Briefing for the Incoming Minister for COVID-19 Response

Hon Dr Ayesha Verrall

17 June 2022

Contents

Section 1 – Introduction

1. The briefing provides you with high-level information in relation to your new portfolio, as well as further background and context. It outlines:

   a. an overview of the COVID-19 response and evolving COVID-19 situation

   b. the legislative and public health tools at your disposal to continue leading its management

   c. the strategy and policy elements of the response by the Ministry of Health (the Ministry) and the key operational efforts led by Health New Zealand.

2. The briefing is not intended to be fully comprehensive. For example, it does not cover matters you dealt with in your previous Associate Minister for COVID-19 Response role including testing and surveillance or contact tracing and case investigation. Further advice on specific matters will be provided as required, from the Ministry and the new health entities being established from 1 July 2022.

COVID-19 response in context

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

Functions and structure of the Health portfolio

4. The COVID-19 response now sits within new structure of the health and disability system, which will go live on 1 July 2022. The final health sector will ultimately be made up of the following organisations and roles:

   a. **Ministry of Health** - will have a range of enduring roles, including as:

      i. strategic advisor to Minister of Health (Minister's 'agent') and Minister for COVID-19 Response

      ii. steward of the health system

      iii. regulator, including statutory roles (for example, Director of Public Health, Director of Mental Health)

      iv. system performance and monitoring

      v. policy and strategy leadership

      vi. Crown Entity monitoring and appointments.

   b. **Public Health Agency (PHA)** – will (within the Ministry of Health) be responsible for leading population and public health policy, strategy, regulation, intelligence, surveillance and monitoring.

c. **Health New Zealand (HNZ)** – will manage the health system across local, district, regional and national functions; plan and commission services for the whole population; provide a national public health service; and improve services, equity and health outcomes for all New Zealanders.

d. **Māori Health Authority (MHA)** – will be responsible for ensuring the health system provides more equitable outcomes for Māori through partnering with the Ministry to advise on hauora Māori, directly funding health services grounded in te ao Māori and working with HNZ to plan and monitor the delivery of health services.

e. **Ministry for Disabled People** – will lead a disability work programme encompassing strategic policy, stewardship, the ongoing transformation of disability support services in line with an Enabling Good Lives approach, and capacity and capability building to remove barriers across government and drive improvements in outcomes for disabled people and whānau.

5. The Ministry is also focused on supporting the new and improved health system to work collaboratively and continue providing a seamless health service for New Zealanders and a joined up COVID-19 response. Given the restructure has deliberately re-balanced priorities, we understand that this will involve reaching out across our colleagues to continue providing integrated advice in a way that is useful and timely for ministerial decision-making.

6. As well as contributing to a health and disability-system-wide response to COVID-19, HNZ is focused on developing new ways of working. These will harness the opportunities presented by the health and disability system reforms, build on the tools and lessons gained through the COVID-19 response to date and strengthen resilience to future outbreaks of infectious diseases, in a way that significantly improves equity (one of the main purposes of the health restructure). This includes:

a. A partnership between HNZ and the MHA, and strong relationships with Iwi-Māori Partnership Boards.

b. The development of locality plans, by HNZ and MHA working with the Iwi-Māori Partnership Boards. These plans will have a strong focus on population health and improving equity by strengthening alignment across sectors to address the determinants of health. They will be developed with local communities and in partnership with social sector agencies. There is an opportunity to build on the Care in the Community model developed as part of the COVID-19 response.

c. Valuing the contribution of Māori and Pacific health providers, the communities they work in, and their commitment to keeping Iwi and whānau safe over the last two years. This will be a continuing focus.

d. Building on the public health, primary care, and community workforces, which have been at the forefront of the COVID-19 response, to support the response to other infectious diseases.

e. Strengthening public health workforce capability beyond responding to COVID-19. This will be a central part of building capacity in the National

Public Health Service. To meet the needs of Māori, prioritising building Māori public health workforce capacity and capability will also be essential to our obligations under Te Tiriti o Waitangi.

f. A data driven approach building on the infrastructure for COVID-19 response, to ensure activities are delivering equity. To achieve this, HNZ will work closely with the PHA, which is leading a strengthened, comprehensive, and robust public health intelligence, knowledge, and surveillance system.

An evolving health sector relationship with the All-of-Government function

7. The Ministry has provided public health advice throughout the pandemic in close collaboration with DPMC coordinating an All-of-Government perspective. While DPMC has coordinated advice on changes to the COVID-19 Public Health Response (Protection Framework) Order, the Ministry provides the public health advice on any such changes. The Ministry will also provide you that advice following its monthly COVID-19 Protection Framework (CPF) assessments separately. This also occurred via the Ministry's support of the Reconnecting New Zealanders programme and the legislative changes to give effect to it.

8. This division of responsibilities has allowed each agency to play to its strengths and appears likely to continue in the same manner until the end of 2022 at the earliest. In this context, the Ministry has focused strongly on its public health advisory role as well as providing Minister's advice on the equity implications of different decisions with respect to COVID-19. Our approach to that advice is described more below.

9. The Ministry recognises that the demands on the health and disability system to respond to the pandemic, while necessary, have resulted in deferred care and unmet needs across various areas of care, This includes influenza and MMR immunisation, screening programmes, COVID-19-related workforce shortages, and the management of regular long-term conditions. Part of the challenge now is to rebalance the response so that it moves from being purely pandemic oriented, to one that integrates with the wider health and disability system.

Overview of the Government's COVID-19 strategy

10. On 18 October 2021, Cabinet replaced the Elimination Strategy and the Alert Level framework with a new "minimisation and protection" approach of the COVID-19 Protection Framework (CPF) [CAB-21-MIN-0421]. This shift in strategy at the time reflected that:

a. the epidemiological context meant that blunt response measures (such as lockdowns) were becoming less effective as they needed to last longer, had high social and economic costs, and required very high levels of compliance.

b. Testing, contact tracing, and managed isolation and quarantine systems were under considerable pressure

c. COVID-19 was now finding its way into more vulnerable communities, often undermining the effective use of certain public health control measures (such as timely contact tracing)

d. growing vaccination rates was reducing hospitalisation and mortality rates enabling the health and disability system to better manage COVID-19

e. social license for the Elimination Strategy was being eroded

f. the case for continuing limiting rights under New Zealand Bill of Rights Act 1990 (in particular, movement and activities like gatherings) was weakened with growing vaccination rates and the public health advice.

11. The CPF has since enabled greater freedoms with fewer population-wide restrictions by minimising the impact of COVID-19 on those most at risk of severe health outcomes from COVID-19, primarily through high vaccination rates and other public health measures.

12. While the public health measures in the CPF remain relevant, we note that DPMC are due to lead a further review of the framework shortly. The Ministry will provide advice on the public health measures needed to respond to the pandemic on an ongoing basis, whether those measures fall into the CPF or not.

The Ministry of Health's approach to advising on COVID-19

An equity-first approach

13. The Ministry takes an 'equity-first' approach to its COVID-19 response which is underpinned by the Government's commitment to Te Tiriti o Waitangi. This is about caring for the health and wellbeing of all New Zealanders in the response. It includes recognising the disproportionate impact of COVID-19 on our most vulnerable populations, including Māori, Pasifika, disabled people, the elderly or immune-compromised.

14. Challenges associated with both the direct impacts of COVID-19 and the measures in place to mitigate its worse impacts remain disproportionate for many groups, including Māori, Pacific People, disabled people, and wider ethnic communities. Work continues to improve the response to reduce these inequities. For example, the Ministry is working actively with the Iwi Chairs Forum and Te Arawhiti to ensure the Ministry provides good access to data and analytical support to empower Iwi and Māori communities to look after their whānau alongside the Government.

15. The COVID-19 Māori Health Protection Plan (the Protection Plan) was published in December 2021 to respond to the pandemic evolving from the Delta variant to community-wide transmission of the Omicron variant. The Protection Plan helps guide health and disability system COVID-19 response actions for Māori through the next three to 12 months. The Ministry continues to monitor the impact of the COVID-19 pandemic on Māori as it is essential to ensure the ongoing response of the health and disability system gives effect to the principles of Te Tiriti o Waitangi.

16. The May 2022 Monitoring Report of the COVID-19 Māori Health Protection Plan: highlighted drivers of improving Māori vaccination uptake and growing Māori community resilience. It showed that since December 2021, targeted communications had improved, funding to Māori providers to lead local

responses had increased, Māori access to testing had improved, and enabled a joined up approach for whānau isolating at home. Despite these improvements, persistent inequities remain in COVID-19 infection and hospitalisation rates, COVID-19 third (booster) dose, and child immunisation rates for Māori.

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

18. Māori health providers are also continuing to voice concerns about the wider socio-economic impacts on whānau, and in 'catching up' on deferred health services (e.g. broader immunisations, childhood MMR, screening services). The Māori health workforce, communities and providers are exhausted and stretched as they provide the health, housing, and manaaki services required to keep protection up. Sustaining this ongoing support and protection requires strong treaty-based partnerships and commitment of resources at all levels of our health and disability system to improve equity and health outcomes.

Advice informed by science, evidence, and public health expertise

19. As you know, throughout the COVID-19 response we have sought to provide the Government public health advice based on a strong evidence and scientific insights. This necessitates that the Minsitry continually update our understanding of COVID-19 and therefore its advice, so that the Government is always grounding its COVID-19 response on the latest evidence, data, and information.

20. For example, while it was initially thought that COVID-19 was largely transmitted via droplets, there is now overwhelming evidence that it is primarily airborne. This means that we now know that measures previously used commonly (such as use of plexiglass), are of limited benefit in preventing transmission.

21. We are also committed to continuing to learn about COVID-19 and other infectious diseases to improve our response over time. In some areas, the knowledge base is taking time to develop until it is useful for decision-makers. For example, evidence around Long COVID continues to evolve and there are still no *internationally*-agreed definitions yet, and many different study designs.

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

Next steps

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

24. It is the Ministry's view that focusing solely on removing public health measures risks minimising larger objectives such as protecting New Zealand (as individuals and whānau) from the current outbreak or new variants. It also risks cutting across equity-first goals. Further, reducing the overall burden of disease, hospitalisation and death is as important for the economy as it is for society.

25. Above all, the Ministry recognises that the pandemic is not yet over. There remains a significant ongoing outbreak across New Zealand with the potential for further (high impact, but low probability) COVID-19 variants in future. In this context, it is critical to retain the ability to deploy the full range of necessary public health measures to manage the pandemic and other illnesses through winter, albeit while minimising the impacts on rights and the impost on individuals and families wherever possible.

Section 2 – Current outbreak situation and outlook

Levels of infection have remained broadly at the same level since mid-April

26. Since the March peak, COVID-19 case rates were declining up to the week of 17 April, after which a plateau has been observed in national case trends. However, case rates remain relatively high.

27. The overall national picture shows a slight decrease in cases in past two weeks compared to the past four weeks of plateau; driven by a decrease in the Northern and Te Manawa Taki regions. However, cases in the Central region have increased by six percent in the previous week compared to all other regions. Cases in the Southern region are still 30 percent higher than overall national case rates.

28. Infection levels are likely higher than the self-reported cases indicate. This is due to wastewater RNA not decreasing since early April until a slight decrease in the past week, despite an overall substantial decrease in case rates since March.

29. Fatigue from following public health requirements, misconception about the level of infection risk and infection trends from reported cases could be impacting infection prevention and control behaviours and public health measures. This may be increasing risk of infection, especially among vulnerable populations.

30. There continues to be detection of BA.4, BA.5 and BA.2.12.1 in the community both in wastewater and in community whole genome sequencing. Current levels are likely to increase in the coming months.

We expect a significant winter wave of respiratory illness

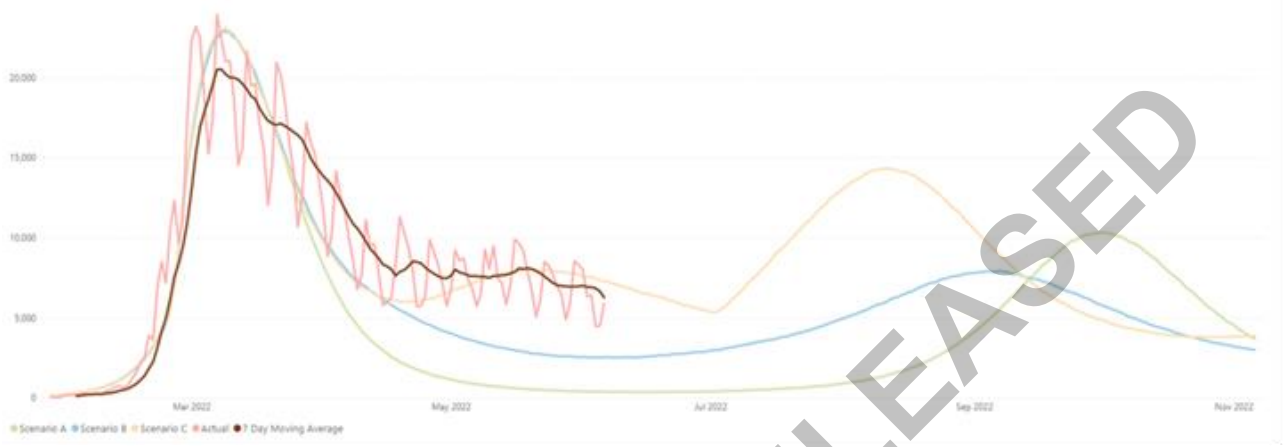
31. These scenarios are based on the current Omicron BA.2 variant. Any significant changes in the virus could cause significantly different case numbers. The BA4/5 variant is now emerging in New Zealand and has a clear transmission advantage. The Minsitry therefore expect that this will add significantly to case numbers over winter leading to further spike in hospital admissions.

32. The size and timing of a second wave will be affected by a combination of changes in modifiable exposure risk factors (behavioural/public health measures).

Changes in the distribution of infections in older and more at-risk populations will also impact the size and timing of the second wave.

33. Currently cases are tracking closely to 'C', the scenario with the largest increase in transmission after the March peak.

Figure 1: COVID Modelling Aotearoa scenarios compared with reported cases nationally



Regular reporting

34. The Ministry and HNZ provides data analysis, epidemiological oversight, and reporting to understand the burden of COVID-19 across New Zealand including:

    a. Situational Report (SitRep) – Released daily, updating current cases, hospitalisations, deaths, health system readiness, vaccination, and testing.

    b. Trends and Insights Report – Released every Friday, provides an abroad, national, and regional overview with key insights based on quantitative trends in the New Zealand, including the trends and scale of infection and diagnosis as well as morbidity and mortality. HNZ weekly reporting will also cover service impacts.

Section 3 – Legislation

Overview of the COVID-19 Public Health Response Act 2020

35. While legal measures only comprise part of the government's response to COVID-19, they remain an important one, even as we look to reduce the burden as much as possible on individuals, whānau and society. As you know, the COVID-19 Public Health Response Act 2020 (the Act) provides the primary legal framework for enabling laws and regulations as part of the COVID-19 response.

36. Principally, the Act allows the Minister for COVID-19 Response to make Orders to give effect to the public health response to COVID-19. It was designed to provide a flexible and adaptable legislative tool for the Government to respond quickly to changing circumstances over the course of the pandemic, ultimately to protect human life.

37. The Act is emergency legislation which was never intended to operate indefinitely. For this reason and reflecting the gravity of powers available under

the Act, there are numerous checks and balances on the making of COVID-19 Orders. These include:

a. **prerequisite conditions for Orders to be made** under the Act, such as an epidemic notice made under the Epidemic Preparedness Act 2006 being in force in relation to COVID-19

b. **strict limits on the purposes for an Order** may be made, specified in the Act

c. **limits on the circumstances in which an Order can be** made by either the Minister or the Director-General of Health

d. **limits on the application of Orders**, for example, an Order may not be made in relation only to a specific individual or impose a requirement on persons within the Parliamentary precinct

e. **extensive requirements for advice, scrutiny, and review of Orders** before and after an Order they are made. In particular:

    i. the Minister must have regard to advice from the Director-General on certain matters before making an Order

    ii. certain other Ministers must be consulted before the Minister makes an Order

    iii. the Minister must be satisfied that the Order does not limit, or is a justified limit, on the rights and freedoms in the NZ Bill of Rights Act 1990 (NZBORA)

    iv. the Minister and the Director-General are required to keep all Orders under review while in force, and

    v. each Order must subsequently be approved by the House of Representatives, after it has come into effect.

f. **automatic self-repeal of the Act** on 13 May 2023, or if the House of Representatives does not pass a resolution to continue the Act at least every 90 days.

38. Consideration of the impact of an Order on the rights and freedoms set out in New Zealand Bill of Rights Act (NZBORA) is central to the making of COVID-19 Orders. Before the Minister may make an Order, she or he must be satisfied that the Order does not limit, or is a justified limit, on these rights and freedoms. For a limit to be justified, it must be proportionate to the public health risk at a given point in time, and likely to be effective in mitigating this risk.

39. In conjunction with the requirement that Orders must be kept under review. This means that where there is a diminishing public health risk from COVID-19, it may not be lawful to maintain existing measures in COVID-19 Orders which were designed to mitigate this risk. For this reason, the Ministry regularly considers the proportionality and likely effectiveness of different COVID-19 Orders and provides advice to the Minister on any changes which may be required.

Current COVID-19 Orders

40. The suite of COVID-19 Orders in place under the Act is changing rapidly. Several recent Ministerial decisions are now being implemented, and some Orders have been recently revoked or will soon be revoked due to the diminished public health risk from COVID-19 in several different settings.

41. While COVID-19 Orders are the primary tool available under the Act to give effect to public health measures, numerous other legislative instruments are currently in force. This includes:

    a. **Regulations under the Act**, dealing with infringement offences under certain Orders and charges levied on individuals subject to managed isolation and quarantine requirements,

    b. **Notices made under certain Orders**, primarily by the Director-General of Health, which specify detailed technical requirements or other matters in relation to requirements in an Order, and

    c. **Exemptions granted by the Minister or Director-General** for individuals and classes of persons from requirements under certain Orders.

42. An overview of all COVID-19 Orders in force is at **Appendix One**, including the status and work underway in relation to each.

Next steps

43. *Extension of the COVID-19 Public Health Response Act 2020* - a motion is currently before Parliament to extend the expiry date of the COVID-19 Public Health Response Act 2020 until 31 December 2022. That motion must be passed by 30 June 2022, before the Act is currently due to expire.

44. *Medicines Amendment Bill* - the Medicines Amendment Bill (to allow further vaccination doses) is before Select Committee. It is due for consideration of all its remaining Parliamentary stages next week.

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

Post winter planning/future legislative arrangements

46. DPMC's parallel briefing to you is the principal briefing in relation to post-winter planning and future COVID-19 legislative arrangements. The Ministry will also keep you up to date with this work.

Section 4 – Key COVID-19 response tools

COVID-19 Protection Framework (CPF)

47. The CPF was designed for the Delta variant with a focus on vaccination status. It was later adjusted for the Omicron variant and the evolving COVID-19 context. New Zealand has been at the Orange setting of the CPF since mid-April 2022,

when Auckland was shifted from Red. This shift saw the removal of capacity limits and face masks in most settings, including schools across the country.

48. The CPF uses population-wide measures with the objective of minimising the impact of, providing protection from, and slowing the spread of COVID-19. With the removal of vaccination status the key measures that remain under the CPF are mask use and capacity limits (only at the red setting).

49. Any future changes will need to be linked to ongoing support for iwi, hapū, whānau, and hapori (communities), including to make decisions about how to protect those communities, regardless of the legal settings introduced by government. As mentioned above, this includes sharing data, information, and relevant analysis with our Treaty partners to enable partnership approaches in our continued response.

The Ministry's COVID-19 Assessment Committee informs our CPF advice to Government

50. The Ministry established an internal committee, led by the Director of Public Health and senior Ministry staff, including the Chief Science Advisor, Chief Medical Officer and other chief clinical officers, and Māori health leadership.

51. The Committee meets on a regular basis, initially fortnightly, now monthly to review the CPF colour settings. In doing so, the Committee reviews the outbreak trajectory, epidemiological trends and receives reports from regional leads across the country that report on health system capacity to meet current demands.

52. At the direction of Cabinet in in early 2022, the Committee also reviews self-isolation periods for cases and household contacts. Current self-isolation settings remain at seven days, consistent with the available evidence on transmissibility and the likely impact on cases, hospitalisations, and deaths of reducing the settings.

Upcoming CPF-related actions:

53. Ministers will consider the CPF colour settings on 27 June 2022 based on advice provided by DPMC which will contain the Ministry's public health advice.

Vaccination against COVID-19

The vaccination programme has been a significant undertaking

54. In 2021, New Zealand embarked on the largest vaccination programme in its history, with the aim of providing 4.2 million eligible people with the opportunity to be double-vaccinated against COVID-19. Since the first vaccines were administered on 19 February 2021, 96 percent of the eligible population over 12 years have received a first dose and 95 percent have completed their primary vaccination course. As of 14 June 2022, close to 2.7 million booster doses have been administered to 77 percent of the eligible population. Booster doses were made available to 16- and 17-year-olds from April 2022, at an interval of 6 months after completion of their primary course.

However, paediatric vaccination rates continue to lag behind adult rates

55. Vaccination of children aged 5-to-11-years-old commenced on 17 January 2022 using the Pfizer Paediatric COVID-19 vaccine. As of 14 June 2022, 55 percent of children in this age group have received a first dose of vaccine, and 27 percent have completed their primary course. Uptake of the paediatric vaccine has been impacted by the Omicron outbreak, with many children either testing positive for COVID-19 or isolating in a household with a positive case.

56. On 14 March 2022 the Novavax COVID-19 vaccine became available as a two-dose primary course. Approval has not yet been given to use this vaccine as a booster. The rollout began with a small number of sites as the start date was brought forward to help protect as many people as possible from the Omicron outbreak. The Programme continues to monitor the status of the vaccine's use as a booster, as this would materially increase demand for the vaccine.

Equity continues to be at the centre of vaccination design and implementation

57. Equity for Māori, Pacific, disabled people, and ethnic communities has been at the centre of the vaccination programme design and implementation since the emergence of COVID-19 in Aotearoa.

58. To achieve this, the Ministry has been working in partnership with district health boards (DHBs), Māori and Pacific health providers, and disability sector leads to develop locally-focused initiatives that suit the needs of communities. You will be briefed further on these initiatives in due course by HNZ.

Fourth dose update

59. This week DHBs started administering second booster doses to people in Aged Residential Care (ARC) facilities who received their first booster more than six months ago. These doses will be administered through use of prescription prior to the legislation change. Once the legislation has passed, the Director-General will decide on the eligible groups for a second booster and enable roll out to these groups without the need for a prescription.

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

Ventilation

61. Given the evidence that SARS-CoV2 transmission is primarily airborne, ventilation is critical for preventing airborne spread indoors. However, there are many challenges in defining what effective ventilation is for the purposes of reducing risk of transmission.

Public advice to individuals and businesses on practical ways to improve ventilation

62. The Ministry has signalled the importance of ventilation in the built environment for more than a year. This work developed from the management of the risk of transmission of COVID-19 within managed isolation. While there is some public messaging on ventilation on the Ministry's website[1], further public advice could

[1] https://www.health.govt.nz/covid-19-novel-coronavirus/covid-19-health-advice-public/covid-19-ventilation

support individuals and businesses to improve ventilation and reduce risk of COVID-19 transmission

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

Engagement with the Ministry of Education

64. The Ministry has ongoing engagement with the Ministry of Education (MoE) about improving ventitlation through a formally constituted advisory body assisting in the development of a ventilation programme managed by MoE.

Future direction

65. Short term goals are primarily directed towards an educational campaign, which will enable building owners and users to ensure adequate ventilation within their spaces. Clear, simple stepwise guidelines have been developed by several agencies, for example the Government of Victoria in Australia[2].

66. Medium-term and long-term goals remain to develop a task force to assess mechanisms for the improvement of ventilation in the built environment through education, guidance, publicity, regulation, and legislation.

Section 5 – Short- to medium-term response planning

Health Border Strategy

67. In December 2020, Cabinet established the Border Executive Board (BEB) to provide a stewardship role ensuring that the border system is well placed for the future, including developing a Border Sector Strategy [CBC-20-MIN-0099 refers].

68. Through the BEB, the Prime Minister has requested the development of a Health Border Strategy led by the Ministry.

69. The PHA is leading this work which will guide agencies on health at the border for the next ten years. The Ministry will also implement it alongside the wider All-of-Government Border Sector Strategy under the BEB. This will focus on a health response at the border that is well connected, proactive and innovative when responding to health threats, and incorporate lessons and insights from our COVID-19 response.

Current situation

70. The PHA is working on the strategy development, engaging with border agencies, and is looking to start initial consultation with stakeholders on the proposed vision, scope, and guiding principles for the strategy.

Next steps

[2] https://www.coronavirus.vic.gov.au/ventilation#ventilation-guidance-for-businesses

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

72. The Ministry will deliver a Health Report s 9(2)(f)(iv) [redacted] seeking agreement on the draft scope, vision, and guiding principles for the strategy (and options for proposed steps to developing the Health Border Strategy).

Winter response

73. COVID-19 will remain a major focus over the coming months as we deal with the increase in pressure on the health system over winter. However, as our borders open, our exposure to new or varied influenza-like illness alongside our current management approach to Omicron has required considered preparation and response. This is not withstanding the potential of new variants of COVID-19 emerging in our community.

74. The Ministry has worked with DHBs on critical care capacity and planning for winter illness, COVID-19, influenza, respiratory syncitial virus (RSV), whooping cough, measles, and acute care surges due to delays in planned care.

75. Due to the high level of COVID-19 preparedness and planning in response to both the Delta and Omicron variants, New Zealand has effectively planned for winter for many months. However, health sector fatigue is a large challenge after two years of COVID-19 response and workforce capacity is under considerable constraint which in turn is impacting on system response.

76. Winter preparedness and now response was based on modelling for RSV, COVID-19, and other respiratory illnesses. Modelling has indicated that peaks may occur between June and October 2022. We are now experiencing peaks in May that are higher than any previous peak.

77. Winter preparedness reviews have been completed by the Ministry, via checklists that replicated the work completed for health system preparedness for COVID-19. Analysis showed an overall uplift in national preparedness, with 88.7 percent of planning activities completed, 4.7 percent of planning activities partially completed, and 6.7 percent of activities outstanding. The significant pressure points identified included:

    a. Workforce – recruiting and retention, absenteeism, wellbeing and fatigue, staff resilience, industrial action, non-regulated workforce, caregiver service continuity and disruption for disability, and the impact of border reopening.

    b. System pressures – primary care capacity, delivery of planned care, limitations of facilities, emergency department volumes, and ARC capacity.

    c. Funding – outcomes-based funding for providers, Care in the Community funding, and funding for planned care delivery by private providers.

78. Workforce constraints due to international and national shortages of qualified health care staff, as well as staff illness, contribute to reduced capacity in the system, for which there is no quick solution. HNZ is establishing a workforce taskforce to address workforce challenges across the health system.

79. Winter preparedness planning forms part of the long-term strategy for managing COVID-19. The strategy evolves from a purely pandemic response, to one that responds to and balances against other health priorities. The Ministry and HNZ are currently working to determine role division and responsibilities within the winter planning space.

HNZ winter response

80. HNZ is establishing its response to lead a nationally consistent approach to the winter response to the increased pressure on the health service delivery system. The interim Director for Hospital and Specialist Services, and the Regional Chief Executive have established a programme of work to:

    a. implement national and regional measures to monitor the capacity of the system

    b. implement a nationally consistent escalation plan that includes associated actions to manage demand, support hospitals to manage capacity and ensure discharge is safely expedited.

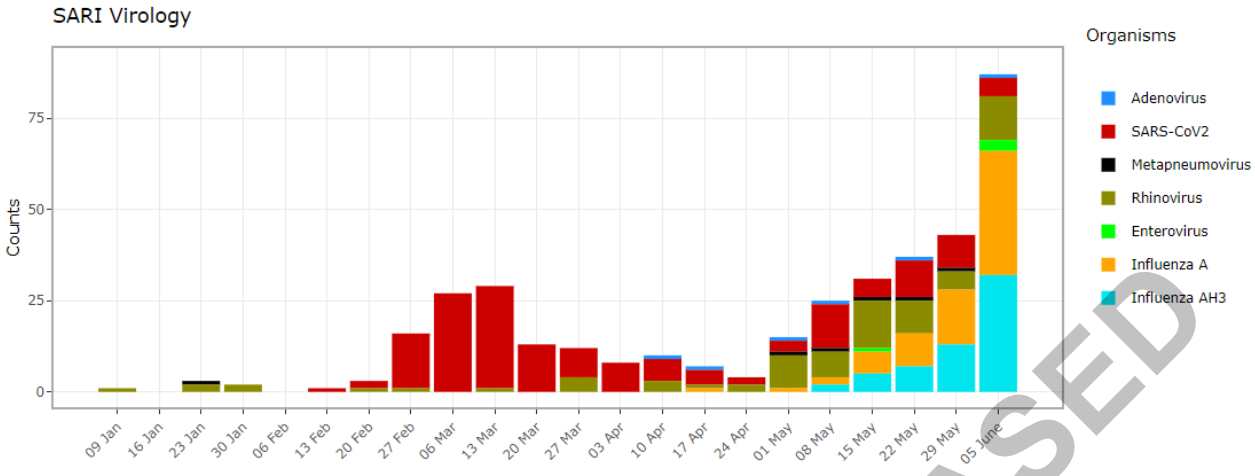
81. This process is supported by regional and national leadership, including a winter IMT.

Demand from COVID-19 on hospital system capacity

82. As shown in Figure 2 below, COVID-19 as a demand pressure is still evident in Auckland, but less so that it was in February/March 2022 with flu now being the most prevalent respiratory illness. In addition to demand, COVID-19 has a considerable impact on capacity as COVID-19 related staff absences (plus wider absences related to winter pressures) limit the systems' ability to expand capacity e.g. open more beds.

83. COVID-19 has led to urgent care pathways becoming less productive due a number of constraints such as time taken to don/doff PPE, testing, social distancing, etc. All of the above will likewise impact primary and community care, who are also under pressure. COVID-19 cases in the community and in ARC limit hospitals' ability to discharge patients in a timely manner to free up acute ward beds. This is all further compounded by other winter pressures – increased demand, increased acuity of patients, which is leading to the challenged performance being seen. HNZ provide weekly reporing on this to COVID-19 Ministers. It includes actions HNZ is taking to help manage capacity constraints through a regional approach.

Figure 2 – Hospitalisation rates for Severe Acute Respiratory Infection (SARI) in the Auckland region



COVID-19 Variant Strategy

84. The Ministry has recently provided you with the updated Variants of Concern Strategic Framework and provided input into the DPMC Cabinet paper *Confirming New Zealand's approach to variants* that went to Cabinet on Monday 13 June 2022. The Strategic Framework remains a living document, and will be updated to reflect feedback and emerging evidence as it becomes available, as well as reviews at regular intervals.

85. To support the operational response to any COVID-19 Variant of Concern, detailed planning continues within the Ministry and across government. This will inform Cabinet report backs on health and disability system and variant preparedness, and ongoing work on ventilation between July and October.

Section 6: Current COVID-19 Health System Service Response

Care in the Community

86. Due to the nature of its role in preparedness and enabling people to manage COVID-19, Care in the Community (and the wider Health System Preparedness Programme) presently report to the Minister of Health. Care in the Community is designed to manage greater levels of COVID-19 across the community and to provide a transition pathway out of a response model. Responsibility for Care in the Community which transitioned from the Ministry to HNZ on 10 June 2022.

87. The framework is locally led, regionally coordinated, and nationally supported, reflecting the diverse needs and inequities of communities. This is achieved through a high level of collaboration between the health and disability sector, the welfare sector, Iwi and Pacific providers, and community groups.

88. Ensuring Care in the Community is delivered equitably is critical to providing the most vulnerable and high-risk communities the care and support required to manage COVID-19. For example, it has used a partnership model that has designed and developed 18 marae-based Māori/Iwi Care Coordination Hubs

(Hubs) to provide appropriate clinical health and manaaki care, helping to mitigate some of the worst impacts of COVID-19 for Māori.

89. Hubs remain the primary structure for coordinating and delivering COVID-19 Care in the Community. There are now 52 Hubs across Aotearoa, including 18 iwi/marae based Hubs, three Pacific Hubs, and two Ethnic Community Hubs.

90. By utilising the Hub model, the welfare and wellbeing support can be tailored to each individual and the needs of the household. This is being led by the Ministry of Social Development in collaboration with Ministry of Education, Kāinga Ora, Iwi and Pacific providers, disability provider organisations, and others.

91. Alternative accommodation can be provided to people and whānau who are unable to safety isolate at home. The procurement and delivery of alternative accommodation is managed by the Ministry of Business, Innovation and Employment.

Primary care services

92. Primary care continues to have a critical front line role in our response to COVID-19 through administering tests, providing telehealth consultations, delivering vaccines, enabling access to RATs and providingCare in the Community services.

93. Likewise, pharmacies provide specialised services to support, administer supervised RATs and vaccines both COVID-19 and now influenza.

Winter surge is placing considerable pressure on the primary care workforce

94. The challenge with shifting work to primary care and community pharmacy to alleviate demand on hospitals and in particular emergency departments is that workforce pressures are also evident in primary and community care. As they are often smaller providers, the workforce is more vulnerable to business continuity impacts from sickness. There is limited access to locum/casual staff.

95. s 9(2)(g)(i) [redacted]

Secondary/tertiary care services

96. The Ministry has been working with DHBs on critical care capacity and planning for the upcoming winter illness, COVID-19, RSV, whooping cough, measles, and acute care surges due to delays in planned care.

Emergency department wait times

97. While the responsibility of the Minister of Health, emergency departments (EDs) continue to receive significant numbers of presentations each week which are often compounded by people with COVID-19 presenting. Nationally approximately 21,000 - 23,000 people are seen in ED each week with seasonal fluctuations seen through the year.

98. . The expectation is that 95 percent of patients are seen within six hours. Most DHBs are not meeting this expectation, with only South Canterbury and Tairāwhiti DHBs regularly meeting expectations.

99. While several hospitals are experiencing short-term surges in increased patient presentations with reduced or limited resourcing (nursing staff), all DHBs have plans in place for managing this increase with limited resourcing. The approach differs by DHB and hospital, based on the local setting and the spaces available to them. ED attendance for the week ending 2 June is among the highest since reporting commenced. Number of ED presentations show the same pattern as the number of admitted patients. This will likely continue for over the winter period due to expected increase in COVID-19 and other infectious diseases.

Intensive Care Units

100. There have been ongoing concerns regarding public hospitals having physical critical care beds, equipment, and personnel to manage the additional demand expected from patients with COVID-19 and other winter illnesses.

101. Care at critical-care level is a relatively small proportion of the care provided for COVID-19. New Zealand has not experienced the pressure on critical care seen in many other jurisdictions. The Care in the Community programme has been instrumental in supporting this in the Delta and Omicron surges.

102. Across the country DHBs have ward, intensive care unit and high dependency unit (ICU-HDU) beds and ventilator capacity available. If a region or hospital comes under additional pressure, they have plans in place to move staff or transfer patients as needed. Across the spectrum of intensive care and high dependency beds, New Zealand has around 250-260 resourced beds daily. If required, hospitals could surge to approximately 550 ICU-HDU capable beds.

103. A key challenge is demand for nurses within the critical care setting, given the ratio of specialist nurses to patients (generally 1:1 and 1:2 depending on patient acuity). A programme of workforce initiatives targeted at nursing and key allied health professions will support the staged implementation of the beds through the 2022/23 year.

Planned Care

104. Planned Care delivery in 2021/22 has been significantly affected by COVID-19. However, Planned Care services have continued with priority being given to patients with the highest clinical need and urgency, including cancer cases.

105. The Government has allocated funding of $282.5 million over three years to enable DHBs to lift levels of Planned Care delivery to support the COVID-19 backlog and to reduce waiting lists. This funding was allocated over three years, recognisng the challenging recovery process due to the continued risk to service provision presented by COVID-19.

106. HNZ has established a Planned Care Taskforce to develop a comprehensive plan to support improved equity of access to Planned Care services and reduce waiting lists. This builds on work already underway within DHBs. Waiting lists are

expected to increase and will take some time to return to a state where patients are being managed within waiting time expectations.

Long COVID services

107. Long-term effects after COVID-19 infection have been reported internationally. Given the amount of people who have been or will be infected with SARS-CoV-2 worldwide, the public health impact of Long COVID could be significant. Due to the lower COVID-19 infection rates in New Zealand prior to 2022, the proportion of the total population with long-term effects from COVID-19 to date has been small. As COVID-19 has disproportionately affected certain populations and exacerbated inequities the burden of Long COVID is likely to continue this trend.

Work on Long COVID continues

108. A Long COVID Expert Advisory Group has been established, meeting for the first time on 1 June 2022. The group's purpose is to provide guidance and input into the development of the clinical rehabilitation guidelines for people with Long COVID in New Zealand, through a Te Tiriti-aligned governance approach. The group has broad representation from Māori, Pacific peoples, disabled people, researchers, clinicians, service providers and people with lived experience.

109. An agreed clinical case definition for post-COVID conditions has been endorsed by the Expert Advisory Group for long COVID programme. This provides clarity to all sectors and the wider population, as well as forming the basis accurate representation for data collection, analysis and reporting. The definitions are:

    a. **Ongoing symptomatic COVID-19**: signs and symptoms of COVID-19 from 4 weeks up to 12 weeks

    b. **Post COVID-19 syndrome (lLng COVID)**: signs and symptoms that develop during or after an infection consistent with COVID-19, continue for more than 12 weeks and are not explained by an alternative diagnosis. It usually presents with clusters of symptoms, often overlapping, which can fluctuate and change over time and can affect any system in the body.

110. Read and SNOMED diagnostic codes for ongoing symptomatic COVID-19 (four-12 weeks) and post COVID -19 syndrome (long COVID), (over 12 weeks) have been developed, to support coding in patient's health records. Further work is underway to enable this coding to be utilised in practice.

111. The Ministry has also held discussions with other jurisdictions (including Australia, United Kingdom and Canada) to understand the approach to the management of Long COVID and associated health impacts and tools, including an initial investigation of a patient-clinician digital tool to support the management of Long COVID.

112. Several presentations have been made to key stakeholders and wider population groups, including a presentation to the national Long COVID Symposium – *Journeying through the Fog*. Next steps include:

a. Development of first iteration of C*linical* rehabilitation *guidelines for people with Long COVID in Aotearoa New Zealand* for Expert Advisory Group review at next meeting 13 July 2022.

b. Publication of the clinical case definition ongoing symptomatic COVID-19 and post-COVID-19 syndrome following approval of the Director-General of Health.

c. Publication of the updated *Guidance for the acute phase of rehabilitation of people with or recovering from COVID-19 in Aotearoa New Zealand* following approval of the Director-General of Health.

d. Future discussions are planned with The Dudley Group NHS Foundation Trust and Italy to continue learning from other jurisdictions.

Section 7 – Administrative matters

Upcoming Cabinet papers and briefings

113. The Ministry and HNZ will continue to update your office on the status of relevant Cabinet papers and briefings commissioned across the COVID-19 health system. A full list of these papers is provided in DPMC's briefing to you. This will ensure you have a good forward view of all papers that sit within your COVID-19 Response portfolio. HNZ will attend the regular Monday Upcoming Advice meeting with your office to support this.

OIAs/proactive release of information

114. Your office is managing a large amount of Official Information Act 1981 (OIA) requests and proactive releases. The Ministry and HNZ will work with your office to progress these as needed.

Litigation

115. Outlined below is a summary of current COVID-19 litigation the Ministry is responding to.

s 9(2)(h) [redacted]

s 9(2)(h) [redacted]

- [redacted]
- [redacted]
- [redacted]

[redacted]

- [redacted]

Appendix One: Summary of current status of COVID-19 Orders

Category	Name	Description	Current status
Border Orders	COVID-19 Public Health Response (Air Border) Order 2021	Sets requirements for people arriving in New Zealand by air.	Ministers recently agreed to changes to changes to certain requirements at the air border, including the removal of pre-departure testing requirements. A draft Order to give effect to these decisions was provided to you on 16 June 2022.
	s 9(2)(f)(iv)		
Vaccination Orders	s 9(2)(f)(iv)		
	COVID-19 Public Health Response (COVID-19 Vaccination Certificate) Order 2021 and the COVID-19 Public Health Response (COVID-19 Vaccination Certificate) Revocation Order 2022	Provides for a system of vaccination certificates for individuals to prove their vaccination status as required.	The COVID-19 Public Health Response (COVID-19 Vaccination Certificate) Order 2021 will be revoked on 17 July 2022.
Isolation and Quarantine Orders	s 9(2)(f)(iv)		

Category	Name	Description	Current status
	s 9(2)(f)(iv) [redacted]		
Testing Orders	COVID-19 Public Health Response (Required Testing) Order 2020	Provides for mandatory periodic testing of certain individuals for COVID-19.	Ministers have agreed to revoke the COVID-19 Public Health Response (Required Testing) Order 2020. A draft Order was provided to you on 16 June 2022 and will come into effect on 30 June 2022.
	COVID-19 Public Health Response (Testing for COVID-19) Order 2022	Provides for the Director-General to specify certain matters relating to COVID-19 tests for individuals who are required to undertake a test under another Order.	This Order enables and operates in conjunction with requirements for certain individuals to undergo COVID-19 testing in other Orders. It is therefore considered from time to time as part of the review of testing requirements in those Orders.
COVID-19 Protection Framework Orders	COVID-19 Public Health Response (Protection Framework) Order 2021	Sets population level requirements under the COVID-19 Protection Framework, such as face covering requirements, capacity limits on certain venues and physical distancing requirements.	The current settings under the CPF are reviewed by the Ministry on a monthly basis. Should any changes to setting be required, the Ministry provides advice to you and other Ministers, which may be given effect through changes to this Order. The most recent review was undertaken on 15 June 2022.