Minutes

COVID-19 Vaccine and Immunisation Programme Governance Group (IPGG)

Date:	Friday, 30 July 2021
Time:	8:30 a.m. – 9.45 a.m.
Location:	Ministry of Health and Microsoft Teams video link
Chair:	Dame Karen Poutasi
Members:	Murray Jack, Ngāhiwi Tomoana
Attendees:	Dr Ashley Bloomfield, Andrew Bailey, Dr Joe Bourne, Astrid Koornneef, Michael Dreyer, Luke Fieldes, Jo Gibbs, Caroline Greaney, Shayne Hunter, Rachel Lorimer (item), Jason Moses, David Nalder, Mat Parr, Maree Roberts, Dr Juliet Rumball-Smith, Dr Ian Town, John Whaanga Jess Hewat (Treasury - observer status) Ben McBride (DPMC - observer status)
Apologies:	Hon. Steve Maharey, Chris Seed, Carolyn Tremain, Dr Caroline McElnay, Colin MacDonald

Item	Agenda Item
1.	**Introductions and opening** • Dame Karen Poutasi welcomed everyone to the meeting. • Ngāhiwi Tomoana opened with a karakia. • Minutes of meeting held 16 July 2021 were accepted. **Conflicts of interest** • No new conflicts of interest were advised. • No conflicts of interest were declared in relation to the meeting's agenda. **Matters Arising** • The Chair confirmed the Group's interest in the development of a Māori Communications Strategy to support roll-out and noted agenda item 9.
2.	**Top of mind assurance issues** To help shape discussion, the Chair asked Group members to briefly note their main issues for the meeting. These were (no order implied): • Better understanding booking status – leading indicators for bookings (rather than actual vaccinations) tell us about demand. • Strategies to continue to grow performance across the peak eight week period, noting that it is harder to attract people after there is about 60 per cent uptake.

	• Confidence in delivery – Current delivery about 50,000 doses per day, however, if we had pressure to go over this and ample supply, how would we deal with this? Consider resource adequacy, points of delivery etc.
	• Equity –
	  ○ there is a national push but it is not always translating into results for Māori and Pacific people. Different DHBs face different issues. We need to understand what is happening at a regional/local level.
	  ○ We need more nuance in how we communicate what the data is showing. The actual story (Māori and Pacific people in older age groups are being vaccinated at similar or higher rates to non-Māori, non-Pacific) is better than the story reflected in public commentary and through production planning.
	• Need to balance 'understanding who the cohort is' with ensuring the right opportunities to be vaccinated at provided to these groups. The latest Horizon research shows that the age group with the lowest intent is 20-40 years. Mass vaccination events may be an effective way to reach this group.

3.	**COVID-19 Immunisation Programme update (Jo Gibbs)**

	Paper 4: COVID-19 Immunisation Programme Update – 25 July 2021
	
	• Significant milestones – opening of "Book my Vaccine", launch of the bookings phone number, media advertisements targeting the over 60s.
	• Another big week for vaccinations, with a seven-day rolling total of 220,000 vaccinations.
	• Good data is coming through the "Book my Vaccine" system:
	  ○ 62,000 bookings on 29 July 2021.
	  ○ 920,000 forward bookings in the system.
	• There are 261 primary care service providers (bookings not in the booking system.)
	• Now have over 10,000 trained vaccinators. Have taken on additional resource and expect to have cleared the backlog caused by the process change by 8 August.
	• Solid progress in workplace-based vaccination:
	  ○ Mainfreight will hold a 'wet run' on 3 August and Fonterra on 10 August.
	  ○ 257 Expressions of Interest received for workplace-based vaccination from a range of private and public organisations.
	• Biggest risk remains achieving equity.
	
	Group discussion
	
	• Question were raised about progressing vaccinations for the balance of Groups 1 & 2 and about the estimated workforce numbers requirements. These were addressed:
	  ○ Groups 1 & 2 have ongoing turnover. DHBs have a system to prioritise these bookings so there is no wait.
	  ○ Group 2 reach is good, with first round Aged Residential Care vaccination completed.
	  ○ Most outstanding vaccinations are in Group 3 with some in Group 2.
	  ○ DHBs with significant maritime ports are working with these ports to ensure access for workers, noting the aligned mandatory testing regime.
	  ○ The Ministry expects to put advice to Ministers in about a week with plans to encourage and place expectations on the health workforce to be vaccinated, and to provide options for extending mandated vaccination to this group.

4.	**Outcome Measures/Leading Indicators (Luke Fieldes/Astrid Koornneef/Michael Dreyer)**
	Paper 5: CVIP Outcome Measures – Status update – data as at 26 July 2021 • This approach to better understanding capacity within the booking system, and interfaces with DHB production plans, was signalled at the last meeting. We will report using this approach from now on. • Now using HSU (health service utilisation) data produced by the Ministry as the denominator for uptake measures. This means that, unlike the census data, we have a known group as the denominator. We can use their gender, age, ethnicity attached to their NHI and thus build up an accurate view of uptake. This can be analysed by age band, territorial authority etc. Can help identify where future effort needs to be focussed.

	• Careful watch on success factor ethnicity. While the current data is showing fairly good results for those aged over 65 years, it is less positive for younger age groups. However, this reflects the way the sequencing tool works. • We aim to have all bookings included in this form of reporting (noting that primary care is not currently included). Working on an IT solution to this. • Expected benefits are that DHBs will have better oversight of their regional situation (bookings, stock in hand, volumes) as smaller sites are brought into production. **Group discussion** • Endorsed the use of tools such as this to give good insights into performance.
5.	**Risk Update (David Nalder)**
5a.	*Paper 6: CVIP Programme risk summary for Governance Group – 27 July 2021* • Reporting is tied to the four Success Framework dimensions. • Three key risks have been fairly consistent. These are embedding equity, legislative compliance, and complexity and change. There is now more confidence on certainty of vaccine supply, which had also been in the 'key risks' group. • Consideration currently being given to Good Operating Practice performance and mapping indicators through to risks to allow us to see emerging risks and trends. • The paper describes all risks and provides a narrative of the programme's response.
5b.	*Paper 7: CVIP Update on recommendations from OAG performance audit report – July 2021* • In May 2017, the Office of the Auditor-General released its report on *Preparations for the nationwide roll-out of the Covid-19 vaccine.* • The report noted the challenges of planning for a large-scale immunisation programme, and made six key recommendations. These covered transparency of communications across a range of audiences, contingency planning and procuring vaccine supply. • The Health Select Committee has asked the Ministry of Health for an update on its progress in implementing the OAG recommendations. **General discussion** • Suggested that positioning the response within a wider picture of overall progress with vaccination roll-out would provide useful context to the Select Committee.

5c.	*Paper 8: CVIP Proposed Internal Audit Assessments – July 2021*
	
	• Seven internal audits are proposed in coming months to give assurance in the processes supporting CVIP roll-out.
	• Audits in three areas have been prioritised and will take place August – October 2021. These are:
	  ○ Service Standards assessment
	  ○ Technology General Controls assessment
	  ○ Logistics assessment.
	• Noted that the Service Standards assessment comprises a programme of reviews touching on DHBs and vaccination sites.
	• Both the Steering Group and Governance Group will receive regular updates on progress with this work.
	General discussion
	• Proposed approaches seem sound. However, some questions were asked about timing, noting the October 2021 completion date signalled for two of the reviews and the fact that the expected peak vaccination period (i.e. the roll-out programme in which people are currently involved) will be completed by this point.
	  ○ Unless there is regular interim reporting, there is a risk that the outputs of the audits may not be able to benefit the programme directly. It was likely to take about a month to do the work and then a similar timeframe to translate this into activity.

	○ It is important to differentiate the changes/improvements that will benefit the programme implementation going forwards vs those that will benefit the future programme. Identified a lot of value going forwards from this work. • It was suggested that if there was flexibility, consideration could be given to moving some of this work forward. • In response to a question, the Programme Director noted that the timing of this assurance activity had to be considered carefully. Some systems have only just been set up (e.g. the booking system) and there was a desire to not set too much assurance in place before these systems were known.''
6.	**Strategy for uptake for peak vaccination period (Mat Parr)**
	Paper 9: CVIP – Maximising Uptake Approach • While the strong early focus of the programme was on confidence of vaccine supply, this is now moving to the demand side. • This paper builds on the research information we have about vaccination willingness and identifies how the programme will work to achieve 85% vaccination uptake in Aotearoa New Zealand. It also draws on recommendations from planning workshops held with DHB SROs. ○ Peak vaccination period will be September to October 2021. In September there will be a 'pivot' from a servicing a model where most appointments are pre-booked to a model that services volume walk-ins. We have expanded our geographic coverage of vaccination site locations. Decisions have included consideration of travel times etc. ○ Equity is a significant consideration. Different groups will need different service models. People will receive invitations through multiple methods. ○ Need to avoid complacency due to New Zealand's unique COVID-free status. ○ We are considering the learnings from international experience. • Cabinet paper will be developed for consideration in late August. **General discussion** • Currently we have the planning and the words – the communications and engagement programme is critical to translate vaccination willingness into action/uptake. • In response to a question, the Ministry confirmed that the modelling was mindful of the quantum of confirmed supply. It has been carefully planned to avoid stock depletion and the subsequent delivery and confidence impacts this would have. However, the point was then made that managing the supply curve and pushing appointments out also had risks (disengagement). • The Ministry noted the current wider demands on the health workforce – including winter illnesses, and the fact that many nursing staff have been moved to work in managed isolation or quarantine facilities. CVIP roll-out must achieve a balance without compromising the rest of the system. • The suggestion was made simply inviting all Māori and Pacific people from now would help to promote equity, given age sequencing works against this. The Ministry noted that full discussions have been had with Ministers and the current approach reflects Cabinet decisions. • Reaffirmed the importance of reaching those in rural locations.

7.	**Myocarditis/12-15 year old DTU for Pfizer and the use of Janssen (Allison Bennett)**

Paper 10: Update on Pfizer 'Decision to Use' for children 12 to 15 years of age, the risks of myocarditis and pericarditis, and use of Janssen - 28 July 2021

- The Ministry has received technical advice from advisory group CV-TAG around the recent Medsafe Pfizer DTU for 12-15 year olds, and in relation to the use of Janssen. A paper is being prepared for consideration by Cabinet in August 2021.

Extending the period between doses

- Following emerging evidence from the United Kingdom that a longer period between doses can enhance the immune response, CV-TAG has recommended an extension of the gap between vaccine doses from three weeks to eight weeks. This extension is likely to impact positively on the incidence of myocarditis, and on safety issues for younger children receiving the vaccine (where little evidence exists).
- Extension of the period between doses would also allow for faster 'first dose' across a wider audience. This partial vaccination status could help to protect if the country experienced a sudden outbreak.
- CVIP is considering the operational implications of this, including the automatic rebooking of those currently booked for a second dose, the extent to which choice will be offered, and how to include primary care bookings (which are outside the booking system). There are considerable IT implications.

12-15 year olds

- The key recommendation is that those aged 12-15 years should be vaccinated if they are at high risk of severe health outcomes from COVID-19, and that decisions relating to wider roll-out to this age group could be deferred. The CVIP programme supports this.
- There are several possible approaches to wider implementation, including applying an equity lens or aligning vaccination of this group with their parents.

Myocarditis and pericarditis

- CV-TAG suggests that the longer interval between doses (see above) may reduce the frequency of some side effects (such as myocarditis and pericarditis) while conferring robust protection from COVID-19.

s 9(2)(g)(i), s 9(2)

[redacted]

Group discussion

- The Governance Group indicated that public sentiment appears to expect that a move will be made shortly to vaccinate those aged 12-15 years.
- Decisions re this issue also interface with the decisions relating to the incidence of myocarditis in those aged under 30 years.
- The above interfaced issues and decisions present a significant communications exercise. The balance to be achieved is to ensure people who have already had both vaccinations remain confident about their outcomes whilst the wider programme moves to reflect the benefits of the emerging evidence about longer dose intervals.
- The Group noted a potential need to factor these matters into contingency planning.

8.	**DHB Accountability of equity targets (Jason Moses)**
	Paper 11: District Health Boards Equity Production Plans and Performance • DHBs are currently at 59% of their delivery against production plans for Māori. This largely reflects the sequencing framework, and the fact that most Māori are in the younger age groups. • Some DHBs are doing an excellent job with Māori aged 55+ years being vaccinated equitably, however, this is now showing through in current reporting. These DHBs are ready to move into vaccinating lower age bands. • DHBs vaccination for Pacific people is generally going very well but some areas still need better targeting to lift performance. **General discussion** • Noted that current sequencing pushes equity results out until late in the programme. The Governance Group asked if the age cohorts for Māori could be lowered to recognise the younger population composition. This could be restricted to DHBs that have met their equity age band targets. Following discussion, it was agreed that the Ministry would raise this matter at the Vaccine Ministers meeting to be held later that day. • The recent move to use HSU data as the denominator (see section 4) will give much better granularity of populations being vaccinated • The Ministry confirmed that regional account managers work closely with DHBs to provide support for targeted communications, including for rural communities. ***Action: Discuss at Vaccine Ministers' meeting on 30 July 2021 whether DHBs that can demonstrate they have completed/near completed their Māori populations aged over 65 years, and aged 60-64 years, may start to vaccinate their younger Māori cohorts.***
9.	**Communications and engagement – general approach (Rachel Lorimer)** • Current focus on launch of 'Book my Vaccine', last part of Group 3 roll-out and Group 4. • As age banding moves into business as usual other communications will be developed or reviewed, such as the 'FAQ'. • Currently doing research to understand attitudes of Māori towards vaccination and their vaccination barriers. • Will also be working with Māori, Pacific and disabilities community representatives to inform the research portfolio supporting future communications development. • Current initiatives with an equity focus include, working with Iwi leaders, Māori leaders, clinicians, and providing targeted funding for champions **Group discussion** • The Governance Group noted that there was now better transparency of information published on the Ministry's website. • The Group noted its desire to understand more detail about regional approaches to promote vaccination uptake with an equity focus, including younger age groups. It expects the Māori Communications approach will provide this overview and level of assurance. The Ministry advised it would also prepare a short update of Māori, Pacific and Disability community engagement, including funding allocations and recipients. • Following a suggestion from a member, the Ministry confirmed it would publish vaccination totals daily on the website. It was also suggested that the Ministry consider publishing the number of bookings made. • Ngāhiwi Tomoana advised he was pleased to learn of the progress made and the work being done to advance age bands. He would provide this feedback to the Iwi Communications Collective the following day. ***Action: Prepare talking points for Ngahiwi Tomoana attendance at the Iwi Communications Collective meeting on 3 August. [Action completed 2 August]***

	Action: Prepare an update of Māori and Pacific communications and engagement to date, including funding allocations. ***Action: Vaccination totals to be published on the Ministry's website on a daily basis. [Action completed] https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-data-and-statistics/covid-19-vaccine-data#by-day*** ***Action: Māori Communications Plan will be put to the meeting of the Governance Group on 13 August 2021.***
10.	**Other business** • The Chair noted that Mat Parr was moving to a new role and thanked him for his contribution to the CVIP Programme over the past several months. • Noted that Fiona Michel will lead the 'strategies for uptake' workstream going forward, and Matt Jones will lead the 'transition to future state' work.

11.	**Sum-up of Governance Group's focus areas for the programme arising from meeting**
	
	• Challenges remain, but the programme has made considerable progress. The launch of the booking system was a significant achievement. Bank the successes while being mindful of the challenges ahead.
	• There is a need for a strong focus on Communications and Engagement to retain confidence and momentum in roll-out:
	  ○ changes to sequencing or population groups,
	  ○ changes to vaccination delivery,
	  ○ to promote vaccination uptake,
	  ○ to meet equity objectives.
	• Internal assurance activities must meet the needs of the programme both for 'real time' and for legacy reasons.

12.	**Meeting close** The meeting ended at 9.45 a.m. due to the prior commitments of several members. John Whaanga closed the meeting with a prayer.
13.	**Next Meeting** Friday 13 August 2021, 8.00 a.m. – 10 a.m.

Minutes

COVID-19 Vaccine and Immunisation Programme Governance Group

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Time:	8:30 a.m. – 10.00 a.m.
Location:	Ministry of Health and Microsoft Teams video link
Chair:	Dame Karen Poutasi
Members:	Murray Jack, Hon. Steve Maharey, Ngāhiwi Tomoana, Carolyn Tremain, John Whaanga
Attendees:	Andrew Bailey, Vince Barry, Astrid Koornneef, Michael Dreyer, Luke Fieldes, Jo Gibbs, Caroline Greaney, Matt Jones, Rachel Lorimer, Colin MacDonald, Fiona Michel Jess Hewat (Treasury - observer status), Ben McBride (DPMC - observer status)
Apologies:	Dr Ashley Bloomfield, Dr Caroline McElnay, Chris Seed, Dr Ian Town

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2.	**Top of mind assurance issues** To help shape discussion, the Chair asked Group members to briefly note their main issues for the meeting. These were (no order implied): • The "Reconnecting New Zealanders" approach just released by the Prime Minister. (See item 4.) • Workforce: ensuring sustainability of a workforce delivering to scale. (See item 5e.) • Achieving flexibility with sequencing to help with scale-up. (See items 6 and 9.) • Actions to increase uptake from Māori, Pacific and Disability groups (noted as being on the meeting's agenda). (See item 7.) • Understanding how the 85% uptake target was identified, its timeframe and trajectory. (See items 5b and 6.)

2. ***Cont.***	**Other issues** • Two members noted positively their own personal experience of COVID-19 vaccination. • The Chair noted she was mindful that the Governance Group must add value to the programme. As the Ministry continued to strengthen and assure of its ability to deliver the programme into the future, a review of the Group's role would be appropriate. ***Action 1: Director-General to work with the Chair to review the future of the CVIP Governance Group at an appropriate point.***
3.	**COVID-19 Immunisation Programme update (Jo Gibbs)**

	Paper 4: COVID-19 Immunisation Programme Update – 08 August 2021
	
	• A number of significant announcements this week:
	  ○ Announcement of change to the interval between doses (21 days out to six weeks). Messaging appears to have been well received with only a small peak in calls at the call centre. Call response times kept to within a minute.
	  ○ Announcement that DHBs who had completed sequencing vaccinations and had capacity could move to lower age bands early. This was well-received by DHBs.
	• Another strong week for vaccination volumes.
	• Primary care: DHBs with maritime ports wish to offer vaccination to all port workers, not just those covered by mandatory testing regime. Will be discussed with Vaccine Ministers later that day.
	• Small additional supply received from Pfizer means we have been able to build up a seven-day stock. We have been able to give DHBs some flexibility but continue to monitor supply closely.
	• Have met with Minister Henare re equity planning; also met with ethnic community leaders. Focus now is to maximise uptake across rest of the year.
	• Cabinet will consider options re vaccination for 12-15 year age group on 16 August. One option is to allow early entry for dependents accompanying parents. There are operational implications (including informed consent procedures) to be worked through for 12-15 year olds seeking vaccination by themselves.

4.	**Reconnecting New Zealanders**
	Papers 5 and 5a: "Reconnecting New Zealanders to the World" and Prime Minister's media release – 12 August 2021 • The Prime Minister outlined five key areas of focus for reconnection, with vaccination playing a key role. Announcement made that all eligible age groups will be able to book their vaccine by 1 September 2021. The elimination strategy will continue to apply. • Noted that the Strategic COVID-19 Public Health Advisory Group led by Sir David Skegg had just released three reports on New Zealand's future strategic approach to managing COVID-19 and reopening the country. **Group discussion** • In response to a question the Chair advised that the Governance Group and the group led by Sir David Skegg did not have direct links. However, a government agency CEO group meeting chaired by the chief executive of DPMC has been updated about the strategic advisory group's work.

5.	**Programme focus areas (workstream leads)** *Paper 6: Programme focus areas – 11 August 2021*
5a.	**Delivering to scale (Vince Barry)** • Programme is reviewing DHB production plans between now and September. Target is 50,000 doses/day delivery on smooth cadence. Logistics are critical to support this. Mindful of potential impact of external influencers (e.g. wider workforce issues). • Maintenance of clinical safety is critical. Must also ensure that any issues that arise within COVID-19 vaccination do not appear more widely. • Encouraged by the involvement of many primary service providers, including pharmacies, who view their involvement in scale-up and roll-out very positively. • Technology: must ensure all key enablers are in place to support scale. Paper being drafted for Steering Group consideration on this issue.
5b.	**Strategy for Uptake (Fiona Michel)** • Noted 85% vaccination target set having regard to research in New Zealand and international settings. • About 20% of primary care providers are delivering vaccination. Larger practices have been onboarded first. Working to include all primary care providers by end October to give resilience going into the new year. However, this second group comprises smaller practices with a smaller overall population coverage. • All DHB providers have their own uptake strategies through their production plans and equity plans. Performance is actively monitored by the Ministry. • CVIP is aware that other countries variously offer incentives for uptake and is reviewing their approaches. • CVIP national director indicated that the cross-sector perspectives of Group members on the draft strategy for maximising uptake would be beneficial once draft is completed. **Group discussion** • The Governance Group noted that the current response to COVID-19 by "all of Aotearoa New Zealand" leaves a legacy of built social capital and of trust at a government level, at a service provision level, etc. New Zealand's unique situation is a significant 'prize' for all New Zealanders, and adding incentives to inspire individuals to essentially 'save their own lives' seems inconsistent. • We must connect with the right people to promote and enable uptake. The importance of connecting with local leaders to lead local approaches to reach local communities was emphasised. The role of the centre is to support this. *(See also discussion at sections 7 and 8.)*
5c.	**Stakeholder engagement (Caroline Greaney)** • Need to build and maintain the confidence of our key stakeholders. • Effective engagement is key to ongoing success of the programme. • Reviewing and refreshing our stakeholder map, and engagement learnings to date, to identify gaps and opportunities to take forwards into future engagement. • Currently looking at cross-agency relationships that will strengthen work with disability communities.
5d.	**Future State design (Matt Jones)** • Building an assumptions map and a future state operating model for COVID-19 vaccination from 2022. • The aim is to be able to apply the final product to other vaccination programmes. **Group discussion** Noted the challenges of designing this in a changing landscape, where the science is not yet fully understood.

5e.	**Worker vaccination (Fiona Michel)** *Workplace vaccination* • Both Fonterra and Mainfreight have completed their first round workplace vaccination with very good uptake. • Good response to the request for expressions of interest from other workplaces interested in offering this service to their workers. These are now being assessed. • Next priority will be supermarkets as essential service providers. • As the government's wider vaccination approach is to implement age sequencing, workplace vaccination has been run in parallel. *Mandatory worker vaccination* • Port workers: There have been some pockets of resistance from this worker group. Work going on to support port employers to have port workers vaccinated including establishing port-based clinics (commencing shortly). • Noted that vaccination is now being offered to all port workers whether or not they are covered by a mandatory vaccination order. **Group discussion** • Workplace: Noted that there is a wide group of essential service providers at AL4 (e.g. couriers, power companies, funeral directors) and this group should be assessed to identify those who must be offered vaccination as an absolute priority. • Courier companies and those servicing supermarkets are likely to be of higher priority. Noted that, mindful of the threat posed by the Delta variant, the all-of-government group led by DPMC was doing some work around the scope of essential service providers. • Port workers: Members noted the public reaction to non-vaccinated workers involved in a previous outbreak. Also noted that the requirements for mandatory testing are phased, with the last cohort (including some port workers) not required to have completed mandatory testing until 30 September 2021. In the meantime, members were aware that maritime port employers were looking at how they could reduce risks in their workplaces e.g. through limiting interactions of certain groups. (Note: The Group's discussion on this issue fed into its wider discussion on New Zealand's preparedness for a Delta outbreak – see section 8.)
5f.	**Vaccinator workforce (Fiona Michel)** • Now have 10,800 trained vaccinators. About half used in the programme to date. • COVID-19 vaccinators: NZQA has approved the training programme. Thirteen people have met all requirements and are now in the vaccination workforce. 370 people in training. Initiative positively received by many DHBs/providers. Māori providers were the early adopters. There is a lot of interest in the legacy potential of this role. • Vaccinator authorisation: Initial backlog (380 applications) created by the temporary deferral of authorisation is cleared. *Hands up (surge) database* • Mindful of the undeployed skillset and wider trained capacity in the network. CVIP therefore now has a dedicated sourcing role to work closely with DHBs and link resources to them to address need. • Looking to maximise use of the "Hands up" database by opening up access to providers more broadly than DHBs. Noted this is still subject to discussion with DHBs.

5f. Cont.	**Group discussion** • The Group noted positively the legacy work associated with the COVID-19 vaccinator role and suggested that consideration by given to micro-credentialing these workers to perform other roles. • In response to a question, the Ministry confirmed that the timeframe to authorise a new COVID-19 vaccinator is about a week, providing all correct information is received with the initial application. ***Action 2: Ministry to consider the following for CVIP legacy activity:*** ***a) Consider what micro-credentialing can be done flowing out of the creation and appointment to the COVID-19 vaccinator role, and*** ***b) Consider how the COVID-19 vaccinator role might endure into the future.***
5g.	**Workforce sustainability (Group-led)** • Group members noted it was important that the programme can demonstrate that it has considered the impacts of both scaling-up and prolonged roll-out on the vaccination workforce, and that it has taken steps to help to DHBs and other health workforce employers to manage this. • Consider actions to keep the essential workforce ahead of the curve, for example, early vaccination of those in essential services not covered by mandatory vaccination. **Ministry comment** • Aware that many employers are working hard to ensure that vaccination staff maintain normal working and leave patterns. The Ministry understood this approach is also applied more broadly across the wider health workforce. Also noted that those in vaccination roles were rotated to other related roles e.g. monitoring those in the waiting room. ***Action 3: Consider if the Ministry should provide 'detailed actions' guidance to support employers to keep their vaccinator workforce fresh. [Fiona Michel]*** (Note: The Group's discussion on this issue fed into its wider discussion on New Zealand's preparedness for a Delta outbreak – see section 8.)
6.	**Reporting against the Success Framework (Luke Fieldes)**
	Paper 7: CVIP Outcome Measures – 13 August 2021 • Tracking well on measures other than efficiency. Reasons for poorer performance in efficiency are that some DHBs have not been able to keep pace with planned capacity increases, and some have not matched demand. (Noted however that the speed of the new age band releases may have had an impact on performance.) • Forward bookings are largely second doses; actual vaccinations are largely first doses. • Noted that the data increasingly provides evidence about gaps in uptake. For example, in group 3 there is a significantly higher uptake by people aged 65+ years with at least one long term condition (LTC) than by those without an LTC. This potentially shows that engagement is having a positive impact for this group. However this is not the case for the 16-64 year age group with LTCs. • Noted that some DHBs have started to run out of people in the released age bands. Vaccine Ministers have agreed to implement 10-year bands in response and this has been well received by DHBs. • Acknowledged that current data is sourced from the booking system and thus excludes primary care. **Group discussion** • The Group noted positively the type of data now able to be provided and the ability to pinpoint gaps.

	• It was queried how CVIP was 'holding' DHBs to the announced sequencing framework. Some DHBs appeared to apply more flexibility. • Closely informs what is needed from Māori and Pacific engagement. But also shows that some groups will need more than just messaging to prompt action. • In response to a question, the Ministry advised that this data was not yet readily available to DHBs due to the recency of the change to using HSU data as the denominator. The Ministry was working to transfer DHB data over. ***Action 4: Provide the Governance Group with information on the specific actions that CVIP will do differently to address the evident gaps showing up in the data. [Fiona Michel]***
7.	**Māori and Pacific Communications (Rachel Lorimer)**

	Paper 8: Communications approach for Maori, Pacific and Disability – 12 August 2021
	
	The Governance Group noted its desire to understand both the broader strategies and the targeted regional approaches to promote vaccination uptake with an equity focus.
	
	• The Ministry noted that there is no 'one size fits all' approach to engagement. The mainstream campaign and funding activities are enhanced by regional and local communications and engagement activity, led within those communities, and variously targeting Māori, Pacific and Disability communities and those in younger age groups. The Ministry has made funding available for many of these local initiatives.
	• Ministry feels confident that it has strong networks and capability, and is reorientating messaging to support strong uptake.
	• Noted that local iwi groups are very well engaged.
	• Digital campaigns and tools will start to gain more prominence as open age banding commences from 1 September 2021. Confirmed that some of these initiatives will be appropriate for Māori audiences.
	• The Ministry undertakes ongoing work to address misinformation where it arises.
	
	Group discussion
	
	• Members discussed the critical importance to scale-up of matching comms and engagement initiatives to the audiences.
	• They sought assurance that the Ministry felt it had the right communications strategies and tools ready for the 1 September launch.
	• Members noted that positive role models and leadership, coupled with continuous positive promotion, are proving very effective, particularly in smaller communities:
	  ○ Community leadership and community spirit in Wairoa has seen over 70 per cent of the population have their first dose.
	  ○ One member had helped provide confidence to a group of workers in his community simply by being vaccinated in their presence.
	  ○ Tribal events create opportunities to increase uptake by Māori.
	• Members queried CVIP communications preparedness for the changes to the interval between doses, announced the day prior on 12 August. The Ministry advised that it was comfortable that direct engagement had taken place with the Iwi Communications Collective and the Cause Collective to target Māori and Pacific communities. There would also be a strong 'push' through social media.
	• Noted positively the freeing up of age bands from 1 September.
	• As an overview, the Group noted there must be a strong link between 'awareness' and 'action', and there must be agility to respond in areas where resistance is encountered so that effort still translates into uptake. Leading indicators now give a granular view of forward bookings. If the effort does not show through in leading indicators then a significant rethink of engagement will be a priority.
	• (Note: The Group's discussion on this issue fed into its wider discussion on New Zealand's preparedness for a Delta outbreak – see section 8.)

8.	**Contingency planning for Delta outbreak (Group-led item)**
	• Members expressed the view that arrival of the Delta variant into New Zealand was a 'when' and not an 'if', noting the current situation in NSW. • Considerable discussion took place about the country's preparedness for the Delta variant, including contingency planning measures, and the actions that can be taken now. • Whilst noting the nation's performance to date, the Delta environment was very different to that which existed in early 2020 and it must not be assumed that the mechanism that has reliably delivered to date will remain effective. To what extent does the approach in the future programme still reflect the situation of early 2020. There is now a need to advance thinking against future risks - what will we do significantly differently in order to address Delta? *Vaccination readiness* • Under AL3/4, essential services remain open. Members are strongly of the view that workers in these services, whether or not subject to mandatory testing, should be fully vaccinated well ahead of the current vaccination curve, and should receive their first dose as soon as possible. Members expressed the view that for many, they did not think a second dose would be possible before Delta was detected in New Zealand. • Port workers were of particular interest to the group. However the scope of essential services could usefully be reviewed and broadened from a vaccination perspective. • It was queried if planning allows for vaccination to continue in an area exposed to the virus. One member suggested this was something that the AOG group was already considering. *All-of-government readiness* • The Chair noted that, from an assurance perspective the Governance Group does not have visibility of the intersect between the vaccination programme and the separate testing programme also led by the Ministry. This 'joined up' overview was something the Governance Group indicated it needs to support its wider conversations with and assurances to Ministers. ***Action 5: National Director to link with Carolyn Tremain re the all-of-government interface, and to clarify the vaccination/testing interface within the Ministry, for report back to the Governance Group.***
9.	**Sum-up of Governance Group's focus areas for the programme arising from meeting** • Members of the Governance Group noted their strongest interest area and concern at this point was the whole-of-government response to a Delta variant outbreak, and the actions that can be taken now from the vaccination perspective to help to protect New Zealanders from COVID-19. The implications for New Zealand of another COVID-19 outbreak are now much broader than just having the disease in the community. • Achieving equity remains a focus for the Group. We must trust local approaches in local communities. The most effective actions will be a combination of Ministry-led communications and engagement activities that supplement the actions of local trusted community voices who can push reach and strengthen acceptance.
10.	**Meeting close** The meeting ended at 10.00 a.m. Ngāhiwi Tomoana closed the meeting with a prayer.
11.	**Next Meeting** Friday 27 August 2021, 8.00 a.m. – 10 a.m.

Minutes

COVID-19 Vaccine and Immunisation Programme Governance Group

Date:	Friday, 27 August 2021
Time:	8:30 a.m. – 9.45 a.m.
Location:	Microsoft Teams video link
Chair:	Dame Karen Poutasi
Members:	Murray Jack, Hon. Steve Maharey, Ngāhiwi Tomoana, John Whaanga, David Taylor (deputising for Chris Seed)
Attendees:	Vince Barry, Allison Bennett, Astrid Koornneef, Michael Dreyer, Jo Gibbs, Caroline Greaney, Dr Tim Hanlon, Matt Jones, Rachel Lorimer, Colin MacDonald, Rachel Mackay, Jason Moses, David Nalder, Maree Roberts (for Dr Ashley Bloomfield), Dr Juliet Rumball-Smith Jess Hewat (Treasury - observer status), Ben McBride (DPMC - observer status)
Apologies:	Members: Chris Seed (CEO MFAT), Carolyn Tremain (CEO MBIE) MoH: Dr Ashley Bloomfield, Dr Caroline McElnay, Dr Ian Town
Format:	To ensure compliance with the Alert Level 4 in place across New Zealand at the time of this meeting, attendees at this meeting joined by Zoom.

Item	Agenda Item
1.	**Introductions and opening** • Dame Karen Poutasi welcomed everyone to the meeting. • Ngāhiwi Tomoana opened with a karakia. • Minutes of meeting held 13 August 2021 were accepted. • It was noted that Dr Ashley Bloomfield was unlikely to attend this meeting due to a prior commitment to meet with the Minister. **Conflicts of interest** • No new conflicts of interest were advised. • No conflicts of interest were declared in relation to the meeting's agenda.
2.	**Top of mind assurance issues (Members)** To help shape discussion, the Chair asked Group members to briefly note their main issues for the meeting. These were (no order implied): • making sure we 'ride the current wave' (i.e. ensuring we can take advantage of the interest created by the current outbreak, in particular from an equity perspective); • ensuring certainty of future vaccine supply; • ensuring that ongoing communications continue a relatable narrative that maintains trust *(the point was made also that the public has strongly positive sentiment towards frontline workers);* • ensuring sustainability of vaccination delivery.

3.	**COVID-19 Immunisation Programme update (Jo Gibbs)**
	Verbal update • Maintaining very high vaccination volumes – more than 90,000 vaccinations on 26 August 2021. Expecting about 520,000 for the week. • This number appears sustainable during Alert Level 4 at least, noting that primary care consultation is undertaken in a different way under this alert level and that providers can currently deliver more COVID-19 vaccination services. • Onboarding about 50 primary care practices a week. • Drive-through vaccination model proving hugely successful. DHBs of all sizes are using it and are providing positive feedback. Maximum four people per car. Model allows for good utilisation of workforce. • Drive-through model appears more sustainable than the mass events model and will be explored further. • If current vaccination rates are maintained, vaccine supply will come under significant pressure mid/late September 2021. However, Ministers are keen that the current demand from New Zealanders should continue to be met and supplies to providers not restricted. • Distribution network is performing well at this level and can continue to do so. • Over quarter of a million bookings made on 25 August. Expect bookings to surge ahead again with the opening to all age groups on 1 September. Strong demand from essential workers. • The Ministry also advised the Governance Group of the death of a female from myocarditis following COVID-19 vaccination. The CV-ISMB considered that the myocarditis was probably due to vaccination. s 9(2)(a) [redacted] Further details cannot be released while the coroner investigates. • A media announcement, with the agreement of her family, would be made in coming days.
4.	**Vaccine Supply (Jo Gibbs/Allison Bennett)**

	Verbal update
	
	• Due to the high demand for vaccination during Alert Level 4, New Zealand has an emerging gap in its future supply. We may run out mid/late September 2021 if current (very high) vaccination rates continue. Significant new supply from Pfizer does not arrive until October.
	• Options being considered to secure additional supply for the interim period are:
	  • s 9(2)(g)(i), s 9(2)(b)(ii) [redacted]
	  • ***secure additional supplies of the European manufactured Pfizer*** (with long use-by dates) from other countries with surplus stock. There are some positive indications in response to New Zealand's enquiries, but several processes will need to be worked through if a supply source can be found. *(See discussion below.)*
	  • s 9(2)(g)(i), s 9(2)(b)(ii) [redacted]
	
	Group discussion
	
	• Members were keen to understand the quantum of future vaccine supply that will be necessary to meet Aotearoa New Zealand's needs. This includes:
	  • what CVIP thinks is sustainable vaccination delivery of the next 2-3 months, and

	• what CVIP thinks it will need to meet third or booster shot requirements (e.g. of border workers who were vaccinated several months ago). • The Ministry indicated that current demand suggested a 'broad brush' requirement of about 500,000 doses per week but it was very hard to pinpoint what sustainable demand will be. DHBs are currently increasing capacity but demand will start to slow at some point. • s 9(2)(g)(i), s 9(2)(b)(ii) [redacted] • MFAT noted that several countries have been approached re the possibility of their unrequired supply coming to New Zealand. Some of these countries are those with which New Zealand has previously engaged on COVID-19 related activity, including vaccine donations to Pacific nations. • Noted that countries may not sell vaccine to one another. In response to a question, the Ministry clarified that if sourcing from another country, New Zealand (as sponsor) will need to enter into a tripartite agreement with Pfizer (or the relevant manufacturer) and the donor country to gain approval to the sponsorship and then manage logistics to ship to New Zealand. • Members were keen to ensure that the Ministry is getting good support from across government to address this 'whole of country' issue. The Ministry agreed that connecting with the Ministry of Business, Innovation and Employment will strengthen its efforts to obtain additional vaccine supply. ***Ministry Action 1: Link with the Ministry of Business, Innovation and Employment into the CVIP effort to source additional vaccine supply from overseas. [Allison Bennett]*** s 9(2)(g)(i), s 9(2)(b)(ii) [redacted]
5.	**Equity (Jason Moses)**
	Verbal update • There has been some improvement in the numbers of Māori being vaccinated. Numbers to date have been at about 8-9 per cent. However, with lockdown and with the age cohorts beginning to move into younger groups, Māori vaccination now stands at 10 per cent. (Noted that on 26 August, 9,000 Māori were vaccinated, and on 25 August, 8,000 Māori were vaccinated.) • DHBs are providing support to providers doing vaccination for Māori and Pacific people. • Biggest challenge area is vaccination for people with disabilities. Nearly all vaccination sites have wheelchair access. Working to ensure that this group has clear communications about how members can be vaccinated. **Group discussion** • Members were keen to know how 'equity' focussed vaccination would proceed, particularly for disability communities, in a lockdown situation. Similarly, what was the likely impact on vaccination for those in rural communities. • Two members noted that Iwi Chairs are all extremely supportive of vaccination and the roll-out drive, but reiterated that regional relationships were a key factor in achieving uptake. Noted also that Māori wardens are playing a key role in engaging and supporting rural communities. • Dealing with misinformation is still an issue. However, the outbreak has provided opportunities in terms of engagement and uptake. • The Group sought assurance about the appropriateness of services and engagement for Māori and Pacific people, and for those with disabilities who wished to access vaccination services. It noted that all of government support for roll-out is critical and asked for some commentary on this wider involvement.

	• In response, the Ministry advised that:
	  o DHBs have a central role and take a range of actions, e.g. supporting pop-up sites in rural communities, vaccinating entire communities during a visit;
	  o Whanau Ora is transporting people to vaccination sites in some places;
	  o DHBs are looking at travel to site to facilitate vaccination for people with disabilities;
	  o Te Puni Kōkiri has agreed to provide support for the vaccination programme through communications. This should help to strengthen equity performance.

6.	**Communications update (Rachel Lorimer)**
	Verbal update • The opening up of the age bands to all over age 12 years on 1 September, and the messaging to all of Aotearoa New Zealand, is the current focus. • Working closely with Department of Prime Minister and Cabinet to ensure the roles and responsibilities for the Unite Against COVID-19 campaign and the Ministry's CVIP programme are clear. • Information packs, including bespoke packs, will be sent out to the various networks by the end of the week. • Will be tracking attitudes and uptake closely through focus groups and other research. • This is a significant campaign that will need to be sustained for some time. From next week the project will report daily on the planned communications releases and dates. At this stage we anticipate a narrative related to where we have come from with the New Zealand response, that we now have a surge situation, and that we will move down to a more sustainable level over time. **Group discussion** • Members emphasised the importance of 'getting the narrative right' for New Zealanders, noting also that it was important to clearly communicate any changes, and the reasons for those changes (potentially including those relating to vaccine supply) in order to maintain trust. The earlier narrative, including that Pfizer was chosen for New Zealand as it is the best available, sits firmly in people's minds now. It can be changed – but needs careful thinking to do so or the programme could be derailed. • The equity narrative must be strengthened as sequencing opens up and we reach the age bands where Māori and Pacific are most heavily represented. • Noted that the narrative must also be able to be readily conveyed to and by Ministers. • Members noted a caution that not all Māori or Pacific families are enrolled with, or feel able to visit, primary care service providers. • Members asked whether the Ministry was considering 'catch up vaccination' for 12-15 year olds later in the year, coinciding with the arrival of expected new vaccine supplies. The Ministry advised it has been working with the Ministry of Education. It had been decided that there would not be a schools-based programme in 2021 mainly because of the curriculum requirements on school students at that time. However, CVIP would be driving a primary care response as the sector has good mechanisms to reach its client base. • Noting the differing types of vaccination that are likely to be required in the future, including booster shots, a schools-based programme is a possibility for 2022. • Members noted that booster shots will soon become an issue for New Zealand, given some border workers were first vaccinated five or six months ago. They indicated they would like to discuss this matter in more detail at the next meeting. ***Ministry Action 3: Include the following as a major agenda item for discussion at the next Governance Group meeting on 10 September - "Booster vaccination and third dose vaccination of those who are immunosuppressed".***

7.	**Format of future meetings**
	• The Chair and members noted their support for the format this meeting, which comprised discussion topics with reduced paperwork. This allowed for a focus on the topics which the Group felt it required to explore further and gain assurance about. • The Chair indicated they would continue with this format for the indefinite future. She also preferred a 1.5 hour meeting to allow time to properly consider items on the agenda. ***Ministry action 4: Note and action the above for future meetings of the Governance Group.***
8.	**Sum-up of Governance Group's focus areas for the programme arising from meeting** • The most effective roll-out – one which ensures no equity gap - must be supported by a 'whole hearted effort' across government agencies. The Ministry of Health must ensure it has effective working relationships with its key stakeholder agencies. • The communications narrative unpinning the public information campaign must be transparent and relatable, so that the credibility of the programme is not undermined.
9.	**Meeting close** The meeting ended at 9.45 a.m. Ngāhiwi Tomoana closed the meeting with a prayer.
10.	**Next Meeting** Friday 10 September 2021, 8.30 a.m. – 10 a.m.

Minutes

COVID-19 Vaccine and Immunisation Programme Governance Group

Date:	Friday, 10 September 2021
Time:	8:30 a.m. – 10.00 a.m.
Location:	Ministry of Health and Microsoft Teams
Chair:	Dame Karen Poutasi
Members:	Murray Jack, Hon. Steve Maharey, Ngāhiwi Tomoana, John Whaanga, Jo Gibbs
Attendees:	Andrew Bailey, Vince Barry, Astrid Koornneef, Michael Dreyer, Luke Fieldes, Matt Jones, Rachel Lorimer, Colin MacDonald, Fiona Michel, Rachel Mackay, Helen Francis (Secretariat) Juliet Rumball-Smith Jess Hewat (Treasury - observer status), Ben McBride (DPMC - observer status)
Apologies:	Dr Ashley Bloomfield, Carolyn Tremain, Caroline Greaney

Item	Agenda Item
1.	**Introductions and opening** • Dame Karen Poutasi welcomed everyone to the meeting. • Ngāhiwi Tomoana opened with a karakia. • Minutes of meeting held 27 August 2021 were accepted. **Note:** Dame Karen Poutasi had to leave the meeting after the Strategies for Uptake item. Murray Jack continued as Chair in her stead. **Actions** • No change to current actions. All currently in progress. **Conflicts of interest** • No new conflicts of interest were advised. • No conflicts of interest were declared in relation to the meeting's agenda.
2.	**Top of mind issues** The Chair invited the members to state items they would like to highlight. These are in no order: • There is a need to shifting the focus of the current communication campaign to include a focus on those that are more hesitant, and those not engaged with the programme. • Iwi chairs and leaders are continuing to push for Māori to be vaccinated. It is recognised that there is a need for Māori to work to re-energise Māori, especially young Māori. • Incentives were raised as another way to help those not engaged. This was tabled for a further discussion under the strategies for uptake item on the agenda.

	• The Ministry recognised our strategy is to vaccinate as many people as possible and not set a target percentage. • It is recommended not to leave the hesitant and unengaged part of the community until last and that we should focus communications on these groups specifically. • Ministers are requesting further information, in particular equity data. We are continuing to pull out all the stops to assist our political champions for the programme. • There is concern about younger age groups being vaccinated as the bulk of the population is under 40 and a significant group is under 25. We should be tailoring our communications campaign to these groups. • A more focussed partnership with Iwi chairs and Ministers, who are strongly supportive of our approach and vaccination programme, should be utilised moving forward. • It is acknowledged that there is 6 or 7 workstreams working in this area but that they are not as well connected as they could be. There are also some great methodologies that we could take into the wider vaccination programmes if achieve the legacy. **Action:** Ability to utilise current methodologies and opportunities to create a legacy for the wider vaccination programme moving into the next year. Chair to discuss with the Director-General and add an item for next meeting. (Dame Karen Poutasi)
3.	**Vaccine Supply (Jo Gibbs / Allison Bennett)**
	• The item under Strategies for Uptake on the agenda will capture most of the areas of this item. • Vaccines landing at 11:20am this morning. The logistics and operational plan for this will see customs work and release these by 5pm tonight and then provide additional supply to Auckland arriving Sunday morning. • There is another deal underway from Europe for 500,000 doses. This will be announced next week and will run with the same process as the recent delivery. Batch numbers have been approved by Medsafe and the Bilateral agreement is ready to be signed. • Pfizer has agreed to send 200,000 more doses which will arrive between September and October. • The Ministry would like to note that although numbers of vaccinated people appear to be reducing, 65,000 doses were completed last week, and the data indicates this is due to the reduction on alert levels. • This weekend there is a full communications campaign expected and walk-in clinics will be available. • Technology is working on identifying areas through the book my vaccine app to enable the public to see digital maps of where walk-ins are. • Geospatial data is available now and we see that rural areas have a lower turn out that urban areas. We can see specific small rural areas have done well as these have been targeted, however larger rural areas closer to urban areas have not as there was an expectation, they would travel into urban area clinics, but this has not happened. Strategies to lift uptake will be discussed in the next agenda item. • There was a debrief with the IMT team recently where being clear on urban, rural, younger people, equity, Māori and Pakeha strategies was highlighted. The Chair and the Ministry recognise, and is very grateful, for the effort undertaken by MFAT, MOH and all those working around the clock to complete the policies and logistics required, to produce such an amazing achievement. Congratulations to the team for securing doses and responding so well under the scenario of trying to vaccinate at the same time as an outbreak.
4.	**Strategies for Uptake (Fiona Michel / Jason Moses)** (This item was meant to be presented fifth but was switched during the meeting)
	• This has been reprovisioned as was previously part of Mat Parr's role who is no longer working on the programme.

- There has been a new working group created to look at this with the optimisation team looking at the day to day working.
- This working group will assist us to see any pain points through great data. We'll be able to understand what is happening in areas, proving expert support when required.
- We are actively looking into taking ideas around incentives to the next steps. We're working with the wider vaccination programme to understand how they've used incentives in the past. Currently it looks more like enabling will work better, that's providing transportation and connecting with like-minded groups, including workplaces and a mixture of private and public services to help with delivering vaccinations.
- There are lots of workplaces working hard to provide vaccinations for their employees.
- Ministers have been advised by the Ministry that an extension to the health order to see how it covers all of New Zealand should be considered along with a more granular personalisation.
- Data can be used to see who isn't responding to invites to be vaccinated so we can reach out to these areas. There is a Mr Whippy model being discussed where we show up in the street and work with people locally.
- There is an alternative to Pfizer vaccine available as it may be that people want to be vaccinated but not with the Pfizer vaccine. We are considering how best to approach this group of the community to offer an alternative.
- We need to stay connected to our communities and Māori health providers as there is a lot of value here, including if we need to move quickly as we saw during the lockdown.
- There is a large focus on communications in these areas from Rangatahi and Iwi communications collective and a specific target response for Māori given that's one of the key gaps at the moment. Providers are also looking into incentives and some have already implemented these in their communities.
- It is encouraging to see momentum in this space and personalisation of this is likely to have the biggest impact on vaccination rates. Communications need to shift to get that last 20-30%. We need to experiment and be more proactive. Providers will need data to see who hasn't been vaccinated in their areas so they can communicate with them directly.
- We suggest that all government agencies, when communicating with people, should be asking, have you had your vaccine yet? Having employers do this would also be helpful.
- There are workplace debates starting and we are looking at possible Health & Safety legislation conflicts.
- Ministers will be lobbied about workplace vaccination and Health & Safety legislation.
- Any assistance we can provide across the government to remove barriers including information sharing and legislation nature should help to ease some of these.
- One of our biggest opportunities for equity is in providing walk-in vaccination clinics and next week these will open to everyone.
- We have a very good cohort of people for each age group and ethnicity health utilisation database, so we know who hasn't responded. With data we can look at the area, post code, ethnicity and can target our approach.
- We have done personal invitations as the different age groups have rolled out and we are supporting different ways of communicating and seeing what people might be more likely to engage with.
- Talking to social science experts will identify techniques to better communicate with communities, including through community based discussions to assist in mobilisation.
- There are 136,000 out 900,000 Māori not affiliated to an Iwi. We need to look at a personalised approach for this group especially as 8-9000 don't have easy access to a provider.
- The Communications Campaign is reorienting themselves to a new phase. Our approach has done well up til now and the next phase is segmentation and specific messages to individual groups, including stakeholders and those on the ground who need to hear from us.
- We are reviewing behaviour and interventions also and strengthening our messaging. Information on safety, protecting yourself, whānau and reconnecting with the world are

	key focus points along with interconnecting sites and moving quickly to utilise touch points. • MSD have fliers going into foodbanks during lockdown. Electoral commission is helping to target small communities. We are continuing a broad approach and also targeting under 30s through more shareable channels to get through to youth, including the radio. We are looking at geographical data to specifically target radio to these areas. • Emotional communications work well. Our previous messaging about recycling rubbish, seatbelts, smoking created huge influences in our children. The children influence adults to make changes. How do we use that influence and the effects of children as we did on earlier campaigns? • There are some negative messages out there, how do we turn these around to positive messages? Iwi chairs and Māori health providers are able to go into Māori communities and partnerships. We should be utilising this much more. Targeting 100% vaccination rates by Christmas for Iwi. Unless we get ambitious, we will be held hostage by the negative messaging. • There is an expectation that DHBs have links to local Iwi, and this should be complimented by nationwide connections with Iwi. **Action:** Next steps of Strategies for Uptake to come to next PLG meeting (Fiona Michel)
5.	**Booster Vaccines (Dr Ian Town)** (This item was meant to be presented fourth but was switched during the meeting)
	• CV-TAG is reviewing. • Third doses and incidents of missed doses our focus at present. • Myocarditis is with the safety board for review. • Janssen as an alternative is being fine-tuned. • Influenza vaccinations are continuing and are being considered as part of the wider integration plan. • Extra vaccines for the immunocompromised, border workers, certificates, and vaccination status for returning New Zealanders as a high proportion have been vaccinated. • Minister Hipkins was advised regarding Pfizer and a science discussion with the Pfizer science advisory board regarding need for boosters and the trials they are currently running. • The Janssen vaccines will be approved for future use but not for booster shots in the first instance although may be something to consider for next year.
6.	**Future Assurance Activities (David Nadler)**
	There are six areas of assurance. • Our intention is to leverage assurance activities already underway. • Utility safety and incident manager. • Tech assurance. • Audit for logistics. • Debrief on IMT group. • OAG come back. • Follow up audit process important, however there is no timing or shape of the exercise yet. • We are signalling to the wider sector for them to self-assure, service standards including performance, and understanding clinic leads have the right oversight in place. A self-assurance confirmation in place. • We have continued to be clear assurance work is required and the expectations of these functions.

7.	**Risk Updates (David Nadler)**
	There are some key themes: • Risk and opportunity. • Delta is the biggest opportunity to the programme on working with risk, public apathy, scaling quickly, contingency programmes. All these plans have been activated and working well. • IMT sped up our decision making process. The debrief and positive opportunity that could continue, including new delivery models, drive, and approaches. • The challenges identified in the risk paper including sustainability of volumes and enduring over the next few weeks of the programme, as there is an end in sight. • Strategy for Uptake to reach hard to reach people. • Future state looking at 2022 and beyond. Items built out of programme can continue. • Inherent risks in the programme didn't change but prominence was more immediate. • Risk only makes a difference if it feeds into decision making. • Complexity as we have different parts of New Zealand in different alert levels. • Managing this part of the programme has many levels. • Materially increase of scale and wider pressure in health workforce. • Risk of clinical issues emphasis needed for incident identification and escalation so we hear and can respond quickly. • Data quality issues. Providers entering vaccinations into CIR. Data quality around all sorts of things, duplications, names are wrong. Providers have gone to paper instead of CIR. There is work being done on this. As we move into certificates this will become more critical. • Emerging issues with travel and certificates if the data quality issues aren't fixed. • There is a complex piece of work to see the data coming through and can issue letters to confirm vaccinations. If this affects 1% then this will be tens of thousands so need fix as soon as possible. • The technology team will require further support to resolve data quality issues. The Ministry congratulates the team for stepping up and getting numbers through as this has been astonishing. We also recognise the good work on contingency planning and the risk work David has done has created a strong platform. **Action:** Return to PLG at next meeting with resourcing requests. (Michel Dreyer)
8.	**Any other business and close** No other business.
9.	**Meeting close** The meeting ended at 10.00 a.m. Ngāhiwi Tomoana closed the meeting with a prayer.
10.	**Next Meeting** Friday 24th September 2021, 8.30 a.m. – 10:00 a.m.

Minutes

COVID-19 Vaccine and Immunisation Programme Governance Group

Date:	Friday, 24 September 2021
Time:	8:00am – 9:30am
Location:	Microsoft Teams
Chair:	Dame Karen Poutasi
Members:	Dr Ashley Bloomfield, Murray Jack, Hon. Steve Maharey, John Whaanga, Dr Caroline McElnay, Carolyn Tremain (CE MBIE), Catriona McCloud
Attendees:	Vince Barry, Allison Bennett, Astrid Koornneef, Michael Dreyer, Jo Gibbs, Dr Tim Hanlon, Matt Jones, Rachel Lorimer, Colin MacDonald, Rachel Mackay, Jason Moses, David Nalder, Dr Juliet Rumball-Smith, Ian Costello, Dr Joe Bourne, Matt Jones, Bridget White, Andrew Bailey, Fiona Michel, Nick Wilson Jess Hewat (Treasury - observer status), Ben McBride (DPMC - observer status)
Apologies:	Caroline Greaney, Maree Roberts, Dr Ian Town, Chris Seed (CE MFAT), Ngāhiwi Tomoana

Item	Agenda Item
1.	**Introductions and opening** • Dame Karen Poutasi welcomed everyone to the meeting. • John Whaanga opened with a karakia. • Minutes of meeting held 10 September 2021 were accepted. **Conflicts of interest** • Dame Karen Poutasi informed the members of her new position on the Health NZ board. • No conflicts of interest were advised. **Actions** **Action 210827-02:** Add agenda item for next governance group meeting on the ability to utilise current methodologies and opportunities to create a legacy for the wider vaccination programme moving into the next year. **Update:** This will be covered in the Future State item on today's agenda. This item is Complete. **Action 210910-02:** Further reporting and summaries to be presented at next meeting. **Update:** This will be covered in the Strategies for Uptake item on today's agenda. This item is Complete. **Action 210910-04:** Return to PLG with resourcing requests. **Update:** Scheduled for PLG next week.

2.	**Top of mind issues** The Chair called for members to briefly note their main issues for the meeting that were at the top of their mind (no order implied): • Volatility of programme: we had an issue of supply and now it's more an issue of demand. Tracking at just under 50,000 doses administered per day. To prevent a long tail to the programme, we need to be more creative and aggressive on outbound strategies, as opposed to awareness. • Equity issues. We need to focus on reaching equity targets. Maori vaccinations and communications campaign for rangatahi. We must mobilise now and take a whanau centred approach. • How do we get to those who don't have the resources to engage with the programme? • How do we address the miss information that is relentless at the moment? • The future has come forward due to the outbreak in Auckland and high vaccination rates. We are looking at quality and not quantity of the plans for uptake. Pressure will mount for vaccination as people will not want to self-isolate for 14 days at home as they've done their bit. How do we bring the programme more into primary care as we move into an integrated health system response? • Targets. Are we working towards a 90% and above target now as this hasn't been something the programme has identified until recently? There is a target to have everyone be vaccinated by the end of the year. • Transitioning the programme. This isn't about an end of year target, but the beginning of November as the programme won't finish on 31 December. What does the programme look like next year, including what we will be building and delivering? • Focus on what's been running well in the programme swim lanes, the configuration, and the drive, and having clear leadership moving into the next year. • Are DHBs using communication campaigns to engage locally? The Chair recognises the great work Jo Gibbs is doing for the programme and acknowledges her effort.
3.	**Strategies for Uptake (Fiona Michel, Nik Wilson)** • Library is active. Available to all providers to use library to find solutions that might work in other regions and duplicate. • Volumes have gone down but has stabilised. Second doses expected to raise numbers. • Critical to drive an all of agency and commercial sector response. • Identifying barriers, what we need and what we need to focus on at the moment. • Providers covering funding flows, comms, engagement with commercial sector and employers. • Making sure not just big industries but smaller ones have vaccines available on site. • Partnership approach. Driving money into system so local providers can spend on primary care, local communications, local advertising campaigns, enablers and they can spend the way they see fit. • Using anyone with a profile to assist in countering misinformation. • Continuing to work with DHBs to ensure clinics are accessible. Including managing open hours. • A programme of calls to ask individuals questions as people can be reluctant to tell us why they are not engaging. Passing calls through to clinical teams to answer questions. Working on adding technology to improve this engagement. • Corrections is bringing in experts to answer questions and raise vaccination rates. • Have signed off on a data sharing agreement with all providers to access geospatial data. • Working with homeless networks to assist in reaching hard to reach areas of the population. • Reviewing data daily, discussing data with Auckland every day to review actions and track progress. Revamping these meetings to a supply model. • Whanau approach is working. Strengthening Maori capabilities and collating their insights.

	• Working through security of provider contracts. **Recommendation:** Review our work with Ministry of Education to assist in working with families going forward.
4.	**Communications (Rachel Lorimer) -** Additional Agenda item added at time of meeting.
	• Collaborating with media agency with strong background in behaviour analysis to encourage change. • Employing someone as a data insights lead. • Collaborating with the group Vodafone used to counter 5G misinformation campaign. • Focussing on those not yet engaged and unlikely to. • Activation and amplification of information campaigns to keep the main awareness on specific messages. • Focussing on emotive and motivating communications campaigns. • Messaging through targeted digital content to paint the future for younger people. • Live nation music touring company doing their own vaccinations for summer concerts. • We're supporting influential musical talent via knowledge as they encourage vaccinations. • Actioning calls through geographically focussed populations. • By labour weekend we will have over 40 businesses nationwide delivering workplace vaccinations. Includes manufacturing, trades, and infrastructure companies. CCDHB will vaccinate Transmission Gully team. We are reviewing the workplace model to ensure it is fit for purpose. **Recommendation:** Review communication messages with Ministry of Education.
5.	**Future State (Matt Jones)**
	COVID-19 Vaccination Immunisation Programme Operating Model for 2022. • Delivery next year will mostly be through primary care providers. • Co-administration to drive a consistent programme. • The programme will have matured. It will need to adapt to the broader national vaccination picture. • Commissioning and sector engagement. • Other functions will be moved to share services in external internal agencies already working in these areas. • Monitoring and surveillance will be key as we move into next phases. • Having a picture of the wider range activities is important. • Three month blocks. First three months focus on everyone getting their two doses. Second block is extending to 5-11 year olds with school based settings playing a role and catching up with other vaccination programmes. Three month block until June is ensuring the third dose is administered, if required, and focussing on the flu vaccination programme. Challenge is forward thinking in rapid pace, continuing to align and not drop between phases. • Ministry looking at establishing a national immunisation unit. • We have recently diverted some key technical resources and launched the national immunisation solution programme which will bring the delivery of all immunisations together into the modern platform by end of March 2022. **Recommendation:** Consider the integration into the wider programme as a matter of urgency, to ensure sustainable readiness for the future. Building on the infrastructure and success of this programme, to build into the national immunisation programme. **Recommendation:** Review all approaches to ensure they are still valid. Assumptions previously made need further examination in a new environment.
6.	**Risk Update (David Nalder)**
	• We inherited some reorientation of risks from supply availability and demand. Important to hold firm while throwing everything at issues. • Now and until the end of the programme we need to maximise uptake and achieve equity.

	• Provide certainty for large proportion of workforce which is temporary. **Recommendation:** Capture risk in the framework and make sure it can guide us.
7.	**Any other business and close**
	• The Chair requested the Director General consider the role of the Governance Group as we move into this next phase of the programme. The Director General acknowledges the positive impact this group has had on the programme and would like to capture and focus this on the next three months phase. The Chair recognises the good work the Governance Group has done so far with a complex, pivoting programme. The programme is in a good assurance space and has the capacity to drive further. • John Whaanga closed with a karakia. • The meeting closed at 9.30am
8.	**Next Meeting** Friday 8 October 2021 8:00am – 10.00am

COVID-19 Vaccine and Immunisation Programme Governance Group

Date:	Friday, 8 October 2021
Time:	8:00am – 9:30am
Location:	Microsoft Teams
Chair:	Dame Karen Poutasi
Members:	Murray Jack, Hon. Steve Maharey, John Whaanga, Carolyn Tremain (CEO MBIE), Catriona McCloud, Colin MacDonald, Dr Juliet Rumball-Smith, Astrid Koornneef, Michael Dreyer
Attendees:	Vince Barry, Allison Bennett, Jo Gibbs, Dr Tim Hanlon, Matt Jones, Rachel Lorimer, Rachel Mackay, David Nalder, Ian Costello, Dr Joe Bourne, Matt Jones, Andrew Bailey, Caroline Greaney, Maree Roberts, Dr Ian Town, Tamati Shepard-Wipiiti Jess Hewat (Treasury - observer status), Sacha O'Dea (DPMC - observer status) Helen Francis (Secretariat)
Apologies:	Dr Ashley Bloomfield, Fiona Michel, Chris Seed (CE MFAT), Ngāhiwi Tomoana, Dr Caroline McElnay

Item	Agenda Item
1.	**Introductions and opening** • Dame Karen Poutasi welcomed everyone to the meeting. • Carolyn Tremaine opened with a karakia. • Minutes of meeting held 24 September 2021 were accepted. **Conflicts of interest** • No conflicts of interest were advised. **Matters Arising** A note from the Chair: This is our final meeting, and I want to take the opportunity of thanking you your contribution to our assurance mahi. I do believe we have added value and that has been because the 'effector arm' has been responsive to our assurance perspective. We have come a long way together with the team that has actually made it happen and I want to acknowledge the commitment and success of that team. Tau Ana. We are in a good space to hand over. Dame Karen Poutasi to all members of the Governance forum.
2.	**Top of mind issues** The Chair called for members to briefly note their main issues for the meeting that were at the top of their mind (no order implied): • Transitioning the programme. Progressed within the Ministry and Ministers to get clarity about what the full immunisation and vaccination initiative looks like, not just covid-19.

	• Opening borders and reconnecting with other countries needs consideration as childhood diseases re-enter the country. • Detecting an over reliance on communications as a critical part of the strategy. Not convinced it's primarily a comms issue, believe it's an engagement issue. Working to not rely on comms and instead supporting an engagement strategy. • Next ten days the drive to have vaccination percentages rising across communities is important. Some of the research is showing complacency. Whenever there's an outbreak engagement levels rise. People tend to act when they feel at risk.
3.	**Reaching the unbooked/unvaccinated – Fiona Michel, Tamati Shepard-Wipiiti, Vince Barry, Rachel Lorimer, Astrid Koornneef** The numbers were stunning this week. Nearly 82,000 vaccinations. Fascinating study on human behaviour, some of these numbers come from rangatahi wanting to have a good summer and attend events. Now working towards Super Saturday. • Rangatahi are hearing the urgency of our messaging as they fear they won't be able to attend festivals and events. • Vaccination data is now loaded into the IDI, which means other agencies can now view it. Social services data can be viewed also. Great support from iwi data group to push boundaries. • Started sharing maps in the public domain yesterday. • Good discussions with privacy commissioner, and iwi chairs and the Data Iwi Leaders Group. Working to have geographical data interactive, ensuring data is not identifiable. Currently DHBs not able to access their own data, getting this sorted for DHBs will enable other employers. The Office of the Privacy Commissioner is involved. **Governance Group discussion:** • We need to sort through big policy questions earlier in programmes; the programme would be in a different place if we had. • There are a number of lessons we've learned that we need to transfer to other areas, so we don't make the same mistakes next time around. • The comms campaign seems to have done its job and we're discussing moving to tackling information using people with mana, recognisable to communities, and word of mouth. • Seeing some unusual behaviour in employment sector as vaccination becomes an employment issue. • Some precedent on how to work with someone who isn't vaccinated would be helpful, from the Ministry, as it is hard at the moment. The Chair acknowledges it is great to hear we're making progress in the data space. If there is an inability to share data across the whole network, is an impediment when dealing with the pandemic. **3a) Ramp up of mobile delivery – Tamati Shepard-Wipiiti / Vince Barry** • Tātou Whaikāha has created disability pathway. • There is a feeling within rangatahi, of being told what to do, and of being harassed in the community by messaging campaigns, such as text messaging from the programme. • Māori mental health is an area of concern. • Whānau delivery should be whānau first, not vaccinate first approach. How come I can get vaccinated but not my kids? The narrative is I want to start vaccinating mokopuna before myself. Need for Māori health workers to be available to answer questions. • Pharmacy and GP approach is good for those registered; success is dependent on how much work the provider has done, otherwise it is limiting to encourage engagement. For instance, one doctor rang every single registered member at their practice to discuss concerns and hesitancies people may have to being vaccinated. • Issues in primary care where this is not the trusted provider, iwi working with doctors to bring the community in to their practices.

	• Ministers have been active, along with the Prime Minister following up with discussions with iwi in lower performing areas. Hon Henare's community visits have been helpful, and there has been an improvement in uptake when he visits. • Comments regarding payments for first and second tranches being discussed with providers. Iwi providers and GPs are not funded in the same way. GPs with high Māori populations need further support. Where iwis are funded by TPK, s 9(2)(g)(i) [redacted] **3b) Coherent behavioural incentive strategy – Rachel Lorimer** • The Ministry is sharing good regional data with local providers and linking with TPK data. • MSD helping to target sub cohorts and able to target areas at a micro level. • There are some concerns regarding primary care vaccination delivery. Coming in to talk to a nurse before getting vaccinated is not working. Might take 30 minutes to see a doctor. There are also concerns regarding potential for violence in practices. • Commissioning model is to pay per vaccination. Keen to understand the augmented model as there will be extra mahi done in outreach settings. • Policy works ongoing for bulk fund interventions. Instructions have gone out to providers and funding is making a difference for outreach providers. • The strategies for uptake library are active for all DHBs, and we are working to enable GPs to see this also. • Through analysis of the online library, we have highlighted tactics and lessons learned. **3c) Reaching the under 40s – Rachel Lorimer/ Tamati Shepard-Wipiiti** • Still vital to provide structure, messaging is still an emergency and needs to be seen through to the end. DHBs are still central and galvanised and not transferring on. • As we move into a more community led programme, we are seeing a dynamic shift. Ministers are enthusiastic, businesses are testing the structure of the DHBs programmes, working hard with DHBs to ensure they have capacity and flexibility to support their communities. • Asking all providers to open on Super Saturday and there will be additional payments to cover costs. We don't want funding to be a barrier. • There are two things to consider as we target specifics. 1. The expectation is for all DHBs that they set up a war room, they maintain control and are central to everything, including encouraging local businesses, regional commissioners, government, and anyone else who is important to delivering, to participate in that war room. 2. The Prime Minister and Minister Hipkins meeting with SROs next week to thank them for their work and that there is more work to do. These conversations are being had with providers as well. **3d) First dose post 7 November – Astrid Koornneef** • Messaging will change once we reach the first dose deadline, and we have community outbreak issues. Helps us to rapidly move to fully immunised population. • The Ministry has been chasing people for first doses and need to do this for second doses also. We will ensure a process is in place to follow up with those that may have missed their first dose or been missed before their second dose. • Need to ensure we don't have leakage between those who have had their first dose and between bookings before second doses. Need to monitor those few who may drop off. 96% conversion rate from first to second dose.
4.	**Future State (Matt Jones)**
	Planning for next year is underway and is broken into quarters. The current quarter is focussed on the following items. **1. Key Messaging to DHBs:** • The immunisation unit will run the wider immunisation and vaccination programme next year. The flu vaccine is a priority in the quarter before winter next year.

- Population protection into the next year.
- Reopening borders
- Establishing National Immunisation Unit
- Using existing channels to leverage this year's model.
- Catch up on childhood immunisations.
- More opportunities to use tools next year.
- New service delivery models regarding children and opening borders, using the same tools, people, and processes.
- Director General of Health has signed off on progressing the programme into the next year.

4a) Mop up strategy (Vince Barry)

- Focus is on the next 10 days.
- A new communications campaign in November driving 90% first doses.
- Hearing tiredness in DHBs with those involved in responding to vaccination campaigns. Working to further support DHBs to keep going.
- Refreshment needed in workforces; lot of people seconded into other roles, what does short term and future state staffing look like.

4b) DHB focus

- It is clear DHBs are focussed on day to day, sending each other boasting texts on who is ahead in vaccinations in each region which is driving competition.

4c) DHB COVID workforce

- We have a DHB focussed workforce, 14,000 people. Some workers have finished their contracts and have moved into new areas.
- It would be good to keep some of this workforce, as the sector, community, primary and retirement care, is short of people.
- Raises models of payments going forward.
- There are anecdotes that for some of the workforce the vaccinator role has been the highlight of their lives.
- It would be a shame to lose people, especially if working in this role changes the lives of their family.
- 300 Maori mums employed across Whakarongorau for the first time into the health sector and over one third are able to korero Maori. These are new jobs in Kaikohe, Rotorua and Hastings making a real difference in regional towns.
- Providers are asking for long term sustainable funding to offer people jobs.
- There are challenges in using the vaccinator role in other areas because of institutional arrangement.
- We will also need boosters in 2022 so the cycle of needing this workforce will continue.
- We are working with Whakarongorau to ensure we maintain the capability in this space for a legacy piece.
- There is an opportunity to inject these insights, regarding the DHB covid workforce, into the reconnection of the programme with the DPMC.DPMC is connected to the programme of health readiness work, we could take the points mentioned, lessons learnt from the vaccination programme, and use it to progress work on our future vaccination strategy.
- How are we running the flu programme, especially running into winter and vulnerable people that we need to protect? We need structures in place to support this, an immunisation centre, and a central immunisation unit.
- Carolyn Tremain will be contacted after this meeting to discuss some of the opportunities, further education, and skills we might need to retain those in the workforce.
- Jo Gibbs and Carolyn Tremain will discuss ways we can secure sustainable funding for DHBs to keep the vaccinator workforce and wrap around services going.

2. Second doses:

- DPMC working with modelling imports, what does that look like over time? How do we extrapolate vaccination rates over time? What does next year look like? Percentage of

	second dose by timeline and reconnecting. Not the full story as there is waning immunity, serious illness, and hospitalisations. • 90% vaccination rate is the number the public thinks is where we will start to open the country. The higher the number the better position we will be in. • How do we keep broader social acceptance for travel if we move the goal posts regarding a vaccination target? • We must be careful we are not creating another level of discrimination between the vaccinated and unvaccinated. • Recent focus groups mention that alert level changes do not motivate people to be vaccinated. The motivation to be vaccinated is doing the things they love and seeing the ones they love. It is also important that mobility and freedom of movement within the country and internationally is possible. • The comms campaign for reconnecting the country will need to consider how young people are feeling. **4d) Minimum level of second dose, Misconception & confusion around second doses** • We need to translate information about second doses into lay language. • Modelling will need to provide an idea of what reconnecting New Zealand looks like as we move from an elimination to control and mitigate strategy. • 90% is the number the public believes we will be reopening the country at. • We need to keep the broader societal acceptance for travel while motivating our vaccine programme. If we change the 90% number to 95% for instance this may not be attainable due to hesitancy and not being able to be vaccinated. s 9(2)(g)(i) [redacted] • We must focus on making sure no-one is left behind in the programme; this is a different focus than reconnecting the country. We don't want the country to be held hostage by 10% of population being unvaccinated before we reconnect. • Need to focus on the bigger picture and how we can connect the dots and retain societies assistance to get to 90%. • We must aware being vaccinated or not vaccinated can potentially create another level of discrimination. • In recent focus groups there was not a strong motivation to be vaccinated in changing the alert levels. The motivation came from doing the things people love and seeing the people they love. Reconnecting the country was where younger people were focussing also. • The are questions raised regarding freedom of movement and mobility both in NZ and internationally.
5.	**Risk Update (David Nadler)**
	The intention of this paper is to headline risk and to cascade a range of risk items, such as: • risks in the rollout of the programme • risks relating to maximising uptake • risk in effective handing over into 2022 • 12 key areas identified. 12 key areas of major uncertainty • risk approach has been non-traditional over the life of the programme • focussed on presenting risks in terms of uncertainty. • Risk is a matter of nuance, what may be leading today may only need a tweak to rectify, like the workforce itself. • The flavour of the framework comes through loud and clear, there are big ticket risks that we are seeing at the moment, which we expect to see, we are able to capture moving forward. • We can see mitigations are in place and effective as we expect them to be. • Mitigations are unclear regarding transition of the programme into next year. • We would like the programme to have a risk focus for a while so we can understand what is needed for the transition.

	• Exit criteria should be at the point of handover and with an explicit definition so the work the programme has done, and the institutional knowledge and workforce, goes to the appropriate risk areas. • There should also be a formal close out of the programme and transfer of risks. The programme has two months to run through the risks for refinement, beyond that we need to transfer to a business owner to manage whatever risks remain. • The Ministry is beginning to formulate business owner and risk handover, pulling together a strategy and discuss scope and leadership also. **Noted:** It is noted it would be good to have a close out/handover of any outstanding/on going issues for the Director General to take to National Immunisation Unit in January 2022. It is suggested Murray Jack will be able to will liaise with members and create a handover document reflecting learnings from the forum.
6.	**Any other business and close**
	The Chair is grateful to the Governance Group members for all of their hard work the great team they have been to work with. At each meeting the Chair has worked through, with the Group, assurance tasks and has walked away feeling as though we have contributed to the programme. The team has been very receptive and hugely successful in delivery as a result. The Chair would like to note that fundamentally the Group has developed the programme in a dignified way, and to not underestimate the success that you have had. The Chair thanks Jo Gibbs in particular for leading the programme and notes that assurance only works if there are people willing to work with you, which Jo has been. The members thank the Chair, Dame Karen Poutasi, for her outstanding leadership and guidance through the Governance Groups existence. The Chair requested the Director General consider the role of the Governance in the programme. • John Whaanga closed final Governance Group meeting with a karakia. • The meeting closed at 9.30am