

Counties Manukau Health

Health Emergency Plan

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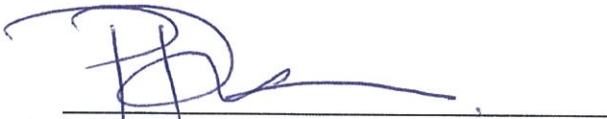
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AUTHORISATION

The Chief Executive Officer of Counties Manukau Health supports the Emergency Management Coordination activities detailed in this plan.



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Date: 7 March 2022

Executive Summary

The Operational Policy Framework from the Ministry of Health (MoH) requires every DHB to have a Health Emergency Plan (HEP). The HEP has been developed to provide a consistent approach to coordination, cooperation and communication across the health sector when responding to an incident. The HEP aims to manage a resilient and sustainable health sector.

The 2021 CM Health HEP is an updated version of the first plan written in 2008. Since that time significant events have occurred both nationally and internationally, that reinforce the need for cooperation and alignment throughout the health sector, emergency services and the community we serve.

The HEP covers the 4 R's of Emergency Management which are:

| | |
|------------------|---|
| Reduction | Risk identification and analysis |
| Readiness | Development of operational systems and capabilities |
| Response | Immediate action |
| Recovery | Coordinated effort for restoration of core services |

This HEP outlines the structures in existence that provide for the best possible response with appropriate use of resources in the quickest time frame to ensure the safety of all people involved. Counties Manukau Health works in partnership with key multi-agency groups:

The Northern Regional Health Coordinating Executive Group (HCEG) which include St John, MoH, Counties Manukau, Northland, Waitemata and Auckland District Health Boards.

Civil Defence Coordinating Executive Group (CEG)

Emergency Management Committee (EMC) Southern Zone

Emergency Services Coordinating Committee (ESCC) along with NZ Police, Fire & Emergency NZ (formally the NZ Fire Service) and St John.

Auckland Airport Joint Emergency Operations Committee, along with Airport services, NZ Police, Fire & Emergency, St John, Red Cross, Air New Zealand, Ministry for Primary Industries (MPI) and tNZ Coastguard.

There are multiple plans referred to within this document, they are not contained in the document but can be found on the Ministry of Health website: <http://www.health.govt.nz> and a hard copy of each of these plans can be found in Middlemore Central, Middlemore Hospital.

The compilation of this document's information has been sourced and used from the National Health Emergency Plan, Northern Region DHBs (Northland, Auckland and Waitemata), Waikato DHB, The Ministry of Health, Primary Health Organisations, Public Health, and a selection of key stakeholders.

The overarching goal of the Counties Manukau Health, Health Emergency Plan is to ensure resilient health services in the Counties Manukau region and a sustainable health sector during any potential or significant health or civil emergency.

Section 1 General Information

Introduction

Emergencies can happen anywhere and at any time. They can be caused by severe weather, acts of nature, infectious diseases, industrial accidents or intentional destructive acts. The very nature of an emergency is unpredictable and can change in scope and impact. When an emergency happens it can threaten public safety, the environment, the economy, critical infrastructure and the health of the public.

Emergency preparedness is progressive, continuously moving the public and local agencies towards greater resilience. This ongoing progression involves careful planning, designing of response actions, testing and evaluating the process and updating the plans. To ensure continuing resilient health services, during any potential or significant health or civil emergency careful planning is critical to protecting the public and healthcare providers and safe-guarding the public's investment in the healthcare system.

This Document

The Counties Manukau Health Emergency Plan (HEP) is a strategic document that establishes the link with specific national and regional Health Emergency plans and procedures. The CM Health HEP is on the CM Health website.

The Counties Manukau Major Response Incident Plan (MIRP) is the operational plan that is activated whenever a major incident occurs and is on the Counties Manukau Health intranet (PAANUI).

The term "Health Emergency Plan" embraces the strategy and preparedness for significant incidents and emergencies referred to in paragraph 30 (s1) of the National Civil Defence Emergency Management Plan Order (2015).

Acknowledgement

This plan has been created with input from the Northern Region DHBs (Northland, Auckland and Waitemata), Waikato DHB, The Ministry of Health, Primary Health Organisations, Public Health, and a selection of key stakeholders.

Rationale

The Counties Manukau Health, HEP has been developed as a requirement of the Ministry of Health (MoH) Operational Policy Framework (OPF) for District Health Boards. The OPF is one of a group of documents, collectively known as the "Policy Component of the District Health Board Planning Package", that sets out the accountabilities of District Health Boards (DHBs). The CM Health, HEP has been developed to provide a consistent approach to coordination, cooperation and communication across the health sector when responding to an incident.

Under the National Civil Defence Emergency Management Plan Order (2015) (National CDEM Plan) and the Crown Funding Agreement, all DHBs and their respective Public Health Units (PHUs) are tasked with developing their own emergency response plans. These plans apply the structures and processes identified in the National Health Emergency Plan (NHEP) by district and region and are required to identify how services will be delivered in a civil defence or related emergency and acknowledge the role of the DHBs as both funder and provider of health services.

The National Civil Defence Emergency Management Plan 2015 requires DHBs to provide adequately for public, primary, secondary, tertiary, mental and disability health services. DHBs shall cover an integrated and regional response and be coordinated with plans of other agencies such as St John Ambulance, Fire & Emergency NZ, NZ Police, local authorities and Civil Defence Emergency Management Groups (CDEMGs). In their response to an emergency incident DHBs use the Coordinated Incident Management System (CIMS), which forms the basis of operational multi-agency response in New Zealand.

Definition

Emergencies occur continually in health and the health and emergency services respond accordingly, the criterion used to activate a Health Emergency Plan is when “usual resources are overwhelmed or have the potential to be overwhelmed”.

The concept of being overwhelmed will be used throughout this HEP without a detailed definition to allow flexibility in the assessment of a pending, developing or current emergency on an hour by hour or day by day basis (use of the term emergency is based upon Civil Defence Emergency Management Act (CDEM Act) definition, 2002 Pt 1, s4).

A health emergency is defined as any event which:

- Presents a serious threat to the health status of the community
- Results in the presentation to a healthcare provider of more casualties or patients in number, type or degree than is staffed or equipped to treat at that time
- Loss of services which prevent a healthcare facility or service from continuing to care for their patients

The health emergency plan may be activated at a local, regional or national level, when the Incident Controller local, regional or nationally believes that a situation exists that is, or has the potential to overwhelm the resources available to respond to the emergency.

Purpose

The purpose of the Plan is to illustrate the emergency management arrangements in place at national, regional and local levels to maintain a resilient and sustainable health sector during any potential or significant health or civil defence emergency.

The HEP will incorporate generic CM Health information; it does not contain service specific plans but refers to them.

The HEP aims to create a framework to manage a resilient and sustainable health sector during any potential or significant health emergency by planning for:

- The reduction of impact consequences (established by hazard analysis) on facilities and supplies
- Continuation of care of existing patients/clients, and provision of business as usual services to the fullest possible extent, should facilities or services be disrupted
- Activation of available resources to meet either a slow but sustained rise in demand such as a Pandemic or sudden rise in demand such as a mass casualty incident
- Alternate facilities and sources of supply
- Communication between health providers prior to, during and after an emergency
- Staff training in health related emergency roles and responsibilities
- Care of staff during an emergency.

The 4R's of Comprehensive Emergency Management

The CM Health, HEP describes the rationale and purpose of how the plan is aligned with regional and national health emergency plans and incorporates the 4 R's of comprehensive emergency management which are:

- **Reduction** – risk identification and analysis to human life and property from natural or man-made hazards.
- **Readiness** – developing operational systems and capabilities before an emergency happens, including self-help and response programmes for the general public and specific programmes for emergency services and other agencies.
- **Response** – actions taken immediately before, during or directly after an emergency, to save lives and property, prevent the spread of disease as well as help communities recover.
- **Recovery** – begins after the initial impact of the response and extends until business can continue and services restored.

Funding Arrangements

The requirement for Counties Manukau Health to develop and maintain a Health Emergency Plan is stipulated in its Crown Funding Agreement.

During response and recovery activities providers must document their response actions and keep a record of all costs incurred during response and recovery activities. Costs should first be billed through normal or per-arranged funding agreements.

For DHB incidents, DHBs will cover the costs of a major incident up to 0.1% of its allocated budget. Following that, costs will be recovered via application to the Ministry of Health or, if relevant, the Ministry of Civil Defence Emergency Management.

In order to assist with tracking of costs associated with the response, an emergency response cost centre has been set up by the DHB to be used during an emergency event.

Reference Documents and Legislative Requirements

The HEP meets the following requirements:

- [Health \(Burial\) Regulations 1946](#)
- [Health Act 1956](#)
- [Health \(Infectious and Notifiable Diseases\) Regulations 1966](#)
- [Medicines Act 1981](#)
- [Health \(Quarantine\) Regulations 1983](#)
- [NZ Public Health and Disability Act 2000](#)
- [Civil Defence Emergency Management Act 2002](#)
- [National Civil Defence Emergency Management Plan Order 2015](#)
- [National Civil Defence Emergency Management Plan 2015](#)
- [Health Practitioners Competence Assurance Act 2003](#)
- [International Health Regulations 2005](#)
- [Epidemic Preparedness Act 2006](#)
- [The health section of the National Civil Defence Emergency Management Plan Order, 2005 \(latest published version\)](#)
- [The National Health Emergency Plan \(NHEP\)](#)
- The National Health Emergency Plan: Guiding Principles for Emergency Management Planning in the Health and Disability Sector, 2015
- The National Health Emergency Plan: Burn Action Plan
- The National Health Emergency Plan: Mass Casualty Plan
- The National Health Emergency Plan: Hazardous Substances Incident Hospital Guidelines, 2005
- The National Health Emergency Plan: National Reserve Supplies Management and Usage Policies (latest published edition)
- [The New Zealand Influenza Pandemic Action Plan \(latest published version\)](#)
- The Environmental Health Protection Manual
- The Law Reform (Epidemic Preparedness) Bill (2006)
- Health and Disability Standards (2008) Part 4.7; 'Essential emergency and security systems'
- Auckland Civil Defence Emergency Management (CDEM) Group Plan
- Any other published National Health Emergency Planning documents or guidelines

Scope

The CM Health, HEP incorporates national and regional planning and information. It encompasses all sectors across Counties Manukau Health including:

- Counties Manukau Health Hospital Services
- Counties Manukau Community Services
- Counties Manukau Support Services

The HEP emphasises the importance of an integrated effort. It includes strategic alliances and partnerships that enable effective planning and response to all hazards that may result in an emergency response by the health sector.

Emergency Management Principles

The National Civil Defence Emergency Management Strategy 2007 (CDEM) stipulates that an all hazards, all risks, multi-agency, integrated and community focused approach is vital to emergency management in New Zealand.

The guiding principles to effectively manage health related risks and consequences of significant hazards are listed below:

- Comprehensive approach: incorporating an all hazards and risks approach based on the four key areas of, reduction, readiness, response and recovery.
- Integrated all agencies approach: developing and continually building relationships with alliance agencies to ensure a collaborated partnership.
- Health wellness and safety: maintaining a structure that supports the protection of all health workers, health and disability service consumers and the population as a whole.
- Health equity: establishing support services to best meet the needs of individuals and communities during and after an emergency event, ensuring provisions are made for vulnerable individuals.
- Continuous improvement: continually improving by reviewing plans and arrangements using an evidence-based approach, education, exercising and professional development.

Counties Manukau Health Inpatient Facilities

Counties Manukau Health has 7 inpatient sites which are:

- Middlemore Hospital
- Manukau Health Park (Manukau Super Clinic, Manukau Surgery Centre)
- Auckland Spinal Rehabilitation Unit
- Franklin Memorial Hospital
- Pukekohe Hospital
- Papakura Maternity
- Botany Maternity

The New Zealand National Burn Centre is situated at Middlemore Hospital

The area to which this plan applies

The area encompassed by this plan is made up of the three local territorial authorities of Manukau City, Papakura and Franklin Districts. The northern boundary of Manukau City runs from the Tamaki Estuary along the boundary between the Auckland Golf Course and Kings College and north along Hospital Road to Westfield Railway Station. The southern boundary extends to and includes Mercer.

Counties Manukau Health District Map



Population Demography

The population of CM Health can be mapped according to the locality in which people live (their residential area). In addition to residential localities, the population can also be mapped according to where they are enrolled for primary care services. This can be termed an 'enrolled population' view of CM Health. The extent to which the resident populations and enrolled populations differ varies across the residential localities of CM Health. For the development of localities for health service provision, the CM Health enrolled population will be divided into four localities. The boundaries for these localities take into account primary care provider affiliations and networks of interest as well as the physical address of primary care services. The service localities will essentially comprise:

- Mangere/Otara (including northern Papatoetoe),
- Eastern (Howick plus the Maraetai/Beachlands and Clevedon),
- Manukau (Manurewa, Papakura and the majority of Papatoetoe), and
- Franklin

Population Composition

- Counties Manukau is multiethnic with high numbers of Maaori*, Pacific and Asian people.

| | Population in NZ | % of NZ population | Population in Counties Manukau | % of Counties Manukau population | % of NZ that Counties Manukau population represents for that ethnicity |
|------------------------|------------------|--------------------|--------------------------------|----------------------------------|--|
| Maaori | 860,100 | 17% | 97,470 | 16% | 11% |
| Pacific Peoples | 346,090 | 7% | 132,020 | 22% | 38% |
| Asian | 853,330 | 17% | 178,970 | 30% | 21% |
| Other | 3,045,860 | 60% | 190,060 | 32% | 6% |
| Total | 5,105,380 | | 598,520 | | 12% |

- Ethnicity mix of the CM population varies by age, with younger groups having higher proportions of Maaori*, Pacific and Asian peoples than the population aged 65 years and over (where two thirds of the population are NZ European/Other groups).
- Within the area served by CM Health, the four major localities have quite distinct mixes of these different population groups. While all areas have people from most ethnic groups, based on the distribution at the time of Census 2018, a high proportion of Pacific peoples live in Mangere/Otara, Maaori in Manukau (particularly Manurewa and Papakura), the Indian population in Manukau, Chinese and Other Asian groups in Eastern and NZ European/Other groups in Eastern and Franklin localities.
- While our population is aging, Counties Manukau still has a higher proportion of children than the overall NZ population. Twenty-two percent of the population is aged 14 or under (132,370); 19% of New Zealand children aged 14 or under live in Counties Manukau.
- Fertility rates in New Zealand have been reducing in the last decade and particularly in the last three-four years. Counties Manukau has a high birth rate compared with many other areas. This contributes to relatively high demand on our maternity, child and youth health services.

<http://www.countiesmanukau.health.nz/about-us/our-region/population-profile/>

Population Growth

- The Counties Manukau population is growing at 1-2% per year, an additional 8,000-9,000 residents each year on average. This rapid growth mirrors growth in the metro-Auckland region, and places a significant load on health service provision.
- The population aged 65 and over is growing at 4-5% per year and projected to increase by 14,700 people from 71,640 people currently to just under 84,000 by 2026. This group are high users of health services.

| | Population 2020/2021 | Population 2025/2026 | Population 2030/2031 | % change 2020/2021 to 2030/2031 |
|------------------|----------------------|----------------------|----------------------|---------------------------------|
| 00-14 yrs | 132,370 | 132,720 | 132,750 | 0.3% |
| 14-29 yrs | 132,000 | 132,690 | 139,330 | 5.6% |
| 30-44 yrs | 125,170 | 142,870 | 151,290 | 20.9% |
| 45-59 yrs | 110,510 | 111,400 | 116,450 | 5.4% |
| 60-74 yrs | 71,390 | 84,130 | 95,540 | 33.8% |
| 75+ yrs | 27,080 | 34,270 | 43,020 | 58.9% |
| Total | 598,520 | 638,080 | 678,380 | 13.3% |

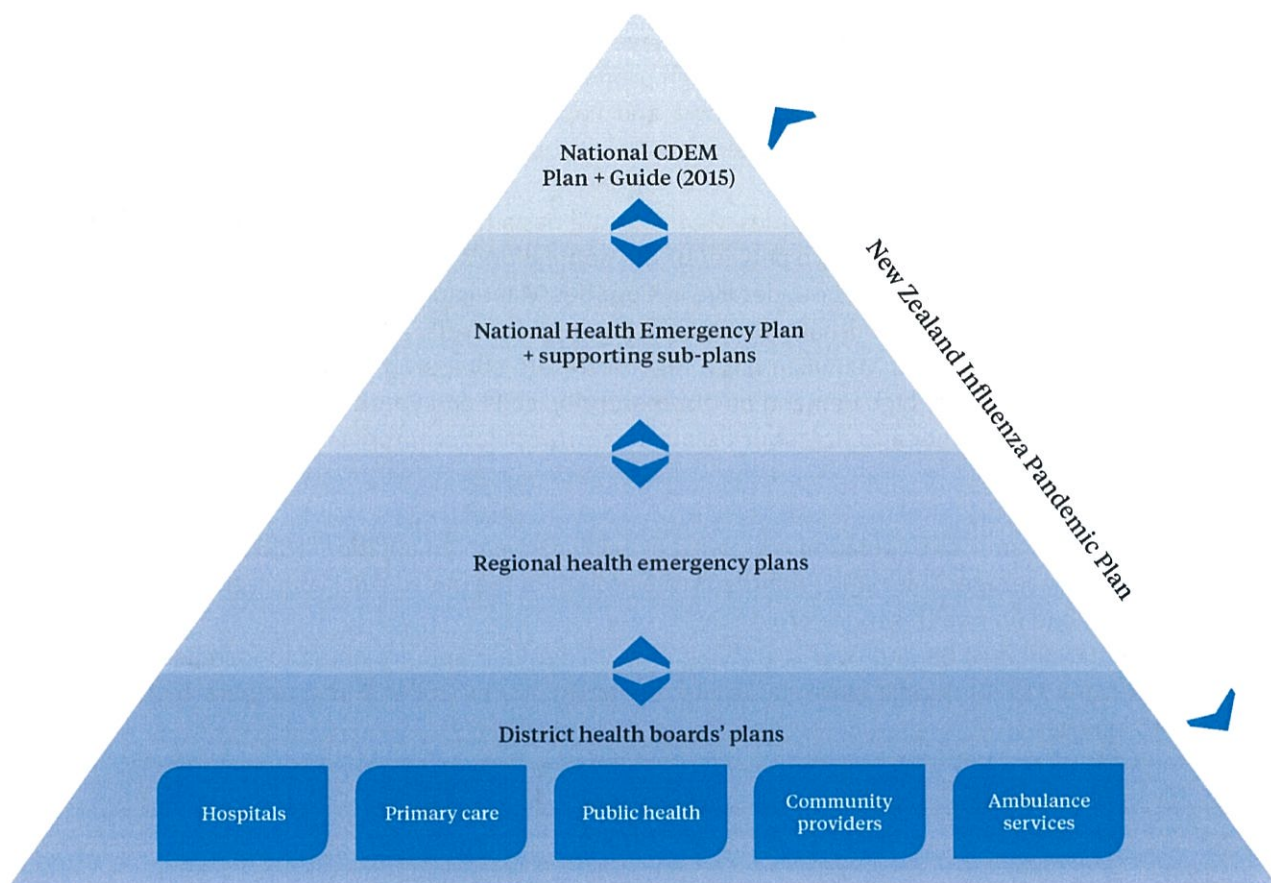
Source: Estimated resident medium projections, Statistics NZ, 2018

Key Objectives and Guiding Principles

The National CDEM Plan requires DHB's to ensure that they are able to function to the fullest possible extent during and after an emergency by ensuring the following:

- The emergency management structure provides a consistent and effective response at a local, regional and national level.
- The emergency management structure supports, to the greatest extent possible, the protection of all health service workers, health and disability service consumers.
- Support for services that are best able to meet the needs of patients/clients and their community during and after an emergency event even when resources are limited.
- Planning that adopts an all hazard approach and considers all natural and man-made hazards and risks.
- Plans for all health and disability providers in the provision of welfare to their own staff who are affected by the emergency, including those operating during it.

Figure 1: Framework for health emergency management documents



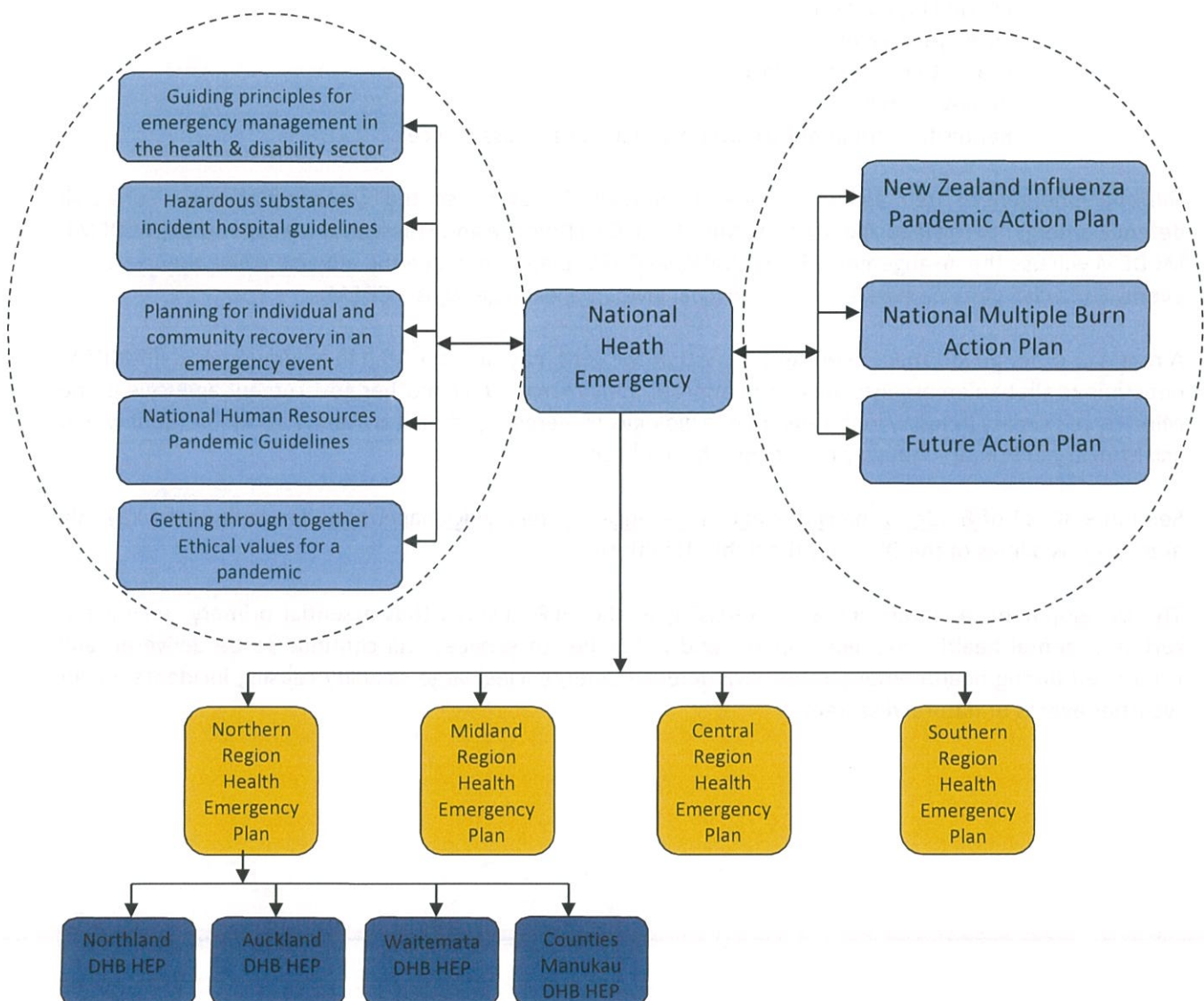
Source: MoH National Health Emergency Plan 2015

New Zealand Health Emergency Management Framework

The Ministry of Health National Health Emergency Plan (NHEP) provides overarching direction for the health and disability sector and all of government. The NHEP:

- Outlines the structure of emergency management in New Zealand and how the health and disability sector fits along with it, and provides a high-level description of responsibilities held by local and regional groups compared to those held at the national level by the Ministry of Health.
- Provides the health and disability sector with guidance and strategic direction on its approach to planning for and responding to health emergencies in New Zealand.
- Provides other organisations and government agencies with contextual information on emergency management in the health sector and the structure the health and disability sector uses in the response to an emergency.

The relationship between DHBs, HEPs, NRHEP and the NEHP is illustrated below:



Civil Defence Emergency Management Framework

National Civil Defence Emergency Management (CDEM) planning in New Zealand is a requirement of the CDEM Act (2002), and is included in the 2015 National CDEM Plan.

The CDEM Act specifies the role and function of CDEM organisations and the role of government organisations. It includes:

- Planning for emergencies
- Declaration if a state of local or national emergency
- Local authority mayors (or delegated representatives) or the Civil Defence Minister can declare a state of local emergency
- The Civil Defence Minister can declare a state of national emergency
- Emergency powers that enable CDEMGs and CDEMG controllers to:
 - Close/restrict access to roads and public places
 - Provide rescue, first aid, food and shelter
 - Conserve essential supplies and regulate traffic
 - Dispose of dead persons and animals
 - Provide equipment
 - Enter into premises
 - Evacuate premises / places
 - Remove vehicles
 - Requisition equipment/materials/facilities and assistance.

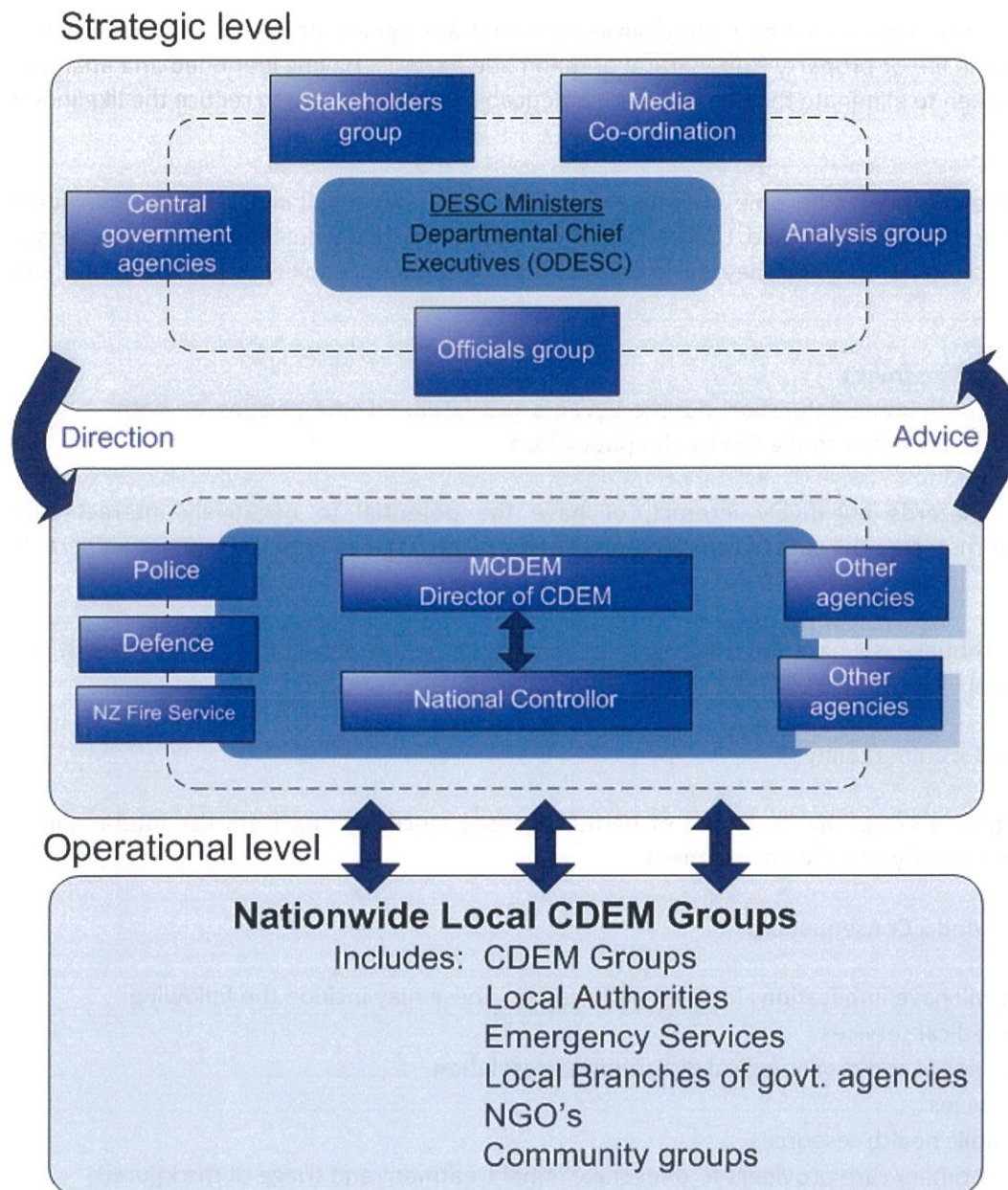
National emergencies are managed by a lead agency, which may be assisted by support agencies. For a civil defence emergency the lead agency is the Ministry of Civil Defence and Emergency Management (MCDEM). MCDEM will use the arrangements in the National CDEM plan to manage the adverse consequences of an event. For a civil defence emergency at the local level, the lead agency is a CDEM.

A range of other government agencies rather than MCDEM may take the lead in an emergency. If MCDEM determined that an emergency was more appropriately managed by another government agency e.g. the Ministry of Primary Industry in the advent of a biological emergency, then it is likely that Government would ask Ministry of Primary Industry to become the lead agency.

Section 9.30+31 of [Guide to the National Civil Defence Emergency Management Plan](#) defines the key role and responsibilities of the DHB and the Public Health Unit.

The development, maintenance and exercising of the HEP ensures that essential primary, secondary, tertiary, mental health, disability support and public health services will continue to be delivered and prioritised during health emergencies, civil defence emergencies, large casualty causing incidents, major weather events or natural disasters.

National emergency management model used when NEMA is the lead agency



Section 2 Reduction

Introduction

The principles of reduction are to identify and analyse risks that are significant due to the likelihood of consequence to human life or property from natural or manmade hazards. Having identified and analysed the risks, steps are taken to eliminate these risks where practicable and where not, to reduce the likelihood of the impact.

Many events have the potential to become a health emergency. These may result in one or more providers being potentially or actually overwhelmed. Each emergency brings its own individual conditions. Emergency events can escalate to the point where they will impact on the health sector's ability to provide health and disability services.

Comprehensive Risk Assessment

The HEP provides for both immediate, short duration events and extended emergencies, on both small and large scales as relevant to the CM Health population.

Risk results, when hazards negatively interact, or have the potential to negatively interact with communities. Risk is therefore the sum of a hazard and the elements of the community that are vulnerable to that hazard.

For example, an earthquake is a hazard but is only a risk if it affects people, infrastructure, livelihoods etc. (vulnerable elements).

- Risk = Hazard x Vulnerability

Risk can also be considered as the likelihood of harmful consequences arising from the interaction of hazards with the community and the environment.

- Risk = Likelihood x Consequences

The risks identified will have implications for the health sector. These may include the following:

- Stretched medical services
- Widespread social and psychological disruption and isolation
- Workforce issues
- Strain on public health resources
- Reliance on primary care providers to undertake initial treatment and triage of the injured
- Requests made from the NGO sector for hospital staff assistance
- Medical supplies not readily available (demand exceeds supply)

Mass casualty events will require significant planning both locally and regionally. These risks are addressed across the emergency management planning process at CM Health and include actions to ensure a state of readiness for health emergencies. Taking a multi hazard approach which incorporates the Auckland Emergency Management Group risk register formed the basis for the CM Health risk analysis. More information can be found on [Auckland AEM Group Plan 2016-2021](#).

The table below shows high and very high hazards, the priority risk rating analysis as determined by assessing residual risk Hazard priorities for the Auckland region have been taken from the Auckland Emergency Management Group Plan. Specific threats not impacting on healthcare services or involving a health sector response have been removed. A comprehensive list in appendix 7.

| Hazard | Risk Analysis | | |
|--|----------------|--------------|-------------|
| | Likelihood | Consequence | Risk Rating |
| Lifeline utility failure: Electricity | Possible | Major | Very High |
| Human Epidemic | Possible | Major | Very High |
| Volcanic eruption: distant source eruption | Likely | Major | Very High |
| Cyclone | Likely | Major | Very High |
| Flooding: River/Rainfalls | Almost certain | Moderate | Very High |
| Erosion: Coastal Cliffs/Landslide/Land | Almost certain | Moderate | Very High |
| Volcanic Eruption: Auckland Volcanic Field | Rare | Catastrophic | High |
| Animal Disease: Epidemic | Possible | Major | High |
| Crash: Aircraft | Possible | Major | High |
| Earthquake | Unlikely | Major | High |
| Hazardous substance spill | Likely | Moderate | High |
| Lifeline Utility Failure: Water Supply/Waste Water | Possible | Moderate | Moderate |
| Lifeline Utility failure: Communications | Possible | Moderate | Moderate |
| Crash: Rail | Possible | Moderate | Moderate |
| Flooding: Tsunami (regional/local) | Unlikely | Moderate | Moderate |
| Crash: Road | Likely | Moderate | Moderate |
| Fire: Urban | Possible | Moderate | Moderate |

Health hazard priority risk rating analysis determined by assessing residual risk Hazard priorities for the Auckland

Region as per the Auckland CDEM Plan (2016 - 2021).

Ongoing Risk Identification

CM Health participates in local and national level disaster preparedness exercises with multiple agencies in order to ensure risk identification and disaster responses are current.

CM Health emergency response procedures were tested during Exercise Train Wreck in 2011 (mass casualty exercise), Exercise Chopper in 2014, (mass casualty and evacuation exercise) and Exercise Purple Smoke in 2016 (mass casualty and psychosocial support including partners from a rest home and psychosocial support agencies). The scope of these exercises included widespread service engagement across the organisation at an operational level to test the organisations Major Incident Response Plan and Service Specific Emergency Plans. During these respective exercises, service plans were validated, gaps identified and plans reviewed and updated.

Inter-agency collaboration and communication

Organisations and communities that have strong day-to-day relationships are more likely to function better during the response phase as well as in the recovery phase decision making processes and operations.

Key stakeholders engage on a regular basis via scheduled meetings to build relationships, networks, information sharing and providing updates, which enables a clear understanding of agency roles and obligations during an emergency. Links to, and alignments with the following agencies, groups and committees:

- Emergency Management Committee (EMC) Southern
- Auckland Airport Joint Emergency Operations Committee (previously known as Ground Safety Meeting)
- Northern Regional Health Coordinating Executive Group (HCEG) in conjunction with MoH, St John, Northland, Waitemata and Auckland District Health Boards.
- Auckland Emergency Management Welfare Group
- Auckland Emergency Management Coordinating Executive Group (CEG)
- Emergency Services Coordinating Committee (ESCC) in conjunction with Police, Fire & Emergency NZ and St John
- Auckland Region Public Health Service, Ministry of Health, Police, Fire and Emergency NZ, St John Ambulance, Civil Defence, Auckland Airport, Auckland Transport, WorkSafe NZ, Corrections, Red Cross, Air New Zealand, Ministry for Primary Industries (MPI) and the Coastguard.

Northern Region Health Coordinating Executive Group (NRHCEG)

Has the responsibility for coordinating emergency management planning activities across the Northern Region. The objective of this group is to: “Ensure the effective coordination of health sector emergency management reduction, readiness, response and recovery for the Northern Region”.

The term Health CEG is used to draw a parallel between the functions of the regional health sector CEG within the sector and the Northland Region Auckland Emergency Management CEG with the broader emergency management sector. The Health CEG is responsible to the DHBs CEOs.

The Terms of Reference for the Health CEG includes: *“identifying areas of health emergency management in the Northern Region in which planning coordination is necessary or desirable to optimise health sector reduction of, readiness for, response to and recovery from health emergencies”*.

The Health CEG is a strategic level group and provides a regional focus to emergency planning in the health sector. Encompassing all health agencies within the Northern Region its membership consists of:

- Senior Manager from each DHB (4)
- District Health Board Emergency Manager (4)
- St John Ambulance representative
- Auckland Regional Public Health Service (ARPHS) representative
- Primary Health representative
- Ministry of Health representative
- Ministry of Civil Defence Emergency Management (MCDEM) representative
- Maori Health representative
- Pacific Health representative

Auckland Regional Public Health Service (ARPHS)

ARPHS have a representative on the Northern Region Health Coordinating Executive Group where relationships are well established with monthly meetings and regular updates. ARPHS emergency activities include pre-disaster planning, emergency response, regulatory activities and interagency liaison with the Auckland Emergency Management Groups, Council environmental health officers, emergency services, lifeline utilities and regional/national health stakeholders and communities to ensure public health aspects of emergency planning are considered and integrated into emergency plans.

Primary Health Organisations (PHOs)

CM Health funds a number of primary health care services through Primary Health Organisations (PHOs), general practices and a wide range of community based providers and other organisations that provide first point of contact to primary health care related services, pharmacies, laboratories. Emergency management is a function that requires collaboration across many agencies including DHBs, PHO, general practices and the MoH. Regional health emergency coordination issues are currently managed through Health CEG with a mandate from DHB CEOs. Emergencies that potentially affect hospital services must link with primary care services.

Auckland Emergency Management Group (AEMG)

Has the overall responsibility for the provision of Emergency Management in the Auckland region and works in partnership with emergency services and other organisations to ensure the effective delivery of AEM functions which are described in Section 17 of the CDEM Act 2002. Supporting the CDEM is the Coordinating Executive Group (CEG), which is a statutory group comprising senior representatives of the Auckland Council and the Auckland Emergency Management member organisations. It provides a strategic overview of Auckland EM and is able to commit the resources of the representative organisation to agreed projects and tasks.

Assistance to Cook Islands, Niue and Tokelau

The New Zealand Government also has obligations to provide assistance to the Cook Islands, Niue and Tokelau in respect of administrative matters, international relations and emergencies. These obligations stem from New Zealand's special relationships with those countries. The Cook Islands and Niue are self-governing states in free association with New Zealand. Tokelau is a dependent territory of New Zealand, moving towards adopting self-government in free association. The inhabitants of all three countries are New Zealand citizens. While all three are autonomous (to a greater or lesser degree), they are linked to New Zealand in ways that set them apart from other countries of the Pacific.

Section 3 Readiness

Introduction

Readiness involves planning and developing operational arrangements before an emergency happens. It includes consideration of Response and Recovery. All systems need to be developed, tested and refined in readiness for an efficient and effective health sector response to a potential emergency. There are national agencies, groups and plans that all assist the state of readiness required to manage a disaster situation. The information in this section identifies groups that the health emergency planner engages with, and the processes for ensuring that the DHB is prepared to meet all requirements during a disaster.

Health Major Incident Response Plan (MIRP – Operational)

CM Health is responsible for the health and wellbeing of its community. To achieve this, planning and preparing for all events is necessary for services to continue to deliver to adequate standards, within appropriate timeframes.

The Major Incident Response Plan (MIRP) provides a framework to assist in the management, coordination and control of major incidents. The MIP provides the procedures to manage an incident at an operational level and includes:

- An Activation pathway
- Actions and responses
- MoH Alert codes
- Major Incident Communication Plan
- Coordinated Incident Management Systems (CIMS)
- Key organisational actions and responses
- Rapid Discharge procedures
- Staff Cascade procedures

The threshold for activation/escalation will be determined by the level of impact (actual or potential) that an emergency has on CM Health. The MIRP's flexibility allows for the level of implementation to vary according to the nature of the incident. The MIRP incorporates the principles of the Coordinated Incident Management Systems (CIMS) model adopted by the other emergency services and lifeline organisations as per the CDEM Act (2002).

Service Specific Emergency Plans

Services throughout CM Health have plans in place, specifying the operational aspects of their department/service to respond to a major incident. The plans are updated annually and include services provided, ward / department profiles, equipment inventory, contingency plans (including IT applications contingencies), leadership structure, staff actions and responsibilities, information on creating capacity and cascade call back procedures. These plans are intended to be read in conjunction with the Major Incident Plan.

Flipcharts

Flipcharts are available throughout all CM Health sites. The flipcharts give advice to staff and members of the public, for the following situations:

- Fire
- Fire alarm sounding
- Essential utility failure
- Hazardous material alert
- Threat to personal safety
- Suspicious activity /unwelcome visitor or media
- Hold up
- Bomb threat/suspicious object
- Natural disaster
- Medical/Surgical emergency calls

National Emergency Plans and Procedures

The Ministry of Health develops and maintains plans and guidelines and these are subject to regular reviews. The current versions are available on the MoH website and are also available on Health Emergency Management Information System (Health EMIS) resource libraries.

Training

Newly appointed staff attend an induction and orientation day (Welcome Day) which includes information on the principles of emergency management. A newly developed e-learning portal has been established by the Northern Region Emergency Managers and will be mandatory training for staff using Ko Awatea Learn. Staff are also encouraged to access their Service Specific Emergency Plan which is easily accessible on the CM Health intranet (Paanui).

Senior staff and Executive/Personal Assistants are encouraged to attend a Health CIMS course that is run a number of times a year. This course gives an overview of emergency response procedures, equipment, and resources. Executive/Personal Assistants are also trained in Health Emergency Management Information System (EMIS) a communication tool used by the Ministry of Health and all DHBs nationwide.

General Managers, Service Managers and staff most likely to be part of the Incident Management Team have been CIMS 4 trained. Emergency Response procedures are tested throughout the year and plans/procedures updated as required.

Exercises

CM Health is committed to exercising the emergency preparedness and response procedures to the fullest extent possible. On occasion, the timing of exercises might not be ideally suited to link with routine work requirements of the DHB but participation in all exercise receives high priority. Participation in exercises is essential for ensuring the best service to the public throughout the time of an emergency. Emergency events can occur without warning, the extra workload that is integral to exercise participation has positive outcomes at an individual, team, organisational and inter-agency level.

CM Health participates in all national Ministry of Health, Ministry of Civil Defence & Emergency Management and local DHB exercises. They provide opportunities to test systems and networks within the sectors and provide learning opportunities in respect to internal and inter-agency collaboration and cooperation.

Dependent on the type of event there may be members of Emergency Services present, Primary Health representative and Auckland Emergency Management personnel.

CDEM National Exercise Programme

The national CDEM exercise programme provides a mechanism by which the operational capacity and capability of government agencies including the health sector, lifeline utilities, Non- Governmental Organisations (NGOs) and regional CDEMs can be assessed. Other mechanisms such as debriefs and reviews also contribute to this understanding.

Core Performance Indicators

Participating in local, regional and national exercises helps CM Health to ensure that it delivers on its commitments and is able to identify opportunities for improvement. It is essential to monitor the performance of its emergency management procedures and key processes. Core performance indicators of assessing capacity and capability are that:

- Effective communication is maintained at all times
- Emergency plans are maintained and exercised
- Work is prioritised effectively
- Response and recovery objectives are achieved without unexpected delay
- Logistics, transport, contract and supply requirements are addressed

- Resources are used efficiently and conflicts over deployments are avoided
- Gaps in capacity or capability are identified and resolved
- All functions are sufficiently resourced with appropriately trained staff
- There is clarity among agencies about roles, responsibilities or actions
- The testing and exercising of the plans and implementation of lessons identified provides for continuous improvement

Human Resources and Staffing

Human resources are an essential part of an effectively managed response to and recovery from a health emergency. Emergency planning must consider the different types of emergencies and their likely impact on staff numbers, staff safety and health during and following both short and long term emergencies. Regional and national staffing arrangements for requests from affected areas must be taken into account.

Organisational Debriefing

Before an emergency occurs, it is important to establish a process for organisational debriefing, review of plans and post event arrangements. The Ministry of Civil Defence and Emergency Management (MCDEM) provide a document on best practice guidelines for debriefing and this can be found [here](#).

Managing Emergency/Spontaneous Volunteers

Volunteers can be a valuable asset during an emergency response. Advanced planning is required to provide for trained, credentialed health volunteers to support local surge capacity. A volunteer management plan should cover all phases of emergency management and considerations include:

- Roles and responsibilities of volunteer coordinators
- Means of accountability
- Protocols for establishing volunteer registration and coordination centres for spontaneous volunteers
- Protocols for managing spontaneous volunteers when they are not required
- Use of technology and social media to relay information on volunteering
- Volunteer credentialing and identification

Infant Feeding in an Emergency

During an emergency, the use of infant formula to feed infants (0-12 months) can become a critical issue. Breastfeeding in an emergency remains the safest and best option for infant feeding and should be continued where possible.

The role of providing infant formula in an emergency will be performed by Auckland Emergency Management or Ministry of Civil Defence and Emergency Management responders. This role includes sourcing and distributing infant formula, water and the associated feeding equipment.

Counties Manukau will continue to provide infant formula to inpatient infants who require it. It is not the role of DHBs to provide infant formula or feeding equipment for the community in an emergency or otherwise.

Counties Manukau will provide advice and guidance to agencies about appropriate measures for infant feeding at the time of an emergency and will act as the single designated health agency to manage any unsolicited donations.

The Ministry of Health has developed a position statement on infant feeding in an emergency (Appendix 6).

Visitors and dependants

In emergencies a significant number of people will present to DHBs, who do not need medical care but would like to be with their sick relatives or to locate missing relatives. This will present challenges in hospital management and consideration into allocated or designated areas to support this response has been planned for.

Other emergency situations that require specific planning is for situations when young, elderly or disabled persons are isolated because of hospitalisation or death of their principle caregiver, liaison with appropriate welfare support agencies may be required.

Mass Casualty

Mass casualty incidents (MCI) require a coordinated response from emergency services and the health and disability sector.

An incident of this nature will increase the demand for DHB services however wherever possible, the process for responding will be consistent with business as usual process to minimise disruption and promote consistency.

DHB actions and responses during a MCI:

- Cease elective surgical and outpatient activity
- Identification of patients for rapid discharge or transfer
- Initiating the staff cascade process
- Sourcing of additional equipment or supplies
- Utilising non-acute facilities and pre-identifying suitable accommodation if required
- Establishing a suitable facility to assist with triage, diagnosis, treatment and support of patients who are not seriously ill or injured
- Provision of contingencies to maintain patients within the four localities and limit or avoid referrals to acute hospitals as much as possible

Evacuation of Health Care Facilities

The evacuation of a health care facility is time consuming and highly complex and requires a regional or national response to support the management process. There is a degree of risk to the patients who may be bed-ridden and dependent on medical equipment. Furthermore, the evacuation process must take into account the transfer of staff, medical records, medications, medical equipment and clinical products.

Core principles:

- **Evacuation** is the urgent movement of patients to a suitable safe location in response to a significant emergency. It has the ability to be scalable and may be a full or partial evacuation.
- **Relocation** is the planned movement of patients and staff from a facility to a designated suitable facility in response to a significant emergency
- **Shelter** in place is to seek safety within a facility rather than to evacuate to a different location – this is the most likely scenario due to the sheer size of the larger facilities at Counties Manukau Health.

The decision to evacuate, relocate or shelter in place must be made on the basis of a hazard assessment that determines the scope of the threat to patients, staff and visitors, against any potential harm that the evacuation may cause. There is no simple formula that can be applied and there are many factors that will influence this decision.

National Reserve Supplies

The MoH manages the national emergency reserves and stockpiles in preparation for when increased demand for the specialist emergency equipment and supplies are required in an emergency and in the recovery phases.

DHBs have access to these supplies during large and prolonged emergencies that generate unusual demands on normal health service stocks and supply chains.

DHBs manage their BAU supplies and supply chain capacity at a level that supports all reasonably predictable local events.

Reserve supplies include:

- Personal Protective Equipment (PPE) including masks, gowns, aprons and eye protection
- Clinical equipment and vaccination supplies
- Medicines and vaccines
- Other supplies including body bags

The MoH:

- Maintains the national reserve stockpiles
- Establishes and communicates policies
- Approves release of national reserve supplies when needed
- Allocates national reserve supplies between DHBs
- Coordinates transportation and distribution to DHBs
- Monitor and forecasts national supplies use
- Funds national reserve supplies use
- Replenishes the national reserve bulk supplies

DHBs:

- Maintain the rotate national reserve supplies held in DHB stores
- Allocates internal DHB supplies in an emergency
- Support neighbouring or regional DHBs
- Reports and forecasts supply usage
- Applies to the National Coordinator for Ministry of release of national reserve supplies as needed
- Coordinates distribution of supplies within DHB districts
- Ensure clinical guidelines, usage policies and appropriate economical use in clinical settings are followed
- Report to the Ministry of all national reserve supplies received and used

The National Health Emergency Plan: [National Reserve Supplies Management and usages Policies, 3rd edition](#) details the responsibilities of the MoH and DHBs in the management and usage of these critical resources.

Quarantine and border health plans

The International Health Regulations 2005 require competent authorities and designated points of entry to establish and maintain public health emergency contingency plans. The World Health Organization has published *International Health Regulations (2005): A guide for public health emergency contingency planning at designated points of entry (WHO 2012)*.

Border health planning in New Zealand is aligned with the World Health Organization's advice and with this plan. Any point-of-entry public health emergency contingency plan should be flexible and adaptable to match a wide variety of public health contingencies, especially emerging diseases. It will also:

- consider national, local and community plans including public and private sectors, laws, regulations and policies
- include plans to develop surge capacity on an 'as required' basis that can be engaged when needed
- fully respect the dignity, human rights and fundamental freedoms of people
- place equal focus on readiness and recovery rather than only on the response phase of an emergency plan
- ensure that regular exercising, refreshing and maintenance of plans are both factored in and budgeted for.

There is a suite of plans and standard operating procedures for border health responses that reflect local and regional arrangements. They cover:

- quarantine facilities – public health unit arrangements with local accommodation and catering facilities for the care of people placed in quarantine
- ill travellers – public health unit procedures for responding to reports of ill travellers
- border health protection responses – public health unit plans for any public health emergency at the border, including biological (pests and diseases of public health significance), chemical and radiological hazards
- port emergency responses – sea or airport emergency and incident response plans that include responding to public health risks arising from biological (pests and diseases of public health significance), chemical and radiological hazards.

Section 4 Response

Introduction

Response involves those actions taken immediately before, during and after an emergency to save lives. It also involves helping communities to recover by mobilising and deploying health resources immediately prior to, or during an emergency, in collaboration with other services and agencies by doing the following:

- The continuation of essential health services
- The relief and treatment of people injured or in distress as a result of the emergency
- The avoidance or reduction of ongoing public or personal health risks to all those affected by the event.

CM Health response describes how essential primary, secondary, tertiary, mental health, disability support and public services will continue to be delivered during the response phase. It outlines how the plan is utilised and the thresholds for activation/escalation, followed by the actions taken at local and regional levels.

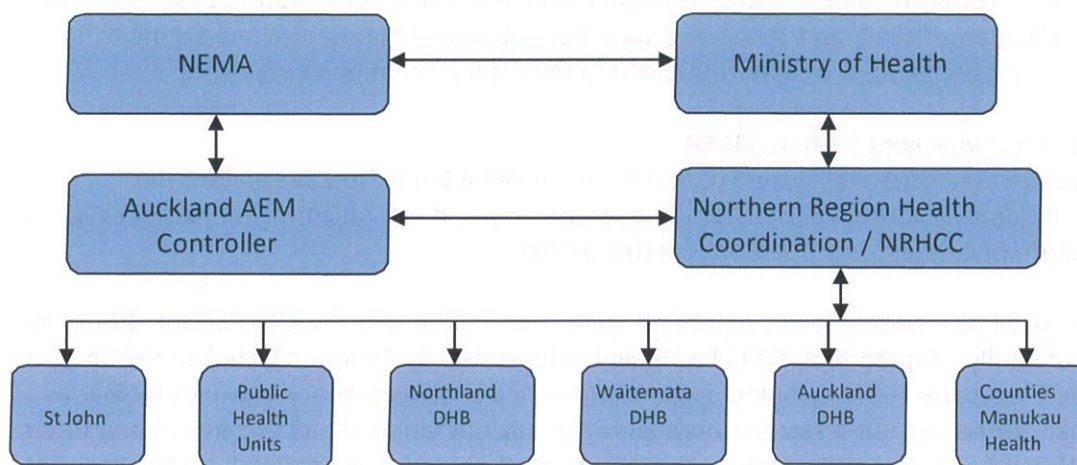
Response to a Health Emergency

In a health related emergency i.e. pandemic, the Ministry of Health are the lead agency. The Director-General of Health on behalf of the Minister of Health has overall responsibility for health and disability matters in all phases of emergency management. The role of the MoH is to coordinate the operational emergency response. The Ministry will initiate and coordinate any national emergency response for the health sector.

Planning for Recovery

Recovery activities commence while response activities are still in process. The priority actions for each are different: however, decisions made during the response phase will have a direct influence on recovery action planning.

The structure used when the Ministry of Health is the national lead agency at the operation level.



Northern Region Health Response Structure

Major Incident Plan (MIRP) alignment with the HEP

CM Health MIRP defines a major incident as an:

- Internal Major Incident is an event occurring within CM Health resulting in disruption to normal activities.
- External Major Incident is an event occurring that impacts on the health sector resulting in disruption to normal activities.

Examples of a major incident may include but are not limited to the following:

- Major epidemic or pandemic
- An event involving mass casualties
- Terrorist threat (includes bomb threat requiring evacuation)
- Loss of essential services (including communications failure to blackouts)
- Critical staff shortage (including strikes)
- Reduced operational capability of neighbouring DHB
- Natural disaster e.g. volcanic eruption.

Activation of the MIRP is reliant on an assessment of the presenting situation by key personnel and departments. A formal handover of responsibility from the Duty Manager to a designated Hospital Incident Controller will be completed. Some events will be initiated from outside the hospital environment and may be managed from the outset by the designated hospital Incident Controller. Notification is an essential element on the activation process and will depend on pre- established channels of communication. Any emergency incident or potential crisis that may overwhelm normal resources has to be escalated by staff using the process described in the MIRP.

Capability and Capacity

New Zealand's overall capacity and capability is made up of combined national and local resources that in some circumstances may be augmented by international assistance. Central and local government both have roles in terms of providing capacity and capability. Certain situations are clearly the responsibility of central government – MoH and MCDEM, while others involve central government working with local government agencies- Northern Region DHBs, Auckland and Northland local authorities. The exact boundaries are a reflection of scale and scope and may develop over time. Central government has a significant role in providing resources to support CDEMGs in the management of emergencies.

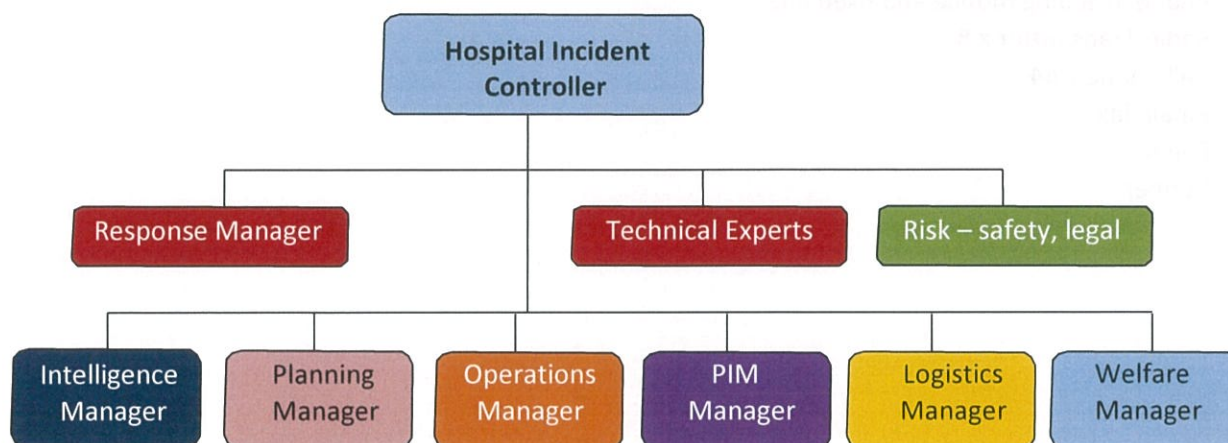
Coordinated Incident Management System (CIMS)

The Coordinated Incident Management System (CIMS) is a model adopted in New Zealand for the coordination of an incident; it forms the basis of the operational response. All emergency services use a CIMS structure to staff their emergency operating centres (EOCs).

CIMS is consistent at all operational levels operating within the health and disability sector during an emergency. As a nationally adopted tool, CIMS has been implemented by Counties Manukau Health. It is intended to provide a structure allowing multiple agencies involved in an emergency to work together as a team. The CIMS structure does not affect the normal day to day operation within CM Health and other health agencies. Normal clinical, managerial and other relationships are maintained within agencies involved in a response.

The Incident Management Team (IMT) assists the hospital incident controller by providing advice and specialist knowledge, and handling detailed work. The roles of the incident management team are shown below. In addition to the CIMS function managers, the incident management team may include:

- A Response Manager
- Technical experts with knowledge relevant to the incident, and
- Risk advisors



Incident Management Team

Emergency Operations Centre (EOC)

An emergency operations centre (EOC) is where the Hospital Incident Controller and IMT manage the response from. The EOC may be as small as a single desk or as large as the situation calls for. Events may last from a few hours to a few months or in some circumstances years.

The CM Health Emergency Operation is situated in Middlemore Central, Level 2, McIndoe Building, Middlemore Hospital. The primary role of the Incident Management Team is the coordination of the response to an incident affecting CM Health. The incident will determine the response set up the event is of short duration the Hospital Incident Controller may be the Duty Manager.

Communications

The aim is to ensure key stakeholders are informed by communicating relevant information about the incident, via appropriate channels at regular intervals.

In an emergency response a formal communication structure is required to be used by key health agencies such as DHBs and Ambulance with the MoH so that critical information is captured and acted on quickly and effectively. The essential areas that require a formal structure include:

- Logging information and tracking tasks
- Requesting information or action and tracking response
- Developing and disseminating reports on the current situation (Situation Reports)
- Summarising and communicating key intelligence on the incident.

Alternate Communications

Alternate communications channels as follows:

External

- Phone including mobile and fixed line
- Paper based templates
- Satellite phones x 2
- Email, fax

Internal

- Phone including mobile and fixed line
- Radio Transmitter x 8
- Cell phone x 44
- Email, fax
- Pager
- Runner

Health Emergency Management Information System (EMIS)

Health EMIS is a web based emergency management system hosted by the Ministry of Health and provided to the New Zealand health sector in order to manage local, regional and national emergencies. Health EMIS compliments existing business as usual systems (EpiSurv and patient management systems). Whilst the focus is on the health sector, it is also intended to facilitate structured information sharing with local, regional, and national partners. The system also provides electronic links between emergency websites. Health EMIS provides each DHB, PHU and other key health responders such as Ambulance, with logging and task tracking system, in order to manage their response to an incident. There is a formal set of standards and processes governing the development of the NZ health sector EMIS. Access to the system is limited to emergency response trained staff.

Single Point of Contact (SPoC)

The Single Point of Contact (SPOC) approach is a communication method that is used to provide an effective contact 24 hour, seven days a week system. The SPOC system connects the Ministry of Health, Ministry of Civil Defence & Emergency Management, DHBs nation-wide and DHB public health units. In line with the requirements of the MoH NHEP, the nominated Counties Manukau Health SPOC for any national health related emergency is the Counties Manukau Health Duty Manager based in Middlemore Central.

The primary response management of an emergency lies with the affected local provider, CM Health or the Northern Region Health CEG if the Regional HEP is activated. In addition, St John has the capability to alert and notify the Northern Region Health Sector, this system is tested regularly.

Health and Safety of Employees

Health and safety of employees is pivotal to a successful response; this include consideration of the following:

- Physical
- Mental
- Social wellbeing
- Maintaining a safe environment

The health and safety role in the IMT will be responsible for ensuring that all the practical steps are applied to the general duties that are carried out by staff and volunteers during an emergency as outlined in the Health and Employment Act 1992. This includes, but is not limited to, ensuring the employees and other people where appropriate have access to:

- Information, policies and procedures
- Personal Protective Equipment (PPE) and decontamination equipment
- Supplies for treatment for anyone who may be exposed to infectious diseases, e.g. antibiotics
- Relief staff
- Facilities to ensure their physical and mental wellbeing throughout the response phase
- Any other protective measures practical to provide

Health Sector Alert Codes

The MoH has developed alert codes to provide a system of communication for an emergency that is easily recognised within the sector. These alert codes are issued via the Single Point of Contact (SPoC) system. The alert codes outlined below have been adopted for use by the health and disability sector at district, regional and national levels.

| PHASE | EXAMPLE SITUATION | ALERT |
|-------------|---|--------|
| Information | Confirmation of a potential emergency that may impact in and/or on New Zealand. For example, a new infectious disease with pandemic potential, early warning on volcanic activity or other threat. | White |
| Standby | Warning of imminent Code Red alert. For example, a possible emergency in New Zealand such as an imported case of a new and highly infectious disease in New Zealand without local transmission of initial reports of a major mass casualty event within one area of New Zealand which may | Yellow |
| Activation | A major emergency exists in New Zealand requiring immediate activation of HEPs. For example, a large scale epidemic or pandemic or major | Red |
| Stand down | Deactivation of the emergency response. For example, end of outbreak, | Green |

Health Sector Alert Codes

Surge Capacity

In response to complex emergencies there may be a need for DHBs to safely decant or/and evacuate health facilities ensuring that patients will be able to continue to have access to health care. Three aspects need to be considered when planning surge capacity:

- Early transfer or discharge of current patients to other areas. Alternative areas in which to manage patients requiring admission. Cancellation of patient clinics and elective services.
- Evacuating patients from facilities where services has been lost or severely reduced
- Deployment of staff from one area to another in order to provide assistance during a response.

Activating the Northern Region HEP

The Northern Region HEP provides an agreed framework, guiding principles and the roles and responsibilities to enable a coordinated response to any emergency (actual or potential) which has overwhelmed (or the potential to overwhelm) local, regional or national health capacity.

Links with regional HEPs i.e. plans for the Northern, Midland, Central and Southern regions are defined in the National Health Emergency Plan. Activation can be triggered by any of the Northern Region DHBs.

Events that could trigger activation include:

- Mass casualty
- Tsunami or volcanic activity
- Mass information service outage
- Outbreak of significant communicable disease

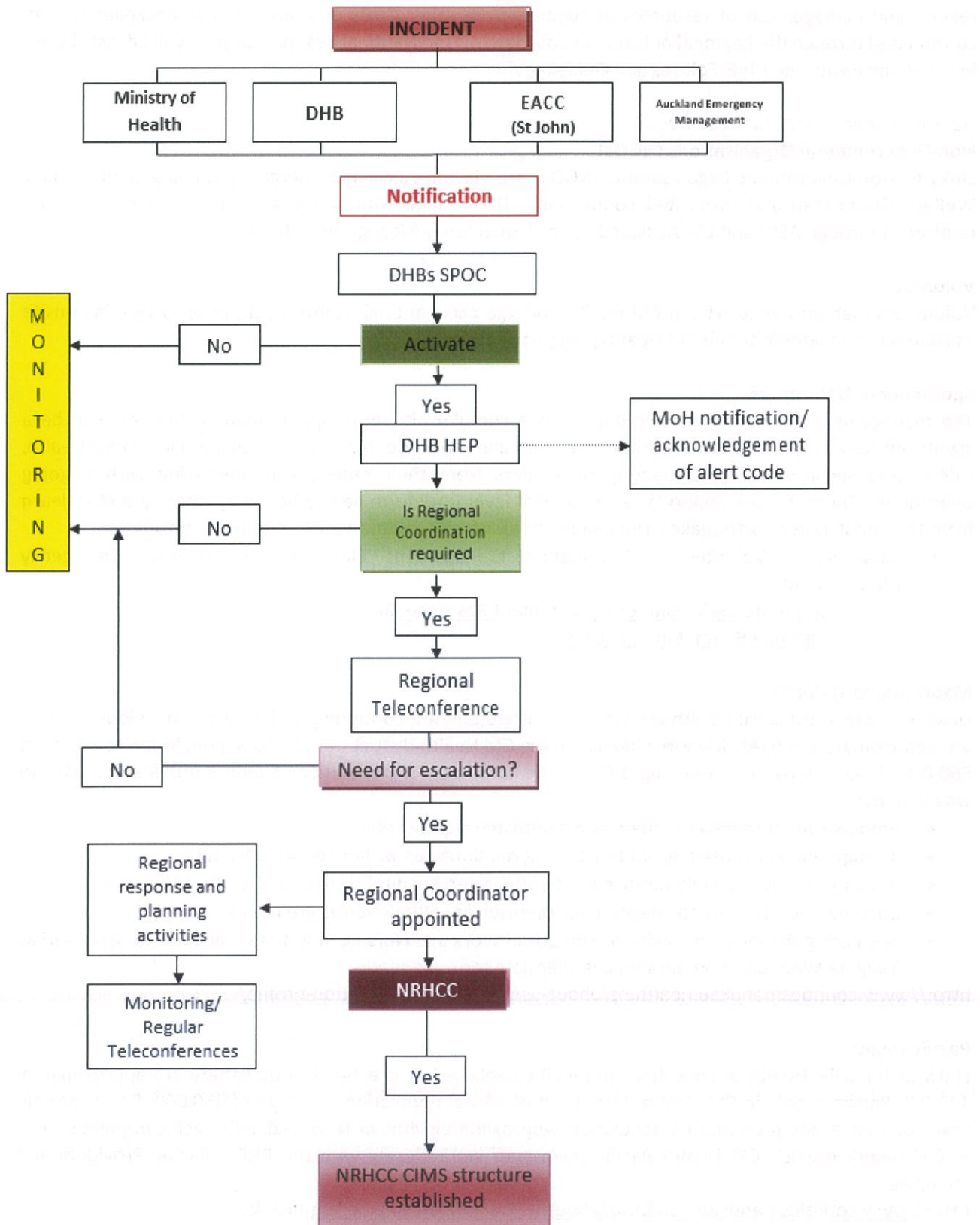
The NRHEP can be activated by notification from:

- A DHB when responding to an incident that requires regional assistance, management and coordination where their resources are overwhelmed, or have the potential to be overwhelmed.
- The MoH when the NHEP is activated requiring DHBs to activate their HEP. This may be in response to a national incident or in support to another health region.
- The Ambulance Communication Centre when an incident or potential incident requires or is likely to require a regionally coordinated response from DHBs and other service providers.

Emergency Ambulance Communication Centre

St John national emergency management team have set up a single point of contact system with the 20 DHBs, in the form of an electronic paging/text notification to provide notification of a major event. The Counties Manukau Health single point of contact is the Duty Manager. This system is tested monthly. NRHCC CIMS structure established

Pathway for Notification and Activation of NRHEP and NRHCC



Resources

Any emergency has the capacity to reduce the workforce required to meet the needs of that emergency, which can lead to the transfer of staff from CM Health to another DHB, or have staff transfer from another DHB to CM Health.

Depending on the availability of staff with the necessary skills and qualifications, it is important to ensure that basic service levels are maintained. This can be done by reviewing a request either via Health EMIS or through current communication channels.

Requests from other DHBs concerning supplies / materials will be received by the IMT. Depending on the availability of the resources requested and ensuring the resources demands of the DHB are maintained. The receipt and management of resources or supplies from other DHBs or from national stockpiles will be coordinated through the Regional or National Coordinator; the National Reserve Supplies will be distributed in accordance with the MoH Policies and Guidelines.

Health Related Roles and Resources

Non-Governmental Organisations (NGOs)

Links to Non-Government Organisations (NGOs) are via the Auckland Emergency Management in their Welfare Group Plan and associated connections. This linkage with NGOs is an area that needs to be reinforced through AEM and the Auckland Council Emergency Management Team.

Volunteers

Volunteers that work regularly for CM Health undergo occupational health checks prior to working onsite as required, and adhere to the CM Health policy at all times.

Spontaneous Volunteers

The management of spontaneous volunteers is a complex situation. Spontaneous volunteers can be a significant resource, but are often ineffectively used and can hinder emergency activities by creating health, safety, and security issues, distracting responders from their duties, and interfering with ongoing operations. There is work underway at a regional level to determine the best way forward and to learn from the Christchurch earthquakes. Documents to assist with Spontaneous Volunteers include:

- Spontaneous Volunteer and Donation Management Planning. Civil Defence Emergency Management
 - [Spontaneous Volunteer Management Resource Kit](#)
 - [National Health Emergency Plan](#)

Maori (Maaori) Health

Links with Maori (Maaori) Health are well established and are continuing to be further developed. There are approximately 100,000 Maaori whaanau in the CM Health district out of a total population coverage of 860,000. Maaori whaanau make up 17% of the total district population. Support provided to Maaori whaanau by:

- empowerment to develop their own health and support plan
- strengthening, maintaining and sustaining relationships within Counties Manukau
- working closely and collaboratively with integrated hospital staff as well as the community
- encouraging whaanau to advocate for themselves so their voices are heard
- promoting the indigenous identity for Social Work and Nursing in Aotearoa and assisting Maaori as Tangata Whenua to obtain services adequate for their needs

<http://www.countiesmanukau.health.nz/about-us/our-region/population-profile/>

Pacific Health

Links with Pacific Health organisations are well established. It is estimated that there are approximately 132,000 Pacific people in CM Health district out of a total population coverage of 350,000. Pacific people make up 22% of the total District population. Approximately 40% of New Zealand's Pacific population live in CM Health district. CM Health Pacific team staff work closely with the PHOs, Pacific Providers and churches.

<http://www.countiesmanukau.health.nz/about-us/our-region/population-profile/>

Vulnerable People

Recent events highlighted several significant sectors of the population were at high risk from the effects of a disaster. These sectors include:

- Aged Residential care
- Immigrants including the Mangere Refugee Resettlement Centre

Documents to assist with these sectors include:

- Best Practice Guidelines for engaging with Culturally and Linguistically Diverse (CALD) Communities in times of Disaster
- Working Together; CDEM Sector (IS8/0)

Standing down the HEP

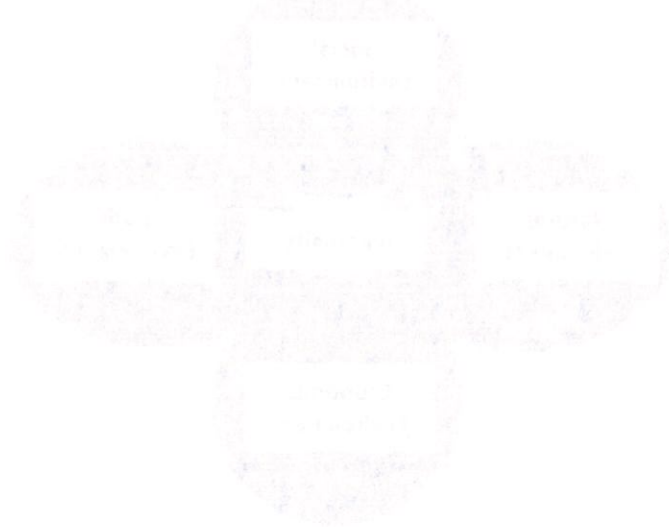
The date and time of the official stand down or deactivation of an emergency response will be determined by either the local or regional agency in consultation with the MoH.

Deactivation of an emergency response is dependent on a wide range of variables that must be satisfied before the announcement occurs. Some basic principles that should be followed are:

- That the emergency response role has concluded.
- That the immediate physical health and safety needs of the affected people have been met.
- That essential health disability services and facilities are re-established and operational.
- That the immediate health concerns arising from the public have been satisfied.
- That it is timely to enter the active recovery phase.

Once confirmed, the MoH will issue a Code Green alert to signify the end of the response period. The time and date of deactivation may be used to determine arrangements implemented by the MoH in the recovery period.

After each activation/exercise the CM Health HEP is reviewed based on debriefings and evaluation outcomes in order to clarify roles and responsibilities at all levels during local, regional and national activation.



Section 5 Recovery

Introduction

Recovery begins after the initial impact has been stabilised and extends until normal business has been restored. It may involve a local, regional, national health related response or it may involve a whole of government response involving economic, social and legislative issues.

Recovery Objectives

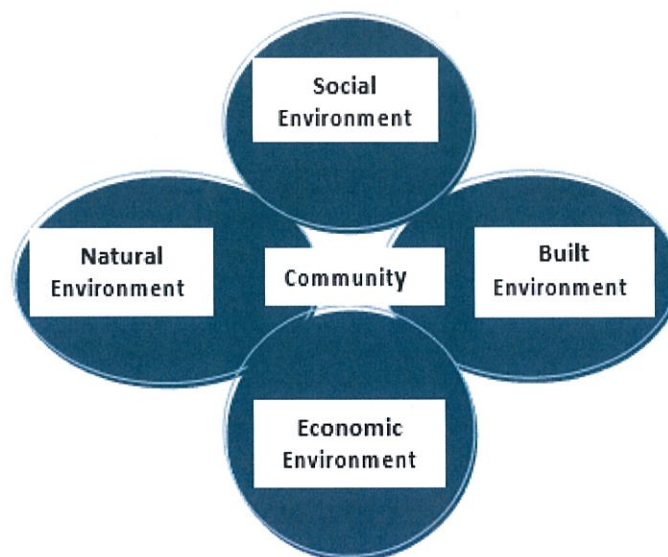
Recovery is a complex social process and is best achieved when the affected community exercises a high degree of self-determination. Recovery extends beyond restoring physical assets or providing welfare services. Successful recovery recognises that both communities and individuals have a wide and variable range of recovery needs and that recovery is only successful where all needs are addressed in a coordinated way. The timeframe for recovery may vary from weeks to years as economic and emotional effects can cause constant stress for many years. Recovery objectives include:

- Minimising the escalation of the consequences of the emergency
- Regeneration of the emotional, social and physical well-being of individuals and communities
- Taking opportunities to adapt to meet the future needs of the community
- Reducing future exposure to hazards and their associated risks.

CM Health – A Whole System Approach

An integrated whole systems framework is needed to consider the multi-faceted aspects of recovery which, when combined support the foundations of community sustainability. The framework used by MCDEM in its [“Focus on Recovery: A Holistic Framework for Recovery in New Zealand”](#) document that encompasses the community and the four environments: social, economic, natural and built as illustrated.

Figure 10: An integrated whole systems approach to recovery



Psychosocial Recovery

Recovery encompasses the psychological and social dimensions that are part of the regeneration of a community. The process of psychological recovery from emergencies involves easing the physical and psychological difficulties for individuals, families/Whanau and communities as well as building and bolstering social and psychological wellbeing.

Psychological recovery is not limited to the recovery phase of an emergency event. Psychosocial recovery in the field of emergency management begins at the level of prevention through risk and reduction - [Psychosocial Recovery Planning Guidelines: National Health Emergency Plan](#).

Psychosocial recovery spans the 4R's of CDEM planning, with most emphasis on the readiness, response and recovery phases. It is just one element of wider social recovery, and also links to the other three components of recovery, namely of the economic, natural and built environments.

CM Health is committed to promoting health recovery measures, actions and operations not only during the recovery phase but across the 4R's in its principles and organisational planning for all aspects of its emergency management planning.

Psychosocial Support

With the rewriting of the National CDEM Plan and subsequent guidelines, the responsibility for community psychosocial recovery is now vested with the Ministry of Health which includes DHBs, and the health and disability sector. A Document outlining responsibilities - [Part II Section 10 Psychosocial Support, Welfare Services in an Emergency Director's Guideline \[DGL 11/15\]](#).

The Ministry has provided strategic advice and guidance to the Government, CDEM agencies and health and disability sector through the Office of the Director of Mental Health. The MoH has provided document outlining required actions: [Framework for Psychosocial Support in Emergencies](#). The Ministry will represent the health and disability sector on the National Welfare Coordination Group.

DHBs will lead the wider local groups responsible for delivery of services that meet the psychosocial needs of a community after an emergency. DHBs will be represented on the welfare coordination group to provide advice, guidance and lead agency responsibilities for psychosocial recovery.

DHBs will coordinate the provision of psychosocial support, specialist public health, mental health and addiction services and will provide advice to government and non-governmental organisations and primary health organisations on the type and nature of services needed for ongoing psychosocial support.

Health and safety of employees

One aspect of health and safety is to consider physical, mental and social wellbeing during the emergency, including the provision of a safe environment in which this wellbeing can be maintained. Providers are required under the Health and Safety in Employment Act 1992 to take all practical steps to mitigate risk and protect employees, especially those at higher risk, such as health care staff, support staff and first responders. The term 'all practical steps' also applies to the general duties that staff and volunteers perform in an emergency. Hazards as far as possible should be eliminated where it is practicable to do so or, when elimination is not practicable, should be isolated. If isolation is not practicable, then the employer must minimise the likelihood that the hazard will harm employees and other people on site.

Health workers and other response workers in emergencies are at risk of experiencing significant psychosocial impact, especially if they are highly exposed to traumatic stimuli. Many staff will experience some psychosocial reaction, usually within manageable range. Some may exhibit more extreme reactions in the short, medium or long term. Most staff will be affected in some way by the experience, either directly or indirectly. In addition, life circumstances of staff after the emergency are likely to have changed. Research indicates that most people who experience an emergency tend to recover with time and support. With proper debriefing and support, the prevalence of conditions such as post-traumatic stress disorder drops relatively quickly in the aftermath of an emergency.

Section 28A of the Health and Safety in Employment Act 1992; states that employees have the right to refuse to perform work if they believe it is likely to lead to their suffering serious harm. However, their belief must be on reasonable grounds and they must have attempted to resolve the matter with their employer before they ultimately refuse. The right to refuse unsafe work does not apply unless the understood risks of the work have increased materially.

Recovery Activities

To align with the requirements of the CDEM Act 2002, definition of recovery activities is the action that CM Health must undertake after an emergency and may include:

- Assessment of the health needs of the affected community
- Coordinating the health resources made available
- Managing the rehabilitation and restoration of the affected community's health care services and health status
- Reassessing measures to reduce hazards and risks.

While the MoH and other government agencies may be the lead government involvement in a response phase (particularly in respect to a health emergency), it is usually MCDEM who becomes the lead government agency for coordinating any necessary government support for recovery. Large scale emergencies require a whole of government response. MCDEM coordinates the recovery activity of relevant CDEM groups, lifeline utilities i.e. electricity, telecommunications and water, government departments and international aid following the transition from response to recovery and during the short, medium and long term. More in depth information on recovery can be found in: [Recovery Management Director's Guidelines for CDEM Groups](#) and the [Guide to the National Civil Defence & Emergency Management Plan](#)

Organisational Debriefing

The aim of organisational debriefing is for staff to communicate their experience of an emergency or exercise so that lessons can be identified. Plans are modified to reflect these lessons, to discuss best practice and improve the organisation's ability to respond in future emergencies.

After each incident a review of the CM Health emergency response plans and procedures is carried out based on debriefings and evaluation outcomes. The model recommended by MCDEM, used by the MoH is outlined in [Organisational Debriefing: Information for the CDEM sector \(2006\)](#).

Three types of organisational debriefing can be used to promote post-event learning. They are the hot or immediate post event debrief, the cold or internal organisational debrief and the multi- agency debrief.

Reports from the debriefings are reviewed by all participants and agencies involved in the response. The purpose of the review is to analyse the existing plans and processes in place. The review will evaluate actions of all participants and their responses and may identify areas for improvement. Review and subsequent actions may require inter-agency collaboration.

Review documents may become public documents. Plans will then be revised with the review findings, these new plans then require testing and validation by exercising to ensure that the lessons learnt have been effectively addressed.

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Appendices

Appendix 1: Abbreviations

| Term | Meaning in the HEP unless otherwise stated |
|--------------------------------|---|
| ADHB | Auckland District Health Board |
| AEM | Auckland Emergency Management previously Auckland Civil Defence |
| ARPHS | Auckland Region Public Health Service |
| CDEM | Civil Defence Emergency Management |
| CDEMG | Civil Defence Emergency Management Group |
| CEG | Coordinated Executive Group |
| CEO | Chief Executive Officer |
| CIMS | Coordinated Incident Management System. |
| CM Health | Counties Manukau Health |
| DESC | Domestic and External Security Coordination. |
| DHB | District Health Board |
| EOC | Emergency Operations Centre |
| EMS | Emergency Management Service |
| EMIS | Emergency Management Information System |
| FENZ | Fire and Emergency New Zealand previously NZ Fire Service |
| Health Emergency | A health emergency exists when the usual resources of the provider are overwhelmed, or have the potential to be overwhelmed. |
| Health CEG | Health Coordinating Executive Group. Health CEG is responsible for coordinating emergency |
| HEP | Health Emergency Plan |
| Hospital IC | Incident Controller. A member of a DHB emergency management team with overall responsibility for coordinating emergency response at the individual DHB level |
| IMT | Incident Management Team. |
| Liaison Officer | Liaison Officers improve the flow of information by acting as single points of contact between agencies. |
| MCDEM | Ministry of Civil Defence and Emergency Management |
| MCI | Mass Casualty Incident |
| MoH | Ministry of Health |
| MIP | Major Incident Plan |
| NEMA | National Emergency Management Agency (Civil Defence) |
| NDHB | Northland District Health Board |
| NGO | Non-Government Organisation |
| NHCC | National Health Coordination Centre |
| NHEP | National Health Emergency Plan |
| NRHCC | Northern Region Health Coordination Centre |
| NRHEP | Northern Region Health Emergency Plan |
| NZMAT | New Zealand Medical Assistance Team |
| ODESC | Officials Committee for Domestic and External Security Coordination |
| OPF | The Operational Policy Framework. Operational Policy Framework is a group of documents collectively known as the “Policy Component of the District Health Board Planning Package” that sets out the operational level accountabilities for DHBs for each fiscal year. |
| PHO | Primary Health Organisation |
| PHU | Public Health Unit |
| PPE | Personal Protective Equipment |
| Primary Care | Care/services provided by general practitioners, nurses, pharmacists, dentists, ambulance services, midwives and others in the community setting. |
| Secondary/Tertiary Health Care | The levels of care provided in a hospital. |
| SPoC | Single Point of Contact |
| TAG | Technical Advisory Group |
| WDHB | Waitemata District Health Board |
| WHO | World Health Organisation |

Appendix 2: Key Roles and Responsibilities (National CDEM Plan) 2015

| Service | Responsibilities |
|---|---|
| <p>District Health Board</p> <p>Every DHB is required to develop and maintain a plan for significant incidents and emergencies. The DHB plans identify how services will be delivered in a civil defence or related emergency and acknowledge the role of DHBs as both funders and providers of health services.</p> | <p>DHBs must:</p> <ol style="list-style-type: none"> ensure that all their plans provide adequately for <ol style="list-style-type: none"> public, primary, secondary, tertiary, mental and disability health services an integrated regional and national response and coordination with plans of other agencies i.e. ambulance, Civil defence, fire service and police, use of CIMS, contribute to the development, implementation and revision of regional plans for health emergencies, contribute to the development, implementation and revision of Ministry of Health national plans, respond to a regional or national health emergency or to the threat of one when necessary liaise with the CDEM Group or local EOC in a significant emergency, ensure that new service agreements contain contractual commitments from providers for an appropriate plan in relation to the services they provide, require health providers to have plans and resources in place to ensure they can respond to emergencies in an integrated and effective manner, ensure that hospitals and health services are ready to function to the fullest possible extent during and after an emergency, <ol style="list-style-type: none"> the provision of continuity of care for existing patients, the management of increased demand for services and assistance with the recovery of services, the preparation of an incident and emergency management plan that is integrated locally and regionally and is aligned with the plans of other emergency services and the regional group plan, their own planning and responses are integrated with public health planning and responses. <p>Hospitals and health services should also ensure evacuation plans are prepared for health care facilities.</p> |
| <p>Ministry of Health</p> <p>The responsibilities of the Ministry of Health include policy development and national planning. These include planning for a health related emergency through the National Health Emergency Plan.</p> | <p>The Ministry of Health:</p> <p>Is responsible for initiating and coordinating any national emergency response from the health sector, i.e. a new infectious disease with pandemic potential, or early warning of possible volcanic activity.</p> <ul style="list-style-type: none"> monitors various functions relating to health and disability including emergency planning and response (monitoring will be done by various means, including the district annual planning process and certification audits carried out by designated agencies develops memoranda of understanding and other agreements or guidelines with various government agencies (these include interventions in a national health related emergency) is charged with ensuring that New Zealand meets its international obligations and complies with international health regulations. |

| Service | Responsibilities |
|--|--|
| <p>Health Sector Alert Codes</p> <p>The Ministry of Health has developed alert codes to provide an easily understood system of communication for an emergency. These alert codes are issued via the single point of contact system.</p> | <p>Code White – Information – Confirmation of a potential emergency situation that may impact in and/or New Zealand.</p> <p>Code Yellow – Standby – Warning of imminent Code Red which will require immediate activation of HEPs. Code Red – Activation – major emergency in New Zealand exists with required immediate activation of HEPs.</p> <p>Code Green – Stand-down – deactivation of emergency response i.e. end of outbreak or epidemic. Recover activities will continue.</p> |
| <p>Public Health Services</p> <p>Public health services will oversee those matters that impinge upon the health, health protection, disease prevention and statutory Public Health response to their population.</p> | <p>Public health units of DHBs and of the Ministry of Health have the responsibility to:</p> <ul style="list-style-type: none"> • develop plans specific to public health emergencies, such as pandemic • integrate public health planning and responses with DHB planning and responses • advise local agencies and lifeline utilities about public health aspects of their business continuity planning • respond to emergencies involving risk to public health • liaise with CDEM Group or local EOC during a significant emergency. <p>The Public Health Service response will also as required address and/or advise on the following issues:</p> <ul style="list-style-type: none"> • drinking water quality control and treatment • food safety and mass feeding facilities • control of sewage and other wastes, rodent control and the disposal of human as well as organic matter • shelter for evacuees and hygiene standards • control and disposal of hazardous substances • radioactive hazards • in associate with the Police, emergency disposal of the dead • ensure there are efficient processes for disseminating health warnings and messages |
| <p>Secondary Hospitals</p> <p>Secondary hospitals will provide the facilities for those affected by the incident. They will also accommodate recuperative patients post operation period.</p> <p>Note: When the resources of public hospitals are fully</p> | <p>Secondary Hospitals will:</p> <ul style="list-style-type: none"> • maintain service specific emergency plans to minimise disruption to services through the loss of staff and the loss of impairment of buildings or utility services • plan for a graduated response, including the evacuation of patients • ensure the emergency plan is integrated locally and regionally and is aligned with public health and other emergency services • manage capacity to accept those needing hospital care • participate in alternate communication network linking key healthcare facilities, including Tertiary Hospitals and CDEM organisations • have arrangements for access to essential supplies during an emergency |

| Service | Responsibilities |
|--|--|
| <p>committed, private medical facilities may be called upon to assist with surgical operations and other treatment within their capacity to provide. This will be coordinated by the DHBs or the Northern Region Health Coordination.</p> | <ul style="list-style-type: none"> participate in coordinated planning, training, exercising and response arrangements with key agencies and MoH agree mutual aid agreements with other providers such as private hospitals ensure readiness of resources provide for incident review and debriefing of staff |
| <p>Mental Health Services</p> <p>Psychological support to the wider community is supplied through a diverse range of health and welfare agencies.</p> | <p>Mental Health Providers will:</p> <ul style="list-style-type: none"> develop service specific emergency plans to minimise disruption to services through loss of staff or the loss of impairment of buildings or utility services ensure readiness of resources provide for incident review and debriefing staff |
| <p>Ambulance Service</p> <p>The ambulance service will plan to retain the capacity to respond to other calls for assistance outside the incident scene. The degree to which the routine function on of the Ambulance Service is affected will depend upon the scale and type of the incident. In response to more severe incident the AMPLANZ coordinates extra resources being brought in from outside the region.</p> | <p>Each ambulance service will:</p> <ul style="list-style-type: none"> prior to the emergency, participate in an alternate communications network that links key health facilities and emergency management organisations develop service continuity plans to minimise disruption to services through the loss of staff or the loss or impairment of vehicles, buildings or utility services ensure the emergency plans integrate with the DHB and the regional emergency services ensure all obligations can be met and there is regular monitoring of staff awareness and training ensure readiness of resources participate in coordinated planning, training, exercising and response arrangements with complementary or neighbouring providers and emergency management organisations maintain its own emergency plan, command structure and communications in order to liaise with the appropriate controller (s) provide for incident review and debriefing of staff |
| <p>Aged and Residential Care</p> | <p>All healthcare providers contracted by the District Health Boards and Ministry of Health are expected to develop emergency plans which identify:</p> <ul style="list-style-type: none"> how the provider as a whole will respond to a crisis at any on it facilities for services who has the coordination role |

| Service | Responsibilities |
|---|---|
| | <ul style="list-style-type: none"> • where they will operate from • where relevant, what the role and responsibilities are of each department • a facility plan which sets out the structure and process of how that facility will respond to any incidents • key roles are identified and persons who will fill those roles are identified • action cards, setting out the duties of those key people are prepared so a considered systematic response is assured • no matter who is on site and filling that role when the incident occurs • how the service of facility can provide support to a community emergency • identify risks and hazards • monitors staff awareness, outlines how training will be provided and ensures resources are available, including emergency supplies • how they will maintain their business continuity plans • provide for incident review and debriefing of staff |
| <p>Primary Care and Community Services</p> <p>Following primary health care or community health services immediately, in the long term or both</p> | <p>Primary Care and Community Services will:</p> <ul style="list-style-type: none"> • develop and maintain services continuity plans, appropriate for their situation to minimise disruption to services through the loss or impairment of buildings or utility services • identify risks and hazards • agree mutual aid agreements with like providers • ensure there is an efficient system for rapidly notifying staff or for staff recall • ensure there is access to essential emergency supplies • following a major incident, wherever possible continue to provide their services to meet the needs of their normal patients or clients and others who as a result of the emergency are unable to access their usual provider. This includes Community Pharmacies, where possible, opening their premises and providing their normal dispensing and retail services to both their usual customers and the general public unable to reach their normal supplier. • Have planned to participate in a response to: <ol style="list-style-type: none"> a) meet the need for care and advice to uninjured casualties or those with minor injuries b) meet changes in workload arising from any early discharge arrangements in hospitals to free up beds c) meet the health care needs of people at reception or evacuation centres, this could include: <ul style="list-style-type: none"> • replacing missing medication • undertake health screening • the provision of information and advice to the public • the provision of social and psychological support in conjunction with social services. d) plan to increase their ability to accept and treat casualties (GP's and Medical Centres) e) ensure all obligations can be met and there is regular monitoring of staff awareness and training and readiness of resources. Provide for incident review and debriefing of staff |

| Service | Responsibilities |
|--|---|
| | <p>f) participate in alternative communications networks that link principal health care facilities with CDEM and the DHB</p> <p>g) report to funders on request about readiness and response to an emergency.</p> |
| <p>Community Medical Laboratories</p> <p>Medical Laboratories are expected to assist the health response through, where possible continuing their normal diagnostic services.</p> | <p>Community Medical Laboratories will:</p> <ul style="list-style-type: none"> • develop service continuity plans to minimise disruption to services through the loss or impairment of buildings or utility services • ensure all obligations can be met and there is regular monitoring of staff awareness and training and readiness of resources • work closely with healthcare providers responding to the emergency to facilitate the treatment of those affected by the incident • provide for incident review and debriefing of staff. |
| <p>Community Radiology Services</p> <p>Radiology Services are expected to assist the health response through, where possible continuing their normal diagnostic services.</p> | <p>Community Radiology Services will:</p> <ul style="list-style-type: none"> • develop service continuity plans to minimise disruption to services through the loss of staff or the loss of impairment of buildings or utility services • ensure all obligations can be met and there is regular monitoring of staff awareness and training and readiness of resources • work closely with healthcare providers responding to the emergency to facilitate the treatment of those affected of those affected by the event • provide for incident review and debriefing of staff |
| <p>Ministry of Health</p> <p>The Ministry of Health is responsible for developing and maintaining the National Health Emergency Plan (NHEP) which is the umbrella plan incorporating other specific plans</p> | <p>The Ministry of Health will, where appropriate:</p> <ul style="list-style-type: none"> • establish and maintain clear communications processes with DHBs and the Northern Region Health Coordination (including Public Health Services) • in the event of a national health related emergency, establish a national coordination team under a CIMS structure and identify a national coordinator • establish national coordination of media and public information • provide timely, accurate and up to date clinical advice and information • facilitate health assessments as part of border control • establish priority groups for vaccines and other medications and provide advice as to which medicines to use • following stand down, initiate a review of actions and outcomes and update with national plan. |

Appendix 3: Health Emergency Planning Partnership

| Organisation/Services Tasks/Roles | GPs/A&M | Rest Homes | St John | Private Hospitals | Mental Health Providers | Maori Health Providers | PHUs | Public Hospitals | Private Labs | Private Radiology | Community Services | Pharmacies | Ministry of Health | Disability Support Services | DHBs – Planning & Funding | NZ Police | Fire and Emergency NZ | Maraes | Auckland Emergency | Welfare Groups |
|---|---------|------------|---------|-------------------|-------------------------|------------------------|------|------------------|--------------|-------------------|--------------------|------------|--------------------|-----------------------------|------------------------------|-----------|-----------------------|--------|--------------------|----------------|
| Care and advice to uninjured/displaced | | | √ | | | | √ | | | | | | | | | √ | | √ | √ | √ |
| Clothing | | | | | | | | | | | | | | | | | | | | √ |
| Communication – Emergency Response | | | √ | | | | | | | | | | | | | √ | √ | | √ | √ |
| Communication – Public Information | | | √ | | | | √ | | | | | | √ | | | √ | | | √ | √ |
| Counselling | √ | | √ | | √ | √ | | | | | | | | √ | | √ | | | | √ |
| Emergency Care | √ | | √ | √ | | | | √ | | | | | | | | | | | | |
| First Aid | √ | | √ | | | | | | | | | √ | | | | | √ | √ | | √ |
| Food Supplies | | √ | | √ | | | | √ | | | | | | | | | | | √ | √ |
| Health screening and evacuation centres | √ | | √ | | | | √ | | | | | | | | | | | | | |
| Health status assessments of the community | | | | | √ | √ | √ | | | | √ | | √ | √ | √ | | | | | |
| Hygiene at evacuation centres | | | | | | | √ | | | | | | | | | | | | | √ |
| Provision of medicines and medical supplies | √ | | | √ | | | | √ | | | | √ | | | | | | | | |
| Quarantine facilities | | | | | | | √ | √ | | | | | | | | | | | | |
| Replacing missing medication | √ | | | √ | | | | √ | | | | √ | | | | | | | | |
| Shelter for displaced and evacuated people | | | | | | | | | | | | | | | | | | | √ | √ |
| Social or psychological support | | | | | √ | | | | | | | | | | | | | | | √ |
| Storage/disposal of the dead – police under the direction of the coroner will transport | | | | | | | √ | √ | | | | | | | | √ | | | | |
| Transport | | | √ | | | | | | | | | | | | | √ | | | √ | √ |
| Supplies of portable water | | | | | | | √ | | | | | | | | | | | | √ | √ |
| Cooking facilities | | √ | √ | √ | | | | √ | | | | | | | | | | √ | √ | √ |
| Accommodation | | | | | | | | | | | | | | | | | | √ | | √ |
| Bedding | | | | | | | | | | | | | | | | | | √ | | √ |

Appendix 4: Distribution List

The CM Health Emergency Plan is a public document and is published on the CM Health website. It is also distributed to the following groups:

- Ministry of Health
- Civil Defence Emergency Management Group
- Auckland Emergency Management
- Auckland District Health Board
- Waitemata District Health Board
- Northland District Health Board
- Auckland Regional Public Health Service
- Counties Manukau Emergency Services Coordinating Committee

Appendix 5: Roles and Responsibilities by Alert Code

| Phase/ Alert Code | National Responsibility | Regional Responsibility | Local Responsibility |
|--|---|--|---|
| ALL ALERT PHASES | <ul style="list-style-type: none"> Co-ordinate the health sector operational response at the national level Provide information and advice to the Minister Provide strategic direction Liaise with other national level agencies Liaise with international agencies Identify and activate national TAG(s) Provide clinical and public health advice on control and management Approve/direct distribution of reserve supplies Provide information to assist response Plan for recovery | <ul style="list-style-type: none"> Coordinate the northern region health response. Liaise between the MoH, northern region DHBs and other agencies Coordinate regional intelligence gathering and regional tasking | <ul style="list-style-type: none"> Coordinate and manage the health sector response in the DHB area. Liaise with other agencies at the local level and within the region. Provide the NRHCC and the MoH with required information. |
| INFORMATION White | <ul style="list-style-type: none"> Issue code white through SPOC system Monitor situation and continue surveillance May activate a national incident on EMIS Advise DHB CEOs, DHB SPOCs and PHU managers of situation and developments Provide media with public information Liaise with Government agencies Liaise with international agencies | <ul style="list-style-type: none"> Not activated in code White. Monitor situation. | <ul style="list-style-type: none"> Monitor situation, obtain intelligence reports and advice from the MoH. Advise all staff, services and service providers of the event Liaise with MoH regarding media statements. Review local and regional HEPs Prepare to activate plans. Liaises with other agencies in the region. |
| STANDBY Yellow | <ul style="list-style-type: none"> Issue code yellow Identify and appoint national IMT May activate a national incident on EMIS Assesses requirement to activate NHCC Determines and communicates strategic actions for response Identifies and activates national TAG(s) Advises the health sector of the situation via the SPOC system Liaison with other | <ul style="list-style-type: none"> Monitor situation via EMIS. Prepare to or activate the NRHCC Note: In some circumstances a single regional coordination team may be activated without the NHEP moving to the Red phase. This may occur when a health related emergency is localised and likely to remain so, or when the MoH considers activation of | <ul style="list-style-type: none"> Prepare to activate DHB EOCs Prepare to activate DHB IMTs Prepares to activate regional coordination. Advise and prepare staff, services and service providers. Manage liaison with local agencies. Monitor situation and liaise with the MoH Prepare to activate CBACs and tele-triage Note: In certain types of |

| Phase/ Alert Code | National Responsibility | Regional Responsibility | Local Responsibility |
|---------------------------------------|--|--|--|
| | <p>government agencies</p> <ul style="list-style-type: none"> Liaison with international agencies. | the NHEP is not required. | emergency PHUs may activate whilst clinical services remain on standby to mount a clinical response |
| <p>ACTIVATION</p> <p>Red</p> | <ul style="list-style-type: none"> Issue code red; then communicate via the four regional co-ordinators Activate a national incident on EMIS Co-ordinates national health response Activate the NHCC as required Monitor situation, revise and communicate strategic actions for response Approve/direct distribution of reserve supplies Consider strategic recovery issues Provide clinical and public health advice Co-ordinate national public information management activities Manage liaison with government agencies Manage liaison with international agencies Implement recovery planning. | <ul style="list-style-type: none"> Activates the Northern Region Health Coordination and identifies a regional Incident Controller. Coordinates the northern region health response. Liaison between the MoH, and northern DHBs and other agencies' regional emergency structures. Monitor EMIS •Coordinates intelligence gathering and tasking in the northern region. | <ul style="list-style-type: none"> Activate DHB EOCs Activate DHB IMTs Manage DHB primary, secondary and PHU response. Liaise with other agencies at local level. Activate CBACs and tele-triage as necessary. Provide NRHCC with DHB / community health intelligence. |
| <p>STAND-DOWN</p> <p>Green</p> | <ul style="list-style-type: none"> Issue code green Advise government / international agencies of stand- down Advise media and public Stands down MoH IMT and NHCC Focus activities on national health sector recovery issues Implements recovery plan in conjunction with other agencies Manage national health debrief / review plans | <ul style="list-style-type: none"> Stands down the NRHCC Participates and/or organise regional debriefings. Review the management of the incident and update the regional relevant plans. | <ul style="list-style-type: none"> Stands down DHB EOC Stands down DHB IMT Focuses activities on health recovery issues in the DHB region. Facilitates debriefs. Provides Ministry information following debriefs. Updates plans. |

Appendix 11 from NHEP 2015: Position statement on infant feeding in an emergency for babies aged 0– 12 months¹

This position statement aligns New Zealand's emergency preparedness and response with international obligations and best practice for feeding babies in an emergency.

Summary

Breastfeeding provides the best possible nutrition for babies and is the safest way to feed babies in an emergency, especially if clean water and electricity are not available.

Where babies are not fed breast milk, a properly prepared, commercial infant formula is the only safe alternative.

Cows' milk should not be given as a drink to babies less than 12 months of age.

Parents and caregivers are encouraged to have emergency supplies to last at least three days.

Breastfeeding in an emergency

Health practitioners and emergency responders will:

encourage women who are breastfeeding to continue breastfeeding as normal

recognise that relactation is an option for women who have recently stopped breastfeeding,² providing the women can access a health professional to help

not distribute infant formula products to breastfeeding mothers

be aware that, if possible:

babies should be fed only breast milk until around six months of age

breastfeeding should continue once complementary foods have been introduced until at least one year of age, or beyond.

More comprehensive information on preparing for an emergency and feeding your baby in an emergency is available in Consumer Resource: Feeding Your Baby during an Emergency (for babies aged 0–12 months) available on the Ministry of Health website (<http://www.health.govt.nz/your-health/healthy-living/emergency-management/feeding-your-baby-during-emergency>).

As a general guide, 'recently' means women who have stopped breastfeeding within the last three weeks or so.

Formula feeding in an emergency

Health practitioners and emergency responders will:

where possible, support families to purchase, safely prepare and use their own supplies of infant formula

only distribute infant formula, feeding equipment and other essential feeding supplies:
to people who need it

that have been provided on behalf of the relevant Civil Defence Controller³ and in accordance with the Controller's assessment of the emergency situation

ensure that follow-on formula and toddler milks are not given to babies under the age of six months.⁴

Supply of infant formula in an emergency

Agencies, health practitioners and emergency responders will:

decline, and not seek out, donations of infant formula, follow-on formula and toddler milks but use only infant formula that has been sourced and distributed on behalf of the relevant Civil Defence Controller and in accordance with the Controller's assessment of the emergency situation

follow Civil Defence donated goods management procedures and suggest that donations of money be made to the emergency relief effort instead of goods

not distribute unsolicited donations of infant formula, follow-on formula and toddler milks but return or remove it, in conjunction with the designated district health board emergency response point-of-contact.

Contacts

Parents and caregivers needing advice on breastfeeding and formula feeding in an emergency can contact:

their lead maternity carer, Well Child/Tamariki Ora provider, lactation consultant or registered dietitian

Plunketline on 0800 933 922 or Healthline on 0800 611 116

the Civil Defence staff / Civil Defence centre to find out which health services are available.

Parents and caregivers needing infant formula, feeding equipment and clean water and who cannot purchase these items in the usual way can contact Civil Defence staff operating in their area or go to their local Civil Defence Centre.

If a baby has special dietary/nutritional needs for medical reasons, contact the nearest hospital or health service.

Civil Defence Emergency Management staff seeking advice on infant feeding in an emergency should contact their local district health board emergency response point-of-contact in the first instance.

Means the person who is the National Controller, in accordance with section 10 of the Civil Defence Emergency Management Act 2002, or a Group Controller appointed under section 26 of that Act.

The Ministry of Health does not recommend follow-on formula and toddler milks. After 12 months of age, babies can be fed whole (dark blue) cows' milk as a drink.

Appendix 7: Risk Analysis – Hazards and their consequences for the health and disability sector

| Hazard | Impact on health facilities and services | Community impacts – response and recovery |
|--|---|--|
| Earthquakes | Damage to facilities and/or critical infrastructure Transportation disruption to supply chain Impact on staff and families (physical, social, homes, transport, etc) Scale: Widespread, local to regional | Death and injury (crush, fractures, lacerations, burns, abrasions, particulate inhalation) Psychosocial impacts Low risk for infectious disease from endemic pathogens Economic impacts |
| Volcanic hazards | Damage to facilities and/or critical infrastructure (within eruption and associated quake zones) Ash impacts on water supplies, air quality, air-conditioning and facilities Loss of staff (self-evacuating) Transportation disruption to supply chain Scale: Local to regional | Illness (respiratory symptoms, exacerbations of pre-existing lung and heart disease) Potential chronic conditions due to environmental contamination Psychosocial impacts Economic impacts |
| Landslides | Damage to facilities and/or critical infrastructure (in slip zone) Transportation disruption to supply chain Scale: Site to area | Injury Psychosocial impacts Economic impacts |
| Tsunami | Damage to facilities and/or critical infrastructure (in low-lying areas) Impact on staff and families (physical, social, homes, transport, etc.) Transportation disruption to supply chain Scale: Local to regional | Death and injury (drowning, serious crush, fractures, lacerations, wound infection) Psychosocial impacts Economic impacts Contamination of environment, water supplies, infrastructure, etc. |
| Coastal hazards (e.g., storm surge and erosion) | Inundation of health services, staff homes, etc., in low-lying areas Access to premises/site compromised or denied Scale: Site to local | Death and injury due mainly to storm surge (drowning, serious crush, fractures, lacerations, wound infection) Contamination of environment, water supplies, infrastructure, etc. Psychosocial impacts Economic impacts |
| Floods | Damage to facilities and/or critical infrastructure (in low-lying areas) Loss/contamination of essential drugs and supplies Isolation of services, staff, patients and/or communities Loss of staff/health workers Water supplies contaminated and/or reduced Transportation disruption to supply chain Scale: Area to regional | Death and injury (from drowning, electrocutions or physical trauma) Illness (due to drinking-water contamination, wound infection, respiratory and dermatological symptoms due to mould growth) Low risk of communicable disease outbreak usually associated with heavy population displacement Psychosocial impacts Economic impacts Evacuation-related health risks |
| Severe winds | Damage to facilities and/or critical infrastructure Transportation disruption to supply chain Scale: Generally local | Injury (vehicle accidents, slips and falls) Hypothermia |
| Snow | Damage to facilities and/or critical infrastructure (due to snow-loading) Isolation of services, staff, patients and/or communities Scale: Local to regional | Injury (vehicle accidents, slips and falls) Hypothermia |

| Hazard | Impact on health facilities and services | Community impacts – response and recovery |
|---|--|---|
| Drought | Water supplies reduced Scale: Regional | Illness (airborne and dust-related respiratory symptoms) Infectious disease (related to population displacement, vulnerable populations, drought-related behaviours such as reduction in hand hygiene practices) Psychosocial impacts (especially those whose livelihoods depend on rainfall) |
| Wildfire | Damage to facilities and/or critical infrastructure (in at-risk areas) Transportation disruption to supply chain Scale: Local | Death and injury (burns, smoke inhalation, eye injuries) Psychosocial impacts Economic impacts Evacuation-related health risks |
| Animal and plant pests and disease | Isolation of services, staff, patients and/or communities Scale: Local to regional | Illness Injuries (culling/disposal) Communities isolated |
| Human disease pandemic (including water-borne illnesses) | Health impacts to staff Impact on staff and families (physical, social, homes, transport, etc.) Critical services compromised Border control and quarantine Scale: Regional, national or international | Death Illness Psychological impacts Communities isolated |
| Infrastructure failure | Critical services compromised Information security compromised Communication impacted Transportation disruption to supply chain Scale: Site to local | Economic impacts Loss of public confidence Loss of confidential information Illness/injury (due to disruption to access to water, heating, power) |
| Hazardous substance incidents | Health impacts/injuries to responders and/or health workers Scale: Site to local | Injury and illness (respiratory, eye and skin symptoms; genotoxic effects; endocrine abnormalities; headache; nausea; dizziness; and tiredness or fatigue) Chronic respiratory disorders Psychosocial impacts Economic impacts Environmental contamination |
| Major transport accidents | Damage to or contamination of facilities and/or critical infrastructure Access to site compromised Patient transport compromised Impact of managing mass casualties on clinical staff and services Scale: Site to area | Death and injury (impact, trauma, burns, hazardous substances) |
| Terrorism | Damage to or contamination of facilities and/or critical infrastructure Critical services compromised Health impacts/injuries to health responders Scale: Site to area Impact of managing mass casualties on clinical staff and services | Death and injury (blast, lacerations, crushing, contamination – chemical, biological, radiological and nuclear) Illness (respiratory symptoms, including loss of pulmonary function) Psychosocial impacts |

| Hazard | Impact on health facilities and services | Community impacts – response and recovery |
|---|--|---|
| | Scale: Site to area | |
| Food safety (e.g., accidental or deliberate contamination) | Health service catering contamination Loss of staff/health workers Food Act 2014 officer investigations Scale: Multi-site with regional/national implications | Illness (due to contamination) |
| Extreme weather incidents (heat or cold) | Critical infrastructure compromised Scale: Local to regional | Death and illness (respiratory symptoms, exacerbation of pre-existing lung and heart disease) Heat exhaustion Hypothermia |

