DEPARTMENT OF THE PRIME MINISTER AND CABINET
TE TARI O TE PIRIMIA ME TE KOMITI MATUA

Proactive Release

The following items have been proactively released by the Rt Hon Jacinda Ardern, Prime Minister:

Paper: Implementing a rapid response to COVID-19 cases in the community and refinements of COVID-19 Alert Level settings

Minute of Decision: Rapid Response and Changes to COVID-19 Alert Level Settings

In Confidence

Office of the Prime Minister

Cabinet Committee

Implementing a rapid response to COVID-19 cases in the community and refinements of COVID-19 Alert Level settings

Proposal

1. This paper outlines how the government intends to respond to any new COVID-19 case in the community.

2. At its meeting of 6 July, Cabinet requested a report back on any necessary or desirable changes to Alert Level settings, including updated risk assessments to guide decisions on moving between Alert Levels [CAB-20-MIN-0330 refers]. This paper also responds to that invitation as well as outlining the plan for rapidly responding to new cases in the community.

Executive Summary

3. In the event there is any new COVID-19 case(s) outside of a managed isolation or quarantine facility, acting with urgency to limit and ultimately prevent any further community transmission is critical. Working from this principle, this paper sets out a plan for an initial rapid response and describes the immediate actions that will be taken and the decisions that will be required and by whom.

4. We need to determine the circumstances surrounding the case (or cases) as quickly as possible and reduce the risk of ongoing transmission. The faster we respond, the less opportunity there is for infected people to unknowingly spread the virus in the community. Overseas experience suggests that a delayed response allows the virus to spread further and ultimately makes gaining control of the outbreak much harder and more costly. It is likely that we will need to go hard and early at a regional level while investigations are carried out to understand the size of the outbreak.

Stage 1: Immediate actions – case investigation and testing, and supporting physical distancing controls

5. When a new case is identified in a community, we are likely to be operating with very limited information. The key overarching question that needs to be answered is whether there is serious risk of further undetected community transmission taking place. This will be informed by the Public Health Unit's case investigation, which includes a case interview. The interview would cover a range of factors including whether the case has a clear connection to the border, the case history including symptom onset and severity, and the individual's movement patterns.

6. The case interview will identify any potential close or casual contacts. These close contacts will be isolated and tested as appropriate. Testing of casual contacts is also likely for casual contacts for the first case in the community. The process is repeated for any newly identified cases. Anyone with symptoms, especially in the affected region, would be encouraged to get tested.

7. At this point I anticipate encouraging only essential travel for people in the affected region. I will be reiterating the core public health messages about hand washing, staying home when sick, and keeping a record of where you have been for the whole

country. We may also implement immediate temporary (e.g. around four days) local or regional controls, including restrictions on movement (particularly between regions), requiring people to stay at home and limiting gathering sizes. These actions would reduce the risk of further transmission while we are learning more about the movements of the cases and any contacts.

8. Such controls could be applied by the Minister of Health or Director-General of Health issuing orders under the COVID-19 Public Health Response Act 2020 (the COVID Act). We anticipate these range of controls being similar to the Alert Level 3 settings, and they could be framed as a region or district[1] temporarily – e.g. for four days – moving to Alert Level 3 to prevent further spread while the nature of the outbreak is investigated and assessed.

Stage 2: A tailored plan based on richer information

9. We anticipate that towards the end of a short period of temporary controls for around three to four days in order to complete the necessary contact tracing and testing, there will be sufficient information to undertake a risk assessment and decide on the most appropriate medium-term response. The key things that Ministers will assess are:

    a. the connection of the case(s) to a known source at the border;

    b. the number of cases (and close contacts); and

    c. the geographic spread of cases, including across regions.

10. Ministers will seek advice from the Director-General of Health and the National Response Leadership team on these matters, as well as drawing on technical experts (including my Chief Science Advisor). Appendices 1 and 2 set out in detail when and how these decisions will be made. While every case will present specific circumstances, possible scenarios and responses could include:

    a. **Only one or two further cases are detected amongst close contacts and there is a connection back to the original source of infection at the border.** The likely response is that the region moves to Alert Level 2 – e.g. physical distancing requirements, restrictions on gatherings and contact tracing requirements. Alternatively remaining at Alert Level 1 with some specific controls may be appropriate.

    b. **A single cluster of connected cases in the region with no evidence of community transmission in the region and no cases in other regions.** The likely response is moving the region to Alert Level 3. Alternatively, a move to Alert Level 2 may be sufficient. The rest of the country could stay at Alert Level 1.

    c. **Widespread community transmission in the region but no confirmed cases detected in other regions.** The region is likely to move to Alert Level 3, or possibly shift to Alert Level 4. It may also be appropriate for the rest of the country to move to Alert Level 2.

    d. **At least one cluster in the region and confirmed cases in other regions.** The region where the cluster began would move to Alert Level 3 and other regions with cases would shift to Alert Level 3 and unaffected regions to Alert Level 2. Depending on the number of affected regions, the Government would have to consider broader national action.

[1] We envisage districts and regions would be defined in accordance with the Local Government Act 2002.

Clarity on movements between Alert Level

11. Relatedly, I propose that we alter the risk assessments so there would have to be a higher degree of risk before there was a nationwide increase in Alert Level. This will need to be balanced with a lower risk tolerance to quickly stamp out any local outbreaks.

Clarity on Alert Level settings

12. I consider that we should generally retain our existing settings at each Alert Level, unless there is a good reason to depart from these (there would be an opportunity to do so when Orders are drafted to give effect to Alert Levels). Our Alert Level framework is coherent and widely understood. It has already been refined through experience and too much change at this time will increase uncertainty. Nevertheless, there are three amendments I propose to make:

    a. allowing a solitary non-essential worker to work from a business premises at Alert Level 4, provided that they do not interact with anyone else at, or on the way to or from, the premises;

    b. allowing online shopping but only allow businesses to fulfil online orders at Alert Level 4 if they otherwise meet the conditions for operating at Alert Level 4; and

    c. a technical change to incorporate reference to the Health Sector Community Response Framework in the Alert Level tables.

13. Attached to this paper as Appendix 1 is an outline of how cases of COVID-19 in the community would be responded to across different functions and agencies. Appendix 2 is a standard operating procedure for Cabinet and Ministers for a rapid response.

Background

14. New Zealand is pursuing an elimination strategy for COVID-19 and we have made remarkable progress. On 6 July 2020, Cabinet considered an overall plan for responding to new cases of COVID-19 in the community, should these emerge [CAB-20-MIN-0330 refers].

15. This plan included the following principles to guide a response to new locally transmitted cases outside of border facilities:

    a. ongoing elimination will remain our strategy on the basis that it supports our continued recovery;

    b. our public health measures across Alert Levels of public health messaging, personal hygiene, testing, contact tracing, and isolation will be the core of our response and our primary safety net;

    c. where these public health measures are insufficient, we will seek to control COVID-19 with the least intrusive measures, including tailored local responses, that give us confidence that we will continue to deliver on our strategy of elimination;

    d. we will seek to avoid going to national Alert Levels 3 or 4 if possible, although we will do so if necessary; and

    e. for all measures, whether local or national, we will maintain national-level visibility and leadership, led by Cabinet.

Lessons from recent outbreaks in other countries

16. The recent events in the Australian State of Victoria illustrate the risk of too hesitant a response on the basis of emerging information, given the lags involved between infection, infectiousness and symptoms becoming apparent. At the early stages of the outbreak, it appeared that new cases were largely limited to certain suburbs and housing estates. Targeted lockdowns for those areas were put into effect on that basis of that understanding, but within days it became clear the virus had already spread wider by the time the targeted lockdowns were in effect. This necessitated the lock down of greater Melbourne now in place, for a longer time than may have been necessary had it been implemented sooner.

17. Similarly, in Hong Kong a seemingly isolated case of local transmission emerged after three weeks without local transmission. Initially Hong Kong avoided reintroducing controls it had only recently relaxed. Within days, however, it became clear the outbreak was already much more widespread, at which point controls were re-introduced. Hong Kong, like Victoria, is now facing record local case numbers.

18. In both Melbourne and Hong Kong, the initial response appeared to be proportionate, but in hindsight, it appears decision-makers did not fully appreciate the seriousness of the situation. Implementing the broader controls earlier would likely have significantly reduced the scale of the outbreak. Any new case in the community probably represents a larger number of undetected cases and requires a hard, early response while the size of the outbreak is established, to prevent the virus spreading out of control.

19. In Vietnam, a single case was identified on 24 July (in a hospitalised patient) after almost 100 days of no community cases. This was followed by the detection of a cluster in that hospital and cases across the country and over 100 new cases. Detecting such a case in New Zealand would require the asymptomatic testing of hundreds of thousands of people.

20. Recent draft modelling (i.e. not peer reviewed) by Te Pūnaha Matatini suggests that if a border worker tests positive, they may already have infected three or four other people. If the first case detected is a contact of that worker (rather than the worker themselves), there are probably already about 15 undetected cases in the community. If the chain of transmission is longer, the number of undetected cases could be exponentially higher.

Stage 1: Case investigation and testing, and supporting physical distancing controls

21. The initial notification of a positive case will come from one of the testing laboratory to the local Medical Officer of Health and the PHU will begin a case investigation. The testing technology is very accurate at detecting fragments of viral RNA but this will not indicate if the person is infectious (or recently infectious). For example, a recovered case can still test positive for several months afterwards. The case interview can provide information that can be used to determine when and if the person was likely to have been infectious. The lab test result can also indicate the amount of the virus detected in the sample, which informs to some extent what point of the infection cycle the case is at.

22. The case investigation generally begins with a case interview. The key immediate question we will need to answer is the status of the case; are they currently appropriately isolated? The immediate priority is to ensure there is no further spread of the virus than has already occurred. The second question is whether there has been any risk of the case unknowingly shedding the virus in community settings before they were isolated. This will be informed by a range of factors including the case history,

symptom onset and severity, and the individual's movements while in the community. The case interview will help understand the case's movements and identify any potential close or casual contacts. The third question is determining potential sources of the infection.

23. The case interview could also be inconclusive about the general level of risk posed by the case and require further investigation. This could include re-testing or verification of details of the case history. In some situations, there may be barriers to getting accurate information from the case, including issues with emotional distress, language barriers etc. In this situation, we would take a precautionary approach and the person would be treated as a probable case and a wider net cast for contact tracing.

24. Once the case interview is completed, close contacts will be contacted, tested if possible, and go into self-isolation. Given that the case is the first case detected in the community, asymptomatic contacts will also be encouraged to be tested. As discussed above, the case interview will be used to trace the source of infection (retrospective view) as well as for contact tracing purposes (prospective view).

25. Currently, we expect positive cases in the community, and their close contacts, to self-isolate at home, as soon as they are identified (even if they have not received a test result). The case interviewer will be assessing if the person in question is likely to be able to comply with self-isolation requirements or if their personal circumstances make home isolation unsafe (e.g. an elderly person with pre-existing health conditions in the household). Those who are unable or unwilling to adequately and safely self-isolate at home can be placed in an appropriate quarantine facility. Arrangements for quarantine and isolation facilities vary by DHB but will generally be a motel room.

26. Everyone in self-isolation will receive daily phone calls from Healthline. There will be wraparound services for those who need them and the COVID-19 Leave Support Scheme remains in place to financially support people in self-isolation. [The operation of the scheme was considered by the Cabinet Economic Development Committee on 5 August [DEV-20-SUB-0163 refers]]. Random daily checks are used to ensure isolation is being adhered to. For anyone who does not comply with self-isolation, or who is assessed as being unlikely to comply, there is a range of powers and enforcement provisions under the Health Act 1956 to enforce isolation.

27. Cabinet has previously contemplated putting all positive cases into managed quarantine facilities (such as motels) [CAB-20-SUB-0220 refers] but this could reduce the incentive for people to get tested in the first place. If compliance with self-isolation is low when case numbers are low, then the use of motels for all positive cases could be re-considered. In addition, any specific instances of non-compliance with self-isolation will be managed through the use of enforcement powers under the Health Act,

28. At all stages of the case investigation process, a risk assessment will be undertaken to determine the risk of community transmission posed by the case. Information will be transmitted rapidly between the PHO, the DHB and the Director-General of Health. Processes for this are well established and functioning well, with formal and informal channels between the entities.

Testing plan

29. Testing the close contacts of the case is most likely to provide useful information to understand the level of community transmission. Based on what we know about virus transmissibility, it is likely that a person identified as a close contact will become a positive case. This is why all close contacts are put into self-isolation as soon as they

are identified and contacted. The PHU will prioritise their tests within the testing system, as appropriate.

30. In some situations, the swabbing of a close contact will be delayed because the case history suggests that the close contact would only have very recently had contact with the positive case. It is not best practice to swab close contacts immediately after their contact with the positive case, as there is a lag time before infection will be detected through a swab (approximately 4 to 5 days after initial exposure).

31. The PHU will also be testing anyone who has symptoms consistent with COVID-19 who has been identified as a casual contact of the case. Testing of casual contacts may support finding the source of infection if not already found. Testing around the positive case (including contacts of contacts) will yield the bulk of information about the extent of the spread of the disease. If this process shows a relatively large number of cases, then it is more likely that broader testing of symptomatic people might identify some positive cases. However, to move as swiftly as possible, testing of symptomatic people will be ramped up at the same time as the testing around the case.

32. Public messaging will encourage anyone with symptoms to seek a test. Previously, public messaging combined with a known case in the community has been very effective at creating strong demand for testing. This messaging will be directed towards people within the affected region as well as across the country. This testing will be important to help build a picture of any undetected infection across the region and the country, though unless the outbreak is relatively large, it is unlikely to yield any positive results.

33. Depending on the case history, the PHU and DHB, on their own initiative or in consultation with the Director-General of Health, may also decide to undertake targeted testing of asymptomatic people in the local area. This testing would be targeted at groups where there is a high risk of impact because:

    a. the group is particularly vulnerable to the effects of COVID-19 (e.g. the elderly or Pasifika communities); or

    b. the group has a high likelihood of spreading the disease (e.g. healthcare workers).

    This asymptomatic testing would be undertaken out of an abundance of caution because of the risks of the consequences of these groups being infected. Previous asymptomatic testing in New Zealand of those with a low exposure risk has not yielded any positive test results.

34. A rapid increase in demand for testing needs to be met with an increase in supply of testing kits and reagents. This requires an expansion in swabbing sites within a few hours. DHBs have plans in place for this scenario, which include mobile and pop-up testing centres.

35. Our current laboratory capacity can extend to 13,000 tests a day. The labs can comfortably process 7,000 to 8,000 tests a day on an ongoing basis. However, the peak capacity is enough to undertake 40,000 to 50,000 tests over the initial three to four days, which is likely to be sufficient but difficult to sustain.

36. The Ministry of Health is currently exploring the possibility of further test pooling with key laboratories, which would extend capacity by another 5,000 tests a day, as well as bringing on board additional labs for another 3,000 to 4,000 tests a day. The Ministry is planning to establish surge capacity to process up to 25,000 tests a day for one to two weeks. I propose inviting the Minister of Health to report back to Cabinet Business Committee by 24 August 2020 describing current plans for surging testing capacity

(both swabbing and laboratory capacity) as well as any possible future enhancements to these current capabilities.

37. Under any scenario, we will need to continue the Managed Isolation Facility (MIF) testing schedule. We know that new cases come in regularly to the MIFs and it is important that we detect these promptly and manage them appropriately to prevent transmission.

Rapidly applying controls to minimise the risk of transmission may be required

38. Managing risk with minimal information is difficult, and suggests a precautionary approach is appropriate. In New Zealand, this situation is most likely to manifest in a new case that is identified through testing in the community without an obvious link to another case.

39. In this situation, rapid, decisive action can serve as 'insurance' against widespread transmission. If the outbreak turns out to be limited, the cost of any short-term localised controls will have been relatively small. However, if the outbreak turns out to be wider, that initial decisive response may save lives and reduce the need for much broader and more enduring controls later. Critical to this is acting quickly to stop spread to other parts of the country.

40. If there is risk of undetected community transmission, in addition to the rapid testing and case investigation, it is likely we would implement immediate temporary local or regional controls to minimise the risk of transmission while we establish more details about the case and the risks it poses. It would take around four days to trace and isolate close contacts, undertake targeted testing of contacts and get results, as well as allow time to see whether any additional cases emerged through regular testing. Once more information was available, we could make a more considered decision about longer-term controls. Such controls are likely to include restrictions on movement, requiring people to stay at home and limiting gathering sizes. Such controls are very similar to the settings at Alert Level 3 and could be applied as a regional or district shift to Alert Level 3 or as a suite of targeted controls. Either way, they would be effected through orders issued by the Minister of Health or the Director General of Health under the COVID Act.

41. As an example, suppose a person in Christchurch with a cough and fever receives a positive COVID-19 test. The person has no immediately obvious connections to the border, or to a managed isolation or quarantine facility. They also have no international travel history in the last year or previous COVID-19 infection. The lab results indicate this is not residual disease, but a new infection. This is a potential case of community transmission and the existence of this case indicates that there is a high chance there are other cases in the community.

42. In this situation, it may be desirable to require people to stay at home to the extent possible, limit the size of gatherings and prevent movement out of the region while the PHU (assisted by the National Investigation and Tracing Centre) identifies, traces and tests all of the person's close and casual contacts to establish the source of the infection. We could do this either by specific controls, or by moving the whole Canterbury region to Alert Level 3 for four days. These temporary controls would be disruptive but would enable us to obtain much better information about the nature of the outbreak and prevent it from spreading further while it is being investigated.

43. A rapid, temporary increase in Alert Level would be consistent with the principle of seeking to avoid going to Alert Levels 3 and 4 nationally, as this rapid local response could prevent a nationwide outbreak.

44. In this situation, the set of controls at Alert Level 3 best balance the need to significantly reduce the risk of further transmission with what we can implement quickly. These controls comprised the following:

    a. everyone staying at home within their bubble (other than for essential personal movement, including to go to work (if they cannot work from home), school if they have to, or for local recreation);

    b. inter-regional travel being prohibited;

    c. maintaining 2 metres physical distance outside one's bubble;

    d. early childhood education centres and schools for students in years 1 to 10 operating but encouraging all children to from home if possible;

    e. some businesses able to open but without physical interaction with customers (i.e. delivery and contactless pick-up allowed), and businesses that can't operate without physical contact with customers (i.e. hairdressers) to close; and

    f. gatherings only be allowed for wedding services, funerals and tangihanga and being capped at 10 people.

45. Orders giving effect to such controls are likely to include exemptions to allow people to return home if they live within the region/district, leave the region or district to return to their usual place of residence (provided that they self-isolate upon return), and to travel between regions for urgent medical treatment.

46. Those that have travelled to the affected area recently but are currently elsewhere will also likely be ordered to self-isolate until fourteen days have elapsed since they departed the affected area. Messaging will focus on the importance of complying with that self-isolation to protect their communities, and being clear that the self-isolation is an enforceable requirement, just as much as those restrictions within the affected area.

47. The decision to impose temporary controls would need to be made within hours, and announced and implemented as quickly as possible. It is unlikely to be practical to have a change in Alert Levels that occurs during normal working hours. My expectation is that we be in a position to do this as close as practicable to the confirmation of a new case. The approach to making this decision is discussed in the following section. I also note it is not practicable to move immediately to Alert Level 4. For example at Level 4 all educational facilities are closed creating child care problems for some essential workers, and workers would need to access some workplaces (such as factories) to enable their shut down if they could not operate at Alert Level 4.

Powers and decision making

48. This approach differs from most of our previous nationwide Alert Level changes, under which preparation for Alert Level shifts typically took place over days or weeks, and in which the public was generally given at least 48 hours' notice before the change took effect. However, the 23 March national shift from Alert Level 2 to 3 was done with less than 12 hours' notice, and at a time when the country had no experience operating under Alert Level 3. We can help the public prepare for this scenario by communicating that such a rapid move to an increased Alert Level or other control in their region is possible, and encouraging people to be prepared, in much the same way that all New Zealanders should remain prepared for an unexpected local or national emergency.

49. I further consider that taking steps to allow us to more fully determine the extent of any community transmission, that could include imposing restrictions on movement and the operation of businesses, is our best chance to manage the risk of community transmission in the early days following confirmation of an infectious case. A significant delay between announcing the introduction of controls or a planned increase in Alert Levels and them coming into effect risks sparking inter-regional movement that could spread the virus further.

Checkpoints to control movement in and out of a region

50. Preventing movement in and out of a district or region will require checkpoints to be established on all roads in and out of an area. In many districts or regions this would require a large number of checkpoints. Under the COVID Act the Police have the power to close roads, though if the Police resourced checkpoints exclusively, this could require the deployment of all on-duty officers in a Police district. The COVID Act, however, makes provision for roads to be closed by a Police constable or an enforcement officer (any suitably trained and qualified person employed or engaged by the Crown or Crown agent, authorised by the Director-General of Health) acting under the direction of a constable. Accordingly, I am confident that checkpoints can be established and sufficiently resourced through the Police working with other Crown agencies.

Mask use by the general public

51. On 5 August 2020, the Cabinet Social Wellbeing Committee noted the updated advice officials provided to the Minister of Health on the use of masks by the general public [SWC-0107 refers].

52. Current advice from the WHO states that the early deployment of masks to the general population can help reduce further transmission of COVID-19 in the community.

53. The Ministry of Health recommends that the wearing of non-medical grade masks (either single-use or reusable) by the general-public be a component of the response to any further outbreak of COVID-19 in the community. Masks remain only one part of the overall elimination strategy, alongside continued public health measures. Good hand hygiene, physical distancing, staying home when sick, self/managed isolation and quarantine, testing and contact tracing remain critical.

54. The table below sets out the advice for who should wear masks and when.

Level	Proportion of population affected	Mask use required or voluntary	Where masks should be worn
Level 1	All	Voluntary	The general-public should be encouraged to source masks and be prepared for possible resurgence in the community.
Level 2	Most (some vulnerable groups will self-isolate)	Voluntary, with public use encouraged, particularly for vulnerable groups	The public should be encouraged to wear masks in public enclosed spaces where physical distancing is not possible (such as public transport, shops) or if working in an environment at higher risk of COVID-19 infection, e.g. ports.
Level 3	Some (more people working	Public may be required to wear	The public will be required to wear masks when interacting outside of their

	from home and fewer public gatherings)	masks in some public settings	work or home 'bubbles' and when in public enclosed spaces where physical distancing is not possible. This will sit alongside broader public health messaging and guidance on staying home where possible.
Level 4	Few (essential workers and people gathering essential supplies or accessing health services)	Public may be required to wear masks in all public settings	The public would be required to use masks outside of their home or work 'bubbles' regardless of whether physical distancing requirements can be met.

55. At all Alert Levels, if people are unwell in the community with COVID-19 symptoms, the advice remains that they should stay at home, self-isolate and seek medical advice. If travel to see a health professional is required, a mask should be worn.

56. To be effective, masks need to be used correctly. Clear guidance and public messaging on the proper use of masks is needed for them to be effective in combatting the spread of COVID-19. The Ministry of Health will ensure that advice on how to wear, handle and dispose of masks correctly is available to the public.

Supply and distribution of masks

57. The COVID-19 All-of-Government Response Group is currently looking at options for the appropriate supply and distribution of masks for the public. Equity of access will be considered as part of this work, including whether targeted distribution to more vulnerable populations should be prioritised over provision to the entire country. Targeted provision could be based on regions or specific groups (e.g. those with a community services card).

58. The Ministry of Health will continue to ensure there is adequate supply and distribution of medical grade masks for the wider health sector.

Stage 2: A tailored plan based on richer information

59. Approaching the end of any temporary controls, there will be enough information to decide on an appropriate longer-term response. I propose at this point the Prime Minister, Deputy Prime Minister and Attorney General, along with the Ministers of Finance, Justice and Health (who have statutory functions under the COVID Act for making orders to control the spread of COVID-19) assess the following:

    a. the connection of the case(s) to any other known cases (including at the border);

    b. the number of cases (and close contacts); and

    c. the geographic spread of cases, including across regions.

60. In making these assessments Ministers will seek advice from the Director-General of Health and the National Response Leadership team on these matters, as well as draw on technical experts (including my Chief Science Advisor). Appendices 1 and 2 set out in detail when these decisions will be made. Ultimately, the specific detail of circumstances will guide decision makers. Nevertheless, potential scenarios and possible responses are likely to include:

    a. **One or two further cases are detected amongst close contacts and there is a connection back to the original source of infection at the border.** The likely

response is that the region relaxes controls to something akin to Alert Level 2 (or even Alert Level 1 if we are confident that the outbreak is contained).

b. **There is a single cluster of connected cases in the region with no evidence of community transmission in the region and no cases in other regions.** The likely response is continuation of the temporary controls (envisaged to be similar to Alert Level 3) in the region or a shift to controls akin to Alert Level 2.

c. **Widespread community transmission in the region but no confirmed cases detected in other regions.** The temporary controls in the region/district would remain (envisaged to be similar to Alert Level 3) or possibly move to Alert Level 4. The rest of the country may move to Alert Level 2.

d. **There is at least one cluster in the region and confirmed cases in other regions.** The original region/district would retain temporary controls (likely to be similar to Alert Level 3 controls). Equivalent controls would be implemented in other regions with cases, and unaffected regions may move to Alert Level 2. Depending on the number of affected regions, the whole country may shift to Alert Level 3.

Powers and decision making

61. Under the COVID-19 Public Health Response Act 2020 (the COVID Act), the Minister of Health and the Director-General of Health both have the power to make Orders that can give effect to our Alert Level framework (the Director-General of Health may only make orders that relate to a single territorial authority). These are independent statutory decision-making roles (although the Minister of Health is required to consult with the Prime Minister and the Minister of Justice before making an Order). Until now, any decisions about moving Alert Level have been taken by Cabinet, which the Minister of Health has had regard to when making an Order under the COVID Act.

62. Cabinet last authorised the group of Ministers with Power to Act on COVID-19 matters on 19 March 2020 [CAB-20-MIN-0130]. I propose to amend the membership of this group to reflect the key roles for decision making under the COVID Act so that it now comprises the Deputy Prime Minister, Minister of Finance, Attorney General, Minister of Justice, the Minister of Health and myself.

63. This group will be best placed to undertake the quick decision making required in a rapid response, and meet the consultation requirement under the COVID Act prior to an Order being made.

64. The COVID Act enables the rapid creation of Orders to give effect to the Alert Level framework. It is important to create legal requirements for the behaviour changes we need to manage the virus. If instead we only ask people to act as if they were at Alert Level 3, with no legal requirements, we will not see the same response. The Orders can come into force immediately upon being signed.

65. Appendix 2 provides a Standard Operating Procedure for Cabinet and Ministers for a rapid response.

66. We have the advantage now that New Zealanders, the Government, businesses and other organisations know how to operate under the Alert Levels. Outside of the need for specific restriction of movement outside the relevant region, the Alert Levels would operate largely unchanged from previous experience when implemented locally. However, a rapid shift potentially from Alert Level 1 to 3 will require updated planning and guidance.

Local operational coordination

67. As with our COVID-19 response to date, a rapid response will require the local coordination of operations. It is critical that the mechanism for this coordination can be stood up quickly. Officials have identified 16 regional leadership groups including mayors, local government chief executives, District Health Board and Public Health Unit leaders and Central Government regional officials such as Police District Commanders, Ministry of Social Development Commissioners and Regional Directors of Education. All 16 groups should be operational by the end of the week of 10 August and able to coordinate an operational response in their region.

Rapid response plan

68. Attached to this paper is a high level plan for a rapid response to new cases in the community (Appendix 1). This builds on the previous "Stamp it out plan" Cabinet approved on 6 July 2020 which covered a range of scenarios [CAB-20-MIN-0330]. It focuses specifically on the first four days of a response to provide clarity on actions, roles and decision-making. These four days provide the time needed to trace contacts, investigate the case and undertake and get results from widespread testing, in order to accurately understand the risk and make decisions on the right approach in the medium term.

69. The plan identifies the critical path to a rapid response, including a rapid lock down if necessary and the steps required to make best use of temporary lockdown to gather intelligence quickly to inform a longer-term decision.

70. The plan proposes a National Response Leadership team made up of the

    a. Chief Executive of the Department of Prime Minister and Cabinet (DPMC)

    b. Director-General of Health

    c. Chief Executive, National Emergency Management Agency

    d. Deputy Chief Executive, COVID-19 All-of-Government Response Group, DPMC.

71. The team would have four primary roles:

    a. provide All-of-Government advice to Cabinet (or COVID-19 Ministers);

    b. provide non-health advice to the Director General of Health to inform his use of powers under the COVID Act;

    c. engaging the COVID-19 National Response Group; and

    d. activating the relevant regional leadership group to coordinate the local operational response and provide direction to that group as required.

72. The plan identifies several actions that need to be undertaken in advance of a new case for a rapid response to be executed as quickly and effectively as possible. Officials are already working on these issues. They include:

    a. pre-drafting of generic orders under the COVID Act to be amended as appropriate for the specific situation;

    b. identification of regional leadership groups; and

    c. developing policy for allowable movement across the boundaries of locked-down areas.

73. The plan will be tested and refined through table top exercises which will include stress testing the contact tracing system.

Localised Alert Level settings

74. As Cabinet discussed on 6 July, there is an opportunity to formally implement Alert Level settings not just at a national level, but also sub-nationally, such as at the level of a region or town. This is in addition to locally-led responses to new cases of COVID-19 under the leadership of a local Medical Officer of Health (such as requiring certain people to self-isolate or potentially closing individual businesses or schools). Decisions regarding formal Alert Level changes will be taken nationally, even if implemented at a local level.

75. It is important to be clear on the situations under which it is feasible and desirable to implement formalised Alert Level settings at the sub-national level. In particular, we need to bear in mind the practicality of implementing different Alert Levels in adjacent places. There are high rates of movement within regions in New Zealand, which has implications for the effectiveness of localised Alert Levels. Consideration will need to be given to the level of regular, daily movement in and out of the proposed area. As demonstrated in Melbourne, an Alert Level change limited to several suburbs within a larger city is unlikely to be very effective because COVID-19 is likely to have already spread within the city before the Alert Level is changed. Conversely, in places with lower population movements it may be quite feasible to have a localised Alert Level for a small rural town or district.

76. Similarly, we also need to be able to create physical borders between areas at different Alert Levels to prevent further population movement and spread. Having different areas at different Alert Levels will require movement restrictions between those areas to be effective. It is difficult to maintain boundaries around single buildings (unless the population inside does not mix much with the surrounding community, such as a prison or an aged residential care facility that has already put restrictions in place) or between neighbouring suburbs. In contrast, most Civil Defence Emergency Management regions can be separated with checkpoints on only a few roads. Some towns or districts with a limited number of access roads could also successfully be put on a different Alert Level.

77. In the event of higher Alert Levels being applied locally, it will be possible for residents to return to an area with a higher Alert Level; restrictions are only required for those seeking to leave that area. In the event of a rapid increase in Alert Levels, it would likely be necessary to allow people to leave the restricted area to return to their primary residence, although they would likely need to self-isolate for 14 days. During the initial four days, while testing and tracing is undertaken, there would be no regular movement in and out of the region.

78. If Alert Level controls were required beyond a brief initial period, and depending on the degree of risk involved, it may also be possible to allow movement in and out a locked down area for those whose daily work or school arrangements require such movement. Anyone electing to move in and out of the region on this basis would be required to self-isolate when outside the affected area. Proof of employer or school location would need to be provided if requested at checkpoints.

79. A decision on whether to allow such movement will need to be informed by an assessment of the risk in the affected region. In general, if widespread community transmission is believed to exist in the affected area, such movement will not be allowed.

Factors and risk assessments for informing Alert Level decisions

80. To provide certainty for individuals, business and communities, it is important that we are as clear as possible about the conditions under which we would move up Alert Levels, if there are new cases beyond the border.

Factors for informing Alert Level decisions

81. Cabinet has previously agreed to the use of the following factors to guide decisions on the appropriate Alert Level for New Zealand [CAB-20-Min-0199 refers]:

    a. the Director-General of Health's satisfaction on four health matters:

        i. trends in the transmission of the virus, including his confidence in the data and having regard to the risk assessment levels agreed by Cabinet;

        ii. the capacity and capability of our testing and contact tracing systems;

        iii. the effectiveness of our self-isolation, quarantine and border measures;

    b. the capacity in the health system more generally to move to the new Level, including the workforce and ICU capacity, plus the availability of PPE for those for whom it is recommended;

    c. evidence of the effects of the measures on the economy and society more broadly;

    d. evidence of the impacts of the measures for at risk populations in particular;

    e. public attitudes towards the measures and the extent to which people and businesses understand, accept and abide by them; and

    f. our ability to operationalise the restrictions, including satisfactory implementation planning.

82. These factors remain fundamentally applicable for considering changes in Alert Levels, whether nationwide or at a more localised level, and I do not propose any changes to them at this time.

Risk assessment regarding trends in the transmission of the virus

83. I do, however, propose changes to the risk assessments that the Director-General should have regard to when considering the first factor above – trends in the transmission of the virus.

84. We have had a set of risk assessments for describing the state of the virus at different Alert Levels since we introduced the Alert Level framework in late March. These are not firm triggers that determine when we change Alert Levels (a variety of factors are taken into consideration for those decisions, as set out above) but are a simple way of signalling the general situation that might lead to escalation or de-escalation.

85. The description of these assessments has changed over time. In part, these changes were made to make the descriptions of the Alert Levels applicable to both escalation and de-escalation (rather than just escalation as originally envisaged). However, the changes also had the effect of materially lowering the risk assessment at Alert Levels 2 to 4, making the threshold for moving up an Alert Level quite low.

86. As discussed in the paper considered by Cabinet on 6 July, we are now much better prepared for new cases in the community than we were in late March. Our testing, contact tracing, and border control measures are more robust and continue to improve.

The country has been up and down the Alert Level systems and understands how they work. Government agencies have experience in implementing the Alert Level system.

87. Given the principles outlined in paragraph 15 and that we are now much better prepared, we will seek to control COVID-19 with the least intrusive measures. We will avoid going to Alert Levels 3 or 4 nationwide if possible, but will do so if necessary. I propose that the Director-General of Health, when advising Cabinet on decisions regarding national Alert Levels, would have regard to an updated set of risk assessments when providing his assessment of trends in the transmission of the virus. The updated risk assessments are better aligned to the principles.

88. The table below presents our original risk assessment for each Alert Level, our current risk assessment, and a proposed revised risk assessment.

Alert Level	Original risk assessment (March)	Current risk assessment (since May)	Proposed risk assessment
Level 4	• Sustained and intensive transmission • Widespread outbreaks	• Community transmission is occurring • Widespread outbreaks and new clusters	• Sustained and intensive community transmission • Widespread outbreaks
Level 3	• Community transmission occurring OR • Multiple clusters break out	• Community transmission might be happening • New clusters may emerge but can be controlled through testing and tracing	• Multiple cases of community transmission occurring • Multiple active clusters in multiple regions
Level 2	• High risk of importing COVID-19 OR • Uptick in imported cases OR • Uptick in household transmission OR • Single or isolated cluster outbreak	• Household transmission could be occurring • Single or isolated cluster outbreaks	• Limited community transmission occurring • Active clusters in more than one region
Level 1	• Heightened risk of importing COVID-19 OR • Sporadic imported cases OR • Isolated household transmission associated with imported cases	• COVID-19 is uncontrolled overseas • Isolated household transmission could be occurring in New Zealand	• COVID-19 is uncontrolled overseas • Sporadic imported cases • Isolated local transmission could be occurring in New Zealand

89. These risk assessments can be applied at a local or national level, with appropriate flexibility and judgement applied based on the range of factors to be considered. In general, it will make sense to have a lower risk tolerance when applying Alert Levels at a local level, particularly in the immediate response as we ascertain the scope of the situation.

90. This supports the approach discussed earlier in the paper of doing everything we can to quickly stamp out the virus while it is contained locally, including with rapid decisive action where necessary.

Adjustments to Alert Level settings

91. While we will be looking to avoid an increase in national Alert Levels where possible, it is nevertheless important that we provide clarity as to what Alert Level settings we will

move to, if there is a need for re-escalation. This is particularly important in terms of providing certainty and confidence for businesses.

92. I consider that we should retain our existing settings at each Alert Level, unless there is a good reason to depart from these. Our Alert Level framework is broadly coherent and, at this point, widely understood. It has already been refined through experience and too much change will increase uncertainty. Rather than make significant changes to our Alert Level settings, our primary focus should be on the steps required to avoid a need to elevate Alert Levels and ensuring that if we do elevate Levels, we do so at the right stage.

93. Nevertheless, there are a small number of areas where I propose to adjust our settings at this time:

    a. allowing solitary non-essential workers to work from business premises at Alert Level 4;

    b. allowing businesses to fulfil online orders at Alert Level 4 if they otherwise meet the conditions for operating at Alert Level 4; and

    c. a technical change relating to the Health Sector Community Response Framework.

Solitary non-essential workers at Alert Level 4

94. Under Alert Level 4, workplaces needed to be closed unless they were deemed to be an 'essential business' – defined in the Order made under the Health Act 1956 as "businesses that are essential to the provision of the necessities of life and those businesses that support them". People that did not work for essential businesses were able to work from home, where this was possible. I propose that all businesses and services that were previously deemed to be essential at Alert Level 4 continue to be deemed to be essential if we re-escalate.

95. I also propose that we add an exemption to our essential services rules at Alert Level 4, to allow a solitary worker (or single existing household bubble) to work from a (non-essential) business premises.[2] This would only apply if the worker is able to work and travel to and from work without interacting with anyone else, and could only be done in situations where it is practical to have a solitary worker on the premises and still comply with broader workplace health and safety requirements.

96. This change would allow a base level of business activity to take place where such activity cannot take place at home, without any material impact on transmission risk.

Fulfilling online orders at Alert Level 4

97. Related to the above, I also propose that we clarify the businesses that can fulfil online orders at Alert Level 4.

[2] The intent would be that there could be one worker per 'defined space'. This means that, for example, only one person (or bubble) would be allowed in a business premises with a single room, but there could be one worker per floor in an office building, provided that there were systems for prevent mixing between floors. If there were to be a second successive solitary worker in the same defined space after the first, the premises would either need to be left empty for a period of time (as specified in guidance by the Ministry of Health) or thoroughly cleaned in between, to prevent transmission via contaminated surfaces.

98. Our position by the end of Alert Level 4 was that all freight could be delivered, with essential freight prioritised. In terms of delivery to consumers, delivery of food (other than takeaways) was allowed, as was delivery of essential non-food goods (subject to the business being registered with the Ministry of Business, Innovation and Employment). Courier and parcel services were intended to only be used for essential goods, but given difficulties faced by couriers in assessing whether what they were carrying was essential, some non-essential goods (such as those from overseas) continued to be delivered to consumers.

99. For any future time spent at Alert Level 4, I propose that we adopt a similar approach, but with the following clarifications:

    a. all freight can be delivered, with essential freight prioritised, as previously;

    b. food orders (excluding takeaways) can be fulfilled, as previously;

    c. essential non-food items can be delivered, as previously, but without a requirement for the business to be registered with MBIE (the registration requirement was highly resource-intensive, without necessarily achieving higher compliance with the 'essential' principle than a system without registration);

    d. non-essential goods can be delivered to the extent that the solitary worker exemption as outlined above is complied with; and

    e. for all other goods, online orders can be taken, but not fulfilled by the supplier, at Alert Level 4 – i.e. the goods will not be delivered.

Incorporating the Health Sector Community Response Framework into the Alert Level framework

100. When the Alert Level system was put in place, the Ministry of Health had established a COVID-19 National Hospital Response Framework to guide hospitals on their operational response, including restrictions on services. This is based on both the risk of transmission and capacity constraints, with individual DHBs responsible for assessing what risk level they are it. This was reflected in the Alert Level framework.

101. Subsequently, a similar framework was established for primary and community care. As this was created after the establishment of the Alert Level framework it is not currently reflected in it, and other guidance is provided with respect to primary care. I therefore propose that the Alert Level framework is changed to note primary and community health providers will operate in line with the Community Response Framework and remove conflicting references to issues governed by it. The Response Framework decouples the provision of primary and community health care from the Alert Level framework. This means the provision of services is only impacted by the level of community transmission and number of clusters in local communities, and whether there are COVID-19 positive patients in local hospitals.

Phasing of Alert Levels

102. When we moved up and down Alert Levels previously, there was an element of phasing as we moved between Alert Levels (e.g. gathering size caps at Alert Level 2). Retaining this flexibility is important for any future re-escalation or de-escalation in Alert Levels, to ensure that our settings reflect the size and scale of the situation at hand.

Other possible changes

103. There is a range of views among agencies and stakeholders about our Alert Level settings, if we need to re-escalate in future. Some consider that there should be a fundamental review of our Alert Level settings, informed by public consultation. Others consider that there should be no, or minimal, changes to our settings.

104. As noted above, I do not propose widespread changes to our Alert Level settings at this time. Given this, I do not propose that we engage in formal public consultation on our Alert Level settings, as this could create unrealistic expectations that there would be significant changes to our settings. Nevertheless, I expect agencies to continue to engage with stakeholders as appropriate on their preparedness for new cases of COVID-19. Where there are proposals for change to our Alert Level settings that have merit, then we should consider these.

105. There may also be an opportunity to make some changes to our Alert Level settings because of emerging public health advice. For example, any changes to advice or requirements regarding mask use could have flow-on effects for other Alert Level settings, such as those relating to physical distancing. I expect the COVID-19 All-of-Government Response Group to maintain an ongoing watching brief on our Alert Level settings.

Financial Implications

106. This paper has no direct financial implications.

Legislative Implications

107. This paper has no direct legislative implications.

Impact Analysis

108. The Treasury has provided the following comment:

> The proposals in the paper relate to the government's response to the COVID-19 outbreak, but are not urgently required to be effective; therefore Cabinet's Impact Analysis requirements apply to the proposals. As no Regulatory Impact Statement has been provided, the preparation of a Supplementary Analysis Report is required [CO 20 (2) refers]. The nature and timing of this review is to be agreed with the Associate Minister of Finance with delegated responsibilities for the Government's Regulatory Management System. The Treasury recommends the Supplementary Analysis Report be included in a more comprehensive assessment of the Alert Level framework that could identify further changes that reduce economic and social costs of higher Alert Levels, while not increasing health risks. Such an assessment should take account of New Zealand and international experience with different levels of restrictions.

Population Implications

109. A resurgence of COVID-19 and the response to it is likely to have a disproportionate impact on priority population groups. New Zealand was fortunate that previosuly COVID-19 did not become established in vulnerable groups, such as low-income communities where people may live in more crowded houses, with greater levels of pre-existing health conditions. This risk factor will need to be carefully considered and mitigated against, should there be a resurgence.

110. Older people are much more likely to experience higher morbidity and mortality from COVID-19 than younger people. For this reason, the public health measures and the Alert Levels have prescribed different advice and protections for older people. Aged residential care facilities have been particularly affected by COVID-19 clusters and the

Ministry of Health has reviewed that experience to ensure that improvements are made in COVID-19 management in all aged residential care facilities.

111. Māori are vulnerable to COVID-19 as they have higher rates of co-morbidities due to pre-existing health inequalities. Māori are generally very aware of the risks that COVID-19 poses to their communities. The Ministry of Health is developing an integrated public health model of care for Māori, which is included in the COVID-19 Māori Health Response Plan.

112. Pacific communities are particularly vulnerable due to a range of factors, including a higher prevalence of long-term conditions and diseases, and access barriers (including financial) to quality health care and social services. Living circumstances, such as low phone or internet coverage and household overcrowding, can also make contact tracing and social distancing difficult or impossible. These factors, challenging in normal circumstances, are likely to be amplified during a COVID-19 outbreak. Based on experience with past outbreaks (e.g. measles), Pacific communities are expected to be disproportionately affected by any COVID-19 resurgence, both in numbers and in severity.

113. Migrant, ethnic and hard to reach communities are highly varied in their demographics and risk profiles but there are potentially some common factors that may make some of these groups more vulnerable to outbreaks. This could include not being reached by mainstream public health messaging, an unwillingness to engage with government services such as testing or contact tracing, and lower levels of health literacy.

114. The proposed change to our Alert Level settings for solitary workers at Alert Level 4 may be of greater economic advantage to men than women, particularly if there are no additional supports provided that would enable more women to continue onsite work (such as funded childcare). This is because women undertake more unpaid labour than men, including care for children and the elderly, and are more likely to be solo parents, which could prevent them from continuing onsite work in the same numbers as men.

Human Rights

115. This paper has no direct human rights implications. A resurgence of COVID-19, and a shift to higher Alert Levels, would entail the reintroduction of measures that place significant restrictions on fundamental human rights affirmed in the New Zealand Bill of Rights Act 1990. For example, restrictions on the rights to freedom of movement, association and peaceful assembly. An assessment of such measures will be made at the time they are introduced to ensure they are proportionate to the risk and justified in the circumstances.

Consultation

116. This paper was prepared by the COVID-19 All-of-Government Response Group within the Department of the Prime Minister and Cabinet. The following agencies were consulted: Ministry of Transport, Te Puni Kōkiri, Te Arawhiti, the Treasury, Ministry for Primary Industries, Crown Law Office, New Zealand Police, Ministry of Health, New Zealand Defence Force, Ministry of Business, Innovation and Employment, Ministry of Foreign Affairs and Trade and the National Emergency Management Agency.

Treasury comment

117. The Treasury agrees that the best way to mitigate the costs of higher Alert Levels is to reduce the need to use them. There are likely to be ways of achieving similar effectiveness at lower economic and fiscal cost if controls are required again in future. Since the regulatory controls discussed in this paper will not be implemented

immediately, the Treasury recommends public consultation on a more detailed and evidence-based review of the Alert Level settings. As a first step, targeted consultation could reveal evidence about risks posed by different activities and inform options about targeting or phasing containment measures.

118. In addition, testing potential thresholds for triggering different local controls could support people to plan for alternative ways of working, prepare businesses for shutdowns of uncertain duration, and improve compliance should controls be imposed. It will be essential to base any decision to re-escalate Alert Levels on a clear assessment of the coherence and transparency of public health preparedness and planning across managed isolation and quarantine, surveillance and testing, contact tracing, and PPE management systems.

Communications

119. In the event of new cases in the community, effective and detailed communication is essential to maintain public trust and confidence in the response to COVID-19 and to enable New Zealanders to comply with any relevant measures.

120. The approach will build on the success of the Unite Against COVID-19 public information campaign that was delivered under Alert Levels 2 through 4, which was received positively by the public. This would be coordinated centrally through the COVID-19 All-of-Government Response Group, and implemented regionally and locally as appropriate. Messaging will focus on public health measures and actions, supplemented by signposting the social and economic support that is available.

121. Communications will be targeted at the affected area(s) and to high-risk and priority communities including iwi, older people, vulnerable people and those least likely to comply (often males under 30). Details of the communications strategy is contained in Appendix 1.

Proactive Release

122. I intend to proactively release this Cabinet paper following Cabinet consideration.

Recommendations

The Prime Minister recommends that Cabinet:

1. **note** that immediately following a new COVID-19 case being detected in the community, there may not be sufficient information to adequately assess risk. In this situation, rapidly applying short-term local or regional controls such as restrictions on movement and physical distancing, requiring people to stay at home and limiting gathering sizes to reduce the risk of further transmission, may be the best way to manage risk while further information becomes available;

2. **note** that the Minister of Health or the Director-General of Health may make an Order under the COVID-19 Public Health Response Act 2020 without prior consideration of the situation by Cabinet or COVID Ministers (although the Minister of Health would be required to consult the Prime Minister and the Minister of Justice). An Order that responds to new cases in the community that are not connected to the border is likely to reflect restrictions up to and including those similar to Alert Level 3 in a local area for a period of up to 96 hours;

3. **authorise** a group of Ministers to have Power to Act to take decisions on the government response to COVID-19, comprising the Prime Minister, the Deputy Prime Minister, Minister of Finance, the Attorney General, the Minister of Health and the Minister of Justice;

4. **note** that this group of Ministers with Power to Act will supersede the previous group of Ministers with Power to Act authorised by Cabinet on 19 March 2020 [CAB-20-MIN-0130];

5. **note** that officials have developed a rapid-response high-level plan to guide the All-of-Government response in the early hours and days following confirmation of a new case in the community;

6. **note** that the plan includes a National Response Leadership team made up of the:

    a. Chief Executive of the Department of Prime Minister and Cabinet (DPMC);

    b. Director General of Health;

    c. Chief Executive, National Emergency Management Agency; and

    d. Deputy Chief Executive, COVID-19 All-of-Government Response Group, DPMC;

7. **note** the team will have four primary roles:

    a. provide All-of-Government advice to Cabinet (or COVID-19 Ministers);

    b. provide non-health advice to the Director General of Health to inform his use of powers under the COVID Act;

    c. engage the COVID-19 National Response Group; and

    d. activate the relevant regional leadership group to coordinate the local operational response and provide direction to that group as required;

8. **approve** the attached rapid-response plan including the role of the National Response Leadership team attached as Appendix 1;

9. **invite** the Minister of Health to report back to Cabinet Business Committee by 24 August 2020 describing current plans for surging testing capacity (both swabbing and laboratory capacity) as well as any possible future enhancements to these current capabilities;

10. **note** that, on 6 July 2020, Cabinet considered an overall plan for responding to new cases of COVID-19 in the community, should these emerge, and invited the Prime Minister to report back to Cabinet on any necessary or desirable changes to Alert Level settings, including updated risk assessments to guide decisions on moving between Alert Levels [CAB-20-MIN-0330 refers];

11. **agree** that the following factors be retained for informing decisions by Cabinet regarding national or local Alert Level changes:

    a. the Director-General of Health's satisfaction on four health matters:

        i. the trends in the transmission of the virus, taking into account his confidence in the data, are consistent with the risk level outlined in paragraph 12 below;

        ii. the capacity and capability of our testing and contact tracing systems;

        iii. the effectiveness of our self-isolation, quarantine and border measures; and

        iv. the capacity in the health system more generally to move to the new Level, including the workforce and ICU capacity, plus the availability of PPE for those for whom it is recommended;

b. evidence of the effects of the measures on the economy and society more broadly;

c. evidence of the impacts of the measures for at risk populations in particular;

d. public attitudes towards the measures and the extent to which people and businesses understand, accept and abide by them; and

e. our ability to operationalise the restrictions, including satisfactory implementation planning;

12. **note** that, in light of New Zealand's increased preparedness for new cases in the community, it is appropriate to alter the risk assessments regarding the state of COVID-19 that informs changes in nationwide Alert Levels;

13. **agree** to rescind the thresholds for transmission outlined in CAB-20-Min-0199 (decision 6) and instead agree to the risk assessments contained in the following table:

Alert Level	**Risk assessment** *The Director-General of Health is satisfied that there is sufficient data from a range of sources to have reasonable certainty that there is/are:*
Level 4	• Sustained and intensive community transmission • Widespread outbreaks
Level 3	• Multiple cases of community transmission occurring • Multiple active clusters in multiple regions
Level 2	• Limited community transmission occurring • Active clusters in more than one region
Level 1	• COVID-19 is uncontrolled overseas • Sporadic imported cases • Isolated local transmission could be occurring in New Zealand

14. **note** it will make sense to take a precautionary approach and have a lower risk tolerance if applying Alert Levels at a local level, particularly in the immediate response as we ascertain the scope of the situation;

15. **agree** that our existing Alert Level settings be retained, with the following exceptions and clarifications:

a. at Alert Level 4, allow a solitary worker (or single household bubble) to work on any business premises, so long as they are able to work and travel to and from work without interacting with anyone else, and the premises are cleaned or left empty for a sufficient period of time between different solitary workers (in accordance with Ministry of Health guidance);

b. at Alert Level 4, provide for the following treatment of freight and fulfilment of online orders:

i. all freight can be delivered, with essential freight prioritised, as previously;

ii. food orders (excluding takeaways) can be fulfilled, as previously;

iii. essential non-food items can be delivered, as previously, but without a requirement for the business to be registered with the Ministry of Business, Innovation and Employment;

iv. non-essential goods can be delivered to the extent that the solitary worker exemption as outlined above is complied with; and

v. for all other goods, online orders can be taken, but not fulfilled by the supplier, at Alert Level 4; and

16. **amend** the Health and Disability Care Services section of the Alert Level framework to note that primary and community providers will operate in accordance with the Ministry of Health's COVID-19 Community Response Framework.

Authorised for lodgement

Rt Hon Jacinda Ardern
Prime Minister

Appendix 1: Operationalising the ‘Stamp it Out’ plan

Appendix 2: Cabinet and Ministerial standard operating procedure for responding to COVID-19 in the community

Operationalising the 'Stamp it out' plan– responding to incidents of COVID-19 in the community

Purpose – To coordinate a nationally-led, regionally-delivered response to community transmission of COVID-19

Response activated by notification of a positive test of COVID-19 in the community that cannot be clearly linked to the border (or MIQ absconder)

Lead agency – COVID-19 AOG Response Group

Primary agency – Ministry of Health

Public health advice remains central to the nature and scope of the response

Scale of response is dependent on scenario – e.g. locally contained/regionally contained/local outbreak with national spread. Tasking is scenario dependent. Timing is dependent on when a case is notified – e.g. if late in the day may wait until morning to announce

When case publicly announced there will be an agreed high level approach to the response

Voluntary compliance with any controls may be encouraged prior to them being legally enforceable

Objectives

1. Minimise number of people infected + exposed to COVID-19
2. Minimise negative health outcomes
3. Minimise the economic + social impacts of any control measures

Key principles

1. Continue to pursue elimination strategy for COVID-19
2. Core of our response will be personal hygiene, staying at home when sick, testing, contact tracing + isolation
3. Where this is insufficient we will seek to control COVID-19 with least intrusive measures including tailored local responses
4. We will seek to avoid going to Alert Levels 3 or 4 if possible, but will do if necessary
5. There will be strong national oversight over any response, regardless of whether the response is local or national in scale

Critical path	0 hour	Phase 1	Phase 2	Phase 3
Critical path depends on the nature + extent of the outbreak – ■ Case identified in community, not linked to border, high risk of community transmission ■ MIQ absconder	■ **Positive case identified** ■ **MIQ absconder** - Case investigation begins - National Response Leadership Group + AOG Response Group notified + stood up - DG engage with PMCSA, COVID-19 TAG, MoH Chief Science Adviser - **DG decision** whether absconder is Code Red – if Amber not dealt with under this plan	■ **PM decide type of response required** e.g. national/regional/targeted closures/other measures + comms approach - **PM/DG/other make public announcement** High level response and what public should do ahead of orders– e.g. stay at home	■ **Immediate response implemented** - Order for AL issued if required (Minister/DG) - Checkpoints established if required	■ **Initial response reviewed + updated** - Decision to extend temporary AL or apply nationally (Minister in consultation with Cabinet) - If necessary steps taken to enable a longer lockdown e.g. support remote learning, wage subsidies

	Who/what?	Key preparation required	0 hour	Phase 1	Phase 2	Phase 3
Decision making + Governance	**National Response Leadership** CE DPMC (Chair) DG Health, DCE DPMC COVID-19 AOG Response Group, CE NEMA	Cabinet mandate for Leadership Group SOP for decision making, reporting + information flows	- Response Leadership Group stood up - DG informs PM, Min of Health	- Advice on immediate controls – e.g. temporary AL3 in district/region (informed by risk assessment)	- Rapid review of immediate responses based on facts as they emerge	- Consider what longer term measures may be required including a move to AL 3 or 4 for district/region to require people to stay at home, physical distancing, contact tracing + mask wearing, control gathering sizes
	COVID-19 National Response Group AOG Planning lead (Chair), AOG Policy lead, AOG Comms lead, Deputy DGs Health (Response + COVID Hub), Director CDEM (+ others dependent on scenario)	Establish Response Group + command structure SOP for decision making , reporting + information flows at local + national levels	- Convene the Response Group + coordinate the planning, communications + assurance functions - AOG Operations Centre stood up - Ascertain intial facts	- Enlist additional personnel from agencies if required - Information + advice to CEs focused on immediate actions (eg, controls, communications, health response)	- Assign tasks - Workstream meetings convened - Monitor implementation of response + compliance	- Enable response at the local level through provision of resources + expertise
	Director General of Health + Minster of Health		- DG engage with PMCSA, COVID-19 TAG, MoH Chief Science Adviser - Oversee case investigation	- Advise PM + Minster of Health re appropriate response	- Issue Orders under Health Act/COVID Act	- Advise PM + Minister of Health on longer term response
	National Security System		- Activation of the National Security System	- Watch Group, ODESC + Ministers convened under urgency or as the situation/scenario requires		- ODESC/WATCH Group/Ministers meet as required
	Regional Leadership Groups – regional governance and oversight Groups already exist – variously comprise local authorities, iwi,	Confirm register + contact details Regional resurgence plans with clear roles + responsibilities consistent with national command structure	- Establish communication with National Response Group - Leader convenes group to coordinate planning, comms + assurance at local level	- Hold VC meeting with National Response Group - Liaise + coordinate with National Response Group + Medical Officer	- Liaise + coordinate with National Response Group	- Work with MSD to determine need and responsibility for longer term welfare support

	Who/what?	Key preparation required	0 hour	Phase 1	Phase 2	Phase 3
	Police, regional Crown officials (including MSD), DHBs, MOoH + CDEM.	Table top exercises involving National Response Group + CDEM Groups SOP developed for how CDEM groups integrate with national response + health system				
	CDEM Groups – regional operational lead				- Action tasks directed by the Regional Leadership Group + National Response Group	- Provision of emergency support if required
	NEMA/CDEM	Brief CDEM Group leads on governance + decision making structure		- Decision to seek declaration of state of emergency from Minister CD (local/national) - Management of wider consequences of the emergency		
Health system	**Health response** DG Health + Medical Officers of Health (MOoH)	Maintenance of Cluster Investigation + Control Guidelines + National Contact Tracing Solution	- Investigate case/outbreak Require individuals to self-isolate +/or close businesses/schools/other facilities (targeted closures) – link to announcement of case	- Directs health assessment of all close contacts - Consider appointing cluster coordinator +/or national cluster coordinator	- Ongoing investigation + cluster control measures	
	Health system preparedness MoH + DHBs Resurgence Action Plan + Response Manual	Finalisation + publication of Resurgence Action Plan		Consider activation of Resurgence Action Plan	Implement COVID National Hospital + Health Sector Community Response Frameworks	
	Testing DHBs, MoH, testing laboratories	MoH Confirm testing capacity can be scaled up if required		- Implement intensive targeted testing, including of close + some casual contacts Expedited testing for close contacts	DHBs scale up testing centres + community testing	
	Contact tracing MoH National Investigation + Tracing Centre + PHUs	Ensure protocols in place for rapid contact tracing (including prioritisation of testing) Continuous improvement of contact tracing system + incorporation of new technologies + information sources e.g. Bluetooth proximity detection	- Begin case investigation process	- Undertake case interview Begin to trace, test + interview all close contacts	Ongoing tracing, testing + interviewing of close contacts	- Ongoing tracing, testing + interviewing of close contacts - Tracing, interviewing + testing of any newly identified cases + their close contacts Appoint cluster coordinator
	PPE MoH, DHBs + PHUs AOG coordinating role for masks	Minister of Health/Cabinet confirm masking policy Ensure appropriate PPE supply in place (AOG role re masks) Ensure PPE guidance is available for different Alert Level settings		- Ensure PPE plans activated in community health sector - Review stock levels + forecasted usage	- Ensure adequate PPE available for health care workers	- Ensure adequate PPE available for health care workers + masks for public (if required) If appropriate, review IPC (infection prevention + control) guidance
Legal + regulatory	DG + COVID-19 AOG Response Group Health Act 1956 , COVID-19 Public Health Response Act 2020 + CDEM Act 2002	Generic template s11 orders drafted for district/regions De-escalation pathway developed		- DG or Minister of Health make temporary regional s11 Order under COVID Act - DG brief Minister of Health - National Response Group consult CDEM on declaration of state of emergency		- AOG seek Cabinet direction to adjust response measures, e.g. increase AL nationally or extend local/regional AL beyond initial period or relax measures (reduce AL or apply to smaller area)
Enforcement + compliance	AOG coordinated. Police, NZDF, MPI, MBIE, WorkSafe as required	Plans + enabling policies to enable scalable response dependent on scenario Ops plan for roadblocks/checkpoints across all key regions Clear policy on allowable movement out of locked-down area (e.g. under AL3)	- Seek, receive + act on intelligence	- Implement check points/road blocks to seal district/region (if required) - Monitoring + enforcement of people self-isolating (including outside of any locked-down region)		

	Who/what?	Key preparation required	0 hour	Phase 1	Phase 2	Phase 3
Intelligence	AOG Insights and Reporting Group MoH COVID Hub	SOP (linked to MoH COVID response manual) to confirm how real time info will flow + to whom + how risk assessments will be undertaken Policy to enable information sharing	MoH will produce a SitRep within 90 minutes including case, cluster + response measure information derived from EpiSurv + other health sector sources	- MoH intelligence brief to National Response Group to support risk assessment Community vulnerability assessment to National Response Group + CDEM Group		Intelligence brief by MoH + AOG Intelligence Group to support decisions post 96 hours
Local government + community outreach	AOG – Caring for Communities, DIA	Continue to engage with key community leaders to build relationships + enable effective response	- DIA + Caring for Communities notified	- Engage with relevant communities + local authorities - Liaise with CDEM Groups	- Monitor + report on issues in community - Liaise with CDEM Groups	- Monitor + report on issues in community - Advise MSD re longer term welfare needs and agree responsibility for longer term welfare support - Liaise with CDEM Groups
Communications	Unite Against Covid-19 Campaign – developed + delivered by COVID-19 AOG Response Group	Develop resurgence response communications plan to ensure an aligned, effective + timely communications response. To include; objectives, key messages, audiences, channels, tactics, spokespeople. Develop resurgence response communications information flows + sign off processes Develop resurgence response templates for collateral (i.e. fliers, letter drops) + campaign (i.e. digital + TV ads) Develop resurgence readiness communications plan to ensure stakeholders + the public are informed + prepared	- Social media posts on UAC-owned channels (we can pay to boost from within DPMC)	- Radio ad libs supplied once messages confirmed (2 hours) - Pre-recorded radio produced and supplied to stations (4 hours) - Paid social media (4 hours) - Digital display (6 hours) - Digital video (8 hours)	- Digital outdoor (12 hours) - TV recorded, animated and supplied to stations (8 - 24 hours)	- National press next day if creative supplied by 6pm day prior - Physical outdoor printed and installed (36 hours) - Letterbox drop (48 – 96 hours)
	Engagement with central + local government, relevant sector agencies, iwi, NGOs + support agencies – convened + coordinated through AOG COVID Response Group		- Engage with key stakeholders across affected area (including iwi, local government, NGOs, response + support agencies), identify comms risks, emerging issues - Provide key messages across all stakeholders to support the response		Develop + deliver targeted comms needed for: - high risk/vulnerable audiences - Businesses - Iwi	
	Coordination across government + response – coordinated through COVID AOG Response Group		- Coordinate information flows, messaging, spokespeople + signoffs across government (central + local) + response agencies - Deliver response communications including preparing key messages + spokespeople + managing media as appropriate - Provide strategic comms + engagement advice + support to inform response related policy + response operations - Work with NEMA to deploy Emergency Mobile Alert if appropriate			
Education	Ministry of Education	Resurgence Plans updated		- Implement closures of school, university + ECE centre sites if ordered by DG/COVID Act Order - School hostels + tertiary hostels continue to operate for students unable to return home		- Education providers to implement distance learning where practicable
Transport	Ministry of Transport AOG	Identify essential transport services that would be exempt from AL restrictions National transport plan to implement restrictions associated with ALs Guidance for transport operators + users at higher ALs	- Scale up Transport Response Team	- Contact key transport sector stakeholders to support them to implement AL or other controls - Publish information + guidance for transport operators + users	- Subject to decision of ODESC, deploy operational staff to support implementation of controls	
Welfare	AOG - Caring for Communities MSD CDEM groups Mental Health	Confirm policy on what support will be available for businesses employees + self-employed, + planning for FMCG Clarify respective roles of CDEM + MSD in the medium/long term in providing welfare support		- AOG liaise with local C4C groups + CDEM to coordinate delivery of services + advise on local needs - Advice on MIF for cases that can't self isolate		- Ministerial decisions on what support to businesses + employees if temporary lock down extended
Businesses + workplaces	MBIE , WorkSafe, MBIE	Revise and update essential services and risk mitigation measures				- Begin compliance activities (focused on education) - -Officials available to respond to enquiries

Cabinet and Ministerial Standard Operating Procedure for responding to COVID-19 in the community

0 hour

INFORMATION FLOWS

- Positive case identified
  - DG Health informs PM (as overall lead)
    - PM or PMO informs DPM, AG, Min of Justice, Min of Finanance + Min of Health as required
  - DG informs Min Health (as health lead)
    - Min of Health informs Min of Justice
  - CE NEMA informs Min of Civil Defence
  - DPMC DCE of COVID-19 Response informs Min of Housing

ADVICE

- DG activates National Response Leadership (NRL)*
  - Initial advice
    - Full advice, from NRL, including advice from DG Health
    - Drafting of legal orders, as directed by NRL

DECISIONS

- Initial briefing of PM, DPM, AG, Min of Finance, Min Justice + Min Health by NRL, deciding:
  - Type of response required (regional/national)
  - Public communications approach
  - Any public actions requested ahead of legal orders
- PM, DPM, AG, Min of Finance, Min Health + Min Justice meeting deciding response e.g. controls or Alert Level
- Signing of section 11 COVID Act orders by Min of Health

PUBLIC COMMUNICATION

- Possible immediate public communications by PM, of recommended public actions, supported by Min of Health **
- Announcements by PM of impending Alert Level changes, supported by Min of Health
- Unite Against COVID-19 digital campaign in place

- NRL = Brook Barrington (Chair, CE DPMC), John Ombler (DCE, DPMC - COVID-19 AOG Response Group), Ashley Bloomfield (DG Health lead health adviser), Carolyn Schwalger (CE NEMA)
- ** Public communications support from Andrew Campbell (PMO),Heather Peacocke (DPMC), Paul Giles (Health) and Richard Trow (Min of Health press sec)

CAB-20-MIN-0387

Cabinet

Minute of Decision

Rapid Response and Changes to COVID-19 Alert Level Settings

Portfolio **Prime Minister**

On 10 August 2020, Cabinet:

Need for rapid response

1 **noted** that:

1.1 immediately following a new COVID-19 case being detected in the community, there may not be sufficient information to adequately assess risk;

1.2 in this situation, rapidly applying short-term local or regional controls, such as restrictions on movement and physical distancing, requiring people to stay at home, and limiting gathering sizes to reduce the risk of further transmission, may be the best way to manage risk while further information becomes available;

2 **noted** that:

2.1 the Minister of Health or the Director-General of Health may make an Order under the COVID-19 Public Health Response Act 2020 (the COVID-19 Act) without prior consideration of the situation by Cabinet or COVID-19 Ministers (although the Minister of Health would be required to consult the Prime Minister and the Minister of Justice);

2.2 an Order that responds to new cases in the community that are not connected to the border is likely to reflect restrictions up to and including those similar to Alert Level 3 in a local area for a period of up to 96 hours;

Ministers with Power to Act

3 **authorised** a group of Ministers to have Power to Act to take decisions on the government response to COVID-19, comprising the Prime Minister, the Deputy Prime Minister, the Minister of Finance, the Attorney General, the Minister of Health and the Minister of Justice (COVID-19 Ministers);

4 **noted** that this group of COVID-19 Ministers supersedes the previous group of Ministers with Power to Act authorised by Cabinet on 19 March 2020 [CAB-20-MIN-0130];

Rapid response plan

5 **noted** that officials have developed a rapid-response high-level plan to guide the All-of-Government response in the early hours and days following confirmation of a new case in the community;

6 **agreed** that the plan include a National Response Leadership team made up of the:

6.1 Chief Executive of the Department of Prime Minister and Cabinet (DPMC);

6.2 Director General of Health;

6.3 Chief Executive, National Emergency Management Agency;

6.4 Deputy Chief Executive, COVID-19 All-of-Government Response Group, DPMC;

6.5 Secretary to the Treasury;

6.6 Commissioner of Police;

7 **noted** that the team will have four primary roles:

7.1 provide All-of-Government advice to Cabinet (or COVID-19 Ministers);

7.2 provide non-health advice to the Director General of Health to inform his use of powers under the COVID-19 Act;

7.3 engage the COVID-19 National Response Group;

7.4 activate the relevant regional leadership group to coordinate the local operational response and provide direction to that group as required;

8 **approved** the rapid-response plan, including the role of the National Response Leadership team, attached as Appendix 1 to the paper under CAB-20-SUB-0387, **subject to** any amendments that are needed to reflect the decisions in this minute;

9 **invited** the Minister of Health to report back to the Cabinet Business Committee by 24 August 2020 describing current plans for surging testing capacity (both swabbing and laboratory capacity) as well as any possible future enhancements to these current capabilities;

Alert Level settings

10 **noted** that on 6 July 2020, Cabinet:

10.1 approved the contents of an overall plan for responding to new cases of COVID-19 in the community, should these emerge;

10.2 invited the Prime Minister to report back to Cabinet on any necessary or desirable changes to Alert Level settings, including updated risk assessments to guide decisions on moving between Alert Levels;

[CAB-20-MIN-0330]

11 **agreed** that the following factors be retained for informing decisions by Cabinet regarding national or local Alert Level changes:

11.1 the Director-General of Health's satisfaction on four health matters:

11.1.1 the trends in the transmission of the virus, taking into account his confidence in the data, are consistent with the risk level outlined in paragraph 12 below;

11.1.2 the capacity and capability of New Zealand's testing and contact tracing systems;

11.1.3 the effectiveness of New Zealand's self-isolation, quarantine and border measures;

11.1.4 the capacity in the health system more generally to move to the new Level, including the workforce and ICU capacity, plus the availability of PPE for those for whom it is recommended;

11.2 evidence of the effects of the measures on the economy and society more broadly;

11.3 evidence of the impacts of the measures for at risk populations in particular;

11.4 public attitudes towards the measures and the extent to which people and businesses understand, accept and abide by them;

11.5 the ability to operationalise the restrictions, including satisfactory implementation planning;

12 **noted** that, in light of New Zealand's increased preparedness for new cases in the community, it is appropriate to alter the risk assessments regarding the state of COVID-19 that informs changes in nationwide Alert Levels;

13 **rescinded** the thresholds for transmission outlined in CAB-20-MIN-0199 (paragraph 6); and instead

14 **agreed** to the risk assessments contained in the following table:

Alert Level	**Risk assessment** *The Director-General of Health is satisfied that there is sufficient data from a range of sources to have reasonable certainty that there is/are:*
Level 4	• Sustained and intensive community transmission • Widespread outbreaks
Level 3	• Multiple cases of community transmission occurring • Multiple active clusters in multiple regions
Level 2	• Limited community transmission occurring • Active clusters in more than one region
Level 1	• COVID-19 is uncontrolled overseas • Sporadic imported cases • Isolated local transmission could be occurring in New Zealand

15 **noted** that it will make sense to take a precautionary approach and have a lower risk tolerance if applying Alert Levels at a local level, particularly in the immediate response as the scope of the situation is ascertained;

16 **agreed** that the existing Alert Level settings be retained, with the following exceptions and clarifications:

16.1 at Alert Level 4: allow a solitary worker (or single household bubble) to work on any business premises, so long as they are able to work and travel to and from work without interacting with anyone else, and the premises are cleaned or left empty for a sufficient period of time between different solitary workers (in accordance with Ministry of Health guidance);

16.2 at Alert Level 4: provide for the following treatment of freight and fulfilment of online orders:

16.2.1 all freight can be delivered, with essential freight prioritised, as previously;

16.2.2 food orders (excluding takeaways) can be fulfilled, as previously;

16.2.3 essential non-food items can be delivered, as previously, but without a requirement for the business to be registered with the Ministry of Business, Innovation and Employment;

16.2.4 non-essential goods can be delivered to the extent that the solitary worker exemption as outlined above is complied with;

16.2.5 for all other goods, online orders can be taken, but not fulfilled by the supplier;

17 **agreed** to amend the Health and Disability Care Services section of the Alert Level framework to note that primary and community providers will operate in accordance with the Ministry of Health's COVID-19 Community Response Framework;

Further work

18 **directed** officials from the COVID-19 All-of-Government Response Group and the Ministry of Business, Innovation, and Employment to further review the operationalisation of the Alert Level settings, and to report back to COVID-19 Ministers as soon as possible;

19 **noted** that work is continuing on the expectations in regards to managed isolation and quarantine for any COVID-19 cases detected in the community and the assurance system for this.

Michael Webster
Secretary of the Cabinet