26 August 2024

Health New Zealand
Te Whatu Ora

Doris Burke
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Tēnā koe Doris

Your request for official information, reference: HNZ00052732

Thank you for your email to Health New Zealand | Te Whatu Ora of 10 June 2024, extended 8 July 2024, asking for the following under the Official Information Act 1982 (the Act):

> *The Covid-19 Vaccine and Immunisation Programme Steering Group of Tuesday, 10 August 2021, chaired by Dr Ashley Bloomfield – Agenda item 10b, update given by Rachel Mackay, which states ….... "The two pilot employers (Mainfreight, Fonterra) will both have completed their first round by 11 August. The Ministry will debrief with both on the learnings from these pilots." Rachel Mackay still works for Te Whatu Ora. Would you kindly provide the information please which is referenced in these minutes https://aus01.safelinks.protection.outlook.com/?url=https%3A%2F%2Ffyi.org.nz%2Frequest%2F15656-covid-19-vaccination-advisory-and-governance-group-meeting-minutes%23incoming-73774&data=05%7C02%7CHNZOIA%40tewhatuora.govt.nz%7C421a0b662753416f8d5f08dc89032623%7Cbed4da513cdb4d0dbaf8fb80d53268e3%7C0%7C0%7C638535893820012302%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C0%7C%7C%7C&sdata=XQ7e7XF60Li6%2BlPRPIGj3XE%2BORq3BtikYwFq2gDN3U8%3D&reserved=0?*

On 6 August 2024, we communicated our decision on your request.

We sincerely apologise for the delay in responding to you.

Response

Our earlier correspondence (ref: HNZ00046611) described how the pilot programme in question was managed by the Ministry of Health prior to the existence of Health NZ. While Health NZ now 'owns' your request on the basis that this subject area is now more closely connected to our functions, because the pilot programme was overseen by the Ministry at that time (in 2021), we still do not hold any information within scope.

However, we have consulted our Ministry colleagues, who have searched their records again and we are pleased to advise some documentation has been found in scope of your request.

We are releasing this information to you in full. These documents are outlined in the table below and enclosed as **Annex One**:

	Title
Doc 1	*COVID-19 messages for Business NZ meeting - 9 July 2021*
Doc 2	*BioNTech/Pfizer COVID-19 Vaccine and Immunisation Programme - Planning blueprint: Workplace sites*
Doc 3	*Public Service Workplace Vaccinations Workshop*
Doc 4	*Pfizer Covid-19 Vaccination and Immunisation Programme - Workplace model lessons learnt*

Please note, the Ministry also undertook a wider IT search of their systems to locate anything else that may be in scope. Their search used keyword(s) including but not limited to “COVID-19 vaccination workplace programme” and “COVID-19 workplace vaccination” and involved key Ministry staff between the dates of 1 July 2021 and 30 September 2021. This search identified over 7,500 results.

While we have been advised many of these items are emails (and possibly only administrative in nature), some of these results may contain documentation also within scope of your request. However, filtering through this number of results need require the Ministry to divert personnel from their core duties and allocate extra time to complete this task. This diversion of these resources would impair their ability to carry out their other core functions

For this reason, Health NZ (on behalf of the Ministry) is refusing any additional documentation that may be in scope of your request under section 18(f) of the Act, as it involves substantial collation and research.

We have considered whether fixing a charge for the supply of the information or extending the timeframe for response would enable us to respond, but we do not consider that either option would remove the impact that supplying the information would have on the Ministry’s other operations. We also hope that the information provided with this response goes at least some way towards meeting your expectations as well as our obligations under the Act.

How to get in touch

If you have any questions, you can contact us at hnzOIA@tewhatuora.govt.nz.

As you know, you still have the right to make a complaint to the Ombudsman if you are not happy with this latest response. Information about how to do this is available at www.ombudsman.parliament.nz or by phoning 0800 802 602.

As this information may be of interest to other members of the public, Health NZ may proactively release a copy of this response on our website. All requester data, including your name and contact details, will be removed prior to release.

Nāku iti noa, nā

Danielle Coe
Manager (OIA) Government Services
Health New Zealand | Te Whatu Ora

COVID-19 messages for Business NZ meeting - 9 July 2021

Current stats

- The Ministry is leading the rollout of the Pfizer vaccine to ensure all people in Aotearoa New Zealand are vaccinated against COVID-19.
- The cumulative number of doses administered by the end of Thursday was 1.3M doses including over 500k people that have been fully vaccinated.
- Whakarongorau services (Healthline) supporting the vaccine rollout. This week for example they've responded to nearly 10,000 calls and make outbound calls as well.
- All DHBs have been migrated to the National Immunisation Booking System (NIBS), which nearly half a million active future bookings at over 100 vaccination sites.
- Average time between first and second dose – 24.80 days. Minimum is 21 days.

Operations

- Implementation largely devolved to DHBs and commissioned third parties e.g. PHOs. Work with DHBs on production plans which are published on MoH website.
- Group 4 – general population can be invited from late July. Approx 2 million people.
- To achieve this goal, a large workforce is required to administer the vaccines along with a range of site options that are convenient to all population groups. Workplace vaccinations is one of these site options.
- Three phases of workplace vaccinations:
    - Have been supporting workplace vaccinations for populations in Groups 1 and 2 of the Sequencing Framework (eg MIQ, border works – NZDF, Police; frontline – FENZ; Corrections – staff and people in Corrections care)
    - 'test sites' - Fonterra, Mainfreight and a couple of other organisations coming in behind these two – applying lessons learned.
    - EOI process to identify interested/ eligible parties – issue today, responses due late July, implement Sept-Nov. Trying to indicate alignment with age banding.

EOI cvipworkplaces@health.govt.nz

- The Ministry is seeking expressions of interest (EOI) from employers/workplaces and potential vaccination providers to identify the eligible demand for this site option. This EOI process does not guarantee that individual employers/workplaces or vaccination providers will be able to participate in the programme

- Seeking joint EOIs from employers and vaccination providers. Where employers or providers are interested but have not been able to submit a joint application, the Ministry will consider these individual expressions of interest in the second instance.

- The COVID-19 vaccination programme requires the parties to use the online National Immunisation Booking System (NIBS) and online COVID-19 Immunisation Register (CIR) during the vaccination event, requiring workplaces to have excellent IT connectivity.
- Workplaces must either
    - be considered one of the largest workplaces/employers (by size of workforce) and have enough workers per site to be vaccinated. As a guide, an indication is workplaces with 1,000+ employees, with the ability to vaccinate several hundred staff per site, or
    - for smaller workplaces/employers – support a DHBs' equity goals of targeting workplaces with high Māori, Pacific or ethnic populations and those harder to reach (e.g. due to rurality or shift work). Note even for smaller workplaces/employers – there is a minimum requirement of 70 vaccinations per site per day

and

- have had a successful vaccine programme previously delivered onsite
- be able to provide staff to undertake specified roles and responsibilities as outlined in the Workplace Model Planning Blueprint – particularly the logistical tasks to support worker engagement, recall processes, and cultural and religious safety.
- Eligibility criteria Workplace Model Planning Blueprint CVIP Operating Guidelines

Timetable

Date	Milestone
9 July 2021	EOI issued
12pm on 21 July 2021	Closing date for respondent queries or clarifications
12pm on 23 July 2021	Closing date for EOI

How companies can support staff

While we encourage workplaces to express interest in this programme, they should also consider other ways they could support workers getting a vaccine, such as allowing workers to be vaccinated during work hours and sharing accurate and reliable information from trusted sources – Health.govt.nz and Covid19.govt.nz.

Workforce

- 8,908 vaccinators have completed vaccine training and 3,787 vaccinators have been active in the programme.
- Workforce to scale up – actively training vaccinator workforce plus bring on board existing medical professionals who undertake vaccinations – GPs, pharmacists, occupational health.
- Reminder that most organisations have no legal authority to mandate vaccination in their workers unless it is included in their signed terms and conditions, but a strong communication programme is encouraged, with reminders to rely on recognised sources.

Supply

- New Zealand is already receiving significant deliveries of the Pfizer vaccine and has secured enough doses of the Pfizer vaccine for the population of New Zealand and our Pacific neighbours, in 2021. 10 million doses.
- Pfizer is meeting delivery commitments.
- Weekly deliveries arrive in Akld from Belgium. Normally lands early Tues morning.
- Going to deliver 4 million doses in July – Sept quarter. 1 million doses on schedule to be delivered in July. 150k this week (arrived ahead of schedule on last week, similar next week, followed by 350k doses in each of the last two weeks of the month)
- Distributed all stock and need to rebuild stock on hand at wholesalers in Akld.

Logistics

- Vaccine arrives in vials – approx. 6 doses per vial, and in boxes of 195 vials – so ~1000 doses.
- Shipped at -70. Once out of -70 can't be stored back in freezers.
- Can be stored at normal cold chain (2-8) for 31 days. Was 5 days – which was very tricky.
- Can split packs into 15's (90 doses) or 5's (30 doses).
- Daily orders received through log team, HCL calculate how many trays to remove and allocate – occasionally need to send slightly more/less depending on how we split the trays.
- Distributed by air and road courier with security, GPS trackers and temperature loggers. Road freight upper North Island; airfreight at night to South Island and then return via Palmerston North for lower North Island. All sites have stock by late morning including remote sites.

- Mixed model for local distribution – some use DHB hospital pharmacy, others use direct distribution to facilities (where vaccine is stored) and out to sites (where it is administered)

Johnson & Johnson / Jannsen vaccine

- Announcement earlier this week that Medsafe (regulatory authority) granted provisional approval of the Janssen COVID-19 vaccine for individuals 18 years of age and older. The medical evidence shows Janssen is a very safe and effective vaccine.
- NZ secured 2 million doses of the Janssen vaccine through an advance purchase agreement last year. We purchased a portfolio of vaccine options to provide us with flexibility, great to have approval now confirmed.
- The Janssen COVID-19 vaccine has also received emergency or provisional approval in Canada, USA and Australia.
- Plan remains to ramp up the roll-out using the Pfizer vaccine from here, having the option of the Janssen vaccine increases our choices and provides us with flexibility if we need it. As a single dose vaccine, it may be useful in hard to reach locations or emergencies, or for those who cannot get the Pfizer vaccine.
- Provisional approval is the first step in the process. Cabinet will weigh up the options on the best use of the Janssen vaccine following advice from officials. A Cabinet 'decision to use' can be expected sometime in August.
- It's good to have a range of options to access safe and effective vaccines to meet the need of New Zealanders now and in the future.

Clinical

- Medsafe follows a rigorous assessment process informed by the most up to date medical and scientific data. Approval has been very carefully considered with safety the key priority.
- Programme includes a clinical quality and safety team incl external expertise.
- Programme includes post event monitoring team; works with Centre for Adverse Event Monitoring (CARM)
- Pfizer vaccine We have secured 10 million doses – enough for 5 million people to get the 2 doses they need to be protected. It works by teaching your immune system to recognise and fight off the virus. Second dose of the vaccine **at least 21 days** (3 weeks) after your first dose.
- The Pfizer vaccine:
  - is a messenger RNA (mRNA) vaccine
  - does not contain any live virus, or dead or deactivated virus
  - can't give you COVID-19
  - can't affect your DNA
  - does not contain any animal products.

How effective is the COVID-19 vaccine, and what does 95% mean?

As with any vaccine, the Pfizer vaccine (Comirnaty) may not fully protect everyone who gets it. However, it is highly effective if people have both doses. That means, if you do catch COVID-19, you're far less likely to fall seriously ill and less likely to transmit the virus to others. Studies have shown that about 95% of people who receive both doses were protected against getting seriously ill.

The COVID-19 vaccine stimulates your body's immune system to produce antibodies and other proteins that will fight the virus if you're exposed to it. This reduces the risk of getting infected and if you do get COVID-19, it means you could have no symptoms or will have much fewer, milder symptoms and recover faster.

While the data is clear that vaccines protect people from the effects of COVID-19, research is ongoing to determine whether a vaccinated person could still transmit the virus to someone else – so to be safe, we must assume there is still a risk of transmission.

The difference between efficacy and effectiveness

Efficacy is the measure used in clinical trials. Efficacy measures how well a vaccine can prevent symptomatic infection (and sometimes transmission) in clinical trials. This is under ideal and controlled conditions, comparing people who receive the vaccine with those who receive a saline placebo.

Effectiveness is the measure used in the real-world. It is how well the vaccine performs in the real world outside of the clinical trials in a mixed population. We would expect a vaccine with a high efficacy to be highly effective in the real-world, but these measures are unlikely to be the same.
The efficacy of the Pfizer vaccine (Comirnaty) was measured in two ways.
Phase 1 clinical trial – level of antibodies. The immune response to the vaccine was measured by looking at the level of antibodies in the bloodstream and how well they worked to neutralise the COVID-19 virus in laboratory tests.

Phase two and three clinical trials – vaccine and placebo. The efficacy of the Pfizer vaccine was tested in about 44,000 participants aged 16 years and over where COVID-19 was already circulating in communities. About half of these participants were randomised to receive the vaccine and the other half received a saline placebo. The trial looked at how many people got COVID-19 symptoms after they were vaccinated compared to how many got COVID-19 after getting the placebo. Participants had two doses of the vaccine or placebo, getting their second dose within 19 to 42 days after their first dose. They were then closely monitored and evaluated for at least 2 months after their second dose.

A consistently high efficacy of over 92% was observed in the clinical trials across age, sex, race, ethnicity and people with underlying medical conditions. This means after getting the Pfizer vaccine, more than 9 out of 10 people are protected against COVID-19 regardless of their age, health status or ethnic group.

Long-term efficacy - to understand the long-term efficacy and safety of the vaccine, participants in the clinical trials are being tracked for another two years after their second dose of the Pfizer vaccine.

Getting your second dose increases protection. For the best protection, impt to get second dose at least 3 weeks after first dose. Clinical trials showed the Pfizer vaccine (Comirnaty) had a higher efficacy against symptomatic COVID-19 infection after receiving the second dose. This is supported by recent real-world data.

The first dose ‘primes’ your immune system but protection doesn’t last as long because the level of antibodies falls. A second dose gives your immune response a boost – with lots more antibodies to help your immune response to mature and provide longer protection.
In the COVID-19 vaccine clinical trials, people were followed very closely for side (adverse) effects for 2 months after the second dose of the vaccine. They compared the results between people who had and hadn’t been vaccinated. To understand the vaccine's long-term effectiveness, safety, and side effects, participants in the clinical trials are tracked for another two years. This is from their second

dose of the Pfizer vaccine. Participants will have their health monitored and attend regular follow-up visits. This clinical trial data is closely monitored by Pfizer/BioNTech and an independent group of experts called the Data Monitoring Committee.

Side effects -like all medicines, the vaccine may cause side effects in some people. Most side effects are mild and don't last long — they're more common after the second dose. They won't stop you from having the second dose or going about your daily life. Some side effects may temporarily affect your ability to drive or use machinery. In the clinical trials, common side effects were reported in every 1 in 10 to 1 in 100 people. These include:

- pain or swelling at the injection site
- feeling tired or fatigued
- headache
- muscle aches
- chills
- joint pain
- fever
- redness at the injection site
- nausea

Uncommon side effects - In the clinical trials, uncommon side effects were reported in every 1 in 100 to 1 in 1,000 people. These include:

- enlarged lymph nodes
- feeling unwell
- pain in limb
- insomnia
- itching at injection site

Rare side effects - In the clinical trials, temporary one-sided facial drooping was reported in every 1 in 1,000 to 1 in 10,000 people.

Allergic reactions - Serious allergic reactions do happen but are extremely rare. They usually show soon after you've had your vaccine, which is why you need to wait at least 20 minutes.

International travel
Vaccine passports – working with other jurisdictions on this. Requires consistent global effort

EVA – early vaccine access process for certain criteria If you need to travel overseas from New Zealand, you can apply for an early COVID-19 vaccine on compassionate grounds or for reasons of national significance. You can now apply for early access to the vaccine if you must travel overseas from New Zealand on or before 31 August 2021. You'll need to apply at least four weeks before you travel. Application process for early access to the vaccine is different depending on your reason for overseas travel.

compassionate grounds

- access critical medical care that is not available in New Zealand for yourself or your dependant
- visit an immediate family member who is dying
- provide critical care and protection for a dependant eg, your child.

reasons of national significance

- to protect the safety and security of New Zealand's right to govern itself
- for Government-approved humanitarian efforts as part of New Zealand's commitments to foreign aid, international disaster responses, or supporting Pacific and Realm countries' recovery from the COVID-19 pandemic
- to participate in major international events where travel is necessary to represent New Zealand
- for nationally significant trade negotiations.

Agency sponsors will apply on your behalf. The agency sponsor responsible for the international event must apply on behalf of those travelling for reasons of national significance. We can't accept applications from individuals. Agencies will contact individuals that are part of a group they're making applications for.

Overseas travel that won't be considered

- to a country New Zealand has approved for quarantine free travel, e.g. Australia and the Cook Islands
- for private, recreational or commercial travel
- to reunite with family
- to attend a funeral or memorial service
- to attend a school or university.

Legacy
Very likely to require booster vaccination programme, turning our minds to that
Legacy systems – new workforce; CIR, booking system, new ways of working e.g. workplace vaccinations contracted with MoH or DHBs.

All information:

https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-vaccines/

https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-vaccines/covid-19-vaccine-strategy-planning-insights/covid-19-supporting-vaccine-rollout#workplace

BioNTech/Pfizer COVID-19 Vaccine and Immunisation Programme

Planning blueprint: Workplace sites

Version 9, Issue 2

09 July 2021

MINISTRY OF HEALTH
MANATŪ HAUORA

Contents

1. Purpose

This document provides guidance to commissioning agencies (the Ministry of Health and District Health Boards), vaccination providers and workplaces/employers in their planning for vaccine delivery to Group 4 in workplaces. It is designed to help workplaces/employers and vaccination providers decide if they can participate in this programme, and if so what planning considerations do they need to consider before rolling out on-site vaccination.

2. Service model

The COVID-19 Vaccine and Immunisation Programme (CVIP) has the following success goals to achieve balanced decision making:

- Honours and upholds Te Tiriti o Waitangi principles.
- Quality and safety – vaccines and immunisation processes are clinically and culturally safe, backed by a strong evidence base, appropriate kaupapa and capability.
- Experience – renewed/increased trust and confidence in the health sector and immunisation, underpinned by positive experiences at system, programme and whānau/individual levels.
- Equity – Māori, Pacific and people with disabilities achieve equitable immunisation outcomes. Everyone in New Zealand and the Pacific has equal opportunity to access the vaccine.
- Access – New Zealand's and Pacific's immunisation needs are met at the right time and place with minimal waste.

Offering different service models is one way the programme can work towards these success goals. The four service delivery models for the CVIP are:

- community sites (in existing healthcare facilities e.g. general practice, community pharmacy, Hauora practices, urgent care)
- hospital sites
- temporary sites (e.g. workplace, marae, church)
- fixed sites (e.g. community hubs).

Workplaces are 'temporary sites' designed to enable employers and vaccination providers to leverage their experience and resources to vaccinate workers at a time and place convenient to them. This model is considered important to drive uptake, by making access convenient and easy (such as in rural communities) and supports equity of access for Māori and Pasifika populations.

It is considered an effective model, as demonstrated by the annual influenza campaign and the rollout of the Pfizer vaccine by occupational health vaccination providers to workplaces in Groups 1 and 2.

The Ministry of Business, Innovation and Employment has published guidance for employers on supporting the vaccination campaign at https://www.employment.govt.nz/leave-and-holidays/other-types-of-leave/coronavirus-workplace/covid-19-vaccination-and-employment/

The Public Service Commission has issued guidance for public sector agencies, which includes the line "Vaccines should be administered in the workplace where possible".

https://www.publicservice.govt.nz/resources/covid-19-workforce-vaccinations-guidance/

This model is for delivery as part of the Group 4 rollout that will start from late July 2021.

2.1 Eligibility criteria for workplaces/employers

Workplaces must:

Either;

- be considered one of the largest workplaces/employers (by size of workforce) and have enough workers per site to be vaccinated. As a guide, an indication is workplaces with 1,000+ employees, with the ability to vaccinate several hundred staff per site, or
- for smaller workplaces/employers – support a DHBs' equity goals of targeting workplaces with high Māori, Pacific or ethnic populations and those harder to reach (e.g. due to rurality or shift work). Note even for smaller workplaces/employers – there is a minimum requirement of 70 vaccinations per site per day

And;

- have had a successful vaccine programme previously delivered onsite
- be able to provide staff to undertake specified roles and responsibilities as outlined in the Workplace Model Planning Blueprint – particularly the logistical tasks to support worker engagement, recall processes, and cultural and religious safety.

2.2 Families/Visitors/Neighbouring Businesses to Sites

It is recommended that family and visitors are not part of the workplace/employer site vaccinations to prevent any public/crowd control issues, ensure compliance with the Health and Safety at Work Act is maintained, and Public Liability risks are managed. As the employer and provider gain experience with the Pfizer vaccination processes, in conjunction with the vaccination providers commissioning agency, they may reconsider this position.

3. Early planning considerations

There are some notable differences between the Pfizer vaccine and other vaccine programmes, such as influenza, that both workplaces/employers and vaccination providers should be aware of. The following considerations have been shared by occupational health vaccination providers who delivered the Pfizer vaccine in Group 2 eligible workplaces:

- The Pfizer vaccine is a national roll out with the goal of offering vaccination all peoples in Aotearoa New Zealand within a set timeframe.
- It requires the administration of two doses separated by at least 21 days. This requires the onsite delivery to be replicated twice.
- It is a delicate vaccine:
    - Nationally, it is stored at ultra-low temperatures and cannot be refrozen once thawed.
    - It is transported to vaccination providers at +2C to +8C and has 31 days of expiry at this temperature.
- It has different logistical constraints:
    - It is provided in boxes of five, 15, 195 vials.
    - Each vial contains multiple doses (six or seven) and sites must be able to administer at least 30 doses per day if moving in mobile chilly bins and if cold chain is maintained.
- Due to the price per dose and other associated costs, there needs to be a minimum number of doses delivered in a sitting to be viable for vaccination providers, this is approximately 70.
- There are additional administration and information requirements;
    - Vaccination providers need to be prepared to answer more questions on the vaccine than they experience in other vaccine programmes.
    - Recording every vaccination in the COVID-19 Immunisation Register (CIR) is mandatory and must be done on the same day as the vaccination.
- There are additional workforce requirements:
    - A three-person team's minimum needed at a site (two clinicians, one administration) instead of one nurse for Influenza.
- There are additional physical location considerations;
    - Workplace staff need to stay in active observation for at least 20 minutes post vaccination event – there needs to be adequate space to allow for this.
    - There needs to be dedicated private and appropriate space available for the drawing up of doses to ensure vaccination providers can concentrate on this process given there are multiple doses to draw per individual vial, and maintain adequate IPC protocols.

- Privacy for workplace staff as they will be answering people's questions and recording details in the CIR.
- Suitable area for stage two observation, as required (including access to stretcher/bed and privacy screening). (refer Programme Standards).

- There are additional vaccine transport considerations;
  - Vaccination providers may need to assess the suitability of existing chilly bins and ensure they meet the standards for their use.
  - Prepared doses cannot be transported to other sites.

3.1 How many people can be catered for?

It is expected that vaccination providers and workplaces/employers work together to determine the best throughput plan for each site. As each workplace is likely to have different needs and variables, the following information is to support joint planning and decision making related to individual site throughput.

- **Financial minimum viable product (MVP)**

  Based on initial assessment of the financial MVP, no less than 70 vaccinations can be administered in a session (day). Variables will change depending on individual vaccination provider and workplace/employer constraints. A tool has been developed to assist vaccination providers calculate the MVP for each situation.

- **Logistical constraints**

  If the number of workers vaccinated per session, for whatever reason, drops below the financial MVP then the following applies:

  - Based on pack size, a minimum of 30 vaccinations, per vaccine delivery, will need to be administered, as the minimum delivery is five vials containing six doses.
  - To mitigate possible vaccine delivery delays, it is recommended the 30 vaccinations are planned to be completed within 1 day.

- **Infection, prevention and control (IPC) requirements**

  IPC requirements are critical considerations for planning.

  Once the vaccine has been diluted, it must be administered within six hours. Any prepared doses not used within this time period must be discarded.

  It is recommended vaccination providers are vigilant of vaccine expiry times and factor in time for date-stamping.

- **Physical site**

  The number and size of available rooms onsite.

  Physical capacity of waiting rooms to meet the 20-minute minimum of the post-vaccination observation period should be considered when estimating throughput.

- **Vaccination provider workforce**

  The number of vaccinators available through the provider, trained first aid and support staff, in relation to the number of people being vaccinated.

The current average number of doses delivered per vaccinator per hour is 12.

- **Workplace/employer operating hours**

  The business hours the workplace/employer deem appropriate and the flexibility of the vaccination provider.

  The workplace/employer's workers working hours will determine available numbers of workers per session. For example, there could be 500 workers, but they work shifts and therefore only a portion may be available during the same period. Shift workers who cannot be interrupted need to be taken into account.

  Workplaces/employers may need to give vaccination providers with access to workplaces after hours.

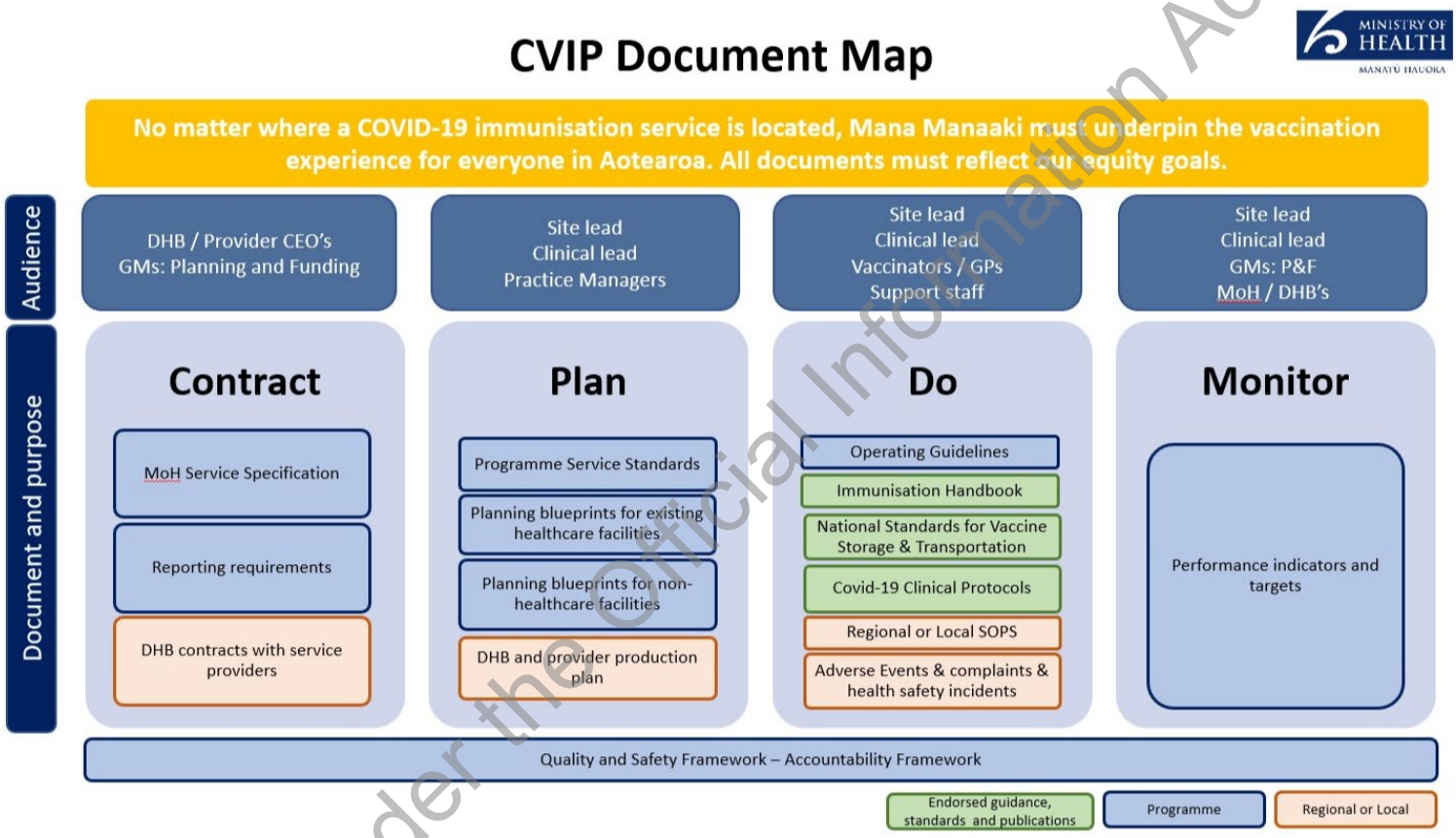
  Further planning to manage people returning for their second dose and new people, such as new workers, getting their first dose.

4. Information for vaccination providers

Vaccination providers must submit a delivery plan to their commissioning agency as part of pre-contracting due diligence. Content in this document will assist in the planning required to develop that plan.

Planning for this model should be done in conjunction with the Programme Standards and Operating Guidelines.

The document map below outlines where this document sits in relation to the wider suite of resources.



4.1 Commissioning of vaccination providers

A vaccination provider will either be commissioned by the Ministry of Health (MoH) or a District Health Board (DHB).

- **MOH will only commission existing occupational health vaccination providers who can serve workplaces/employers that are geographically spread across multiple DHB boundaries.**
- **DHBs will utilise any workforce/provider to best serve workplaces/employers residing in their geographical boundary.**

MoH and DHBs will operate an 'open book' process to collaborate on what vaccination providers are being commissioned to serve what workplaces. They are responsible for designing, communicating and implementing how vaccination providers will be commissioned and how workplaces/employers can engage in the programme. They are also responsible for the on-boarding of new providers into the programme.

Both commissioning agencies should consider equity, accessibility and acceptability when commissioning vaccination providers.

4.2 Eligibility criteria for vaccination providers;

Vaccination providers must:

- be established vaccination providers with a Health Provider Index number
- have experience in delivering a vaccine programme
- have a workforce that can ensure cultural and religious safety of workplace staff; they must have clearly defined clinical quality and equity leads.
- be able to comply with the Programme Standards, Service Specifications, Immunisation Handbook and Operating Guidelines including:
    - existing cold chain accreditation
    - active clinical quality and safety oversight mechanisms
    - mandatory use of the National Booking System and call centre
    - Deliver to the set Price per Dose
- be able to operate with agility, as the programme evolves, and be prepared to engage in the development of the programme.

4.3 Providing a safe and quality vaccination experience

No matter where a COVID-19 vaccination service is located, mana manaaki must underpin the vaccination experience for everyone in Aotearoa New Zealand. This includes a culturally and clinically safe vaccination experience.

A 'one size fits all' approach to service delivery will not work for our priority population groups. Different considerations will be required dependent on a consumer's health and/or disability, where they live, and how they access services. Refer to Appendix 1 for guidance on delivery models for Māori, Pasifika, ethnic communities and disability groups.

4.4 Clinical quality management systems and governance

Clinical safety and quality requirements are sourced from the MoH Immunisation Handbook, Operating Guidelines, and Programme Service Standards. It is expected that vaccination providers delivering the workplace model have active clinical governance and systems in place, including a defined quality and safety lead. In addition, each DHB region must have appropriate quality and safety oversight of the vaccination programme rollout through their existing quality and safety and/or clinical governance mechanisms. Vaccination providers contracted directly to the Ministry must also have clearly documented clinical quality and safety assurance people and processes (as per the documents above – Immunisation Handbook, Operating Guidelines, Service Standards), including reporting mechanisms for review of significant events and accountable clinical leads and quality leads.

Vaccination providers must submit a delivery plan to their commissioning agency that includes;

- an overview of existing clinical quality and safety systems; at a minimum, this includes oversight of adverse events, complaints, risk and incident management (note: in this context, 'adverse event' does not refer to an adverse reaction following vaccination)

- names and contact details for clinical lead(s) and quality manager(s), and details of their clinical governance/quality and safety groups within their organisation including frequency of meetings and responsibilities.

4.5 Business Continuity Planning

Business Continuity Plans should be in place to; manage disruption to systems (CIR, Booking, Internet access etc), manage impact to business as usual in the event of surge demand and manage impact in the event of COVID-19 alert level changes or vaccine loss or wastage. Refer to the Operating Guidelines for additional guidance.

In the event of COVID-19 alert level changes, vaccination providers will follow all government direction regarding continuation or not of the Pfizer vaccine programme.

4.6 Vaccination workforce

Vaccination workforce decisions should be considered in alignment with the Operating Guidelines, the Immunisation Handbook and clinical resources provided by the Immunisation Advisory Centre (IMAC).

4.7 Vaccination Training

MoH has partnered with IMAC to provide the mandatory training required to administer the COVID-19 vaccine. This includes clinical training for the Pfizer vaccine and non-clinical training for using CIR. Evidence of completion of mandatory training is required, as well as any training undertaken to be an authorised vaccinator.

Commissioning agencies may seek to supplement this training by providing practical observation of operating vaccination centres if appropriate.

4.8 Planning for booking appointments

Workplaces/employers and vaccination providers will need to collaborate and be flexible with regards to appointment timings and what is feasible for both parties at any given site. This is especially the case with workplaces with shifts and where it is difficult to take workers out of work.

4.9 Engagement and invitation

The workforce model has a fixed population group to serve. Workplaces/employers are responsible for engagement and communication with their workers. Vaccination providers are responsible for communicating when and where they will be onsite and when there are any changes to planned bookings/sessions.

4.10 Booking appointments

Vaccination providers are responsible for managing appointment bookings. It is mandatory for providers to use the CVIP National Booking System.

MoH recommends all sites open bookings at least one week before vaccinations start to allow the provider to supply an accurate order of vaccine and consumables, and ensure adequate time to communicate with workers at the workplace. Having a clear idea of the number of bookings will also allow vaccination providers to staff sites to meet demand.

However, it is highly likely that workplaces will need to open bookings well in advance of one week, depending on individual business planning needs. Workplaces/employers and vaccination providers will need to collaborate and be flexible with regards to appointment timings. This is especially the case with workplaces with shifts and where it is difficult to take workers out of work.

MoH recommends second appointments are booked with vaccination providers while individuals are onsite for their first dose.

4.11 Worker follow up

If a worker either:

- did not respond to the initial invite
- did not attend the first dose booked appointment
- do not have a second dose booked
- did not attend the second dose booked appointment.

As the vaccination provider runs the booking process/system, they are responsible for worker follow up with the direct support of the workplace/employer. Where this requires the sharing of individual data to an employer, such as who has had a vaccination and who has not, consent must have been obtained from employees prior.

4.12 Second dose follow up

Vaccination providers should consider how demand planning will cater for individuals who only receive a single dose at the workplace vaccination site – for example, they choose to get their second dose at a different location or got their first dose elsewhere.

4.13 Administering leftover vaccines

Wastage through leftover vaccine should be actively minimised by planning a back-up or standby list. Vaccination providers are responsible for administering vaccine before expiry. Any wastage must be reported in the CIR and mitigated for future vaccination events.

Workplaces/employers are responsible for managing a process to invite non-booked workers to utilise leftover vaccines.

4.14 Onsite functions

The table below outlines the required onsite functions and responsible parties.

Depending on the operating hours and size of the site, the number of people filling roles in these function areas may vary; however, the functions across sites won't change.

Functions on site	Responsible / accountable for
Site operations	Responsible for onsite inventory management.
	Should any assistance be required, provide or access another basic life support trained adult onsite to manage and/or deliver the appropriate response.

Clinical oversight	Nominated COVID-19 clinical on-site lead who will coordinate all vaccination activities including vaccine logistics (ordering, receiving and storage). (Note: this is not the same role as the over-arching clinical lead with a local governance role, as per the Programme Standards). Must have vaccination experience in order to be responsible for all clinical aspects of the vaccination site which can include: • providing on-site clinical advice and guidance including managing any adverse events following vaccine (AEFI) • ensuring that equipment and medications for the management of medical emergencies, including anaphylaxis, is available, consistent with the programme Service Standards, and considers specifics of the site (i.e. remoteness) • running a closed 'dry run' session with provider staff • leading team huddles pre- and post-vaccination clinics • submitting significant event analysis reporting to the relevant DHB and/or the Centre for Adverse Reaction Monitoring (CARM) as necessary.
Welcoming (including registration)	Confirm the NHI number and workplace staff details. Provides information to gain informed consent. Checks that workplace staff are well.
Vaccination preparation	Dilutes and draws up vaccine in line with established IPC protocols and vaccine preparation guidance. Second person checks the processes and vaccine dose and confirms vaccine vial information.
Vaccination administration	Confirm identity (does not require being shown an identifying document). Ensures workplace staff are ready for vaccination, aware of potential side effects, conducts the pre-vaccination clinical assessment, etc. Gains informed consent. Administers vaccine.

Post vaccination monitoring	Observe individuals post vaccination to monitor for possible adverse event. Should any assistance be required, this function will manage and/or deliver the appropriate response and liaise with emergency providers as appropriate.

4.15 Adverse events

The provider-nominated site clinical lead is responsible for the clinical management of vaccine related adverse events at the place of vaccination. Vaccine-related adverse events must be recorded and reported to CARM and to the workplace/employer lead. These can be reported through:

- the CIR for adverse events during the observation period.
- the CARM website[1] for any post event presentation after the workplace staff member has left the site.

Further functionality on CARM reporting and other systems for ease of access is being explored.

Refer to the Programme Standards for information on emergency equipment required on site.

4.16 Vaccination provider workforce capacity

Vaccination providers should consider how to manage their BAU activities while delivering COVID vaccinations, including how sustainable it is to deliver BAU activities alongside vaccinations.

4.17 Vaccine and consumables logistics

The Operating Guidelines have specific information on vaccine supply chain and onsite storage requirements for the Pfizer vaccine, including that fridges must have the ability to detect temperature breaches.

Commissioning agencies and their respective vaccination providers must agree a delivery plan of the vaccine and consumable stock reflective of the anticipated throughput.

The first initial vaccination sessions at a new site should be at a reduced scale to test systems and processes before scaling vaccine administrations later.

It is essential that supply is planned for within a 31-day expiry time. Delivery planning must factor in the following logistics constraints:

- Minimum six people must be vaccinated within six hours.
- Minimum 30 vaccinations need to occur within 1 day.

Stock deliveries can be made seven days a week. Stock is delivered in packs of five vials (30 doses), 15 vials (90 doses) or a tray (1170 doses) at standard 2-8˚C cold chain.

Stock must be ordered two days in advance to ensure provision for the variances in demand that can occur daily.

An identified person at each site must manage vaccine and consumable stock. This will allow for effective management of vaccine and consumables with the ability to order new stock.

[1] https://report.vaccine.covid19.govt.nz/s/

4.18 Onsite IT requirements and support

Every vaccination given must be recorded in the CIR.

The supporting equipment and infrastructure to access the CIR is outlined in the Operating Guidelines and includes access to high-speed internet, a laptop, computer or tablet, and a separate smartphone.

Currently, each person accessing the CIR requires a non-public email address. This is required to mitigate security concerns on access to the CIR and supporting information.

Vaccination providers should ensure there is an available Superuser (someone who is a frequent and competent system user) to provide local support.

4.19 Consumables

Consumables listed in the Operating Guidelines will be provided directly to sites from the distribution provider. Other consumables not specified in the Operating Guidelines should be covered by vaccination providers within the provided funding.

In the event of COVID-19 alert level changes, PPE is to be sourced through existing channels.

4.20 Other equipment requirements

Minimum equipment standards for management of medical emergencies are outlined in the Programme Standards document. Additional equipment provided for use at the site must take into consideration the accessibility of the site to emergency services, remoteness, and the skill sets of on-site vaccination providers.

4.21 Physical locations

Vaccination providers must ensure the workplace/employer site is appropriate for use according to the Programme Standards and Operating Guidelines.

When choosing the physical site for vaccinations at the workplace, consideration needs to be taken about whether the physical space available will support the volume planned for the site and the end-to-end administration process.

How the site is arranged, and the throughput, will depend on a range of factors, including the size of the site.

Space must be available for people to remain on site for at least 20 minutes after their vaccination so they can be observed. Space and appropriate equipment must be available for stage two recovery observation, as outlined in the Programme standards.

Emergency vehicle access must be identified in case of an adverse event.

There must be consideration of how a space may be rearranged or throughput reduced in the event of COVID-19 alert level changes. The site must be set up so it is easy to see most areas used for the immunisation process and provider staff must be able to communicate easily if they need help.

4.22 Site readiness self-assessment check list

Vaccination providers must complete the 'site readiness checklist' and submit to their respective commissioning agency.

4.23 Funding and reporting

Vaccination providers cannot charge workplaces/employers for any costs associated with the delivery of the Pfizer vaccine.

The MoH set Price per Dose (PPD) (both for during and after business hours) for varying providers and reporting requirements are available in the relevant service specifications.

The PPD for Occupational Health Providers is **$33.91** for ordinary hours, and **$46.59** for after hours. Both prices are inclusive of recalls.

"Out of hours" is defined as:

(a) 8pm to 8am the next day, Monday to Thursday; or

(b) 5pm Friday to 8am Monday; or

(c) any Public Holiday.

Where a DHB commissions a primary care provider, the approved PPD for primary care will be applied.

From 1 July 2021, an automated PPD payment solution will be implemented based on the events recorded in CIR. When an immunisation event is appropriately recorded in CIR, the combination of contract, provider and site will be used to automatically determine the payment amount due and the contracted party will receive payment for the service automatically. It will be not be necessary to generate and send additional invoices for PPD services.

Where a contract is not on a PPD basis, or where there are special payment arrangements outside of the national PPD pricing arrangement, these will usually be managed on an invoice basis.

Full terms and conditions for payment of COVID-19 vaccinations services will be specified in individual contracts with the commissioning agency.

5. Information for Workplaces/Employers

5.1 Supporting providers

Workplaces/employers need to work alongside the vaccination provider serving their workers. This includes inputting into and agreeing the delivery plan vaccination providers must provide their commissioning agency, which will include the volume of workers to be vaccinated and the booking schedule and approach.

It will be critical for workplaces/employers to consider physical locations that vaccination providers will need. This includes consideration about whether the physical space available will support the volume planned for the site, including the space for the minimum for the 20-minute active observation area, emergency vehicle access, and consideration of how a space may be rearranged or throughput reduced in the event of COVID-19 alert level changes.

Workplaces/employers also need to provide onsite support, such as access to high-speed internet and support during the vaccination sessions as laid out below.

5.2 Planning for booking appointments

Workplaces/employers and vaccination providers will need to collaborate and be flexible with regards to appointment timings and what is feasible for both parties at any given site. This is especially the case with workplaces with shifts and where it is difficult to take workers out of work.

5.3 Engagement and invitation

The workforce model has a fixed population group to serve. Workplaces/employers will need to communicate to workers through existing employer channels to promote the opportunity, provide information about who the vaccination provider is and when/where they will be onsite and how to book.

Workplaces/employers are strongly encouraged to work directly with Māori, Pacific and ethnic staff in their workplace to ensure communication and engagement is tailored appropriately.

5.4 Booking appointments

Vaccination providers will manage booking systems. It is mandatory for all providers to use the CVIP National Booking System. Workplaces/employers will need to support workers who need assistance with making a booking.

MoH recommends second appointments are booked with vaccination providers while individuals are onsite for their first dose.

5.5 Worker follow up

If a worker(s) either;

- did not respond to the initial invite
- did not attend the first dose booked appointment
- do not have a second dose booked
- did not attend the second dose booked appointment.

Workplaces/employers will need to provide support to the vaccination provider to provide follow up. Where this requires the sharing of individual data such as who has had a vaccination and who has not, consent must have been obtained from the employee prior for this data to be shared with their employer.

5.6 Administering leftover vaccines

Wastage through leftover vaccine should be actively minimised by planning a back-up or standby list. Where vaccine is available due to booked staff not turning up, the workplace/employer needs to have a process in place to invite other workers on site to take up the opportunity.

5.7 Onsite functions

The table below outlines the required onsite functions that workplaces/employers are responsible for:

Functions on site	Responsible / accountable for
Traffic and site management (non-clinical)	Manage traffic and people flow in and out of the carpark and venue (if required). Oversight and management (including health and safety) of site. Ensure facilities meet the Programme Standards by way of adequate facilities, such as bathroom access.
Hauora support	Across the vaccination pathway (from welcoming to post-vaccination monitoring), provide support for the wellbeing of the people seeking a vaccine.
Welcoming (including registration)	Meet people and manage flows of people to keep social distancing regardless of COVID-19 alert level. Identify whether there are additional supports or considerations required to facilitate an inclusive, safe and accessible experience for workers. Refer Appendix 1. Ask if second dose appointment has been made in advance, encourage staff to book for this if not.
Post vaccination monitoring	Sign off workers as fit for work and able to return to work, or sent them home if unwell.

5.8 Adverse events

If a vaccine related adverse event occurs on-site while the worker is under the care of the vaccination provider, that provider is responsible for the clinical care and reporting of the event. Refer to vaccination provider section for more information.

Vaccine-related adverse events must be reported to a nominated workplace/employer lead in the event a notification to WorkSafe is required.

Where an employee experiences a vaccine related adverse event after they have completed the required 20 minute observation period, and the provider is no longer on site, the employee or employer can call Healthline on 0800 358 5453, or if they are concerned about their safety, call 111. Tell them they've had a COVID-19 vaccination so they can assess them properly. More information about adverse events and how to report them, is available on the MoH Website https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-vaccines/covid-19-vaccine-side-effects-and-reactions.

Liability for the CVIP is consistent with other onsite vaccination programmes, such as influenza.

Appendix 1: Guidance on delivery models for Māori, Pacific, ethnic communities and disability groups

The following examples show how an equitable approach to Māori, Pacific, ethnic and disabled communities may be incorporated into vaccination site planning and operations. Note that these are examples of equitable practices to support your planning, not a checklist of requirements that you must meet.

Māori

Partnership: Wai 2575 Te Tiriti o Waitangi principle

The principle of partnership, which requires the Crown and Māori to work in partnership in the governance, design, delivery and monitoring of health and disability services. Māori must be co-designers with the Crown, of the CVIP for Māori.

Whānau/Family
- Non-residential care
- Mobile units
- Workplace
- GPs

Hapu/Community
- Marae
- Churches
- Rural schools
- Community centres
- Pharmacies

Iwi/Large community
- Iwi headquarters
- DHB's
- Large Hauora provider
- Sporting facilities

Pan Iwi/ Large Metro
- Large community based vaccination clinic
- Hospital site
- Arenas/stadiums

Manaaki

Pre vaccination	Vaccination	Post Vaccination
• Kaiāwhina to support • Culturally appropriate communication • Whānau and/or Carers present • Safe environment & site setup • Alternative access methods • Translation services • Cup of tea	• Kaiāwhina to support • Culturally appropriate communication • Whānau and/or Carers present • Safe environment & site setup • Translation services • Vaccinators match the population	• Kaiāwhina to support • Culturally appropriate communication • Whānau and/or Carers present • Safe environment & site setup • Alternative transport methods • Translation services • Cup of tea and discussion about hauora

Pacific

Equity
Equity for Pacific peoples is focused on identifying and removing barriers to achieve equitable outcomes. This includes working with Pacific experts to identify the appropriate approaches and service settings best suited for Pacific peoples.

Family
- Non-residential care
- Mobile units
- GPs

Community
- Churches
- Schools
- Community centres
- Workplace
- Pharmacies

Trusted Providers
- DHB's
- Large Pacific provider
- Sporting facilities

Large metro
- Large community based vaccination clinic
- Hospital site
- Arenas/stadiums

Manaaki

Pre vaccination	Vaccination	Post Vaccination
• Community health workers to support • Culturally appropriate communication • Family support and/or Carers present • Safe environment & site setup • Alternative transport methods • Translation services • Cup of tea	• Community health workers to support • Culturally appropriate communication • Family support and/or Carers present • Safe environment & site setup • Translation services • Vaccinators match the population	• Community health workers to support • Culturally appropriate communication • Family support and/or Carers present • Safe environment & site setup • Alternative transport methods • Translation services • Cup of tea and discussion about wellbeing

Disability

Equity
Equity for disabled people is focused on increasing accessibility to achieve equitable outcomes. Consideration must be given to disabled people in particular with disabilities that might hinder their ability to receive vaccination and disabled people who are at greater risk if they contracted the virus, to support all aspects of rights, access, adaptable approaches and equity. This includes working with disability representatives, agencies and providers to identify the appropriate approaches and service settings best suited for a diverse population of disabled people.

Whānau/Family
- Homes
- Non-residential care
- Mobile units
- GPs

Trusted Providers
- Support network
- Disability provider
- Support Worker
- Home and Community Support Provider

Community
- Schools
- Community centre
- Marae
- Churches
- Workplace
- Pharmacies

Circles of Support
- General Practitioner (Family Doctor)
- Wider social network
- Natural Support network

Manaaki

Pre vaccination	Vaccination	Post Vaccination
• Kaiāwhina and trusted sources of information • Planned Social stories • Culturally appropriate, targeted communication • Alternate format communication • Translation services • Alternative transport methods • Informed consent understood and planned by person • Safe environment & site setup • Specific approach to complex groups	• Kaiāwhina and trusted support onsite • Carers present • Culturally appropriate communication • Alternate format communication • Translation services • Safe environment & site setup suitable to persons sensory needs • Vaccinators trained on informed consent	• Kaiāwhina to support • Carers present • Culturally appropriate and targeted communication • Alternate format communication • Translation services • Feedback about the experience captured • Alternative transport methods • Safe environment & site setup • Cup of tea and discussion about hauora

In order to deliver an equitable vaccination programme, vaccination services and settings must be inclusive and accessible vaccination options for disabled people and their communities. This includes consideration of accessibility across the vaccination journey, for example, providing early information on the benefits of vaccination and awareness of service delivery options and associated accessibility features.

All vaccination sites (with the exception of mobile sites delivering to specific groups) must meet accessibility standards.[2]

Core components include

- Appropriate disability specific accommodations in all sites.
- Alternate formats translations of all public facing communications and engagement.
- Developed supported decision-making process in alignment to of the Health and Disability Code Of Rights (Right 7).

Ethnic Communities

Equity for ethnic communities can be achieved by targeting members of the community who cannot ordinarily be reached because of communications barriers and lack of understanding of the health system. The target approach involves enagaging with community leaders and stakeholders, including faith and religious leaders, local champions, and engagement teams who can encourage and relay key information on the vacine rollout.

[2] NZS 4121:2001 Design for access and mobility: Buildings and associated facilities. Ministry of Health guidance

Family	Community	Trusted vaccination providers	Large Metro
GPs Mobile sites in local communities	Churches, Mosques, Temples and Gurdwara Community centres Workplaces Schools Pharmacies Ethnic media platforms English for Speakers of Other Languages (ESOL) programme Centres	DHBs Large ethnic vaccination providers	Community base event vaccination clinic Hospital sites

Pre vaccination	Vaccination	Post Vacination
• Community/religious leaders and regional enagagement teams to support community health workers • Appropriate cultural and religious communiications • Family and community leaders support • Alternative communication formats and channels • Safe environment and site set up especially for Muslim women • Translation service	• Some Vaccinators match the population • Appropriate cultural and religious communiications • Family and community leaders support • Alternative access method • Safe environment and site set up especially for Muslim women • Translation service	• Appropriate culutural and religious communiications • Family and community leaders support • Alternative communication formats and channels • Safe environment and site set up especially for Muslim women • Translation service

Public Service Workplace Vaccinations Workshop

MINISTRY OF HEALTH
MANATŪ HAUORA

Unite against COVID-19

LATEST FACTS AND FIGURES

- The Covid-19 Vaccine and Immunisation Programme is an important part of New Zealand's recovery and business continuity plan
- The more people who are vaccinated, the greater our protection as a community
- All eligible ages will be able to book in their vaccine by 1 September
- The interval between doses has been extended to six weeks
- As at 15 August :
  - 1,571,371 first doses have been administered
  - 910,731 second doses have been administered (fully vaccinated)
  - Total 2,482,102 doses administered

WORKPLACES AS VACCINATION SITES

- Need to make it as easy as possible for people to get vaccinated – workplaces have a role to play in that
- The Public Service has to date played a vital role in providing workplace vaccinations.
- NZ Police, Corrections, NZDF and FENZ have been at the forefront of vaccinating their staff.
- To date 46,000 workplace vaccinations have been delivered through centrally contracted arrangements with the Ministry of Health.
- A workplace vaccination pilot is underway at 4 large New Zealand employers – Mainfreight, Fonterra, The Warehouse Group and Fisher & Paykel Healthcare.

WIDER ROLL OUT

- The Ministry of Health has received EOIs from more than 250 workplaces from across a range of industries who want to enable their staff to be vaccinated at work.
- The focus for inclusion as vaccination sites is workplaces with large staff numbers, high numbers of Māori and /or Pasifika workers, rural workforces or shift workers.
- Submissions currently being assessed by an evaluation panel of DHB and MoH people.
- Workplaces which met the evaluation criteria will be contacted later this week to get more information to see if suitable.

TIPS & TRICKS

- Minimum 70 vaccinations per day, ideally 100+
- Site set-up: space for active observation 20 minutes; emergency access
- Challenges of vaccine: super-cold storage, 31 day expiry, 6 hour once drawn up, manage wastage
- Workplace ability to have a ‘reserves list’
- Internal project team, and ‘lead’ for each site
- Privacy
- Key documents: operating guidelines and blueprint
- https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-vaccines/covid-19-vaccine-information-health-professionals#operate
- https://www.health.govt.nz/system/files/documents/pages/workplace-sites-service-design-blueprint-09072021.pdf

WAYS WORKPLACES CAN HELP

- Encourage your staff to get vaccinated when they are eligible
- Support your staff with time off work to get the vaccination
- Promote the national vaccination programme by displaying supporting materials at your work site
- Promote the vaccination programme on your social media channels
- Ensure staff are aware of misleading or false information and what to do if they see it

DISCUSSION

- Learnings from current workplace vaccination sites
- Group discussion:
  - Workplace vaccinations
  - Other ways to support
  - Extending vaccination to other workplaces
- Final questions

Covid-19 Vaccine and Immunisation Programme

MINISTRY OF HEALTH
MANATŪ HAUORA

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MINISTRY OF HEALTH
MANATŪ HAUORA

Pfizer Covid-19 Vaccination and Immunisation Programme

Workplace model lessons learnt

24 September 2021

Approach

- Due to limited time, resources and the current DELTA lockdown, the planned evaluation of the Workplace model has been scaled down.
- The purpose of this light evaluation is to identify what has worked well and what has not, to improve the model prior to a larger group of workplaces coming onboard.
- The insights gathered will also support future decision making on the size and scope of the model in relation to wider uptake and CVIP future state.
- The primary areas focused on are;
    - Provider capacity
    - Pre-engagement
    - Invitation strategy
    - Booking system and processes
    - Reporting
    - Equity
    - CVIP supporting structures
    - Considerations for scaling up
- Insights will be gathered through structured discussions with the Workplace Delivery team, and workshop with providers and employers.
- The Workplace Delivery team will utilise this document to identify what issues/recommendations have;
    - already been **resolved**
    - are in the **pipeline**
    - **need escalating** for consideration, or
    - are known to **not be feasible**.
- This can then be used to input into the workplan for improvements.

Provider Capacity

How are providers managing their capacity and reach?

Feedback	Status
Some providers have overcommitted in the EOI process and it is unclear how they will manage the expectations and scheduling of the workplaces they have committed to.	Escalate
Having access to NIBs has been critical to demand/capacity planning if using Book My Vaccine. Access needs to be given before workplaces/providers start.	Resolved
Workplaces prefer to use a walk-in model which may be difficult to capacity plan. Some noted that many staff did not have access to tech to book online and the workplace had to undertake additional tasks to support this i.e. making the bookings for them.	Escalate
Demand dries up at a point and a decision then needs to be made as to weather it is viable for providers to continue or if staff are then informed to seek vaccination elsewhere. Some providers are doing half days to accommodate low numbers at the tail end.	
There was added work for Mainfreight to create staff contact lists that were then sent to each Branch contact ahead of vaccination events so they could support staff reminders.	
Daily check in's with providers was critical to track numbers and address capacity issues.	
Where numbers were low, some workplaces engaged household contacts to fill gaps.	
Capacity planning gets impacted when other vaccination sites get located close to the workplace. For example, Auckland Airport Drive-in was located around the corner from Mainfreight and impacted staff numbers as some chose to head there.	
Don't wait until the end of the day to manage demand issues. One workplace called 'no-shows' after 15mins and communicated the importance of not wasting vaccine.	
The booking system sent reminders for the first dose but not the second. This led to 'no shows' being higher for the second dose. There was also a problem with duplicate bookings occurring during level 4 lock down. Some workplaces sent mass text reminders to staff to try and mitigate this as best possible.	

Pre-engagement with staff

What activities have been carried out that have led to best possible uptake? How can workplaces support staff to maximise this opportunity?

Feedback	Status
Fisher & Paykel activated engagement with staff a couple of months in advance. As they have an ethnically diverse workforce, they translated intel into 5 languages. Info was shared through volunteer staff at vaccination booths set up on campus. There was a direct link between booths operating and registration numbers.	
Mainfreight utilised the Fisher & Paykel material and approach. They had a person on site at each branch. Started with posters. Knowing your team and knowing how to get them involved is the critical factor, for example knowing when you just need to fill in forms for people to make the process easy. Did not use incentives as it didn't fit with their culture. Being able to bring families to also get vaccinated increased engagement. First big spike occurred when people went back to branch with vaccinated sticker on, prompting others. The DELTA outbreak drove increased engagement.	
Fonterra utilised the Fisher & Paykel and Mainfreight materials and approach and found these really effective. They received advice from FENZ regarding the value of live virtual Q/A sessions and these worked well. They had medical officers and the global head of Health & Safety front it which went a long way to make people feel safe. There were lots of individual circumstance questions. Experts are always critical especially if not an employee or from the programme – more independence the better for webinars. The team curated the questions as they came through. This approach also helped managed vaccine hesitancy.	
Anyone coming into the programme now will need to consider different engagement tactics as early adopters are likely to already be vaccinated. The workplace model may just be targeting those now hard to reach or hesitant. The target audience has now shifted.	**Escalate**
It is important for workplaces to have a known position on vaccination to set the tone for their staff.	
There are opportunities for workplaces to work collaboratively with other community sites to support staff rather than try and capture the minority on-site. Noting that workplaces with shift workers may still need on-site access as community sites may not be accessible in the hours they have available. The advantage to hosting on-site is that workplaces can manage shift workers and ensure access to all shifts. If off-site options were available all hours required, Fisher & Paykel wound not be doing on-site vaccinations in the workplace.	**Escalate**
Flexibility was identified as a critical factor to engagement success.	

Invitation Strategy

What worked, what were the challenges, how have the roles and responsibilities been applied

Feedback	Status
Workplaces led the invitation approach and activities. Keep it simple. If people have to do too much work it gets too hard and they opt out.	
Some workplaces didn't invite people to 5 min slots, rather 15 o 30 mins slots to support their planning.	
Some workplaces found that emails and texts were not always effective, especially in environments where staff do not have access to workplace tech or are unable to use tech while working.	
Some workplaces delegated invitations to branch contacts in a hub and spoke model. Hub leads had the flexibility to customise to meet local needs.	
Health and Safety staff were utilised in some workplaces to send out all communications regarding the vaccination opportunity.	
Fisher & Paykel used their internal call centre that was set up specifically for COVID to contact people who registered interest at their info booths.	
When considering pre-engagement and invitation approaches, consider providing to those who want it, convincing those who are hesitant, and not leaving a large gap between making bookings available as part of the invite and the vaccinations actually starting.	
Flexibility is key. Mainfreight found that Friday and Saturdays were most popular so catered for that. The workplace model offers such flexibility that other delivery models do not. The more flexible the better the outcome.	
Some workplaces created a deadline as part of the invite approach to encourage early uptake and avoid people leaving it to the last minute. They used messages like 'take it or leave it while we have guaranteed supply close to us', and 'it's about keeping everyone around you safe'. Interest increased when people were given a deadline.	
Further clarity and consistency on the consent process including appropriate wording is required.	**Escalate**

Bookings

What worked, what were the challenges, what would we do differently?

Feedback	Status
Need to either only use Book My Vaccine or internal process, not both. If using Book My Vaccine, workplaces must have access to NIBS.	Resolved
Book My Vaccine is good for individuals but not for groups. People could make last minute changes that impacted demand scheduling. Text reminders were deemed the main/only value of using Book My Vaccine for the Workplace Model. It was noted however, that the text reminders were inconsistent as some staff did not get them.	Escalate
The end-to-end admin process is top heavy and could be simplified.	Escalate
Applying the codes is good but the system still asks for your address to locate the best site which is irrelevant for this model.	Escalate
Mainfreight asked people to indicate how many people were coming together in the car to help understand numbers and balance supply.	
Fisher & Paykel – pre-Book My Vaccine, they used an internal booking process and used their internal call centre to contact employees and give them an appointment. When BMV was utilised, confirmation texts worked well. Overall – having a central group to manage the interaction and support staff worked well, especially for staff without tech access. Set up home bubble events over 3 days and used Book My Vaccine for this. Had no 'no-shows'. Managed walk-ins easily. Eventually moved to a booking from hard copy and consent to make the processes easier.	
Mainfreight - Prior to NIBS access – couldn't see who was actually booked, and people could make changes themselves which caused chaos. Notifications of bookings were good but people only get it prior to first dose. Worked closely with provider to reconcile booking schedule daily. When people used Book My Vaccine and out internal process it made it really complicated.	
Fonterra – Book My Vaccine needs a bulk up-load capability to be useful in the workplace model. Used booking co-ordinators at each hub (admin).	

Reporting

How can we support people, and organisations to have the data they need in a safe way?

Feedback	Status
Access to data in NIBS is critical.	Resolved
If someone from the employer is given concierge access, it would be useful to arrange internal privacy training for them, so their use of identifiable data is appropriate. MoH will need to provide this if the employer can't.	Escalate
Some workplaces had requests from other internal teams wanting access to identifiable data, e.g. HR teams wanting to know who had been vaccinated so they could reconcile that with leave applications. Fisher & Paykel captured vaccinations via employees sending in a photo of the vaccination appointment care. But these cards could eb lost and put through the wash. Need a more efficient way to do this. Vaccination cards were helpful but have changed and no longer include batch numbers etc.	Pipeline

Equity

Who is being served by this model?

Feedback	Status
Serves those who otherwise wouldn't due to simplified access – already at the workplace site. • Shift workers and flexible workers are well served by workplace model, also suits those in rural areas • Suits those less tech literate or those who would otherwise not be inclined to	

Scaling up considerations

What do we need to stop, start or change to successfully scale up?

Feedback	Status
• By guided by the provider and work closely together • Flexible and simple • Know your team and what works for your people • Lockdown and delta – people have been scared about members going to work but by including family/whānau it increased confidence/ feelings of safety in going to work.	

Other

What have been the intended and unintended consequences if any?

Feedback	Status
• Lot of gratitude from workers, particularly ahead of age bands • Peer pressure has been mostly positive for breaking down barriers • People who weren't for it, made calls to book anyway • Workplaces thinking about mandatory vaccination in future • Time off for AEFI doesn't impact leave • Anti-vaxxers are in the minority, most convos happened at branch level.	
Operating Guidelines are still DHB centric and causing confusion	**Escalate**
CVIP needs established systems and processes for stakeholder management for Occupational Health and Central Government.	**Escalate**
Consider an Advisor from the Occupational Health sector to join the team and support sector relationships.	**Escalate**

Supporting Structures

What has worked well, what are the challenges? From the Workplace Delivery Team's perspective

Feedback	Status
The shared support service approach of other teams is not assisting in solving the problem due to other priorities, capacity, and capability. The Workplace model is unique in that MoH is directly commissioning national providers to complement the DHBs, and it requires a 3-way relationship between commissioning agent, provider and employer. This means a specific small team is established to manage the national delivery within CVIP. No other service model requires this approach. The implications of this being the only model to have this approach, is that the structure of key enabling teams, systems and processes are primarily designed to serve DHB delivery. Accessing key teams to support the end-to-end implementation process has been difficult due to competing priorities and unknown capacity of other teams to support critical process like provider onboarding.	
The Workplace delivery team has by default become the 'shop front' for providers and employers without the resource required to do that as best as possible, impacting the focus they need to have on running the processes well. If this cannot be addressed the RAM resource requirement will need to increase.	**Escalate**
There is no dedicated budget to support the team. Steering Group requests are being made to seek agreement on spend. This is not time efficient and a new approach with the Programme Office should be sought.	**Escalate**
The tool built to identify bottle necks in the end-to-end process has been invaluable.	