Document 1

Minutes/ Actions

IIAG Special Meeting

Date:	Tuesday 2 March 2021
Time:	12:00pm – 1.15pm
Location:	Teams
Attendees:	Ana Bidois, Api Telemaitoga, Angela Ballantyne, Carl Billington, Denise Mackay, Dr Rawiri McKree Jansen, Keriana Brooking, Loretta Roberts, Michael Dryer, Nikki Turner, Rhonda Sherriff, Taima Campbell, Te Puea Winiata, Wendy Illingworth, Casey Pickett, Nicky Birch

Item	Agenda Item
1.	**Introduction** • Wendy opened explaining that there are two pieces of advice that the Programme is working on this week; a process for alert level decisions and what they mean for the immunisation programme, and a paper on what the current outbreak means for sequencing scenarios. • Casey explained the current situation and a view of next steps. Cabinet wants reframed advice on the Sequencing Framework with a strong link back to the elimination strategy. The team is updating the paper this week, which will include options for responding to the current outbreak in South Auckland.
2.	**Open discussion** • There was some consensus from the group that mashing scenario 1 and 2 is problematic. Casey clarified that changes in early February talked about a relentless focus at the border, which is why there is an option to bridge scenarios 1 and 2, as the border isn't finished yet. • Mat noted that from the MOH Covid Directorate point of view, we should stay in Scenario 1 because the cluster is controlled. However the team is also thinking about South Auckland and is undertaking operational planning to speed up delivery. There is potential for a large scale vaccination centre in South Auckland next week. • Rawiri suggested that if Auckland stays at level 3, it will be hard to argue against going to scenario 2. If Auckland moves to level 4 we need to focus only on South Auckland. This could include one dose for everyone and drive-through vaccination centres. • Keriana noted the difference between urgent and important. It will be important we don't lose sight of all the different strategies e.g. from an equity perspective, at what point do we stop feeling ok about the data? ***Action 1: Nikki Birch requested a direct contact for iwi in each region as they don't know who to work with and don't want to miss opportunities.***
3.	**Clarification of actions for IIAG** • Mat clarified that the discussion landed in two places: 1. MOH requested a consolidated position from IIAG on which sequencing scenario to operate under next week. This will be copied into the Cabinet paper. 2. The agenda for IIAG on Friday will focus on the design of the programme, including success criteria and tolerances, and workforce issues and options

	Action 2: The MOH team requested a consolidated position from IIAG on which sequencing scenario to operate under next week.
4.	**Closing comments** • Rawiri requested that MOH be really direct on what they're expecting from DHBs. • Te Puia requested updates from MOH on a daily basis ***Action 3: Mat Parr to come back to the group with update on daily comms to IIAG.***

Document 2

IIAG Minutes/Actions

Date:	5 Poutū-te-rangi/March 2021
Time:	1:00 pm – 4:00 pm
Chair:	Keriana Brooking
Attendees:	Dr Rawiri Jansen, Nikki Turner, Loretta Roberts, Beth Williams, Rhonda Sherriff, Kevin Pewhairangi, Silao Vaisola-Sefo, Dr Tristram Ingham, Nicky Birch, Vince Barry, Angela Ballantyne, Taima Campbell, Apisalome Talemaitoga, Mathew Parr, Carl Billington, Michael Dreyer, Tamati Shepherd-Wipiiti, Te Puea Winiata, Allison Bennett, Fleur Keys, Mat Parr, Jo Bourne, Ray Finch
Apologies:	

Item	Agenda Item
1	**Introduction and welcome** • Opened with a karakia. • Minutes from the last meeting and the special meeting on 2 March were confirmed.
2	**Conflicts of interest register – any updates** • No conflicts of interests were registered.
3	**Programme update** *Mat Parr (Programme Director) provided an update about the programme* • Mat noted that in response to the special meeting on scenarios for the sequencing framework, MOH is looking to send a letter directly from IIAG to Minister Hipkins. The group supported the letter and this approach. • The Sequencing Framework has been lodged for Cabinet on Monday. • Mat noted that there are multiple important components that are starting to come together to create and overarching strategy for the programme. Discussion: • The group noted that they are interested to see how everything is coming together and would like to have a view across the programme. The group would also like updates on how the programme is going. **Action 6:** Mat Parr to share daily reporting with the group and ask Jo Gibbs to give an update at the next meeting.
4	**Success framework** *Allison Bennett and Fleur Keys (Policy) provided an update about the vaccinator workforce*

	• Allison explained that this framework responds to Ministers' interest in targets for the Immunisation Programme. The framework aims to help decision-making within the programme and provide clarity around the different aspects and trade-offs that need to be thought about. Group feedback: • General consensus that the concept is good, but lots of suggestions for refinement. For example: ○ Disabilities should be added to the equity section. ○ There shouldn't be public measures about hesitancy as this could exacerbate the problem. ○ Need a separate box to represent Te Tiriti – the partnership in itself will be a very important measure of success ○ There is a need to have a sophisticated monitoring programme alongside this framework and decide whether it will be done from inside the programme or outside. • The group suggested other measures that could be included in the framework: ○ High quality data, as well as denominators for what we can measure e.g. ethnic groups, rural communities ○ Sustainability of the programme e.g. training new workers and providing ongoing opportunities. ○ Health literacy ○ Avoided hospital admissions ○ Link to other immunisation programmes • The group noted that there are so many different things that can be measured, but they would like to be involved in deciding on priorities for monitoring. **Action 7:** Allison and Fleur to refine the framework and return to the IIAG with a second iteration.
5	**Workforce update** *Fiona Michelle provided an update on the vaccination workforce.* • At the time of reporting, there were 851 vaccinators. • Data this week suggests that not as many vaccinators are needed as originally thought; now 1200-1500 instead of 2-3000 but this is early data. Group discussion: • Fiona noted that there is a plan to put more Māori and Pacific vaccinators through training. MOH is currently looking into options for the non-regulated workforce. In response to this, Kevin noted that he thinks Pharmacy insurance covers technicians. • There was a discussion about whether more people should be put through the training now. IMAC explained that there is technically no limit but they are focussing on an information module about vaccines this week. The group noted that they would like to be involved further in discussions about training numbers.

Document 2

6	**Auditor General advice update** *Mat Parr noted that the Auditor General is conducting an audit on the vaccine and immunisation programme to provide independent advice to parliament. This will involve a series of interviews, including with IIAG members. Mat suggested that IIAG will have a valuable view, seeing as they have been involved in the programme since the beginning.*
7	**Service Delivery Models** *Joe Bourne (GM, Event Pillar) presented an update on service delivery models.* • Jo ran presented MOH's work on service delivery models. The goal of this work is to ensure every site is safe, makes the most of existing processes, and manages constraints and trade-offs. Joe also noted that MOH is focussed on creating partnerships with stakeholders in the event design work, to ensure that people have trust in the programme to meet their needs. Discussion: • The group raised the fact that they haven't seen all the documents as a whole and would like to see alignment across the whole programme. • The balance between DHBs and MOH managing the immunisation programme was raised. Jo mentioned that he is doing a lot of thinking on this point and there are positives and negatives with both. • A question was raised about whether anyone can receive the same services in any region e.g. a person with disabilities. Jo explained that the idea with the different service delivery models is that there will be underlying consistency across the programme, but the partnership approach means that DHBs will be responsible for ensuring that everyone in their region has the ability to get vaccinated. • The issue of monitoring was raised again with a request for a central point for all the information to feed back to.
8	**Te tiriti and equity framework** *Tamati Shepherd-Wipiiti and Ray Finch provided an update on the equity strategies.* • Last week a set of funding instruments for the Māori and Pacific strategies was approved by the Governance Group and by Ministers. • Tamati explained that there is a cross-agency equity team that is being led by MOH in partnership with other agencies that work with specific populations e.g. OEC, TPK, MSD, MPP • The goal of this work is to line up all of the support, regardless of where it comes from so that there is a match of local and regional support around the country. There will be a monitoring framework next week that explains how these outcomes can be measured. • Ali gave an update on the Pacific strategy, explaining that it is on track and embedded into the governance of the programme. A focus at the moment is working with MPP on community fonos. • Rae provided an update on the disability strategy, including that a disability subgroup of IIAG is being set up.

	• Tamati explained that the Māori strategy is separate from the other equity strategies to honour te tiriti. Discussion: • The Asian elderly population was raised as a vulnerable group and should be considered in the equity approach. • Hesitancy was raised. It will be important that the system does a good job of informing people and making the process easy. **Action 8:** Tamati to follow-up on start dates for Māori and Pacific communications plans.
9	**Technology update** *Michael Dreyer (Group Manager, National Digital Services) presented an update on the technology landscape.* • Michael presented a diagram of the technology landscape. • The CIR is working well and later in the year everything from the old NIS will be migrated to create the new NIR. At the moment the CIR captures everything that's critical to the campaign and includes online training so vaccinators can use it on day 1. • Michael explained that the immunisation programme is a national campaign that is being delivered locally, so it is important that the technology can see what is happening at both levels and has an end-end view. • The national booking system is underway. It will be an extension of the covid tracer app and will have a consumer channel for people to book, see their vaccination status, report an adverse reaction, learn about vaccines, and update personal information e.g. iwi, disability. Discussion: • The group asked whether it would be possible to see RAG ratings for the different tech components at the next meeting. It would be useful to see how the system is tracking as a whole. • The group asked Michael what was worrying him and he noted that getting the booking system delivered nationally is a big task and is essential to scaling later in the year. **Action 9:** Michael Dreyer to provide RAG ratings for the technology components to the group.
10	**Communications and Engagement** *Carl Billington presented an update on communications and engagement.* • The team is reclarifying roles in comms and engagement and Carl will share new responsibilities with the group. • The team is looking to pick key messages back up going forward, which will be shared with the group. • Rachel from DPMC provided an update on the campaign which is being run under the broader "unite against covid brand". Rachel noted that they are starting with a low-level media campaign to begin with focussing on the fact that people need to remain vigilant. They don't want to go out too early and create demand for vaccinations we can't meet, however they are balancing

	this with the need to reassure people that the vaccines are safe and there are enough for everyone.
11	**Closing/Karakia whakamutunga**

Action Tracker 5 March

Item	Action	Lead	Due Date
01	Share daily reporting with the group and ask Jo Gibbs to give an update at the next meeting.	Mat Parr	19 March
02	Refine the success framework and return with a second iteration.	Allison Bennett	19 March
03	Follow-up on start dates for Māori and Pacific communications plans.	Tamati Shepherd-Wipiiti	19 March
04	Provide RAG ratings for the technology components to the group.	Michael Dreyer	19 March

Document 3

IIAG Minutes/Actions

Date:	19 Poutū-te-rangi/March 2021
Time:	1:00 pm – 4:00 pm
Chair:	Keriana Brooking
Attendees:	Dr Rawiri Jansen, Nikki Turner, Loretta Roberts, Beth Williams, Rhonda Sherriff, Kevin Pewhairangi, Dr Tristram Ingham, Nicky Birch, Vince Barry, Angela Ballantyne, Taima Campbell, Apisalome Talemaitoga, Mathew Parr, Carl Billington, Michael Dreyer, Tamati Shepherd-Wipiiti, Te Puea Winiata, Allison Bennett, Fleur Keys, Mat Parr, Joe Bourne, Ray Finch
Apologies:	Silao Vaisola-Sefo

Item	Agenda Item
1	**Introduction and welcome** • Tristram opened with a karakia. • Minutes from the last meeting confirmed.
2	**Conflicts of interest register – any updates** • No conflicts of interests were registered.
3	**Communications and engagement** *John Walsh provided an update about the comms programme* • John is leading the comms programme out of DPMC for the next 3 months. • The tentative overarching position of the campaign is "the stronger our immunity, the greater our possibilities" • There are three tasks for the comms campaign: ○ Inform people ○ Help people to understand their role and plan for it ○ Share the notion of possibilities from immunisation • John will send a plan to the group next week for discussion at the next meeting • The advertising campaign could begin in early April *Rachel provided an update on the "soft launch" last weekend* • A press ad and radio ad went live last week and will continue until April 11. • The social media campaign started on Wednesday • The campaign is based around "safe, effective, free" messaging Group discussion: • There were questions about how the general campaign relates to the Māori comms campaign. General consensus from the group was that the overarching campaign doesn't work for Māori and isn't moving quickly enough. Māori and

	Pacific groups and agencies (including MPP and TPK) are moving ahead with their own comms campaigns. • Concerns were raised about IIAG's role in providing advice as the group doesn't feel like their advice has been listened to. There was also concern raised about Ministers leading a health programme and Mat Parr agreed to pick this action up with a briefing to Ashley. **Action 1:** Gabe to share Mahi Tahi videos with the group **Action 2:** Carl to bring back a report on "soft launch" campaign and who it has reached **Action 3:** Mat Parr will send a briefing to Ashley on Monday about role of IIAG.
4	**Workforce training** *Loretta Roberts provided an update about vaccinator training* • Over 4000 people have gone through provisional training and close to 100 have completed peer assessments. • The Train the Trainer module has been delivered in some regions and will be rolled out in additional regions over the next two weeks. • The programme for GPs and information course is on hold due to clinical changes. • Regular webinars are being held for GPs and primary care. Any healthcare workers will be able to do the general course on the website from next week. Group discussion: • There was discussion about deciding to only use Pfizer and the group not being consulted on this. Mat Parr explained that the Pfizer purchase didn't preclude the other vaccines being used at some point / for some parts of the programme. • There was concern raised about DHBs acting as gate keepers for vaccine training. There is potential for the group to write a piece of advice on this. • Tristram requested that disability information be collected from the vaccinator workforce. Michael Dreyer and IMAC will pick this up. **Action 4:** Michael and Loretta to organise the collection of disability information for vaccinator workforce.
5	**Sequencing Framework update** *Wendy Illingworth provided an update on the sequencing framework.* • Wendy explained the process for deciding the sequencing framework • While the framework has been agreed by Cabinet, there will be a pragmatic and flexible approach to delivery. Group discussion: • The group raised concerns over information flows from the Ministry of Health. For example, IMAC found out about the sequencing framework from the press release and then had to adapt the vaccinator training. Carl took this as an action. • Concerns were raised about policy decisions not following science and Ministers needing to be clear that this presents risk for the programme. **Action 5:** Carl to ensure IIAG is looped into significant decisions / progress in the programme.

6	**Service delivery models** *Joe Bourne gave an update on service delivery models, explaining that they are a work in progress so there is time for the group to provide input. While the plan is to have national consistency, there will also be variability and flexibility for what DHBs need for their regions.* Group discussion: • The group raised that marae centres will need to be a relationship building exercise with iwi. • Taima asked how Māori providers are linked to DHBs. Tamati explained that there are multiple avenues but we need to manage communications between them. This is a work in progress. • Concerns were raised about providers obligation to abide by the standard operating model e.g. how much vaccinators are being paid differs across providers. MOH acknowledged this is an issue that is being worked through and a paper is going to Steering Group next week.
7	**Tech update (Michael Dreyer)** *Michael Dreyer provided a technology update.*
8	**Programme update including ops (Luke Fieldes)** *Luke provided an update on the programmes reporting.* Group discussion: • Need to also provide public facing reporting for transparency • Agree with iwi data being collected predicated on having Māori data sovereignty and Māori data governance in place, and using standardised iwi data sharing protocol
	Closing/Karakia whakamutunga

Action Tracker 19 March

Item	Action	Lead	Due Date
1	Share Mahi Tahi videos with the group	Gabe Para	
2	Bring back a report on "soft launch" campaign and who it has reached to next IIAG	Carl Billington	
3	Send a briefing to Ashley on Monday about role of IIAG.	Mat Parr	
4	Organise the collection of disability information for vaccinator workforce.	Michael Dreyer & Loretta Roberts	
5	Ensure IIAG is looped into significant decisions / progress in the programme.	Carl Billington	
6	Agenda items for next meeting: • Comms update for Māori, Pacific, Asian and Disabilities • Logistics of the programme		

Document 3

Document 4

IIAG Minutes/Actions

Meeting - Friday 14 Haratua 2021

Date:	14 May 2021
Time:	1:00 pm – 4:00 pm
Co-Chairs:	Te Puea Winiata, Keriana Brooking
Members attending	Dr Angela Ballantyne, Nicky Birch, Taima Campbell, Dr Tristram Ingham, Rhonda Sherriff, Kevin Pewhairangi
MoH Attendees:	Jason Moses, Mat Parr, Carl Billington, Joe Bourne (item), John Harvey (item), Fiona Michel (item), Petrus van der Westhuizen (item), Tamati Shepherd-Wipiiti Carol Hinton (Minutes)
Apologies:	Dr Helen Petousis-Harris, Loretta Roberts, Dr Apisalome Talemaitoga, Dr Nikki Turner, Silao Vaisola-Sefo

Item	Agenda Item
1	**Introduction and welcome** • Keriana Brooking opened with a karakia. • Mat Parr noted that the Director-General of Health, Dr Ashley Bloomfield, was unable to attend this IIAG meeting but was keen to in the future. • Mat Parr apologised that due to a change of timing for the weekly Vaccine Ministers' meeting, he could only attend part of the IIAG meeting. • No conflicts of interest were registered.
2	**Terms of Reference (ToR) refresh** *Context* • Te Puea Winiata acknowledged Keriana's contribution in the expression of the concerns of the group over past weeks. • This meeting was an opportunity regroup and review the ToR. • Keriana felt the group would be happy to put forward its thoughts but leave Te Puea to work with the Ministry to refresh the ToR. She also acknowledged that some may not wish to continue their membership. *Role of IIAG* • Te Puea noted the Director-General's letter confirmed IIAG was the principal advisory group helping to design the overall programme, and assured us that the Group has been influential, with many recommendations moving into Cabinet papers. • Members want to feel there is a point to the amount of time and advice they will be giving going forward. Being advised in a more timely way when the Group's

	advice is incorporated into advice to Ministers and Cabinet would be helpful. They would also like a 'whole system' understanding - how advice that is subsequently accepted translates into action 'on the ground' at DHB level. • The group noted it incorporates an 'equity' lens into its advice, but did not delineate this, considering it an integral part of 'doing the right thing'. ***Action 1: MoH (Mat Parr) to consider how best to provide 'whole system' advice to IIAG so that it is clear what advice is incorporated into policy advice, and what then moves into decisions and implementation.***
	Group discussion Keriana invited members to share their reflections: • Nicky Birch: felt the group had potential to make a significant difference to both policy planning and delivery, and noted her disappointment that the group had not had the impact she had expected. • Taima Campbell: asked what had changed over the interim period in terms of consideration of IIAG advice. The CVIP Programme does not have good access to 'grass roots local provider' level insights and needs to ensure DHBs have the right information. As a provider she directly experiences the impact of disconnect and mixed messaging from DHBs. • Kevin Pewhairangi: Focus on vaccination rollout through pharmacies. Noted that prior communications and engagement with Māori communities is essential for effective rollout. Misinformation is a constant challenge. • Angela Ballantyne: Felt the advice of the group had not made a substantive impact outside of the programme, for example, to equity and fairness. Happy to move forward but had some reservations that the Director-General's letter responding to the IIAG's concerns did not acknowledge all the substantive issues raised. • Rhonda Sherriff: Also concerned about disconnect between IIAG and delivery 'on the ground'. There is a disconnect between DHBs and providers. • Tristram Ingham: Committed to seeing the group move forwards as it does have value. However he does have concerns and suggests that comms and engagement needs to be strengthened, and certainly for the disability sector. Suggests something like a 'daily digest email' from the Ministry could help with this. ***Action 2: MoH to consider how best to provide regular updates on programme progress to IIAG members.***
3	**Operational Update (John Harvey/Joe Bourne)** • DHB vaccination planning to end June is agreed. As at 9 May, we were at 107% of plan. Need to monitor carefully due to constrained supply of Pfizer to end June. • Establishing a national Quality and Safety framework, including defining minimum standards, to support delivery of the programme and to provide assurance about the quality of delivery and vaccination. • Will also establish a national clinical network across a provider backdrop to monitor planning and development of quality assurance for the programme. *Group discussion* • Keriana noted the A3 operational update and asked if this could be more detailed so that it could be provided to the groups that members represent.

	• Taima asked if the vaccine supply constraints related to supply as a whole, or were simply about sequencing, and whether there would be opportunities to be involved on the safety and quality network. • Mat Parr said that confirmed DHB plans to end June required 1.161 million vaccines against 1.25 million supply. He confirmed that New Zealand had enough vaccine in hand to deliver to these plans but needed to manage distribution and storage carefully to avoid wastage. We expect confirmation of ongoing supply in the new few weeks and are in daily contact with Pfizer. He also noted that DHBs were expected to have a strong equity focus when prioritising distribution of any unused vaccine. • Keriana asked if DHB plans were available to IIAG members (in particular the plan relating to a member's DHB). Mat will follow up on this. ***Action 3: MoH to consider how the information in the A3 can be enhanced to include more information which Members can circulate more widely.*** ***Action 4: MoH to follow up re membership of safety and quality network.*** ***Action 5: Mat Parr to consider if IIAG members can receive the rollout plan for their own DHB.***
4	**Service delivery/rollout sequencing (Joe Bourne)** • Joe noted findings of a recent research article re large scale vaccination sites across Europe. Large sites are best suited to those who are keen to be vaccinated and do not have provider preference. NZ rollout planning must consider groups who are not comfortable in that environment and who want a trusted local provider. • Taima agreed, also noting that many people in her area are keen to be vaccinated but nonetheless would not attend a large site. So mass vaccination may address volume, but not equity. • Te Puea endorsed she would like to see more DHBs working with providers to do smaller bespoke events over the larger events. She also noted that the group had no visibility over funding streams, in particular for disability support for community service providers. • Mat Parr advised that Vaccine Ministers have been clear with the Ministry, and the Ministry has in turn been clear with DHBs, that funding should not be a barrier to maximising uptake. Funding is only partially 'fee for service'. There is also a significant amount of money for targeted high needs services including in rural and whanau settings and the Ministry's expectation is that this money is available over and above the 'fee for service' amount. • Taima noted that funding issues in her region have meant that both DHBs and providers had expended their own resources to deliver vaccination services, and she was pleased this appeared to be on track to be resolved. • Taima noted she had been asked to set up a large vaccination centre with little advice or guidance. She asked if guidelines are available. ***Action 6: MoH to follow up re operating guidelines for setting up large vaccination centres.***
5	**Focus on equity** • Te Puea invited Jason Moses to update the Group. • Jason introduced himself as the vaccine programme's new Group Manager Equity. He confirmed that Ministers had a very strong focus on equity for the rollout programme.

	• Members discussed what equity might look like. Some members suggested population-based parameters. Nicky saw the requirement for DHBs to work with Māori as a Treaty issue. • Getting comms and engagement/the invitation strategy right was reinforced by members as critical to prompting people to come for vaccination. • Funding certainty and payment disparities are big issues. Many clinics have started vaccinating based on goodwill. • MoH will be seeking equity 'targets' from all DHBs. Members noted the importance of not confusing rights and obligations with targets, and the importance of considering desired outcomes. Keriana cautioned that we don't want to 'hit the target but miss the point'. • Mat confirmed that IIAG advice re sequencing had been incorporated into the sequencing decision paper to Ministers. • Tristram noted his aspirational targets for vaccination for people with disabilities, being that everyone who wanted to will be fully vaccinated. He also noted the importance of measuring customers' positive vaccination experiences. • Tristram also noted national level data limitations. Tristram noted he was on an NHI disability project current in scoping mode, which aimed to cover groups currently not in the Socrates database. • Members noted their appreciation for the data and discussion provided by Petrus van der Westhuizen, noting an emerging gap between Māori and non-Māori, and for Pacific peoples not returning for second vaccine. Petrus cautioned about the impact of Group 1 and 2 sequencing in interpreting this, however. ***Action 7: MoH to provide IIAG with regular updates for equity and disability progress within the CVIP programme rollout.***
6	**Workforce training** *Fiona Michel provided an update about vaccinator training.* • There are 5,025 trained vaccinators, 1,826 of whom are active or have been active under the programme. • We need about 1,600 vaccinator FTEs for peak delivery - about 6,000 people. • Maori representation is at 10%. Pacific representation very low at 3%. Working to improve this representation. Need to understand DHB planning at more granular level to understand exact requirements and ensure the right settings are provided. • Working with IMAC and Careerforce to look at the non-regulated workforce for the 'vaccinator assistant' role to build skillsets and language to better recognise the cultural needs of whanau being vaccinated. These people will operate under supervision. Consultation generally supportive with some concerns from NZ Nurses Organisation. The Minister has agreed to seek Cabinet approval for the necessary legislation change. *[NB: since the IIAG meeting the new role has been renamed "COVID-19 vaccinator*."] *Group discussion* • Several members noted strong support for this initiative, noting its value-add to whanau experience of vaccination, and also noting that it can be incorporated into several roles already in existence. • Tristram Ingham thanked Fiona and team for their work and support, saying this new role was also significant as it reduced barriers to entry into the health sector workforce and increased the work opportunities for many. In particular, he saw increased opportunities for people in the disability community.

	• Members were also very positive about the future opportunities this new role could provide beyond COVID-19 vaccination. Fiona confirmed this was a longer-term goal of the Ministry, noting further legislation change would be needed. **Surge workforce** • Tristram asked if disability data could be incorporated into the surge workforce database. • Fiona confirmed that the recent refresh of the database meant that MoH is now asking those registering on the database for this type of information.
	Closing/Karakia whakamutunga - Te Puea Winiata

Document 5

IIAG Minutes/Actions

Meeting - Friday 28 Haratua 2021

Date:	28 May 2021
Time:	2:30 pm – 4:00 pm
Co-Chairs:	Te Puea Winiata, Keriana Brooking (apology)
Members attending	Dr Angela Ballantyne, Taima Campbell, Dr Helen Petousis-Harris, Rhonda Sherriff, Kevin Pewhairangi
MoH Attendees:	Mat Parr, Allison Bennett, Joe Bourne, Luke Fieldes, Fiona Michel (item), (item), Tamati Shepherd-Wipiiti Carol Hinton (Minutes)
Apologies:	Nicky Birch, Dr Tristram Ingham, Loretta Roberts, Dr Apisalome Talemaitoga, Silao Vaisola-Sefo, Jason Moses (MoH)

Item	Agenda Item
1	**Introduction and welcome** • Te Puea Winiata noted that co-Chair Kereana Brooking would be late or unable to attend due to an unexpected delay. • Taima Campbell then opened the meeting with a karakia. • The minutes of meeting held 14 May were accepted with a correction to record Nikki Turner as an apology rather than being in attendance. • Te Puea advised that Nikki Turner had submitted her resignation from the IIAG due to her workload. Nicky had advised she will, however, be able to provide input as may be requested from time to time. Te Puea thanked Nicky for her support during her time as a member of the Group. • No conflicts of interest were registered.
2	**Matters arising from the previous Minutes** Te Puea invited Mat Parr to update on progress re the actions from the 14 May meeting, noting members' desire to receive regular updates on progress across the programme: • Re actions 1-3, Mat advised that: o the meeting's agenda contemplated substantive discussion on the 'success framework'. The IIAG's advice would then be incorporated into a paper for the Steering Group and Cabinet in the next fortnight. This discussion would be important to help shape how the future success of the programme will be defined and measured. o MoH is considering how the A3 (COVID-19 Immunisation Programme Update – paper 2) can be enhanced to better inform the IIAG.

	• Re action 4, Mat confirmed he had sent through a paper on the Quality Framework mid-morning and indicated that a paper is about to go to the Steering Group. He looked forward to discussion at the meeting and would also put Safety and Quality on the next meeting's agenda. • Re action 5, Mat advised that DHB plans had only just been received and they had not been analysed. He will advise the IIAG in between meetings re how they can each receive information relevant to rollout by their respective DHBs. • Re action 6, Mat advised that operating guidelines for large vaccination centres is being incorporated into guidance for Mass events. • Re action 7, the IIAG will receive regular updates on equity across the programme rollout. Finally, Mat confirmed that it had been helpful to receive an advance list of questions from Taima Campbell, as this had helped develop the agenda. He also confirmed that members of the MoH team are always available to discuss matters outside of the meeting schedule.
3	**Operational updates**
	3.1 Service rollout – strong focus on primary care (Mat Parr/Joe Bourne/Astrid Koornneef) Joe Bourne advised that DHBs are placing a strong focus on vaccination service delivery through primary care settings. DHB planning shows 700-800 sites spread across GPs, pharmacies and other sites. The Canterbury, Nelson/Marlborough and Auckland Metro DHBs in particular are actively engaging with GP practices as part of a suite of delivery options. Vaccine delivery is likely to start from early July, however, Joe noted that it takes some time to bring a GP or pharmacy on board. Early delivery will therefore have regard to the population being served and vaccination vulnerability. Likely to move to more distributed models later in sequencing.
	3.2 Changes to Pfizer vaccine storage Medsafe has approved that the Pfizer Comirnaty vaccine can be stored at 2-8°C for 31 days. This now means it can be treated similarly to many other vaccines and has considerable implications for rollout planning in terms of GP storage, ordering, and the interface with the booking system. Astrid Koornneef noted the new storage approvals mean we need to review the quality and safety arrangements. A consultation document including CVIP programme standards and considering their alignment with the wider Quality and Safety framework has just been finalised. This will be sent to members in anticipation of discussion at the next meeting. Taima Campbell agreed she would be keen to see these. ***Action 1: Send consultation document on Quality and Safety Framework and performance standards to IIAG members. [Mar Parr]***
	3.3 Accreditation for cold chain storage IIAG members asked for clarity around the extent to which providers were or were required to hold additional accreditation to store the Pfizer vaccine. Joe Bourne indicated that the objective is to work within the existing frameworks so that most providers will simply apply their existing cold chain accreditation. MoH is engaging with relevant professional bodies (Royal College of GPs, Immunisation Advisory Centre) to confirm this. Providers using more mobile facilities may need to

	implement some new practices. Joe encouraged these providers to apply to IMAC for adjustments to their accreditation as soon as possible so that they don't impact on their starting date. Finally, Joe confirmed that MoH will provide guidance to help all sites know exactly what they have to do to be ready for their 'day 1'. *Group discussion re accreditation for cold storage* Te Puea Winiata and Kevin Pewhairangi strongly endorsed the approach outlined. Kevin noted that additional accreditation would impose a significant burden on providers and Te Puea noted her service already held three different forms of accreditation. Taima Shepherd asked if it was correct that only DHB personnel could supply the vaccine to sites. Joe Bourne confirmed this was correct currently, however, the model under development for Group 3 rollout has a main hub in each island, and the hub will supply directly to accredited vaccination sites. DHBs will be able to see where the vaccine is being delivered. Joe also advised that, as long as there is assurance about managing the cold chain during transportation, there will be no reason why a staff member from the vaccination service provider cannot collect directly from the DHB. IIAG members endorsed this model as taking a common sense approach.
	3.4 Workplace vaccination (Mat Parr) • A workplace vaccination model is under development. CVIP needs to work out which businesses/ workplaces will be able to have a vaccinator on site and how to apply a pro equity approach. ***Action 2: Provide 'high level project update' to next IIAG meeting and discuss the service design for delivery of vaccination through businesses and workplaces – issues include how we take a pro equity approach to this. [Mat Parr].***
	3.5 Funding • Fee for Service model is in place for DHBs - $500 million. • Additional money will be paid for higher needs vaccination – for example mobile services. • CVIP is monitoring DHBs to get more clarity on costings for their different vaccination service provision models. *Group discussion – funding model* Te Puea Winiata agreed that a 'fee for service' model works for scenarios such as rest home care. However there were challenges in being able to adequately describe a service provision model (and therefore a funding model) adequately for more remote/rural areas such as in the Far North, and for delivery to Maori and Pasifika communities. Therefore flexibility is also required. Several members of the group noted their 'on the ground' experiences of service provision and current funding arrangements could usefully inform the funding model discussion going forwards: ○ Te Puea's organisation had operated five different mobile facilities, and had experienced some frustrations with the funding model.

	○ Taima Campbell's organisation was keen to work collaboratively with pharmacists but was hindered as pharmacists wanted funding up front. ○ Taima also sought clarity from the Ministry/DHBs about how consumables were to be funded, and payment expectations for vaccinators and others working weekends. Mat Parr agreed that the CVIP programme would work with the IIAG to formalise a position (acknowledging that high level funding commitments provide the wider parameters) and provide advice to the Steering Group. ***Action 3: Draft a position for IIAG on the adequacy of the 'fee for service' funding model and circulate to members, before providing final IIAG comments back to the Steering Group.*** *Group discussion – funding flows* Tamati Sheppard-Wipiiti noted delays in funding flows e.g. to Whānau hauora providers who are providing many vaccination-related services on trust while they wait for funding. Much of this work goes unrecognised. The expected guidance from MoH and consumables from DHBs have not yet eventuated. However, providers will not sign up staff to vaccinate to roster/weekends without a formal agreement mechanism in place. ***Action 4: Tamati Sheppard-Wipiiti and IIAG members will meet to discuss the challenges they face, and form a position to take discuss with DHBs to progress this.***
	3.6 DHB planning for readiness for rollout (Astrid Koornneef/Jason Moses) • Astrid advised that the current focus areas ahead of Group 3 rollout are the booking system (see below), the Quality and Safety framework for the CVIP programme, and ensuring DHBs have appropriate plans for their delivery over July to October. All plans have now been received. • Jason Moses advised that MoH had worked closely with DHB CEOs and Senior Responsible Officers during development of their regional plans for operating at scale, and reinforced the importance of them having an equity focus at the front end. Some plans are excellent and all show a significant increase in their equity focus. *Group discussion* Taima noted that her organisation would like direct access to vaccine supplies for their Maori providers to support to give them confidence about their ability to scale up. Te Puea endorsed that having to order through a DHB introduced an uncertainty. Tamati Sheppard-Wipiiti agreed there was a disjunct with supply management and he was aware of cancellation of some orders. This is difficult when vaccination clinics have been planned and bookings have already been accepted. ***Action 5: Astrid Koornneef and Mat Parr to look into mechanisms to provide direct access to the COVID-19 vaccine for providers.***

3.7 National Booking System (Astrid Koornneef)

- The National Booking System has been piloted in Christchurch and in Auckland will be rolled out to all sites managed by DHBs over the next six months. It represents a significant change to current processes and allows New Zealanders to engage with the process. Taranaki and Wairarapa DHBs will be first to 'go live' – both scheduled for early June.
- CVIP is still considering how the booking system might be used in other settings e.g. settings that will take family or group bookings, or specific settings that are not available to other members of the public.

Group discussion – National Booking System

Taima Campbell noted that her Waikato-based organisation uses its general practice system to book appointments for both the flu and COVID-19 vaccine. They understand this system. It is reliable. It generates reminders. Taima wondered about the 'add value' of introducing a duplicatory system for COVID-19 vaccination, noting that many of those in Group 3 are people who are unlikely to use the booking system.

Astrid Koornneef and Mat Parr acknowledged that primary care providers may have a preference to use existing systems and agreed that CVIP is mindful of the need to not to create confusion. They agreed that the national booking system was one conduit only, and confirmed that decisions have not been made about its use by primary care providers. A real benefit of the booking system was in supporting bookings for mass vaccination sites, which will be essential to achieve the volume required by Group 3 rollout. It can also provide a consistent single focus from a 'public communications' perspective.

Wider discussion across all attendees agreed that the most important thing was to get people to come for their first vaccine as they are then recorded in the Immunisation Register (CIR) and will automatically get second dose follow up. Joe Bourne noted that he was noting the points raised to feed into a paper he was preparing on the national booking system.

3.8 Workforce and skills (Fiona Michel)

- Fiona Michel advised that the changes to regulations to allow for the establishment of the COVID-19 Vaccinator role had been gazetted that week. The Minister was likely to make the announcement.
- There are now 6,293 trained vaccinators, of whom 2,320 are/have been active in CVIP. However, 62% of these people are not being used in the programme. Fiona said she is working with DHBs to ensure that those who have taken the effort to train for the programme were in fact used for that purpose. She expected the final total of trained vaccinators to be about 8,000.
- The refreshed surge database is now live (weblink below) and available in English, Te Reo, Samoan and Tongan. Fiona noted this is a list of people with required skills, and their availability to assist with rollout workforce requirements. However, with only about 6% of registrations from Māori, and 2% Pasifika, we need to look more widely to address workforce equity issues.

Surge database website:
https://customervoice.microsoft.com/Pages/ResponsePage.aspx?id=JMfOIyBt0Uuf6dxER-3R-rPtHQW4g5dMvLRp5o2K1E1UN1Y3WkxBTUxLUTVDVFgyNk8yN1QxRFY4Ri4u

	Group discussion – Workforce and skills Taima Campbell noted that there were some issues with the requirement for a person who has completed the COVID-19 vaccinator training to then be independently assessed before being able to start practising. For example, assessors were not available in some areas, or there may not be anyone available to be vaccinated for the assessment. Fiona advised that there was flexibility to do assessment in a variety of ways, including online, or demonstrating injection technique another way. She would raise this with IMAC and report back to IIAG. In response to a question from Rhonda Sherriff, Fiona advised that there was no target for the size of the new workforce. However, the DHB rollout planning means that the workforce will be more nuanced (workforce ethnicity mix, clinic location etc.) to meet community needs. Te Puea thanked Fiona and congratulated her on the progress made. ***Action 6: Advise on how timely access to independent assessment of newly trained COVID-19 vaccinators can be achieved. (Fiona Michel)***
4	**Quality (Success) Framework (Allison Bennett/Luke Fieldes)** • Alison first reflected on the value of the IIAG's input provided in March 2021 on an early draft of the Success Framework, which is now called the "Quality Framework". This new iteration of the framework evolved from that feedback. • The Framework focuses our attention on priorities; this means we are transparent about what we are delivering and how we then transparently assess performance against this. • Allison spoke to a presentation showing the six components of the Framework, and noted that none operate in isolation: ○ Effectiveness (strong focus on clinical quality and safety) ○ Equity ○ Experience (both provider and consumer) ○ Efficiency ○ Te Tiriti o Waitangi ○ Sustainability/legacy (support health system as a whole and into the future). • Luke Fieldes said there were challenges with 'scoring'. It is necessary to build up a picture of the overall success, however, a high score is not necessarily a good thing if it has significant negative impacts elsewhere in the framework. • Allison and Luke agreed that noted the challenge now is to present the framework for 'easy consumption'. They sought the views of IIAG on both content and presentation. • It is intended that the Quality Framework be owned by the whole programme, not just the Ministry of Health. Ultimately it will go into a Cabinet paper for final agreement by Ministers. It will be publicly available. *Group discussion –Quality Framework* • Taima Campbell suggested indicators could be weighted. She also noted the importance of building in accountability. • Dr Helen Petousis-Harris suggested 'sustainable active vaccine safety monitoring' as a potential success indicator. • Some members indicated that they were happy to be contacted separately to discuss the framework further.

	• Allison confirmed that it was intended to be a 'living' document as rollout will provide valuable information that will feed back into the framework. • Joe Bourne noted that the intention is to use current reporting as much as possible when assessing performance against the Quality Framework. A 'low touch' approach will avoid burdening providers. ***Action 7: Send copy of the draft Quality Framework to IIAG members for their consultation comment (Mat Parr, Allison Bennett)*** ***Action 8: IIAG members who so wish to provide comments on the draft Quality Framework back to Mat Parr and Allison Bennett.***
5	**Focus on equity – disability communities** • Tamati Sheppard-Wipiiti noted that obtaining reliable data on the disability sector is a significant issue hindering identifying and reaching disability communities, even though we know these groups form a significant part of the population. DHBs share this problem. It is not solely an issue for COVID-19. • Tamati noted he will be meeting with Dr Tristram Ingham (who is an apology from this IIAG meeting) and others early in the following week to try to work this through in respect of the COVID-19 vaccination rollout. Some research will be required. However, leveraging local relationships will be critical to ensure people are not missed. • Te Puea Winiata agreed that this was something Dr Ingham had raised with the IIAG at an early stage and said that his support and networks will be critical. She saw that mobile support and home visits, combined with whanau vaccination bookings will be the key things in reaching members of the disability community.
	Closing/Karakia whakamutunga – Kevin Pewhairangi

Document 6

IIAG Minutes

Meeting - Friday 25 Pipiri 2021

Date:	25 June 2021
Time:	1:00 pm – 3:30 pm
Co-Chairs:	Te Puea Winiata, Keriana Brooking
Members attending	Dr Angela Ballantyne, Nicky Birch, Taima Campbell, Dr Helen Petousis-Harris, Loretta Roberts, Rhonda Sherriff, Kevin Pewhairangi
MoH Attendees:	Andrew Bailey, Carl Billington, Joe Bourne, Geoff Gwynn, Rachel Mackay, Fiona Michel, Jason Moses, Mathew Parr, Petrus van der Westhuizen
Apologies:	Dr Tristram Ingham, Dr Apisalome Talemaitoga, Silao Vaisola-Sefo, Luke Fieldes (MoH), Tamati Sheppard-Wipiiti (MoH)
Format:	Most attendees at this meeting attended online. However, to ensure compliance with the Alert Level 2 in place in Wellington on 25 June, those present in the meeting room maintained appropriate social distancing.

Item	Agenda Item
1.	**Introduction and welcome** • Te Puea Winiata welcomed members. • Jason Moses opened with a karakia timatanga. • The minutes of meeting held 28 May 2021 were confirmed. The deferral and subsequent cancellation of the meeting scheduled for 11 June was noted. • No conflicts of interest were registered. **Matters arising from the previous Minutes** • Mat Parr advised he would report back after the meeting on the mechanism for sharing DHB production plans. • COVID-19 vaccinator assessments: Fiona Michel said that Loretta Roberts had confirmed the pathway for simulated assessment. The assessment can be arranged through the regional co-ordinator or directly through IMAC.
2.	**Strategy for Transition to BAU (Mat Parr)** • Focus over the second half of the year is driving uptake for New Zealanders, acknowledging that some will require more proactive effort to achieve this. We need to balance this activity against the need to transition COVID-19 vaccination into future BAU. • The Ministry will be preparing advice for Cabinet. Mat emphasised that nothing was written as yet and that 'blue sky' views of IIAG members were sought on where the system should be directed, including: ○ Access – ensuring the vaccine gets to those it is intended to reach. What vaccination settings are sustainable – what is the balance

between primary care, GP, pharmacies, after hours services? Input sought on locations, sites, providers.
    - What will the workforce look like – where will it be?
    - Incentivisation – does New Zealand need to follow international approaches?
- Also need to think about what 2022 might look like. Planning parameters include:
    - Recognising that the science and technology will continue to evolve (e.g. number of doses and frequency of vaccination);
    - Identifying the impacts of this on purchasing/supply;
    - developing the immunisation programme.
- Noted that Pfizer is currently the most expensive of the COVID-19 vaccines available. Cost per dose is nearly double that for the flu vaccine.
- Objective is to make best placed decisions early, but be flexible enough to change if required.
- There is a considerable Legacy component to identify what will carry over into the new Health system.

Group discussion

Members endorsed the early thinking being given to this, noting the significant impacts on the workforce and on funding flows for planning. Views expressed *(no priority implied)* included:

- This is a new behaviour being introduced into New Zealand. Several members said that creating demand and ensuring access are key, so focus on raising awareness and visibility first. Māori simply may not know about the issue – with consequent impact on uptake.
- Are there any broader learnings – including internationally – about behaviour change to promote wider uptake to vaccination that can be drawn from?
- The concept of an annual vaccination is good. Links with current approaches. A joint vaccine (flu/COVID-19) would facilitate uptake but is unlikely to be a possibility in the foreseeable future. Many members preferred “Pfizer, one dose, once a year” as a future scenario.
- Ensure flexibility in the booking system so that people have choices.
- Workforce – significant future opportunities through the new COVID-19 vaccinator training. Important to continue to consider how broader workforce can be deployed if required (UK model cited as example) . Some concerns noted around DHB vaccination service provision. Noted that a skilled (vaccination) workforce must always be available in a DHB, however, some members understood that some contracts were being terminated for periods when not required. Potential impact on skillsets.
- COVID-19 is an epidemic. While we are currently low risk, we need to get New Zealanders ready for having COVID-19 in the community because it is unlikely we can keep it out forever.
- If it is found that the Sydney traveller (Wellington community case, June 2021) was less contagious because he had had one vaccination, can that messaging be used to promote community benefit? This is the sort of situation that potentially could build confidence in vaccination.
- To what extent will government fund ongoing vaccination?
- Group members emphasised a point discussed at the previous meeting, being that vaccination service providers (and Māori providers in particular) would benefit from direct relationship with the vaccine distributor, avoiding DHB

	• distribution channels and the potential supply disruption they have seen in the past. • The Co-Chair summed up that from an equity perspective, 2020 saw the best ever response to immunisation. Evaluation of workforce and service settings could provide opportunities to help achieve equity objectives for COVID-19 vaccination roll-out. ***Action 1: Ministry to consider doing a Horizon Scan for research and published articles on the international experience to create demand for vaccination and make vaccination accessible.*** ***Action 2: Keep IIAG updated on the thinking about funding for COVID-19 vaccination into the future.***
3.	**Equity Programme overview (Jason Moses and Mat Parr)** Considerable work under way to promote equitable outcomes for Māori, Pacific and disability communities during the vaccination delivery phase: • To help improve uptake, the Ministry is providing funding for targeted support that is culturally appropriate and meets the needs of specific communities. Noted that five marae sites are already delivering vaccination services. • Further research has been undertaken into vaccine hesitancy and the factors preventing update by Māori and Pacific people. Results are encouraging. Overall potential uptake (those already vaccinated and those likely to get a vaccine), has increased to 80 per cent, up from 69 per cent in March 2021. Of these: ○ Māori potential uptake is now 75 per cent, up from 71 per cent in April; ○ Pasifika potential uptake is steady at 78 per cent, similar to 79 per cent in April, but up from 59 per cent in March. • The Ministry identifies Group 3 as the opportunity to take a pro equity approach within the sequencing framework. • DHBs now have agreed targets for Māori and Pacific people in their regions. This is a 'stretch' target identified by using burden of disease study, and information of underlying health conditions in regions. Targets were based on NHI data, and not census data. This builds some 'stretch' in that fewer people are known to identify as Maori in census data). (*See Paper 11.)* • DHB 'letters of readiness' provide assurance of the overall readiness of each DHB to scale up. These letters are signed by DHB CEOs and have a specific focus on equity and on service quality. • The Ministry has appointed regional co-ordinators who work locally and engage directly with providers in the regions as needed. • The Director-General of Health is sending a letter to the DHB CEOs and to CEOs of social service agencies that contract with Māori and Pacific health providers, to see if there is opportunity to be flexible with these contracts including postponing some deliverables. This will better allow providers to target their resources to the COVID-19 vaccination programme. • Equity is the key risk identified for scale roll-out. The Ministry is closely monitoring the population breakdown for the first dose vaccination. This provides a check on uptake across population groups. It was noted that Māori have been tracking at 10 per cent of the population to date but for Group 3 this figure was around 19 per cent. • The Ministry would welcome the views of Group members on what more could be done to support and promote equity.

	Group discussion • Clarification sought around the basis of the 10 per cent vs 19 per cent mentioned, noting that a 'percentage of population' measure would not support equity, even if achieved. Some DHBs are currently achieving high vaccination rates but are not meeting ethnicity targets. • A target is more than just a target. It represents a measure of what we value and starts to shift public service thinking about what equity is, and what it is not. Māori are twice as likely to die if they contract COVID-19 than are those in other population groups. Targets need to acknowledge and reflect the risk rate of any group. • Acknowledged that roll-out to Groups 1 and 2 did not have an equity approach and that Group 4 provides the real opportunity. However, expressed a hope that progress would start to be seen quite promptly. • Suggested that the words 'vaccine hesitancy' could be replaced by 'vaccine acceptance'. • Noted some concerns about Māori providers being required to expand their services considerably, but not being aware of the funding that is available to support them or how they access this. Aware that some money is paid to DHBs to pay to providers but this can create delays. *(See also section 8b.)* • In terms of promoting uptake by individuals, be clear about the possibility of a reaction within 2-3 days after being vaccinated and normalise this through comms on 'what to expect after your vaccination'.
4.	**Contingency Planning (Geoff Gwynn)** *Paper 4, and papers 4a- 4e considered: CVIP Contingency Planning – Draft for discussion - 21 June 2021* • Have identified six risk scenarios that would affect delivery of the national plan and developed contingency plans for each of them: ○ Community outbreak, ○ Disruption to vaccine supply, ○ Disruption to COVID-19 vaccination workforce, ○ Unavailability of IT systems, ○ Clinical safety issue, ○ Significant privacy or security breach. • Plans focus on response at first hour, first day and first week – identify triggers, impacts and critical resources. New plan likely required from that point. **Group discussion** • Members noted that equity is not one of the areas identified for contingency planning. Noting that under the Terms of Reference, IIAG advice is provided within the context of honouring Te Tiriti o Waitangi, with a particular focus on equity, members noted concerns that not achieving the equity objective for COVID-19 vaccination would certainly reach the threshold for an event requiring contingency planning. • The Ministry agreed with this level of significance but clarified that equity was not regarded as a "sharp shock" event (as were the six scenarios above). Rather it is something that requires regular monitoring and adjustment (and actions might be at a local or regional level). The intention was to 'not wait' until there was a catastrophic failure but to take early action. • The matter was discussed further, and the Ministry agreed with the IIAG's suggestion that the approach could usefully be clarified within the contingency planning document.

	Action 3: Clarify in contingency planning documents that poor performance against the equity objective is not regarded as a "sharp shock" event but is something that requires regular monitoring and adjustment.
5.	**Approach to Workplace Vaccination (Rachel Mackay)** • Rachel noted she had just been meeting with Ministers and as a consequence the papers circulated would need to be updated. • The Ministry is trialling workplace vaccination at two worksites in South Auckland, both of which have potential to contribute strongly to the roll-out equity focus. • A "blueprint" for vaccination at worksites has been developed. Both Equity teams in the Ministry reviewed this. • Participation criteria are established for participating employers and their service providers. Focus is on larger employers with a large Māori or Pacific workforce. Rural or outer urban factories. There is an opportunity to take a whanau approach with vaccination service delivery. • Care is being taken to protect and expand current employer relationships with occupational health service providers. The DHB is accountable for delivery under this trial programme so the Ministry will work with them over final decisions. **Group discussion** • Noted that Māori providers could potentially be included service delivery for workplaces that provide vaccination for COVID-19 under these arrangements. ***Action 4: Presentation to be updated and distributed to Members of IIAG.***
6.	**Outcome measures (Petrus van der Westhuizen)** *Paper 6 considered – CVIP Outcome Measures – 18 June 2021* • Objective of having outcome measures is to enable the programme to ask questions. They differ from the Success Framework, which is a tool to assist decision-making. • Measures are proposed for: ○ Population acceptance ○ Workforce ○ Vaccine and consumables ○ Technical Approach ○ Access – Location • Vaccine consumption is a 'good news' story with current usage in the high 90 per cent measures. • For population acceptance, the opportunity is likely to be those who are 'unsure' rather than those who say they are 'unlikely'. We would appreciate views on how we can that movement in perspectives. • We will do work to benchmark our outcome measures internationally. • Consideration will be given to how this could be made interactive so that users can do their own reporting. **Group discussion** • Suggested give consideration to rural vs urban vaccination uptake and possibly also age bands. Specific level data helps inform response.

	• Supported the concept of having input data made interactive. Asked if the data would be publicly available? Strongly supported that public access would support the legacy objectives of the CVIP programme. ***Action 5: Co-Chairs and Mat Parr to discuss offline the extent to which supporting data is widely accessible into the future as part of the CVIP Programme "legacy' activity.***
7.	**Communications (Carl Billington)** • The ministerial announcements on 22 June re Group 4 roll-out had created two points of anxiety for the public: ○ The perception that the start of Group 4 means the end of other groups. ○ Perceptions re timeliness of contact re vaccination. • Carl apologised that information on progress with roll-out had been publicly released before the Ministry had had a chance to inform members of IIAG. He acknowledged and thanked those members who had had media approach them for comment and who had responded without any prior 'heads up'. • The Ministry is encouraging providers to contact their clients with advice about their invitation. • There is a focus on workers at the border as the requirements for vaccination by this group are increased. • Regular engagement established with the aged care sector. For Pacific people there is considerable engagement with the Recognised Seasonal Employer workforce. **Group discussion** • In response to a question, Carl advised that CVIP has had a lot of guidance from IIAG member Dr Tristram Ingham and comms material is available in accessible format. However, there is a gap in comms for Maori with disabilities and Carl confirmed that he would be increasing the focus on this group. • Key issues for comms and engagement with members of the disability community include identifying 'what consensus looks like' and how those who need support provide their informed consent. There are also barriers to accessing early information about the vaccine and the vaccination process.
8.	**Other Business** ***8a. Planning for future engagement with IIAG*** Co-chairs and Mat Parr agreed to book some time to discuss and agree a cadence for how engagement with the IIAG would operate for the rest of 2021: • Develop workplan (members can prioritise and plan), • Update Terms of Reference (Ministry to do first cut), • Co-chair representation at Steering Group (previously agreed – Ministry to send invitations) . ***Action 6: Review the IIAG ToR to better recognise the advisory role of the IIAG and to ensure IIAG as a group has visibility over consideration and incorporation of its advice into policy development and ministerial/Cabinet processes.*** ***Action 7: Send invitations to Co-Chairs re CVIP Steering Group attendance.***

	8b. Primary Care and funding for equity As raised during the Equity discussion (section 3), Māori providers have had to expand their services considerably, but are often not aware of the funding that is available to support them or how they access this. Members of IIAG are aware that money (additional to 'fee for service') is paid to DHBs to allow them to better fund higher cost services e.g. in rural locations, requiring use of mobile facilities etc. Many of these are linked closely to the equity objective. Members are very concerned that this additional money is not getting through to the providers and that its use is not transparent. ***Action 8: Ministry to follow this up with DHBs. Ministry to identify extent of funding passed on from DHBs to Māori providers for COVID-19 service provision.*** ***Action 9: Include a 'deep dive' into Primary Care on the agenda for the next meeting.***
9.	**Closing/Karakia whakamutunga –** Jason Moses
10.	**Next meeting –** Friday 9 July 2021

Document 7

IIAG Minutes

Meeting - Rāmere 9 Hūrae 2021

Date:	Friday 9 July 2021
Time:	1:00 pm – 3:00 pm
Co-Chairs:	Te Puea Winiata, Keriana Brooking
Members attending	Dr Angela Ballantyne, Nicky Birch, Taima Campbell, Dr Tristram Ingham, Dr Helen Petousis-Harris, Loretta Roberts, Rhonda Sherriff,
MoH Attendees:	Andrew Bailey, Joe Bourne, Astrid Koornneef, Rachel Lorimer, Rachel Mackay, Sonia Marshall (for item), Rachel Mackay (for item), Jason Moses, Mathew Parr, Dr Juliet Rumball-Smith, Tamati Sheppard-Wipiiti.
Apologies:	Kevin Pewhairangi, Dr Apisalome Talemaitoga, Silao Vaisola-Sefo

Item	Agenda Item
1.	**Introduction and welcome** • Te Puea Winiata welcomed members. • The minutes of meeting held 25 Piripiri 2021 were confirmed, with minor editing to bullet 3 of item 1. • It was noted that Dr Apisalome Talemaitoga and Silao Vaisola-Sefo had submitted apologies for the 9 July meeting due to attending a Pacific Providers meeting at the same time. • No conflicts of interest were registered. **Matters arising from the previous Minutes** Members noted their appreciation for the action tracker, set clearly set out actions and their status. • Action 210625-01 – MoH confirmed that the horizon scan re articles on the international experience re demand for vaccination has been commissioned and will be shared with IIAG once available. • Action 210625-08: Andrew Bailey will contact Te Puea Winiata after the meeting to begin this conversation. • MoH noted other actions as pending.

2.	**Modelling increased uptake (Mat Parr and Sonia Marshall)** *Paper 3 considered – Vaccine roll-out (Pfizer only) – Sequenced population aged 12 years+* • Previous modelling to reach 'scale' has been based on 70 per cent uptake. • Mat and Sonia advised on the modelling of the numbers of vaccines administered and vaccinators required to achieve scale roll-out, noting that modelling is now being done for a stretch target 85 per cent uptake. • This compares well with international achievements e.g Canada is at 69 per cent currently and Israel at about 60 per cent. • Research in New Zealand by Horizon shows that 80 per cent of people are willing to be vaccinated. • A high uptake now helps with 'future state' for the ongoing programme. • As per paper 3, international experience shows there is an eight week window of working at peak before delivery starts to reduce. • There are three settings possibilities to 'push' uptake: ○ Through primary care services (well established, trusted, ○ Through mass events; ○ Through schools (i.e. delivery to students, noting that school settings are already being used by some DHBs for sequential vaccination). • IIAG views were sought on the 85 per cent target, and the on balance of delivery channels, in particular those we should maximise (in particular for the eight-week peak delivery period). **IIAG perspectives and advice** • Delivery to younger age group through schools needs to be pre-planned around the school year. Identify what we need to be doing now for roll-out next year or during school holidays. • Think more widely about who uses school sites and how these groups can be used to help (e.g. Allied Health, providers with school contracts). • School based vaccination could be seen as a family/whanau site. School sites provide an accessible 'focal point' even during holidays. • Consider how faith based and 'character' schools can help us to reach out more widely to different ethnicities.
3.	**Quarter 3 Work Programme (Mat Parr)** *Draft Paper: IIAG Work Programme to September 2021* • The IIAG considered a one-pager overview of the proposed Quarter 3 work programme. Key areas on which IIAG advice will be sought are: ○ Primary care role and future COVID-19 vaccination ○ Access to vaccine and options to increase uptake ○ Leading indicators/outcome measures ○ Equity monitoring ○ 2022 strategy and vaccine portfolio. • Following recent decisions by Medsafe about COVID-19 vaccines, the Ministry is developing advice to the Minister/Cabinet and will consult 'out of cycle' with those IIAG members who are available: ○ the use of Pfizer by 12-15 year olds, and ○ the use of Janssen. ***Ministry action 1: Send a draft of the advice to IIAG Members for comment as soon as this is available. (Allison Bennett)***

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4.	**IIAG Governance**
4a.	**Revised IIAG Terms of Reference** *Paper 5 considered: COVID-19 Immunisation Implementation Advisory Group – Terms of Reference* • Members considered the "Draft Version 2" of the IIAG Terms of Reference, which had been updated to address issues raised previously by the Co-Chairs and to better reflect the focus and role of the Group. • A key new provision to ensure transparency over the Ministry's consideration of IIAG advice, is that the IIAG Co-Chair representing DHBs will be invited to attend weekly meetings of the CVIP Steering Group, and both Co-Chairs will present to the Steering Group on at least a monthly basis. **IIAG perspectives and advice** • Members indicated no major concerns. Due to the full agenda, the Co-Chair asked that members submit any comments they had to Andrew Bailey. (andrew.bailey@health.govt.nz) ***Action 2: IIAG members who wish to make comments on the Draft Terms of Reference should submit these to Andrew Bailey of the Ministry.***
4b.	**IIAG meeting times** • The Ministry noted that the current Friday afternoon meeting timing clashes with the weekly meeting of the seven Vaccine Ministers. • IIAG members were asked if the IIAG meeting could be moved to a Thursday afternoon. This would also allow the Ministry to improve its flow of decisions and actions through to updates to members and also to take advice from IIAG and pass it to the CVIP Steering Group meetings on Tuesdays. ***Ministry action 3: Ministry to conduct a 'straw poll' re a new meeting time. (Mat Parr)***
5.	**Safety and Quality Network update (Dr Juliet Rumball-Smith)** *Papers 6 and 6a considered – CVIP Quality and Safety Framework and Actions, and National Clinical Quality and Safety Forum Terms of Reference* • This update outlined the framework in place to promote delivery of a safe and quality COVID-19 vaccination service. This aligns with the Health Quality Safety Commission's four 'building blocks' of effective clinical governance: ○ Consumer engagement and participation; ○ Clinical effectiveness; ○ Quality improvement and patient safety; ○ An effective, engaged workforce. **IIAG perspectives and advice** • Members asked that the importance of Equity be emphasised and given more prominence. ***Ministry action 4: Dr Juliet Rumball-Smith agreed that an inequitable programme was neither clinically competent nor safe. She will amend the framework and report back to IIAG once completed.***

5.	**Cont. (Safety and Quality Network)**
	• Members noted the importance of ensuring people knew how they could make complaints should they need to. Ideally this should be a quick, likely local process. • Members asked if it was going to be possible to connect pharma-covigilance data into epidemiology. ***Ministry action 5: Dr Juliet Rumball-Smith and Dr Tim Hanlon will meet with Helen Petousis-Harris to discuss the connection between pharma-covigilance data into epidemiology further and report back to the IIAG when the matter has been discussed.***
6.	**Equity Update (Jason Moses and Tamati Sheppard-Wipiiti)** ***Overview*** There are 77 providers funded to support the programme. Some are currently supporting DHBs to deliver, but will not commence direct provision until August, depending on their DHB. Many using a whanau-based invitation approach. DHBs have signed off on their accountability documents. These include equity targets. The challenge is in the monitoring. ***Promoting uptake by Māori*** The numbers of Māori who will be vaccinated between July and October 2021 will be significantly higher than the current numbers, due to sequencing. Target doses per week for Māori is 20,000 during this period. An update was provided on the Five Point Plan to increase Māori vaccine uptake. This covered: • *Promoting contract flexibility* by CEOs of DHBs, Te Puni Kōkiri and other social service agencies engaging Hauora and Pacific providers. • Ensuring that *primary care providers* are in the right settings and right volumes to support vaccination in priority areas. • Redistributing existing 'yet to be used' Māori communications funding to fund readiness across a wider range of Maori providers. • Providing *funding to support rural vaccine delivery.* • *Ensuring Hauora providers know how they can order vaccine supplies directly* from the Ministry. ***Promoting uptake by Pasifika*** • 23 Pacific providers will deliver the vaccine across the country. • Key focus to promote update is in two DHB regions: Auckland Metro; and Hutt Valley/Capital & Coast. • Also a focus on increasing the Pacific vaccinator workforce. This is about 3 per cent currently whereas the population composition is 6-7 per cent. ***Promoting uptake by disability communities*** • More work is needed to understand and address the needs of Māori disability communities. • Have met with Tātou Whaikaha to help gain a better understanding of issues and responses and to better ensure accessibility at vaccination sites.

	• Ministry is looking at how it can influence and support DHB planning for services to people with disabilities. There are also crossovers for Māori with disabilities. • Data collection and monitoring is a strong focus. ***Ministry action 6: The Ministry will work offline with some IIAG members to gain better insights into the provider perspectives on accessible service delivery.*** ***IIAG perspectives and advice*** • Providing what are effectively 'bespoke' services for disability community members takes time and effort. Care is needed to not also put volume pressure on providers. • Both equity target setting (which has to consider need and risk and access) and monitoring are key. There are issues and pressures here for DHBs with rural communities. • Aware that some regions are taking a 'marae by marae' based approach to vaccination to meet rural needs. • Some instances of 'vaccination tourism' have been noted. • Emphasised the importance of people having a good vaccination experience as they then pass this on to others. • IIAG members thanked Jason and Tamati for the mahi that had gone into the Equity focus.
7.	**Primary care**
7a.	**Primary care implementation plan** *Paper 8 considered – CVIP Primary care playbook - Steps for setting up a COVID vaccination site* • Astrid Koornneef and Dr Joe Bourne noted the Ministry was reaching out more deeply into primary care to support vaccination roll-out. The discussion draft "Primary Care Playbook" aims to provide assistance to providers setting up vaccination sites. • As much as possible, the Ministry wants providers to have a smooth, streamlined experience to 'come on board'. Some need for local variation is acknowledged. • Aware that some providers will not want to participate, but there are also many who do but who need the assistance. • The initial views of IIAG members were sought now, but there would be opportunity for further input through sub-group conversations. ***IIAG perspectives and advice*** • Agree that providers (e.g. community based social support groups) who want to provide vaccination services but are not doing so currently will need considerable support to go through the establishment process. Many simply do not have the resources. • What are the opportunities for partnerships? Who is brokering these relationships? • Encourage PHOs to think differently and to collaborate – examples given re a group of seven Pacific providers.

	• Links to the surge workforce – providers need to know how to access the specialised workforces and skillsets. • Can this document include an equity lens – e.g. what supported decision-making looks like in practice? Not all providers understand this. • Accreditation can be a significant burden. Can this be rationalised across multiple sites? Some providers see the requirements and are reluctant to provide the services. Fewer providers means higher dependency on those who are willing. • Funding issues – some providers are concerned that Māori providers are paid to set up vaccination services but they are not. Are those providers who set up for scale entitled to some of the programme development money also? • Concerns that trained staff will not stay with current employers but will be actively sought by other providers. • A number of providers are doing this because they want to do the right thing for their community. • The name 'playbook' on the draft was queried, with members noting care was needed not to downplay the significant work that will be needed by primary care providers to provide COVID-19 vaccination services. ***Ministry action 7: Hold further 'sub group' conversations with IIAG members on particular issues relating to primary care vaccination roll-out as required.***
7b.	**Funding flows into primary care** Members noted their ongoing concerns that in some places, contracts for COVID-19 vaccination-related services were not yet in place and that the funding flows from DHBs into primary care were still very slow. Some providers have yet to receive funding. This is impacting on provider willingness to provide vaccination services. ***Ministry action 8: Mat Parr advised that this matter had been escalated to the Director-General, and direct conversations are being held with DHB SROs.***
8.	**Environmental scanning of issues** • Noted that environmental issues had largely been raised in the discussion of equity (item 6), and primary care provision at item 7.
7.	**Communications (Rachel Lorimer)** • Will start promoting a COVID-19 Healthline shortly – nearly ready to launch and will let IIAG know in advance. Noted however that different DHBs will have different capacity to answer specific questions. • GPs are a 'trusted place' in a community and have an important role in education. ***Ministry action 9 – ensure IIAG members are advised in advance of the launch of the COVID-19 Healthline.***
8. **8a.**	**Other Business** **National booking system** An enhanced call centre opens on 17 July – will support the new booking system which will be launched on 28 July. The booking system will support whanau bookings. Ministry is developing material and tool kits to support providers. *(Cont. over)*

8b.	***IIAG Perspectives and advice*** • Members noted some provider confusion in that the booking system is 'live' but is not 'launched'. Some DHBs are phoning GPs but advise they are not clear on the processes from here. ***Ministry action 10 - Astrid Koornneef will work offline with Taima Campbell to clarify and address this issue.*** • Noted that the meeting was nearing its end time but disability communications and the interface with the booking system needed active consideration. (There are 1.1 million people in New Zealand recorded as having disabilities. The Ministry had data on only 40,000 of these people – those who receive disability support funding.) ***Ministry action 11: Astrid Koornneef will work with Dr Tristram Ingham offline to clarify and progress this issue.*** ***Privacy of information*** • An IIAG member noted the importance of the Ministry ensuring its web page commentaries are aligned about how personal data is stored and shared and the basis for recording it. • The point was made solely from a transparency perspective. ***Ministry Action 12: Ministry to check web content to ensure basis for recording data is clear, and that commentary about how data is stored and shared is consistent. (Rachel Lorimer).***
9.	**Closing/Karakia whakamutunga –** Nicky Birch
10.	**Next meeting –** Friday 23 July 2021

Document 8

IIAG Minutes

Meeting - Rāpare 22 Hūrae 2021

Date:	Thursday 22 July 2021
Time:	1:00 pm – 3:00 pm
Chair:	Keriana Brooking
Members attending	Nicky Birch, , Dr Tristram Ingham, Dr Helen Petousis-Harris, Kevin Pewhairangi, Dr Apisalome Talemaitoga, Loretta Roberts
MoH Attendees:	Andrew Bailey, Dr Joe Bourne, Astrid Koornneef, Rachel Lorimer, Jason Moses, Mathew Parr, Tamati Sheppard-Wipiiti.
Apologies:	Dr Angela Ballantyne, Taima Campbell, Rhonda Sherriff, Silao Vaisola-Sefo, Te Puea Winiata

Item	Agenda Item
1.	**Introduction and welcome** • Keriana Brooking welcomed members. • Nicky Birch opened with a karakia. • The minutes of meeting held 9 Hūrae 2021 were confirmed. • Keriana Brooking advised that due to a prior commitment, she would need to leave the meeting at 2.30 p.m. • No conflicts of interest were registered. • There were no matters arising from the previous Minutes.
2.	**Environmental scan / issues being raised (Chair)**
	• It has been agreed that an IIAG Co-chair will attend the CVIP Steering Group meeting on a regular basis (meetings held weekly on Tuesdays). • The Steering Group is the programme's key decision-making body for vaccination roll-out. It considers a wide range of matters, for example, development of the booking system, matching of supply and demand. This may include consideration of the approach taken by other countries. • The Co-Chair noted she could see an end to the design and development phase which had been such a strong focus until now. • Noting the role of the IIAG, papers to Steering Group would desirably reflect consultation advice from IIAG, particularly from the perspective of operational impacts. It was noted that some papers are developed at considerable speed and this consultation has not been possible. The IIAG continues to reinforce the benefits to the Steering Group discussion and decision-making processes of considering papers that understand and articulate the operational impact of their proposals.

	• Noted that the workforce has been stretched for some time and this may impact on the ability of some DHBs to deliver COVID-19 vaccination. • Hospital services are heavily loaded at this time. The same is also true of aged residential care services. The Chair noted her own DHB was working closely with service providers to ensure services continue to be delivered. ***Ministry Action 1: The Ministry will provide a summary of the key issues raised at this meeting to the Co-Chairs to support their attendance at the CVIP Steering Group meeting on 27 July 2021***. (Completed 23 July 2021)
3.	**Equity Monitoring (Jason Moses)**
	Paper 3: Monitoring and accountability measures to support DHBs in meeting equity targets • Several measures are in place to support DHB accountability on equity targets. These include equity production plans (which set out on a week-by-week basis the number of Māori and Pacific people the DHB plans to vaccinate based on their Māori and Pacific populations) and letters of readiness, which outline the DHB's level of preparedness for vaccination roll-out. *Papers 4 and 4a DHB performance against equity production plans (12-18 July and cumulative 5-18 July 2021)* • These tables show actual performance for the week and cumulative performance since the start of Group 4 roll-out. Performance status is highlighted by colour for each of Māori, Pacific and non- Māori/non-Pacific. If DHBs achieve their targets the programme will be on track with its equity objectives. • At a national level, results are at 98 per cent. However, there are regions with early flags, including three DHBs that have to date delivered well under their planned services to Māori and Pacific. DHB overall delivery to Māori is at 58 per cent. • These tables are shared with DHB SROs and the Steering Group each week. • Ministers have a strong focus on equity of vaccination, although it is recognised that sequencing means that Māori will not be vaccinated in volume until the younger age groups. • Whilst it is still early in overall delivery, neither Māori nor Pacific people featured as prominently in Group 3 as originally hoped (i.e. those with underlying health conditions). • There is a desire to move earlier than sequencing allows, however, it is easier to identify people by age band than it is by health status. • The views of IIAG members are sought in helping to identify actions that can help to improve vaccination delivery. **IIAG perspectives and advice** • Members noted that Group 4 roll-out was at a relatively early stage and some people will just be starting to make the transition to action. • Members would like to be able to understand the issues underpinning the variable performance. A cumulative graph and a 'key points' commentary would be useful as roll-out progresses, particularly in relation to equity access and coverage. • Concern was expressed that this table was unable to reflect disability vaccination performance. • Members offered support to the CVIP programme if local workforce or education issues were identified as some offer local weekend training and have other support mechanisms available.

4.	**Access to vaccine and options to increase uptake**
4a.	*Paper 5: Disability vaccine uptake action plan* • A 'Five Point Plan' has been developed to increase disability vaccine uptake by those people with disabilities. Key components are: ○ Communications ○ Accessible invitation and accommodations ○ Ensuring processes are in place to support decision-making and consent. • Considerable from input has been received Tātou Whaikaha, chaired by Dr Tristram Ingham. The Minister for Disability Issues, Hon. Carmel Sepoluni, may be approached to lead public engagement for COVID-19 vaccination. • It has also been noted that supported decision-making is not being implemented uniformly across the country so some additional training will be put in place. **IIAG perspectives and advice** • Members noted the Five Point Plan, however, considered that effective implementation will need a culture change within the system to acknowledge the problems that need addressing. • Members acknowledged national data limitations but noted considerable concern in relation to access to vaccination, and reporting, for people with disabilities. Noted that Ministry's record of those receiving disability support services (about 30,000) provides a possible denominator for monitoring, even though this is a much smaller number than those reporting a disability in the census (well over one million). • CVIP should be collecting disability information routinely as part of the programme. The IIAG suggested that the Washington Short Set Questions could provide a mechanism for the purposes of CVIP. This information could be requested at the time of booking or vaccination. ***Ministry action 2: Monitoring the uptake of COVID-19 vaccination by people with disabilities will be raised at the next Steering Group meeting and the programme's position formalised back to IIAG.***
4b.	*Papers 6 & 6a: Horizon Research – COVID-19 Vaccine – 25-30 June 2021* Key research results are: • Respondent sample showed 17.3 per cent of the population aged 16 years and over has been vaccinated (i.e. 705,100 people). This is in line with figures published by the Ministry of Health at 29 June 2021 (705,062). • The number who state they will 'definitely' be vaccinated has not changed from May. • The number who state they 'intend' to be vaccinated has gone down. • The number who state they were 'unlikely' to be vaccinated is 19% (i.e. 650,100 people). **Ministry comment** • The results include trends for Māori and Pacific peoples. Noted however that the current sample size is not large. • It was noted that as the number of people vaccinated increases, the proportion of people who state they intend to be vaccinated will drop (equity, invitation and booking system).

	• The Ministry has commissioned a second Horizon survey into the perspectives of Māori to track changes. This will provide more indepth insights to guide future engagement and communication.
4c.	**Group 4 Communications (Rachel Lorimer)** *Paper 7: UAC-19 Vaccine – Group 4 Campaign Planning* • This is a flexible framework approach that will apply to communications surrounding the rolling age group announcements about access to vaccination. • Objectives are to keep it simple, memorable, to have messaging that applies across a range of channels, and to help to manage expectations. • Those in older age groups have a greater risk of a poor health outcome if they contract COVID-19. • However, age bands do not fit well with equity considerations. The Ministry is keen to obtain IIAG views on how engagement will best align with the whānau approach also being promoted for vaccination (for example – which artists/ personalities will best resonate with Māori?) **IIAG perspectives and advice** • Agreed that the age band approach does not translate well for Māori or Pacific populations. • Early involvement of key figures/role models is suggested. • Media channels are different for Māori and Pacific. • In terms of the Group 4 messaging, the "It's your time to book" messaging may not resonate with Māori and needs to sit alongside the idea of protecting whānau. • Some of the Group 4 comms concepts seemed a little "American". Group members would like to see more "Aotearoa". • Concerns were expressed that Group 4 bands continue to be rolled out while Group 3 is not completed. This puts vaccination sites under pressure and impacts negatively on delivery for equity. • Members are keen to continue to be involved in this dialogue.
5.	**Advice about Primary Care and the future state of COVID-19 vaccinations (Dr Joe Bourne and Astrid Koornneef)** • The 'stretch target' is for 85% population vaccination. • As roll-out continues, the intention is to push harder into primary care service provision. Aim to have most of those who deliver the flu vaccine also delivering COVID-19 vaccine by October 2021. • Funding – the service price is set and DHBs do have the funding. There are a few steps a vaccination service provider needs to go through to be commissioned. The Ministry understands this can take about four weeks and is trying to reduce this timeframe. The Royal New Zealand College of General Practitioners is keen for its standards to be accepted as being aligned with programme standards. This will work well where DHBs use a commissioning model that has them accountable for the standards met by their providers. • The Ministry requested views of IIAG about how the Ministry can best assist uptake by this sector, noting that a level of national consistency is required to ensure quality and safety standards are met. *(Cont. over)*

	IIAG perspectives and advice • Members noted that at a pragmatic level, they are not turning away people who present for vaccination. IIAG's advice covered a range of issues: • Primary care providers are trusted providers. Many people do not want to participate in a mass vaccination event and will simply wait until they can go to someone they trust. • Caution was noted to not try to 'over-manage' too much of the roll-out to the primary sector. Numbers of those vaccinated will lift if GPs and primary care are allowed to start vaccinating. A 'just do it' approach should be adopted and IIAG encouraged the programme to push harder and faster into primary care. • Some providers are hesitant because they are worried that delivering COVID-19 vaccination is logistically difficult. • Cost is an issue. Ease of funding to providers is essential.
6.	**International Comparisons (Mat Parr)** *Paper 8a: Percentage of total population vaccinated in OECD countries* • The table provided vaccination statistics for the 38 OECD countries. • The OECD uses 140 day implementation period as the benchmark comparison, being the shortest period of time that a country has been vaccinating. However, most countries have been vaccinating for significantly longer than this, with 20 countries at 200 days or longer. • New Zealand ranks at 37 for population fully vaccinated (with only Australia being lower).
7.	**General Business** The following papers were noted: • *Paper 9: COVID-19 Immunisation Programme Update – 18 July* • *Paper 10: IIAG work programme to September 2021.*
8.	**Closing/Karakia whakamutunga** – Jason Moses
9.	**Next meeting** Thursday 5 July 2021 1.00 p.m. – 1.30 p.m. (IIAG member session) 1.30 p.m. – 3.00 p.m. (Full attendance)