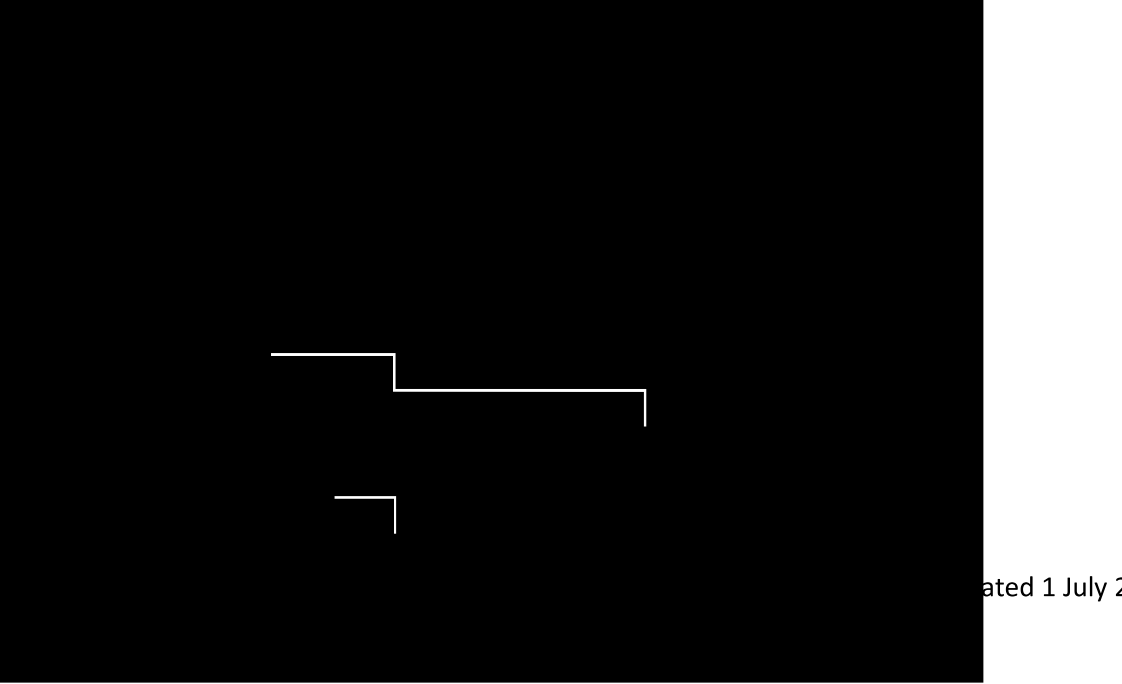
MDHB Responses to OIAs received July to September 2021

Suicides at PN Hospital April-June 2021 (Y21-988)
Ambulance delays (OIA Y21-940)
Board reports on abortion (OIA Y21-941)
Progressive procurement policy (OIA Y21-942)
OPCAT inspections of Secure Aged Care Facilities (OIA Y21-1137)
Contraception Funding (OIA Y21-1033)
Staff surveys (OIA Y21-1044)
Mental Health Service Provision (OIA Y21-1110)
Schools & Gardasil vaccination programme (OIA Y21-1114)
Children in Care (OIA Y21-1153)
Pharmacy Staff Seconded to COVID-19 Vaccination Programme (OIA Y21-1154)
All OPCAT correspondence re Aged Care facilities (OIA Y21-1172)
IT systems reports & Francis Group (OIA Y21-1059)
Enable NZ services and bathroom upgrades (OIA Y21-1066)
HIMSS maturity assessments (OIA Y21-1109)
ED RMO FTE & ED Presentations (OIA Y21-1139)
Psychologists FTE (OIA Y21-1140)
Sonography wait times (OIA Y21-1171)
Complaints re in-home care providers (OIA Y21-1189)
IV chemotherapy (OIA Y21-1183)
Fossil fuel usage (OIA Y21-1299)
ICU capacity (OIA Y21-1263)
Admittance protocol on receipt of COVID-19 patients (OIA Y21-1282)
ARC Facilities (OIA Y21-1288)
COVID Preparedness documents (OIA Y21-1301)
Te Uru Arotau - Business Continuity Plan (attachment OIA Y21-1301)
Te Uru Pa Harakeke - Business Continuity Plan (attachment OIA Y21-1301)
Pandemic Plan 2019-2022 -
http://www.midcentraldhb.govt.nz/Publications/AllPublications/Documents/Pandemic%20Plan%202019-2022.pdfResurgence Plan
COVID-19 Resurgence Plan (attachment to OIA Y21-1301)
OIA response times (OIA Y21-1380)
Mental Health Services waitlists (OIA Y21-1381)
Hypospadias repairs etc (OIA Y21-1293)
ICU bed occupancy (OIA Y21-1292)
Funding acute admissions (OIA Y21-1325)
Outpatient radiology procedures (OIA Y21-1326)
Handling of COVID close contact (OIA Y21-1337)

Rest home nursing shortages (OIA Y21-1340)
Appointments delayed during lockdown (OIA Y21-1351)
Medical Day-stay infusion capacity (OIA Y21-1379)
ICU Beds & CPAC thresholds (OIA Y21-1388)
Elective surgery in private sector (OIA Y21-1395)
Staff Survey (OIA Y21-1411)
Gender-affirming healthcare treatments (OIA Y21-1475)
Community-based Isolation and Quarantine Plan (OIA Y21-1521)
Radiation Therapist data (OIA Y21-1534)
Endometriosis (OIA Y21-1407)
Online ICU training (OIA Y21-1412)
Prostate ultrasounds (OIA Y21-1414)
Immunisation rates for children (OIA Y21-1308)
Trans vaginal ultrasounds (OIA Y21-1478)
COVID Protocols (OIA Y21-1485)



ated 1 July 2021.

Further to my previous email, please confirm is at Palmerston North hospital have there been any suspected suicides in the last 3 months.

On behalf of MDHB I can confirm there was an unexpected incident in Palmerston North Hospital on 8 June 2021. This incident, which resulted in a death, is under investigation by the Coroner. MDHB are awaiting further information from the Coroner and will comply with all requests for reports or information. In addition, under our adverse events policy, MDHB is also investigating the event.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website ten working days after your receipt of this response.

If you are not satisfied with our response to your information request, you have the right to seek a review by way of complaint by the Ombudsman of your decision. Information about how to make a complaint is available at ww.ombudsman.parliament.nz or freephone 0800 802 602.

Yours sincerely,

Judith Catherwood
General Manager, Quality & Innovation

Official Information Act (OIA) Request

Your OIA request of 2 July 2021 to MidCentral District Health Board (MDHB) is acknowledged and has been passed on to me for response.

You have requested the following information.

- **Whether ambulances have found delays when handing people over to A&E so far this winter.**

  MDHB does not monitor the drop off/waiting times for ambulances. St John is a separate organisation to the DHB. We suggest you contact them directly for a response.

- **How frequently people are waiting more than 15 minutes to be handed over to A&E from the ambulance.**

  Please refer to the above.

- **How this winter compares to the previous three years.**

  Please find below comparable figures over the past three years for April, May and June, given that we are only a month into July this year.

  Note: 2020 patient presentations were significantly influenced by COVID-19 lockdown guidelines.

Month	2019	2020	2021
April	3,847	2,696	3,900
May	3,946	3,167	4,024
June	4,002	3,825	4,357

Operations Executive, Acute & Elective Specialist Services
MidCentral District Health Board, PO Box 2056, Palmerston North 4440
Telephone (06) 356 9169

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website 10 working days after your receipt of this response.

Yours sincerely

Lyn Horgan
Operations Executive
Acute & Elective Specialist Services

MIDCENTRAL DISTRICT HEALTH BOARD

Te Pae Hauora o Ruahine o Tararua

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

23 July 2021

Dear

Official Information Act (OIA) request – Y21-941
Quarterly reports on abortion

Thank you for your request for information dated 2 July 2021. Your email has been acknowledged and passed onto me for a response.

You have requested MidCentral District Health Board (MDHB) provide you with information to the following questions:

A copy of the information on abortion provided to the Ministry of Health in your Boards quarterly reports for the last quarter of 2020 and the first quarter of 2021.

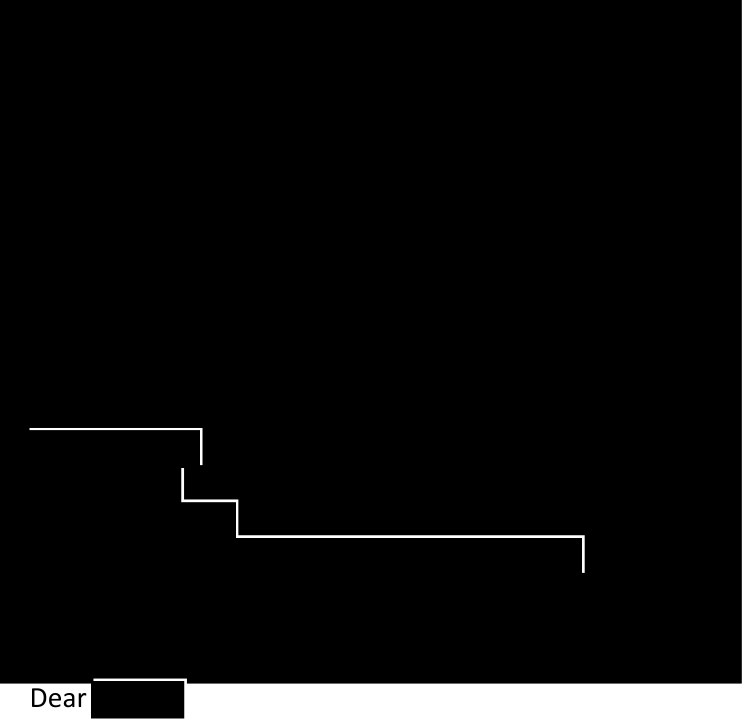
No information on abortion has been featured in MDHB Board reports to the Ministry of Health over the stated time period.

Please note that this response, or an edited version may be published on the MDHB website ten working days after your receipt of this letter. Please let me know if you have any objections to this as soon as possible

I hope this information is what you require.

Yours sincerely

Sarah Fenwick
Operations Executive
Te Uru Pā Harakeke
Healthy Women Children and Youth



Dear

In response to your recent Official Information Act 1982 request regarding:

1. *Copies of any communications you have sent to suppliers or contractors asking whether they meet the definition of a Māori business.*
2. *Copies of any communications you have sent to suppliers or contractors advising them of the requirements of the Progressive Procurement policy.*
3. *The number/value of contracts your agency has terminated because a supplier or contractor didn't meet the definition of a Māori business since the Progressive Procurement Policy came into force.*
4. *The number/value of contracts your agency has signed with Māori businesses since the Progressive Procurement Policy came into force.*

We advise for MidCentral DHB as follows:

1. The attached template is sent to all new vendors following a tender process, or to existing vendors as part of the contract variation process.
2. No blanket communications have been sent out. All communication has been managed by the process/template referred to in question 1.
3. No contracts have been terminated since the Progressive Procurement Policy came into force.
4. No contracts have been signed with Māori businesses since the Progressive Procurement Policy came into force.

If you are not satisfied with this response you have the right to raise any concerns regarding our response with the Ombudsman – www.ombudsman.parliament.nz or 0800 802 602.

Please note that this response, or an edited version, may be published on the MidCentral DHB website ten working days after your receipt of this response.

Yours sincerely

Neil Wanden
General Manager, Finance & Corporate Services

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

[Date]

[Name]
[Company]
[Address line 1]
[Address line 2]
[Address line 3].

Email: [email address]

Sent by Email

Dear [Name]

Government Procurement – are you a Maori business?

Kia ora,

Cabinet approved a policy last year to increase broader cultural, economic, environmental, and social outcomes when purchasing goods, services or works to ensure Government suppliers' spend reaches into our communities.

Mandated government agencies, including MidCentral DHB (MDHB), must now award at least 5% of their contracts to Māori businesses each year to support this new Government policy.

Te Puni Kōkiri and Ministry of Business, Innovation and Employment (MBIE) are implementing the progressive procurement policy to support Māori enterprise. For this policy, a Māori business is defined as:

- having at least 50% Māori ownership; or
- a Māori Authority as defined by the Inland Revenue Department.

Please let us know if you are a Māori business by circling one of the statements below and returning to the author of this letter so MDHB can identify who we currently purchase goods and services from to monitor our progress against meeting the 5% threshold:

We [Company name] [are/ are not] a Maori business as defined by Te Puni Kōkiri and MBIE.

Find out more about progressive procurement at tpk.govt.nz/progressiveprocurement.

Ngā mihi,

[Author]
[Position]
Contracts & Procurement team
MidCentral DHB

Contracts Department
MidCentral District Health Board, Gate 2, Heretuanga Street, Palmerston North;
P O Box 2056, Palmerston North. Phone (06) 350 8844

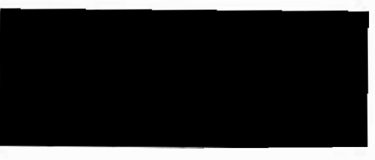
A division of MldCentrol Olsirtct Health Boord provtdinp spec/alts/ health ond disob/1/ty services

30 July 2021

MidCentral Health
Phone (06) 356 9169
Fax /06) 350 88 IU

Postal Address:
Private Bop JJ 036
Monowotu Moll Centre
Palmerston North 4442
Newleatand

Phys/col Address:
Ruohine Street
Potmerston Norlh
Newlealond



Dear

OIA Request - OPCAT inspections of Secure Aged Care Facilities
Our Ref: Ao8-39

In reference to your official information request dated 29 July 2021 for copies of OPCAT (the United Nations Optional Protocol to the Convention Against Torture) inspections of secure aged care facilities, and copies of any response to these reports.

MidCentral District Health Board (MDHB) has not received or holds any OPCAT reports regarding inspections of MDHB secure aged care facilities.

Yours sincerely

Lyn Horgan
Operations Executive
Healthy Ageing and Rehabilitation

MIDCENTRAL HEALTH

A division of MidCentral District Health Board providing specialist health and disability services

Phone (06) 356 9169
Fax (06) 350 8818

Postal Address:
Private Bag 11036
Manawatu Mail Centre
Palmerston North 4442
New Zealand

Physical Address:
Ruahine Street
Palmerston North
New Zealand

5 August 2021

Dear

Official Information Request (OIA) for Contraception Funding

Thank you for your OIA request dated 8 July 2021. Your request is acknowledged and has been passed onto me for a response.

Your request sought:

I am now following up on this press release from 2019: https://www.beehive.govt.nz/release/thousands-women-benefit-contraceptive-changes about the total of $6 million per annum in funding that was allocated to the better access to contraception initiative and also this article I recently wrote for New Zealand Doctor Rata Aotearoa: https://www.nzdoctor.co.nz/article/news/free-clinics-general-practice-improve-access-contraception-counties-manukau.

As I understand, this funding was allocated to the 20 DHBs to be delivered within primary healthcare. In the article, I was told that Counties Manukau DHB has redirected the funding given as part of this initiative to allow general practices to provide this free service.

I want to know how this funding has been allocated and spent over the last 2 years by MidCentral DHB – would it be possible to get a full breakdown of how much of the $6 million the DHB receives, how, where and to who they've been distributing it and whether the funding has been used up or if it has been underspent?

MidCentral DHB receive a contract from the Ministry of Health for $190,000 per annum for Contraceptive Access. This funding is bolstered with additional MDHB funding for the provision of Sexual Health Services through THINK Hauora (PHO) across the MDHB rohe.

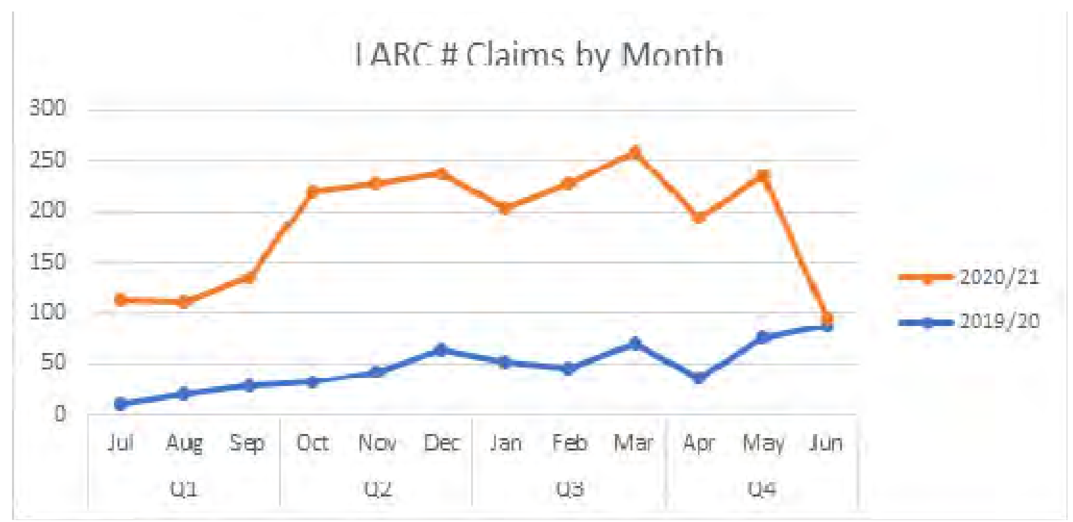
THINK Hauora in turn contract providers for Primary Sexual & Reproductive Health Services including LARC services, including general practices and other community providers (YOSS/Massey

Medical/Women's Health Clinic - Magma and Well Women Clinic on Grey).

There has been a significant increase in claims made by providers between the two years as detailed in the graph below (NB the drop for June 2021 is due to claims not being presented to date).

The funding for 2019/20 for the LARC component of the funding was carried forward as we anticipated an increase in expenditure in 2021/22 due to increased number of LARC providers contracted to ensure equitable access.

Going forward we envision that there will be an overspend in the provision of services.

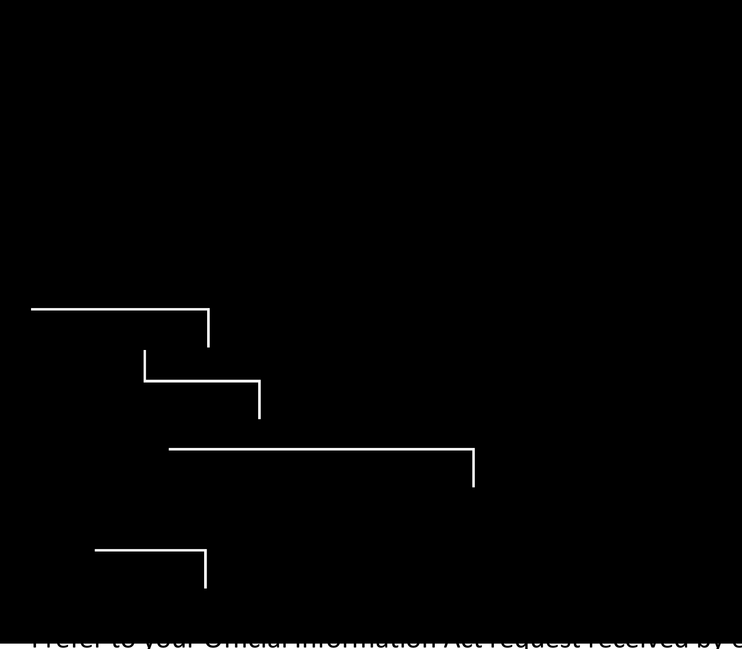


Please note that this response, or an edited version of it, may be published on the MidCentral DHB website ten working days after your receipt of this letter.

We hope this information is what you require.

Yours sincerely

Chiquita Hansen
Interim General Manager
Strategy, Planning and Performance



I refer to your Official Information Act request received by email on 16 July 2021 with regard to staff surveys at MidCentral DHB, and respond as follows:

1. *The latest two staff surveys relating to morale, job safety, security, bullying and harassment and similar from all departments*

    a) MidCentral DHB Staff Engagement and Safety Culture Survey May-June 2018
    b) Employee Engagement Survey Results – July 2020

2. *In whatever format or formats it has been communicated to senior leadership.*

    a) MDHB Staff Engagement & Safety Culture Survey 2018 – to the Clinical Council
    b) A paper dated 6 September 2018 to the Executive Leadership Team
    c) A paper dated 31 July 2020 to the Organisational Leadership Team is attached.

3. *And any resulting changes from leadership including emails to staff and/or unions*

    a) As a result of the 2018 Staff Engagement Survey, *He kura te Tāngata - a plan for our people 2019-2023* was developed. A copy is attached for your information.

    b) The MDHB Engagement Action Planning Guidelines are also attached for your information. They give an insight into the approach MDHB takes to engagement action planning, an overview of the planning process, areas which managers and the team should focus on, and the deep dive into engagement drivers to name a few.

Please note that this response, or an edited version of it, may be published on the MidCentral DHB website ten working days after your receipt of this letter.

Yours faithfully

Keyur Anjaria
General Manager
People & Culture

YOUR VOICE

He kupu kōrero

MidCentral DHB Staff Engagement & Safety Culture Survey May-June 2018

Introduction

In May-June 2018, 1,160 people responded to our first "Your Voice – He Kupu Korero" staff survey. This report summarises the results that will be made available to managers via dashboards on their PC. It outlines:

- Overall engagement and scores from the survey.
- Our key strengths and overall opportunities for improvement.
- The factors that influence engagement and how respondents scored them.
- Recommendations to improve response scores in key factors influencing engagement.

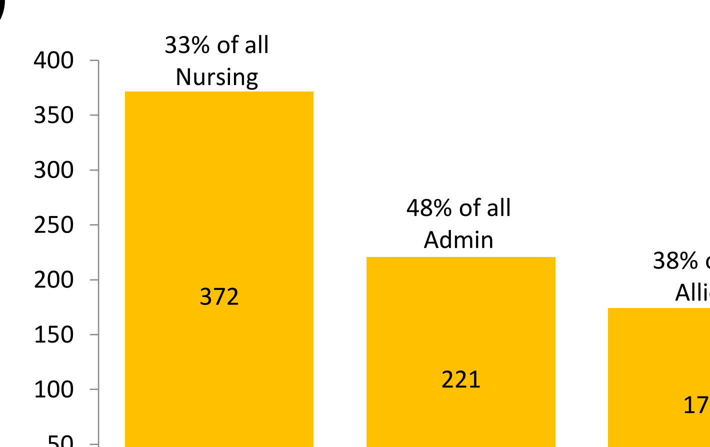
Managers can access an on-line dashboard to see their own team's results and compare these to the overall organisation.

We will be supporting every senior manager to discuss results with their teams and have developed a support toolkit including advice on interpreting results and team discussion guides. Excerpts from the discussion guide are included for information.

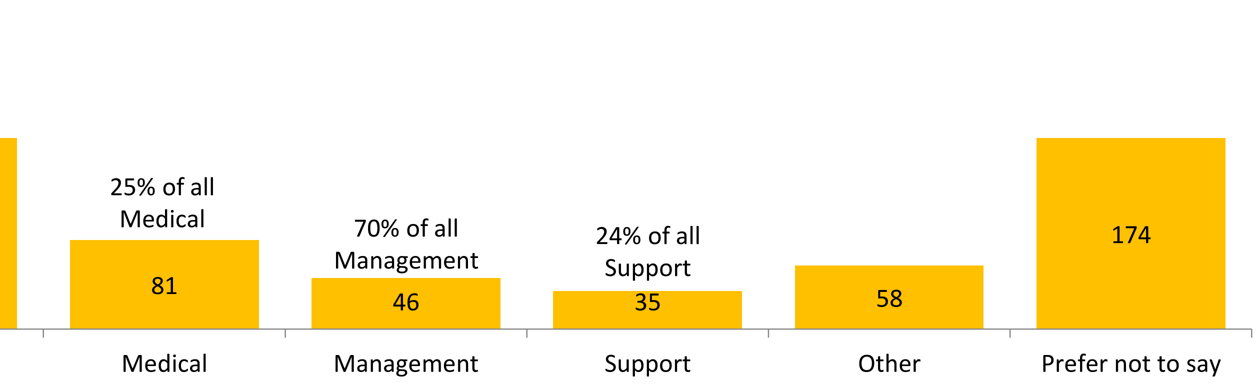
For subsequent years we will be able to compare progress over time, identify actions that are driving improvement and factors where change is slower, but for the first year's report, without historical data, our focus will be on identifying key areas where there is obvious opportunity for improvement.

Benchmarks with other DHB's who have used the survey tool will be available in August 2018

Response rate (47%)



2,491 Staff were invited to respond to the survey.
A total of 1,160 responses were received.



How to read this report

This report presents The DHB's overall results from the 2018 Employee Survey. The results represent an overview of the engagement levels of our employees and the factors that drive their engagement (and disengagement).

To protect individual staff confidentiality, reporting 'anonymity thresholds' have been set at 5 responses, meaning 5 people in a team, group or demographic need to have responded to a specific question or category for results to displayed. If any section of a report is blank it is because this threshold has not been met.

The survey contains three kinds of question

Overall engagement. This is an outcome measure. Higher levels of overall engagement has been shown to correlate with safer and higher quality care

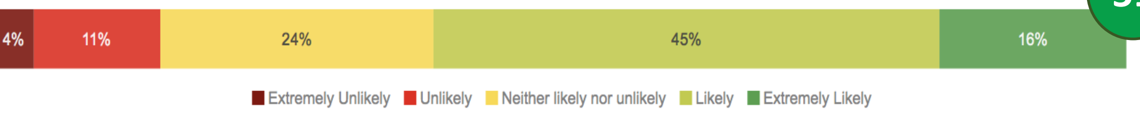
Drivers of engagement. These are factors that can be influenced to improve engagement.

Free text questions. Insight is presented as word-clouds.The individual free-text responses are not presented at the team level, to protect people's anonymity.

In addition, the survey asked about '**emotions at work'**. Studies have shown that emotions at work are an important driver of employee satisfaction, and in healthcare employee's emotions can directly affect patient emotions – which in turn influence outcomes.

Most results are displayed as follows with the question, distribution of responses (from dark red – typically , the favourability % (inside the green bar) and the overall company % as a comparison.

Breakdown bars



The distribution bar gives a quick visual view of your results and as follows:

For most questions / positive emotions the breakdown is as follows

Dark Green = Strongly agree
Light green = Agree
Yellow = Neutral
Red = Disagree
Dark Red = Strongly Disagree

Questions about *negative* experiences / emotions e.g. 'I have been bullied' are marked with an asterisk *

Dark Green = Strongly disagree (ie good score)
Light green = Disagree
Yellow = Neutral
Red = Agree
Dark Red = Strongly Agree (ie bad score)

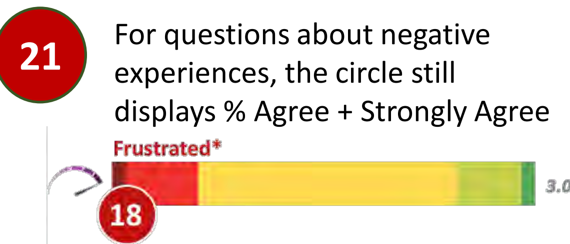
Favourability score

51

The 'favourability' % is the total % of people who scored either Strongly Agree or Agree with the statement.

21

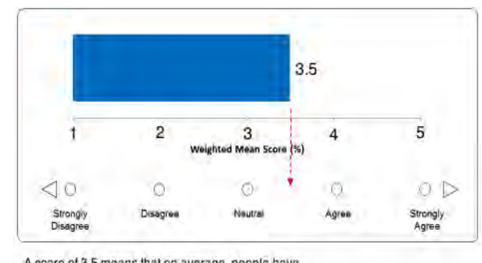
For questions about negative experiences, the circle still displays % Agree + Strongly Agree



Mean scores

For each individual question the mean figure shown is a 'weighted mean' - a score between 1 and 5, showing the average score people gave for that question.

For example, if every person who responded to a question 'strongly agreed' the mean would be a perfect 5.0. If all respondents strongly disagreed with a statement it would give a mean of 1.0.



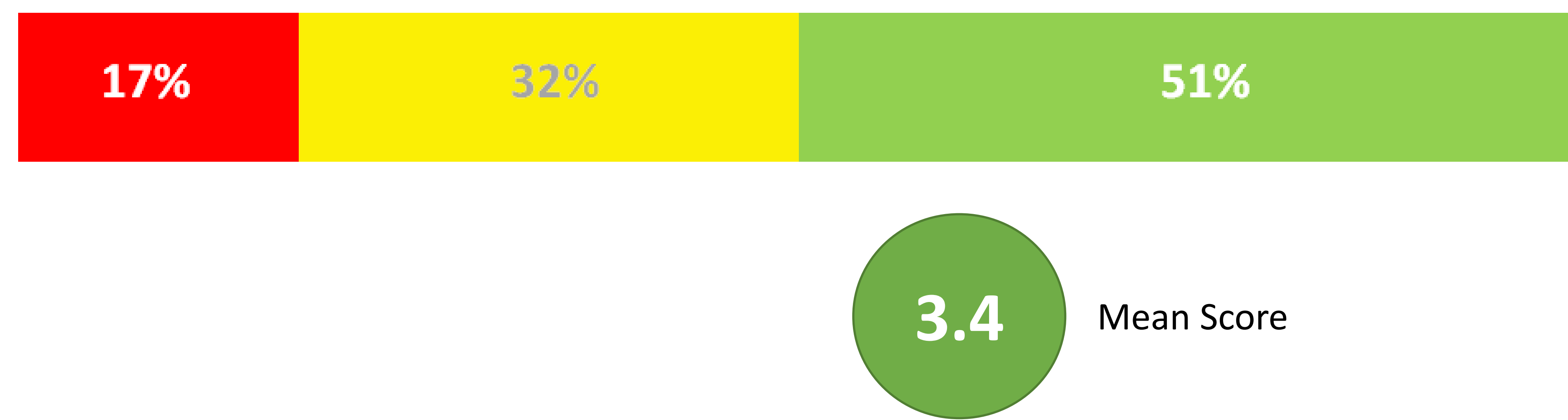
A score of 3.5 means that on average, people have responded between 'Neutral' and 'Agree' on the rating scale.

** For questions about negative experiences, as scores are reversed, a higher mean is still a better score.*

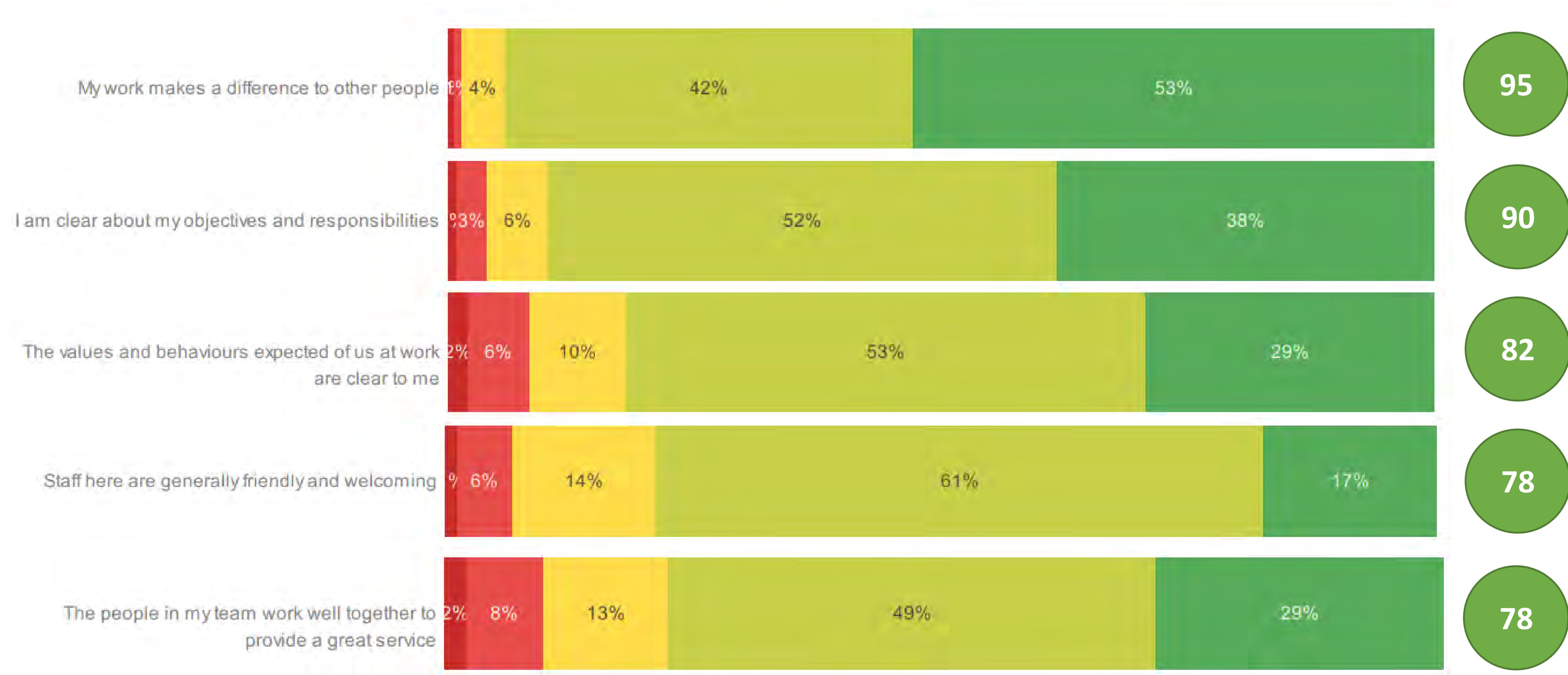
Overall Engagement

Within the survey, six questions are identified as being key indicators of overall staff engagement:

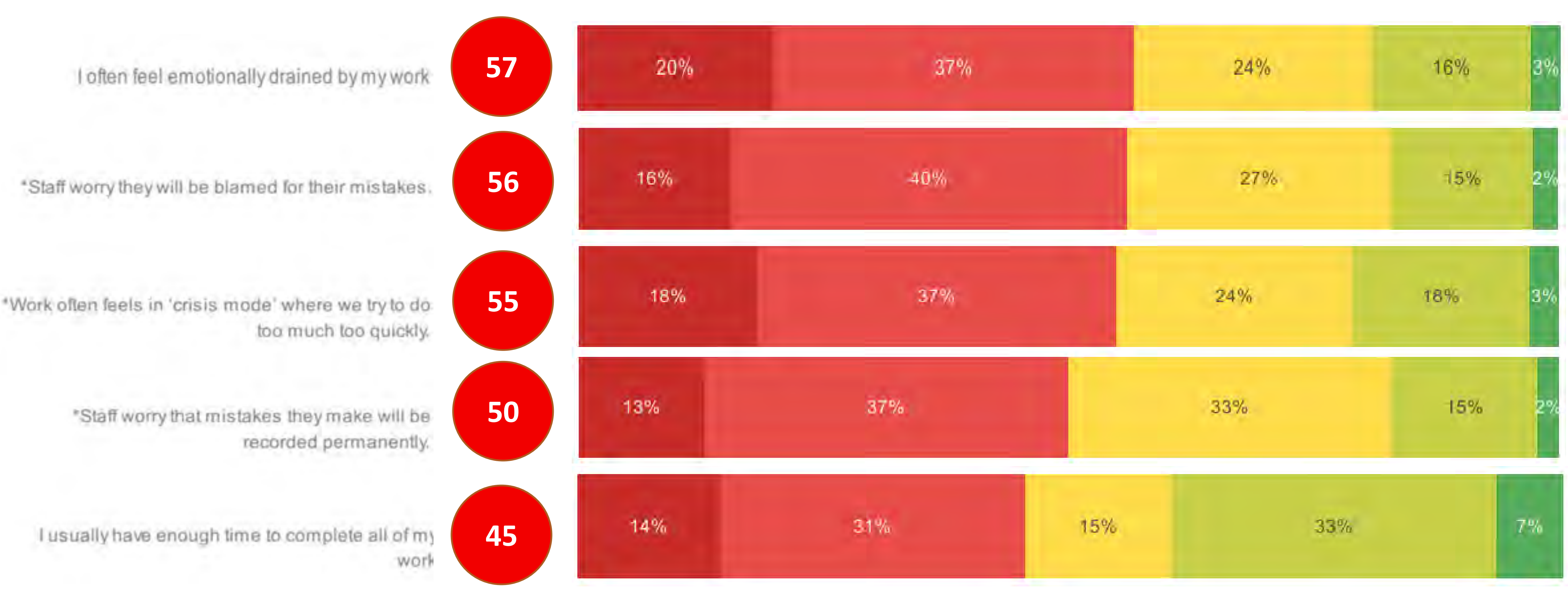
- How likely are you to recommend this DHB to friends and family as a place to work?
- How likely are you to recommend the DHB to friends and family if they needed care or treatment?
- How often is the following true? ‘When I get up in the morning, I look forward to going to work’
- Thinking of the last week at work, how often have you experienced the following emotions:
    - Proud
    - Valued
    - Motivated



Top Five – Most Favourable (Things we are doing well)



Low Five – Most Unfavourable (Areas for Improvement)

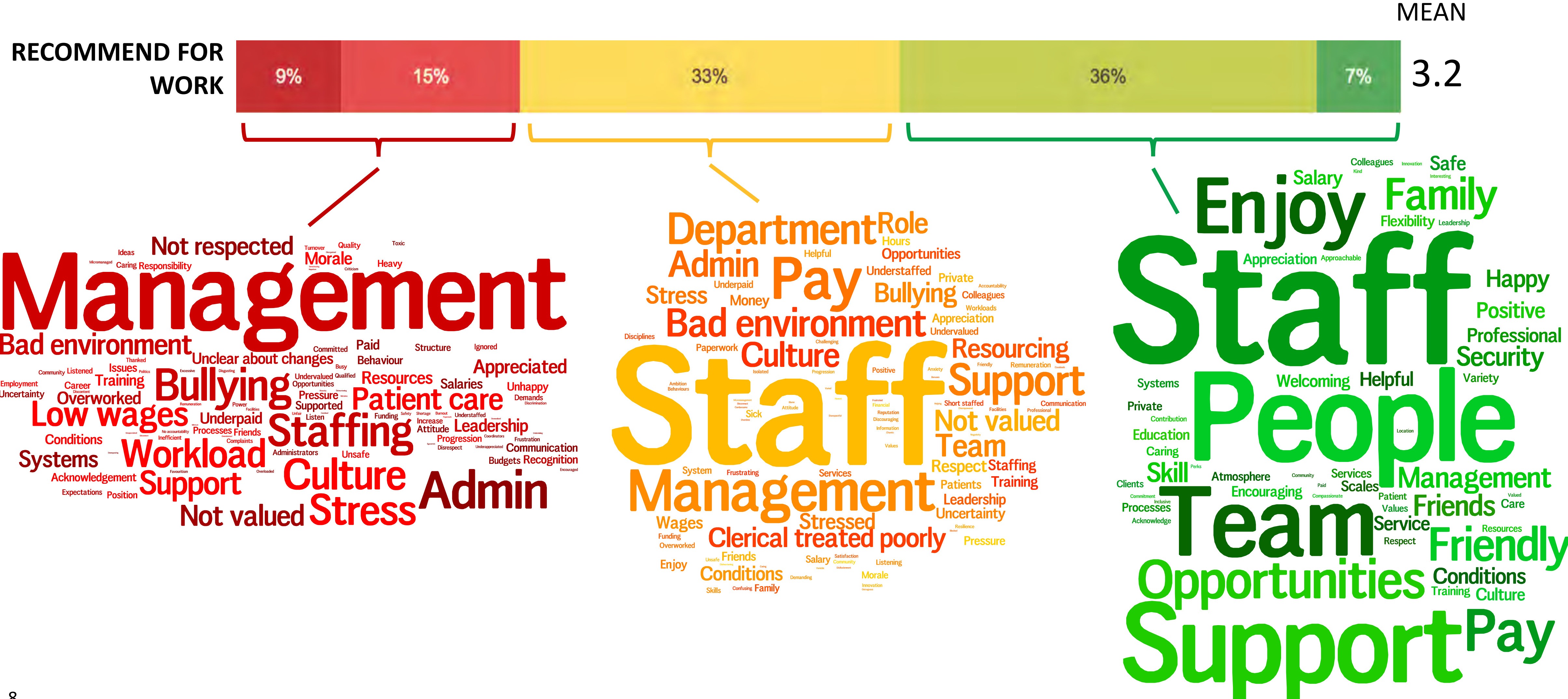


Organisation Scorecard – Overall Results

ENGAGEMENT: Would you recommend DHB as a place to work?

The question 'would you recommend the DHB as a place to work' is a strong proxy for overall engagement – it represents up to 70% of the variation in other survey questions that are typically asked to measure employee engagement. As such it is the key question in our survey.

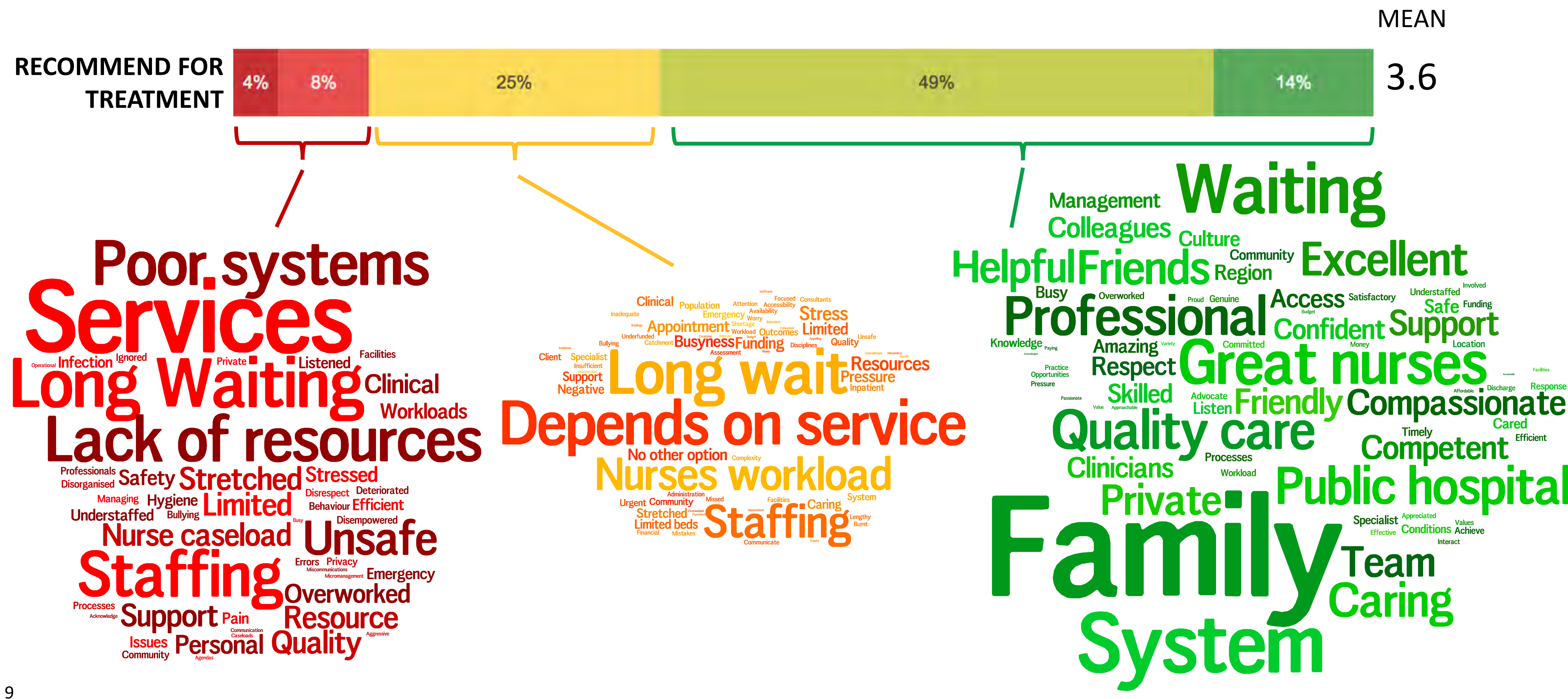
The world clouds show the key words of phrases used in response to the question 'please tell us why you gave that score'.



QUALITY: Would you recommend the DHB as a place for treatment?

The question ‘would you recommend the DHB as a place to be treated’ is a good measure of the quality of care which staff believe is being provided.

The world clouds show the key words of phrases used in response to the question ‘please tell us why you gave that score’, and as such are a good indicator of the drivers of great or poor care at the DHB.



Breakdown: Direction & Purpose

Admin & Clerical v overall:
I am happy with career progression (31% v 44%)

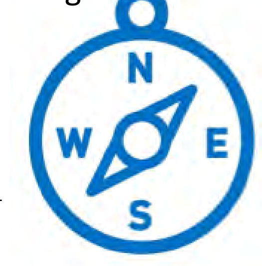
Direction & purpose

When people find meaning in their work, understand what's expected of them, and see that in others too.

Discussion points

- Are we clear about what's expected of us – individually and as a team?
- Do our individual objectives help to meet the team's objective?
- How could we be clearer about our expectations of each other?
- How can we be more positive about what we are doing?

Studies have shown that managers can increase engagement by setting challenging SMART goals. [1]



	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
Work makes a difference	1%	1%	4%	42%	53%
Clear about objectives & responsibilities	1%	3%	6%	52%	38%
Values & behaviours clear	2%	6%	10%	53%	29%
Person I report to communicates goals & objectives	8%	16%	20%	37%	18%
Happy with career progression opportunities	8%	22%	26%	34%	10%
People here display a positive attitude	7%	27%	32%	28%	6%

Breakdown: Contribution & Control

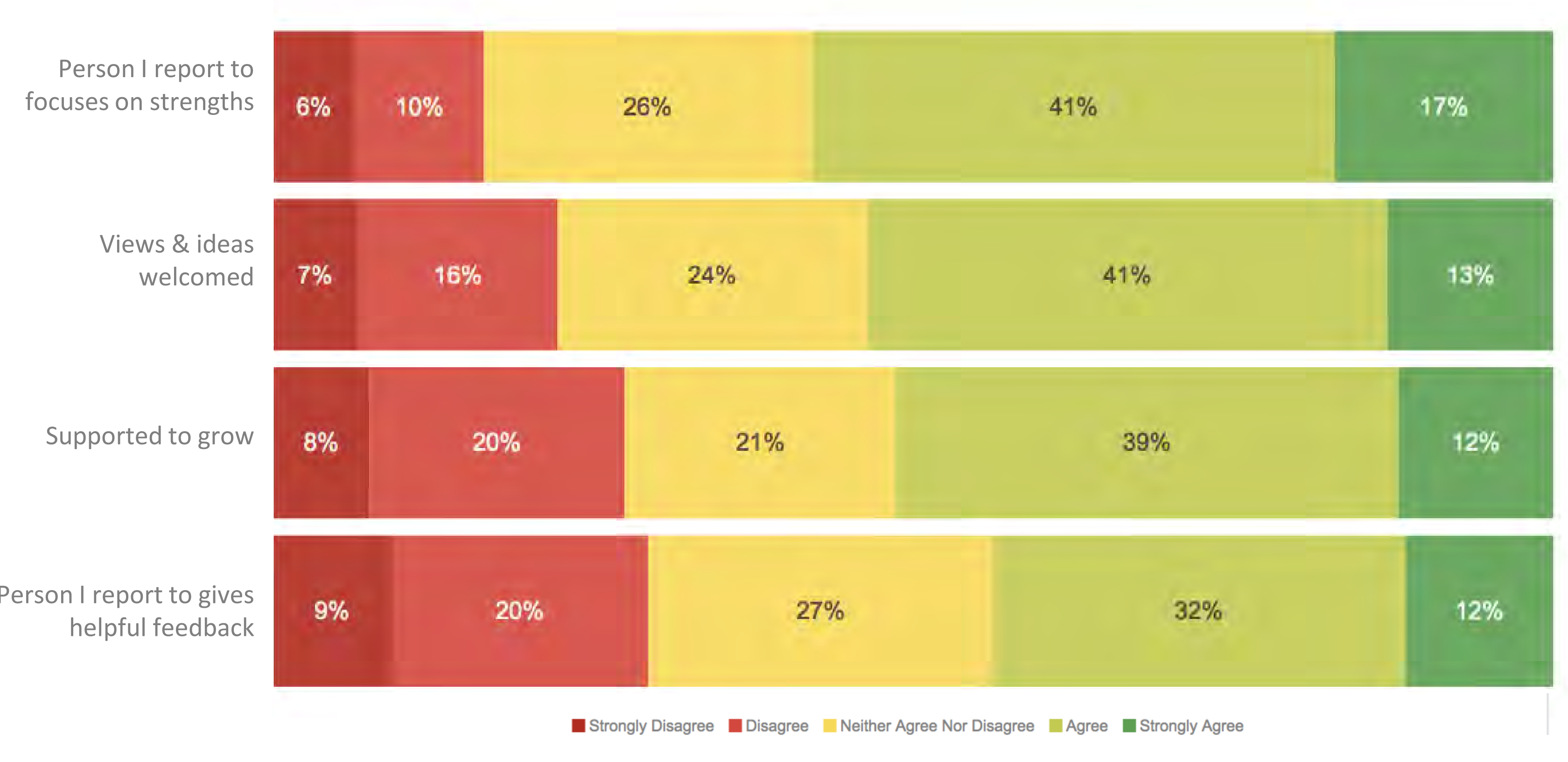
Contribution & control

When people are able to develop their skills, strengths and ideas and put them to good use.

Discussion points

- Do we know what each other's strengths are in the team?
- Do we know what skills or areas our colleagues want to develop?
- How we can we help each other to do our best work?
- How can we nurture more ideas?

Gallup research shows people whose managers focus on their strengths are twice as likely to be engaged as people whose managers focus on their weaknesses. [2]



- **Admin & Clerical v overall:** I am supported to grow (42% v 51%), person I report to focuses on my strengths rather than my weaknesses (51% v 58%)
- **Medical v overall:** person I report to gives helpful feedback (32% v 44%)

Breakdown: Recognition & Value

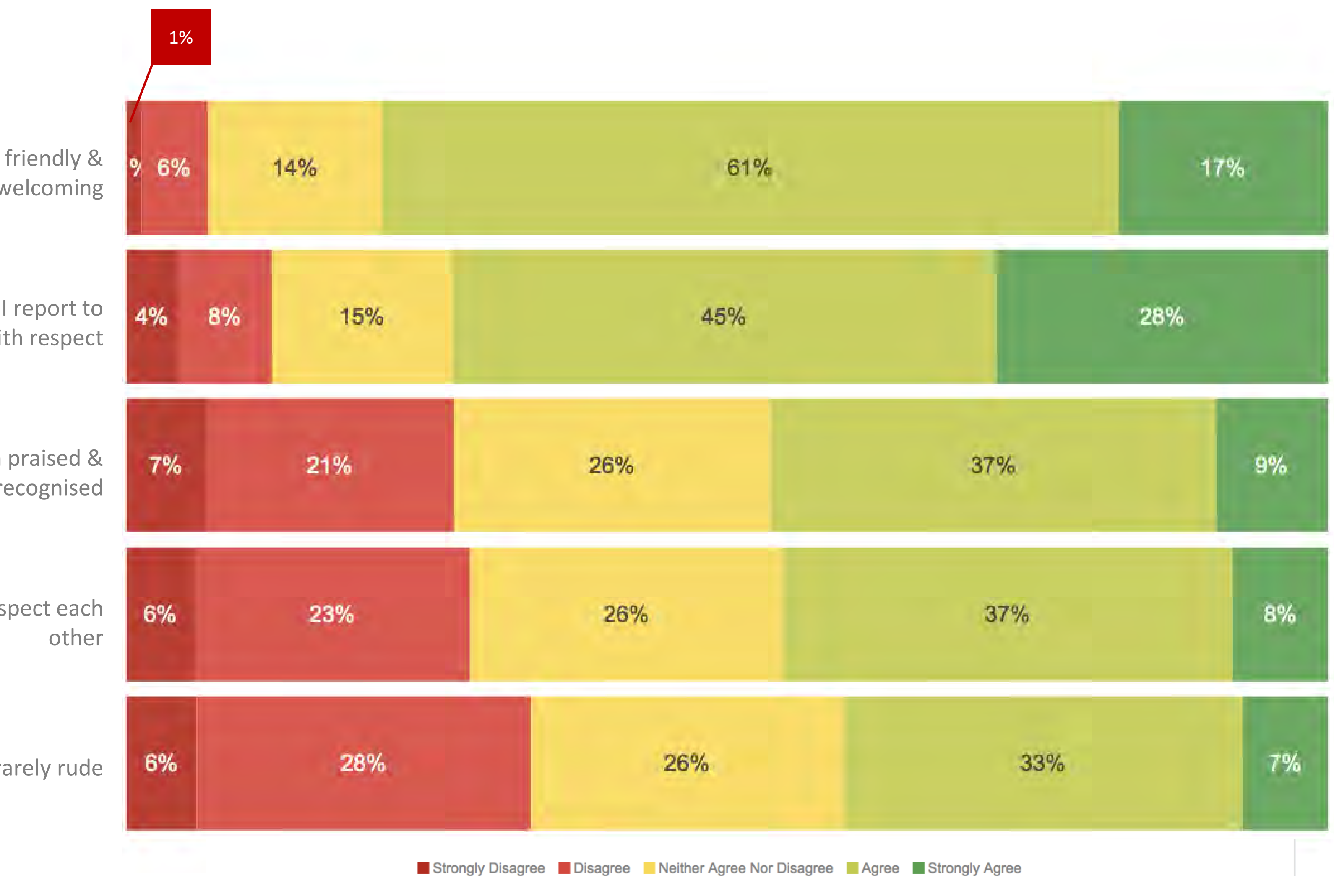
Recognition & value

When people feel respected for who they are, and that their efforts are noticed and valued.

Discussion points

- Have we had experiences recently where they weren't respected?
- What recognition or appreciation have people received recently?
- How do we want to recognise each other's good work or efforts?
- What specifically would we like to notice and appreciate in the team?

The Harvard Business Review says successful teams receive five times as much appreciation as criticism. [3]



Support roles v overall: I feel praised and recognised (38% v 46%) the person I report to treats me with respect (62% v 73%)

Breakdown: Connection & Support

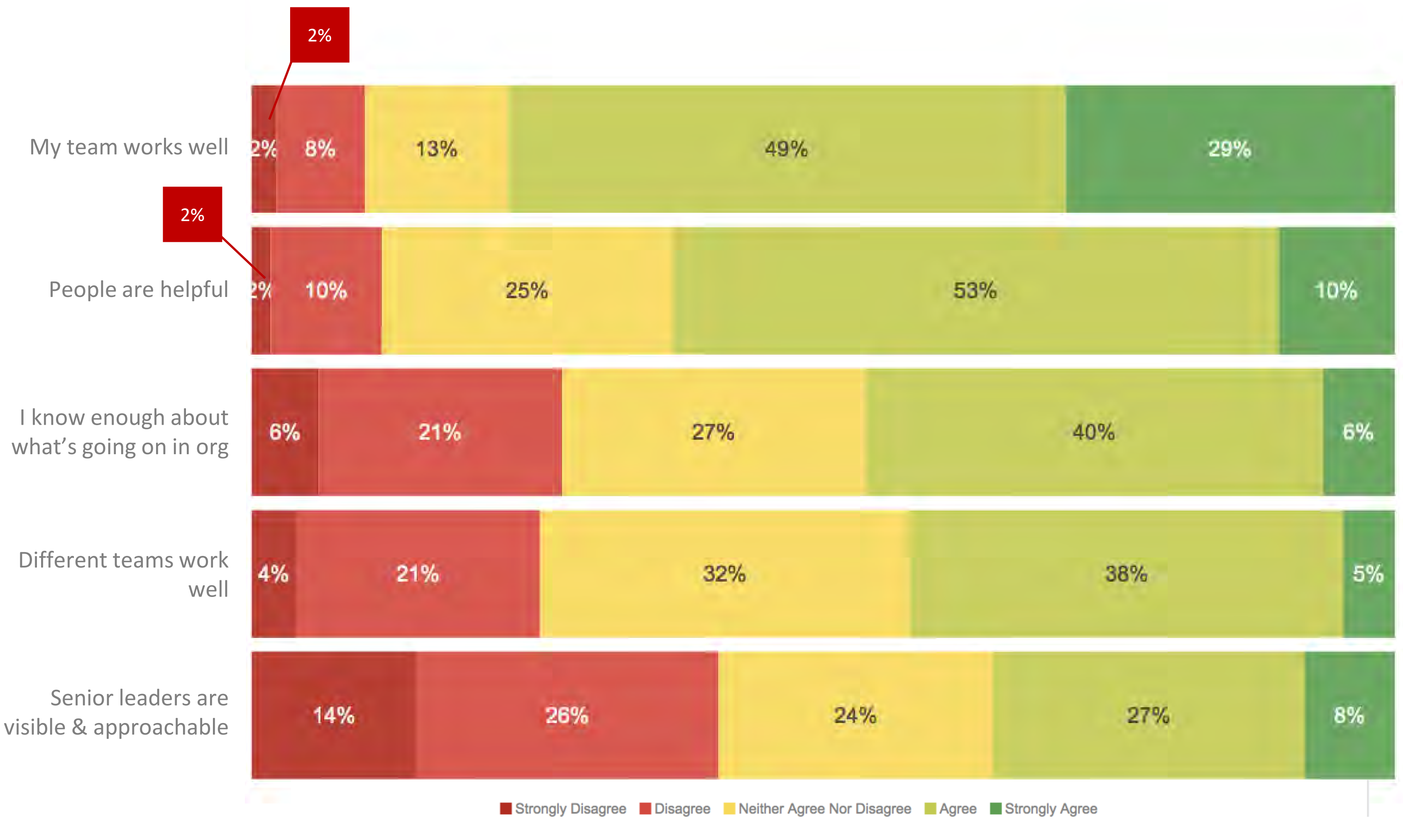
Connection & support

When people feel a good sense of teamwork and support in their team, with other teams and from leaders.

Discussion points

- What does a 'real team' look like? What support do we want from each other?
- Do we know what other teams want from us? How could we change how we work with them?
- Do we get what we need from other teams? Have we told them what we need from them?

In an NHS study, a 5% increase in team-working scores in staff surveys correlated with a 3.3% fall in mortality rates. [4]



- **Allied Health v overall:** different teams work well (34% v 42%)
- **Medical v overall:** I know enough about what's going on (35% v 46%) and senior leaders are visible (24% v 35%)

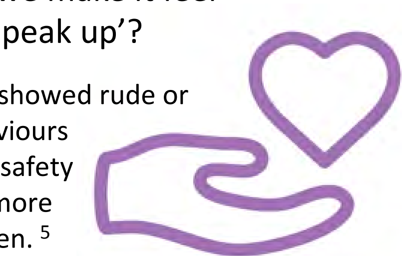
Breakdown: Safety & Wellbeing

Safety & wellbeing

When people feel safe from poor behaviours, and that their work contributes to their wellbeing.

Discussion points

- Have members of our team been bullied recently? We don't need to know who it is. But what could we do to help or support them?
- Are there behaviours we've seen in our team that we want less of?
- How can we support each other when things are really busy?
- How can we make it feel safer to 'speak up'?



A BMJ article showed rude or bullying behaviours make patient safety errors much more likely to happen. [5]

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
Org honours Treaty of Waitangi	1%	6%	34%	49%	11%
Safe to speak up (errors)	3%	11%	15%	56%	15%
Staff demonstrate cultural competency	2%	13%	31%	46%	7%
Org promotes equality & diversity	4%	14%	31%	41%	9%
Happy with work life balance	4%	19%	28%	42%	8%
Safe to speak up (behaviour)	5%	19%	18%	47%	12%
Health & wellbeing has not suffered	12%	28%	27%	28%	6%
Enough time to complete my work	14%	31%	15%	33%	7%
Experienced discrimination	6%	16%	18%	42%	19%
Experienced bullying	9%	20%	15%	37%	19%
Often feel emotionally drained by work	20%	37%	24%	16%	3%

Overall vs Medical Staff.
Emotionally drained (9% v 19%)
H&W suffered (24% v 33%
Not enough time (26% v 40%)
Work life balance (33% v 50%)
Promotes equality (38% v 51%)
Honours Treaty of Waitangi (44% v 59%)

Maori staff vs Overall

- Have experienced more discrimination (33% v 22%)
- And more bullying and harassment (35% v 29%)
- Fewer agree the DHB honours the Treaty of Waitangi (44% v 59%)

Breakdown: Safety Culture

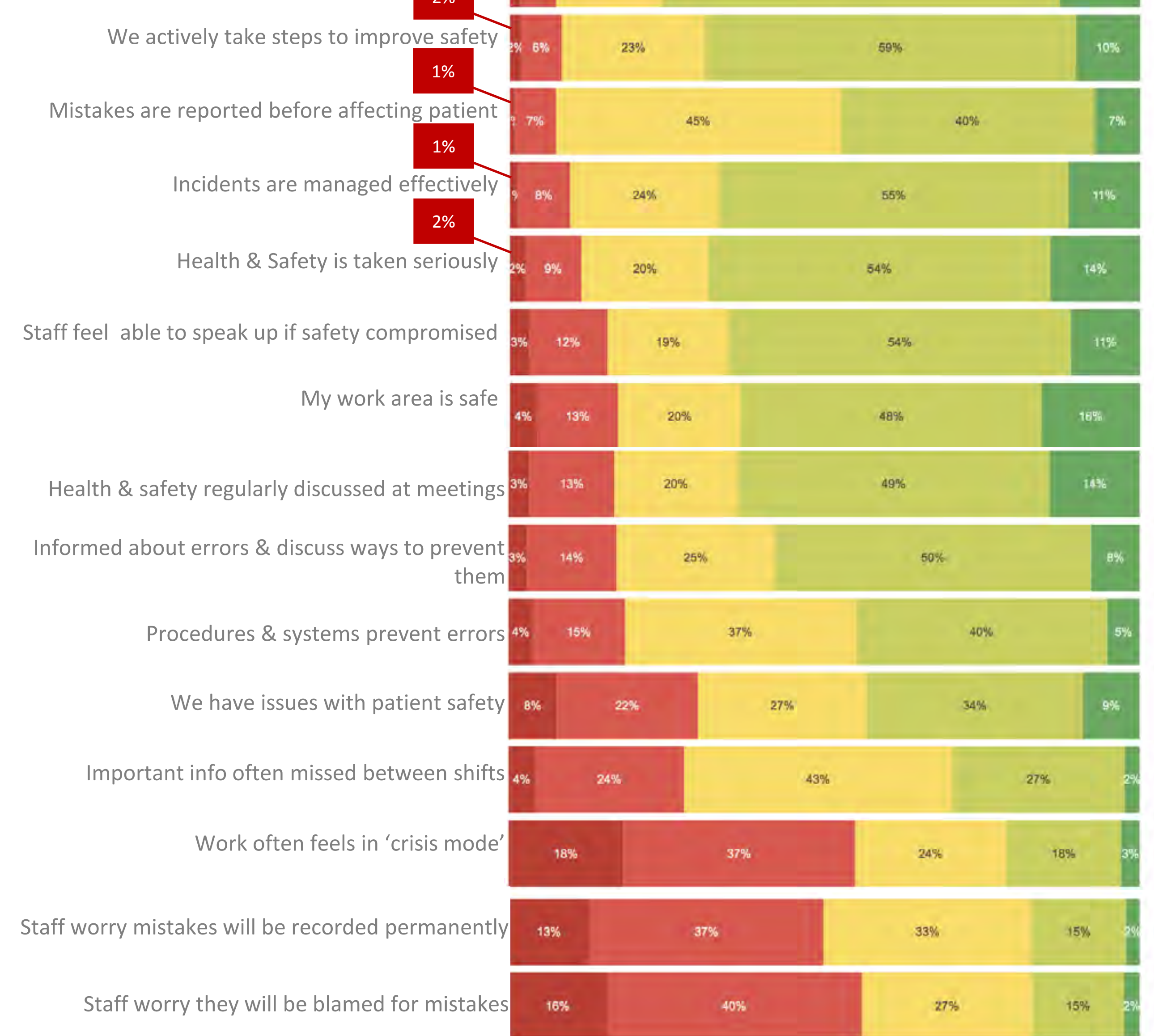
Safety Culture

When we have the correct attitude towards workplace safety and sufficient procedures in place to protect staff and patients from harm.

Discussion points

- How do we currently approach workplace safety? Is it a priority?
- How can our work practices and habits potentially impact on safety? Either directly or indirectly?
- Do our procedures adequately ensure safety is not compromised and are they followed sufficiently?
- What can we do to ensure safer practice?

Addressing Safety Culture is an important component of overall Culture and can help aid change[6]



Breakdown: Our Values

Living our values

When we consistently experience colleagues, managers and leaders behaving and making decisions that are aligned to our values.

Discussion points

- Which one of our values do we experience most consistently? How does that help us?
- Which one of our values are we not experiencing as much as we'd like? What behaviours do we experience instead? Is this from other teams or from each other?
- Which of our values could we as a team more consistently live up to?

Our staff values of Compassion, Courageous and Respectful help define acceptable behaviours.

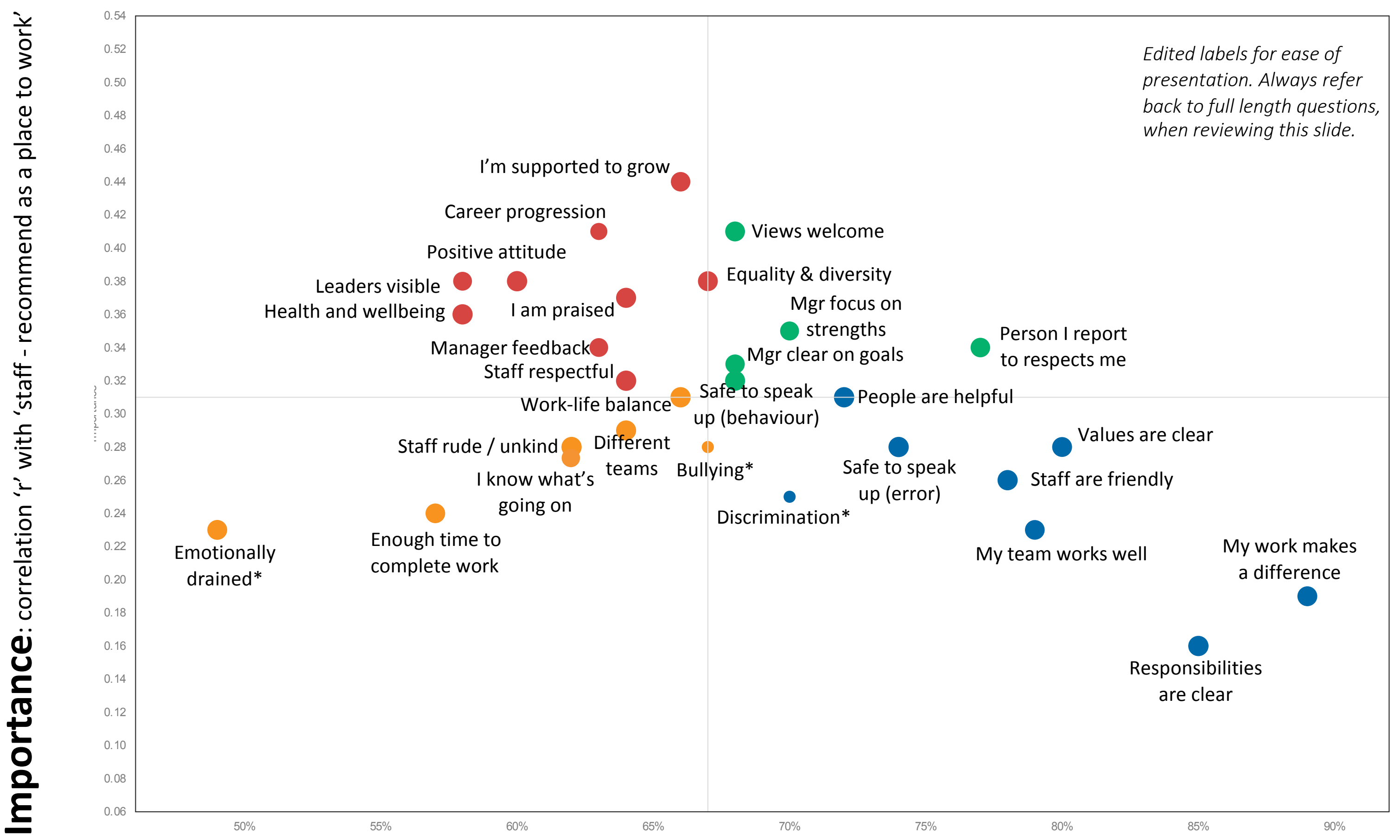
Values improve care	3%	10%	38%	38%	11%
Live up to 'respected'	3%	13%	32%	45%	7%
Live up to 'courageous'	3%	14%	44%	33%	5%
Live up to 'compassionate'	3%	16%	30%	43%	9%
Live up to 'accountable'	5%	19%	33%	38%	6%

Breakdown: Emotions

	All of the time	Most of the time	Some of the time	Hardly any of the time	Not at all
Bored	1%	4%	23%	31%	42%
Lonely	1%	4%	21%	33%	41%
Low	2%	5%	34%	31%	29%
Ignored	2%	9%	39%	31%	19%
Isolated	1%	9%	30%	32%	27%
Anxious	1%	9%	47%	28%	14%
Overwhelmed	2%	10%	44%	26%	17%
Cynical	2%	11%	47%	23%	17%
Stressed	3%	15%	48%	23%	10%
Frustrated	4%	19%	57%	15%	5%
Drained	4%	21%	49%	17%	9%

	Not at all	Hardly any of the time	Some of the time	Most of the time	All of the time
Helpful	1%	3%	30%	55%	12%
Confident	1%	3%	30%	57%	9%
Motivated	2%	7%	32%	50%	8%
Calm	1%	7%	37%	49%	6%
Happy	2%	7%	42%	44%	5%
Involved	3%	8%	36%	44%	10%
A sense of belonging	4%	8%	35%	41%	12%
Respected	4%	9%	35%	43%	8%
Proud	5%	9%	38%	39%	9%
Connected	4%	10%	43%	38%	5%
Enthusiastic	3%	10%	37%	42%	7%
Optimistic	5%	12%	37%	39%	7%
Listened to	6%	12%	39%	36%	7%
Valued	7%	13%	38%	36%	6%
Appreciated	6%	15%	40%	32%	7%
Gratitude	6%	16%	41%	31%	6%
Lost in my work	10%	21%	45%	21%	3%

Key driver analysis – introduction



Worse scores

Performance: mean score represented as a %

Better scores

* NB for negatively worded questions (bullying / discrimination) and for negative emotions, scores are reversed, so that for all questions, scores to LEFT are bad, scores to the RIGHT are good.

The next two slides are a statistical analysis to help to prioritise improvement actions – as explained in the panel below.

- On the X-axis (left to right) "Performance" shows 'mean' score for each question in the survey – expressed as a percentage (i.e. mean/5 * 20). Underperforming questions (to the left of chart) have more room for improvement.
- (The three negative questions and negative emotions again have scores reversed... so *scores to the left are always worse* and *scores to the right are always better*)
- On the Y-axis "Importance" shows strength of correlation between each question and "recommend as a place to work" (a strong proxy for overall employee engagement). Improving questions with higher correlation will more quickly improve staff engagement.
- The **red dots** are important in driving engagement, and have most room for improvement'. Acting on red dots is likely to more readily impact on engagement; other factors are still important for sections of the organisation
- The **green dots** are aspects of best practice to be shared
- The **orange dots** show us the questions that scored poorly and which have a low correlation with overall engagement.
- The **blue dots** show us the questions that scored well and which have a low correlation with overall engagement.
- *Axes placed for roughly equally number of coloured dots per quadrant (for the DHB overall)*

Key drivers: Experience – where to act first

WORK EXPERIENCE - correlated with 'recommend DHB as a place to work'

Importance: correlation 'r' with 'staff - recommend as a place to work'

0.54
0.52
0.50
0.48
0.46
0.44
0.42
0.40
0.38
0.36
0.34
0.32
0.30
0.28
0.26
0.24
0.22
0.20
0.18
0.16
0.14
0.12
0.10
0.08
0.06

Edited labels for ease of presentation. Always refer back to full length questions, when reviewing this slide.

I'm supported to grow
Career progression
Views welcome
Positive attitude
Equality & diversity
Leaders visible
Health and wellbeing
I am praised
Mgr focus on strengths
Manager feedback
Mgr clear on goals
Person I report to respects me
Staff respectful
Safe to speak up (behaviour)
People are helpful
Work-life balance
Staff rude / unkind
Different teams
Bullying*
Values are clear
I know what's going on
Safe to speak up (error)
Staff are friendly
Discrimination*
Emotionally drained*
Enough time to complete work
My team works well
My work makes a difference
Responsibilities are clear

50% 55% 60% 65% 70% 75% 80% 85% 90%

Worse scores

Performance: mean score represented as a %

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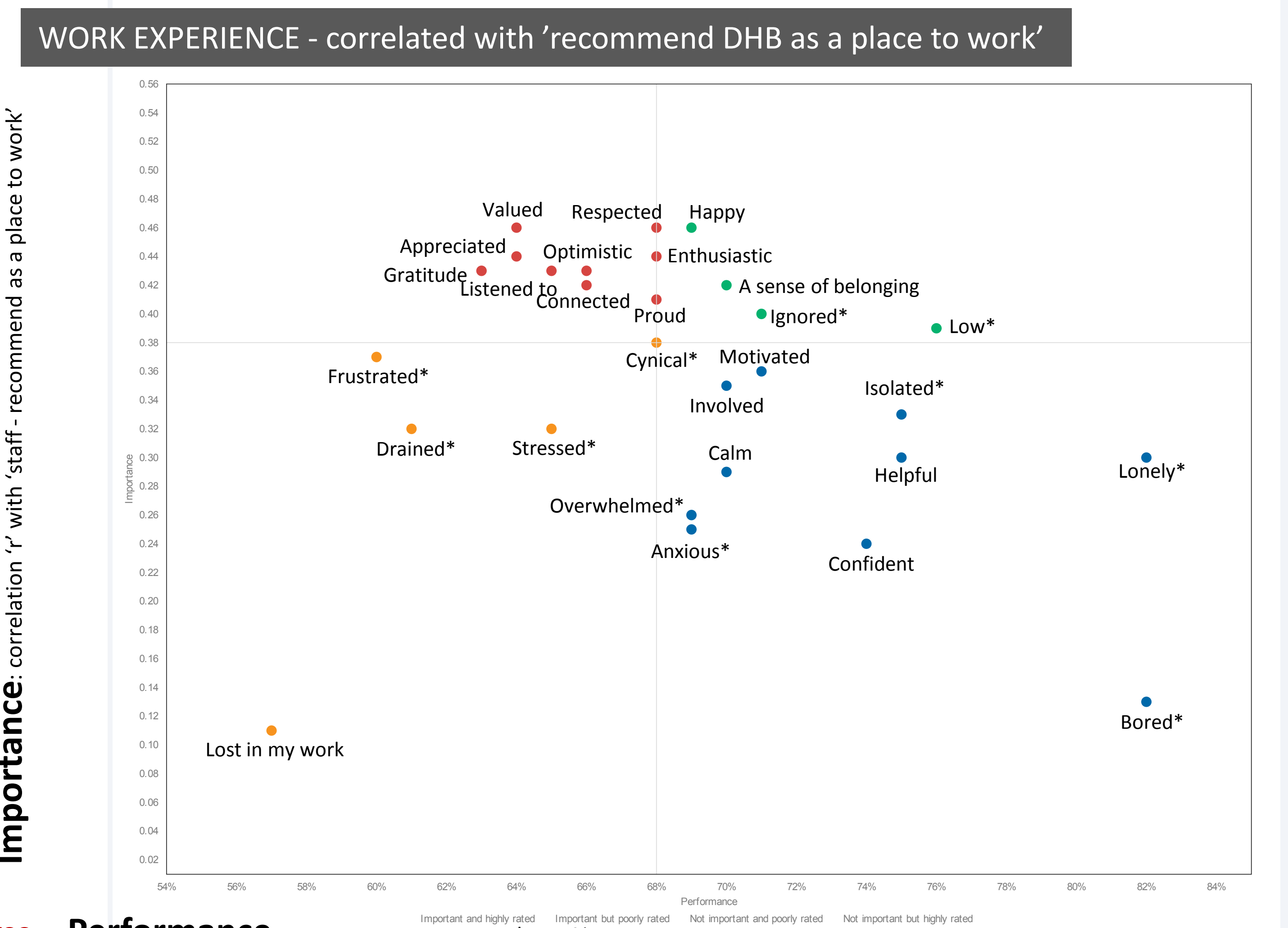
Where to Act First (RED dots)

1. I am supported to grow and develop at work
2. I am happy with my career progression opportunities
3. People working here display a positive attitude
4. Senior leaders here are visible and approachable
5. This organisation promotes equality and diversity
6. I am praised and recognised when I do a good job
7. My health and wellbeing has not suffered because of my work
8. The person I report to gives me regular, helpful feedback on my work
9. Staff respect each other, whoever they are and whatever their role

Where to Maintain (GREEN dots)

1. My views and ideas are welcomed and encouraged
2. The person I report to focusses on my strengths rather than my weaknesses
3. The person I report to treats me with respect
4. The person I report to communicates the goals and objectives of the team effectively
5. I feel safe and confident to speak up about inappropriate behaviour

Key drivers: Emotions – where to act first



Worse scores

Performance: mean score represented as a %

Better scores

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Where to Act First (RED dots)

1. Valued
2. Respected
3. Appreciated
4. Enthusiastic
5. Gratitude
6. Listened to
7. Optimistic
8. Connected
9. Proud

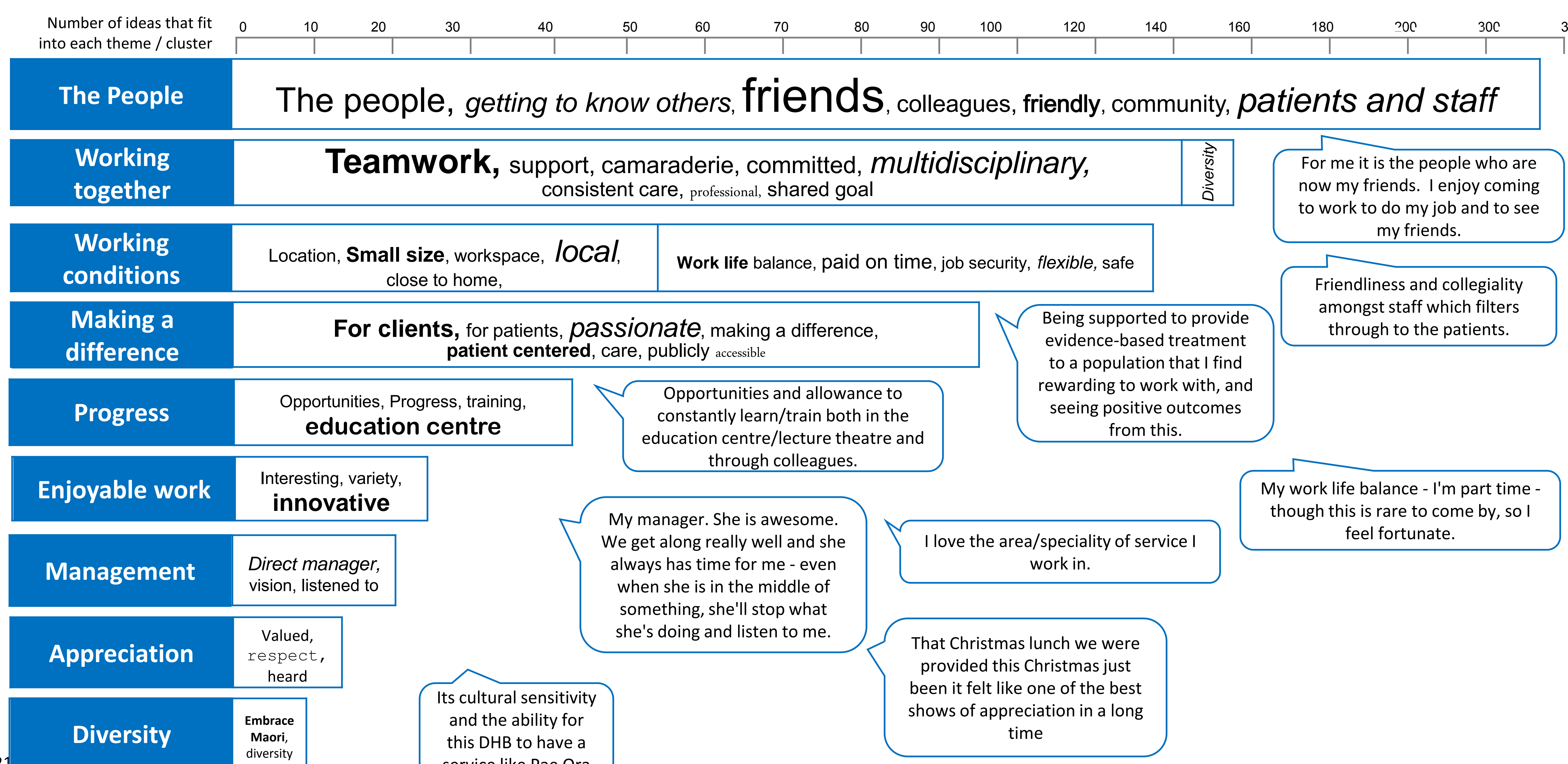
Where to Maintain (GREEN dots)

1. Happy
2. A sense of belonging
3. *Ignored
4. *Low

***Survey feedback indicated that those who would recommend this DHB as a place to work <u>rarely</u> experienced feeling ‘ignored’ or ‘low’. This is something we should seek to maintain.**

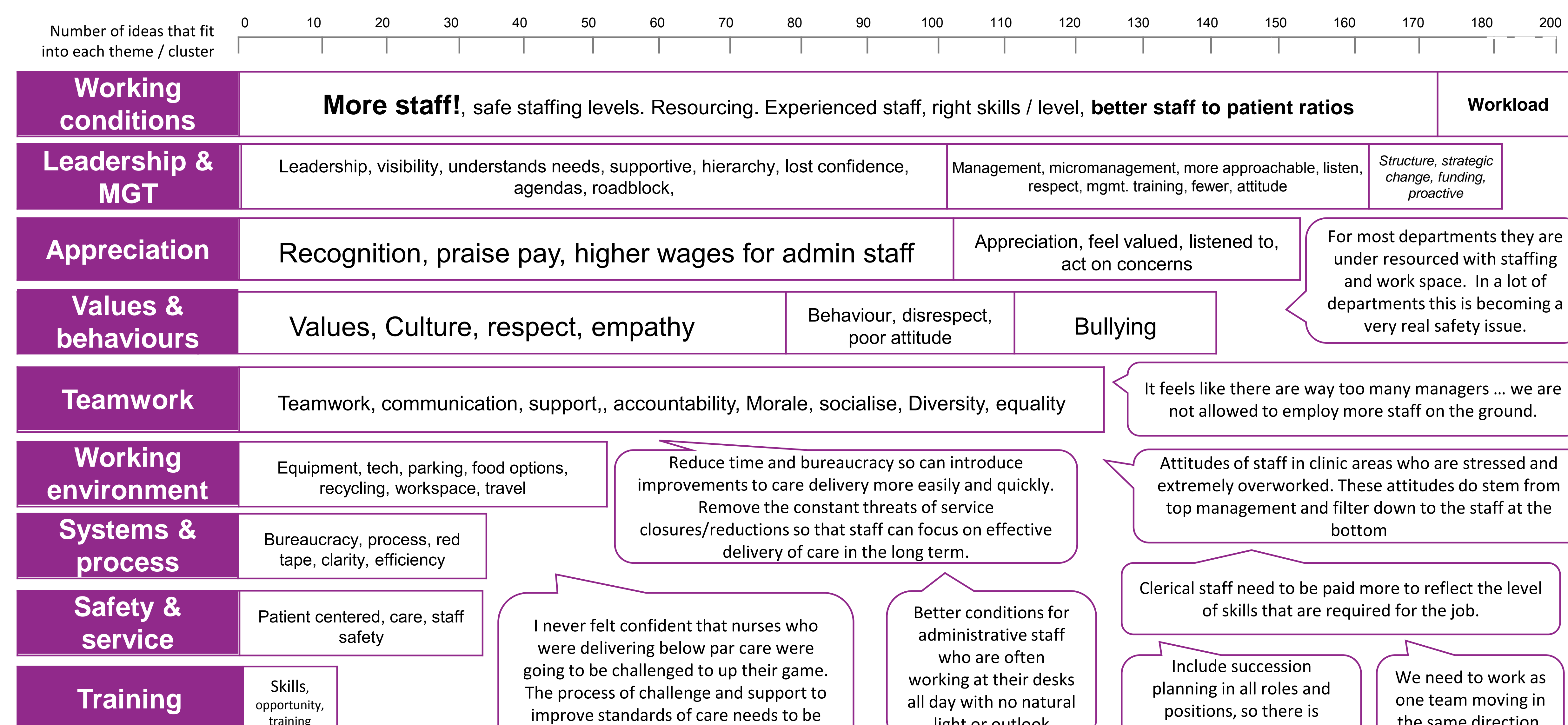
Comments Analysis: What makes MidCentral DHB a great place to work?

Free text responses to this question have been sorted into themes. The number of responses within each them is shown in the bars.



Comments Analysis: Improvement priorities for staff

Free text responses to this question have been sorted into themes. The number of responses within each them is shown in the bars.



MidCentral DHB
Employee Engagement Survey Results
September 2020

Introduction

- He Kupu Kōrero – Your Voice (2018 and 2020)
- Administered by Qualtrics
- Analysed by April Strategy
- Process ensure both anonymity and objectivity
- Survey assess key staff engagement drivers
- Important notes for interpretation of results:
  - 3% or more variance = **substantial** change
  - **Favorability** means a negative statement has been counteracted for in reporting

Why we undertook the survey?

To understand what

- is important to everyone
- motivates everyone
- What we should
  - keep doing,
  - stop doing and
  - Start doing

Understand the current status of our key drivers and engagement

What is Engagement?

Staff engagement is an employee's **rational** and **emotional** commitment to their **job, manager, team and the organisation** which directly impact on people's **discretionary effort** and **intent to stay** in the organisation.

Source: Corporate Leadership Council (Gartner), 2004

Why is engagement important?

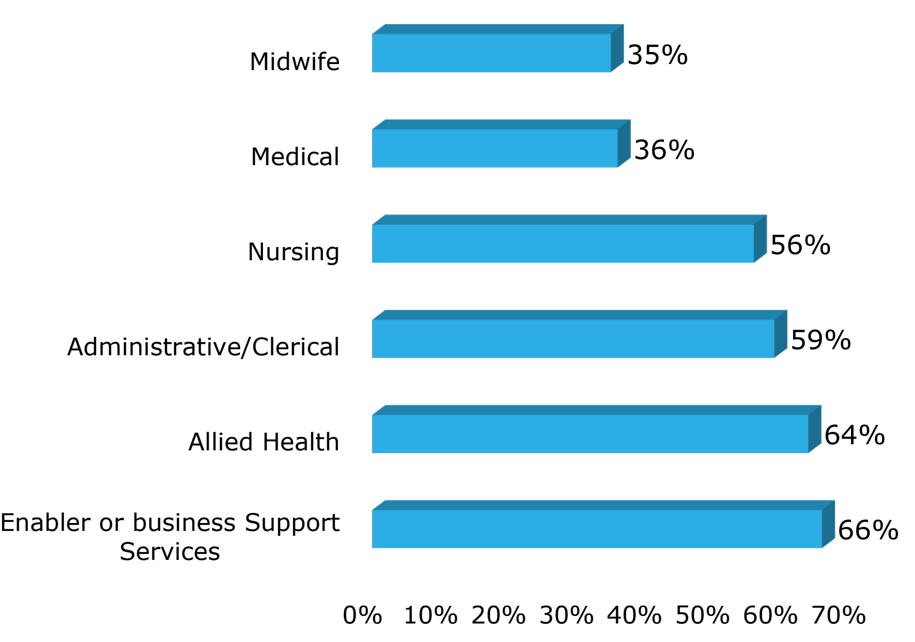
- Greater staff work experiences
- Staff enjoy their work more
- Staff stay because they want to!
- Better patient experiences
- A proven increase in service quality
- Be able to attract quality talent

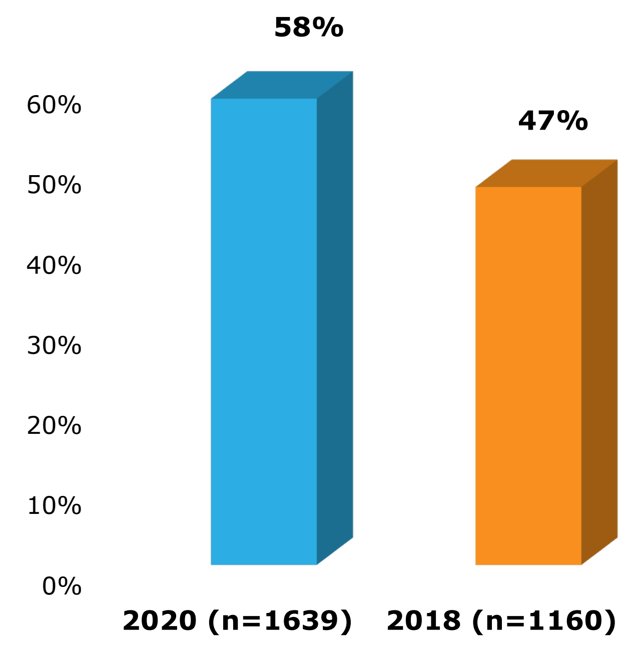
Everybody is a winner!

Overview of Survey Results

- Participation
- Engagement Score
- Factors impacting on engagement
- Things we are doing well
- Areas for improvement
- Key Driver Analysis
- Comment Analysis
- Quality of our working relationships
- Insights and recommendations

Participation





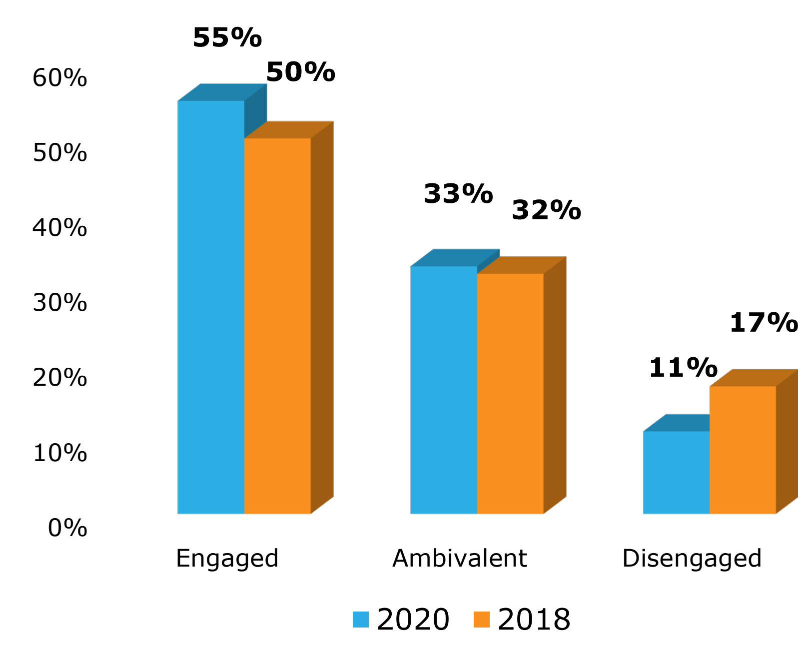
Engagement Score

Calculation of Engagement Score

Based on the **following items in the survey**:

- How likely are you to recommend this DHB to friends and family as a place to work?
- How likely are you to recommend the DHB to friends and family if they needed care or treatment?
- How often is the following true? 'When I get up in the morning, I look forward to going to work'
- Thinking of the last week at work, how often have you experienced the following emotions:
  - Proud
  - Valued
  - Motivated.

MDHB Engagement Score



Engagement Score analysis

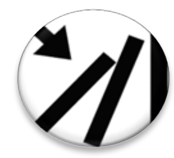
Overall Engagement Score breakdown

	Unfavourable	Neutral	Favourable	2018 Results
Valued	19%	36%	45%	42%
Recommend as an organisation to work	8%	39%	53%	43%
Proud	10%	36%	54%	48%
Look forward to going to work	20%	26%	55%	49%
Motivated	7%	31%	62%	58%
Recommend for Care or Treatment	4%	33%	63%	62%

0% 20% 40% 60% 80% 100% 120%

■ Unfavourable ■ Neutral ■ Favourable

Overall Results



Favorability scores:

	2020	2018
Direction and purpose	70%	63%
Contribution and control	60%	51%
Recognition and value	64%	51%
**Connection and Support	58%	53%
Wellbeing	54%	48%
Our Values	69%	53%
Our Safety Culture	52%	43%
* Job Connection	66%	0%
Overall Engagement Score	55%	50%
Positive Emotion	54%	47%
Negative Emotion	41%	46%

Top 5 – Most favourable

Statement	Unfavourable	Neutral	Favourable	2018 Results
My work makes a difference to other people	1%	5%	94%	94%
I am clear about my objectives and responsibilities	4%	7%	89%	89%
The values and behaviours expected of us at work are clear to me	5%	13%	82%	81%
The people in my team work well together to provide a great service	7%	13%	80%	77%
Staff in this organisation are generally friendly and welcoming	6%	16%	78%	77%

0% 20% 40% 60% 80% 100% 120%

Unfavourable Neutral Favourable

Top 5 - Most Unfavourable

	Unfavourable	Neutral	Favourable	2018 Results
My health and wellbeing has not suffered because of my work	**37%**	24%	39%	33%
People in my team worry they will be blamed for their mistakes.*	**37%**	32%	31%	17%
People in my team worry that mistakes they make will be recorded permanently.*	**33%**	38%	29%	17%
Work often feels in 'crisis mode' where we try to do too much too quickly.*	**45%**	27%	28%	21%
I often feel emotionally drained by my work*	**50%**	26%	24%	19%

0% 20% 40% 60% 80% 100% 120%

■ Unfavourable ■ Neutral ■ Favourable

Key Driver Analysis, Some insights into what you told us to focus on to increase your experiences at work…

Requires active improvement:

- Acknowledgement and recognition
- Senior Leadership visibility and approachability
- Health and wellbeing
- Career progression
- Staff displaying more positive attitudes
- Promoting equality and diversity
- Work-life balance
- Helpful feedback from managers
- Information about what is going on in the organisation

Maintain because we are getting this right:

- Being supported to adapt to change
- Staff ideas and views are welcomed
- Supported to grow and develop
- Managers communicate goals and objectives clearly
- Staff are helpful
- Manager focus on staff's strengths
- Staff feel safe to speak up about errors
- Staff feel supported by their teams
- The organisation makes good use of people's skills
- Staff feel that they are treated with respect by managers

Comment THEMES

How can we support staff to better live our values…

1. Values should be **showcased and role modelled** more
2. Staff wants to feel that they are heard and **listened** to
3. **Recognise positive behaviours** (values, positivity and kindness)
4. **Sufficient staffing**, to address workloads and burn-out
5. Transparency in dealings
6. Address **negative behaviours** (bullying and harassment)
7. Holding staff **accountable for their behaviours**
8. Values training, more team building, visuals to **display our values**
9. Promote more **equality and fairness**
10. Incorporate **more Te Reo** into our work environment

Comment THEMES

Views on why you would recommend MDHB as a place to work….

- Staff feel supported by their teams
- Supportive management
- Training and development opportunities

Views on why you would not recommend MDHB as a place to work…

- Insufficient demonstration of respect and valuing staff
- Poor behaviours amongst staff (bullying)
- Low staffing levels, access to resources and IT systems.

Comment THEMES

Views on why you would recommend MDHB as a place to receive care…

- High quality of service and patient care
- Great supportive teams
- Quality care despite limited resources
- Friendly, respectful and positive staff

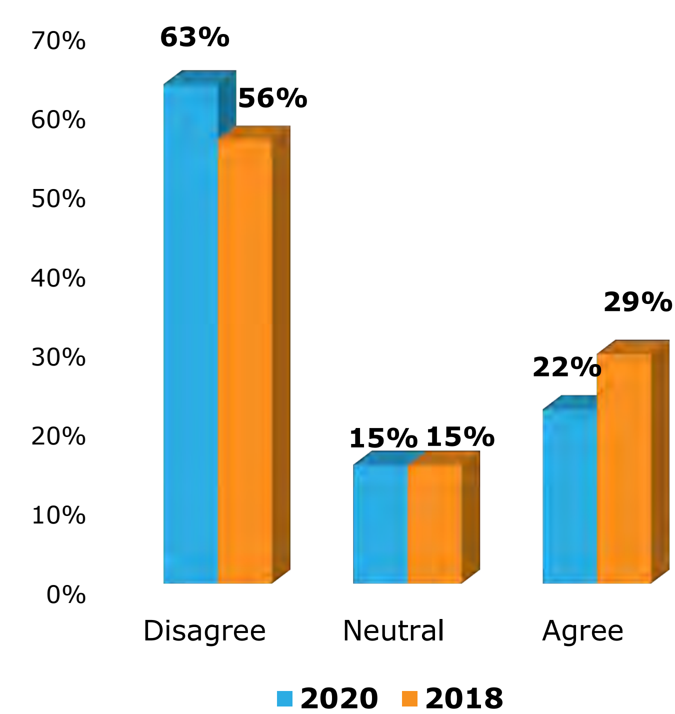
Views on why you would not recommend MDHB as a place to receive care…

- Improved standards of care for some services
- Low Staffing and resources resulting in longer waiting times and delays
- Lack of support and transparent decision making

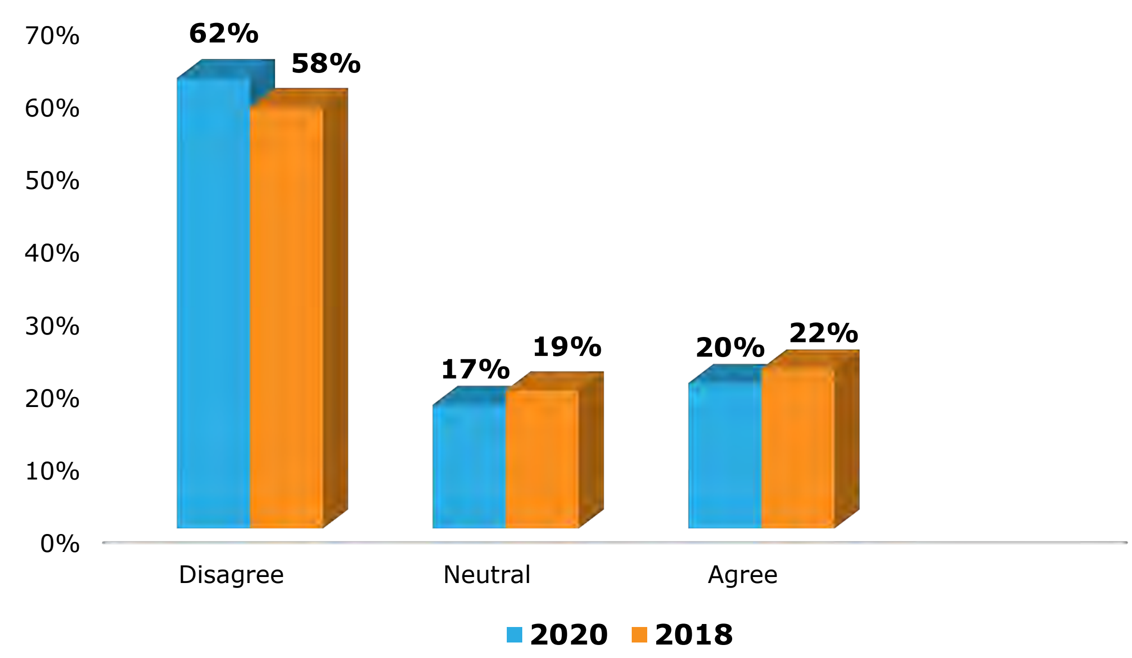
Quality of our working relationships

Staff reported that poor behaviours……

- Occur **mostly on the job** and during group meetings;
- Predominantly consist of **hostile verbal/ non-verbal** communication;
- Involve **blaming, criticism, accusations, shouting or overbearing supervision**.
- Most frequently displayed by **senior members and/or peers and colleagues.**
- Happened **once or twice** in the year.



Quality of our working relationships



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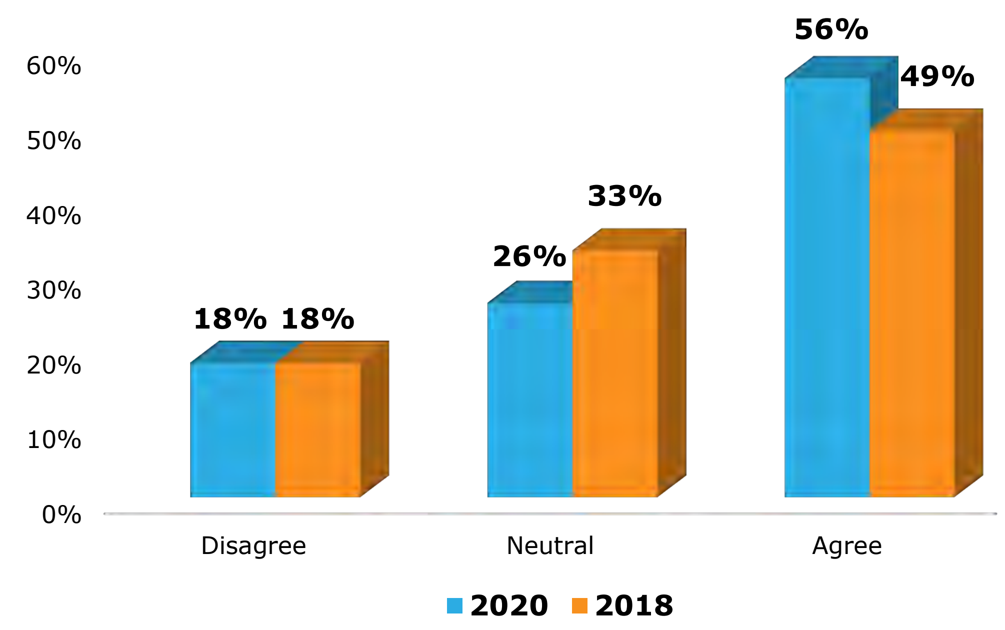
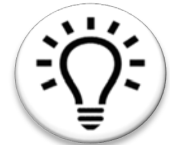


Insights



- Progress has been made, but more needs to be done
- Employee wellbeing is important
- Effective awards and recognition practices
- Consistent leadership capabilities
- Increased cooperation across different teams
- Dealing constructively with poor behaviour
- Living and demonstrating our values daily
- Understand how we can improve performance conversations
- Clear career progression pathways for non clinical staff and leadership
- Enhanced promotion of equality and diversity

(8) Engagement Survey 2022

(7) Engagement Action Planning - 2021

(6) What can I do, what can my team do, what should our manager focus on, and what should the organisation know about?

(5) Identify Vital Few goals that would impact on team engagement

(3) Not ONLY about numbers, it is about: curiosity & participation

(4) Courageous, Compassionate, Respectful & Accountable conversations

(2) Analyse and discuss results in teams

(1) Survey 2020

Steps ALONG THE Journey

Accountable
– Kia noho
haepapa

YOUR VOICE

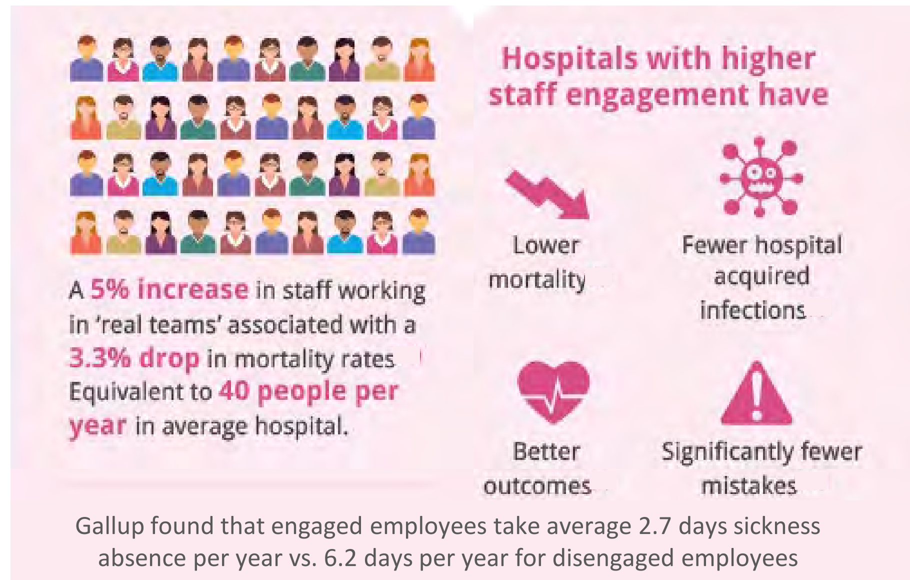
He kupu kōrero

High-Level Action Plan

MDHB Staff Engagement & Safety Culture Survey 2018

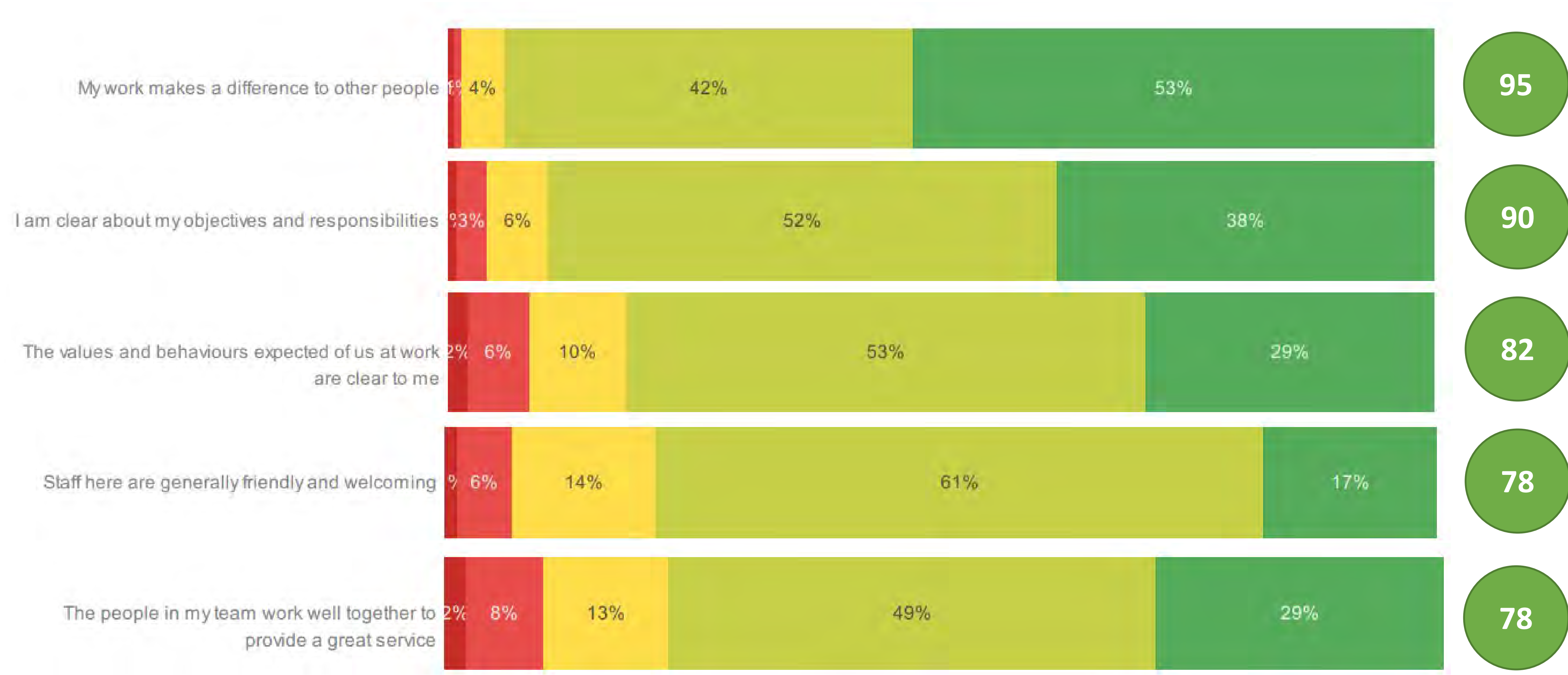
Staff Engagement Affects Health Outcomes and the Bottom Line

- **When healthcare staff have a better work experience, patient care, safety and outcomes improve.** True for staff in clinical & enabling roles
- Engaged staff are more productive, ensuring the best outputs for staff costs.
- Engaged staff are more likely to be retained by the organisation, reducing the costs of turnover.
- Engaged staff recommend the workplace to others, attracting quality talent.

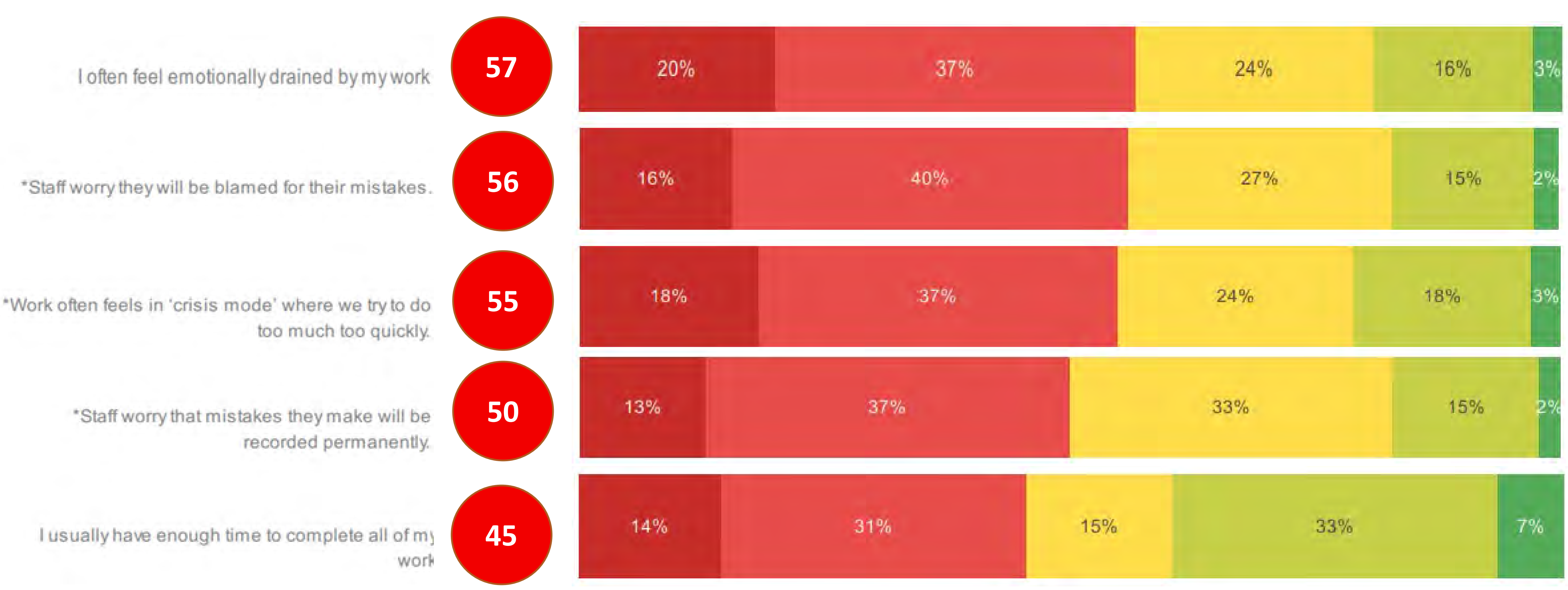


MDHB OVERALL ENGAGEMENT RESULTS 2018

Top Five – Most Favourable (Things we are doing well)



Low Five – Most Unfavourable (Areas for Improvement)



Key drivers: Experience – where to act first

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0.54
0.52
0.50
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0.16
0.14
0.12
0.10
0.08
0.06

50% 55% 60% 65% 70% 75% 80% 85% 90%

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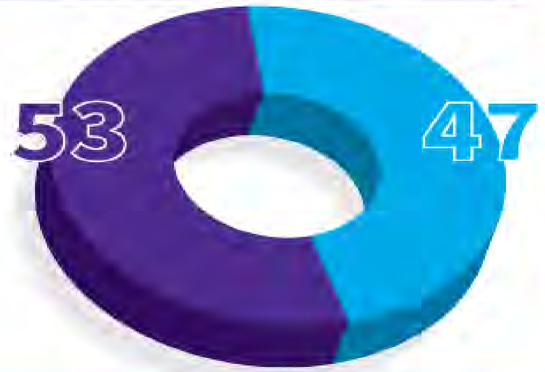
MidCentral DHB Staff Engagement survey

Response rate (%)



A total of 1,160 responses were received

Overall Engagement

Within the survey, six questions are identified as being key indicators of overall staff engagement:

- How likely are you to recommend this DHB to friends and family as a place to work?
- How likely are you to recommend the DHB to friends and family if they needed care or treatment?
- How often is the following true? 'When I get up in the morning, I look forward to going to work'
- Thinking of the last week at work, how often have you experienced the following emotions:
- *Proud* • *Valued* • *Motivated*

Mean Score 3.4

17%	32%	51%

Overall Results

Name	Mean	Distribution
Contribution and Control	3.3	52%
Recognition and Value	3.4	57%
Direction and Purpose	3.7	67%
Contribution and Control	3.3	52%
Recognition and Value	3.4	57%
Connection and Support	3.4	53%
Wellbeing	3.3	50%
Our Safety Culture	3.3	51%
Our Values	3.7	47%

Top 5 - Most Favourable

Things we are doing well

Statement	Distribution		Score
"My work makes a difference to other people"	42%	53%	95
"I am clear about my objectives and responsibilities"	52%	38%	90
"The values and behaviours expected of us at work are clear to me"	53%	29%	82
"Staff here are generally friendly and welcoming"	61%	17%	78
"The people in my team work well together to provide a great service"	49%	29%	78

Low 5 - Most Unfavourable

Areas for improvement

Score	Statement	Distribution			
57	"I often feel drained by my work"	20%	37%	24%	16%
56	"Staff worry they will be blamed for their mistakes"	16%	40%	27%	15%
55	"Work often feels in 'crisis mode' where we try to do too much too quickly"	18%	37%	24%	18%
50	"Staff worry that mistakes they make will be recorded permanently"	13%	37%	33%	15%
45	"I usually have enough time to complete all of my work"	14%	31%	15%	33%

Next Steps ...

- Team Results
- Lead Action Planning
- Review OP Plan

Taking Action on Our Survey Results

- Initiatives have been developed that focus on key insights gained through the survey
- Key Drivers Analysis show us where to focus our efforts to achieve maximum impact on overall engagement
- Top five and low five provide opportunities to impact in a visible way
- The Organisational Development Plan is being reviewed:
    - Include the new initiatives
    - Adjust priorities for some initiatives
    - Exclude some initiatives

OD Plan - Process

1. Discuss and agree with Senior Leadership Team
2. Submit refreshed plan to Board for endorsement
3. Communicate broadly to staff

It is critical that staff can see that action is being taken based on the feedback they provided. This will build trust and influence higher Participation in future surveys.

Staff Feedback, Recognition and Development

Recognition and Value
When people feel respected for who they are, and that their efforts are noticed and valued.

Contribution And Control
When people are able to develop their skills, strengths and ideas and put them to good use.

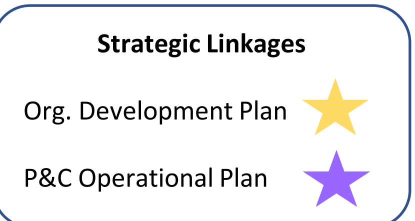
Direction and Purpose
When people find meaning in their work, understand what's expected of them, and see that in others too.

Redesign performance management framework

- Modern approach/tool, reducing administration
- Effective, timely feedback conversations and recognition opportunities
- 360 Feedback Processes for leaders, open and honest two-way feedback
- Structured approach to implementing development opportunities
- Talent identification, career and succession planning

Implement annual awards for staff to be delivered at end of year celebrations

Review training, education and research functions across the organisation. Implement improvements that strengthen growth and development of staff.



Areas for Improvement
Key Drivers:
- I am supported to grow and develop at work
- I am happy with my career progression opportunities
- I am praised and recognised when I do a good job
- The person I report to gives me regular, helpful feedback on my work

Areas to Maintain
Key Drivers
- The person I report to focusses on my strengths rather than my weaknesses
- The person I report to communicates the goals and objectives of the team effectively
- My views and ideas are welcomed and encouraged

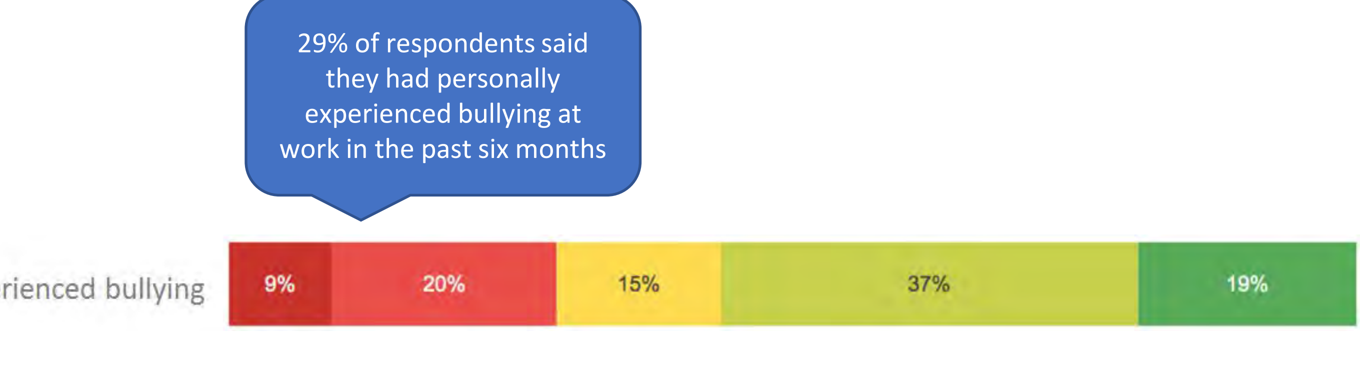
Top Five
- I am clear about my objectives and responsibilities
- My work makes a difference to other people

Staff Safety, Health and Wellbeing

★Preventing Occupational Violence and Responsive Workplaces Programmes

Bullying Prevention Programme – 2019/20

★Continue with implementation of Speaking Up For Safety and Promoting Professional Accountability programmes.



Strategic Linkages

Org. Development Plan ★

P&C Operational Plan ★

Safety Culture
When we have the correct attitude towards workplace safety and sufficient procedures in place to protect staff and patients from harm.

Safety & Wellbeing
When people feel safe from poor behaviours, and that their work contributes to their wellbeing.

Areas for Improvement

Key Drivers:

- My health and wellbeing has not suffered because of my work

Low Five:

- I often feel emotionally drained by my work
- Staff worry they will be blamed for their mistakes and that mistakes will be recorded permanently

Areas to Maintain

Key Drivers

- I feel safe and confident to speak up about inappropriate behaviour

Workplace Culture, Values and Behaviours

★ Introduce Values Awards and Rewards when people demonstrate they are living MDHB's values.

Values-based selection frameworks developed and implemented.

Performance Management and Leader 360 feedback processes to include MDHB's values.

★ Workshops with staff – creating a shared understanding and living the values. Supported by Speaking up For Safety and Promoting Professional Accountability frameworks.

Connection and Support
When people feel a good sense of teamwork and support in their team, with other teams and from leaders.

Living Our Values
When we consistently experience colleagues, managers and leaders behaving and making decisions that are aligned to our values.

Areas for Improvement

Key Drivers:

- People working here display a positive attitude
- Staff respect each other, whoever they are and whatever their role

Areas to Maintain

Key Drivers

- The person I report to treats me with respect

Top Five

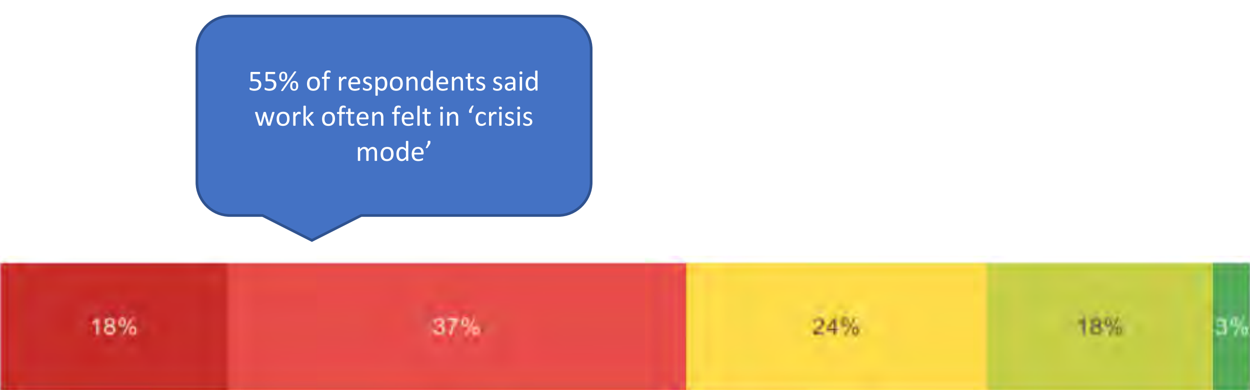
- The values and behaviours expected of us at work are clear to me
- The people in my team work well together to provide a great service
- Staff here are generally friendly and welcoming

Safe Staffing and Manageable Workloads

Implement CCDM for all nursing workforces, then for Allied Health workforces.

Medical Service Sizing

Conduct a review of workloads for administrative staff across the organisation, starting in areas where this has been identified as an issue.



Safety Culture
When we have the correct attitude towards workplace safety and sufficient procedures in place to protect staff and patients from harm.

Safety & Wellbeing
When people feel safe from poor behaviours, and that their work contributes to their wellbeing.

Areas for Improvement
Low Five:

- I usually have enough time to complete all of my work
- Work often feels in 'crisis mode' where we try to do too much too quickly

Visibility of Senior Leaders

★ Quality & Safety walk arounds and action plans

★ Executive attendance at values workshops, regular interactions between ELT and key workforce groups

★ Cluster leadership proposal – reduction of structural layers

Connection and Support
When people feel a good sense of teamwork and support in their team, with other teams and from leaders.

Areas for Improvement
Key Drivers:
- Senior leaders are visible and approachable

Promoting Equality and Diversity

★ Establish Diversity & Inclusion Committee

★ Continue to support staff networks for minority and diversity groups

★ Support implementation of Maori Workforce Development Strategy including embedding cultural competency across the organisation

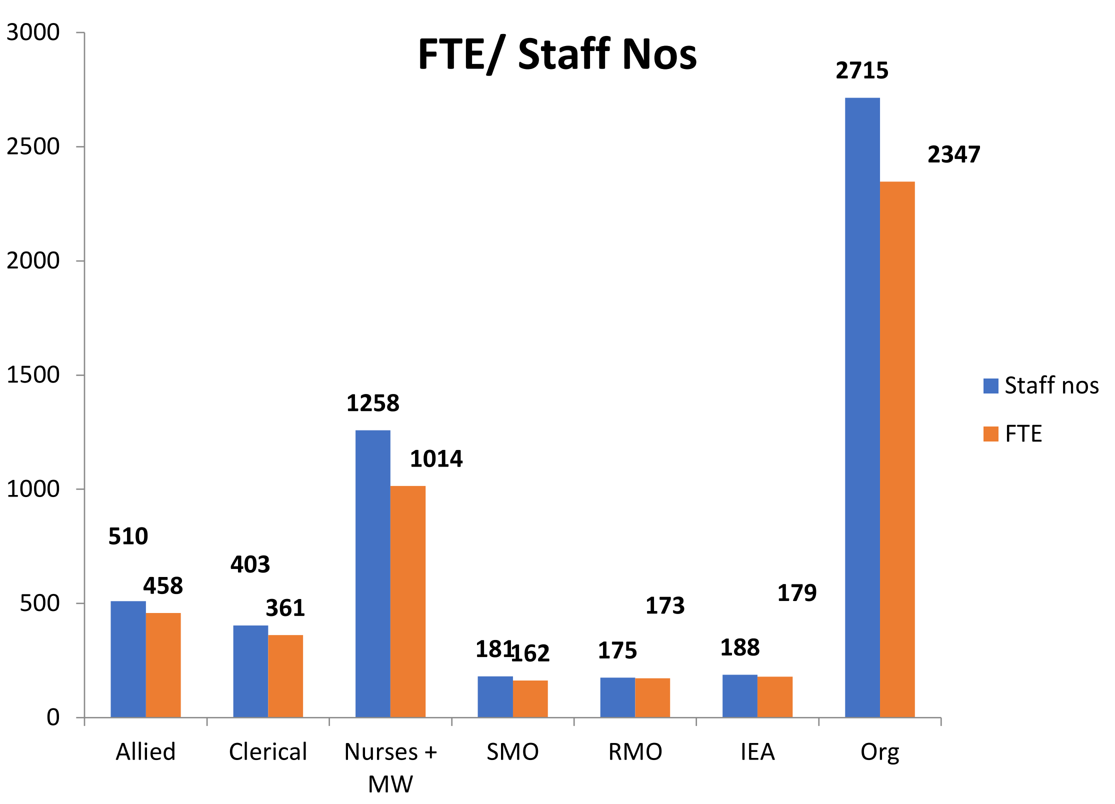
Safety & Wellbeing
When people feel safe from poor behaviours, and that their work contributes to their wellbeing.

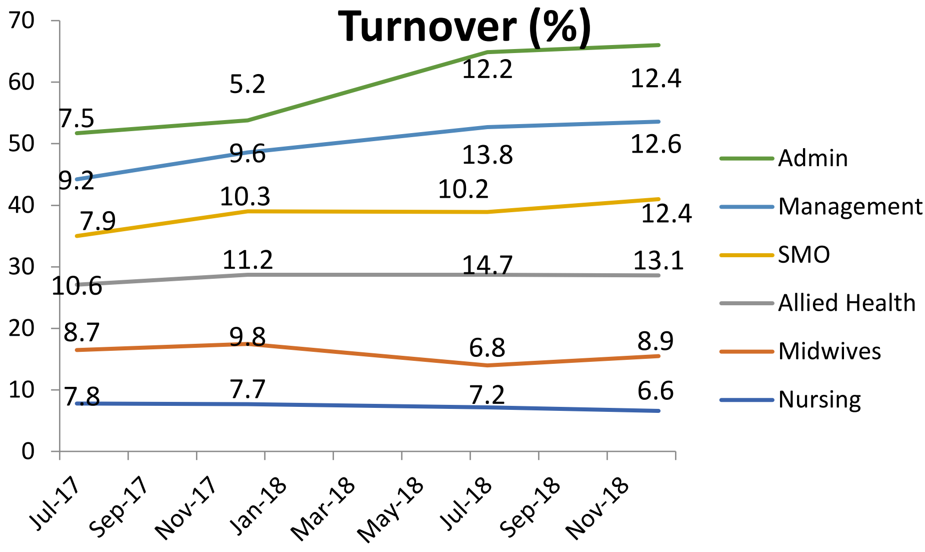
Areas for Improvement
Key Drivers:
- This organisation promotes equality and diversity

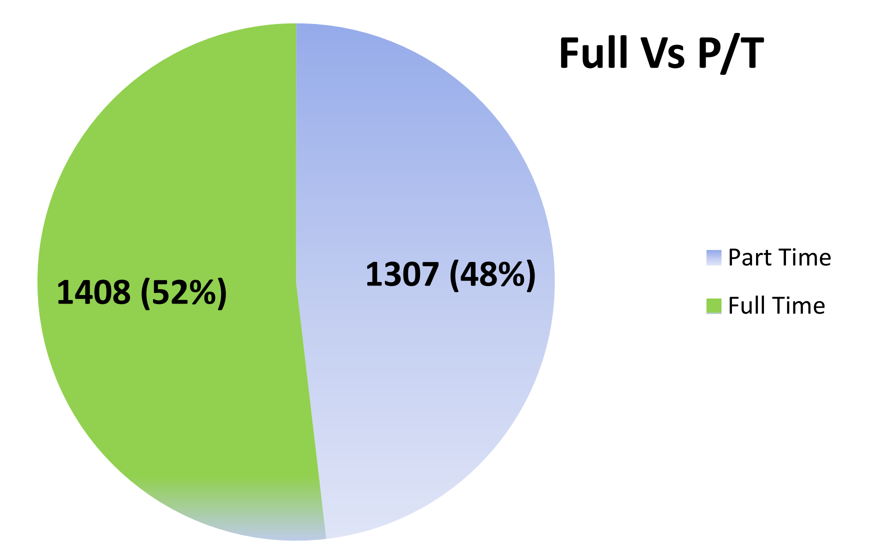
Other initiatives

- Leadership development for 2 and 3 Tier leaders
- Restructuring the HR team into a Business Partnering Model – more specialist recruitment focus
- Workforce data and dashboards
- KOH internships
- Health and Safety Strategy and Plan

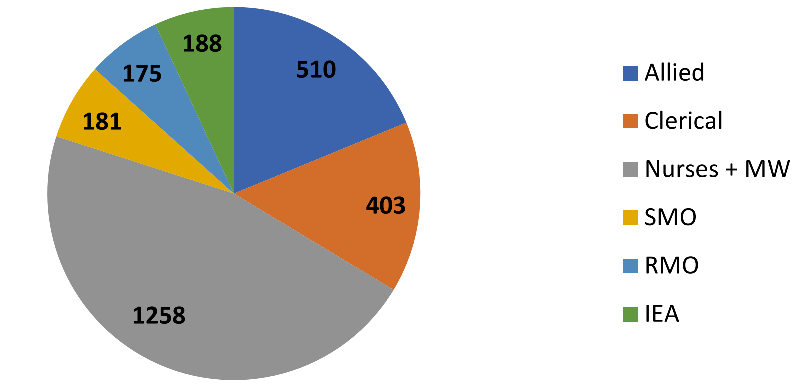
Workforce info

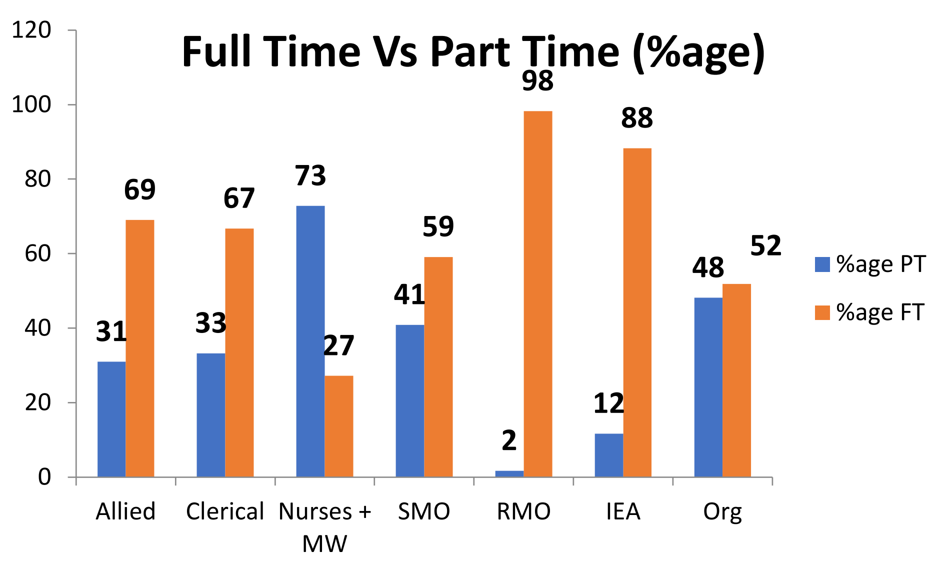


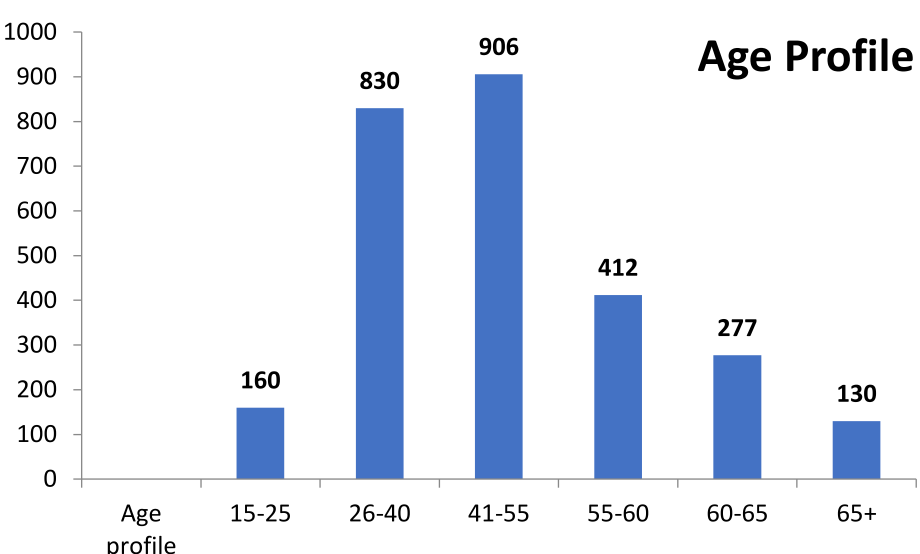


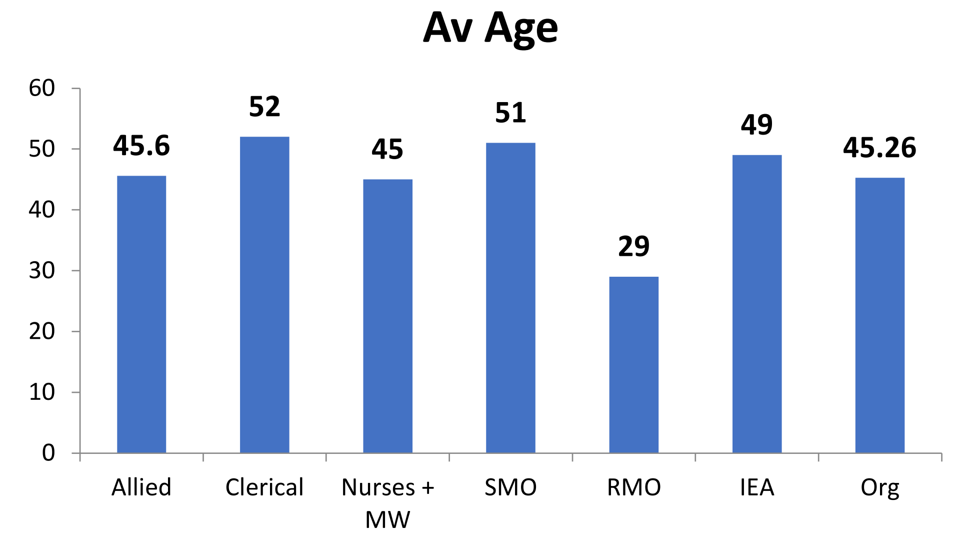


Workforce Profiles









For:

	Decision
X	Endorsement
X	Noting

To	Executive Leadership Team
Author	Keyur Anjaria, General Manager People and Culture
Endorsed by	Kathryn Cook, Chief Executive Officer
Date	6 September 2018
Subject	**Staff Engagement and Safety Culture Survey Report**

RECOMMENDATION

It is recommended that the Board:

- **note** the MDHB Staff Engagement and Safety Culture Survey 2018 report
- **endorse** refreshing the OD Plan and development of new initiatives, following a detailed analysis of the survey results

Strategic Alignment

This report aligns to MidCentral District Health Board's Strategy, and to our Organisational Development Plan which is one of the five key enabler plans to support the achievement of our strategic imperatives.

Glossary

DHB	District Health Board
ELT	Executive Leadership Team
HR	Human Resources Consultant
HRC	Human Resources and Organisational Development
MDHB	MidCentral District Health Board
ODP	Organisational Development Plan

COPY TO:

Human Resources & Organisational Development
MidCentral DHB
Heretaunga Street
PO Box 2056
Palmerston North 4440
Phone 06 350 8859

1. PURPOSE

The purpose of this paper is to provide the Board with the results of the staff engagement and safety culture survey for 2018. This report is being provided for discussion and noting. Endorsement is being sought to refresh the Organisational Development Plan with new initiatives on the basis of the survey results, which was approved by the Board in February 2017.

2. SUMMARY

Following endorsement by the ELT and the Board, the staff engagement and safety culture survey for MDHB was conducted from 24 May to 26 June 2018. The survey, branded "Your Voice – He Kupu Korero", provided an opportunity to measure staff perceptions of the current work environment. The survey also measured the overall staff satisfaction and their perception of safety, wellbeing and quality within the workplace.

The survey was conducted by April Strategy using the Qualtrics platform. A key objective for the survey was to gather feedback from staff that results in actionable insights, and provides a basis for reviewing our current and future plans for engagement and safety culture initiatives. Questions were therefore grouped across ten key indices. Six other DHBs in New Zealand use the selected survey tool to conduct a similar survey. Questions that are common across these surveys have been aggregated, and MDHB's responses against those questions have been benchmarked.

3. BACKGROUND

Objective

A key objective of this survey was to seek feedback from staff that resulted in actionable insights and provided a basis for reviewing our current and future plans for engagement and safety culture initiatives. In order to achieve this, the survey was focussed on:

1. Asking the right questions
2. Employing an effective communications campaign that supported maximum participation from staff and provide them with assurance of anonymity
3. Being deployed effectively to ensure all staff had access and ability to complete the survey
4. Ensuring feedback was delivered to the right people in the right format.

Survey Content

In determining the question set, a review of the questions used by other DHBs in New Zealand was undertaken. A copy of the core question set was developed following feedback, which ensured that the:

1. Survey should take less than 20 minutes to complete on average.
2. Language used should be clear, simple and relevant to our organisation.

3. Questions related to MDHB's organisational values were included.
4. Free text components were kept to a minimum and only used where this would be most valuable.
5. Staff awareness towards the Treaty of Waitangi, cultural values, bullying and harassment and cultural discrimination was assessed.

Benchmarking

One of the main considerations of using this survey tool was so that MDHB's responses could be benchmarked against responses of other participating DHBs in New Zealand.

Five other DHB's (in addition to MDHB) use the survey instrument and the core question set. While not all questions are used across all DHBs, questions that are common across all DHBs, provide a benchmark against whom MDHB's responses have been compared. The other DHBs using this survey tool against whom the benchmark has been developed are:

- Auckland,
- Bay of Plenty
- Hawke's Bay
- Hutt Valley
- Wairarapa.

Communication Campaign

Over the weeks commencing 14 May 2018, a communications campaign was run to promote and raise awareness of the staff survey, its goals and messages. The campaign was also aimed at encouraging staff participation and assuring staff of the anonymity of participation.

Staff Engagement Levels

The first step of any culture improvement strategy is to measure employee engagement levels. Staff Engagement measures the passion, commitment and willingness that respondents demonstrated to go the extra mile in order to help the organisation succeed. It is the core of workplace relationships between the employee and the employer and emphasises the two-way nature of this relationship.

April Strategy (our survey provider) embedded the following six critical questions across various indices within the survey to establish an indicator of overall staff satisfaction and engagement levels.

- How likely are you to recommend this DHB to friends and family as a place to work?
- How likely are you to recommend the DHB to friends and family if they needed care or treatment?
- How often is the following true? 'When I get up in the morning, I look forward to going to work'

- Thinking of the last week at work, how often have you experienced the following emotions:
    - Proud
    - Valued
    - Motivated.

Engaged employees: these are suitably motivated by their workplace experiences to respond to the engagement questions positively (strongly agree/ agree). These staff are promoters within the organisation and will go the extra mile to deliver services that would be categorised as 'over and beyond'. Respondents who identified as engaged are reflected in green (dark green and light green).

Ambivalent employees: these are respondents who tend to be more hesitant in their responses to the engagement questions. They are not sufficiently engaged to indicate that they are either highly satisfied or as likely to go the extra mile to deliver outstanding services. On the other hand, neither are they particularly dissatisfied or uncommitted. For the purpose of the survey, this is a term that is used for respondents who have mixed feelings about the workplace. This is a target group of respondents that can move to either side with a little bit of effort. Respondents who identified as ambivalent are reflected in amber.

Disengaged employees: these are respondent groups that are not sufficiently motivated to respond positively overall to the six engagement questions. They may instead offer neutral responses that suggest a disconnect with the organisations values and direction. Active engagement across the organisation can often provide more clarity to this group about the organisation's direction. Respondents who identified as disengaged are reflected in red (dark red and light red).

Dashboards showing the progress of the survey were made available to managers at the start of the survey so that they could monitor the response rates of their teams and encourage greater participation.

The survey provided an opportunity for staff to comment on things that they believed were being done well at MDHB and those that needed improvement. Comments received were analysed by April Strategy and presented as word clouds across relevant questions and as an overall summary within the report to ensure that respondent's identities remained anonymous.

All responses were totally confidential and reporting is only available for demographic groups of more than five respondents.

4. SURVEY REPORT AND KEY FINDINGS

A copy of the benchmarked organisational results of the survey is attached as Appendix A.

Key findings are summarised below.

- 1160 staff responded to the survey. This amounts to about 47 per cent of our total staff.

- All indices have mean scores attributed to them. The mean scores reflect the distribution of responses from most unfavourable (1) to most favourable (5), with the midpoint being a score of 3. MDHB scored above the midpoint across all ten indices that were surveyed.
- The aggregated engagement score for MDHB indicates that 17.2 percent of the respondents identify as disengaged, 32 percent identify as ambivalent and 50.4 percent of the respondents identify as engaged. The aggregated mean score was 3.4. This is a favourable score and is above midpoint.
- MidCentral DHB's deviation from the DHB median is minimal or moderate at most, and equally represented on either side of the benchmark.
- The top five most favourable responses (areas where the DHB is doing well) were:
  - My work makes a difference to other people
  - I am clear about my objectives and responsibilities
  - The values and behaviours expected of us at work are clear to me
  - Staff here are generally friendly and welcoming
  - The people in my team work well together to provide a great service.
- The top five most unfavourable responses (areas for improvement) were:
  - I often feel emotionally drained by my work
  - Staff worry they will be blamed for their mistakes
  - Work often feels in crisis mode where we try to do too much too quickly
  - Staff worry that mistakes they make will be recorded permanently
  - I usually have enough time to complete all of my work.
- The Key Driver Analysis is in intelligent measure of survey responses and provides another source of useful information that correlates individual responses against their critical drivers of engagement. They help prioritise improvement actions for the DHB. The key areas that this analysis shows us we should focus efforts in order to achieve improved overall engagement are:
  - Individual growth and career progression
  - Leaders being more visible
  - Health and wellbeing
  - Praise, recognition and ways of feedback
  - Staff being respectful of one another and showing a positive attitude
  - Promoting equality and diversity.

  The analysis also shows us that we should apply effort in these areas where the DHB scored well, in order to support high overall engagement:
  - The organisation welcomes people's views
  - Managers focus on individual's strengths
  - Staff feel safe to speak up
  - Managers are clear on goals
  - Managers treat staff with respect.

5. NEXT STEPS

The consolidated staff survey results have been shared widely with all staff. As many staff may not have the time to go through a lengthy report, a one-page poster that reflects key results of the consolidated organisational survey was prepared and has been displayed in staff only areas. A sample copy of this poster is provided as Appendix B.

Managers have been provided with access to the results for their own teams via their dashboard. In addition, the ELT has been provided with a dashboard that allows them to explore organisation-wide results.

Members of the HR team are working with team managers (and professional leads) to access and interpret the results, share them with their teams (and professional groups). The next stage will be to develop relevant action plans at team level.

The General Manager, People & Culture is analysing various findings of the survey and will be developing an action plan that identifies organisation-wide initiatives. Once developed, these initiatives will be socialised with staff and union partners. The process will commence by the end of October 2018.

6. CONCLUSION

MDHB conducted its staff engagement and safety culture survey over May and June 2018. The result of the survey serves as vital input in refreshing the DHB's OD plan and related activities.

7. RECOMMENDATION

It is recommended that the Board:

- **note** the MDHB Staff Engagement and Safety Culture Survey 2018 report
- **endorse** refreshing the OD Plan and development of new initiatives, following a detailed analysis of the survey results

Keyur Anjaria
General Manager
People & Culture

Appendix A

YOUR VOICE

He kupu kōrero

MidCentral DHB Staff Engagement & Safety Culture Survey May-June 2018

Introduction

In May-June 2018, 1,160 people responded to our first "Your Voice – He Kupu Korero" staff survey. This report summarises the results that will be made available to managers via dashboards on their PC. It outlines:

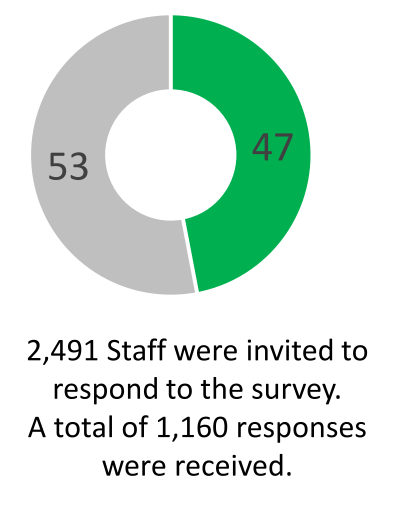
- Overall engagement and scores from the survey.
- Our key strengths and overall opportunities for improvement.
- The factors that influence engagement and how respondents scored them.
- Recommendations to improve response scores in key factors influencing engagement.

Managers can access an on-line dashboard to see their own team's results and compare these to the overall organisation.

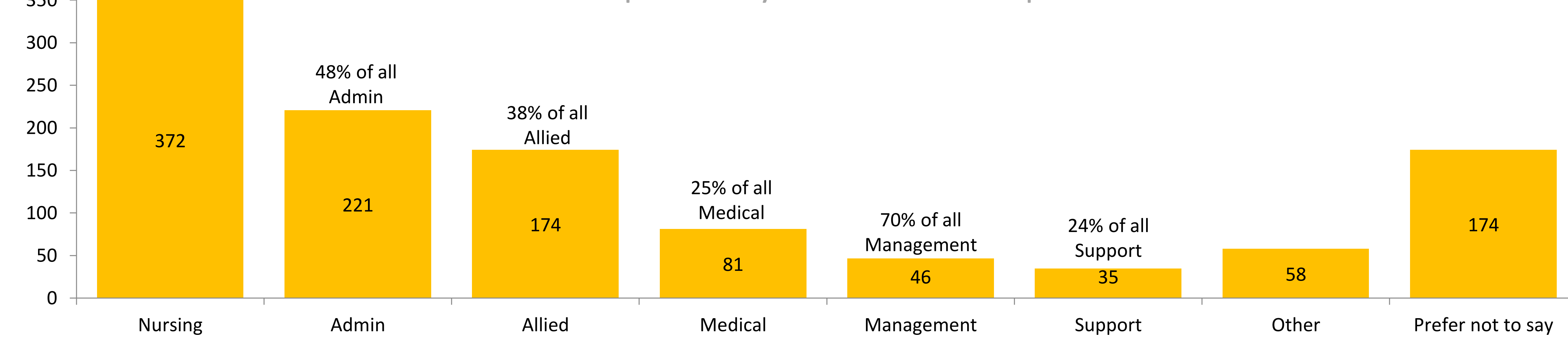
We will be supporting every senior manager to discuss results with their teams and have developed a support toolkit including advice on interpreting results and team discussion guides. Excerpts from the discussion guide are included for information.

For subsequent years we will be able to compare progress over time, identify actions that are driving improvement and factors where change is slower, but for the first year's report, without historical data, our focus will be on identifying key areas where there is obvious opportunity for improvement.

Response rate (47%)



2,491 Staff were invited to respond to the survey.
A total of 1,160 responses were received.



How to read this report

This report presents The DHB's overall results from the 2018 Employee Survey. The results represent an overview of the engagement levels of our employees and the factors that drive their engagement (and disengagement).

The survey contains three kinds of question

Overall engagement. This is an outcome measure. Higher levels of overall engagement has been shown to correlate with safer and higher quality care

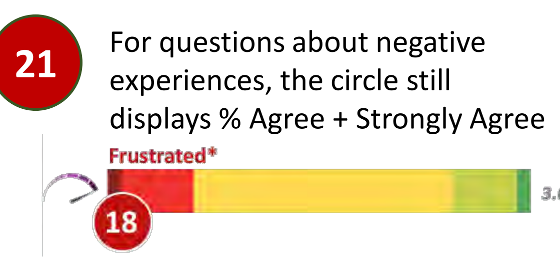
Drivers of engagement. These are factors that can be influenced to improve engagement.

Free text questions. Insight is presented as word-clouds. The individual free-text responses are not presented at the team level, to protect people's anonymity.

In addition, the survey asked about '**emotions at work**'. Studies have shown that emotions at work are an important driver of employee satisfaction, and in healthcare employee's emotions can directly affect patient emotions – which in turn influence outcomes.

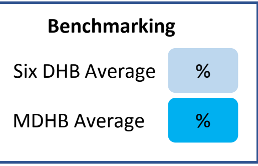
Favourability score

51 The 'favourability' % is the total % of people who scored either Strongly Agree or Agree with the statement.



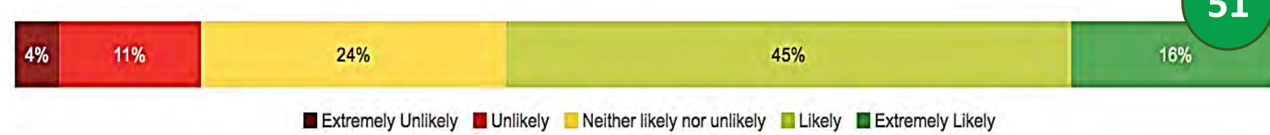
Benchmarking

Six other DHB's have undertaken a staff survey using the tool developed by April. Benchmarking information is available for the common questions used across the seven surveys.



Benchmarking	
Six DHB Average	%
MDHB Average	%

Breakdown bars



The distribution bar gives a quick visual view of your results and as follows:

For most questions / positive emotions the breakdown is as follows

Dark Green = Strongly agree

Light green = Agree

Yellow = Neutral

Red = Disagree

Dark Red = Strongly Disagree

Questions about *negative* experiences / emotions e.g. 'I have been bullied' are marked with an asterisk *

Dark Green = Strongly disagree (ie good score)

Light green = Disagree

Yellow = Neutral

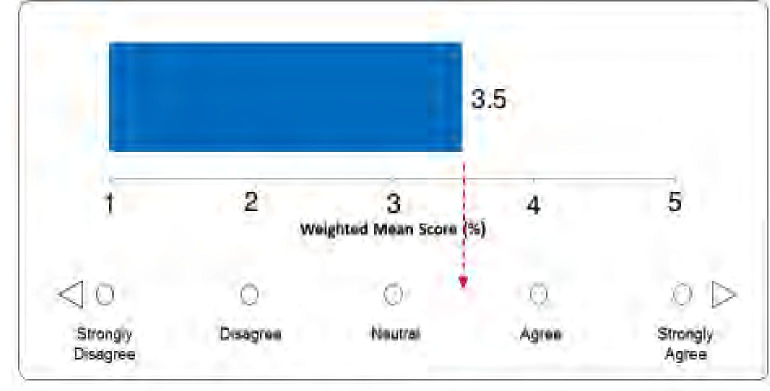
Red = Agree

Dark Red = Strongly Agree (ie bad score)

Mean scores

For each individual question the mean figure shown is a 'weighted mean' - a score between 1 and 5, showing the average score people gave for that question.

For example, if every person who responded to a question 'strongly agreed' the mean would be a perfect 5.0. If all respondents strongly disagreed with a statement it would give a mean of 1.0.



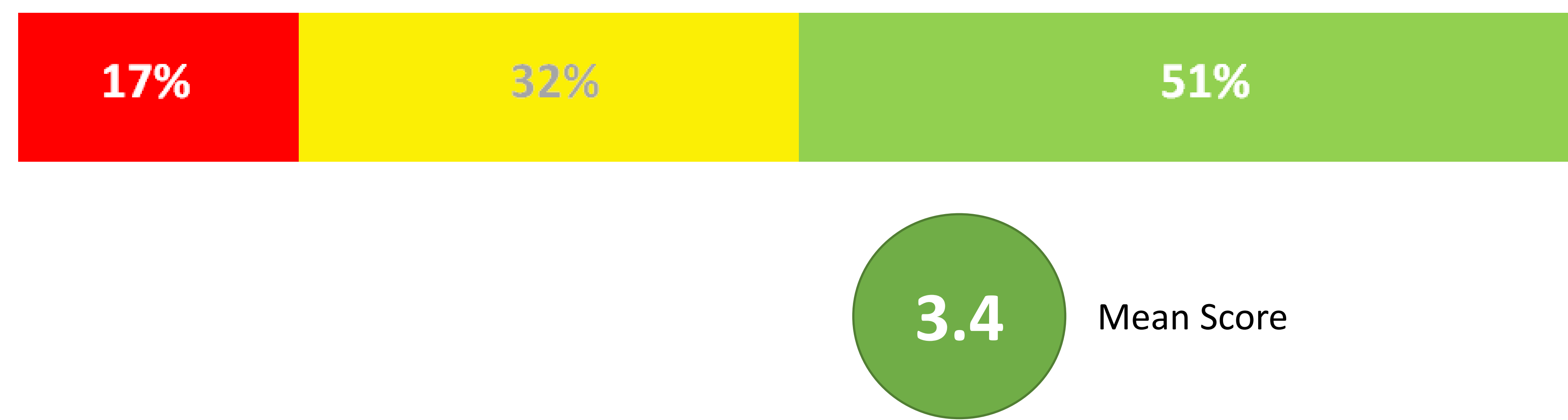
A score of 3.5 means that on average, people have responded between 'Neutral' and 'Agree' on the rating scale.

** For questions about negative experiences, as scores are reversed, a higher mean is still a better score.*

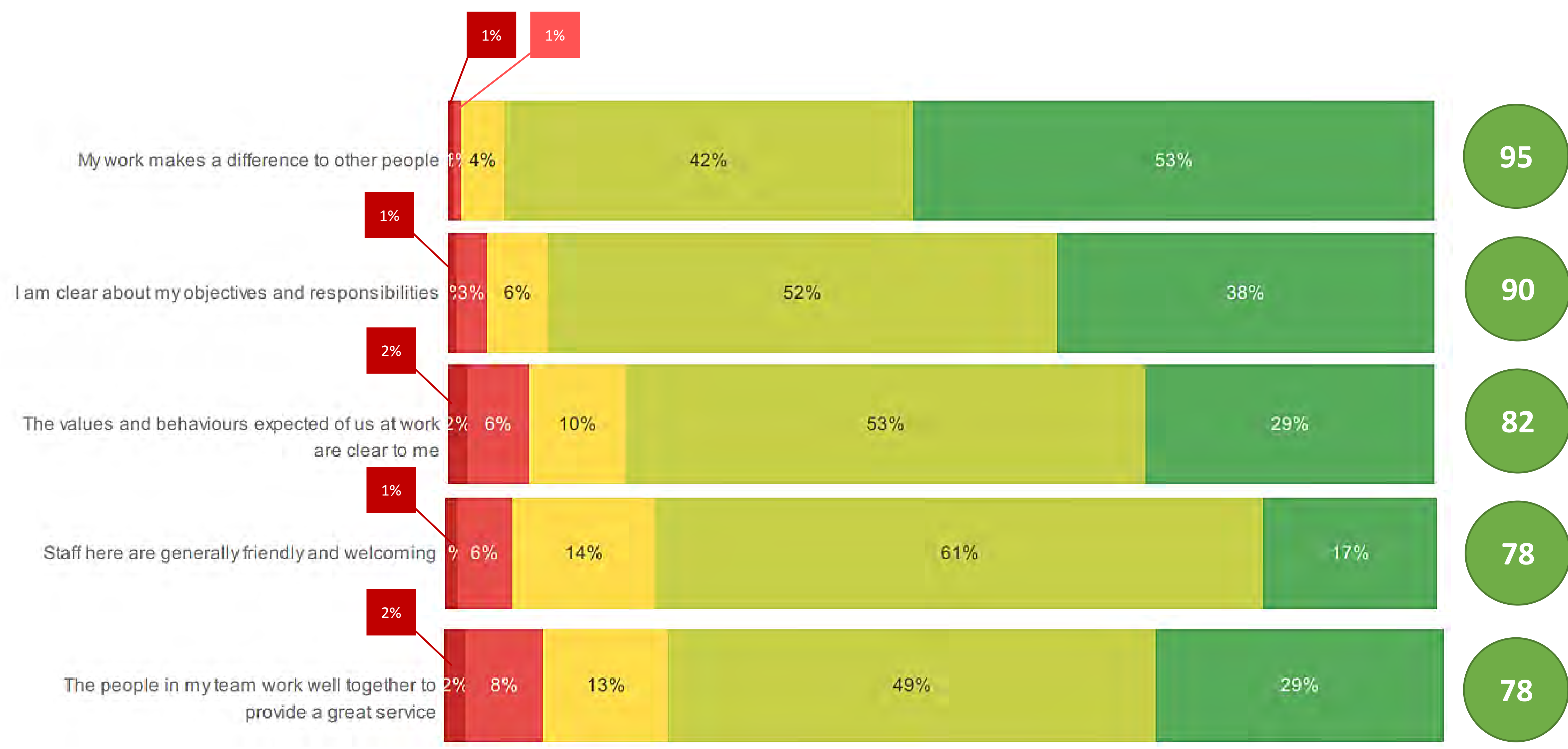
Overall Engagement

Within the survey, six questions are identified as being key indicators of overall staff engagement:

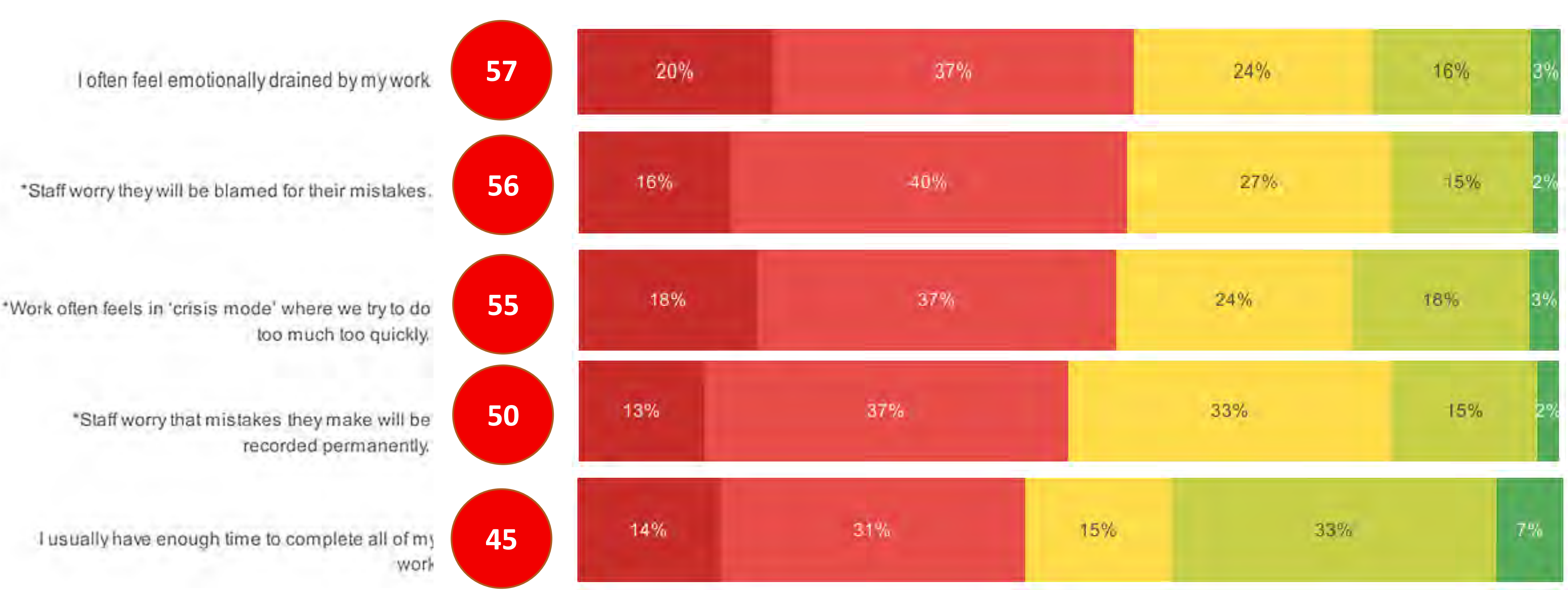
- How likely are you to recommend this DHB to friends and family as a place to work?
- How likely are you to recommend the DHB to friends and family if they needed care or treatment?
- How often is the following true? 'When I get up in the morning, I look forward to going to work'
- Thinking of the last week at work, how often have you experienced the following emotions:
  - Proud
  - Valued
  - Motivated



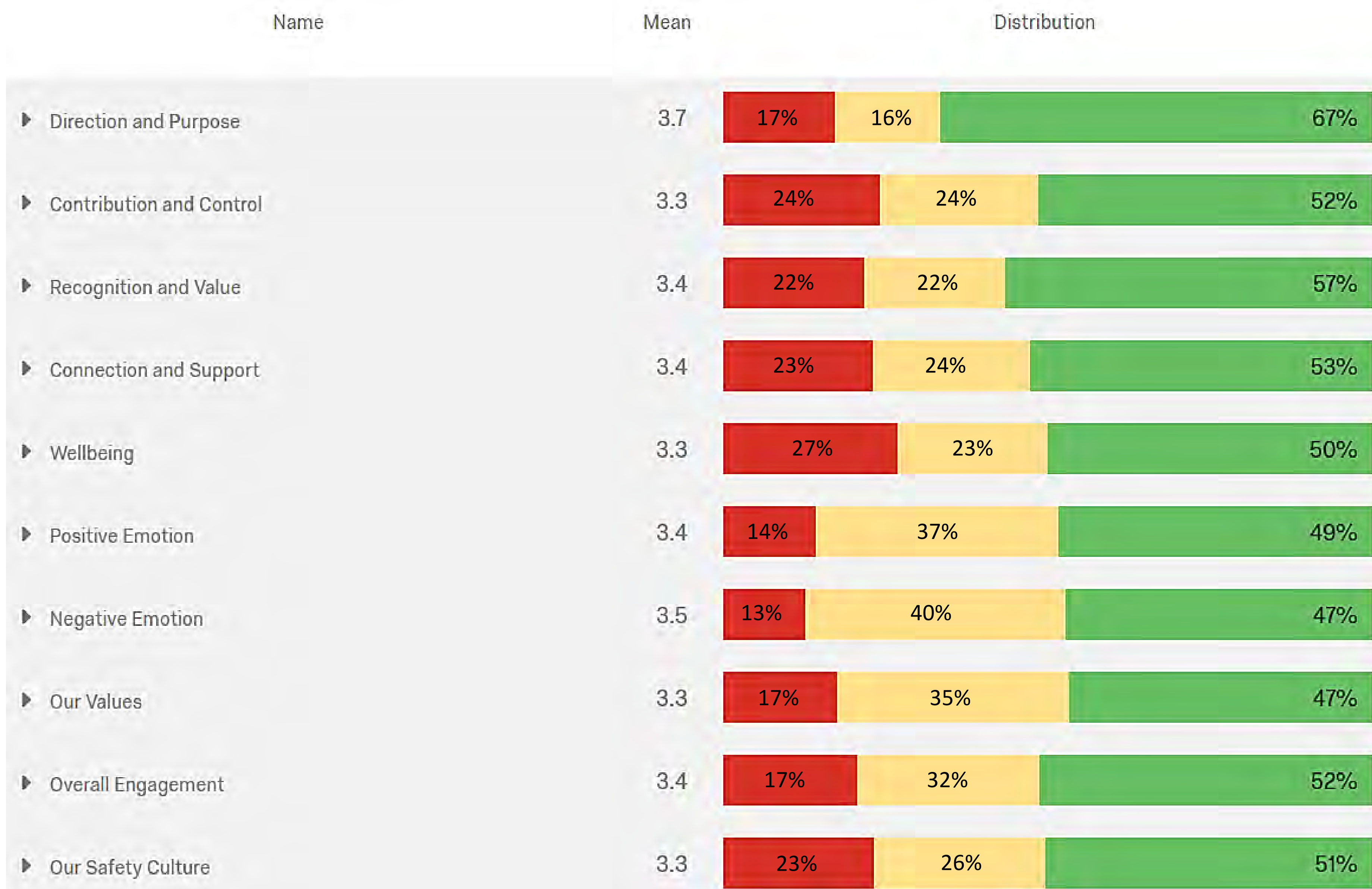
Top Five – Most Favourable (Things we are doing well)



Low Five – Most Unfavourable (Areas for Improvement)



Organisation Scorecard – Overall Results

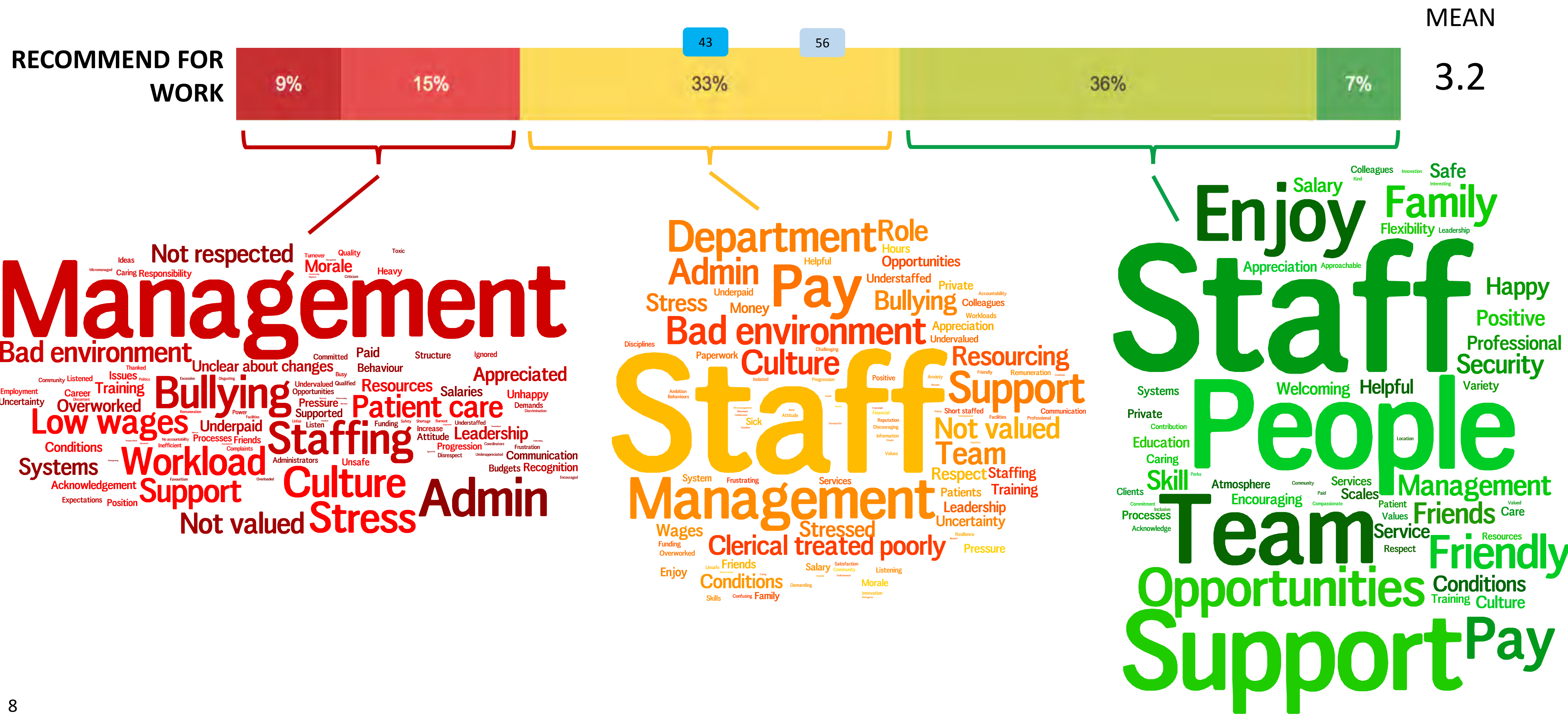


ENGAGEMENT: Would you recommend DHB as a place to work?

Benchmarking	
Six DHB Average	%
MDHB Average	%

The question 'would you recommend the DHB as a place to work' is a strong proxy for overall engagement – it represents up to 70% of the variation in other survey questions that are typically asked to measure employee engagement. As such it is the key question in our survey.

The world clouds show the key words of phrases used in response to the question 'please tell us why you gave that score'.

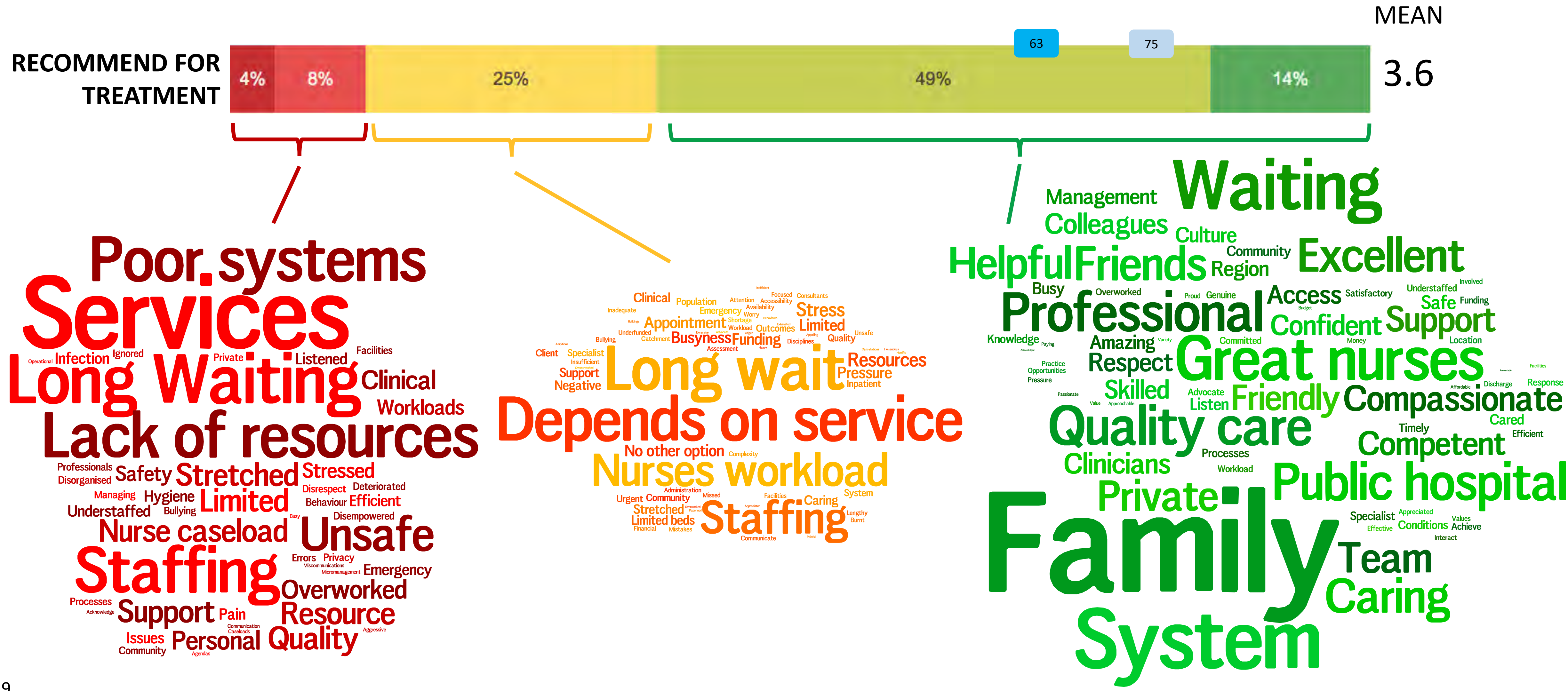


QUALITY: Would you recommend the DHB as a place for treatment?

Benchmarking	
Six DHB Average	%
MDHB Average	%

The question 'would you recommend the DHB as a place to be treated' is a good measure of the quality of care which staff believe is being provided.

The world clouds show the key words of phrases used in response to the question 'please tell us why you gave that score', and as such are a good indicator of the drivers of great or poor care at the DHB.



Breakdown: Direction & Purpose

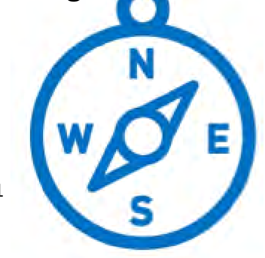
Direction & purpose

When people find meaning in their work, understand what's expected of them, and see that in others too.

Discussion points

- Are we clear about what's expected of us – individually and as a team?
- Do our individual objectives help to meet the team's objective?
- How could we be clearer about our expectations of each other?
- How can we be more positive about what we are doing?

Studies have shown that managers can increase engagement by setting challenging SMART goals. [1]



Admin & Clerical v Overall: I am happy with career progression (31% v 44%)

Benchmarking

	Six DHB Average	MDHB Average
Work makes a difference	90	94
Clear about objectives & responsibilities	87	90
Values & behaviours clear	81	82
People here display a positive attitude	37	34

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
Work makes a difference	1%	1%	4%	42%	53%
Clear about objectives & responsibilities	1%	3%	6%	52%	38%
Values & behaviours clear	2%	6%	10%	53%	29%
Person I report to communicates goals & objectives	8%	16%	20%	37%	18%
Happy with career progression opportunities	8%	22%	26%	34%	10%
People here display a positive attitude	7%	27%	32%	28%	6%

Breakdown: Contribution & Control

Benchmarking	
Six DHB Average	%
MDHB Average	%

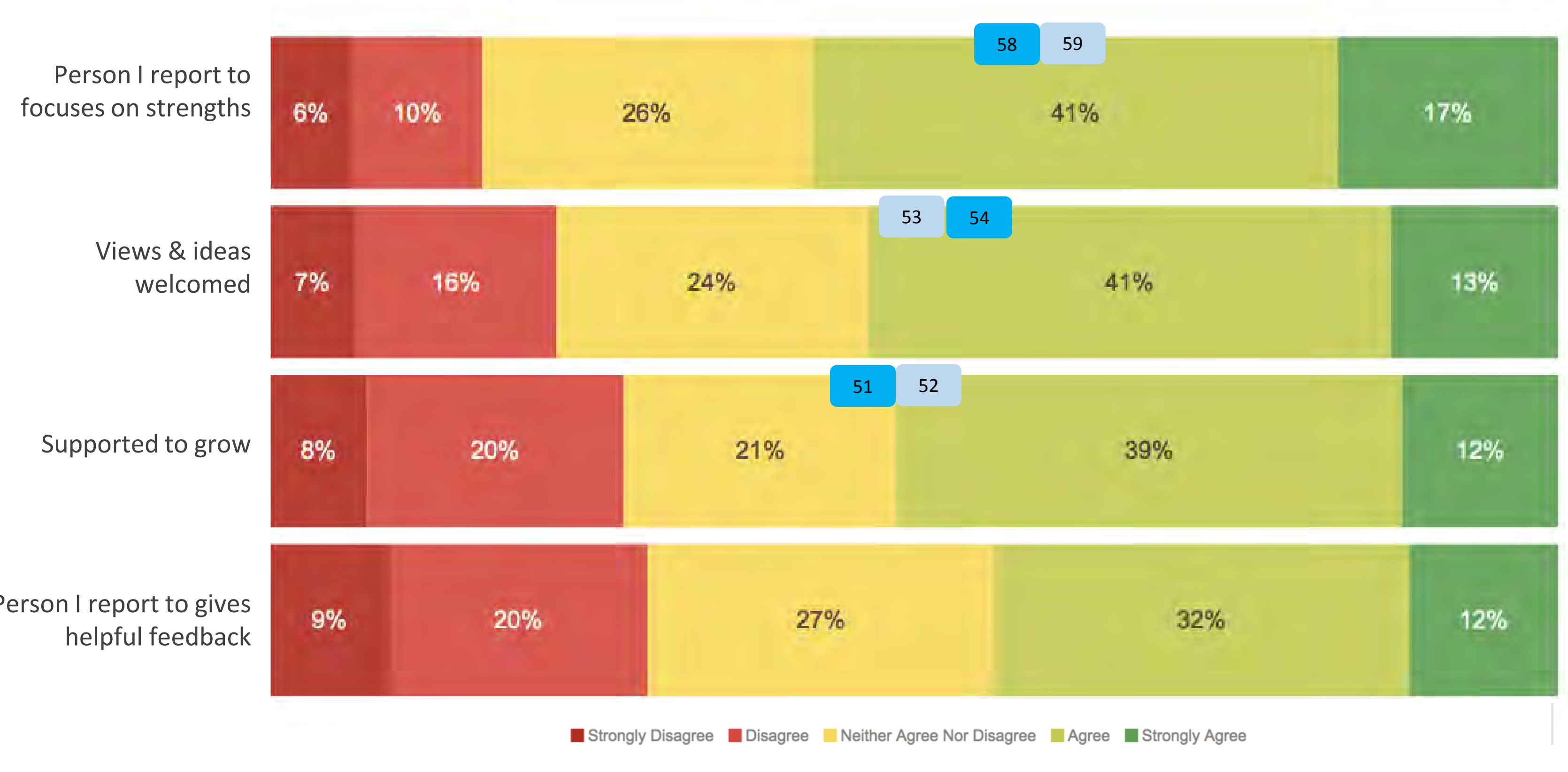
Contribution & control

When people are able to develop their skills, strengths and ideas and put them to good use.

Discussion points

- Do we know what each other's strengths are in the team?
- Do we know what skills or areas our colleagues want to develop?
- How we can we help each other to do our best work?
- How can we nurture more ideas?

Gallup research shows people whose managers focus on their strengths are twice as likely to be engaged as people whose managers focus on their weaknesses. [2]



- **Admin & Clerical v Overall:** I am supported to grow (42% v 51%), person I report to focuses on my strengths rather than my weaknesses (51% v 58%)
- **Medical v overall:** person I report to gives helpful feedback (32% v 44%)

Breakdown: Recognition & Value

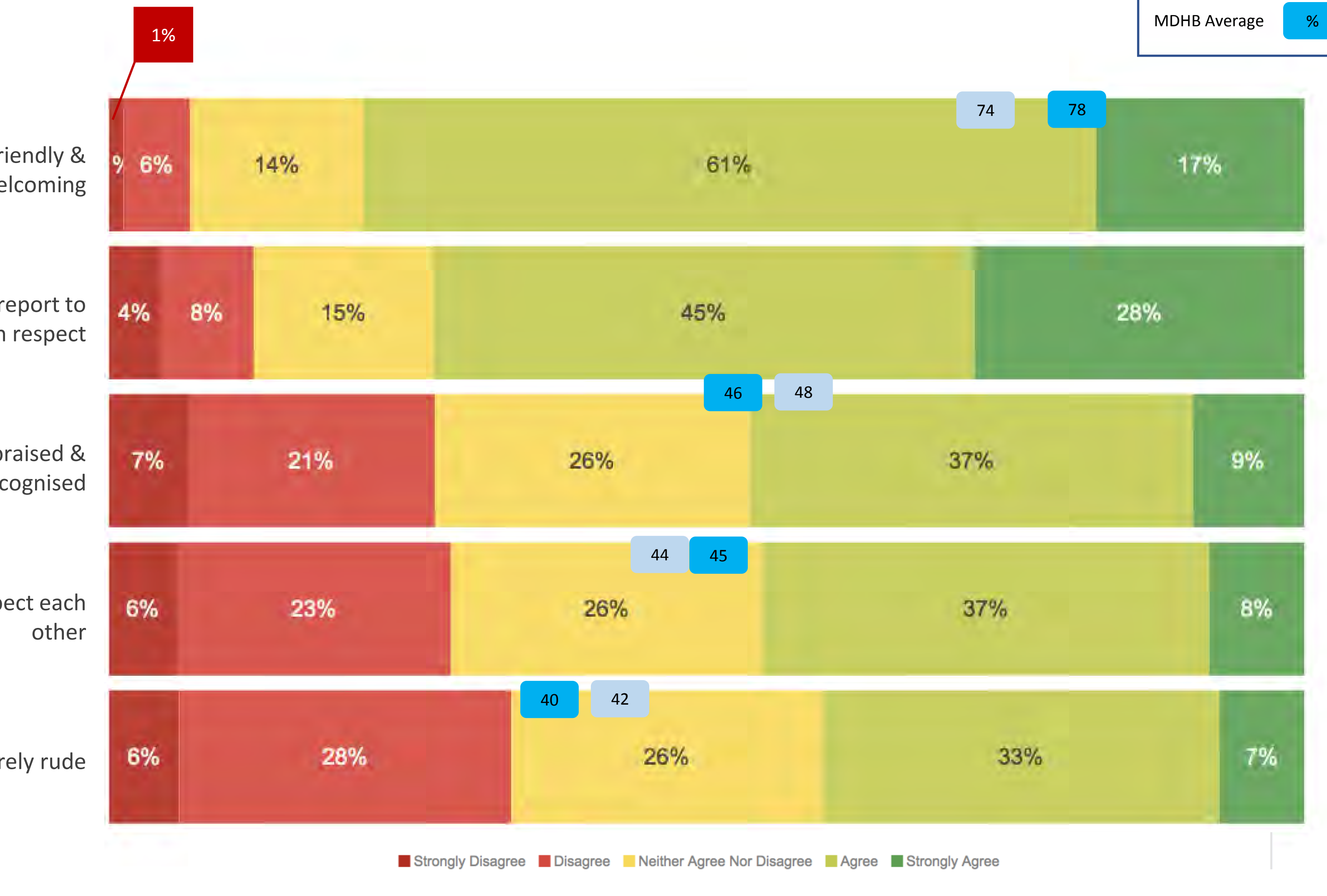
Recognition & value

When people feel respected for who they are, and that their efforts are noticed and valued.

Discussion points

- Have we had experiences recently where they weren't respected?
- What recognition or appreciation have people received recently?
- How do we want to recognise each other's good work or efforts?
- What specifically would we like to notice and appreciate in the team?

The Harvard Business Review says successful teams receive five times as much appreciation as criticism. [3]



Support Roles v Overall: I feel praised and recognised (38% v 46%) the person I report to treats me with respect (62% v 73%)

Breakdown: Connection & Support

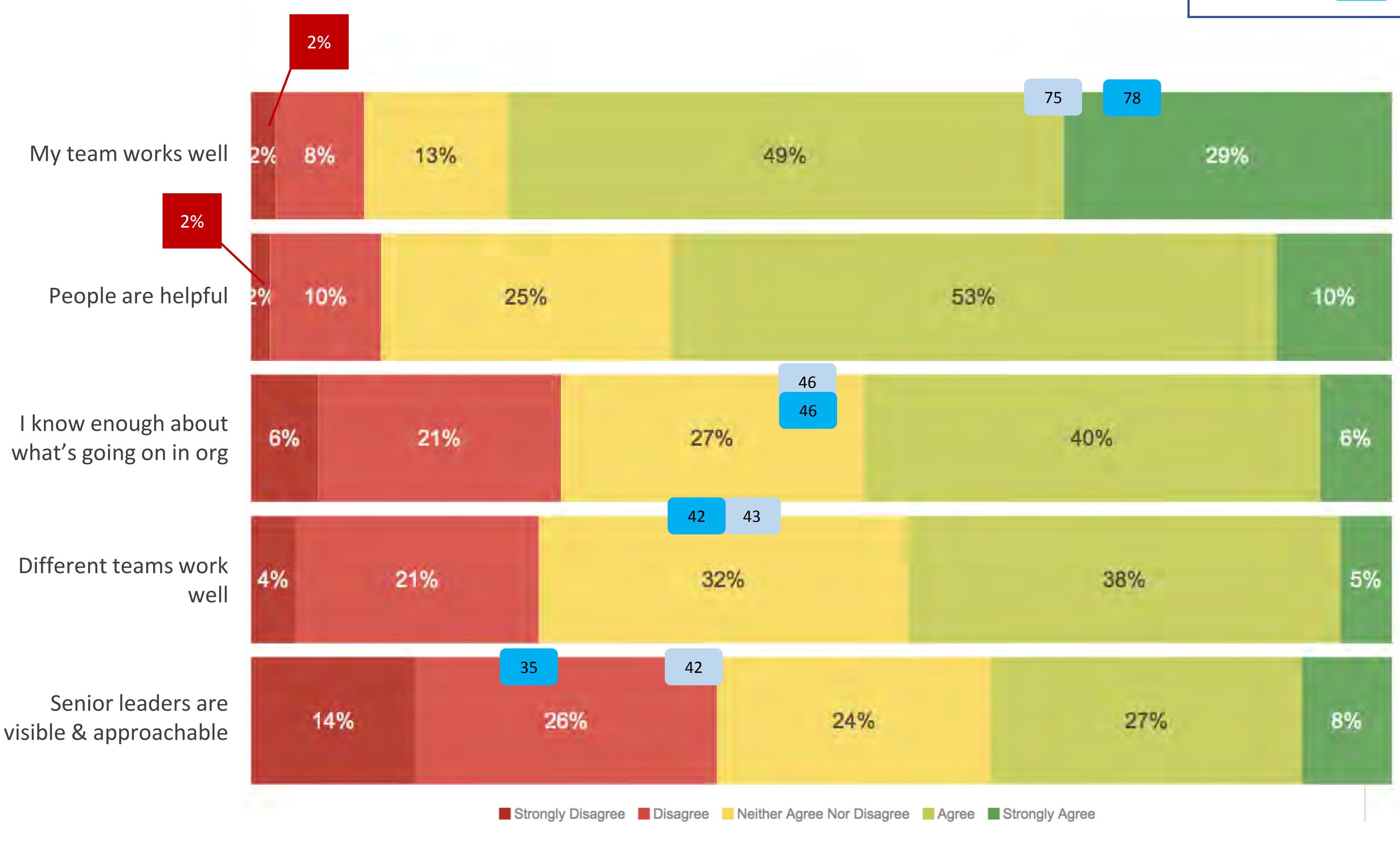
Connection & support

When people feel a good sense of teamwork and support in their team, with other teams and from leaders.

Discussion points

- What does a ‘real team’ look like? What support do we want from each other?
- Do we know what other teams want from us? How could we change how we work with them?
- Do we get what we need from other teams? Have we told them what we need from them?

In an NHS study, a 5% increase in team-working scores in staff surveys correlated with a 3.3% fall in mortality rates. [4]



- **Allied Health v Overall:** different teams work well (34% v 42%)
- **Medical v overall:** I know enough about what's going on (35% v 46%) and senior leaders are visible (24% v 35%)

Breakdown: Safety & Wellbeing

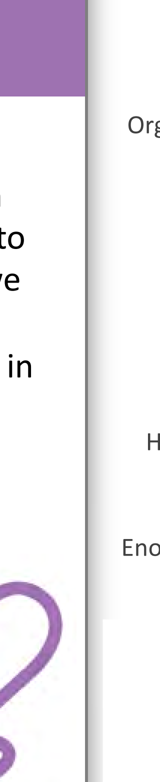
Safety & wellbeing

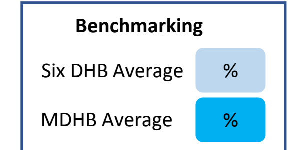
When people feel safe from poor behaviours, and that their work contributes to their wellbeing.

Discussion points

- Have members of our team been bullied recently? We don't need to know who it is. But what could we do to help or support them?
- Are there behaviours we've seen in our team that we want less of?
- How can we support each other when things are really busy?
- How can we make it feel safer to 'speak up'?

A BMJ article showed rude or bullying behaviours make patient safety errors much more likely to happen. [5]





Item	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree	Six DHB Average	MDHB Average
Org honours Treaty of Waitangi	1%	6%	34%	49%	11%		
Safe to speak up (errors)	3%	11%	15%	56%	15%		
Staff demonstrate cultural competency	2%	13%	31%	46%	7%		
Org promotes equality & diversity	4%	14%	31%	41%	9%		
Happy with work life balance	4%	19%	28%	42%	8%		
Safe to speak up (behaviour)	5%	19%	18%	47%	12%	68	71
Health & wellbeing has not suffered	12%	28%	27%	28%	6%	36	34
Enough time to complete my work	14%	31%	15%	33%	7%		40
Experienced discrimination	6%	16%	18%	42%	19%	63	61
Experienced bullying	9%	20%	15%	37%	19%	56	56
Often feel emotionally drained by work	20%	37%	24%	16%	3%		

Overall vs Medical Staff.

Emotionally drained (9% v 19%)

H&W suffered (24% v 33%

Not enough time (26% v 40%)

Work life balance (33% v 50%)

Promotes equality (38% v 51%)

Honours Treaty of Waitangi (44% v 59%)

Maori staff vs Overall

- Have experienced more discrimination (33% v 22%)
- And more bullying and harassment (35% v 29%)
- Fewer agree the DHB honours the Treaty of Waitangi (44% v 59%)

Breakdown: Safety Culture

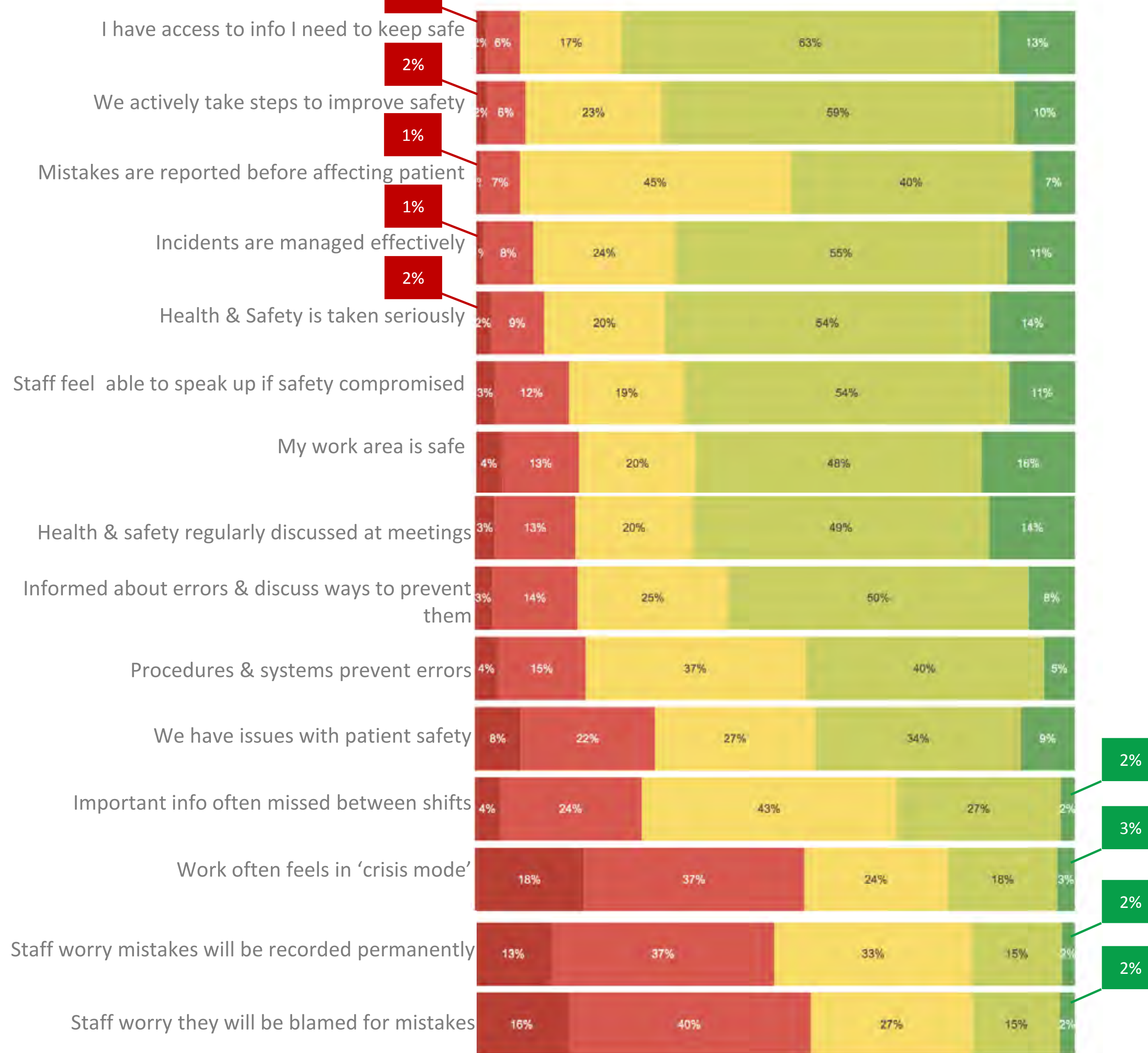
Safety Culture

When we have the correct attitude towards workplace safety and sufficient procedures in place to protect staff and patients from harm.

Discussion points

- How do we currently approach workplace safety? Is it a priority?
- How can our work practices and habits potentially impact on safety? Either directly or indirectly?
- Do our procedures adequately ensure safety is not compromised and are they followed sufficiently?
- What can we do to ensure safer practice?

Addressing Safety Culture is an important component of overall Culture and can help aid change[6]



Breakdown: Our Values

Living our values

When we consistently experience colleagues, managers and leaders behaving and making decisions that are aligned to our values.

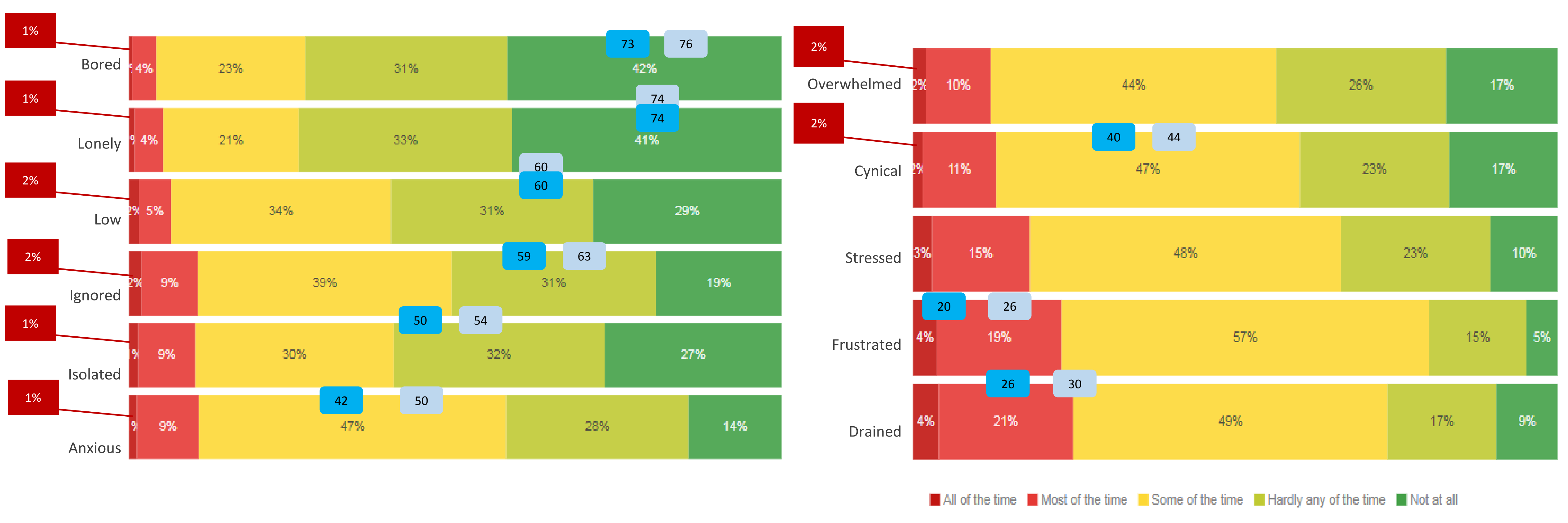
Discussion points

- Which one of our values do we experience most consistently? How does that help us?
- Which one of our values are we not experiencing as much as we'd like? What behaviours do we experience instead? Is this from other teams or from each other?
- Which of our values could we as a team more consistently live up to?

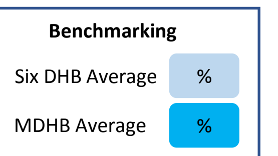
Our staff values of Compassion, Courageous and Respectful help define acceptable behaviours.

Values improve care	3%	10%	38%	38%	11%
Live up to 'respected'	3%	13%	32%	45%	7%
Live up to 'courageous'	3%	14%	44%	33%	5%
Live up to 'compassionate'	3%	16%	30%	43%	9%
Live up to 'accountable'	5%	19%	33%	38%	6%

Breakdown: Negative Emotions



Breakdown: Positive Emotions



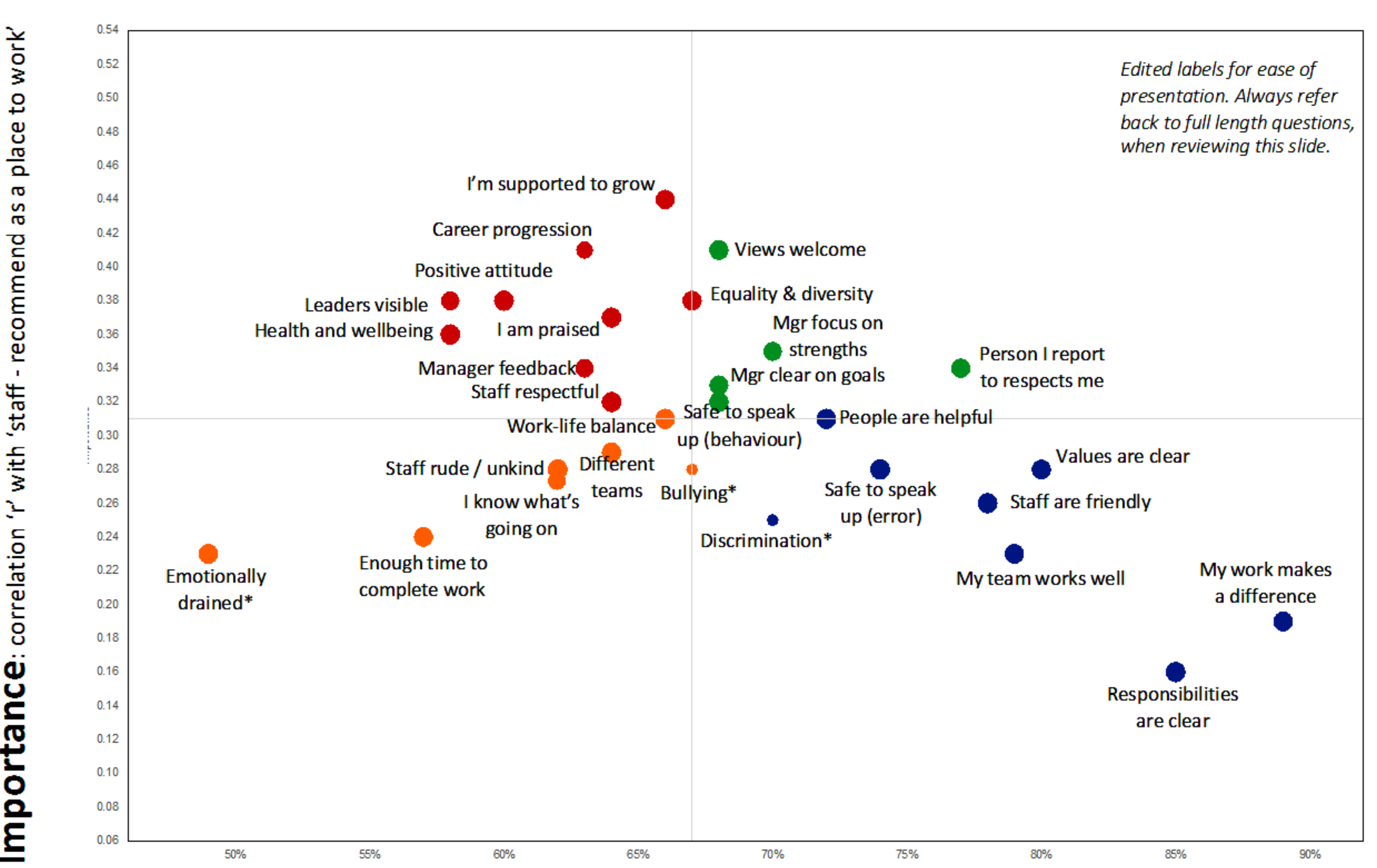
	Not at all	Hardly any of the time	Some of the time	Most of the time	All of the time
Helpful	1%	3%	30%	55%	12%
Confident	1%	3%	30%	57%	9%
Motivated	2%	7%	32%	50%	8%
Calm	1%	7%	37%	49%	6%
Happy	2%	7%	42%	44%	5%
Involved	3%	8%	36%	44%	10%
A sense of belonging	4%	8%	35%	41%	12%
Respected	4%	9%	35%	43%	8%
Proud	5%	9%	38%	39%	9%

Benchmark labels on the chart, from top to bottom (MDHB Average / Six DHB Average): 66 / 67; 58 / 57; 55 / 53; 49 / 53; 54 / 57; 53 / 57; 52 / 53; 48 / 53

	Not at all	Hardly any of the time	Some of the time	Most of the time	All of the time
Connected	4%	10%	43%	38%	5%
Enthusiastic	3%	10%	37%	42%	7%
Optimistic	5%	12%	37%	39%	7%
Listened to	6%	12%	39%	36%	7%
Valued	7%	13%	38%	36%	6%
Appreciated	6%	15%	40%	32%	7%
Gratitude	6%	16%	41%	31%	6%
Lost in my work	10%	21%	45%	21%	3%

Benchmark labels on the chart, from top to bottom (MDHB Average / Six DHB Average): 49 / 54; 47 / 48; 43 / 46; 45 / 42; 39 / 44

Key driver analysis – introduction



Worse scores

Performance: mean score represented as a %

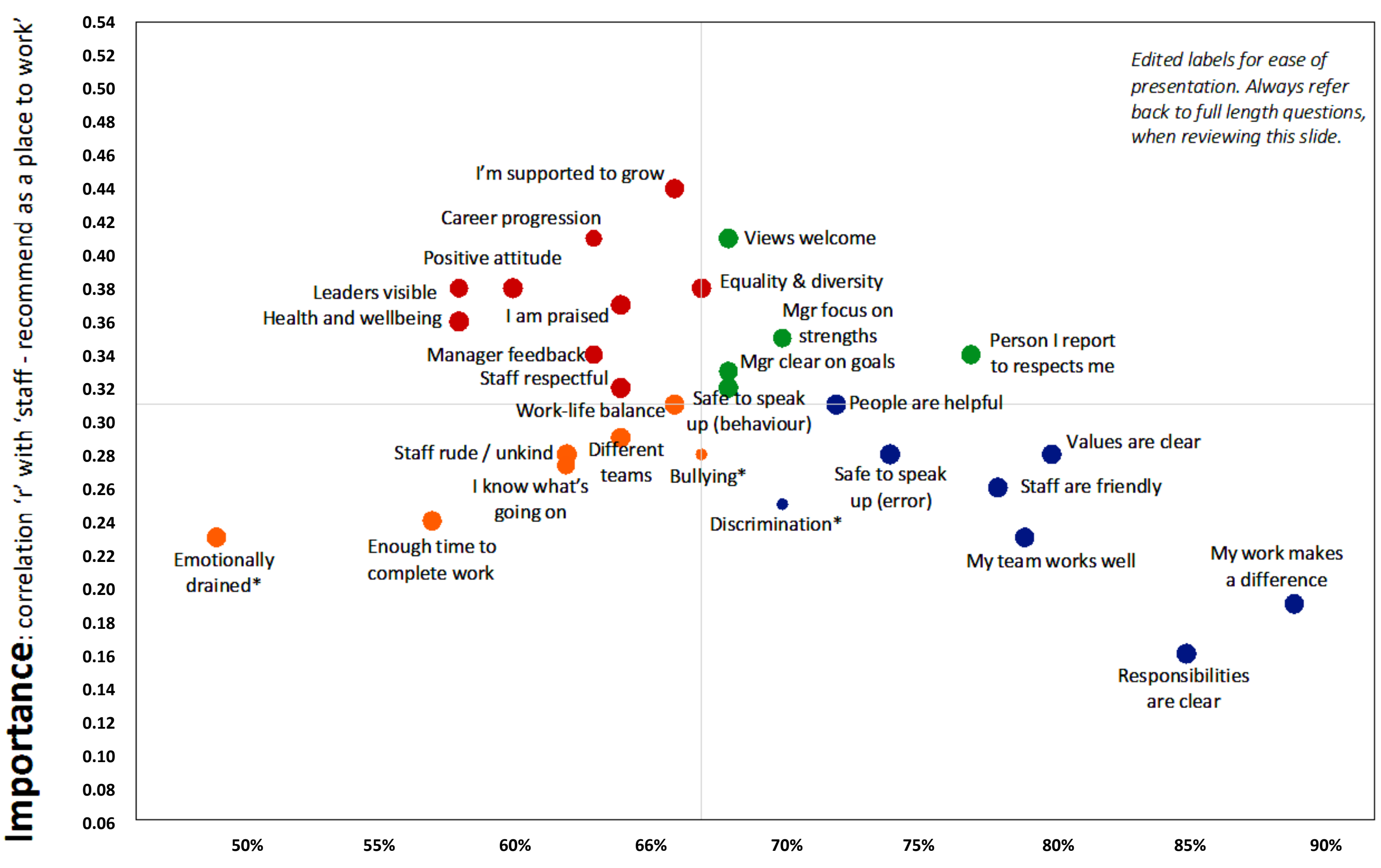
Better scores

* NB for negatively worded questions (bullying / discrimination) and for negative emotions, scores are reversed, so that for all questions, scores to LEFT are bad, scores to the RIGHT are good.

The next two slides are a statistical analysis to help to prioritise improvement actions – as explained in the panel below.

- On the X-axis (left to right) "Performance" shows 'mean' score for each question in the survey – expressed as a percentage (i.e. mean/5 * 20). Underperforming questions (to the left of chart) have more room for improvement.
- (The three negative questions and negative emotions again have scores reversed… so *scores to the left are always worse* and *scores to the right are always better*)
- On the Y-axis "Importance" shows strength of correlation between each question and "recommend as a place to work" (a strong proxy for overall employee engagement). Improving questions with higher correlation will more quickly improve staff engagement.
- The **red dots** are important in driving engagement, and have most room for improvement'. Acting on red dots is likely to more readily impact on engagement; other factors are still important for sections of the organisation
- The **green dots** are aspects of best practice to be shared
- The **orange dots** show us the questions that scored poorly and which have a low correlation with overall engagement.
- The **blue dots** show us the questions that scored well and which have a low correlation with overall engagement.
- *Axes placed for roughly equally number of coloured dots per quadrant (for the DHB overall)*

Key drivers: Experience – where to act first



Worse scores **Performance**: mean score represented as a % **Better scores**

* NB for negatively worded questions (bullying / discrimination) and for negative emotions, scores are reversed, so that for all questions, scores to LEFT are bad, scores to the RIGHT are good.

Where to Act First (RED dots)

1. I am supported to grow and develop at work
2. I am happy with my career progression opportunities
3. People working here display a positive attitude
4. Senior leaders here are visible and approachable
5. This organisation promotes equality and diversity
6. I am praised and recognised when I do a good job
7. My health and wellbeing has not suffered because of my work
8. The person I report to gives me regular, helpful feedback on my work
9. Staff respect each other, whoever they are and whatever their role

Where to Maintain (GREEN dots)

1. My views and ideas are welcomed and encouraged
2. The person I report to focusses on my strengths rather than my weaknesses
3. The person I report to treats me with respect
4. The person I report to communicates the goals and objectives of the team effectively
5. I feel safe and confident to speak up about inappropriate behaviour

Key dri

0.54
0.52
0.50
0.48
0.46
0.44
0.42
0.40
0.38
0.36
0.34
0.32
0.30
0.28
0.26
0.24
0.22
0.20
0.18
0.16
0.14
0.12
0.10
0.08
0.06

Valued
Respected
Happy
Appreciated
Optimistic
Enthusiastic
Gratitude
Listened to
Connected
A sense of belonging
Proud
Ignored*
Low*
Cynical*
Motivated
Frustrated*
Involved
Isolated*
Drained*
Stressed*
Calm
Helpful
Lonely*
Overwhelmed*
Anxious*
Confident
Bored*
Lost in my work

% 56% 58% 60% 62% 64% 66% 68% 70% 72% 74% 76% 78% 80% 82% 84%

Importance: correlation ‘r’ with ‘staff - recommend as a place to work’

Worse scores

Performance: mean score represented as a %

Better scores

* NB for negatively worded questions (bullying / discrimination) and for negative emotions, scores are reversed, so that for all questions, scores to LEFT are bad, scores to the RIGHT are good.

Where to Act First (RED dots)

1. Valued
2. Respected
3. Appreciated
4. Enthusiastic
5. Gratitude
6. Listened to
7. Optimistic
8. Connected
9. Proud

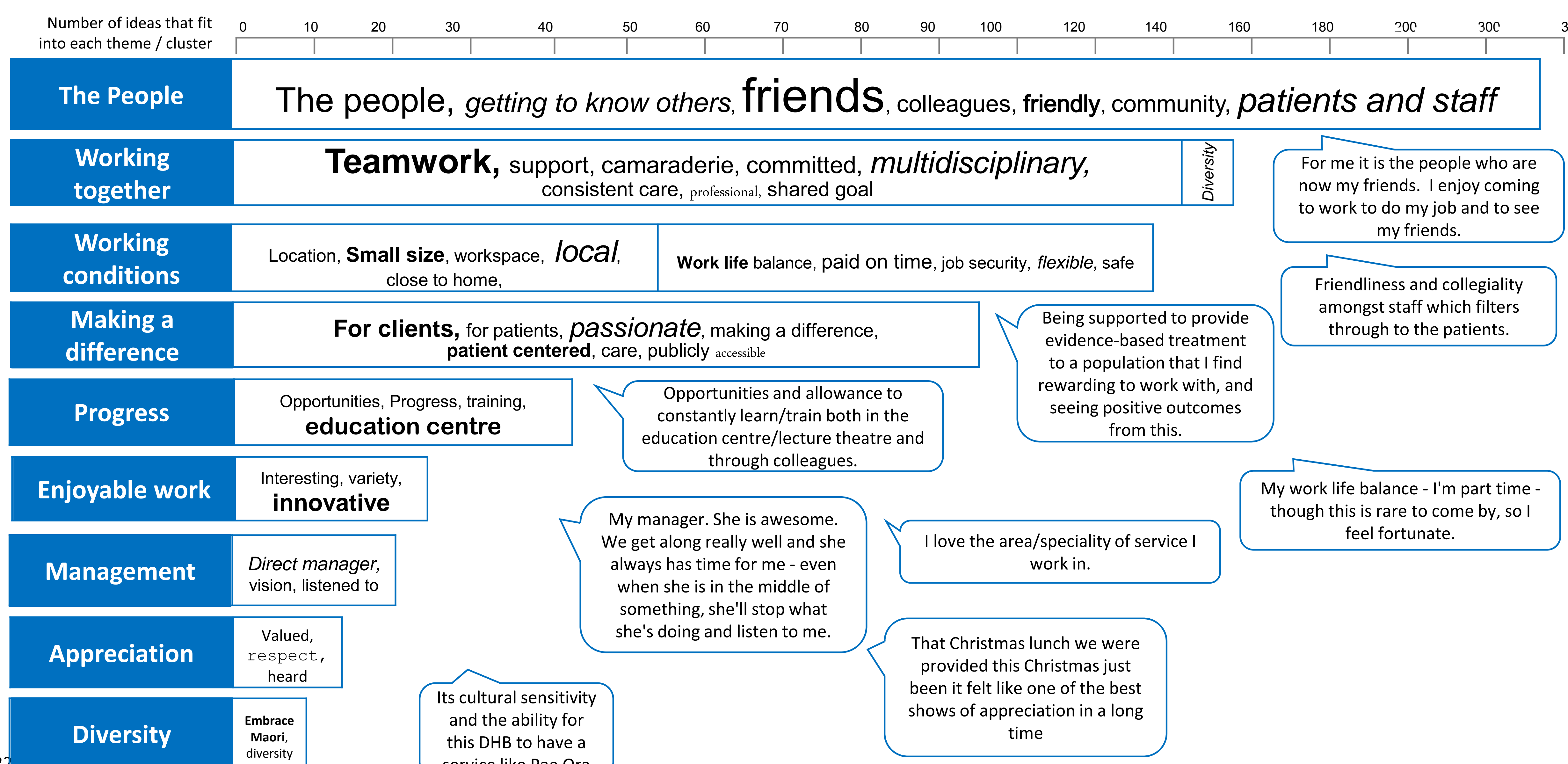
Where to Maintain (GREEN dots)

1. Happy
2. A sense of belonging
3. *Ignored
4. *Low

***Survey feedback indicated that those who would recommend this DHB as a place to work <u>rarely</u> experienced feeling ‘ignored’ or ‘low’. This is something we should seek to maintain.**

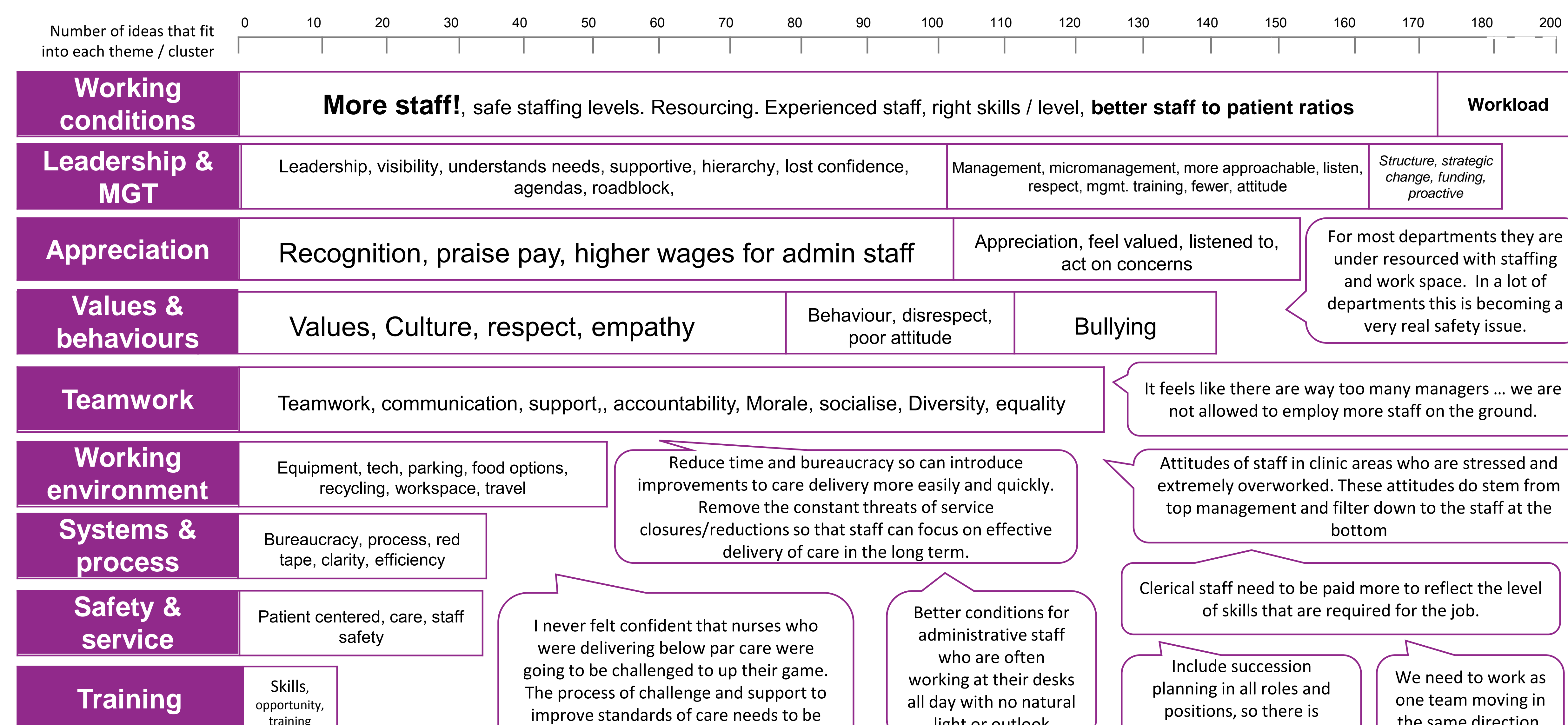
Comments Analysis: What makes MidCentral DHB a great place to work?

Free text responses to this question have been sorted into themes. The number of responses within each them is shown in the bars.



Comments Analysis: Improvement priorities for staff

Free text responses to this question have been sorted into themes. The number of responses within each them is shown in the bars.



<table>
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</td><td>For:
<table><tr><td></td><td>Approval</td></tr><tr><td>X</td><td>Endorsement</td></tr><tr><td></td><td>Noting</td></tr></table></td></tr>
<tr><td>To</td><td colspan="2">Organisational Leadership Team</td></tr>
<tr><td>Author</td><td colspan="2">Keyur Anjaria, General Manager People and Culture</td></tr>
<tr><td>Endorsed by</td><td colspan="2"></td></tr>
<tr><td>Date</td><td colspan="2">31 July 2020</td></tr>
<tr><td>Subject</td><td colspan="2">Staff Engagement and Safety Culture Survey Report</td></tr>
</table>

RECOMMENDATION

It is recommended that the Organisational Leadership Team:

- **endorse** the release of the results of the survey to all staff
- **note** the MDHB Staff Engagement and Safety Culture Survey 2020 report
- **note** the next actions and next steps that the District Health Board is intending to take to progress team based action planning, to further enhance the engagement and culture across the District Health Board
- **note** that this report will be provided to the Board in its meeting of 18 August

Strategic Alignment

This report aligns to MidCentral District Health Board's (MDHB) Strategy and to our People Plan which is one of the five key enabler plans to support the achievement of our strategic imperatives.

1. PURPOSE

The purpose of this paper is to provide the Organisational Leadership Team (OLT) with the results of the Staff Engagement and Safety Culture Survey for 2020. This report is being provided for discussion and noting.

2. SUMMARY

Following endorsement by the OLT and the Board, the Staff Engagement and Safety Culture Survey for MDHB was conducted between 27 May and 6 July 2020. The survey, branded Your Voice – He Kūpu Kōrero, provided an opportunity to measure staff perceptions of the current work environment. The survey also measured the overall level of staff engagement and their perception of safety, wellbeing and quality within the workplace.

As in 2018, the survey was conducted by April Strategy using the Qualtrics platform. A key objective for the survey was to gather feedback from staff that would result in actionable insights and provides a basis for developing engagement action plans at an organisational, team and professional group level. The eight key indices (key factors impacting on engagement) used in the 2018 survey, were re-used to provide consistency. However, in 2020 an index that included five additional questions which focussed on staff connection to their jobs, including performance assessment, was added. Two indices which measured emotions (positive and negative), used in the 2018 survey were also included this time around. The outcome of these emotions contributed towards overall engagement and the Key Driver Analysis (mentioned later in the report).

All responses were totally confidential and response groups of less than five were not reportable in order to preserve the confidentiality of respondents. Dashboards indicating the progress of survey participation were made available to managers so that they could monitor the response rates of their teams, and encourage greater participation. Paper copies of the survey were also made available to staff (51 submitted) who may not have had access to a computer.

The survey also provided an opportunity for staff to provide verbatim comments. These were themed in order to identify emotions of respondents.

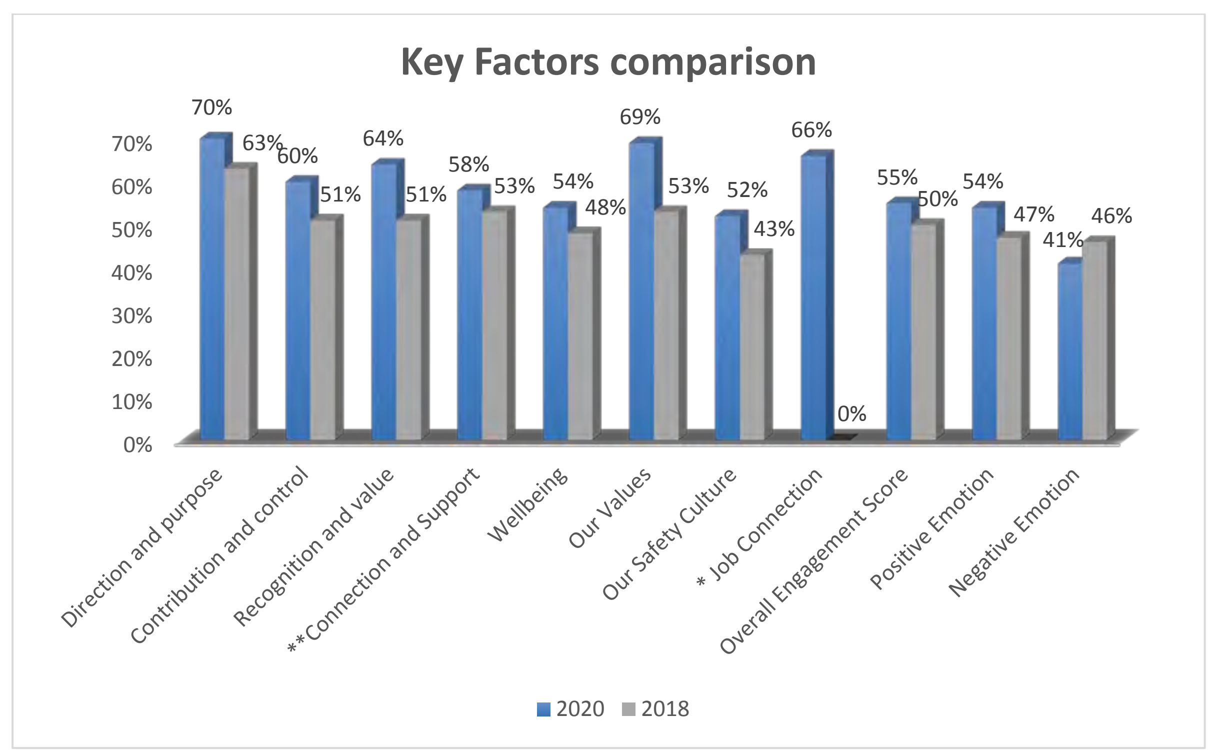
Academic research published by *(Reilly, C., & Wrensen, L. B. (2007). Employee engagement & satisfaction surveys: Implications of high response rates & tips for increasing participation.)*, indicates that survey results of at least 30 percent provide a fair representation of respondent views and can be considered valid - higher response rates carry greater validity. Research also indicates that change to survey scores of three percent and more are considered to be substantial, mean that response numbers are reliably different, and that the difference is not due to chance. This is helpful to assess whether changes in scores between the 2018 and 2020 surveys are meaningful (or not).

The full staff survey result is attached as Appendix A.

3. KEY SURVEY RESULT FINDINGS

Key findings of the 2020 staff engagement survey are summarised below:

- The staff response rate increased from 47 percent (1160) in 2018 to 58 percent (1639) in 2020. This is a significant increase and indicates a greater willingness for staff to engage and 'have their say'. Other DHBs using the same survey instrument have reported response rates between 55 and 60 percent. However, whilst the total response rates indicated an increase, the number of respondents that identified as Māori reduced from 49 percent in 2018 to 36 percent in 2020.
- The overall staff engagement score across the DHB increased from 50 percent in 2018 to 55 percent in 2020. Again, this is a significant increase. Respondents who identified as Māori indicated an increased level of engagement when compared against the DHB average (62 percent as compared to the DHB average of 55 percent). More information around the organisational engagement profile is provided below.
- All eight indices returned significant increases, with scores ranging from 5 percent being the minimum (Connection and Support) and 16 percent (Our Values) being the maximum. All increased scores are significant, and very encouraging. A graph indicating the results by index benchmarked against the 2018 scores is provided below. Please note that as the index of job connection was only introduced in 2020, there is no benchmarking available from the 2018 survey result.



* *Job Connection is a key factor which was not measured in the 2018 survey. Hence a 0% score is reported.*

** *Connection and support contains amended questions which refer specifically to teams, and not to staff in general. This may impact on the direct comparability with 2018 survey results*

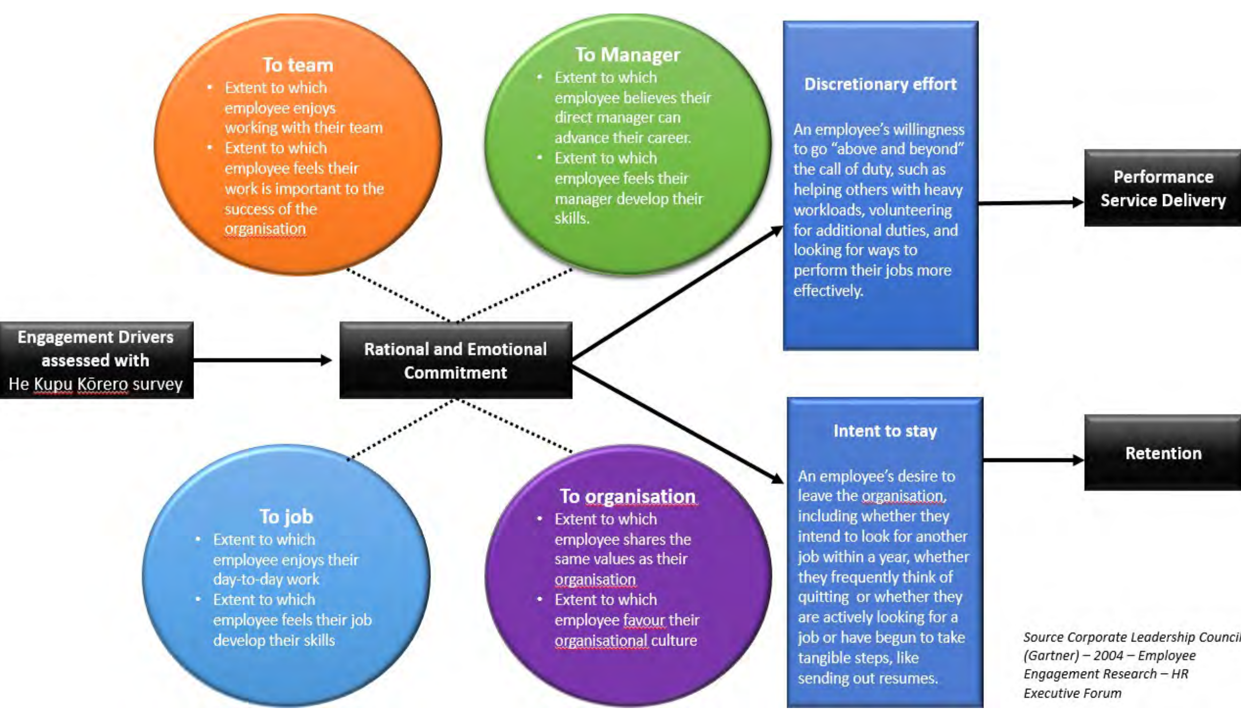
- One of the lower scoring questions in the survey of 2018 was "Senior Leaders here are visible and approachable". This has shown a significant increase in the 2020 staff survey and is up 11 percent to 45 percent, from 34 percent in 2018). "Senior Leaders" in this specific question were defined

as being Executive Leaders and related directly to the OLT.

- Amongst the emotions indices, while the positive emotion index returned a significantly higher score (staff felt motivated, optimistic and proud), staff also felt anxious, drained, bored and resultantly cynical. This outcome would not be unusual and is most likely attributed to the timing of the survey, being soon after the DHB's response to the COVID pandemic.
- The top five most favourable responses (areas where the DHB is doing well) were:
  1. My work makes a difference to other people
  2. I am clear about my objectives and responsibilities
  3. The values and behaviours expected of us at work are clear to me
  4. Staff here are generally friendly and welcoming
  5. The people in my team work well together to provide a great service.
- The top five most unfavourable responses (areas for improvement) were:
  1. I often feel emotionally drained by my work
  2. Staff worry they will be blamed for their mistakes
  3. Work often feels in crisis mode where we try to do too much too quickly
  4. Staff worry that mistakes they make will be recorded permanently
  5. My health and wellbeing has not suffered because of my work.

3.1 Staff Engagement Levels

Staff Engagement is considered to be an employees' rational and emotional commitment to their job, manager, team, and organisation. It results in employee retention and increased levels of performance. This is diagrammatically represented below:

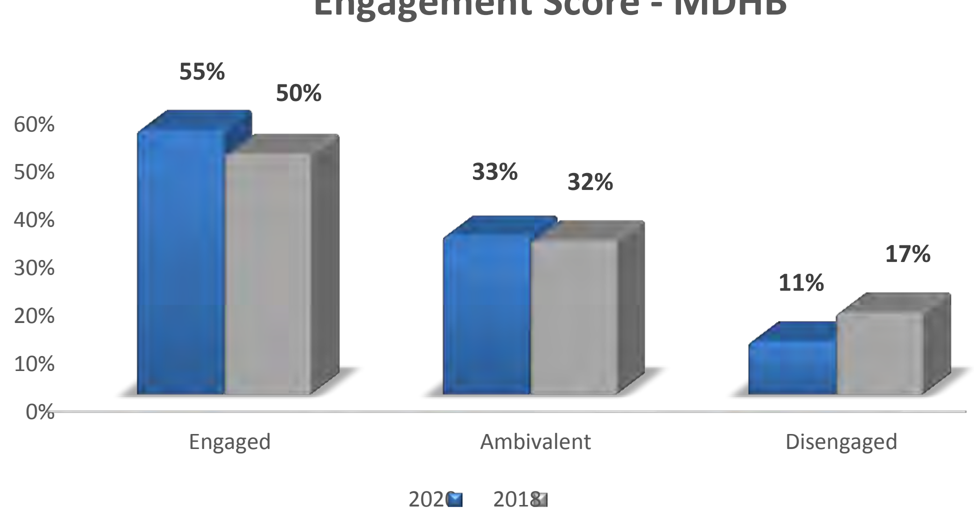


The staff survey uses the following critical questions across various indices to establish a measure of the overall staff engagement score:

- How likely are you to recommend this DHB to friends and family as a place to work?

- How likely are you to recommend the DHB to friends and family if they needed care or treatment?
- How often is the following true? ‘When I get up in the morning, I look forward to going to work’
- Thinking of the last week at work, how often have you experienced the following emotions:
    - Proud
    - Valued
    - Motivated.

A graphical representation of the DHBs engagement profile, benchmarked against the 2018 result is provided below:



The intention of an organisation should be to create organisational initiatives that enhance the employee experience, and influence the overall engagement of the employee.

A descriptor of the engagement groups is provided below.

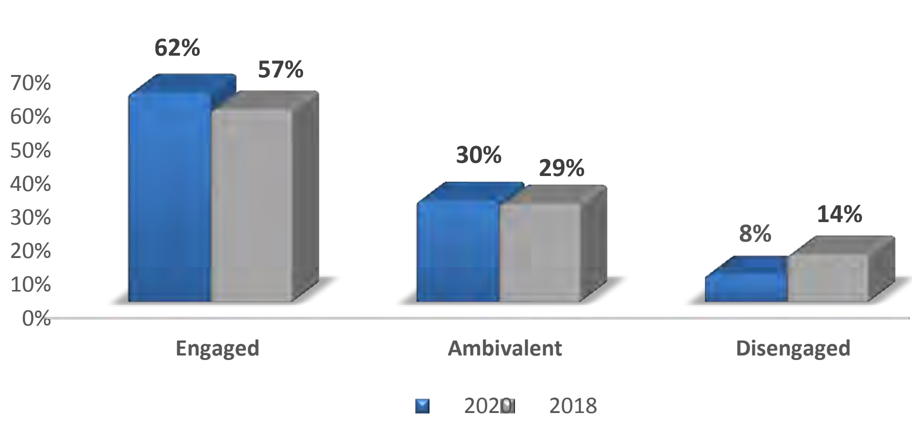
***Engaged employees*:** These are suitably motivated by their workplace experiences to respond to the engagement questions positively (strongly agree/agree). These staff members are promoters within the organisation and will invest high levels of discretionary effort to deliver services that would be categorised as ‘above and beyond’. They would also typically state their intent to stay with the organisation.

***Ambivalent employees*:** These are respondents who tend to be more hesitant in their responses to the engagement questions. They are not sufficiently engaged to indicate that they are either highly satisfied, or likely to go the extra mile to deliver outstanding services. On the other hand, neither are they particularly dissatisfied or uncommitted. For the purpose of the survey, this is a term that is used for respondents who have mixed feelings about the workplace. This is a target group of respondents that can move to either side with a little bit of effort.

***Disengaged employees*:** These are respondent groups that are not sufficiently motivated to respond positively to the engagement questions. They may instead offer neutral or negative responses that suggest a 'disconnect' with the organisation's values and direction. Active engagement across the organisation can often provide more clarity to this group about the organisation's direction.

3.2 Engagement Profile of Māori Workforce.

Respondents who identify as Māori continue to return a higher than average engagement profile. The survey results for 2020 continue to echo a similar trend, and are indicative of high levels of engagement for our Māori workforce.

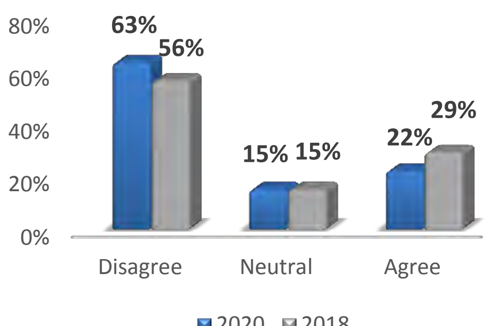


3.3 Bullying, Harassment, Discrimination and Promoting Equality and Diversity

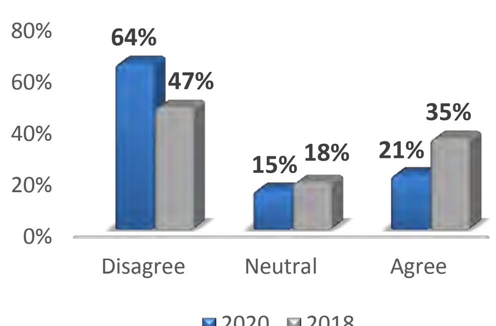
MDHB has made a conscious decision to measure bullying, harassment and discriminatory experiences as a part of the wellbeing indices since 2018. This wellbeing factor also explores how well MDHB is promoting equality and diversity in the workplace.

The survey results continue to indicate pleasing progress across all these indices and indicate a significant increase in response rates. The responses indicate a decrease in the number of respondents who have experienced or witnessed bullying or harassment in the workplace, and a significant (7 percent) increase in the number of respondents who believe that the DHB promotes equality and diversity. A breakdown of these metrics and questions is provided below. A full breakdown of staff experiences with bullying and harassment is provided in Appendix B.

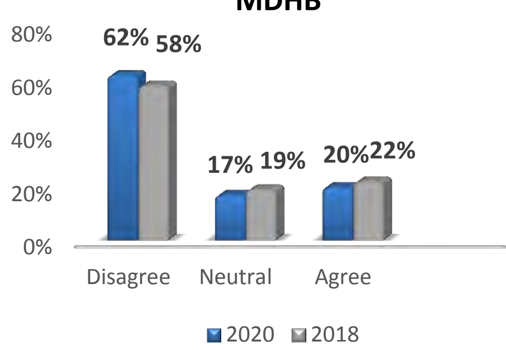
Bullying and Harassment Measure MDHB



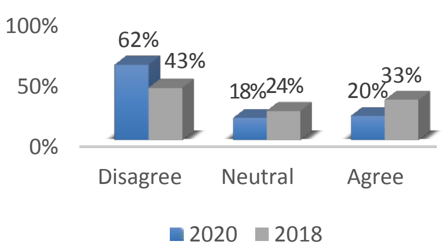
Bullying and Harassment Measure Māori Workforce



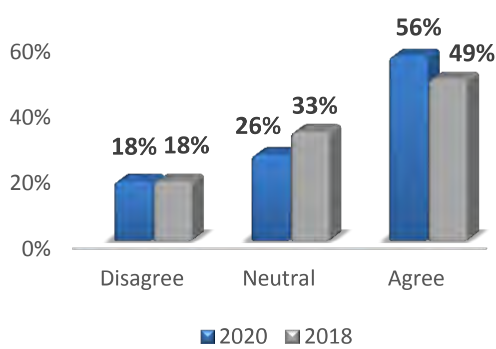
Discrimination Measure MDHB



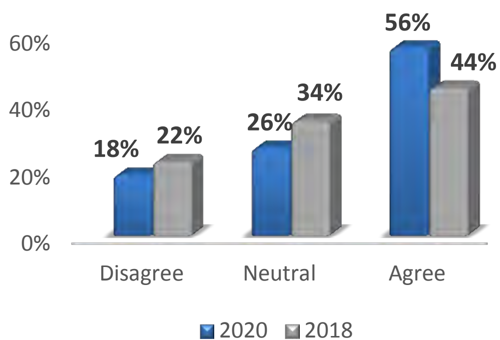
Discrimination Measure Māori Workforce



Promoting Equality and Diversity MDHB



Promoting Equality and Diversity Māori Workforce



3.4 Analysis of free text comments

The following free text questions were asked:

- How can we help staff to better live our values?
- Views about staff experiences at this organisation

- Views on why they would (or would not) recommend MDHB as a place to work?
- Views on why they would (or would not) recommend MDHB as a place to receive care?
- What would make MDHB a great place to work?

These responses were grouped into themes, and the key themes that emerged are as below:

- Staff feel well **supported by their teams.** Staff are helpful to each other and feel a sense of belonging. Colleagues were also the most mentioned source for making MDHB a great place to work, and a key reason for why staff would recommend it as a place to work. However, staff did identify that other teams and services should be doing more to work well together.
- Manager support was an important topic for staff and generally the DHB is performing well in this area. On balance, staff feel managers treat them with respect, are 'strengths' focused, and that they communicate the goals and objectives of their teams well. Despite this, a level of inconsistency in experience of managers is indicated in free text comments, and not all staff are experiencing the same degree of support from managers. In addition, certain areas are identified as priorities for improvement, such as managers giving more regular and meaningful feedback to staff.
- Organisational leadership visibility and approachability remains an important aspect and whilst significant improvement has been made in this direction, momentum around these initiatives needs to continue.
- Health and wellbeing is a critical area identified by staff as being key to increasing engagement levels. Staff have reported feeling 'drained' at work.
- Staff felt that managers and senior leaders should be showcasing the DHB's values. They also felt that managers should take more time in listening to what their staff had to say ('being listened to').
- Staff continue to be interested in happenings around the DHB and felt that more effort needs to be made in this area.
- Staff reported increased levels of workload and anxiety. Given the timing of the survey (post COVID-19 response), this emotion is not unusual and the DHB will need to continue to work within the wellbeing space to assist staff recover post COVID-19.
- Responses indicated that greater effort was required in promoting equity and respect for Māori and creating a more inclusive environment.
- Staff indicated a greater need for reward and recognition, coaching and leadership.
- Greater requirement for digitised workflows and automation.
- Staff feel increasingly confident about speaking up and reducing errors.

4. NEXT STEPS

Many staff have been curious about the outcomes of the staff survey. It is intended that a full copy of the survey results will be made available to staff via the staff intranet. A staff forum has been scheduled for mid-August to share the

results with staff. Additionally, as in 2018, a one-page poster reflecting the key results of the survey (benchmarked against the 2018 results) will be displayed in staff only areas (tea rooms etc) so that staff can view the results at a glance (attached as Appendix C).

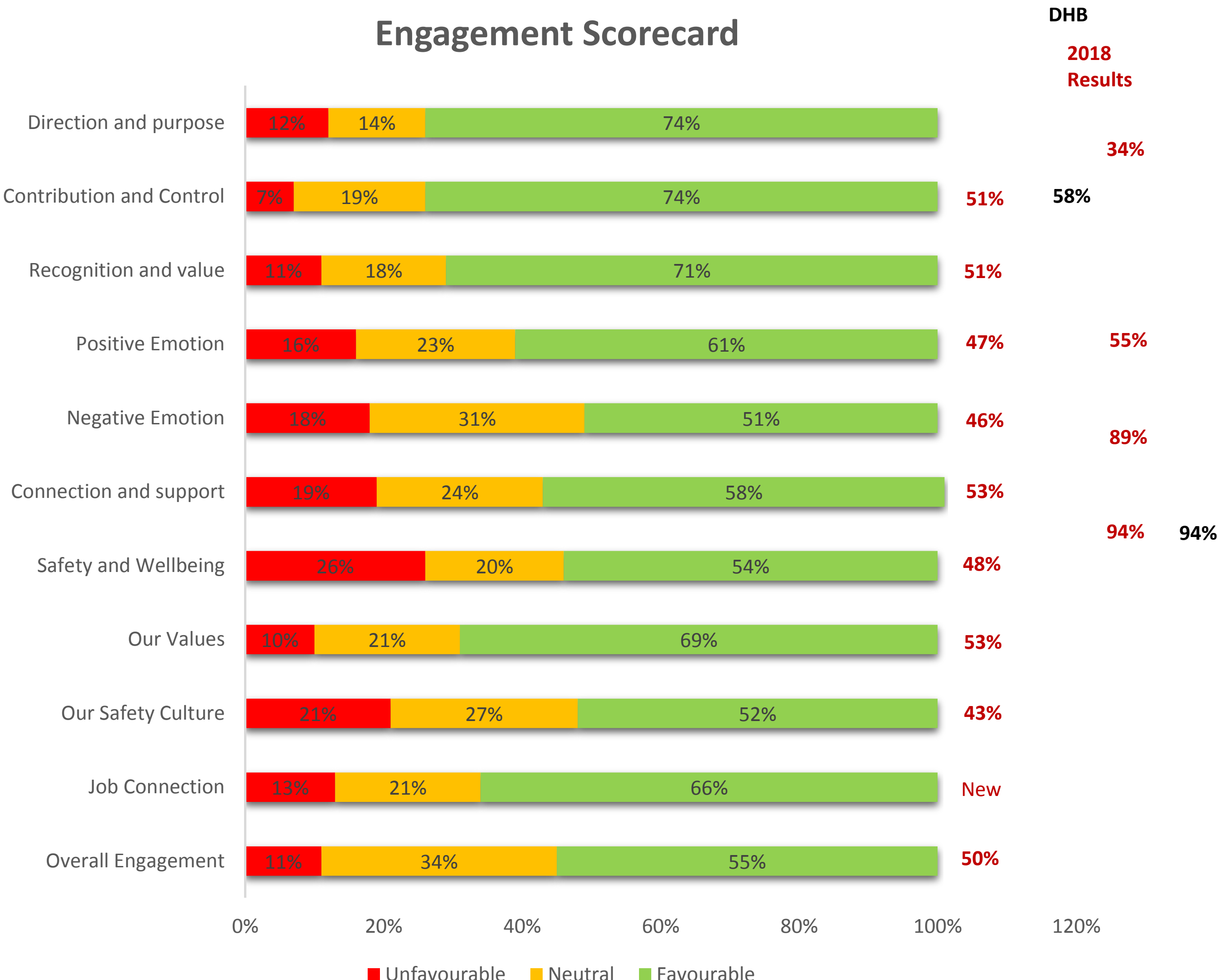
The survey was structured in a way that allowed responses to be broken down by team and professional group. A member of the People and Culture team will be working with managers and professional leads to help them understand the results of the survey, as it relates to their team, and assist them with engagement action planning.

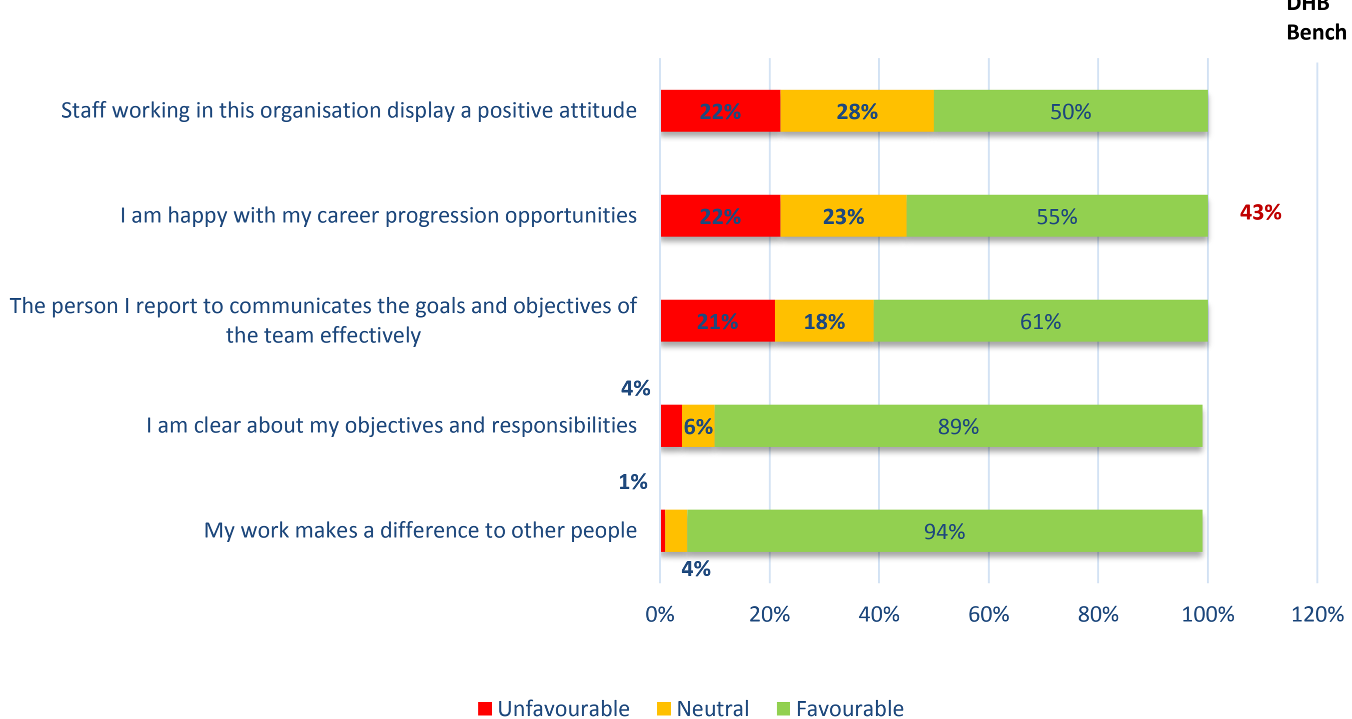
Key Driver Analysis (attached as Appendix D) is a valuable resource that will assist the DHB in focussing on initiatives that increase staff engagement levels. The analysis provides an insight into the factors that the DHB needs to continue to focus on will inform organisational initiatives.

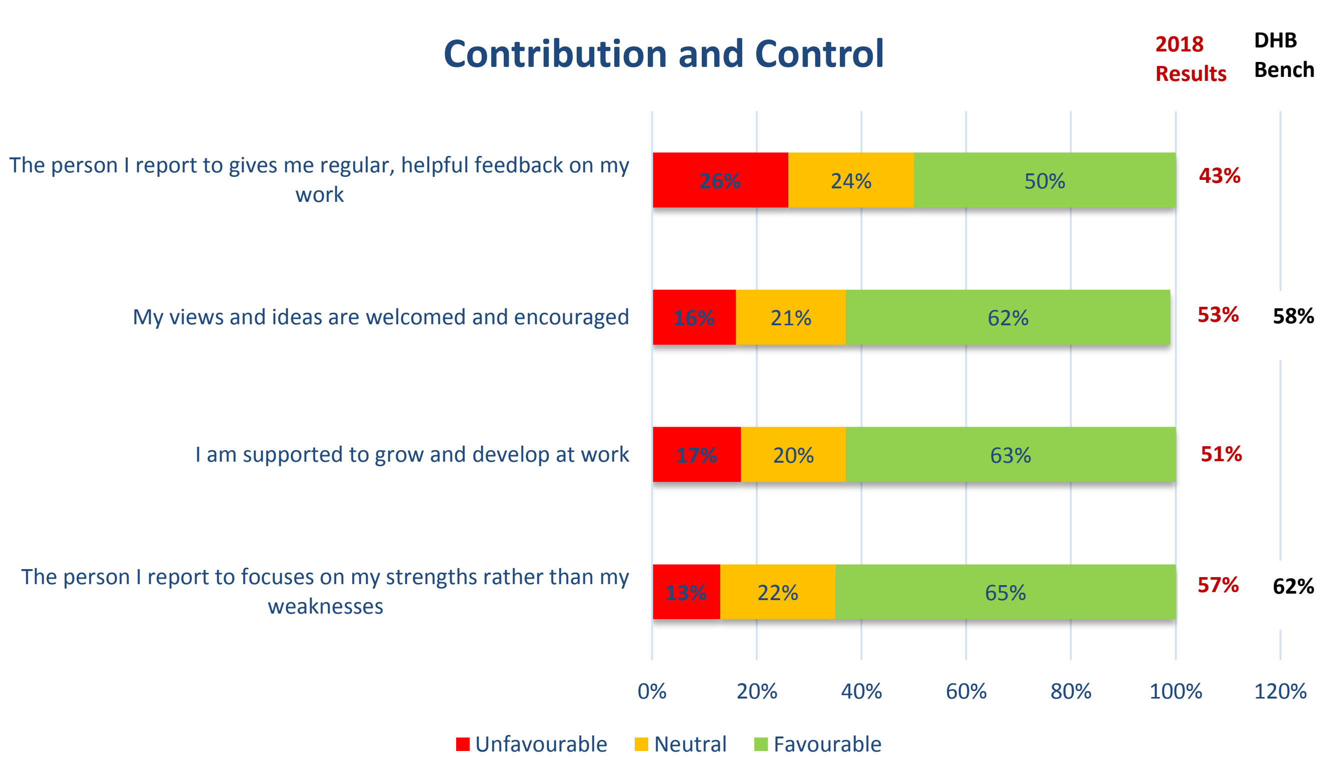
5. CONCLUSION

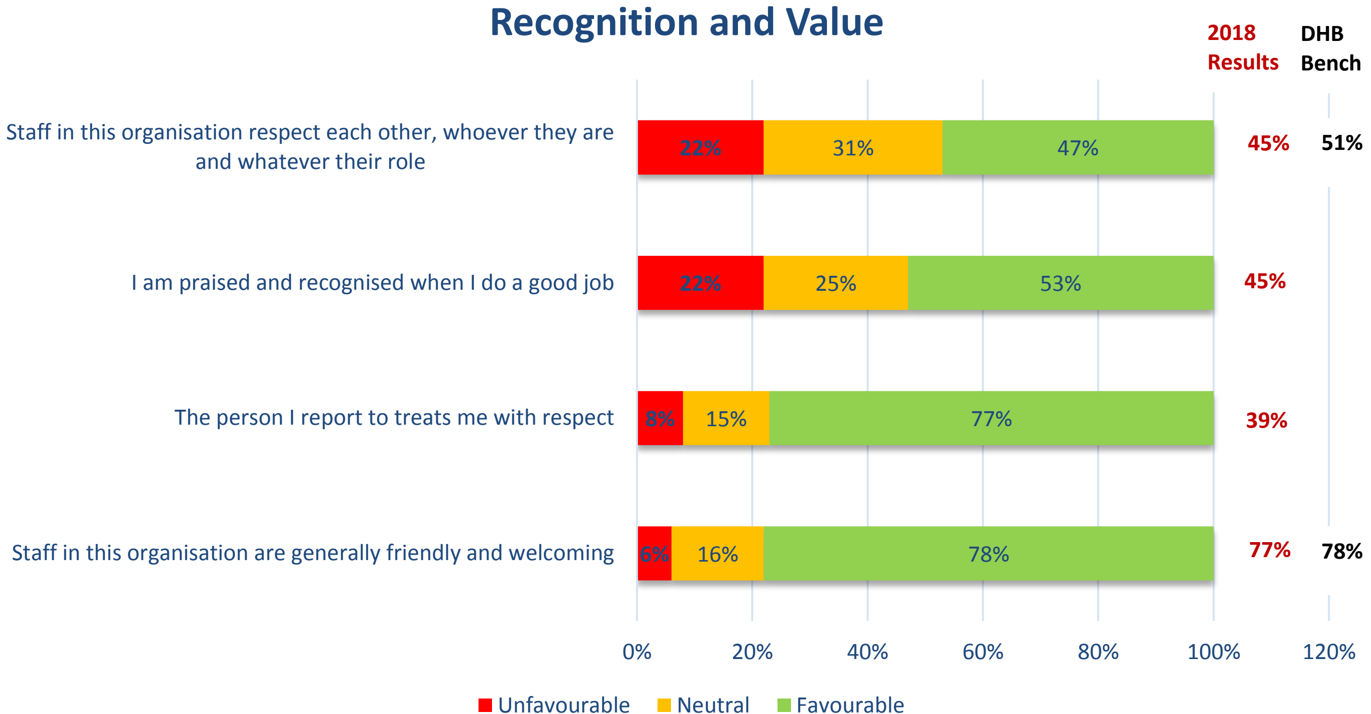
MDHB conducted its Staff Engagement and Safety Culture Survey in 2020. The results of the survey indicate a consistent increase to all indices which were measured. Work will now be undertaken to ensure that survey results are widely distributed to staff, and managers are able to draw engagement action plans to support initiatives relevant to their teams.

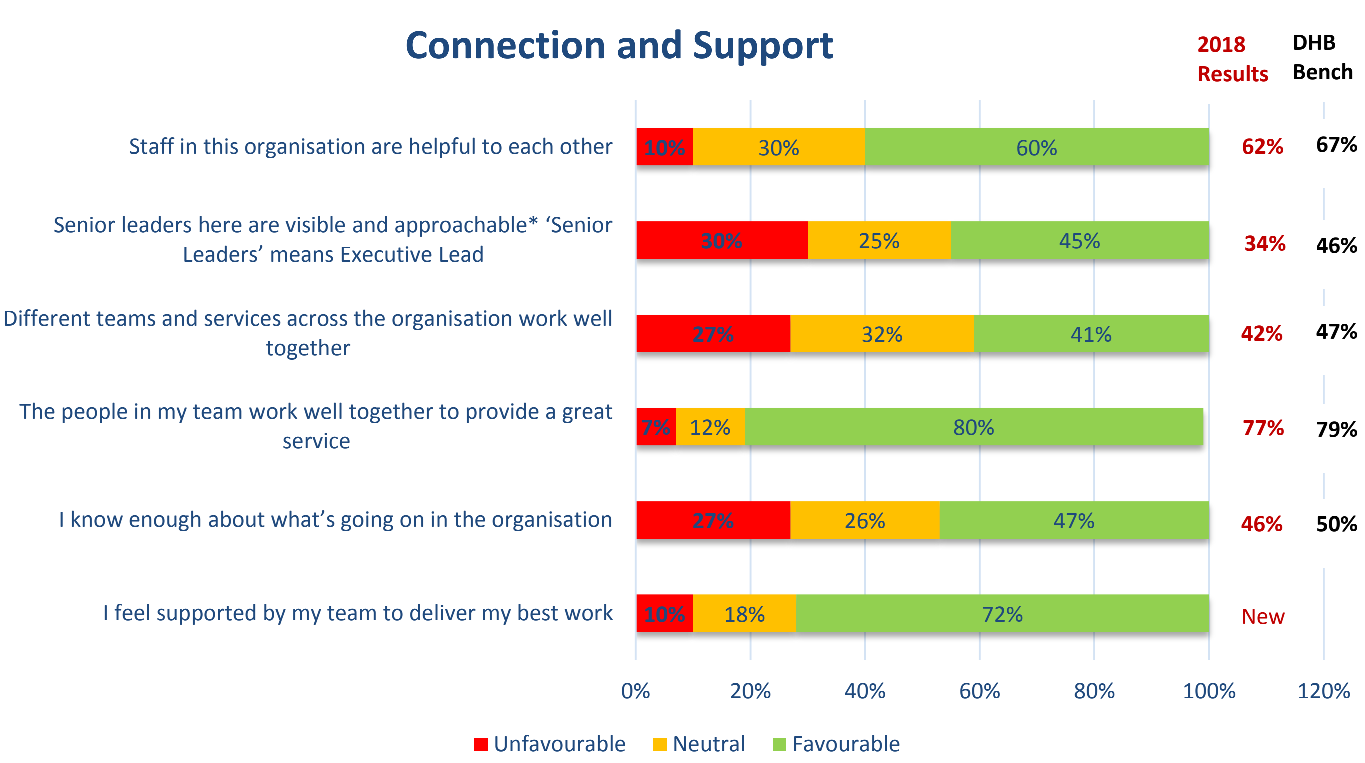
Appendix A




Direction and Purpose
DHB Bench
Staff working in this organisation display a positive attitude
22%
28%
50%
I am happy with my career progression opportunities
22%
23%
55%
43%
The person I report to communicates the goals and objectives of the team effectively
21%
18%
61%
4%
I am clear about my objectives and responsibilities
6%
89%
1%
My work makes a difference to other people
94%
4%
0%
20%
40%
60%
80%
100%
120%
Unfavourable
Neutral
Favourable


Contribution and Control
2018 Results
DHB Bench
The person I report to gives me regular, helpful feedback on my work
26%
24%
50%
43%
My views and ideas are welcomed and encouraged
16%
21%
62%
53%
58%
I am supported to grow and develop at work
17%
20%
63%
51%
The person I report to focuses on my strengths rather than my weaknesses
13%
22%
65%
57%
62%
0%
20%
40%
60%
80%
100%
120%
Unfavourable
Neutral
Favourable


Recognition and Value
2018 Results
DHB Bench
Staff in this organisation respect each other, whoever they are and whatever their role
22%
31%
47%
45%
51%
I am praised and recognised when I do a good job
22%
25%
53%
45%
The person I report to treats me with respect
8%
15%
77%
39%
Staff in this organisation are generally friendly and welcoming
6%
16%
78%
77%
78%
0%
20%
40%
60%
80%
100%
120%
Unfavourable
Neutral
Favourable

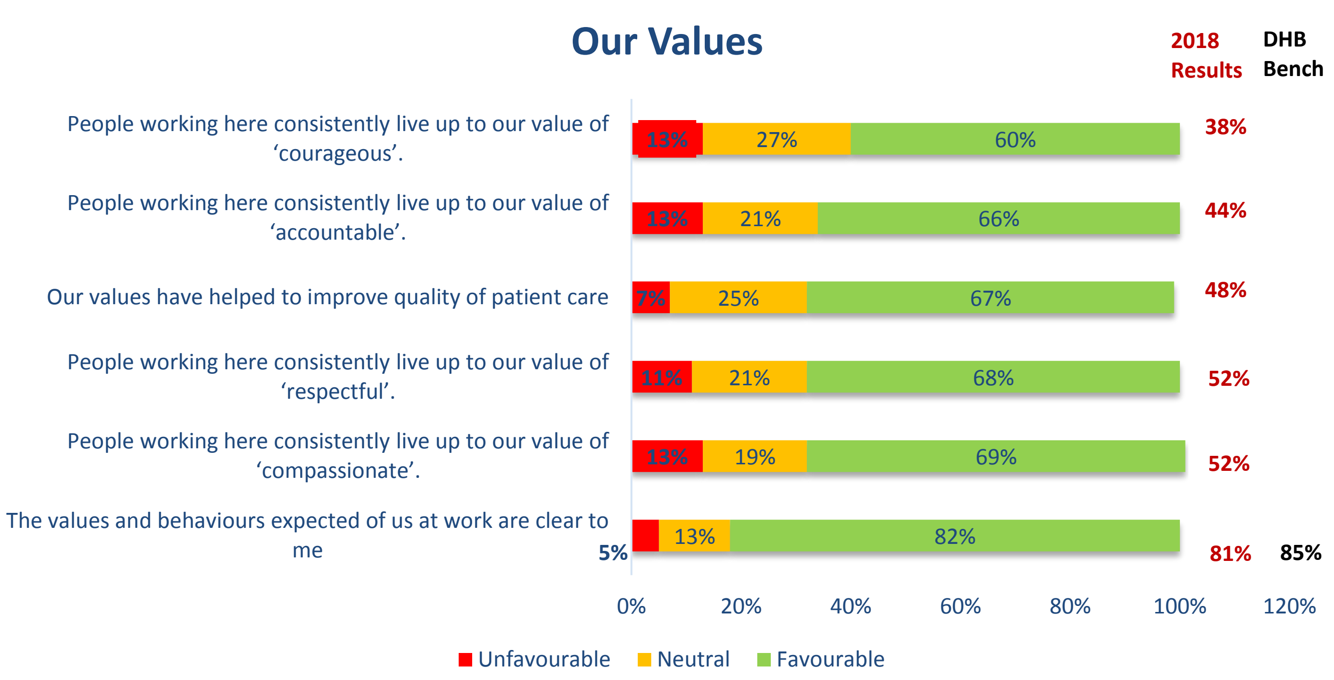

Connection and Support
2018 Results
DHB Bench
Staff in this organisation are helpful to each other
10%
30%
60%
62%
67%
Senior leaders here are visible and approachable* 'Senior Leaders' means Executive Lead
30%
25%
45%
34%
46%
Different teams and services across the organisation work well together
27%
32%
41%
42%
47%
The people in my team work well together to provide a great service
7%
12%
80%
77%
79%
I know enough about what's going on in the organisation
27%
26%
47%
46%
50%
I feel supported by my team to deliver my best work
10%
18%
72%
New
0%
20%
40%
60%
80%
100%
120%
Unfavourable
Neutral
Favourable

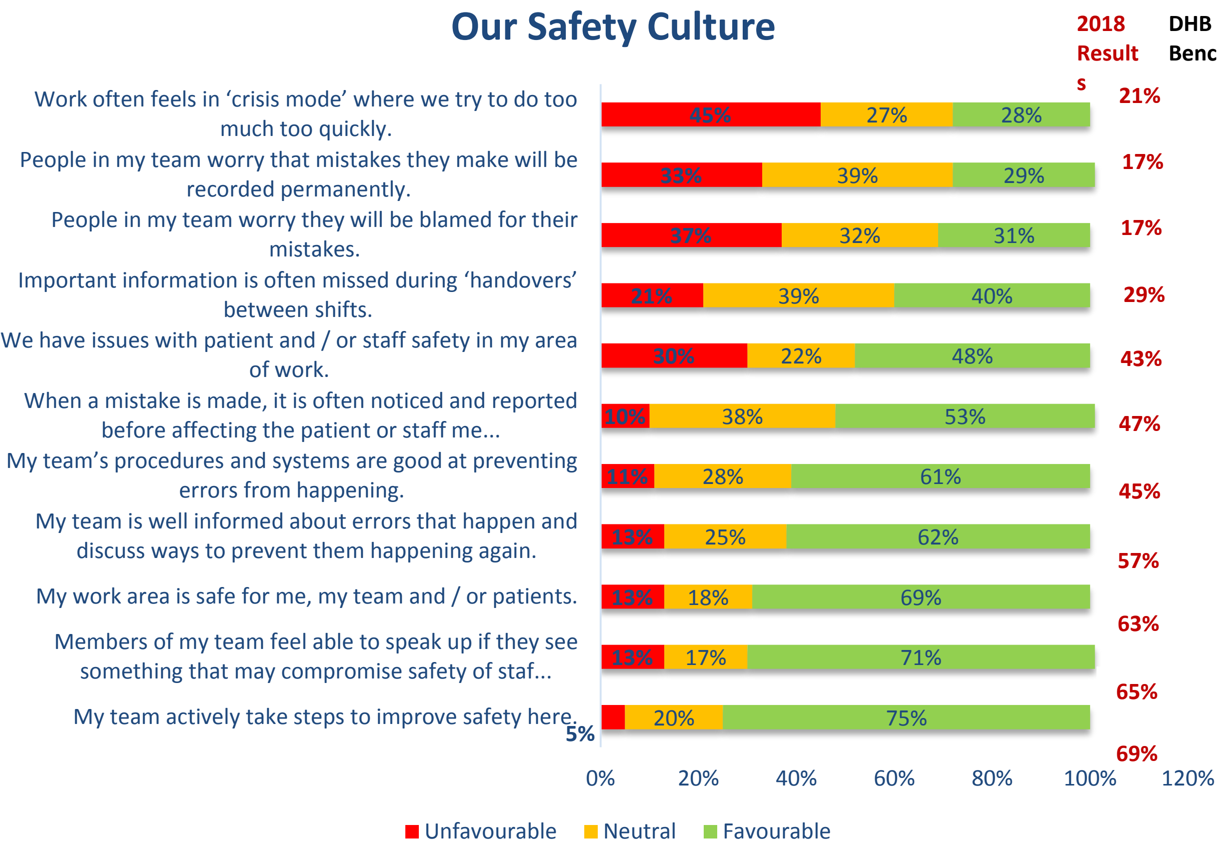
Safety and Wellbeing

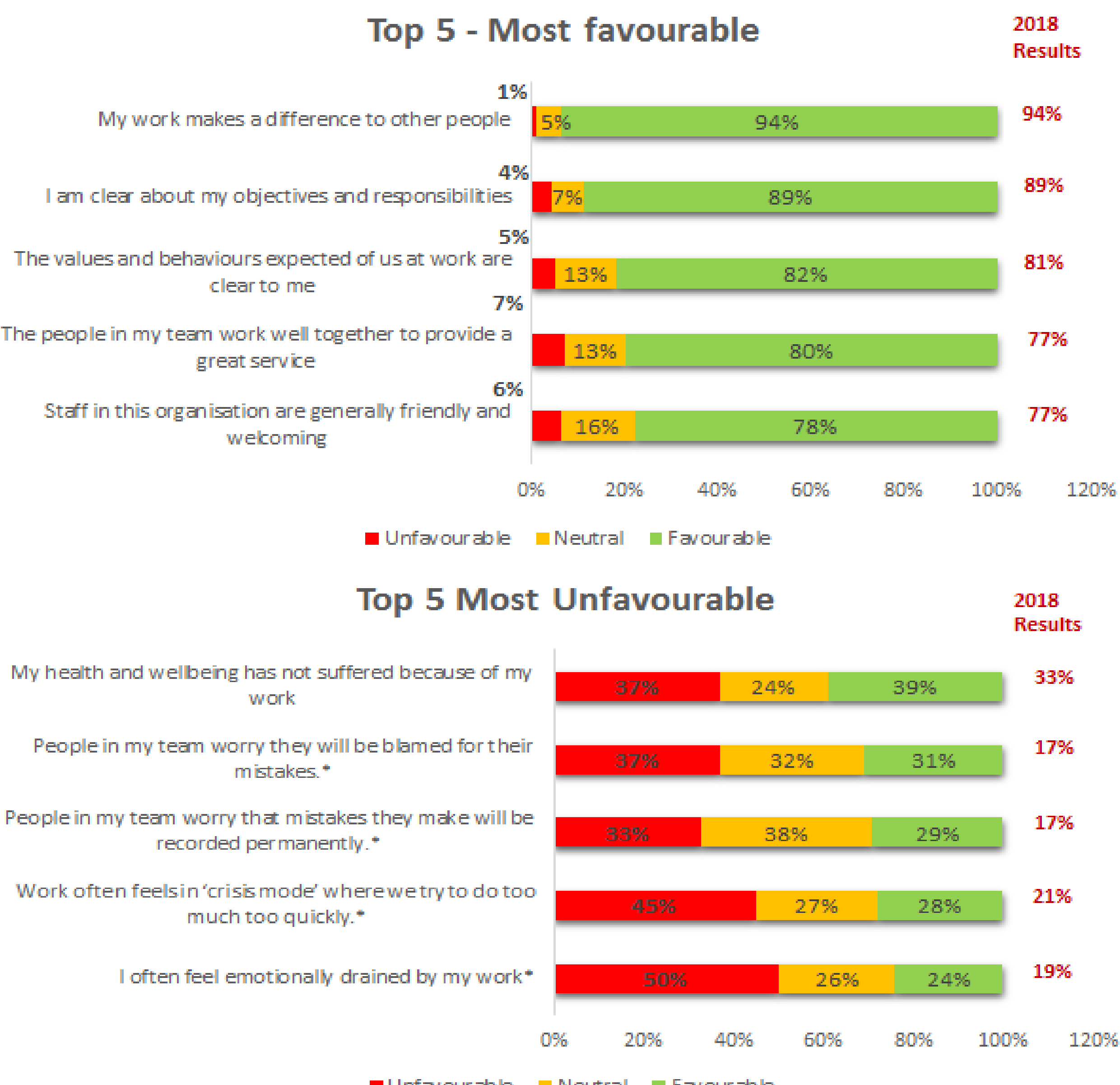
	Unfavourable	Neutral	Favourable	2018 Results	DHB Bench
I often feel emotionally drained by my work	50%	26%	24%	19%	
My health and wellbeing has not suffered because of my work	37%	23%	39%	33%	39%
I usually have enough time to complete all of my work	32%	17%	51%	40%	46%
I am happy with my work-life balance	22%	23%	55%	49%	
This organisation promotes equality and diversity	18%	26%	56%	49%	
I feel safe and confident to speak up about inappropriate behaviour	19%	19%	62%	57%	59%
I have personally experienced discrimination at work in the past 6 months	20%	17%	62%	58%	65%
I have personally experienced bullying or harassment at work in the past 6 months	21%	15%	64%	55%	60%
If I notice an error or issue I feel safe to speak up about it	14%	13%	73%	70%	73%

0% 20% 40% 60% 80% 100% 120%

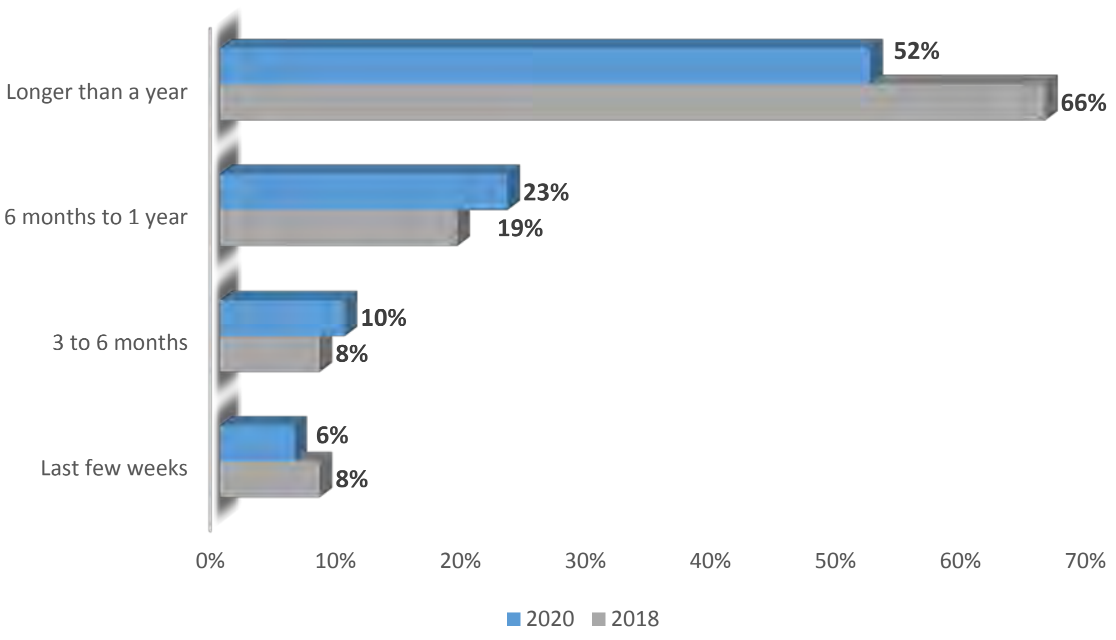
■ Unfavourable ■ Neutral ■ Favourable

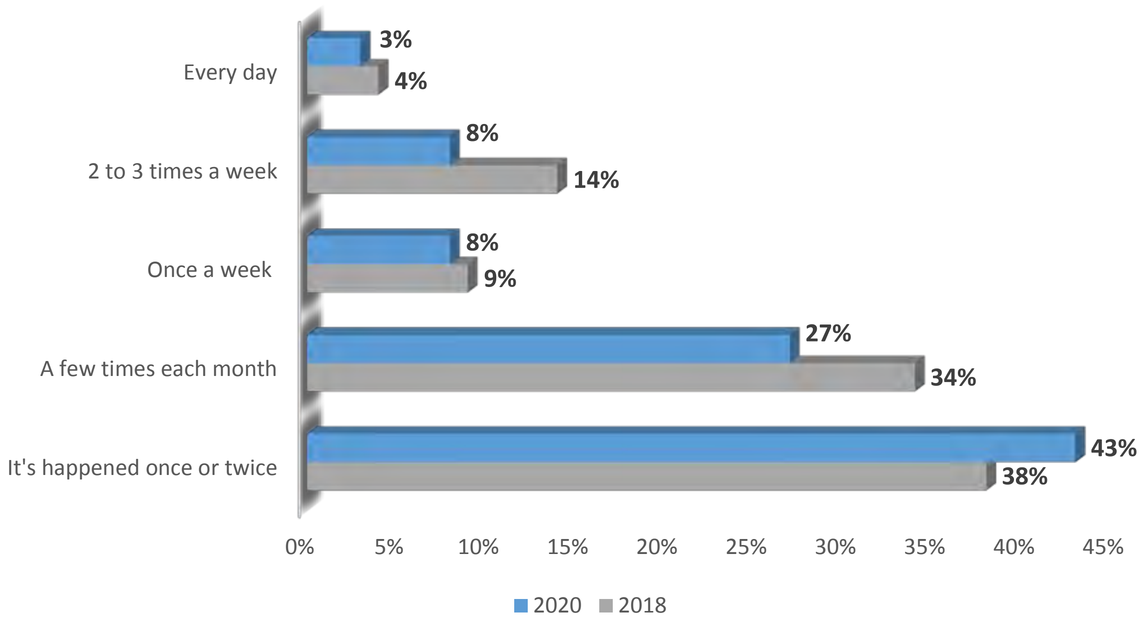



Our Safety Culture
2018 Results
DHB Benc
Work often feels in 'crisis mode' where we try to do too much too quickly.
45%
27%
28%
21%
People in my team worry that mistakes they make will be recorded permanently.
33%
39%
29%
17%
People in my team worry they will be blamed for their mistakes.
37%
32%
31%
17%
Important information is often missed during 'handovers' between shifts.
21%
39%
40%
29%
We have issues with patient and / or staff safety in my area of work.
30%
22%
48%
43%
When a mistake is made, it is often noticed and reported before affecting the patient or staff me...
10%
38%
53%
47%
My team's procedures and systems are good at preventing errors from happening.
11%
28%
61%
45%
My team is well informed about errors that happen and discuss ways to prevent them happening again.
13%
25%
62%
57%
My work area is safe for me, my team and / or patients.
13%
18%
69%
63%
Members of my team feel able to speak up if they see something that may compromise safety of staf...
13%
17%
71%
65%
My team actively take steps to improve safety here.
5%
20%
75%
69%
0%
20%
40%
60%
80%
100%
120%
Unfavourable
Neutral
Favourable

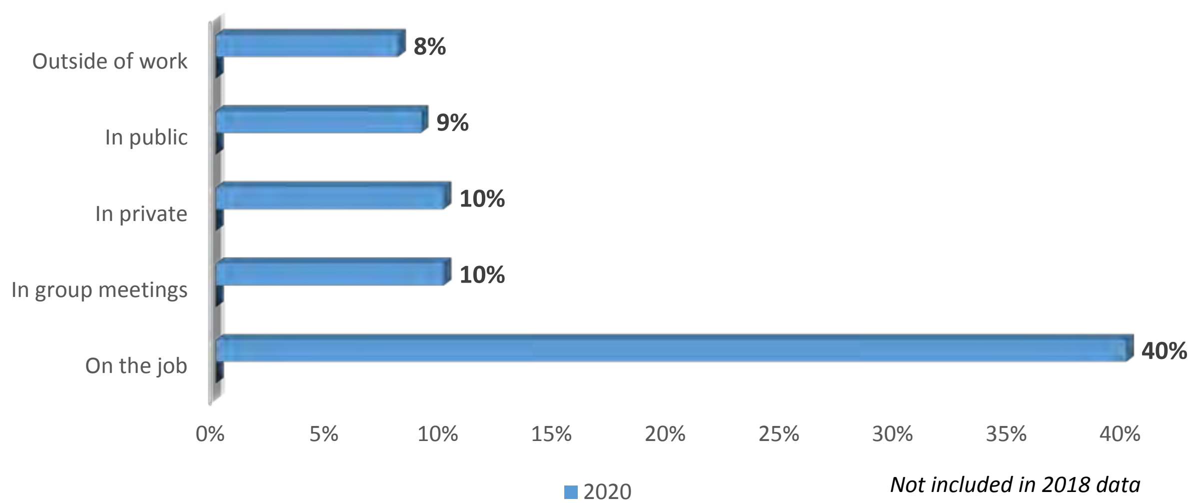

Top 5 - Most favourable
2018 Results
My work makes a difference to other people
1%
5%
94%
94%
I am clear about my objectives and responsibilities
4%
7%
89%
89%
The values and behaviours expected of us at work are clear to me
5%
13%
82%
81%
The people in my team work well together to provide a great service
7%
13%
80%
77%
Staff in this organisation are generally friendly and welcoming
6%
16%
78%
77%
0%
20%
40%
60%
80%
100%
120%
Unfavourable
Neutral
Favourable
Top 5 Most Unfavourable
2018 Results
My health and wellbeing has not suffered because of my work
37%
24%
39%
33%
People in my team worry they will be blamed for their mistakes.*
37%
32%
31%
17%
People in my team worry that mistakes they make will be recorded permanently.*
33%
38%
29%
17%
Work often feels in 'crisis mode' where we try to do too much too quickly.*
45%
27%
28%
21%
I often feel emotionally drained by my work*
50%
26%
24%
19%
0%
20%
40%
60%
80%
100%
120%
Unfavourable
Neutral
Favourable

Appendix B

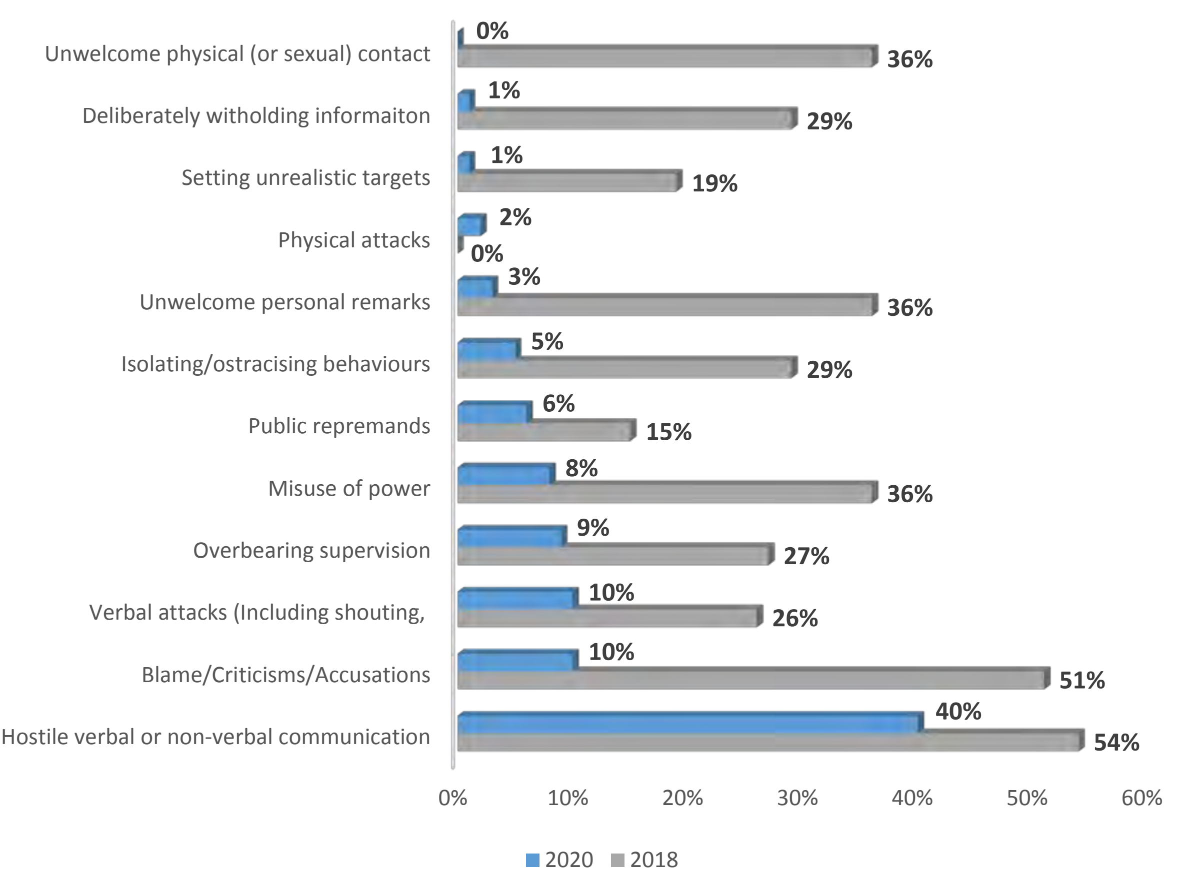


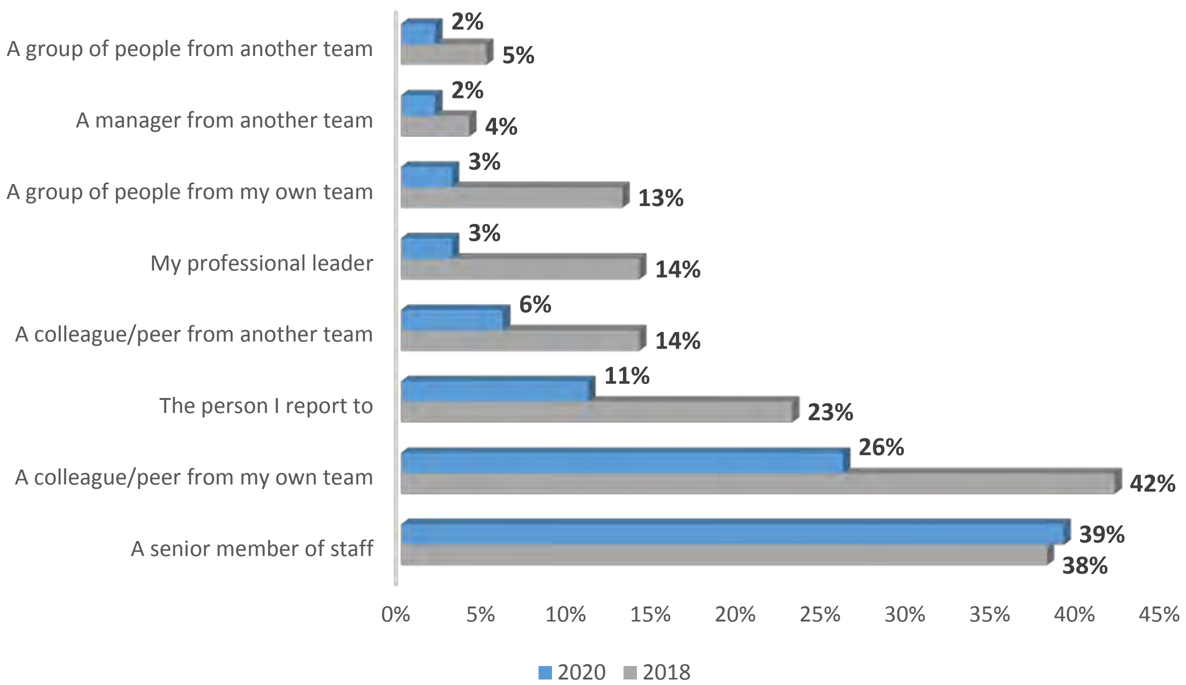


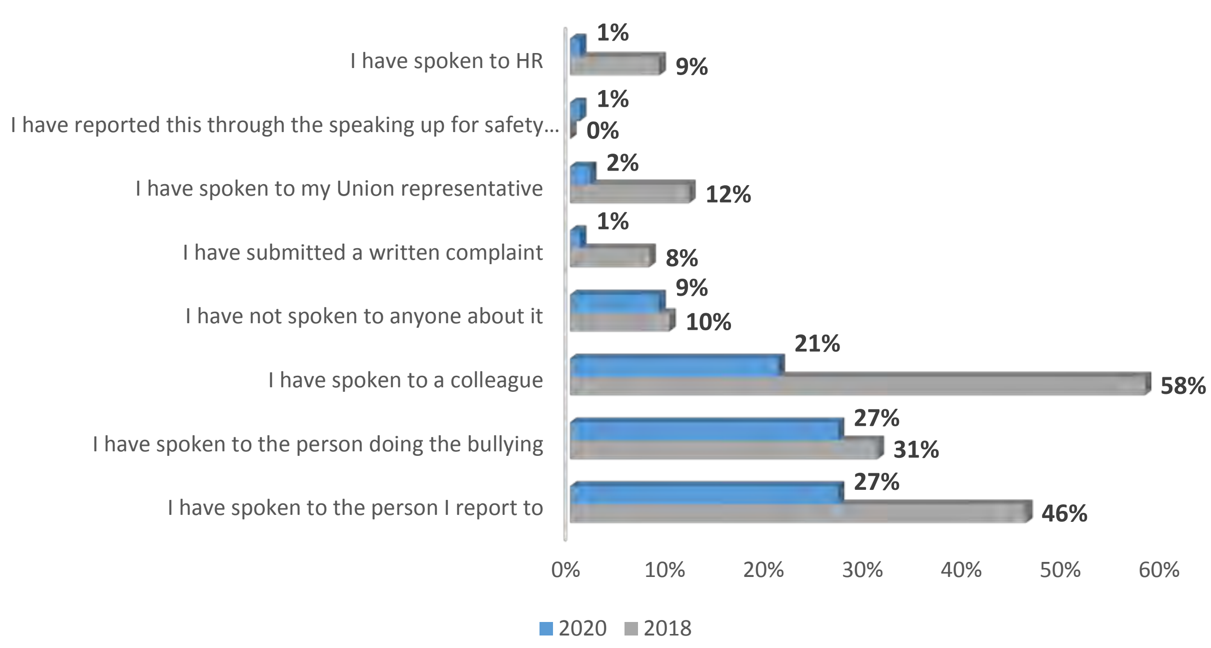
Where does this behaviour happen?



Which term would best describe this behaviour?




In terms of job roles, who is the person who displays this behaviour?
A group of people from another team
2%
5%
A manager from another team
2%
4%
A group of people from my own team
3%
13%
My professional leader
3%
14%
A colleague/peer from another team
6%
14%
The person I report to
11%
23%
A colleague/peer from my own team
26%
42%
A senior member of staff
39%
38%
0%
5%
10%
15%
20%
25%
30%
35%
40%
45%
2020
2018


Have you brought this behaviour to anyone's attention?
I have spoken to HR
1%
9%
I have reported this through the speaking up for safety...
1%
0%
I have spoken to my Union representative
2%
12%
I have submitted a written complaint
1%
8%
I have not spoken to anyone about it
9%
10%
I have spoken to a colleague
21%
58%
I have spoken to the person doing the bullying
27%
31%
I have spoken to the person I report to
27%
46%
0%
10%
20%
30%
40%
50%
60%
2020
2018

He kupu kōrero

MidCentral DHB 2020 Staff Engagement Survey

Our response rate has improved!

	2018	2020
Staff Responded	1,160 (47%)	1,639 (58%)

Our engagement increased significantly by 5%

Studies show good employee experiences contribute to better patient safety and care, which means increased engagement is important to all.

2018: **50%** 2020: **55%**

Examples of things staff say we are getting right

95% of staff agree that their work makes a difference to other people

90% of respondents reported that they are clear about their objectives and responsibilities

82% say our values and behaviours expected at work are clear to them

80% agreed that the people in their team work well together to provide a great service

78% say that staff in this organisation is generally friendly and welcoming

We've improved since 2018, guided by "Speaking Up" – we know there is still more to do here

71% of respondents believe that members of their team feel able to speak up if they see something that may compromise the safety of staff or patients.

75% of people reported that their team actively take steps to improve safety here.

73% of staff stated that they feel safe to speak up if they notice an error or issue.

21% noted that they have experienced bullying or harassment at work in the past 6 months. This is a significant decrease of 8% since 2018.

37% of staff are still worried that they will be blamed for their mistakes.

Your safety, health and wellbeing is important to us. We have improvements planned.

37% feel their health and wellbeing has suffered because of work.

32% of people are worried that their mistakes may be recorded permanently.

45% agreed that work often feels in crisis mode where we try to do too much too quickly.

55% are happy with their work life balance

50% of respondents feel emotionally drained by their work.

2020	2018	
70%	63%	Direction and purpose
60%	51%	Contribution and control
64%	51%	Recognition and value
54%	47%	Positive Emotion
41%	46%	Negative Emotion
58%	53%	Connection and Support
54%	48%	Wellbeing
69%	53%	Our Values
52%	43%	Our Safety Culture
66%	Not Assessed	Job Connection

Next Steps...

- Discuss the results within teams
- Contribute towards meaningful conversation about the results
- Identify useful improvements at team level, group and organisational level
- Participate in engagement action planning
- Update our people plans and priorities in accordance with engagement action plans.

Appendix D

Key Driver Analysis

How to read this chart

The charts below show us that the questions in the survey correlated against overall engagement. The purpose of these charts is to help you to identify areas of priority in your team.

- The X-axis tells us how well statements are performing. The performance score for each question is based on the mean expressed out of 100 (i.e. not the overall percentage favourable as reported elsewhere in the dashboard). The further along the axis, the better the statement is performing.
- The Y-axis tells us how the statement correlates to engagement. The further up the axis, the stronger the correlation between the statement and engagement.
- Questions with a higher correlation are more likely to have a greater impact on staff engagement scores.
- Statements marked with an Asterix are negatively worded so have had their scores reversed to make them comparable with other statements in the chart.

The chart is split into four quadrants based on the average overall scores:

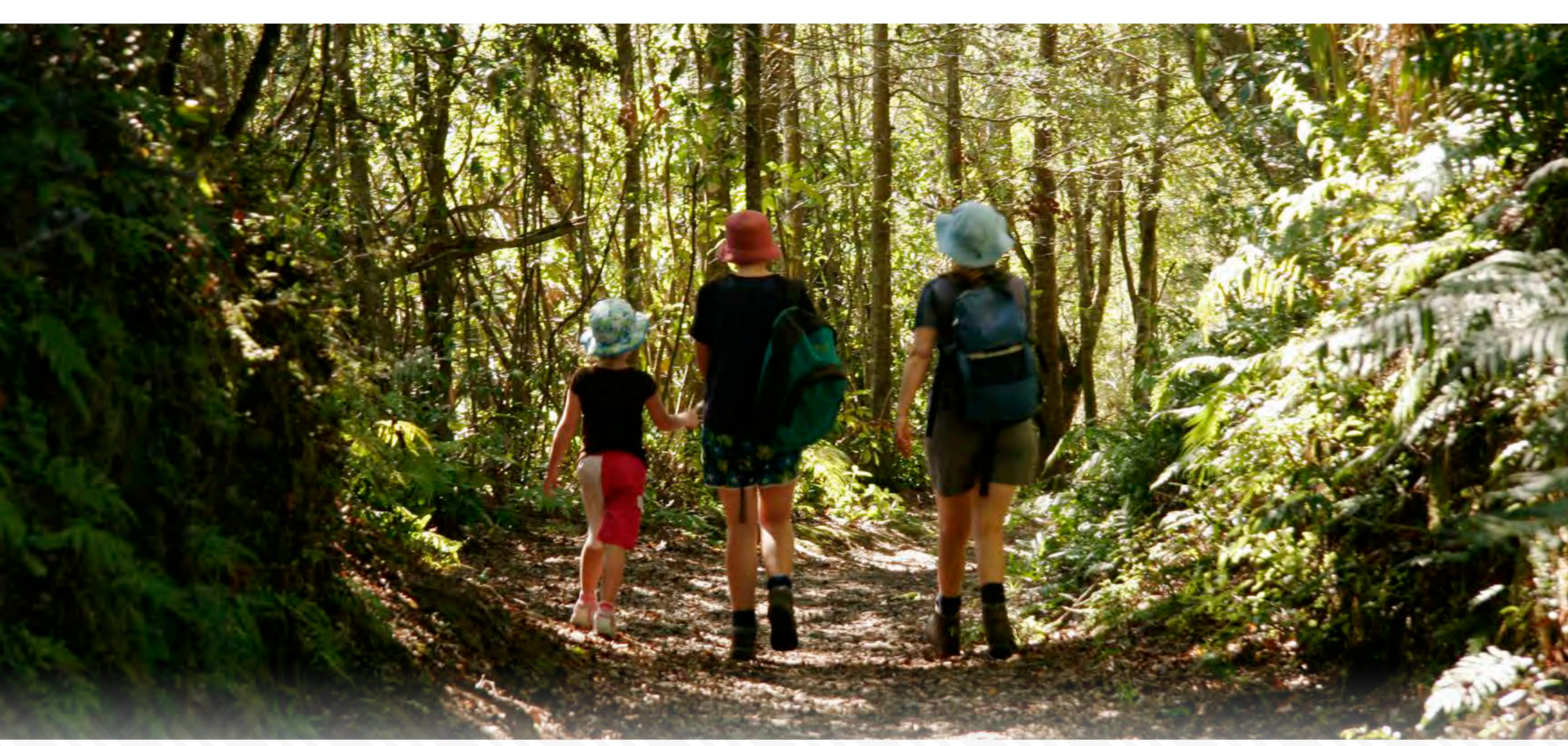
- **Areas to maintain:** Green dots tell us which statements are performing well relative to others and are also correlating more highly with engagement. Ensuring these are maintained will help to maintain engagement scores.
- **Actively improve:** Red dots tell us which statements are not performing well relative to others and are also correlating more highly with engagement. Acting on these first will have a greater impact on engagement scores in future.
- **Cause to celebrate:** Blue dots tell us which statements are performing well but don't have as big an impact on engagement scores. These should be recognised and appreciated.
- **Continue to monitor:** Orange dots tell us which statements are performing less well in relation to other statements. These should be monitored to ensure they don't slip further.

Key Drivers - Your experience at work 1,586 Responses

He kura te Tāngata A plan for our people for MidCentral District Health Board

2019-2023

Advancing Quality Living, Healthy Lives, and Well Communities through our People



Kia pai te noho
Quality Living

Kia ora te tangata
Healthy Lives

Kia ora te hapori
Well Communities

Contents

Introduction	3
Background	4
Purpose of our Plan for our People	5
How we will Achieve Success	6
Our Values	7
Our Vision for our People	8
Our Commitment to Te Tiriti o Waitangi	8
Our Culture	9
Our Capability	9
Our Ways of Working	10
Our Environment	10
Our Promise to our People	11
Our Roadmap for our People Plan	12
Milestones to Transform our Areas of Focus into a Current State	13
Tracking our progress	17
Next Steps	18

Te Horo to the south
Rangiwāhia to the north
From Aohanga to Mātaikona
to the east
Tāwhirihoe to the west
Ruahine and Tararua
are the summits
The many tributaries flow from
the peaks to the ocean
This is the beautiful region
of MDHB

1. Introduction – Kupu Whakataki

These places provide insight into the area MidCentral DHB covers. We all live in this district. Our family and friends live here too. It's our community. We want nothing but the best health care, and the best health and wellbeing for everyone. This includes our local population and the people who require our support from other districts and neighbouring health boards. Support is provided in these places through people and employees. Real partnerships between our communities, our people leaders and our employees will build a great place to work, crafting an environment where we can live our values, take care of one another and be a part of a remarkable team. These partnerships will enable us to achieve our strategic vision of quality living, healthy lives and well communities.

We have committed to the concept of Te Wao nui a Tāne (the forest ecology) to support our health workforce to be connected and integrated in our service approach and delivery. We are committed to partnering with individuals and whānau on their healthcare journey and we strive to ensure that their experience is seamless and easily navigable. The naming of the clusters using the Te Wao nui a Tāne concept, imagery and whakatauki (wise sayings) remind us daily that we need to be connected in our relationships with each other to truly provide an integrated system of care for consumers and whānau.

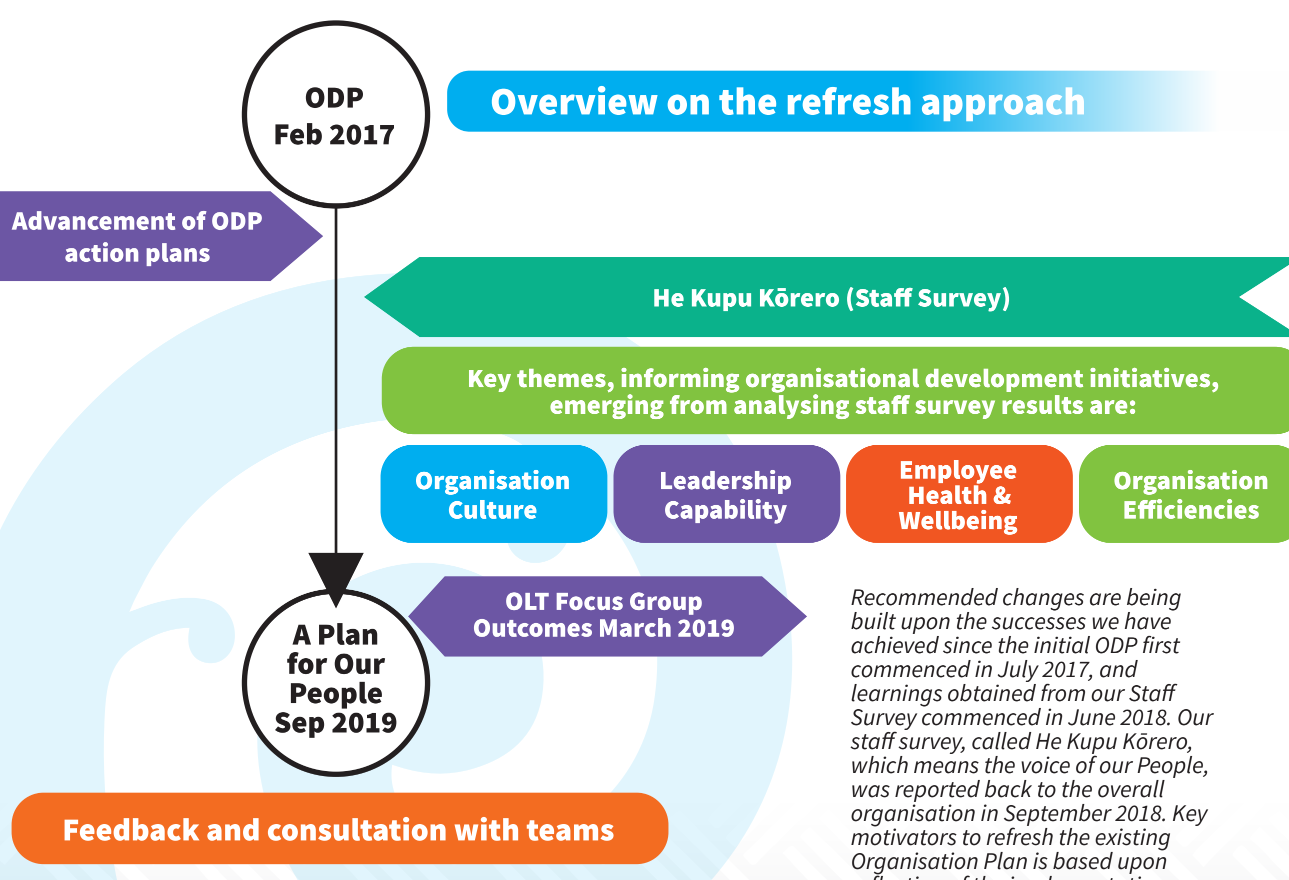
This People Plan is about articulating how best we enable and support the many people that work within MidCentral DHB's system of care, while they deliver the best possible health care services to the communities we serve.

2. Background – Aa Muri Raa

Refreshing the Organisational Development (OD) Plan

The refresh of the OD Plan took into account:

1. Responses from staff via the staff survey (He Kupu Kōrero) conducted in June 2018; and
2. Feedback from a focus group to align the previous OD plan with the organisational strategy and key focus areas identified from the staff survey.



Recommended changes are being built upon the successes we have achieved since the initial ODP first commenced in July 2017, and learnings obtained from our Staff Survey commenced in June 2018. Our staff survey, called He Kupu Kōrero, which means the voice of our People, was reported back to the overall organisation in September 2018. Key motivators to refresh the existing Organisation Plan is based upon reflection of the implementation of our existing organisational development activities and what our people have told us.

Staff Survey

Staff satisfaction survey, “He Kupu Kōrero”, was conducted in 2018. Almost fifty percent of our staff responded to the survey. Responses resulted in developing a Key Driver Analysis and Emotional Perception analysis. These indicated the four themes for refreshed activities to focus.

Organisational Culture

- Focus on transferring organisational values into real-life practices.
- Champion behaviours that consistently reflect the DHB’s values and vision.

Leadership Capability

- Focus on growing leadership at all levels.
- Support our people to grow their careers through constructive feedback.

Employee Health and Wellbeing

- Greater emphasis on employee health, safety and wellbeing.

Organisational Efficiencies

- Focus on improve ‘business processes’, making them easy and simple to provide enhanced work experience for our people.

Focus Group Feedback

- Recommend a new name for the refreshed OD Plan, now called “A Plan for our People”.
- Emphasised the need to ensure the DHB’s commitment to the Treaty of Waitangi is explicit.

3. Purpose of our Plan for our People – Te Whāinga

MDHB's vision is to deliver quality living, healthy lives and well communities. Our vision statement signals our commitment to the health outcomes of our population and to making necessary changes that enable us to continuously improve our health system as part of the wider health sector and social service network.

The organisation's strategy has four strategic imperatives (priorities) that focus over the next three to four years on achieving improvements in the health and wellbeing of people across our communities. We see this as the shared responsibility of all of our employees, service users and communities. For these priorities to make a difference to the health and wellbeing of individuals, whānau and communities it will require all of us individually and collectively to focus our energies.

We will:

- Achieve quality and excellence by design
- Partner with people and whānau to support health and wellbeing
- Connect and transform primary, community and specialist care
- Achieve equity of outcomes across communities.

The five key enablers identified to support our collective work programmes and successes, are:

- Innovation
- People
- Partners
- Stewardship
- Information.

This plan sets out the vision to maximise the contribution our people make to support the achievement of our strategic imperatives and identified milestones. It will be used to support and guide us over the next three to four years to make our vision for our people real. Based on a thorough analysis, a need was identified for the 2017 ODP to be refreshed to better reflect our strategic imperatives and to ensure the themes from the staff survey identified by our people were reflected and given focus. The voices of our people have informed the priorities within this plan.

The overview below illustrates how the People Plan and key strategic focus areas connect to the Organisational Strategy. These vital key strategic areas of focus intend to craft the future we want for our people.

We will achieve success through our				
Innovation	**People**	**Partners**	**Stewardship**	**Information**
People Plan: Happy, Healthy & High Performing				
Our Commitment to Te Tiriti o Waitangi Kia ū ki te tika *Inspire our people towards enhanced cultural responsiveness.*	**Our Culture Kia ū ki te pai** *Support a healthy and productive workplace culture that enables excellence.*	**Our Capability Kia toi te mana** *Empower an increased capability of our people.*	**Our ways of working Kia pono te mahi** *Encourage our people to be agile, innovative and respond effectively to our patients, whānau, and community.*	**Our Environment Kia tau te mauri** *Design a work environment which delivers an exceptional employee experience.*
1. Our systems and practices ensure that Māori needs are met. 2. A pro-equity approach is applied to Māori workforce. 3. We drive and measure the progress of Māori health gains. 4. Our employment processes value matauranga and are inclusive of tikanga Māori. 5. Our employees demonstrate cultural confidence.	1. Our values guide everything we do. 2. We participate in constructive working relationships. 3. Success is recognised, shared and acknowledged. 4. Distributed leadership and collaborative teams facilitate transformation. 5. Our internal communications embed language which aligns to our culture.	1. Leadership excellence inspires our people. 2. Career development enables our people to develop and grow. 3. Training programmes are of high quality and transferable into the workplace. 4. Development programs empower key capabilities. 5. Our people utilise technology to enable efficiencies and informed decision making.	1. Collaboration and partnerships are strong with internal and external stakeholders. 2. Our people are empowered to make decisions. 3. Innovative thinking is encouraged by our people and enabled by business process. 4. Our people are agile and responsive to change. 5. Our people are enabled to deliver programmes of work, timely, and efficiently.	1. We are able to attract the right people and place them into the right roles, at the right time. 2. Our people know what success looks like. 3. Our people have a voice in the way we do things. 4. Our people embrace diversity. 5. Our people are safe and well. 6. Our people processes are sensitive, efficient, and data-driven.

Compassionate
Kia whai aroha

Respectful
Kia whai ngākau

Courageous
Kia Mātātoa

Accountable
Kia noho haepapa

4. Our Values – Whanonga Pono

In establishing our revised People Plan we incorporated the values that underpin everything we do. These values are:

Compassionate – Kia whai aroha

Being responsive to the needs of the people, whānau and community and being compassionate towards ourselves.

Respectful – Kia whai ngākau

Demonstrate appreciation for another person, showing politeness or respect to someone or something, and to not intentionally cause offence. Actively listening when someone is speaking and showing you value other perspectives.

Courageous – Kia Mātātoa

Participate with confidence and enjoyment. Speaking up when things are not right, being assertive, being open to feedback, and willing to try out new things and take measured risks.

Accountable – Kia noho haepapa

Acknowledge and assume responsibility for our actions and not blaming others when things go wrong. Striving for excellence and delivering high quality care that focuses on the needs of consumers and whānau. Understand the context in which we operate as a publicly-funded organisation and utilise our resources wisely.

5. Our Vision for our People – Happy, Healthy and High Performing – Te Wawata

The vision identified by our people for our people is to provide a safe, supportive working environment that enables their ability to partner well with consumers and their whānau. These relationships need to be built on trust that allows for innovative and equitable ways of achieving health and wellness outcomes. Collaboration within our relationships should further encourage efficient utilisation of resources and acknowledge self-care and manaaki of consumers and their whānau, amongst our teams. We want to enable an environment that supports all of our people to treat one another as treasures, maintaining the belief that everyone has something significant to offer – He Kura te Tangata.

We are committed to our people sharing the tools they need to be successful in their roles. They will be supported to perform in a physically and emotionally safe environment, and be inspired to experience purpose, meaning and clarity while achieving the organisational objectives successfully. We want to foster an environment where our values define the way we conduct ourselves, and the way we interact among ourselves and with others. We are keen for our values to be visibly reflected within our daily practice with consumers, their families and carers, other healthcare providers, interagency collaborators, and within community and across multiple settings.

Our commitment to Te Tiriti o Waitangi – Kia ū ki te tika forms a central part of seeing our people in a prosperous bi-cultural environment. This plan explicitly defines our commitment to Te Tiriti as one of the key focus areas for our people. Our future narrative for our organisational culture, capability and ways of working will reflect an organisation that upholds the articles of Te Tiriti o Waitangi and ensures that mātauranga Māori (Māori worldview knowledge) is central to the way we provide care and how we partner with individuals and whānau using our services.

In order to move towards this, we will invest in the following five focus areas:

5.1 Our Commitment to Te Tiriti o Waitangi – Kia ū ki te tika

Te Tiriti o Waitangi commitments are central to the priorities and actions identified within our People Plan. We are committed to working with Māori to strengthen connections with whānau, hapū and iwi to bring about quality living, healthy lives, and well communities, while leading the way in achieving equitable health outcomes for the Māori population. The environments and settings we work within and the way we partner and provide care needs to actively contribute to the achievement of our Treaty obligations, which include genuine partnership, normalising Māori worldview approaches and solutions, pro equity actions that advance Māori health gain, and culturally safe and holistic practice. We are committed to a partnership with our local Iwi and hapū through our Manawhenua Hauora partnership Board. We will ensure we have defined clear goals and actions and that we track progress against these actions. We will remain open to new ways of doing things, and will embed kaupapa practice to accelerate Māori health gain within community and specialist service settings. Te Tiriti o Waitangi articles underpin all workforce roles and practice across our health system. These are articulated below:

Kāwanatanga – Our processes, actions and decision-making are informed and shaped by both tangata whenua and tangata Tiriti worldviews/perspectives. We work in partnership with tangata whenua.
Tino Rangatiratanga – We support tangata whenua-led processes, actions and decision-making through sharing power and resources.
Ōritetanga – We undertake specific actions to ensure equitable outcomes for tangata whenua.
Wairuatanga – Tangata whenua worldviews, values and wairuatanga are present in our work.

5.2 Our Culture – Kia ū ki te pai

Our values define and drive the way we interact with and support each other. We treat each other in a respectful manner, recognising and valuing the contribution each individual makes to our overall success as an organisation. We aspire to uphold the highest standards of behaviour and conduct, and provide safe and supported processes to enable constructive conversations when we differ in our thinking and beliefs. We recognise that our values define our identity as an organisation, which in turn determines our organisational culture. It is evident that organisational culture and employee engagement are directly linked and therefore influence our employer brand, employee value proposition, diversity and inclusion, and ultimately impact directly on our performance.

We provide a work environment that supports, recognises and celebrates the successes of our people and we are able to share our stories of achievement to encourage and inspire others. We want to ensure that our spaces, environments and culture support each other and our practises.

5.3 Our Capability – Kia toi te mana

We support our people to build the right skills, at the right time, in the right way across all levels within the organisation. Leadership capability sets the tone for the organisation, and role models the highest standards of behaviour and conduct. We want our leaders to recognise the impact they have on our culture and environment, and act accordingly to create a positive and productive work environment for our people. They inspire, support and encourage our diverse workforce to excel, removing barriers so that all employees can reach their potential. We will support our leaders to develop in line with these aspirations.

Our people are supported to excel in their roles and in their careers with us. Our development programmes will build high levels of capability in our people, and support them to achieve their ambitions. Personal development planning processes and the ability to coach and mentor, provide our people with meaningful feedback. People understand their contribution to the organisation, and are engaged in ongoing development and learning.

We embrace technology and use digital solutions to enhance our own efficiencies in the workplace. We are open to change and acknowledge how technology can contribute to overall organisational efficiencies and better data-driven, time-saving decision making.

5.4 Our Ways of Working – Kia pono te mahi

We enable our people to discuss ideas openly, to demonstrate behaviours in line with our values and to work in an agile manner to deliver appropriate solutions for our patients, whānau, and community. Our ability to work in new and efficient ways enables higher levels of responsiveness to the needs of our communities.

We work in partnership with our communities, healthcare providers, and other agencies to build an integrated healthcare system. We develop strong cross-team collaboration to ensure our community has access to a connected suite of health services. We are a connected organisation where effective communication and sharing of ideas drive an integrated approach to service provision.

We are recognised for our innovative practice and we have a strong culture of innovation where our people are provided with time, resources and support to identify and implement new and improved ways of working.

5.5 Our Environment – Kia tau te mauri

Our people are actively engaged in the success of our organisation, and have the ability to contribute their ideas and influence the way we deliver our services. We recognise that high employee engagement has significant benefits for the support of our vision and organisational strategy. When our people have better experiences, there are improvements in patient care, safety and health outcomes.

We are an organisation where people feel safe and supported in expressing their views. We are inclusive and recognise our diverse workforce for the richness of their input which contributes to overall organisational success. We support our people to perform to the best of their ability and focus on supporting their health and wellbeing effectively. We recognise that health and wellbeing stretches beyond the work environment and we support a range of initiatives to encourage a holistic approach to wellbeing.

The strategic direction for our people is to place them at the centre of everything we do, ensuring that our people processes are easy to apply, sensitive, and respectful.

Our physical work environment, work design and work processes support clinical excellence, effective healthcare provision, family/whānau support, efficiency, effectiveness and, most importantly, improved health outcomes. We have a strong focus on supporting the wellbeing of our people to enable them to maximise their contribution to better health outcomes and better healthcare for our communities.

Our Promise to our People – Kia tutuki te wawataia

We strive to create an exceptional employee experience and acknowledge that this will require both investment and courage. We are up for the challenge and this People Plan outlines our commitment to support an inclusive, healthy, safe and inspiring work experience.

Our People Plan also explains the expectations around new ways of working and how we intend to support our people through growing their capabilities, having constructive conversations which add to an enhanced employee experience.

We will ensure our employment processes embody our strategic imperatives and support pro-equity approaches. We will socialise, advance and integrate our Kaimahi Ora – Māori Health Workforce Strategy. Māori models of practice within general services will support our people to offer the following:

He āhuru mōwai – a safe haven.

He koanga ngākau – a happy heart.

He kounga mahi – quality actions.

Kia tū ko taikaha anake – let just the heartwood stand, always work with professionalism.

Kia tau te mauri – allow a healthy attitude to flourish.

Kia toi te mana – retain equity on listening to ideas.

6. Our Roadmap for our People Plan

7. Milestones to Transform our Areas of Focus into a Current State

Year 1 | 2019–2020

Establish a people driven infrastructure to excel

Our Commitment to Te Tiriti o Waitangi Kia ū ki te tika	*Our Culture* Kia ū ki te pai	*Our Capability* Kia toi te mana	*Our Ways of Working* Kia pono te mahi	*Our Environment* Kia tau te mauri
Our systems and practices ensure that Māori needs are met. • Include cultural competency into the performance management framework. • Compile an action plan, which ensures that karakia, waiata, whakawhanaungatanga, pōwhiri, and Te Reo Māori are embedded into our daily practices. **A pro-equity approach is applied to Māori workforce.** • Report on the current profile of our ethnic make-up. • Compile an implementation plan to drive Kaimahi Ora. **We drive and measure the progress of Māori health gains.** • Identify metrics to track cultural responsiveness. **Our employment processes value matauranga and are inclusive of tikanga Māori.** • Apply tikanga Māori into attraction strategies and recruitment practices. **Our employees demonstrate cultural confidence.** • Enhance cultural competence components in orientation and induction programmes. • Deliver cultural competence programmes.	**Our values guide everything we do.** • Review Code of Conduct and align with our values framework. • Deliver a visually inspiring values framework. **We participate in constructive working relationships.** • Define standards of behaviour and conduct. • Approve protocols to respond to inappropriate behaviour and conduct. • Roll-out Promoting Professional Accountability programme. • Develop an Employee Relations Strategy. **Success is recognised, shared and acknowledged.** • Set-up an Awards and Recognition Committee. • Develop remuneration policy and strategy for IEA staff. **Distributed leadership and collaborative teams facilitate transformation.** • Develop a systematic approach to identify team structures across the organisation, which is fit-for-purpose within each cluster or enabler group. **Our internal communications embed language which aligns to our culture.** • Develop and deliver the communications strategy. • Include consumer voice in our communication initiatives.	**Leadership excellence inspires our people.** • Integrate and socialise the Leadership Success Profile (LSP) as a framework for our leadership programmes. • Implement Organisational Leadership Team Development Programme. • Implement 360 Degree Feedback processes at CE and OLT level. • Establish coaching resources for senior leaders. • Implement an action plan to enhance senior leadership visibility. • Design culturally responsive and LSP driven recruitment processes at an executive leadership level. **Career development enables our people to develop and grow.** • Review leadership development programmes to ensure they are fit for purpose. • Establish an agreed career/ talent management philosophy. • Implement personal development planning, progressively. **Training programmes are of high quality and transferable into the workplace.** • Review non-clinical learning programmes. **Development programmes empower key capabilities.** • No activities planned for Year 1. **Our people utilise technology to enable efficiencies and informed decision making.** • Support the Digital District Health Strategy – Te Awa.	**Collaboration and partnerships are strong with external and internal stakeholders.** • Support the Integrated Service Model (Te Wao nui a Tāne). • Implement consistent business partnering models. • Implement a co-design framework. • Evaluate CAGs. **Our people are empowered to make decisions.** • Implement the Quality Agenda (Clinical Governance Framework). • Identify decision-making models and processes. • Develop governance and delivery of a Quality Improvement Education Programme. • Develop clinical governance arrangements across clusters. • Enable decision making delegations at appropriate levels. • Enable effective decision making applications to deliver core clinical, clerical and organisational stewardship excellence. **Innovative thinking is encouraged by our people and enabled by business process.** • Build internal capacity to implement innovative thinking. • Establish Innovation Champions. • Continuously improve business process. **Our people are agile and responsive to change.** • Define and develop fit-for-purpose agile methodologies. • Implement a change management model that drives and supports transformation. • Implement a Business Partnering model of operations across all enabler groups. **Our people are enabled to deliver programmes of work, timely and efficiently.** • Develop a project prioritisation framework. • Implement robust governance to monitor project and programme delivery. • Establish a framework to enable executive sponsorship of programmes and projects. • Review and strengthen the Improving Value Programme (IVP).	**We are able to attract the right people and place them into the right roles, at the right time.** • Build a high performing recruitment process • Implement an applicant tracking system to improve efficiencies in terms of recruitment administration and hiring times. • Promote an attractive employer brand. **Our people know what success looks like.** • Investigate and implement inspiring on-boarding practices. • Update and automate performance framework to align with best practice. **Our people have a voice in the way we do things.** • Develop engagement action planning processes and capability. **Our people embrace diversity.** • Lead responsive workplace initiatives. • Widen employee support networks. • Establish a Diversity and Inclusion Committee. **Our people are safe and well.** • Roll-out psychological harm prevention programmes. • Develop and implement occupational violence prevention strategy. **Our people processes are sensitive, efficient and data-driven.** • Implement paper-free people processes. • Investigate and scope a project plan for a fully-integrated HRIS system.

Year 2 | 2020–2021

Enable our People

Our Commitment to Te Tiriti o Waitangi Kia ū ki te tika	*Our Culture* Kia ū ki te pai	*Our Capability* Kia toi te mana	*Our Ways of Working* Kia pono te mahi	*Our Environment* Kia tau te mauri
Our systems and practices ensure that Māori needs are met. • Implement and assess an action plan which ensures that karakia, waiata, whakawhanaungatanga, pōwhiri, and Te Reo Māori are embedded. **A pro-equity approach is applied to Māori workforce.** • Report on progress made for attracting and retaining Māori workforce. **We drive and measure the progress of Māori health gains.** • Increase recruitment and retention of Māori employees. **Our employment processes are inclusive of Te Tiriti knowledge and tikanga Māori.** • Ensure organisational processes are inclusive of Te Tiriti and tikanga Māori. **Our employees demonstrate cultural confidence.** • 50% of the workforce has completed at least one cultural competence training programme.	**Our values guide everything we do.** • Socialise a visually inspirational values framework. • Equip teams with tools and strategies to enhance organisational culture. **We participate in constructive working relationships.** • Socialise our code of conduct and values framework. • Embed Professional Accountability and Speaking Up for Safety programmes. • Implement Employment Relations Strategy. **Success is recognised, shared and acknowledged.** • Roll-out awards and recognition programmes and framework. **Distributed leadership and collaborative teams facilitate transformation.** • Roll-out collaborative team principles into working groups and team structures. • Embed distributed leadership decision making abilities into team functionality. **Our internal communications embed language which aligns to our culture.** • Develop internal communication guidelines and toolkits. • Raise communication competence at all levels.	**Leadership excellence inspires our people.** • Operationalise internal and external mentoring and coaching models across T3 leadership levels. • Implement 360 degree feedback processes at a T3 level. • Integrate clearly defined leadership expectations at a T3 level. • Develop succession and retention planning frameworks. • Deliver operational business partnership models per enabler group. • Increase senior leader visibility. **Career development enables our people to develop and grow.** • Roll-out talent mapping. • Connect new and existing technical and/or non-technical career pathways. • Embed personal development planning into performance framework at a T3 level. **Training programmes are of high quality and transferable into the workplace.** • Assess and improve training programmes based on learner feedback. **Development programmes empower key capabilities.** • Partner with professional bodies to ensure currency of key technical capabilities. • Consolidate strategic learning needs with input from personal development plans, talent mapping and performance plans. **Our people utilise technology to enable efficiencies and informed decision making.** • Continue to support the implementation of the Digital District Health Strategy – Te Awa.	**Collaboration and partnerships are strong with external and internal stakeholders.** • Embed the co-design framework. • Support the maturity of the Integrated Service Model (Te Wao nui a Tāne). • Deliver a fully developed and engaged consumer panel, able to demonstrate success in the advancement of service delivery. • Apply identified improvements to CAGs. **Our people are empowered to make decisions.** • Embed shared governance models. • Present fully operational clinical outcomes and quality dashboard. **Innovative thinking is encouraged by our people and enabled by business process.** • Enable fully functional innovation champions who are empowered to support innovation process across the organisation. • Embed innovative thinking and work practices. **Our people are agile and responsive to change.** • Apply efficient change management methodologies in key strategic programmes. • Establish transformation metrics for all change management programmes. • Educate people in the agile ways of working. • Support agile thinking, decision-making and implementation through business process and appropriate structures. **Our people are enabled to deliver programmes of work, timely and efficiently.** • Report on measured benefits of the IVP and other programmes of improvement.	**We are able to attract the right people and place them into the right roles, at the right time.** • Integrate talent acquisition with relevant people practices to engage in pro-active recruitment. • Develop an organisational workforce plan. • Embed applicant tracking system. **Our people know what success looks like.** • Assess progress on revised on-boarding practices. • Empower leaders with tools and guidelines to provide constructive feedback. **Our people have a voice in the way we do things.** • Deliver effective engagement action plans that support the cultural direction of the organisation. • Administer the staff survey (He Kupu Kōrero). **Our people embrace diversity.** • Lead diversity initiatives. • Embed support networks. • Deliver programmes for employees working with people living with disabilities. • Lead initiatives to employ more disabled people in our DHB. **Our people are safe and well.** • Review existing wellness and wellbeing programmes. • Review the Employee Assistance Programme. **Our people processes are sensitive, efficient and data-driven.** • Automate and implement reviewed electronic business processes. • Automate and roll-out priority HR processes. • Develop automated digital dashboard reporting systems.

Year 3 | 2021–2022

Embed our approaches

Our Commitment to Te Tiriti o Waitangi **Kia ū ki te tika**	***Our Culture*** **Kia ū ki te pai**	***Our Capability*** **Kia toi te mana**	***Our Ways of Working*** **Kia pono te mahi**	***Our Environment*** **Kia tau te mauri**
Our systems and practices ensure that Māori needs are met. • Implement action plan which ensures that karakia, waiata, whakawhanaungatanga, pōwhiri, and Te Reo Māori are embedded into all DHB practices. **A pro-equity approach is applied to Māori workforce.** • Targeted development practices are embedded for Māori workforce. **We drive and measure the progress of Māori health gains.** • Report progress on Māori workforce development. **Our employment processes are inclusive of tikanga Māori.** • Implement project plan to ensure inclusivity of organisational people processes. **Our employees demonstrate cultural confidence.** • 70% of the workforce has completed at least one cultural competence training programme. • Apply Māori values into an integrated Leadership development programme approach. • Integrate cultural competence as a part of performance conversations across the organisation.	**Our values guide everything we do.** • Analyse team responsiveness to cultural development programmes, tools, and strategies. **We participate in constructive working relationships.** • Embed healthy and consistent employee relations practices. **Success is recognised, shared and acknowledged.** • Awards and recognition committee fully functional. **Distributed leadership and collaborative teams facilitate transformation.** • 30% of teams have completed team development activities. **Our internal communications embed language which aligns to our culture.** • Embed communication capability across all levels of Management.	**Leadership excellence inspires our people.** • Fully functional career boards, projects, secondment, and career development practises are in place. • Leaders consistently practise career mapping and conversations, and succession and retention planning in a respectful and transparent way. • Embed fully functional business partnership model. **Career development enables our people to develop and grow.** • Embed active engagement with personal development planning. • Inform Training and Development Committee of needs analysis results pertaining to active personal development planning. **Training programmes are of high quality and transferable into the workplace.** • Establish a Training and Development Committee to oversee consistent clinical and non-clinical learning and development needs. **Development programmes empower key capabilities.** • Ensure clearly defined framework to identify mandatory, recommended and optional learning programmes. **Our people utilise technology to enable efficiencies and informed decision making.** • Implement change action plans to establish employee confidence and empower leaders to support the achievement of the Digital Health Strategy – Te Awa.	**Collaboration and partnerships are strong with external and internal stakeholders.** • Establish fully integrated Service Model (Te Wao nui a Tāne) across all clusters. **Our people are empowered to make decisions.** • Deliver quality services through the implementation of evidence based continuous improvement programmes. • Apply core clinical, clerical and organisational stewardship excellence into business as usual. **Innovative thinking is encouraged by our people and enabled by business process.** • Review innovation programme. **Our people are agile and responsive to change.** • Assess impact of change management initiatives and acceptance of ownership to generate workable solutions, across the organisation. • Assess impact of agile methodologies to recommend improvements. **Our people are enabled to deliver programmes of work, timely and efficiently.** • IVP is embedded in all philosophies and cluster and enabler plans.	**We are able to attract the right people and place them into the right roles, at the right time.** • Model future workforce requirements and compile a projected workforce plan. • Review and report on benefits of e-recruitment system and employer branding. **Our people know what success looks like.** • Rollout a fully refreshed on-boarding programme to support and establish our Employee Value Proposition and employer brand. • Embed principles of effective performance conversations, which informs sound career management practices. **Our people have a voice in the way we do things.** • Embed processes so organisational activities are informed by employees input. **Our people embrace diversity.** • Promote our diversity and inclusivity practices. • Implement disability action plan. **Our people are safe and well.** • Implement a comprehensive employee wellbeing programme. • Implement programmes to support an ageing workforce. **Our people processes are, sensitive, efficient, and data-driven.** • Embed automated and efficient HR processes. • Continue to refine digital dashboard reporting.

Year 4 | 2022–2023

Assess for Impact to re-establish our plan for our people

Our Commitment to Te Tiriti o Waitangi Kia ū ki te tika	*Our Culture* Kia ū ki te pai	*Our Capability* Kia toi te mana	*Our Ways of Working* Kia pono te mahi	*Our Environment* Kia tau te mauri
Our systems and practices ensure that Māori needs are met. • Assess the extent to which employees embrace Māori practices. • Assess leadership contributions to inspire cultural competence practices. • Analyse consumer reports to assess Māori responses. **A pro-equity approach is applied to Māori workforce.** • Demonstrate that the DHB workforce is representative of Māori make-up in the community. **We drive and measure the progress of Māori health gains.** • Analysis of data informs pro-active decision making and initiatives. • Metrics and reports confirm increased achievements of targets. **Our employment processes are inclusive of Te Tiriti obligations and tikanga Māori.** • Processes are inclusive. **Our employees demonstrate cultural confidence.** • Refresh the delivery of cultural competence programmes. • Normalise Cultural responsiveness as part of our daily interactions.	**Our values guide everything we do.** • Measure organisational culture improvement through employee engagement surveys. **We participate in constructive working relationships.** • Report on our employee relations improvement programmes. **Success is recognised, shared and acknowledged.** • Review the impact of the remuneration strategy, awards and recognition programmes and make recommendations. **Distributed leadership and collaborative teams facilitate transformation.** • Measure impact of team programmes to determine levels of inter and cross-functional team relations and decision-making. **Our internal communications embed language which aligns to our culture.** • Deliver effective internal and strategically intended communications across all levels of leadership.	**Leadership excellence inspires our people.** • Conduct a skills audit of the Leadership Success Framework and Management Framework. • 80% of our leaders have completed a leadership development programme. **Career development enables our people to develop and grow.** • Integrate and apply technical and non-technical career pathways with career mapping and development frameworks. **Training programmes are of high quality and transferable into the workplace.** • Assess the application and visibility of clinical and non-clinical learning programmes to recommend improvements. **Development programmes empower key capabilities.** • Link training and development needs of people, accurately with available and appropriate training and development programmes. **Our people utilise technology to enable efficiencies and informed decision making.** • Monitor and assess employee feedback to track confidence in applying new technology.	**Collaboration and partnerships are strong with external and internal stakeholders.** • Identify new ways of working to enhance outcomes of the Integrated Service Model (Te Wao nui a Tāne). • Survey cross sectoral partnerships and community engagement through a feedback system and report results. **Our people are empowered to make decisions.** • Assess decision-making capacity, which impacts on quality of healthcare. **Innovative thinking is encouraged by our people and enabled by business process.** • Operate as a centre of excellence for innovative practice. **Our people are agile and responsive to change.** • Embed agile thinking as a part of business as usual. **Our people are enabled to deliver programmes of work, timely and efficiently.** • Assess improved health outcomes through consumer feedback.	**We are able to attract the right people and place them into the right roles, at the right time.** • Report significant decrease in hiring times and an increase in the appointment of high quality candidates. • Continue to identify and automate HR processes. • Report clearly on the future workforce landscape in terms of demand, supply and potential disruptions. **Our people know what success looks like.** • Deliver high quality on-boarding programmes which continuously improve and align with our employee value proposition. • Demonstrate constructive involvement in performance conversations by all employees because of the value it adds to their levels of career satisfaction. **Our people have a voice in the way we do things.** • Review and refresh OD plan with input from employees and staff survey reports. **Our people embrace diversity.** • Confirm that our people naturally embrace diversity and that our leaders role-model inclusivity. • Report on the work experience of people from diverse backgrounds to assess success of diversity programmes. • Link the employee experience of people from diverse backgrounds to our employee value proposition. **Our people are safe and well.** • Integrate fully functional fit-for-purpose wellbeing programmes, holistically across the organisation. **Our people processes are, sensitive, efficient, and data-driven.** • Monitor, track and report on the implementation of prioritised HR processes and revised people practices. • Establish clear people management metrics so leaders make informed and accurate people decisions. • Monitor the level of sensitivity and inclusivity of our people processes on a continuous basis.

8. Tracking our progress

Over the next three to four years we will continue to monitor key markers to ensure our initiatives progress as planned. Our success will be assessed through the bi-annual results of our staff satisfaction survey, He Kupu Kōrero, and through presenting a tracking report against our People Plan to the MidCentral Board, as agreed in the work programme.

Measures of success across the duration of the four-year People Plan are provided below:

Measures of success				
Our Commitment to Te Tiriti o Waitangi	**Our Culture**	**Our Capability**	**Our Ways of Working**	**Our Environment**
Our people are culturally responsive in delivering equitable whānau-centred care, which is evident through: • Our Māori workforce being reflective of our population. • All employees having undertaken at least one programme in cultural awareness. • The use of Te Reo Māori and kaupapa Māori being normalised and commonplace.	Our people feel safe and contribute to a productive, happy workplace, which is evident through: • Employees demonstrating behaviours that are in line with our values at all times. • He Kupu Kōrero reflecting an overall increased engagement profile. • Teams performing to a high level.	Our employees demonstrate greater levels of leadership at all levels, which is evident through: • Practising the capabilities as illustrated in the Leadership Success Profile. • Aligned efforts across the organisation to achieve key strategic objectives. • All employees having clearly defined performance and individual development plans. • Employees reporting that they regularly receive constructive feedback from their managers.	Our people feel confident to support and demonstrate our new ways of working, which is evident through: • Our people embracing change, being innovative and demonstrating agile behaviour. • Our system and procedures supporting our work practices and increasing efficiencies. • Our work practices reducing bureaucracy and enhancing efficient ways of working.	Our work environment results in a safe and positive work experience for our people, which is evident through: • Key HR processes being automated and delivering a great user interface experience across the employee life cycle. • People knowing exactly how to achieve success. • People embracing collaboration and constructive working relationships across diverse groups of people. • People achieving noticeable development and growth in terms of their career aspirations. • Our people feeling emotionally and physically safe with us.

9. Next Steps – Te Ara Tika

Our vision is for employees to be happy, healthy, and high performing in order to deliver on our strategic commitments to our community. We will continue to partner with all our stakeholders and work to align our priorities to ensure that we are focusing on the strategies that provide the greatest benefits to the communities we serve. We will strive to build a workplace culture that gives life to a satisfied, supported and engaged workforce, who are committed to delivering unparalleled standards of consumer care.

Next steps to ensure we are successful:

8.1 **Sponsor** – Keyur Anjaria, General Manager, People and Culture, MidCentral District Health Board will oversee the People Plan working Group.

8.2 **Working Group** – The working group will represent a wide range of work areas across the DHB. Working group members will jointly or individually lead individual initiatives. The working group will oversee the delivery of initiatives identified within this plan. It will further be accountable to re-align the people plan for the future based on current Organisational Strategy, cluster and enabler planning, and engagement survey results.

8.3 **Monitor** – The working group will further oversee that the identified People Plan activities and initiatives gets transferred into the operational planning of the Enabler groups.

8.4 **Meetings** – Will be held monthly.

8.5 **Reporting** – The Sponsor will report to the Board on a six-monthly basis in accordance with the Board’s work programme.

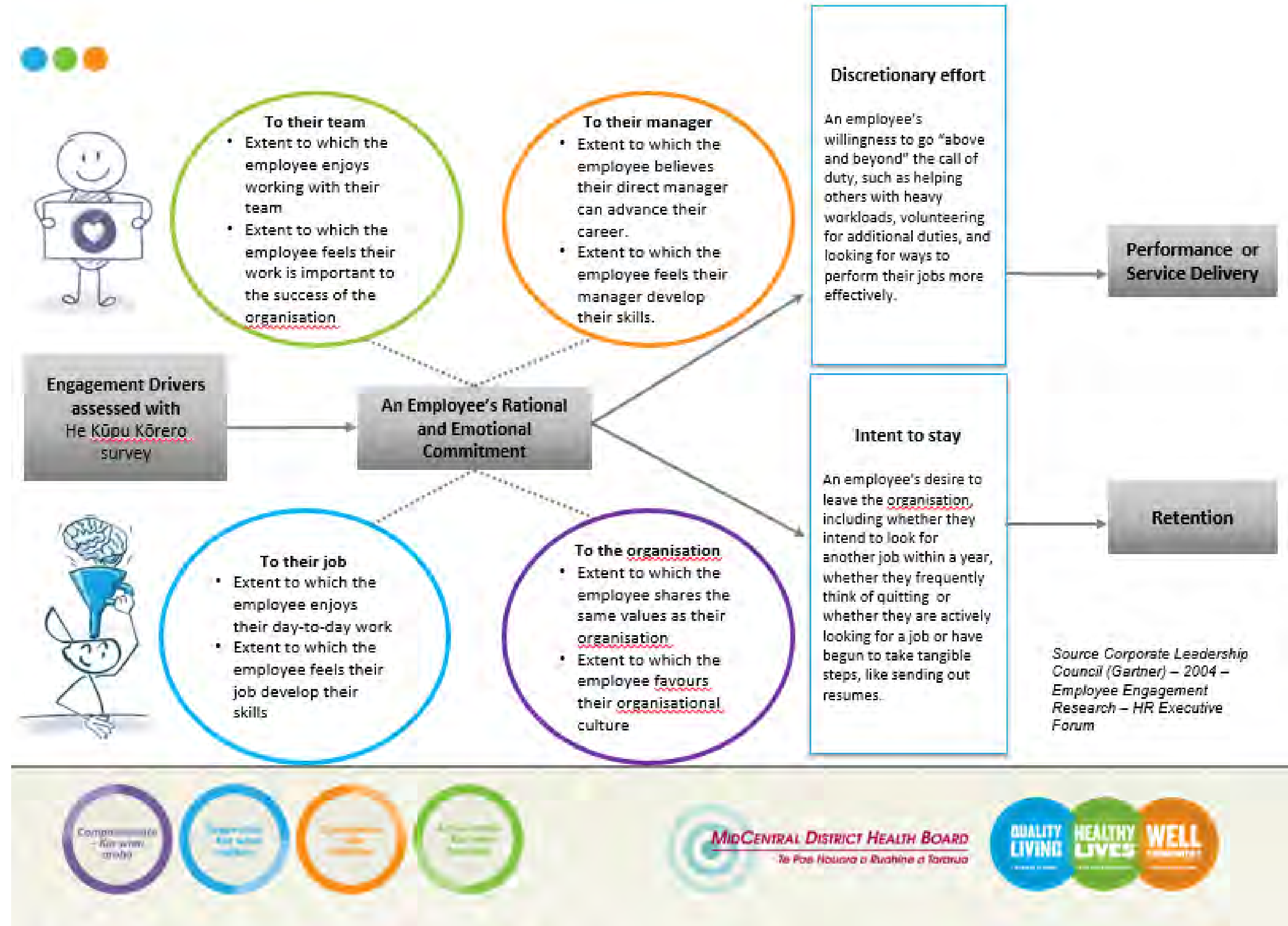
QUALITY LIVING
Kia pai te noho
HEALTHY LIVES
Kia ora te tangata
WELL COMMUNITIES
Kia ora te hapori

MDHB Engagement Action Planning – Guidelines

What is Employee Engagement?

Employee Engagement is defined as the rational and emotional commitment employees feel toward their place of work, their manager, team and their job. Rational commitment refers to the extent to which employees believe that their manager, team or the organisation would act in their best interest, and emotional commitment refers to the extent to which an employee values, enjoys and believes in their job, manager, team and their place of work. Employee engagement is a workplace approach designed to ensure that employees are committed to their organisation's purpose, goals and values, while being motivated to contribute to organisational success and able, at the same time, to enhance their own sense of well-being.

Engagement is a tool for organisational success. If money is the language of business, engagement is the language of motivation. Engaged employees are intrinsically motivated to do work which is interesting, meaningful rewarding and supported. For this reason, over the past couple of decades, employee engagement has transitioned from a nice-to-have metric, to an essential medium of communication and motivation to do what we, as the MidCentral DHB aspire to. Measuring engagement is about translating perceptions into numbers, numbers into insights, and insights into actionable intelligence. These metrics and points for having conversations are available through our bi-annual staff survey called "Your Voice - He Kūpu Kōrero". Below is a visual demonstration of how we define engagement:



What are the benefits of focusing on employee engagement?

- A great opportunity for employees to express how they feel, and for the organisation to consider this input when compiling strategies and operational plans for our people.
- Good engagement scores would help us to retain talent because we will be able to shape our people processes based on employee input.
- Engaged staff recommend our place of work to others, **attracting** quality talent.
- Engagement surveying is an opportunity for staff to raise open honest feedback anonymously and confidentially.
- If we were able to create an environment that would encourage happy employees, this would naturally flow over to an environment for happy consumers of our services.
- Evidence based in sound research demonstrates that increased employee wellbeing correlates with increased patient wellbeing
- Healthcare organisations with higher levels of employee engagement have **fewer hospital acquired infections**, significantly **fewer mistakes**, **better outcomes** and **lower mortality rates.**
- Measurement enables understanding and informs areas for improvement and opportunities for cross-learning.
- Good principles of engagement are a win-win for all stakeholders.

Approach to engagement action planning in MidCentral DHB

Engagement survey results are not about the numbers but about being curious about what we can learn from the results and from each other. It is about honest and courageous conversations and about giving each other the opportunity to participate in solutions to concerns, and about celebrating and acknowledging what we are good at. It is about insights, learning from each other, good leadership, equally constructive teams and being better, together, every day.

The following principles underpin the approach to engagement action planning in MidCentral DHB:

- **Share and collaborate:** Sharing results with the team and involving them in the process encourages more relevant actions, and leads to greater employee commitment to an action plan.
- **Focus on one opportunity at a time:** Identifying just one focus area makes it easier to achieve alignment in effort, clarity in communication and visibility of impact.
- **Maintain momentum:** Making action planning as lightweight as possible allows teams to move efficiently from results, to action, to being able to see the impact. Keep it simple.
- **Track and communicate progress:** Share action plan and progress in an open forum. A visible space allows team members to track progress and shows that their original feedback was heard and addressed.
- **Increase collaboration:** Taking a more collaborative approach to acting on results by including team members, creates a sense of ownership, enables creativity, develops trust and builds upon the momentum you have gained in sharing the results.

What is your role as a Manager in engagement action planning?

- Read the He kura te Tāngata – A Plan for our people and the Engagement Survey FAQ's
- Monitor participation
- Answer employee questions openly and honestly
- Assume good will
- Analyse, share and discuss team information
- Opportunity to establish a strong employee voice and involvement through engagement action planning
- Understand and be open to hearing team-level feedback

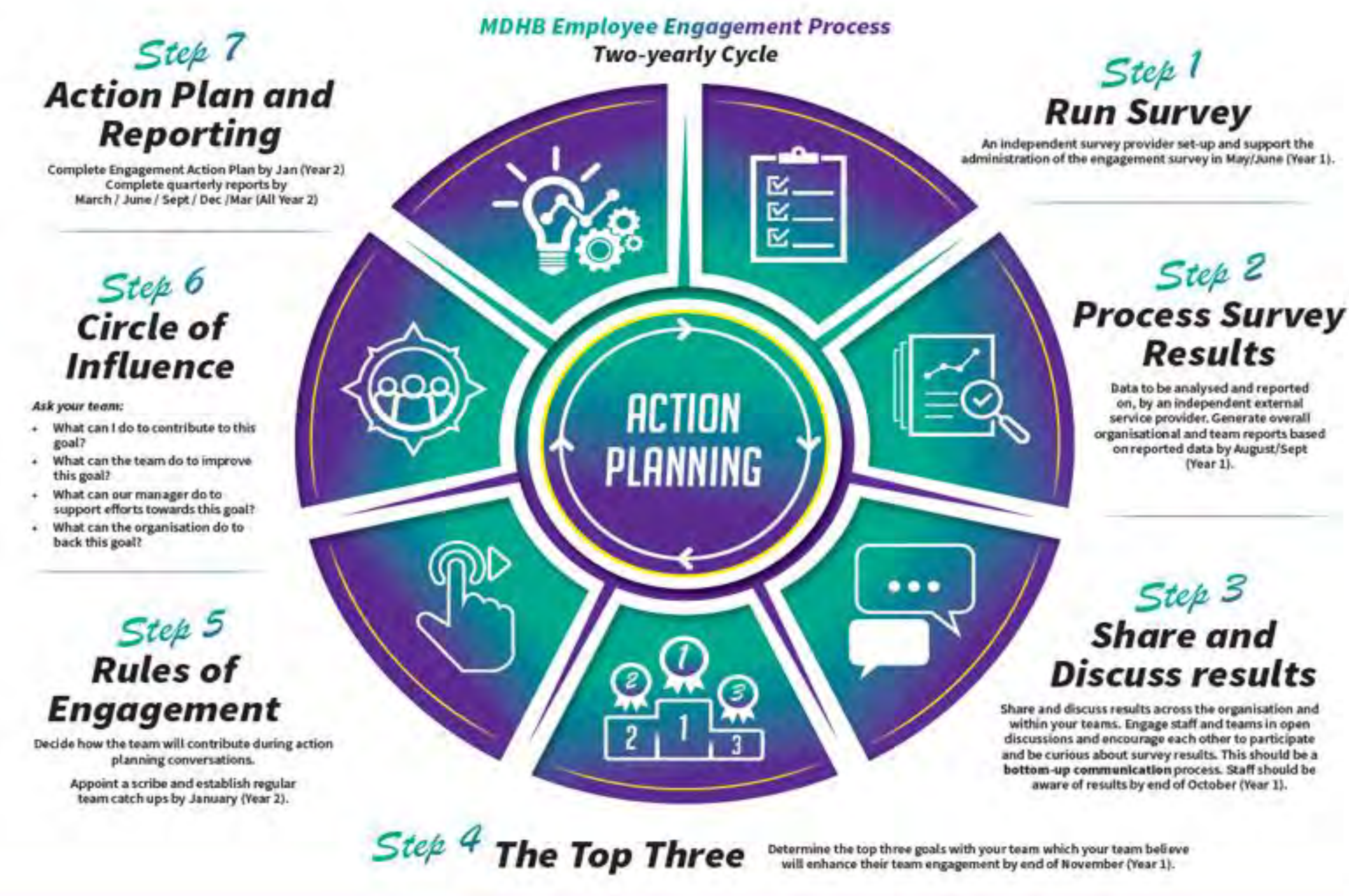
- Facilitate team discussions, participation and agreed action plans
- Encourage a bottom-up open and explorative communication process
- Follow up with employees and monitor progress.

What is the role of team members during engagement action planning?

- Assume good will
- Be open
- Think about needs and things we can influence together to make our place of work a great place to be
- Share your voice
- Participate
- Be respectful and compassionate
- Provide candid and actionable feedback
- Take personal accountability over your commitment, behaviour and contributions.

Please note these guidelines are in no way intended to be prescriptive but rather provided to assist with the process. It will be important to design the process in a way which feels comfortable to you and your team. However, it would be important to honour the time line expectations outlined in the info graph on the next page as best you can. We will refine these as we travel on this journey and receive feedback from the groups and clusters. The following pages discuss each step in the graph below in more detail. Please note the required feedback to your HR or OD Business partner in accordance to step four through to step seven. These steps are colour coded in accordance to the [report template] that you can access here, for easy reference.

Overview on the MDHB engagement action planning process



Step 1: Run Survey (May to July, Year 1)

Identified and independent survey providers will run, administer and interpret the survey data every two years. Currently Qualtrics is the service provider who offers the data process platform and April Strategy advises on the survey content and interpretation of the survey results. These service providers are external to ensure that staff can be confident in the anonymity of their feedback. During this process, it would be essential for managers to encourage their staff to participate in the survey, and to navigate through any obstacles that may prevent employees from participating in the survey. High participation rates will ensure we can be confident in the voice of our employees being representative of the overall organisation, groups or clusters and at team level.

Step 2: Process Data (August to September, Year 1)

Results of the survey will be processed and analysed across the organisation. April Strategy conducts a full interpretation and analysis of our engagement survey results. These findings and recommendations are reported to the Board, Organisational Leadership Team, Groups and Clusters. Results at a team level would only be available if the team have more than a 30% participation rate. In order to achieve the percentages, individual respondents to the survey need to feel confident to choose their team demographics as this setting is voluntary. Clusters or Group settings are mandatory in nature.

Step 3: Share and Discuss Results (End of October, Year 1)

It is critical to get staff engaged in discussing and sharing of results. A bottom-up approach will be an effective means of generating ideas for improvement initiatives, and an important part of the action planning process. It would also clearly demonstrate to staff how the gathered survey data is being utilised. Studies have proven that successful organisations source 80% of solutions from their frontline staff.

What Managers should focus on:

- Prior to your meeting, take time to review your results and identify key findings.
- Circulate the data report amongst your team to provide them with some time to think about the results and formulate their input, ideas and/or questions.
- At the meeting, set the scene:
- Provide your team with an overview of the engagement survey process
- Share organisation-wide and team results.
- Discuss the team results and encourage comments and discussion from all team members by exploring open-ended questions – see samples below.
- Apply a bottom-up approach; remember "Your Voice - He Kūpu Kōrero" is about understanding context and input from an employee point of view.

Sample questions to explore with your team:

- What surprised you in the results?
- What is your take on the survey results?
- What are we doing well? What's not going so well?
- What are we most neutral about? Can we try to understand why?
- What are our biggest improvements? Where could we improve?
- What initiatives could be implemented?

What the team should focus on:

- Read the report distributed by your manager and think about the results.
- Be open to discussions and provide open and honest feedback on the team results.
- Think about high impact areas to focus on – the next step (See Step 4) will be to then identify the 3-4 critical goals the team believe would have the biggest impact on their engagement.
- As a team, set team expectations for next steps, participate and commit to follow-up.

Step 4: The Top Three (End of November, Year 1)

Reach consensus within your team about the three most important goals which could enhance your team engagement for the next year. Action planning as a team is about asking the question: "What can our team focus on to make things better during the next year? You can also use the tool in Appendix A to focus on specific engagement drivers which you believe to be important for your team according to your survey results.

What Managers should focus on:

- Brainstorm with your team and focus on high impact areas which you as a manager, individuals, the team or the organisation, can influence.
- Explain that engagement is a process and not an event. We will continue to learn and refine our engagement processes while we travel down this road.
- As a manager, you should act as a moderator/facilitator and guide the discussion to maximise the action-planning meeting. To better facilitate and engage your team, review your team's engagement results in advance and prepare some open-ended, high-value questions from these results. Here are a few examples:
  - How do you think we can improve on "X" dimension?
  - How could we work as a team to address this issue?
  - How could making a change here improve our team results?
- Empower your team to come up with team-based solutions by stepping back and listening. Refrain from judging their input. Remember to encourage participation from less vocal team members or probe for details when team members seem to be avoiding an issue or not addressing potential root causes.
- Ensure there are clearly defined goals to improve overall engagement for your team:
  - Allocate the responsibility to someone in the team, to update and maintain information in the Engagement Action Plan Report (excel spreadsheet) in the red section. This person needs to record and coordinate the Engagement Action Planning decisions and provide progress reports for subsequent meetings and their HR or OD Business partner.
  - Ask your team to prioritise the **three most important goals** for increasing engagement. What's most important according to the survey results and the context of their conversations? What needs to be addressed first?
  - Capture the top three goals through consensus and agreement with the team, in the red goal sections within the engagement action planning spreadsheet.

What Teams should focus on:

- Focus on the high impact areas to address from the engagement survey by placing it in a ranking order.
- Agree and confirm the top three priority goals which would enhance team engagement. Everyone should feel involved and accountable for these goals.
- Keep it simple and choose only three goals to start with. If the team believe these three goals were addressed they can move down their list of important goals and add these to the spreadsheet later in the year.
- Review these goals regularly to check progress and make any necessary changes.

A goal will be something that:

- Has a strong impact on employee engagement
- You or your team are willing to put resources behind (effort, time, people)
- Something you or your team can impact – not something that relies on another team or individual to do
- You as a manager feel optimistic about addressing and getting employees behind
- Where possible, is aligned with your broader team or directorate goals and objectives.

Consider using a SMART approach.

- **S**pecific: Can you define the steps required to reach the goal?
- **M**easurable: How will you measure progress? How often do we need to track progress?
- **A**chievable: Is this something you have control over?
- **R**elevant: Does it relate to the issue at hand? Are we sure that this action is relevant and relates to a wider organisational goal? If so – what does this action link with?
- **T**ime-Based: What is your target date for this goal/action step? Is it an achievable timeframe?

Remember – successful goals/action steps have the following:

- Accountability: Identified clear owners of the actions
- Time-focused: Dates for progressing (by when) and Review Periods (start/end dates)
- Aligned actions to team needs and goals and feedback
- Clearly define the resources needed to implement
- Do not fall into the trap of over complicating your plans. Put something into action and refine it as you go. The most important aspect is for the organisation, managers and teams to have these conversations and ultimately identify the central themes as well as the things we are able to influence.
- Quarterly reports can help to track, monitor and celebrate achievements in engagement action plans.
- Improvement is a journey, not an event. Review and follow up to ensure you are meeting your action milestones, which, in turn, should result in actual improvements in next year's survey results

Step 5: Rules of Engagement (End of March, Year 2)

What Managers should focus on:

- Lay down the ground rules (frequency of meetings, participation). Everyone on the team should be on the same page with respect to expectations and norms for action planning conversations.
- Revisit these rules every few months to ensure everyone is getting the most out of these conversations.
- Establish regular times to catch-up and talk about engagement, e.g. standing point on meeting agenda's.
- Allocate the responsibility to someone in the team, to update and maintain data in the engagement action planning excel spreadsheet; this person would also be able to generate progress reports for catch-up meetings and submission to HR.
- Connect with your HR Business Partner or OD Business partner if you have questions or concerns around reporting.
- Agree who in the team will do what, and by when.
- Explore what every person on the team is willing to do about the team's engagement.
- Agree on how members will contribute and act during action planning conversations. Encourage the team to come to these conversations with an open mind and willingness to participate.
- Establish regular times to catch-up and talk about engagement. This could be on a one on one basis with your manager or as a team.
- Record and maintain an updated version of your rules of engagement in the purple section of the Engagement Action Plan Report.

What Teams should focus on:

- Participate and share your ideas and thoughts.
- Always present constructive behaviours and input.
- Demonstrate respect towards others during conversations and interaction.
- Be present.
- Seriously consider your contribution to make a difference to agree activities and goals.
- Honour your commitments to your manager and the rest of the team.

Step 6: Circle of Influence and Control (End of March Year 2)

The circle of influence is our primary methodology to identify action steps to achieve our three top engagement goals. This is the most important part of the engagement action planning and should be recorded in the light orange section of the Engagement Action Plan Report.

The principles that would guide our action planning conversations are:

- Survey results are about feelings; action planning is about behaviours.
- Changes can only occur when you identify the behaviours that lead to feelings—the goal is to identify behaviours, which have led to negative feelings, and behaviours that will lead to positive feelings.
- Solutions should come from your team; an action plan can only be successful if your team believes in it—let them offer the best approaches to improvement. This is therefore a bottom-up approach.
- Employees might avoid giving you honest, useful feedback. An action plan can only be successful if your team believes in it—let them work together to determine the best approach to improvement.
- If the issues in need of attention include feedback or discussions about your management style, be open and gracious in receiving this feedback and mindful of not acting defensive. If you believe this to be to challenging, park that particular action step and involve your HR or OD Business Partner to unpack this in a safe and dignified way which is comfortable for you. If you feel you would benefit from some additional advice or guidance always feel confident to reach out to your HR or OD Business Partners.
- If the issues in need of attention are not about you (supervision), you might consider being involved, but recognise when to leave the process. Facilitate the discussion, mostly listen and guide the group back on course if they get far off-topic, and encourage less vocal team members to make suggestions without putting them on the spot.

The Circle of Influence and Control is a tool created by Stephen Covey. We use this to help you and your team look at all the things that are important to you. It may also illustrate that at times we have more power than we realise over things, which feel, out of our control. This exercise is also helpful to paint a clear picture that all of us have a role to play - the organisation, the manager, the team as well as individual employees.

The aim of Circles of Influence and Control, and the resulting conversations, is to help people take responsibility for their concerns about work, and thus be more proactive, productive and happier. It would also enable us to label what commitments need to be pursued by the organisation, manager, team and our individual staff members.

Here is an example of how to run the exercise – it is best to do within a group setting:

1. Once you have identified and agree on your critical three engagement goals that would be most meaningful to uplift engagement in your team, you would need to decide what action steps to take to achieve each goal.
2. On a large sheet of paper, draw a big circle; this is the Circle of Concern.
3. Layer the circle as follow:
    - Put the core goals for you team in the core of the circle
    - Draw a bigger circle around the core and label it “me”

- Draw another bigger circle around the core and label it "my team"
- Another bigger circle around the core called "my manager"
- Final and biggest circle to be named "MDHB"
- Outside the circle is the environment or context in which we must operate and can refer to things such as the Ministry of Health, Budget, legislation, Medical schools and colleges, MECA's. These are all factors affecting our daily business, but would mostly be outside of our immediate control or much harder to influence.

4. Facilitate these discussions by asking your team:
   - What can I do to contribute to this goal?
   - What can the team do to improve this goal?
   - What can our manager do to support efforts towards this goal?
   - What can the organisation do to back this goal?
   - What may be outside of the organisation's immediate control?
5. Get your team members to write possible action steps to pursue each of your three engagement goals on sticky notes. Ask them to be open-minded and think of as many things they can, even if it is aspirational in nature.
6. Ask your team now to allocate their ideas for action steps within the appropriate circle. You may require a circle for each goal if you have a large team. There may be many things to do and you would want to capture all of the ideas.
7. When they are done, discuss these ideas and reach consensus on the most important and do-able action steps for your team. Ask your engagement lead to capture the agreed action steps under each goal in your excel spreadsheet (the light orange section). There is a dropdown under the cell called influencer, ensure to label these in accordance with your discussion. This data will be analysed at an organisational level to inform our people plans and strategies in areas which the organisation needs to look into. The excel spreadsheet would be your reporting mechanism on engagement action planning.

You may uncover some ***challenging conversations*** or disagreements amongst the team when trying to encourage participation during action planning conversations. Some team members may show a level of disinterest or choose not to participate at all. They may feel that they did not complete the survey out of distrust, feeling that nothing will be done. If this happens, refrain from being defensive, and explore why they feel that way? They may or may not feel comfortable to share their thoughts, and that is ok.

Ensure that you take some time to read the FAQ's concerning engagement. It would enable you to respond to most of the points raised and it would be very educational to build confidence in the organisational engagement processes. It is also fair to acknowledge that this is the first time that the organisation is going down a pathway of engagement action planning and that the data is used to inform our people plans He kura te Tāngata – A Plan for our people. This is however, not common knowledge and not very transparent to most of the organisation. Through the engagement action planning process, we intend to have everyone more directly involved in conversations to inform the quality of organisational decision making in reference to our people plans and processes.

Mentally prepare yourself to stay completely open and receptive of both negative and positive feedback. When action planning, you may encounter disagreement of results or actions should be taken. Even though difficult, a robust discussion shows engagement and that your team care about what happens. **Use the tool in appendix B to assist in guiding final team consensus.**

Please talk to your HR or OD Business partner if you have any questions in relation to this exercise. Below are some more tools to support your 'Circle of Influence' conversations, intended to assist in identifying goals or action steps.

Step 7: Action Plan and Reporting (Engagement action plan due by March Year 2 and quarterly progress reports due by June Year 2, Sept Year 2 and December Year 2 and March Year 1)

Action Steps for Managers:

- Complete Engagement Action Plan Report template, first tab by the end of March to ensure you record the content of your conversations and enable the OD department to analyse the information for people planning purposes. You can access the template here. Colours of the template matches with the step colours for easy reference.
- Complete the four quarterly reports on the alternative tabs to monitor progress and launch new goals if you are ready. A minimum of three goals are expected to be pursued per engagement cycle.
- Connect the agreed activities and goals agreed to in the engagement action plan, decisions and staff participation into one-on-one performance conversations.
- You will need to report on your action plans on a quarterly basis. Quarterly report templates are available via your OD or HR Business Partner.
- Ensure you have identified a coordinator who would be able to capture the data in the report template and would be able to present progress updates and feedback during meetings as agreed.
- Be sure to review action steps you have implemented and share information you are yet to implement with your team and OD or HR Business Partner.
- The 4th quarterly report will be followed by the launch of the two-yearly survey and will restart the engagement process at step 1.

Appendix 1: Tool One – deep dive into engagement drivers

If you believe you need to focus on specific areas based on your team engagement survey results, the below cards relates to questions to explore specific index conversation points. These relates directly to each engagement driver on the on the He kupu korero engagement survey:

How to use these cards

As a team

Review the questions in each section

For good results

- What is it about how we work, that makes this a strength for us?
- How can we learn from this? How else could it be useful?

For areas of concern

- Why might this be happening? What underlying factors cause it?'
- What can we do about it as a team? What's in our sphere of influence to change? What is 'up to us'?.

As a leader

- What could you do differently?
- How can you role model the changes the team need?

Direction & purpose

When people find meaning in their work, understand what's expected of them, and see that in others too.

Discussion points

- Are we clear about what's expected of us – individually and as a team?
- Do our individual objectives help to meet the team's objective?
- How could we be clearer about our expectations of each other?
- How can we be more positive about what we are doing?

Studies have shown that managers can increase engagement by setting challenging SMART goals. [1]

Contribution & control

When people are able to develop their skills, strengths and ideas and put them to good use.

Discussion points

- Do we know what each other's strengths are in the team?
- Do we know what skills or areas our colleagues want to develop?
- How we can we help each other to do our best work?
- How can we nurture more ideas?

Gallup research shows people whose managers focus on their strengths are twice as likely to be engaged as people whose managers focus on their weaknesses. [2]

Recognition & value

When people feel respected for who they are, and that their efforts are noticed and valued.

Discussion points

- Have they had experiences recently where they weren't respected?
- What recognition or appreciation have people received recently?
- How do we want to recognise each other's good work or efforts?
- What specifically would we like to notice and appreciate in the team?

The Harvard Business Review says successful teams receive five times as much appreciation as criticism. [3]

Wellbeing

When people feel safe from poor behaviours, and that their work contributes to their wellbeing.

Discussion points

- Have members of our team been bullied recently? We don't need to know who it is. But what could we do to help or support them?
- Are there behaviours we've seen in our team that we want less of?
- How can we support each other when things are really busy?
- How can we make it feel safer to 'speak up'?

A BMJ article showed rude or bullying behaviours make patient safety errors much more likely to happen. [5]

Connection & support

When people feel a good sense of teamwork and support in their team, with other teams and from leaders.

Discussion points

- What does a 'real team' look like? What support do we want from each other?
- Do we know what other teams want from us? How could we change how we work with them?
- Do we get what we need from other teams? Have we told them what we need from them?

In an NHS study, a 5% increase in team-working scores in staff surveys correlated with a 3.3% fall in mortality rates. [4]

How to use these cards

As a team

Review the questions in each section

For good results

- What is it about how we work, that makes this a strength for us?
- How can we learn from this? How else could it be useful?

For areas of concern

- Why might this be happening? What underlying factors cause it?'
- What can we do about it as a team? What's in our sphere of influence to change? What is 'up to us'?.

As a leader

- What could you do differently?
- How can you role model the changes the team need?

Our values

When we consistently experience colleagues, managers and leaders behaving and making decisions that are aligned to our values.

Discussion points

- Which one of our values do we experience most consistently? How does that help us?
- Which one of our values are we not experiencing as much as we'd like? What behaviours do we experience instead? Is this from other teams or from each other?
- Which of our values could we as a team more consistently live up to?

Our staff values of Compassion, Courageous and Respectful help define acceptable behaviours.

Safety Culture

When we have the correct attitude towards workplace safety and sufficient procedures in place to protect staff and patients from harm.

Discussion points

- How do we currently approach workplace safety? Is it a priority?
- How can our work practices and habits potentially impact on safety? Either directly or indirectly?
- Do our procedures adequately ensure safety is not compromised and are they followed sufficiently?
- What can we do to ensure safer practice?

Addressing Safety Culture is an important component of overall Culture and can help aid change[6]

Appendix 2: Tool Two – Extracting the vital few

This tool is to assist you with a framework to reach consensus in your team to identify either the top three goals or the most significant action steps.

IMPACT

HIGH IMPACT, EASY TO IMPLEMENT	HIGH IMPACT, HARD TO IMPLEMENT
Focus your efforts on these actions to ensure your action plan is realistic and impactful	*These are your long term actions which might be higher investment but are worthwhile improvements*
LOW IMPACT, EASY TO IMPLEMENT	**LOW IMPACT, HARD TO IMPLEMENT**
These are your 'quick wins' and are important in creating a sense of momentum in taking action quickly after the survey	*These are the actions you can drop from your list, they may involve you wasting effort and investment*

EFFORT

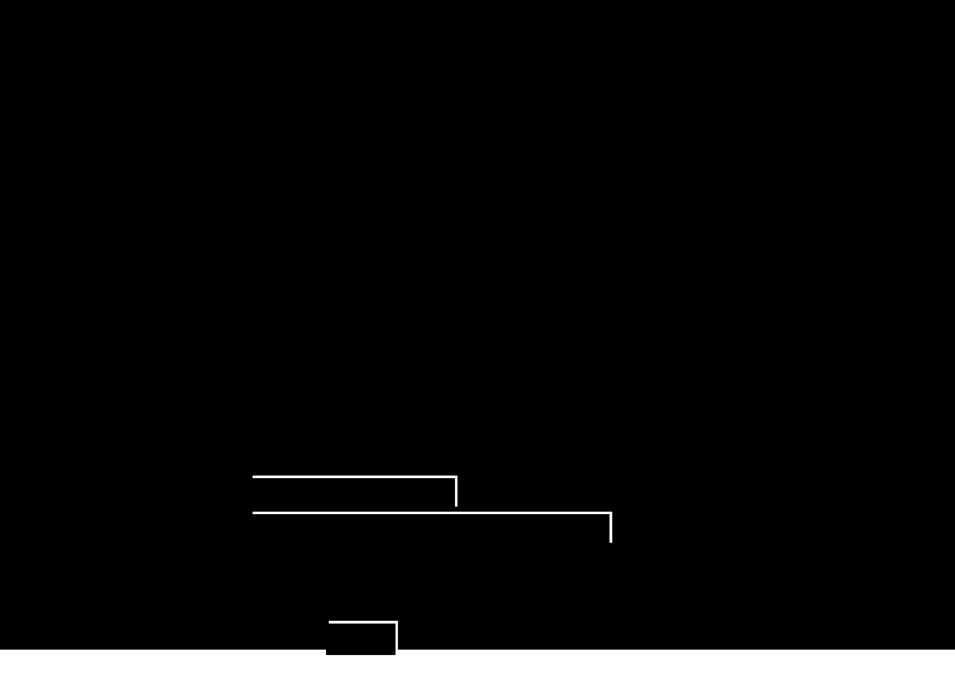
The objective

At the end of this exercise, we are looking to have narrowed down our actions to a targeted list that we take forward.

High Impact, Easy to Implement; The majority of actions taken forward should be within this quadrant.

High Impact, Hard to Implement/Low Impact, Easy to Implement; Including an action from one of these quadrants can help to either maintain momentum or tackle a long term objective.

Low Impact, Hard to Implement; These are actions you should not be taking forward.



We are in receipt of your Official Information request dated 24 July 2021.

You advised that you would like the following information as stated below:

1. Information from MidCentral DHB in conjunction with mental health service provision between the dates of 31 March 2021 - 30 June 2021 inclusive:

   a. the total number of patients referred to for assessment
   b. the number of urgent referrals received by the DHB
   c. the number of individuals who experienced an adverse event prior to assessment, and the nature of that event
   d. the number of individuals who are assessed by a service and subsequently have had adverse event outcomes within 24/48/168 hours of assessment; the nature of those adverse events and patient status at the time of the event

In response to question 1a. the total number of patients referred for assessment during this time was 1,030. In response to question 1b. the number of urgent referrals during this time was 372 which is made up of a total of 347 Immediate referrals and 25 Urgent referrals.

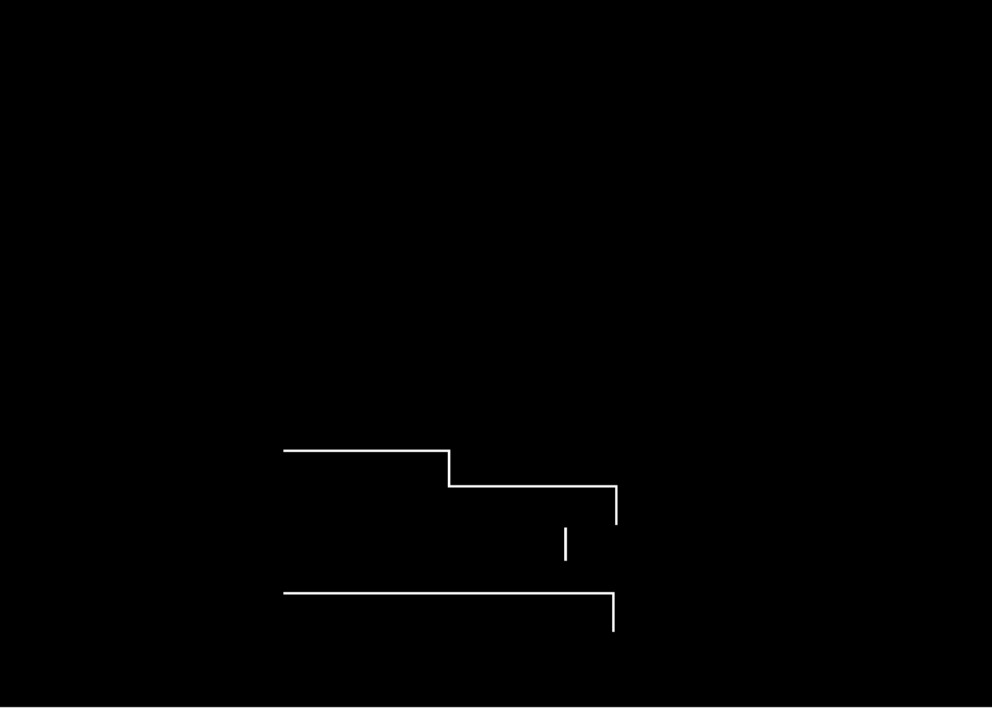
Regarding questions 1c. and 1d., MidCentral DHB does not keep this information and therefore cannot provide it.

You have the right to seek an investigation and review by the Ombudsman of this decision. 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 response, may be published on the MidCentral DHB website ten working days after your receipt of this response.

Yours sincerely

Vanessa Caldwell
Clinical Executive
Mental Health & Addiction Services



Dear

Official Information Act (OIA) request – Y21-1153 children in care admitted to hospital

Thank you for your request for information dated 2 August 2021. Your email has been acknowledged and passed onto me for a response.

You have requested MidCentral District Health Board (MDHB) provide you with information to the following questions:

What is the DHB's policy regarding children in care being a. admitted to hospital and b. admitted to hospital in lieu of a care placement?

There is no MDHB hospital policy relating to either of these situations

Are children in care admitted to hospitals if placements cannot be found?

This is not usual practice at MDHB, however may occur in exceptional circumstances.

How many children in care are currently in hospital in the DHB?

Unfortunately, MDHB does not hold the information you have requested. I am therefore refusing your request under section 18(g) of the OIA.

Are there any children in care currently in hospital?

Unfortunately, MDHB does not hold the information you have requested. I am therefore refusing your request under section 18(g) of the OIA.

Please provide figures for the past 5 years showing the number of children in care admitted to a DHB hospital, length of stay and reason for being admitted to hospital.

Unfortunately, MDHB does not hold the information you have requested. I am therefore refusing your request under section 18(g) of the OIA.

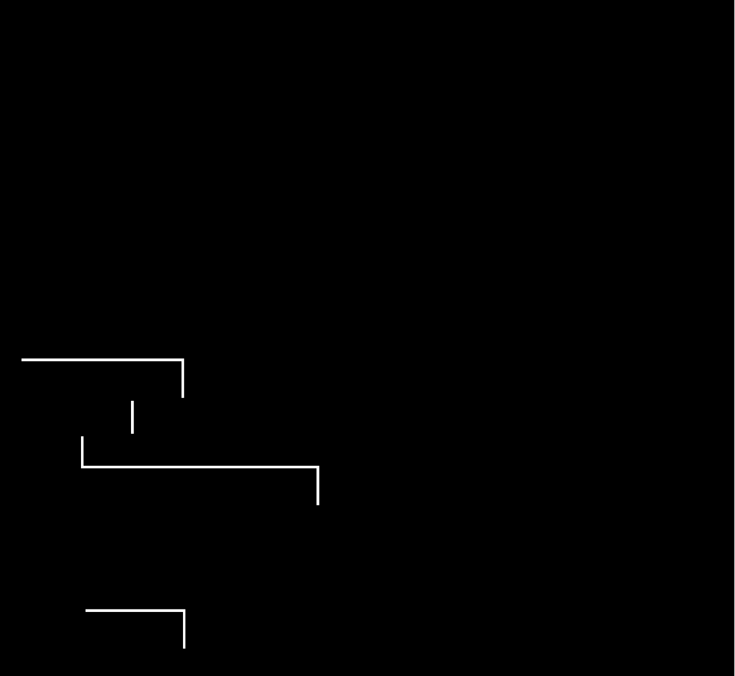
You have the right to seek an investigation and review by the Ombudsman of our decision. Information about how to make a complaint is available at www.ombudsman.parliament.nz or freephone 0800 802 602.

Please note that this response, or an edited version may be published on the MDHB website ten working days after your receipt of this letter. Please let me know if you have any objections to this as soon as possible

I hope this information is what you require.

Yours sincerely

Sarah Fenwick
Operations Executive
Te Uru Pā Harakeke
Healthy Women Children and Youth



Official Information Act Request: Y21-1154 Regarding MDHB Pharmacy Staff Seconded to COVID-19 Vaccination Programme

The information below is in response to your Official Information Act request dated Monday 02 August 021.

Your request was as follows:

Pursuant to section 12 of the Official Information Act 1982 the Association of Professionals and Executive Employees requests the following information:

1. *The number of Pharmacy employees at your DHB that are currently seconded to the COVID-19 Vaccination Programme and what their profession is (e.g. Pharmacist, Pharmacy Technician, Pharmacy Assistant etc.)*
2. *What they were paid prior their secondment and what they are currently paid under the Covid Vaccination Programme.*

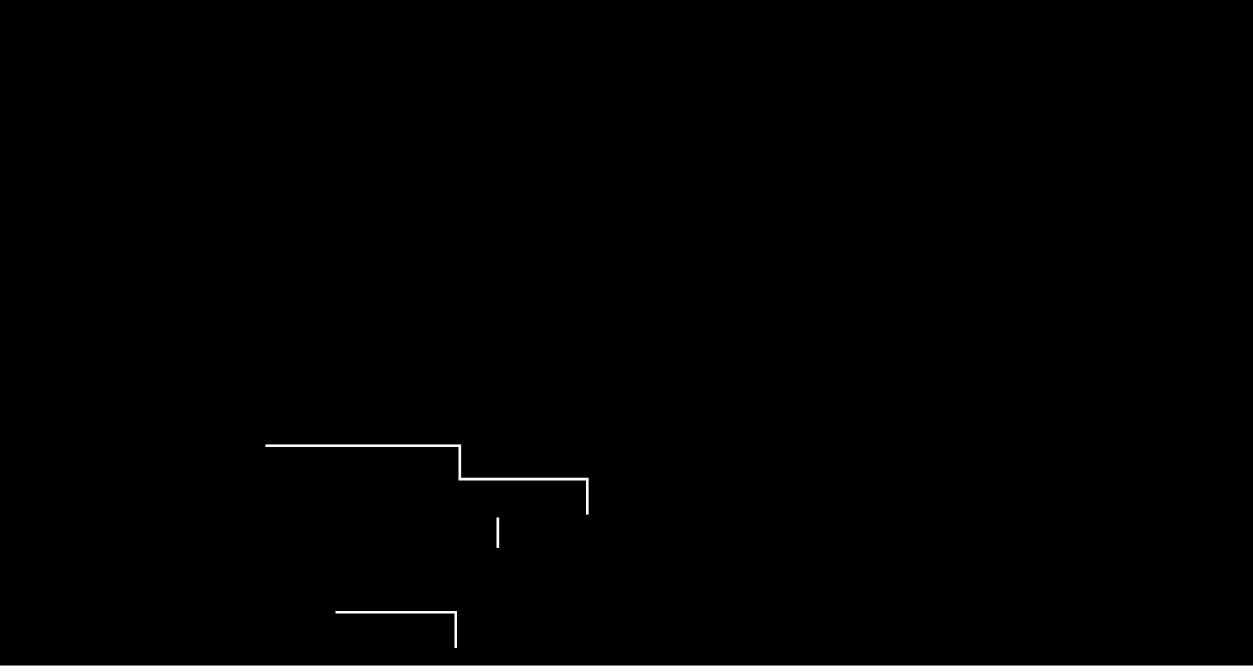
I can confirm that MidCentral District Health Board currently do not have Pharmacy employees seconded to the COVID-19 Vaccination Programme. Question two is therefore not applicable.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website ten working days after your receipt of this response.

If you are not satisfied with our response to your information request, you have the right to seek a review by way of complaint by the Ombudsman of your decision. Information about how to make a complaint is available at ww.ombudsman.parliament.nz or freephone 0800 802 602.

Yours sincerely,

Deborah Davies
Operations Executive
Te Uru Kiriora, Primary Public and Community Health



OIA request – OPCAT reports of secure aged care facilities
Our Ref: A08-39

In reference to your official information request dated 9 August 2021 for any correspondence, both internal and external, since 2020 and regarding any inspections of aged care facilities carried out in relation to OPCAT, and any documentation or reports related to any such inspections.

In March 2020 a link was shared with DHB's sent by the TAS Project Manager Health of Older person https://mailchi.mp/ombudsman.parliament.nz/aged-care-inspections-programme-update-3821889 advising of the inspection programme.

In April 2020 HealthCERT Manager for Quality Assurance and Safety provided an update from the Chief Ombudsman copy attached. An OPCAT aged care inspections programme was received in August 2020. Copy attached.

In the 2 March update, the Ombudsman stated that the OPCAT teams would be directly contacting each facility. *As these are orientation visits, not inspections, we are not producing individual reports on, or making recommendations to, facilities as a result of these visits. And, for the same reason, we will not be publishing our visit schedule nor are we identifying any individuals, facilities or resultant themes from these visits.*

MidCentral District Health Board (MDHB) was not notified or received any correspondence from the Chief ombudsman's OPCAT team regarding any dates for inspections to be carried out in secure aged care facilities in the MDHB area in the period 27 May 2020 and 18 June 2020. MDHB has not received or holds any OPCAT reports or recommendations about any individual facility.

Healthy Ageing and Rehabilitation
MidCentral Health, Private Bag 2056, Palmerston North 4440
Phone 06 350 8825

Yours sincerely

Lyn Horgan
Operations Executive
Healthy Ageing and Rehabilitation

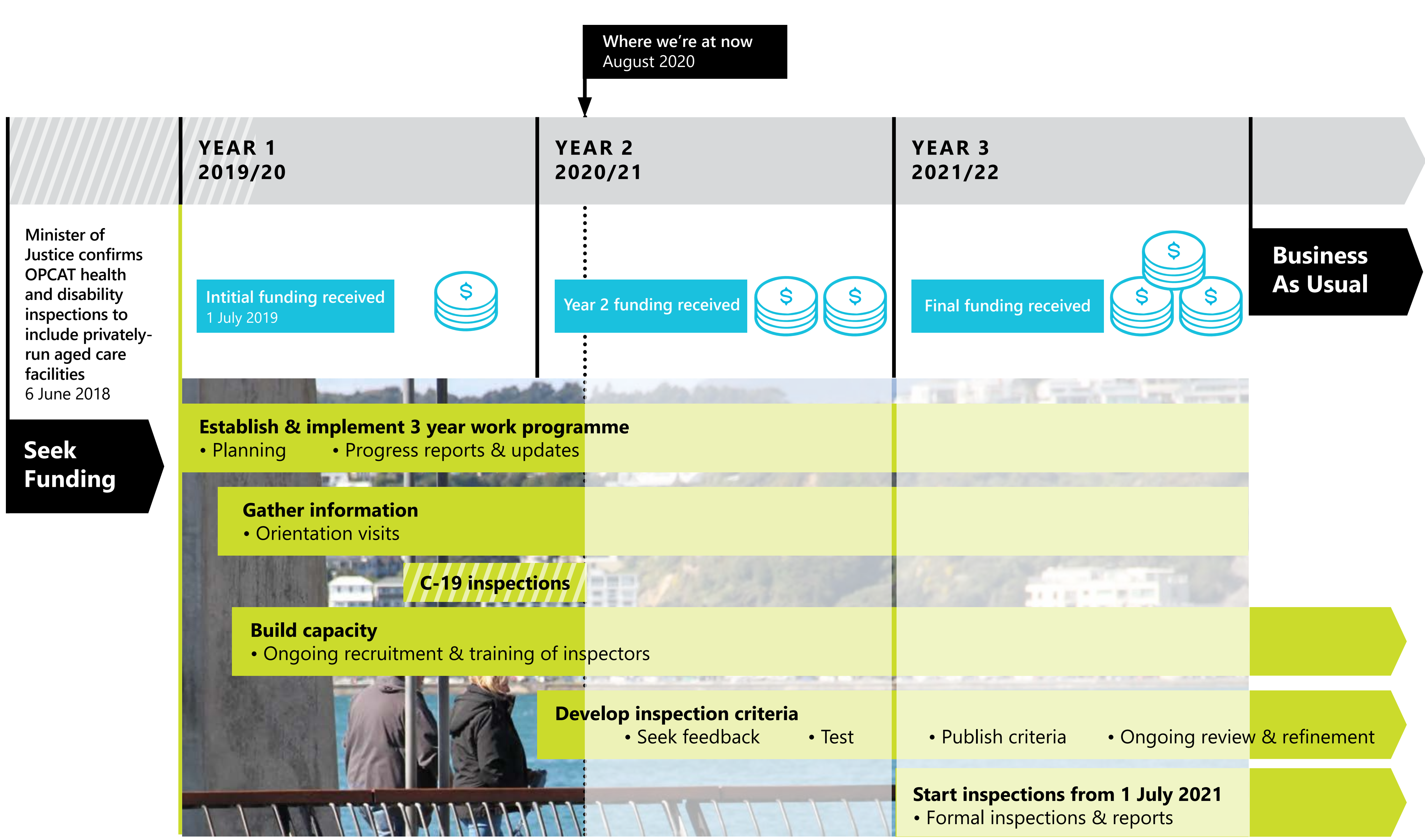
Appendix

Latest update on the Chief Ombudsman's Aged Care Inspections Programme 15 April 2020

OPCAT Aged Care Inspections Programme: A three-year programme of work

OPCAT aged care inspections programme:
A three year programme of work

AUGUST 2020



From:	Ruihua.Gu@health.govt.nz
Sent:	Wednesday, 15 April 2020 12:29 p.m.
To:	Quality_Assurance_and_Safety_-_HealthCERT_Team@health.govt.nz; DHB_Contacts_-_HOP_Portfolio_Managers@health.govt.nz
Subject:	FYI: Ombudsman's Aged care inspections programme: Update

Ruihua Gu
Manager
HealthCERT
Quality Assurance and Safety
Health System Improvement and Innovation
Ministry of Health
DDI: 04 4962298
Mobile: 021347098

http://www.health.govt.nz
mailto:Ruihua.Gu@health.govt.nz

----- Forwarded by Ruihua Gu/MOH on 15/04/2020 12:28 p.m. -----

From: "Chief Ombudsman" <communications@ombudsman.parliament.nz>
To: "Name" <Ruihua.Gu@health.govt.nz>,
Date: 15/04/2020 12:24 p.m.
Subject: Aged care inspections programme: Update

Latest update on the Chief Ombudsman's aged care inspections programme.

View this email in your browser

15 April 2020

Kia ora

I am writing to give you an update of how the Chief Ombudsman Peter Boshier intends to carry out his OPCAT role in regards to privately-run aged care facilities during this COVID-19 pandemic.

On 1 April 2020, the Secretary for Justice designated the Chief Ombudsman's OPCAT role to be an 'essential service' as Mr Boshier must make sure that the use of extraordinary measures do not have an unnecessary or disproportionate impact on the rights of people in detention.

He has also seen reports of families and whānau asking for assurance about their how their loved ones are being cared for as they cannot visit and see for themselves under present circumstances.

You will be aware that prior to the pandemic, Mr Boshier did intend to continue with orientation visits until he started formal inspections from July 2021. However, in the current circumstances he has now reset his programme and will introduce a limited inspection programme of secure aged care facilities, starting at the end of this week.

To minimise any disruption, these inspections will be announced to the facilities concerned in advance. The

inspection teams with be small and focused on COVID-19 issues. Individual facilities will be notified at least 48 hours ahead of these inspections and they will be asked in advance for relevant information, including a copy of the facility's health and safety protocols.

Inspectors will be using protective equipment when visiting facilities and will have regard to the Ministry of Health's COVID-19 health and safety guidance, and any health and safety protocols the facility itself has in place.

Following the inspection, the team will raise any initial issues immediately with the person in charge of the facility. A report on the Chief Ombudsman's COVID-19 inspections will be published in due course. Individual residents and staff will not be identified in this report.

Prisons, mental health facilities and other places of detention are also covered under the Chief Ombudsman's mandate and will be part of a similar inspection programme during the present pandemic. Mr Boshier intends making a public announcement on his plans shortly. The Director-General of Health, the Prime Minister, the Minister for Seniors and the Associate Minister for Health have been similarly advised of Mr Boshier's plans. Further information will be on his website soon.

Hei konā mai

.

Emma Leach
Assistant Ombudsman Compliance & Practice

BACKGROUND INFORMATION
New Zealand is required to have independent inspections of 'places of detention' under a United Nations Convention, to ensure people are being treated humanely.

The Chief Ombudsman is one of the independent inspectors in New Zealand. The Chief Ombudsman has a prevention focus, to make sure facilities have sufficient safeguards in place to prevent any human rights violations. If not, he recommends practical improvements to address any risks, poor practices, or systemic problems.

On 6 June 2018, the places to be inspected by the Chief Ombudsman were extended by the Minister of Justice to include people detained in privately-run aged care facilities.

Parliament gave the Chief Ombudsman funding which is progressively available from 1 July 2019, to develop and implement this new inspections programme over the next three years.

For any concerns or complaints about the provision of aged care services, first check out the Ministry of Health's website.

Office of the Ombudsman
0800 802 602 (+64 4 4739533)

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****

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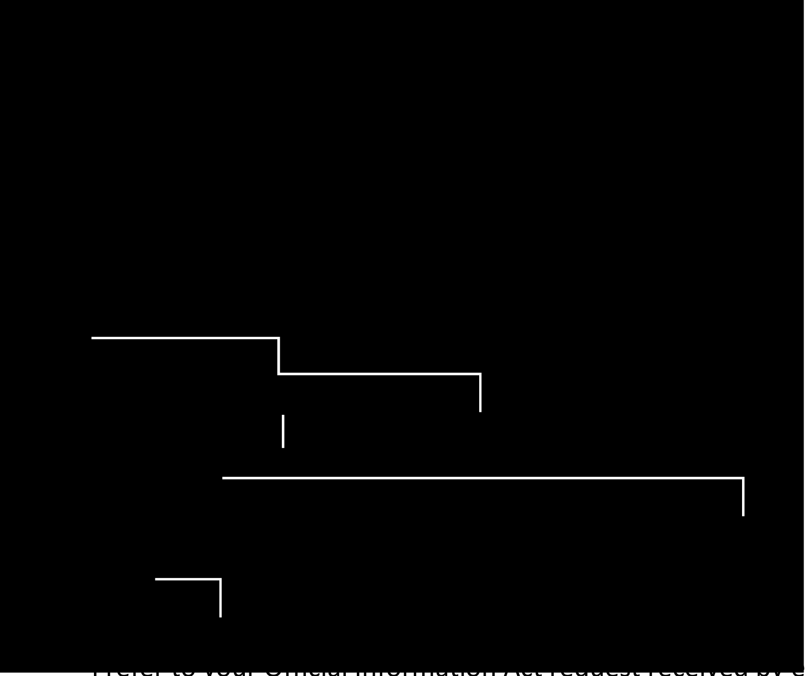


I refer to your Official Information Act request received by email on 20 July 2021 and respond as follows:

1) *Full text copies of all reports received by the DHB relating to their Information Technology Systems over the past 5 years. I understand there have been at least three such reports, but I cannot find them on the Web Site.*

   There have been many reviews, assessments and reports related to Information Technology systems and functions at MDHB over the last few years. I have asked for further specificity for the reports you seek. Through your response via the OIA office of 26 July, you have said, "*it is hard to be precise because as far as we can make out the results of these have not been discussed in any forum that we are aware of so we need to take a shotgun approach and ask for whatever there is.*" Based on that response, I have attached three such reviews undertaken on the IT systems which involved input from clinical staff. Again, if there is any specific report that you seek, please let us know.

2) *A full text copy of the recent report regarding the progress of the managerial changes involved with Integrated Service Model or Cluster System. The report was completed a few months ago and full access was promised to the medical staff but has never been delivered.*

   Upon request made via the OIA office dated 26 July, you responded that," you do not require the ISM model report as has received via ." I have therefore treated this request as resolved.

3) *Up to date figures for payments made over the last 7 years to The Francis Group of management consultants and their employees. This should include payments for their investigations into various DHB services and the reports from those investigations plus fees paid for DHB employees to attend management training courses run by the Francis Group and finally salary payments made to of the Francis Group who I understand is paid a regular salary by this DHB.*

   Before I provide you with the figures you require, I would like to provide you with some context to this expenditure.

   Francis Health offers a vast range of services, including consulting, training & development, and support across various aspects of health services across Australia, New Zealand, and the UK.

Over the years, MDHB has used Francis Health across many of these services. This includes providing input into clinical and non-clinical projects and training and development. This is publicly available within Board papers. You have also asked for copies of reports that came about from these investigations undertaken by Francis Health. In the absence of any specific report that you are looking for, I can advise that information from such reports and documents are normally provided to the Board and published on the DHBs public website. Papers for the Board and Board Committees can be accessed via Board and Committees: Governing the DHB (midcentraldhb.govt.nz). If there are any specific reports that you are looking for, please identify these and I shall endeavour to provide them to you

Since 2017, MDHB has invested in developing its second and third tier managers and leaders. Up until the time of providing this information, forty clinical and non-clinical managers and leaders have attended these training programmes. MDHBs participation in these programmes has been part of wider regional and national training initiatives and has included participation from 18 of the District Health Boards and several other health organisations. Some MDHB participants have participated in more than one course (basic and advanced leadership courses). Attendance to some of these programmes was funded by individuals on their own (usually through CME). However, given that the payment occurred via the DHB account office, these costs have been included in the information provided below. Feedback from participants attending these programmes has been overwhelmingly positive.

Francis Health have been also recently been commissioned by the Ministry of Health through an open, competitive process to co-develop a health leadership programme for the sector.

As part of reviewing the administrative function across the executive team, a role of Director of the Office of the Chief Executive was established. Recruitment to this role commenced and was advertised publicly from 17 April to 17 May 2020 via SEEK, LinkedIn, KiwiHealth jobs and the DHB's external website. No suitable applicants were identified. Around that time, the Heather Simpson report (on the Health and Disability sector) was released and a subsequent decision was made to not appoint to this role on a permanent full-time basis. from Francis Health was approached and agreed to be seconded to this role. The role provides support to both the Board and the Chief Executive's Office. Francis Health provided support to improve the reporting processes and dashboards for the DHB.

The table below provides details of all payments made to Francis Health by the DHB. The payments have been grouped together to align with the context provided above and include travel and other disbursement costs.

	Coaching, Mentoring and Staff support	Consultancy Services Clinical	Consultancy Services Non-clinical	Support to CEO's office and Board processes	Non-Clinical Training and Development	Grand Total
16/17		12,825				**12,825**
17/18	34,560	863,678	36,273		63,250	**997,761**
18/19	18,950	115,062	783,637		3,300	**920,949**
19/20	78,075		42,421		2,450	**122,946**
20/21	52,620	61,300	51,100	291,813	29,893	**486,726**
Total	**184,205**	**1,052,865**	**913,431**	**291,813**	**98,893**	**2,541,207**

For some context, the total expenditure on Francis Health equates to approximately 0.05 percent of the DHB's budget over that period, and 0.16 percent of the CME Budgets.

Please let me know if you need any specific information.

Please note that this response, or an edited version of it, may be published on the MidCentral DHB website ten working days after your receipt of this letter.

Yours faithfully

Keyur Anjaria
General Manager
People & Culture

HIMSS assessment

Health Information Systems Society

Introduction HIMSS assessment

- HIMSS international organization, vendor agnostic, performs assessments against standards which focus on differing aspects of Health Information Management. Each scale is scored 0-7
- Achieving level 7 is associated with improved patient outcomes, improved financial performance and clinical staff being happy with their Digital systems.
- Basic cycle is individually the questionnaires and completed, then there is a moderation session and the final report is produced.
- MDHB has also completed reference architecture assessment of applications across the organization.
- Each DHB is completing these assessments and there will be a meeting later in the year to discuss individual results and sector implications.

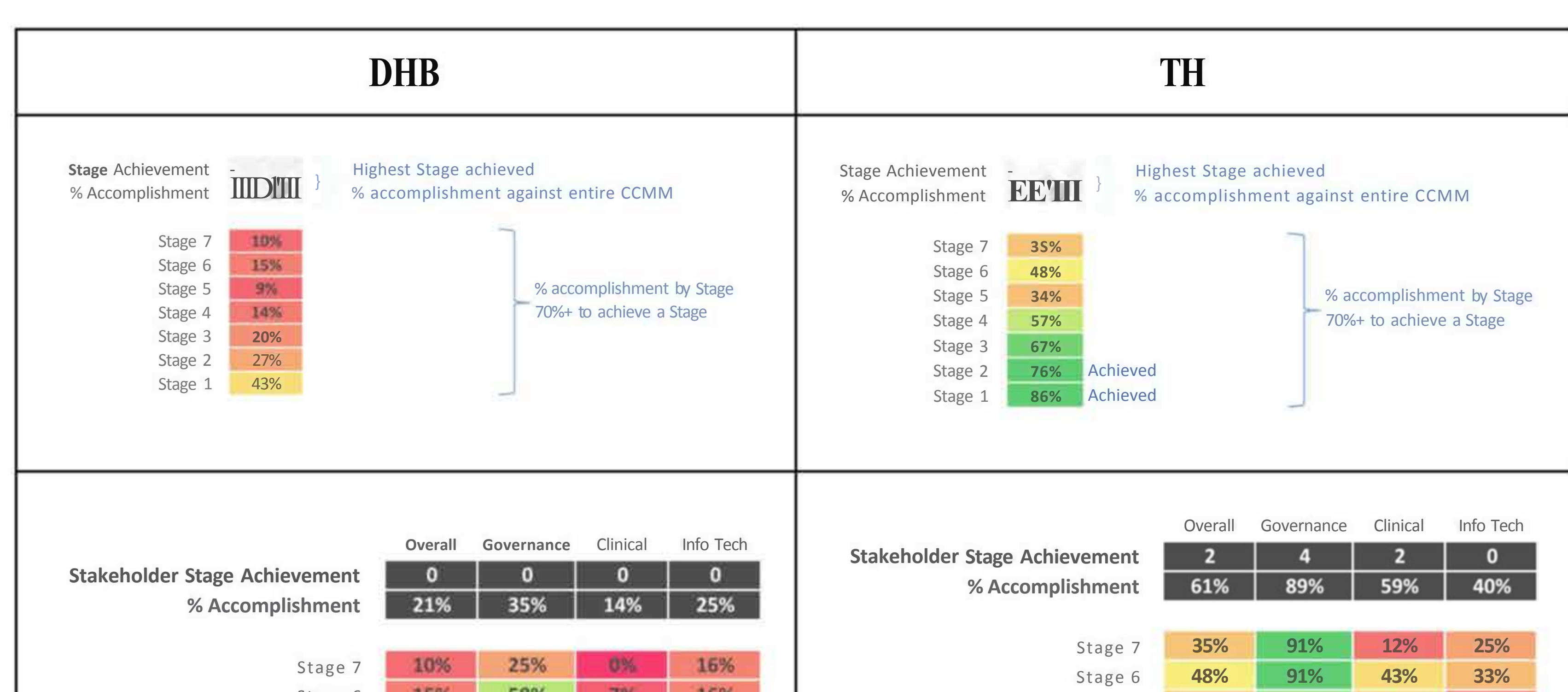
Continuity of care maturity model

CCMM - definition

HIMSS Analytics created the Continuity of Care Maturity Model™ (CCMM) to guide healthcare organisations implementing seamlessly coordinated patient care across a continuum of care sites and providers. The CCMM is a strategic framework to guide continuity of care implementation. The internationally applicable CCMM helps healthcare providers focus critical capabilities associated with coordinated patient care, health information exchange, patient engagement, and advanced analytics.

CCMM - DHB result

STAGE	HIMSS Analytics CCMM Continuity of Care Maturity Model Cumulative Capabilities
7	Knowledge driven engagement for a dynamic, multi-vendor, multi-organizational interconnected healthcare delivery model
6	Closed loop care coordination across care team members
5	Community wide patient records using applied information with patient engagement focus
4	Care coordination based on actionable data using a semantic interoperable patient record
3	Normalized patient record using structural interoperability
2	Patient centered clinical data using basic system-to-system exchange
1	Basic peer-to-peer data exchange
0	Limited or no e-communication



DHB	TH

DHB

Stage Achievement – Highest Stage achieved
% Accomplishment – % accomplishment against entire CCMM

Stage	%
Stage 7	10%
Stage 6	15%
Stage 5	9%
Stage 4	14%
Stage 3	20%
Stage 2	27%
Stage 1	43%

% accomplishment by Stage
70%+ to achieve a Stage

	Overall	Governance	Clinical	Info Tech
Stakeholder Stage Achievement	0	0	0	0
% Accomplishment	21%	35%	14%	25%
Stage 7	10%	25%	0%	16%
Stage 6	15%	58%	7%	16%
Stage 5	9%	12%	3%	18%
Stage 4	14%	37%	1%	18%
Stage 3	20%	25%	16%	28%
Stage 2	27%	36%	25%	21%
Stage 1	43%	46%	39%	46%

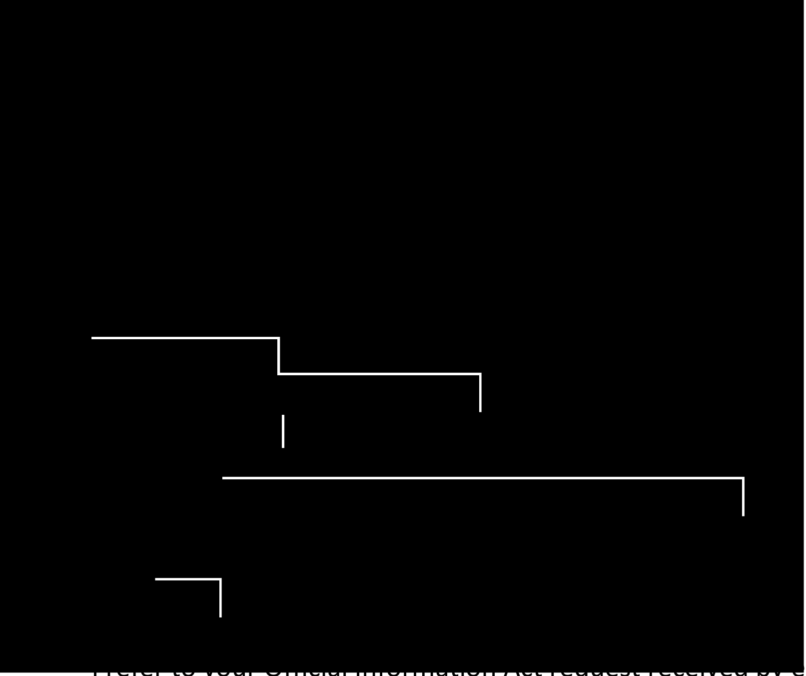
TH

Stage Achievement – Highest Stage achieved
% Accomplishment – % accomplishment against entire CCMM

Stage	%	
Stage 7	35%	
Stage 6	48%	
Stage 5	34%	
Stage 4	57%	
Stage 3	67%	
Stage 2	76%	Achieved
Stage 1	86%	Achieved

% accomplishment by Stage
70%+ to achieve a Stage

	Overall	Governance	Clinical	Info Tech
Stakeholder Stage Achievement	2	4	2	0
% Accomplishment	61%	89%	59%	40%
Stage 7	35%	91%	12%	25%
Stage 6	48%	91%	43%	33%
Stage 5	34%	62%	38%	12%
Stage 4	57%	100%	50%	37%
Stage 3	67%	87%	69%	50%
Stage 2	76%	88%	83%	50%
Stage 1	86%	96%	91%	64%



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EMRAM - DHB result

STAGE	HIMSS Analytics® EMRAM EMR Adoption Model Cumulative Capabilities
7	Complete EMR; External HIE; Data Analytics, Governance, Disaster Recovery, Privacy and Security
6	Technology Enabled Medication, Blood Products, and Human Milk Administration; Risk Reporting; Full CDS
5	Physician documentation using structured templates; Intrusion/Device Protection
4	CPOE with CDS; Nursing and Allied Health Documentation; Basic Business Continuity
3	Nursing and Allied Health Documentation; eMAR; Role-Based Security
2	CDR; Internal Interoperability; Basic Security
1	Ancillaries - Laboratory, Pharmacy, and Radiology/Cardiology information systems; PACS; Digital non-DICOM image management
0	All three ancillaries not installed

A progressively sophisticated roadmap that enables …

Quality, safety, and Operations efficiencies

O-EMRAM - DHB result

HIMSS Analytics O-EMRAM

Outpatient EMR Adoption Model Cumulative Capabilities

STAGE	Outpatient EMR Adoption Model Cumulative Capabilities
7	Complete EMR: external HIE, data analytics, governance, disaster recovery
6	Advanced clinical decision support; proactive care management, structured messaging
5	Personal health record, online tethered patient portal
4	CPOE, Use of structured data for accessibility in EMR and internal and external sharing of data
3	Electronic messaging, computers have replaced paper chart, clinical documentation and clinical decision support
2	Beginning of a CDR with orders and results, computers may be at point-of-care, access to results from outside facilities
1	Desktop access to clinical information, unstructured data, multiple data sources, intra-office/informal messaging
0	Paper chart based

O-EMRAM

Outpatient Electronic Medical Record Adoption Model

Scoring healthcare clinics on the maturity of their EMR environments.

HIMSS Analytics

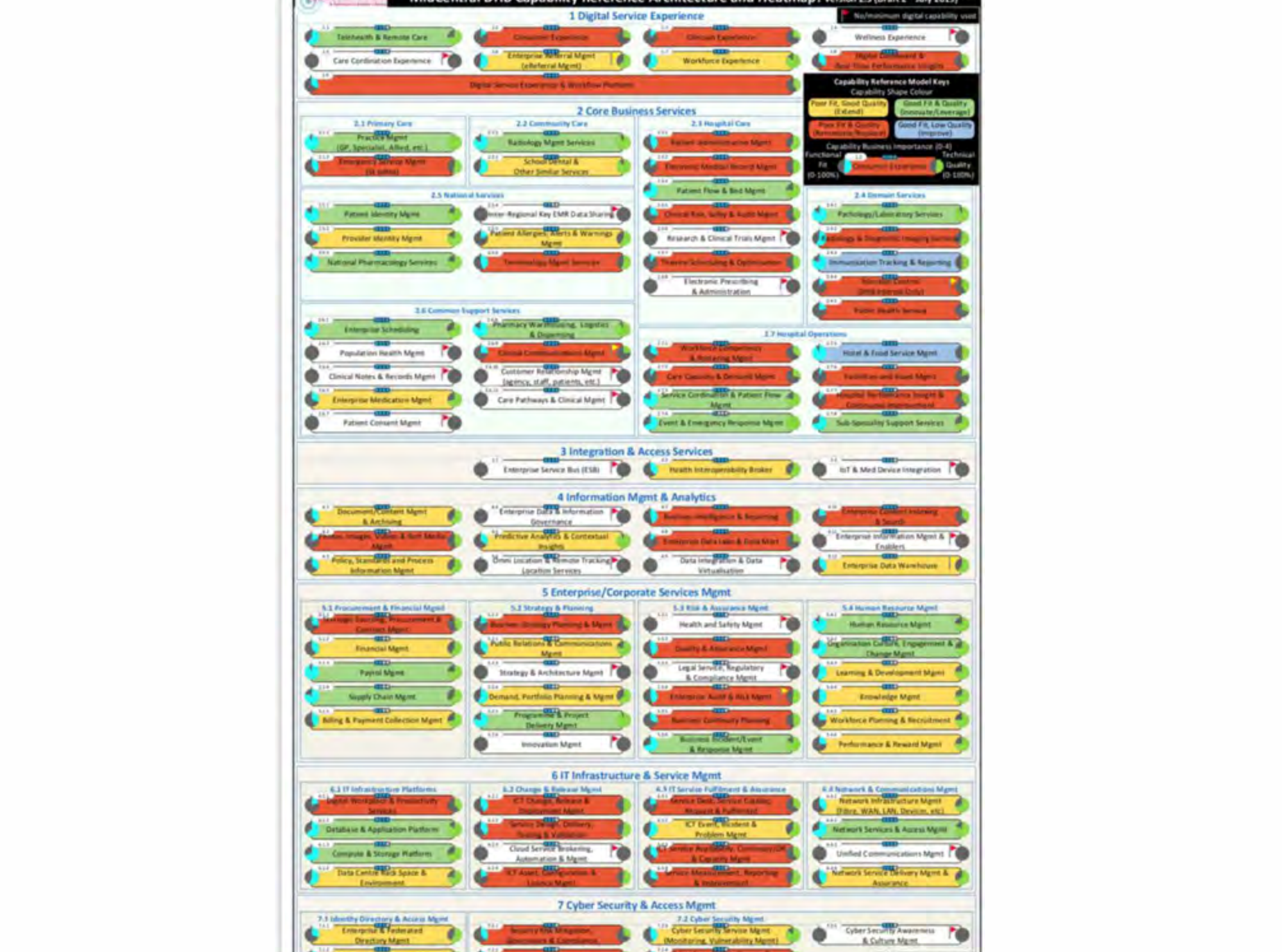
INFRAM - result

STAGE	HIMSS Analytics INFRAM Infrastructure Adoption Model Cumulative Capabilities
7	Adaptive and flexible network control with software defined networking; home-based tele-monitoring; internet/TV on demand
6	Software defined network automated validation of experience; on-premise enterprise/hybrid cloud application and infrastructure automation
5	Video on mobile devices; location-based messaging; firewall with advanced malware protection; real-time scanning of hyperlinks in email messages
4	Multiparty video capabilities; wireless coverage throughout most premises; active/active high availability; remote access VPN
3	Advanced intrusion prevention system; rack/tower/blade server-based compute architecture; end-to-end QoS; defined public and private cloud strategy
2	Intrusion detection/prevention; informal security policy; disparate systems centrally managed by multiple network management systems
1	Static network configurations; fixed switch platform; active/standby failover; LWAP-only single wireless controller; ad-hoc local storage networking; no data center automation
0	No VPN, intrusion detection/prevention, security policy, data center or compute architecture

AMAM - interim result

Adoption Model for Analytics Maturation	
STAGE 7	Personalized medicine & prescriptive analytics
STAGE 6	Clinical risk intervention & predictive analytics
STAGE 5	Enhancing quality of care, population health, and understanding the economics of care
STAGE 4	Measuring & managing evidence based care, care variability, and waste reduction
STAGE 3	Efficient, consistent internal and external report production and agility
STAGE 2	Core data warehouse workout: centralized database with an analytics competency center
STAGE 1	Foundation building: data aggregation and initial data governance
STAGE 0	Fragmented point solutions

Reference architecture - applications



MidCentral DHB Capability Reference Architecture and Heatmap: Version 2.3 (Draft 2nd July 2019)
1 Digital Service Experience
Telehealth & Remote Care
Consumer Experience
Clinician Experience
Wellness Experience
Care Cordination Experience
Enterprise Referral Mgmt (eReferral Mgmt)
Workforce Experience
Digital Dashboard & Real-Time Performance Insights
Digital Service Experience & Workflow Platform
Capability Reference Model Keys
Capability Shape Colour
Poor Fit, Good Quality (Extend)
Good Fit & Quality (Innovate/Leverage)
Poor Fit & Quality (Remediate/Replace)
Good Fit, Low Quality (Improve)
Capability Business Importance (0-4)
Functional Fit (0-100%)
Technical Quality (0-100%)
2 Core Business Services
2.1 Primary Care
Practice Mgmt (GP, Specialist, Allied, etc.)
Emergency Service Mgmt
2.2 Community Care
Radiology Mgmt Services
School Dental & Other Similar Services
2.3 Hospital Care
Patient Administration Mgmt
Electronic Medical Record Mgmt
Patient Flow & Bed Mgmt
Clinical Risk, Safety & Audit Mgmt
Research & Clinical Trials Mgmt
Theatre Scheduling & Optimisation
Electronic Prescribing & Administration
2.5 National Services
Patient Identity Mgmt
Inter-Regional Key EMR Data Sharing
Provider Identity Mgmt
Patient Allergies, Alerts & Warnings Mgmt
National Pharmacology Services
Terminology Mgmt Services
2.4 Domain Services
Pathology/Laboratory Services
Radiology & Diagnostic Imaging Services
Immunisation Tracking & Reporting
Infection Control (DHB Internal Only)
Public Health Service
2.6 Common Support Services
Enterprise Scheduling
Pharmacy Warehousing, Logistics & Dispensing
Population Health Mgmt
Clinical Communications Mgmt
Clinical Notes & Records Mgmt
Customer Relationship Mgmt (agency, staff, patients, etc.)
Enterprise Medication Mgmt
Care Pathways & Clinical Mgmt
Patient Consent Mgmt
2.7 Hospital Operations
Workforce Competency & Rostering Mgmt
Hotel & Food Service Mgmt
Care Capacity & Demand Mgmt
Facilities and Asset Mgmt
Service Coordination & Patient Flow Mgmt
Hospital Performance Insight & Continuous Improvement
Event & Emergency Response Mgmt
Sub-Speciality Support Services
3 Integration & Access Services
Enterprise Service Bus (ESB)
Health Interoperability Broker
IoT & Med Device Integration
4 Information Mgmt & Analytics
Document/Content Mgmt & Archiving
Enterprise Data & Information Governance
Business Intelligence & Reporting
Enterprise Content Indexing & Search
Photos, Images, Videos & Rich Media Mgmt
Predictive Analytics & Contextual Insights
Enterprise Data Lake & Data Mart
Enterprise Information Mgmt & Enablers
Policy, Standards and Process Information Mgmt
Omni Location & Remote Tracking Location Services
Data Integration & Data Virtualisation
Enterprise Data Warehouse
5 Enterprise/Corporate Services Mgmt
5.1 Procurement & Financial Mgmt
Strategic Sourcing, Procurement & Contract Mgmt
Financial Mgmt
Payrol Mgmt
Supply Chain Mgmt
Billing & Payment Collection Mgmt
5.2 Strategy & Planning
Business Strategy Planning & Mgmt
Public Relations & Communications Mgmt
Strategy & Architecture Mgmt
Demand, Portfolio Planning & Mgmt
Programme & Project Delivery Mgmt
Innovation Mgmt
5.3 Risk & Assurance Mgmt
Health and Safety Mgmt
Quality & Assurance Mgmt
Legal Service, Regulatory & Compliance Mgmt
Enterprise Audit & Risk Mgmt
Business Continuity Planning
Business Incident/Event & Response Mgmt
5.4 Human Resource Mgmt
Human Resource Mgmt
Organisation Culture, Engagement & Change Mgmt
Learning & Development Mgmt
Knowledge Mgmt
Workforce Planning & Recruitment
Performance & Reward Mgmt
6 IT Infrastructure & Service Mgmt
6.1 IT Infrastructure Platforms
Digital Workplace & Productivity Services
Database & Application Platform
Compute & Storage Platform
Data Centre Rack Space & Environment
6.2 Change & Release Mgmt
ICT Change, Release & Deployment Mgmt
Service Design, Delivery, Testing & Validation
Cloud Service Brokering, Automation & Mgmt
ICT Asset, Configuration & Licence Mgmt
6.3 IT Service Fulfilment & Assurance
Service Desk, Service Catalog, Request & Fulfilment
ICT Event, Incident & Problem Mgmt
ICT Service Availability, Continuity/DR & Capacity Mgmt
Service Measurement, Reporting & Improvement
6.4 Network & Communications Mgmt
Network Infrastructure Mgmt (Fibre, WAN, LAN, Devices, etc)
Network Services & Access Mgmt
Unified Communications Mgmt
Network Service Delivery Mgmt & Assurance
7 Cyber Security & Access Mgmt
7.1 Identity Directory & Access Mgmt
Enterprise & Federated Directory Mgmt
Identity & Access Mgmt
Security Risk Mitigation, Governance & Compliance
Cyber Security Platform Mgmt
7.2 Cyber Security Mgmt
Cyber Security Service Mgmt (Monitoring, Vulnerability Mgmt)
Cyber Security Intelligence & Forensics Mgmt
Cyber Security Awareness & Culture Mgmt
DXC.technology

MidCentral District Health Board

Ta Awa Delivery Review

Prepared by Scott Rodgers

24 February 2021

THE KEY STEPS TO YOUR GOALS

Document Approval

Name	Date	Signature
Steve Miller District Chief Digital Officer MidCentral District Health Board		
Michell Riwai General Manager Enable New Zealand MidCentral District Health Board Acting Executive Sponsor for Digital Services		
Scott Rodgers Managing Director Link Consulting Group Limited Reviewer		

Document Control

Service Name	Te Awa Delivery Review
Author	Scott Rodgers
Title	MDHB Ta Awa Delivery Review DRAFT v0.2

Document Version Control

Version	Date	Author/Editor
Initial DRAFT v0.1 – findings and recommendations	24/02/2021	Scott Rodgers
Update with feedback from Steve Miller and Aaron McLaughlin	16/03/2021	Scott Rodgers

DRAFT for review

Executive Summary

MidCentral District Health Board's Digital Services group is tasked with delivering the Te Awa Digital Strategy roadmap of digital capability. Te Awa provides the digital foundation to enable a fully integrated health system consistent with the vision of Te Wao nui a Tāne, the Integrated Service Model (ISM).

Digital Services are, however, not well set up to deliver and support the Te Awa programme of work.

The ISM is a transformational approach which will directly improve services and reduce cost and across the District Health Board (DHB) and region. Te Awa's digital enablers will likewise deliver transformational change for the DHB and its workers and wider community. While the strategy relies upon digital capability, ISM outcomes it supports, the investment decisions required, and the financial and performance benefits are DHB wide, business, responsibilities.

As such the ownership of the Te Awa delivery programme should not be vested in Digital Services.

Summary findings and recommendations:

- The Te Awa Strategy is a transformational activity impacting the DHB and region. While it is a digitally enabled strategy, the benefit and impact need to be managed at the most senior levels of the DHB, and should be run as a multi-year, business focussed, Programme rather than as a technology portfolio.
- The imminent decision at Cabinet about the future of the New Zealand Health System has already paused, and potentially cancelled, some Te Awa deliverables, some initiatives may become more critical, and others may be modified to reflect new or different service delivery structures. Introducing a Senior Programme Manager to tune and adjust the outcomes of the Te Awa delivery allows for a greater level of flexibility in the system.
- The funding model for Te Awa is unclear and is subsumed into Digital Services' operating and capital budgets. The funding for Digital Services is inadequate for operating MDHB services without including Te Awa transformational activities.
    - The funding model to deliver the Strategy, and for Digital Services operating activities, are primarily dependent on Capital (Capex) funding. The strategic direction to move to as-a-Service (Cloud), and to operate and maintain the services, requires a greater degree of Operating (Opex) than is currently available.
    - The Strategy is delivered on a case-by-case basis which primarily focuses of the delivery cost of projects. There is limited consideration of the long-term operating cost for the service.
- When considering initiatives, it is important to focus on expected financial and efficiency savings and on improvement in services to the community. Such savings and effectiveness considerations cannot be initiated or managed by Digital Services. Decisions about changing practices for the workforce and reducing cost are the responsibility of DHB business leaders, not the leaders of support functions like Digital Services.
- To deliver the Te Awa Strategy, and to support the needs of the DHB more effectively, Digital Services needs to clearly differentiate between MidCentral's support of national, regional and DHB strategic initiatives, and operations support and maintenance. A senior Digital Operations Manager should be appointed to manage day-to-day delivery and management of Digital Services delivered services and supporting systems.

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Background

In 2019, the Te Awa Digital Health Strategy (Te Awa) was endorsed by the MidCentral Board, the Central Primary Health Organisation, Mana Whenua Hauora, and the Clinical and Consumer Councils. Te Awa is aimed at enabling the delivery of improved healthcare outcomes for the district over a period of five years.

The Strategy outlines the development of an investment and management approach to deliver a range of capabilities and initiatives to support seamless, accessible, timely care closer to home, and develop a state of readiness for connecting all participants across the district.

This review was commissioned in response to concern about the ability of Digital Services to deliver Te Awa.

The review assessed Digital Services capability to deliver Te Awa, as well as advising on how to better position Digital Services to deliver services.

The scope of the review is focused on MidCentral's implementation of Te Awa:

- How are Digital Services tracking in implementing the vision of the strategy?
- What are Digital Services doing well and what could they do better? Including:
    - Engaging and communicating with the business to meet their requirements.
    - Implementation approach, portfolio, programme, and project structure.
    - Financial management.
- Are Digital Services set up for success?

The review also considered the implications on the Te Awa Strategy of the imminent decisions, by Cabinet, of the future shape of the New Zealand Health and Disability System.

Despite the challenges a range of key initiatives have been progressed, and many completed. This included the rapid response to Covid-19 pandemic conditions.

Caveats

Our feedback and recommendations have been provided after the collection and analysis of a wide variety of information and opinion from MidCentral DHB and nominated external parties. We believe our findings reflect the current situation but may change with new information or future developments.

This review makes high-level recommendations. We have been careful to avoid making detailed recommendations of structure or process for Digital Services or MDHB. Our recommendations are necessarily founded on our experience delivering similar programmes of work and operating ICT businesses. Some recommendations, like converting Te Awa into a Programme, are consistent with commonly accepted good-practice approaches. How such a Programme is structured, and how Digital Services configures itself to deliver great services, are subject to a more detailed work programme.

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Findings & Recommendations

1. Is delivery of Te Awa appropriately led from Digital Services?

The current delivery model for Te Awa, where the strategic programme is being led by Digital Services, is subject to unpredictable demand and supply constraints. The delivery model, while making progress in some foundational initiatives, is not working effectively, nor it is transparent to the wider business.

Digital Services is a financially and capability constrained supplier of enabling services. The Chief Digital Officer holds what is, effectively, a single budget for all Digital Services costs, including for Te Awa initiatives and must, therefore make decisions to ration resources. Financial and resource constraints mean it is difficult to deliver to plan or delivery may be compromised.

Digital Services has made progress on building and deploying foundational services and remains focussed on delivering sound underpinning platforms and services. However, the progress is not well understood outside of Digital Services; there is little awareness in the wider DHB that Digital Services are making progress. That situation is exacerbated by a lack of trust due to a consistent perception that Digital Services is not meeting the needs of Clinicians or other business users.

Digital Services does communicate with the wider user community, but not clearly and not in the language that engages or informs the user community about progress, achievements, and issues and delays.

The Te Awa strategy was developed and approved for the benefit of the operating business of the DHB and to resolve substantial issues facing clinicians and support personnel. While it does involve making technology choices founded on a defined architecture and technology roadmap, decisions on tools needed to support work processes and methods need business leader decisions, not ICT focused Digital Services. That decision ownership is especially true if cost-savings or other efficiency gains within MidCentral's operating businesses are being considered.

	Recommendations:	Priority
1.1.	The delivery of the Te Awa Strategy should be treated as a DHB wide transformational programme. As such it would have a senior programme manager with a reporting line to an Organisational Leadership Team member who is not in a direct line of responsibility for Digital Services. The Te Awa Strategy delivers for all the DHB and care must be taken to avoid association with any one cluster (silo risk). For MidCentral the likely reporting line would be through the Office of the Chief Executive, or through a Strategy and Planning function. The Digital Services approach being used where Te Awa and all other projects are coordinated using a portfolio model is appropriate for coordinating and overseeing digital initiatives, but the model, as applied at MDHB, needs further work – it is appropriate for the long-term oversight and orchestration of investment activity, but is not well placed to manage delivery. **Context and terminology** A portfolio does not deliver initiatives. It is fundamentally a secretariat function for an organisation's investment decision-making and investment governance. The role of the portfolio is to inform investment decisions and track progress against those decisions. Portfolio is about enabling good decisions and overseeing delivery of the expected outcomes. Managing programme and project resources, methods, and processes is a function of the more tactical programme and project management office.	HIGH

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	Programme is a conceptual construct which may be configured and managed differently for each investment outcome. While there are programme definitions and good-practice approaches, it is fundamentally a flexible model to achieve business outcomes, and a good programme manager is active in defining and negotiating outcomes. A programme manager is not a project manager promoted. It is a fundamentally different skill set albeit having similar training and delivery disciplines. A programme manager negotiates and adjusts – their focus is on the big picture and a good programme manager is both a diplomat and a strategist/architect. They work with business and strategic leaders to define how the outcomes will be delivered and then establish the projects needed to achieve that. For MDHB and the current Te Awa delivery strategy, a programme manager would be pivotal for adjusting the focus to meet sector changes. Project is about delivering products or services which, within a Programme, delivers the outputs which, collectively, support the outcomes the programme is charged with achieving. The Programme Manager would commission Digital Services, or external parties through Digital Services, to deliver defined projects. That person would be responsible for defining and refining Programme outcomes and delivery method and establishing a Programme business case which builds upon the Strategy with clear costs, financial savings and other benefits and performance measures. The programme model is inherently flexible which allows for the Programme Manager to support organisational and digital strategies in response to the potential changes to the sector. The Programme Manager would help shape, and lead, projects to support MidCentral, regional and sector changes. To make such a change would require acknowledgement that the Te Awa strategy is not 'business as usual' and must be funded, managed, and governed appropriately, and that the imminent announcement by Cabinet is likely to require disciplined management of a complex and disruptive change process which the Programme Manager would need to contribute to, if not lead, on behalf of MidCentral DHB. Lifting the direction, funding, and leadership of the Te Awa Strategy out of Digital Services allows Digital Services to become a strategic partner for the DHB; the DHB's centre of expertise for technology delivery, and operating management, rather than the gatekeeper of limited funding and resources. It transfers the role of Digital Services from owning and rationing the change programme, to responding to defined, and funded, demand.	
1.2.	Develop a self-contained programme business case which considers and establishes the case and funding for the life of the programme. Funding may continue to be allocated year on year but should be locked in for the life of the programme and released in tranches subject to annual prioritisation and availability of funds. It is possible that many costs for some initiatives may be self-funded through efficiency savings. The business case needs to be clear about sources of funding which may include long term reduction in operating cost with improved and more efficient services. While the Te Awa delivery is currently centrally funded, the link to direct savings may allow for more diverse funding from line-of-business savings.	**HIGH**

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	Funding, scope-of-work, and initiative phasing is a business decision which must be led by non-ICT Executives, particularly where savings impact their cluster workforce. Importantly, as the outcomes are likely to have a direct effect on the whole organisation, the Programme business case and delivery models must have a very strong focus on business led Stakeholder Management and Change Management. Digital products and services are simply enablers for the changes required by the ISM. For context, when transformational initiatives fail the most common cause of failure is lack of business leadership, wide-ranging and clear business engagement, and well established and resourced change management practices.	
1.3.	Using the technology roadmap as a foundation, develop an outcomes focused programme blueprint. A blueprint is an outcomes focused view of the delivery programme which, for MDHB, needs to factor in all streams of work required to achieve the outcome, not just the digital workstreams. The blueprint must align with the ISM programme of work.	**MEDIUM**

DRAFT - for review

2. Funding and financial model

The projected four-year cost of Te Awa initiatives is currently sitting at $29M. It is likely to be higher as more information is gained and projects are more formally scoped. There is, however, limited funding available. While there is apparent commitment to funding the Te Awa Strategy's full programme of work, the funds are allocated from within Digital Services limited, general-use, allocation of capital funds. Digital Services has many calls on that funding.

Digital Services funding is inadequate and not focused; it is used to fund Te Awa projects, other new initiatives which can arise with little notice, and for maintaining older systems and services.

Digital Services Capital (Capex) allocation is used to fund operating maintenance and management activities such as application maintenance, patching and updates which would, for most organisations, be funded from operating (Opex) budgets. In those instances, no new assets are created. Using Capex for elements which should ordinarily be treated as Opex further erodes the available funds for Te Awa. It also results in compounding capital (depreciation) charges for already depreciated or partly depreciated assets.

Many of the initiatives being delivered, or in planning, are likely to be deployed on cloud platforms, applications, or other services, which further increases the need for Opex to replace capital purchases. Cloud computing is primarily an economic model where organisations procure access to systems or applications on a periodic (usually month by month), variable consumption basis. The model is, effectively, renting access rather than purchasing equipment or licenses. While the project work needed to design and configure such an asset may be capitalised, accessing, and using, the platforms is an operating expense. Digital Services do not have Opex to manage and maintain Cloud services which means that capital funding needs to be used. Which, again, directly increases the depreciation charges imposed on operating budgets.

We note that while Cabinet has directed agencies to use Cloud services before considering capital purchases, the Treasury approach to transitioning Capex to Opex is overly complex and very expensive; it is unworkable for many agencies.

Digital Services operates using a cost recovery approach, which means that every activity performed by team members needs to be funded either out of the capital allocation or directly by the consuming business. While not an unreasonable approach it does constrain Digital Services ability to manage and maintain environments, and more pertinently, to commit time to supporting early-stage initiatives for Te Awa as, for example, some simple initial conceptual and project framing discussions cannot occur without capital

funding committed or other funding sources found.

All the above means that Te Awa delivery becomes erratic, ad hoc, and opportunistic – projects cannot be programmed readily as without a dedicated funding stream any urgent requirement can divert or stop strategic initiatives with little notice.

The graphic included in the November DDIGG pack: Te Awa Roadmap DDIGG Workshop Presentation, indicates a combined shortfall of Digital Services Capex and Opex funding of $26M in the 20/21 FY. That shortfall directly impacts on Digital Services ability to deliver the Te Awa Strategy.

Recommendations:		Priority
2.1.	Fund the Te Awa Strategy as a discrete programme of work subject to a programme level business case. While much of the project work will require funds to be allocated to, or through, Digital Services to deliver supporting and enabling technology projects, those funds should be managed external to Digital Services.	HIGH
2.2.	To enable Digital Services to support delivery of the Te Awa Strategy, tactical projects, and to manage and maintain existing assets and services, there is an urgent need to review and redesign the funding model and year on year funding allocations.	HIGH

3. **Digital Services operating model and delivery approach**

Digital Services delivery approach is constrained by resource and structural issues.

The Digital Services operating structure is top heavy with a disproportionately large leadership group covering a range of disciplines referred to as the Digital Leadership Team (DLT). Despite the large leadership group, very few leaders have direct line-management responsibility or authority. The current model has a single line manager with leadership and management accountability for, effectively, every non managerial employee and contractor. That model is unsustainable. We know that consideration is currently being given to resolving that situation.

Digital Services operating practices do not clearly differentiate between day-to-day operational management and project demands, nor does it have an identifiably authoritative and responsible executive level operations manager with clear accountability for performance of all DHB digital systems.

The operating model and resource constraints has two direct impacts on delivery and management of DHB services:

- With operating resources being tightly constrained Digital Services must outsource design, delivery, and operation of key initiatives. While outsourcing services is an appropriate model if managed well, Digital Services is not set up to manage the volume of outsourced initiatives or the ongoing management of services when in operations.
- With Digital Services resources being tightly constrained and a defined, but inflexible, technology architecture there is clear frustration by users which means they are making their own technology decisions and procuring systems themselves. This, Shadow IT, is not necessarily visible to Digital Services until they are required to connect it to core systems. Digital Services roadmap and target architecture for new systems and services are treated as an inflexible roadblock to rapid innovation: they are used as a reason to say no.

When interviewing Clinicians and other business leaders there is a consistent and strongly held view that Digital Services is not performing, does not respond to need, and does not deliver on the programme of work. There is low trust in Digital Services ability to deliver and very low confidence that interviewees needs will be met. There are examples of poor delivery referenced in the interviews to support the claim of

DRAFT - for review

poor performance.		
Recommendations:		Priority
3.1.	Appoint a senior level Operations Manager, or similar, with responsibility for all delivery services. The appointee needs to have considerable experience working across all facets of ICT and business services and, most importantly, be well versed in building relationships across the DHB and the wider sector. The role is essential to ensure continued focus on the user community, to ensure services are efficient and effective at meeting business needs, to build trust in the services, and to lead, protect, and build, the Digital Services delivery team. With the imminent Health Sector review decisions expected to, potentially, reshape the structure, roles, and functions of DHBs, the DCDO is likely to become heavily involved in the design and shaping of health-related ICT services for the DHB, for the region, and nationally. An Operations Manager, while focusing on ensuring services are operating effectively, will also need to support and inform the DCDO's strategic decisions. Decisions on the scope of the role and the teams which fall in, or out, of the Operations Manager scope, and detailed structural decisions should be decided in conjunction with a prospective Operations Manager, although wider discussion, which is currently happening, will be useful to inform the definition of scope for the role and for the affected teams.	**HIGH**
3.2.	Shadow IT needs to be managed positively and proactively. Digital Services need to become facilitators of innovation by clearly defining and providing advice and guidance to help users avoid major mistakes, establishing guard rails that keep the environment safe and ensuring business need is at the forefront of technology decisions. Digital Services needs to become an enabler of well-informed risk-based decisions by DHB leaders. Digital Services cannot, and for the time being, should not attempt to stop Shadow IT, but there is a lot that can be done to reduce the risk and impact of poorly informed decisions. Until a change of approach and engagement with Shadow IT decisions takes effect there will continue to be an acknowledged risk of poor choices. Such choices can introduce privacy and security issues, or have products being purchased with little consideration of how they need to fit with wider systems, and the risk of a poorly thought out 'pet' product choice becoming a long-term liability for the user community and the wider DHB. Critically, this recommendation is not a license to avoid good-practice method and advice, nor to purchase products without considering the real cost of the supporting infrastructure and systems. A decision to positively engage with Shadow IT requires the procuring manager to take responsibility for the risks, for the cost of supporting and managing the systems, and for the real risk of any investment being written off at short notice as more sustainable systems come online. It is not a case of buying something and expecting Digital Services to support it and to bear the cost of managing and maintaining it. Business leaders who procure Shadow IT must remain accountable for their choices and bear responsibility for their choices when	**HIGH**

DRAFT - for review

	things go wrong. Digital Services role is to help business leaders make informed, risk based, decisions. The business leaders must own their decisions if they ignore advice. Should, in the absence of a credible solution from Digital Services, a business leader chooses to invest in a tool with a limited lifespan, technology limitations, and/or additional cost to integrate and decommission then that risk should be clearly stated up front and accepted by the leader. Digital Services should be providing balanced, well informed, and well-documented advice to enable good decisions. If a poor decision is made, then the impact of such a decision belongs with the decision-maker. If inherently risky decisions are likely to be made, then Digital Services needs to have the ability to escalate and raise concerns to a senior level oversight forum.	
3.3.	With Digital Services initiatives, in many cases, being delivered by external suppliers there is a need to ensure that Digital Services has a clear and effective supplier engagement and management strategy. This need has been recognised with a senior leader appointed to build supplier engagement and management systems and tools, and to further develop supplier relationships. That capability is critical for the delivery of Te Awa and other initiatives and the migration of those services from project to operations. A strong and well managed procurement and commercial capability for complex ICT services management is becoming more and more critical. With the active shift to consume as-a-Service (such as Cloud services) there is less and less need for classic ICT engineering skills. While technology design, build and operate skills remain essential, there will be a gradual migration to high-end commercial management, service integration and operating skills as physical, on-premise, systems are retired. Vendor and supplier strategies and management plans become even more critical now as the long-term use of any existing supplier could cease with the potential changes in the sector. Sound and forward-looking commercial arrangements and contracts are needed, with the DHB, potentially, needing to cancel or change terms of existing contracts if there are Machinery of Government changes which could merge the ICT services of multiple DHBs.	**HIGH**
3.4.	Digital Services needs to improve engagement and underlying relationships across the DHB. The best and quickest was to do so is to be seen to deliver simple requests quickly and efficiently. It is important that Digital Services is seen to respond to need, to deliver some quick wins. While doing so may divert resources from some longer-term goals and may mean compromise decisions to ensure clinical and business services can see early results, the benefits gained will, eventually, mean that Digital Services is given more trust and more tolerance of delay or mistakes. There appear to many such quick win opportunities. To respond quickly means that decisions may be made which may deviate from the pure technology roadmap. That is not necessarily a bad thing – technology roadmaps and architectures should never be fixed, they are the basis for, and inform, the next decision. Like the Shadow IT recommendation in 3.2 such decisions should be pragmatic, well-informed, and risk based.	

DRAFT - for review

4. **Digital and Data Intelligence Governance Group**

<table>
<tr><td colspan="3">The Digital and Data Intelligence Governance Group (DDIGG) is an appropriate forum for overseeing Digital Services performance and initiatives. The group is recently formed but should be effective when it becomes more established.

It may not, however, be the appropriate forum to act as a Programme Board should the decision be made to establish Te Awa as a stand-alone Programme.

In government and the private sector true governance committees are a rarity. For programmes and projects such committees are usually advisory only. They do not govern; they support the SRO or Sponsor who is the accountable decision maker. There is usually only one decision maker.

For Digital Services and for Te Awa in particular, funding decisions currently fall to the Chief Digital Officer (CDO) with the support of the DDIGG Co-Chair, the Chief Medical Officer (CMO).

Oversight forums, such as DDIGG, have responsibilities beyond supporting sound decision making. They have a responsibility to champion Digital Services successes within their business and wider in the DHB, and to be a resource for Digital Services when dealing with challenging issues. They are there to help Digital Services be successful as an enabler of the ISM and supporting services for the DHB and region.</td></tr>
<tr><td colspan="2">Recommendations:</td><td>Priority</td></tr>
<tr><td>4.1.</td><td>No substantive recommendation – the DDIGG needs time to establish and to settle into its role. There may be further reshaping needed in the future as the DDIGG establishes, but that is a decision for the DDIGG and, in particular, for the co-chairs.</td><td>LOW</td></tr>
</table>

DRAFT - for review

APPENDIX

Interviews Undertaken

Names are listed in alphabetical order of surnames.

Name	Position
Scott Ambridge	Operations Executive – Mental Health and Addiction
Keyur Anjaria	GM - Human Resources
Carolyne Ayre	Contract Senior Project Manager/Programme manager
Kelvin Billinghurst	Chief Medical Officer
Hine Bishara	Digital Capability Business Partner- DS
Tristan Boot	Service Management Consultant- DS
Robert Bradnock (Sooty)	Systems Specialist - Infrastructure- DS
Judith Catherwood	GM – Quality and Innovation
Tricia Drew	PMO Coordinator - DS
Amanda Driffill	Operations and Clinical Programme Lead
Toby Elliott	Head of Strategy and Architecture
Celina Eves	Executive Director – Nursing and Midwifery
Sarah Fenwick	Operations Executive – Healthy Women, Children and Youth
Katherine Gibbs	Project Manager - Clinical
Simon Green	Systems Specialist - Customer Services - DS
Doug Gregg	Systems Specialist - Infrastructure- DS
Sharon Hastie	Head of Operations
Grant Highstead	Emergency Physician
Lyn Horgan	Operations Executive – Acute and Elective Services
Hannah Jansson	Service Specialist Lead - DS
Sonya Jones	Senior Business Analyst- DS
Chanelle Lewis	Head of Team Development
Leith Marshall	Business Partner Manager
Rory Matthews	Interim Director -Office of the Chief Executive
Daniel Merriott	Consultant, Partner Consulting
Wayne McKoy	Head of Portfolio Delivery
Jason Prior	Medical Lead - General Medicine/General Physician
Alberto Ramirez-Rodriguez	Clinical Lead – Surgery
Darryl Ratana	Deputy CFO

DRAFT – for review

Dr Greig Russell	Principal Medical Information Officer
Leah Scott	Finance Manager
Robyn Shaw	Planned Care and Administrative Services Manager
Chris Simpson	Operations Lead AESS
Neil Wanden	GM Corporate Services
Lee Welch	Quality Improvement Advisor
Ara Yonge	Programme/Project Manager across DWP

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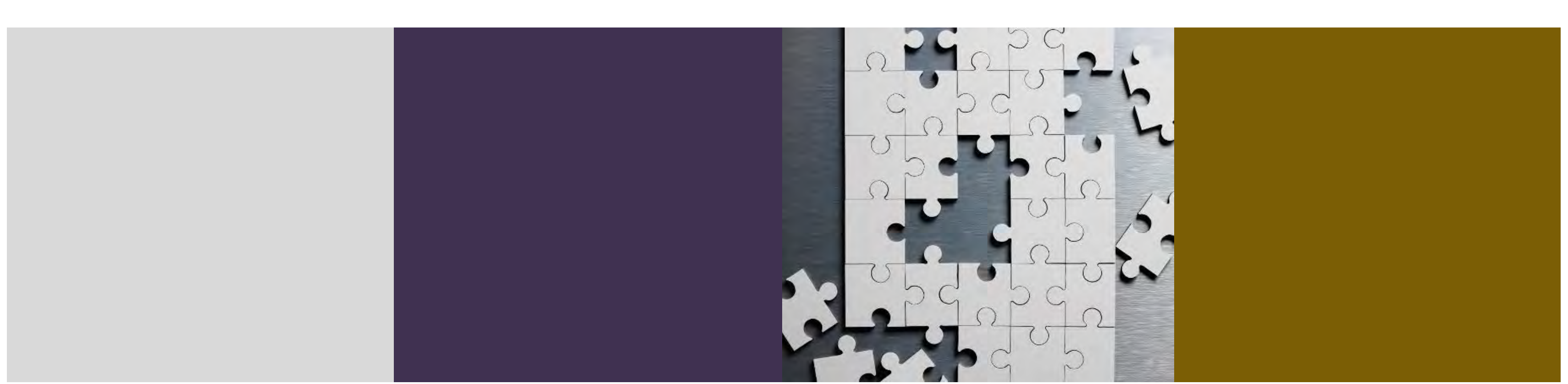
Data flows, data quality and reporting

An analysis of current data flows and reporting at MidCentral District Health Board

April 2020



Context and motivation

MidCentral DHB aims to be a more data driven organisation. Part of the motivation for this is to have confidence in their data to support service planning for Clusters.

However, last year there were some concerns about the integrity of the data. Reports on key hospital metrics such as ESPI measures were showing significant differences between what the Ministry of Health was reporting and what was being reported internally to the Executive team.

WebPAS was implemented at the start of 2018, replacing Homer. A lot of work had gone into remedying go-live issues and data capture so it was not considered to be the cause of the issue.

The Executive team wanted to know what was happening to the data through its lifecycle that was leading to the discrepancies they were seeing in the final reports. This would also to inform further work to establish a data governance and stewardship framework.

What we were asked to do

1. Map the end-to-end processes to show:
   - the capture, curation and management of data
   - the analysis of data
   - output as reports and dashboards.

2. Validate existing reports for Elective Services Patient Flow Indicators (ESPI) 2 and 5. Identify why there are variances between internal reports and those being reported by the Ministry of Health.

3. Document the roles and functions that exist across the mapped process.

Our approach

- Staff interviews and process mapping - to document what is currently happening we spoke with 17 DHB staff, TAS and the Ministry of Health to understand the data flows.
- Workshop to validate and discuss the findings – those we interviewed, their managers and other interested staff were invited to feedback on our initial findings.
- Validation of ESPIs 2 and 5 – reconciliation of internal ESPI data compared to Ministry of Health data.
- Provide a report on our findings and recommendations.

What we found

A complex array of systems and data

The DHB creates and manages a significant amount of clinical data from over 10 systems, including webPAS, RIS, MOSAIQ, Trendcare. The flow of data from creation to storage and its eventual use in reports is complex with some parts of the process managed by external parties (TAS, the Ministry of Health and software vendors).

Key risk is divergence between National Collections and internal data

The key reporting risk to MidCentral DHB is related to the extraction and supply of data into Ministry of Health National Collections, rather than any issues with the accuracy of the data flowing through internal systems. Some of the extraction processes are designed and managed by software vendors (e.g. DXC who manage webPAS) and there is little visibility over how the data is extracted. There may also be discrepancies introduced through the load process into National Collections and how the Ministry calculates its reports using this data. It is difficult in these circumstances to ensure that internal reporting uses exactly the same data as that used in the National Collections.

What we found ctd…

NBRS and internal data became out of sync during migration to webPAS

In relation to the data that is used for reporting on ESPIs 2 and 5, the key source of the discrepancy is due to data in National Collections becoming out of sync with webPAS data. This is a result of the migration from Homer to webPAS where some patient level identifiers used to link records in webPAS and NBRS have been broken. We have provided a reconciliation of the two sources to explain the differences.

A lack of coordination and responsibility for ensuring data and reports are accurate

There are a large number of reports produced and sent externally and there does not appear to be a review or approval process to ensure the accuracy of these reports. We also noticed a disconnect between those producing reports and those doing work to validate and reconcile these reports to source data. A lack of clarity over who is responsible for ensuring the accuracy of the data is contributing to this issue.

Some opportunities to realigns some functions

We noticed several examples where people were doing tasks that would appear outside the scope of their role or were an inefficient use of their time. For example, service managers and clinicians are spending a lot of time reconciling data, validating reports and undertaking their own analysis. We have recommended some changes to the functions undertaken within each role.

What we found ctd…

Strong case for improving data integrity processes and data governance to mitigate similar issues in the future

The Victorian Agency for Health Information provides this description of data integrity based on the WHO definition:

> **Data integrity is the degree to which data are complete, consistent, accurate, trustworthy and reliable and that these characteristics of the data are maintained throughout the data life cycle. The data should be collected and maintained in a secure manner, such that they are attributable, legible, contemporaneously recorded, original or a true copy and accurate. Assuring data integrity requires appropriate quality and risk management systems, including adherence to sound scientific principles and good documentation practices.**

(Victorian Agency for Health Information, 2018, pp4)

We found a number of examples where good practices were followed and data was routinely validated against its source. However, this is not consistently done throughout the end to end flow of the data and it relied on individuals identifying the need rather than policies and procedures governed internally. Some staff also reported correcting patient records based on errors they had identified. It's not clear what documentation, if any, has been kept to keep track of these changes and the reasons for making them.

Developing clear processes and internal standards for validating data throughout its lifecycle would allow the DHB to maintain control over its data and ensure staff making any corrections to the data are doing so safely. For example, even though some data processes are a black box, a good reconciliation process on the resulting data can ensure any issues are identified and corrective action can be taken – this may also lead to changes or improvements in how data is collected and processed.

Improving data integrity also relies on good oversight of the end to end flow of data and clear accountabilities for ensuring the processes and standards are met through good data governance and stewardship.

1. Current state analysis

Focus of current state analysis

Primary focus on ESPIs 2 and 5

In mapping data flows we focussed predominantly on tracking ESPI 2 and 5 data from source to final report.

Radiology and Cancer also documented

As part of the current state we also documented reporting processes for radiology and cancer treatment services.

Stocktake of external reports

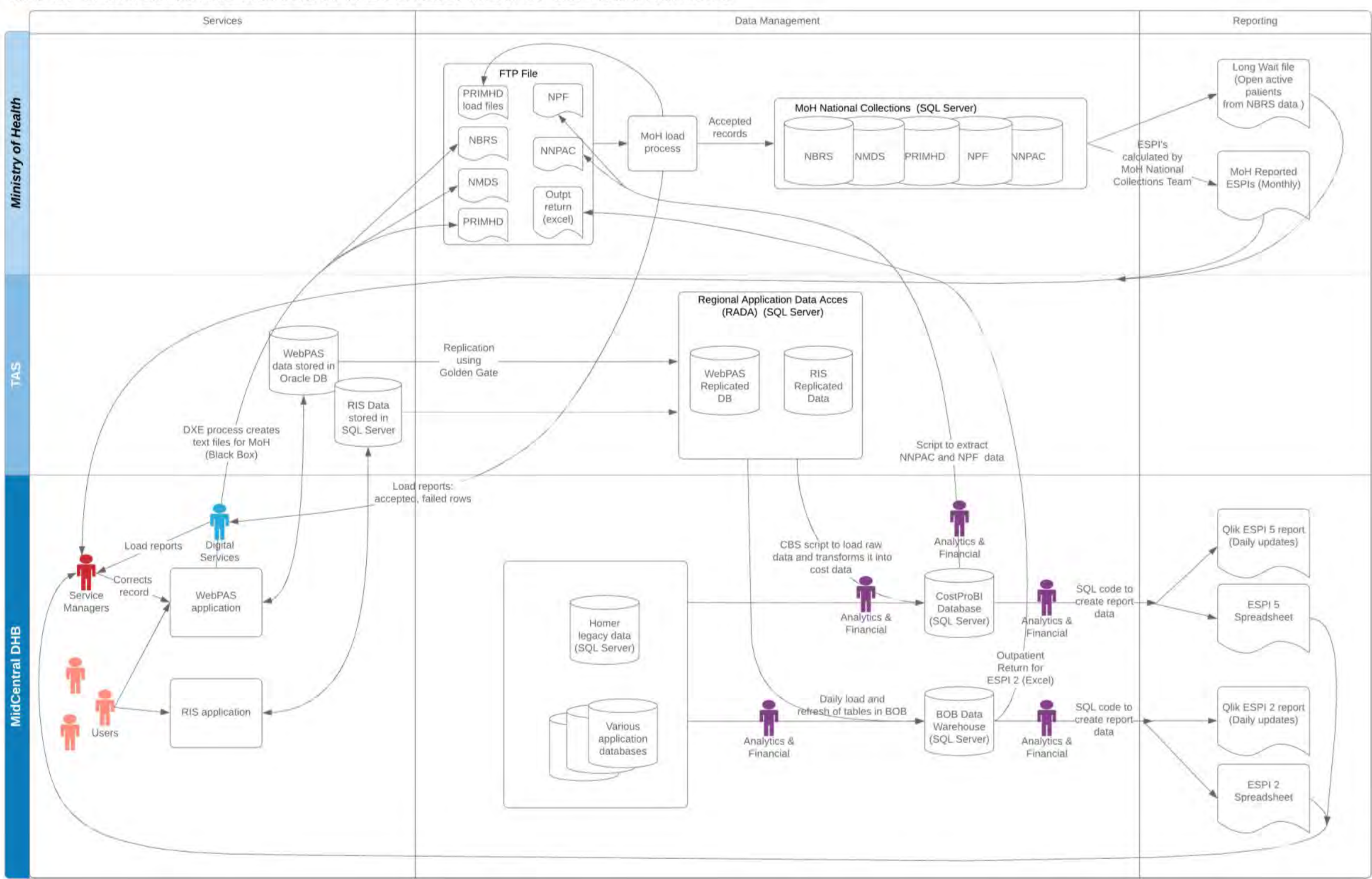
We asked staff to identify any reports they send to to external agencies or the DHB's Executive Team and the Board.

ESPI 2

Patients waiting longer than 4 months for their first specialist assessment (FSA)

ESPI 5

Patients given a commitment to treatment but not treated within 4 months



MAP OF DATA FLOWS AND ACTORS IN THE DEVELOPMENT OF ESPI 2 & 5 REPORTS
Services
Data Management
Reporting
Ministry of Health
TAS
MidCentral DHB
FTP File
PRIMHD load files
NPF
NBRS
NNPAC
NMDS
Outpt return (excel)
PRIMHD
MoH load process
Accepted records
MoH National Collections (SQL Server)
NBRS
NMDS
PRIMHD
NPF
NNPAC
Long Wait file (Open active patients from NBRS data)
ESPI's calculated by MoH National Collections Team
MoH Reported ESPIs (Monthly)
Regional Application Data Acces (RADA) (SQL Server)
WebPAS data stored in Oracle DB
Replication using Golden Gate
WebPAS Replicated DB
RIS Replicated Data
RIS Data stored in SQL Server
DXE process creates text files for MoH (Black Box)
Script to extract NNPAC and NPF data
Load reports: accepted, failed rows
Load reports
Digital Services
Analytics & Financial
Corrects record
Service Managers
WebPAS application
CBS script to load raw data and transforms it into cost data
CostProBI Database (SQL Server)
SQL code to create report data
Qlik ESPI 5 report (Daily updates)
ESPI 5 Spreadsheet
Homer legacy data (SQL Server)
Outpatient Return for ESPI 2 (Excel)
Users
RIS application
Various application databases
Daily load and refresh of tables in BOB
BOB Data Warehouse (SQL Server)
Qlik ESPI 2 report (Daily updates)
ESPI 2 Spreadsheet

Key tasks in the creation of ESPIs 2/5

Task	Who	Description	Comments / Issues
1. Users enter information into webPAS	Hospital staff – administrators/booking clerks, clinical staff	Add, change, update patient bookings and process referrals	• This is a source of error – checks are done every day to fix incorrectly entered information. • Inconsistent standards for entering the data, lack of validation at source of entry and high turnover of staff have been identified as issues.
	Recommendations 1. Develop clear guidelines and training for staff to reduce data entry errors. 2. Where possible, work the WebPAS vendor and your regional DHBs to build in point of entry validation.		
2. Create replicate of webPAS data and store in Regional Application Data Access (RADA)	TAS	Regional webPAS application data is stored and managed by TAS in an Oracle database located in Wellington. The data is replicated in RADA (SQL Server) and read only access is provided to DHBs. RADA also contains other regional application data such as RIS.	• Data in RADA is critical to business operations. • MCDHB rely on TAS to ensure RADA is an accurate replication of the source. • Tables, fields and data are added to RADA. There have been instances in the past where data has been deleted. • Not all tables are replicated, only those considered relevant to the business.
	Recommendation 3. Request regular validation of source to replicated data from TAS to ensure this is not a source of error.		
3. Download data from RADA into BOB (a local SQL server data warehouse) – scheduled process	Analytics & Financial Advisory (AFA) (Rahul & Greg)	Changes to webPAS data are downloaded from RADA and stored locally on SQL server. Downloads run daily with smaller updates occurring at intervals during the day.	• Usually changes to the data structure are notified in advance. If a change hasn't been notified this process will fail and an error is returned. • Deletions in RADA have been identified through this process. Insert datetime fields enable MCDHB to track deletions and additions.

Key tasks continued...

Task	Who	Description	Comments / Issues
3. Download data from RADA into BOB (a local SQL server data warehouse) – scheduled process	Analytics & Financial Advisory (Rahul & Greg)	Changes to webPAS data are downloaded from RADA and stored locally on SQL server. Downloads run daily with smaller updates occurring at intervals during the day.	• Changes to the data structure are typically notified in advance. If a change hasn't been notified this process will fail and an error is returned. • Deletions in RADA have been identified through this process. Insert datetime fields enable MCDHB to track deletions and additions.
	Recommendation		

Key tasks continued...

Task	Who	Description	Comments / Issues
4. Populate tables in BOB using the latest data – scheduled process linked to the above task (BOB is the source for most internal reporting)	Analytics & Financial Advisory (Rahul & Greg)	A scheduled process that runs as part of the RADA download. The code brings in data from RADA and local sources to create the tables used by the business for analysis and reporting. These tables are stored in BOB, a data warehouse on SQL Server. BOB contains data from about 11 applications including webPAS, RIS, Clinical Portal, Trend Care and Mosiaq. Smaller scripts are scheduled to run at set intervals throughout the day and a larger extract is run overnight. Each load is validated using row counts.	• webPAS tables and column names are unusable in their raw form so a complex mapping process has been developed by Rahul & Greg to create tables with common names that can be used by analysts. • A data dictionary was provided by DXC. For customised fields a data dictionary was provided by TAS. Incorrectly mapped columns continue to be an issue and are corrected when identified. • User defined fields in webPAS are an issue. Sometimes used without notification of what the data is. TAS are responsible for maintaining a dictionary of these fields but MCDHB staff are doubtful they are maintaining it. • A truncate/load process is used for the Outpatient related fact table. No data is altered in the data warehouse.
	Recommendations 4. Work with TAS and other regional DHBs to ensure data dictionaries are up-to-date and accurate. 5. Include reporting requirements as part of any project that could impact on data sources. This could include the use of a senior technical expert in the project team, in an advisory role or as part of project governance.		

Key tasks continued...

Task	Who	Description	Comments / Issues
5. Run Costing Business Solutions (CBS) stored procedure to create cost data (CostProBI)	Analytics & Financial Advisory (Grant, Paul)	A daily process to execute a stored procedure developed by CBS. The script transforms raw data from webPAS and other systems into cost data containing purchase units and other financial information. This process takes roughly 1 hour to run. Output data is stored in the CostProBI SQL database.	• The data used and stored in CostProBI is a subset of what's in BOB. • Raw data is sometimes split into multiple cost categories so row counts are not a good way to validate the data. • CostPro is used extensively throughout NZ and Australia. The CostPro script is trusted, the analyst would not alter the script or question its output. Like DXC scripts, if it's wrong for MCDHB it's wrong for all DHBs using it.
	Recommendations		
6. Validation of data in BOB and Cost Pro	Analytics & Financial Advisory (Paul)	Validation is part systematic, part adhoc.	• From time to time reports such as ESPIs are run from both BOB and CostProBI as a check for accuracy. Mostly they are close. The differences are believed to be related to timing. • Attention needs to be given to match the data seen in reporting databases to what is seen in the webPAS application. A number of mapping errors and issues related to the migration have been found and corrected this way. • If it's a migration issue the patient record may need to be changed directly through the webPAS application.
	Recommendations 6. Establish routine reconciliation between CostProBI and BOB.		

Key tasks continued…

Task	Who	Description	Comments / Issues

7. Create ESPI 2 & 5 reports for business users using internal data (updated daily)	Analytics & Financial Advisory (Mike Yang)	Update the data and reports that track progress against ESPIs 2 & 5. Reports are updated daily and are provided to business users via Qlik or spreadsheet for those without access to Qlik.
		
		The reports were developed by the analysts based on their knowledge of the data and methods for calculating ESPIs.
			• The code for ESPI 5 is reasonably simple – the data is extracted from CostProBI.
			• ESPI 2 reporting much more complex. The source of this data is BOB. Lots of filters and manual adjustments built into the code. Some discrepancies between MoH and internal reports are likely to occur due to:
			  • Homer data being used internally - related to open referrals that should have been closed (migration issue).
			  • Calculation differences, internal starts day count from referral date, MoH start from end of month.
			• Both reports have the ability to drill down to NHI level – useful for the business to know which patients they need to follow up on and for validation purposes.

Recommendations

7. Establish monthly reconciliation of ESPI 5 data against NBRS data. An exceptions report of records that do not match should be provided to the service manager for review. A process to correct records or document reasons for the discrepancy could then be actioned.
8. Automate routine ESPI reporting where possible. For example, the stored procedure that creates the data for ESPI 2 reports could be scheduled to run after the CostProBI daily load.
9. Produce one set of published results. Providing the data in Qlik and Excel creates additional work to produce the information and to keep them in alignment.

Key tasks continued…

Task	Who	Description	Comments / Issues
8. Run DXC Extract and send NBRS data to MoH FTP server (Monthly)	Digital Services (Tama)	Use DXC (webPAS vendor's) tool to extract data directly from webPAS to a text file and upload this to an MoH FTP location. A load report is sent back to the DHB and loaded into webPAS by Digital Services. The load report shows which rows loaded successfully and which failed.	• The DXC script is a black box to MCDHB – there is a document outlining how to run the extract but the DHB has no visibility over the code being used to generate the extracts. • The DXC tool is used by many DHBs and is not considered to be a source of error. • NMDS and PRIMHD data are also extracted directly from webPAS in a similar process.
	Recommendations 10. Shift responsibility for running Ministry extracts and managing load reports to Analytics and Financial Advisory. There is added value in having those that understand the data managing routine extracts and reports, particularly those that feed into National Collections. If there are issues with the extract they are most qualified to spot them and investigate the cause.		
9. Correct records that failed NBRS load process	Service Manager (Robyn)	Review load reports and make corrections to patient records as needed. Changes to patient records are resubmitted the next time a DXC extract is run.	• Rows that failed to load are not always due to input errors, they may relate to migration issues or other changes made by the MoH. Fixing these errors sometimes involves checking records in Homer to confirm what action needs to be taken. • The service manager prefers to take ownership over this process due to the level of understanding required to know what corrections need to be made.
	Recommendations 11. Shift responsibility for checking load reports to Analytics and Financial Advisory (same reasoning as described in the recommendation above)		

Key tasks continued...

<table>
<tr><th>Task</th><th>Who</th><th>Description</th><th>Comments / Issues</th></tr>
<tr><td rowspan="2">10. Extract National Patient Flow (NPF) and National Non-admitted Patient Collection (NNPAC) data for the Ministry of Health</td><td>Analytics & Financial Advisory (Grant, Paul)</td><td>Data is extracted from CostProBI and saved in a text file. The files are then uploaded to the Ministry via FTP.</td><td>• Extracts completed weekly</td></tr>
<tr><td colspan="3">Recommendations
12. Investigate options to schedule and automate routine data extraction of NNPAC and NPF data.</td></tr>
<tr><td rowspan="2">11. Extract and enter data into the Outpatient Return template and submit to the Ministry via FTP</td><td>Analytics & Financial Advisory (Paul)</td><td>NBRS Monthly Outpatient Returns template is populated and uploaded the Ministry via FTP.

The data is aggregated by specialty, patient level data is not provided.</td><td>• MoH load the data from the spreadsheet into the NBRS. ESPI 2 reports are then calculated from this data.</td></tr>
<tr><td colspan="3">Recommendations
13. Work with the Ministry and DHB colleagues to investigate better options for routine data collection. There is currently an overreliance on DHBs to manually extract and submit text files or excel files via FTP. For example, in some instances it might be more appropriate for the Ministry to pull data from DHB databases rather than relying on DHBs to push data up as monthly extracts.

We note that the Outpatient file and the NBRS extract will be phased out when reporting using the NPF collection begins.</td></tr>
</table>

Key tasks continued…

Task	Who	Description	Comments / Issues
12. Compare internal ESPI 5 data to NBRS and make fixes as needed	Service managers (Robyn)	Validation of internal reporting on ESPI 5 with NHI level data from NBRS (provided by MoH). Following each NBRS load, the MoH send a .NAH file back to the DHB. This file contains open active patient records in NBRS by NHI and Local System Identifier. While not routinely done, this file can be used to check local data against what's in the NBRS (which the Ministry calculate ESPI 5 from). Corrections can either be made in the NBRS or webPAS depending on the nature of the discrepancy. This process is currently being undertaken by the service manager due to a large discrepancy in the reports being produced from internal data and the NBRS.	• There have been (and continue to be) a significant number of errors that require correction. These include: o Referrals appearing open in webPAS but were closed in Homer. o An MoH change that prevented ENT data being submitted to NBRS. • webPAS keeps a record of data loaded into NBRS but may differ to what's held at MoH due to: o Use of "fix files" send to MoH to correct records in NBRS. o NBRS containing data pre-webPAS, this remains unchanged until the patient's record is updated triggering a new record in NBRS. Reconciliation of wait lists found approximately 130 patients missing from webPAS. • The Service Manager is expecting most data migration issues to be resolved soon. • The clinical risk associated with all of the migration errors is believed to be low.
	Recommendations 14. Establish a process to check the .NAH file each month. This process should be lead by Analytics and Financial Advisory and differences should be documented and corrected with advice from the service manager.		

Reporting on Radiology Services

Description	Comments / Issues
Data for radiology services is entered into the RIS application. The flow of data is the same as that documented for webPAS i.e. RIS data is collected and managed by TAS and made available to the DHB through RADA. Data is downloaded from RADA and loaded into BOB for reporting and analysis. Multiple reports are provided to the service to help with planning and management of their six week target. A diagnostics report is also sent to Ministry with data on patient wait times for radiology services.	• The service manager has noticed discrepancies between RIS, internal reports and the diagnostics report sent to the Ministry relating to the number of people waiting longer than 6 weeks. • In transitioning to webPAS, the analysts had to recreate a large number of existing reports. During this process some useful reports for service planning were lost. As a result the service manager spends time each week updating a spreadsheet to help predict service demand and capacity.

Recommendations

1. Reconcile the differences between RIS, and internal reporting and the diagnostic report sent to the Ministry.
2. Establish a monthly reconciliation process to improve the accuracy of the data and reporting. This should be led by Analytics and Financial Advisory with advice from the Radiology service manager.
3. Analysts to ensure the reporting and analysis provided to the service meets their needs. For example, the demand analysis done by the service manager is a core analytical function and should be done within Analytics and Financial Advisory.

Reporting on Cancer Treatments

Description	Comments / Issues

Data for oncology services comes from two systems – webPAS and MOSAIQ. There are two regular reports/files generated from this data:
1. File sent to MoH for the Radiation Oncology Minimum Dataset (ROMDS). A script to extract was developed 2 years ago and it is now run by Digital Services.
2. Faster Cancer Treatments spreadsheet created weekly and uploaded to an MoH FTP location.
 	
For the Faster Cancer Treatment spreadsheet, the Analytics & Finance team extract and compile the data. However, MOSAIQ data does not map well to webPAS at an event level so rules are applied to determine the dates and services a patient has received. The resulting data is sent in an Excel spreadsheet to the oncology service for checking before being sent to the MoH. Oncology staff validate data by looking up patient records in MOSAIQ.
 	
For adhoc data requests such as Ministerial and OIA requests the same process of creating the data and validating it against patient records is followed.
	• Manual data checking is costing an estimated 10-30 hours of service manager/senior staff time per month. Potential opportunity to automate some of this work to save time and reduce the likelihood of human error.
	• There is demand within the service for additional information and reporting, including:
	  ○ Regular reporting to DHB partners
	  ○ Data by clinician on types of cancers, outcomes to help clinicians with their audit obligations.
	  ○ Reporting on equity e.g. intervention rates at a local or regional level.
	• The service manager expressed some concern about the accuracy of ethnicity data.

Recommendations

1. Review the process of creating and manually validating cancer treatment data. There is significant time and cost saving to be had if part of that process could be automated or streamlined.
2. Establish a process to routinely reconcile ROMDS with internal data. This will ensure if the Ministry begins reporting from ROMDS the data should match internal reports.
3. Work with the service to identify other information that would add value to clinicians and the service. Develop these as standard reports that are easily accessible to the business, e.g. within Qlik.

Reports/files delivered externally

Report name	Created by	To	Frequency
ESPI2	Analytics	MOH Spreadsheet Template	Monthly
Ophthalmology Follow Ups	Analytics	MOH Spreadsheet Template	Monthly
National Patient Flow (NPF)	Analytics – NPF module CostProBI	MOH FTP File	Fortnightly
National Non Admitted Patient Collection (NNPAC)	Analytics – NNPAC module CostProBI	MOH FTP File	Monthly
Diagnostics Scorecard	Analytics	MOH Spreadsheet Template	Monthly
ESPI5	Analytics	QLIK Sense dashboard PIP Weekly-Management	Daily Weekly
Follow Ups	Analytics	QLIK Sense dashboard-Management & Services	Daily
Scorecard KPIs	Analytics	Internal Business SSRS KPI Scorecard – some stuff to board	Monthly
HR KPIs	Analytics	External	Monthly
Ophthalmology OQIC measures report	Analytics	TAS	Monthly (From Nov 19)

Report name	Created by	To	Frequency
HRT Inpatient	Analytics	Health Round Table	Quarterly
HRT Diagnoses	Analytics	Health Round Table	Quarterly
HRT Procedures	Analytics	Health Round Table	Quarterly
HRT Emergency	Analytics	Health Round Table	Quarterly
Pressure Injuries	Analytics +Others	HQSC	Quarterly
Falls	Analytics +Others	HQSC	Quarterly
Patient Deterioration	Analytics +Others	HQSC	Quarterly
Central Region Electives	Analytics	Capital Coast DHB	Monthly
Patient Survey Files	Analytics	Cemplicity	Fortnightly
Faster Cancer Treatment	Analytics	MOH FTP	Weekly
DSS funding under 65s	Analytics	MOH Spreadsheet Template	Quarterly
Maternal Mental Health	Analytics	MOH Word Template	Quarterly
Stroke	Analytics	MOH Spreadsheet Template	Quarterly
School Based Health	Analytics	MOH Spreadsheet	Quarterly
MH02 (formerly PP7)	Analytics	MoH Non-Financial Performance Measures	Quarterly
MH04 (formerly PP26)	Analytics	MoH Non-Financial Performance Measures	Quarterly

Observations

- webPAS data is the source of truth but for reporting there are up to three potential data sources for ESPI 2 & 5 – the Ministry of Health NBRS collection and internal databases BOB and CostProBI. Reconciliation of the three sources is either not done at all or done on an ad hoc basis.
- Routine reconciliation of the three sources would provide confidence in the data and avoid reporting discrepancies. Where they do not reconcile the reasons need to be understood and documented. This is particularly important for national datasets as MidCentral DHB has little visibility control over the extraction, load and analysis of Ministry data so there will always be a risk internal reporting will diverge from that reported by the Ministry of Health.
- There are still some known issues attributed to the migration from Homer. The key source of error is due to data in National Collections becoming out of sync with webPAS data where some of the linkages between webPAS and NBRS have been broken at a patient record level. However, as a result, a small amount of legacy data (Homer) is still being used to produce internal ESPI 2 reports.
- Identifying and correcting the webPAS migration issues continues to consume service managers' and analysts' time reconciling Ministry data to webPAS and making corrections.
- Corrections are made by service managers and analysts without a managed process to make these fixes – this creates an unsafe environment for staff should something go wrong.
- The webPAS migration issues provides two key learnings:
  1. The importance of considering the flow on implications to business reporting as a result of systems changes
  2. Ensuring there is a sound process to ensure the migration is complete. This includes ensuring the information used by those making the decision to sign off on any changes is complete and accurate.

Observations cont.

- External reports can come from multiple sources and business units and, while checks may be done before reports are sent, there do not appear to be any standards for ensuring data and reports are accurate.
- The analytics and financial team appear to have a data management heavy role. Does this match their position descriptions and accountabilities or has this evolved over time based on the capability of staff and their knowledge of the data?
- We found many examples where service managers were doing analytical functions. These tasks are time consuming and would be more effectively managed by the analysts with input from subject matter experts.
- We see an opportunity to improve oversight and responsibility over the entire data lifecycle to ensure it is optimised and fit for purpose.

Workshop to validate the current state and discuss our findings

Workshop with MidCentral DHB staff

The description of the current state was presented to MidCentral DHB staff at a workshop on 5 February 2020.The purpose was to validate our assessment and discuss some of our observations.

The workshop was well attended. Fifteen staff from across Digital Services, Analytics and Financial Services, three service managers and an epidemiologist were involved.

What is presented in this slide pack is the validated current state assessment.

Top 5 issues raised by staff

The top five issues raised by staff in the workshop were:

1. A lack of data validation at user entry – high error rate resulting from a lack of good policies, processes and procedures
2. Reporting and data requirements not being included in projects up front
3. Missing opportunities to fully utilise application functionality
4. A lack of ownership over the data
5. Lacking end to end visibility of the data including checks and balances from one system to the next

Other issues raised

- Still data migration issues creating a reliance on legacy data
- Lack of validation of the mappings between systems e.g. Reliance on out of date data dictionaries
- Not taking oppotunities to automate data validation processes
- Lack of clarity on how data is extracted and used by the MoH in its reporting
- Inflexibile systems and regional configurations inhibit local changes to improve data e.g. can't add validation rules for data entry within webPAS
- Not using modern tools and techniques. A lot of effort is put into nursemaiding old systems e.g. still using FTP
- When data is wrong people feel blamed

A case for improved data governance and stewardship

There were a number of issues raised in the workshop relating to the governance and stewardship over the data. These were:

- a lack of understanding and oversight of the end to end flow of clinical data
- a lack of ownership over the data, and as a result it was not clear to staff who was responsible for the accuracy of the data and reports being produced
- a loss of confidence in the quality of the data being presented in reports – mostly from service managers or at executive level
- a lack of control over how data errors are managed and fixed in a way that is justifiable and safe for those making the changes.

2. Validation of ESPIs 2 and 5

Validation is still underway

Validation of ESPIs 2 and 5 is still underway.

3. Mapping of roles and functions

What we did

Based on our current state analysis and through staff interviews we have documented the functions that were undertaken by various roles.

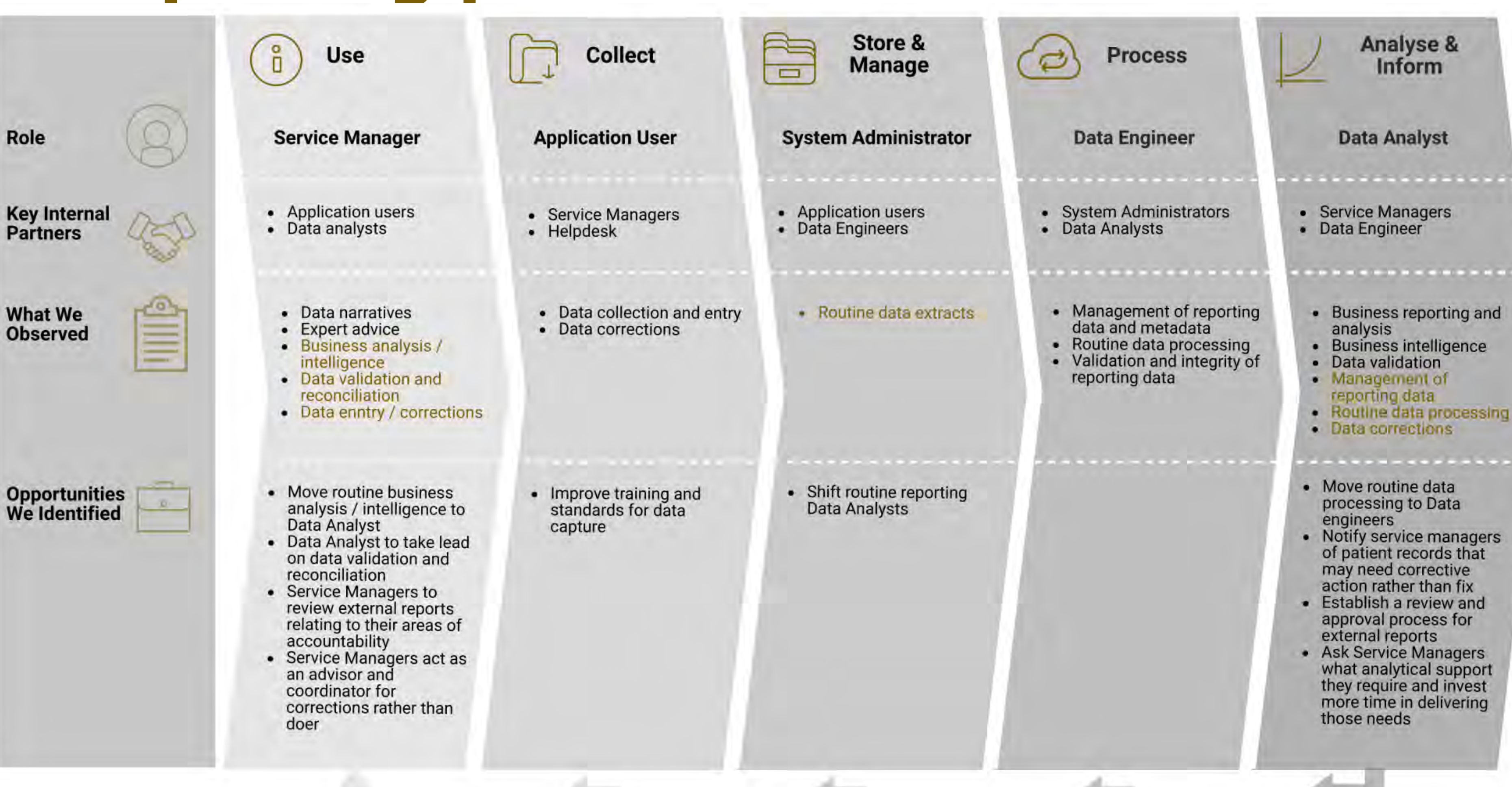
Where we have identified inefficiencies or things that appear out of scope for some roles we have highlighted these in our recommendations.

The diagram on the next slide outlines the high level functions we observed during our current state analysis. We note some management roles, data architects and much of the system administration functions have not been included in our analysis as these were not specifically canvassed during our current state mapping.

What we did not do

We did not undertake an a full current state assessment of existing job titles, role descriptions and accountabilities. Nor have we recommended any structural changes as a result of our analysis.

Roles and functions across the reporting process*



*We have highlighted in gold the things that appeared out of scope or could be more effectively done by someone in another role.

Recommendations relating to roles and functions

1. Move routine business analysis / intelligence to data analysts – some service managers are doing this out of need but this should be a core responsibility of the data analysts. Analysts should be asking business units what information they need to do their job and invest more time into delivering on these needs.
2. Use service managers as advisors rather than the person responsible for validating and reconciling data and reports.
3. Establish a review and approval process for external reports – service managers should be part of the process as a reviewer.
4. If errors in patient records are identified these should be notified to the relevant service manager to work through a process of correction.
5. Service managers act as an advisor and coordinator for corrections rather than doer.
6. Improve training and standards for those collecting and entering data.
7. Shift routine extracts to data engineers or analysts – there is added value in having those that understand the data managing routine extracts and reports, particularly those that feed into National Collections. If there are issues with the extract they are most qualified to spot them and investigate the cause.
8. Move routine data processing to data engineers – routine processing of data can be efficiently managed by data engineers e.g. as part of a scheduled load or triggered by an update.

Summary of recommendations

Recommendations

General recommendations

1. **Review data governance and stewardship framework** - Data governance is a framework for ensuring organisations comply with all relevant legislation and standards in how it handles health information. It is a set a policies, procedures and guidelines that support staff working with health data. Several of the recommendations we have made rely on having good oversight and clear accountabilities to ensure good practice is followed.

2. **Develop clear processes and internal standards for improving the integrity of the data throughout its lifecycle** - Before it uses or discloses health information, an agency must take reasonable steps to check that information is accurate, complete, relevant, up-to-date and not misleading (Health Information Privacy Code 1994, Rule 8, Rule 9, Rule 10 and Rule 11). We found a number examples where good practices were followed and data was routinely validated to maintain the integrity of the data. However, this is not consistently done throughout the end to end flow of the data and it relied on individuals identifying the need rather than policies and procedures governed internally.

3. **Develop a process to safely capture and manage data issues** – when errors are identified staff need to be supported to identify these and take corrective action in a way that enables them to comply with all relevant legislation and standards.

Recommendations

Specific recommendations related to the calculation of ESPIs 2 and 5

4. Develop clear guidelines and training for staff to reduce data entry errors.
5. Where possible, work the WebPAS vendor and your regional DHBs to build in point of entry validation.
6. Request regular validation of source data to replicated data from TAS to ensure this is not a source of error.
7. Work with TAS and other regional DHBs to ensure data dictionaries are up-to-date and accurate.
8. Include reporting requirements as part of any project that could impact on data sources. This could include the use of a senior technical expert in the project team, in an advisory role or as part of project governance.
9. Develop routine reconciliation between CostProBI and BOB.
10. Establish monthly reconciliation of ESPI 5 data against NBRS data. An exceptions report of records that do not match should be provided to the service manager for review. A process to correct records or document reasons for the discrepancy could then be actioned.
11. Automate routine ESPI reporting where possible. For example, the stored procedure that creates the data for ESPI 2 reports could be scheduled to run after the CostProBI daily load.

Recommendations

Related to the calculation of ESPIs 2 and 5, ctd…

12. Produce one set of published results. Providing the data in Qlik and Excel creates additional work to produce the information and to keep them in alignment.
13. Shift responsibility for running Ministry extracts and managing load reports to Analytics and Financial Advisory. There is added value in having those that understand the data managing routine extracts and reports, particularly those that feed into National Collections. If there are issues with the extract they are most qualified to spot them and investigate the cause.
14. Shift responsibility for checking NBRS load reports to Analytics and Financial Advisory (same reasoning as described in the recommendation above)
15. Investigate options to schedule and automate routine data extraction of NNPAC and NPF data.
16. Work with the Ministry and DHB colleagues to investigate better options for routine data collection. There is currently an overreliance on DHBs to manually extract and submit text files or excel files via FTP. For example, in some instances it might be more appropriate for the Ministry to pull data from DHB databases rather than relying on DHBs to push data up as monthly extracts.
17. Establish a process to check the NBRS .NAH file each month. This process should be lead by Analytics and Financial Advisory and differences should be documented and corrected with advice from the service manager.

Recommendations

Specific recommendations related to radiology reporting

18. Reconcile the differences between RIS, and internal reporting and the diagnostic report sent to the Ministry.
19. Establish a monthly reconciliation process to improve the accuracy of the data and reporting. This should be led by Analytics and Financial Advisory with advice from the Radiology service manager.
20. Analysts to ensure the reporting and analysis provided to the service meets their needs. For example, the demand analysis done by the service manager is a core analytical function and should be done within Analytics and Financial Advisory.

Specific recommendations related to reporting on cancer treatments

21. Review the process of creating and manually validating cancer treatment data. There is significant time and cost saving to be had if part of that process could be automated or streamlined.
22. Establish a process to routinely reconcile ROMDS with internal data. This will ensure if the Ministry begins reporting from ROMDS the data should match internal reports.
23. Work with the service to identify other information that would add value to clinicians and the service. Develop these as standard reports that are easily accessible to the business, e.g. within Qlik.

Recommendations

Additional recommendations related to the mapping of roles and functions

24. Establish a review and approval process for external reports – service managers should be part of the process as a reviewer.
25. If errors in patient records are identified these should be notified to the relevant service manager to work through a process of correction.
26. Service managers act as an advisor and coordinator for corrections rather than doer.
27. Move routine data processing to data engineers – routine processing of data can be efficiently managed by data engineers e.g. as part of a scheduled load or triggered by an update.

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independence, integrity and objectivity

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18 August 2021

Via e-mail:

Tēnā koe

Official Information Act (OIA) request – Y21-1066

I refer to your Official Information Act request dated 21 July 2021. Your email has been acknowledged and passed on to me for a response.

Before responding to each of the separate requests for information, it is important to set out some of the context in which Enable New Zealand operates. Enable New Zealand (Enable) is an operating division of MidCentral District Health Board (MDHB). As part of MDHB, we are committed to working in partnership with iwi, underpinned by Te Tiriti o Waitangi, to achieve equitable outcomes for Māori. We wish to recognise and acknowledge that there is still a long way to go before equity is achieved for Māori. At every step, in terms of policy, planning and practise, equity needs to be considered and addressed and we are working hard to make this happen.

It is also important to note that the funding criteria and policy for housing modifications is set by the Ministry of Health (the Ministry). A link to their website[1] with further detail is provided. While Enable is not the policy owner, issues related to equity for Māori are raised with the Ministry as and when identified.

Enable is contracted to manage the back-office administration on behalf of the Ministry, including receiving and reviewing applications for funding and to project manage the building process. Needs Assessments are completed by Occupational Therapists, who are typically employed by the local District Health Board/Public Health Organisation. They are primarily responsible for liaising with the disabled person and their whānau, completing the Needs Assessment and then submitting an application to Enable to process.

When a decision made by Enable is challenged and/or cannot be resolved, it is referred to the Ministry's independent panel for final review and decision. Exceptional cases are also referred to the panel for approval.

As per your OIA request, all hard copies of the documentation, together with a copy of this letter, will follow by post in due course. We also note that any reference to Midland DHB in the request was made in error and have, in all cases, treated the request as referring to MidCentral DHB.

You have requested that MDHB provide you with information to the following questions:

1.

Some information is redacted in these documents under Sections 2(b)(ii) and 9(2)a of the OIA.

[1] https://www.health.govt.nz/your-health/services-and-support/disability-services/types-disability-support/equipment-and-modifications-disabled-people/housing-modifications-disabled-people

Palmerston North Head Office
1st Floor, 585 Main St, Palmerston North
PO Box 4547, Palmerston North 4442
06 353 5800

Christchurch Locality Office
78A Hammersmith Drive, Wigram, Christchurch
PO Box 33054, Christchurch 8244
03 343 8900

Hamilton Locality Office
8 Clow Place, Melville, Hamilton
PO Box 5744, Frankton, Hamilton 3242
07 843 9170

2. The Treaty of Waitangi commitments that MidCentral abide by and the Treaty of Waitangi commitments that they expect of Enable

Ka Ao, Ka Awatea Refresh 2020-2022 (page 6) states:

> ***Our Tiriti o Waitangi Commitment***
> *MidCentral DHB and THINK Hauora are committed to working in partnership with iwi, underpinned by Te Tiriti, to achieve equitable health outcomes for Māori. Furthermore, iwi are committed to providing their time and resource into ensuring the health sector is well advised and guided into making effective decisions that contribute to improving health outcomes for their constituencies.*
>
> *Te Tiriti o Waitangi articles legislate the requirement for Crown agencies to work with iwi. These articles are described as:*
> - *Kawanatanga: Governance and the relationship between Treaty partners,*
> - *Tino Rangatiratanga: The right to be self-determining in all areas,*
> - *Oritetanga: Authentic contributions that drive equitable access and outcomes; and*
> - *Te Ritenga: Honouring the beliefs, values and aspirations of Māori, affirming sovereignty and guaranteeing the protection of hauora (health) for Māori.*
>
> *Additionally, the Ministry's Whakamaua Māori Health Action Plan 2020-2025 make recommendation to a series of principles creating interdependency between the principles and the articles of Te Tiriti. These will underpin the actions of Ka Ao, Ka Awatea, and demonstrate the commitment to Te Tiriti o Waitangi by MidCentral DHB and THINK Hauora and therefore inclusive of the MidCentral rohe health system.*
> - *Tino Rangatiratanga: Actively creating an environment to enable Māori self-determination and mana motuhake in the provision of health and disability services,*
> - *Equity: Commitment to intentionally and systematically work towards a steady improvement in Māori health, considering wider determinants, access, quality and appropriateness of services,*
> - *Active Protection: Acting to the fullest extent practicable to actively protect Māori health and wellbeing, including the active protection of Māori autonomy in relation to health and wellbeing,*
> - *Options: Providing for and properly resourcing kaupapa Māori health and disability services and ensuring that all health and disability services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care; and*
> - *Partnership: Working in partnership with Iwi and Māori in the governance, design, delivery and monitoring of health and disability services.*
> -
>
> *Te Tiriti o Waitangi articles, and additional principles, form the foundation for how the health and disability system meets its obligations. It guides us in how we govern and conduct ourselves, how true partnership with iwi is demonstrated, how beliefs, values and tikanga are cherished, and how excellence, in all its definitions, is attained. The articles and principles underpin this refreshed version of Ka Ao, Ka Awatea, utilising the aligned Te Tiriti o Waitangi organisational policy as the driver, to ensure Te Tiriti articles remain at the forefront of the strategic direction for Ka Ao, Ka Awatea, and therefore Māori health.*

Te Tiriti o Waitangi Policy MDHB 2031 states:

> *4.3 Chief Executive, Management and Staff*
> *The Chief Executive, management and staff roles and responsibilities are to:*
> - *Ensure that services provided by MDHB are responsive to partnering Iwi and Māori to exercise tino rangatiratanga, and mana motuhake in design, delivery and monitoring of the MDHB systems toward health and wellbeing for Iwi and Māori*
> - *Ensure that Section 4 of the NZPHD Act 2000 is actioned in meaningful partnership ways with Iwi and Māori*

- *Commit to achieving equitable outcomes for Iwi and Māori thus ensuring all health and disability services are provided in a way that recognises iwi and Māori needs and aspirations*
- *Redirect funding and commissioning toward improving Māori health through local Iwi and Māori providers*

3. What protections and Māori cultural and assurances does Midland DHB require of its contractors, specifically Enable.

Enable is an operating division of MidCentral District Health Board. All employees of Enable are employees of MDHB.

Within MDHB, the Pae Ora Paiaka Whaiora Hauora Māori Health Directorate has a Tikanga and Cultural Facilitator who is employed at .5FTE, and partners with Enable to support tikanga and support staff with their knowledge of mātauranga Māori. They are of local iwi descent and a respected kāumātua who is also an active participant at Manawhenua Hauora meetings. This Tikanga and Cultural Facilitator works alongside three other Tikanga and Cultural Facilitators who are employed at .5 FTE, 1.0 FTE and .4 FTE. Their mahi is important to ensure consistency and application of cultural responsiveness across MDHB.

All staff are expected to attend the trainings offered. These are listed below:

- *Te Tiriti o Waitangi -Equity and Health* is a mandatory two-day session with Facilitator Jen Margret and is offered monthly. All Staff are expected to have attended Te Tiriti o Waitangi training within the past five years. Almost all staff at Enable have recently completed MDHB's provided Te Tiriti o Waitangi Equity and Health Training. Those remaining staff have been scheduled to attend later in 2021.
- *Māori Cultural Responsiveness in Practice* is to be completed after Te Tiriti training. Facilitator x2 Pae Ora Tikanga and Cultural Facilitators. Pae Ora Māori Health Directorate created this workshop in conjunction with the Treaty of Waitangi in Health workshop to purposefully and systematically develop Māori cultural skills, knowledge and practice, which were identified as **essential** by our regional iwi in 2010 for all health workers.
- Staff are expected to enter the organisation through new staff pōwhiri, where they get an introduction and practical experience around pōwhiri and an introduction to local iwi and Pae Ora Paiaka Whaiora Hauora Māori.
- Staff are expected to be able to use and apply Whakamaua 2020-2025 to all action plans and improvement processes.
- Staff are expected to be able to apply equity frameworks to all areas of work and include in all planning and strategies – The Health Equity Assessment Tool (HEAT)
- To apply, develop and create bicultural job descriptions utilising MDHB Bicultural Model of Practice – copyright Pae Ora provided document
- Currently developing a Māori Policy Analysis Framework to assist all staff to incorporate Māori concepts and approaches to advance Māori health gains and prioritise the health and wellbeing of whānau – draft v3 provided.

4. The contract and services Enable provide to Midland DHB.

Please refer to the documentation provided.

5. Statistical breakdown by region, ethnicity and age and decisions for the country for bathroom updates for past 10 years

Enable can only provide data for its service area, which is from south of the Bombay Hills. Therefore, we are unable to provide National Data under Section 18(g)(i) of the OIA.
In addition, our system does not allow us to pull out the data you have requested prior to August 2020. To provide the information you have requested would require us to manually review every

request. Based on this, we have only provided data from August 2020 onward. Therefore, your request for data between 2012-2020 cannot be provided under Section 18(f) of the OIA.

6. Criteria for funding regarding bathroom updates

Please refer to the documentation attached.

7. Names and Iwi affiliations of committee members of Enable that were involved with decision making of our case

Please note that the Ministry has an independent panel that reviews decisions about individual cases that do not meet criteria but should be considered by exception and/or are challenged by a third party. This panel does not include Enable staff members and therefore we are unable to provide the information you have requested. We understand that you have made a similar request to the Ministry for their response.

We are unable to provide any names and iwi affiliations of the panel under Section 18(g)(i) of the OIA.

Regarding this specific case, [redacted] Professional Advisor for Enable New Zealand, declined the original application as it did not meet the Ministry's set criteria. All other decisions in relation to this case were *not* made by Enable.

Under Section 9(2)a of the OIA, we are withholding the Iwi of our member of staff.

We have provided the policy of the Appointment to Board Committees for MDHB, for your information.

8. A copy of the Māori ethics policies and procedures provided are as follow:

MDHB-7660 MDHB Maori Review of Research Form
MDHB-7661 MDHB Approval Form for Low-Risk Research Activity Form
MDHB-1997 Health Research Policy
MDHB-7361 Pae Ora Maori Health Care Services Documentation Policy
MDHB-1349 Translation of Written Information into Maori Policy
MDHB-2862 Professional Presentation-Behaviour and Dress Standards Policy
MDHB-6326 Aromatawai Maori - Cultural Assessment Form
MDHB-4530 Aromatawai Maori Cultural Assessment Kowhiri Choice Form
MDHB-7363 Pae Ora Maori Health Service Sticker 1157561 Form
MDHB-8101 Pae Ora Maori Health Services Virtual Contact Form INTERACTIVE Form
MDHB-7364 Whanau Assessment - Pae Ora Maori Health Care Service 1157587 Form
MDHB-2031 Te Tiriti o Waitangi Policy
MDHB-6660 Koha Policy
MDHB-1949 Te Whare Rapuora Accommodation Policy
MDHB-7594 Cash Handling Procedure - Te Whare Rapuora Procedure
MDHB-7365 Pae Ora Patient Referral and Te Whare Rapuora Accommodation Booking Form 1157579
MDHB-4768 Consumer Engagement and Payment Policy
MDHB-1887 Core Skills - Mandatory Training Policy
MDHB-7188 Professional Development and Recognition Programme (PDRP) Advisory Committee Terms of Reference
MDHB-2003 Official Functions Policy
MDHB-8063 Completing an Application for Approval of Low-Risk Research Activity Form Guideline
MDHB-5647 In-service Training Packages for Mental Health Staff (Compulsory and Recommended) Procedure
MDHB-2955 Funding Division Record Retention and Disposal Policy

MDHB-6854 Paruru Mowai Terms of Reference
MDHB-3126 Breastfeeding Policy
MDHB-577 Admission to Assessment, Treatment and Rehabilitation Service Inpatient STAR 2 Procedure
MDHB-8069 Telehealth Policy
MDHB-8070 Telehealth Interactions by Healthcare Professionals Procedure
MDHB-4947 Public Consultation Policy
MDHB-7417 Child-Young Person Protection Procedure
MDHB-7622 Social Work - Initial Assessment 1166598 Form
MDHB-6853 Service User and Family-Whanau Engagement Policy
MDHB-4710 Nursing Performance Assurance and Just Culture Policy
MDHB-5857 Gender Mixing within Wards Policy
MDHB-8092 Gender Inclusive Practices Guideline
MDHB-1890 Diversity and Inclusion Policy
MDHB-5443 Nutrition and Physical Activity Policy
MDHB-2051 Appointment to Board Committees Policy
MDHB-1884 Bereavement-Tangihanga Leave Policy
MDHB-1901 Recruitment-Appointment Policy
MDHB-4801 Family/Intimate Partner Violence Policy
MDHB-2021 Feedback Policy
MDHB-2642 Interpreter Policy
MDHB-4723 Interpreter Procedure
MDHB-148 Return of Body Parts Procedure
MDHB-4176 Nursing Professional Practice Model Policy
MDHB-5565 Health and Disability Ethics Application Guideline
MDHB-6397 Death of a Patient Policy

9. Any Iwi MOU's that Midland District DHB have with Manawhenua and other Iwi.

Please refer to the attached documentation.

If you are not satisfied with our response to your information request, you have the right to seek a review by way of complaint by the Ombudsman of our decision. Information about how to make a complaint is available at www.ombudsman.parliament.nz or calling 0800 802 602.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website ten working days after your receipt of this response. This will not include any private information.

Nāku noa, nā

Michelle Riwai
General Manager
Enable New Zealand

Transferred OIA regarding MDHB's HIMSS maturity assessments

Your OIA request is acknowledged and has been passed on to me for response.

You have requested the following information:

All original communications including briefings, reports, memos, aides' memoirs, cabinet papers and texts around the eight DHBs who reported HIMSS maturity levels."

***Response*:**

For context, the MidCentral District completed Te Awa, the District Digital Strategy in 2018. This is a five-year strategic approach to transform the way the MidCentral District delivers digital Healthcare Services which will be done over three phases.

Key to the strategy is a whole of the system approach for all providers across the District. The Central PHO (now Think Hauora) were integral to the development anddesign of the strategy, and the process to develop the strategy had extensive District engagement including locality-based community roadshows across the District.

As part of the first phase of the implementation of Te Awa, HIMSS Digital Maturity Assessments across 5 areas have been completed. The aim was to establish a baseline and identify any opportunities for improvement. The two main participants were MidCentral DHB and Think Hauora PHO. Although some representatives fromresidential and community care providers completed the assessment, they were in no way a representative of all such providers across our District, and therefore theirresults were not included. It should be noted that HIMSS DMA process is quite hospital centric, however MidCentral DHB, THINK Hauora and other community partners, collectively found the process useful, as it has established a common language and understanding of the baseline

of our digital maturity.

The results of the HIMSS assessment across 5 areas are as follows:

HIMSS Assessment	MidCentral DHB	Think Hauora
Continuity of Care MaturityModel	0	2
Electronic Medical RecordAdoption Model	0	Not applicable
Outpatient - Electronic Medical Record AdoptionModel	1	5
Infrastructure adoptionModel	0	Not applicable
Analytics Adoption Modelfor Analytics Maturity	0	Not applicable

The results of the assessments were not un-anticipated and were consistent with otherinternal reviews undertaken to obtain a baseline of our digital maturity and capability. For MidCentral DHB, it has highlighted, that in some of the higher levels of digital maturity, MidCentral DHB has almost completed the requirements, therefore for small investments we expect to have some quick wins improving our overall digital maturity.

In parallel to the HIMSS assessment process, the District has developed an initialview of a District Reference Architecture and reviewed seven layers of capability within this.

For MidCentral DHB, both the HIMMS assessments and Reference Architecture review highlights the effect of a sustained lack of historic investment, and the burdenof legacy technology and application portfolio creates.

Both HIMMS assessments and Reference Architecture review describe the startingpoint for our Te Awa journey, where the delivery of digital health will enable new ways of working to support Clinicians to improve consumer outcomes. This will include guiding the development of our long term EMR/EPR roadmap and importantly the required portfolio investment to deliver it.

As a result of this activity the District will now move onto the next stage of the Districts Te Awa digital strategy by developing a road map of digital health activitythat will be implemented in the District in the coming years.

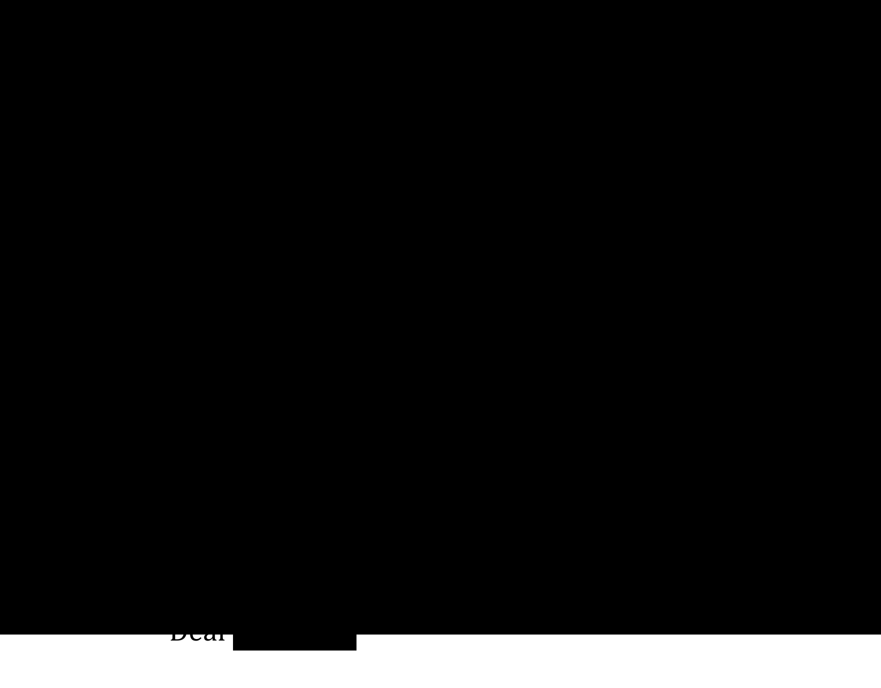
In conclusion I trust the above gives context, however we simply don't have any means of gathering what is being requested during these unprecedented times.

Digital Services
MidCentral Health, P O Box 2056, Palmerston North 4440 Telephone (06) 350 8841

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website ten working days after your receipt of this response.

Kind regards

Steve Miller
Chief Digital Officer



Dear

Official Information Act (OIA) Request

Your OIA request of 29 July 2021 to MidCentral District Health Board (MDHB) is acknowledged and has been passed on to me for response.

You have requested the following information.

1. **RMO FTE as at 1 July 2021 on ED runs for each ED department, broken down into House Officer and Registrar.**

   RMO FTE (budgeted) for this time period was 18 FTE. This was assigned as nine Registrars and nine House Officers.

2. **RMO FTE as at 1 July 2016 on ED runs for each ED department, broken down into House Officer and Registrar**

   RMO FTE (budgeted) for this time period was 18 FTE. This was assigned as nine Registrars and nine House Officers.

3. **Patient volumes in ED by month for the last five years.**

Months	2016	2017	2018	2019	2020	2021
Jan	3443	3493	3649	3961	3997	3962
Feb	3619	3300	3569	3628	3765	3744
Mar	3701	3632	3870	4105	3396	4204
Apr	3456	3360	3542	3847	2696	3900
May	3681	3589	3730	3946	3167	4024
Jun	3560	3486	3854	4002	3825	4357
Jul	3717	3820	3953	4065	3815	4288
Aug	3699	3798	4253	4140	4080	
Sep	3692	3672	3778	3937	3666	
Oct	3562	3608	3796	3892	4121	
Nov	3492	3479	3693	3754	4040	
Dec	3788	3670	3941	3951	4055	
Grand Total	**43410**	**42907**	**45628**	**47228**	**44623**	**28479**

Operations Executive, Acute & Elective Specialist Services
MidCentral District Health Board, PO Box 2056, Palmerston North 4440
Telephone (06) 356 9169

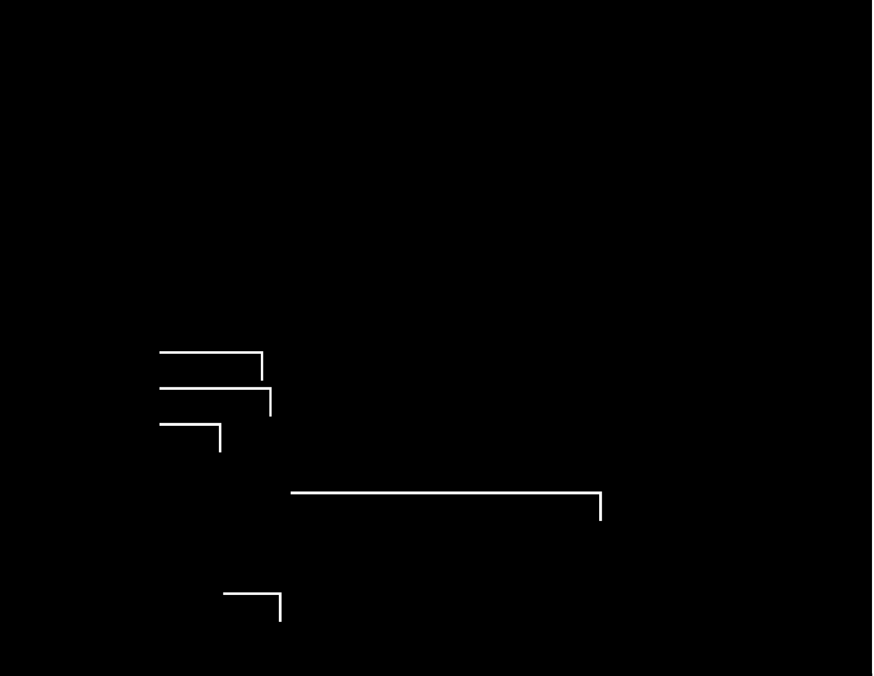
4. Patient presentations in ED in January 2021 and June 2021 broken down by time band (as below) and day of the week;
a. 0800 to 1600 hours
b. 1600 to 0000 hours
c. 0000-0800 hours

	Jan				Jun			
	08:00-15:59	16:00-23:59	0:00 - 07:59	Total	08:00-15:59	16:00-23:59	0:00 - 07:59	Total
Sunday	304	262	92	658	288	219	92	599
Monday	237	194	83	514	305	247	90	642
Tuesday	236	210	67	513	363	276	91	730
Wednesday	241	221	66	528	339	269	73	681
Thursday	265	197	65	527	297	215	76	588
Friday	276	246	84	606	262	221	101	584
Saturday	269	241	106	616	241	199	93	533
Total	**1828**	**1571**	**563**	**3962**	**2095**	**1646**	**616**	**4357**

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website 10 working days after your receipt of this response.

Yours sincerely

Lyn Horgan
Operations Executive
Acute & Elective Specialist Services



I refer to your Official Information Act request received by email on 29 July 2021 with regard to Psychologists at MidCentral DHB, and respond as follows:

1. *How many psychologists does the DHB employ, both in body count and FTE.*

17 – 15.25 FTE.

2. *How many psychologists who are APEX Members are on the APEX MECA pay scale between steps 1-9?*

7.

3. *How many psychologists who are APEX Members are on the APEX MECA pay scale on Steps 10 and above?*

10.

4. *How many psychologists on Step 10 or above on the APEX MECA pay scale applied for merit progression, applying for a one step increase?*

2.

5. *How many psychologists on Step 10 or above on the APEX MECA pay scale applied for merit progression, applying for more than a one-step increase?*

0.

6. *How many psychologists on Step 10 or above on the APEX MECA pay scale were successful in their merit application for more than a one-step increase?*

N/A.

7. *How many psychologists between steps 1-9 on the APEX MECA pay scale applied for accelerated advancement as per clause 9 (a).*

0.

8. *How many psychologists between steps 1-9 on the APEX MECA pay scale were successful in their application for accelerated advancement as per clause 9 (a), and how many steps were they awarded?*

N/A.

Please note that this response, or an edited version of it, may be published on the MidCentral DHB website ten working days after your receipt of this letter.

Yours faithfully

Keyur Anjaria
General Manager
People & Culture

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

Phone (06) 350 8061
Fax (06) 355 0616

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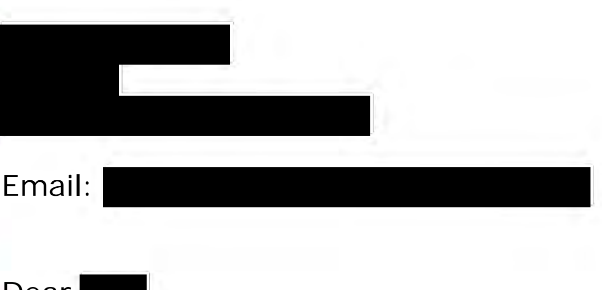
20 August 2021



Email:

Dear

Official Information Act (OIA) request – Y21-1171
Sonography Wait Times

Thank you for your request for information dated 6 August 2021. Your email has been acknowledged and passed onto me for a response.

You have requested MidCentral District Health Board (MDHB) provide you with information to the following questions:

We are wanting to verify anecdotal reports about sonography waiting times for ovarian cancer symptoms in your region as part of our submission to the Health Select Committee - can you please provide the current wait time for an urgent, semi urgent and routine transvaginal ultrasound (or just ultrasound generally if your data does not make the distinction), and the criteria for evaluating the urgency of a request (general, or ovarian if you have) and include the current Health Pathways criteria for your DHB for ovarian cancer.

All ultrasound referrals are triaged by the Charge Sonographer.

The current wait times for urgent ultrasound examinations is 1-2 weeks and would include:

- All referrals marked as urgent by referrer
- All referrals marked high suspicion of cancer
- Any referrals with high risk factors:
    - Mass felt on examination
    - Mass found on imaging
    - Previous history of breast cancer
    - Family History
    - BRCA gene
    - Raised CA125
    - Unexplained weight loss

- Abdominal distension/signs of ascites

The wait time for semi urgent referrals is 2-3 months, which would include all other referrals.

No referrals of this category are triaged as routine (7-9 months).

MDHB utilise Canterbury Health pathways. The relevant pathways for gynaecological cancer are attached.

You have the right to seek an investigation and review by the Ombudsman of our decision. 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 may be published on the MDHB website ten working days after your receipt of this letter. Please let me know if you have any objections to this as soon as possible.

I hope this information is what you require.

Yours sincerely

Sarah Fenwick
Operations Executive
Te Uru Pā Harakeke
Healthy Women Children and Youth

Community HealthPathways Whanganui & MidCentral

Postmenopausal Bleeding

Background

About postmenopausal bleeding

Assessment

1. History:
   - Take a history of all postmenopausal vaginal bleeding (PMB}, including recurrent PMB.

     > **Recurrent postmenopausal bleeding (PMB)**
     >
     > Patient has had a previous episode of PMB, followed by a 4-month interval with no vaginal bleeding.

   - Assess:
     - risk factors for endometrial cancer.

       > **Risk factors for endometrial cancer**
       >
       > - History of chronic anovulation, including associated polycystic ovarian syndrome (PCOS}
       > - Exposure to unopposed oestrogen
       > - Familial disposition fulfilling the Amsterdam criteria
       > - Nulliparity
       > - Obesity
       > - Maori or Pasifika
       > - Diabetes

     - pattern of bleeding.
     - use of hormone replacement therapy (HRT) and tamoxifen.

Postmenopausal bleeding on tamoxifen

Use an endometrial biopsy to assess these women as transvaginal ultrasound scan (TVS) has been shown to be neither sensitive nor specific for neoplasia.

2. Perform examinations:
   - Abdominal examination
   - Speculum:
     - Inspect vulva, vagina, and cervix.
     - Take cervical smear if last smear was> 3 months ago.
     - Offer swabs if appropriate.

Swabs

- Vulvovaginal NAAT swab for chlamydia and gonorrhoea (prior to speculum insertion). Vulvovaginal swabs are significantly better than endocervical swabs at detecting chlamydia.
- High vaginal culture swab for bacterial vaginosis, candida, and trichomonas.

   - Bimanual examination
3. For private or Whanganui patients, arrange transvaginal ultrasound scan (TVS) indicating urgent, post menopausal bleeding, and high suspicion of cancer (HSC) - request for the report to include endometrial thickness.
   - For public MidCentral patients with an intact uterus, TVS is not indicated before referral as it will be done at the clinic.
   - For patients on sequential HRT, TVS measurements should take place during the first half of the cycle.

Management

Practice point

Endometrial cancer risk

Around 1 in 10 women with postmenopausal bleeding will have endometrial cancer. Refer patients with normal results if the bleeding is recurrent, and atrophic vaginitis has been treated.

1. For public MidCentral patients with an intact uterus, request non-acute gynaecology assessment from a postmenopausal bleeding clinic using the HSC referral form.
2. If the patient has had a partial or total hysterectomy, and there is no cervical, vaginal, or vulval abnormality on examination, treat with vaginal oestrogens (Ovestin) for 4 months. If bleeding still persists, request non-acute gynaecology assessment.

Vaginal oestrogens

- Seek gynaecology advice if considering low-dose vaginal estrogens for a patient who has had breast cancer.
- Vaginal irritation and stinging can initially be a problem with estriol cream, so a gradual starting regimen is often needed.
- Initial side-effects can include breast pain and bleeding. This is more common with cream or pessary formulations, especially in older women.

Topical estrogens

For full prescribing details, see GTopical Estrogens.

- Ovestin cream:
  - Prescribe for use twice a week. This is different to NZ Formulary guidance. Local experts recommend not using daily loading doses because of increased risk of reactive vaginitis to the cream.
  - Providing good hygiene standards are met, there is no need to discard the applicator after a calendar month's use.
  - 1 full applicator twice a week works out to 13 g of Ovestin in 3 months. It comes in tubes of 15 g.
  - Ovestin pessaries twice weekly are an alternative.
- Vagifem has been discontinued.

3. If recurrent PMB, request non-acute gynaecology assessment indicating HSC, regardless of normal investigations.

Recurrent postmenopausal bleeding (PMB)

Patient has had a previous episode of PMB, followed by a 4-month interval with no vaginal bleeding.

4. If examination shows cervical or vaginal abnormality (apart from atrophic vaginitis):
   - Manage any cervical polyps.

- Otherwise, request a non-acute gynaecology assessment.
- Always arrange TVS, indicating postmenopausal bleeding, as abnormality may not be the cause of bleeding.

5. Otherwise, manage according to endometrial thickness found on TVS:
   - If< 4 mm:
     - Treat atrophic vaginitis . No other treatment is required.

Atrophic vaginitis

Atrophic vaginitis is the most common benign cause of postmenopausal bleeding.

Vaginal oestrogens:

- Effective treatment for moderate to severe symptoms of vaginal atrophy.
- Systemic absorption of vaginal oestrogens is negligible with serum levels remaining within the postmenopausal range.
- Discuss the use of low-dose vaginal oestrogens in women who have had breast cancer with a specialist.
- Vaginal irritation and stinging can initially be a problem with oestriol cream, so a gradual starting regimen is often needed.
- Initial side-effects can include breast pain and bleeding. This is more common with cream or pessary formulations, especially in older women.

Topical estrogens

For full prescribing details, see **GTopical** Estrogens.

- Ovestin cream:
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  - Providing good hygiene standards are met, there is no need to discard the applicator after a calendar month's use.
  - 1 full applicator twice a week works out to 13 g of Ovestin in 3 months. It comes in tubes of 15 g.
  - Ovestin pessaries twice weekly are an alternative.
- Vagifem has been discontinued .
-

- Review in 2 months. Schedule a practice recall and, if further bleeding occurs, request non-acute gynaecology assessment.

- If 4 mm, request non-acute gynaecology assessment indicating HSC.

Request

- Request non-acute gynaecology assessment:
  - for MidCentral patients with an intact uterus - specify postmenopausal bleeding clinic and use the HSC referral form.
  - if an abnormality is found, including endometrial thickness 4 mm on TVS - indicat HSC.
  - if bleeding persists despite treatment with vaginal oestrogens.
- Discuss the use of low-dose vaginal oestrogens in women who have had breast cancer with a specialist.

Information

For health professionals

Further information

Patient - HRT: Follow-up Assessments

For patients

Health Info - Abnormal Bleeding After Menopause

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SOURCES

References

1. Cancer Australia. Abnormal vaginal bleeding in pre-, peri- and post-menopausal women: a diagnostic guide for general practitioners and gynaecologists [Internet]. [updated 2015 Oct 13]. 2011. [Abstract]

PAGE INFORMATION

Last Updated: 03 August 2021

Last Reviewed: 08 October 2020

Keywords: ——

Topic ID: 787089

Community HealthPathways Whanganui & MidCentral

Abnormal Uterine Bleeding

See also:

- Postcoital Bleeding
- Postmenopausal Bleeding

Red flags

Endometrial cancer or hyperplasia

Cervical cancer

Background

v About abnormal uterine bleeding (AUB)

About abnormal uterine bleeding (AUB)

Definitions:

- Abnormal uterine bleeding (AUB) - bleeding that is abnormal in duration, volume, and/or frequency.
- Heavy menstrual bleeding (HMB)-the most common complaint of AUB. It is defined as excessive menstrual blood loss which interferes with a woman's physical, social, emotional and/or material quality of life. It can occur alone or in combination with other symptoms.
- Intermenstrual bleeding (IMB) -vaginal bleeding at any time other than during normal menstruation or following intercourse.
- Postcoital bleeding (PCB) - bleeding following intercourse.

Assessment

1. Take a history, giving special attention to:
   - risk factors for endometrial cancer or hyperplasia.

Risk factors

- Aged ?:45 years, or
- Aged> 35 years and has one or more of the following:
  - **BMI:?: 30**
  - Exposure to unopposed oestrogen or tamoxifen
  - Nulliparity, infertility, polycystic ovarian syndrome (PCOS)
  - Maori or Pasifika
  - Diabetes
  - Familial disposition fulfilling the v Amsterdam Criteria

- v related symptoms suggesting structural or histological abnormality.

Related symptoms

- Intermenstrual bleeding (1MB) - vaginal bleeding at any time other than during normal menstruation or following intercourse
- Postcoital bleeding (PCB)
- Pelvic pain
- Pressure symptoms

- nature of bleeding.
- symptoms of anaemia.
- sexual and reproductive history.
- symptoms indicative of systemic causes of bleeding - if polycystic ovarian syndrome (PCOS) is suspected, follow the Polycystic Ovarian Syndrome pathway.

Systemic causes

- Hypothyroidism
- Polycystic ovarian syndrome (PCOS)
- Hyperprolactinaemia
- Coagulation disorders
- Adrenal or hypothalamic disorders

- medications that can be associated with AUB .

Medications that can be associated with AUB

- Anticoagulants
- Antidepressants - selective serotonin reuptake inhibitors and tricyclics
- Hormonal contraceptives e.g.:
  - Jadelle
  - Mirena - usually only in the first 6 months
  - Depot medroxyprogesterone acetate (Depo-Provera) - can influence bleeding patterns for many months after the last injection

  See Faculty of Sexual Reproductive Healthcare - Problematic Bleeding with Hormonal Contraception .
- Tamoxifen
- Antipsychotics - first generation and risperidone
- Corticosteroids

2. Examination - perform:
   - general assessment, including weight, height, BMI, and abdominal examination.
   - speculum examination:
     - Check the vulva, vagina, cervix, urethra meatus, and anus.
     - Take STI swabs if increased risk of sexually transmitted infection, or if Mirena IUS is a management option.

Increased risk

Risk is increased if:

- within the last year, the patient has had:
  - more than 2 sexual partners.
  - a new sexual partner in the last 3 months.
  - an STI.
  - a sexual partner with an STI.
- the patient is aged younger than 30 years.

STI swabs

- Vulvovaginal NAAT swab for chlamydia and gonorrhoea prior to speculum insertion. Vulvovaginal swabs are significantly better than endocervical swabs at detecting chlamydia.
- High vaginal culture swab for bacterial vaginosis, candida, and trichomonas.

  - Perform cervical screening if due.
- bimanual examination.

3. Investigations:
   - Consider pregnancy test.
   - Arrange CBC and ferritin.
   - Arrange TSH only if other signs or symptoms of thyroid disease are present.
   - Consider coagulation screening only if:
     - heavy menstrual bleeding (HMB) since menarche, and
     - a personal or family history suggesting a coagulation disorder.

   Hormone testing of women who have heavy menstrual bleeding (HMB) is not recommended.

4. Do not arrange further investigations before treatment if heavy menstrual bleeding with **no** risk factors, **no** related symptoms, and normal examination.

Risk factors

- Aged 45 years, or
- Aged > 35 years and has one or more of the following:
  - BMI 30
  - Exposure to unopposed oestrogen or tamoxifen
  - Nulliparity, infertility, polycystic ovarian syndrome (PCOS)
  - Maori or Pasifika
  - Diabetes
  - Familial disposition fulfilling the Amsterdam Criteria

Heavy menstrual bleeding (HMB)

- The most common complaint of AUB
- Defined as excessive menstrual blood loss which interferes with a woman's physical, social, emotional, or material quality of life

- Can occur alone or in combination with other symptoms

5. Arrange transvaginal pelvic ultrasound (IVS) to exclude endometrial hyperplasia or cancer, noting on the form "urgent" and "high suspicion of cancer (HSC)", if:
   - aged ;= 45 years, or aged > 35 years with one or more risk factors

     Risk factors in patients aged > 35 years

     - BMI;::: 30
     - Exposure to unopposed oestrogen or tamoxifen
     - Nulliparity, infertility, polycystic ovarian syndrome (PCOS)
     - Maori or Pasifika
     - Diabetes
     - Familial disposition fulfilling the Amsterdam Criteria

   - HMB associated with intermenstrual bleeding (1MB) or postcoital bleeding (PCB), pelvic pain, or pressure symptoms.
   - uterus is palpable abdominally.
   - vaginal examination reveals a pelvic mass of uncertain origin.

Management

1. If the examination or pelvic ultrasound results indicate high suspicion of cancer, request non-acute gynaecology assessment using High Suspicion of Cancer (HSC).
2. If scan shows fibroids causing significant uterine enlargement or cavity distortion, request non-acute gynaecology assessment.
3. If scan shows normal endometrium, but other pathology requiring advice e.g., endometrial polyp, seek gynaecology advice.
4. If unwell due to blood loss e.g., severe anaemia (Hb < 80 g/L), request acute gynaecology assessment.
5. If the patient has acute bleeding, provide pharmacological treatment

   Pharmacological treatment

   1. Treat with:
      - Otranexamic acid 1.0 to 1.5 g three to four times a day for 3 to 5 days, and/or

- 10 days of either:
  - norethisterone (Primolut N) 5 mg three times a day, or
  - medroxyprogesterone acetate (Provera) 10 mg three times a day (or 30 mg once a day if compliance is difficult).

  A withdrawal bleed will occur about 10 days after stopping this treatment, and that is the goal.

2. Continue hormonal treatment after the withdrawal bleed for at least 3 months using either:
   - any oral contraceptive pill in monthly cycles, or
   - progestogen (norethisterone 5 mg twice a day or medroxyprogesterone acetate 10 mg once a day) from day 5 to 25 of the menstrual cycle.

6. If the patient has chronic bleeding:
   - treat iron deficiency anaemia.
   - consider non-hormonal and hormonal treatment options.

Hormonal treatment options

- Levonorgestrel-releasing intrauterine system (Mirena IUS) if long-term use (at least 12 months) is anticipated
- Combined oral contraceptrve (COC) pill - consider tricyclical or continuous use
- Injected long-acting progestogens e.g., depot medroxyprogesterone acetate (Depo-Provera)
- Norethisterone or medroxyprogesterone acetate

Non-hormonal treatment options

Non-hormonal treatments are more effective if bleeding is cyclic or predictable in timing.

Use:

- Gtranexamic acid.
- **NSAIDS:**
  - Start either just before, or at the earliest onset of, menses and continue to take regularly every 6 to 8 hours for the first 3 to 4 days of the cycle.

- Emphasise the need to start these early and continue at a therapeutic dose.
- For full prescribing details, see NZ Formulary- G NSAIDs.

- trial alternative options for medical management if AUB persists despite treatment. If the patient has failed a 3-month trial of medical management, and more than one option for medical management has been tried:
  - arrange transvaginal pelvic ultrasound (TVS) to exclude endometrial hyperplasia or cancer- note on the form "urgent" and "high suspicion of cancer (HSC)".
  - request non-acute gynaecology assessment.

7. Request non-acute gynaecology assessment for consideration of endometrial ablation or hysterectomy if failed medical management and no wish for future fertility.

Request

- If unwell due to blood loss e.g., severe anaemia (Hb < 80 g/L), request acute gynaecology assessment.
- Request non-acute gynaecology assessment if:
  - the patient has failed a 3-month trial of medical management, and more than one option for medical management has been tried.
  - endometrial ablation or hysterectomy to be considered.
  - fibroids causing significant uterine enlargement or uterine cavity distortion.
  - examination or ultrasound results indicate high suspicion of cancer.
- If scan shows normal endometrium, but other pathology requiring advice e.g., endometrial polyp, seek gynaecology advice.

Information

Further information

- Faculty of Sexual Reproductive Healthcare - Problematic Bleeding with Hormonal Contraception
- National Institute for Health and Care Excellence (NICE) - Heavy Menstrual Bleeding: Assessment and Management

For patients

- HealthInfo:
  - 0, Heavy Periods
  - 0, Pipelle Biopsy
- Health Navigator:
  - Heavy Bleeding in Periods
  - Mirena IUD for Heavy Periods

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PAGE INFORMATION

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AUB

dysfunctional uterine bleeding

HMB

menorrhagia

vaginal bleeding

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Community HealthPathways Whanganui & MidCentral

Ovarian Cancer Symptoms

See also Familial Breast and Ovarian Cancer Syndromes.

Red flags

Genetic risk - strong family history or known HNPCC or BRCA mutation

Background

About ovarian cancer symptoms

About ovarian cancer symptoms

- Ovarian cancer is more common in postmenopausal women.
- The mean age of diagnosis is 65 years.
- The lifetime incidence for women is 1.6%.
- In premenopausal women, ovarian cancer is uncommon but more likely if there is a strong family history of known HNPCC or BRCA mutations.
- Around 10% of ovarian cancer is caused by hereditary cancer syndromes.
- Non-specific symptoms make diagnosis difficult.
- Examination is important as there may be a mass and clinical evidence of abdominal disease.
- Patients with one first- or second-degree relative with ovarian cancer occurring when aged older than 50 years have a 5% lifetime risk, which is slightly increased from the general female population lifetime risk of 1.6%. Patients with known genetic mutations, e.g. BRCA mutation, have a much higher risk.
- There is currently no proven role for Ca125 or ultrasound screening in asymptomatic women.1

Assessment

1. Assess possible ovarian cancer if new abdominal or pelvic symptoms are present on a persistent or frequent basis - particularly more than 12 times per month:
   - Persistent abdominal distension or bloating
   - Early satiety or loss of appetite
   - Pelvic or abdominal pain without a known cause
   - Increased urinary urgency or frequency
   - Irritable bowel symptoms, especially if new onset and aged older than 50 years
   - Unexplained weight loss or fatigue
   - Postmenopausal bleeding
2. Consider genetic risk.

Genetic risk

Patients with one first- or second-degree relative with ovarian cancer occurring when aged older than 50 years have a 5% lifetime risk, which is slightly increased from the general female population lifetime risk of 1.6%. Patients with known genetic mutations, e.g. BRCA mutation have a much higher risk. Ovarian cancer risk is up to 44% with BRCA1 and 17% with BRCA2.

3. Consider a differential diagnosis for other causes of chronic, vague abdominal symptoms, including bowel cancer.

Differential diagnosis

Conditions commonly associated with chronic pelvic pain:

- Gynaecological:
  - Endometriosis
  - Adenomyosis
  - Chronic PID
  - Vulvodynia, vaginismus and sexual dysfunction
  - Pelvic congestion syndrome
- Adhesions:
  - Endometriosis
  - Previous surgery
  - Pelvic infection
- Urological:
  - Interstitial cystitis

Interstitial cystitis

- Interstitial cystitis/bladder pain syndrome is a chronic bladder condition with pelvic pain, dysuria, urinary frequency, urgency and pressure in the bladder and pelvis, in the absence of proven urinary infection or other obvious pathology. There is no known cause or consensus on treatment but management is generally symptomatic and supportive.
- As well as MSU, ask patients to fill in a bladder diary , and to include comments about pain.
- Avoid any irritants which may exacerbate symptoms, e.g. caffeine, alcohol, artificial sweeteners, and hot p_epper. There is some evidence to suggest certain exclusion diets may help, but this is not conclusive.
- There is limited evidence for any oral medications.
  - Consider medications for chronic pain, e.g. tricyclic antidepressants.
  - Local specialists suggest a trial of nonsteroidal anti-inflammatory drugs {NSAIDs) or Goxybutynin if not contraindicated.
- See Patient - Interstitial Cystitis/Painful Bladder Syndrome .

  - Recurrent UTI
- Gastrointestinal:
  - Irritable bowel syndrome
  - Diverticular disease
  - Coeliac disease
  - Inflammatory bowel disease
- Musculoskeletal:
  - Pelvic floor tension myalgia
  - Coccydynia
  - Fibromyalgia
  - Chronic abdominal wall pain
- Neurological - neuralgia which may be associated with previous surgery
- Psychological:
  - Depression and/or anxiety
  - Sexual abuse

- Somatisation
- Opiate dependency

4. Examine the abdomen and pelvis for signs suggesting ovarian cancer, including a pelvic or abdominal mass or ascites.
5. Investigations:
   - Arrange initial blood tests - Ca125 , LFT, CBC, CRP, calcium, creatinine, and electrolytes.
   - If signs include a pelvic or abdominal mass or ascites, arrange an ultrasound scan within 2 weeks.
   - If no signs, manage according to Ca125 result.

Management

1. If scan is abnormal, e.g. shows ascites or complex cyst, request non-acute gynaecology assessment or seek gynaecology advice. If criteria for high suspicion of gynaecological cancer are met, select ERMS priority high suspicion of cancer, or write "high suspicion of cancer" on the request. Consider referring the patient to Cancer Support Services.
2. If there are no signs, manage according to Ca125 results and whether the woman is premenopausal or postmenopausal:
   - Premenopausal women

Premenopausal women

For premenopausal women with elevated Ca125 (even when Ca125 greater than 200 units/ml), benign conditions are the most likely cause.

Manage investigation results for possible ovarian cancer in premenopausal women:

1. If serum Ca125 is less than 35 units/ml, assess for other causes of symptoms. If no other causes are evident after full assessment, advise the patient to return if symptoms increase or are persistent.
2. If Ca125 greater than 35 units/ml but less than 200 units/ml, in the presence of normal clinical findings, repeat serum Ca125 in 6 weeks' time. If this is repeatedly high or climbing, arrange ultrasound scan. The patient is eligible for publicly-funded radiology. Once scan result is obtained, seek gynaecology advice.
3. If Ca125 decreases by any amount in the 6 week time frame, reassure the patient that this is not ovarian cancer and advise there is no need for further investigation unless symptoms deteriorate.

4. If Ca125 greater than 200 units/ml, arrange ultrasound scan.The patient is eligible for publicly-funded radiology. Once scan result is obtained, seek gynaecology advice.
5. If unsure of the management of the Ca125 result or the scan result, seek gynaecology advice.

- Postmenopausal women

Postmenopausal women

1. If serum Ca125 less than 35 units/ml, assess for other causes of symptoms. If no other causes are evident after full assessment, advise the patient to return if symptoms increase or are persistent. Reassess and arrange ultrasound scan.
2. If Ca125 greater than 35 units/ml, arrange ultrasound scan. The patient is eligible for publicly-funded radiology. If the scan is abnormal, request non-acute gynaecology assessment.
3. If Ca125 greater than 35 units/ml and scan is normal, seek gynaecology advice.
4. If unsure of the management of the Ca125 result or the scan result, seek gynaecology advice.

3. If known genetic mutation, persistent symptoms, no signs, and investigation results do not meet criteria for referral, seek gynaecology advice.

Request

- If scan is abnormal, e.g. shows ascites or complex cyst, request non-acute gynaecology assessment or seek gynaecology advice. If criteria for high suspicion of gynaecological cancer are met, select ERMS priority high suspicion of cancer, or write "high suspicion of cancer" on the request. Consider referring the patient to Cancer Support Services.
- Request non-acute gynaecology assessment or seek gynaecology advice after ultrasound pelvis result is obtained if:
  - initial Ca125 is 35 to 200 units/ml in premenopausal women and repeat Ca125 (6 weeks) is high or dim.bing.
  - Ca125 is greater than 200 units/ml in premenopausal women.
  - Ca125 is greater than 35 units/ml and scan is normal in postmenopausal women.
- If unsure of the management of the Ca125 result or the scan result, seek gynaecology advice.
- If known genetic mutation, persistent symptoms, no signs, and investigation results do not meet criteria for referral, seek gynaecology advice.

Information

For health professionals

Education

BMJ Learning - The Royal New Zealand College of General Practitioners Modules [requires registration] - Recognising Early Symptoms of Ovarian Cancer

Further information

- Journal of Clinical Oncology- Risk Algorithm Using Serial Biomarker Measurements Doubles the Number of Screen-detected Cancers Compared With a Single-Threshold Rule in the United Kingdom Collaborative Trial of Ovarian Cancer Screening
- National Institute for Health and Care Excellence (NICE) - Ovarian Cancer: Recognition and Initial Management
- Patient - Cancer Antigen 125

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PAGE INFORMATION

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Community HealthPathways Whanganui & MidCentral

Ovarian Cyst

This pathway is about the management of ovarian cysts confirmed by ultrasound scan.

Red flags

Ovarian cancer

Torsion

Background

About ovarian cysts

About ovarian cysts

Ovarian cysts may be found incidentally or when investigating gynaecological or gastrointestinal symptoms.

Common types of ovarian cysts include:

- functional cysts - arising from the follicle or corpus luteum. These will shrink over 4 to 6 weeks.
- paratubal and para-ovarian cysts - almost always asymptomatic.
- hydrosalpinx - blocked fallopian tube full of fluid.
- endometriomas - due to deposits of endometriosis on the ovary.
- dermoid cysts - often contain hair, skin, teeth, bone, and many other tissues.
- cystadenomas - mucinous or serous.

Uncommon and rare types include:

- ovarian cancers.
- borderline ovarian tumours.

Management

1. Use the Ovarian-Adnexal Reporting and Data System (O-RADS) guidelines to manage these lesions alongside clinical features.

Ovarian-Adnexal Reporting and Data System (O-RADS)

The O-RADS ultrasound risk stratification and management system is a way to consistently interpret, and decrease ambiguity in, ultrasound reports assigning risk of malignancy.

For risk stratification, the O-RADS system uses 5 categories (O-RADS 1 to 5), from normal (1) to high risk of malignancy (5). An O-RADS 0 (zero) category is used for an incomplete evaluation.

Classification	Descriptors
O-RADS USO - An incomplete evaluation due to technical factors	-
O-RADS US 1 - Physiologic category (normal premenopausal ovary)	• Ovarian follicle (less than 3 cm) • Corpus luteum (less than 3 cm)
O-RADS US 2 - Almost certainly benign category (less than 1% risk of malignancy)	• Simple cyst 3 to 10 cm • Benign lesions less than 10 cm with no concerning features
O-RADS US 3 - Low risk of malignancy (1 to 10%)	• Unilocular cyst greater than 10 cm (simple or non-simple) • Lesions looking like typical dermoid cysts, endometriomas, or haemorrhagic cysts greater than 10 cm • Solid smooth lesion of any size with colour score 1 • Multilocular cyst less than 10 cm, smooth inner wall, with colour score 1 to 3
O-RADS US 4 - Lesions with an intermediate risk of malignancy (10 to 50%)	• Unilocular cyst with a solid component, any size, 1 to 3 papillary projections, any colour score • Multilocular cyst with solid component, any size, colour score 1 to 3

	• Multilocular cyst without solid component: • Greater than 10 cm, smooth inner wall, with colour score 1 to 3 • Any size, smooth inner wall, with colour score of 4 • Any size with an irregular inner wall or irregular septation, of any colour score
O-RADS US 5 - Lesions with a high risk of malignancy (50% or higher)	• Presence of ascites and/or peritoneal nodularity • Unilocular cyst with papillary projections • Multilocular cyst with a solid component • Solid lesion (some criteria apply), colour score 4 • Solid irregular lesion of any size

2. If v torsion of ovarian cyst is suspected, request acute gynaecology assessment.

Torsion of ovarian cyst

- Key diagnostic factors:
  - Severe abdominal pain
  - Nausea, vomiting, or diarrhoea
  - Abdominal or pelvic tenderness
  - Palpable adnexal mass
- Other diagnostic factors:
  - Feeding intolerance, vomiting, abdominal distension, and fussiness (neonates)
  - Strenuous exercise
  - Peritoneal signs
  - Cervical motion tenderness

3. Otherwise, manage according to cohort:

- 'V Prepubertal

If cyst of any size or type, request non-acute gynaecology assessment.

- Premenopausal

- Manage simple cysts:
  - For simple cysts measuring:
    - less than S cm and the patient is asymptomatic, no follow-up is required.
    - between Sand 10 cm, check sJ Ca12S and repeat ultrasound pelvis in 10 weeks.
    - less than 10 cm and the patient is unable to cope with the pain, seek gynaecology advice.
  - If the cyst enlarges on repeat ultrasound, or Ca12S is abnormal, request non-acute gynaecology assessment.
- Manage dermoid cysts:
  - If the diagnosis is confident at the initial scan, arrange a follow-up scan in one year for lesions less than SO mm in asymptomatic premenopausal women.
  - If the lesion is stable and the patient is asymptomatic, no further follow-up is required.
  - If the reporting radiologist is uncertain about the diagnosis at the initial scan, consider a follow-up scan in 10 weeks.
  - For dermoid cysts greater than SO mm, request non-acute gynaecology assessment.
- Manage endometriomas:
  - Arrange a follow-up ultrasound pelvis in 10 weeks to differentiate from haemorrhagic follicle or cyst.
  - If the patient is symptomatic, needs additional counselling, and the lesion persists on follow-up scan and remains in keeping with an endometrioma, request non-acute gynaecology assessment.
  - If the patient is asymptomatic, arrange a follow-up ultrasound pelvis in 6 months. If there is interval change in morphology or a developing vascular component within the lesion, request non-acute gynaecology assessment.

- Postmenopausal

- If the cyst is simple, less than 3 cm, the patient is asymptomatic, and has no family history of breast or ovarian cancer, no Ca125 measurement or follow-up is required.
- If the cyst is simple and greater than or equal to 3 cm and less than 10 cm, check Ca125.
  - If Ca125 is abnormal, request non-acute gynaecology assessment.
  - If Ca125 is normal, repeat scan and Ca125 in 1 year, or 6 months if personal or family history of breast or ovarian cancer.
    - If the repeat scan shows the cyst has increased or Ca125 is abnormal, request non-acute gynaecology assessment.
    - If the cyst is stable after 1 year's follow-up, no further scans are required. Seek written gynaecology advice.
- If the cyst is simple and greater than 10 cm, order Ca125, LFT, and request non-acute gynaecology assessment.
- For any solid/complex cyst lesion (of any size) which falls into the O-RADS 3, 4, or 5 category groups, order Ca125, LFT, and request non-acute gynaecology assessment.
- Manage dermoid cysts:
  - If the lesion is stable after repeat scans at 6 or 12 months and the patient is asymptomatic, no further follow-up is required.
  - If the reporting radiologist is uncertain about the diagnosis at the initial scan, consider a follow-up scan in 10 weeks.
  - For dermoid cysts greater than 50 mm, request non-acute gynaecology assessment.
- Manage endometriomas:
  - Arrange a follow-up ultrasound pelvis in 10 weeks.
  - If the patient is symptomatic and the lesion persists on follow-up scan and remains in keeping with an endometrioma, request non-acute gynaecology assessment.
  - If the patient is asymptomatic, arrange a follow-up ultrasound pelvis in 6 months. If there is interval change in morphology or a developing vascular component within the lesion, request non-acute gynaecology assessment.

Request

- If torsion of ovarian cyst suspected, request acute gynaecology assessment.

Torsion of ovarian cyst

- Key diagnostic factors:
  - Severe abdominal pain
  - Nausea, vomiting, or diarrhoea
  - Abdominal or pelvic tenderness
  - Palpable adnexal mass
- Other diagnostic factors:
  - Feeding intolerance, vomiting, abdominal distension, and fussiness (neonates)
  - Strenuous exercise
  - Peritoneal signs
  - Cervical motion tenderness

- Request non-acute gynaecology assessment, noting specific triage information using the Ovarian Cyst ERMS form if:

Triage information

Requests must include O-RADS number and clinical information, including:

- current (within 6 months) height and weight measurements.
- menstrual status (prepubertal/premenopausal/postmenopausal).
- symptoms and level of discomfort.
- attachments:
  - Pelvic ultrasound(s)
  - Ca125 (if high suspicion of malignancy on ultrasound, order test, but do not wait for result)
  - Liver function tests

- cyst enlarges on repeat ultrasound.
- cyst has changed in vascularity or morphology.
- dermoid cysts greater than 50 mm.
- scan suggests endometrioma and patient is symptomatic and needs additional counselling.
- concerned about the patient.

  - cyst is greater than 10 cm (any type), unless the cyst is clearly reported as a haemorrhagic cyst in a premenopausal patient.
  - Ca125 is abnormal.
  - cyst is solid/complex (any size) and falls into 0-RADS 3, 4, or 5 category groups.
  - patient is prepubertal.
- Seek gynaecology advice if:
  - a simple cyst is less than 10 cm and patient is premenopausal and unable to cope with the pain.
  - after 1 year's follow-up of a postmenopausal patient and cyst is stable.

Information

For health professionals

Further information

- American College of Radiology (ACR) - 0-RADS Ultrasound Risk Stratification
- bpacnz - Appropriate Use of Tumour Markers

For patients

Patient - Ovarian Cyst

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25 August 2021

Dear

OIA request - Complaints against in-home care providers
Our Ref: Y21-1189

In reference to your official information request dated 12 August 2021 for copies of all complaints submitted to the MidCentral District Health Board (MDHB) regarding in-home care providers or care plans between 1 January 2018 and 12 August 2021 as well as copies of all correspondence regarding these complaints between complainers and the District Health Board (DHB), and correspondence between the DHB and the providers?

MidCentral DHB has received and logged five complaints from four people for the period of 1 January 2018 through to 12 August 2021 regarding home-based support services in our district. These are summarised below.

We have not provided a copy of the complaint documents or care plans in order to protect the privacy of the clients involved and their families (Section 9 (2)(a) of the Official Information Act 1982).

You have the right to seek an investigation and review by the Ombudsman of this decision. Information about how to make a complaint is available at www.ombudsman.parliament.nz or Freephone 0800 802 602.

Summary

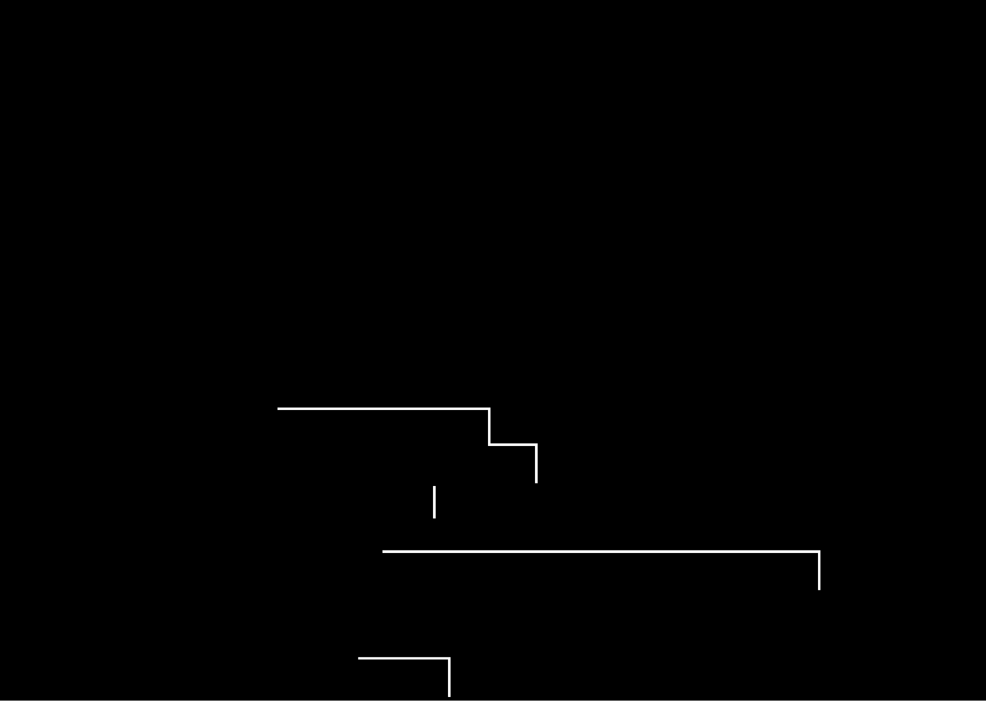
MidCentral DHB complaints received regarding in-home care providers 1 January 2018 and 12 August 2021				
Date received	**From**	**Summary of complaint**	**Outcome and Findings**	**Date closed out**
13 August 2020	Client	Long call wait times and not receiving support as required	Investigated by the provider. A national system has been put in place for monitoring of calls and additional staff for the call centre. The request for additional support had not been requested but was put in place once identified	17 August 2020

18 August 2020	Clients Family member	The level of competence of management and rostering staff; Service delivery of the call centre; managing risk for the client	Investigated by the provider at regional management level. Daily monitoring and reporting of the call centre activity, crisis management team for resolution of issues put in place	8 September 2020
12 October 2020	Client	Service and communication availability of trained staff, wait times for call centre	Investigated by provider steps taken around their communication which included daily monitoring and reporting of the call centre. Additional staff trained to cover sick and annual leave.	27 October 2020
20 April 2021	Clients family member	Delivery of services at wrong address staff not identifying themselves or having identity badges	Investigated by the provider and put some steps in place with changes to processes and policy and additional staff training and auditing of same.	11 May 2021
12 August 2021	Clients family member	Frustration with services and poor communication and current phone systems	Client under ACC not MDHB Client referred back to the Provider.	17 August 2021

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website ten working days after your receipt of this response.

Your sincerely

Lyn Horgan
Operation Executive
Te Whakamauora
Healthy Ageing and Rehabilitation



Official Information Act (OIA) request – OIA Y21-1183

Thank you for your request for information dated 10 August 2021. Your request is acknowledged and has been passed onto me for a response.

You have requested MidCentral District Health Board (MDHB) provide you with information to the following questions:

1. **The utilisation rate for, outpatient or day stay attendance for IV chemotherapy, expressed as a. patients per chair per day (plus definition of a chair day) b. occupancy expressed as percentage of time on average that a chemo chair is occupied, annually for the past 5 years?**

The IV chemotherapy rates per chair and as a percentage of time are displayed in the table below:

	Patients per Chair per day	% time occupied
2016/17	6.1	62%
2017/18	6.5	65%
2018/19	7	70%
2019/20	6.8	68%
2020/21	7.3	73%

2. **Average waiting time for first treatment of, outpatient or day stay attendance for day stay IV chemotherapy, expressed in days per year for the past 5 year?**

The average waiting time for first treatment of IV chemotherapy is displayed in the table below:

	Average wait time in days
2016/17	15.50
2017/18	14.24
2018/19	14.32
2019/20	14.33
2020/21	14.49

3. **Number of, outpatient or day stay attendance for IV chemotherapy, nursing staff expressed as FTEs annually for the past 5 years in absolute numbers and then per capita?**

The number of IV chemotherapy treatments, nursing FTE and per capita treatments are displayed in the table below:

	Treatments	Nursing FTE	Treatment/nurse
2016/17	4770	5.9	808.5
2017/18	5415	5.9	917.8
2018/19	5948	5.9	1008.1
2019/20	5600	5.9	949.2
2020/21	6413	5.9	1086.9

4. **Number of oncologists managing, outpatient or day stay attendance for IV chemotherapy, expressed as FTEs annually for the past 5 years in absolute numbers and then per capita?**

The number of IV chemotherapy treatments, Medical Oncologist FTE and per capita treatments are displayed in the table below:

	Treatments	SMO FTE	Treatment/SMO
2016/17	4770	6.8	701.5
2017/18	5415	6.9	784.8
2018/19	5948	8	743.5
2019/20	5600	8.2	682.9
2020/21	6413	8.4	763.5

5. **Number of people who have had, outpatient or day stay attendance IV chemotherapy, expressed as total, Maori (absolute and as a percentage of the total) and Non Maori (absolute numbers and as a percentage of the total), annually for the past 5 years?**

The number of Māori and non-Māori receiving IV chemotherapy as an absolute and as a percentage are displayed in the table below:

	Maori	% Maori	Non Maori	% Non Maori	Total	Total %
2016/17	80	12%	590	88%	670	100%
2017/18	107	14%	638	86%	745	100%
2018/19	116	15%	640	85%	756	100%
2019/20	102	14%	652	86%	754	100%
2020/21	87	15%	501	85%	588	100%

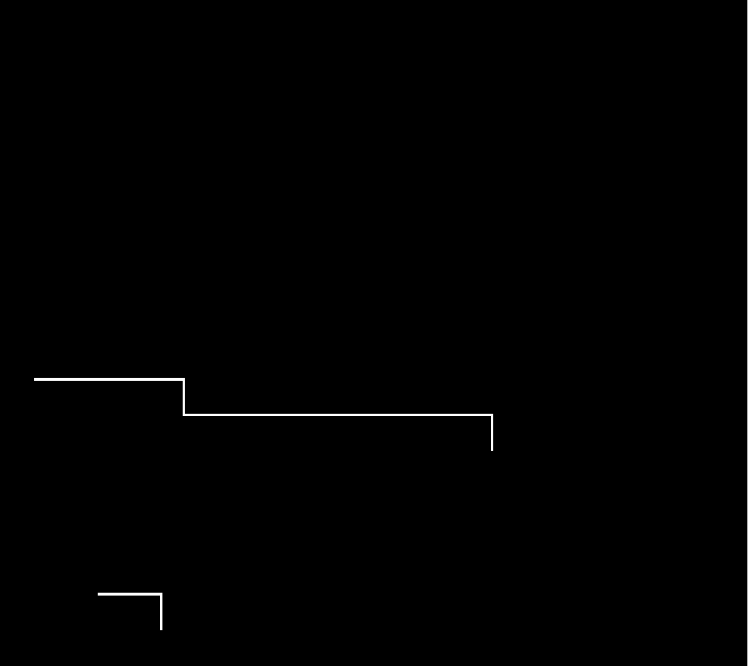
Please note that this response, or an edited version may be published on the MDHB website ten working days after your receipt of this letter. Please let me know if you have any objections to this as soon as possible.

I hope this information is what you require.

Yours sincerely

Sarah Fenwick
Operations Executive
Te Uru Mātai Matengau
Cancer Treatment, Screening and Support

CC



In response to your recent Official Information Act 1982 request regarding:

1. *A list of all hospital, mental health wards, psychiatric care facilities, rest homes & healthcare facilities as well as administrative & miscellaneous buildings the Ministry of Health knows are using fossil fuels, with a breakdown of fossil fuel type, and region.*
2. *An outline of any plans that the Ministry of Health or Energy Efficiency Conservation Authority have to transition these institutions off fossil fuels, and the names of these institutions and the transition plan*

We advise for MidCentral DHB as follows:

1. At the Palmerston North Hospital natural gas is used for hot water and heating. The hospital has two main boilers that supply the main hospital building with hot water and steam. In the event that gas supply is lost, diesel fuel is used for two backup generators.

   There are smaller units that supply the other buildings on site, ie the laundry, North Side, the board offices, education centre etc.

   The Horowhenua Health Centre uses a natural gas boiler with a diesel backup.

2. There are no immediate plans to replace existing gas boilers with low-emission alternatives. All new builds will be using electric heat pump technology. MidCentral has several projects underway to improve energy use including lighting and water chiller upgrades.

If you are not satisfied with this response you have the right to raise any concerns regarding our response with the Ombudsman – www.ombudsman.parliament.nz or 0800 802 602.

Please note that this response, or an edited version, may be published on the MidCentral DHB website ten working days after your receipt of this response.

Yours sincerely

Neil Wanden
General Manager, Finance & Corporate Services

Finance & Corporate Services
MidCentralDHB, PO Box 2056, Palmerston North Central, 4440.
Tel: 06 350 8800 Fax: 06 350 8080

MIDCENTRAL DISTRICT HEALTH BOARD

Te Pae Hauora o Ruahine o Tararua

20 September 2021

Phone (06) 350 8061
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Postal Address:
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Palmerston North Central
Palmerston North 4440
New Zealand

Phys/ca/ Address:
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Heretaunga Street
Palmerston North
New Zealand

E-mail:

Dear

Official Information Act (OIA) Request

Your OJA request of 23 August 2021 to MidCentral District Health Board (MDHB) is acknowledged and has been passed on to me for response.

You have requested the following information.

- **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.**

The following table shows the number of resourced and physical ICU beds and the occupancy for the period you have requested.

Month/Year	Resourced Beds	Physical Beds
01/03/2020	6	8
01/04/2020	6	8
01/05/2020	6	8
01/06/2020	6	8
01/07/2020	6	8
01/08/2020	6	8
01/09/2020	6	8
01/10/2020	6	8
01/11/2020	6	8
01/12/2020	6	8
01/01/2021	6	8
01/02/2021	6	8
01/03/2021	6	8
01/04/2021	6	8
01/05/2021	6	8
01/06/2021	6	8
01/07/2021	6	8
01/08/2021	6	8

Operations Executive, Acute & Elective Specialist Services
MidCentral District Health Board, PO Box 2056, Palmerston North 4440
Telephone (06) 356 9169

The following table shows a breakdown of all ICU staff and any vacancies.

Nursing FTE

Month	Actual FTE	Budget FTE	Vacancies
March 2020	22.6	26.4	3.9
April 2020	22.7	26.3	3.6
May 2020	22.7	26.4	3.7
June 2020	24.7	26.5	1.9
July 2020	24.2	26.3	2.1
August 2020	23.7	26.2	2.5
September 2020	23.4	26.2	2.8
October 2020	22.5	26.6	4.1
November 2020	22.1	26.2	4.1
December 2020	22.8	26.0	3.2
January 2021	22.1	27.4	5.3

The following table shows the number of surgeries that were rescheduled or postponed/ cancelled.

Month/Year	Surgeries Rescheduled/ Postponed/Cancelled Due to ICU Bed Availability
01/03/2020	0
01/04/2020	0
01/05/2020	1
01/06/2020	0
01/07/2020	0
01/08/2020	1
01/09/2020	1
01/10/2020	1
01/11/2020	0
01/12/2020	0
01/01/2021	1
01/02/2021	1
01/03/2021	1
01/04/2021	1
01/05/2021	0
01/06/2021	0
01/07/2021	0
01/08/2021	1

- **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.**

Ministry of Health Reporting - each day the CHRIS (Australia and New Zealand Critical Health Resource Information System) is updated with the following information:

Patient
- ICU patients
- HDU /ICUZ patients (under the care of ICU)
- Confirmed COVID '+' cases in your ICU/HDU
- Confirmed COVID '+' cases in your ICU requiring invasive ventilation
- Confirmed COVID '+' cases admitted to your hospital

Treatment
- Invasive ventilation
- Non-invasive ventilation
- Renal replacement therapy
- ECMO

Availability
- Physical ICU capable beds
- Presently open staffed and equipped ICU bed spaces (including vacant and occupied ICU beds)
- Patients awaiting admission to ICU
- Patients awaiting admission to HDU/ICU
- Critical care medical and nursing staff unavailable due to COVID exposure or illness

Stock
- Spare ventilators
- Spare dialysis/filters
- ICU PPE stock (low <3 days, medium up to 7 days, ok = more than 7 days)

Please also find attached the following documents;

- Intensive Care Unit Treatment Spaces Set Up
- COVID-19 ICU /OT (Operating Theatre)/PACU (Post Anaesthetic Care Unit) Escalation Plan
- MidCentral DHB's COVID-19 Resurgence Plan

- **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.**

  MidCentral DHB declines to answer this based on substantial research and collation (particularly during COVID).

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website 10 working days after your receipt of this response.

Yours sincerely

Lyn Horgan
Operations Executive
Acute & Elective Specialist Services

Encl

Intensive Care Unit (ICU)

The Intensive Care Unit has been set up to provide 5 levels of Covid-19 response which includes the use of PACU for activation levels 4 and 5

A negative pressure zone has been created in the main entrance are of ICU to provide a negative pressure vestibule for delineate Covid-19 and non Covid-19 zones. Whenever a Covid-19 patient is in either of the two negative pressure rooms **only Covid-19 related activities must take place in this area.** All other access to ICU, including patients, is via the western end access to the department past the Charge Nurse's office.

The specific features installed in ICU are:

1. Extract fan and HEPA filter installed in the equipment room to provide a negative pressure entrance vestibule. This area is to be set up in conjunction with Infection Control to provide appropriate "donning and doffing" practices are in place to ensure cross contamination is not possible.
2. Extract system permitting 12 air changes per hour with discharge via HEPA filter system is installed in both sections of ICU.
3. Renal dialysis facilities are provided in ICU at Level 2 Activation.

The specific features for ICU Overflow installed in PACU are:

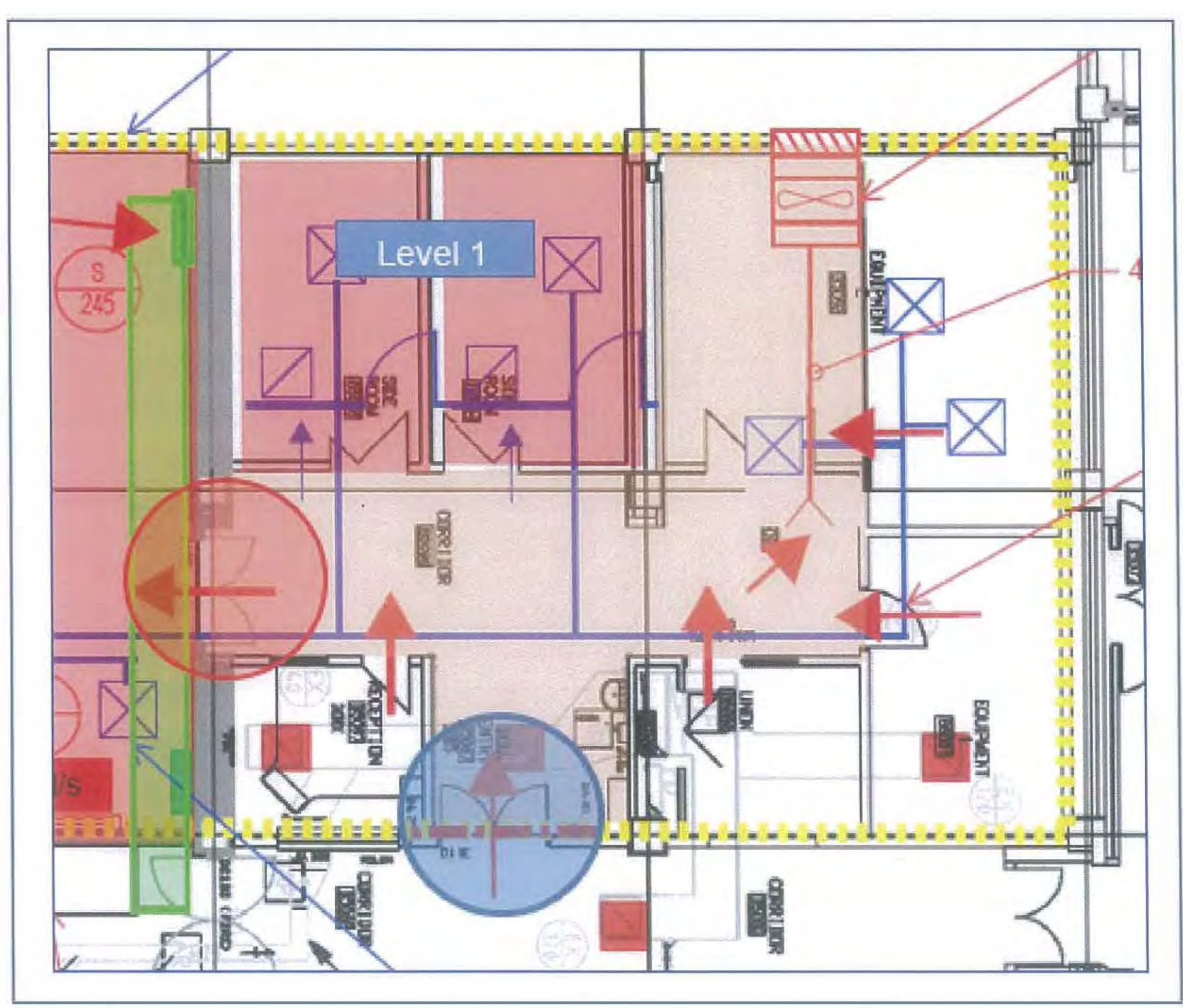
1. Independent extract from PACU B to be installed to provide alternative extract at 12 air changes per hour.
2. A temporary door has been installed between PACU A and PACU B for segregation of zones.
3. Independent extract duct is available in PACU A to facilitate the setup of PACU A as an activation level 5 area. This area has no further facilities at this stage and will be constructed if required.

ICU Activation - Levels 1 - 5

Activation of ICU **Level 1**

This level provides for the use of the two ICU negative pressure rooms as Covid treatment areas.

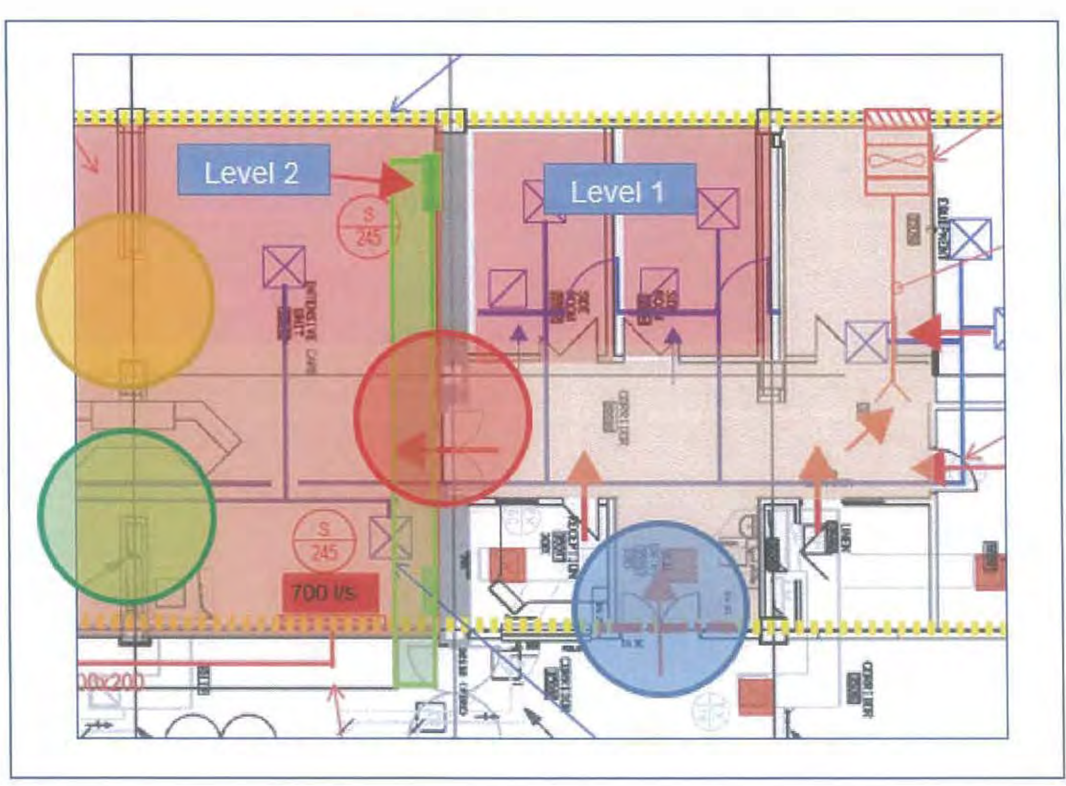
1. The door from the corridor to the ICU must be closed and an "authorised access only" sign must be attached to these doors (blue circle on diagram below). **This is the only access to the Covid-19 treatment areas**
2. The door to the main ICU must be closed and an **"no access"** si�n must be attached to these doors on both sides (red circle on diagram below).
3. The fan in the equipment room must be operating.
4. All other access to ICU, including patients, is via the western end access to the department past the Charge Nurse's office.



Activation of ICU **Level 2**

This level provides for the use of the two ICU negative pressure rooms and half of the current ICU for Covid-19 treatment areas.

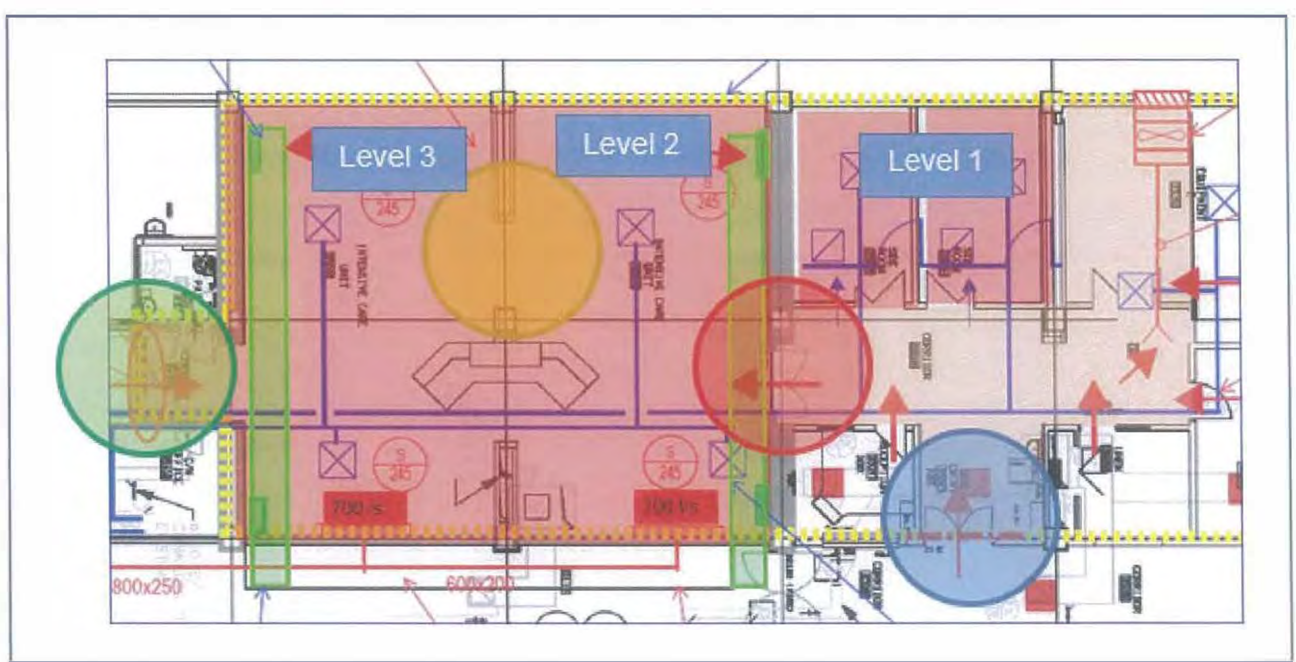
1. The door from the corridor to the ICU must be closed and an "authorised access only" sign must be attached to these doors (blue circle on diagram below). **This is the only access to the Covid-19 treatment areas**
2. The door to the main ICU may now be used for access to the second stage activation area. This door must be normally closed and a sign "access only keep closed" attached (red circle on diagram below).
3. The fan in the equipment room must be operating.
4. The temporary wall behind the nurse's station must be installed (green circle on diagram below).
5. The temporary door installed between the Nurse Station and wing wall must be closed and a **"no access"** sign must be attached to this door on both sides (orange circle on diagram below).
5. The fan providing extract to this zone must be operating and normal extract ducts closed. This must be confirmed with facilities management.
6. All other access to ICU, including patients, is via the western end access to the department past the Charge Nurse's office.



Activation of ICU **Level 3**

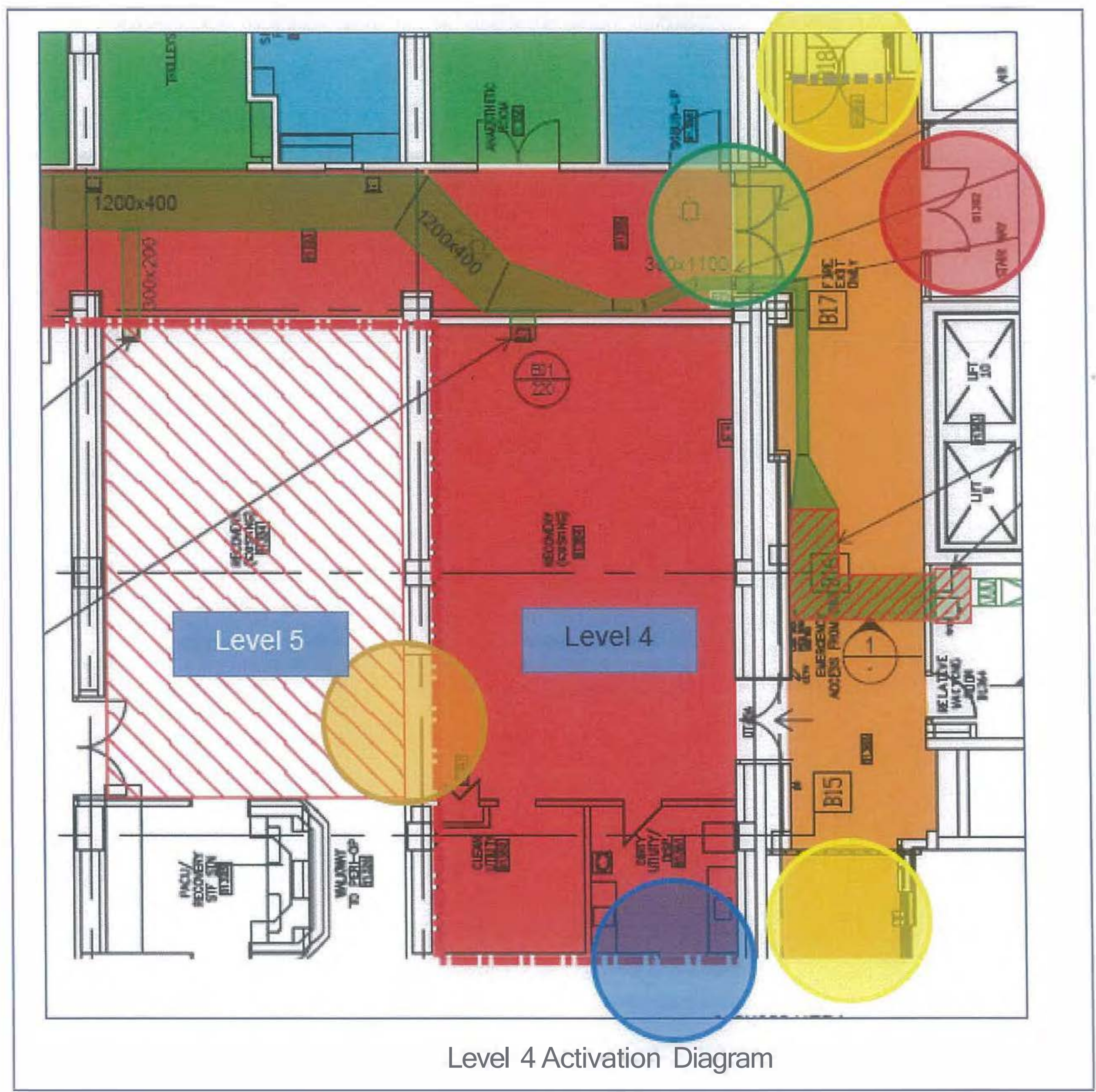
This level provides for the use of the two ICU negative pressure rooms and the entire ICU for Covid-19 treatment areas.

1. The door from the corridor to the ICU must be closed and an "authorised access only" sign must be attached to these doors (blue circle on diagram below). **<u>This is the only access to the Covid-19 treatment areas</u>**
2. The door to the main ICU is the access to the second and third stage activation area. This door must be normally closed and a sign "access only keep closed" attached (red circle on diawam below).
3. The fan in the equipment room must be operating.
4. The temporary door installed between the Nurse Station and wing wall may now be opened to provide access between the two halves of ICU (orange circle on diagram below).
5. The fan providing extract to all zones must be operating and normal extract ducts closed. This must be confirmed with facilities management.
6. The access door to ICU adjacent to the Charge Nurse's office **<u>must not be used</u>** and a **<u>"no access"</u>** sign attached. This door is for fire escape and emergency purposes only (green circle on diagram below).



Activation of ICU **Level 4**

1. The anteroom arrangement utilising the main corridor must be set up if not already in place with theatre activation. Security / Waterfords must be advised to initiate the Covid-19 lockdown on the corridor doors (yellow circle on diagram below). This corridor remains a fire escape and must be kept clear for this purpose even under Covid-19 activation.
2. An "authorised access only" sign must be attached to the door from the stairwell (red circle on the attached plan). This door should be taped up but available for fire evacuation purposes.
3. Unless theatre is already activated the access door adjacent Theatre 3 **must not be used** and a **"no access"** sign attached. This door is for fire escape and emergency purposes only (green circle on diagram below). However, if theatre is activated for Covid-19 treatment this door must be normally closed and used for access to the theatre Covid-19 spaces only.
4. The access door between PACU A and PACU **B** **must not be used** and a **"no access"** sign attached. This door is for fire escape and emergency purposes only (orange on diagram below).
5. The door between the utility room and the DOSA **must not be used** and a **"no access"** sign attached (blue on diagram below).
6. Special access consideration may be required for emergency maternity procedures to be agreed with Infection Control.



Level 4 Activation Diagram

Activation of ICU Level 5

Level 5 ICU Activation will require the building of separate isolation areas. These will be constructed on an as required basis. A duct has been pre-installed to permit alternative negative pressure extraction to 12 air changes an hour to be installed at short notice.

Theatre

Theatre has been configured to permit the treatment of Covid-19 patients in the Theatres 3 through 7.
When a Covid-19 patient is being treated in any of the named theatres, **all theatres and associated corridors within the same zone are considered contaminated.**
The recently installed Covid-19 facilities must be activated under these circumstances.

The specific features of this Area are below and detailed on the shown on the plan below:

1. Extract air systems on the dirty and clean corridor have been redirected via alternative low level duct and fan systems via HEPA filters.
2. Entrance vestibules are located outside Theatre 7, the main corridor adjacent Theatre 3 / PACU and outside Theatre 6 on the dirty corridor. These provide the delineation between Covid-19 and non covid-19 zones. These are to be set up in conjunction with Infection Control to ensure appropriate "donning and doffing" practices are in place to ensure cross contamination is not possible.
3. Magnetic locks have been installed on the two doors in the corridor to create a secure zone for the entrance vestibule adjacent to theatre 3 (yellow circle). These doors are normally held open and close on fire activation. During a covid activation they will be locked and will release on fire activation,
4. PACU A and B have been configured for potential Covid Treatment Zones for ICU should that be required. *Activation details in ICU Section.*
5. A temporary door and Air Conditioning Ducts have been installed in PACU A and PACU B for ICU overflow. *Activation details in ICU Section.*

Activating Theatre Covid Treatment Facilities

To activate Theatre as a Covid-19 facility all non-covid patients must be treated in Theatre 1 and 2 and Spotless Facilities advised to confirm mechanical systems are operational.

1. Temporary doors outside Theatre 7 and access to the dirty corridor and access doors SSU must be closed. An "authorised access only" sign must be attached to these doors (blue circles on diagram below).
2. The door from theatre 7 to this space **must not be used** and a **"no access"** sign attached - access to theatre 7 must be from the main clean corridor only (orange circle on the diagram below).
3. Temporary doors outside Theatre 6 - dirty corridor must be closed. An "authorised access only" sign must be attached to these doors (green circle on diagram below).
4. Security / Waterfords must be advised to initiate the Covid-19 lockdown on the corridor doors (yellow circle on diagram below). This corridor remains a fire escape and must be kept clear for this purpose even under Covid-19 activation.
5. An "authorised access only" sign must be attached to the door from the stairwell (red circle on the attached plan). This door should be taped up but available for fire evacuation purposes.
6. All appropriate DHB operational and infection control procedures must be in place.

COVID-19 ICU/OT/PACU ESCALATION PLAN

STAGE 1

Trigger:

- 1-7 patients with suspected/confirmed COVID-19 in the negative pressure rooms on wards (not severely unwell, ward level Airvo 15L/min, FiO2 < 50%)
- Suspected/confirmed COVID-19 patient in ICU in the negative pressure room

Action:

- Acute and urgent non deferable surgery continues
- Implement ICU COVID-19 Plan

STAGE 2

Trigger:

- Suspected/confirmed COVID-19 patient(s) in the main ICU

Action:

- Cohort COVID-19 patients in ICU
- Decant Non-COVID-19 ICU patients into PACUa
- Theatres 3-7 available to manage ICU patients

STAGE3

Trigger:

- ICU at capacity with COVID-19 patients

Action:

- Decant the existing Non-COVID-19 patients from PACUa to PACUb
- Admit COVID-19 patients to PACUa
- Theatres 3-7 managing ICU patients

STAGE 4

Trigger:

- PACUa at capacity
- Theatres 3-7 at capacity

Action:

- Decant NON-COVID-19 patients to Patient Reception Area
- Admit COVID-19 patients to PACUb

Your OIA request of 28 August 2021 to MidCentral District Health Board (MDHB) is acknowledged and has been passed on to me for response.

You have requested the following information.

- **Please could you advise your admittance protocol on receipt of COVID-19 patients?**

A copy of the MDHB admission protocol for patients who have a high suspicion of COVID-19 is attached as Appendix 1.

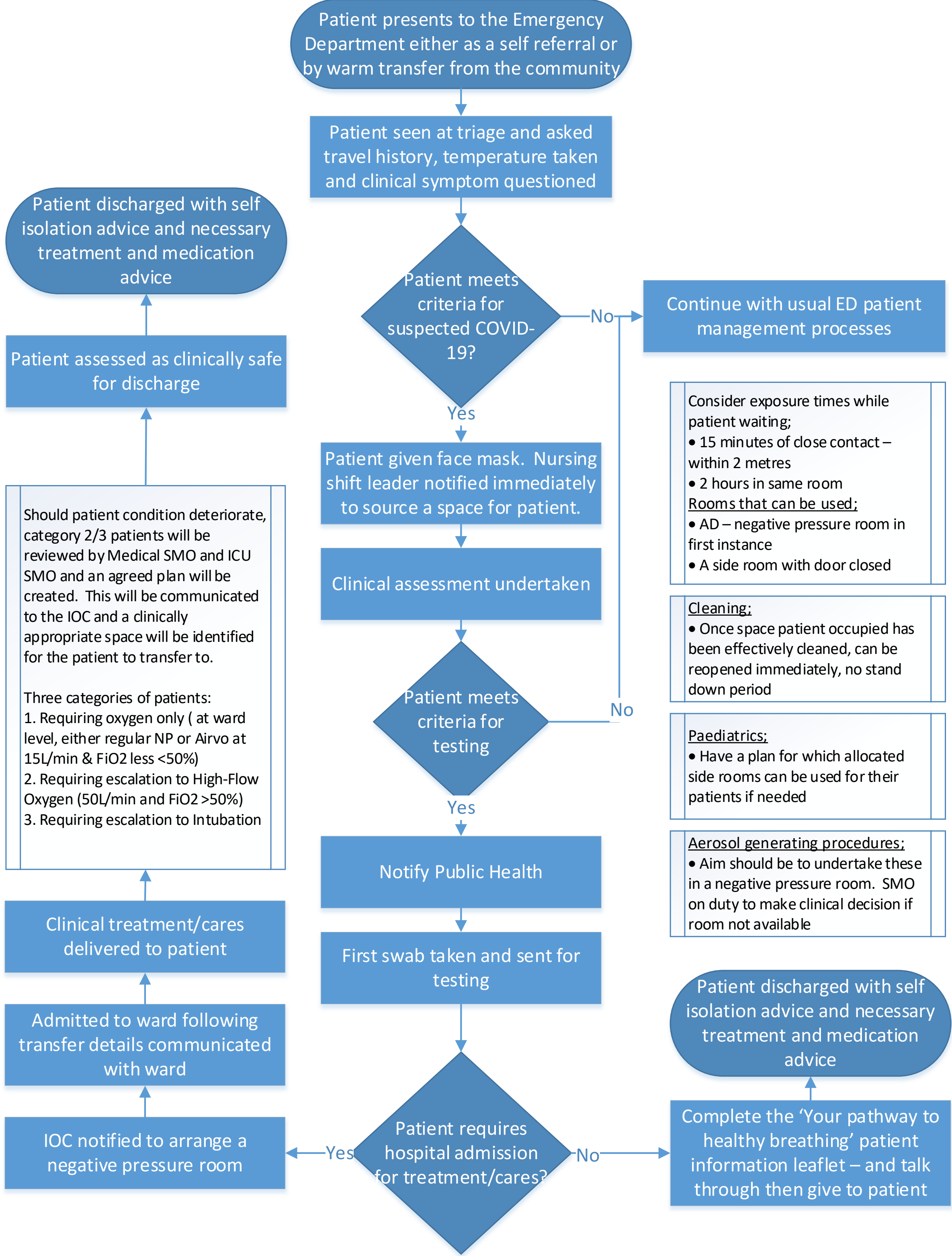
Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website ten working days after your receipt of this response.

Yours sincerely

Lyn Horgan
Operations Executive
Acute & Elective Specialist Services

Operations Executive, Acute & Electives Specialist Services
MidCentral District Health Board, PO Box 2056, Palmerston North 4440
Telephone (06) 356 9169

Appendix 1



Version 0.5 – 24/02/21

MIDCENTRAL DISTRICT HEALTH BOARD

Te Pae Hauora o Ruahine o Tararua

15 September 2021

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Fax (06) 355 0616

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Palmerston North 4440
New Zealand

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Palmerston North
New Zealand

Email:

OIA request - ARC Facilities
Our Ref: Y21-1288

In reference to your official information request dated 31 August 2021 for information regarding a news article about age care facilities in New Zealand.

We have set our response to the questions below (for ease of reference we have included the text of your questions in bold).

1. What is the total number of DHB funded aged residential care facilities in the MidCentral district between 2015 and 2021, broken down by year?

Number of Aged Care Facilities in MDHB	Year
36	2015
36	2016
37	2017
37/36	2018
36	2019
36	2020
37	2021

2. The number of people in aged residential care facilities in the MidCentral district, between 2015 and 2021, broken down by year?

Number of people in Aged Care Facilities in MDHB using December figures	Year
1,494	2015
1,421	2016
1,465	2017
1,527	2018
1,506	2019
1,551	2020
Not available	2021

Source: ARC HOP Bed Survey

- The survey counts resident numbers on one night per quarter, on the stated Survey Date. These totals cannot be summed as this will double count residents who are in the facility for more than one quarter.
- Not all people in ARC facilities are ARC residents, for example retirement village

residents who do not qualify for aged residential care, people fully funded by ACC or people with long-term conditions who are not assessed for aged residential care. Total residents include all people residing in an ARC facility, whereas Total ARC Residents includes only those who are classified as receiving aged residential care.

3. What is the number of MDHB funded aged residential care facilities that have closed between 2015 and 2021, broken down by year?

Number of closures of Aged Care Facilities in MDHB	Year
Nil	2015
Nil	2016
Nil	2017
One	2018
Nil	2019
Nil	2020
Nil	2021

4. Could you please provide the name and locations of the MCDHB funded aged residential care facilities that have closed between 2015 and 2021?

Name and Location of Aged Care Facilities that closed in MDHB	Year
Nil	2015
Nil	2016
Nil	2017
Ruawai Rest Home, 34 Ruawai Road Feilding 4702	2018
Nil	2019
Nil	2020
Nil	2021

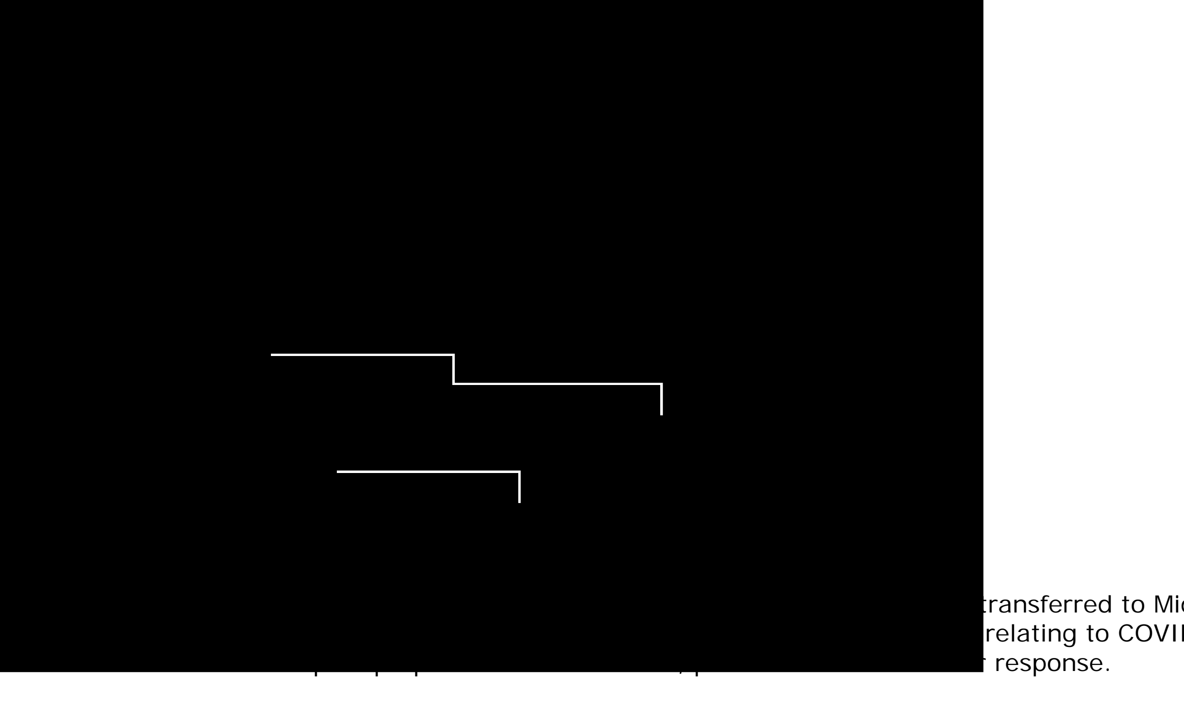
5. What is the reason each of the facilities above were closed?

Ruawai Rest home closed due to low occupancy.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website ten working days after your receipt of this response.

Your sincerely

Lyn Horgan
Operation Executive
Te Whakamauora
Healthy Ageing and Rehabilitation



transferred to MidCentral
relating to COVID-19
response.

You requested:

Documents held by the Ministry related to Hospital COVID-19 preparedness.

MDHB has interpreted this as to reflect our overarching planning and preparedness documents. This includes the MDHB Pandemic Plan and the MDHB COVID-19 Resurgence Plan. I have also included an example of two of the MDHB Directorate Business Continuity Plans as they may be enacted should this be required, as a result of cases of COVID-19 in our community. MDHB has six Directorates, however these two plans cover the main hospital services.

Our COVID-19 preparedness documents are living documents and will be updated as circumstances change.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website ten working days after your receipt of this response.

Yours sincerely

Judith Catherwood
General Manager
Quality & Innovation

MIDCENTRAL DISTRICT HEALTH BOARD

BUSINESS CONTINUITY PLAN –

Te Uru Arotau

ACUTE & ELECTIVE SPECIALIST SERVICES

MDHB Te Uru Arotau Acute & Elective Specialist Services identify the following critical functions that must be maintained during significant events:

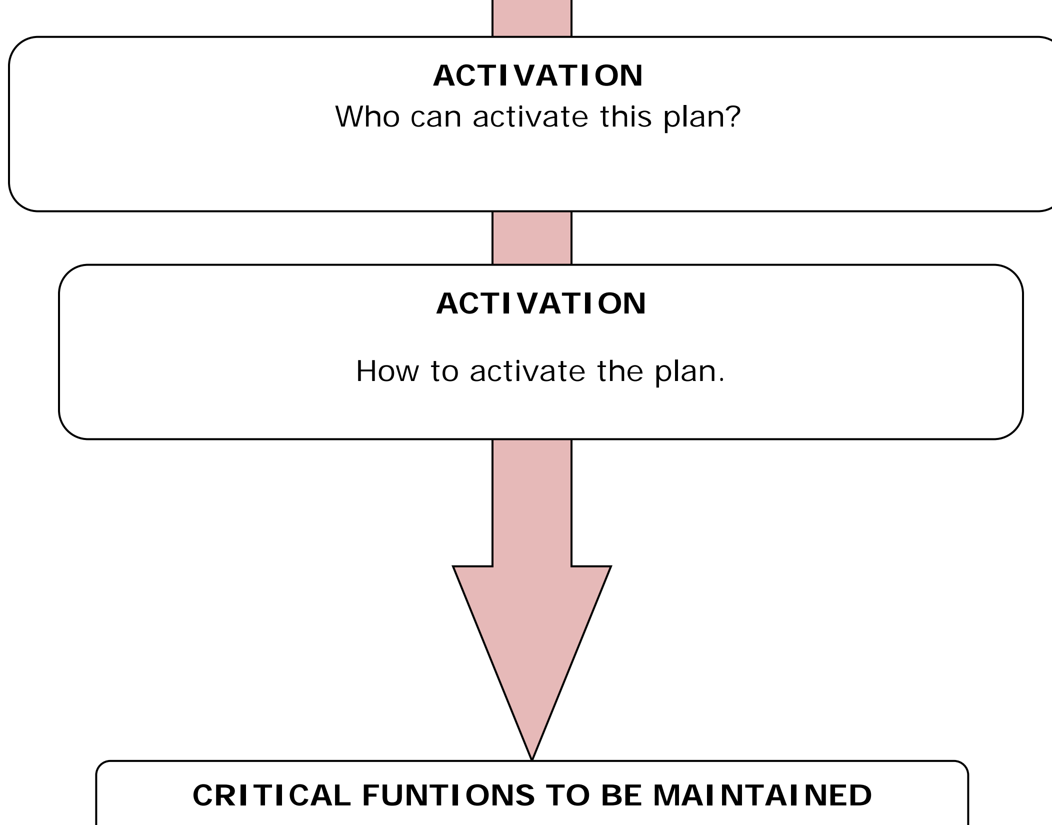
- Emergency Department
- MAPU/General Medicine/Infectious Diseases
- Orthopaedics
- Perioperative Services/ICU/Anaesthetics
- Surgical and Medical Wards
- Sterile Supply Services
- Medicines Supply
- General X-ray, CT and Ultrasound

MDHB Te Uru Arotau Acute & Elective Specialist Services the following critical over time functions that must be recovered at the earliest opportunity during significant events:

- General Surgery, TCU, Respiratory, Cardiology, Ophthalmology, Urology, Renal ENT, Hospital Pharmacy (compounding, clinical supplies), Medical Imaging (MRI, Interventional)

If you are opening this Plan for the first time and as part of an activation, go directly to the next page – Quick Action Guide

This page is a quick guide to initiating the Business Continuity Plan if you have not familiarised yourself with the contents of this plan prior to the event.



Foreword & Authorisation

Business Continuity is the ability of an organisation to maintain essential functions during, as well as after, a significant event has occurred. Business continuity planning establishes risk management processes and procedures that aim to prevent interruptions to critical services and re establish full function to the organisation as quickly and as smoothly as possible.

A Business impact analysis (BIA) has been undertaken to differentiate between critical (urgent), critical over time and non-critical (non-urgent) cluster functions/activities.

MDHB Te Uru Arotau Acute & Elective Specialist Services identify the following critical functions[1]:

- Emergency Department
- MAPU/General Medicine/Infectious Diseases
- Orthopaedics
- Perioperative Services/ICU/Anaesthetics
- Surgical and Medical Wards
- Sterile Supply Services
- Medicines Supply
- General X-ray, CT and Ultrasound

MDHB Te Uru Arotau Acute & Elective Specialist Services identify the following critical over time functions[2]:

- General Surgery, TCU, Respiratory, Cardiology, Ophthalmology, Urology, Renal, ENT, Hospital Pharmacy (compounding, clinical supplies), Medical Imaging (MRI, Interventional)

Signed:_____________________	Signed: ____________________
Name:	[redacted]
Clinical Executive	Operational Executive
Te Uru Arotau Acute & Elective Specialist Services	Te Uru Arotau Acute & Elective Specialist Services

[1] Critical functions identified as part of the Uru Arotau Acute & Elective Specialist Services Business Impact Analysis. The analysis phases consisted of impact analysis, threat analysis and impact scenario's.
[2] Critical over time function are services and business outputs that although not an immediate recovery focus do have the potential to impact within 4 to 7 days of an ongoing event.

KEY STAKEHOLDER CONTACT NUMBERS

Cluster Name	Acute & Elective Specialist Services	
Clinical Executive	VACANT	☎
Clinical Lead – Medical		
Clinical Lead – Surgical		
Operational Executive		
Planning & Integration Lead		
Clinical Programmes Lead		
Associate Director of Nursing		

Service Contacts		
UNPLANNED CARE	Operations Lead,	☎
	Emergency Department – CN –	☎
	ED – Medical Lead –	☎
	MAPU – CN –	☎
	General Medicine Medical Lead –	☎
	Medical Wards Ward 26 –CN Ward 28/CCU – CN	☎ ☎
	PEDAL Team –	☎
PLANNED CARE	Operations Lead,	☎
	Operating Theatre CN – Dental/General/Resp – CN – ORL/Ophthalmology – TBC CN – Ortho/Acute – TBC CN – Urology/O&G – Theatre Coordinator –	☎ ☎ ☎ ☎ ☎ ☎ M
	ICU – CN ICU – Intensivist Anaesthetics – Head Anaesthetic Tech –	☎ ☎ ☎ ☎
	Endoscopy/Gastroenterology CN – Medical Lead –	☎ ☎
	Surgical Wards Ward 24 – CN Ward 27 – CN Ward 29 – CN	☎ ☎ ☎
	Hospital Dental/Oral & Maxillofacial –	☎
	Sterile Supply Services –	☎
OUTPATIENT SERVICES	Operations Lead – VACANT	☎
	CN –	☎
	Ambulatory Care – Reception A Ambulatory Care – Reception B	☎ ☎
	General Surgery –	☎
	Rheumatology –	☎
	Transitory Care Unit – CN S	☎
	Respiratory –	☎
	Cardiology – Temp.	☎
	Neurology – VACANT	☎

	Diabetes/Endocrinology –		
	Orthopaedics –		
	Ophthalmology –		
	Urology –		
	Otorhinolaryngology –		
	Audiology – Lead Audiologist		
	Podiatry –		
	Renal/Nephrology –		
	Infectious Diseases –		
	Dermatology – Contractor ( )		
Service Contacts (continued)			
Medical Imaging	Manager –		
	Medical Lead –		
	Duty Radiologist		
	Ultrasound – Sonographers		
	MRI –		
	Nuclear Medicine –		
	CT –		
	DSA –		
	Clerical Coordinator –		
	Quality MIT –		
	Medical Photographer –		
	RIS/PACS Admin –		
	General Coordinator		
	UCOL Clinical Tutor –		
Hospital Pharmacy	Chief Pharmacist		
	Pharmacy Dept		
	Oncall Pharmacist		
KEY STAKEHOLDERS			
Duty Nurse Manager	Duty Nurse Manager		
Ventia Facilities	Administration Front Desk		
	Shift Engineer		
	Ventia Building Services		
Clinical Engineering	clinicalengineering@midcentraldhb.govt.nz		
Compass Facilities (Hotel Services)	Patient meals	HorowhenuaPatientDHB@compass-group.co.nz	
	Retail Catering	PalmerstonPatientDHB@compass-group.co.nz	
	Cleaning Services	☏	
	Orderlies	☏	
	Security	☏	
	Cleaning – Horowhenua	HHC	
	Meals on Wheels	(P.Nth & HHC) or MOWcentral@compass-group.co.nz	
Fleet & Transport	Enquiries	☏ Please use the Ventia shortcut on your desktop. For emergencies please	
Materials Management	Short Term Loans	☏	
	Main Store	☏	M:
	Duty Supplier		

	Reception	☏ ▇▇▇	
Information Systems	Help Desk	☏ ▇▇▇	
Principle Risk & Resilience Officer	▇▇▇	☏ ▇▇▇	▇▇▇
Occupational Health & Safety	▇▇▇	☏ ▇▇▇	
	▇▇▇	☏ ▇▇▇	

POLICY OVERVIEW AND REVIEW PROCESS

Plan Status	Version
Draft	V7.1
Revised	V7.2

This Policy & Procedure document is reviewed two yearly or if there is amendment required post exercise or actual event.

HISTORY OF DOCUMENT REVIEW AMENDMENT

All amendments are to be reviewed and approved by the CEO and changes entered in the table below.

Version	Date	Changes
V1	16/01/20	Populating disruption templates
V2	10/02/20	Populating Medical Imaging disruption with Business Lead
V3	11/02/20	Update with Business Leads
V4	12/02/20	Update with Business Leads
V5	20/02/20	Update with Business Leads
V6	5/03/20	Update with Business Leads
V7	11/05/20	Update with Business Leads
V7.1	7/09/20	Update with Business Leads
V7.2	5/03/21	Update with change of vendors

REVIEWERS/CONTRIBUTORS

Name	**Position Title**
▇▇▇	Planning & Integration Lead
▇▇▇	Principal Risk & Resilience Officer
▇▇▇ ▇▇▇ ▇▇▇	Business Leads

RECORD OF AMENDMENTS

Page No	Section	Amendment Outline	Date Amended

Author	[redacted]
Review Date	
Approved/Authorised	
Document Reference	• Business Impact Analysis - Te Te Uru Arotau Acute & Elective Specialist Services • MDHB Strategic Business Continuity Policy & Plan

Table of Contents

Introduction	9
Purpose	10
Aims	10
Planning Assumptions	11
Plan Limitations	11
Cluster Overview	12
Roles & Responsibilities	16
Maintenance Criteria	17
Measurement Criteria	17
Managing the Disruption	18
Unplanned Care Internal Disruption	20
Unplanned Care External Disruption	31
Planned Care Internal Disruption	41
Planned Care External Disruption	54
Outpatient Services Internal Disruption	67
Outpatient Services External Disruption	100
Hospital Pharmacy Internal Disruption	133
Hospital Pharmacy External Disruption	136
Medical Imaging Internal Disruption	139
Medical Imaging External Disruption	142
Medical Imaging Service Suppliers	145
Annex A Critical Clinical Equipment Inventory	147
Annex B Call Tree Development Process	149
Annex C Call Tree Activation Guide	150

Annex D Individual Small Unit Phone Tree Template 151

Annex E Larger Unit/Multi Departmental Delegated Call Tree Template 152

1. INTRODUCTION

Emergency preparedness is progressive, continuously moving the public and agencies toward greater resilience. Business Continuity Planning (BCP) forms a significant part of the preparedness and planning for the health sector, to protect the public and healthcare providers and to safe-guard the public's investment in the healthcare system.

1.1 Disruptive Events

Disruptive events are most likely to occur with little no warning and can be broadly catergorised as follows:

- **Internal -** MidCentral District Health Board outputs may be impacted by the loss internal services/support systems/surge events/industrial action.
- **External -** MidCentral District Health Board outputs may be impacted by 3rd party disruption i.e. the loss of key suppliers/lifeline & infrastructure outages/health emergencies/ civil disaster.

2.0 PURPOSE

MDHB has an obligation to have strategies in place that ensures the delivery of essential services during a significant disruption or emergency situation. [3]

The purpose of this plan is to outline all procedures involved in the response to a significant disruption to services and business streams employed within the Te Uru Arotau Acute & Elective Specialist Services cluster.

Copies of this completed plan are to be provided to:

- Operational Executive
- Clinical Executive
- Business Lead(s)
- Manager Risk & Resilience
- Emergency Operations Centre

3.0 AIMS

The aims of the Te Te Uru Arotau Acute & Elective Specialist Services cluster Business Continuity Plan are too:

1. Maintain life and safety by ensuring critical functions remain in operation

[3] MDHB Strategic Business Continuity Policy and Plan.

2. Manage a disruption to limit loss
3. Promote early recovery

4.0 PLANNING ASSUMPTIONS

This plan has been developed using the following assumptions:

- Preventative actions identified during the risk management process have failed or were not first identified.
- It is designed to address a "most likely worst-case" scenario.
- It is applicable in the 'all hazards' context.
- That the level of detail in this Plan is based on the premise that sufficient and knowledgeable people will be available to execute the Plan and support business recovery operations.
- During a disruption, those staff considered essential MDHB Incident Management Team members will be released to support an all of MDHB response.
- All staff are aware of and understand their responsibilities contained within this document.
- Whilst the Principal Risk & Resilience Officer will assist in supporting the Cluster to develop, review, test and maintain their Business Continuity Plan overall responsibility for an individual Cluster Business Continuity Plans remains with the relevant Cluster Business Lead.

5.0 PLAN LIMITATIONS

The Te Uru Arotau Acute & Elective Specialist Services cluster Business Continuity Plan is not designed to:

- Be fully prescriptive in the event of contingency activities being undertaken.
- Take effect where relatively minor disruptions within a short timescale are experienced.

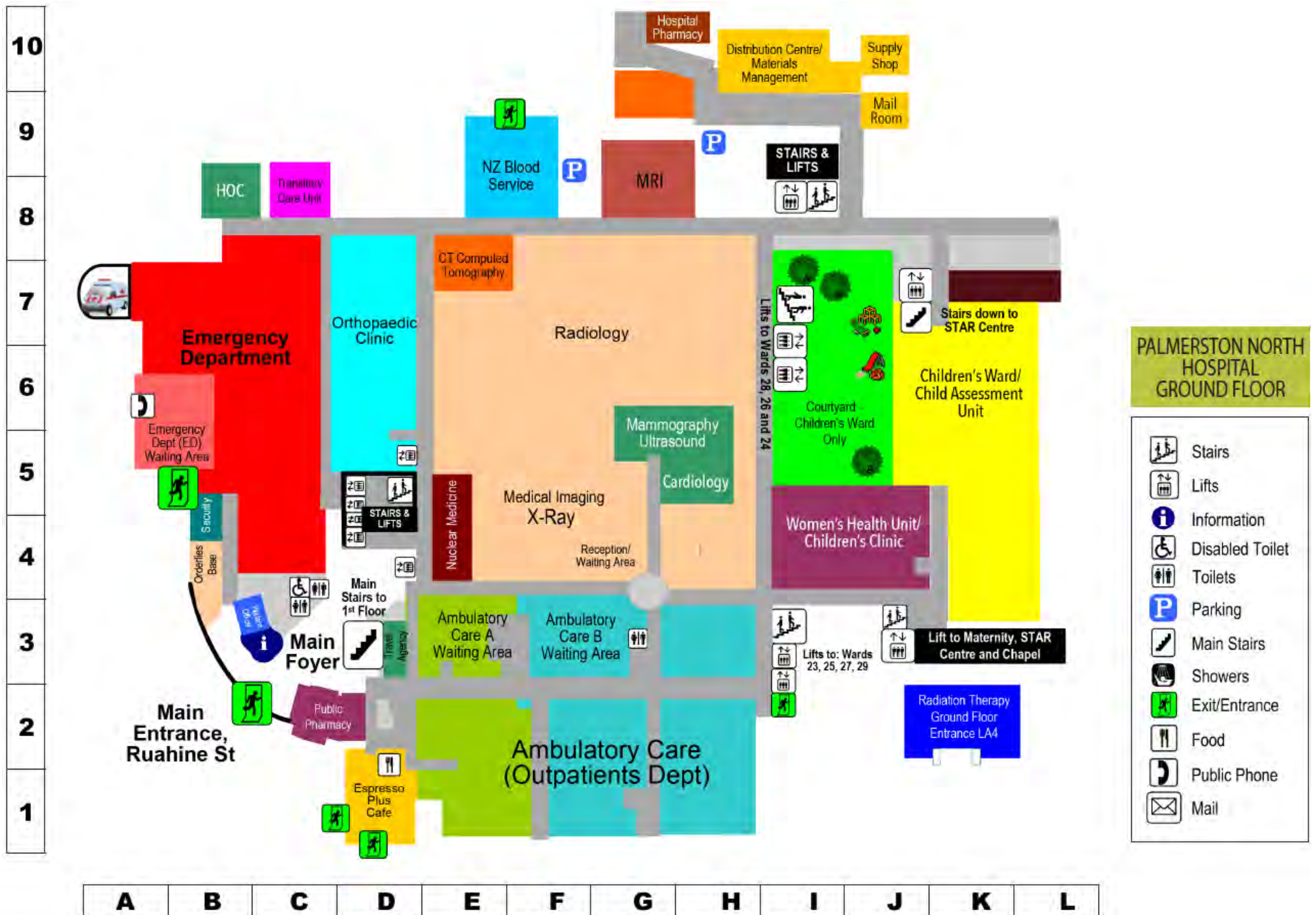
6.0 Te Uru Arotau Acute & Elective Specialist Services Cluster Overview

Te Uru Arotau Acute & Elective Specialist Services comprises of the following services:

Please refer to facility maps on the following pages.

	Service/Unit	Location	Deputy/Delegate
Planned Care Ops Lead [redacted]	Perioperative services	1st Floor Main Hospital	Deputy – other Business Lead
	ICU & Anaesthetics	5th Floor Main Hospital	
	Endoscopy/ Gastroenterology	1st Floor Main Hospital	
	Surgical Wards	24 – 2nd Floor 27 – 3rd Floor 29 – 5th Floor	
	Hospital Dental/ OMF	Ground Floor Outpatients	
	Sterile Supply Services	1st Floor Main Hospital	
Unplanned Care Ops Lead [redacted]	Emergency Dept	Ground Floor	Deputy – other Business Lead
	MAPU	4th Floor Main Hospital	
	General Medicine		
	Medical Wards	26 – 3rd Floor 28/CCU – 4th Floor	
	PEDAL	Ground Floor, IOC	
Outpatients Ops Lead VACANT	Amb Care Facility	Ground Floor	Deputy – other Business Lead
	Rheumatology	Ambulatory Care	
	Respiratory	Ambulatory Care	
	Neurology	Ambulatory Care	
	Orthopaedics	Ground Floor adjacent to ED	
	Urology	Ambulatory Care	
	Audiology	Ambulatory Care	
	Renal	1st Floor Main hospital adjacent to Gastro	
	Dermatology	Ambulatory Care	
	General Surgery	Ambulatory Care	
	TCU	Ground Floor adjacent to ED and IOC	
	Cardiology	Ambulatory Care	
	Diabetes / Endocrinology	Northside Building	
	Ophthalmology	Ambulatory Care	
	Otorhinolaryngology	Ambulatory Care	
	Podiatry	STAR 2	
	Infectious Diseases	Ambulatory Care	
Hospital Pharmacy Chief Pharmacist [redacted]	Hospital Pharmacy	Ground Floor	
	Pharmacy on Ruahine	Ground Floor adjacent to main entrance.	
Medical Imaging	General X-ray	Ground Floor	Any Grade MIT or Clerical Coordinator

Manager ██████	DSA/Specials	Ground Floor	Any Grade MIT or Clerical Coordinator
	CT	Ground Floor	Any Grade MIT or Clerical Coordinator
	MRI	Ground Floor adjacent to main hospital	Any Grade MIT or Clerical Coordinator
	Ultrasound	Ground Floor	Any Grade MIT or Clerical Coordinator
	Nuclear Medicine	Ground Floor	Any Grade MIT or Clerical Coordinator
	Medical Photography	Ground Floor	Any Grade MIT or Clerical Coordinator



PALMERSTON NORTH HOSPITAL GROUND FLOOR
Hospital Pharmacy
Distribution Centre/ Materials Management
Supply Shop
Mail Room
NZ Blood Service
MRI
STAIRS & LIFTS
HOC
Emergency Department
Emergency Dept (ED) Waiting Area
Security
Orderlies Base
Orthopaedic Clinic
CT Computed Tomography
Radiology
Mammography Ultrasound
Cardiology
Nuclear Medicine
Medical Imaging X-Ray
Reception/ Waiting Area
Lifts to Wards 28, 26 and 24
Courtyard Children's Ward Only
Stairs down to STAR Centre
Children's Ward/ Child Assessment Unit
Women's Health Unit/ Children's Clinic
Main Stairs to 1st Floor
Main Foyer
Ambulatory Care A Waiting Area
Ambulatory Care B Waiting Area
Lifts to: Wards 23, 25, 27, 29
Lift to Maternity, STAR Centre and Chapel
Radiation Therapy Ground Floor Entrance LA4
Main Entrance, Ruahine St
Public Pharmacy
Espresso Plus Cafe
Ambulatory Care (Outpatients Dept)
Stairs
Lifts
Information
Disabled Toilet
Toilets
Parking
Main Stairs
Showers
Exit/Entrance
Food
Public Phone
Mail
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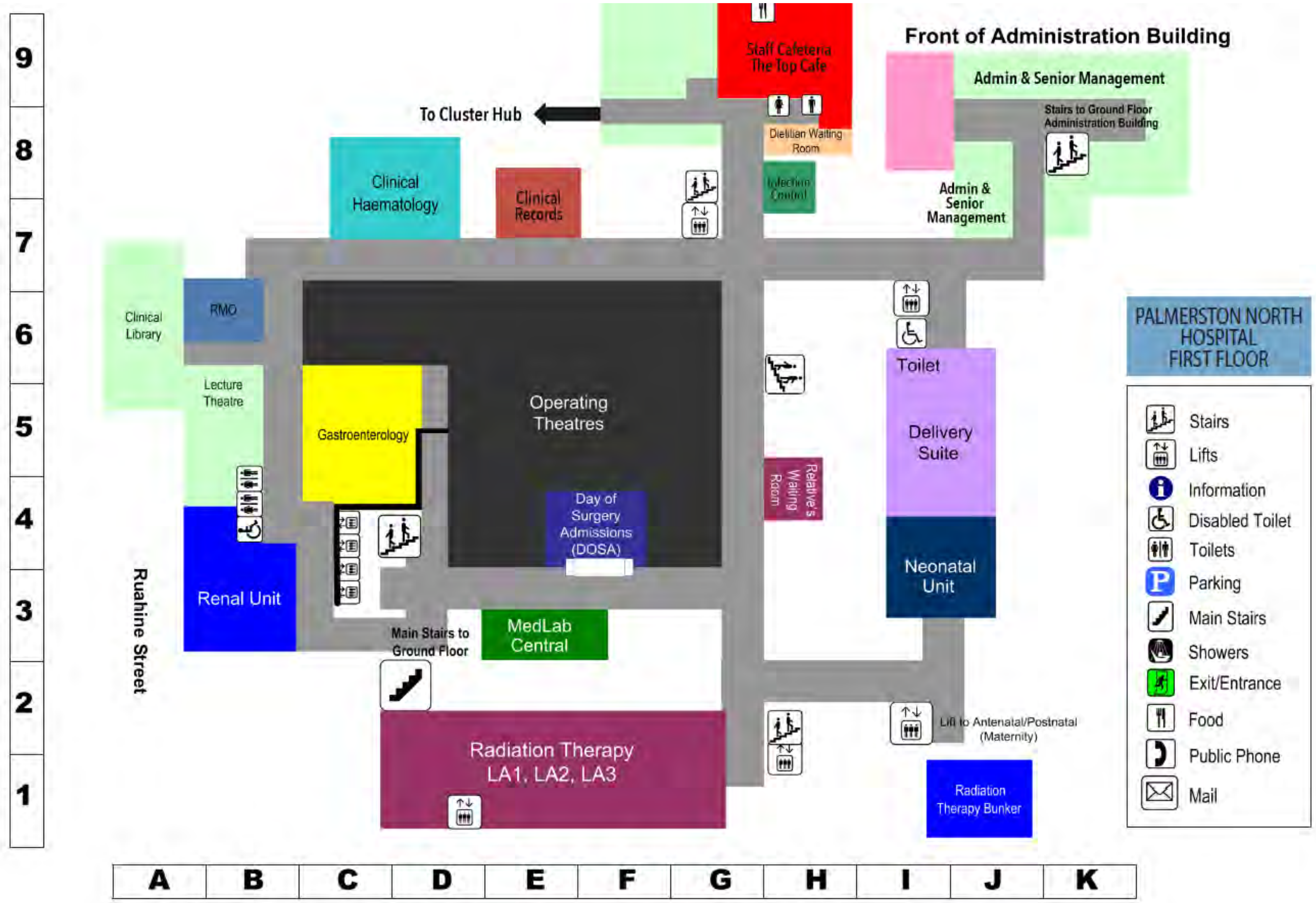

Front of Administration Building
Admin & Senior Management
Stairs to Ground Floor Administration Building
Admin & Senior Management
Staff Cafeteria The Top Cafe
Dietitian Waiting Room
Infection Control
To Cluster Hub
Clinical Haematology
Clinical Records
Clinical Library
RMO
Lecture Theatre
Gastroenterology
Operating Theatres
Day of Surgery Admissions (DOSA)
Relative's Waiting Room
Toilet
Delivery Suite
Neonatal Unit
Renal Unit
Ruahine Street
Main Stairs to Ground Floor
MedLab Central
Radiation Therapy LA1, LA2, LA3
Lift to Antenatal/Postnatal (Maternity)
Radiation Therapy Bunker
PALMERSTON NORTH HOSPITAL FIRST FLOOR
Stairs
Lifts
Information
Disabled Toilet
Toilets
Parking
Main Stairs
Showers
Exit/Entrance
Food
Public Phone
Mail
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7.0 ROLES AND RESPONSIBIITIES

7.1 Business Continuity Plan Sponsor

The Operational Executive Te Uru Arotau Acute & Elective Specialist Services cluster is the sponsor of the BCM. The sponsor has the responsibility, as delegated by the Chief Executive Officer (CEO), of promoting Business Continuity expectations and culture within the Uru Whakamauora Healthy Ageing & Rehabilitation cluster.

7.2 Business Continuity Plan Governance

The Te Uru Arotau Acute & Elective Specialist Services Cluster Leadership Team will maintain governance and ensure advancement of the Business Continuity Plan and supporting unit plans throughout the Cluster.

7.3 Business Continuity Plan Owner

The Business Lead (Te Uru Arotau Acute & Elective Specialist Services Cluster) is the owner of the Business Continuity Plan.

The owner has the role of ensuring the relevance of Business Continuity Planning (BCP), the competencies of key staff to implement plans as well as adequate awareness of BCP expectations throughout the Cluster.

7.4 Department/Unit/Service Leaders and equivalent roles

Department/Unit/Service Leaders and equivalent roles, in partnership with key clinical and other leadership roles, are responsible for developing and maintaining the Business Continuity Plan in line with relevant policies and all associated plans and strategies.

7.5 All Staff

All staff and contractors are responsible for contributing to the Business Continuity Plan with appropriate guidance, as well as assisting with the response and recovery action following a crisis, emergency, disruption or disaster event.

7.6 Guidance & Support

The Principal Risk and Resilience Officer will provide guidance and support as appropriate noting overall responsibility for an individual Cluster Business Continuity Plans remains with the relevant Cluster Business Lead.

8.0 MAINTENANCE CRITERIA

Business continuity maintenance activities will include:

- Regular scheduled exercising, testing and review of plans against agreed criteria, to maintain and evolve the adequacy of business continuity management across the organisation, for response and recovery purposes.
- Consideration of business continuity implications on organisational policies and future projects.
- Periodic updating, evolving and documentation of factual and assessed information.

9.0 MEASUREMENT CRITERIA

- Aligned to AS/NZS 5050:2010 Business Continuity - Managing disruption related risks
- Aligned to ISO 22301: Societal security - Business continuity management systems - Requirements
- Number of plan exercises completed
- Plan reviewed ANNUALLY, on the addition or deletion of a service/function and as part of debrief post disruptive event.

10.0 MANAGING THE DISRUPTION

10.1 Authority to Activate

Activation of the Te Uru Arotau Acute & Elective Specialist Services Business Continuity Plan will be determined by the scope and magnitude of the disruption and the impact on the ability for the cluster to deliver part or all of its services.

Any activation will be on the authority of the Operational Executive,

or in their absence the Business Lead,

or in their absence the under the direction of the Manager on Call in discussion with the Duty Nurse Manager,

or when requested by the MDHB Incident Controller as part of an all of DHB response.

10.2 Command, Control & Coordination

Command and control define who has the authority to make decisions and what the parameters of that authority are. Command and control then assist with coordination by defining authority between and within organisations. It is important to have a common understanding and application of these terms:

- **Command** - is the authority within a team, unit or organisation and includes the internal ownership, administrative responsibility and detailed supervision of personnel, tasks and resources.
- **Control** - is the authority to set objectives and direct tasks across teams, units and organisations within their capability and capacity. This may include control over another team, unit or cluster resources but does not include interference with that team, unit or clusters command authority or how its tasks are conducted.

- **Coordination** - brings together response elements and resources to ensure a unified and effective response. Command and Control assist with coordination by defining authority between and within organisations.

Where a disruptive event impacts the whole of DHB, or critical functions employed within the DHB, the MDHB Incident Management Team will established with the Incident Controller taking Control of the response.

10.3 Cluster/Unit/Department Call Trees

A call tree is a layered hierarchal communication model used to notify specific individuals of an event, conduct welfare checks and coordinate recovery where necessary.

Individual units and departments are to establish a call tree and ensure that both electronic and manual copy is available. Any manual copy must be secured to ensure private personal information is not accessible.

A review and update of the call tree should be completed at regular interval and as part of the induction of new staff.

10.3.1 Executing the Call Tree

1. The call tree is to be implanted on confirmation of a significant disruptive event and it is determined that employees must be notified.

2. Each unit/department/ward will designate one on duty employee to launch the call tree.

3. The designated caller will follow the hierarchal sequence of contacts allowing no more than 10 rings before hanging up and moving on to the next contact.

*Where no contact has been made the designated caller will annotate the call sheet and attempt to ring once the call tree has been completed.

Annex B identifies a process with which to develop a call tree.

Annex C identifies a process for executing the call tree.

Annex D provides a call tree template (small unit)

Annex E provides a call tree template (larger unit)

UNPLANNED CARE

Internal Disruptive Event

The following tables identify individual units/departments:

- **Critical functions**
- **Alternate care site preference**
- **Impact analysis against threat types (Service functions impacted)**
- **Likely consequences (impact of delivery of services)**
- **Response and Recovery strategies.**

Unplanned Care – Internal Disruptive Event

Unplanned Care

- Emergency Department
  -

Alternate Care Site Identified:

Service	Alternate Care Site
Emergency Department	Other suitable facility to set up, eg AmbCare, TCU, Ortho

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives		
		Within (Hours)		
		2	4	8
	Emergency Department	2		

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives		
		Within (Days)		
		2	4	7

Internal Disruptive Event - the organisation may suffer serious internal disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Industrial Action
- Loss of one or more key internal clinical support services

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	• Patient Cares • Communication systems • Information systems & support • Department integrity i.e Security doors • MedDispense, telemetry, etc • Patient Information & Flow Information system (• Loss of suction • Patient Monitoring equipment • Mechanical Cardiac/respiratory support (ventilators etc)	Patient Harm Inability to provide ventilatory support. Lab/Blood/Imaging data Security of Dept	Patient Cares -Staffing to acuity -All essential Point of Care equipment to be plugged into critical power supply. -Battery back-up of point of care equipment – limited supply of battery back up. -Hand written Bradma's (patient identity bracelet / patient documentation) -Emergency lights Communication -Runners & -mobile phone for CN Patient Information & Flow -Critical power supply to staff station computers. -Ipad (Wifi connectability)

			Negative Pressure Room
Water	Patient Cares Sanitary/Sluicing Infection Prevention Control (Staff/Patients) Drinking water	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash Drinking water from cafe Purifying tablets (CD Locker) Utilise toilet outside department Use ward sanitiser Use sterile supplies for sterile equipment. Sterile water
Medical Gases	Patient Cares (O2) Entonox Medical Air	Patient Harm	Portable O2, Entonox
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
As per identified in Cluster BIA page 8	• Patient Cares • Patient Information & Flow	Loss of administration systems (partially/full) Loss of Clinical Data and results impacting of clinical decision making	Manual copy of telephone book Manual copy data entry Paper records Runners/phones
Industrial Action	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Clinical / Non Clinical	Limited staffing resource Patient Cares Administration services	Inability to deliver non-essential cares or delays in care Data entry Administration support	MDHB strategic planning
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
EDs key dependencies	Theatre All inpatient wards Medical Imaging Laboratory Services NZ Blood Orderlies Clinical supply chain Pharmacy Allied Health specialties Hotel services (soft FM)	Patient Harm Delays Infection Inability to provide essential emergency support	Hospital wide response and escalation protocols for surges. MDHB strategic planning

Unplanned Care – Internal Disruptive Event

<table>
<tr><td>Unplanned Care
• MAPU
-</td><td>Alternate Care Site Identified:
<table><tr><td>Service</td><td>Alternate Care Site</td></tr><tr><td>MAPU</td><td>Alternative Ward</td></tr></table></td></tr>
<tr><td>Critical Functions
<table><tr><td rowspan="3">Service / Business Unit</td><td rowspan="3">Function/Output</td><td colspan="3">Recovery Time Objectives</td></tr><tr><td colspan="3">Within (Hours)</td></tr><tr><td>2</td><td>4</td><td>8</td></tr><tr><td></td><td>MAPU</td><td>2</td><td></td><td></td></tr></table></td><td>Functions Critical Over Time
<table><tr><td rowspan="3">Service / Business Unit</td><td rowspan="3">Function/Output</td><td colspan="3">Recovery Time Objectives</td></tr><tr><td colspan="3">Within (Days)</td></tr><tr><td>2</td><td>4</td><td>7</td></tr><tr><td></td><td></td><td></td><td></td><td></td></tr></table></td></tr>
</table>

Internal Disruptive Event - the organisation may suffer serious internal disruption as a result of:
- Lifelines / Infrastructure failure
- Information Systems outage
- Industrial Action
- Loss of one or more key internal clinical support services

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	• Patient Cares • Communication systems • Information systems & support • Ward integrity i.e Security doors • Medication rooms uncontrolled • Patient Information & Flow Information system • Loss of suction • Pt Monitoring equipment	Patient Harm Inability to pull Lab/Blood/Imaging data Security of Ward	Patient Cares -Staffing to acuity -All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment – limited supply and ability to recharge. Look to borrow. -Hand written Bradma's -Head torches (CD Locker) Communication -Runners / Pagers / Mobile Phone CN Patient Information & Flow -Critical power supply to staff station computers. -Laptop (query Wifi connectability)
Water	Patient Cares Sanitary/Sluicing	Patient Harm Increased risk of infection	Handwash Hospital Café for drinking water

	Infection Control (Staff/Patients) Drinking water	Staff/patient/visitor well being	Other wards for Sanitisers Sterile supplies unit for sterile equipment Purifying tablets (CD Locker)
Medical Gases	Patient Cares (O2) Loss of CPAP ability for overnight pts	Patient Harm	Portable O2 Portable cpap machines / plug into essential powers.
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
As per identified in Cluster BIA page 8	• Patient Cares • Patient Information & Flow	Loss of administration systems (partially/full) Loss of Clinical Data and results impacting of clinical decision making	Papercopies Runners Mobile phones Manual copy data entry
Industrial Action	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Clinical / Non Clinical	Limited staffing resource Patient Cares Administration services	Inability to deliver non-essential cares Data entry Administration support	MDHB strategic planning
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Key dependencies	Emergency Department Medical Wards	Patient Harm Delays	Whole of hospital wide escalation plan enact as appropriate. Patients stay in ED and go direct to other wards

Unplanned Care – Internal Disruptive Event

Unplanned Care	Alternate Care Site Identified:
• General Medicine - (staffing function)	Service: General Medicine — Alternate Care Site: Mobile staff

Service	Alternate Care Site
General Medicine	Mobile staff

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives		
		Within (Hours)		
		2	4	8
	General Medicine	2		

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives		
		Within (Days)		
		2	4	7

Internal Disruptive Event - the organisation may suffer serious internal disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Industrial Action
- Loss of one or more key internal clinical support services

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	• Delays for discharge summaries • Admission assessments and planning.	Delays to find access to information services	-Staffing to acuity Access computers which have emergency power supply. Communication -Runners & Pagers Mobile phones
Water	Sanitary/Sluicing Infection Control (Staff) Drinking water	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash
Medical Gases	Nil Impact		

Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
As per identified in Cluster BIA	• Patient Cares • Patient Information & Flow	Loss of administration systems (partially/full) Loss of Clinical Data and results impacting of clinical decision making	Manual copy data entry Papercopies

Industrial Action	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Clinical / Non Clinical	Limited staffing resource Patient Cares	Inability to deliver non essential cares	MDHB strategic planning

	Administration services	Data entry Administration support	
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Key dependencies	ED Medical Wards Surgical Wards MAPU Ambulatory Care	Patient harm Delays	Staffing to acuity. Working with General Medicine Teams Other DHBs Supervisor or any RMOs

Unplanned Care – Internal Disruptive Event

Unplanned Care	Alternate Care Site Identified:	
• Medical Wards -	Service	Alternate Care Site
	Medical Wards	Between 26, 28/CCU, OPAL or surgical wards.

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8
	Ward 26	2		
	Ward 28	2		
	CCU	2		

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)		
		2	4	7

Internal Disruptive Event - the organisation may suffer serious internal disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Industrial Action
- Loss of one or more key internal clinical support services

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Ward integrity i.e Security doors •Medication rooms uncontrolled •Patient Information & Flow Information system •Loss of suction Patient monitoring equipment	Patient Harm Inability to pull Lab/Blood/Imaging data Security of Ward Delays for inpatient dialysis	-Staffing to acuity -All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment -Hand written Bradma's (patient identity bracelet / patient documentation) -Emergency lighting Communication:-Runners/Pagers -Critical power supply to staff station computers. -ipad (Charge Nurse) Wifi connectability Renal Unit for any inpatient dialysis Transport telemetry for CCU. – on essential power
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients)	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash Hospital Café for drinking water Other wards for sanitisers

	Drinking water		Sterile Services/Supplies Unit
Medical Gases	Patient Cares – O2 (Loss of CPAP ability)	Patient Harm	Portable O2 medical gases Plug CPAP machine into essential power outlets
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
As per identified in Cluster BIA page 8	• Patient Cares • Patient Information & Flow	Loss of administration systems (partially/full) Loss of Clinical Data and results impacting of clinical decision making	Manual copy of telephone book Papercopies of documentation Phones Runners
Industrial Action	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Clinical / Non Clinical	Limited staffing resource Patient Cares Administration services	Inability to deliver non essential cares Data entry Administration support	MDHB strategic planning
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Key dependencies	ED Medical Wards Surgical Wards OPAL Community GPs (direct admissions) Medical Imaging	Delays Patient Harm	Onboarding Hospital Wide escalation plan

Unplanned Care – Internal Disruptive Event

Unplanned Care • PEDAL Team -	Alternate Care Site Identified:

Service	Alternate Care Site
PEDAL Team	Mobile – can move with Patients

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)			
		2	4	7	30
	PEDAL				

Internal Disruptive Event - the organisation may suffer serious internal disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Industrial Action
- Loss of one or more key internal clinical support services

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Communication systems •Patient Information & Flow Information system	Delays to access data	Face to face coordination Go to the patient on wards Phone
Water	Infection control	Hand hygiene	Handwash Other washing facilities
Medical Gases	Nil impact		

Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
As per identified in Cluster BIA page 8	• Patient Information & Flow	Loss of administration systems (partially/full) Loss of Clinical Data and results impacting of clinical decision making	Face to face coordination Go to the patients on wards Phones

Industrial Action	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Clinical / Non Clinical	Limited staffing resource Patient Cares Administration services	Inability to deliver non essential cares Data entry Administration support	MDHB strategic planning

Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
	ED Wards	Delays	Mobile service

UNPLANNED CARE

External Disruptive Event

The following tables identify individual units/departments:

- **Critical functions**
- **Alternate care site preference**
- **Impact analysis against threat types (Service functions impacted)**
- **Likely consequences (impact of delivery of services)**
- **Response and Recovery strategies**

Unplanned Care – External Disruptive Event

Unplanned Care	Alternate Care Site Identified:
Unplanned Care • Emergency Department -	Service: Emergency Department — Alternate Care Site: Community as per Organisation wide BCP or Amb Care.

Service	Alternate Care Site
Emergency Department	Community as per Organisation wide BCP or Amb Care.

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8
	Emergency Department	2		

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)		
		2	4	7

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Department integrity i.e Security doors •Medication rooms uncontrolled •Patient Information & Flow Information system •Loss of suction Patient monitoring equipment Ventilators and respiratory support	Patient Harm Inability to pull Lab/Blood/Imaging data Security of Ward	Patient Cares -Staffing to acuity -All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment -Hand written Bradma's (patient identity bracelet / patient documentation) -Head torches (CD Locker) Communication -Runners & Pagers Patient Information & Flow -Critical power supply to staff station computers.
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash Bottled water Purifying tablets (CD Locker)

Gas	Hot water		Dual Boilers
Information Systems Outage	**Service Functions Impacted**	**Likely Consequences**	**Readiness & Response Strategies**
Connectivity Cyber Attack	• Patient Cares • WebPas/Clinical Portal Patient Information • Bookings • Discharges	Loss of administration systems (partially/full) Inability to access Clinical Data and results Bookings/Discharges/Assessments Data breach	Paper based files
Loss of one or more key supplies	**Service Functions Impacted**	**Likely Consequences**	**Readiness & Response Strategies**
NZ Blood			
Allied Laundry			
Natural Disaster/Health Emergency	**Service Functions Impacted**	**Likely Consequences**	**Readiness & Response Strategies**
MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans			

Unplanned Care – External Disruptive Event

Unplanned Care • MAPU -	Alternate Care Site Identified:

Service	Alternate Care Site
MAPU	Any vacant ward

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8
	MAPU	2		

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)		
		2	4	7

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Department integrity i.e Security doors •Medication rooms uncontrolled •Patient Information & Flow Information system •Loss of suction Patient monitoring equipment	Patient Harm Inability to pull Lab/Blood/Imaging data Security of Ward	Patient Cares -Staffing to acuity -All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment -Hand written Bradma's (patient identity bracelet / patient documentation) -Head torches (CD Locker) Communication -Runners & Pagers Patient Information & Flow -Critical power supply to staff station computers.
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients)	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash Bottled water Purifying tablets (CD Locker)

	Drinking water		
Gas	Hot Water		Dual Boilers
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Connectivity Cyber Attack	• Patient Cares • WebPas/Clinical Portal Patient Information • Bookings • Discharges	Loss of administration systems (partially/full) Inability to access Clinical Data and results Bookings/Discharges/assessments Data breach	Paper based files
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
NZ Blood			
Allied Laundry			
Hotel Services (Soft FM)			
Facilities Management (Hard FM)			
Natural Disaster/Health Emergency	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans			

Unplanned Care – External Disruptive Event

Unplanned Care	Alternate Care Site Identified:
• General Medicine - workforce mobile – go to the patients	Service: General Medicine — Alternate Care Site: Mobile

Service	Alternate Care Site
General Medicine	Mobile

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8
	General Medicine	2		

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)		
		2	4	7

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support • Security doors •Patient Information & Flow Information system •Loss of suction	Patient Harm Inability to pull Lab/Blood/Imaging data Security of area	Patient Cares -Staffing to acuity -All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment -Hand written Bradma's (patient identity bracelet / patient documentation) -Head torches (CD Locker) Communication -Runners & Pagers Patient Information & Flow -Critical power supply to staff station computers.
Water	Patient Cares Sanitary/Sluicing	Patient Harm Increased risk of infection	Handwash Bottled water

	Infection Control (Staff/Patients) Drinking water	Staff/patient/visitor well being	Purifying tablets (CD Locker)
Gas	Hot Water		Dual Boilers
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Connectivity Cyber Attack	• Patient Cares • WebPas/Clinical Portal Patient Information • Bookings • Discharges	Loss of administration systems (partially/full) Inability to access Clinical Data and results Bookings/Discharges/assessments Data breach	Paper based files
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
NZ Blood			
Allied Laundry			
Natural Disaster/Health Emergency	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans			

Unplanned Care – External Disruptive Event

<table>
<tr><td>Unplanned Care
• Medical Wards
-</td><td>Alternate Care Site Identified:
<table><tr><td>Service</td><td>Alternate Care Site</td></tr><tr><td>Medical Wards</td><td>Any other ward/area.</td></tr></table></td></tr>
</table>

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8
	Ward 26	2		
	Ward 28/CCU	2		

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)		
		2	4	7

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Department integrity i.e Security doors •Medication rooms uncontrolled •Patient Information & Flow Information system •Loss of suction Patient monitoring equipment Nurse Call Bells/System	Patient Harm Inability to pull Lab/Blood/Imaging data Security of Ward	Patient Cares -Staffing to acuity -All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment -Hand written Bradma's (patient identity bracelet / patient documentation) -Head torches (CD Locker) Communication -Runners & Pagers Patient Information & Flow -Critical power supply to staff station computers. -ipads
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients)	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash Purifying tablets (CD Locker)

	Drinking water		
Gas			
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Connectivity Cyber Attack	• Patient Cares • WebPas/Clinical Portal Patient Information • Bookings • Discharges	Loss of administration systems (partially/full) Inability to access Clinical Data and results Bookings/Discharges/Assessments Data breach	Paper based files
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
NZ Blood			
Allied Laundry			
Natural Disaster/Health Emergency	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
MDHB Strategic Business Continuity Plan enacted			

Unplanned Care – External Disruptive Event

Unplanned Care
- PEDAL Team
  -

Alternate Care Site Identified:

Service	Alternate Care Site
PEDAL TEAM	Mobile

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)			
		2	4	7	30
	PEDAL				30

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:
- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	Access to information systems	Delays	Emergency Lighting
Water	Nil Impact		
Gas	Nil impact		

Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Connectivity Cyber Attack	• Patient Cares • WebPas/Clinical Portal Patient Information	Loss of administration systems (partially/full) Inability to access Clinical Data and results Bookings/Discharges/Assessments Data breach	Paper based files

Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies

Natural Disaster/Health Emergency	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans			

PLANNED CARE

Internal Disruptive Event

The following tables identify individual units/departments:

- **Critical functions**
- **Alternate care site preference**
- **Impact analysis against threat types (Service functions impacted)**
- **Likely consequences (impact of delivery of services)**
- **Response and Recovery strategies.**

Planned Care – Internal Disruptive Event

<table>
<tr><td colspan="4">Planned Care
- Peri Operative Services</td><td colspan="4">Alternate Care Site Identified:
<table><tr><td>Service</td><td>Alternate Care Site</td></tr><tr><td>Peri Operative Services / incl Theatre</td><td>CREST, Massey Vets, Medical Imaging</td></tr></table></td></tr>
<tr><td colspan="4">Critical Functions
<table><tr><td rowspan="3">Service / Business Unit</td><td rowspan="3">Function/Output</td><td colspan="3">Recovery Time Objectives</td></tr><tr><td colspan="3">Within (Hours)</td></tr><tr><td>2</td><td>4</td><td>8</td></tr><tr><td></td><td>Theatre</td><td>2</td><td></td><td></td></tr></table></td><td colspan="4">Functions Critical Over Time
<table><tr><td rowspan="3">Service / Business Unit</td><td rowspan="3">Function/Output</td><td colspan="3">Recovery Time Objectives</td></tr><tr><td colspan="3">Within (Days)</td></tr><tr><td>2</td><td>4</td><td>7</td></tr><tr><td></td><td></td><td></td><td></td><td></td></tr></table></td></tr>
<tr><td colspan="8">Internal Disruptive Event - the organisation may suffer serious internal disruption as a result of:
• Lifelines / Infrastructure failure
• Information Systems outage
• Industrial Action
• Loss of one or more key internal clinical support services</td></tr>
<tr><td colspan="2">Loss of Lifelines/Infrastructure</td><td colspan="2">Service Functions Impacted</td><td colspan="2">Likely Consequences</td><td colspan="2">Readiness & Response Strategies</td></tr>
<tr><td colspan="2">Electrical Power</td><td colspan="2">•Patient Cares/Surgery
•Communication systems
•Information systems & support
•Unit integrity i.e Security doors
•Meddispense
•Patient Information & Flow Information system
•Loss of suction
• Limited diathermy
• Overhead theatre lights
• Patient monitoring equipment</td><td colspan="2">• Patient Harm
• Inability to pull Lab/Blood/Imaging data
• Security of Unit</td><td colspan="2">• Assess situation and manage surgeries as appropriate.
Patient Cares
-Staffing to acuity
-All essential Point of Care equipment to be plugged into critical power supply.
-Battery back up of point of care equipment

-Hand written Bradma's (patient identity bracelet / patient documentation)
Manual Documentation and data entry (e.g. nursing, safer sleep anaesthetic data information)
Emergency Lighting

Communication
-Runners & Pagers</td></tr>
</table>

			Utilise Mobile Phones from Theatre Patient Information & Flow -Critical power supply to some computers. -Laptop / ipads to be used
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water	Patient Harm Increased risk of infection Staff/patient/visitor well being	• Assess situation and manage surgeries as appropriate. Handwash Bottled water Waterless scrub solution
Medical Gases	Medical Air Nitrous oxide O2	Patient harm	Portable cylinders for Nitrous oxide and O2 • Assess situation and manage surgeries as appropriate.
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
As per identified in Cluster BIA page 8	• Patient Cares • Patient Information & Flow	Loss of administration systems (partially/full) Loss of Clinical Data and results impacting of clinical decision making	Manual copy data entry Manual data collection and entry Manual documentation
Industrial Action	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Clinical / Non Clinical	Limited staffing resource Patient Cares Administration services	Inability to deliver non-essential cares Data entry Administration support	MDHB strategic planning Assess situation and manage surgeries as appropriate
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
	Laundry Sterile Services Ventia - Orderlies		Assess situation and manage surgeries as appropriate Limited disposables

Planned Care – Internal Disruptive Event

Planned Care
- ICU
- Anaesthetics (people & equipment)

Alternate Care Site Identified:

Service	Alternate Care Site
ICU	Operating Theatre / Split
Anaesthetics (people & equipment)	Operating Theatre / Split

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8
	ICU	2		
	Anaesthetics	2		

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)		
		2	4	7

Internal Disruptive Event - the organisation may suffer serious internal disruption as a result of:
- Lifelines / Infrastructure failure
- Information Systems outage
- Industrial Action
- Loss of one or more key internal clinical support services

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Ward integrity i.e Security doors •Medication rooms uncontrolled •Patient Information & Flow Information system •Loss of suction Loss of Ventilators and patient monitoring	• Patient Harm • Inability to pull Lab/Blood/Imaging data • Security of Unit • Manual override for beds	• Assess clinical situation and individual patient requirements. Patient Cares -Staffing to acuity -All essential Point of Care equipment to be plugged into critical power supply. -Small battery supplies Plug in bed batteries Battery back up of point of care equipment -Hand written Bradma's (patient identity bracelet / patient documentation) -Head torches (CD Locker) Communication -Runners & Pagers Patient Information & Flow

			-Critical power supply to staff station computers.
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash Purifying tablets (CD Locker) Waterless scrub available
Medical Gases	Medical Air Nitrous oxide O2	Assess situation and manage elective surgeries as appropriate	Portable cylinders for Nitrous oxide and O2
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
As per identified in Cluster BIA page 8	• Patient Cares • Patient Information & Flow	Loss of administration systems (partially/full) Loss of Clinical Data and results impacting of clinical decision making	Manual copy of telephone book Manual copy data entry Manual data / documentation Manual Observations/monitoring
Industrial Action	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Clinical / Non Clinical	Limited staffing resource Patient Cares Administration services	Inability to deliver non-essential cares Data entry Administration support	MDHB strategic planning
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
	Laundry Pharmacy Orderlies – Ventia Medical Imaging Other clinical areas eg OT Clinical supply chain	Delays Run out of stock	Assess situation and manage elective surgeries as appropriate

Planned Care – Internal Disruptive Event

Planned Care - Endoscopy/Gastroenterology	Alternate Care Site Identified:

Service	Alternate Care Site
Endoscopy/ Gastroenterology	Operating Theatre/Medical Imaging

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)		
		2	4	7
	Endoscopy/Gastro			7

Internal Disruptive Event - the organisation may suffer serious internal disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Industrial Action
- Loss of one or more key internal clinical support services

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares/Surgery •Communication systems •Information systems & support •Unit integrity i.e Security doors •Meddispense •Patient Information & Flow Information system •Loss of suction • Limited diathermy • Overhead theatre/procedure lights	• Patient Harm • Inability to pull Lab/Blood/Imaging data • Security of Unit	• Assess situation and manage surgeries as appropriate. •Patient Cares/Surgery •Communication systems •Information systems & support •Unit integrity i.e Security doors •Meddispense •Patient Information & Flow Information system •Loss of suction • Limited diathermy • Overhead theatre lights
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash Purifying tablets (CD Locker) Waterless scrub
Medical Gases	Medical Air Nitrous oxide O2	Patient Harm Delays for procedures	Assess situation and manage procedures as appropriate Portable cylinders for Nitrous oxide and O2
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies

As per identified in Cluster BIA page 8	• Patient Cares • Patient Information & Flow	Loss of administration systems (partially/full) Loss of Clinical Data and results impacting of clinical decision making	Manual copy data entry Same Assess situation and manage procedures as appropriate
Industrial Action	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Clinical / Non Clinical	Limited staffing resource Patient Cares Administration services	Inability to deliver non essential cares Data entry Administration support	MDHB strategic planning Assess situation and manage procedures as appropriate
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
	Sterile supplies (decontamination) Laundry Orderlies Food services Pharmacy	Delays or cancellations of procedures.	Assess situation and manage procedures as appropriate

Planned Care – Internal Disruptive Event

Planned Care	Alternate Care Site Identified:	
- Surgical Wards	**Service**	**Alternate Care Site**
	Surgical Wards - Ward 24 - Ward 27 - Ward 29	Available ward and/or area.

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives		
		Within (Hours)		
		2	4	8
	Ward 24	2		
	Ward 27	2		
	Ward 29	2		

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives		
		Within (Days)		
		2	4	7

Internal Disruptive Event - the organisation may suffer serious internal disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Industrial Action
- Loss of one or more key internal clinical support services

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Ward integrity i.e Security doors •Medication rooms uncontrolled •Patient Information & MIYA Flow Information system •Loss of suction • Nurse Call bells/system • No lifts (across the wards)	• Delays • Patient harm • Unable to transfer patients depending on clinical acuity • Delays to discharges/admission from ED/operating theatre/PACU	Assess situation and manage surgeries as appropriate
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash Purifying tablets (CD Locker) Waterless scrub
Medical Gases	O2 Suction	• Patient harm	Portable O2 & suction

Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
As per identified in Cluster BIA page 8	• Patient Cares • Patient Information & Flow	Loss of administration systems (partially/full) Loss of Clinical Data and results impacting of clinical decision making	Manual copy of telephone book Manual copy data entry
Industrial Action	**Service Functions Impacted**	**Likely Consequences**	**Readiness & Response Strategies**
Clinical / Non Clinical	Limited staffing resource Patient Cares Administration services	Inability to deliver non-essential cares Data entry Administration support	Assess situation and manage surgeries as appropriate MDHB strategic planning
Loss of one or more key internal clinical support services	**Service Functions Impacted**	**Likely Consequences**	**Readiness & Response Strategies**
	Ventia Orderlies Food Pharmacy Lifts NZBlood Radiology		

Planned Care – Internal Disruptive Event

Planned Care - Hospital Dental - Oral & Maxillofacial	Alternate Care Site Identified:

Service	Alternate Care Site
Hospital Dental/Oral & Maxillofacial	Operating Theatre

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)			
		2	4	7	30
	Hospital Dental/Oral & Maxillofacial				30

Internal Disruptive Event - the organisation may suffer serious internal disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Industrial Action
- Loss of one or more key internal clinical support services

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Ward integrity i.e Security doors •Medication rooms uncontrolled •Patient Information & Flow Information system •Loss of suction Patient monitoring equipment	Patient Harm Inability to pull Lab/Blood/Imaging data Security of Ward	Patient Cares -Staffing to acuity -All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment Assess situation and manage elective surgeries as appropriate -Hand written Bradma's (patient identity bracelet / patient documentation) -Head torches (CD Locker) Communication -Runners & -Pagers Patient Information & Flow -Critical power supply to staff station computers.
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients)	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash Waterless scrub Purifying tablets (CD Locker)

	Drinking water		
Medical Gases	O2 Suction	Cancelling of all non-urgent procedures	Prioritisation Portable OT
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
As per identified in Cluster BIA page 8	• Patient Cares • Patient Information & Flow	Loss of administration systems (partially/full) Loss of Clinical Data and results impacting of clinical decision making	Manual copy of telephone book Manual copy data entry
Industrial Action	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Clinical / Non Clinical	Limited staffing resource Patient Cares Administration services	Inability to deliver non essential cares Data entry Administration support	MDHB strategic planning
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Sterile Services			

Planned Care – Internal Disruptive Event

Planned Care - Sterile Supply Services	Alternate Care Site Identified:

Service	Alternate Care Site
Sterile Supply Services	Other DHBs/Private

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8
	Sterile Supplies	2		

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)		
		2	4	7

Internal Disruptive Event - the organisation may suffer serious internal disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Industrial Action
- Loss of one or more key internal clinical support services

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Department security i.e Security doors •Medication rooms uncontrolled •Patient Information & Information system •Loss of suction Sterilisation equipment	Delays to process equipment for sterilisation Security of department	Patient Cares -Staffing to acuity -All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment Assess situation and manage surgeries as appropriate. Small supply of disposables. -Head torches (CD Locker) Communication -Runners & -Pagers Patient Information & Flow -Critical power supply to staff station computers.
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water	Patient Harm Increased risk of infection Staff/patient/visitor well being	Assess situation and manage surgeries as appropriate. Handwash Purifying tablets (CD Locker)

		Delays to process equipment (decontaminate) before sterilisation	
Medical Gases	Nil impact		
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
As per identified in Cluster BIA page 8	• Patient Cares • Patient Information & Flow	Loss of administration systems (partially/full) Loss of Clinical Data and results impacting of clinical decision making	Manual copy of telephone book Manual copy data entry
Industrial Action	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Clinical / Non Clinical	Limited staffing resource Patient Cares Administration services	Inability to deliver non essential cares Data entry Administration support	MDHB strategic planning
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies

PLANNED CARE

External Disruptive Event

The following tables identify individual units/departments:

- **Critical functions**
- **Alternate care site preference**
- **Impact analysis against threat types (Service functions impacted)**
- **Likely consequences (impact of delivery of services)**
- **Response and Recovery strategies.**

Planned Care – External Disruptive Event

Planned Care - Peri Operative Services	Alternate Care Site Identified:

Service	Alternate Care Site
Peri Operative Services	Other provider/DHB

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8
	Theatre	2		

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)		
		2	4	7

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Ward integrity i.e Security doors •Medication rooms uncontrolled •Patient Information & Flow Information system •Loss of suction Diathermy Theatre lights Patient monitoring equipment Anaesthetic equipment	Patient Harm Inability to pull Lab/Blood/Imaging data Security of Ward Assess situation and manage elective surgeries as appropriate	Environmental assessment of all aspects for safe management of services delivery. (ED/OPTH/Wards etc) Patient Cares -Staffing to acuity -All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment -Hand written Bradma's (patient identity bracelet / patient documentation) -Head torches (CD Locker) Communication -Runners & -Pagers Patient Information & Flow -Critical power supply to staff station computers.
Water	Patient Cares	Patient Harm	Handwash

	Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water	Increased risk of infection Staff/patient/visitor well being	Purifying tablets (CD Locker)
Gas	Hot Water		Dual Boilers
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Connectivity Cyber Attack Loss of Priority 1 system	• Patient Cares • WebPas/Clinical Portal Patient Information • Bookings • Discharges	Loss of administration systems (partially/full) Inability to access Clinical Data and results Bookings/Discharges/assessments Data breach	Paper based files
Loss of one or more key suppliers	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
NZ Blood			
Allied Laundry			
Natural Disaster/Health Emergency	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans			

Planned Care – External Disruptive Event

Planned Care
- ICU
- Anaesthetics

Alternate Care Site Identified:

Service	Alternate Care Site
ICU	Other provider/Other DHB
Anaesthetics	Other provider/Other DHB

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8
	ICU	2		
	Anaesthetics	2		

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)		
		2	4	7

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:
- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Ward integrity i.e Security doors •Medication rooms uncontrolled •Patient Information & Flow Information system •Loss of suction Ventilatory support Patient monitoring equipment	Patient Harm Inability to pull Lab/Blood/Imaging data Security of Ward	Environmental assessment of all aspects for safe management of services delivery. (ED/OPTH/Wards etc) Patient Cares -Staffing to acuity -All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment -Hand written Bradma's (patient identity bracelet / patient documentation) -Head torches (CD Locker) Communication -Runners &-Pagers Patient Information & Flow

			-Critical power supply to staff station computers.
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash Purifying tablets (CD Locker)
Gas	Hot Water		Dual Boilers
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Connectivity Cyber Attack Loss of Priority 1 system	• Patient Cares • WebPas/Clinical Portal Patient Information • Bookings • Discharges	Loss of administration systems (partially/full) Inability to access Clinical Data and results Bookings/Discharges/assessments Data breach	Paper based files
Loss of one or more key suppliers	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
NZ Blood			
Allied Laundry			
Natural Disaster/Health Emergency	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans			

Planned Care – External Disruptive Event

Planned Care - Endoscopy/Gastroenterology	Alternate Care Site Identified:

Service	Alternate Care Site
Endoscopy Gastroenterology	OT or Other provider

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)		
		2	4	7
	Endoscopy			7

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Ward integrity i.e Security doors •Medication rooms uncontrolled •Patient Information & Flow Information system •Loss of suction Patient monitoring equipment	Patient Harm Inability to pull Lab/Blood/Imaging data Security of Ward	Environmental assessment of all aspects for safe management of services delivery. (ED/OPTH/Wards etc) Patient Cares -Staffing to acuity -All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment -Hand written Bradma's (patient identity bracelet / patient documentation) -Head torches (CD Locker) Communication -Runners &-Pagers Patient Information & Flow -Critical power supply to staff station computers.
Water	Patient Cares	Patient Harm	Handwash

	Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water	Increased risk of infection Staff/patient/visitor well being	Purifying tablets (CD Locker)
Gas	Hot Water		Dual Boilers
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Connectivity Cyber Attack Loss of Priority 1 system	• Patient Cares • WebPas/Clinical Portal Patient Information • Bookings • Discharges	Loss of administration systems (partially/full) Inability to access Clinical Data and results Bookings/Discharges/assessments Data breach	Paper based files
Loss of one or more key suppliers	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
NZ Blood			
Allied Laundry			
Natural Disaster/Health Emergency	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans			

Planned Care – External Disruptive Event

Planned Care	Alternate Care Site Identified:	
- Surgical Wards	**Service**	**Alternate Care Site**
	Surgical Wards - Ward 24 - Ward 27 - Ward 29	Other ward/area

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives		
		Within (Hours)		
		2	4	8
	Ward 24	2		
	Ward 27	2		
	Ward 29	2		

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives		
		Within (Days)		
		2	4	7

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Ward integrity i.e Security doors •Medication rooms uncontrolled •Patient Information & Flow Information system •Loss of suction Nurse Call bells/system Patient monitoring Patient observation equipment	Patient Harm Inability to pull Lab/Blood/Imaging data Security of Ward	Environmental assessment of all aspects for safe management of services delivery. (ED/OPTH/Wards etc) Patient Cares -Staffing to acuity -All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment -Hand written Bradma's (patient identity bracelet / patient documentation) -Head torches (CD Locker) Communication -Runners & Pagers

			Patient Information & Flow -Critical power supply to staff station computers.
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash Purifying tablets (CD Locker)
Gas	Hot Water		Dual Boilers
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Connectivity Cyber Attack Loss of Priority 1 system	• Patient Cares • WebPas/Clinical Portal Patient Information • Bookings • Discharges	Loss of administration systems (partially/full) Inability to access Clinical Data and results Bookings/Discharges/assessments Data breach	Paper based files
Loss of one or more key suppliers	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
NZ Blood			
Allied Laundry			
Natural Disaster/Health Emergency	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans			

Planned Care – External Disruptive Event

Planned Care - Hospital Dental - Oral & Maxillofacial	Alternate Care Site Identified:

Service	Alternate Care Site
Hospital Dental	Other provider / DHB

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)			
		2	4	7	30
	Hospital Dental				30
	Oral & Maxillofacial				30

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Ward integrity i.e Security doors •Medication rooms uncontrolled •Patient Information & Flow Information system •Loss of suction Patient monitoring equipment Autoclaves Dental X-rays	Patient Harm Inability to pull Lab/Blood/Imaging data Security of Ward	Patient Cares -Staffing to acuity -All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment -Hand written Bradma's (patient identity bracelet / patient documentation) -Head torches (CD Locker) Communication -Runners &-Pagers Patient Information & Flow -Critical power supply to staff station computers.
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients)	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash Purifying tablets (CD Locker)

	Drinking water		
Gas	Hot Water		Dual Boilers
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Connectivity Cyber Attack Loss of Priority 1 system	• Patient Cares • WebPas/Clinical Portal Patient Information • Bookings • Discharges	Loss of administration systems (partially/full) Inability to access Clinical Data and results Bookings/Discharges/assessments Data breach	Paper based files
Loss of one or more key suppliers	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
NZ Blood			
Allied Laundry			
Natural Disaster/Health Emergency	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans			

Planned Care – External Disruptive Event

Planned Care - Sterile Supply Services	Alternate Care Site Identified:

Service	Alternate Care Site
Sterile Supply Services	Other provider/DHB

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8
	Sterile Supplies	2		

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)		
		2	4	7

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Communication systems •Information systems & support •SSU Security doors •Patient Information & Flow Information system Sterilisation equipment	Patient Harm Inability to pull Lab/Blood/Imaging data Security of Ward	Environmental assessment of all aspects for safe management of services delivery. Patient Cares -Staffing to acuity -All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment -Hand written Bradma's (patient identity bracelet / patient documentation) Communication -Runners Patient Information & Flow -Critical power supply to staff station computers.
Water	Sterilisation and decontamination	Delays to process equipment	
Medical Gases	Sanitary/Sluicing	Patient Harm	Handwash

	Infection Control (Staff/Patients) Drinking water	Increased risk of infection Staff/patient/visitor well being	Purifying tablets (CD Locker)
Gas	Hot Water		Dual Boilers
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Connectivity Cyber Attack Loss of Priority 1 system	• Patient Cares • WebPas/Clinical Portal Patient Information • Bookings • Discharges	Loss of administration systems (partially/full) Inability to access Clinical Data and results Bookings/Discharges/Assessments Data breach	Paper based files
Loss of one or more key suppliers	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Natural Disaster/Health Emergency	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans			

OUTPATIENT SERVICES

Internal Disruptive Event

The following tables identify individual units/departments:

- **Critical functions**
- **Alternate care site preference**
- **Impact analysis against threat types (Service functions impacted)**
- **Likely consequences (impact of delivery of services)**
- **Response and Recovery strategies.**

Outpatient Services – Internal Disruptive Event

Outpatient Services - General Surgery	Alternate Care Site Identified:

Service	Alternate Care Site
General Surgery	Other suitable clinic space

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)		
		2	4	7
	General Surgery Clinic	2		

Internal Disruptive Event - the organisation may suffer serious internal disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Industrial Action
- Loss of one or more key internal clinical support services

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Security doors •Medication rooms uncontrolled •Patient Information & Flow Information system	Patient Harm Inability to pull Lab/Blood/Imaging data Security of Ward	Patient Cares -Staffing to acuity -All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment -Hand written Bradma's (patient identity bracelet / patient documentation) -Head torches (CD Locker) Communication -Runners &-Pagers Patient Information & Flow -Critical power supply to staff station computers.
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients)	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash

	Drinking water		
Medical Gases	Nil Impact		
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
As per identified in Cluster BIA page 8	• Patient Cares • Patient Information & Flow	Loss of administration systems (partially/full) Loss of Clinical Data and results impacting of clinical decision making	Manual copy of telephone book Manual copy data entry
Industrial Action	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Clinical / Non Clinical	Limited staffing resource Patient Cares Administration services	Inability to deliver non-essential cares Data entry Administration support	MDHB strategic planning
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Medical Imaging Pharmacy Sterile Services			

Outpatient Services – Internal Disruptive Event

Outpatient Services	Alternate Care Site Identified:
- Rheumatology	

Service	Alternate Care Site
Rheumatology	Virtual or other clinic space

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)			
		2	4	7	30
	Rheumatology				30

Internal Disruptive Event - the organisation may suffer serious internal disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Industrial Action
- Loss of one or more key internal clinical support services

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Department integrity i.e Security doors •Medication rooms uncontrolled •Patient Information & Flow Information system	Patient Harm Inability to pull Lab/Blood/Imaging data	Patient Cares -All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment -Hand written Bradma's (patient identity bracelet / patient documentation) -Head torches (CD Locker) Communication -Runners &-Pagers
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash
Medical Gases			

Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
As per identified in Cluster BIA page 8	• Patient Cares • Patient Information & Flow	Loss of administration systems (partially/full)	Manual copy data entry

		Loss of Clinical Data and results impacting of clinical decision making	
Industrial Action	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Clinical / Non Clinical	Limited staffing resource Patient Cares Administration services	Inability to deliver non essential cares Data entry Administration support	MDHB strategic planning
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies

Outpatient Services – Internal Disruptive Event

Outpatient Services - Transitory Care Unit	Alternate Care Site Identified:

Service	Alternate Care Site
Transitory Care	Ambulatory Care

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)		
		2	4	7
	TCU	2		

Internal Disruptive Event - the organisation may suffer serious internal disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Industrial Action
- Loss of one or more key internal clinical support services

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Department integrity i.e Security doors •Medication rooms uncontrolled •Patient Information & Flow Information system •Loss of suction	Patient Harm Inability to pull Lab/Blood/Imaging data Security of Ward	Patient Cares -Staffing to acuity -All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment -Hand written Bradma's (patient identity bracelet / patient documentation) -Head torches (CD Locker) Communication -Runners & Pagers
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash Purifying tablets (CD Locker)
Medical Gases	O2 Suction		Portable O2 and suction
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies

As per identified in Cluster BIA page 8	• Patient Cares • Patient Information & Flow	Loss of administration systems (partially/full) Loss of Clinical Data and results impacting of clinical decision making	Manual copy of telephone book Manual copy data entry
Industrial Action	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Clinical / Non Clinical	Limited staffing resource Patient Cares Administration services	Inability to deliver non essential cares Data entry Administration support	MDHB strategic planning
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies

Outpatient Services – Internal Disruptive Event

Outpatient Services - Respiratory	Alternate Care Site Identified:

Service	Alternate Care Site
Respiratory	Other Amb care area/provider

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)		
		2	4	7
	Respiratory	2		

Internal Disruptive Event - the organisation may suffer serious internal disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Industrial Action
- Loss of one or more key internal clinical support services

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Department integrity i.e Security doors •Specific spirometry and other specialty tests based in respiratory clinic •Patient Information & Flow Information system •Loss of suction Spirometry equipment Resp. Physiologist equipment Resp Lab	Patient Harm Inability to pull Lab/Blood/Imaging data Security of Ward Delays to treatment	Patient Cares -Staffing to acuity -All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment -Hand written Bradma's (patient identity bracelet / patient documentation) -Head torches (CD Locker) Communication -Runners &Pagers
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash
Medical Gases	TBC		
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies

As per identified in Cluster BIA page 8	• Patient Cares • Patient Information & Flow	Loss of administration systems (partially/full) Loss of Clinical Data and results impacting of clinical decision making	Manual copy of telephone book Manual copy data entry
Industrial Action	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Clinical / Non Clinical	Limited staffing resource Patient Cares Administration services	Inability to deliver non essential cares Data entry Administration support	MDHB strategic planning
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies

Outpatient Services – Internal Disruptive Event

Outpatient Services	Alternate Care Site Identified:
- Cardiology	

Service	Alternate Care Site
Cardiology	OT, ICU, Cardiac protected area

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)		
		2	4	7
	Cardiology	2		

Internal Disruptive Event - the organisation may suffer serious internal disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Industrial Action
- Loss of one or more key internal clinical support services

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Department integrity i.e Security doors •Medication rooms uncontrolled •Patient Information & Flow Information system •Loss of suction • PACING • Echo: TTE and TOE • Angiography • ETT, Holter monitoring • Treadmill • Sestamibi	Patient Harm Inability to pull Lab/Blood/Imaging data Security of Ward	Patient Cares -Staffing to acuity -All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment -Hand written Bradma's (patient identity bracelet / patient documentation) -Head torches (CD Locker) Communication -Runners &-Pagers
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash Purifying tablets (CD Locker)
Medical Gases	Nil Impact		
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies

As per identified in Cluster BIA page 8	• Patient Cares • Patient Information & Flow	Loss of administration systems (partially/full) Loss of Clinical Data and results impacting of clinical decision making	Manual copy of telephone book Manual copy data entry
Industrial Action	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Clinical / Non Clinical	Limited staffing resource Patient Cares Administration services	Inability to deliver non essential cares Data entry Administration support	MDHB strategic planning
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies

Outpatient Services – Internal Disruptive Event

Outpatient Services	Alternate Care Site Identified:
Outpatient Services - Neurology	Alternate Care Site Identified: Service: Neurology — Alternate Care Site: Other clinic/ward area

Service	Alternate Care Site
Neurology	Other clinic/ward area

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)		
		2	4	7
	Neurology			7

Internal Disruptive Event - the organisation may suffer serious internal disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Industrial Action
- Loss of one or more key internal clinical support services

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Department integrity i.e Security doors •Medication rooms uncontrolled •Patient Information & Flow Information system	Patient Harm Inability to pull Lab/Blood/Imaging data	Patient Cares -Staffing to acuity -All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment -Hand written Bradma's (patient identity bracelet / patient documentation) -Head torches (CD Locker) Communication -Runners &-Pagers
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash Purifying tablets (CD Locker)
Medical Gases	Nil Impact		
Information Systems Outage	**Service Functions Impacted**	**Likely Consequences**	**Readiness & Response Strategies**
As per identified in Cluster BIA page 8	• Patient Cares • Patient Information & Flow	Loss of administration systems (partially/full)	Manual copy of telephone book Manual copy data entry

		Loss of Clinical Data and results impacting of clinical decision making	
Industrial Action	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Clinical / Non Clinical	Limited staffing resource Patient Cares Administration services	Inability to deliver non essential cares Data entry Administration support	MDHB strategic planning
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies

Outpatient Services – Internal Disruptive Event

Outpatient Services - Diabetes/Endocrinology	Alternate Care Site Identified:

Service	Alternate Care Site
Diabetes & Endocrinology	Other ward area/community

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)			
		2	4	7	30
	Diabetes & Endocrinology				30

Internal Disruptive Event - the organisation may suffer serious internal disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Industrial Action
- Loss of one or more key internal clinical support services

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Medication rooms uncontrolled •Patient Information & Flow Information system	Patient Harm Inability to pull Lab/Blood/Imaging data Cancellation of appointments.	Patient Cares -Staffing to acuity Virtual/Telephone consults. Communication -Runners & -Pagers
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash
Medical Gases	Nil Impact		

Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
As per identified in Cluster BIA page 8	• Patient Cares • Patient Information & Flow	Loss of administration systems (partially/full) Loss of Clinical Data and results impacting of clinical decision making	Manual copy of telephone book Manual copy data entry

Industrial Action	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Clinical / Non Clinical	Limited staffing resource Patient Cares	Inability to deliver non essential cares	MDHB strategic planning

	Administration services	Data entry Administration support	
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies

Outpatient Services – Internal Disruptive Event

Outpatient Services	Alternate Care Site Identified:
- Orthopaedics	

Service	Alternate Care Site
Orthopaedics	Amb Care/TCU

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8
	Orthopaedics	2		

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)		
		2	4	7

Internal Disruptive Event - the organisation may suffer serious internal disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Industrial Action
- Loss of one or more key internal clinical support services

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Department integrity i.e Security doors •Medication rooms uncontrolled •Patient Information & Flow Information system Patient observation and monitoring equipment	Patient Harm Inability to pull Lab/Blood/Imaging data Security of Dept Cancellation of appointments/prioritisation	Patient Cares -Staffing to acuity -All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment Communication -Runners & Pagers
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water	Patient Harm Increased risk of infection Staff/patient/visitor well being Delays to apply plaster/cast	Handwash Alternative supplies for casts
Medical Gases	?O2, Entonox (Plaster room,)	Delays to treatment	Portable O2 and entonox
Information Systems Outage	**Service Functions Impacted**	**Likely Consequences**	**Readiness & Response Strategies**
As per identified in Cluster BIA page 8	• Patient Cares • Patient Information & Flow	Loss of administration systems (partially/full) Loss of Clinical Data and results impacting of clinical decision making	Manual copy of telephone book Manual copy data entry
Industrial Action	**Service Functions Impacted**	**Likely Consequences**	**Readiness & Response Strategies**

Clinical / Non Clinical	Limited staffing resource Patient Cares Administration services	Inability to deliver non essential cares Data entry Administration support	MDHB strategic planning
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies

Outpatient Services – Internal Disruptive Event

Outpatient Services - Ophthalmology	Alternate Care Site Identified:

Service	Alternate Care Site
Ophthalmology	Other DHB, Community Provider

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)		
		2	4	7
				7

Internal Disruptive Event - the organisation may suffer serious internal disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Industrial Action
- Loss of one or more key internal clinical support services

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Department integrity i.e Security doors •Patient Information & Flow Information system	Patient Harm Inability to pull Lab/Blood/Imaging data Security of Dept Cancellation of appointments Delays for treatment	Patient Cares -Staffing to acuity -All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment Communication -Runners & Pagers Outreach service in private provider/other DHB.
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water	Patient Harm Increased risk of infection Staff/patient/visitor well bein	Handwash Purifying tablets
Medical Gases	Nil Impact		
Information Systems Outage	**Service Functions Impacted**	**Likely Consequences**	**Readiness & Response Strategies**
As per identified in Cluster BIA page 8	• Patient Cares • Patient Information & Flow	Loss of administration systems (partially/full)	Manual copy of telephone book Manual copy data entry

		Loss of Clinical Data and results impacting of clinical decision making	
Industrial Action	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Clinical / Non Clinical	Limited staffing resource Patient Cares Administration services	Inability to deliver non essential cares Data entry Administration support	MDHB strategic planning
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies

Outpatient Services – Internal Disruptive Event

Outpatient Services - Urology	Alternate Care Site Identified:

Service	Alternate Care Site
Urology	Theatre/TCU

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)		
		2	4	7
	Urology	2		

Internal Disruptive Event - the organisation may suffer serious internal disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Industrial Action
- Loss of one or more key internal clinical support services

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Department integrity i.e Security doors •Medication rooms uncontrolled •Patient Information & Flow Information system •Loss of suction Patient monitoring equipment	Patient Harm Inability to pull Lab/Blood/Imaging data Security of department	Patient Cares -Staffing to acuity -All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment -Hand written Bradma's (patient identity bracelet / patient documentation) -Head torches (CD Locker) Communication -Runners & -Pagers Prioritisation and cancellation of appointments
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash Bottled water Purifying tablets
Medical Gases	O2 Suction		Portable units

Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
As per identified in Cluster BIA page 8	• Patient Cares • Patient Information & Flow	Loss of administration systems (partially/full) Loss of Clinical Data and results impacting of clinical decision making	Manual copy data entry
Industrial Action	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Clinical / Non Clinical	Limited staffing resource Patient Cares Administration services	Inability to deliver non essential cares Data entry Administration support	MDHB strategic planning
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies

Outpatient Services – Internal Disruptive Event

Outpatient Services	Alternate Care Site Identified:
- Otorhinolaryngology	

Service	Alternate Care Site
Otorhinolaryngology	Ambulatory Care/OT

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)		
		2	4	7
	Otorhinolaryngology			7

Internal Disruptive Event - the organisation may suffer serious internal disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Industrial Action
- Loss of one or more key internal clinical support services

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Department integrity i.e Security doors •Medication rooms uncontrolled •Patient Information & Flow Information system	Patient Harm Inability to pull Lab/Blood/Imaging data Security of Dept	Patient Cares -Staffing to acuity -All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment Communication -Runners & Pagers
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash Purifying tablets
Medical Gases	Nil impact		
Information Systems Outage	**Service Functions Impacted**	**Likely Consequences**	**Readiness & Response Strategies**
As per identified in Cluster BIA page 8	• Patient Cares • Patient Information & Flow	Loss of administration systems (partially/full) Loss of Clinical Data and results impacting of clinical decision making	Manual copy of telephone book Manual copy data entry
Industrial Action	**Service Functions Impacted**	**Likely Consequences**	**Readiness & Response Strategies**

Clinical / Non Clinical	Limited staffing resource Patient Cares Administration services	Inability to deliver non essential cares Data entry Administration support	MDHB strategic planning
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies

Outpatient Services – Internal Disruptive Event

Outpatient Services
- Audiology

Alternate Care Site Identified:

Service	Alternate Care Site
Audiology	Private Audiology facilities

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)			
		2	4	7	30
	Audiology				30

Internal Disruptive Event - the organisation may suffer serious internal disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Industrial Action
- Loss of one or more key internal clinical support services

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Department integrity i.e Security doors •Medication rooms uncontrolled •Patient Information & Flow Information system	Patient Harm Inability to pull Lab/Blood/Imaging data Security of Dept	-All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment Communication -Runners & -Pagers
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash
Medical Gases	Nil impact		

Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
As per identified in Cluster BIA page 8	• Patient Cares • Patient Information & Flow	Loss of administration systems (partially/full) Loss of Clinical Data and results impacting of clinical decision making	Manual copy of telephone book Manual copy data entry

Industrial Action	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies

Clinical / Non Clinical	Limited staffing resource Patient Cares Administration services	Inability to deliver non essential cares Data entry Administration support	MDHB strategic planning
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies

Outpatient Services – Internal Disruptive Event

Outpatient Services - Podiatry	Alternate Care Site Identified:

Service	Alternate Care Site
Podiatry	Other clinic space

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)		
		2	4	7
	Podiatry			7

Internal Disruptive Event - the organisation may suffer serious internal disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Industrial Action
- Loss of one or more key internal clinical support services

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Department integrity i.e Security doors •Patient Information & Flow Information system	Patient Harm Inability to pull Lab/Blood/Imaging data Security of Dept	Patient Cares -Staffing to acuity -All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment -Hand written Bradma's (patient identity bracelet / patient documentation) -Head torches (CD Locker)
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash
Medical Gases	Nil Impact		
Information Systems Outage	**Service Functions Impacted**	**Likely Consequences**	**Readiness & Response Strategies**
As per identified in Cluster BIA page 8	• Patient Cares • Patient Information & Flow	Loss of administration systems (partially/full)	Manual copy of telephone book Manual copy data entry

		Loss of Clinical Data and results impacting of clinical decision making	
Industrial Action	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Clinical / Non Clinical	Limited staffing resource Patient Cares Administration services	Inability to deliver non essential cares Data entry Administration support	MDHB strategic planning
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies

Outpatient Services – Internal Disruptive Event

Outpatient Services
- Renal/Nephrology

Alternate Care Site Identified:

Service	Alternate Care Site
Renal/Nephrology	Incentre Dialysis/Self Care unit/Inpatient Wards

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)		
		2	4	7
	Renal/Nephrology	2		

Internal Disruptive Event - the organisation may suffer serious internal disruption as a result of:
- Lifelines / Infrastructure failure
- Information Systems outage
- Industrial Action
- Loss of one or more key internal clinical support services

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Department integrity i.e Security doors •Medication rooms uncontrolled •Patient Information & Flow Information system Patient monitoring equipment Observation equipment	Patient Harm Inability to pull Lab/Blood/Imaging data Security of dept	Patient Cares -All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment -Hand written Bradma's (patient identity bracelet / patient documentation) Communication -Runners & -Pagers Patient Information & Flow -Critical power supply to staff station computers.
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water Filtered/water for dialysing	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash Purifying tablets (CD Locker)
Medical Gases	O2		

Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
As per identified in Cluster BIA page 8	• Patient Cares • Patient Information & Flow	Loss of administration systems (partially/full) Loss of Clinical Data and results impacting of clinical decision making	Manual copy of telephone book Manual copy data entry
Industrial Action	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Clinical / Non Clinical	Limited staffing resource Patient Cares Administration services	Inability to deliver non essential cares Data entry Administration support	MDHB strategic planning
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies

Outpatient Services – Internal Disruptive Event

Outpatient Services - Infectious Diseases	Alternate Care Site Identified:

Service	Alternate Care Site
Infections Disease	IPC/Public Health

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)		
		2	4	7

Internal Disruptive Event - the organisation may suffer serious internal disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Industrial Action
- Loss of one or more key internal clinical support services

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Patient Information & Flow Information system	Patient Harm Inability to pull Lab/Blood/Imaging data	Patient Cares -Hand written Bradma's (patient identity bracelet / patient documentation) Communication -Runners & -Pagers
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash Purifying tablets (CD Locker)
Medical Gases	?		
Information Systems Outage	**Service Functions Impacted**	**Likely Consequences**	**Readiness & Response Strategies**
As per identified in Cluster BIA page 8	• Patient Cares • Patient Information & Flow	Loss of administration systems (partially/full) Loss of Clinical Data and results impacting of clinical decision making	Manual copy of telephone book Manual copy data entry
Industrial Action	**Service Functions Impacted**	**Likely Consequences**	**Readiness & Response Strategies**
Clinical / Non Clinical	Limited staffing resource Patient Cares Administration services	Inability to deliver non essential cares Data entry	MDHB strategic planning

		Administration support	
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
	MedLab Pressure Rooms Medical Imaging Public Health Infection Prevention & Control		

Outpatient Services – Internal Disruptive Event

Outpatient Services	Alternate Care Site Identified:
- Dermatology	

Service	Alternate Care Site
Dermatology	Other clinic

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)			
		2	4	7	30
	Dermatology				30

Internal Disruptive Event - the organisation may suffer serious internal disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Industrial Action
- Loss of one or more key internal clinical support services

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Department integrity i.e Security doors •Medication rooms uncontrolled •Patient Information & Flow Information system	Patient Harm Inability to pull Lab/Blood/Imaging data Security of dept Cancellation of appointments	Patient Cares -Staffing to acuity Communication -Runners & Pagers Prioritisation of appointments. Work from alternative location.
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash
Medical Gases	Liquid nitrogen	Unable to provide treatment using Liquid nitrogen	Prioritisation of treatment
Information Systems Outage	**Service Functions Impacted**	**Likely Consequences**	**Readiness & Response Strategies**
As per identified in Cluster BIA page 8	• Patient Cares • Patient Information & Flow	Loss of administration systems (partially/full) Loss of Clinical Data and results impacting of clinical decision making	Manual copy of telephone book Manual copy data entry

Industrial Action	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Clinical / Non Clinical	Limited staffing resource Patient Cares Administration services	Inability to deliver non essential cares Data entry Administration support	MDHB strategic planning
Loss of one or more key internal clinical support services	**Service Functions Impacted**	**Likely Consequences**	**Readiness & Response Strategies**

OUTPATIENT SERVICES

External Disruptive Event

The following tables identify individual units/departments:

- **Critical functions**
- **Alternate care site preference**
- **Impact analysis against threat types (Service functions impacted)**
- **Likely consequences (impact of delivery of services)**
- **Response and Recovery strategies.**

Outpatient Services – External Disruptive Event

Outpatient Services - General Surgery	Alternate Care Site Identified:

Service	Alternate Care Site
General Surgery	Other clinic space

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)		
		2	4	7
	General Surgery	2		

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Department integrity i.e Security doors •Patient Information & Flow Information system	Patient Harm Inability to pull Lab/Blood/Imaging data Security of Dept	Patient Cares -Staffing to acuity -All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment -Hand written Bradma's (patient identity bracelet / patient documentation) Communication -Runners & -Pagers
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash
Medical Gases	Nil impact		
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies

Connectivity Cyber Attack Loss of Priority 1 system	• Patient Cares • WebPas/Clinical Portal Patient Information • Bookings • Discharges	Loss of administration systems (partially/full) Inability to access Clinical Data and results Bookings/Discharges/assessments Data breach	Paper based files
Loss of one or more key suppliers	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Natural Disaster/Health Emergency	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans			

Outpatient Services – External Disruptive Event

Outpatient Services - Rheumatology	Alternate Care Site Identified:

Service	Alternate Care Site
Rheumatology	Other clinic space

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)			
		2	4	7	30
	Rheumatology				30

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Department integrity i.e Security doors •Patient Information & Flow Information system	Patient Harm Inability to pull Lab/Blood/Imaging data Security of dept	Patient Cares -Staffing to acuity -All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment Communication -Runners & -Pagers
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash Staff café for drinking water
Medical Gases	Nil Impact		
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies

Connectivity Cyber Attack Loss of Priority 1 system	• Patient Cares • WebPas/Clinical Portal Patient Information • Bookings • Discharges	Loss of administration systems (partially/full) Inability to access Clinical Data and results Bookings/Discharges/assessments Data breach	Paper based files
Loss of one or more key suppliers	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Natural Disaster/Health Emergency	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans			

Outpatient Services – External Disruptive Event

Outpatient Services	Alternate Care Site Identified:
- Transitory Care Unit	

Service	Alternate Care Site
Transitory Care Unit	Amb Care/IHFC/Community Clinic

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)		
		2	4	7
	TCU	2		

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Department integrity i.e Security doors •Medication rooms uncontrolled •Patient Information & Flow Information system •Loss of suction Patient monitoring equipment Patient observation equipment	Patient Harm Inability to pull Lab/Blood/Imaging data Security of Ward	Patient Cares -Staffing to acuity -All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment -Hand written Bradma's (patient identity bracelet / patient documentation) -Head torches (CD Locker) Communication -Runners & Pagers
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash Bottled water
Medical Gases	O2	Patient Harm	Portable
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies

Connectivity Cyber Attack Loss of Priority 1 system	• Patient Cares • WebPas/Clinical Portal Patient Information • Bookings • Discharges	Loss of administration systems (partially/full) Inability to access Clinical Data and results Bookings/Discharges/assessments Data breach	Paper based files
Loss of one or more key suppliers	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Natural Disaster/Health Emergency	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans			

Outpatient Services – External Disruptive Event

Outpatient Services	Alternate Care Site Identified:
- Respiratory	

Service	Alternate Care Site
Respiratory	Amb care/ward

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)		
		2	4	7
	Respiratory	2		

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Department integrity i.e Security doors •Patient Information & Flow Information system •Specific spirometry and respiratory tests.	Patient Harm Inability to pull Lab/Blood/Imaging data Security of Dept Delays to diagnostic / respiratory tests/procedures.	Patient Cares -Staffing to acuity -All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment. Communication -Runners & -Pagers
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash Bottled water
Medical Gases			

Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Connectivity Cyber Attack Loss of Priority 1 system	• Patient Cares • WebPas/Clinical Portal Patient Information • Bookings • Discharges	Loss of administration systems (partially/full) Inability to access Clinical Data and results Bookings/Discharges/assessments Data breach	Paper based files

Loss of one or more key suppliers	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Natural Disaster/Health Emergency	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans			

Outpatient Services – External Disruptive Event

Outpatient Services - Cardiology	Alternate Care Site Identified:

Service	Alternate Care Site
Cardiology	Amb Care, CCU

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)		
		2	4	7
	Cardiology	2		

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Department integrity i.e Security doors •Patient Information & Flow Information system • ECG • Treadmill • PACING	Patient Harm Inability to pull Lab/Blood/Imaging data Security of Dept	Patient Cares -Staffing to acuity -All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment -Hand written Bradma's (patient identity bracelet / patient documentation) Communication -Runners & -Pagers Patient Information & Flow -Critical power supply to staff station computers.
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash Bottled water
Medical Gases	O2		Portable O2

Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Connectivity Cyber Attack Loss of Priority 1 system	• Patient Cares • WebPas/Clinical Portal Patient Information • Bookings • Discharges	Loss of administration systems (partially/full) Inability to access Clinical Data and results Bookings/Discharges/assessments Data breach	Paper based files
Loss of one or more key suppliers	**Service Functions Impacted**	**Likely Consequences**	**Readiness & Response Strategies**
Natural Disaster/Health Emergency	**Service Functions Impacted**	**Likely Consequences**	**Readiness & Response Strategies**
MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans			

Outpatient Services – External Disruptive Event

Outpatient Services - Neurology	Alternate Care Site Identified:

Service	Alternate Care Site
Neurology	Ambulatory Care

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)		
		2	4	7
	Neurology			7

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Department integrity i.e Security doors •Medication rooms uncontrolled •Patient Information & Flow Information system	Patient Harm Inability to pull Lab/Blood/Imaging data Security of Ward	Patient Cares -Staffing to acuity -All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment -Hand written Bradma's (patient identity bracelet / patient documentation) -emergency lighting. Communication -Runners & Pagers Patient Information & Flow -Critical power supply to staff station computers.
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash Bottled water Purifying tablets (CD Locker)
Medical Gases			

Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Connectivity Cyber Attack Loss of Priority 1 system	• Patient Cares • WebPas/Clinical Portal Patient Information • Bookings • Discharges	Loss of administration systems (partially/full) Inability to access Clinical Data and results Bookings/Discharges/assessments Data breach	Paper based files
Loss of one or more key suppliers	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Natural Disaster/Health Emergency	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans			

Outpatient Services – External Disruptive Event

Outpatient Services
- Diabetes/Endocrinology

Alternate Care Site Identified:

Service	Alternate Care Site
Diabetes/Endocrinology	Ambulatory Care/Community

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives		
		Within (Hours)		
		2	4	8

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives			
		Within (Days)			
		2	4	7	30
	Diabetes/Endocrinology				30

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Department integrity i.e Security doors •Medication rooms uncontrolled •Patient Information & Flow Information system	Patient Harm Inability to pull Lab/Blood/Imaging data Security of Ward	Patient Cares -Staffing to acuity -All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment -Hand written Bradma's (patient identity bracelet / patient documentation) -Head torches (CD Locker) Communication -Runners Patient Information & Flow -Critical power supply to some staff computers.
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash Bottled water Purifying tablets (CD Locker)
Medical Gases	Nil Impact		

Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Connectivity Cyber Attack Loss of Priority 1 system	• Patient Cares • WebPas/Clinical Portal Patient Information • Bookings • Discharges	Loss of administration systems (partially/full) Inability to access Clinical Data and results Bookings/Discharges/assessments Data breach	Paper based files
Loss of one or more key suppliers	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Natural Disaster/Health Emergency	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans			

Outpatient Services – External Disruptive Event

Outpatient Services - Orthopaedics	Alternate Care Site Identified:

Service	Alternate Care Site
Orthopaedics	Ambulatory Care/TCU/CREST

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8
	Orthopaedics	2		

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)		
		2	4	7

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Department integrity i.e Security doors •Medication rooms uncontrolled •Patient Information & Flow Information system •Plaster room saw	Patient Harm Inability to pull Lab/Blood/Imaging data Security of Ward	Patient Cares -Staffing to acuity -All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment -Hand written Bradma's (patient identity bracelet / patient documentation) -Head torches (CD Locker) Communication -Runners Patient Information & Flow -Critical power supply to staff station computers.
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash Bottled water Purifying tablets (CD Locker)

	Preparing casts		Need filter on drainage for plaster room sinks.
Medical Gases	O2, Entonox		Portable
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Connectivity Cyber Attack Loss of Priority 1 system	• Patient Cares • WebPas/Clinical Portal Patient Information • Bookings • Discharges	Loss of administration systems (partially/full) Inability to access Clinical Data and results Bookings/Discharges/assessments Data breach	Paper based files
Loss of one or more key suppliers	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Natural Disaster/Health Emergency	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans			

Outpatient Services – External Disruptive Event

Outpatient Services - Ophthalmology	Alternate Care Site Identified:

Service	Alternate Care Site
Ophthalmology	Amb Care/Community

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)		
		2	4	7
	Ophthalmology			7

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Department integrity i.e Security doors •Medication rooms uncontrolled •Patient Information & Flow Information system	Patient Harm Inability to pull Lab/Blood/Imaging data Security of Ward	Patient Cares -Staffing to acuity -All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment -Hand written Bradma's (patient identity bracelet / patient documentation) -Head torches (CD Locker) Communication -Runners & Pagers Patient Information & Flow -Critical power supply to staff computers.
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash Bottled water Purifying tablets (CD Locker)
Medical Gases	Nil impact		

Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Connectivity Cyber Attack Loss of Priority 1 system	• Patient Cares • WebPas/Clinical Portal Patient Information • Bookings • Discharges	Loss of administration systems (partially/full) Inability to access Clinical Data and results Bookings/Discharges/assessments Data breach	Paper based files
Loss of one or more key suppliers	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Natural Disaster/Health Emergency	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans			

Outpatient Services – External Disruptive Event

Outpatient Services	Alternate Care Site Identified:
Outpatient Services - Urology	Alternate Care Site Identified: Service: Urology — Alternate Care Site: Ambulatory Care/Community

Service	Alternate Care Site
Urology	Ambulatory Care/Community

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)		
		2	4	7
	Urology	2		

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Department integrity i.e Security doors •Medication rooms uncontrolled •Patient Information & Flow Information system •Loss of suction Patient Monitoring equipment	Patient Harm Inability to pull Lab/Blood/Imaging data Security of Ward	Patient Cares -Staffing to acuity -All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment -Hand written Bradma's (patient identity bracelet / patient documentation) -Head torches (CD Locker) Communication -Runners & -Pagers Patient Information & Flow -Critical power supply to staff computers.
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash Bottled water Purifying tablets (CD Locker)
Medical Gases	O2		Portable O2

Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Connectivity Cyber Attack Loss of Priority 1 system	• Patient Cares • WebPas/Clinical Portal Patient Information • Bookings • Discharges	Loss of administration systems (partially/full) Inability to access Clinical Data and results Bookings/Discharges/assessments Data breach	Paper based files
Loss of one or more key suppliers	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Natural Disaster/Health Emergency	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans			

Outpatient Services – External Disruptive Event

Outpatient Services - Otorhinolaryngology	Alternate Care Site Identified:

Service	Alternate Care Site
Otorhinolaryngology	Amb Care/Community

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)		
		2	4	7
	Otorhinolaryngology			7

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Department integrity i.e Security doors •Medication rooms uncontrolled •Patient Information & Flow Information system	Patient Harm Inability to pull Lab/Blood/Imaging data Security of Ward	Patient Cares -Staffing to acuity -All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment -Hand written Bradma's (patient identity bracelet / patient documentation) -Head torches (CD Locker) Communication -Runners & Pagers Patient Information & Flow -Critical power supply to staff station computers.
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash Bottled water Purifying tablets (CD Locker)
Medical Gases			

Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Connectivity Cyber Attack Loss of Priority 1 system	• Patient Cares • WebPas/Clinical Portal Patient Information • Bookings • Discharges	Loss of administration systems (partially/full) Inability to access Clinical Data and results Bookings/Discharges/assessments Data breach	Paper based files
Loss of one or more key suppliers	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Natural Disaster/Health Emergency	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans			

Outpatient Services – External Disruptive Event

Outpatient Services - Audiology	Alternate Care Site Identified:

Service	Alternate Care Site
Audiology	Community Provider

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)			
		2	4	7	30
					30

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Communication systems •Information systems & support •Department integrity i.e Security doors •Medication rooms uncontrolled •Patient Information & Flow Information system • Audiology equipment	Inability to pull Lab/Blood/Imaging data Security of dept Delays for testing/fitting of hearing aids.	-All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment -Hand written Bradma's (patient identity bracelet / patient documentation) Communication -Runners & Pagers Patient Information & Flow -Critical power supply to staff computers.
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash Bottled water Purifying tablets (CD Locker)
Medical Gases	Nil Impact		
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies

Connectivity Cyber Attack Loss of Priority 1 system	• Patient Cares • WebPas/Clinical Portal Patient Information • Bookings • Discharges	Loss of administration systems (partially/full) Inability to access Clinical Data and results Bookings/Discharges/assessments Data breach	Paper based files
Loss of one or more key suppliers	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Natural Disaster/Health Emergency	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans			

Outpatient Services – External Disruptive Event

Outpatient Services - Podiatry	Alternate Care Site Identified: Service: Podiatry — Alternate Care Site: Amb Care/Community

Service	Alternate Care Site
Podiatry	Amb Care/Community

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)		
		2	4	7
	Podiatry			7

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Department integrity i.e Security doors •Medication rooms uncontrolled •Patient Information & Flow Information system	Patient Harm Inability to pull Lab/Blood/Imaging data Security of Ward	Patient Cares -Staffing to acuity -All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment -Hand written Bradma's (patient identity bracelet / patient documentation) -Head torches (CD Locker) Communication -Runners &Pagers Patient Information & Flow -Critical power supply to staff computers.
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash Bottled water Purifying tablets (CD Locker)
Medical Gases	Nil impact		

Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Connectivity Cyber Attack Loss of Priority 1 system	• Patient Cares • WebPas/Clinical Portal Patient Information • Bookings • Discharges	Loss of administration systems (partially/full) Inability to access Clinical Data and results Bookings/Discharges/assessments Data breach	Paper based files
Loss of one or more key suppliers	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Natural Disaster/Health Emergency	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans			

Outpatient Services – External Disruptive Event

Outpatient Services - Renal/Nephrology	Alternate Care Site Identified:

Service	Alternate Care Site
Renal	Wards with dialysis capability
Nephrology	Other DHB

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)		
		2	4	7
	Renal Unit	2		

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Department integrity i.e Security doors •Medication rooms uncontrolled •Patient Information & Flow Information system • Dialysing machines • Patient monitoring equipment	Patient Harm Inability to pull Lab/Blood/Imaging data Security of area	-All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment -Hand written Bradma's (patient identity bracelet / patient documentation) -Head torches (CD Locker) Communication -Runners & Pagers Patient Information & Flow -Critical power supply to staff station computers.
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water Water for dialysing	Patient Harm Increased risk of infection Staff/patient/visitor well being Delays to dialysing	Handwash Bottled water Purifying tablets (CD Locker)
Medical Gases	O2		Portable O2

Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Connectivity Cyber Attack Loss of Priority 1 system	• Patient Cares • WebPas/Clinical Portal Patient Information • Bookings • Discharges	Loss of administration systems (partially/full) Inability to access Clinical Data and results Bookings/Discharges/assessments Data breach	Paper based files
Loss of one or more key suppliers	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Natural Disaster/Health Emergency	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans			

Outpatient Services – External Disruptive Event

Outpatient Services - Infectious Diseases	Alternate Care Site Identified:

Service	Alternate Care Site
Infectious Diseases	Amb Care/Community

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8
	Infectious Diseases	2		

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)		
		2	4	7

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Department integrity i.e Security doors •Medication rooms uncontrolled •Patient Information & Flow Information system	Patient Harm Inability to pull Lab/Blood/Imaging data Security of area	Patient Cares -Staffing to acuity -All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment -Hand written Bradma's (patient identity bracelet / patient documentation) -Head torches (CD Locker) Communication -Runners -Pagers Patient Information & Flow -Critical power supply to staff station computers.
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients)	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash Bottled water ? Purifying tablets (CD Locker)

	Drinking water		
Medical Gases	Nil impact		
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Connectivity Cyber Attack Loss of Priority 1 system	• Patient Cares • WebPas/Clinical Portal Patient Information • Bookings • Discharges	Loss of administration systems (partially/full) Inability to access Clinical Data and results Bookings/Discharges/assessments Data breach	Paper based files
Loss of one or more key suppliers	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Natural Disaster/Health Emergency	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans			

Outpatient Services – External Disruptive Event

Outpatient Services - Dermatology	Alternate Care Site Identified:

Service	Alternate Care Site
Dermatology	Ambulatory Care/Community

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)			
		2	4	7	30
	Dermatology				30

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Department integrity i.e Security doors •Medication rooms uncontrolled •Patient Information & Flow Information system	Patient Harm Inability to pull Lab/Blood/Imaging data Security of Ward	Patient Cares -Staffing to acuity -All essential Point of Care equipment to be plugged into critical power supply. -Battery back up of point of care equipment -Hand written Bradma's (patient identity bracelet / patient documentation) -Head torches (CD Locker) Communication -Runners & Pagers Patient Information & Flow -Critical power supply to staff computers.
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water –	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash Bottled water ? Purifying tablets (CD Locker)
Medical Gases	Liquid Nitrogen		

Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Connectivity Cyber Attack Loss of Priority 1 system	• Patient Cares • WebPas/Clinical Portal Patient Information • Bookings • Discharges	Loss of administration systems (partially/full) Inability to access Clinical Data and results Bookings/Discharges/assessments Data breach	Paper based files
Loss of one or more key suppliers	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Natural Disaster/Health Emergency	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans			

HOSPITAL PHARMACY

Internal Disruptive Event

The following tables identify individual units/departments:

- **Critical functions**
- **Alternate care site preference**
- **Impact analysis against threat types (Service functions impacted)**
- **Likely consequences (impact of delivery of services)**
- **Response and Recovery strategies.**

Hospital Pharmacy – Internal Disruptive Event

Hospital Pharmacy	Alternate Care Site Identified:

Service	Alternate Care Site
Hospital Pharmacy	Ed centre

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8
	Medicines Supply		4	

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)		
		2	4	7
	Compounding	2		
	Clinical Supplies		4	

Internal Disruptive Event - the organisation may suffer serious internal disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Industrial Action
- Loss of one or more key internal clinical support services

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Loss of suction Negative pressure room Medicines Fridges (if critical power fails or fridge fails)	Patient Harm Inability to access epharmacy	Patient Cares -Staffing to acuity -All essential Point of Care equipment is plugged into critical power supply. – Nil Disruption. -Head torches Temporary NHIs Manual Pharmacy System as per Pharmacy Business Continuity Plan. Communication: Runners & Pagers Patient Information & Flow -Laptop (Wifi connectability)
Water	Compounding Medicines Infection Control (Staff)	Increased risk of infection Staff well being	Water for irrigation for dishes Handwash
Medical Gases	Nil impact		

Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
As per identified in Cluster BIA page 8	• Patient Information & Flow • Epharmacy	Inability to purchase medicines Loss of administration systems (partially/full)	Paper templates for Pharmacy Compounding and imprest Stand-alone laptop and printer

	• Compounding • Dispensing	Loss of Clinical Data and results impacting of clinical decision making Inability to pull Lab / Blood / data Admission and discharge protocols	Patient Information & Flow - Critical power supply connected to all computers - Laptop (Wifi connect ability)
Industrial Action	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Clinical / Non Clinical	Limited staffing resource Patient Cares Administration services	Inability to deliver non-essential cares Data entry Administration support	MDHB strategic planning
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
	Digital Services Hotel services (soft FM) - Orderlies - Cleaning - Laundry - Security	Increased waiting times Patient Harm from delays in patients receiving medicines	Enact Pharmacy Business Continuity Plan

HOSPITAL PHARMACY

External Disruptive Event

The following tables identify individual units/departments:

- **Critical functions**
- **Alternate care site preference**
- **Impact analysis against threat types (Service functions impacted)**
- **Likely consequences (impact of delivery of services)**
- **Response and Recovery strategies.**

Hospital Pharmacy – External Disruptive Event

Hospital Pharmacy	Alternate Care Site Identified:
	Service: Hospital Pharmacy — Alternate Care Site: Ed centre

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8
	Medicines Supply		4	

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)		
		2	4	7
	Compounding		4	
	Clinical Supplies		4	

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	•Patient Cares •Communication systems •Information systems & support •Loss of suction Negative pressure room Medicines Fridges (if critical power fails or fridge fails)	Patient Harm Inability to access epharmacy	Patient Cares -Staffing to acuity -All essential Point of Care equipment is plugged into critical power supply. – Nil Disruption. -Head torches Temporary NHIs Manual Pharmacy System as per Pharmacy Business Continuity Plan. Communication: Runners & Pagers Patient Information & Flow -Laptop (Wifi connectability)
Water	Compounding Medicines Infection Control (Staff)	Increased risk of infection Staff well being	Water for irrigation for dishes Handwash
Gases	Nil Impact		
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies

Connectivity Cyber Attack Loss of Priority 1 system	• Compounding • Dispensing • WebPas/Clinical Portal Patient Information • Epharmacy • Discharges	Inability to purchase medicines Loss of administration systems (partially/full) Inability to access Clinical Data and results Discharges Data breach	Enact Pharmacy Business Continuity Plan Paper templates for Pharmacy Compounding and imprest Stand-alone laptop and printer Patient Information & Flow - Critical power supply connected to all computers - Laptop (Wifi connect ability)
Loss of one or more key suppliers	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
CDC	Supply of medicines	Delays Patient Harm	CDC has a BCP
AirLab	Validation and repair of aseptic equipment.	Delays	Utilise alternate supplier
Judd Refrigeration	Fridges	Loss of stock	Alternative Locations as per Pharmacy Business Continuity Plan Utilise alternate supplier
Natural Disaster/Health Emergency	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans			

Supplier	Product/Service	Contact Person	Contact Details
CDC (Pharmaceutical wholesaler)	Supply of medicines	[redacted]	[redacted] [redacted] Email: [redacted]
Judd Refrigeration		[redacted]	[redacted]
AirLab		[redacted]	[redacted] Service Support Engineer at **Airlab Ltd** A: Unit 7, 2 Tyers Road, Ngauranga, Wellington 6035 P: [redacted] M: [redacted] E: [redacted] W: [redacted] P O Box: 13278, Johnsonville, Wellington 6440

MEDICAL IMAGING

Internal Disruptive Event

The following tables identify individual units/departments:

- **Critical functions**
- **Alternate care site preference**
- **Impact analysis against threat types (Service functions impacted)**
- **Likely consequences (impact of delivery of services)**
- **Response and Recovery strategies.**

Medical Imaging – Internal Disruptive Event

Medical Imaging

Alternate Care Site Identified:

Service	Alternate Care Site
General X-ray	Pacific and Broadway Radiology and UCOL.
CT	Broadway Radiology
MRI	Pacific and Broadway Radiology and Whanganui DHB
DSA/Specials	CCDHB
US	Pacific and Broadway Radiology
Nuclear Medicine	Hawkes Bay DHB, CCDHB
Medical Photographer	Internal camera (ED, Theatre)

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8
	General X-ray	2		
	CT	2		
	US		4	

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)		
		2	4	7
	DSA/Specials		4	
	MRI		4	

Internal Disruptive Event - the organisation may suffer serious internal disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Industrial Action
- Loss of one or more key internal clinical support services

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	Loss of CT Loss of MRI Information systems – RIS/PACs	Delays for clinical management (diagnosis) Cancellation of appointments Increased waiting times.	Enact Medical Imaging Business Continuity Plan Critical power (generator)
Water	Cooling systems for CT & MRI Infection Prevention & Control Sluice room	Unable to use CT Increased risk of Infection Staff and patient wellbeing Cancellation of appointments Increased waiting times	Enact Medical Imaging Business Continuity Plan Hand sanitisers
Medical Gases	No General Anaesthetic used	Limited clinical impact	Portable medical gases

Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
As per identified in Cluster BIA page 8	• Patient Cares • Patient Information & Flow • Loss of rosters	Loss of administration systems (partially/full) Loss of Clinical Data and results impacting of clinical decision making Inability to pull Lab / Blood / Imaging data Admission and discharge protocols	Manual copy of telephone book Manual copy data entry - Hand written Bradma's (patient identity bracelet / patient documentation) Patient Information & Flow - Critical power supply to staff station computers. - Laptop (query Wifi connect ability) - Paper copy rosters

Industrial Action	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Clinical / Non Clinical	Limited staffing resource Patient Cares Administration services	Inability to deliver non-essential cares Data entry Administration support	MDHB strategic planning

Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
	Clinical supply chain – contrast Digital Services Hotel services (soft FM) - Orderlies - Cleaning - Laundry Pharmacy	Cancellation of appointments Increased waiting times Patient Harm Delays Infection	Enact Medical Imaging Business Continuity Plan

MEDICAL IMAGING

External Disruptive Event

The following tables identify individual units/departments:

- **Critical functions**
- **Alternate care site preference**
- **Impact analysis against threat types (Service functions impacted)**
- **Likely consequences (impact of delivery of services)**
- **Response and Recovery strategies.**

Medical Imaging – External Disruptive Event

Medical Imaging

Service	Alternate Care Site
General X-ray	Pacific and Broadway Radiology and UCOL.
CT	Broadway Radiology
MRI	Pacific and Broadway Radiology and Whanganui DHB
DSA/Specials	CCDHB
US	Pacific and Broadway Radiology
Nuclear Medicine	Hawkes Bay DHB, CCDHB
Medical Photographer	Internal camera (ED, Theatre)

Alternate Care Site Identified:

Critical Functions

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Hours)		
		2	4	8
	General X-ray	2		
	CT	2		
	US		4	

Functions Critical Over Time

Service / Business Unit	Function/Output	Recovery Time Objectives Within (Days)		
		2	4	7
	DSA/Specials		4	
	MRI		4	

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	Loss of CT Loss of MRI Information systems – RIS/PACs	Delays for clinical management (diagnosis) Cancellation of appointments Increased waiting times.	Enact Medical Imaging Business Continuity Plan Critical power (generator)
Water	Cooling systems for CT & MRI Infection Prevention & Control Sluice room	Unable to use CT Increased risk of Infection Staff and patient wellbeing Cancellation of appointments Increased waiting times	Enact Medical Imaging Business Continuity Plan Hand sanitisers
Medical Gases	No General Anaesthetic used	Limited clinical impact	Portable medical gases
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies

Connectivity Cyber Attack Loss of Priority 1 system	• WebPas/Clinical Portal Patient Information • Bookings • Regional RIS/PACS	Loss of administration systems (partially/full) Inability to access Clinical Data and results Bookings/Discharges/Assessments Data breach Regional access to imaging information	Medical Imaging Continuity Plans
Loss of one or more key suppliers/vendor support	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Maintenance support	Imaging Equipment	Cancellation of appointments Delays in diagnosis and treatment Delays to stand up equipment	Enact Medical Imaging Business Continuity Plans
Natural Disaster/Health Emergency	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
MDHB Strategic Business Continuity Plan enacted Medical Imaging Business Continuity Plans enacted			

Service: MEDICAL IMAGING			
Supplier	Product/Service	Contact Person	Contact Details
Carestream	RIS, PACS	Helpdesk	
Carestream (now Quantum)	'Carestream' Mobile Machines	Quantum Help Desk	
GE Medical	X-Ray Equipment	Address: 8 Tangihua St, Auckland 1010	
Philips	X-Ray Equipment Ultrasound Equipment Help Desk Faults		Address: Philips Medical Systems, 2 Wagener Pl, Mt Albert, PO box 1041, Auckland

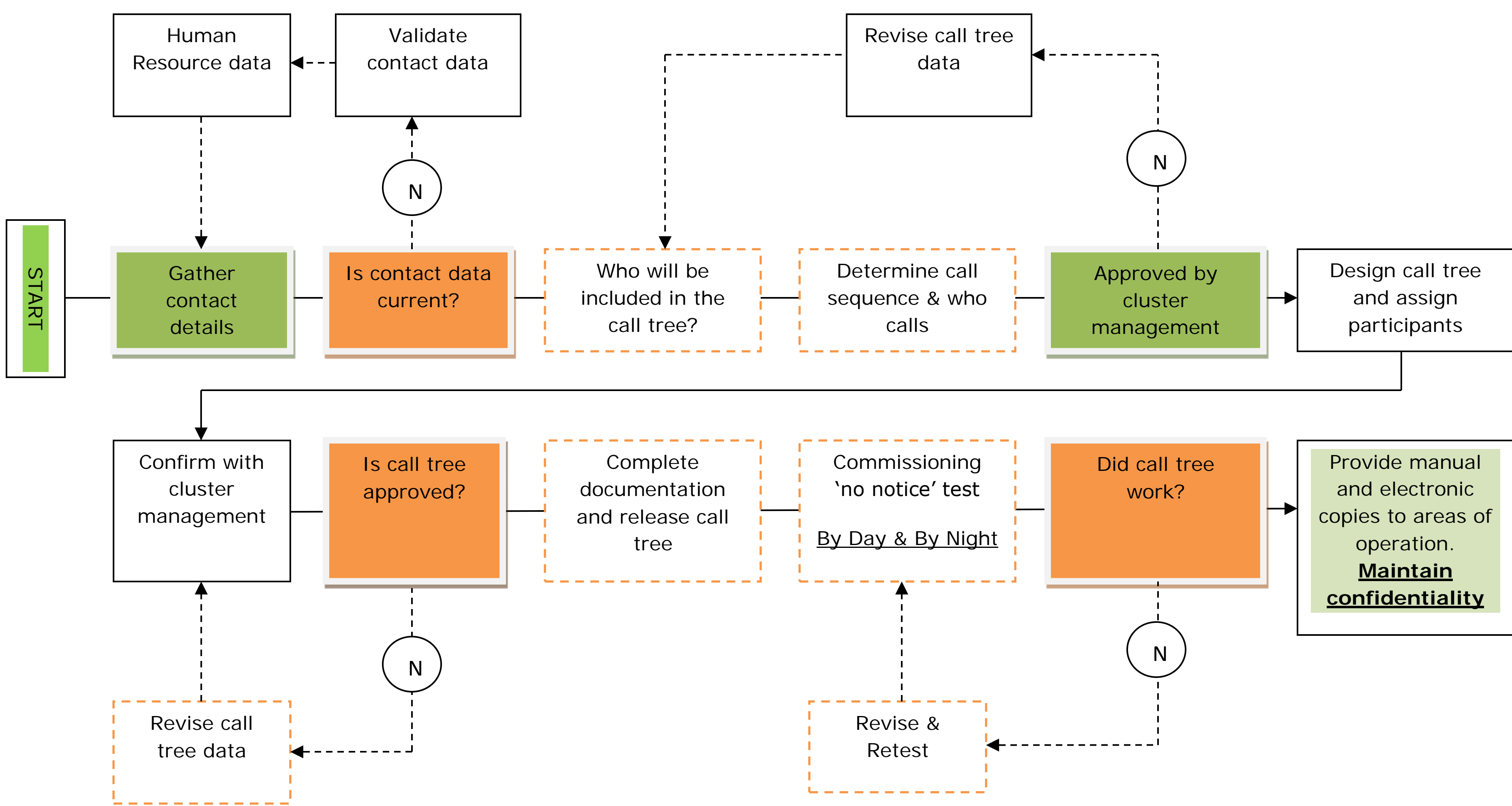
Siemens	CT Radiology and Nuclear Medicine ECAM Gamma Camera MRI	[redacted] Help desk	Address: 55 Hugo-Johnston Drive, Penrose, PO Box 14 046, Panmore, Auckland [redacted]
Technisonic	CT & Room 5 Injectors	[redacted] All services and Maintenance	Address: 16A Tarndale Grove, Albany, Auckland [redacted]

CRITICAL CLINICAL EQUIPMENT INVENTORY **ANNEX A**

Equipment Identifier (Name/Description)	Brand/Model	Number of Units Held	Location Held	Equipment Supplier / Equipment Servicing Agent	Alternative Equipment
Airvo	Fisher & Paykel Healthcare				
Cardiac Monitoring Equipment	GE Dash 4000 (wall mounted)				
Portable Cardiac Monitoring Equipment	GE Dash 3000				
Emergency Trolleys	Defibrillator - Zoll				
Ventilators	-Hamilton GG -Drager				
Portable ventilators	Drager				
Anaesthetic machines	-GE Datex Ohmega Aisys -Carestation 650				
Portable O2					
Dialysis machines	Gambro				
Portable cylinders with regulators					
Portable suction	Laerdal Suction Unit				
Thermometers - tympanic					
Beds/plinth exam table	Beds: Howard-Wright				
Wheelchairs					
Lazyboys					
Patient monitoring (BP, O2, HR, Sats)	GE Dash 4000 (wall mounted)				
PPE					

(Gloves, gowns, scrubs, masks, eye protection)					
Infusion pumps	Carefusion Alaris PC				
Syringe drivers	NIKI T34				
PCA pumps	CADD				
Patient warmers	-Bairhugger Model 505 -Blanketrol III				

CALL TREE DEVELOPMENT PROCESS **Annex B**



CALL TREE ACTIVATION GUIDE **Annex C**

DISRUPTION

Alerted to event

Working Day

Cluster Leadership Team meets to assess impact

Out of hours

Duty Nurse Managers, Manager on Call, Team Leaders on duty meets to assess impact

Activation of call tree approved

Agree message content (keep short) i.e.
'Attendance required' /' welfare check' /' report to'

Call Tree commenced.

No more than 10 rings

Note non answers (follow up)

Provide status report to Emergency Operations Centre if activated.

INDIVIDUAL SMALL UNIT PHONE TREE TEMPLATE (ATIVIATION/TESTING) Annex D

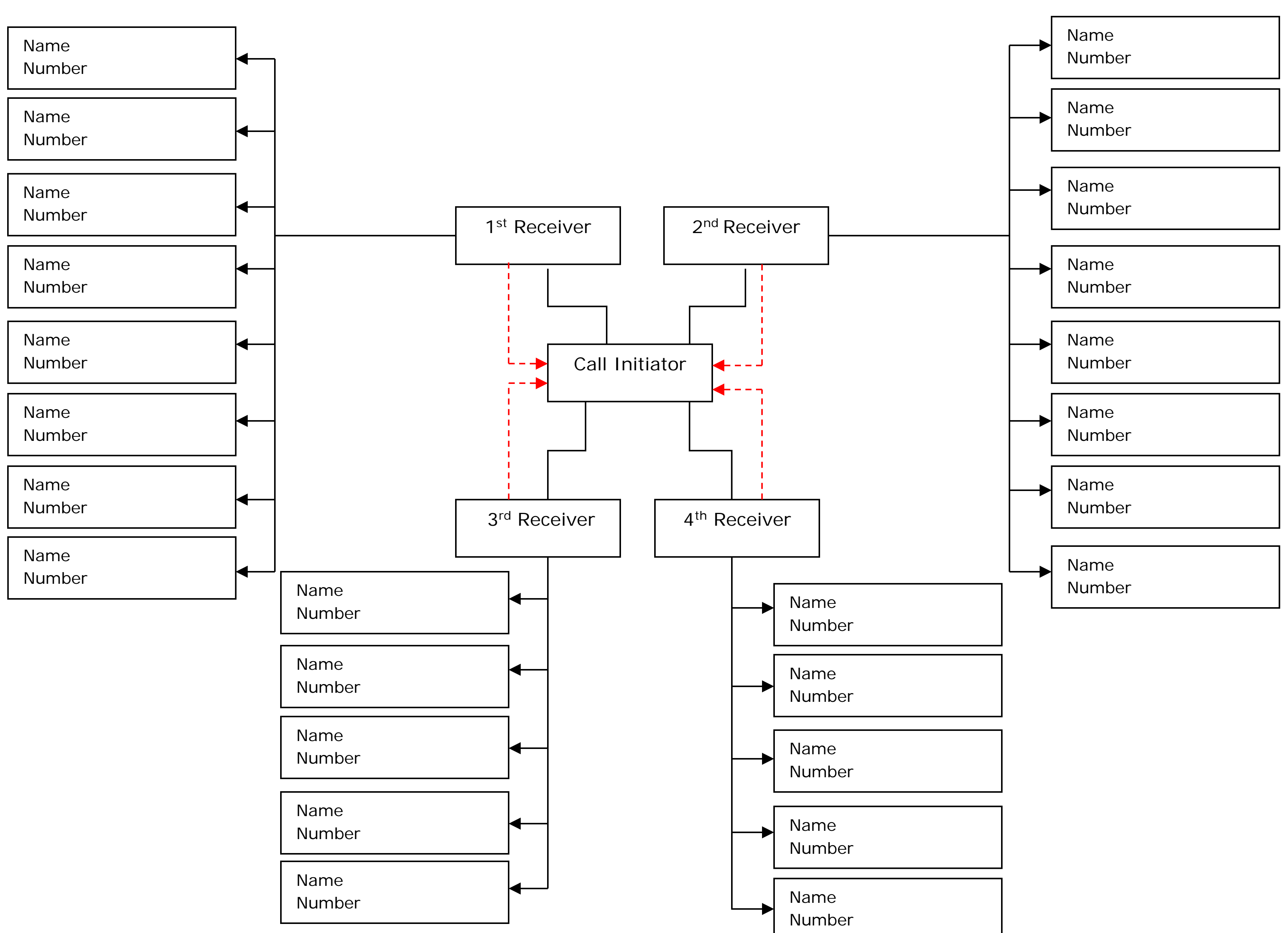
Date		Cluster/Enabler		Authorised By:	
Time		Department/Unit/Ward		Operator:	

Message Script
Disruptive Event - Action Required – 'Attendance' / ' Welfare Check ' / 'For Information only' Location to report to – Brief will be given on arrival Receiver acknowledges message – minimal conversation.

Hierarchal Call Tree Process							
Name	Role/Position	Contact No	Contact Made		If No - Follow up required on completion of first call tree	Follow up achieved	
			Yes	No		Yes	No

LARGER UNIT/MULTI DEPARTMENTAL DELEGATED CALL/GROUP TEXT TREE

Annex E



BUSINESS CONTINUITY PLAN (BCP)

Version 3

NOTE

- If you are opening this plan for the first time as part of an activation go directly to the QUICK ACTIVATION guide on page 3

- A list of contact numbers sits at the back of this document

POLICY OVERVIEW AND REVIEW PROCESS

This Policy and Procedure document is reviewed two yearly unless there is an amendment required post exercise or actual event.

All amendments are to be reviewed and approved by the Cluster Executive and changes entered in the tables below:

Plan Status	Version
Draft	V1
Pre Release	V2
Updated	V3

HISTORY OF DOCUMENT REIVEW AMENDMENT		
Version	**Date**	**Changes**
V1	September 2019	Ongoing updating of individual unit findings
V2	March 2020	Submission to Cluster Executive and sign off
V3	June 2020	COVID responses added
V4	June 2021	Full review

REVIEWERS AND CONTRIBUTORS	
Name	**Position Title**
	Operations Executive
	Clinical Programmes Lead
	Principal Risk and Resilience Officer
	Service/Unit Leads

RECORD OF AMENDMENTS			
Page No.	**Section**	**Amendment Outline**	**Date Amended**

Author		
Review Date	April 2021	
Approved/Authorised		Cluster Clinical Executive Cluster Operational Executive
Document Reference	• Business Impact Analysis – Te Uru Pā Harakeke Healthy Women, Children and Youth • MDHB Strategic Business Continuity Policy and Plan	

Quick Activation Guide

This Page is a quick guide to initiating the Business Continuity Plan if you have not familiarized yourself with the contents of this plan prior to the event.

When to activate the plan

There are a number of events that will trigger the use of this plan broadly categorized as follows:

- External Disruption
- Internal Disruption

Who can activate the plan?

Activation of Te Uru Pā Harakeke Healthy Women, Children and Youth Business Continuity Plan (BCP will be determined by the scope and magnitude of the disruption and the impact on the ablility for the cluster to deliver part or all of its services

Any activation will be on the authority of the Operational Executive

Or in the absence the Business Lead,

Or in the absence of both of the above, under the direction of the Manager on Call in discussion with the Duty Nurse Manager,

Or when requested by the MDHP Incident Controller as part of an all of DHB response.

How to activate the plan

Individual units are to carry out readiness and response strategies as identified in their unit BCPs as identified in this document

Unit/ Team Leaders are to provide updates to the Cluster Operational Executive

	Table of Contents	Page
	Quick Activation Guide	3
	Foreword and Authorisation	5
	Critical Functions to be maintained	7
	Introduction	8
	Purpose	8
	Aims	9
	Planning Assumptions	9
	Plan Limitations	9
	Te Uru Pā Harakeke Healthy Women Children and Youth Cluster Overview	10
	Roles and Responsibilities	11
	Maintenance Criteria	12
	Measurement Criteria	12
	Managing the Disruption	12
	Child Health – Internal Disruptive Event	15
	Child Health – External Disruptive Event	33
	Child Health - Service Planning Recovery in Levels	53
	Women's Health – Internal Disruptive Event	62
	Women's Health – External Disruptive Event	84
	Women's Health - Service Planning Recovery in Levels	105
	Family Violence – Disruptive Event Response	109
	Critical Clinical Equipment Inventory	112
	Call Tree Development Process	114
	Call Tree Activation Guide	115
	Individual Small Unit Phone Tree Template (Activation/Testing)	116
	Child Development Service	116
	Primary Child Health Team	118
	Neonatal Staff	119
	Paediatric Medical Staff	121
	Horowhenua Maternity Unit	125
	Key Stakeholder Contact Numbers	126
	Cluster Contact Information	129

Foreword & Authorisation

Business Continuity is the ability of an organisation to maintain essential functions during, as well as after, a significant event has occurred. Business continuity planning establishes risk management processes and procedures that aim to prevent interruptions to critical services and re-establish full function to the organisation as quickly and as smoothly as possible.

A Business impact analysis (BIA) has been undertaken to differentiate between critical (urgent), critical over time and non-critical (non-urgent) cluster functions/activities.

MDHB Te Uru Pā Harakeke Healthy Women Children and Youth identify the following critical functions[1]:

- Child Health
  - Children's Ward
  - Neonatal Unit
- Women's Health
  - Delivery Suite
  - Maternity

MDHB Te Uru Pā Harakeke Healthy Women Children and Youth identify the following critical over time functions[2]:

- Children's Outpatient – Day Procedures
- Women's Health
  - Antenatal Clinic and Antenatal Day Unit
  - Gyaecology Day Unit
  - Horowhenua Maternity

______________________	______________________
Clinical Executive	Operational Executive
Te Uru Pā Harakeke Healthy Women, Children & Youth	Te Uru Pā Harakeke Healthy Women, Children & Youth

[1] Critical functions identified as part of the MDHB Te Uru Pā-Harakeke Healthy Women Children and Youth Business Impact Analysis. The analysis phases consisted of impact analysis, threat analysis and impact scenario's.

[2] Critical over time function are services and business outputs that although not an immediate recovery focus do have the potential to impact within 4 to 7 days of an ongoing event.

Critical Functions to be maintained

Mid Central District Health Board (MDHB) Te Uru Pā Harakeke (Healthy Women, Children and Youth) identify the following critical functions that must be maintained during significant events:

- Child Health
  - Children's Ward
  - Neonatal Unit
- Women's Health
  - Delivery Suite
  - Maternity

MDHB Te Uru Pā Harakeke Healthy Women, Children and Youth identify the following critical over time functions that must be recovered at the earliest Opportunity during significant events:

- Children's Outpatients – Day Procedures
- Women's Health
  - Antenatal Clinic an Day Unit
  - Gynaecology day Unit
  - Horowhenua Maternity

1. INTRODUCTION

Emergency preparedness is progressive, continuously moving the public and agencies toward greater resilience. Business Continuity Planning (BCP) forms a significant part of the preparedness and planning for the health sector, to protect the public and healthcare providers and to safe-guard the public's investment in the healthcare system.

1.1 Disruptive Events

Disruptive events are most likely to occur with little no warning and can be broadly catergorised as follows:

- Internal - MidCentral District Health Board outputs may be impacted by the loss internal services/support systems/surge events/industrial action.
- External - MidCentral District Health Board outputs may be impacted by 3rd party disruption i.e. the loss of key suppliers/lifeline & infrastructure outages/health emergencies/ civil disaster.

2. PURPOSE

MDHB has an obligation to have strategies in place that ensures the delivery of essential services during a significant disruption or emergency situation[3]

The purpose of this plan is to outline all procedures involved in the response to a significant disruption to services and business streams employed within the MDHB Te Uru Pā-Harakeke Healthy Women Children and Youth cluster.

Copies of this completed plan are to be provided to:

- Operational Executive
- Clinical Executive
- Senior Leaders
- Manager Risk & Resilience
- Emergency Operations Centre

[3] MDHB Strategic Business Continuity Policy and Plan.

3. AIMS

The aims of the Te Uru Pā Harakeke Healthy Women Children and Youth cluster Business Continuity Plan are too:

1. Maintain life and safety by ensuring critical functions remain in operation
2. Manage a disruption to limit loss
3. Promote early recovery

4. PLANNING ASSUMPTIONS

This plan has been developed using the following assumptions:

- Preventative actions identified during the risk management process have failed or were not first identified.
- It is designed to address a "most likely worst-case" scenario.
- It is applicable in the 'all hazards' context.
- That the level of detail in this Plan is based on the premise that sufficient and knowledgeable people will be available to execute the Plan and support business recovery operations.
- During a disruption, those staff considered essential MDHB Incident Management Team members will be released to support an all of MDHB response.
- All staff are aware of and understand their responsibilities contained within this document.
- Whilst the Principal Risk & Resilience Officer will assist in supporting the Cluster to develop, review, test and maintain their Business Continuity Plan overall responsibility for an individual Cluster Business Continuity Plans remains with the relevant Cluster Business Lead.

5. PLAN LIMITATIONS

The Te Uru Pā Harakeke Healthy Women Children and Youth cluster Business Continuity Plan is not designed to:

- Be fully prescriptive in the event of contingency activities being undertaken.
- Take effect where relatively minor disruptions within a short timescale are experienced.

6. TE URU PĀ-HARAKEKE HEALTHY WOMEN CHILDREN AND YOUTH CLUSTER OVERVIEW

Te Uru Pā Harakeke Healthy Women Children and Youth comprises of the following services:

		Service/Unit	Location	Alternate Care Site
Child Health	Inpatients	Children's Ward	Ground Floor C Block	TBC
		Child Assessment Clinic	GF C Block	Potential to close
		Neonatal	1st Floor C Block	TBC
	Outpatients	Children's Clinic	GF C BLOCK	Potential to close
		Homecare	GF C BLOCK	Health on Main
		Outreach	COMMUNITY	Potential to close
		Visiting Specialists	SAME	Postspone
	Community	Continence	Village	Health on Main – or Community
		Child Development Service	Village	Community Base/Work from home
		Community Child Health Team	200 Broadway	Potential to close
		Gateway	Northside	Potential to close
Research		Children's	na	Research trials cease
		Women's	na	Research trials cease
Women' s Health	Inpatients	Delivery Suite	1st Floor C Block	Birthing centre where appropriate
		Maternity	2nd Floor C Block	Send home where possible
		Gynaecology	Main Hospital + Main Theatre	TBC
	Out-patients	Antenatal Clinic	2nd Floor C Block	Birthing Centre
		Gynaecology	Ground Floor C Block	Consider Primary Birthing Unit / Amb Care
Community		Midwife - PN		Birthing Centre
		Midwife - Feilding		Birthing Centre
		Horowhenua		Birthing centre or Palmerston North Hospital

7. ROLES AND RESPONSIBILITIES

7.1 Business Continuity Plan Sponsor

The Operational Executive Te Uru Pā Harakeke Healthy Women Children and Youth cluster is the sponsor of the BCM. The sponsor has the responsibility, as delegated by the Chief Executive Officer (CEO), of promoting Business Continuity expectations and culture within the Te Uru Pā Harakeke Healthy Women Children and Youth cluster.

7.2 Business Continuity Plan Governance

Te Uru Pā Harakeke Healthy Women Children and Youth Cluster Leadership Team will maintain governance and ensure advancement of the Business Continuity Plan and supporting unit plans throughout the Cluster.

7.3 Business Continuity Plan Owner

The Business Lead for Te Uru Pā Harakeke Healthy Women Children and Youth Cluster is the owner of the BCP.

The owner has the role of ensuring the relevance of BCP, the competencies of key staff to implement plans as well as adequate awareness of BCP expectations throughout the Cluster.

7.4 Department/Unit/Service Leaders and equivalent roles

Department/Unit/Service Leaders and equivalent roles, in partnership with key clinical and other leadership roles, are responsible for developing and maintaining the Business Continuity Plan in line with relevant policies and all associated plans and strategies.

7.5 All Staff

All staff and contractors are responsible for contributing to the Business Continuity Plan with appropriate guidance, as well as assisting with the response and recovery action following a crisis, emergency, disruption or disaster event.

7.6 Guidance & Support

The Principal Risk and Resilience Officer will provide guidance and support as appropriate noting overall responsibility for an individual Cluster Business Continuity Plans remains with the relevant Cluster Business Lead.

8. MAINTENANCE CRITIERIA

Business continuity maintenance activities will include:

- Regular scheduled exercising, testing and review of plans against agreed criteria, to maintain and evolve the adequacy of business continuity management across the organisation, for response and recovery purposes.
- Consideration of business continuity implications on organisational policies and future projects.
- Periodic updating, evolving and documentation of factual and assessed information.

9. MEASUREMENT CRITERIA

- Aligned to AS/NZS 5050:2010 Business Continuity - Managing disruption related risks
- Aligned to ISO 22301: Societal security - Business continuity management systems - Requirements
- Number of plan exercises completed
- Plan reviewed ANNUALLY, on the addition or deletion of a service/function and as part of debrief post disruptive event.

10. MANAGING THE DISRUPTION

10.1 Authority to Activate

Activation of the Te Uru Pā Harakeke Healthy Women Children and Youth Business Continuity Plan will be determined by the scope and magnitude of the disruption and the impact on the ability for the cluster to deliver part or all of its services.

Any activation will be on the authority of the Operational Executive, or in their absence the Business Lead,

or in their absence the under the direction of the Manager on Call in discussion with the Duty Nurse Manager,

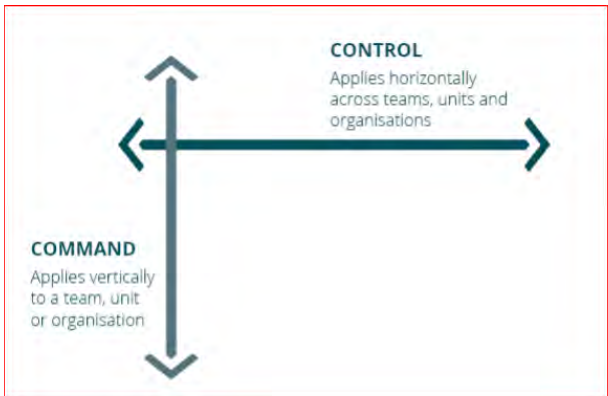
or when requested by the MDHB Incident Controller as part of an all of DHB response.

10.2 Command, Control & Coordination

Command and control define who has the authority to make decisions and what the parameters of that authority are. Command and control then assist with coordination by defining authority between and within organisations. It is important to have a common understanding and application of these terms:

Command - is the authority within a team, unit or organisation and includes the internal ownership, administrative responsibility and detailed supervision of personnel, tasks and resources.

Control - is the authority to set objectives and direct tasks across teams, units and organisations within their capability and capacity. This may include control over another team, unit or cluster resources but does not include interference with that team, unit or clusters command authority or how its tasks are conducted.



Coordination - brings together response elements and resources to ensure a unified and effective response. Command and Control assist with coordination by defining authority between and within organisations.

Where a disruptive event impacts the whole of DHB, or critical functions employed within the DHB, the MDHB Incident Management Team will established with the Incident Controller taking Control of the response.

10.3 Cluster/Unit/Department Call Trees

A call tree is a layered hierarchal communication model used to notify specific individuals of an event, conduct welfare checks and coordinate recovery where necessary.

Individual units and departments are to establish a call tree and ensure that both electronic and manual copy is available. Any manual copy must be secured to ensure private personal information is not accessible.

A review and update of the call tree should be completed at regular interval and as part of the induction of new staff.

10.3.1 Executing the Call Tree

1. The call tree is to be implanted on confirmation of a significant disruptive event and it is determined that employees must be notified.
2. Each unit/department/ward will designate one on duty employee to launch the call tree.
3. The designated caller will follow the hierarchal sequence of contacts allowing no more than 10 rings before hanging up and moving on to the next contact.

Note - Where no contact has been made the designated caller will annotate the call sheet and attempt to ring once the call tree has been completed.

CHILD HEALTH

Internal Disruptive Event

The following tables identify individual units/departments:

- Critical functions
- Alternate care site preference
- Impact analysis against threat types (Service functions impacted)
- Likely consequences (impact of delivery of services)
- Readiness and Response

C- Block – Internal Disruptive Event – Dual lift outage

Inpatients	Alternate Care Site Identified:	
• Children's Ward • Maternity ward • WASU • Birthing Suite Neonatal Unit	Service	Alternate Care Site
	C-Block	

Critical Functions					**Functions Critical Over Time**				
Service/Business Unit	Function/Output	Recover time objectives Within (Hours)			Service/Business Unit	Function/Output	Recover time objectives Within (Hours)		
		2	4	8			2	4	8
	C-block								

Internal Disruptive Event - the organization may suffer serious internal disruption as a result of: • Dual lift failure in block C			
Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Dual lift outage	• Unable to transfer patients to floor 2 c-block and across to other clinical areas beyond c-block • Inability for ambulance to transfer women up to birthing suite • Change in the way all staff access floor 2 c-block including distribution and meal service	• Patient Harm if unable to transfer high acuity patients to other areas • Potential need to reschedule renal dialysis of bed bound patients	• Notify immediate managers, DNM, IOC, security, orderlies and facilities lead (on call manager after hours) • Designate a central person for ongoing communication across parties • Notify all Charge Nurses • Notify managers through the 'Whats App' • Contact shift engineer who will then contact lift maintenance staff • Assess patient risk on 2nd floor and move high risk antenatal women to birthing suite • All low risk patients to remain on 2nd floor • High risk WASU patients: consider moving via stairs to other wards

			• Sort extra personnel to coordinate flow around the hospital and to areas beyond c-block • Contact ambulance control to redirect ambulances to back of ED, TCU entrance • Notice on lifts • Notify LMC group via social media • Notify communications if lifts potentially out for more than 30mins to get staff and community news out • Notify MET team of need to use stairs • Notify front reception to re-direct people • Contact the renal unit coordinator in case renal treatments have to be rescheduled due to access from tower block

Child Health – Internal Disruptive Event – Inpatient - Children's Ward

Inpatients • Children's Ward including - High Dependency Care 1:1	Alternate Care Site Identified:	
	Service	Alternate Care Site
	Children's Ward	

Critical Functions					**Functions Critical Over Time**				
Service/Business Unit	Function/Output	Recover time objectives Within (Hours)			Service/Business Unit	Function/Output	Recover time objectives Within (Hours)		
		2	4	8			2	4	8
	Children's Ward								

Internal Disruptive Event - the organization may suffer serious internal disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Industrial Action
- Loss of one or more key internal clinical support services

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	• Patient Cares • Communication systems • Information systems & support • Ward integrity i.e Security doors • Medication rooms uncontrolled • Patient Information & Flow Information system • Loss of suction? • Unable to transfer patients to services not on ground floor due to lift outage eg: theatre, ICU	• Patient Harm • Inability to pull information Lab/Blood/Imaging data loss • Security of Ward	• Critical patients to be supported by critical power supply (this is awaiting instalment on the CH ward). • Battery backup of point of care equipment. • Runners – if telephones out • Clinical records - paper copy.
Water	• Patient Cares • Sanitary/Sluicing • Infection Control (Staff/Patients) • Drinking water – Formula/Drinking	• Patient Harm • Increased risk of infection • Staff/patient/visitor well being	• Hand Sanitizer • Bottled water • Purifying tablets (CD Locker) • Limit water to essential needs only • Ready-made formula stock
Medical Gases	• Patient Cares • Loss of CPAP ability • Respiratory services	• Patient Harm	• Portable medical gases • Transfer/decant patients as required

Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
As per identified in Cluster BIA page 8	• Patient Cares • Patient Information & Flow	• Loss of administration systems (partially/full) • Loss of Clinical Data and results impacting of clinical decision making	• Manual copy of telephone book • Manual copy data entry
Industrial Action	**Service Functions Impacted**	**Likely Consequences**	**Readiness & Response Strategies**
Clinical / Non Clinical	• Limited staffing resource • Patient Cares • Administration services	• Inability to deliver non-essential cares • Data entry • Administration support	• MDHB strategic planning
Loss of one or more key internal clinical support services	**Service Functions Impacted**	**Likely Consequences**	**Readiness & Response Strategies**

	• Theatre
	• Emergency Department
	• Medical Imaging
	• Laboratory Services
	• NZ Blood
	• ICU
	• Orderlies
	• Clinical supply chain
	• Pharmacy
	• Allied Health specialties
	  - Social Work
	  - Speech Language
	  - Dietician
	  - Physiotherapist
	• Hotel services (soft FM)
	  • Orderlies
	  • Cleaning
	  • Laundry
		• Patient Harm
		• Inability to deliver some essential cares
		• Delays in care
		• Increased risk of infection
			• Consider transfer of critical patients to Starship/Wellington hospital
			• Supply rationing
			• Prioritise resource

Child Health – Internal Disruptive Event – Inpatients Child Assessment Unit

<table>
<tr><td colspan="5" rowspan="3">Inpatients
• Child Assessment Unit</td><td colspan="6">Alternate Care Site Identified:</td></tr>
<tr><td colspan="2">Service</td><td colspan="4">Alternate Care Site</td></tr>
<tr><td colspan="2">Child Assessment Unit</td><td colspan="4"></td></tr>
<tr><td colspan="6">Critical Functions</td><td colspan="6">Functions Critical Over Time</td></tr>
<tr><td rowspan="3">Service/Business Unit</td><td rowspan="3">Function/Output</td><td colspan="4">Recover time objectives</td><td rowspan="3">Service/Business Unit</td><td rowspan="3">Function/Output</td><td colspan="4">Recover time objectives</td></tr>
<tr><td colspan="4">Within (Hours)</td><td colspan="4">Within (Hours)</td></tr>
<tr><td>2</td><td>4</td><td>7</td><td>28</td><td>2</td><td>4</td><td>7</td><td>28</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>Child Assessment Clinic</td><td></td><td></td><td></td><td></td></tr>
</table>

Internal Disruptive Event - the organization may suffer serious internal disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Industrial Action
- Loss of one or more key internal clinical support services

<table>
<tr><td>Loss of Lifelines/Infrastructure</td><td>Service Functions Impacted</td><td>Likely Consequences</td><td>Readiness & Response Strategies</td></tr>
<tr><td>Electrical Power</td><td colspan="3">Cancellation of service
Space & resources made available</td></tr>
<tr><td>Water</td><td colspan="3">Cancellation of service
Space & resources made available</td></tr>
<tr><td>Medical Gases</td><td colspan="3">Cancellation of service
Space & resources made available</td></tr>
<tr><td>Information Systems Outage</td><td>Service Functions Impacted</td><td>Likely Consequences</td><td>Readiness & Response Strategies</td></tr>
<tr><td>As per identified in Cluster BIA page 8</td><td>• Patient Cares. Blood results etc.
• Patient Information & Flow
• Bookings
• Admission & Discharges</td><td>• Loss of administration systems (partially/full)
• Loss of Clinical Data and results impacting of clinical decision making</td><td>• Paper based
• Manual copy of telephone book
• Manual copy data entry
• Manual policies and guidelines</td></tr>
<tr><td>Industrial Action</td><td>Service Functions Impacted</td><td>Likely Consequences</td><td>Readiness & Response Strategies</td></tr>
<tr><td>Clinical / Non Clinical</td><td>• Limited staffing resource
• Patient Cares
• Administration services</td><td>• Inability to deliver non-essential cares
• Data entry
• Administration support</td><td>• MDHB strategic planning</td></tr>
</table>

Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies

	• ED
	• Medical Imaging
	• Laboratory Services
	• Clinical supply chain
	• Pharmacy
	• Allied Health specialties
	  - Social Work
	• Hotel services (soft FM)
	  - Orderlies
	  - Cleaning
	  - Laundry
		• Patient Harm
		• Delays
		• Infection
			• Cancellation of service
			• Space & resources made available
			• Supply rationing

Child Health – Internal Disruptive Event – Inpatients Neonatal

<table>
<tr><td colspan="5" rowspan="3">Inpatients
• Neonatal</td><td colspan="5">Alternate Care Site Identified:</td></tr>
<tr><td colspan="2">Service</td><td colspan="3">Alternate Care Site</td></tr>
<tr><td colspan="2">Neonatal</td><td colspan="3">Delivery Suite/Theatre</td></tr>
<tr><td colspan="5">Critical Functions</td><td colspan="5">Functions Critical Over Time</td></tr>
<tr><td rowspan="3">Service/Business Unit</td><td rowspan="3">Function/Output</td><td colspan="3">Recover time objectives</td><td rowspan="3">Service/Business Unit</td><td rowspan="3">Function/Output</td><td colspan="3">Recover time objectives</td></tr>
<tr><td colspan="3">Within (Hours)</td><td colspan="3">Within (Hours)</td></tr>
<tr><td>2</td><td>4</td><td>8</td><td>2</td><td>4</td><td>7</td></tr>
<tr><td></td><td>Neonatal</td><td></td><td></td><td></td><td></td><td>Neonatal</td><td></td><td></td><td></td></tr>
<tr><td colspan="10">Internal Disruptive Event - the organization may suffer serious internal disruption as a result of:
• Lifelines / Infrastructure failure
• Information Systems outage
• Industrial Action
• Loss of one or more key internal clinical support services</td></tr>
<tr><td colspan="2">Loss of Lifelines/Infrastructure</td><td colspan="3">Service Functions Impacted</td><td colspan="2">Likely Consequences</td><td colspan="3">Readiness & Response Strategies</td></tr>
<tr><td colspan="2">Electrical Power</td><td colspan="3">• Patient Cares
• Communication systems
• Information systems & support
• Ward integrity i.e Security doors
• Patient Information & Flow Information system
• Loss of suction
• Thermostatic environment control
• Baby monitoring/alarm system
• Negative pressure room
• Loss of fridge/freezer (not on critical power)
• Patient labelling system
• Lighting</td><td colspan="2">• Patient Harm
• Inability to pull Lab / Blood / Imaging data
• Inability to access Badgernet
• Security of Ward
• Inability to access/insert patient data
• Staff wellbeing
• Access control camera inoperative
• Increased risk of infection
• Loss of expressed milk</td><td colspan="3">Patient Cares
• Staffing to acquity
• All essential Point of Care equipment to be plugged into critical power supply.
• Battery backup of point of care equipment
• Consider baby transfer
• Double bunk babies in ICU Bay
• Hand written Bradma’s (patient identity bracelet / patient documentation)
• Ready-made formula (Materials Management)
• Head torches (CD Locker)
Communication
• Runners
• Pagers</td></tr>
</table>

			Security (One point of entry / Two points of exit) • Entry Control Officer (non essential staff member) **Patient Information & Flow** • Critical power supply to staff station computers. • Laptop (query Wifi connect ability) **Thermostatic environment control (24 degrees c norm)** • Cold: Transfer to incubator • Hot: consider use of fans **Negative Pressure Room** • Baby transfer to another in hospital negative pressure room
Water	• Patient Cares • Sanitary/Sluicing • Infection Control (Staff/Patients) • Drinking water/Formula	• Patient Harm • Increased risk of infection • Staff/patient/visitor well being	• Hand wash • Wet wipes (not in stock) • Bottled water (not in stock) • Ready-made formula (Materials Management) • Purifying tablets (CD Locker)
Medical Gases (Air/Oxygen)	• Patient Cares	**Patient Harm – Inability to provide respiratory support** • Ventilator • CPAP • High Flow	• Self-inflating Ambi Bag may be used to give manual breaths • Staffing to acuity • Portable gases (100% Oxygen) • Internal / External transfer
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
As per identified in Cluster BIA page 8	• Patient Cares • Patient Information & Flow • Loss of rosters	• Loss of administration systems (partially/full) • Loss of Clinical Data and results impacting of clinical decision making • Inability to pull Lab / Blood / Imaging data • Inability to access Badgernet	• **Manual copy of telephone book** **Manual copy data entry** • Hand written Bradma's (patient identity bracelet / patient documentation) **Patient Information & Flow** • Critical power supply to staff station computers.

		• Admission and discharge protocols	• Laptop (query Wifi connect ability) • Paper copy rosters
Industrial Action	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Clinical / Non Clinical	• Limited staffing resource • Patient Cares • Administration services	• Inability to deliver non-essential cares • Data entry • Administration support	• MDHB strategic planning
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
	• Medical Imaging • Laboratory Services • NZ Blood • Clinical supply chain • Pharmacy **Allied Health specialties** • Social Work • Speech Language • Dietician **Hotel services (soft FM)** • Orderlies • Cleaning • Laundry • Meals	• Patient Harm • Delays • Infection	

Child Health – Internal Disruptive Event – Outpatients – Children's Ward

Outpatients	Alternate Care Site Identified:	
• Children's Clinic – With Separate Day Procedure, those services to be stood up in 7 days, those not critical	Service	Alternate Care Site
	Children's Clinic	

Critical Functions

Service/Business Unit	Function/Output	Recover time objectives Within (Hours) 2	4	8

Functions Critical Over Time

Service/Business Unit	Function/Output	Recover time objectives Within (Hours) 2	4	7
	Children's Clinic			
	Day Procedures			

Internal Disruptive Event - the organization may suffer serious internal disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Industrial Action
- Loss of one or more key internal clinical support services

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	• Loss of Clinics insitu • Day procedures	• Patient harm • Customer dissatisfaction • Reputational harm • Interruption to long term planned cares	• Relocation • Transfer patients to children' s ward if available • Essential power
Water	• Patient Cares • Sanitary • Infection Control (Staff/Patients)	• Patient Harm • Increased risk of infection • Staff/patient/visitor well being	• Hand sanitizer • Bottled water? • Purifying tablets (CD Locker)
Medical Gases	Portable Medical Gases (Transfer to treatment room Children's Ward – query availability ?)		

Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
As per identified in Cluster BIA page 8	• Patient Cares. Blood results etc. • Patient Information & Flow • Bookings • Admissions & Discharges	• Loss of administration systems (partially/full) • Loss of Clinical Data and results impacting of clinical decision making	• Paper based • Manual copy of telephone book • Manual copy data entry • Manual policies and guidelines

		Likely Consequences	
		• Inability to maintain patient documentation, registering referrals and booking system	
Industrial Action	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Clinical / Non Clinical	• Limited staffing resource • Patient Cares • Administration services	• Inability to deliver non-essential cares • Data entry • Administration support	• MDHB strategic planning
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
	• Medical Imaging • Laboratory Services • Clinical supply chain • Pharmacy **Allied Health specialties** • Social Work • Physio • Dieticians • Speech Language Therapists **Hotel services (soft FM)** • Orderlies • Cleaning • Laundry	• Patient Harm • Delays • Infection	• Transfer oncology children to starship if on active chemotherapy treatment. • Supply rationing • Prioritise resource

Child Health – Internal Disruptive Event – Inpatients - Homecare

<table>
<tr><td colspan="6" rowspan="3">Inpatients
• Homecare</td><td colspan="6">Alternate Care Site Identified:</td></tr>
<tr><td colspan="3">Service</td><td colspan="3">Alternate Care Site</td></tr>
<tr><td colspan="3">Homecare</td><td colspan="3"></td></tr>
<tr><td colspan="6">Critical Functions</td><td colspan="6">Functions Critical Over Time</td></tr>
<tr><td rowspan="3">Service/Business Unit</td><td rowspan="3">Function/Output</td><td colspan="3">Recover time objectives</td><td rowspan="3"></td><td rowspan="3">Service/Business Unit</td><td rowspan="3">Function/Output</td><td colspan="3">Recover time objectives</td><td rowspan="3"></td></tr>
<tr><td colspan="3">Within (Hours)</td><td colspan="3">Within (Hours)</td></tr>
<tr><td>2</td><td>4</td><td>8</td><td>2</td><td>4</td><td>7</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>Homecare</td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="12">Internal Disruptive Event - the organization may suffer serious internal disruption as a result of:
• Lifelines / Infrastructure failure
• Information Systems outage
• Industrial Action
• Loss of one or more key internal clinical support services</td></tr>
<tr><td colspan="3">Loss of Lifelines/Infrastructure</td><td colspan="3">Service Functions Impacted</td><td colspan="3">Likely Consequences</td><td colspan="3">Readiness & Response Strategies</td></tr>
<tr><td colspan="3">Electrical Power</td><td colspan="9">Community based service delivery consider ‘Co – op’ Office Space
Access to information system i.e. laptop</td></tr>
<tr><td colspan="3">Water</td><td colspan="9">Community based service delivery consider ‘Co – op’ Office Space
Access to information system i.e. laptop</td></tr>
<tr><td colspan="3">Medical Gases</td><td colspan="9">Community based service delivery consider ‘Co – op’ Office Space
Access to information system i.e. laptop</td></tr>
<tr><td colspan="12"></td></tr>
<tr><td colspan="3">Information Systems Outage</td><td colspan="3">Service Functions Impacted</td><td colspan="3">Likely Consequences</td><td colspan="3">Readiness & Response Strategies</td></tr>
<tr><td colspan="3">As per identified in Cluster BIA page 8</td><td colspan="3">• Patient Cares. Blood results etc.
• Patient Information & Flow
• Bookings
• Admissions & Discharges</td><td colspan="3">• Loss of administration systems (partially/full)
• Loss of Clinical Data and results impacting of clinical decision making
• Inability to maintain patient documentation, registering referrals and booking system</td><td colspan="3">• Paper based
• Manual copy of telephone book
• Manual copy data entry
• Manual policies and guidelines</td></tr>
</table>

Industrial Action	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Clinical / Non Clinical	• Limited staffing resource • Patient Cares • Administration services	• Inability to deliver non-essential cares • Data entry • Adminstration support	• MDHB strategic planning
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
	• Fleet Wise • Medical Imaging • Laboratory Services • Clinical supply chain • Pharmacy **Allied Health specialties** • Social Work • Physio • Dieticians • Speech Language Therapists	• Patient Harm • Delays in care • Customer dissatisfaction • Reputational harm	• Source alternative transport • Supply rationing • Prioritise resource

Child Health – Internal Disruptive Event – Community – Child Development Services

<table>
<tr><td colspan="7">Community
• Child Development Service</td><td colspan="7">Alternate Care Site Identified:
Service: Child Development Service
Alternate Care Site:</td></tr>
<tr><td colspan="7">Critical Functions</td><td colspan="7">Functions Critical Over Time</td></tr>
<tr><td rowspan="3">Service/Business Unit</td><td rowspan="3" colspan="2">Function/Output</td><td colspan="4">Recover time objectives</td><td rowspan="3">Service/Business Unit</td><td rowspan="3" colspan="2">Function/Output</td><td colspan="4">Recover time objectives</td></tr>
<tr><td colspan="4">Within (Hours)</td><td colspan="4">Within (Hours)</td></tr>
<tr><td>2</td><td>4</td><td>7</td><td>28</td><td>2</td><td>4</td><td>7</td><td>28</td></tr>
<tr><td></td><td colspan="2"></td><td></td><td></td><td></td><td></td><td></td><td colspan="2">Child Development Services</td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="14">Internal Disruptive Event - the organization may suffer serious internal disruption as a result of:
• Lifelines / Infrastructure failure
• Information Systems outage
• Industrial Action
• Loss of one or more key internal clinical support services</td></tr>
<tr><td colspan="2">Loss of Lifelines/Infrastructure</td><td colspan="5">Service Functions Impacted</td><td colspan="3">Likely Consequences</td><td colspan="4">Readiness & Response Strategies</td></tr>
<tr><td colspan="2">Electrical Power</td><td colspan="12">Relocation of service – Community/Work from home</td></tr>
<tr><td colspan="2">Water</td><td colspan="12">Relocation of service – Community/Work from home</td></tr>
<tr><td colspan="2">Medical Gases</td><td colspan="12">Relocation of service – Community/Work from home</td></tr>
<tr><td colspan="2">Information Systems Outage</td><td colspan="5">Service Functions Impacted</td><td colspan="3">Likely Consequences</td><td colspan="4">Readiness & Response Strategies</td></tr>
<tr><td colspan="2">As per identified in Cluster BIA page 8</td><td colspan="5">• Patient Cares
• WebPas/Clinical Portal Patient Information
• Bookings
• Discharges</td><td colspan="3">• Loss of administration systems (partially/full)
• Inability to access Clinical Data and results
• Bookings/Discharges/Assessments</td><td colspan="4">• Paper based files</td></tr>
<tr><td colspan="2">Industrial Action</td><td colspan="5">Service Functions Impacted</td><td colspan="3">Likely Consequences</td><td colspan="4">Readiness & Response Strategies</td></tr>
<tr><td colspan="2">Clinical / Non Clinical</td><td colspan="5">• Limited staffing resource
• Patient Cares/Assessment/Therapy
• Administration services</td><td colspan="3">• Inability to deliver therapy
• Equipment application and distribution
• Data entry
• Administration support</td><td colspan="4">• MDHB strategic planning</td></tr>
</table>

Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
	• Supply chain **Hotel Services** • Orderlies • Mail Services • Dieticians • Cleaners • Fleet Wise • Facilities Management • Outlying Health Centre's	• Patient Harm • Delays in treatment • Increased average length of stay	

Child Health – Internal Disruptive Event – Community – Community Child Health Team

Community • Community Child Health Team	Alternate Care Site Identified:	
	Service	Alternate Care Site
	Community Child Health Team	

Critical Functions						**Functions Critical Over Time**					
Service/Business Unit	Function/Output	Recover time objectives Within (Hours)				Service/Business Unit	Function/Output	Recover time objectives Within (Hours)			
		2	4	7	28			2	4	7	28
							Community Child Health Team				

Internal Disruptive Event - the organization may suffer serious internal disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Industrial Action
- Loss of one or more key internal clinical support services

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	• Patient management system	• Inability to maintain patient documentation, registering referrals and booking system	• Revert to paper based system
Water	• Infection control precautions	• Inability to adequately maintain infection control precautions - hand washing	• Hand sanitizer
Medical Gases	• Nil impact	• Nil impact	• Nil impact
Information Systems Outage	**Service Functions Impacted**	**Likely Consequences**	**Readiness & Response Strategies**
	• Patient management system	• Inability to maintain patient documentation, registering referrals and booking system	• Revert to paper based system
Industrial Action	**Service Functions Impacted**	**Likely Consequences**	**Readiness & Response Strategies**
Clinical / Non Clinical	• Clinical service delivery	• Inability to deliver clinics	• MDHB strategic planning
Loss of one or more key internal clinical support services	**Service Functions Impacted**	**Likely Consequences**	**Readiness & Response Strategies**
	• Clinical service delivery	• Inability to provide services and provide health and/or social support	• Prioritise resource

Child Health – Internal Disruptive Event – Community – Gateway Programme

Community • Gateway Programme						Alternate Care Site Identified:					
						Service		Alternate Care Site			
						Gateway Programme					
Critical Functions						**Functions Critical Over Time**					
Service/Business Unit	Function/Output	Recover time objectives Within (Hours)				Service/Business Unit	Function/Output	Recover time objectives Within (Hours)			
		2	4	7	28			2	4	7	28
							Gateway Programme				

Internal Disruptive Event - the organization may suffer serious internal disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Industrial Action
- Loss of one or more key internal clinical support services

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	• Patient management system	• Inability to maintain patient documentation, registering referrals and booking system	• Revert to paper based system
Water	• Infection control precautions	• Inability to adequately maintain infection control precautions - hand washing	• Hand sanitizer
Medical Gases	• Nil impact	• Nil impact	• Nil impact
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
	• Patient management system	• Inability to maintain patient documentation, registering referrals and booking system	• Revert to paper based system
Industrial Action	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Clinical / Non Clinical	• Clinical service delivery	• Inability to deliver clinics	• MDHB strategic planning
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
	• Clinical service delivery	• Inability to provide services and provide health and/or social support	• Prioritise resource

CHILD HEALTH

External Disruptive Event

The following tables identify individual units/departments:

- Critical functions
- Alternate care site preference
- Impact analysis against threat types (Service functions impacted)
- Likely consequences (impact of delivery of services)
- Readiness and Response

Child Health – External Disruptive Event – Inpatients – Children's Ward

<table>
<tr><td colspan="7">Inpatients
• Children's Ward including
- High Dependency Care 1:1</td><td colspan="7">Alternate Care Site Identified:
Service: Children's Ward
Alternate Care Site:</td></tr>
<tr><td colspan="7">Critical Functions</td><td colspan="7">Functions Critical Over Time</td></tr>
<tr><td rowspan="3">Service/Business Unit</td><td rowspan="3">Function/Output</td><td colspan="4">Recover time objectives</td><td rowspan="3"></td><td rowspan="3">Service/Business Unit</td><td rowspan="3">Function/Output</td><td colspan="4">Recover time objectives</td><td rowspan="3"></td></tr>
<tr><td colspan="4">Within (Hours)</td><td colspan="4">Within (Hours)</td></tr>
<tr><td>2</td><td>4</td><td>7</td><td>28</td><td>2</td><td>4</td><td>7</td><td>28</td></tr>
<tr><td></td><td>Children's Ward</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table>

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	• Patient Cares • Communication systems • Information systems & support • Ward integrity i.e Security doors • Medication rooms uncontrolled • Patient Information & Flow Information system • Loss of suction	• Patient Harm • Inability to pull information Lab/Blood/Imaging data • Security of Ward	• Critical patients to be supported by critical power supply. • Battery backup of point of care equipment. • Runners – telephones • Clinical records - paper copy.
Water	• Patient Cares • Sanitary/Sluicing • Infection Control (Staff/Patients) • Drinking water – Formula/Drinking	• Patient Harm • Increased risk of infection • Staff/patient/visitor well being	• Hand sanitizer • Bottled water • Purifying tablets (CD Locker) • Limit water to essential needs only • Supply of ready-made formula
Medical Gases	• Hot Water	• Patient Harm • Increased risk of infection • Staff/patient/visitor well being	• Dual Boilers

Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
• Connectivity • Cyber Attack	• Communication systems • Information systems & support • Patient Information & Flow Information system	• Loss of administration systems (partially/full) • Loss of Clinical Data and results impacting of clinical decision making • Patient harm • Delays in admissions and discharges	• Paper based • Manual copy of telephone book • Manual copy data entry • Manual policies and guidelines
Loss of one or more key suppliers	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
NZ Blood	• Patient cares	• Patient harm	• Follow recommended clinical guidelines for replacement of blood products. • Consider transfer of critical patients to Starship/Wellington hospital
Allied Laundry	• Patient cares • Infection control	• Patient harm • Increased risk of Infection	• Supply rationing • Prioritise resource
Hotel Services (Soft FM)	• Patient cares • Cleaning services • Food services	• Patient harm • Increased risk of infection	• Supply rationing • Prioritise resource
Facilities Management	• Patient cares • Building maintenance • Bio medical	• Patient harm • Potential lack of medical equipment due breakdowns	• Ensure medical equipment maintenance is kept up to date. • Prioritise resource
Med Lab	• Patient cares	• Patient harm • Customer dissatisfaction • Reputational harm	• Likely cancellation arranged admissions
Natural Disaster/Health Emergency	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Pandemic	• Patient cares • Clinical area above capacity • Infection control	• Patient harm due to lack of staffing to deliver care • Inability to deliver non- essential cares • Staff/patient wellbeing • Increased risk of infection • Delays in care	• Staffing variance response plans • Follow essential care guidelines
Civil/Natural Disaster	MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans		

Child Health – External Disruptive Event – Inpatients – Child Assessment Clinic

Inpatients • Child Assessment Clinic	Alternate Care Site Identified:	
	Service	Alternate Care Site
	Child Assessment Clinic	

Critical Functions							**Functions Critical Over Time**					
Service/Business Unit	Function/Output	Recover time objectives					Service/Business Unit	Function/Output	Recover time objectives			
		Within (Hours)							Within (Hours)			
		2	4	7	28				2	4	7	28
								Child Assessment Clinic				

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power		Cancellation of service Space & resources made available	
Water		Cancellation of service Space & resources made available	
Medical Gases		Cancellation of service Space & resources made available	

Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
• Connectivity • Cyber Attack	• Communication systems • Information systems & support • Patient Information & Flow Information system	• Loss of administration systems (partially/full) • Loss of Clinical Data and results impacting of clinical decision making • Patient harm • Delays in admissions and discharges	• Paper based • Manual copy of telephone book • Manual copy data entry • Manual policies and guidelines

Loss of one or more key suppliers	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Allied Laundry	• Patient cares • Infection control	• Patient harm • Increased risk of Infection	• Supply rationing • Prioritise resource
Hotel Services (Soft FM)	• Patient cares • Cleaning services • Food services	• Patient harm • Increased risk of infection	• Supply rationing • Prioritise resource
Facilities Management	• Patient cares • Building maintenance • Bio medical	• Patient harm • Potential lack of medical equipment due breakdowns	• Ensure medical equipment maintenance is kept up to date.
Med Lab	• Patient cares	• Patient harm • Customer dissatisfaction • Reputational harm	• Likely cancellation of service
Natural Disaster/Health Emergency	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Pandemic	• Patient cares • Clinical area above capacity • Infection control	• Delays in care Patient harm due to lack of staffing to deliver care • Customer dissatisfaction • Reputational harm • Interruption to long term planned cares • Increased risk of infection	• Staffing variance response plans • Follow essential care guidelines
Natural Disaster	• Patient cares	• Patient harm due to lack of staffing to deliver care • Customer dissatisfaction • Reputational harm • Interruption to long term planned cares	• Staffing variance response plans • Following essential care guidelines
MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans			

Child Health – External Disruptive Event - Neonatal

<table>
<tr><td colspan="5">Inpatients
• Neonatal</td><td colspan="5">Alternate Care Site Identified:
Service: Neonatal
Alternate Care Site:</td></tr>
<tr><td colspan="5">Critical Functions</td><td colspan="5">Functions Critical Over Time</td></tr>
<tr><td rowspan="3">Service/Business Unit</td><td rowspan="3">Function/Output</td><td colspan="3">Recover time objectives</td><td rowspan="3">Service/Business Unit</td><td rowspan="3">Function/Output</td><td colspan="3">Recover time objectives</td></tr>
<tr><td colspan="3">Within (Hours)</td><td colspan="3">Within (Hours)</td></tr>
<tr><td>2</td><td>4</td><td>8</td><td>2</td><td>4</td><td>8</td></tr>
<tr><td></td><td>Neonatal</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table>

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	• Patient Cares • Communication systems • Information systems & support • Ward integrity i.e Security doors • Patient Information & Flow Information system • Loss of suction • Thermostatic environment control • Baby monitoring/alarm system • Negative pressure room • Loss of fridge/freezer (not on critical power) • Patient labelling system • Lighting	• Patient Harm • Inability to pull Lab / Blood / Imaging data • Inability to access Badgernet • Security of Ward • Inability to access/insert patient data • Staff wellbeing • Access control camera inoperative • Increased risk of infection • Loss of expressed breast milk	**Patient Cares** • Staffing to acuity • All essential Point of Care equipment to be plugged into critical power supply. • Battery backup of point of care equipment • Consider baby transfer • Double bunk babies in ICU Bay • Hand written Bradma’s (patient identity bracelet / patient documentation) • Ready-made formula (Materials Management) • Head torches (CD Locker) **Communication** • Runners • Pagers

<table>
<tr><td></td><td></td><td></td><td>Security (One point of entry / Two points of exit)
Entry Control Officer (non-essential staff member)
Patient Information & Flow
Critical power supply to staff station computers.
Laptop (query Wifi connect ability)
Thermostatic environment control (24 degrees Celsius norm)
Cold: Transfer to incubator
Hot: consider use of fans
Negative Pressure Room
Baby transfer to another in hospital negative pressure room</td></tr>
<tr><td>Water</td><td>Patient Cares
Sanitary/Sluicing
Infection Control (Staff/Patients)
Drinking water/Formula</td><td>Patient Harm
Increased risk of infection
Staff/patient/visitor well being</td><td>Hand wash
Wet wipes (not in stock)
Bottled water (not in stock)
Ready-made formula (Materials Management)
Purifying tablets (CD Locker)</td></tr>
<tr><td>Gas</td><td>Patient Cares</td><td>Patient Harm
Inability to provide respiratory support
Ventilator
CPAP
High Flow</td><td>Self-inflating Ambi Bag may be used to give manual breaths
Staffing to acuity
Portable gases (100% Oxygen)
Internal / External transfer</td></tr>
<tr><td>Information Systems Outage</td><td>Service Functions Impacted</td><td>Likely Consequences</td><td>Readiness & Response Strategies</td></tr>
<tr><td>Connectivity
Cyber Attack</td><td>Support programmes
NICU tools
Wellington Medication and Infusion Calculators
Treatment guideline and policies from other DHB's
Clinical Records</td><td>Delays</td><td>Up to date and printed copies of Monographs for Medication and Infusions
Up to date and printed local guidelines/policies and procedures
Use of Wifi/mobile data</td></tr>
</table>

	• Inability to assess to patient clinical records via Badgernet for both Mother and Infant	• Loss of Clinical Data and results impacting of clinical decision making	
Loss of one or more key suppliers	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
NZ Blood	• Patient Care	• Patient Harm • Delays • Staff Wellbeing/Stress	• Transfer required blood products from another source/DHB/private hospitals • Transfer infant to another DHB to receive blood products
Allied Laundry	• Patient Care	• Patient discomfort • Delays • Infection risk	• Monitor and reduce usage where possible • Transport linen from another DHB • Purchase linen from another provider
Air Ambulance	• Patient Care	• Patient Harm • Delays • Staff Wellbeing/Stress	• Transfer infant to another intensive care unit by road • Call in experienced staff to support infant's care • Tele-medicine consultation with clinical expert
St John	• Patient Care	• Patient Harm • Delays • Staff Wellbeing/Stress	• Use another mode of transport with medical/nursing staff from unit
Starship	• Patient Care	• Patient Harm • Delays • Staff Wellbeing/Stress	• Transfer infant to another intensive care unit • Call in experienced staff to support infant's care • Tele-medicine consultation with clinical expert
Clever Med (NCIS)	• Patient Care	• Loss of past records • Patient Harm • Delays • Staff Wellbeing/Stress	• Documentation completed on paper
Natural Disaster/Health Emergency	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Pandemic Civil/Natural Disaster	MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans		

Child Health – External Disruptive Event – Outpatients – Children's Clinic

Outpatients	Alternate Care Site Identified:	
• Children's Clinic – With Separate Day Procedure, those services to be stood up in 7 days, those not critical	Service	Alternate Care Site
	Children's Clinic	

Critical Functions

Service/Business Unit	Function/Output	Recover time objectives Within (Hours)		
		2	4	8

Functions Critical Over Time

Service/Business Unit	Function/Output	Recover time objectives Within (Hours)		
		2	4	7
	Children's Clinic			
	Day Procedures			

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	• Loss of Clinics insitu • Day procedures	• Patient harm • Customer dissatisfaction • Reputational harm • Interruption to long term planned cares	• Relocation • Transfer patients to children' s ward if available • Consideration of cancellation of clinics so resources made available
Water	• Patient Cares • Sanitary • Infection Control (Staff/Patients)	• Patient Harm • Increased risk of infection • Staff/patient/visitor well being	• Hand sanitizer • Bottled water? • Purifying tablets (CD Locker) • Consideration of cancellation of clinics so resources made available
Gas	Portable Medical Gases		

Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
• Connectivity • Cyber Attack	• Communication systems • Information systems & support • Patient Information & Flow Information system	• Loss of administration systems (partially/full) • Loss of Clinical Data and results impacting of clinical decision making • Patient harm	• Paper based • Manual copy of telephone book • Manual copy data entry • Manual policies and guidelines
Loss of one or more key suppliers	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
NZ Blood	• Patient cares	• Patient harm	• Follow recommended clinical guidelines for replacement of blood products. • Consider transfer of critical patients to Starship/Wellington hospital
Allied Laundry	• Patient cares • Infection control	• Patient harm • Increased risk of Infection	• Supply rationing • Prioritise resource
Hotel Services (Soft FM)	• Patient cares • Cleaning services • Food services	• Patient harm • Increased risk of infection	• Supply rationing • Prioritise resource
Facilities Management (Hard FM)	• Patient cares • Building maintenance • Bio medical	• Patient harm • Potential lack of medical equipment due breakdowns	• Ensure medical equipment maintenance is kept up to date.
Med Lab	• Patient cares	• Patient harm • Customer dissatisfaction • Reputational harm	• Likely cancellation of service
Natural Disaster	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Pandemic Civil/Natural Disaster	MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans		

Child Health – External Disruptive Event – Outpatients - Homecare

<table>
<tr><td colspan="5" rowspan="3">Outpatients
• Homecare</td><td colspan="4">Alternate Care Site Identified:</td></tr>
<tr><td colspan="2">Service</td><td colspan="2">Alternate Care Site</td></tr>
<tr><td colspan="2">Homecare</td><td colspan="2"></td></tr>
<tr><td colspan="5">Critical Functions</td><td colspan="4">Functions Critical Over Time</td></tr>
<tr><td rowspan="3">Service/Business Unit</td><td rowspan="3">Function/Output</td><td colspan="3">Recover time objectives</td><td rowspan="3">Service/Business Unit</td><td rowspan="3">Function/Output</td><td colspan="2">Recover time objectives</td></tr>
<tr><td colspan="3">Within (Hours)</td><td colspan="2">Within (Hours)</td></tr>
<tr><td>2</td><td>4</td><td>8</td><td>2</td><td>4 | 7</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td>Homecare</td><td></td><td></td><td></td></tr>
<tr><td colspan="9">External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:
• Lifelines / Infrastructure failure
• Information Systems outage
• Loss of one or more key suppliers
• Natural Disaster/Health Emergency</td></tr>
<tr><td>Loss of Lifelines/Infrastructure</td><td colspan="2">Service Functions Impacted</td><td colspan="3">Likely Consequences</td><td colspan="3">Readiness & Response Strategies</td></tr>
<tr><td>Electrical Power</td><td colspan="8">Community based service delivery consider ‘Co – op’ Office Space
Access to information system i.e. laptop</td></tr>
<tr><td>Water</td><td colspan="8">Community based service delivery consider ‘Co – op’ Office Space
Access to information system i.e. laptop</td></tr>
<tr><td>Gas</td><td colspan="8">Community based service delivery consider ‘Co – op’ Office Space
Access to information system i.e. laptop</td></tr>
<tr><td>Information Systems Outage</td><td colspan="2">Service Functions Impacted</td><td colspan="3">Likely Consequences</td><td colspan="3">Readiness & Response Strategies</td></tr>
<tr><td>• Connectivity
• Cyber Attack</td><td colspan="2">• Patient Cares. Blood results etc.
• Patient Information & Flow
• Bookings
• Admissions & Discharges</td><td colspan="3">• Loss of administration systems (partially/full)
• Loss of Clinical Data and results impacting of clinical decision making
• Inability to maintain patient documentation, registering referrals and booking system</td><td colspan="3">• Paper based
• Manual copy of telephone book
• Manual copy data entry
• Manual policies and guidelines</td></tr>
</table>

Loss of one or more key suppliers	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Fleetwise	• Patients Care	• Patients harm	• Prioritise resource • Patient to attend outpatients for treatment
Natural Disaster/Health Emergency	**Service Functions Impacted**	**Likely Consequences**	**Readiness & Response Strategies**
Pandemic	• Patient cares • Clinical area above capacity • Infection control	• Patient harm due to lack of staffing to deliver care • Customer dissatisfaction • Reputational harm • Interruption to long term planned cares • Increased risk of infection	• Staffing variance response plans • Follow essential care guidelines
Civil/Natural Disaster	• Patient cares	• Patient harm due to lack of staffing to deliver care • Customer dissatisfaction • Reputational harm • Interruption to long term planned cares	• Staffing variance response plans • Follow essential care guidelines
MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans			

Child Health – External Disruptive Event – Outpatients – Outreach Clinics

Outpatients • Outreach Clinics	Alternate Care Site Identified:	
	Service	Alternate Care Site
	Outreach Clinics	

Critical Functions					**Functions Critical Over Time**					
Service/Business Unit	Function/Output	Recover time objectives Within (Hours)			Service/Business Unit	Function/Output	Recover time objectives Within (Hours)			
		2	4	8			2	4	7	28
						Outreach				

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	Cancellation of service Space & resources made available		
Water	Cancellation of service Space & resources made available		
Gas	Cancellation of service Space & resources made available		

Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
• Connectivity • Cyber Attack	• Patient Cares. Blood results etc. • Patient Information & Flow • Bookings • Admissions & Discharges	• Loss of administration systems (partially/full) • Loss of Clinical Data and results impacting of clinical decision making • Inability to maintain patient documentation, registering referrals and booking system	• Paper based • Manual copy of telephone book • Manual copy data entry • Manual policies and guidelines

Loss of one or more key suppliers	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Fleetwise	• Patients Care	• Customer dissatisfaction • Reputational harm	• Likely cancellation of service • space & resources made available
MedLab	• Patients Care	• Patient harm • Customer dissatisfaction • Reputational harm	• Likely cancellation of service
Natural Disaster/Health Emergency	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Pandemic Civil/Natural Disaster	MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans		

Child Health – External Disruptive Event

<table>
<tr><td colspan="6">Outpatients
• Visiting Specialists</td><td colspan="6">Alternate Care Site Identified:
Service | Alternate Care Site
Visiting Specialists |</td></tr>
<tr><td colspan="6">Critical Functions</td><td colspan="6">Functions Critical Over Time</td></tr>
<tr><td rowspan="3">Service/Business Unit</td><td rowspan="3">Function/Output</td><td colspan="3">Recover time objectives</td><td></td><td rowspan="3">Service/Business Unit</td><td rowspan="3">Function/Output</td><td colspan="4">Recover time objectives</td></tr>
<tr><td colspan="3">Within (Hours)</td><td></td><td colspan="4">Within (Hours)</td></tr>
<tr><td>2</td><td>4</td><td>8</td><td></td><td>2</td><td>4</td><td>7</td><td>28</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>Visiting Specialists</td><td></td><td></td><td></td><td></td></tr>
</table>

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	Cancellation of service Space & resources made available		
Water	Cancellation of service Space & resources made available		
Gas	Cancellation of service Space & resources made available		
Information Systems Outage	**Service Functions Impacted**	**Likely Consequences**	**Readiness & Response Strategies**
• Connectivity • Cyber Attack	• Patient Cares. Blood results etc. • Patient Information & Flow • Bookings • Admissions & Discharges	• Loss of administration systems (partially/full) • Loss of Clinical Data and results impacting of clinical decision making • Inability to maintain patient documentation, registering referrals and booking system	• Paper based • Manual copy of telephone book • Manual copy data entry • Manual policies and guidelines

Loss of one or more key suppliers	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
MedLab	• Patients Care	• Patient harm • Customer dissatisfaction • Reputational harm	• Likely cancellation of service
Allied Laundry	• Patient cares • Infection control	• Patient harm • Increased risk of Infection	• Supply rationing • Prioritise resource
Hotel Services (Soft FM)	• Patient care • Cleaning Services • Food services	• Patient Harm • Increased risk of infection	• Supply rationing • Prioritise resource
Facilities Management (Hard FM)	• Patient cares • Building maintenance • Bio medical	• Patient harm • Potential lack of medical equipment due breakdowns	• Ensure medical equipment maintenance is kept up to date.
Natural Disaster/Health Emergency	**Service Functions Impacted**	**Likely Consequences**	**Readiness & Response Strategies**
Pandemic Civil/Natural Disaster	MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans		

Child Health – External Disruptive Event – Community – Continence Programme

<table>
<tr><td colspan="5" rowspan="2">Community
• Continence Programme</td><td colspan="6">Alternate Care Site Identified:</td></tr>
<tr><td colspan="2">Service</td><td colspan="4">Alternate Care Site</td></tr>
<tr><td colspan="5"></td><td colspan="2">Continence</td><td colspan="4"></td></tr>
<tr><td colspan="5">Critical Functions</td><td colspan="6">Functions Critical Over Time</td></tr>
<tr><td rowspan="3">Service/Business Unit</td><td rowspan="3">Function/Output</td><td colspan="3">Recover time objectives</td><td rowspan="3">Service/Business Unit</td><td rowspan="3">Function/Output</td><td colspan="4">Recover time objectives</td></tr>
<tr><td colspan="3">Within (Hours)</td><td colspan="4">Within (Hours)</td></tr>
<tr><td>2</td><td>4</td><td>8</td><td>2</td><td>4</td><td>7</td><td>28</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td>Continence</td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="11">External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:
• Lifelines / Infrastructure failure
• Information Systems outage
• Loss of one or more key suppliers
• Natural Disaster/Health Emergency</td></tr>
<tr><td>Loss of Lifelines/Infrastructure</td><td>Service Functions Impacted</td><td>Likely Consequences</td><td>Readiness & Response Strategies</td></tr>
<tr><td>Electrical Power</td><td colspan="3">Cancellation of service
Space & resources made available</td></tr>
<tr><td>Water</td><td colspan="3">Cancellation of service
Space & resources made available</td></tr>
<tr><td>Gas</td><td colspan="3">Cancellation of service
Space & resources made available</td></tr>
<tr><td>Information Systems Outage</td><td>Service Functions Impacted</td><td>Likely Consequences</td><td>Readiness & Response Strategies</td></tr>
<tr><td>Connectivity
Cyber Attack</td><td>• Communication systems
• Information systems & support
• Patient Information & Flow Information system</td><td>• Loss of administration systems (partially/full)
• Loss of Clinical Data and results impacting of clinical decision making
• Patient harm
• Delays in admissions and discharges</td><td>• Paper based
• Manual copy of telephone book
• Manual copy data entry
• Manual policies and guidelines</td></tr>
<tr><td>Loss of one or more key suppliers</td><td>Service Functions Impacted</td><td>Likely Consequences</td><td>Readiness & Response Strategies</td></tr>
<tr><td>USL products</td><td>• Patient care</td><td>• Patient discomfort
• Customer dissatisfaction</td><td>• Source alternative continence supplies</td></tr>
<tr><td>Fleet wise</td><td>• Patient care</td><td>• Customer dissatisfaction
• Reputational harm</td><td>• Cancellation of service space & resources made available</td></tr>
<tr><td>Natural Disaster/Health Emergency</td><td>Service Functions Impacted</td><td>Likely Consequences</td><td>Readiness & Response Strategies</td></tr>
<tr><td>Pandemic
Civil/Natural Disaster</td><td colspan="3">MDHB Strategic Business Continuity Plan enacted
Individual Service enact Internal Disruption Plans</td></tr>
</table>

Child Health – External Disruptive Event – Community – Child Development Service

<table>
<tr><td colspan="5">Community
• Child Development Service</td><td colspan="6">Alternate Care Site Identified:</td></tr>
<tr><td colspan="5"></td><td colspan="2">Service</td><td colspan="4">Alternate Care Site</td></tr>
<tr><td colspan="5"></td><td colspan="2">Child Development Service</td><td colspan="4"></td></tr>
<tr><td colspan="5">Critical Functions</td><td colspan="6">Functions Critical Over Time</td></tr>
<tr><td rowspan="3">Service/Business Unit</td><td rowspan="3">Function/Output</td><td colspan="3">Recover time objectives</td><td rowspan="3">Service/Business Unit</td><td rowspan="3">Function/Output</td><td colspan="4">Recover time objectives</td></tr>
<tr><td colspan="3">Within (Hours)</td><td colspan="4">Within (Hours)</td></tr>
<tr><td>2</td><td>4</td><td>8</td><td>2</td><td>4</td><td>7</td><td>28</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td>Child Development Service</td><td></td><td></td><td></td><td></td></tr>
</table>

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	Cancellation of service Space & resources made available		
Water	Cancellation of service Space & resources made available		
Gas	Cancellation of service Space & resources made available		
Information Systems Outage	**Service Functions Impacted**	**Likely Consequences**	**Readiness & Response Strategies**
Connectivity Cyber Attack	• Patient Cares • WebPas/Clinical Portal Patient Information • Bookings • Discharges	• Loss of administration systems (partially/full) • Inability to access Clinical Data and results • Bookings/Discharges/Assessments • Data breach	• Paper based files
Loss of one or more key suppliers	**Service Functions Impacted**	**Likely Consequences**	**Readiness & Response Strategies**
Allied Laundry	• Minimal Service Impact		
Enable New Zealand	• Patient Access to Equipment	• Potential safety issues for children and families	• Staff to work with families re alternative solution
Natural Disaster/Health Emergency	**Service Functions Impacted**	**Likely Consequences**	**Readiness & Response Strategies**
Pandemic Civil/Natural Disaster	MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans		

Child Health – External Disruptive Event – Community – Child Health Team

<table>
<tr><td colspan="5" rowspan="3">Community
• Community Child Health Team</td><td colspan="7">Alternate Care Site Identified:</td></tr>
<tr><td colspan="3">Service</td><td colspan="4">Alternate Care Site</td></tr>
<tr><td colspan="3">Community Child Health Team</td><td colspan="4"></td></tr>
<tr><td colspan="5">Critical Functions</td><td colspan="7">Functions Critical Over Time</td></tr>
<tr><td rowspan="3">Service/Business Unit</td><td rowspan="3">Function/Output</td><td colspan="3">Recover time objectives</td><td rowspan="3">Service/Business Unit</td><td rowspan="3" colspan="2">Function/Output</td><td colspan="4">Recover time objectives</td></tr>
<tr><td colspan="3">Within (Hours)</td><td colspan="4">Within (Hours)</td></tr>
<tr><td>2</td><td>4</td><td>8</td><td>2</td><td>4</td><td>7</td><td>28</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td colspan="2">Community Child Health Team</td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="12">External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:
• Lifelines / Infrastructure failure
• Information Systems outage
• Loss of one or more key suppliers
• Natural Disaster/Health Emergency</td></tr>
<tr><td colspan="2">Loss of Lifelines/Infrastructure</td><td colspan="3">Service Functions Impacted</td><td colspan="3">Likely Consequences</td><td colspan="4">Readiness & Response Strategies</td></tr>
<tr><td colspan="2">Electrical Power</td><td colspan="3">• Patient management system</td><td colspan="3">• Inability to maintain patient documentation, registering</td><td colspan="4">• Revert to paper based system</td></tr>
<tr><td colspan="2">Water</td><td colspan="3">• Infection control precautions</td><td colspan="3">• Inability to adequately maintain infection control precautions - handwashing</td><td colspan="4"></td></tr>
<tr><td colspan="2">Gas</td><td colspan="3">• Nil Impact</td><td colspan="3"></td><td colspan="4"></td></tr>
<tr><td colspan="2">Information Systems Outage</td><td colspan="3">Service Functions Impacted</td><td colspan="3">Likely Consequences</td><td colspan="4">Readiness & Response Strategies</td></tr>
<tr><td colspan="2">Connectivity
Cyber Attack</td><td colspan="3">• Patient Management System</td><td colspan="3">• Loss of administration systems (partially/full)
• Inability to access Clinical Data and results
• Bookings/Discharges/Assessments
• Data breach</td><td colspan="4">• Paper based files</td></tr>
<tr><td colspan="2">Loss of one or more key suppliers</td><td colspan="3">Service Functions Impacted</td><td colspan="3">Likely Consequences</td><td colspan="4">Readiness & Response Strategies</td></tr>
<tr><td colspan="2">Allied Laundry</td><td colspan="3">• Minimal Service Impact</td><td colspan="3"></td><td colspan="4"></td></tr>
<tr><td colspan="2">Enable New Zealand</td><td colspan="3">• Patient Access to Equipment</td><td colspan="3">• Potential safety issues for children and families</td><td colspan="4">• Staff to work with families re alternative solution</td></tr>
<tr><td colspan="2">Natural Disaster/Health Emergency</td><td colspan="3">Service Functions Impacted</td><td colspan="3">Likely Consequences</td><td colspan="4">Readiness & Response Strategies</td></tr>
<tr><td colspan="2">Pandemic
Civil/Natural Disaster</td><td colspan="10">MDHB Strategic Business Continuity Plan enacted
Individual Service enact Internal Disruption Plans</td></tr>
</table>

Child Health – External Disruptive Event – Community – Gateway Programme

<table>
<tr><td colspan="5">Community
• Gateway programme</td><td colspan="6">Alternate Care Site Identified:</td></tr>
<tr><td colspan="5"></td><td colspan="2">Service</td><td colspan="4">Alternate Care Site</td></tr>
<tr><td colspan="5"></td><td colspan="2">Gateway programme</td><td colspan="4"></td></tr>
<tr><td colspan="5">Critical Functions</td><td colspan="6">Functions Critical Over Time</td></tr>
<tr><td rowspan="3">Service/Business Unit</td><td rowspan="3">Function/Output</td><td colspan="3">Recover time objectives</td><td rowspan="3">Service/Business Unit</td><td rowspan="3">Function/Output</td><td colspan="4">Recover time objectives</td></tr>
<tr><td colspan="3">Within (Hours)</td><td colspan="4">Within (Hours)</td></tr>
<tr><td>2</td><td>4</td><td>8</td><td>2</td><td>4</td><td>7</td><td>28</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td>Gateway Programme</td><td></td><td></td><td></td><td></td></tr>
</table>

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	Patient management system	Inability to maintain patient documentation, registering	Revert to paper based system
Water	Infection control precautions	Inability to adequately maintain infection control precautions - hand washing	Hand sanitizer
Gas	Nil Impact		

Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Connectivity Cyber Attack	• Patient Management System	• Inability to maintain patient documentation, registering referrals and booking system	• Revert to paper based system

Loss of one or more key suppliers	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
	• Clinical Service Delivery	• Inability to provide services and health and/or social support	• Prioritize resource

Industrial Action	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
	• Clinical service delivery	• Inability to deliver clinics	• MDHB strategic planning

CHILD HEALTH

Service Planning Recovery in Levels

The following tables identify individual units/departments:

- Response Level and Recovery Strategies

Hospital Framework Response Level	Service Name – Paediatrics	Redeployment % time away
	• Normal service delivery • Face to Face clinics • Virtual clinics where appropriate	100% BAU
	• Acute paediatric & neonatal services continue as normal • Prioritisation of clinics • Virtual clinics for as many patients as possible • Face to Face clinics for urgent only • NP's to support clinic	60% NP's redeployed from Community Child Health to support
	• Split Teams • Acute paediatric & neonatal services continue as normal • Urgent clinics only face to face only if essential • NP's to support follow ups	NP's redeployed from Community Child Health to support
	• Split Teams • Acute paediatric & neonatal services only • Urgent acute clinics only (ideally virtual, face to face where critical) all other clinics cancelled	NP's redeployed from Community Child Health to support

Hospital Framework Response Level	Service Name – Child Health Community Team	Redeployment % time away
	• Re implement delivery of clinics at all sites and resume BAU	All BAU
	• Face to face appointments with screening questions • No appointment if unwell/+ve screening questions • Home visits/ school visits if required • Provide paediatric nursing cover for main testing station for 2 hr block at end of day as required • Re implement NP support to GPT's to manage acute paediatric presentations • Continue to utilise Webinars and Zoom capabilities where appropriate	One Nurse and Social Worker on the phones during an event other team members will be deployed appropriately
	• Can be in office/home – with measures to ensure social distancing • Continue to provide paediatric nursing cover for main testing station • Work bubbles • Zoom • Face to face assessments and interventions for acute reviews to prevent adverse health and social outcomes • Professional development & service improvement projects	– 40 % testing – 70% testing – 40% – 60 % Maintain one Nurse and Social Worker on the phones during an "event" other team members will be deployed appropriately
	• Staff redeployed and/or staff to work from home if able. Staff may work from 200 Broadway or the hospital in order to be able to access clinical systems and have an appropriate space to maintain clinical work. • Provide paediatric nursing cover for main testing station • Zoom • Face to face assessments and interventions to prevent adverse health and social outcomes only	– 60 % testing – 70 % testing – 50% – 100 % Maintain one Nurse and Social Worker on the phones during an "event" other team members will be deployed appropriately

Hospital Framework Response Level	Service Name - Child Development Service	Redeployment % time away
	• BAU • Face to face seminars	
	• Face to face appointments with screening questions • No appointment if unwell/+ve questions • Home visits/ school visits • Webinars for seminars	
	• Can be in office/home – with social distancing • Work bubbles • Zoom and Telehealth • Face to face assessments and interventions to prevent adverse health and disability outcomes only • Professional development & service improvement • Refinement of Telehealth processes	
	• All staff working from home and/ or redeployed • Zoom and Telehealth • Face to face assessments and interventions to prevent adverse health and disability outcomes only	

Hospital Framework Response Level	Service Name - Neonates	Redeployment % time away
(Green)	**Follow COVID inpatients pathway** • Screening of parents • Consider returning parents to café for meals • Re open parent tearoom/lounge • Hospital wide education • Return to business as usual with continuance of neonatal assessment room	
(Yellow)	**Follow COVID inpatients pathway** • Screening of parents • Mahi Tahi meals for parents • Hot drinks and extra food for parents in foyer of NNU • Visiting policy as per level two directives • NNU assessment room - consultation and discussion to move assessment room process closer to unit • Group staff education reduced numbers and social distancing	Category 3 staff working from home or non-patient facing role Category 2 staff work in green area Managing nursing skill mix/transfers from theatre if two or more Category 2 staff are rostered together Medical staff continue in two teams to ensure timely management in-between children's and NNU Medical staff wearing scrubs
(Orange)	**Follow COVID inpatients pathway** • Screening of parents • Mahi Tahi meals for parents • Hot drinks and extra food for parents in foyer of NNU • Visiting policy as per level three directives • Critical staff education only	Category 3 staff redeployed Category 2 staff Green zone only Managing nursing skill mix/transfers from theatre if two or more Category 2 staff are rostered together Medical staff continue in two teams to ensure timely management in-between children's and NNU Medical staff wearing scrubs
(Red)	**Follow COVID inpatients pathway** • Screening of parents • Mahi Tahi meals for parents • Hot drinks and extra food for parents in foyer of NNU • Visiting policy as per level four directives • Wall in foyer to provide extra ante-room • No staff education	Category 2 staff Green zone only Medical staff in Alpha/Bravo teams Medical staff wearing scrubs

- COVID Pathways apply across all levels
- Parental screening to continue across all levels
- Suggestions for NNU Visiting
- NZ Alert Level 4 - Mother can visit.
- NZ Alert Level 3 - Mother or Father/parent/main support person can visit, one person in unit at a time, must be from the same bubble, no children
- NZ Alert Level 2 - Mother and Father/parent/main support person can visit together, must be from the same bubble, no children

Hospital Framework Response Level	Service Name – Children's Ward	Redeployment % time away
(green)	**Follow COVID inpatients pathway, reducing the red zone within the children's ward** • Screening of parents • Consider returning parents to café for meals • Hospital wide education	
(yellow)	**Follow COVID inpatients pathway, reducing the allocated red zone area** • Screening of parents • Mahi Tahi meals for parents • Visiting policy as per level two directives • Essential staff education only	Category 4 staff working from home if possible (policies procedures etc) Category 3 staff redeployed working from home if possible Category 2 staff redeployed if COVID present ideally within cluster to Neonates or maternity
(orange)	**Follow COVID inpatients pathway with red and green zones** • Screening of parents • Mahi Tahi meals for parents Visiting policy as per level three directives • CAU used as red assessment area • Education if critical on one to one	Category 4 staff working from home if possible (policies procedures etc) Category 3 staff redeployed working from home if possible Category 2 staff redeployed if COVId present, ideally within cluster to Neonates or maternity
(red)	**Follow COVID inpatients pathway with red and green zones** Using PPE	

Hospital Framework Response Level	Service Name – P2A	Redeployment % time away
	• All staff provide service delivery • Face to face appointments with screening questions • Continue to utilise phone contacts	
	• All staff to provide service delivery • Face to face appointments with screening questions • Continue to utilise phone contacts • Reinstate office space	40% internally or externally as workforce stream deem appropriate
	• Service on hold • All staff redeployed • CN of Paeds to take all enquires	100% internally or externally as workforce stream deem appropriate
	• Service on hold • All staff redeployed	100% internally or externally as workforce stream deem appropriate

Hospital Framework Response Level	Service Name – Children's outpatients	Redeployment % time away
	• **Homecare**: Continue providing service. Home visits with screening questions, 2 nurses to attend home visit if probable or COVID positive. Follow home visit/district nursing pathway. Continue to utilise Zoom capabilities where possible • **Procedure clinic**: Re-establish appointments • **Outpatients**: Resume service	
	• **Homecare**: Continue providing service, home visits with screening questions .Continue to utilise Zoom capabilities, 2 nurses to attend home visit if probable or COVID positive. Follow home visit/district nursing pathway • **Procedure** Clinic: review procedures to rebook non-essential appts. Continue essential procedures • **Outpatients**: Face to face appointments with screening questions. No appointment if unwell/+ve screening questions	
	• **Homecare**: Continue providing service, home visits with screening questions, Continue to utilise Zoom capabilities 2 nurses to attend home visit if probable or COVID positive. Follow home visit/district nursing pathway • **Procedure Clinic:** Only essential procedures to occur • **Outpatients**: Phone/virtual clinic consultations. Paediatricians to triage new referrals and booked appointments	50% to be utilised on children's ward
	• **Homecare**: Continue providing service with revision of frequency of home visits, utilise phone contacts. Ensure screening questions are done prior to home visits. 2 nurses to attend home visit if probable or COVID positive. Follow home visit/district nursing pathway. Continue to utilise Zoom capabilities. • **Procedure Clinic**: only essential procedures to occur. • **Outpatients**: Phone/virtual clinic consultations. Paediatricians to triage new referrals and booked appointments	50% to be utilised on children's ward

Hospital Framework Response Level	Service Name – Children's Continence Service	Redeployment % time away
	• All staff provide service delivery • Face to face appointments with screening questions • No home visits of unwell families • Continue to utilise phone contacts	
	• All staff provide service delivery • Face to face appointments with screening questions • No home visits of unwell families • Continue to utilise phone contacts	CNS 50% 100% of other RN and EN
	• Very limited service delivery by phone contact only. • No face to face contact with patients/families. • CNS and receptionist to provide a 2-3 day a week service • Other staff redeployed	CNS 80% 100% of other Rn and EN
	• Service on hold • All staff re deployed • Answer machine checked Monday-Thursday by receptionist, any enquires are directed to CN of Paeds service to assess and take appropriate action.	All staff

WOMENS HEALTH

Internal Disruptive Event

The following tables identify individual units/departments:

- Critical functions
- Alternate care site preference
- Impact analysis against threat types (Service functions impacted)
- Likely consequences (impact of delivery of services)
- Readiness and Response Strategies

Woman's Health – Internal Disruptive Event – Inpatient – Delivery Suite

<table>
<tr><td colspan="5">Inpatient
• Delivery Suite</td><td colspan="6">Alternate Care Site Identified:</td></tr>
<tr><td colspan="5"></td><td colspan="3">Service</td><td colspan="3">Alternate Care Site</td></tr>
<tr><td colspan="5"></td><td colspan="3">Delivery Suite</td><td colspan="3"></td></tr>
<tr><td colspan="5">Critical Functions</td><td colspan="6">Functions Critical Over Time</td></tr>
<tr><td rowspan="3">Service/Business Unit</td><td rowspan="3">Function/Output</td><td colspan="3">Recover time objectives</td><td rowspan="3">Service/Business Unit</td><td rowspan="3">Function/Output</td><td colspan="4">Recover time objectives</td></tr>
<tr><td colspan="3">Within (Hours)</td><td colspan="4">Within (Hours)</td></tr>
<tr><td>2</td><td>4</td><td>8</td><td>2</td><td>4</td><td>7</td><td>28</td></tr>
<tr><td>Inpatient</td><td>Delivery Suite</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="11">Internal Disruptive Event - the organisation may suffer serious internal disruption as a result of:
• Lifelines / Infrastructure failure
• Information Systems outage
• Industrial Action
• Loss of one or more key internal clinical support services</td></tr>
</table>

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	• Patient Cares • Communication systems • Information systems & support (MIYA/TRENDCARE/MCIS/NHI/ Rosters) • Ward integrity i.e Security doors • Patient Information & Flow Information system • Loss of suction • Thermostatic environment control • CTG Monitoring • Loss of cooling/heating cabinets (essential power but not UPS) • Drug Fridge (essential power but not UPS) • Patient labelling system • Lighting • Resus tables • Transport cot • IV Pumps/Syringe drivers	• Patient Harm • Inability to pull Lab / Blood / Imaging data • Inability to access Badgernet • Clinical decision making (patient history) • Security of Ward • Inability to access/insert patient data • Staff wellbeing • Access control camera inoperative • Increased risk of infection • Inability to access rosters	**Patient Cares** • Staffing to acquity • All essential Point of Care equipement to be plugged into critical power supply. • Battery back up of point of care equipment except CTG - use intermittent Doppler monitoring • Consider patient transfer, delay of inductions and cancellation of elective CS • Hand written Bradma's (patient identity bracelet / patient documentation) • Head torches (CD Locker) • Hard copy of staff rosters

	• Computers on Wheels (COWS) • Access control camera inoperative • LAMSON • Emergency assisted vacuum extraction • Bed operation		**Communication** • Runners • Pagers • Emergency Phones • Paper copy phone book (switchboard) **Security (4 points of entry / exit)** • Entry Control Officer (non-essential staff member) **Patient Information & Flow** • Critical power supply to staff station computers. • Critical Power to ADU, DS rooms • Laptop (query Wifi connectability) **Thermostatic environment control (20 degrees c norm – INDIVISUALISED FOR ROOMS)** • Skin to Skin • Hot: consider use of fans
Water	• Patient Cares • Sanitary/Sluicing • Infection Control (Staff/Patients) • Drinking water	• Patient Harm • Increased risk of infection • Staff/patient/visitor well being	• Hand wash • Soap wipes • Bottled water (Materials Management) • Purifying tablets (CD Locker) • Consider unit transfer/evacuation
Medical Gases Oxygen Nitrous Air	• Patient Cares	Patient Harm – Inability to provide respiratory support • Resus • Maternal Support • Analgesia	• Self-inflating Ambi Bag may be used to give manual breaths • Staffing to acuity • Portable gases (100% Oxygen) • Internal / External transfer

Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
As per identified in Cluster BIA page 8	• Patient Cares • Patient Information & Flow • Loss of rosters	• Loss of administration systems (partially/full) • Loss of Clinical Data and results impacting of clinical decision making • Inability to pull Lab / Blood / Imaging data • Inability to access Badgernet • Admission and discharge protocols	**Manual copy of telephone book** **Manual copy data entry** • Hand written Bradma's (patient identity bracelet / patient documentation) **Patient Information & Flow** • Critical power supply to staff station computers. • Laptop (query Wifi connect ability) • Paper copy rosters • Remote access of portal for rosters
Industrial Action	**Service Functions Impacted**	**Likely Consequences**	**Readiness & Response Strategies**
Clinical / Non Clinical	• Limited staffing resource • Patient Cares • Administration services	• Inability to deliver non-essential cares • Data entry • Administration support	• MDHB strategic planning
Loss of one or more key internal clinical support services	**Service Functions Impacted**	**Likely Consequences**	**Readiness & Response Strategies**

	• Main Theatre
	• Neonatal
	• Post Natal Ward
	• Birthing Centre
	• Medical Imaging
	• Laboratory Services
	• NZ Blood
	• Clinical supply chain
	• Pharmacy
	• Allied Health specialties
	    • Social Work
	• Hotel services (soft FM)
	    • Orderlies
	    • Cleaning
	    • Laundry
	    • Meals
	    • Security
		• Patient Harm
		• Delay in information transfer
		• Increased risk of Infection
			• MDHB strategic planning
			• Ultrasound in delivery suite

Woman's Health – Internal Disruptive Event – Inpatient - Maternity

Inpatient • Maternity	Alternate Care Site Identified:	
	Service	Alternate Care Site
	Maternity	

Critical Functions

Service/Business Unit	Function/Output	Recover time objectives Within (Hours)		
		2	4	8
Inpatient	Maternity			

Functions Critical Over Time

Service/Business Unit	Function/Output	Recover time objectives Within (Hours)			
		2	4	7	28

Internal Disruptive Event - the organization may suffer serious internal disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Industrial Action
- Loss of one or more key internal clinical support services

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	• Patient Cares • Communication systems • Information systems & support (MIYA/TRENDCARE/MCIS/NHI/ Rosters) • Ward integrity i.e Security doors • Patient Information & Flow Information system • Loss of suction • Thermostatic environment control • CTG Monitoring • Loss of cooling/heating cabinets (not on critical power?) • Drug Fridge (not on critical power?) • Patient labelling system • Lighting • Resus tables • Transport cot • IV Pumps/Syringe drivers • Computers on Wheels (COWS)	• Patient Harm • Inability to pull Lab / Blood / Imaging data • Inability to access Badgernet • Clinical decision making (patient history) • Security of Ward • Inability to access/insert patient data • Staff wellbeing • Access control camera inoperative • Increased risk of infection • Inability to access rosters	**Patient Cares** • Staffing to acuity • All essential Point of Care equipment to be plugged into critical power supply. • Battery backup of point of care equipment • Consider patient transfer • Hand written Bradma's (patient identity bracelet / patient documentation) • Head torches (CD Locker) • Hard copy of staff rosters **Communication** • Runners • Pagers • Emergency Phones • Paper copy phone book (switchboard) **Security (4 points of entry / exit)**

	• Access control camera inoperative • LAMSON • Bed operation		• Entry Control Officer (non-essential staff member) **Patient Information & Flow** • Critical power supply to staff station computers. • Critical Power to all patient rooms in MATY • Laptop (query Wifi connectability) **Thermostatic environment control (20 degrees c norm –** • Skin to Skin • Hot: consider use of fans
Water	• Patient Cares • Sanitary/Sluicing • Infection Control (Staff/Patients) • Drinking water	• Patient Harm • Increased risk of infection • Staff/patient/visitor well being	• Handwash • Soap wipes • Bottled water (Materials Management) • Purifying tablets (CD Locker) • Consider unit transfer/evacuation
Medical Gases	• Patient Cares	**Patient Harm – Inability to provide respiratory support** • Resus • Maternal Support	• Self-inflating Ambi Bag may be used to give manual breaths • Staffing to acuity • Portable gases (100% Oxygen) • Internal / External transfer
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
As per identified in Cluster BIA page 8	• Patient Cares • Patient Information & Flow • Loss of rosters	• Loss of administration systems (partially/full) • Loss of Clinical Data and results impacting of clinical decision making • Inability to pull Lab / Blood / Imaging data • Inability to access Badgernet • Admission and discharge protocols	**Manual copy of telephone book** **Manual copy data entry** • Hand written Bradma's (patient identity bracelet / patient documentation) **Patient Information & Flow** • Critical power supply to staff station computers. • Laptop (query Wifi connectability)

			• Paper copy rosters
Industrial Action	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Clinical / Non Clinical	• Limited staffing resource • Patient Cares • Administration services	• Inability to deliver non-essential cares • Data entry • Administration support	• MDHB strategic planning
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
	• Main Theatre • Neonatal • Post Natal Ward • Birthing Centre • Medical Imaging • Labortory Services • NZ Blood • Clinical supply chain • Pharmacy **Allied Health specialties** • Social Work **Hotel services (soft FM)** • Orderlies • Cleaning • Laundry • Meals • Security	• Patient Harm • Delay in information transfer • Increased risk of Infection	• MDHB strategic planning

Women's Health – Internal Disruptive Event – Inpatient - Antenatal

Inpatient	Alternate Care Site Identified:	
• Antenatal Clinic	Service	Alternate Care Site
	Antenatal Clinic	

Critical Functions					**Functions Critical Over Time**					
Service/Business Unit	Function/Output	Recover time objectives Within (Hours)			Service/Business Unit	Function/Output	Recover time objectives Within (Hours)			
		2	4	8			2	4	7	28
						Antenatal Clinic				

Internal Disruptive Event - the organisation may suffer serious internal disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Industrial Action
- Loss of one or more key internal clinical support services

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	• Patient Cares • Communication systems • Information systems & support (MIYA/TRENDCARE/MCIS/NHI/ Rosters) • Ward integrity i.e Security doors • Patient Information & Flow Information system • Loss of suction • Thermostatic environment control • CTG Monitoring • Loss of cooling/heating cabinets (not on critical power?) • Drug Fridge (not on critical power?) • Patient labelling system • Lighting • Resus tables • Transport cot • IV Pumps/Syringe drivers	• Patient Harm • Inability to pull Lab / Blood / Imaging data • Inability to access Badgernet • Clinical decision making (patient history) • Security of Ward • Inability to access/insert patient data • Staff wellbeing • Access control camera inoperative • Increased risk of infection • Inability to access roster	**Patient Cares** • Staffing to acuity • All essential Point of Care equipment to be plugged into critical power supply. • Battery backup of point of care equipment • Consider patient transfer • Hand written Bradma's (patient identity bracelet / patient documentation) • Head torches (CD Locker) • Hard copy of staff rosters **Communication** • Runners • Pagers • Emergency Phones • Paper copy phone book (switchboard)

	• Computers on Wheels (COWS) • Access control camera inoperative • LAMSON • Bed operation		**Security (4 points of entry / exit)** • Entry Control Officer (non-essential staff member) **Patient Information & Flow** • Critical power supply to staff station computers. • Critical Power to ADU, DS rooms • Laptop (query Wifi connect ability) **Thermostatic environment control (20 degrees c norm –** • Skin to Skin • Hot: consider use of fans
Water	• Patient Cares • Sanitary/Sluicing • Infection Control (Staff/Patients) • Drinking water	• Patient Harm • Increased risk of infection • Staff/patient/visitor well being	• Hand wash • Soap wipes • Bottled water (Materials Management) • Purifying tablets (CD Locker) • Consider unit transfer/evacuation
Medical Gases	• Patient Cares	• Patient Harm – Inability to provide respiratory support • Resus • Maternal Support • Analgesia	• Self-inflating Ambi Bag may be used to give manual breaths • Staffing to acuity • Portable gases (100% Oxygen) • Internal / External transfer
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
As per identified in Cluster BIA page 8	• Patient Cares • Patient Information & Flow • Loss of bookings	• Loss of administration systems (partially/full) • Loss of Clinical Data and results impacting of clinical decision making • Inability to pull Lab / Blood / Imaging data • Inability to access Badgernet • Admission and discharge protocols	• Manual copy of telephone book • Manual copy data entry • Hand written Bradma's (patient identity bracelet / patient documentation) • Patient Information & Flow • Critical power supply to staff station computers. • Laptop (query Wifi connect ability)

			• Paper copy rosters
Industrial Action	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Clinical / Non Clinical	• Limited staffing resource • Patient Cares • Administration services	• Inability to deliver non-essential cares • Data entry • Administration support	• MDHB strategic planning
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
	• Main Theatre • Neonatal • Post Natal Ward • Birthing Centre • Medical Imaging • Laboratory Services • NZ Blood • Clinical supply chain • Pharmacy **Allied Health specialties** • Social Work **Hotel services (soft FM)** • Orderlies • Cleaning • Laundry • Meals • Security	• Patient Harm • Delay in information transfer • Increased risk of Infection	• MDHB strategic planning • Ultrasound in delivery suite

Women's Health – Internal Disruptive Event - Outpatients – Gynaecology Clinic

Outpatients	Alternate Care Site Identified:	
	Service	Alternate Care Site
• Gynaecology Clinic - Coloscopy - Urodynamics - Gynaecology Day Unit	Gynaecology Clinic - Coloscopy - Urodynamics - Gynaecology Day Unit	

Critical Functions

Service/Business Unit	Function/Output	Recover time objectives Within (Hours)		
		2	4	8

Functions Critical Over Time

Service/Business Unit	Function/Output	Recover time objectives Within (Hours)			
		2	4	7	28
	Gynaecology Clinic				
	Coloscopy				
	Urodynamics				
	Gynaecology Day Unit				

Internal Disruptive Event - the organisation may suffer serious internal disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Industrial Action
- Loss of one or more key internal clinical support services

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	• Loss of Clinics insitu • Day procedures	• Patient harm • Customer dissatisfaction • Reputational harm • Interruption to long term planned cares	• Relocation • Essential power
Water	• Patient Cares • Sanitary • Infection Control (Staff/Patients)	• Patient Harm • Increased risk of infection • Staff/patient/visitor well being	• Handwash • Bottled water • Purifying tablets (CD Locker)
Medical Gases	Piped Gas Only Use of portable Medical Gas trolley required (not on site)		
Information Systems Outage	**Service Functions Impacted**	**Likely Consequences**	**Readiness & Response Strategies**
As per identified in Cluster BIA page 8	• Patient Cares. Blood results etc. • Patient Information & Flow	• Loss of administration systems (partially/full) • Loss of Clinical Data and results impacting of clinical decision making	• Paper based

	• Bookings • Administration & Discharges		
Industrial Action	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Clinical / Non Clinical	• Limited staffing resource • Patient Cares • Administration services	• Inability to deliver non-essential cares • Data entry • Administration support	• MDHB strategic planning
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
	• Medical Imaging • Laboratory Services • Clinical supply chain • Pharmacy **Allied Health specialties** • Social Work **Hotel services (soft FM)** • Orderlies • Cleaning • Laundry	• Patient Harm • Delays • Infection	

Women's Health – Internal Disruptive Event – Community Horowhenua Maternity

<table>
<tr><td colspan="5" rowspan="2">Community
• Horowhenua Maternity (Kohungahunga)
(Consider the impact on the community if not functioning)</td><td colspan="5">Alternate Care Site Identified:</td></tr>
<tr><td colspan="2">Service</td><td colspan="3">Alternate Care Site</td></tr>
<tr><td colspan="5"></td><td colspan="2">Horowhenua Maternity</td><td colspan="3"></td></tr>
<tr><td colspan="5">Critical Functions</td><td colspan="5">Functions Critical Over Time</td></tr>
<tr><td rowspan="3">Service/Business Unit</td><td rowspan="3">Function/Output</td><td colspan="3">Recover time objectives</td><td rowspan="3">Service/Business Unit</td><td rowspan="3">Function/Output</td><td colspan="3">Recover time objectives</td></tr>
<tr><td colspan="3">Within (Hours)</td><td colspan="3">Within (Hours)</td></tr>
<tr><td>2</td><td>4</td><td>8</td><td>2</td><td>4</td><td>8</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td>Horowhenua Maternity</td><td></td><td></td><td></td></tr>
</table>

Internal Disruptive Event - the organisation may suffer serious internal disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Industrial Action
- Loss of one or more key internal clinical support services

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	• Patient Cares • Communication systems • Information systems & support (MCIS/NHI/ Rosters) • Ward integrity i.e Security doors • Thermostatic environment control • CTG Monitoring • Loss of cooling/heating • Drug Fridge • Patient labelling system • Lighting • Resus tables • Computers on Wheels (COWS) • Access control camera inoperative • Blood sugar machine • Bed operation	• Patient Harm • Inability to pull Lab / Blood / Imaging data • Inability to access Badgernet • Clinical decision making (patient history) • Security of Ward • Inability to access/insert patient data • Staff wellbeing • Access control camera inoperative • Increased risk of infection • Inability to access rosters	**Patient Cares** • Staffing to acuity • All essential Point of Care equipment to be plugged into critical power supply. • Battery backup of point of care equipment • Consider patient transfer • Hand written Bradma's (patient identity bracelet / patient documentation) • Head torches (CD Locker) • Hard copy of staff rosters **Communication** • Runners • Pagers • Handheld radio • Paper copy phone book **Security (2 points of entry / exit)**

			• Entry Control Officer (non essential staff member) **Patient Information & Flow** • Critical power supply to staff station computers. • Laptop (query Wifi connectability) **Thermostatic environment control (20 degrees c norm – INDIVISUALISED FOR ROOMS)** • Skin to Skin • Hot: consider use of fans
Water	• Patient Cares • Sanitary/Sluicing • Infection Control (Staff/Patients) • Drinking water	• Patient Harm • Increased risk of infection • Staff/patient/visitor well being	• Handwash • Soap wipes • Bottled water (Materials Management) • Purifying tablets (CD Locker) • Consider unit transfer/evacuation
Medical Gases (Portable Gas only)	• Patient Cares	Patient Harm – Inability to provide respiratory support • Resus • Maternal Support • Analgesia	• Self-inflating Ambi Bag may be used to give manual breaths • Staffing to acuity • Portable gases (100% Oxygen) • Internal / External transfer
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
As per identified in Cluster BIA page 8	• Patient Cares • Patient Information & Flow • Loss of rosters	• Loss of administration systems (partially/full) • Loss of Clinical Data and results impacting of clinical decision making • Inability to pull Lab / Blood / Imaging data • Inability to access Badgernet • Admission and discharge protocols	**Manual copy of telephone book** **Manual copy data entry** • Hand written Bradma's (patient identity bracelet / patient documentation) **Patient Information & Flow** • Critical power supply to staff station computers. • Laptop (query Wifi connect ability) • Paper copy rosters **Patients carry own notes**
Industrial Action	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Clinical / Non Clinical	• Limited staffing resource • Patient Cares	• Inability to deliver non-essential cares • Data entry	• MDHB strategic planning

	• Administration services	• Administration support	
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
	• Birthing Centre • Medical Imaging • Laboratory Services • Clinical supply chain • Pharmacy **Allied Health specialties** • Social Work **Hotel services (soft FM)** • Orderlies • Cleaning • Laundry • Meals • Security	• Patient Harm • Delay in information transfer • Increased risk of Infection	• Ultrasound capability on site (Broadway)

Women's Health – Internal Disruptive Event – Te Papaieoa Maternity unit

<table>
<tr><td colspan="5" rowspan="4">Primary Birthing Unit</td><td colspan="5">Alternate Care Site Identified:</td></tr>
<tr><td colspan="2">Service</td><td colspan="3">Alternate Care Site</td></tr>
<tr><td colspan="2">Palmerston North Birthing Suite</td><td colspan="3"></td></tr>
<tr><td colspan="2"></td><td colspan="3"></td></tr>
<tr><td colspan="5">Critical Functions</td><td colspan="5">Functions Critical Over Time</td></tr>
<tr><td rowspan="3">Service/Business Unit</td><td rowspan="3">Function/Output</td><td colspan="3">Recover time objectives</td><td rowspan="3">Service/Business Unit</td><td rowspan="3">Function/Output</td><td colspan="3">Recover time objectives</td></tr>
<tr><td colspan="3">Within (Hours)</td><td colspan="3">Within (Hours)</td></tr>
<tr><td>2</td><td>4</td><td>8</td><td>2</td><td>4</td><td>7</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td>Primary Birthing unit</td><td></td><td></td><td></td></tr>
</table>

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:
- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	• Patient Cares • Communication systems • Information systems & support (MIYA/TRENDCARE/MCIS/NHI/ Rosters) • Ward integrity i.e Security doors • Patient Information & Flow Information system • Loss of suction • Thermostatic environment control • CTG Monitoring • Patient labelling system • Lighting • Resus tables • IV Pumps/Syringe drivers • Computers on Wheels (COWS) • Access control camera inoperative • Bed operation	• Patient Harm • Inability to pull Lab / Blood / Imaging data • Inability to access Badgernet • Clinical decision making (patient history) • Security of Ward • Inability to access/insert patient data • Staff wellbeing • Access control camera inoperative • Increased risk of infection • Inability to access rosters	**Patient Cares** • Staffing to acuity • All essential Point of Care equipment to be plugged into critical power supply. • Battery backup of point of care equipment • Consider patient transfer • Hand written Bradma's (patient identity bracelet / patient documentation) • Head torches (CD Locker) • Hard copy of staff rosters **Communication** • Runners • Pagers • Emergency Phones • Paper copy phone book (switchboard) **Security (4 points of entry / exit)**

			• Entry Control Officer (non-essential staff member) • Patient Information & Flow • Critical power supply to staff station computers. • Laptop (query Wifi connect ability) **Thermostatic environment control (20 degrees c norm – INDIVISUALISED FOR ROOMS)** • Skin to Skin • Hot: consider use of fans
Water	• Patient Cares • Sanitary/Sluicing • Infection Control (Staff/Patients) • Drinking water	• Patient Harm • Increased risk of infection • Staff/patient/visitor well being	• Hand wash • Soap wipes • Bottled water (Materials Management) • Purifying tablets (CD Locker) • Consider unit transfer/evacuation
Gas	•	•	•
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Connectivity Cyber Attack	• Patient Cares • Patient Information & Flow • Loss of rosters	• Loss of administration systems (partially/full) • Loss of Clinical Data and results impacting of clinical decision making • Inability to pull Lab / Blood / Imaging data • Inability to access Badgernet • Admission and discharge protocols	• Manual copy of telephone book • Manual copy data entry • Hand written Bradma's (patient identity bracelet / patient documentation) • Patient Information & Flow • Critical power supply to staff station computers. • Laptop (query Wifi connect ability) • Paper copy rosters
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
	•	•	•
Natural Disaster/health Emergency	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
	MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans		

Women's Health – Internal Disruptive Event – Community - Midwife – double check on BCP it refers to external

Community	Alternate Care Site Identified:	
• Midwife Palmerston North • Midwife Feilding	Service	Alternate care site
	Midwife Palmerston North Midwife Feilding	

Critical Functions

Service/Business Unit	Function/Output	Recover time objectives Within (Hours)		
		2	4	8

Functions Critical Over Time

Service/Business Unit	Function/Output	Recover time objectives Within (Hours)		
		2	4	7
	Midwife Palmerston North			
	Midwife Feilding			

Internal Disruptive Event - the organisation may suffer serious internal disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Industrial Action
- Loss of one or more key internal clinical support services

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power			
Water			
Medical Gases			
Information Systems Outage	**Service Functions Impacted**	**Likely Consequences**	**Readiness & Response Strategies**
As per identified in Cluster BIA page 8	• Patient Cares. Blood results etc. • Patient Information & Flow • Bookings • Admissions & Discharges	• Loss of administration systems (partially/full) • Loss of Clinical Data and results impacting of clinical decision making • Inability to maintain patient documentation, registering referrals and booking system	• Paper based • Manual copy of telephone book • Manual copy data entry • Manual policies and guidelines
Industrial Action	**Service Functions Impacted**	**Likely Consequences**	**Readiness & Response Strategies**
Clinical / Non Clinical	• Limited staffing resource • Patient Cares • Administration services	• Inability to deliver non-essential cares • Data entry • Administration support	• MDHB strategic planning
Loss of one or more key internal clinical support services	**Service Functions Impacted**	**Likely Consequences**	**Readiness & Response Strategies**

	• Fleet Wise • Medical Imaging • Laboratory Services • Clinical supply chain	• Patient Harm • Delays in care • Customer dissatisfaction • Reputational harm	• Source alternative transport • Supply rationing • Prioritize resource

Women's Health – Internal Disruptive Event – Women's Assessment and Surgical Unit

<table>
<tr><td colspan="5" rowspan="3">Inpatient
• Women's Assessment and Surgical Unit</td><td colspan="5">Alternate Care Site Identified:</td></tr>
<tr><td colspan="2">Service</td><td colspan="3">Alternate care site</td></tr>
<tr><td colspan="2">Women's Assessment and Surgical Unit</td><td colspan="3"></td></tr>
<tr><td colspan="5">Critical Functions</td><td colspan="5">Functions Critical Over Time</td></tr>
<tr><td rowspan="3">Service/Business Unit</td><td rowspan="3">Function/Output</td><td colspan="3">Recover time objectives</td><td rowspan="3">Service/Business Unit</td><td rowspan="3">Function/Output</td><td colspan="3">Recover time objectives</td></tr>
<tr><td colspan="3">Within (Hours)</td><td colspan="3">Within (Hours)</td></tr>
<tr><td>2</td><td>4</td><td>8</td><td>2</td><td>4</td><td>7</td></tr>
<tr><td>Inpatient</td><td>Women's Assessment and Surgical Unit</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="10">Internal Disruptive Event - the organisation may suffer serious internal disruption as a result of:
• Lifelines / Infrastructure failure
• Information Systems outage
• Industrial Action
• Loss of one or more key internal clinical support services</td></tr>
</table>

<table>
<tr><td>Loss of Lifelines/Infrastructure</td><td>Service Functions Impacted</td><td>Likely Consequences</td><td>Readiness & Response Strategies</td></tr>
<tr><td>Electrical Power</td><td>• Patient Cares
• Communication systems
• Information systems & support (MIYA/TRENDCARE/MCIS/NHI/ Rosters)
• Ward integrity i.e Security doors
• Patient Information & Flow Information system
• Loss of suction
• Thermostatic environment control
• Drug Fridge (not on critical power?)
• Patient labelling system
• Lighting
• IV Pumps/Syringe drivers
• Access control camera inoperative
• LAMSON
• Bed operation</td><td>Patient Harm
Inability to pull Lab / Blood / Imaging data
Clinical decision making (patient history)
Security of Ward
Inability to access/insert patient data
Staff wellbeing
Access control camera inoperative
Increased risk of infection
Inability to access rosters</td><td>Patient Cares
• Staffing to acquity
• All essential Point of Care equipment to be plugged into critical power supply.
• Battery backup of point of care equipment
• Consider patient transfer
• Hand written Bradma's (patient identity bracelet / patient documentation)
• Head torches (CD Locker)
• Hard copy of staff rosters
Communication
• Runners
• Pagers
• Emergency Phones
• Paper copy phone book (switchboard)
Security (4 points of entry / exit)
• Entry Control Officer (non essential staff member)
Patient Information & Flow</td></tr>
</table>

			• Critical power supply to staff station computers. • Critical Power to all patient rooms in MATY • Laptop (query Wifi connectability) **Thermostatic environment control (20 degrees c norm - Skin to Skin** • Hot: consider use of fans
Water	Patient Cares Sanitary/Sluicing Infection Control (Staff/Patients) Drinking water	Patient Harm Increased risk of infection Staff/patient/visitor well being	Handwash Soap wipes Bottled water (Materials Management) Purifying tablets (CD Locker) Consider unit transfer/evacuation
Medical Gases	• Patient Cares	• Patient Harm – Inability to provide respiratory support • Resus • Maternal Support	• Hand wash • Soap wipes • Bottled water (Materials Management) • Purifying tablets (CD Locker) • Consider unit transfer/evacuation
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
	• Patient Cares. Blood results etc. • Patient Information & Flow • Loss of Rosters	• Loss of administration systems (partially/full) • Loss of Clinical Data and results impacting of clinical decision making • Inability to pull Lab / Blood / Imaging data • Inability to access Badgernet • Admission and discharge protocols	• Manual copy of telephone book • Manual copy data entry • Hand written Bradma's (patient identity bracelet / patient documentation) • Patient Information & Flow • Critical power supply to staff station computers. • Laptop (query Wifi connectability) • Paper copy rosters
Industrial Action	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Clinical / Non Clinical	• Limited staffing resource • Patient Cares • Administration services	• Inability to deliver non-essential cares • Data entry • Administration support	• MDHB strategic planning

Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
	• Main Theatre • Post Natal Ward • Medical Imaging • Laboratory Services • NZ Blood • Clinical supply chain • Pharmacy • Allied Health specialties • Social Work • Hotel services (soft FM) • Orderlies • Cleaning • Laundry • Meals • Security	• Patient Harm • Delay in information transfer • Increased risk of Infection	• MDHB strategic planning

WOMEN'S HEALTH

External Disruptive Event

The following tables identify individual units/departments:

- Critical functions
- Alternate care site preference
- Impact analysis against threat types (Service functions impacted)
- Likely consequences (impact of delivery of services)
- Readiness and Response strategies.

Women's Health – External Disruptive Event – Inpatient - Delivery Suite

Inpatient • Delivery Suite	Alternate Care Site Identified:	
	Service	Alternate Care Site
	Delivery Suite	

Critical Functions

Service/Business Unit	Function/Output	Recover time objectives Within (Hours)		
		2	4	8

Functions Critical Over Time

Service/Business Unit	Function/Output	Recover time objectives Within (Hours)		
		2	4	7

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	• Patient Cares • Communication systems • Information systems & support (MIYA/TRENDCARE/MCIS/NHI/ Rosters) • Ward integrity i.e Security doors • Patient Information & Flow Information system • Loss of suction • Thermostatic environment control • CTG Monitoring • Loss of cooling/heating cabinets (not on critical power?) • Drug Fridge (not on critical power?) • Patient labelling system • Lighting • Resus tables • Transport cot • IV Pumps/Syringe drivers • Computers on Wheels (COWS)	• Patient Harm • Inability to pull Lab / Blood / Imaging data • Inability to access Badgernet • Clinical decision making (patient history) • Security of Ward • Inability to access/insert patient data • Staff wellbeing • Access control camera inoperative • Increased risk of infection • Inability to access rosters	**Patient Cares** • Staffing to acuity • All essential Point of Care equipment to be plugged into critical power supply. • Battery backup of point of care equipment • Consider patient transfer • Hand written Bradma's (patient identity bracelet / patient documentation) • Head torches (CD Locker) • Hard copy of staff rosters **Communication** • Runners • Pagers • Emergency Phones • Paper copy phone book (switchboard)

	• Access control camera inoperative • LAMSON • Emergency assisted vacuum extraction • Bed operation		**Security (4 points of entry / exit)** • Entry Control Officer (non-essential staff member) **Patient Information & Flow** • Critical power supply to staff station computers. • Laptop (query Wifi connectability) **Thermostatic environment control (20 degrees c norm – INDIVISUALISED FOR ROOMS)** • Skin to Skin • Hot: consider use of fans
Water	• Patient Cares • Sanitary/Sluicing • Infection Control (Staff/Patients) • Drinking water	• Patient Harm • Increased risk of infection • Staff/patient/visitor well being	• Handwash • Soap wipes • Bottled water (Materials Management) • Purifying tablets (CD Locker) • Consider unit transfer/evacuation
Gas			
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Connectivity Cyber Attack	• Patient Cares • Patient Information & Flow • Loss of rosters	• Loss of administration systems (partially/full) • Loss of Clinical Data and results impacting of clinical decision making • Inability to pull Lab / Blood / Imaging data • Inability to access Badgernet • Admission and discharge protocols	• Manual copy of telephone book • Manual copy data entry • Hand written Bradma's (patient identity bracelet / patient documentation) • Patient Information & Flow • Critical power supply to staff station computers. • Laptop (query Wifi connectability) • Paper copy rosters
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
NZ Blood	• Supply of blood products and immunoglobulins	• Patient Harm – Inability to provide hemodynamic support • Resus	

		• Maternal Support • PPH	
Allied Laundry	• Supply of clean linen • Supply of staff scrubs	• Patient Harm • Increased risk of infection • Staff/patient/visitor well being	
Air Ambulance	• Patient Transfer	• Patient Harm – delay or lengthened travel times • - Inappropriate location of care	
St John	• Patient Transfer	• Patient Harm – delay or lengthened travel times • Inappropriate location of care	
MCIS	• Patient Cares • Communication systems • Information systems & support	• Patient Harm • Inability to pull Lab / Blood / Imaging data • Inability to access Badgernet • Clinical decision making (patient history) • Inability to access/insert patient data	
Natural Disaster/health Emergency	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
	MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans		

Women’s Health – External Disruptive Event – Inpatient Maternity

<table>
<tr><td colspan="5">Inpatient
• Maternity</td><td colspan="5">Alternate Care Site Identified:</td></tr>
<tr><td colspan="5"></td><td colspan="2">Service</td><td colspan="3">Alternate Care Site</td></tr>
<tr><td colspan="5"></td><td colspan="2">Maternity</td><td colspan="3"></td></tr>
<tr><td colspan="5">Critical Functions</td><td colspan="5">Functions Critical Over Time</td></tr>
<tr><td rowspan="3">Service/Business Unit</td><td rowspan="3">Function/Output</td><td colspan="3">Recover time objectives</td><td rowspan="3">Service/Business Unit</td><td rowspan="3">Function/Output</td><td colspan="3">Recover time objectives</td></tr>
<tr><td colspan="3">Within (Hours)</td><td colspan="3">Within (Hours)</td></tr>
<tr><td>2</td><td>4</td><td>8</td><td>2</td><td>4</td><td>7</td></tr>
<tr><td></td><td>Maternity</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table>

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	• Patient Cares • Communication systems • Information systems & support (MIYA/TRENDCARE/MCIS/NHI/ Rosters) • Ward integrity i.e Security doors • Patient Information & Flow Information system • Loss of suction • Thermostatic environment control • CTG Monitoring • Loss of cooling/heating cabinets (not on critical power?) • Drug Fridge (not on critical power?) • Patient labelling system • Lighting • Resus tables • Transport cot • IV Pumps/Syringe drivers	• Patient Harm • Inability to pull Lab / Blood / Imaging data • Inability to access Badgernet • Clinical decision making (patient history) • Security of Ward • Inability to access/insert patient data • Staff wellbeing • Access control camera inoperative • Increased risk of infection • Inability to access rosters	**Patient Cares** • Staffing to acuity • All essential Point of Care equipment to be plugged into critical power supply. • Battery backup of point of care equipment • Consider patient transfer • Hand written Bradma’s (patient identity bracelet / patient documentation) • Head torches (CD Locker) • Hard copy of staff rosters **Communication** • Runners • Pagers • Emergency Phones • Paper copy phone book (switchboard) **Security (4 points of entry / exit)**

	• Computers on Wheels (COWS) • Access control camera inoperative • LAMSON • Emergency assisted vacuum extraction • Bed operation		• Entry Control Officer (non-essential staff member) **Patient Information & Flow** • Critical power supply to staff station computers. • Laptop (query Wifi connect ability) **Thermostatic environment control (20 degrees c norm – INDIVISUALISED FOR ROOMS)** • Skin to Skin • Hot: consider use of fans
Water	• Patient Cares • Sanitary/Sluicing • Infection Control (Staff/Patients) • Drinking water	• Patient Harm • Increased risk of infection • Staff/patient/visitor well being	• Handwash • Soap wipes • Bottled water (Materials Management) • Purifying tablets (CD Locker) • Consider unit transfer/evacuation
Gas			
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Connectivity Cyber Attack	• Patient Cares • Patient Information & Flow • Loss of rosters	• Loss of administration systems (partially/full) • Loss of Clinical Data and results impacting of clinical decision making • Inability to pull Lab / Blood / Imaging data • Inability to access Badgernet • Admission and discharge protocols	• Manual copy of telephone book • Manual copy data entry • Hand written Bradma's (patient identity bracelet / patient documentation) • Patient Information & Flow • Critical power supply to staff station computers. • Laptop (query Wifi connect ability) • Paper copy rosters

Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
NZ Blood	• Supply of blood products and immunoglobulins	Patient Harm – Inability to provide haemodynamic support • Resus • Maternal Support • PPH	
Allied Laundry	• Supply of clean linen • Supply of staff scrubs	• Patient Harm • Increased risk of infection • Staff/patient/visitor well being	
Air Ambulance	• Patient Transfer	• Patient Harm – delay or lengthened travel times • Inappropriate location of care	
St John	• Patient Transfer	• Patient Harm – delay or lengthened travel times • Inappropriate location of care	
MCIS	• Patient Cares • Communication systems • Information systems & support	• Patient Harm • Inability to pull Lab / Blood / Imaging data • Inability to access Badgernet • Clinical decision making (patient history) • Inability to access/insert patient data	
Natural Disaster/health Emergency	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
	MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans		

Women's Health – External Disruptive Event – Outpatients – Antenatal Clinic

Outpatients • Antenatal Clinic	Alternate Care Site Identified:	
	Service	Alternate Care Site
	Antenatal Clinic	

Critical Functions					**Functions Critical Over Time**					
Service/Business Unit	Function/Output	Recover time objectives Within (Hours)			Service/Business Unit	Function/Output	Recover time objectives Within (Hours)			
		2	4	8			2	4	7	28
						Antenatal Clinic				

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	• Patient Cares • Communication systems • Information systems & support (MIYA/TRENDCARE/MCIS/NHI/ Rosters) • Ward integrity i.e Security doors • Patient Information & Flow Information system • Loss of suction • Thermostatic environment control • CTG Monitoring • Loss of cooling/heating cabinets (not on critical power?) • Drug Fridge (not on critical power?) • Patient labelling system • Lighting • Resus tables • Transport cot • IV Pumps/Syringe drivers • Computers on Wheels (COWS)	• Patient Harm • Inability to pull Lab / Blood / Imaging data • Inability to access Badgernet • Clinical decision making (patient history) • Security of Ward • Inability to access/insert patient data • Staff wellbeing • Access control camera inoperative • Increased risk of infection • Inability to access rosters	**Patient Cares** • Staffing to acuity • All essential Point of Care equipment to be plugged into critical power supply. • Battery backup of point of care equipment • Consider patient transfer • Hand written Bradma's (patient identity bracelet / patient documentation) • Head torches (CD Locker) • Hard copy of staff rosters **Communication** • Runners • Pagers • Emergency Phones • Paper copy phone book (switchboard) **Security (4 points of entry / exit)**

	• Access control camera inoperative • LAMSON • Emergency assisted vacuum extraction • Bed operation		• Entry Control Officer (non-essential staff member) **Patient Information & Flow** • Critical power supply to staff station computers. • Laptop (query Wifi connect ability) **Thermostatic environment control (20 degrees c norm – INDIVISUALISED FOR ROOMS)** • Skin to Skin • Hot: consider use of fans
Water	• Patient Cares • Sanitary/Sluicing • Infection Control (Staff/Patients) • Drinking water	• Patient Harm • Increased risk of infection • Staff/patient/visitor well being	• Hand wash • Soap wipes • Bottled water (Materials Management) • Purifying tablets (CD Locker) • Consider unit transfer/evacuation
Gas			
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Connectivity Cyber Attack	• Patient Cares • Patient Information & Flow • Loss of rosters	• Loss of administration systems (partially/full) • Loss of Clinical Data and results impacting of clinical decision making • Inability to pull Lab / Blood / Imaging data • Inability to access Badgernet • Admission and discharge protocols	• Manual copy of telephone book • Manual copy data entry • Hand written Bradma's (patient identity bracelet / patient documentation) • Patient Information & Flow • Critical power supply to staff station computers. • Laptop (query Wifi connect ability) • Paper copy rosters
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
NZ Blood	• Supply of blood products and immunoglobulins	• Patient Harm – Inability to provide hemodynamic support • Resus • Maternal Support • PPH	•

Allied Laundry	• Supply of clean linen • Supply of staff scrubs	• Patient Harm • Increased risk of infection • Staff/patient/visitor well being	•
Air Ambulance	• Patient Transfer	• Patient Harm – delay or lengthened travel times • Inappropriate location of care	•
St John	• Patient Transfer	• Patient Harm – delay or lengthened travel times • Inappropriate location of care	•
MCIS	• Patient Cares • Communication systems • Information systems & support	• Patient Harm • Inability to pull Lab / Blood / Imaging data • Inability to access Badgernet • Clinical decision making (patient history) • Inability to access/insert patient data	•
Natural Disaster/health Emergency	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
	MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans		

Women's Health – External Disruptive Event – Gynaecology Clinic

Outpatients	Alternate Care Site Identified:	
• Gynaecology Clinic	Service	Alternate Care Site
- Coloscopy	Gynaecology Clinic	
- Urodynamics	- Coloscopy	
- Gynaecolgy Day Unit	- Urodynamics	
	- Gynaecology Day Unit	

Critical Functions

Service/Business Unit	Function/Output	Recover time objectives Within (Hours)		
		2	4	8

Functions Critical Over Time

Service/Business Unit	Function/Output	Recover time objectives Within (Hours)			
		2	4	7	28
	Gynaecology Clinic				
	Coloscopy				
	Urodynamics				
	Gynaecology Day Unit				

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	• Loss of Clinics insitu • Day procedures	• Patient harm • Customer disatifaction • Reputational harm • Interuption to long term planned cares	• Relocation • Essential power
Water	• Patient Cares • Sanitary • Infection Control (Staff/Patients)	• Patient Harm • Increased risk of infection • Staff/patient/visitor well being	• Handwash • Bottled water ? • Purifying tablets (CD Locker)
Gas	• Loss of hot water • Loss of heating	• Infection • Staff/ Patient Welfare	• Dual fuel boilers

Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Connectivity Cyber Attack	• Patient Cares. Blood results etc. • Patient Information & Flow • Bookings • Administration & Discharges	• Loss of administration systems (partially/full) • Loss of Clinical Data and results impacting of clinical decision making	• Paper based
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
NZ Blood	•	• Patient harm • Delays	• Re-book surgeries • Prioritise resources
Allied Laundry	•	• Patient harm • Delays • Infection	• Re-book clinics/theatre • Prioritise resources
Natural Disaster/health Emergency	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
	MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans		

Women's Health – External Disruptive Event – Community – Horowhenua Maternity

Community • Horowhenua Maternity (Kohungahunga) (Consider the impact on the community if not functioning)					Alternate Care Site Identified:				
					Service		Alternate Care Site		
					Midwife Palmerston North				
					Midwife Feilding				
Critical Functions					**Functions Critical Over Time**				
Service/Business Unit	Function/Output	Recover time objectives Within (Hours)			Service/Business Unit	Function/Output	Recover time objectives Within (Hours)		
		2	4	8			2	4	7
						Horowhenua Maternity			

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	• Patient Cares • Communication systems • Information systems & support (MIYA/TRENDCARE/MCIS/NHI/ Rosters) • Ward integrity i.e Security doors • Patient Information & Flow Information system • Loss of suction • Thermostatic environment control • CTG Monitoring • Patient labelling system • Lighting • Resus tables • IV Pumps/Syringe drivers • Computers on Wheels (COWS) • Access control camera inoperative • Bed operation	• Patient Harm • Inability to pull Lab / Blood / Imaging data • Inability to access Badgernet • Clinical decision making (patient history) • Security of Ward • Inability to access/insert patient data • Staff wellbeing • Access control camera inoperative • Increased risk of infection • Inability to access rosters	**Patient Cares** • Staffing to acuity • All essential Point of Care equipment to be plugged into critical power supply. • Battery backup of point of care equipment • Consider patient transfer • Hand written Bradma's (patient identity bracelet / patient documentation) • Head torches (CD Locker) • Hard copy of staff rosters **Communication** • Runners • Pagers • Emergency Phones • Paper copy phone book (switchboard) **Security (4 points of entry / exit)**

			• Entry Control Officer (non-essential staff member) • Patient Information & Flow • Critical power supply to staff station computers. • Laptop (query Wifi connect ability) **Thermostatic environment control (20 degrees c norm – INDIVISUALISED FOR ROOMS)** • Skin to Skin • Hot: consider use of fans
Water	• Patient Cares • Sanitary/Sluicing • Infection Control (Staff/Patients) • Drinking water	• Patient Harm • Increased risk of infection • Staff/patient/visitor well being	• Hand wash • Soap wipes • Bottled water (Materials Management) • Purifying tablets (CD Locker) • Consider unit transfer/evacuation
Gas	•	•	•
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Connectivity Cyber Attack	• Patient Cares • Patient Information & Flow • Loss of rosters	• Loss of administration systems (partially/full) • Loss of Clinical Data and results impacting of clinical decision making • Inability to pull Lab / Blood / Imaging data • Inability to access Badgernet • Admission and discharge protocols	• Manual copy of telephone book • Manual copy data entry • Hand written Bradma's (patient identity bracelet / patient documentation) • Patient Information & Flow • Critical power supply to staff station computers. • Laptop (query Wifi connect ability) • Paper copy rosters
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
	•	•	•
Natural Disaster/health Emergency	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
	MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans		

Women's Health – External Disruptive Event – Te Papaieoa Maternity unit

Primary Birthing Unit	Alternate Care Site Identified:	
	Service	Alternate Care Site
	Palmerston North Birthing Suite	

Critical Functions					**Functions Critical Over Time**				
Service/Business Unit	Function/Output	Recover time objectives Within (Hours)			Service/Business Unit	Function/Output	Recover time objectives Within (Hours)		
		2	4	8			2	4	7
						Primary Birthing unit			

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	• Patient Cares • Communication systems • Information systems & support (MIYA/TRENDCARE/MCIS/NHI/ Rosters) • Ward integrity i.e Security doors • Patient Information & Flow Information system • Loss of suction • Thermostatic environment control • CTG Monitoring • Patient labelling system • Lighting • Resus tables • IV Pumps/Syringe drivers • Computers on Wheels (COWS) • Access control camera inoperative • Bed operation	• Patient Harm • Inability to pull Lab / Blood / Imaging data • Inability to access Badgernet • Clinical decision making (patient history) • Security of Ward • Inability to access/insert patient data • Staff wellbeing • Access control camera inoperative • Increased risk of infection • Inability to access rosters	**Patient Cares** • Staffing to acuity • All essential Point of Care equipment to be plugged into critical power supply. • Battery backup of point of care equipment • Consider patient transfer • Hand written Bradma's (patient identity bracelet / patient documentation) • Head torches (CD Locker) • Hard copy of staff rosters **Communication** • Runners • Pagers • Emergency Phones • Paper copy phone book (switchboard) **Security (4 points of entry / exit)**

			• Entry Control Officer (non-essential staff member) • Patient Information & Flow • Critical power supply to staff station computers. • Laptop (query Wifi connect ability) **Thermostatic environment control (20 degrees c norm – INDIVISUALISED FOR ROOMS)** • Skin to Skin • Hot: consider use of fans
Water	• Patient Cares • Sanitary/Sluicing • Infection Control (Staff/Patients) • Drinking water	• Patient Harm • Increased risk of infection • Staff/patient/visitor well being	• Hand wash • Soap wipes • Bottled water (Materials Management) • Purifying tablets (CD Locker) • Consider unit transfer/evacuation
Gas	•	•	•
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Connectivity Cyber Attack	• Patient Cares • Patient Information & Flow • Loss of rosters	• Loss of administration systems (partially/full) • Loss of Clinical Data and results impacting of clinical decision making • Inability to pull Lab / Blood / Imaging data • Inability to access Badgernet • Admission and discharge protocols	• Manual copy of telephone book • Manual copy data entry • Hand written Bradma's (patient identity bracelet / patient documentation) • Patient Information & Flow • Critical power supply to staff station computers. • Laptop (query Wifi connect ability) • Paper copy rosters
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
	•	•	•
Natural Disaster/health Emergency	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
	MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans		

Women's Health – External Disruptive Event – Community – Midwife

Community • Midwife Palmerston North • Midwife Feilding	Alternate Care Site Identified:	
	Service	Alternate Care Site
	Midwife Palmerston North	
	Midwife Feilding	

Critical Functions					**Functions Critical Over Time**				
Service/Business Unit	Function/Output	Recover time objectives Within (Hours)			Service/Business Unit	Function/Output	Recover time objectives Within (Hours)		
		2	4	8			2	4	7
								4 days	

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	Community based service delivery Access to information system i.e. laptop		
Water	Community based service delivery Access to information system i.e. laptop		
Gas	Community based service delivery Access to information system i.e. laptop		
Information Systems Outage	**Service Functions Impacted**	**Likely Consequences**	**Readiness & Response Strategies**
As per identified in Cluster BIA page 8	• Patient Cares. Blood results etc. • Patient Information & Flow • Bookings • Admissions & Discharges	• Loss of administration systems (partially/full) • Loss of Clinical Data and results impacting of clinical decision making • Inability to maintain patient documentation, registering referrals and booking system	• Paper based • Manual copy of telephone book • Manual copy data entry • Manual policies and guidelines
Industrial Action	**Service Functions Impacted**	**Likely Consequences**	**Readiness & Response Strategies**
Clinical / Non Clinical	• Limited staffing resource • Patient Cares • Administration services	• Inability to deliver non-essential cares • Data entry • Administration support	• MDHB strategic planning

Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
	• Fleet Wise • Medical Imaging • Laboratory Services • Clinical supply chain	• Patient Harm • Delays in care • Customer dissatisfaction • Reputational harm	• Source alternative transport • Supply rationing • Prioritise resource

Women's Health – External Disruptive Event – Women's Assessment and Surgical Unit

Inpatient • Women's Assessment and Surgical Unit (WASU)					Alternate Care Site Identified:				
					Service		Alternate Care Site		
					Women's Assessment and Surgical Unit				
Critical Functions					**Functions Critical Over Time**				
Service/Business Unit	Function/Output	Recover time objectives Within (Hours)			Service/Business Unit	Function/Output	Recover time objectives Within (Hours)		
		2	4	8			2	4	7
	Women's Assessment and Surgical Unit								

External Disruptive Event - the organisation may suffer 3rd party disruption as a result of:

- Lifelines / Infrastructure failure
- Information Systems outage
- Loss of one or more key suppliers
- Natural Disaster/Health Emergency

Loss of Lifelines/Infrastructure	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Electrical Power	• Patient Cares • Communication systems • Information systems & support (MIYA/TRENDCARE/MCIS/NHI/ Rosters) • Ward integrity i.e Security doors • Patient Information & Flow Information system • Loss of suction • Thermostatic environment control • Drug Fridge (not on critical power?) • Patient labelling system • Lighting • IV Pumps/Syringe drivers • Computers on Wheels (COWS) • Access control camera inoperative • LAMSON	• Patient Harm • Inability to pull Lab / Blood / Imaging data • Inability to access Badgernet • Clinical decision making (patient history) • Security of Ward • Inability to access/insert patient data • Staff wellbeing • Access control camera inoperative • Increased risk of infection • Inability to access rosters	**Patient Cares** • Staffing to acquity • All essential Point of Care equipment to be plugged into critical power supply. • Battery backup of point of care equipment • Consider patient transfer • Hand written Bradma's (patient identity bracelet / patient documentation) • Head torches (CD Locker) • Hard copy of staff rosters **Communication** • Runners • Pagers • Emergency Phones • Paper copy phone book (switchboard)

	• Emergncy assisted vaccum extraction • Bed operation		**Security (4 points of entry / exit)** • Entry Control Officer (non-essential staff member) • Patient Information & Flow • Critical power supply to staff station computers. • Laptop (query Wifi connect ability) **Thermostatic environment control (20 degrees c norm – INDIVISUALISED FOR ROOMS)** • Hot: consider use of fans
Water	• Patient Cares • Sanitary/Sluicing • Infection Control (Staff/Patients) • Drinking water	• Patient Harm • Increased risk of infection • Staff/patient/visitor well being	• Hand wash • Soap wipes • Bottled water (Materials Management) • Purifying tablets (CD Locker) • Consider unit transfer/evacuation
Gas	•	•	•
Information Systems Outage	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
Connectivity Cyber Attack	• Patient Cares • Patient Information & Flow • Loss of rosters	• Loss of administration systems (partially/full) • Loss of Clinical Data and results impacting of clinical decision making • Inability to pull Lab / Blood / Imaging data • Inability to access Badgernet • Admission and discharge protocols	• Manual copy of telephone book • Manual copy data entry • Hand written Bradma's (patient identity bracelet / patient documentation) • Patient Information & Flow • Critical power supply to staff station computers. • Laptop (query Wifi connect ability) • Paper copy rosters
Loss of one or more key internal clinical support services	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
NZ Blood	• Supply of blood products and immunoglobulins	• Patient Harm – Inability to provide haemodynamic support • Resus •	• Follow recommended clinical guidelines for replacement of blood products. • Consider transfer of critical patients to Wellington hospital

Allied Laundry	• Supply of clean linen • Supply of staff scrubs	• Patient Harm • Increased risk of infection • Staff/patient/visitor well being	• Supply rationing • Prioritise resource
Air Ambulance	• Patient Transfer	• Patient Harm – delay or lengthened travel times • Inappropriate location of care	• Transfer patients to another intensive care unit by road • Call in experienced staff to support • Tele-medicine consultation with clinical expert
St John	• Patient Transfer	• Patient Harm – delay or lengthened travel times • Inappropriate location of care	• Use another mode of transport with medical/nursing staff from unit
Natural Disaster/health Emergency	Service Functions Impacted	Likely Consequences	Readiness & Response Strategies
	MDHB Strategic Business Continuity Plan enacted Individual Service enact Internal Disruption Plans		

WOMEN'S HEALTH

Service Planning Recovery in Levels

The following tables identify individual units/departments:

- Response Level and Recovery Strategies

Hosptital Framework Response Level	Service Name – Gateway Service	Redeployment % time away
	• Business resumes practice as was prior to Covid-19.	
	• Gateway will resume face to face clinic appointments. This could be completed with the Social Worker being available by phone to consult then the Paediatrician seeing the parent/caregiver and children. Or the social worker is seen first, then the family. Or the child is brought to the appointment with one parent/caregiver and the social worker- Limiting the amount of people in the consultation room would support social distancing. • Gateway Coordinator and Gateway Administrator to resume duties as normal. • Gateway MDT meetings to be completed in large meeting rooms with social distancing supported. The meetings are held at Oranga Tamariki in the Family Group Conference room where social distancing could be supported.	
	• Gateway will offer telephone consults to all referrals where it is clearly identified that a physical examination is not required. • Gateway Coordinator will liaise with the Oranga Tamariki Social Worker to ensure that they and the family are able to engage in the process- that there is the necessary technology (telephone) available. A clinic date and time will be set (Wednesday's as when Paediatricians available). • Paediatrician will make contact with Social Worker, then the family. Paediatrician will complete assessment. If there are safety concerns, Paediatrician to make contact with Social Worker or Gateway Coordinator to make plan to address. • Coordinator will make two waitlists, one for children who need to come in for the full assessment appointment as the family were unable to be contacted and a second waitlist for children who need to come in for only a physical examination appointment. • Gateway Administrator could continue to support the Emergency Department as have in Level 4 and complete Webpas requirements for Gateway clinics to be booked. Should Level 3 continue for longer than 2 weeks, Gateway Administrator would be requested to return to Gateway unless there was typing support available due to the Paediatricians dictated assessments requiring typing. • Integrated Service Agreement (ISA) plans are to be reviewed by the Gateway MDT group. These will be sent via email to the group and feedback to be provided from the agencies about the follow up required. Feedback to be recorded as minutes as per normal protocol. • Gateway Coordinator to contact Oranga Tamariki Site Managers and Practice Leaders via email to detail the process whereby Gateway Assessments could be completed. Gateway Governance and partners to be copied in to this email.	
	• Service on hold. • Notifications to Oranga Tamariki and agreed service on hold. • Social Worker at home with dependent children and older family member. • Administrator deployed to ED.	

Hospital Framework Response Level	Service Name - Gynaecology Outpatients	Redeployment % time away
	• Usual appointments • Face to Face where required • Virtual where possible • All clinics recommenced virtual where appropriate • Urodynamics clinic re • Pessary Clinic to restart • Fertility & urogynaecology clinics to restart. Peripheral clinics to restart.	Return to Usual Roles
	• Continence 50% - Prioritisation of women following 3rd & 4th perineal tears for face to face on a Monday AM and Friday PM. Minimise potential for multiple women in waiting area. • Continuation of virtual clinics. • Face to Face if appropriate following RANZCOG guidance. Face to face gynaeoncology follow-up clinic. Staggered appointments to minimise people in waiting room. • 2 staff per day (3 if hysteroscopy) • Redeploy staff to support other areas if required	- 40% 100% - 80% - 20%
	• Urgent continence – review urgent patients via phone contact • Prioritised new referrals depending on clinical risk & condition as per RANZCOG • Urgent Clinic new referrals: virtual or phone. face to face only if essential • Virtual follow up clinics • Virtual consultation for tubal ligation requests • Mirena clinic for urgent contraceptive needs only.	– ED 80% – Testing 100% – Testing 80% – Front Door 20% – 20%
	• Referral s still prioritised as usual. Urgent clinics only – high suspicion cancer (face to face) • 2 nursing staff at all times (3 if a hysteroscopy or colposcopy clinic) • Where possible: - Mirena clinic for urgent contraceptive needs only. - Colposcopy for high grade lesions, LLETZ, hysteroscopy, PMB clinic, GDU. Virtual follow ups continue as long as medical staff not deployed elsewhere - Other staff redeployed - Defer all non-urgent procedures Urodynamics, low grade colposcopy and continence	- 100% - 100% - 100% F - 60% a – 20%

Use the RANZCOG guidelines for prioritising patients according to clinical risk

Hospital Framework Response Level	Service Name – Maternity Inpatients and Outpatients	Redeployment % time away
	• Face to face clinics resume, consider telephone clinics for VBAC consults, scan reviews, peripheral clinics • Maternity visiting returns to baseline, women able to have support people antenatal, labour & birth and one support person to stay with her for entire postnatal stay • Flu vaccines resume in Antenatal Clinic • All primary birthing units open and accepting postnatal transfers	
	• Screening of all women/support people/visitors • Clinics: majority by phone consultation, no peripheral clinics, face to face for urgent consultations • Fortnightly high risk meetings via zoom • Flu vaccines at pharmacy/GP • Scanning: Follow MOH guidelines • Up to two support people for labour/birth, one consistent postnatal support person • Postnatal transfer to primary birthing units (depending on national alert level)	
	• Clinics: Referrals triaged, phone consultations for all antenatal clinics, community midwives (LMC & employed) seeing patients for BP & U/A, virtual pre-assessment clinics for high risk ELCS patients • Flu vaccines at pharmacy/GP • Scanning: Follow MOH guidelines • One well, consistent support person for labour/birth/postnatal (from same bubble) who stays in woman's room (no coming and going from hospital) • Consider temporary closure of Horowhenua maternity to allow PN hospital to decant patients. • Stand up emergency birthing room at Horowhenua • Mahi Tahi Meals for Parents • Critical Staff education only	
	• Clinics: Referrals triaged, phone consultations for all antenatal clinics, community midwives (LMC & employed) seeing patients for BP & U/A, virtual pre-assessment clinics for high risk ELCS patients • If clinicians deployed elsewhere capacity for consultations would reduce • Flu vaccines at pharmacy/GP • Scanning: Follow MOH guidelines • One well, consistent support person for labour/birth and up to 4 hours post birth (unless COVID positive) • Horowhenua Maternity unit closed temporarily to allow PN hospital to decant patients (Emergency Birthing room stood up) • No transfers out to primary birthing units • No staff education	

Family Violence

Disruptive Event Response

The following tables identify individual units/departments:

- Business as usual
- Business continuity Plan
- Pandemic Response

Family Violence – Disruptive Event Responce

Service	Business as Usual (BaU)	Business Continuity Plan (BCP)	Pandemic Response
Emergency Department (ED)	• One FTE is dedicated to the Emergency Department. • The role is shared by two people and supplemented by social workers from the team when required. • Presentations to ED during the weekend are followed up by the ED social workers on the following Monday. • Staff currently contact the social workers if they require support out of hours or on the weekend.	• MDHB Strategic Business Continuity Plan enacted • Individual Service enact Internal Disruption Plans • Staffing variance response plans • Follow essential care guidelines	• Two social workers will meet with key ED staff every day, this will include discussing the Family Violence and Child Protection numbers. • As numbers increase social workers will begin and continue the process from disclosure. • Where there is child protection concerns Social Workers will assist/complete a Report of Concern to Oranga Tamariki. • Presentations to ED over the weekend will be followed up as per normal BaU practice. • A team of child specialised social workers will be available to support the above process.
Wards	• Each ward has a dedicated social worker. • As part of the Social Work Assessment, family screening occurs for patients whom they are involved. • If a patient is identified by nursing or medical staff as having a risk of family violence, social work follows up with screening, assessment and intervention	• MDHB Strategic Business Continuity Plan enacted • Individual Service enact Internal Disruption Plans • Staffing variance response plans • Follow essential care guidelines	• The social work presence on wards is expected to reduce during lockdown. • BaU processes will be maintained as normal.
Woman's Health, Child Health and Neonatal Unit	• Dedicated team currently works with Women and Children. Inclusive of their social work role, is the management of child abuse, neglect and family violence. They work	• MDHB Strategic Business Continuity Plan enacted • Individual Service enact Internal Disruption Plans • Staffing variance response plans	• BaU practice will continue as normal. • If there is an increase in child abuse, Social Workers will be deployed from within the current

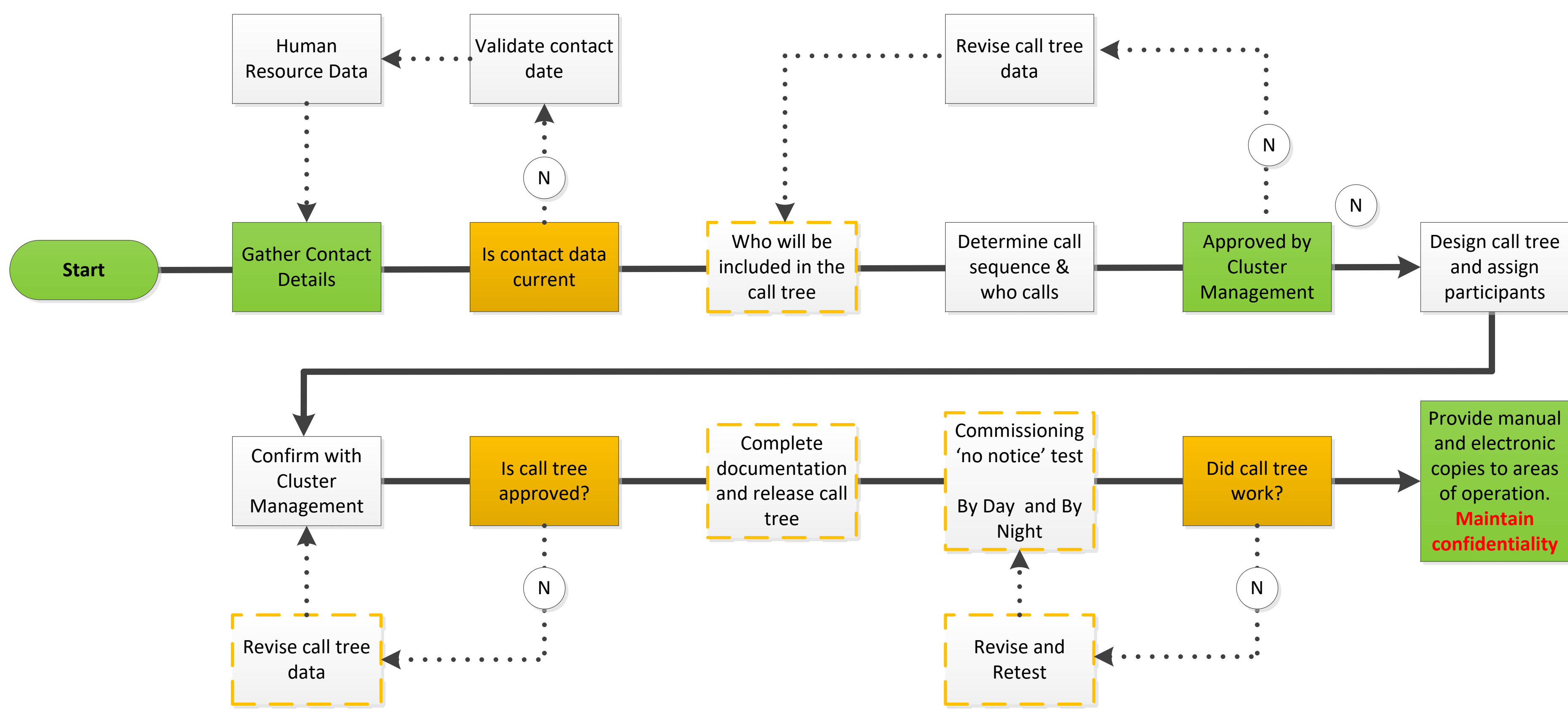
	closely with Oranga Tamariki, Police and other providers as required.	• Follow essential care guidelines	Social Work team and from across the hospital.
Woman's Health, Child Health and Neonatal Unit (continued)			• Contact details for the Oranga Tamariki hospital liaison are held by the Social Work team. • Maternity is introducing package of care to new mothers on discharge from the delivery suite. A team of facilitators (who will be supported by the Social Workers with education and advice), will follow up with new mothers after their discharge from the Maternity ward. • Daily triage meetings will be held with the facilitators and Social Workers to discuss and allocate referrals. • The Social Workers are aware of expectant Mothers, names will be placed in the red book located in Delivery suite. When these expectant Mothers present to give birth staff on the delivery suite will notify the Social Workers. Mothers will be contacted after they have been discharged from the Maternity ward and in addition Social Workers will file a Report of Concern with Oranga Tamariki. • Plans involving CSI will continue as per BaU. • Child Protection Alerts will continue • A reduced group of four will attend the fortnightly meetings to consider if an alert is placed.

CRITICAL CLINICAL EQUIPMENT INVENTORY ANNEX XX

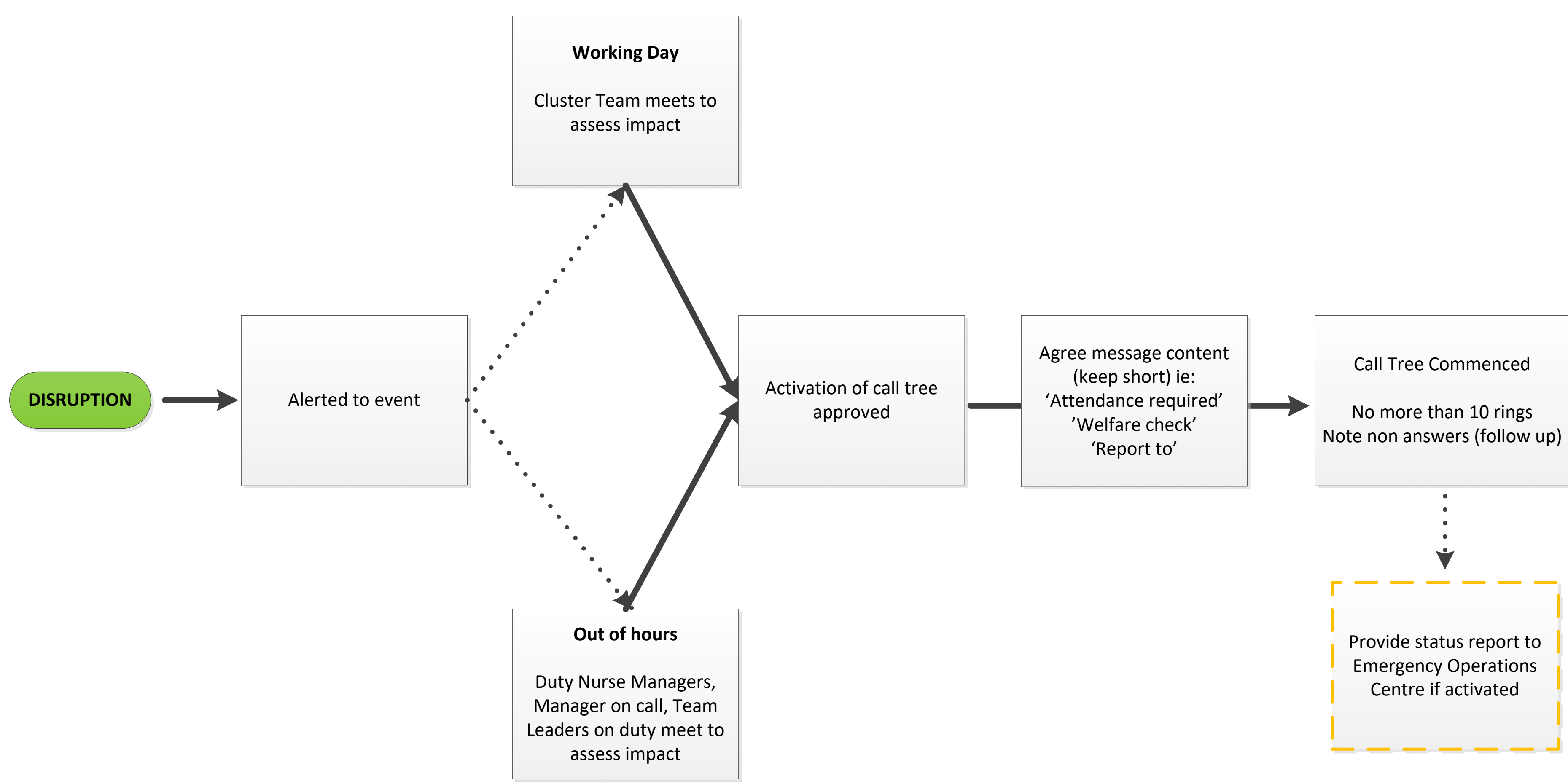
	Equipment Identifier (Name/Description)	Number of Units Held	Location Held	Equipment Supplier/ Equipment Servicing Agent	Alternative Equipment
Maternity/Delivery Suite	Emergency trolley inc Defibrillator. IV pumps	2	Delivery Suite Maternity Ward		
	Ventous Equipment	1	Delivery Suite		Kiwi cup Forceps
	Alaris IV Pump	6 2	Delivery Suite Maternity Ward		
	Syringe Driver	2	Delivery Suite		
	Epidural Pump	6	Delivery Suite		
	Ultrasound(large)	1	Antenatal Clinic		Ultrasound (portable)
	Ultrasound(portable)	1	Delivery Suite		N/A
	ECG	1	Delivery Suite		N/A
	CTG	10 3 1	Delivery Suite Maternity Ward Antenatal Clinic		Hand held dopplers
	Dopplers	4	Delivery Suite		
	Newborn Resuscitaire	8	Delivery Suite		
	Newborn Resuscitaire (portable)	2	Delivery Suite Maternity Ward		
	Dynamap (fixed)	9 7	Delivery Suite Maternity Ward		Sphygmometer
	Dynamap (portable)	2 4 1	Delivery Suite Maternity Ward Antenatal Clinic		Sphygmometer
	Sterilizer	2 1	Delivery Suite Maternity Ward		
	Breast pumps	3	Maternity Ward		
	Blanket Warmer	1	Delivery Suite		
	Fluid Warmer	1	Delivery Suite		
	Glucometer	3 2 1	Delivery Suite Maternity Ward Antenatal Clinic		
	Light Source	1 1	Delivery Suite Antenatal Clinic		
	Drug Fridge	2	Delivery Suite Maternity Ward		
	Milk Fridge	1	Maternity Ward		
	Milk Freezer	1	Maternity Ward		

	Equipment Identifier (Name/Description)	Number of Units Held	Location Held	Equipment Supplier/ Equipment Servicing Agent	Alternative Equipment
Neonatal					
Woman's Surgical and Assessment Unit (WASU)	Emergency trolley inc Defibrillator. IV pumps	1	Maternity		
	Alaris IV Pump		WASU		
	ECG		Delivery Suite		N/A
	Dynamap (portable)		WASU		Sphygmometer
	Glucometer		WASU		
	Drug Fridge		WASU		

CALL TREE DEVELOPMENT PROCESS **ANNEX XX**



CALL TREE ACTIVATION GUIDE **ANNEX XX**



INDIVIDUAL SMALL UNIT PHONE TREE TEMPLATE (ACTIVATION/TESTING)

Date		Cluster/Enabler		Authorized by	
Time		Department/Unit/Ward		Operator:	
Message Script					
Disruptive Event - Action Required – 'Attendance' / ' Welfare Check ' / 'For Information only' Location to report to – Brief will be given on arrival Receiver acknowledges message – minimal conversation.					

Hierarchal Call Tree Process							
Name	**Role/Position**	**Contact No**	**Contact Made**		**Follow up achieved**		
			Yes	**No**	**Yes**	**No**	
	Co-coordinator						
	VNT						
	Receptionist/Administrator						
	Occupational Therapist						
	Speech Language Therapist						
	ASD Coordinator						
	Psychologist						
	VNT (Tararua)						
	VNT (Horowhenua)						
NOTE - If no contact is made follow up required on completion of first call tree							

Name	Job Function	Job Title	Telephone	Mobile
	Other Therapists	Neurodeumtl Therapist		
	Psychologists	Psychologists		
	Physiotherapists	Neurodeumtl Therapist		
	Social Workers	Autism Spectrum Coordinator		
	Admin, Clerical - Clinical	Receptionist		
	Social Workers	Autism Spectrum Coordinator		
	Physiotherapists	Physiotherapist		
	Managers	Coordinator		
	Social Workers	Social Worker		
	Occupational Therapists	Occupational Therapists		
	Occupational Therapists	Occupational Therapists		
	Physiotherapists	Physiotherapists		
	SLT	SLT		
	Physiotherapists	Physiotherapists		
	Social Workers	Social Workers		
	Psychologists	Clinical Psychologist		
	Speech Therapists	Speech-Language Therapist		
	Occupational Therapists	Occupational Therapist		

PRIMARY CHILD HEALTH TEAM

Hierarchal Call Tree Process						
Name	**Role/Position**	**Contact No**	**Contact Made**		**Follow up achieved**	
Community Paediatric Team			**Yes**	**No**	**Yes**	**No**
	Clinical Nurse Specialist – lead					
	NP					
	NP					
	Social Worker – Advanced Practitioner					
	Administrator					
	Clinical Nurse Specialist					
	Clinical Nurse Specialist					
	Registered Nurse					
	Social Worker					
	Coordinator					
	Co-ordinator					
NOTE - If no contact is made follow up required on completion of first call tree						

NEONATAL STAFF

Currently in the Neonatal Unit uses a messaging application called WhatsApp, whereby one message is sent out by the Charge Nurse, Acting Charge or Shift Coordinator with the details of what is required in the unit. Staff are generally very prompt at responding to messages.

If WhatsApp is unavailable, assessment of what skills are needed for the situation and staff would be contacted from the list below.

Airway and Ventilator Confident	Role/Position	Landline	Mobile
	Charge Nurse		
	ADON/previous educator		

Second Level	Role/Position	Landline	Mobile

New Staff/Grads	Role/Position	Landline	Mobile

Support Staff	Role/Position	Landline	Mobile
	Lactation Consultant		
	Enrolled Nurse		
	HCA		
	HCA		
	Receptionist		

Casuals	Role/Position	Landline	Mobile
	HCA		
	HCA		

PAEDIATRIC MEDICAL STAFF

Name	Job Function	Job Title	Telephone	Mobile
	House Officers	Senior House Officer		
	Specialist Medical Officer	Clinical Executive		
	Registrars	Registrar		
	Specialist Medical Officer	Paediatrician		
	Specialist Medical Officer	Paediatrician		
	MOSS	Medical Officer Paediatrics		
	Specialist Medical Officer	Paediatrician		
	Specialist Medical Officer	Medical Lead Child Health		
	Specialist Medical Officer	Paediatrician		
	Specialist Medical Officer	Paediatrician		

Women's Health Unit staff

Name	Job Function	Job Title	Telephone	Mobile
	Registered Midwives	New Graduate Midwife		
	Registered Midwives	Midwife		
	Registered Midwives	Midwife		
	Health Service Assistants	Health Care Assistant		
	Registered Midwives	Midwife		
	Registered Midwives	Midwife		
	Admin, Clerical - Clinical	Ward Clerk		
	Senior Nurses	Associate Charge Midwife		
	Senior Nurses	Associate Charge Midwife		
	Registered Midwives	Midwife		
	Registered Midwives	Midwife		
	Admin, Clerical - Clinical	Personal Assistant		

	Registered Nurses	Registered Nurse	
	Registered Midwives	Midwife	
	Registered Midwives	Midwife	
	Health Service Assistants	Health Care Assistant	
	Registered Midwives	Midwife	
	Health Service Assistants	Health Care Assistant	
	Registered Midwives	Midwife	
	Registered Nurses	Registered Nurse	
	Registered Nurses	Registered Nurse	
	Registered Midwives	Midwife	
	Registered Midwives	Midwife	
	Registered Midwives	Midwife	
	Senior Nurses	Associate Charge Midwife	
	Registered Midwives	Staff Nurse Midwife	
	Registered Midwives	Midwife	
	Registered Midwives	Midwife	
	Health Service Assistants	Health Care Assistant	
	Registered Nurses	Registered Nurse	
	Registered Midwives	Midwife	
	Registered Midwives	Midwife	
	Registered Midwives	Midwife	
	Registered Midwives	Midwife	
	Registered Nurses	New Graduate Nurse	
	Registered Midwives	Midwife	
	Registered Midwives	Midwife	

		Registered Midwives	New Graduate Midwife			
		Registered Nurses	Registered Nurse			
		Registered Nurses	Registered Nurse			
		Registered Midwives	Midwife			
		Registered Midwives	Midwife			
		Senior Nurses	Associate Charge Midwife			
		Registered Midwives	Midwife			
		Registered Midwives	Midwife			
		Registered Nurses	Registered Nurse			
		Registered Midwives	Midwife			
		Registered Nurses	Registered Nurse			
		Registered Midwives	New Graduate Midwife			
		Registered Midwives	Midwife			
		Enrolled Nurses	Enrolled Nurse			
		Registered Midwives	Staff Nurse Midwife			
		Registered Midwives	Midwife			
		Senior Nurses	Associate Charge Midwife			
		Registered Nurses	Registered Nurse			
		Registered Nurses	Registered Nurse			
		Registered Nurses	Registered Nurse			
		Registered Nurses	Registered Nurse			
		Registered Midwives	Midwife			
		Registered Nurses	Registered Nurse			
		Registered Midwives	New Graduate Midwife			
		Registered Nurses	Registered Nurse			
		Registered Midwives	Midwife			
		Registered Midwives	Midwife			

		Registered Nurses	Registered Nurse		
		Registered Midwives	Midwife		
		Registered Midwives	Midwife		
		Registered Midwives	Midwife		
		Health Service Assistants	Health Care Assistant		
		Registered Midwives	Staff Nurse Midwife		
		Registered Midwives	Midwife		
		Registered Midwives	Midwife		
		Health Service Assistants	Health Care Assistant		
		Enrolled Nurses	Enrolled Nurse		
		Registered Midwives	New Graduate Midwife		
		Senior Nurses	Associate Charge Midwife		
		Senior Nurses	Associate Charge Midwife		
		Registered Midwives	Staff Nurse Midwife		
		Registered Midwives	Midwife		
		Registered Midwives	Midwife		

Name	Job Function	Job Title	Telephone	Mobile
	Registered Midwives	Midwife		
	Senior Nurses	Charge Midwife Horowhenua		
	Registered Midwives	Staff Nurse Midwife		
	Registered Midwives	Midwife		
	Registered Midwives	Midwife		
	Registered Midwives	Midwife		
	Registered Midwife	Midwife		
	Registered Midwives	Midwife		
Casual	Registered Midwives	Midwife		
Casual	Registered Midwives	Midwife		
Casual	Registered Midwives	Midwife		
	Registered Midwives	Midwife		

Provider Name	PUID	Purchase Unit Description	Cluster	
Ara Karo Ltd		Well Child Tamariki Ora CRM Solution	Women & Child Health	4
Barnardos NZ	W01010	Pregnancy & Parenting Information and Education Services	Women & Child Health	3
Barnardos NZ	W01011	Pregnancy & Parenting Information and Education Services	Women & Child Health	3
Best Care (Whakapai Hauora) Charitable Trust	C01016	Well Child Services	Women & Child Health	2
Best Care (Whakapai Hauora) Charitable Trust	C01016	Well Child Services - Additional Contacts	Women & Child Health	2
Best Care (Whakapai Hauora) Charitable Trust	COCH0026	Youth Justice Facility Health Service	Women & Child Health	1
Central PHO		Keeping babies safe administration Support	Women & Child Health	4
Central PHO	COPA0005	Pacifika Maternal & Child Services - Community Support Worker / Navigator	Women & Child Health	2
Central PHO	COPA0005	Pacifika Maternal & Child Services - Project Coordinator	Women & Child Health	2
Central PHO	SHO1006	Sexual Reproductive Health - Management	Women & Child Health	4
Central PHO	SHO1006	Sexual Reproductive Health - Otaki Womens Health	Women & Child Health	4
Central PHO	SHO1006	Sexual Reproductive Health - Provider Payments	Women & Child Health	4
Central PHO	HS0015	Youth Medical Health Services (YOSS)	Women & Child Health	1
Central Regions Technical Advisory Services Ltd		RVU Formula for Well Child Providers	Women & Child Health	2
Child Youth and Family		Mou CYFs and NZ Police	Women & Child Health	4
Community Birth Services Charitable Trust	COOC0015	Breastfeeding Information and Support	Women & Child Health	3
Community Birth Services Charitable Trust	COOC0015	Breastfeeding Information and Support	Women & Child Health	3
Crest Hospital Ltd	SH01004	Administration & Management Fee (SAO1)	Women & Child Health	1
Crest Hospital Ltd	SH01004	Clinical Supervision (SAC1)	Women & Child Health	1

Crest Hospital Ltd	SH01004	Infrastructure Contribution (SAO5)	Women & Child Health	1
Crest Hospital Ltd	SH01004	Lead Clinician (SAL1)	Women & Child Health	1
Crest Hospital Ltd	SH01004	Roster Fee (SAO8)	Women & Child Health	1
Crest Hospital Ltd	SH01004	SAATS Services (WDHB)	Women & Child Health	1
He Puna Hauora	C01011	Hearing & Vision Services	Women & Child Health	3
He Puna Hauora	[redacted]	School Based Clinical Services	Women & Child Health	3
MAGMA Healthcare	M00002	General Medicine - 1st attendance	Women & Child Health	2
MAGMA Healthcare	S30011	Medical Termination of pregnancy - FU	Women & Child Health	2
MAGMA Healthcare	S30010	Medical Termination of Pregnancy - Treatment	Women & Child Health	1
MAGMA Healthcare	S30006	Surgical Termination Establishment and Admin Costs	Women & Child Health	1
MAGMA Healthcare	S30006	Surgical Termination of Pregnancy- 1st trimester	Women & Child Health	1
Massey University	COOC0074	Psychodiagnostic Assessment for Children - MDHB	Women & Child Health	1
Massey University	COOC0074	Psychologice Support for Children & Youth with Chronic Disease	Women & Child Health	1
New Zealand Police & Crest Hospital Ltd & Abuse and Rape Crisis Support (ARCS)		New Zealand Police & Crest Hosptial Ltd & Abuse and Rape Crisis Support (ARCS)	Women & Child Health	4
NZ Endometriosis Foundation		New Zealand Police & Crest Hospital Ltd & Abuse and Rape Crisis Support (ARCS)	Women & Child Health	4
Rangitane O Tamaki Nui-a-Rua	MAOR0105	Asthma Education	Women & Child Health	4
Rangitane O Tamaki Nui-a-Rua	COGP0003	Well Child Immunisation	Women & Child Health	4
Rangitane O Tamaki Nui-a-Rua	C01016	Well Child Services	Women & Child Health	2
Rangitane O Tamaki Nui-a-Rua	C01016	Well Child Services - Additional Contacts	Women & Child Health	2
Raukawa Whanau Ora	MAOR104B	Support Services for Mothers & their Pepi - Non Clinical	Women & Child Health	2
Raukawa Whanau Ora	COGP0003	Well Child Immunization	Women & Child Health	2
Raukawa Whanau Ora	C01016	Well Child Services	Women & Child Health	2
Raukawa Whanau Ora	C01016	Well Child Services - Additional Contacts	Women & Child Health	2

Royal NZ Plunket Trust	CO1013	Before School Check Programme	Women & Child Health	2
Royal NZ Plunket Trust	CO1013	Before School Check Programme - Incentive High Deprivation	Women & Child Health	2
Royal NZ Plunket Trust	CO1013	Before School Check Programme -Incentive 80-90%	Women & Child Health	2
Tararua Early Years' Service (Pahiatua Community Services Trust)	COGP0028	Family Support Worker	Women & Child Health	2
Tararua Health Group Ltd	COOC0055	Alcohol and Other Drug Services for Youth	Women & Child Health	2
Tararua Health Group Ltd	W02007	Labour & Delivery in Primary Maternity Facility	Women & Child Health	2
Tararua Health Group Ltd	W02008	Postnatal stay in Primary maternity Facility (Mother)	Women & Child Health	2
Te Papaioea Birthing Centre	W02020	Primary Birthing Services	Women & Child Health	1
Te Wakahuia Manawatu Trust	C01016	Well Child Services	Women & Child Health	2
Te Wakahuia Manawatu Trust	C01016	Well Child Services - Additional Contacts	Women & Child Health	2
University of Otago		Epidemiology Report Children & Young People	Women & Child Health	4
Whanganui DHB		Local Child Mortality Review Coordination	Women & Child Health	4
Whanganui District Health Board	DSS221	ASD Developmental Coordination Function	Women & Child Health	4
Youth One Stop Shop	COOC0055	Admin Support - Levin	Women & Child Health	1
Youth One Stop Shop	COOC0055	Counselling Services	Women & Child Health	1
Youth One Stop Shop	SHO1006	Sexual Reproductive Health Services	Women & Child Health	1
Youth One Stop Shop	COOC0055	Social Work Services	Women & Child Health	1
Youth One Stop Shop	COOC0055	Waiopehu School Based Health Services (GP Hours)		1
Youth One Stop Shop	COOC0055	Youth Health GP Horowhenua		1

CLUSTER CONTACT INFORMATION				
Clinical Executive				
Operational Executive				
Clinical Programmes Lead				
Planning &Integration Lead				
Director of Midwifery				
Children's Health				
Charge Nurse Children Ward				
Charge Nurse Neonatal Unit				
Coordinator Child Development				
Clinical Nurse Manager				
Medical Lead				
Women's Health				
Medical Lead				
Charge Midwife Delivery Suite				
Midwife Maternity Ward				
Gynaecology Charge Nurse				
HOSPITAL CONTACT INFORMATION				
Facilities Manger				
Spotless Manger				
Administration (Front Desk)				
Shift Engineer				
Catering				
Hotel services manager				
Cleaning Services				
Orderlies				
Security				
Short Term Loan				
Duty Supplier				
Information Services	Help Desk			
Risk and Emergency Management				
Occupational Health and Safety				
Pharmacy				
Fleetwise	Helpdesk			
Fleetwise	After hours			
Duty Nurse manager				

COVID-19 Resurgence Plan

MidCentral District Health Board

Contents

Introduction 4
Section 1 – Planning and Response Context 5
Situation 5
Purpose 5
Alignment 5
MDHB Strategy and Guiding/Planning Principles/Values 6
Planning principles 6
Te Tiriti o Waitangi 7
Equity 7
Flexibility and scalability 8
Scientific evidence base 8
Infection Prevention and Control 8
Health and Safety for our staff and our population 9
Communications and engagement 9
Sustainability 10
Workforce, personal development and planning 10
Integration of response 11
Quality and safety of care 11
Our district 12
National Response Coordination and Leadership 13
All of Government (AoG) 13
COVID-19 Alert Levels 13
AoG COVID-19 Resurgence Plan 14
Ministry of Health 15
NEMA and Manawatū/Whanganui CDEM 15
Response Scenarios and Planning Assumptions 16
Ministry of Health 16
MidCentral District Health Board 17
Social and economic environment 17
The broader health and wellbeing provider partnership 17
MDHB systems and processes 18
Section 2 – Readiness and Response Coordination 19
Governance arrangements 19

Coordination arrangements 19
Mission, intent and objectives 19
Local scenario 19
AoG response scenarios 20
Readiness and response phases 21
Readiness 21
Response 21
Scenarios for escalation 21
Scenarios 21
Triggers 22
Section 3 – Roles and Responsibilities 23
Manawatū-Whanganui Regional Leadership Group 23
MidCentral District Health Board 23
Manawatū-Whanganui CDEM Group 23
MDHB Organisational Leadership Team 23
MDHB Incident Management Team 24
MDHB People Leaders, Clinical Leaders, and Operations 24
Section 4 – Operational Context and Sub Plans 25
Section 5 – Legislative Frameworks 26
COVID-19 Public Health Response Act 2020 26
NZ Public Health and Disability Act 2000 26
Health Act 1956 27
Civil Defence Emergency Act 2020 and CDEM Plan Order 2015 28
Coordination and Enforcement 28
Appendix One – New Zealand COVID-19 Alert Levels 29
Appendix Two – Ministry of Health Resurgence Planning Framework: DHB Responsibilities/Action Plan 30
Appendix Three – Adapted MDHB CIMS Structure 35
Appendix Four – National Hospital Response Framework 36
Appendix Five – National Community Response Framework 37

Introduction

This Resurgence Plan describes the MidCentral District Health Board (MDHB) plan to prepare for and manage the local response to further outbreaks of novel coronavirus disease 2019 (COVID-19). This plan aims to provide people in leadership positions with a framework for the delivery of the actions required to respond rapidly to an outbreak, whilst at the same time maintaining 'business as usual' (BAU) as much as possible. This plan operationalises an elimination strategy that seeks to eradicate or minimise cases of COVID-19 from MDHB to a level that is manageable by the health system and covers vaccination to achieve population-level immunity.

The key goal is to achieve a response that is proportionate to the level of risk, acknowledging that the risk is not the same across population groups. A response that is appropriate to the level of impact the novel coronavirus outbreak is likely to have on our community at large, and on vulnerable populations such as Māori, Pasifika and refugee populations within the community, will make the best use of the resources available.

The plan will be updated as new information becomes available and will be used to:

- guide the allocation of resources
- put in place strategies to support our population in partnership with local health providers, iwi, Māori, and intersectoral partners
- reduce the risk to the most vulnerable people in our population.

The plan has been developed in collaboration with other District Health Boards (DHBs) and partner agencies. MDHB has used the guidance from the Ministry of Health, and elements of resurgence planning approaches used by Horizons Regional Council and other DHBs in our region, to ensure consistency. This enables coordination of efforts, which are critical in a response to a pandemic.

This plan covers the needs of the population of MidCentral District with appropriate attention to the needs of people more susceptible to COVID-19. The priority population groups of focus include Māori, Pacific peoples, older people, people with disabilities, people with mental health conditions, people in residential care settings, migrant and refugee communities, and people with pre-existing health conditions.

Having a detailed integrated plan with commitment across the sector, will ensure that we can respond quickly and effectively to any resurgence of COVID-19 within the district, and minimise the potential negative health impacts on our population. The plan will remain under continual review as more information on the management of the response becomes available.

Section 1 – Planning and Response Context

Situation

Since COVID-19 was declared a Public Health Emergency by the World Health Organization in January 2020, the direct and indirect impacts of the virus have been felt around the world. The New Zealand Government has determined it will follow an elimination strategy.

The Government is currently pursuing an elimination strategy that aims to eradicate or minimise cases of COVID-19 from New Zealand to a level that is manageable by the health system, until sufficient numbers of the population have received the vaccine to enable a level of population immunity to be achieved. Achieving this and maintaining it over time will be challenging and requires the deployment of a range of control measures to:

- **Identify and stop transmission** – through rigorous testing and community surveillance; rapid intensive contact tracing and action to manage clusters including quarantine and isolation and prevention strategies such as vaccination.
- **Prevent undetected transmission** – through protocols for self-isolation of suspected cases; prohibiting mass gatherings; physical distancing and hand hygiene.
- **Prevent overseas infection spreading** – through border measures, restrictions on travel and isolation or quarantine.

COVID-19 was first detected in New Zealand in March 2020. There was a national Level Four lockdown from March 2020 for five weeks. Since that time there has been resurgence and small clusters of infections. This plan aims to support MDHB in its response to resurgence of the virus.

Purpose

To outline the readiness and response arrangements relating to the coordination and leadership across the MDHB District, to enable a coordinated whole of district response to resurgence.

Alignment

The plan is aligned to national guidance and MDHB's strategy, priorities, and values. It follows the expectations of the National Emergency Management Agency (NEMA) and the requirement to work within regional planning arrangements and under Civil Defence Emergency Management (CDEM) guidance. The plan references the MDHB Pandemic Plan and has several operational plans which support the delivery of this in action.

MDHB Strategy and Guiding/Planning Principles/Values

MDHB has a vision of quality living, healthy lives and well communities. During COVID-19 resurgence the commitment to our vision through the delivery of our four strategic priorities has never been more important. Our strategic priorities are:

- Achieve equity of outcomes across our communities
- Partner with people, whānau and communities to support health and wellbeing
- Connect and transform primary, community and specialist care
- Commit to quality and excellence in everything we do.

Our values will underpin the way in which we plan and deliver activities associated with resurgence. We will be true to our values, and be compassionate, respectful, accountable and courageous in all activities in this plan.

Planning principles

Planning activity for any increase in case numbers will focus on:

- honouring our commitment to Te Tiriti o Waitangi
- ensuring safe sustainable hospital services including regional responsibilities
- ensuring safe sustainable community services to meet demand
- ensuring safe sustainable Public Health Services to meet demand
- ensuring that our staff are safe and supported in delivering this plan
- ensuring a proportionate, scalable, evidence informed and flexible response
- providing a coordinated approach across the health and disability sector and with other sectors
- balancing COVID-19 with other business as usual (BAU) health and disability services
- recognising that other emergencies (e.g., natural disasters) may occur during this time
- supporting and maintaining quality health and disability services
- focusing on priority, at risk populations and improving equity
- communications to engage, empower and build confidence in the wider community (customising as appropriate for certain populations)
- supporting the health, welfare, and social needs of health care workers
- prioritising the ongoing maintenance of effective infection prevention and control practices

- handling the management and distribution of personal protective equipment (PPE) consistently, transparently, and equitably
- coordinating and ensuring consistency of communications to and from key stakeholders
- reviewing and/or documenting systems, processes, policies, standard operating procedures (SOPs), standard communications etc. for training and future use
- working with and developing people we have locally, so that we can be self-sufficient should we need to be
- ensuring all plans and responses across the health and disability sector are prioritised and integrated.

Te Tiriti o Waitangi

Te Tiriti o Waitangi and its articles and principles, as articulated by the Courts and the Waitangi Tribunal, legislate our commitment to our iwi partners; Muaūpoko, Ngāti Kahungunu ki Tāmaki nui a Rua, Ngāti Kauwhata, Ngāti Raukawa ki te Tonga, Rangitāne o Manawatū, and Rangitāne o Tamaki Nui a Rua.

MDHB acknowledges the significance of Te Tiriti o Waitangi as a foundational document for public policy. Te Tiriti guides MDHB in how it governs and conducts itself, how true partnership with iwi is demonstrated, how beliefs, values and tikanga are cherished and how excellence, in all its definitions, is attained.

Equity

Equitable access to health and disability services and health outcomes is central to all planning and response measures for any outbreak of COVID-19. Eight priority populations facing specific risks because of COVID-19 have been identified:

- Māori
- Pacific peoples
- Older people, especially those over 70 years
- People living in residential care facilities
- People with long term conditions
- People with disabilities
- People with mental health conditions
- Refugees and migrant community members.

All planning must include targeted approaches to support these groups.

In addition to these priority groups, special consideration must also be given to healthcare workers, including those who work in residential care settings.

Flexibility and scalability

Given the unpredictability of the timing, nature, and scale of any potential resurgence of COVID-19 in MDHB District, all planning needs be scalable to a range of scenarios and progressively implemented based on the situation and circumstances existing at the time. Flexibility in all planning is required such that actions can be modified as necessary to meet these uncertainties and potentially changing situations.

Scientific evidence base

Actions taken to give effect to the objectives of this plan should reflect scientific principles and be either based on, or informed by, the best available evidence. In practice, this means referring to and applying knowledge that has been developed through examination of the evidence base and robust consideration of the suitability for application in the New Zealand and the MDHB district context.

Infection Prevention and Control

Effective infection prevention and control (IPC) practices are, and will continue to be, a priority. This applied to all health care settings is relevant to preventing, planning for, and responding to any further outbreaks, providing a safe environment for health care workers, caregivers and their patients, clients, and visitors.

Infection prevention and control objectives and actions will be reflected through all planning including:

- ensuring IPC guidance measures and contingencies are in place
- regularly updating IPC protocols based on current scientific/clinical knowledge
- maintaining adequate stock of health sector PPE including their actual and projected use
- ensuring that all staff required to wear respiratory protective devices are qualitatively fit tested
- reinforcing infection prevention and control interventions and messages.

Health and Safety for our staff and our population

The plan will protect individuals who are most at risk of severe infections from exposure to COVID-19. MDHB will:

- use the nationally agreed 'vulnerable' staff assessments undertaken by Occupational Health to assess individual risk within the workforce
- redeploy vulnerable staff based on the assessed category into appropriate work areas
- define and establish protected workspaces to enable universal protection as far as is feasible
- define levels of physical distancing
- require physical distancing for people working in or with at-risk communities.
- identify interventions to protect people who are high risk, if they or their close contacts develop COVID-19
- enable staff to work off site in line with MDHB's working from home guidelines
- maintain up to date registers on all employed staff vaccination status.

Communications and engagement

Engaging with and using the strength of our community is critical to an effective response to resurgence, minimising harm and keeping everyone safe. Communicating effectively has been one of the cornerstones of the response to COVID-19 to date and is crucial to all involved in preparing for and responding to a pandemic. Good communications with all stakeholders and our community are critical to a successful resurgence response. Key considerations include:

- Customisation – both content and means of delivery, particularly to priority groups.
- Accessibility – information about COVID-19 should be accessible for all New Zealanders and may need to be translated into alternate formats and key languages.
- Cross-sector engagement – needs to be open, transparent, consistent, and able to transcend organisational boundaries.
- Partnerships and empowerment of community – we have seen how effective this is when we seek and support community leaders to enable and support others.
- Following the principle of 'nothing about us without us' in developing communications.

Sustainability

All international evidence and experience indicate that COVID-19 outbreaks are difficult to control once community transmission takes hold and that response activities put significant pressure on health system resources. Planning for any resurgence within New Zealand therefore needs to acknowledge that should current elimination strategies be unsuccessful we could find ourselves in a significant response phase that could go on for some weeks or even months, requiring us to sustain an appropriate level of response over this time.

Sustainability needs to be considered in relation to the following:

- Health system workforce – health, wellbeing, and resilience.
- Patient Management Systems and the effective sharing of information.
- Coordinated Incident Management System (CIMS) roles, systems, and processes including effective two teaming and handover.
- Facilities – readiness, capacity and flexibility.
- Equipment – access, transportation and supply chain.
- PPE
- Finance
- Public/community support.

Workforce, personal development and planning

A sustainable workforce and response structure are critical, ensuring we have people trained and developed to fill, backup and/or support key roles.

Specific areas identified for special attention in the current environment include:

- Incident Controllers and other CIMS leadership roles
- CIMS/Incident Management support expertise
- Public Information Management
- IPC and Occupational Health and Safety
- Security
- Welfare leadership and support navigators
- Digital connectivity.

Specific training is also required for some procedures and processes including:

- PPE/mask fit testing
- Swabbing

- Contact tracing
- Medapp usage
- Vaccination delivery and coordination
- Laboratory services (including registration)
- Information system user guides and training documentation.

The need for training and development must be considered in the review of all plans and standard operating procedures.

Integration of response

The MidCentral district health community of providers is a system of inter-connected parts. As services develop resurgence plans and strategies as part of this plan, each will need to consider the impact of any activity on any other connected or supporting component, to ensure effective and efficient flow through the system. At times there may be a need to compromise on business as usual activity, due to the (non)availability of logistic or personnel support, and/or a constraint or 'bottle-neck' in the system further up the line. Flexibility to work together and differently, to meet the needs of the community will be paramount.

The requirement for integration also extends through the entire response, ensuring that all key functions are aligned and focused on the same key outcome or objective.

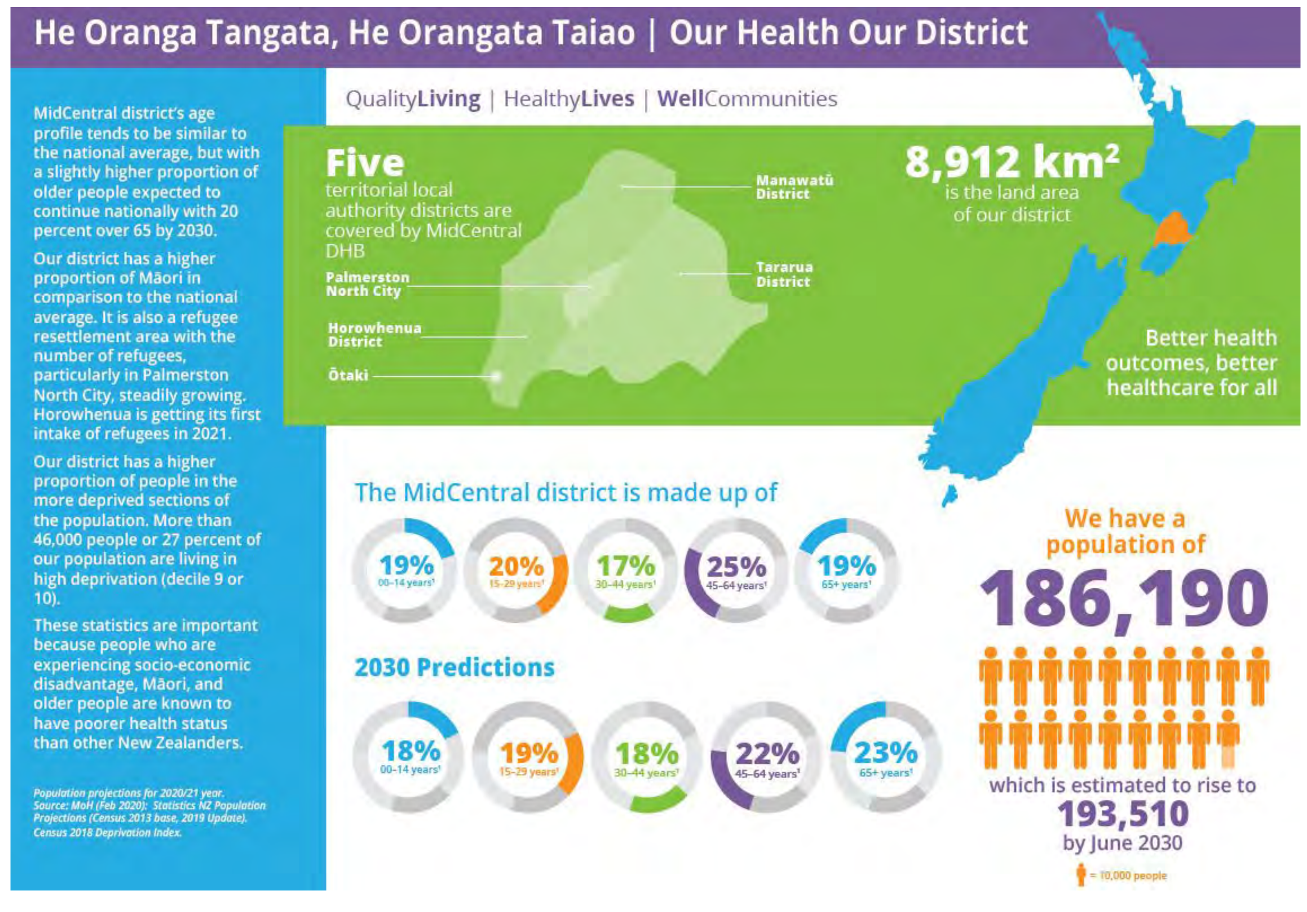
Quality and safety of care

As providers of public funded health and disability services, all MDHB staff and contracted providers need to ensure they continue to meet the best possible standards of clinical quality and patient safety. It is acknowledged that during a pandemic, pressures of demand may at times exceed the ability of our staff, other providers or supporting services to satisfactorily meet that demand, and that some compromise to the 'normal' standard may be necessary. Delays in the delivery of non-urgent care may be one of these compromises during a resurgence response. This requires coordinated clinical risk management and strong clinical governance systems to minimise and mitigate risk.

In developing resurgence plans, MDHB will develop guidance and/or processes that can assist decision makers faced with the possible situation of demand exceeding the capacity, in the short and long term.

Our district

Understanding our district and communities enables us to work in partnership with them to better plan responses and services that meet the community and its people's needs.



National Response Coordination and Leadership

All of Government (AoG)

The New Zealand Government is taking an 'All of Government' approach to responding to COVID-19. This includes establishing a National Response Leadership Team (which includes the Chief Executive of the National Emergency Management Agency (NEMA) and the Director-General of Health) to provide advice direct to Cabinet.

Key to the national response to date has been the development and application of COVID-19 alert levels.

COVID-19 Alert Levels

Level 1

- **Prepare** – Disease is contained.

Level 2

- **Reduce** – Disease is contained but risks of community transmission are growing.

Level 3

- **Restrict** – Heightened risk that disease is not contained.

Level 4

- **Eliminate –** Likely that disease is not contained.

A range of measures that can be applied locally or nationally have been developed for each of these alert levels. Details of these are attached as **Appendix One.**

AoG COVID-19 Resurgence Plan

An AoG Resurgence Plan has been developed, based on the following principles:

- Continue to pursue an elimination strategy for COVID-19. This means a sustained approach to keeping it out, finding it, stamping it out.
- The core of our response will be personal hygiene, staying home when sick, testing, contact tracing and isolation.
- When this is insufficient, we will seek to control COVID-19 with the least intrusive measures, including tailored local responses that will give us confidence that we will continue to deliver on our strategy of elimination.
- We will seek to avoid going to Alert Levels 3 or 4, if possible, although we will do so if necessary.
- There will be strong national oversight over any response, regardless of whether the response is local or national in scale. This will ensure adequate national level support and resourcing, continued confidence in our response, and the ability for the government to take appropriate action.

Three high level national objectives are set out in the AoG plan:

1. Minimise the number of people affected and exposed to COVID-19.
2. Minimise the negative health outcomes for those infected with COVID-19.
3. Minimise the economic and social impacts from any control measures.

The Ministry of Health (the Ministry) and NEMA are the two agencies primarily tasked with planning, implementing, and monitoring resurgence control measures. MDHB is directly accountable to the Ministry for regional resurgence planning and delivery of health-related services. It is also indirectly accountable to NEMA through the Regional Civil Defence and Emergency Management Group (CDEM) for supporting the AoG response.

Ministry of Health

As the lead agency, the Ministry of Health is responsible for coordinating the health and disability sector. It has developed a COVID – 19 System Response Plan. It is located here https://www.health.govt.nz/publication/covid-19-health-and-disability-system-response-plan

This plan supports the health sector with operational planning and ensures a coordinated and consistent response.

The purpose of the Plan is to:

- describe the health and disability system actions that will be triggered or could pe considered
- provide additional detail to support activities at an operational level
- be used by planners prior to or during an outbreak as an operational checklist of activities that will need to be implemented.

Targeted response measures need to focus on:

- ensuring a proportionate and effective response
- providing a coordinated and consistent approach
- supporting and maintaining quality health and disability services
- focusing on priority, at risk populations
- communication to engage, empower, and build confidence in the wider community.

The plan sets out some background, several key principles, a summary of roles and a Health and Disability System Response Action Plan. This Action Plan sets expectations for operational level planning by DHBs, Public Health Units and other agencies within the health and disability sector.

NEMA and Manawatū/Whanganui CDEM

NEMA has activated its National Coordination Centre (NEMA NCC) to coordinate the CDEM Sector response to any resurgence. NCC operates under a CIMS structure. Overall direction for the CDEM response is provided by the Director CDEM in their role as National Controller.

The Regional CDEM Group is the lead agency mandated to lead the coordination of the regional operational response to COVID-19 resurgence in the MDHB area. It is supported by MDHB, Territorial Local Authorities, Iwi, Horizons Regional Council, the Public Health Services, New Zealand Police, Ministry of Business, Innovation and Employment (MBIE), Ministry of Social Development (MSD), New Zealand Defence Force, Te Tihi Ruahine Whānau Ora Alliance and other local bodies.

MDHB is the lead for the health and psychosocial wellbeing response to COVID-19.

A Regional Public Service Leadership Group (RPSLG) has been established to provide governance and advice at a regional level to guide and support community resurgence planning and operational response activity. The MDHB Chair and CEO are members of the RPSLG.

Operationally, CDEM Group has agreed a Mission:

> Aligned to the principles of the Manawatū-Whanganui CDEM Group Plan of Consistency, Accountability, Best Practice, and Support, the mission of the Group is "To provide a planned and coordinated response to a COVID-19 resurgence in order to minimise the impacts on the regional community which we serve".

Response Scenarios and Planning Assumptions

Ministry of Health

Ministry of Health planning for resurgence is based on the following assumptions:

- The Elimination Strategy remains the overarching framework for the health and disability sector.
- In addition to the community cases detected in Auckland in mid-August and again in November 2020, further clusters of COVID-19 in New Zealand will occur in the coming months or year – new community cases could be detected at any time and case numbers could rise rapidly.
- The overall size and duration of subsequent outbreaks may well be different from the first outbreak and the recent Auckland clusters.
- The severity of the disease and the population groups affected may be similar to the first outbreak or the August Auckland community cluster, but ongoing vigilance will be needed to detect and respond to any changes in affected populations and severity.
- Resurgence may occur in conjunction with a concurrent event such as a flood, earthquake, or other emergency.

All sector organisations will use a CIMS framework in the immediate response to a resurgence.

MidCentral District Health Board

Given the current environment in MDHB, current assumptions about the future include:

- Timing of a potential increase in COVID-19 remains uncertain – new community cases could be detected at any time and with little or no warning.
- The overall size, steepness, and duration of a second outbreak may well be different from the first outbreak.
- The severity of the disease and the population groups affected may (or may not) be like the first outbreak, but ongoing vigilance will be needed to detect and respond to any changes in affected/at risk populations and severity.
- Any resurgence will result in some loss of life in MDHB at some stage.
- Vaccination has commenced and is progressing well, but it will be some months before population level immunity is achieved.

Social and economic environment

- The community will behave appropriately to minimise potential for transmission.
- The public will become more complacent and the level of voluntary compliance with control measures, heighten during any resurgence, but will decline over time.
- The NZ economy will decline, and unemployment will rise.
- Securing, building, and maintaining sufficient housing stock will continue to be a significant challenge in our district.
- Domestic violence is a challenge and may increase.
- Self-harm may increase.
- Social media will create misinformation and potential 'panic'.

The broader health and wellbeing provider partnership

- Management and all staff remain committed to investing in and support resurgence planning.
- Required training will be provided for key roles.
- A level of BAU will be retained during response.
- Demand for mental health services will increase.
- Health workers will suffer from fatigue which will need to be managed. It is highly likely that public health staff will be called upon to have surge capacity for other regions impacted and that MDHB will need to call on other regions if we have a significant outbreak.
- General Practice Teams will be doing telehealth-based triage/consults.

- There will be stockpiling of PPE in various areas.
- At Alert Levels 3 and 4, many essential workers will not be available due to either being at risk, caring for family members etc.
- There may be some resistance from staff to re-engage, but a level of goodwill will remain.
- We will cope with what we have, should any outbreak become national and 'outside' support not be available.

MDHB systems and processes

- The MDHB Pandemic Plan is up to date and relevant.
- A COVID-19 specific operating procedure will bring together the disease-specific actions required and will complement the Pandemic Plan and the COVID -19 Resurgence Plan – work is underway to create a nationally consistent approach, but this may fall behind the need for it.
- Issues identified from debriefs of the first outbreak will have been addressed.
- Robust business continuity plans exist and are readily available.

Section 2 – Readiness and Response Coordination

Governance arrangements

MDHB Board is accountable to ensure decision making is robust and supports our community during any civil or health emergency. MDHB will work in partnership with the Regional Leadership Group to support any regional or intersectoral response. The Chair of the Board and the Chief Executive (CEO) are members of this leadership group.

The CEO is accountable for making decisions relating to the operational activity of MDHB during any resurgence and when to establish an incident management team to respond and coordinate a response.

The Organisational Leadership Team is collectively accountable for the delivery and coordination of the response under the overall direction of the CEO and the IMT (if established).

Coordination arrangements

MDHB will establish the incident management team to coordinate and manage the district health response to any resurgence or risk of resurgence of COVID-19 in our community based on national guidance, alert levels, hospital management frameworks and other triggers.

Mission, intent and objectives

Mission: To manage all aspects of Health Response to COVID-19 resurgence to enable MDHB to maintain essential health services for our communities.

Intent and objectives:

1. Minimising the potential for the spread of COVID-19 in accordance with national alert level protocols.
2. Supporting people with acute health needs to get appropriate treatment and ongoing care where necessary.
3. Keeping the community well informed.
4. Supporting our staff, volunteers and providers to stay well.
5. Maintaining essential services across the DHB.

Local scenario

The MDHB District spans a geographic area of over 22,000 kms2 from Manawatū District in the north and Ōtaki and Horowhenua District in the south, and Tararua

District in the east. Any road travel from the south of the North Island to the north of the North Island requires traversing through the CDEM Group area.

The district is also host to two large military bases (Ohakea and Linton). Military personnel have and continue to be used for the staffing of COVID-19 Managed Isolation and Quarantine Facilities across New Zealand. MDHB is also responding to Ministry of Health requirements to establish secure isolation and quarantine facilities in our district.

The most likely scenario regarding the potential for community transmission from COVID-19 is that of it being brought into the region from an external source, either traversing through the region, or returning to the region.

AoG response scenarios

There are four high-level resurgence scenarios that are being used to support AoG resurgence planning. The MDHB response to these scenarios is indicated. The scenarios are:

Scenario	Description	MDHB response
Scenario One	**Only one or two further cases are detected amongst close contacts and there is a connection back to the original source of infection at the border.** The likely response is that the region moves to Alert Level 2 – e.g., physical distancing requirements, restrictions on gatherings and contact tracing requirements. Alternatively remaining at Alert Level 1 with some specific controls may be appropriate.	Maintain business as usual and activate Level 2 protocols if required
Scenario Two	**A single cluster of connected cases in the region, with no evidence of community transmission in the region and no cases in other regions.** The likely response is moving the region to Alert Level 3. Alternatively, a move to Alert Level 2 may be sufficient. The rest of the country could stay at Alert Level 1.	Follow national direction and activate Level 2, 3, 4 protocols as directed. Activate IMT if required.
Scenario Three	**Widespread community transmission in the region but no confirmed cases detected in other regions.** The region is likely to move to Alert Level 3 or 4. It may also be appropriate for the rest of the country to move to Alert Level 2	Follow national direction, activate appropriate Level 2, 3, 4 protocols. Activate IMT if required.
Scenario Four	**At least one cluster in the region and confirmed cases in other regions.** The region where the cluster began would move to Alert Level 3 and other regions with cases would shift to Alert Level 3 and unaffected regions to Alert Level 2. Depending on the number of affected regions, the Government would have to consider broader national action.	Follow national direction, activate appropriate Level 2, 3, 4 protocols as required. Activate IMT if required.

Readiness and response phases

Readiness

MDHB maintains a number of CIMS trained personnel with which to form and sustain an Incident Management Team. All activities are conducted in accordance with Coordinated Incident Management System (3rd Edition) CIMS protocols.

Response

MDHB will establish the incident management team (IMT) to coordinate and manage the district health response to any resurgence or risk of resurgence of COVID-19 in our community based on national guidance and alert levels, national hospital and community response frameworks or other relevant triggers.

The MDHB IMT will ensure timely updates to our regional partners through:

- daily Situation Reports (Sit Reps)
- twice-daily teleconferences – emergency operations centre to other regional centres
- MDHB Incident Actions Plans.

Scenarios for escalation

Of the four AoG response scenarios there are three that could potentially require an escalation from the countries current setting of Alert Level 1, however all four scenarios do require a level of MDHB coordination. They will also require MDHB to work with the Regional Leadership Group within the CDEM response.

Given the unpredictability of the timing and scale of any potential resurgence of COVID-19 in MDHB, relevant components of this Plan will need be scalable to a range of scenarios and progressively implemented based on a number of triggers.

Scenarios

For planning purposes, four scenarios will be used:

- No active cases in the MDHB district.
- Small number of active cases in MDHB or out of region requiring a Public Health response.
- Cases increase in MDHB but contained to small number of clusters.
- Substantial number of cases – community transmission is evident across the community.

Triggers

MDHB will use the national alert levels and the national hospital and community alert framework as a guide to the actions we take against status in the hospital or community setting. Specific components of this plan will need to be activated at various times within any of these scenarios to appropriately meet the needs of the community.

Section 3 – Roles and Responsibilities

Manawatū-Whanganui Regional Leadership Group

- **Convene** regional leadership and ensuring a regional Strategy/Plan that caters to different communities.
- **Connect** local government, iwi, Pasifika, ethnic communities and key central government personnel.
- **Support** the distribution of key messages and aid to community networks.

MidCentral District Health Board

- **Lead** the identification, control, and elimination of any COVID-19 outbreaks in the Manawatū-Whanganui region.
- **Coordinate** the health sectors response to COVID-19.
- **Lead** regional testing efforts by establishing appropriate facilities as relevant.
- **Maintain** a functional relationship with the CDEM Group Controller and advise and update on existing and emerging issues.
- **Lead** the provision of psychosocial support for the region.
- **Identify and establish** appropriate regional quarantine facilities – if required.
- **Provide** health support to the region's Managed or Supported Isolation and Quarantine Facilities – if established.
- **Maintain** readiness for any other health or Civil Defence emergency.

Manawatū-Whanganui CDEM Group

- **Lead** the regional coordination of readiness, response, and recovery for the Group.
- **Support** local CDEM activities across the Group.
- **Coordinate** the provision of emergency welfare services via the Welfare Coordination Group if required due to all other options being exhausted.
- **Create** and maintain situational awareness.

MDHB Organisational Leadership Team

- **Lead** the MDHB operational response.
- **Maintain** business as usual to the extent that it is feasible based on the level of resurgence in the community and the national alert level requirements.

MDHB Incident Management Team

- **Coordinate** and lead the incident response team.
- **Lead** decisions and reporting.

MDHB People Leaders, Clinical Leaders, and Operations

- **Support** delivery of quality care.
- **Support** and protect workforce wellbeing and ensure health and safety of the workforce.
- **Enable** the response through coordination of activities as directed through the IMT.

Section 4 – Operational Context and Sub Plans

MDHB will deliver the COVID-19 Resurgence Plan in the context of the MDHB wider Pandemic Plan. Detailed Resurgence Operating Plans and Procedures have been developed for the following focus areas:

- MDHB Resurgence Readiness Plan
- Community Resurgence Plan
- Testing Surge Plan
- Contract Tracing Surge Plan
- Hospital Plan
- Incident Action Plans
- Business Continuity Plans.

Action plans are in place for each area of our response, against all levels of national alert (Level 1 to 4).

Section 5 – Legislative Frameworks

COVID-19 Public Health Response Act 2020

The COVID-19 Public Health Response Act 2020 (COVID-19 Act) is the primary legislation for addressing COVID-19 Response and recovery issues. The purpose of the Act is to support a public health response to COVID-19 that:

- prevents and limits the risk of the outbreak or spread of COVID-19 (considering the infectious nature and potential for asymptomatic transmission of COVID-19).
- avoids, mitigates, or remedies the actual or potential adverse effects of COVID-19 outbreak (whether direct or indirect).
- is coordinated, orderly, proportionate and has enforceable measures, in addition to the relevant voluntary measures and public health and other guidance that also support the response.

This Act created a comprehensive legal framework to support the Government's alert level system to limit the spread of COVID-19 in NZ and other measures necessary to respond to COVID-19.

Particularly relevant is that the COVID-19 Act enables the Director General of Health or the Minister of Health to make 'Section 11' Orders which can require specific actions to be taken, measures to be complied with, or restrictions to be put in place to prevent or limit the extent or spread of COVID-19. This power is broadly based on the powers in sections 70 and 921 of the Health Act 1956 but lifts the 'approval' level to the Minister of Health rather than just the Director-General.

The COVID-19 Act provides the legislative authority for all Maritime and Aviation Orders for the effective management of relevant issues at our borders. With a port (receiving overseas ships) and an airport within Hawkes Bay, our Medical Officers of Health and Public Health Unit are actively involved in monitoring and managing compliance with these Orders.

The COVID-19 Act also over-rides many of the powers conferred on Group Controllers under the Civil Defence Emergency Management Act 2002, when dealing with COVID-19 related issues.

NZ Public Health and Disability Act 2000

Under this Act, an objective of DHBs is to improve, promote and protect the health of people and communities.

To this end DHBs have several statutory functions, including 'ensuring the provision of services for its resident population' and 'collaborating with relevant organisations to plan and coordinate at local, regional and national levels for the most effective and efficient delivery of health services.'

Health Act 1956

The Health Act 1956 (HA) is the primary statute for the prevention and control of infectious diseases within the country and at the border. This Act works alongside the more general CDEM Act and other statutes.

Of relevance, with the Prime Minister issuing an epidemic notice pursuant to s5 of the Epidemic Preparedness Act 2006, this triggered the ability of the Director General of Health and Medical Officers of Health to make orders pursuant to s70 of the Act.

Section 70 notices can cover a wide variety of topics. Potentially relevant, the order may:

- require people to report themselves or submit themselves for medical examinations.
- require people to report or submit themselves for medical testing.
- require persons, places, buildings, ships, vehicles, aircraft, animals, or things to be isolated, quarantined, disinfected, or tested.
- forbid people, ships, vehicles, aircraft, animals, or things to come or be brought to any port or place in the health district from any port or place which is or is supposed to be infected with any infectious disease.
- require people to remain in the health district or the place in which they are isolated or quarantined until they have been medically examined and found to be free from infectious disease, and until they have undergone such preventive treatment as the Medical Officer of Health may prescribe.
- forbid the removal of any ships, vehicles, aircraft, animals, or things from the health district, or from the place where they are isolated or quarantined, until they have been disinfected or examined and found to be free from infection.
- use or authorise any local authority to use as a temporary site for a special hospital or place of isolation any reserve or endowment suitable for the purpose.
- require a premise to be closed (conditions apply).
- forbid people to congregate in outdoor areas (conditions apply).

In terms of property, s 71(1) of the HA empower the Medical Officer of Health to:

- take possession of, occupy, and use any land or building that in his or her opinion is required for the accommodation and treatment of patients.
- take possession of, occupy, and use any land, building, or craft (other than an aircraft), that in his or her opinion is required for the storage or disposal of bodies.

- take possession of or use any vehicle or craft that in his or her opinion is required for the transport of:
    - patients, medical personnel, medicine, medical equipment or devices, food, or drink or clothing, bedding or tents or other temporary facilities or structures
    - personnel involved in loading, moving, distributing, erecting, or otherwise dealing with anything transported under the above.

Civil Defence Emergency Act 2020 and CDEM Plan Order 2015

The CDEM Act 2002 and CDEM Plan Order 2015 provide the legislative basis for CDEM Groups to coordinate the multi-agency response to an emergency (declared or undeclared) within their region.

The CDEM Act s17 (1)(d) provides that it is a function of CDEM Groups to respond to and manage the adverse effects of emergencies in its area. The CDEM Act contains provisions relating to the declaration of emergencies and gives Group Controllers a variety of powers to manage an emergency.

Section 6 of the CDEM Act provides that the '*CDEM Act does not limit, is not in substitution for, and does not affect the functions, duties or powers of any person under the provisions of any enactment or other rule of law'.* This means that the COVID-19 Act provisions take precedence over the CDEM Act, and that powers under the CDEM Act will only be used to fill any 'gaps' not covered in the COVID Act.

Coordination and Enforcement

The COVID-19 Act, Health Act and CDEM Act work together to create and maintain controls over the management and responses to COVID-19. There is a significant overlap between their powers. Coordination is therefore important.

COVID-19 is, at least during the response phase, primarily a health issue. Locally this means responsibility sits with MDHB. The wider social and economic impacts, however, require an all-of- government approach, which at a local level is coordinated by CDEM and the Regional Leadership Group.

If a person refuses to comply with any requirement issues under any of the three Acts, it is for the Police to exercise enforcement powers as is needed. Section 71A of the Health Act confers upon the police significant, and broad, powers to assist the Medical Officer of Health in the implementation of s70 and s71 powers. As a final port of call, s72 of the Health Act makes it an offence to obstruct or hinder a Medical Officer of Health or the Police in the execution of their duties under this Act.

Appendix One – New Zealand COVID-19 Alert Levels

New Zealand COVID-19 **Alert Levels**

Unite against COVID-19

- These alert levels specify the public health and social measures to be taken.
- The measures may be updated on the basis of (i) new scientific knowledge about COVID-19 and (ii) information about the effectiveness of intervention measures in New Zealand and elsewhere.
- The alert levels may be applied at a town, city, territorial local authority, regional or national level.
- Different parts of the country may be at different alert levels. We can move up and down alert levels.
- In general, the alert levels are cumulative, e.g. Level 1 is a base-level response. Always prepare for the next level.
- At all levels, health services, emergency services, utilities and goods transport, and other essential services, operations and staff, are expected to remain up and running. Employers in those sectors must continue to meet their health and safety obligations.

LEVEL	RISK ASSESSMENT	RANGE OF MEASURES (can be applied locally or nationally)
Level 4 - Eliminate Likely that disease is not contained	• Sustained and intensive transmission • Widespread outbreaks	• People instructed to stay at home • Educational facilities closed • Businesses closed except for essential services (e.g. supermarkets, pharmacies, clinics) and lifeline utilities • Rationing of supplies and requisitioning of facilities • Travel severely limited • Major reprioritisation of healthcare services
Level 3 - Restrict Heightened risk that disease is not contained	• Community transmission occurring OR • Multiple clusters break out	• Travel in areas with clusters or community transmission limited • Affected educational facilities closed • Mass gatherings cancelled • Public venues closed (e.g. libraries, museums, cinemas, food courts, gyms, pools, amusement parks) • Alternative ways of working required and some non-essential businesses should close • Non face-to-face primary care consultations • Non acute (elective) services and procedures in hospitals deferred and healthcare staff reprioritised
Level 2 - Reduce Disease is contained, but risks of community transmission growing	• High risk of importing COVID-19 OR • Uptick in imported cases OR • Uptick in household transmission OR • Single or isolated cluster outbreak	• Entry border measures maximised • Further restrictions on mass gatherings • Physical distancing on public transport (e.g. leave the seat next to you empty if you can) • Limit non-essential travel around New Zealand • Employers start alternative ways of working if possible (e.g. remote working, shift-based working, physical distancing within the workplace, staggering meal breaks, flexible leave arrangements) • Business continuity plans activated • High-risk people advised to remain at home (e.g. those over 70 or those with other existing medical conditions)
Level 1 - Prepare Disease is contained	• Heightened risk of importing COVID-19 OR • Sporadic imported cases OR • Isolated household transmission associated with imported cases	• Border entry measures to minimise risk of importing COVID-19 cases applied • Contact tracing • Stringent self-isolation and quarantine • Intensive testing for COVID-19 • Physical distancing encouraged • Mass gatherings over 500 cancelled • Stay home if you're sick, report flu-like symptoms • Wash and dry hands, cough into elbow, don't touch your face

Appendix Two – Ministry of Health Resurgence Planning Framework: DHB Responsibilities/Action Plan

Planning, Coordinating and Reporting

- Anticipate how the mental health and wellbeing of communities will or may be affected and develop, review, or maintain a psychosocial plan as appropriate.
- Maintain awareness of legislative instruments and authorisations.
- 'Localise' any Ministry of Health PPE distribution plan.

Intelligence

- Develop escalation points with triggers that identify the appropriate response.
- Regularly review surveillance indicators, the surveillance (testing) plan and intelligence reporting.
- Develop a clear picture of the data that can be accessed.
- Enhanced monitoring of health and disability sector capacity during a second outbreak.

Public Health Interventions

- Maintain readiness to implement rapid cluster control measures, particularly in high-risk settings, managed facilities, and communities, including:
    - identifying key cluster control staff
    - ensuring the system machinery is ready to be operationalised immediately, with a ready workforce.
- Plan arrangements for managed isolation and quarantine for community cases (and in some cases their household close contacts) who may be unwilling or able to self-isolate, including welfare support and psychosocial resources.
- Continue seasonal influenza immunisation campaign.
- Provide information and resources to health professionals across all providers and communities as determined by local needs and planning.
- Maintain International Health Regulations core capacity requirements.

Health Care and Emergency Response

- For consistency of messaging, ensure streamlined communications with one key point of contact for services and/or communities.

- Ensure health and disability sector readiness for new cases that may trigger a second outbreak – address potential pressure points in resurgence plans covering:
    - Primary Care – including coordination with local primary care providers, general practice, pharmacists, midwives, ambulance etc., regarding ICP protocols, distribution of and access to BAU consumables and national reserve supplies.
    - Capability to establish and then scale up community-based assessment centres (CBACs) and other testing centres at short notice.
    - Clear guidance and support for Residential Care (RC) providers, and on DHB obligations and responsibilities for Residential Care.
    - Guidance and support for Māori, Pacific, rural communities, mental health, disability, Lead Maternity Carer (LMC) providers.
    - Planning for continuation of care for vulnerable populations, particularly for those with long term conditions.
    - Proactive support for high-risk people and communities – including the provision of information on how to access health services, phone check ins, psychosocial and home support.
    - Telehealth services and technology to support relevant aspects of primary care with remote/virtual solutions.
    - ICUs (Intensive Care Units) – including staff training, bed space, ventilators, clinical networks.
    - Laboratory services – including surge capacity for testing (e.g., reagents, testing kits, workforce).
    - Ensure primary and secondary care has surge capacity, including plans for workforce and improvised health care facilities, and regularly assess DHB staff capability to ensure skills required are maintained.
    - Capability to care for and support patients at home.
    - Innovative/enhanced arrangements for palliative/hospice care.
    - Plans and policies for an outbreak in Residential Care.

Communications and Health Education

- Prepare, maintain, and review communications plan.
- Update the public and agencies/providers on the pandemic situation and key messages through regular media reports, websites, social media etc.
- Customise delivery of key messages to older people, Māori, Pacific, disabled people, residential care settings, people who experience psychosocial needs, rural populations, and any groups at higher risk of infection or severe outcomes.

- Disseminate key messages for all sectors, consistent with MoH plans and communications.
- Regular reviews of communication strategies.

Cross-Sectoral Actions

- Keep other agency staff and sectors updated on the situation and plans.
- Maintain up to date role and contact details of agency staff and key contacts in the sector.
- Coordinate planning between agencies when required.

RESPOND

Planning, Coordination and Reporting

- Activate resurgence action plan based on Ministry of Health advice.
- Lead/coordinate response for the local health sector.
- Set response objectives.
- Activate emergency management structures and processes, including business continuity plans, as required.

Intelligence

- Continue/intensify surveillance, including monitoring trends in case numbers.
- Closely monitor demographic/epidemiological trends in cases and clusters to ensure response measures prioritise affected groups/communities.
- Analyse the event, complete ongoing risk assessments, including impacts and event evolution.
- Ensure clear, accurate and up-to-date intelligence is disseminated appropriately.
- Provide regular situation reports and maintain distribution lists.
- If incidence and/or severity increases, review the need for additional intelligence and interventions.
- Ensure that equity remains at the centre of all decisions.
- Maintain communication with NZ Police and other emergency agencies to ensure that we have accurate intelligence about communities or people at high risk and needing early intervention or additional psychosocial support.
- Monitor and report on demand for and capacity of health services including inpatient numbers/capacity, ICU (Intensive Care Units) occupancy, mental health and addiction services, primary care, and ambulance call outs.

Public Health Interventions

- Intensify contact tracing, case finding, case and contact management and cluster control measures.
- Activate links with local Māori, Pacific, mental health and disability providers for contact tracing and cluster management.
- Review and revise as required information for health professionals on Ministry of Health website.
- Adopt and adapt further response measures at short notice.
- Coordinate with the Ministry of Health for the management of complex, large or multi-region clusters.
- Review, revise and implement as required, arrangements for supported isolation and quarantine.
- Review border control measures
- Continue seasonal influenza campaign (March to September)
- Continue disease prevention services.

Health Care and Emergency Response

- Activate resurgence action plans.
- Implement appropriate alert level of the Ministry of Health COVID-19 National Hospital Response Framework, and community-based providers take appropriate actions under COVID-19 Community Response Framework.
- Work alongside primary health and ambulance services to ensure capacity to manage an increase in cases of COVID-19 and those with respiratory symptoms.
- Support iwi and Māori partners to deliver health and welfare services to their communities.
- Ensure up to date guidance is disseminated and that distribution channels are agreed ahead of time.
- Provide guidance on the management/deferral of planned care and elective procedures.
- Maintain essential services and as much BAU health, mental health, and disability services as possible.
- Prioritise primary care access for vulnerable groups.
- Consider activating/or coordinate local facilities for managed isolation/quarantine of community cases/contacts.
- Provide funded temporary accommodation for health workers who cannot return home due to COVID-19 related issues.
- Review, update and disseminate clinical guidance as required.

- Provide guidance and support to Residential Care, LMC, general practice, pharmacy, and ambulance providers.
- Activate designated testing sites and other testing facilities as required.
- Maximise resilience of, monitor and where necessary, manage the supply chain for health care consumables and equipment, particularly critical supplies.
- Promote use of Healthline, 1737 and other wellbeing services.
- Monitor and report on service delivery, capability, capacity, and take action to address bottlenecks.

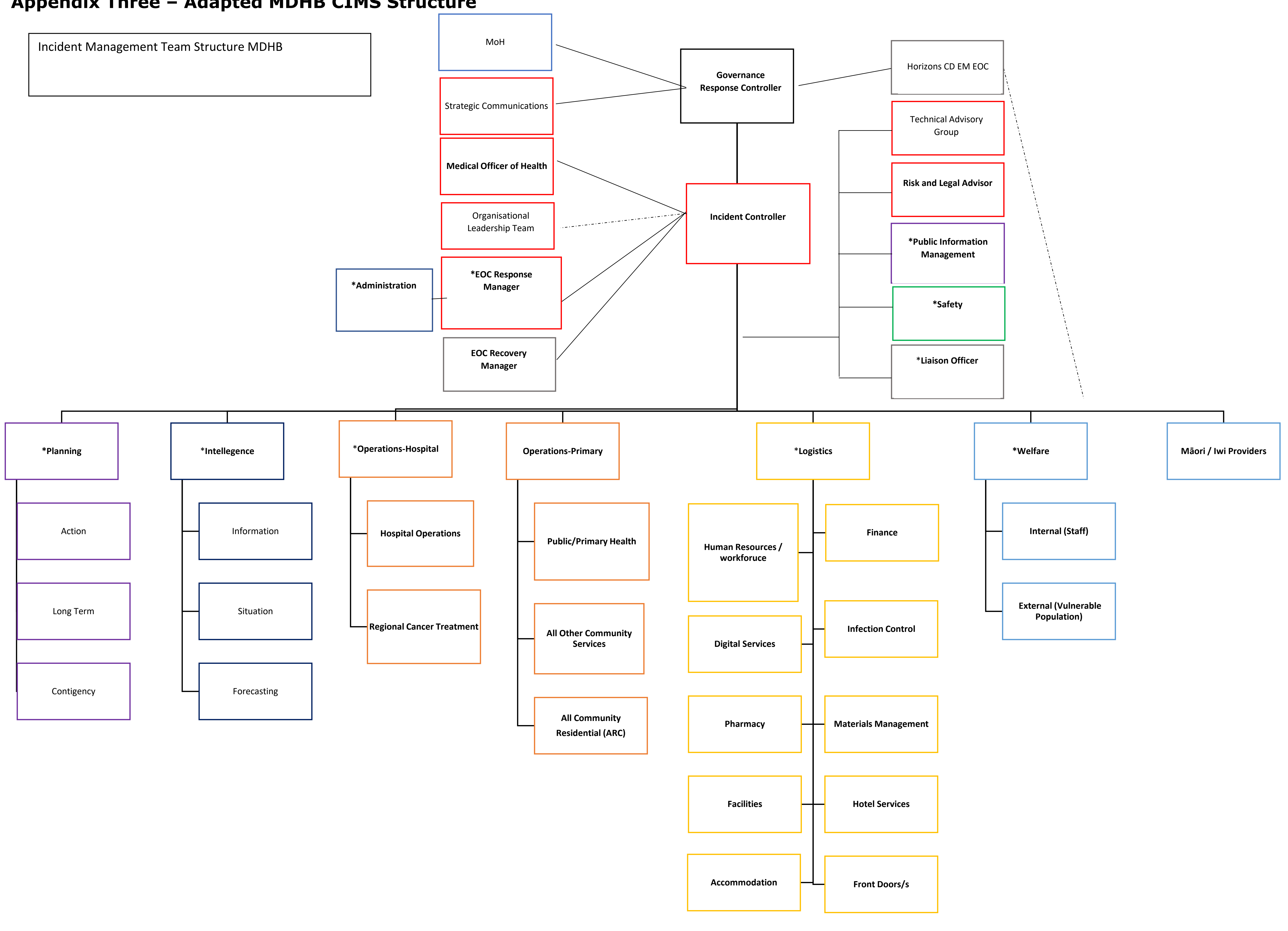
Communications and Health Education

- Update all available COVID-19 related public information.
- Release media updates.
- Ensure smooth and timely information communication with stakeholders.
- Continue to disseminate key messages to the public.
- Ensure material is customised, relevant and accessible and delivery platforms are appropriate to reach at risk populations.

Cross-Sectoral Actions

- Engage with the lead agency (or take lead as appropriate).
- Ensure all related agencies can be contacted 24/7.
- Keep staff and sectors updated.

Appendix Three – Adapted MDHB CIMS Structure



30/08/2021

All District Health Boards

National Hospital COVID-19 Escalation Framework – The Process

Purpose

- This Hospital Response Framework provides high level, nationally consistent guidance to support facilities and hospitals to appropriately and safely operate, while maintaining as much planned care and other service delivery as safely as possible, during any COVID-19 resurgence.
- The Alert Levels in this Framework are different from (though may be informed by) the Government's National COVID-19 Alert Levels and relate to COVID-19 activity within the local community and the risk present locally, as assessed by DHBs. They do not include activity related to Managed Isolation or Quarantine Facilities, except where a DHB assesses significantly heightened risk within their region that must be managed.
- The Framework aims to ensure that patients remain at the centre of care by making proportionate responses to escalations and de-escalations in the COVID-19 pandemic, to minimise disruption to planned and unplanned care delivery while maintaining quality and safety.
- It is possible for different hospital facilities and/or departments within a DHB to be at different Alert Levels at any given time.
- The overall DHB Alert Level should be reported each day to the Ministry of Health so that a national view of escalation can be compiled. This will be via the DHB SitRep.

Planning

- Hospitals are expected to operate in line with their current Alert Levels and have systems and processes proactively in place to identify and respond to any changes in levels (up or down) so that changes are made in a well-managed and planned manner with staff and resources prepared and trained beforehand.
- DHBs should ensure their ongoing capability to safely operate within this framework by periodic reassessment against the COVID-19 Resurgence Checklist.
- Each region should agree the means by which DHBs will keep each other informed of changes in Alert Levels and triggers for enacting agreed regional management plans.
- DHBs must develop their plans and decision-making processes in partnership with their DHB GM Māori Health and their DHB Iwi/Māori Relationship Board. This plan should identify Māori and other vulnerable populations and ensure health disparities do not increase as a result of the response to the COVID-19 pandemic. DHBs must maintain rigorous oversight of waiting lists, including a comprehensive plan setting out how the risk of patients deteriorating while waiting for assessment and treatment will be identified and managed.
- Te Tiriti o Waitangi and Equity are at the centre of each level of the Framework. Critically, DHB escalation and de-escalation will be managed in a way that actively protects the health and wellbeing of Māori and other vulnerable population groups. This includes active surveillance and monitoring of health outcomes for Māori and other vulnerable groups, to ensure a proportionate and coordinated response to health need for COVID-19 and non-COVID patients.
- DHBs' plans for management of Alert Levels must include a regional context and be discussed with primary care and other providers.
- When relevant (during any local resurgence) daily EEC meetings should be the mechanism whereby Alert Levels are changed or confirmed, and actions initiated in daily reporting. This decision should be clearly documented and evidenced, and communicated with senior clinicians, managers and other relevant senior personnel as part of the local response plan.
- This Framework may evolve over time and be revised and reissued as appropriate.

National Hospital COVID-19 Escalation Framework

COVID-19 Hospital Readiness

GREEN ALERT

Trigger Status: No COVID-19 positive patients in your facility; any cases in your community are managed and under control; managing service delivery as usual with only staffing and facility impact being for training & readiness purposes

- Screen patients for COVID-19 symptoms & epidemiological criteria for any Emergency Department attendances, pre-op sessions, planned admission, or clinic attendance
- Maintain ability to return, if necessary, to triage physically outside the Emergency Department (or outside the hospital building)
- Maintain a separate stream for COVID-19 suspected cases in the Emergency Department
- Undertake regular training and exercises for management of a COVID-19 suspected case in the Emergency Department, Wards, Theatres, ICU/HDU
- Maintain PPE training for COVID-19 care in the Emergency Department, wards, theatres, ICU/HDU, outpatients, other relevant settings
- Maintain plan for isolation of a single case & multiple cases/cohorting
- Maintain capability for instigation, if necessary, of Early Supported Discharge, aggressive discharge and step-down arrangements, including with other partners as appropriate (e.g. private, aged residential care, community providers)
- Maintain ability to instigate, if necessary, 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
- Maintain ability to instigate, if necessary, a dedicated COVID-19 ward
- Maintain engagement with alternative providers (such as private) regarding assistance during higher escalation levels, and to fast-track urgent, lower complexity care procedures
- Maintain and further develop the provision of outpatient activity via telehealth and phone screening for virtual assessment, and MDTs to videoconference wherever clinically appropriate and acceptable for patients
- Planned Care surgery, acute surgery, urgent elective and non-deferrable surgery to operate as usual, National Services to operate as usual, NTA to operate as usual
- Review patients on the waiting list (surgery, day case, other interventions) and group patients by urgency level
- Prioritise Planned Care surgery and other interventions by focusing on those with the most urgent need, and where ICU/HDU **is** required

COVID-19 Hospital Initial Impact

YELLOW ALERT

Trigger Status (individual or cumulative): One or more COVID-19 positive patients in your facility; any cases in your community are being managed; isolation capacity & ICU capacity manageable; some staff absence and some staff redeployment to support response and manage key gaps

- Continue screening for COVID-19 symptoms and epidemiological criteria 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 known or suspected 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)
- Engage across other DHBs to appropriately discharge out of area patients back to domicile hospital or other setting (to be considered in conjunction 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 patient is non-domicile
- Maximise the provision of pre-op assessments and outpatient appointments to be undertaken virtually, or in an off-site setting as necessary
- Plan to defer non-urgent pre-assessments and non-urgent clinic patients if necessary, ensuring clinical and equity risk is managed
- Activate any outsourcing arrangements, and engage on options for supporting 'cold trauma' cases and less-complex urgent cancer surgery
- 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, in accordance with agreed regional plan
- 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 only as essential

COVID-19 Hospital Moderate Impact

ORANGE ALERT

Trigger Status (individual or cumulative): 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

- Continue screening for COVID-19 symptoms and epidemiological criteria as per Green Alert
- Activate plans as described in Hospital Green and Yellow Alert levels
- Work with palliative care and other providers to agree alternative end of life services for non-COVID patients
- Provide Emergency Department services with prioritisation on high acuity medical and trauma care. Provide advice in non-contact settings where possible
- Fully activate any agreements with other hospitals or providers, including private
- Acute surgery to operate as staffing and facilities allow, with priority on trauma cases
- Prioritise urgent non-deferrable Planned Care cases not requiring ICU/HDU care
- Review and manage all non-urgent, high risk Planned Care surgery requiring HDU/ICU, adjusting the prioritisation threshold for surgery with Senior Clinicians for non-deferrable cases
- Increase ICU/HDU capacity as needed, retaining cohorting of known or suspected COVID-19 and non-positive patients, including moving non-COVID-19 ICU/HDU to theatre complex
- Implement acute ambulatory assessments or virtual/telehealth assessments for urgent, non-deferrable cases as staffing allows
- Manage outpatient referrals to ensure clinical and equity risk is understood and managed
- Activate regional management arrangements to support service delivery and minimise risk of patients waiting for services

COVID-19 Hospital Severe Impact

RED ALERT

Trigger Status (individual or cumulative): Multiple COVID-19 positive patients in your facility; community transmission uncontrolled; isolation and ICU 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
- Work with palliative care and other providers to agree alternative end of life services for non-COVID-19 patients
- Continue acute surgery as staffing and capacity allows, prioritising non-deferrable, life-saving surgery
- Cancel non-acute surgery to reduce transmission risk, and reprioritise capacity
- 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 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
- Only accept urgent outpatient referrals, but ensure clinical risk is understood and managed
- If other hospitals in the region are at the same Alert Level, activate out of region management arrangements

Version 4 released 18 August 2021

COVID-19 Community Response Framework v2.0

21 September 2020

The COVID-19 Community Response Framework was originally developed in April 2020 by the sector with support from the NHCC. The guidance aligned to the National Hospital Response Framework, to ensure that the actions and shifts required from the primary and community care sectors were in sync with hospitals.
Given the August outbreak of COVID-19 in Auckland, the document was refreshed to incorporate the latest learnings, progress and actions.
The intention is to revisit and update this document on a regular basis as the pandemic evolves.

Overarching Principles

- Equity should remain central to care with a focus on Māori, Pacific, people with disabilities and vulnerable populations.
- Maintain accurate records of all clients, particularly those more vulnerable.
- Where possible, in-person visits are preceded by screening for COVID-19 symptoms and Higher Index of Suspicion criteria, with referral to general practice/urgent care or testing centres as appropriate.
- Ensure cleaning and hand hygiene are incorporated into routine practice.
- Adhere to physical distancing and other Infection Prevention Control (IPC) advice.
- Personal protective equipment (PPE) should be used according to guidance from the Ministry of Health (MoH)
- Ensure sufficient stocks of PPE, alcoholic hand gel and cleaning products.
- Staff who are unwell or are contacts of cases should follow MoH and public health guidance.
- Occupational risk assessment tools and guidance should be used to identify staff more vulnerable to COVID-19 and to assess and mitigate their risks through workplace restrictions and modifications.
- Services should support and enable contact tracing, for example using the NZCOVID Tracer app or other records.
- The National Telehealth Service advice lines are available. This includes Healthline (0800 611 116) and the dedicated COVID-19 health advice line (0800 358 5453) – both available 24/7. The COVID-19 clinical advice line for community health professionals is available Monday to Saturday 8am to 7pm.

ALERT LEVEL	General Practice (GP) & Urgent Care (UC)	Community Pharmacy	Aged Residential Care (ARC)	Home Based Support (over 65s)	Government Contracted Emergency Ambulance Services (EAS) (Road and Air)	Maternity	Well Child Tamariki Ora (WCTO)	Family Planning, Sexual & Reproductive Health	School Based Health Services (SBHS)
COVID-19 Community Readiness GREEN ALERT ***Trigger Status: No COVID-19 positive patients in your***	**General Guidance** • Provide training in the correct use of PPE (donning, doffing and disposal), appropriate hand hygiene and use of cleaning products. • Plan and rehearse triaging of patients at entrances in particular patients with COVID-19 symptoms. • Plan for patient-to-patient and staff-to-patient physical distancing as per MoH guidance (check MoH website). • Plan how care may be delivered virtually at higher Alert Levels. This includes: - Plan for management of an increase in phone calls, telehealth consults for majority of population, including provision for vulnerable populations with limited phone, internet and data access. - Refresh telehealth options, including ensuring sufficient hardware (devices, webcams), phone lines, high speed internet access. • Where possible enable staff to take leave as required (so staff are refreshed and resilient) and plan possible staff rosters and shifts ahead of time. • Plan with additional support staff to confirm arrangements for their assistance during higher Community Alert Levels. • Identify staff welfare support and pastoral care (e.g. counselling services).								

facility; Any cases in your community are managed and under control; managing service delivery as usual with only staffing and facility impact being for training & readiness purposes	**Telehealth/Virtual Care** • Have systems in place to deliver care via telehealth (phone, video, portal) and use these tools (and others, such as NZePS) where appropriate as part of usual practice and use. **Care of vulnerable populations** • Identify and plan for care of: ▪ vulnerable patients ▪ palliative care ▪ chronic conditions ▪ Māori and Pacific patients ▪ cancer treatment patients. **Service Planning & Delivery** • Deliver usual services • Screen and swab for COVID-19 as per current MoH guidance. • Enable telephone triage and screening by giving consistent message to patients to 'phone first' • Have COVID swabbing processes running efficiently. • Ensure access to local up-to-date guidance from MoH (e.g. via DHB/PHO/ HealthPathways).	**Care of vulnerable populations** • Identify vulnerable patients who may need additional medicines support. • **Service Planning & Delivery** • Screen for COVID-19 symptoms & Higher Index of Suspicion criteria and refer as appropriate. • Consider providing home medicine deliveries (if not already offering this service), and if appropriate develop a plan. • Review arrangements with couriers to reinforce that medicines deliveries should be a priority e.g. medicines deliveries to the pharmacy and to ARC facilities. • Continue with influenza vaccinations (and MMR when contracted for this service). • Plan to be able to defer non-essential services, noting vulnerable populations may still need to receive care.	**Staffing** • Plan staffing to minimise number working across facilities in higher alert levels, identify and prepare for a surge workforce if required. **Care of vulnerable populations** • Identify vulnerable patients who may need additional social supports, care planning or pre-emptive care and assign specific resource to work with these groups. **Service Planning & Delivery** • Plan for increased media enquiries. • Use ARC COVID-19 screening form for admissions. • Refer all residents and staff who exhibit symptoms for assessment and testing. • ARC facilities and local PHUs connect with each other to prepare for response to COVID-19 cases in a facility. • Contact tracing systems established. • Plan to have separated streams for people with symptoms consistent with COVID-19 and non COVID-19 cases to manage isolation as required. • Identify services that can be deferred with no risk to patients • Explore the possibility of continuing religious/spiritual services by digital means.* • Ensure adequate systems in place to ensure residents and family/whānau are supported to express their concerns and make complaints, and complaints are documented and responded to* • All interRAI assessments continue as per usual requirements. • HealthCERT develop auditing framework for Community Yellow and Community Orange Alert	**Service Planning & Delivery** • Plan how to manage home and community support services to minimise. unnecessary contact and prioritise those with highest need. • Identify vulnerable patients who may need additional social supports, care planning, pre-emptive care and assign specific resource to work with these groups. • Plan to have a separated stream for people with symptoms consistent with COVID-19 and non COVID-19 cases to manage isolation as required, including streaming of workforce. • Identify services that can be deferred with no risk to patients • Implement alert level admission and discharge plans with DHBs. • Create psychosocial messaging, appropriate to all clients, including for their personal support network. **Visiting** • Develop clear COVID-19 service visit policies to reflect physical distancing requirements, good hygiene and infection control measures, and alternative methods of contact should visiting be restricted.	**Service Planning & Delivery** • Develop and test plans considering business continuity, PPE access, workforce availability, surge resources, engagement with other EAS providers and DHBs • Plan for higher level scenarios where EAS may need to move a large number of COVID-19 or non COVID-19 patients around the country to improve bed availability. • Identify pathways that could be used to stream patients away from in-person care if Alert Levels increase. • Plan for regional COVID-19 Alert Level variation and changes to destination protocols (e.g. Trauma, STEMI, Stroke) with other providers and DHBs. • Plan for appropriate 'disaster response' (e.g. earthquake) incorporating regional COVID risks/ levels.	**PPE** • Ensure all community-based Lead Maternity Carers (LMCs) have access to PPE stocks. **Care of vulnerable populations** • Identify vulnerable women who may need additional care planning. • Ensure accessibility to health services for rural communities, particularly Māori and Pacific groups (e.g. through virtual consults or in-person when needed). **Service Planning & Delivery** • Plan how to deliver essential care and support to women, including where this contact will take place. • Plan for clinically appropriate early discharge from hospitals for postnatal care in the community, for Community Orange and Red Alert Levels. • Plan for whānau/community-centred responses for priority populations to ensure access to the necessary care, and to support equity e.g. through virtual consults or in-person when needed. • Plan how care may be delivered in non-contact ways, thus enabling shorter in-person time with women.	**Care of vulnerable populations** • Identify vulnerable patients who may need additional care planning. **Service Planning & Delivery** • Plan how to deliver essential care and support to clients including where contact is required. • Plan for whānau/community-centred responses for priority populations to ensure access to necessary care and to support equity.	**Care of vulnerable populations** • Identify vulnerable patients who may need additional care planning. **Service Planning & Delivery** • Provide full range of sexual and reproductive health services. • Plan for provision of essential services where contact is required. • Plan for provision of non-contact services that are deemed non-essential or deferrable. • Plan whānau/community-centred responses for priority populations to ensure access and equity.	**Care of vulnerable populations** • Identify vulnerable rangatahi who may need additional care planning. **Service Planning & Delivery** • Plan how care may be delivered in non-contact ways or be deemed non-essential. • Plan how to deliver essential care and support to rangatahi including where contact is required. • Plan for whānau/ community-centred responses for rangatahi to ensure access to necessary care and to support equity, especially mental health care. • Ensure information such as key contact phone numbers/emails are up to date for students, school administration and nurses to enable effective communication at higher alert levels. • A risk assessment is done for rangatahi with sore throats, including those at schools with a sore throat management programme. Refer to the MoH website for testing guidance.

			Levels. • Create psychosocial messaging, appropriate to all clients. • Rehearse higher alert level scenarios with staff. **Visiting in Aged Residential Care** • Develop clear COVID-19 visitor policies and establish alternative methods of contact should visiting be restricted. • Plan and communicate with residents and family/whānau about limitation on number of visitors and frequency of visits at Community Yellow, Orange and Red Alert Levels*						

* as per Optional Protocol to the Convention Against Torture thematic report recommendations

COVID-19

COVID-19 Community Mild Impact YELLOW ALERT	**General Practice (GP) & Urgent Care (UC)**	**Community Pharmacy**	**Aged Residential Care (ARC)**	**Home Based Support (over 65s)**	**Government Contracted Emergency Ambulance Services (EAS) (Road and Air)**	**Maternity**	**Well Child Tamariki Ora (WCTO)**	**Family Planning, Sexual & Reproductive Health**	**School Based Health Services (SBHS)**
Trigger Status (individual or cumulative): One or more COVID-19 positive patients in your facility; cases in your community are being managed; isolation capacity & ICU capacity manageable; some staff absence and some staff redeployment to support response and manage key gaps	**General Guidance** • Activate plans as required at Community Yellow Alert. • Refer patients and staff for assessment and testing according to current MoH guidance. • Continue screening for COVID-19 symptoms and Higher Index of Suspicion criteria with referral to general practice/ testing centre as appropriate. • Reinforce cleaning and hand hygiene plans. • Activate PPE plans and ensure PPE supply chain well established. • Activate triaging at entrances and physical distancing. • Contact tracing systems in place. • Activate plans to undertake virtual appointments and non-contact care delivery, where possible. • Activate plans to support mental health and wellbeing of staff • Engage with vulnerable workers to mitigate their risk and review impact on staffing.								
	Telehealth & Virtual • Increase delivery of service via telehealth to 50% in GP and as high as practicable in Urgent Care. **Care for vulnerable populations** • Activate plans for care of vulnerable patients (identified in Green Alert). **Service Planning & Delivery** • Deliver usual services, including immunisation programmes. Vulnerable groups may require prioritisation. • Screen and swab for COVID-19 as per current MoH guidance. • Increase COVID-19 testing capacity via designated practices or testing facilities. • Ensure in-person consultations are available, with phone first. • Establish systems for care of COVID-19 patients in the community. • Develop systems for increased delivery of secondary care services in the community.	**Telehealth & Virtual** • Activate plans to manage increased phone calls. **Care for vulnerable populations** • Contact vulnerable patients and provide additional support with their medicines management as appropriate. **Staffing** Activate (if appropriate) at Community Yellow Alert Level staff rosters and shift system plans. **Service Planning & Delivery** • Consider activating physical barrier plan. • Activate home medicine delivery plans (if appropriate.) • Continue with influenza vaccinations (and MMR when contracted this service). • Defer lowest priority non-essential services, noting vulnerable populations may still need to receive care.	**Screening & Triage** • Use ARC COVID-19 screening form prior to any admission of residents. **Staffing** • Staff movement between ARC facilities restricted where practical in regions affected. • Continue health checks for staff. **Service Planning & Delivery** • No admissions to facilities with COVID-19 positive residents/staff. • 14-day isolation required in affected regions. • 14-day isolation not mandatory in unaffected regions, but risk based as per result of the ARC COVID-19 screening assessment. • Separated streams for people with symptoms consistent with COVID-19 and non COVID-19 cases to manage isolation as required. • Entry/exit of services - only essential and emergency movement in regions affected by cases. • Ensure hygiene/infection control and distancing guidance is adhered to, isolation areas are maintained, and mental health and wellbeing is	**Service Planning & Delivery** • Manage patients in their place of residence and activate isolation plans where required. • Activate admission and discharge pathways developed with DHB. • Needs assessment and service coordination prioritised to patients with highest need. • Implement the referral process developed for non-health related welfare concerns. **Visiting** • Activate Yellow Alert Level visitor policies.	**PPE** • Practice PPE use for COVID-19 care in the relevant settings. **Staffing** • Activate plan for appropriate staffing levels by agreement (e.g. leave). **Service Planning & Delivery** • Review plans considering business continuity, PPE access, workforce availability, surge resources, engagement with other EAS providers and DHBs. • Identify pathways that could be used to stream patients away from in-person care if alert levels increase. • Activate plan for regional COVID-19 Alert Level variation and changes to destination protocols (e.g. Trauma, STEMI, Stroke) with other providers and DHBs, if required. • Plan for appropriate 'disaster response' (e.g. earthquake) incorporating regional COVID risks/Alert Levels. • Implement use of QR codes in all facilities including all public facing vehicles (road and air)	**Service Planning & Delivery** • Plan for clinically appropriate early discharge from hospitals for postnatal care in the community. • Activate whānau/community-centred responses for priority populations to ensure access to the necessary care, and to support equity. • Reduce non-essential in-person service delivery. • Implement the referral/delivery process for non-health related welfare concerns.	**Service Planning & Delivery** • Refer to Level specific guidance provided by WCTO Interim Clinical Governance Group on MoH website • Criteria set for priority populations and for essential in-person contacts. • Activate whānau/community-centred responses for priority populations to ensure access to necessary care to support equity.	**Service Planning & Delivery** • Reduce non-essential in-person service delivery. • Review outreach clinics and assess whether to close (case-by-case). • Activate whānau/community-centred responses for priority populations to ensure access and equity. • Implement the referral/ delivery process for non-health related welfare concerns.	**Service Planning & Delivery** • Activate local whānau/ community-centred responses for rangatahi to ensure access to necessary care and to support equity, especially mental health care. • Reduce delivery of non-essential services. • Utilise local referral/ delivery processes for non-health related welfare concerns, especially to ensure a safe living situation. • Youth with a sore throat, should be isolated, collected from school and directed with their caregiver to a place where they can be tested for COVID-19 and have a bacterial throat swab done at the same time, if at high risk of Rheumatic fever. Follow GAS Sore Throat Management algorithm for treatment. Some specific schools may have a locally managed Rheumatic Fever prevention programme, in which case, they will have their own protocols for management of sore throat in COVID-19 context.

			supported. • Reduce resident activities to those that maintain physical distancing. • Continue religious/spiritual services by digital means where possible* • Ensure residents and family/whānau are supported to express their concerns and make complaints, and complaints are documented and responded to.* • interRAI assessments must be completed on admission. • Six monthly interRAI reassessments, and interRAI assessments for a change in level of care, are waived if there are not enough staff to complete the assessments. • On site audits stopped in regions affected except for MoH inspections and DHBs issue-based audits if any serious concerns about quality and safety of care. • Minimise use of restrictive practices and report critical incidents. • Planned respite care suspended, urgent respite care provided. **Visiting in Aged Residential Care** • Activate visitor policies • All family visits stopped except for residents receiving palliative/end of life care in regions affected. • Limited general family visits in regions where there is no evidence of community transmission for example limiting number of visitors and frequency of visits and by appointment. • Essential non-family visits (e.g. health care related visits including pharmacy) allowed if screening shows low risk of COVID-19. • All family and non-family visitors are screened for COVID-19 risks and follow public health measures and IPC protocols						

* as per Optional Protocol to the Convention Against Torture thematic report recommendations

COVID-19

COVID-19 Community Moderate Impact ORANGE ALERT	General Practice (GP) & Urgent Care (UC)	Community Pharmacy	Aged Residential Care (ARC)	Home Based Support (over 65s)	Government Contracted Emergency Ambulance Services (EAS) (Road and Air)	Maternity	Well Child Tamariki Ora (WCTO)	Family Planning, Sexual & Reproductive Health	School Based Health Services (SBHS)
Trigger Status (individual or cumulative): 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	**General Guidance:** • Activate plans as required at Community Orange Alert. • Continue screening for COVID-19 symptoms and Higher Index of Suspicion criteria with referral to general practice/ testing centre as appropriate. • Maintain triaging at entrances and physical distancing. • Activate appropriate PPE Plans, aligned with MoH guidance. • Maintain stock levels of PPE, alcoholic hand gel and cleaning products. • Reinforce cleaning and hand hygiene, incorporate into routine practice. • Activate virtual and non-contact delivery where possible. • Activate plan to support mental health and wellbeing of staff • Engage with vulnerable workers to mitigate their risk and review impact on staffing..								
	Telehealth & Virtual • Increase delivery of service via telehealth to 70% in GP/as high as practicable in UC. • Increase availability of secondary care services into community via telehealth and other mechanisms. • Identify and manage high risk patients with support of secondary care services via telehealth. **Service Planning & Delivery** • Restricted services targeting vulnerable populations. • Screen and swab for COVID-19 as per current MoH guidance. • Increase COVID-19 testing capacity via designated practices or testing facilities. • Continue to deliver immunisation programmes, with prioritisation of vulnerable populations. • Cancer screening programmes prioritised to vulnerable populations. • Support for services with staffing issues. • Investigations and treatments normally accessed in hospitals may be moved into the community. • Support for non-health related welfare concerns readily accessible.	**Telehealth & Virtual** • Move to even greater delivery of care by telehealth or non-contact means wherever possible whilst ensuring access for priority and vulnerable populations. **Staffing** • Activate/maintain staff rosters and shift system plans. **Service Planning & Delivery** • Activate physical barrier plan. • Activate/maintain home medicine delivery plans (if appropriate). • Provide tailored services to vulnerable patients and provide additional support with their medicine's management as appropriate. • Continue with influenza vaccinations (and MMR when contracted service). • Defer non-essential services, noting vulnerable populations may still need to receive care.	**Telehealth & Virtual** • Maintain virtual medical care with primary care and specialist care. **Staffing** • Workforce Backup Plans in Place with DHB. • Staff movement between ARC facilities restricted where practical. **Service Planning & Delivery** • Contact tracing systems in place. • Use ARC COVID-19 screening form for admissions. • 14 days isolation upon admission. • Refer all patients and staff who exhibit symptoms for assessment and testing. • Separated stream for people with symptoms consistent with COVID-19 and non COVID-19 cases to manage isolation as required. • Operate with restrictions on entry/exit so essential and emergency movement only. • Providers continue to accept admissions from DHBs and community. • Ensure hygiene/infection control and distancing guidance is adhered to, isolation areas are maintained, and mental health and wellbeing is supported.	**Telehealth & Virtual** • Maintain virtual and non-contact primary and specialist medical care and community care, such as day programmes. **Staffing** • Workforce Backup Plans in Place with DHB. **Service Planning & Delivery** • Separated stream for people with symptoms consistent with COVID-19 and non COVID-19 cases to manage isolation as required. • Activate Orange Alert Level admission and discharge pathways developed with DHBs. • Providers continue to accept admissions from DHBs and NASCs within agreed care levels including early discharge. • Essential home and community support care provided to clients as identified by client risk assessment, such as showering, bathing, toileting, essential hygiene and skin care, positioning, medicine administration, support with nutrition, hydration and mental health. • Cease non-essential home and community supports • Activate Safety Check - Phone/ video from family or friend. • Implement pro-active support for non-health related welfare	**Service Planning & Delivery** • Activate plans considering business continuity, PPE access, workforce availability, surge resources, engagement with other EAS providers and DHBs. • Activate pathways that could be used to stream patients away from in-person care if Alert Levels increase, if appropriate. • Activate plan for regional COVID-19 Alert Level variation and changes to destination protocols (e.g. Trauma, STEMI, Stroke) with other providers and DHBs, if required. • Plan for appropriate 'disaster response' (e.g. earthquake) incorporating regional COVID-19 risks/ levels.	**Service Planning & Delivery** • Prioritise support for vulnerable and high-risk women. • Support clinically appropriate early discharge from hospitals for postnatal care in the community. • Activate whānau/community-centred responses for priority populations to ensure access to the necessary care, and to support equity. • Activate pathways of care for women at high risk of contracting COVID-19 and for low-risk women. • High-risk groups continue to receive in-person midwifery care. • Cease non-essential in-person service delivery. • Implement the referral/delivery process for non-health related welfare concerns.	**Telehealth & Virtual** • Activate virtual and non-contact delivery for population based on priority criteria for WCTO and B4SC. **Staffing** • Staffing: review staff rosters, minimise staff in office and support working from home **Service Planning & Delivery** • Refer to Level specific guidance provided by WCTO Interim Clinical Governance Group on MoH website • Collaboration with community midwifery and primary care to support prioritised essential in-person care for vulnerable or high-risk patients only. • Activate whānau/community-centred responses for priority populations to ensure access to necessary care and to support equity.	**Telehealth & Virtual** • Prioritise virtual appointments for abortion referrals, ECP. **Service Planning & Delivery** • Cease non-essential service delivery. • Cease all outreach clinics. • Provide in-person appointments for: LARC, symptomatic STIs, Depo repeats and smears. All other appointments done virtually. • Client Contact Centre moves to working in teams; one in the contact centre one at home. • Prioritise vulnerable and high-risk patients. • Upscale clinical resource to virtual appointments and non-contact delivery. • Activate whānau/community-centred responses for priority populations to ensure access and equity. • Implement the referral/ delivery process for non-health related welfare concerns.	**Telehealth & Virtual** • Activate virtual and non-contact delivery where possible. **Service Planning & Delivery** • Activate local whānau/ community-centred responses for rangatahi to ensure access to necessary care and to support equity, especially mental health care. • Cease non-essential service delivery. • Utilise local referral/ delivery processes for non-health related welfare concerns, especially to ensure a safe living situation. • If schools are open to students; Youth with a sore throat, should be isolated, collected from school and directed with their caregiver to a place where they can be tested for COVID-19 and have a bacterial throat swab done at the same time, if at high risk of Rheumatic fever. Follow GAS Sore Throat Management algorithm for treatment. Some specific schools may have a locally managed Rheumatic Fever prevention programme, in which case, they will have their own protocols for management of sore throat in COVID-19 context.

			• Reduce resident activities to those that maintain physical distancing. • Continuing religious/spiritual services by digital means where possible.[*] • Ensure residents and family/whānau are supported to express their concerns and make complaints, and complaints are documented and responded to.[*] • InterRAI assessments must be completed on admission. • Six monthly interRAI reassessments, and interRAI assessments for a change in level of care, are waived. • Minimise use of restrictive practices and report critical incidents. • Planned respite services suspended, urgent respite care provided. • On site audits stopped except for the MoH inspections and DHB's issue-based audits if any serious concerns about quality and safety of care. **Visiting in Aged Residential Care** • All family visits stopped except for families with residents receiving palliative care/end of life care – this is subject to public health direction and provider assessment on a case by case basis. These visits are by appointment only with a maximum of one family member visiting at a time. • Essential non-family visits (e.g. health care related visits including pharmacy) allowed if screening shows low risk of COVID-19. • All family and non-family visitors are screened for COVID-19 risks and follow public health measures and IPC protocols	concerns. **Visiting** • Activate Orange Alert Level visitor policies					

[*] as per Optional Protocol to the Convention Against Torture thematic report recommendations

COVID-19

COVID-19 Community **Severe Impact** **RED ALERT**	**General Practice (GP) & Urgent Care (UC)**	**Community Pharmacy**	**Aged Residential Care (ARC)**	**Home Based Support (over 65s)**	**Government Contracted Emergency Ambulance Services (EAS) (Road and Air)**	**Maternity**	**Well Child Tamariki Ora (WCTO)**	**Family Planning, Sexual & Reproductive Health**	**School Based Health Services (SBHS)**
Trigger Status (individual or cumulative): Multiple COVID-19 positive patients in your facility; community transmission uncontrolled; isolation and ICU at capacity; all available staff redeployed to critical care	**General Guidance** • Activate plans as required at Community Red Alert. • Continue screening for COVID-19 symptoms and Higher Index of Suspicion criteria with referral to general practice/testing centre as appropriate. • Refer all patients and staff who exhibit symptoms for assessment and testing. • Activate appropriate PPE plans, aligned with MoH guidance. • Maintain stock levels of PPE, alcoholic hand gel and cleaning products. • Ensure cleaning and hand hygiene incorporated into routine practice. • Maintain triaging at entrances and physical distancing. • Non-essential service delivery should have ceased • Activate plan to support mental health and wellbeing of staff. • Work with vulnerable workers to mitigate their risk and review impact on staffing.								
	Telehealth & Virtual • Increase delivery of service via telehealth to 90% in GP/as high as practicable in Urgent Care. **Staffing** • Minimise staff numbers in centres; support working from home. **Service planning & delivery** • Urgent and acute care delivered as needed. • Continue to deliver immunisation programmes, with prioritisation of vulnerable populations. • Screening programmes may cease according to regional capacity. • COVID-19 testing and assessment primarily at designated centres and mobile services. • Proactively protect, support and focus care of vulnerable populations. • Increase support for management of COVID-19 patents in community. • Designated services for non-health related welfare concerns. • Actively manage patients who have had deferred hospital level care.	**Telehealth & Virtual** • Maintain delivery of care by telehealth or non-contact means wherever possible whilst ensuring access for priority and vulnerable populations. **Staffing** • Activate/maintain staff rosters and shift system plans. **Service planning & delivery** • Activate/maintain home medicine delivery plans (if appropriate). • Provide tailored services to vulnerable patients and provide additional support with their medicines management as appropriate. • Continue to deliver immunisation programmes, with prioritisation of vulnerable populations. • Defer non-essential services, noting vulnerable populations may still need to receive care.	**Telehealth & Virtual** • Maintain virtual primary health care including medical, pharmacy, allied and nursing specialist care. • Activate virtual and non-contact delivery where possible. **Staffing** • Workforce Backup Plans in place with DHBs. • No staff movement between residential facilities. **Service planning & delivery** • 14 days isolation upon admission. • Use ARC COVID-19 screening form for all admissions. • Contact tracing systems in place. • Separated streams for people with symptoms consistent with COVID-19 and non COVID-19 cases to manage isolation as required – this may be across facilities. • Restrictions on entry/exit so essential and emergency moves only. • Provide palliative care support where appropriate and necessary.	**Telehealth & Virtual** • Maintain virtual and non-contact primary and specialist medical care and community care, such as day programmes. **Staffing** • Workforce Backup Plans in place with DHBs. **Service planning & delivery** • Activate Community Red Alert Level admission and discharge pathways developed with DHB including alternative admission pathways. • Separated stream for people with symptoms consistent with COVID-19 and non COVID-19 cases to manage isolation as required. • Provide palliative care support where appropriate and necessary. • Essential home and community support care provided to clients as identified by client risk assessment, such as showering, bathing, toileting, essential hygiene and skin care, positioning, medicine administration, support with nutrition,	**Service planning & delivery** • Activate plans considering business continuity, PPE access, workforce availability, surge resources, engagement with other EAS providers and DHB. • Activate pathways that could be used to stream patients away from in-person care if alert levels increase, if required. • Work with other EAS and DHB to nationally develop transfer of patients if required. • Activate plans for regional COVID-19 Alert Level variation and changes to destination protocols (e.g. Trauma, STEMI, Stroke) with other providers and DHBs as appropriate. • Plan for appropriate 'disaster response' (e.g. earthquake) incorporating regional COVID risks/levels as needed.	**Telehealth & Virtual** • Virtual and non-contact appointments where possible. **Service planning & delivery** • Prioritise support for vulnerable or high-risk women. • High-risk groups continue to receive in-person midwifery care. • Early discharge where clinically appropriate from hospitals for postnatal care in the community. • Whānau/community-centred responses for priority populations to ensure access to the necessary care, and to support equity. • Implement the referral /delivery process for non-health related welfare concerns.	**Telehealth & Virtual** • Virtual and non-contact delivery only for prioritised WCTO and B4SC populations. **Staffing** • Staffing: review staff rosters, minimise staff in office and support working from home. **Service planning & delivery** • Refer to Level specific guidance provided by WCTO Interim Clinical Governance Group on MoH website • Support prioritised in-person care under strict infection prevention and control procedures for vulnerable or high-risk patients only, and in collaboration with community midwifery and primary care. • Whānau/community-centred responses for priority populations to ensure access to necessary care and to support equity.	**Telehealth & Virtual** • Increase clinical resources on providing increased virtual services and non-contact delivery where possible. • Prioritise virtual appointments for abortion referrals, ECP. **Service planning & delivery** • Stop all outreach clinics. • Support prioritised for vulnerable or high-risk patients. • Provide in-person appointments for: LARC, symptomatic STIs, Depo repeats. All other appointments done virtually. • Client Contact Centre moves to working in teams; one in the contact centre one at home. • Whānau/community-centred responses for priority populations to ensure access and equity. • Implement the referral/ delivery process for non-health related welfare concerns.	**Telehealth & Virtual** • Virtual and non-contact delivery where possible. **Service planning & delivery** • Ensure rangatahi with health needs are aware of currently operating services to receive in person help, e.g. access to primary care and mental health care and sexual health services, and how they can contact the school nurse. • Whānau/community-centred responses for rangatahi to ensure access to necessary care and to support equity, especially mental health care. • Utilise local referral/ delivery processes for non-health related welfare concerns, especially to ensure a safe living situation.

			• Ensure hygiene/infection control and distancing guidance is adhered to, isolation areas are maintained, and mental health and wellbeing is supported. • InterRAI assessments must be completed on admission. Six monthly interRAI reassessments, and interRAI assessments for a change in level of care, are waived. • Reduce resident activities to those that maintain physical distancing. • Continuing religious/spiritual services by digital means where possible*. • Ensure residents and family/whānau are supported to express their concerns and make complaints, and complaints are documented and responded to*. • Minimise use of restrictive practices and report critical incidents. • Planned respite services suspended, urgent respite care provided. • Onsite audits stopped except for the MoH inspections and DHB's issue-based audits if any serious concerns about quality and safety of care. **Visiting in Aged Residential Care** • All family visits stopped except for families with residents receiving palliative care/end of life care – this is subject to public health direction and provider assessment on a case by case basis. These visits are by appointment only with a maximum of one family member visiting at a time. • Essential non-family visits	hydration and urgent mental health care. • Cease non-essential home and community supports. • Activate Safety Check - phone/ video from family or friend. • Implement proactive support for non-health related welfare concerns. **Visiting** • Activate Red Alert Level visitor policies.					

* as per Optional Protocol to the Convention Against Torture thematic report recommendations

			(e.g. health care related visits including pharmacy) allowed if screening shows low risk of COVID-19. • All family and non-family visitors are screened for COVID-19 risks and follow public health measures and IPC protocols.						

numbers of Official
h Board, and other data
ow.

1. **From 1 January to 30 June 2021, how many OIA requests did your agency receive?**

   89

2. **From 1 January to 30 June 2021, what was the average OIA response time, in working days (including any extension time)?**

   13

3. **From 1 January to 30 June 2021, what was the longest OIA response time, in working days (including any extension time)?**

   39

4. **From 1 January to 30 June 2021, what percentage of OIA's required a time extension?**

   1.78%

5. **From 1 January to 30 June 2021, what percentage of OIAs were refused?**
   2.67%

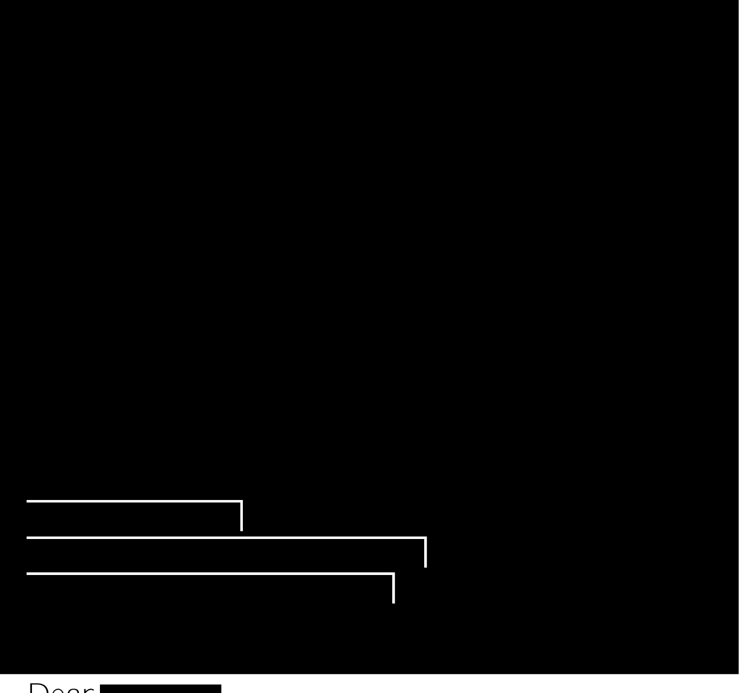
6. **From 1 January to 30 June 2021, what percentage of OIAs were partially refused or redacted?**

   0.89%

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website ten working days after your receipt of this response.

Yours sincerely

Judith Catherwood
General Manager
Quality & Innovation



Dear [redacted]

We are in receipt of your Official Information request dated 12 September 2021.

You advised that you would like the following information as stated below:

1. How many people are on the waitlist for inpatient youth mental health services?

   MidCentral DHB does not have inpatient youth mental health services.

2. How many people are on the waitlist for outpatient youth mental health services?

   We currently have no young person on waitlist, all have been allocated (we do this weekly). However, although allocated they may be waiting to see a therapist for up to eight weeks but will have been seen by our duty team and possibly a Psychiatrist in the interim. All urgent cases are seen within 24 hrs and if no therapist is available, they will be followed up assertively by our duty team and Psychiatrist.

3. How many people are on the waitlist for inpatient adult mental health services?

   We don't operate a waitlist for inpatient adult mental health services.

4. How many people are on the waitlist for outpatient adult mental health services?

   We don't operate a waitlist for outpatient adult mental health services.

Te Uru Rauhī - Mental Health & Addictions Services
PN Hospital, Private Mail Bag 11036, PALMERSTON NORTH
Phone: + 64 (6) 350 8354

5. How many people have died of suicide, or are believed to have died of suicide, in the last 10 years while on the waitlist for inpatient youth mental health services?

   None.

6. How many people have died of suicide, or are believed to have died of suicide, in the last 10 years while on the waitlist for outpatient youth mental health services?

   None.

7. How many people have died of suicide, or are believed to have died of suicide, in the last 10 years while on the waitlist for inpatient adult mental health services?

   None.

8. How many people have died of suicide, or are believed to have died of suicide, in the last 10 years while on the waitlist for outpatient adult mental health services?

   None.

You have the right to seek an investigation and review by the Ombudsman of this decision. 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 response, may be published on the MidCentral DHB website ten working days after your receipt of this response.

Yours sincerely

Scott Ambridge
Operations Executive

Your OIA request of 31 August 2021 to MidCentral District Health Board (MDHB) is acknowledged and has been passed on to me for response.

You have requested the following information.

1. **How many surgical procedures have been carried out each year in relation to hypospadias ("hypospadias repair") in the last 4 years (2016-2017, 2017-2018, 2018-2019, 2019-2020)? Please give specific numbers for each of the following age groups 0-4, 5-9, 10-14, 15-19 years.**
2. **How many surgical procedures have been carried out to repair post-operative urethral fistula in the last 4 years (2016-2017, 2017-2018, 2018-2019, 2019-2020)? Please give specific numbers for each of the following age groups 0-4, 5-9, 10-14, 15-19 years.**
3. **What other procedures have been carried out in relation to anomalies of male genitalia including, but not limited to, procedures intended to alter the shape or curvature of the penis, or to reposition the urethra in the last 4 years (2016-2017, 2017-2018, 2018-2019, 2019-2020)? Please give specific numbers for each procedure carried out on people within the following age groups 0-4, 5-9, 10-14, 15-19.**
4. **How many surgical procedures have been carried out in relation to reducing or adjusting clitoral size or appearance in the last 4 years (2016-2017, 2017-2018, 2018-2019, 2019-2020)? Please identify the diagnoses and give specific numbers for each of the following age groups 0-4, 5-9, 10-14, 15-19.**

Operations Executive, Acute & Elective Specialist Services
MidCentral District Health Board, PO Box 2056, Palmerston North 4440
Telephone (06) 356 9169

5. **How many surgical vaginal construction (or reconstruction) procedures were undertaken in the last 4 years (2016-2017, 2017-2018, 2018-2019, 2019-2020)? Please identify the diagnoses and give specific numbers for each of the following age groups 0-4, 5-9, 10-14, 15-19.**
6. **What other procedures have been carried out (including, but not limited to, vaginal dilation, labiaplasty, vulvoplasty and surgery to modify the urogenital sinus) in relation to anomalies of female genitalia in the last 4 years (2016-2017, 2017-2018, 2018-2019, 2019-2020)? Please give specific numbers for each procedure carried out on people within the following age groups 0-4, 5-9, 10-14, 15-19.**
7. **How many gonadectomies have been performed in the last 4 years? Please identify the diagnoses and the reason for removing the gonads. Please give answers broken down by age groups (0-4, 5-9, 10-14, 15-19 years) and year in which interventions took place (2016-2017, 2017-2018, 2018-2019, 2019-2020).**
8. **If gonads have been removed from people aged under 18 years in the last 4 years, (i) in how many instances was the diagnosis confirmed using molecular genetic techniques, and (ii) over what period of time were the gonads monitored or observed using MRI prior to gonadectomy? Please give answers broken down by age groups (0-4, 5-9, 10-14, 15-19 years) and year in which interventions took place (2016-2017, 2017-2018, 2018-2019, 2019-2020).**

Response to questions 1-8

Urology Service staff advise that this is not data that is routinely collected and thus it would involve considerable time to manually collate. Specifically, a manual search would be required within patient records, a task not normally undertaken without prior ethics approval.

The manual research would be required because, as an example, Urology would do a handful of hypospadias operations which could be coded under a number of different codes – urethroplasty, glans resurfacing, 2 stage urethral repair, etc. Within each code there will be many cases that are not related to hypospadias, hence the manual search to confirm the diagnosis.

Gonadectomies have a number of indications in urology, infection, cancer, torsion, gender affirmation, congenital. I don't think the researcher is wanting most of that information.

In conclusion, this is a very complex request. MidCentral DHB has determined to decline pursuant to s18(f) – the information cannot be made available without substantial research.

Response to questions 9-11

9. What is the current protocol followed (in this region or hospital) in relation to the retention or removal of the gonads of people with Androgen Insensitivity Syndrome? At what ages is there consideration of; (i) the opportunity to retain gonads, (ii) the removal of gonads?

MidCentral DHB does not perform surgery for the removal of gonads of people with AIS.

Should there be an instance where it is considered this surgery is required, each case is considered on it's own merits and all decisions are made by patients in collaboration with the appropriate tertiary providers.

(In how many instances) have removed gonads or tissue been retained for future research purposes in the last 4 years (2016-2017, 2017-2018, 2018-2019, 2019-2020)?

Nil.

10. Does the protocol (mentioned in the question above) include explicit discussion of the pros and cons of gonadectomy with people diagnosed with AIS? At what age(s) does such discussion happen, according to the protocol? Who has this discussion with the young people/families concerned (e.g. surgeon, psychologist, peer support person)? At what stage and over what duration, is a psychologist involved?

As above, this occurs on a case by case basis and MidCentral DHB does not collect the data requested.

11. To whom are young people and families referred for support and information prior to gonadectomy? Please may we see a copy of the resources shared with families and individuals under these circumstances?

As above, this is on a case by case basis. Most families are referred to either Starship Hospital or another tertiary provider.

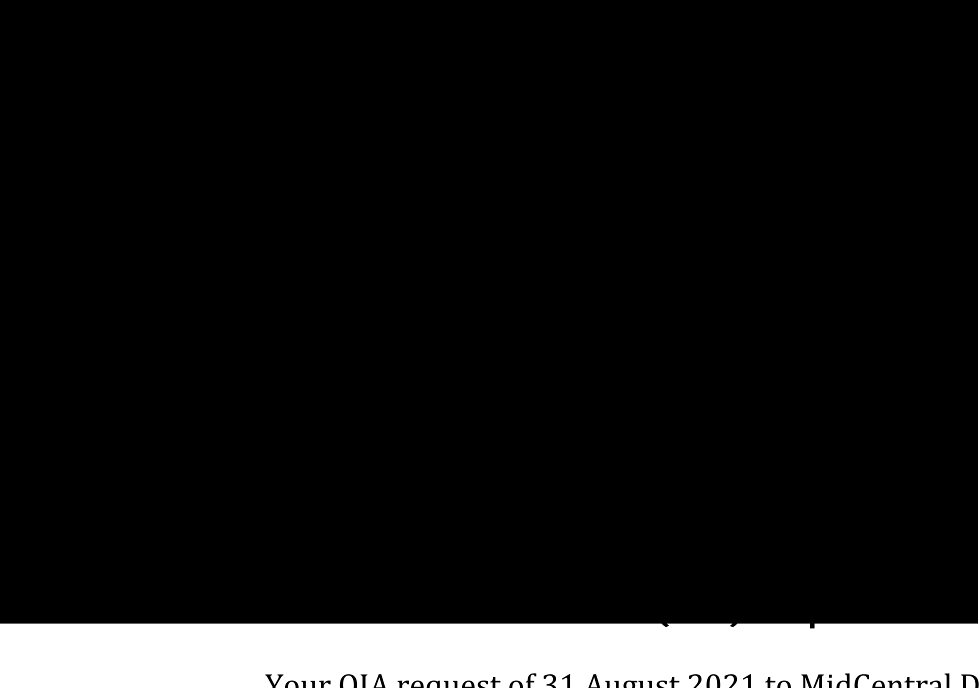
Families are offered the contact details for ITANZ (http://www.ianz.org.nz/) or other support organisations. Resources include https://www.nhs.uk/conditions/androgen-insensitivity-syndrome/treatment/

You are entitled to seek a review of this 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 response, may be published on the MidCentral DHB website 10 working days after your receipt of this response.

Yours sincerely

Lyn Horgan
Operations Executive
Acute & Elective Specialist Services



Your OIA request of 31 August 2021 to MidCentral District Health Board (MDHB) is acknowledged and has been passed on to me for response.

You have requested the following information.

- **ICU bed occupancy (% of ICU beds occupied or number of occupied bed days and total number of available beds) for the period 1 January 2018 until the most recent available date. Could this please be provided in the smallest time periods possible (days, if available, otherwise weeks, otherwise months).**

  The ICU bed occupancy information for MDHB follows.

Month/ Year	Average Beds Occupied	Resourced Beds	Occupancy Rate
01/01/2018	4	6	63%
01/02/2018	4	6	67%
01/03/2018	4	6	69%
01/04/2018	3	6	58%
01/05/2018	3	6	58%
01/06/2018	3	6	57%
01/07/2018	4	6	69%
01/08/2018	4	6	65%
01/09/2018	3	6	58%
01/10/2018	4	6	62%
01/11/2018	3	6	58%
01/12/2018	4	6	60%
01/01/2019	2	6	40%
01/02/2019	3	6	54%
01/03/2019	3	6	58%
01/04/2019	4	6	65%
01/05/2019	4	6	59%
01/06/2019	4	6	66%
01/07/2019	4	6	69%
01/08/2019	4	6	59%

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MidCentral District Health Board, PO Box 2056, Palmerston North 4440
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Month/ Year	Average Beds Occupied	Resourced Beds	Occupancy Rate
01/09/2019	4	6	67%
01/10/2019	3	6	47%
01/11/2019	4	6	61%
01/12/2019	3	6	57%
01/01/2020	3	6	58%
01/02/2020	4	6	61%
01/03/2020	3	6	50%
01/04/2020	2	6	31%
01/05/2020	4	6	60%
01/06/2020	4	6	60%
01/07/2020	3	6	47%
01/08/2020	3	6	47%
01/09/2020	4	6	61%
01/10/2020	3	6	53%
01/11/2020	3	6	51%
01/12/2020	4	6	66%
01/01/2021	3	6	45%
01/02/2021	4	6	64%
01/03/2021	4	6	62%
01/04/2021	3	6	54%
01/05/2021	3	6	53%
01/06/2021	4	6	62%
01/07/2021	4	6	69%
01/08/2021	3	6	49%

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website 10 working days after your receipt of this response.

Yours sincerely

Lyn Horgan
Operations Executive
Acute & Elective Specialist Services

In response to your recent Official Information Act 1982 request regarding:

1. *The amount of funding spent on acute admissions per year for the past 5 years as a total, Māori, Non-Māori, and for each of these categories as per capita for the total DHB population, Māori and Non-Māori populations?*

2. *How is funding for acute admissions to DHBs funded, and is it open ended in that every admission is funded and there is no cap, and what has been that funding per year for the past 5 years?*

Reply 37494 (2021) has been answered
Portfolio: Health (Hon Andrew Little)

We advise on question 1 for MidCentral DHB as follows:

	2016/17			
	$ spend	**Admissions**	**Population %**	**Per Capita Spend $**
Māori	59,912,120	4,541	12.6%	13,194
Non-Māori	318,741,012	23,550	16.8%	13,535
Total	378,653,132	28,091	15.9%	13,480

	2017/18			
	$ spend	**Admissions**	**Population %**	**Per Capita Spend $**
Māori	67,293,525	4,896	13.3%	13,745
Non-Māori	329,634,024	23,097	16.2%	14,272
Total	396,927,549	27,993	15.6%	14,180

	2018/19			
	$000 spend	**Admissions**	**Population %**	**Per Capita Spend $**
Māori	74,582,451	5,447	14.2%	13,692
Non-Māori	360,596,489	24,600	17.0%	14,658
Total	435,178,940	30,047	16.4%	14,483

Finance & Corporate Services
MidCentralDHB, PO Box 2056, Palmerston North Central, 4440.
Tel: 06 350 8800 Fax: 06 350 8080

	2019/20			
	$000 spend	Admissions	Population %	Per Capita Spend $
Māori	74,091,036	5,499	14.0%	13,474
Non-Māori	371,004,790	24,561	16.8%	15,105
Total	445,096,006	30,060	16.2%	14,807

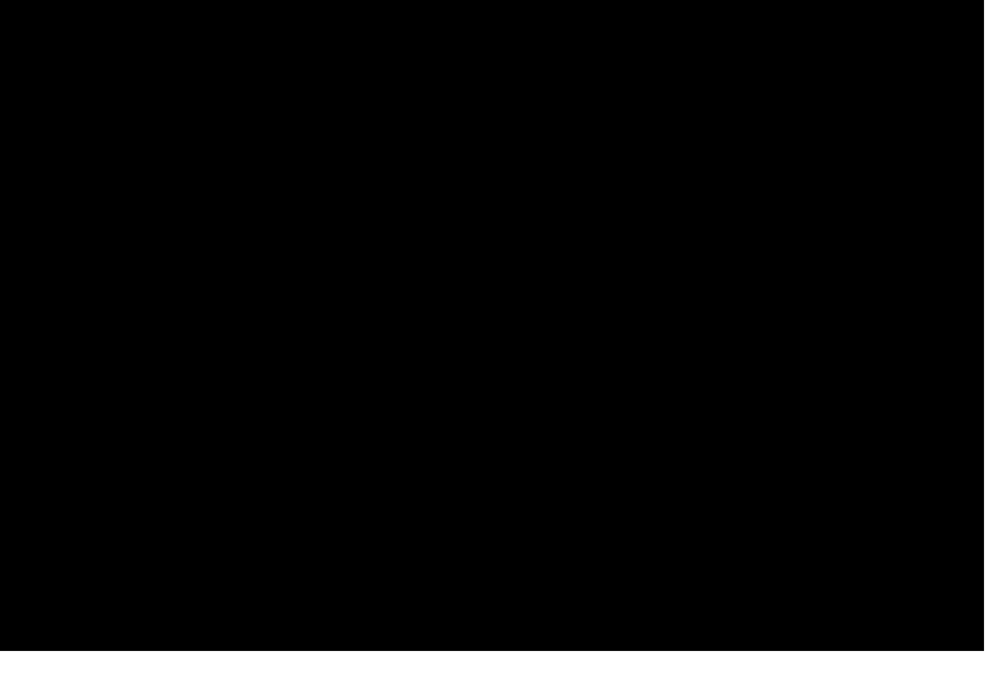
	2020/21			
	$000 spend	Admissions	Population %	Per Capita Spend $
Māori	95,642,377	6,039	15.0%	15,837
Non-Māori	434,424,193	26,182	17.7%	16,592
Total	530,066,570	32,221	17.2%	16,451

If you are not satisfied with this response you have the right to raise any concerns regarding our response with the Ombudsman – www.ombudsman.parliament.nz or 0800 802 602.

Please note that this response, or an edited version, may be published on the MidCentral DHB website ten working days after your receipt of this response.

Yours sincerely

Neil Wanden
General Manager, Finance & Corporate Services



Dear

Official Information Act (OIA) Request

Your OIA request of 6 September 2021 to MidCentral District Health Board (MDHB) is acknowledged and has been passed on to me for response.

You have requested the following information;

- **The number of outpatient radiology assessments/investigations per year for the past 5 years broken down under categories for X-ray, MRI, CT, Other, listed as an absolute number, percentage change from the previous year, number per capita for Māori and non-Māori and total for each category.**

  The table below has the investigations by modality for Māori and non-Māori as an absolute number.

Number	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021	Grand Total
Non-Maori	**25286**	**24201**	**22923**	**25474**	**28579**	**126463**
CT	4180	4612	4404	4476	4847	22519
MRI			95	2961	3637	6693
Ultrasound	4710	4597	4307	4202	4188	22004
XRAY	16396	14992	14117	13835	15907	75247
Maori	**3877**	**3950**	**4265**	**4425**	**5154**	**21671**
CT	501	667	642	603	692	3105
MRI			4	388	532	924
Ultrasound	873	841	880	839	857	4290
XRAY	2503	2442	2739	2595	3073	13352
Grand Total	**29163**	**28151**	**27188**	**29899**	**33733**	**148134**

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MidCentral District Health Board, PO Box 2056, Palmerston North 4440
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The table below has the investigations by modality for Māori and non-Māori as a percentage change from the previous year.

% Change	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021
Non-Maori		**-4.3%**	**-5.3%**	**11.1%**	**12.2%**
CT		10.3%	-4.5%	1.6%	8.3%
MRI				3016.8%	22.8%
Ultrasound		-2.4%	-6.3%	-2.4%	-0.3%
XRAY		-8.6%	-5.8%	-2.0%	15.0%
Maori		**1.9%**	**8.0%**	**3.8%**	**16.5%**
CT		33.1%	-3.7%	-6.1%	14.8%
MRI				9600.0%	37.1%
Ultrasound		-3.7%	4.6%	-4.7%	2.1%
XRAY		-2.4%	12.2%	-5.3%	18.4%
Grand Total		**-3.5%**	**-3.4%**	**10.0%**	**12.8%**

(Blank fields indicate no data collection or prior to MRI installation)

The table below has the investigations by modality for Māori and non-Māori as a percentage change from the previous year.

Rate per 1,000 popn.	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021
Non-Maori	**179.1**	**168.4**	**157.8**	**172.6**	**193.8**
CT	29.6	32.1	30.3	30.3	32.9
MRI	0.0	0.0	0.7	20.1	24.7
Ultrasound	33.4	32.0	29.6	28.5	28.4
XRAY	116.1	104.3	97.2	93.7	107.8
Maori	**105.9**	**103.9**	**109.6**	**111.2**	**126.6**
CT	13.7	17.6	16.5	15.2	17.0
MRI	0.0	0.0	0.1	9.7	13.1
Ultrasound	23.9	22.1	22.6	21.1	21.1
XRAY	68.4	64.3	70.4	65.2	75.5
Grand Total	**164.0**	**154.9**	**147.6**	**159.5**	**179.2**

- **The number of outpatient radiology assessments/investigations per year for the past 5 years broken down under categories where there is a primary or main provisional diagnosis of cancer for X-ray, MRI, CT, Other, listed as an absolute number, percentage change from the previous year, number per capita for Māori and non-Māori and total for each category.**

The table below has the investigations by modality for Māori and non-Māori as an absolute number where cancer is the primary or main provisional diagnosis.

Number	exam_type	cancertriage_categorydesc	2017/2018	2018/2019	2019/2020	2020/2021	Grand Total
Non Maori	**CT**	Confirmed diagnosis	57	351	281	263	952
		High suspicion	146	511	705	779	2141
		Not high suspicion	211	502	572	721	2006
		NULL	513	1597	1459	1496	5065
	CT Total		**927**	**2961**	**3017**	**3259**	**10164**
	MRI	Confirmed diagnosis		1	140	145	286
		High suspicion		1	169	230	400
		Not high suspicion		26	732	920	1678
		NULL		14	1318	1616	2948
	MRI Total			**42**	**2359**	**2911**	**5312**
	Ultrasound	Confirmed diagnosis	13	61	49	45	168
		High suspicion	38	139	145	111	433
		Not high suspicion	250	931	1020	938	3139
		NULL	346	1450	1580	1701	5077
	Ultrasound Total		**647**	**2581**	**2794**	**2795**	**8817**
	XRAY	Confirmed diagnosis	138	579	527	456	1700
		High suspicion	224	744	885	819	2672
		Not high suspicion	1697	6655	6093	6540	20985
		NULL	2385	3001	3875	5314	14575
	XRAY Total		**4444**	**10979**	**11380**	**13129**	**39932**
Non Maori Total			**6018**	**16563**	**19550**	**22094**	**64225**
Maori	**CT**	Confirmed diagnosis	7	54	47	44	152
		High suspicion	28	80	84	130	322
		Not high suspicion	24	75	80	95	274
		NULL	89	215	202	191	697
	CT Total		**148**	**424**	**413**	**460**	**1445**
	MRI	Confirmed diagnosis			12	23	35
		High suspicion			25	39	64
		Not high suspicion		1	78	111	190
		NULL		2	190	255	447
	MRI Total			**3**	**305**	**428**	**736**
	Ultrasound	Confirmed diagnosis	4	9	7	9	29
		High suspicion	7	17	25	13	62
		Not high suspicion	64	204	238	181	687
		NULL	74	315	306	329	1024
	Ultrasound Total		**149**	**545**	**576**	**532**	**1802**

	XRAY	Confirmed diagnosis	25	114	87	75	301
		High suspicion	25	119	149	136	429
		Not high suspicion	282	1300	1191	1307	4080
		NULL	425	624	754	1003	2806
	XRAY Total		**757**	**2157**	**2181**	**2521**	**7616**
Maori Total			**1054**	**3129**	**3475**	**3941**	**11599**
Grand Total			**7072**	**19692**	**23025**	**26035**	**75824**

The below table has the investigations by modality for Māori and Non-Māori as a percentage change from previous year, where cancer is the primary or main provisional diagnosis

Not appropriate 2018/19 due to partial data collection in prior year

% Change	exam_type	cancertriage_categorydesc	2017/2018	2018/2019	2019/2020	2020/2021
Non Maori	**CT**	Confirmed diagnosis			-19.9%	-6.4%
		High suspicion			38.0%	10.5%
		Not high suspicion			13.9%	26.0%
		NULL			-8.6%	2.5%
	CT Total				**1.9%**	**8.0%**
	MRI	Confirmed diagnosis			13900.0%	3.6%
		High suspicion			16800.0%	36.1%
		Not high suspicion			2715.4%	25.7%
		NULL			9314.3%	22.6%
	MRI Total				**5516.7%**	**23.4%**
	Ultrasound	Confirmed diagnosis			-19.7%	-8.2%
		High suspicion			4.3%	-23.4%
		Not high suspicion			9.6%	-8.0%
		NULL			9.0%	7.7%
	Ultrasound Total				**8.3%**	**0.0%**
	XRAY	Confirmed diagnosis			-9.0%	-13.5%
		High suspicion			19.0%	-7.5%
		Not high suspicion			-8.4%	7.3%
		NULL			29.1%	37.1%
	XRAY Total				**3.7%**	**15.4%**
Non Maori Total					**18.0%**	**13.0%**

Maori	**CT**	Confirmed diagnosis			-13.0%	-6.4%
		High suspicion			5.0%	54.8%
		Not high suspicion			6.7%	18.8%
		NULL			-6.0%	-5.4%
	CT Total				**-2.6%**	**11.4%**
	MRI	Confirmed diagnosis			#DIV/0!	91.7%
		High suspicion			#DIV/0!	56.0%
		Not high suspicion			7700.0%	42.3%
		NULL			9400.0%	34.2%
	MRI Total				**10066.7%**	**40.3%**
	Ultrasound	Confirmed diagnosis			-22.2%	28.6%
		High suspicion			47.1%	-48.0%
		Not high suspicion			16.7%	-23.9%
		NULL			-2.9%	7.5%
	Ultrasound Total				**5.7%**	**-7.6%**
	XRAY	Confirmed diagnosis			-23.7%	-13.8%
		High suspicion			25.2%	-8.7%
		Not high suspicion			-8.4%	9.7%
		NULL			20.8%	33.0%
	XRAY Total				**1.1%**	**15.6%**
Maori Total					**11.1%**	**13.4%**
Grand Total					**16.9%**	**13.1%**

The below table has the investigations by modality for Māori and Non-Māori per capita, where cancer is the primary or main provisional diagnosis.

Rate per 1000	exam_type	cancertriage_categorydesc	2017/2018	2018/2019	2019/2020	2020/2021
Non Maori	**CT**	Confirmed diagnosis	0.40	2.42	1.90	1.78
		High suspicion	1.02	3.52	4.78	5.28
		Not high suspicion	1.47	3.45	3.88	4.89
		NULL	3.57	10.99	9.88	10.14
	CT Total		**6.45**	**20.38**	**20.44**	**22.09**
	MRI	Confirmed diagnosis	0.00	0.01	0.95	0.98
		High suspicion	0.00	0.01	1.14	1.56
		Not high suspicion	0.00	0.18	4.96	6.24
		NULL	0.00	0.10	8.93	10.96
	MRI Total		**0.00**	**0.29**	**15.98**	**19.74**

	Ultrasound	Confirmed diagnosis	0.09	0.42	0.33	0.31
		High suspicion	0.26	0.96	0.98	0.75
		Not high suspicion	1.74	6.41	6.91	6.36
		NULL	2.41	9.98	10.70	11.53
	Ultrasound Total		**4.50**	**17.76**	**18.93**	**18.95**
	XRAY	Confirmed diagnosis	0.96	3.98	3.57	3.09
		High suspicion	1.56	5.12	6.00	5.55
		Not high suspicion	11.81	45.80	41.28	44.34
		NULL	16.60	20.65	26.25	36.03
	XRAY Total		**30.93**	**75.56**	**77.10**	**89.01**
Non Maori Total			**41.88**	**113.99**	**132.45**	**149.79**
Maori	**CT**	Confirmed diagnosis	0.18	1.39	1.18	1.08
		High suspicion	0.74	2.06	2.11	3.19
		Not high suspicion	0.63	1.93	2.01	2.33
		NULL	2.34	5.53	5.08	4.69
	CT Total		**3.89**	**10.90**	**10.38**	**11.30**
	MRI	Confirmed diagnosis	0.00	0.00	0.30	0.57
		High suspicion	0.00	0.00	0.63	0.96
		Not high suspicion	0.00	0.03	1.96	2.73
		NULL	0.00	0.05	4.77	6.27
	MRI Total		**0.00**	**0.08**	**7.66**	**10.52**
	Ultrasound	Confirmed diagnosis	0.11	0.23	0.18	0.22
		High suspicion	0.18	0.44	0.63	0.32
		Not high suspicion	1.68	5.24	5.98	4.45
		NULL	1.95	8.10	7.69	8.08
	Ultrasound Total		**3.92**	**14.01**	**14.47**	**13.07**
	XRAY	Confirmed diagnosis	0.66	2.93	2.19	1.84
		High suspicion	0.66	3.06	3.74	3.34
		Not high suspicion	7.42	33.42	29.92	32.11
		NULL	11.18	16.04	18.94	24.64
	XRAY Total		**19.92**	**55.45**	**54.80**	**61.94**
Maori Total			**27.74**	**80.44**	**87.31**	**96.83**
Grand Total			**38.92**	**106.91**	**122.87**	**138.34**

(Outpatient appointments are not coded for diagnoses. At point of referral Clinicians can indicate suspicion of cancer. Information on this that can be linked to outpatient referrals.)*
*(** While radiology assessments are booked into the Radiology Information System as an outpatient appointment many of these bookings form part of an inpatient event. The inpatient event does not record suspicion of cancer. The combination of these factors, partial data match and completeness, not all appointments being derived from an outpatient referral means numbers in this table are much lower than the previous table.)*

- **The number of outpatient radiology investigations cancelled, delayed or postponed in Levels 3 & 4 for the Coronavirus outbreaks of 2020 and 2021, listed by level and year.**

  - 2020 Level 3 & 2020 Level 4: Data not collected
  - 2021 Level 3 & 2021 Level 4 have been aggregated as some patients fall into both categories. There were a total of 644 investigations cancelled, delayed or postponed.

- **The number of outpatient radiology investigations cancelled, delayed or postponed in Levels 3 & 4 for the Coronavirus outbreaks of 2020 and 2021, where the primary diagnosis or main provisional diagnosis was cancer, listed by level and year.**

  No patients with a primary diagnosis or main provisional diagnosis of cancer had investigations cancelled, delayed or postponed during the 2020 and 2021 alert Levels 3 & 4.

- **The number of cancelled, delayed or postponed inpatient procedures in Levels 3 & 4 to date where the primary diagnosis or main provisional diagnosis was cancer, listed by level.**

  During Levels 3 & 4 all acute and non-deferrable cancer patients received their procedures.

  Any procedures that were postponed were done so with clinical input. Those procedures postponed during alert Levels 3 & 4 were not coded and we are, therefore, unable to provide this information.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website 10 working days after your receipt of this response.

Yours sincerely

Lyn Horgan
Operations Executive
Acute & Elective Specialist Services

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

4 October 2021

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Palmerston North Central
Palmerston North 4440
New Zealand

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Dear

Official Information Act (OIA) Request

Your OIA request of 6 September 2021 to MidCentral District Health Board (MDHB) is acknowledged and has been passed on to me for response.

You have requested the following information;

- **Could I request all correspondence about the handling of the close contact.**

  There was no written correspondence in relation to the handling of the case you refer to. All communication at the time was verbal.

- **How the DHB ensured all the lessons from the handling were considered and implemented.**

  Please find attached the patient flow documentation covering inpatient admission from the Emergency Department presentation to discharge. These are living documents due to the need to respond to national and international best practice and as directed via the Ministry of Health guidelines.

  The key learning from the handling was not procedural change but rather continued staff knowledge and awareness of the patient flow process and how to access the information. All staff have been reminded on how to access the patient flow documentation.

- **Could I request any other reports or information on this as well please.**

  We attach for your reference;

  - COVID-19 In-patient Pathway – Green Hospital
  - Paediatric Admission (COVID-19 Flowchart)
  - MDHB COVID-19 Resurgence Plan

  These documents continue to be reviewed in response to any changes to international and national guidelines.

Operations Executive, Acute & Elective Specialist Services
MidCentral District Health Board, PO Box 2056, Palmerston North 4440
Telephone (06) 356 9169

- **Could I also request any DHB correspondence and other information about changes to its revised patient pathway for handling COVID-19 patients.**

  Please refer to the above.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website 10 working days after your receipt of this response.

Yours sincerely

Lyn Horgan
Operations Executive
Acute & Elective Specialist Services

Encl

COVID-19 In-patient Pathway

Green Hospital There are no positive patients with COVID-19 in hospital

Patient presents to the Emergency Department either as a self referral or by warm transfer from the community

Patient seen at triage and asked travel history, temperature taken and clinical symptom questioned

Patient meets criteria for suspected COVID-19?

No → Continue with usual ED patient management processes

Yes ↓

Patient given face mask. Nursing shift leader notified immediately to source a space for patient.

Clinical assessment undertaken

Patient meets criteria for testing

No → Continue with usual ED patient management processes

Yes ↓

Notify Public Health

First swab taken and sent for testing

Patient requires hospital admission for treatment/cares?

No → Complete the 'Your pathway to healthy breathing' patient information leaflet – and talk through then give to patient → Patient discharged with self isolation advice and necessary treatment and medication advice

Yes → IOC notified to arrange a negative pressure room → Admitted to ward following transfer details communicated with ward → Clinical treatment/cares delivered to patient

Should patient condition deteriorate, category 2/3 patients will be reviewed by Medical SMO and ICU SMO and an agreed plan will be created. This will be communicated to the IOC and a clinically appropriate space will be identified for the patient to transfer to.

Three categories of patients:

1. Requiring oxygen only (at ward level, either regular NP or Airvo at 15L/min & FiO2 less <50%)
2. Requiring escalation to High-Flow Oxygen (50L/min and FiO2 >50%)
3. Requiring escalation to Intubation

→ Patient assessed as clinically safe for discharge → Patient discharged with self isolation advice and necessary treatment and medication advice

Consider exposure times while patient waiting;

- 15 minutes of close contact – within 2 metres
- 2 hours in same room

Rooms that can be used;

- AD – negative pressure room in first instance
- A side room with door closed

Cleaning;

- Once space patient occupied has been effectively cleaned, can be reopened immediately, no stand down period

Paediatrics;

- Have a plan for which allocated side rooms can be used for their patients if needed

Aerosol generating procedures;

- Aim should be to undertake these in a negative pressure room. SMO on duty to make clinical decision if room not available

Paediatric Admission (COVID-19 Flowchart)

Version2: 26/08/21

Child presents to ED

1. Assessment and screening
2. Requires paediatric admission

1. **Meets HIS and Clinical Criteria: rapid swab and treat as covid +ve**
   (rapid swabbing will depend on availability but priority will be given to High Dependency Children)
2. **Close contact and family self-isolating: swab, treat as covid +ve**
3. **Meets Clinical Criteria but HIS negative: surveillance swab and treat as normal**

1 & 2: COVID Swab Positive or awaiting swab for HIS and clinical criteria but can't remain in ED

-Child transferred to negative pressure room in tower block (or Room 12 in ward 24 if COVID ward activated)
-All staff to wear PPE and child to wear mask during transfer (2nd staff person can assist by opening doors)

-Paediatric Nurse from children's ward sent to provide nursing care (adult ward to provide RN runner as support for nurse in isolation)

If ward 24 activated: Rooms 11 and 12 will be used for Children's Hub

Paediatric staff will provide care for all children in ward 24 supported by the COVID nursing team in this ward

3. Surveillance swabbed for clinical symptoms but HIS negative OR Swab Negative

Business as usual

Take: Paediatric Trolley and black resuscitation equipment bag when caring for inpatient children outside the paediatric ward

In emergencies DIAL 777 and call a **Code Blue** (state specific location) as usual

(Adult MET team will also be available to ward 24 for additional assistance if required)

One parent may accompany child but must remain in room and not leave

COVID-19 Resurgence Plan

MidCentral District Health Board

Contents

Introduction 4

Section 1 – Planning and Response Context 5

Situation 5

Purpose 5

Alignment 5

MDHB Strategy and Guiding/Planning Principles/Values 6

Planning principles 6

Te Tiriti o Waitangi 7

Equity 7

Flexibility and scalability 8

Scientific evidence base 8

Infection Prevention and Control 8

Health and Safety for our staff and our population 9

Communications and engagement 9

Sustainability 10

Workforce, personal development and planning 10

Integration of response 11

Quality and safety of care 11

Our district 12

National Response Coordination and Leadership 13

All of Government (AoG) 13

COVID-19 Alert Levels 13

AoG COVID-19 Resurgence Plan 14

Ministry of Health 15

NEMA and Manawatū/Whanganui CDEM 15

Response Scenarios and Planning Assumptions 16

Ministry of Health 16

MidCentral District Health Board 17

Social and economic environment 17

The broader health and wellbeing provider partnership 17

MDHB systems and processes 18

Section 2 – Readiness and Response Coordination 19

Governance arrangements 19

Coordination arrangements 19
Mission, intent and objectives 19
Local scenario 19
AoG response scenarios 20
Readiness and response phases 21
Readiness 21
Response 21
Scenarios for escalation 21
Scenarios 21
Triggers 22
Section 3 – Roles and Responsibilities 23
Manawatū-Whanganui Regional Leadership Group 23
MidCentral District Health Board 23
Manawatū-Whanganui CDEM Group 23
MDHB Organisational Leadership Team 23
MDHB Incident Management Team 24
MDHB People Leaders, Clinical Leaders, and Operations 24
Section 4 – Operational Context and Sub Plans 25
Section 5 – Legislative Frameworks 26
COVID-19 Public Health Response Act 2020 26
NZ Public Health and Disability Act 2000 26
Health Act 1956 27
Civil Defence Emergency Act 2020 and CDEM Plan Order 2015 28
Coordination and Enforcement 28
Appendix One – New Zealand COVID-19 Alert Levels 29
Appendix Two – Ministry of Health Resurgence Planning Framework: DHB Responsibilities/Action Plan 30
Appendix Three – Adapted MDHB CIMS Structure 35
Appendix Four – National Hospital Response Framework 36
Appendix Five – National Community Response Framework 37

Introduction

This Resurgence Plan describes the MidCentral District Health Board (MDHB) plan to prepare for and manage the local response to further outbreaks of novel coronavirus disease 2019 (COVID-19). This plan aims to provide people in leadership positions with a framework for the delivery of the actions required to respond rapidly to an outbreak, whilst at the same time maintaining 'business as usual' (BAU) as much as possible. This plan operationalises an elimination strategy that seeks to eradicate or minimise cases of COVID-19 from MDHB to a level that is manageable by the health system and covers vaccination to achieve population-level immunity.

The key goal is to achieve a response that is proportionate to the level of risk, acknowledging that the risk is not the same across population groups. A response that is appropriate to the level of impact the novel coronavirus outbreak is likely to have on our community at large, and on vulnerable populations such as Māori, Pasifika and refugee populations within the community, will make the best use of the resources available.

The plan will be updated as new information becomes available and will be used to:

- guide the allocation of resources
- put in place strategies to support our population in partnership with local health providers, iwi, Māori, and intersectoral partners
- reduce the risk to the most vulnerable people in our population.

The plan has been developed in collaboration with other District Health Boards (DHBs) and partner agencies. MDHB has used the guidance from the Ministry of Health, and elements of resurgence planning approaches used by Horizons Regional Council and other DHBs in our region, to ensure consistency. This enables coordination of efforts, which are critical in a response to a pandemic.

This plan covers the needs of the population of MidCentral District with appropriate attention to the needs of people more susceptible to COVID-19. The priority population groups of focus include Māori, Pacific peoples, older people, people with disabilities, people with mental health conditions, people in residential care settings, migrant and refugee communities, and people with pre-existing health conditions.

Having a detailed integrated plan with commitment across the sector, will ensure that we can respond quickly and effectively to any resurgence of COVID-19 within the district, and minimise the potential negative health impacts on our population. The plan will remain under continual review as more information on the management of the response becomes available.

Section 1 – Planning and Response Context

Situation

Since COVID-19 was declared a Public Health Emergency by the World Health Organization in January 2020, the direct and indirect impacts of the virus have been felt around the world. The New Zealand Government has determined it will follow an elimination strategy.

The Government is currently pursuing an elimination strategy that aims to eradicate or minimise cases of COVID-19 from New Zealand to a level that is manageable by the health system, until sufficient numbers of the population have received the vaccine to enable a level of population immunity to be achieved. Achieving this and maintaining it over time will be challenging and requires the deployment of a range of control measures to:

- **Identify and stop transmission** – through rigorous testing and community surveillance; rapid intensive contact tracing and action to manage clusters including quarantine and isolation and prevention strategies such as vaccination.
- **Prevent undetected transmission** – through protocols for self-isolation of suspected cases; prohibiting mass gatherings; physical distancing and hand hygiene.
- **Prevent overseas infection spreading** – through border measures, restrictions on travel and isolation or quarantine.

COVID-19 was first detected in New Zealand in March 2020. There was a national Level Four lockdown from March 2020 for five weeks. Since that time there has been resurgence and small clusters of infections. This plan aims to support MDHB in its response to resurgence of the virus.

Purpose

To outline the readiness and response arrangements relating to the coordination and leadership across the MDHB District, to enable a coordinated whole of district response to resurgence.

Alignment

The plan is aligned to national guidance and MDHB's strategy, priorities, and values. It follows the expectations of the National Emergency Management Agency (NEMA) and the requirement to work within regional planning arrangements and under Civil Defence Emergency Management (CDEM) guidance. The plan references the MDHB Pandemic Plan and has several operational plans which support the delivery of this in action.

MDHB Strategy and Guiding/Planning Principles/Values

MDHB has a vision of quality living, healthy lives and well communities. During COVID-19 resurgence the commitment to our vision through the delivery of our four strategic priorities has never been more important. Our strategic priorities are:

- Achieve equity of outcomes across our communities
- Partner with people, whānau and communities to support health and wellbeing
- Connect and transform primary, community and specialist care
- Commit to quality and excellence in everything we do.

Our values will underpin the way in which we plan and deliver activities associated with resurgence. We will be true to our values, and be compassionate, respectful, accountable and courageous in all activities in this plan.

Planning principles

Planning activity for any increase in case numbers will focus on:

- honouring our commitment to Te Tiriti o Waitangi
- ensuring safe sustainable hospital services including regional responsibilities
- ensuring safe sustainable community services to meet demand
- ensuring safe sustainable Public Health Services to meet demand
- ensuring that our staff are safe and supported in delivering this plan
- ensuring a proportionate, scalable, evidence informed and flexible response
- providing a coordinated approach across the health and disability sector and with other sectors
- balancing COVID-19 with other business as usual (BAU) health and disability services
- recognising that other emergencies (e.g., natural disasters) may occur during this time
- supporting and maintaining quality health and disability services
- focusing on priority, at risk populations and improving equity
- communications to engage, empower and build confidence in the wider community (customising as appropriate for certain populations)
- supporting the health, welfare, and social needs of health care workers
- prioritising the ongoing maintenance of effective infection prevention and control practices

- handling the management and distribution of personal protective equipment (PPE) consistently, transparently, and equitably
- coordinating and ensuring consistency of communications to and from key stakeholders
- reviewing and/or documenting systems, processes, policies, standard operating procedures (SOPs), standard communications etc. for training and future use
- working with and developing people we have locally, so that we can be self-sufficient should we need to be
- ensuring all plans and responses across the health and disability sector are prioritised and integrated.

Te Tiriti o Waitangi

Te Tiriti o Waitangi and its articles and principles, as articulated by the Courts and the Waitangi Tribunal, legislate our commitment to our iwi partners; Muaūpoko, Ngāti Kahungunu ki Tāmaki nui a Rua, Ngāti Kauwhata, Ngāti Raukawa ki te Tonga, Rangitāne o Manawatū, and Rangitāne o Tamaki Nui a Rua.

MDHB acknowledges the significance of Te Tiriti o Waitangi as a foundational document for public policy. Te Tiriti guides MDHB in how it governs and conducts itself, how true partnership with iwi is demonstrated, how beliefs, values and tikanga are cherished and how excellence, in all its definitions, is attained.

Equity

Equitable access to health and disability services and health outcomes is central to all planning and response measures for any outbreak of COVID-19. Eight priority populations facing specific risks because of COVID-19 have been identified:

- Māori
- Pacific peoples
- Older people, especially those over 70 years
- People living in residential care facilities
- People with long term conditions
- People with disabilities
- People with mental health conditions
- Refugees and migrant community members.

All planning must include targeted approaches to support these groups.

In addition to these priority groups, special consideration must also be given to healthcare workers, including those who work in residential care settings.

Flexibility and scalability

Given the unpredictability of the timing, nature, and scale of any potential resurgence of COVID-19 in MDHB District, all planning needs be scalable to a range of scenarios and progressively implemented based on the situation and circumstances existing at the time. Flexibility in all planning is required such that actions can be modified as necessary to meet these uncertainties and potentially changing situations.

Scientific evidence base

Actions taken to give effect to the objectives of this plan should reflect scientific principles and be either based on, or informed by, the best available evidence. In practice, this means referring to and applying knowledge that has been developed through examination of the evidence base and robust consideration of the suitability for application in the New Zealand and the MDHB district context.

Infection Prevention and Control

Effective infection prevention and control (IPC) practices are, and will continue to be, a priority. This applied to all health care settings is relevant to preventing, planning for, and responding to any further outbreaks, providing a safe environment for health care workers, caregivers and their patients, clients, and visitors.

Infection prevention and control objectives and actions will be reflected through all planning including:

- ensuring IPC guidance measures and contingencies are in place
- regularly updating IPC protocols based on current scientific/clinical knowledge
- maintaining adequate stock of health sector PPE including their actual and projected use
- ensuring that all staff required to wear respiratory protective devices are qualitatively fit tested
- reinforcing infection prevention and control interventions and messages.

Health and Safety for our staff and our population

The plan will protect individuals who are most at risk of severe infections from exposure to COVID-19. MDHB will:

- use the nationally agreed 'vulnerable' staff assessments undertaken by Occupational Health to assess individual risk within the workforce
- redeploy vulnerable staff based on the assessed category into appropriate work areas
- define and establish protected workspaces to enable universal protection as far as is feasible
- define levels of physical distancing
- require physical distancing for people working in or with at-risk communities.
- identify interventions to protect people who are high risk, if they or their close contacts develop COVID-19
- enable staff to work off site in line with MDHB's working from home guidelines
- maintain up to date registers on all employed staff vaccination status.

Communications and engagement

Engaging with and using the strength of our community is critical to an effective response to resurgence, minimising harm and keeping everyone safe. Communicating effectively has been one of the cornerstones of the response to COVID-19 to date and is crucial to all involved in preparing for and responding to a pandemic. Good communications with all stakeholders and our community are critical to a successful resurgence response. Key considerations include:

- Customisation – both content and means of delivery, particularly to priority groups.
- Accessibility – information about COVID-19 should be accessible for all New Zealanders and may need to be translated into alternate formats and key languages.
- Cross-sector engagement – needs to be open, transparent, consistent, and able to transcend organisational boundaries.
- Partnerships and empowerment of community – we have seen how effective this is when we seek and support community leaders to enable and support others.
- Following the principle of 'nothing about us without us' in developing communications.

Sustainability

All international evidence and experience indicate that COVID-19 outbreaks are difficult to control once community transmission takes hold and that response activities put significant pressure on health system resources. Planning for any resurgence within New Zealand therefore needs to acknowledge that should current elimination strategies be unsuccessful we could find ourselves in a significant response phase that could go on for some weeks or even months, requiring us to sustain an appropriate level of response over this time.

Sustainability needs to be considered in relation to the following:

- Health system workforce – health, wellbeing, and resilience.
- Patient Management Systems and the effective sharing of information.
- Coordinated Incident Management System (CIMS) roles, systems, and processes including effective two teaming and handover.
- Facilities – readiness, capacity and flexibility.
- Equipment – access, transportation and supply chain.
- PPE
- Finance
- Public/community support.

Workforce, personal development and planning

A sustainable workforce and response structure are critical, ensuring we have people trained and developed to fill, backup and/or support key roles.

Specific areas identified for special attention in the current environment include:

- Incident Controllers and other CIMS leadership roles
- CIMS/Incident Management support expertise
- Public Information Management
- IPC and Occupational Health and Safety
- Security
- Welfare leadership and support navigators
- Digital connectivity.

Specific training is also required for some procedures and processes including:

- PPE/mask fit testing
- Swabbing

- Contact tracing
- Medapp usage
- Vaccination delivery and coordination
- Laboratory services (including registration)
- Information system user guides and training documentation.

The need for training and development must be considered in the review of all plans and standard operating procedures.

Integration of response

The MidCentral district health community of providers is a system of inter-connected parts. As services develop resurgence plans and strategies as part of this plan, each will need to consider the impact of any activity on any other connected or supporting component, to ensure effective and efficient flow through the system. At times there may be a need to compromise on business as usual activity, due to the (non)availability of logistic or personnel support, and/or a constraint or 'bottle-neck' in the system further up the line. Flexibility to work together and differently, to meet the needs of the community will be paramount.

The requirement for integration also extends through the entire response, ensuring that all key functions are aligned and focused on the same key outcome or objective.

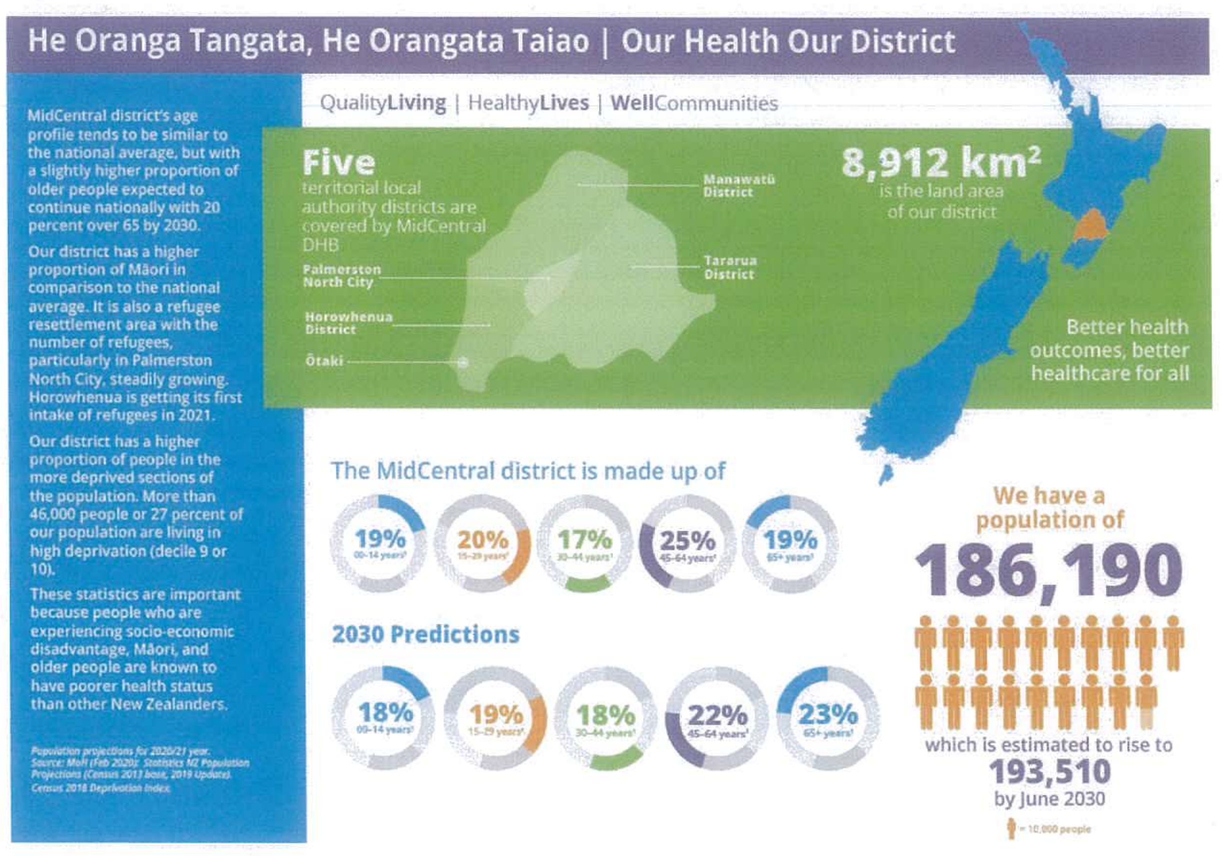
Quality and safety of care

As providers of public funded health and disability services, all MDHB staff and contracted providers need to ensure they continue to meet the best possible standards of clinical quality and patient safety. It is acknowledged that during a pandemic, pressures of demand may at times exceed the ability of our staff, other providers or supporting services to satisfactorily meet that demand, and that some compromise to the 'normal' standard may be necessary. Delays in the delivery of non-urgent care may be one of these compromises during a resurgence response. This requires coordinated clinical risk management and strong clinical governance systems to minimise and mitigate risk.

In developing resurgence plans, MDHB will develop guidance and/or processes that can assist decision makers faced with the possible situation of demand exceeding the capacity, in the short and long term.

Our district

Understanding our district and communities enables us to work in partnership with them to better plan responses and services that meet the community and its people's needs.



National Response Coordination and Leadership

All of Government (AoG)

The New Zealand Government is taking an 'All of Government' approach to responding to COVID-19. This includes establishing a National Response Leadership Team (which includes the Chief Executive of the National Emergency Management Agency (NEMA) and the Director-General of Health) to provide advice direct to Cabinet.

Key to the national response to date has been the development and application of COVID-19 alert levels.

COVID-19 Alert Levels

Level 1

- **Prepare** – Disease is contained.

Level 2

- **Reduce** – Disease is contained but risks of community transmission are growing.

Level 3

- **Restrict** – Heightened risk that disease is not contained.

Level 4

- **Eliminate –** Likely that disease is not contained.

A range of measures that can be applied locally or nationally have been developed for each of these alert levels. Details of these are attached as **Appendix One.**

AoG COVID-19 Resurgence Plan

An AoG Resurgence Plan has been developed, based on the following principles:

- Continue to pursue an elimination strategy for COVID-19. This means a sustained approach to keeping it out, finding it, stamping it out.
- The core of our response will be personal hygiene, staying home when sick, testing, contact tracing and isolation.
- When this is insufficient, we will seek to control COVID-19 with the least intrusive measures, including tailored local responses that will give us confidence that we will continue to deliver on our strategy of elimination.
- We will seek to avoid going to Alert Levels 3 or 4, if possible, although we will do so if necessary.
- There will be strong national oversight over any response, regardless of whether the response is local or national in scale. This will ensure adequate national level support and resourcing, continued confidence in our response, and the ability for the government to take appropriate action.

Three high level national objectives are set out in the AoG plan:

1. Minimise the number of people affected and exposed to COVID-19.
2. Minimise the negative health outcomes for those infected with COVID-19.
3. Minimise the economic and social impacts from any control measures.

The Ministry of Health (the Ministry) and NEMA are the two agencies primarily tasked with planning, implementing, and monitoring resurgence control measures. MDHB is directly accountable to the Ministry for regional resurgence planning and delivery of health-related services. It is also indirectly accountable to NEMA through the Regional Civil Defence and Emergency Management Group (CDEM) for supporting the AoG response.

Ministry of Health

As the lead agency, the Ministry of Health is responsible for coordinating the health and disability sector. It has developed a COVID – 19 System Response Plan. It is located here https://www.health.govt.nz/publication/covid-19-health-and-disability-system-response-plan

This plan supports the health sector with operational planning and ensures a coordinated and consistent response.

The purpose of the Plan is to:

- describe the health and disability system actions that will be triggered or could pe considered
- provide additional detail to support activities at an operational level
- be used by planners prior to or during an outbreak as an operational checklist of activities that will need to be implemented.

Targeted response measures need to focus on:

- ensuring a proportionate and effective response
- providing a coordinated and consistent approach
- supporting and maintaining quality health and disability services
- focusing on priority, at risk populations
- communication to engage, empower, and build confidence in the wider community.

The plan sets out some background, several key principles, a summary of roles and a Health and Disability System Response Action Plan. This Action Plan sets expectations for operational level planning by DHBs, Public Health Units and other agencies within the health and disability sector.

NEMA and Manawatū/Whanganui CDEM

NEMA has activated its National Coordination Centre (NEMA NCC) to coordinate the CDEM Sector response to any resurgence. NCC operates under a CIMS structure. Overall direction for the CDEM response is provided by the Director CDEM in their role as National Controller.

The Regional CDEM Group is the lead agency mandated to lead the coordination of the regional operational response to COVID-19 resurgence in the MDHB area. It is supported by MDHB, Territorial Local Authorities, Iwi, Horizons Regional Council, the Public Health Services, New Zealand Police, Ministry of Business, Innovation and Employment (MBIE), Ministry of Social Development (MSD), New Zealand Defence Force, Te Tihi Ruahine Whānau Ora Alliance and other local bodies.

MDHB is the lead for the health and psychosocial wellbeing response to COVID-19.

A Regional Public Service Leadership Group (RPSLG) has been established to provide governance and advice at a regional level to guide and support community resurgence planning and operational response activity. The MDHB Chair and CEO are members of the RPSLG.

Operationally, CDEM Group has agreed a Mission:

> Aligned to the principles of the Manawatū-Whanganui CDEM Group Plan of Consistency, Accountability, Best Practice, and Support, the mission of the Group is "To provide a planned and coordinated response to a COVID-19 resurgence in order to minimise the impacts on the regional community which we serve".

Response Scenarios and Planning Assumptions

Ministry of Health

Ministry of Health planning for resurgence is based on the following assumptions:

- The Elimination Strategy remains the overarching framework for the health and disability sector.
- In addition to the community cases detected in Auckland in mid-August and again in November 2020, further clusters of COVID-19 in New Zealand will occur in the coming months or year – new community cases could be detected at any time and case numbers could rise rapidly.
- The overall size and duration of subsequent outbreaks may well be different from the first outbreak and the recent Auckland clusters.
- The severity of the disease and the population groups affected may be similar to the first outbreak or the August Auckland community cluster, but ongoing vigilance will be needed to detect and respond to any changes in affected populations and severity.
- Resurgence may occur in conjunction with a concurrent event such as a flood, earthquake, or other emergency.

All sector organisations will use a CIMS framework in the immediate response to a resurgence.

MidCentral District Health Board

Given the current environment in MDHB, current assumptions about the future include:

- Timing of a potential increase in COVID-19 remains uncertain – new community cases could be detected at any time and with little or no warning.
- The overall size, steepness, and duration of a second outbreak may well be different from the first outbreak.
- The severity of the disease and the population groups affected may (or may not) be like the first outbreak, but ongoing vigilance will be needed to detect and respond to any changes in affected/at risk populations and severity.
- Any resurgence will result in some loss of life in MDHB at some stage.
- Vaccination has commenced and is progressing well, but it will be some months before population level immunity is achieved.

Social and economic environment

- The community will behave appropriately to minimise potential for transmission.
- The public will become more complacent and the level of voluntary compliance with control measures, heighten during any resurgence, but will decline over time.
- The NZ economy will decline, and unemployment will rise.
- Securing, building, and maintaining sufficient housing stock will continue to be a significant challenge in our district.
- Domestic violence is a challenge and may increase.
- Self-harm may increase.
- Social media will create misinformation and potential 'panic'.

The broader health and wellbeing provider partnership

- Management and all staff remain committed to investing in and support resurgence planning.
- Required training will be provided for key roles.
- A level of BAU will be retained during response.
- Demand for mental health services will increase.
- Health workers will suffer from fatigue which will need to be managed. It is highly likely that public health staff will be called upon to have surge capacity for other regions impacted and that MDHB will need to call on other regions if we have a significant outbreak.
- General Practice Teams will be doing telehealth-based triage/consults.

- There will be stockpiling of PPE in various areas.
- At Alert Levels 3 and 4, many essential workers will not be available due to either being at risk, caring for family members etc.
- There may be some resistance from staff to re-engage, but a level of goodwill will remain.
- We will cope with what we have, should any outbreak become national and 'outside' support not be available.

MDHB systems and processes

- The MDHB Pandemic Plan is up to date and relevant.
- A COVID-19 specific operating procedure will bring together the disease-specific actions required and will complement the Pandemic Plan and the COVID -19 Resurgence Plan – work is underway to create a nationally consistent approach, but this may fall behind the need for it.
- Issues identified from debriefs of the first outbreak will have been addressed.
- Robust business continuity plans exist and are readily available.

Section 2 – Readiness and Response Coordination

Governance arrangements

MDHB Board is accountable to ensure decision making is robust and supports our community during any civil or health emergency. MDHB will work in partnership with the Regional Leadership Group to support any regional or intersectoral response. The Chair of the Board and the Chief Executive (CEO) are members of this leadership group.

The CEO is accountable for making decisions relating to the operational activity of MDHB during any resurgence and when to establish an incident management team to respond and coordinate a response.

The Organisational Leadership Team is collectively accountable for the delivery and coordination of the response under the overall direction of the CEO and the IMT (if established).

Coordination arrangements

MDHB will establish the incident management team to coordinate and manage the district health response to any resurgence or risk of resurgence of COVID-19 in our community based on national guidance, alert levels, hospital management frameworks and other triggers.

Mission, intent and objectives

Mission: To manage all aspects of Health Response to COVID-19 resurgence to enable MDHB to maintain essential health services for our communities.

Intent and objectives:

1. Minimising the potential for the spread of COVID-19 in accordance with national alert level protocols.
2. Supporting people with acute health needs to get appropriate treatment and ongoing care where necessary.
3. Keeping the community well informed.
4. Supporting our staff, volunteers and providers to stay well.
5. Maintaining essential services across the DHB.

Local scenario

The MDHB District spans a geographic area of over 22,000 kms2 from Manawatū District in the north and Ōtaki and Horowhenua District in the south, and Tararua

District in the east. Any road travel from the south of the North Island to the north of the North Island requires traversing through the CDEM Group area.

The district is also host to two large military bases (Ohakea and Linton). Military personnel have and continue to be used for the staffing of COVID-19 Managed Isolation and Quarantine Facilities across New Zealand. MDHB is also responding to Ministry of Health requirements to establish secure isolation and quarantine facilities in our district.

The most likely scenario regarding the potential for community transmission from COVID-19 is that of it being brought into the region from an external source, either traversing through the region, or returning to the region.

AoG response scenarios

There are four high-level resurgence scenarios that are being used to support AoG resurgence planning. The MDHB response to these scenarios is indicated. The scenarios are:

Scenario	Description	MDHB response
Scenario One	**Only one or two further cases are detected amongst close contacts and there is a connection back to the original source of infection at the border.** The likely response is that the region moves to Alert Level 2 – e.g., physical distancing requirements, restrictions on gatherings and contact tracing requirements. Alternatively remaining at Alert Level 1 with some specific controls may be appropriate.	Maintain business as usual and activate Level 2 protocols if required
Scenario Two	**A single cluster of connected cases in the region, with no evidence of community transmission in the region and no cases in other regions.** The likely response is moving the region to Alert Level 3. Alternatively, a move to Alert Level 2 may be sufficient. The rest of the country could stay at Alert Level 1.	Follow national direction and activate Level 2, 3, 4 protocols as directed. Activate IMT if required.
Scenario Three	**Widespread community transmission in the region but no confirmed cases detected in other regions.** The region is likely to move to Alert Level 3 or 4. It may also be appropriate for the rest of the country to move to Alert Level 2	Follow national direction, activate appropriate Level 2, 3, 4 protocols. Activate IMT if required.
Scenario Four	**At least one cluster in the region and confirmed cases in other regions.** The region where the cluster began would move to Alert Level 3 and other regions with cases would shift to Alert Level 3 and unaffected regions to Alert Level 2. Depending on the number of affected regions, the Government would have to consider broader national action.	Follow national direction, activate appropriate Level 2, 3, 4 protocols as required. Activate IMT if required.

Readiness and response phases

Readiness

MDHB maintains a number of CIMS trained personnel with which to form and sustain an Incident Management Team. All activities are conducted in accordance with Coordinated Incident Management System (3rd Edition) CIMS protocols.

Response

MDHB will establish the incident management team (IMT) to coordinate and manage the district health response to any resurgence or risk of resurgence of COVID-19 in our community based on national guidance and alert levels, national hospital and community response frameworks or other relevant triggers.

The MDHB IMT will ensure timely updates to our regional partners through:

- daily Situation Reports (Sit Reps)
- twice-daily teleconferences – emergency operations centre to other regional centres
- MDHB Incident Actions Plans.

Scenarios for escalation

Of the four AoG response scenarios there are three that could potentially require an escalation from the countries current setting of Alert Level 1, however all four scenarios do require a level of MDHB coordination. They will also require MDHB to work with the Regional Leadership Group within the CDEM response.

Given the unpredictability of the timing and scale of any potential resurgence of COVID-19 in MDHB, relevant components of this Plan will need be scalable to a range of scenarios and progressively implemented based on a number of triggers.

Scenarios

For planning purposes, four scenarios will be used:

- No active cases in the MDHB district.
- Small number of active cases in MDHB or out of region requiring a Public Health response.
- Cases increase in MDHB but contained to small number of clusters.
- Substantial number of cases – community transmission is evident across the community.

Triggers

MDHB will use the national alert levels and the national hospital and community alert framework as a guide to the actions we take against status in the hospital or community setting. Specific components of this plan will need to be activated at various times within any of these scenarios to appropriately meet the needs of the community.

Section 3 – Roles and Responsibilities

Manawatū-Whanganui Regional Leadership Group

- **Convene** regional leadership and ensuring a regional Strategy/Plan that caters to different communities.
- **Connect** local government, iwi, Pasifika, ethnic communities and key central government personnel.
- **Support** the distribution of key messages and aid to community networks.

MidCentral District Health Board

- **Lead** the identification, control, and elimination of any COVID-19 outbreaks in the Manawatū-Whanganui region.
- **Coordinate** the health sectors response to COVID-19.
- **Lead** regional testing efforts by establishing appropriate facilities as relevant.
- **Maintain** a functional relationship with the CDEM Group Controller and advise and update on existing and emerging issues.
- **Lead** the provision of psychosocial support for the region.
- **Identify and establish** appropriate regional quarantine facilities – if required.
- **Provide** health support to the region's Managed or Supported Isolation and Quarantine Facilities – if established.
- **Maintain** readiness for any other health or Civil Defence emergency.

Manawatū-Whanganui CDEM Group

- **Lead** the regional coordination of readiness, response, and recovery for the Group.
- **Support** local CDEM activities across the Group.
- **Coordinate** the provision of emergency welfare services via the Welfare Coordination Group if required due to all other options being exhausted.
- **Create** and maintain situational awareness.

MDHB Organisational Leadership Team

- **Lead** the MDHB operational response.
- **Maintain** business as usual to the extent that it is feasible based on the level of resurgence in the community and the national alert level requirements.

MDHB Incident Management Team

- **Coordinate** and lead the incident response team.
- **Lead** decisions and reporting.

MDHB People Leaders, Clinical Leaders, and Operations

- **Support** delivery of quality care.
- **Support** and protect workforce wellbeing and ensure health and safety of the workforce.
- **Enable** the response through coordination of activities as directed through the IMT.

Section 4 – Operational Context and Sub Plans

MDHB will deliver the COVID-19 Resurgence Plan in the context of the MDHB wider Pandemic Plan. Detailed Resurgence Operating Plans and Procedures have been developed for the following focus areas:

- MDHB Resurgence Readiness Plan
- Community Resurgence Plan
- Testing Surge Plan
- Contract Tracing Surge Plan
- Hospital Plan
- Incident Action Plans
- Business Continuity Plans.

Action plans are in place for each area of our response, against all levels of national alert (Level 1 to 4).

Section 5 – Legislative Frameworks

COVID-19 Public Health Response Act 2020

The COVID-19 Public Health Response Act 2020 (COVID-19 Act) is the primary legislation for addressing COVID-19 Response and recovery issues. The purpose of the Act is to support a public health response to COVID-19 that:

- prevents and limits the risk of the outbreak or spread of COVID-19 (considering the infectious nature and potential for asymptomatic transmission of COVID-19).
- avoids, mitigates, or remedies the actual or potential adverse effects of COVID-19 outbreak (whether direct or indirect).
- is coordinated, orderly, proportionate and has enforceable measures, in addition to the relevant voluntary measures and public health and other guidance that also support the response.

This Act created a comprehensive legal framework to support the Government's alert level system to limit the spread of COVID-19 in NZ and other measures necessary to respond to COVID-19.

Particularly relevant is that the COVID-19 Act enables the Director General of Health or the Minister of Health to make 'Section 11' Orders which can require specific actions to be taken, measures to be complied with, or restrictions to be put in place to prevent or limit the extent or spread of COVID-19. This power is broadly based on the powers in sections 70 and 921 of the Health Act 1956 but lifts the 'approval' level to the Minister of Health rather than just the Director-General.

The COVID-19 Act provides the legislative authority for all Maritime and Aviation Orders for the effective management of relevant issues at our borders. With a port (receiving overseas ships) and an airport within Hawkes Bay, our Medical Officers of Health and Public Health Unit are actively involved in monitoring and managing compliance with these Orders.

The COVID-19 Act also over-rides many of the powers conferred on Group Controllers under the Civil Defence Emergency Management Act 2002, when dealing with COVID-19 related issues.

NZ Public Health and Disability Act 2000

Under this Act, an objective of DHBs is to improve, promote and protect the health of people and communities.

To this end DHBs have several statutory functions, including 'ensuring the provision of services for its resident population' and 'collaborating with relevant organisations to plan and coordinate at local, regional and national levels for the most effective and efficient delivery of health services.'

Health Act 1956

The Health Act 1956 (HA) is the primary statute for the prevention and control of infectious diseases within the country and at the border. This Act works alongside the more general CDEM Act and other statutes.

Of relevance, with the Prime Minister issuing an epidemic notice pursuant to s5 of the Epidemic Preparedness Act 2006, this triggered the ability of the Director General of Health and Medical Officers of Health to make orders pursuant to s70 of the Act.

Section 70 notices can cover a wide variety of topics. Potentially relevant, the order may:

- require people to report themselves or submit themselves for medical examinations.
- require people to report or submit themselves for medical testing.
- require persons, places, buildings, ships, vehicles, aircraft, animals, or things to be isolated, quarantined, disinfected, or tested.
- forbid people, ships, vehicles, aircraft, animals, or things to come or be brought to any port or place in the health district from any port or place which is or is supposed to be infected with any infectious disease.
- require people to remain in the health district or the place in which they are isolated or quarantined until they have been medically examined and found to be free from infectious disease, and until they have undergone such preventive treatment as the Medical Officer of Health may prescribe.
- forbid the removal of any ships, vehicles, aircraft, animals, or things from the health district, or from the place where they are isolated or quarantined, until they have been disinfected or examined and found to be free from infection.
- use or authorise any local authority to use as a temporary site for a special hospital or place of isolation any reserve or endowment suitable for the purpose.
- require a premise to be closed (conditions apply).
- forbid people to congregate in outdoor areas (conditions apply).

In terms of property, s 71(1) of the HA empower the Medical Officer of Health to:

- take possession of, occupy, and use any land or building that in his or her opinion is required for the accommodation and treatment of patients.
- take possession of, occupy, and use any land, building, or craft (other than an aircraft), that in his or her opinion is required for the storage or disposal of bodies.

- take possession of or use any vehicle or craft that in his or her opinion is required for the transport of:
  - patients, medical personnel, medicine, medical equipment or devices, food, or drink or clothing, bedding or tents or other temporary facilities or structures
  - personnel involved in loading, moving, distributing, erecting, or otherwise dealing with anything transported under the above.

Civil Defence Emergency Act 2020 and CDEM Plan Order 2015

The CDEM Act 2002 and CDEM Plan Order 2015 provide the legislative basis for CDEM Groups to coordinate the multi-agency response to an emergency (declared or undeclared) within their region.

The CDEM Act s17 (1)(d) provides that it is a function of CDEM Groups to respond to and manage the adverse effects of emergencies in its area. The CDEM Act contains provisions relating to the declaration of emergencies and gives Group Controllers a variety of powers to manage an emergency.

Section 6 of the CDEM Act provides that the *'CDEM Act does not limit, is not in substitution for, and does not affect the functions, duties or powers of any person under the provisions of any enactment or other rule of law'.* This means that the COVID-19 Act provisions take precedence over the CDEM Act, and that powers under the CDEM Act will only be used to fill any 'gaps' not covered in the COVID Act.

Coordination and Enforcement

The COVID-19 Act, Health Act and CDEM Act work together to create and maintain controls over the management and responses to COVID-19. There is a significant overlap between their powers. Coordination is therefore important.

COVID-19 is, at least during the response phase, primarily a health issue. Locally this means responsibility sits with MDHB. The wider social and economic impacts, however, require an all-of- government approach, which at a local level is coordinated by CDEM and the Regional Leadership Group.

If a person refuses to comply with any requirement issues under any of the three Acts, it is for the Police to exercise enforcement powers as is needed. Section 71A of the Health Act confers upon the police significant, and broad, powers to assist the Medical Officer of Health in the implementation of s70 and s71 powers. As a final port of call, s72 of the Health Act makes it an offence to obstruct or hinder a Medical Officer of Health or the Police in the execution of their duties under this Act.

Appendix One – New Zealand COVID-19 Alert Levels

New Zealand COVID-19 **Alert Levels**

Unite against COVID-19

- These alert levels specify the public health and social measures to be taken.
- The measures may be updated on the basis of (i) new scientific knowledge about COVID-19 and (ii) information about the effectiveness of intervention measures in New Zealand and elsewhere.
- The alert levels may be applied at a town, city, territorial local authority, regional or national level.
- Different parts of the country may be at different alert levels. We can move up and down alert levels.
- In general, the alert levels are cumulative, e.g. Level 1 is a base-level response. Always prepare for the next level.
- At all levels, health services, emergency services, utilities and goods transport, and other essential services, operations and staff, are expected to remain up and running. Employers in those sectors must continue to meet their health and safety obligations.

LEVEL	RISK ASSESSMENT	RANGE OF MEASURES (can be applied locally or nationally)
Level 4 - Eliminate Likely that disease is not contained	• Sustained and intensive transmission • Widespread outbreaks	• People instructed to stay at home • Educational facilities closed • Businesses closed except for essential services (e.g. supermarkets, pharmacies, clinics) and lifeline utilities • Rationing of supplies and requisitioning of facilities • Travel severely limited • Major reprioritisation of healthcare services
Level 3 - Restrict Heightened risk that disease is not contained	• Community transmission occurring OR • Multiple clusters break out	• Travel in areas with clusters or community transmission limited • Affected educational facilities closed • Mass gatherings cancelled • Public venues closed (e.g. libraries, museums, cinemas, food courts, gyms, pools, amusement parks) • Alternative ways of working required and some non-essential businesses should close • Non face-to-face primary care consultations • Non acute (elective) services and procedures in hospitals deferred and healthcare staff reprioritised
Level 2 - Reduce Disease is contained, but risks of community transmission growing	• High risk of importing COVID-19 OR • Uptick in imported cases OR • Uptick in household transmission OR • Single or isolated cluster outbreak	• Entry border measures maximised • Further restrictions on mass gatherings • Physical distancing on public transport (e.g. leave the seat next to you empty if you can) • Limit non-essential travel around New Zealand • Employers start alternative ways of working if possible (e.g. remote working, shift-based working, physical distancing within the workplace, staggering meal breaks, flexible leave arrangements) • Business continuity plans activated • High-risk people advised to remain at home (e.g. those over 70 or those with other existing medical conditions)
Level 1 - Prepare Disease is contained	• Heightened risk of importing COVID-19 OR • Sporadic imported cases OR • Isolated household transmission associated with imported cases	• Border entry measures to minimise risk of importing COVID-19 cases applied • Contact tracing • Stringent self-isolation and quarantine • Intensive testing for COVID-19 • Physical distancing encouraged • Mass gatherings over 500 cancelled • Stay home if you're sick, report flu-like symptoms • Wash and dry hands, cough into elbow, don't touch your face

Appendix Two – Ministry of Health Resurgence Planning Framework: DHB Responsibilities/Action Plan

Planning, Coordinating and Reporting

- Anticipate how the mental health and wellbeing of communities will or may be affected and develop, review, or maintain a psychosocial plan as appropriate.
- Maintain awareness of legislative instruments and authorisations.
- 'Localise' any Ministry of Health PPE distribution plan.

Intelligence

- Develop escalation points with triggers that identify the appropriate response.
- Regularly review surveillance indicators, the surveillance (testing) plan and intelligence reporting.
- Develop a clear picture of the data that can be accessed.
- Enhanced monitoring of health and disability sector capacity during a second outbreak.

Public Health Interventions

- Maintain readiness to implement rapid cluster control measures, particularly in high-risk settings, managed facilities, and communities, including:
  - identifying key cluster control staff
  - ensuring the system machinery is ready to be operationalised immediately, with a ready workforce.
- Plan arrangements for managed isolation and quarantine for community cases (and in some cases their household close contacts) who may be unwilling or able to self-isolate, including welfare support and psychosocial resources.
- Continue seasonal influenza immunisation campaign.
- Provide information and resources to health professionals across all providers and communities as determined by local needs and planning.
- Maintain International Health Regulations core capacity requirements.

Health Care and Emergency Response

- For consistency of messaging, ensure streamlined communications with one key point of contact for services and/or communities.

- Ensure health and disability sector readiness for new cases that may trigger a second outbreak – address potential pressure points in resurgence plans covering:
  - Primary Care – including coordination with local primary care providers, general practice, pharmacists, midwives, ambulance etc., regarding ICP protocols, distribution of and access to BAU consumables and national reserve supplies.
  - Capability to establish and then scale up community-based assessment centres (CBACs) and other testing centres at short notice.
  - Clear guidance and support for Residential Care (RC) providers, and on DHB obligations and responsibilities for Residential Care.
  - Guidance and support for Māori, Pacific, rural communities, mental health, disability, Lead Maternity Carer (LMC) providers.
  - Planning for continuation of care for vulnerable populations, particularly for those with long term conditions.
  - Proactive support for high-risk people and communities – including the provision of information on how to access health services, phone check ins, psychosocial and home support.
  - Telehealth services and technology to support relevant aspects of primary care with remote/virtual solutions.
  - ICUs (Intensive Care Units) – including staff training, bed space, ventilators, clinical networks.
  - Laboratory services – including surge capacity for testing (e.g., reagents, testing kits, workforce).
  - Ensure primary and secondary care has surge capacity, including plans for workforce and improvised health care facilities, and regularly assess DHB staff capability to ensure skills required are maintained.
  - Capability to care for and support patients at home.
  - Innovative/enhanced arrangements for palliative/hospice care.
  - Plans and policies for an outbreak in Residential Care.

Communications and Health Education

- Prepare, maintain, and review communications plan.
- Update the public and agencies/providers on the pandemic situation and key messages through regular media reports, websites, social media etc.
- Customise delivery of key messages to older people, Māori, Pacific, disabled people, residential care settings, people who experience psychosocial needs, rural populations, and any groups at higher risk of infection or severe outcomes.

- Disseminate key messages for all sectors, consistent with MoH plans and communications.
- Regular reviews of communication strategies.

Cross-Sectoral Actions

- Keep other agency staff and sectors updated on the situation and plans.
- Maintain up to date role and contact details of agency staff and key contacts in the sector.
- Coordinate planning between agencies when required.

RESPOND

Planning, Coordination and Reporting

- Activate resurgence action plan based on Ministry of Health advice.
- Lead/coordinate response for the local health sector.
- Set response objectives.
- Activate emergency management structures and processes, including business continuity plans, as required.

Intelligence

- Continue/intensify surveillance, including monitoring trends in case numbers.
- Closely monitor demographic/epidemiological trends in cases and clusters to ensure response measures prioritise affected groups/communities.
- Analyse the event, complete ongoing risk assessments, including impacts and event evolution.
- Ensure clear, accurate and up-to-date intelligence is disseminated appropriately.
- Provide regular situation reports and maintain distribution lists.
- If incidence and/or severity increases, review the need for additional intelligence and interventions.
- Ensure that equity remains at the centre of all decisions.
- Maintain communication with NZ Police and other emergency agencies to ensure that we have accurate intelligence about communities or people at high risk and needing early intervention or additional psychosocial support.
- Monitor and report on demand for and capacity of health services including inpatient numbers/capacity, ICU (Intensive Care Units) occupancy, mental health and addiction services, primary care, and ambulance call outs.

Public Health Interventions

- Intensify contact tracing, case finding, case and contact management and cluster control measures.
- Activate links with local Māori, Pacific, mental health and disability providers for contact tracing and cluster management.
- Review and revise as required information for health professionals on Ministry of Health website.
- Adopt and adapt further response measures at short notice.
- Coordinate with the Ministry of Health for the management of complex, large or multi-region clusters.
- Review, revise and implement as required, arrangements for supported isolation and quarantine.
- Review border control measures
- Continue seasonal influenza campaign (March to September)
- Continue disease prevention services.

Health Care and Emergency Response

- Activate resurgence action plans.
- Implement appropriate alert level of the Ministry of Health COVID-19 National Hospital Response Framework, and community-based providers take appropriate actions under COVID-19 Community Response Framework.
- Work alongside primary health and ambulance services to ensure capacity to manage an increase in cases of COVID-19 and those with respiratory symptoms.
- Support iwi and Māori partners to deliver health and welfare services to their communities.
- Ensure up to date guidance is disseminated and that distribution channels are agreed ahead of time.
- Provide guidance on the management/deferral of planned care and elective procedures.
- Maintain essential services and as much BAU health, mental health, and disability services as possible.
- Prioritise primary care access for vulnerable groups.
- Consider activating/or coordinate local facilities for managed isolation/quarantine of community cases/contacts.
- Provide funded temporary accommodation for health workers who cannot return home due to COVID-19 related issues.
- Review, update and disseminate clinical guidance as required.

- Provide guidance and support to Residential Care, LMC, general practice, pharmacy, and ambulance providers.
- Activate designated testing sites and other testing facilities as required.
- Maximise resilience of, monitor and where necessary, manage the supply chain for health care consumables and equipment, particularly critical supplies.
- Promote use of Healthline, 1737 and other wellbeing services.
- Monitor and report on service delivery, capability, capacity, and take action to address bottlenecks.

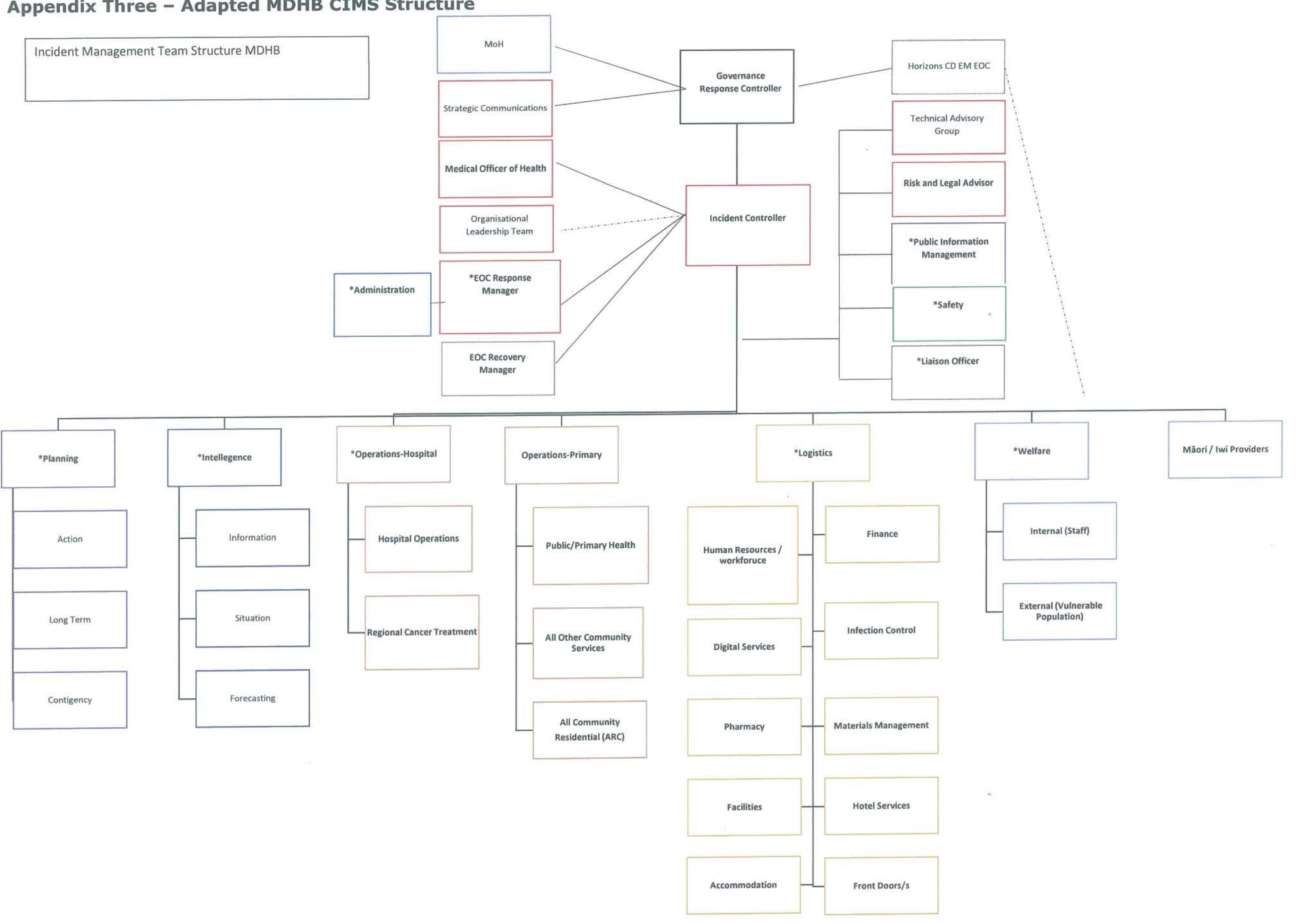
Communications and Health Education

- Update all available COVID-19 related public information.
- Release media updates.
- Ensure smooth and timely information communication with stakeholders.
- Continue to disseminate key messages to the public.
- Ensure material is customised, relevant and accessible and delivery platforms are appropriate to reach at risk populations.

Cross-Sectoral Actions

- Engage with the lead agency (or take lead as appropriate).
- Ensure all related agencies can be contacted 24/7.
- Keep staff and sectors updated.

Appendix Three – Adapted MDHB CIMS Structure



30/08/2021

National Hospital COVID-19 Escalation Framework – The Process

Purpose

- This Hospital Response Framework provides high level, nationally consistent guidance to support facilities and hospitals to appropriately and safely operate, while maintaining as much planned care and other service delivery as safely as possible, during any COVID-19 resurgence.
- The Alert Levels in this Framework are different from (though may be informed by) the Government's National COVID-19 Alert Levels and relate to COVID-19 activity within the local community and the risk present locally, as assessed by DHBs. They do not include activity related to Managed Isolation or Quarantine Facilities, except where a DHB assesses significantly heightened risk within their region that must be managed.
- The Framework aims to ensure that patients remain at the centre of care by making proportionate responses to escalations and de-escalations in the COVID-19 pandemic, to minimise disruption to planned and unplanned care delivery while maintaining quality and safety.
- It is possible for different hospital facilities and/or departments within a DHB to be at different Alert Levels at any given time.
- The overall DHB Alert Level should be reported each day to the Ministry of Health so that a national view of escalation can be compiled. This will be via the DHB SitRep.

Planning

- Hospitals are expected to operate in line with their current Alert Levels and have systems and processes proactively in place to identify and respond to any changes in levels (up or down) so that changes are made in a well-managed and planned manner with staff and resources prepared and trained beforehand.
- DHBs should ensure their ongoing capability to safely operate within this framework by periodic reassessment against the COVID-19 Resurgence Checklist.
- Each region should agree the means by which DHBs will keep each other informed of changes in Alert Levels and triggers for enacting agreed regional management plans.
- DHBs must develop their plans and decision-making processes in partnership with their DHB GM Māori Health and their DHB Iwi/Māori Relationship Board. This plan should identify Māori and other vulnerable populations and ensure health disparities do not increase as a result of the response to the COVID-19 pandemic. DHBs must maintain rigorous oversight of waiting lists, including a comprehensive plan setting out how the risk of patients deteriorating while waiting for assessment and treatment will be identified and managed.
- Te Tiriti o Waitangi and Equity are at the centre of each level of the Framework. Critically, DHB escalation and de-escalation will be managed in a way that actively protects the health and wellbeing of Māori and other vulnerable population groups. This includes active surveillance and monitoring of health outcomes for Māori and other vulnerable groups, to ensure a proportionate and coordinated response to health need for COVID-19 and non-COVID patients.
- DHBs' plans for management of Alert Levels must include a regional context and be discussed with primary care and other providers.
- When relevant (during any local resurgence) daily EEC meetings should be the mechanism whereby Alert Levels are changed or confirmed, and actions initiated in daily reporting. This decision should be clearly documented and evidenced, and communicated with senior clinicians, managers and other relevant senior personnel as part of the local response plan.
- This Framework may evolve over time and be revised and reissued as appropriate.

National Hospital COVID-19 Escalation Framework

COVID-19 Hospital Readiness

GREEN ALERT

Trigger Status: No COVID-19 positive patients in your facility; any cases in your community are managed and under control; managing service delivery as usual with only staffing and facility impact being for training & readiness purposes

- Screen patients for COVID-19 symptoms & epidemiological criteria for any Emergency Department attendances, pre-op sessions, planned admission, or clinic attendance
- Maintain ability to return, if necessary, to triage physically outside the Emergency Department (or outside the hospital building)
- Maintain a separate stream for COVID-19 suspected cases in the Emergency Department
- Undertake regular training and exercises for management of a COVID-19 suspected case in the Emergency Department, Wards, Theatres, ICU/HDU
- Maintain PPE training for COVID-19 care in the Emergency Department, wards, theatres, ICU/HDU, outpatients, other relevant settings
- Maintain plan for isolation of a single case & multiple cases/cohorting
- Maintain capability for instigation, if necessary, of Early Supported Discharge, aggressive discharge and step-down arrangements, including with other partners as appropriate (e.g. private, aged residential care, community providers)
- Maintain ability to instigate, if necessary, 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
- Maintain ability to instigate, if necessary, a dedicated COVID-19 ward
- Maintain engagement with alternative providers (such as private) regarding assistance during higher escalation levels, and to fast-track urgent, lower complexity care procedures
- Maintain and further develop the provision of outpatient activity via telehealth and phone screening for virtual assessment, and MDTs to videoconference wherever clinically appropriate and acceptable for patients
- Planned Care surgery, acute surgery, urgent elective and non-deferrable surgery to operate as usual, National Services to operate as usual, NTA to operate as usual
- Review patients on the waiting list (surgery, day case, other interventions) and group patients by urgency level
- Prioritise Planned Care surgery and other interventions by focusing on those with the most urgent need, and where ICU/HDU **is** required

COVID-19 Hospital Initial Impact

YELLOW ALERT

Trigger Status (individual or cumulative): One or more COVID-19 positive patients in your facility; any cases in your community are being managed; isolation capacity & ICU capacity manageable; some staff absence and some staff redeployment to support response and manage key gaps

- Continue screening for COVID-19 symptoms and epidemiological criteria 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 known or suspected 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)
- Engage across other DHBs to appropriately discharge out of area patients back to domicile hospital or other setting (to be considered in conjunction 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 patient is non-domicile
- Maximise the provision of pre-op assessments and outpatient appointments to be undertaken virtually, or in an off-site setting as necessary
- Plan to defer non-urgent pre-assessments and non-urgent clinic patients if necessary, ensuring clinical and equity risk is managed
- Activate any outsourcing arrangements, and engage on options for supporting 'cold trauma' cases and less-complex urgent cancer surgery
- 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, in accordance with agreed regional plan
- 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 only as essential

COVID-19 Hospital Moderate Impact

ORANGE ALERT

Trigger Status (individual or cumulative): 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

- Continue screening for COVID-19 symptoms and epidemiological criteria as per Green Alert
- Activate plans as described in Hospital Green and Yellow Alert levels
- Work with palliative care and other providers to agree alternative end of life services for non-COVID patients
- Provide Emergency Department services with prioritisation on high acuity medical and trauma care. Provide advice in non-contact settings where possible
- Fully activate any agreements with other hospitals or providers, including private
- Acute surgery to operate as staffing and facilities allow, with priority on trauma cases
- Prioritise urgent non-deferrable Planned Care cases not requiring ICU/HDU care
- Review and manage all non-urgent, high risk Planned Care surgery requiring HDU/ICU, adjusting the prioritisation threshold for surgery with Senior Clinicians for non-deferrable cases
- Increase ICU/HDU capacity as needed, retaining cohorting of known or suspected COVID-19 and non-positive patients, including moving non-COVID-19 ICU/HDU to theatre complex
- Implement acute ambulatory assessments or virtual/telehealth assessments for urgent, non-deferrable cases as staffing allows
- Manage outpatient referrals to ensure clinical and equity risk is understood and managed
- Activate regional management arrangements to support service delivery and minimise risk of patients waiting for services

COVID-19 Hospital Severe Impact

RED ALERT

Trigger Status (individual or cumulative): Multiple COVID-19 positive patients in your facility; community transmission uncontrolled; isolation and ICU 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
- Work with palliative care and other providers to agree alternative end of life services for non-COVID-19 patients
- Continue acute surgery as staffing and capacity allows, prioritising non-deferrable, life-saving surgery
- Cancel non-acute surgery to reduce transmission risk, and reprioritise capacity
- 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 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
- Only accept urgent outpatient referrals, but ensure clinical risk is understood and managed
- If other hospitals in the region are at the same Alert Level, activate out of region management arrangements

Version 4 released 18 August 2021

MINISTRY OF HEALTH
MANATŪ HAUORA

COVID-19 Community Response Framework v2.0

21 September 2020

The COVID-19 Community Response Framework was originally developed in April 2020 by the sector with support from the NHCC. The guidance aligned to the National Hospital Response Framework, to ensure that the actions and shifts required from the primary and community care sectors were in sync with hospitals.
Given the August outbreak of COVID-19 in Auckland, the document was refreshed to incorporate the latest learnings, progress and actions.
The intention is to revisit and update this document on a regular basis as the pandemic evolves.

Overarching Principles

- Equity should remain central to care with a focus on Māori, Pacific, people with disabilities and vulnerable populations.
- Maintain accurate records of all clients, particularly those more vulnerable.
- Where possible, in-person visits are preceded by screening for COVID-19 symptoms and Higher Index of Suspicion criteria, with referral to general practice/urgent care or testing centres as appropriate.
- Ensure cleaning and hand hygiene are incorporated into routine practice.
- Adhere to physical distancing and other Infection Prevention Control (IPC) advice.
- Personal protective equipment (PPE) should be used according to guidance from the Ministry of Health (MoH)
- Ensure sufficient stocks of PPE, alcoholic hand gel and cleaning products.
- Staff who are unwell or are contacts of cases should follow MoH and public health guidance.
- Occupational risk assessment tools and guidance should be used to identify staff more vulnerable to COVID-19 and to assess and mitigate their risks through workplace restrictions and modifications.
- Services should support and enable contact tracing, for example using the NZCOVID Tracer app or other records.
- The National Telehealth Service advice lines are available. This includes Healthline (0800 611 116) and the dedicated COVID-19 health advice line (0800 358 5453) – both available 24/7. The COVID-19 clinical advice line for community health professionals is available Monday to Saturday 8am to 7pm.

<table>
<tr><th>ALERT LEVEL</th><th>General Practice (GP) & Urgent Care (UC)</th><th>Community Pharmacy</th><th>Aged Residential Care (ARC)</th><th>Home Based Support (over 65s)</th><th>Government Contracted Emergency Ambulance Services (EAS) (Road and Air)</th><th>Maternity</th><th>Well Child Tamariki Ora (WCTO)</th><th>Family Planning, Sexual & Reproductive Health</th><th>School Based Health Services (SBHS)</th></tr>
<tr><td>COVID-19 Community Readiness GREEN ALERT

Trigger Status: No COVID-19 positive patients in your</td><td colspan="9">General Guidance
• Provide training in the correct use of PPE (donning, doffing and disposal), appropriate hand hygiene and use of cleaning products.
• Plan and rehearse triaging of patients at entrances in particular patients with COVID-19 symptoms.
• Plan for patient-to-patient and staff-to-patient physical distancing as per MoH guidance (check MoH website).
• Plan how care may be delivered virtually at higher Alert Levels. This includes:
- Plan for management of an increase in phone calls, telehealth consults for majority of population, including provision for vulnerable populations with limited phone, internet and data access.
- Refresh telehealth options, including ensuring sufficient hardware (devices, webcams), phone lines, high speed internet access.
• Where possible enable staff to take leave as required (so staff are refreshed and resilient) and plan possible staff rosters and shifts ahead of time.
• Plan with additional support staff to confirm arrangements for their assistance during higher Community Alert Levels.
• Identify staff welfare support and pastoral care (e.g. counselling services).</td></tr>
</table>

COVID-19

facility; Any cases in your community are managed and under control; managing service delivery as usual with only staffing and facility impact being for training & readiness purposes	**Telehealth/Virtual Care** • Have systems in place to deliver care via telehealth (phone, video, portal) and use these tools (and others, such as NZePS) where appropriate as part of usual practice and use. **Care of vulnerable populations** • Identify and plan for care of: ▪ vulnerable patients ▪ palliative care ▪ chronic conditions ▪ Māori and Pacific patients ▪ cancer treatment patients. **Service Planning & Delivery** • Deliver usual services • Screen and swab for COVID-19 as per current MoH guidance. • Enable telephone triage and screening by giving consistent message to patients to 'phone first' • Have COVID swabbing processes running efficiently. • Ensure access to local up-to-date guidance from MoH (e.g. via DHB/PHO/ HealthPathways).	**Care of vulnerable populations** • Identify vulnerable patients who may need additional medicines support. • **Service Planning & Delivery** • Screen for COVID-19 symptoms & Higher Index of Suspicion criteria and refer as appropriate. • Consider providing home medicine deliveries (if not already offering this service), and if appropriate develop a plan. • Review arrangements with couriers to reinforce that medicines deliveries should be a priority e.g. medicines deliveries to the pharmacy and to ARC facilities. • Continue with influenza vaccinations (and MMR when contracted for this service). • Plan to be able to defer non-essential services, noting vulnerable populations may still need to receive care.	**Staffing** • Plan staffing to minimise number working across facilities in higher alert levels, identify and prepare for a surge workforce if required. **Care of vulnerable populations** • Identify vulnerable patients who may need additional social supports, care planning or pre-emptive care and assign specific resource to work with these groups. **Service Planning & Delivery** • Plan for increased media enquiries. • Use ARC COVID-19 screening form for admissions. • Refer all residents and staff who exhibit symptoms for assessment and testing. • ARC facilities and local PHUs connect with each other to prepare for response to COVID-19 cases in a facility. • Contact tracing systems established. • Plan to have separated streams for people with symptoms consistent with COVID-19 and non COVID-19 cases to manage isolation as required. • Identify services that can be deferred with no risk to patients • Explore the possibility of continuing religious/spiritual services by digital means.* • Ensure adequate systems in place to ensure residents and family/whānau are supported to express their concerns and make complaints, and complaints are documented and responded to* • All interRAI assessments continue as per usual requirements. • HealthCERT develop auditing framework for Community Yellow and Community Orange Alert	**Service Planning & Delivery** • Plan how to manage home and community support services to minimise. unnecessary contact and prioritise those with highest need. • Identify vulnerable patients who may need additional social supports, care planning, pre-emptive care and assign specific resource to work with these groups. • Plan to have a separated stream for people with symptoms consistent with COVID-19 and non COVID-19 cases to manage isolation as required, including streaming of workforce. • Identify services that can be deferred with no risk to patients • Implement alert level admission and discharge plans with DHBs. • Create psychosocial messaging, appropriate to all clients, including for their personal support network. **Visiting** • Develop clear COVID-19 service visit policies to reflect physical distancing requirements, good hygiene and infection control measures, and alternative methods of contact should visiting be restricted.	**Service Planning & Delivery** • Develop and test plans considering business continuity, PPE access, workforce availability, surge resources, engagement with other EAS providers and DHBs • Plan for higher level scenarios where EAS may need to move a large number of COVID-19 or non COVID-19 patients around the country to improve bed availability. • Identify pathways that could be used to stream patients away from in-person care if Alert Levels increase. • Plan for regional COVID-19 Alert Level variation and changes to destination protocols (e.g. Trauma, STEMI, Stroke) with other providers and DHBs. • Plan for appropriate 'disaster response' (e.g. earthquake) incorporating regional COVID risks/ levels.	**PPE** • Ensure all community-based Lead Maternity Carers (LMCs) have access to PPE stocks. **Care of vulnerable populations** • Identify vulnerable women who may need additional care planning. • Ensure accessibility to health services for rural communities, particularly Māori and Pacific groups (e.g. through virtual consults or in-person when needed). **Service Planning & Delivery** • Plan how to deliver essential care and support to women, including where this contact will take place. • Plan for clinically appropriate early discharge from hospitals for postnatal care in the community, for Community Orange and Red Alert Levels. • Plan for whānau/community-centred responses for priority populations to ensure access to the necessary care, and to support equity e.g. through virtual consults or in-person when needed. • Plan how care may be delivered in non-contact ways, thus enabling shorter in-person time with women.	**Care of vulnerable populations** • Identify vulnerable patients who may need additional care planning. **Service Planning & Delivery** • Plan how to deliver essential care and support to clients including where contact is required. • Plan for whānau/community-centred responses for priority populations to ensure access to necessary care and to support equity.	**Care of vulnerable populations** • Identify vulnerable patients who may need additional care planning. **Service Planning & Delivery** • Provide full range of sexual and reproductive health services. • Plan for provision of essential services where contact is required. • Plan for provision of non-contact services that are deemed non-essential or deferrable. • Plan whānau/community-centred responses for priority populations to ensure access and equity.	**Care of vulnerable populations** • Identify vulnerable rangatahi who may need additional care planning. **Service Planning & Delivery** • Plan how care may be delivered in non-contact ways or be deemed non-essential. • Plan how to deliver essential care and support to rangatahi including where contact is required. • Plan for whānau/ community-centred responses for rangatahi to ensure access to necessary care and to support equity, especially mental health care. • Ensure information such as key contact phone numbers/emails are up to date for students, school administration and nurses to enable effective communication at higher alert levels. • A risk assessment is done for rangatahi with sore throats, including those at schools with a sore throat management programme. Refer to the MoH website for testing guidance.

			Levels. • Create psychosocial messaging, appropriate to all clients. • Rehearse higher alert level scenarios with staff. **Visiting in Aged Residential Care** • Develop clear COVID-19 visitor policies and establish alternative methods of contact should visiting be restricted. • Plan and communicate with residents and family/whānau about limitation on number of visitors and frequency of visits at Community Yellow, Orange and Red Alert Levels*						

* as per Optional Protocol to the Convention Against Torture thematic report recommendations

COVID-19

New Zealand Government

COVID-19 Community Mild Impact YELLOW ALERT	General Practice (GP) & Urgent Care (UC)	Community Pharmacy	Aged Residential Care (ARC)	Home Based Support (over 65s)	Government Contracted Emergency Ambulance Services (EAS) (Road and Air)	Maternity	Well Child Tamariki Ora (WCTO)	Family Planning, Sexual & Reproductive Health	School Based Health Services (SBHS)
Trigger Status (individual or cumulative): One or more COVID-19 positive patients in your facility; cases in your community are being managed; isolation capacity & ICU capacity manageable; some staff absence and some staff redeployment to support response and manage key gaps	**General Guidance** • Activate plans as required at Community Yellow Alert. • Refer patients and staff for assessment and testing according to current MoH guidance. • Continue screening for COVID-19 symptoms and Higher Index of Suspicion criteria with referral to general practice/ testing centre as appropriate. • Reinforce cleaning and hand hygiene plans. • Activate PPE plans and ensure PPE supply chain well established. • Activate triaging at entrances and physical distancing. • Contact tracing systems in place. • Activate plans to undertake virtual appointments and non-contact care delivery, where possible. • Activate plans to support mental health and wellbeing of staff • Engage with vulnerable workers to mitigate their risk and review impact on staffing.								
	Telehealth & Virtual • Increase delivery of service via telehealth to 50% in GP and as high as practicable in Urgent Care. **Care for vulnerable populations** • Activate plans for care of vulnerable patients (identified in Green Alert). **Service Planning & Delivery** • Deliver usual services, including immunisation programmes. Vulnerable groups may require prioritisation. • Screen and swab for COVID-19 as per current MoH guidance. • Increase COVID-19 testing capacity via designated practices or testing facilities. • Ensure in-person consultations are available, with phone first. • Establish systems for care of COVID-19 patients in the community. • Develop systems for increased delivery of secondary care services in the community.	**Telehealth & Virtual** • Activate plans to manage increased phone calls. **Care for vulnerable populations** • Contact vulnerable patients and provide additional support with their medicines management as appropriate. **Staffing** Activate (if appropriate) at Community Yellow Alert Level staff rosters and shift system plans. **Service Planning & Delivery** • Consider activating physical barrier plan. • Activate home medicine delivery plans (if appropriate.) • Continue with influenza vaccinations (and MMR when contracted this service). • Defer lowest priority non-essential services, noting vulnerable populations may still need to receive care.	**Screening & Triage** • Use ARC COVID-19 screening form prior to any admission of residents. **Staffing** • Staff movement between ARC facilities restricted where practical in regions affected. • Continue health checks for staff. **Service Planning & Delivery** • No admissions to facilities with COVID-19 positive residents/staff. • 14-day isolation required in affected regions. • 14-day isolation not mandatory in unaffected regions, but risk based as per result of the ARC COVID-19 screening assessment. • Separated streams for people with symptoms consistent with COVID-19 and non COVID-19 cases to manage isolation as required. • Entry/exit of services - only essential and emergency movement in regions affected by cases. • Ensure hygiene/infection control and distancing guidance is adhered to, isolation areas are maintained, and mental health and wellbeing is	**Service Planning & Delivery** • Manage patients in their place of residence and activate isolation plans where required. • Activate admission and discharge pathways developed with DHB. • Needs assessment and service coordination prioritised to patients with highest need. • Implement the referral process developed for non-health related welfare concerns. **Visiting** • Activate Yellow Alert Level visitor policies.	**PPE** • Practice PPE use for COVID-19 care in the relevant settings. **Staffing** • Activate plan for appropriate staffing levels by agreement (e.g. leave). **Service Planning & Delivery** • Review plans considering business continuity, PPE access, workforce availability, surge resources, engagement with other EAS providers and DHBs. • Identify pathways that could be used to stream patients away from in-person care if alert levels increase. □ Activate plan for regional COVID-19 Alert Level variation and changes to destination protocols (e.g. Trauma, STEMI, Stroke) with other providers and DHBs, if required. • Plan for appropriate 'disaster response' (e.g. earthquake) incorporating regional COVID risks/Alert Levels. • Implement use of QR codes in all facilities including all public facing vehicles (road and air)	**Service Planning & Delivery** • Plan for clinically appropriate early discharge from hospitals for postnatal care in the community. • Activate whānau/community-centred responses for priority populations to ensure access to the necessary care, and to support equity. • Reduce non-essential in-person service delivery. • Implement the referral/delivery process for non-health related welfare concerns.	**Service Planning & Delivery** • Refer to Level specific guidance provided by WCTO Interim Clinical Governance Group on MoH website • Criteria set for priority populations and for essential in-person contacts. • Activate whānau/community-centred responses for priority populations to ensure access to necessary care to support equity.	**Service Planning & Delivery** • Reduce non-essential in-person service delivery. • Review outreach clinics and assess whether to close (case-by-case). • Activate whānau/community-centred responses for priority populations to ensure access and equity. • Implement the referral/ delivery process for non-health related welfare concerns.	**Service Planning & Delivery** • Activate local whānau/ community-centred responses for rangatahi to ensure access to necessary care and to support equity, especially mental health care. • Reduce delivery of non-essential services. • Utilise local referral/ delivery processes for non-health related welfare concerns, especially to ensure a safe living situation. • Youth with a sore throat, should be isolated, collected from school and directed with their caregiver to a place where they can be tested for COVID-19 and have a bacterial throat swab done at the same time, if at high risk of Rheumatic fever. Follow GAS Sore Throat Management algorithm for treatment. Some specific schools may have a locally managed Rheumatic Fever prevention programme, in which case, they will have their own protocols for management of sore throat in COVID-19 context.

			supported. • Reduce resident activities to those that maintain physical distancing. • Continue religious/spiritual services by digital means where possible* • Ensure residents and family/whānau are supported to express their concerns and make complaints, and complaints are documented and responded to.* • interRAI assessments must be completed on admission. • Six monthly interRAI reassessments, and interRAI assessments for a change in level of care, are waived if there are not enough staff to complete the assessments. • On site audits stopped in regions affected except for MoH inspections and DHBs issue-based audits if any serious concerns about quality and safety of care. • Minimise use of restrictive practices and report critical incidents. • Planned respite care suspended, urgent respite care provided. **Visiting in Aged Residential Care** • Activate visitor policies • All family visits stopped except for residents receiving palliative/end of life care in regions affected. • Limited general family visits in regions where there is no evidence of community transmission for example limiting number of visitors and frequency of visits and by appointment. • Essential non-family visits (e.g. health care related visits including pharmacy) allowed if screening shows low risk of COVID-19. • All family and non-family visitors are screened for COVID-19 risks and follow public health measures and IPC protocols						

* as per Optional Protocol to the Convention Against Torture thematic report recommendations

COVID-19

New Zealand Government

COVID-19 Community Moderate Impact ORANGE ALERT

Trigger Status (individual or cumulative): 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

General Guidance:

- Activate plans as required at Community Orange Alert.
- Continue screening for COVID-19 symptoms and Higher Index of Suspicion criteria with referral to general practice/ testing centre as appropriate.
- Maintain triaging at entrances and physical distancing.
- Activate appropriate PPE Plans, aligned with MoH guidance.
- Maintain stock levels of PPE, alcoholic hand gel and cleaning products.
- Reinforce cleaning and hand hygiene, incorporate into routine practice.
- Activate virtual and non-contact delivery where possible.
- Activate plan to support mental health and wellbeing of staff
- Engage with vulnerable workers to mitigate their risk and review impact on staffing..

General Practice (GP) & Urgent Care (UC)

Telehealth & Virtual

- Increase delivery of service via telehealth to 70% in GP/as high as practicable in UC.
- Increase availability of secondary care services into community via telehealth and other mechanisms.
- Identify and manage high risk patients with support of secondary care services via telehealth.

Service Planning & Delivery

- Restricted services targeting vulnerable populations.
- Screen and swab for COVID-19 as per current MoH guidance.
- Increase COVID-19 testing capacity via designated practices or testing facilities.
- Continue to deliver immunisation programmes, with prioritisation of vulnerable populations.
- Cancer screening programmes prioritised to vulnerable populations.
- Support for services with staffing issues.
- Investigations and treatments normally accessed in hospitals may be moved into the community.
- Support for non-health related welfare concerns readily accessible.

Community Pharmacy

Telehealth & Virtual

- Move to even greater delivery of care by telehealth or non-contact means wherever possible whilst ensuring access for priority and vulnerable populations.

Staffing

- Activate/maintain staff rosters and shift system plans.

Service Planning & Delivery

- Activate physical barrier plan.
- Activate/maintain home medicine delivery plans (if appropriate).
- Provide tailored services to vulnerable patients and provide additional support with their medicine's management as appropriate.
- Continue with influenza vaccinations (and MMR when contracted service).
- Defer non-essential services, noting vulnerable populations may still need to receive care.

Aged Residential Care (ARC)

Telehealth & Virtual

- Maintain virtual medical care with primary care and specialist care.

Staffing

- Workforce Backup Plans in Place with DHB.
- Staff movement between ARC facilities restricted where practical.

Service Planning & Delivery

- Contact tracing systems in place.
- Use ARC COVID-19 screening form for admissions.
- 14 days isolation upon admission.
- Refer all patients and staff who exhibit symptoms for assessment and testing.
- Separated stream for people with symptoms consistent with COVID-19 and non COVID-19 cases to manage isolation as required.
- Operate with restrictions on entry/exit so essential and emergency movement only.
- Providers continue to accept admissions from DHBs and community.
- Ensure hygiene/infection control and distancing guidance is adhered to, isolation areas are maintained, and mental health and wellbeing is supported.

Home Based Support (over 65s)

Telehealth & Virtual

- Maintain virtual and non-contact primary and specialist medical care and community care, such as day programmes.

Staffing

- Workforce Backup Plans in Place with DHB.

Service Planning & Delivery

- Separated stream for people with symptoms consistent with COVID-19 and non COVID-19 cases to manage isolation as required.
- Activate Orange Alert Level admission and discharge pathways developed with DHBs.
- Providers continue to accept admissions from DHBs and NASCs within agreed care levels including early discharge.
- Essential home and community support care provided to clients as identified by client risk assessment, such as showering, bathing, toileting, essential hygiene and skin care, positioning, medicine administration, support with nutrition, hydration and mental health.
- Cease non-essential home and community supports
- Activate Safety Check - Phone/ video from family or friend.
- Implement pro-active support for non-health related welfare

Government Contracted Emergency Ambulance Services (EAS) (Road and Air)

Service Planning & Delivery

- Activate plans considering business continuity, PPE access, workforce availability, surge resources, engagement with other EAS providers and DHBs.
- Activate pathways that could be used to stream patients away from in-person care if Alert Levels increase, if appropriate.
- Activate plan for regional COVID-19 Alert Level variation and changes to destination protocols (e.g. Trauma, STEMI, Stroke) with other providers and DHBs, if required.
- Plan for appropriate 'disaster response' (e.g. earthquake) incorporating regional COVID-19 risks/ levels.

Maternity

Service Planning & Delivery

- Prioritise support for vulnerable and high-risk women.
- Support clinically appropriate early discharge from hospitals for postnatal care in the community.
- Activate whānau/community-centred responses for priority populations to ensure access to the necessary care, and to support equity.
- Activate pathways of care for women at high risk of contracting COVID-19 and for low-risk women.
- High-risk groups continue to receive in-person midwifery care.
- Cease non-essential in-person service delivery.
- Implement the referral/delivery process for non-health related welfare concerns.

Well Child Tamariki Ora (WCTO)

Telehealth & Virtual

- Activate virtual and non-contact delivery for population based on priority criteria for WCTO and B4SC.

Staffing

- Staffing: review staff rosters, minimise staff in office and support working from home

Service Planning & Delivery

- Refer to Level specific guidance provided by WCTO Interim Clinical Governance Group on MoH website
- Collaboration with community midwifery and primary care to support prioritised essential in-person care for vulnerable or high-risk patients only.
- Activate whānau/community-centred responses for priority populations to ensure access to necessary care and to support equity.

Family Planning, Sexual & Reproductive Health

Telehealth & Virtual

- Prioritise virtual appointments for abortion referrals, ECP.

Service Planning & Delivery

- Cease non-essential service delivery.
- Cease all outreach clinics.
- Provide in-person appointments for: LARC, symptomatic STIs, Depo repeats and smears. All other appointments done virtually.
- Client Contact Centre moves to working in teams; one in the contact centre one at home.
- Prioritise vulnerable and high-risk patients.
- Upscale clinical resource to virtual appointments and non-contact delivery.
- Activate whānau/community-centred responses for priority populations to ensure access and equity.
- Implement the referral/ delivery process for non-health related welfare concerns.

School Based Health Services (SBHS)

Telehealth & Virtual

- Activate virtual and non-contact delivery where possible.

Service Planning & Delivery

- Activate local whānau/ community-centred responses for rangatahi to ensure access to necessary care and to support equity, especially mental health care.
- Cease non-essential service delivery.
- Utilise local referral/ delivery processes for non-health related welfare concerns, especially to ensure a safe living situation.
- If schools are open to students;
  Youth with a sore throat, should be isolated, collected from school and directed with their caregiver to a place where they can be tested for COVID-19 and have a bacterial throat swab done at the same time, if at high risk of Rheumatic fever. Follow GAS Sore Throat Management algorithm for treatment. Some specific schools may have a locally managed Rheumatic Fever prevention programme, in which case, they will have their own protocols for management of sore throat in COVID-19 context.

			• Reduce resident activities to those that maintain physical distancing. • Continuing religious/spiritual services by digital means where possible.* • Ensure residents and family/whānau are supported to express their concerns and make complaints, and complaints are documented and responded to.* • InterRAI assessments must be completed on admission. • Six monthly interRAI reassessments, and interRAI assessments for a change in level of care, are waived. • Minimise use of restrictive practices and report critical incidents. • Planned respite services suspended, urgent respite care provided. • On site audits stopped except for the MoH inspections and DHB's issue-based audits if any serious concerns about quality and safety of care. **Visiting in Aged Residential Care** • All family visits stopped except for families with residents receiving palliative care/end of life care – this is subject to public health direction and provider assessment on a case by case basis. These visits are by appointment only with a maximum of one family member visiting at a time. • Essential non-family visits (e.g. health care related visits including pharmacy) allowed if screening shows low risk of COVID-19. • All family and non-family visitors are screened for COVID-19 risks and follow public health measures and IPC protocols	concerns. **Visiting** • Activate Orange Alert Level visitor policies					

* as per Optional Protocol to the Convention Against Torture thematic report recommendations

COVID-19

COVID-19 Community

Severe Impact

RED ALERT

Trigger Status (individual or cumulative): Multiple COVID-19 positive patients in your facility; community transmission uncontrolled; isolation and ICU at capacity; all available staff redeployed to critical care

General Practice (GP) & Urgent Care (UC)	Community Pharmacy	Aged Residential Care (ARC)	Home Based Support (over 65s)	Government Contracted Emergency Ambulance Services (EAS) (Road and Air)	Maternity	Well Child Tamariki Ora (WCTO)	Family Planning, Sexual & Reproductive Health	School Based Health Services (SBHS)

General Guidance

- Activate plans as required at Community Red Alert.
- Continue screening for COVID-19 symptoms and Higher Index of Suspicion criteria with referral to general practice/testing centre as appropriate.
- Refer all patients and staff who exhibit symptoms for assessment and testing.
- Activate appropriate PPE plans, aligned with MoH guidance.
- Maintain stock levels of PPE, alcoholic hand gel and cleaning products.
- Ensure cleaning and hand hygiene incorporated into routine practice.
- Maintain triaging at entrances and physical distancing.
- Non-essential service delivery should have ceased
- Activate plan to support mental health and wellbeing of staff.
- Work with vulnerable workers to mitigate their risk and review impact on staffing.

General Practice (GP) & Urgent Care (UC)	Community Pharmacy	Aged Residential Care (ARC)	Home Based Support (over 65s)	Government Contracted Emergency Ambulance Services (EAS) (Road and Air)	Maternity	Well Child Tamariki Ora (WCTO)	Family Planning, Sexual & Reproductive Health	School Based Health Services (SBHS)
Telehealth & Virtual • Increase delivery of service via telehealth to 90% in GP/as high as practicable in Urgent Care. **Staffing** • Minimise staff numbers in centres; support working from home. **Service planning & delivery** • Urgent and acute care delivered as needed. • Continue to deliver immunisation programmes, with prioritisation of vulnerable populations. • Screening programmes may cease according to regional capacity. • COVID-19 testing and assessment primarily at designated centres and mobile services. • Proactively protect, support and focus care of vulnerable populations. • Increase support for management of COVID-19 patents in community. • Designated services for non-health related welfare concerns. • Actively manage patients who have had deferred hospital level care.	**Telehealth & Virtual** • Maintain delivery of care by telehealth or non-contact means wherever possible whilst ensuring access for priority and vulnerable populations. **Staffing** • Activate/maintain staff rosters and shift system plans. **Service planning & delivery** • Activate/maintain home medicine delivery plans (if appropriate). • Provide tailored services to vulnerable patients and provide additional support with their medicines management as appropriate. • Continue to deliver immunisation programmes, with prioritisation of vulnerable populations. • Defer non-essential services, noting vulnerable populations may still need to receive care.	**Telehealth & Virtual** • Maintain virtual primary health care including medical, pharmacy, allied and nursing specialist care. • Activate virtual and non-contact delivery where possible. **Staffing** • Workforce Backup Plans in place with DHBs. • No staff movement between residential facilities. **Service planning & delivery** • 14 days isolation upon admission. • Use ARC COVID-19 screening form for all admissions. • Contact tracing systems in place. • Separated streams for people with symptoms consistent with COVID-19 and non COVID-19 cases to manage isolation as required – this may be across facilities. • Restrictions on entry/exit so essential and emergency moves only. • Provide palliative care support where appropriate and necessary.	**Telehealth & Virtual** • Maintain virtual and non-contact primary and specialist medical care and community care, such as day programmes. **Staffing** • Workforce Backup Plans in place with DHBs. **Service planning & delivery** • Activate Community Red Alert Level admission and discharge pathways developed with DHB including alternative admission pathways. • Separated stream for people with symptoms consistent with COVID-19 and non COVID-19 cases to manage isolation as required. • Provide palliative care support where appropriate and necessary. • Essential home and community support care provided to clients as identified by client risk assessment, such as showering, bathing, toileting, essential hygiene and skin care, positioning, medicine administration, support with nutrition,	**Service planning & delivery** • Activate plans considering business continuity, PPE access, workforce availability, surge resources, engagement with other EAS providers and DHB. • Activate pathways that could be used to stream patients away from in-person care if alert levels increase, if required. • Work with other EAS and DHB to nationally develop transfer of patients if required. • Activate plans for regional COVID-19 Alert Level variation and changes to destination protocols (e.g. Trauma, STEMI, Stroke) with other providers and DHBs as appropriate. • Plan for appropriate 'disaster response' (e.g. earthquake) incorporating regional COVID risks/levels as needed.	**Telehealth & Virtual** • Virtual and non-contact appointments where possible. **Service planning & delivery** • Prioritise support for vulnerable or high-risk women. • High-risk groups continue to receive in-person midwifery care. • Early discharge where clinically appropriate from hospitals for postnatal care in the community. • Whānau/community-centred responses for priority populations to ensure access to the necessary care, and to support equity. • Implement the referral /delivery process for non-health related welfare concerns.	**Telehealth & Virtual** • Virtual and non-contact delivery only for prioritised WCTO and B4SC populations. **Staffing** • Staffing: review staff rosters, minimise staff in office and support working from home. **Service planning & delivery** • Refer to Level specific guidance provided by WCTO Interim Clinical Governance Group on MoH website • Support prioritised in-person care under strict infection prevention and control procedures for vulnerable or high-risk patients only, and in collaboration with community midwifery and primary care. • Whānau/community-centred responses for priority populations to ensure access to necessary care and to support equity.	**Telehealth & Virtual** • Increase clinical resources on providing increased virtual services and non-contact delivery where possible. • Prioritise virtual appointments for abortion referrals, ECP. **Service planning & delivery** • Stop all outreach clinics. • Support prioritised for vulnerable or high-risk patients. • Provide in-person appointments for: LARC, symptomatic STIs, Depo repeats. All other appointments done virtually. • Client Contact Centre moves to working in teams; one in the contact centre one at home. • Whānau/community-centred responses for priority populations to ensure access and equity. • Implement the referral/ delivery process for non-health related welfare concerns.	**Telehealth & Virtual** • Virtual and non-contact delivery where possible. **Service planning & delivery** • Ensure rangatahi with health needs are aware of currently operating services to receive in person help, e.g. access to primary care and mental health care and sexual health services, and how they can contact the school nurse. • Whānau/community-centred responses for rangatahi to ensure access to necessary care and to support equity, especially mental health care. • Utilise local referral/ delivery processes for non-health related welfare concerns, especially to ensure a safe living situation.

			• Ensure hygiene/infection control and distancing guidance is adhered to, isolation areas are maintained, and mental health and wellbeing is supported. • InterRAI assessments must be completed on admission. Six monthly interRAI reassessments, and interRAI assessments for a change in level of care, are waived. • Reduce resident activities to those that maintain physical distancing. • Continuing religious/spiritual services by digital means where possible*. • Ensure residents and family/whānau are supported to express their concerns and make complaints, and complaints are documented and responded to*. • Minimise use of restrictive practices and report critical incidents. • Planned respite services suspended, urgent respite care provided. • Onsite audits stopped except for the MoH inspections and DHB's issue-based audits if any serious concerns about quality and safety of care. **Visiting in Aged Residential Care** • All family visits stopped except for families with residents receiving palliative care/end of life care – this is subject to public health direction and provider assessment on a case by case basis. These visits are by appointment only with a maximum of one family member visiting at a time. • Essential non-family visits	hydration and urgent mental health care. • Cease non-essential home and community supports. • Activate Safety Check - phone/ video from family or friend. • Implement proactive support for non-health related welfare concerns. **Visiting** • Activate Red Alert Level visitor policies.					

* as per Optional Protocol to the Convention Against Torture thematic report recommendations

			(e.g. health care related visits including pharmacy) allowed if screening shows low risk of COVID-19. • All family and non-family visitors are screened for COVID-19 risks and follow public health measures and IPC protocols.						

Your OIA request of 7 September 2021 to MidCentral District Health Board (MDHB) is acknowledged and has been passed on to me for response.

You have requested the following information;

- **Since 1 January 2021 copies of any reports, documents, memoranda, meeting minutes or agendas and briefings, both internal and external, regarding nursing shortages in aged residential care, including but not limited to any impact on, or potential impact on, facilities' ability to operate (such as restrictions on admissions, bed closures and the possibility of facility closures).**
- **Since 1 January 2021 copies of any correspondence with aged care providers regarding nursing shortages in aged residential care, including but not limited to any impact on, or potential impact on, facilities' ability to operate (such as restrictions on admissions, bed closures and the possibility of facility closures).**

MDHB believes the information you have requested is more closely aligned with the functions of the Ministry of Health. For this reason, we consulted with the Ministry of Health regarding the transfer your request in full under section 14(b)(ii) of the Act. The Ministry of Health has informed us that they have also received a request from you for the same information and, therefore, a transfer is not necessary. You can expect a reply from the Ministry of Health in due course.

Yours sincerely

Lyn Horgan
Operations Executive
Healthy Ageing and Rehabilitation

Operations Executive, Acute & Elective Specialist Services
MidCentral District Health Board, PO Box 2056, Palmerston North 4440
Telephone (06) 356 9169

Your OIA request of 7 September 2021 regarding elective procedures, imaging (MRI, CT scans) and Mental Health appointments delayed under lockdown Levels 3 & 4 is acknowledged.

MidCentral DHB has provided the following information based on the COVID-19 lockdown from 17 August 2021 until 8 September 2021.

1. **How many surgeries, planned procedures, including MRI and CT scans, and appointments were postponed at level 4 and 3?**

- The number of MRI scans postponed during Level 4 was 51
- The number of MRI scans postponed during Level 3 was 0

- The number of CT scans postponed during Level 4 was 79
- The number of CT scans postponed during Level 3 was 0

- The number of surgeries postponed during Level 4 was 333
- The number of surgeries postponed during Level 3 was 75

2. **How many colonoscopies were delayed at level 4 and 3?**

- The number of colonoscopies that were delayed at Level 4 was 127
- The number of colonoscopies that were delayed at Level 3 was 3

3. **How many Mental Health outpatient appointments were delayed under Levels 4 & 3?**

Mental Health and Addiction Services provided an alternative of Zoom or telephone contact if a non-urgent face-to-face appointment was planned during Level 3 or Level 4. However, if a person needed to be seen for a routine treatment, such as a depot injection, or if they were in crisis, they were seen face-to-face either at home or in the Community Mental Health centre.

4. At the time of the announcement of a second nationwide level 4 lockdown on 17 August 2021, was your DHB still dealing with a backlog of planned care due to the first Level 4 lockdown which began in March 2020?

MidCentral DHB still had a number of planned care procedures from the March 2020 lockdown when New Zealand moved into the 17 August 2021 lockdown.

5. How long do you expect it will take to clear these backlogs (assuming we have no more lockdowns)?

- As of 3 September 2021, MidCentral DHB had recovered 31 of the 51 postponed MRI scans. We expected to clear the additional 20 MRI scans over the month of September 2021.
- For the same period, we recovered 48 of the 79 postponed CT scans and we expected to clear the other 31 CT scans over the month of September 2021.
- For surgery MidCentral DHB has agreed Ministry of Health (MoH) Elective Services Patient Flow Indicators (ESPI 5) trajectories. These are used as our production plan to recover our planned care waiting lists. The longest-on specialty will be recovered by the end of September 2022, assuming there are no further impacts on service delivery.

6. How will you prioritise those people who had their appointments postponed at Level 3 & 4?

Please see question 3.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website 10 working days after your receipt of this response.

Yours sincerely

Lyn Horgan
Operations Executive
Acute & Elective Specialist Services

Your OIA request of 3 September 2021 to the Ministry of Health regarding is acknowledged and has been passed on to District Health Boards for their response.

The information you have requested as it relates to MidCentral District Health Board (MDHB) follows.

1. What is the Medical Day-Stay (non-oncology) infusion capacity where capacity is defined as the maximum number of infusions that can occur at any given time?

If there are no beds in use for anything other than intravenous therapy and the department is fully staffed with the appropriate skill mix, up to 10 infusions could be administered over the working day. However, the Medical Day Stay infusion/procedural unit is also used for procedures.

2. Average number of infusions per week?

The average number of infusions at MDHB is 35 per week.

3. Opening days & hours?

The opening hours for MDHB's Medical Day Stay infusion/procedural unit is Monday to Friday, 0730 to 1800 hours.

4. Which products are most commonly infused (top 10)?

The products most commonly infused at MDHB (from the highest to the lowest) are;

- Infliximab
- Red blood cells
- Normal Saline Infusions pre and post radiology procedures
- Intragam P
- Iron
- Privigen
- Antibiotics
- Albumin
- Pamidronate
- Methylprednisolone

Operations Executive, Acute & Elective Specialist Services
MidCentral District Health Board, PO Box 2056, Palmerston North 4440
Telephone (06) 356 9169

5. Does the DHB run satellite infusion services outside of its main hospitals? If so, in what locations?

This is not something that MDHB currently provides. However, we are in the process of implementing a Community Infusion Service Pilot. The pilot will focus on two infusions: Infliximab and Intragam P (immunoglobulin). These will be provided by community providers such as General Practice Teams/Primary Care, under contract to the DHB.

6. How often (percentage of total patients) is travel assistance (e.g. buses, shuttles, taxis, or monetary assistance) to attend infusions provided to patients? What are the monthly costs?

Most patients are brought in by a support person or a public health shuttle.

7. How often do patients not attend infusion appointments as scheduled?

Non attendance is rare for this cohort of patients, but we have experienced a small number of non attendances during COVID-19 restrictions.

8. Are scheduled IV infusions ever provided outside of the Medical Day Stay Unit (e.g. General Medical Ward)? If so, on average, how many times a month would this occur?

This is something that rarely happens within MDHB.

9. What is the average cost of an infusion on the Medical Day Stay Unit vs the General Medical Ward?

Please see below the average cost for two infusions that are currently undertaken in the Medical Day Stay Unit;

- The average cost for an Infliximab infusion is around $1,200
- The average cost for an Intragam P infusion is around 3,300

These estimates include three hours for each infusion (nursing time, pharmaceuticals, clinical and consumables costs).

10. Does method of administration (e.g. IV vs subcutaneous) pose a barrier to treatment due to capacity constraints.

No, this is not an issue.

11. Is there a need for new medicines that are community or home-based as an alternative to infusions?

Safe home or community-based treatment if available should always be considered for patients.

12. Are infusion bookings ever delayed due to capacity constraints?

Very rarely does this happen. We have had four in the last 12 months. When this does occur, due to hospital capacity all bookings are prioritised and re-booked based on acuity and the condition of the patient at the time.

If so;

a. How many days (on average) from the date an infusion is required to the date it is booked for?

As soon as a referral is received patients are contacted and appointments are made with the patient to facilitate days and times. On occasions, due to acute presentation at a clinic, the unit is contacted and arrangements are made on the day for the infusion which could be from clinic or the next day.

b. What is the longest period (in days) that an infusion has been delayed for in the past year?

If the infusion is required on a specific day it is given on that day. Very occasionally a patient may request the day to be changed for personal circumstances. We have had four patients that had their infusions delayed due to capacity. These patients' infusions were delayed two days.

c. Over the past 12 months, how many patients have had an infusion delayed due to capacity constraints?

We have had four patients that had their infusions delayed due to capacity. These patients' infusions were delayed two days.

d. How are bookings prioritised?

The bookings are prioritised on acuity and the condition of the patient at the time.

13. What is the forecasted increase in infusion numbers over the next two years?

Infusion numbers are increasing. However, we have not projected these out over a two year period. This is being looked at as part of a Community Infusion Service pilot.

14. Is the DHB planning to expand infusion capacity?

Initially the Community Infusion Service pilot is looking to transition two types of infusions into the community – Infliximab and Intragam P infusions. These are currently provided in the Transitory Care Unit (hospital setting). Once the pilot is completed the intention is to move this service into the community as BAU – "business as usual". (Note; not all patients will meet the criteria to transition to the community.)

All patients will receive their initial (induction) infusions in a hospital setting prior to transitioning out to the community.

If so;

a. By how much?

It is estimated that around 80% of all Infliximab patients will be suitable to transition to the community.

It is estimated that around 45% of Intragam P patients will be suitable to transition to the community.

b. What is the timeframe for completion?

The pilot will be completed by the end of January 2022.

c. Will capacity meet demand?

Initially three community sites are being considered for the Community Infusion Service pilot. Moving forward to BAU there is the potential for additional sites to provide the service if they have the capability and capacity to do so.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website 10 working days after your receipt of this response.

Yours sincerely

Lyn Horgan
Operations Executive
Acute & Elective Specialist Services

Health Board (MDHB) in which you have requested information regarding available ICU beds and CPAC thresholds is acknowledged and has been passed on to me for response.

You have requested the following information.

- **How many intensive care unit (ICU) beds are available at MidCentral DHB that meet the staffing requirements outlined in the College of Intensive Care Medicine (CICM) minimum standards for Level I, II, III and Paediatric ICUs?**

  MDHB's ICU is recognised as a Level II unit. It is an eight bed unit (six in the main unit and two side rooms). These are flexible beds that provide both ICU and HDU level care with the appropriate roster.

  The unit is staffed medically by Specialist Intensive Care Consultants, Consultant Anaesthetists with an interest in Intensive Care and Senior House Officers who are generally aspiring Anaesthetic Trainees.

  The nursing FTE is guided by the Australian College of Critical Care Nurses' guidelines with 1:1 patient ratio for all ICU ventilated or critically ill patients and 1:2 for lower acuity patients. The unit has a Charge Nurse, an Associate Charge Nurse and an Educator.

  The unit is also supported by Allied Health staff (Physiotherapists, Radiographers, Dietitians) with other axillary staff such as Biomedical and Māori liaison to support the unit as required.

  The ICU admits and cares for Paediatric patients who are anticipated to have short term requirement for intensive care and also looks after those Paediatric patients who are awaiting transfer to Starship ICU.

- **What is the DHB's current Clinical Priority Assessment Criteria (CPAC) threshold for each speciality?**

  Below are the National CPAC Scoring thresholds for each speciality at MDHB.

Operations Executive, Acute & Elective Specialist Services
MidCentral District Health Board, PO Box 2056, Palmerston North 4440
Telephone (06) 356 9169

Department	Threshold
Ear Nose & Throat	67
Gynaecology	60
Ophthalmology (Cataracts)	54
Orthopaedic	73
General Surgery	70
Urology	89

- **What were the CPAC thresholds over the previous 5 years and how many patients**

Increase in Threshold in the Last 5 Years	
Speciality	**CPAC Score**
Orthopaedic	61 – 73
Gynaecology	55 – 60
Cataracts	44 – 54
ENT	60 – 67

Declined FSAs

Below are the First Specialist Assessment (FSA) referrals that have been declined in the last three Calendar years. MDHB had a change of Patient Management System and, therefore, information for the previous two years is not readily available.

Speciality	Calendar Year 2019	Calendar Year 2020	Calendar Year 2021 YTD
Cardiology	55	0	0
Dental	234	414	296
Diabetes	1	2	7
Ear Nose & Throat	4	41	192
Endocrinology	2	4	82
Gastroenterology	0	2	2
General Medicine	1	2	0
General Surgery MC	91	197	219
Gynaecology	27	128	57
Maxillo-Facial Surgery	1	1	0
MC Dermatology	28	91	75
Neurology	11	105	200
Ophthalmology	77	9	88
Orthopaedics	17	2	3
Renal Medicine	0	2	0
Respiratory	0	1	0
Rheumatology	43	72	35
Urology MC	18	56	8

<u>Inpatient Surgery Declines</u>

MDHB does not record surgery referral declines. The clinical teams are using the Ministry of Health's National Clinical Prioritisation tool. This tool enables clinicians to score patients at their appointments and if they do not meet the threshold for surgery, patients are advised immediately. Therefore, a Booking Form for Surgery is not completed for entry into our Patient Management System if the patient is not given certainty of treatment.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website 10 working days after your receipt of this response.

Yours sincerely

Lyn Horgan
Operations Executive
Acute & Elective Specialist Services

Your recent OIA request to the Ministry of Health (the Ministry) regarding elective surgery is acknowledged. As you are aware, the Ministry has transferred Part B of your request to District Health Boards for response.

The information you have requested as it relates to MidCentral District Health Board (MDHB) follows.

(b) To what extent is contracting out elective surgery to the private sector being increased?

MDHB contracts with our private provider, Crest Hospital, to perform elective surgery.

We are currently working with Crest Hospital who are commissioning a theatre which MDHB will utilise to increase our elective surgery. This is expected to commence in July 2022.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website 10 working days after your receipt of this response.

Yours sincerely

Lyn Horgan
Operations Executive
Acute & Elective Specialist Services

Operations Executive, Acute & Elective Specialist Services
MidCentral District Health Board, PO Box 2056, Palmerston North 4440
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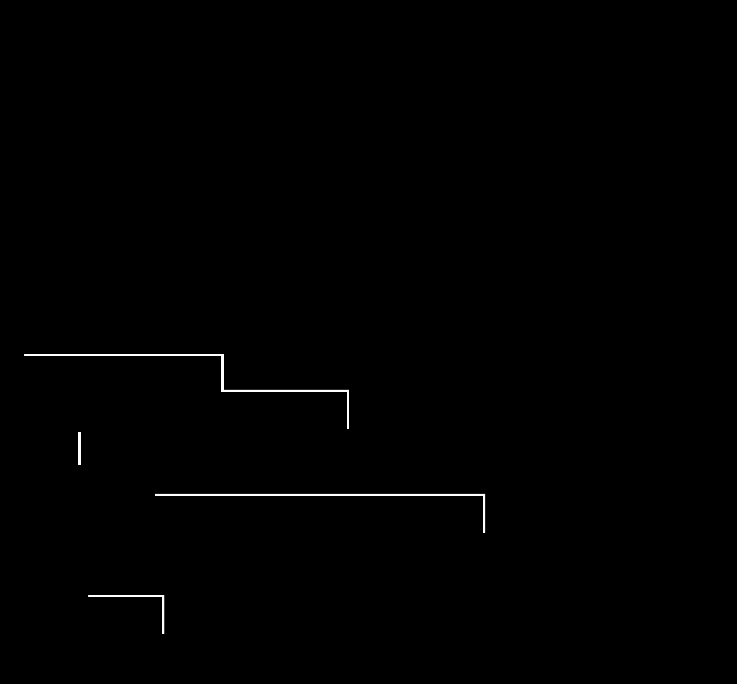


I refer to your Official Information Act request received by email on 22 September 2021 with regard to the MidCentral 2018 and 2020 Staff Survey's, and respond as follows:

1) *The 2020 survey has 76 per cent of staff feeling neutral or unfavourable responding to the statement "I often feel emotionally drained by my work". Similarly 72 per cent reacted the same way about being in crisis mode and 61 per cent were neutral or unfavourable about their health and well being not suffering because of work. What is the board's response to those numbers and what is being done to address these issues?*

The staff survey conducted in 2020 was a follow on from the one conducted in 2018. The same survey instrument and questions were used to provide consistency in monitoring progress. All indices measured in 2020 showed significant improvements against the same questions from 2018. In surveys such as these, any improvement in excess of 3 percent is considered significant. The survey report provided to the Board (of which I understand you have a copy) substantiates this. You will also note that the response rate(s) increased from 47 percent in 2018 to 58 percent in 2020. Increased response rates will also result in lower percentage counts as the responses are spread across a larger denominator.

In analysing the results, one needs to take into account external factors prevalent at the time. Around the time the survey was conducted, the DHB (and New Zealand) was responding to the first wave of the COVID-19 pandemic and were moving through various alert levels. Anxieties were heightened and staffing was affected as a result of the vulnerability status of our staff which resulted in some significant decreases to overall staff numbers, because many staff were unable to come to work due to their vulnerability status. Undoubtedly, this would have caused increased levels of work in the workplace, and the resultant survey findings are reflective of that sentiment.

In terms of readings, whilst your findings are not inaccurate, the neutrals can be counted on both sides and therefore a fair assumption here could also be:

> "50 percent of the respondents DO NOT feel emotionally drained by their work."

Also, another factor to consider is to compare MDHB's response rates from the last survey held in 2018. The response results for the same question from the previous survey shows continued improvement.

Turning now to your interpretation about the question on 'crisis mode'; again, using the ambivalent respondents, 55 percent of the respondents can be interpreted as NOT feeling in crisis mode. MDHB has again, shown improvement in the measurement of this index.

Measurement of the last question in this section being the *health and wellbeing not suffering because of work*. The responses can be interpreted as 62 percent of the respondents reporting that their health and wellbeing has NOT suffered because of their workplace.

That said, the DHB has continuously been working on increasing staff engagement and wellbeing, and wellness initiatives. In terms of workforce measures, the last workforce report to the Board, sent in May 2020, showed national and local comparisons on matters such as staff overtime rates of MDHB against other DHBs, with MDHB being the lowest in terms of overtime numbers. In terms of staff vacancies, again, MDHB's staff vacancy numbers are lower than many other DHBs. The overall clinical staffing FTEs too, have been progressively increasing over the years.

The DHB has put in many initiatives to support staff health and wellbeing. Details of some of these initiatives are included in the 'Workforce' and 'Health and Safety' reports to the Board. However, of particular note is the development of a separate Wellbeing Strategy and associated Action Plan. This strategy will be provided to the Board for approval soon. The DHB has also subscribed to a wellbeing tool which has been developed by the Mayo Clinic specifically focused at health care professionals.

2) When is the next staff engagement survey planned?

June/July 2022.

3) Specifically mentioned are concerns about bullying, staffing shortages and poor IT systems. What can be done and what has been done to improve these areas?

I have responded to matters related to staff shortages, vacancies, and overtime in my response above. More detail about this can be found in Board papers which are publicly available.

The DHB condemns bullying and has categorically measured this in the staff survey of 2018 and again in 2020. The responses indicate that this metric has improved. The questions further investigate details of the types and make up of bullying and harassment experienced by respondents. The data indicates that you will note that most reports of bullying are peer-to-peer. The DHB has systems and processes which allow staff to safely report matters associated with bullying in the workplace. *Speaking Up for Safety* is an internationally used system which allows staff to report matters of concern (including behaviours and bullying) via a confidential pathway. Reports are managed confidentially and staff against whom complaints have been made, are managed in accordance with the outline of the programme. Training in this programme is mandatory for all staff, and it provides staff with tools and resources to be able to speak up when they see unsafe work practices or behaviours which may cause harm to patients and/or staff.

Bullying prevention training and support is also available to staff and in addition, the DHB provides confidential employee assistance via an EAP programme.

Please note that this response, or an edited version of it, may be published on the MidCentral DHB website ten working days after your receipt of this letter.

Yours faithfully

Keyur Anjaria
General Manager
People & Culture

Official Information Act (OIA) Request

Your OIA request of 25 September 2021 to MidCentral District Health Board (MDHB) is acknowledged.

The information you have requested follows.

1. Please advise (Y/N) whether the following gender-affirming healthcare treatments are provided by your DHB for transgender patients:

Treatment	Yes	No	Notes
Voice therapy/vocal training	✓		Limited – demand exceeds capacity.
Permanent facial hair removal by electrolysis, IPL or laser treatment		✓	
Chest binding prosthetics (binders)		✓	
Chest reconstruction (double mastectomy & contouring for transgender men)		✓	There are no Plastic Surgeons at MDHB. Tertiary referrals not accepted by DHB providing plastic surgery services.
Breast augmentation for transgender women		✓	
Fertility preservation for sperm	✓		Through Fertility Associates
Fertility preservation for eggs		✓	
GnRH Puberty suppressants (puberty blockade)	✓		Through Paediatrics
Readiness assessment for hormone therapy	✓		Use informed consent model and multidisciplinary discussion for complex cases. Psychologist recently appointed for pre-surgical assessment but not a requirement for commencing hormones.
Hormone therapy (estrogen, progesterone and testosterone treatment)	✓		Through Sexual Health Service.
Hysterectomy and oophorectomy	✓		For gynaecological pathology/symptomatology
Orchidectomy/orchiectomy	✓		
DHB public pathway to care		✓	

2. Are gender-affirming healthcare services under your DHB based on the Guidelines for Gender Affirming Healthcare for Gender Diverse and Transgender Children, Young People and Adults in Aotearoa New Zealand (2018)? If not, which guidelines are they based on, if any?

MDHB uses the above named guidelines as well as referring to the University of California San Francisco (UCSF) and Endocrine Society guidelines on a case by case basis.

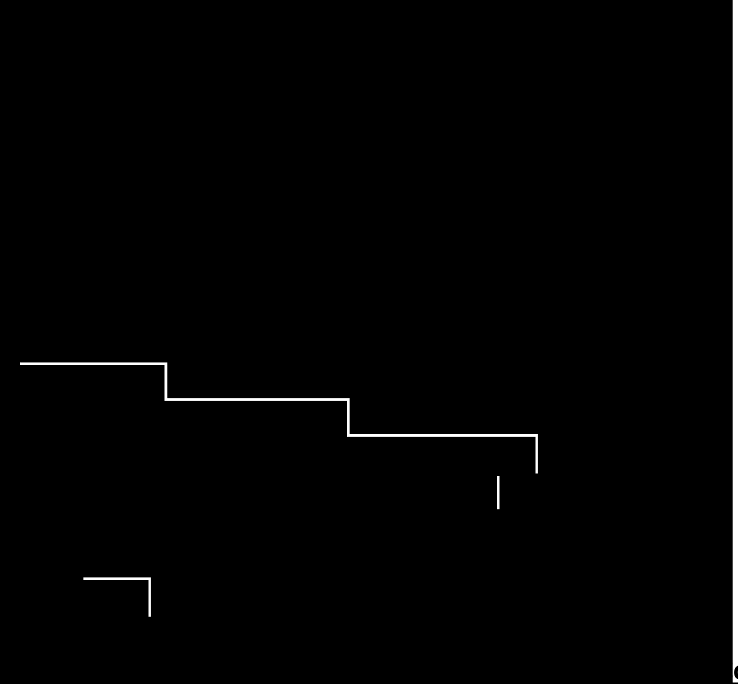
3. Are there transgender training programmes routinely provided or promoted through your DHB? If so, which training programmes or materials are used, and which organisations provide these? If not, do you have mechanisms for providing or promoting such training, and is there a date by which you plan to provide these?

Diversity based training is offered to all staff (developed in-house). For those requesting more, information can be referred to the Goodfellow Unit and Gender Minorities resources.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website 10 working days after your receipt of this response.

Yours sincerely

Lyn Horgan
Operations Executive
Acute & Elective Specialist Services



ommunity-Based Isolation and Quarantine Plan

The information attached is in response to your Official Information Act request dated Saturday 09 October 2021.

Your request was as follows:

I understand from a Stuff article that the Ministry of Health is working with district health boards throughout New Zealand to develop a community-based isolation and quarantine plan to respond to potential outbreaks of COVID-19.

Under the OIA I seek a copy of your plan please.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website ten working days after your receipt of this response.

If you are not satisfied with our response to your information request, you have the right to seek a review by way of complaint by the Ombudsman of your decision. Information about how to make a complaint is available at ww.ombudsman.parliament.nz or freephone 0800 802 602.

Yours sincerely,

Deborah Davies
Operations Executive
Te Uru Kiriora, Primary Public and Community Health

Encl.: Brief Operational Plan

<table>
<tr><th colspan="2">Brief Operational Plan</th></tr>
<tr><td>Date</td><td>13/10/2021</td></tr>
<tr><td>DHB/ Region

- C-SIQ coordinator name & contact details
- If partnering with another region in developing options</td><td>MidCentral DHB

Various relationships with Wanganui, Wairarapa, CapitalCoast and Hutt DHBs.</td></tr>
<tr><td>Accommodation Options:

- Accommodation details
- How many individuals/bubbles can you accommodate?
- IPC approved?
- Security information
- Details of any ongoing planning</td><td>Current situation:

4 bubbles in Palmerston North – 16 persons:
• 1 x 1 bed motel unit - 2 persons
• 1 x 2 bed motel unit - 4 persons
• 1 x 3 bed motel unit - 6 persons
• 1 x 2 bed DHB flat – 4 persons
• 3 accommodation units in a shared facility with Capital Coast, Wairarapa and Hutt City in Silverstream. (# of persons unknown)

The 2 and 3 bed motel rooms can be combined into 1 large bubble with 5 bedrooms and 3 bathrooms.

All are self-contained suites / flats with kitchen and laundry facilities plus separate living / sleeping areas.

All are IPC approved

No security in place as these are not MIQ facilities and we need to maintain the privacy of motelier and guests, but all can be easily monitored by a security service if required. The Silverstream facility is where we would move people who needed security to support them to isolate successfully.

Ongoing Planning:

In discussions with 2 x motels in Levin regarding 1 x 2 bedroom (4 persons), 1 x 1 bedroom (2 persons) and 1 x 1 bedroom (2 persons), 1 x 3 bedroom house (6 persons).

Considering whether we can secure an accommodation unit in the Tararua District.

Request placed to Kainga Ora to see if they have any suitable houses currently suiting empty. These would be furnished and be available to Wairarapa and Wanganui DHBs as well.</td></tr>
</table>

Wrap Around Services - Welfare support - Meals - Maori & Pacifica liaison (if any) - Any plans around supporting cases requiring clinical care - Any additional information	**Overall Approach** In the CDEM environment the lead agency can request the support of other agencies and roles to provide assistance. Health is the lead agency in a pandemic and we have asked the local CDEM teams, via CDEM Group Manager, to provide Welfare assistance. The support provided is to act as a clearing house, forwarding specific requests for welfare provision on to the appropriate local provider for delivery. This distributed model taps into existing networks and relationships, avoids duplication and confusion, and accesses local knowledge. It also ensures a sustainable approach that can scale up as we do not want to risk having too few providers who quickly become overwhelmed. Each local CDEM team established procedures to manage purchasing and invoicing during the first lock down. Consolidated invoicing is then made to the DHB weekly or monthly for reimbursement of actual and appropriate costs. We have a pool of runners available to deliver goods to those isolating. Volunteers must be doubled vaccinated, wear masks, carry out good hand hygiene and will be matched 1 volunteer to 1 Street address to minimise accidental transmission. **Service Navigators** In the interim, until a plan is completed, hospital social workers and CDEM coordinators carry out this function while we commission a number of providers to ensure a culturally appropriate matching of Service Navigator to those we are supporting in SIQ. A paper has been written by the SIQ Coordinator which represents the views of the iwi and Māori providers within the region after several hui to discuss the SIQ service and to commission their services as Service Navigators. It proposes a different way of approaching this role that we believe will deliver a sustainable COVID-19 outcome to Māori. The proposition is that a FFS arrangement will not work for the iwi and Māori providers and instead they would like 1 FTE for each provider and 1 to coordinate the whole. When required they will deliver the Service Navigator role but the rest of their time will be spent working with whānau on health initiatives that will ultimately contribute to a better COVID-19 outcome eg. vaccination education. We have agreement in principle to commission The Salvation Army and are in early discussions with a provider from the Pasifika Community.

	Clinical Care MidCentral is currently supporting a case in SIQ and this has given us the opportunity to test our clinical processes, including transfer to and care in hospital. Planning for provision of clinical care is well underway and will click into the SIQ service design once completed. **Meals** We are mindful that we are designing a process that must be sustainable and able to scale up if and when required. It also needs to provide options, be culturally appropriate and allow those we are supporting to have control and influence over what they can. Food is one of the few things they can control. For each situation we will discuss the best approach that suits the whanau. These contactless options can all be implemented: • Food parcels – through The Salvation Army (for those isolating at home). • Ingredients for home cooking – through online shopping and home delivery (in alternative accommodation, at our cost) • Prepared meals – through friends and culturally appropriate support networks (at home or alternative accommodation) • Fast food – prepared meals through uber eats (where available). • Hospital / Meals on Wheels (yet to be developed)
Transportation - What plans, if any, are in place for local/inter-regional transport of cases/ contacts	This has not been developed yet but will follow the MoH guidance document.
Any additional information	

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

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Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

22 October 2021

Email:

Dear

Official Information Act (OIA) request - OIA Y21-1534

Firstly, please accept my sincere apologies for the delay in our response to your request for information dated 5 August 2021. This has been passed onto me for a response.

You have requested MidCentral District Health Board (MDHB) provide you with information to the following questions:

1. **Current employed radiation therapist (including therapists, assistants, students and those substantially employed as radiation therapists) FTE and headcount and a table showing how many radiation therapists are employed on each step of the scale**

   Please see below table that notes Radiation Therapist salary scale, head count and FTE.

Step	Head Count	FTE
Radiation Therapists	**55**	**42.16**
2	4	4.00
3	1	1.00
4	1	1.00
5	4	3.60
6	1	1.00
7	19	11.50
8	3	1.40
9	4	1.76
10	10	9.20
11	5	4.70
13	1	1.00
14	1	1.00
15	1	1.00
Radiation Therapy Assistant	**2**	**2.00**
3	2	2.00

2. **Current employed radiation therapists (including therapists, assistants, students and those substantially employed as radiation therapists) turnover broken down by classification group (1 July 2020 to 1 July 2021).**

   The turnover rate for 1 July 2020 to 1 July 2021 is 3.77 percent.

3. **Vacancy rate (FTE) for radiation therapists.**

   There are currently no vacancies for radiation therapists

4. **Numbers waiting for radiation oncology FSA as at 1 July 2021.**

   Patients are prioritised into being seen at FSA within one week, two weeks or four weeks from referral based on the clinical pathway. Patients are seen within these timeframes, unless there is an exceptional circumstance.

5. **Average waiting list between FSA and first radiotherapy treatment.**

   All patients treated within four weeks from FSA and decision to treat.

6. **Radiotherapy treatment sessions provided per month for months July 2020 to July 2021.**

   The number of treatments delivered from July 2020 to July 2021 are detailed in the table below:

July	3267
August	2686
September	2408
October	2394
November	1951
December	2275
January	1901
February	1805
March	1895
April	1853
May	1792
June	1919
Total	26146

7. **Number of radiation therapy employees recognised as specialist and a list of what specialisms are currently recognised.**

   There is one employee recognised as a specialist – Planning Specialist.

8. **Average and median sick leave days taken per radiation therapist (including therapists, assistants, students and those substantially employed as radiation therapists) 1 July 2020 to 1 July 2021.**
   - The average sick leave per Radiation Therapist is 83.4 hours
   - The median sick leave per Radiation Therapist is 73.8 hours

   (Note: The above includes all categories of sick leave including ACC etc)

9. **Numbers of hypofractionated treatments, normal fractionated standard treatments and stereotactic treatments completed each month for all the months between July 2020 and July 2021.**

   The table below displays the Stereotactic and Standard treatments by month for July 2020 -June 2021. The "Standard" includes hypofractionated techniques which are treated on normal protocols and data is not captured to differentiate between the two

	Stereotactic	Standard
July	18	3249
August	25	2661
September	4	2404
October	21	2373
November	16	1935
December	10	2265
January	5	1896
February	5	1800
March	12	1883
April	0	1853
May	4	1788
June	4	1915
Total	124	26022

I hope this information is what you require.

Please note that this response, or an edited version may be published on the MDHB website ten working days after your receipt of this letter. Please let me know if you have any objections to this as soon as possible.

Yours sincerely

Sarah Fenwick
Operations Executive
Te Uru Mātai Matengau
Cancer Treatment, Screening and Support

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

19 October 2021

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Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
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Palmerston North
New Zealand

Email:

Dear

Official Information Act (OIA) request – Y21-1407
Wait times for endometriosis

Thank you for your request for information dated 21 September 2021. Your email has been acknowledged and passed onto me for a response.

You have requested MidCentral District Health Board (MDHB) provide you with information to the following questions:

1. **Of all the patients with pelvic pain seen by a specialist in the last 12 months, what was the average wait time for that appointment?**

   84 days.

2. **Of all the patients with pelvic pain seen by a specialist in the last 12 months, what was the longest and shortest wait time for that appointment?**

   Longest 194 days
   Shortest 0 days.

3. **In the last 12 months how many patients have seen a specialist at the DHB for pelvic pain?**

   78 patients attended for the period of 1 October 2020 to 30 September 2021.

4. **In the last 12 months, how many patients have been transferred to another hospital to treat possible endometriosis?**

   No patients were referred to another organisation.

5. **How many specialists does the DHB have available to diagnose and treat pelvic pain and possible endometriosis?**

   MidCentral Health currently has six consultants, and we follow the New Zealand consensus document on Diagnosis and Management of Endometriosis published in 2020.

6. **Of the patients who had advanced laparoscopic surgery to treat suspected endometriosis in the last 12 months, what was the average wait time to get that operation?**

   82 days.

7. **Of the patients who had laparoscopic surgery to treat pelvic pain in the last 12 months, what was the longest and shortest wait time to get that operation?**

   For those with endometriosis the range was six days to 158 days.

8. **A copy of the DHBs clinical pathway to treat suspected endometriosis.**

   MidCentral clinicians follow the New Zealand consensus document on the Diagnosis and Management of Endometriosis.

9. **Of the patients who saw a specialist with serious back pain, in the last 12 months, what was the average wait time for that appointment?**

   98 days (exclude two extreme events and average = 72 days).

10. **Of the patients who saw a specialist with serious back pain, in the last 12 months, what was the longest and shortest wait time for that appointment?**

    Longest 256 days
    Shortest 0 days.

11. **Of the patients who had orthopedic surgery to treat back pain, in the last 12 months, what was the average wait time for that appointment?**

    144 days.

12. Of the patients who had orthopedic surgery to treat back pain, in the last 12 months, what was the longest and shortest wait time for that operation?

Longest 248 days
Shortest 41 days.

You have the right to seek an investigation and review by the Ombudsman of our decision. 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 may be published on the MDHB website ten working days after your receipt of this letter. Please let me know if you have any objections to this as soon as possible.

I hope this information is what you require.

Yours sincerely

Sarah Fenwick
Operations Executive
Te Uru Pā Harakeke
Healthy Women Children and Youth

Official Information Act (OIA) Request

Your OIA request of 6 September 2021 to the Ministry of Health, a part of which has been transferred to District Health Boards for their response, is acknowledged.

The information you have requested as it relates to MidCentral District Health Board (MDHB) follows.

- **A breakdown by DHB showing how many nurses had completed the online ICU training module for nurses by August 17, and also now (most up to date figures available).**

  As at 17 August 2021, the information related to the training module had not been circulated to nursing staff at MDHB.

  As at 13 October 2021, 127 nurses have undertaken the online training module.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website 10 working days after your receipt of this response.

Yours sincerely

Lyn Horgan
Operations Executive
Acute & Elective Specialist Services

Operations Executive, Acute & Elective Specialist Services
MidCentral District Health Board, PO Box 2056, Palmerston North 4440
Telephone (06) 356 9169

Your OIA request of 23 September 2021 to MidCentral District Health Board (MDHB) is acknowledged and has been passed on to me for response.

You have requested information in regard to waiting times for prostate ultrasounds. At MDHB there are two services that perform ultrasounds for prostate disease and we have provided separate responses below for each service.

- **How long men are waiting for a booking?**
- **How that compares with targets for how soon urgent and semi-urgent referrals should be seen.**

Medical Imaging

All cancer related referrals would be prioritised as urgent and are scanned within the goal time of 14 days. This prioritisation relies on the referrer indicating they are investigating cancer or suspicion of cancer. Other referrals would be prioritised as semi urgent and have a goal time of three months and are generally scanned between two and three months. Occasionally patients will be unable to attend and the rescheduled appointment will fall outside these guidelines as a result.

Urology

Urgent and semi urgent patients are triaged and managed within the appropriate clinical timeframes.

- **How many people are on the waiting list?**
- **How long are they typically waiting?**

Medical Imaging

There are approximately 1,100 people from all categories and diagnoses.

Urology

There are currently 36 people waiting for an ultrasound guided prostate biopsy. Of those, 20 have been given an urgent "clinical" timeframe of less than four weeks and 16 have been given a semi urgent "clinical" timeframe of less than eight weeks.

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- **Is there an issue about staffing or equipment that is causing delays?**

  Medical Imaging

  There are currently no staffing issues. However, one Sonographer has joined the team in the last month and there had been a vacancy prior to that. There is no equipment issue contributing to a delay.

  Urology

  No.

- **Is there a plan to get more men seen more quickly?**

  Medical Imaging

  MDHB is in the process of contracting a locum over the months of November and December to assist in reducing the total wait time for all patients. Over 500 of the longest waiting cases will be cleared from the wait list.

  Urology

  The Urology Service are managing patients within the appropriate clinical timeframes.

- **What are the clinical risks if people do not have ultrasounds done promptly?**

  Medical Imaging / Urology

  This depends on the clinical scenario for each patient and what is being investigated.

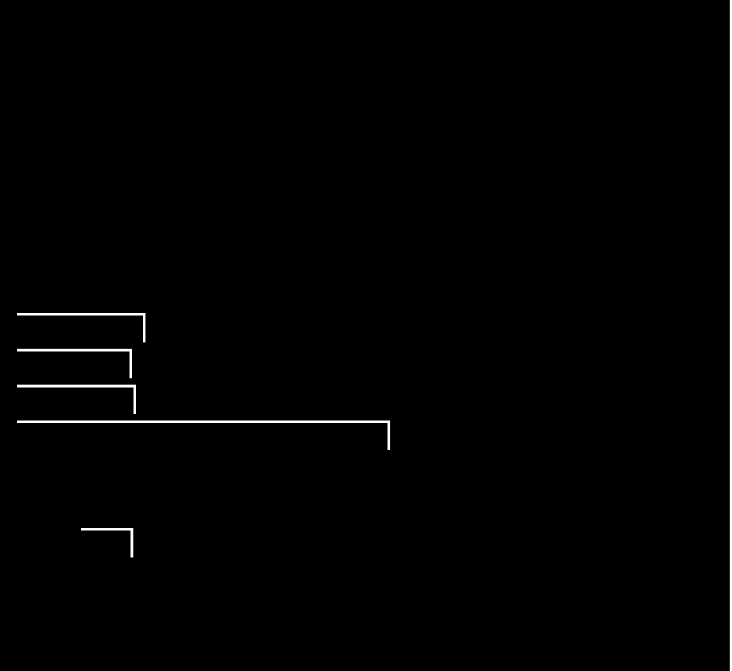
- **Any other information you have on the subject would be helpful.**

  We would be happy to discuss the above further and are happy to be made aware of any patient that has fallen outside our above guidelines for planned care.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website 10 working days after your receipt of this response.

Yours sincerely

Lyn Horgan
Operations Executive
Acute & Elective Specialist Services



I refer to your email dated 3 September 2021 requesting the following information under the Official Information Act from MidCentral DHB (MDHB). Specifically:

1. **Data showing immunisation rates for children at eight months of age, broken down by ethnic group, for each month in the past three years. Please provide this in a CSV or Excel spreadsheet format if possible.**

This information is provided on the Ministry of Health website and is publicly available.

https://www.health.govt.nz/our-work/preventative-health-wellness/immunisation/immunisation-coverage/national-and-dhb-immunisation-data
We are therefore declining a response to this question pursuant to section 18(d) of the Official Information Act.

2. **Analysis or advice created in 2021 that examines possible reasons for a decline in vaccination rates among Māori and/or Pacific children.**

No formal analysis or advice has been created in 2021 which looks at the reason for "declines" among this group, which is where a family is saying "No" to being vaccinated. From a brief analysis the declines seem to be consistent at approximately 4.5% and appear to be slightly decreasing although not as low as the 2.5% MDHB had previously.

However, MDHB is seeing an increase in children who cannot be reached before their milestone age. This tells us that whānau want to be vaccinated but there is some barrier / challenge to achieving this, within the current environment.

The reasons for this are multifactorial, potentially including;
Vaccine hesitancy fuelled by social media
Decreased access into GPTs, with increased waiting times for an appointment
Geographical issues, a quadrant of Palmerston North with the lowest socioeconomic rating has lost two general practitioners with merging of a general practice leaving a shortfall in that vulnerable area.
Loss of confidence in the health system, within the MDHB rohe Maori rates have declined more than most. Historically there was a 2 or 3 percent equity gap, where now there an equity gap of 10 percent. The reasons for this again could be multifactorial, and no detailed analysis has been undertaken.

The below data (Table one) will show that 'declines' have ranged between 1.0% and 7.3% over the past three years and 'opt-offs' have ranged between 0.0% and 1.0%. Normally they do balance out and range between 3.2% and 4.4%. However, as detailed previously the percentage of missed children has increased, which is the key group to focus on.

Table 1: Monthly 8 month milestone age Immunisation Rates for MidCentral DHB

Report Month	Total	NZE	Maori	Pacific	Asian	Other	Declined	Opt off	Combined Decline / Opt off	Missed	3 Month Average decline %	3 Month Average Missed %
Aug-18	85%	89%	72%	100%	100%	92%	7.3%	0.6%	7.9%	7.1%		
Sep-18	91%	95%	84%	89%	100%	90%	5.7%	0.0%	5.7%	3.3%		
Oct-18	95%	96%	92%	100%	100%	83%	2.9%	0.0%	2.9%	2.1%	5.3%	4.2%
Nov-18	89%	94%	88%	83%	82%	70%	4.7%	0.5%	5.2%	5.8%	4.4%	3.7%
Dec-18	90%	90%	90%	100%	100%	75%	4.8%	0.5%	5.3%	4.7%	4.1%	4.2%
Jan-19	88%	91%	85%	75%	95%	75%	5.6%	0.5%	6.1%	5.9%	5.0%	5.5%
Feb-19	90%	93%	87%	78%	100%	83%	6.4%	0.5%	6.9%	3.1%	5.6%	4.6%
Mar-19	90%	94%	87%	60%	89%	100%	5.6%	0.0%	5.6%	4.4%	5.9%	4.5%
Apr-19	93%	98%	87%	90%	100%	64%	3.1%	0.5%	3.6%	3.4%	5.0%	3.6%
May-19	89%	91%	84%	100%	100%	90%	5.9%	0.0%	5.9%	5.1%	4.9%	4.3%
Jun-19	87%	89%	82%	86%	100%	85%	5.9%	0.5%	6.4%	6.6%	5.0%	5.0%
Jul-19	90%	93%	86%	89%	100%	73%	4.2%	0.6%	4.8%	5.2%	5.3%	5.6%
Aug-19	89%	90%	85%	100%	90%	93%	6.2%	0.0%	6.2%	4.8%	5.4%	5.5%
Sep-19	88%	93%	73%	100%	100%	92%	4.6%	0.0%	4.6%	7.4%	5.0%	5.8%
Oct-19	86%	92%	73%	100%	96%	78%	3.6%	0.1%	3.7%	10.3%	4.8%	7.5%
Nov-19	88%	91%	83%	60%	95%	75%	3.8%	0.4%	4.2%	7.8%	4.0%	8.5%
Dec-19	90%	95%	80%	83%	100%	100%	3.0%	0.0%	3.0%	7.0%	3.5%	8.4%
Jan-20	92%	94%	89%	78%	100%	100%	2.3%	0.0%	2.3%	5.7%	3.0%	6.8%
Feb-20	83%	89%	65%	100%	100%	100%	5.6%	0.0%	5.6%	11.4%	3.6%	8.0%
Mar-20	86%	88%	77%	92%	100%	100%	4.7%	0.0%	4.7%	9.3%	4.2%	8.8%
Apr-20	86%	90%	78%	71%	100%	85%	2.7%	0.0%	2.7%	11.3%	4.3%	10.7%
May-20	80%	87%	72%	86%	93%	64%	2.2%	1.0%	3.2%	16.8%	3.2%	12.5%
Jun-20	90%	96%	79%	100%	100%	100%	1.0%	0.0%	1.0%	9.0%	2.0%	12.4%
Jul-20	87%	93%	75%	100%	95%	90%	3.0%	0.0%	3.0%	10.0%	2.1%	11.9%
Aug-20	84%	93%	68%	69%	69%	100%	5.1%	1.0%	6.1%	9.9%	3.0%	9.6%
Sep-20	90%	90%	83%	100%	96%	100%	3.1%	0.0%	3.1%	6.9%	3.7%	8.9%
Oct-20	84%	89%	71%	92%	95%	100%	5.4%	0.0%	5.4%	10.6%	4.5%	9.1%
Nov-20	86%	92%	72%	100%	96%	96%	3.1%	0.6%	3.7%	10.3%	3.9%	9.3%
Dec-20	89%	95%	84%	80%	93%	78%	1.8%	0.0%	1.8%	9.2%	3.4%	10.0%
Jan-21	83%	84%	78%	58%	100%	100%	8.4%	0.0%	8.4%	8.6%	4.4%	9.4%
Feb-21	82%	85%	75%	100%	87%	100%	3.8%	0.0%	3.8%	14.2%	4.7%	10.7%
Mar-21	83%	88%	77%	75%	93%	80%	3.5%	0.0%	3.5%	13.5%	5.2%	12.1%
Apr-21	84%	87%	74%	80%	95%	0%	6.0%	0.0%	6.0%	10.0%	4.4%	12.6%
May-21	87%	95%	72%	80%	100%	83%	3.7%	0.0%	3.7%	9.3%	4.4%	10.9%
Jun-21	84%	91%	73%	83%	91%	100%	5.1%	0.0%	5.1%	10.9%	4.9%	10.1%
Jul-21	85%	93%	70%	86%	100%	100%	5.3%	1.0%	6.3%	8.7%	4.7%	9.6%
Aug-21	83%	93%	64%	75%	100%	100%	5.5%	0.0%	5.5%	11.5%	5.3%	10.4%
Sep-21	82%	88%	68%	83%	100%	100%	4.4%	0.0%	4.4%	13.6%	5.1%	11.3%

3. **Analysis or advice created in 2021 that examines vaccine hesitancy, including in relation to the Covid-19 vaccines.**

No formal analysis or advice has been created in 2021 by MDHB which looks at the reason for vaccine hesitancy among children and young people. It was only announced recently that young people aged 12+ were eligible for the Covid vaccination.

4. **High-level correspondence in 2021 with senior executives from other DHBs in relation to increasing childhood immunisations or addressing the decline in vaccination of Māori and/or Pacific children.**

We do not hold any high-level correspondence in relation to this. (Declined pursuant to section 18(g) of the Official Information Act.)

5. **High-level correspondence in 2021 between the DHB and Ministry of Health relating to increasing childhood immunisations or addressing the decline in vaccination of Māori and/or Pacific children.**

MidCentral DHB received a letter from the Deborah Woodley – Deputy Director-General, Population Health and Prevention, Ministry of Health on the 28 June 2021. MidCentral DHB was asked to develop an Action Plan. Both the MoH letter (Appendix 1) and the MidCentral DHB action plan (Appendix 2) are attached.

6. **Data showing the number of staff involved in childhood vaccinations for each month in 2021.**

There are several key staff areas involved in the delivery of childhood immunisation – it is not possible to break down their staff each month for 2021. However, the following areas are involved in this system

- **General Practice** - The majority of childhood immunisations are delivered by general practice. It is a major piece of work to identify the number of staff in individual practices. (Declined pursuant to section 18(f) of the Official Information Act i.e. "to provide the information requested would take substantial collation and research"
- **Immunisation Coordinators** - we contract with our sole Primary Health Organisation THINK Hauora to provide this service and they provide 1.3 FTE. These staff provide clinical support (education, training, compliance) to general practice and other vaccinators such as pharmacy and hospital services.
- **Outreach Immunisation** - MDHB contracts with a community provider to deliver Outreach Immunisation Services. This team has 2 FTE delivering this.
- **National Immunisation Register** - this is a team of 3 administrators working in the Public Health Team. These are non-clinical staff who identify children overdue for an immunisation event and work with Immunisation Coordinators and Outreach Immunisation Service. These administrators are not all full time on immunisation.

7. **Data showing the number of staff who were moved from childhood vaccinations to the Covid-19 response at any time in 2021.**

- **General Practice** – most general practices have continued to provide childhood immunisations, across alert levels so service delivery has been maintained. The practices have been directed to provide additional resource for COVID 19 Vaccinations.
- **Immunisation Coordination** – no impact on staff from the COVID-19 programme
- **Outreach Immunisation** – no impact on staff from the COVID-19 programme
- **National Immunisation Register** - no impact on staff from the COVID-19 programme

8. **Details of any recovery or action plan created in 2021 to improve the rates of childhood immunisation and reduce decline rates for Māori and/or Pacific children.**

- See appendix D. Woodley Immunisation Action Plan. A key aspect of this is to gain a better understanding of why whanau are declining immunisation or not being vaccinated on time. This requires both engagement with community providers and a better understanding from the whanau who are making these decisions.
- When the Immunisation Team is contacting parents, they are asking them what their barriers are and often this has to do with capacity at general practice.
- On-time vaccination clinics continue in two key areas of the MDHB rohe coupled with additional home visits to whanau in one of these key areas.
- The PHO is providing a weekly performance report to us at the DHB.

I trust that this satisfies your interest in this matter.

You may, under section 28(3) of the Official Information Act, seek a review of our decision to withhold information by the Ombudsman. 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 response, may be published on the MidCentral DHB website after your receipt of this response.

Yours sincerely,

Deborah Davies
Operations Executive
Te Uru Kiriora, Primary Public and Community Health

Appendices:

Appendix 1: MoH Letter

Appendix 2: Action Plan

Appendix 1

133 Molesworth Street
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New Zealand
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28 June 2021

Kathryn Cook
MidCentral District Health Board
kathryn.cook@midcentraldhb.govt.nz

Tēnā koe Kathryn

I'm getting in touch to share my concern about the decline in the childhood immunisation coverage in MidCentral and ask you to take immediate action.

As you know, childhood immunisation is vital for protecting our tamariki from a range of preventable diseases. These are only a plane ride away and present increased risk once our borders reopen to more countries.

We have recently received quarter three 2020/21 milestone immunisation data. This shows national and regional childhood immunisation coverage at eight months, 24 months and five years for the quarter ending 31 March 2021.

Table 1 (below) shows an overall decrease in national coverage across all three milestones and a worrying equity gap for our tamariki Māori and Pacific children.

Table 1. Quarter three national child immunisation coverage by milestone and ethnicity

Milestone	Total		NZ European		Māori		Pacific	
	Q3	Change from Q2	Q3	Change from Q2	Q3	Change from Q2	Q3	Change from Q2
8 months	87.6%	-1.6%	90.4%	-1.7%	75.7%	-1.9%	86.0%	-4.9%
24 months	88.0%	-1.8%	90.2%	-0.6%	78.7%	-3.4%	86.0%	-5.3%
5 years	86.1%	-1.1%	88.2%	-0.9%	79.2%	-1.7%	85.2%	-2.5%

Table 2 (below) shows your DHB's coverage across the three milestones.

Table 2. Mid Central's quarter three national child immunisation coverage by milestone and ethnicity

MidCentral	Total			Māori			Pacific		
	%current quarter	%previous quarter	Change	%current quarter	%previous quarter	Change	%current quarter	%previous quarter	Change
8 months	83.7%	87.2%	-3.6%	78.3%	75.9%	2.4%	76.7%	96.3%	-19.6%
24 months	87.8%	87.1%	0.7%	83.6%	81.3%	2.3%	88.9%	85.7%	3.2%
5 years	85.3%	88.2%	-2.9%	79.2%	86.5%	-7.3%	75.7%	84.6%	-8.9%

DHB Coverage

The Ministry's target for DHBs is for 95 percent of all children to be fully vaccinated at each milestone.

Like most DHBs, MidCentral has not achieved coverage of 85 percent (noted in pink) across a number of immunisation milestones. This raises serious concerns about equity as well as an absence of herd immunity to several vaccine-preventable diseases.

COVID-19 and impacts on the immunisation sector

We acknowledge the complexity of the current health environment you're working in and the particular pressures on the immunisation workforce over the past year or so.

The immunisation sector has told us that:

- primary care services are under pressure with closed books in some areas and significant delays to the availability of GP appointments,
- outreach services have experienced significant growth in numbers affecting capacity, and
- the COVID-19 response has resulted in resources being diverted from childhood vaccination.

We are listening. We're aware of the changes we need to make at a Ministry level. We are strengthening our immunisation governance and implementing an action plan to support you to address factors impacting immunisation rates.

However, I need assurance from you that your DHB will immediately address this, particularly the immunisation coverage for Māori and Pacific children. Child wellbeing is a major priority for the Government and delivering essential health services to all children is fundamental to achieving this. Experience shows that a relentless focus and high expectation from senior executives is essential for high immunisation rates to be achieved.

The Minister of Health and Director-General of Health have raised this directly with DHB Chairs.

Next steps

I am therefore asking that your DHB provides us with a draft plan by Tuesday 20 July 2021. This should include:

- the steps your DHB is taking to address childhood immunisation outcomes, particularly regarding equity. This should be detailed and specific with key actions, timelines and expected outcomes
- how you are working with your Māori and Pacific communities to improve outcomes for tamariki Māori and Pacific children
- how outreach services are being deployed to improve coverage
- details of what's working well in your DHB.

It is my expectation that your Māori and Pacific general managers will be very involved in the planning and delivery of your regional response and will sign off your plan.

We are providing you with a designated contact person to work with your DHB and provide support to your team. If you let us know who your lead for Immunisation is, we will contact them. Please let us know who your lead is by close of business Friday 2 July 2021.

Please email this plan to immunisation@health.govt.nz. Kath Blair, Manager Immunisation, and the team are also happy to answer any questions through this email address. Once we have your draft plan, we will engage directly with your team to finalise it, similar to the process we've used for COVID-19 vaccination plans.

It's important to share this data across your PHOs, immunisation workforce and provider network. Their own data and input will be a key part of your planning. Of course, the Māori and Pacific providers in your region will be important partners in reaching into the communities in your region and supporting you to close the equity gap.

We must act now to lift coverage and close the equity gap to reduce the risk of outbreaks and long-term health implications for our tamariki. Thank you for your ongoing commitment to this important mahi.

Ngā mihi nui

D J Woodley

Deborah Woodley
Deputy Director-General
Population Health and Prevention

cc: Chiquita Hansen - GM Planning and Funding

Appendix 2

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

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Palmerston North
New Zealand

20 July 2021

Deborah Woodley
Deputy Director-General
Population Health and Prevention
Ministry of Health

Dear Deborah

In response to your letter dated 28 June 2021, I acknowledge your concern regarding childhood immunisation rates in the MidCentral DHB rohe, which is a significant local concern. Childhood immunisation is vital to protect tamariki from preventable diseases and is a specific focus area currently for our DHB.

Following the inaugural report on childhood immunisations through Te Ara Angitū, our MDHB Māori Health Equity Dashboard late 2020, which is provided quarterly to both the DHB Board and Manawhenua Hauora our treaty partners; several key focus areas are underway as follows:

- review of data integrity to ensure a robust ongoing plan
- revised invitation and recall processes
- ensuring sufficient vaccinator resource is focussed on childhood immunisations
- increasing Outreach Immunisation Resource (OIS) and support
- diversifying immunisation delivery within communities
- focussed management of performance at the PHO and General Practice level
- public communication and engagement are linked to planned national communication, addressing safety and the importance of immunisation.

Oversight and coordination of immunisation in the MDHB is provided by an immunisation coordination team delivered by THINK Hauora the local PHO. Pae Ora Paiaka Whaiora Hauora, MDHB Māori Directorate provides leadership to iwi and Māori engagement, such as for the COVID-19 Vaccination Programme and is working with iwi leaders and providers to determine and facilitate the vaccination approach across localities. MDHB is committed to utilising a 'by Māori, for Māori' approach with the vaccination programme. A specific focus is being developed to ensure engagement with whanau for all immunisations to improve tamariki immunisation rates.

THINK Hauora has a Pasifica Health Team consisting of nurses, navigators, and a coordinator. Members of this team work with fanau, Pasifika groups, and many health and social agencies to help Pasifika people navigate and access health and social services. The immediate focus is on enrolment and immunisation.

In considering what is working well; earlier this year, the THINK Hauora Immunisation Team commenced On-Time Immunisation Clinics to support practice populations that could not or would not present to general practice for their tamariki's childhood immunisations. Clinics in Horowhenua and Palmerston North are experiencing increased numbers of attendance, with feedback from parents saying they are finding it difficult to access general practice. Due to no enrolling practices in Horowhenua, these clinics provide an easily accessible space to have immunisations completed (and an opportunity for the THINK Hauora staff to facilitate enrolment elsewhere). Close working relationships with Horowhenua Iwi Raukawa Whānau Ora (co-located for immunisation clinics) have supported this.

An active partnership exists with Te Wakahuia o Manawatū Trust (Outreach Immunisation Service) with regular engagement and focussed planning. This includes support to access timely immunisation status reports to facilitate timely follow up and management.

A coordinated approach for the 'Year of the Immunisation' media campaign has been underway since March 2021 (https://www.thinkhauora.nz/immunisations). Te Tihi o Ruahine are also developing and disseminating Māori focussed immunisation messaging through varying mediums.

In addition, the THINK Hauora Pasifika Health Team and Immunisation Team work closely together to facilitate opportunities for Pasifika fanau to access immunisations in alternative community spaces, including strong Pasifika footholds such as churches. The Immunisation Team have been attending Pasifika ECE Education sessions, aimed at parents, to talk about childhood vaccinations.

Please find appended the current immunisation action plan and a summary of key activities as examples of recent progress. We look forward to further working with the Immunisation team to finalise and advance our local plan to achieve the intended outcomes. This has been approved by Adele Small, Acting GM Māori, MDHB.

Ngā mihi nui

Kathryn Cook
Chief Executive

IMMUNISATION ACTION PLAN – QUARTER 1 2021/22

AIM District wide achievement of ≥ 90% (Herd Immunity Rate) for all children aged under 5yrs overdue for their Childhood Immunisations, all ethnicities, and all age groups (8mths/2yrs/5yrs) by end Q1 2021/22.

Actions / how	Who?	Due by	What does success look like?	Status
Data & Process review and revision				
Data clean up in practice recall systems (PCV*, MMR from Schedule changes, update data transcribing issues^), removal of redundant recalls and timely update of decliners.	Imms Team Clinical Quality Facilitator (RN)	End July	Reduced incorrect 'overdue' numbers for MMR and PCV. Accurate reflection of overdue milestones in the NIR	Started
During data clean-up, all children overdue for PCV and MMR will be offered option to attend alternative spaces for catch up immunisations.	Imms Team Clinical Quality Facilitator (RN)	End July	Increased completion rates for actual overdue MMR and PCV catch up doses.	Started
Management of 'current milestone overdue list' Telephone contact with every infant/child's whānau by Immunisation Team	Imms Team Clinical Quality Facilitator (RN) GPT/ Immunisation Champion	End July	Increased completion rates for those who have missed their milestone age (including accuracy of decline numbers)	In progress
Management of 'approaching overdue for milestone' list: • Priority 1 - infants aged 8 weeks and overdue for 6weeks immunisations. • Priority 2 – infants aged 6 months old, and overdue for 3mth and 5mth immunisations. • Priority 3 – those approaching two-year milestone. Priority 4 – those approaching four-year milestone.	Imms Team GPT's OIS	July – Sept	All infants/children contacted in time to arrange alternatives for receiving vaccinations prior to milestone age being reached.	Started
Recall review Review of recall systems and processes in all general practice teams under target – including timing of referral to OIS/other services	Imms Team Clinical Quality Facilitator (RN) GPT Network Support Team	End July	Increased vaccination completion rates for Māori/Pasifika infants/children (including accuracy of decline numbers) OIS and Imms team report timely referrals	Started

Increase frequency of coming due/overdue lists available to the practice network	Imms Team THINK Hauora Admin with NIR access	July	Timely and accessible data for practices to closely follow all coming due/overdue children	Started
Increase access to performance data Addition of district immunisation completion rates trends/practice specific performance as an interactive dashboard on Te Kete Kōrero (THINK Hauora Data Warehouse)	THINK Hauora Knowledge and Insights Team	Q2	Immunisation Champions in practice can ascertain status of Childhood Vaccination Rates for the practice directly	Not started
Capacity review and revision				
Increase PHO resource THINK Hauora Childhood Schedule Vaccinators deployed to Childhood Vaccination activity only (with allocated THINK Hauora COVID-19 Support Vaccinators and Provisional Vaccinators deployed for required COVID-19/Flu Vaccination support)	GM Clinical Quality Imms Team	Mid-June	Increased FTE available for Childhood Vaccination dedicated activity	Completed
Increase Outreach immunisation resource Additional FTE for the Te Wakahuia Outreach Immunisation Team (OIS).	MDHB Pae Ora Paiaka Whaiora	End July	OIS able to maintain in-business hours BAU in addition to afterhours clinics	In progress
Increase Pacifica vaccinator workforce THINK Hauora Pacifica RN to complete training	GM Clinical Quality	July	Increased vaccination completion rates for Pasifika infants	Started
Improve vaccinator availability for childhood immunisations Actively identify the alternative COVID-19 vaccination workforce that can supplement the vaccination campaign in partnership with Māori and iwi providers	MDHB COVID-19 vaccination Workforce working group	Q1	Diversified workforce in place to deliver the COVID-19 vaccination campaign, with sufficient capacity in place to deliver childhood immunisations.	Started
Managing performance				
Review governance of Immunisation programme Review stakeholder group makeup	Operations Executive Te Uru Kiriora MDHB	July	Stakeholders engaged and coordinated in progress and outcomes	In progress
Monitoring of General Practice 1. Weekly monitoring of all practices offering COVID-19 Vaccination Clinics to ensure Childhood Vaccination Clinics are prioritised 2. Weekly monitoring of practice performance for those not achieving target to include:	Imms Team Clinical Quality Facilitator (RN) GPT	Ongoing from July	Practice performance will be monitored and managed with improved outcomes	Started

• Data accuracy • Recall process and approach • Referrals to OIS and use of on-time vaccination clinics • Capacity issues and mitigation			All general practices will have stable additional staff available for COVID-19 Vaccination Clinics to ensure Childhood Vaccination activity is protected	
Monitoring of PHO Weekly PHO monitoring report to DHB on: 1. Key focus areas of immunisation plan 2. Risk and mitigations	GM Clinical Quality	Ongoing from July	Practice and provider performance will be monitored and managed with improved outcomes	Not started
Diversify Immunisation Delivery				
Commence OIS/THINK Hauora After-hours Immunisation Clinics (co-located with Urgent Care service).	GM Clinical Quality The Palms Medical Centre Imms Team/OIS	End July	Whānau report satisfaction with options for early evening/weekend appointments	Not started
Improve access to immunisations Complete the procurement of the mobile vehicle	MDHB Te Uru Kiriora Directorate	Q1	Vehicle commissioned and integrated into immunisation delivery	Started
THINK Hauora On-Time Childhood Immunisation Clinics to support OIS in Palmerston North and Levin (through Raukawa)	GM Clinical Quality	Q2	Increased access choice, increased tome vaccinations	
Engagement				
Engagement with priority communities via the THINK Hauora 'Year of the Immunisation' campaign which commenced in March (https://www.thinkhauora.nz/immunisations) to promote message of on-time vaccinations/where to go/FAQ. Year of the Immunisation	Imms Team THINK Hauora/ MDHB Comms Teams	Ongoing	Consistent messaging multiple platforms ensure focus of Childhood Imms not eclipsed by COVID-19 Vaccination campaign.	Started

* Note: review of the NIR childhood overdue immunisation lists demonstrated that the Indici PMS recalls for all infants requiring a PCV booster at 12mths was not activated (Vendor has been advised to rectify ASAP).

^ Note: there remains ongoing issues of completed events in the PMS not transcribing to the NIR (est. 10-20% of events currently on overdue list)

IMPROVEMENT ACTIVITY COMPLETED OR UNDERWAY IN Q4 2020/2021

Below is a summary of key activities that were initiated in Q4 20/21 as are further detailed in the action plan above.

	Action	Status
1	Obtain new overdue list from NIR (Klick)	Completed/ongoing
2	THINK Hauora On-Time Childhood Immunisation Clinics to support OIS	Completed/ongoing
3	All identified unenrolled children to be referred to the THINK Hauora Immunisation clinics and enrolment facilitated by THINK Hauora	Ongoing
4	Assign THINK Hauora admin time to target practice overdue lists and phone most urgent/overdue children/whānau to book into THINK Hauora childhood vaccination clinics or refer to OIS	Completed/ongoing
5	Additional authorised vaccinator (1FFTE) recruited for Immunisation Team - protected FTE for Childhood Immunisation activity (practice support and clinics)	Completed
6	Imms lead removed from imms clinics (Childhood and Covid/Flu) to complete new vaccinator authorisations and cold chain accreditation assessments	In progress
7	Further 2.0FTE Vaccinator resource until end Dec 2021 for COVID-19 Programme Support	Completed
8	THINK Hauora to meet with OIS team and discuss options to co-deliver additional imms services	Completed
9.	Explore option OIS/THINK Hauora partnership for using UC Centre unused GP rooms early evening/Saturday mornings for afterhours Imms clinics	Completed/Agreed
10	PMS review of every identified overdue child on Qlik/NIR overdue list and follow up with practices to discuss overdue management/processes	In progress
11	Key personnel from THINK Hauora and Te Wakahuia to complete accreditation process for accessing Klick	Completed
12	Scope the procurement of a mobile vehicle to provide access in rural and remote communities	Completed

Your OIA request of 29 September 2021 to MidCentral District Health Board (MDHB) is acknowledged and has been passed on to me for response.

You have asked if a person responsible for triaging ultrasound referrals would be so kind as to tell us what priority (urgent, semi urgent, routine, declined) and timeframe (in days or weeks) your clinicians would put on the following 12 referral scenarios for a trans vaginal ultrasound from a community General Practitioner (GP) (under a COVID Level 1 scenario)?

- **Premenopausal 36 year old women with new onset bowel habit changes and bloating of**;

  A. **1 month's duration, normal pelvic exam, negative family history – with CA-125 of 15.**
  This would be a routine priority seen in approximately five months.

  B. **3 months' duration, normal pelvic exam, negative family history – with CA-125 of 15 (stable).**
  This would be a routine priority seen in approximately five months.

  C. **3 months' duration and new onset urinary frequency, normal pelvic exam, negative family history – with CA-125 of 18 (previously 15).**
  This would be a semi-urgent priority seen in approximately 2-3 months.

  D. **1 month's duration, normal pelvic exam, negative family history – with CA-125 of 37.**
  This would be a routine priority seen in approximately five months.

  E. **1 month's duration, normal pelvic exam, negative family history – with CA-125 of 205.**
  This would be an urgent priority seen within 1-2 weeks.

  F. **1 month's duration, mass on pelvic exam, negative family history – with CA-125 of 205.**
  This would be an urgent priority seen within 1-2 weeks.

- **Menopausal 50 year old woman presenting with new bowel habit changes and bloating of**;

  A. **1 month's duration, normal pelvic exam, negative family history – with CA-125 of 15.**
  This would be a routine priority seen in approximately 5 months

  B. **3 months' duration, normal pelvic exam, negative family history – with CA-125 of 15 (stable).**
  This would be a routine priority seen in approximately 5 months.

  C. **3 months' duration and new onset urinary frequency, normal pelvic exam, negative family history – with CA-125 of 18 (previously 15).**
  This would be a semi-urgent priority seen in approximately 2-3 months.

  D. **1 month's duration, normal pelvic exam, negative family history – with CA-125 of 37.**
  This would be a routine priority seen in approximately 5 months.

  E. **1 month's duration, normal pelvic exam, negative family history – with CA-125 of 205.**
  This would be an urgent priority seen within 1-2 weeks.

  F. **1 month's duration, mass on pelvic exam, negative family history – with CA-125 of 205.**
  This would be an urgent priority seen within 1-2 weeks.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website 10 working days after your receipt of this response.

Yours sincerely

Lyn Horgan
Operations Executive
Acute & Elective Specialist Services

MIDCENTRAL DISTRICT HEALTH BOARD

Te Pae Hauora o Ruahine o Tararua

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29 October 2021

Email:

Dear ,

Thanks for your request for information. I have added some comments below to the questions you are asking. I would point out a couple of considerations first –

- COVID is a rapidly changing environment with information coming available daily (currently there are over 180,000 per review scientific articles ono the American Pubmed web site related to COVID)
- We are amid a global pandemic equal in intensity to the Influenza pandemic of 1918 and the HIV pandemic of 1980's. The way scientific information is actioned may occur of that reflective of the global emergency that we are in (even if we are in relative isolation in New Zealand).

1) What is the Covid-19 treatment protocol for hospitalised cases?
Each case is assessed on a case by case basis but following the general guidelines provided by the following site –
interim_guidance_-_clinical_management_of_covid-19_in_hospitalised_adults_2 (health.govt.nz)

2) Are some DHB's following different treatment protocols from others?
Most DHB's will be following the nationally set guidelines. Some hospitals can manage different levels of complexities than others and so variations between the hospitals can be expected. Some hospitals for example don't have ICU facilities and hence patients might be expected to be transferred into facilities that do.

3) Are DHB's free to make decisions about treatments for individuals with Covid-19?
Yes, as each case is managed on a case to case basis. Individual patients have their own level of complexities and have to be managed accordingly. The overall general principles will be consistent throughout.

4) To what extent are patients able to participate in decision-making about their treatment programmes?
This is strongly encouraged and partnership between patient / whanau and clinician demonstrates the best outcomes.

5) If a patient requests a blood test for Vitamin D and/or the administration of high dosage Vitamin C, are hospital staff able to provide these?
Where this is evidenced base through the peer reviewed literature, most clinicians would be supportive. I would think that an open two way conversation between both parties occur from a position of mutual respect and sharing of information and knowledge.

However not all medications, procedures and processes that are available in other countries have passed through the regulatory process that exists in New Zealand.

6) Do hospital staff have the right to refuse a patient's request and, if so, is there a process for a patient to appeal the decision?
Clinicians follow the best available evidenced based practice in their respective professions. Usually, the first point of discussion when a major "disagreement" between patient and treating clinician occurs is to get a second opinion. This may occur on treatment modalities, prognosis estimates and planning around discharge.

I trust these answer your issues or concerns.

Please note that this response, or an edited version may be published on the MDHB website ten working days after your receipt of this letter. Please let me know if you have any objections to this as soon as possible.

Yours sincerely

Dr Kelvin Billinghurst

Chief Medical Officer, Primary Public & Community Health Executive
MidCentral District Health Board