MINISTRY OF HEALTH
MANATŪ HAUORA

New Zealand Health & Disability System: Priority Areas

Ministry of Health, July 2020

Contents

Employment Relations

Governance

- The District Health Board (DHB) Chief Executives (CEs) as the employers are responsible for negotiating and agreeing terms and conditions of employment for DHB workers. Their agents for negotiations are Technical Advisory Services (TAS).
- The New Zealand Public Health and Disability Act 2000, Schedule 3, clause 44 requires the DHB CEs to consult with the Director-General of Health prior to agreeing terms in a collective agreement.
- The DHBs currently have a Workforce Governance Group that is overseeing workforce issues, including employment relations. The members are two DHB CEs, two GMs HR, Director Employment Relations TAS and Deputy Director-General Health Workforce.
- Employment relations are collectively governed by DHBs and the Ministry. There is an Employment Relations Governance Group. It is comprised of two DHB CEs (one being the lead CE for employment relations), the Chair of the DHB Chairs, the Director-General of Health and Deputy Director-General Health Workforce.

NZNO Bargaining

- The DHB New Zealand Nurses Organisation (NZNO) Nursing and Midwifery MECA expires on 31 July 2020.
- The Director-General has appointed a lead advocate for bargaining, Andrew Wilson. This has been endorsed by DHB CEs. Andrew reports to a DHB and Ministry oversight group that includes the Deputy Director-General Health Workforce.
- The DHBs have commenced bargaining with NZNO for the nursing and midwifery collective agreement. The DHB and NZNO bargaining teams met on 23, 24 and 25 June.
- s 9(2)(j) [redacted]
- s 9(2)(j) [redacted]
- The next round of bargaining is 7, 8 and 9 July. The teams will continue to work through claims.
- NZNO have indicated following this next round they will hold stop work meetings with their membership, likely from late July through to mid-August.
- s 9(2)(j) [redacted]
- The Ministry understands that NZNO also plans to hold stop work meetings for its members who are covered by the Primary Care MECA (this agreement is outside of the State sector) in the second half of July. s 9(2)(j) [redacted]

Pay Equity

- There is a Crown Negotiator acting for DHBs in relation to pay equity bargaining – Doug Martin.
- The DHB CEs have approved a bargaining strategy for the PSA Clerical and Admin claim. This is due to be considered by the State Sector Pay Equity Governance Group on 8 July.

- s 9(2)(j) [redacted]
- The nursing and midwifery pay equity claims are currently at the stage of interviewing and developing role profiles for potential comparator roles.

Holidays Act

- s 9(2)(f)(iv) [redacted]
  - s 9(2)(j) [redacted]
- Central agencies and the Ministry of Business, Innovation and Employment (MBIE) have been consulted with extensively on the paper. s 9(2)(j) [redacted]
- s 9(2)(j) [redacted]

Mental Health and Addiction

Initial priorities in the Government's response to He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction (MHA)

The Government formally responded to He Ara Oranga in May 2019 [CAB-19-MIN-0182]. The table below outlines progress and next steps in areas identified as initial priorities.

Initial priority area	Progress in 2019/20	Current state and upcoming activities
Establishing the Mental Health and Wellbeing Commission to provide system-level oversight of mental wellbeing	• Establishment of the Initial Commission to develop an outcomes framework and report on progress (interim report released in June, full report expected in November) • Introduction of the Bill to establish the permanent Commission as an independent Crown entity	• Initial Commission scheduled to meet with the Minister of Health on 21 July • Bill received Royal assent on 30 June with the expectation that the Commission will be operating by February 2021 • Appointment process to be finalised post-election
Repealing and replacing the Mental Health (Compulsory Assessment and Treatment) Act 1992 to embed a human rights-based approach	• Cabinet agreement to principles for policy development as part of longer-term legislative change programme • Public consultation on revisions to Mental Health Act Guidelines to improve current practice	• s 9(2)(f)(iv) [redacted] • Revised Guidelines expected to be published by September 2020
Enhancing suicide prevention efforts	• Released Every Life Matters, the national strategy and action plan • Established the Suicide Prevention Office, initially as a team within the Ministry • Implementation of Budget 2019 suicide prevention and postvention initiatives	• Ongoing implementation of Every Life Matters s 9(2)(f)(iv) [redacted] and Budget initiatives • Working with Office of the Chief Coroner on the upcoming release of provisional suspected suicide data in August 2020
Expanding access and choice of primary MHA services	• Budget 2019 investment of $455 million over four years for a national roll-out • Focus on workforce development, sustaining existing integrated	• Announcement of $40 million to expand integrated primary MHA services to over 100 general practice sites by mid-2021

	primary MHA services accessed through general practice and engagement to design new services • Release of RFPs to expand or replicate existing kaupapa Māori and Pacific services, and for existing or new youth services, in late 2019/early 2020	• Evaluation of proposals slowed due to COVID-19 but officials expect services to commence from September 2020 • Release of RFP for new Pacific services in June, upcoming release of RFP for new kaupapa Māori services (sector asked to delay release due to COVID-19)

s 9(2)(f)(iv) [redacted]

Budget 2019 investment

In addition to expanding access and choice of primary mental health and addiction services, the Budget 2019 mental wellbeing package included investment in suicide prevention, addiction treatment, school-based mental wellbeing, forensic mental health and crisis response services. Of the approximately $150 million of Vote Health funding available in 2019/20, approximately $125 million has been committed. Of this, approximately $110 million had been spent as at the end of May 2020. The Minister of Health reports monthly to the Cabinet Priorities Committee on these initiatives. s 9(2)(f)(iv) [redacted]

Psychosocial response

The Ministry has led the psychosocial response to COVID-19, including the development of Kia Kaha, Kia Māia, Kia Ora Aotearoa: Psychosocial and Mental Wellbeing Recovery Plan, which sets out the national framework and actions to support mental and social wellbeing over the next 12–18 months. As part of the COVID-19 response, $15 million was allocated to support the psychosocial response, including investment in wellbeing promotion, digital self-help tools, telehealth services and targeted supports for priority populations.

Health Infrastructure Unit

The Health Infrastructure Unit (HIU) has been established to provide stronger oversight, assurance, and standardised project delivery across a national portfolio of DHB owned and operated infrastructure. Following establishment of the HIU in November 2019 [GOV-19-MIN-0055 refers] work has progressed to build the capability and capacity of the team.

Prior to the HIU's establishment, the Capital Investment Management team serviced a high level DHB Business Case review and Crown funding prioritisation only, with a team of six people. Since November 2019, the HIU has grown to a total team of 41 people, with recruitment currently underway for an additional 12 roles. The three-year work programme for the HIU will see capacity grow to 64 people.
The core functions of the HIU are being developed to address Governance & Engagement, Service Planning, Asset Management, Investment Strategy, Monitoring and Assurance, and Programme Management & Delivery.

Health Capital Infrastructure

There are 89 health capital projects moving through the health capital process, which are being overseen or led by the Ministry's HIU. There are two funding pools:

- Health Capital Envelope (HCE) – project budget, progress, spend, and high-level scenarios for Budget 20 (51 projects)
- Health Infrastructure Package (HIP) announced in January 2020 – progress with Business case approval (38 projects including two place holders for Canterbury DHB and Hawke's Bay DHB)

A brief update on the three most significant infrastructure projects that are being led from the HIU are noted here, along with summary updates on the wider portfolio.

- Canterbury DHB: Acute Services Building (Hagley) – The new s 9(2)(b)(ii) facility has experienced ongoing delays. The building is in the final stages of remedial works and defect closeout. A pipe leak earlier this year caused some interior damage, which is currently under repair. The Ministry expects the building to be handed over to the DHB for recommencement of migration within the next 2 months.
- West Coast DHB: Grey Base Hospital – Following delays in completion, the new $121 million facility is now in the final stages of completion. The DHB has commenced migration into the new facility. Legal transfer of the building to the DHB will occur on 1st August 2020, and the facility will be receiving it's first patients from August 2020.
- s 9(2)(f)(iv) [redacted]

Further information can be seen in Health Report 20200999 – Joint Ministers 'Health Check-Up' June 2020.

Health Capital Envelope (HCE) update

In total there are 51 projects currently funded under the HCE totalling $4.2 billion (including $1.2 billion for New Dunedin Hospital[1]), in total $812.8 million in funding has been drawn down by DHBs for these projects to date.

Pre-Budget 2018 Projects

- There are 22 projects underway from budgets prior to Budget 2018 under the HCE. These projects have total Crown funding allocation of $913.2 million, and in total $742.3 million has been drawn down against these projects.
- Several of these are large projects where construction has almost been completed and DHB occupation should occur this calendar year (Acute Services Building at Canterbury DHB, and Grey Base Hospital at West Coast DHB).
- Post occupancy reviews will be undertaken to evaluate the projects and facilities to ensure that benefits have been achieved. Timeframes for reviews will be confirmed once occupation has been agreed.

Budget 2018 Projects

- There are 15 projects underway from Budget 2018 under the HCE. These projects have total Crown funding allocation of $744.8 million, and in total $48 million has been drawn down against these projects.
- Of these 15 projects, six are in post Business Case approval design and six are in construction. There are three projects that are in the Business Case stage - these projects are being looked at in conjunction with some projects prioritised under Budget 2019, to form two larger projects both are under Counties Manukau DHB.

Budget 2019 Projects

- There are 24 projects covered under the 2019/20 year, with 22 prioritised from HCE funding of $1.7 billion, the New Dunedin Hospital Budget allocation of $1.2 billion, and 1 project (Auckland DHB - Hospital Administration Replacement Project (HARP) - Phase 1) that has not received HCE funding (DHB funded) but is overseen by the HIU due to the value of the project. In total $22.4 million has been drawn down against these projects.
- Of the 22 projects that were prioritised for funding from the HCE from Budget 2019 (2019/20 and 2020/21) good progress has been made with Business Cases being supplied by the DHBs and being presented to the Capital Investment Committee (CIC).
- The remaining funding held under the HCE is held as contingency for known and/or unknown issues that may arise with DHB capital projects. The HCE contingency is currently fully allocated to support known risk across the capital project portfolio. This allocation does not consider the

[1] *Excludes land purchase, which are covered under the HCE*

recent impacts from COVID-19 including cost incurred during alert level 4 shut down, and flow on cost from project delays.

s 9(2)(f)(iv) [redacted]

- s 9(2)(f)(iv) [redacted]
- s 9(2)(f)(iv) [redacted]

Health Infrastructure Package (HIP) update

- Joint Ministers approved the final list of 38 projects, which include two place holders for projects at Hawke's Bay and Canterbury DHB. Total funding for the HIP is $300 million but this includes some funding held aside for contingency.
- No equity has been drawn down for these projects in the year-to-date, as Business Cases are still in the process of being approved, and this had been delayed during the COVID-19 response.
- We communicated final decisions to DHBs in June 2020 and have received updated information on project timeframes, financial forecast and any new risk or delays in delivery related to COVID-19 and national alert levels.
- Progress to date:
    - Seven Business Cases, with maximum Crown funding of $45.0 million have been endorsed by CIC and are being progressed for Joint Ministers' approval.
    - 20 Business Cases have been signalled for submission to CIC in the next three months, with a maximum Crown funding of $133.0 million.
    - Some DHBs have experienced specific delays in progressing with the HIP projects. The HIU is continuing to support DHBs to progress these projects and to get these into delivery phase as soon as possible. This is being achieved using streamlined Business Cases.

DHB Performance – financial and service

DHBs provide or fund most health services in New Zealand. DHB performance concerns have become more acute over the last few years, with the financial performance of many DHBs deteriorating, and service performance metrics being below expectations in some areas. Collective DHB performance needs to improve in relation to financial sustainability and some service areas to support better and more equitable health outcomes for the New Zealand population.

s 9(2)(f)(iv) [redacted]

To keep up in this context, DHBs have had to deliver efficiencies. Some have been achieved through streamlined care models that make more effective use of resources, and through productivity initiatives that reduce unnecessary waste. Others have been achieved through re-prioritising investments, leading to a shortfall spanning workforce, capital investment, data and digital, innovation, and leadership, governance & capability.

While there have been significant financial pressures in the health sector following several years of relatively low funding increases, the current Government has committed to investing in the sector through both capital and operating funding. Budgets 2018, 2019 and 2020 have delivered significant additional funding to relieve the pressures and lay the foundations for more sustainably funded DHBs.

DHB Performance Programme and Sustainability

To support improvement, the Ministry restructure in 2018 established a directorate with a focus on lifting DHB performance (DHB Performance, Support and Infrastructure, DHBPSI). These groups have responsibility for delivering the DHB Performance Programme, underpinned by a work programme that focuses on strengthening the foundations of DHB performance, including:

- the way we appoint, induct and develop our leaders
- the way we lead system and service planning
- the way we support innovation and improvement
- how we measure and monitor performance
- how we engage with the sector
- how we leverage performance through accountability frameworks.

Budget 2019 provided new funding of $23.681 million per year for initiatives to improve the financial sustainability and performance of DHBs, including further lifting the DHB performance function of the Ministry. In December 2019, Cabinet agreed for the 2019/20 funding allocation to support initiatives / projects across the following three themes:

- Support **national planning activities** including: service planning and building a nationally consistent analytics approach.

[2] Once insurance payments to Canterbury DHB following the 2011 earthquake are excluded.

- Implement **DHB-led improvements,** including supporting DHBs to develop and execute savings plans; advancing DHB-led initiatives that generate measurable and sustainable efficiency gains in the medium term; and helping to share successful innovations between DHBs.
- Support the **capability lift** that DHBs need through upskilling operational and clinical leaders to initiate their financial and clinical sustainability efforts; leadership training and development for current and future DHB leaders; establishing panels of experts to support specific issues; establishing dedicated governance development activities.

Planned Care

Planned Care is the description adopted in 2019/20 to describe a subset of activity, incorporating elective services. Planned Care generally begins from the point a person is referred by their primary care provider for specialised care. It encompasses medical and surgical services that are not required as an emergency or funded through the Accident Compensation Corporation (ACC). It includes all appointments and support people may need during their healthcare journey. The programme of Planned Care covers a wide range of activities including surgery and other interventions as well as enablers such as Radiology and First and Follow Up Assessments.

Access to and quality of planned care (including elective surgery) is an important marker of the performance of New Zealand's public health and disability system. DHBs are currently struggling to meet performance expectations for planned care, with the level of delivery slowing, and the number of people waiting beyond expected waiting times increasing.

A prioritised work programme is focused on improving access, timeliness, quality, equity and experience of care.

Planned Care activity represents investment of more than $1 billion a year, with a share of funding held and contracted centrally to lift delivery, on a payment for delivery basis. Budget 2020 provided new funding for Planned Care of $125.4 million over four years, supporting DHBs to improve access to Planned Care Interventions for their population. A further one-off investment of $282.5 million over three years was also provided in Budget 2020 to address waiting list impacts as a result of COVID-19. This funding will support elective surgery, radiology scans, assessments and follow-ups, and procedures completed in outpatients' facilities.

DHB performance reporting

A set of regular DHB performance reports are provided to the Minister of Health, including:

- Planned Care dashboard (produced monthly) – provides summary information on DHB performance against Planned Care expectations.
- Quarterly performance heatmap (produced quarterly) - provides summary information on DHB performance against the planning priority areas included in DHB annual plans and regional service plans.
- Balanced scorecard (produced quarterly) - a four-quadrant scorecard covering DHB financial performance, service performance, workforce, and quality and safety and is intended to support and help inform performance monitoring conversations with DHB stakeholders.
- Year to date sector financial reporting (produced monthly) - highlights where the sector, or an individual DHB, reports a significant variance against their Annual Plan financial budgets and provides information on sector wide issues with financial implications.
- DHB Financial Flash Report Summary.

Each month, a 'Health Check-Up' meeting is held between the Minister of Health and the Minister of Finance. Within the meeting briefing, qualitative updates are provided on the DHBs that have the highest levels of performance risk – Auckland, Canterbury, Counties Manukau, Hawke's Bay, Southern, and Waikato.

Attached separately to this document as Appendix A are:

- An example of a Planned Care dashboard, a quarterly performance heatmap, and a balanced scorecard (Bay of Plenty DHB example used)
- The May financial 'flash' report.

DHB financial performance

s 9(2)(f)(iv) [redacted]

DHB service performance

In recent years, DHB performance in key service areas, such as planned care and emergency department waiting times, has been a cause for concern. Some DHBs continue to perform well in these areas, but overall sector performance has been deteriorating. At a summary level, national service performance for the quarter three period (January – March 2020) shows:

- More planned care interventions were delivered compared to plan. As with quarter two, wait times for specialist assessment and treatment continue to slowly increase, particularly for Māori.
- Wait times for cancer treatment on or within 31 days and breast screening rates met the national expectation.
- The new-born enrolment with general practice at three months old rate met the national expectation, however the rate for Māori is below the national expectation.
- The following measures remain below the national expectation, however show small improvement compared to the previous data period:

    a. immunisation rate at five years old
    b. wait times at ED

c. waiting times for CT scans, and non-urgent and surveillance colonoscopies.

- The following data for screening rates and wait times are not meeting the national expectation and have worsened since the previous data period – cervical screening rates and wait times for MRI and urgent colonoscopies.

Ambulatory Sensitive Hospitalisation (ASH) rates for 0-4 year olds decreased for the total population as well as for Māori and Pacific populations. Acute hospital bed day rates for Māori and Pacific populations remain higher than total population rates, however these rates have decreased slightly compared to quarter two 2019/20.

COVID-19

Background

On 6 January 2020 the World Health Organization (WHO) were informed of a number of cases of viral pneumonia with unknown source in the Wuhan Province of China. The Ministry of Health Public Health Group began active surveillance of the outbreak, and on 28 January 2020, the National Health Coordination Centre was stood up to begin responding to the emerging risks from the outbreak, driven by the New Zealand Influenza Pandemic Action Plan (NZIPAP). It is important to note that, while this plan was designed with an influenza pandemic in mind, the actions are applicable to any respiratory illness regardless of the nature of the infectious agent. On 31 January 2020, a Public Health Emergency of International Concern (PHEIC) was declared by WHO. On 11 March 2020, the WHO declared COVID-19 to be a global pandemic. During this time, the Ministry worked with cross-government agencies, including the National Crisis Management Centre (NCMC), the OCC, and the All-of-Government Response team, to run the emergency response to COVID-19.

The Ministry of Health National Health Coordination Centre remained active until 18 May 2020, when a dedicated COVID-19 Hub was set up within the Ministry of Health to provide additional structure and support to the response. The COVID-19 Hub is supported by workstreams across the wider Ministry to coordinate the response to COVID-19 across the health and disability sector. The key role of the Ministry of Health in the All-of-Government COVID-19 response is to provide leadership and coordination across the health and disability, sector, as well as provide the technical public health advice and requirements to facilitate an evidence-based response to the global pandemic.

Funding

The COVID-19 pandemic has had a major effect on Vote Health, and a total funding of approximately $1.6 billion has been provided to date as part of the public health response. This includes funding approved prior to Budget 2020 and included in the Estimates of Appropriations for 2020/21 and funding approved since then. Where this subsequent funding has been appropriated to 2019/20, it is included in the Addition to the Supplementary Estimates.

Key messages

Funding included in the 2019/20 Supplementary Estimates and reported in the Policy Initiatives in the 2020/21 Estimates document - total operating funding of $265.2 million was initially provided to Vote Health in 2019/20 as part of the initial $500 million boost for health services announced by the Government. This included:

- COVID-19: Public Health Response package of $238.2 million to delay the onset of community transmission of COVID-19, including initial funding for Healthline, General Practice support, establishment of Community Based Assessment Centres (CBAC), COVID-19 testing - laboratory capacity, and additional ventilated and non-ventilated ICU capacity. Within this package, $17 million was dedicated towards the Māori lead response, including a targeted immunisation programme, Māori communications campaign and public health initiatives.
- COVID-19: Māori Health Response package also included an additional $13 million for Māori specific investment purposes on top of the Public Health Response with a further $10 million transferred to Te Puni Kōkiri (TPK) for the Whanau Ora component for the public health tagged contingency.
- COVID-19: Pacific Response package of $14 million to ensure that the overall national response to COVID-19 pandemic delivers equitable health outcomes for Pacific peoples. In addition, a further $3 million has been reprioritised within existing Vote Health baselines for this initiative.

Funding approved subsequently - additional operating funding of $1.3 billion and capital funding of $51.3 million has been provided to Vote Health in 2019/20 and outyears since the 2020/21 Estimates document was finalised. This includes:

- COVID-19 Public Health Response: Additional funding of $276 million (all included in Addition to the Supplementary Estimates) in operating to purchase essential equipment and supplies required by the health and disability system for the elimination strategy.
- COVID-19 Contact Tracing Action Plan - Cabinet established a $55.0 million tagged contingency to further strengthen our contact tracing. $20m was drawn down immediately (included in Addition to the Supplementary Estimates) to implement a comprehensive approach to contact tracing.
- COVID-19: Response and Recovery Fund Foundation Package of $363.1 million in operating funding and $50 million in capital funding to support the health sector to respond and recover from COVID-19. Operating funding of $105.6 million for 2019/20 is included in the Addition to the Supplementary Estimates.
- Outstanding COVID-19 Response and Recovery initiatives of $254.4 million in operating funding and $1.3 million in capital funding to further support the COVID-19 response and the maintenance of the health and disability system. Operating funding of $201.9 million for 2019/20 is included in the Addition to the Supplementary Estimates.
- A managed arrivals contingency drawdown of $58 million in operating funding (included in the Addition to the Supplementary Estimates) to meet the costs in providing managed isolation or quarantine facilities.

- Support Plan for COVID-19 Cases and Close Contacts in the Community under Alert Levels 2 and 1 of $20 million in operating funding to cover the estimated costs to establish local wraparound services and managed isolation facilities for 2020/21.
- A Sustainable Quarantine and Managed Isolation System of $298 million in operating funding to fund costs related to the delivery of quarantine and managed isolation arrangements for arrivals to New Zealand to 31 December 2020.
- Significant resources have also been redirected within Vote Health in response to COVID-19 from within existing baselines.

Issues or risks

- The ongoing response and recovery of the health and disability system will require further funding as much of the investment to date has been to cover the initial response through to 30 June 2020.

Additional Information

- Work completed by the Ministry in determining its final forecast year-end position has identified the need for further in-principle expense transfers. This accounts for the impact of COVID-19 efforts on our work programmes and appropriations.
- COVID 19 has impacted on a number of areas of activity such as the National Bowel Screening Programme, where there is some further delay in the programme roll-out and only ten of the 20 DHBs will have implemented the programme by June 2020.

Testing

The laboratory testing regime was a hugely collaborative effort between the Ministry, DHBs, Health Partnerships Ltd and the country's medical laboratories.

- The rapid establishment of Community Based Assessment Centres (CBACs) has been an important component of the COVID-19 response driven by the New Zealand Influenza Pandemic Action Plan (NZIPAP). A total of $32m one-off funding was allocated to DHBs on 3 April 2020 to support this activity.
- Since early March 2020, over 400,000 tests have been completed.
- During Alert Levels 3 and 2, approximately 30,000 tests were also performed for surveillance purposes on asymptomatic individuals in higher risk groups, including healthcare workers, aged care centres and general public in communities where outbreaks have occurred.

Key messages

Testing plan/strategy

- We have significant capacity for laboratory testing with the ability to process 13,000 tests per day with a large volume of stocks on hand.
- The Ministry of Health has an elimination strategy to ensure that COVID-19 is kept out of the New Zealand community. This is continually being reviewed to ensure it remains as effective as possible in the changing environment.
- The Ministry has recently introduced a change to the case definition for COVID-19 and updated the testing strategy (on approval from Cabinet) to reflect the current situation in New Zealand, where our greatest risk of re-introduction of COVID-19 and spread is via our border.
- Under the new testing strategy, priority for publicly funded testing is given to those who are more at risk of being exposed to COVID-19 because of where they work or where they have been or are close contacts of a case. Additional testing at the border will be undertaken to mitigate risk including:
    - surveillance testing of these border workforce groups
    - testing international travellers twice while in managed isolation facilities
    - testing some quarantine exempt people (such as air crew)
    - regular health checks of border-facing workers (for example customs, biosecurity, immigration or aviation security staff at airports) and staff in managed isolation facilities and testing those who have symptoms consistent with COVID-19.
- Furthermore, those with a higher index of suspicion for COVID-19 will be required to be tested and those with clinical symptoms consistent with COVID-19 will be tested based on clinical assessment.
- While we have no current evidence of community transmission of COVID-19, it is important that testing focuses on those most likely to have COVID-19. s 9(2)(f)(iv) [redacted] Those considered high risk without symptoms will also be required to have a test for COVID-19.

CBACS/Swabbing facilities

- DHBs and PHUs have done significant testing over the last few weeks of both symptomatic and asymptomatic individuals (mainly in facilities – day three and 12 guests).

Laboratory capacity and supply chain

- Success in managing the global demands on limited lab supplies was achieved by growing the use of open platforms to reduce reliance on proprietary products.
- The second part of the testing strategy was to scale up the capacity of the existing testing labs, with a clear focus on quality results. The laboratories have trained and utilised staff from disciplines other than molecular biology within the laboratory; and collaborated with universities and other molecular biology laboratories to utilise their resources.
- All newly commissioned molecular biology testing labs have been assessed by IANZ and confirmed as meeting the required quality standard.
- The laboratories have been working together as a national network in a way that they have not done before. This collaboration has involved sharing of ideas, reagents, and capacity.
- All testing in NZ utilises laboratory-based PCR methodology. This includes a limited volume of testing using Rapid-PCR testing platforms.
- s 9(2)(f)(iv) [redacted]

Border Controls

Importation of COVID-19 from overseas is the main source of new cases in New Zealand. Border restrictions are regularly reviewed to ensure risks from infected people entering New Zealand are managed.

Key messages

- Only New Zealand residents and citizens (and children and partners) are permitted to enter New Zealand, with some exceptions e.g. essential health workers, humanitarian workers etc.
- This includes the Realm countries (the Cook Islands, Niue, Tokelau), Australian citizens and permanent residents ordinarily resident in New Zealand, airline and marine crew.
- Every traveller arriving in to New Zealand on a flight which departs from another country:
    - is disembarked in small groups and met by officials at the gate
    - is not allowed to connect to a domestic flight
    - is screened for COVID-19 on arrival: they must answer questions about potential exposures, COVID-19 testing, symptoms and are given a temperature check
    - **if symptomatic on arrival**, will be tested and placed in a quarantine facility for 14 days
    - **if not symptomatic on arrival**, will be placed in an approved managed isolation facility for 14 days
    - are able to leave a facility at the end of the 14 days and travel to their final destination, provided they pass a final health check. They will also be tested for COVID-19 on or around days three and 12 of their stay in managed isolation.

- A very small number of people will be eligible for exemption from managed isolation. From 17 June 2020, **compassionate leave exemptions were suspended**. Legal guardians can apply to join unaccompanied minors in managed facilities.
    - if an exemption is granted, the person must complete their 14-day self-isolation at home at an approved location.

- Foreign-flagged vessels (including yachts and pleasure craft) are prohibited from entering New Zealand (land, ports and territorial sea (except for innocent passage)), unless they are specifically exempted.

Issues or risks

- Aircraft pilots, flight crew members, maritime crew (immediately transferring to a vessel), and medical attendants assisting with medical air transfers are exempted from 14 days of managed isolation or quarantine if they follow the Ministry of Health requirements.

Aircrew

- Aircrew who live in New Zealand and who remain airside or do not stay overnight when overseas are low risk and have no additional requirements
    - Aircrew who leave the airport when overseas must wear PPE, use private transport, and must self-isolate in their hotel (except for essential trips when they must wear PPE).

- Overseas based aircrew must stay in a managed facility or equivalent while in New Zealand.

Marine crew

- Marine crew arriving by air to join a vessel are to travel immediately and directly by private transport to the vessel where they must complete 14 days of self-isolation.
- Marine crew arriving by sea must self-isolate on the vessel for 14 days since they departed the overseas port OR took on new crew. Shore leave is not permitted during the self-isolation period.
- If a marine crew needs to depart a vessel before 14 days have passed, they must isolate until 14 days from the last day of possible exposure to a case. The vessel (or employer) will need to meet the costs of isolation.

Review of border controls

The COVID-19 Public Health Response (Maritime Border) Order 2020 was recently made to strengthen maritime border controls to further mitigate the risks from COVID-19 entering New Zealand via the maritime pathway, including extending the ban on cruise vessels and extending restrictions on maritime crew.

- s 9(2)(f)(iv) [redacted]
- s 9(2)(f)(iv) [redacted]

Managed Isolation and Quarantine

Managed isolation and quarantine of arrivals into New Zealand remains the mainstay and most effective method of preventing transmission of COVID-19 in the community. Mandatory isolation for 14 days, with symptom checking and testing provides the opportunity to identify cases of COVID-19 in travellers who may be have been infected in their country of origin, or in transit. Testing of those in managed isolation and quarantine is performed at least twice, regardless of the nature of symptoms in the traveller (aka the traveller will be tested even if they are symptom-free).

Managed isolation and quarantine is led by the All-Of-Government Response under Air Commodore Darren Webb. The Ministry of Health has a responsibility for the health component of managed isolation and quarantine and coordinates the provision of health services in the facilities.

The requirement for managed isolation and quarantine for those arriving in New Zealand is underpinned by an order under section 70(1)(e), (ea), and (f), of the Health Act 1956 in which the Director-General of Health acting as a Medical Officer of Health for all districts of New Zealand has required medical examination, testing, isolation, and quarantining of all persons arriving in New Zealand other than excluded arrivals.

Further information on the specific work areas in managed isolation and quarantine are detailed below.

Key messages

- While the risk of exposure to COVID-19 and transmission in the New Zealand community is very low, COVID-19 is still uncontrolled overseas.
- Strict border controls will remain under Alert Level 1 to prevent new cases entering the country.
- Since 11:59pm on 9 April, when the managed isolation regime was implemented, we have had more than 21,000 people stay in a managed isolation or quarantine facility.
- Our border measures are effective – we have caught 56 cases at our border (35 prior to routine testing being introduced) and we have not had COVID-19 transmitted to anyone in New Zealand as a result of a case at a managed isolation facility to date.
- From 9 June 2020, we began testing guests in facilities around day 12, and from 16 June began testing people around day 3 of their stay to ensure we are catching imported cases of COVID-19.
- No one can now leave a managed isolation facility, for any reason, without returning a negative COVID-19 result to assure the Director-General of Health that they present a low risk to the community.
- More than 6,000 people have had tests completed at managed isolation facilities in Auckland since 9 June 2020.
- We have completed a quality improvement review of facilities in Auckland, with a set of recommendations (covering both health and general operations within facilities). The final of this report is due 6 July 2020.
- Health services are delivered in the main via DHBs except in Auckland, where Counties Manukau DHB has undertaken to deliver these services from 1 August 2020.

Upcoming milestones

A new system has come online last week, which will capture passenger information at the border which will then be linked to NHI numbers so their information can be tracked through the system. This will include information on facility locations and test dates and results.

Health Services into Managed Isolation and Quarantine

Current state

There are a full range of Standard Operating Procedures (SOPs) in place in the Auckland facilities, which we are currently adapting as a national set of SOPs for other DHBs.

With respect to the services expected and required from health providers, a minimum set of service components exist. These include the provision of the following:

- Provide a comprehensive health assessment on arrival, including a mental health and alcohol and drug assessment.
- Provide a daily health assessment (COVID-19 symptom check) service for all guests at managed isolation and quarantine facilities.
- Undertake a COVID-19 swab for all residents on around day three and 12 of their isolation
- Provide immediate primary health care services as required.
- Provide access to allied health care services for any immediate needs.
- Ensure a mental health care pathway and immediate support system is provided.
- Enforce protocols to ensure that cases of COVID-19 are identified, contained and referred to appropriate health facilities.
- Ensure strong clinical governance (including quality and risk management practices) and health and safety protocols are in place to meet the nationally determined standards.
- Provide all partner agencies with advice to ensure health and safety plans and protocols for staff management and safety reflect best practice.
- Maintain engagement with key stakeholders - health care providers, Regional Isolation and Quarantine (RIQ), DHB, Public Health Units and Ministry of Health.
- Ensure welfare and wellness needs are catered for.
- Integrate into Public Health Unit services for case investigation and contact tracing.
- Integrate guest and testing information into the National Contact Tracing System (as it is stood up for isolation and quarantine).
- Maintain reporting requirements.
- Follow national Ministry of Health policy and guidance, ensuring any required changes are discussed and agreed with the Ministry of Health.

Issues or risks

- s 9(2)(g)(i) [redacted] Supporting health delivery in small more rural regions also has a fundamental impact on the operation of health services generally.

Exemptions

While the Director-General of Health issued an order under Section 70 of the Health Act 1956 to require those arriving to New Zealand to undertake 14 days of managed isolation or quarantine on arrival, there are certain conditions which, when assessed against a risk matrix, can gain an individual/s an exemption from this order. These conditions are regularly reviewed in relation to the alert levels and public health landscape.

The Ministry of Health's Managed Isolation Exemptions (MIE) team is responsible for receiving, assessing and making decisions in response to applications for exemptions from managed isolation. The MIE team's internal process starts when they receive an application through to an application being granted or declined.

The end to end 'macro' process for all exemptions, from an application being filled out by an applicant, through to the subject person leaving managed isolation involves various stakeholders including Ministry of Health functions, facilities, border, health care facilities and other government agencies.

Exemptions from managed isolation are categorised into different areas; Compassionate, Medical, Medivac and Transit. While compassionate exemptions are currently suspended, medical, medivac and transit exemptions are still being approved as appropriate albeit it with clear testing, travel and self-isolation plans.

Current state

To date, the MIE team have received 1,794 applications and other requests (most of the other requests are requests to join MI). Of these 388 exemption applications have been approved and 746 exemption applications have been declined. The remainder are in progress or not progressed (application withdrawn or no further correspondence received).

Breakdown of approvals

- 203 Compassionate exemptions
- 79 Medical/needs that can't be met in the facilities
- 54 Transits
- 44 Medivacs
- 4 Extradition
- 4 Critical Worker

Breakdown of declines

- 374 compassionate
- 349 medical and other needs
- 6 transits
- 1 medivac
- 2 extradition
- 8 critical worker

Medical exemptions can include those who have mental health needs (the majority are these), highly complex medical needs and palliative care requirements. They are assessed by an external organisation as to their health needs and the facility then has to sign off to say whether their needs can be met or not on site.

Transit exemptions are for those that are only moving through New Zealand and who stay in MI less than 14 days to transit on to a different destination. For those who are in MI less than 72 hours, they do not require a test and can transit out of the country with an approved exemption.

Medivacs are arranged with air ambulance and a receiving health care provider (DHB or private health care facility) for acute health care needs. The patient's support person has to stay in MI unless the patient is a minor and then the parent can join the patient in hospital. There are strict guidelines for PPE and social distancing protocols to ensure the receiving organisation mitigates the risk.

For all of the above scenarios we require detailed testing, transport and self isolation plans which are signed off and monitored.

Compassionate exemptions

Exemption from managed isolation on compassionate grounds are suspended temporarily. s 9(2)(h) [redacted]

On 16 June, the Government suspended all compassionate exemptions from managed isolation, with the view that they would be reinstated once the Government had confidence that the system was appropriately ready. Compassionate exemptions include scenarios such as leaving to grieve with family and leaving to see a dying loved one. In previous months we have given compassionate exemptions to attend funerals/tangihanga, but these are currently suspended due to the relaxing of community restriction (and therefore numbers attending these events).

An action plan to improve the end to end process has been developed by Health/AOG colleagues with a goal of 'reinstating' compassionate exemptions on 13 July 2020.

Areas for improvement

- A number of areas are underway to improve the process for managed isolation exemptions, including implementation of an electronic solution for the application process, updating the online application form including consent for sharing information and adherence to compliance plan, updates to the testing processes, processes for sharing of information across agencies including transparency of decision making points and progress and development of a robust compliance model to ensure applicants meeting requirements for self-isolation and understanding escalation should requirements not be met.

Quarantine Policy and Regulation

A report back to Cabinet is required in July 2020 on the regulatory model for managed isolation and quarantine. This report back will be in conjunction with the Minister of Housing who will be responsible for the cost recovery regime for managed isolation and quarantine.

s 9(2)(f)(iv) [redacted]

s 9(2)(f)(iv) [redacted]

Key messages

The Regulatory model regime for managed isolation and quarantine would:

- Allow multiple agencies and/or businesses to establish facilities.
- Set requirements that facilities must meet, using existing instruments to the fullest potential.
- Set requirements for facilities will be epidemiologically and clinically sound.
- Ensure assurance measures are being considered such as pre-approvals, audits, and enforcement options using exiting instruments to the fullest potential.

Trends

- The number of people arriving in New Zealand is expected to rise, as the categories of people who can enter New Zealand widens in support of events, educational organisations, businesses and industry sectors.

Issue or risks

- New Zealand has moved to Alert Level 1 in an environment of increasing confidence that COVID-19 is not circulating in the wider population. At Alert Level 1, the re-introduction of COVID-19 to the population is likely to support further transmission. In this environment, international arrivals to New Zealand are the main source of risk for new COVID-19 infections.
- Internationally, there are community outbreaks of COVID-19 in some countries and regions and increasing moves to lower community infection prevention and control measures.

Health Supply Chain

In response to the COVID-19 pandemic, additional funding was provided to the Public Health Services purchasing operating appropriation to support publicly-funded healthcare providers and essential emergency services in their provision of healthcare. The appropriation totals are:

- $350 million in relation to the supply of Personal Protective Equipment (PPE)
- $42 million to support lab testing
- $10 million to provide ventilators
- $31.5 million ICU capacity for ventilated and unventilated capacity.

Usual DHB spending on PPE is approx. $17-19 million per annum to provide business as usual services in a non-pandemic context.

Key messages

- Despite all the challenges that were faced, we did not run out of critical supplies in New Zealand.
- There are no known cases of infection caused by a lack of PPE. There were cases of poor use and some people felt they did not get PPE when they wanted it, but the supply, in line with Infection Prevention and Control guidance, did not result in harm.
- Supply of testing consumables was not a constraint in the determination of the testing strategy.
- Development of a procurement strategy for ongoing PPE supply is underway.
- We will shortly be providing our response to the Office of the Auditor-General (OAG) report titled *Ministry of Health: Management of personal protective equipment in response to COVID-19*.

Management of supply chain

- To eliminate procurement competition for critical items (PPE, ventilators and testing consumables) between DHBs and shared service agencies, the Ministry has established an integrated Health Supply Chain function to oversee the procurement and supply of key PPE items, manage lab testing capacity and provide quality assurance of PPE and ventilators. The group includes regional procurement leads from individual DHBs, Health Partnerships and PHARMAC (national) and HealthSource (Northern Region).
- The group allows for national and centralised coordination and distributed workload for sourcing and procuring significantly higher volumes of critical items than previous arrangements.

Provision of PPE nationally

- The Ministry has set up and managed a national Health Supply Chain to source, procure and test key specified PPE, coordinate lab testing capacity and testing supplies and ventilators.
- DHBs have been distributing PPE to publicly-funded healthcare providers in their regions.
- National health expenditure for PPE is split across three streams:
    - National Pandemic Reserve – this has been maintained at a level that provides three months' supply of stock - enough coverage to support emergency critical health needs in extraordinary circumstances
    - Health sector
    - Non-health sectors.

- The Ministry has not imported or procured any PPE specifically for entities or sectors outside of public health and disability providers. Limited supply of PPE has been provided to areas outside of public health and disability providers, where a level of exposure to COVID-19 has been anticipated in the course of services provided (e.g. Managed Isolation Facilities, Air NZ, Ministry of Social Development, Fire and Emergency New Zealand) and to a limited number of private businesses, which were considered essential services providing emergency work under Alert Level 4 and Alert Level 3 (e.g. plumbers).
- s 9(2)(f)(iv) [redacted]
- Non-government entities/sectors can import/procure their own PPE, however, they do require advice and guidance on use, which is made available via the Ministry's communication channels.

Issues or risks

- On 17 June, officials received the final report by the Auditor-General into the management of PPE over the March and April period. Officials welcomed the review, accepted the recommendations and are currently working through their response to the report.
- Obsolescence of pandemic stocks needs to be carefully thought through. For example, 20 years of business as usual stock may only last a month in a pandemic. We are working on the future national reserve stock settings to ensure that we minimise the risk of obsolescence as much as possible.
- There are continuing concerns regarding the reliability and quality of manufacturers and the international supply chain, and inflation in cost of internationally sourced products and materials. We are continuing to assess developments in global supply chains and ensure that we are responding to minimise any risk to the NZ health supply chain. New quality control checks have been implemented prior to PPE being released for distribution.

Upcoming milestones

- Formalisation of expectations for a "reserves target" (product scope and quantity) and replenish national reserves by the end of July 2020.
- Development and use of an integrated demand forecast model for all Alert levels, that links expected incidence of COVID-19 to lab testing, PPE, ventilator demand, and other important supply chain categories by the end of August 2020.
- Development of a procurement strategy (including a sourcing plan and product catalogue) to support PPE procurement for the future by the end of July 2020.
- s 9(2)(f)(iv) [redacted]
- Development of the ventilator allocation plan and oxygen infrastructure plan by the end of August 2020.

Contact Tracing (Rapid Audit and Rapid Review)

Contact tracing is a fundamental component in the response to eliminating COVID-19 in Aotearoa. A comprehensive contact tracing system effectively allows the Ministry to 'vaccinate until a vaccine becomes available' through ensuring rapid identification and isolation of new cases.

On 9 April 2020, Dr Ayesha Verrall undertook a rapid audit which sets out recommendations to strengthen the contact tracing response to COVID-19. In April 2020 the Ministry contracted Allen+Clarke to undertake a rapid report of PHU COVID-19 contact tracing to provide the Ministry assurance of how well PHUs are positioned for contact tracing and the level of national consistency in operating models.

The Contact Tracing Assurance Committee (CTAC) was established under section 11 of the New Zealand Health and Disability Act 2000 to provide the Minister of Health with independent advice on the Ministry's improvements to the contact tracing system recommended in Dr Verrall's report.

Key messages

- The Ministry supports the recommendations from Dr Verrall's 9 April 2020 Rapid Audit of Contact Tracing for COVID-19 in New Zealand and has made significant progress on implementing all the recommendations. The Ministry is also progressing recommendations from the 8 May 2020 Public Health Unit Contact Tracing 'Deep Dive' Rapid Report undertaken by Allen+Clarke.
- The Ministry has addressed all eight recommendations from Dr Verrall's audit and eight of the nine recommendations in the Allen+Clarke Report. The Ministry is progressing the remaining recommendation:

  The Ministry will work with PHUs to share learning from any reviews of the initial response that they undertake, including the critical roles and FTE requirements (Rapid Report Recommendation 3) that are of value to the sector as part of Quality Improvement.

Upcoming milestones

Capacity Uplift plans will be implemented by PHUs by early July.

National Contact Tracing Solution

To support the Ministry's contact tracing work an IT system (the National Contact Tracing Solution (NCTS)) was rapidly developed and stood up on 6 April 2020. The NCTS is the national repository of data about individuals who have been identified as confirmed or probable COVID-19 cases and their close contacts. This information is recorded by and visible to staff across the contact tracing services.

The NCTS provides a centralised national database across all Public Health Units (PHUs) that allows the collation and monitoring of end-to-end performance for contact tracing. The PHUs are all providing data to the Ministry that is integrated into the NCTS to enable a singular view of all cases. This provides the mechanism to monitor indicators nationally and make improvements where required to ensure that the contract tracing service is 'gold standard'.

Key messages

- The NCTS is a flexible modern system that can be scaled and adapted as the circumstances require.
- The NCTS went live on 6 April 2020.
- To date 11 of 12 PHUs have onboarded with the NCTS and have access to the full NCTS functionality.
- The remaining PHU is on track to onboard by 31 July and a direct data feed has been built to enable monitoring of performance and integration of Close Contact data.
- The Ministry's external contract providers also have access, which supports the end-to-end view of contact tracing and nationally consistent contact tracing IT infrastructure.

Upcoming milestones

Future developments of the NCTS focus on the supporting the health response at borders including:

- The interim tactical solution which was deployed on Monday 29 June for the Border case management.
- Exemption application management is due for release on 9 July
- A long-term solution for borders and MIQ, including integration with wider border system is due for release at the end of July.

s 9(2)(f)(iv) [redacted]

Contact Tracing Capacity

The 12 Public Health Units (PHUs) are accountable for management of infectious notifiable diseases, including COVID-19. The National Close Contact Service (NCCS) was established by the Ministry on 24 March 2020 to support the PHUs to manage the contact tracing process. The PHUs delegate Close Contacts to the NCCS or may choose to manage the Close Contacts themselves.

The National Contact Tracing Preparedness Plan forms the basis for the development of a nationally coordinated contact tracing service. The approach in the preparedness plan recognises that the public health expertise resides within PHUs and that localised knowledge and relationships are key to delivering an effective service.

To date, one-off funding of $15 million has been provided to PHUs to cover COVID-19 costs and increase contact tracing capacity and capability. A second tranche of one-off COVID-19 funding of $15 million will be allocated to the PHUs, from 1 July 2020, to build on the initial funding allocation and increase capacity and capability to support the ongoing COVID-19 public health response.

Key messages

- Since the NCCS was stood up in March 2020, significant improvements have been made to establish national contact tracing infrastructure for COVID-19. The Ministry continues to work closely with PHUs on standardised national processes, policies and training material for contact tracing.
- Capacity and capability to manage an increase in COVID-19 cases up to 1,000 cases per day is being established though:
    - Ready Capacity: PHU management of up to 350 COVID-19 cases per day
    - Surge Capacity: PHU management of up to 500 COVID-19 cases per day
    - Extended Capacity: NCCS and PHU management of up to 1,000 COVID-19 cases per day
    - Close Contact Call Capacity: NCCS Ready capacity of 10,000 calls with scalable capacity of up to 20,000 calls per day.
- The Ministry is working with DHBs and PHUs to co-design an integrated public health model of care for Māori. DHBs and PHUs are expected to partner with whānau, hapu, iwi and Māori organisations and communities to design, develop and deliver COVID-19 services for Māori, including contact tracing services.
- DHBs and PHUs are also expected to integrate with All of Government services (e.g. health, education, social development, Māori development and Whānau Ora agencies) to maximise their ability to contact trace Māori by using a wide range of Māori networks.

The NCCS has the ability to assign callers with particular language skills and match this to the need of the person who is a close contact. The NCCS continue to engage with the contracted providers to ensure that they undertake the necessary cultural competency training to meet the needs of all communities. They are also required to ensure they have a diversity of workforce to meet the language and cultural needs of the persons.

Issues or risks

The current low volume of cases and close contacts create challenges in maintaining a skilled workforce, making it difficult to activate large scale contact tracing at short notice. This is mitigated by

the NCCS and PHUs ensuring staff are maintaining competency in systems and processes and building capacity through a mix of ready and trained workforce who can be available at short notice for surge capacity.

Upcoming milestones

- PHUs will have ready and surge capacity and plans for accessing surge capacity in place by the end of July.
- The NCCS will establish additional scalable call capacity for close contacts for extended capacity in August 2020.

Health and Disability Resurgence Action Plan

Key messages

While continuing to focus on recovery and the ongoing implementation the elimination strategy, the Ministry is also leading preparations for a possible second wave of infections.

This will provide a framework for readiness and response for the wider health and disability system, with a particular emphasis on operational planning by the Ministry, DHBs and public health units. The draft Plan sets out three high level objectives: first to **prevent** a second wave, primarily by giving effect to the elimination strategy; second to **plan for** any resurgence, and; thirdly to **respond** to any second wave.

The Plan outlines a series of high-level actions to inform preparedness and response activities. Based on experience to date, it also identifies some key themes that must be addressed in all stages of planning and response. These include equity, the use of scientific principles, the importance of infection prevention and control, public communications and close monitoring and management of personal protective equipment. The Plan has been developed in conjunction with and is closely aligned to the DPMC all of government re-escalation plan.

The Plan includes several worked examples to illustrate how the different actions and actors work together and how roles may change as a second wave progresses.

Upcoming milestones

Multistage sign-out of this document is expected to begin the week of 6 July 2020.

s 9(2)(g)(i)

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