COUNTIES MANUKAU HEALTH

8th October 2021

s9(2)(a)

Dear s9(2)(a)

Official Information Act Request for – ICU Data

I write in response to your Official Information Act request received by us 23rd August 2021, you requested the following information:

1. **Since March 2020 and by each month thereafter, the number of fully staffed/operational ICU beds available, ICU capacity, a breakdown of all ICU staff (such as numbers of ICU nurses) and any vacancies, and how many surgeries were rescheduled or postponed/cancelled.**
2. **Since March 2020, copies of any reports, documents or briefings that include information about ICU capacity, including (but not limited to) in relation to Covid-19, such as contingency plans to scale up capacity.**
3. **Since March 2020, copies of all correspondence with the Ministry of Health regarding critical care and ICU, in relation to Covid-19, such as confirmation of current capacity and plans to scale up capacity.**

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.

1. **Since March 2020 and by each month thereafter, the number of fully staffed/operational ICU beds available, ICU capacity, a breakdown of all ICU staff (such as numbers of ICU nurses) and any vacancies, and how many surgeries were rescheduled or postponed/cancelled.**
   At CM Health, our Critical Care Complex is made up of our Intensive Care Unit and our High Dependency Unit. Intensive Care Unit (ICU) is a facility where regional, supra-regional and national specialist services provided to children (paediatric medicine) and adults. Some bed spaces within ICU are grouped, others dedicated (paediatrics) and/or equipped (dialysis capable) within environments (isolation) specific to the needs (positive air flow and consistent heating) and support of the patient.

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In the Critical Care Complex, our capacity available is 18 bed spaces. In ICU, we are staffed to resource 12 beds with 12 nurses per shift (1 Nurse to 1 Patient) to provide bedside patient care. In HDU, we are staffed to resource 6 beds with 3 nurses per shift. The unit is staffed with 3 Senior Medical Officers during the day (reduced to 2 Senior Medical Officers over the weekend) and one Senior Medical Officer overnight 24/7, 7 days a week.

Capacity variables include number of patients that can be grouped, stabilised or recovering (post-surgery, medical intervention) in a single day requiring transfer to the ward for ongoing care, treatment and discharge planning. Variables reviewed each morning and at midday resulting in very few actual theatre cancellations.

Vacancies vary, when one occurs we are always in the process of trying to cover that vacancy immediately, for example Maternity leave cover. Due to Covid-19 and the borders being closed at various times over the last year the vacancies have reduced the number of staff leaving to travel for experience, or to reunite with family.

The below tables reflect the occupancy from January 2020 to August 2021.

2021	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Bed Days	277	320	346	269	278	335	308	293	-	-	-	-
Available	496	448	496	480	496	480	496	496	-	-	-	-
Occupancy %	56%	71%	70%	56%	56%	70%	62%	59%	-	-	-	-

2020	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Bed Days	252	270	259	244	316	280	317	309	336	312	338	323
Available	496	464	496	480	496	480	496	496	480	496	480	496
Occupancy %	51%	58%	52%	51%	64%	58%	64%	62%	70%	63%	70%	65%

Data Sourced: Middlemore Central

In relation the number of surgeries that were postponed/cancelled since March 2020 due to Covid-19 was 593 surgeries. Please note, Urology or Orthopaedics recovered lost volumes so these are excluded from the final count). This also excludes both surgical cases lost to Industrial Action and surgical cases lost to Acute workload deferring Planned Care.

With the ongoing Covid lockdown continuing (August 16 2021 – current) CM Health is continuing to operate at reduced capacity. Between 16th August 2021 and 20th September 2021 we have needed to cancel/reschedule around 1,150 Elective surgical procedures. The ongoing nature of Auckland's lockdown will see deferred surgeries continue.

2. **Since March 2020, copies of any reports, documents or briefings that include information about ICU capacity, including (but not limited to) in relation to Covid-19, such as contingency plans to scale up capacity.**
Attached as appendix 1 is the most up to date version of the Critical Care Complex Alert Level Preparedness Framework to Covid-19 throughout the changing National Alert Levels.

In addition, publicly available on our website is the CM Health Alert Level Preparedness Framework. The high level framework can be found at the following link, it is a living document and is updated as circumstances change:

- https://www.countiesmanukau.health.nz/covid-19/resources/

3. **Since March 2020, copies of all correspondence with the Ministry of Health regarding critical care and ICU, in relation to Covid-19, such as confirmation of current capacity and plans to scale up capacity.**
   This is not routinely collected or centrally stored by CM Health and would involve considerable time for individuals to manually search through to retrieve this information. In order to provide this information would take the frontline staff who are currently responding to the Covid Delta outbreak away from their work. We have, therefore, determined to decline this element of your request under Section 18(f) of the Official Information Act due to substantial collation and research.

I trust this information answers your request. 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

Fepulea'i Margie Apa
Chief Executive Officer
Counties Manukau Health

CM Health Critical Care Complex - Covid-19 Preparedness Plan

Risks	NZ COVID-19 Alert Level 1 Prepare (Inc. Community Transmission)	NZ COVID-19 Hospital Alert Level 1 Readiness	NZ COVID-19 Hospital Alert Level 2 Intial Impact	NZ COVID-19 Hospital Alert Level 3 Moderate Impact 5-10 patients	NZ COVID-19 Hospital Alert Level 4 Severe Impact 10-13 patients	NZ COVID HOSPITAL CODE BLACK - Widespread Community transmission >13 patients
Create Capacity	• Ensure all bedspaces operational • Fit HEPA filters into ISO 1 and 2 • Liaision with other services regarding preparation for alternate high dependency care areas	• Continue cohorted area for COVID and non -COVID areas • Identify patients for earlier than usual safe discharge (particularly HDU) • MMC to start prioritizing ICU discharges • Notify DCCM and NSH ICU – initiate regular teleconferences	• Close HDU and concentrate nurses in ICU area • Start moving elective surgery from MMH to alternate areas. • Daily teleconferencing with ACH and NSH – monitor patient loads across all 3 DHBs • Cancel all elective admissions to CCC. Further electives to be negotiated according to urgency and staffing resource allocated in advance. May use other areas.	Aim to maintain 7 bed non COVID ICU for other acute admissions in the HDU Area • Bypass of SCi patients from regions outside of Auckland Metropolitian • All ICU discharges to get beds allocated within 6 hours. • Identify areas for placement for palliation of existing patients • Open alternate care areas for high level surgical patients • Diversion of all paediatric patients to PICU • Consider transfer of PCU to MMH to aid in the managment of post surgical patients	• PACU fully operational for all post surgical ICU other than requiring multi-organ support including RRT • Consider use of OT spaces for ventilation of non-COVID patients - TADU first line • Explore airflow and consequences of OT use for ventilating areas COVID patients • Consider changes in nursing ratios for lower acuity ICU patients • Identify beds across city and in nearest regions eg Waikato	• Placement of intubated patients into open unit (if negative air flow establihsed) • Operationalise OT areas for management of COVID patients • Seek assistance for Nursing Staff from other facilities eg private hospitals • Change nursing model especially in the HDU / non ventilated cohort
Protect Workforce	• PPE protocols to be refined and finalized • Ensure adequate supply • Look at staffing for safe PPE – PPE check nurse and buddies	• Continue PPE monitoring • Anticipate increased use • Fully section off cohorted COVID area • Visitor limitations in place for COVID patients	• Consider visitor limitations for all patients moving then to close unit to visitors • Increase PPE ordering and supply	• Additional resource from IC and members of staff for PPE checking • Closure of unit to visitors	• Full PPE for whole unit • No visitors • Explore change in PPE to boiler suit and dedicated HEPA masks to assist comfort and duration of use	• Consider change in PPE to boiler suit and dedicated hEPA masks to assist comfort and duration of use
Increase Workforce	• Identify critical care capable nurses around hospital and region and contact • Identify nurses that may be trained to operate at critical care level • Liaison with Anaesthesia about mixed workforce and provision of medical staff • Aim to improve nursing shift numbers to allow 12 ICU + 6 HDU • Work with PAR team lead and NPs in creating alternate RRT model	• Additional nurse resource – maintain full 12 ICU / 8 HDU staffing	• Deploy extra nursing staff. • Initiate rapid ICU nursing education • Aim to increase regular nursing numbers to 16 + 3 per shift • Anticipate when to deploy SMO roster with additional out of hours cover • Begin requests for deployment of Registrars to ICU including Senior Registrars (from Anaesthesia) • Redeploy ex PAR interns from ED back to PAR • Initiate new RRT model with Anaesthesia support, PAR team and NPs to take oversight of MET system. Integrate this with increased primary team responsibility	• Increase nursing roster to 21+3 • Switch to full partial shift Roster for SMOs • Consider additional Anaesthesia resource for Registrars / Senior Registrars • Assess and plan to for esculation into open space areas in ICU - requirements for ventilation • Confirm population plan for COVID patients into bed spaces - and resources / requirments to open further capacity in the open / main ICU - Explore and activate plans to change airflow in the ICU to negative flow	• Increase nursing roster to 25 + 3 • Use of non ICU nurses supervise 1 2 or 1 3 by ICU trained nurses • All electives cancelled – use additional Anaesthesia workforce • Implement COVID bed escuation model as follows - Double bunking in Flex 1 - 3 (6 patients) - Utilisation of Iso 1 - 3 (3 Patients) - Investigate Double bunking in Flex 4 - 7 if possible (4 - 8 patients) - Confirm safety of placing Intubated COVID patients in Open ICU area • Investigate requirments to convert HDU into COVID area	• Implement **maximum** COVID bed escuation model - Priority Non Ventilated Patients / COVID suspected (not proven) into Isolation Rooms - Double bunking in Flex 1 - 3 (6 patients) - Utilisation of Iso 1 - 3 (3 Patients) - Double bunking in Flex 4 non intubated patients (8 patients) - Intubated patients to open ward (if air flow changes have been undertaken) - 8 patients
Secure equipment	• Equipment counts and bio-med • Gas supplies to hospital • Identify alternate sources of essential equipment – ventilators and pumps • Identify and mobilise additional ventilators from PB – aim for 26 + 6 vents	• Monitor all essential equipment • Maintain operational levels with Bio-med	• Start to move equipment from stores to clinical areas • Identify additional resource from outside hospital eg private hospitals and begin to move	• Check and assess equipment stock and	• Mobilise all equipment resources across region	• Seek assistance for a National response
Service demands	• Liaison with Surgical services re escalation plan • Liaison with Paeds and PICU	• Start process to defer all non urgent elective surgery • Liase with Anaesthesia regarding process of PACU set up and Paeds regarding KF HDU	• Consider use of TADU or PACU for post surgical HDU demand • Open KF medical Paediatric HDU • Transfer children direct to PICU • Liaise with Gen Med re opening low level HDU capacity (metaraminol)	• Notify surgical services for initiation of alternate care pathways for SCI and potentially Burns	• Triage all requests for provision of SCI care. • Utilise regional Burns centres for major Burns	• Triage all requests for provision of SCI care. • Utilise regional Burns centres for major Burns, and support ongoing treatement in those centres
Consider level of triage	• Normal clinical criteria for admission	• Normal triage criteria	• No palliative admissions or admissions for very limited HDU therapies only • No admissions for monitoring only or when do not require specific ICU only therapy. • Initiate process of front door identification of patients not for escalation to ICU and clear documentation	• Initiate formal triage criteria for admission and de-escalation • Additional SMO to be used for opinions re triaging	• Full / highest level triage criteria	• Regional triage for all patients requiring ICU care (COVID and Non-COVID)
Tracking	Daily monitoring of community case load of COVID patients and any hospital cases	• Monitor COVID case numbers in hospital • Start modelling for increased admissions	• Monitor numbers across all 3 DHBs using whiteboard	• Monitor admissions and ICU capacity nationally		Ongoing regional daily Updates

September 2021 - This is a living document and is subject to ongoing updates as required