STRICTLY CONFIDENTIAL

Business Continuity Plan

**For XXX District Health Board**

**An integrated contingency plan:**

To ensure the on-going delivery of health and disability services in the event of any withdrawal of labour by staff during a period of industrial action

XX District Health Board  
Private Bag  
XX

**Contact** [Name] Contingency Planner  
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**PSA ALLIED AND TECHNICAL, NURSING, ADMIN**

**Standard Template**

This template will be customised by the National

Contingency Planner prior to DHB completion

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# Document Control

**Document Distribution List**

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| 1 | Contingency Planner |
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| 2 | Chief Executive Officer |
| 3 | Chief Operating Officer, |
| 4 | Executive Director Clinical |
| 5 | Executive Director Operational |
| 6 | Chief Medical Advisor |
| 7 | Director of Nursing |
| 8 | Manager, Communications |
| 9 | Director of Allied Health |
| 10 | Director of Planning and Funding |
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| 32 | Manager Pharmacy services |
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| 34 | Manager, Infection Control |
|  | Mental Health and Intellectual Disability  Distributor: Personal Assistant to Director, Mental Health and Intellectual Disability |
| 35 | Group Manager, Mental Health and Intellectual Disability |
| 36 | Clinical Director, Mental Health |
| 37 | Charge Nurse Managers |
|  | Public Health and Dental Health  Distributor: Personal Assistant to Director Public Health and Dental Health |
| 38 | Director, Public Health Services |
| 39 | Clinical Director, Dental Health |
| 40 | Office Manager Dental Services |

# Record of Changes and Amendments to this Plan

Locally record in this table, each set of plan amendments.

|  |  |  |  |
| --- | --- | --- | --- |
| **Version** | **Amendment Date** | **Amended by:** | **Sections amended** |
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# Plan Testing and Programme Maintenance

Routine audits of this plan, especially the activities listed in the 14 day countdown are required and should be managed by the Contingency Planning Coordinator for the DHB.

# Foreword

XXX District Health Board is responsible for the health and well being of its district.

In the event that there is a withdrawal of labour from the health sector our ability to deliver services to patients is compromised. The degree to which service is compromised is dependent on the staff category which has determined that the only recourse left to them is to withdraw their labour and on the nature of the strike notice.

We must ensure that effective systems are quickly enacted and alternative staffing approaches identified to enable health and disability services to be provided as required. This responsibility not only covers the provision of our secondary and speciality community services, but extends beyond that to coordination with other health providers and agencies to secure their support as required and to the wider New Zealand health sector.

To ensure we are ready for this eventuality our contingency plans need to be in place, be readily understood by all, and be capable of immediate enactment. We are also required by law to have contingency plans in place and to ensure this planning enable us to make any request of the union for Life Preserving Service.

This revised version of the Business Continuity Plan has been produced to align our planning with the new environment we now work within.

Our overall Business Continuity Plan:

* Actively and adequately prepares for the consequences of the withdrawal of staff labour so we can continue to deliver our services to adequate standards within appropriate time-frames
* Supports the need for national or regional coordination of hospital services during a period of withdrawal of labour
* Ensures we have linked to and co-ordinated with other health and disability providers to maintain the integrity and continuity of district-wide health services
* Provides for an integrated and co-ordinated national approach and consistent management of the action.

Contingency planning for industrial action is a national process and we use national templates and agreements to ensure national consistency and maximum safety for our patients. To be successful, this Plan must be a living document and relevant to the particular impact of action by the staff group. It is the responsibility of all to be aware of the contents, aware of their designated responsibilities, and to suggest changes and improvements.

Chief Executive Officer

[Date]

# Introduction

Overall Goal of Business Continuity Plan

To maximise available resources and deliver services according to highest priority needs, manage demand for services, and minimise risk whilst enabling the safe delivery of services not affected by industrial action

The national approach to contingency planning, decision making and managing non-deferrable care is based on a series of key principles. These are:

* The needs of the patient come first – patients will be protected from harm
* There will be case-by-case assessment of clinical need for treatment and care
* Triage will be conducted by the Medical Officer who completes the patient assessment – assessment of any need for the use of union staff to meet life preserving needs will be the responsibility of the assessing SMO. In determining the need for calling in union members the assessing SMO should follow the escalation processes defined within each DHB and take advice from others as required
* Quality of care delivered to those patients who require care must not be compromised
* LPS cover is requested where care which can not be deferred and is unable to be provided without union support
* DHBs will take all reasonable steps to reduce demand – demand management will be part of the internal DHB Strike Control Centre process
* DHBs will deliver care elsewhere where it is safe, reasonable and practicable to do so.

This contingency plan details the response structure for the potential industrial activity by the PSA allied and Technical staff. Nursing staff and administration staff The negotiations are national and it is expected that any action taken will be national in nature. It is likely to involve both periods of full and partial withdrawal of labour in conjunction with area specific withdrawal of labour and work to rule. Experience has shown that planning needs to consider both short term and long term strategies for disrupted labour supply within the health sector.

All 20 DHBs will be affected.

The potential industrial action applies to individuals covered under:

* PSA South Island Administration/Clerical MECA
* PSA Auckland and Rest of New Zealand Nursing MECAS
* the PSA Auckland and Rest of New Zealand Allied and Technical Staff MECA. This staff group encompasses most sites and the following staff categories (as per the MECA coverage): Audiologists, Counsellors, Dietitians, Dental Therapists, Genetic counsellors, Health Protection Officer/Advisors, Health Promotion Officers/Advisors, Neurodevelopmental therapists, Paediatric therapists, pharmacists, physiotherapists, play specialists, psychotherapists, podiatrists, Occupational therapists, Social workers, Speech Language therapists, Pharmacy interns and technicians, alcohol and other drug clinicians, psychologists, pharmacy assistants, audiometrists, Biomedical electrical technicians, clinical physiologists, dental technicians, ECG technicians, food supervisors, medical laboratory technicians, Medical photographers, Mortuary technicians, Orthotists, Scientific Officers, Sonographers, Sterile services technicians and Vision Hearing testers

There will be national coordination. The National Contingency Planner (NCP) will ensure consistent approaches for each DHB and lead the overarching strategy to ensure maximum safety of patients, minimal disruption to service delivery across the sector, an integrated plan and approach, and provide support/media responses as required.

The potential/possibility of industrial action by Allied and Technical staff poses a significant national and organisational risk. Preparation of Business Continuity plans - contingency plans - is a risk management strategy aimed at minimising the potential associated risk. Given the nature of the legislation we need to complete planning in advance of any notice of industrial action being served. There is a 24 hour (one working day) time-frame for seeking assistance from the union for staff to cover any situations which can be defined as life preserving and determining such a need takes considerable time.

This Business Continuity Plan is in three parts. Part one consists of the high level planning assumptions and the DHB’s high level approach to contingency planning including their strategic framework. Part Two contains detailed contingency plan for services affected and will be reviewed and updated on a regular basis from the time the notice to action is received to the day(s) of industrial action (1four days). Part Three contains the Appendices.

**Part One**

This part is divided into six sections. Sections One, Two, Three and Four are standard across all DHBs. Section One contains key objectives, general principles and strategies, general assumptions. Section Two contains national risk identification and issues. Section Three is the risk matrix for each hospital/DHB. Section Four details the role of the National Coordination service and outlines the national communication strategy and principles as well as defining the escalation process. Section Five provides the organisational structure and contact list for the DHB’s contingency planning team and defines the DHB roles and responsibilities and escalation processes. Section Six contains the high level contingency plan customised for each hospital/DHB/provider and the detailed LPS request.

**Part Two**

This part contains the detailed contingency plan for each DHB service and facility.

* Section Seven defines the detailed plans by service and identified Life Preserving service requirements should they be required. This section is prepared for each division and it outlines the plans, staffing gaps, the staffing required, actions to be taken and allocates responsibility for that. It also includes the DHB timeline for pre-strike activity
* Section Eight describes the Countdown plan. This records the activity required on each day from receipt of notice of industrial action throughout the pre-strike and strike periods. These are completed by each provider at a Divisional/ service and DHB level. This should give an integrated action list for the DHB.

**Part Three**

This section contains Appendix I which details the normal rosters for each area and Appendix II the proposed rosters for the period of action. Appendix III gives the local DHB communication plan and provides some standard letter templates. Appendix IV is the internal staff education pack for the DHB. Other Appendices V- IX detail roles and responsibilities for staff in the Control Centre and other Control Centre related documentation.

PART ONE

High Level Contingency Planning

# Section 1 Key Objectives of Contingency Planning

* To maintain essential hospital services, especially acute services, for the preservation of life and the prevention of disability
* To understand the services which can be delivered during the action and to plan accordingly
* To identify, and plan for management of major risks and minimise the risk to patients, staff and communities
* To manage demand for services through a collaborative regional and national approach to the management of patient throughput
* Wherever possible, to keep disruption to hospital services at a minimum and facilitate the delivery of services not directly affected by the strike
* To communicate with patients, families, staff and communities in a way which proactively informs and instructs whilst managing anxieties and information needs/expectations
* To provide support, guidance and communication to staff who will be working through this period
* To maximise available resources within own DHB, in other DHBs and with other providers.

# Section 1 General Principles of Planning

* Planning will occur at national, DHB and service level with clearly defined national and DHB coordination and decision making consistent with national agreements and plans. Individual services will plan for management of their specialties/services but within a DHB context and the need to create an integrated plan
* Plans are to enable the maintenance of an objective focus on ensuring the safety of all patients who are affected by the industrial action especially those for whom there is no option but inpatient or in-hospital care
* National coordination of all DHB planning and day to day operations will support individual DHBs to prepare plans and develop strategies which will enable the smoothest possible management of a period of action and will provide for a coherent national framework to maintain business continuity
* Hospital wide issues identified as a result of this process will be managed centrally under the auspices of the DHB Coordinator. The Coordinator will have the authority to make decisions for that DHB and immediate access to COO/GM and if necessary CEO for complex issues. The Coordinator will represent the DHB on national teleconferences, planning meetings and LPS discussions
* Each service will have a Coordinator of their planning who has detailed knowledge of the operation of that service reporting to the DHB Coordinator
* The roles of those working within the DHB Coordination team will be clearly defined
* DHB’s will manage situations in relation to unacceptable risks to the DHB seeking advice or input from the NCP as required
* Hospital staff and non-striking workers will continue to perform their normal duties as far as is practical, but particularly ensuring that LPS services receive the highest priority
* Elective services with dependence on the affected staff group will only proceed where risk is clinically assessed as low, appropriately skilled staff are available and appropriate informed patient consent obtained
* DHBs will operate a coordination centre appropriate for the duration of any action and there will be a national coordination centre/capacity for the duration of the action.

# Section 1 General DHB Planning Strategies

The Business Continuity Plan encompasses consideration of all aspects of clinical and commercial activities. To ensure business continuity, planning needs to include the following:

* Active risk identification and mitigation which commences during the planning stage and continues until the post industrial action period including debrief. This includes the management of any indirect action by other employees which may be taken if the dispute escalates
* Reducing demand in so far as is possible or necessary
* Providing a substitute for ED for patients who can be diverted to or maintained in a community based resource. Wherever practicable, community services will be accessed to provide care once the acute care phase is past. This will include alternatives for hospital avoidance or earlier discharge
* Ensuring access to an adequately prepared staff resource to manage the range of services which will continue to be provided and preparing them to manage industrial action related plans and strategies. This includes maintaining through non-striking staff, other providers or LPS request an adequate capacity for provision of LPS or acute and non-deferrable services
* Maintaining clarity about which of the affected staff groups are performing which duties and managing rosters and services accordingly
* Ensuring there is an accepted process nationally for the appropriate transfer of patients/resources e.g. ICU transfers, retrievals
* Preparing plans in such a manner that any potential LPS requests are predicted within 12 hours of receipt of strike notices
* Provision of information packs for all staff, and sound communication to inform referrers, community, primary care providers and staff at every stage of the process
* Maintaining access for staff coming to and from work during any action.

# Section 1 Assumptions

The following assumptions have been made in developing the national approach to contingency planning:

1. Whilst the DHB is unable to predict the nature or duration of the industrial action we will plan for the action confirmed in PSA communication regarding the ballot. This is

- A work to rule e.g."strictly observing start, finish and break times, completing job description task only", commencing from 25 August 2014 to 10 September 2014.

- A ban on all overtime work from 1 September to 10 September 2014.

- The complete withdrawal of labour on 2 September 2014, from either 1pm to 3pm, 9pm to 11pm or 5am to 7am depending on the shift being worked. (2 hours).

- The complete withdrawal of labour on 10 September 2014, from either 8am to 11am, 3pm to 6pm or 12 midnight to 3am depending on the shift being worked. (3 hours).

1. There will be a period of 14 days from receipt of notice until action taken.
2. Industrial action will be nation-wide and will occur in all DHBs at the same time, potentially varying in nature at each hospital as staff groups vary from DHB to DHB.
3. There is one day in which to request LPS support and actual details of union membership may not fully known when the request needs to be made.
4. Applications to the union to provide staffing for life preserving situations will be made within the terms of the legislation should they be required .i.e. within one working day of receipt of the notice.
5. Industrial action will proceed.
6. All PSA Nursing, South ISland administration/clerical and Allied and Technical staff will be involved in, or supportive of, the potential industrial action. There will be few non-union/non-striking members’ available and therefore limited back up support.
7. Acute/non-deferrable work will continue.
8. Maintenance of Business of Usual at all hospitals is unlikely to be achieved – some elective services will be disrupted.
9. Hospital staff and non-striking workers will continue to perform their normal duties as far as is practical, but particularly ensuring that LPS services receive the highest priority. Some other health professionals may be sympathetic to the potential industrial action and will not do “additional” work and may be disruptive.
10. In the period leading up to the strike, bed numbers will be progressively reduced to the lowest possible level. Operational managers will work to ensure efficient and effective patient flow, particularly managing demand and reducing LOS to reduce demands on affected services.
11. All DHBs will continue to receive transfers from other DHBs and acute patients from our communities.
12. In the lead up to and during action, all patients suitable for transfer within the region will be received without barrier or delay.
13. There will be significant media coverage and a detailed communication strategy – national and local – will be prepared to manage this.
14. The minimum steps in managing patient care prior to and during the period of industrial action will be:

15.1 Reduce demand as much as possible

15.2 Ensure full use of private providers for service and back up

15.3 Where appropriate ensure full use of capacity in other DHBs

15.4 Ensure the use of all appropriately trained non union or non striking staff and prioritise the work they will do accordingly

15.5 Manage the treatment of existing and new patients prior to the period of industrial action in a way which does not increase the risk or likelihood of life preserving situations or clinical deterioration arising

15.6 Transferring patients to their DHB of domicile as much as possible (to facilitate discharge and spread the workload)

15.7 Reduce and then eliminate all affected elective services for three days prior

15.8 Use of full capacity in any DHBs where appropriate skilled resources available.

# Section 1 Life Preserving Services Requests

Section 1B to the Employment Relations Act defined the requirements for Contingency planning and established a Code of Good Faith for the public health sector, providing for the health and safety of patients, staff and the public during industrial action in the health sector.

Clause 3 of the Code **defines life preserving services** as:

1. Crisis intervention for the preservation of life.
2. Care required for therapeutic services without which life would be jeopardised.
3. Urgent diagnostic procedures required to obtain information on potentially life threatening conditions.
4. Crisis intervention for the prevention of permanent disability.
5. Care required for therapeutic services without which permanent disability would occur.
6. Urgent diagnostic procedures required to obtain information on conditions that could potentially lead to permanent disability.

Clause 11 of the Code covers **General obligation for employers to provide for patient safety during industrial action.**

During industrial action, employers must provide for patient safety by ensuring that life preserving services are available to prevent a serious threat to life or permanent disability.

Clause 12 of the Code covers **Contingency Plan**

1. As soon as notice of industrial action is received or given, an employer must develop (if it has not already done so) a contingency plan and take all reasonable and practicable steps to ensure that it can provide life preserving services if industrial action occurs.
2. If an employer believes that it cannot arrange to deliver any life preserving services during industrial action without the assistance of members of the union, the employer must make a request to the union seeking the union’s and its members’ agreement to maintain or to assist in maintaining life preserving services.
3. The request must include specific details about –
   1. The life preserving service the employer seeks assistance to maintain and
   2. The employers’ contingency plan i.e. relating to that life preserving service; and
   3. The support it requires from union members.
4. A request must be made by the close of the day after the date of the notice of industrial action.
5. As soon as practicable after the employer has made a request but not later than four days after the date of the notice of industrial action, the parties must meet and negotiate in good faith and make every reasonable effort to agree on –
   1. The extent of the life preserving services necessary to provide for patient safety during the industrial action: and
   2. The number of staff necessary to enable the employer to provide that life preserving service; and
   3. A protocol for the management of emergencies which require additional life preserving services.
6. An agreement reached between the parties must be recorded in writing.

Clause 13 of the Code covers **Adjudication**

1. If the parties cannot reach agreement under clause 12(5) they must, within 5 days after the date of the notice of industrial action, refer the matter for adjudication by a clinical expert or other suitable person as agreed under clause 8.
2. The adjudicator must conduct the adjudication in a manner he or she considers appropriate and must –
   1. Receive and consider representations from the parties; and
   2. In consultation with the parties, seek expert advice if the adjudicator considers that it is necessary to do so; and
   3. Attempt to resolve any differences between the parties to enable them to reach agreement and, if that is not possible, make a determination binding on the parties; and
   4. Provide a determination to the parties as soon as possible but not later than 7 days after the date of the notice of industrial action.
3. The parties must use their best endeavours to give effect to the determination.
4. The parties must bear their own costs in relation to adjudication.

# The parties have agreed that the Chief Medical Officer of each DHB will fulfill the role of adjudicator for that DHB.

# Section 2 National Risk Identification/Issues

The Risks and Issues identified in this section are consistent with the key assumptions outlined in Section 1 and form the basis of the risk planning for each DHB.

# Section 2 Patient Related

1. Preparatory activity may over commit staff and reduce/restrict their ability to deliver business as usual services for patients in the lead up to the strike.
2. Failure of key services due to inability to fill skill gaps or required numbers especially for acute services.
3. Lack of familiarity with procedures and tasks where other health professionals e.g. nurses or RMOs, do not undertake these on a regular basis.
4. A nationwide action limits access to resources from other districts or providers – inadequate numbers of staff, availability of alternative providers/DHBs for diversion of admissions, hospital transfers.
5. Service reduction due to restraints with capacity, support and capability. Key risks are service disruption, elective deferrals, postponements, management of semi-acute and rehabilitating patients, and staff uncertainty over patient access. The nature of action will determine the extent of this disruption.
6. Inability to reduce demand on services to the level agreed e.g. discharging patients, and inadequate information to determine likely service demand.
7. Potential clinical risks associated with the withdrawal of labour include:
   1. Insufficient trained manpower for
      1. Managing sterile services, laboratory services or pharmaceutical distribution
      2. assisting with operations/procedures
      3. Managing telephone services in emergencies
      4. Maintaining patient safety in mental health servics
      5. Adequate medication management
      6. Patient assessment
      7. Roster cover
   2. Failure to note changes in patient conditions, and insufficient resources for on-going patient assessment and post-acute in-patient management.
   3. Sufficient resource to liaise with GPs/ alternative service providers.
8. Inability to communicate with other health care providers to ensure potential admissions are carefully managed or care diverted.

# Section 2 Staff related

1. Damage to relationships between staff and employer, employee to employee.
2. Other staff (health professionals) will be supportive of PSA staff’s strike action and will not do ‘additional’ work and may also be disruptive. This includes those whose MECA negotiations are incomplete.

# Section 2 Business related

1. Intense media interest and community pressure to conclude strike.
2. Business continuity failure
   1. in the event of an external or internal incident requiring the activation of a disaster response
   2. due to the impact of an extended and disruptive period of industrial action.
3. Inability to achieve agreed elective service case weights, or agreement from Ministry of Health to defer electives and thus leading to significant financial deficit.
4. Loss of public confidence.

# Section 3 {Sample} XXX DHB Service Risk Analysis

For potential PSA ndustrial action [August/September/2014]

There is potential for significant organisational risk. Preparation of this DHB plan is a risk management strategy aimed at minimising the potential risk associated with the withdrawal of staff whilst supporting business continuity.

| Risks | Probability (Low, medium, high) | Impact (Low, medium, high) | Risk Management Strategy | Residual Risk |
| --- | --- | --- | --- | --- |
| Patient Related | | | | |
| 2.1 Preparatory activity in the lead up to strike may over commit staff and reduce/ restrict their ability to deliver business as usual services for patients | High | Medium | * Separate the responsibilities for contingency planning from day to day business * Assign dedicated administrative resources to manage any changes in elective activity * Use of nationally available resources and expertise * Daily contingency planning meetings focus activities on planning for the latest possible safe wind-down of services * Establishment of coordination centre * Complete impact analysis (Appendix 1) and Communications strategy (Appendix IV). | Low |
| 2.2 Failure of key services due to inability to fill skill gaps or required numbers especially for acute services | Medium | High | * Provide suitable alternative management in community * One point entry (ED) for acute patient management * Establish and document acute management pathway for the period of the action and assign staff wherever centralisation occurs e.g. Initial placement in AAU * “Flying IV/pain” teams and discharge planning teams * Transfer of tertiary patients as able * Return of patients to DHB of domicile pre-strike to facilitate community based management * Seek early discharge options * Use of better resourced DHBs or private hospitals as able * Hospital/ward closures where relevant * GP support/assistance/primary care liaison activity * Enlist all non-union staff early * Use of residential care for longer with support from primary care. | Medium |
| 2.3 Lack of familiarity with procedures and tasks where other health professionals e.g. nurses or RMOs do not undertake these on a regular basis. | Low | Medium | * Undertake training in lead up to action to overcome any shortfalls in skill set * Roster to ensure best possible complement of skills at all times * Increase Duty and after Hours management staff through  re-rostering. | Low |
| 2.4 A nationwide action limits access to resources from other districts or providers – inadequate staff numbers, availability of alternative DHBs/ providers for diversion of admissions, hospital transfers | High | Low as action assumed to be elective only | * Establish options for retrieval and transfer * National coordination and planning * Clearly defined transfer pathways, algorithms and criteria. | Low |
| 2.5 Service reduction due to support and restraints with capacity, support and capability. Key risks are service disruption, elective deferrals, postponements, management of semi-acute and rehabilitating patients, and staff uncertainty over patient access. (The nature of action will determine the extent of this disruption). | High | High | * Clarify nature of labour withdrawal * Confirm deferrals early * Dedicated contingency team separated from BAU * Complete impact analysis * Plan service closures early. * Develop clear definition and pathway for acute patient management to ensure post acute care managed safely * Strong communications strategy. | High |
| 2.6 Inability to reduce demand on services to the level agreed e.g. discharging patients and inadequate information to determine likely service demand | Medium | High | * SMOs to focus on admissions and referrals to ED * Strong management plans on admission * Determine likely acute workload and increase other health professionals as appropriate e.g. senior nurses/Practitioners * Post acute admissions screened for alternative care options * Discharge teams * Liaison with rest home and alternative care providers in advance and regularly during action * GP liaison activities heightened. | Low |
| 2.7 Potential clinical risks associated with the withdrawal of labour include:  a)Insufficient trained manpower for  -Managing sterile services, laboratory services or pharmaceutical distribution  -assisting with operations/procedures  - Managing telephone services in emergencies  -Maintaining patient safety in mental health services  -Adequate medication management  -Patient assessment  - Roster cover  b) Failure to note changes in patient conditions, and insufficient resources for on-going patient assessment and post acute inpatient management  c) Sufficient resource to liaise with GPs/ alternative service providers | High | Medium | * Roster developed using all available team members * Reduction in workload during period of action * Development of acute-patient pathway * Dedicated resources for discharge management, medication management * Rapid assessment teams * Resources targeted to sub-acute community teams * Early consideration of predicted workload * Maximise pre-action time for staff preparation * LPS agreements which meet predictable acute demand * Early rostering * Training * Staff education pack * Access to regional staff with appropriate mental health assessment skills * Sound DHB based escalation processes. * Planning patient rehabilitation and treatment sessions to best match staff availability * Early discharge management wherever practicable * Limiting elective work in the immediate lead up to the period of action | Medium |
| 2.8 Inability to communicate with other health care providers to ensure potential admissions are carefully managed. | Low | Medium | * Establish communication four days in advance * Link with national and regional communications * Advise of and involvement with contingency planning * Telephone referral service established * Develop ED brochures to advise walking patients of service limitations. | Low |
| Staff Related | | | | |
|  |  |  |  |  |
| 2.9 Damage to relationships between staff and employer, employee to employee | Low | Low | * Communication strategies * Management and senior staff visibility * Open transparent communication and information channels * Fair and transparent management of Business as Usual * Post-industrial action debrief. | Low |
| 2.10 Other staff will be supportive of PSA strike action and will not do ‘additional’ work and may also be disruptive. This may include staff whose MECA negotiations are incomplete | Medium | Medium | * Communication plan actioned * Senior staff develop key messages appropriate to DHB which inform of steps taken re services, GPs, negotiations * Any remuneration strategies to be agreed in advance with relevant unions * Management and senior staff visibility * Consistency of messages. | Low |
| Business Related | | | | |
| 2.11 Intense media interest and community pressure to conclude strike | Medium | Low | * Centralised media management process * National management of contingency planning information. | Low |
| 2.12a) Business continuity failure in the event of an external or internal incident requiring the activation of a disaster response. | Low | High | * Ensure agreement to disaster response confirmed locally and nationally * Confirm agreement as part of LPS agreement process. | Low |
| 2.12b) Business continuity failure due to the impact of an extended and disruptive period of industrial action | Low | High | * Ensure rosters are balanced and rotating to provide required support or staff * Maintenance of national coordination ad daily communications * Nature of action well documented * Staff relocated from closed to functioning Departments * Sufficient provision of breaks and rostered time off * Service reductions and deferrals as able. | Low |
| 2.13 Inability to attain agreed elective service case weights or agreement from MoH to elective deferral and thus leading to significant financial deficits | High | High | * Discuss issues with MoH and gain agreement to strategy in advance * Develop Recovery Plan. | High |
| 2.14 Loss of public confidence | Medium | Medium | * Telephonists briefed re information and communication channels to be used * Communication plan activated – positive messages. Good information about service availability * Clear communications with community, media and primary care. Objective and positive messages * Information line manned * Consistent messages agreed on daily national teleconferences. | Low |

# Section 4 National Coordinating Centre/Coordinator

### Role and Responsibilities

* Development of core Contingency Planning documentation, preparation of national templates and review of documentation
* Advice to DHBs and other providers and establish contact network at each hospital
* Prepare new contingency planners for their role as required
* Liaise with DHBs across the country and provide central coordination of issues/activities
* Confirmation of contingency plans and providing advice where gaps are evident. Ensuring plans are complete when countdown begins
* Reporting national progress on contingency planning and preparation to CEOs, Ministry etc.
* Coordination of LPS requests and common definitions
* Coordination of national daily teleconferences
* Receive status report Day -1 and during action
* General communications to DHBs and contractors
* Advising and managing risk and assisting with risk mitigation and elimination strategies. Particular focus on high risk areas, alerting the lead CEO as indicated
* 24 hour support to Contingency Planners
* Maintaining confidence in service provision
* Managing contingency related media
* Coordination of any resource willing to work nationally
* Assist with high profile strategies e.g. hospital closures
* Development of national or regional plans which support contingency plans e.g. patient transfer protocols
* Liaison with national ER and Communication teams to ensure consistency of national approach.

# Section 4 Expectations of coordination teams and all DHBS

* There will be daily operational group meetings in each DHB leading up to action and during the action. DHB groups will be representative of clinical and support staff across the organisation and all efforts will be made to ensure the widest possible communication across the organisation
* Key risk areas will be confirmed with the NCP immediately they are identified
* There will be a Coordination Centre set up for DHB Coordination
* Each DHB will build on the national contingency planning framework and develop a contingency plan which includes high level strategy as well as detail at a service level, combined into a DHB plan and finalised to meet legislative timeframes
* The average expected patient volumes are known, can be provided and used throughout the planning process
* There will be regular reporting between DHB Coordinators and the NCP to enable successful management of national action – volumes, hospital status
* A reporting framework will be developed by the NCP to capture our position during industrial action and this will be completed at the time requested
* All timeframes are met
* Demand for services will be reduced
* Risk Mitigation strategies are implemented.

# Section 4 Assumptions

* DHB of domicile will meet all costs of patient/family transfer
* RDA, SFWU, NZNO,APEX, ASMS will confirm support for PSA and there will be a subsequent inability to negotiate with staff to work outside their normal role and place
* Daily national teleconferences will occur and every affected provider will participate
* A national teleconference would be held at 9am on the morning after the strike notice received
* LPS requests will be centrally reviewed before submitted and will be submitted within the legislative timeframe.

### Contact details for National Contingency Planning Support Group

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Title | Contact number | Email |
| Anne Aitcheson | National Contingency Planner | 0274 323 534 | Anne.a@clear.net.nz |
|  | National Communication Coordinator |  |  |
|  | ER |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

# Section 4 National Communication Strategy

xxxxx is working on this at a national level.

### Communication Objectives

The objectives of the communication plan are to:

* Support a negotiated outcome in line with DHB parameters
* Ensure our position on matters in the public domain is fairly and accurately reported
* Ensure those writing about the negotiations understand the key issues
* Ensure the advice or comment of DHBs is actively sought.

### Communication Principles

In all our communication we will aim to be timely and responsive – it may also be necessary to be proactive on occasion. On a tactical level this will involve:

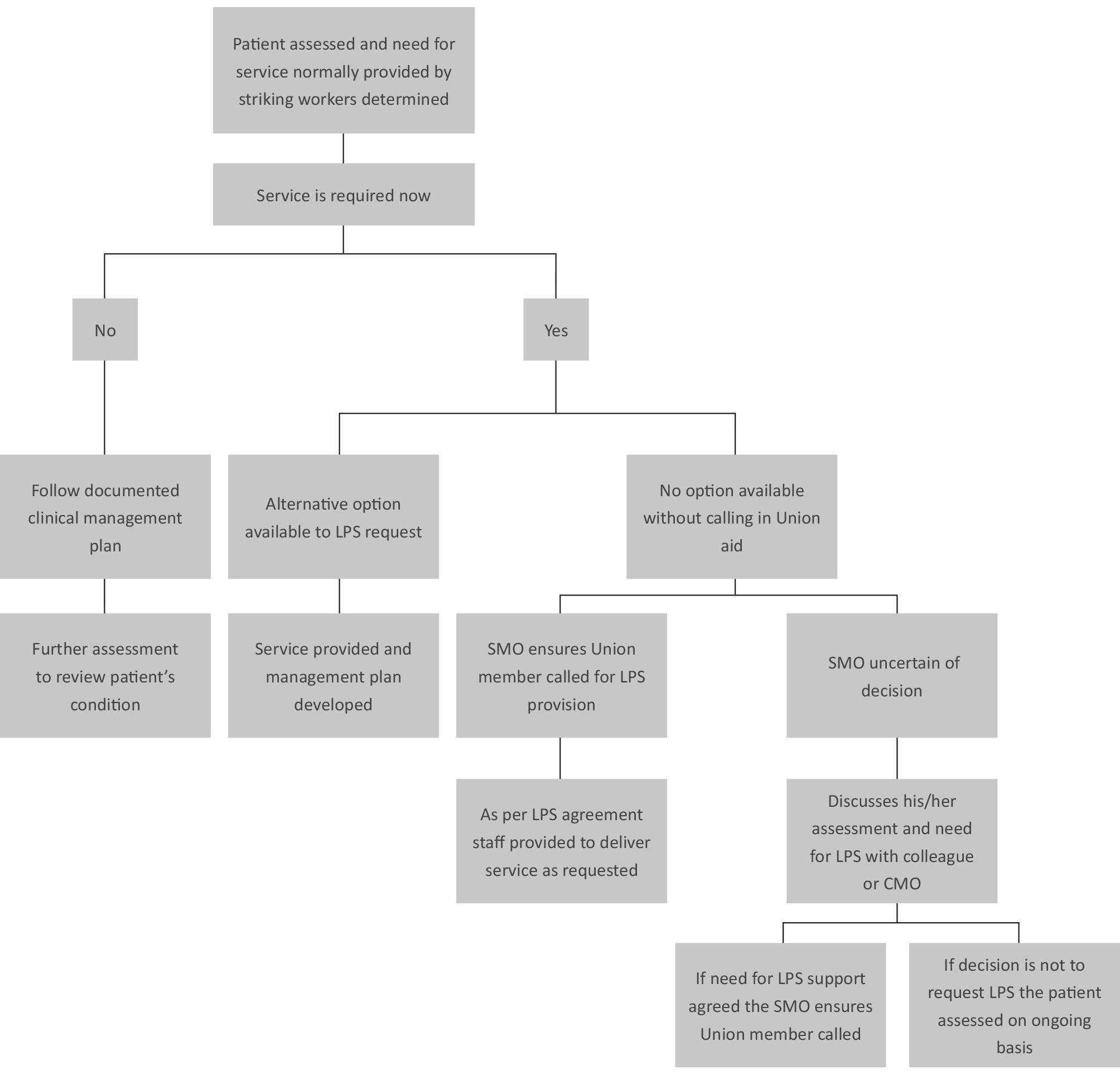
* Updates and progress reports
* Telling our side of the story
* Clarifying misinformation
* Regular and timely stakeholder communications
* Being accessible to the media and stakeholders
* Maintaining consistent and clear communications.

### Local Communications Strategy – attached as Appendix IV

* DHBs will be responsible for communicating the impact of strike action on services in their respective areas – in particular
  + Keeping stakeholders informed and ensuring key DHB staff are well informed of the negotiation issues and that all practicable steps are being taken to achieve a settlement
  + Making it clear that the DHBs value their SMOs and avoiding an adversarial relationship developing through these negotiations
  + The media reporting the threatened strike action understand the key issues and actively seek information or comment of DHBs
  + Maintaining consistent and clear communications to ensure the DHBs position on matters in the public domain is fairly and accurately reported.

# Section 4 Agreed Escalation Process for Accessing Life Preserving Services

This approach was agreed by the DHB’s Chief Medical Officers in 2010 and remains core to current DHB and national planning.

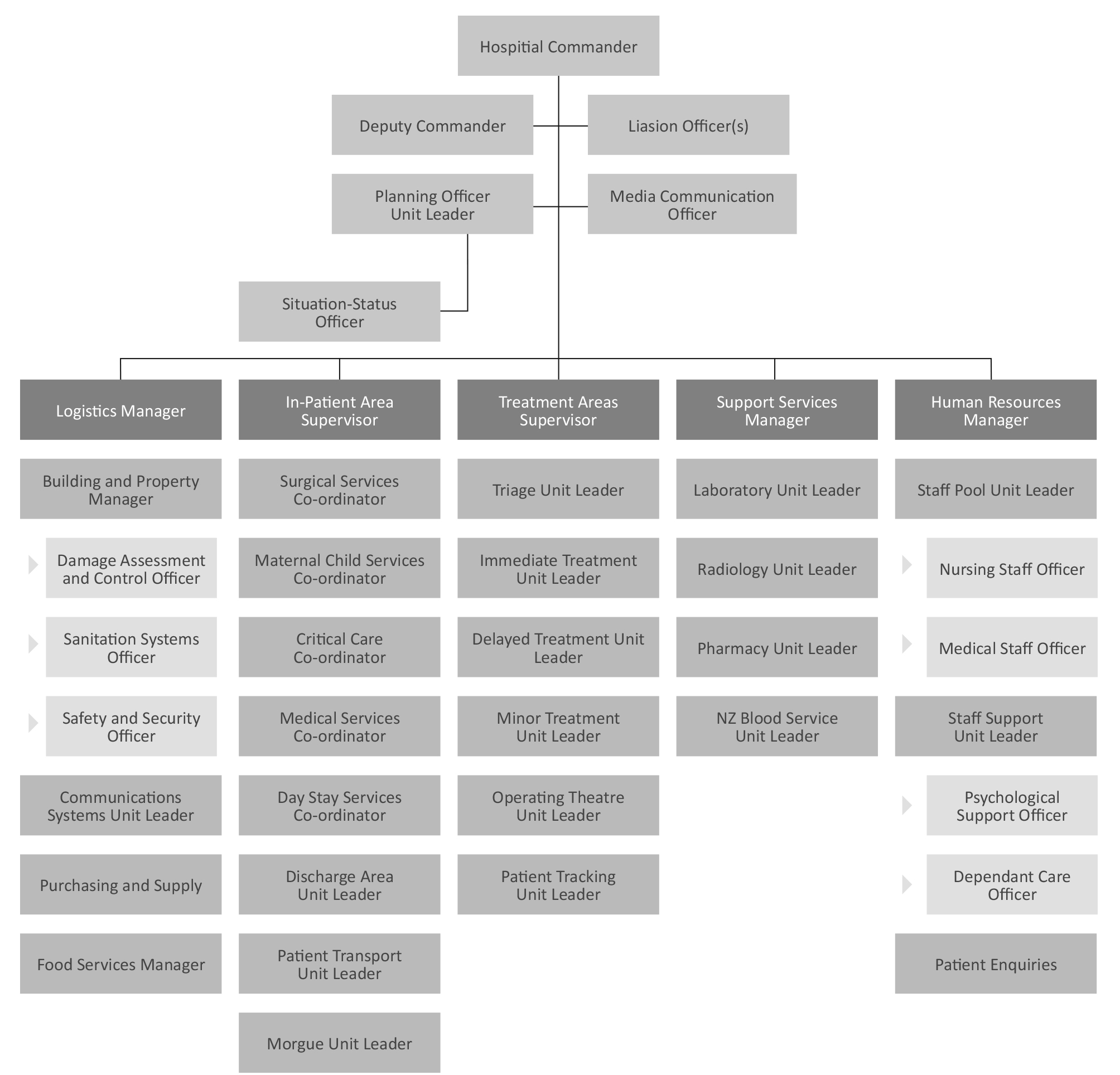


# Section 5 DHB Business Continuance Structure

*Sample Only.*

Southern DHB Coordination Diagram [month/year]

Dunedin Hospital Disaster Plan Organisational Chart



### Contact details for XXXXX DHB Contingency Planning Group to Support Business Continuity

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Title | Contact number | Email |
|  | Coordinator Contingency Planning |  |  |
|  | Manager Emergency Management |  |  |
|  | DHB Communications Manager |  |  |
|  | Chief Medical Officer |  |  |
|  | Director of Nursing |  |  |
|  | Director Allied Health |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

### Local DHB Escalation Process for LPS requests:

Each DHB needs to define its in-house escalation process in accordance with the approach agreed by the Chief Medical Officers. The process needs to consider the role of:

1. The Strike Coordination Control Centre
2. SMO advice/peer support to the requestor of LPS service
3. The process to be followed by the doctor responsible for the assessment of the patient
4. The officer responsible for making the call out for LPS

# Section 6 High Level Contingency Plan – [month/year]

### XXXXXDHB Contingency Plan– High level hospital plan

| Item | Object | Action |
| --- | --- | --- |
| 1 | Manage in-patient numbers to match staff availability  Assumption is that acute presentations will reduce for initial period of action but soon return to normal levels | **Services Remaining Open**  The following services have been identified as critical areas and are to remain open, while keeping occupancy levels reduced and attempting to optimise patient safety.  **Emergency Department**   * Establish active liaison with PHOs, GPs, and After Medical Clinics, et al regarding referral criteria * Consultants and non-striking RMOs to be rostered to cover 24/7 during strike * Staff to maintain “business as usual” for acute presentations. Ensure the public are informed. * Utilise non-hospital care options where possible. * Enact an active communication programme designed to defer referrals from primary care with GPs, private hospitals and rest homes. * Increased nursing cover in ED. * Enhance Allied Health support as able   **AAU**  Act in accordance with the agreed acute patient management pathway for the period of industrial action e.g.   * Patients to have a secondary assessment in AAU before transfer to in-patient wards * Aim to discharge early wherever appropriate with increased community support, minimise admissions to wards * Maximise medical and nursing staffing in AAU * Utilise convalescent/step down beds in community settings * Enhance Allied Health support as able to enhance timely, early and safe discharge |
|  |  | **Intensive Care Unit**   * Cancel all elective surgery requiring ICU / CCU support with sufficient lead time to ensure cases are cleared * Transfer cardio-thoracic, neuro-surgical, burns patients as per usual criteria * Place retrieval services on alert for potential transfers to other centres * Redeploy Anaesthetic Registrars to assist in the area under the direction of ICU consultant staff * Maintain an increased SMO cover |
|  |  | **Paediatric Assessment Unit**   * Maintain an increased SMO cover * Increase staffing of the Paediatric Nursing Service where possible to support children in the community and minimise admissions * Paediatric cases to be cohorted in so far as is sensible * PAU will have priority status for the allocation of additional available nursing resources * Retrieval services will be placed on alert for potential transfers to other centres * Transfer Level 3 babies. |
|  |  | **Coronary Care Unit**   * Cancel elective procedures with sufficient lead time to ensure discharges from ward settings * Cancel Outpatient services * Increased RMO presence/cover of CCU   **Acute Surgery**   * Elective surgery will be cancelled with sufficient lead time (4-5 days) to ensure cases are discharged from ward settings * Day surgery will be wound down 48 hours out from date of strike (10-15% of day cases become inpatients) * At least two (2) acute theatres will be maintained * The staffing of normal number of acute theatres will have a priority status for the allocation of available nursing resources * Explore use of private hospital for some acutes (excluding complex or multiple trauma, e.g. routine fracture reduction) to prevent backlog where applicable.   **Mental Health and Addiction Services**   * Maintain acute inpatient (IPCU) and in-patient ward with Consultant/GP cover * Manage semi acute in the community * Increase medical and nursing cover for CATT * Cancel clinics as necessary once acute roster is developed * Mental Health Act work will continue |
|  |  | **Closed Services**  Main activity is the cancellation of elective procedures with sufficient lead time to ensure cases are discharged from hospital. The following services would be closed during strike:   * Dental Department * Outpatient Clinics with the exception of urgent outpatients who will be directed to ED/single point * Elective Gastroscopies * Surgical: Day Surgery * Sexual health clinics * ATandR Outpatients/Community/limb centre patients * Procedural suites   **Reduced Services**   * All services will be reduced to the lowest possible levels as acute managed only * Exercise Tolerance Testing * TOEs * Procedural suites * Elective cardioversions * CT imagery * Perfusion scans |
| 2 | Arrange alternative care | **Hotline**  0800 hot line in ED activated for General Practitioners and referring hospitals for discussing issues/consultation.  Establish linkages with the following: to be confirmed as part of regional overview plan   * Other Tertiary and Secondary Centres for transferring and referring appropriate patients * General Practitioners, Private Hospitals and Rest Homes, Local Medical clinics * Other secondary centres * Ambulance, Air Ambulance and other services that could assist with transferring patients * Utilise medical and surgical RMOs to assess non-acute patients presenting at ED with the view of diverting to other external health providers * Review alternative care options with other providers. * Include Allied Health workers in initial patient assessment and discharge plan * Community nurses to reprioritise workload for improved discharge planning. Supplement numbers from elective services if appropriate. |
| 3 | Maximise staff resource | * Cancel elective procedures as detailed above * No further leave approval for the period of the unforeseen event * Identify staff willing to work additional duties during an unforeseen event * Utilise casual/locum medical staff * Identify staff with clinical experience, e.g. technicians * Identify staff on temporary contracts * Cardiac Arrest Strategy including the identification of a cardiac response team * Clarification of inpatients on site from day one of any unforeseen event * Utilise the bed manager (bed management and staff roster patterns) as well as Duty and after hours managers in operational oversight * Reduce non clinical workload and pressures * Cancel staff training days * Perioperative and Outpatient nursing staff to be redeployed to AAU/ED/CHS and inpatient units – Unit Managers to confirm numbers available/required and roster appropriately * Use beds on same floor or level as much as possible – patient consolidation * Train staff in areas with which they are unfamiliar * Establish on call manager rosters * Arrange staff indemnity prn * Establish payment guidelines * Close wards and hospitals |
| 4 | Coordinate Volunteer Assistance | * To be finalised once strike notice received. |
| 5 | Ensure sufficient supplies | * Ensure supplies are at hand in reconfigured wards. * Stop regular deliveries to elective areas to prevent stock piling |
| 6 | Communication to patients and other caregivers | * Ensure Communications Manager is briefed on correct messages for the Hospital * Develop standard letters for affected services, General Practitioners and referring hospitals * Information booklet for patient and family including preferred entrance to the Hospital * Establish communications process with other hospitals and MOH * Establish Public Information Plan   + Public Notices   + Media Plan   + Public Enquiries 0800   + Letter to patients. |
| 7 | Internal communication | * Chief Executive/COO to brief all staff * Regular and on-going communication with all staff * Direct Media enquiries to the Communications Manager * Communication to all working staff detailing action taken to ensure their safety * Develop information pack for SMOs and RMOs * Put out daily and more frequent staff bulletins * Notices to staff * Standard responses * Downsizing of services * Develop information pack for SMOs and all working staff. |
| 8 | Maintain security | * Confirm security personnel roles and additional staffing required- utilise local security firms as required * Full and on-going briefings of Security/Risk Manager * Increase car parking and other security * Plan in place to deal with possible sabotage. |
| 9 | Ensure non striking staff and volunteer access | * Arrange off-site parking (prn) and suitable transport * Liaise with police to ensure safe access to site. |
| 10 | Look after those working | * Set up area for accommodation * Ensure sufficient food available * Keep all working staff well informed * Provide additional requirements e.g. Dictaphones/clerical support to assist with rounds, at discharge. |
| 11 | Escalation of Potential risks | Develop risk management strategy Ensure key risk manager involved in risk identification and mitigation. |
| 12 | Student placement | Consider and cancel as appropriate. |
| 13 | Cancel non essential services | Assess if relevant  Complete impact analysis, identify services to be cancelled and cancel |
| 14 | Recovery Plan | Complete a recovery plan to ensure effective management of return to full service delivery. |

### LPS Requirements based on high level plan evaluation:

Prepare this sheet in the LPS letter and cut and paste details into BCP

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Department / Service | Location | Normal volumes in or through Department per 24 hours | Likely volumes for 24/7 for which LPS requests likely to be made | Shift | Other staff available who are appropriately trained | Non Union/non striking Staffing Available | Life Preserving Services Requested  (Should be listed as on duty, or on call on site or on call off site) |
| Emergency Department | Middlemore Hospital | 165 | 2 | Am | 4 | 1 SHO am 1 Registrar nocte | AM – 1 on call |
| ICU | Middlemore Hospital | 14 | 40 | Am Pm Nocte | 0 | 0 | AM – 2 on site PM – 2 on site Nocte – 1 on site |
| Medical Acute assessment Unit | Middlemore Hospital | 58 | 7 | Am Pm Nocte | 0 | 0 | AM – 1 on site PM – 1 on site Nocte – 1 on call |
| Civil Defence or Major emergency | CMDHB | NA | NA | all |  |  | Access to staff required should this situation arise |
| Mental Health | Middlemore Hospital | 46 | Unknown | 24/7 | 1 | 0 | Assumed to be covered by staff on shift – Daily requirements only expected to be covered. |

Note:

* Please note that non union staffing numbers still need to be confirmed

PART TWO

Preparatory strategies to support business continuity

* List of areas for which there are detailed contingency plans
* XXXX DHB coordination steering group 14 day plan
* Detailed service level planning
* Timelines
* Operational DHB wide countdown plan

# Section 7 Preparatory Strategies: Core Operation Issues

| Action Ref | Topic | Action | Owner | Target Date | Remarks and References |
| --- | --- | --- | --- | --- | --- |
| Core Operation Issues | | | | | |
| 1 | Service Prioritisation | Formally categorise the criticality of services, based on the recovery priority and ‘tolerable down time’ for each service. | Group Managers |  | To be done by the Contingency Planning team |
| 2 | Liaisons With ‘Like’ Organisations | Formalise mutual aid in units where solutions to service disruption are likely to involve mutual aid associations. | CEO |  | A memorandum of understanding is required with each organisation expected to provide aid in a crisis. |
| 3 | Supply of Materials | Review and formalise contingencies for the availability of stock, consumables and products likely to be required during industrial action taking into account any closures or service relocations. | Group Manager   * Commercial Support |  | Group Managers to be responsible for on-going maintenance and informing Group Manager, Commercial Support of changes to inventory. |

# Section 7 Preparatory Strategies: Management Issues

| Action Ref. | Topic | Action | Owner | Target Date | Remarks and References |
| --- | --- | --- | --- | --- | --- |
| Management Issues | | | | | |
| 4 | Priority Notifications And Press Releases | Develop a Local Communications Plan with which to manage communications (internal and external) to the best DHB advantage. | Contingency Planner with Manager communications |  | This is to include pre-arranged communications to stakeholders, patients and media as well as a list of contacts |
| 5 | Emergency Response Manual | Review the Emergency Response Manual to align it with the Business Continuity (this) Plan. | General Manager   * Corporate Services |  | Manager, Emergency Management |
| 6 | Business Continuity (this) Plan | Incorporate and augment details from the Emergency Response Manual to align the plans. | General Manager   * Corporate Services |  | Risk Management. |
| 7 | Human Resources plan | Develop material for the Human Resources support to this plan | Group Manager   * HR |  |  |

# Section 7 Preparatory Strategies: Staff Issues

| Action Ref. | Topic | Action | Owner | Target Date | Remarks and References |
| --- | --- | --- | --- | --- | --- |
| Staff Issues | | | | | |
| 8 | Skill Sets - Vulnerable | Develop and formalise succession plans throughout DHB to reduce dependence on key staff. | Group Manager   * HR |  |  |
| 9 | Extra Skills | Develop formal personnel records which catalogue skills that may be useful during a crisis, but extend beyond those required during ‘business as usual’. | Group Manager   * HR |  |  |
| 10 | Expectations of personnel during crisis | Review and update DHB expectations of personnel loyalty and activities during crisis situations. Communicate these expectations with personnel if they are not already published. | General Manager   * Corporate Services |  | Reviewed within Emergency Response Manual. |

# Section 7 Detailed plans

### Service specific plans for each area:

|  |  |
| --- | --- |
| 1. Central Coordination Unit 2. Acute Assessment Unit 3. Emergency Department (ED) 4. Intensive Care Unit (ICU) 5. Renal Dialysis 6. Surgical /Surgical Service (including CCU) 7. Perioperative | 1. Health Village (Out-patients) 2. Paediatric Ward and Paediatric Assessment Unit (PAU) 3. Special Care Baby Unit (SCBU) 4. Maternity Service 5. Assessment, Treatment and Rehabilitation Unit (ATandR) 6. Mental Health inpatient Unit 7. District Nursing Service |

### Key points to note:

* The overall goal, key objectives, general principles, general strategies, risk factors and risk mitigation strategies outlined in the high-level hospital plan are not repeated in each service/department plan.
* Issues/actions coordinated in high-level hospital plan have been excluded from service/department plans to enable service leaders to concentrate on their specific services.
* Any area specific additional items are included for relevant service/department.

### The minimum steps in managing patient care prior to and during the period of industrial action will be:

* Reduce demand as much as possible
* Reduce elective services from xxxxxxx to xxxxxxxxxxxxx
* Ensure full use of private providers for service and back up if indicated
* Transferring patients to the DHB of domicile as much as possible (to facilitate discharge).
* Ensure full use of capacity in other DHBs where practicable
* Ensure the use of all appropriately trained non Union staff

### Staffing abbreviations used in this plan:

SMO= Senior Medical Officer (includes MOSS) RMO =Resident Medical Officer

RN = Registered Nurse CA = Care Associate

MRT= Medical Radiation Technologist HA = Hospital Aide

FACEM =Fellow of Australasian College of Emergency Medicine

### **xxxDHB Coordination Steering Group 14 Day Plan**

| Action | Timeline | Comments | Completed |
| --- | --- | --- | --- |
| Establish xxxDHB / Steering Group | Day 14 |  |  |
| Representatives identified for the National Group/LPS discussions | Day 14 |  |  |
| Establish Staff availability – Complete Impact Analysis if indicated | Day 14 |  |  |
| Establish LPS cover requirements for xxxDHB (consider prior to notification).   * Send LPS letter to Union within 24 hour Hours of receipt of Industrial Action. * Organise time to agree requirements (within three working days ) | Day 14 |  |  |
| Regional Communication Plan (key messages) set up | Day 14 |  |  |
| Assess potential service and associated risk, according to level of Strike Action, and establish level of service that can continue | Day 14 |  |  |
| Establish communication process with M.O.H.  Concerns that LPS cover requested is insufficient or not appropriate. To be addressed DHB by DHB | Day 14 |  |  |
| Establish Planning Team and Clinical Service Planning Teams. | Day 14 |  |  |
| Meet with relevant managers and issue organisation instructions including approach regarding service reductions.   * Email central approach re cancelling electives and clinics to relevant administrative department | Day 14  Day 12 |  |  |
| Notify external services of situation and include in planning process as appropriate   * Ambulance * Primary Care Providers * Private Hospitals and Rest homes (Request bed numbers and confirm ability to transfer patients) * Access Holders | Day 14 |  |  |
| Establish Internal Communication Plan   * General information with daily updates * Intranet site set up * Key Clinicians | Day 14 |  |  |
| * Set up separate cost centre to capture costs of Strike | Day 14 |  |  |
| * Contact Funder and agree strategy re revenue loss / protection * Ascertain how private providers invoice for private services if appropriate | Day 14­–10 |  |  |
| * Confirm legal requirements for service provision | Day 14 |  |  |
| * Regional approach to service delivery to be established. | Day 13 |  |  |
| Notify all DHBs, GPS and private providers who may be affected by service curtailments and inform them of alternate arrangements – | Day 12 |  |  |
| Establish Communication process with other DHBs, GPs and other affected providers (letters/ networking) | Day 12 |  |  |
| Set up support required by staff working additional or longer hours | Day 10 |  |  |
| Set up spread sheet for strike re patients not receiving assessments/ procedures and outcomes | Day 5 |  |  |
| Confirm all elective and clinic patients have been notified | Day 3 |  |  |
| Documentation template for impact analysis sent to impacted services with the instructions | Day 3 |  |  |
| Finalise education pack for staff and circulate | Day 3 |  |  |

### **DETAILED PLAN – Perioperative Unit**

Responsible Service Leader

| Issue | Action | Comment / Response | Person responsible | By When |
| --- | --- | --- | --- | --- |
| Support Staff | * Confirm availability of staff for routine and additional work. | No additional support staff required. |  | N/A |
| * Additional staff required for strike period – numbers, types, times | As above |  | N/A |
| * List requirements for training of staff outside the service | Orientation to outlying areas. |  | -14 to -12 |
| * Roster agreed for available staff | Notification as per MECA requires a month’s notice. Would look to relocate staff to other units but retain agreed duties |  | -12 |
| * Detail leave being taken at strike time | Staff not required ability to take leave if requested. Would need to ensure that staff were not required in any other areas before leave would be approved. -day to day |  | -5 |
| Volunteers | * Requirement for volunteers | N/A |  | N/A |
| Training | * Training Requirements for staff | N/A |  | N/A |
| Cancellations / Postponements | * List services to be cancelled | Complete impact analysis  See below, surgery would be postponed and rescheduled |  | -14 to -4 |
| * List services to be postponed | All elective surgery, all pre admission clinics? anaesthetic clinics (as these are run by SMOs) |  | -14 to -4 |
| * Last date for outpatient services | Very low risk Day Surgery may be undertaken up to the day prior to strike only. |  | -1 |
| * Last date for elective services | Inpatient majors 5-7 days prior Inpatient minors 2 days prior DSU 1 day prior |  | -7 to -2 |
| * Last date for transfers in from other hospitals | *We will liaise with other hospitals, work with them to prepare contingency plans to redirect transfers to other hospitals – but not applicable to peri-op unit.* |  | N/A |
| * Detail process for notification of patients of cancelled / postponed events | Usual EBC notification process. A week prior to strike date. |  | -7 to -4 |
| Transfer out of patients | * Date of transfer for patients to other HHSs | N/A |  | N/A |
| * Preferred site by specialty for outward patient transfer |  |  | N/A |
| * Preferred mode of transport |  |  | N/A |
| * Management of any on-going retrieval services |  |  | N/A |
| Community / Day Support | * Identify need for increased community / day support to enable management of patients outside the hospital | DSU nurses may be utilised to support DNs for surgical pts if deemed appropriate. |  | -12 |
| Management Support | * Confirm management support and availability over strike period | Peri-op services Manager CCNs Theatre clinical Coordinator Charge AT |  | -7 |
| Earlier Discharge | * Confirm plans for earlier patient discharge over the period | N/A |  | N/A |
| Communication Process | * Detail communication process throughout the service | Usual communication avenues in Peri-op. Central whiteboard, comm./book, staff noticeboard + organisation staff briefings – refer to communication plan |  | Daily from –14 till strike end |
| Resource Utilisation  Priorities | * Document priorities for resource utilisation | Must be able to provide staff for 2 acute theatres for a 16hr period and 1 acute theatre for 8hrs overnight.  **Am  RNs** 9 FTE AT 3 FTE (peri-op and ICU)  **Pm RNs** 4 FTE + 4 o/call AT 2 FTE + 1 o/call (peri-op and ICU)  **Night RNs** 2 + 2 o/call AT 1 o/call for OT + 1 o/call for ICU  **DSU RNs and CAs** can be utilised on surgical wards or assist DN’s (if deemed appropriate)  **PACU RNs** can be utilised in HDU/AAU and ICU.  **OT RNs** can assist with procedures in ED/ICU or assist on wards  **Anaesthetic Technicians** can assist in ED/ICU/ Radiology with supervision and provide transport/ transfer assistance |  | -10 |
| Risk Management | * Document risks and action for minimising | Acute surgery must be covered. Depending on the length of the strike, urgent surgery may become an issue where a third theatre may need to be provided for these cases.  May need to increase pre admission clinics where can be accommodated prior to strike period to prepare pts for surgery post strike. |  | On-going till strike end |

### **DETAILED PLAN – Therapies and Rehabilitation**

Responsible Service Leader

| Issue | Action | Comment / Response | Person responsible | By When |
| --- | --- | --- | --- | --- |
| Support Staff | * Confirm availability of staff for routine and additional work. | RNs could be released to back fill RNs from the tower block going to ED/AAU |  | -12 |
| * Additional staff required for strike period – numbers, types, times | More CAs to do basic nursing care if RNs utilised as above |  | -12 |
| * List requirements for training of staff outside the service | RNs would need cannulation and blood taking refresher/certification. Consider standing orders to requisition x-rays. |  | -12 to -0 |
| * Roster agreed for available staff | Confirm roster and additional staff to b utilised/and or moved. |  | -10 |
| * Detail leave being taken at strike time | Check rosters and A/L – recall |  | -12 |
| Volunteers | * Requirement for volunteers | Utilise to transport pts e.g. to x-ray etc. |  | -10 |
| Training | * Training Requirements for staff | Cannulation and blood taking |  | -10 to -0 |
| Cancellations / Postponements | * List services to be cancelled | OPD/community list/limb centre |  | -12 |
| * List services to be postponed | Don’t accept patients onto the contracts minimising patients in ATandR which frees up staff to help perform other chores. |  | -14 onwards |
| * Last date for transfers in from other hospitals | Tbc. We will liaise with other hospitals; work with them to prepare contingency plans to redirect transfers to other hospitals. |  | -2 |
| * Detail process for notification of patients of cancelled / postponed events | We will phone and send letters to people on the community waiting list |  | -12 onwards |
| Transfer out of patients | * Date of transfer for patients to other HHSs | When instructed |  | -7 to -0 |
| * Preferred site by specialty for outward patient transfer | Consider use of rest home beds as interim during strike if not able to be accepted on contracts from community and if number of pts transferred from acute wards increases. |  | -10 |
| * Preferred mode of transport | Ambulance |  | -2 |
| * Management of any on-going retrieval services |  |  | -10 |
| Community / Day Support | * Identify need for increased community / day support to enable management of patients outside the hospital | Liaison with rest homes and community support |  | -14 onwards |
| Management Support | * Confirm management support and availability over strike period |  |  | -10 |
| Earlier Discharge | * Confirm plans for earlier patient discharge over the period | Consult with physicians |  | -14 |
| Communication Process | * Detail communication process throughout the service | All services. See organisation communication plan. Make use of notice board and phone communication to staff not on duty PRN |  | -14 until end of strike |
| Resource Utilisation  Priorities | * Document priorities for resource utilisation | RN will back fill in acute areas.  Patients for discharge will be discharged. If awaiting house modifications may need transition in rest homes.  RN to complete admission process usually done by RMOs (RMO action) |  | -10 |
| Risk Management | * Document risks and action for minimising | Early and comprehensive communication with stakeholders   * Families aware of their responsibilities. * Rest homes not being able to take patients as and when required * Staff – ensure they are kept informed * GPs and other providers – ensure regular updates provided. |  | -14 onwards till one week post strike. |

### **DETAILED PLAN – Outpatient Services**

Responsible Service Leader

| Issue | Action | Comment / Response | Person responsible | By When |
| --- | --- | --- | --- | --- |
| Support Staff | * Confirm availability of medical staff for routine and additional work. | Will use dedicated extra admin staff prior to strike to reschedule all the clinics.  Will need staff during strike for urgent clinics.  if we still have urgent fracture clinics and Oncology treatments we would need 1 CA and 3-4 RNs for fracture and 2-3 RNs for Oncology treatments.  if we still have urgent medical tests - resp lab, cardiology tests etc., we would need 2 resp techs, 2 cardiac techs, 2 cardiac RNs.  Staff that therefore would be available for working in other areas would be around 20 part time RNs, 2 ENs, 4 med techs. Of course RNs in O/Ps would be very limited to where they could assist as few have inpt experience. |  | -12 |
| * Arrange for additional staff during the strike period – note number, type and time |  |  |  |
| * List requirements for training of staff outside the service | Nil |  | N/A |
| * Roster agreed for available staff | As per usual roster |  | N/A |
| * Detail leave being taken at strike time | N/a |  | N/A |
| Volunteers | * Requirement for volunteers | Usual volunteer service provide mail delivery for O/Ps. If clinics cancelled they would not be rqd. Could look to redirect them to alternative support role. |  | -7 |
| Training | * Training Requirements for staff | If nurses and techs asked to work in other areas, training will be rqd. |  | -10 |
| Cancellations/  Postponements | * List services to be postponed | All non urgent clinics, tests and treatments |  | -7 |
| * Last date for outpatient services | Day before strike for non urgent |  | -1 |
| * Last date for elective services | As for Outpatient above |  | -1 |
| * Detail process for notification of patients of cancelled / postponed events | About 5 days before scheduled appt to allow for post time. |  | -5 (working days) |
| * Last date for transfers in from other hospitals | Liaise with other hospitals to prepare contingency plans to arrange and manage patient transfers |  |  |
| Community / Day Support | * Identify need for increased community / day support to enable management of any outpatients outside the hospital | O/P may be able to provide more day treatments if rqd to support patients out of hospital |  | -10 onwards |
| Management Support | * Confirm management support and availability over strike period | Service Manager and CCNs |  | -5 |
| Earlier discharge | * Confirm plans for earlier patient discharge over the period |  |  | -10 |
| Communication Process | * Detail communication process throughout the service | See organisation communication plan. Make sure that all staff are kept informed/notified by phone PRN. Ensure early discussions regarding the proposal to relocate staff during strike period. |  | -14 thru till post strike |
| Resource Utilisation Priorities | * Document priorities for resource utilisation | Urgent O/P treatments and tests. |  | -8 |
| Risk Management | * Document risks and action for minimising | Huge administrative workload to postpone and rebook patients. Some may not get the message and turn up. Will need to look at the process for confirmation of receipt of letter.  May need to consider additional security support during the period of industrial action  Some patients may need to be seen via ED/admitted as SMO clinics are not available.  Some staff may not want to work elsewhere – early communication and “buy-in” to the plan |  | -7 onwards |

### **DETAILED PLAN – Maternity Services**

Responsible Service Leader

| Issue | Action | Comment / Response | Person responsible | By When |
| --- | --- | --- | --- | --- |
| Support Staff | * Confirm availability of staff for routine and additional work. | RMOs would have to provide cover where insufficient non-striking SMOs available (yet to be determined) |  | -12 |
| * Additional staff required for strike period – numbers, types, times | X1 Registered Midwife per shift |  | N/A |
| * List requirements for training of staff outside the service | Nil |  | N/A |
| * Roster agreed for available staff |  |  | -10 |
| * Detail leave being taken at strike time | Need to confirm approved leave once strike notice received. No new leave to be approved from date of strike notice. Consider whether some leave needs to be cancelled. |  | -12 |
| Volunteers | * Requirement for volunteers assessed |  |  | -12 |
| Training | * Training Requirements for staff | Nil |  | N/A |
| Cancellations / Postponements | * List services to be cancelled | Routine Antenatal clinics may be rebooked or sent to GPs/midwife for check |  | -7 |
| * List services to be postponed | ?Elective LSCS – depending on timing/length of strike |  | -5 |
| * Last date for outpatient services | As above, antenatal clinics may be rescheduled. |  | -1 |
| * Last date for elective services | Elective LSCS may be deferred or rebooked, depending on SMO availability |  | -1 and during strike |
| * Last date for transfers in from other hospitals * We will liaise with other hospitals; work with them to prepare contingency plans to redirect transfers to other hospitals. | May have to accept patients during strike depending on circumstances. |  | -1 |
| * Detail process for notification of patients of postponed events | Letters and phone calls |  | -5 |
| Transfer out of patients | * Date of transfer for patients to other DHBs | Will depend on situation and patient/baby |  | -1 |
| * Preferred site by specialty for outward patient transfer | Dependent on patient condition/domicile/baby condition. Look at threshold for transferring patients post delivery |  | -2 and during strike |
| * Preferred mode of transport | Air ambulance or road ambulance depending on reason for transfer |  | N/A |
| * Management of any on-going retrieval services | Midwives are the main resource for transfers, so shouldn’t be an issue. See HCS transport/retrieval plan |  | N/A |
| Management Support | * Confirm management support and availability over strike period | Usual mgmt. staff will be available. |  | -7 |
| Community/Day support | * Identify need for increased community/day support to enable management of patients outside the hospital |  |  |  |
| Earlier Discharge | * Confirm plans for earlier patient discharge over the period | May transfer to rurals earlier, but no early discharges likely |  | -1 |
| Communication Process | * Detail communication process throughout the service | See organisation communication plan. Make sure that all staff are kept informed/notified by phone PRN. |  | -14 till end of strike |
| Resource Utilisation Priorities | * Document priorities for resource utilisation |  |  |  |
| Risk Mgt. | * Document risks and action for minimising |  |  |  |

### **DETAILED PLAN – Adult Inpatient Services**

Responsible Service Leader

| Issue | Action | Comment / Response | Person responsible | By When |
| --- | --- | --- | --- | --- |
| Support Staff | * Confirm availability of staff for routine and additional work. | Rosters are completed 4 weeks minimum in advance and this work is on-going. Some gaps on rosters due to vacancies. |  | -14 and thru strike period |
| * Additional staff required for strike period – numbers, types, times | High level meeting to determine best use of additional resources will be held to identify how best to utilise resources in terms of supporting senior medical staff |  | -12 and on-going |
| * List requirements for training of staff outside the service | Will be further determined once plans are able to be firmed up but could include   * Scribing techniques for health records to maintain legal requirements * Discharge summaries * Location of equipment and items * Process issues * Technology support and access |  | -10 |
| * Roster agreed for available staff | In principle areas where there may/will be reduction in service provision, i.e. OPD and/or OT, staff will be redeployed to areas where support of assistance.  Meeting to coordinate planning arranged |  | -10 |
| * Detail leave being taken at strike time | Roster planning  All areas will have at least 2 RN’s and 1 CA on annual leave which is booked and agreed in advance. May need to look at cancellation of leave. |  | -10 |
| Acute Patient Pathway | * Detail process steps for period of Industrial Action | Ensure confirmed with all staff likely to be at work  Address post acute phase of care as well as roles and responsibilities |  |  |
| Volunteers | * Requirement for volunteers | May make use of additional volunteers to support staff/visitors |  | -5 |
| Training | * Training Requirements for staff | As above |  | -10 |
| Cancellations / Postponements | * List services to be cancelled | Minimum |  | -5 |
| * List services to be postponed | All elective procedures where possible, OPD and surgical, but inpatient services includes   * Exercise Tolerance testing ( is nurse-led, but may require back-up at short notice) * TOE’s * Elective cardioversions * CT imagery * Perfusion Scans |  | -2 |
| * Last date for outpatient services | To be determined, probably –day2 depending on procedure. |  | -2 |
| * Last date for elective services | To be determined but decision will be withheld until critical point and all services will only be deferred one day in advance to reduce contract risks |  | -7 to –1 |
| * Last date for transfers in from other hospitals   *We will liaise with other hospitals; work with them to prepare contingency plans to redirect transfers to other hospitals.* | 1-2days prior , but individual cases dependant, some returning from tertiary require minimal intervention and can be discharged following day |  | -1 |
| * Detail process for notification of patients of cancelled / postponed events | Patients are not booked in advance of 2 weeks generally, therefore bookings would not be made and patients would be verbally warned if this a concern |  | -5 |
| Transfer out of patients | * Date of transfer for patients to other DHBs | Individual clinical needs must be paramount. |  | -1 |
| * Preferred site by specialty for outward patient transfer | Depends on patient condition |  | N/A |
| * Preferred mode of transport | Air or road ambulance depending on patient condition |  | N/A |
| * Management of any on-going retrieval services | Via the transport/retrieval team |  | -0 thru strike |
| Community / Day Support | * Identify need for increased community / day support to enable management of patients outside the hospital | GP’s support  District Nursing |  | -10 |
| Management Support | * Confirm management support and availability over strike period |  |  | -7 |
| Earlier Discharge | * Confirm plans for earlier patient discharge over the period | Arrange meeting to clarify global process acute patient pathway  Liaison person between rest homes  Proactively managing discharges ( as usual, however aggressive emphasis must be ensured) |  | -7 onwards |
| Communication Process | * Detail communication process throughout the service | Cascade tree  Verbal 1-1 discussion groups, regular E-mail, Telephones, Pagers, Centralised communication plan with regular(daily) releases,  See also organisation communication plan. Make sure that all staff are kept informed/notified by phone |  | Once plans are consolidated and definitely commencing day -14 |
| Resource Utilisation  Priorities | * Document priorities for resource utilisation | Clinical Care, to ensure patients move thru the system   * Case review, * Assessment, * Diagnosis * Plan * Treatment, |  | -7 onwards till end of strike |
| Risk Management | * Document risks and action for minimising | Clinical errors, mistakes/ overlook symptoms results,   * Medical and Nursing Staff have regular breaks, rostered work patterns, * Increase nursing staff to review results for abnormalities, * Response teams to form first triage point of call, reduce workload on SMOs * Legal /complaint issues due to poor inadequate documentation * Migration, training and education * Over-run acute admissions< * -ensure GP’s are informed and aware of situation, -communicate to public to attend emergency services elsewhere i.e. medical centres, |  | N/A |

### **DETAILED PLAN – Community Services (affects only home health team)**

Responsible Service Leader

| Issue | Action | Comment / Response | Person responsible | By When |
| --- | --- | --- | --- | --- |
| Support Staff | * Confirm availability of staff for routine and additional work. | HH Allied health team currently understaffed and will be needed for short-term home loan equipment to get people out of hospital.  Some DN’s on flexi contracts and can flex up to take extra work |  |  |
| * Additional staff required for strike period – numbers, types, times | * It will depend on current workload at time of the strike but can increase CVNS to 2 per day. Otherwise staff could do 12 hour shifts instead of current 10 * DNs can change work patterns but may need additional RN’s * Will institute “walking wounded clinics” if necessary and ask patients to attend. |  |  |
| * List requirements for training of staff outside the service | Must be able to cope in a community setting. Able to manage complex dressings and Home IV’s. Minimum of level 3 NPS. |  |  |
| * Roster agreed for available staff | Currently being reviewed. Two rosters being developed. One strike and one non strike |  |  |
| * Detail leave being taken at strike time | Will defer if required. |  |  |
| Volunteers | * Assess requirements | Arrange as required |  | -10 |
| Training | * Training Requirements for staff | Will depend on staff allocated from other areas |  |  |
| Postponements | * List services to be postponed | N/A |  |  |
| * Last date for elective and outpatient services | N/A |  |  |
| * Last date for transfers in from other hospitals * *We will liaise with other hospitals; work with them to prepare contingency plans to redirect transfers to other hospitals.* | Regular transfers of patients returning home from Oncology Unit requiring service. Likely to increase in number |  |  |
| * Detail process for notification of patients of cancelled / postponed events |  |  |  |
| Transfers out of patients | * Date of transfer for patients to other HHS’s |  |  |  |
| * Preferred site by specialty for outward patient transfer |  |  |  |
| * Preferred mode of transport |  |  |  |
| * Management of any on-going retrievals |  |  |  |
| Community / Day Support | * Identify need for increased community / day support to enable management of patients outside the hospital | Wound clinics as above  Possible IV clinics for day doses.  ***High case loads will continue after the strike until patients are ready for discharge***  ***HH will require priority on cars if extra staff on the road*** |  |  |
| Management Support | * Confirm management support and availability over strike period | Available |  |  |
| Earlier Discharge | * Confirm plans for earlier patient discharge over the period | N/A |  |  |
| Communication Process | * Detail communication process throughout the service |  |  |  |
| Resource Utilisation  Priorities | * Document priorities for resource utilisation | Palliative care  Home IV  Wound management |  | -10 0nwards |
| *Risk Management* | * Document risks and action for minimising | Preparation of staff – burnout  Adequate supplies on hand for increased workload |  |  |

### **DETAILED PLAN – Flight team – Interhospital transfers**

Responsible Service Leader

### Flight Team

The flight team is managed by a Clinical Charge Nurse, who reports to the Acute Service Manager. There are xxx FTE flight nurses who are rostered and on-call. (See sample roster). 95% of all transports require a nurse escort only. Flight nurses are trained 8-10 flights/month require a medical escort. PICU – are used currently to retrieve/transport babies. This will continue.

### Contingency Plan

* Medical escort is currently provided by the XXX SMO. If no SMOs are available for this work during industrial action, the Clinical Director will make the decision regarding medical escort, to ensure the clinical safety of all patients and the safety of staff using the following steps:

1. Appropriate on-call RMO will be utilised
2. An appropriate on-call RMO will be called back
3. Life flight will be contacted
4. The receiving DHB will be requested to assist

### **DETAILED PLAN – Acute Assessment Unit**

Responsible Service Leader

The presence in AAU of XXXXX (Physician) along with liaison with ED FACEMs will provide senior level acute patient management in both areas. In the absence of a House Surgeon or Registrar, an AAU senior nurse would be available to assist in ward rounding, completion of blood and radiology forms and ordering/liaison with departments for investigations. Documentation and signing off of orders would be the responsibility of the Senior Doctor.

Nursing requirements: 1 extra RN would be required on each shift, including night shift to manage the more acute patients in the absence of Registrar or House surgeon on night shift.

1 or 2 rooms in AAU could be dedicated during the normal working day to cater for community follow ups, particularly reviews of home IV. Set hours could be negotiated for this.

# Section 8 14 Day DHB Integrated Planning Timelines

### High Level Contingency Action Plan Countdown (Day 14 to Day 1)

### Key Issues

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Action Item** | **14** | **-13** | **12** | **-11** | **10** | **-9** | **-8** | **-7** | **-6** | **-5** | **-4** | **-3** | **-2** | **-1** |
| 1. Set up acute patient pathway |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. Complete Impact Analysis |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. Letter to all elective patients |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. Letters to all LMCs Carers and Access Holders |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. Letter to all GP’s |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. Letters to clients with Outpatients appointments |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. Stocktake supplies (re-order as necessary) or cancel regular orders to elective areas. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. Set up Emergency Team |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. Begin consultation with RMOs and confirm availability/rosters/cover |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Action Item** | | **14** | | **-13** | | **12** | **-11** | **10** | **-9** | **-8** | **-7** | **-6** | **-5** | **-4** | **-3** | **-2** | **-1** |
| 1. Retain updated list of patients transferred out |  | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |
| 1. Liaise with NCP |  | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |
| 1. Manage admissions and possibility of Transfers |  | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |
| 1. Discharge of clinically well patients |  | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |
| 1. Relocate In-patients |  | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |
| 1. Place message on answer phone |  | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |
| 1. Close Suite/Hospitals at 1700 hours |  | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |
| 1. Cancel elective surgery, clinics procedures |  | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |

# Section 9 Detailed Countdown Plan

Key: **🗸** + completed

**U** = underway

### Other issues will be included and addressed as identified

| Day | Actions Planned | **🗸** or  ”**U**” | Person/Group Responsible |
| --- | --- | --- | --- |
|  | Develop detailed clinical criteria for “acute/life preserving” services | **🗸** | Regional Coordination Group/CDs |
| **Strike notice appears inevitable** | Services to review own plans and service priorities and adjust contingency plans PRN | **🗸** | GMs/UMs/ CDs |
|  | Develop Communication Plan using national/regional templates | **🗸** | Comms Manager |
| **Strike notice served -14** | Urgent Contingency Planning Group Meeting called to clarify scope of industrial action and prepare briefs. |  |  |
|  | CEO to brief ELT |  | CEO |
|  | COO to brief Clinical Directors, Group Managers, and HCS mgmt. team |  | COO |
|  | Cease accepting patients onto TandR contracts. Consider use of Rest Home beds during strike period. |  | UM ATandR |
|  | Call urgent meeting with SMOs |  | COO |
|  | Work with SMOs to determine availability and complete Impact template |  |  |
|  | Review ATandR patients; aim to discharge prior to strike where possible. Those waiting for house modifications could be temporarily transferred to Rest Homes |  | UM/SMOs |
|  | Group Managers to brief Unit Managers |  |  |
|  | Implement communication plan |  | Comms Manager |
|  | Inform PHOs, GPs and other private providers |  | Comms Manager (C Lord) |
|  | Second administration staff to assist Coordinator and planning team. |  |  |
|  | Each service to implement specific countdown plans and review and revise PRN |  | GP Managers/ Unit Managers |
|  | Each Service to nominate a person to lead and coordinate the action plans. |  |  |
|  | Nominate Coordinator for patient retrieval/transfer.  Identify patients who will need to be returned to domicile DHB |  | Contingency group |
|  | Identify patients whose surgery/procedures/clinic appt will need to be deferred |  |  |
|  | Liaise with National Coordination regarding assistance required from other DHBs/MoH. |  |  |
|  | Liaise with other DHBs regarding return of patients to HBDHB |  |  |
|  | Request additional administration/clerical staff to begin rescheduling process for outpatients clinics |  | Unit Manager/CCNs (Villa)/Administration Manager |
|  | Schedule daily meetings for strike planning group, to the day after the end of the strike |  |  |
|  | Each service to start confirms assistance required/resource requirements during the strike. |  | GP Managers |
|  | Daily report to NCP |  |  |
|  | COO to issue directive regarding multiple rounding commencing on day -5 |  |  |
|  | Prepare memo to SMOs advising that contingency planning is being implemented including deferment of all elective surgery and most Out-patients clinics |  | COO/Planning Coordinator |
|  | Review leave and determine if any to be cancelled |  | COO/HR Manager |
|  | Increase Midwife/RN cover on all shifts X1 |  | UM |
|  | Look at increasing the number of wound clinics and possibly IV clinics for day doses (District Nursing service) |  | UM/ADON |
|  | Increase D/Ns roster by flexing up part-time staff. Review appropriateness of deploying senior/experienced RNs from non-critical areas. Look at feasibility of running “walking wounded” District Nursing clinics which could be staffed by deployed staff. Confirm ability to provide taxi-chits/transport to transport patients to clinics |  | UM/ADON |
| **-13** | Confirm LPS cover provisions/definitions with ASMS |  | National Coordinator |
|  | Develop “standing orders” for nurses to request chest x-rays, bloods. |  | Clinical Directors |
|  | Communicate details of agreed “exemption” once granted |  | Planning Coordinator ) |
| **-12** | Finalise numbers of non-striking RMOs. CDs and HODs to review and revise draft rosters accordingly. |  | CDs |
|  | Liaise with Cranford regarding assessment at AAU where patient could be directly accepted to Cranford care team. Consider patients appropriate to transfer to Cranford during strike. |  | Clinical Directors |
|  | Consider what treatments could be provided via Outpatients to prevent hospitalisation |  | UM/CDs |
|  | Confirm theatre roster to provide cover for 2 acute theatres (16 hours) and 1 acute (8 hours overnight). |  | Peri-op Manager |
|  | Finalise plans to redeploy nursing staff (Theatre, Villas) |  | ADON/Ums |
|  | Review need to redeploy nurses from ATR and back-fill with Care Associates |  | ADON/Ums |
|  | Confirm any orientation/up skilling requirements of redeployed nursing staff |  | ADON/Ums |
|  | Develop acute response team/s |  |  |
|  | Finalise acute pathway |  |  |
|  | Review all planned surgery identified that need to be rescheduled to from strike days. N.B: Last date for major surgery (5-7 days prior), minor surgery - (2 days prior)  DSU – (1 day prior) |  | Perioperative UM |
|  | Review all clinic appointments during time of strike and confirm those which must be deferred |  | UM and SMOs |
|  | Training - Review planned training and cancel as necessary |  | ADON/ HR Manager |
|  | Bed Management Coordination - Finalise overall plan for Hospital including which beds to be closed |  | ADON/ |
|  | Administration staff - Briefing and Coordination |  | Administration Manager |
|  | Staff Support – Plan developed to include “walk around/ personal support” |  | OCC Health Nurses/COO/HR Consultants |
| **-11** | Daily report for National Coordination |  | Contingency Coordinator |
|  | Finalise training plans for SMOs (ACLS, IV access etc.) |  | Emergency Response Coordinator |
|  | Identify numbers/types of staff resources available |  | Unit Managers |
|  | Draft revised theatre lists scheduled for strike period and prepare postponement letters in readiness |  | Peri-operative Unit Manager ( |
|  | Contingency Team meeting |  |  |
|  | Prepare Staff briefing informing organisation of strike notice and contingency plan status. |  |  |
|  | Develop script/info pack for 0800 help line staff (prior to sending letters) |  |  |
|  | Local media releases |  |  |
| **-10** | Staffing/resource requirements finalised by each Service |  |  |
|  | Daily report for National Coordination |  |  |
|  | Consider redeployment of Senior nurses with current APCs to clinical support roles |  | ADON |
| **-9** | Daily report for National Coordination |  |  |
| **-8** | Daily report for National Coordination |  |  |
| **-7** | Confirm elective cases to be deferred on day/s of strike |  | CD/Ums |
|  | Commence sending deferment letters to patients (timing TBC) |  |  |
|  | Confirm outpatients to be deferred from day/s of strike |  |  |
|  | Daily report for Regional Coordination. |  |  |
|  | Staffing/resource requirements finalised by each Service. |  | Unit/Service Managers |
|  | Confirm 0800 help line is active (when deferrals are posted). |  |  |
| **-6** | Contingency team meeting |  |  |
|  | Daily ward rounds focus on discharge planning and identifying patients that can be discharged. |  | CDs/UMs/CCNs |
|  | Staff Support – detailed plans to be developed. |  | OCC Health/Staff Counsellor |
|  | Daily report for Regional Coordination. |  |  |
|  | Notify orderlies, kitchen, laundry, mailroom, operators, security re strike planning requirements/changes to services |  |  |
|  | Contingency operation centre set up |  |  |
|  | Briefing for medical staff including GPs at “Grand Round” |  |  |
|  | Radio and newspaper “spots” tentatively booked |  |  |
|  | Primary care services updated |  |  |
| **-5** | Ensure discharge planning is maximised and identify patients who could be discharged prior to day of strike |  | CCNs/Medical staff |
|  | Contingency team meeting |  |  |
|  | Notify Volunteer Coordinator that assistance with mail for Villas not required during strike period |  | UM |
|  | Send letters or phone patients deferring procedure clinics requiring radiological support for |  |  |
|  | Agree emergency teams on-call |  |  |
|  | Ensure Complaints/Compliment Management System is in place and ready |  | Customer Services Manager |
|  | Daily report for National Coordination |  |  |
|  | Ensure Police informed and security/picket line plan commenced. |  |  |
|  | Agreement re picket line protocols to be signed by all parties |  |  |
|  | Arrange to use intra net – “What’s on today” to update staff daily |  |  |
|  | Develop patient information leaflets and public notices |  |  |
| **-4** | Send deferment letters to outpatients, reschedule and notify |  | Outpatients UM |
|  | Finalise medical//nursing rosters |  | CDs/GMs |
|  | Review current inpatient numbers. |  | CCNs/Ums |
|  | Confirm intended security and staff transport measures |  | Security Manager |
|  | Arrange ID access for management team, as required |  | Security Manager |
|  | Daily report for National Coordination |  |  |
|  | Review planned training/study days and cancel/defer as appropriate |  | COO/Service Managers |
|  | Finalise/confirm bed management plan for hospital, including ward closures |  | Bed Manager |
|  | Update key stakeholders: TLAs, MPs, CEO group, Board |  |  |
|  | Daily updates: staff, primary care, media – to continue until strike action is over … |  |  |
| **-3** | Parking to be confirmed for staff working through strike |  | Security Manager |
|  | Staff counsellors to be briefed |  | HR |
|  | Arrange additional clerical staff to areas transferring patients |  | Admin Manager |
|  | Advise patients of transfer if appropriate./required |  | CCNs/SMOs |
|  | Ward round to discharge as many patients as possible |  | SMOs/CCNs |
|  | Confirm staff rosters and locations |  | Unit Managers |
|  | Finalise central contacts list of all key personnel |  |  |
|  | Fax/Media releases sent |  |  |
|  | Additional Transport Nurse to be rostered to work w/e to assist with transporting pts |  | CCN Flight Team |
|  | Provide instructions for interacting with striking staff |  |  |
|  | Daily report for National Coordination |  |  |
|  | Full media briefing |  |  |
| **-1** | Contingency team meeting |  |  |
|  | Finalise strike management team and management plan |  |  |
|  | Daily report for National Coordination |  |  |
|  | Discharge/place patients on leave as necessary |  | CCNs |
|  | Daily report for National Coordination |  |  |
|  | Ward and Community Health staff commence transfer of patients into the community (as appropriate) |  | CCNs |
|  | Close down clinics, ensure al notifications completed, and media, and hotline notified that this is last day of clinics |  |  |

# 

# Section 9 Industrial action commences

|  |  |  |
| --- | --- | --- |
| Day and Date: Day of Industrial Action | | |
| Action: | By Whom: | Time Frame: |
| Activate Control Centre and appropriate plans |  |  |
| Staff Allocation: |  |  |
| Emergency Teams: During strike |  |  |
| Look after those working: Food; Rest; Security; Communication |  |  |
| Security: Site security maintenance; Staff access maintenance |  |  |
| No Phlebotomy rounds or Micro Collect rounds |  |  |

|  |  |  |
| --- | --- | --- |
| Day and Date: Day 1 | | |
| Action: | By Whom: | Time Frame: |
| Control Centre commences management of contingency plan | All | Today |
| Ward Rounds increased – extra and earlier discharges sought | CD/SMO | On-going |
| Review Stock, Phone lists, IT, Passwords, Location of Manuals, Staff support | All | Today |
| Hold briefing sessions for Contingency management team |  |  |
| Hold briefing sessions for Clinicians and front line managers |  |  |
| Commence daily information bulletin |  |  |
| Reporting to NCP and national teleconferences |  |  |
|  |  |  |
| Day 2 |  |  |
|  |  |  |
|  |  |  |
| Day 3 |  |  |
|  |  |  |
|  |  |  |

PART 3

Appendices

# Appendix I Normal Rosters for Staff Group

# Appendix II Staff Rostered Throughout the Strike

# Appendix III Local Communications Plan

### **External Communications**

Local external communications encompass the following recipients:

The Public Information which is intended to provide guidance and instructions to the general public and possible patients about local contingency planning

This can be disseminated by:

* Press releases and press conferences - material issued to the media for journalistic and editorial manipulation/intervention and presentation,
* Advertisements and advertorials - material issued for paid publication in exactly the way you want.

Stakeholders Information which is targeted at specific stakeholders or groups of stakeholders (including staff away from the work place) for differing purposes, such as providing them with reassurance of matters under control, and seeking action from them. A variety of communications media may be available, including telephone, fax, mail and e-mail.

### **Internal Communications**

Preparatory Communication.

On-going communications to staff prior to strikes is always important, and staff are to be given information that alleviates matters of anticipated concern to them. These include:

* Management’s expectations about the requirement to report for work
  + How, where, and when to report
  + Employment status, pay arrangements (if perceived to be threatened)
  + Leave status if staff members are not required for a few days.

Response Communication.

Describe the measures to ensure that staff are kept well informed (regularly and frequently) throughout the period of a strikes, on what is going on now, and what is being done to improve matters.

### **Strategy Notes**

This appendix contains:

* Purpose and key positioning statements
* Key actions
* Channels of Communication and communication tree
* Draft letters and media releases

### **Communication plan for strike contingency**

### Purpose: To provide smooth, co-ordinated communications, which support and enable contingency activities in the event of strike action and/or strike notice.

#### Key Positioning Statements

* Contingency communications begin as soon as strike notice is issued.
* All actions are designed for maximum patient safety during the event.
* Contingency actions are being undertaken earlier and more publicly than in the past because any industrial action will affect all hospitals.
* We approach this event in a way that minimises on-going fall-out after the event.
* Hawke’s Bay DHB accepts the right of individuals and organisations to take industrial action and its activities through this period are simply based on ensuring patient safety (we will, therefore, make no statements which are critical of the SMOs action).
* All public statements will be confined to the issues around the contingency.
* Hawke’s Bay DHB is one of twenty one DHBs involved in this negotiation and all other statements on the bargaining position will come from the appointed spokesperson who will speak on behalf of the whole group.
* All internal and external communications must be co-ordinated.
* The DHB owes it to all staff and the community to keep them as informed as possible during this event.
* The DHB will ensure its public announcements are co-ordinated with other DHBs wherever necessary.
* The NCP role is critical to overall contingency activities.

#### Key Actions

* Information pack for Board members and CEO (spokesperson)
* Appoint spokespeople for DHB both internally and externally.
* Establish communications responsibilities within contingency team.
* Ensure fax/email groupings are up to date and accessible for:
  + GPs
  + Private hospitals
  + Rest homes
  + Specialists
  + Maternity lead providers
* Establish draft messages ready for radio and newspaper advertisements and co-ordinate with other Region DHBs.
* Establish how patients who will be affected will be informed, what they’ll be told and by who – draft letters and dot points and ensure required resources are available. [use templates provided]
* Draft letters to:
  + GPs
  + Specialists
  + Lead Maternity Carers
  + Rest homes
  + Private hospitals
  + Maori/pacific providers
  + PHOs
  + After hours medical centres
  + All other DHBs (may need to be co-ordinated with other regional DHBs)
  + TLAs (Mayors)
  + Local MPs
  + Councils
* Content of letters to include:
  + Advise notice of strike and dates
  + Expected impact of industrial action
  + Contingency plan development
  + Service to be provided, closed and reduced
  + Request – only refer patients that clearly demand immediate hospital intervention/treatment
  + Before referring patient, call to discuss with ED/specialist/registrar or consultant or the on-call “physician of the week” for advice give DDI
* Draft memos to internal staff including details regarding:
  + Regular meetings/updates for SMOs
  + Details of Notice
  + Expected Impact
  + What we are doing
  + Updates on plans for communication during countdown, strike and recovery
* Establish hotline for GPs utilising ”physician of the week”
* Ensure switchboard has resources, key messages and point of referral.
* Identify tasks for volunteers

#### Distribution

* **Draft internal letter to all staff** – distribute via internal email
* **Draft external letter to:**
  + GPs - distribute via Public Health Smartfax / email tree + hard copy
  + Mid wives – distribute via email
  + Rest Homes – distribute via email and hard copy
  + Private Hospitals – Parkside and Royston
  + Maori/Pacific Providers – distribute via Maori Health Unit
  + PHOs – Wairoa – distribute via email + new chair for HB
  + Others (Tbc)
* After hours medical centres
  + City Medical (distribute via email)
  + The Doctors (distribute via email)
  + Hastings Health Centre (distribute via email)
* All other DHBs
* **Letters to Patients whose appointment/treatment may/will be postponed:** 
  + Inpatients
  + Outpatients
* **Public/Advertisements**
  + Radio – community notices + advertising
  + Newspapers – editorial + advertising
  + Draft messages ready to go regarding:
    - Potential dates
    - Save emergency department for emergencies – use your GP or other after-hours medical centres
    - Surgery, outpatient clinics affected – we have sent out letters to those who may be affected – if in doubt, call the 0800 number
    - Promote the 0800 number
    - We will be working with reduced staff numbers – if you have someone in hospital, we’d appreciated any non-clinical support you can offer your family member.
* **Other information needed**
  + RMOs/Locum availability
  + GP Contact list
  + Rest homes lists
  + Private hospital lists
  + Midwives
* **Spokesperson**
  + CEO

#### Media

The media often has no interest in corporate conventions and will explore every avenue to get a story. Strikes make good stories, and managers can expect approaches from reporters, with or without having checked though the national or local communication staff. This requires careful planning to ensure messages we want to get to the public are available and other stories are controlled in their release to protect patients, their families and the contingency planning essential for patient and staff safety.

To ensure this is well managed we will:

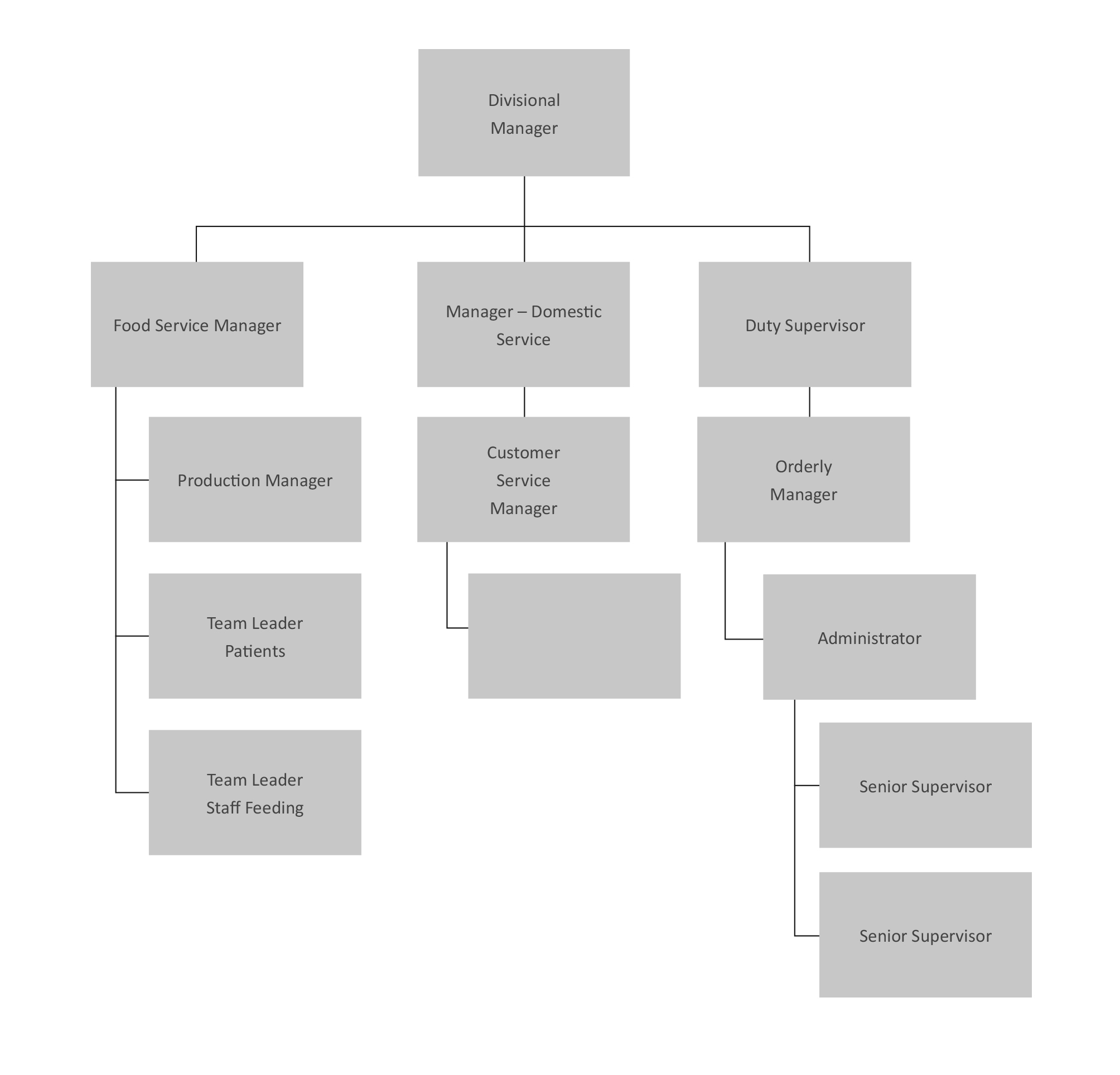
1. Determine who has the authority to speak to the media and the limitations if any on that
2. Agree statements in advance
3. List the names of media to be contacted
4. Prepare drafts of media release and get sign off from the CEO
5. Have pre-prepared advertising material regarding cancelled services or contact numbers
6. Give guidance to those speaking to the media
7. Determine the varied interest of other stakeholders and ensure messages are tailored to give them the information required.

#### Channels of Communication

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Communications Required | Person Responsible | Date Draft Complete | Date to be sent | Date Sent |
| Board Members | CEO |  | Day 14 |  |
| MoH, ACC, Other contract holders | CEO |  | Day 14 |  |
| All xxxx DHB – initial release | COO/Ops Manager |  | Day 14 |  |
| All xxxxxxx DHB On-going information updates | COO/Ops Manager |  | Within 72 hours of first update |  |
| GPs and PHOs | COO/Ops Manager |  | Day 12 |  |
| Rest Homes |  |  |  |  |
| Other DHBs and key referring Laboratories |  |  |  |  |
| Rural Trusts |  |  |  |  |

### **Communication tree**

Complete the communication tree with names and contact details of managers, staff and clients with whom you will be communicating during the emergency.



### **Draft Media Release (In event of strike notice being issued and for immediate release upon receipt of notice)**

xxx District Health Board is preparing to close most of the elective services provided at xxx Hospital in xxxx, and reduce the level of services provided at this facility from (date) to cope with strike action by PSA staff, said xxxxx, Chief Executive xxxxxxxx District Health Board.

Yesterday the PSA union issued national strike notice to Hawke’s Bay DHB and all other DHBs that its members will strike for xx days from yy date in support of their wage claims.

“We will be able to maintain only the very minimum services during the strike and all outpatient clinics will be closed,” xxxxxxxx said. “This action will have a more drastic affect on services we can provide because there can be no support from neighbouring DHBs.” xxxxx said preparations would begin immediately and some services, such as elective surgery, would actually close before the strike date to ensure the number of patients in the hospital when the strike begins is as low as possible. “Our number one consideration will be patient safety,” he said.

### Services which will remain open will be:

* Emergency Department
* Intensive care unit
* Paediatric acute assessment unit
* Coronary Care Unit
* Acute surgery
* High dependency units
* Mental Health Intensive Care Unit
* Renal Dialysis unit
* Special Care Baby unit

### Services which will be closed will be:

* Dental Department
* Outpatient Clinics with the exception of urgent outpatients directed to ED
* Endoscopy Unit
* Elective surgery
* Cardiology
* Rheumatology
* Specialist Rehab and Day surgery
* Day Procedures unit
* 4 of the hospital’s 6 operating theatres

XX Patients will be consolidated into fewer wards and serious Intensive Care patients will be transferred to tertiary hospitals in other regions.

Members of the public wanting information about their position can telephone 0800 XXX XXX.

### **Draft letter to GPs**

Dear

Re: Strike Action

Last night/yesterday/today xxxxxxxx DHB received notice from PSA union that their members will strike in support of their claims from xxxx date. This notice affects all DHBs in New Zealand.

We will be doing our utmost to ensure patient safety leading up to and throughout this period, but, of course, we will need to reduce services significantly. We need to move quickly because we do not have the option of moving patients to nearby hospitals and over the next few days will be implementing our contingency plan.

Services which will remain open will be:

* Emergency Department
* Intensive care unit
* Paediatric acute assessment unit
* Coronary Care Unit
* Acute surgery
* High dependency unit
* Mental health intensive care unit
* Renal Dialysis unit
* Special Care Baby unit

Services which will be closed will be:

* Dental Department
* Outpatient Clinics with the exception of urgent outpatients directed to ED
* Endoscopy Unit
* Elective surgery
* Cardiology
* Rheumatology
* Day Procedures unit
* 4 of the hospital’s 6 operating theatres

Serious Intensive Care patients will be transferred to tertiary hospitals in other regions **(we need to give dates from which each department will be closed or reducing services)**

We request that during these periods you refer only patients that clearly demand immediate hospital intervention or treatment. It would also be helpful if before referring a patient, you call to discuss with an ED doctor, specialist or registrar.

We have set up a hotline to assist you in doing this. The number is xxxxxxxx.

We appreciate your co-operation through this difficult period.

Yours sincerely

### **Draft letter to patient – #1 surgery postponed**

[dd/mm/yyy]

Patient name

Address

Dear Mr/Mrs/Ms/Miss xxxxxxxxxx

**Re: Surgery postponed due to x staff Strike**

xxxxxxxxxxx District Health Board has received notice of strike action by members of the PSA union. This means that x staff will strike for xx days from yy date. This involves staff in all District Health Boards throughout New Zealand.

This will severely impact on our ability to carry out elective surgery, and regrettably, your surgery may have to be postponed/will be postponed

We will be in touch again to let you know if this is the case.

We are hopeful that the staff’s claims may be settled before the planned strike takes place; however, we will need to significantly reduce the number of patients in hospital over the period of industrial action.

Please be assured, if your surgery does have to be postponed, you will be re-booked to the next available session.

I apologise in advance for the inconvenience this will cause.

If the planned strike does go ahead, we will set up a toll-free number to enable you to phone us to check whether your surgery is going ahead. Note: This phone will not be ‘live’ until x (insert date).

Yours sincerely

### **Draft letter to patient – #2 outpatient appointment postponed**

[dd/mm/yyy]

Patient name

Address

Dear Mr/Mrs/Ms/Miss xxxxxxxxxx

**Re: Outpatient appointment postponed due to x staff’s Strike**

xxxxxxxxxxx District Health Board has received notice of strike action by members of the PSA unions. This means that x staff will strike for xx days from yy date. This involves staff in all District Health Boards throughout New Zealand.

This will severely impact on our ability to carry out outpatient appointments, and regrettably, your appointment may have to be postponed/ will have to be postponed. We will be in touch again to let you know if this is the case.

We are hopeful that the staff’s claims may be settled before the planned strike takes place; however, we will need to significantly reduce the level of service provided over the period of industrial action.

Please be assured, if your appointment is postponed, you will be re-booked to the next available session.

I apologise in advance for the inconvenience this will cause.

If the planned strike does go ahead, we will set up a toll-free number to enable you to phone in to check whether your appointment is going ahead. Note: This phone will not be ‘live’ until x (insert date).

Yours sincerely

### **Sample Community Notice – Radio (for 15 sec ads)**

Staff at xxxxx Hospital and all other District Health Boards are striking from x to x (dates)

Services will be severely reduced, and you are asked to ‘save the hospital emergency department for emergencies’

If it’s not an emergency, please contact your GP or after-hours medical centre

If you are scheduled to have surgery or have an appointment at the hospital between x and x (dates) phone 0800 xxx xxx to check whether it’s been postponed.

That’s 0800 xxx xxx

# Appendix IV Staff Education Pack

This should contain all important information including:

* Advice regarding LPS and the escalation process for LPS requests
* Confirmation of the agreement with the Union regarding LPS requests
* Information re role and location of the Strike Control Centre
* Link to Contingency plans
* Relevant phone numbers
* Rosters

# Appendix V Roles and Responsibilities for Strike Control Centre

The primary venue for the Strike Control Centre is the Old Anaesthetic Department Pathology Lecture Theatre (2nd Floor of the Clinical Services Block, above Ambulatory Care).

### Telecommunication Details

The primary telephone number for the Control Centre is 09-3708999, or ext. 27999.

The primary fax number for the Centre is 09-3708998, or ext. 27998.

### xxxDHB Radio Network

xxx DHB maintains an internal radio communications network between all hospitals. Base radio sets are held at:

* Wellington Hospital (Network Controller)
* Horowhenua Hospital
* Timaru Hospital
* Hawkes Bay Hospital

### Roles and Responsibilities

The following Roles and Responsibilities tables outline the actions that need to be taken, and the personnel who need to perform them, in order to manage the strike control centre. It may well be that one or more of the roles are amalgamated into another position. This will be at the discretion of the DHB Strike Coordinator.

|  |  |
| --- | --- |
| Strike Control Centre Role | Table # |
| DHB Strike Coordinator/Control Centre Coordinator | VI.1 |
| Clinical Operations Director | VI.2 |
| Emergency and Risk Manager | VI.3 |
| Safety/Security | VI.4 |
| Communications | VI.5 |
| Human Resources | VI.6 |
| Finance | VI.7 |
| Administrative Support | VI.8 |

### **Table V.1 – DHB Strike Coordinator/Control Centre Coordinator**

Role: To provide overall direction for the coordination of hospital operations and to ensure that all administrative and personnel resources are co-ordinated to meet the Aim of the Business Continuity Plan and the LPS agreement.

|  |  |  |
| --- | --- | --- |
| Responsibility | Action | Priority |
| **Establish effective management** | Convene the Control Centre at a suitably equipped venue. | 1 |
| Become well informed of the national and local situation and its potential consequences. | 1 |
|  | Review the leadership and make-up of Control Centre to suit the circumstances. | 2 |
|  | Review Control Centre members’ responsibilities, and adjust as necessary. | 2 |
|  | Adjust the management structure and leadership at all levels (to ensure adequate experience and capabilities), to suit the circumstances. | 2 |
| **Provide effective communications** | Establish and maintain effective communications and reporting requirements within the Business Continuity structure, and with the Board/CEO as appropriate. | 2 |
|  | Activate internal communications to personnel. Keep staff fully informed and motivated throughout the crisis (visits, staff briefings, newsletters etc.). | 2 |
|  | Liaise with union regarding any LPS queries | 2 |
|  | Activate effective ‘channel(s)’ for external communications (particularly the news media). Appoint Communications officer. Approve press releases and national reports. | 3 |
| **Provide adequate resources** | Authorise a patient prioritisation assessment or the purposes of designating appropriate early discharge if additional bed space is needed | 2 |
| Review/adjust ‘delegations of authority’ to facilitate effective recovery, as appropriate to the circumstances. | 3 |
|  | Regularly review personnel requirements (experience/skills) for the circumstances and facilitate the remedy of any shortfalls. | 3 |
|  | Ensure personnel are deployed to best longer-term effectiveness, supported by adequate welfare to match abnormal demands on them. | 3 |
| **Provide effective leadership** | Plan for the Initial Control Centre Meeting, and as the basis for subsequent meetings. | 1 |
|  | Provide positive leadership to the Control Centre and monitor the effectiveness of its effort, through interchange of information and ideas. | 3 |
|  | Lead and actively participate in national teleconferences and national reporting. | 1 |
|  | Resolve particular difficulties that are unable to be readily solved at lower levels, including critical contractual arrangements with external parties. | 3 |

### **Table V.2 - Clinical Operations Director**

Role: To direct and organise clinical services and to ensure that all administrative and personnel resources are co-ordinated to meet the Aim of the BCP Programme. By default, position-holders will organise services that they are responsible for during business-as-usual, however organisation of services outside this scope may be required dependent on the availability of other members of the contingency planning team.

|  |  |  |
| --- | --- | --- |
| Responsibility | Action | Priority |
| **Provide effective response/recovery management for Clinical Operations** | Activate to the Control Centre venue | 1 |
| Review Clinical Operations response/recovery strategies as appropriate.  Assist in the planning process with other Control Centre members. | 2 |
|  | Review the make-up of each team for relevant skills and experience to match the circumstances (to balance crisis with business-as-usual requirements). | 2 |
| **Provide reliable information** | Establish and maintain communications between Control Centre and the Clinical Directors complete with an appropriate reporting regime. | 1 |
|  | Provide reliable and timely briefings to Control Centre on the impacts of the strike on clinical operations, capabilities and sites, as well as likely implications for customers/community/other parties. | 2 |
|  | Determine the status of activation of plans and the likely timelines for continued work-around and/or service failures. | 3 |
|  | Ensure appropriate Clinical Operations representation on support group team(s) to communicate clinical needs. | 3 |
| **Ensure Response Plan Activation** | Ensure clinical workarounds and other contingencies are activated and adjusted for optimum effectiveness in the circumstances. | 1 |
|  | Support clinical decision making regarding LPS requests, providing advice and collegial support as required |  |
| Identify and quantify abnormal demands placed on clinical operations and sites, and seek interim remedies to these as appropriate. | 2 |
| Provide advice on alterative options for service provision |  |
| **Optimise contingency planning** | Accurately identify and prioritise problems and impacts (internal and external). | 3 |
| Ensure strategies are developed and authorised at appropriate levels. | 3 |
| Develop and maintain timelines for clinical strategies and regularly communicate relevant milestones to all affected parties. | 4 |
|  | Identify and engage resources (e.g. seconded and temporary staff, equipment, and materials) required continuing to strengthen services and operations. | 4 |

### **Table V.3 – Planning Manager**

Role: To direct and organise all aspects of the Planning Section. Ensure the dissemination of critical information and compile and effect long term planning. By default, position-holders will organise services that they are responsible for during business-as-usual, however organisation of services outside this scope may be required dependent on the availability of other contingency planning team members.

To coordinate the provision of risk management services as required.

|  |  |  |
| --- | --- | --- |
| Responsibility | Action | Priority |
| **Provide effective response/recovery management for Business Services** | Activate to the Control Centre venue | 1 |
| Ensure suitable teams including a risk management team are activated, accommodated and equipped to supplement the Planning Section. | 1 |
|  | Review the make-up of each team for relevant skills and experience to match the circumstances (to balance crisis with business-as-usual requirements). | 2 |
|  | Facilitate the Control Centre in long term planning identifying recovery priorities/strategies as appropriate. | 3 |
| **Provide reliable information** | Establish and maintain communications between the Control Centre and each planning team complete with an appropriate reporting regime. | 1 |
|  | Provide reliable and timely sitreps to the Control Centre of impacts of the crisis on respective operations and the resulting implications for dependent groups. | 2 |
|  | Determine the status of activation of contingency plans and the likely timelines for continued work-around and/or service failures. | 1 |
|  | Coordinate reports for national coordination and reporting |  |
|  | Ensure appropriate operational teams’ representation on their respective dependent groups’ teams to optimise communications between them. | 3 |
| **Ensure Response Plan Activation** | Ensure disaster recovery and contingency plans and arrangements are activated and suitably adjusted to optimise effectiveness for the circumstances. | 1 |
|  | Prepare and present specific, measurable, achievable, relevant and timely plans to respond to the needs of the DHB | 2 |
| **Optimise recovery planning** | Accurately analyse information on the crisis problems and impacts (internal and external) and brief the ICP. | 2 |
|  | Develop and maintain timelines for operational planning strategies and regularly communicate to all affected parties. | 4 |

### **Table V.4 – Safety/Security**

Role: To have authority over security and safety issues, to monitor hazardous conditions and safety of rescue operations. Facilitate site security.

|  |  |  |
| --- | --- | --- |
| Responsibility | Action | Priority |
| **Establish effective response to the incident** | Convene at the Control Centre or suitably equipped venue | 1 |
| Become well informed of the strike situation and its potential consequences. | 1 |
|  | Facilitate the Control Centre in its review of the incident as to how the organisation is coping and what further impacts are likely for xxxDHB | 2 |
|  | Review the security of XXXXDHB and identify areas of risk as they affect staff, patients and assets.  Propose a strategy to overcome these areas to assist the Control Centre | 3 |
| **Provide effective communications** | Establish and maintain effective communications and reporting requirements within the BC structure.  Provide accurate and timely sitreps to the Control Centre | 1 |
|  | Provide immediate situation report to Control Centre of any unsafe, hazardous or security related condition within xxxxDHB | 2 |
| Brief security staff as to their roles and the need to document incidents, actions and relevant observations. | 2 |
| Communicate any signs of stress or inappropriate behaviour present with staff, patients and volunteers | 3 |
| **Ensure adequate resourcing** | Review /adjust staffing levels as appropriate. Ensure staff are deployed to their appropriate effectiveness, supported by adequate welfare measures | 2 |
| Assist with sourcing of materials and supplies for clinical purposes from other areas. | 3 |

### **Table V.5 – Communications**

Role: To co-ordinate the release of information (external and internal).

|  |  |  |
| --- | --- | --- |
| Responsibility | Action | Priority |
| Manage communications procedures | Ensure that the Communications Unit is suitably activated and collating information (internal and external) regarding the crisis. | 1 |
| Maintain link with National Communication Coordinator | 1 |
| Review the makeup of the Communications Unit for adequate skills and experience to match the circumstances. | 2 |
| Ensure that an internal communications structure is in place with effective controls, appropriate expertise and pre-planned channels. | 2 |
| Prepare communications | Facilitate Control Centre to formulate its Communications strategies in alignment with its other response and recovery initiatives. | 2 |
|  | Implement strategies using the Communications Unit. | 2 |
|  | Manage all information to be released externally in conjunction with DHB Contingency Planner, NCP and CEO. | 2 |
| Deliver communications | Identify/confirm approved communications channels and spokespersons, for consistency of messages, to xxxDHBs best overall advantage. | 2 |
|  | Establish and deliver co-ordinated crisis-response communications across:   * Board, Ministers and other key stakeholders * Internal (management and staff) * Key support contractors and similar entities * Patients and families * Public/community. | 2 |
|  | Co-ordinate regular communications to personnel. | 3 |

### **Table V.6 – Human Resources**

Role: To co-ordinate the duties and welfare of staff and volunteers.

To manage all public relations.

To support the DHB Contingency Planner in relationships with National ER Manager and Union.

|  |  |  |
| --- | --- | --- |
| Responsibility | Action | Priority |
| **Manage the HR support team** | Assemble the HR Team with relevant skills and experience to support team leaders with particular personnel problems. | 1 |
|  | Monitor the situation with regard to current and potential impacts and demands upon personnel. | 1 |
|  | Assist with Staff Bureau if required | 2 |
| **Assist with staff deployment** | Assist managers with:   * Staff call-outs/deployment * Staff redeployment * Staff rosters/shifts, etc. | 3 |
|  | Assist key personnel with difficult commuting arrangements as appropriate. | 3 |
|  | Provide support to management for recruitment/employment of additional response/recovery personnel. | 3 |
|  | Appoint liaison officers for corporate representatives and official visitors | 3 |
| **Provide staff crisis support** | Advise Control Centre Coordinator of any personnel implications arising from its strategies and decisions, and develop suitable HR support to unit management and individual staff, as appropriate. | 2 |
|  | Maintain communication of HR related information/news to all personnel throughout the crisis, via the Communications Unit. | 3 |
|  | Monitor work place conditions (and associated morale) | 3 |
| **Support Contingency planning** | Provide health monitoring, stress management, counselling and other personal support to personnel affected by long term withdrawal of labour. | 3 |
|  | Manage matters involving the relationships between DHB and Union | 3 |

### **Table V.7 – Finance**

Role: To ensure continuity of financial functions.

|  |  |  |  |
| --- | --- | --- | --- |
| Responsibility | Action | Priority | Reference/ Comment |
| **Ensure continuing core operation** | Ensure the continuation of payroll and provide contingency support arrangements as necessary. | 3 | Finance Dept. BCP |
| **Manage financial controls** | Ensure that adequate financial controls and work around are in place as needed, for management and recording of response and recovery expenditure. | 3 |  |
|  | Activate financial personnel to monitor crisis expenditure of all other units at appropriate frequency. | 3 |  |
| **Provide reliable information** | Provide reliable/timely sitreps to Control Centre of any financial impacts of the action. | 2 |  |

### **Table V.8 – Administrative Support**

Role: To support and document Control Centre operations.

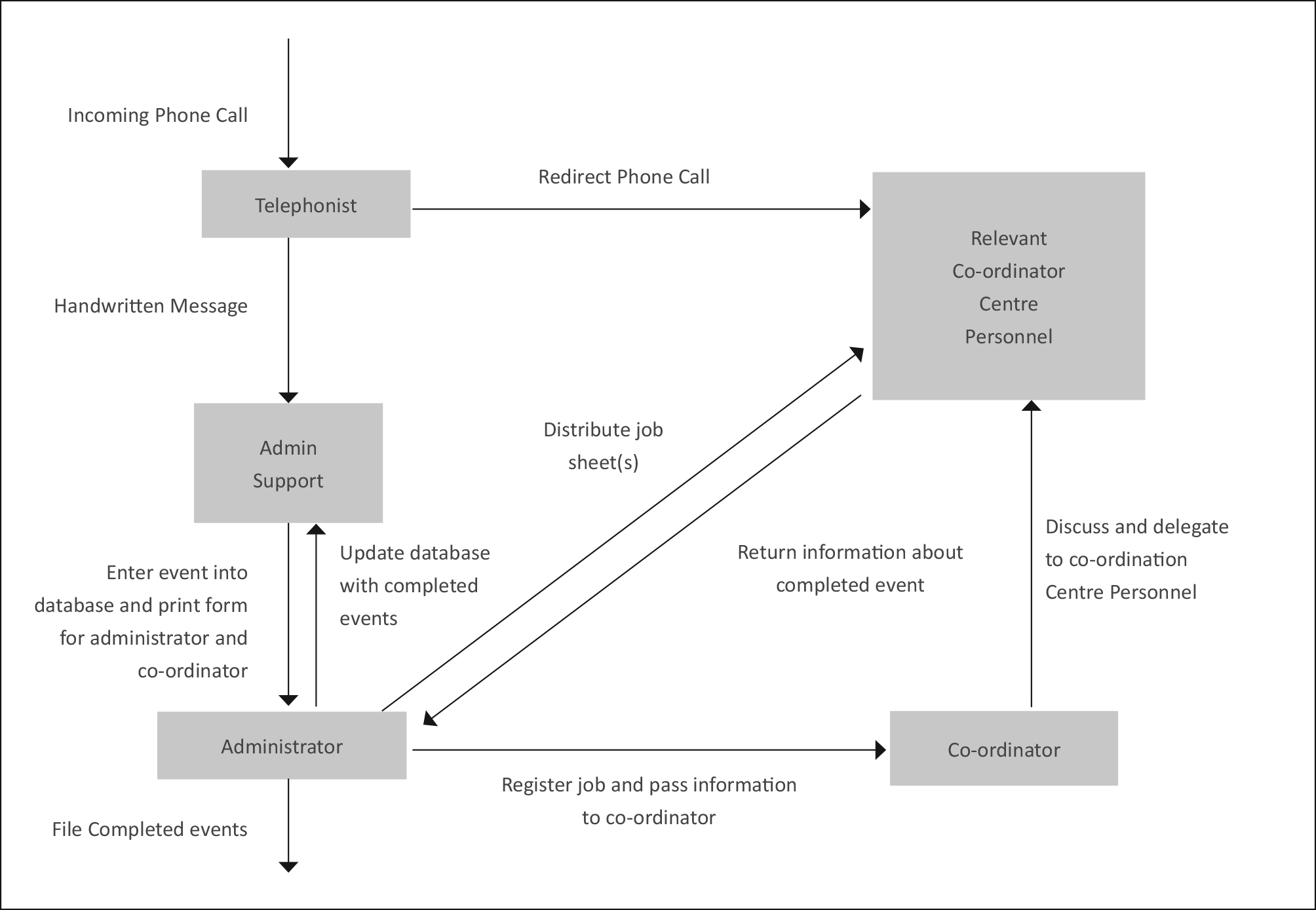
|  |  |  |
| --- | --- | --- |
| Responsibility | Action | Priority |
| **Provide effective response/recovery management** | Ensure suitably resourced administrative support personnel are activated. | 1 |
| Review the make-up of the Admin Support team for relevant skills and experience to match the circumstances. | 2 |
| **Control Centre Support** | Manage Control Centre and facilities, including the coordination of requests for goods and services. | 2 |
|  | Maintain a communication log in the Control Centre as both hard copy and in the Event Database. | 2 |
|  | Maintain a continuity of crisis information flow, including regular updating of notice boards and sitreps. | 2 |
|  | Perform voice and data services such as answering and receiving:   * Telephone calls * Faxes * E-mails * Radio | 2 |
|  | Collate and file all completed documentation for future reference. | 2 |
|  | Perform secretarial duties. | 2 |

# Appendix VI Contacts Lists

# Appendix VII Communications Log

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Date | Time | To | From (Unit/Ext) | Event | Action | Action Completed |
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# Appendix VIII Control Centre Information Flow



# Appendix IX Control Centre Event Form

|  |  |
| --- | --- |
| Event Number: |  |
| Event Date: |  |
| Event Time: |  |
| Event Category: |  |
| Event Location: |  |
| Event Resolved: |  |
| Person Reporting: |  |
| Extension: |  |
| Person Notified: |  |
| Event Description |  |
| Actions Taken: |  |
| Comments: |  |