TE WAIORA Nelson Marlborough Health

DHB Office
Braemar Campus

Private Bag 18
Nelson, New Zealand

19 October 2021

[redacted]

Response to a request for official information

[redacted]

Thank you for your request for official information received 23 August 2021 by Nelson Marlborough Health (NMH), followed by the necessary extension of time 20 September 2021 where you seek the following information:

1. ***Since March 2020 and by each month thereafter-***

    a. ***the number of fully staffed/operational ICU beds available***

Response:
Nelson Hospital has a 7 bed Intensive Care Coronary Care Unit (ICCU), which incorporates Cardiology as well as ICU.

    b. ***ICU capacity***

Response:
Nelson Hospital ICCU and Wairau Hospital High Dependency Unit (HDU) have a total capacity of 16 beds.

    c. ***a breakdown of all ICU staff (such as numbers of ICU nurses) and any vacancies***

Response:
Appendix 1 (attached) includes Table One: ICU staffing and Table Two: ICU advertised vacancies – Full Time Equivalent (FTE), by month, since March 2020.

    d. ***and how many surgeries were rescheduled or postponed/cancelled.***

Response:
Table Three below outlines the number of deferred surgeries as a result of Nelson Hospital Ward and ICU bed unavailability, by month, since February 2021, noting our Theatre system does not separately identify ICU bed unavailability, and no data was captured for 2020.

TABLE THREE

	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Sep-21
*No Ward or ICCU bed	5	2	1	1	2	1	2

*These numbers are not specifically ICU bed unavailability

2. ***Since March 2020, copies of any reports, documents or briefings that include information about ICU capacity, including (but not limited to) in relation to Covid-19, such as contingency plans to scale up capacity.***

Response:
Please see attached Nelson Marlborough COVID 19 *National Hospital Response Framework*. Our COVID-preparedness documents are living documents and will be updated as circumstances change.

3. ***Since March 2020, copies of all correspondence with the Ministry of Health regarding critical care and ICU, in relation to Covid-19, such as confirmation of current capacity and plans to scale up capacity.***

Response:
This information is not held in an easily retrievable central data system and it would take a significant amount of time and resources to identify, retrieve and collate any information to meet this element of your request. As such, NMH declines a response under section 18(f) as *'the information requested cannot be made available without substantial collation and research'*.

This response has been provided under the Official Information Act 1982. You have the right to seek an investigation by the Ombudsman of this decision. Information about how to make a complaint is available at www.ombudsman.parliament.nz or free phone 0800 802 602. If you have any questions about this decision please feel free to email our OIA Coordinator OIArequest@nmdhb.govt.nz

I trust that this information meets your requirements. NMH, like other agencies across the state sector, supports the open disclosure of information to assist the public's understanding of how we are delivering publicly-funded healthcare. This includes the proactive publication of anonymised Official Information Act responses on our website from 10 working days after they have been released. If you feel that there are good reasons why your response should not be made publicly available, we will be happy to consider.

Yours sincerely

Lexie O'Shea
Chief Executive

Appendix 1: Table One: ICU staffing and Table Two: ICU Advertised vacancies
Encl: National Hospital Response Framework (2 pages)

Appendix 1

Q1c '*a breakdown of all ICU staff (such as numbers of ICU nurses) and any vacancies*'

Table One: ICU staffing – FTE by month since March 2020

Occupation	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Administrative employee	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5
Registered nurse	20.6	21.2	22.1	21.5	22.7	22.6	23	23	22.7	21.6	23	24.2	24	21.5	21.5	22	22.3	23.2

Table Two: ICU 'Advertised' vacancies – FTE by month since March 2020*

Occupation	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Administrator	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Registered nurse	0.6	1.6 Parental leave	0.6	1.6 Incl. 0.8 parental leave	Nil	Nil	0.8	2.4	Nil	Nil	Nil	Nil	0.8	1.6	1.7	Nil	0.8	1.4 Incl. 0.6 parental leave

***Note:** If a position is not filled within the month advertised, it will be counted in subsequent months until filled.

Specialist Medical Officer

We have 1x10 hour shift SMO 7 days a week since March 2020.

We have a Clinical Director role of 0.1 FTE.

Our provision of ICU services has been reviewed with advertising for 5 additional positions to be shared between ICCU and Anaesthetics.

COVID 19 National Hospital Response Framework – The Process

- This Hospital Response Framework is designed to provide escalation levels to support facilities and hospitals to appropriately and safely operate at each agreed Alert Level.
- The Framework provides high level, nationally consistent guidance to support your facility's own emergency response procedures that will need to be deployed at each Alert Level.
- The alert levels in this Framework are different to the Government's National COVID-19 Alert Levels, which note that hospitals will operate in line with the National Hospital Response Framework.
- Hospitals are expected to operate in line with their current Alert Levels and have systems and processes proactively in place to identify and respond to any changes in levels (up or down) so that changes are made in a well-managed and planned manner with staff and resources prepared and trained beforehand.
- It is expected that alert levels may change rapidly, and decisions are made locally at a hospital or facility to move status up or down.
- The Framework aims to ensure that patients remain at the centre of care by making proportionate responses to escalations and de-escalations in the COVID-19 pandemic.
- This plan should identify Māori and other vulnerable populations and ensure health disparities do not increase as a result of the response to the COVID-19 pandemic. DHBs must maintain rigorous oversight of waiting lists, including a comprehensive plan setting out the manner by which the risk of patients deteriorating while waiting for assessment and treatment will be identified and managed.
- Te Tiriti o Waitangi and Equity are at the centre of each level of the Framework. Critically, DHB escalation and de-escalation will be taken in a way that actively protects the health and wellbeing of Māori and other vulnerable population groups. This includes active surveillance and monitoring of health outcomes, for Māori and other vulnerable groups, to ensure a proportionate and coordinated response to health need for COVID-19 and non-COVID patients.
- DHBs should share their planning for management of Alert Levels with primary care and other providers.
- Daily EEC meetings should be the mechanism whereby Alert Levels are confirmed, and actions initiated in daily reporting.
- It is possible for different hospital facilities and/or departments within a DHB to be at different Alert Levels at any given time.
- The overall DHB Alert Level should be reported each day to the National Health Coordination Centre (NHCC) so that a national view of escalation can be compiled. This will be via the NHCC DHB SitRep.
- A hospital should determine its Alert Level and readiness and reconfirm daily with senior clinicians, senior managers and other relevant senior personnel as part of the local response plan. This decision should be clearly documented and evidenced.
- These criteria may evolve over time and be revised by the National Hospital Response Group, then reissued as appropriate.

All District Health Boards

COVID-19 National Hospital Response Framework

COVID-19 Hospital Readiness

GREEN ALERT

Trigger Status: No COVID-19 positive patients in your facility; Any cases in your community are managed and under control; managing service delivery as usual with only staffing and facility impact being for training & readiness purposes

- Screen for COVID-19 symptoms & travel history for any new Emergency Department attendances, pre-op sessions, planned admission, or clinic attendance
- Plan for triage physically outside the Emergency Department (or outside the hospital building)
- Plan to have a separated stream for COVID-19 suspected cases and non COVID-19 cases in Emergency Department
- Undertake regular training and exercises for management of a COVID-19 suspected case in the Emergency Department, Wards, Theatres, ICU/HDU
- Maintain PPE training for COVID-19 care in the Emergency Department, wards, theatres, ICU/HDU, outpatients, other relevant settings
- Plan for isolation of a single case & multiple cases/ cohorting
- Plan for Early Supported Discharge, aggressive discharge and step-down arrangements, including with other partners as appropriate (e.g. private, aged residential care, community providers)
- Plan for separate streams for staffing, cleaning, supplies management and catering
- Plan for management of referrals, and increased workload on booking and call centre teams
- Plan to have a COVID-19 capable theatre for acute surgery for a known or suspected positive patient
- Plan and prepare a dedicated COVID-19 ward
- Engage with alternative providers (such as private) to confirm arrangements for their assistance during higher escalation levels, and to fast-track urgent, lower complexity care procedures such as cataracts, endoscopy etc.
- Arrange for outpatient activity to move to telehealth and phone screening for virtual assessment, and MDTs to videoconference wherever possible
- Planned Care surgery, acute surgery, urgent elective and non-deferrable surgery to operate as usual, National Services to operate as usual, NTA to operate as usual
- Review patients on the waiting list (surgery, day case, other interventions) and group patients by urgency level

COVID-19 Hospital Initial Impact

YELLOW ALERT

Trigger Status (individual or cumulative): One or more COVID-19 positive patients in your facility; cases in your community are being managed; isolation capacity & ICU capacity manageable; some staff absence and some staff redeployment to support response and manage key gaps

- Continue screening for COVID-19 symptoms and travel history as per Green Alert
- Activate plans as described in Hospital Green Alert, as appropriate
- Activate Emergency Department triaging in a physically separate setting
- Activate streaming of suspected COVID-19 or COVID -19 positive and non-positive patients as planned across Emergency Department, Wards, Theatres, ICU/HDU, and have dedicated COVID-19 capable theatre available
- Activate Early Supported Discharge, aggressive discharge and step-down arrangements, including with other partners as appropriate (e.g. private, aged residential care, community providers)
- Engage across other DHBs to appropriately discharge out of area patients back to domicile hospital or other setting (to be considered in conjunction with current Hospital Alert Level at other DHBs)
- Acute surgery, urgent elective, and non-deferrable surgery to operate as usual, with consideration given to repatriation processes if patient is non-domicile
- Start to move pre-op assessments and outpatient appointments to be undertaken virtually, or in an off-site setting as necessary
- Plan to defer non-urgent pre-assessments and non-urgent clinic patients if necessary, ensuring clinical and equity risk is managed
- Activate any outsourcing arrangements reached, and engage on options for supporting 'cold trauma' cases and less-complex urgent cancer surgery
- Planned Care surgery and other interventions to be prioritised based on urgency, and where ICU/HDU **is not** required, delivery should continue as much as possible

COVID-19 Hospital Moderate Impact

ORANGE ALERT

Trigger Status (individual or cumulative): Multiple COVID-19 positive patients in your facility; community transmission is not well controlled; isolation capacity and ICU capacity impacted; significant staff absence, extensive staff redeployment, gaps not being covered

- Continue screening for COVID-19 symptoms and travel history as per Green Alert
- Activate plans as described in Hospital Green and Yellow Alert levels
- Work with palliative care and other providers to agree alternative end of life services for non-COVID patients.
- Provide Emergency Department services with prioritisation on high acuity medical and trauma care. Provide advice in non-contact settings where possible.
- Fully activate any agreements reached with private (or other) providers
- Acute surgery to operate as usual, with priority on trauma cases, as staffing and facilities allow
- Prioritise urgent non-deferrable Planned Care cases not requiring ICU/HDU care
- Review and manage all non-urgent high risk Planned Care surgery requiring HDU/ICU, adjusting the prioritisation threshold for surgery with Senior Clinician for non-deferrable cases
- Increase ICU/HDU capacity as needed, retaining cohorting of suspected COVID-19 and COVID-19 positive and non-positive patients, including moving non-COVID-19 ICU/HDU to theatre complex
- Implement acute ambulatory assessments or virtual/telehealth assessments for urgent, non-deferrable cases as staffing allows
- Manage outpatient referrals to ensure clinical and equity risk is understood and managed

COVID-19 Hospital Severe Impact

RED ALERT

Trigger Status (individual or cumulative): Multiple COVID-19 positive patients in your facility; community transmission uncontrolled; isolation and ICU at capacity; all available staff redeployed to critical care

- Emergency Department services limited to high acuity medical and trauma care
- Activate plans as described in Hospital Green, Yellow and Orange Alert levels
- Work with palliative care and other providers to agree alternative end of life services for non-COVID-19 patients.
- Continue acute surgery as staffing and capacity allows, prioritising non-deferrable, life-saving surgery
- Cancel all non-acute surgery
- Activate additional streaming, including non-COVID-19 ICU/HDU to theatre complex, or private provider if agreement reached
- As a last resort, move ventilated COVID-19 patients to repurposed ICU/HDU theatre complex for overflow; aim is to not impact on ability to meet non-deferrable, life-saving acute surgery
- Continue with acute ambulatory assessments or virtual/telehealth assessments for urgent, non-deferrable cases only, as staffing allows
- Only accept urgent outpatient referrals, but ensure clinical risk is understood and managed

Version 2.0, released 21 April 2020

MINISTRY OF HEALTH
MANATŪ HAUORA