Network Disaster Resilience Response Plan

Human Disease Annex – COVID-19

V4.3 – 30 September 2020

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1. INTRODUCTION

Background

1.1. The WHO declared a global pandemic related to a novel Coronavirus infection (COVID-19) on the 11th of March 2020, following the detection of a new viral pathogen on the 30th of December 2019 and its spread across 188 countries in the following months.

1.2. Coronaviruses are a large family of viruses that cause illnesses that can range from the common cold to more severe respiratory diseases, including complications such as pneumonia. Transmission occurs person to person through close contact with an infectious person, contact with droplets from an infected person's cough or sneeze, or through contaminated surfaces. COVID-19 to date is characterised by fever or acute respiratory infection (e.g. shortness of breath or cough) with or without fever, and has an average incubation period of 5.2 days, with an infectious period of 1 – 14 days, however, the case definition for COVID-19 is still evolving, with possible asymptomatic carriers.

1.3. A viral respiratory disease pandemic, such as that posed by COVID-19, will disrupt South Australia's social and economic functioning, and a whole of government response will be required to maintain essential services. The Central Adelaide Local Health Network (CALHN) will see and need to treat a large number of COVID-19 patients whilst maintaining a level of business continuity needed to best support the health and wellbeing of our local population.

Scope

1.4. The purpose of this plan is to clearly outline the roles, responsibilities and operational functions when preparing for, responding to and recovering from the COVID-19 pandemic. This plan will guide the implementation of the CALHN response, and is subject to change based on the evolution of the pandemic, our knowledge of the COVID-19 virus and the complexity of the situation in South Australia.

1.5. This plan applies to all Central Adelaide Local Health Network (CALHN) services and sites, when preparing for, responding to and recovering from the COVID-19 pandemic. It is specific to the local context and the current situation, drawing from and sitting below the CALHN Disaster Resilience Response Plan. Additionally, it is closely linked to the Commonwealth Australian Health Management Plan for Pandemic Influenza (AHMPPI) as well as the SA Health response plan, as well as plans from our system partners including SA State-wide Clinical Support Services, SALHN, NALHN, CHSA and community (Primary Health Network - PHN) and private partners.

Strategic Aims

1.6. CALHN's response to the COVID-19 pandemic is grounded by the following guiding principles:

- Delivery safe and appropriate care to our patients
- Ensure the system capability and capacity is used to best effect for all South Australians
- Support equity of access across the system

- Support the community to self-care where possible and remain well in the community
- Implement a scalable, tiered and proportionate response to escalation in demand
- Support a strong public health focus with regards to its sites
- Maintain normal operations (business as usual) as long as possible, and maintain quaternary services throughout
- Provide safe staffing levels
- Ensure staff are adequately prepared to respond and deliver care in setting and approaches that are safe but different than business as usual
- Provide strong governance through accountable and transparent decision making
- Revert to business as usual as soon as is practicable

Plan authority and activation

1.7. The CALHN Human Disease Annex – COVID-19 has been developed with input from across the organisation, and is endorsed by the CALHN COVID Commander and its Incident Management Team.

1.8. The plan will be managed by the Network Incident Management Team during an incident and the CALHN Disaster Resilience Unit at other times.

1.9. This plan can be activated by the following personnel;

1.9.1. Network Commander,

1.9.2. Executive Director – Operations,

1.9.3. Executive Director – Medical Services.

1.10. This plan can be activated separate to the activation of any state level extreme human disease plan activation.

1.11. This plan will be activated upon a formal declaration under the following legislation(s);

1.11.1. Human disease with pandemic potential, under the Biosecurity Act 2015 and/or

1.11.2. Public Health Emergency under the SA Public Health Act 2011, and/or

1.11.3. Public Health related declaration (human disease) under the Emergency Management Act 2004.

Plan assumptions

1.12. The assumptions below form the framework upon which this plan is based;

- The control agency for human disease incidents is SA Health,
- The safety of hospital staff, patients and visitors, as well as the protection of hospital facilities, during human disease incidents are paramount, and must be carefully considered in all aspects of the planning, response and recovery process,
- RAH will be the primary receiving site for vulnerable cohort patients and will develop and/or maintain a capacity of receiving up to 20 patients within 12 - 24 hours.
- CALHN will contribute to human disease data collection and reporting via the SA Health Emergency Management System (SAHEMS), when directed, and
- No other significant disaster or business disruption incident is present/occurring.

Planning

1.13. The following principles (as taken from AHMPPI) shall be adopted for human disease incident planning in CALHN;

- the use of **existing systems** and governance mechanisms, particularly those for seasonal influenza;
- a **flexible** approach that can be scaled and varied to meet the needs experienced at the time;
- **evidence-based decision making**;
- strong linkages with **emergency response** arrangements;
- the potential to apply this plan to **seasonal influenza**, when it threatens to overwhelm our health systems;
- clear guidance on the collection of local, state and national **surveillance** data; and
- an emphasis on **communications** activities as a key tool in management of the response.

1.14. A core consideration in any response will be **proportionality** – this means that the level of response needs to be proportionate to the level of risk and acknowledging that the risk is not the same across population groups.

1.15. The level of threat of any pandemic will depend on a number of factors;

- Clinical severity
- Transmissibility
- Capacity of health service
- Effectiveness of interventions
- Vulnerability of the population

1.16. Qualitative descriptions of three different levels shall be used when planning and modelling;

1.16.1. Clinical severity is low (*best case scenario*)

1.16.2. Clinical severity is moderate (*conservative case scenario*)

1.16.3. Clinical severity is high (*worst case scenario*)

1.17. Operational plans and their related 'plan on a page' (found in the appendix to this plan) will be developed, reviewed and maintained by their respective plan owners.

1.18. The IMT/DRU shall be responsible for coordinating the uploading of these operational plans to the IMT Sharepoint page and the DRU intranet page, during 'peacetime' operations.

1.19. At the activation of an incident management team, the CALHN Planning Officer shall be responsible for ensuring that all operational plans and their 'plan on a page' are reviewed in near real time based on the latest known human disease intelligence and impacts. The CALHN Planning Officer/Section shall be responsible for the ongoing oversight of plans during the duration of the incident until a stand down is declared.

1.20. Planning assumptions shall include;

1.20.1. Lack of herd immunity will cause elevated numbers presenting to some level of medical assistance,

1.20.2. Existing arrangements will need to be augmented to cope with the changed and extended demands,

1.20.3. Increased pressure will occur across the spectrum of health services,

1.20.4. Initial drive to identify cases will put pressure on laboratory capacity,

1.20.5. SA Health expects to utilsie RAH as a primary site for the cohorting of positive cases from vulnerable cluster groups, mental health, residential aged care and prisons etc, and

1.20.6. At risk (including vulnerable populations) will experience higher morbidity and mortality.

Planning – Gate reviews

1.21. A formal intelligence analysis process shall be utilised to ensure that all decisions and operations are as informed as possible. An outline of how to undertake a Gate Review can be found in the Appendix.

1.22. This shall be undertaken by the Planning Section.

1.23. This shall be based on the three scenarios as outlined in Section 1.17.

1.24. The frequency under which gate reviews occur can be seen as follows;

1.24.1. CoSTAT 1 - 2 weekly – monthly
1.24.2. CoSTAT 2a - 1 – 2 weekly
1.24.3. CoSTAT 2b - Weekly
1.24.4. CoSTAT 3 - 4 – 7 days
1.24.5. CoSTAT 4 - 2 – 5 days
1.24.6. CoSTAT 5 - 1 – 3 days

Supporting arrangements

This section looks at existing arrangements that support the response to a human disease incident (COVID-19).

1.25. The CALHN Disaster Resilience Response Plan outlines a scalable and whole of network approach to incident/command management. This plan is an annex to the Network Plan.

1.26. The Commonwealth shall maintain the overarching plan; Australian Health Management Plan for Pandemic Influenza (AHMPPI).

1.26.1. Website - COVID-19 health alerts.

1.27. In response to COVID-19, the Commonwealth has developed the following plan, Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19).

1.28. SA Health / CDCB also maintain a public website (here) intended to inform clinicians and consumers/public alike of COVID information.

1.29. CALHN shall maintain several relevant OWI;

1.29.1. Novel Respiratory Pathogens including Pandemic Influenza OWI
1.29.2. COVID -19 (SARS-CoV-2) – Management Guide OWI
1.29.3. Influenza – Outbreak OWI
1.29.4. Influenza – Management OWI
1.29.5. COVID-19 – Onsite management of interstate visitors during the COVID 19 pandemic
1.29.6. COVID-19 – Management of Patients who fail to comply with direction to remain in hospital for treatment

1.30. A broader register of plans shall be maintained by the IMT in conjunction with the DRU.

1.31. CALHN Communications shall manage an intranet/internet page that will provide a 'source of truth' for all internal communications – internal web link (COVID example – here)

1.32. This annex should be read with the SA Health – Disaster Resilience Glossary for definition of terms/acronyms.

AHMPPI Stages

1.33. The AHMPPI outlines the relevant phases. The phases are shown below:

Preparedness *No novel strain detected (or emerging strain under initial investigation)*	PREPAREDNESS	• Establish pre-agreed arrangements by developing and maintaining plans; • research pandemic specific influenza management strategies; • ensure resources are available and ready for rapid response; • monitor the emergence of diseases with pandemic potential, and investigate outbreaks if they occur.
Response	STANDBY *Sustained community person to person transmission overseas*	• Prepare to commence enhanced arrangements; • identify and characterise the nature of the disease (commenced in Preparedness); and • communicate to raise awareness and confirm governance arrangements.
	ACTION *Cases detected in Australia*	Action is divided into two groups of activities: <u>Initial</u> (when information about the disease is scarce) • prepare and support health system needs; • manage initial cases; • identify and characterise the nature of the disease within the Australian context; • provide information to support best practice health care and to empower the community and responders to manage their own risk of exposure; and • support effective governance. <u>Targeted</u> (when enough is known about the disease to tailor measures to specific needs.) • support and maintain quality care; • ensure a proportionate response; • communicate to engage, empower and build confidence in the community; and • provide a coordinated and consistent approach.
	STAND-DOWN *Public health threat can be managed within normal arrangements and monitoring for change is in place*	Support and maintain quality care; • cease activities that are no longer needed, and transition activities to seasonal or interim arrangements; • monitor for a second wave of the outbreak; • monitor for the development of antiviral resistance; • communicate to support the return from pandemic to normal business services; and • evaluate systems and revise plans and procedures.

Definitions

1.34. This annex should be read with the SA Health – Disaster Resilience Glossary for definition of terms/acronyms.

Human Disease: "any impairment of normal physiological function affecting all or part of an organism, especially a specific pathological change caused by infection, stress etc., producing characteristic symptoms, illness or sickness in general" detected in humans

Epidemic: An outbreak or unusually high occurrence of a disease or illness in a population or area (Australian Health Management Plan for Pandemic Influenza AHMPPI). In the context of the State Human Disease Hazard Plan reference is made to: "human disease/s that have the potential to cause harm to people, the environment, or economy of South Australia to an extent which could overwhelm the capacity of existing health response resources."

Pandemic: "A pandemic is the worldwide spread of a new disease. A pandemic occurs when a new virus emerges and spreads around the world, and most people do not have immunity. Viruses that have caused past pandemics typically originated from animal viruses".

COVID-19: Coronavirus disease 2019: The name of the disease caused by the virus SARS-CoV-2, as agreed by the World Health Organization, the World Organization for Animal Health and the Food and Agriculture Organization of the United Nations.

SARS-CoV-2: Severe acute respiratory syndrome coronavirus 2: The formal name of the coronavirus that causes COVID-19, as determined by the International Committee on Taxonomy of Viruses. Previously, this coronavirus was commonly known as 'novel coronavirus 2019 (2019-nCoV)'.

Confirmed Case: A person who tests positive to a validated specific SARS-CoV-2 nucleic acid test or has the virus identified by electron microscopy or viral culture.

Suspect Case: This is a dynamic determination based on advice developed by AHPPC and documented in the COVID SoNG.

Role and responsibilities

1.35. A brief overview of the key roles can be found here, however

1.35.1. State Controller / Chief Public Health Officer

- Legislative responsibility to oversee the whole of response to a human disease incident

1.35.2. State Health Commander

- Responsible for the operational activities occurring at a state level on behalf of the State Controller

1.35.3. Executive Director – Operations

- Responsible for ensuring that activation and implementation of this plan occurs and a suitable Network Commander and incident management team is appointed.

1.35.4. Network (COVID) Commander

- Responsible for leading whole of CALHN response, once incident management arrangements have been invoked, in accordance with CALHN doctrine.

1.35.5. IMT – Functional Officer (Section)

- Responsible for leading their functional section, once incident management arrangements have been invoked, in accordance with CALHN doctrine.

1.35.6. IMT – Functional Unit (cell) lead

- Responsible for leading their functional sub-unit, once incident management arrangements have been invoked, in accordance with CALHN doctrine.

1.35.7. Network Executive

- Provide a stratgeic crisis management, broader organisational leadership and staff well-being role.

Incident management and command

1.36. The activation of the incident management arrangements and associated command centre status can be found discussed in more details elsewhere, however a summary is below, subject to

Incident Response Synchronisation Matrix – Incident Management

CoSTAT	AHMPPI DESCRIPTION	COMMAND CENTRE OPERATIONS	IMT REQUIREMENTS
1	Standby	• No physical ICC operations • NICC Support Section – virtual NICC operations only • Nil support to IMT	• Identify Network Commander and core IMT (Operations, Planning, Logistics and Public Info & Comms) • Exec Director – Operations retains overall responsibility
2	Initial Response	• 5 – 7 day NICC operations • Approx 8 - 10 hour operations • Min. Twice weekly NICC briefings	• Commander and core IMT onsite, as required - determined by Commander
3	*(Enhanced)* Initial Response	• 7 day NICC operations • 8 – 12 hour operations • 6 – 13 NICC briefings	• Commander and Operations Officer, Logistics Officer on site (minimum). • Planning Officer and Public Info & Comms – as required
4	Targeted Response	• 7 day NICC operations • 12 – 18 hour operations • 2 – 4 hourly briefings	• Commander and core IMT onsite during NICC operations • NICC Support(s) personnel available for recall

5	*(Sustained)* Targeted Response	• 7 day NICC operations • 12 – 24 hour operations • 1 – 4 hourly briefings	• Commander and core IMT onsite during NICC operations • NICC Support personnel available for recall

Hazard Vulnerability / Risk Assessment

1.37. A formal risk assessment has been undertaken at a State level to assess Human Disease – Pandemic Influenza to assess the risk of a human disease incident against the state of South Australia.

1.38. CALHN will develop and maintain a risk assessment related to COVID.

1.39. The Network Commander and their IMT shall be responsible for its development and monitoring, in conjunction with Safety, Quality and Risk Management.

Lessons identified / management

1.40. It is crucial that from the invocation of this plan and NICC operations that a reflective process is established to ensure that dynamic review occurs of systems, processes and outcomes that occur under the auspice of incident management.

1.41. These lessons shall be documented and tracked in accordance with the CALHN Incident / Exercise Debrief Guidelines (or similar).

BEFORE THE DISEASE INCIDENT

2. PREVENTION

2.1. Novel human disease incidents (endemics and pandemics) will occur and are unable to be prevented by the Hazard Leader or SA Health, including CALHN.

2.2. SA Health as Human Disease Hazard Leader;

2.2.1. The State Emergency Management Plan (SEMP) has assigned SA Health the role of Human Disease Hazard Leader.

2.2.2. The role of Hazard Leader is described in Part 2 of the SEMP.

International - Prevention Support and Direction

2.3. World Health Organization

2.3.1. The World Health Organization (WHO) is an agency of the United Nations (UN) that acts as a coordinating authority on international public health. Its major task is to combat disease, especially key infectious diseases, and to promote the general health of the people of the world. It coordinates international efforts to monitor outbreaks of infectious diseases, such as severe acute respiratory syndrome (SARS), malaria and ebola virus disease.

National - Prevention Support and Direction

2.4. AHPPC

2.4.1. The Australian Health Protection Principal Committee (AHPPC) provides advice and recommendations to the Health Ministerial Advisory Council on:

- health protection matters to mitigate emerging health threats related to infectious diseases, the environment, natural disasters, and disasters related to human endeavour in a context of prevention;
- national health protection priorities and the coordination of resources to address these priorities;
- coordination of emergency operational activity in health responses to disasters, and health protection issues of national significance;

2.5. South Australia's representative on the AHPPC is the DHW Chief Public Health Officer (CPHO).

South Australia - Prevention Support and Direction

2.6. SA Health – Public Health and Clinical Systems

2.6.1. The Public Health and Clinical Systems Division works with and for the South Australian community to improve public health and clinical care.

2.6.2. This encompasses providing services, advice, education, support, policy, leadership and advocacy, administering legislation and partnering with service providers, government agencies and the nongovernment sector to identify and respond to current and emerging public health and clinical issues and opportunities.

2.7. SA Health - Communicable Disease Control Branch (CDCB)

2.7.1. The Communicable Disease Control Branch (CDCB) aims to reduce the incidences of communicable and infectious diseases in South Australia. They do this by having specialist services in medical and epidemiological advice and laboratories, coordination of state's responses to notifiable conditions

BEFORE AND DURING THE DISEASE INCIDENT

3. PREPAREDNESS

3.1. CALHN shall look for opportunities in any human disease incident to lean in and undertake a timely and proportionate preparedness and response. This relies on shared, related intelligence and building on key relationships with public health specialists both within Australia and internationally.

3.2. The AHMPPI identifies its first stage as "Preparedness" – this is prior to any formal activation of the CALHN plan, with CoSTAT 1 being outlined in AHMPPI as a 'standby' phase.

3.3. Early awareness and sharing of intelligence should occur between Clinical Executive, Infectious Disease / Infection Prevention Control Unit (IPCU) leads (including relevant Clinical Program Delivery Manager) and Manager, Disaster Resilience Unit to ensure that a preparatory phase can commence outside of a formal activation of this plan (and prior to a CoSTAT 1 initiation).

3.4. Actions that may arise at this stage include;

- 3.4.1. International case and surveillance data monitored and analysed,
- 3.4.2. Seasonal influenza (and other relevant) vaccination program
- 3.4.3. Fit testing (Priority – high risk/exposure areas first)
- 3.4.4. Review of supply chain management and stock holdings
- 3.4.5. Commence CALHN tactical and operational plan review,
- 3.4.6. Exercise related plans,

3.5. Undertake briefings with the other LHNs and DHW.The Incident Response Synchronisation Matrix is comprised of a series of 'statuses' that show a relationship between the AHMPPI phases and the increasing intensity of activity in response operations. Preparedness occurs prior to any formal CALHN plan activation.

3.6. Below is a summary of CALHN 'CoSTAT' against the AHMPPI descriptors and key 'triggers'.

Incident Response Synchronisation Matrix - PHASES & TRIGGERS *(taken from V4.1 – 10 August 2020)*

CoSTAT	AHMPPI DESCRIPTION	TRIGGER POINT	LEADERSHIP	DECISION BY
1	Standby	• Nil in-patient COVID Cases in SA • 2 - 3 cases of community transmission • State Human Disease / Public health declaration (Public Health Act) • State Emergency Management Declaration (Emergency Management Act)	Heightened organisational awareness / Consider Incident management & Command arrangements	ED - Operations or CALHN (COVID) Network Commander
2	Initial Response	• 1 - 15 admitted in-patients (COVID / General wards) AND/OR • Analysis of community transmission, indicating significant community exposure / cluster • 1 x Confirmed COVID positive ICU case from community transmission • Jurisdictional intelligence indicating high burden / load • Impact of deployment of SA / CALHN personnel to other jurisdictions	Incident management & Command arrangements	CALHN (COVID) Network Commander & Incident Management Team (IMT)
3	*(Enhanced)* Initial Response	• Sustained and/or escalating cases via community transmission AND/OR • >16 admitted COVID-19 inpatients in RAH OR • 3+ positive COVID ICU admissions	Incident management & Command arrangements	CALHN Command Centre and State Control Centre – Health (SCC-H) operations
4	Targeted Response	• >24 COVID-19 ICU patients OR • >64 COVID-19 inpatients general ward RAH OR • 3+ consecutive days of ED presentations >290	Incident management & Command arrangements	CALHN Incident Command Centre and State Control Centre – Health (SCC-H) operations
5	*(Sustained)* Targeted Response	• COVID-19 ICU patients exceed RAH capacity OR • COVID-19 GenMed/102 patients exceed RAH capacity OR • Workforce no longer capable of staffing all COVID-19 beds at normal ratios	Incident management & Command arrangements	State Disaster arrangements

3.7. The below document register is an overview of current known CALHN related plans.

3.7.1. Hyperlinks in the table below shall take the reader to the IMT Sharepoint page for the 'full' operational version of each plan (may need permission to access the Sharepoint folder).

3.7.2. It is expected that these plans will be uploaded to the CANH DRU Intranet page.

Plan Name
Blood - CALHN COVID-19 EBMP V1docx.pdf
CC&PO - RAH ICU COVID Planning Working Document 6 May 2020.pdf
COVID - Facility Access Plan - Annex CALHN parking processes ATTACHMENT 1 - CALHN Program + Stream triage model for pandemic parking applications.pdf
COVID - Facility Access Plan - Annex CALHN parking processes ATTACHMENT 1a - CALHN Program + Stream triage model working document.pdf
COVID - Facility Access Plan - Annex CALHN parking processes ATTACHMENT 2 - CALHN engagement with overflow providers.pdf
COVID - Facility Access Plan - Annex CALHN parking processes for staff access during a COVID-19 pandemic response V1.pdf
COVID - Facility Access Plan - Annex CALHN RAH facility access recommendations in line with screening for all staff and visitors V1.pdf
COVID - Facility Access Plan - V2.0 - July 2020.pdf
COVID - Facility Support Services Plan - V1.0 - July 2020.pdf
COVID_RAH_DECANT_v2_D.pdf
COVID_RAH_DECANT-Surgical Program.pdf
COVID-19 Gifts and Benefits Procedures.pdf
CWH_ID_IPCU - 20200630_CALHN IPCU_ID_CWH CALHN COVID 19 Network Plan.pdf
Integrated Care - DRAFT CALHN Service Level COVID 19 MCGS.pdf
Integrated Care - DRAFT CALHN Service Level COVID 19 Plan CAPCS.pdf
Integrated Care - DRAFT CALHN Service Level COVID 19 Plans - RHS.pdf
Integrated Care - DRAFT CALHN Service Level COVID 19 Plans- BIRCH.pdf
Integrated Care - DRAFT CALHN Service Level COVID 19 Plans- CF.pdf
Integrated Care - DRAFT CALHN Service Level COVID 19 Plans- GP Liaison Unit CALHN.pdf
Integrated Care - DRAFT CALHN Service Level COVID 19 Plans- Hospital in The Home (6) (3).pdf
Integrated Care - DRAFT CALHN Service Level COVID 19 Plans- Mental Health.pdf
Integrated Care - DRAFT CALHN Service Level COVID 19 Plans OBS- Template.pdf
Integrated Care - DRAFT CALHN Service Level COVID 19 Plans- Rehab In The Home (6).pdf
Integrated Care - DRAFT CALHN Service Level COVID 19 Plans- SORT.pdf
Integrated Care - DRAFT CALHN Service Level COVID 19 Plans-Aboriginal Patients.pdf
Integrated Care - DRAFT COVID Service Level Plan- HASDC Outreach- Sefton.pdf
Integrated Care - DRAFT COVID-19 Update Falls & TCP.pdf
Integrated Care - REGISTER CALHN Community Service Level COVID 19 Plans.pdf
Mental Health - COVID 19 Response Plan v1.0 040520_signatures.pdf
Mental Health - COVID-19 Mental Health bed plan V4 .pdf
RAH ED COVID PANDEMIC RESPONSE PLAN.pdf
SADS COSTAT planning 2020 0804.pdf
SAPHS COVID Positive Patients Managament V3.pdf
SAPHS Service Continuity_Outbreak_Positive Management Plan.pdf
Workforce - 200505 COVID-19 CALHN Workforce Plan.pdf

DURING THE DISEASE INCIDENT

4. RESPONSE

SA Health and CALHN response principles

4.1. Effective response and management of the current COVID-19 pandemic requires a coordinated response across South Australia; to enable the following principles have been set by SA Health and agreed by the Executive of each LHN.

4.2. All principles reflect the requirement for a proportionate and safe level of operation across the State prior to, during, and post-pandemic. It is likely that, as the state-wide pandemic response is clarified and finalised, the parameters will be amended to reflect these changes.

4.2.1. Each metropolitan LHN to plan for a COVID-19 screening and assessment clinic within their LHN boundaries which meets the national infrastructure guidelines

4.2.2. LHNs would activate the screening and assessment clinic either as demand required or at the request of the Deputy State Controller

4.2.3. During the Initial Response (CoSTAT-2) and Enhanced Initial Response (CoSTAT-3) phases:

- Royal Adelaide Hospital will admit all confirmed COVID-19 adult presentations in negative pressure or single rooms. This includes adult intensive care presentations.
- Royal Adelaide Hospital will admit all confirmed cases as referred from vulnerable, high risk cohorts.
- Women's and Children's Hospital will cohort paediatric and family confirmed COVID-19 patients in negative pressure or single rooms.
- Flinders Medical Centre will cohort neo-natal and high risk pregnancy confirmed COVID-19 patients in negative pressure or single rooms.

4.2.4. During the Enhanced Initial Response (CoSTAT-3), Targeted Response (CoSTAT-4) and Enhanced Targeted Response (CoSTAT-5) phases:

- SA Ambulance Services will expand their boundaries for suspected (or confirmed) respiratory patients to enable transfers to the Royal Adelaide Hospital.
- SA Ambulance Services will narrow their boundaries for all other transfers (i.e. excl. respiratory).
- Royal Adelaide Hospital will be utilised to cohort confirmed COVID-19 adult patients, however state in-patient plans have identified a threshold at which point additional cases will be placed at other sites, in a cascading order.
- Women's and Children's Hospital will cohort paediatric and family confirmed COVID-19 patients.

- Flinders Medical Centre will cohort neo-natal and high risk pregnancy confirmed COVID-19 patients.
- Suspected COVID19 patients presenting to LHN's will be admitted to a negative pressure or single room pending results and positive unwell cases transferred to the RAH
- Out of Hospital pathways (Hospital in the Home) will be utilised by all LHNs to manage COVID-19 asymptomatic or low risk patients

4.3. The RAH will continue its role as the quaternary hospital, including its state-wide services e.g. burns, spinal

4.4. The RAH will continue its emergency surgery caseload as the State's quaternary hospital leading up to and during the pandemic response

4.5. TQEH will be the CALHN COVID-19 non-COVID site

4.6. LHNs will utilise private hospital capacity to manage elective surgery demand as possible and appropriate:

4.6.1. All LHNs to bring forward as much elective surgery as possible. Surgery Escalation Plans to be developed in concert with DHW.

4.6.2. LHNs will coordinate the procurement of their required capacity in concert with DHW

4.6.3. The decision to suspend the elective surgery program will be made at a state-wide level via the Incident Management Team

4.6.4. WCHN to continue paediatric elective multi day surgery during the pandemic response. Paediatric demand will be reviewed daily.

4.7. LHNs will undertake to commence communication and training of select surgical staff (Nursing, Resident Medical Officers and Interns) in other specialties at different locations e.g. Intensive Care Unit, General Medicine

4.8. As a system, all public hospitals will attempt to minimise, where appropriate, intra- and interstate patient transfers to RAH, as the State's COVID hospital, and other sites. *Decanting the Royal Adelaide Hospital will be a priority*.

4.9. All LHNs will develop a strategy to manage the transfer of their sites long stay patients (including NDIS, maintenance, care awaiting placement) in concert with DHW

4.10. Where appropriate, post-acute (transfer ready) patients at RAH will be relocated to other Health sites, including Country Health SA LHN peri-urban sites.

4.11. Where appropriate, post-acute (transfer ready) patients at other LHNs will be relocated to other Health sites, including Country Health SA LHN peri-urban sites.

4.12. Focussed effort to repatriate Country Health SA LHN patients to Country Health SA LHN General Hospitals or their home with suitable support where clinically appropriate, from all participating metropolitan sites in the lead up to the move.

4.13. No Emergency Departments will close without the express permission of the State Controller or Deputy State Controller.

Incident leadership and command

4.14. The CALHN Incident Management Framework – Part A – Incident Doctrine and the CALHN NDRRP allows for a scalable incident management approach, ensuring that the key incident management principles are maintained;

4.14.1. Implement incident command leadership

4.14.2. Management by objectives

4.14.3. Functional management
4.14.4. Span of control

4.15. A Network Commander and associated functional management approach IMT shall be identified and appointed.

4.16. Functional IMT Officer roles shall lead Sections.

4.17. These functional sections may be scalable and supported by sub-entities called Cells.

4.18. These Cells shall be led by a Cell Lead, as outlined below;

4.18.1. Operations Officer (Section)
- Infectious Disease (ID), IPCU and Clinical Worker Health (CWH) Cell (and Lead)
- Mental Health Cell (and Lead)
- Clinical Operations Cell (and Lead)

4.18.2. Logistics Officer (Section)
- Logistics Support Cell (and Lead)
- Supply Chain Cell (and Lead)
- PPE Cell (and Lead)

4.18.3. Planning Officer (Section)
- Planning Support Cell (and Lead)
- Plan Cell (and Lead)
- Workforce Cell (and Lead)

4.18.4. Communications and Public Information Officer (Section)
- Comms and Public Info Support Cell (and Lead)

4.18.5. Recovery Officer (Section)
- Recovery Support Unit (and Lead)

4.18.6. NICC Support Section
- NICC Manager
- NICC Support

4.19. For further information, the CALHN Incident Management Framework and Network Disaster Resilience Response Plan (NDRRP) provides further information regarding incident management.

Activation of the Incident Management Team

4.20. The Commander and their Incident Management Team shall be activated by;

4.20.1. In-hours – via Executive Director – Operations or Network Commander

4.20.2. Out of hours – Executive On-call or Network Commander

4.21. To activate the CALHN COVID IMT, the caller shall;

4.21.1. Telephone 33# and instruct a message for the “COVID Hotkey”

4.21.2. Switchboard shall take the message – its character limited and send the message

4.21.3. The IMT will receive the message as a SMS

4.21.4. The IMT will SMS confirmation of receipt of the message to the Commamnder and advise of estimated time of arrival (ETA) to the NICC.

4.22. The IMT are expected to be avauilable for a 90 minute recall, unless advised differently.

Overview of response

4.23. CALHN will operate a five tiered response plan, with the Royal Adelaide Hospital (RAH) acting as the primary site for COVID-19 positive unwell patients. All efforts will be taken to maintain the Queen Elizabeth Hospital, Hampstead Rehabilitation Centre, St Margaret's Rehabilitation Hospital and Glenside Hospital as 'clean' (i.e. non-COVID-19) sites.

4.24. SA Health will provide guidance as to when site assessment clinics shall commence.

4.25. CALHN ID, IPCU and CWH with Outpatients Services shall lead the establishment and management of site based assessment clinics, in accordance with the Screening and Assessment Clinic Plans.

4.26. A high level summary of the actions at each stage is shown in the Incident Response Synchronisation Matrix.

4.27. Further detail of the response at each tier can be found in the appendix of this plan.

RAH Capacity creation (Decant)

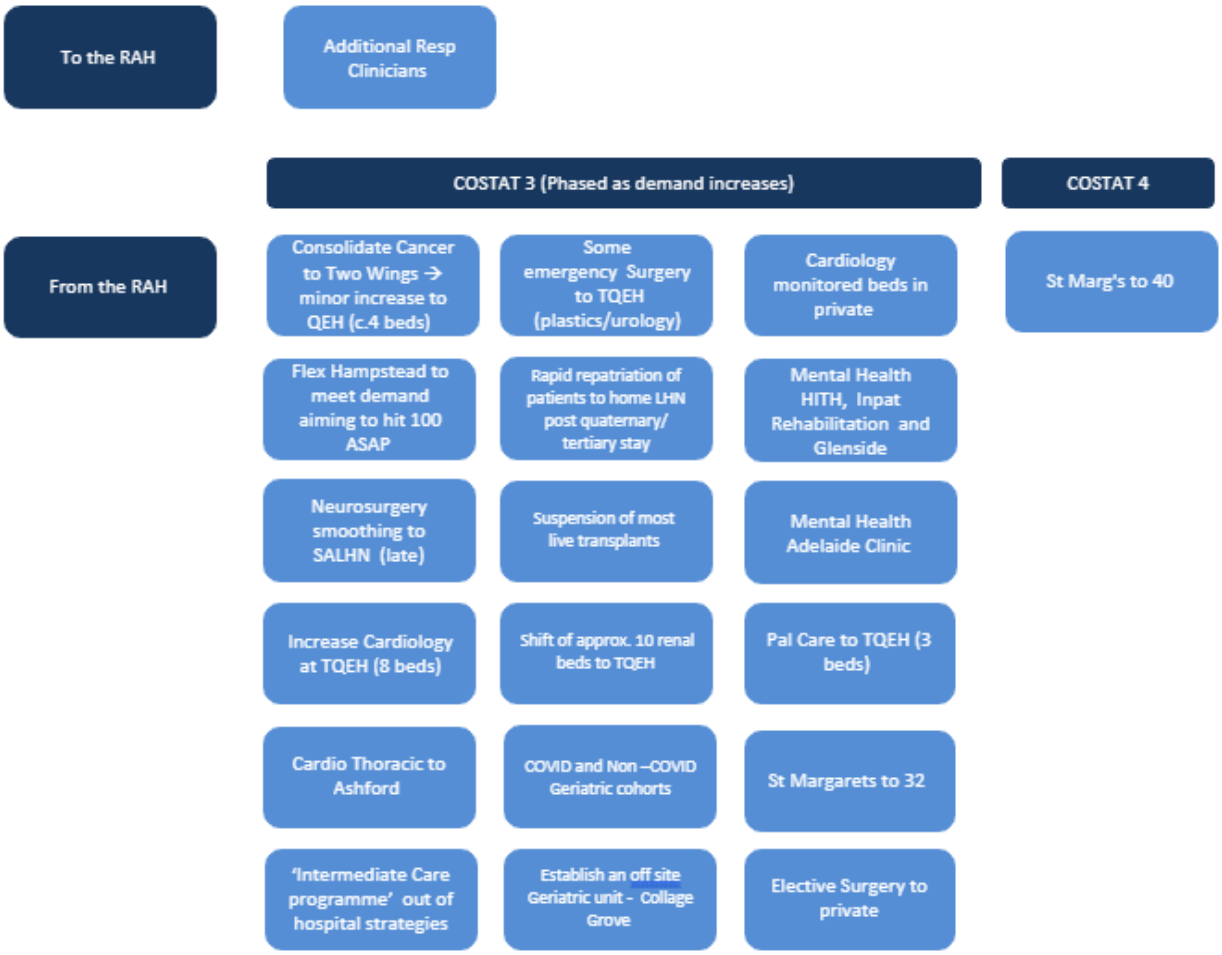
4.28. The RAH has been designated as the COVID-19 receiving hospital for South Australia and will be the primary inpatient facility caring for adult COVID-19 positive patients during Co-STAT-2 through Co-STAT-4.

4.29. To enable this, the RAH will need to create capacity by reducing current inpatient occupancy, in a controlled, systematic manner to optimise proportionate and suitable capacity and capability, reducing planned and emergency activity and moving patients to alternate locations.

4.30. The support of the entire system, both within CALHN and externally (including SAAS, RFDS, SA Health, neighbouring LHNs and private providers) is needed to facilitate this capacity creation.

4.31. Co-STAT-3 has the largest planning and service configurations required. A summary of the service shifts currently planned are outlined below which will reduce the non-critical care footprint at the Royal Adelaide Hospital from 627 beds to 241 beds assuming full implementation and execution.

4.32. Details regarding the creation of capacity through decanting shall be found in the RAH Decant Plan.


To the RAH
Additional Resp Clinicians
COSTAT 3 (Phased as demand increases)
COSTAT 4
From the RAH
Consolidate Cancer to Two Wings → minor increase to QEH (c.4 beds)
Some emergency Surgery to TQEH (plastics/urology)
Cardiology monitored beds in private
St Marg's to 40
Flex Hampstead to meet demand aiming to hit 100 ASAP
Rapid repatriation of patients to home LHN post quaternary/ tertiary stay
Mental Health HITH, Inpat Rehabilitation and Glenside
Neurosurgery smoothing to SALHN (late)
Suspension of most live transplants
Mental Health Adelaide Clinic
Increase Cardiology at TQEH (8 beds)
Shift of approx. 10 renal beds to TQEH
Pal Care to TQEH (3 beds)
Cardio Thoracic to Ashford
COVID and Non –COVID Geriatric cohorts
St Margarets to 32
'Intermediate Care programme' out of hospital strategies
Establish an off site Geriatric unit - Collage Grove
Elective Surgery to private

AFTER THE DISEASE INCIDENT

5. RECOVERY

5.1. As activity and demand reduces, CALHN will de-escalate promptly and activate a recovery phase to return operations to business as usual, whilst capturing the lessons learnt and best practice from the incident.

5.2. CALHN shall appoint a Recovery Section Officer at Co-STAT-3 to develop a recovery framework.

5.3. Stand down activities will start with the onset of a decline in presentations and recorded cases and will take a number of weeks in the event that case numbers do not again peak in. Activities will include:

- 5.3.1. Support and maintain quality care
- 5.3.2. Cease activities that are no longer needed, and transition activities to seasonal or interim arrangements
- 5.3.3. Monitor for subsequent waves of outbreaks
- 5.3.4. Monitor for the development of antiviral resistance
- 5.3.5. Communicate to support the return from pandemic to business as usual
- 5.3.6. Evaluate systems and revise plans/procedures.

Service resumption

5.4. As a downgrade through CoSTAT phases occurs and need to initiate service resumption and recant services arises, then the IMT and NICC shall advice service owners and leads of the specific resumption and re-cant process required to support this.

6. APPENDICIES

1 - Incident Management / Command arrangements

	CoSTAT 1	CoSTAT 2		CoSTAT 3		CoSTAT 4		CoSTAT 5
Area / Theme	1	2A	2B	3A	3B	4A	4B	5
Commander	Ramp Up • Network Commander identified Ramp Down • Maintain Network Commander for extraordinary COVID matters.	• Network Commander onsite and daily 'check in' with NICC Manager / Support • Network Executive briefed initially and then as required		• Network Commander based in NICC Identify Deputy Commander for 12+ hour / 7 day operations • Network Executive briefed daily by Network Commander		• Network Commander based in NICC • Brief Deputy Commander daily • Network Executive briefed twice daily by Network Commander		• Network Commander based in NICC • Formally undertake shift handover to Deputy Commander at end of shift
Incident Management Team	Ramp Up • Core IMT identified Ramp Down • Core IMT stand down – available for recall	Ramp Up • Core IMT assume roles • Identify Functional Section and Cell requirements • Heavy emphasis on "PLANNING" and "PUBLIC INFO" functions Ramp Down • Core IMT on-call • Scale back Functional Section and Cell • Logistics Officer to reconcile and plan for reversion of facility changes.	Ramp Up • Core IMT attend NICC • Activate Functional Sections • Plan Functional Section(s) and Cells(s) footprint Ramp Down • Core IMT light touch in NICC • Scale back Functional Section and Cell • Planning Officer/Section to reconcile plans and arrangements	Ramp Up • Core IMT attend NICC • Functional Section and Cell operations • Heavy emphasis on "OPERATIONS" and "LOGISTICS" functions • Review weekend IMT requirements • Implement Functional Section and Cell office accommodation (Min. 5 days)	• Full core IMT operations • Implement Functional Section and Cell office accommodation (as required, up to 7 days)	• Implement Functional Section and Cell office accommodation (7 days) • Consider split shifts and/or Deputy Officer role rostering (+/- recall)		• Formally undertake shift handover to Deputy Officer at end of shift
NICC operation	Ramp Up • NICC Support Section prepare for NICC activation • NICC Support Section activate NICC mailbox • NICC Support initiate decision register Ramp Down • Revert to virtual NICC operations • NICC Support maintain decision register	• NICC Activated / operational • 5 day operations • 8 hour day • 1 x NICC Manager • 1 x NICC Support • 1 – 2 NIMT Support	• 5 - 7 day operations • 8 hour day • NICC roster developed	• NICC roster implemented • 7 day operations • 8 – 12 hour day • 1 x NICC Manager • 1-2 x NICC Support • 2 – 4 NIMT Support	• 7 day operations • 8 – 12 hour day	• 7 day operations • 10 - 14 hour day • Consider spilt shifts • 1 x NICC Manager • 2-3 x NICC Support • 3 – 6 NIMT Support		• 7 day operations • 14 - 24 hour operations • Implement rostered shift arrangements

	• No NICC support to Functional Units							
Briefing cycle	Ramp Up • As directed Ramp Down • As directed	Ramp Up • Min. 3 x weekly Ramp Down • Min. 2 x weekly		Ramp Up • Min. Daily Ramp Down • Min. 3 x weekly		Ramp Up • Min. 2 – 4 hourly Ramp Down • Min. 2 x daily		• Min. 1 – 2 hourly
Gate Review	• 2 – 4 weekly	• 1 – 2 weekly	Weekly	4 – 7 days		2 – 5 days		1 – 3 days

2 - CALHN COVID Gate Review Procedure

Objective

Provide IMT with accurate modelling and intelligence to review COVID status of CALHN in order to ensure CALHN responds appropriately to the COVID-19 pandemic.

Purpose

To review/update the assumptions and intelligence using the latest information/intelligence to guide remodelling and provide recommendations for IMT's consideration around CALHN's COVID status.

Gate Review Content

1. Situation Awareness Summary

- COVID Situational Report (SITREP)
    - Current CoSTAT level/ overview and key areas of the current status
    - Current overview from a state, national and international level
    - Current hot topics
- OPERATIONS
    - Any clinical service delivery changes
    - Any decompress / decant / change to current status
- PLANNING
    - Any shift in intelligence / data sources or modelling
    - Any workforce changes
- LOGISTCS
    - Any changes to current facility management
    - Any non-clinical service delivery changes
    - Any PPE changes
- COMMUNICATIONS & PUBLIC INFORMATION
    - Any targeted/key message changes

2. Operating Environment

- RAH and CALHN more broadly
    - Current operational overview of hospital capacity and bed plan
    - Clinic testing
    - Cell intelligence (ID, Clinical Operations)

3. Modelling/ intelligence

- Scenario modelling based on pre discussions as a planning and operations cell
    - SA numbers
    - SA hospital demand
    - SA ICU occupancy
    - PPE data CALHN and state
    - Pharmaceuticals
    - Other issues/intelligence for consideration

4. Recommendations

- Structure and Response
- Activity and decant
- Next gate review timeline

Process

Responsibilities

- Planning develop the Gate review content in collaboration with Operational and other relevant areas of the IMT
- The Gate review is delivered by the Planning Officer

Timelines

- The gate review is delivered at timelines as instructed by the IMT and guided by the Covid status of the organisation. Refer to CoSTAT matrix for further information.
- The IMT can also request ad-hoc gate reviews at any point in time.

Preparation

- The gate review pre meeting is hosted by the planning cell and suitable IMT representatives are invited.
- The planning intelligence role is required to update the data and modelling as close as possible to the review to ensure data relevance.

Delivery

- The initial gate review is presented to the IMT on the scheduled date with recommendations discussed and agreed to.
- A summarised gate review is then shared more broadly with the organisation via a larger invitation to the IMT sit rep and communication strategies to be considered to be shared more widely with the organisation such as Covid CEO Bulletins and potential for virtual video sharing. It should be highlighted that the information contained within the Gate Review was accurate and current as at the date the the review was delivered to the IMT.