COUNTIES MANUKAU HEALTH

18th May 2022

Official Information Act Request for – Building an Agile Healthcare System

I write in response to your Official Information Act request received by us 22nd December 2022.

The 20 DHBs' Technical Advisory Service (TAS) advised us that they were in contact with you over a period of several weeks to rescope your request and advise that the deadline for responding would be extended by DHBs.

On the 10th February 2022, we contacted you to advise that we were extending the timeframe to providing a response to your request until the 11th May 2022 under Sections 15 (a) and (b) of the OIA, whereby:

> (a) the request is for a large quantity of information and meeting the original time limit would unreasonably interfere with the operations of the agency, and
> (b) consultations necessary to make a decision on the request are such that a proper response to the request cannot reasonably be made within the original time limit.

TAS further advised that you had confirmed that your request for information was for a snapshot in time and you were aware that the info that you had requested will be out-of-date by the time you receive it.

Counties Manukau Health Response:
For context Counties Manukau Health (CM Health) employs over 8,500 staff and provides health and support services to people living in the Counties Manukau region (approx. 601,490 people). We see over 118,000 people in our Emergency Department each year, and over 2,000 visitors come through Middlemore Hospital daily.

Our services are delivered via hospital, outpatient, ambulatory and community-based models of care. We provide regional and supra-regional specialist services i.e. for orthopaedics, plastics, burns and spinal services. There are also several specialist services provided including tertiary surgical services, medical services, mental health and addiction services.

A. Administration Information

1. **Please let us know which DHB you represent**
   Counties Manukau District Health Board

Counties Manukau Health
Private Bag 93311, Otahuhu, Auckland
T: 09 276 0000 | cmdhb.org.nz

2. **Please let us know who we can contact. (Please note: this information will be confidential, and will only be used in response to this survey. We will also send this person our write-up of the survey results when it becomes available.)**
   Please contact the OIA Specialist at oia.request@middlemore.co.nz.
   For queries affecting all DHBs please contact Technical Advisory Services at oia@tas.health.nz.

B. Integrated health care strategy (general)

The following questions discuss (i) your DHB integrated health care strategy to mid-2022 and (ii) the level of consultation that has taken place since 1 June 2021.

Definition: ***For the purposes of this survey, an 'integrated health care strategy' refers to a comprehensive and coherent approach that brings together COVID-19 and business as usual (BAU) health care services.***

Note: We are aware that the health care system is likely to change in mid-2022 when DHBs are replaced by one national organisation, Health NZ.

3. **Have you prepared an integrated health care strategy on how the health care system in your district will manage COVID-19 and BAU health care services?**
   The Northern Region DHBs (Northland, Waitemata, Auckland and Counties Manukau) work closely together in planning its responses to the COVID-19 pandemic.

   We are well- prepared for COVID-19 and a potential resurgence and have provided national leadership in the implementation and development of best practice and equity-focused models over the duration of the Delta outbreak.

   The Northern Region DHBs Resurgence Planning document outlines how the region will manage COVID-19 and BAU health care services – see Attachment 2: Question 3 - Northern Region DHBs Resurgence Planning.

4. **If you have created an integrated health care strategy on how the health care system in your district will manage COVID-19 and BAU health care services, have you collaborated with other DHBs?**
   Yes, CM Health collaborated with other DHBs in our region and nationally on development of the Resurgence Plan and Care in the Community Framework.

   The work was led by the Chief Operating Officers National Forum and the General Managers Planning and Funding National Forum and supported by the Ministry of Health COVID Directorate.

5. **If you have prepared an integrated health care strategy, does the strategy align with the Civil Defence response plan? See response planning here and Coordinated Incident Management System (CIMS) here.**
   Yes, Civil Defence is a key partner in the preparedness of all emergency response planning. The CIMS Framework is used in an ECC/EOC response phase. DHB resurgence and resilience planning is the health system response framework during the pandemic.

6. **We are interested in the extent to which your DHB has consulted with other parts of the health care system when preparing your strategy. Please advise if you have consulted with any of the following groups since 1 June 2021**

It should be noted that consultation work was largely undertaken regionally by NRHCC on behalf of DHBs, but organisations we did connected with are ticked below. While we have not ticked all boxes below, indirectly professional networks would have linked into all of the below in some shape or form.

- ☑ A wide range of healthcare workers operating in your district
- ☑ Primary health organisations (PHOs) that you fund in your district
- ☑ Mental health organisations that you fund in your district
- ☑ Surgeons working in hospitals in your district
- ☑ Rest homes in your district
- ☑ Iwi and hapū in your district
- ☑ Pasifika organisations in your district
- ☑ Churches and other religious organisations in your district
- ☑ Funeral homes in your district
- ☐ Philanthropic organisations in your district
- ☐ Private businesses in your district
- ☑ Midwives in your district
- ☑ Schools in your district (as part of the vaccination programme)
- ☑ Ministry of Health
- ☑ New Zealand Aged Care Association
- ☑ New Zealand Nurses Organisation
- ☑ New Zealand College of Midwives
- ☐ New Zealand Plunket
- ☑ Immunisation Advisory Centre
- ☐ New Zealand Doctors Orchestra
- ☐ New Zealand Private Surgical Hospitals Association
- ☐ New Zealand Psychologists Board
- ☐ Mental Health Foundation
- ☑ Association of Salaried Medical Specialists
- ☐ Medicus Indemnity New Zealand Inc
- ☐ New Zealand Medical Association
- ☑ New Zealand Medical Students Association
- ☐ New Zealand Medical Professionals Ltd
- ☑ New Zealand Resident Doctors' Association
- ☐ New Zealand Rural General Practice Network Inc
- ☐ Pasifika Medical Association
- ☐ Pharmaceutical Society of NZ
- ☐ Te ORA Māori Medical Practitioners Association
- ☐ Te Rōpū Whakakaupapa Urutā: National Māori Pandemic Group
- ☐ The Medical Protection Society
- ☐ Auckland University Faculty of Medical Health & Sciences
- ☐ University of Otago, Wellington
- ☐ University of Otago, Christchurch
- ☐ Otago Medical School

The Care in the Community Framework and Resurgence Plan incorporate a multi-disciplinary approach and input from many sectors and business partners. We are declining to provide any further information under Section 18(f) of the Official Information Act due to substantial research and collation.

C. COVID – 19

The following questions explore: (i) the *COVID-19 National Hospital Response Framework*, (ii) capacity, data and logistics and (iii) hospital visiting policies.

Abbreviations

- **FTE means: Full-time employee**
- **HDU means: High-dependency unit**
- **HFNO means: High-flow nasal oxygen**
- **ICU means: Intensive care unit**

Definitions from the *COVID-19 National Hospital Response Framework* (version 4)
-'Orange Alert' – COVID-19 Hospital Moderate Impact: Multiple COVID-19 positive patients in your facility; community transmission is not well controlled; isolation capacity and ICU capacity impacted; significant staff absence, extensive staff redeployment, gaps not being covered.
-'Red Alert' – COVID-19 Hospital Severe Impact: Multiple COVID-19 positive patients in your facility; community transmission uncontrolled; isolation and ICU at capacity; all available staff redeployed to critical care.

7. **Was your DHB invited by MOH to comment on an early version of the COVID-19 National Hospital Response Framework?**
   DHBs contributed to the development of this Framework via their Chief Operating Officers. The Chair of the Chief Operating Officers was responsible for drafting this policy and guideline.

8. **Is your DHB intending to make available the latest version of the COVID-19 National Hospital Response Framework on your website? Note: We are aware of the *COVID-19 National Hospital Response Framework,* but only a few DHBs have a copy on their websites (often an older version).**
   Not applicable as this Framework was retired from use in November 2021.

9. **Please advise the following numbers for your district:**
   As at 22nd December 2021
   - **Number of employed FTE ICU/HDU Nurses**
     79.95 FTE Registered Nurses
     6.9 FTE Associate Charge Nurse Manager

   - **Number of available ICU/HDU beds (approximately) (excluding private hospitals)**
     12 Intensive Care Unit and 6 High Dependency Unit.

   - **Number of available HFNO beds (approximately) (in addition to ICU/HDU beds mentioned above) (excluding private hospitals)**
     Nil in addition. All Critical Care Complex beds have HFNO capability

10. **The Institute is interested in illustrating how the health care system has been impacted by COVID-19 surges. To this end, we would appreciate any data on the existing system. Please provide any retrospective data from your district on the following: (Note: Please include the date e.g. 6500 GP consultations in person from 1 March 2020 to 30 May 2020)**
    - **Number of elective surgeries**
      This information is publicly available on the Ministry of Health website at: https://www.health.govt.nz/publication/services-delivered-patient-discharge-and-case-weight-information

    - **Number of GP consultations in person**

- **Number of GP consultations by phone or video call**
- **Number of GP consultations by email**

  In relation to questions about GP consultations, we are declining this under section 18(f) of the Official Information Act as CMDHB does not hold GP consultation data requested.

  To collect this data, we would need to request it from each Primary Health Organisation (PHO) who would then need to request from each of their member General Practices. To ask each practice to pull this data and for PHOs to collate for their member practices and to forward to the DHB would be unreasonable at a time when general practice teams remain under high levels of stress and subject to potential burn out due to the response required to the ongoing COVID-19 outbreaks. A request such as this would add additional undue burden upon them.

- **If you do not collect this information, please advise who we can contact for this information**

  Information on the PHOs in our district is publicly available on our website at:
  - https://www.countiesmanukau.health.nz/for-health-professionals/primary-health-organisation-pho/

11. **Can you please explain what activating your 'regional' and 'out of region' management arrangements (as described in the COVID-19 National Hospital Response Framework (version 4)) will look like for your DHB? (Note: Please provide a copy/copies of any relevant documents using the upload button on the last page of the survey or email to survey@mcguinnessinstitute.org).**
    - **Regional management arrangements (see COVID -19 National Hospital Response Framework 'Orange Alert')**

      This Framework was retired from use in November 2021.

    - **Out of region management arrangements (see COVID-19 National Hospital Response Framework 'Red Alert')**

      This Framework was retired from use in November 2021.

12. **Has your management team raised concerns with the Board Members over the supply of any of the following resources in preparation for 2022? Please explain these concerns in detail in the comment box below.**
    - **Staff training to manage**
    - **COVID-19 patients**
    - **Funds (e.g. paying overtime or employing additional staff)**
    - **Health care and support of medical staff**
    - **PPE**
    - **Negative pressure Rooms**
    - **Oxygen**
    - **Pulse oximeters**
    - **Medicine**
    - **ICU/HDU beds**
    - **HFNO beds**
    - **Premises**
    - **Access to vaccination certificates of patients**
    - **Providing data security**

The CMDHB Incident Management Team kept the CMDHB Board regularly updated on everything related to the DHB COVID response and did not specifically raise any concerns that we were requesting the Board to act on. Any other issues are logged into our Risk Register which is regularly reported on to the Board.

13. What is your DHB's current number of FTE nursing staff, and what is your DHB's ideal number of FTE nursing staff as at 1 January 2022 (or another date of your preference)?

- **Current number of FTE nursing staff (A)**
  The number of DHB FTE nursing staff as at 31 December 2021 can be found at the following link:
  - https://tas.health.nz/assets/Workforce/DHB-Employed-Workforce-Quarterly-Report-December-2021.pdf

  The 'ideal' number of staff has been interpreted as outstanding vacancies at the time.

- **Ideal number of FTE nursing staff (B)**
  There is no 'ideal' number as nursing requirements flex up and down, based on how seasonal illnesses track, along with COVID-19 rates, level of acuity of presenting patients to the Emergency Department and demand on services.

- **Current deficit of FTE nursing staff (C = A – B)**
  As at 31 December 2021, vacancy FTEs of senior nurses, registered nurses and enrolled nurses was 288.74. Please note that this data is under revision as the senior nursing data includes some senior midwifery vacancies.

14. Does your DHB have a FTE nursing staff plan/s (discussing projections and how staffing gaps might be filled)?

CM Health does not have a plan as you describe. The following information may be of use:

The 20 District Health Boards collectively run the KiwiHealthJobs website. In December 2021, a Critical Care Nursing campaign was being prepared by the 20 District Health Boards collectively, for commencement in February 2022. The focus was to encourage New Zealand-trained or internationally qualified critical care nurses to come to Aotearoa New Zealand, to support the increased need for critical care nurses.

In addition, a generalist nursing campaign is also planned. This will target all nurses to support the needs identified through existing nursing vacancies and the nursing workforce pipeline work.

In terms of nursing training, the Nursing Pre-Registration Pipeline Working Group is a 20 DHB Director of Nursing (DoN) led programme of work in partnership with the Ministry of Health, NZNO, Nursing Council, education providers, aged residential care, and nursing leaders from across the sector. This working group operated through 2021 and continues to do so.

It aims to understand the pre-registration pipeline and to work with Tertiary Education Commission and education providers to ensure the supply and demographics of nurses match the demands and needs of the populations nursing serves. One initiative is development of an interactive supply and demand model for the nursing pipeline, to enable prediction of nursing supply and demand requirements in New Zealand over the next 10 years.

More information can be found at the following link: https://tas.health.nz/employment-and-capability-building/workforce-information-and-projects/nursing-workforce-resources/

15. Have your management staff or Board Members requested additional funding from MOH for any of the following resources in preparation for 2022? Please explain in detail in the comment box below.

- **Staff training to manage COVID-19 patients**
- **Funds (e.g. paying overtime or employing additional staff)**
- **Health care and support of medical staff**
- **PPE**
- **Negative pressure Rooms**
- **Oxygen**
- **Pulse oximeters**
- **Medicine**
- **ICU/HDU beds**
- **HFNO beds**
- **Premises**
- **Access to vaccination certificates of patients**
- **Providing data security**

No, we did not request additional funding as the Ministry of Health made specific bundles of funding available in regards to the DHB's COVID-19 response.

16. We understand that Auckland DHB is providing oximeters to all COVID-19 patients recovering at home (see here); is this something your DHB is considering providing?

Pulse oximeters are supplied to patients via the Northern Region Health Coordination Centre (NRHCC).

When Hospital in the Home was established, all COVID+ patients referred to COVID Hospital in the Home were provided with a pulse oximeter either at ED presentation or for patients discharging home after ward admission.

17. At what oxygen level are you suggesting COVID-19 positive individuals go to the hospital (e.g. <92)? Please explain.

We do not provide public advice on this matter.

All COVID positive patients referred to COVID Hospital in the Home were provided with a pulse oximeter either at ED presentation or for patients discharging home after ward admission.

As at 22nd December 2021, advice was as follows (before Whaanau HQ documents were produced).

(Information as per the *Monitoring COVID-19 symptoms at home* leaflet)

Patient Information November-December 2021 for COVID Hospital in the Home:

The Oxygen Saturation for patients to dial an ambulance and return to hospital was 92% and lower – i.e. do not hesitate and dial for immediate assistance.

COVID Hospital in the Home could be contacted (and St Johns after hours) for SpO2 93-94%.

18. **Below are key measures the Institute believes would be useful to make public. Do you agree? (The Institute is interested in creating a dashboard of key measures.)**
    - **The current 'alert level' (using the COVID-19 National Hospital Response Framework) for each hospital in your district (i.e. green, yellow, orange or red)**
    - **The number of COVID- 19 cases in your DHB or in each hospital**
    - **The number of COVID-19 cases in ICU/HDU in your DHB or in each hospital**
    - **The vaccination status of COVID-19 cases in ICU/HDU in your DHB or in each hospital**
    - **The number of COVID- 19 deaths in your DHB or in each hospital**

    This is requesting an opinion of the DHB and is not a request for Official Information.

19. **When your district was last at Alert Level 4, did your DHB stipulate the hospital visiting policy, or did each hospital stipulate the hospital visiting policy?**
    CM Health referred to the National COVID-19 DHB Hospital and Clinical Patient Visiting Guidance which provides overall guidance which DHBs can adapt for their local situation as relevant.

    We have attached our last local Alert Level 4 Hospital Visiting Policy as attachment 2.

20. **Has your DHB considered the placement of COVID-19 hospitals/oxygen hubs in regional communities?**
    No. CM Health follows the Care in the Community Framework. Any management of this would be overseen by the Northern Region Health Coordination Centre.

D. Future-proofing the health care system

Definition: ***For the purposes of this survey, 'COVID-19 ready' means that the DHB has the necessary resources to deal with COVID-19 surges in 2022 (e.g. staff training, staff numbers, protocols, treatments, beds and other resources in place).***

21. **Is your DHB COVID-19 ready?**
    Yes. Via the Northern Region Health Coordination Centre, we have a regionally developed Resurgence Plan and a Care in the Community Framework as at 22 December 2021.

22. **Have you developed a dashboard to measure the quality of the health care system you are delivering to people in your district?**
    We have developed a number of dashboards; these are reported to the Board via our Hospital Advisory Committee (HAC) and Community and Public Health Advisory Committee (CPHAC). We also use a business intelligence tool, 'QLIK' that is able to provide a wide variety of quality indicator information on an as-required and routine basis.

    Our Metrics that Matter dashboards can be accessed online in our HAC and CPHAC agendas, these dashboards include the Health System Indicators (Government priorities):
    - https://www.countiesmanukau.health.nz/about-us/who-we-are/governance/committee-meeting-agendas/

    Quality indicators are also available via the Ministry of Health and the Health Quality & Safety Commission:
    - https://www.health.govt.nz/nz-health-statistics/national-collections-and-surveys
    - https://www.hqsc.govt.nz/our-data/quality-dashboards/dashboard-of-health-system-quality/

23. **Have you raised concerns with the Minister of Health, MOH or Health NZ about the timing of the health care system reform proposed for implementation in July 2022 (given that COVID-19 surges are likely to peak around this time)?**
    CMDHB did not raise any concerns with Minister of Health, MoH about the timing of the reforms in July 2022 based on an assumption that COVID-19 would peak around this time. In addition, Health NZ did not exist as an entity at this time.

24. **In retrospect, is there anything your DHB would have done differently in preparing for a pandemic since January 2020?**
    We have worked effectively regionally and nationally to establish appropriate and timely protocols, guidelines and frameworks. DHBs constantly review and refine responses to meet the evolving needs of the pandemic.

25. **The Institute is currently developing our work programme for 2022. Is there any particular area of research we could undertake that would be useful for your DHB and/or the wider health care system? For example, are there areas where you believe the health care system needs strengthening (e.g. in terms of being prepared for low-probability high-magnitude events, such as burn units for eruptions, heat stroke units due to climate change, or respiratory units for wild fire victims)? Please expand**
    This is requesting an opinion of the DHB and is not a request for Official Information.

26. **Any other comments?**
    No.

27. **If you answered yes to 'Q3: Have you prepared an integrated health care strategy on how the health care system in your district will manage COVID-19 and BAU health care services?', please provide a copy of this strategy here.**
    Please see response to question 3 and attachment 1.

28. **If you answered yes to 'Q7: Was your DHB invited by MOH to comment on an early version of the COVID-19 National Hospital Response Framework?', please provide a copy of any written feedback here.**
    Please find the following attached as attachment 3:
    - COVID 19 Hospital Response Framework Version 1 Released 22 03 20_ DHB Feedback 22.3.20

    Chief Operating Officers (COO) feedback in red given to MoH by the Chair of Chief Operating Officers based on conversations with some COOs in March/April 2020.
    - COVID 19 Hospital Response Framework Version 1 Released 22 03 20_DHB Feedback 15.4.20

29. **If you have any relevant documents relating to 'Q11: Can you please explain what activating your 'regional' and 'out of region' management arrangements (as described in the COVID-19 National Hospital Response Framework (version 4)) will look like for your DHB? ', please provide a copy/copies of these here.**
    Please see response to question 11. The National Hospital Response Framework was retired from use in November 2021

30. **If you answered yes to 'Q14: Does your DHB have a FTE nursing staff plan/s (discussing projections and how staffing gaps might be filled)?', please provide a copy/copies of this here.**
    Please refer to the response to question 14.

31. **If you answered yes to 'Q15: Have your management staff or Board Members requested additional funding from MOH for any of the following resources in preparation for 2022?', please provide a copy/copies of this correspondence here.**
    N/A – please see response to question 15.

32. **For 'Q19: When your district was last at Alert Level 4, did your DHB stipulate the hospital visiting policy, or did each hospital stipulate the hospital visiting policy?', if you answered 'The DHB stipulated the hospital visiting policy for all hospitals in the district' please provide a copy of this policy document here.**
    As per question 19, please find attached as attachment 2.

33. **If you answered yes to 'Q22: Have you developed a dashboard to measure the quality of the health care system you are delivering to people in your district?', please provide a copy of your DHB's dashboard here.**
    Please see response to question 22 where publicly available links are supplied.

34. **If you answered yes to 'Q23: Have you raised concerns with the Minister of Health, MOH or Health NZ about the timing of the health care system reform proposed for implementation in July 2022?', please provide a copy/copies of this correspondence here.**
    N/A - please see response to question 23.

You are entitled to seek a review of the response by the Ombudsman under section 28(3) of the Official Information Act. Information about how to make a complaint is available at www.ombudsman.parliament.nz or Freephone 0800 802 602.

Please note that this response or an edited version of this may be published on the Counties Manukau Health website. If you consider there are good reasons why this response should not be made publicly available, we will be happy to consider this.

Yours sincerely

Dr Peter Watson
Acting Chief Executive Officer
Counties Manukau Health

Attachments:

- **Attachment 1 (Q3 & Q27): Northern Region DHBs Resurgence Planning (as at 23 December 2021).** Please note that the 20 DHBs provided their resurgence planning documents to the Ministry of Health in December 2021. The Northern Region's document reflects a particular point-in-time and significant work has taken place in the time since.
- **Attachment 2 (Q19 & Q32): Level 4 Visiting Policy (COVID-19)**
- **Attachment 3 (Q28): COVID 19 Hospital Response Framework Version 1 Released 22 03 20_ DHB Feedback 22.3.20** and **COVID 19 Hospital Response Framework Version 1 Released 22 03 20_DHB Feedback 15.4.20** (including COO comments/feedback to the MoH).

Attachment 1 (for question 3)

Provided to the Ministry of Health in December 2021

Northern Region DHBs Resurgence Planning

Confirmation of Preparedness

The Northern Region is well prepared for a Covid resurgence and has provided national leadership the implementation and development of best practice and equity-focused models over the duration of this Delta outbreak. All elements in this checklist are well established and stress-tested through real-time use.

Questions	**Response:** *(Complete/ Partially Complete/ Not Started)*	Comments
1. Care in the Community	**1.**	**2.**
a. Has the DHB established, or joined with, a Care Coordination Hub (see COVID-19 Care in the Community Framework)? (May refer 2a)	**Complete**	NRHCC has been managing community cases for the last four months for the Northern Region DHBs, working alongside: • ARPHS • MSD • Maaori health providers • Pacific health providers • Primary care providers • MBIE • Whakarongorau Whaanau HQ is the regional community COVID coordination hub for Metro Auckland, with a dedicated Northland COVID coordination hub also established. As part of the development of Whaanau HQ, both a Māori and Pacific regional coordination hub have been set up.
b. Are the Care coordination Hub roles, responsibilities and processes documented and well understood by all stakeholders and parties involved? (May refer 1c)	**Complete**	
c. Has a clear triage protocol been established to determine who from welfare, public health or clinical health, makes the initial contact with the positive case to begin discussing their ongoing care plan and who of these providers need be in contact and when?	**Complete**	
d. Are there clearly defined pathways for individuals who tests positive for COVID-19, with clearly defined roles and responsibilities covering:	**Complete**	
(1) - clinical health assessments?	**Complete**	
(2) - public health assessments?	**Complete**	
(3) – welfare assessments?	**Complete**	
e. Do all clinical care providers have 24-hour access to clinical advice for acute exacerbations?	**Complete** *(aligned with appropriate escalation pathways)*	
f. Have relevant staff been trained in the use of national IT solutions (BCMS, NCTS)?	**Complete** *(as new staff are on-boarded etc)*	
g. Has a process for discharging someone	**Complete**	

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with COVID-19 been established?		Strong multi-agency processes are in place to manage cases and are regularly reviewed and updated as needed. A regional clinical governance group for Whānau HQ has been established. The Covid Care at Home, or Hospital in the Home programmes are also in place, as a step between discharge and Whānau HQ.
2. Leadership, Planning and Relationships		
a. Has a well-established resurgence plan for COVID-19 been developed in conjunction with iwi, community groups and other health providers?	**Complete**	Each DHB has a resurgence plan, and the Northern Region has been actively managing COVID community cases for the last four months.
b. Has a regional or local coordination hub has been stood up, that includes members of relevant hospital, public health iwi, PHO, Māori health providers, welfare representatives, NGO and community groups?	**Complete**	NRHCC coordination hubs established to include these groups. Initial roles and responsibilities have been established with ongoing work as hubs evolve.
c. Have clear roles and responsibilities been defined between involved parties?	**Partially Complete**	
d. Has the resurgence plan been tested through a simulation exercise?	N/A	The Northern Region has been actively managing COVID community cases for the last 4 months, therefore the resurgence plan has been tested.

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e.	Do all staff and members of relevant hospital, public health iwi, PHO, Māori health providers, welfare representatives, NGO and community groups understand their role and what is expected of them?	**Complete**	NRHCC and coordination hubs established to include these groups.
f.	Are effective mechanisms for coordination and communication with MOH, MSD, community groups, Iwi, and other health providers are in place.	**Complete**	NRHCC coordinates all of this.
3.	**Workforce (includes hospital, ARC, community nursing and PHO)**		
a.	Have staffing requirements been estimated to prepare for and respond to the potential COVID-19 caseload and BAU services?	**Partially complete**	The Northern Region has been managing community COVID cases for the last four months. Contingency plans are in place and being enacted through well-established decision-making structures, however these will not address underlying significant workforce shortages. DHBs have recently completed a peer review of additional workforce requirements for COVID response inclusive of ICUs, Emergency Departments, COVID inpatient wards, security and visitor screening to ensure regional consistency. The MOH was informed of all Northern Region workforce requirements
b.	Are there staffing contingency plans to cover varying staff levels including absenteeism, sick leave, etc?	**Partially complete**	
c.	Is a decision-making structure, procedures, and arrangements in place to support the repurposing, reassignment and supplementing of staff (including community staff) where possible and required in the event of a surge?	**Partially complete**	

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		on 29/11/21 and has not yet provided a response.
d. Have additional workforce support pools been identified and trained (where required and appropriate)?	**Complete**	NRHCC is coordinating a regional surge workforce pool where appropriate. DHB providers are managing their own workforce requirements, noting that there are significant workforce vacancies across the Northern region DHBs, and this impacts inpatient capacity and requires re-prioritisation of planned care services on an ongoing basis. ICU nursing surge workforce training has been completed across regional DHBs with escalation triggers in place.
e. Are health and well-being procedures in place to manage staff wellness and care, including mental wellbeing and fatigue?	**Partially complete**	The Northern Region has been managing community COVID cases for the last four months. Staff well-being procedures are in place, however there are underlying workforce shortages that these cannot address. The MOH was informed of all Northern Region workforce requirements on 29/11/21 and has not yet provided a response.

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4. Equity		
a. Have strong relationships with iwi and iwi health providers been established?	**Complete**	The NRHCC recognise the importance of a strong and functional partnership with Māori stakeholders including Māori and iwi-led health providers in the region. The governance and working relationship has been lifted in the revised NRHCC governance and operational structure to ensure there is clear and joined up partnerships. The Māori Health IMT have been leading much of the engagement with iwi and MoU partners as part of this response. In terms of operational services, the NRHCC has supported Māori and iwi health providers in the way of community and outreach vaccination and testing mobile services, community testing centres, Whānau HQ support and focused vaccination campaigns and administration. Northland DHB have continued to work closely with iwi and community and one particular highlight are the five iwi-led community coordination hubs across

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		Te Tai Tokerau.
b. Have mechanisms for communicating with isolated communities been identified and activated e.g., access to therapeutics and medicines?	**Complete**	Plans in place with rural practices. E.g., Oximeters delivered to Great Barrier Island.
c. Are the specific issues for isolated communities without access to cell phone or internet coverage identified and arranged?	**Complete**	Cases without cell phones or internet have been managed for the last four months. Coordination hubs have the ability to support cases with these needs, working with MSD as appropriate.
d. Are Māori & Pacific first point of contact support personnel identified and available as well as translators of other languages?	**Complete**	Māori and Pacific regional coordination hubs have been stood up, working with local Providers to ensure cases are appropriately culturally assigned.
e. Are plans in place to ensure unvaccinated can be effectively transported and treated without marginalisation?	**Complete**	Unvaccinated cases have been managed in the Northern Region for the last four months.
f. Are mechanisms for managing communication with isolated communities without access to cell phone coverage and/or interest identified and arranged?	**Complete**	Plans in place with rural practices. E.g., Oximeters delivered to Great Barrier Island. Coordination hubs have the ability to support cases with these needs, working with MSD as appropriate.
g. Is there a plan in place to ensure continued access to testing and lab facilities in the case of delays due to surges in COVID-19 or other factors?	**Complete**	A prioritisation framework and process is in place to inform the trade-off between processing COVID-19 tests and BAU.
5. Welfare		
a. Is there a clear plan is in place to	**Complete**	Cases with Welfare

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	Question	Status	Comment
	ensure welfare needs are assessed simultaneously with clinical and public health needs and are the relevant groups well connected and coordinated?		requirements have been managed in the Northern Region for the last four months. NRHCC are coordinating this alongside MSD. Overall accountability for welfare has now transitioned to MSD. Some digital and process changes are still being worked through to support streamlined working and safe isolation in the community
b.	Is the DHB aware of, and involved in, the MSD welfare service delivery plan, with clear local and regional leadership and adequate DHB/PHO representation?	**Partially Complete**	
c.	Have adequate SIQ facilities been identified, which can house people for isolation up to 30 days and is the modelling of different surge scenarios factored into this plan?	**Complete**	Metro Auckland MIQ facilities exist and are being effectively used. Campervans are being used in Northland as an emergency option. Further modelling work is required to reflect the recently announced changes to 10 days stay and an extended period before medium risk border reopening occurs. Planning is required to ensure there are adequate SIQ facilities for a surge in community cases.
6.	**Facilities**		
a.	Has there been an assessment to identify the ability of hospital inpatient, outpatient, and intensive care unit capacity to adapt and expand	**Partially Complete**	All Northern region DHBs have facility plans in place for surge. While physical

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according to various surge scenarios?		capacity is in place and additional surge capacity identified, it should be noted that workforce availability will limit the use any surge capacity, noting planned care is already being impacts by physical inpatient bed and workforce capacity constraints. Additional negative pressure capacity has already been brought on stream to manage the current COVID outbreak.
b. Is there a plan in place for sharing patients across the region or with private care facilities, where appropriate and necessary?	**Complete**	There is an established Northern region inpatient and ICU COVID capacity plan that has worked well throughout the ongoing COVID response in Auckland. There is a plan in place to facilitate transfer of patients to Auckland from Northland DHB should this be needed Auckland private surgical providers have no capacity to support the ongoing delivery of planned care at this time due to their own reduced capacity and need to recover privately funded waiting lists
c. Has the DHB identified and prioritized essential support services that should be available, with adequate and backup resources for maintenance of these services?	**Complete for key services**	Business continuity plans have been developed for essential support services.

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d. Have backup resources necessary to optimally maintain essential support services been identified and are they accessible?	**Complete for key services**	Business continuity plans have been developed for essential support services.
e. Has the DHB identified, sourced, and planned for access to required infrastructure e.g., additional ICU facilities and/or wards?	**Complete**	As identified in the Northern region submission to the HIU.
7. Funding		
a. Does the DHB understand the funds it has access to in relation to COVID-19 activities and has plans and capability to access those funds?	**Partially complete**	COVID tracker used, but no feedback from MOH provided on COVID resilience funding bid provided 29 November 2021.
b. Is the DHB tracking expenses related to COVID-19?	**Complete**	COVID tracker used.
3.c. Has the DHB determined how specified services will be contracted and confirmed as loaded by Sector Operations so that payments can be made?	4.	Contracts have been extended to meet demand, with projected contingency capacity. Primary Care/pharmacy via POAC payment mechanism in place. New tranche underspend contracts progressing well. Sector ops and DHB contracting teams are closing down so any contractual changes/requirements will have to be retrospective if immediate additional capacity required (this has been done before).
8. Accessibility of data		
a. Does the DHB have direct access or via	**Partially complete**	Metro Auckland DHBs

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a regional arrangement to the Ministry's data warehouse (Snowflake)?		have full access. Northland DHB need permission for automatable access to Snowflake to automate Northland vaccination data.

SENT ON BEHALF OF THE CHIEF EXECUTIVES OF NORTHERN REGION DISTRICT HEALTH BOARDS

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COUNTIES MANUKAU HEALTH

Policy: Level 4 Visiting Policy - COVID 19

Purpose

The purpose of this policy is to communicate the actions which need to be taken by all staff to prevent the transmission of COVID-19 whilst NZ is in Level-4 COVID response where only essential work and travel is permitted and social distancing is required. It explains the exceptional circumstances (on compassionate grounds) that patients can receive visitors and the process for managing visitors who are attending outpatient appointments.

Scope of Use

This policy applies to all staff across the District Health Board, where there are inpatient services except Acute Mental Health.

Policy

- **No Visiting is permitted except in essential and compassionate circumstances and with prior arrangement with the Charge Nurse/Midwife Manager (Duty Manager if out of hours). No children under 15.** This approach has been agreed to by our regional partners and is aligned with our Counties Tikanga: "Haumara te taonga - Keeping our treasures safe".
- An example of essential and compassionate circumstances is the **critically ill or dying patient, Amber Care or Manawanui pathway.** Other agreed exceptions to the policy are below.
- Masks must be worn by all visitors and out patients

Agreed exceptions

Area	Policy
CCC	One named person on a case by case basis and with prior approval of Charge Nurse/Midwife Manager None - when they have a COVID patient
NICU	Mother only For those babies expected to stay over 48 hours the Father / one nominated support person for the mother can visit.
Kidz First	1 Primary caregiver 1 additional caregiver if seriously unwell child / Palliative/dying child Expected length of stay is >14 days. Ideally the same person to minimise risk.
Maternity	None unless approved by the Charge Midwife except for birthing (one person) and compassionate circumstances (still birth, extreme distress). Ideally the same person to minimise risk.

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ED	Patients <u>may</u> be allowed one support person in the department to assist with diagnosis and treatment. Once disposition in ED has been decided no visitor policy applies including ward and short stay areas.
All other areas	Must meet the criteria above for compassionate visiting (e.g.: discharge lounge, dialysis etc.).
Area	**Policy**
COVID-19 suspected or confirmed patients	**The Charge Nurse / Midwife Manager must consult with the Duty Manager before making compassionate visiting decisions** Minimise visitors and if they are essential/compassionate, help them to use same PPE protocol. *Visiting patients who have been admitted with COVID-19 is only permitted* ***at the discretion of the Clinical Nurse/Midwife Manager or senior clinician who is managing the patient and under the supervision of nursing staff****. The reason for this is to ensure Personal Protection Equipment processes are adhered to, and to minimise any risk of avoidable transmission. Other methods of communicating with a patient with COVID-19 should be facilitated as appropriate, such as video conference, Zoom, Skype etc.*[1].

Responsibilities

<u>Charge Nurse/Midwife, Managers & Shift Co-ordinators</u>

- Make **compassionate visiting decisions** given the clinical judgement: patient status, situation, consistency, and clinical environment situation, as all these aspects need to be taken into account.
- If unsure discuss with the Clinical Nurse Director in hours or Duty Nurse Manager out of hours.
- Speak to your patients; inform them of the **no visiting** rule and help them find alternative meansof keeping in touch via phone or zoom etc.
- Review your patients at the beginning of the shift for those that you think meet the criteria for compassionate visiting
- Complete the MS Teams form by 08:00 to create the list of visitors approved for coming on site including those attending for family meetings and carer education.
- Advise Security and the Visitor Entrance Coordinator immediately of patients who are **rapidly deteriorating** and where family have been asked to come in and update the MS Teams form contemporaneously.
- <u>Note we are not allowing people to bring or drop off food or clothes – so please do not raise expectations with patients.</u>
- Double check that patient has family/whanau contact via virtual means following the no-visitor decision

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For visitors to COVID positive patients:

- Undertake a risk assessment and advise the visitor of the risks before the visit takes place.
- Inform the visitor that they will be considered a casual contact. Following the visit Auckland
- Regional Public Health Service (ARPHS) will follow up with the visitor relating to the management of casual contacts. Provide the relevant information to ARPHS Emergency Operations (ADHB) arphsops@adhb.govt.nz particularly if there are any PPE breaches which would change the categorisation/risk profile of the visitor

Duty Nurse Managers

- Provide after-hours support to ward staff to make the compassionate visiting decision given the clinical judgement: patient status, situation, consistency, and clinical environment situation, as all these aspects need to be taken into account.
- Reiterate to the ward teams on each interaction to manage the visitor as the numbers for compassionate or visits cannot be managed by the front screening team.
- Escalate concerns to the COVID Response Manager on M: 021 348 252

Security

- Check that people attending entrances have a valid reason – see table below
- Provide security support to the Visitor Entrance Coordinator to manage visitors
- Manage queuing ensuring social distancing of 2 meters and manage gathering crowds

Visitor Entrance Coordinator

- Manage the briefing and induction process for screeners for each shift
- Enforce the policy and manage exceptions
- Liaise with wards and Duty Managers and Security to manage exceptions and changes in policy
- Ensure rapid processing of visitors for the quickly deteriorating patient / dying patient
- Identify and manage emerging risks
- Ensure continuity of screening staff and manage the roster
- Allocate screeners to areas according to meet the changing needs
- Review the shift with screeners for identification of improvement
- Develop and manage processes to support the effective and compassionate application of this policy

Entrance screeners

- Ask all visitors and patients the visitor screening questions using the Visitor App found on Paanui.
- If NO to all questions provide dated visitor sticker and approve for entry.
- Visitors that answer YES to any screening questions are not allowed entry.
- Provide visitor with a leaflet and suggest they return home, contact Healthline 0800 358 5453 or their GP.
- Encourage virtual means of contact with patient

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Procedure

Person	Nature of visit	Action
Outpatients	GP referred Radiology patients for chest X-ray	• Screen • If they answer YES to any screening questions, contact the department for their advice, extension number 52368 and 58629. • If answer NO to all questions provide dated sticker, a mask and send through.
	Patients attending the Galbraith Infusion Centre or haematology day ward	• No support people unless approved by the Charge Nurse Manager due to small space in the unit. Approval may be given if a support person is required to assist the patient with communication or to assist with self-cares • On arrival at the entrance screeners are to contact the relevant area and a nurse will attend to screen the patient. If they answer YES to questions and / or have a raised temperature they will be sent home and advised to contact GP, or sent to ED if acute management is required • If they answer NO to the questions & the temperature is normal provide a mask, dated sticker and send through
	Other patients attending appointments (have appointment letter or text message)	• Screen • If they answer YES to any screening questions, advise the department for their advice. • If answer NO to all questions provide dated sticker, a mask and send through
	Patients who have been phoned and asked to attend appointment	• Screen • Contact department to check appointment and advise result of screen. • If appointment confirmed and screen is negative provide dated sticker, a mask and send through

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	Patients with support people	• If patients are accompanied by a Support Person because they need assistance (e.g.: elderly / frail, needing assistance with communication / language but not interpreting) and the ONE support person also passes the screening tests, provide both with a mask, a dated sticker and send through. • Support people / family cannot interpret. Contact the Department who should arrange interpreter or make alternative arrangements e.g.: use telephones or virtual means
	Patients with children under 15	• Send home or ensure arrangements are made to collect the child
Visitors including repeat visitors	Visiting patients	• Screen (even if repeat visitor) • If answer NO to screening questions and they area approved compassionate visitor provide a mask, a dated sticker and send through. • If they answer YES to any screening questions decline entry, and suggest they contact HealthLine for advice. Advise the ward. • Children under 15 are not permitted. They should be sent home or arrangements made to collect the child.
	Visitor wants to drop off essential items to patients	• **Not permitted - Food** • Permitted – hearing aids, dentures, spectacles, phones, chargers, I Pad, Lap Top, E Readers, toiletries (100ml size), personal hygiene products, a change of clothes, expressed breast milk and/or specialised formula (NICU / Paediatric service). • Screener will provide labelled plastic bags for visitors to place permitted items in and logs. • Note baby car seats do not go up to the ward – staff
Business Visitor	On business or delivery of medical supplies	• Screen – if negative screen provide with dated sticker and send through. • If positive screen do not permit through but organise immediate delivery of the supplies (contact Orderly Service via Smart Page)

Approved by the IMT 31st March 2020 (updated essential items 17 April 2020).

This version 20 August 2021

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All District Health Boards

COVID 19 National Hospital Response Framework – The Process

- This Hospital Response Framework is designed to provide escalation levels to support a nationally consistent and managed approach to clinical service delivery in hospitals.
- These hospital escalation levels are specifically for hospitals and are different to the Pandemic Plan Levels and the National Alert Levels (announced by the Prime Minister on 21 March 2020) but are aligned.
- Each DHB may have hospitals at different levels of the Hospital Response Framework depending on the local situation. At whatever level a hospital is at, a consistent approach will be taken by following the Framework.
- The Framework aims to ensure that patients remain at the center of care by making proportionate responses to escalations in the COVID-19 pandemic.
- This document provides high level, nationally consistent guidance to support your DHBs' own emergency response procedures that will need to be deployed at each level.
- It is expected that alert levels may change rapidly and decisions are made locally at a DHB to move status up or down.
- Daily meetings should be the mechanism whereby alert levels are confirmed and actions initiated in daily reporting.
- The DHB escalation level should be reported each day to the National Health Coordination Centre (NHCC) so that a national view of escalation can be compiled. This will be via the NHCC DHB SitRep.
- A DHB should determine its escalation level daily with senior clinicians, senior managers and other relevant senior personnel as part of your local response plan. This decision should be clearly documented and evidenced.
- We know these criteria may evolve over time and be revised by the National Hospital Response Group and reissued as appropriate.

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COVID-19 National Hospital Response Framework

COVID-19 Hospital Readiness

GREEN ALERT

Trigger Status: 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

- Screen for COVID-19 symptoms & travel history for any new Emergency Department attendances, pre-op sessions, planned admission, or clinic attendance
- Plan for triage physically outside the Emergency Department (or outside the hospital building)
- Plan to have a separated stream for COVID-19 suspected cases and non COVID-19 cases in Emergency Department
- Undertake training and practice runs for management of a COVID-19 suspected case in the Emergency Department, Wards, Theatres, ICU/HDU
- Practice PPE use for COVID-19 care in the Emergency Department, wards, theatres, ICU/HDU, outpatients, other relevant settings
- Plan for isolation of a single case & multiple case/ cohorting
- Plan for Early Supported Discharge, aggressive discharge and step down arrangements, including with other partners as appropriate (e g private, aged residential care, community providers)
- Plan for separate streams for staffing, cleaning, supplies management and catering
- Plan for management of referrals, and increased workload on booking and call centre teams
- Plan to have a COVID-19 capable theatre for acute surgery for a known or suspected positive patient
- Plan and prepare a dedicated COVID-19 ward
- Engage with alternative providers (such as private) to confirm arrangements for their assistance during higher escalation levels, and to fast-track urgent, lower complexity care procedures such as cataracts, endoscopy etc
- Arrange for outpatient activity to move to telehealth and phone screening for virtual assessment, and MDTs to videoconference wherever possible
- Planned Care surgery, acute surgery, urgent elective and non-deferrable surgery to operate within a Covid-19 planning approach
- Review patients on the waiting list (surgery, day case, other interventions) and group patients by urgency level

COVID-19 Hospital Initial Impact

YELLOW ALERT

Trigger Status: One or more COVID-19 positive patients in your hospital; cases quarantined in your community; isolation capacity and ICU capacity manageable; some staff absence and some staff redeployment to support response and manage key gaps

- Continue screening for COVID-19 symptoms and travel history as per Green Alert
- Activate plans as described in Hospital Green Alert, as appropriate
- Activate Emergency Department triaging in a physically separate setting
- Activate streaming of suspected COVID-19 or COVID -19 positive and non-positive patients as planned across Emergency Department, Wards, Theatres, ICU/HDU, and have dedicated COVID-19 capable theatre available
- Activate Early Supported Discharge, aggressive discharge and step down arrangements, including with other partners as appropriate (e g private, aged residential care, community providers)
- DHBs to ensure appropriately discharged out of area patients back to domicile hospital or other setting (to be considered in conjunction with current and the destination Hospital's Alert Level)
- Acute surgery, urgent elective, and non-deferrable surgery to operate as usual, with consideration given to repatriation processes if patient is non-domicile
- Start to move pre-op assessments and outpatient appointments to be undertaken virtually or in an off-site setting as necessary
- Defer non-urgent pre-assessments and non-urgent clinic patients unless can continue to be managed
- Activate any outsourcing arrangements reached, and engage on options for supporting 'cold trauma' cases and less-complex urgent cancer surgery
- Redeployment of staff as needed/available to ensure perioperative workforces are in place to run theatre, including anaesthesia, anaesthetic technicians, nursing Scale back delivery of non-urgent Planned Care as needed
- Planned Care surgery and other interventions to be prioritised based on urgency, and where ICU/HDU **is not** required, delivery should continue as much as possible

COVID-19 Hospital Moderate Impact

ORANGE ALERT

Trigger Status: One or more COVID-19 positive patients in your hospital; community transmission/multiple clusters in your community; isolation capacity and ICU capacity impacted; significant staff absence, extensive staff redeployment, gaps not being covered

- Continue screening for COVID-19 symptoms and travel history as per Green Alert
- Activate plans as described in Hospital Green and Yellow Alert levels
- Divert end of life patients to alternative providers
- Provide Emergency Department services with prioritisation on high acuity medical and trauma care where outcomes are likely to be good Provide advice in non-contact settings where possible
- Fully activate any agreements reached with private (or other) providers
- Acute surgery to operate as usual, with priority on trauma and urgent care cases, as staffing and facilities allow and where outcomes are likely to be good
- Prioritise urgent non-deferrable Planned Care cases not requiring ICU/HDU care
- Postpone all non-urgent high risk Planned Care surgery requiring HDU/ICU, adjusting the prioritisation threshold for surgery with Senior Clinician for non-deferrable cases
- Increase ICU/HDU capacity as needed, retaining cohorting of suspected COVID-19 and COVID-19 positive and non-positive patients, including moving non-COVID-19 ICU/HDU to theatre complex or other location that is manageable
- Postpone all outpatient activity and pre-op assessments, and implement acute ambulatory assessments or virtual/telehealth assessments for urgent, non-deferrable cases only, as staffing allows

COVID-19 Hospital Severe Impact

RED ALERT

Trigger Status: One or more COVID-19 positive patients in your hospital; community transmission/widespread outbreaks in your community; isolation capacity, ICU capacity at capacity; all available staff redeployed to critical care

- Emergency Department services limited to high acuity medical and trauma care
- Activate plans as described in Hospital Green, Yellow and Orange Alert levels
- Do not accept end of life patients
- Continue acute surgery as staffing and capacity allows, prioritising non-deferrable, life-saving surgery
- Cancel all non-acute surgery
- Activate additional streaming, including non-COVID-19 ICU/HDU to theatre complex, or private provider if agreement reached
- As a last resort, move ventilated COVID-19 patients to repurposed ICU/HDU theatre complex or other locations manageable for overflow; aim is to not impact on ability to meet non-deferrable, life-saving acute surgery
- Continue with acute ambulatory assessments or virtual/telehealth assessments for urgent, non-deferrable cases only, as staffing allows

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MINISTRY OF HEALTH
MANATŪ HAUORA

COVID 19 National Hospital Response Framework – The Process

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- A DHB should determine its escalation level daily with senior clinicians, senior managers and other relevant senior personnel as part of your local response plan. This decision should be clearly documented and evidenced.
- We know these criteria may evolve over time and be revised by the National Hospital Response Group and reissued as appropriate.

Commented [DC1]: Will align to new parameters and updated here

Commented [DC2]: Reference a new bullet point about how we are to use the current process of CPAC and existing triage practices to make explicit for services

Commented [DC3]: Do we then look to include services within a hospital may have different levels enabling them to operate within the framework

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All District Health Boards

COVID-19 National Hospital Response Framework

COVID-19 Hospital Readiness

GREEN ALERT

Trigger Status: No COVID-19 positive patients in your hosp tal; no cases in your community; managing service delivery as usual with only staffing and facility impact being for training & readiness purposes

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- Undertake training and practice runs for management of a COVID-19 suspected case in the Emergency Department Wards Theatres ICU/HDU
- Practice PPE use for COVID-19 care in the Emergency Department wards theatres ICU/HDU outpatients other relevant settings
- Plan for isolation of a single case & multiple case/ cohorting
- Plan for Early Supported Discharge aggressive discharge and step down arrangements ncluding with other partners as appropriate (e.g. private aged residential care community providers)
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- Arrange for outpatient activity to move to telehealth and phone screen ng for virtual assessment and MDTs to videoconference wherever poss ble
- Planned Care surgery acute surgery urgent elective and non-deferrable surgery to operate as usual
- Review patients on the waiting list (surgery day case other interventions) and group patients by urgency level

COVID-19 Hospital Initial Impact

YELLOW ALERT

Trigger Status: One or more COVID-19 positive patients in your hospital; cases quarantined in your community; isolation capacity and ICU capacity manageable; som[illegible] aff [illegible]bsence and some staff redeployment to support response and manage key gaps

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- Activate Early Supported Discharge aggressive discharge and step down arrangements including with other partners as appropriate (e.g. priv[illegible]te a[illegible] residential care community providers)
- Engage across other DHBs to appropriately discharge out of area patients back to domicile hospital or other setting (to be considered [illegible] conju[illegible]ctio[illegible] with current Hospital Alert Level at other DHBs)
- Acute surgery urgent elective and non-deferrable surgery to operate as usual with consideration given to repatriation processes if [illegible]ati[illegible]t is [illegible]on-domicile
- Start to move pre-op assessments and outpatient appointments to be undertaken virtually or in an off-site setting as necessary
- Defer non-urgent pre-assessments and non-urgent clinic patients unless can cont nue to be managed
- Activate any outsourcing arrangements reached and engage on options for supporting 'cold trauma' cases and less-complex [illegible]rgent c[illegible]ncer surgery
- Planned Care surgery and other interventions to be pr oritised based on urgency and where ICU/HDU **is not** required delivery s[illegible]d continue as much as possible
- Redeployment of staff as needed/available to ensure perioperative workforces are in place to run theatre ncluding ana[illegible]hesia anaesthetic technicians nursing. Scale back delivery of non-urgent Planned Care as needed.

COVID-19 Hospital Moderate Impact

ORANGE ALERT

Trigger Status: One or more COVID-19 positive patients in your hospital; community transmission/multiple clus[illegible]ers [illegible] your commun ty; iso ation capacity and ICU capacity impacted; significant staff absence, extensive staff redeployment, gaps not being covered

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- Fully activate any agreements reached with private (or other) providers
- Acute surgery to operate as usual with priority on trauma cases as staffing and faci[illegible]s allo[illegible]
- Prioritise urgent non-deferrable Planned Care cases not requiring ICU/HDU care
- Postpone all non-urgent high risk Planned Care surgery requiring HDU/ICU a[illegible]ju[illegible]ting [illegible]e prioritisation threshold for surgery with Senior Clinician for non-deferrable cases
- Increase ICU/HDU capacity as needed retaining cohorting of suspected [illegible] 19 [illegible]nd COVID-19 pos tive and non-positive patients including moving non-COVID-19 ICU/HDU to theatre complex
- Postpone all outpatient activity and pre-op assessments and implemen[illegible] ac[illegible]e ambulatory assessments or virtual/telehealth assessments for urgent non-deferrable cases only as staffing allows

COVID-19 Hospital Severe Impact

RED ALERT

Trigger Status: One or more COVID-19 positive patients in your hospital; community transmission/widespread outbreaks in your community; isolation capacity, ICU capacity at capacity; all available staff redeployed to critical care

- Emergency Department services limited to high acuity medical and trauma care
- Activate plans as described in Hosp tal Green Yellow and Orange Alert levels
- Do not accept end of life patients
- Continue acute surgery as staffing and capacity allows prioritising non-deferrable life-saving surgery
- Cancel all non-acute surgery
- Activate additional streaming including non-COVID-19 ICU/HDU to theatre complex or private provider if agreement reached
- As a last resort move ventilated COVID-19 patients to repurposed ICU/HDU theatre complex for overflow aim is to not impact on ab lity to meet non-deferrable life-saving acute surgery
- Continue with acute ambulatory assessments or virtual/telehealth assessments for urgent non-deferrable cases only as staffing allows

Released under Official Information Act

Version 1.0, released 22 March 2020

MINISTRY OF HEALTH
MANATŪ HAUORA