MINISTRY OF HEALTH
MANATŪ HAUORA

Health Report

Current status and future sustainability of the MIQF health workforce

Date due to MO:	N/A	**Action required by:**	N/A
Security level:	IN CONFIDENCE	**Health Report number:**	20210510
To:	Hon Chris Hipkins, Minister for COVID-19 Response		

Contact for telephone discussion

Name	Position	Telephone
Sue Gordon	Deputy Chief Executive, COVID-19 Health System Response	s 9(2)(a)
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Minister's office to complete:

☐ Approved ☐ Decline ☐ Noted

☐ Needs change ☐ Seen ☐ Overtaken by events

☐ See Minister's Notes ☐ Withdrawn

Comment:

Current status and future sustainability of the MIQF health workforce

Purpose of report

1. This report provides you with an update on the Managed Isolation and Quarantine Facilities (MIQF) health workforce. Specifically, it identifies what is known about:
   a. current workforce capacity and utilisation
   b. current demand on the MIQF health workforce
   c. risks and challenges to sustaining an adequate MIQF health workforce until it is no longer required
   d. current funding of the MIQF health workforce
   e. projections regarding future demand and capacity requirements.
2. The report details strategies for identified opportunities and risks. This includes actions and timeframes to ensure that workforce capacity will continue to match, and is responsive and resilient to, evolving and variable demand.

Summary

3. The MIQF workforce plays a vital and effective role in supporting the government's interagency COVID-19 strategy. There are 32 facilities across five regions involving six DHBs, with nearly two thirds of MIQF accommodation capacity in the Auckland region.
4. Models of staffing and service delivery were established in each region to meet the requirements of the MIQF Operations Framework. There is variation in workforce models including skill-mix, delegation of activities and deployment.
5. The workforce is delivering a high-quality service and has needed to sustain a high level of effort for almost a year. There are signs of fatigue and stress, and reports of community stigma and discrimination that need to be addressed.
6. Workload demands are high and have intensified due to policy changes resulting in increased testing requirements, more stringent Infection Prevention and Control (IPC) policies, and changes in the healthcare requirements of returnees.
7. Several regions are having trouble recruiting and retaining a workforce sufficient to match their current models of staffing and service delivery. The health sector does not have spare workforce capacity and the vaccination workforce is drawing from the same pool.
8. DHBs receive funding from the Ministry of Health (the Ministry) for their involvement in MIQF. The current funding model was based on the projected costs and will require review once sufficient data are available to support a detailed analysis of actual spend and variation by facility and region.

9. It is expected that there will be a need for this workforce into 2022. Management of the workforce will need to be flexible to respond to ongoing changes in demand. Consideration will also need to be given to how the workforce will be systematically 'stood-down' once no longer required.

10. Failure to support and sustain an adequate MIQF health workforce carries significant risks:

    a. not being able to support current rates of returnees

    b. not being able to sustain the quality of service

    c. negative workforce impacts.

11. The Ministry, in collaboration with MBIE and the DHBs, has a range of strategies and actions to support the workforce, ensure productive investment, and to sustain a workforce of sufficient size and capability to meet the ongoing need. Specifically, work is being undertaken to:

    a. identify workload demand and match this with an appropriate workforce.

    b. relieve workload pressure through improving IT, optimising workload management practices, and ongoing recruitment strategies.

    c. identify ways to support workforce wellbeing through targeted actions.

Recommendations

We recommend you:

a)	**Note** the report.	**Yes/No**
b)	**Note** that this report and the action items form part of the cross-government work programme that is underway to reduce and mitigate the risk of COVID-19 transmission across the MIQ system (Health Report 20210294).	**Yes/No**

Sue Gordon
Deputy Chief Executive,
COVID-19 Health Systems Response
Date: 11/3/21

Hon Chris Hipkins
Minister for COVID-19 Response
Date:

Current status and future sustainability of the MIQF health workforce

Background / context

12. MIQ facilities were initially established in Auckland by the Ministry in March 2020, with agency staff resourcing the health workforce component. As additional facilities were established in other regions, DHBs assumed responsibility, including staffing. In July 2020, the Auckland region, led by Counties Manukau Health (CMH) transitioned from agency to predominantly DHB staffing. Recruiting a dedicated workforce drawn from the existing DHB workforce has posed significant recruitment challenges.

13. The MIQF health workforce operates across five regions, servicing 27 Manage Isolation Facilities, four dual isolation/quarantine facilities and one dedicated quarantine facility. The facilities were set up with urgency and are not purpose-designed for the delivery of health care. Criteria for an acceptable facility were largely based around operational requirements to enable fast and effective set up, while managing public health and security risks and ensuring the wellbeing of returnees.

14. The DHBs provide excellent oversight and operational management and maintain good inter-agency collaboration. The clinical work is supported by stable and experienced DHB leadership teams who manage the health operations in each region.

15. The MIQF health workforce provide comprehensive support to meet the health needs of returnees during isolation/quarantine, undertake returnee and staff health checks and testing, and provide IPC support, training and advice to the wider MIQF workforce.

16. While all facilities operate under the requirements of the MIQF Operations Framework, the DHBs in each region have developed health-workforce solutions resulting in variation in the composition and utilisation of the workforce.

17. Since the establishment of the facilities, there has been significant evolution in the profile and associated complexity of health needs of returnees, as well as expansion of the requirements relating to the wider MIQF workforce (for example, policy changes around staff / returnee testing and IPC training). This has resulted in increasing demand being placed on the health workforce.

18. The workforce has proven flexible and resilient to shifting demands and pressures. Teams have been able to sustain a high-quality service in a context of constant change and in challenging conditions. Staff have responded to the need to rapidly evolve practice in response to emergent knowledge about the virus and the risks it poses.

19. We appreciate the level of commitment from staff, and how they have adapted to the challenges they have faced. We know that staff have been working under trying conditions for a significant length of time, including experiencing discrimination in the community.

20. Turnover, recruitment and retention of staff have been identified as a significant challenge by several DHBs. It is likely that the demands on the MIQF workforce will continue to evolve. It is expected that there will be a requirement to maintain MIQFs into 2022.

21. In order to continue to provide a quality service to returnees and to effectively manage the associated public health risk, there are specific target areas that would support the health workforce to be successful:

    a. providing greater guidance about optimal models of care (the make-up of the workforce and how it is utilised) would support productivity and matching workforce capacity to demand

    b. multi-agency actions targeted at workforce wellbeing and recruitment would support existing staff and ensure that the workforce is able to be sustained until no longer required

    c. strategies to forecast, as accurately as possible, the short and medium term demand on the workforce would support the ability to proactively ensure that the workforce is able to meet evolving requirements

    d. considering whether there is a case for special remuneration or benefits for this workforce with all-of-government support given the unique features of this work.

Current workforce profile (about the workforce)

Workforce capacity and deployment

22. Current data on the MIQF workforce shows significant differences between regions relating to:

    a. the size of regional workforces relative to the percentage of total returnees

    b. the occupational make-up of nursing-led teams, for example some regions are fully staffed with Registered Nurses (RNs) while others employ a significant number of Enrolled Nurses (ENs) and Health Care Assistants (HCAs)

    c. the scope of roles and delegation of activities (the model of care)

    d. the amount and type of specialist IPC support provided

    e. provision of primary care support and whether the cost is covered by returnees

    f. provision of mental health and addiction services

    g. staff vacancies

    h. variation in regional scale of the service with close to two-thirds of the hotel capacity situated in Auckland.

MIQF Nursing Team Workforce – Current February 2021						
	Nurse Manager/CNM	Nurse Coord.	RN	EN	HCA	IPC
AUCKLAND						
Budgeted FTE	12.0		160.0		55.0	3.0
Current FTE	12.0		88.6	5.2	43.1	3.0
Surplus/Deficit			-71.4		-11.9	
Notes: Agency used to back-fill vacancies						
HAMILTON						
Budgeted FTE	1.0	4.0	22.8	1.7	0.8	0.8
Current FTE	1.0	3.0	11.6	1.7	1.0	1.0
Surplus/Deficit		-1.0	-11.2		+0.2	+0.2
Notes: Agency used to back-fill up to 3.0 FTE						
ROTORUA						
Budgeted FTE	1.4		28.6		10.0	0.6
Current FTE	1.4		23.9		5.6	0.6
Surplus/Deficit			-4.7		-4.6	
Notes: Agency used to back-fill vacancies. Currently developing a budget for FTE as transitioning to a business unit model.						
WELLINGTON						
Budgeted FTE	1.0		16.6			
Current FTE	1.0		14.0			
Surplus/Deficit			-1.4			
Notes: No agency use. IPC provided by existing DHB services. Current vacancies expected to be filled by the end of March.						
CHRISTCHURCH						
Budgeted FTE	3.0		89.96		14.66	
Current FTE	3.0		80.95		0.0	
Surplus/Deficit			-9.0		14.66	
Notes: No agency use. IPC provided by existing DHB services.						

23. Analysis of the significance of differences is complicated by variation in models of service delivery, the level of input from other roles/services, and differences in the health profile of different returnee groups. We are devising a standardised format for the DHBs to use in reporting workforce numbers. This is due to be in place by 16 March 2021.

24. In Auckland, scheduling of shifts is based around the flow of returnees, whereas other regions have a more standardised approach to staff numbers and rosters. Meeting minimum roster requirements at times relies on the goodwill of staff to work extra time including, overtime, and double and extra shifts. While this method is satisfactory to fill short term gaps, there are longer term risks involved in continuing to rely on this practice.

25. Auckland, Hamilton and Rotorua use agency staff to top up to their required rostered staff numbers, while Wellington and Christchurch are staffed solely by the DHB. Auckland, Hamilton, and Christchurch are experiencing recruitment issues to sustain their current model of care, while Rotorua and Wellington are currently stable.

26. Variation in models of care (skill-mix and how work is organised and conducted) suggests that there is potential for productivity and efficiency gain. Some models are more resource intensive than others, particularly with regards to the scope of the RN role. In Auckland and Rotorua for example, HCAs are used for swabbing, whereas other regions use RNs. We are encouraging other regions to adopt this practice as it may assist with staff capacity.

Opportunities and risk mitigation

27. The Ministry is currently reviewing models of care across facilities as a project led by the Office of the Chief Nurse, with input from the MIQF Nurse Leaders, Director Health Services (MBIE), and the MIQ Operations team. It is expected that this work will assist with planning, allocation of workload, staff well-being, risk reduction, staff retention, productivity, and consistency across the MIQFs. A workload analysis will be undertaken to provide guidance to MIQFs on:

    a. matching the workload demand with appropriately qualified and trained staff
    b. fitting the work to the scope of the registered and non-registered workforce including appropriate delegation
    c. calculating skill-mix and the total FTE requirement
    d. standards for and monitoring of MIQF health workforce capacity/sufficiency.

    The project is targeted for completion by May 2021.

28. A number of other actions are currently underway:

    a. a strategy to collect regular standardised national level data on MIQF health workforce size and vacancies will be implemented by 16 March 2021
    b. health workforce capacity / capability in relation to demand will be added to MBIE's risk register by 8 March 2021. This will ensure a sustained focus and ongoing active risk management
    c. advice is being provided to DHBs on options for recruitment of categories of workers other than RNs (such as HCAs), to relieve pressure on the RN workforce

d. Nurse Leads are being provided with support to get consistent policy guidance on staff who decline vaccination. This advice will be provided by 15 March 2021

Recruitment and employment models

29. Recruitment to the MIQF health staff draws largely from the current DHB workforce which has minimal 'spare' healthcare staff available, particularly RNs. The current policy of having a dedicated workforce constrains the income earning capacity for this group (i.e. nurses and healthcare assistants cannot work shifts in other settings) and this loss of potential is not compensated for.

30. Owing to the occupational health risks to staff, recruitment of staff is restricted to those categorised as low risk[1]. The low risk 'Category 1' prevents recruitment of people over 60, with any chronic health condition, high BMI or who are pregnant. This limits the pool from which to recruit. Until recently, Waikato was employing some Category 2 staff and are transitioning to a Category 1 workforce.

31. DHBs are reporting instances where MIQF staff are choosing to take roles as vaccinators. There are concerns that this will have a negative impact on the workforce (particularly in Auckland and Christchurch) as the vaccination programme rolls out nationally. Vaccinators could potentially be employed from categories other than Category 1 and this needs consideration and discussion.

32. Deployment of staff who decline vaccination and the workforce implications of this for health staffing and the ability to maintain current levels of service needs active discussion between the Ministry, MBIE and the DHBs.

33. Although all directly employed staff are covered by the DHB Nurses & Midwives Collective Employment Contract, there are differences in employment conditions across the regions:

    a. Auckland nurses have access to a higher pay scale and have been offered retention bonuses. This was a recruitment strategy to support the move from 100 percent agency staffing to predominantly DHB staffing.

    b. there is variation in the length of contracts offered to staff, with shorter term contracts risking staff leaving to take up more secure positions. The recent extension of funding through until the end of June 2022 now allows longer contract terms to be offered to staff.

Opportunities and risk mitigation

34. A range of potential strategies have been identified for further exploration including:

    a. engaging with DHBs nationwide around strategies to 'share the load' across all DHBs, through offering short-term deployments to MIQFs

[1] The tool for vulnerable workers was developed the national GM HR group in conjunction with the OCC Health Physicians group and the Clinical Advisory Group led by Dr Vanessa Thornton and involving an engagement process beginning March 2020 that included DHBs, health unions and clinical advisory groups. All DBH staff including MIQF staff should be covered by this approach.

b. explore the potential for bringing in nurses from overseas for specific contracts working within MIQFs

c. improving demand modelling in order to proactively recruit to evolving demand, (e.g. commencement of quarantine free travel zones with consequent higher needs returnees in MIQF)

d. engaging with DHBs around consistent employment strategies that attract healthcare workers, for example contracts that maximise the term of employment, consistent contractual conditions, and incentivised options

e. engaging in a whole of government approach to reward/compensate this workforce in ways that do not compromise national collective employment agreements.

Workforce wellbeing

35. Nurse leaders report that staff commitment is high, but that they are challenged by constantly changing workload and work practices. Short notice policy changes are resulting in change fatigue and impact workflow and workload. Workloads are reported to be consistently high, and where staff shortages are being experienced, impacts are compounded.

36. Many MIQF health staff have been working since March 2020, and there are reports of fatigue and burn out. Due to staff shortages in some regions, it is difficult to schedule leave for staff.

37. The work involves daily exposure to the risk of contracting COVID-19 due to the close contact required with returnees which adds stress, has social implications and restricts work opportunities as staff are unable to undertake secondary employment.

38. There are ongoing anecdotal reports of community discrimination towards border workers including housing discrimination, denial of access to community services including medical care, social stigma and isolation, inability to meet with vulnerable relatives and difficulties accessing education if not allowed on DHB sites.

Opportunities and risk mitigation

39. MBIE is currently recruiting and training staff health and safety representatives.

40. It is expected that there will be a roll out of planned maintenance on each hotel which would result in closure for a short time. This will provide an opportunity for staff to take leave.

41. The strategies outlined in paragraph 34 to address recruitment should help to relieve workload pressure and support retention.

42. There is a need to work with MBIE and DHBs to actively investigate ways to mitigate and reduce the discrimination being experienced by staff in the community. While some of this may be reduced by the positive media surrounding the introduction of vaccinations, nurse leaders have suggested further community campaigns, highlighting the important work of MIQFs staff.

Funding model

43. The Ministry has a commitment to funding the DHB's actual costs of delivering the health service in MIQFs. Initially DHBs are reimbursed at the rate of $40 per returnee per

night. DHBs send follow-up invoices to the Ministry based on actual spend. Detailed, quantifiable data on the cost per returnee and differences by region and facility are not currently available. These data will improve as data from 'wash-up' funding claims becomes available.

44. Some regions have accessed funding from the Temporary Accommodation Fund where issues relating to housing have been experienced (e.g. MIQF workers who are living with healthcare workers who work with vulnerable populations, landlord discrimination, or locality criteria). In addition, MBIE currently provides accommodation for nurses in Auckland who meet specific criteria (i.e. based on the location of their home or if they live with vulnerable people). This is not a long-term solution and is currently under review from MBIE.

Opportunities and risk mitigation

45. A needs and utilisation assessment of the Temporary Accommodation Fund is planned for March 2021 in collaboration with the Ministry's Workforce Team. The aim is to better understand the current and predicted need and to make recommendations about policy changes around qualifying for and accessing the fund.

46. A review of the actual costs associated with the MIQF healthcare workforce per returnee and by facility and region would be useful to better understand the funding requirement and to identify opportunities for increasing efficient spend in this area.

Workload demands on the MIQF health workforce (about the work)

47. The workload demands on the MIQF health workforce are complex and are driven by the requirement to meet the full range of health and well-being needs of returnees, managing the risk of transmission of COVID-19 through returnee and staff health checks and testing requirements, and other IPC activities including environmental monitoring and staff training.

48. Recently (since December 2020), there have been multiple policy changes that have increased the responsibilities of the MIQF health workforce. Some changes have resulted in time-limited workload 'surge', while others have had ongoing workload implications.

Patterns of returnees

49. Unpredictability in the numbers of returnees to New Zealand on any given day is a challenge for workforce planning and supply. Whilst, on average, there are around 400 arrivals per day, this number varies between 300 and 600.

50. A multitude of factors add to the complexity of allocating incoming flights to hotel sites and returnees to rooms. Not only do the capacity numbers vary by region, but there is also great complexity in ensuring maximum occupancy in the regional MIFs.

51. Moving to a cohort approach to filling hotels, and limitations on time out of rooms are being considered in order to limit returnees' contact at different stages in their isolation period. While this would allow for better IPC practices, it would cause additional stress on the health workforce, for example:

    a. increases the number of people who arrive and need to be tested at the same time within the hotels.

b. reduction in efficiency in undertaking daily health checks and testing if there are restrictions on the timing of when returnees can be out of their rooms.

Workload associated with returnees

52. In addition to the risk of arriving in New Zealand carrying COVID-19, returnees bring with them pre-existing and emergent physical, and mental health conditions along with a range of complex and often urgent social pressures. The workload is dynamic due to daily fluctuations in demand and the ongoing need to adjust to meet policy changes in response to new evidence about the management of COVID-19. Patient management systems are currently being implemented that will provide better clinical reporting and returnee data.

53. In many instances, the full scope of needs of returnees are not known until a health assessment takes place, shortly after arrival to an MIQF. This adds to management complexity, with some returnees requiring urgent medical and nursing input and coordination of services. There is anecdotal evidence from the facilities that more returnees are arriving in fragile health.

54. The scope of returnees has widened, with groups such as Recognised Seasonal Employees (RSEs) and refugees now arriving regularly. Both groups are higher needs and often require translators to convey information.

55. Increasingly, facilities are becoming more 'bespoke' to better meet the needs of particular categories or groups of returnees. In Auckland, the Waipuna Hotel has been set up to manage returnees with more complex medical and mental health needs. The SO Hotel caters for unaccompanied minors, and the Ramada Hotel accommodates deportees. Christchurch is more likely to cater for sporting groups.

56. Currently, the main tasks of the health workforce in relation to returnees are:

- undertaking daily health checks on returnees (in person at least once every second day)
- swabbing of returnees (at least twice during the returnee's isolation)
- responding to symptoms indicative of COVID-19
- managing any positive cases
- responding to existing and emergent physical and psycho-social health needs.

57. Policy changes introduced with minimal notice can exert significant changes on the daily routines of the health workforce. For example, from the 15 January 2021 the introduction of day 0/1 testing required testing to be completed within 24 hours of arrival from a high-risk country.

58. Upcoming policy changes being considered relating to reducing the risk of airborne transmission are likely to increase workload, for example if testing at returnee's doors becomes the default practice. The new requirement for regular health monitoring of returnees who are, if safe to do so, required to discontinue CPAP, will also require increased healthcare team time.

Workload associated with the MIQF workforce

59. The health workforce is responsible for undertaking health checks and COVID-19 testing for the whole MIQF workforce and providing training and support to all staff with IPC

protocols and practices. Regular NZDF and Police staff rotations, as well as general staff turnover means that the need for these activities is constantly high.

60. The implementation of N95/P2 particulate respirators for all health staff when within two meters of a confirmed or probable positive case temporarily impacted workload. Particulate respirators require fit testing to ensure maximum efficacy. On 18 December 2020 around 90 percent of the Health workforce were fit-tested for N95/ P2 particle respirators. On 22 December 2020 many of the masks were then recalled. This meant many staff needed to be re-fit tested.

61. In addition to swabbing, voluntary saliva testing for workers in quarantine and dual-use sites was introduced on 25 January 2021. Voluntary saliva testing has now commenced at dual use sites in Wellington and Christchurch. To date there has been very low uptake.

Other factors influencing workload

62. The need for stringent personal IPC practices add time and complexity to daily work. Ongoing facility risk assessment and monitoring are background requirements particularly for IPC specialists and RNs.

63. The facilities were not built for the purpose of isolation or quarantine. MBIE and the Ministry are currently undertaking a desktop review of the criteria for suitable MIQF. Aspects such as ventilation, appropriate areas for nurse's stations, swabbing areas, and returnees' entry and exit areas are in many cases not ideal and require extra time-consuming measures from health staff to ensure their own and others' safety.

Opportunities and risk mitigation

64. Improvements to IT systems are currently being introduced to streamline and reduce the work associated with data capture including a patient information system. The data will provide a better picture of healthcare needs that drive the model of care and staffing requirement.

65. A workload assessment tool developed by the office of the Deputy Director General of Public Health is currently being finalised as part of the model of care project. This will provide improved data capture of the work and the associated workload for the health workforce (time and resourcing). This information will be able to be used to support optimal staffing models and workload planning.

66. We will consider and respond to the MBIE facility review to identify opportunities to improve the environmental working conditions.

67. The Workforce team plans to meet with the New Zealand Nurses Organisation (NZNO) and senior DHB and Ministry officials to discuss concerns NZNO have raised about the working conditions within MIQ facilities.

68. The implications for workforce capacity and distribution relating to the needs of returnees and where they are placed across the entire MIQ system will be addressed as part of the cross-agency government work programme.

69. We note the recommendation in the independent review of the Pullman Hotel to develop a multidisciplinary clinical governance framework and network with local (MIQF), regional and national governance.

Projected future demand trends

Projected changes in numbers and distribution of returnees

70. Currently the demand for places in MIQF currently exceeds capacity. It is expected that over time, as the global pandemic resolves and quarantine free travel introduced, the demand for MIQFs will decrease. This decrease may be off-set by increases in categories of returnees such as RSE and other skilled workers.

71. There are unknowns about potential future policy decisions relating to the continuation of current facilities, or the establishment and location of any new facilities. Any changes would have significant workforce implications and maximum lead-in time would be required. There is no guarantee that a suitable local workforce could be produced or that existing staff would be prepared to relocate.

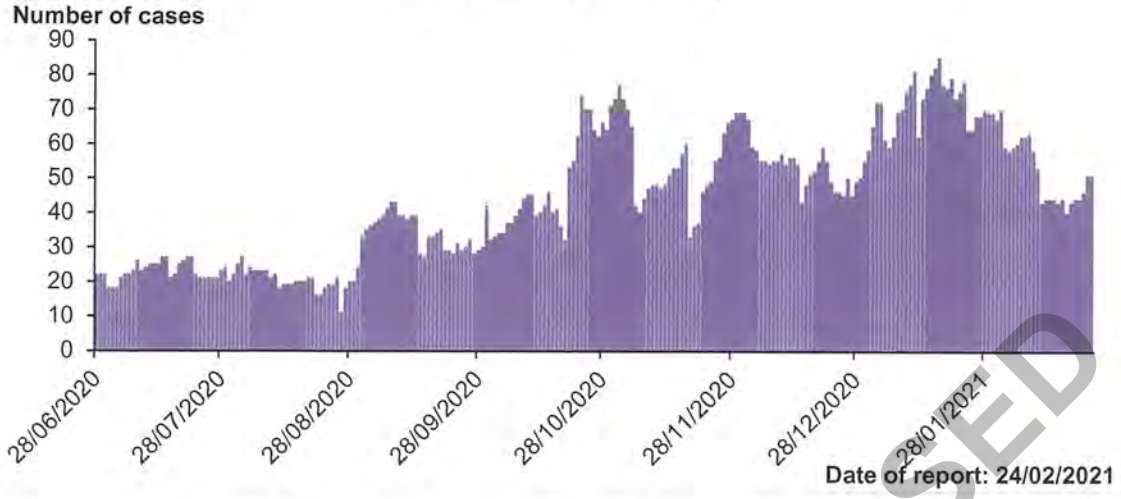
72. The introduction of quarantine free travel with Australia has the potential to further change the make-up of returnees, as many of the lower needs (and lower risk) returnees come from Australia. If MIQF continue to operate at the same capacity without Australians, this will challenge the capacity of the health staff. Depending on final policy decisions, quarantine free travel may also pose some changes in the way the MIQF are operated and could also mean additional health staff are required to undertake testing at the point of entry.

Projected changes in management of returnees

73. It is expected policies and the associated practices will continue to evolve as more is learnt about COVID-19. The workload implications of this are not predictable but are expected to increase workload in the short to medium term. Longer term, as world-wide vaccination rates increase, demand may decrease, however this remains speculative and will need to be monitored.

74. As shown below, the number of returnees testing positive for COVID-19 has shown a recent decline, likely to be a result of the introduction of pre-departure testing. The continuation of this trajectory is subject to the future course of the virus and vaccination regimes in other countries.

Daily active cases in MIQ



75. Predicting changes to the profile of returnees and their associated health requirements is challenging. Past experience suggests some upward trend in health requirements may continue but this is not certain.

Opportunities and risk mitigation

76. We will continue to incorporate and improve data modelling to support medium term workforce strategy and planning to allow maximum lead-in times to prepare the workforce and adapt policy and practice.

77. There is a medium-term need to consider how the workforce will be systematically 'stood-down' once no longer required. This will need to include supporting staff to transition to other parts of the health sector where possible.

Next steps

78. An update will be provided on progression of our action points by April 15, 2021.

ENDS.

Appendix 1

Summary of actions

Actions currently underway	**Start date**	**Completion date**
Introduction of a standardised format for DHBs to collect national level data on MIQF health workforce size and vacancies (28)		16 March 2021
Add health workforce capacity / capability / demand to MBIE's risk register (28)		08 March 2021
Provide guidance to Nurse Leads on deployment of staff who decline vaccination (28)		15 March 2021
Model of Care Review (27)		End of April 2021
Introduction of a workload assessment tool to capture workload data (65)		End of April 2021
MBIE recruitment and training of staff health and safety representatives (39)		Ongoing
Improvements to IT systems are currently being introduced to streamline and reduce the work associated with data capture (64)		Ongoing
Continue to incorporate and improve data modelling to support medium term workforce strategy and planning to allow maximum lead-in times to prepare the workforce and adapt policy and practice (75)		Ongoing
Planned actions	**Start date**	**Completion date**
DHBs will enable staff to take deferred leave during the planned maintenance of the hotels (40)	TBA	Ongoing
Undertake a needs and utilisation assessment of the Temporary Accommodation Fund in collaboration with the Ministry's Workforce Team (45)	08 March 2021	28 March 2021
Respond to the MBIE facility review to identify opportunities to improve the environmental working conditions (66)	08 March 2021	26 March 2021
The Workforce team plans to meet with NZNO and senior DHB and Ministry officials to discuss concerns raised about the working conditions in MIQ Facilities (67)	March 2021	March 2021
Develop and introduce a pathway (that will include the provision of pre-travel health needs information by returnees) so that 'best-fit' managed isolation options can be planned for prior to arrival (53)	March 2021	April 2021

Actions for further exploration with other agencies

Recruitment and workforce sustainability (34) – Engage with DHBs nationwide around strategies to 'share the load' across all DHBs, through offering short term deployments to MIQFs. – Explore the potential for bringing in nurses from overseas for specific contracts working within MIQFs. – Engage with DHBs around consistent employment strategies that attract healthcare workers for example contracts that maximise the term of employment, consistent contractual conditions, and incentivised options. – Engage in a whole of government discussion about options to reward/compensate this workforce in ways that do not compromise national collective employment agreements (34e).
Exit planning for the workforce (74) – Consider how the workforce will be systematically 'stood-down' once no longer required. This will need to include supporting staff to transition to other parts of the health sector where possible.
Cost management of providing the service – Review the actual costs associated with the MIQF healthcare workforce per returnee and by facility and region would be useful to better understand the funding requirement and to identify opportunities for increasing efficient spend in this area (46).
Addressing workforce discrimination and stigmatisation – Support and extend the November 2020 multi-agency approach to increasing positive perceptions and reducing stigmatisation and/or discrimination against MIQF and border workers (42). Memo to CE group.docx

MINISTRY OF BUSINESS, INNOVATION & EMPLOYMENT
HĪKINA WHAKATUTUKI

MĀIA BOLD & BRAVE | PAE KAHURANGI BUILD OUR FUTURE | MAHI TAHI BETTER TOGETHER | PONO ME TE TIKA OWN IT

MEMO TO MIQ Cross-Sector Chief Executive Group

Subject	Communications approach to promote the work of Managed Isolation and Quarantine (MIQ) and border staff and prevent Covid-19 based discrimination
Meeting date	Wednesday 18th November 2020
Prepared by	s 9(2)(a) Team Leader (Regional Engagement and Communications Advisors), MIQ
Presenter(s)	s 9(2)(a), Manager Engagement and Communications, MIQ

Item purpose and summary

Government agencies and partner organisations are aware of MIQF and border workers being stigmatised and discriminated against back in their communities, because of where they work. Several of the District Health Boards (DHBs), Regional Isolation and Quarantine (RIQs) and others have expressed concern.

This is a multi-agency approach which we look to the MIQ Leadership Team and public sector leaders to champion. While the communications approach is in development, there is a need for an increased understanding of the extent of the problem to ensure an appropriately targeted response which achieves the desired results.

Recommendations

It is recommended that the Group:

a) Agree the proposed communications approach.
b) Discuss the Senior Engagement workstream (workstream 3) and how to best to support this.

Detail (prepared by comms leads at Ministry of Health, MBIE, DPMC and ADHB)

BACKGROUND

At the frontline of the COVID-19 response, MIQ and border workers support New Zealanders returning home and other guests through their arrival and completion of the managed isolation and quarantine process, which for most people is completed within 14 days from arrival in the country. While the majority of feedback on the service our workers provides is overwhelmingly positive, there has been increasing feedback communities are concern that staff (and their families) risk carrying COVID-19 to their communities.

Government agencies and partner organisations are aware of MIQ and border workers being stigmatised and discriminated against back in their communities, because of where they work. Several of the DHBs, RIQs and others have expressed concern. With examples of MIQ and border staff positive cases, there is a heightened perception that communities of our workers and members of the public are at risk.

What we are hearing is that workers and families are being asked to stay away from certain locations because others are concerned about the risk of COVID-19 – this includes (and is not limited to) being:

- excluded from preschools, schools and medical centres in Auckland
- landlords refusing to rent properties
- NZDF staff being requested not to wear uniforms in public dining areas in Hamilton

As well as the obvious health, education and housing issues, the impact of this discrimination includes flow-on problems with the recruitment and retention of MIQ and border staff, as well as low morale for the workers, which potentially impacts their work and their families.

ABOUT THIS DOCUMENT

This document sets out a communications approach to help address the above issue.

More detailed planning and implementation will be delivered by the agencies assigned to the individual work streams below, in consultation with the wider group.

COMMUNICATIONS OBJECTIVE AND STRATEGY

Our aim is to increase the positive perceptions and reduce stigmatisation and/or discrimination against MIQF and border workers, both generically and in specific known contexts (e.g. education and healthcare) through a planned multi-channel communications and engagement approach.

WHAT'S ALREADY BEEN DONE

There have been a few activities undertaken already, but they have been ad hoc to date. These include:

- provision of collateral to staff that they can take into the community
- occasional media stories about MIQF staff (e.g. the recent Richard Chen item)
- a media visit to Jet Park is being organised now (MoH and MBIE media teams discussing)
- the Mental Health Foundation has created a couple of nice stories, as part of the "Getting through together" campaign.
- Regional community engagement coordinated by RIQ engagement and communication leads
- Auckland health officials have been addressing some individual cases as they become aware of them.

PROPOSED COMMUNICATIONS APPROACH

Five streams of activity are proposed:

1. a **public campaign** (in regions with MIQFs) in support of MIQF/border workers (**MBIE/DPMC lead**):
   - primarily (free) media and social media based, with information also on agency websites (the MIQ website is developing a new section with a working title of *Our communities | our people*)
   - use agreed key messaging (draft below) and tell 'hero' stories – position as frontline workers who deserve appreciation, respect and support. We'll use MIQ and border staff to tell their stories and returnees to share their stories and appreciation of the workers.
   - Funding has been agreed for the public campaign and the agency (Clemengers) has been briefed.
2. targeted **push into known discrete problem areas** (**MoH Lead**):
   - medical centres and schools/ECE (plus any others identified)
   - work through relevant agency channels (Health/DHBs and Ministry of Education). Auckland Regional Public Health is already addressing any specific health sector cases it hears about.
   - strong messaging delivered to the relevant frontline organisations (primary care, schools etc)
3. provision of **additional advice, information and support to MIQF/border workers** (already had some material) – what are their legal rights, where to go for support, how to escalate etc. We'll also actively encourage staff to let us know of specific incidents, so we can follow up. (**MBIE lead**)
4. **senior engagement** (**DPMC/MOH/MBIE**)

- government leaders actively engaging in interviews and opportunities to promote the campaign, weave key messages into their communications and address the issues.
- engage with influencers who can amplify our message to specific audiences

5. regular **local engagement** – as part of their ongoing local engagement, RIQ and DHB staff will actively:
   - communicate 'how we work' in our facilities (how we keep our workers, the returnees and our communities safe) so that local government, community groups and iwi can champion our workers
   - showcase local heroes through our local channels and those of our local partners
   - promote the many examples of great feedback about staff from the returnees and guests
   - help staff tell their stories to their networks and guide them on how to do it (social media)
   - address 'the issue' when the opportunity presents (MBIE/ADHB lead)

WORKING WITH OTHERS

To be successful, we will need to work with other agencies and organisations to support this campaign:

- Iwi – regionally based bespoke plans
- Unions:
  - PSA has already offered to help however it can
  - NZ Nurses Organisation
  - relevant border unions
  - CTU – who have recently signed joint letters to employers/employees on staff testing
- Human Rights Commission – experienced in these issues.
- Royal NZ College of GPs and Mental Health Foundation
- Other agencies with frontline staff – NZDF, Police, AvSec, Customs, Immigration etc
- Other stakeholders who engage with our audiences (Ministry of Education and education sector groups)
- Partner organisations – hotels, security firms, Air New Zealand (for air crew)
- Local government and communities

To facilitate this, we will share our messages and campaign material with them, to use via their channels.

TIMING

Initial work has begun, the priority delivery period is aimed for the period December 20 to February 21.

- Stream 1 (public campaign) to run until the end of the summer holidays

- Stream 2 (known discrete problem areas) will be from now until Christmas
- Stream 3 (additional resourcing for staff) to be done ASAP
- Stream 4 (senior engagement) from now until Christmas
- Stream 5 (local engagement) – ongoing, to be enhanced

An evaluation is planned for February 21.

RISKS

- It's anecdotal – we currently can't quantify the scope of the problem. We need to prioritise the introduction of a staff pulse survey.
- We shouldn't overstate the problem until we understand it fully.
- Budget – funding has been agreed for workstream 1 (public campaign) but not for other workstreams.
- Cut through – there's a lot going on, not just on COVID-19 but more generally. That's why we're taking a multi-tiered approach.
- Further work is required on measuring outcomes and outputs.
- We don't want to get into naming/shaming specific organisations.
- The issue is wider than our frontline workforce (there are examples of returnees being targeted) however this is currently out of scope of this campaign.

DRAFT KEY MESSAGES

- We want to celebrate the amazing people working at our managed isolation and quarantine facilities and at the border.
- They are our frontline defence against COVID-19. Every day they put themselves between us and the virus, to keep returning New Zealanders and our communities safe.
- Whether they're health staff, defence personnel, hotel workers or others, they're all doing vital tasks and we owe them a debt of gratitude.
- In return we work really hard to keep them safe. The facilities they work in are kept highly clean, they follow strict safety protocols, use PPE and are given daily health checks and regular COVID tests.
- We should treat them as the front-line heroes they are, and not be concerned to mix or associate with them or their families.
- So it's very disappointing to hear some workers are made to feel unwelcome and even turned away in some community settings – that's not okay.
- It's not the New Zealand way – everyone has the right to be treated fairly.
- We will talk to anyone found to be discriminating against them.
- People are not the problem, the virus is the problem