MINISTRY OF HEALTH
MANATŪ HAUORA

Document 1

Briefing

Internal Review of the June Sydney to Wellington Traveller Case 2021

Date due to MO:	24 September 2021	**Action required by:**	N/A
Security level:	IN CONFIDENCE	**Health Report number:**	20211771
To:	Hon Chris Hipkins, Minister for COVID 19 Response		
Copy:	Hon Dr Ayesha Verrall, Associate Minister of Health		

Contact for telephone discussion

Name	Position	Telephone
Bridget White	Deputy Chief Executive, COVID 19 Health System Response	s 9(2)(a)

Minister's office to complete:

☐ Approved ☐ Decline ☐ Noted

☐ Needs change ☐ Seen ☐ Overtaken by events

☐ See Minister's Notes ☐ Withdrawn

Comment:

Internal Review of the June Sydney to Wellington Traveller Case 2021

Security level:	IN CONFIDENCE	**Date:**	24 September 2021
To:	Hon Chris Hipkins, Minister for COVID-19 Response		
Copy:	Hon Dr Ayesha Verrall, Associate Minister of Health		

Purpose of report

1. The purpose of this briefing is to provide you with an overview of the internal review of the health system response to the June Sydney to Wellington Traveller Case.

Summary

2. As part of the Ministry of Health's (the Ministry) commitment to continuous improvement, an interval review was undertaken into the response of the June Sydney to Wellington Traveller Case that resulted in Wellington moving into Alert Level Two on 23 June 2021.

3. The review highlights that the overall response was rapid and effective which led to no community outbreaks occurring.

4. There have been lessons identified and this review makes six recommendations with specific actions to strengthen these areas. The relevant teams within the Ministry have been made aware of the actions necessary to support these findings and the report outlines progress made against these. Consistent with our approach for continuous improvement, we have already enhanced and adjusted some crucial processes and systems derived from these learnings. These have been outlined in the review.

5. Please note that the *Interval Review of June Sydney to Wellington Traveller Case 2021* was completed prior to the current Auckland outbreak. A review which captures lessons identified throughout the current outbreak will be explored at the conclusion of the response.

Recommendations

We recommend you:

a) **Note** that the Ministry has undertaken a review of the June Sydney to Wellington Traveller Case 2021 which makes recommendations to further strengthen the ongoing COVID 19 response. **Yes/No**

b) **Indicate** whether you would like the Ministry to proactively release the report on its website. We will provide a communications pack to support this decision, if you decide to do so. **Yes/No**

Dr Ashley Bloomfield
Director-General of Health
Date: 15/9/21

Hon Chris Hipkins
Minister for COVID-19 Response
Date:

Internal Review of June Sydney to Wellington Traveller Case 2021

Context

1. The June Sydney to Wellington Traveller Case 2021 begun on 23 June when it was identified that an individual who travelled from Sydney to Wellington on 18 June and returned on the 21 June returned a positive test result for COVID-19.

2. The Case resulted in zero community cases, two close-plus contacts, 981 close contacts and 1743 casual plus contacts. The Case was confirmed by New South Wales health authorities as an epidemiological link to the Bondi/Westfield Cluster in Sydney, Australia.

3. On July 6 2021, the formal process to review the outbreak began through a series of debriefs and reports. In addition, a questionnaire self-assessment tool was developed to inform the process and gain further insight into key learnings identified.

4. On 23 July 2021, an eight-week quarantine-free travel suspension from all Australian states and territories to New Zealand came into effect due to the deteriorating COVID-19 situation in Australia.

Review Overview

5. The COVID-19 Advisory Group within the COVID-19 Health System Response Directorate led the review into the Case. The organisations, groups and agencies involved in the response included:

   a. Department of the Prime Minister and Cabinet
   b. Capital and Coast District Health Board
   c. Ministry of Business, Innovation and Employment
   d. Ministry of Foreign Affairs and Trade
   e. Ministry of Health
   f. Ministry for Primary Industries
   g. National Emergency Management Agency
   h. New Zealand Police
   i. Regional Public Health
   j. Wairarapa District Health Board

Recommendations

6. The recommendations that the review make are outlined below. The review provides further details and current progress.

   a. Further mitigate risk of staff fatigue and workforce pressures across the health system through providing resource support and assistance.

b. Re evaluate the available surge capacity health workforce so that the Ministry is well prepared to deliver increased operational resources in response to future incidents and/or outbreaks

c. Examine communication channels with Australian counterparts to clarify delays and ensure efficient information flow.

d. Review operational procedures and protocols to adjust to the developing COVID-19 situation, including the presence of the Delta variant and how this may affect our response processes and practice.

e. Explore self-isolation procedures for individuals who are unable to self-isolate safely

f. Improve communication, collaboration and engagement across government agencies so that decision-makers are well supported and are provided with the best possible advice.

7. Many any of these recommendations were already underway or already have existing processes.

Communications Approach

8. The release of the report may generate moderate public and media interest.

9. If you choose to publicly release the report, we will provide you with a communications pack to support your decision.

Next steps

10. We will provide you with an update in the coming months regarding the progress of the review recommendations.

11. We will provide you with a communications pack if you wish to proactively release the report and work with your office on necessary steps for release.

ENDS.

Appendix 1: June Sydney to Wellington Traveller Case 2021

Document 1

June Sydney to Wellington Traveller Case 2021

Internal Review of the June Sydney to Wellington Traveller Case Response

MINISTRY OF HEALTH
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INTRODUCTION

A key strength of New Zealand's response to COVID-19 is the commitment to continually review, adjust and apply learnings to future activities.

The purpose of this internal review of the Ministry of Health's (the Ministry) public health response to the 'June Sydney to Wellington Traveller Case,' is to uncover the challenges experienced and lessons identified, to inform our process of, and commitment to, continuous improvement. The review outlines specific actions and work streams addressing issues identified.

CASE SUMMARY AND TIMELINE

On 23 June 2021, the Ministry was notified through the Australian National Focal Point that a confirmed COVID-19 case travelled to Wellington from Sydney on 18 June 2021; returning to Sydney on 21 June 2021. While the incident reported zero community cases, there were two close-plus contacts, 981 close contacts and 1743 casual plus contacts identified. The case returned a positive test result in Sydney from a test taken on 21 June 2021. s 9(2)(a) [redacted] and received their first vaccination dose for COVID-19. New South Wales health authorities confirmed an epidemiological link to the Bondi/Westfield Cluster.

In response to the incident, the Greater Wellington region moved to Alert Level 2 at 6:00pm on 23 June 2021, with the remainder of New Zealand staying at Alert Level 1. Further to the Alert Level change, a public health risk assessment was undertaken regarding the Quarantine Free Travel (QFT) status with New South Wales, Australia. As a result, at 11:59pm on 22 June 2021 a pause on QFT was put in place for a period of 72 hours. At 11:59pm on 29 June 2021, the Greater Wellington region moved back to Alert Level 1 alongside the remainder of New Zealand.

The COVID-19 situation has since deteriorated in New South Wales and expanded to the Queensland and South Australian States. Subsequently, on 23 July 2021, the Australian QFT status was demoted and an eight-week QFT suspension from all Australian States and territories to New Zealand came into effect.

INCIDENT MANAGEMENT TEAM STRUCTURE

The Ministry's COVID-19 Incident Management Team (IMT) manages and coordinates the national health response to COVID-19 incidents and outbreaks and is the point of contact for public health units (PHUs), district health boards (DHBs), Ministers, the Ministry's Executive Leadership Team, and other stakeholders. IMT is activated upon identification of a community case of COVID-19 and includes a range of expertise from across the Ministry.

External organisations involved in the response include:

- Department of the Prime Minister and Cabinet

- Capital and Coast DHB
- Ministry of Business, Innovation and Employment
- Ministry of Foreign Affairs and Trade
- Ministry for Primary Industries
- National Emergency Management Agency
- New Zealand Police
- Regional Public Health
- Wairarapa DHB

REVIEW METHODOLOGY PROCESS

This internal review of the June Sydney to Wellington Traveller Case encompasses findings from the following:

1. A memo to Dr Ashley Bloomfield, Director-General of Health on 5 July 2021 titled *Situation Summary Report: Sydney to Wellington Acute Case*.
2. A joint Ministry and DPMC briefing titled *Quarantine-Free Travel with Australia: Key Learnings and Process Improvements.* This briefing outlined key learnings from QFT incidents, including how these learnings have informed actions to strengthen the QFT system and better inform decision making.
3. A debrief with key stakeholders on 6 July 2021, chaired by the Group Manager, IMT.
4. A self-assessment questionnaire of the incident was developed by the Ministry's COVID-19 Advisory Group for this review and distributed on 21 July 2021 to key stakeholders listed above who were involved in the response. Findings were collected, analysed and summarised to inform this review.
5. A review and debrief analysis of the May-June 2021 Incidents titled *May-June 2021 Incidents Analysis Reviews & Debriefs*. This focused on key learnings and process improvements in relation to the QFT incidents. These incidents include the Victoria QFT pause, June Sydney to Wellington Traveller Case, New South Wales QFT pause and the Australia-wide QFT pause.

SUMMARY KEY FINDINGS

The review found that the Ministry response has continued to operate under a process of ongoing improvement and agility throughout the maritime responses, which has proved effective in responding to the incident.

The key findings identified in this review are:

- **IMT:** Robust structure and processes, as well as timely updates to key stakeholders which provided assurance that the response was 'fit for purpose'.
- **Cross government agency and stakeholder:** Positive relationships and clear communication channels ensured an efficient and aligned incident response.

- **Sector communications:** Proactive communications ensured smooth information flow to the wider health and government sectors.

While findings were largely positive, some areas are in need of strengthening:

- **External communications:** Clarity of messaging and information provided to the public is required, such as the communication of places of interest and the definition of close contacts.
- **Workforce capacity and capability:** Improved surge workforce capacity could alleviate staff pressure and fatigue across the health system.
- **Isolation facilities:** Ensuring there is facility capacity and contingency planning for contacts required to self-isolate but do not have an appropriate place to do so.
- **Contact tracing and testing:** Improved QR code placement advice, plans to mitigate the challenges of congestion at testing sites and availability of a surge contact tracing workforce.

THE INCIDENT MANAGEMENT TEAM RESPONSE

The Ministry IMT processes for managing incidents were clear and efficient which allowed for quick activation and notification of the incident which enabled a proactive response. Regular training ensured that staff were familiar with response standard operating procedures (SOPs) resulting in a rapid response while providing flexibility to adjust as the situation evolved.

Regular IMT updates to response stakeholders ensured roles and responsibilities were clearly defined. This included systematic IMT meetings with internal and external stakeholders, held daily, which allowed for good information sharing and helped frame issue management during the response.

The review has also shown that some SOPs should be reviewed and adjusted as COVID-19 variants emerge and the global situation develops.

COMMUNICATIONS

There have been noticeable improvements in incident response communication, in terms of pace, external communication and cross-agency collaboration in comparison to previous events. The established communication channels and flow of information through the system allowed for any issues raised to be immediately addressed and effectively managed. However, there is an identified need to reduce confusion around information sources and the movement of unconfirmed information. It is necessary for IMT to be the single source of truth, to avoid any misinformation or duplication of effort.

Critical information and messaging to the public must be quick and accurate, especially regarding information for contacts of a case and providing places of interest. Due to unclear messaging following the June Sydney to Wellington Traveller Case, testing stations were crowded by people that did not need to be tested.

There were initial challenges due to the delay of the provision of information regarding the traveller case from Australian colleagues. In the future, the Ministry will set clearer expectations for incident responses where international time zones and different processes between jurisdictions may cause a delay in information gathering and sharing.

CAPACITY AND CAPABILITY

It is clear from the findings that health system capacity and capability continue to be a concern across the sector.

Firstly, there is a need for the system to continue to work proactively to develop the existing capability and recruit or employ additional work force. Enabling swift response action and ensuring flex in the system will support the fatigue of our key health workers externally, and Ministry staff internally in the event of an incident or outbreak.

Secondly, there is a system wide issue concerning the placement of those identified as being a close contact not having a suitable facility to self-isolate safely. There are various reasons individuals are unable to safely self-isolate e.g. living with family members or travellers. In this instance, 29 contacts were placed in managed isolation facilities (MIF) to self-isolate. A risk was identified in this area as there are no clear procedures in place for contacts or community cases in the event that they do not have anywhere to safely self-isolate. MBIE is responsible for the network of managed isolation and quarantine facilities, with the Ministry holding relevant health components. As multiple agencies contributed to this work, this will need to be escalated through the DPMC.

Other key pressures noted included:

- The impact of rapidly commissioned policy changes for programmes such as QFT and Alert Levels, on Ministry teams who were already fatigued from expanded business as usual deliverables.
- The limited capacity to redeploy workforce to operational areas in order to provide adequate surge. It was indicated that surge capacity could not sustain long periods of operation due to limited resourcing, e.g. testing can scale up to 40,000 swabs a day but can only be sustained at this level for a three-week period.

CONTACT TRACING AND TESTING

There were numerous lessons identified in the contact tracing and testing components of the response.

In this incident, over 2500 contacts were identified for a single traveller. Although the current contact tracing capability was able to cope in this event, it was recognised that a larger scale operation would put the National Investigation and Tracing Centre (NITC) under immense strain to

support the response to an incident or outbreak. In addition, there was QR code confusion, for example, one location may have one QR code for upstairs and downstairs areas. There is a need to ensure consistency of QR codes across locations so that they are easy to find and use, resulting in more people scanning and accurate location information.

There were capacity issues with testing stations in terms of availability, waiting times, appointments, drop ins, and priority groups for people who were identified as close contacts and at locations of interest. As a result, some people did not receive their test result within the 48-hour period. It was observed that PHUs need to update contingency plans to stand up sufficient testing sites to meet increased demand in response to an incident, especially with the emergence of more infectious variants of COVID-19 that could put immense strain on resources. In addition, people seeking information or guidance from Healthline often faced long wait times (in some instances, waiting times reached up to two hours) due to capacity challenges and the increase of callers. This resulted in many people giving up; increasing the risk of the public not getting the information they require.

RECOMMENDATIONS

As a result of the above findings, outlined below are recommendations to streamline and enhance the response to future incidents. These will be as part of SOP and process, amendments, to improve the Ministry's response to community outbreaks and incidents. The key themes identified to strengthen planning for, and execution of, future responses are:

1. **Further mitigate the risk of staff fatigue and workforce pressures** across the health system through providing resource support and assistance
2. **Re-evaluate the available surge capacity health workforce** so that the Ministry is well prepared to deliver increased operational resources in response to future incidents and/or outbreaks
3. **Examine communication channels with Australian counterparts** to reduce delays and ensure efficient information flow
4. **Review operational procedures and protocols** to adjust to developing COVID-19 situation, including the presence of the Delta variant and how this may affect our response processes and practice
5. **Explore self-isolation procedures** for individuals who are unable to self-isolate safely
6. **Improve communication, collaboration and engagement** across Government agencies so that decision makers are well supported and are provided with the best possible advice.

Many of these recommendations were already underway or already have existing processes in place during or shortly after this response was concluded. However, by undertaking this review and identifying recommendations, this provides the Ministry an opportunity to further strengthen its response processes and procedures.

NEXT STEPS

Identified actions to be implemented as a result of the key recommendations discussed can be found in Appendix 1.

In addition, the Ministry's practice to review and reflect on each incident has developed a culture of continuous improvement. As a result, actions will continue to be tracked and updated as part of our business-as-usual processes which includes sharing this review and the identified recommendations with the COVID-19 Independent Continuous Review, Improvement and Advice Group and Minister for COVID-19 Response.

APPENDIX 1: RECOMMENDATIONS

RECOMMENDATION 1: Further mitigate risk of staff fatigue and workforce pressures across the health system through providing resource support and assistance

Action	Owner	Progress	Status as of August 17 2021
Continue to monitor workload, fatigue and strain on PHUs and staff within the COVID-19 Directorate	GM COVID-19 Response and Coordination	Response team are continuing to offer support and assistance to PHUs as they manage high workloads. The COVID-19 Directorate is collaborating with the Ministry's Population Health and Prevention Directorate and Office of Director of Public Health to ensure there is an aligned work programme to assist PHUs address wider workforce and resourcing issues	Completed

RECOMMENDATION 2: Re-evaluate the available surge capacity health workforce so that the Ministry is well prepared to deliver increased operational resources in response to future incidents and/or outbreaks

Action	Owner	Progress	Status as of August 17 2021
Review external surge testing plans to support future national responses in light of more infectious variants	GM COVID-19 Testing and Supply	The Ministry's COVID-19 Testing and Supply Group have contacted all 20 district health boards (DHBs) to provide updated surge planning templates and have requested that the DHBs amend plans to ensure these plans are fit for purpose	Completed
Review contract tracing surge capacity plans to support future national responses in light of more infectious variants	GM COVID-19 Contact Tracing	The Ministry's Contact Tracing team is progressing work to address contact tracing surge capacity to ensure capacity to respond to more infectious variants. At the time of writing,	Completed

		a report is currently with Hon Chris Hipkins, Minister for COVID-19 Response, for his consideration. The Ministry will continue to update Ministers as this work progresses.	
Develop self-isolation options and alternatives for individuals who are unable to safely self-isolate	DPMC COVID-19 Response Group (Health input/DPMC led)	The Ministry has identified this issue with DPMC and they are working to identify suitable alternatives to address this issue.	Underway – to be competed by November 2021
Re-evaluate DHBs and PHUs contingency planning to stand up COVID-19 testing centres	GM Response and Coordination	The Ministry IMT are undertaking regional visits with all DHBs and PHUs to ensure readiness testing and provide assurance on contingency planning. This includes pre-identified pop up COVID-19 testing centres that have the ability to rapidly surge in response to a Delta variant outbreak or incident.	Completed

RECOMMENDATION 3: Examine communication channels with Australian counterparts to reduce delays and ensure efficient information flow

Action	Owner	Progress	Status as of August 17 2021
Continue to review the process of gathering information through Australian National Focal Point portal	GM COVID-19 Intelligence and Surveillance	There are monthly meetings with Australian counterparts that the Ministry attends to discuss a range of matters including information sharing and any issues that may arise with the current process. These have been very productive to date and the Ministry is continuing to build relationships with our Australian counterparts.	Completed

RECOMMENDATION 4: Review operational procedures and protocols to adjust to developing COVID-19 situation, including the presence of Delta

Action	Owner	Progress	Status as of August 17 2021
Review of COVID-19 response process in light of emerging Delta variant to ensure these methods are fit for purpose	GM COVID-19 Advisory	The Ministry has established an internal working group to drive a programme that will review each of the response areas and update them if necessary, to ensure they are fit for purpose to respond to the increased threat posed by the Delta variant.	Underway – to be completed by November 2021
Review of Alert Level frameworks in light of emerging Delta variant	GM System, Strategy and Policy	As part of the working group above, the Alert Level guidance will be reviewed to ensure that the framework is fit for purpose to respond to the increased threat posed by the Delta variant.	Underway - to be completed by November 2021
Review Public Health Risk Assessment criteria	Office of the Director of Public Health	As part of the workstream above, the Public Health Risk Assessment criteria will be reviewed to ensure that the framework is fit for purpose to respond to the increased threat posed by the Delta variant.	Underway to be completed by November 2021

RECOMMENDATION 5: Explore self-isolation procedures for individuals who are unable to isolate safely

Action	Owner	Progress	Status as of August 17 2021
Support the develop of self-isolation options and alternatives for individuals who have unsuitable facilities to safely self-isolate	DPMC COVID-19 Response Group (Health input/DPMC led)	The Ministry has identified this issue with DPMC and they are working to identify suitable alternatives to address this issue.	Underway – to be completed by October 2021

RECOMMENDATION 6: Improve communication, collaboration and engagement across Government agencies so that decision makers are well supported and are provided with the best possible advice.

Action	Owner	Progress	Status as of August 17 2021
Providing SOPs/diagram outlining sources of contact and how and when to engage with the Ministry of Health during a response to an outbreak and/or incident.	Manager, Office of the Deputy Chief Executive	The Ministry is reviewing and standardising our current approaches and finalising a flowchart for circulation to the relevant agencies in due course.	Underway – to be completed October 2021
Continue to clarify the key health messages and guidance provided to the public, so that there is greater public understanding of actions needed and decisions made. This will ease the current pressure felt by COVID-19 operations.	GM Communications and Engagement	The Ministry has further clarified our key messages about who needs to be tested, particularly with regards to secondary contacts (ie about them not needing to isolate or be tested, unless their contact develops symptoms); and communicate this to key stakeholders such as Ministers, DPMC, DHBs etc.	Completed
		The Ministry are also updating our 'easy read' materials on the website to ensure the most up-to-date public health advice is disseminated. The Ministry continues to work with the DPMC Communications team who are developing a fact sheet on staying at home/self-isolating for people with English as a second language or who have a disability.	Underway – to be completed September 2021

MINISTRY OF HEALTH
MANATŪ HAUORA

Briefing

Changes to implement shorter stay MIQ and self-isolation

Date due to MO:	4 November 2021	**Action required by:**	N/A
Security level:	IN CONFIDENCE	**Health Report:**	20212389
To:	Hon Chris Hipkins, Minister for the COVID-19 Response		

Contact for telephone discussion

Name	Position	Telephone
Maree Roberts	Deputy-Director General, System Strategy & Policy	s 9(2)(a)
Bridget White	Deputy Chief Executive, COVID-19 Health System Response	s 9(2)(a)

Minister's office to complete:

☐ Approved	☐ Decline	☐ Noted
☐ Needs change	☐ Seen	☐ Overtaken by events
☐ See Minister's Notes	☐ Withdrawn	

Comment:

MINISTRY OF HEALTH
MANATŪ HAUORA

Changes to implement shorter stay MIQ and self-isolation

Security level:	IN CONFIDENCE	**Date:**	04 November 2021
To:	Hon Chris Hipkins, Minister for COVID-19 Response		

Purpose of report

1. This paper updates you and seeks your agreement to changes for the implementation of shorter stay MIQ and self-isolation for people crossing the border into New Zealand.

Summary

2. This paper provides information on how the 7 days managed isolation followed by 3 days in self isolation will be implemented ahead of November 14.
3. We are proposing a high-trust model for the self-isolation component that requires people to stay at home, and will provide guidance to support self-management.
4. To manage the public health risk, we are enhancing the testing regime to allow for a day 0/1 test, day 3 test, day 5/6 test, a rapid antigen test on departure from Managed Isolation when required, and a compulsory day 9 test once in self-isolation.
5. We will be amending the COVID-19 Public Health Response (Isolation and Quarantine) Order 2020 to enact this new regime, and will be making subsequent amendments to the Air Border Order and Maritime Border Order to enact these changes.
6. There are processes underway to identify solutions to manage unique situations where people may not be able to enter self-isolation, or may require assistance to identify an appropriate setting for self-isolation.

Recommendations

We recommend you:

a)	**Note** that the changes we are proposing are necessarily light touch and high trust due to the low public health risk and competing pressures on the health and managed isolation system	**Noted**
b)	**Note** that people who are self-isolating will be expected to travel to their home or accommodation and be self-sufficient for 3 days, only leaving to undertake a day 9 test	**Noted**

c)	**Agree** that the COVID-19 Public Health Response (Isolation and Quarantine) Order 2020 be amended to reflect the 7 day managed isolation and 3 day self-isolation requirements	**Yes/ No**
d)	**Note** that we are developing guidance to support people during self-isolation, including access to health services	**Noted**
e)	**Note** that an email-based compliance check will occur on day 10 for those who have not yet accessed their day 9 test at a community testing centre, and then on days 11, 12, 13 and 14 if needed	**Noted**
f)	**Note** we are enacting changes to the Isolation and Quarantine Order and an associated direction under clause 9 of the Order to make tests on day 9 compulsory while people are self-isolating	**Noted**
g)	**Agree** to move from a day 6/7 PCR test to a day 5/6 PCR test to increase the likelihood that people will receive a test result prior to leaving managed isolation and to help manage workforce pressures	**Yes/No**
h)	**Agree** that rapid antigen tests are only used prior to departure when a day 5/6 PCR test result has not been received and the person is travelling outside of the Auckland region	**Yes/No**
i)	**Agree** that the Maritime Border Order is amended to align maritime arrivals to a 10 day isolation period	**Yes/No**
j)	**Note** that we are working through potential situations where the Maritime Border Order may need to retain a 14 day isolation period, including where people are not vaccinated or due to undertake onwards travel	**Noted**
k)	**Note** we are actively developing processes to enable day 9 testing including regulatory changes to make this compulsory	**Noted**
l)	**Note** we are not going to proceed with the saliva based PCR testing trial in MIQ facilities at this time due to resource pressures	**Noted**
m)	**Note** we are working to enact changes to relevant legislation to enable these changes to occur and you will receive further advice to enact these changes	**Noted**

Dr Ashley Bloomfield
Director-General of Health
Te Tumu Whakarae mō te Hauora
Date: 4/11/2021

Hon Chris Hipkins
Minister for COVID-19 Response
Date: 5/11/21

MINISTRY OF HEALTH
MANATŪ HAUORA

Changes to implement shorter stay MIQ and self-isolation

Context

1. On 28 October 2021 Ministers agreed to shorter stays in MIQ and self-isolation until receipt of a negative day 9 test result from 14 November 2021 for those arriving by air [HR20212360 refers].
2. The length of stay in managed isolation will reduce from 14 days (336 hours) to 7 days (168 hours) followed by self-isolation until individuals return a negative day 9 test before they are able to exit self-isolation. Note that this may mean a slightly longer period of self-isolation than 3 days, depending on lab turnaround times from the day 9 test.
3. This paper provides information on how we will implement these changes.
4. These changes are taking place at a time when the MIQ and health system are both under considerable pressure. Given the limited public health risk from reducing MIQ stays, we have prioritised light touch and high trust interventions where possible.
5. The changes also provide an opportunity to trial self-isolation at scale and learn for future changes to support a greater role for large scale self-isolation.

Changes to implementation shorter stay MIQ and self-isolation

Testing regime

6. There are several changes to the testing regime that are recommended in order to better align with shorter stays in MIQ and the self-isolation component.

Shifting to a day 5/6 test from a day 6/7 test

7. To support more people receiving the result of their last PCR test before they leave MIQ, we recommend changing to a day 5/6 test from the current day 6/7 test.
8. This change has a range of benefits. It spreads out the testing workload for the MIQF health workforce, managing surges in demand for testing that could exceed workforce capability in MIQ facilities. There is a real risk that if we remain with day 6/7 testing as well as additional rapid antigen tests on departure, some testing could not occur due to workforce limitations.
9. Changing the day of testing would also reduce the likelihood that a rapid antigen test would need to be used, as the confirmatory PCR test would have already been received. This helps to manage the risks of false positive test results delaying travel.
10. From a public health perspective there is a low risk of missing cases by testing a day or two earlier, especially given the low numbers of cases in MIQ and the earlier

identification of positive cases through testing of the Delta variant. The addition of day 9 tests also helps to promptly identify cases that may emerge later.

Implementing day 9 testing

11. The day 9 test will need to be provided through a community testing centre or by GPs. Access to the day 9 test may be limited in some cases, especially remote areas of New Zealand with no weekend testing providers and where people need to travel many hours to their closest community testing centre or GP.

12. Testing on day 9 will be compulsory, as required by the testing requirement in the Isolation and Quarantine Order. Compliance will be tracked through an automated system that will send emails to people who have not undertaken a test on day 9, on days 10 through 14 as needed.

13. The Ministry for Business Innovation and Employment (MBIE) is preparing changes to the Isolation and Quarantine Order to enact the changes to Managed Isolation and the 3 day self-isolation requirement, as well as acting on advice from the Ministry of Health to make a day 9 test compulsory.

Rapid antigen testing on departure from Managed Isolation

14. We recommend the use of rapid antigen tests only when the result of the day 5/6 test has not been received prior to an individual's scheduled release on day 7.

15. The use of rapid antigen testing will be a new process in MIQ facilities. We recommend that rapid antigen tests are only required of those who have not yet received their result from a day 5/6 test and those who are travelling outside the Auckland region.

16. We propose the testing will be conducted by a MIQ health worker and provide a level of assurance pending the result of the PCR test result. It will also help to streamline and not hold up the departure process.

17. The change in approach from elimination to managed protection in Auckland means that the use of rapid antigen tests to promptly identify cases is of less value. Other regions in Alert Level 3 will still require testing before travel particularly to provide an added layer of assurance for those without day 5/6 test results if they are using public transport (e.g. domestic flights) to travel to their place of self-isolation.

18. When a rapid antigen test provides a positive result, the person will need to remain isolated until the result of the PCR test is received. If both the rapid antigen test and PCR test are positive, they will be required to enter quarantine or self-isolation depending on the assessment of the Medical Officer of Health

Saliva testing

19. With the shortening of MIQ stays, Ministers agreed to pause the pilot to introduce saliva testing at MIQFs. DHBs will continue to use PCR nasopharyngeal tests in the new shorter duration model MIQF system as these are considered the best test for the purpose of diagnosing COVID-19 in facilities before returnees are released into self-isolation, and because the operational processes for administering nasopharyngeal swabbing are well established.

20. We will re-visit whether and how saliva testing could be incorporated into the returnee testing regime in the first quarter of 2022, once these changes to the MIQF system are bedded in.

Review of testing regime for managed isolation and self-isolation

21. As part of implementing these new changes, we will be conducting a review of the new testing regime and assessing implementation. The review process will inform future changes to the testing process, particularly for those in self-isolation.

Self-isolation component

Self-isolation will be similar in practice to self-isolation for low-risk contacts

22. The self-isolation approach for those arriving by air will be light touch and high trust. There is a relatively low risk to public health by those arriving by air self-isolating compared to the public health risks posed by community cases or close contacts, particularly in the Auckland region.

23. Individuals will be strongly encouraged to self-isolate in a dwelling that does not accommodate anyone except themselves and their travel bubble members. However, if this is not available, self-isolating in a household with whānau or friends that are already in Aotearoa New Zealand will be permitted. In this instance, self-isolation involves isolating away from other members in the household (for example, have no physical contact, minimise time in shared spaces like kitchens and bathrooms, and do not share items such as cutlery and linen) while in their home or accommodation.

24. No visitors to the household will be permitted during the period of self-isolation, however, household members who are not part of the travel bubble will not be required to self-isolate i.e. they will be permitted to go to work and school while the returnee(s) are self-isolating.

25. Unlike in the self-isolation pilot, no restrictions will be placed on the nature or requirements of the self-isolation dwelling (e.g. specific ventilation requirements), except that:

    a. It cannot be in a shared accommodation venue that requires use of facilities (e.g. bathrooms and/or kitchens) that are shared with someone that the returnee does not know (e.g. hostels, boarding houses), and

    b. It must be somewhere with cell-phone coverage, so that returnees can be called and/or texted by public health officials if needed, and

    c. It must be somewhere from which the returnee(s) can access a COVID-19 testing centre, so that they can meet the requirement to be tested on day 9.

26. There will be no individual assessment of people's self-isolation plans before they leave. People will be provided communication to ensure they understand expectations of them and how to raise questions or concerns.

27. People will travel to their home or accommodation and be expected to stay there until they receive a negative day 9 test result. Private transportation (i.e. self-driving) will be strongly recommended. However, if this is not available, they will be permitted to use public transportation (e.g. taxis or domestic flights) to travel to their place of self-

isolation. It is not operationally feasible to require or provide private transportation services for all those entering self-isolation.

28. Returnees will be advised to adhere to typical public health measures during travel, including mask use, maintaining physical distancing from those not in their bubble where possible, and performing regular hand hygiene. Returnees will be advised to take the fastest and most direct route to their place of self-isolation, and will not be permitted to stop at public venues (e.g. supermarkets) or visit people along the way.

29. Returnees will be responsible for their own basic supplies during their period of self-isolation. People will be encouraged to have supplies delivered wherever possible, however we acknowledge that will not always be possible.

30. We are developing guidance for self-isolation that will cover where people can access support and health care, wellbeing advice, information on testing, as well as self-isolation requirements. This guidance will be shared with returnees at multiple points prior to their travel (e.g. on public websites and in MIAS), as well as during their stay in a MIQF.

This will operate as a high trust model

31. Given the lower public health risk of people in self-isolation in this model, the need for intensive compliance monitoring is lower. Given resource restraints, we will not be able to review self-isolation arrangements.

32. A final health check will be completed on leaving the MIQ facility and no further health checks will be completed during the final three days of self-isolation. People will be given clear guidance on what to do if they develop symptoms during that period which will require them to contact Healthline or their GP.

33. People who do not attend testing on day 9 will be in breach of the Isolation and Quarantine order. People are released from self-isolation once they receive the result of their day 9 test.

People who self-isolate will have access to health support

34. People will have access to Healthline, or their GP, as a first point of contact for health issues. As part of guidance provided to people in self-isolation, we will provide advice on how they can contact Healthline (or their GP), and wording to declare that they are currently in self-isolation. Healthline will be able to triage people and provide advice on access to further health services.

35. We will not be conducting daily health or symptom checks during the self-isolation period. The email on days 10 to 14 will be to check for compliance when a test has not been completed. If a person becomes unwell, they will call their GP or Healthline advising that they are a recent returnee, or go to a community testing centre to be tested.

Isolation requirements for specific groups

36. We expect that nearly all people will be able to go into self-isolation after 7 days, however we are working with MBIE on the implications of the change for specific groups, including people travelling to Antarctica, sports teams and Russian mariners.

Maintaining a fixed 7 day time period assists planning, and prevents potential inequities where blanket rules could lead to inequities between groups.

37. We are working through what will happen in particular cases where people will be unlikely to have access to accommodation or be subject to particular requirements during the transitional period, including refugees, '501' deportees or people travelling to Antarctica.

Management of positive cases

38. If cases are identified in Managed Isolation, they will continue to be treated in the same way as current cases, i.e. they will be transferred to quarantine. If people have symptoms, but no positive test result, these cases will be screened through the low-risk indicators process and released following clearance from a health professional following existing processes and protocols.

39. For cases identified when people are self-isolating, their management will depend on their accommodation and any other needs that they may have. We are proposing that as with other community cases, they will be assessed by a Medical Officer of Health and an appropriate plan put in place.

Regulatory changes to enable these changes

Changes to the IQO will be enacted

40. Changes to the COVID-19 Public Health Response (Isolation and Quarantine) Order 2020 will be made to reflect the change to a 7 day managed isolation stay followed by 3 day self-isolation. We will also be developing changes to enact the compulsory day 9 test for people in self-isolation. We will also be drafting subsequent changes to the Air Border Order and Maritime Border Order to reflect the shorter MIQ stay.

Changing the Maritime Border Order to align to the IQO

41. We seek your approval to amend the Maritime Border Order to reduce the length of isolation from 14 days to 10 days to align with the changes for those arriving by air

42. Consistency across the air and maritime border in terms of isolation period is important. A difference in isolation period for those coming across the maritime border could result in an inequitable outcome for both the commercial and recreational maritime sector.

43. The risk associated with reducing the isolation requirements at the maritime border is considered to be manageable. This reflects that the incubation period of the Delta variant is less than 10 days and that there are a range of stringent public health controls in place for seafarers disembarking their vessel. If crew are seeking shore leave, they must satisfy the low-risk indicators of a negative PCR test and be permitted to disembark by the Medical Officer of Health situated at the port.

44. For the majority of recreational maritime vessels, the transit time to New Zealand is usually longer than 14 days and they tend to have smaller crew sizes that are arriving from lower-risk countries (i.e. Pacific Countries).

45. We are working through potential circumstances where a longer stay in MIQ may be required.

Equity

46. Those returning to New Zealand should not have to stay in MIQF any longer than is necessary to protect the public health of New Zealanders.

47. Recent evidence indicates that the increased risk of transmission of COVID-19 from reducing a returnee's isolation period to 10 days is low, with the series of tests and other appropriate mitigations now in place. This is consistent with our proposed approach to the management of community close contacts.

48. Reducing the length of stay in MIQF will half the cost for returnees making the system more affordable and equitable to a wider range of people.

Next steps

49. We are continuing work on detailed implementation planning. We will be working closely with MBIE and other agencies to develop appropriate support for people who will not be able to self-isolate. The expectation is that people leave Managed Isolation on day 7, unless there is an exceptional reason.

50. Health and MBIE will continue to work through the legislative options. We will provide advice on enacting changes to the COVID-19 Public Health Response (Isolation and Quarantine) Order 2020, and subsequent regulatory changes outlined in this briefing before 14 November.

51. We have recently met with the Office of the Ombudsman who are keen to proactively engage to support the development of processes that are consistent with relevant human rights frameworks. We will work with them as we fine tune proposals.

ENDS.

Document 3

Briefing

Public health settings for medium-risk pathway

Date due to MO:	18 November 2021	**Action required by:**	19 November 2021
Security level:	IN CONFIDENCE	**Health Report number:**	20212528
To:	Hon Chris Hipkins, Minister for COVID-19 Response		

Contact for telephone discussion

Name	Position	Telephone
Maree Roberts	Deputy Director-General, System Strategy and Policy	<Mobile>
Stephen Harris	COVID-19 Policy, System Strategy and Policy	<Mobile>

Minister's office to complete:

☐ Approved ☐ Decline ☐ Noted

☐ Needs change ☐ Seen ☐ Overtaken by events

☐ See Minister's Notes ☐ Withdrawn

Comment:

Public health settings for medium-risk pathway

Security level:	IN CONFIDENCE	**Date:**	18 November 2021
To:	Hon Chris Hipkins, Minister for COVID-19 Response		

Purpose of report

1. This briefing seeks your approval on public health settings for the medium-risk pathway as part of the plan for Reconnecting New Zealanders with the world.

Summary

2. New Zealand is now entering the next phase as we near a 90 percent vaccination rate across the country and we shift our Elimination Strategy to a minimisation and protection approach and adopt the new COVID-19 Protection Framework [CAB-21-MIN-0421].

3. Under the new approach – and with increasing vaccination rates – many systems and processes designed with the goal of stamping out COVID-19 must now be adjusted to reflect the new goals of minimising the spread of COVID-19 in the community and protecting those most vulnerable to the disease and ensuring the health system is not overwhelmed.

4. This shift in our overall context is also shaping the way we reconnect with the world; settings for arrivals is adapting to reflect the changing risk. Critically, as part of the Reconnecting New Zealanders strategy, international travellers self-isolating is intended to become one of the primary ways that people enter New Zealand from early 2022.

5. This approach for medium-risk travellers will complement low- and high-risk pathways as part of the risk-based approach to international arrivals Cabinet has agreed to adopt.

6. Even with high vaccination rates domestically and internationally, and a general reduction in risk of international arrivals transmitting COVID-19, residual risks are likely to remain for categories of international travel.

7. For this reason, we will need to implement public health settings and entry requirements for incoming travellers under medium risk-pathway to reflect and manage the evolving level of COVID-19 risk posed.

8. This paper seeks your decision on the public health requirements under the medium-risk pathway including vaccination, testing and isolation settings.

Recommendations

Document 3

We recommend you:

a)	**Note** that opening the border under steps 1 and 2 of the medium-risk pathway for Reconnecting New Zealanders require consideration of public health settings to reflect and manage the evolving level of COVID-19 risk posed	**Yes/No**
b)	**Note** that as part of the Reconnecting New Zealanders strategy, international travellers self-isolating is intended to become one of the primary ways that people enter New Zealand from early 2022	**Noted**
c)	**Note** that recent Hight Court ruling has thrown into question the NZ BORA public health justification of the MIQ requirements for New Zealand arrivals	**Noted**
d)	**Note** that this ruling and expected further legal challenges mean we must consider self-isolation for both vaccinated and unvaccinated New Zealand arrivals	**Noted**
e)	**Agree** to one of the following options for vaccination requirements for arrivals under the medium-risk pathway:	
	i. Allow all returnees regardless of the vaccination status, to go into self-isolation with 7 days for vaccinated and 10 days for unvaccinated; or	**Yes/No**
	ii. Allow all returnees regardless of the vaccination status, to go into self-isolation except for unvaccinated individuals arriving from higher risk countries, who will need to go into MIQ	**Yes/No**
f)	**Agree** that the current standards for pre-departure testing are continued under the medium-risk pathway	**Yes/No**
g)	**Note** that public health advises that mixed flights do not pose a risk as long as other checks are in place including vaccination, isolation, and testing requirements.	**Noted**
h)	**Note** that to manage risk on arrival, the most effective option would involve an initial test, either by RAT or PCR	**Noted**
i)	**Agree** we recommend that a RAT is the most effective test to conduct at the airport but could pose significant operational challenges	**Yes/No**
j)	**Agree** to require self-declaration of previous 14 days travel history for arrivals under the medium-risk pathway	**Yes/No**
k)	**Agree** that self-isolation and quarantine of returnees under the medium risk pathway will be under the same conditions as for cases and contacts in the community, and will include:	
	i. No limitations or requirements on how people travel from their arrival airport to their location of isolation/quarantine	**Yes/No**
	ii. No limitations on where people undertake self-isolation or who may be present in the home in the home while a person is undertaking	**Yes/No**

self-isolation. However, if a returnee were to test positive, their household contacts would be required to self-isolate for 7 days (vaccinated) or 10 days (unvaccinated)

iii. duration of self-isolation of 7 days for vaccinated and 10 days for unvaccinated returnees **Yes/No**

l) **Agree** that testing for returnees in self-isolation would be day 0/1 test and a day 5/6 test **Yes/No**

m) **Agree** that if a returnee tests positive while in isolation, they contact Healthline **Yes/No**

Maree Roberts
Deputy Director-General
System Strategy and Policy
Date: 18 November 2021

Hon Chris Hipkins
Ministry of COVID-19 Response
Date:

Health settings for medium-risk pathway

Context

9. New Zealand is now entering the next phase as we near a 90 percent vaccination rate across the country and we shift our Elimination Strategy to a minimisation and protection approach and adopt the new COVID-19 Protection Framework [CAB-21-MIN-0421].

10. Under the new approach – and with increasing vaccination rates – many systems and processes designed with the goal of stamping out COVID-19 must now be adjusted to reflect the new goals of minimising the spread of COVID-19 in the community and protecting those most vulnerable to the disease and ensuring the health system is not overwhelmed.

11. The ongoing Delta outbreak is also part of our changing context in terms of our domestic risk profile and providing us with community models of care and support.

12. This shift in our overall context is also shaping the way we reconnect with the world; settings for arrivals is adapting to reflect the changing risk. Critically, as part of the Reconnecting New Zealanders strategy, international travellers self-isolating is intended to become one of the primary ways that people enter New Zealand from early 2022.

13. This approach for medium-risk travellers will complement low- and high-risk pathways as part of the risk-based approach to international arrivals Cabinet has agreed to adopt.

14. Even with high vaccination rates domestically and internationally, and a general reduction in risk of international arrivals transmitting COVID-19, residual risks are likely to remain for categories of international travel.

15. For this reason, we will need to implement public health settings and entry requirements for incoming travellers under medium risk-pathway to reflect and manage the evolving level of COVID-19 risk posed.

16. This paper seeks your decision on the public health requirements under the medium-risk pathway including vaccination, testing and isolation settings. These settings aim to provide the base on which specific measures can be built, maintained, and adjusted in response to developments. It does not address operational consideration, which will be subject to separate advice including from other agencies.

17. The advice set out in this briefing for the medium-risk pathway ties in with the recent advice to you on the updated public health risk assessment of current border settings. That assessment concludes that the risk presented by cases arriving at the border has changed, and self-isolation is now considered a more proportionate management measure for most arrivals. This advice on also notes that any transition will need to be carefully managed to reduce potential impacts on communities and the health system resulting from the risks of changing from one system to another too quickly.

Expected stages of the medium-risk pathway

18. On Monday 15 November 2021, Cabinet endorsed the approach to Reconnecting New Zealanders with the World, by opening up the medium-risk pathway in the following steps:

a. Step 1 – opening the medium-risk pathway to fully vaccinated New Zealand citizens, residence-class visa holders, and other travellers eligible under our current restrictive border settings from Australia from 11.59 pm on 16 January 2022 (provided they have been in Australia or New Zealand for the past 14 days);

b. Step 2 – expanding the medium-risk pathway to fully vaccinated New Zealand citizens, residence-class visa holders, and other travellers eligible under our current restrictive border settings, from all but higher-risk countries, by 14 February 2022, with staging if required;

c. Step 3 – expanding the medium-risk pathway to fully vaccinated foreign nationals (possibly staged by visa category) by 31 May 2022.

19. Under step 1, we expect approximately 9,000 arrivals a week. While in step 2, we would open up to significant extra volumes and a wider lane of risk. However, we envisage that the same public health settings would manage the risk proportionately.

Timing of reopening will align with domestic settings

20. To achieve our goals of protecting people and minimising health impacts by containing outbreaks, we will need to be confident in the effectiveness of the COVID-19 Protection Framework to manage COVID-19 and protect the vulnerable alongside changes to our border settings.

21. This includes ensuring that changes to domestic settings, such as the increased movement across the Auckland boundary, are bedded in before significant changes are made to border settings.

22. Health system preparedness must also be taken into consideration as measures to allow greater freedom of movement, both domestically and across our borders, must not create undue impacts on the health system's ability to cope. There will be increased pressures in the next few weeks to manage COVID-19 domestically, including supporting cases to isolate safely at home.

23. We will learn more about how to support returnees to self-isolate and quarantine more successfully during an initial period at step 1 that will inform a more sustainable model of self-isolation and quarantine at step 2 and beyond.

Public health requirements for medium-risk pathway

24. The medium-risk pathway aims to ensure that there are suitable risk mitigations in place for travellers in line with our minimisation and protection strategy, while also enabling a larger number of travellers to enter New Zealand. In essence this means detecting as much as possible infection prior to departure using PDT and using vaccination status as a measure of protection to guide management of individuals after arrival.

25. The following section lays out the proposed settings to inform Cabinet advice. We note that any final settings will be subject to a public health assessment at the time of reopening to ensure they are proportionate to the level of risk posed.

Holding risk off-shore – pre-departure settings

Pre-departure testing will remain a measure to hold risk offshore

26. A negative pre-departure test prior to boarding provides a key layer of protection by detecting and holding risk offshore.

27. It is recommended that the current standards are continued as we move forward with the medium-risk pathway. Currently, to enter New Zealand, most travellers are required to have a negative COVID-19 test within 72 hours of their first international departure. This can be a PCR, LAMP, or antigen test.

Rapid-antigen test at point of departure has been explored

28. Current options for testing at the point of departure include rapid antigen testing (RAT) and PCR testing. Rapid antigen testing is a potential tool to enable quicker COVID-19 testing, as some tests are capable of point of care and community-based application.

29. RATs which usually test anterior nasal swab samples (that can be self-collected, or collected by a healthcare worker), are able to provide a much quicker turnaround time for individual tests than most polymerase chain reaction (PCR) tests and have the potential to be deployed as point of care or self-tests without the need for a laboratory. While these are highly desirable characteristics, the main disadvantage of RATs is reduced sensitivity when compared with PCR testing.

30. Rapid antigen test at departure has been explored as a possible option to provide assurance that a person is not acutely infectious during travel and therefore reduces the chance of in-flight transmission. Current options require significant oversight, space to conduct at any volume, and time before results are known. One option, yet to be explored, might be to conduct any RAT pre-departure, eg in a departure area, while passengers are held in a confined area for a sufficient period before boarding.

31. However, given the expected volumes, there are constraints around feasibility of this measures, particularly in countries/airports that are not as well-resourced.

Establishing vaccination status

32. If we are to differentiate between vaccinated and unvaccinated, it is also critical to define what we mean by 'fully vaccinated'. The efficacy of different COVID-19 vaccines currently in use internationally varies. While most vaccines offer protection against severe disease and illness, some do not appear to offer the same level of protection against infection and transmission.

33. On 11 November, you agreed that the recognised vaccines for New Zealand's definition of "fully vaccinated" are any of the Medsafe or World Health Organization Emergency Use Listing approved vaccines.

34. It is expected that where unvaccinated children under 17 are travelling with adults who are eligible for the medium-risk pathway, they will enter on the same entry pathway as their adult guardians.

Vaccination credentials are also a critical consideration

35. Since 1 November, for all non-New Zealand citizen arriving by air must provide proof of vaccination, in order to enter MIQ. Under this policy a broad approach has been taken for

defining what will constitute proof of vaccination, given that additional risk mitigation measures are in place (including testing, isolation and quarantine). This decision reflects a number of pragmatic and equity-related factors.

36. For the medium risk pathway, we may wish to apply a more rigorous approach, in order to have greater confidence in the authenticity, integrity and validity of the documentation. However, if we were only to accept digital certificates in the medium-risk pathway, there may be unacceptable trade-offs such as NZ BORA and equity impacts for those who were vaccinated in countries that do not issue digital certificates.

37. Under Reconnecting New Zealanders step 1, we can assume that most returning New Zealander citizens and residents entering via Australia will hold a digital vaccination certificate issued in either New Zealand, Australia, the United Kingdom or one of the other 49 countries who are members of the EU Digital COVID-19 Certificate framework. However, not all will hold such certification.

38. As the Travel Health Declaration System will not be operational until later in Q1 2022, assessing vaccination status will need be done in person, by presenting a document to a border official for checking. This will require manually checking both the pre-departure test document and the vaccination document and will have impacts on managing passenger flow through airports.

39. While needing to have reasonable confidence in the authenticity of vaccination documentation, it is recognised this is another layer in the COVID-19 protection, and therefore understanding some level of risk may be acceptable.

Vaccination status of returnees may need to be considered as part of entry requirements

40. In all our previous advice on risk-based pathways under the Reconnecting New Zealanders framework, the Ministry of Health has recommended that any returnees coming through the medium-risk pathway should be fully vaccinated with appropriate credentials.

41. However, the public health advice on this issue has shifted: to recommending entry of both vaccinated and unvaccinated returnees through the medium-risk pathway. This is due to the high vaccination rates domestically, which shifts the risk calculus and puts in question the public health justification under the New Zealand Bill of Rights Act 1990 (NZ BORA) to require vaccination as entry requirements.

En-route settings

42. Under the risk-based approach, it is assumed that the risk-profile of travellers on some flights will be mixed, which may include some vaccinated and non-vaccinated travellers on the same flight. Additionally, many airlines will not allow non-vaccinated passengers to board.

43. Based on public health advice, we do not consider that mixed flights pose a risk as long as other checks are in place including vaccination, isolation, and testing requirements.

Post-arrival settings

44. Public health advice has maintained the value of MIQ for unvaccinated arrivals. The recent High Court ruling in the Bolton case has not changed this public health rationale, but it is expected to continue to be tested in the courts. The public health view is that we can manage the possible risk presented by unvaccinated returnees not just through short-stay MIQ, but also through other measures, including self-isolation and testing. COVID-19 Vaccination Certificate (CVC) requirements will allow us to buffer the risks presented by

unvaccinated returnees, who would be limited in their access to many domestic locations without a CVC.

45. We have considered the option of allowing only fully vaccinated returnees to enter through the medium-risk pathway. This would reduce any infection risk presented by unvaccinated returnees – which current evidence shows is around three times higher than from a vaccinated individual. The likelihood of legal challenges referred to above makes this option less tenable.

46. Therefore, there are two options regarding for vaccination requirements for the medium-risk pathway:

> **Option 1** – Allow all returnees, regardless of the vaccination status, to go into self-isolation with 7 days for vaccinated and 10 days for unvaccinated; or
>
> **Option 2** – Allow all returnees, regardless of the vaccination status, to go into self-isolation except for unvaccinated individuals arriving from higher risk countries, who will need to go into MIQ. This is because the residual risk presented by these individuals is greater than posed by unvaccinated individuals from lower risk places (eg low-risk Australian states).

47. Should unvaccinated arrivals bypass MIQ we recommend they be required to self-isolate for 10 days, as opposed to seven days for vaccinated New Zealand arrivals under steps 1 and 2 of the medium-risk pathway.

Arrival settings

Initial testing

48. Point of arrival testing has been considered as an option for an added layer of protection. It has shown to detect a significant number of cases - previously 60% of cases were detected through this test but this percentage has dropped more recently. There are a few options for conducting the initial test:

RAT for point of arrival testing at the airport

49. The advantages of RAT are that the test itself is straightforward to perform on an individual. From the point the swab is collected, it is only 15 minutes before a result can be read. The Auckland Airport trial has shown that the use of the RAT test is currently not significantly affecting processing rates due to low demand.

50. However, with expected volumes, this will likely change, and it may not be feasible to conduct this test on every returnee. The delays in conducting the tests and awaiting the results, plus operational logistics including having sufficient workforce and infrastructure remains a key concern.

51. Further, the public health perspective is that RAT on arrival is most effective for people that are highly infectious, so there is some merit in having capability present at the airport to conduct RAT on arrival for some categories of arrivals, eg those who are unvaccinated or coming from higher risk places, or who are symptomatic.

52. RAT can be through nasal or mouth swab, or through a saliva sample.

53. Operational agencies support the option of having some RAT capability at the airport that would allow us to test some categories of passengers when and if needed. It is expected that all airports have existing provisions to facilitate the option of some RAT testing.

PCR as option for point of arrival testing at the airport

54. Alternatively, PCR testing has been considered as an option. However, there are several constraints, particularly laboratory capacity. Another significant issue is that we lose the benefit of seeing the results immediately (as we would with RAT) and there is a risk of PCR picking up historical cases.

PCR as option for testing at Day 0/1

55. Day 0/1 PCR testing is currently being used and remains a reliable option. This could be an alternative to a test at the airport as the test at the start of the home isolation/quarantine period.

Verification on arrival at the airport

56. Self-declaration of previous 14 days travel history is recommended.

57. This requirement should remain as we still have the 'very high risk' (VHR) countries category. Additionally, knowledge of travellers' routes to New Zealand is needed to enable ongoing monitoring of any potential traveller origin specific risks including the emergence of new variants.

Self-isolation settings

58. Any domestic settings imposed on returnees will need to align with the shift in our management of cases and contacts in the community, with self-isolation and self-isolation now being the default position. As we are no longer generally managing close contacts of cases in a managed isolation facility, there is a case for treating New Zealand international arrivals in the same way, because we now consider the risks posed by both groups of people to be broadly equivalent.

Duration and location for self-isolation and quarantine of returnees

59. In order to facilitate a large and increasing number of travellers is recommended entering through the medium-risk pathway, a high-trust approach will need to be taken to self-isolation requirements, supported by appropriate, targeted testing. A high-trust approach is also consistent with the level of public health risk posed by travellers entering through the medium-risk pathway not being significantly greater than the infection risk from cases in the community.

60. Broadly, and as agreed in the recent joint briefing between the Ministry of Health and the Ministry of Business, Innovation and Employment [HR 20212434 refers], we recommend that this includes:

    a. no limitations or requirements on how people travel from their arrival airport to their location of isolation; and

    b. no limitations or requirements on where people may undertake their self-isolation or who else may be present in the home while a person is undertaking self-isolation. However, if a returnee were to test positive, their household contacts would be required to self-isolate for 7 days (vaccinated) or 10 days (unvaccinated).

61. In line with the management of close contacts of community cases, we also recommend the duration of self-isolation for returnees coming under the medium-risk pathway to be 7 days for those who are vaccinated, and 10 days for those who unvaccinated (if they are allowed to bypass MIQ).

62. We recommend that support is traveller-initiated and in-home welfare support for people undertaking their self-isolation is focused on highlighting existing community services to travellers, with the expectation that they would be 'self-sufficient'.

63. Further consideration will be given to directing travellers towards resources that they can access through existing community services that can be accessed remotely (eg Healthline). This mirrors the approach recommended for travellers self-isolating under the current short-stay MIQ model[1].

Testing requirements for self-isolation and quarantine of returnees

64. This period of self-isolation will be supported through appropriate, targeted testing that will allow us to find cases among the returnees.

65. It is likely that there is a greater risk of transmission for close contacts of community cases, as compared to returnees. This has implications as to where we target the resources of discretionary testing.

66. Our recommended testing requirements for returnees who are self-isolating would be the same as we do for close contacts of community cases – day 0/1 test and day 5/6 test. This will ensure consistency but may mean that resources are diverted from community where they are needed more.

67. Within these the initial settings, the default for the test would be a PCR. As we move forward, we may start seeing a transition to more usage of RAT. However, there are concerns about how effective a RAT may be when self-administered.

Escalation pathway for returnees who test positive

68. We recommend that if returnee tests positive while in isolation, they are expected to contact Healthline and follow the instructions.

Compliance and monitoring requirements will be a high-trust, low touch model

69. Issues of compliance are still being worked through with the relevant agencies.

Equity

70. Those returning to New Zealand should not have to stay in MIQF any longer than is necessary, if at all, to protect the public health of New Zealanders.

71. However, we need to still take some risk mitigation measures. If a large number of additional COVID-19 cases are seeded at the border, there is a risk that there may be some additional health and non-health effects of COVID-19 in the community. We know that COVID-19 has had a disproportionate health impact on Māori and Pacific communities as Māori, and younger age groups of Pacific peoples currently have low rates of vaccination compared with the wider population and could be disproportionately impacted.

72. The settings outlined in this briefing will help to ensure that the impacts of COVID-19 in the community are minimised, and that vulnerable population groups are protected.

[1] This approach is for travellers who are self-isolating, and is distinct from health and welfare support that is provided to individuals who test positive for COVID-19 and are medically assessed as being able to safely and appropriately isolate at home. Such individuals will continue to receive appropriate support under the care in the community model.

Next steps

73. This advice will feed into Reconnecting New Zealanders paper going to the Cabinet on 22nd November 2021 and will subsequently feed into the expected government announcements relating to the Reconnecting New Zealanders' plan.

ENDS.