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MINISTRY OF HEALTH
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Minutes

COVID-19 Vaccine and Immunisation Programme Steering Group

Date:	Tuesday, 25 May 2021
Time:	4.30 pm – 6:15 pm
Location:	1N.3
Chair:	Dr Ashley Bloomfield Maree Roberts - latter part of meeting
Members Attending:	Dr Dale Bramley, Michael Dreyer, Jo Gibbs, Sue Gordon, Wendy Illingworth, Dr Caroline McElnay, Maree Roberts, John Whaanga, Deborah Woodley
Other Attendees:	Andrew Bailey, Ian Costello, Stephen Crombie, Chris Fleming, Rachel Haggerty, Tim Hanlon, Astrid Koornneef, Colin MacDonald, Rachel Mackay, Fiona Michel, Jason Moses, David Nalder, Mat Parr, Dr Juliet Rumball-Smith, Dr Ian Town, John Walsh
Apologies:	Shayne Hunter, Joe Bourne, Megan McCoy, Grant Pollard
Secretariat:	Carol Hinton

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#	Agenda Item
1.	**Introduction and minutes** The minutes from the previous meeting on 18 May 2021 were approved.
2	**Operational update – progress last week (Jo Gibbs)** *Paper 2 considered: COVID-19 Immunisation Programme Update 23 May* Jo Gibbs noted that as at 23 May 2021, CVIP had delivered over half a million vaccines. • All DHB plans are in and are being analysed, including from an equity perspective. Meetings are scheduled with all chief executives commencing 26 May. • We continue to have about 2,500 trained vaccinators. • Māori representation is at about 10% and we want to ensure this continues to grow. • The legislative change to allow workforce changes is well under way. The Minister will make an announcement over the coming week. Group discussion • Mat Parr noted that Group 3 provides an opportunity for strong pro-equity gains across the overall population. • Dr Bloomfield congratulated the team on both the achievement of the milestone and the longer-term legacy of the legislative change in expanding and diversifying the workforce.
3	**Standing item on science and technical advice through CV-TAG** (Dr Ian Town) Dr Ian Town advised that CV-TAG met on 25 May and discussed the following:

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	• **Research project on BMI and Immunogenicity:** this looks at the effect of BMI and arm size of intramuscular vaccine delivery. CV-TAG endorsed this, noting the importance of considering the impact of race/ethnicity on outcomes and requesting that the research be shared when available. Proposal being considered for funding. • **Updated 'decision to use' (DTU) the Pfizer CVID-19 vaccine** in Group 3 sequencing: MoH had sought CV-TAG advice on this. CV-TAG agreed that safety and effectiveness data, to date, regarding this vaccine are consistent with previous evidence and recommended no changes to the DTU would be required. • **Pregnancy advice**: CV-TAG reviewed use of the Pfizer vaccine during pregnancy and recommended that it be routinely offered at any stage of pregnancy. CV-TAG will provide this advice to CVIP.
4	**Programme progress against milestones** Papers considered: *Paper 4: CVIP POAP 24 May 2021 and paper 4a – POAP updated 24 May* *Paper 4b: Readiness Criteria for review* *Paper 4c tabled: Options for inviting New Zealanders to be vaccinated for COVID-19.* • **Service Design (Mat Parr/Andrew Bailey)** Mat Parr noted the current strong focus on scaling up – ensuring comms align with supply and ensuring national consistency. • Supply remains the key constraint. Need to continue to manage demand with vaccine availability. Acceptance to date is not at 100%. • Focus on the number of people who can be immunised in any particular month – this reiterates a staged approach and is fewer than the headline 'actual doses' number. • Ministers have strong interest in everything, including booking system, going 'live' on Day 1. CVIP identifies this as a risk. Cannot design completely as do not yet know all sites and or delivery models (e.g. workplace and education settings). • Mat Parr noted a workshop on 26 May would 'deep dive' into testing at scale. Current objective is for sign-off on 'readiness to operate' by end June. • Sue Gordon asked about contingency planning. This was clarified as covering a range of scenarios including natural disaster, workforce shortage, IT systems, vaccine batch recall, a significant post-event episode, or another community outbreak. Matt tabled the paper "*Options for inviting New Zealanders to be vaccinated for COVID-19*" which set out options for segmenting the population over coming months – by age and ethnicity (current preferred option), by region, by open access etc. This generated substantial discussion: Group discussion: • Agreed that whilst segmenting can be changed, we cannot make the qualifying population number greater than supply. • Walk-ins will need to be managed. For a variety of reasons, many people are unlikely to book, or respond to an invitation. • Perceptions of 'fairness' will vary and need to be managed. For example, two neighbours may receive invitations for completely different dates. A 'postcode' rollout was likely to generate perceptions of unfairness. • CVIP needs to decide if it will carry forward current prioritisation into Group 3. Rachel Haggerty reinforced the need for this, citing new healthcare workers as an example of those whose need for the vaccine will be ongoing. • The comms approach was discussed. This included the extent to which a person who met the 'early vaccination' criteria might also be invited to attend vaccination along with their family and whanau whether or not these people also met the 'early' criteria.

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- John Walsh noted that Group 3 as a whole needed to receive message in the week commencing 31 May but this would be a 'soft launch' – i.e. to clarify that they would receive an invite during June and July but the appointment may be later.
- Dr Dale Roberts strongly endorsed an approach of going into communities and inviting people to attend in a group. He noted that 'whanau' are not necessarily just genetically linked – but are a grouping of people who engage with each other. We must be as enabling as possible about this. Our comms should prepare for this and proactively communicate the approach.
- Rachel Haggerty also reiterated the importance of local networks and relationships in bringing people into the system. The invitation system was only one factor in getting people to be vaccinated.
- Maree Roberts reinforced the need to remain mindful of Ti Tiriti when considering the various options
- Dr Bloomfield noted the importance of agreeing a recommended approach prior to discussion with the Minister. Jo Gibbs noted her understanding that the Minister wished to discuss on 26 May.

Action 1: Dr Bloomfield requested that the paper be reviewed and resubmitted, to focus on rollout 'how and when' for further consideration on 26 May.

- **Equity (Jason Moses)**

Papers considered:

Paper 5 – Equity Programme Overview
Paper 6 – Redirection of Pacific COVID-19 virtual vaccine support service
Paper 7 – Pacific Peoples' experience of managing health in COVID-19 context (research report)

- Jason Moses confirmed all DHB plans have been received and are being analysed, including from an equity perspective. Some need further work but some, including Taranaki, Whanganui and Nelson, are very good and their approach will be used as a basis for strengthening others.
- Strong focus on service design and blueprints – partnering with Māori providers and ensure their thinking is incorporated.
- Funding for COVID-19 comms is now being distributed to successful applicants. Appreciated the assistance of DHBs in assessing applications.
- Paper 6 notes the intention to redirect $2.4 million from developing a virtual support network to directly support DHBs and Pacific health providers to delivery vaccine support services.

Group discussion

- Dr Bloomfield noted the increase in intention to vaccine amongst Māori and Pasifika is pleasing, and commended Jason and his team for their role in this change.
- Dr Caroline McElnay asked if the change might flow into uptake of other vaccination. Jason indicated he was hopeful, and that actuals from Group 3 will be a good indicator.
- John Whaanga said he was feeling more confident about increased representation and 'hitting the target', but cautioned that the work of Māori themselves in bringing about these changes must not be under-estimated. Māori leaders have really stepped up to lead and encourage vaccination.
- Rachel Haggerty noted this was the first programme she has seen that has commissioned for equity first. There are many learnings to be taken from this.
- John Whaanga endorsed this, also noting the positive move to change the profile of vaccinators (see also section 2). However, John wanted to see much more acknowledgment of the importance of mobile services in reaching communities.

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- **Operations (Astrid Koornneef, Dr Juliet Rumball-Smith, Michael Dreyer)**

Paper 9 considered - CVIP Quality and Safety Framework and Actions

Dr Juliet Rumball-Smith updated on work to ensure all DHBs have a safety and quality framework in place (action 4 from meeting on 11 May refers).

- The clinical quality and safety dimension of the CVIP Quality and Safety Framework has been strengthened to better support delivery of the CVIP programme.
- Two groups will provide assurance to CVIP governance re the integrity of clinical safety and quality:
  - an internal CVIP incident review group (IRG) – to consider the role of incidents, adverse events and complaints and identify where learnings can be applied, including to mitigate possible systemic issues. Weekly meeting cadence.
  - the National Clinical Quality and Safety Forum (NCQSF) – to act as 'relationship lynchpin' with DHBs, and through them with CVIP providers. The first meeting of this group will be 26 May.
- Generic standards have been developed to support safety and quality in any situation in which a vaccine could be delivered.
- All DHBs have now provided advice to CVIP on how their quality and safety mechanisms are structured. Most have well-established systems and meet every 1-2 weeks. However, four did not provide detail and Juliet said that extra support may be required for these DHBs. She will be following up.

Group discussion

- Dr Bloomfield acknowledged the considerable work that had gone into developing this framework to respond to his earlier request, and said that the arrangements outlined felt very 'solid'. This was endorsed by Dr Ian Town and Dr Dale Bramley.

- **Technology (Michael Dreyer/Loren Shand/Astrid Koornneef)**

Paper 8 considered: National Immunisation Booking Service – 'Go Live' Approval

- A decision is required to move from pilot mode and into implementation.
- The change is not just a technical change – systems must be moved safety but without impacting unfairly or unduly on the consumer. We need to ensure people (and their bookings) are not 'lost' through the changes.
- Three requirements need to be met this week for 'go live':
  - Work with DHBs to ensure all have implementation plans to migrate existing data systems (this is a collaborative exercise between Whakarongorau, DHBs and MoH).
  - Work with DHBs develop an engagement plan to co-ordinate and communicate their implementation plan
  - Training and support for DHBs re the changes.
- We have 'triaged' DHB assistance according to complexity, risks and timeframes. Risks are being carefully tracked.
- Web link to booking system has been trialled on a diverse group of 100 people – no issues arose which tells us that usability is excellent.

Group discussion

- Stephen Crombie congratulated the team on what he said as an 'impressive achievement' done in a very short space of time. He asked when the 'mandatory to use or not mandatory to use' decision would be made.

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- Jo Gibbs felt it could potentially be mandatory at DHB level, however, agreed with Astrid Koornneef that further work was still required re the primary care interface.
- Rachel Haggerty noted the view that the booking system would not be a universal system and there was a need to ensure people understood this. Transparency of the booking system is important but equity will not be achieved if the booking system is the only one that can be used.
- Dr Dale Bramley asked if the programme had confidence that the training pilots supported full scale rollout. Loren Shand and Michael Dreyer said the Kaikoura trial went very well and they now wished to progress to sign-off on roll-out. They acknowledged there may be future changes as we learn, but confirmed that the system can quickly iterate.
- Colin MacDonald noted that the decision paper would need to cover off this discussion i.e. this was not a single system but that we have confidence that the combination of the methods and techniques used would result in people being vaccinated.

- **Comms and Engagement (John Walsh)**

Papers 10 – 13 considered: Comms and Engagement update 24 May and associated promotions and research

John Walsh updated on Comms and engagement activity:

- Proactive media developed to mark the half a million vaccine doses milestone.
- Well-organised misinformation was still circulating and there will be two papers for the Steering Group on 1 June.
- MoH has engaged directly with a named individual quoted in media to address the Ministry's concerns re the attributed comments, and had then communicated the outcome to the Iwi Communications Collective, which had also held significant concerns.

Action 2: Develop paper on managing misinformation for the 1 June 2021 Steering Group meeting. [John Walsh]

- **Workforce (Fiona Michel)**

Fiona updated on the Workforce stream:

- 6,025 trained vaccinators at 25 May. About 2,200 active/have been active.
- Percentage of Māori vaccinators is still at 9.5%. Pasifika is 2.9%. We are gaining workforce numbers but not getting the right level of diversity. The challenge is to ensure this new workforce does well in terms of CVIP delivery as this has potential to become a 'legacy' role.
- CPR training is under way.
- Sue Gordon noted that the surge workforce database also had potential for wider and legacy functionality.
- Engagement under way with NZNO to address its concerns expressed during consultation over the proposed new COVID-19 Vaccinator role.

- **Logistics (Ian Costello)**

Ian outlined preparations for Group 3 rollout including:
- Planning with transport providers re delivery to the hundreds of sites is now finalised.
- Co-design (delivery and storage) is completed and is being considered by SROs.

- **Post Event (Tim Hanlon)**

Tim Hanlon noted that New Zealand's support to Polynesia continues to progress well.

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	• MedSafe will be the business owner of the pharmacovigilance system. The intention is to provide active monitoring. Michael Dreyer confirmed this will be in place in two months' time. • Tim noted that the pharmacovigilance work did not affect sequencing – it was about providing assurance. It was a legacy system rather than simply being a CVIP rollout requirement. • **Polynesian Rollout** No separate update this week.
5	**Programme risk update (David Nalder and risk owners)** *Paper 14 considered: CVIP Programme Status and Risk Summary - Steering Group 24 May* David Nalder updated on risk management activity: • Per page 3 of the paper – the table "This week" now shows the 'risk journey' – i.e. how risks have been tracking over the current week and previous three weeks. Operational leads confirmed they had no additional risks to raise beyond any raised in the discussion at Agenda Item 4.
6	**Real time assurance update** (Colin MacDonald and Stephen Crombie) • Endorsed the strengthened Quality and Safety framework outlined by Dr Juliet Rumball-Smith. • Reinforced the importance of finalising the accountability framework and its link assurance. • Stephen Crombie noted that once both mechanisms were firmly in place, then the programme itself provides its own assurance framework.
7	**Any other business** • Noted that the "Proof of vaccination" paper will be discussed at the PLG meeting on 26 May. A paper would be submitted to the Steering Group likely for 8 June. • Consideration of paper 15 (Funding and Contracting) was deferred. ***Action 3: Submit paper on "Proof of vaccination" to Steering Group (likely timing noted as 8 June 2021).*** ***Action 4: Resubmit paper on Funding and Contracting at an appropriate date.***

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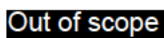

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MINISTRY OF HEALTH
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Minutes

COVID-19 Vaccine and Immunisation Programme Steering Group

Date:	Tuesday, 1 June 2021
Time:	8.00 am – 9:05 am
Location:	1N.3
Chair:	Dr Ashley Bloomfield
Members Attending:	Dr Dale Bramley, Michael Dreyer, Jo Gibbs, Sue Gordon, Shayne Hunter, Wendy Illingworth, Dr Caroline McElnay, Maree Roberts, John Whaanga, Deborah Woodley
Other Attendees:	Andrew Bailey, Allison Bennett, Jeff Brandt, Ian Costello, Chris Fleming, Tim Hanlon, Astrid Koornneef, Colin MacDonald, Fiona Michel, Jason Moses, David Nalder, Mat Parr, Grant Pollard, Andi Shirtcliffe, Dr Ian Town (until 8.30 am), John Walsh, Jo Williams
Apologies:	Stephen Crombie, Luke Fieldes
Secretariat:	Carol Hinton

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#	Agenda Item
1.	**Introduction and minutes** Dr Bloomfield advised that due to surrounding commitments, the meeting this week would be for one hour. The draft minutes from the previous meeting on 25 May 2021 were approved, subject to a change to wording under the section headed 'Post Event' on pages 5 and 6 as provided by Tim Hanlon: • "MedSafe will be the business owner of the pharmacovigilance system (including active monitoring). The intention is to provide active monitoring and a new pharmacovigilance database as part of an integrated approach. Michael Dreyer confirmed this will be in place in two months' time. • Tim noted that the pharmacovigilance development work did not affect readiness for scale up – it was about providing a richer data set and enhancing public confidence in the safety of the vaccine, as well as reducing the effort to detect safety signals. Additionally, it would provide New Zealand with a legacy system."
2.	**Operational update – progress in the past week (Jo Gibbs)** *Paper 2 considered: COVID-19 Immunisation Programme Update 30 May* • Significant number of vaccinations in the previous week – almost 100,000. • DHB planning – the last chief executive-level meeting takes place that day (1 June). Some plans are excellent, some will need more work. All have significantly strengthened their equity focus. • Other key themes for discussion have been scaling up the workforce, implementing the booking system, and focussing on outcomes for the disability community (noting this is a priority population where data to support initiatives is poor).

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	• DHB accountability framework will be finalised at an SRO workshop on 3 June. For smaller DHBs, the next implementation phase will require a significant increase in volume. • Two DHBs will be onboarded to use of the booking system this week - Taranaki (1June) and Wairarapa (2 June). Group discussion • Dr Bloomfield noted that the development of the booking system had been an extremely complex piece of work and he would like to engage with media to increase the level of public understanding about this. He was mindful of the comment from the external assurers at a recent Steering Group meeting which commended the efficient rollout of the booking system, in particular having regard to the size of the project. ***Action 1: To promote media understanding of the complexities of the national rollout, invite some journalists to a presentation/discussion on the CVIP approach to development of the booking system from all angles – IT, and matters such as privacy*** **Incident and adverse event reporting (Jo Gibbs)** • Jo Gibbs noted that the death of a s 9(2)(a) four days after vaccination had been reported. s 9(2)(a) The matter is with the coroner and being investigated by CARM. • Vaccination of children aged under 16 years continues to be reported, including one of a child who had received both doses. *(See 3 below for further discussion and actions on this matter.)* • Jo noted the need to check that every vaccination clinic must have in place appropriate health and safety systems before being allowed to operate. • Jo noted the potential implications of this to be considered from a safety systems perspective. From a professional perspective, the administering health professional is using a non-regulated medicine and risks disciplinary action.
3	**Standing item on science and technical advice through CV-TAG** (Dr Ian Town) • CV-TAG will consider the formal advice from Medsafe re its updated 'decision to use' the Pfizer vaccine (covering 12-15 year olds) at its next meeting. • Medicines Assessment Advisory Committee decision re Janssen is due 15 June. Decisions on AstraZeneca may be later. Group discussion The key topic of discussion here was Medsafe's updated 'DTU'. • Dr Bloomfield stated that extension of the vaccine, including through Group 3 and/or 4 sequencing, is a matter for Cabinet consideration. • Jo noted that communications relating to any reduction in vaccination age (e.g. 12 to 15 years) will need careful thought as there is a risk that the perspectives of some re the appropriate vaccination age will drop below the lowest accepted age bracket. • Dr Bloomfield and Maree Roberts supported that some contingency work be done if the Pfizer supply is not confirmed or if we have an outbreak situation and need volume before it arrives – i.e. how Janssen would be deployed. • Mat Parr suggested some rework of existing training material would be required but agreed on the desirability of a 'Plan B'. ***Action 2: Report back to SG on CV-TAG consideration of the Medsafe updated decision to use (DTU).*** ***Action 3: Dr Bloomfield asked for the timeframes and decision-making processed for the 12-15 year old inclusion in Group 3 rollout be written up and given to him as soon as possible.***

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	Action 4: incorporate the Medsafe DTC, CV-TAG advice and other relevant information into the Cabinet paper on readiness for general roll-out. ***Action 5a: John Walsh to consider the communications required if NZ has to deploy the Janssen vaccine under urgency.*** ***Action 5b: Develop a 'Plan B' in the event NZ must roll out the Pfizer vaccine in an outbreak situation (where implementation does not rely on a state of emergency being declared).*** ***Action 6: Clarify the mechanism/content to communicate the CV-TAG advice that the Pfizer vaccine can routinely be offered at any stage of pregnancy,*** ***Action 7: ensure that Minister Verrall is advised of how it will be communicated that the Pfizer vaccine can routinely be offered at any stage of pregnancy.***
4	**Programme progress against milestones (Mat Parr/Andrew Bailey)** *Paper 3 considered: CVIP POAP* • **Service Design (Mat Parr/Andrew Bailey)** • Key issue as we move to scale is obviously confirmation of vaccine supply. Based on plans we are on track until end June. • Our planning also has some 'give' in that it is based on 6 doses less 2%. Wastage is decreasing over time. • One documented risk associated with unconfirmed supply is that people who have had dose 1 might have to wait longer for dose 2. However we have accepted the risk on the basis of past reliability. Critical that we review delivery drop on 3 June. Group discussion: • Jo Gibbs noted there are several DHBs ready to go should supply become available earlier. **Strategy – implications of the Pfizer storage announcement** *Paper 5 considered – change to cold-chain storage timeframe – strategy check in* • SG considered this paper and noted the four points made on pages 2 and 3. Dr Bloomfield acknowledged the huge amount of work that had gone into preparing it. Action 16: Adjust the second noting point in Paper 5 to add missing words, and minute accordingly. • **Operations (Astrid Koornneef)** *Paper tabled – Target dates for DHB go-live on National Immunisation Booking System* • Astrid Koornneef circulated a table showing the target dates for DHB 'go live' on the national booking system, by region. Two regions go live in the current week. • There is a high level of engagement from DHBs on this work. Astrid noted she is comfortable that this is well on track. • **Comms and Engagement (John Walsh)** *General communications discussion* • Focus on group 3 sequencing – CVIP working closely with wider Ministry comms team. • Planning session for group 4 scheduled for 2 June. • Jo Gibbs noted a little nervousness from some DHBs about the wider communications on something they do not yet have capacity to deliver. • Dr Bloomfield commended the work done to date. *Paper 7 considered: Ethnic Communities engagement and communication plan*

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- John Walsh updated on work to be done to enhance engagement and communication with ethnic communities, primarily MELAAA communities, which make up nearly a quarter of NZ's population. This group is underserved in rollout, primarily because of lack of translated information.
- Funding was requested to put in place a range of initiatives to engage and communicate more effectively with these communities.

Action 8: Agreed to establish a fund totalling $1 million to assist ethnic community stakeholders, leaders and health providers to carry out communications activities in their respective communities (per recommendation 1 of paper 7).

Paper 8 considered: Proposal to provide a Tactical response to COVID-19 vaccine disinformation

- John Walsh advised that CVIP is now referring to disinformation/misinformation as "tactical response".
- Propose to split accountability between John Walsh and Geoff Gwynn and increase the focus on this. Two approaches:
  - Continual stream of robust information. Will 'call out' some of the more problematic material being circulated from other sources.
  - Geotargeted responses to particular regions.
- Are looking at digital marketing techniques to provide information to vaccine hesitant people.

Group discussion

- s 9(2)(g)(i)

Action 9: consider whether operating guidelines should be developed for vaccination centres to assist them to deal with any protest action that may arise at their site.

- **Equity**

Considered largely from a Comms and Engagement section (see John Walsh/Paper 7 consideration above).

- **Workforce (Fiona Michel)**

Paper 6 considered: Operationalising changes to Medicines Regulations 1984: COVID-19 Vaccinator Workforce

- Fiona updated that we now have just over 6,500 trained vaccinators.

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	• In developing the proposals for the necessary legislative change to support the new COVID-19 vaccinator role, we have undertaken 'light' consultation. This acknowledges current wider sensitivities. • There will be a 'soft launch'. Noted that the Minister is supportive of the work proceeding. A ministerial announcement may potentially be made at some future point. Group discussion • John Whaanga endorsed this work as positioning for future workforce development and expansion. It contributed very well to the 'legacy' component of rollout. • In response to a question, Fiona confirmed that DHBs and providers are literally 'waiting for the pack' to arrive so they can begin with the training of people for this new role. Some have already developed plans for working with Kaiāwhina workforce. **Decisions in relation to Paper 6:** • Agreed to recommendation 2 – "to a minimum requirement ratio of a maximum 1:6 Supervisor: COVID-19 Vaccinator" • Agreed to recommendation 3 – "to the definition of Supervision in the context of the Vaccination Clinical Supervisor role, as described at paragraph 27 of the paper". • Agreed to recommendation 9 – "to amend the relevant COVID-19 Immunisation Service Standards and associated artefacts". (*See note below*) • Agreed to receive further information on point 7 to enable a decision to be made by SG in the future • Noted – points 1, 4, 5, 7 and 8. *Note for the Minutes: Recommendation 9 includes the training material – action 5 from meeting on Tuesday 11 May* **Action 10 - Give effect to the decisions in regard to this Paper 6.** • **Logistics** No separate update this week due to shorter meeting duration. • **Post Event** No separate update this week due to shorter meeting duration. • **Polynesian Rollout** No separate update this week due to shorter meeting duration.
5	**Quality Framework (Luke Fieldes, Allison Bennett)** *Papers 10 & 10a considered: Proposed Quality Framework for COVID-19 and powerpoint* Alison Bennett updated on work to develop the Quality Framework (previously the Success Framework) • The Quality Framework aims to establish expectations about services delivered under the CVIP, and how these are experienced by New Zealanders. • Also allows us to assess the overall success of CVIP implementation. • Do not want to set targets – but want to be able to portray implementation in a successful light. • Six key dimensions are proposed: effectiveness, equity, efficiency, experience, honouring Te Tiriti, sustainability/legacy impact. • The current draft incorporates stakeholder consultation. Rich feedback has been received from the IIAG. Group discussion

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	• Dr Bloomfield commended the work on the framework. His main suggestion was to suggest that 'safety' be made explicit, noting that communications about the programme have always been reinforced it as being 'safe and effective'. • Mat Parr noted that efficiency is closely linked to how we manage supply and have everyone offered vaccination by year end. • Sue Gordon agreed that the detail of the framework was very good, but agreed that fewer measures would make it easier to 'tell the story'. ***Action 11: Put an outline of the framework into the forthcoming Cabinet paper on readiness for rollout.*** ***Action 12: Consider changes to the quality framework to ensure 'safety' is an explicit feature, and to consider whether/how efficiency could be combined with effectiveness.***
6	**Programme risk update (David Nalder and risk owners)** *Paper 11 considered: CVIP Programme Status and Risk Summary – 1 June 2021* • David Nalder advised that an exercise to match key risks to the Success (Quality) Framework had just been completed and he would report back to the Steering Group in a fortnight. • Dr Bloomfield noted that achieving equity objectives was a key risk. Jason Moses agreed that CVIP needed to be confident that DHBs understand their populations and how to reach them for vaccination rollout. • Jason advised that DHBs are well engaged for rollout. DHB plans have all been considered for equity, and some are very good. Some have targets but others do not. He is encouraged by planning work to date, but the proof will be in implementation. No additional risks were raised by members. ***Action 13: Bring paper to Steering Group 15 June meeting to show where controls are embedded and that risks are being appropriately managed.***
7	**Real time assurance update** (Colin MacDonald and Stephen Crombie) • Reinforced the importance of finalising the accountability framework and receiving active plans from DHBs which show the framework as the basis of their future performance. The workshop scheduled for 3 June was important in supporting this.
8	**Privacy Impact Assessments (Geoff Gwyn)** *Paper 12 considered: National Booking System – Privacy Impact Assessments (internal memo and two significant assessment documents covering Pre-event and First Phase, and Second Phase)* • Geoff Gwyn noted that the Ministry had worked with the Office of the Privacy Commissioner and the Chief Government Privacy Officer to develop the assessments of Pre-event/First Phase, and Second Phase of development and planned release of the National Booking System (NBS). • Assessment included verification against the 13 rules of the Health Information Privacy Code 2020. • For Phase 2, all but two rules were low risk (storage/security of information, and accuracy of information) were medium risk. ***Action 14: Agreed to the next steps (set out on page 5 of the paper) as per recommendation 8 of the paper.***

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9	**Any other business**
	• An outline Cabinet paper on CVIP Readiness for General Roll-out has been considered by the Minister's office and will be considered by Cabinet on 8 June. Jo Williams/Mat Parr hold the pen to finalise. • Sue Gordon noted a recent internal CVIP paper that mentioned consultation with specific organisational roles, one of which she holds. She asked that authors ensure that relevant roles with the Ministry are consulted appropriately when drafting papers on matters of relevance to them. • Dr Bloomfield acknowledged the significant amount of work that has been done to keep New Zealand free of COVID-19, in particular since the start of quarantine-free travel. ***Action 15. Ensure that relevant roles with the Ministry are consulted appropriately on matters of relevance to them.*** ***Action 17: Ensure that implementation and comms approaches are informed by analytics and behavioural insights, and that the CVIP programme rollout is informed by and aligned with wider MoH intelligence in this regard.***

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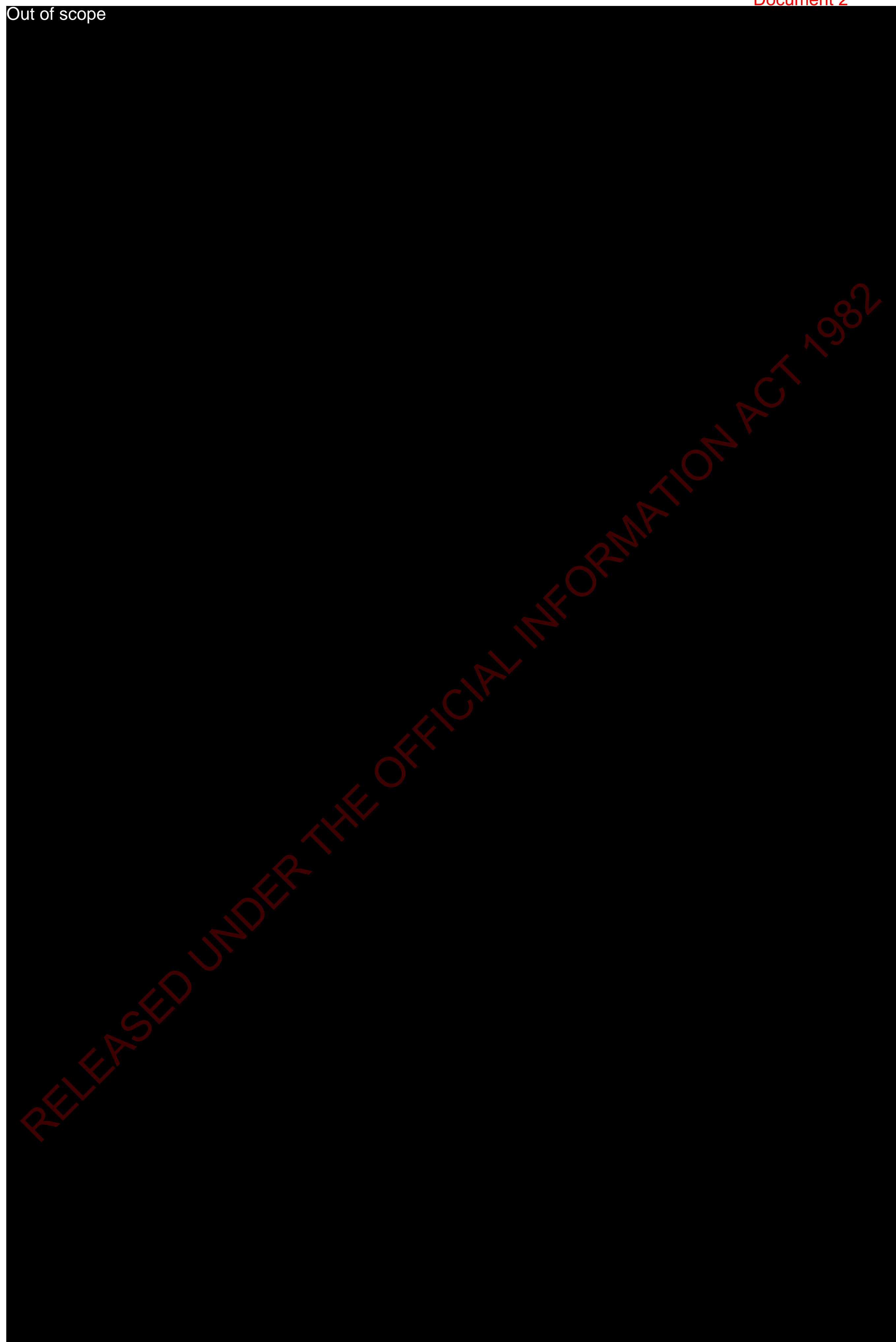

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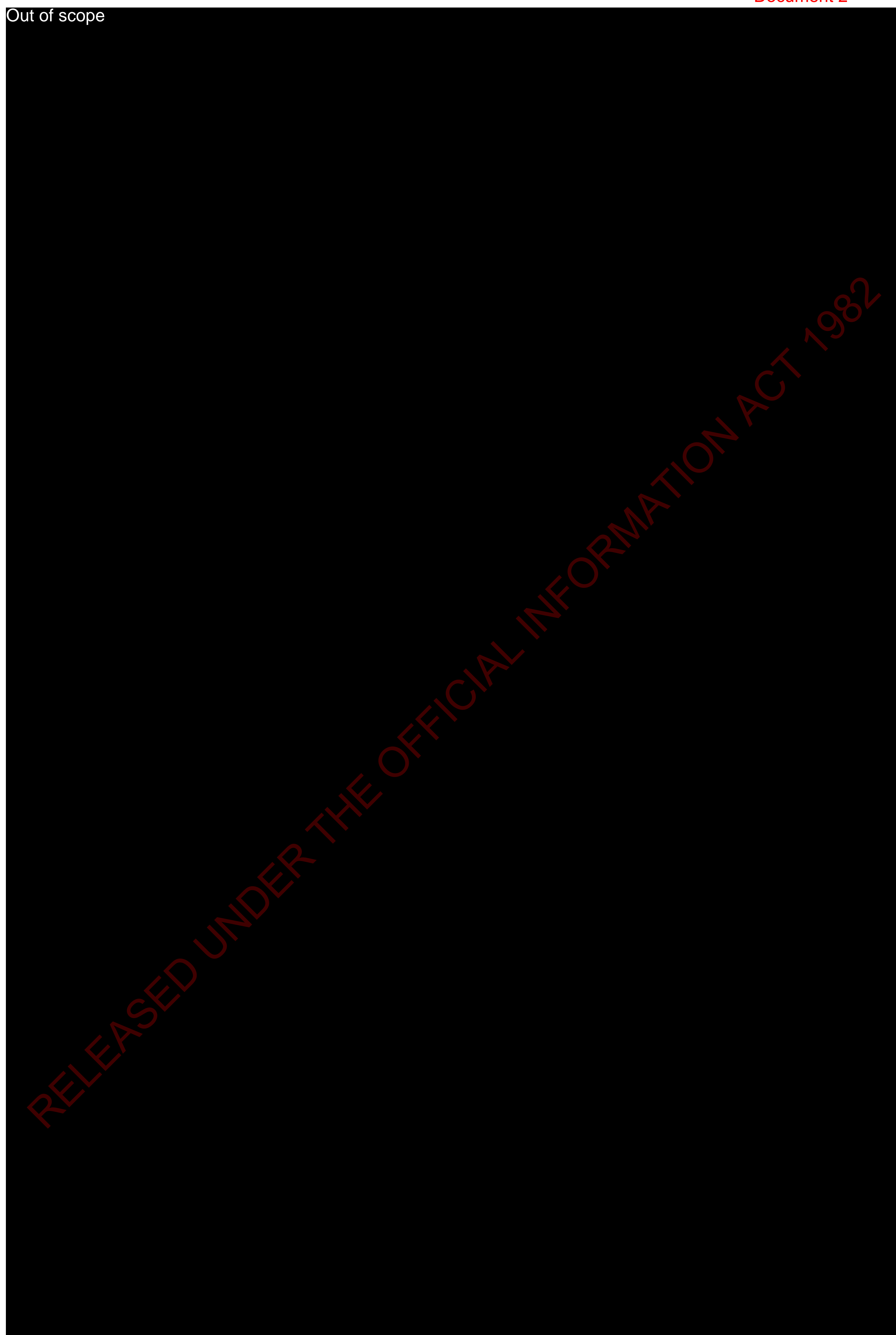

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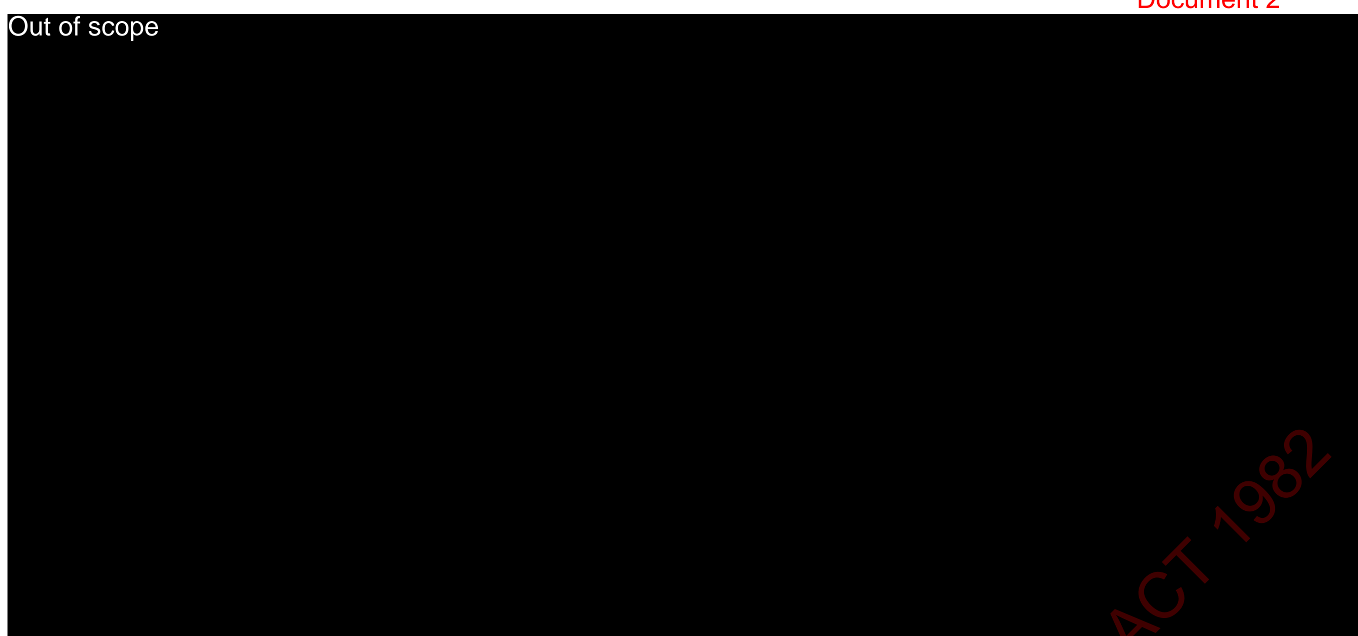

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Minutes

COVID-19 Vaccine and Immunisation Programme Steering Group

Date:	Tuesday, 8 June 2021
Time:	4.30 pm – 6:30 pm
Location:	1N.3
Chair:	Dr Ashley Bloomfield
Members Attending:	Dr Dale Bramley, Michael Dreyer, Jo Gibbs, Sue Gordon, Wendy Illingworth, Maree Roberts,
Other Attendees:	Andrew Bailey, Allison Bennett, Joe Bourne, Ian Costello, Stephen Crombie, Cam Elliott, Chris Fleming (SDHB), Dr Tim Hanlon, Astrid Koornneef, Colin MacDonald, Fiona Michel, Jason Moses, David Nalder, Andi Shirtcliffe, Dr Ian Town, John Walsh
Apologies:	Dr Caroline McElnay, Mat Parr, Cassie Pickett, Dr Juliet Rumball-Smith, John Whaanga, Deborah Woodley
Secretariat:	Carol Hinton

#	Agenda Item
1.	**Introduction and minutes** The Minutes from the previous meeting on 1 June 2021 were approved. **Matters arising** • [*From Tuesday 11 May Item 1*] Dr Tim Hanlon updated on the action to implement the anaphylaxis checklist at vaccination sites that the current plan was for the checklist to be made available in CIR on 22 June. • [*From Tuesday 11 May Item 2*] Dr Tim Hanlon updated on the action to ensure that there is a process and focal point in place for analysing adverse events of special interest (AESIs). Tim confirmed that the first data from the University of Auckland study had now been received into the Post Event Team. The first data related to thrombosis with thrombocytopenia syndrome (TTS); Bell's Palsy and other AESIs being closely monitored by the Post Event Team and Medsafe. Work is under way with the CVIP Data and Digital Team to develop Rapid Cycle Analysis to determine whether the observed and expected rates of AESIs correspond. ***Action 1: Do thorough review of Actions templates within the Steering Group Minutes.***

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2

Operational update – progress last week (Jo Gibbs)

Paper 2 considered: COVID-19 Immunisation Programme Update

- Jo Gibbs noted that the Vaccine Ministers' meeting was being used in a more structured way and now included an action tracker. A demonstration of "Book my Vaccine" was also planned for Ministers.
- Dr Ashley Bloomfield endorsed that the recent meeting with Vaccine Ministers had been very productive, with endorsement to the key communications messaging surrounding the delivery of the new Pfizer supply and Groups 3 and 4. It was noted that the actual detail of Pfizer vaccine delivery to New Zealand will not be publicised.
- Jo Gibbs indicated that currently most DHBs are flagging more capacity to vaccinate than we are allowing them to use at present.

Action 2: Circulate the Action Tracker developed to support Vaccine Ministers' meetings.
Action 3: Confirm that the Minister for COVID-19 made his media announcement confirming the supply of Pfizer in July 2021.

- ***Post-event reporting***

- Dr Tim Hanlon gave a brief update on the recent issue with a number of Serious AEFIs at s 9(2)(a). These had all been down-graded from anaphylaxis to hypersensitivity reaction. There was no batch issue identified. The Clinical Quality and Safety Team have connected with s 9(2)(a) service standards and clinical governance.

3

Standing item on science and technical advice through CV-TAG (Dr Ian Town)

- Dr Ian Town advised that, following the recent confirmation from Pfizer, the Minister was likely to make an announcement relating to use of the Pfizer vaccine by pregnant women the following day. MoH would write to CEOs before this announcement.
- There will also be an announcement this week about a new VAANZ research project into immunogenicity. MBIE is providing $2 million to support this. Māori and Pasifika will be strongly represented.
- Medsafe is expected to make its announcements about the Janssen vaccine in mid-June. Noted that a policy paper regarding use of the Janssen COVID-19 vaccine in New Zealand will be required.
- Some work is under way relating to targeted vaccination in an outbreak situation. Andrew Olds of NRHCC is engaged on this work.

- Note: *The discussion about CV-TAG consideration of the Medsafe 'Decision to Use' the Pfizer vaccine for those aged 12-15 years is recorded in section 7 of these Minutes.*

Action 4: Develop a paper on the 'who/what/when re use of the Janssen vaccine within the New Zealand/CVIP context.

4

Programme progress against milestones (Andrew Bailey/Cam Elliott)

Paper 4 considered: CVIP POAP – 4 June
Paper tabled: COVID-19 Vaccination Programme [A3 table of cost breakdowns]

- Cam Elliott tabled a paper showing original and revised forecasts re CVIP funding and the rationale for change. He advised that before the May Budget, we had signalled an additional funding requirement of $350-400 million to Ministers. This has now been refined to $360 million.
- Key changes relate to immunisation scheduling, and a big increase in activities supporting Equity. There are some savings on the purchasing side likely to be offset.

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- We are actively engaged with Treasury. Main feedback is they want absolute clarity of what is required and why.

Group discussion

- Dr Bloomfield said that $360 million is a significant amount of additional money and he will go through the figures in more detail.
- Jo Gibbs noted it was also useful to understand what are 'committed costs' irrespective of activity, and what costs are activity-dependent.
- Sue Gordon noted the need to think about COVID-19 costs and invoicing more widely, cautioning that we do not want to find ourselves in a huge 'wash up' situation with DHBs.

- **Equity (Jason Moses)**

Jason Moses advised that the current focus is ensuring enough is being done to promote and achieve equity through provider implementation plans. Planning is currently a mix of production targets and narrative.

General discussion

- Dr Bloomfield advised that he has been concerned to see the flu vaccination rates this year which show Māori at below 80%. This has real implications for COVID-19 vaccination.
- Dr Bloomfield emphasised the critical importance of all DHBs having a very strong implementation focus on equity. He asked if DHBs had actual production targets. This would help give the Ministry the level of granularity required in terms of monitoring
- Jason indicated that about 8 DHBs have production targets. Some are stronger with their equity narrative. He cited Southern DHB as a good example.
- Dr Dale Bramley supported this, noting he held similar concerns. He agreed with the idea of providing suggestions to DHB chief executives about actions and approaches they could take.
- Jo Gibbs indicated that DHBs should all be well aware of the expectations and noted that equity, workforce and data/digital were standard items for discussion with DHBs and included in their accountability framework.

- **National Booking System (Astrid Koornneef)**

Astrid Koornneef advised that the booking system was now being rolled out in some DHBs.

- The key question was whether we wanted a 'one system for all' approach, or to be able to take different approaches where required e.g. for different types of provider.
- A centralised approach offers a number of benefits including an ability to see the whole customer journey, to monitor and measure progress and success, and better ability to maintain data integrity.
- Some of the disbenefits include the fact the booking system is not integrated with the CIR (immunisation register), gaps in overall data, and the fact that 'all provider' onboarding is not aligned to the roll-out sequencing. To achieve this would require significant resource effort. Delayed start is a likely consequence.
- Astrid also noted that uptake by the primary care sector may be variable – many general practices have well-developed, well-recognised systems which they prefer to continue to use. Pharmacies appear to have more readiness to accept the booking system.

Group discussion:

There was robust discussion over the extent to which the National Booking System should or should not be mandated:

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- Jo Gibbs noted that it may be necessary to mandate the booking system for any primary care or hauora providers who do not have their own system already.
- Shayne Hunter noted that there will always be a data gap, regardless of whether there is a centralised system or not, because not everyone will book. He had spent a lot of time with primary care providers and noted that many operate multiple systems. He cautioned about the need to be clear that we understand these before we mandate additional systems.
- Stephen Crombie and Colin MacDonald endorsed this, saying that there was a risk of adding uncertainty and variability into primary care.
- Jo Gibbs agreed that the 'mandating' may be about the need to provide certain information, rather than the mechanism through which it is provided.
- In response to a question from Dr Bloomfield, Astrid confirmed that a provider not using the booking system will not appear as a 'provider option' for people who choose to book through the system. Michael Dreyer noted that in the UK, providers who wanted to access the 'pool' of people wanting to be vaccinated therefore used the centralised booking system.
- Michael Dreyer also noted that at this point the booking system is not yet proven. He felt mandating would be premature. Sue Gordon agreed that there would need to be a delay in roll-out if the booking system was to be mandated.
- Dr Dale Bramley noted that we need visibility of what is going on, and where and asked if standardised tracking and reporting would consolidate those views?
- It was agreed that the fundamental information needed for success of the programme is whether someone has been vaccinated, and who they were.
- Maree Roberts noted her understanding that ministerial interest was in assuring that as many New Zealanders as possible received their vaccinations.

- **National Call Centre (Astrid Koornneef)**

Astrid Koornneef updated that she has met a group of the large government agencies (including MBIE, IRD, MSD, Internal Affairs, ACC) to discuss their ability to provide surge capacity for messaging for Group 3.

- CVIP needs to be cleared about what we expect 'surge' to look like and she will be getting back in touch with those she met to clarify this and offer assistance to remove any barriers.
- Initial indications are that the ability of these agencies to scale up is limited, and only MBIE and ACC said they may have some capacity. However they do not have weekend capacity and have month-ed commitments.
- We have asked DHBs to further scale up their call centres as they are likely to need some level of surge capacity to handle bookings.

- **SRO Workshop (Fiona Michel)**

Fiona Michael advised that the workshop of Senior Responsible Officers was held on the previous Thursday with all DHBs except Tairāwhiti (fog cancelled flight) in personal attendance. It as a constructive workshop. Key issues covered:

- Attendees acknowledged the need for dependability and confidence in the process as the vaccination programme rolls out.
- Discussion on how DHBs can better align delivery processes, including for scale-up.
- Looked at 'pain points' and 'what works well'. Attendees were happy to share experiences and learnings.
- A good discussion on 'human factors' surfaced differences between what is important to government, vs Chairs, vs CEOs, vs the consumer.
- Considerable discussion that 'alignment' does not mean 'consistency'. For example it was agreed there will be valid reasons why large, medium, and small DHBs may all

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have different approaches to the same broad issue depending on the size of their DHB.

- **Comms and Engagement (John Walsh)**

Papers 5, 5a and 5b considered: Comms and Engagement support for COVID-19 vaccine rollout

John Walsh advised of the several big announcements for the week:

- Confirmation that New Zealand will receive 1 million doses of the Pfizer COVID-19 vaccine during July 2021;
- Confirmation of high level information of Group 4 roll-out;
- Decisions relating to the ability of 12-15 year olds to receive the Pfizer vaccine;
- A decision from Medsafe re use of the Janssen vaccine in New Zealand;
- Announcement of dates for the mass vaccination clinic.

John also advised that:

- Campaign planning for Group 4 will be completed by 11 June.
- Some in Group 3, who had expectations that they would have had their vaccination date/s confirmed by now, have become a little unsettled and this is evident in some media coverage. John noted that members of the disability community were amongst those keen to see action.

Group discussion:

- Dr Bloomfield noted that the more information we can provide to the public about 'when and how' the better.

- **Workforce (Fiona Michel)**

Fiona updated on workforce statistics:

- About 7,000 trained vaccinators as at 8 June.
- Percentage of Māori vaccinators is still at 9.18% - a slight drop over the previous fortnight.

Paper 6: Employment Relations and the COVID-19 Vaccinators

- Commencement of the new role of COVID-19 Vaccinator was recently gazetted.
- Rates of pay and terms and conditions of employment have been agreed with the PSA and APEX. NZNO continues to oppose the role.

Group discussion

- Dr Dale Bramley noted his broad support for the COVID-19 role and proposals, seeing the legacy opportunities from creation of this role.
- Fiona clarified that DHBs (rather than MoH) would employ many of those in the new role and the recommended pay rates related to DHB employment terms and conditions.
- Commissioned providers may choose to employ COVID-19 vaccinators directly via a collective or individual employment agreement. DHBs should fund these roles in line with the DHB recommended pay rates.

Decisions:

Agreed that COVID-19 Vaccinators will be employed via DHBs rather than the Ministry of Health;
Noted that some commissioned providers may choose to employ COVID-19 Vaccinators directly;
Agreed that the existing PSA and APEX collective agreements with DHBs can be used to provide coverage for the role of COVID-19 Vaccinator;

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	Agreed that COVID-19 Vaccinators employed directly by DHBs will be paid $22.68/hour ($47,305 p.a.) • **Logistics (Ian Costello)** *Paper 7 considered: Distribution Network Update* Ian Costello outlined progress made to ensure vaccine distribution meets the needs of Group 3 rollout including: • s 6(a) ; • Ensuring contingency planning is in place to support unexpected demand or supply interruptions. Group discussion • s 6(a) s 6(a) • **Post Event (Dr Tim Hanlon)** Dr Tim Hanlon advised that • The COVID-19 CARM AEFI Repository Auto-triage work went live but has had to be pulled from the production environment due to incomplete and inconsistent de-duplication of reports. An IT fix is scheduled to be done on 20 June. Auto-triage is the last element of the scale up work for CARM processes. • The Post-Event Team is supporting the pharmacovigilance arrangements for the Realm Countries with some operational work to triage AEFI reports and refer to CARM for medical assessment as required. • There has been a sudden death a few days post vaccination in the s 6(a). Initial information suggests a significant condition not related to vaccination. s 9(2)(a) The Ministry is providing support to the s 6(a) counterparts. • GM Data and Digital (Michael Dreyer) has agreed an Integrated plan for Post Market Monitoring for Covid-19 Vaccines (Active Monitoring and new Pharmacovigilance System) with GM Medsafe (Business Owner for the new systems) and GM Post Event. This work is progressing to plan.
	• **Programme risk update (David Nalder)** No update this week to allow focus on agenda item 8 – CVIP Programme Assurance Framework. David Nalder advised that risks continued to be monitored and discussed at PLG meetings on a weekly basis.
5	**Success Framework update (Allison Bennett)** *Paper 8 considered: COVID-19 Immunisation Programme – Success Framework* Allison Bennett advised that: • Ministers are engaged with this framework and have provided feedback.

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	• Following feedback from Dr Bloomfield, 'Safety' had now been included as a headline measure. The four headline indicators (efficiency, equity, safety, experience) are all considered to have direct alignment with the success dimension. Group discussion • Dr Bloomfield noted he was happy with how the framework was progressing. • Jo Gibbs suggested further consideration be given to having 'not completed vaccine course within six weeks' as a safety measure. She noted that due to supply constraints, some people are being delayed longer than this. • Dr Dale Bramley suggested consideration by given to adding 'equity' to the box on page 2. ***Action 8: Allison Bennett and Jo Gibbs will further consider the 'six weeks' safety measure offline, and consider how equity can be added as suggested.***

6	**Review of non-residents' eligibility (Wendy Illingworth)**
	Paper 9 considered: Review of non-residents' eligibility for COVID-19 vaccines – 4 June 2021
	• Wendy Illingworth, deputising for Cassie Pickett, advised that under the COVID-19 Eligibility Direction 2021, everyone in NZ is eligible to receive the COVID-19 vaccine regardless of their immigration status. The Direction followed Cabinet decisions about Quarantine Free Travel.
	• Vaccine eligibility settings have been reviewed following changes to border settings. However border settings are likely to continue to change. Therefore rather than change the eligibility direction, operational tools should be used to encourage visitors to NZ to be vaccinated in their own country. Wider QFT decisions would continue to be monitored.
	Group discussion
	• The meeting agreed that the population cohort most likely to seek a COVID-19 vaccination in NZ is people who are in Australia legitimately, who are not Australian citizens, and who decide to go to NZ to be vaccinated.
	• Dr Bloomfield made a number of points:
	  o there were difficulties in achieving a balance if offering to vaccinate overseas nationals on holiday here, when many NZers are still waiting for their first vaccination;
	  o non-residents may be offered vaccination in NZ in certain circumstances e.g. if there is an outbreak while they are here;
	  o We also need to consider people here for special immigration purposes; and New Zealanders posted overseas who are back in NZ for a few weeks.
	• Dr Bloomfield requested that the paper be adjusted to provide more specificity around the latter part of the paper.
	Action 9: Amend paper to strengthen the proposed actions/advice about the parameters for receiving a COVID-19 vaccination in New Zealand, and on ways to encourage visitors to New Zealand to be vaccinated in their own country.

7	**Decision to use Pfizer vaccine for 12-15 year olds (Allison Bennett)** *Paper 10 considered: Decision to Use Comirnaty (Pfizer/BioNTech) COVID-19 Vaccine for children who are aged 12-15 years* Allison Bennett advised: • At the time of the Cabinet decision to use the Pfizer vaccine for roll-out in New Zealand, clinical trials had not included those aged under 16 years. Pfizer has now applied to allow the vaccine to be used in NZ by those aged 12-15 years. • Medsafe is working with Crown Law Office re use of the vaccine by those aged 12-15 years.

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	• The paper sought Steering Group decision re how to incorporate this age group into roll-out for groups 1 to 3. Group discussion • There was considerable discussion on this issue. If made now, a decision could be included in the "Readiness for Roll-out" paper to be considered by Cabinet on 14 June. • However, MoH would generally take a decision after Medsafe has issued its 'Decision to Use' and the CV-TAG has considered the matter and provided its technical advice to MoH. • Dr Ian Town advised that CV-TAG was awaiting Medsafe consideration/conditions with interest. One potential safety issue emerging is risk of myocarditis for younger people. However he said the 'concerns' re Pfizer were not so much systemic safety issues as they were that trials have only been held on small numbers. So there was a balance to be considered. • Dr Bloomfield noted that ultimately Cabinet would need to make the decision regarding extension of use for the purposes of roll-out. He asked for some changes to be made to the paper but also recognised the desirability of prompt decision-making. ***Action 10: At Friday's meeting ask Vaccine Ministers to give a 'power to act' to some Ministers so that decisions re use of the Pfizer vaccine in roll-out can be progressed promptly following Medsafe and CV-TAG consideration. [Andrew Bailey/Jenny Stevens]*** ***Action 11: Amend the Cabinet paper on readiness for roll-out to note that Cabinet will be asked for a decision once Medsafe has made its decision and advice has been received from CV-TAG. [Mat Parr/ Jo WIlliams]*** ***Action 12: Consider whether the policy advice should be amended to 'extend the age range for provisional approval of the vaccine. [Allison Bennett]***
8	**Proposed assurance framework** (David Nalder) *Paper 11 considered: CVIP Assurance Framework – 4 June 2021* • David stated that successful rollout of vaccinations relied on effective design, alignment of activity, and adequate controls. • This paper aimed to describe how the programme will define its future assurance needs to ensure that what is expected is done, and that critical controls relied on to managed risk are in place and are working as expected. This includes both within the Ministry and DHBs. There is a strong focus on using BAU processes wherever practicable. • Letters of Readiness will need to be agreed with DHBs to give the Ministry confidence of their final approach to rollout. ***(Proposed assurance framework – Cont.)*** Group discussion • Dr Bloomfield commended David on this work, saying the programme overall now had a high degree of confidence from Vaccine Ministers. He commended the table on page 6, which showed the 'fit' of wider programme management and accountability documents with the proposed approach. • The external assurers, Colin MacDonald and Stephen Crombie, endorsed that the document was 'comprehensive but achievable'. They supported its shift from dependency on external assurers to self-management. • A caution was noted to ensure the adequacy of DHB resourcing in supporting delivery under the framework.

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	• Sue Gordon also suggested that consideration be given to expanding the 'three lines of defence' model within the framework. ***Action 13: Ensure that the Assurance Framework is a scheduled time for robust discussion at the next Steering Group meeting (15 June).***
9	**Any other business** Nil.

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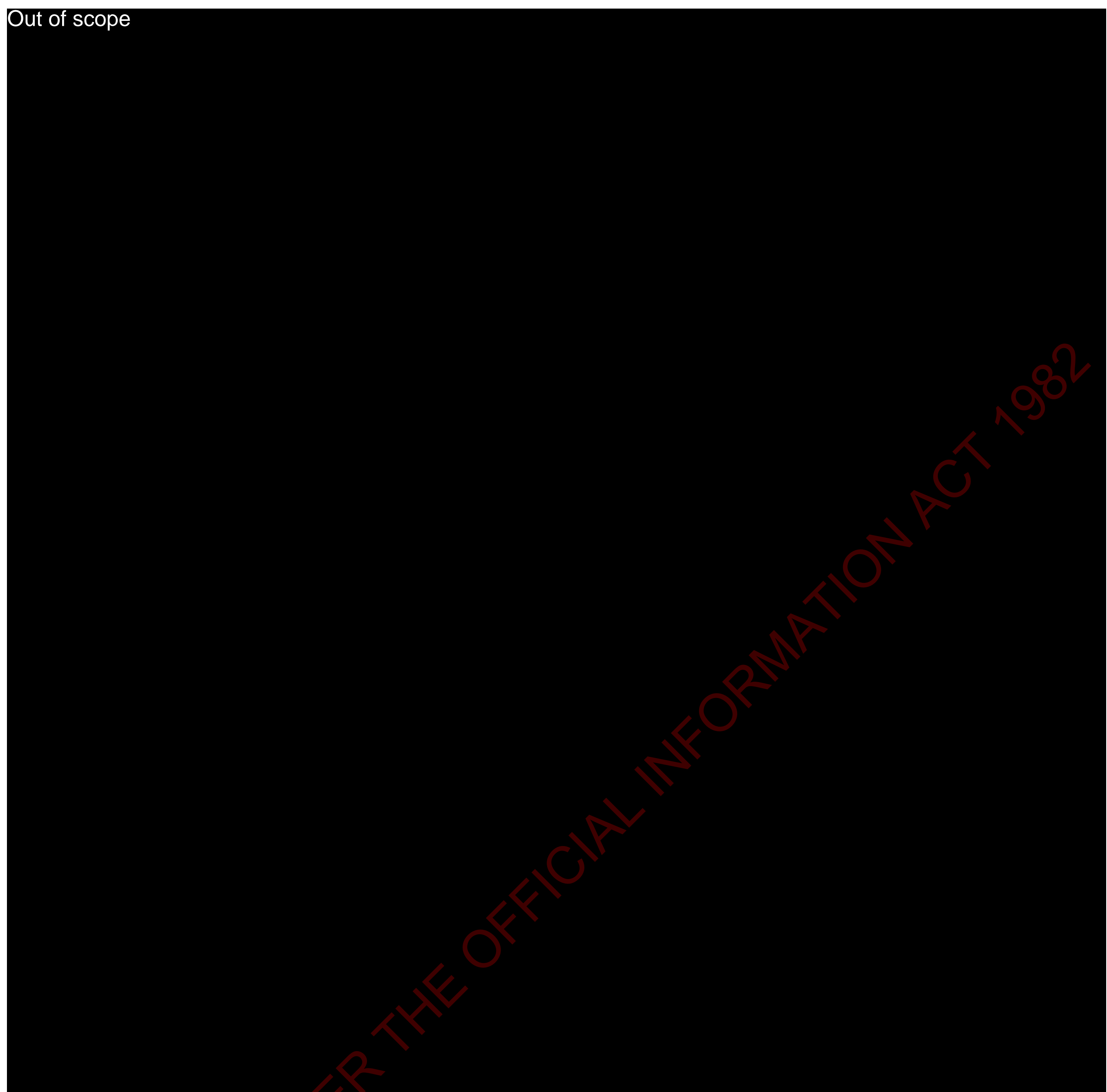

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