MINISTRY OF HEALTH
MANATŪ HAUORA

Briefing

Review of the dedicated MIQF health workforce policy: report back

Date due to MO:	15 October 2021	**Action required by:**	18 October 2021
Security level:	IN CONFIDENCE	**Health Report number:**	20212280
To:	Hon Chris Hipkins, Minister for COVID-19 Response		
Copy to:	Hon Andrew Little, Minister of Health Hon Dr Ayesha Verrall, Associate Minister of Health		

Contact for telephone discussion

Name	Position	Telephone
Bridget White	Deputy Chief Executive, COVID-19 Health System Response	s 9(2)(a)
Dr Caroline McElnay	Director of Public Health	s 9(2)(a)

Minister's office to complete:

☐ Approved ☐ Decline ☐ Noted

☐ Needs change ☐ Seen ☐ Overtaken by events

☐ See Minister's Notes ☐ Withdrawn

Comment:

Review of the dedicated MIQF health workforce policy: report back

Security level:	IN CONFIDENCE	**Date:**	15 October 2021
To:	Hon Chris Hipkins, Minister for COVID-19 Response		

Purpose of report

1. This briefing provides a report back on our review of the dedicated managed isolation and quarantine facility (MIQF) health workforce policy, which we first reported to you in May 2021 [HR20211071 refers]. This report discloses all relevant information and implications.

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.

3. There is 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 P2/N95 particulate respirators in all returnee-facing zones, 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.

4. 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.

5. We consider the risk of fully vaccinated[1] MIQF healthcare workers being infected with COVID-19 – 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.

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. The MIQF health workforce experiences fluctuations in workload. For example, cohorting practices lead to higher peak workloads on certain days, with periods of reduced workload and productivity on others.

8. Additionally, in the context of the current community outbreak, the MIQF health workforces in Auckland and Waikato are under significant additional strain as they support community cases and contacts that are isolating/quarantining in MIQ. The policy exacerbates this strain by preventing non-MIQF healthcare workers from filling the MIQF health workforce gaps.

9. 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 (and be supported by) the wider health system workforce, reduce stigma and discrimination of the MIQF health workforce, and continue to engage and retain this highly specialised health workforce.

10. We have identified two options for your consideration:

    - **Option 1 (recommended)**: Remove the requirement for a dedicated MIQF health workforce and allow MIQF healthcare workers to work in other health settings without restriction.
    - **Option 2:** Status quo – retain the current MIQF dedicated health workforce policy settings.

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, frequent surveillance testing, and vaccination, and that as a result, we consider the public health risk associated with removing the dedicated MIQF health workforce policy to be low. **Yes/No**

b) **Note** that the current dedicated MIQF health workforce policy is affecting health staff recruitment and retention, and is exacerbating the strain the MIQF health workforce in Auckland and Waikato are currently experiencing as they support the community outbreak response. **Yes/No**

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

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

Option 1 (recommended): 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: Status quo – retain the current dedicated MIQF health workforce policy **Yes/No**

Bridget White
Deputy Chief-Executive
COVID-19 Health System Response
Date: 15/10/2021

Hon Chris Hipkins
Minister for COVID-19 Response
Date: 15/10/2021

Review of the dedicated MIQF health workforce policy: report back

Background

11. Robust IPC measures are the primary mitigations in place in MIQFs to protect healthcare workers from COVID-19, and are routinely audited to support a continuous improvement approach. Healthcare workers are well-trained in IPC, and over the past eighteen months, the MIQF health workforce in particular have become highly skilled and meticulous in IPC practices.

12. 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[2].

13. Note that these MIQF healthcare worker infections occurred prior to the introduction of:

- P2/N95 particulate respirators in MIQFs (December 2020),
- The implementation of 7-day surveillance testing for all MIQF healthcare workers (April 2021),
- Vaccination of the full workforce (30 April 2021),
- System-wide upgrades to ventilation systems within MIQFs, and the deployment of air filtration units to reduce the risk of aerosol transmission,
- Work to review our health assessment processes in order to better utilise remote health check methods, thereby reducing the frequency and duration of face-to-face contact between healthcare workers and returnees.

14. These risk mitigations, alongside those detailed in paragraphs 19 – 28, have significantly reduced the risk of infection among the MIQF health workforce.

The dedicated MIQF health workforce policy

15. 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.

16. 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:

[2] **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.**

- 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.

17. 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 and may be deployed to other settings as needed.

18. We provided you with advice regarding the policy in May 2021 [HR20211071 refers], and recommended that the policy be progressively revoked as part of a phased approach. You did not agree to this recommendation at the time, however, requested we report back to you at a later date.

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

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

20. Under the RTO, MIQF healthcare workers are currently required to undergo weekly nasopharyngeal swab testing. Supplementary saliva testing is also available on a voluntary basis in certain facilities, and work is underway to expand the availability and uptake of saliva testing for workers across the MIQ system (HR20211161 refers). This is being expanded to increase the frequency of surveillance testing for workers across all facilities by the end of October 2021 [HR20212149 and HR20211983 refer].

21. 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

22. 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

23. 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 use P2/N95 particulate respirators whenever they are in returnee-facing zones.

24. The MIQ ventilation work programme is progressing well, with on-site ventilation assessments of all facilities complete, remediation work underway in over 80% of facilities, and ventilation remediation already complete in 7 facilities. This work to optimise ventilation within MIQFs will further reduce the risk of aerosol transmission, alongside the roll out of air filtration units.

25. In addition to installing air filtration units in shared spaces (e.g. lifts and corridors), we have progressed with installing air filtration units within the rooms used by positive cases in our quarantine facilities. This reduces the exposure risk to staff by cleaning the air at source, thereby reducing the likelihood that infectious aerosols exit a case's room upon door opening.

COVID-19 vaccination

26. Since 4 June 2021, in order to comply with the COVID-19 Public Health Response (Vaccinations) Order 2021, all staff working in MIQFs were required to have received their second dose of the Pfizer vaccine (or had been re-deployed to alternative non-frontline positions).[3]

27. In addition to the strong evidence demonstrating that the Pfizer vaccine is protective against infection from SARS-CoV-2, severe illness following infection, and onward transmission, 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)[4, 5]. We are continuing to monitor emerging international evidence of the efficacy on the Pfizer vaccine.

28. 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[6] 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.

[3] 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.

4 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

5 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

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

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

29. 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).

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

31. 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.

32. In HR20211071, we advised you that the other policies and operational activities such as cohorting and scheduled hotel/ventilation maintenance contribute to periods of significant fluctuation in workload for the MIQF health workforce. This results in periods of significantly increased workloads, such as to accommodate testing surges among returnees, as well as periods of reduced occupancy and lost productivity.

33. The former presents challenges in managing the load of clinical work and ensuring the quality of service delivery, whilst the latter represents 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.

34. Now, in the context of the community outbreak in Auckland and Waikato, the Auckland and Waikato MIQF health workforces are under significant strain. Other regions have been providing some short-term secondment support, however, this is logistically complex to manage and remains insufficient to meet the workforce deficit currently experienced in these regions. The ability to utilise the wider (non-MIQ) health workforce would significantly alleviate the pressure the MIQF health workforces are under.

There is an opportunity to amend the dedicated MIQF health workforce policy to improve the flexibility and agility of the health workforce, and to support the current community outbreak.

35. As detailed in HR20211071, the public health risk profile of the MIQF health workforce has changed considerably since the establishment of MIQFs and the introduction of the policy in mid-2020. A wide suite of robust public health and IPC mitigations are in place (HR20212083 *'The in-MIQF transmission risk mitigation map: findings and ongoing work programme'*), and therefore the MIQF health workforce are at low risk of becoming infected or being sources of transmission, even within a Delta environment.

36. 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.

37. 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;
- Alleviate the pressure currently faced by the MIQF health workforces in Auckland and Waikato as they manage the current community outbreak, by allowing the wider (non-MIQ) health workforce to provide support;
- 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, 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

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

38. Within the context of the current community outbreak and the pressure this is placing on the MIQ system, as well as our continued confidence that there is a low public health risk associated with allowing the MIQF health workforce to work across a range of clinical settings, we recommend removing the requirement for a dedicated MIQF health workforce.

39. 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.

40. It will also allow non-MIQF employed healthcare workers to support the MIQF health workforce throughout high workload periods. This is particularly important in the Auckland and Waikato as they support community cases/contacts that are isolating/quarantining in MIQ.

41. 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 16.

42. 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.

43. With the range of public health and IPC mitigations in place summarised in paragraph 37, we have continued confidence that the public health risk of allowing MIQF healthcare workers to move between MIQFs and other clinical settings is considered to be both low and manageable. 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.

44. Currently, the range of public health and IPC measures summarised in paragraph 37 are sufficient to permit the MIQF health workforce to go about their normal lives outside of work e.g. attending places of worship and other community events. 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.

45. 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.

46. Note that this 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). Additionally, the following suite of public health and IPC measures will continue to apply:

- Healthcare workers will continue to undergo regular surveillance testing, as required under the Required Testing Order;
- 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, including the use of P2/N95 particulate respirators in returnee-facing zones.
- We will review the change after 3 months.

Implications

47. 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 52- 54.

48. 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.

49. 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.

Option 2: Status quo – retain current MIQF dedicated health workforce policy

50. If no change is made to the policy at this time, the capacity challenges the Auckland and Waikato MIQF health workforces are currently facing will continue, as the ability for other regions to provide short-term secondment support is both insufficient and unsustainable. Additionally, 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.

51. 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.

Communications

52. 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.

53. 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).

54. 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

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

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

END