Briefing

Review of the dedicated MIQF health workforce policy

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To:	Hon Chris Hipkins, Minister for COVID-19 Response		
Copy to:	Hon Dr Ayesha Verrall, Associate Minister for Health		

Contact for telephone discussion

Name	Position	Telephone
Sue Gordon	Deputy Chief-Executive, COVID-19 Health System Response	s 9(2)(a)

Minister's office to complete:

☐ Approved ☐ Decline ☐ Noted

☐ Needs change ☐ Seen ☐ Overtaken by events

☐ See Minister's Notes ☐ Withdrawn

Comment:

Now is not the right time to change. TTSTZ potentially increases the concentration of risk in MIQ. International rates of infection remain a concern. I'm open to discussing other ways of dealing with recruitment + retention challenges (eg. allowances)

CH

Review of the dedicated MIQF health workforce policy

Security level:	IN CONFIDENCE	**Date:**	24 May 2021
To:	Hon Chris Hipkins, Minister for COVID-19 Response		

Purpose of report

1. This report provides a briefing on our review of the Managed Isolation and Quarantine Facility (MIQF) health workforce policy and seeks your decision on an approach to amending the dedicated MIQF health workforce policy.

Summary

2. The dedicated MIQF health workforce policy ('the policy') was implemented in August 2020 and was intended to provide an additional precautionary measure to prevent the transmission of COVID-19 to the community via the MIQF health workforce. Of particular concern was protecting vulnerable elderly populations in Aged Related Residential Care facilities (ARRCs).

3. The policy requires District Health Boards (DHBs) to employ a health workforce solely for the purposes of providing health services in MIQFs. The dedicated MIQF health workforce are therefore unable to have secondary employment or attend work in other clinical settings (e.g. in hospitals). Further details of the policy are provided in paragraphs 17 – 19.

4. There are a suite of public health and infection prevention and control (IPC) measures in place to protect the MIQF health workforce and prevent onward transmission of COVID-19 to the community. These measures include:

   - Frequent surveillance testing, as well as self-isolation and testing following the onset of symptoms;
   - Robust contact tracing systems and the contractual requirement to keep a record of movements;
   - Strict adherence to IPC measures. This includes the stringent use of personal protective equipment (PPE), including N95/P2 particulate respirators, which provide a high level of protection to the wearer from aerosolised viral particles;
   - Ongoing system-wide improvements to the ventilation systems within MIQFs and roll-out of air filtration units, in order to further reduce the risk of aerosol transmission; and
   - COVID-19 vaccination.

5. Since August 2020, there have been three cases of in-MIQF transmission to MIQF healthcare workers – one in August 2020, and two in October 2020 related to tranche

one of the international mariners in Christchurch. This was a higher risk environment due to the size of the international mariners cohort and the number of highly infectious mariners being managed simultaneously. Based on learnings from tranche one, we have implemented improvements to our processes for managing and planning for large groups prior to arrival to reduce the risks for MIQF workers (HR20202280 refers).

6. There are challenges in the recruitment and retention of the MIQF health workforce in some regions, particularly Registered Nurses (RNs). This is exacerbated by the stigma and discrimination experienced by some MIQF healthcare workers in the community, as well as the restrictive nature of the policy itself.

7. Trans-Tasman quarantine-free travel, the introduction of cohorting, and scheduled hotel maintenance have impacted occupancy across the MIQ system and introduced fluctuations in workload for the MIQF health workforce. As a result, some regions are experiencing higher peak workloads on specific days, while others are experiencing extended periods of significantly reduced workload and lost productivity.

8. In general, fluctuations of higher peak workload can be managed with careful planning, but in rare cases there may be a need to adopt some flexibility around the day 3 and 12 testing regime in order to spread the load of clinical work and improve quality of service delivery. Given cohorting significantly reduces the risk of late in-facility transmission, slight changes to testing days in limited circumstances remain appropriate from a public health perspective.

9. Periods of significantly reduced workload are an inefficient use of a highly skilled MIQF health workforce, who cannot work elsewhere during these periods due to the requirements of the current policy. Most critically, it also risks loss of specialist MIQF healthcare workers through disengagement and lost productivity.

10. Therefore, there is a need reassess the policy settings to reflect the current risk profile of MIQF healthcare workers, improve the flexibility of the MIQF health workforce to support the wider health system workforce demands during periods of low occupancy and workload in MIQFs, reduce stigma and discrimination of the MIQF health workforce, and continue to engage and retain this highly specialised health workforce.

11. We have identified three options for your consideration:

    - **Option 1**: Remove the requirement for a dedicated MIQF health workforce and allow MIQF healthcare workers to work in other health settings without restriction.
    - **Option 2:** Allow the MIQF health workforce to work across five COVID-19 focussed settings – in MIQFs, border screening at airports and seaports, COVID-19 vaccination centres, community-based COVID-19 testing centres, and contact tracing – without restriction (**recommended** – as part of a phased approach towards implementing Option 1).
    - **Option 3:** Status quo – retain the current MIQF dedicated health workforce policy settings.

12. The full suite of public health and IPC measures that currently keep the MIQF health workforce safe will continue to apply to all three options, if implemented. This includes ongoing regular surveillance testing, thorough symptom-checking and isolation/testing

following onset of symptoms, and strict adherence to the IPC and PPE requirements while at work.

Recommendations

We recommend you:

a) **Note** that public health advice is that any risk of COVID-19 transmission to the community via the MIQF health workforce is significantly reduced through the use of robust IPC measures, surveillance testing, and vaccination. **Yes/No**

b) **Note** that the current dedicated MIQF health workforce policy is affecting health staff recruitment and retention. **Yes/No**

c) **Agree** that in exceptional circumstances, senior MIQ health staff are authorised to either delay day 3 testing to day 4, or conduct day 12 testing on day 11, in MIQFs where cohorting is implemented. **Yes/No**

d) **Indicate** your preferred option for the amendment to the dedicated MIQF health workforce policy: **Yes/No**

> **Option 1:** Remove the requirement for a dedicated MIQF health workforce and allow MIQF healthcare workers to work in other clinical settings without restriction. **Yes/No**
>
> **Option 2:** Allow the MIQF health workforce to work across five COVID-19 focussed settings – in MIQFs, border screening at airports and seaports, COVID-19 vaccination centres, community-based COVID-19 testing centres, and contact tracing – without restriction (**recommended** – as part of a phased approach towards implementing Option 1). **Yes/No**
>
> **Option 3:** Status quo – retain the current dedicated MIQF health workforce policy **Yes/No**

e) **Agree** that your preferred option should be reviewed ~~three~~ two months after implementation. **Yes/No**

Sue Gordon
Deputy Chief Executive
COVID-19 Health System Response
Date:

Hon Chris Hipkins
Minister for COVID-19 Response
Date: 26/5/2021

Review of the dedicated MIQF health workforce policy

Background

13. Robust IPC measures – such as the safe and proper use of PPE, maintaining physical distancing, and regular hand hygiene – are the primary mitigations in place in MIQFs to protect healthcare workers from COVID-19. These IPC practices are routinely audited to support a continuous improvement approach.

14. Healthcare workers are well-trained in IPC, and over the past year, the MIQF health workforce in particular have become highly skilled and meticulous in IPC practices. This is evident in the low numbers of MIQF healthcare worker transmissions to date. Only three MIQF healthcare workers across the MIQ system have been infected with COVID-19 to date – one in August 2020 at the Jet Park Auckland Quarantine Facility, and two in October 2020 related to tranche one of the international mariners.

15. Note that the October 2020 infections occurred in a higher risk environment involving a large number of highly infectious individuals, and that in both the August 2020 and October 2020 transmission events, there were no secondary cases resulting from these healthcare worker infections.

16. Note that these MIQF healthcare worker infections occurred prior to the introduction of N95/P2 particulate respirators in MIQFs (December 2020), prior to the implementation of 7-day surveillance testing for all MIQF healthcare workers (April 2021), and prior to vaccination of the full workforce (30 April 2021). These risk mitigations, alongside those detailed in paragraphs 20 – 31, have significantly reduced the risk of infection among the MIQF health workforce.

The dedicated MIQF health workforce policy

17. The policy was first implemented in August 2020. As a precautionary approach, it was intended to provide an additional measure to prevent the transmission of COVID-19 to the community via the MIQF health workforce, and in particular, to protect vulnerable populations in health care settings such as ARRCs.

18. The policy requires DHBs to employ a health workforce solely for the purposes of providing health services in MIQFs, under the following requirements:

- Those employed in the dedicated MIQF health workforce are not permitted to have secondary employment, or attend or work in settings where:
    - There are non-MIQF health staff present, including in clinical settings, non-clinical settings, and during training sessions;
    - There are vulnerable populations, including in hospitals, primary care, prisons, ARRCs, mental health facilities, and disability facilities;
- Stand down for 48 hours (minimum) and return of a negative test result is required:

- Before moving from working in a quarantine facility or dual-use facility (a facility with both managed isolation and quarantine zones) to a managed isolation facility;
- After ending employment in a MIQF, and before moving to work in another health setting.

19. Note that the policy only applies to the MIQF health workforce. Other MIQF workforces, such as New Zealand Defence Force (NZDF) personnel or hotel employees are subject to the employment conditions required by their employer.

There are a suite of public health and infection prevention and control measures in place to protect the MIQF health workforce, and reduce the risk of onward transmission to the community

Routine weekly surveillance testing

20. Routine surveillance testing of MIQF healthcare workers, as required by the COVID-19 Public Health Response (Required Testing) Order 2020, provides an additional layer of protection to support early identification of worker transmission.

21. Under the Required Testing Order, MIQF healthcare workers are currently required to undergo weekly nasopharyngeal swab testing. Supplementary saliva testing is also available on a voluntary basis in quarantine/dual-use facilities including Jet Park Auckland, Commodore Hotel Christchurch and Grand Mercure Wellington, and work is underway to expand the availability and uptake of saliva testing for workers across the MIQ system (HR20211161 refers).

22. In addition to routine weekly surveillance testing, all MIQF workers are required to self-isolate and be tested if they experience COVID-19 related symptoms. Furthermore, following incidents of in-MIF transmission or other potential exposure events, MIQF healthcare workers undergo additional testing as advised by the local Public Health Unit (PHU).

Contact tracing

23. MIQF healthcare workers are contractually obliged to keep a record of their movements when outside of work, for example, by using the COVID-19 tracer app. This supports contact tracing efforts in the unlikely event of a worker testing positive.

Strict adherence to PPE protocols and strengthening of IPC mitigations to reflect emerging evidence

24. As our understanding of the transmission mechanisms of SARS-CoV-2 has evolved, particularly with respect to the risk of aerosol transmission of the virus, our IPC measures have been progressively strengthened as part of our continuous improvement approach.

25. In addition to rigorous adherence to basic IPC measures – including performing regular hand hygiene, maintaining physical distancing (wherever possible), and following safe PPE donning and doffing practices – the MIQF health workforce uses a level of PPE during clinical interactions that is based on the assumption that any returnee could have COVID-19. This includes the use of N95/P2 particulate respirators, which provide a high level of protection to the wearer from aerosolised viral particles.

26. There are ongoing improvements underway to optimise ventilation within MIQFs in order to further reduce the risk of aerosol transmission. This includes site-specific ventilation assessments of all MIQFs – both the design of the systems and real performance – and the roll out of air filtration units.

COVID-19 vaccination

27. As at 1 May 2021, in order to comply with the COVID-19 Public Health Response (Vaccinations) Order 2021, all healthcare staff working in MIQFs had received their first dose of the Pfizer vaccine, or had been re-deployed to alternative non-frontline positions. By 4 June 2021, all current MIQF healthcare workers are required to have received their second dose of the vaccine.

28. Note that for new employees, the Vaccinations Order requires them to receive their first dose of the vaccine prior to commencing employment, and their second dose within 35 days of commencing employment.

29. There is strong documented evidence to suggest that the Pfizer vaccine is protective against infection from SARS-CoV-2, severe illness following infection, and onward transmission.

30. Furthermore, recent research assessing the effectiveness of the Pfizer vaccine specifically in healthcare workers demonstrated an encouragingly low incidence of infection among healthcare workers following full vaccination (i.e. following receipt of both doses)[1, 2]. We are continuing to monitor emerging international evidence of the efficacy on the Pfizer vaccine and expect further evidence to emerge over the coming months.

31. Accordingly, when taking into account the vaccination coverage, high frequency of routine surveillance testing, and continued strict adherence to robust IPC measures among MIQF healthcare workers, we consider the risk of fully vaccinated[3] MIQF healthcare workers being infected with SARS-CoV-2 – or being a source of onward transmission to the community – to be both low and manageable with the range of risk mitigations currently in place.

The MIQF health workforce is highly specialised and valuable, but it is under stress

There are ongoing challenges in recruitment, retention, and managing the workload of the MIQF health workforce

32. As you have been advised previously, there have been persistent challenges in the recruitment and retention of the MIQF health workforce in some regions, particularly Registered Nurses (RNs).

33. The stigma and discrimination experienced by some MIQF healthcare workers in the community, including when accessing healthcare in the community, has contributed to

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1 Benenson, S et al., (2021). BNT162b2 mRNA Covid-19 vaccine effectiveness among health care workers. N Engl J Med 2021; 384:1775-7. DOI: 10.1056/NEJMc2101951

2 Keehner, J et al., (2021). SARS-CoV-2 Infection after Vaccination in Health Care Workers in California. N Engl J Med 2021; 384:18. DOI: 10.1056/NEJMc2101927

3 'Fully vaccinated' meaning at least 14 days after receiving the second dose of the vaccine

challenges in recruitment and retention. The policy may be contributing to this stigma and discrimination by signalling that these workers pose a public health risk.

34. DHBs have advised that the restrictive nature of the current policy – in particular the prohibition of secondary employment or attendance in other health settings – creates further challenges for recruitment and retention of healthcare workers.

35. Note that in HR20210510 '*MIQF health workforce update*', we updated you on the range of actions underway to optimise models of care, monitor and manage workload demand, and manage risks and challenges to sustaining an adequate MIQF health workforce.

36. These actions include reviewing the models of care in each region, including maximising opportunities for delegation of activities from RNs to Healthcare Assistants (HCAs), and more efficient sharing of activities (such as pastoral and social care) from core health teams to other teams (where appropriate). This will relieve some of the workload pressure on the RN workforce in MIQFs.

The impact of cohorting, trans-Tasman quarantine-free travel, and scheduled maintenance on occupancy has introduced additional challenges for the MIQF health workforce

37. Trans-Tasman quarantine-free travel, the introduction of cohorting, and scheduled hotel maintenance have impacted occupancy across the MIQ system, resulting in a range of operational implications for the MIQF health workforce [MBIE Aide Memoire 2021-3379 refers].

38. This has temporarily alleviated some of the pressure on health workforce shortages, particularly in the Auckland region. As a result, deferred leave has been taken, there has been a reduction in reliance on supplementary agency staff, and health staff have been able to complete catch-up training to meet their professional development requirements. However, in some regions, such as in Christchurch, occupancy has reduced significantly and resulted in lost productivity [HR20210510 refers].

39. Such extended periods of significantly reduced workload for MIQF healthcare workers is an inefficient use of a highly skilled workforce, who have been guaranteed a minimum number of hours work at the MIQFs as part of the dedicated workforce, and who cannot work elsewhere during these periods due to the conditions of the current policy. Most critically, it also risks loss of specialist MIQF healthcare workers through disengagement.

40. To address these challenges, Christchurch MIQF healthcare workers have been supporting airport staff with health screens for trans-Tasman quarantine-free travel arrivals, as well as supporting the rapid expansion of the Canterbury vaccination programme, following the requisite 48 hour stand down period and receipt of a negative COVID-19 test. Eight RNs are also being sent from Christchurch to Auckland MIQFs on short-term secondments.

The impact of cohorting will also lead to periods of significantly increased workloads for the MIQF health workforce

41. Demands on health staff will be particularly high on day four after the arrival of the first cohort. This is because of the staggered 96-hour window for arrival. Health staff will need to manage day 0/1 and day 3 swabs, daily health checks for all returnees in the MIF, and arrival health and wellbeing screens for any new arrivals, in addition to

providing additional care to higher-needs returnees as required (e.g. the clinical management of chronic, non COVID-19 related conditions).

42. The DHBs are confident that this fluctuation in workload can be managed with appropriate planning. However, in exceptional and unexpected circumstances such as when there is staff sickness, we recommend that the senior clinical teams within the Regional Isolation and Quarantine Coordination Centres (RIQCCs) be authorised to either delay day 3 testing to day 4, or conduct day 12 testing on day 11. This will help spread the load of clinical work and improve quality of service delivery.

43. From a public health perspective, these small deviations in test days remain appropriate with respect to the viral incubation period. Note that day 3 swabbing would not be conducted earlier, nor day 12 testing delayed, as this would be incongruent with public health advice regarding the incubation period of the virus.

44. You previously confirmed that day 12 testing is not to occur on day 11 in your response to HR20210466, the primary public health rationale for this being to ensure that returnees' final tests are conducted at the latest possible time to identify any potential cases of late in-MIF transmission.

45. However, with the implementation of cohorting across the MIQ system, the risk of late undetected in-MIF transmission is significantly reduced. Accordingly, conducting day 12 testing on day 11 – in exceptional and unexpected circumstances only – would be acceptable from a public health perspective.

46. This will only apply in facilities where cohorting is implemented. Health staff in the few facilities used to accommodate groups that are not cohorted (e.g. medical arrivals, air crew, international transfers etc.) will continue to carry out testing in line with current standard operating procedures.

There is an opportunity to amend the dedicated MIQF health workforce policy to improve the flexibility, responsiveness, productivity, and agility of the health workforce in order to make best use of this scarce workforce resource

47. Since the introduction of the policy, the public health risk profile of MIQF healthcare workers has changed considerably. Robust public health and IPC mitigations are in place, and the MIQF health workforce are at low risk of becoming infected or being sources of transmission, despite the increasing prevalence of more transmissible variants of concern.

48. Given their low risk profile, MIQF healthcare workers are already considered as other members of the community in their non-work settings and face no greater restrictions on community activity or travel. In this context, the current prohibition on MIQF healthcare workers working in other clinical settings or on attending training days with non-MIQ DHB colleagues appears inconsistent with the level of public health risk.

49. Furthermore, with the range of robust public health measures (vaccination, daily symptom checking, strong contact tracing systems, and frequent surveillance testing) and IPC measures (including PPE-use, physical distancing, and hand hygiene) in place, there is a need to reassess the policy settings to:

- Better reflect the current risk profile of MIQF healthcare workers, particularly following full vaccination;

- Improve the flexibility of the MIQF health workforce to support the wider health system workforce demands during periods of low occupancy and workload in MIQFs. These wider health system demands include the roll-out of the COVID-19 vaccination programme, as well as the typical demands on the health system during the winter months;
- Reduce stigma and discrimination of the MIQF health workforce; and
- Crucially, to continue to engage and retain this highly specialised health workforce, through the opportunity to work across a range of clinical settings. This has benefits for staff and supports the productive use of this specialist health workforce.

Options for amending the dedicated MIQF health workforce policy

50. We have identified three options for amending the policy, all of which would **only apply to healthcare workers who are fully vaccinated** (i.e. it has been at least 14 days since their second dose of the vaccine)[4].

51. Additionally, the following suite of public health and IPC measures will continue to apply to all three options, if implemented:

- Healthcare workers will continue to undergo regular surveillance testing, as required under the Required Testing Order. This will include frequent supplementary saliva testing (e.g. every two or three days) as it becomes available across the system (HR20211161 refers);
- Healthcare workers will continue to remain vigilant for any COVID-19 related symptoms. The requirement to continue thorough symptom checking and isolation/testing of individuals who report any symptoms will continue to apply;
- Healthcare workers will continue to be contractually obliged to keep a record of their movements while outside of work, for example through the COVID-19 tracer app;
- Healthcare workers will continue to adhere to the IPC and PPE requirements while at work; and
- The option implemented will be re-evaluated after 3 months. The evidence of the effectiveness of the Pfizer vaccine in preventing infection and onward transmission is rapidly evolving. Within 3 months, we expect further evidence to be available about the longevity of the immune response to the vaccine, as well as the reduction in risk of onward transmission in vaccinated individuals who become infected. This will support decision-making regarding any further amendments to the policy, if appropriate.

[4] **Note that as detailed in paragraphs 27 and 28, while new employees must have received their first dose prior to commencing work in a MIQF, they have 35 days following commencement to receive their second dose. These workers are therefore excluded from any of the proposed amendments to the policy until they are fully vaccinated.**

Option 1: Remove the requirement for a dedicated MIQF health workforce and allow MIQF healthcare workers to work in other clinical settings without restriction

52. Removing the requirement for a dedicated MIQF health workforce would allow MIQF healthcare workers to seek secondary employment and work in any other clinical setting without a 48-hour stand down and negative test requirement. This will facilitate greater flexibility and agility to utilise the MIQF health workforce to respond to surges in need across the health system during periods of lower occupancy and workload in MIQFs.

53. During times of reduced occupancy and low workload, the MIQF healthcare workforce could be available to support the rapidly up-scaling roll-out of the COVID-19 vaccination programme, which is facing challenges in maintaining vaccinator coverage.

54. Typically, the wider health system experiences pressure throughout the winter months as other respiratory illnesses become more prevalent. Option 1 would also allow the MIQF health workforce to alleviate some of this pressure during periods of under-utilisation in MIQFs.

55. Note that Option 1 will also support greater flexibility and utilisation of the health workforce *within* the MIQ system by allowing MIQF healthcare workers to move from working in a quarantine facility or dual-use facility to a managed isolation facility, without the 48-hour stand down and negative test requirement as described in paragraph 18.

56. In allowing the MIQF health workforce greater flexibility to work across a range of clinical settings, Option 1 will support the ongoing engagement of MIQF healthcare workers, thereby retaining this specialist workforce in the MIQ system while enabling the workforce to develop a broader range of skills through work in other clinical settings.

57. With the range of public health and IPC mitigations in place summarised in paragraph 51, the public health risk of allowing MIQF healthcare workers to move between MIQFs and other clinical settings is low and manageable.

58. Removing the requirement for a dedicated MIQF health workforce achieves greater consistency in the approach to managing the public health risks associated with the MIQF workforce.

59. Currently, the range of public health and IPC measures summarised in paragraph 51 are sufficient to permit the MIQF health workforce to go about their normal lives outside of work e.g. attending places of worship, large gatherings, other community events, and more recently, travel within the trans-Tasman quarantine-free travel zone. These same public health and IPC measures should therefore also be sufficient to permit the MIQF health workforce to work safely across a range of clinical settings.

60. Option 1 may also reduce the stigma and discrimination this workforce experiences by signalling that Health and Government officials have confidence that the suite of public health and IPC measures in place to protect this workforce enable them to safely work across a range of clinical environments, just as these measures and mitigations allow the workforce to safely engage with their communities outside of work.

Implications

61. Prior to implementation, communications with the sector and the public will be needed to provide reassurance that the MIQF healthcare workforce are safe and present a low

public health risk to others. Further detail regarding a high-level communications plan that will be applied to any of the options discussed in this briefing is provided in paragraphs 78 - 80.

62. Different DHBs and healthcare providers (e.g. ARRCs) already have variable levels of risk tolerance for MIQ workers. For example, anecdotally, some MIQ workers have reported being turned away from accident and emergency (A&E) centres due to their occupation. Work to address this is already underway, including through communications to DHB Chief Executives.

63. However, we note that regardless of policy changes, there may be some DHBs and/or healthcare providers, particularly ARRCs, that do not allow MIQF healthcare workers to work in non-MIQ related clinical settings.

64. Although Option 1 is acceptable from a public health risk perspective, we recommend a phased approach towards implementing Option 1 (refer to paragraphs 71 - 74 for further detail).

Option 2: Allow the MIQF health workforce to work across five COVID-19 focussed settings – in MIQFs, border screening, COVID-19 vaccinations, community-based COVID-19 testing, and contact tracing – without restriction (recommended)

65. Option 2 allows for the establishment of a specialised 'COVID-19 workforce' that can be managed across five key COVID-19 related settings without imposing the current 48-hour stand down and negative test result requirements: MIQFs, border health screening, COVID-19 vaccinations, community-based COVID-19 testing, and contact tracing.

66. As detailed in paragraphs 53 and 54, this will provide the flex required to enable and support other parts of the COVID-19 related health system that are under stress during periods of low occupancy and workload in MIQFs.

67. Crucially, this will increase the availability of vaccinators to support the roll-out of the COVID-19 vaccination programme, particularly when the programme progresses to group 4 vaccinations of the wider population. Note that additional resource will be required to train staff as COVID-19 vaccinators and remove the barriers under the current policy to accessing training in non-MIQ clinical settings (refer to paragraph 18).

68. Note that you have previously agreed to healthcare staff conducting border health screens being permitted to move between green and red zones of airports (HR20210974). Given red zone passengers go on to MIQFs from the airport, from a public health perspective the risk posed to border health screening staff by red zone passengers is equal to the risk posed within MIQFs. Accordingly, border health screening is a logical workplace extension for the MIQF health workforce.

69. Additionally, as detailed in paragraph 55, Option 2 will also increase the flexibility of the MIQF health workforce to move throughout the MIQ system to respond to demand. This recognises the need to utilise staff differently in different regions.

70. Option 2 will support greater utilisation of the MIQF health workforce across areas of demand – most notably, COVID-19 vaccinations – thereby reducing redundancy in the system and enabling the ongoing engagement and retention of staff.

Implications and a proposed phased approach towards Option 1

71. The advice from public health is that the risk of transmission from vaccinated MIQF healthcare workers is low and manageable, and that Option 1 is therefore acceptable from a public health perspective.

72. However, we note that a phased approach of progressively expanding the settings that MIQF healthcare workers are permitted to work in would be beneficial in building public trust and confidence in the public health risk mitigations in place, and therefore the low and manageable risk of the MIQF health workforce working in other settings.

73. Accordingly, we recommend that you agree to Option 2 at this time, with a view to continue monitoring the emerging evidence regarding the efficacy of the Pfizer vaccine and the effectiveness of the current public health and IPC mitigations in place. We will then provide you with further advice in late August 2021 regarding whether a transition to Option 1 is appropriate.

74. Note that while Option 1 would provide the greatest level of flexibility to the health workforce to respond to fluctuations in demand across the wider health system, the flexibility offered by Option 2 will also support the retention of the MIQF health workforce, as well as support surges in demand in other COVID-19 related settings – particularly vaccinations.

Option 3: Status quo – retain current MIQF dedicated health workforce policy

75. If no change is made to the policy at this time, the risk of loss of staff through disengagement and lost productivity will persist. This is a risk to the ongoing sustainability of the MIQF health workforce.

76. Note that the current policy is not reflective of the current public health risk profile of the MIQF health workforce, and is inconsistent with the wider public health risk management approach applied to the MIQF health workforce – who are able to engage with their local communities without any additional restrictions outside of work.

77. If Option 3 is agreed to, we will continue to review the emerging evidence regarding the efficacy of the Pfizer vaccine. We will provide you with further advice in late August 2021 regarding whether additional amendments to the policy are warranted to allow greater flexibility for the MIQF health workforce to work in other clinical settings.

Communications

78. While the rationale for amending the policy is clear, this issue may attract public/media attention and interest among staff in other health settings. In particular, there could be concern among these stakeholders about transmission risks posed by MIQF healthcare workers in other settings.

79. Accordingly, if an amendment to the policy is agreed, it is recommended that a communications plan be finalised before any announcement is made. The key elements of the communications plan would be:

- A media pack (a media release and 'frequently asked questions');
- Web content for the Ministry of Health's website; and

- A one-page 'fact sheet' for potentially impacted organisations (e.g. DHBs, ARRCs, and primary care providers).

80. It is also recommended that key stakeholders are informed in advance of the announcement and provided with the above information, to assist with conversations with their staff.

Next steps

81. Subject to your decision, we will work to implement the changes to the dedicated MIQF health workforce policy and keep you informed of progress in our regular weekly updates.

82. We will develop a detailed communications plan to support the operationalisation of this work.

83. Your preferred option will be reviewed three months after implementation, and we will provide you with further advice at that time.

END