Authorisation
The Chief Executive Officer of Hutt Valley DHB supports the Emergency Management activities detailed within this plan:

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Executive summary

The Operational Policy Framework from the Ministry of Health (MoH) requires every District Health Board to have a Health Emergency Plan (HEP). The HEP has been developed to provide procedures and guidelines to respond and recovery from an emergency. Preparedness is a primary consideration in emergency management planning, particularly where the safety and security of patient, staff, contractors and visitors is a priority.

This document uses a comprehensive, risk-based approach to emergency management intended to improve the understanding of the risk context we operate within and the development of mitigation strategies to reduce risks. Expectations of the Ministry of Health and Civil Defence Emergency Management on Hutt Valley District Health Board (HVDHB) in relation to roles and responsibilities within the readiness, response and recovery phases are also described. The overarching goal of the DHB is to continue delivering health services and respond effectively to a health or civil emergency.

The HEP outlines the existing structures developed to provide a coordinated response with appropriate use of finite resources to ensure the emergency is dealt with and that critical service delivery is not interrupted. HVDHB works in partnership with local and regional health and disability sector and Civil Defence agencies including the following:

- Wellington Region Civil Defence Coordinating Executive Group
- Central Region Health Emergency Managers Group
- Greater Wellington Health Services Group
- Hutt Valley Emergency Services Coordinating Committee
Plan development and review

This edition of the Hutt Valley District Health Board (HVDHB) Health Emergency Plan has been revised and updated to reflect current thinking on the health aspects of emergency management in New Zealand and internationally. It reflects the sophistication of a second-generation, risk-based plan.

The plan was developed in consultation with local emergency managers and planners in the health and disability sector, and other key stakeholders.

To maintain its alignment with the National Health Emergency Plan, the HVDHB Health Emergency Plan will be reviewed and updated as required following any new developments or substantial changes to the operations or organisation of the health and disability services, as a result of lessons identified from a significant emergency affecting the health of communities or the health and disability sector itself or if new hazards and risks are identified.

The plan is to be read in conjunction with DHB policies, the New Zealand Coordinated Incident Management Systems (CIMS) manual and other health related manuals.
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**Introduction**

An emergency is a situation that poses an immediate risk to life, health, property, or the environment that requires a coordinated response.

By their very nature, emergencies have consequences that are difficult to predict. They can happen anywhere, at any time, with little or no warning. An emergency can vary in scope, intensity and impact. However, we can ensure that we have an adequate understanding of the nature of hazards our communities, health services and partner organisations face and that we are all as prepared for them as possible. We all have a role to play in building resilience to hazards and reducing vulnerabilities before, during and after emergencies.

An emergency can affect access to health services and the health and disability sector’s ability to respond to the public’s health needs. The greater the complexity, impact and geographic scope of an emergency, the more multi-agency coordination will be required. To prevent, prepare for, respond to and recover from such emergencies, a whole-of-sector approach is needed which combines expertise and capabilities at all levels across all agencies.

Emergency preparedness is progressive, continuously moving public agencies towards greater resilience. This on-going process requires careful planning, designing of agile response structures, testing and evaluation of processes and updating of plans.

**Purpose and objectives**

The purpose of this plan, and its supporting sub-plans and associated documents, is to ensure that HVDHB is positioned to effectively meet the health needs of the community during an emergency in an appropriate and sustainable manner. The plan will provide a resource to assist in the response to an emergency, minimise the impacts of the emergency on the health of individuals and the community, facilitate the recovery process and help to build a resilient community and health and disability sector. This plan is about understanding the nature of risks and hazards, building resilience and reducing vulnerabilities. The plan provides a framework that HVDHB can use to inform planning to meet expected capacity in these circumstances.

The HVDHB Health Emergency Plan objectives are to:

- create the strategic framework to guide our approach to planning for, responding to and recovering from health-related risks and consequences of significant hazards regionally and nationally
- clarify how the DHB fits within the health and disability sector in the context of emergency management
- support civil defence and other organisations with contextual information on the health and disability sector’s emergency management response structure

**Context**

The Civil Defence Emergency Management Act 2002 (and amendments) and National CDEM Plan Order (2015) outlines the roles and responsibilities of key agencies, including The Director General and the Ministry of Health, District Health Boards, Public Health Units, Land and Air Ambulance providers and Health and Disability service providers, in an emergency. A
range of supporting and enabling legislation provides the legislative framework for health emergency management planning. This legislation includes but is not limited to the following:

- Health (Burial) Regulations 1946
- Health Act 1956
- Health (Infectious and Notifiable Diseases) Regulations 1966
- Medicines Act 1981
- Health (Quarantine) Regulations 1983
- Hazardous Substances and New Organisms Act 1996
- New Zealand Public Health and Disability Act 2000
- Civil Defence Emergency Management Act 2002
- Health Practitioners Competence Assurance Act 2003
- International Health Regulations 2005
- Epidemic Preparedness Act 2006

In 2004, in response to the threat of the severe acute respiratory syndrome (SARS) virus, the Ministry of Health produced the original National Health Emergency Plan: Infectious Diseases (Ministry of Health 2004). Since then the Ministry has published a series of documents related to emergency management to guide the health and disability sector.

The National Health Emergency Plan provides the overall strategic framework and is underpinned by specific sub-plans. These specific sub plans help assist the DHB develop appropriate regional and local plans. Figure 1. Illustrates the relationship between DHB, regional and national planning.

Figure 1: Plan relationship at a local, regional and national level
Guiding principles

The guiding principles for HVDHB to effectively manage the health-related risks and consequences of significant hazards are listed below.

1. **Comprehensive approach**: Encompass all hazards and associated risks, and inform and enable a range of risk treatments concerned with reduction, readiness, response and recovery.

2. **Integrated all agencies approach**: Develop and maintain effective relationships among individuals and organisations, both in the health and disability sector and with partners, to enhance collaborative planning and operational management activities at all levels (local, regional and national).

3. **Stakeholder engagement**: Facilitate stakeholder input to and understanding of the full spectrum of risk identification, reduction, readiness, response and recovery activities and arrangements.

4. **Hazard risk management**: Take a contemporary all-hazards approach based on sound risk management principles (hazard identification, risk analysis and impact analysis).

5. **Health wellness and safety**: Maintain an emergency management structure that supports, to the greatest extent possible, the protection of all health workers, health and disability service consumers and the population at large.

6. **Health equity**: Establish, maintain, develop and support services that are best able to meet the needs of patients/clients and communities during and after an emergency, even when resources are limited, and ensure that special provisions are made for vulnerable people and hard-to-reach communities so that emergency responses do not create or exacerbate inequalities.

7. **Continuous improvement**: Undertake continuous improvement, through on-going monitoring and review, updating capabilities, plans and arrangements using an evidence-based approach. Continuous improvement incorporates education, professional development, exercising, post-operational debrief, review, evaluation and ethical practice.

Scope

The plan incorporates National, Regional and Local planning and information to identify potential gaps in the planning; it encompasses all sectors including:

- Provider Arm
- Community
- Support Services
Hazard risk analysis

Hazardscape

Every health provider has an obligation to understand both the hazards and the risks it faces. In understanding these risks, an organisation can make informed decisions about how to manage risk and develop needed capabilities; if it knows the origins of risk, it is better able to identify ways of reducing that risk; and if it can calculate a value for risk, the service can more easily set priorities for reducing risk.

At the national level, the National Hazardscape Report, published by the Officials’ Committee for Domestic and External Security Coordination (ODESC 2007), identifies and considers the range of natural and artificial hazards that have relevance to New Zealand from national and regional perspectives. The report identifies the following 17 types of hazards, all of which have the potential to cause emergencies that require coordination or management at a regional or national level:

- earthquakes
- volcanic hazards
- landslides
- tsunami
- coastal hazards (for example, storm surge and coastal erosion)
- floods
- severe winds
- snow
- droughts
- wildfires
- animal and plant pests and disease
- infectious human disease pandemics (including water-borne illnesses)
- infrastructure failure
- hazardous substance incidents (including chemical, biological and radiological)
- major transport accidents (air, land and water)
- terrorism
- food safety (for example, accidental or deliberate contamination of food)

These hazards require management by Civil Defence Emergency Management (CDEM) Groups.

Risk analysis and hazard prioritisation

Table 1 details an outline analysis of these hazards identifying a range of risk and consequences for the health and disability sector. These hazards were prioritised by Wellington CDEM Group; this risk rating has been applied to Table 1.
<table>
<thead>
<tr>
<th>Hazard</th>
<th>Risk Rating</th>
<th>Impact on health facilities and services</th>
<th>Community impacts – response and recovery</th>
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</table>
| Earthquakes                    | Very High   | 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 |
| Floods                         | High        | 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 |
| Human disease pandemic         | High        | 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  
Psychosocial impacts  
Communities isolated |
| Human disease pandemic (including water-borne illnesses) | High        | 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. |
<table>
<thead>
<tr>
<th>Hazard</th>
<th>Risk Rating</th>
<th>Impact on health facilities and services</th>
<th>Community impacts – response and recovery</th>
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<tbody>
<tr>
<td>Landslides</td>
<td>High</td>
<td>Damage to facilities and/or critical infrastructure (in slip zone)</td>
<td>Death and injury</td>
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<td></td>
<td></td>
<td>Transportation disruption to supply chain</td>
<td>Psychosocial impacts</td>
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<tr>
<td></td>
<td></td>
<td>Scale: Site to area</td>
<td>Economic impacts</td>
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<tr>
<td>Drought</td>
<td>Moderate</td>
<td>Water supplies reduced</td>
<td>Illness (airborne and dust-related respiratory symptoms)</td>
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<td></td>
<td>Scale: Regional</td>
<td>Infectious disease (related to population displacement, vulnerable populations, drought-related behaviours such as reduction in hand hygiene practices)</td>
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<td></td>
<td></td>
<td>Psychosocial impacts (especially those whose livelihoods depend on rainfall)</td>
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<tr>
<td>Animal and plant pests and disease</td>
<td>Moderate</td>
<td>Isolation of services, staff, patients and/or communities</td>
<td>Illness</td>
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<tr>
<td></td>
<td></td>
<td>Scale: Local to regional</td>
<td>Injuries (culling/disposal)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Communities isolated</td>
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<tr>
<td>Severe winds</td>
<td>Moderate</td>
<td>Damage to facilities and/or critical infrastructure</td>
<td>Death and injury (debris, vehicle accidents, electrocutions)</td>
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<td>Transportation disruption to supply chain</td>
<td>Psychosocial impacts</td>
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<td>Scale: Generally local</td>
<td>Economic impacts</td>
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<tr>
<td>Terrorism</td>
<td>Moderate</td>
<td>Damage to or contamination of facilities and/or critical infrastructure</td>
<td>Death and injury (blast, lacerations, crushing, contamination – chemical, biological, radiological and nuclear)</td>
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<td></td>
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<td>Critical services compromised</td>
<td>Illness (respiratory symptoms, including loss of pulmonary function)</td>
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<td>Health impacts/injuries to health responders</td>
<td>Psychosocial impacts</td>
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<td></td>
<td></td>
<td>Impact of managing mass casualties on clinical staff and services</td>
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<td>Scale: Site to area</td>
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<tr>
<td>Wildfire</td>
<td>Low</td>
<td>Damage to facilities and/or critical infrastructure (in at-risk areas)</td>
<td>Death and injury (burns, smoke inhalation, eye injuries)</td>
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<td>Transportation disruption to supply chain</td>
<td>Psychosocial impacts</td>
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<td></td>
<td>Scale: Local</td>
<td>Economic impacts</td>
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<td>Evacuation-related health risks</td>
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<td>Hazard</td>
<td>Risk Rating</td>
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<td>Community impacts – response and recovery</td>
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<td>Infrastructure failure</td>
<td>Low</td>
<td>Critical services compromised&lt;br&gt;Information security compromised&lt;br&gt;Communication impacted&lt;br&gt;Transportation disruption to supply chain&lt;br&gt;Scale: Site to local</td>
<td>Economic impacts&lt;br&gt;Loss of public confidence&lt;br&gt;Loss of confidential information&lt;br&gt;Illness/injury (due to disruption to access to water, heating, power)</td>
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<td>Hazardous substance incidents</td>
<td>Low</td>
<td>Health impacts/injuries to responders and/or health workers&lt;br&gt;Scale: Site to local</td>
<td>Injury and illness (respiratory, eye and skin symptoms; genotoxic effects; endocrine abnormalities; headache; nausea; dizziness; and tiredness or fatigue)&lt;br&gt;Chronic respiratory disorders&lt;br&gt;Psychosocial impacts&lt;br&gt;Economic impacts&lt;br&gt;Environmental contamination</td>
</tr>
<tr>
<td>Major transport accidents</td>
<td>Low</td>
<td>Damage to or contamination of facilities and/or critical infrastructure&lt;br&gt;Access to site compromised&lt;br&gt;Patient transport compromised&lt;br&gt;Impact of managing mass casualties on clinical staff and services&lt;br&gt;Scale: Site to area</td>
<td>Death and injury (impact, trauma, burns, hazardous substances)&lt;br&gt;Psychosocial impacts&lt;br&gt;Economic impacts</td>
</tr>
<tr>
<td>Volcanic hazards</td>
<td>Very Low</td>
<td>Damage to facilities and/or critical infrastructure (within eruption and associated quake zones)&lt;br&gt;Ash impacts on water supplies, air quality, air-conditioning and facilities&lt;br&gt;Loss of staff (self-evacuating)&lt;br&gt;Transportation disruption to supply chain&lt;br&gt;Scale: Local to regional</td>
<td>Illness (respiratory symptoms, exacerbations of pre-existing lung and heart disease)&lt;br&gt;Potential chronic conditions due to environmental contamination&lt;br&gt;Psychosocial impacts&lt;br&gt;Economic impacts</td>
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The 4Rs

The New Zealand integrated approach to emergency management can be described by the four areas of activity, known as the ‘4Rs’. They are:

**Reduction**: identifying risks to human health and property from hazards and taking steps to eliminate these risks if practicable or, if elimination is not practicable, reducing the magnitude of their impact and the likelihood of their occurring

**Readiness**: developing operational systems and capabilities before an emergency happens, including self-help and response programmes for communities and specific programmes for emergency services, lifeline utilities and other agencies

**Response**: actions taken immediately before, during or directly after an emergency to save lives and protect property, and to help communities recover

**Recovery**: the coordinated efforts and processes used to bring about the immediate, medium-term and long-term holistic regeneration of a community following an emergency

Health and Disability Sector Roles and Responsibilities

The MoH have developed roles and responsibilities in readiness and reduction; detailed in Appendix 1 and response and recovery, detailed in Appendix 2 for the following:

- Ministry of Health
- healthAlliance (FPSC) Ltd
- DHBs
- Public health units
- Land and air ambulance providers
- Community and private providers
Reduction

The objective of reduction is to avoid or mitigate adverse consequences before they occur and to realise the sustainable benefits of managing risks at acceptable levels

Risk reduction activities

Internal risk management
The organisation has adopted the International AS/NZS ISO 31000:2009 standard for Risk Management as detailed in the following documents:
- Hutt Valley DHB Risk Management and Reporting Procedure (2011)

Contingency plans have been developed at a service level and supported by the DHB Business Continuity Plan.

External risk management
HVDHB is a member of the following Civil Defence Emergency Management Groups and Health Sector Groups:

Wellington Region Civil Defence Coordinating Executive Group
Is made up of chief executives of the Wellington Region Group and provides advice to the CDEM Group Joint Committee and implements their decisions, overseeing implementation, development, maintenance, monitoring and evaluation of the CDEM Group Plan

Greater Wellington Health Services Group
Emergency management leads from the three DHBs, Regional Public Health, Primary Health Organisations, Ambulance Service and the Regional MoH representative meet monthly to achieve a consistent approach to emergency management across the sub region.

Central Region Health Emergency Managers Group
Chaired by the MoH Regional Emergency Management Advisor, Emergency Management leads from the health sector meet biannually to achieve a consistent approach to emergency management across the region.

Regional Inter Agency Planning Committee
Chaired by Wellington Region Emergency Management Office (WREMO), leads from Emergency Services and partner agencies meet quarterly to ensure appropriate relationships are maintained, consider options and scenarios to test response capacity and capability and to maintain awareness of agency roles

Regional Welfare Coordination Group
Chaired by WREMO, representatives from agencies with roles and responsibilities in the delivery of welfare services post emergency meet to ensure that welfare service delivery is planned, organised, integrated and coordinated.

Hutt Valley Emergency Services Coordinating Committee
Chaired by New Zealand Police, local emergency services discuss and plan for operational arrangements, to build and strengthen relationships. Representatives from Regional Public Health and Te Awakairangi Health Network also attend.
Readiness

The objective of emergency readiness is to build the capacity and capability of Hutt Valley DHB to respond to emergencies and to assist the recovery of the community and health services from the consequences of those emergencies.

Introduction
Readiness involves developing operational systems and capabilities before an emergency occurs, based on sound risk management principles. Another aspect of readiness is to use public education and community engagement programmes to promote resilient communities.

New Zealand’s health and disability sector and its communities have finite capacity and capability to respond to and recover from impacts on community health and the health services themselves. Building and maintaining capacity and capability for emergency health response and recovery requires on-going processes to identify and address significant gaps and shortfalls. The Ministry of Health provides funding to DHBs to support and enhance emergency management preparedness and response. Further details are provided in Appendix 3.

If they are to function to the fullest possible extent, even at a reduced level, during and after an emergency, and to contribute to response and recovery, all health providers must take steps to identify and address issues specifically related to their capability and capacity. On-going readiness activities include:

- planning, training, exercising and testing of arrangements
- monitoring and evaluating capacity and capability to perform across different emergency situations
- establishing and maintaining necessary equipment and operational systems, including addressing any need for interoperability and coordination with interdependent agencies

Development of plans
All DHB funded primary health providers must have plans and resources in place to ensure that their emergency response is integrated, coordinated and exercised with the DHB Health Emergency Plan.

Exercising and testing of plans
Planning for emergencies cannot be considered reliable until it is exercised and has proved to be workable, especially since false confidence may be placed in the integrity of a written plan. Hutt Valley DHB will engage in regional and NHEP exercises as required by the regional group or by the Ministry, and will fully participate in all national Tier 4 exercises. Exercises will include tests of single points of contact communications at various times of the day and night.

The exercise schedule will include DHB funded ambulance; primary, secondary, tertiary, mental health, disability support and public health providers, and other DHB service providers. The DHB will advise the Ministry of Health of the HEP sections or sections to be
exercised, and of the exercise dates and times. Appendix 4 details the DHB training and exercise schedule.

**Planning considerations**
Hutt Valley DHB will include the following factors to facilitate effective planning:

- Ethical values underpinning decision making
- Inter DHB coordination and support
- Whole of community services
- Human resources and staffing
- Organisational debriefing
- Professional development
- Managing emergency volunteers
- Infant feeding
- Visitors and dependants
- Mass casualty
- Mass evacuation
- Evacuation of health care facilities
- Management of the deceased
- Quarantine and border health plans
- Mass prophylaxis
- National reserve supplies

**Capability development and monitoring**
Effective delivery of emergency management across all agencies depends on building and maintaining effective human resource and technology capabilities. A common framework of competencies, supported by education, training and exercise standards and accredited programmes, underpins professional development for emergency response and recovery roles.

The DHB will develop, maintain and annually assess its level of capability centred on the following components:

- Capability development activities for staff who are involved in emergency management and response
- Professional development
- National, regional and local exercising programme
- Exercising and testing activities
Response

The objective of the DHB is to provide health services during emergencies to minimise the impacts of the emergency on the health of individual and the community

Threshold for activation
Local, regional or National HEPs are activated when resources are overwhelmed or have the potential to be overwhelmed.

Response to a health emergency
In a health related emergency i.e. pandemic, the Ministry of Health is 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 Ministry is to coordinate the operational emergency response.

Standby
Intelligence received of an imminent threat/situation will afford the opportunity to risk assess and declare a standby phase.

Activating a response
Due to the potential interruption to normal service delivery, the decision to activate significant aspects of emergency health response and coordination capabilities should be made by executive managers or other senior personnel with delegated authority to do so. Appendix 5 details the Hutt Valley DHB incident response activation process.

A key aspect of all responses is to communicate any changes in the level of activation and share information on the hazard, impact and response within health services and with partner agencies and recovery organisations.

DHBs are required to notify the Ministry of Health of any activation where the Emergency Operations Centre (EOC) is established to manage an event. Notification can be made through normal reporting mechanisms, or if the event is out of hours through the Ministry’s emergency 0800 number. This will enable the appropriate levels of support to be provided to the affected DHB(s) if required.

Advisories and Warnings
MoH Single Point of Contact
The Ministry of Health and each DHB and public health unit maintain a single point of contact (SPOC) system that is available on a 24-hour, 7-days-a-week basis. The SPOC system is an integral part of health and disability sector coordination for emergency management, especially for those with a role focused on response. The purpose of the system is to enable effective and rapid communications between senior Ministry of Health officials, DHBs and public health units at any time, via a dedicated SPOC email, to notify each other of a potential or actual emergency.

These are received by Duty Nurse Managers, assessed and escalated to Senior Management On Call as required. Appendix 6 provides details of all emergency management advisories and warnings received by HVDHB.
Alert Codes
The Ministry of Health has developed alert codes to provide an easily understood system of high-priority communication leading up to and during emergency response activations. These alert codes are issued from the Ministry via the SPOC system. The alert codes outlined in Table 2 are intended for use in relation to nationally led communication.

It is not necessary for all DHBs to be at equally corresponding levels of alert. The appropriate level will be determined by the impact and the ability for DHB(s) to respond or provide support for the response. For example, a single or group of DHBs may be in code red, while the remaining DHBs are in code yellow.

Table 2: Health and disability sector alert codes

<table>
<thead>
<tr>
<th>Phase</th>
<th>Measures</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information</td>
<td>Notification of a potential emergency that may impact in and/or on New Zealand or specific information important to the health and disability sector. Example: emergence of a new infectious disease with pandemic potential, or early warning of volcanic activity.</td>
<td>White</td>
</tr>
<tr>
<td>Standby</td>
<td>Warning of imminent code red alert that will require immediate activation of health emergency plans. Example: imported case of a new and highly infectious disease in New Zealand without local transmission, or initial reports of a major mass casualty incident within one area of New Zealand which may require assistance from unaffected DHBs.</td>
<td>Yellow</td>
</tr>
<tr>
<td>Activation</td>
<td>Major emergency in New Zealand exists that requires immediate activation of health emergency plans. Example: large-scale epidemic or pandemic or major mass casualty incident requiring assistance from unaffected DHBs.</td>
<td>Red</td>
</tr>
<tr>
<td>Stand-down</td>
<td>Deactivation of emergency response. Example: end of outbreak or epidemic. Recovery activities will continue.</td>
<td>Green</td>
</tr>
</tbody>
</table>

Emergency Ambulance Communication Centre Notification
St John notifies DHBs of an incident through a text alert and these are received and assessed by Duty Nurse Managers and escalated to Senior Management as required.

Roles and responsibilities by alert codes
The initial response for the management of an emergency is made by the affected provider which may be Hutt Valley DHB, or the Central Region DHB region group if support between DHBs is required. At each phase of the emergency there are actions that need to be taken at local, levels. Appendix 7 lists key DHB roles and responsibilities at each of these levels during each alert code.

The Ministry of Health’s alert codes should be read in conjunction with the five levels of response described in Appendix 8.
Structures and tools for response management

National Health Coordination Centre
The Ministry of Health established the National Health Coordination Centre (NHCC) as a structure through which the Ministry can nationally coordinate and manage the health responses to and recovery from emergencies. The centre is kept in a constant state of readiness for activation for a response to any emergency.

When the Ministry is the lead agency in a response, it may also use the National Crisis Management Centre (NCMC), maintained by Ministry of Civil Defence Emergency Management (MCDEM), depending on the extent of the response required. The Ministry of Health maintains alternative National Health Coordination Centre (NHCC) capabilities, depending on the needs of any particular emergency.

Central Region Health Co-ordination Centre
During a regional or national emergency, the Central Region Health Coordination Centre (CRHCC) may be established to co-ordinate and control the response and recovery phase. The location will be determined on the nature, type and location of the incident.

Hutt Valley DHB Emergency Operations Centre
The EOC is a structure through which the DHB can locally coordinate and manage an internal emergency or local health and disability sector response. The EOC can operate from a ‘virtual’ function to a fully activated response depending on the nature of the emergency.

The EOC primary location is in Emergency Department Training Room, Emergency Department Theatre Building. The EOC function can be delivered from other locations depending on the location and type of emergency.

Coordinated Incident Management System (CIMS)
The organisational structures, roles and processes used by the health and disability sector in its response to a national health-related emergency or to manage health aspects of any emergency are based on CIMS, tailored for use within the health context. CIMS provides a structure to allow and support the multiple agencies or units involved in an emergency to work together effectively and efficiently, see Figure 2.

Figure 2: Formal liaison structure for DHBs and other local response agencies
The application of CIMS does not detract from or replace the normal day-to-day vertical management and service delivery, and horizontal dependencies and collaboration, within DHBs and other health agencies. Rather, it incorporates management, dependencies and collaboration into a coordination model that goes beyond normal processes. Normal clinical, managerial and other relationships are maintained within units and agencies involved in a response. CIMS, as such, has no impact on the identity of individual services or the way they carry out their statutory responsibilities, although emergency management requirements may have implications for priorities and reporting lines. Appendix 8 sets out the CIMS structure for a national health emergency response assuming all regions are activated. Figure 3 provides an example of a CIMS structure that could be used at a local level depending on the type and scale of the emergency.

The CIMS organisational structure is built around the following major elements:

- **control** – coordinates and controls the response
- **intelligence** – collection, analysis and dissemination of incident information and intelligence related to the context
- **planning** – multi-function and multi-agency planning of response activities
- **operations** – multi-function and/or multi agency direction, coordination and supervision of response elements
- **logistics** – acquisition and management of facilities, services and materials to support response activities
- **public information management** – develops and delivers messages to the public, directly and through the media, and liaises with the community if required
- **welfare** – coordinates the delivery of emergency welfare services and resources to affected individuals, families, whanau and communities

Please note that this structure is flexible, positions can be added or removed as the situation dictates. If Hutt Valley DHB is part of a wider multi-agency response then we may need to create identify a liaison officer role. Role cards for the above CIMS positions are located at Appendix 10.

**Figure 3: CIMS Structure for a local response**
A suite of document templates developed to support CIMS e.g. situational report, action plan and incident response log are located in Appendices 11-13. These can be amended to fit the organisational response requirements based on the nature and type of incident.

**Health EMIS**

Health EMIS, the health and disability sector’s web-based ‘emergency management information system’, is the primary tool for managing significant incidents and emergencies at inter-DHB and national levels.

Health EMIS provides an electronic system to manage information produced during an incident or emergency. It does not replace verbal communications between agencies and service providers. It provides DHBs, public health units and other key health responders, such as ambulance services, with a logging and task-tracking system which they can use to manage their local response to an incident. The system complements other business-as-usual information systems.
Recovery

Recovery objectives include:

- minimising the escalation of the consequences of the emergency
- regenerating the emotional, social and physical wellbeing of individuals and communities
- taking opportunities to adapt to meet the future needs of the health services and communities
- reducing future exposure to hazards and their associated risks

Introduction

Recovery from an emergency is imperative and requires a co-ordinated approach from the DHB, the health and disability sector, partner agencies and communities depending upon the type and scale of the emergency. The recovery phase should begin at the earliest opportunity following the start of an emergency and should run in parallel with the response. The recovery phase does not end until all disruption has been rectified, demands on services have returned to normal levels and the physical and psychosocial needs of those involved have been met.

Recovery is not about returning to normality. It is more about regeneration; building back smarter, better, more sustainably and with more resilience. The post-emergency environment poses new challenges and opportunities to re-plan and perhaps even relocate.

Health services need to transition from the immediate response to longer-term recovery with partner agencies and affected communities.

Considerations for immediate and long-term community recovery can include:

- providing immediate health services to affected individuals and families
- assessing community health and psychosocial recovery needs and prioritising the actions required
- developing, implementing and monitoring the provision of community health recovery activities
- enabling communication with the vulnerable community and participation in decision-making
- adapting existing organisational structures and procedures in order to minimise the time needed to get post-disaster institutions functioning
- contributing to future mitigation needs or improvements to planning

A holistic framework is needed to consider the multi-faceted aspects of recovery that support the foundations of community sustainability. The framework used by MCDEM encompasses the community and its four environments (social, economic, natural and built), as illustrated in Figure 4.
Health agencies and service providers contribute to all four environments of recovery. As well as ensuring that services are accessible and sustainable, the health and disability sector must adjust to emerging requirements and changes in demand by reshaping services and models of care delivery.

Figure 4: Integrated + holistic recovery

Source: Focus on Recovery: A holistic framework for recovery in New Zealand, MCDEM (2005)

Roles and Responsibilities

DHB Recovery Coordinating Group Manager
The Incident Controller should appoint a senior staff member to fulfil this role; key responsibilities may include the following:

- Maintaining links with the Incident Controller and the Incident Management Team
- Overseeing development of a recovery strategy, that is approved by ELT
- Completing an impact assessment covering impact on staff, services, infrastructure, utilities, environment, community etc.
- Identifying health service recovery needs
- Determine risks and vulnerabilities that may impede the ability of health services to deliver essential services to the community
- Developing and implementing an action plan
- Locating suitable facilities for the Recovery Coordinating Group
- Determine membership and meeting frequency of the group (this will be based on the type and scale of the emergency)
- Liaising with local, regional or national recovery groups
• Implementing recovery reporting systems, including clear audit trails with comprehensive records of timings, notifications, decisions, actions and expenditure
• Requesting CEO approval to stand Recovery Coordinating Group down
• Commissioning a debrief to capture issues identified, including recommendations to be implemented, and planning assumptions to be reviewed

**Psychosocial recovery**
Hutt Valley DHB is responsible for coordinating the provision of psychosocial support following an emergency. The DHB will lead the wider local groups responsible for delivery of services that meet the psychosocial needs of a community after an emergency. The DHB will assign the role of Psychosocial Support Coordinator to a senior staff member to ensure that the DHB can deliver its responsibilities at the readiness, response and recovery phase. The DHB is represented on welfare coordination groups to provide advice, guidance and lead agency responsibilities for psychosocial recovery.

During an incident, the Psychosocial Support Coordinator reports to the CDEM Group Welfare Manager in the WREMO led Emergency Coordination Centre (ECC), and to the Director, Emergency Management at the Ministry of Health.

**Recovery structures and organisations**
The recovery structures implemented will be based on the type and scale of the emergency. The DHB will need to be appropriately represented in the relevant aspects of recovery management for their own communities, local areas or regions and could involve some or all of the following:

- Health and Disability sector
- Hutt City Council
- CDEM Group
- Central Government
- Communities

**Management and coordination of the recovery phase**

**Activation**
The Incident Controller in conjunction with the Chief Executive Officer or delegate will appoint a Recovery Coordinating Group Manager. A key duty of the Recovery Coordinating Group is to develop a recovery strategy, and also informing the Incident Management Team (IMT) of this strategy to ensure decisions made by the IMT do not compromise medium to long term recovery. The Recovery Coordinating Group reports into the IMT until the IMT stands down.

Membership of the Recovery Coordinating Group will be based on the type and scale of the emergency.

**Strategy of the Recovery Coordinating Group**
A clear recovery strategy should be developed and could cover some or all of the following objectives:

- Complete an impact assessment covering impact on services, communities, infrastructure, utilities, environment etc.
• Determine at an early stage if there is an opportunity for longer term regeneration as part of the recovery process
• Determine at an early stage if there is an opportunity to enhance the resilience of the affected area
• Develop a concise, balanced, affordable recovery action plan that can be quickly implemented, involving all relevant services, partner agencies and fits the needs of the emergency
• Restoration of utilities as soon as practicable
• Affected areas are restored to an agreed standard so that they are ‘suitable for use’ for their defined future purposes
• Information and media management of the recovery process is coordinated
• Targets/milestones for the recovery are established and agreed. Ensuring that affected services, communities and partner agencies are involved in establishing these targets where appropriate. These targets provide a means of measuring progress within the recovery process, and may assist in deciding when specific recovery activities can be scaled down

Handover from response to recovery phase
In order to ensure that services, partner agencies are aware of the implications and arrangements for handover from the response to recovery phase, a meeting should occur within a few days of the start of the emergency. Membership of this meeting should be as, a minimum, the CEO, Chief Financial Officer or their delegates, Incident Controller and Recovery Coordinating Group Manager, and should consider how:

• This is communicated within the DHB, partner agencies and communities
• Information collated as part of the response phase is effectively, efficiently and securely handed over to the Recovery Coordinating Group Manager

Location and operation of the Recovery Coordinating Group (RCG)
In the early part of the recovery phase when the RCG is running in parallel with the IMT, consider co-locating to facilitate communication and collaboration.

Frequency of RCG meetings will be determined by the group on a case-by-case basis. The need for accurate record keeping is of paramount importance. There needs to be a clear audit trail with comprehensive records of timings, notifications, decisions, actions and expenditure. Therefore it would beneficial to use the same information management system used in the response phase as the recovery phase.

Stand down of the Recovery Coordinating Group
The Recovery Coordination Manager in conjunction with group members will decide when it’s appropriate to stand down the Group, and seek approval from the CEO or their delegate.

Debriefing and identifying lessons to be learned
It is important to ensure that a continuous evaluation of the recovery phase takes place, and that lessons identified are captured and learned. The Incident Response Debriefing Procedure is located at Appendix 9.
### Appendix 1: Health and disability sector roles and responsibilities in readiness and reduction

| **Ministry of Health** | a. Develop, maintain and review policy.  
| b. Maintain the International Health Regulations National Focal Point.  
| c. Undertake national planning for health-related aspects of emergencies.  
| d. Develop, maintain and exercise the National Health Emergency Plan and supporting documents.  
| e. Maintain primary and alternative capabilities of the National Health Coordination Centre.  
| f. Maintain the Health Emergency Management Information System (Health EMIS) and related capability development, to support the health and disability sector in risk reduction, readiness, response and recovery.  
| g. Maintain and exercise a Ministry of Health business continuity management plan and capabilities.  
| h. Provide leadership and guidance to the health and disability sector for education, planning and national guidelines. |

| **healthAlliance (FPSC) Ltd** | a. Ensure processes are in place for national supply chain services for the health and disability sector to meet estimated surges in demand, through plans, contracts and capability development, professional development and exercises.  
| b. Ensure that entities involved in procurement and supply chains for DHBs have effective and exercised business continuity management plans and capabilities and that suppliers contracted by shared services or Pharmaceutical Management Agency Ltd (PHARMAC) have appropriate requirements for business continuity management within their contracts. |

| **DHBs** | a. Lead and coordinate local readiness planning and capability development activities across health service providers within their district.  
| b. Develop, maintain and exercise health emergency plans and more detailed response management procedures for emergencies affecting their district and in support of other districts.  
| c. Cooperate with neighbouring DHBs in developing and exercising inter-DHB, sub-regional, regional and national emergency management plans and capabilities:  
| i. as appropriate to identify how services will be delivered in an emergency  
| ii. acknowledging DHBs’ role as both funders and providers of health services.  
| These arrangements should include the provision of support directly or indirectly to other affected parts of the country.  
| d. Ensure that all their plans adequately provide for public, primary, secondary, tertiary, mental and disability health services, and vulnerable people.  
| e. Monitor health provider plans and resources to ensure that they can respond to emergencies in an integrated and effective manner.  
| f. Ensure that hospitals and health services are ready to function to the fullest possible extent during and after an emergency by preparing and exercising mutually supportive plans and capabilities that:  
| i. provide for continuity of care for existing patients, the management of increased demand for services, including the provision of surge capacity, and assistance with the recovery of services, including business continuity management  
| ii. are integrated across the sector and are aligned with the plans of the other emergency services and respective CDEM Group plans and other response agencies and with public health planning and responses.  
| g. Be represented on committees of CDEM Groups as required. |
### Public health units

a. Develop and maintain plans specific to public health emergencies.

b. Integrate public health planning and responses with comprehensive DHB emergency management planning, exercises and responses.

c. Cooperate with other PHUs in developing and exercising local, inter-unit, regional and national emergency management plans and capabilities:
   i. as appropriate to identify how services will be delivered in an emergency.

d. Advise local agencies and lifeline utilities about public health aspects of their business continuity management processes and activities.

e. Maintain liaison and coordination with DHB regional groups, CDEM Groups and other response agencies as required.

f. Contribute to emergency planning capability-building and exercises in conjunction with DHBs and the Ministry of Health, as required.

g. Maintain up-to-date epidemiological surveillance data.

### Land and air ambulance providers

a. Ensure the provision of continuity of care for existing patients, the management of increased demand for services, including the provision of surge capacity, and assistance with the recovery of services, including business continuity management.

b. Prepare and maintain incident and emergency management plans that are integrated across the ambulance sector and are aligned with the plans of the DHB, other emergency services and the regional group plans and with public health planning and responses.

c. Be represented on committees of DHB regional groups and CDEM Groups as required.

d. Contribute to emergency planning capability-building and exercises in conjunction with DHBs and the Ministry of Health, as required.

### Community and private providers

a. Ensure the provision of continuity of care for existing patients, the management of increased demand for services, including the provision of surge capacity, and assistance with the recovery of services, including business continuity management.

b. Prepare and maintain incident and emergency management plans that are integrated across the community-care sector and are aligned with the plans of the DHB, other emergency services and the regional group plan and with public health planning and responses.

c. Be represented on committees of DHB regional groups and CDEM Groups as required.

d. Contribute to emergency planning capability-building and exercises in conjunction with DHBs and the Ministry of Health, as required.
### Appendix 2: Health and disability sector roles and responsibilities in response and recovery

| Ministry of Health       | a. Monitor any developing emergencies.  
|                          | b. Activate the national health emergency response capabilities and process and the National Health Coordination Centre as appropriate.  
|                          | c. Coordinate and manage the health and disability sector response during and recovery from emergencies that have significant regional or national impacts.  
|                          | d. Coordinate health responses with those led by other national-level agencies, including the designated lead agency and relevant support agencies. (See more on the Ministry’s role as a support agency under ‘Lead and support agencies’.)  
|                          | e. Act as lead agency in an all-of-government response to a health emergency such as an epidemic or pandemic. (See more on the Ministry’s role in this capacity under ‘Lead and support agencies’.)  
|                          | f. Provide managed release of resources and support to New Zealand Medical Assistance Team deployments.  
| healthAlliance (FPSC) Ltd| a. Ensure that the shared services continue their delivery and manage any increased demand.  
|                          | b. Coordinate with the National Health Coordination Centre, DHBs and suppliers as required.  
| DHBs                     | a. Coordinate the local health and disability sector response to and recovery from emergencies. Ensure appropriate coordination of all health and disability service providers and close liaison with civil defence and recovery management at regional and local levels.  
|                          | b. Coordinate the provision of psychosocial support, specialist public health, mental health and addiction services and advise government and non-governmental organisations and primary health organisations on the type and nature of services needed for ongoing psychosocial support.  
|                          | c. Ensure that hospitals and health services are able to function to the fullest possible extent during and after an emergency.  
|                          | d. Continue their services and manage any increased demand.  
|                          | e. Reshape services and funding to meet changes in demand.  
| Public health units      | a. Maintain their services and manage any increased demand.  
|                          | b. Respond to emergencies involving risk to public health.  
|                          | c. Contribute to epidemiological surveillance and communicate information to the relevant emergency operations centre (EOC) and to the Ministry.  
|                          | d. Coordinate with local DHB EOCs if operating.  
|                          | e. Liaise with the CDEM Group or local EOC during an emergency.  
|                          | f. Coordinate public health initiatives during the recovery phase.  
| Land and air ambulance providers | a. Continue their services and manage any increased demand.  
|                              | b. Coordinate via local DHB EOCs, the National Ambulance Crisis Coordination Centre, the National Health Coordination Centre and other ambulance providers.  
| Community and private providers | a. Continue their services and manage any increased demand.  
|                               | b. Coordinate via local DHB EOCs.  

_Hutt Valley District Health Board, Health Emergency Plan, Issue 1.7 09/06/2017_
Appendix 3: Framework for funding during planning and response cycles

The Ministry of Health provides funding to all DHBs to support and enhance emergency management preparedness and response. This funding acknowledges each DHB’s population mix, tertiary loading and hazard complexity. Funding for an emergency is to be used to:

- provide for the development and maintenance of emergency plans
- ensure planning reaches beyond the hospital environment to encompass a response across the whole health and disability sector
- ensure the response links robustly with local services
- provide sustained and effective education and training on emergency management
- ensure the capacity of DHBs and the primary health sector can be fully used in an emergency response
- develop and maintain effective means of emergency communication with identified stakeholders.

The Ministry will be closely involved in Crown decisions on whether to provide DHBs with additional funding to cover the cost of additional services required during a health emergency response. In almost all cases, such services will be funded through existing pathways. All existing contracts contain provisions for variation of funding arrangements or additional funding, should this become necessary in exceptional circumstances, such as a major mass casualty incident or a pandemic.

DHB funding – Operational Policy Framework

The Operational Policy Framework (OPF) states that the DHB emergency management function is to be funded by sustainable funding provided for the purpose through the Crown Funding Agreement and other Ministry contracts, plus any additional DHB funds required to meet legislative and Ministry requirements relating to emergency planning and management.

Funding required to be met through the need to respond to an emergency will be covered by the DHB as per the OPF. If the funding exceeds 0.1 per cent of the DHB’s total population based funding, the Crown will determine on a case-by-case basis, and in consultation with the DHB, whether:

- the DHB is able to fund additional services purchased
- to provide the DHB with additional funding
- there will be any negative effects on the DHB’s baseline services.

An emergency response related to an epidemic, pandemic or accidental or deliberate mass casualty incident will be regarded as a ‘major incident’. All DHB planning should be undertaken with the above section of the OPF in mind.

Clearly, identifying what the 0.1 percent figure represents and tracking the emergency response-related expenses directly related to it will require comprehensive financial involvement within DHBs and the Ministry from the start of any emergency.

Detailed, realistic and fully completed accounts will be necessary to support any funding discussions between DHBs and the Crown. Normal practice during an emergency response will
be for a finance representative to be included in CIMS structures at national and local levels, who will track extraordinary costs incurred. It is strongly recommended that this involvement commence at the beginning of any emergency response.

All DHB-funded services are covered by the OPF. These include provider-arm services (personal and mental health), primary care services, laboratories, pharmacies and other referred services, public health units, and much of disability support services.

As part of primary or provider-arm services, an emergency response might require DHBs to establish special facilities or services, such as community-based assessment centres or staff vaccination programmes. These services are covered by this section.

The potential range and scope of DHB activities during an emergency response will require close financial monitoring. Section 25 of the Public Finance Act 1989 provides authority for the Minister of Finance to approve the incurring of expenses or capital expenditure necessary in the event of a defined emergency. Early notification by the Ministry of Health to the Treasury will help obtain rapid approval from the Minister of Finance in the event of such an emergency. The Ministry’s corporate finance staff should be contacted urgently if such emergency funding is required.

**Inter-district flows**

Clinically driven referrals and transfers between hospitals in different DHBs are part of normal day-to-day business, enabled by the inter-district flow (IDF) business rules for funding contained in the OPF. The standard IDF business rules provide for financial adjustments between DHBs if there are abnormal numbers of IDF referrals or transfers for any reason, for example, as a result of a mass casualty incident, disease epidemic or pandemic.

**Eligibility for publicly funded health and disability services**

The Health and Disability Services Eligibility Direction 2011 sets out the groups of people eligible for publicly funded health and disability services in New Zealand (available on the Ministry website at www.health.govt.nz/new-zealand-health-system/eligibility-publicly-funded-health-services). Later eligibility directions may supersede this document. Individual DHBs should apply their normal cost-recovery rules where treatment has been provided to people not eligible for publicly funded health and disability services in New Zealand, according to the current eligibility direction.
## Appendix 4: HVDHB Training and Exercise Schedule 2016/17

### 2016

<table>
<thead>
<tr>
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<tr>
<td>CIMS in Health</td>
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<tr>
<td>Date: 22 November</td>
<td></td>
</tr>
<tr>
<td>Trainees: 16 places</td>
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</tr>
<tr>
<td>Duration: 6 hours</td>
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<tr>
<td>Location: Hutt Hospital</td>
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<tr>
<td>Trainer: MoH Regional Emergency Management Advisor</td>
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<tr>
<td>Health EMIS</td>
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<td>Date: 20 October</td>
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<td>Trainees: Emergency planning leads from HVDHB/WDHB/RPH</td>
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<td>Trainer: MoH Regional Emergency Management Advisor</td>
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<tr>
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<tr>
<td>Single Point of Contact</td>
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<td>Date: November 10</td>
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<td>Coordinator: HVDHB</td>
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### 2017

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<td>CIMS in Health</td>
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<tr>
<td>Dates: Feb, Apr, Jun, Aug, Oct, Dec</td>
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<tr>
<td>Trainees: 16 places</td>
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<tr>
<td>Duration: 6 hours</td>
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<tr>
<td>Location: Hutt Hospital</td>
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<tr>
<td>Trainer: MoH Regional Emergency Management Advisor</td>
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<tr>
<td>Health EMIS</td>
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<tr>
<td>Date: TBC</td>
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<tr>
<td>Trainees: HVDHB staff</td>
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<tr>
<td>Duration: TBC</td>
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<tr>
<td>Trainer: Emergency Planning Manager</td>
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<td>Tier 4 National Pandemic</td>
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<td>Date: December</td>
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<td>Single Point of Contact</td>
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<tr>
<td>Dates: Mar, Jun, Sept, Dec</td>
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<tr>
<td>Duration: 1hr</td>
<td></td>
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<tr>
<td>Participants: Sub Regional Health Sector</td>
<td></td>
</tr>
</tbody>
</table>

| Discussion Based Scenarios |  |
| Dates: Feb, May, Aug, Dec |  |
| Duration: 1 hr |  |
| Participants: Those with a role in emergency response |  |
| Emergo Train |  |
| Dates: TBC |  |
| Duration: 1 day |  |
| Participants: Those with a role in emergency response |  |
Appendix 5: Incident Response Activation Process

1. Notify Duty Nurse Manager (DNM)
2. Actively Coordinate Incident Management System (CIMS) and Emergency Operations Centre
3. DNM Appointed Incident Controller

- Can DNM manage normal duties and incident control role?
  - Yes: Continue to manage incident
  - No: Notify senior management on call

- Incident escalates?
  - Yes: Notify senior manager on call appointed incident controller
  - No: Continue to manage incident

- Incident formally declared over by incident controller
## Appendix 6: Emergency Management Advisories and Warnings

### Ministry of Health (MoH)

**Sent by:** Email from MoH, National Health Coordination Centre nhep@moh.govt.nz  
**Received at HVDHB by:** eoc@huttvalleydhb.org.nz  
**Automatically forwarded to:** Duty Nurse Manager  
General Manager Quality, Service Improvement + Innovation  
Service Group Manager Medical + Acute Care  
Emergency Planning Manager  
**Information assessment + internal/external cascade by:**  
1) Initial assessment by Duty Nurse Manager  
2) If escalation or support required, liaise with Senior Management On Call

### St John

**Sent by:** Text from Emergency Ambulance Communication Centre 4068 or 4067  
**Received at HVDHB by:** Duty Nurse Manager  
Duty Nurse Manager  
General Manager Quality, Service Improvement + Innovation  
Service Group Manager Medical + Acute Care  
Emergency Planning Manager  
**Information assessment + internal/external cascade by:**  
1) Initial assessment by Duty Nurse Manager  
2) If escalation or support required, liaise with Senior Management On Call

### Regional Public Health - Health Alerts

**Sent by:** Email from Regional Public Health (variety of email accounts)  
**Received at HVDHB by:** Duty Nurse Manager  
Chief Medical Officer  
ED Clinical Nurse Manager  
Emergency Planning Manager  
Infection Prevention and Control Communications  
**Information assessment + internal/external cascade by:**  
1) Initial assessment by Duty Nurse Manager  
2) If escalation or support required, liaise with Senior Management On Call

### Ministry of Civil Defence + Emergency Management (MCDEM)

**Sent by:** Email from MCDEM National Crisis Management Centre  
National_warning_system@moh.govt.nz  
**Received at HVDHB by:** eoc@huttvalleydhb.org.nz  
**Automatically forwarded to:** Duty Nurse Manager  
General Manager Quality, Service Improvement + Innovation  
Service Group Manager Medical + Acute Care  
Emergency Planning Manager  
**Information assessment and internal/external cascade by:**  
1) Initial assessment by Duty Nurse Manager  
2) If escalation or support required, liaise with Senior Management On Call
### Appendix 7: DHB Roles by Ministry of Health Alert Codes

#### All alert phases

Coordinates and manages the health and disability sector’s response in its particular area  
Liaises with other agencies at the local level and within the region  
Provides the region and the Ministry with required information  
Activates inter-DHB response support and coordination as required  
Coordinates input and use of Health EMIS within health services

#### Information

**Information**

**Code White**

- Monitors situation and obtains intelligence reports and advice from the Ministry  
- Advises all relevant staff, services and service providers of the event and developing intelligence  
- Liaises with the Ministry regarding media statements  
- Reviews local and regional health emergency plans  
- Prepares to activate emergency plans  
- Liaises with other emergency management agencies within the region

**Standby**

**Code Yellow**

- Prepares to activate DHB emergency operations centre  
- Identifies need for and appoints DHB incident management team  
- Prepares to activate regional coordination  
- Advises and prepares all staff, services and service providers  
- Manages liaison with local agencies  
- Monitors local situation and liaises with the Ministry  
- Prepares to activate CBACs and teletriage as necessary  

**Activation**

**Code Red**

- Activates DHB emergency operations centre  
- Activates DHB incident management team  
- Manages DHB primary, secondary and public health service response  
- Liaises with other agencies at a district level  
- Activates CBACs and teletriage as necessary  
- Provides inter-DHB coordination with DHB/ community health intelligence  
- Activates inter-DHB response support and coordination as required  
- Notifies health providers of change of alert level and appoints a recovery manager

**Stand-down**

**Code Green**

- Stands down DHB emergency operations centre  
- Stands down DHB incident management team  
- Focuses activities on health recovery issues in the DHB region  
- Stands down inter-DHB coordination if appropriate  
- Facilitates debriefs  
- Provides Ministry with information following debriefs and updates plans
Appendix 8: Response, including health response, at five levels of incident or emergency

<table>
<thead>
<tr>
<th>Level of incident/emergency</th>
<th>Status and procedures</th>
<th>Health ECC/EOC roles</th>
<th>Health Controllers’ roles</th>
<th>NCMC operating mode</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1 Community</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Site incident:</td>
<td>Can be dealt with by community/emergency services and/or local authority resources alone. Specialists may be required for specific circumstances.</td>
<td>Communities, organisations and businesses self-respond to emergencies, either as part of official pre-existing arrangements or on their own in a spontaneous or emergent manner. Response agencies need to accommodate, link with, support and coordinate with community participation in response.</td>
<td>Hospital or health service EOCs Incident Management Teams may be alerted or be partially operative in support of the lead agency and to coordinate health resources and activities.</td>
<td>DHB Incident controller and Incident Management Team are notified if EOC is likely to be involved.</td>
</tr>
<tr>
<td><strong>2 Incident</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local/site multi-agency incident:</td>
<td>Can be dealt with by emergency services and/or local authority resources though remote support (Incident Control Point) is likely to be required. Specialists may be required for specific circumstances.</td>
<td>Incident level response is the first official level of multi-agency response and is carried out by first responders and the communities involved. A Civil Defence Declaration is made only if emergency powers are required, ie, response agencies cannot manage using their normal arrangements, or significant coordinated response is required.</td>
<td>Hospital or health services EOC is a key support agency. Lead agency EOC is partially or fully activated and coordinates agreed functions. CDEM Group and DHB EOC or emergency coordination centre (ECC) may be partially activated in a monitoring role.</td>
<td>DHB Incident Controller coordinates the agreed functions. Group and DHB EOCs/controllers are notified.</td>
</tr>
<tr>
<td><strong>3 Local</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Coordination or support necessary.</td>
<td>Imminent or state of local emergency involves a single local territorial authority. The event may not or cannot be managed without the adoption of emergency powers.</td>
<td>The coordination centre for a local level response is an EOC. EOCs are usually activated for the purpose of multi-agency or multi-incident coordination. EOCs are staffed and managed by the lead agency, and supplemented by personnel representing, or provided by, other agencies. Declaration of state of local emergency in a single local territorial authority may be considered or has been deemed necessary. Declaration can be for an entire district or one or more wards.</td>
<td>Hospital or health service EOC Incident Management Team is fully activated and coordinates responses to the emergency. CDEM Group, DHB EOC and adjacent EOCs are alerted or partially activated to monitor situation and respond if it deteriorates.</td>
<td>Local CDEM controller may exercise statutory powers. DHB controller supports the CDEM Group Controller and considers further escalation. Adjacent DHBs and CDEM Groups and National Controller are notified. Consideration is given to use of medical officer of health powers pursuant to ss 70–71 of the Health Act 1956.</td>
</tr>
<tr>
<td><strong>Monitor</strong></td>
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</tr>
<tr>
<td>Incident Control Point (ECC)</td>
<td>Monitor and assess threats and incidents that may lead to a local emergency.</td>
<td>Monitor and assess threats and incidents that may lead to a local emergency.</td>
<td>DHB Incident Controller coordinates the agreed functions. Group and DHB EOCs/controllers are notified.</td>
<td>DHB Incident Controller coordinates the agreed functions. Group and DHB EOCs/controllers are notified.</td>
</tr>
<tr>
<td><strong>Engage</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>In addition to monitoring activities: collect, analyse, and disseminate information on emergencies; report to or advise Government; provide public information service.</td>
<td>In addition to monitoring activities: collect, analyse, and disseminate information on emergencies; report to or advise Government; provide public information service.</td>
<td>In addition to monitoring activities: collect, analyse, and disseminate information on emergencies; report to or advise Government; provide public information service.</td>
<td>In addition to monitoring activities: collect, analyse, and disseminate information on emergencies; report to or advise Government; provide public information service.</td>
</tr>
<tr>
<td><strong>Lead agency</strong></td>
<td>on standby. Minimal staffing to monitor impending or actual emergency.</td>
<td>on standby. Minimal staffing to monitor impending or actual emergency.</td>
<td>on standby. Minimal staffing to monitor impending or actual emergency.</td>
<td>on standby. Minimal staffing to monitor impending or actual emergency.</td>
</tr>
<tr>
<td><strong>Support agencies</strong></td>
<td>on standby.</td>
<td>on standby.</td>
<td>on standby.</td>
<td>on standby.</td>
</tr>
<tr>
<td>Level of incident/ emergency</td>
<td>Status and procedures</td>
<td>Health ECC/EOC roles</td>
<td>Health Controllers’ roles</td>
<td>NCMC operating mode</td>
</tr>
<tr>
<td>----------------------------</td>
<td>----------------------</td>
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</tr>
</tbody>
</table>
| **4 Regional**             | Inter-DHB or regional coordination or support is required. Local emergency is regionally significant: The event impacts on one local authority but requires response and resources from outside that local authority, or the event impacts on two or more local authorities within a CDEM Group/DHB area, or coordinated assistance is required to support an adjoining (or distant) DHB or CDEM Group(s). | A regional level response may be activated:  
- to direct, coordinate, and support incidents with regional or national implications  
- when a local response requires wider coordination, and  
- when the Regional Health Coordinator or their governance deems it necessary.  
The Regional Health Coordinator coordinates the regional level response for the incident, and directs, supports and coordinates local responses. The coordination centre for a regional level response is an ECC (RHCC).  
Declaration of state of local emergency for a region may be considered or has been deemed necessary. | ECCs and EOCs are fully activated.  
NHCC and adjacent DHB EOCs may be alerted or partially activated to monitor the situation and be ready to respond if the situation deteriorates. | Group controller may exercises statutory powers.  
National Controller considers further escalation.  
DHB controllers respond to priorities set by the Local/Group CDEM controller.  
Consideration is given to use of medical officer of health powers pursuant to ss 70–71 of the Health Act 1956. | Assist  
In addition to engagement activities: process or coordinate requests for support from regional and local organisations, including assistance from overseas, and international liaison; report to or advise Government.  
Lead agency: partial to full staffing.  
Support agencies: most activated.  
NCMC: fully operational. |
| **5 National**             | Coordination or support is required.  
State of national emergency is possible, imminent or declared. | National response, information and resources are coordinated.  
Coordination of national response is applied.  
The response is consistent with CIMS.  
Declaration of state of national emergency is being considered, or has been deemed necessary. | NHCC, ECCs and EOCs are fully activated. | National Controller exercises statutory powers.  
DHB controller responds to priorities set by the National Controller and National Health Coordinator.  
DHB controller responds to priorities set by the local CDEM controller.  
Consideration is given to use of medical officer of health powers pursuant to ss 70–71 of the Health Act 1956. | Direct  
In addition to assisting activities: control and direct the overall response.  
Lead agency: full staffing.  
Support agencies: all activated.  
NCMC: fully operational. |
Appendix 9: CIMS in the health context

CIMS functions further broken down into functional areas to meet incident circumstances

CIMS structure determined by region

CIMS structure determined by DHB
### Role Card - Incident Controller

Reports to Chief Executive Officer

**Nominated Post Holders**
Executive Leadership Team, Service Group Manager, Senior Management On Call and Duty Nurse Manager

#### Responsible for:
- Coordinating and controlling the response element
- Establishing and directing the Incident Management Team
- Directing the response
- Setting objectives and providing an Action Plan that describes how they will be achieved
- Controlling personnel and equipment, and all subsidiary response elements
- Activating and deactivating the Emergency Operations Centre
- Maintaining situational awareness
- Determining critical resources and managing their use
- Briefing governance
- Coordinating the response of health service providers
- Ensuring the response stays within proscribed resource and budget limits
- Acting as spokesperson if a dedicated spokesperson has not been appointed
- Records management
- Managing the transition from response to recovery with the Recovery Manager

#### Need to:
- Balance the need for accurate advice and information against the need for timely decisions
- Document key decisions and their rationale, as they are being made
- Follow the intentions of governance structure, and/or higher Controllers e.g. Ministry of Health
- Focus on the actions of their response element
- Be aware of decisions of neighbouring Controllers
# Role Card - Intelligence

**Reports to Incident Controller**

## Nominated Post Holders

Executive Leadership Team, Service Group Manager, Senior Management On Call and Duty Nurse Manager

## Responsible for:

- Gather, collate and analyse response information
- Develop and distribute processed intelligence as situation reports, situation maps and other inputs aimed at developing a common operating picture
- Develop and distribute intelligence that forecast how the incident may develop
- Manage the collection plan
- Contribute to the development of the Action Plan
- Analyses information from all response functions and sources, the incident context may include:
  - Hazards (natural or man-made)
  - Community, demographic, cultural and human factors
  - Terrain
  - Climate and weather
  - Infrastructure
  - Economic factors

## Intelligence sub-functions

**Information:** responsible for managing the intelligence, collection plan, identifying sources and collating information, and carrying out the initial analysis and initial verification.

**Situation:** responsible for identifying the intelligence need of various audiences (and feeding these back to Information), analysing, and distributing intelligence outputs.

**Forecasting:** responsible for intelligence relating to subsequent operational periods which may be days, weeks or months into the future.
### Role Card - Operations

**Reports to Incident Controller**

**Nominated Post Holders**
Executive Leadership Team, Service Group Manager, Senior Management On Call and Duty Nurse Manager

**Responsible for:**
- Coordinating day-to-day response activities on behalf of the Controller
- Contributing to the development of the Action Plan
- Implementing the Action Plan, making minor amendments as the situation changes (the Operations Manager is responsible for assessing whether any changes require the Controller’s approval)
- Planning response tasks in detail
- Integrating Liaison Officers into the Emergency Operations Centre
- Forecasting resource use or needs to Logistics
- Recommending to the Controller which resources are critical
- Coordinating volunteer activities
- Keeping the Controller and IMT informed about the response
- Resolving minor conflicts between response agencies

**Operations sub-functions**
Operational Coordination: responsible for most of Operation’s responsibilities. It coordinates the activities, plans, tasks, monitors the implementation of the Action Plan, and resolves any operational problems that do not need to be escalated to the Controller. Subordinate response elements report on their progress to Operational Coordination, either directly or through Liaison Officers.

Liaison: responsible for establishing personal communication between agencies, enabling more accurate and timely information sharing. We might receive agency Liaison Officers or have to deploy our own to the Wellington Region Emergency Management Office Emergency Coordination Centre or to Hutt City Council Emergency Operations Centre.

Volunteer Coordination: responsible for liaising with volunteers groups (both established and spontaneous), and ensuring that their efforts are coordinated with the rest of the response. Logistics are responsible for the registration and any required training of spontaneous volunteers, and Operations for their coordination and tasking.
### Role Card - Planning

#### Reports to Incident Controller

#### Nominated Post Holders
Executive Leadership Team, Service Group Manager, Senior Management On Call and Duty Nurse Manager

#### Responsible for:
- Overseeing the development of Action Plans
- Developing long-term plans and contingency plans
- Assisting with planning the transition to recovery
- Convening and conducting planning meetings
- Forecasting medium-to-long term resourcing requirements that will need to be provided by Logistics and supporting agencies

#### Planning sub-functions

**Action Planning:** responsible for developing the Action Plan to meet the Controller’s intentions. The Action Plan needs to be the first priority for Planning.

**Long-term Planning:** responsible for scoping and developing plans for response activities within hours, days, weeks, or even months, depending on the response level and the scale of the incident. Long-term planning may include the provision for the transition from Response to Recovery.

**Contingency Planning:** responsible for developing plans for a particular situation that has not, but may occur. Contingency plans may be developed after an Action Plan has been completed or may be developed in parallel. The need for a contingency plan is often identified during the development of the Action Plan.

Long-term planning and contingency plans use the same process, inputs, and personnel as the Action Plan. They are often completed with less detail because of the personnel and time constraints. Long-term plans and contingency plans depend on more assumptions and estimates than Action Plans, as they cover situations yet to happen.
## Role Card - Logistics

Reports to Incident Controller

### Nominated Post Holders

Executive Leadership Team, Service Group Manager, Senior Management On Call and Duty Nurse Manager

### Responsible for:

- Receiving authorised requests, and procuring the resources
- Requesting, receiving, storing, maintaining, and issuing procured resources
- Participating in the development of the Action Plan
- Tracking resources use and financial expenditure
- Providing transport
- Overseeing communications in and out of the Emergency Operations Centre
- Establishing and maintaining information technology networks
- Providing record-keeping and administration support
- Collating and matching offers of assistance
- Advising the Controller and the IMT of logistics issues and resource levels

### Logistics sub-functions

Supply: responsible for procuring resources, tracking offers of assistance, and providing supply information to Planning.

Transport: responsible for providing transport.

Finance: tracks response costs, pays accounts and invoices, provides authorised cash advances, and audits financial accounts. This team should be as far as possible, use business as usual finance system. Depending on the incident, Finance may be a stand-alone system.

Information communications technology: responsible for establishing and maintaining the communications links and information technology networks in the emergency Operations Centre. Communications receives messages, logs them, and then distributes them to relevant functions, and send radio or courier messages on behalf of other functions. In more complex responses, a communications plan may be needed.

Facilities: is responsible for securing buildings and land for use by response personnel and maintaining these throughout the response.

Catering: provides meals and drinks to response personnel where an incident lasts longer than six hours.

Personnel: is responsible for managing human resources, including registering and training response personnel (including spontaneous volunteers), and payment of staff (where required). Personnel from other agencies report to Personnel for registration, attend any briefings or training, and are then directed to their assigned team.

Administration: is responsible for arranging clerical support and record keeping (particularly of key response documents).
### Role Card – Public Information

Reports to Incident Controller

**Nominated Post Holders**
Executive Leadership Team, Service Group Manager, Senior Management On Call and Duty Nurse Manager

**Responsible for:**

- Preparing and sharing information directly to the public (via social media, public meetings, pamphlets etc.), or via the media. Note that the content of official information such as warnings is generated by official processes, and approved by the Controller.
- Monitoring the public and media reactions and passing information to the relevant CIMS functions.
- Coordinating with other response agencies’ PIM activities.
- Preparing spokespeople for interviews and media conferences.
- Liaising with the community.
- Working with the media, including arrangements for media visits and media conferences.
- Liaising with VIPs and their personnel about site visits.
- Ensuring call centres, helplines and reception personnel have current public information and key messages.
- Participating in the development of the Action Plan.
- Advising the Controller on PIM issues.

**Public Information sub-functions**

Media: works with media organisations to distribute key messages through interviews, media releases and media conferences, as well as monitoring media broadcast. This sub-function monitors and interacts with social media to distribute key messages direct to the public, to gather response information and to gauge public reaction. It also advises spokespeople, prepares for media conference, and ensures helplines have updated information.

Community liaison: carries out two-way communication with affected communities to obtain local knowledge, needs and intentions.

Information and warnings: gathers information from other functions to provide tailored information, warnings and advisories (approved by the Controller) to the public. These are then normally distributed through Media and Community Liaison.
<table>
<thead>
<tr>
<th>Role Card - Welfare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reports to Incident Controller</td>
</tr>
</tbody>
</table>

**Nominated Post Holders**

Executive Leadership Team, Service Group Manager, Senior Management On Call and Duty Nurse Manager

**Responsible for:**

- Managing the consequences of an incident on staff, patients, and community
- Ensuring a Psychosocial Support Coordinator is appointed to coordinate the provision of the psychosocial support sub function
- Develop medium to long-term recovery plans with other/support agencies
- Adapt services to support recovery as required

**Welfare sub-functions**

Please refer to Welfare Services in an Emergency, Directors Guideline for CDEM Groups and agencies with responsibilities for welfare services in an Emergency [DGL 11/15]
## Appendix 11: Action Plan Template

### Details

<table>
<thead>
<tr>
<th>Details</th>
<th>Hutt Valley DHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>EOC</td>
<td>Hutt Valley DHB</td>
</tr>
<tr>
<td>Document type</td>
<td>Action Plan</td>
</tr>
<tr>
<td>Document number</td>
<td>V1.0</td>
</tr>
<tr>
<td>Incident</td>
<td>Type of incident, date and time</td>
</tr>
<tr>
<td>Date and time issued</td>
<td>XX/XX/201X XXXXhrs</td>
</tr>
<tr>
<td>Operational period covered</td>
<td></td>
</tr>
</tbody>
</table>

### Main body

<table>
<thead>
<tr>
<th>Summary of incident</th>
<th>A summary of the hazard impacts, environment and response actions to date. This is based on issued SitReps.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aim</td>
<td>A statement of the intent of the Action Plan</td>
</tr>
<tr>
<td>Objectives</td>
<td>Clear objectives that lead to achieving this aim</td>
</tr>
<tr>
<td>Plan of action/strategy</td>
<td>Concept of operations describing the response actions that will be done to achieve the aim and objectives. A broad statement of what must happen and when.</td>
</tr>
<tr>
<td>Designated tasks</td>
<td>Specific tasks and timings for each agency under the plan.</td>
</tr>
<tr>
<td>Limiting factors</td>
<td>Matters that may or will limit options, timeframes and outcomes.</td>
</tr>
<tr>
<td>Coordination measures</td>
<td>Times, locations, boundaries, and other measures designed to coordinate the response.</td>
</tr>
<tr>
<td>Resource needs</td>
<td>Who will provide what and when they will do it – including: information, supply, personnel, equipment, transport.</td>
</tr>
<tr>
<td>Information flow</td>
<td>Who needs to know and who has information we need.</td>
</tr>
<tr>
<td>Public information plan</td>
<td>Outline of intended public information processes and outputs. This may be an appendix.</td>
</tr>
<tr>
<td>Communications plan</td>
<td>Frequencies/purpose/coverage, role mobile phone numbers, communications schedule etc.</td>
</tr>
<tr>
<td>Organisation</td>
<td>List/organisation chart of key roles, contact details, and rosters of people assigned to the roles</td>
</tr>
<tr>
<td>Appendices</td>
<td>Specialist functions, lists, tables, maps etc.</td>
</tr>
</tbody>
</table>

### Approval and distribution

<table>
<thead>
<tr>
<th>Approval and distribution</th>
<th>Name, role, response role, signature and contact details.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action Plan prepared by</td>
<td>Name, role, response role, signature and contact details.</td>
</tr>
<tr>
<td>Action Plan approved by</td>
<td>Name, role, response role, signature and contact details of response element’s Controller.</td>
</tr>
<tr>
<td>Distribution</td>
<td>Include CIMS functions, all partner agencies representative at the EOC and any other activated sub-functions.</td>
</tr>
</tbody>
</table>
Appendix 12: Situational Report Template

**HUTT VALLEY DHB SITUATION REPORT 001 AS AT XX:XX NZDT XX XXX 201X**

<table>
<thead>
<tr>
<th>Event Name:</th>
<th>EOC Contact Details:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><a href="mailto:EOC@huttvalleydhb.org.nz">EOC@huttvalleydhb.org.nz</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Response Level:</th>
<th>MoH Alert Code:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**RESPONSE PRIORITIES**

1.

**ENDSTATE**

•

**OVERVIEW**

SUMMARY OF EVENT AND RESPONSE TO DATE

PREDICTED EVENT PROGRESSION

RESPONSE ACTIONS CARRIED OUT

PLANNED RESPONSE ACTIVITIES IN THE NEXT 24 HOURS

RESOURCES REQUIRED

CASUALTY INFORMATION

BED AVAILABILITY

PERSONNEL ASSESSMENT
### BUILT INFRASTRUCTURE

**DHB – ON SITE**
- Heretaunga:
- EDT:
- TWA:
- CARE Block:
- Clocktower:
- Community Health:
- Pilmuir House:
- Kowhai House:

**DHB – OFF SITE**
- CREDS:
- RPH:
- Regional Dental Clinics:
- Community Mental Health:

### LIFELINE UTILITY STATUS

<table>
<thead>
<tr>
<th>Utility</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>WATER</td>
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<tr>
<td>ELECTRICITY</td>
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<tr>
<td>FUEL</td>
<td></td>
</tr>
<tr>
<td>TELECOMMS</td>
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</tr>
</tbody>
</table>

### OTHER HEALTH ORGS

- WELLINTON FREE AMBULANCE
- PHARMACIES
- COSINE PRIMARY CARE NETWORK TRUST
- TE AWAKAIRANGI HEALTH NETWORK
- CARE COORDINATION
- REGIONAL PUBLIC HEALTH
- AGED RESIDENTIAL CARE
HOME AND COMMUNITY SUPPORT SERVICES

BOULCOTT HOSPITAL

WELLINGTON SCL

CAPITAL COAST DISTRICT HEALTH BOARD

WAIRARAPA DISTRICT HEALTH BOARD

INFORMATION MANAGEMENT

DHB

HEALTH SECTOR

COMMUNITY

WELFARE

PSYCHOSOCIAL

RECOVERY

LOCAL

REGIONAL

ADDITIONAL INFORMATION

KEY CONTACT INFORMATION

Report Authorised by: DHB Incident Controller
Date/Time of approval: XX:XX NZDT on XX XXX 201X
Prepared by: EOC Intelligence
Next SITREP will be issued at:
XX:XX NZDT on XX XXX 201X
## Appendix 13: Incident Response Log

**Incident Name:**  
**Date and Time Log started:**  

**Author + Role:**  
**Date and Time Log finished:**

<table>
<thead>
<tr>
<th>Entry No.</th>
<th>Date</th>
<th>Time (24hr)</th>
<th>Information/Message to Post Holder/Action by Post Holder</th>
<th>Completed Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
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Add rows as required
Appendix 14: Incident Response Debriefing Procedure

Overview

The aim of debriefing is for staff to communicate their experiences of the incident response so that lessons can be identified and learned. All personnel involved in the response should have an opportunity to participate in the debrief process.

Debriefings are a quality improvement activity to help improve an organisation’s ability to respond to future emergencies. They also provide an opportunity for the organisation to thank its staff and to provide positive feedback.

Consideration should be given to the community’s need for debriefing, which will depend on the type and scale of the incident.

Authority to request an organisational debrief:

1. Incident Controller
2. Member of the Executive Leadership Team or senior manager

Core Principles

Debriefing should:

- be conducted openly and honestly
- pursue personal, department or organisational understanding and learning
- be consistent with professional responsibilities
- recognise positive outcomes
- be published and distributed appropriately
- respect the rights of individuals

The debrief facilitator should be appropriately trained, experienced and not involved in the emergency to ensure impartiality. Debriefing is subject to the Official Information Act 1982, and privacy principles apply.

Types of organisational debriefing

The following types of organisational debriefing can be used to facilitate post-event learning.

1. The ‘hot’ or immediate post-event debrief

A ‘hot’ debrief is held immediately after the incident response or after the shift is completed. Hot debriefs allow a rapid ‘offload’ of a variety of issues. They provide a forum in which to address key health and safety issues. Hot debriefs may be facilitated by a range of people within the organisation, and a number of hot debriefs may be held within an organisation simultaneously following an incident.

The Incident Controller who communicates the stand-down within the organisation will ensure that an initial debrief is held immediately. This debrief should be attended by all key staff involved in the management of the incident and those who will be assuming responsibility for the on-going management of any affected services. At a minimum, the hot debrief should include discussion on the:
• identification and management of matters that need to be addressed urgently
• management of any extraordinary measures that may need to remain in place
• restoration of a response capability
• process for the ‘cold’ debrief and/or the multi-agency debrief
• process of reporting the hot debrief

2. The ‘cold’ or internal organisational debrief
A ‘cold’ debrief should be held within 2 weeks of the incident. If the incident continues to be managed over the medium to long term, it may be necessary to hold regular internal organisational debriefs at key milestones. Cold debriefs are attended by those within the organisation that were involved in the response to the incident. They address organisational issues, rather than personal or psychological issues. They focus on strengths and weaknesses, as well as ideas for future learning. The Incident Controller will oversee and implement the debrief schedule.

3. The multi-agency debrief
Whenever an emergency involves more than one agency, it will be necessary to hold a multi-agency debrief. If the incident continues to be managed over the medium to long term, it may be necessary to hold regular multi-agency debriefs at key milestones. Multi-agency debriefs focus on the effectiveness of inter-agency coordination. They address multi-agency organisational issues, rather than personal or psychological issues. They look for strengths and weaknesses, as well as ideas for future learning. Multi-agency debriefs may be facilitated by a range of emergency organisations, for example Wellington Region Emergency Management Office, the Ministry of Health, Police or NZ Fire Service. They may also form part of a tiered debriefing process, for example, at local, regional and national levels. The Incident Controller will select the appropriate individuals to attend these events.

Debriefing reports
Following debriefing, a report will be produced containing an action plan and recommendations in order to update any relevant plans, implement system improvements and outline any training and further exercising required. These must be reinforced by achievable timeframes. The report should then be disseminated to all participants, along with other providers or agencies that may benefit from the information gathered and lessons learnt from the debriefing. Reports are to be signed off by the Incident Controller.
### Glossary and Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>CDEM</td>
<td>Civil Defence Emergency Management</td>
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<tr>
<td>CEO</td>
<td>Chief Executive Office</td>
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<td>CIMS</td>
<td>Coordinated Incident Management System</td>
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<td>CRHCC</td>
<td>Central Regional Health Coordination Centre</td>
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<tr>
<td>ECC</td>
<td>Emergency Coordination Centre</td>
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<tr>
<td>Emergency</td>
<td>For the purposes of this plan, an emergency is a situation that poses an immediate risk to life, health, property, or the environment that requires a coordinated response (ODESC 2014)</td>
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<tr>
<td>EOC</td>
<td>Emergency Operations Centre</td>
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<td>HEP</td>
<td>Health Emergency Plan</td>
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<td>HVDHB</td>
<td>Hutt Valley District Health Board</td>
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<tr>
<td>IMT</td>
<td>Incident Management Team</td>
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<tr>
<td>MCDEM</td>
<td>Ministry of Civil Defence and Emergency Management</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<td>NCMC</td>
<td>National Crisis Management Centre</td>
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<td>NHCC</td>
<td>National Health Coordination Centre</td>
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<td>ODESC</td>
<td>Officials’ Committee for Domestic Security and External Security Coordination. A committee of government chief executives charged with providing strategic policy advice to ministers. It provides support to DESC and oversees emergency readiness, intelligence and security, terrorism and maritime security. Activation of ODESC is at ministerial request; for example, where a growing risk of a particular threat has been identified</td>
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<tr>
<td>OPF</td>
<td>Operational Policy Framework</td>
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<td>RCG</td>
<td>Recovery Coordinating Group</td>
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<td>SARS</td>
<td>Severe Acute Respiratory Syndrome</td>
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<td>SPOC</td>
<td>Single Point of Contact</td>
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<tr>
<td>WREMO</td>
<td>Wellington Region Emergency Management Office</td>
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