Waitematā
District Health Board
Best Care for Everyone

Planning, Funding & Outcomes
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9 March 2021

[redacted]

Dear [redacted]

Re: OIA request – Wait times for diabetic retinopathy screening

Thank you for your Official Information Act request received 22 January 2021 seeking copies of any reports, documents or correspondence regarding wait times for diabetic retinopathy screening since 1 July 2020 from Waitematā District Health Board (DHB).

In response to your request, we can provide the following information:

Since July 1 2020, copies of any reports, documents, memoranda or correspondence (internal and external) regarding waiting times/backlogs for diabetic eye/retinal screening.

Some email correspondence between Waitematā DHB staff and our two contracted community-based providers has not been included as these do not include discussion around waiting times but are purely administrative requests for relevant data or seeking clarification of the data provided and so are considered outside scope of your request.

Other emails have been withheld under the following section 9(2)(g)(i) of the Official Information Act 1982 on the basis that:

a) withholding is necessary to maintain the effective conduct of public affairs through the free and frank expression of opinions between members of a public sector agency/organisation in the course of their duty and
b) the withholding of the information is not outweighed by other considerations which render it desirable, in the public interest, to make the information available.

A paper presented to Waitematā DHB's Executive Leadership Team on 15 December 2020 entitled *'Waitematā DHB Diabetic Retinal Screening: Proposed solutions to address waiting lists and unmet need'* has been withheld under sections 9(2)(b) of the Official Information Act 1982 as it is considered commercially sensitive and would be likely to unreasonably to prejudice the commercial position of those who are the subject of the information and 9(2)(j) to allow Waitematā DHB to carry on, without prejudice or disadvantage, negotiations.

This paper is being presented to the Waitematā DHB Board in closed session on 10 March. Disclosure of the information contained in the paper may prejudice our ability to negotiate future contracts for our diabetes retinal screening service.

However, we attach the following information:

Attachment 1 - Northern Region Diabetes Retinal Screening Clinical Governance group (CGG) December 2020 meeting minutes. These are watermarked "Draft" as, although they have been sent to all members, they will be ratified at the April 2021 meeting. Please note the following clarifications of these minutes:

[1]CD – clinical directors.

[2]DSLA – the Diabetes Service Level Alliance.

[3]NHCC or NRHCC – the Northern Regional Health Coordination Centre.

[4]This figure changes daily as people come on to the wait list while others come off due to appointments being scheduled or patients being non-contactable. Since the minutes were taken Waitematā DHB has worked with the contracted providers to reduce the waiting list and to ensure that when patients cannot be contacted they are referred back to their GP.

[5] Additional wording added for clarity.

[6] February 3 meeting was not held as a quorum was not achieved due to the unavailability of key clinical staff. The next meeting will be held in April 2021.

Attachment 1a - attachment to the minutes: Diabetes Retinal Screening triaging framework. Please note the following clarifications:

Page 2: Priority one (P1) and Priority two (P2) patients – Māori and Pacific have a higher risk factor for diabetes and eye disease is often already evident at the time of presentation.

Page 2: Note 2 at the bottom of the page refers to OPDR, which is the Ophthalmic Photographic Diabetic Review service. Mention that criteria "will be ignored by Waitematā DHB" is because this screening criteria for patients rated M3 and R3 is not used by us. These patients should be seen by the OPDR service, which is provided by Auckland DHB.

Page 4: Review of framework period – the March 2021 review will now occur at the April 2021 CGG meeting.

Attachment 1b - attachment to the triaging framework: National Framework V4 120820.

Attachment 2 - Information sent to all general practices within the Waitematā DHB catchment in January 2021 regarding referrals and re-prioritisation of patients.

You have the right to seek an investigation and review by the Ombudsman of the decisions made in providing this response. Information about how to seek a review is available at www.ombudsman.parliament.nz or freephone 0800 802 602.

I trust that this information is helpful.

Waitematā DHB supports the open disclosure of information to assist community understanding of how we are delivering publicly funded healthcare. This includes the proactive publication of anonymised Official Information Act responses on our website from 10 working days after they have been released.

If you consider there are good reasons why this response should not be made publicly available, we will be happy to consider your views.

Yours sincerely

[redacted]

Director Funding
Waitematā District Health Board

Attachment 1

Northern Region Diabetes Retinal Screening Clinical Governance

Minutes

MEETING DETAILS	
Date and Time	Wednesday 02 December 2020 0800 to 0900
Venue	Zoom
Present	David Squirrell (chair), Carol Ennis, Carol Barker, Helen Liley, Stephanie Emma, Barbara Miller, Tracy Molloy, Tahira Malik, Aroha Hudson, Ole Schmiedel, Sarah Welch, Sarah Welch, Dene Coleman, Ros Moffatt
In attendance	Eirean Gamble, Lis Cowling, Leanne Kirton, Keryn Bradley
Apologies received	Brandon Orr-Walker, Lorraine Bailey, Siobhan Matich, Boyd Broughton, Janice Kirkpatrick, Simon Young,

Item	Discussion
Welcome, Introductions and Apologies	Welcome to Siobhan Matich who replaces Edward from NHC, and Boyd Broughton, General Manager for Te Ha Oranga who replaces Tracy and Ros Moffatt from Auckland DHB Apologies Thank you to Stephanie Emma for her hard work in the area of diabetic retinal screening and wish her the best of luck in her new role at CMDHB
Minutes from October meeting **Action points:**	Minutes from 7 October 2020 accepted as a true reflection of the October meeting Accepted

Activity	Action point	By whom	By when	Outcome
Eligibility for screening in the Northern Region	Eirean to liaise with the diabetes CD[1] across metro	Eirean	ASAP	Ole responded and DSLA endorse that the Health Pathway are the basis for

Northern Region Diabetes Retinal Screening Clinical Governance

Minutes

		Auckland asking them to confirm what is a diagnosis of what is type 2 diabetes that can be used to accept people into the retinal screening services across the region ie one or two HbA1c. Then we will take this to DSLA[2] and the Counties Manukau Long term conditions clinical governance group for endorsement and then put this on health pathways Barbara happy for DSLA to make call and accept the decision			diabetes management in Auckland, and they should be used for triaging purposes **Action Point:** Eirean to take changed diagnosed criteria to Purvi for Counties endorsement so HealthPathyway can be updated
	prioritization framework and guidance on when patients should be screened by community providers	group to review and endorse via email Eirean to liaise with NHCC[3] to get HealthWEST, Auckland Eye, Auckland DHB and Comprehensive Care to	ASAP ASAP		Endorsed with one change endorsed framework.docx Eirean to send a copy to David Dalziel to get his endorsement Concern raised: practicality if implementation Email sent after meeting and David Dalziel endorsed the

Northern Region Diabetes Retinal Screening Clinical Governance

Minutes

		receive communication from NHCC Barbara reported that Northland able to screen at level 3			framework therefore the framework is now endorsed and a final copy
	When to start eye screening Paed patients with diabetes	Health Pathways will be updated after the review based on the new Australasian Endocrinology group guidelines has occurred Eirean to update MoH via an email Screening providers to start screening paeds from 11years.	Helen Eirean Screening providers	When guidelines reviewed ASAP ASAP	Email sent to MoH representative no response
Retinal Screening October 2019 data match results	Carol talked to this paper and the take home message is the metro Auckland coverage is well below MoH 90% target. Counties was commended for its ability to rapidly ramp up its screening volumes after lockdown.				

Northern Region Diabetes Retinal Screening Clinical Governance

Minutes

New model of care	Carol talked to this paper. This relates to Auckland and Waitemata DHB, this paper stocktakes and outlines the decisions made to date. Aroha raised the concern that this paper needs to be more transparent re unit price of retinal screening across Auckland and Waitemata DHB. Carol acknowledged this concern and explained that one of the drivers of the new model is about aligning the funding across the region Comment from the Chair: the current model of care at Waitemata and Auckland urgently needs review and treading water waiting for the proposed new model of care, which may be 18 months, clearly has risks. It was acknowledged that it would be desirable to accelerate the development of a new model of care but due process has to be followed. Need to have more co-ordination of people trying to fix the current model of care while we wait for the new model of care to be developed **Action point**: a meeting with all people involved in updated/fixing the model of care to be organised, membership to email Eirean who should be attending this meeting and Eirean will organise
Waitemata DHB waitlist and proposed solutions **Auckland DHB waitlist and proposed solutions**	Waitemata have a very large waitlist with 8,930[4] overdue and another 7,000 due in the next 12months. Funding and Planning are writing a paper to the Executive Leadership team to ask for additional funding to reduce the waitlist and serve those not currently known to service. Auckland DHB waitlist is manageable and they have an in house plan to be able to catch up by mid 2021
Other business	PHO would like to confirm what messaging to provide to their practices re: referring patients known to retinal screening but are overdue ie if overdue >12months should they re-refer? **Action point**

Northern Region Diabetes Retinal Screening Clinical Governance

Minutes

	Eirean to send an email to group asking about the above.[5] **Deferred to the February meeting** Conflict of interests – Policies – can we share
Meeting closed at 0910	
Next meeting: 3 February 2020 0800 to 0900via Zoom[6]	

Action points

Activity	**Action point**	**By whom**	**By when**
Eligibility for screening in the Northern Region	Eirean to work with Counties to see if we can have a metro Auckland Agreement	Eirean	ASAP
Need to have more co-ordination of people trying to fix the current model of care while we wait for the new model of care	Action point: a meeting with all people involved in updated/fixing the model of care to be organised, membership to email Eirean who should be attending this meeting and Eirean will organise	Membership Eirean	ASAP
PHO would like to confirm what messaging to provide to their practices re: referring patients known to retinal screening but are overdue ie if overdue >12months should they re-refer?	Email group asking for recommendation, was proposed by those left in the room to ask Primary Care to re-refer if patient has not been seen 1.5 time due ie if due to be screened 6months after last screen, wait for 3months and then re-refer	Eirean	ASAP

Northern Region Diabetes Retinal Screening Clinical Governance

Minutes

Future meeting agenda items

Retinal screening data match draft monitoring and reporting framework

- Carol B

Update Terms of Reference – Eirean (aim for the February or April meeting)

Workplan – Eirean (aim for the April or June meeting)

Please refer to the response letter for clarifications of some aspects of the recorded minutes.

Diabetic Retinal Screening

The Northern Region Diabetic Retinal Screening Clinical Governance triage prioritisation working group have developed and endorsed the following triaging framework on 02 December 2020 that is to be used by all Northern Region Diabetic Retinal Screening providers to ensure that during times when demand exceeds capacity or/and during COVID-19 lockdown that patients at the highest risk of developing or progressing diabetic eye disease are seen in a timely manner.

These are guidelines and clinical discretion should be used for any patients of concern. If a screening group consistently finds the guidelines difficult to adhere to for whatever reason, please alert your organisations representative on the Northern Region Retinal Screening Clinical Governance Group and ask that they report back to the governance group. Your DHB programme manager should also be alerted to any difficulties in applying this framework.

Triaging framework for new and follow up patients

Immediate and priority one new patients and recall patients should be triaged as a higher priority to other new and recall patients. Then work down the priority for new and recall patients. However, clinical judgement and discretion should be used for any patients of concern and the Clinical Lead can use their clinical discretion to adjust priorities.

Triaging new referrals

	Latest HbA1c recording in mmol/mol				
Ethnicity	**95+**	**85-94**	**75-84**	**65-74**	**<=64**
Māori and Pacific	1	1	1	2	2
Indian and Other Asian	1	1	2	2	3
Other	1	2	2	3	4

Priority 1	Priority 2	Priority 3	Priority 4

Immediate screen:

Regardless of ethnicity or HbA1c the following new referrals should be screened immediately

- Pregnant
- Serious systemic manifestations of Diabetes eg lower limb ulcer/amputation, renal impairment/or their Diabetologist requests urgent screening.

Proposed timeframes for new referrals (as per the Ministry of Health guidelines)

Priority one: should be seen within two weeks
Priority two: should be seen within six weeks
Priority three: should be seen within three months
Priority four: should be seen within four months

Triaging recalls [1]

Based on analysis of risk factors for disease progression using local data (60,000 screening images) (reference to be provided)

Immediate screen: No delay in recall ie screen on time

- Pregnant
- Serious systemic manifestations of diabetes eg lower limb ulcer/amputation, renal impairment/or their Diabetologist requests urgent screening

Priority one (P1) (2 or more of): Could be deferred by up to 2 months

- Māori or Pacific ethnicity
- Type 2 diabetes on insulin, or type 1 diabetes duration > 10 years
- HbA1c greater than 90 mmol/mol
- Retinopathy grade three and above or Maculopathy grade three and above at last screen[2].

Priority 2 (P2): (2 or more of): Could be deferred up to 6 months

- Māori or Pacific ethnicity
- Type 1 diabetes, or Type 2 Diabetes on oral tablets
- Duration of diabetes 5-10 years
- HbA1C between 65-90 mmol/mol
- Retinopathy grade less than or equal to two and Maculopathy grade less than or equal to two at last grade.

Priority 3 (P3) (all of the following): Could be deferred by up to 9 months

- Type 2 diabetes not on insulin (diet controlled or on oral tablets)
- Duration of diabetes less than 5 years
- HbA1C less than or equal to 64 mmol/mol
- Retinopathy or Maculopathy grade of zero at last grade

Patients who were lost to follow up and re-referred

These patients should be triaged as per the recall triaging criteria (above) as they will have historical retinal screening results which will better identify their risk of future eye disease and thus guide how urgently they should be followed up.

When can patients be seen when we are at the different COVID alert levels

[1] If your centre is not able to generate recall lists with all of these criteria, it is encouraged that the recall lists/decisions are based on as many of these criteria as possible.

[2] In Waitematā DHB due to the structure of the retinal screening programme patients with a score of greater than M3 and R3 will be seen in OPDR therefore this criteria will be ignored by Waitematā DHB screening providers

The Community Diabetic Retinal Screening will follow the Hospital Response Framework and not the national lockdown levels. However, the following caveat applies:

1. If capacity[3] becomes an issue Providers will book patients based on priority ie only see priority one new patients and high risk recalls and all immediate screen patients

Community Primary Care Alert Response Framework - Long-term conditions care	**Hospital alert level**	**New patients that can be seen**	**Follow up patients that can be seen**
Green ALERT: Community readiness - Level 1	**COVID-19 Hospital Readiness GREEN ALERT**	all patients	
Yellow ALERT: Community impact mild – Level 2	**COVID-19 Hospital Initial Impact YELLOW ALERT**	immediate patients, P1, P2 and P3	immediate patients, P1 and P2
Orange ALERT: Community moderate impact – Level 3	**COVID-19 Hospital Moderate Impact ORANGE ALERT**	immediate patients, P1	immediate screen patients, P1
Red ALERT: Community severe impact - Level 4	**COVID-19 Hospital Severe Impact RED ALERT[4]**	Screen immediate screen patients and P1 deemed urgent by clinicians[5]	Screen immediate screen patients and high risk deemed urgent by clinicians[2]

National Hospital Framework V4 12082

Link to the COVID-19 Primary Care Alert Response Framework Username: [redacted] Password: [redacted]

[3] Capacity issues include, but are not limited to: capacity issue at location, inability to social distance (1meter social distancing within wait rooms), inability to perform required cleaning, staffing issues (being redeployed or having to step down for other reasons) or loss of screening locations.

4 At Red Alert, staff may be deployed for other duties and screening may be shut. Therefore, it may be appropriate to treat a few patients in the respective ophthalmology departments.

[5] At hospital level red capacity issues and patient self-selection will most likely determine which of the highest need population is seen

NOTE: Providers to use the alert system that is used by your service

Messaging to patient this needs to be clear allowing patients to make an informed decision about whether they wish to be seen or not. If a patient self selects to not be seen their priority must not reduced. They should then be offered an appointment as the national and hospital alert levels drop but the patient should also be reassured that they can contact the service when they feel ready/safe to be seen.

Review of patients on waitlist

It is expected that waitlists are reviewed as part of normal booking process. However, a formal review of waitlists should happen every 3months to identify if any patients have been waiting longer than 1.5 times their due date or a maximum of three and a half years since last review. If this is the case then the patient's priority should be moved up a level; ie if a patient was due to be seen in 6months after 9months if they have not been seen their priority levels moves up.
During waitlist reviews the Screening Co-ordinator and Lead Ophthalmologist should review the reasons for the increased waiting times and a plan developed to address this. At the same time the Programme Manager/Funder and the Regional Retinal Screening Clinical Governance should be notified.

As part of business as usual the Screening Co-ordinator/ Lead Ophthalmologist will bring the services waitlist times to the quarterly Regional Retinal Screening Clinical Governance meeting for review/discussion.

Review of framework period

It is expected that this framework will be reviewed again in March 2021. However, if providers are adjusting the framework on a regular basis due to clinical risk/clinical judgement etc then this review will be brought forward.

COVID 19 National Hospital Response Framework – The Process

- This Hospital Response Framework provides high level, national consistent guidance to support facilities and hospitals to appropriately and safely operate, while maintaining as much planned care as safely possible, during any COVID 19 resurgence.
- DHBs should ensure their ongoing capability to safely operate within this framework by periodic reassessment against the COVID 19 Resurgence Checklist.
- The Alert Levels in this Framework are different to the Government's National COVID-19 Alert Levels and relate to COVID 19 activity within the local community. They do not include activity related to Managed Isolation Facilities, unless a DHB assesses significantly heightened risk that must be managed.
- Hospitals are expected to operate in line with their current Alert Levels and have systems and processes proactively in place to identify and respond to any changes in levels (up or down) so that changes are made in a well-managed and planned manner with staff and resources prepared and trained beforehand.
- Each region should agree the means by which DHBs will keep each other informed of changes in alert levels and triggers for enacting agreed regional management plans.
- The Framework aims to ensure that patients remain at the centre of care by making proportionate responses to escalations and de-escalations in the COVID-19 pandemic, to minimise disruption to planned and unplanned care delivery while maintaining quality and safety.
- DHBs must develop their plans and decision-making processes in partnership with their DHB GM Māori health and their DHB Iwi/Māori Relationship Board. This plan should identify Māori and other vulnerable populations and ensure health disparities do not increase as a result of the response to the COVID-19 pandemic. DHBs must maintain rigorous oversight of waiting lists, including a comprehensive plan setting out the manner by which the risk of patients deteriorating while waiting for assessment and treatment will be identified and managed.
- Te Tiriti o Waitangi and Equity are at the centre of each level of the Framework. Critically, DHB escalation and de-escalation will be managed in a way that actively protects the health and wellbeing of Māori and other vulnerable population groups. This includes active surveillance and monitoring of health outcomes, for Māori and other vulnerable groups, to ensure a proportionate and coordinated response to health need for COVID-19 and non-COVID patients.
- DHBs' plans for management of Alert Levels must include a regional context and be discussed with primary care and other providers.
- When relevant (during any local resurgence) daily EEC meetings should be the mechanism whereby Alert Levels are changed or confirmed, and actions initiated in daily reporting. This decision should be clearly documented and evidenced, and communicated with senior clinicians, managers and other relevant senior personnel as part of the local response plan.
- It is possible for different hospital facilities and/or departments within a DHB to be at different Alert Levels at any given time.
- The overall DHB Alert Level should be reported each day to the Ministry of Health so that a national view of escalation can be compiled. This will be via the DHB SitRep.
- This Framework may evolve over time and be revised by the National Hospital Response Group, then reissued as appropriate.

All District Health Boards

COVID-19 National Hospital Response Framework

COVID-19 Hospital Readiness

GREEN ALERT

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

- Screen patients for COVID-19 symptoms & epidemiological criteria for any Emergency Department attendances, pre-op sessions, planned admission, or clinic attendance
- Maintain ability to return, if necessary, to triage physically outside the Emergency Department (or outside the hospital building)
- Maintain a separate stream for COVID-19 suspected cases in the Emergency Department
- Undertake regular training and exercises for management of a COVID-19 suspected case in the Emergency Department, Wards, Theatres, ICU/HDU
- Maintain PPE training for COVID-19 care in the Emergency Department, wards, theatres, ICU/HDU, outpatients, other relevant settings
- Maintain plan for isolation of a single case & multiple cases/ cohorting
- Maintain capability for instigation, if necessary, of Early Supported Discharge, aggressive discharge and step-down arrangements, including with other partners as appropriate (e.g. private, aged residential care, community providers)
- Maintain ability to instigate, if necessary, separate streams for staffing, cleaning, supplies management and catering
- Plan for management of referrals, and increased workload on booking and call centre teams
- Plan to have a COVID-19 capable theatre for acute surgery for a known or suspected positive patient
- Maintain ability to instigate, if necessary, a dedicated COVID-19 ward
- Maintain engagement with alternative providers (such as private) regarding assistance during higher escalation levels, and to fast-track urgent, lower complexity care procedures.
- Maintain and further develop the provision of outpatient activity via telehealth and phone screening for virtual assessment, and MDTs to videoconference wherever clinically appropriate and acceptable for patients
- Planned Care surgery, acute surgery, urgent elective and non-deferrable surgery to operate as usual, National Services to operate as usual, NTA to operate as usual
- Review patients on the waiting list (surgery, day case, other interventions) and group patients by urgency level
- Prioritise Planned Care surgery and other interventions by focusing on those with the most urgent need, and where ICU/HDU **is** required

COVID-19 Hospital Initial Impact

YELLOW ALERT

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

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

COVID-19 Hospital Moderate Impact

ORANGE ALERT

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

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

COVID-19 Hospital Severe Impact

RED ALERT

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

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

Version 4 released 10 August 2020

MINISTRY OF HEALTH
MANATŪ HAUORA

Waitematā DHB diabetes retinal screening services

Diabetic retinal screening services in Waitematā DHB were disrupted due to COVID-19 and some people living with diabetes may be experiencing delays in receiving retinal screening appointments.

Retinal screening services are working to safely manage waiting lists and will ensure those at highest risk of diabetic eye disease are screened first.

If you are concerned that your patient's situation has changed and they need to be seen urgently or the wait has been inappropriate, please re-refer via e-referrals and include information on what has changed in order for the referral to be re-prioritised.

Otherwise, please have confidence that we will be seeing your patients in a timely manner based on their level of clinical risk.

Please continue to send referrals for people with diabetes who are newly diagnosed or not currently engaged with the diabetes retinal screening services. If you are unsure of the referral criteria, please visit HealthPathways.