MINISTRY OF HEALTH
MANATŪ HAUORA

National Health Emergency Plan

2008

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Foreword

Disasters and emergencies are as old as mankind, and we can be sure that new ones will occur without warning. It is the health sector's responsibility to respond in a way that mitigates the damage these events cause and which restores normality as soon as possible.

Health emergencies can range from the slow build-up of an infectious disease outbreak to the sudden devastation of an earthquake. Often the consequences are extreme and the likelihood is certain, but the actual timing is impossible to predict. All we can be sure of is that they will certainly happen, that the health sector has to be ready to respond and that our plans need to be robust enough to last, yet flexible enough to deal with any foreseeable circumstances.

The *National Health Emergency Plan* 2008 shows how we in the health and disability sector would work together in a co-ordinated way with other government agencies to respond to disasters and emergencies.

Stephen McKernan
Director-General of Health

Request for feedback

The National Health Emergency Plan (NHEP) has been in existence since 2004 and will continue to evolve. The Ministry of Health (Ministry) welcomes any feedback on structure, process and content, and will consider all feedback for future versions.

Please send comments to:

NHEP
Risk and Assurance
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Or email comments to: nhep@moh.govt.nz

Purpose of the NHEP

The NHEP provides overarching direction to the health and disability sector and all of government.

Specifically the NHEP:

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

Definition

Emergencies impacting on the health sector occur continually, and the health and emergency services respond accordingly. The trigger for activating a health emergency plan is the point at which usual resources are overwhelmed or have the potential to be overwhelmed.

The concept of being overwhelmed will be used throughout the NHEP without a detailed definition. This will allow for provider flexibility in the assessment of a pending, developing or current emergency on an hour-by-hour or day-by-day basis.

A health emergency plan may be activated at the local, regional or national level when the incident controller – for example a chief executive or deputy, regional or national co-ordinator – believes that a situation exists that is overwhelming or has the potential to overwhelm the resources available.

Structure

This document is in three parts.

A) The NHEP

This section provides information on the emergency management approach used throughout the NHEP, based on the four 'R's of emergency management: reduction, readiness, response and recovery. These four phases are addressed sequentially.

B) Supporting material

This section contains further information, explaining the national Civil Defence Emergency Management (CDEM) framework, outlining the co-ordinated incident management structure used in a health emergency, and thereafter providing information on the framework used for funding during the planning and response cycles. The section ends with an overview of the ethical values that underpin decision-making in an emergency.

C) Appendices

This section provides information on relevant legislation and gives website addresses and references for key documents that may be useful for agencies involved in developing health emergency plans. The section concludes with a glossary and list of abbreviations used throughout the NHEP.

The NHEP has been written using the verbs 'shall' and 'may'. The use of the verb 'shall' indicates that the action described is mandatory or a requirement. The use of the verb 'may' indicates that the action is permissive and not mandatory.

Audience

The NHEP and reference materials are relevant for anyone involved in planning for or responding to an emergency involving the New Zealand health and disability sector.

The audience for this document is primarily providers of residential health and disability services throughout New Zealand, plus those agencies who interact with these providers, such as ambulance, fire and police services, the Ministry of Civil Defence and Emergency Management and other government agencies.

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The National Health Emergency Plan

Introduction

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

A national emergency often affects access to health care services and the health care system's ability to respond to the public's health needs.

Emergency preparedness is progressive, continuously building increased resilience among the public and relevant agencies. This ongoing process involves careful planning, designing of response actions, testing and evaluating of processes and continual updating. For the health sector, careful planning in particular is critical to safe-guarding the public health care system. Education and training of the health workforce, who will activate the health emergency plan should it be required, are also essential.

A number of Acts and Regulations covering emergency management apply. These are listed in Appendix 1.

In 2002 the New Zealand Government repealed the Civil Defence Act 1983, replacing it with the Civil Defence and Emergency Management Act 2002. This Act stipulates the roles and responsibilities of key government agencies, including the Ministry, in an emergency.

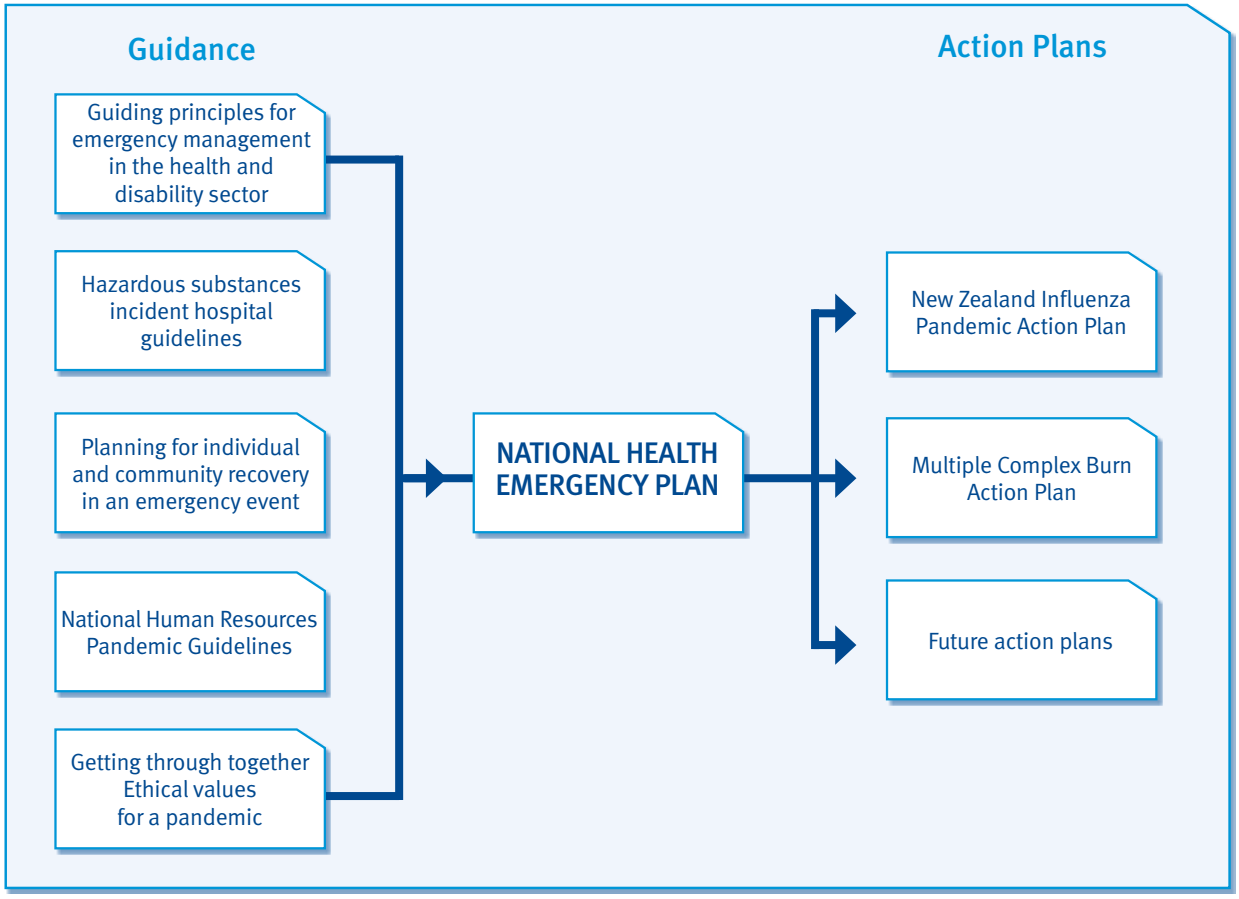
In 2004, in response to the threat of the Severe Acute Respiratory Syndrome (SARS) virus, the Ministry produced the original *National Health Emergency Plan: Infectious Diseases* (NHEP:ID). Since then the role of the health and disability sector in the event of an emergency, as both a lead and a supporting agency, has been more clearly defined.

Since 2004 the Ministry's focus in this area has included publication of a series of emergency management-related documents to provide guidance in a health-related emergency. These mostly strategic documents are underpinned with specific action plans. The suite of guidance documents and action plans includes:

- *Getting Through Together: Ethical values for a pandemic,* 2007 (published by the National Ethics Advisory Committee)
- *Guiding Principles for Emergency Management Planning in the Health and Disability Sector,* 2005
- *Hazardous Substances Incident Hospital Guidelines*, 2005
- *National Human Resources Pandemic Guidelines*, 2007
- *Influenza Pandemic Action Plan*, 2008
- *Planning for Individual and Community Recovery in an Emergency Event: Principles for psychosocial support*, 2007.

The relationship between these documents and the NHEP is illustrated below.

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



The latest electronic versions of all NHEP documents are available at http:/www.moh.govt.nz/emergencymanagement

Guiding principles and objectives

The guiding principles for managing health emergencies are to provide:

- a plan that encompasses reduction, readiness, response and recovery
- effective planning enabling an appropriate response to all hazards that may result in an emergency
- an emergency management structure that enables a consistent and effective response at the local, regional and national level
- an emergency management structure that supports, to the greatest extent possible, the protection of all health service workers, health and disability service consumers and the population at large
- support for services that are best able to meet the needs of patients/clients and their communities during and after an emergency event, even when resources are limited, and ensure that special provisions are made for hard-to-reach, vulnerable communities so that emergency responses do not create or exacerbate inequalities
- planning that adopts an all-hazards ('hazardscape') approach and considers all natural and man-made hazards cumulatively across a given area
- planning that recognises the importance of engaging with different cultures and communities to ensure an inclusive approach
- planning that includes an awareness of the way resources, both human and other, can be used to help people from culturally and linguistically diverse communities, and overseas visitors who may be unfamiliar with New Zealand practices
- planning for the use of all health and disability providers in the provision of welfare to their own staff who are affected by the emergency, including those operating during it.

The objectives of the NHEP are to:

- describe the larger context within which the Ministry and all New Zealand heath and disability services will function during any national health-related emergency, including New Zealand's responsibilities under international agreements and regulations
- clarify the roles and responsibilities of the Ministry, district health boards (DHBs) and their public health services and other key organisations
- provide specific advice to assist health and disability services to prepare their own action plans
- outline the Ministry's emergency management system
- prescribe expectations for DHB emergency management systems.

Emergency management approach

The four phases of emergency management are referred to as the four 'R's. These are defined in the National Civil Defence Emergency Management Plan Order 2005 as follows:

- Reduction – (identifying and analysing long-term risks to human life and property from natural or non-natural hazards; taking steps to eliminate these risks if practicable and, if not, reducing the likelihood and the magnitude of their impact and the likelihood of their occurring)
- Readiness – (developing operational systems and capabilities before a civil defence emergency happens, including self-help and response programmes for the general public, and specific programmes for emergency services, lifeline utilities, and other agencies)
- Response – (actions taken immediately before, during, or directly after a civil defence emergency to save lives and property, and to help communities recover)
- Recovery – (the co-ordinated efforts and processes used to bring about the immediate, medium-term and long-term holistic regeneration of a community following a civil defence emergency).

The following sections of this document sequentially address each of these four Rs.

Reduction

Reduction involves a consideration of natural or man-made risks that are significant because of the likely adverse consequences they represent for human life and property. The key factor within reduction is risk mitigation.

Risk mitigation strategies start with the identification and analysis of significant natural and man-made hazards. Analysis of these hazards, using a matrix based on their likelihood and consequence, enables calculation of a value representing the level of risk involved. The risk can then be prioritised. Thereafter a risk mitigation strategy can be developed accordingly, to eliminate risks where practicable and, where not, to reduce the likelihood and magnitude of their impact.

Many events have the potential to become a health emergency. These may result in providers being potentially or actually overwhelmed. Different emergencies pose different challenges. Emergency events can escalate to the point where they will impact on the health sector's ability to provide health and disability services.

This section begins with a consideration of the concept of an all-hazards approach to identifying, analysing and reducing long-term risk to human life and property. Thereafter the section discusses reducing risk and hazard surveillance.

Identifying and analysing hazards

When developing an emergency management response, planners shall take an all-hazards, all-risks, multi-agency, integrated and community-focused approach, in accordance with the National CDEM Strategy. All hazards that may occur in the area should be considered, and then, having identified the likelihood of each occurring and the likely consequences, risks should be prioritised and ranked. The use of the joint Australian/New Zealand Standard AS/NZS 4360:2004 Risk Management is recommended for undertaking the process of risk identification.

At the national level, *The National Hazardscape Report* (2007), published by the Officials Committee for Domestic and External Security Co-ordination (ODESC), identifies and considers the range of natural and man-made hazards that have relevance to New Zealand from a national perspective. These include the following:

- earthquakes
- volcanoes

- landslides
- tsunamis
- coastal hazards (for example, swells and storm surges)
- floods
- severe winds
- snow
- droughts
- wildfires
- animal and plant pests and diseases
- infectious human disease pandemics (including water-borne illnesses)
- infrastructure failures
- hazardous substance incidents
- major transport accidents
- terrorism
- food safety (for example, accidental or deliberate contamination of food).

Most of the above hazards might involve the heath and disability sector, and some may cause providers to be overwhelmed. Health emergency plans should include assessment and prioritisation of hazards based on the impact they will have on provision of services.

More detailed information on each hazard and its implications for particular areas of New Zealand can be found in the *National Hazardscape Report*. Additional information can be obtained from CDEM group plans, accessible via the Ministry of Civil Defence and Emergency Management (MCDEM)'s website at http://www.civildefence.govt.nz. All planners shall use this information to develop a regional listing of hazards – where appropriate, in consultation with local CDEM groups.

Reducing risk

A hazardscape analysis is then used to inform and develop risk mitigation strategies. Local CDEM groups have already developed strategies for managing most natural and man-made hazards. Providers should work with their local CDEM groups and health agencies within their local and/or regional area to ensure that strategies are appropriate, realistic and well integrated.

National hazard surveillance

The Ministry gathers intelligence in various ways. In keeping with the principles of hazard management and reducing risk, the Ministry, in consultation with MCDEM and other government agencies, conducts a 'watching brief' on emerging hazards and changing risks, both national and international. It receives alerts through MCDEM regarding national and international events, for example earthquakes and potential tsunamis. The Institute of Environmental Science and Research Ltd (ESR) provides national surveillance information, while the National Centre for Biosecurity and Infectious Disease (NCBID) operates early aberration detection and provides communicable disease alerts to the Ministry and public health units. As hazards and risks become known, information is collected and disseminated by the Ministry to the health and disability sector, and vice versa.

Readiness

Readiness involves planning and developing operational arrangements before an emergency happens. It includes consideration of response and recovery. It involves equipping, training and exercising in preparedness for all emergencies identified in the risk analysis. All systems need to be developed, tested and refined in readiness for response.

This section covers the development of emergency plans, and the exercise and revision of those plans. It then addresses key considerations for planning, such as human resources, volunteers, visitors and dependents, public information management, teletriage and community-based assessment centres. Finally, the section outlines the single point of contact system, national reserve supply planning and surge capacity.

Development of emergency plans

Readiness involves the development of operational systems before an emergency happens. Successful emergency management is heavily reliant on excellent planning.

All providers shall have emergency plans that correspond to their hazardscape and in accordance with the specifications in their funding agreements. In addition, providers required to be certified under the Health and Disability Services (Safety) Act 2001 shall ensure that their plans meet the Health and Disability Standards (2008) Part 4.7: 'Essential, emergency and security systems', and ensure that their plans are linked with their local DHB's plans. DHB plans shall be developed in accordance with Operational Policy Framework (OPF) requirements within the Crown funding agreement and include the use of WebEOC, which is the web-based emergency management information system used in the health sector. DHBs have overall accountability for the emergency preparedness of health and disability services in their area.

All health and disability providers are also required to plan for management of any significant risks to the continuity of their service. Business continuity planning shall take into account the range of hazards that may disrupt a provider's service, or require an emergency response by that service. Additional information on business continuity plans and some useful links are available at http://www.civildefence.govt.nz. Business continuity plans also need to take recovery issues into consideration. Providers should discuss their business continuity plans with their employees, their main suppliers and their financial advisors. Special funding arrangements for DHBs during the planning and response phase of an emergency are addressed in Part B of this document.

Primary health organisations (PHOs) shall also develop and maintain emergency response plans. These plans are required to address processes for protecting an organisation's enrolled population and staff and its continuity of business. The plans will also demonstrate the PHOs' ability to respond to the NHEP and provide an integrated response framework for an emergency situation for the individual practitioner and at the level of each independent general practice.

Ambulance providers are required to develop and maintain a National Major Incident and Emergency Plan (AMPLANZ) in accordance with the NZ8156 Standard, as well as specific regional plans, which shall be integrated with DHB emergency plans. DHBs should be the main local co-ordination points for ambulance providers in their emergency planning and response, in order to ensure an integrated operational response. Ambulance providers shall also develop a mechanism of national co-ordination to ensure the most appropriate use of resources in a major emergency. Ambulance providers may also work with CDEM groups.

DHBs and other health and disability agencies shall liaise with each other to ensure they can provide an integrated emergency response at a local level. DHBs shall also work with the Ministry and with local authorities and other relevant agencies to ensure plans are integrated at a local and regional level.

Each DHB shall work with the other DHBs in their regional grouping as listed below in Table 1 to develop a regional health emergency plan (RHEP). This is in accordance with the requirements of the National Civil Defence Emergency Management Plan Order 2005.

Table 1: DHB regional groups

Region	District Health Boards
Northern	Northland, Waitemata, Auckland, Counties Manukau
Midland	Waikato, Bay of Plenty, Lakes, Tairawhiti, Taranaki
Central	Whanganui, MidCentral, Hawke's Bay, Wairarapa, Hutt Valley, Capital & Coast
Southern	Nelson Marlborough, West Coast, Canterbury, South Canterbury, Otago, Southland

Public health units within DHBs are contracted directly by the Ministry to deliver programmes that protect the health of the population. This protection also includes emergency planning. The Ministry requires that the emergency planning of public health units complements plans developed by DHBs and regional groupings of DHBs.

Regional health emergency plans (HEPs) shall be activated when the emergency requires a regional response. DHBs within each region are responsible for their development and maintenance. A regional response will be required when local providers are overwhelmed and the situation warrants regional management. Any incident requiring a response from more than one DHB, or a request for assistance from one region to another, shall be dealt with regionally.

Exercising and reviewing emergency plans

All HEPs require ongoing testing through exercising to ensure they will be effective when activated. The education and training of staff likely to be involved in the activation of a health emergency plan is essential to ensure effective functioning in what will be a highly stressful and unusual situation. The ongoing exercising of emergency plans will increase the pool of appropriately trained people competent in emergency management.

Providers shall also participate in joint exercises with other health and disability providers and emergency response agencies. This will ensure that all HEPs are well integrated, which is important in light of the fact that most emergencies require some degree of inter-agency response.

Following each exercise, all HEPs shall be evaluated and reviewed as appropriate. Reviewing of plans will necessitate further training and exercising.

Key considerations in planning

This section covers vulnerable communities, human resources, volunteers, visitors and dependents, public information management, teletriage, community based assessment centres, the single point of contact system, national reserve supplies and surge capacity.

Vulnerable communities

Identifying communities that may be particularly vulnerable in an emergency is of particular importance during the planning process. There are likely to be several communities that need special consideration.

Such communities can include:

- Māori
- Pacific
- other ethnic communities where English is not spoken or is a second language
- remote/isolated communities
- the aged and/or infirm, including those within aged care facilities
- people with disabilities, including those within disability residential facilities
- tourists.

Consideration of the specific needs of Māori, cultural sensitivity issues and the possible impact of emergency planning on traditional Māori protocols (tikanga) should be an integral aspect of health emergency preparedness planning at all levels. Māori concerns can be most effectively addressed through active engagement with Māori and the distribution of key messages to Māori through a variety of media.

DHBs shall establish and maintain effective dialogue with their vulnerable communities, and in particular those groups that may be particularly vulnerable during an emergency. Engaging in dialogue during the planning process can help determine solutions to potential challenges. Involving organisations that support vulnerable sections of the community will promote alignment of HEPs within the area.

Further information is available from the following MCDEM publications: *Working Together: Guidelines for emergency managers working with culturally and linguistically diverse communities*, 2006 and *Mass Evacuation Planning: Director's guidelines for civil defence emergency management (CDEM) groups*, 2008.

Human resources

Human resources are an essential part of an effectively managed response to a health emergency. Plans shall take into account different types of emergencies and their likely impact on staff numbers and capabilities, as well as on staff safety and health, during both short and long-term emergencies.

Staff shall be educated and trained in the co-ordinated incident management system (CIMS) structure used in the emergency operating centre (EOC), as outlined in Part B. They shall have knowledge of how the HEP for their area will work in an emergency, what their likely role within the CIMS structure will be, and how the services they normally provide will be affected in an emergency.

The demand for skilled staff to manage the response during the early stages of an emergency means there will be little time during an emergency situation for education and training in basic competencies. In keeping with the principles of readiness, DHBs shall ensure the ongoing competency of staff in order to avoid the need for significant extra training at that time.

All providers, including the Ministry, shall plan to have sufficient staff capable of maintaining a 24 hours a day, seven days a week response using the CIMS structure over an extended period of time until a stand-down is issued. The CDEM plan order (28(4)(f) and 28(5)(e)) requires health providers to train as appropriate. Staffing levels in an EOC are likely to fluctuate over the period of the emergency. Depending on the emergency, multiple teams of staff may be required to staff an EOC using the CIMS structure.

Providers shall develop a system of communicating with their off-duty staff during an emergency. In developing this system, consideration shall be given to ensuring off-duty staff can travel under their own means to the provider when required in an emergency. Consideration shall also be given to the reverse situation, in which a larger number of staff than is immediately necessary respond to the emergency. The need for staff to be able to rest in the early stages of an emergency so that they remain fresh for upcoming shifts shall also be taken into account.

One of the challenges to providers in responding to an emergency will be the ability of the provider to manage the emergency with what may be a reduction in their permanent workforce. The casual workforce may be under no obligation to work in an emergency. Some staff may not be willing or have the ability to work in an emergency: for example, staff with dependent children.

Any reduction in normal capacity is likely to involve redeployment of staff, which may affect capabilities. Redeployment may involve professional regulation issues regarding scope of practice. In any emergency staff should still work within their normal scope of practice, as prescribed by section 8 of the Health Practitioners Competence Assurance Act 2003 (HPCA Act). Section 8(3a) of the HPCA Act states that an exemption applies ‘in an emergency’, but the term ‘emergency’ is not defined in the Act.

Plans need to consider how best to redeploy the workforce. This includes the use of health professionals who may volunteer their services. Plans shall acknowledge that redeployed staff may face the stress of unfamiliar environments and procedures, lack of confidence and high-pressure working conditions.

Providers shall also plan for the health and welfare of their staff in the recovery period. The resilience of the workforce during an emergency and staff’s ability to recover well after the event is directly related to planning and preparedness.

Preparation of the workforce also includes personal emergency planning. Workers are generally not able to focus on delivering care to others when they have concerns for their own personal and family wellbeing.

Further information on human resource matters can be found in the *National Human Resources Pandemic Guidelines*, 2007. The Ministry is working with DHBs currently to develop a national human resources emergency planning toolkit for DHBs, which will be based on the *National Human Resources Pandemic Guidelines* and other relevant best practice standards. This toolkit will have relevance to other health and disability providers.

Further information can be located on the Ministry's emergency management web page: http:/www.moh.govt.nz/emergencymanagement.

Volunteers

Many people may offer their assistance in times of emergency including existing volunteers. Some of these people may have no prior experience in working in a health and disability organisation.

It is important that planning for the involvement of volunteers occurs prior to an emergency, rather than in an ad hoc way at the time. DHBs shall therefore plan for the use of both existing and spontaneous volunteers.

Volunteers may be required to provide non-clinical support in an emergency, especially in situations where the workforce is reduced and unable to meet demand. Health professional volunteers may be able to provide assistance to clinical staff. Volunteers can provide non-clinical support in the form of undertaking administration tasks, assisting in rescue efforts or in communication, providing transportation, completing physical/structural repairs, moving people out of harm's way and directing traffic.

MCDEM, in consultation with partner agencies such as the New Zealand Red Cross and Volunteering NZ, has produced a best practice guide titled *Spontaneous Volunteer Management: A guide for CDEM practitioners*, 2006, which is available on MCDEM's website. The guide was developed to assist CDEM groups in planning for the management of spontaneous volunteers. It contains sections on preparing for, briefing and managing spontaneous volunteers and the legal issues associated with using volunteers, and provides other resources, such as templates for job descriptions and name badges.

Visitors and dependants

In emergencies, DHBs can expect to have to cope with large numbers of people not needing care but wanting to be with sick relatives or friends, or wanting to locate missing relatives. This will present additional management challenges. Plans will need to take different type of emergencies into account in this context.

An emergency may also result in numbers of dependants, young, elderly or disabled, being effectively orphaned and/or isolated because of the hospitalisation or death of their principal caregiver. Planning will need to take these situations into consideration: liaison with welfare agencies may be required.

Public information management

Effective public information management involves collecting and analysing information and disseminating it to the public. This promotes effective leadership and decision-making and enables people affected by an emergency to understand what is happening and to take the appropriate actions to protect themselves. Successful public information management should create strong public confidence in the emergency response, support public safety, positively influence public behaviour and fulfil public expectations.

These ends are achieved by the provision of timely, accurate and clear information to those who need it. Effective information management is also desirable between government agencies, CDEM groups, emergency services, lifeline utilities, the media and the public.

People respond differently to information. The provision of public health information shall consider both the nature of the message (taking into account, for example, language and literacy levels), and the best mechanisms for disseminating it, in terms of what will be most effective for its intended audiences.

The Ministry and DHBs shall take an active role in public information management in a national health emergency. National media communication in a health emergency is likely to be managed by the Ministry in consultation with other government agencies and DHBs. DHBs, in developing their public information management plans, shall take this into consideration. DHB plans shall address methods of disseminating national messages to their local populations and reinforcing local messages for their local populations. A guide for public information management has been developed for CDEM groups and is available on the MCDEM website.

Teletriage

DHBs shall plan to activate teletriage systems that the public can access over the telephone for health information and advice in an infectious disease outbreak. These systems reduce the need for the public to come to a hospital for information. Establishing a 24 hours a day, seven days a week call centre system using a free call line will give the public continuous access to professional advice and information on urgent and non-urgent health-care conditions. DHBs, in consultation with primary and community providers, ambulance communications centres and ambulance services, shall plan the most effective way of responding to large volumes of demand while maintaining other services to the greatest degree possible.

Community-based assessment centres

A national or regional health-related emergency is likely to put significant pressure on primary and community services as well as hospital emergency services and ambulances. DHBs, in consultation with primary and community providers and ambulance services, shall plan the most effective way of responding to large volumes of demand in a significant health emergency, while maintaining other health services to the greatest degree possible.

DHBs' planning, in conjunction with local primary health care services, shall plan for the establishment of community based assessment centres (CBACs) in provision for the activation period of an emergency. Planning shall acknowledge the requirement to inform the Ministry of any decision to activate a CBAC.

The purpose of a CBAC is to provide additional primary health care capacity. A sudden increase in demand for primary care services may arise from the need to provide separate facilities for people with infectious disease symptoms during a significant outbreak such as an influenza pandemic, or when there has been a mass casualty incident, or evacuation from a DHB or region.

CBACs will require clear clinical leadership, with strong management and administrative support. They will provide clinical assessment, advice, triage and referrals as necessary. They will not provide in-patient or observation services.

These centres can be established in any facility where the resources for the required clinical services can be provided and where they can best meet the needs of the local community: for example, within a medical centre, a hospital outpatient facility, a community hall, or a marae. Different approaches will be required in considering the use of a marae compared with that of a community hall; consultation will be required. CBACs may also need to be closely co-located to pharmacy services.

The final decisions on the nature, location and activation of CBACs shall be made locally by the DHB. These centres, once established, shall have their purpose and location widely publicised.

The Ministry has published a 'Guidance for CBACs' document. This information is available at http:/www.moh.govt.nz/emergencymanagement.

Single point of contact system

The single point of contact (SPOC) system is a method used to provide effective 24-hours, seven-days-a-week communication between DHBs, their public health units and the Ministry. The Ministry and each DHB currently maintain this system with the Ministry maintaining the SPOC contact lists, and regularly testing and reviewing the integrity of the system.

All DHBs and medical officers of health are able to contact senior officials at the Ministry at any time via an 0800 number, for the purpose of notification of a potential or actual health-related emergency requiring a national or regional response. The Ministry SPOC system is specifically maintained for this purpose.

The SPOC system is an integral component of readiness that remains in place at all times. It supplements but does not replace normal day-to-day non-emergency communication channels and processes. The SPOC system is only intended to be used for initiating an emergency response.

National reserve supplies

In readiness for increased demand for specialist emergency equipment and supplies, during an emergency and in the recovery period, the Ministry shall manage a number of national reserve emergency supply reserves and stockpiles.

Reserve supplies include:

- personal protective equipment (for example, P2 respirators and general-purpose face masks, gowns and gloves)
- clinical equipment and vaccination supplies (for example, needles, syringes and intravenous fluids)
- medicines and vaccines (for example, Tamiflu antivirals, and pandemic antibiotics)
- other supplies (for example, body bags).

The Ministry shall distribute these reserve supplies if or when normal supply chains are overwhelmed or cannot meet demand. DHBs shall use supplies from their own stores and normal suppliers and any supplies available from other DHBs in their region before utilising national reserve supplies. The Ministry shall relocate and restock these supplies as necessary.

Surge capacity

Worldwide experiences in responding to complex emergencies have demonstrated the need to plan for enough facilities and resources for patients and clients to be able to be decanted safely and continue to have access to health care. Facilities and resources need to be able to expand quickly in order to respond to an unexpected increased demand or 'surge' of patients in a health emergency.

Providers, particularly DHBs, shall consider three aspects when planning their surge capacity. First, the provider shall have the capacity to accommodate a surge in place when early transfer or discharge of current patients to other areas is required. Alternative areas may need to be arranged in which to manage patients requiring admission, and patient clinics and elective services may need to be cancelled. Secondly, the decanting of patients or clients from facilities in which services have been lost or severely reduced will need to be considered. Thirdly, providers need to consider the deployment of staff from one area to another to assist with the response.

Response

Response involves those actions taken immediately after the recognition an emergency is taking place or is imminent, during, and after an emergency. It also involves the recovery of affected communities.

This section covers the trigger for activation of an emergency plan, the issuing of health sector alert codes and the roles, responsibilities and actions to be taken at the local, regional and national levels. Thereafter there is discussion on communications, employee health and safety, roles of medical officers of health and care of the deceased. The section concludes with comments on planning for recovery and standing down following activation of a HEP.

Activation trigger

Health emergency plans are activated when usual resources are overwhelmed or have the potential to be overwhelmed in a local, regional, or national health emergency. To trigger the activation of a HEP, the event must require more than the business-as-usual management of emergencies.

All providers can activate their HEP in these circumstances. DHBs can activate both local and regional HEPs, and the Ministry can activate the NHEP. The Ministry can also require DHBs to activate their local and regional plans once the NHEP has been activated.

Health sector alert codes

The Ministry has developed alert codes to provide an easily understood system of communication for an emergency. These alert codes are issued via the SPOC system.

The alert codes outlined in Table 2 have been adopted for use by the health and disability sector at district, regional and national levels. Other government agencies may choose to align their response to a health emergency to this structure; however, this is not a requirement.

Table 2: **Health sector alert codes**

Phase	Situation	Alert Code
Information	Confirmation of a potential emergency situation that may impact in and/or on New Zealand Example: emergence of a new infectious disease with pandemic potential, or early warning of volcanic activity.	**White**
Standby	Warning of imminent code red alert which will require immediate activation of HEPs Example: imported case of a new and highly infectious disease in New Zealand without local transmission, or initial reports of a major mass casualty event within one area of New Zealand which may require assistance from unaffected DHBs.	**Yellow**
Activation	Major emergency in New Zealand exists which requires immediate activation of HEPs Example: large-scale epidemic or pandemic or major mass casualty event requiring assistance from outside the affected region.	**Red**
Stand-down	Deactivation of emergency response Example: end of outbreak or epidemic. Recovery activities will continue.	**Green**

Roles and responsibilities by alert codes

The role of the Ministry in an emergency is national co-ordination of health and disability services. The Ministry shall also co-ordinate all international arrangements for the health and disability sector, in partnership with the Ministry of Foreign Affairs and Trade and MCDEM.

The primary response for the management of an emergency lies with the affected local provider, which may be the local DHB, or the DHB regional group, if a regional emergency plan is activated. At each phase of an emergency there are specific actions that need to be taken at the local, regional and national level. Table 3 summarises key roles and responsibilities at the local, regional and national level during each alert code.

Table 3: Key roles and responsibilities at the local, regional and national level

Phase/ alert code	National (Ministry)	Regional	Local (DHB)
All alert phases	• Co-ordinates the health sector operational response at the national level • Provides information and advice to the Minister • Provides strategic direction on health sector response • Liaises with other agencies at the national level • Liaises with international agencies • Identifies and activates national technical advisory group(s) as required • Provides clinical and public health advice on control and management, where possible • Approves/directs distribution of national reserve supplies • Ensures technical advisory groups analyse critical data • Provides information to assist with response • Plans for recovery.	• Co-ordinates the regional health response • Liaises between the Ministry, DHB groupings and other agencies' regional emergency structures • Co-ordinates intelligence-gathering and tasking in region.	• Co-ordinates and manages the health sector 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.

Phase/ alert code	National (Ministry)	Regional	Local (DHB)
Information (code white)	• Issues code white alert through SPOC system • Monitors situation and continues surveillance • May activate a national incident on WebEOC • Advises DHB chief executives, DHB single points of contact and all public health unit managers of the emerging situation and potential developments • Provides media with public information and advice, as necessary • Liaises with other Government agencies at the national level as necessary • Liaises with international agencies as necessary.	• Not activated in 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 HEPs • Prepares to activate emergency plans • Liaises with other emergency management agencies within the region.

Phase/ alert code	National (Ministry)	Regional	Local (DHB)
Standby (code yellow)	• Issues code yellow alert • Identifies and appoints national incident management team • May activate a national incident on WebEOC • Assesses whether activation of the National Health Co-ordination Centre is required, and activates if necessary • Determines and communicates strategic actions for response to the incident • Identifies and activates national technical advisory group(s) as required • Advises the health sector of the situation via the SPOC system • Manages liaison and communications with other government agencies • Manages liaison with international agencies.	• Not activated in code yellow. Note: in some circumstances a single regional co-ordination team may be activated without the national plan moving to the red phase. This may occur when a health-related emergency is localised and likely to remain so, or when the Ministry considers activation of the NHEP is not currently required.	• Prepares to activate DHB emergency operations centre • Identifies need for and appoints DHB incident management team • Prepares to activate regional co-ordination • 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. Note: in certain types of emergencies (such as a pandemic) public health units may fully deploy whilst clinical services remain on standby to provide assistance to public health units if required, and to mount a clinical response.

Phase/ alert code	National (Ministry)	Regional	Local (DHB)
Activation (code red)	• Issues code red alert; thereafter communicates via the four regional co-ordinators • Activates a national incident on WebEOC • Co-ordinates health response at the national level, as required • Activates the National Health Co-ordination Centre, as required • Monitors the situation, revises and communicates strategic actions for response, as appropriate • Approves/directs distribution of national reserve supplies when required • Considers strategic recovery issues • Provides clinical and public health advice on control and management, where possible • Carries out national public information management activities • Manages liaison with other government agencies • Manages liaison with international agencies • Implements recovery planning.	• Activates regional incident management structure and identifies a regional co-ordinator • Co-ordinates the regional health response • Communicates with the Ministry, regional DHBs and other agencies' regional emergency structures • Co-ordinates regional intelligence gathering.	• 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 regional co-ordination centre with DHB/ community health intelligence.

Phase/ alert code	National (Ministry)	Regional	Local (DHB)
Stand-down (code green)	• Issues code green alert • Advises other government and international agencies of stand-down • Advises media and public • Stands down Ministry incident management team • Stands down the National Health Co-ordination Centre • Focuses activities on national recovery issues for the health sector • Implements recovery plan in conjunction with other agencies • Supplies national public information on recovery • Manages national debrief and evaluation of events • Reviews plans.	• Stands down regional co-ordination • Participates in debrief • Updates plans.	• Stands down DHB emergency operations centre • Stands down DHB incident management team • Focuses activities on health recovery issues in the DHB region • Facilitates debriefs • Provides Ministry with information following debriefs • Updates plans.

During a national emergency, individual providers may move through the alert levels at different times.

Activating a local HEP

A provider can activate their HEP when they believe they are overwhelmed or have the potential to be overwhelmed. When a provider activates their HEP they shall communicate this to their local DHB. It is likely that all local providers will simultaneously activate their HEPs if, for example, a major earthquake occurs. Individual plans having been activated by the various providers, the DHB will then determine the level of activity required and will activate its HEP accordingly. When a DHB activates its HEP it shall advise the Ministry.

An affected DHB shall immediately notify the Ministry of a potential or actual large-scale emergency through the Ministry's SPOC system (although if the Ministry has advised the DHB of the need to activate their local HEP this action is not required). The affected DHB shall communicate with the Ministry through the SPOC system and WebEOC for the duration of the emergency.

Activating a regional HEP

An affected DHB may activate its regional HEP with the agreement of other DHBs in its region. Each regional HEP includes the structure of the response at the regional level. DHBs in each region shall have a process for activating their HEPs.

A regional HEP is always activated if the NHEP is activated. It shall also be activated if the emergency is such that it involves the whole region, or if a local DHB is overwhelmed and not able to manage a local response.

Resourcing and supporting a regional health co-ordination centre in an emergency is the collective responsibility of the DHBs within each region. The mechanism for doing so shall be documented in the regional HEP even when some aspects, such as location, may be dependent on the context of the particular emergency.

In activating a regional response, DHBs shall appoint a regional co-ordinator, who shall notify the Ministry of the regional structure and contact point as noted above. The person appointed to the role of regional co-ordinator is likely to be a senior DHB staff member employed within the DHB. Deputies to regional co-ordinators will also need to be appointed to ensure leadership in the absence of the regional co-ordinator. Other teams of staff will need to be appointed using the CIMS structure. The number of teams required will depend on whether the emergency is likely to continue over an extended period of time. All communications between the region and the Ministry shall be channelled through the regional co-ordinator.

Although the Ministry currently employs staff to provide regional emergency management advice to all DHBs, as well as having staff employed in unrelated capacities in regional offices, it is not intended that these staff be appointed to act as local or regional co-ordinators or in other roles within DHB CIMS structures. The Ministry shall determine the role of their staff in the event of an emergency.

Activating the NHEP

The Ministry will activate the NHEP when local or regional responses are overwhelmed or have the potential to be overwhelmed. At this point the Ministry will also assess whether the National Health Co-ordination Centre (NHCC) needs to be activated. The role of the NHCC is to provide national co-ordination of the health sector in an emergency.

Co-ordination of a health emergency at the national level will be affected by two factors in particular:

- whether the Ministry of Health is the lead government agency involved, or providing support to the lead agency
- the size and scope of the health sector and inter-agency co-ordination required to manage the response.

The Ministry will appoint an emergency management team as required and will provide the contact details to the health sector via the agreed health sector emergency communications structure.

Ministry as lead government agency

In a national emergency where the Ministry is the lead government agency, it has two roles:

- coordinating the health and disability sector response
- coordinating the all-of-government response.

In this scenario, the Ministry, in conjunction with the Department of the Prime Minister and Cabinet (DPMC), will make an assessment of what level of all-of-government co-ordination is required. If the level of co-ordination able to be achieved is limited, for example during border management operations, it is possible that both the health and disability sector response and the all-of-government response will be co-ordinated by the NHCC. If significant all-of-government co-ordination is required in order to support the domestic and external security co-ordination (DES) system, the National Crisis Management Centre (NCMC) may require activation.

The NCMC is activated by ODESC in consultation with the DPMC. It facilitates an all-of-government response in support of government crisis management arrangements by providing a secure, centralised facility for information gathering and information management, strategic level oversight, decision-making and co-ordination of national responses.

In this situation, the health sector co-ordination will continue to be based at the NHCC, and the all-of-government co-ordination will occur at the NCMC. Both centres will be led by the Ministry. The NHCC is staffed by health officials, but the NCMC may be staffed by a range of officials from across government.

Ministry as supporting government agency

In a national emergency where the Ministry is only providing support, depending on the nature of the emergency, the Ministry may provide a liaison officer to the lead government agency to act as a conduit between the health sector and the lead agency in terms of requests, information transfers and so on.

Health liaison officers may also be provided to key all-of-government groups or other government agencies to facilitate emergency co-ordination and response across agencies. For example, health liaison officers may be provided to the National Welfare Co-ordination Group (NWCG).

Communications

Health sector emergency communications structure

In an emergency response a formal communication structure is required between key health agencies, such as DHBs and the ESR, and the Ministry, so that critical information is captured and acted on quickly and effectively by mechanisms which efficiently develop and disseminate critical information, both within the health sector and to other organisations involved in the response.

The key areas of the formal structure include:

- logging information and tracking tasks
- requesting information or action and tracking response
- developing and disseminating reports on the current situation (situation reports)
- summarising and communicating key intelligence on the incident.

This structure provides a consistent and agreed formal communication system for critical information. It complements the informal communication mechanisms that will naturally be used in an emergency response, for example telephone conversations and briefings. Critical information that results from informal communications shall be formally logged using the agreed structure to stop multiple lines of communication forming and to minimise the risk that crucial information is not captured and acted upon.

Health sector emergency management information system (WebEOC)

WebEOC, the health sector's web-based emergency management information system, is the primary tool for the management of significant incidents and emergencies at a local, regional and national level.

WebEOC provides an electronic system to manage information produced during an incident. It does not replace verbal communications between agencies. 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, for example EpiSurv, which is an information system used by public health. The system includes standard templates for logging of requests for information or action, and a mechanism to track progress on these requests. In addition, the system includes standardised templates for situation reports and reporting of key intelligence information.

WebEOC is an adaptable system, regulated by a formal set of standards and processes which are aligned to best practice, and include a formal change management process.

Information in WebEOC is visible to all organisations having access rights who are involved in the response. Access can be obtained through http:/www.moh.govt.nz/emergencymanagement. In the event of an emergency other government agencies may be given access rights, in order to enhance visibility of the health sector response in an emergency.

The system is managed and hosted by the Ministry. The Ministry has ensured that appropriate disaster recovery systems are in place to minimise the risk that WebEOC will be unavailable due to an information technology outage.

Further information, online training and other materials are available to all, irrespective of access rights, at http:/www.moh.govt.nz/emergencymanagement.

24-hour information cycle

Planned times for certain activities that must occur at least once every 24 hours or more regularly during an emergency response are outlined in Table 4. These times are default times and may be increased or decreased depending on the level of the response.

Table 4: Activities in a 24-hour response period

Time	Activity
0900	Briefing of regional co-ordinators by NHCC
1000	Regional situation reports received by NHCC
1100	Media briefing
1300	Regional situation reports received by NHCC
1500	Media briefing
1830	Regional situation reports received by NHCC
2200	Regional situation reports received by NHCC

Situation reports are incident briefs usually given at regular intervals which provide a snapshot of the situation and response. They are generally indicative of the situation some hours previously and are widely used in emergency management to communicate essential information.

Alternative communication and emergency information management methods

There may be periods of time in which WebEOC is inaccessible. In these instances, an alternative system replicating the main WebEOC functions will be achieved using paper-based templates. Alternative communication links, such as satellite phones and/or radio links, may be used to convey necessary information.

Paper-based templates have been developed for situation reports, intelligence reports and requests for information and action. Dissemination of the completed templates will be via the SPOC system using email, fax, satellite or radio. DHBs are responsible for developing their own alternative mechanisms for logging information and tracking tasks locally. Use of the templates will ensure that necessary verbal communication is quick and succinct, and that it is supported by an existing record of pertinent information.

Public information management

Managing media interest will be a significant challenge to all agencies in an emergency. DHBs shall co-ordinate significant information releases with the Ministry. Copies of all official DHB media releases shall be forwarded to the Ministry preferably before but always after release.

The Ministry shall be responsible for communicating with the media on national health issues during a national health-related emergency. It will use information from and intelligence summaries provided by the sector as the basis for briefing the media and other government agencies.

Medical officers of health under their special powers may also issue media statements in an emergency. It is expected that medical officers of health will liaise with the Ministry and if necessary DHBs prior to releasing media statements.

Websites

In an emergency the Ministry shall place information specific to the health sector on its website. This will allow health and disability providers, other agencies and the general public direct access to information.

The web address is http:/www.moh.govt.nz/emergencymanagement. Health and disability providers should make use of and monitor the information on this website during an emergency; information on it may change at short notice as the situation evolves.

In a health-based emergency the Ministry's emergency website shall be used for information of general relevance to other agencies. However, other agencies remain responsible for generating customised information relevant to their sector, and disseminating it through appropriate channels for those sectors. The Ministry's website may provide links to other agency websites as applicable.

In a civil defence emergency information shall be displayed on the MCDEM website, http://www.civildefence.govt.nz. Other websites that will provide useful information are listed in Appendix 4.

Communicating with local, national and international emergency agencies

DHBs are responsible for communicating directly with other local emergency agencies that may be involved in the response, including CDEM groups and ambulance, police and fire services.

In an unexpected, sudden-onset event, a teleconference involving affected parties at the local, regional and national level may be held on the nearest half hour or hour to the event.
In the event of a progressively escalating event a series of teleconferences may occur.
The ongoing communication framework will be established during initial teleconferences.

During the activation of a local or regional health emergency response, formal liaison shall be established between DHBs and other local response agencies. To achieve this, DHBs shall plan for the provision of a liaison officer to their local or regional CDEM group emergency operations centre. DHBs shall also provide for liaison officers from other agencies within their own emergency operations centre. The liaison officer will communicate and disseminate inter-agency information when either a DHB HEP or a regional or national HEP is activated. All formal inter-agency communications shall go through established liaison channels.

The Ministry shall co-ordinate all communications at a national level with MCDEM, national representatives of ambulance, police and fire services, ODESC and all-of-government, including the all-of-government communications group. The all-of-government communications group's role is to co-ordinate government agencies in developing national and international key messages that will guide all communications and to advise the DPMC on communications matters. The group will be convened by the lead agency involved in the response to an emergency.
During the initial response phase, the group will include communications managers from the Ministry plus communications managers from the Department of Internal Affairs, Ministry of Foreign Affairs and Trade, Ministry of Social Development, Ministry of Transport and a representative from DPMC.

When the NHEP is activated in a health-based response, liaison officers from other agencies, operating at a national level, will be involved in order to facilitate national decision-making and liaison.

The Ministry, along with the NCMC international desk, shall co-ordinate requests for and offers of international assistance. The international desk may be staffed by a range of agencies. It is run by MCDEM with input from the Ministry of Foreign Affairs and Trade. When the Ministry receives bilateral requests for or offers of assistance it shall ensure that the international desk, if activated, or the Ministry of Foreign Affairs, and Trade, if not, are aware of the request.

Communications with other international health organisations, such as the World Health Organization or the United States Centers for Disease Control and Prevention, will also be managed by the Ministry. In addition the Ministry may liaise with sector experts.

Health and safety of employees

The health and safety of employees will be pivotal to a successful response by health and disability services in the event of an emergency. Health and safety includes consideration of physical, mental and social wellbeing during the emergency, including the provision of a safe environment in which this can be maintained.

Providers are required under the Health and Safety in Employment Act 1992 to take all practical steps to mitigate risk and protect employees, especially those at higher risk, such as health-care staff, support staff and first responders. The term 'all practical steps' also applies to the general duties that are carried out by staff and volunteers in an emergency.

Significant hazards should be eliminated, where practical, and isolated, where not. If isolation is not practical then the employer shall minimise the likelihood that the hazard will harm employees and other people on site.

Providers as far as practicable shall ensure that their employees and other people, where appropriate, have access to:

- information in the form of policies and procedures relevant to implementing the HEP
- the required personal protective equipment and decontamination facilities
- supplies for the treatment of anyone who may be exposed to infectious diseases, for example antibiotics and antivirals
- relief staff
- facilities to ensure their physical and mental wellbeing throughout the response phase
- any other protective measure that is practical to provide.

Health workers and other response workers in emergency situations are at risk of experiencing significant psychosocial, impact, especially if they have a high exposure to traumatic stimuli. Many staff will experience some psychosocial reaction, usually within manageable range. Some may exhibit more extreme reactions in the short, medium or long term. Most staff will be affected in some way by the experience, either directly or indirectly. In addition, life circumstances of staff after the emergency are likely to have changed.

Research indicates that most people who experience an emergency tend to recover with time and support. The prevalence of conditions such as post-traumatic stress disorder drops relatively quickly in the aftermath of an emergency.

During an emergency event, administrative controls designed to reduce the impact on staff welfare are essential. Ideally health worker shifts should be limited to no more than 12 hours and staff should be rotated between high, medium and low-stress areas; and sufficient relief teams should be provided.

Section 28A of the Health and Safety in Employment Act 1992 states that employees have the right to refuse to perform work if they believe it is likely to lead to their suffering serious harm.

However, their belief must be on reasonable grounds, and they must have attempted to resolve the matter with their employer before they ultimately refuse. The right to refuse unsafe work does not apply unless the understood risks of the work have increased materially.

Medical officers of health

Medical officers of health are employed by a number of DHBs in public health units throughout the country. They have wide-ranging powers designed to prevent the outbreak or spread of any infectious disease. These powers are listed in the schedules to the Health Act 1956.

When the Ministry learns of a potential national health-related emergency, such as a disease epidemic, or if a state of emergency has been declared under the Civil Defence Emergency Management Act 2002, the Minister may declare a health emergency, thereby authorising a medical officer of health's access to the special powers exercisable under the Health Act during the response phase. These powers automatically come into play in a CDEM Act declared emergency and when the Prime Minister issues an epidemic notice under the Epidemic Preparedness Act 2006.

These powers include the ability to:

- require people to report themselves or submit themselves for medical examination at specified times and places
- require people, places, buildings, ships, vehicles, aircraft, animals and things to be isolated, quarantined or disinfected
- forbid people, ships, animals or things to be brought to any (air or sea) port or place in the health district from any port or place which is or is supposed to be infected
- forbid people to leave a place or area until they have been medically examined and found to be free from infectious disease
- require theatres and other places of public amusement, such as racecourses and recreation grounds, bars, billiard rooms, churches, reading rooms and public halls, and all other premises where people are accustomed to assemble for any purpose within the district, to be closed for admission to the public
- prohibit the attendance of children under the age of 16 years in schools, Sunday schools, theatres or places of public amusement within the district
- have infected animals destroyed.

Medical officers of health have other wide-ranging powers. Because of these existing responsibilities, it is not recommended that medical officers of health act as incident controllers or regional co-ordinators within the CIMS structure during an emergency.

Medical officers of health have the power to make media statements and to take any executive actions they believe are necessary. To prevent the potential for confusion that may result from differing media messages, in an emergency the Ministry shall communicate with medical officers of health regarding statutory powers and professional and technical issues. DHBs shall make provision for all other communications with medical officers of health within their area.

Care of the deceased

In a major emergency (for example, a pandemic) there may be an increased number of deaths. As a consequence of any death it is important that, wherever possible, relatives and friends have the opportunity to grieve. It is likely that in the event of a health-related emergency such as a pandemic, the Ministry would discourage mass gatherings in light of the risks of transmission of disease. However, restricting gatherings in which people are grieving, funerals and tangi can create other health problems.

There are a number of agencies involved in managing the dead in an emergency.

- The Ministry is responsible for public health issues and burial and cremation legislation. Medical officers of health and health protection officers in DHBs and public health units may implement many functions on behalf of the Director-General of Health.
- A CDEM group may, under the CDEM Act section 85(1)(g), undertake emergency measures for the disposal of dead persons or animals if it is satisfied that the measures are urgently necessary in the interests of public health while a state of emergency is in force in its area.
- Births Deaths and Marriages, in the Department of Internal Affairs, are responsible for maintaining the registers and receiving certification of the death.
- The Ministry of Justice has responsibility for the coronial system. Normal coronial process would be expected to continue in an emergency.
- The New Zealand Police are involved as agents for the coroner.
- The Department of Labour is responsible for health and safety in the workplace, including issues pertaining to deaths in workplaces.
- Territorial authorities are responsible for registering mortuaries and providing cemeteries. There may be resource implications for funeral directors and managers of denominational burial grounds, as well as space requirement implications, in a major emergency such as a pandemic.
- Regional councils and territorial authorities are responsible for ensuring compliance with the Resource Management Act 1991. This may have implications for the establishment or extension of cemeteries and burial grounds and the installation and operation of cremators.
- Funeral directors will carry out their existing roles.
- The Health (Burial) Regulations 1946 enable medical officers of health, health protection officers and coroners to perform a number of roles. They are able to obtain information, direct embalming processes and set conditions for the hygienic storage (including long-term storage for identification purposes), transport and disposal of the dead, as required. In an emergency situation there may be a need to issue a modification order under the Epidemic Preparedness Act.

Further information on care of the deceased can be obtained from the Influenza Pandemic Action Plan (2008).

Planning for recovery

Consideration of recovery spans all four phases of emergency planning. Recovery activities commence while response activities are still in progress. The priority actions for each are different; however, decisions made during the response phase will have a direct influence on recovery action planning.

DHBs and the Ministry shall begin implementing plans for recovery after the initial impact of the emergency has been stabilised. The appointment of a recovery manager shall occur in the response phase. The recovery manager is responsible for ensuring that early planning is acted upon in order that essential health and disability services can be restored as soon as possible.

The success of deployment of plans for recovery will depend on reliable data collected from impact assessments. The recovery manager will be informed by information held in WebEOC and other resources available within the Ministry and other government agencies.

Standing down a HEP

The date and time of the official stand-down, or deactivation of an emergency response, will be determined by either the local or regional agency, in consultation with the Ministry. Other agencies may need to be involved in the decision-making process; for example, MCDEM.

The time that the deactivation of an emergency response is announced will be dependent on a wide range of variables. Some basic points that should have been passed before deactivation can be declared are as follows:

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

When the Ministry is satisfied, it shall issue a code green alert to signify the end of the response period. The time and date of deactivation may be used to determine arrangements implemented by the Ministry in the recovery period.

Recovery

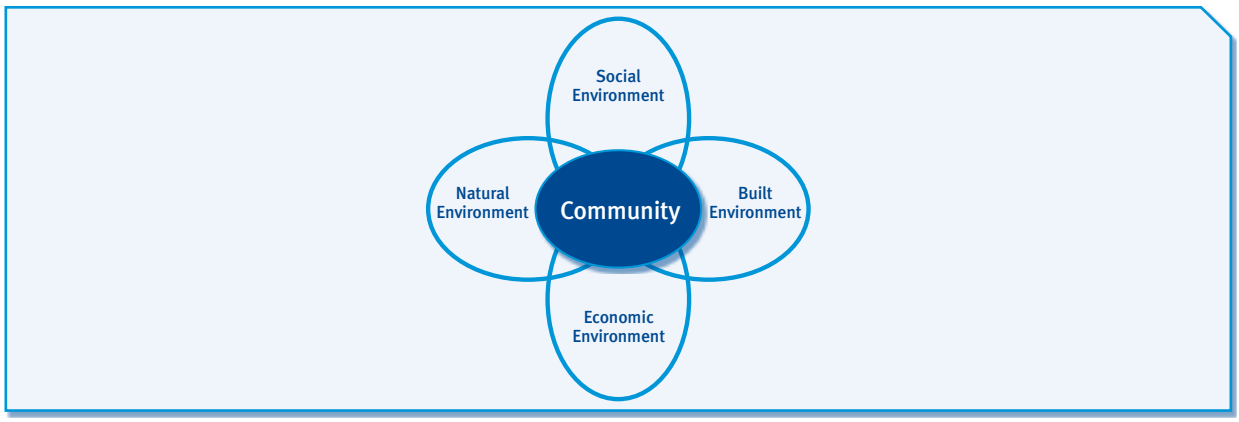
Recovery includes those processes that begin after the initial impact has been stabilised and extends until normal business has been restored. The aim is the immediate, medium-term and long-term holistic regeneration of a community following a civil defence emergency. Recovery also encompasses all opportunities to learn from a successfully managed emergency response in order to reduce the risks from future emergencies. Health-related agencies from a local, regional, national or all-of-government level may be involved, and economic, social or legislative issues may be considered.

Recovery is a complex social process, best achieved when the affected community exercises a high degree of self-determination. Recovery extends beyond restoring physical assets or providing welfare services. Successful recovery recognises that both communities and individuals have a wide range of recovery needs, which must be addressed in a co-ordinated way.

The recovery period may last for any amount of time, from weeks to decades. During the recovery process the recovery team shall be resourced on top of business-as-usual services. The size of the recovery team will fluctuate in the short, medium and long term.

A holistic framework is needed to consider the multi-faceted aspects of recovery which 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 2 below.

Figure 2: Integrated and holistic recovery



Source: *Focus on recovery: A holistic framework for recovery in New Zealand: Information for the CDEM sector (MCDEM 2005).*

While the Ministry or other government agencies may lead government involvement in a response phase, it is usually MCDEM which leads co-ordination of government-supported recovery. Large-scale emergencies require an all-of-government response. MCDEM co-ordinates the recovery activity of relevant CDEM groups, lifeline utilities (for example, electricity, telecommunications and water), government departments and international aid following the transition from response to recovery during the short, medium and long term.

Additional information on recovery is available from the following publications:

- *National Health Emergency Plan: Planning for individual and community recovery in an emergency event: Principles for psychosocial support,* 2007
- *Focus on recovery: A holistic framework for recovery in New Zealand: Information for the CDEM sector,* 2005
- *Recovery Management: Director's guidelines for CDEM groups,* 2005
- *Guide to the National Civil Defence Emergency Management Plan, Section 25,* 2007.

Recovery also involves evaluation of the emergency that has just been responded to. Debriefings will be held throughout the process, and will inform system reviews.

Restoration of services

A number of factors will affect the speed of recovery. The Ministry, DHBs and other health and disability providers may need to maintain emergency response mode for some time. Factors affecting recovery include the following.

- Critical infrastructure may not be able to be restored for a considerable period of time.
- Health sector staff levels may be reduced following an emergency. Staff may have worked longer hours at a higher intensity during the emergency. Once the emergency is over, not only will the workforce reduce to 'normal', but it will probably drop to below 'normal', for example if staff take leave to recuperate.
- International supply chains may take time to return to the way they normally function following an international event such as a pandemic.
- It may take a considerable time to return health services to 'normal' given the volume of deferred electives.
- The appropriate level of health services to be provided within the affected area will need to be determined.

The drop in service capacity for staffing reasons, as well as infrastructure and supply reasons, will mean that the Ministry, DHBs and other health providers may need to maintain an emergency response capability for the initial months of the recovery period.

Local and DHB actions to aid recovery

Local and DHB responsibilities may include participating in an all-of-government recovery response at district and regional levels. DHBs may also have to maintain oversight of district and regional co-ordination of the health sector recovery response. DHBs may be required to implement national policy for the prioritisation of health supplies and services to ensure national consistency across DHB districts.

DHBs shall work with the Ministry and other government agencies on public information management so that messages communicated to the public are clear and complementary. There will be a need to disseminate advice concerning psychosocial recovery for individuals and affected communities and to implement support and recovery programmes for the public and for health personnel in partnership with civil defence welfare clusters.

Ministry actions to aid recovery

The Ministry's responsibilities may include participating in an all-of-government recovery response and maintaining oversight of national co-ordination of the health sector recovery response. It may need to develop national policy for the prioritisation of health supplies and services to ensure national consistency across DHB districts.

The Ministry shall take the lead in managing national public information on recovery of health services. It will work with other government agencies and the national recovery manager (where appointed) to ensure a co-ordinated recovery response.

The Ministry may enable relevant emergency powers to be retained for a time if such an action will assist in significantly reducing the duration of the recovery period and protecting public health. The Ministry shall also be responsible for ensuring triggers for a change in health sector recovery response levels are 'event'-driven.

Finally, the Ministry will provide advice on psychosocial recovery activities and support programmes to the public and health personnel, in partnership with agencies represented on the NWCG.

Evaluation of the emergency response

Evaluation of the emergency occurs in the recovery phase. The Ministry and DHBs shall conduct debriefings and an internal review of their plans following the exercise and activation of any HEP.

Debriefings

A number of different models are used for debriefing. For the purposes of inter-agency information sharing, the model adopted by the Ministry is that recommended by MCDEM. Details of MCDEM's model are outlined in *Organisational Debriefing: Information for the CDEM Sector,* 2006, which is available at http://www.civildefence.govt.nz.

The aim of a debriefing is for staff to communicate their experiences of a particular exercise or activity (including an emergency), so that lessons can be identified and plans can be modified to reflect those lessons and best practice. Debriefings provide an opportunity for the organisation to thank its staff and to provide positive feedback. They improve an organisation's ability to respond to future emergencies. They are a quality improvement activity the purpose of which is to improve performance, rather than to assign blame. Debriefings are subject to the Official Information Act 1982, and privacy principles apply.

Consideration should be given to the community's need for debriefing, which will be dependent on the type and scale of the emergency. DHBs, public health units and PHOs may be actively involved.

Three types of organisational debriefing can be used to facilitate post-event learning: the 'hot' or immediate post-event debrief, the 'cold' or internal organisational debrief and the multi-agency debrief. These will now be explained in more depth.

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 'off-load' 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 number of people within the organisation, and a number of hot debriefs may be held within an organisation simultaneously following an incident.

The person who communicates the stand-down within the organisation shall 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 ongoing 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
- the management of any extraordinary measures that may need to remain in place
- the restoration of a response capability
- the process for the 'cold' debrief and/or the multi-agency debrief (see below)
- the process of reporting the hot debrief.

The 'cold' or internal organisational debrief

A 'cold' debrief is held within four 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 shall involve 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. Cold debriefs may be facilitated by a range of people within the organisation.

The multi-agency debrief

A multi-agency debrief is held within six weeks of the incident. Whenever an emergency involves more that 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 co-ordination. 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, MCDEM, the Ministry, police or fire services. They may also form part of a tiered debriefing process: for example local, regional and national.

Following debriefing, reports should be compiled which 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.

Reviews

Reports from the debriefings should be reviewed by all recipient participants and agencies. Review and subsequent actions may require inter-agency collaboration, and review documents may become public documents. The purpose of the review is to analyse the plans and arrangements in place at the time of the event. The review shall evaluate the actions of all participants and their responses, and may identify areas for improvement. Plans may then be revised, taking review findings into account. These new plans will then require testing and validation by exercising to ensure that the lessons learnt have been effectively applied.

Part B:

Supporting materials

Civil defence emergency management framework

National civil defence emergency management (CDEM) planning in New Zealand is a requirement of the Civil Defence Emergency Management Act 2002 (CDEM Act). National civil defence emergency management arrangements are set out in:

- the National Civil Defence Emergency Management Plan Order 2005 (national CDEM plan)
- the Guide to the National Civil Defence Emergency Management Plan 2006, which contains additional supporting and explanatory material for the national CDEM plan.

The plan and the guide came into effect on 1 July 2006.

The CDEM Act provides for (among other things):

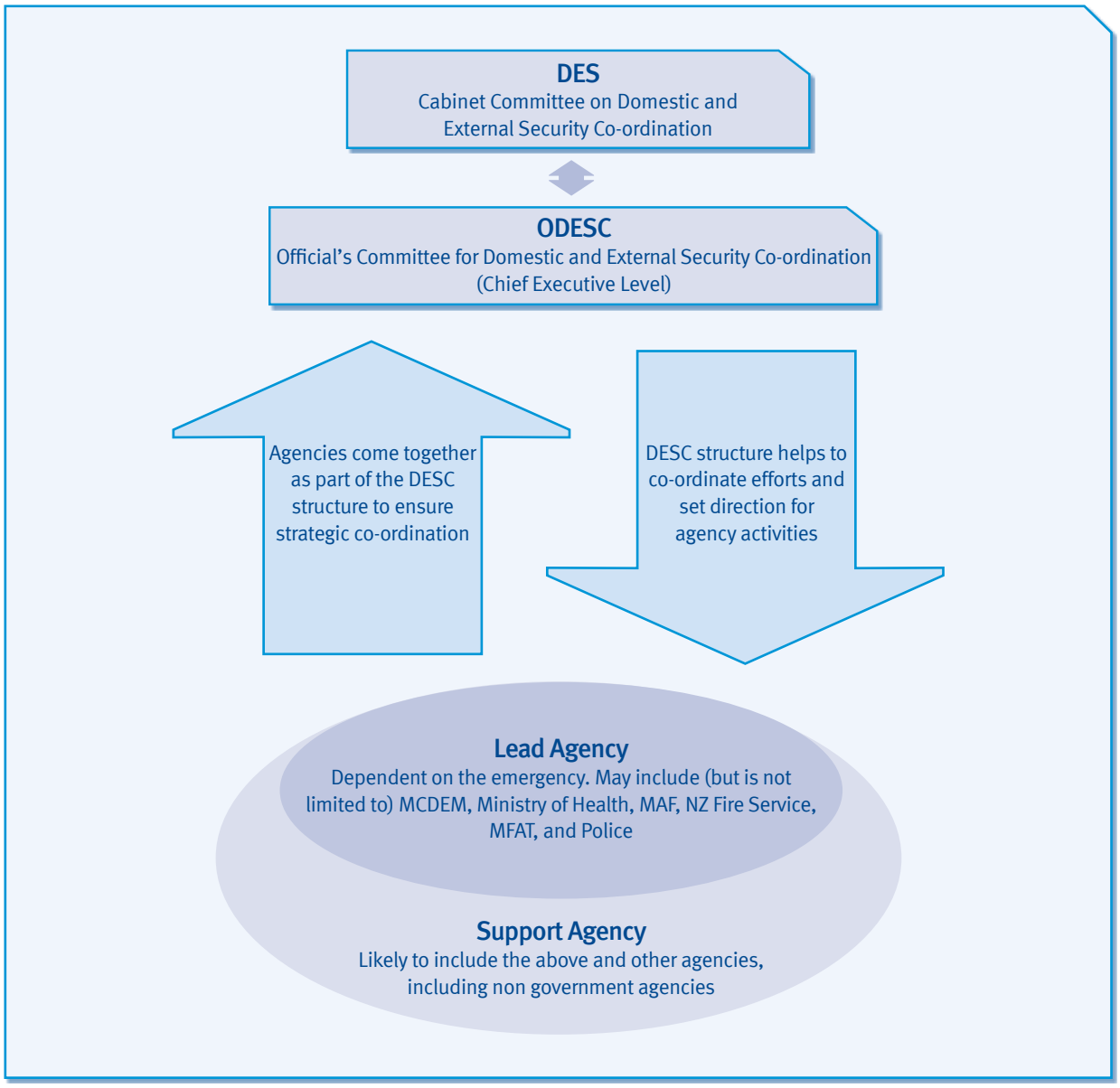
- planning for emergencies
- declaration of a state of local or national emergency (local authority mayors, delegated representatives or persons appointed under section 25 of the CDEM Act and the Minister of Civil Defence can declare a state of national emergency)
- emergency powers that enable CDEM groups and controllers to:
  - close/restrict access to roads and public places
  - provide rescue, first aid, food or shelter
  - conserve essential supplies and regulate traffic
  - dispose of dead persons and animals
  - provide equipment
  - enter premises
  - evacuate premises/places
  - remove vehicles
  - requisition equipment/materials/facilities and assistance.

An all-hazards, all-risks, multi-agency, integrated and community-focused approach is central to emergency management in New Zealand. The central decision-making body of executive government that addresses emergency management is the Cabinet Committee on Domestic and External Security Co-ordination (DES). The DES committee is chaired by the Prime Minister,

and includes those ministers responsible for departments that play essential roles in such situations. To support the process, the Officials' Committee for Domestic and External Security Co-ordination (ODESC) is a committee made up of government chief executives from relevant government agencies charged with providing strategic policy advice to ministers on such matters. ODESC oversees the areas of emergency readiness, intelligence and security, terrorism and maritime security. The Chief Executive of the Department of the Prime Minister and Cabinet chairs the committee, and members are the chief executives from relevant government agencies.

CDEM is one part of the overall emergency management structure in New Zealand. Figure 3 below outlines the national crisis management arrangements that operate in any emergency, while the following section describes the CDEM framework.

Figure 3: National crisis management arrangements



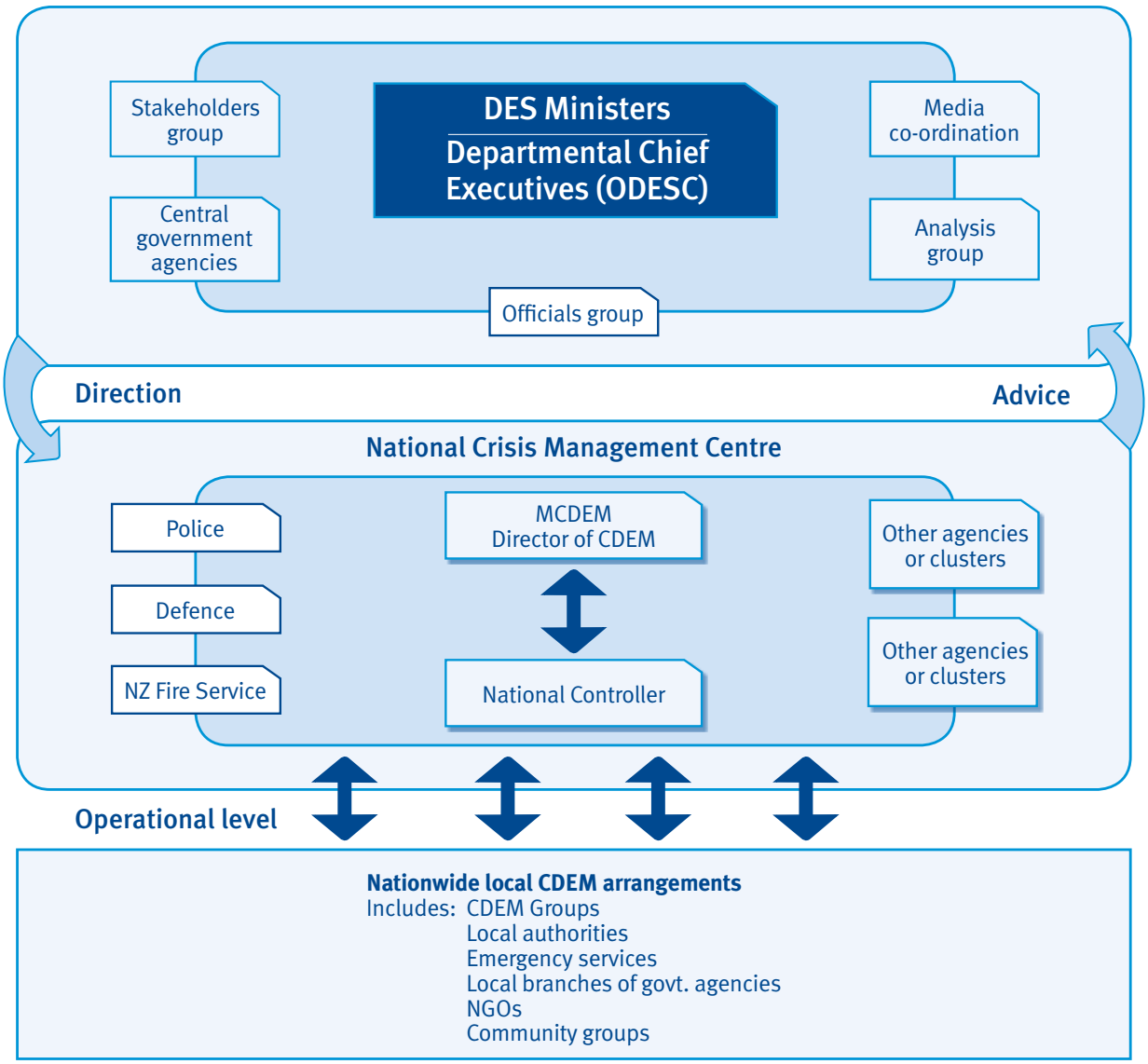
Source: Department of Internal Affairs. 2008.
National Civil Defence Emergency Management Strategy 2007.

The CDEM Act required the establishment of CDEM groups, which are consortia of local authorities based on existing regional council boundaries, working in partnership with emergency services (police, fire and health), lifeline utilities and others to deliver CDEM at the local level.

Every local authority must be a member of a CDEM group. Under the CDEM Act, CDEM groups were required to prepare a CDEM group plan within two years of their establishment. These plans form an important part of the CDEM framework in New Zealand, as they identify hazards and risks faced by the group and the CDEM arrangements necessary to manage them. CDEM group plans are required by legislation to be consistent with the national CDEM strategy.

Figure 4 below illustrates the national crisis management arrangements used when MCDEM is the lead agency. It shows the relationship between DES, ODESC, MCDEM and other key agencies.

Figure 4: National crisis management arrangements when MCDEM is the national lead agency at the operational level



Source: MCDEM. *Guide to the National Civil Defence Emergency Management Plan, 2007 Revision*.

When MCDEM is the lead agency, all other government agencies, including the Ministry of Health, support MCDEM.

Leading the response to a health emergency

In a national health emergency, such as an infectious disease pandemic, the lead agency would be the Ministry of Health. In this situation 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 support and co-ordinate the operational emergency response within the health and disability sector.

Under the national CDEM plan and the Crown funding agreement, all District Health Boards (DHBs) and their public health units are tasked with developing and maintaining their own emergency response plans. These plans apply the structures and processes identified in the National Health Emergency Plan by district and region.

Plans are required to identify how services will be delivered in an emergency, and acknowledge the role of DHBs as both funders and providers of health services. The national CDEM plan requires DHBs to provide adequately for public, primary, secondary, tertiary, mental and disability health services in an emergency. DHBs shall acknowledge their part in an integrated and regional response and develop their plans alongside those of other agencies, for example ambulance, fire, police, local authorities and CDEM groups. They shall also use the co-ordinated incident management system (CIMS), which forms the basis of operational response in New Zealand.

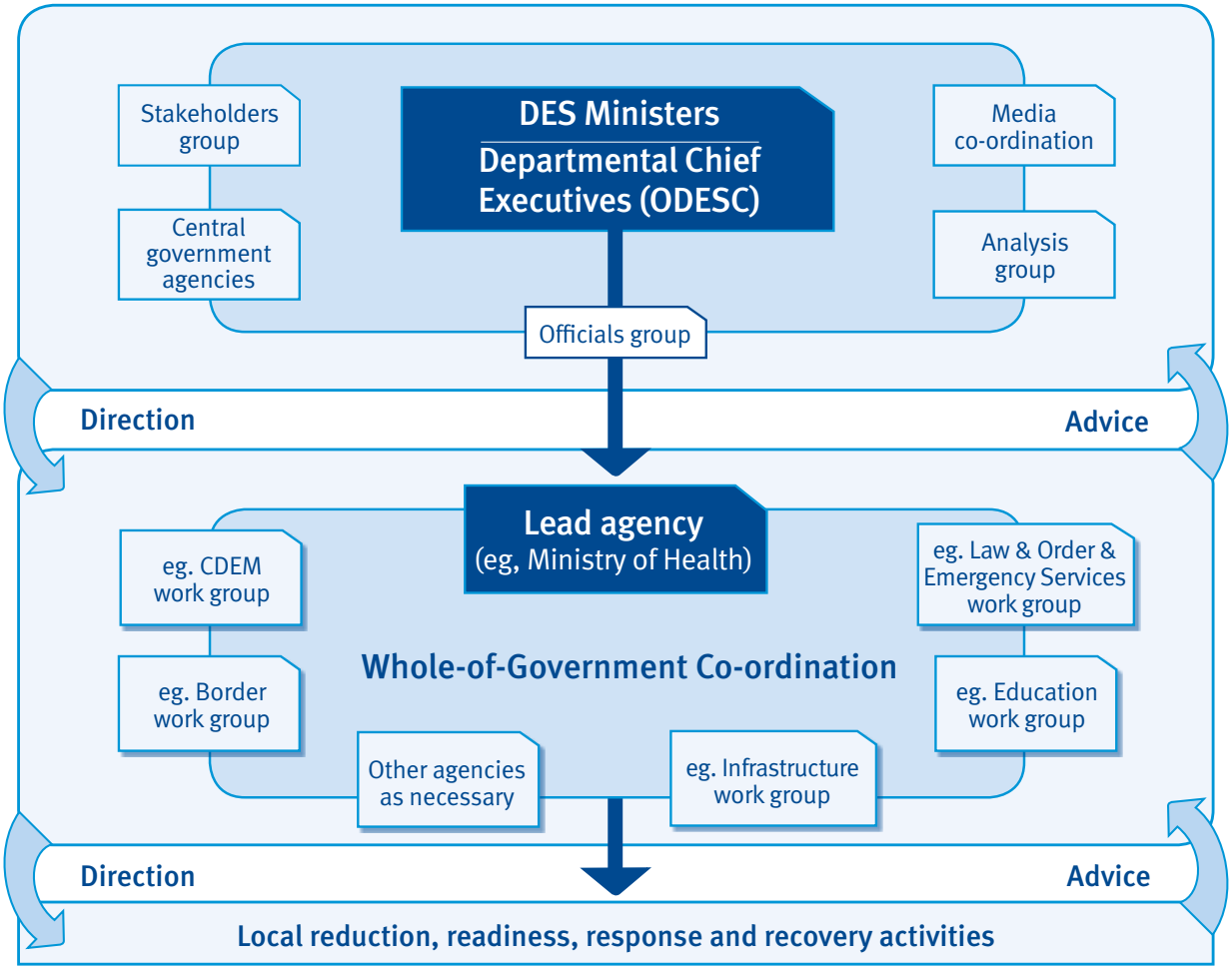
The Ministry's obligations include policy development, national planning and exercising. It is responsible for initiating and coordinating any national emergency response from the health sector, monitoring emergency planning and response, and developing memoranda of understanding and other agreements with various government agencies.

The Ministry is also charged with ensuring that New Zealand meets its international obligations in terms of international health regulations, in particular the World Health Organization (WHO)'s International Health Regulations (IHR) 2005. The purpose of the IHR is to prevent the international spread of disease in ways that are commensurate to the level of risk and which minimise unnecessary interference with international traffic and trade. Disease is defined as including anything that may cause harm to human populations (chemical, radiological or biological), whether naturally occurring or attributable to human activity. Specific obligations under the IHR are listed in Appendix 2.

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

The structure used in an emergency situation in which the Ministry is the national lead agency at the operational level is outlined below in Figure 5. This diagram shows the relationship of the Ministry to ODESC, and the example used is that of a pandemic.

Figure 5: National emergency management model in an emergency for which the Ministry of Health is the lead government agency at the operational level



Source: MCDEM. *Guide to the National Civil Defence Emergency Management Plan, 2007 Revision*.

The CIMS

The CIMS structure is New Zealand's model for the systematic management of an emergency response. It is designed primarily to improve the management of the response phase to emergency incidents through effective co-ordination between major emergency services. All emergency services in New Zealand use a CIMS organisational structure to staff their emergency operations centres.

The CIMS organisational structure is built around four major components, as follows:

- control – management of the incident
- planning/intelligence – collection and analysis of incident information and planning of response activities
- operations – direction of an agency's resources in managing the incident
- logistics – provision of facilities, services and materials required to manage the incident.

Further information on CIMS can be found in *The New Zealand Co-ordinated Incident Management System (CIMS): Teamwork in emergency management*, 1998, published by the New Zealand Fire Commission.

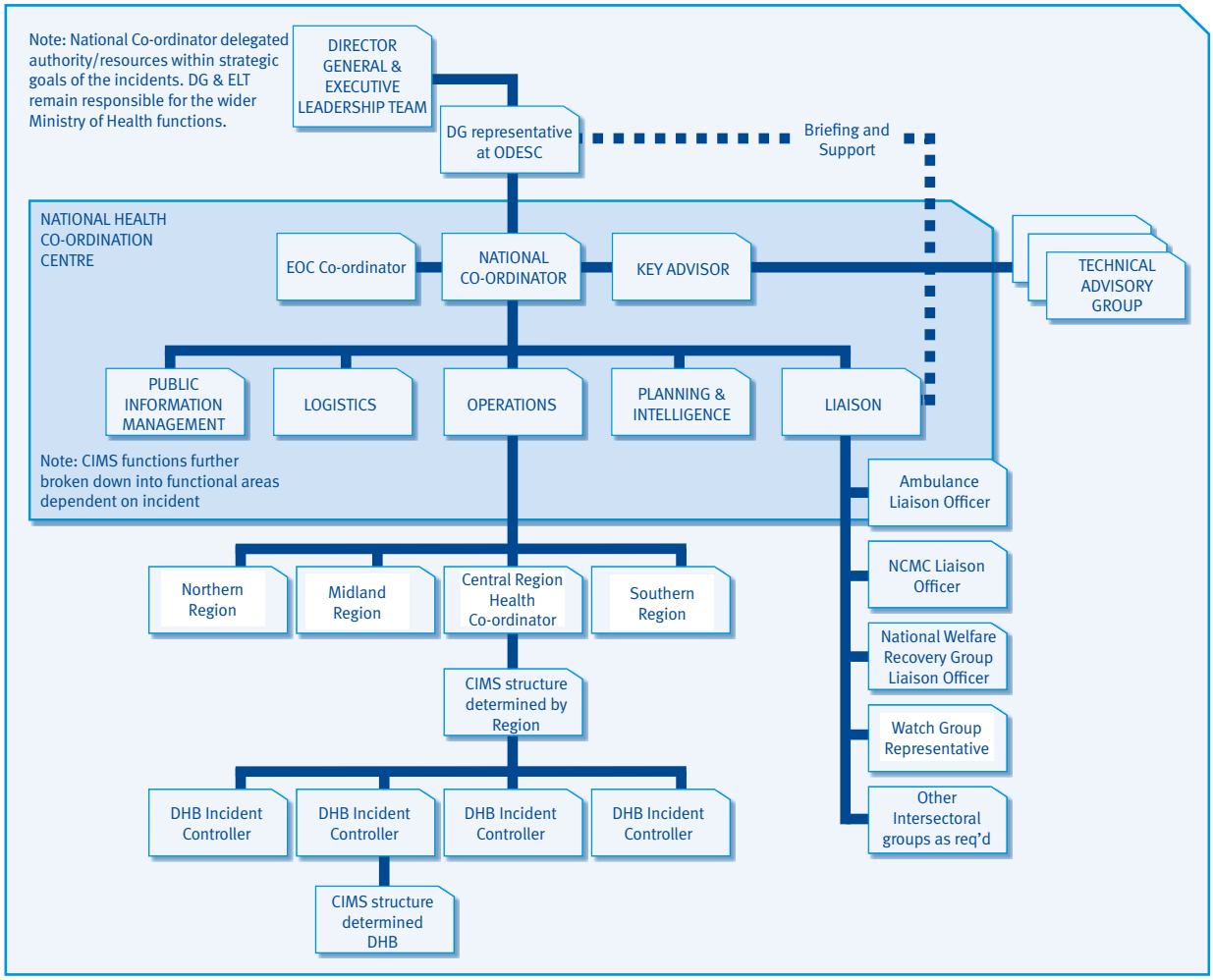
CIMS structure used in a health emergency

The organisational structure used by the health and disability sector's in its response to a national health-related emergency is based on CIMS, tailored for use within the health and disability sector. It provides a structure allowing the multiple agencies or units involved in an emergency to work together in their response.

The CIMS structure does not affect the normal day-to-day vertical operation of command within DHBs and other health agencies. Normal clinical, managerial and other relationships are maintained within units and agencies involved in a response. CIMS has no impact on the identity of individual services or the way they carry out their statutory responsibilities.

Figure 6 sets out the CIMS structure for a national health emergency response, assuming all regions are activated.

Figure 6: CIMS organisational structure used a health emergency



The CIMS structure for emergency response is consistent at all operational levels within the health and disability sector, in acknowledgment of the fact that consistency is necessary for effective communication both within the health sector and across the whole of government. This structure shall be used whenever a health emergency response is activated.

Local, regional and national plans shall provide for the staffing the CIMS structure requires to manage an emergency response. The response may be required over an extended period of time and for 24 hours a day, seven days a week. This may require a number of teams of staff to ensure coverage for all shifts. Providers shall plan the appropriate number of staff and shift structure required to support their CIMS organisational structure.

Framework for funding during planning and response cycles

The Ministry 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 shall be used for the following:

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

The Ministry shall 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 event or a pandemic.

DHB funding – Operational Policy Framework

The Operational Policy Framework (OPF) on good financial management outlines requirements concerning the cost of additional services purchased in response to a major incident. For example, Section 5.6.2.5, paragraph 3 of the OPF, effective 1 July 2007, states that each DHB is to:

> ... cover the cost of additional services purchased in response to a major incident up to 0.1 percent of the DHB's total population based funding. Above this 0.1 percent level, 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 event will be regarded as a 'major incident'. All DHB planning should be undertaken with the above section of the OPF in mind.

Clearly, the identification of what the 0.1 percent figure represents and the tracking of direct emergency response-related expenses in relation 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, 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 to the Treasury will help ensure rapid approval is obtained from the Minister 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 event, disease epidemic or pandemic.

Eligibility for publicly funded health and disability services

Groups of people eligible for publicly funded personal health and disability services in New Zealand are prescribed in the 2003 Direction of the Minister of Health Relating to Eligibility for Publicly Funded Health and Disability Services in New Zealand (the eligibility direction). The eligibility direction is available on the Ministry website at http://www.moh.govt.nz/eligibility. 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.

Ethical values underpinning decision-making

The response by health and disability service providers in a health emergency will require a balancing of individual rights and collective interests that will depend on the particular emergency. For example, in an infection-related emergency, the community's health and safety may be given a higher priority than that of individual rights.

WHO has recommended that ethical values be considered as part of pandemic planning. In 2007 the Ministry asked the National Ethics Advisory Committee to provide guidance on ethical values applicable to a pandemic. The National Ethics Advisory Committee produced *Getting Through Together: Ethical Values for a pandemic*, 2007. This document provides guidance on the shared ethical values that inform the methods and outcomes of decision-making. Although it was developed for a pandemic situation, the values it discusses have relevance for decision-making in all emergencies. The guidance aims to be useful at all levels of decision-making and across all sectors. The values and characteristics of good decision-making processes are summarised in Table 5 below. Table 6 outlines the values on which good decisions are based.

Table 5: Ethical values to inform how decisions are made

Ethical Value	Actions associated with the value
Inclusiveness	• including those who will be affected by the decision • including people from all cultures and communities • taking everyone's contribution seriously • striving for acceptance of an agreed decision-making process, even by those who might not agree with the particular decision made.
Openness	• letting others know what decisions need to be made, how they will be made and on what basis they will be made • letting others know what decisions have been made and why • letting others know what will come next • being seen to be fair.
Reasonableness	• working with alternative options and ways of thinking • working with and reflecting cultural diversity • using a fair process to make decisions • basing decisions on shared values and best evidence.

Ethical Value	Actions associated with the value
Responsiveness	• being willing to make changes and be innovative • changing when relevant information or the context changes • enabling contributions whenever possible from decision-makers and others • enabling others to challenge our decisions and actions.
Responsibleness	• acting on our responsibility to others for our decisions and actions • helping others to take responsibility for their decisions and actions.

Table 6: **Ethical values to inform what decisions are made**

Ethical Value	Actions associated with the value
Minimising harm	• not harming others • protecting one another from harm • accepting restrictions on our freedom when needed to protect others.
Respect/manaakitanga	• recognising that every person matters and treating people accordingly • supporting others to make decisions on behalf of people who cannot make their own decisions • restricting freedom as little as possible, but as fairly as possible, if freedom must be restricted for the public good.
Fairness	• ensuring everyone gets a fair go • prioritising fairly when there are not enough resources for all to get the services they need • supporting others to get what they are entitled to • minimising inequalities.
Neighbourliness/ whanaungatanga	• helping and caring for neighbours and friends • helping and caring for family/whānau and relations • working together when there is a need to be met.
Reciprocity	• helping one another • acting on any social standing or special responsibilities we may have, such as those associated with professionalism • agreeing to extra support for those who have extra responsibilities to care for others.
Unity/kotahitanga	• being committed to getting through the situation together • showing commitment to strengthening individuals and communities.

The supporting discussion in the document examines the above values and how they might apply in pandemic planning and response. The document includes hypothetical cases to illustrate the relevance of the values.

Part C:

Appendices

Appendix 1:
Legislation

Primary acts and associated regulations outlining legislative responsibilities for health sector organisations are the:

- Civil Defence Emergency Management Act 2002
- Epidemic Preparedness Act 2006
- Health Act 1956
- National Civil Defence Emergency Management Plan Order 2005
- New Zealand Public Health and Disability Act 2000.

Other important acts and regulations covering emergency management include, but are not restricted to, the:

- Biosecurity Act 1993
- Building Act 1991
- Burial and Cremation Act 1964
- Civil Defence Emergency Management Regulations 2003
- Fire Service Act 1955 (section 330)
- Food Act 1981
- Food Hygiene Regulations 1974
- Food Regulations 1984
- Forest and Rural Fires Act 1977
- Hazardous Substances and New Organisms Act 1996
- Health (Burial) Regulations 1946
- Health (Drinking Water Amendment) Act 2007
- Health (Infectious and Notifiable Diseases) Regulations 1966
- Health and Safety in Employment Act 1992
- Health Practitioners Competence Assurance Act 2003
- Local Government Act 2002
- Maritime Transport Act 1994
- Public Finance Act 1989
- Radiation Protection Act 1965
- Resource Management Act 1991
- Tuberculosis Act 1948
- (WHO) International Health Regulations 2005.

Appendix 2:
International Health Regulations 2005

The International Health Regulations 2005 (IHR) was implemented around the world on 15 June 2007. This legally binding international law significantly contributes to public health security by providing a new framework for the management of events that may constitute a public health emergency of international concern, and aims to improve prevention, detection, assessment, notification and response in terms of public health threats that have the potential to cross borders and affect health worldwide. The IHR is an international legal instrument that is binding on 194 countries across the globe, including all the member states of WHO.

In the globalised world, diseases can spread far and wide as a corollary of international travel and trade. A health crisis in one country can impact health and economies in many parts of the world. Such crises can result from emerging infections like Severe Acute Respiratory Syndrome (SARS), or a new human influenza pandemic. The IHR also applies to other public health emergencies such as chemical spills, leaks and dumping, or nuclear melt-downs. The IHR aims to limit interference with international traffic and trade while ensuring public health through the prevention of disease spread.

The IHR requires countries to report certain disease outbreaks and public health events to WHO. Taking advantage of the unique experience of WHO in global disease surveillance, alert and response, the IHR defines the rights and obligations of countries in reporting public health events, and establishes a number of procedures that WHO must follow to uphold global public health security.

The IHR also requires countries to strengthen their existing capacities for public health surveillance and response. WHO is working closely with countries and partners to provide technical guidance and support to mobilise the resources needed to implement the new rules in an effective and timely manner. Timely and open reporting of public health events is of benefit to world security.

Specific obligations under the IHR as they pertain to New Zealand include:

- maintaining capacities to detect, assess, respond to and report any events which are of potential significance to public health
- operating these capacities locally/regionally and at the border (primarily through DHB-based public health units) and nationally through the Ministry

- designating a national IHR focal point, to perform a whole-of-health-sector, all-of-government communication and information collation and dissemination function (the Office of the Director of Public Health in the Ministry is the designated national focal point)
- assessing any potentially significant public health event within 48 hours to determine whether or not WHO must be notified. Where an assessment indicates that notification is required, the Ministry has a further 24 hours to notify WHO via the national focal point (during this time, the Ministry may need to liaise with other ministers and government agencies).

Following a notification to WHO, or in circumstances where WHO has declared (or is considering whether to declare) a public health emergency of international concern, the national focal point is required to maintain communications with WHO, including the collation and dissemination of information throughout the health sector and to and from other government agencies as appropriate.

Any formal recommendations from WHO as to emergency health measures must be rapidly considered and implemented as appropriate.

New Zealand is party to various other international obligations, as noted in other relevant Acts.

Appendix 3:
Useful websites

Ministry of Civil Defence and Emergency Management

- http://www.civildefence.govt.nz

Ministry of Health Emergency Management

- http:/www.moh.govt.nz/emergencymanagement

United States Centers for Disease Control and Prevention

- http://www.cdc.gov

World Health Organization

- http://www.who.int/en

Appendix 4:
Key documents

Department of Internal Affairs. 2008. *National Civil Defence Emergency Management Strategy 2007*. Wellington: Department of Internal Affairs.

Ministry of Civil Defence and Emergency Management. 2005. *Focus on Recovery: A holistic framework for recovery in New Zealand: Information for the CDEM sector*. Wellington: Ministry of Civil Defence and Emergency Management.

Ministry of Civil Defence and Emergency Management. 2007 Revision. *Guide to the National Civil Defence Emergency Management Plan*. Wellington: Ministry of Civil Defence and Emergency Management.

Ministry of Civil Defence and Emergency Management. 2008. *Mass evacuation planning: Director's guidelines for civil defence emergency management (CDEM) groups*. Wellington: Ministry of Civil Defence and Emergency Management.

Ministry of Civil Defence and Emergency Management. 2006. *Organisational Debriefing: Information for the CDEM sector*. Wellington: Ministry of Civil Defence and Emergency Management.

Ministry of Civil Defence and Emergency Management. 2007. *Public Information Management: Information for the CDEM sector*. Wellington: Ministry of Civil Defence and Emergency Management.

Ministry of Civil Defence and Emergency Management. 2005. *Recovery Management: Director's guidelines for CDEM groups*. Wellington: Ministry of Civil Defence and Emergency Management.

Ministry of Civil Defence and Emergency Management. 2006. *Spontaneous Volunteer Management: A guide for CDEM practitioners*. Wellington: Ministry of Civil Defence and Emergency Management.

Ministry of Civil Defence and Emergency Management. 2006. *Working Together: Guidelines for emergency managers working with culturally and linguistically diverse communities*. Wellington: Ministry of Civil Defence and Emergency Management.

Ministry of Health. 2005. *National Health Emergency Plan: Guiding principles for emergency management planning in the health and disability sector*. Wellington: Ministry of Health.

Ministry of Health. 2005. *National Health Emergency Plan: Hazardous substances incident hospital guidelines 2005*. Wellington: Ministry of Health.

Ministry of Health. 2004. *National Health Emergency Plan: Infectious diseases.* Wellington: Ministry of Health.

Ministry of Health. 2007. *National Human Resources Pandemic Guidelines.* Wellington: Ministry of Health.

Ministry of Health. 2008. *National Health Emergency Plan: Influenza pandemic action plan.* Wellington: Ministry of Health.

Ministry of Health. 2007. *Planning for Individual and Community Recovery in an Emergency Event: Principles for psychosocial support. National Health Emergency Plan.* Wellington: Ministry of Health.

Ministry of Health. 2006 revision. *Protecting your health in an emergency.* Wellington: Ministry of Health.

National Ethics Advisory Committee. 2007. *Getting Through Together: Ethical values for a pandemic.* Wellington: Ministry of Health.

New Zealand Fire Commission. 1998. *The New Zealand Co-ordinated Incident Management System (CIMS): Teamwork in emergency management.* Wellington: New Zealand Fire Commission.

Officials Committee for Domestic and External Security Co-ordination. 2007. *The National Hazardscape Report.* Wellington: Officials Committee for Domestic and External Security Co-ordination.

Standards Australia and Standards New Zealand. 2004. AS/NZS 4360:2004 Risk Management. Sydney: Standards Australia.

Standards New Zealand. 2008. NZS 8134:2008. Health and Disability Services Standards. Wellington: Standards New Zealand.

Appendix 5:
Glossary and abbreviations

For the purposes of this plan, the following interpretations shall apply.

Agencies

- Government agencies, including public service departments, non-public service departments, Crown entities and Offices of Parliament
- non-governmental agencies
- lifeline utilities.

Alert codes

A series of codes issued by the Ministry to DHBs to alert DHBs and to trigger a series of actions.

- Code white – Information
- Code yellow – Standby
- Code red – Activation
- Code green – Stand-down/Recovery.

AMPLANZ

Ambulance National Major Incident and Emergency Plan. 2005. AMPLANZ is based on the Ambulance Service Standard (NZ8156:2002).

CBACs

Community based assessment centres. CBACs are set up by DHBs during an emergency. They are commonly used in instances of mass evacuations or in an infectious disease outbreak affecting a large number of people.

CIMS

Co-ordinated incident management system. A structure to systematically manage emergency incidents, which allows multiple agencies or units involved in an emergency to work together in emergency incidents.

Clusters

A group of agencies that interact to achieve common civil defence emergency management outcomes.

Debriefing

A critical examination of a completed operation in order to evaluate actions for documentation and future improvements.

Decanting

A process by which people, supplies and or equipment are moved from one area to another.

DES

The Cabinet Committee for Domestic and External Security Co-ordination. The committee is chaired by the Prime Minister, and includes those ministers responsible for departments that may play essential roles in emergency situations. The committee is used by central government for the management of nationally significant crises or security events where the co-ordination of national effort is warranted. The DES system comprises DES, ODESC and the Officials' Group.

DHB

District health board. DHBs provide hospital and community-based health services. DHBs are funders and providers of publicly funded services for the populations of specific geographical areas in New Zealand.

DHB incident controller

A member of a DHB emergency management team, with overall responsibility for coordinating emergency response at the individual DHB level. There is one incident controller for each DHB.

DHB emergency management team

A body to manage the local emergency response in the event of a health-related emergency and contribute to the relevant regional co-ordination team. Each DHB will convene a team.

DHEP

District health emergency plan, produced by individual DHBs.

DPMC

The Department of the Prime Minister and Cabinet.

Emergency

A situation that:

a. is the result of a 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 of or disruption to an emergency service or a lifeline utility, or actual or imminent attack or warlike act; and

b. 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; and

c. cannot be dealt with by normal emergency services, or otherwise requires a significant and co-ordinated approach under the CDEM Act 2002.

EOC

Emergency operations centre. An established facility where the response to an incident may be co-ordinated.

Epidemic

A disease affecting or tending to affect an atypically large number of individuals within a population, community or region at the same time.

ESR

The Institute of Environmental Science and Research Limited. ESR provides a system for surveillance of infectious disease (SurvINZ and EpiSurv), forensic services and specialist and reference microbiological laboratory services to all clinical laboratories. ESR collects and collates disease burden data and, if required, provides cultures or isolates to WHO reference laboratories.

Four Rs

Reduction – (identifying and analysing long-term risks to human life and property from natural or non-natural hazards; taking steps to eliminate these risks if practicable and, if not, reducing the likelihood and the magnitude of their impact and the likelihood of their occurring); and

Readiness – (developing operational systems and capabilities before a civil defence emergency happens, including self-help and response programmes for the general public, and specific programmes for emergency services, lifeline utilities, and other agencies); and

Response – (actions taken immediately before, during, or directly after a civil defence emergency to save lives and property, and to help communities recover); and

Recovery – (the co-ordinated efforts and processes used to bring about the immediate, medium-term and long-term holistic regeneration of a community following a civil defence emergency).

Hazard

Something that may cause or contribute substantially to the cause of an emergency.

Hazardscape

The net result of natural and man-made hazards and the risks they pose cumulatively across a given area.

Health emergency

A health emergency exists when the usual resources of a provider are overwhelmed, or have the potential to be overwhelmed.

Information reports

Information reports provide information on any aspect of an emergency, and are produced as required. A DHB may produce several on one day, and none the next, depending on the change in situation. They are a primary means for reporting situational change, and relevant agencies must issue them as soon as they are required. They are also the main means of documenting informal communications, especially phone calls.

Intelligence summaries

An intelligence summary is an update containing intelligence information surplus to that in a situation report, or information which cannot wait for the next situation report. The NHCC is the main conduit for intelligence information across the health sector. Intelligence summaries are sent out on an as-required basis. They tie together intelligence from across all-of-government. If the NHCC is responsible for coordinating an all-of-government response, it may be required to issue intelligence summaries on non-health matters.

Lead agency

The agency that has a statutory responsibility to manage a particular emergency.

Liaison officers

Those who act as single points of contact between agencies to improve the flow of information.

Lifeline utilities

Services or networks which provide the necessities of life. For example: power and gas, water, sewerage, petrol, roading, transporters of essential supplies, radio, television, air transport and shipping.

Likelihood

Used in risk management as a general description of probability or frequency.

Local

A designated population or a provider group working in a specific geographical area. The DHB of a local area has overall responsibility for providing health and disability services in an emergency to a local population; however, local provider groups also have obligations to provide for services in an emergency.

Logistics

A logistics team is responsible for the provision of facilities, services and materials in an emergency.

MAF

The Ministry of Agriculture and Forestry.

MCDEM

The Ministry of Civil Defence and Emergency Management.

Ministry regional emergency management advisors

The Ministry has four emergency management advisors based in Auckland, Hamilton, Palmerston North and Christchurch, who are members of the Ministry's emergency management team. They work with DHBs, their public health units and other agencies/ organisations (for example CDEM groups or police) to enhance regional co-ordination in an emergency. They also lead or contribute to other health-related emergency projects to ensure the needs of the Ministry, DHBs and other significant organisations concerned with health-related emergencies are met, and that planning is well co-ordinated across sectors.

National CDEM plan

The national civil defence and emergency management plan for New Zealand.

National co-ordinator

A single position which leads the Ministry national co-ordination team, with overall responsibility for coordinating emergency response at the national level.

National health co-ordination team

A body whose function is to co-ordinate the national emergency response in the event of a health-related emergency. Based in the Ministry, it comprises members of all directorates.

National co-ordinator

This single position leads the Ministry national co-ordination team, with overall responsibility for coordinating emergency response at the national level.

National CDEM Plan
The National Civil Defence and Emergency Management Plan for New Zealand.

NCMC
National Crisis Management Centre.

NGO
Non-government organisation.

NHCC
National Health Co-ordination Centre.

NHEP
The *National Health Emergency Plan*. A Ministry 'umbrella' plan incorporating other health emergency-specific action plans: for example, the *National Health Emergency: Multiple complex burn action plan*, and the *New Zealand Influenza Pandemic Action Plan*. The NHEP provides guidance for the New Zealand health and disability sector for emergency management.

NHEP:ID
The *National Health Emergency Plan: Infectious diseases*, 2004, which was the predecessor to the NHEP.

NIISG
National Influenza Immunisation Strategy Group. Co-ordinates the promotion of annual influenza vaccination and awareness during inter-pandemic periods.

NWCG
National Welfare Co-ordination Group. A national-level, strategic welfare group that plans, supports and helps co-ordinate welfare activity in the response and recovery phases of an emergency.

ODESC
Officials Committee for Domestic and External Security Co-ordination. A committee of government chief executives charged with providing strategic policy advice to ministers. It provides support to DES 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. One of a group of documents collectively known as the 'Policy Component of the District Health Board Planning Package' that sets out the operational level accountabilities for DHBs for each fiscal year. The OPF is executed through Crown funding agreements between the Minister of Health and each DHB. The OPF covers emergency obligations based on the four Rs.

Pandemic
An epidemic that spreads to the point that it affects a whole region, a continent or the world.

PHO

Primary health organisation. A grouping of primary health care providers; local structures through which DHBs implement the primary health care strategy.

Planning and intelligence

A team responsible for the collection, evaluation and dissemination of information related to an emergency incident.

PPE

Personal protective equipment. Equipment used by all clinical and non-clinical staff in the event of an emergency: for example, gloves, masks, eye protection, respirators, gowns and footwear.

Primary care

Care/services provided by general practitioners, nurses, pharmacists, dentists, ambulance services, midwives and others in the community.

Provider

For the purposes of clarity within this document only, the term refers to any health and disability provider: for example, a DHB, PHO, health-related NGO or ambulance service.

Public health units

Public health units provide health services to populations rather than individuals. There are 12 public health services providing environmental health, communicable disease control and health promotion programmes. Public health units administrate public health services, led by a manager and staffed by medical officers of health, public health nurses, health protection officers and others.

Public information management

Public information management involves collecting, analysing and disseminating information to the public in a timely manner.

Regional co-ordination team

A body to co-ordinate the regional emergency response of DHBs in the event of a health-related emergency.

Regional health co-ordinator

The regional health co-ordinator has overall responsibility for coordinating the emergency response at the regional level. They are an agreed appointee of the DHBs and their public health unit(s), who are members of the regional co-ordination team.

RHEP

Regional health emergency plan. Sets out the proposed response of DHBs in a given region to a regional incident, and sets out a generic process for the management of regional incidents, irrespective of origin. It contains task assignments, assignments of roles and responsibilities, standard forms and other relevant guidance.

Risk

The likelihood and consequences of a hazard. A risk is often specified in terms of an event or circumstance.

Secondary/tertiary health care

The levels of care provided in a hospital. Secondary care is treatment by a specialist to whom a patient has been referred by a primary care provider. Tertiary care is treatment given in a health care centre that includes highly trained specialists and often advanced technology.

Situation reports

Situation reports are standardised briefs of an incident, usually given at regular intervals. They provide a snapshot of the situation and response. They do not provide up-to-date situational awareness. There is a specific template for a situation report in WebEOC.

SPOC

Single point of contact system. Used to facilitate communications in the health sector.

Support agency

Any government agency that assists the lead agency during an emergency. Support agencies are determined by the consequences of the emergency. MCDEM and CDEM groups can use arrangements under the CDEM Act, national CDEM plan, and/or CDEM group plan to support a lead agency. Support agencies may change as an emergency situation changes.

Technical advisory group

Technical advisory group. A national advisory group convened to provide co-ordinated expert technical advice to the Ministry, as required.

Triage

The sorting or classification of casualties according to the nature or degree of illness or injury.

WebEOC

A web-based emergency management information system for the health sector hosted by the Ministry. WebEOC is the primary tool for the management of significant health incidents and emergencies at a local, regional and national level. WebEOC complements existing business-as-usual systems (such as EpiSurv and patient management systems). While the focus is on the health sector, it is also intended to facilitate structured information-sharing with local, regional and national partners.

WHO

World Health Organization.