Te Whatu Ora
Health New Zealand
Te Tai Tokerau

MASS CASUALTY PLAN 2022 - 2024

Mass Casualty

Any occurrence that presents a serious threat to the health of the community or disruption to the health services, or causes (or is likely to cause) numbers of types of casualties that require special measures to be implemented by appropriate responding agencies, e.g. ambulance and health services.

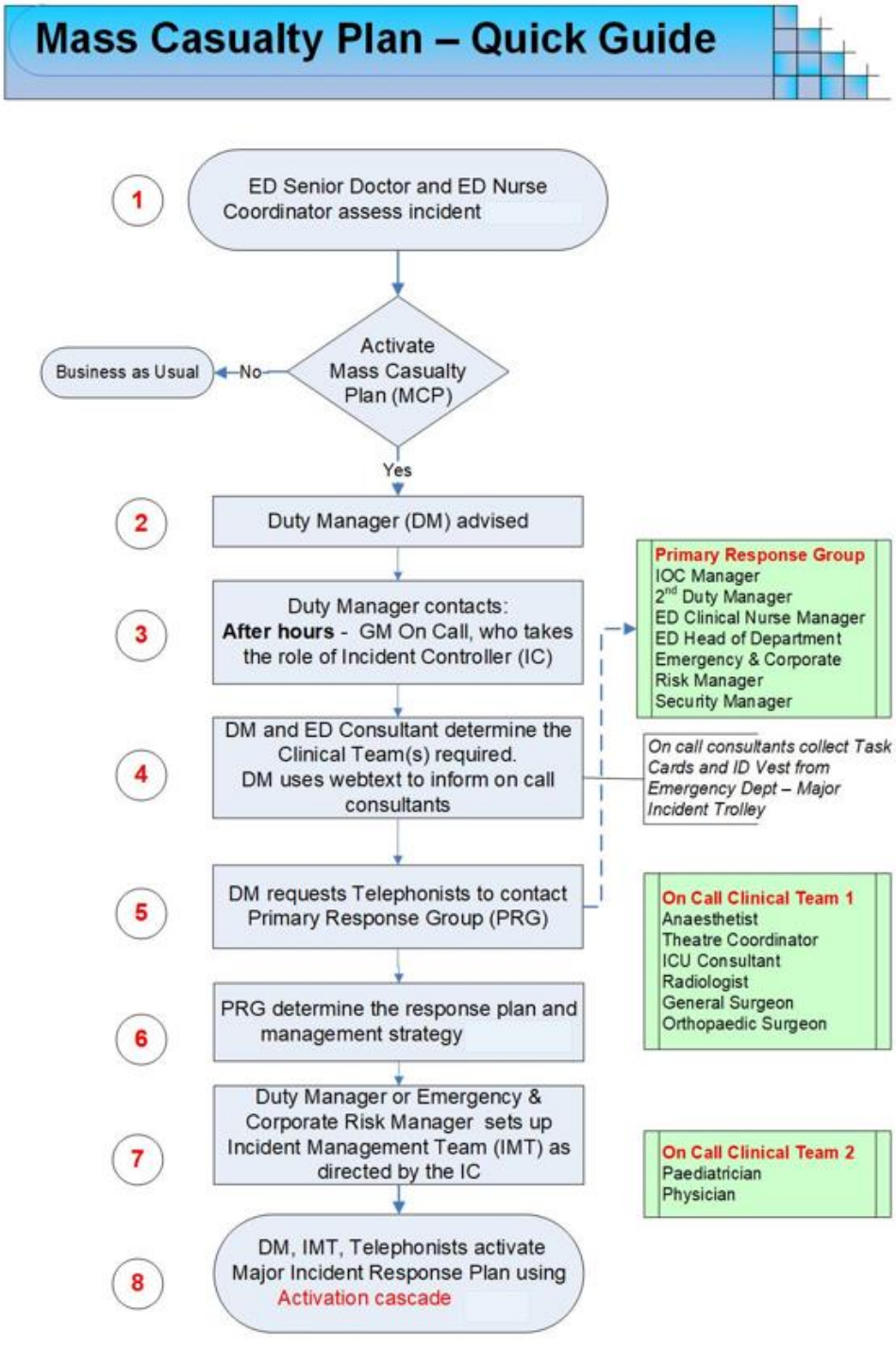
AUTHORISATION
Signed:

Interim District Lead, Te Whatu Ora – Health New Zealand Te Tai Tokerau Date:

Te Whatu Ora – Health New Zealand Te Tai Tokerau	
Document Owner: Emergency & Corporate Risk Manager	**Version:** 5.0
Authorisers: Operational Management Group	**Last Updated:** Dec 2023
Identifier: CD05526	**Next Review:** Dec 2024
If printed, this protocol is valid only for the day of printing or for the duration of a specific patient's admission:	14 December 2023

Quick Guide

https://www.health.govt.nz/system/files/documents/publications/nhep-mass-casulty-action-plan.pdf



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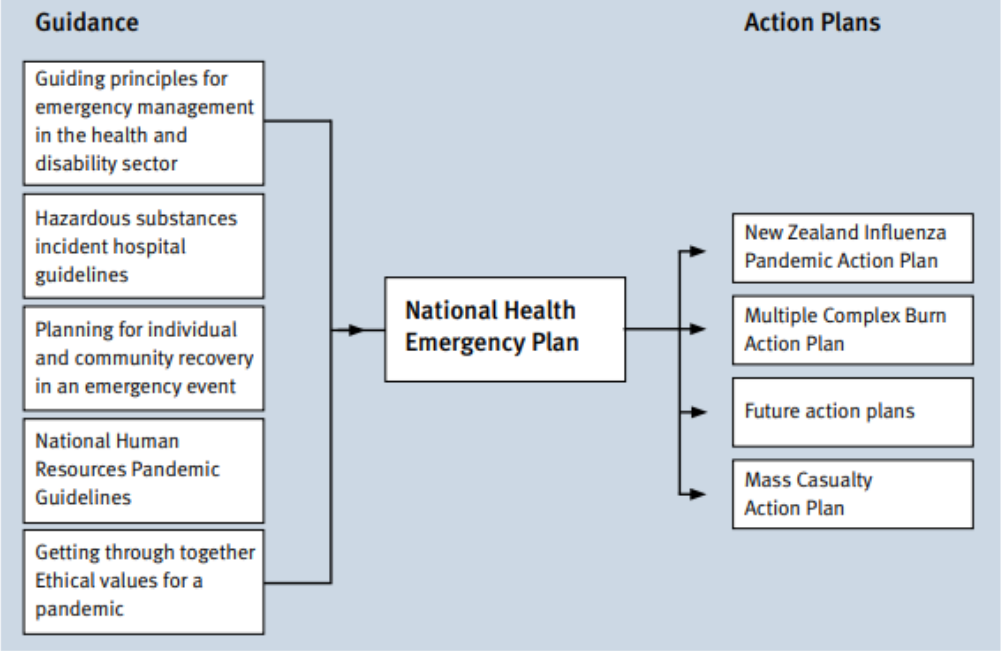
1. Purpose

Dealing with a mass casualty incident (MCI) requires a coordinated plan and response from emergency services and the health sector. An MCI will create a significant increase in demand for services from all agencies involved in the response.
https://www.health.govt.nz/system/files/documents/publications/nhep-mass-casulty-action-plan.pdf

Figure 1: The relationship between guidance documents, the NHEP and national action plans



2. Definitions

Mass Casualty Incidents (MCI's) fall into two main types:

1. Those that result from no-notice incidents and;
2. Those where a surge in the number of casualties occurs over time.

Both types of incidents produce challenges for response efforts. An MCI has the potential to overwhelm the available resources and interrupt business as usual arrangements within the receiving health NZ districts. MCI response can vary due to a different combinations of factors (e.g., type, time of day and location).

2.1 The key differences between managing a major incident and a mass casualty incident

Major Incident	Mass Casualty
May not always have a clinical aspect.	Is always about clinical.
May or may not involve a significant number of staff, e.g. major hazard leak in laboratory has a minimal number of staff involved.	Always involves large numbers of highly skilled staff to be onsite ASAP with a large volume of patients with complex injuries.
Can be due to offsite or infrastructure causes, e.g. a major earthquake in Wellington or a burst water pipe under Whangarei hospital.	Is generally on Te Tai Tokerau site, but can be at a district hospital.
Can be national, regional or local and involve other agencies such as public health, or civil defence e.g. a pandemic of influenza or a major storm.	Local emergency services will be temporarily involved, but may escalate to a national event for clinical support in terms of bed capacity.
This may not require decisions regarding rapid discharge and transferring of patients.	This often results in rapid discharge and transferring of patients.
Quality of care; There should be no altered level of care in a major incident.	Quality of care; The level of care may differ from normal due to the significantly increased volume and complex demands for immediate clinical attention.

3. Te Tiriti

3.1 Te Tiriti Principles and Application

Te Tiriti o Waitangi provides the imperative for the Crown and its agents to protect and promote the health of Māori. The Crown has a responsibility to respond to Māori health aspirations and to meet Māori health needs. Māori leadership is a significant enabler for achieving Māori health equity and wellbeing. Engaging and partnering with Māori is key to supporting and reinforcing Te Tiriti obligations and principles.

Whakamaua: Māori Health Action Plan 2020-2025 further outlines its outcomes (Table 1), objectives and priority areas. These areas of priority are inclusive in Emergency Management planning and processes.

Table 1: Whakamaua Outcomes

OUTCOME 1	Iwi, hapū, whānau and Māori communities can exercise their authority to improve their health and wellbeing.
OUTCOME 2	The health and disability system is fair and sustainable and delivers more equitable outcomes for Māori.
OUTCOME 3	The health and disability system addresses racism and discrimination in all its forms.
OUTCOME 4	The inclusion and protection of mātauranga Māori throughout the health and disability system.

3.2 Equity Focus

Incorporating an equity focused approach across the four 'R's, including improving equity of access, outcomes and experience for Māori in Te Tai Tokerau and other priority populations including Pasifika peoples is important. The governance structure of current emergency response includes Iwi/Māori-Crown partnership models and Pasifika presence and participation.

3.3 Coordinated Incident Management System (CIMS)

The Coordinated Incident Management System (CIMS) structure is the model adopted in New Zealand for the coordination of an emergency. It forms the basis of operational response. This is outlined in Te Whatu Ora IMT/CIMS document. We will follow this system in Mass Casualty.

4. Readiness

4.1 Human Resources

Staffing

The Operational Policy Framework (OPF) requires personnel likely to be involved in a District Emergency Operations Centre (EOC) to be educated and trained in the CIMS structure and have knowledge of the NZ Health Emergency Management Framework. Te Whatu Ora – Health New Zealand Te Tai Tokerau (Te Whatu Ora) ensures its number of trained staff is sufficient to maintain a 24/7 response over an extended period. Processes for the movement of staff between districts during an emergency event should be documented. Health and welfare of staff in the response and recovery periods must be considered.

Volunteers

Many people may offer assistance in times of emergency, including existing volunteers. Some of these people may have no prior experience working in a health and disability organisation or in emergency situations. Districts do not accept spontaneous volunteers and offers of assistance from health professionals will be managed through normal HR and credentialing processes. Other volunteers will be directed to Civil Defence Emergency Management (CDEM).

Visitors and Dependents

Large numbers of people may arrive with the casualties from an emergency event. Dependent upon the situation, these people will present additional management issues. Once the Major Incident Response Plan (MIRP) is activated, messages and welfare provision need to be consistent and delivered throughout the District in liaison with the National Emergency Management Agency (NEMA), CDEM & Northland Welfare Coordination Group.

5. Response

The objective of the health and disability sector is to provide health services during emergencies to minimise the impacts of the emergency on the health of individuals and the community. (MOH 2015, NHEP)

5.1 Surge Capacity

In response to complex emergencies, Districts may need to safely decant or/and evacuate health facilities to ensure that all patients can continue to access appropriate healthcare.

Three aspects need to be considered when planning for surge capacity:

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

Implementation of the measures above will require coordination and consistency across the Northern Health Region.

5.2 Single Point of Contact System (SPoC)

The SPoC system is a 24/7 method for the communication and receipt of national warnings and communication of Te Whatu Ora emergency management related information. It is used for alerting Districts and Public Health Units (PHU) to an existing or imminent threat or health emergency. The SPoC system is also used to alert the health sector of any messages sent via the NEMA Warning System.

Health organisations must maintain 24/7 systems to acknowledge, distribute and respond to SPoC alerts. Te Whatu Ora through the NHEP uses the SPoC to deliver:

- Warnings to provide information about the imminent threat or sudden onset of hazard events, e.g. tsunami, emerging infectious diseases or severe weather events.
- Information to assist an emergency response in the aftermath of quick onset events, e.g. earthquake. Such information will indicate the likely magnitude of the event and which areas/districts are affected.

5.3 Health Sector Alert Code

Te Whatu Ora has implemented an alert code system to communicate with the New Zealand health sector during an emergency. These Alert Codes (see Table 2) are communicated to the District/PHU SPoCs. The roles and responsibilities associated with each Alert Code at local and regional levels are described in 5.10.

Table 2: Alert Codes

Phase	Measures	Code
Information	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.	White
Standby	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 Districts.	Yellow
Activation	Major emergency in New Zealand exists that requires immediate activation of health emergency plans. Example: large-scale epidemic, pandemic, or major mass casualty incident requiring assistance from unaffected Districts.	Red
Stand-down	Deactivation of emergency response. Example: end of outbreak or epidemic. Recovery activities will continue.	Green

5.4 St John Ambulance Communication Centres & National Operations Effectiveness Centre – Major Incident Notifications

St John Ambulance Communications Centre(s) and the National Coordination Management Centre (NCMC) will notify all relevant agencies, Te Whatu Ora, REM's, Police, FENZ and NRHCC of a major incident that requires or may require a regional coordinated health response.

The St John notification to partner agencies will be sent via St John Level 1 - 3 major incident paging groups and may request agency Single Point of Contact (SPOC) to attend a Teleconference via MS TEAMs. The St John Medical Director may request District SPOC's to confirm their current hospital capacity to receive air/road transported patients/casualties.

All efforts will be taken to prevent overloading of individual hospitals and any St John/District national destination policies will continue to be followed where applicable. These include:

- National Out-of-Hospital STEMI Pathway
- National Out-of-Hospital Major Trauma Destination Policy
- National Out-of-Hospital Acute Stroke Destination Policy
- National Out-of-Hospital Spinal Cord Injury Destination Policy

5.5 Inter-agency and Public/Media communication

Public information management is part of an integrated strategy to provide leadership for the public, the health sector and other agencies in an emergency and aims to inform the public during a response. Managing the media and public interest will be a significant challenge to all agencies. The objectives are:

- Providing timely and accurate information (general, advice or instruction) to the public in times of emergency.
- Building public confidence to inform and protect the community.
- Promoting the effective management and coordination of public information between government agencies, emergency services, CDEM Groups, the media and the public.

The following table describes these guidelines and provides examples of messages that might be assigned to each priority category.

Table 3: Emergency communications

Message Type	Scheduling	Delivery Method	Example
Critical	IMMEDIATELY Sent 5 minutes after being published on the Medinz dashboard.	All methods (fax, email, and/or SMS)	Hospital ED closed due to flooding, divert patients to other EDs
Urgent	DAILY Released at either 7:30AM or 12PM	Email or SMS (user choice)	HealthPathways: pathway update

5.6 Activation of the Hospital Mass Casualty Plan (MCP)

The decision to activate the MCP in response to a major incident will be made by the ED nurse coordinator and ED senior doctor on duty using the ED criteria for Mass Casualty Activation.

The notification is sent to the duty manager, incident controller and the Emergency and Corporate risk manager, and the system is tested monthly.

The duty manager organises standing up the Primary Response Group (PRG) to decide the level of response. See Quick Guide (Pg. 2). The PRG will use the Activation/Response Tiers table at 5.8.

The team will then either initiate that response or return to their usual work, remaining available for a rapid response by himself or herself or a delegate.

- If the decision is to return to work as usual, the incident controller may direct the Emergency and Corporate risk manager to keep a watching brief on the situation and advise of new or pertinent developments as they arise

- In an incident where there is a clear threat to safety or services, e.g. fire or hazardous spill, dial 777 and the telephonists will call the appropriate agency. If required, the Decontamination Unit is to be erected by the Fire Service

- If a significant incident occurs while the Emergency Department is in overload, the threshold for activating the Whangarei Hospital Mass Casualty Plan may be lowered. This may involve a limited activation of some supporting services, e.g. relatives' management by the Social Work service

- Limited activation does not restrict any service from scaling its response up to meet the demands of the incident

- Internal notification that the Whangarei Hospital Mass Casualty Plan has been activated will initially be by text, public address system and/or email

- The primary responding staff/wards/units will be advised by the duty manager or Incident Management Team operations manager

- Other wards/units, which may have a secondary response, will be advised by a combination of the public address system, telephone, web text, or email.

5.7 Emergency Department Coordination

Medical and nursing liaison will be the responsibility of the ED senior doctor and ED clinical nurse manager or their delegates.

A. The Resuscitation/Monitoring Area is coordinated by an ED senior doctor (i.e. the ED consultant on duty at the time until the ED clinical director is available) and the ED nurse coordinator. Depending on the scale of the incident, these roles may be sufficient to manage the ED response.

B. Clinical codes

Table 4:

EMERGENCY DEPARTMENT TRIAGE CODES		
TRIAGE 1 & 2	**TRIAGE 3**	**TRIAGE 4 & 5**
For most serious/life threatening	For moderately serious	Stable and walking wounded
* Palliative care patients. Those patients whose prognosis is poor and whose resource needs may compromise the care of other patients will be assigned by the ED senior doctor to medical teams and Special Care nurses.		

5.8 Activation Response Tiers

RESPONSE TIERS		
TIER 1 An emerging threat, or potential for, may require further escalation. Local and Regional monitoring and assessment of the situation.	**TIER 2** Regionally significant incident (or several incidents) confirmed. The response of individual districts would benefit from being regionally coordinated. Activation of Regional Incident Management Team structure.	**TIER 3** Regionally/nationally significant incident (or several incidents) confirmed requiring support from a regional (and national) coordinated response. Activation of the NRHCC.
• Incident involving single or multiple district/s • District/s responding at a local level • Communication and interaction taking place between districts • District Incident Management Teams (IMTs) monitor events in the region via teleconferences • Districts maintain a watching brief on incident development • Districts collectively evaluate response activities and resource allocation.	• Confirmation of a potential or actual emergency situation which may or has impacted one or more Northern Region Districts • Incident/s managed by individual district/s • District EOCs may be activated • Regional communication initiated • Regional and national teleconferencing • Formation of specialised regional groups (e.g. renal, ICU, health of older people) • Districts maintain a watching brief on incident development • Districts evaluate response activities and resource allocation • District consider appointment of Regional Controller • Districts prepare to activate NRHCC as appropriate.	• NRHCC fully activated and operational • NRHCC coordinates the regional health response • Regional health resources pooled • Set teleconference times • District EOCs fully activated and operational.

5.9 Response Activation

If activation thresholds are met districts, PHUs, health service providers and ambulance services will respond by activating procedures, plans e.g. HEP, and will coordinate with the designated lead agency.

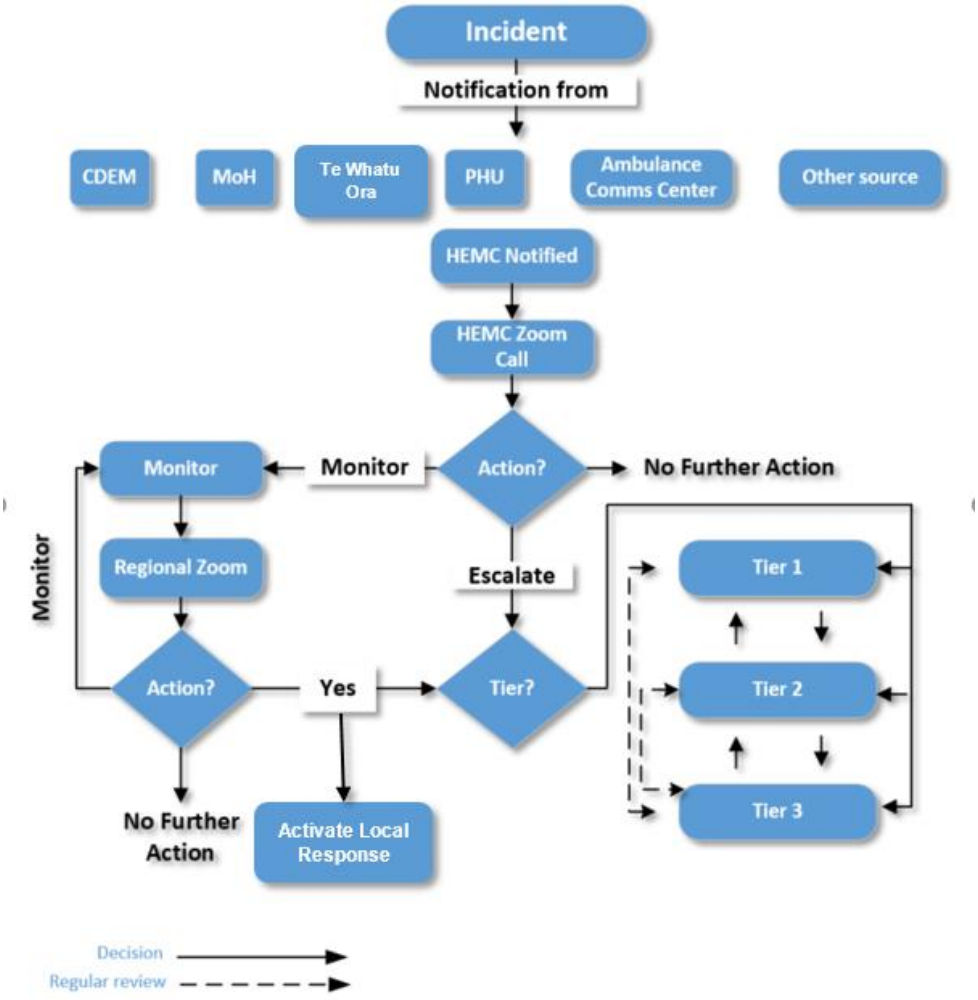
Response activation will include assessing the need for assistance from districts, other health regions, Te Whatu Ora – National Team, other emergency services and agencies for example, CDEM.

Key triggers for activation of a Northern Health Region response include:

- A significant local, regional or national health emergency
- Notification that assistance is required to managing a local health emergency or other local emergencies affecting health services
- Activation of the MIRP requiring regional coordination
- Other circumstances as deemed necessary by the northern region Health Emergency Management Committee) or Te Whatu Ora National Team.

Details of response activation procedures - refer flowchart below.

Northern RHEP Activation Flowchart



5.10 Alert Colours and Levels for Action: Mass Casualty Event or Major Incident

Response Level	Duty Manager Action	Telephonist Action	Primary Response Group (PRG) Action	Ward/Dept. Action	Incident Management Team Action
Stage 1 – White	• Attend the area of incident to facilitate fast and safe resolution of the incident. • Assist ED to prepare for Mass Casualty /Major Incident as required • Notify general manager on call as per protocol. • Enact Variance Response Plans	• Notify duty manager if advised of an event (phone, pager, RT etc.)		Follow Business Continuity Plans	
Stage 2 – Yellow Potential for a significant impact on Te Whatu Ora Note: May escalate to Stage 3 – Red	• Assist ED to set up for Mass Casualty/Major Incident response • Notify general manager on call as per protocol. • Assess the need for duty manager support to maintain business as usual • Provide information to IMT. • Ensure units/ departments are following the plan by completing 'MINT' Major Incident Notification Template (see appendix) • Assume role of incident controller until IMT set up. • Activate the Emergency Operation Centre. • Commence document log • Complete Situation Report	• Send text alert to ED HoD, GM on call, ED clinical nurse manager, Emergency and Corporate Risk manager, Communications manager. • Put PRG pager message out, "notification and potential impact". • Communicate response results to duty manager or incident controller	• Assess information and assist ED set-up. • Liaise with the Incident Management Team in the Emergency Operation Centre. • Return to workplace and prepare response as per Mass Casualty/ Major Incident Response Plan	• Emergency Department • All departments to follow Mass Casualty Plan, task cards and the unit specific Business Continuity Plans. • Assess staffing levels and expected requirements for the next 24 hours • Evaluate potential discharges as required • Activate telephone tree text messages. • Complete MINT and send to the Emergency Operation Centre either electronically or hard copy.	• Assign CIMS roles • Bring advisory teams on board. • Receive briefing from PRG and/or duty manager. • Develop initial action plan • Construct information package with incident controller. • All usual IMT functions

Response Level	Duty Manager Action	Telephonist Action	Primary Response Group (PRG) Action	Ward/Dept. Action	Incident Management Team Action
Stage 3 – Red	• Continue business as usual, with potential for extra assistance from Integrated Operations Centre manager • Provide updates for the IMT team regularly re current resource availability and requirements including: - Staffing - Bed occupancy - Theatre occupancy - ICU / HDU	• Continue to notify duty manager as per business as usual • Be alert for systems overload and seek assistance from Communications manager for 0800 numbers etc. • Assess the need for telephonist support.		• Continue business as usual with the potential for Rapid Discharge process as per the task cards and business continuity plans. • Assess staffing and resource levels and expected requirements for the next 24 hours • Respond to Major Incident Notification Template (MINT)	• Manage the situation with evaluation for regional or national escalation and response as required.
Stand Down – Green	• Receive communication to 'Stand down' from IMT. • Continue to monitor wards/ departments where activity level may remain high • Attend debrief	• Receive Notification from incident controller to send text message "Stand Down".		• Receive communication to "stand down" via e-mail or text message.	• Assess the ability to return to business as usual • Instruct telephonists to send Major • Incident Communications Plan "Stand Down" message • All members to attend debrief facilitated by Emergency and • Corporate Risk manager.

6. Recovery

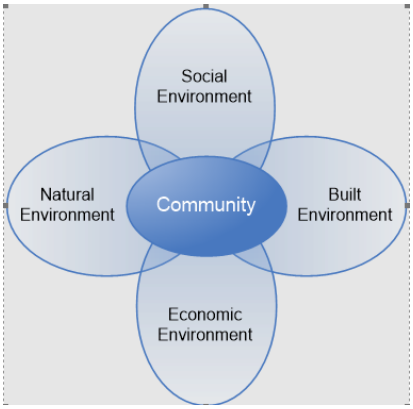
Planning for recovery is integral to preparing for emergencies and is not simply a post-emergency consideration. Recovery is not about returning to normality. It is more about regeneration; building back smarter, better, more sustainably and with more resilience. Recovery includes those activities that begin after the initial impact has been stabilised and extends until normal business has been restored. It considers all opportunities to reduce the risks from future emergencies. It may involve a local, regional, national health-related response or it may involve a whole-of-government response involving economic, social and legislative issues.

6.1 Recovery Objectives

Recovery is a complex social process and is best achieved when the affected community exercises a high degree of self-determination. The timeframe for recovery may vary from weeks to years. Recovery objectives include:

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

An integrated whole systems approach to recovery:



Source: *Focus on Recovery: A holistic framework for recovery in New Zealand*, MCDEM (200

6.2 Psychosocial Recovery

Recovery encompasses the psychological and social dimensions that are part of the regeneration of a community. The process of psychosocial recovery from emergencies involves easing the physical and psychological difficulties for individuals, families/whanau and communities, as well as building and bolstering social and psychological wellbeing. It spans the 4R's of Health Emergency Planning. Te Whatu Ora is the lead agency for Northland for Psychosocial support and meets regularly with the various welfare groups to plan and prepare in readiness for any emergency. Ensuring ongoing staff wellness is important and will be supported by Te Whatu Ora workforce and wellbeing initiatives.

Psychosocial support aims to improve psychosocial wellbeing, which has three core domains:

1. Support and promote human capacity (strengths and values).
2. Improve social ecology (connections and support, through relationships, social networks and existing support systems of people in their communities).
3. Understand the influence of culture and value systems and their importance alongside individual and social expectations.

Psychosocial wellbeing depends on having resources from these three domains to respond to emergency conditions and events. The challenging circumstances can deplete these resources, resulting in the need for external interventions and help to bolster and build individual and community psychosocial wellbeing.

Refer Psychosocial Guiding Principles (MOH 2016, page 15)

6.3 Recovery Exit Strategy

The end-state of any recovery activity is the transition from recovery to 'business-as-usual'. Therefore, all recovery operations should be planned with the development and preparation of an exit strategy.

6.4 Standing-down

The date and time of the official stand down or deactivation of an emergency response will be determined by either the local or the regional agency in consultation with Te Whatu Ora. Deactivation of an emergency response is dependent on a wide range of variables that must be satisfied before the announcement occurs.

Some basic principles that should be followed are:
That the emergency response role has concluded;

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

When Te Whatu Ora is satisfied, it shall issue a Code Green Alert (*refer 7.6 Health Sector Alert Code*) to signify the end of the response period. The time and date of deactivation may be used to determine arrangements implemented by the Te Whatu Ora in the recovery period.

6.5 Debriefing

A review of emergency management procedures and existing plans and procedures will be conducted after each activation and exercise of the TTHEP. This will be based on debriefings and evaluation outcomes in order to clarify roles and responsibilities at all levels during local, regional and national activation. In cases where Health is the lead agency this will be a multi-agency debriefing. At local and regional level, when health has been involved in a response, District representatives will attend debriefing conducted by other agencies.

7. Appendices

Appendix 1 - Glossary and abbreviations

AMPLANZ	*Ambulance National Major Incident and Emergency Plan. 2005.* Detailed operational framework for the New Zealand ambulance sector.
ARPHS	Auckland Regional Public Health Service. http://www.arphs.govt.nz/
BCP	Business Continuity Plan – documented procedures that guide to respond, recover, resume and restore to a pre-defined level of operation following disruption.
CDEM	Civil Defence Emergency Management
CDEM Forums	Auckland and Northland CDEM Forums exchange experiences and present work streams conducted around the 4Rs, as well as raising public awareness.
CDEM Act	Civil Defence Emergency Management Act 2002.
CDEMG	Civil Defence Emergency Management Group, a group established under section 12 of the CDEM Act (2002).
CEG	Coordinating Executive Group
CIMS	Coordinated Incident Management System. A structure to systematically manage emergency incidents. The organisational structure allows multiple agencies or units involved in an emergency to work together.
Civil (Defence) Emergency	The Civil Defence and Emergency Management Act (2002) defines an emergency as 'a situation that: *Is the result of any happening, whether natural or otherwise, including without limitation, any explosion, earthquake, eruption, tsunami, land movement, flood, storm, tornado, cyclone, serious fire, leakage or spillage of any dangerous gas or substance, technological failure, infestation, plague, epidemic, failure or disruption to an emergency service or lifeline utility, or actual or imminent attack or warlike act and causes or may cause loss of life or injury or illness or distress or in any way endangers the safety of the public or property in New Zealand or any part of New Zealand and cannot be dealt with by the emergency services or otherwise requires a significant and coordinated response under this Act.*
DPMC	The Department of the Prime Minister and Cabinet.
Emergency managers	(Also known as emergency coordinators or emergency service leaders). Tasked with their organisation's responsibilities under the CDEM Act, this National Health Emergency Plan or the Ministry's Operational Policy Framework.
ECC	Emergency Coordination Centre, the Coordination Centre for a regional level response is an ECC, led by a Regional Controller.
EOC	Emergency Operations Centre, an established facility where the response to an emergency may be supported or coordinated at a local level.
ESCC	Emergency Services Coordinating Committee, a group coordinated by the NZ Police at District level. Committees provide a forum for emergency services to discuss emergency planning issues.
FENZ	Fire and Emergency NZ
Hazard	Something that may cause, or contribute substantially to the cause of, an emergency

HEP	Health Emergency Plan, every District is required to develop and maintain a plan for significant incidents and emergencies
Hospital and health service	As defined by the Health and Disability Services Act 1993
IHR	International Health Regulations 2005
iHNZ	Interim Health New Zealand
IMT	Incident Management Team, a group of personnel carrying out the functions of the CIMS structure
Lead Agency	The agency that has a mandate (through legislation or expertise) to manage a particular emergency
Lifeline utilities	Services or networks that provide the necessities of life, for example, power and gas, water, sewerage, petrol, roading, transporters of essential supplies, fast-moving consumer goods, radio, television, air transport and shipping
Likelihood	In risk management terminology used to refer to the chance of something happening (probability or frequency over a given time)
MCI	Mass Casualty Incident
MHA	Māori Health Authority – Te Aka Whai Ora
MoH	Ministry of Health. http://www.health.govt.nz/
NCDEMG	Northland Civil Defence Emergency Management Group
NCMC	National Coordination Management Centre
NGO	Non-Government Organisation
NEMA	The National Emergency Management Agency is the Government lead for emergency management. NEMA works with central and local government, communities, iwi, and business to make sure responses to and recoveries from emergencies are effective and integrated. http://www.civildefence.govt.nz/
NHCC	National Health Coordination Centre. A structure to coordinate the national health emergency response (Primary location Te Whatu Ora, Wellington).
NHEP	National Health Emergency Plan. https://www.health.govt.nz/system/files/documents/publications/national-health-emergency-plan-oct15-v2.pdf
NRHCC	Northern Region Health Coordination Centre. A structure to coordinate the northern region health emergency response.
NRHEP	Northern Region Health Emergency Plan. Provides an agreed framework and guiding principles, roles and responsibilities and efficient coordination process for Districts, their PHUs and providers
NZBS	New Zealand Blood Service. http://www.nzblood.co.nz/
ODESC	Officials' Committee for Domestic 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.

OPF	Operational Policy Framework. A group of documents that sets out the operational level accountabilities for Districts for each fiscal year. The OPF covers emergency obligations based on the 4Rs.
PHO	Primary Health Organisation. A grouping of primary health care providers; local structures through which Districts implement the Primary Health Care Strategy
PHU	Public Health Unit. Provide health services to populations rather than individuals. Led by a manager and staffed by medical officers of health, public health nurses, health protection officers and others
Primary Care	Care services provided by general practitioners, nurses, pharmacists, dentists, ambulance services, midwives and others in the community setting
Public Health Emergency	An unexpected adverse event that overwhelms the available public health resources or capabilities at a local or regional level. Public Health emergencies may or may not be declared civil defence emergencies. A non-civil defence public health emergency can be declared by a Medical Officer of Health when authorised by the Minister of Health, under the provisions of section 71 of the Health Act 1956
Regional Health Emergency	May arise when the resources of a District, or more than one District, are or have the potential to be overwhelmed and the incident requires regional assistance, management and coordination, either from within the northern region or nationally
REMS	Regional Emergency Management Service. Supports the emergency management deliverables in the four northern districts
Risk	The chance of something happening that will have an impact upon service delivery. The likelihood and consequences of a hazard
SOP	Standard Operating Procedure
Sitrep	Situation report used by emergency services to share information related to an incident
Welfare Coordination Groups (WCGs)	Chaired by the Welfare Manager and comprise government and non-government agencies working together to develop regional arrangements for the coordination of community welfare and recovery in the event of an emergency. Northland is a member of the Northland WCG; the Metro Districts/Te Whatu Ora and ARPHS have one representative each on the Auckland WCG plus Auckland Regional Public Health, Ministry of Health, Auckland Council Environmental Health and St John.
Te Whatu Ora Health NZ	An organisation established under Section 19 of the Public Health and Disability Services Act (2000). Formerly called District Health Boards up until 30 June 2022.
WHO	World Health Organisation http://www.who.int/en/

Appendix 2 - Roles and Responsibilities

Under the CDEM Act and National CDEM Plan, the Director-General of Health, on behalf of the Minister of Health, has overall responsibility for health matters related to emergency management. Districts lead the planning and response for emergencies at local level, including engagement with community-based providers. Other specified roles are summarised in the National Health Emergency Plan (NHEP) 2015 . (Page 8)
These are aligned with the National Civil Defence Emergency Management Plan Order 2015

Service	Responsibilities
Te Whatu Ora - Health NZ **1 July 2022**	Health NZ will manage all health services, including hospital and specialist services, and primary and community care. Primary health, wellbeing and community-based services will be planned and then purchased through four new regional divisions of Health NZ. The NZ Health reform disestablished the 20 existing District Health Boards and merged their functions into Health NZ.
Māori Health Authority	The Māori Health Authority works in partnership with the Ministry of Health and Health New Zealand, ensuring the health system works well for Māori.
Regional Coordination Centre	The Regional Coordination Centre has the responsibility for the delivery and coordination of a northern region health emergency response, e.g. NRHCC support effective and sustainable emergency management through: 1. Providing a faster and more flexible response; ensuring services can be rapidly scaled up and building equity-led regional governance for outbreak services. 2. Enabling quicker escalation and resolution of issues, sharing resources within region and providing enhanced support for smaller localities. 3. Minimising duplication of effort, doing things once per region instead of once per locality and quickly sharing information and best practice across a region.
Te Whatu Ora – Health New Zealand Te Tai Tokerau *(Previously – Northland District Health Board; DHB)*	Districts provide hospital and community-based health services (including Public Health Units). Districts are funders and providers of publicly funded services for the populations of specific geographical areas in New Zealand. Refer NHEP Table 1 (Page 9) & 2 (Page 11) National Health Emergency Plan.

Note:
- Effective supply chains are critical to reduction, readiness planning, reviews of, and updates to supply chain management should be considered as part of the planning process.

• Continuity of care for existing patients includes the development of integrated plans for the evacuation, relocation, or shelter in place of staff and patients due to fire or other hazards.	
Secondary Hospitals When the resources of public hospitals are fully committed, private medical facilities may be called upon to assist with surgical operations and other treatment within their capacity to provide.	**Secondary Hospitals will:** • Provide the facilities in which the majority of acute treatment for those affected by the incident is undertake • Accommodate the majority of recuperative patients during their immediate post operation period. • Maintain service continuity plans to minimise disruption to services through the loss of staff and the loss or impairment of buildings or utility services. • Plan for a graduated response, including the evacuation of patients. • Ensure the emergency plan is integrated locally and regionally and is aligned with public health and other emergency services. • Manage capacity to accept those needing hospital cares as a result of the incident. • Participate in an alternate communications network linking key healthcare facilities, including Tertiary Hospitals, and CDEM organisations; • Have arrangements for access to essential supplies during an emergency. • Participate in coordinated planning, training, exercising and response arrangements with complementary and neighbouring providers, the Ministry of Health and other key agencies • Agree mutual aid agreements with other providers, such as private hospitals; • Ensure all obligations can be met and there is regular monitoring of staff awareness and training; • Ensure readiness of resources; • Provide for incident review and debriefing of staff; • Private hospitals will plan to admit low acuity patients transferred from public hospitals; • Private hospitals will be prepared to make facilities available for public hospital patients; • Private hospitals will be prepared to make medical equipment and supplies available for public hospitals.

Mental Health Services Disastrous events cause psychological stress and may impair the mental health of both those immediately involved and the wider community. Psychosocial support to the wider community is supplied through a diverse range of health and welfare agencies.	**Mental Health Providers will:** • Develop service continuity plans to minimise disruption to services through the loss of staff or the loss or impairment of buildings or utility services. • Ensure all obligations can be met and there is regular monitoring of staff awareness and training; • Ensure readiness of resources; • Make provision for the psychological needs of those patients it has; • Provide for incident review and debriefing of staff;
Health and disability service providers	**Service providers will:** • Develop and maintain service continuity plans that minimise disruption to services through the loss of staff, impairment of buildings or utility services. • Ensure all obligations can be met and there is regular monitoring of staff awareness and training. • Ensure readiness of resources. • Work closely with social services departments, agencies and voluntary organisations, especially in relation to social and psychological support. • Provide for incident review and debriefing of staff.

Appendix 3 - Legislation

- Health (Burial) Regulations 1946
- Health Act 1956
- Health (Infectious and Notifiable Diseases) Regulations 2016
- 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
- Epidemic Preparedness Act 2006
- National Civil Defence Emergency Management Plan Order 2015
- Civil Defence Emergency Management Amendment Act 2016

International

- World Health Organisation International Health Regulations 2005

National Plans and Guidelines

- Guide to the National Civil Defence Emergency Management Plan (2015)
- National Health Emergency Plan; Ministry of Health (2015)
- New Zealand Influenza Pandemic Action Plan; Ministry of Health (2017)
- New Zealand Ambulance Services Ambulance National Major Incident Plan 2011
- Welfare Services in an Emergency Directors Guideline for CDEM Groups and agencies with responsibilities for welfare services in an emergency (2015)
- National Disaster Resilience Strategy (2019)

Regional Documents

- Northland Civil Defence Emergency Management Plan 2016-2021
- Auckland Civil Defence and Emergency Management Group Plan 2016-2021
- Emergency – Psychosocial response, Welfare Plan
- Auckland Welfare Coordination in emergencies 2019
- Northland CDEM Group Welfare Plan

Appendix 4 - Profile of the Northern North Island

Appendix 5: Factors to consider in a Mass Casualty Event

- Communications internal and external
- BAU, Bed-state and staffing numbers
- Rapid discharge
- Primary Care, Aged Residential Care, Ambulance
- District Hospitals
- Outpatients
- Elective Surgery
- Radiology electives
- ED Reports from Duty Manager liaising with clinical support, e.g. surgical and medical consultants.
- Liaison from the scene, i.e. type of injuries and volume expected for planning occupancy and staffing predictions
- Engagement of Metro Auckland hospitals, possibly National involvement. (The Emergency & Corporate Risk Manager can assist with this)
- Location of key facilities :
    - Dead and dying
    - Staff sign-in area
    - Media Centre
    - Volunteers
    - Family
    - Public room
- Discharge Lounge, and reconciliation team
- What is the impact on patient care?
- Are security and safety needs being met?
- Has the affected area been secured and access control implemented?
- Consider traffic control / hospital lockdown.
- Is the event likely to attract media interest?
- Is the event likely to escalate?
- Does the event have regional implications or the potential to escalate?
- Will the event require a multi-disciplinary and/or multi-agency response?
- Does the event have public health implications or will public health issues affect patient care services
- Communications internally/externally
- Is the hospital able to accept new acute patients?
- Security