Megan King

From: Andrew Connolly
Sent: Monday, 1 November 2021 8:24 am
To: Michael Shepherd
Subject: Fwd: National guidance needed

Mike

I wasn't at COO meeting -but here are my concerns regarding NZOA and not seeing unvaccinated without a swab. Needs a nationally consistent approach I think. Vast differences between Auckland situation and for example Dunedin etc.

Andrew

Andrew Connolly
Chief Medical Officer
Ministry of Health
Mobile s 9(2)(a)

From: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Sent: Monday, November 1, 2021 8:16 AM
To: John Hazeldine
Subject: Fwd: National guidance needed

Robyn and Ashley have this summary of my thoughts

Andrew

Andrew Connolly
Chief Medical Officer
Ministry of Health
Mobile s 9(2)(a)

From: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Sent: Sunday, October 31, 2021 11:42:29 AM
To: Gerrie Snyman <Gerrie.Snyman@lakesdhb.govt.nz>; Nick Baker <nick.baker@nmdhb.govt.nz>
Subject: Re: National guidance needed

Thanks Gerrie

I have significant concerns with the NZOA recommendations. I spoke to the RACS NZ folk about it late last week

1. no mention of under 12s
2. Unscientific - a vaccinated health care worker is very safe with right PPE
3. Vaccinated people have incredibly low risk if hospitalisation if they do catch Covid. I acknowledge they my pass infection in to children etc though .
4. May worsen equity - an ACC client declined a review in private will need to go public hence crowding the system
5. Access to screening is limited - what about shift workers etc? Again an equity issue
6. Ignores the fact that the vaccinated can carry the virus - albeit at reduced risk of transmission
7. Ignores public health assessments such as waste water being negative is a vg sign if no covid in a particular area

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Whilst Private facilities can it seem dictate who comes in it seems the thin end of a dangerous ethical wedge.

Re Public - it's unacceptable - the experience in metro Auckland shows how safe we are in public facilities . Rapid antigen testing may well come but this approach from NZOA is in my view unacceptable - for public at least .

Andrew

Andrew Connolly
Chief Medical Officer
Ministry of Health
Mobile s 9(2)(a)

From: Gerrie Snyman <Gerrie.Snyman@lakesdhb.govt.nz>
Sent: Sunday, October 31, 2021 11:30:24 AM
To: Nick Baker <nick.baker@nmdhb.govt.nz>
Cc: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Subject: National guidance needed

Nick

Could you please forward this to the national CMO group for opinion, advice and hopefully some consensus.
I have had requests from a small but persistent number of clinicians who wishes to refuse to see/treat unvaccinated patients. Initially it was sufficient to defer these dissidents (but not achieve silence) to state that, broadly speaking, we have a duty of care to provide unbiased and non-judgemental care to all our patients and as public servants, we do not have the right to refuse to see a patient that cannot go anywhere else.
I have given the opinion that they could potentially refuse to see a patient in private, as the patient will have an alternative choice of seeking care in the public system.
s 9(2)(g)(i) [redacted]

Quoting random acts and statements from law and MCNZ have been helpful as very few of them know these well enough to counter argue. However, clinicians being who they are, are getting smarter and are starting to challenge these under the health and safety banner etc. (including the law). I have attached a letter from the orthopaedic college to illustrate this, and if they are already putting pen to paper you can guarantee the other colleges will be not far behind.

Nic/Andrew
I have chosen to read the email trail included as permission to share as I see fit in order to clarify the questions being asked. I have no issue with the distribution of the orthopaedic statement, but please consider carefully if we need to distribute the email as it does contain a lot of clinician info. I would prefer for the email to be read as clarification of the questions and scenarios being questioned supporting this email, and not be forwarded to anyone else outside the three of us.

What do I think we need?
A nationally consistent/MOH mandated statement that simply states something along the lines of: MOH expects all DHBs to treat and see all patients without prejudice regardless of vaccination status. This will still allow for different DHBs (and at different levels) to find their own comfort zone for how they will make this work. It will at least remove any of the re-interpretations of laws and acts and associated challenges.
Guidance to be incorporated into the national matrix that distinguishes between un/vaccinated patient access to hospital in elective settings, i.e. recommendations regarding pre-visit swabbing under level 2/green conditions (all

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other screening etc. taken as a given). I acknowledge that at higher levels different sets of guidance comes into play. The latter may very well be left up to local DHBs as we live endemically, so feel less invested in it.

Thank you

Gerrie Snyman

General Surgeon
Chief Medical Officer
s 9(2)(a)

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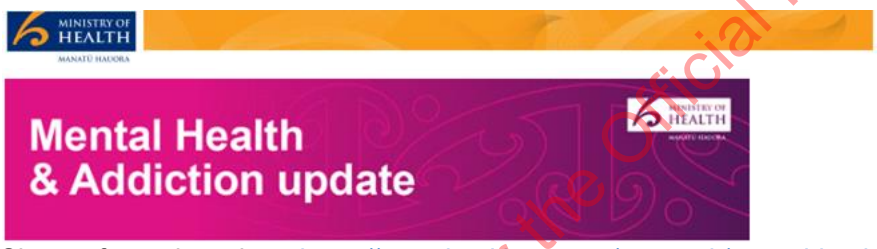
Megan King

From: Arran Culver
Sent: Tuesday, 2 November 2021 5:01 pm
To: Andrew Connolly; Juliet Rumball-Smith; Jess Smaling; Robyn Shearer; Ian Town; Martin Chadwick; Lorraine Hetaraka
Cc: Ashley Bloomfield
Subject: RE: Unvaccinated patients - plan for consistency

Kia ora Andrew,
I'm happy to help out with developing a formal response.
The number of MH&A services declining service to unvaccinated people is growing rapidly and needs an assertive response, which would best be aligned with a whole of Ministry position.
I agree that this will exacerbate existing inequities, and is not based on any kind of well-informed risk assessment.
We can't deny essential health services on the basis of vaccination status, and we need to be taking steps to protect unvaccinated people within the health system.
A meeting to clarify the issues and potential scope of a response seems like a good first step.

Ngā mihi,
Arran

Dr Arran Culver (he/him)
Chief Clinical Advisor Mental Health and Addiction
I Mobile: s 9(2)(a) **I Email** arran.culver@health.govt.nz



Sign up for updates here https://www.health.govt.nz/our-work/mental-health-and-addictions/updates-mental-health-and-addiction-directorate/subscribe-mental-health-and-addiction-update

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From: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Sent: Tuesday, 2 November 2021 12:26 pm
To: Juliet Rumball-Smith <Juliet.Rumball-Smith@health.govt.nz>; Jess Smaling <Jessica.Smaling@health.govt.nz>; Robyn Shearer <Robyn.Sxxxxx@xxxxxx.xxxx.nz>; Arran Culver <Arran.Culver@health.govt.nz>; Ian Town <Ian.Town@health.govt.nz>; Martin Chadwick <Martin.Chadwick@health.govt.nz>; Lorraine Hetaraka <xxxxxxxx.xxxxxxxx@xxxxxx.xxxx.nz>
Cc: Ashley Bloomfield <Ashley.Bloomfield@health.govt.nz>
Subject: Unvaccinated patients - plan for consistency

Hi all

We need to I think quite rapidly get advice / directive out to all providers of publicly funded services – so includes NGOs and GPs as well as DHBs. Major issue is a stance of "won't see without a negative swab" through to "won't see an unvaccinated person"

I acknowledge the fully Private system have a bunch if property rights etc that are too complex for me to navigate so I'm only referring to publicly contracted or funded work – any site.

This is clearly a threat to safe and effective delivery of care.

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I have been / am speaking to MCNZ and HDC as well as NZMA and HQSC about the broad issue. Suggest having an urgent meeting of these groups and ACC and us to outline a consistent national message.

Points to consider:

1. The unvaccinated are a much greater threat to themselves than to a fully vaccinated health worker with appropriate PPE
2. Unvaccinated are only a significant threat to vaccinated if the vaccinated need health care and capacity has been taken up by unvaccinated infected with Covid
3. Role of screening for active infection needs determining by science – the issue is far more relevant in a site with active high community transmission, but only for a few key reasons:
    a. In-patient logistics – if we know a case is positive then it's geographic site in the hospital may be different than if we do not know the status (ie "Covid ward" vs other wards)
    b. Good evidence that outcome far worse for an unvaccinated patient catching Covid in perioperative period – the brief immunosuppression associated with major surgery - definition is variable but basically anything involving GA for over an hour etc. means someone catching Covid in this period or being already asymptomatically infected is significantly more likely to have a severe course and has higher chance of death that is unvaccinated and not in perioperative phase – hence screening in widespread community outbreak may be wise to protect unvaccinated patients
    c. Logistics for timing of out-patients and diagnostic services where clinical timeframes will not be harmed by deferral if positive on screen test.

But note the alternative in widespread community spread is to treat every patient as if they are positive irrespective of vaccination status.

4. Ban on unscreened unvaccinated (or on unvaccinated irrespective) is going to worsen inequities.
5. U-12s cannot be vaccinated – are we seriously going to insist every child even neonates is swabbed? Public health assessment of risk in a region is crucial – waste water negative etc. all should be considered under a common-sense approach

I think we urgently need a coherent statement; science based as well as ethical and legal

Arron already has examples of MH&A services saying they will treat unvaccinated, NZOA have written to all orthopaedic surgeons, some ultrasound people refusing to scan unvaccinated women in pregnancy, an RA Board has endorsed no vaccine no care, and some (small but noisy) number of clinicians are saying will not see an un-swabbed patient.

Thoughts please

Ngā mihi

Andrew

Andrew Connolly
Chief Medical Officer I Ministry of Health
E: andrew.connolly@health.govt.nz I s 9(2)(a) I www.health.govt.nz

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Megan King

From: Margie Apa (CMDHB) <xxxxxx.xxx@xxxxxxxxxx.xx.xx>
Sent: Wednesday, 3 November 2021 10:18 am
To: Keriana Brooking; Clare Perry; Andrew Connolly
Cc: russell simpson-EXT; Bridget White
Subject: Fwd: NZ Ortho Assoc advice to prviate ortho surgeons not to see unvaccinated patients
Attachments: Guidance_on_the_Management_of_Unvaccinated_Orthopaedic_Patients_October_2021.docx

My view is that a MoH sponsored position statement is part of the answer that gives us local mandate against which we can test variations in practice. We will lose ground on the ethics of this practice and advice if this prevails - can we discuss a process please.

Sent from my iPad

Begin forwarded message:

> **From:** "Peter Watson (CMDHB)" <Peter.Watson@middlemore.co.nz>
> **Date:** 3 November 2021 at 8:47:23 AM NZDT
> **To:** "Margie Apa (CMDHB)" <Margie.Apa@middlemore.co.nz>, "Pauline McGrath (CMDHB)" <Pauline.McGrath3@middlemore.co.nz>
> **Subject: NZ Ortho Assoc advice to prviate ortho surgeons not to see unvaccinated patients**
>
> Further to our chat on this approach being taken by prviate providers....
> P

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GUIDANCE ON THE MANAGEMENT OF UNVACCINATED ORTHOPAEDIC PATIENTS
October 2021

1. Introduction

NZOA Members have requested guidance on how to respond to unvaccinated patients who have been referred to them. This guidance is not intended to be legal advice, it instead serves to highlight the relevant laws, standards and ethics.

2. Human Rights Legislation

There are two main New Zealand laws that specifically promote and protect human rights. One is the Human Rights Act 1993, and the other is the Bill of Rights Act 1990. The New Zealand Bill of Rights protects the right to life, the right to refuse medical treatment, and the right to manifest one's religion. The Human Rights Act includes the right not to be discriminated against. Even during a pandemic, everyone has human rights and freedoms under the Bill of Rights Act and Human Rights Act. However, there are times when limiting these rights and freedoms can be justified under Section 5 of the New Zealand Bill of Rights Act.

A recent case in the Hight Court considered this and concluded that the benefits of the vaccine outweighed the potential discrimination against the complainant, and that the limitation of rights was proportionate and justified. The Judge decided the scientific support for the vaccine and the benefits of the COVID-19 Public Health Response (Vaccinations) Order 2021 to the wider community outweighed any potential discrimination against the employees. Whilst this decision does not directly apply to private businesses, it is illustrative.

3. Health and Safety

The Health and Safety at work Act applies to employees and contractors. The Act requires that workers and others are given the highest level of protection from workplace health and safety risks, so far as is reasonably practicable. This includes risks to both physical and mental health. A worker has the right to stop work, or refuse to carry out work, if they believe that doing the work would expose them, or anyone else, to a serious risk to health or safety from an immediate or imminent hazard.

This Act applies to you as employers, and there are significant fines for failure to comply.

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4. Guidance from Regulators

As the COVID-19 pandemic is an unprecedented event, there is little guidance available.

4.1 The Medical Council of New Zealand (MCNZ)

We approached the Medical Council of New Zealand. They advised that they did not provide legal advice or guidance, that they waited until complaints were received and they judged the behaviour of the practitioner against their standards. The following excerpt from the Good Medical Practice Standard, Paragraphs 19-21 was forwarded to us for our consideration:

Personal beliefs and the patient

19. *You must not refuse or delay treatment because you believe that a patient's actions have contributed to their condition. Nor should you unfairly discriminate against patients by allowing your personal views to affect your relationship with them.*
20. *Your personal beliefs, including political, religious and moral beliefs, should not affect your advice or treatment. If you feel your beliefs might affect the advice or treatment you provide, you must explain this to patients and tell them about their right to see another doctor. You must be satisfied that the patient has sufficient information to enable them to exercise that right.*
21. *Do not express your personal beliefs to your patients in ways that exploit their vulnerability or that are likely to cause them distress.*

In our opinion, this standard is not particularly relevant to the current situation. Unvaccinated persons have made a choice unless it is due to medical reasons (which are very rare). A decision not to have an in-person consultation with an unvaccinated person is about the health and safety of your practice and family, not a personal belief as such.

4.2 The New Zealand Medical Association (NZMA)

The New Zealand Medical Association (NZMA) Code of Ethics Position Statement, Clause 18 is possibly the most helpful we have found:

> *Doctors have the right, except in an emergency, to refuse to care for a particular patient. In any situation which is not an emergency, doctors may withdraw from or decline to provide care as long as an alternative source of care is available and the appropriate avenue for securing this is known to the patient. Where a doctor does withdraw care from a patient, reasonable notice should be given and an orderly transfer of care facilitated.*

5. Unvaccinated Patients in Public Facilities

DHB's are able to include the COVID vaccination status for all patients in their patient notes. If this is yet to occur at your DHB, we strongly urge you to insist upon this information.

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In our view, doctors have a duty of care for acute and emergent presentations in the public health sector. As you are employees of the DHB, you will need to treat non-vaccinated public electives and outpatients, however we recommend consideration be given to a different pathway for these patient groups. Options include a negative COVID test within 72 hours prior to their appointment, and perhaps self-isolation prior to any surgery.

6. Unvaccinated Patients in your Private Practice

We suggest that rather than refuse to see a non-COVID vaccinated patient, that you make vaccination a requirement for an in-person consultation.

The following steps could be considered:

- Your receptionist/secretary asks a referred patient their vaccination status if unknown.
- If it is negative, ask whether it is a personal or medial reason.
- Ask the patient if they would like to speak to the surgeon about any concerns they have about vaccination.
- For non-vaccinated patients, the surgeon may offer a Telehealth consultation. The rational for this is that in-person attendance puts other patients, staff and the surgeon at increased risk because of the higher viral load that an unvaccinated person can potentially carry.
- If there is a very important clinical reason to see an unvaccinated patient face-to-face, then you can require a negative COVID test within 72 hours prior to their appointment.
- Refer to another provider or suggest they visit "Find a Surgeon" on the NZOA website Find a Surgeon.

7. Concluding Remarks

With the introduction of mandated vaccinations for front-line health workers and education workers, we consider this provides good support for the argument that unvaccinated patients create an unnecessary risk to your Orthopaedic practice. It is to be remembered that people make a choice not to be vaccinated.

We are aware that other organisations are also considering this very question, and our guidance may well evolve as other opinions are known.

In our opinion Orthopaedic surgeons in private should not be compelled to see an unvaccinated patient. Health practitioners can decline to accept referrals.

We urge you to exercise caution as to how you approach this sensitive and complex situation.

Peter Devane, President
John McKie, First President Elect
Haemish Crawford, Second President Elect
Peter Robertson, Immediate Past President
Andrea Pettett, Chief Executive

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Document 1

Megan King

From: Ian Town
Sent: Wednesday, 3 November 2021 1:25 pm
To: Andrew Connolly
Subject: Paper
Attachments: Unvaccinated patients-IAN.docx Refer to following page

A few notes from me Andrew

Ian

Dr Ian Town (he/him)
Chief Science Advisor | Ministry of Health | Mob: s 9(2)(a)

MINISTRY OF HEALTH
MANATŪ HAUORA

For appointments and meeting arrangements please contact:
Janice Tomlin: Janice.Tomlin@health.govt.nz | Cell: 021 347 085

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Unvaccinated patients.

DRAFT ONLY - subject to alteration after consultation & review

Health care is a fundamental human right and Health care workers (HCW) have a right to be safe in their workplace.

With rights come responsibilities. For clinicians, such a responsibility is to act logically and with scientific reasoning as a core foundation.

The tension around the unvaccinated patient needs resolution. It is relevant mainly to Planned Care, but there are already examples of avoidable delays in acute care whilst swabs are awaited when a safer clinical approach would be to adopt "covid precautions" for any case where a swab is required, but where the clinical risk of further time delay is not acceptable.

Regarding the desire of some to avoid seeing unvaccinated patients without a negative swab, there are three key issues to consider:

1. Risk to health equity of any poorly conceived and applied approach to unvaccinated patients
2. Risk of the unvaccinated patient to others:
    a. to HCWs
    b. to other patients
3. Risk of the unvaccinated patient to themselves

A risk based, scientific approach is necessary to avoid worsening inequity and driving perverse practice. We must use our public health tools to assess risk – for example, when wastewater is negative and there are no locations of interest or cases of covid in a particular community, the risk posed by an unvaccinated patient on any given day is negligible.

The unvaccinated in society pose the greatest risk to themselves and to other unvaccinated people. For the vaccinated health care worker, the most likely risk from the unvaccinated is when a HCW needs health care themselves – the issue being one of capacity. If the health system is overwhelmed by covid patients we know the vast majority of these cases will be unvaccinated. In this situation, access to care for non-covid illnesses may well be significantly reduced. This is the most realistic risk posed to a vaccinated HCW by the unvaccinated, as opposed to the risk posed by an individual unvaccinated patient to an individual vaccinated and PPE competent HCW.

Equity Issues:

Any approach that mandates unvaccinated patients are screened prior to planned care risks worsening access to health care for some of the more disadvantaged of our community.

1. Access to swabbing is not 24/7 – shift workers or those working multiple jobs will struggle to access a testing service
2. Those lacking transport may not be able to obtain a test in time to allow for their appointment to proceed

Commented [IT1]: separate issues ? hippocratic oath?

Commented [IT2]: Put as a problem statement

Commented [IT3]: Vaccination is probably irrelevant it is the risk of being infectious that is relevantr ?

Commented [IT4]: not a health care system problem at first glance

Commented [IT5]: At this stage the risk is of community transmission per se. LOI are largely irrelevant now unless they were a HC facility itself

Commented [IT6]: But this is changing as larger % of popn are vaccinated - hopefull they will not be as sick...

Commented [IT7]: RATs have a role here

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3. If the testing system is overwhelmed by planned Care tests then symptomatic test results may be delayed, further risking spread and preventable exposure to Covid. The current outbreak is affecting particularly disadvantaged areas of metro Auckland therefore any un-resourced expansion of testing may well further worsen inequity caused by more spread of Covid.
    a. This issue of testing capacity needs resolution if community spread reaches a point where it is logical and reasonable to screen all patients.
        i. This includes the type of test that would be used to screen as RAT can be done on site at the facility on day of appointment; but note this also may impact attendance due to time issues for patients.

Commented [IT8]: Agree altho SURV codes can assist here

Commented [IT9]: Yes and staff are need to supervise

When realistic concerns about community spread of Covid exist, we must assess the logical reasons to change practice.

Risk to a Health care worker:

1. Experience from metro Auckland is that transmission in the workplace from a Covid positive person to a vaccinated HCW is extremely rare
2. A fully vaccinated HCW with appropriate PPE and good workplace practices is safe at work, as is their family when the HCW returns home.

Risk to other patients:

To date, there are no examples of patient-to-patient transfer of Covid 19 in our health system

Commented [IT10]: check this
There have been cases in ARC

Risk of the unvaccinated patient to themselves:

Major surgery introduces a brief period of immunosuppression – this is one of the reasons why infections occur post-operatively despite antibiotics. There is good evidence of increased morbidity and mortality for those patients who contract covid in the perioperative period. This is a significant risk for asymptomatic cases having planned surgery given that for acute care there is not the luxury of deferral.

Screening:

The key question remaining to be answered is the role of a screening test (swab, saliva or RAT) in the face of active, significant community spread?

Any screening policy needs to apply to all patients irrespective of vaccination status as asymptomatic infection is the issue, not the vaccine status of the patient. Symptomatic cases would of course be handled as per existing testing protocols.

Commented [IT11]: Agree

There is a need to answer the question of when to start screening? As it impacts patient care and clinical behaviour. Screening when a community has active and "unknown degrees" of spread offers several main advantages:

1. Identification of asymptomatic cases allowing for urgent isolation and testing of close contacts
2. May allow early administration of new agents for Covid (as per recent Govt/Pharmac announcements)

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3. Ability to defer many aspects of planned care for positive cases given risks as noted above
    a. Where not deferable, screening positive will allow mitigation - for example, switching to a telehealth consultation
4. For non-deferrable cases, screening would allow for logical geographic distribution of in-patients; for example, a surgical patient with a condition that can only be managed operatively who test positive for Covid on screening would be nursed either on the Covid ward or at least in a single room on a surgical ward with strict covid protocols in place. Knowing a non-deferable case is covid positive would also allow for logical approaches to treatments such as the experience of the anaesthetic and surgical team being of an appropriate level.

Commented [IT12]: all sensible

Paediatric cases:
Under-12s are not eligible as yet for vaccination. Careful consideration of any screening of children will need to be completed if screening was felt to be necessary for attendance at a planned care appointment.

Andrew Connolly
CMO, MOH
3/11/2021

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Document 1

Megan King

From: Nick Baker <xxxx.xxxxx@xxxxx.xxxx.xx>
Sent: Thursday, 4 November 2021 9:55 am
To: Andrew Connolly
Cc: John Tait [CCDHB]
Subject: RE: Unvaccinated patients NOT for Circulation outside this group
Attachments: Unvaccinated patients Nick insertion.docx Refer to end of email chain

Andrew

Looks good. I have added a few bits to help justifications which we should test.

Also table which if we agree on it could be deleted as really adds nothing.

Still needs a bit of a clean up in places but did not get time.

Nga Mihi

Nick

Dr Nick Baker BSc. MB ChB, DCH, FRACP, AFRACMA

Paediatrician/Chief Medical Officer

Nelson Marlborough Health

Nelson Hospital,Private Bag 18, Nelson, 7042, New Zealand

<mailto:nick.baker@nmhs.govt.nz>

Direct Dial Line 03 546 1235
Hospital Phone 03 546 1800

(Will to Act + Tools to Measure + Tools for Change)(Used Effectively) = Harm Free Care

---

From: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Sent: Wednesday, 3 November 2021 11:35 AM
To: Julia Carr <Julia.Carr@waikatodhb.health.nz>; RobynCarey <RobynCarey@scdhb.health.nz>; Nigel Millar <nigel.millar@southerndhb.govt.nz>; Nick Baker <Nick.Baker@nmdhb.govt.nz>; Andrew Old (WDHB) <Andrew.Old@waitematadhb.govt.nz>; Anil Nair <Axxx.xxxx@xxx.xxx.xx>;Gerrie.Snyman@lakesdhb.govt.nz; Graham Roper <graham.roper@wcdhb.health.nz>; Greg Simmons-EXT <Greg.Simmons@tdhb.org.nz>; Helen Skinner <Helen.Skinner@cdhb.health.nz>; Ian Murphy <Ian.Murphy@wdhb.org.nz>; Jennifer.walker@northlanddhb.org.nz; John Tait [CCDHB] <John.Taxx@xxxxx.xxg.nz>; Jonathan Christiansen <Jonathan.Christiansen@waitematadhb.govt.nz>; Kate Grimwade <kate.grimwade@bopdhb.govt.nz>; Kelvin Billinghurst (Kelvin.Billinghurst@midcentraldhb.govt.nz) <Kelvin.Bxxxxxxxxxxx@xxxxxxxxxxxxx.xxxx.xx>; Luke.Bradford@bopdhb.govt.nz; Margaret Fisher <Margaret.Fisher@waikatodhb.health.nz>; M Wilsher-EXT <xxxxxxxx@xxxx.xxxx.xx>; Peter Freeman <Peter.freeman@lakesdhb.govt.nz>; Peter Watson <Peter.Watson@middlemore.co.nz>; Robin Whyman <Robin.Whyman@hbdhb.govt.nz>; Shawn Sturland <shawn.sturland@ccdhb.org.nz>
Cc: CMO Support <cmo.support@tas.health.nz>; Lynda Edney <Lynda.Edney@tas.health.nz>; John Eastwood <John.Eastwood@southerndhb.govt.nz>
Subject: Unvaccinated patients NOT for Circulation outside this group

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Dear Colleagues, please see attached

NOTE: This is literally a back of the envelop first draft and NOT Ministry advice or communication – it needs a lot of review but it is a starter nonetheless

Please do NOT circulate as it will be amended and it is not official.

Will take initial feedback/discussion at 1pm meeting.

Note it is referring to Public work – fully private sector is not our emit as private property rights etc. will exist. But I do believe whatever the MOH et al finally settles on needs to apply nationally and apply to any patients/service attracting any public funding.

I have discussed with HDC and MCNZ – further meetings asap planned.

Ngā mihi

Andrew

Andrew Connolly
Chief Medical Officer | Ministry of Health
E: andrew.connolly@health.govt.nz | Mobile: s 9(2)(a) | www.health.govt.nz

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From: Nick Baker <Nick.Baker@nmdhb.govt.nz>
Sent: Tuesday, 2 November 2021 20:40
To: Andrew Connolly <Andrew.Connolly@health.govt.nz>; Andrew.Old@waitematadhb.govt.nz; Anil Nair <Anil.Nair@tdh.org.nz>; Gerrie.Snyman@lakesdhb.govt.nz; graham.roper@wcdhb.health.nz; Greg Simmons [TDHB] <Greg.Simmons@tdhb.org.nz>; Helen Skinner <Helen.Skinner@cdhb.health.nz>; Ian Murphy <Ian.Murpxx@xxxx.xxx.nz >; Jennifer.walker@northlanddhb.org.nz; John Tait <John.Tait@ccdhb.org.nz>; Jonathan Christiansen <Jonathan.Christiansen@waitematadhb.govt.nz>; Julia.Carr@waikatodhb.health.nz; Kate Grimwade <kate.grimwade@bopdhb.govt.nz>; Kelvin Billinghurst (Kelvin.Billinghurst@midcentraldhb.govt.nz) <Kelvin.Billinghurst@midcentraldhb.govt.nz>; Luke.Bradford@bopdhb.govt.nz; Margaret Fisher <Margaret.Fisxxx@xxxxxxxxxx.xxxxth.nz >; Margaret Wilsher <MWilsher@adhb.govt.nz>; Nick Baker <Nick.Baker@nmdhb.govt.nz>; Nigel Millar <Nigel.Millar@southerndhb.govt.nz>; Peter Freeman <Peter.freeman@lakesdhb.govt.nz>; Peter Watson (CMDHB) <xxxxx.xxxxxx@xxxxxxxxxx.xx.nz >; Robin Whyman <Robin.Whyman@hbdhb.govt.nz>; RobynCarey <RobynCarey@scdhb.health.nz>; Shawn Sturland <shawn.sturland@ccdhb.org.nz>
Cc: CMO Support <cmo.support@tas.health.nz>; Lynda Edney <Lynda.Edney@tas.health.nz>
Subject: CMOs Weekly Stand Up and More

Dear CMOs

s 9(2)(k) [redacted]

Some items for discussion have been suggested and some correspondence has arrived.

1. **Welcome and agenda check-in** – Chair

Out of scope

4. **National position on Care for unvaccinated people? – see e-mail attached** – what care modifications are reasonable? Ability to decline care and duty to take vaccination status into account when planning care – Gerrie Synman, Andrew Connolly, Nick Baker

Out of scope

Nga Mihi

Nick

Dr Nick Baker BSc. MB ChB, DCH, FRACP, AFRACMA

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Nelson Marlborough Health

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<mailto:nick.baker@nmhs.govt.nz>

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(Will to Act + Tools to Measure + Tools for Change)(Used Effectively) = Harm Free Care

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Unvaccinated patients.

DRAFT ONLY - subject to alteration after consultation & review.
NOT MOH official policy

Health care is a fundamental human right and Health care workers (HCW) have a right to be safe in their workplace.

With rights come responsibilities. For clinicians, such a responsibility is to act logically and with scientific reasoning as a core foundation.

The tension around the unvaccinated patient needs resolution. It is relevant mainly to Planned Care, but there are already examples of avoidable delays in acute care whilst swabs are awaited when a safer clinical approach would be to adopt "covid precautions" for any case where a swab is required, but where the clinical risk of further time delay is not acceptable.

Background

Screening and Streaming is a key tool to minimise risk to staff and patients. It is important it occurs consistently and takes into account

- the circumstances prevailing in the community at the time
- risks posed by the patient
- risks related to the nature of health care delivery.

A table sets out to describe various situations

Issue	Vaccinated	Not Vaccinated	Note
1. Any symptoms?	If yes Swab	If yes Swab	Exclude from non-urgent care pending assessment
2. Screening questions	If yes Swab	If yes Swab	Plan care based on situation
3. Negative responses to above	Proceed with care	Proceed with care	Screening swabs may at benefit in some settings – high levels of disease in community or vulnerable setting

Vaccinated or Not - both vaccinated and not vaccinated patients can catch and spread Covid. (Singanayagam et al)The risks posed by vaccinated patients are lower than from non vaccinated as fewer symptoms and shorter duration of carriage. However the different in risk is not sufficient to have major impact on the way health care is delivered and in particular not sufficient to deny unvaccinated people access to care.

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Swabbing PCR RAT - swabbing only provides evidence that viral antigen is present in sufficient amounts to be noted. People incubated Covid test negative. So care must be taken to ensure swabbing is not used to obtain a false sense of security.

Excessive use of swabbing in asymptomatic people puts pressure on the system and delays test results for others. Swab use must be selective and only used as a screening test in asymptomatic people when the result will alter patient journeys. Vaccination status does not impact on indications for swabbing.

Regarding the desire of some to avoid seeing unvaccinated patients without a negative swab, there are three key issues to consider:

1. Risk to health equity of any poorly conceived and applied approach to unvaccinated patients
2. Risk of the unvaccinated patient to others:
    a. to HCWs
    b. to other patients
3. Risk of the unvaccinated patient to themselves

A risk based, scientific approach is necessary to avoid worsening inequity and driving perverse practice. We must use our public health tools to assess risk – for example, when wastewater is negative and there are no locations of interest or cases of covid in a particular community, the risk posed by an unvaccinated patient on any given day is negligible.

The unvaccinated in society pose the greatest risk to themselves and to other unvaccinated people. For the vaccinated health care worker, the most likely risk from the unvaccinated is when a HCW needs health care themselves – the issue being one of capacity. If the health system is overwhelmed by covid patients we know the vast majority of these cases will be unvaccinated. In this situation, access to care for non-covid illnesses may well be significantly reduced. This is the most realistic risk posed to a vaccinated HCW by the unvaccinated, as opposed to the risk posed by an individual unvaccinated patient to an individual vaccinated and PPE competent HCW.

Equity Issues:

Any approach that mandates unvaccinated patients are screened prior to planned care risks worsening access to health care for some of the more disadvantaged of our community.

1. Access to swabbing is not 24/7 – shift workers or those working multiple jobs will struggle to access a testing service
2. Those lacking transport may not be able to obtain a test in time to allow for their appointment to proceed
3. If the testing system is overwhelmed by planned Care tests then symptomatic test results may be delayed, further risking spread and preventable exposure to Covid. The current outbreak is affecting particularly disadvantaged areas of metro Auckland therefore any un-resourced expansion of testing may well further worsen inequity caused by more spread of Covid.

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    a. This issue of testing capacity needs resolution if community spread reaches a point where it is logical and reasonable to screen all patients.
        i. This includes the type of test that would be used to screen as RAT can be done on site at the facility on day of appointment; but note this also may impact attendance due to time issues for patients.

When realistic concerns about community spread of Covid exist, we must assess the logical reasons to change practice.

Risk to a Health care worker:

1. Experience from metro Auckland is that transmission in the workplace from a Covid positive person to a vaccinated HCW is extremely rare
2. A fully vaccinated HCW with appropriate PPE and good workplace practices is safe at work, as is their family when the HCW returns home.

Risk to other patients:

To date, there are no examples of patient-to-patient transfer of Covid 19 in our health system

Risk of the unvaccinated patient to themselves:

Major surgery introduces a brief period of immunosuppression – this is one of the reasons why infections occur post-operatively despite antibiotics. There is good evidence of increased morbidity and mortality for those patients who contract covid in the perioperative period. This is a significant risk for asymptomatic cases having planned surgery given that for acute care there is not the luxury of deferral.

Screening:

The key question remaining to be answered is the role of a screening test (swab, saliva or RAT) in the face of active, significant community spread?

Any screening policy needs to apply to all patients irrespective of vaccination status as asymptomatic infection is the issue, not the vaccine status of the patient. Symptomatic cases would of course be handled as per existing testing protocols.

There is a need to answer the question of when to start screening? As it impacts patient care and clinical behaviour. Screening when a community has active and "unknown degrees" of spread offers several main advantages:

1. Identification of asymptomatic cases allowing for urgent isolation and testing of close contacts
2. May allow early administration of new agents for Covid (as per recent Govt/Pharmac announcements)
3. Ability to defer many aspects of planned care for positive cases given risks as noted above
    a. Where not deferable, screening positive will allow mitigation - for example, switching to a telehealth consultation
4. For non-deferrable cases, screening would allow for logical geographic distribution of in-patients; for example, a surgical patient with a condition that can only be

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managed operatively who test positive for Covid on screening would be nursed either on the Covid ward or at least in a single room on a surgical ward with strict covid protocols in place. Knowing a non-deferable case is covid positive would also allow for logical approaches to treatments such as the experience of the anaesthetic and surgical team being of an appropriate level.

Paediatric cases:
Under-12s are not eligible as yet for vaccination. Careful consideration of any screening of children will need to be completed if screening was felt to be necessary for attendance at a planned care appointment.

Andrew Connolly
CMO, MOH
3/11/2021

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Megan King

From: Juliet Rumball-Smith
Sent: Thursday, 4 November 2021 11:05 am
To: Andrew Connolly; Ian Town; Martin Chadwick; Robyn Shearer; Russell Simpson; Jess Smaling
Subject: RE: Unvaccinated Draft 2

This looks good Andrew. My only comment is that there will be unknown infections in vaccinated patients also – vaccination status can only be one data point in the risk assessment process - there is a significant risk of transmission/inadvertent infection if there is an assumption that fully vaccinated patients are automatically screen negative.

Cheers,
Juliet

From: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Sent: Thursday, 4 November 2021 8:50 am
To: Ian Town <Ian.Town@health.govt.nz>; Martin Chadwick <Martin.Chadwick@health.govt.nz>; Robyn Shearer <Robyn.Shearer@health.govt.nz>; Russell Simpson <Russell.Simpson@health.govt.nz>; Juliet Rumball-Smith <Juliet.Rumball-Smith@health.govt.nz>; Jess Smaling <Jessica.Smaling@health.govt.nz>
Subject: Unvaccinated Draft 2

Updated after initial feedback.

I've clarified the purpose etc. The issue of screen testing is very live in metro (for good reason I think) hence why this is in.

Critique please.

MPS are holding a webinar next week – be great to have this out prior if possible?

Ngā mihi

Andrew

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Document 1

Megan King

From: Andrew Connolly
Sent: Monday, 8 November 2021 1:33 pm
To: Rachel Starkey
Subject: Draft document re unvaccinated patients
Attachments: Unvaccinated patients-V2 (1).docx

Refer to following page

hi Rachel

Can you please send to everyone on the 1130 Tuesday meeting? And can we invite Ian Town – he's had a lot to do with this and may wish to attend.

Covering email – Draft document for discussion at meeting on unvaccinated patents.

Ngā mihi

Andrew

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Unvaccinated patients.

DRAFT ONLY - subject to alteration after consultation & review
Not official MOH Policy

Purpose of this Paper:
To address the concerns of some clinicians and providers have regarding face-to-face consultations with unvaccinated patients.

Background:
Some health care providers are focused on what they perceive the risk to be from face-to-face contact with unvaccinated patients, however, the real issue is the risk from inadvertently seeing an infectious person without the health care worker (HCW) being in appropriate personal protection equipment (PPE), in an appropriate physical environment.

Fundamental tenets

1. Health care is a fundamental human right.
2. Health care workers have a right to be safe in their workplace.

With rights come responsibilities. For clinicians, such a responsibility is to act logically and with scientific reasoning as a core foundation.

What issues need consideration?
Regarding the desire of some to avoid seeing unvaccinated patients without a negative swab, there are three key issues to consider:

1. Risk to health equity of any poorly conceived and poorly applied approach
2. Risk of the unvaccinated patient to others:
    a. to HCWs
    b. to other patients
3. Risk of the unvaccinated patient to their own health if they were infected with covid at the time of having certain health treatments

A consistent, risk based, scientific approach is necessary to avoid worsening inequity and driving perverse practice.

Whilst relevant mainly to Planned Care, but there are also examples of avoidable delays in acute care whilst swabs are awaited, when a safer clinical approach would be to adopt "covid precautions" for any case where a swab is required, but where the clinical risk of further time delay is not acceptable.

The unvaccinated in society pose the greatest risk to themselves and to other unvaccinated people.

For the vaccinated health care worker, the most likely risk from the unvaccinated is when a HCW needs health care themselves – the issue being one of capacity in the health system. In this situation, access to care for non-covid illnesses may be significantly reduced. This is the most realistic risk posed to a vaccinated HCW by the unvaccinated, in contrast to the risk

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posed by an individual unvaccinated patient to an individual vaccinated and PPE competent HCW.

Where clinically acceptable, non-face-to-face clinical reviews are appropriate and obviously significantly reduce the risk of any inadvertent contact with an infectious person. All providers should continue to develop and utilize such opportunities.

Equity Issues:
Any approach that mandates unvaccinated patients are swabbed for Covid-19 prior to planned care risks worsening access to health care for some of the more disadvantaged of our community.

1. Access to swabbing is not 24/7 – shift workers or those working multiple jobs will struggle to access a testing service (unless Rapid Antigen Testing can be provided on a sufficient scale at the time of a planned appointment).
2. Those lacking transport may not be able to obtain a test in time to allow for their appointment to proceed
3. If the testing system is overwhelmed by planned Care tests then symptomatic test results may be delayed, further risking spread and preventable exposure to Covid. The current outbreak is affecting particularly disadvantaged areas of metro Auckland therefore any un-resourced expansion of testing may well further worsen inequity caused by more spread of Covid.
    a. This issue of testing capacity needs resolution if community spread reaches a point where it is logical and reasonable to screen all patients.
        i. This includes the type of test that would be used to screen. RAT can be done on site at the facility on day of appointment; but note this also may impact attendance due to time issues for patients. There is also a staffing need for test supervision.

When realistic concerns about community spread of Covid exist, we must assess the logical reasons to change practice.

Risk to a Health care worker:

1. Experience from metro Auckland is that transmission in the workplace from a Covid positive person to a vaccinated HCW is extremely rare
2. A fully vaccinated HCW with appropriate PPE and good workplace practices is safe at work, as is their family when the HCW returns home.

Risk to other patients:
To date, there are no examples of patient-to-patient transfer of Covid 19 in our secondary and tertiary health facilities, but there have been examples in Aged Residential Care settings where such transfer is likely to have occurred.

Risk of the unvaccinated patient to themselves:
Major surgery introduces a brief period of immunosuppression – this is one of the reasons why infections occur post-operatively despite antibiotics. There is growing evidence of increased morbidity and mortality for those patients who contract covid in the perioperative

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period. Given in acute surgical care there is not the luxury of deferral, pre-operative testing for Covid is most relevant for planned surgery to identify asymptomatic Covid cases.

The issue of risk to the unvaccinated patient should form part of the discussion with the patient regarding informed consent/ informed choice.

Testing of Patients presenting for Health Care

The key question remaining to be answered is the role of a "screening" test (swab, saliva or RAT) in the face of active, significant community spread?

Any such policy needs to apply to all patients irrespective of vaccination status as asymptomatic infection is the issue, not the vaccine status of the patient. Symptomatic cases would of course be handled as per existing testing protocols.

There is a need to have a consistent approach to starting screening testing as it impacts patient care and clinical behaviour.

Screening by testing when a community has active and "unknown degrees" of spread offers several main advantages:

1. Identification of asymptomatic cases allowing for urgent isolation and testing of close contacts
2. May allow for early administration of new agents for Covid (as per recent Govt/Pharmac announcements)
3. Ability to defer many aspects of planned care for positive cases given risks as noted above
    a. Where not deferable, screening positive will allow mitigation - for example, switching to a telehealth consultation
4. For non-deferrable cases, such a testing strategy would allow for logical geographic distribution of in-patients; for example, a surgical patient with a condition that can only be managed operatively who test positive for Covid on screen testing would be nursed either on the Covid ward or at least in a single room on a surgical ward with strict Covid protocols in place. Knowing a non-deferable case is Covid positive would also allow for logical approaches to treatments such as the experience of the anaesthetic and surgical team being of an appropriate level.

Paediatric cases:

Under-12s are not eligible, as yet, for vaccination. Careful consideration of any screen testing of children will need to be completed if such testing was felt to be necessary for attendance at a planned care appointment.

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Document 1

Megan King

From: Andrew Connolly
Sent: Monday, 8 November 2021 3:02 pm
To: s 9(2)(a) @nursingcouncil.org.nz; s 9(2)(a) @nursingcouncil.org.nz; chair@pharmacycouncil.org.nz; s 9(2)(a) chair@mcnz.org.nz
Cc: Rachel Starkey
Subject: Draft paper for consideration 1130 Tuesday
Attachments: Unvaccinated patients-V2 (1).docx Refer to following page

Dear Colleagues

Attached is a draft for our consideration tomorrow. The background as you are aware is a growing call from various sections of clinical practice to only see non-urgent unvaccinated cases after a negative covid test. This does not withstand scientific scrutiny and it threatens to further degrade issues of equity.

I am aware various professional groups including the Medical Protection Society are planning on giving advice to various groups and I think we should ideally aim for a consensus to "educate".

I am aware of course that Private facilities seeing private patients may well be able to impose their own requirements as businesses shortly can, hence my thinking behind this document is the need to be clear regarding public services or publicly funded services

I look forward to seeing you on screen tomorrow

Ngā mihi

Andrew

Andrew Connolly
Chief Medical Officer | Ministry of Health
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Unvaccinated patients.

DRAFT ONLY - subject to alteration after consultation & review
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Purpose of this Paper:
To address the concerns of some clinicians and providers have regarding face-to-face consultations with unvaccinated patients.

Background:
Some health care providers are focused on what they perceive the risk to be from face-to-face contact with unvaccinated patients, however, the real issue is the risk from inadvertently seeing an infectious person without the health care worker (HCW) being in appropriate personal protection equipment (PPE), in an appropriate physical environment.

Fundamental tenets

1. Health care is a fundamental human right.
2. Health care workers have a right to be safe in their workplace.

With rights come responsibilities. For clinicians, such a responsibility is to act logically and with scientific reasoning as a core foundation.

What issues need consideration?
Regarding the desire of some to avoid seeing unvaccinated patients without a negative swab, there are three key issues to consider:

1. Risk to health equity of any poorly conceived and poorly applied approach
2. Risk of the unvaccinated patient to others:
    a. to HCWs
    b. to other patients
3. Risk of the unvaccinated patient to their own health if they were infected with covid at the time of having certain health treatments

A consistent, risk based, scientific approach is necessary to avoid worsening inequity and driving perverse practice.

Whilst relevant mainly to Planned Care, but there are also examples of avoidable delays in acute care whilst swabs are awaited, when a safer clinical approach would be to adopt "covid precautions" for any case where a swab is required, but where the clinical risk of further time delay is not acceptable.

The unvaccinated in society pose the greatest risk to themselves and to other unvaccinated people.

For the vaccinated health care worker, the most likely risk from the unvaccinated is when a HCW needs health care themselves – the issue being one of capacity in the health system. In this situation, access to care for non-covid illnesses may be significantly reduced. This is the most realistic risk posed to a vaccinated HCW by the unvaccinated, in contrast to the risk

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posed by an individual unvaccinated patient to an individual vaccinated and PPE competent HCW.

Where clinically acceptable, non-face-to-face clinical reviews are appropriate and obviously significantly reduce the risk of any inadvertent contact with an infectious person. All providers should continue to develop and utilize such opportunities.

Equity Issues:
Any approach that mandates unvaccinated patients are swabbed for Covid-19 prior to planned care risks worsening access to health care for some of the more disadvantaged of our community.

1. Access to swabbing is not 24/7 – shift workers or those working multiple jobs will struggle to access a testing service (unless Rapid Antigen Testing can be provided on a sufficient scale at the time of a planned appointment).
2. Those lacking transport may not be able to obtain a test in time to allow for their appointment to proceed
3. If the testing system is overwhelmed by planned Care tests then symptomatic test results may be delayed, further risking spread and preventable exposure to Covid. The current outbreak is affecting particularly disadvantaged areas of metro Auckland therefore any un-resourced expansion of testing may well further worsen inequity caused by more spread of Covid.
    a. This issue of testing capacity needs resolution if community spread reaches a point where it is logical and reasonable to screen all patients.
        i. This includes the type of test that would be used to screen. RAT can be done on site at the facility on day of appointment; but note this also may impact attendance due to time issues for patients. There is also a staffing need for test supervision.

When realistic concerns about community spread of Covid exist, we must assess the logical reasons to change practice.

Risk to a Health care worker:

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2. A fully vaccinated HCW with appropriate PPE and good workplace practices is safe at work, as is their family when the HCW returns home.

Risk to other patients:
To date, there are no examples of patient-to-patient transfer of Covid 19 in our secondary and tertiary health facilities, but there have been examples in Aged Residential Care settings where such transfer is likely to have occurred.

Risk of the unvaccinated patient to themselves:
Major surgery introduces a brief period of immunosuppression – this is one of the reasons why infections occur post-operatively despite antibiotics. There is growing evidence of increased morbidity and mortality for those patients who contract covid in the perioperative

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period. Given in acute surgical care there is not the luxury of deferral, pre-operative testing for Covid is most relevant for planned surgery to identify asymptomatic Covid cases.

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Megan King

From: Andrew Connolly
Sent: Monday, 8 November 2021 4:20 pm
To: Jeremy Tuohy
Cc: Martin Chadwick
Subject: RE: Vaccination and healthcare pathways MEMO
Attachments: Unvaccinated patients-V2 (1).docx Refer to end of email chain

Thanks Jeremy

Along the same general pathway attached is a draft designed to inform the professions – I have set up a meeting with HDC, ACC, MCNZ and NCNZ tomorrow to discuss further. I see our two processes as complimentary. If you are able to join tomorrow it would be greatly advantageous. Ultimately the hope is a consensus document. I'm not suggesting we have to merge – they are complimentary etc.

I'll forward the meeting details in case you are able to join.

Ngā mihi

Andrew

Andrew Connolly
Chief Medical Officer | Ministry of Health
E: andrew.connolly@health.govt.nz | Mobile: s 9(2)(a) | www.health.govt.nz

From: Jeremy Tuohy <Jeremy.Tuohy@health.govt.nz>
Sent: Monday, 8 November 2021 3:44 pm
To: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Cc: Martin Chadwick <Martin.Chadwick@health.govt.nz>
Subject: Vaccination and healthcare pathways MEMO

FYI,
I am still working on this so please consider it a draft.
The main point is that unvaccinated or unmasked patients are more likely to be infected with COVID and transmit it to others, but as they will be a very small proportion of the entire population, transmission is more likely to occur from a vaccinated masked individual than an unmasked or unvaccinated individual.

In addition the risk of transmission from these individuals is currently very low. As the rate of infection increases, the total risk will increase, but not necessarily the ratio of the risk of transmission between vaccinated and unvaccinated individuals.

Finally, the issue of what to do with Children who are unmasked and unvaccinated is not clear.

Jeremy

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period. Given in acute surgical care there is not the luxury of deferral, pre-operative testing for Covid is most relevant for planned surgery to identify asymptomatic Covid cases.

The issue of risk to the unvaccinated patient should form part of the discussion with the patient regarding informed consent/ informed choice.

Testing of Patients presenting for Health Care

The key question remaining to be answered is the role of a "screening" test (swab, saliva or RAT) in the face of active, significant community spread?

Any such policy needs to apply to all patients irrespective of vaccination status as asymptomatic infection is the issue, not the vaccine status of the patient. Symptomatic cases would of course be handled as per existing testing protocols.

There is a need to have a consistent approach to starting screening testing as it impacts patient care and clinical behaviour.

Screening by testing when a community has active and "unknown degrees" of spread offers several main advantages:

1. Identification of asymptomatic cases allowing for urgent isolation and testing of close contacts
2. May allow for early administration of new agents for Covid (as per recent Govt/Pharmac announcements)
3. Ability to defer many aspects of planned care for positive cases given risks as noted above
    a. Where not deferable, screening positive will allow mitigation - for example, switching to a telehealth consultation
4. For non-deferrable cases, such a testing strategy would allow for logical geographic distribution of in-patients; for example, a surgical patient with a condition that can only be managed operatively who test positive for Covid on screen testing would be nursed either on the Covid ward or at least in a single room on a surgical ward with strict Covid protocols in place. Knowing a non-deferable case is Covid positive would also allow for logical approaches to treatments such as the experience of the anaesthetic and surgical team being of an appropriate level.

Paediatric cases:

Under-12s are not eligible, as yet, for vaccination. Careful consideration of any screen testing of children will need to be completed if such testing was felt to be necessary for attendance at a planned care appointment.

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Document 1

Megan King

From: Andrew Connolly
Sent: Tuesday, 9 November 2021 2:13 pm
To: Jeremy Tuohy
Subject: RE: Unvaccinated patients-V2 (1) (002)
Attachments: Notes from meeting JT AC.docx Refer to end of email chain

Hi Jeremy

A couple of additions as an aide memoire. Many thanks for doing this

Andrew

From: Jeremy Tuohy <Jeremy.Tuohy@health.govt.nz>
Sent: Tuesday, 9 November 2021 12:15 pm
To: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Subject: Unvaccinated patients-V2 (1) (002)

Hi Andrew.
I made a few notes during the meeting. (at the end of the document)

If you would like to add anything I will write them up more formally

Jeremy

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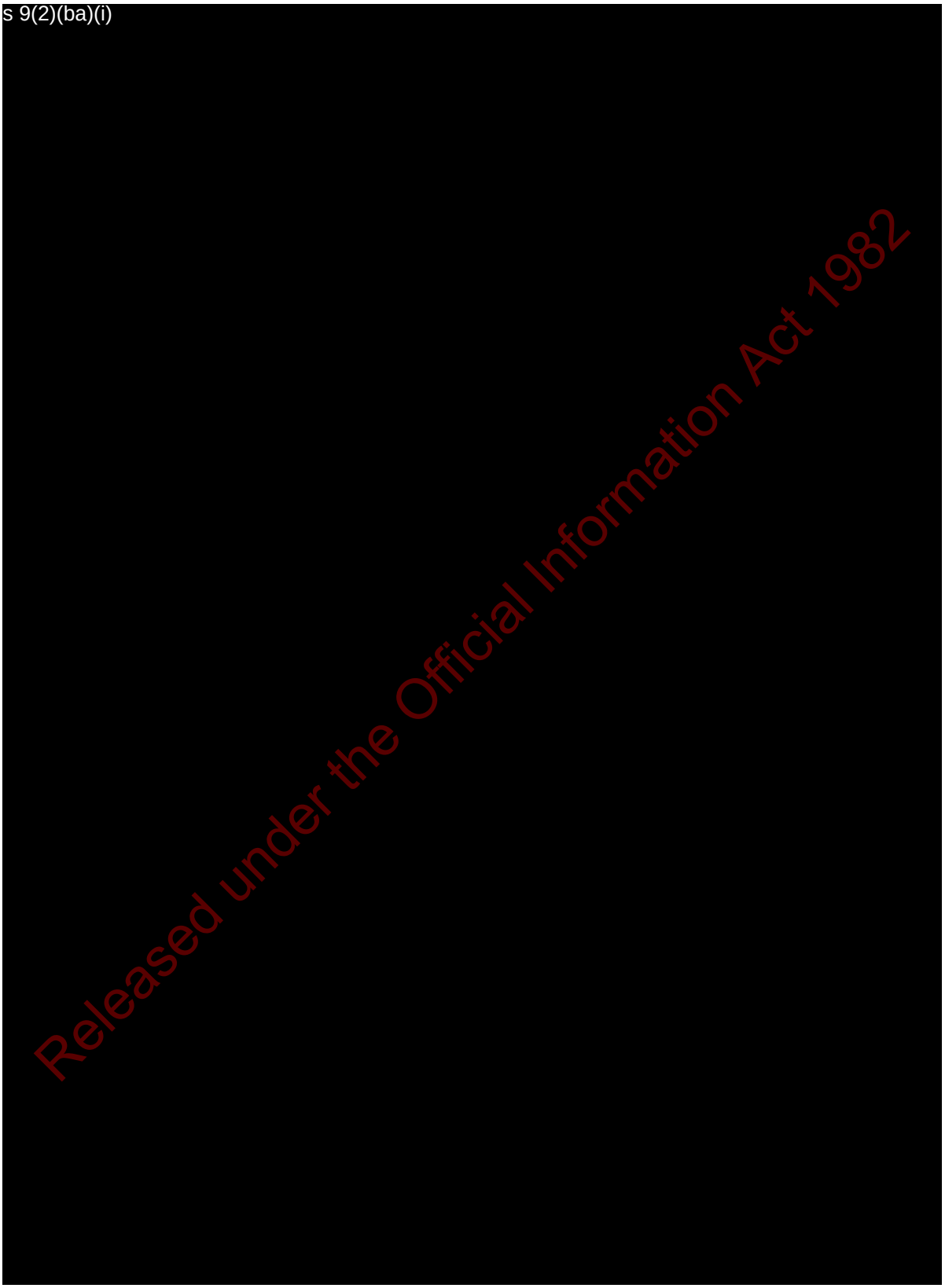
Notes from meeting. 9 November 2021

s 9(2)(ba)(i)



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Document 1

Megan King

From: Martin Thomas <Martin.Thomas@hqsc.govt.nz>
Sent: Tuesday, 9 November 2021 5:12 pm
To: Andrew Connolly; Jeremy Tuohy
Subject: RE: Draft 3 vaccination status
Attachments: 20211109_165757.jpg; Unvaccinated patients-V3_MT.docx Refer to end of email chain

Here's my initial thoughts and comments. I think we need to say up front who the document is for and be explicit whether it is recommendations, guidance or a statement.
I do have concerns that the fall back will be routine testing of all planned care (and consequently the impact of that on lab capacity) as this is the easiest solution....
Jeremy – I don't know if there are any figures for risks to staff an any of the scenarios? Or if this should be included
I think a flow diagram would be of benefit – my rudimentary example attached. The question then is if this should be detailed and mandated – this goes back to the nature of the document (as per my first point)
I'll ponder again overnight and happy to catch up and brainstorm some more

Ngā mihi

Martin Thomas
Medical Director and Executive Lead Quality Systems
Health Quality & Safety Commission
DDI: 04 912 0302 | Mobile: s 9(2)(a)
Email: martin.thomas@hqsc.govt.nz
www.hqsc.govt.nz | www.open.hqsc.govt.nz

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From: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Sent: Tuesday, 9 November 2021 2:54 pm
To: Jeremy Tuohy <Jeremy.Tuohy@health.govt.nz>; Martin Thomas <Martin.Thomas@hqsc.govt.nz>
Subject: Draft 3 vaccination status

Hi

Attached is my latest iteration. I've added bits- broadly highlighted - and move a section of two around .

Value panel beating – Martin I know you have vg ideas re additional aspects.

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Jeremy – please feel free as well!

Interestingly I've had a call or two later after the meeting from various DHB folk keen to see something ASAP so I think our timing is right!

Ngā mihi

Andrew

Andrew Connolly
Chief Medical Officer | Ministry of Health
E: andrew.connolly@health.govt.nz | Mobile s 9(2)(a) | www.health.govt.nz

****
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Unvaccinated patients. Draft 3
DRAFT ONLY - subject to alteration after consultation & review. Not official MOH Policy

Purpose of this Paper:
To address the concerns of some clinicians and providers have regarding face-to-face consultations with unvaccinated patients.

Background:
Perceived risk from face-to-face contact with unvaccinated patients is changing the way ~~S~~some health care providers are managing this patient group. The unintended consequence of this is the potential for worse outcomes for patients and increased inequity. ~~focused on what they perceive the risk to be from face to face contact with unvaccinated patients, however, t~~The real issue ~~-~~ is the risk ~~from~~ of inadvertently seeing an infectious person (regardless of vaccination status) without the health care worker (HCW) being aware, in appropriate personal protection equipment (PPE) or ~~,~~ in an appropriate physical environment.

Fundamental tenets

1. Health care is a fundamental human right.
2. Health care workers have a right to be safe in their workplace.

With rights come responsibilities. For clinicians, such a responsibility is to act logically and with scientific reasoning as a core foundation to guiding patient management.

Testing prior to Health Care when there is no evidence of uncontrolled community spread:
There is no scientific support for testing asymptomatic patients who lack any other indication for a Covid test other than their vaccination status.

Such an approach cannot be justified if the health care worker is fully vaccinated and able to wear appropriate mask.

Introduction of this type of policy, ~~of~~ which mandate~~sing~~ testing~~s~~ for unvaccinated patients, ~~also~~ risk~~s~~ ~~the~~overloading laboratory capacity. This impacts directly on ~~necessary for~~ capacity for symptomatic testing and consequently the ability to expedite care for this patient group.

Testing of Patients when there is uncontrolled community spread:
This is the scenario where there may be logic to the testing of asymptomatic patients including those lacking any risk factors, but such a policy should not ~~-~~ be restricted to just the unvaccinated.

Any such policy needs to apply to all patients irrespective of vaccination status as asymptomatic infection is the issue, not the vaccine status of the patient.

Symptomatic cases would of course be handled as per existing testing protocols.

Commented [MT1]: Need to draw a stake in the ground to say if a guideline, advice or position statement
Who is it for – DHBs/Primary care/all outward facing health workers?

Commented [MT2]: Outline a process to risk assess and develop a plan for managing planned care in communities with Covid spread to address.....

Commented [MT3]: Are we able, (or do we want) to put some risk analysis around this in terms of transmission risk ???Jeremy

Commented [MT4]: This is going to be the challenge and major use of lab resources once endemic everywhere. Again I wonder what the risk of transmission is for asymptomatic vaccinated vs unvaccinated?

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There is a need to have a consistent approach to starting screening testing as it impacts patient care and clinical behaviour. ~~Currently unnecessary PCR testing risks laboratory delays for swabs in symptomatic cases. This is not desirable~~

Commented [MT5]: Above

Why not test all unvaccinated patients irrespective of community transmission?
There are three key issues to consider:

1. Risk to health equity of any poorly conceived and poorly applied approach
2. Risk of the unvaccinated patient to others:
    a. to HCWs
    b. to other patients
3. Risk of the unvaccinated patient to their own health if they were infected with covid at the time of having certain health treatments

A consistent, risk based, scientific approach is necessary to avoid worsening inequity and driving perverse practice. Healthcare regulators are clear that ~~P~~healthcare providers cannot allow personal beliefs to impact on the ~~cannot affect~~ high standard of health care patients should receive. Where no scientific support for Covid testing exists, such a requirement is likely to be interpreted as a personal belief and therefore is not accepted practice.

Whilst relevant mainly to p~~P~~lanned c~~C~~are, ~~but~~ there are ~~also~~ examples of avoidable delays in acute care provision whilst swabs are awaited, ~~when~~ aA safer clinical approach would be to adopt "covid precautions" for any case where a swab is required, but where the clinical risk of further time delay is not acceptable.

The unvaccinated in society pose the greatest risk to themselves and to other unvaccinated people. Statistically, a health care worker is far more likely to inadvertently see an asymptomatic covid positive patient who is vaccinated rather than see an asymptomatic unvaccinated covid positive patient. This highlights the need to assess the risk from the virus rather than the risk from the vaccination status of the patient. Assessment of the risk from the virus is strongly informed by the presence or absence of uncontrolled community spread.

Commented [MT6]: What is this risk

For the vaccinated health care worker, the most likely risk from the unvaccinated is when a HCW needs health care themselves. ~~I~~The issue then is ~~being~~ one of capacity in the health system. ~~In this situation,~~ where access to care for non-covid illnesses may be significantly reduced. ~~This is the most realistic risk posed to a vaccinated HCW by the unvaccinated, in contrast to the~~ rather than the risk posed by an individual unvaccinated patient to an individual vaccinated and PPE competent HCW.

Where clinically acceptable, non-face-to-face clinical reviews are appropriate and obviously significantly reduce the risk of any inadvertent contact with an infectious person. All providers should continue to develop and utilize such opportunities.

Equity Issues:
Any approach that mandates unvaccinated patients are swabbed for Covid-19 prior to planned care risks worsening access to health care for some of the more disadvantaged of our community who are already unequally impacted.

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1. Access to swabbing is not 24/7 – shift workers or those working multiple jobs will struggle to access a testing service (unless Rapid Antigen Testing can be provided on a sufficient scale at the time of a planned appointment).
2. Those lacking transport may not be able to obtain a test in time to allow for their appointment to proceed
3. If the testing system is overwhelmed by planned Care tests then symptomatic test results may be delayed, further risking spread and preventable exposure to Covid. The current outbreak is affecting particularly disadvantaged areas of metro Auckland therefore any un-resourced expansion of testing may well further worsen inequity caused by more spread of Covid.

~~3.~~

   a. This issue of testing capacity needs resolution if community spread reaches a point where it is logical and reasonable to screen all patients.
      i. This includes the type of test that would be used to screen. RAT can be done on site at the facility on day of appointment; but note this also may impact attendance due to time issues for patients. There is also a staffing need for test supervision.

Commented [MT7]: I just wonder if this needs a section on its own?

When planning testing regimes in any scenario it is essential that the issues above and the impact on equity are considered.

When realistic concerns about community spread of Covid exist, we must assess the logical reasons to change practice.

Risk to a Health care worker:

1. Experience from metro Auckland is that transmission in the workplace from a Covid positive person to a vaccinated HCW is extremely rare
2. A fully vaccinated HCW with appropriate PPE and good workplace practices is safe at work, as is their family when the HCW returns home.

Risk to other patients:

To date, there are no examples of patient to patient transfer of Covid 19 in our secondary and tertiary health facilities, but there have been examples in Aged Residential Care settings where such transfer is likely to have occurred.

Risk of the unvaccinated patient to themselves:

Given in acute surgical care there is not the luxury of deferral, pre-operative testing for Covid is most relevant for planned surgery to identify asymptomatic Covid cases. Major surgery introduces a brief period of immunosuppression – this is one of the reasons why infections occur post-operatively despite antibiotics. There is growing evidence of increased morbidity and mortality for those patients who contract covid in the perioperative period. This highlights the risk posed of ~~of~~ asymptomatic covid positive patients.

~~Given in acute surgical care there is not the luxury of deferral, pre-operative testing for Covid is most relevant for planned surgery to identify asymptomatic Covid cases.~~

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The issue of risk to the unvaccinated patient should form part of the discussion with the patient regarding informed consent/ informed choice.

Paediatric cases:
Under-12s are not eligible, as yet, for vaccination. Careful consideration of any screen testing of children will need to be completed if such testing was felt to be necessary for attendance at a planned care appointment.

Role of Widespread testing when there is uncontrolled community spread:
Widespread testing of asymptomatic patients should be restricted to defined periods when a community has active and "unknown degrees" of spread.

This offers several main advantages:

1. Identification of asymptomatic cases allowing for urgent isolation and testing of close contacts
2. May allow for early administration of new agents for Covid (as per recent Govt/Pharmac announcements)
3. Ability to defer many aspects of planned care for positive cases given risks as noted above
    a. Where not deferable, screening positive will allow mitigation - for example, switching to a telehealth consultation
4. For non-deferrable cases, such a testing strategy would allow for logical geographic distribution of in-patients; for example, a surgical patient with a condition that can only be managed operatively who test positive for Covid on screen testing would be nursed either on the Covid ward or at least in a single room on a surgical ward with strict Covid protocols in place. Knowing a non-deferable case is Covid positive would also allow for logical approaches to treatments such as the experience of the anaesthetic and surgical team being of an appropriate level.

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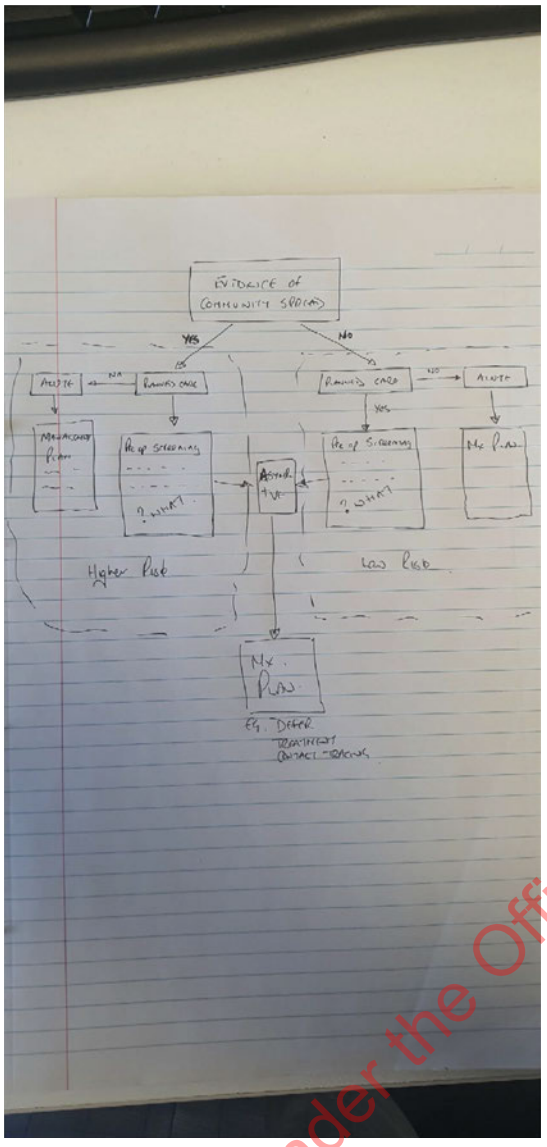

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Megan King

From: Andrew Connolly
Sent: Wednesday, 10 November 2021 9:55 am
To: Martin Thomas; Jeremy Tuohy
Subject: Unvaccinated draft 4
Attachments: Unvaccinated patients-V4 post MT.docx

Draft 4 attached. I've incorporated feedback from Martin and highlighted the most significant change.

I am aware MPS held a webinar last night – s 9(2)(g)(i) [redacted] He recommended us getting this out ASAP. I think we should aim for spped and can always refine?

Ngā mihi

Andrew

Andrew Connolly
Chief Medical Officer | Ministry of Health
E: andrew.connolly@health.govt.nz | Mobile: s 9(2)(a) [redacted] | www.health.govt.nz

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Unvaccinated patients. Draft 4
DRAFT ONLY - subject to alteration after consultation & review. Not official MOH Policy

Purpose of this Paper:
To address the concerns of some clinicians and providers have regarding face-to-face consultations with unvaccinated patients, especially the issue of requiring a negative covid test prior to such a consultation.

Background:
The perceived risk from face-to-face contact with unvaccinated patients is changing the way some health care providers are managing this patient group. The unintended consequence of this is the potential to worsen access and outcomes for patients and increased inequity.

The real issue is the risk of inadvertently seeing an infectious person (regardless of vaccination status) without the health care worker (HCW) being aware, in appropriate personal protection equipment (PPE) or in an appropriate physical environment.

Fundamental tenets

1. Health care is a fundamental human right.
2. Health care workers have a right to be safe in their workplace

With rights come responsibilities. For clinicians, such a responsibility is to act logically and with scientific reasoning as a core foundation to guiding patient management.

Testing prior to Health Care when there is no evidence of uncontrolled community spread:
There is no scientific support for testing asymptomatic patients who lack any other indication for a Covid test other than their vaccination status.

Introduction of this type of policy, which mandates testing for only unvaccinated patients, risks overloading laboratory capacity. This impacts directly on capacity for symptomatic testing and consequently the ability to expedite care for this patient group.

Testing of Patients when there is uncontrolled community spread:
This is the scenario where there may be a medical justification to the testing of asymptomatic patients including those lacking any risk factors, but such a policy should not be restricted to just the unvaccinated.

Any such policy needs to apply to all patients irrespective of vaccination status as asymptomatic infection is the issue, not the vaccine status of the patient.

Symptomatic cases would of course be handled as per existing testing protocols.

There is a need to have a consistent approach to starting screening testing as it impacts patient care and clinical behaviour.

Why not test all unvaccinated patients irrespective of community transmission?
There are three key issues to consider; each centres on Risk:

Commented [MT1]: Need to draw a stake in the ground to say if a guideline, advice or position statement
Who is it for – DHBs/Primary care/all outward facing health workers?

Commented [AC2R1]: Yes needs work – I'm anxious about private facility owners vs clinicians in this – I think this should be aimed at clinicians

Commented [MT3]: Outline a process to risk assess and develop a plan for managing planned care in communities with Covid spread to address.....

Commented [MT4]: This is going to be the challenge and major use of lab resources once endemic everywhere. Again I wonder what the risk of transmission is for asymptomatic vaccinated vs unvaccinated?

Commented [AC5R4]: I think the issue really needs to be about the risk to the patient – an asymptomatic person having any immune dampening treatment – steroids, surgery, etc is at significant risk of bad covid

Commented [MT6]: Above

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1. Risk to health equity of any poorly conceived and poorly applied approach
2. Risk of the unvaccinated patient to others:
    a. to HCWs
    b. to other patients
3. Risk of the unvaccinated patient to their own health if they were infected with covid at the time of having certain health treatments

A consistent, risk based, scientific approach is necessary to avoid worsening inequity and driving perverse practice. Healthcare regulators are clear that healthcare providers cannot allow personal beliefs to impact on the high standard of health care patients should receive. Where no scientific support for Covid testing of specific groups exists, such a requirement is likely to be interpreted as a personal belief and therefore is not accepted practice.

Whilst relevant mainly to planned care, there are examples of avoidable delays in acute care provision whilst swabs are awaited. A safer clinical approach would be to adopt "covid precautions" for any case where a swab is required, but where the clinical risk of further time delay is not acceptable.

The unvaccinated in society pose the greatest risk to themselves and to other unvaccinated people. Statistically, a health care worker is far more likely to inadvertently see an asymptomatic covid positive patient who is vaccinated rather than see an asymptomatic unvaccinated covid positive patient. This highlights the need to assess the risk from the virus rather than the risk from the vaccination status of the patient. The level of risk will vary depending on various circumstances including the presence or absence of uncontrolled community spread of Covid and a through risk assessment by Public Health and other experts

For the vaccinated health care worker, the most likely risk from the unvaccinated is when a HCW needs health care themselves. The issue then is one of capacity in the health system where access to care for non-covid illnesses may be significantly reduced rather than the risk posed by an individual unvaccinated patient to an individual vaccinated and PPE competent HCW.

Where clinically acceptable, non-face-to-face clinical reviews are appropriate and obviously significantly reduce the risk of any inadvertent contact with an infectious person. All providers should continue to develop and utilize such opportunities.

Equity Issues:
Any approach that mandates unvaccinated patients are swabbed for Covid-19 prior to planned care risks worsening access to health care for some of the more disadvantaged of our community who are already suffering health inequities.

1. Access to swabbing is not 24/7 – shift workers or those working multiple jobs will struggle to access a testing service (unless Rapid Antigen Testing can be provided on a sufficient scale at the time of a planned appointment).
2. Those lacking transport may not be able to obtain a test in time to allow for their appointment to proceed

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3. If the testing system is overwhelmed by planned Care tests then symptomatic test results may be delayed, further risking spread and preventable exposure to Covid. The current outbreak is affecting particularly disadvantaged areas of metro Auckland therefore any un-resourced expansion of testing may well further worsen inequity caused by more spread of Covid.

Testing Capacity:
This issue of testing capacity needs resolution if community spread reaches a point where it is logical and reasonable to screen all patients.

i. This includes the type of test that would be used to screen. RAT can be done on site at the facility on day of appointment; but note this also may impact attendance due to time issues for patients. There is also a staffing need for test supervision.

When planning testing regimes in any scenario it is essential that the issues above and the impact on equity are considered.

When realistic concerns about community spread of Covid exist, we must assess the logical reasons to change practice.

Risk to a Health care worker:

1. Experience from metro Auckland is that transmission in the workplace from a Covid positive person to a vaccinated HCW is extremely rare
2. A fully vaccinated HCW with appropriate PPE and good workplace practices is safe at work, as is their family when the HCW returns home.

Risk to other patients:
To date, there are no examples of patient-to-patient transfer of Covid 19 in our secondary and tertiary health facilities, but there have been examples in Aged Residential Care settings where such transfer is likely to have occurred.

Risk of the unvaccinated patient to themselves:
Given in acute surgical care there is not the luxury of deferral, pre-operative testing for Covid is most relevant for planned surgery to identify asymptomatic Covid cases. Major surgery introduces a brief period of immunosuppression – this is one of the reasons why infections occur post-operatively despite antibiotics. There is growing evidence of increased morbidity and mortality for those patients who contract covid in the perioperative period. This highlights the risk posed of asymptomatic covid positive patients.

The issue of risk to the unvaccinated patient should form part of the discussion with the patient regarding informed consent/ informed choice.

Paediatric cases:
Under-12s are not eligible, as yet, for vaccination. Careful consideration of any screen testing of children will need to be completed if such testing was felt to be necessary for attendance at a planned care appointment.

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Role of Widespread testing when there is uncontrolled community spread:
Widespread testing of asymptomatic patients should be restricted to defined periods when a community has active and "unknown degrees" of spread.

This offers several main advantages:

1. Identification of asymptomatic cases allowing for urgent isolation and testing of close contacts
2. May allow for early administration of new agents for Covid (as per recent Govt/Pharmac announcements)
3. Ability to defer many aspects of planned care for positive cases given risks as noted above
    a. Where not deferable, screening positive will allow mitigation - for example, switching to a telehealth consultation
4. For non-deferrable cases, such a testing strategy would allow for logical geographic distribution of in-patients; for example, a surgical patient with a condition that can only be managed operatively who test positive for Covid on screen testing would be nursed either on the Covid ward or at least in a single room on a surgical ward with strict Covid protocols in place. Knowing a non-deferable case is Covid positive would also allow for logical approaches to treatments such as the experience of the anaesthetic and surgical team being of an appropriate level.

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Document 1

Megan King

From: Jeremy Tuohy
Sent: Wednesday, 10 November 2021 3:13 pm
To: Andrew Connolly
Subject: Management of Unvaccinated People
Attachments: Management of Unvaccinated People FC_.docx Refer to following pages

Kia ora Andrew,

I have formulated the information in emails into a memo for the DG, as I gather that is the way that things were going.

The section at the end estimating the risk of transmission might be going out on a bit of a limb. The point I was trying to get across is that the risk is very low. Maybe the actual calculations could be put into an appendix instead.

Kind regards

Jeremy

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MINISTRY OF HEALTH
MANATŪ HAUORA

Memo

Management of unvaccinated people in healthcare settings

Date:	11 November 2021
To:	Ashley Bloomfield, Director General, Ministry of Health.
Copy to:	? Ian Town, ? public health ? testing
From:	Andrew Connolly, Chief Medical Officer, Ministry of Health
For your:	Action and decision

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Purpose of report

1. Unvaccinated people are at increased risk of infection with, and transmission of SARS-CoV-2 compared to vaccinated people. This report assesses the increased risk in the healthcare setting and the steps, if any, which may be required to mitigate this risk.
2. This report recognises that access to healthcare is a fundamental human right and that any actions which restrict access to care must be justified by a documented risk.
3. This report also acknowledges that healthcare workers have a right to a safe environment and that reasonable steps must be taken by employers to ensue the safety of their employees.

Background and context

The role of vaccination in preventing COVID-19

4. Vaccination against SARS-CoV-2 is a safe an effective method of decreasing the risk of infection, hospitalisation, and severe outcomes from COVID-19. Vaccination also decreases the risk of transmission from an individual infected with SARS-CoV-2 (a case) to a contact.
5. Vaccination with the Pfizer vaccine decreases the risk of symptomatic infection by approximately 80%. However, evidence suggests that the risk of infection (symptomatic or asymptomatic) is decreased by approximately 50%. This protection wanes over time, so that the protection from any infection may be as low as 30% by 6 months. Vaccinated individuals have lower risk of infection than unvaccinated, but when a breakthrough infection does occur, approximately 30-50% of all vaccinated cases will experience asymptomatic COVID-19 disease. (refs)
6. Data is emerging, but evidence suggests that, if a breakthrough infection does occur, vaccination also decreases the risk of onwards transmission of the virus from a case to a contact by approximately 50%. However, current evidence indicates that during the most infectious

period, the difference in viral load based on Ct values between vaccinated and unvaccinated individuals is minimal, in the period immediately after infection and reduces more rapidly in vaccinated individuals.

7. A proportion of individuals will fail to develop an adequate immune response to vaccination. Some of these individuals can be identified as being at risk for having inadequate immune response as they have a known condition resulting in immunocompromise. However, there are no validated tests which are able to determine which individuals are immune from infection with SARS-CoV-2.

8. Therefore, transmission of SARS-CoV-2 can, and does occur from both vaccinated and unvaccinated cases.

9. This document does not discuss the reasons why some individuals choose not to be vaccinated and works on the assumption that for the purposes of this document, this knowledge is not useful, nor able to be obtained in a reliable manner.

The impact of vaccination on the risk of transmission

10. The rate of vaccination in a community will influence the relative proportion of potential exposure episodes for vaccinated and unvaccinated individuals. High rates of vaccination mean that, a correspondingly higher proportion of cases will tend to be vaccinated. In addition, vaccinated individuals are more likely to be asymptomatic carriers of infection than unvaccinated individuals and as a result be unaware that they are potentially infectious

The impact of disease prevalence on the risk of transmission

11. The overall risk of transmission is determined in part by the prevalence of active disease in the community. In areas with very limited or no community spread the risk of contracting COVID-19 during any interaction is close to zero. Therefore, unvaccinated people are at no greater risk of being infected with or transmitting SARS-CoV-2 than vaccinated individuals in areas with no or very limited community transmission.

12. If the prevalence of disease in a community is high, transmission from either vaccinated or unvaccinated individuals is an ongoing risk. In this situation measures will need to be taken by all healthcare providers to minimise their risk of infection in most, if not all consultations, irrespective of vaccination status.

13. In an endemic scenario, pathways for management of individuals through the healthcare system need to be developed. These pathways need to be consistent. For example, the management of an unvaccinated individual as a high-risk patient in a general practice setting, should align with protocols a hospital or dental setting.

Identification of individuals at high risk of infection with, or transmission of COVID-19.

Clinical risk factors

14. Individuals with COVID-19 may be identified due to the presence of symptoms or on the basis of being a contact of a case. Previously, in the absence of community transmission, contacts of cases were almost exclusively limited to having travelled overseas or working at a managed isolation centre. That situation has changed for Auckland, Waikato, and Northland, where there is ongoing community spread.

15. Individuals with symptoms suggestive of COVID-19 will always be managed as being at risk of infection and any consultation will be undertaken with the appropriate precautions. Therefore, the unvaccinated individuals for whom guidelines may need to be developed are those who are

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symptomatic for disease presenting for an unrelated condition who are not a known close contact of a recent case.

16. As these individuals have no history of exposure to or symptomatology of COVID-19, it is highly unlikely that a set of useful and valid clinical criteria could be developed which would identify an at-risk group.

Testing

17. Testing for SARS-CoV-2 may be possible for some situations where a planned consultation will occur. However current testing workloads for RT-PCR are a constraint. The current constraint on testing does not mean that testing for routine consultations is an invalid approach, but it must be recognised that when resources are constrained, that routine testing of an unvaccinated asymptomatic individual is unlikely to be prioritised above testing of a contact or a symptomatic individual. Deferment of routine laboratory work for testing of asymptomatic unvaccinated individuals would require a careful assessment of the risks and benefits, but cannot be assumed to be a valid use of testing resources.

18. For urgent consultations the time required for a RT-PCR result to be obtained precludes the use of this testing modality. Rapid Antigen Testing (RAT) and rapid PCR testing are alternatives. Both have advantages and disadvantages. Rapid antigen testing has been shown to be effective at identifying individuals with a high viral load and at most risk of transmitting SARS-CoV-2. However, the ability of the test to identify all individuals with active infection by screening only those individuals who are unvaccinated will primarily be influenced by the relative proportion of cases who are vaccinated and unvaccinated. This issue is discussed above.

19. Access to COVID-19 testing may require review, particularly the ability of a wide range of healthcare providers to arrange RATs.

20. Any testing strategy must be assessed in the clinical context and will be influenced by the factors discussed above but also other variables, such as the consequences of false positive rates and the interventions undertaken when a positive test is obtained.

Potential pathways for unvaccinated individuals

21. This document is based on the premise that an individual who is unvaccinated, for whatever reason, cannot be refused healthcare. It is further assumed that the development of legislation governing the COVID Vaccine Certificate explicitly states that there are situations in which this certificate cannot be applied to exclude an individual from any dwelling or service. This would imply that no dwelling or building in which a healthcare provider is operating is able to refuse entry to an unvaccinated individual, or to place unreasonable barriers to their entry.

22. A healthcare provider may, at their own discretion and at any time protect themselves from infection if they consider themselves at risk by the use of appropriate PPE and / or by the use of other mitigation measures. Furthermore, it would be expected that healthcare providers utilise the full range of mitigations to prevent transmission during periods of community transmission in order to protect themselves, staff, and other patients.

23. A management pathway for symptomatic individuals exists. Any individual who is considered to be at significant risk of infection could be managed through that pathway. However, the decision to manage an individual through a high- or low-risk pathway should be evidence based, transparent and not impose any undue burden on the individual.

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24. There is currently no evidence that managing all unvaccinated individuals through a high-risk pathway would result in a significant reduction in the risk of transmission. The available evidence would suggest that any reduction in risk would be marginal at best. (discussed below).

25. Currently, vaccination is limited to adults and children 12 years and over. Managing all children through an at-risk pathway would appear to be disproportionate to the clinical risk. Children with respiratory symptoms would be considered to be at-risk of infection. However, it is important to note that at Alert level 1, it is considered unnecessary to take COVID-19 swabs from children with respiratory disease due to the low risk of infection.

Ethical Issues

26. The ethical issues of treating unvaccinated individuals differently to vaccinated individuals are complex. This document does not address these in detail. The purpose of this paper to address the risks of transmission from unvaccinated individuals compared to vaccinated individuals.

Modelling of the risk of infection

27. The following example outlines the risk of infection at any consultation. (numbers to be validated) Although the underlying rates may change the rationale is as follows:

    a. The proportion of individuals in the community who are infectious at any one time is low.

    b. With high rates of vaccination most cases will be fully vaccinated

    c. Transmission from both vaccinated and unvaccinated cases occurs.

    d. The risk of transmission in a healthcare setting is low.

    e. Therefore, the absolute risk of transmission at any single interaction is very low and despite the fact that unvaccinated individuals are more likely to be infected with SARS-CoV-2 and to transmit virus to others, the fact that unvaccinated individuals are such a small proportion of the population results in transmission being more likely to occur from a vaccinated individual than an unvaccinated individual.

The risk of infection in Auckland and other regions.

28. Currently Auckland is the only region with significant community spread. Therefore, any proposal to manage vaccinated and unvaccinated individuals differently would only apply to this region. The following modelling attempts to assess the risk of transmission of infection to a healthcare practitioner undertaking their routine employment.

Vaccination Status

29. Complete vaccination, defined as at least one week after the second dose, is rapidly approaching 90% in Auckland. Therefore, for each 100,000 people 90,000 will be vaccinated and 10,000 unvaccinated.

30. The new case rate for Auckland is approximately 160 cases per day for 1.6 million people. This is equivalent to a case rate of 10 per 100,000 people per day. Each individual will remain infectious for approximately 4 days for an infectious case rate of roughly 40 per 100,000 people at any one time. Note that unvaccinated individuals have contributed a larger proportion of individuals to the current outbreak as the data for the current outbreak includes a period of time when vaccination rates were relatively low, and that more vaccinated than unvaccinated individuals are not detected as they are asymptomatic.

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31. However approximately 50% of cases are known contacts and 50% of individuals are symptomatic. Assuming no interaction between these variables, the infectious rate in asymptomatic cases who are not known contacts in Auckland is approximately 10 per 100,000.

32. As unvaccinated individuals are twice as likely to be infected as vaccinated individuals the infection rate in unvaccinated would be roughly 20 per 100,000 individuals, or 2 in 10,000 people, while vaccinated individuals would contribute 10 in 90,000 individuals.

33. The risk of transmission in different settings varies. Within a household the risk is approximately 50% or a close household contact and 10% for other contacts. In healthcare settings the risk is low. The risk of infection in a healthcare setting is probably less than 1%. For an unvaccinated case the risk of transmission may be double that of a vaccinated case. A risk of transmission (secondary attack rate) of 2% would be a high estimate of risk for an unvaccinated individual.

34. However, data from these settings will incorporate a wide range of mitigations including PPE. Surgical or medical masks will decrease the risk of transmission. A fit tested P2 or N95 mask compared to a medical mask is an efficient method of preventing infection.

35. Therefore, the risk of infection from an unvaccinated individual is approximately 4 in one million while for a vaccinated individual the risk is approximately 1 in a million. However, as 90% of all cases are vaccinated, the risk of transmission from a vaccinated individual is approximately double that of an unvaccinated individual.

Recommendations

It is recommended that you:

1.	Agree	That urgent guidance to the sector regarding the management of unvaccinated people in healthcare settings is required.	Yes/No
2.	Agree	That this guidance includes the unequivocal message that it is not acceptable / legal to refuse access to healthcare to unvaccinated people	Yes/No
3.	Agree	That this guidance emphasises the observation that currently the risk of infection during a healthcare consultation is very low.	Yes / No
4.	Agree	That this guidance emphasises that practitioners have a range of non-pharmaceutical interventions available to protect themselves from infection. This includes but is not limited to access to fit tested P2 / N95 masks.	
5.	Note	That limitations on the availability of testing may impact the management of individuals considered to be at risk of infection on the basis on vaccination status	Yes/No
6.	Note	That health practitioners will be provided with substantial protection against symptomatic COVID-19 by vaccination, which is now mandatory	Yes/No

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7.	Agree	This guidance will provide an interim statement of intent and form the basis of further discussions with a range of professional bodies, regulatory agencies, and healthcare providers	Yes/No

Signature _____ Date: 11 November 2021
Mr Andrew Connolly, Chief medical Officer, Ministry of Health
[Title]

Signature _____ Date:
[Name]
[Title]

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Document 1

Megan King

From: Andrew Connolly
Sent: Friday, 12 November 2021 9:23 am
To: Robyn Shearer
Subject: FW: Draft one: Approach to unvaccinated patients draft one
Attachments: Unvaccinated patients-Prospect draft for circulation.docx Refer to end of email chain

FYII

A

From: Andrew Connolly
Sent: Friday, 12 November 2021 9:21 am
To: Keriana Brooking <Keriana.Brooking@hbdhb.govt.nz>
Cc: Andrew Bichan <Andrew.Bichan@health.govt.nz>
Subject: RE: Draft one: Approach to unvaccinated patients draft one

Kia ora Keriana

Done – going through to Ashley (not sure if he physically has it) to ensure we are all happy with it (Andrew B – Jeremy Tuohy is doing the briefing paper)

Attached is draft 4 – this one is getting a minor tweak and some editing/ formatting .

HDC, MCNZ and MCNZ all will put out their own lines around the regulator. HDC view of wilfully being in opposition.

Note it is carefully worded to talk about the clinicians so as to avoid any fight with private business owners who may well not be subject to HPCAA . In other words we cannot get iinto a fight about fully private facility and non-public funded/subsidised care but message very clear and these scenarios are covered by regulators and HDC.

Ngā mihi

Andrew

Andrew Connolly
Chief Medical Officer | Ministry of Health
E: andrew.connolly@health.govt.nz | Mobile: s 9(2)(a) | www.health.govt.nz

From: Keriana Brooking <Keriana.Brooking@hbdhb.govt.nz>
Sent: Friday, 12 November 2021 9:07 am
To: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Cc: Andrew Bichan <Andrew.Bichan@health.govt.nz>
Subject: RE: Draft one: Approach to unvaccinated patients draft one

Kia ora koutou

Just checking what the status of this work is?

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Ngā mihi

Keriana Brooking (she/her)
Te Tumu Whakarae (Chief Executive Officer)
Hawke's Bay District Health Board
Private Bag 9014, Hastings 4156
T: ++64 6 878 1690 | F: ++ 64 6 878 1648 | s 9(2)(a)
Email: keriana.brooking@hbdhb.govt.nz
W: www.hawkesbaydhb.govt.nz
Tauwhiro Rāranga te tira He kauanuanu Ākina

More information on personal pronouns:
https://www.publicservice.govt.nz/our-work/diversity-and-inclusion/pronoun-use-in-email-signatures/

This email may be sent to you outside your normal working hours. I do not expect a reply until you are "back at work". Mauriora

---

From: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Sent: Wednesday, 3 November 2021 11:13 AM
To: Robyn Shearer <Robyn.Shearer@health.govt.nz>; Ashley Bloomfield <Ashley.Bloomfield@health.govt.nz>; Jess Smaling <Jessica.Smaling@health.govt.nz>; Russell Simpson <xxxxxxx.xxxxxxx@xxxxxx.xxxx.xx >; Phil Knipe <Phil.Knipe@health.govt.nz>; Martin Chadwick <Martin.Chadwick@health.govt.nz>; Juliet Rumball-Smith <Juliet.Rumball-Smith@health.govt.nz>; Lorraine Hetaraka <Lorraine.Hetaraka@health.govt.nz>; Margie Apa-Ext <Margie.Apa@middlemore.co.nz>; Keriana Brooking <Keriana.Brooking@hbdhb.govt.nz>; Martin Thomas <Martin.Thomas@hqsc.govt.nz>; Morag McDowell <Morag.McDowell@hdc.org.nz>; Ian Town <Ian.Town@health.govt.nz>; Jeremy Tuohy <Jeremy.Txxxx@xxxxxx.xxxx.nz >; Dan Bernal <Daniel.Bernal@health.govt.nz>; Emma Hickson <xxxx.xxxxxxx@xxxxxx.xxxx.xx >
Cc: Andrew Bichan <Andrew.Bichan@health.govt.nz>
Subject: FW: Draft one: Approach to unvaccinated patients draft one

Dear Colleagues

The attached is a first draft of my thoughts on the unvaccinated patient. We have an urgent need to have science and logic predominate given we have some clinicians and some groups (including at least 2 RAs!) advising to various degrees the approach (or lack of) to unvaccinated patients. This inconsistent (and frankly incoherent) approach threatens equity, patient safety and access for many people.

You will see I've tried to construct an argument against the differentiation between vaccinated and unvaccinated except where science indicates a benefit to the patient.

I think a key area for consideration is the role, if any, of screening of all patients when a point in community spread is reached – point not defined by me

I have spoken to some of you personally and apologise to those whom I've not yet contacted, but urgency exists.

I propose a joint meeting ASAP – my EA, Rachel will contact to set up a time to zoom in coming few days of those who need to be party to the debate.

In the mean time I suggest review the attached and feedback the errors/omissions.

Keriana has asked me to speak to this at the CEs meeting tonight and I am meeting the national CMOs today where this item is on the agenda.

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Ngā mihi

Andrew

Andrew Connolly
Chief Medical Officer | Ministry of Health
E: andrew.connolly@health.govt.nz | Mobile: s 9(2)(a) | www.health.govt.nz

****
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Should Unvaccinated patients be required to have a Covid Test before Care?.
Draft 4
DRAFT ONLY - subject to alteration after consultation & review. Not official MOH Policy

Purpose of this Paper:
To address the concerns of some clinicians and providers have regarding face-to-face consultations with unvaccinated patients, especially the issue of requiring a negative covid test prior to such a consultation outside of an emergency situation.

Background:
The perceived risk from face-to-face contact with unvaccinated patients is changing the way some health care providers are managing this patient group. The unintended consequence of this is the potential to worsen access and outcomes for patients and increased inequity.

The real issue is the risk of a fully vaccinated Health Care Worker (HCW) inadvertently seeing an infectious person (regardless of vaccination status).

Fundamental tenets

1. Health care is a fundamental human right.
2. Health care workers have a right to be safe in their workplace.

With rights come responsibilities. For clinicians, such a responsibility is to act logically and with scientific reasoning as a core foundation to guiding patient management.

Testing prior to Health Care when there is no evidence of uncontrolled community spread:
There is no scientific support for testing asymptomatic patients who lack any other indication for a Covid test other than their vaccination status.

Introduction of this type of policy, which mandates testing for only unvaccinated patients, also risks overloading laboratory capacity. This impacts directly on capacity for symptomatic testing and consequently the ability to expedite care for this patient group.

Testing of Patients when there is uncontrolled community spread:
This is the scenario where there may be a medical justification to the testing of asymptomatic patients including those lacking any risk factors, but such a policy should not be restricted to just the unvaccinated.

Any such policy needs to apply to all patients irrespective of vaccination status as asymptomatic infection is the issue, not the vaccine status of the patient.

Symptomatic cases would of course be handled as per existing testing protocols.

There is a need to have a consistent approach to starting screening testing as it impacts patient care and clinical behaviour.

Why not test all unvaccinated patients irrespective of community transmission?
There are three key issues to consider; each centres on Risk:

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1. Risk to health equity of any poorly conceived and poorly applied approach
2. Risk of the unvaccinated patient to others:
    a. to HCWs
    b. to other patients
3. Risk of the unvaccinated patient to their own health if they were infected with covid at the time of having certain health treatments

A consistent, risk based, scientific approach is necessary to avoid worsening inequity and driving perverse practice. Healthcare regulators are clear that healthcare providers cannot allow personal beliefs to impact on the high standard of health care patients should receive. Where no scientific support for Covid testing of specific groups exists, such a requirement is likely to be interpreted as a personal belief and therefore is not accepted practice.

Whilst relevant mainly to planned care, there are examples of avoidable delays in acute care provision whilst swabs are awaited. A safer clinical approach would be to adopt "covid precautions" for any case where a swab is required, but where the clinical risk of further time delay is not acceptable.

The unvaccinated in society pose the greatest risk to themselves and to other unvaccinated people. Statistically, given the high rate of vaccination in our country, a health care worker is far more likely to inadvertently see an asymptomatic covid positive patient who is vaccinated rather than see an asymptomatic unvaccinated covid positive patient. This highlights the need to assess the risk from the virus rather than the risk simply from the vaccination status of the patient. The level of risk will vary depending on various circumstances including the presence or absence of uncontrolled community spread of Covid and a through risk assessment by Public Health and other experts.

For the vaccinated health care worker, the most likely risk from the unvaccinated is when a HCW needs health care themselves. The issue then is one of capacity in the health system where access to care for non-covid illnesses may be significantly reduced rather than the risk posed by an individual unvaccinated patient to an individual vaccinated and PPE-competent HCW.

Where clinically acceptable, non-face-to-face clinical reviews are appropriate and obviously significantly reduce the risk of any inadvertent contact with an infectious person. All providers should continue to develop and utilize such opportunities.

Equity Issues:
Any approach that mandates unvaccinated patients are swabbed for Covid-19 prior to planned care risks worsening access to health care for some of the more disadvantaged of our community, many of whom are already suffering health inequities.

1. Access to swabbing is not 24/7 – shift workers or those working multiple jobs will struggle to access a testing service (unless Rapid Antigen Testing can be provided on a sufficient scale at the time of a planned appointment).
2. Those lacking transport may not be able to obtain a test in time to allow for their appointment to proceed

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3. If the testing system is overwhelmed by planned Care tests then symptomatic test results may be delayed, further risking spread and preventable exposure to Covid. The current outbreak is affecting particularly disadvantaged areas of metro Auckland therefore any un-resourced expansion of testing may well further worsen inequity caused by more spread of Covid.

Testing Capacity:
This issue of testing capacity needs resolution if community spread reaches a point where it is logical and reasonable to screen all patients.

1. This includes the type of test that would be used to screen. RAT can be done on site at the facility on day of appointment; but note this also may impact attendance due to time issues for patients. There is also a staffing need for test supervision.

When planning testing regimes in any scenario it is essential that the issues above and the impact on equity are considered.

When realistic concerns about community spread of Covid exist, we must assess the logical reasons to change practice.

Risk to a Health care worker:

1. Experience from metro Auckland is that transmission in the workplace from a Covid positive person to a vaccinated HCW is extremely rare
2. A fully vaccinated HCW with appropriate PPE and good workplace practices is safe at work, as is their family when the HCW returns home.

Risk to other patients:
To date, there are no examples of patient-to-patient transfer of Covid 19 in our secondary and tertiary health facilities, but there have been examples in Aged Residential Care settings where such transfer is likely to have occurred.

Risk of the unvaccinated patient to themselves:
Given in acute surgical care there is not the luxury of deferral, pre-operative testing for Covid is most relevant for planned surgery to identify asymptomatic Covid cases. Major surgery introduces a brief period of immunosuppression – this is one of the reasons why infections occur post-operatively despite antibiotics. There is growing evidence of increased morbidity and mortality for those patients who contract covid in the perioperative period. This highlights the risk posed of asymptomatic covid positive patients.

The issue of risk to the unvaccinated patient should form part of the discussion with the patient regarding informed consent/ informed choice.

Paediatric cases:
Under-12s are not eligible, as yet, for vaccination. Careful consideration of any screen testing of children will need to be completed if such testing was felt to be necessary for attendance at a planned care appointment.

Role of Widespread testing when there is uncontrolled community spread:

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Widespread testing of asymptomatic patients should be restricted to defined periods when a community has active and “unknown degrees” of spread.

This offers several main advantages:

1. Identification of asymptomatic cases allowing for urgent isolation and testing of close contacts
2. May allow for early administration of new agents for Covid (as per recent Govt/Pharmac announcements)
3. Ability to defer many aspects of planned care for positive cases given risks as noted above
    a. Where not deferable, screening positive will allow mitigation - for example, switching to a telehealth consultation
4. For non-deferrable cases, such a testing strategy would allow for logical geographic distribution of in-patients; for example, a surgical patient with a condition that can only be managed operatively who test positive for Covid on screen testing would be nursed either on the Covid ward or at least in a single room on a surgical ward with strict Covid protocols in place. Knowing a non-deferable case is Covid positive would also allow for logical approaches to treatments such as the experience of the anaesthetic and surgical team being of an appropriate level.

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Megan King

From: Martin Chadwick
Sent: Monday, 15 November 2021 10:29 am
To: Clinical Oversight Group; Phil Knipe; Jeremy Tuohy; Andrew Connolly; Ian Town; Emma Hickson
Cc: Dan Bernal
Subject: RE: Unvaccinated patients-V5

I am happy that it goes for an initial conversation.
Ngā mihi
Martin

From: Jess Davis <xxxx.xxxxx@xxxxxx.xxxx.xx> **On Behalf Of** Clinical Oversight Group
Sent: Monday, 15 November 2021 9:36 am
To: Phil Knipe <Phil.Knipe@health.govt.nz>; Jeremy Tuohy <Jeremy.Tuohy@health.govt.nz>; Andrew Connolly <Andrew.Connolly@health.govt.nz>; Ian Town <Ian.Town@health.govt.nz>; Martin Chadwick <Martin.Chadwick@health.govt.nz>; Emma Hickson <Emma.Hickson@health.govt.nz>
Cc: Dan Bernal <Daniel.Bexxxx@xxxxxx.xxxx.xx>
Subject: RE: Unvaccinated patients-V5

Kia ora.
Would this be something you would like to have go through at todays COG meeting at 1pm? I'm happy to add to the agenda if you feel it's ready.

Ngā mihi,
Jessie

Jess Davis(She/Her) I Coordinator I Office of the Deputy Chief Executive I COVID-19 Health System Response I Ministry of Health
E: xxxx.xxxxx@xxxxxx.xxxx.xx

From: Phil Knipe <Phil.Knipe@health.govt.nz>
Sent: Friday, 12 November 2021 3:24 pm
To: Jeremy Tuohy <Jeremy.Tuohy@health.govt.nz>; Andrew Connolly <Andrew.Connolly@health.govt.nz>; Ian Town <Ian.Town@health.govt.nz>; Martin Chadwick <Martin.Chadwick@health.govt.nz>; Emma Hickson <Emma.Hickson@health.govt.nz>
Cc: Dan Bernal <Daniel.Bernal@health.govt.nz>; Jess Davis <xxxx.xxxxx@xxxxxx.xxxx.xx>
Subject: RE: Unvaccinated patients-V5

s 9(2)(h)

Cheers,

Phil Knipe

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Chief Legal Advisor
Ministry of Health
DDI: 04 496 2137
Mobile: s 9(2)(a)

http://www.health.govt.nz
mailto: phil.knipe@health.govt.nz

From: Jeremy Tuohy <Jeremy.Tuohy@health.govt.nz>
Sent: Friday, 12 November 2021 2:55 pm
To: Andrew Connolly <Andrew.Connolly@health.govt.nz>; Ian Town <Ian.Town@health.govt.nz>; Phil Knipe <Phil.Knipe@health.govt.nz>; Martin Chadwick <Martin.Chadwick@health.govt.nz>; Emma Hickson <Emma.Hickson@health.govt.nz>
Cc: Dan Bernal <Daniel.Bernal@health.govt.nz>; Jess Davis <xxxx.xxxxx@xxxxxx.xxxx.xx>
Subject: RE: Unvaccinated patients-V5

Thank you all.
Please note that Andrew has obtained feedback from Nursing Council, pharmacy council, HQSC, MCNZ ACC and HDC prior to preparing this document.

- I have updated the document.
- I will send on to Phil Knipe (legal), Justine Lancaster (primary care), Emma Hickson (IPC) and Martin (COG) for review initially.
- s 9(2)(h) [redacted]

The decision to use as interim advice I will need to leave to Andrew.

For completeness I attach the full document consisting of three parts. Refer to end of email chain

1. Memo to DG regarding the rationale for providing a Ministry position
2. Appendix one with an interim analysis of the risks of transmission in a healthcare setting (NOTE: I am still waiting on Epidemiological review of this appendix 1.)
3. The position statement document.

Ka kite

Dr Jeremy Tuohy BMedSci, MBChB, DDU, PhD
Principal Advisor
Science and Technical Advisory | Rōpū tohutohu i te pūtaiao me te hangarau
COVID-19 Health System Response
Ministry of Health - Manatū Hauora
New Zealand

http://www.health.govt.nz
mailto:Jeremy.Tuohy@health.govt.nz

From: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Sent: Friday, 12 November 2021 1:00 pm
To: Ian Town <Ian.Town@health.govt.nz>; Jeremy Tuohy <Jeremy.Txxxx@xxxxxx.xxxx.nz >

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Cc: Dan Bernal <Daniel.Bernal@health.govt.nz>
Subject: RE: Unvaccinated patients-V5

Great – noted – thanks

May be interim is a good idea – plenty of pressure from sector

---

From: Ian Town <Ian.Town@health.govt.nz>
Sent: Friday, 12 November 2021 12:59 pm
To: Jeremy Tuohy <Jeremy.Tuohy@health.govt.nz>; Andrew Connolly <Andrew.Connolly@health.govt.nz>
Cc: Dan Bernal <Daniel.Bernal@health.govt.nz>
Subject: RE: Unvaccinated patients-V5

Hi all

I don't think this is ready yet.

If it is to be a MoH position statement I think it will need peer review, health legal opinion and consultation including primary care

COG would also need to review

If it is needed today it could be classified as interim

Ian

From: Jeremy Tuohy <Jeremy.Tuohy@health.govt.nz>
Sent: Friday, 12 November 2021 12:34 pm
To: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Cc: Dan Bernal <Daniel.Bernal@health.govt.nz>; Ian Town <Ian.Town@health.govt.nz>
Subject: Unvaccinated patients-V5

Hi Andrew,

I have tidied up the document (v4) you sent, with comments.
Hopefully I have captured the relevant points. I have tried to keep this as guidance, but as a result if the information regarding testing need more work it may need to be a separate piece of work.
I think it depends on how much pressure there is to test unvaccinated asymptomatic individuals. I don't think there is any rationale, but clearly there is a lot of work going on n this space. It is clear that the amount of testing is under serious review.

Jeremy

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Appendix 1.

Estimation of transmission risk based on the current outbreak in Auckland.

The estimation of the risk of infection is summarised in simplified form below. This is designed to provide an estimate only and is not definitive.

The risk of infection in Auckland and other regions.

- Currently Auckland is the only region with significant community spread. Therefore, any proposal to manage vaccinated and unvaccinated individuals differently would only apply to this region. The following modelling attempts to assess the risk of transmission of infection to a healthcare practitioner undertaking their routine employment.

Vaccination Status

- Complete vaccination, defined as at least one week after the second dose of the Pfizer vaccine, is rapidly approaching 90% in Auckland. Therefore, for each 100,000 people 90,000 will be vaccinated and 10,000 unvaccinated.

Case rates

- The current case rate for Auckland(as of mid-November) is approximately 160 cases per day diagnosed for 1.6 million people. This rate is likely to increase and does not include undiagnosed patients. This is equivalent to a case rate of 10 per 100,000 people per day. Each individual remains infectious, on average, for approximately 4 days, therefore, the prevalence of infectious cases is roughly 40 per 100,000 people at any one time.
- Note: Unvaccinated individuals are a larger proportion of cases in the current outbreak as the current outbreak includes a period of time when vaccination rates were relatively low, and unvaccinated cases are more likely to be diagnosed as they are more likely to be asymptomatic, especially as the outbreak progresses and contact tracing is becoming less effective for case finding

Symptomatic vs Asymptomatic infection

- At the beginning of the current outbreak approximately 50% of cases are known contacts and 50% of individuals are symptomatic. These variables may change as the outbreak continues with fewer cases being linked to a known case and with an increasing number of asymptomatic cases as the rate of vaccination increases. ~~Assuming no interaction between these variables~~, The infectious rate in asymptomatic cases who are not known contacts in Auckland is approximately 10 per 100,000 assuming no interaction between these variables.
- NOTE: the overall rate of disease, in particular asymptomatic disease in the community will be a key indicator of risk. However the issue for this discussion is to identify if there is a clinically significant difference in the risk of transmission of COVID-19 from vaccinated or unvaccinated individuals at any prevalence within the community.

Risk of Infection

- Vaccine efficacy for the Pfizer vaccine in preventing symptomatic disease is approximately 80%. Vaccine efficacy in preventing ANY infection is approximately 50%. As unvaccinated individuals are twice as likely to be infected compared with vaccinated individuals the infection rate in unvaccinated would be roughly 20 per 100,000 individuals, or 2 in 10,000 people, while vaccinated individuals would contribute 10 in 100,000 individuals.

Risk of transmission

- The risk of transmission in different settings varies. Within a household the risk is approximately 50% or a close household contact and 10% for other contacts. In healthcare settings the risk is low. The risk of infection in a healthcare setting is probably less than 1%. For an unvaccinated case the risk of transmission may be double that of a vaccinated case. A risk of transmission (secondary attack rate) of 2% would be a high estimate of risk for an unvaccinated individual.

Commented [AR1]: Interaction is almost certain so this is a flawed estimate. Also are asymptomatic cases less infectious? Lastly, is this 50% of individuals are symptomatic when detected? I think in MIQ a substan ial proportion go on to become symptomatic after early detection, but we don't have that for community cases

Commented [AR2]: Given the overall estimate 10/100,000 and unvaccinated make up the highest proportion of cases, this doesn't look correct

Commented [AR3]: 10% for private gatherings, need to define other contacts, and most interactions are <0.5% SAR

Commented [AR4]: Depends on setting, but overall in he outbreak it was 2.7%, so 2% isn't high

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- However, data from these settings will incorporate a wide range of mitigations including PPE. Surgical or medical masks will decrease the risk of transmission. A fit tested P2 or N95 mask compared to a medical mask is an efficient method of preventing infection.

Estimation of transmission during a consultation

- Therefore, the risk of infection from an unvaccinated individual is approximately 4 in one million while for a vaccinated individual the risk is approximately 1 in a million. However, as 90% of all cases are vaccinated, the risk of transmission from a vaccinated individual is approximately double that of an unvaccinated individual.

Commented [AR5]: Risk of transmission in a consultation needs to take into account the vaccination status of the contact – in a healthcare setting they will be vaccinated. Potentially this means there is very little difference in risk from a vaccinated or unvaccinated individual – you need the SARs limited to vaccinated contacts, then you need to mention this will be an over-estimate of risk due to the non-pharmaceutical interventions that will also be adhered to in a healthcare settings. We don't have enough data on heathcare settings, but I could provide from my latest data extract hat SAR from vaccinated v unvaccinated individuals limited to vaccinated contacts. One other hing to bear in mind about the prevalence calculation of 40/100,000 – I presume the infectious period is shorted in vaccinated indivuduals

Commented [AR6]: I think I may be getting confused as risk is perhaps not what you mean here. More like an attributable fraction?

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Megan King

From: Jeremy Tuohy
Sent: Monday, 15 November 2021 1:59 pm
To: Pippa Scott
Cc: Dan Bernal; Andrew Connolly
Subject: Appendix 1 estimation of rates V2
Attachments: Appendix 1 estimation of rates V2.docx Please refer to following page

Kia ora all,

Andrew, here is the latest version of the risk assessment which Antoinette has reviewed, but which she suggested is reviewed by others.

If this approach is useful, it may be that a more formal request from TPM is made to assess the risk of transmission in healthcare settings. I personally think this would justified as much of the argument will come down to proportionality…. Does Risk A justify response B.

Pippa, This replaces the previous document. The purpose of this memo is to identify the actual risk. If you feel you are able to amend this sow's ear into a silk purse then that's good. However, if you think that formal modelling is necessary then please feed that back to Andrew.

Thanks.

jt

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Appendix 1.

Estimation of transmission risk based on the current outbreak in Auckland.

The estimation of the risk of infection is summarised in simplified form below. This is designed to provide an estimate only and is not definitive.

The risk of infection in Auckland and other regions.

- Currently Auckland is the only region with significant community spread. Therefore, any proposal to manage vaccinated and unvaccinated individuals differently would only apply to this region. The following modelling attempts to assess the risk of transmission of infection to a healthcare practitioner undertaking their routine employment.

Vaccination Status

- Complete vaccination, defined as at least one week after the second dose of the Pfizer vaccine, is rapidly approaching 90% in Auckland. Therefore, for each 100,000 people 90,000 will be vaccinated and 10,000 unvaccinated.

Case rates

- The current case rate for Auckland(as of mid-November) is approximately 160 cases per day diagnosed for 1.6 million people. This rate is likely to increase and does not include undiagnosed patients. This is equivalent to a case rate of 10 per 100,000 people per day. Each individual remains infectious, on average, for approximately 4 days, therefore, the prevalence of infectious cases is roughly 40 per 100,000 people at any one time.
- Note: Unvaccinated individuals are a larger proportion of cases in the current outbreak as the current outbreak includes a period of time when vaccination rates were relatively low, and unvaccinated cases are more likely to be diagnosed as they are more likely to be asymptomatic, especially as the outbreak progresses and contact tracing is becoming less effective for case finding

Symptomatic vs Asymptomatic infection

- At the beginning of the current outbreak approximately 50% of cases are known contacts and 50% of individuals are symptomatic. These variables may change as the outbreak continues with fewer cases being linked to a known case and with an increasing number of asymptomatic cases as the rate of vaccination increases. ~~Assuming no interaction between these variables~~, The infectious rate in asymptomatic cases who are not known contacts in Auckland is approximately 10 per 100,000 assuming no interaction between these variables.
- NOTE: the overall rate of disease, in particular asymptomatic disease in the community will be a key indicator of risk. However the issue for this discussion is to identify if there is a clinically significant difference in the risk of transmission of COVID-19 from vaccinated or unvaccinated individuals at any prevalence within the community.

Risk of Infection

- Vaccine efficacy for the Pfizer vaccine in preventing symptomatic disease is approximately 80%. Vaccine efficacy in preventing ANY infection is approximately 50%. As unvaccinated individuals are twice as likely to be infected compared with vaccinated individuals the infection rate in unvaccinated would be roughly 20 per 100,000 individuals, or 2 in 10,000 people, while vaccinated individuals would contribute 10 in 100,000 individuals.

Risk of transmission

- The risk of transmission in different settings varies. Within a household the risk is approximately 50% or a close household contact and 10% for other contacts. In healthcare settings the risk is low. The risk of infection in a healthcare setting is probably less than 1%. For an unvaccinated case the risk of transmission may be double that of a vaccinated case. A risk of transmission (secondary attack rate) of 2% would be a high estimate of risk for an unvaccinated individual.

Commented [AR1]: Interaction is almost certain so this is a flawed estimate. Also are asymptomatic cases less infectious? Lastly, is this 50% of individuals are symptomatic when detected? I think in MIQ a substan ial proportion go on to become symptomatic after early detection, but we don't have that for community cases

Commented [AR2]: Given the overall estimate 10/100,000 and unvaccinated make up the highest proportion of cases, this doesn't look correct

Commented [AR3]: 10% for private gatherings, need to define other contacts, and most interactions are <0.5% SAR

Commented [AR4]: Depends on setting, but overall in he outbreak it was 2.7%, so 2% isn't high

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- However, data from these settings will incorporate a wide range of mitigations including PPE. Surgical or medical masks will decrease the risk of transmission. A fit tested P2 or N95 mask compared to a medical mask is an efficient method of preventing infection.

Estimation of transmission during a consultation

- Therefore, the risk of infection from an unvaccinated individual is approximately 4 in one million while for a vaccinated individual the risk is approximately 1 in a million. However, as 90% of all cases are vaccinated, the risk of transmission from a vaccinated individual is approximately double that of an unvaccinated individual.

Commented [AR5]: Risk of transmission in a consultation needs to take into account the vaccination status of the contact – in a healthcare setting they will be vaccinated. Potentially this means there is very little difference in risk from a vaccinated or unvaccinated individual – you need the SARs limited to vaccinated contacts, then you need to mention this will be an over-estimate of risk due to the non-pharmaceutical interventions that will also be adhered to in a healthcare settings. We don't have enough data on heathcare settings, but I could provide from my latest data extract hat SAR from vaccinated v unvaccinated individuals limited to vaccinated contacts. One other hing to bear in mind about the prevalence calculation of 40/100,000 – I presume the infectious period is shorted in vaccinated indivuduals

Commented [AR6]: I think I may be getting confused as risk is perhaps not what you mean here. More like an attributable fraction?

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Megan King

From: Michael Pead <x@x>
Sent: Tuesday, 16 November 2021 2:02 pm
To: Andrew Connolly
Subject: RE: Latest draft for consideration - proposed for circulation

Superb thanks. Michael

From: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Sent: Tuesday, November 16, 2021 2:01 PM
To: Michael Pead <m.pead@pharmacycouncil.org.nz>
Subject: Re: Latest draft for consideration - proposed for circulation

Kia ora Michael

It's with Ashley at present - it's been well panel beaten but I expect it to be released likely tomorrow

Ngā mihi

Andrew

Andrew Connolly
Chief Medical Officer
Ministry of Health
Mobile s 9(2)(a)

From: Michael Pead <m.pead@pharmacycouncil.org.nz>
Sent: Tuesday, November 16, 2021 1:53:59 PM
To: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Subject: RE: Latest draft for consideration - proposed for circulation

Kia ora Andrew

Just wondering likely timing of MoH's release of a stand-alone statement on this matter – we had understood it was meant to be yesterday?

Pharmacy Council has prepared a supportive statement to be issued off the back of MoHs and will issue it very soon after MoH's.

Ngā mihi
Michael

Michael Pead
Chief Executive
phone: +64 4 495 0332
mobile: s 9(2)(a)
email: m.pead@pharmacycouncil.org.nz
web: pharmacycouncil.org.nz

Pharmacy Council Te Te Pou Whakamana Kaimatū o Aotearoa
Ensuring public wellbeing through safe pharmacist practice
Level 8, Kordia House, 109 Willis Street, Te Aro, Wellington 6011 | PO Box 25137, Wellington 6140

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From: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Sent: Wednesday, November 10, 2021 11:41 AM
To: s 9(2)(a) @nursingcouncil.org.nz; s 9(2)(a) @nursingcouncil.org.nz; s 9(2)(a) @pharmacycouncil.org.nz>; Michael Pead <m.pead@pharmacycouncil.org.nz>; Martin Thomas <Martin.Thomas@hqsc.govt.nz>; s 9(2)(a) @mcnz.org.nz>; John Robson <John.xxxxxx@xxx.xx.xx >; Morag McDowell <Morag.McDowell@hdc.org.nz>; chair@mcnz.org.nz; s 9(2)(a) @nursingcouncil.org.nz>; Peter Watson <Peter.Watson@middlemore.co.nz>
Cc: Ian Town <Ian.Town@health.govt.nz>; Jeremy Tuohy <Jeremy.Txxxx@xxxxxx.xxxx.nz >
Subject: Re: Latest draft for consideration - proposed for circulation

Excellent - thanks Pete

Re second point - I'll be guided by RA colleagues on how to express that and if it's in this or a separate RA communication

Andrew

Andrew Connolly
Chief Medical Officer
Ministry of Health
Mobile s 9(2)(a)

From: Peter Watson (CMDHB) <xxxxx.xxxxxx@xxxxxxxxxx.xx.xx >
Sent: Wednesday, November 10, 2021 11:22:04 AM
To: Andrew Connolly <Andrew.Connolly@health.govt.nz>; s 9(2)(a) @nursingcouncil.org.nz s 9(2)(a) @nursingcouncil.org.nz>; s 9(2)(a) @nursingcouncil.org.nz s 9(2)(a) @nursingcouncil.org.nz>; chair@pharmacycouncil.org.nz <chair@pharmacycouncil.org.nz>; Michael Pead <m.pead@pharmacycouncil.org.nz>; Martin Thomas <Martin.Thomas@hqsc.govt.nz>; s 9(2)(a) @mcnz.org.nz>; John Robson <John.Robson@acc.co.nz>; Morag McDowell <Morag.McDowell@hdc.org.nz>; chair@mcnz.org.nz <xxxxx@xxxx.xxx.xx>; s 9(2)(a) @nursingcouncil.org.nz>
Cc: Ian Town <Ian.Town@health.govt.nz>; Jeremy Tuohy <Jeremy.Txxxx@xxxxxx.xxxx.nz >
Subject: RE: Latest draft for consideration - proposed for circulation

Nga mihi Andrew
I think it would be helpful to be clearer in the title – the qn being asked by practitioners is "can a HCW refuse to see unvaccinated patients" So maybe use that as the title – and then be clear that the answer is NO….
Be good to include the professional, ethical and legal basis for this – and the risk to those HCW who do choose to decline access – purely in the basis of vax status…
P

From: Andrew Connolly [mailto:Andrew.Connolly@health.govt.nz]
Sent: Wednesday, 10 November 2021 11:07 am
To: s 9(2)(a) @nursingcouncil.org.nz; s 9(2)(a) @nursingcouncil.org.nz; chair@pharmacycouncil.org.nz; Michael Pead <m.pead@pharmacycouncil.org.nz>; Martin Thomas <Martin.Thomas@hqsc.govt.nz>; s 9(2)(a) @mcnz.org.nz>; John Robson <John.Robson@acc.co.nz>; Morag McDowell

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<Morag.McDowell@hdc.org.nz>; chair@mcnz.org.nz; s 9(2)(a) @nursingcouncil.org.nz>; Peter Watson (CMDHB) <Peter.Watson@middlemore.co.nz>
Cc: Ian Town <Ian.Town@health.govt.nz>; Jeremy Tuohy <Jeremy.Txxxx@xxxxxx.xxxx.nz >
Subject: Latest draft for consideration - proposed for circulation

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Colleagues

I have worked closely with Martin and Jeremy on this. We are very concerned that this issue risks getting well out of control based on various areas of feedback and intelligence. For example, Pete attended a webinar last night where the Med Protection Society were not "in line" with our thinking.

I would be grateful for any obvious errors or gross omissions such as "can't say that" ASAP.

In terms of next steps, there are several options:

1. MOH standalone with each RA adding their own "flavour" to it
2. A joint release – aware we did not include most RAs in the discussions
3. Approach every RA – NOT advised due to time and politics

I'd also value thoughts on the title!!

Note I will need to run via a small group for signoff in the MOH – will be today.

I have avoided any reference to Private – the murky issues of Private business owners vs. private practitioners is a mine-field. I think (and have briefly touched on this with others) that we focus on practitioners. I think we have to accept that some facilities which may well be owned by people NOT covered by the HPCAA may impose own rules, but at least this will aid their thinking re logic. Facilities irrespective of ownership can be tackled by colleagues such as ACC and HDC.

Please note I do not have emails for everyone on the call – for example, Stafford's. I'd be grateful John, if you could pass on.

Ngā mihi

Andrew

Andrew Connolly
Chief Medical Officer | Ministry of Health
E: andrew.connolly@health.govt.nz | Mobile: s 9(2)(a) | www.health.govt.nz

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Megan King

From: Andrew Connolly
Sent: Wednesday, 17 November 2021 4:11 pm
To: Janette Deed - Staff
Cc: Joan Simeon - Staff
Subject: Re: MOH Guidance on unvaccinated patients

Simply waiting on Ashley sign off - I was expecting it today

Andrew

Andrew Connolly
Chief Medical Officer
Ministry of Health
Mobile s 9(2)(a)

From: s 9(2)(a) @mcnz.org.nz>
Sent: Wednesday, November 17, 2021 3:58:15 PM
To: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Cc: s 9(2)(a) @mcnz.org.nz>
Subject: MOH Guidance on unvaccinated patients

Kia ora Andrew,

Joan has asked me to touch base with you to see if you have any indication of when we might expect the guidance on unvaccinated patients to come through from the Ministry. We're keen to get our supplement guidance released.

Ngā mihi
s 9(2)(a)

s 9(2)(a)

Te Kaunihera Rata o Aotearoa | **Medical Council of New Zealand**
04 381 6782 | 0800 286 801 Ext 782
www.mcnz.org.nz | jdeed@mcnz.org.nz

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Document 1

Megan King

From: Jarrod Williams
Sent: Thursday, 18 November 2021 1:29 pm
To: Andrew Connolly
Subject: RE: Approach to unvaccinated patients - final version for DG's consideration prior to publication
Attachments: Ministry of Health position statement on the management of unvaccinated individuals in healthcare settings.pdf Refer to Document 1A

Just confirming this has gone – Victoria is going to make sure it goes to all of the colleges, and TAS will get it to DHBs. It's also going up on the website and out via Awhina this afternoon too. Sorry for the delay, I just want to get the branding on it so it looked 'official'.

Ngā mihi,

Jarrod Williams | Manager | Office of the Chief Clinical Officers
Ministry of Health | www.moh.govt.nz
Mobile: s 9(2)(a)

If this email reaches you out of hours, I don't expect a response outside of your office hours, it's just a convenient time for me to send an email

---

From: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Sent: Thursday, 18 November 2021 9:33 am
To: Jarrod Williams <Jarrod.Williams@health.govt.nz>
Subject: RE: Approach to unvaccinated patients - final version for DG's consideration prior to publication

Thanks Jarrod – excellent. I'd ask TAS to distribute to the DHB people – that is best way. DHBs would be CE, COO, CMO

Please add Council of Medical Colleges to list

From: Jarrod Williams <Jarrod.Williams@health.govt.nz>
Sent: Thursday, 18 November 2021 8:26 am
To: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Subject: RE: Approach to unvaccinated patients - final version for DG's consideration prior to publication

Morning,

The EA's are pulling together the email addresses, but are you happy with the short note below to go with it?

> *We are aware that there are concerns from clinicians and providers regarding face-to-face consultations with unvaccinated patients, and the issue of requiring a negative COVID-19 test prior to a non-urgent consultation. To help address these concerns, the we have developed a position statement on the management of unvaccinated individuals in healthcare settings.*
>
> *In summary, the individuals cannot be refused access to health care. Any restrictions to access health care must be based on risk assessment and the onus is on the provider to justify that any risks support restrictions. There is currently no evidence that the application of an alternative pathway based solely on*

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vaccination status, or the routine incorporation of unvaccinated asymptomatic individuals into a high-risk pathway is justified.

Please disseminate this information widely among your networks.

Ngā mihi,

Jarrod Williams | Manager | Office of the Chief Clinical Officers
Ministry of Health | www.moh.govt.nz
Mobile: s 9(2)(a)

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From: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Sent: Wednesday, 17 November 2021 6:37 pm
To: Jarrod Williams <Jarrod.Williams@health.govt.nz>
Subject: Re: Approach to unvaccinated patients - final version for DG's consideration prior to publication

Thanks Jarrod

A

Andrew Connolly
Chief Medical Officer
Ministry of Health
Mobile s 9(2)(a)

From: Jarrod Williams <Jarrod.Williams@health.govt.nz>
Sent: Wednesday, November 17, 2021 6:37:00 PM
To: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Subject: Re: Approach to unvaccinated patients - final version for DG's consideration prior to publication

Will pick this up first thing in the morning, and will do a cover note to run past you.

Jarrod Williams
Manager - Office of the Choef Clincal Officers

From: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Sent: Wednesday, November 17, 2021 6:26:35 PM
To: Andrew Bichan <Andrew.Bichan@health.govt.nz>
Cc: Jarrod Williams <xxxxxx.xxxxxxxx@xxxxxx.xxxx.xx>; Catherine Pearson <Catherine.Pearson@health.govt.nz>
Subject: Re: Approach to unvaccinated patients - final version for DG's consideration prior to publication

Thanks Andrew

We will work with comms but in first instance I think it's fine to go to RAs and DHBs, colleges with a brief covering note.

I'll work with Jarrod on that

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Andrew

Andrew Connolly
Chief Medical Officer
Ministry of Health
Mobile s 9(2)(a)

From: Andrew Bichan <Andrew.Bichan@health.govt.nz>
Sent: Wednesday, November 17, 2021 6:25:06 PM
To: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Cc: Jarrod Williams <xxxxxx.xxxxxxxx@xxxxxx.xxxx.xx>; Catherine Pearson <Catherine.Pearson@health.govt.nz>
Subject: FW: Approach to unvaccinated patients - final version for DG's consideration prior to publication

Hi Andrew

Apologies for the delay – Ashley happy with this. Not sure how it is going to be promulgated but assume it will be adjusted depending on audience and channel it is going through.

Andrew B

Andrew Bichan I Chief of Staff
Director-General I Ministry of Health I Mobile s 9(2)(a)
(He/him)

Manaakitanga, Kaitiakitanga, Whakapono, Kōkiri ngātahi

From: Andrew Bichan
Sent: Tuesday, 16 November 2021 4:46 pm
To: Catherine Pearson <Catherine.Pearson@health.govt.nz>
Subject: FW: Approach to unvaccinated patients - final version for DG's consideration prior to publication

Andrew Bichan I Chief of Staff
Director-General I Ministry of Health I Mobile s 9(2)(a)
(He/him)

Manaakitanga, Kaitiakitanga, Whakapono, Kōkiri ngātahi

From: Jarrod Williams <Jarrod.Williams@health.govt.nz>
Sent: Tuesday, 16 November 2021 3:50 pm
To: Andrew Bichan <Andrew.Bichan@health.govt.nz>
Cc: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Subject: FW: Approach to unvaccinated patients - final version for DG's consideration prior to publication

Hi Andrew,

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Revised version attached, Andrew C has approved. Let me know if you want me to drop a hard copy around.

Thanks,

Jarrod Williams | Manager | Office of the Chief Clinical Officers
Ministry of Health | www.moh.govt.nz
Mobile: s 9(2)(a)

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---

From: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Sent: Tuesday, 16 November 2021 3:18 pm
To: Jarrod Williams <Jarrod.Williams@health.govt.nz>
Subject: RE: Approach to unvaccinated patients - final version for DG's consideration prior to publication

Looks vg – happy to accept as is

Andrew

From: Jarrod Williams <Jarrod.Williams@health.govt.nz>
Sent: Tuesday, 16 November 2021 3:03 pm
To: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Subject: RE: Approach to unvaccinated patients - final version for DG's consideration prior to publication

Hi Andrew,

Comments refused under section 18(e) of the Act.

I've gone through and addressed Ashley's comments and just tidied a bit (pen vs scalpel I guess?). Probably just needs a quick skim from you then can go back to Ashley if you're happy.

Give me a bell if needed.

Jarrod Williams | Manager | Office of the Chief Clinical Officers
Ministry of Health | www.moh.govt.nz
Mobile: s 9(2)(a)

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From: Andrew Bichan <Andrew.Bichan@health.govt.nz>
Sent: Tuesday, 16 November 2021 1:52 pm
To: Andrew Connolly <Andrew.Connolly@health.govt.nz>; Jarrod Williams <Jarrod.Williams@health.govt.nz>
Subject: RE: Approach to unvaccinated patients - final version for DG's consideration prior to publication

Hi Andrew

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Ashley has quite a few comments but I think these can largely be addressed - there may or may not have been some ribald commentary about wielding pens versus scalpels but I won't be drawn on that. Jarod Williams has kindly agreed to have a go and we'll run it back past you.

Cheers

Andrew B

Andrew Bichan I Chief of Staff
Director-General I Ministry of Health I Mobile s 9(2)(a)
(He/him)

Manaakitanga, Kaitiakitanga, Whakapono, Kōkiri ngātahi

From: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Sent: Tuesday, 16 November 2021 12:30 pm
To: Ashley Bloomfield <Ashley.Bloomfield@health.govt.nz>
Cc: Andrew Bichan <Andrew.Bichan@health.govt.nz>
Subject: Approach to unvaccinated patients - final version for DG's consideration prior to publication

Hi Ashely

Attached is the final version. This version (other than some formatting) has signoff from Ian Town, Jeremy Touhy and Phil Knipp

Earlier versions had approval from Carolyn McElnay and Harriette Carr in PH and from the Clinical Oversight Group. Differences form earlier versions to this version are style not substance the exception of adding the Legal bits (in italics in the Principles section of the document)

Ngā mihi

Andrew

Andrew Connolly
Chief Medical Officer I Ministry of Health
E: andrew.connolly@health.govt.nz I Mobile: s 9(2)(a) I www.health.govt.nz

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Megan King

From: Jarrod Williams
Sent: Friday, 19 November 2021 9:52 am
To: Andrew Connolly
Subject: RE: Urgent changes to vaccination statement

Way ahead of you!

Ngā mihi,

Jarrod Williams | Manager | Office of the Chief Clinical Officers
Ministry of Health | www.moh.govt.nz
Mobile: s 9(2)(a)

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From: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Sent: Friday, 19 November 2021 9:51 am
To: Jarrod Williams <Jarrod.Williams@health.govt.nz>
Subject: Re: Urgent changes to vaccination statement

Just noticed title needs “individuals” not individual - sorry!

Andrew Connolly
Chief Medical Officer
Ministry of Health
Mobile s 9(2)(a)

From: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Sent: Friday, November 19, 2021 9:02:40 AM
To: Jarrod Williams <Jarrod.Williams@health.govt.nz>
Subject: Re: Urgent changes to vaccination statement

Thanks

Andrew Connolly
Chief Medical Officer
Ministry of Health
Mobile s 9(2)(a)

From: Jarrod Williams <Jarrod.Williams@health.govt.nz>
Sent: Friday, November 19, 2021 8:52:48 AM
To: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Subject: Re: Urgent changes to vaccination statement

On it, will confirm when it's all sorted.

Jarrod Williams

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Manager - Office of the Choef Clincal Officers

From: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Sent: Friday, November 19, 2021 8:43:29 AM
To: Jarrod Williams <Jarrod.Williams@health.govt.nz>
Cc: Ashley Bloomfield <Ashley.Bloomfield@health.govt.nz>
Subject: Urgent changes to vaccination statement

Hi Jarrod

I've discussed the following with he Director General so just needs to be put into action. Bold is the amendment

Re yesterday's statement:

Please urgently remove first one from website and amend as follows:
"Ministry of Health position statement on **pre-consultation testing of** unvaccinated individual in a health care setting"

Under Purpose please amend to "…..consultations with unvaccinated patients….**in particular** the issue of requiring a negative test…

On the website itself please add a note that this statement is directed at in particular the issue of pre-consultation testing of unvaccinated patients

Then we need to re-circulate to all who got it yesterday with a note that we recognised the title was unclear as that we were referring to pre-consultation testing and this has been clarified. We apologise for the inconvenience but wished to ensure clarity for all parties.

Ngā mihi

Andrew

Andrew Connolly
Chief Medical Officer | Ministry of Health
E: andrew.connolly@health.govt.nz | Mobile: s 9(2)(a) www.health.govt.nz

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Megan King

From: Andrew Connolly
Sent: Friday, 19 November 2021 2:11 pm
To: s 9(2)(a) - Staff; Jarrod Williams
Cc: s 9(2)(a) - Staff; s 9(2)(a) - Staff
Subject: Re: Ministry of Health position statement | scare testing wording ???

Definitely a typo- well spotted!

Andrew

Andrew Connolly
Chief Medical Officer
Ministry of Health
Mobile s 9(2)(a)

From: s 9(2)(a) @mcnz.org.nz>
Sent: Friday, November 19, 2021 2:07:52 PM
To: Jarrod Williams <Jarrod.Williams@health.govt.nz>
Cc: Andrew Connolly <Andrew.Connolly@health.govt.nz>; s 9(2)(a) @mcnz.org.nz>; s 9(2)(a) @mcnz.org.nz>
Subject: Ministry of Health position statement | scare testing wording ???

Kia ora Jarrod,

We have just been alerted to the summary on page 2 of your updated position statement (snip below).

Is the use of the expression "scare testing" intentional ....or is this a typographical error meaning "scarce testing resources" ?

- Routine testing of asymptomatic individuals prior to consultation would identify some infectious individuals and decrease the risk of transmission. However, the feasibility, cost and effectiveness of strategy has not been determined and must be assessed prior to diversion of scare testing resource from urgent work.

Ngā mihi,
s 9(2)(a)

s 9(2)(a)

Te Kaunihera Rata o Aotearoa | **Medical Council of New Zealand**
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www.mcnz.org.nz | jdeed@mcnz.org.nz

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From: Jarrod Williams <Jarrod.Williams@health.govt.nz> **On Behalf Of** Office of the Chief Clinical Officers
Sent: Friday, 19 November 2021 10:06 a.m.
Subject: Re: Ministry of Health position statement on the management of unvaccinated individuals in healthcare settings

*** Externally generated email ***

Kia ora koutou,

Attached is a revised version of the position statement we shared yesterday. We recognised that the title was unclear, and we have now clarified that we are referring to pre-consultation of unvaccinated patients in particular. We apologise for the inconvenience, but wised to ensure clarity for all parties. This version also reflects other minor feedback we have received from some parties.

A revised version will also be on the Ministry of Health website today.

Ngā mihi,

Office of the Chief Clinical Officers

Ministry of Health | www.moh.govt.nz

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From: Jarrod Williams on behalf of Office of the Chief Clinical Officers <occo@health.govt.nz>
Sent: Thursday, 18 November 2021 3:32 PM
Subject: Ministry of Health position statement on the management of unvaccinated individuals in healthcare settings

Kia ora koutou,

We are aware that there are concerns from clinicians and providers regarding face-to-face consultations with unvaccinated patients, and the issue of requiring a negative COVID-19 test prior to a non-urgent consultation. To help address these concerns, we have developed a position statement on the management of unvaccinated individuals in healthcare settings.

In summary, the individuals cannot be refused access to health care. Any restrictions to access health care must be based on risk assessment and the onus is on the provider to justify that any risks support restrictions. There is currently no evidence that the application of an alternative pathway based solely on vaccination status, or the routine incorporation of unvaccinated asymptomatic individuals into a high-risk pathway is justified.

Please disseminate this information widely among your networks.

Ngā mihi,

Office of the Chief Clinical Officers
Ministry of Health | www.moh.govt.nz

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Megan King

From: Jeremy Tuohy
Sent: Friday, 19 November 2021 4:02 pm
To: Dan Bernal; Andrew Connolly
Cc: Justine Lancaster; Ian Town
Subject: RE: UPDATED MoH management of unvaccinated individuals in healthcare settings

Kia ora,

1. I agree that some detailed modelling of the risk of transmission to healthcare workers from unvaccinated and vaccinated patients is required. AS this will be widely critiqued I think it should be undertaken by a professional in disease modelling. What I have tried to point out is the fundamental dilemma here, that managing unvaccinated individuals through a different pathway will not remove the risk of transmission and may not even reduce it significantly depending on the rate of disease in the community and the rate of vaccination. That is because it is individuals with infection that transmit the virus, not people who are unvaccinated which is just a proxy for risk of infection.
2. I agree that vaccine mandates are directed to reducing the amount of infection in the community, but they are site specific. Primarily hey prevent unvaccinated individuals accessing sites which could be superspreading events. It may not be much consolation to a GP who is infected, but transmission to your GP is probably not going to be a superspreading event. That is not to minimise the risk of the GP infecting their patients, but a clear differentiation between actions which work at a population based level and at an individual level need to be understood.
3. What are the proposed "systems that practices are putting in place"? have they been assessed? Are they proportionate? Will they result in difficulties in access to healthcare? If the response is that GPs want to wear N95 masks for ever unvaccinated patient, what is the evidence for that? The marginal benefit for an N95 vs a medical mask is probably low as the STA has repeatedly identified and reported on.
4. The summary that the document indicates that "there is no need to provide extra care for the unvaccinated" or that "they do not present any increased risk" is not a correct take home message. The message is "Is the increased risk sufficient to justify an alternative care pathway that (may) place a burden on the patient and (may) result in difficulties in access of care. The example of an ultrasound provider refusing to see unvaccinated pregnant women is a clear example. The risk of a pregnant women in the Hutt in October having COVID (and probably still now) is about Zero and is exactly the same as the risk of a vaccinated women having COVID.

Finally, I doubt this discussion is about risk, so I have probably wasted my time and yours with this email. It is about GPs having as many N95 masks as they want. Unfortunately all the N95 masks in the world won't stop them from being exposed to COVID-19 from asymptomatic vaccinated cases.

Dr Jeremy Tuohy BMedSci, MBChB, DDU, PhD
Principal Advisor
Science and Technical Advisory | Rōpū tohutohu i te pūtaiao me te hangarau
COVID-19 Health System Response
Ministry of Health - Manatū Hauora
New Zealand

http://www.health.govt.nz
mailto:Jeremy.Tuohy@health.govt.nz

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From: Dan Bernal <xxxxxx.xxxxxx@xxxxxx.xxxx.xx>
Sent: Friday, 19 November 2021 2:43 pm
To: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Cc: Justine Lancaster <Justine.Lancaster@health.govt.nz>; Ian Town <Ian.Town@health.govt.nz>; Jeremy Tuohy <Jeremy.Tuohy@health.govt.nz>
Subject: RE: UPDATED MoH management of unvaccinated individuals in healthcare settings

Kia ora,
Without diving into the detail of the wording – that last point frustrates me somewhat (about what the epi's are saying) – IMO you can't write that kind of statement without having some genuine statistical analysis to support it. We could probably have something of that sorts to address it and I think Jeremy has explored this a little in prep of the background for this document.

Cheers
Dan

From: Dr Bryan Betty <Bryan.Betty@rnzcgp.org.nz>
Sent: Friday, 19 November 2021 12:47 pm
To: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Cc: Justine Lancaster <Justxxx.xxxxxxxxx@xxxxxx.xxxx.xx>; Dan Bernal <Daniel.Bernal@health.govt.nz>; Ian Town <Ian.Town@health.govt.nz>; s 9(2)(a)
Subject: FW: UPDATED MoH management of unvaccinated individuals in healthcare settings

Hi Andrew,

Thank you for the work regarding renaming the position statement to focus on Pre-testing of patients. Clarity around the fact it is not required we are in total agreement on. It is appreciated.

However there are a range of issues that are arising over the way the document has been worded that is causing confusion in the general practice community that has since come into me this morning post our conversation. I have tried to list the key points that have been reflected back to me on the document which I do think have validity….

- Practices understand that part of the rationale for vaccine mandates has been to reduce the risk of transmission of covid from the unvaccinated to others
- Practices are putting in place systems that will not present barriers to those who are not yet vaccinated, but will provide them with the assurance of safety when accessing healthcare
- The original statement was seen to provide general guidance around the issues of how to manage this group of people, changing the title goes only a small step in explaining the true intent of the document
- The document is not specific enough to address the actual issue it seeks to provide guidance on.
- The way it is written and the information it contains will be extrapolated to inform the management of those without vaccines in a general sense which may not then address the need to protect the unvaccinated
- The document indicates there is no need to provide extra care for those who are unvaccinated, and implies they do not present any increased risk to health care providers or other patients which is at odds with the information from epidemiologists, and at odds with the advice from the NZMC which came out shortly after this was released last night.

I think the last point in particular needs addressing although I understand it was not the intent. However it is how it is being interpreted.

I had one suggestion come through with the following comment to rename and focus the document as follows:

- Is there value in pre-testing patients for covid before they present to a health care setting?

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It seems what has happened here is the intent of the document is to quite rightly highlight on evidence pre consultation testing is not required. However this seems have been conflated in the way it is worded with advice on management of patients within a practice setting who are non-vaccinated versus vaccinated.

I can only reflect back what is being received to me this morning on the document. I have not focussed on the specific e-mails from practises asking for clarification. I would ask the points above be addressed and request the way the document has been worded be re-considered to reduce the l confusion that has arisen.

Regards
Bryan

Nāku noa, nā

Dr Bryan Betty
MBChB, FRNZCGP (Dist.), FACRRM
Medical Director | Mātanga Hauora

The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

The Royal New Zealand College of General Practitioners
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PO Box 10440 ► Wellington 6140

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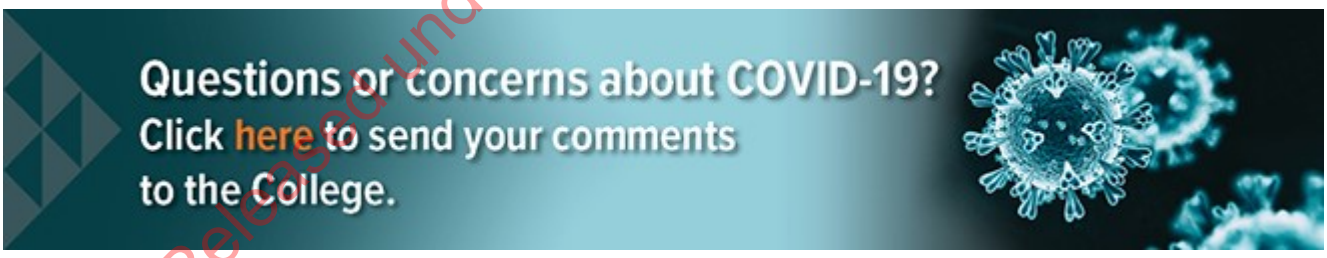
www.rnzcgp.org.nz



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From: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Sent: Friday, 19 November 2021 10:24 AM
To: Dr Bryan Betty <Bryan.Betty@rnzcgp.org.nz>
Subject: Fwd: UPDATED MoH management of unvaccinated individuals in healthcare settings

Hi Bryan

Revised - title and purpose amended. Not sure when you on website but feel free to disseminate with our apology for inconvenience note below

TAS handle full distribution

Regards

Andrew

Andrew Connolly
Chief Medical Officer
Ministry of Health
Mobile s 9(2)(a)

From: CMO Support <cmo.support@tas.health.nz>
Sent: Friday, November 19, 2021 10:21 AM
To: O365.DHB - CMOs
Subject: UPDATED MoH management of unvaccinated individuals in healthcare settings

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SENT ON BEHALF OF THE MINISTRY OF HEALTH

From: Jarrod Williams <Jarrod.Williams@health.govt.nz>
Sent: Friday, 19 November 2021 10:07 am
To: Health Info <healthinfo@tas.health.nz>
Cc: Health System Readiness & Response Planning <hsrrp@health.govt.nz>
Subject: RE: Ministry of Health position statement on the management of unvaccinated individuals in healthcare settings

Kia ora,

> Attached is a revised version of the position statement the Ministry of Health shared yesterday. The Ministry recognised that the title was unclear, and have now clarified that they are referring to pre-consultation of unvaccinated patients in particular. The Ministry apologises for the inconvenience, but wished to ensure clarity for all parties. This version also reflects other minor feedback received from some parties.

Ngā mihi,

Jarrod Williams | Manager | Office of the Chief Clinical Officers
Ministry of Health | www.moh.govt.nz
Mobile s 9(2)(a)

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Megan King

From: Jonathan Christiansen (WDHB) <Jonathan.Christiansen@waitematadhb.govt.nz>
Sent: Sunday, 21 November 2021 11:10 am
To: Andrew Moot (WDHB)
Cc: Andrew Connolly
Subject: RE: Interesting publication

Categories: Red Category

Thanks Andrew.

The MoH are struggling to find the right messaging around Simpson's paradox.

For example we have >95% first dose in the ADHB area – and at those rates it is inevitable that the actual numbers of breakthrough infections in vaccinated people will exceed infections in unvaccinated.

But as I have highlighted in my weekly update this morning that is NOT Auckland's reality yet – Gary Jackson's prevalence and case numbers are pretty clear on this.

Personally I find the MoH document muddled and unhelpful – and as you point out fuel for the Anti-vaxers – but its not an easy problem to have optimal comms on!

Cheers

Jonathan

From: Andrew Moot (WDHB)
Sent: Sunday, 21 November 2021 9:01 a.m.
To: Jonathan Christiansen (WDHB)
Subject: Fwd: Interesting publication

From s 9(2)(a)
We have 10% in Church not vaccinated and not intending to do so
I suspect one of them sent him this document from the Ministry of Health

It actually says-

> transmission is more likely to occur from a vaccinated than an unvaccinated individual.

It's poorly worded, and the 80% figure is quite unlikely to be correct in any case.
Certainly gives the person opposed to vaccination good ammunition.

Can we complain to the Ministry about this?

Andrew Moot

Begin forwarded message:

> **From:** s 9(2)(a)
> **Date:** 20 November 2021 at 8:57:44 PM NZDT

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To: Andrew [redacted] Moot [redacted]
Subject: Interesting publication

https://www.health.govt.nz/system/files/documents/pages/ministry_of_health_position_statement_on_the_management_of_unvaccinated_individuals_in_healthcare_settings.pdf?fbclid=IwAR2_Qnbuu22dvYHKn78e4rPaz9PvY3T7VVe5xOKEb_sOKz_yG-2jYwU8uOo

" When there is high COVID-19 vaccine coverage (i.e., above 80 percent of eligible people are fully vaccinated), transmission is more likely to occur from a vaccinated than an unvaccinated individual."

R
--

[redacted]

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Document 1

Megan King

From: Andrew Connolly
Sent: Monday, 22 November 2021 8:57 am
To: Jarrod Williams
Subject: Re: Unvaccinated document

Thanks

Andrew Connolly
Chief Medical Officer
Ministry of Health
Mobile s 9(2)(a)

From: Jarrod Williams <Jarrod.Williams@health.govt.nz>
Sent: Monday, November 22, 2021 8:51:56 AM
To: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Subject: RE: Unvaccinated document

Sure – see attached.

Ngā mihi,

Jarrod Williams | Manager | Office of the Chief Clinical Officers
Ministry of Health | www.moh.govt.nz
Mobile: s 9(2)(a)

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From: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Sent: Monday, 22 November 2021 8:41 am
To: Jarrod Williams <Jarrod.Williams@health.govt.nz>
Subject: Unvaccinated document

Hi Jarrod

The gift that keeps giving……

Can you flick me a Word version of what is on the website – I want to see if I can split the document into two to calm nerves!

Refer to Document 1A

Ngā mihi

Andrew

Andrew Connolly
Chief Medical Officer | Ministry of Health
E: andrew.connolly@health.govt.nz | Mobile: s 9(2)(a) | www.health.govt.nz

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Megan King

From: Andrew Connolly
Sent: Monday, 22 November 2021 11:27 am
To: Jonathan Christiansen (WDHB)
Subject: RE: Draft revision unvaccinated

Thanks Jonathan

Vg thoughts – ii will integrate into next draft

I'm in discussion with Ashley etc.

Andrew

From: Jonathan Christiansen (WDHB) <Jonathan.Christiansen@waitematadhb.govt.nz>
Sent: Monday, 22 November 2021 11:23 am
To: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Subject: RE: Draft revision unvaccinated

Hi Andrew,

I wonder if the document should be more clearly separated into two parts. At the moment the two are inter-linked (in the summary especially)

Part 1:

Providing healthcare – can unvaccinated patients be declined health care?

This section will have the comments about the code etc.
Clear statement that care cannot be declined solely on the basis of a patient's Covid vaccination status.

One wrinkle – our DHB Ethics and Legal teams have consistently agreed that non-urgent care can be deferred in a patient who consistently refuses to follow basic public health measures (eg: refuses to wear a mask) Our 2020 ethics committee opinion attached.

We deferred a surveillance colonoscopy the other weekend as an unvaccinated patient refused to follow any public health guidance, and declined to follow the pre-AGP pathway (which included a doing a RAT).

Part 2:

Assessing and managing risk in the context of unvaccinated patients

This section would have content:

1. Processes for screening and assessing risk should apply to all patients, and be focused on the safety of the patient themselves (eg: not operating while they have undetected covid), and the wellbeing of staff and other patients/visitors
2. The nature of the healthcare being provided is an important part of the risk assessment (eg: AGP vs OP visit, duration and nature of contact (ENT), urgency etc).
3. The risk of an individual patient having asymptomatic Covid is closely tied to the local community prevalence, which can vary widely over time.
4. If the local prevalence data suggests that unvaccinated patients may present a significantly higher risk, that risk can reasonably be integrated into an overall risk assessment (which I would argue is where Auckland is at the moment).

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5. Risk assessment and management pathways should be carefully designed and audited to ensure they are not inadvertently promoting increased inequity.
6. If pre-consultation/procedure testing is part of the pathway of risk assessment and mitigation, that testing should not adversely impact the ability of our lab systems to deliver urgent testing elsewhere.

Cheers

Jonathan

From: Andrew Connolly [mailto:Andrew.Connolly@health.govt.nz]
Sent: Monday, 22 November 2021 9:23 a.m.
To: Jonathan Christiansen (WDHB)
Subject: Draft revision unvaccinated

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Jonathan – candid feedback before I tackle the science guys!

Ngā mihi

Andrew

Andrew Connolly
Chief Medical Officer I Ministry of Health
E: andrew.connolly@health.govt.nz I Mobile: s 9(2)(a) I www.health.govt.nz

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Megan King

From: Andrew Connolly
Sent: Monday, 22 November 2021 12:04 pm
To: Michael Shepherd
Subject: Re: Unvaccinated draft

Cheers

Andrew Connolly
Chief Medical Officer
Ministry of Health
Mobile s 9(2)(a)

From: Michael Shepherd (ADHB) <MichaelS@adhb.govt.nz>
Sent: Monday, November 22, 2021 12:00:59 PM
To: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Subject: RE: Unvaccinated draft

Refer to document at end of email chain

Hi
My quick go at this – tracked changes
Definitely on the improve ☺
Cheers
Mike

From: Andrew Connolly [mailto:Andrew.Connolly@health.govt.nz]
Sent: Monday, 22 November 2021 9:19 AM
To: Michael Shepherd (ADHB) <Michael@xx
Subject: Unvaccinated draft

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Mike

What do you think of this?

Ngā mihi

Andrew

Andrew Connolly
Chief Medical Officer | Ministry of Health
E: andrew.connolly@health.govt.nz | Mobile: s 9(2)(a) | www.health.govt.nz

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COVID-19

Ministry of Health position statement on pre-consultation testing of unvaccinated individuals in healthcare settings

22 NOVEMBER 2021

The Ministry of Health position statement is in three parts:

- the principles on which the statement is based
- a discussion of the risks of transmission occurring from unvaccinated individuals seeking healthcare
- actions which can be taken and the rationale for these actions to mitigate those risks.

Purpose

The purpose of this statement is to address concerns from clinicians and providers regarding in person consultations with unvaccinated patients, and in particular the issue of requiring a negative test for COVID-19 prior to a non-urgent consultation.

Principles of this statement

Health services need to provide services in accordance with the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996. Appropriate justification is needed if a health service is proposing to refuse access to services or to not comply with rights under the Code.

The onus is on the provider to make that justification. Justification should be made based on a risk assessment that considers both the provider and the patient, the other patients they see, the risk of attending a premise where there are unvaccinated persons present, and the requirements outlined in Clause 3 of the Code.

The Ministry is of the view that in in most cases, with vaccinated staff and other precautions in place, that the risks are unlikely to be high enough to provide sufficient justification to not follow the Code. In other words, denying access to health care on the basis of vaccination status is unacceptable.

1. Access to health care is a fundamental right.
    a. An individual seeking healthcare cannot be refused care because of their beliefs. In this case an individual who believes that a vaccine is harmful cannot be refused care for that belief.

    b. A practitioner's personal beliefs should not influence that practitioner's duty of care for any individual. In this case a practitioner must not allow their opinion of an individual who refuses to be vaccinated to influence the care that they offer that individual.
2. Health care workers have a right to be safe in their workplace in accordance with the Health and Safety at Work Act 2015 (the Act).

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   a. All workers have a right to work within a safe environment. Healthcare settings are associated with some intrinsic risks, for example the risk of contracting an infectious disease from a member of the public seeking healthcare. Usually these risks are recognised, understood and a set of recommended actions are in place to reduce this risk to an acceptable level. This residual risk is not a zero risk.
   b. The actions taken to mitigate any risks must be reasonable and proportionate to that risk.
   c. Any actions taken to mitigate risk must be based, wherever possible on evidence.
3. Employers have a duty to ensure that their staff are able to work in a safe environment, in accordance with the Act.
4. Employees have a responsibility to follow reasonable guidelines set by their employers to ensure safety.

The introduction of vaccine certificates has provided some validity to the concept that unvaccinated individuals should be managed differently to individuals who are vaccinated because of their public health risk. It is important to note that vaccine certificates are dependent upon the prevalence of disease in the community and are a community based risk mitigation not a marker of individual risk. The legislation will be very clear that access to essential services, including healthcare services, cannot be restricted based on vaccination status.

Summary

- Individuals cannot be refused access to health care.
- Restrictions to access to health care must be informed by a risk assessment, and the onus is upon the provider to justify that the risks are sufficiently high to support those restrictions.
- Total vaccination coverage and the prevalence of COVID-19 in the community are important factors in the efficacy of any mitigations aimed to prevent transmission.
- Vaccination status is one of many risk factors for infection and transmission. There is currently no evidence that the application of an alternative pathway based solely on vaccination status, or the routine incorporation of unvaccinated asymptomatic individuals into a high-risk pathway is justified.
- Pathways exist for decreasing the risk of transmission from any asymptomatic individual. These pathways must be utilised effectively prior to the introduction of additional interventions.
- The management of unvaccinated individuals through an alternative pathway is highly likely to negatively impact access to care which must be balanced by a demonstrable benefit.
- Children form a large group of individuals who are unable to vaccinated and as such are likely to form a majority the group managed through an alternative pathway. Specific consideration must be given to how this would impact on children's clinical care.

Testing prior to health care for unvaccinated people

Testing as a screening tool vs targeted testing

Testing of individuals for COVID-19 can provide a high degree of reassurance that an individual does not have active infection, however **asymptomatic infection is the more important issue, rather than the vaccination status of the patient.** The risk of an individual having asymptomatic COVID infection is not materially altered by vaccination.

Commented [MS(1)]: I think this is what we are actually saying ☺

Testing can be carried out for all individuals as a screening programme, or on groups or specific individuals considered to be at higher risk. As symptomatic individuals or those who are a contact of a positive case are considered high risk whether vaccinated or not, testing as a screening tool will only apply to asymptomatic low risk individuals. As indicated above, ~~there is not sufficient~~current **evidence** does not support~~to cc~~lassifying ~~all~~ **unvaccinated individuals as being in a group of that should be tested prior to a consultation**.

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There may be situations in which a combination of risk factors, such as known immunosuppression, may result in a medical justification for the testing of asymptomatic patients. Any such policy needs to apply to all patients irrespective of vaccination status as asymptomatic infection is the issue, not the vaccination status of the patient.

Note: When community spread is significant, there are risks to the health especially of unvaccinated patients having major planned care interventions. This is a specific issue for secondary and tertiary care providers to address.

Equity

Any approach that mandates a different approach to unvaccinated patients (including testing) ~~are swabbed for COVID-19~~ prior to planned care, risks worsening access to health care for those already suffering health inequities. For example access to testing is likely to be more difficult for shift workers disability or transport issues. Furthermore increased asymptomatic testing may result in delays to symptomatic testing worsening outcomes for those most at risk of COVID (in current outbreak this is Māori). :

- ~~Access to testing is not available 24/7 shift workers or those working multiple jobs will struggle to access a testing service (unless Rapid Antigen Testing can be provided on a sufficient scale at the time of a planned appointment)~~
- ~~Those without transport may not be able to obtain a test result in time to allow for their appointment to proceed~~
- ~~If the testing system is overwhelmed by such testing, symptomatic test results may be delayed, further risking spread and preventable exposure to COVID-19. The current outbreak is particularly affecting disadvantaged areas of metro Auckland therefore any un-resourced expansion of testing may worsen inequity caused by increased spread of COVID-19.~~

Protection of the health workforce

A range of guidance documents have been developed to minimise the risk of transmission of infection to the healthcare workforce.[1] The measures in these guidance documents have been largely effective. The rate of infection within health care settings has been very low, despite being one of the most at risk environments.

It is recognised that the impact of health care workers being unavailable because of acute illness can have a significant impact in areas where healthcare resources are restricted.
Plans to manage workforce shortages are required irrespective of the management for unvaccinated individuals, as healthcare provides are at risk of infection outside of their workplaces.

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[1] https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-information-specific-audiences/covid-19-personal-protective-equipment-central-supply/personal-protective-equipment-use-health-and-disability-care-settings

Megan King

From: Andrew Connolly
Sent: Monday, 22 November 2021 4:59 pm
To: Jeremy Tuohy
Subject: RE: AC edits 2 Ministry of Health position statement on the management of unvaccinated individuals in healthcare settings_JT

Thanks Jeremy

Absolutely no apologies necessary – we all acted in good faith and enthusiasm is what we all need! It is a vg document but unfortunately one that has led to unintended consequences!

I agree re modelling of transmission – I think for front line clinical staff this will be very valuable

Kind regards

Andrew

From: Jeremy Tuohy <Jeremy.Tuohy@health.govt.nz>
Sent: Monday, 22 November 2021 4:47 pm
To: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Subject: AC edits 2 Ministry of Health position statement on the management of unvaccinated individuals in healthcare settings_JT

Hi Andrew,

I think the document looks good. A couple of minor suggestions

I completely agree that removing the science is a good idea. The main issue is to ensure that individuals are not refused care. It is highly likely that different services will develop different management plans specific to their own situations.

I apologise that my enthusiasm to delve into the science of risk has caused grief. However, a lesson learned on that.

I still think that modelling of risk of transmission in healthcare settings by professional modellers would be useful. I think it will be necessary for managing the testing strategy that will evolve from the work.

Kind regards

Jeremy

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Megan King

From: Andrew Connolly
Sent: Tuesday, 23 November 2021 9:01 am
To: Dr Bryan Betty
Subject: RE: Updated unvacc document for feedback

Wish me luck !!

Andrew

From: Dr Bryan Betty <Bryan.Betty@rnzcgp.org.nz>
Sent: Tuesday, 23 November 2021 9:00 am
To: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Subject: RE: Updated unvacc document for feedback

Thanks Andrew. Been through it a couple of times and I think is clear re intent and the justification. I wouldn't be suggesting anything further at this point.

Thanks for taking this up.

Cheers
Bryan

Nāku noa, nā

Dr Bryan Betty
MBChB, FRNZCGP (Dist.), FACRRM
Medical Director | Mātanga Hauora

The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

The Royal New Zealand College of General Practitioners
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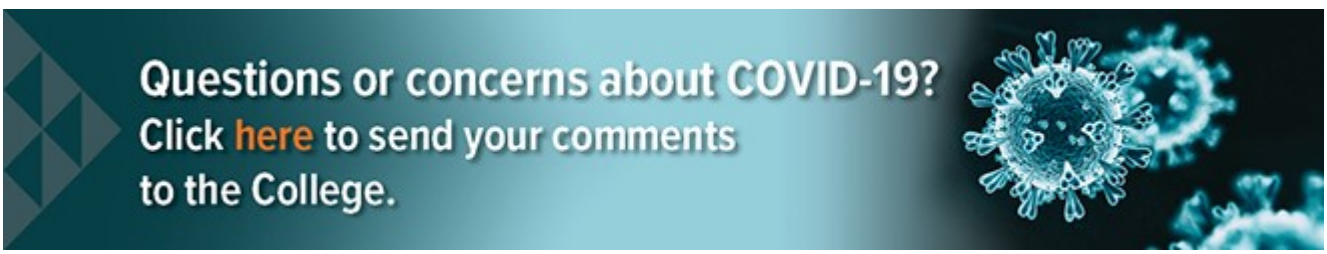

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From: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Sent: Tuesday, 23 November 2021 8:36 AM
To: Dr Bryan Betty <Bryan.Betty@rnzcgp.org.nz>
Subject: RE: Updated unvacc document for feedback

Bryan

This is the latest after all the feedback I've received – clarified face to face, made changes as per your recommendation in the summary (simply cut and pasted – thanks!) and been clear that the issue of major planned care stuff is surgery. I've added a sentence at the top re why the change

If happy I'm going to push for this to go up today to replace the existing one. We will email stakeholders to say we have focused purely on the core issue of routine pre-consult testing in low risk environments of only the unvaccinated and removed extraneous information regarding statistical stuff etc as it was distracting from the core message etc.(we will word better!)

Be grateful for your once-over (again!)

Andrew

From: Dr Bryan Betty <Bryan.Betty@rnzcgp.org.nz>
Sent: Monday, 22 November 2021 4:46 pm
To: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Subject: Re: Updated unvacc document for feedback

Hi Andrew,

It's much better and clear. The only bit I am struggling with is these two points in the summary to me seem to conflict...

- Vaccination status is one of many risk factors for infection and transmission. Unvaccinated patients who contract Covid-19 pose a high risk to themselves and to others. However, there is currently no evidence that the routine application of an alternative approach to delivering care based solely on vaccination status, or the routine incorporation of unvaccinated asymptomatic individuals into a high-risk pathway is justified.
- Pathways exist for decreasing the risk of transmission from any asymptomatic individual. These pathways should be utilised effectively prior to the introduction of additional interventions.

I wonder if the following would be better worded...

- Vaccination status is one of many risk factors for infection and transmission. Unvaccinated patients who contract Covid-19 pose a high risk to themselves and to others. However there is no evidence that the routine application of an approach incorporating pre consultation testing is justified.

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- Pathways exist for decreasing the risk of transmission from any asymptomatic individual. These pathways should be utilised effectively prior to the introduction of additional interventions such as pre-consultation testing..
-

My feeling is that would read much better and clear to say that routine testing is not justified. A variety of pathways already exist and vary in many practices and I think the second statement gives enough leeway to acknowledge that.

Bryan

Dr Bryan Betty
Medical Director
RNZCGP
Mobile: s 9(2)(a)
E-mail: Bryan.Betty@rnzcgp.org.nz

Nāku noa, nā

Dr Bryan Betty
MBChB, FRNZCGP (Dist.), FACRRM
Medical Director | Mātanga Hauora

The Royal New Zealand College of General Practitioners
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TEL: +64 4 496 5999 ▶ FAX: +64 4 496 5997
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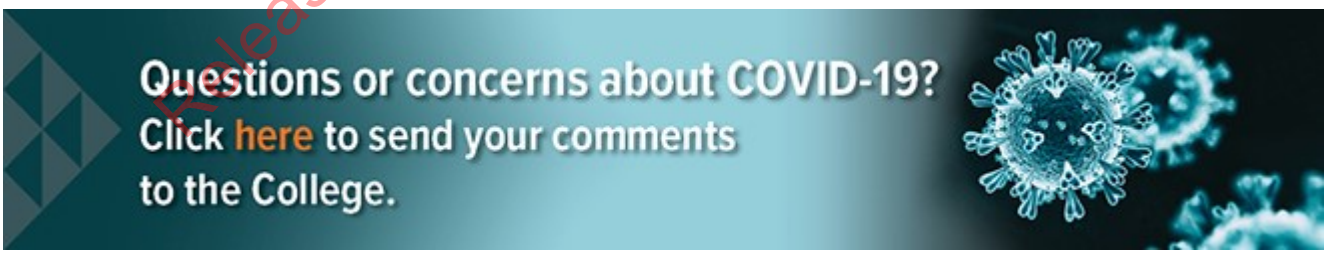

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From: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Sent: Monday, 22 November 2021 4:05 pm

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Document 1

To: Dr Bryan Betty <Bryan.Betty@rnzcgp.org.nz>
Subject: Updated unvacc document for feedback

Hi Bryan

Feedback on this would be good! As you will see I've focused on routine testing and stressed that H& S issues are also important. Cut out all the science stuff as it was accurate but very confusing – even for clinicians. I've also sent it to a couple of CMOs who made similar comments to you and to the science guys who have agreed it needed major work

Ngā mihi

Andrew

Andrew Connolly
Chief Medical Officer | Ministry of Health
E: andrew.connolly@health.govt.nz | Mobile: s 9(2)(a) | www.health.govt.nz

****
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Megan King

From: Andrew Connolly
Sent: Tuesday, 23 November 2021 9:54 am
To: Jeremy Tuohy
Subject: Re: Final version

Thanks Jeremy

Ashley wants to finally sign off and will review today

Andrew

Andrew Connolly
Chief Medical Officer
Ministry of Health
Mobile s 9(2)(a)

From: Jeremy Tuohy <Jeremy.Tuohy@health.govt.nz>
Sent: Tuesday, November 23, 2021 9:53:15 AM
To: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Subject: RE: Final version

I agree, this needs to be shut down and we can regroup
jt

From: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Sent: Tuesday, 23 November 2021 9:31 am
To: Jeremy Tuohy <Jeremy.Tuohy@health.govt.nz>
Subject: Final version

Hi Jeremy

This version meets with full support of RNZCGP and the CMOs I've been interacting with – I've added a sentence at the top re this being a focused version on the one issue

Any other changes were purely grammatical/trivial in nature

I think we should just get it loaded on website to stop further confusion

Ngā mihi

Andrew

Andrew Connolly
Chief Medical Officer | Ministry of Health
E: andrew.connolly@health.govt.nz | Mobile: s 9(2)(a) | www.health.govt.nz

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Document 1

Megan King

From: Andrew Connolly
Sent: Tuesday, 23 November 2021 11:00 am
To: Jarrod Williams
Cc: Lisa McPhail
Subject: A green sheet urgent
Attachments: FINAL revised Ministry of Health position statement on the management of unvaccinated individuals in healthcare settings.docx Refer to following page

Hi Jarrod

The attached revision is with the Director General – he wants a Green sheet signed off. Can I leave with you?

I suggest:

Jeremy Touhy
Dan Bernal
Caroline McElnay
Martin Chadwick

Can you send with the following:

Dear Colleagues

The attached document is a replacement for a more extensive one we loaded to the website last week. That document contained statistical and other information about risk of covid form both unvaccinated and vaccinated patients.
Unfortunately aspects of the document are being used by anti-vaccination groups to misrepresent the facts. But more importantly feedback from the RNZCGP and some DHBs (notable the CMO of Waitemata and the Director of Clinical Services at ADHB) has indicated the document has caused considerable anxiety and distraction at the coal face. Hence we have revised. Note this revision has involved the external parties referred to here and all support this approach.

Final sign-off rests of course with the Director General who has asked for MOH approvals to be noted.

I would be grateful for your urgent attention.

Ngā mihi

Andrew

Andrew Connolly
Chief Medical Officer I Ministry of Health
E: andrew.connolly@health.govt.nz I Mobile: s 9(2)(a) www.health.govt.nz

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Ministry of Health position statement on routine pre-consultation testing of unvaccinated individuals in healthcare settings

22 NOVEMBER 2021 Version 2.0

This statement has been updated to focus on the core issue of routine pre-consultation testing of unvaccinated patients.

The Ministry of Health position statement is in three parts:

- the principles on which the statement is based
- a discussion of the approach to pre-consultation testing of unvaccinated individuals seeking healthcare
- aspects of health equity and the potential impact of any pre-consultation testing of unvaccinated patients

Purpose

The purpose of this statement is to address concerns from clinicians and providers regarding in person consultations with unvaccinated patients, and in particular the issue of routinely requiring a negative test for COVID-19 prior to a non-urgent face to face consultation.

Vaccination offers the best protection against Covid-19 both for individuals and for those they interact with, including health care workers and other patients, however some New Zealanders do not qualify for vaccination and some have chosen not to be vaccinated. It is important that there is a consistent and scientifically logical approach to pre-consultation testing.

Principles of this statement

Health services need to provide services in accordance with the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996. Appropriate justification is needed if a health service is proposing to refuse access to services or to not comply with rights under the Code.

The onus is on the provider to make that justification. Justification should be made based on a risk assessment that considers both the provider and the patient, the other patients they see, the risk of attending premises where there are unvaccinated persons present, and the requirements outlined in Clause 3 of the Code.

The Ministry is of the view that in in most cases, with vaccinated staff and other precautions in place, that the risks are unlikely to be high enough to provide sufficient justification to not follow the Code. In other words, denying access to health care on the basis of vaccination status is unacceptable.

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1. Access to health care is a fundamental right.
    a. An individual seeking healthcare cannot be refused care because of their beliefs. In this case an individual who believes that a vaccine is harmful cannot be refused care for that belief.

    b. A practitioner's personal beliefs should not influence that practitioner's duty of care for any individual. In this case a practitioner must not allow their opinion of an individual who refuses to be vaccinated to influence the care that they offer that individual.
2. Health care workers have a right to be safe in their workplace in accordance with the Health and Safety at Work Act 2015 (the Act).
    a. All workers have a right to work within a safe environment. Healthcare settings are associated with some intrinsic risks, for example the risk of contracting an infectious disease from a member of the public seeking healthcare. Usually these risks are recognised, understood and a set of recommended actions are in place to reduce this risk to an acceptable level. This residual risk is not a zero risk.
    b. The actions taken to mitigate any risks must be reasonable and proportionate to that risk.
    c. Any actions taken to mitigate risk must be based, wherever possible on evidence.
3. Employers have a duty to ensure that their staff are able to work in a safe environment, in accordance with the Act.
4. Employees have a responsibility to follow reasonable guidelines set by their employers to ensure safety.

Health and safety procedures in a Health Care facility must be adhered to, such as the wearing of masks and observing distancing requirements where possible. If a patient refuses to do so and care can be safely be deferred, it may be reasonable to require a negative Covid-19 test prior to a subsequent consultation.

The introduction of vaccine certificates has provided some validity to the concept that unvaccinated individuals should be managed differently to individuals who are vaccinated because of their public health risk. It is important to note that the use of vaccine certificates is dependent on the prevalence of disease in the community and are a community-based risk mitigation, not a marker of individual risk. Irrespective of changing to a "traffic light" system access to essential services, including healthcare services, cannot be restricted based on vaccination status.

Summary

- Individuals cannot be refused access to health care. Restrictions to access to health care must be informed by a risk assessment, and the onus is upon the provider to justify that the risks are sufficiently high to support those restrictions.
- Individual patients have a responsibility to follow Health and Safety guidelines and procedures when utilizing a health service. Requiring a negative covid -19 test prior to a non-urgent consultation would likely be justified if patients refuse to comply with such requirements
- Total vaccination coverage and the prevalence of COVID-19 in the community are important factors in the efficacy of any mitigations aimed to prevent transmission.
- Vaccination status is one of many risk factors for infection and transmission. Unvaccinated patients who contract Covid-19 pose a high risk to themselves and to others. However, there is no evidence that the routine application of an approach incorporating pre consultation testing is justified.
- Pathways exist for decreasing the risk of transmission from any asymptomatic individual. These pathways should be utilised effectively prior to the introduction of additional interventions such as pre-consultation testing.
- Children form a large group of individuals who are unable to vaccinated and as such are likely to form a majority the group managed through an alternative pathway. Specific consideration must be given to how this would impact on children's clinical care.

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Testing unvaccinated people prior to health care

Testing as a screening tool vs targeted testing

Testing of individuals for COVID-19 can provide a high degree of reassurance that an individual does not have active infection. However, for health care workers, the risk of seeing a patient with asymptomatic infection is the more important issue, rather than the vaccination status of the patient. Vaccination significantly reduces the risk of developing severe infection and whilst vaccinated patients are much less likely to transmit the virus, transmission is still possible. This emphasises the need to be vigilant for asymptomatic spread in the community based on thorough public health assessment rather than on patient vaccination status alone.

Testing can be carried out for all individuals as a screening programme, or on groups or specific individuals considered to be at higher risk. As symptomatic individuals or those who are a contact of a positive case are considered high risk, whether vaccinated or not, testing as a screening tool will only apply to asymptomatic low risk individuals. As indicated above, current evidence does not support classifying unvaccinated individuals as being in a group of that should be routinely tested prior to a consultation to the exclusion of others.

There may be situations in which a combination of risk factors, such as known immunosuppression, may result in a medical justification for the testing of asymptomatic patients. Any such policy needs to apply to all patients irrespective of vaccination status as asymptomatic infection is the issue, not the vaccination status of the patient.

Note: When community spread is significant, there are significant risks to the health especially of asymptomatic, covid positive unvaccinated patients having major planned care surgery which may clinically support the need to test for Covid-19 prior to the procedure. This is a specific issue for secondary and tertiary care providers to address. Where any clinically justified reason exists to test asymptomatic unvaccinated patients care must be taken to avoid unintended barriers to access and timeliness of care

Equity

Any approach that mandates a different approach to unvaccinated patients (including testing) prior to planned care, risks worsening access to health care for those already suffering health inequities. For example, access to testing is likely to be more difficult for shift workers, disability or transport issues. Furthermore, increased asymptomatic testing may result in delays to symptomatic testing worsening outcomes for those most at risk of COVID (in current outbreak this is Māori).

A range of guidance documents have been developed to minimise the risk of transmission of infection to the healthcare workforce.[1] The measures in these guidance documents have been largely effective. The rate of infection within health care settings has been very low, despite being one of the most at risk environments.

It is recognised that the impact of health care workers being unavailable because of acute illness can have a significant impact in areas where healthcare resources are restricted.

Plans to manage workforce shortages are required irrespective of the management for unvaccinated individuals, as healthcare provides are at risk of infection outside of their workplaces.

[1] https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-information-specific-audiences/covid-19-personal-protective-equipment-central-supply/personal-protective-equipment-use-health-and-disability-care-settings

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Megan King

From: Andrew Connolly
Sent: Tuesday, 23 November 2021 11:42 am
To: Anne Stewart; Jarrod Williams
Subject: RE: Urgent for Ashley

Once signed off by the audit trail Ashley will decide if we replace the current one on the website with this one.

A

From: Anne Stewart <Anne.Stewart@health.govt.nz>
Sent: Tuesday, 23 November 2021 11:41 am
To: Andrew Connolly <Andrew.Connolly@health.govt.nz>; Jarrod Williams <Jarrod.Williams@health.govt.nz>
Subject: RE: Urgent for Ashley

Thanks Andrew that is much clearer. What are next steps with this?

Ngā mihi

Anne

Anne Stewart | Group Manager | Office of the Chief Clinical Officers
Manatū Hauora - Ministry of Health | www.moh.govt.nz
Mobile: s 9(2)(a) | Email: Anne.Stewart@health.govt.nz

From: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Sent: Tuesday, 23 November 2021 11:38 am
To: Anne Stewart <Anne.Stewart@health.govt.nz>; Jarrod Williams <Jarrod.Willxxxx@xxxxxx.xxxx.xx >
Subject: RE: Urgent for Ashley

Thanks Anne

I've reworded that sentence – highlighted in yellow. Point is the unvaccinated covid pos undergoing deferrable major surgery is a specially bad thing to do!

Re-word my bits if necessary but it does not need recirculating for more signatures as its grammatical in nature only

Andrew

From: Anne Stewart <Anne.Stewart@health.govt.nz>
Sent: Tuesday, 23 November 2021 11:10 am
To: Andrew Connolly <Andrew.Connolly@health.govt.nz>; Lisa McPhail <xxxx.xxxxxxx@xxxxxx.xxxx.nz>
Subject: RE: Urgent for Ashley

Hi Andrew

some suggested changes from me – I understand Jarrod is going to help with this.

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Ngā mihi

Anne

Anne Stewart | **Group Manager** | **Office of the Chief Clinical Officers**
Manatū Hauora - Ministry of Health | www.moh.govt.nz
Mobile: s 9(2)(a) | Email: Anne.Stewart@health.govt.nz

From: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Sent: Tuesday, 23 November 2021 10:06 am
To: Lisa McPhail <Lisa.McPhail@health.govt.nz>
Cc: Anne Stewart <Anne.Stewart@health.govt.nz>
Subject: RE: Urgent for Ashley

Just this – he's aware

From: Lisa McPhail <Lisa.McPhail@health.govt.nz>
Sent: Tuesday, 23 November 2021 10:05 am
To: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Cc: Anne Stewart <Anne.Stewart@health.govt.nz>
Subject: RE: Urgent for Ashley

Hi Andrew,

Are you happy for me to provide this version or is there a memo or cover briefing to accompany?

Thanks
Lisa

Lisa McPhail
Chief Advisor | Office of the Director-General | Ministry of Health
E: lisa.mcphail@health.govt.nz | s 9(2)(a) |
http://www.health.govt.nz

My working hours may not be your working hours. Please do not feel obligated to reply outside of your normal work schedule

---

From: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Sent: Tuesday, 23 November 2021 10:03 am
To: Anne Stewart <Anne.Stewart@health.govt.nz>; Lisa McPhail <Lisa.McPhail@health.govt.nz>
Subject: Urgent for Ashley
Importance: High

Hi Lisa and Anne

Ashley wants to see this today for urgent review and his ultimate sign-out.

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Ngā mihi

Andrew

Andrew Connolly
Chief Medical Officer | Ministry of Health
E: andrew.connolly@health.govt.nz | Mobile: s 9(2)(a) | www.health.govt.nz

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Megan King

From: Andrew Connolly
Sent: Tuesday, 23 November 2021 3:20 pm
To: Jarrod Williams
Subject: Re: That document!

Great - thanks

Andrew Connolly
Chief Medical Officer
Ministry of Health
Mobile s 9(2)(a)

From: Jarrod Williams <Jarrod.Williams@health.govt.nz>
Sent: Tuesday, November 23, 2021 3:19:32 PM
To: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Subject: RE: That document!

Na I think it's all good – I sent her a couple of points along those lines.

Ngā mihi,

Jarrod Williams | Manager | Office of the Chief Clinical Officers
Ministry of Health | www.moh.govt.nz
Mobile: s 9(2)(a)

If this email reaches you out of hours, I don't expect a response outside of your office hours, it's just a convenient time for me to send an email

---

From: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Sent: Tuesday, 23 November 2021 3:19 pm
To: Jarrod Williams <Jarrod.Williams@health.govt.nz>
Subject: Re: That document!

Does Caroline need anything further? The issues were we confused the coal face. The Mis- use by anti- vacc is an aside. Most confusion and concern arose in primary care who felt it was difficult to follow and lost the emphasis on not requiring unvaccinated to be swabbed before non urgent contact.

This latter point is the whole reason we started this document in first place

Andrew

Andrew Connolly
Chief Medical Officer
Ministry of Health
Mobile s 9(2)(a)

From: Jarrod Williams <Jarrod.Williams@health.govt.nz>
Sent: Tuesday, November 23, 2021 3:14:59 PM

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To: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Subject: RE: That document!

Martin has signed off, Caroline asked for more details about the concerns with the initial version, but nothing else back as yet.

Jarrod Williams | Manager | Office of the Chief Clinical Officers
Ministry of Health | www.moh.govt.nz
Mobile: s 9(2)(a)

If this email reaches you out of hours, I don't expect a response outside of your office hours, it's just a convenient time for me to send an email

---

From: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Sent: Tuesday, 23 November 2021 3:14 pm
To: Jarrod Williams <Jarrod.Williams@health.govt.nz>
Subject: That document!

Any progress in sign offs?

No action needed - just interested!

Andrew

Andrew Connolly
Chief Medical Officer
Ministry of Health
Mobile s 9(2)(a)

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Document 1

Megan King

From: Andrew Connolly
Sent: Wednesday, 24 November 2021 11:08 am
To: Jarrod Williams
Subject: RE: Feedback on the position statement
Attachments: Revised v1 after Pub Health feedback .docx

Refer to end of email chain

Try this one

A

From: Jarrod Williams <Jarrod.Williams@health.govt.nz>
Sent: Wednesday, 24 November 2021 11:01 am
To: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Subject: RE: Feedback on the position statement

I can't open it – can you resend? Sorry

Ngā mihi,

Jarrod Williams | Manager | Office of the Chief Clinical Officers
Ministry of Health | www.moh.govt.nz
Mobile s 9(2)(a)

If this email reaches you out of hours, I don't expect a response outside of your office hours, it's just a convenient time for me to send an email

---

From: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Sent: Wednesday, 24 November 2021 10:42 am
To: Jarrod Williams <Jarrod.Williams@health.govt.nz>
Subject: RE: Feedback on the position statement

Attached – I've highlighted in yellow the major changes and incorporated all Niki's points.

Can you get Niki and Caroline to check and if ok we then go back to others?

Andrew

From: Jarrod Williams <Jarrod.Williams@health.govt.nz>
Sent: Wednesday, 24 November 2021 9:59 am
To: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Subject: Feedback on the position statement

Hi Andrew,

Niki Stefanogiannis has given some feedback on behalf of Caroline, see below and in the attached – sorry I'm not sure I am qualified to address it fully. The open comments are the ones that are outstanding for your consideration.

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- There is no discussion on how the risk to health care workers (and vaccinated patients) of exposure to COVID-19 is mitigated through vaccination, the focus is only on the fact that unvaccinated patients can transmit. Taking into account the basic public health measures in place, and widespread vaccination in this setting, the risk is very low. In addition, the vaccination status of the patient will be known, so steps can be taken to further mitigate the risk without requiring testing, which may mean that someone may have to go and get a test two days before their appointment and hope the result is back before their appointment.
- There is no discussion that a test is a point in time measure, there is no guarantee that someone may be exposed to COVID-19 after they are tested.
- The current capacity of the lab system is under strain, so careful consideration of pre-consultation testing needs to be made.
- The documents focus is on unvaccinated individuals, but in section titled **Testing as a screening tool vs targeted testing,** it talks about vaccinated people still being able to transmit and that asymptomatic testing is more important. This section is a bit confusing.
- It is not clear whether the statement is directed towards primary healthcare settings or whether it includes secondary and tertiary – these settings are quite different.

I haven't managed to get anything back from Dan or Jeremy, so once you're happy I might just put this up.

Ngā mihi,

Jarrod Williams | Manager | Office of the Chief Clinical Officers
Ministry of Health | www.moh.govt.nz
Mobile: s 9(2)(a)

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COVID-19

Ministry of Health position statement on routine pre-consultation testing of unvaccinated individuals in healthcare settings

22 NOVEMBER 2021 Version 2.0

This statement has been updated to focus on the core issue of routine pre-consultation testing of unvaccinated patients in both community and secondary care settings.

The Ministry of Health position statement is in three parts:

- the principles on which the statement is based
- a discussion of the approach to pre-consultation testing of unvaccinated individuals seeking healthcare
- aspects of health equity and the potential impact of any pre-consultation testing of unvaccinated patients

Purpose

The purpose of this statement is to address concerns from clinicians and providers regarding in person consultations with unvaccinated patients, and in particular the issue of routinely requiring a negative test for COVID-19 prior to a non-urgent face to face consultation.

Vaccination offers the best protection against Covid-19 both for individuals and for those they interact with, including health care workers and other patients, however some New Zealanders do not qualify for vaccination and some have chosen not to be vaccinated. It is important that there is a consistent and scientifically logical approach to pre-consultation testing.

A range of guidance documents have been developed to minimise the risk of transmission of infection to the healthcare workforce.[1] The measures in these guidance documents have been largely effective. The rate of infection within health care settings has been very low, despite being one of the most at risk environments. These measures reduce the risks for both health care workers and patients.

What is the intent of pre-consultation testing?
There are two aspects to consider:

a. Any reduction in risk to health care workers?
b. Any reduction in risk to other patients?

To date strong public health and infection, prevention and control measures have protected both health care workers and patients. This protection has been further enhanced by the vaccination programme. Routine pre-consultation testing of unvaccinated individuals has not been part of this success.

[1] https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-information-specific-audiences/covid-19-personal-protective-equipment-central-supply/personal-protective-equipment-use-health-and-disability-care-settings

Commented [NS1]: Is the focus on primary care settings only or does it include secondary / tertiary care? Need to be clear

Commented [AC2R1]: Added to the bit below the date

Commented [NS3]: This para makes an important point and needs to included earlier in the position statement.

Commented [AC4R3]: done

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COVID-19

Principles of this statement

Health services need to provide services in accordance with the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996. Appropriate justification is needed if a health service is proposing to refuse access to services or to not comply with rights under the Code.

The onus is on the provider to make that justification. Justification should be made based on a risk assessment that considers both the provider and the patient, the other patients they see, the risk of attending premises where there are unvaccinated persons present, and the requirements outlined in Clause 3 of the Code.

The Ministry is of the view that in most cases, with vaccinated staff and other precautions in place, that the risks are unlikely to be high enough to provide sufficient justification to not follow the Code. In other words, denying access to health care on the basis of vaccination status is unacceptable.

1. Access to health care is a fundamental right.
    a. An individual seeking healthcare cannot be refused care because of their beliefs. In this case an individual who believes that a vaccine is harmful cannot be refused care for that belief.

       A practitioner's personal beliefs should not influence that practitioner's duty of care for any individual. In this case a practitioner must not allow their opinion of an individual who refuses to be vaccinated to influence the care that they offer that individual.
2. Health care workers have a right to be safe in their workplace in accordance with the Health and Safety at Work Act 2015 (the Act).
    a. All workers have a right to work within a safe environment. Healthcare settings are associated with some intrinsic risks, for example the risk of contracting an infectious disease from a member of the public seeking healthcare. Usually these risks are recognised, understood and a set of recommended actions are in place to reduce this risk to an acceptable level. This residual risk is not a zero risk.
    b. The actions taken to mitigate any risks must be reasonable and proportionate to that risk.
    c. Any actions taken to mitigate risk must be based, wherever possible on evidence.
3. Employers have a duty to ensure that their staff are able to work in a safe environment, in accordance with the Act.
4. Employees have a responsibility to follow reasonable guidelines set by their employers to ensure safety.

Individual patients have a responsibility to follow Health and Safety guidelines and procedures when utilising a health service, such as the wearing of masks and observing distancing requirements where possible. If a patient refuses to do so and care can be safely be deferred,, it may be reasonable to require a negative COVID-19 test prior to a subsequent consultation following a risk assessment as to whether it is required. However, vaccination of staff within a health care facility will also mitigate the risk and if it is known that the patient is unvaccinated, then steps can be taken to ensure that the risk to other patients in the facility are managed.

Summary

- Individuals cannot be refused access to health care. Restrictions to access to health care must be informed by a risk assessment, and the onus is upon the provider to justify that the risks are sufficiently high to support those restrictions.
- Total vaccination coverage and the prevalence of COVID-19 in the community are important factors in the efficacy of any mitigations aimed to prevent transmission.

Commented [NS5]: I think a key statement that is missing is what we might achieve by requiring a pre-consultation test. Are we trying to prevent transmission to the health care worker / other staff? The measures that are in place currently have worked in preventing transmission even without widespread (and mandated) vaccination of health provider staff. Are we trying to prevent transmission to other patients? Again – what other measures have we got in place? These measures have worked to date.

Commented [AC6R5]: See section above

Commented [NS7]: However, as per first principles, a risk assessment needs to be undertaken (hierarchy of controls) as to whether this is needed. If a

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- Other public health measures in place also contribute to reducing the risk.
- Vaccination status is one of many risk factors for infection and transmission. Unvaccinated patients who contract Covid-19 pose a high risk to themselves and to others. However, there is no evidence that the routine application of an approach incorporating pre consultation testing is justified.
- Individual patients have a responsibility to follow Health and Safety guidelines and procedures when utilizing a health service.
- Pathways exist for decreasing the risk of transmission from any asymptomatic individual. These pathways should be utilised effectively prior to the introduction of additional interventions such as pre-consultation testing.
  Children form a large group of individuals who are unable to vaccinated and as such are likely to form a majority the group managed through an alternative pathway. Specific consideration must be given to how this would impact on children's clinical care

Testing unvaccinated people prior to health care

Testing as a screening tool vs targeted testing

Testing of individuals for COVID-19 can provide a high degree of reassurance that an individual does not have active infection. However, for health care workers, the risk of seeing a patient with asymptomatic infection is the more important issue, rather than the vaccination status of the patient. Vaccination significantly reduces the risk of developing severe infection and whilst vaccinated patients are much less likely to transmit the virus, transmission is still possible. This emphasises the need to focus on strong public health measures and vigilance for asymptomatic spread in the community based on thorough basic public health measures rather than on patient vaccination status alone (noting that vaccinated health care staff further reduces any risk).

Commented [NS8]: What this emphasises to me, is that we should continue with the basic public health measures. This ignores the fact that the health care staff are vaccinated – this further reduces the risk.

Commented [AC9R8]: Edited – agree

Testing can be carried out for all individuals as a screening programme, or on groups or specific individuals considered to be at higher risk. As symptomatic individuals or those who are a contact of a positive case are considered high risk, whether vaccinated or not, testing as a screening tool will only apply to asymptomatic low risk individuals. As indicated above, current evidence does not support classifying unvaccinated individuals as being in a group of that should be routinely tested prior to a consultation to the exclusion of others.

There may be situations in which a combination of risk factors, such as known immunosuppression, may result in a medical justification for the testing of asymptomatic patients. Any such policy needs to apply to all patients irrespective of vaccination status as asymptomatic infection is the issue, not the vaccination status of the patient.

Note: When community spread is significant, there are significant risks to the health care system, including patients, especially unvaccinated asymptomatic, covid positive patients undergoing major planned care surgery. This may clinically support the need to test unvaccinated patients for COVID-19 prior to the procedure. This is a specific issue for secondary and tertiary care providers to address. Where any clinically justified reason exists to test asymptomatic unvaccinated patients, care must be taken to avoid unintended barriers to access and timeliness of care

Equity

Any approach that mandates a different approach to unvaccinated patients (including testing) prior to planned care, risks worsening access to health care for those already suffering health inequities. For example, access to testing is likely to be more difficult for shift workers, disability or transport issues. Furthermore, increased asymptomatic testing may result in delays to symptomatic testing worsening outcomes for those most at risk of COVID (in current outbreak this is Māori).

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COVID-19

It is recognised that the impact of health care workers being unavailable because of acute illness can have a significant impact in areas where healthcare resources are restricted.

Plans to manage workforce shortages are required irrespective of the management for unvaccinated individuals, as healthcare provides are at risk of infection outside of their workplaces.

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Megan King

From: Dr Bryan Betty <Bryan.Betty@rnzcgp.org.nz>
Sent: Thursday, 25 November 2021 4:06 pm
To: Andrew Connolly
Subject: RE: FYI - Ashley has just approved the position statement, will get it out now

Thanks Andrew – good work! Wills send out.

Nāku noa, nā

Dr Bryan Betty
MBChB, FRNZCGP (Dist.), FACRRM
Medical Director | Mātanga Hauora

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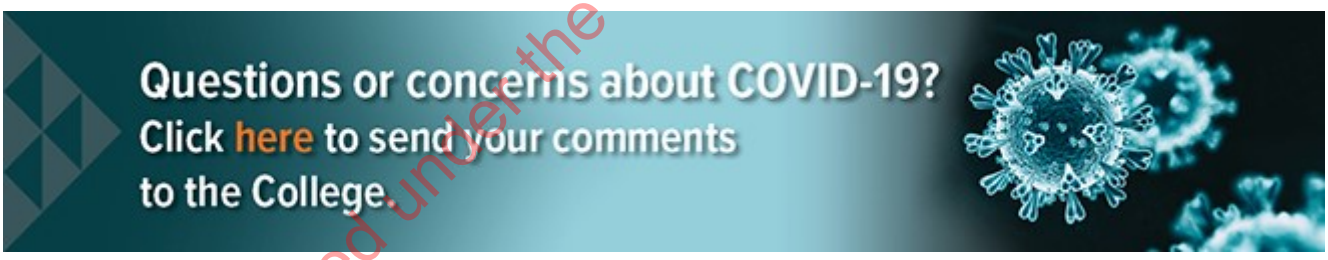

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From: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Sent: Thursday, 25 November 2021 1:40 pm
To: Dr Bryan Betty <Bryan.Betty@rnzcgp.org.nz>
Subject: Fwd: FYI - Ashley has just approved the position statement, will get it out now

Bryan - final signed off - being sorted for website etc now

Thanks for all your help on this and the wider confusion etc!!

Andrew

Document 1

Andrew Connolly
Chief Medical Officer
Ministry of Health
Mobile s 9(2)(a)

From: Jarrod Williams <Jarrod.Williams@health.govt.nz>
Sent: Thursday, November 25, 2021 1:22:20 PM
To: Andrew Connolly <Andrew.Connolly@health.govt.nz>
Subject: FYI - Ashley has just approved the position statement, will get it out now

Final version attached for your records Refer to website

Ngā mihi,

Jarrod Williams | Manager | Office of the Chief Clinical Officers
Ministry of Health | www.moh.govt.nz
Mobile s 9(2)(a)

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