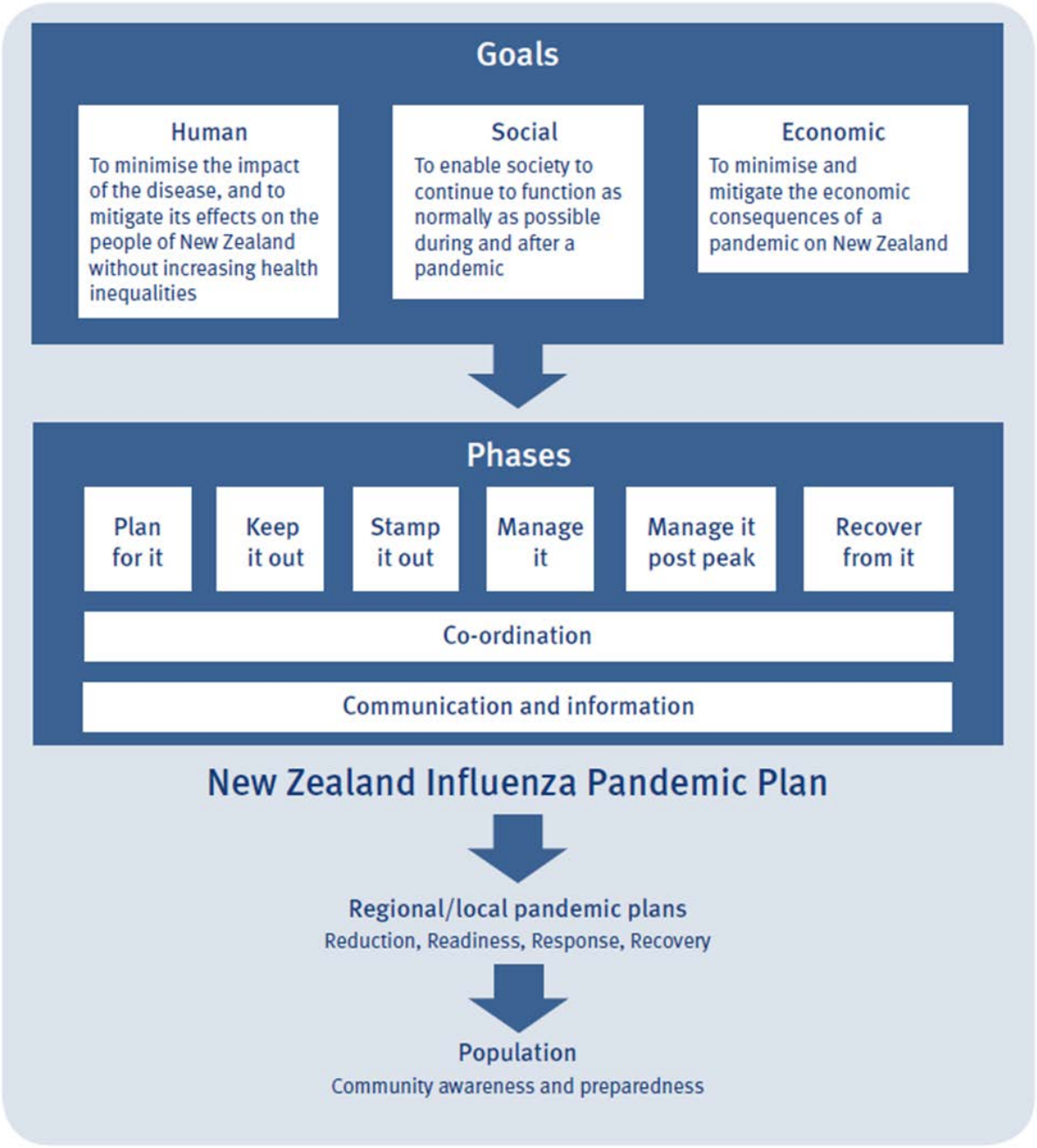
- New Zealand Influenza Pandemic Plan - A Framework for Action (NZIPAP) – https://www.health.govt.nz/publication/new-zealand-influenza-pandemic-plan-framework-action

District Health Boards are the lead agencies for planning and responding to pandemics (and other health emergencies) at a local level.

- CDHB Pandemic Plan – https://www.cdhb.health.nz/wp-content/uploads/2481a260-canterbury-dhb-pandemic-plan-2018.pdf
- CDHB Hospitals' and Community and Public Health Pandemic Plans – held in house.
- CPRG Pandemic Plan – https://www.primaryhealthresponse.org.nz/wp-content/uploads/2018/06/CPRG-Pandemic-Plan-FINAL.pdf

[1] New Zealand Influenza Pandemic Plan: A framework for action.

Figure 1. MoH Influenza Pandemic Plan structure



The Canterbury Primary Health COVID 19 Response Plan

Goals of the Response

- To support general practice and community pharmacies to continue to maintain capacity and capability to provide health services to the wider community.
- Equity of access to primary healthcare is planned, prioritised and maintained for all of our communities; this means we consider strategies to ensure that our vulnerable communities do not miss out and are able to access healthcare in everything we do.
- To support general practice and community pharmacy to respond and manage risk to the wider community as well as the healthcare team.
- To promote a collaborative, coordinated and supported health system response to the COVID-19 pandemic.
- To actively work in collaboration with national (MoH) and local (CDHB) health planning and responses to the pandemic.
- To be ready to manage a region or population surge in COVID-19 without overwhelming our health system capacity.

The Canterbury strategy for the COVID-19 pandemic response is based on the Civil Defence Emergency Management (CDEM) cycle of: Reduction, Readiness, Response and Recovery (4 R's) and on reducing the impact of the pandemic on the hospital system. The CDHB expectation of primary care as outlined in Table 3 is based on this cycle.

Such planning has the express intention of identifying and managing COVID-19 cases and reducing the likelihood of its spread and any subsequent waves.

All phases and components of the response must apply an enhanced equity focus/Māori lens. Partnership with iwi/Māori is essential to ensure the pandemic strategy recognises and responds to the needs of these communities. Members of the Primary Emergency Operations team provide a Māori perspective and an equity lens. See Appendix C for activities to support equity in the emergency response across alert levels.

A coordinated primary care pandemic response may include (but is not limited to):

- Supporting Community and Public Health in the event of a pandemic
- Supporting population health management of the pandemic, i.e., surveillance testing in the community
- Supporting other agencies such as St John Ambulance and/or hospital(s) emergency departments (ED) in such an event
- Supporting medical care in residential facilities, palliative care, quarantine or isolation facilities
- Providing community-based health services during a pandemic that affects normal services (such as community-based testing and assessment)
- Ensuring ongoing primary care services prior, during and following a pandemic
- Providing essential community services should Canterbury DHB services or facilities have reduced capacity for any reason
- Supporting the health needs for a coordinated welfare response under the control of CDEM and/or CDHB.

Components of the Response

The strategy includes these components:

- General Practice
    - Testing and assessing of patients
    - Maintaining healthcare service delivery
    - Community-based testing and assessment
- Community Pharmacy
    - Maintaining medication and healthcare service delivery, including medicines supply and distribution
- Primary Care Emergency Response
    - Incident Control and EOC management
    - Clinical Leadership
    - Operations
    - Intelligence
    - Logistics
    - Human Resources
    - Planning
    - Communications including website management, emails, telephone queries
    - Integration:
        - Community & Public Health
        - Laboratory
        - Primary/Secondary care
    - Public Welfare – primarily a District Health Board responsibility, although we will ensure our activities contribute to this including maintaining usual health services such as vaccination and WellChild programmes
    - Staff Welfare – primarily a PHO and EOC support function by EOC HR
    - Recovery

Alert Levels

The NZ government has determined alert levels to specify the public health and social measures to be taken, based on scientific knowledge about COVID-19 and information about the effectiveness of control measures overseas and in NZ, with the aim to eliminate COVID-19[2]. These measures have had and will continue to have an impact on primary care and the community. These are:

Table 1: NZ Government Alert Levels

Level 4 – Lockdown	Likely the disease is not contained. Community transmission is occurring. Widespread outbreaks and new clusters. Rationing of supplies and requisitioning of facilities possible. Reprioritisation of healthcare services. People instructed to stay home. Travel severely limited. Gatherings cancelled. Businesses are closed except for essential services. Schools closed.
Level 3 – Restrict	High risk the disease is not contained. Community transmission might be happening. New clusters may emerge but can be controlled through testing and contact tracing. Healthcare services use virtual, non-contact consultations where possible. No physical interaction with customers at businesses. People at

[2] https://covid19.govt.nz/

	high risk of severe illness encouraged to stay home and take extra precautions when leaving home. People instructed to stay home other than for essential personal movement, i.e., work, school. Physical distancing of two metres outside home. Limited capacity at schools. Public venues closed. Gatherings of up to 10 people allowed.
Level 2 – Reduce	The disease is contained, but the risk of community transmission remains. Household transmission could be occurring. Single or isolated cluster outbreaks. Health services operate as normally as possible. Physical distancing of one metre in public. Gatherings of up to 100 people allowed (500 outside). Most businesses open with appropriate measures in place.
Level 1 - Prepare	The disease is contained in New Zealand. COVID-19 is uncontrolled overseas. Isolated household transmission could be occurring in NZ. Intensive testing for COVID-19. Rapid contact tracing of any positive case. Self-isolation and quarantine required. Border entry measures. Physical distancing encouraged. Stay home if you're sick; report flu-like symptoms. Avoid public transport or travel if sick.

New Zealand's elimination strategy is a sustained approach to keep it out, find it and stamp it out. We do this through controlling entry at the border with routine quarantine or supervised self-isolation for 14 days; disease surveillance; physical distancing and hygiene measures; testing for and tracing all potential cases; isolating cases and their close contacts; and broader public health controls depending on the Alert Level.

The plan needs to account for surge, suppression, mitigation, multiple waves, reducing indirect COVID health harms, lockdown management, and vaccination.

While the country has operated under different alert levels as set by the government, so, too, has the Ministry of Health identified alert levels for the health sector - a Community Response Framework has been developed[3]. (See Appendix B.) Triggers for moving between these levels are likely to be directed by clinical/epidemiological knowledge gained and disseminated by the Technical Advisory Group/s throughout the health system.

Table 2: Community Response Framework - Activities to support a coordinated community response are activated on different levels of these alerts:

Community Readiness GREEN ALERT	No COVID-19 positive patients in your hospital; no cases in your community; managing service delivery as usual with only staffing and facility impact being for training, readiness, and COVID-19 testing facilities
Community Mild Impact YELLOW ALERT	Cases quarantined in your community; contact tracing active; one of more COVID-19 positive patients in your hospital; there may be some staff absence and some staff redeployment to support the response
Community Moderate Impact	Community transmission/multiple clusters in your community; one or more COVID-19 positive patients in

[3] As has a Hospital Response Framework.

ORANGE ALERT	your hospital; significant staff absence; extensive staff redeployment
Community Severe Impact RED ALERT	Community transmission/widespread outbreaks in your community; COVID-19 positive patients in your hospital; urgent care facilities and primary care at capacity; all available staff deployed

The Incident Controller determines the alert level, in conjunction with advice received from the ECC and the Technical Advisory Group/s appointed to the response.

Expectations of the Response

Table 3: CDHB Expectations of Primary Care – General Practice and Community Pharmacy

	Reduction/ Mitigation	Readiness/ Preparedness		Response	Recovery
Primary Care	✓ Influenza vaccination programme for staff and patients to reduce other infectious risk ✓ Promote self and family care and protection ✓ Provide regular updated advice on signs, symptoms and testing standards and management	✓ Red and green streaming planning ✓ Adaptable models of care including ability to work virtually (telehealth including telemedicine, e-prescriptions) ✓ Communication to patients of potential new models of care ✓ Review infection prevention and control protocols, e.g., signage, PPE ✓ Promote self and family care and protection ✓ Emergency and business continuity plans in place ✓ Plan supply of medications, e.g. access to OST, delivery of medications	**Service continuity plans activated**	✓ Assess symptomatic patients and test for COVID-19 ✓ Influenza vaccination programme for the at risk community ✓ Workload prioritised ✓ Plans for extending healthcare service capacity/capability ✓ Maintain healthcare service provision in a virtual environment wherever possible ✓ Manage clinical risk for patients who cannot be treated virtually ✓ Workload monitoring and reporting ✓ Surveillance or sentinel testing	✓ Planning for new models of care ✓ Communication with patients ✓ Debrief on the response from primary health providers ✓ Review emergency plans ✓ Assess staff wellbeing and take measures to mitigate risk

				as required ✓ Medical and pharmacy services to aged care and long term care facilities ✓ Maintain medication supply chains	

Table 4: Primary Care Expectations of CPRG Emergency Response

	Reduction/ Mitigation	Readiness/ Preparedness		Response	Recovery
Primary Care	✓ Communication with providers ✓ CIMS training for EOC staff ✓ Agreement of EOC staff to be involved; clarify and agree roles ✓ Monitor intel from C&PH, CDHB, MOH, international sources	✓ Policy agreement with DHB ✓ Resource planning and identification ✓ Planning support for designated clinics and CBACs – communications with practices ✓ Review red/green streaming planning in practices or other primary care or community locations ✓ Review infection prevention and control protocols, e.g., signage, PPE ✓ Renew links with CDHB ECC, Supply, etc. ✓ Review pharmacy pandemic plans	**Service continuity plans activated**	✓ Activate an emergency operations team to deliver support to general practices and community pharmacies ✓ Support for extending general practice capacity/ capability (including CBACs) ✓ Workload monitoring and reporting ✓ Partnership with other community providers and DHB entities ✓ Assistance to primary care with managing exposure risk, i.e., PPE ✓ Activation of CBAC, if required ✓ Intel gathering	✓ Debrief ✓ Monitoring of INTEL ✓ Review emergency response plans ✓ Handover to management service structures for BAU ✓ Monitoring of situation and preparedness for escalation

				and dissemination to primary care	

Out of scope

- It is expected that expert advice will be sought to provide evidence-based clinical practice guidelines and it is required that primary care are consulted regarding the development and feasibility of any such guidelines.
- Communication with the public will typically be the responsibility of the MoH, CDHB ECC Public Information Manager and/or Community & Public Health working with HealthInfo and usual media channels – except communications undertaken by general practice or community pharmacy directly to their patients.
- Support for community nursing including midwifery has been undertaken in the COVID-19 response by the CDHB.
- Aged care and long term care facilities have been supported through the CDHB Vulnerable People team. Medical care provided by general practice teams has been supported via the Primary EOC.
- Welfare of the greater community has been delegated nationally to the Ministry of Civil Defence and Emergency Management (CDEM) and regionally and locally to CDEM groups, working with DHB teams such as Community & Public Health and the CDHB ECC Welfare team. The psychosocial sub-function is led by Health, linking with Welfare. In local environments such as rural settings welfare groups have been established and are working alongside the EOC, primary care, St John Ambulance, TLAs and Civil Defence.
- Liaison with CDEM is through CDHB or local TLAs in rural settings.
- Mortuary and death plans are the responsibility of Labs EOC.
- Allied health/private providers – the supply of PPE and support to these organisations is not the responsibility of the Primary EOC. (Non-publicly funded community providers are not supplied PPE or directly supported under the CDHB ECC response.)
- St John is aligned to the response under the CIMS structure but not directly responsible to the Primary EOC.

Roles in the Primary Care Response

The health system must work together to deliver care and manage risk in the community. This involves DHB, hospital, laboratory, public health, primary and community care forming critical partnerships with open, formal and informal communications channels. See the Appendix for more information about the roles and corresponding activities across each alert level.

CPRG Role

Canterbury Primary Response Group is mandated to provide support to general practice and community pharmacy for emergency planning as well as coordination of a response to an emerging threat. A response will be a variation of an Emergency Operations team along the lines of the CIMS structure, supported by stakeholders from across the Canterbury health system. See the CPRG Emergency Plan for position descriptions for each role.

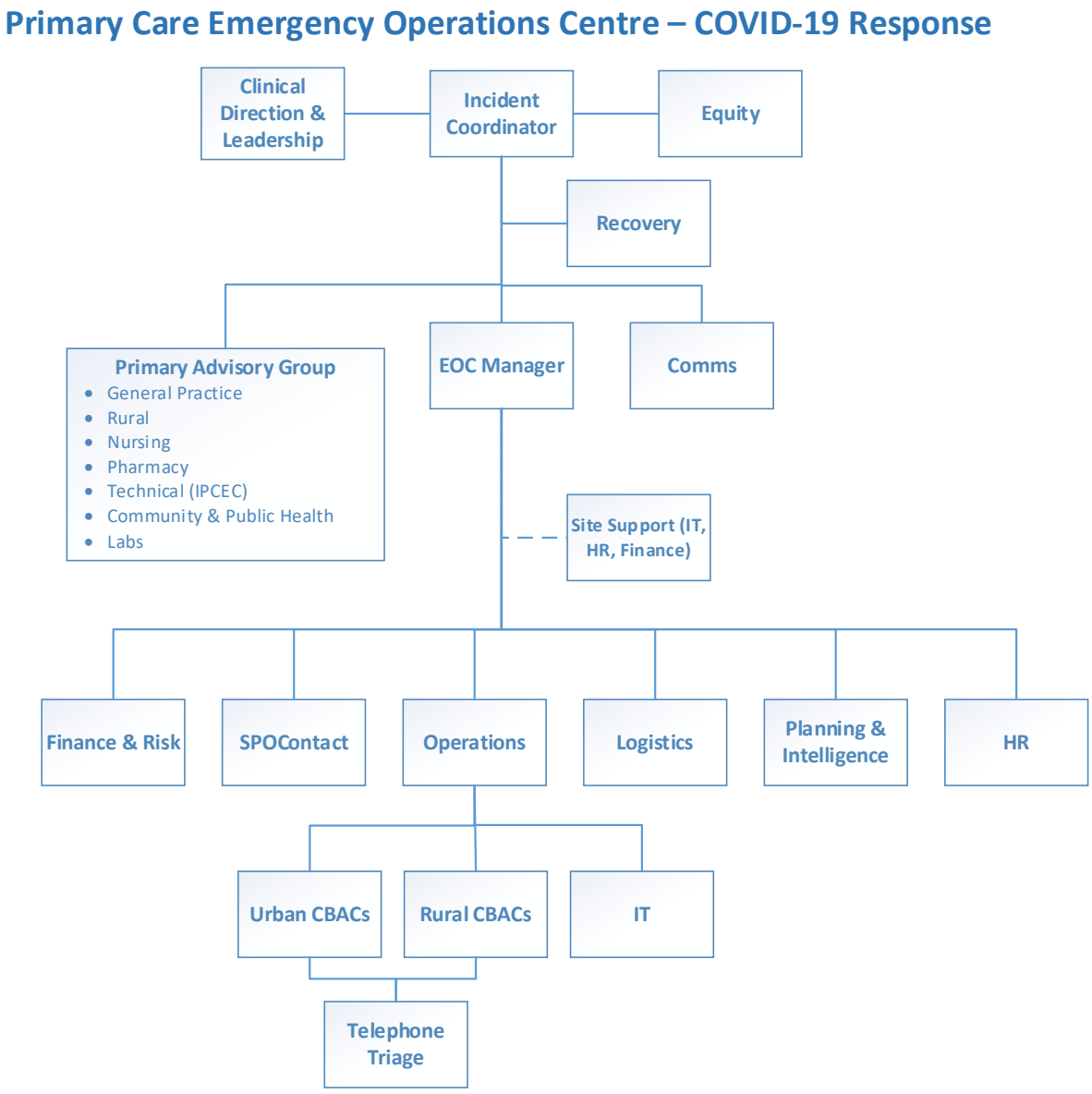
Primary Emergency Operations Centre (EOC)

This Primary EOC structure is flexible and modular – positions can be expanded or contracted to meet the needs of the response, combined with the availability of staff. If warranted, positions can be combined.

The Primary Emergency Operations Centre (EOC) will be activated as directed or necessitated by one or more of these groups:

- Canterbury Primary Response Group,
- Health Emergency Governance Group (HEGG),
- Infection Prevention and Control Executive Committee (IPCEC),
- CDHB Emergency Coordination Centre (ECC),
- Community & Public Health, or
- Agreement with primary care organisations.

Figure 2. Primary Care Emergency Operations Centre Structure



For detail on the functions within the Primary EOC see the appendix.

COVID 19-Plan Activation

The COVID Primary EOC response was activated in March. The response was activated by the Primary EOC Incident Controller and Clinical Leadership upon direction from the ECC Incident Controller. Determination of the level of response required has been and will continue to be a joint decision of all key stakeholders based on information gathered. This plan has been requested by and

approved by the Incident Controller for ongoing readiness and response to the COVID-19 pandemic that requires a higher level of support and coordination in primary care than business as usual.

Escalation/Re-activation

At the time of writing the country is at Alert Level 3, preparing to reduce to Alert Level 2. Plans contained in this document (see appendices) accommodate an escalation of risk as well as a de-escalation of risk, which is based primarily on the prevalence of COVID-19 cases in the community and impacts on hospital and on present knowledge of the nature of this disease and the required response.

Deactivation of COVID 19 Plan

The COVID-19 Plan and the EOC will be deactivated on the decision of the Primary EOC Incident Controller based on their assessment of the de-escalating situation, reduced response needs and in consultation with health providers and the ECC Incident Controller.

De-escalation will be based on the prevalence of COVID-19 cases in the community and reduced or nil impact on hospital.

Deactivation of the Primary EOC team may be staged over time to allow staff deployed from other roles to return while maintaining vigilance.

On deactivation Primary EOC resources must be restocked and records of the event and response recorded for debrief and training purposes. Records of any financial expenditure and staff hours must be prepared for reconciliation.

Review of COVID 19 Plan

This plan is a living document. Nationally the number of COVID cases continues to be monitored. As the country eases restrictions on work and travel the Director General of Health will monitor the impact and communicate priorities. This plan must be prepared for a second wave of infection requiring changes at short notice. Any changes will be notified and published on the CPRG website. (www.primaryhealthresponse.org.nz)

Response Debrief

A debrief of the primary care response to COVID 19 shall be conducted at a time decided by the Primary EOC Incident Coordinator or appointee and will cover:

- What worked well
- What could be strengthened
- What didn't work or caused concerns and needs development
- Suggestions for future response

The Primary EOC may participate in a system-wide debrief facilitated by the ECC or its appointee.

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Appendix A: Glossary

Table 5: Glossary of Emergency Response Terms

Activation	Activation in terms of an emergency or non-emergency event is the point at which an emergency plan is called into action. This may mean a specially trained team come together to coordinate a response to the event.
CBAC	A Community-based Assessment Centre is a general practice or other facility that has been designated by the Primary EOC and the CDHB to provide assessment and treatment to patients with the particular virus/illness (in this case COVID-19), i.e., red stream patients. It may serve a wider community than its own enrolled patients. Clinics may also be established in other facilities, such as community halls, or as a mobile clinic and staffed by clinical teams.
CDHB	Canterbury District Health Board. District health boards (DHBs) and their public health units are responsible for leading the planning and response to a pandemic at the local and regional level.
Cluster	As of April 2020, a cluster is defined as where there are 10 or more positive cases in the same place.
Community & Public Health	Community & Public Health have an obligation to the community and to the Ministry of Health to provide a public health response to all emergencies. They ensure drinking water is available, environmental hazards are managed, the public receive relevant information and the risk of infectious disease is minimised.
Coronavirus	COVID-19 is a novel coronavirus identified in early January 2020. Understanding of the virus is still evolving but it predominately affects the lungs and airways. Symptoms include: a cough, high temperature, shortness of breath, sore throat, sneezing and runny nose, and/or temporary loss of smell.
CPRG	The Canterbury Primary Response Group (CPRG) is a collaborative group of health professionals and provider organisations tasked by the CDHB to lead Canterbury's primary care emergency planning, response and recovery. The CPRG meets periodically and issues updates to primary care providers as well as communicating with the CDHB and other relevant organisations in Canterbury. The Primary EOC is activated on behalf of CPRG.
Designated Clinic/Practice	A general practice or other facility who, in agreement with CPRG and the CDHB, agree to provide red stream services for their own enrolled patients as well as people from neighbouring general practices in the event of an increased influenza season or pandemic.
Endemic	Prevalent infection amongst a specific group of people.

ECC	Emergency Coordination Centre. A facility to support a Controller in coordinating a response, or part of it and provides support to national, regional and local level responses. (MOH National Health Emergency Plan 2015) Emergency Operations Centres for smaller teams may be formed and report into the ECC.
EOC	The Emergency Operation Centre (EOC) is a facility where the response to an event may be supported and managed. In this context the EOC usually refers to the Canterbury Primary EOC, responsible for managing the response of primary care providers. The EOC team may come from across the health sector, including PHO and partner organisations' staff.
Epidemic	A widespread occurrence of an infectious disease in a community at a particular time.
Green stream	Patients who present to general practice for reasons other than symptoms of COVID-19 illness.
Health emergency	Natural or man-made event that suddenly or significantly: • Disrupts the environment of care • Disrupts the care and treatment of patients • Changes or increases demand for an organisation's services May have no warning (e.g. earthquake) or prior warning (pandemic). Can be internal or external: • Internal – events in the health facility that result in business disruption (loss of resources, equipment, people, etc.) used for regular activities, e.g., fire, fume, loss of utilities, release of chemicals, hostage situations • External – events that occur in the community outside the health facility that may affect the facility's ability to carry out regular activities, e.g. floods, storms, snow, earthquakes, power outages, civil disorder
Incident Controller (may also be called the Primary Care Coordinator)	Leads the Primary Emergency Operations Centre (EOC) team, is responsible to the CDHB ECC Incident Controller for the overall coordination of any primary care emergency response.
Infectious Disease	An infectious disease is caused by pathogenic microorganisms, such as bacteria, viruses, parasites or fungi; the diseases can be spread, directly or indirectly, from one person to another. (WHO)
Isolation	Where a person has been repatriated from an overseas location they are required to remain in isolation for a specific period of time. This may also apply to people such as probable cases who may be in close contact with at risk individuals.
LEG	Local Emergency Group - A group of general practices and

	community pharmacies in a geographic area that is within easy biking distance (in the case of transport disruption). LEGs are encouraged to keep in touch with each other in 'peace time' so that relationships are already established in an emergency event.
MoH	Ministry of Health. The Ministry of Health is the lead agency for planning for and responding to pandemics on a national scale.
Outbreak	An outbreak may be defined as a greater rate of infection than expected within a population over a period of time. The point at which intervention is required will vary according to the risks of infection to those exposed and the transmissibility of the pathogen. An outbreak of infectious disease may either seriously affect individuals' health or have the ability to disrupt the organization's ability to provide normal services**.** An outbreak may be identified by: • Local/national surveillance systems • Laboratory microbiological data • Regional Community & Public Health, National or International alerts
Pandemic	An epidemic that becomes very widespread and affects a whole region, a continent or the world.
Primary Care Coordinator – also called the Incident Controller	Leads the Primary Emergency Operations Centre team, is responsible to the CDHB Incident Controller for the overall coordination of any primary care emergency response.
Quarantine	Where a person has been repatriated from an overseas location and is symptomatic of COVID-19 or where there was a possible exposure to COVID-19 they are required to enter a designated quarantine facility until cleared of any signs of symptoms of the virus (at April 2020 this is typically 14 days).
Red stream	Patients with suspected COVID-19 are triaged and guided (streamed) through a medical facility to minimise contact with people who do not have ILI.
Response	Activities taken immediately before, during or directly after an emergency that can: • Save lives. • Minimise injury, illness and suffering. • Reduce damage to property and infrastructure. • Minimise the disruption of support services. • Make recovery easier.
Sector	An area in Canterbury corresponding to an urban ward, rural district or geographic location. Canterbury has been divided into sectors to facilitate the coordination of an emergency response. The sector will encompass many general practices and

	community pharmacies. A Sector Coordinator in the EOC acts as a conduit between LEGs (general practices and community pharmacies) and the central Primary EOC team.
Single-Point-of-Contact (SPOC)	Single Point of Contact is a role within the EOC, is central and responsible for all incoming emails and phone calls from General Practice and Pharmacy and CDHB ECC and other EOCs during a response. Requests are logged in a central database.
Vulnerable Persons	These people with significant health and disability needs that are unable to access support through the usual channels, or whose needs are much greater than can be provided for through other support agencies.

Appendix B: MoH Community Response Framework

MoH has released a Response Framework for several key areas of the health system. The Community Response Framework has been used as the basis for the Canterbury Primary Care COVID-19 Response Plan.

Table 6: MoH Community Response Framework

	Community Activities across Alert Levels
COVID-19 Community Readiness **GREEN ALERT** **Trigger Status summary: No COVID-19 positive patients in your hospital; no cases in your community; managing service delivery as usual with only staffing and facility impact being for training & readiness purposes**	**Managing service delivery as usual with only staffing and facility impact being for training & readiness purposes** • Screen for COVID-19 symptoms & travel history for all attendances to primary care and community facilities • Plan for triage including physical separation • Plan to separately stream COVID-19 suspected cases and non COVID-19 cases • Practice PPE availability and use for COVID-19 care in appropriate areas • Undertake training and practice runs for management of a COVID-19 suspected case • Ensure shared medical record, secure provider communication, telehealth, virtual consultation and electronic prescribing options available that consider the needs of the community served. • Ensure local clinical guidance is available e.g. HealthPathways, connected to local processes and directories • Plan for management of calls, phone triaging, remote and virtual consults and virtual MDTS for the majority population, including provision for vulnerable populations with limited phone and internet access. • Plan for community based assessment and testing clinics and mobile assessment teams and welfare response teams for all of the levels below including immediate response to any possible or actual outbreak in any community • Plan for whānau/community centred responses for priority populations to ensure access to necessary care and equity • Plan to defer non-essential (non-urgent) services, noting vulnerable populations may still need to receive care • Plan and prepare a dedicated COVID-19 area and staff, including dedicated Māori, Pacific and Disability health workers • Plan with additional support staff to confirm arrangements for their assistance during higher escalation levels • Identify vulnerable patients who may need additional social supports, care planning, pre-emptive care • Resource kit developed for supporting people with own wellbeing and welfare need
COVID-19 Community Mild Impact **YELLOW ALERT** **Trigger Status summary: Cases**	**Presence of a COVID-19 probable or small outbreak: May be some staff absence and redeployment to support response** • Continue screening for COVID-19 symptoms and travel history as per Green Alert • Activate Plans as required at Community Yellow Alert • Move to delivery of care by virtual or non-contact means wherever possible whilst ensuring access for priority and vulnerable populations. • Primary care providing initial assessments of patients with COVID-like

	Community Activities across Alert Levels
quarantined in your community, contact tracing active; one or more COVID-19 positive patients in your hospital, there may be some staff absence and some staff redeployment to support response	symptoms • Activate PPE Plans • Activate streaming of suspected COVID-19 positive and non-positive patients to separate areas • Activate plans for management of calls, phone triaging, remote and virtual consults and virtual MDTS for the majority population, including provision for vulnerable populations with limited phone and internet access • Activate plans for community-based testing clinic(s), by referral only and close to any known possible outbreaks and mobile assessment teams. • Activate plan for whānau/community centred responses for priority populations to ensure access to necessary care and equity • Activate specific plans for Advanced Care; Palliative Care; Age Residential Care and Mental Health and Addiction support provided by primary care. • Deploy resource kit to support people with own wellbeing and welfare need
COVID-19 Community Moderate Impact **ORANGE ALERT** **Trigger Status summary: Community transmission/multiple clusters in your community; one or more COVID-19 positive patients in your hospital; significant staff absence, extensive staff redeployment**	**Urgent care facilities and primary care capacity severely affected, significant staff absence, extensive staff redeployment** • Continue screening for COVID-19 symptoms and travel history as per Green Alert • Activate additional plans as required at Community Orange Alert • Delivery of care by virtual or non-contact means wherever possible. • Patients with COVID-like symptoms referred to Community Based Assessment Units • Expand Community Based Assessment Clinics in multiple locations with good access for priority populations, mobile teams for immobile or isolated patients and outreach to vulnerable and priority populations ensuring proximity to any known possible outbreaks and mobile assessment teams. • Expand whānau/community centred responses for priority populations to ensure access to necessary care and equity • Move to even greater delivery of care by virtual or non-contact means wherever possible whilst ensuring access for priority and vulnerable populations. • Expand specific plans for Advanced Care; Palliative Care; Age Residential Care and Mental Health and Addiction support provided by primary care including postponing non-essential care and pre-emptive care is in place for end of life patients. • Activate the plan for extended acute demand service available to manage people including extended large-scale illness and palliative care to all community facilities. • Activate the plan for all hospital activity that transfers to community options. • Identify and support high risk patients, those awaiting elective services which are postponed and those with chronic conditions • Pharmacies activate tele advice for medicine management and non-contact delivery mechanisms for patients • Continue with influenza vaccinations and primary care administered childhood immunisations, prioritising vulnerable populations • Implement pro-active support for non-health related welfare concerns

	Community Activities across Alert Levels
	• Deploy resource kit to support people with own wellbeing and welfare need
COVID-19 Community Severe Impact RED ALERT **Trigger Status summary: Community transmission/widespread outbreaks in your community; COVID-19 positive patients in your hospital, urgent care facilities and primary care at capacity, all available staff**	**Urgent care facilities and primary care at capacity, all available staff redeployed to non-deferrable care** • Activate additional plans as required at Community Red Alert • Streaming of suspected COVID-19 and non COVID-19 positive patients, either within or between facilities as agreed via local incident control • All patients with COVID-like symptoms referred to CBACs with assessment, testing, mobile medical teams and welfare responses located across districts with a focus on priority communities; • Expand whānau/community centred responses for priority populations ensure access to necessary care and equity • All clinical services triaged and limited to urgent non-deferrable care including acute, palliative • Non-essential delivery of care ceased. • Provide medical support to Palliative Care; Age Residential Care and Mental Health and Addiction support and pre-emptive care is in place for end of life patients. • Activate the plan for extended acute demand service available to manage people including extended large-scale illness and palliative care to all community facilities. • Activate the plan for all hospital activity that transfers to community options. • Identify and support high risk patients, those awaiting elective services which are postponed and those with chronic conditions • Pharmacies provide only tele advice for medicine management and non-contact delivery mechanisms for patients • Implement pro-active support for non-health related welfare concerns • Deploy resource kit to support people with own wellbeing and welfare need • Provider and team wellbeing support systems are proactive

The Incident Controller determines the alert level, in conjunction with advice received from the ECC.

Appendix C: Equity Access to Healthcare – Activities across Alert Levels

Table 7: Equity Activities across Alert Levels

	Equity of Access to Healthcare
Community Readiness **GREEN ALERT**	• Access to support, information and healthcare is prioritised for vulnerable communities. • Collaborative sharing of information in a number of different ways and languages, partnering with existing community networks. • Empowering community leaders and supporting their work with information and support. • Ensuring relationships and partnerships with iwi and hapū are prioritised and strengthened. • Planning for and setting up of any new systems, structures and services (including different ways of working for existing services) the needs of vulnerable communities are prioritised. • All points of contact with vulnerable communities including holistic welfare checks. • Accessible messaging about proactive wellbeing targeted at vulnerable communities. • Additional consideration and support for aspects of the response which have particular cultural lenses, e.g., self-isolating in homes with multi whānau, tangihanga guidelines, etc. • Supporting general practices and other healthcare organisations who have access to vulnerable communities. • Ensure healthcare workers who are targeted to work with Māori, Pasifika and other vulnerable communities have everything they need to continue to work.
Community Mild Impact **YELLOW ALERT**	• In addition to the above mentioned, focuses on equity, all new systems structures and services at yellow alert ensure equity of access to healthcare for vulnerable communities and peoples are prioritised.
Community Moderate Impact **ORANGE ALERT**	• In addition to the above mentioned, focuses on equity, all new systems structures and services at yellow alert ensure equity of access to healthcare for vulnerable communities and peoples are prioritised. • Collaborative and accessible information about what services are available. • Support for all providers to collaborate and collectively provide support to vulnerable communities. • Isolation may be difficult in crowded, multi-generational homes. May need to link with Civil Defence or other isolation facilities. • Culturally important practices such as tangi may be disrupted, causing significant distress. • There may be cultural differences in the way people interpret COVID-19 disease and the recommended infection control management practices. • Consider use of culturally sensitive language around Acute Plans and Advance Care Plans.
Community Severe Impact	• In addition to the above mentioned, focuses on equity, all new systems structures and services at yellow alert ensure equity of access to healthcare for vulnerable communities and peoples are prioritised.

	Equity of Access to Healthcare
RED ALERT	• Access to clear, up-to-date and collaborative information is available in a varied way to meet the needs of vulnerable communities. • Proactive, holistic welfare support for vulnerable communities are prioritised.

Appendix D: General Practice Role in the COVID Response

General practice teams must plan and be prepared for any health emergency or non-emergency scenario. Their emergency response and business continuity plans should dictate the actions of their team within their facility, determined by the event and guided by CPRG and the wider health sector.

General practice provides the first line of assessment in the COVID-19 pandemic and it is essential that they have planned and prepared for this role. An essential element of this is to limit the spread of any virus from those presenting with symptoms to other patients or staff.

Their critical functions during the COVID-19 response are:

- Assessing and testing symptomatic patients including in some cases the establishment and staffing of community-based testing and assessment centres and mobile services
- Streaming the flow of patients to limit cross infection
- Promoting protection and self-care
- Managing all other acute and chronic non-COVID care
- Providing infection prevention and control measures according to current rational use guidelines, e.g., PPE, hand-gel and signage
- Keeping updated on clinical guidelines as described in Community HealthPathways
- Participating in vaccination programme(s)
- Participating in reporting and data gathering as/if required.

Rural practices may require different supports, or their normal models of care may need to increase capacity. Rural practices typically work within wider health and welfare structures, including local government, Civil Defence, St John, Police and district nursing.

In this pandemic at Alert Levels 2, 3 and 4, many non-COVID related general practice in-person consultations have been replaced by virtual consultations, wherever possible. Symptomatic people may be seen in practice (or another location) for assessment and testing for COVID-19.

Clinical guidelines, including assessment, testing, and COVID-positive patient management plans, have been developed and documented in Community HealthPathways.

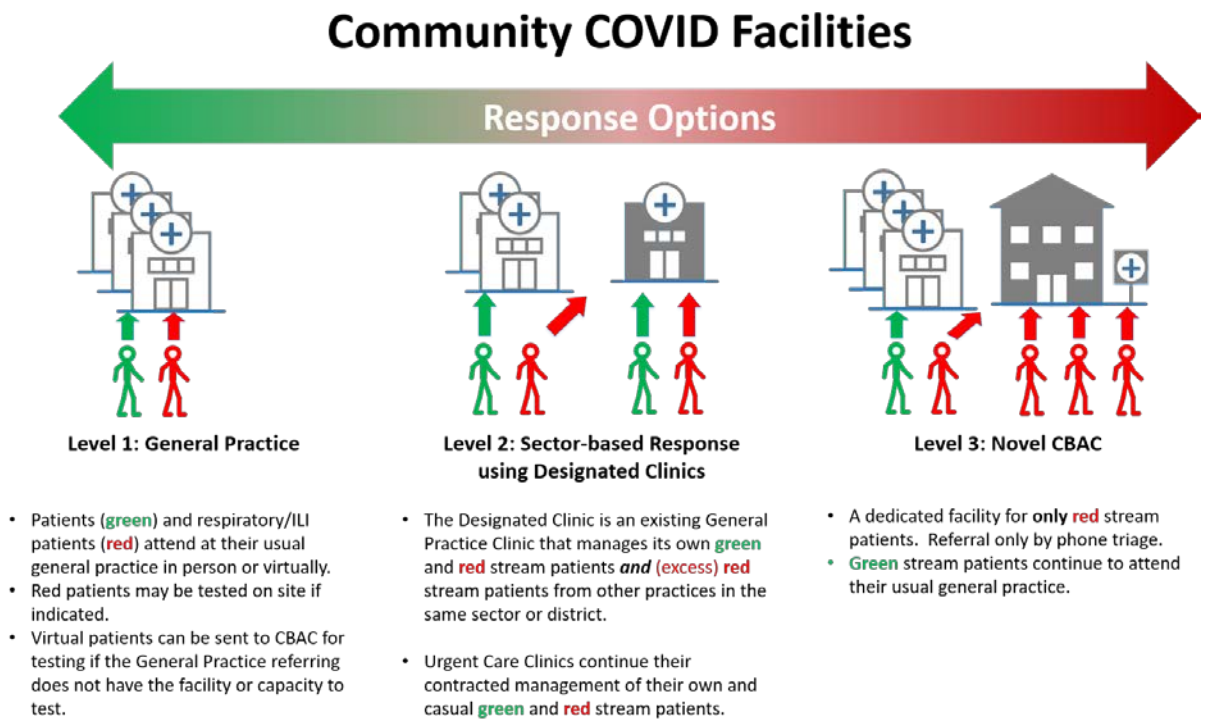
Subsidies have been agreed to support general practice assessment and testing of COVID-suspect patients. See Community HealthPathways.

General Practice Streaming – Managing Patient Flow Safely

Primary care should actively prepare their own facilities to cope with patients presenting with symptoms associated with any pandemic.

This planning should include screening business as usual presenting patients (Green stream) from those presenting with COVID-like symptoms (or exposure to COVID-19) (Red stream) to prevent the virus spreading.

Figure 3: Escalation of Community Response



The aim is to manage the response so we go no further to the right (above) than we have to, for no longer than we have to, with no more practices than we have to.

With the expected ongoing nature of the COVID-19 response, implementation locally of a 'pink stream' is under discussion, and if this, or another 'middle' stream national option is introduced, will be switched on and off depending on the local and national epidemiology as it would only be appropriate to use if COVID prevalence in the population is very low.

Figure 4: Streaming

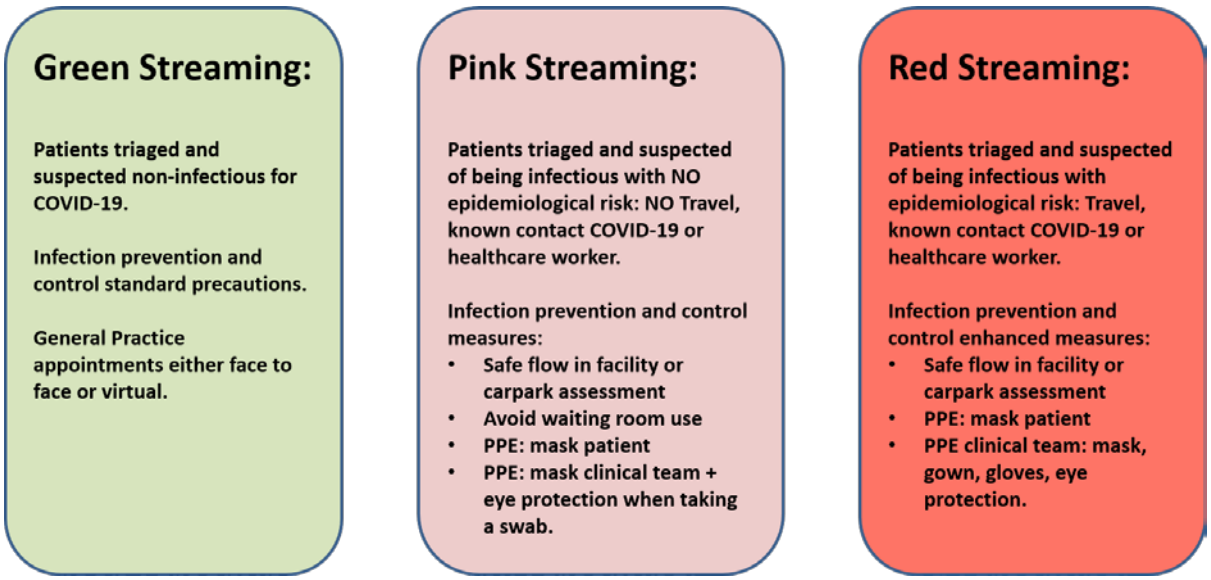


Table 8: General Practice Activities across Alert Levels

	General Practice
Community Readiness **GREEN ALERT**	Green Alert as we go backwards through the levels is not the same as Green Alert on the way up. Green Alert signals the 'New Normal' post COVID-19. It encompasses both a state of readiness to escalate up through the levels, and the embedding of the new way of delivering ongoing primary care with the advances we have made in virtual care, and the long term ongoing infectious risk. • All patients will be managed in general practice, with respiratory patients assumed not to have COVID-19 and managed with enhanced respiratory infection protocols which are embedded in the 'new normal.' • Full range of general practice care to be offered – manner of care may differ from pre-COVID-19. • Maintain readiness to move to higher alert level. • Maintain and expand virtual care systems and processes, e.g., remote practice access, logins for ARC prescribing, hardware/software for virtual care. Support and training for staff. • Focus on proactive care for vulnerable groups of people. **Practice systems and infection control** Streaming – practices will operate green and pink streams: • Testing – as directed by MoH – both symptomatic individuals (according to risk profile determined by MoH) and targeted asymptomatic surveillance testing. • Designated practices will operate higher capacity pink streams[4] to test and/or assess patients who cannot be accommodated in their usual general practice. • Novel CBACs (including mobile and pop-up CBACs) will operate in association with urgent care facilities to provide testing for surveillance, general practice overflow, and out of hours testing (at CBAC) and assessment if required (at after hours facility). Appointments: • General Practice will offer appointments in all streams - to be in-person or virtual depending on appropriateness. • Appointment booking – triage to assess virtual or in-person consult, possibly online questions (e.g. for online bookings) or phone triage by reception and/or practice nurse. Protocols for appropriate clinical situations for virtual consults. • General practice needs to remain aware that virtual services are a barrier to some patients who may need extra time or sensitivity when managing these services. • Consultations: o Virtual – training and guidance re documentation, managing storage of photos and/or recordings/ safety netting advice. o In-person – infection control, risk assessment. Management of health conditions: • Normal or near normal capacity in health system, usual management of most health conditions and referrals. • Management of COVID-19 suspected, confirmed and probable cases as per

[4] Under local discussion as at May 2020.

	General Practice
	MoH and local guidelines. Staffing: • General practice operates as per normal apart from potentially freeing some staff to operate in testing facilities. • Designated clinics and CBACs remain as predominantly testing centres with limited diagnostics and referral to general practice or after hours facility for management if required. • Staff to be vigilant with personal illness – staff should not be at work with ANY respiratory symptoms. Additional planning will be required to manage potentially higher rates of staff sick leave. Infection prevention and control: • Signage promoting hand hygiene, cough etiquette, door signs. • Hand hygiene for all, physical distancing in common areas, potentially infectious patients (respiratory, febrile, vomiting) separated from others, waiting in cars, use of technology to pre-assess/call people in from car/monitor post-immunisation, etc. • PPE use: o Green stream – consider surgical mask on patient, and surgical mask on clinician when within two metres. o Pink stream – surgical mask on patient and clinician, full droplet precautions when appropriate. If an aerosol-generating procedure is required (e.g. nebuliser) the use of an N95 mask as part of PPE is appropriate. **Vulnerable people** This section calls for proactive planning for patients and populations at higher risk of poor outcomes in COVID-19 pandemic, such as: • People vulnerable to poor health outcomes overall, related in part to poverty, poor housing, unemployment, lack of health literacy, serious mental health and addiction issues, and lack of connection to health and social services. • People with underlying conditions, including diabetes, heart disease, lung disease, hypertension, immunosuppression, and older age. • Māori and Pasifika populations. • People living in Aged Residential Care (ARC) and long term care facilities. Welfare: • Ensure practice systems are adequate to identify vulnerable people. • Proactively ensure contact details and NOK/whānau details are up-to-date. • Develop or update care plans or 'goals of care' documents; encourage vulnerable people to put EPOA in place. • Link patients to support networks where possible. • Information regarding welfare assistance available, in appropriate languages. • Develop and maintain practice relationships with community workers and any other appropriate local support agencies. Chronic disease management: • Acute and Personalised Care plans are up-to-date. • Optimal control of chronic condition is supported. • Adequate medication on hand, including 'back pocket prescriptions' where appropriate.

	General Practice
	• Prioritise for influenza vaccination. ARC and other facilities: • Liaise with facility regarding infection control protocols. • Care plans or goals of care documented and able to be seen across health system. • Ability to do virtual consults and e-prescribing in place and tested. • GP has RealMe profile and a back-up plan for GP cover for illness/quarantine in place.
Community Mild Impact **YELLOW ALERT**	Yellow alert may last for a significant period of time. Most respiratory illnesses will not be COVID-19, but the occasional case will occur – important to maintain heightened level of vigilance. • Full range of general practice services to be offered, with potential to defer these for unwell individuals. Manner of care may differ from previously. • Usual health care should NOT be deferred, although it may be appropriate to defer non-urgent care for patients with respiratory symptoms. • Maintain focus on access and proactive care for vulnerable populations. **Practice systems and infection control** Streaming – practices will operate Green, Pink and Red streams: • Testing – as directed by MoH to ECC/EOC and planned locally – likely to be all symptomatic individuals plus targeted surveillance. • Designated practices will operate higher capacity pink and red streams to test and/or assess patients who cannot be accommodated in their usual general practice. • Novel CBACs (including mobile and pop-up CBACs) will operate in association with urgent care facilities to provide testing for general practice overflow, and out of hours testing (at CBAC) and assessment if required (at after hours facility). CBACs will also provide targeted asymptomatic surveillance testing as directed by the Ministry of Health and local priority need. Appointments – systems as for Green Alert. Management of health conditions: • Normal or near-normal capacity in health system, usual management of most health conditions and referrals. • Management of COVID-19 suspected, confirmed and probable cases as per MoH and local guidelines. Staffing: • General practice operates as per normal apart from potentially freeing some staff to operate in testing facilities. • Staff to be vigilant with personal illness – staff should not be at work with ANY respiratory symptoms. Additional planning will be required to manage potentially higher rates of staff sick leave. Infection prevention and control: • Signage promoting hand hygiene, cough etiquette, door signs. • Hand hygiene for all, physical distancing in common areas, potentially infectious patients (respiratory, febrile, vomiting) separated from others, waiting in cars, use of technology to pre-assess/call people in from car/monitor post immunisation, etc. • PPE use:

	General Practice
	o Green stream – consider surgical mask on patient, and surgical mask on clinician when within two metres. o Pink stream – surgical mask on patient and clinician, full droplet precautions when appropriate. o Red stream – surgical mask on patient, full droplet precautions. If an aerosol-generating procedure is required (e.g. nebuliser) the use of an N95 mask as part of PPE is appropriate. **Vulnerable people** • Similar to plan for Green alert. • Vulnerable patients should be more cautious about exposure in the community, particularly high risk settings such as large social gatherings. • Consultations should be virtual unless there is significant advantage in seeing the person. • Careful management of chronic conditions is important to keep risk as low as possible. • Proactive engagement with vulnerable people and communities to enhance understanding of changes in health services and encourage active engagement in health care.
Community Moderate Impact ORANGE ALERT	Significant change of patient with respiratory symptoms having COVID-19, smaller but not insignificant chance that asymptomatic patients could also be infected. Significant risk or COVID-19 transmission in the general practice setting: • To patients from each other • To patients from staff • To staff from patients. In this context the benefit of reducing general practice in-person contacts is likely to outweigh the harm of deferred care. **Practice systems and infection control** Streaming – practices will operate Green and Red streams: • Testing – as directed by MoH to ECC/EOC and planned locally – both symptomatic individuals and targeted asymptomatic surveillance testing, including identifying and testing contacts. • Designated practices will operate higher capacity red streams to test and/or assess patients who cannot be accommodated in their usual general practice, and may offer limited assessment and initial management. • Novel CBACs (including mobile and pop-up CBACs) will operate in association with urgent care facilities to provide testing for surveillance, general practice overflow, and out of hours testing (at CBAC) and assessment if required (at after hours facility) . Additional novel facilities will be commissioned as appropriate - provide testing and may offer limited assessment and initial management. Appointments and management of health conditions: • Green stream care should be virtual as much as possible, and only acute or non-deferrable conditions that require examination or procedure should be seen in person. Remain cognisant that virtual services are a barrier to some vulnerable patients who may need extra assistance to access health care in this way. • Patients should be seen in person for: o Acute conditions which require examination

	General Practice
	o Acute minor surgery, e.g. skin wound or abscess o Routine care where delay may cause deterioration, e.g. heart failure management o Flu vaccination and early childhood vaccination o Potential malignancy, e.g. melanoma, SCC. • Management and referral of COVID-19 suspected, confirmed and probable cases as per MoH and local guidelines, including hospital admission and ICU care where appropriate. • If significantly reduced capacity in health system, deferral of care should be considered for: o Routine national screening programmes o Minor surgery other than melanoma and SCC o B12, alendronate and other non-urgent parenteral therapy o IUCD, Depo Provera, if other contraceptive options are available o Referral for non-urgent radiology and lab testing (may refer as normal, however, if deferrable, not all services will be provided). • Referral should continue for: o Acute or urgent care o Suspected malignancy or other non-deferrable condition o Specialist advice only o Mental health – brief intervention services may be available as virtual consults as will many other mental health services, depending on staff capacity o Non-urgent referrals to secondary care continue though not all services will be provided. Staffing: • Some staff working on site at General practices and some working remotely. • Practices consider splitting on-site staff into two teams with no physical contact between teams, to reduce the risk of large scale quarantine in the event of exposure. • Some staff released to work in CBACs. • Designated clinics and CBACs remain as predominately testing centres with limited diagnostics and referral to general practice or after hours facility for management if required. • Staff to be vigilant with personal illness – staff should not be at work with ANY respiratory symptoms. Additional planning will be required to manage potentially higher rates of staff sick leave. Infection prevention and control: • Signage promoting hand hygiene, cough etiquette, door signs. • Hand hygiene for all, social distancing in common areas, potentially infectious patients (respiratory, febrile, vomiting) separated from others, waiting in cars, use of technology to pre-assess/call people in from car/monitor post immunisation, etc. • PPE use: o Green stream – consider surgical mask on patient, and surgical mask on clinician when within two metres. If an aerosol-generating procedure is required (nebuliser) then the use of a N95 mask as part of

	General Practice
	PPE is appropriate. o Red Stream - Surgical mask on patient, full droplet precautions. If an aerosol-generating procedure is required (nebuliser) then the use of a N95 mask as part of PPE is appropriate. **Vulnerable people** PHOs will engage with community organisations to coordinate active engagement with vulnerable communities to encourage early reporting of symptoms, early testing, and effective isolation and quarantine strategies. They will also support linkages into any CDEM Welfare activity through the CDHB Welfare function. Practices and individual health care professionals will need to engage at a local level with community and health workers in their community. Potential for increased mental health supports to be needed as families may be impacted financially and emotionally. Practices need to be mindful of the barriers to the use of virtual consultation systems for some users, and to be persistent and patient in the use of these. ARC considerations: • ARC facilities will be 'locked down', causing distress to both patients and relatives. Practices will need to manage family and whānau expectations. • Some facilities may experience outbreaks, with profound effects on staff and patients. • Workload will vary but may be very heavy at times, and require large amount palliative care input – the availability of clinical support for the GP may be important. • Staff illness or quarantine may mean working with staff who are unfamiliar with the facility, the patients and the GP – good clinical documentation will be important in this situation. • Consider pre-emptive palliative care prescribing and medication availability. • Consider liaison with GP colleagues/PHO network to provide cover for ARC facilities. • Additional services by an expansion of usual services such as 24 Hour Surgery, Acute Demand Management Service (ADMS), CREST or a roster of GP/PN/Palliative care if needed.
Community Severe Impact **RED ALERT**	At Red alert the health system as a whole is severely strained. **Practice systems and infection control** Streaming – practices will operate limited Green and full Red stream processes: • Testing – as directed by MoH to ECC/EOC and planned locally – both symptomatic individuals and targeted asymptomatic surveillance testing, including identifying and testing contacts. • Designated practices will operate higher capacity red streams to test and/or assess patients who cannot be accommodated in their usual general practice, and may offer limited assessment and initial management. • Novel CBACs (including mobile and pop-up CBACs) will operate in association with urgent care facilities to provide testing for surveillance, general practice overflow, and out of hours testing (at CBAC) and assessment if required (at after hours facility) . Additional novel facilities will be commissioned as appropriate - provide testing and increasingly some assessment and management. Appointments and management of health conditions:

	General Practice
	• All available primary care resource will be used to manage acute primary care conditions (including COVID-19) and to support secondary care by managing many people in the community who would normally be admitted. This would entail an escalation of the ADMS system, using plans similar to the COVID-positive patient management pathway with additional facility space and clinical staff. • Routine care will be at a standstill, with all resource diverted to acute lifesaving care, relief of severe symptoms, or palliative care. This would require a shared workforce with district nursing, virtual input from the palliative care team, ARC team and facility with additional primary care support. • Community radiology and laboratory testing may be severely limited or unavailable except for priority cases. • Secondary care admissions will be available only according to capacity, ethical framework considerations and criteria which will be available at the time. • Virtual or in-person consultations, with or without referral to secondary care, will remain appropriate for: o Acute life threatening conditions e.g. acute exacerbations of asthma/COPD, CHF, chest pain, acute abdominal issues, GI bleed o Severe mental health conditions e.g. suicidality, psychosis o Urgent antenatal and postnatal care o Palliative care. • Virtual consults for less serious acute conditions e.g. skin infections, UTI, may be available as capacity allows. • Management and referral of COVID-19 suspected, confirmed and probable cases as per MoH and local guidelines, including hospital admission and ICU care where appropriate. • Community based care where hospital admission is unavailable – in conjunction with expanded community-based services such as 24 Hour Surgery, Acute Demand Management Service (ADMS), CREST or a roster of GP/NP/PN/Palliative care if needed. • Initiation and management of palliative care in patients for whom admission is unavailable or inappropriate. Staffing: • As for Orange level. Infection prevention and control: • Signage promoting hand hygiene, cough etiquette, door signs • Hand hygiene for all, social distancing in common areas, potentially infectious patients (respiratory, febrile, vomiting) separated from others, waiting in cars, use of technology to pre-assess/call people in from car/monitor post immunisation, etc. • PPE use: o Green stream – consider surgical mask on patient, and surgical mask on clinician when within two metres. If an aerosol-generating procedure is required (nebuliser) then the use of a N95 mask as part of PPE is appropriate. o Red Stream - Surgical mask on patient, full droplet precautions. If an aerosol-generating procedure is required (nebuliser) then the use of a N95 mask as part of PPE is appropriate.

	General Practice
	Vulnerable people • Vulnerable patients are likely to be severely affected. Many will not be good candidates for ICU care or ventilation and will need to be managed with palliative care in the community. • Availability of community nursing may be stretched and in many cases family may need to assist with nursing cares, potentially causing stress to both patient and family and increasing risk of transmission of COVID-19 within families. • Families may be stressed as they are unable to be with vulnerable family members due to lockdown. • Patients without family or friends may be dependent on community services and welfare organisations for assistance. • GPs will need to be prepared for palliative care in people's homes with appropriate packs of PPE and hand sanitiser for their cars, and adequate skills in donning/doffing and disposal of PPE in the home visit situation. • Additional cover by an expansion of usual services such as 24 Hour Surgery, Acute Demand Management Service (ADMS), CREST or a roster of GP/NP/PN/Palliative care if needed. • Palliative care medications need to be on hand. • Death certificates and cremation certificates are now able to be done online in certain circumstances. • Many community services will still be available, in person or virtually.

To support testing in the community, other structures have been established in the COVID response:

- Telephone Support
- Telephone Triage
- Designated Clinics, Community-based Assessment Centres (CBACs) and Mobile Testing Units.

Primary Health Telephone Support

To support the health system's activities, a special telephone line has been established. In COVID-19 the Ministry tasked the National Telehealth Service with providing the publicly accessible Healthline telephone service (0800 358 5453). This service developed algorithms to match the Ministry's case definition as well as respond to the public's concerns and need for clinical advice. (The national mental health helpline service is also available on '1737'.)

In Canterbury people have always been encouraged to ring their general practice in the first instance. If the practice is unable to answer their phone (i.e. closed, after hours or too busy), the phone is transferred to the National Telehealth Service, which provides a 24 hour nurse phone triage service.

Laterally Healthline was enabled to do 'warm handovers' to the CBAC telephone triage team. Callers to Healthline who met the criteria for COVID-19 were forwarded to the triage team and given the option of booking for a COVID test at a CBAC within 24 hours.

Telephone Triage Service

To enable access to designated clinics and the novel CBAC facilities, the Primary EOC established a local telephone triage service. General practices who are not swabbing patients can refer their symptomatic patient via ERMS to a CBAC. Healthline can also direct calls to the triage service.

Canterbury's telephone triage service is operating from Pegasus House on behalf of the Primary EOC by nurses and administrators to triage ERMS referrals and screen callers.

Patients meeting the case definition are contacted to make an appointment at a CBAC or designated clinic or given details of the walk-in Whānau Ora clinic, if they prefer. Patient details are entered into the Medtech PMS and they are given details of the location of the clinic.

The CBAC assesses the patient, does the test, and the swab is delivered to the lab. Negative test results are notified by the lab via the PMS back to the triage team who text the patient their results. (Positive cases are managed by Community & Public Health.)

The triage service capacity is scalable and will be determined by testing demand in the community.

Appendix E: Community-based Assessment Centre (CBAC) and Designated Clinics Planning

To support the assessment and testing of patients in the community, novel community-based assessment centres (CBACs) have been established and special arrangements (e.g., capacity contracts) for designated testing clinics have been undertaken with some general practices teams in both urban and rural settings. Mobile units have also been established with clinical staff to support testing elsewhere in the community.

CDHB have delegated the establishment and operation of designated clinics and CBACs to general practice and to be coordinated by the Primary EOC.

Ministry of Health Definition/Purpose:

The purpose of a CBAC is to provide additional primary-care capacity when there is a sudden increase in demand for primary care services.

CBACs will be facilities where staff can provide clinical assessment, advice, triage and referrals to other services. They will not provide in-patient or observation services, or operate as field hospitals.

Canterbury CBAC scope in the context of COVID19 (in current state of alert):

- Primary role: Creating testing capacity in the system.
- Secondary role: Assessment, triage and referral onto required services.

In the COVID-19 pandemic testing guidelines (the 'case definition') have been established by the Ministry of Health and have changed to meet the ongoing clinical description as more is known about the pathogen's infectiousness and virility.

Identified Need

- Provide testing capacity in areas and times based on data – at the height of CBAC utilisation, capacity was 250-300 daily on weekdays and 100 daily on weekends.
- Model needs to have scalability for a surge and flexibility in terms of meeting higher clinical needs, as required to support primary care.
- Patient-centred model – close to home and allow for variance, e.g., rural, ethnicity, deprivation.
- Welfare supports for vulnerable people.

Specialised or designated testing or assessment clinics were established when the risk of undetected COVID-19 positive cases in the community was identified. Government and Ministry expected testing to rapidly increase and facilities needed to be made available to test suspect patients across the region. The region also needed to be prepared for a high level of illness in the general practice teams due to risk of exposure to undetected cases, compounded by the onset of winter illness. In addition, an ongoing need to maintain surveillance in the community has required long-term access to testing.

Testing is done as part of a normal General Practice (i.e. streaming within the practice facility) or as an explicit response (streaming in a bespoke or alternate area of the practice, i.e., a portacom or in the carpark). Some practices have had a capacity contract arrangement to provide community-based testing for the wider community (this may be called a 'designated clinic'). Or a stand-alone static or mobile facility commonly referred to as Community-Based Assessment Centre (CBAC) has been warranted.

Clinical protocols and procedures were developed and reviewed. Equipment was procured from CDHB and hospital facilities and Ara Institute's simulation laboratories. Sites were made available by

CDHB and other agencies, including portacoms which were procured from local providers. (Community dental buses were also considered.) Modifications of facilities was provided by local contractors, facilitated by Civil Defence and TLAs. Organising and operationalising the CBACs was typically a joint effort amongst several different agencies.

CBACs are staffed by a combination of doctors (typically a general practitioner), administrators, nurses and security guards.

Designated clinics operating as CBACs have been supported in these areas in the COVID-19 response:

- Amberley – on the Amberley Medical Centre site
- Riccarton
- Halswell
- Rolleston

In addition to general practices testing patients and designated clinics, novel CBACs have been established for the COVID-19 response in key geographic areas to ensure appropriate access across the region. These have been set up in:

- Central city – at the old Ophthalmology Outpatients portacom on Hagley Ave
- Ashburton – on the Ashburton Hospital grounds
- Aranui – at the Community Dental Centre at Haeata Community College
- Rangiora – at the Waimakariri Hockey Turf
- Whānau Ora CBAC walk-in clinic established at Nga Hau e Wha marae in Aranui
- CDHB CBAC to assess and test DHB staff including ARC staff.

Walk-up testing capacity is also available at the 24 Hour Surgery, Moorhouse Medical and ED but these are not currently part of the CBAC network.

Access to CBAC

- GP referral via ERMS
- Healthline warm handover to telephone triage centre
- Whānau ora – drive up, walk up
- Mobile CBAC

To support the static clinics a mobile service has been developed. Mobile units support urban and rural testing.

The mobile service consists of a doctor and medical student or nurse or community worker in a car, or a team of clinicians and admin staff in a caravan. They are able to test people who are unable to get to their general practice or to a CBAC. The mobile unit can also be deployed to support testing at other facilities, such as aged residential care facilities.

A six-berth motor home has been rented to support pop-up and rapid response testing needs. The 'COVID Express,' was procured for the Ashburton area and provided testing capacity at community settings such as the local marae and a rugby field.

Areas to focus on asymptomatic testing have been directed by the Ministry of Health and Community and Public Health, as well as identified through primary data collection (EOC Intelligence function).

Staffing and rostering of clinical and administration staff at the CBACs has been a significant exercise, managed by the EOC HR function carried out by Pegasus HR managers. Offers for assistance were received by CPRG and expressions of interest were sought through normal general practice channels.

Issues

Novel CBACs are an expensive model:

- High staffing costs
- Leases, buildings, fit-out, servicing and IT to set up and manage
- Not connected to existing health services – increases potential risk and inhibits linkage into existing welfare and medical services.

Potential barriers to access:

- Appointment based model to manage flow and capacity
- Whānau ora model has demonstrated benefits of immediate access capacity and potential for welfare supports on site.

Variability in model of delivery leading to inconsistencies in capacity.

Not patient centred model:

- Potential barriers to access
- Not in familiar locations
- If illness other than COVID-19 identified, requires the patient to seek further input from GP or urgent care.

Equity and Welfare

After review, it is evident that the urgency of the clinical situation led to a lack of consultation around equitable access and delivery. Although significant thought and action around this has since been put in place, moving forward it will become an integral part of any decisions that are made.

After collaboration with population health leads, we have agreed a way in which welfare and social issues can be flagged during a CBAC visit, and referred to a single point of entry (with patient consent) to access community workers' support and referral on to appropriate services.

De-escalation

The current plan is to reduce the number of novel CBAC facilities and move the CBAC function into existing primary care services including urgent care clinics. This will:

- Make testing more patient-centred by being provided in familiar locations with familiar systems and locations.
- Support existing primary care model.
- Allow access to existing social and welfare supports.
- Allow access for non-enrolled people.
- Improve safety and reduce staffing cost as nurse-led testing and triage model will now be possible.
- Offer a more flexible model that can be scaled up or down in line with the health system response.

Mobile unit may continue to be deployed to provide rapid response for identified clusters and for reaching hard to access communities and groups.

The CBAC units must be balanced by geographical and population spread.

Escalation

The main CBACs will be situated at the three urgent care facilities in Christchurch. Additional CBAC capacity will be in designated practices with onsite medical capacity to see red and green stream patients. Hagley site will be available to increase testing capacity if required.

It will be important to differentiate the CBAC from the on-site medical facility. The CBAC should always be a transitional facility that supports the existing health system to the level required.

At higher levels of alert the CBAC transitions from a nurse-led testing and assessment facility to a clinician-led assessment and triage facility that can manage flow of patients and allocate patients to the most appropriate level of care available at that time.

Table 9: CBAC Activities and Triggers

Alert Level	Clinical Profile	Trigger (EOC Lead)
Green	• Testing and brief assessment. • Referral back to GP or existing services. • Nurse-led, clinician supported.	No community spread. Ongoing community testing. Supporting primary care testing capacity.
Yellow	• Testing and brief assessment. • Flex up in testing capacity as we move up in Alert Levels. • Referral to existing services including onsite medical facility. • Nurse-led, clinician supported.	Low levels of community spread. Maintain levels of community testing and support primary care to manage red stream patients.
Orange	• Assessment and triage +/- testing. • Triage according to community care plan to home, urgent care for acute treatment and streaming, hospital, home with palliative support. • Transition to clinician-led model.	Community spread. Primary care at capacity. Manage flow across whole of health system.
Red	• Assessment and triage. • Triage according to community care escalation plan (as in Orange) and streaming. • Designated facilities will be made available in the community if hospital capacity exceeded. • Clinician-led.	High levels of community spread. Whole of health system at capacity. Manage flow of patients to most appropriate stream of care available.

Appendix F: Community Pharmacy Role in the COVID Response

Community pharmacies contribute an essential function in the COVID-19 pandemic cycle and it is necessary that they plan and prepare for this role.

Their critical functions are:

- Ensuring pharmaceutical care is prioritised and maintained
- Protecting patient care through maintaining a secure supply chain and dispensing of medications
- Promoting protection and self-care of staff and customers
- Providing infection prevention and control measures, including operating procedures for managing patient flow, cleaning protocols and schedules, triaging, good hand hygiene, signage, etc.
- Promoting contactless dispensing such as e-prescription transmission and delivery of medications
- Keeping up-to-date with national and local guidelines for treatments and care via appropriate information sources such as Community HealthPathways
- Prioritising and maintaining the delivery of services such as Opioid Substitution Therapy (OST) and Community Pharmacy Anticoagulation Management Service (CPAMS)
- Collaborating with general practices to meet the shared needs of people including monitoring of medication therapy and point-of-care testing (e.g., blood pressure, blood glucose, weight checks, etc.)
- Delivering immunisation programme(s) collaboratively across the system with our populations
- Planned and proactive pharmaceutical care for specific populations including Māori, Pasifika, CALD, mental health clients, people with complex chronic conditions, people in ARC facilities and other vulnerable at risk groups
- Participating in mass community and public health programmes.

In this pandemic, community pharmacists and their staff have remained accessible to the public for their pharmaceutical care. To achieve and maintain their physical presence in the community they have implemented infection control measures, triaged people and changed workflows. Face-to-face contact has been minimised by deferral of non-urgent medication management services, increased electronic transmission of prescriptions, phone consultations and home delivery of medications. Patients accessing close contact services such as OST and CPAMS have been triaged so that only asymptomatic patients are seen within the pharmacy premises.

Prescribing and dispensing of medications have continued to be underpinned by legislative and regulatory frameworks with a shared responsibility between prescribers and pharmacists in meeting their legal obligations.

Table 10: Community Pharmacy Activities across Alert Levels

	Community Pharmacy
Community Readiness **GREEN ALERT**	Green Alert is the new normal post-COVID-19, where there are no known active cases in the community. • Signals a state of readiness in pharmacies to either escalate through the levels as required or continue to work and progress pharmacy practice in the community, using some of the workflows and infection control measures developed through the pandemic. • Examples include: virtual care, electronic prescription options and rationalising services.

	Community Pharmacy
	Service delivery • Pharmacies will be open and readily accessible to the public. • However, all consultations will require risk assessment and infection control procedures. • Respiratory patients are assumed not to have COVID-19 but will be managed with enhanced respiratory infection protocols (see infection control below). • At this level the full range of pharmacy services will be offered, including close contact pharmacist services such as CPAMS, Sildenafil, OST, selected oral contraceptives and vaccinations. • Medication management including the Long-Term Conditions Service (LTC), Medication Use Reviews (MURs) and Medication Therapy Assessments (MTAs) will continue to be encouraged throughout Canterbury to support adherence, best use of medicines and the long-term health of people. More use will be made of other forms of communication for medication management including phone calls and virtual consultation. However, pharmacies will be cognisant of vulnerable populations who may not be well connected and who may require face-to-face consultations. • Lifestyle interventions such as offering smoking cessation or dietary advice and/or navigation to other relevant services will continue to be made, alongside medication management. **Infection control** • Staff to be vigilant with personal illness – staff should not be at work with respiratory symptoms. Additional planning will be required to manage potentially higher rates of sick leave and lower staff levels. • Signage must be in place to manage and reduce staff and customer exposure to infection. Use door signs to promote hand hygiene, cough etiquette and physical distancing. • Pharmacy staff will initiate and/or maintain additional cleaning protocols, good hand hygiene and appropriate physical distancing within the pharmacy where possible. • Have masks, gloves, hand sanitiser and a specific cleaning kit available for appropriate use by staff and customers. • Screen all people with respiratory conditions with the following questions: o Ascertain if they are experiencing COVID-19 symptoms such as fever, cough, shortness of breath, loss of smell or sore throat. o Have they or someone they know travelled outside of NZ in the last 14 days? o Have they been in close contact with a suspected or positive case of COVID-19? • Direct people with COVID-19 symptoms for testing, depending on MoH guidance at the time. • Use the following enhanced respiratory infection protocol for all people entering the pharmacy with respiratory symptoms, who are therefore potentially infectious: o Customer to sanitise hands o Put on a mask o Separate them from other customers and staff o If the pharmacy staff member is unable to maintain a 2m distance

	Community Pharmacy
	from the customer, also wear a mask o Post-visit clean any surfaces touched by the person. **Planning to move to a higher level** Refer to the Community HealthPathways COVID-19 Pharmacy Staff page for more information: https://canterbury.communityhealthpathways.org/744116.htm • Appoint a dedicated pandemic staff member who keeps abreast of national and local guidance and who is responsible for sharing knowledge within the pharmacy team. • Educate staff on the use of PPE and infection prevention and control measures. • Plan for managing entry of people into the pharmacy when higher levels are reached. • Improve dispensary workflows with new electronic platforms. Maintain and expand virtual care systems and processes with support and training for staff. • Forward plan for prioritising prescriptions, managing and supplying repeats, and delivering of medications. • Plan for managing with lower staff levels. • Plan for what to do if the pharmacy needs to temporarily close, e.g. surge teams, team-viewer for dispensary staff in isolation so they can log into the pharmacy PC, etc. • Develop a resource kit for supporting staff through the pandemic including a key contact for HR issues. Include a plan for establishing communication systems for staff, e.g., a Whatsapp group. • Continue daily team meetings. • Develop plans with medical centres for shared care and e-communications. **People at risk of poor outcomes in the COVID-19 pandemic** These include: • Those with serious mental health and addiction issues including those taking Clozapine and OST • Those using the CPAMs service • Māori and Pasifika • Elderly, including people in Aged Residential Care (ARC) and long-term care facilities • Those with disabilities • People with underlying conditions, including diabetes, heart disease, lung disease, hypertension and those who are immunosuppressed • People at risk of poor health outcomes due to socioeconomic reasons (e.g., poverty, poor housing, unemployment), low health literacy and/or lack of connection with health and social services. Planning for at risk populations: • Identify at risk population groups • Develop medication management plans (e.g., goals of care through the LTC service) for people in these groups, which include planning for continued access to medications and close contact services at higher levels. • Keep contact details up-to-date including best ways to contact people virtually. • Prioritise these people for immunisation as per MoH guidance.

	Community Pharmacy
	• Develop plans, together with rest home service providers and medical staff, for care of patients in rest homes in the pandemic. • Identify and plan for meeting the needs of diverse populations, Maori, Pasifika, and CALD populations. • Identify support networks to refer people to within the community as appropriate.
Community Mild Impact **YELLOW ALERT**	At Yellow Alert where cases are quarantined in the community and contact tracing is active, most respiratory illnesses will not be COVID-19. However, the occasional case will occur. Therefore, there is a heightened level of vigilance, especially where the yellow alert level lasts for a significant length of time. This may happen particularly with increased travel. **Service Delivery** • Pharmacies will be open and readily accessible to the public. • All consultations will require risk assessment and infection control procedures. • Pharmacies will continue to provide close contact pharmacy services. • These services, including the LTC service, MUR, MTA, CPAMS, smoking cessation, immunisation and OST should in general not be deferred. However, defer or make alternative arrangements for patients with respiratory symptoms. • Adjust medication supply services through management of repeats and increased delivery services and/or family pick up. Consider prioritisation of prescriptions and supply of medications. • Under Yellow Alert normal clinical monitoring of Clozapine should be maintained. • More frequent virtual (where possible) contact should be made with at risk populations particularly those the pharmacy has enrolled on the LTC service, those who have limited contact with other health professionals, or those with mental health and addiction issues, to ascertain well-being and refer to their GP or social service as necessary. • The use of online tools for managing e-prescriptions and prescriber and consumer communications should be increased. **Infection Control** • Staff to be vigilant with personal illness – staff should not be at work with respiratory symptoms. • Consider staggering staff breaks and run two shifts if possible. • Signage must be in place to manage and reduce staff and other customers' exposure to infection, which includes guidance on if/how to enter the pharmacy, physical distancing, and infection control measures to be used in the pharmacy. Phone numbers should be included for Healthline and the pharmacy. • Maintain appropriate physical distancing within the pharmacy (1 metre between staff and 2 metres between customers and/or staff). • Rearrange the pharmacy environment to manage staff and patient flow, e.g., floor markings and the use of counter shields. • Have masks, gloves, hand sanitiser and a specific cleaning kit available for appropriate use by staff. • Pharmacy staff to maintain good hand hygiene and increase regular cleaning

	Community Pharmacy
	and disinfecting schedules. Particular attention to be given to high touch surfaces such as door handles and EFTPOS terminals. • Provide hand sanitiser for the public to use before entering and when leaving the pharmacy and have masks available for symptomatic patients. • Triage all people with respiratory symptoms before entry to the pharmacy. It may be appropriate for people to ring from their vehicle. • Those with COVID-19 symptoms should be given a mask not enter the pharmacy, and be directed to be tested. If triage staff cannot keep a 2 metre distance they should also wear a mask. • If a patient with respiratory symptoms enters the pharmacy through unforeseen circumstances or where they have a negative COVID-19 test results, follow the Enhanced Respiratory Infection protocol under Green Alert. • For at risk people, consider consulting while they remain in their vehicle. **Activating plans** • All staff should be aware of where the PPE decontamination kit is kept and what to do if a consultation room is contaminated by a person who could potentially have COVID-19. See Community HealthPathways COVID-19 Pharmacy Staff page for more information. • Activate priority plans for if staff are away, i.e. managing with a lower staff level, employing locums, or the need for a locum surge team. • Activate plans with local general practice teams, ARC facilities, secondary care (where applicable) to deliver shared care, manage e-prescriptions and e-communications. • Activate plans for at risk populations. • Activate staff care resources. • Continue with daily team meetings, in person or virtually, with updates driven by the dedicated pandemic staff member.
Community Moderate Impact ORANGE ALERT	At Orange Alert level, significant risk exists for both staff and people coming to the pharmacy of COVID-19 exposure with multiple clusters in the community. **Service Delivery** • Pharmacies, including extended hours pharmacies, will operate from a closed and/or triaged door. • Dispensary workflow will be rearranged concentrating on management of e-prescriptions, prioritising supply for acute patients, and forward planning through the utilisation of bulk text systems, telephone calls etc. to manage supply and delivery of repeat prescriptions. • Dispensary systems to also manage regulatory and legislative requirements related to the supply of controlled and non-controlled medications. • Medication advice will continue to be given by telephone or virtually where possible. However, in person adherence services such as the Canterbury Medication Management Service will be deferred. • Close contact services will be deferred where possible. • Vaccinations will still be given to people who are asymptomatic. However, measures will be taken to minimise risk, such as handwashing before and after vaccination, asking the patient to turn their head away and vaccination in cars. Refer to guidance at the time from the Immunisation Advisory Centre (IMAC).

	Community Pharmacy
	• Pharmacies will collaborate with GP surgeries re the frequency of INR testing for asymptomatic patients. If patients have respiratory symptoms, they are referred to their GP surgery or other testing facility. • Pharmacies will work with CORS and where appropriate the number of takeaway doses for OST are increased and pharmacists are given discretion to choose which days these takeaway doses are used in collaboration with the patient. • Clozapine blood testing may be deferred by the prescriber in certain circumstances. However, pharmacists should remain vigilant to the possibility of infection and blood dyscrasias. • Pharmacies to continue with daily team meetings, if necessary by virtual means, with updates driven by the pandemic team member. **Infection Control** • Staff to be vigilant with personal illness – staff should not be at work with respiratory symptoms and be referred to Healthline or their GP for testing. • Vulnerable staff members, e.g. those who are immunocompromised or pregnant staff should not be working and supported through their annual and/or sick leave as well as wage subsidies. • Stagger staff breaks and split into two shifts if possible or keep one staff member separate from the team to coordinate a locum surge team if necessary. • Operate from a closed or triaged door. Hatches may be employed for contactless service. However, paper prescriptions will be actively discouraged. • Provide cones and barrier methods for crowd control both inside and outside the pharmacy. • Contactless payment should be used where possible. • Prominent signage outlining the triage procedure must be in place to manage and reduce staff and customers' exposure to infection. Include phone numbers for Healthline and the pharmacy and guidance on infection control measures if entering. • Maintain appropriate physical distancing within the pharmacy (1 metre between staff and 2 metres between customers and/or staff). • Rearrange the pharmacy environment to manage staff and patient flow, e.g., floor markings and the use of counter shields. Rope off, cover and/or move retail stock to prevent customer self-selecting. • Have masks, gloves, hand sanitiser and a specific cleaning kit available for appropriate use by staff. • Pharmacy staff to maintain good hand hygiene and increase regular cleaning and disinfecting schedules, e.g., cleaning should occur at least every four hours, between shifts, and every hour on high touch surfaces such as door handles. More frequent cleaning may be required between customers. • Provide hand sanitiser for the public to use before entering and when leaving the pharmacy and have masks available for symptomatic people. • Triage all people according to the MoH case definition and guidance around close contacts at the time. However, at this level it is expected that additional questions will be asked as to whether people are in close contact with others who are symptomatic and/or are being tested for COVID-19, and if so, they will not be able to enter the premises. Suggest that people ring from their

	Community Pharmacy
	vehicles. • If triage staff cannot keep a 2 metre distance they should also wear a mask. • Those with COVID-19 symptoms should not enter the pharmacy and be directed to be tested. • If a patient with respiratory symptoms enters the pharmacy through unforeseen circumstances or where in an exceptional circumstance a pharmacy service is provided for a person with suspected, probable or confirmed COVID-19, follow the PPE guidance for cleaning and disinfection on the Community HealthPathways COVID-19 Pharmacy Staff page. • For at risk people, consider consulting while they remain in their vehicle. **Activating plans** • All staff should be aware of where the PPE decontamination kit is kept and use this if an area is contaminated or if staff have respiratory symptoms and need to stand down (necessitating a decontamination clean). • Have in place an ordering and distribution system for PPE. • Activate priority plans if staff are away, i.e. managing with a lower staff level, employing locums, or the need for a locum surge team. • Activate planned care in collaboration with wider primary care and the social sector reaching at risk populations with need for pharmacy services. • Activate enhanced delivery options for prescriptions. • Activate plans for at risk populations and specific communities e.g. Māori/Pacific, CALD. • Activate staff care resources. • Continue with daily team meetings, in person or virtually, with updates driven by the dedicated pandemic staff member.
Community Severe Impact **RED ALERT**	At Red Alert level there is extreme risk of infection to staff and people accessing pharmacy services, with widespread COVID-19 in the community. **Service Delivery** • The pharmacy is closed and there is no direct contact with people coming to the pharmacy. • Medications will be dispensed from a closed door with non-contact delivery to the patients' addresses. • Close contact services will be deferred, or if required (e.g. OST) or urgent, delivered by mobile medical/pharmacy teams and welfare organisations with appropriate PPE. • Alternatively, close contact pharmacy services will be delivered through novel clinics or CBACs with appropriate PPE and cones and barrier methods for crowd control. • Urgent medication advice can be given by telephone or by virtual consults. • Vulnerable patients in the community to be proactively followed up by pharmacy staff through phone calls or virtual care and referred to their GP or other medical or social service provider as needed. • Plans activated for pharmacy management and staff welfare as above. **Infection Control** • Staff to be vigilant with personal illness – staff should not be at work with respiratory symptoms and be referred to Healthline or their GP for testing. • Vulnerable staff members, e.g., those who are immunocompromised or

	Community Pharmacy
	pregnant, should not be working and should be supported through their annual and/or sick leave as well as wage subsidies. • Operate from a closed door. Hatches may be employed for contactless service. • All prescriptions need to be transmitted electronically. Controlled drugs will be managed according to MoH guidelines at the time. • Contactless methods of payment to be used. • Prominent signage outlining that the pharmacy is operating from a closed door must be in place to manage and reduce staff exposure to infection. Include phone numbers for Healthline and the pharmacy, • Maintain appropriate physical distancing within the pharmacy. • Have masks, gloves, hand sanitiser and a specific cleaning kit available for appropriate use by staff. • Pharmacy staff to maintain good hand hygiene and increase regular cleaning and disinfecting schedules, e.g., cleaning should occur at least every four hours, between shifts, and every hour on high touch surfaces such as keyboards and phones.

Appendix G: Primary EOC Functions in the COVID Response

The Primary EOC is led by the Incident Controller, with the responsibility of leading, planning and coordinating primary care emergency response activities within the CDHB region to minimise the health impact of the pandemic emergency. This role is informed and supported by the clinical direction and leadership to the EOC team, typically a member of the Canterbury Primary Response Group (CPRG) or appointee.

Roles and positions in the Primary EOC structure have been activated and will be maintained to meet the needs of the evolving situation and the availability to resource positions – staff may be deployed from any of the partner organisations and may need to return to their usual roles at any time.

Functions in the COVID Response:

- Incident Controller
- Clinical Leadership
- EOC manager
- Comms
- Advisory Group: General Practice, Nursing, Pharmacy, Equity, Technical, Community & Public Health and Labs, Primary-Secondary Integration (Canterbury Initiative)
- Ops Manager
    - Urban CBACs
    - Rural CBACs
    - Telephone Triage
    - IT
- Finance & Risk manager
- Single-point-of-contact team
- Logistics manager and team
- Planning & Intelligence manager
- HR manager

See the CPRG Emergency Plan for position descriptions for each role.

Table 11: Primary EOC Activities across Alert Levels

	Primary EOC
Community Readiness **GREEN ALERT**	• Staff appointed to EOC functions in part-time capacity • CIMS training delivered for appointed staff and annual exercises • Technology to support the EOC reviewed and maintained • Contacts maintained; distribution lists maintained • CPRG phone and email monitored • Dashboard tool reviewed; processes reviewed and make required improvements (consider moving to Office 365; review tools available) • PPE supply agreements in place • MoU between CPRG, Pegasus and funder in place • Regular meetings held with key stakeholders in emergency planning/response and influenza/pandemic • General practice and community pharmacy business owners supported to review and update emergency and business continuity plans • Regular liaison with lab and Community & Public Health staff to monitor testing volumes and outcomes

	Primary EOC
	• Escalation plans for designated clinics and CBACs reviewed; key practice sites and urgent care clinics in regular communication • National Telehealth Service in regular communication; reports monitored • Debrief from current pandemic response and lessons applied • HealthPathways content reviewed against current status • EOC team to meet once a week to maintain oversight of the situation
Community Mild Impact **YELLOW ALERT**	• EOC Team mobilised to assume roles identified as necessary; Incident Controller assumes control • EOC meeting schedule established • Primary care needs identified; survey status of general practice and community pharmacies • Funder engaged in planning, budgeting and forecasting • Reporting to ECC initiated/maintained • CBAC plans activated; deployment of clinical staff into CBACs prepared; staff recruiting begins and contracts arranged; Police checks • Māori and vulnerable community leaders engaged • Website updated; relevant information sent out to stakeholders; HealthPathways clinical editing team engaged
Community Moderate Impact **ORANGE ALERT**	• EOC team fully engaged in EOC roles; two teams model employed • Daily liaison with ECC via Zoom or teleconference facility; regular reporting • Incoming intel collated and disseminated; internal EOC reports initiated • Expressions of interest for locums, pharmacists, technicians, and nurses to fill general practice and community pharmacy vacancies • Rosters established across EOC; CBACs, etc. • Any ERMS and ePortal special tools activated with current codes, funding, etc. • Funder engaged in planning, budgeting and forecasting • Website content monitored daily; relevant information sent out to stakeholders; HealthPathways clinical editing team engaged
Community Severe Impact **RED ALERT**	• All non-essential staff work from home; non-essential work ceases • EOC team wellbeing monitored and replacements trained if required • Monitor hospital and community activity • EOC team may need to work remotely

A plan for a transitional EOC has been developed. The transitional team consists of:

- Clinical Leads – supporting both clinical direction and clinical operations
- Equity Lead
- EOC Manager
- Operations & Logistics – oversight of CBAC ops, telephone triage team, logistics

This team will meet weekly with staff from labs, Community & Public Health, ECC/CDHB, and HealthPathways until such time as the 'emergency' period either returns to business-as-usual, or the threat is deemed to be manageable with existing structures.

This transitional EOC has some key tasks:

- Maintain operations such as CBACs, telephone triage team until such time they need to be decommissioned
- Plan for and respond to ongoing general practice, urgent care clinics, and community pharmacy COVID-related needs including PPE
- Respond to incoming queries; maintain website; prepare comms as required
- Monitor the situation
    - manage phased reduction in EOC operations including CBACs;
    - identify any increasing risks
    - prepare to escalate if community transmission increases and Alert Level changes
- Review the plan; modify as needed
- Identify and deliver ongoing reporting needs
- Arrange the COVID debrief exercise; identify lessons; celebrate successes
- Identify and act on improvements required including EOC dashboard; make recommendations to CPRG or other organisation re next steps post-COVID
- Document processes, tidy up records
- Monitor expenditure
- Liaise with CDHB, ECC and PHOs as required
- Work with CPRG re contributing to planning for future emergency/pandemic responses.

Out of Scope

- General Practice contact and support, other than COVID-related, will revert to Recovery functions within each PHO.
- CCPG will be responsible for their normal ongoing relationships and responsibilities with community pharmacies, etc.
- CPRG will be responsible for ongoing pandemic, influenza and emergency planning.

Plans for each EOC Role follow.

Logistics Function

In the COVID-19 response Logistics have primarily been focussed on supporting general practice, community pharmacy, urgent care facilities and CBACs (predominately novel and mobile) with the supply and distribution of PPE and hand gel. PPE in this case includes surgical masks, gloves, gowns and eye protection/goggles. Despite significant demand for N95 masks, supplies were unavailable and surgical masks were deemed sufficient for droplet precautions.

Supplies were generally obtained via ECC Logistics from CDHB Supply including utilisation of aged pandemic stock (gowns, hand sanitiser and masks) held on behalf of Pegasus/CPRG. Pandemic stock (excluding gloves) which had expired was clinically assessed and efficacy assured prior to use or distribution. At times stock was limited and difficult to obtain with several discussions held during the pandemic early days. Alternative supply lines were utilised to ensure resources were available to maintain service delivery (e.g. face shields).

Logistics are heavily involved in sourcing equipment, medical supplies and consumables to establish and maintain the novel and mobile CBACs, often at short notice as testing strategies and priorities changed.

- A PPE policy has been produced to support the Logistics team's position on what type of PPE was appropriate and how much was able to be distributed, to whom. [link to PPE policy]

- Guidelines on donning and doffing PPE were updated upon advice from Infection Prevention & Control experts.
- An online ordering system was developed and made available to general practice and community pharmacy teams: https://www.primaryhealthresponse.org.nz/personal-protective-equipment-online-request-form/
- Orders were collated and provided to the Logistics team by the Admin team from the website tool twice daily.
- Special GP kits supporting doctors visiting ARC facilities were developed and distributed on request.
- PPE and a cleaning kit for community pharmacy was also prepared and distributed.

Table 12: Logistics Activities across Alert Levels

	Primary EOC: LOGISTICS
Community Readiness **GREEN ALERT**	• Review pandemic stocks and re-supply as appropriate • Maintain PPE appropriate use guidelines • Re-establish standard supply lines for General Practice/Urgent Care and Pharmacy for PPE and cleaning consumables and other daily requirements • Support Surveillance testing with equipment and PPE as required • No dedicated Logistics team
Community Mild Impact **YELLOW ALERT**	• Implement PPE Supply process and procedures • Assign Logistics role • Identify dedicated resources to manage Logistics activities • Open supply lines with ECC Logistics and DHB stores for PPE and other consumables • Identify alternative supply lines for restricted items (example, face shields) • Support establishment of novel CBACs with PPE and other equipment • Support operation of novel CBACs • Align Community HealthPathways, CPRG site and Allied Healthways regarding ordering and access to PPE • Implement ordering and distribution process for Urgent Care Clinics, General Practice, and Community Pharmacy.
Community Moderate Impact **ORANGE ALERT**	• Build further stock levels of essential PPE equipment within primary care logistics function to enable urgent supply and responsiveness • Dedicated Primary Care Logistics team established – consider two separate teams • PPE ordering by Urgent Care clinics, General Practice and Community Pharmacy fully operational. • Novel and mobile CBACs PPE and other consumables managed • Community based COVID-19 care roles supported with PPE e.g. Acute Demand service, GP kits for visiting residential care etc. • Transition to proactive PPE supply arrangements to general practice, Community Pharmacy and Urgent Care Facilities.
Community Severe Impact **RED ALERT**	• Parallel Logistics teams implemented to support sustainability and risk of transmission. o Additional logistics team members identified and trained o Specialist functions supporting PPE, general CBACs and other logistics

	Primary EOC: LOGISTICS
	requirements • Extended Logistics supporting general practice and Community Pharmacy with addressing conventional supply chain requirements • PPE stock levels actively maintained and reported • Any identified PPE supply constraints escalated rapidly to appropriate groups • Align with national purchasing, supply and reporting as required.

Intelligence Function

The Primary EOC was requested to provide daily SITREPs to the ECC. Activity was documented from the daily EOC team meetings. Testing volume data was collected from the CBACs.

Reporting to the EOC team was created to reflect testing volumes as well as demographics of people being tested. Lab data was matched with patient demographics to identify gaps in testing by ethnicity and by geographic location.

Incoming intelligence reports such as MoH and CDHB Situation Reports (SITREPs) were received, although these were not originally received regularly.

Table 13: Intelligence Activities across Alert Levels

	Primary EOC - INTELLIGENCE
Community Readiness **GREEN ALERT**	• Continue to monitor lab results for new COVID-19 cases. Report to EOC any identified cases as soon as possible. • Weekly status reporting. • Refine CBAC Patient Management System to ensure it aligns with: o Canterbury DHB requirements (lead organisation for file submission) o The HISO 10082-2020 COVID-19 Community Based Data Standard o COVID-19 CBAC File Specification • Maintain systems and processes to enable timely reporting of CBAC activity reporting. • Maintain templates for primary care situation analysis. • For new situations, plan for what data requirements are likely to be needed and seek the relevant sharing permissions and agreements.
Community Mild Impact **YELLOW ALERT**	• Daily SITREPs to ECC and Primary Care situation analysis reports produced on a daily basis. • Commence daily reporting of CBAC activity aligned with: o Canterbury DHB requirements (lead organisation for file submission) o The HISO 10082-2020 COVID-19 Community Based Data Standard o COVID-19 CBAC File Specification • Commence daily reporting associated with lab testing including: o Test sources o Geographic location of tested patients o Geographic locations of positive results • Review planning for implementing intelligence gathering to identify issues associated with general practice and community pharmacy operational

	Primary EOC - INTELLIGENCE
	capacity and capability. • Enact data sharing processes – set up data feeds, automate as much as possible.
Community Moderate Impact ORANGE ALERT	• As per yellow. • Expand reporting to provide a focus on health inequalities relating to access to testing and care • Implement plans to gather general practice and community pharmacy operational capacity and capability intelligence.
Community Severe Impact RED ALERT	• As per orange. • Double-check the frequency of reporting – is more frequent reporting (than daily) required?

Examples of INTEL reports are available.

HR Function

The HR function is responsible for the staffing and wellbeing of the EOC team as well as recruiting and employing clinical and administration staff to support testing in the community as required. This latter role was supported by nursing leaders within the PHOs.

Table 14: Human Resource Activities across Alert Levels

	Primary EOC – HUMAN RESOURCES
Community Readiness GREEN ALERT	• Staff appointed to EOC functions and contacts maintained • EOC plan and escalation plans for designated clinics, community based assessment centres (CBACs), mobile units, whānau/community centres responses are reviewed to understand and plan for the necessary operational HR support requirements and HR resourcing. Also consider changes required during the higher escalation levels. • Employment Agreements and Contract for Service: Documentation reviewed to ensure compliance and relevance, including positon descriptions and other terms such as rates of pay by role and travel etc. • Recruitment: Identify clinical and administration staff who could be immediately deployed to establish CBACs etc. • Onboarding: Developed and in place for EOC and CBACs etc. • Health and Safety: Policy and procedures are reviewed to ensure compliance to Health and Safety at Work Act • Systems review: Budget; Payroll; Reporting requirements • Wellbeing: Resource kit developed for supporting the teams with own wellbeing and welfare need
Community Mild Impact YELLOW ALERT	• Staffing: EOC team mobilised to assume roles; Incident Controller assumes control. • Recruitment: Deployment of clinical staff into CABAC's prepared; work with Clinical Leads and Ops to determine staffing models; communication launched for expressions of interest for roles; interested people contacted and screened (interviews if required) and offered roles • Onboarding: Agreements issued and processed along with police checks; APC

	Primary EOC – HUMAN RESOURCES
	and any other necessary screening • Rostering: Advised on the staffing model (mix) requirements and opening hours of each service, rosters development and communicated; ensure staff rosters enable sufficient breaks • Health and Safety: Continuous review of guidelines from the Ministry of health and safety of workers (including "vulnerable" workers). Ensure H & S processes are implemented for each service and location. • Wellbeing: Deploy resource kit to support teams with own wellbeing and welfare need • Systems: Implement systems to validate hours to ensure accurate staff payment (via payroll or finance), reporting
Community Moderate Impact ORANGE ALERT	• Staffing: EOC team fully engaged in EOC roles; two team model implemented across all teams in the EOC. Roles maintained to meet the needs of the evolving situation. Staff may be deployed from any of the partner organisations and balance the need to return to their usual role at any time. • Recruitment: Continue to support expansion of CBAC's in multiple locations, mobile teams for immobile, to vulnerable and priority populations; plus any other new service requirements. Liaise with all PHO's to access available clinical and non-clinical staff. • Onboarding: Staff continue to be onboarded appropriately and safely. • Rostering: Continue to evolve and respond to the staffing models across locations and services. • Health and Safety: Continuous review of guidelines from the Ministry for health and safety of workers (including "vulnerable" workers). H & S audits in place. • Wellbeing: Deploy resource kit to support teams with own wellbeing. Wellbeing check-ins. • Systems: Implement systems to validate hours to ensure accurate staff payment (via payroll or finance), reporting
Community Severe Impact **RED ALERT**	• Staffing: EOC team fully engaged in EOC roles; two team model continues. Continue to balance the staffing needs of the EOC and individuals' usual roles. Wellbeing monitored and replacements identified and trained as required. • Recruitment: Continue to support needs liaising across the system to recruit. All non-essential work ceases therefore possible broader pool of people to recruit from. Expressions of interest for locums, pharmacists, technicians, and nurses (secondary care) to fill primary care general practice and community pharmacy vacancies. • Onboarding: Staff continue to be onboarded appropriately and safely. • Rostering: Continue to evolve and respond to the staffing models across locations and services. • Health and Safety: Continuous review of guidelines from the Ministry for health and safety of workers (including 'vulnerable' workers). H & S audits in place. • Wellbeing: Deploy resource kit to support teams with own wellbeing. Wellbeing check-ins. • Systems: Implement systems to validate hours to ensure accurate staff payment (via payroll or finance), reporting

Communications and the Single-Point-of-Contact Functions

The single-point-of-contact (SPOC) function in the COVID-19 response has been the hub and central point of all incoming emails and phone calls from a variety of different sources, from all levels of the CIMS structure hierarchy.

Emails come to the EOC as requests, SITREPs, intelligence, operations, planning and general queries at various levels:

- National level – NHCC, CDEM, MoH
- Regional level – CDHB ECC, other EOCs
- Primary EOC – all EOC functions and PHO partners and partner organisations
- Primary and Community Care – general practice, community pharmacy, allied health providers and community providers, and the public.

Incoming emails are forwarded to the appropriate function within the EOC team and are logged in the EOC SharePoint dashboard.

SPOC has been the hub for all outgoing CPRG Comms updates and has also been the central point for the collation, administration and distribution of daily EOC meetings and meeting minutes. SPOC has supported the communications processes and digital innovations have been required to support the EOC logistics function for PPE requests. Website development (www.primaryhealthresponse.org.nz) work was undertaken to support the user experience. Content was monitored and updated daily.

The Pegasus intranet (SharePoint) Dashboard and Contact Centre was adapted and customised to fit the requirements of the COVID-19 response. All queries are logged and exported to Excel spreadsheets. The Dashboard is visible to all EOC managers and is a continuing work in progress – improvements must be made. The future direction is to interface with CDHB ECC Office 365 SharePoint platform and Justice Precinct-based agencies such as Civil Defence and St John Ambulance.

Microsoft Teams was set up as an adjunct to access clinical support but this was not ultimately widely used as not everyone in the team had access to the software.

The Comms function in the Primary EOC managed all the media requests to the primary EOC as well as the liaison role with the CDHB Comms function and ECC PIM function. Comms supported the development of local advertising for rural testing as well as consulted on comms aimed at the urban sector.

Table 15: Comms & SPOC Activities across Alert Levels

	Primary EOC – COMMUNICATIONS & SINGLE-POINT-OF-CONTACT
Community Readiness **GREEN ALERT**	• Telephone and email inbox accessible to key staff. • Staff monitor EOC queries but predominately focussing on BAU activity. Queries responded to within 24 hours. • Community HealthPathways and HealthInfo content updated as required. • Website content monitored for relevancy. • National and local media events monitored to be aware of any changes in alert status. • Review EOC communications methods and protocols. System improvements made where necessary. • All media requests managed promptly in liaison with CDHB Comms.
Community Mild Impact	• Staff assigned to monitor EOC inbox and telephone. Queries responded to within 8 hours. • EOC team meetings established.

	Primary EOC – COMMUNICATIONS & SINGLE-POINT-OF-CONTACT
YELLOW ALERT	• CPRG website content updated. • Make any modifications necessary to communications methods to meet the need of the response. Establish EOC team communications links and ensure agreement of methods to be used. • Reporting requirements identified and EOC reporting begins or is maintained. • General practice and community pharmacy status check scheduled. • Ongoing liaison with CDHB ECC; ECC Public Information Manager (PIM) functions. • Community HealthPathways and HealthInfo content updated as required. • Production and distribution of CPRG updates to primary/community as required. • All media requests managed promptly in liaison with CDHB Comms.
Community Moderate Impact ORANGE ALERT	• Staff assigned to actively monitor EOC inbox and telephone. • Clinical supports in place to respond to queries. • Queries responded to within 4 hours. • Regular contact with ECC and PIM roles to address communication needs in the community. • Contact with Canterbury Initiative for production of content and uploading of clinical guidance to Community HealthPathways and HealthInfo as required. • Daily review of CPRG website content. • Production and distribution of CPRG updates to primary/community as required. • All media requests managed promptly in liaison with CDHB Comms.
Community Severe Impact **RED ALERT**	• Staff assigned to actively monitor EOC inbox and telephone. • Clinical supports in place to respond urgently to queries. • Queries responded to ASAP. • General practice and community pharmacy status checks – feedback collated. Daily SITREPs to EOC controller for review and sign off (INTEL sends to ECC). • Twice daily review of CPRG website content. Monitoring of Ministry of Health and other relevant websites. • Production and distribution of CPRG updates to primary/community as required – may include fax, text messages as well as emails. • Contact with Canterbury Initiative for production of content and uploading of clinical guidance to Community HealthPathways and HealthInfo as urgently required. • All media requests managed promptly in liaison with CDHB Comms. • Ongoing liaison with CDHB ECC; ECC PIM functions.

Other roles and relationships in the COVID Response:

Technology

Technology support has been Canterbury-wide and system-wide:

- The ERMS team has been engaged in enabling ERMS to be used for referrals to CBACs as well as signature-less prescriptions to pharmacy, enabled by the MoH waivers.

- PHOs have supported their practices to operationalise virtual consults as well as enabled staff to work remotely.
- PHOs provided IT support to the Primary EOC, the designated clinics and CBACs as well as mobile units, including software and hardware systems and equipment to manage patient information and data collection for reporting.
- Developers have set up ePortal claims functionality to enable COVID-19 claims[5].
- EOC Intelligence team worked with the PHOs to obtain population data to match with laboratory testing data to inform the EOC.

Laboratory Service

Canterbury Health Laboratory is one of the country's designated COVID-19 testing centres. In this pandemic the lab has had to cope with exceptional pressure to meet demand from Canterbury and other regions. Lab staff have been an integral part of the Primary EOC team.

Testing kits were carefully managed at the start of the pandemic as supplies were limited. Tight controls were eased somewhat with increased supply as well as a wider definition from the Ministry of who should be swabbed.

Delivery and pick up of swabs to swabbing practices and CBACs was deployed by the EOC to support seven days a week service via Waitaha Primary Health vehicles and CDHB drivers.

Community & Public Health (C&PH)

C&PH's intention is to 'keep it out, stamp it out' by managing contact tracing, disease surveillance, isolation and quarantine in accordance with MoH requirements. This means their key tasks remain the same at all alert levels. They are:

- Supporting the psychosocial response to COVID-19 and the impact of control measures on our community.
- Providing effective communication links with clinicians, including a streamlined notification process, joint public health and clinical management where required, and ensuring consistent advice to cases and contacts across the health system.
- Effective case and contact management, including identifying and mitigating any social or other barriers to effective isolation or quarantine, regardless of low or potentially much higher case numbers.
- Integrated investigation and management of clusters, in partnership with infection prevention and control, CDHB Occupational Health, Aged Residential Care management, and primary care, as required.
- Supporting an effective border response, including public health management of incoming travellers in quarantine.

Documentation of Clinical Guidance and Processes

In the COVID-19 pandemic evidence-based and timely clinical guidance was identified as a key requirement to support primary care. CPRG, Canterbury Initiative and CDHB staff have liaised with clinicians and managers across the system to facilitate the development of relevant information, for instance: COVID-positive patient pathway; quarantine and isolation protocols; aged residential care and palliative care guidelines; opioid substitution therapy guidelines; subsidies for COVID-19 assessment and testing, e-prescribing, and more. (See Community HealthPathways: https://canterbury.communityhealthpathways.org/723535.htm.) CPRG, Canterbury Initiative,

[5] Level A, B, and C claims are available through ePortal for static amounts. Level D claims are paid through Acute Demand.

HealthPathways and HealthInfo clinical editors work to produce timely advice accessible across primary care and the public.

Appendix H: Standard Operating Procedures

The Primary EOC functions have required the development of policies and procedures. Specifically, the establishment of the CBACs and telephone triage team, but also Logistics (for the supply of PPE and other equipment).

All SOPs available on OneDrive:
https://onedrive.live.com/?authkey=%21AKFmPyWJy2y3SEw&id=B6112FC4EF0A8006%21125&cid=B6112FC4EF0A8006

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Administrative SOPs

1. GP Notice – Covid-19 assessment form template
2. The Daily Huddle
3. Covid Lab request form
4. Covid-19 Patient info after test
5. HealthInfo self-isolation advice leaflet
6. Self-isolation advice algorithm

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Clinician SOPs

1. Starting your day in the assessment room
2. What to do between patients
3. Stock list (assessment room)
4. Closing your room down after the last patient
5. End of day - Cleaning Room
6. Cleaning footwear
7. Notifying patients of negative results
8. Closing facility
9. How to assess patients
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Facilities SOPs

1. The rooms that make up a CBAC
2. Hallway
3. Waiting room

4. Assessment room
5. Holding Room
6. Inventory of assessment room. Instruments and stock
7. Whiteboard template
8. Resus equipment checklist

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Staffing SOPs

1. Clinical shift leader role
2. The role of floor nurse

Mobile Units and Pop-Up SOPs

1. House visit SOPs

Technology SOPs

1. [to come]

Logistics SOPs

1. [to come]

Telephone Triage Team SOPs

1. http://resource.pegasus.org.nz/teams/CBAC_Triage/SitePages/Home.aspx