6 May 2021

Hon Chris Hipkins
Minister for COVID-19 Response
Parliament Building
Wellington
New Zealand

Dear Minister Hipkins

COVID-19 Independent Continuous Review, Improvement and Advice Group rapid review of Auckland February 2021 outbreak

You have requested as part of its initial work that the COVID-19 Independent Continuous Review, Improvement and Advice Group undertake a rapid review of the Auckland February 2021 Outbreak to identify opportunities for continuous improvement in the ongoing response to COVID-19. That phase of work is now complete.

Overall, while we found that the February response builds on some lessons from previous outbreaks, there are a number of areas where continuous improvements should be made to further enhance and de-risk performance.

Relationships between the operational agencies and other groups including the Auckland Regional Public Health Service (ARPHS), the Northern Region Health Coordination Centre and Papatoetoe High School worked well during the response. While we acknowledge that connections and engagement between central government agencies and the Auckland operational agencies have improved, from conversations held with these operational agencies, it appears that in spite of the challenges in working with the Ministry of Health, they did well to respond how they did and be as connected as they were with each other.

Furthermore, we have observed that relationships and communications between central government agencies are not working optimally. This lack of coherency between central agencies in terms of messaging, instructions and leadership has caused uncertainty and confusion for broader stakeholders such as businesses.

While recommendations have been made multiple times from earlier reviews, scenario planning has not been carried out. We do note that the table-top exercises held prior to Christmas improved the system's ability to coordinate itself in certain outbreak events over the summer period, which in itself reveals how key scenario planning is for system readiness.

While we recognise that the Ministry of Health's establishment of formal Incident Management Team leadership and their increased internal use of epidemiological and other scientific advice through their Science and Insights Group is encouraging, we strongly recommend that there is formal input of external scientific expertise through established processes to incorporate external expert peer review and advice.

The shift to an early aggressive approach to attempt early elimination is a sound use of system capacity. However further thought needs to be given to the formalisation of this approach and

the use of the additional contact categories reconsidered given the complexity and confusion they have caused. We recommend that the contact categories return to two (close and casual) and that individual outbreak plans define what is required for close and casual contacts. This will be different for the aggressive and standard approaches and for particular scenarios, such as a school.

We also note that there did not appear to be a clear plan for communication about the early aggressive approach, with mixed messaging across various platforms. It is important to get the timing and content of messaging as clear and simple as possible. We cannot afford to lose the confidence and trust of the public by creating unnecessary complexity or airing conflicting messages. Consideration of the diversity of communities also needs to occur in developing communications to ensure these are appropriate, targeted, timely and effective. To that end, we need to continue to refine the messaging and broader communications strategy.

We acknowledge there has been increased focus on equity through the use of Pae Ora and Pacific teams in the Public Health Unit, engagement with Whānau Ora commissioning agencies and providers, and improved wrap-around care and support for contacts. While this is a pleasing development, we have identified further areas that need focus to address the challenges faced by diverse communities. Given the elevated risk profiles of these groups, ongoing attention and engagement with such groups will be critical to ensure successful responses in the future.

We also commend the maintenance of testing timeframes at a 'gold standard' throughout the outbreak.

The stretched workforce and general signs of weariness and fatigue together with system capacity issues are of particular concern. The fatigue factor is completely understandable at a human level and the demands that have been placed on people within the system are extraordinary. However, experience suggests that when such behavioural conditions prevail, the ability of the system and those involved to innovate and adapt is compromised. This puts the operating model at significant risk. We are encouraged by the work being undertaken by the Public Service Commission and would support its ongoing implementation and recommend that front line health agencies explicitly consider the issue of burn out and how best to reinforce resilience, whether that be through the rotation of key staff or through other mitigations. The lack of clarity about the system's capacity to handle a large outbreak was identified in previous reviews and remains a high priority to be resolved and acted upon.

The competing priorities for resource allocation within the system and the increasing complexities of our diverse communities mean that there are barriers and challenges as we continue forward in the response to COVID-19.

As a further note, through conversations in this review, we have seen that a significant body of expertise has been built through real-world lessons, particularly at the ARPHS. We feel that this needs to be factored into the balance of decision making between central and peripheral agencies to help ensure that responses to further outbreaks are successful.

Further to this, we recommend that the Group explore in more depth issues of strategic leadership and managerial complexity (including the ongoing development of clinical governance) in the COVID-19 response as part of our work programme going forward. This will include exploring how clearly roles and responsibilities are defined from the central decision makers to the frontline specialists, and the various components that need to be in place to ensure high quality practice.

There is also a need to find credible mechanisms to involve stakeholders such as epidemiologists, modellers, and business in the operating model enhancements we will be

exploring over the coming weeks. That will allow for broader perspectives to be brought to the table and help to mitigate the risks of relying on key individuals and agencies for expertise.

The system has been subject to a number of reviews over the last year and the recommendations from which have not all been actioned. We consider as a matter of priority that a full stocktake be undertaken of what has been actioned, what hasn't and why, and what the timeline for addressing them will be. Accountabilities should be assigned to individual agencies and then the implementation be monitored by the DPMC COVID-19 Group's System Assurance and Continuous Improvement team as a matter of priority.

The future context of the required operating model around the COVID-19 response is fundamentally changing as we increasingly operate in a post-vaccinated world and greater freedoms at the border. From the Group's perspective we see the fundamentals of that operating model building on what has been deployed to date, namely surveillance, testing, MIQ (in some form), and contact tracing. From a continuous improvement perspective we will be looking from a whole-of-system perspective as to how the components inter-relate, the nature of the processes to be used, the evidence base (including international lessons and developments) upon which actions and decisions are made all within a working assumption that COVID-19 will be an ongoing threat for some time, and that, as a country, we will continue to eliminate the virus when it is identified in the community. Innovation rather than just sticking with the 'tried and true' will be key to keeping up with the evolving COVID-19 environment. Furthermore, a critical success factor is that we have the infrastructure, processes and accountabilities documented and stress tested to allow successful deployment anywhere within Aotearoa New Zealand.

I have appended to this letter a summary from the full report of what we consider are the initial key areas for continuous improvement, recommendations and a suggested framework for implementation. As further work is undertaken by the group there will in all likelihood be other issues that we will need to bring to your attention.

We are available to discuss and or elaborate on any aspects of this letter and or the attached report recommendations.

Yours sincerely

Brian Roche

Sir Brian Roche

Chair of the COVID-19 Independent Continuous Review, Improvement and Advice Group

Appendix 1 – Opportunities for continuous improvement

Improvements in planning

Formalisation of the early aggressive approach

The shift to an aggressive early approach to community case and contact management is not fully formed or formalised as an approach[1].

The addition of two contact categories (close plus and casual plus) added complexity that caused confusion among the public and providers (including general practitioners). The addition of the categories also went against the basic underlying principles of contact definitions in public health outbreak management where contacts should be defined by the actual level of contact.

Communications on the early aggressive approach and what this means for people should be simpler.

Scenario planning

It appears that there are few, if any, scenario plans that would detail specific plans for situations where cases are identified in particular settings. While it is felt that there needs to be flexibility to treat each real-world situation on the circumstances as it unfolds, there would likely be clear benefit in having a plan in place at least for the early stages of an outbreak before circumstances are clear.

	Key recommendations	Suggested timeframe
1.	The early aggressive approach to an outbreak should be fully formed as a proper plan.	One month
2.	The new contact definitions should be removed. Individuals should simply be aware of whether they are a close or a casual contact and what, for the particular outbreak, they need to do, as defined in the outbreak plan.	Immediate
3.	Scenario planning and system stress testing should be done, coordinated by DPMC specialists, and completed in an agreed timeframe.	Two weeks

Leadership and decision-making

In New Zealand, leadership of an outbreak is complex involving central policy agencies, operational agencies and Ministers operating within the complex architecture of government. This can lead to a lack of clarity where it comes to accountability and decision-making responsibilities.

As part of this complexity, the unintended consequences of directives and orders are not necessarily fully considered, despite there being some checks and balances in place. A

[1] For example, it is not described in the Ministry's latest COVID-19 Resurgence Plan.

more consultative approach with strongly mandated Public Health Unit (PHU) would be optimal to ensure that operational implications are taken into account in decision-making. Given the significant body of expertise based on real-world lessons that has built up within operational agencies (especially at ARPHS), this should be factored into the balance of decision-making between the centre (ie. the Ministry of Health) and the PHU.

	Key recommendations	Suggested timeframe
4.	Leadership of an outbreak needs to be clarified and adjusted accordingly, adopting an improved consultative approach between the centre and periphery and the need for a primary role for the public health specialists.	One month

System capacity

The risk of a large outbreak in New Zealand is real. While the early aggressive approach was successful for the Auckland February 2021 Outbreak, if an outbreak is advanced already when it is detected, or an early aggressive approach fails, the back-up surge capacity should continue to be substantial[2]. It appears, however, that the Ministry of Health are developing advice based on the assumption that the need for capacity to surge to be able to trace the contacts of 1000 cases per day is obsolete.

	Key recommendations	Suggested timeframe
5.	The system capacity necessary to contain a large outbreak should be clarified and agreed, then established properly, including with adequate resource and staffing.	One week; three months

External expert input

The formal Technical Advisory Groups have been disbanded which has introduced the risk of external advice and peer review not being sought when it should be. Expert input is particularly important in the review of key strategic documents to ensure that any shifts in policy or the implementation of policy are based on sound evidence and rationale.

	Key recommendations	Suggested timeframe
6.	Nationally important documents and plan changes should undergo mandatory expert external peer review in their planning and completion, monitored by the Minister for COVID-19 Response's office.	One week

[2] There have been previous recommendations that there should be surge capacity of up to 1000 cases per day (refer to the Verrall Report Recommendation 2). Since the Verrall Report, Singapore and Melbourne (both with similar populations to NZ) have had outbreaks that reached over 900 cases per day.

Equity and diverse communities

A range of issues were experienced by diverse groups in the South Auckland community. For example, those with disabilities may have not had access to support, or restrictions of food quantities of certain items at supermarkets may have been difficult for larger families. A large number of the border workforce live in South Auckland, and people often face stigma which has even led to stories of border workers being turned away from health care providers.

There are high levels of fear and anxiety in the community and together with the issues they have experienced and the well documented barriers to accessing services by Māori, Pacific and other groups highlight the need for implementing policies and communications that are made relevant for diverse communities.

An equity approach requires that resources are organised and targeted to diverse communities that are underserved. Appropriate monitoring, evaluation, and metrics are also required to support quality improvement and the design of recovery interventions.

Narratives through the media and social media indicated that unconscious bias is an issue, whereas the reality was that there were high levels of compliance in these communities where many are providing critical and high-risk services to keep New Zealanders safe.

	Key recommendations	Suggested timeframe
7.	The design of interventions needs to ensure equity and access for diverse communities, whānau-centred wellbeing metrics are required for monitoring and evaluation, and all messaging should reflect the hard work and collective action of the South Auckland community.	Ongoing

Stretched workforce

There is a consistent theme of a stretched workforce that has been in crisis and response mode for a majority of the COVID-19 response, with people placing themselves or being placed under unreasonable time pressures even between outbreaks. Evidence from interviews indicates that tiredness and burnout is occurring at all levels across the response.

	Key recommendations	Suggested timeframe
8.	Strategies for addressing tiredness and burnout, while injecting freshness and ongoing self-reflection and self-criticism should be evident and implemented at all levels.	Ongoing

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