MINISTRY OF HEALTH
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16 November 2021

Sebastian

By email: fyi-request-15656-6ba830ae@requests.fyi.org.nz
Ref: H202106802

Tēnā koe Sebastian

Response to your request for official information

Thank you for your request under the Official Information Act 1982 (the Act) on 3 June 2021 for information relating to the COVID-19 Vaccine Technical Advisory Group:

1) *Copies of all minutes of COVID-19 Vaccine Technical Advisory Group meetings*
2) *Copies of all minutes of CVIP Governance Group meetings*
3) *Copies of all minutes of CVIP Steering Group meetings*

Please refer to Appendix 1 of this letter for copies of the requested documents and decisions on release.

I sincerely apologise for the delay in responding.

I trust this fulfils your request and assists with your complaint with the Ombudsman (ref: 561559).

Please note that this response, with your personal details removed, may be published on the Ministry of Health website at: www.health.govt.nz/about-ministry/information-releases.

Nāku noa, nā

Jo Gibbs
National Director
COVID-19 Vaccine and Immunisation Programme

Appendix 1: List of documents for release

<table>
<tr><th>#</th><th>Date</th><th>Document details</th><th>Decision on release</th></tr>
<tr><td>1</td><td>2 February 2021-23 March 2021</td><td>Minutes of COVID-19 Vaccine Technical Advisory Group meetings</td><td rowspan="3">Released with some information withheld under the following sections of the Act:
Section 9(2)(k) to prevent the disclosure or use of official information for improper gain or advantage.
section 9(2)(b)(ii) where its release would likely unreasonably prejudice the commercial position of the person who supplied the information.
section 9(2)(g)(i) to maintain the effective conduct of public affairs through the free and frank expression of opinions by or between or to Ministers and officers and employees of any public service agency.</td></tr>
<tr><td>2</td><td>12 February-26 March 2021</td><td>Minutes of CVIP Governance Group meetings</td></tr>
<tr><td>3</td><td>2 February- 30 March 2021</td><td>Minutes of CVIP Steering Group meetings</td></tr>
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MINUTES COVID-19 Vaccine Technical Advisory Group

Date:	Tuesday 02 February 2021
Time:	11:00 am – 12:00 pm
Location:	s 9(2)(k)
Chair:	Dr Ian Town
Members:	Dr David Murdoch, Prof Peter McIntyre, Dr Helen Petousis-Harris, Dr Nikki Turner, Assoc Prof James Ussher, Dr Pippa Scott, Dr Tony Walls, Dr Sean Hanna, Dr Elizabeth Wilson
Ministry of Health Attendees:	Dr Caroline McElnay, Sarah Mitchell, Dr Fiona Callaghan
Guests:	
Apologies:	Assoc Prof Sue Crengle, Dr John Taylor, Dr Nikki Moreland, Prof Ian Frazer, Dr Matire Harwood, Chriselle Braganza, Daniel Bernal

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1.0	**Welcome, introductions and previous minutes** Dr Ian Town welcomed all Members and Attendees in his capacity as Chair of the COVID-19 Vaccine Technical Advisory Group In particular, the new members of the group were thanked for joining at short notice, which was due to the bringing forward of potential availability of the Pfizer vaccine. Clinical expertise will be key to informing vaccine delivery. Minutes of the last meeting (27 January 2021) were accepted. Members were asked the send any edits to COVID-19 Vaccine TAG Secretariat. Updated Terms of Reference (ToR) was included in the agenda circulated to Vaccine TAG members for review Some overlap with the scope of the IIAG has been pointed out. The DG receives advice from both groups. Nikki Turner commented that although there will be some overlap, updated ToR are clearer. This group is primarily focused on the Decision to Use Framework. Medsafe are meeting today regarding the Pfizer vaccine and will report to the DG this afternoon. For the purposes of this group, will be especially interested in any conditions set out by Medsafe. This group will help ensure the New Zealand community is fully and accurately informed about COVID-19 vaccines.
2.0	**Role of the COVID-19 Immunisation Implementation Group (IIAG)**

	The Terms of Reference and membership list of the IIAG were included in the supporting documents. Equity is a key focus of the IIAG. It was noted that Dr Nikki Turner and Dr Helen Petousis-Harris are members on both the IIAG and the COVID-19 Vaccine Technical Advisory Group. It was suggested that a standing item be added to the agenda for the COVID-19 Vaccine TAG to allow for a short report/comment on matters of common interest between the groups. The Chair agreed this should be done.
3.0	**Terms of Reference** The ToR for COVID-19 Vaccine TAG have been moved from previous STAG draft into the Ministry's Science & Technical Advisory format. Members were asked the send any comments to COVID-19 Vaccine TAG Secretariat for the Chair to attend to.
4.0	**Pfizer Vaccine Science Overview** Dr Pippa Scott and Dr David Murdoch were thanked for their work in putting this document together, which is a longer science overview. This document will be dated and timestamped to reference the current state of knowledge about this vaccine. Dr Scott gave an overview of the key points in the document, and the chair asked the group for comment or discussion, whether anything was worrisome or inconsistent with their current knowledge about the vaccine. Key points of discussion following update: • the rate of anaphylaxis with the first dose of the vaccine is 11x higher than the usually quoted rate of anaphylaxis with vaccination, which will be a critical issue for public information • the vaccine has not yet been tested significantly in children under 16. It would be useful to know what companies are planning in terms of immunogenicity studies in children. It was noted that a small number of children have been vaccinated in Phase 3 • Israel is vaccinating pregnant women, though data quality may be an issue • implications of new, more transmissible variants on vaccine efficacy will be important to watch • a lack of data (due to limited numbers) in Phase 3 trials for Pacific Island participants, those over 75 and people with co-morbidities was noted. Pippa will add this to the document. However, at this stage the group did not express concern about recommending those groups receive the vaccine. Measuring immunogenicity in these groups post rollout will provide some reassurance, and ethnic specific safety data will be reported • all the trials have limited information on severe disease compared to mild disease, will be relying on post marketing for more insight here. Pfizer are informally looking at vaccine impact on asymptomatic cases • there will be intense scrutiny on post-marketing data • papers on US vaccine safety showed rates of adverse reactions were quite similar in older and younger people, and the majority were occurring after 30 minutes (Rates of anaphylaxis are higher than we have seen with other vaccines)

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	• there was discussion about whether if anaphylaxis occurs, would there be indication to do skin testing or other further evaluation • it was noted that primary care health workers are skilled in managing anaphylaxis, and we do not want to undermine this, rather support them. Current thinking is to recommend that everyone wait 30 minutes after vaccination, but those with a history of allergies or asthma would be indicated to monitor closely and give additional information • noted that asthma is a risk factor for death with anaphylaxis, and an important screening question. If someone has an allergy to a product in the vaccine, this might indicate consultation with an allergy specialist • those with presumptive anaphylaxis post-vaccine might be recommended not to receive further dose. Though if they still want the next dose, it would be good to have a pathway to facilitate this safely • noted that many of the individual case reports of safety issues were minor reactions e.g. lip swelling, minor wheeze • noted that advice regarding screening questions and potential role of skin testing etc will need to be fine tuned • IAC are developing a consent form and • It was noted that there are subgroups that lack safety data, for example people aged over 75 years, Maori and Pacific communities, and particular comorbidities. It was noted that Dr Scott is also working on an A3 document that will be used for sharing with colleagues across government agencies and can also be a foundation for communication teams. Importance of communicating what we do not know was highlighted. Any further comments on this Science Overview document welcomed via email immediately after the meeting.
5.0	**Pfizer Vaccine Data Update** This is a shortened version of the previously discussed documents, intended as a high-level summary for attaching to government papers which go to the DG and to the COVID-19 Minister. Key aspects include side effects and safety, which will be of concern for the public. There was a comment that the current version may be a little long. Group was asked to check whether any of the content did not align with the longer document.
6.0	**Questions on the Pfizer Vaccine** • The STAG Decision to Use Framework paper was attached for background information, most of the group would have had this information already • Also attached was a memo to the Vaccine TAG outlining advice sought on the use of the COVID-19 Pfizer vaccine, requesting advice on who the vaccine is or is not appropriate for. • Medsafe will be deciding today regarding provisional approval of the Pfizer vaccine in New Zealand. Any conditions applied to this that relate to the eligibility of target populations and safety will be extracted and sent to the Vaccine TAG for their meeting on February (strictly confidential).

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	• The meeting scheduled for Thursday will discuss any comments or concerns with the provisional approval. • Page 36 of the full pdf of supporting papers for this meeting (or page 2 of the Memo to the Vaccine Technical Advisory Group, requesting advice on the Pfizer COVID-19 vaccine) outlines the kinds of question the DG has asked the group to, many of these were covered in the discussion today. A written statement on Items 8 and 9 (page 36) will need to be provided by the chair, so there was a request for the group to consider these questions further before Thursday's meeting. It was noted that Peter will work with Pippa on drafting responses to these questions.
7.0	**Any Other Business** No other business discussed.
8.0	**Agenda Items for Next Meeting** The meeting scheduled for Thursday will focus on the Decision to Use Framework, any relevant conditions attached to provisional approval of the Pfizer vaccine by Medsafe (if this is the decision), and confirming answers to the questions outlined in the memo to the Vaccine TAG (see item 6 of these minutes).
9.0	**New Action Items Raised During Meeting**

Action #	Agenda item	Actions	Action Owner
01	Role of the COVID-19 IIAG	Standing agenda item to be added: Update from IIAG	Chair
02	Pfizer Vaccine Science Overview	A3 overview to be sent to the group, including new members	Dr Pippa Scott
03	Questions on the Pfizer Vaccine	Group to consider questions under items 8 and 9 (in the memo to the Vaccine TAG) for further discussion on Thursday.	All
04	Questions on the Pfizer Vaccine	Prof McIntyre to work with Dr Scott on drafting responses to these questions.	Prof Peter McIntyre Dr Pippa Scott

Meeting closed at **12:00pm**

Next meeting **Thursday 04 February 2021 – 8:30am to 9:30am**

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Open Actions:

Action #	Agenda item	Actions	Action Owner	Updates	Status
01	Role of the COVID-19 IIAG	Standing agenda item to be added: Update from IIAG.	Chair	02/02 - Action raised	Open
02	Pfizer Vaccine Science Overview	A3 overview to be sent to the group, including new members.	Dr Pippa Scott	02/02 - Action raised	Open
03	Questions on the Pfizer Vaccine	Group to consider questions under items 8 and 9 (in the memo to the Vaccine TAG) for further discussion on Thursday.	All	02/02 - Action raised	Open
04	Questions on the Pfizer Vaccine	Prof McIntyre to work with Dr Scott on drafting responses to these questions.	Prof Peter McIntyre Dr Pippa Scott	02/02 - Action raised	Open

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MINUTES: COVID-19 Vaccine Technical Advisory Group (CVTAG)

Date:	Thursday 04 February 2021
Time:	8:30am to 9:30am
Location:	s 9(2)(k)
Chair:	Dr Ian Town
Members:	Prof David Murdoch, Prof Peter McIntyre, Dr Nikki Turner, Dr Nikki Moreland, Assoc Prof James Ussher, Dr Pippa Scott, Dr Tony Walls, Dr Sean Hanna, Dr Elizabeth Wilson
Ministry of Health Attendees:	Dr Caroline McElnay, Daniel Bernal, Sarah Mitchell, Fiona Callaghan
Guests:	Amy Auld; Kris Golding
Apologies:	Assoc Prof Sue Crengle, Dr Matire Harwood, Chriselle Braganza, Dr Helen Petousis-Harris, Dr John Taylor, Prof Ian Frazer

1.0	**Welcome, introductions and previous minutes** Dr Ian Town welcomed all Members, Attendees and Guests in his capacity as Chair of the COVID-19 Vaccine Technical Advisory Group (CVTAG). Minutes of the last meeting (02 February 2021) were accepted. Members were asked to send any edits to CVTAG Secretariat. The primary purpose of the meeting was outlined: to make recommendations to the Director-General about the Decision to Use the Pfizer vaccine and conditions under which it should be used. It was noted that Medsafe's provisional approval of the Pfizer vaccine included 57 conditions, mostly related to manufacturing and batch quality assurance.
2.0	**COVID-19 IIAG Update** IIAG is meeting on 5 February, and an update will follow. They will be discussing the same questions regarding immunisation targets
3.0	**Pfizer Vaccine Science Overview** Dr Scott to add the additional safety information discussed in the meeting into the Science overview.
4.0	**Decision to Use**

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	The conditions from the provisional approval from Medsafe relevant to discussion for this group were outlined (copied below), and the group agreed the conditions were as expected (these are confidential). The sponsor (Pfizer) must: • Provide updated stability data for ALC-0159. Due date: July 2021. Interim report: April 2021 • Provide any reports on the duration of efficacy and the requirement for booster doses within five working days of these being produced. • Provide the six months analysis data from Study C4591001. Report due: April 2021. • Provide any reports on efficacy including asymptomatic infection in the vaccinated group, vaccine failure, immunogenicity, efficacy in population subgroups and results from post-marketing studies, within five working days of these being produced. • Provide the final Clinical Study Reports for Study C4591001 and Study BNT162-01 within five working days of these being produced. • Provide Periodic Safety Update Reports according to the same schedule as required by the EMA. • Provide monthly safety reports, as well as all safety reviews they conduct or become aware of. • Perform the required pharmacovigilance activities and interventions detailed in the agreed RMP and any agreed updates to the RMP. An RMP should be submitted at the request of Medsafe or whenever the risk management system is modified, especially as the result of new information being received that may lead to a significant change to the benefit/risk profile or as the result of an important milestone being reached. The decision to use document will be drafted following this meeting.
5.0	**Patient information sheet and data sheet** The chair asked if anyone had concerns to raise about either document. • The data sheet notes that the frequency of anaphylaxis is not known, however we do have some information about this (e.g. originally thought to 11 x higher than background rate, and we know have some updated numbers) Action – to ask Medsafe to include more specific information here. Updated data from VAERS indicates anaphylaxis rate is 5 per million. This phase 4 safety data needs to be disseminated. • There has also been a study on older patients up to 30 days after vaccination, the results were reassuring regarding giving the vaccine to older frail patients. • It was noted that common reactions are very common, and this needs to be acknowledged. • There was discussion around the recommended observation times following vaccination. • Noted that Vaccine safety datalink (VSD) data (which is the most reliable as it is active surveillance) is not reporting a major anaphylaxis signal associated with the vaccine. • Question was therefore raised whether 30-minute wait times is unnecessarily conservative • The general sense was that updated safety data is reassuring, but NZ will continue with a precautionary 30-minute observation time, at least initially. Can reflect after initial experience. • There was discussion about whether allergy screening checklists could be shortened in light of this updated safety data. IAC to continue to fine tune screening questions and raise

	questions with the group via email for feedback. It was seen as very important to keep history of asthma as a screening question, and possibly history of allergy to medications. • The importance of ensuring people wait the full 30 minutes was highlighted. • It was noted that information materials will be going to Unions in the next day, so important to confirm wait times etc as soon as possible.
5.0	**Questions on the Pfizer Vaccine** It was noted that precautions need to be clear, but there are few contra-indications. Draft responses to the questions were discussed. The D-G requires specific statements about what is being recommended, with explanatory notes to go in a footnote or appendix. It was noted that all advice is qualified by monitoring new data and therefore may change over time. Responses to these questions are due mid-afternoon today. Key points for incorporation into responses: • Taking immune checkpoint inhibitors was generally agreed to be contra-indication • Note to name the 4 checkpoint inhibitors approved in NZ • Noted however that UpToDate do not consider these medications to be a contra-indication. • Consultation with Edwin Reynolds was recommended. • Confirmed at this stage the vaccine is to be given to people 16 years of age and older. Though noting if there was an outbreak in high schools, vaccination in this age group could be considered. Pregnancy was seen as a precaution but not necessarily a contra-indication. • Noted that Israel is offering the vaccine to pregnant women. • It was generally thought there is no reason the vaccine would cause a problem in pregnancy, but there is limited data. • The issue of the risk of fever in pregnancy, particularly first and early second trimester, was raised. Further investigation of fever rates and thresholds may be warranted (if the vaccine is usually associated with only low-grade fever this would be less of a concern). • The group thought the vaccine should be recommended for lactating women, though at this stage it is unknown whether it would be excreted in breastmilk. • VAERS study increases confidence re giving the vaccine to the elderly
6.0	**COVID-19 Immunisation Target** Ministers have requested advice regarding immunisation targets. This paper is due Friday 5 Feb. Key points from discussion: • Lack of information about duration of immunity and efficacy in reducing transmission makes it very difficult to recommend a specific numerical target. From first principles, you would expect some reduction in transmission, but it is unlikely to be equal to the effectiveness of the vaccine in reducing severe disease (as assumed by the modelling). AstraZeneca vaccine recently had some information about reduced transmission of approximately 70%, and would expect mRNA vaccine to be even better

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	• Noted that COVID-19 immunisation campaign could disrupt normal immunisation programme delivery, and there should be proactive surveillance of usual vaccination practices to ensure that GP practices are coping with increased demand. Group was reassured that this issue is being worked on by the Ministry and they will receive a report back on this topic • Need for improved vaccine registers was noted. This is actively being pursued by a team of IT specialists in the Vaccine Programme. • Noted that the table in Appendix 1 from the modellers has a large number of caveats, and the estimates are likely to be over-optimistic – if this table is kept in the document, it should be strongly emphasized that these estimates are best case scenarios. Some recommended removing the table altogether and noted other modelling is available that is more nuanced. • Risks of pushing the population/herd immunity concept – e.g. people may be more inclined to rely on others to take the vaccine • Advice should focus more of the benefits of individual protection rather than trying to predict a percentage required to achieve herd immunity, which has many unknowns • However, the concept of encouraging personal vaccination to protect one's family should not be completely lost – there is likely to be some protection of others and protection of whanau is an important NZ concept • Noted that a time frame is needed for any suggested target – this will be 2021 calendar year in the first instance. • Meeting any target will be dependent on timely arrival of vaccines into the country • Recommend emphasising two sentences quoting Paul Fine et al (2011)[1] at the start of the document: "Theory provides a useful background, but managers of vaccination programs face many nontheoretical problems in attempting to protect populations. Managers must be wary of target thresholds for vaccination, insofar as thresholds are based on assumptions that greatly simplify the complexity of actual populations. In most circumstances, the sensible public health practice is to aim for 100% coverage, with all the doses recommended, recognizing that 100% is never achievable, hoping to reach whatever is the ''real'' herd immunity threshold in the population concerned." • When it comes time for general population rollout, equity for Māori and Pacific peoples will be a key focus • The group recommended aiming to vaccinate all eligible New Zealanders
6.0	**Any Other Business** No other business discussed.
7.0	**Agenda Items for Next Meeting** No agenda items for next meeting were discussed.

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[1] Paul Fine, Ken Eames, David L. Heymann, "Herd Immunity": A Rough Guide, *Clinical Infectious Diseases*, Volume 52, Issue 7, 1 April 2011, Pages 911–916, https://doi.org/10.1093/cid/cir007

8.0	New Action Items Raised During Meeting			
	Action #	**Agenda item**	**Actions**	**Action Owner**
	04	Questions on the Pfizer Vaccine	Consultation with Edwin Reynolds re immune checkpoint inhibitors	Dr Nikki Turner
	05	Patient information sheet and data sheet	Ask Medsafe to include more specific information re anaphylaxis in data sheet	Chair

Meeting closed at **9:25am**

Next meeting: **To be confirmed**

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Open Actions:

Action #	Agenda item	Actions	Action Owner	Updates	Status
04	Questions on the Pfizer Vaccine	Consultation with Edwin Reynolds re immune checkpoint inhibitors	Dr Nikki Turner	04/02 - Action raised	Open
05	Patient information sheet and data sheet	Ask Medsafe to include more specific information re anaphylaxis in data sheet	Chair	04/02 - Action raised	Open

Closed Actions:

Action #	Agenda item	Actions	Action Owner	Updates	Status
01	Role of the COVID-19 IIAG	Standing agenda item to be added: Update from IIAG.	Chair	02/02 - Action raised 03/02 – Agenda updated	Closed
02	Pfizer Vaccine Science Overview	A3 overview to be sent to the group, including new members.	Dr Pippa Scott	02/02 - Action raised 03/02 – Document distributed	Closed
03	Questions on the Pfizer Vaccine	Prof McIntyre to work with Dr Scott on drafting responses to these questions.	Prof Peter McIntyre Dr Pippa Scott	02/02 - Action raised 04/02 – Action closed	Closed

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MINUTES: COVID-19 Vaccine Technical Advisory Group

Date:	Friday 19 February 2021
Time:	9:00am to 10:30am
Location:	s 9(2)(k)
Chair:	Dr Ian Town
Members:	Prof David Murdoch, Dr Elizabeth Wilson, Dr Helen Petousis-Harris, Assoc Prof James Ussher, Dr John Taylor, Dr Nikki Moreland, Dr Nikki Turner, Prof Peter McIntyre, Dr Pippa Scott, Dr Sean Hanna, Assoc Prof Sue Crengle, Dr Tony Walls
Ministry of Health Attendees:	Daniel Bernal, Dr Juliet Rumball-Smith, Sarah Mitchell, Fiona Callaghan, Chriselle Braganza, Niki Stefanogiannis, Aoife Kenny, Kristen Davison, Andi Shirtcliffe
Guests:	Fran Priddy, Tim Hanlon
Apologies:	Dr Caroline McElnay, Prof Ian Frazer, Dr Matire Harwood

1.0	**Welcome and previous minutes** Dr Ian Town welcomed all Members, Attendees and Guests in his capacity as Chair of the COVID-19 Vaccine Technical Advisory Group (CV TAG). Minutes of the last meeting (04 February 2021) were accepted subject to the following correction being made to Item 5: s 9(2)(g)(i) • Taking immune checkpoint inhibitors was identified as a precaution rather than a contraindication for receiving the Pfizer BioNTech vaccine. These patients should consult a specialist. • The four immune checkpoint inhibitors approved in New Zealand should be specifically named
2.0	**Overview of Immunisation Roll Out** The Chair acknowledged the rushed nature of the Pfizer Decision to Use meeting and explained that notes from that meeting were included in the Cabinet paper, following which the decision to use was approved. There was a misunderstanding by the media team between the terminology “contraindication” and “should not use”, with the latter being incorrectly translated into the advice. The Ministry has since worked to ensure that the correct material is published in the future.

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	With regards to immunisation targets, the language is shifting. The DG has now said that the target is "as many eligible New Zealanders as possible". This includes border and health care workers in Tier 1. Tier 2 and 3 of the immunisation rollout have been reframed through a treaty and equity lens and a massive effort has gone into this space, with the IIAG also considering these issues. • There was a comment that not having a numerical target may mean that if there are lower rates of uptake by Māori, this may be incorrectly attributed to vaccine hesitancy rather than systemic issues. The Chair noted that reporting frameworks will be in place and that tailored and bespoke initiatives will be carried out to encourage uptake by various communities in different regions.
3.0	**Science Updates** The purchase of four vaccines means that there is an opportunity for sequencing, contingent on global safety monitoring of the vaccines. There will need to be careful consideration around the messaging about vaccines so that people don't feel like they are getting a second-rate vaccine. The science summaries on the four candidates have all been updated and will be provided to the steering group on Tuesday. The summaries will continue to be updated and date stamped as needed. A recent conversation with Oxford University gave insight into their strong commitment to clarifying the dosing interval and making further improvements to the AstraZeneca vaccine. It was noted that it would be useful for the summaries to contain: • A comment on the number of people in each race/ethnic group as some of this data is available in the publications. • A description about how disease severity is classified or an overarching comment to highlight the lack of uniform classification of severity. Some companies define severe disease as a respiratory rate over 30, but hospitalisation is probably the clearest indicator of severity. In addition, participants in vaccine trials are often young, and don't tend to get severe disease very often, so event rates are low in absolute terms. • A description of the nature of the antigen (e.g. whether it is pre-fusion). Any reactogenic events that impact the ability to attend work Members of the CV TAG were asked to send any edits to Dr Scott to finalise and be signed off by the Chair by Monday lunchtime These summaries will be made available to Ministers. It was suggested that a document summarising the caveats and limitations across all vaccines might be useful as a cover sheet for the science updates. The chair agreed this should be done. It was noted that a recent pre-print about the AstraZeneca vaccine showed that neutralisation was virtually absent against the South African variant. Concern was raised that the vaccine may not be able to prevent severe disease for B.1.351. It was also noted that there is almost no sequencing carried out in Brazil, with regards to the P.1 or P.2 variant particularly.
4.0	**Vaccines for Children** Dr Scott provided an overview of the children and adolescent trials planned by various vaccine developers, including those that New Zealand has not purchased. The Ministry has approached the four vaccine developers to seek more information on any planned trials in children and is awaiting responses from AstraZeneca, Pfizer and Novavax. There is a high level of Ministerial interest in the age cut offs for COVID-19 vaccines. Currently it appears that data will emerge for 12-16-year olds over time, but it is uncertain if there will be significant data for younger children. Key points from the discussion:

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	• There is no precedent to think that investigation in younger subjects will be an issue. For every recent inactivated vaccine, younger people have responded more robustly, but without additional safety concerns. • However, the group expressed concern about the idea of vaccinating infants (Janssen has a trial, not yet in the public database, where they plan to vaccinate newborns and upwards). We are not in a position to be recommending COVID-19 vaccines for infants or very young children. • As a group, we may need to make a statement regarding whether children need to be vaccinated ahead of any data being available, which will prevent discrimination against children and help answer questions families may raise about which children should and shouldn't be vaccinated. • It is unlikely that we might see different safety concerns in children down to age 12, we are likely to get more information from lower ages (e.g. down to age 6). It would be great to get data about primary age children, but it seems unlikely that most companies will conduct trials in children under 12.
5.0	**Pillar 7 Activities** **5.a - Adverse Event Committee** • Tim Hanlon gave an overview of Pillar 7 activities. Given the volume of vaccines that will be administered and the reactogenicity associated with these vaccines, the passive reporting may become overwhelming. • Part of the programme is to support the Centre for Adverse Reactions Monitoring (CARM) to make sure it is as ready as possible. The Ministry is working with Medsafe and CARM on various infrastructure improvements, including digitising workflow and putting the database into the cloud, which will have a lasting impact on the way CARM operates. • The COVID Immunisation Register (CIR) that will be used for the vaccine rollout will include adverse events during the 30-minute observation period following immunisation. Adverse events after the observation period will be reported via an electronic form. All of this data will be pulled into a portal, which CARM will have access to. • The reporting of raw data will be real time. However, the raw data requires proper interpretation. CARM will require advice around more serious events and a COVID-19 Vaccine Independent Safety Monitoring Board (ISMB) has been established for this purpose. The Ministry is currently working on the TOR and membership to ensure minimal conflict of interest. The Chair of the CV TAG will sit on ISMB in an *ex officio* capacity. The Chair of the COVID-19 Vaccine Independent Safety Monitoring Board is John Tate (Chief Medical officer at CCDHB). **5.b - Research Projects** Fran Priddy gave a brief overview of the observational cohort study proposed by VAANZ. The study would be funded by MBIE. The purpose of the study is to look at safety and immunogenicity of vaccines in New Zealanders. It would be useful to characterise safety early on and share this information publicly. There could be some differences in immune responses, which will be interesting. The study will look at immune responses for about a year and will include 250 people per vaccine, with enrichment of Māori/Pacific populations. There will be biobanking of specimens, which will allow for additional studies. Key points of discussion: • Māori and Pacific populations can be quite different. It will be important to separate those groups out further.

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	• BMI is an issue with Pacific populations, particularly with regards to responsiveness and injection. • It would be useful to look at any concomitant delivery within the study. • For measuring immunogenicity, it will be important to use assays that can be expressed in the WHO international units so that the data can be internationally comparable. • It would be good to use the sera to test against variants of concern. • As part of our Te Tiriti obligations, we need to have Māori involved in this process. Dr Priddy will work with Andi Shirtcliffe to ensure this. The Chair recommended that the study look at outcomes in Māori and Pacific, which is a fundamental Ministry expectation, followed by potential future work that can add to international literature. Overall, there was consensus that the CV TAG supports this programme.
6.0	**Baseline Survey of Adverse Events** This work is being undertaken to establish baseline rates of conditions that might be of special interest. The work is on target to achieve first deliverables to Medsafe and The Ministry by April. The list of special interests keeps growing and consequently has been narrowed down to a manageable list for now, which allows for rapid testing of sensitivity and specificity of the codes. This work is being carried out in collaboration with the chief clinical coder at the Ministry, as well as epidemiologists. It was noted that the baseline rates for pregnancy have been established as part of a previous maternal study. This work is being led by Dr Helen Petousis-Harris at the University of Auckland on contract to the Ministry.
7.0	**Using Pfizer/BioNTech Vaccine as Post-exposure Prophylaxis in a COVID-19 Outbreak** Aoife Kenny gave an overview of the memo and requested feedback from members of the CV TAG to advise the DG, so that a position statement could be prepared. Key points of discussion: • It was noted that post-exposure prophylaxis is generally for long incubation diseases. However, there needs to be clear differentiation between ring vaccination and post-exposure prophylaxis. • There is a real risk that New Zealand could have cluster outbreaks and we should have a protocol for managing these outbreaks. The Chair suggested shortening the advice to not use Pfizer for post-exposure prophylaxis, to add a commitment to develop a formal approach to cluster management, and to strengthen the section on ring vaccination with inclusion of a case study.
8.0	**Any Other Business** It would be good to have a landscape review of the all the studies underway on key questions (proposed by Dr Nikki Turner).
9.0	**Agenda Items for Next Meeting** 1. Concomitant delivery of vaccines (Dr Nikki Turner) 2. Proactive position statement on vaccinating children (Prof. Peter McIntyre, Dr Tony Walls, Dr Elizabeth Wilson)
	New Action Items Raised During Meeting

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Action #	Agenda item	Actions	Action Owner
06	Overview of Immunisation rollout	Include information on respiratory vaccine side-reactions in the post-vaccination information sheet	STA Team
07	Vaccines for Children	Provide a written summary of the current state of trials planned in children	Dr Pippa Scott
08	Vaccines for Children	Work towards a proactive position statement on vaccinating children	Prof. Peter McIntyre Dr Tony Walls Dr Elizabeth Wilson
09	Using Pfizer/BioNTech Vaccine as Post-exposure Prophylaxis in a COVID-19 Outbreak	Amend the memo to include suggestions by the Chair and circulate to CV TAG	Aoife Kenny
10	Pillar 7 Activities 5.a - Adverse Event Committee	Circulate the TOR and membership for the COVID-19 Independent Safety Monitoring Board	Tim Hanlon
11	Baseline Survey of Adverse Events	Provide a brief written report on progress of the work	Dr Helen Petousis-Harris

Meeting closed at **10:30am**

Next meeting: **To be confirmed**

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Open Actions:

Action #	Agenda item	Actions	Action Owner	Updates	Status
04	Questions on the Pfizer Vaccine	Consultation with Edwin Reynolds re immune checkpoint inhibitors	Dr Nikki Turner	04/02 - Action raised	Open
05	Patient information sheet and data sheet	Ask Medsafe to include more specific information re anaphylaxis in data sheet	Chair	04/02 - Action raised	Open
06	Overview of Immunisation rollout	Include information on respiratory vaccine side-	STA Team MoH	19/02 - Action raised	Open

		reactions in the post-vaccination information sheet			
07	Vaccines for Children	Provide a written summary of the current state of trials planned in children	Dr Pippa Scott	19/02 - Action raised	Open
08	Vaccines for Children	Work towards a proactive position statement on vaccinating children	Prof. Peter McIntyre Dr Tony Walls Dr Elizabeth Wilson	19/02 - Action raised	Open
09	Using Pfizer/BioNTech Vaccine as Post-exposure Prophylaxis in a COVID-19 Outbreak	Amend the memo to include suggestions by the Chair and circulate to CV TAG	Aoife Kenny	19/02 - Action raised	Open
10	Pillar 7 Activities 5.a - Adverse Event Committee	Circulate the TOR and membership for the COVID-19 Independent Safety Monitoring Board	Tim Hanlon	19/02 - Action raised	Open
11	Baseline Survey of Adverse Events	Provide a brief written report on progress of the work	Dr Helen Petousis-Harris	19/02 - Action raised	Open

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MINISTRY OF HEALTH
MANATŪ HAUORA

MINUTES: COVID-19 Vaccine Technical Advisory Group

Date:	Tuesday 02 March 2021
Time:	12:30pm to 2:00pm
Location:	s 9(2)(k)
Chair:	Ian Town
Members:	David Murdoch, Elizabeth Wilson, Ian Frazer, James Ussher, John Taylor, Nikki Moreland, Nikki Turner, Peter McIntyre, Pippa Scott, Sean Hanna, Tony Walls
Ministry of Health Attendees:	Caroline McElnay, Juliet Rumball-Smith, Fiona Callaghan, Chriselle Braganza
Guests:	Kristen Davison
Apologies:	Helen Petousis-Harris, Matire Harwood, Sue Crengle, Daniel Bernal, Aoife Kenny

1.0	**Welcome and previous minutes** Ian Town welcomed all Members, Attendees and Guests in his capacity as Chair of the COVID-19 Vaccine Technical Advisory Group (CV TAG). Minutes of the last meeting (19 February 2021) were accepted. Members were asked to send any edits to CV TAG Secretariat. The Chair signalled that the Secretariat is trying to organise a regular schedule for the CV TAG meetings moving forward, which will most likely be an hour slot on Tuesdays. This will be a placeholder slot and will be cancelled if there is no need for the CV TAG to meet that week.
2.0	**Science Updates** The Chair noted that the science summary documents are being updated periodically and were circulated for information. Members were asked to send any updates to Dr Scott to include into the next version.
3.0	**Research in Children** The Chair noted that the summary of trials in children is being updated as more information comes to light. Members were thanked for their feedback and input to the summary document.
4.0	**Vaccines in Pregnancy** The Chair explained that the maternity team within the Ministry will be reporting to Minister Verrall, the Minister for maternity services, on this matter. The Ministry in conjunction with IMAC has prepared information for women who may need support in making a decision to receive a COVID-19 vaccine. Discussion included: • It was noted that the Australian Government has a good decision support checklist for pregnant women.

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	• IMAC has put together an advisory sheet that has recently been circulated to the College of obstetricians and midwives. • It would be important to make sure that the language in this sheet matches that of the Ministry so that we have the clearest possible guidance. It will also be important to have the advice in line with RANZCOG recommendations. Members were asked to send any final comments to the TAG Secretariat by COB today.
5.0	**Vaccine Sitrep** A daily report is sent to the Ministers office that contains summary information on how many people are being vaccinated daily, any vaccination trends, and the number of vaccinators. • The Chair noted that the daily vaccination report will be made available to the CV TAG members. The Ministry is aiming to have a live dashboard internally.
6.0	**Vaccine Deployment in an Outbreak** Kristen Davison provided an overview of the vaccine deployment paper. Comments and feedback from the last meeting were incorporated into the revised version and a request was made for further advice on the use of the Pfizer vaccine in an outbreak situation. The paper has shifted away from focus of using the vaccine as post-exposure prophylaxis and now focuses more on ring vaccination. The Chair noted that the discussion points from this meeting would be collated to inform recommendation to the DG. • Increasing amounts of data are showing that a single dose of the Pfizer vaccine provides some protection as early as 12 days post immunisation, it would be good to have some modelling around this. There are also data showing that the second dose doesn't need to be given after 3 weeks and it may be better to delay the second dose further. Overall, the priority in a major outbreak would be to get the initial dose to as many people in the target population as possible rather than calling people back for their 2nd dose. • There was discussion around potential merit from geographical prioritisation rather than risk-based sequencing, which will feed into decision making around processes for mass immunisation versus outbreak response. We will need a clear strategy with several deliveries where multiple constraints such as vaccine supply have to be considered to address this both nationally and locally. • Discussions have begun with Pfizer to request accelerated delivery to support early roll out. • Australia is still at the beginning of their rollout focussing on healthcare and frontline workers, and people aged 80+. There has been no suggestion of vaccines being held back for an outbreak. • There is data starting to come out on vaccine efficacy against transmission, e.g. Moderna shows around 61% reduction in transmission. Data from Pfizer is expected shortly. • There was discussion about a recent publication from Israel regarding asymptomatic transmission. It is important to note that the Israel experience is quite different to the rollout in the UK. • The overall thinking of experts in the field is that the vaccine will reduce transmission significantly. This thinking is being incorporated into the communication campaign, which builds on promoting self-protection but also contributing towards preventing transmission in the community. • The topic of geographic prioritisation has been discussed by Peter McIntyre with Fran Priddy (VAANZ) as an opportunity to undertake an informative study.

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7.0	**Vaccine Sequencing** The Chair gave a brief overview on this topic. Cabinet discussed vaccine sequencing yesterday and are reviewing the work going into Tier 2. However, there are a number of conflicting priorities including geographic priorities and high-risk populations. The Chair will keep CV TAG informed on Cabinet's thinking in this area.
8.0	**30-Minute Observation Time Post Vaccine** CV TAG members considered a request from the CV Immunisation Programme to review the 30-minute observation period requirement post vaccination. Discussion at the meeting identified three options for consideration: a) Continue to require a 30-minute observation period with an intention to review after 1 month based on operational experience and data available at that time; or b) Reduce the observation period to 20 minutes for people with no history of immediate allergic reaction or anaphylaxis, and utilise a 30 minute observation period for those at higher risk of this event (i.e. who have a history of hypersensitivity to vaccines or any injectable therapy, or of anaphylaxis due to any cause, including those who have a prescribed adrenalin autoinjector);* or c) Reduce the observation period to 20 minutes as a standard practice, with vaccinators encouraged to be flexible around the need for a longer period in some circumstances (e.g. if the person lives in a rural/remote area). * * Note that this advice would not apply to those who experienced anaphylaxis following the first dose of the Pfizer vaccine - who should not be given a second dose - and those with known hypersensitivity to any of the vaccine excipients for whom the vaccine is contraindicated. **Recommendation:** CV TAG advised that option (c) should be implemented.
9.0	**Concomitant Delivery of Vaccines** Nikki Turner gave an overview of the situation around concomitant delivery of vaccines. There was a pragmatic call at the start that it would be sensible to separate different vaccines by two weeks because there is no data available on this matter. This recommendation was given because we do not want to mix up which vaccine causes the side effects profile. While there is also a theoretical possibility for vaccine blunting, this would be minimal given the high performance of the vaccines. However, this advice was applied very diligently by the sector, almost as a contraindication for other vaccines. Consequently, we need clearer advice and consensus on the following points: • If it is not practicable to keep a two-week gap between vaccines, then do not delay. • If a live vaccine has been administered, wait a month before giving a COVID-19 vaccine but if not practicable, then do not delay. • If a COVID-19 vaccine is administered first, then maintain a two-week gap before any other vaccines. Key discussion points: • There has not been much discussion in Australia about this as there is no data for these vaccines being given concomitantly. • Some questions were raised about whether a COVID-19 vaccine could be administered after being infected with COVID-19, and the timing of dosage for effective protection. The Chair noted that these questions are being considered and will be discussed in future meetings.

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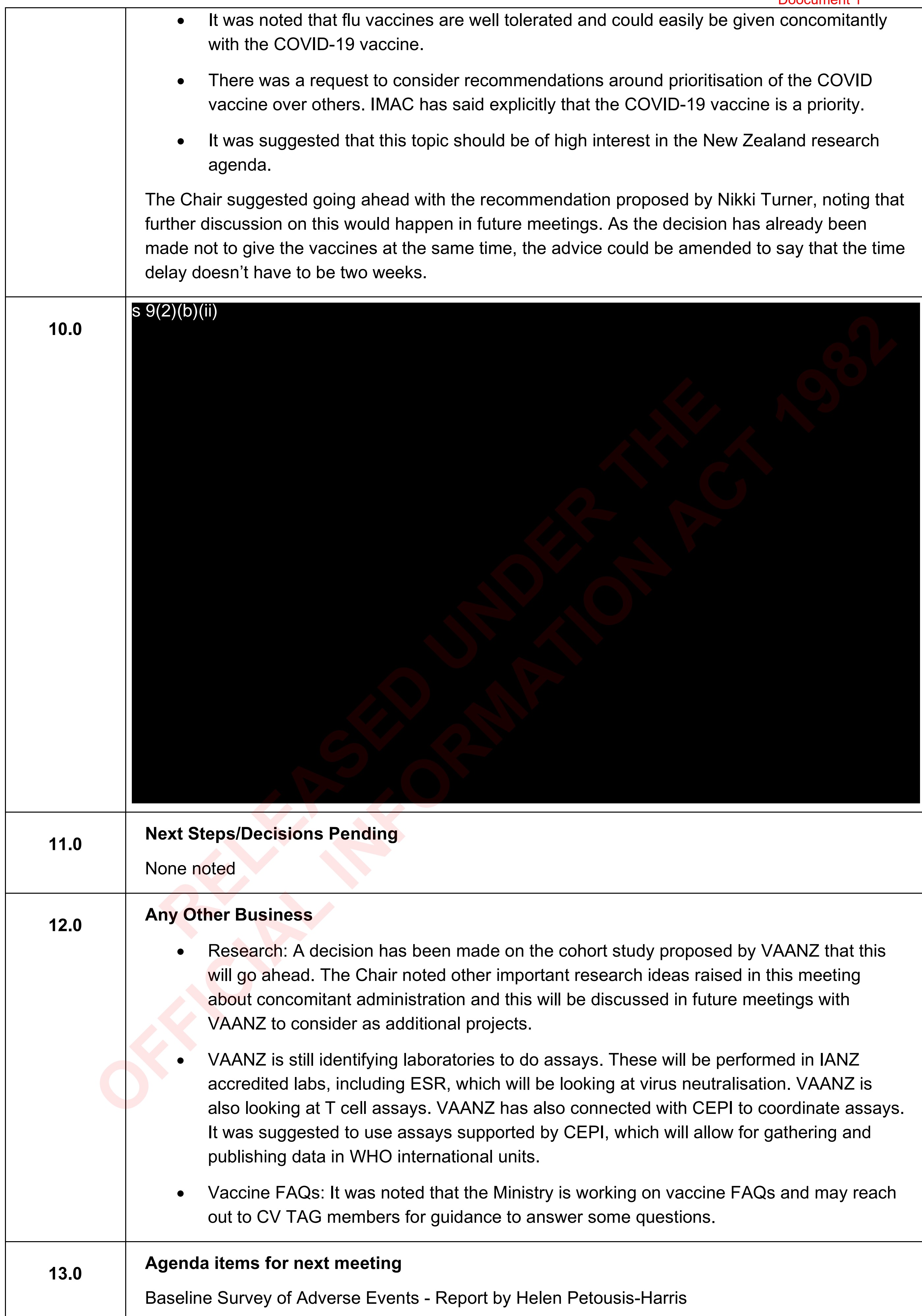

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	• It was noted that flu vaccines are well tolerated and could easily be given concomitantly with the COVID-19 vaccine. • There was a request to consider recommendations around prioritisation of the COVID vaccine over others. IMAC has said explicitly that the COVID-19 vaccine is a priority. • It was suggested that this topic should be of high interest in the New Zealand research agenda. The Chair suggested going ahead with the recommendation proposed by Nikki Turner, noting that further discussion on this would happen in future meetings. As the decision has already been made not to give the vaccines at the same time, the advice could be amended to say that the time delay doesn't have to be two weeks.
10.0	s 9(2)(b)(ii)
11.0	**Next Steps/Decisions Pending** None noted
12.0	**Any Other Business** • Research: A decision has been made on the cohort study proposed by VAANZ that this will go ahead. The Chair noted other important research ideas raised in this meeting about concomitant administration and this will be discussed in future meetings with VAANZ to consider as additional projects. • VAANZ is still identifying laboratories to do assays. These will be performed in IANZ accredited labs, including ESR, which will be looking at virus neutralisation. VAANZ is also looking at T cell assays. VAANZ has also connected with CEPI to coordinate assays. It was suggested to use assays supported by CEPI, which will allow for gathering and publishing data in WHO international units. • Vaccine FAQs: It was noted that the Ministry is working on vaccine FAQs and may reach out to CV TAG members for guidance to answer some questions.
13.0	**Agenda items for next meeting** Baseline Survey of Adverse Events - Report by Helen Petousis-Harris

New Action Items Raised During Meeting

#	Agenda item	Action	Action Owner
12	Vaccines in Pregnancy	Send information document to Minister Verrall's office	Chair
13	Vaccine Sitrep	Send report to CV TAG members	Chair
14	Vaccine Sitrep	Check with Intel team whether there will be a publicly facing register	STA Team
15	Concomitant Delivery of Vaccines	Discuss this topic at the COVID Expert Advisory meeting in Australia	Ian Frazer
16	Concomitant Delivery of Vaccines	Talk to Fran Priddy regarding research on this topic	Chair
17	30-Minute Observation Time Post Vaccine	Send revised documentation to CV TAG members	Juliet Rumball-Smith

Meeting closed at **1:40pm**

Next meeting: **Tuesday 09 March – time to be confirmed**

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Open Actions:

#	Agenda item	Action	Action Owner	Updates	Status
08	Vaccines for Children	Work towards a proactive position statement on vaccinating children	Peter McIntyre Tony Walls Elizabeth Wilson	19/02 - Action raised 02/03 - Tony Walls provided an overview of the recommendations, final document will be circulated for consideration.	Open
11	Baseline Survey of Adverse Events	Provide a brief written report on progress of the work	Helen Petousis-Harris	19/02 - Action raised 02/03 - Helen Petousis-Harris to provide a preliminary report at the next CV TAG meeting.	Open
12	Vaccines in Pregnancy	Send information document to Minister Verrall's office	Chair	02/03 - Action raised	Open
13	Vaccine Sitrep	Send report to CV TAG members	Chair	02/03 - Action raised	Open

14	Vaccine Sitrep	Check with Intel team whether there will be a publicly facing register	STA Team	02/03 - Action raised	Open
15	Concomitant Delivery of Vaccines	Discuss this topic at the COVID Expert Advisory meeting in Australia	Ian Frazer	02/03 - Action raised	Open
16	Concomitant Delivery of Vaccines	Talk to Fran Priddy regarding research on this topic	Chair	02/03 - Action raised	Open
17	30-Minute Observation Time Post Vaccine	Send revised documentation to CV TAG members	Juliet Rumball-Smith	02/03 - Action raised	Open

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Closed Actions Since Last Meeting:

#	Agenda item	Actions	Action Owner	Updates	Status
04	Questions on the Pfizer Vaccine	Consultation with Edwin Reynolds re immune checkpoint inhibitors	Nikki Turner	04/02 - Action raised 02/03 - Nikki Turner noted that Edwin is a key expert for adult high-risk groups and recommended that Edwin be considered to join the CV TAG. The Chair accepted the recommendation. Nikki will send the contact details to the Chair.	Closed
05	Patient information sheet and data sheet	Ask Medsafe to include more specific information re anaphylaxis in data sheet	Chair	04/02 - Action raised 02/03 - STA Team to cross-check that the Medsafe data sheet lines with material from the Ministry and IMAC.	Closed
06	Overview of Immunisation rollout	Include information on respiratory vaccine side-reactions in the post-vaccination information sheet	STA Team	19/02 - Action raised 02/03 - Handled directly by clinical leads in conjunction with the immunisation rollout team.	Closed
07	Vaccines for Children	Provide a written summary of the current state of trials planned in children	Pippa Scott	19/02 - Action raised 01/03 - Document included in the agenda for 02/03 meeting	Closed

09	Using Pfizer/BioNTech Vaccine as Post-exposure Prophylaxis in a COVID-19 Outbreak	Amend the memo to include suggestions by the Chair and circulate to CV TAG	Aoife Kenny	19/02 - Action raised 01/03 - Updated memo included in the agenda for 02/03 meeting	Closed
10	Pillar 7 Activities 5.a - Adverse Event Committee	Circulate the TOR and membership for the COVID-19 Independent Safety Monitoring Board	Tim Hanlon	19/02 - Action raised 24/02 – Documents circulated	Closed

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MINISTRY OF HEALTH
MANATŪ HAUORA

MINUTES: COVID-19 Vaccine Technical Advisory Group

Date:	Tuesday 09 March 2021
Time:	11:00am to 12:00pm
Location:	s 9(2)(k)
Chair:	Ian Town
Members:	David Murdoch, Elizabeth Wilson, Helen Petousis-Harris, James Ussher, John Taylor, Nikki Turner, Peter McIntyre, Pippa Scott, Sue Crengle, Tony Walls, Edwin Reynolds, Sean Hanna
Ministry of Health Attendees:	Caroline McElnay, Juliet Rumball-Smith, Daniel Bernal, Fiona Callaghan, Chriselle Braganza, Shayma Faircloth
Guests:	Diana Sarfati, Richard Sullivan
Apologies:	Andi Shirtcliffe, Ian Frazer, Matire Harwood, Nikki Moreland

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1.0	**Welcome and previous minutes** Ian Town welcomed all Members, Attendees and Guests in his capacity as Chair of the COVID-19 Vaccine Technical Advisory Group (CV TAG). Minutes of the last meeting (02 March 2021) were accepted subject to the following correction being made to Item 10: s 9(2)(g)(i) s 9(2)(b)(ii) As things can come up for discussion urgently and unexpectedly, the CV TAG meeting will be a recurring slot in the calendar but will be cancelled if no meeting is required. Dr Edwin Reynolds was co-opted into the CV TAG. Edwin has been working in vaccinology within IMAC for about 12 years, is a GP in Northland, and works for Auckland Regional Public Health in their COVID response space.
2.0	**Science Updates** The Chair thanked Dr Scott for maintaining the science summary documents and requested that the Pfizer document to be updated regularly, particularly with details of any immunogenicity data after a first dose in humans. This will inform any future conversations regarding the degree of protection after a single dose, which may occur in terms of outbreak management.
3.0	**Research in Children**

	The Chair noted that the summary of trials in children will be updated as more information comes to light, especially with regards to any data on the Pfizer candidate.
4.0	**Vaccine Guidance to Cancer Clinicians** The Cancer Control Agency (CCA) is a standalone organisation that provides advice in relation to cancer, which is independent from the Ministry. However, the CCA wants to ensure that their COVID immunisation advice is in line with the Ministry. • There has been a lot of work done in relation to immune checkpoint inhibitors (ICIs), both nationally and internationally. The CCA is in close contact with international colleagues and has access to data and information that is not yet published, which is very helpful as more evidence is emerging. • The Chair apologised for the conflicting advice that was published by the Ministry's media team, however, this was promptly corrected. • Following Medsafe's approval of the Pfizer vaccine, CV TAG advised on the decision to use the Pfizer vaccine. It was advised that patients receiving ICIs Pembrolizumab, Nivolumab, Ipilimumab or Atezolizumab should get advice from their specialist in relation to receiving the Pfizer vaccine. Today's discussion is to determine whether this remains the best advice or whether there is any information to consider amending this advice. • There is no data indicating that immune therapy or ICIs should be a contraindication. There is some data showing that inactivated vaccines are safe for cancer patients, however, there very little data for the Pfizer vaccine. Considering the available data, the CCA's view on this matter is that cancer patients should not risk being left out and instead should be supported to take the vaccine. Some subgroups, such as haematology and lung cancer patients, have been shown to be more vulnerable to COVID-19 and could be prioritised, however this is not a suggestion for now. • In December 2017, Medsafe alerted IMAC about the possibility of an interaction between the flu vaccine and ICIs. However, this was never considered as a contraindication but was added as a precaution in the handbook because there was little data at the time. Nurses administering any subunit vaccine would generally be in contact with the oncologist to make sure it was okay. A systematic review of studies evaluating influenza vaccines and patients receiving ICIs has recently been published. The studies have mostly shown that the vaccines are safe. However, the review concluded that larger studies are required in order to define a consensus on the use of vaccines during immunotherapy. • The CCA would like to see the cautionary advice relating to ICIs removed for both the flu and COVID vaccines on the basis that this has been considered by clinicians around the country and they would like to give patients consistent advice. If not, there is a risk that clinicians might make different decisions. The CCA has also been discussing this matter with colleagues in the UK, Canada and Australia. Amending our advice would lead to consistency within the country and with the rest of world. • Data from Israel and the UK are expected in a few weeks and there has been no indication to be concerned for patients receiving ICIs. • The Chair welcomed any questions or concerns from the CV TAG about removing the cautionary advice in relation to the Pfizer vaccine. There were no questions or objections on this matter and CV TAG members unanimously agreed with the proposed change to the advice. • The Ministry will take steps to remove the cautionary advice from professional and public-facing material.

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	It was noted that it would also be logical to remove any cautionary advice on ICIs in relation to the flu vaccine, for consistency. This will be discussed with the Immunisation team within the Ministry.
5.0	**Baseline Survey of Adverse Events** Helen Petousis-Harris noted that the research into baseline rates of adverse events is going well. Helen will be providing an overview of this research to the Medsafe DSMB meeting. Australia (NCIRS) has established some of their vaccine baseline rates, however, this New Zealand study is more in-depth. Key points of discussion: • Bell's palsy did not seem to be reported in the data presented to ACIP but is being captured as one of the priorities. • The research intends to look at all four tiers but initially had to establish priorities in order to collect data as soon as possible. Limited chart reviews are being carried out to estimate the predictive values of the ICD codes. It would be difficult to perform this on all the conditions, but if something comes up, they will be in a good position to undertake a rapid assessment. The tiers were determined through the Brighton Collaboration. • It was noted that it is often difficult to tease out conditions from each other in Tier 1. The list of ICD codes was harmonised with those from Australia, with advice on neurology also sought for NZ context. Medsafe was also requested to provide raw data to give an idea of many codes are required for each Tier. Helen will provide the summary of research periodically as a monthly report to the CV TAG.
6.0	**Pfizer Dosing Interval** The Manager of the STA Team noted that advice is being prepared with regards to evidence around delaying the second dose of Pfizer and whether there is any value for NZ in delaying the second dose. The STA team recognises that this would delay our rollout, so there is no obvious advantage for NZ to do this regardless of what the evidence says about the effectiveness after one dose. The STA team will prepare a short piece on this topic. The Chair noted that this will be useful, especially with regards to an outbreak situation. Key points of discussion: • Single doses are relevant globally but not for NZ. Since we only have one vaccine to look at currently, there may be some research capacity in this space. As the Pfizer Phase 3 trial and the rollout in Israel adhered to the protocol terms of dosing, further immunogenicity data for delayed doses would be useful. • The Chair noted that the timing currently states at least three weeks to account for any scheduling issues. The STA Team will present the advice being developed at a future meeting for any further discussions on this matter.
7.0	**Vaccine Rollout** The PM has announced that NZ will follow Pfizer strategy for the foreseeable future and was questioned on what this would mean for the other vaccines. Key points of discussion: • Pacific is concerned that approval of the Janssen/J&J vaccine may be less of a priority for New Zealand given the current Pfizer strategy. The Chair noted that discussions are ongoing between New Zealand and the Pacific being led by MFAT but will be escalated internally within the Ministry.

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	• s 9(2)(b)(ii) [redacted] • The PM has announced that the rollout scheduling will be announced on Wednesday as the opposition has been calling for much more detail. The CVIP are working on this to provide clarity, however, the contracting process has not locked in the Pfizer delivery schedule, which is a constraint in terms of the wider rollout. Consequently, the scheduling still lists June/July for the wider rollout, but this could change depending on vaccine availability. • There was discussion around a potential regional rollout, e.g. South Auckland. The Chair noted that the DHBs are leading the rollout and we will see significant and useful prioritisation amongst DHBs as they are very familiar with the demographics in their region. There are also scalability issues that may impact regions differentially. • There was a question regarding whether health professional students would be prioritised similar to healthcare workers. Laboratory and research staff have been prioritised but if there is a particular sector interest, members are welcome to email the Chair to follow up on this.
8.0	**Next Steps/Decisions Pending** None noted
9.0	**Any Other Business** • Change in observation period post-vaccination: The Chair thanked everyone for the prompt work on this matter. This has been sent to the implementation team. The communication and documentation will be amended to reflect this change. • IMAC needs a definitive answer for the change in advice regarding observation period and ICIs. This is needed rapidly to update the training documentation by early next week. The Chair noted that the changes to the ICI advice will be documented and signed-off today and tabled at the meeting this afternoon. • Analysis by Office of the Auditor-General: The OAG has been given two weeks to do an analysis on the Vaccine Taskforce and the Immunisation Implementation Programme. The Chair requested that anyone contacted answer any questions openly. • Logistics for Pfizer: Pfizer has early stability data in ordinary freezer conditions but has not shared this publicly or with Medsafe yet. It would be good to encourage Pfizer to present this data to Medsafe as soon as possible. This would make a big difference towards making a recommendation or decision for vaccines in the Pacific. It was suggested that IIAG contact Medsafe directly and raise the flag about the logistical benefits.
10.0	**Agenda items for next meeting** None noted

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New Action Items Raised During Meeting

#	Agenda item	Action	Action Owner
18	Vaccine Rollout	Contact Medsafe about progress of Janssen approval	STA Team
19	Vaccine Guidance to Cancer Clinicians	Talk to the Immunisation team regarding removal of cautionary advice on ICIs for the flu vaccine	Caroline McElnay
20	Any Other Business	Contact Medsafe about stability of Pfizer vaccine	STA Team

Meeting closed at **11.45am**

Next meeting: **Tuesday 23 March – 11:00am to 12:00pm**

Open Actions:

#	Agenda item	Action	Action Owner	Updates
08	Vaccines for Children	Work towards a proactive position statement on vaccinating children	Peter McIntyre Tony Walls Elizabeth Wilson	19/02 - Action raised 02/03 - Tony Walls provided an overview of the recommendations, final document will be circulated for consideration. 09/03 - Tony will circulate the documentation when ready.
18	Vaccine Rollout	Contact Medsafe about progress of Janssen approval	STA Team	09/03 - Action raised
19	Vaccine Guidance to Cancer Clinicians	Talk to the Immunisation team regarding removal of cautionary advice on ICIs for the flu vaccine	Caroline McElnay	09/03 - Action raised
20	Any Other Business	Contact Medsafe about stability of Pfizer vaccine	STA Team	09/03 - Action raised

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Closed Actions Since Last Meeting:

#	Agenda item	Actions	Action Owner	Updates
04	Questions on the Pfizer Vaccine	Consultation with Edwin Reynolds re immune checkpoint inhibitors	Nikki Turner	04/02 - Action raised 02/03 - Nikki Turner noted that Edwin is a key expert for adult high-risk groups and recommended that Edwin be considered to join the CV TAG. The Chair accepted the recommendation. Nikki will send the contact details to the Chair.
05	Patient information sheet and data sheet	Ask Medsafe to include more specific information re anaphylaxis in data sheet	Chair	04/02 - Action raised 02/03 - STA Team to cross-check that the Medsafe data sheet lines with material from the Ministry and IMAC.
06	Overview of Immunisation rollout	Include information on respiratory vaccine side-reactions in the post-vaccination information sheet	STA Team	19/02 - Action raised 02/03 - Handled directly by clinical leads in conjunction with the immunisation rollout team.
07	Vaccines for Children	Provide a written summary of the current state of trials planned in children	Pippa Scott	19/02 - Action raised 01/03 - Document included in the agenda for 02/03 meeting
09	Using Pfizer/BioNTech Vaccine as Post-exposure Prophylaxis in a COVID-19 Outbreak	Amend the memo to include suggestions by the Chair and circulate to CV TAG	Aoife Kenny	19/02 - Action raised 01/03 - Updated memo included in the agenda for 02/03 meeting
10	Pillar 7 Activities 5.a - Adverse Event Committee	Circulate the TOR and membership for the COVID-19 Independent Safety Monitoring Board	Tim Hanlon	19/02 - Action raised 24/02 – Documents circulated
11	Baseline Survey of Adverse Events	Provide a brief written report on progress of the work	Helen Petousis-Harris	19/02 - Action raised 02/03 - Helen Petousis-Harris to provide a preliminary report at the next CV TAG meeting. 08/03 – Included in the agenda for 09/03 meeting
12	Vaccines in Pregnancy	Send information document to Minister Verrall's office	Chair	02/03 - Action raised

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				03/03 – Action completed
13	Vaccine Sitrep	Send report to CV TAG members	Chair	02/03 - Action raised 08/03 – Included in the agenda for 09/03 meeting
14	Vaccine Sitrep	Check with Intel team whether there will be a publicly facing register	STA Team	02/03 - Action raised 03/03 – Action completed
15	Concomitant Delivery of Vaccines	Discuss this topic at the COVID Expert Advisory meeting in Australia	Ian Frazer	02/03 - Action raised 09/03 - Ian Frazer was an apology for this meeting and may provide an update at the next meeting.
16	Concomitant Delivery of Vaccines	Talk to Fran Priddy regarding research on this topic	Chair	02/03 - Action raised 09/03 - The initial research proposed by VAANZ has been approved in principle. The Chair will notify CV TAG on whether there is any additional funding to research these topics.
17	30-Minute Observation Time Post Vaccine	Send revised documentation to CV TAG members	Juliet Rumball-Smith	02/03 - Action raised 03/03 – Action completed

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MINISTRY OF HEALTH
MANATŪ HAUORA

MINUTES: COVID-19 Vaccine Technical Advisory Group

Date:	Tuesday 23 March 2021
Time:	11:00am to 12:00pm
Location:	s 9(2)(k)
Chair:	Ian Town
Members:	David Murdoch, Elizabeth Wilson, Helen Petousis-Harris, James Ussher, Nikki Moreland, Pippa Scott, Sean Hanna, Sue Crengle, Tony Walls
Ministry of Health Attendees:	Andi Shirtcliffe, Caroline McElnay, Daniel Bernal, Juliet Rumball-Smith, Fiona Callaghan, Chriselle Braganza, Shayma Faircloth
Guests:	Fran Priddy, James Harris, Mark Ayson
Apologies:	Edwin Reynolds, Ian Frazer, John Taylor, Matire Harwood, Nikki Turner, Peter McIntyre

1.0	**Welcome and previous minutes** Ian Town welcomed all Members, Attendees and Guests in his capacity as Chair of the COVID-19 Vaccine Technical Advisory Group (CV TAG). Minutes of the last meeting (09 March 2021) were accepted.
	Update on Open Actions • Action 18 – Progress on Jansen approval: The rolling submission is progressing well and Medsafe were expecting the next set of data last week. The current ETA for going to the MAAC (expert advisory group) is mid-April. It is worth noting that US FDA and Health Canada have granted Emergency Use Authorisation whereas Medsafe is assessing for a provisional approval (i.e. a formal approval). At this stage, no one has formally approved Janssen yet. • Action 20 - Stability of Pfizer Vaccine: Medsafe received the data from Pfizer on 8th March. They have assessed the data and have sent questions for clarification of some data points. It is possible that Pfizer sent data to the FDA before anyone else in the world because Pfizer is US based and they have an "us first" agreement.
2.0	**Science Updates** The Chair asked for an update on the AstraZeneca document to reflect today's announcement of the Phase 3 results from the US trial. The summary document will be submitted to the Minister's office later this week. The latest results from the US trial are very encouraging, especially with regards to the recent media around AstraZeneca. Pippa Scott provided a brief description of the update documents and noted that there is little information available around transmissibility. With regards to single dose immunogenicity, there is

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	not much data for the Pfizer vaccine. The Chair noted that everyone who is eligible should be offered two doses of the vaccine as per Medsafe's approval. A recent editorial has been published in the BMJ, which covers the concerns around protection levels associated with a single dose. There may be specific situations internationally that lead to delaying the second dose (e.g., supply issues) but this does not currently apply to NZ. Pippa will also work with Peter McIntyre to document any information from SAGE on these matters.
3.0	**Research in Children & Pregnancy** This document is being updated routinely. Of note is that Pfizer is currently actively enrolling pregnant women for a trial. Tony Walls provided an overview of the recommendations for vaccinating children. It was anticipated that the main areas of questioning would arise around children who are in high school and those with co-morbidities. • High school age (year 9 and above) was chosen as a cut off because in an outbreak situation, the age criteria for vaccination could be extended to include children of high-school age at the discretion of the local public health authority. • The UK have included children who have multiple disabilities because there have been some childhood deaths in this population. If individual clinicians feel strongly or are pressured by parents, decisions can be made around this, however, in the interest of avoiding complicated recommendations and given the current NZ context, there is no reason to recommend vaccinating children with co-morbidities. • The recommendations will be reviewed if the situation in NZ changes. Members were asked to review and send any comments to the Secretariat for the paper to be converted to a formal memo.
4.0	**Revised VAANZ Cohort Study; Flu Co-administration** Fran Priddy described the revised study, which now only includes the Pfizer vaccine for which about 300 participants will be enrolled. Many doses of the Pfizer vaccine have been administered internationally and there is a lot of pharmacovigilance data available already. Consequently, the reactogenicity and long-term safety evaluation were removed from this study, it will now be a one-year immunogenicity study. The number of centres has been reduced to two but Māori and Pasifika co-investigators and international collaborators will still be involved. Key points of discussion: • Adverse events will still be monitored generally (CARM) but not as part of the project. Everyone that gets the vaccine will be part of the pharmacovigilance system. • Immunogenicity analyses will be sub-grouped by Māori, Pasifika, age, and co-morbidities (anticipated enrolment of 50 people per group). There is sufficient power to identify ethnic differences in immunogenicity (up to 50 international units for antibody responses). The study will enrol a minimum of 75 Māori participants. • The cellular immunology assays (ELISpot and ICS) will be undertaken in NZ and additional exploratory assays (antibody phage display and microarray) will be done internationally, in Australia and the US. The vaccinology aspect will look at how pre-existing factors (e.g., previous exposure to other respiratory viruses) predict the ability to have a strong immune response to the vaccine. The data from New Zealand will be compared with international data. • There was discussion around reactogenicity being linked with immunogenicity and that it would be useful to have comparative data for communication purposes. There were mixed opinions about the benefit of collecting reactogenicity data. While this data might be useful

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for assessing acceptability, current data indicate that side effects are not a major concern with regards to vaccine hesitancy. Collection of this data can be included in the study but a clear directive and significantly more funding is required. It was noted that acceptability data will be collected 28 days post vaccination and questions about the impact of reactogenicity could be included in this questionnaire to address this matter.

- Due to the narrowing of the study to focus on the Pfizer vaccine, there is an opportunity to look at other research questions in this rollout (subject to funding). One of the questions that was raised during the previous CV TAG meeting was co-administration of the flu vaccine and its impact on immunogenicity. VAANZ has discussed this with Seqirus (flu vaccine provider) but there is a multi-arm large trial planned by the Oxford group in the UK, which will include participants under and over 65 years of age. They will be recruiting for the AstraZeneca and the Pfizer vaccines, and both Seqirus vaccines (adjuvanted and non-adjuvanted) in about two weeks. If the cohort study in NZ were to go ahead, this would be to a similar timeframe and it may not be as relevant as this large trial.

VAANZ have reached out to the Oxford group to understand whether there is a gap in the UK study for NZ to contribute. However, in light of the large nature and higher capacity of their study, members agreed that the flu co-administration study is not a current priority for NZ to pursue.

5.0

Health Advice on Symptoms 48 hours Post Vaccination – Discrepancy for Border Workers

CV TAG were asked to comment on the paper requesting advice to inform implementation guidance on routine testing of vaccinated border workers. While the advice is currently relevant to border workers in Tier 1, it needs to be pragmatic as it will also apply to the Tier 2 rollout, which will include healthcare and critical workers.

CV TAG noted that:

- Anosmia and respiratory symptoms are unique to COVID-19 and have not been reported after any vaccinations.
- In general, the duration of post-vaccination side effects is usually short and they decline in severity. COVID-19 infection is more likely if symptoms continue after 48 hours or if they worsen.
- The guidance should be contextual and based on the level of risk management, e.g., Tier 1 workers are at high risk of infection whereas Tier 2 workers are at low risk of infection (outside of an outbreak).
- Vaccine efficacy rate is < 100%, so infection should always be considered as a possible cause of symptoms in people at high risk of exposure.

Juliette Rumball-Smith and James Harris will draft a proposed guidance document and email to CV TAG for review. The final advice will be distributed widely to GPs, Healthline, pharmacies, and other vaccinators.

6.0

Next Steps/Decisions Pending

None noted

7.0

Any Other Business

Advice from CV TAG: Minuted recommendations from CV TAG meetings are turned into a memo, signed out, and submitted to the vaccine leadership group.

8.0

Agenda items for next meeting

None noted

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New Action Items Raised During Meeting

#	Agenda item	Action	Action Owner
21	Health Advice on Symptoms 48 hours Post Vaccination – Discrepancy for Border Workers	Draft a proposed guidance document and email to CV TAG for review	Juliet-Rumball Smith James Harris

Meeting closed at **11:48am**

Next meeting: **Tuesday 06 April – 11:00am to 12:00pm**

Open Actions:

#	Agenda item	Action	Action Owner	Updates
19	Vaccine Guidance to Cancer Clinicians	Talk to the Immunisation team regarding removal of cautionary advice on ICIs for the flu vaccine	Caroline McElnay	09/03 - Action raised
21	Health Advice on Symptoms 48 hours Post Vaccination – Discrepancy for Border Workers	Draft a proposed guidance document and email to CV TAG for review	Juliet-Rumball Smith James Harris	23/03 - Action raised

Closed Actions Since Last Meeting:

#	Agenda item	Actions	Action Owner	Updates
08	Vaccines for Children	Work towards a proactive position statement on vaccinating children	Peter McIntyre Tony Walls Elizabeth Wilson	19/02 - Action raised 02/03 - Tony Walls provided an overview of the recommendations, final document will be circulated for consideration. 09/03 - Tony will circulate the documentation when ready. 23/03 - Document circulated.
18	Vaccine Rollout	Contact Medsafe about progress of Janssen approval	STA Team	09/03 - Action raised 23/03 - Update added to these minutes

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20	Any Other Business	Contact Medsafe about stability of Pfizer vaccine	STA Team	09/03 - Action raised 23/03 - Update added to these minutes

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Minutes/ Actions

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

Date:	Friday 12 February 2021
Time:	8:00am – 10:00am
Location:	Ministry of Health and Microsoft Teams video link
Chair:	Dame Dr Karen Poutasi
Members:	John Whaanga, Ngāhiwi Tomoana, Steve Maharey, Dr Fa'afetai Sopoaga, Chris Seed, Carolyn Tremain, Murray Jack,
Attendees:	For items: Heather Peacock, Karl Ferguson, Paul Giles, Heather Peacock, Michael Dreyer, Simon Everitt, Matt Jones, Geoff Gwyn, David Nalder, Andrew Bailey, Wendy Illingworth, Andrew Bailey, Dr Ian Town, Ben McBride (observer status), Mathew Parr, Colin Macdonald, Stephen Crombie
Apologies:	Dr Ashley Bloomfield
Secretariat Support:	Kirsten Curry

Item	Agenda Item
1	**Introductions and open** Introductions • Ngāhiwi opened with a karakia • Update to the agenda – security item will be discussed at the same time as risk • David Nalder, who has stepped into risk lead role, was introduced to the group Minutes • Minutes accepted as read Conflicts of interest • If there are new conflicts, Chair reminded group to raise any conflicts if identified • No new conflicts identified Announcement • First batch of Pfizer will be arriving in New Zealand on Monday – discussion considered the announcement of arrival and operational implications, including security and the expectation of when we start vaccinating • Programme requires clear communications around date and assessment of readiness to give assurance • Prime Minister announcement at 9:00 that will be ready to vaccinate MIQ on 20 February, messaging is that was planned for Q2 but has been brought forward • Comms notice to be circulated to GG, and border CEs and DHBs for information. The arrival date is not being confirmed in statement

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2 End-to-end walkthrough session update and readiness assessment

Key notes and discussion

- Walk through was part of the assurance process and put programme in a better position to deliver
- Acknowledgement and thanks to Defence for supporting the exercise with their expertise, and engagement and contribution from all agencies
- Process identified gaps, including three significant issues which have needed to be resolved post the exercise
- Mathew Parr provided an overview of the roll out plan:
    - Roll out starts in Auckland gradually rolling out across DHBs
    - Day 14 moving to all DHBs
    - First 9 days standing up locations in phased and controlled manner to successfully manage the programme
- Following the announcement, will confirm the go live date for each DHB
- Programme is establishing dry run exercises on sites for preparation
- Discussion of sequencing associated border worker definition
    - Clarification that cleaners are included
    - Carolyn raised that definition sounds straight forward but reality that workforce is dynamic, as evidenced with testing and establishing database. Significant complexity in identifying and reaching and this shouldn't be underestimated
    - MBIE is putting in immense amount of work border worker information right with an augmented team
    - Process will be ongoing and dynamic
    - Sue raised that have learnt a lot from the border testing and need to get good data. Group that we need to focus on are the ones that get tested. There is wider longer tail that need to be captured. DHBs are aware and working closely on this where they have the relationship
    - Chair and Dr Bloomfield held session with DHB Chairs and CE to provide clear messaging about importance of processes and policies that have put in place and will have another session with DHBs that have MIFs to reinforce these messages
    - Confirmation of the multiple request approach to get household contact data
    - There is risk that the denominator can't be identified, and how to manage that which have been amplified many fold when household contacts are considered. Message is that there is need to provide ability to get immunised.
- Strict adherence to sequencing is operationally challenging to match vaccine distribution to sites, locations and minimising wastage. There needs to be some flexibility on this to minimise wastage.
- Discussion on border worker testing management system – it has been in operation for a period of time and there is ongoing work to collect more data into the system. There are gaps where people and organisation may not be loading data, therefore need to provide a different path, e.g. dial in option to Homecare Medical. Will be an ongoing multi-pronged effort to collect data
- Question as to whether people will be able to get invite for second jab electronically. At this stage there is not a fully fledged booking system. The DG has requested the technology team bring forward the build for the national booking system. The current expectation is that DHBs will notify people of the second dose and DHBs are aware of the expectation
- Point raised that clarity of process, and agreement of roles and responsibilities including DHBs and other agencies is important for success. DHBs vary in operations and behaviour. The letter from Ministers clearly outlines expectations, supported by meeting with Chairs and CEs with Governance Group chair and senior programme leadership
- Colin raised that clarity is essential, with a high level of command and control, balanced with providing people on the ground the flexibility and freedom to solve problems. Equally important are the channels to inform the centre of issues and advising those in DHBs of subsequent solutions

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	• Ngāhiwi queried whether there was a number used for household contacts. A planning assumption of three people in addition to the border worker was used, but is not a limit and is a planning assumption only. Providing clear comms about the definition is important to ensure that scope is wide enough • Query as to what percentage of vaccine is used for household contacts. From a sequencing perspective, we wouldn't want the programme to be held up because have not provided vaccine to enough household workers. Will roll out to subsequent tiers regardless of household contact uptake – it is about providing the opportunity. *Comms update* • First phase completed which included direct engagement with employers and agencies as to what their employees need. • Expect PM will make further announcement on Monday as to specifics of what has occurred and what to expect. Information will be sent to DHBs as well • Focus for next week to provide operational detail about how this will work. Ministry wukk support employers, providing information and asking questions and supporting engagement. • Question on the specific work with health workforce as uptake has historically been a problem which will impact on the undecided. DHB CE group focussed on workforce issues and have put the challenge to them. Group of workers in MIQ who need to be vaccinated, focus on this cohort first. Planning on liaising with unions underway. Specific reporting around health workforce uptake will be required • Public sentiment scanning shows the public are quite knowledgeable and aware of the complexities. Need to balance media and political focus on speed to rollout with public preference for getting it right. • Challenge for comms is the speed that operational decisions are made, and producing the subsequent material • There is a daily email to border CEs with most up to date talking points and collateral starting from Sunday and aim to provide everyday until group is completed. Will do similar for health workforce employers and then other high priority groups. Consideration into the best channels and approaches in which to target these groups • Clarification about consent – consent is verbal and captured in CIR. Question raised as to whether this is in multiple languages – working closely with DHBs colleagues and providers that right work force is present. There is a consent video which is broken down in plain English about what is required as well. **Action: Report back before the 20th Feb on how people engage with consent.** • Discussion about campaign – currently planning to launch with first vaccination. Messaging has shifted away from those that are hesitant and focus more on a strong message to be vaccinated: safe, effective, reliable and free. *Equity discussion* • John raised that current focus is on MIQ but need to consider equity. If the programme is to be successful in terms of its objectives around equity, there is a need to identify early and meet those responsibilities and accountability. Includes appropriate engagement iwi and Māori organisations, which was critical in uplifting rates for the flu vaccine. COVID vaccine could leave legacy and will impact on other health improvement opportunities • Ngāhiwi – Māori and Pacifica and ethnic providers were successful during lockdown providing wrap around services and should not be overlooked as can get into most difficult households and develop relationships with difficult communities • Sequencing framework and aged residential care definition raised. Inclusion of Māori kaumatua and pacific elders not immediately represented – needs to be recognised as a critical influencer for wider whanau • Query raised as to whether there were outstanding issues associated to logistics and distribution. Matt Jones spoke to the issues identified in simulation event which have raised issues with regulation and accountability of distribution which required further

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<table>
<tr><td></td><td>planning. A way forward has been developed, socialised with one DHB yesterday, working with four others today. Feel comfortable that this plan will work but future phases will need additional thinking
• Critical change is that we now know we can break down packs into 5 vial, 15 vial and full tray.
• Fonterra were at dry run exercise, and working with team presently. Will provide advice on future scaling plans.
• Stephen advised that process is fundamentally manual so cannot scale at present. Can manage a week or two at most with the current system. The current deadline for new system until end of March. Then there is risk that may not have full functionality. There may be some overlap between the manual and new process

<u>Reporting dashboards</u>

• Paper has been subject to discussion overnight with Ministers offices
• The daily dashboard provides view of how many are being immunised daily, stock and inventory management, workforces (training), adverse reactions
• Working denominators into this (i.e. coverage) and splitting into cohorts to be developed. Requires confidence on the numbers that are being presented and some numbers are combining a couple of different processes, of which some are manual (inventory), which is a risk
• Working through cadence and processes for daily reporting – information to Ministers, Governance and operational coordination and command, also DHBs and possibly employers about management
• Working hard to manage expectations about what information can be provided upwards and outwards as there is a risk of providing incorrect information. There will be a risk when migrating systems and updating processes
• Plan to establishing reasonable size reporting function in operations structure to manage the function
• Working through what the media access to the reporting will be</td></tr>
<tr><td>3</td><td>Maximising uptake

• Crown Law and Attorney General are supporting the developing the advice
• Paper noted as read
• Update that further work requested from border agencies to support and associated health and safety advice
• Will be topic of discussion in briefing with Prime Minister</td></tr>
<tr><td>4</td><td>Communications and stakeholder engagement

Discussion
• Covered in general discussion.
• Comms to provide visibility over campaign early next week</td></tr>
<tr><td>5</td><td>Updated risk approach (including security and privacy

<u>Security and Privacy update – Geoff Gwyn</u>
• Taken security and privacy papers as read. Outlines key mitigations to thematic risks.
    ○ Certification and accreditation activities to be completed today.
    ○ In progress of resolving existing privacy impact assessment and will continue to update on fortnightly basis given pace of change.
    ○ Issues with unencrypted emails and spreadsheets with critical information sharing moving to Microsoft Teams.
    ○ DHBs will be required to perform risk assessment for each site and providing SOPs, working with DHB security managers
    ○ Working closing items with Privacy Commission for awareness over PIAs
    ○ Further work to integrate risk and mitigations into a wider risk assurance approach</td></tr>
</table>

	Programme risk assurance lead update – David Nalder • Work has progressed to collate risks and define clear success criteria, moving from what could go wrong to reframe into what needs to occur to mitigate and support decision making and timing of decision making. Paper outlines principles and frame to the approach • Commended the framework – Murray raised question as to how do you create ownership and accountability for risks across the system where you have multiple parties where you have limited control and have people who are responsible for risks and actions are also accountable for outcomes • Discussion considered the tolerance element and how to provide GG the line of sight that the critical risks are covered and managed • Recognition that 1a is effectively pilot and that full readiness will not be in place for next week but when reach scale want to know everything is in place • Stephen Crombie raised that clarity around operating model leads into clarity around readiness, and associated clarity of roles. Programme is not in this phase yet, the framework will help with this complexity, complemented by readiness requirements • Question raised as to where the decision for readiness for go live sit and what is the process to get to this point. An explicit decision about go-live readiness is required. • Explicit decision can be made against risk appetite for each risk – frame about how can think about risk appetite and how to advise DG on these components. Request for clarity on how to manage risk discussion in a more programmatic way and how to present with the learnings from Phase 1

6	**Real time assurance lead update**
	
	Stephen Crombie
	• Clarity about the operating model is required. There is tension in the high complexity of scale and significant work that needs to occur
	
	Colin MacDonald
	• Has been working with the Post Event team. Observation is that there is good work occurring but there was a lack of visibility of the work
	    ○ Is more confident that the likely volume of adverse events that the existing process will work adequately
	    ○ Confident that the steps to bolster CARM will be sufficient in the initial stage. Core activities that database is moved to cloud – advice that need to do full risk assessment before move to cloud but needs to progress quickly
	    ○ Second piece is workflow automation – assumptions have been adverse events have surfaced but need to manage the noise that might be created (consent, information) so that assessors only look at what they need to and improve confidence
	    ○ MedSafe holds the contract with CARM, however Dr Tim Hanlon is the programme lead. This additional business ownership lens creates challenge as this is done on behalf of MedSafe which needs to be worked through
	    ○ There will be a group who need to consider adverse events to support Medsafe: this needs to be independent
	• Comms has been Colin's other focus for the week. They are playing catch-up, but have done well this week to transition from strategy to plan. Have asked them to clarify operating model between AoG and wider system to provide clarity
	    ○ Seeking comms to provide a four week rolling communication plan including events and collateral as a control document so programme can see it occurring
	    ○ Group are playing catch-up on resourcing
	
	• Question raised as to how equity is represented or covered in risk assurance activity – action to discuss with Mat on how to provide lens across the whole programme as an issue that keeps arising in Governance and Steering. Mat advised that conversation has begun with Chappie, which may provide this.

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	Next meeting week of 22 February
	Meeting close • John closed with a karakia

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ACTION TRACKER

NO.	ACTION	OWNER	STATUS – DATE (Due or closed)	COMMENTS
210129 -01	Consider the sign off process for readiness	Mathew Parr	In progress	To be linked to sign out of the operational guidelines and end to end process.
210115 -02	Consider if this Governance Group should have a continued role overseeing the Pacific Health Corridors support for Vaccine	MoH and MFAT	In progress	Still under consideration
210115-03	Provide Governance Group an update on the new group established under Dr Ian Town	Mathew Parr	New decision structures to be provided for the next meeting.	With the standing down of the Taskforce over the coming weeks we can provide an updated overview of the key groups.
210129-01	For MoH to consider the 'readiness' process that it will seek to put in place with leads to ensure accountability	Mathew Parr		

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Minutes/ Actions

MINISTRY OF HEALTH
MANATŪ HAUORA

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

Date:	Friday 19 February 2021
Time:	8:00am – 9:00am
Location:	Ministry of Health and Microsoft Teams video link
Chair:	Dame Dr Karen Poutasi
Members:	Ngāhiwi Tomoana, Dr Fa'afetai Sopoaga, Chris Seed, Carolyn Tremain, Murray Jack, Dr Ashley Bloomfield, Steve Maharey
Attendees:	For items: Jo Gibbs, Mathew Parr, Shayne Hunter, Cameron Elliot, Dr Joe Bourne, Sue Gordon, Michael Dreyer, Paul Giles Dr Ian Town, Ben McBride (observer status), Mathew Parr, Colin Macdonald, Stephen Crombie
Apologies:	John Whaanga
Secretariat Support:	Kirsten Curry

Item	Agenda Item
1	**Introductions and open** Introductions • Ngāhiwi opened with a karakia • Meeting called to provide brief update given first vaccinations to be delivered today, purpose of which for GG to receive update on state of readiness and consider residual risks • Next meeting focussed on next steps
2	**Discussion** • Programme provided advice to Director General, PM and Minster that prepared to deliver vaccine at a smaller scale at border, however, there remains a broader body of work to complete before widescale rollout • Soft launch today as part of testing and formal launch tomorrow. Programme has done enough from safety and efficiency perspective to be ready • The primary risk is around the mass vaccination programme rather than the border • Programme has done significant work in the last two weeks, with support from John Whaanga, Geraldine Clifford-Lidstone, Māori Ministers and Minster Sio to support Māori and Pacific engagement • There is increasing sentiment towards adopting vaccination for our key communities • Wednesday dry run event was a useful exercise, operating across four locations (Auckland, Wellington, Christchurch and Wellington ops centre) demonstrating further areas for improvement and raising the comfort of those who are responsible for

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coordinating and administering. This is something that will be replicated as new DHBs are brought online.
- 66 actions were identified under four main themes – distribution and inventory, CIR, collateral and household contacts.
- Distribution and inventory continue to be area most concerned about. The manual process is sufficient at present, will focus on what is needed to achieve scale next week
- Carolyn raised concerns about reporting – and the support that stakeholders require to support the border rollout e.g monitoring compliance. Shayne advised that do not have functionality in systems to report against workplace on day 1 but will be added quickly, in the interim have a work around system in place. Consent is required for worker to share information with employer but can be reported at aggregate level. Messaging in weekly calls with PM, building system as we go and there will be improved reporting at later
- Activity over the next week will include 1-1 conversations with DHBs with ports as they come online to ensure ability to continue to safely scale while putting in systems. Teams need to grow as well to service the system.
- Post event assurance committee has been established with Dr John Tait as independent chair to work with CARM, MedSafe and technical advisors. The group, have signed ToR and ready to mobilise if there is a need to respond to significant clinical events. The Chair will have accountability to Ashley, Ministers, and Chair of the Programme Governance Group
- Michael Dreyer reiterated that the current systems and processes are interim and off the shelf inventory management system will be considered. There is confidence in the current system for Tier 1
- The programme was requested to bring the mapping of technology, workforce, and supply in consideration of scaling scenarios to future Governance Groups.
- Advice to Ministers has been very deliberate that the ability to go live in this phase differs compared to wider scaling. Minister Hipkins has asked for a broader view of scaled rollout
- Cabinet has made a decision to purchase offer from Pfizer for additional 4m courses. s 9(2)(b)(ii)
- Minister Henare and Minister Davis met with iwi and Māori providers.

Update from Real Time Assurance Leads

Stephen Crombie
- Observed dry run – found to be an excellent process, and approach. Commented on the culture that it built
- Ability to respond to events will be critical and the associated support structure if there are issues

Colin MacDonald
- Ensure that we can respond to emerging issues and the interface and feedback between the operations team and design team will be important moving forward

Discussion
- Question raised as to what GG can see over the next week. **Action: Daily Ministers reporting to be circulated with GG**
- Once move into volume have a formal format that has been agreed with Ministers – GG to be cc'd.

Communications – Paul Giles
- Messaging today that not just someone getting vaccinated, but a significant milestone for NZ in our response to COVID 19. There is high level of interest from PM and Minister

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	• Comms is conscious that the site is at Jet Park, which comes with constraints. There will be a Ministry videographer present but not media. There will be a media event later in the day. • Campaign is not being launched this week. There is not a huge rush to get out to market with material, focus on getting tag line right • Governance Group provided congratulations, acknowledgement to the team and appreciation for reaching this moment
	Meeting close • Ngāiwi closed with a karakia

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MINISTRY OF HEALTH
MANATŪ HAUORA

Minutes/ Actions

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

Date:	Friday 26 February 2021
Time:	8:00am – 10:00am
Location:	Ministry of Health and Microsoft Teams video link
Chair:	Dame Dr Karen Poutasi
Members:	Ngāhiwi Tomoana, Dr Fa'afetai Sopoaga, Chris Seed, Carolyn Tremain, Murray Jack, Dr Ashley Bloomfield, Steve Maharey, John Whaanga
Attendees:	For items: Jo Gibbs, Mathew Parr, Andrew Bailey, Matt Jones, Shayne Hunter, Dr Joe Bourne, Michael Dreyer, Paul Giles, Heather Peacock, Karl Billington, David Nalder Ben McBride (observer status), Jess Hewat (observer status), Stephen Crombie
Apologies:	
Secretariat Support:	Hannah Lobb

Item	Agenda Item
1	**Introductions and open** Introductions • John opened with a karakia. • Minutes accepted from 12 February and 18 February. • Agenda adapted to provide a stocktake at Item 2. • The group decided that a polytechnic being a vaccination site is not a conflict.
2	**Operations update – Joanne Gibbs** • The programme is going well so far. In terms of learnings from the first week, there will be an independent review of the serious adverse event, and buffer supplies will be re-evaluated to minimise wastage. • The Daily Report is now automated and being distributed to DHB CEs, Ministers and Governance Groups. Access is restricted due to adverse events information. • The run structure has more people coming on board today and the Operations Centre will be in full run mode from Monday. • Logistics and inventory management has been identified as an issue and Joanne is working closely with the team and Fonterra. **Stocktake of current issues – group discussion** • The discussion focussed on risks associated with scaling for Phase 2. The group noted limited lead in time to get the technology ready to support Phase 2. In particular, there will be limited time to integrate the different systems and then test the whole operation. • The Group agreed that the focus areas for moving towards Phase 2 should be landing event design in next few days and resourcing the run and design functions

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- Ashley noted the importance of avoiding scaling up before the programme is ready and requested support from the Governance Group to manage this.
- Carolyn raised concern that privacy/security issues might be forgotten while moving so fast.

Action 1: Mat Parr to report back on where the Public Sector can help with resourcing.

Plan for the year – Mat Parr

- The A3 Plan presented to the group is based on Pfizer being the backbone of the campaign. It aligns with current best estimates of delivery schedule and indicates that the next phase will start before the previous phase is finished, to reduce drop-off.
- The next stage is to create a “Plan on a page” for the three main stakeholder groups: Community, Public Sector, and Businesses and Unions
- In terms of next steps for readiness, the only new issue is supply and demand management for the Pfizer vaccine. Storage at -20 could open up additional options, but this will still be challenging. The team is also keeping an eye on the Janssen vaccine and delivery schedules.
- Consensus from the group was that the event types are still too broad. The focus should be on four core event types for Phase 2:
    1. GP hubs
    2. Community sites
    3. Workplaces
    4. Mobile clinics

Action 2: Take refined events model to the Steering Group on Tuesday.

Action 3: Shayne and Michael to report back on key details about event design that they need for IT delivery.

Additional discussion

- There was a discussion about partnering with stakeholders and experts. Karen noted that this is already happening. DHBs have strongly welcomed Standards of Practice and are working with their communities on delivery. MOH’s job is to be really clear about what they need from partners.
- The group decided that the design of large events should be left until later.
- Discussion on smoothing growth in vaccination numbers so as not to lose the workforce. Mat Parr’s team is conscious of this.
- The need for internal comms for workers was raised, as they are ambassadors for the programme. Michael Dryer noted that the channel is public and border and contact tracing workforces are already on board, so just need to get the vaccinator workforce added.
- Ashley asked about stock track and trace. Michael noted there are updates planned for 9 March but there is a question about whether an additional system is needed on top of this.

Action 4: Update will be presented to GG in next two weeks, including decisions on procurement.

3. **Comms and engagement - Paul**

- Last week the team held national and regional Q&A sessions with vaccine experts and border workers. These have been successful and the public feels positively about last week. Evidence shows that the most effective comms channel is person to person.
- Next week the team is continuing with individual stories in regional media, targeting misinformation, and repurposing resources for household contacts and healthcare workers. There will also be more person-to-person engagement through regional fono and a hui with Waikato Tainui.
- The public are interested in the roll-out plan and sequencing.
- Heather noted that AOG is trying to ensure agencies across government can be involved and reach into their core communities (e.g. seniors). AOG are also working on a Vaccine strapline and are holding a workshop with range of stakeholders.

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	• Carolyn thanked the team for the quality of comms, noting that the webinars over the weekend were really helpful and would be useful to continue. • Paul noted that the comms team is well-resourced centrally to manage a large scale campaign.
4.	No further discussion – this was covered in Item 2.
5.	**Embedding risks – David** • The risk management approach aims to capture risks alongside the critical pathway to ensure that the things we need to have in place have been thought about. • There is a Confidence Plan for each of the 8 elements, and next David will work on plans for each activity with the project owners. The goal is to have specific controls in place for scalability and readiness. These plans will go into risk assessments for next "go lives". ***Action 5: David to present risks and mitigations at every SG meeting and ensure they are linked to observations from Steven and Colin.***
6.	**Updated programme structure – Mat Parr and Joanne Gibbs** • The updated structure reflects the standing down of taskforce and TAG. It also includes Dr Ian Town's COVID Vaccine Executive Advisory Group which is meeting regularly. • Mat noted that there is need for a reset that covers event pillars and timeframes so that everyone is set on the same pathway for Phase 2. • Joanne noted that MOH is partnering with Defence on operations. There are some capability concerns for logistics and inventory. *Discussion* • Karen noted that there's no more time to focus on policy now, we need to focus on the Phase 2 roll-out design. • Carolyn suggested it would be useful to focus on what decisions to we need to make next week and a plan for if they don't get made. • There was discussion that the programme structure doesn't reflect the relationship with Te Tiriti and Iwi. The group noted that a lot of work is already underway but this is not reflected in the programme structure document. • Michael noted that regional stakeholder oversight is great but the important thing is to having the single controlling mind over event types.
	Meeting close • John closed with a karakia

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ACTION TRACKER

NO.	ACTION	OWNER	STATUS – DATE (Due or closed)	COMMENTS
210129 -01	Consider the sign off process for readiness	Mathew Parr	In progress	To be linked to sign out of the operational guidelines and end to end process.
210115 -02	Consider if this Governance Group should have a continued role overseeing the Pacific Health Corridors support for Vaccine	MoH and MFAT	In progress	Still under consideration
210115-03	Provide Governance Group an update on the new group established under Dr Ian Town	Mathew Parr	New decision structures to be provided for the next meeting.	With the standing down of the Taskforce over the coming weeks we can provide an updated overview of the key groups.
210129-01	For MoH to consider the 'readiness' process that it will seek to put in place with leads to ensure accountability	Mathew Parr	In progress	Linked to David's work on confidence plans.
210226-01	Report back on where the Public Sector can help with resourcing.	Mathew Parr	In progress	
210226-02	Present refined events model A3 to SG on Tuesday.	Mathew Parr	Closed at Steering Group 2 March	
210226-03	Shayne and Michael to report back on key details about event design that they need for IT delivery.	Shayne and Michael Dryer	Closed at Steering Group 2 March	Event design has a lot of repetition which is a positive in terms of IT delivery needs.
210226-04	Return to GG in 2 weeks with update on additional infrastructure for track and trace, including decisions on procurement.	Michael Dryer	In progress	Distribution item
210226-05	Present risks and mitigations at every SG meeting and ensure they are linked to observations from Steven and Colin at GG.	David Nalder	Closed at Steering Group 2 March	

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MINISTRY OF HEALTH
MANATŪ HAUORA

Minutes/ Actions

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

Date:	Friday 12 March 2021
Time:	8:00am – 10:00am
Location:	Ministry of Health and Microsoft Teams video link
Chair:	Dame Dr Karen Poutasi
Members:	Dr Ashley Bloomfield, John Whaanga, Murray Jack, Ngāhiwi Tomoana, Steve Maharey, Carolyn Tremain, Dr Fa'afetai Sopoaga
Attendees:	For items: Heather Peacock, Karl Ferguson, Paul Giles, Shayne Hunter, Matt Jones, David Nalder, Andrew Bailey, Wendy Illingworth, Jo Gibbs, Sue Gordon, Caroline McElnay Ben McBride (observer status), Jess Hewat (observer status), Stephen Crombie, Mathew Parr, Colin Macdonald
Apologies:	Dr Ian Town, Chris Seed
Secretariat Support:	Hannah Lobb

Item	Agenda Item
1	**Introductions and open** Introductions • John opened with a karakia. • Minutes accepted from 26 February, but noted attendees required correction • Actions from last week were covered off. • No new conflicts raised.
2	**Operations update – Joanne Gibbs** • The programme is going well so far. The NZDF went live at 5 sites yesterday and the Auckland sites continue to build up capacity slowly. • The main challenge is reconciliation of data against the groups being vaccinated. The team is working to get more clarity on the data. • DHBs have received the roll-out model for this year for their populations. We expect to hear back from DHBs with delivery plans to April 2 on Monday, and to the end of April the following week. **Group discussion** • Colin asked about how we would know if we started to lose the confidence of the sector. Jo explained that we are engaging with the sector at multiple different levels and she is confident we will have a good grasp of this. • There was a question about available vaccinators. Jo said we are at expected levels currently and there is ongoing work to expand the workforce using different roles. • Colin asked about data on border workforce and agreed to take this offline.
3.	**Phase 2 scale-up scope and plan**

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Resourcing:

- There has been a reset around design and run responsibilities.
- Colin asked about SROs and Sue and Jo confirmed the lines of responsibility are clearer now, with Sue responsible for design and build and Jo responsible for run. Colin raised the issue of having a clear transition plan when design hands over to run.

Model for the year:

- There is still uncertainty around the Pfizer delivery schedules after April but the plan is to deliver 250,000 doses per week by July.
- There was a discussion around the number of vaccines in cold storage. Ministers are thinking about the narrative around this. Mat Parr noted that our current trajectory and modelled throughput is designed to consume around ~97% of available supply until June when large volumes are expected to arrive.

Group discussion:

- Sue and Jo were asked whether there is anything that will help make the programme successfully scale up and deliver to this model. Their view was that time and building public confidence will be the critical factors.

Action 1: Bring a 1 pager on the sequencing framework to the Governance Group

Technology update

- Starting to get more resources on board in the operations space, which is freeing up people to work on design
- In terms of next steps:
  - need to figure out what is needed in terms of technology for the event types
  - need to figure out how to optimise at the front end e.g. educating the workforce on how to use the systems
  - get an integrated view of how all the systems will work together
  - figure out roles for MOH v DHBs
- In terms of risk management, the Plan B at present is DHBs using their own local booking systems

Group discussion

- Murray asked where the critical point is for technology. There was a discussion about some of the critical factors and timing, and an action was taken for the programme to return to Governance Group with more detail on the critical path and when the technology will become a barrier to scaling.
- Carolyn noted that seeing as there is limited time, we need to figure out what are the most important questions and what the public service can help with in terms of supporting via resource, networks, and expertise.

Action 2: Return to GG with an answer to where the critical point is in terms of technology.

Logistics and inventory

- In the process of building a more flexible model to deal with walk-ups.
- From next week there will be a trial of a locally embedded inventory manager in Auckland.

Workforce

- Ongoing work recognises that there a range of roles needed for the workforce and there is thinking about how to use a wider workforce and create a legacy

Action 4: Update the definition of equity in the workforce plan

4.	**Advice on single doses of the Pfizer vaccine**

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	• CV-TAG considered the science on whether single doses, or a 'first doses first' strategy would be an option. Dr Ian Town updated the group that their considered advice is that there is no need to delay a second dose in NZ while we are not in an emergency setting. It was noted that 3-5 weeks is a reasonable period between doses, however people going overseas on compassionate or other urgent grounds may only be able to have one dose before they go and we may need to be pragmatic in some situations.
5.	**Comms and engagement** • Paul Giles provided an update on the communications and engagement process. • Shifting to show people what getting the vaccine will look like for them and providing information on the sequencing framework. • Comms needs to be more segmented than in has been e.g. thinking about vaccine hesitancy and TV channels for particular ethnic groups as well as mainstream channels. • The DPMC campaign is starting via a "soft launch" this weekend on radio and in press. There is ongoing thinking about how to engage Ministers in the campaign. • The DG made the point that his perspective is that the sooner the public campaign kicks off the better, as this would provide the wrap around support for local activities and counter any misinformation and disinformation that was raised by the Governance Group.
6.	**Risk summary** • Roles and responsibilities between the 'design and build' and 'run' parts of the programme, between the Ministry and DHBs, and across the wider health system are still unclear and this is the major risk the programme currently carries. • Colin and Stephen noted that the programme will need to provide a clear link between risk and readiness reporting in order to give more confidence.
7.	**Meeting close** • Ashley congratulated the team on the work to date. • Ngāhiwi closed with a karakia

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ACTION TRACKER

NO.	ACTION	OWNER	STATUS – DATE (Due or closed)	COMMENTS
210115 -02	Consider if this Governance Group should have a continued role overseeing the Pacific Health Corridors support for Vaccine	MoH and MFAT	In progress	Still under consideration
210129-01	For MoH to consider the 'readiness' process that it will seek to put in place with leads to ensure accountability	Mathew Parr	In progress	Linked to David's work on confidence plans – for decision by Steering Group 30 March linked to the 'critical path'.
210312-01	Bring a 1 pager on the sequencing framework to the GG	Mathew Parr	Closed	In Governance Group pack 26 March
210312-02	Return to GG with an answer to where the critical point is in terms of technology.	Shayne Hunter Michael Dreyer	Closed	Update in Governance Group pack 26 March
210312-04	Update the definition of equity in the workforce plan	Fiona Michel	Closed	Updated

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Minutes/Actions

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

Date:	Friday 26 March 2021
Time:	8:00am – 10:00am
Location:	Ministry of Health and Microsoft Teams video link
Chair:	Dame Karen Poutasi
Members:	Dr Ashley Bloomfield (until 9.30 am), Murray Jack, Hon Steve Maharey, Dr Fa'afetai Sopoaga (until 9.30 am), Ngāhiwi Tomoana, Carolyn Tremain, John Whaanga
Attendees:	Joe Bourne, Ian Costello, Jo Gibbs, Sue Gordon, Shayne Hunter, Matt Jones, Fiona Michel, David Nalder, Mat Parr, Dr Ian Town, John Walsh *Independent Programme Assurance*: Stephen Crombie, Colin MacDonald
Apologies:	
Secretariat Support:	Carol Hinton

Item	Agenda Item
1	**Introductions and opening** • Ngāhiwi opened with a karakia. • Minutes of Meeting held 12 March 2021 were accepted. • There were no actions to consider from the previous meeting. • No new conflicts of interest, or conflicts in relation to the meeting's agenda, were raised.
2	**Programme status and risk summary (David Nalder and Mat Parr)** *Paper considered – COVID-19 Vaccine and Immunisation Programme – 23 March 2021* ***a) Context of paper's development*** • David Nalder noted that the paper had been developed prior to the announcement re changes to Pfizer's vaccine storage conditions. (See section 4a.) ***b) Key programme issues*** • Noted that the first six (of total 14) issues in this report were the key issues for the programme. • Dame Karen asked for an overview of the key mitigations put in place during the week to address these. • Responding to this, Dr Bloomfield advised of three key pieces of work under way: a) *Critical path*: We are now in initial 'scale up' to get from 2,000 vaccinations per day to 10,000 per day to coincide with volume arrival of vaccine into New Zealand. This delivery is still within the current operating model. However, to support increased volume and pace, the programme is currently merging its 'Design' and 'Run' teams.

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b) *Workforce:* There is a strong focus on training and deployment of vaccinators, which he advised was the subject of a separate agenda item. (See section 4b.)

c) *Communicating a shared responsibility*: Dr Bloomfield noted that to date, protection of the country has been through decisions of Government. However, once the vaccination roll-out is well under way, future protection will sit more at an individual level and it will be appropriate to shift our communications messaging accordingly.

- Building on the critical path commentary, Dame Karen agreed that everything must align to support the operational drive, with the Operations team eventually leading. However, while the 'highway was running fast', she noted that some risk writing appears to be about a week behind. She sought assurance that the programme's risk awareness is actually keeping pace with the reality.

Group discussion:

- Murray Jack agreed it was important to align the risk analysis to the critical path. He felt that in most cases the currently identified 'risks' were more 'issues' but he noted a need for greater clarity about who is responsible for mitigating the risks and whether the issue is such that it needs to be resolved by reference to the critical path. Murray noted that languishing issues would threaten the ability to deliver to the critical path. Several members signalled their agreement to this.
- Colin MacDonald advised that he and Stephen Crombie had just done a 'deep dive' on programme planning tools and were generally pleased with these. However, there is capacity within the planning process to more clearly articulate when and how risks will be mitigated. Accountabilities must also be clarified.
- Colin and Steve indicated they had asked the programme team for some 'greenfields' thinking on what an optimum delivery-led structure would look like. This approach will provide a good opportunity to clarify accountabilities.
- Both Dame Karen and Steve Maharey endorsed the approach of Colin and Stephen to have accountabilities clarified.

Action 1: Ensure programme planning documents include named individuals who are accountable for core deliverables.

3

Operations update – Joanne Gibbs plan to end April for DHBs

Paper considered – Daily COVID-19 Vaccine and Immunisation Programme Report for 24 March 2021

a) Daily reporting

Jo Gibbs indicated that momentum is building, and provided a verbal update on some key statistics.

- The rolling 7-day average from 19 March sitting at just over 17,000 doses. A 'locked in' delivery schedule to 31 March sees a further 36,000 doses.
- The last DHB to go live is Wairarapa on 7 April. MoH did site visit to confirm readiness.
- All DHBs live from 7 April.
- Border worker testing is sitting at 104% meaning numbers will be revisited. One third have had their second doses

b) DHB plans to end April

- In response to a question from Murray Jack, Jo advised that MoH has all DHB plans to end April. MoH has strong confidence in some but others will need support, including DHBs with no borders/border workers. MoH meets the Senior Responsible Officers (SROs) at DHBs 2-3 times a week, has a workshop scheduled for 29 March, and a CEO meeting on 30 March.
- DHBs share plans. John Whaanga has been instrumental in sharing plans from Tumu Whakarae members.

4.

Critical Path to operate at scale

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Paper considered – Critical path summary

a) Overview (Matt Jones, Joe Bourne)

- Four core groups of work are in place to reach the 1 July objective of 50,000 doses per day.
- Planning includes all streams moving together into the one team.
- Engagement is critical – 40% of the population more regularly engage with the health system and will need less intervention to get vaccinated.
- Open access population – we need planning so that we can subdivide and get our messaging to the right groups. Noted smaller population groups can be harder to reach.
- National booking system will be live in advance to support this.
- Storage adequacy is important. We have a push on planning capacity so we don't exceed either storage or delivery needs.
- Dr Bloomfield clarified that the general population (high risk) roll-out will start with those aged over 65 or over 75 with pre-existing conditions, before moving to general population (low risk) of those 16+. On average those aged over 65 have 6-8 GP visits a year. Delivery model may use different channels eg GP for over 65 age group but major sports functions for younger age groups.
- Joe Bourne noted it was important we use channels such as iwi and hapu to connect with groups who may not use GP services as frequently.

Group discussion

- Murray Jack indicated he could see the programme coming together but he was keen to see more integration and a steady pathway to support the scale activities. He cautioned that the lower volume six-week period to end May could create risks for scale roll-out date.
- Carolyn Tremain agreed, noting the importance of smoothing and asked if the constraints were due to resourcing or vaccine availability? She noted the likely risks to public perception if vaccine is stored in volume rather than being deployed.
- Sue Gordon confirmed that we have supply constraints. Responding to a question from Dame Karen, she said that we are actively engaging with Pfizer to secure additional supplies but have been unable to increase delivery in the current quarter.
- Sue also noted that the sequenced cohort delivery model meant that delivery settings differed from the large-scale settings (East Tamaki) through to GPs and residential care settings. There is no 'one size fits all' model.
- Steve Maharey commented that access to Māori communities would need to go wider than iwi and hapu, noting that in his experience over 70% of Māori were not accessible through these routes.

b) Distribution and Inventory update (Ian Costello)

Ian Costello advised that the objective is to have a flexible supply model so that vaccine supply is never a reason why a vaccination cannot be administered in any circumstance, planned or unplanned.

- DHBs have existing -20° storage capability which is aligned with Pfizer vaccine storage requirements *(see below).*
- MoH is working with DHBs to co-design a flexible 'hub and spoke' distribution model. Model has been piloted in Auckland. MoH expects to formalise this by early April 2021.
- Will next move to establishing a second warehousing facility in Canterbury. This will require an RFP to contract.
- Contracts will also be required for storage and transport in areas where no local hub can be established.

Group discussion

- Murray Jack indicated his support for this concept but asked for key risks to be clarified.
- Carolyn Tremain similarly supported the model but noted the differing skillsets required in a DHB hub compared to a DHB pharmacy. Carolyn and Sue Gordon both noted the current pressures on the health sector workforce.

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- Ian agreed that a key risk was ensuring correct expertise at DHB hubs. This would be met through a combination of reframing current resources and adding new resources.

c) Pfizer vaccine storage decision (Not on agenda)

- Dr Bloomfield advised that he had received advice from Medsafe the day prior (25 March) that Pfizer has announced changes to storage conditions for its COVID-19 vaccine (Comirnaty).
- New advice is that unopened vials may be stored and transported at -25°C to -15°C for a total of 2 weeks on one occasion only and can then be returned to -90°C to -60°C. Other storage information is unchanged.
- Members noted with interest the ability to return the vaccine to the -90°C to -60°C range after being held in the -25°C to -15°C range.
- Dame Karen asked that DHBs be advised of the Medsafe decision promptly.

Action 2: Ensure DHBs are promptly advised of the Medsafe decisions re Pfizer Comirnaty vaccine storage. (Joe Bourne)
Action 3: Medsafe decision to be factored into critical path decisions. (Mat Parr)

d) Workforce strategy update

- Fiona Michel advised that she is establishing a new team to focus on ensuring the national workforce delivers sufficient appropriately trained people to support and enable the 1 July vaccination objective. This means a strong focus on volume hire, training, and deployment.
- Active engagement with DHBs to understand how many trained people DHBs have available to use in vaccination events. While we know training requirements for a specific event, and know how many people are trained, the understandings re availability of a trained person to perform vaccination are not always consistent where those people are doing other work within a DHB. Fiona is working to align supply with need.
- The surge database is currently quite 'blunt' and we are working to see how we can help DHBs to make better use of it e.g. by doing some 'screening' on people so that DHBs can obtain a filtered list of people who may more closely meet their requirements.
- Important to attract new people into the workforce and we are working with relevant responsible authorities to do this e.g. student populations. The Programme is establishing a new group to work on a non-regulated vaccinator training programme. This includes representation from the Immunisation Advisory Centre (IMAC) and the CareerForce ITO.
- We are mindful of ensuring appropriate representation of and for people from differing ethnicities. This area needs considerable strengthening.
- Fiona noted that as expected, there has been some reticence from regulated parts of the workforce. She noted it is critical the final product must be safe for everyone.

Group discussion

- Dame Karen clarified that the non-regulated workforce comprised individuals who were not required to be registered.
- Dr Fa'afetai Sopoaga agreed with the broad focus being applied to understanding the wider workforce requirements and reinforced the need to ensure that equity is front of mind in service design and delivery.
- Dr Bloomfield noted that for every vaccinator we needed 3-4 other people as well. This is an area where the student workforce could play a big role.
- Carolyn Tremain asked the extent to which we could 'call up' people in the public sector who have previously held roles in the healthcare sector e.g. retired nurses.

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Document 2

5.	**Technology (Shayne Hunter)** • Want to integrate the COVID-19 immunisation register and other technology more deeply into patient management systems. • Demonstrations of the booking system have gone well. To support mass vaccination, we are cutting back on the requirements/process around matching to NHI; a detailed NHI match will be able to be done onsite in 20 seconds. The key focus is to get the person to site, rather than hinder them at the booking stage. • System co-design with is underway in Christchurch. Local trials with a small number of providers will be under way by end April 2021. We aim to give them a package that they can load directly into their own systems. • Dame Karen noted positively the progress made since the last meeting.
6.	**Communications and engagement (John Walsh)** • John Walsh introduced himself, advising that he has held two roles at MPI (Director Readiness and Response, Director Communications and Engagement) and had led the United Against COVID-19 campaign communications from March – June 2020. • He has now been asked by the Chief Executive of DPMC (Brook Barrington) and the Director-General of Health to manage a joined-up COVID-19 vaccination function. He has identified ten key focus areas for this work, including partner engagement, operational communications, and strategic communications. Important to engage more effectively with DHBs. The wider communications function is significantly under-resourced. • A national campaign to start garnering widespread support for immunisation through "strength in numbers" and similar messaging will start around 20 April 2021. • Carolyn Tremain and Steve Maharey agreed on the significant importance of the communications and engagement function and endorsed the approach outlined by John.
7.	**Real Time Assurance Leads Update (Colin MacDonald and Stephen Crombie)** • Colin MacDonald and Stephen Crombie noted that solid progress had been made at the programme level since the last meeting. • Colin noted that they had worked with Shayne Hunter to simplify the programme model and remove friction from the overall process. • Roles and responsibilities between the 'design and build' , 'transition' and 'run' parts of the programme are now linked, with a consequent reduction in the risks as raised at the last meeting. • Presentation of core project documents is also considerably improved and integration around the critical path can now been seen. • Colin noted that he considered the workforce area still posed considerable challenges and he would be turning his attention to that next. **Group discussion** • Murray Jack agreed he was more comfortable seeing this integration on the critical path but noted that the programme is complex and the supply chain runs across multiple organisations. The risks are still high and thus ongoing vigilance is important. In particular, he could not ascertain accountabilities and would like to see these clarified. • Steve Maharey reminded that with the complexity of the project, a culture of trust was needed. Mistakes will happen and reporting should reflect the issue and the mitigation. • Stephen asked if all present were clear on what the mission is for this programme of work and received at least two variations on this - hitting the implementation target date; educating New Zealanders of the benefits of 'strength in numbers'. • Colin noted both were inextricably linked but agreed on the need to clarify the mission and purpose, linked to an open and 'high trust' environment.
8	**Other** • Dame Karen thanked Dr Ian Town for the Science and Clinical overview paper.

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9.	**Meeting close** • Dame Karen noted the strong programme focus on 'achieving volume' was well aligned with the focus at a Ministerial level. She noted that in a volume/pace environment mistakes will happen. However, there was a preference (by both Programme Governance and at Ministerial level) to explain why mistakes happened in a 'mass roll-out' environment, and to learn from these, rather than to try to ensure a perfect pathway before even starting. The strong Ministerial focus is on moving quickly through to population-wide roll-out. • Ngāhiwi closed with a karakia.

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ACTION TRACKER

NO.	ACTION	OWNER	STATUS – DATE (Due or closed)	COMMENTS
210115 -02	Consider if this Governance Group should have a continued role overseeing the Pacific Health Corridors support for Vaccine	MoH and MFAT	In progress	Still under consideration
210129-01	For MoH to consider the 'readiness' process that it will seek to put in place with leads to ensure accountability	Mathew Parr	In progress	7 April update – to be linked to the new status reporting but still TBC and closed out actual readiness and planning
210326-01	Ensure programme planning documents have named individuals who are accountable for key deliverables	Mathew Parr	In progress	New structure and accountability plus 'straw person' programme plan will ensure this is completed by the next meeting
210326-02	Ensure DHBs are promptly advised of the Medsafe decisions re Pfizer Comirnaty vaccine storage	Joe Bourne	Complete	Raised 26 March 2021
210326-03	Medsafe decision to be factored into critical path decisions	Mat Parr	Complete	Raised 26 March 2021

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Minutes/Actions

Date:	Tuesday 2 February 2021
Time:	4.30 – 6pm
Chair:	Dr Ashley Bloomfield
Members:	Sue Gordon, Shayne Hunter, Chris Fleming, Dr Dale Bramley, Michael Dreyer, Dr Ian Town, John Whaanga, Maree Roberts, Deborah Woodley, Dr Caroline McElnay
Attendees:	Colin MacDonald, Stephen Crombie, Simon Everitt, Casey Pickett, Paul Giles, Karl Fergusson, Mat Parr
Apologies:	Wendy Illingworth
Secretariat Support:	Lillias Henderson

Item	Agenda Item
1	**Introduction and minutes** • Today's meeting is a full agenda and we are going to focus our time on implementation readiness • Minutes from the previous meeting are accepted
2	**Report back from PM & Ministers meeting (29 Jan) and look forward to next PM & Ministers meeting (5 Feb)** *Mat Parr (Programme Director) talked through the plan for the meeting with the PM* • The agenda will focus on giving an update into the key workstreams. This was sent over from the PM's office and we will respond to all subject areas • Anticipating that we will start a rhythm of weekly reporting for the Prime Minister *Mat Parr (Programme Director) gave an update about the Cabinet Paper* • The Cabinet paper was well received. A small change has been made to ensure the following Ministers are jointly involved with the power to act: Prime Minister, Minister of Finance, Minister of Foreign Affairs, Minister of Health, Minister for COVID-19 Response, and Associate Minister of Health (Dr Verrall) Group discussion • The paper will be proactively released. It is well written and will support our transparent approach to share information • The DG briefed his public sector colleagues earlier today and shared the Cabinet paper with them. They were very supportive and eager to get involved where possible, especially NZDF **Action** for Karl Fergusson and Maree to follow up with the Minister's office about when we can expect the Cabinet Paper to be made public.
3	**Verbal update on policy advice to Ministers**

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	Maree Roberts (DDG, System, Strategy & Policy) gave a verbal update about advice that the policy team is drafting in response to Ministerial requests • The policy team will provide a regular update about advice that is being submitted so that Steering Group has visibility • Elimination strategy – working out what happens strategically once the vaccine is in use and how this affects the strategy. This will look at the impact for border settings, our relationship with the international community and other aspects • Sequencing framework – transitioning from the strategy to supporting the CVIP to implement it in practise • Vaccine uptake – considering the options and levers we have to encourage vaccine uptake, and what we can do if people refuse • Vaccination targets – the PM requested advice about what possible target rates of immunisation could be for the programme • Privacy considerations – considers how we share information in a way that is sensitive to privacy needs • Vaccination certification – what is international best practise and how are other countries approaching this • Restricting personal access to vaccines – to ensure that people cannot import the vaccine as individuals • COVAX implications – what are our plans for the COVAX facility
4	**DHB response summary & DHB engagement next steps** *Simon Everitt (Lead, Service Design) presented an update on planning with DHBs* • We are continuing to work closely with DHBs to confirm their model of delivery for Phase 1A – border workers and household contacts • DHB responses have been received (excluding one) and they have been compiled in a spreadsheet and have been attributed a RAG model. Tomorrow we will hold an assessment session on all 20 DHBs to determine their readiness • There are still gaps in information and we will go back to DHBs on a 1:1 basis to help them with their plans • Comms will be shared with DHBs following the approval announcement and DHBs will receive a run sheet for how things will work over the coming days • A simulation activity takes place next Tuesday 9 February with Fonterra, NZDF staff and DHBs • We are commencing tri-weekly stand-ups with DHB vaccine leads who are responsible for the delivery plans so they have an opportunity to ask questions, and we can share information *Mat Parr (Programme Director) gave an update on the rollout plan over the coming weeks* • Purchase order for the Pfizer vaccine was placed last Friday • Vaccine will be shipped to Auckland in the first instance, then sequentially to other DHBs around New Zealand in the following order: Wellington, Hamilton, Waikato, Rotorua. These cities will prioritise Tier 1A, then we can turn to the next cohort • Timing of rollout will be informed by delivery schedules, as well as our ability to plan and deliver sufficiently for each vaccination site Group discussion • We can't give specific details into the date of vaccination because we are yet to receive the flight information • Sequencing of rollout means that Auckland may have finished vaccinating Tier 1B by the time other DHBs receive the vaccine for Tier 1A. This means Auckland could be vaccinating household contacts while other DHBs are just starting • Close contacts definition has been finalised. There are some data privacy issues around requesting information from employees. We are attempting to request the household

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	contact information in advance of the employee coming in for their vaccine and work is actively being done in this space • It will be important for the programme to reach out to individual DHBs • Need to ensure all DHBs have a consistent definition of 'health workforce' – there have been inconsistencies in interpretation so far • Border workforce includes everyone working at the border, as well as health staff who are in these locations, such as for testing purposes • We are not yet in a position to communicate with individuals who are getting vaccinated, meaning our previous focus of "why you should be vaccinated" will swiftly become "here is your appointment" • Occupational health providers are being engaged to deliver to large frontline workforces, such as Police and Fire & Emergency. More information will be presented to SG on this option • Important to acknowledge the role that primary care plays. Regular catchups for the whole sector should start and provide everyone an opportunity to come along and listen • May be an option to second someone to support with DHB comms from organisations in the sector. We have a number of groups asking for briefings and it is difficult to reach everyone all the time • Reiterate that GMs Planning & Funding should be updating their own teams within their DHBs and not rely on the Ministry to deliver separate briefings • Vaccinator training will commence next Tuesday with IMAC, with training on the vaccine and also how to use the CIR • Relationship with NZDF is still developing but they are eager to help where possible, especially with vaccinating their own workforce

5	**Status report & readiness assessment**
	
	Mat Parr (Programme Director) provided an update on key items in the status report
	
	• Distribution and inventory
	    ○ A cold chain simulation and QA session with Fonterra is taking place soon
	    ○ This risk area has been identified as red for some time
	    ○ A distinction has been made between sites and locations. Number of sites is smaller than locations because it encompasses a larger area
	    ○ NZDF Director of supply chain has been seconded into our team full time
	• Post event monitoring
	    ○ We need to swiftly ensure that everything is fit for purpose and ready for the readiness date
	    ○ Shayne Hunter and Chris James had a useful session to determine what Medsafe needs so a rapid plan can be developed
	    ○ CARM is based in Otago and a team of people will travel down. This is to ensure we strengthen the current system as much as possible to upscale CARM
	    ○ Eventually we will receive the Dutch monitoring system. There are some procurement matters that need to be worked through
	    ○ Colin noted that it will be difficult to scale up the current system and a conversation needs to happen offline about our ability to do this
	    ○ There is increasing Ministerial interest in the technology components of the programme and we need to present a clear narrative for this
	
	<u>Group discussion</u>
	
	• All status reports need to be completed before presenting to Steering Group
	• Lots of collateral is being produced to support providers with the rollout. We need a clear sign out process for this to ensure it is consistent
	• Reporting templates will be developed next week, and people will receive different information depending on who they are. Recipients will include PM, Ashely, Sue, and other SROs
	• The provider has not been finalised for inventory management. Ashley would like more information about this

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	• A common issue raised by Māori providers and iwi is that the Ministry is not being proactive enough about how we have accounted for equity. This is an area that needs further work as Māori and iwi are involved throughout many layers of the Programme across governance and leadership. We want to front foot this narrative and tell a positive story **Action** for Caroline and Deborah to discuss the effect on other vaccines and whether advice should be given about interference with another scheduled immunisation. **Action** for Mat to update Ashley about inventory providers **Action** for John to meet with Karl and Ana about equity communications.
6	**Security and privacy assessment** *Geoff Gwyn (Lead, Security and Privacy) presented an update* • Purpose is to ensure we have a coordinated view of security and privacy across physical security, cyber security, and privacy • Last week a GCSB and SIS briefing took place to complete a readiness assessment and we have dedicated resources into privacy • This assessment will build on the previous report completed in December last year, and will be presented to Steering Group next week Group discussion • Engagement is being had with the right people and groups • Data sharing is a significant policy issue and we need to be careful how we collect this from people. Individuals are very concerned about their personal security
7	**Iwi data collection decision – ITEM DEFERRED**

8	**Communications strategy refresh**
	
	Paul Giles (GM, Communications and Engagement) gave an update about the vaccine approval announcements tomorrow
	
	• We will be reiterating the safety message throughout all announcements tomorrow
	• Research indicates around 20% of border workers are still uncertain about receiving the vaccine. We want to start speaking to the cohort who will receive it first and reassure them
	• Tomorrow's announcement will be the beginning of considerable public and media interest in the vaccine
	  ○ 2pm: PM stand up and PR released – focused on approval and next steps
	  ○ 2.45pm: DG and Chris James will do a stand up at Ministry – focused on approvals process and safety
	  ○ Thursday morning: DG will do a media round
	• A document with key messages will also be released to be used in communications material
	• We are anticipating long form interviews to take place over the weekend and addressing issues such as vaccine hesitancy
	• Potential for a media briefing to take place on Friday
	• Campaign is still on track to commence on 15 February
	• Communications with the workforce will kick off urgently
	
	Karl Fergusson (COVID-19 Vaccine Comms Lead) provided an update about the updated Communications & Engagement Strategy
	
	• PM and Joint Ministers saw this strategy last week and seemed broadly happy. We are expecting some feedback from the PM
	• The four underlying pillars for communications are: safe, timely, free and essential to protect NZ

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	• We are using our engagement with stakeholders to inform campaign planning which is well underway. Need to ensure people are at a position of informed consent. Our ultimate goal is ensuring that people have confidence in the vaccine that leads to high levels of uptake Group discussion • It will be important to have an accessible point for the public to track our progress. This will need a website landing page so people can get a status report of numbers vaccinated etc • Most people will get their information from the COVID-19 Unite channels, and the Ministry will provide advice for the workforce on the MoH website • Everyone will want to know what this means for them. Having a clear place for the public to go and get their information is key • All of Government meeting will work through the use of Unite channels and information that is put on the MoH website • The principles of the strategy make sense if we weren't operating in a constrained environment, but we need to be conscious that people will hold off from making their decision until we have more supply • There has been no public comment about arrival timelines for the vaccines, and the border workforce aren't yet aware of how quickly this could take place • The Programme has been working through border workforce requirements and definitions • Comms are needed for the DG to share with his colleagues following the announcement on Tuesday. Could be an email or fact sheet to public sector employees that includes the key messages • Note that the Prime Minister's office will publish the Cabinet Paper next week • Colin noted that more information is needed about the detailed comms plan **Action** for Paul to draft an email that Ashley can send to his colleagues with key documents for reference.
9	**Any other business** *Mat Parr (Programme Director) gave a general update* • There is a lot that needs to be achieved within tight timeframes. • Where possible, we are coordinating engagement to avoid individual briefings • It is likely that each week we will need to make a judgement about the relative capacity of the system. This is something that we can assess closer to the rollout date to ensure we are well placed to deliver successfully. Ashley signalled he is contactable should there be any reservations at any stage *An additional paper to be presented by Casey Pickett will be delayed until next week.*

Action tracker 2 February 2021

Item	*Action*	*Who*	*Due date*	*Status*
Tuesday 2 February				
2	Maree and Karl to follow up with the Ministers office about when we can expect the Cabinet paper to be made public	Maree & Karl	9/2	Completed
3	Caroline and Deborah to discuss the effect on other vaccines and whether advice should be given about interference with another scheduled immunisation	Caroline & Deborah	9/2	

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4	Mat to update Ashley about inventory providers	Mat	3/2	In progress
5	John to meet with Karl and Ana about the equity comms piece	John, Karl & Ana	9/2	Completed
8	Paul to draft an email that Ashley can send to his colleagues with key documents for reference	Paul Giles	3/2	Completed
Tuesday 26 January				
5/6	Implications of COVID and Flu vaccine campaigns converging	Deborah/Mat/Maree	Watching brief	
7	Identify target surveillance methodologies to report reactions for New Zealand cohorts	Ian		
8	Outline how risk approach is made more active	Stephen/Colin/Mat	1/2/21	Resource to be identified

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Minutes/Actions

MINISTRY OF HEALTH
MANATŪ HAUORA

Date:	Tuesday 9 February 2021
Time:	4.30 – 6pm
Chair:	Dr Ashley Bloomfield
Members:	Sue Gordon, Shayne Hunter, Dr Dale Bramley, Michael Dreyer, Dr Ian Town, John Whaanga, Maree Roberts, Deborah Woodley, Dr Caroline McElnay
Attendees:	Colin MacDonald, Stephen Crombie, Simon Everitt, Casey Pickett, Paul Giles, Karl Fergusson, Mat Parr, Allison Bennett, Matt Jones, Wendy Illingworth, Tanya Maloney
Apologies:	Chris Fleming
Secretariat Support:	Lillias Henderson

Item	Agenda Item
1	**Introduction and minutes** • The meeting started late due to a meeting with Ministers • An updated agenda and additional papers were circulated shortly ahead of the meeting **Approved** the minutes from last week's meeting.
2	**Report back from PM & Ministers meeting 5 Feb** *Ashely Bloomfield shared an update from the meeting with Ministers last Friday* • The meeting went well, and we have another one scheduled for this coming Friday. This is reflective of the regular reporting cadence we are in • A separate meeting took place with Minister Hipkins this afternoon where he was alerted to the distribution issues for the Pfizer vaccine. He would like to know whether we have the consumables in the country to deliver this
3 4	**DHB Chair's Letter and DHB Engagement Next Steps** **Status report, readiness assessment, and update from 'dry run' simulation with DHBs and other agencies** Note: Items 3 and 4 were discussed together <u>Simulation event</u> *Mat Parr (Programme Director) gave an update about DHB engagement and the simulation event* • A letter was sent to DHB CEs last week with information about the programme, and providing feedback on the DHB plans that had been submitted • A letter will be sent this week to DHB Board Chairs from Ministers Hipkins and Little to set out high level expectations

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	• Tuesday's simulation event was an end to end walkthrough of the plan for vaccination. It was a productive session that involved several stakeholders which included DHBs, sector partners (IMAC), AoG, IIAG, primary care
	Group discussion – simulation session areas of concern
	• Generally, the session reinforced that there are several gaps and we have lots of work to do in order to be ready on time
	• 1. Distribution – needs more focus, specifically whether DHBs would be required to split the trays and whether it could take place outside of a pharmacy. Further sessions will be held on this in the coming weeks
	    o Preference from DHBs is this takes place from HCL
	    o The cold chain capacity needs to be managed very tightly, particularly given the regulatory compliance needs
	    o Discussed further at Item 5
	• 2. Booking and registration system – we need a mechanism for measuring demand and managing the queue of people who are eligible in Phase 1. There is not a national solution in place currently, so we are working with DHBs on an individual basis to understand what each DHB has in place and how they will use this
	    o Developing a nationwide booking system in the short time available is not advisable and instead we are looking to pursue localised solutions
	    o Northern region DHBs are using a system which is the most advanced.
	    o If we had more time, we would develop a Salesforce solution which is the platform that the NIR and CIR are using
	    o This is a piece of technology as part of a wider package and it would be useful to know how it compares in relation to other elements
	• 3. Balancing strategic and operational elements is challenging, particularly when it comes to managing the sequencing framework without avoiding wastage
	    o Need to take a pragmatic approach to this and we can't just give the vaccine to anyone. Should have a list of people who fit within the categories who can be contacted at short notice and make sure they receive a vaccine, or take people from the hospital in a van etc
	    o Possibility to book appointments until 3pm each day and have a 2-hour window for using up the rest of stock
	    o This will be a focus in the media, so we need to have a strong narrative
	    o Our SOP should include guidance on wastage and the trade-offs of this from a central perspective – it should not be a localised decision
	• Equity was discussed, especially in relation to the ethnicity of the border workforce. We have shared information with the Minister's office about the ethnicity breakdown. Equity has also been reinforced in conversations with DHBs and we have been asking what their plans are for ensuring this remains a focus
	Action for Ashley to have a conversation with Shayne about a national booking system.
	Action for Michael and Shayne to report back on the critical path and identify the trade-offs for each piece of technology. This will be presented to the technology governance group, and then back to Steering Group
	<u>Other discussion items</u>
	Tanya Maloney (Workforce Lead) presented an update on the workforce
	• Training will go live on Wednesday 10th for the IMAC online system. This will include any updates from the walkthrough session today and is for existing vaccinators
	• We are expecting 100 people to complete the training by next week, and by week 4 we will have needed to train 500 people to meet demand.
	• A definitive list of vaccinators from DHBs still hasn't been secured
	• We are working with IMAC to ensure they are upholding their Treaty obligations. We are aiming to achieve the right balance of the workforce, as well as ensuring cultural

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	responsibility is a key focus of the programme. We will explore ways to include iwi and help them navigate the system *Group discussion – general* • We have finalised a push model for the inventory system so we can calculate demand backwards. The inventory can be accessed at any stage to see how much is in any location, including transfers between DHBs which will be managed on an exceptions handling process. Reconciliation will be carried out using CIR data at the end of each day • More information is needed on the critical path and how a booking system fits within the overall package of technology solutions eg. Inventory, track and trace, CIR. All these components require an MVP before we can deliver training so this needs to be kept in mind • Advice will be sent to Ministers this week on possible levers to ensure the border and MIQ workforces receive a vaccine. MoH received advice from the Solicitor General on this which has informed what was put up to Ministers • Post event monitoring is top of mind as it continues to be a risk. We are working to ensure readiness for Phase 1, which will scale up for Phases 2 and 3. The interim solution is to boost CARM's capability so they can accommodate the anticipated increase (expected to be double the current capacity) and there is strong process management to support this *Assurance update from Colin Macdonald* • It has been difficult to get a clear picture of the plan for Phase 1 and it seems that some discussions haven't yet taken place • There is a lack of clarity in the anticipated numbers of people who will have adverse reactions and this ambiguity means it is difficult for CARM to understand what they are getting into • Currently lacking a plan for scaling up to Phase 2 and 3 • Side effects are not unexpected, but the best way to work around this is to manage public expectations and signal that people could expect a sore arm, for example, to avoid the influx of reports **Action** to include an update about post event monitoring on next week's Steering Group agenda.
5	s 9(2)(c)

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	s 9(2)(c)
6	s 9(2)(c)
7	**COVID-19 vaccinator workforce – inclusion of non-regulated workforces as vaccinators** *Casey Pickett (Manager, System Strategy & Policy) presented a paper on non-regulated vaccinators* • Including non-regulated workforces as vaccinators can present some ACC issues as coverage is limited to medical interventions which are delivered by registered healthcare professionals • Issue has been presented to Steering Group to get confirmation this is an area we are willing to explore before exploring regulatory amendments • We are being mindful that we don't want to undermine access or limit ACC coverage if people experience an adverse reaction Group discussion • If we exclude non-registered workers, this is contributing to a legacy issue. One of the purposes of the programme was to address legacy issues and provide opportunities for people, particularly in Māori communities, to contribute to vaccine delivery for their communities • We need to involve non-registered workforces in the vaccination effort because they will be able to support us to navigate the system and increase access, as well as determine the regulatory change that needs to take place • People are ready and willing, and we should involve them. This will only strengthen our response

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	Agreed to explore regulatory change to include non-regulated vaccinators in the workforce.
8	**Preliminary security and privacy assessment** *Geoff Gwynn (Security Lead) shared the preliminary PIA* • Would be interested in any feedback from Steering Group about the paper • Main areas of concern are site security, and information breaches • Today's walkthrough suggested DHBs are currently thinking about vaccination sites like the pop-up testing facilities when they have vastly different risk profiles. Controlling access is a key consideration and much more difficult for vaccination and we will work with DHB security managers to undertake risk assessments for security aspects • Guidance around expectations will be included in the SOPs shared with DHBs • PIAs need to remain current and be updated on a regular basis, particularly mitigations that are being followed up and actions Group discussion • We need to be explicit around our expectations when it comes to security • Privacy and information risks may arise when we are seeking to engage with communities • Technology should be used in a way that minimises risk • The intelligence community has agreed to proactively monitor in this space on our behalf
9	**Iwi data collection – verbal update** *Michael Dreyer (GM, National Digital Services) presented a verbal update on iwi data collection* • Work has been done with John's team in the Māori Health Directorate on this issue and develop a strategic vision • Collecting information at the vaccination point is not a desirable outcome • An approach is being drafted and will come back to the Steering Group for approval Group discussion • A number of things are coming together in this space across broader technology workstreams. We should leverage this work and be upfront with our delivery partners about the challenges of this work • Need to maintain alignment with Statistics and All of Government • We are falling behind on proactively telling the equity narrative. Communities are concerned we are following past practise and we are underselling the work we have done in this space

10	**Any other business**
	General discussion
	• Documents appended at Item 10 have been noted, including:
	  ○ 11. Real time assurance action tracker
	  ○ 12. Interim advice on maximising uptake of vaccines by border workforces
	  ○ 13. Definitions of Tier 1 and Tier 2 in the Sequencing Framework
	• There are a number of people writing to the programme with offers of help and want to be included. We will continue to receive letters and should be prepared to give answers to these
	• Narrative is shifting and this will be delivered by the PM, Minister Hipkins and Ashley as the main channels for sharing information
	Governance Group – Friday 12 February
	• Members will want to know about the narrative and our comms plans. Paul and Karl to present on our comms plans with a more detailed view, rather than just a strategy eg. 5-page plan on how we intend to vaccinate all of New Zealand in 2021. A plan is going to Ministers offices to get feedback ahead of the PM meeting on Friday

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	• Agenda will include:
	  ○ Readiness discussion
	  ○ Comms and engagement
	  ○ Risks and mitigations of key issues
	Action to inform Karen we would like her to attend the Prime Minister's meeting also.

Action tracker 9 February 2021

Item	*Action*	*Who*	*Due date*	*Status*
Tuesday 9 February				
3/4	Ashley to have a conversation with Shayne about a national booking system.	DG and Shayne	15/2	
3/4	Michael and Shayne to report back on the critical path and identify the trade-offs for each piece of technology for the booking system. This will be presented to the technology governance group, and then back to Steering Group	Michael Dreyer	15/2	In progress
3/4	Include an update about post event monitoring on next week's Steering Group agenda.	Mat Parr	15/2	Complete
10	Inform Karen we would like her to attend the Prime Minister's meeting also.	Mat Parr	11/2	Complete

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MINISTRY OF HEALTH
MANATŪ HAUORA

Agenda

COVID-19 Vaccine and Immunisation Programme Steering Group

Date:	Tuesday, 16 February 2021
Time:	4.30 – 6.45pm
Location:	1N.3
Chair:	Dr Ashley Bloomfield
Members:	Maree Roberts, Sue Gordon, John Whaanga, Shayne Hunter, Deborah Woodley, Dr Dale Bramley, Chris Fleming, Wendy Illingworth; Michael Dreyer; Grant Pollard; Optional: Dr Caroline McElnay; Dr Ian Town
Attendees:	Casey Pickett, Mat Parr, Colin MacDonald, Stephen Crombie, Matt Jones, Petrus van der Westhuizen, Luke Fieldes, Jo Gibbs, Dr Tim Hanlon, Ana Bidois, Rachel Haggerty, Karl Ferguson, Chris James
Apologies:	
Secretariat Support:	TBC

#	Agenda Item
1.	**Introduction and minutes** • The Chair acknowledged the support of the DHBs including Rachel, Dale Chris, and Jo presence at Steering Group. • The importance of this meeting was highlighted with the arrival of the vaccine. The PM, Minister and Cabinet relayed their high degree of confidence in the programme. • Te Tiriti and sequencing items were added as late agenda items
2.	**Status report and readiness assessment** *Mat Parr outlines the readiness assessment building from the dry run, governance group and meetings with the PM.* These meetings identified key action items that needed to happen before a state of readiness could be made. **Distribution plan**: • 1 to 1 with DHBs and Medsafe to test processes is achieveable and allowable within the rules. Stress testing again with DHBs at their sites to test point to point delivery. *Group discussion* • Medsafe to complete an audit on the pack size from full trays to smaller box sizes. • Stress testing before going live with a DHB there will be a dry run and stress test. • s 9(2)(b)(ii) and have receied all the conditional documents from Pfizer before the vaccine is to be released. • s 9(2)(b)(ii) .

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- No further issues for the first 2 weeks, but scaling this will present further issues.

Booking and registration

- The programme has agreed with DHBs to manage demand upfront by working with agencies to identify and book people in.
- Employers have been asked to update the Border testing register.
- The interim measure is to make the lists, contact the persons in the list and updating the lists as the vaccination programme continues in the initial phases over a 3 day rolling cycle
- If persons were not in the system, it was a judgement call on whether to vaccinate or turn them away.

Consent discussion

Ashley questioned whether booking and registration included consent and the meaning chosen

- The consent process was outlined as a verbal process; which was recorded in the CIR. A paper back up was available in the event of technology failure.
- People are invited to be vaccinate and will provide verbal consent on the day.
- A key concern was for permission to enable employers to know whether staff were vaccinated was a key concern. **This was agreed to be operationalised in the CIR.**
- A formal consent protocol was raised for all providers; It was noted that protocols would give providers assurance, however there were inconsistencies on vaccination protocols around the country
- The DG requested a written consent process instead of a verbal process was raised. He cited as a new vaccine a form should be signed citing uncertainty around verbal consent process in a database and issues in aged cases of EPOA.
- Advice that the verbal consent process exists in Australia, and the creation of medical document through written consent and the lead time to create the necessary translations was noted.

Policy and how to balance waste and sequencing.

- The paper drafted has been socialised with DHB and provider teams to be updated by the end of the week.
- It was agreed that Jo Gibbs as National Director would sign off on the operational guidelines

Dry run – vaccinating vaccinators beforehand

- Northern Region requested a day to practice using the actual vaccine to ensure safety and that all people have confidence in process.
- NR would run a vaccine session a day prior without media for vaccinators and other key people as a risk mitigation.

Group discussion

- Paul (comms) outlined only the Ministry of Health communications team would be pressent.
- Dale (NR) outlined the benefits of testing the process in a 'live' environment and feedback that vaccinators wanted to be seen to be leading as well as needing protection.
- Dale also notes the kick off in Jet Park is a Maori Provider to have a formal opening to the programme from a Tikanga perspective.
- Sue noted the assurance provided by the dry run, full E2E run with DHBs tomorrow and the live practice run on Friday which provided assurance to the Minister. All events will have MoH media presence.
- Joe need to be clear that the people on the ground are not overwhelmed and are providing honest feedback
- The Steering group agreed as long as it was planned to not impact the vaccinator workforce

Agreement: NR and other DHBs should have the option to have a live practice sessions (wet run) a day before vaccinating the sequenced population

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	High level review of the pillars
	Ashley requested the group review the pillars at a high level to check their readiness.
	
	1. Purchasing and approval: Ready as vaccine has arrived
	2. Sequencing: Ready as cohorts are known
	3. Inventory and distribution: Ready as dry run was completed
	4. Workforce: 65 vaccinators and understanding the barriers, and confident will have enough workforce for the next 2 weeks.
	    a. Barrier of the individuals required to provide a work email address prevented people from accessing the service.
	    b. Working with IMAC to check lists for errors and expedite the process
	5. Provider management (funding):
	    a. A draft letter going out to DHBs on payment and process which outlines how the broader system will work and provides assurance that funding is available.
	    b. Bulk funding for February and March is expected to communicated tomorrow.
	    c. Working group is being established for the wider GP and other providers. Chris Fleming asks whether theres consistent funding for like services (confirmed).
	6. Registration: CIR system went live today. Data from MBIe going into the CIR and data can be extracted tomorrow.
	7. Post event to be picked up in seprate agenda item.
	
	Discussion: readiness
	Joe provided an update on the readiness documents – these provide a high level overview of DHB reainess and assurance of readiness at each site
	
	DHB readiness group discussion
	• Further conversations with remaining DHBs will be conducted through account managers.
	• These DHBs are smaller and capability to deliver must be kept in mind
	• A written letter of readiness to each of the DHBs should be explored
	Action for Jo to examine CE's letter of readiness
	
	Overall readiness group discussion
	• Ashley outlined a slow and steady approach (crawl, walk, run) was required and would raise the need to stop if required/advised by the programme.
	• Colin reiterated the need for the programme and its team to raise concerns of programme failure
	• Border agencies as a critical stakeholder will need to be empowered through ongoing discussions to overcome any concerns

3.	**Day 1 reporting dashboards update**
	
	Mat, Luke and Petrus Mat tables the paper, outlining the challenges in the report and in Appendix A
	The possible reports include
	    a) Daily reporting for upwards management (ministers, DG, DDGs)
	    b) Downwards reporting for DHBs and operational ministry staff
	
	• Reporting options/features will be initially focused on critical information and expand over time. It was cautioned that too many initial requests and requirements would cause operational impacts
	• Later in the process, there will be daily reporting similar to a sitrep report used in testing this will produced later in the day on the vaccination this will sent to a smaller group content of the report will be developed.
	
	Group discussion
	• Key controls on sourcing this information will be through the CIR as a single source of truth. This builds on learnings from the COVID-19 testing experience
	    o Critical stakeholders will be kept informed and provided channels.
	    o A data controller position will also be created to manage this.

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	• Possible problems were indicated as
	  ○ (1) denominators of the cohorts to understand what proportion has been vaccinated and who to follow up with.
	  ○ (2) the repeat vaccine given, how many have complete the cycles
	  ○ (3) ensuring Maori and pasifika specific profiles are setup to ensure equity is met.
	• Rachel supported the need for a data controller for requests. Access to CIR downloads to stay ontop of population analysis to stay ontop of equity, reach, performance, etc. AND access to this information not be delayed

4.	**Māori and Pacific support service recommendations**
	
	Ana Bidois outlined the tabled paper noting service for Maori to be actively protected under the Treaty and Pacific more widely.
	
	The paper proposed readying the sector through a proposal for 4 interventions
	1) Vaccine navigators -using an existing workforce or using a combination of new staff
	2) Vaccine coordinations – connected up with DHBs
	3) Vitual support – telehealth
	4) Local champions – influencers on social media, media, etc – to ensure a legacy of leadership.
	
	• If needed there will further uplift to further coordination with TPK, pacific peoples, MSD and DPMC
	• Mat advises the programme budget can be meet these through its integrated funding approach for vaccine delivery.
	• Jon notes the programme lacks an obvious equity and treaty strategy to this programme.
	  ○ This was evident through daily requests from the Minister office on its equity approach to Maori.
	  ○ The Maori immunisation strategy was successful last year through the work with Maori providers and local community partners, and agreed with supporting these dedicated resources.
	  ○ Suggested continuing this partnership in the programme and cited there is a contracting team and preferred partnering group that is available.
	
	<u>Group discussion</u>
	• National Chair and CE meeting featured strong views on programme's equity approach in relation to ARC sequencing and lowering the age of maori and Pasifika groups.
	• Dale outlined NR's approach through forming relationships through iwi partnership boards, sub commitees and delivering the response as locally as possible. Money is seeded to local providers.
	• Ashley agreed the Ministry could not mediate from the centre and DHBs mediate with their local providers. The narrative for equity was being done but the story not commnunicated well. Ashley requests the meeting with Henare is circulated to help frame the programme's equity approach.
	• Mat asks whether the Ministry provides the lists of Maori and Iwi providers to DHBs and whether local contracting for DHB.
	• DG notes preferences for local contracting. Dale agrees but notes some DHBs won't have the strengths of partnerships. Chris requests a strong expectation is given to DHBs and an obligation to engage on the other parts required including CPR training.
	• Jon notes that Ministers will be interested in what resources are allocated and how its being spent.

5.	**Update on national booking and appointment solutions** *Michael Dreyer outlined the booking system timeline from Saturday to the next month to support the DHBs.* <u>Initial solution</u>

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	• The CIR does a lot of the work but each DHB will use its own booking service (outpatient or other interim solution). Canterbury and Wellington to be met to review Northern Region solution or progress their own.
	• The process has been mapped including household contacts.
	• The key part of this is once the BW and address is obtained a webportal is sent. A back up phone contact line.
	
	National booking and scheduling system
	• s 9(2)(b)(ii) will be expanded to allow delivery expansion.
	• Expected to be delivered and to be used in Sprint 1 and 2 (back end of April).
	• There are three components needed for the national system
	  o booking and scheduling service,
	  o extend the consumer channel behind the covid-tracer app and
	  o the digital identity.
	• There is no digital identity for health going live in March – but there is a risk given its initial stand up. There is a change management piece noting the requirements may change.
	• Once created the tool will be shared with DHBs, iwi providers and other providers to allow them to do their own bookings.
	
	Group discussion: Risks and concerns
	• Stephen observes difficulties with the actors involved (provider, persons, ministers). There is no time for adaption and how it will operate will need to be settled soon. There is low tolerance as requires design upfront.
	• Colin asks whether there is a comprehensive assurance around this.
	• Mat outlines the programme is limited in shifting resources to run and pivot back to design as this a week 10 concern. The discussion should focus on whether the business process has been met and assurance met.
	• Shayne asks whether there are resrouces to move the project in parallel of sustaining the CIR and other projects. If not, there is a possibility of programme stoppage.
	
	Action for Jo, Sue and Shayne there is a proposal on the future structure on design, build and run and what they looks like.

6.	**Communications and engagement update** *Paul and Sarah outlinethe messaging is now to be vaccinated rather than be informed to be vaccinated to remove areas of doubt.* • Strategy is to appeal to the 70% group of the population who are likely to be vaccinated. • This critical mass will be an influencer for those percent who are hesitant. • Notes the Ministry comms team and DHB comms team are duplicating effort. • The campaign is not strong call to action due to the stage of campaign. • It will provide reassurance that people will be vaccinated, where information can be obtained if they are seeking it and the opportunity to reinforce the good practices of scanning, sanitisting hands etc. • Radio, digital and press (not using tv yet). Using static images and going into phases of well known new Zealanders and stronger calls to action. **Action** for comms team to provide Ian a copy of the collateral for future discussions
7.	**National Director Operations, run structure initial thoughts – not discussed**
8.	**CARM uplift and adverse event subcommittee** *Tim Hanlon outlines two key points* 1) CARM readiness update: Highlight enduring risks in short term and the mitigations 2) Expert advice on adverse events: establishing an independent body

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(1) Focuses discussion on readiness of CARM

- Long term plan is to change the system due to the identified capacity concern
- Work programme to digitisation of workflow into the cloud, other BCP and expanding the medical assessor (currently 1).
- The long term risk mitigation is to streamline the workflow – the risk is that it won't be achieved within the 2-3 window.
- The short term mitigations is adding the medical assessors and the website which is not fully complaint into the MoH infrastructure.

Group discussion

- The same platform or parts of it will be used across CARM and Data and Digital. There is a team in place to manage the project and there are sufficient resource across CARM and Data and Digital
- In the first 28 days; expected adverse events are expected to be low.

(2) Independent group

- Group to provide advice to pause, stop or continue in the event of adverse effects.
- Terms of Reference has been drafted and the membership and the Chair to be identified.
- This group will meet as a panel when required and advised by CARM. It must be independent ot meet the requirement of the regulator'
- John tate CMO Capital and Coast – as the chair – established by Thursday once due diligence of documents and process is completed.
- On Thursday a walk through the process and the immediate response should an adverse reaction occur.

Group discussion

- Medsafe is comfortable with this approach as it provides expert advice andthe nature of the chair and memberships pending conflict of interest register made.
- Ian notes his position will be a non voting member to provide a link to the Ministry.
- Wendy outlines the key to outline who and how decision were made given the membership is being formed at piece.
- Sue agrees this and suggests this is advised to the wider ecosystem given the existing other governance type groups.
- Mat suggests Jo is signor of the TOR, which is then sent to the DG as chair of the steering group. Jon asks that the competencies of the group is clear in the TOR and the respective skills and experience.

9. **Sequencing to honour Te Tiriti and promote equity [NEW ITEM]**

Casey outlines the covering memo is a draft advice for comment and review.

- Due to the pace of the programme the advice may need to be readily available.
- The paper outlined the implication of lowering the age for Maori and Pasifika.
- It also outlined there was not enough vaccines to cover tier 3 and the approach where people are at increased risk of virus and transmission is outlined in the paper.
- There are two proposed approaches, (1) use prescriptive nation wide approach based on criteira to manage the vaccine or (2) use a regional approach but to have a strong focus on the particular area.

Group discussion

- The challenge raised at the DHB chairs and CEs meeting was on the ARC residents vs kuia and kaumatua related to scarcity and inadequate supply of vaccine.
- Initially ARC was in tier 3; however Cabinet agreed to the approach that ARC residents would be vaccinated at the same time as the ARC workforce
- There was agreement that the horse had bolted with the public announcements
- Jon suggests an overall discussion on equity on tier 1, tier 2, tier 3, etc is needed. if we can't shift tier 3 to tier 2, can we move a subset. If theres a more comprehensive message

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	of equity. Looking at tier 3 there is no equity approach as tier 3 is all new Zealanders rather than no preference ot Maori and Pasifika. • Sue requests the policy team recasts this paper/position is made before checking with Ana and Jon before tomorrow's discussion with the DG.
10.	**Tier 3 sequencing framework initial proposals for phasing - not discussed**

11.	**Any other business**
	
	• PM briefing at 3:30pm Thursday – for an hour the meeting is being brought forward. Thinking about the agenda and what is discussed.
	
	• Proposed agenda to PMO
	    ○ Focus on readiness (Equity narrative to be included this discussion item)
	    ○ Communications
	    ○ Porftolio update generally
	    ○ Purchase of additional Pfizer doses
	    ○ Access to the pacific (Monday a cabinet paper will be tabled for discussion)
	
	• Pacific discussion notes that discussions with Pacific partners will need to be undertaken to facilitate this access being developed.
	
	• Jo suggests coming to the next meeting with a draft structure on the operational run team.

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Agenda

COVID-19 Vaccine and Immunisation Programme Steering Group

Date:	Tuesday, 23 February 2021
Time:	4.30 – 5:30pm
Location:	1N.3
Chair:	Dr Ashley Bloomfield
Members:	Sue Gordon, John Whaanga, Shayne Hunter, Deborah Woodley, Dr Dale Bramley, Chris Fleming, Michael Dreyer, Jo Gibbs, Dr Ian Town
Attendees:	Mat Parr, Stephen Crombie, Matt Jones, Karl Ferguson, Paul Giles, Simon Tucker (Item 6), David Cheetham (Item 6), Joe Bourne, Allison Bennett
Apologies:	Maree Roberts, Wendy Illingworth, Grant Pollard, Colin MacDonald, David Nalder, Simon Everitt, Dr Caroline McElnay
Secretariat Support:	Lisa Hunkin

#	Agenda Item
1.	**Introduction and minutes** The minutes from the previous meeting on 16 February 2021 were approved.
	Run
2	**Initial reflections on the first weekend and issues raised** Group discussion: • More sites are being brought online and this is going well. The programme needs to be ready to manage the operations while also designing the next phase. • The IT system can meet the programme's needs, but the operational side of the technology teams is coming under pressure. The biggest challenge is to book and contact people. • Rolling out the vaccine programme needs an emergency response. The Northern Region pulled the DHB CEs into one place to make timely decisions.
3	**Readiness assessment for DHBs going live this week** Jo Gibbs presented the Readiness Assessment Summary for DHBs. The Northern region is currently 'Ready' but all other regions need further support to go live this week. Group discussion: • All DHB CE conference tonight • SROs to ensure that the implementation process goes well

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	• There is a need to reinforce the single points of contact – right now there are multiple layers of contact within the DHBs
4	**'Run' structure** Jo Gibbs tabled the proposed draft run structure and operating model to support the go-live of Phase 1 (Tier 1 and 2). Jo noted that the draft structure is likely to change in future. There are still many aspects to discuss, including a national booking system and large-scale call centre. This structure will start next week. This will enable the Design and Build team to focus on the design of the next phase. The 'Design and Build' and 'Run' phases will run in parallel so that learnings from the 'Run' team feed into the programme. Group discussion: • The core roles in the structure have an emphasis on sector engagement and co-design. DHBs have the most expertise for designing the workforce. • The same people who designed the programme were also running it over the weekend. It is important to separate teams into 'Run' and 'Design and Build' and be clear on who is doing what. • There are some practicalities for exemption for recruitment that need to be worked through, as the Operations Centre will need people for more than six months. The programme should appoint people for the duration of the programme and make it more attractive for senior appointments. • Many of the processes are repeatable between both the run and design phases. However, the difference is in the scaling up. • The programme needs to think about vaccination event types and what that means for the service design work as the programme progresses. • Some roles shouldn't be separated. For example, the clinical and Pacific teams should be a resource for both run and design. This will also help to avoid silos. • It would be good to include expertise from Defence in the operational structure. A conversation about an ongoing relationship in this way has not happened yet. • The Operations Centre will move to a seven-day structure. An on-call arrangement will be introduced as the current way of working is not sustainable for members of the team. The same will be implemented for the Technology team. • Consideration needs to be given to the product to marketing campaign management. Someone should own the end-to-end campaign and ramping up as we go through. • Managing the booking system and the event types are two different roles and require different skillsets. Defence could help in the organisation of the booking system. • There is also a role for upscaling and offering a product to market. There is some nuance in the different event types (e.g., large-scale versus community). This could be a function of the operational side of it that is picked up somewhere in the structure. This is also why comms is part of the strategic team (via a dotted line). • Engagement is different by person and event type (e.g., workplace vs rural). Therefore comms is part of the strategic team (dotted line). • There needs to be more thinking about client-centred integration points around events. • Does the programme have the right balance between strategic and operational? There is a risk across both areas. Resources are stretched because the specialist contract workforce in Wellington is almost depleted. As such, deciding to do one project will mean that another will not get done.

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5	**Communications and engagement update – four-week plan** Karl and Paul provided an update on the comms and engagement plan. They noted that it was a great team effort on Saturday. There will be rolling announcements over the next couple of weeks as the vaccination programme ramps up. The Comms team is working closely with DHBs and MBIE staff for smaller events that appeal to local media. Seeing the faces from the media getting vaccinated is popular with the public. Currently, the Comms focus is on border workers, and will roll into household contacts shortly. The teams are starting to develop resources for household contacts, which will be adapted from the resources for border workers. The same approach will be used for ARC. The campaign is currently on hold due to the current COVID-19 outbreak. This is to avoid over-saturating the advertising market with vaccine content. Group discussion: • There are conversations with Māori MPs about how to integrate them with the Comms plan, specifically with Māori. The Comms team is meeting with their Press Secretaries to share info and facilitate the MPs' involvement. • Need to be thoughtful and consistent about the term 'vulnerable people'. • John Whaanga met with the Māori Caucus to agree a joined-up plan. The Māori Caucus are looking for opportunities for MPs and Ministers to be involved and support the campaign. • Matt met with Pacific Caucus. The Pacific Caucus are also keen to help the campaign. How do we support them into that and keep everyone on the same message? • The speed that operational decisions need to be turned into communications products is challenging. There are national resources but DHBs will adapt it based on their local population's needs.
	Design and build
6	**Fonterra introduction and update on distribution** Simon Tucker and David Cheetham from Fonterra joined the hui. Mat Parr introduced them and explained that the programme had contacted Fonterra for support in distribution and inventory management. Simon and David were attending the meeting for a quick check in with the programme. Simon noted that the Fonterra CE appreciated the opportunity to contribute to this national priority. Fonterra is open to further suggestions of how they can support the programme. David and Simon discussed their involvement in the programme so far: • David is a leading supply chain expert. • Fonterra works with many other private sector companies and will bring other opportunities into the programme as they identify them. • Fonterra was involved in the simulation event and online dry run last week. They are reviewing the collateral from early stages of the rollout. • Fundamental planning principles can be applied to this programme – supply/demand, number of vaccinators, vials, etc. • Consider a detailed planning roadmap including inventory and replenishment. • Should be considered how demand offsets the different risks. There are different techniques to model this. Dr Bloomfield thanked Fonterra for being involved and reiterated how the programme valued their support and advice.

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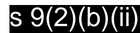
Additional item not on agenda: Update on additional Pfizer doses

Alison provided an update on the negotiation with Pfizer to secure more doses of the vaccine. This negotiation would bring New Zealand to a total of 8.5 million doses.

Alison noted that:

- Ministers support the purchase of additional doses.



s 9(2)(b)(ii)

Group discussion:

- The programme was expecting more vaccine in Q2. There was discussion on whether this is likely to be shifted forward. There is still uncertainty around delivery schedule and still things could go wrong. The programme should attempt to smooth the delivery schedule of the vaccine as much as possible.
- The programme should seek a strong delivery plan from Pfizer that meets the programme's needs.
- The additional doses may mean that programme needs to revisit the infrastructure for distribution and think about a range of delivery models.
- Call tonight with DHB CEs to update them. The planning is based on Pfizer. However, no announcement is made until it is signed.
- The negotiation for additional Pfizer doses remains confidential until the contract has been secured.

7 **High level plan for the year**

Mat Parr introduced the high-level vaccine rollout plan for the year.

This plan is based on our understanding of how much supply we will have. This is still in draft because the population sequencing has not been decided.

Phase 1 will vaccinate 445,000 people. This is a targeted group and we know that we have supply and can deliver between fifty and sixty-thousand vaccinations per week.

After that, in Phases 2 and 3 the programme will ramp up to have vaccinated 3.6 million people by the end of 2021. Phase 2 and 3 will require a focus on service design – more community-based outreach, DHBs, primary care.

Group discussion about the high-level plan:

- The rollout plan is lumpy because of estimates of delivery phasing. Ideally, the ramp up would be smooth and then reach a flat line. The phases should overlap – this is better as it smooths the ramp. Finding a targeted group is harder and pausing to find this group before moving onto the next phase does not make sense.
- There is a risk in sharing this rollout plan more widely, as there are variables that are critical to this model that could change.
- The language was changed from vaccinators to vaccination team. Vaccination team includes unregulated workforce.
- Dr Bloomfield noted that there was a Cabinet paper with an updated sequencing approach. In this paper, Phase 1 included a wider range of residential settings (eg

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	ARC, corrections, youth justice, disability) and included workforce and residents. Māori and Pacific who are not necessarily in care but are high risk.
	• In Phase 2, there is an explicit need to vaccinate Māori and Pacific at younger age because of their higher risk.
	• John will help to ensure that equity is the driver for each part of the programme. For example, the data needed and the composition of the teams.
	• Increasingly, the programme has been able to show more transparently how equity is influencing decisions.
	Group discussion about progress toward scaling up in May:
	• There were many short-term manual processes that are now in the process of being automated.
	• There are a range of decisions needed in late May. The first ones relate to:
	    o Distribution and inventory
	    o Logistics (Pfizer)
	    o Limited delivery settings (rollout vs storage)
	• Additionally, the operational centre needs to be up and running for the programme to ramp up.
	Group discussion about event types:
	• Need to decide which event types to focus on. It will be challenging to cater for all scenarios.
	• An earlier decision on event types will help IT systems to be set up well.
	• Process for landing those decisions – the go ahead to limit the number of models – our community pop up looks like a small medium. When is large – later date. Mobile options. GP clinics in phase 2, pharmacies phase 3.
	• There will be a different approach for different DHBs and regions.
	• There is an opportunity to learn from NHS and Israel and videoconferences have been set up with them.
	• It is not feasible to send vaccines out to 800 pharmacies.
	• There is an opportunity to align this with the flu vaccine. Carpark type events worked quite well for the flu.
	Action: Mat Parr – Draft of the key event types to focus on, by Friday.
	Action: Dale – Share the paper that went to DHB CE's and modelled the community approach (big, medium, pop-ups).
	Action: Deborah – Draft the system solution to the two-week gap between the Covid and flu vaccines.

8	**Status report** Mat Parr noted one critical point: how we resource appropriately across the run and design sides of the programme. The programme has hit the start line, but the focus now shifts to scaling up vaccinations.
9	**Risk refresh update** Mat Parr introduced the risk refresh update. He noted that it was important to consolidate risk with other views. Group discussion:

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	• For the selected delivery models (event types), need to identify readiness and success criteria for each of them. • There is a risk that the Covid vaccination rollout will have an impact on other areas that require the same workforce.
10	**Occupational health service delivery for New Zealand Police and Fire & Emergency New Zealand** Noted and signed by the DG.
11	**Science update** The Science update was noted: a. Science updates on the four current NZ vaccine candidates b. Initial scan of clinical vaccine trials that are enrolling people under the age of 16 years
12	**Any other business** The assurance tracker was noted. A decision is expected back from Cabinet on Monday about sequencing.

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Action tracker 23 February 2021

Item	Action	Who	Due date	Status
Tuesday 23 February				
7	Mat Parr – Draft of the key event types to focus on.	Mat Parr	26 Feb	
7	Draft the system solution to the two-week gap between the Covid and flu vaccines.	Deborah Woodley	5 Mar	
7	Share the paper that went to DHB CE's and modelled the community approach (big, medium, pop-ups).	Dale Bramley	2 Mar	

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MINISTRY OF HEALTH
MANATŪ HAUORA

Minutes

COVID-19 Vaccine and Immunisation Programme Steering Group

Date:	Tuesday, 2 March 2021
Time:	4.30 – 6:20pm
Location:	1N.3
Chair:	Dr Ashley Bloomfield
Members:	Sue Gordon, John Whaanga, Shayne Hunter, Deborah Woodley, Dr Dale Bramley, Michael Dreyer, Jo Gibbs, Dr Ian Town
Attendees:	Mat Parr, Matt Jones (item 3),Simon Everitt (item 3), Ana Bidois (item 4), Rae Finch (item 4), David Nalder (item 5), Karl Ferguson (Item 7), Laura O'Sullivan (item 9)
Apologies:	Chris Fleming
Secretariat Support:	Hannah Lobb

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#	Agenda Item
1.	**Introduction and minutes** The minutes from the previous meeting on 23 February 2021 were approved. • Ashley asked for clarification of whether the comms campaign is ready to go. Karl confirmed it is nearly ready but is on hold from PMO. ***Action 1: Ashley requested Ministry of Health input into when the campaign goes live.***
	Run
2	**Standing item on run programme** Jo provided an update on the roll-out and an overview of the plan for next week. • From next week, active sites and a rolling allocation plan will be added to the Sit Rep. ○ Sue noted that Ministers are going to keep working for a forward estimate of vaccinations in the Sit Rep. Jo is working on this. • Next week will be a big week in Auckland, with a mass vaccination centre starting from Monday. Important to note that it will start slowly and build up during the week. • The Run structure is taking shape and by Thursday the Operation Centre will be more organised and have better work stations. • A paper on the Logistics strategy is being prepared for Steering Group and Governance Group next week. Discussion on allowance for walk ins:

	• Dale noted that there is a need to have a set allocation of doses available for walk-ins. e.g. 10% in addition to booked vaccinations. However, this will mean people get turned away and vaccination numbers will drop to about half next week. • The Group agreed that 10% is reasonable, and the bigger issue is making sure border workers and their household contacts are booked in. ***Action 2: A clear description of the process, roles and responsibilities for getting border workers and household contacts booked for vaccinations.*** ***Action 3: Create a plan to improve use and data quality of border testing register.*** Discussion on vaccinating frontline health workers: • There was discussion that if not enough border workers and household contacts are booked in for vaccinations, then numbers will start dropping. The group agreed that to counter this, vaccinations should start being given to frontline health workers. This aligns with Cabinet agreeing up to Tier 2a of the Sequencing Framework.
	Design and build
3	**Event design** Matt Jones tabled the A3 on event design and provided an update on the team's work. Matt noted the work is going well and the team is now focussing on the number of sites in each event type as a barrier, rather than the number of different event types. The next phase of this work will be talking to DHBs and creating straw man maps of the types of sites they want to stand up and when. Then the team will need to create site readiness checklists for each event, including tech and logistics requirements and physical site requirements (traffic management, cold storage). Group discussion: • Ashley asked whether this will work from a tech perspective. Shayne and Michael said it looked good because there is a lot of repeatable characteristics across event types. • Ashey asked whether the design approach will include Maori and Pacific providers. Simon said this happens via DHBs, but he will request they are explicitly included from the start. ***Action 4: Simon will test approach for aged care (large providers) with the Design Authority.*** ***Action 5: Simon to request that Maori and Pacific providers are included in design from the start (via DHBs).*** **Interaction between Covid and flu campaigns** Deborah explained that this is a work in progress. There will be an overlap between the two programmes that needs to be managed. Group discussion: • Mat highlighted that a major issue will be workforce capacity and the timing needs some extra thinking. • Ashley noted there will need to be comms around this e.g. defer your flu vaccine until two weeks after your second covid vaccine ***Action 6: Return to Steering Group with further work on timing and comms for interaction betweem covid and flu campaigns***
4	**Equity update**

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	Ana noted that the Covid Chairs Board were updated on the equity work programme this morning and introduced Rae who will lead on the disability strategy. Rae noted that he is establishing a disability subgroup of IIAG and the first meeting will be on Friday. Group discussion: • John raised the issue that the equity strategy hasn't been communicated publically and asked whether Maori are part of the regular DHB working groups. Ana will follw up on this. • John also raised the need to connect with other agencies on this work. Sue noted that Tamati made this message clear at the Covid Chairs Board this morning. • Jo noted that the strategy presents a relatively narrow view of equity and that it will be important for other groups to be brought in too e.g. mental health. • Ashley congratulated the team on this work and noted that Cabinet were very supportive of the equity focus. ***Action 7: Ana to follow up with DHB working groups re: Maori GM attendance.*** ***Action 8: A clear narrative of the equity focus by next week, reinforcing the messaging that everyone needs to get vaccinated for the programme to succeed.***
5	**Confidence plans** David tabled the confidence plans and Mat explained that this framework will be used for readiness decisions and design work going forward. David explained the next steps and noted that next week he will bring a 1-2 page detailed risk summary of the programme to steering group. Group discussion: • Ashley said the plans look good and we need people to be able to raise things when they are going off-track • Sue asked about presenting risk tolerances e.g. reaching 80% of a target population. David explained that the success framework from the policy team should help answer some of these questions. • John asked whether there is confidence in IMAC to deliver Maori and Pacific training and noted that success measures will require evaluating customer experiences.
6	**Vaccines safety and immunogenicity study memo** Ashley agreed to the recommendations, providing that the right people are involved from the Ministry of Health and the right governance and oversight structures are in place. Ian noted this will be managed through the co-design process. Additional discussion: • John asked what is happening with messaging for under 16s. Ian noted there is no data at the moment and the next group will be 12-16 year olds. It is unlikely under 12s will be vaccinated anytime soon but comms will be important. • Karl added that questions about under 16s are not appearing much in the media at the moment but the comms team is monitoring this.
7	**Communications and engagement update** Karl provided an update on comms and engagement: • the team is holding daily conversations with DHB communication leads to ensure needs are being met • next focus is on household contacts and health workforce; collateral will be adapted to suit these groups • working with Ministers offices and teams across MOH on the "Sequencing Story", noting that this will also help strengthen the equity narrative

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	• continuing to support Ministers to tell the "roll-out story" • the Pfizer announcement will potentially be pushed out until after Thursday as negotiations are ongoing
8	**Business engagement memo** The memo was noted and recommendations approved. Discussion: • Sue noted that there was great feedback from Ministers and attendees on this engagement • Businesses had a desire to continue to learn from others and this should be included in the next engagement if possible. ***Action 9: Minister Henare should be looped into future engagements.***
9	**Workforce mobilisation and non-regulated workforce** Laura introduced the paper, noting that using the non-regulated workforce is a possibility but there are risks to be managed e.g. types of workers to include. The team offered to do further work and come back with a list of decisions that the Steering Group needs to make. The group supported advancing work on the non-regulated workforce, noting that other work is underway to assist with total workforce numbers. There will need to be further engagement with DHBs about workforce management and prioritisation as we deal with outbreaks/general response. Discussion: • Sue raised the issue of moving the same people around the health sector, suggesting that we need to find new people to bring in as well as think about shifting capabilities within the health sector e.g. using kai awhina for testing to free up nurses • Dale expressed support for finding new members to add to the workforce, especially focussing on new workers that are representative of populations. • John suggested that we need to think about the longer term development of the health workforce and where we can contribute to building capability.
10	**Status report** Noted.
11	**Any other business** • Dale asked whether the CVTAG can consider reducing the observation period of 30 minutes. Ian said the group is working on an answer. • Dale asked whether there should be definitions of the sequencing scenarios, a process for who makes these decisions, and a contingency plan for operating in other scenarios. ○ Sue said yes to all these suggestions. ***Action 10: Mat to connect with Dale about getting a joint team to work on contingency planning.***

Document 3

Action tracker 2 March 2021

Item	*Action*	*Who*	*Due date*	*Status*
Tuesday 23 February				
7	Mat Parr – Draft of the key event types to focus on.	Mat Parr	26 Feb	Complete
7	Draft the system solution to the two-week gap between the Covid and flu vaccines.	Deborah Woodley	5 Mar	Closed with new action - 2 March
7	Share the paper that went to DHB CE's and modelled the community approach (big, medium, pop-ups).	Dale Bramley	2 Mar	Complete
Tuesday 2 March				
2	A clear description of the process, roles and responsibilities for getting border workers and household contacts booked for vaccinations for Ashley to pass on to Border CEs.	Michael Dryer	4 Mar	Plan in progress
2	A plan to improve use and data quality of border worker testing register.	Michael Dryer	4 Mar	Work ongoing. Policy work progressing to make it compulsory.
3	Return to Steering Group with further work on timing and comms for the interaction between covid and flu campaigns.	Mat Parr	9 March	
4	Clear narrative of the equity focus by next week, reinforcing the messaging that everyone needs to get vaccinated for the programme to succeed.	Ana Bidois	9 March	Expected next SG.
11	Mat to connect with Dale about getting a joint team to work on contingency planning.	Matt Parr / Dale Bramley	9 March	

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MINISTRY OF HEALTH
MANATŪ HAUORA

Minutes

COVID-19 Vaccine and Immunisation Programme Steering Group

Date:	Tuesday, 9 March 2021
Time:	4.30 – 6:30pm
Location:	1N.3
Chair:	Dr Ashley Bloomfield
Members:	Sue Gordon, John Whaanga, Shayne Hunter, Deborah Woodley, Dr Dale Bramley, Michael Dreyer, Jo Gibbs, Dr Ian Town
Attendees:	Mat Parr, Matt Jones, Andrew Bailey, David Nalder, Paul Giles, Michael Dreyer, Allison Bennett
Apologies:	Chris Fleming
Secretariat Support:	Hannah Lobb

#	Agenda Item
1.	**Introduction and minutes** The minutes from the previous meeting on 2 March 2021 were approved.
	Run
2	**Standing item on run programme** Jo provided an update on the roll-out and an overview of the plan for next week. • The plan from the Northern Region is looking good and the team is working with other regions to get plans for the next 30 days. Mat Parr is working on a DHB-level model for the next 30 days, 90 days and the rest of the year. • There were some issues with black dots on a vial which provided a good opportunity to test the quality review panel processes. • There are ongoing issues with using stock before it expires in the Northern region. This is being worked through with the logistics team over the next few days. Discussion on numbers of household contacts: • There was a discussion about the accuracy of capturing details of household contacts. Ashley explained that Ministers have an expectation that this information was loaded before the programme started. • Rachel suggested that a conversation with DHBs will be important to understand where the issues are and what processes might help. Rachel took this as an action. • Dale explained that 50% of people who have come through the vaccination centres are un-coded and asked whether the system is ready for scaling-up in two weeks.

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	Dale requested a formal response from MOH on these issues and how they are being mitigated. • Ashley noted that the team needs to focus on the design of the next phases, but there also needs to be some resolution for capturing whanau. ***Action 1: Mat Par to provide an update to Ministers on household contacts process*** ***Action 2: Rachel to talk to DHBs to understand where the issues are and what processes might help*** ***Action 3: MoH to provide a formal response to DHBs about coding issues and what the plan is going forward.***
	Design and build
3	**Update from CVTAG** Ian provided an update on the CVTAG. • A process is in place to escalate issues and there is potential for the group to have a weekly meeting going forward. • There has been a careful process of working with the Cancer Control Agency and it has been decided that there should be no restrictions for people receiving cancer treatments. • s 9(2)(g)(i) • 15 individuals have had a reaction to the first dose and the group is working on advice for their second dose. • The group is looking at pacing of second dose e.g. longer than 6 weeks. • Ian provided advice to MFAT on diplomats receiving the vaccine before they go overseas. The risk assessment is now MFAT's responsibility.
4	**Delivery status and risks** Mat opened the item explaining that the regular reporting on risk is being embedded into the programme and guiding discussions. The main risks for this week will be covered in items 5 and 6. Group discussion: • There was some discussion about having strategies but not knowing what is happening on the ground. • Sue raised the concern on workforce that it is easier for DHBs to move people around than find new people. Rachel suggested DHBs need to be included in the design process to ensure that the strategies will work for them.
5	**Scale-up** David tabled the confidence plans and Mat explained that this framework will be used for readiness decisions and design work going forward. • There is a new success framework which presents the mission statement for the programme and highlights the key trade-offs. • A refined version of the plan with tangible actions will be presented next Tuesday. • Sue noted the importance of having feedback loops between the design and run sides of the programme.

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6	**Programme reset** Jo introduced this item, noting that a clear plan will be presented to Steering Group next week with an outline of expenditure to date and what is needed across design and run. • There are 146 FTE in the programme at the moment (including 67 tech FTE) and it is expected that an additional 55-65 FTE are required to build towards Phase 2. • Most of the senior tier has been recruited so the team is now looking for Tier 4 FTEs Discussion on resourcing: • Sue noted that a lot of new people are coming on board and the SROs will be in charge of looking after the culture and ensuring things stay connected. • Ashley noted that the health sector has already been drawn on heavily so we will need to look across the public sector and ask PSC fairly urgently. • Sue noted that the programme still makes use of resources across the Ministry, so the funding arrangements will have to be worked through carefully. • Colin raised concern over the 4 SRO model, noting that one meeting per week won't be enough and it will have to be at least 3x weekly. Ashley agreed that this needs to be thought about. • There was discussion about needing an integrator role between design and run as the same people can't be responsible for both sides. It is not clear who sits in this role so further thinking is necessary. • Maree raised the issue of it not being clear when the programme moves away from the policy phase and into delivery. This transition will need to be clear. ***Action 4: Identify the people that are needed from across the public sector as soon as possible. Ashley can help with requests if needed.*** ***Action 5: Ashley to consider SRO model.***
7	**Booking system** Michael introduced the item, noting that the booking system is one of the "big rocks" needed for Phase two. • One of the major questions with the booking system is the model for getting consumers booked in. The tech team needs to work with the design team on this to ensure the model is equitable. • The team is aiming to build a basic system to begin with and then continue to make improvements. Discussion: • Dale asked whether the current systems can cope until this system is set up. Michael said the answer is yes but it will get more difficult as vaccination numbers increase and the transition to the new system will have to be managed well. Mat added that in Phase 1 we step through groups that are more easily identifiable so that we can cope without the booking system.
8	**Update on Pfizer** Allison introduced this item noting that the memo was intended to outline the commitment to purchase the additional Pfizer doses and outline the risks for consumables and storage. • There is a pressure point in August for consumables but the team has had verbal confirmation for additional consumables. • The next steps are to continue working with Pfizer on delivery schedules, monitoring consumables and storage (which may change with service design choices) and managing the portfolio to ensure that we have back-ups available. ***Action 6: Add information about consumables into the Year Plan model.***

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9	**Communications** Paul provided an update on the communications approach. • There was a media walkthrough of the vaccination centre in East Tamaki on Tuesday. It went well and there was lots of interest from the media. • The team is focussing on media at the moment but is thinking about how to broaden the approach to capture people who might be more hesitant of the vaccine. • Continuing work with Ministers Offices on the release of the sequencing framework on Wednesday. • Thinking about how to bring all the comms work from MOH and others together. There is nothing to tie the work back to at the moment, as the DPMC programme hasn't started yet.
10	**Status report** Noted.
11	**Any other business** • No other business.

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Action tracker 2 March 2021

Item	*Action*	*Who*	*Due date*	*Status*
Tuesday 2 March				
2	A clear description of the process, roles and responsibilities for getting border workers and household contacts booked for vaccinations for Ashley to pass on to Border CEs.	Michael Dryer	4 Mar	Plan in progress
2	A plan to improve use and data quality of border worker testing register.	Michael Dryer	4 Mar	Work ongoing. Policy work progressing to make it compulsory.
3	Return to Steering Group with further work on timing and comms for the interaction between covid and flu campaigns.	Mat Parr	9 March	Expected 16 March.
4	Clear narrative of the equity focus by next week, reinforcing the messaging that everyone needs to get vaccinated for the programme to succeed.	Ana Bidois	9 March	Expected 16 March.
11	Mat to connect with Dale about getting a joint team to work on contingency planning.	Matt Parr / Dale Bramley	9 March	
Tuesday 8 March				

2	Provide an update to Ministers on household contacts process	Mat Parr	16 March	
2	Rachel to talk to DHBs to understand where the issues are and what processes might help	Rachel?	16 March	
2	MoH to provide a formal response to DHBs about coding issues and what the plan is going forward.	Mat Parr	16 March	
6	Identify the people that are needed from across the public sector as soon as possible. Ashley can help with requests if needed.	Mat Parr	16 March	
6	Consider four SROs model.	Ashley Bloomfield	16 March	
8	Add information about consumables into the Year Plan model.	Allison & Mat	16 March	

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Minutes

COVID-19 Vaccine and Immunisation Programme Steering Group

Date:	Tuesday, 16 March 2021
Time:	4.30 – 6:30pm
Location:	1N.3
Chair:	Dr Ashley Bloomfield
Members:	Sue Gordon, John Whaanga, Shayne Hunter, Deborah Woodley, Dr Dale Bramley, Jo Gibbs, Dr Ian Town, Chris Fleming
Attendees:	Mat Parr, Matt Jones, Andrew Bailey, David Nalder, Paul Giles, Casey Pickett, Colin MacDonald
Apologies:	Michael Dreyer
Secretariat Support:	Hannah Lobb

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#	Agenda Item
1.	**Introduction and minutes** The minutes from the previous meeting on 9 March 2021 were approved, noting that Item 6 didn't capture the action about formalising the relationship between the programme and DHBs. Ashley went through the action tracker from last meeting.
	Run
2	**Managing the relationship between the programme and DHBs** This item was moved to the front of the meeting to address Chris' concern about the programme structure not acknowledging the DHB structure and resources that are a key part of the programme. • Dale explained that the structure needs to include DHBs in thinking inside MOH and in real time, otherwise gaps will start to emerge between delivery and expectations. E.g. the DHB current numbers and MOH calculated volumes are quite different. • There is a lot of different avenues for engagement with DHBs and it isn't clear what happens where Ashley noted that we need a controlling mind on this work for household contacts and Jo Gibbs took responsibility for this. ***Action 1: Bring a plan for engaging with DHBs to next steering group***

2	**Standing item on run programme** Jo provided an update on the roll-out and an overview of information received from DHBs this week. • Jo noted that DHBs are still revising their plans, which at this point are behind the MOH model but are projected to catch-up by the end of April. • There will be a second version of DHB plans next week, which will provide detail out to the end of April. • Ashley asked what would help DHBs to scale up in the next few weeks and what the constraints are. Jo explained that some DHBs are still getting their programme structure up and running and until last week, DHBs didn't have a clear idea of what MoH was requesting of them. The local booking systems, vaccinator workforce and finding new premises are also barriers. • Jo noted that they are thinking about creating a Taskforce that can go out and help DHBs. • Rachel noted that the speed of communication needs to be improved so that decisions can be made more quickly and DHBs have access to the latest information and requests.
3	**Update on written consent** Item removed from the agenda.
	Design and build
4	**Update from CVTAG** Ian provided an update on the CVTAG. • Jo is the main recipient of CVTAG advice • The 20 minute stand-down period is being implemented and cancer drugs have been removed from precautionary list • Advice was provided to Ashley about managing the approach to vaccines in an outbreak • The research question and budget process for the vaccines study is underway with MBIE • Advice was prepared on high risk criteria for COVID-19 vaccines based on flu criteria Shayne asked how the 20 minute stand-down period will be implemented. Ian explained that it will be reviewed over time and could become shorter at some point but will likely stay at 20 minutes while the vaccine is still new.
5	**Delivery status and risks** David opened the item explaining that there are three new risks and the reporting is aligned to pillar structures so accountabilities are clear. There is additional reporting on how the risks are changing over time. From next Tuesday, the risk report will be combined with the Real Time Assurance report to create a programme risk report. Discussion: • It was noted that risk 11 on sector engagement sounds like a pain point. This is also covered in risk 1. • There was a question about including a post-event risk on scaling CARM reporting. Mat explained that this isn't currently a risk as the data system is planned to go live on 29 March which is ahead of schedule and additional assessors have come on board. There may still be risk to this down the line when vaccination capacity increases.

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Document 3

	• Colin noted that the risk register reinforces importance of getting accountability and resourcing decisions taken soon, and highlighted the risks on the report that required a decision or support from the Steering Group • Rachel raised the issue of information sharing with DHBs. Paul and Helen agreed to take this offline.
6	**Comms and engagement** Paul gave an update on comms and engagement. • Proactive media has been the most visible and useful stream so far. This week the team is progressing with more media around delivering second doses of the vaccine and pursuing options for alternative media outlets (Māori, Asian channels). • The team is working closely with Counties Manukau DHB on having a presence at the Pasifika festival to give people an opportunity to ask questions in person. • John Walsh is joining the DPMC vaccine campaign team. The campaign began with a "soft launch" on the weekend and plans are underway for a sustainable campaign that can last the 8-12 months of roll-out. • There has been a reasonably high volume of misinformation and the team is currently preparing a plan to manage this. ***Action 2: Plan for managing misinformation at next steering group.*** ***Action 3: Paul to organise for John Walsh to give Ashley a briefing on the DPMC campaign.***
7	**Phase 2 planning** Matt Jones introduced this item, explaining that the piece of work has been pulled together quickly and the next step of working with DHBs will be really important. • The focus is to optimise for volume – peak of 12,000 before June then need to hold that for a month, then increase to 40-50,000 in July. Design and run need to be focussed on the big step change and feedback loops need to be strengthened. • As a next step, the model will be overlaid with the operational plan and event types. Next week there will be a zoomed out version of the model to June. • Four basic service delivery models have been worked through with DHB partners but more work is needed. • There are key things that need to be available across all sites e.g. funding arrangements and how they will interact with existing systems. o Darren and Tom Love are working on funding and there is a DHB/MOH working group tomorrow on funding. Group discussion: • Sue raised the importance of working towards a minimum viable product for scaling that that this will require a lot of collaboration with DHB SROs in terms of what they absolutely need. • Mat raised the importance of sorting providers in the next month (Māori, Pacific, Aged Residential Care) • Rachel noted that DHBs are already engaging with providers so the team needs to make sure that everything is linked together. • John asked for assurance that DHBs are involving iwi and Māori in thinking and planning. • Ashley confirmed that the programme is not elaborating on everything before starting and there will be phasing and adapting as things progress.

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	The Steering Group to an in-principle decision to optimise for volume and agreed to the four event types. More detail is required next week for formal sign-off and then plans will go to the GG next Friday. ***Action 4: Provide GG next week with certainty about ability to scale and timeframes for critical milestones.*** ***Action 5: In the first column in the service delivery models document, include another definition of Iwi that applies to urban populations alongside Whānau/Hapu/Iwi.***
8	**Polynesia cabinet paper** No discussion.
9	**Sequencing framework** Casey introduced this item, noting two papers for discussion: 1. Criteria for underlying health conditions to receive the COVID-19 vaccine o This paper was considered by CVTAG and sits with Ashley for decision. o Ashley requested a paragraph on ethnicity overlay is added to the paper including the additional risk measures to manage this. o Jo questioned the operationalisation of this advice and raised the importance of informing Ministers that we are unlikely to be able to report on this. 2. Sequencing framework for remaining groups (national interest and compassion categories) o Seeking feedback on how the analysis and advice is being pitched. o Ashley noted he was really impressed with this work. He suggested there should be a difference between athletes representing the country and those who are not. It also needs to clarify what the requirements are for tangi. o Sue noted that an implementation programme needs to be ready to go. ***Action 6: Casey to include a paragraph on ethnicity in the underlying health conditions paper, including the approach to equity and risk measures.*** ***Action 7: Jo to inform Ministers that we are unlikely to be able to report on the vaccination rates for people with underlying health conditions.***
10	**Programme structure and resourcing** Covered in other agenda items.
11	**Any other business** • No other business.

Item	*Action*	*Who*	*Due date*	*Status*
Tuesday 2 March				
4	Clear narrative of the equity focus by next week, reinforcing the messaging that everyone needs to get vaccinated for the programme to succeed.	Ana Bidois	9 March	Paper 23 March.
11	Mat to connect with Dale about getting a joint team to work on contingency planning.	Matt Parr / Dale Bramley	9 March	Workshop with Andrew Old completed;

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				paper due 30 March
Tuesday 8 March				
2	MoH to provide a formal response to DHBs about coding issues and what the plan is going forward.	Mat Parr	16 March	Expected w/c 22 March
Tuesday 16 March				
1	Discuss plan for engaging with DHBs to next steering group	Jo Gibbs, Dale Bramley, Chris Fleming	23 March	Update 23 March
2	Bring a plan for managing misinformation to next steering group	Geoff Gwyn	23 March	Update 23 March
3	Organise for John Walsh to give Ashley a briefing on the DPMC campaign.	Paul Giles	23 March	Complete
4	Provide Governance Group next week with certainty about ability to scale and timeframes for critical milestones.	Mat Parr	23 March	In progress
5	In the first column in the service delivery models document, include another definition of Iwi that applies to urban populations alongside Whānau/Hapu/Iwi.	Matt Jones	23 March	In progress
6	Include a paragraph on ethnicity in the underlying health conditions paper, including the approach to equity and risk measures.	Casey Pickett	23 March	Complete
7	Inform Ministers that we are unlikely to be able to report on the vaccination rates for people with underlying health conditions.	Jo Gibbs	23 March	Complete

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Minutes

COVID-19 Vaccine and Immunisation Programme Steering Group

Date:	Tuesday, 23 March 2021
Time:	4.45 pm – 6:45 pm
Location:	1N.3
Chair:	Dr Ashley Bloomfield; Sue Gordon (from 5.55 pm)
Members:	Sue Gordon, Maree Roberts, Dr Dale Bramley, Stephen Crombie, Chris Fleming, Shayne Hunter, Jo Gibbs, Dr Ian Town, Dr Caroline McElnay; Deborah Woodley
Attendees:	Joe Bourne, Matt Jones, Astrid Koornneef, Colin MacDonald, Mat Parr, John Walsh, David Nalder
Apologies:	John Whaanga
Secretariat Support:	Carol Hinton

#	Agenda Item
1.	**Introduction and minutes** The Director-General apologised for the delayed start to this meeting (originally scheduled for 4.30 pm start), caused by the attendance by several members of the Steering Group at a meeting immediately prior with Minister Henare. Dr Bloomfield advised that he would need to leave the meeting to meet a commitment at 6 pm. He outlined the four priority areas he wished to cover before leaving: • Update on DHB roll-out (agenda item 5) • Critical path – and assurances re achievement of this (agenda item 8) • Vaccinator workforce – expansion and deployment (agenda item 13) • Communications (agenda item 10) These items are numbered 2-5 below in the order of consideration. Dr Bloomfield confirmed that Sue Gordon would act as Chair following his departure. Minutes of the previous meeting on 16 March 2021, and the action tracker, were not considered at this meeting. ***Action 1: At the next meeting on 30 March 2021, move for agreement to the minutes of meeting held 16 March 2021.***

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	Run
2.	**Standard item - Update on DHB rollout**
2.1	*DHB rollout planning (Jo Gibbs)* • Last week (ending 21 March), DHBs provided their rollout plans to the end of March, and this week are submitting plans to the end of April in line with the modelling to ramp up locations and move through the sequencing framework. • Roll-out in East Tamaki and Waipareira is expected to be in place by 3 April, following resolution of legal and landlord issues. • Overall national delivery by DHBs is close to the target, however, solid performance by some larger groups (e.g. NZ Defence Force and Auckland DHB) is a key factor in this overall picture. MOH is providing tailored support to DHBs that require assistance with roll-out to ensure this is a focus from executive leadership downwards. • We are aware of strong interest including by Minister re DHB performance at detailed level. ***Action 2: Jo Gibbs to phone CEOs of DHBs that have not provided plans, or are not meeting their roll-out plan targets if required.***
2.2	*Booking system / coding* issues *(Astrid Koornneef)* *Paper considered: Identification and booking of border worker household contacts* Online booking system: • MOH is working with the NRHCC to address some elements of the Auckland system that have hindered about 5,000 people from booking their vaccination online. • Work continues on ensuring that the national booking system and other supporting technology is ready for Phase 2 rollout. • A Pulse survey is being used to help to identify the barriers for people not turning up for their vaccination bookings. Border worker household denominator: • The denominator for border workers and families is still not defined even though we know details for over 90% of the workforce. This is needed to clarify the likely number of household contacts qualifying for early vaccination. The D-G emphasised the importance of the right people getting the vaccine at roll-out and noted a concern that this could create a lack of confidence in the project. • Use of organisations such as the Employers and Manufacturers' Association and the MBIE call centre to assist with outbound calling to employers was discussed. The D-G confirmed his willingness to call wider colleagues on this. ***Action 3: The D-G requested a group be established which is dedicated to identifying the denominator numbers.***
3.	**Critical Path** *(Matt Jones, Mat Parr)* Objective: deliver about 50,000 doses per day across New Zealand from 1 July. *Paper considered: Critical path summary.* Matt Jones and Mat Parr explained the critical path. Four blocks of work are needed to achieve this. • Engagement campaign • Establishment of system-wide delivery capacity • Operating model in place • Logistics and distribution

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	The targeted access approach will change as we move to open access. The move to 10,000 per day is quite quick but progression after that is slower. • We know that 40% of the population will need little intervention to get their vaccine. However, a disproportionate effort is required for the rest (this also reinforces importance of getting the denominator right – *see No.2 above*). Questions and suggestions about the critical path were raised for discussion: • The importance of being able to give the Government absolute confidence in rollout was acknowledged. • Dr Bloomfield noted the critical path showed the pathway to full scale, but not the pathway to move to ~10,000 vaccinations per day. • Clarification is required on the links between real activities and the sprints – these need to feed into the critical path (Colin MacDonald). Suggested that ideally there will be a single critical path which is clearly annotated. • Noted that because of the new and uncertain nature of this, many DHBs were seeking permission for actions that were actually within their jurisdiction. It was important that the centre not be too prescriptive. It was noted that decisions about the types of events and the location of sites were for the DHB, with strong support from MOH re delivery of vaccines and the supporting national capability that needed to be in place to enable certain types of events. ***Action 4: Update the critical path for the Governance Group session on Friday 26 March, particularly to show the volume change over time and the number of sites of which type would need to be in place over time ahead of 1 July.***
	Vaccinator Workforce The demand for vaccinators continues to grow as roll-out progresses. Feedback from DHBs is that they often experience difficulties identifying resources through the surge database. Several initiatives are under way to increase the size of the vaccinator workforce and help DHBs to do conversions, including: • Reviewing how the workforce surge database can be better utilised to 'screen' those on the database and enable DHBs to more readily locate suitable candidates. Aligning skillsets by DHB region is also being explored. • Investigating further opportunities to deploy new worker/vaccinator solutions. The Ministry is actively working with other organisations where staff are already able to vaccinate (such as ambulance services) and to also consider non-registered and non-regulated workforces (such as NZDF, which has 100 people able to vaccinate although only 25 are registered). • Ensuring some 2,500 GPs have access to vaccinator training. Dr Bloomfield noted his keen interest in having vaccination of NZDF personnel completed as this potentially frees a significant number of vaccinators for wider deployment. He would like signed, written agreements in place to cover this. ***Action 5: Fiona Michel to provide an update on expected agreements in place with NZDF.***
5.	**Comms and engagement** *(John Walsh)* John Walsh, seconded to the DPMC vaccine campaign team from his role at MPI as Director Readiness and Response, gave an update on comms and engagement for the wider project. Development of a clear overarching plan is a priority to ensure messaging can be separated and targeted to the right audiences. There will be a dual messaging focus on:

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	• Informing and engaging with New Zealanders on the benefits of vaccination – i.e. a 'call for action' to encourage uptake. • Operational communications to assist stakeholders e.g. DHBs with supply and service design. A stronger focus is needed on engagement with Māori – at a project level this requires additional resource. Production of processes, technology, and collateral to support wider rollout will also receive a stronger focus and requires a different skillset.
	Design and build
6.	**Funding** *(Joe Bourne/Simon Everitt)* • Advised that a 'skeleton' costing model for a minimum viable product (for DHB SROs) would be available shortly. This will be brought to the next meeting of the Steering Group for consideration. This is based on 'bottom up' funding due to the more expensive nature of the Pfizer vaccine. • Initial costings were done on 'fee for service' but this only works if established sites used, as there are • Dr Bloomfield expressed concerns over the timeframe taken to finalise the model. He noted the need to give the Governance Group confidence in the proposed rollout. ***Action 6: Simon Everitt to work to finalise the model and develop approach for delivery at next meeting.***
7.	**Exemptions process** On 22 March 2021, Cabinet approved the criteria for individuals and groups who will be able to apply for early COVID-19 vaccinations. These are: • on compassionate grounds; • for reasons of national significance; • consideration of the level of risk that travellers will be exposed to COVID-19 in the destination country. A short update on planning for implementation was provided, noting this will open from 31 March and the existing interregional travel exemptions team and mechanisms will support this, but will require additional resourcing.
8.	**Delivery status and risks** *Paper considered: COVID-19 Vaccine and Immunisation Programme – status report including Risk and Issue summary – 23 March 2021* Discussion: • Everyone must be on the same page regarding delivery so that all programme work supports the critical path. • Sue Gordon noted that the Steering Group must be able to assure re delivery to the critical path. She asked project managers if they were all clear on the products that will support delivery against the timeframes. She noted this was critical so that the Governance Group had confidence and would in turn assure Ministers and the Prime Minister. • Joe Bourne strongly emphasised the importance of a single, agreed critical path. It was important that we were not swayed to make alternative decisions e.g. about sequencing, even if the proposed new group was small. Small groups required disproportionate effort to bring in. This was endorsed by Sue Gordon, who also noted the challenge of balancing the sometimes differing interests of five Ministers.

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	• Sue and Colin noted the potential role of the Governance Group in helping to address these balancing challenges should they arise. • Stephen Crombie noted that there appeared to be a lot of risks and a low probability of delivery and this has been the situation for some time. There needs to be a simple and clear plan showing how 'what will be delivered' meets the roll-out schedule, along with mitigation actions for those risks to give the plan meaning. • Sue Gordon asked David Nalder (?) to pull out the actions in the paper that address the risks in the critical path and make that clear. ***Action 7: Mat Parr to follow-up with pillar leads and delivery leads to ensure absolute clarity of the products that will be delivered to support timeframes in the critical path.*** ***Action 8: David Nalder to highlight actions in the paper that address the risks in the critical path.***
9.	**Logistics – Distribution and inventory management (Ian Costello)** *Paper considered - Approval in principle: For Distribution and Inventory Management of Vaccine* The Ministry is working with DHBs to develop a flexible 'hub and spoke' distribution model. The objective is to be able to respond quickly to variations in demand for the vaccine, service all vaccination site models and maximise vaccine availability to support widespread uptake. The model will involve establishing local hubs within DHBs which will manage flow and provide 'live' reporting. Contracts will be required for storage and transport in areas where no local hub can be established. More detail on how this would work in practice will be available in about a fortnight when Medsafe has made its decision on vaccine storage at -20C and we have a better understanding of DHB capacity.

10.	**Any other business**
	• No Ministers' meeting this week.
	• Items to be carried to the next meeting:
	    o Plan for managing misinformation
	    o Update on written consent

Item	*Action*	*Who*	*Due date*	*Status*
Tuesday 2 March				
4	Clear narrative of the equity focus by next week, reinforcing the messaging that everyone needs to get vaccinated for the programme to succeed.	Ana Bidois	9 March	Complete
11	Mat to connect with Dale about getting a joint team to work on contingency planning.	Matt Parr / Dale Bramley	9 March	Workshop with Andrew Old completed; paper due 30 March
Tuesday 8 March				
2	MoH to provide a formal response to DHBs about coding issues and what the plan is going forward.	Mat Parr	16 March	Expected w/c 22 March
Tuesday 16 March				

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1	Discuss plan for engaging with DHBs to next steering group	Jo Gibbs, Dale Bramley, Chris Fleming	23 March	Update 23 March
2	Bring a plan for managing misinformation to next steering group	Geoff Gwyn	23 March	Deferred - Update 30 March
4	Provide Governance Group next week with certainty about ability to scale and timeframes for critical milestones.	Mat Parr	23 March	Complete
5	In the first column in the service delivery models document, include another definition of Iwi that applies to urban populations alongside Whānau/Hapu/Iwi.	Matt Jones	23 March	Complete
Tuesday 23 March				
1	At SG on 30 March 2021, move for agreement to the minutes of meeting held 16 March 2021.	Chair	30 March	In progress
2	CEs of DHBs that have not provided plans, or are not meeting their roll-out plan targets to be contacted if required.	Jo Gibbs	30 March	Complete
3	A group to be established which is dedicated to identifying the denominator numbers.	Mat Parr	6 April	In progress
4	Update the critical path for the Governance Group session on Friday 26 March, particularly to show the volume change over time and the number of sites of which type would need to be in place over time ahead of 1 July.	Matt Jones Shayne Hunter	26 March	Complete
5	Secure written agreements with NZDF on the use of their workforce following completion of their programme	Fiona Michel	6 April	In progress
6	Finalise the model and develop approach for delivery at next meeting.	Simon Everitt	30 March	In progress
7	Pillar leads and delivery leads to ensure absolute clarity of the products that will be delivered to support timeframes in the critical path.	Matt Jones Mat Parr	30 March	In progress
8	Risk paper to identify risks and actions that address the risks in the critical path	David Nalder	30 March	In progress

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Minutes

COVID-19 Vaccine and Immunisation Programme Steering Group

Date:	Tuesday, 30 March 2021
Time:	4.30 pm – 6:30 pm
Location:	1N.3
Chair:	Dr Ashley Bloomfield;
Members:	Sue Gordon, Dr Dale Bramley, Stephen Crombie, Chris Fleming, Shayne Hunter, Jo Gibbs, Dr Ian Town, Dr Caroline McElnay; Deborah Woodley
Attendees:	Astrid Koornneef, Matt Jones, Colin MacDonald, Stephen Crombie, Mat Parr, John Walsh, David Nalder, Fiona Michel, Wendy Illingworth, Rachel Haggerty
Apologies:	Joe Bourne, Maree Roberts
Secretariat Support:	Isabel Cockburn

#	Agenda Item
1.	**Introduction and minutes** The minutes from the previous meeting on 23rd March 2021and meeting on 16th March were approved. Ashley went through the action tracker from last meeting. ***Action 1: Talk to CEs about Easter plans at 6:30pm meeting***
2.	**Programme status and risk report (**Mat Parr, David Nalder)
2.1	At governance group there was a discussion around the differences between design and build and build elements of the programme, a desire was articulated to bring the two together and consolidate a programme plan across the board. Creating a PMO team perspective with unified view linked to milestones. Going forward steering group can get status reports linked into those milestones. Aim is to get a fully consolidated reporting plan with a DHB view as part of forward planning to see if, as a system, targets are being hit. DG asked about what a single programme combining design and run, looks like in terms of organisational structure and accountabilities? Jo Gibbs thinks we need to be clear that DHBs have the depth of plans they need across design and run. Sue Gordon would want policy capability included in discussion as there is still a significant body of policy work required. Rachel Haggerty highlighted the short timeframe for DHBs to create plans.

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	Action 2: Have a strawman plan created by 7th April, in time for governance group on Friday 9th April
2.2	David covered how risk update has evolved to top risks and a broader view of inherent risks: • He supported the need for alignment across programme, risk reporting will overlay milestone integrated plan and help monitor risks and support mitigations. • He has updated the way top risks are expressed to reflect how things have changed over the past week and is working on providing clarity and programme symbiosis around top risks. Updates highlight broader risks that overlay across the programme, which tie into most of the papers presented today. • The sector are engaging on risks through pillar and engagement leads which feed back to David • Ashley brought up inherent risk of aggregate risk of the media and how critical the media will be in maintaining confidence, or not. There was a discussion on clinical issues and quality assurance issues given the number of Service delivery models and gave the example of if sites could go live without appropriate quality assurance. • There is piece of work being done in service design on site readiness. Currently working through issues around pop ups and mobile sites requiring a review at every new site. Juliet has picked up on practises from the UK. • There is a readiness assessment in the handbook but proper clinical governance should be implemented both locally and nationally. • Caroline McElnay reported that Juliet is drafting a paper on quality safety, DHBs should have a technical advisory group set up but this shouldn't be assumed and should be made a requirement. ***Action 3: Follow up next week on ensuring project local clinical governance arrangements in place, and feedback on Juliet's work.*** • Lack of an accountability framework is a known gap in the programme • What is the accountability framework across the range of providers as we scale up, this needs to be mapped into the critical path.
	Run
3. 3.1	**Standing item on science and technical advice through CV-TAG** (Dr Ian Town) Quite a lot of what Jo Gibbs has asked for been signed out and moved to implementation. Still working on the 2/4 week stand down after flu/MMR vaccination, there has been a media enquiry, Ian to discuss further with Caroline. • Need clarity from an operational POV, this becomes a challenge w EVA • Immunisation comms went out today which highlighted that COVID is the priority, need to make sure that is mirrored by the COVID programme. • Ashley would like a fortnightly update on website, publishing science publicly. This will need to interface with comms. • MOH will invite DHBs to work in partnership on population immunity but Ashley assured this is not about a percentage number and we cannot have pockets of unvaccinated people. Changes to cold chain vaccine requirements • MOH has adopted advice that the vaccine can spend 5 to 20 days at -20 and may be refrozen. Work is needs to be done on logistics as wastage is a consideration. Jo will get a timeframe but it won't be in ops guide this week.

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	Action 4: CV-TAG to provide advice on use of vaccine in any scenario whether it is alongside the use of flu, MMR, prophylactic etc. Population immunity is joined up work, wholly dependent on successful vaccination programme. ***Action 5: Proposal to put out science publicly, this needs to be signed out through comms and public health. Putting out raw info could be counterproductive.***
4.	**Standing item on run and early vaccine access application and approval process** (Jo Gibbs and Astrid Koornneef) • Jo Gibbs has had positive conversations with RAMS and SROs on how work effectively on the codesign process and bring DHBs in earlier to integrate but clear accountability will be necessary. She expects to land this work in the next few days. • There is concern about DHBs not delivering on numbers in plans, with Easter weekend vaccinations falling well short of the model. The issues have been identified as; • Workforce issues around vaccinator availability, raw numbers look good but many are not FTE, i.e. they may have limited availability • Jo is having conversations with vitality and MedPro about which vaccinators they can release back to DHBs in the next few weeks. • Non-vaccinator workforce, particularly admin as they are currently running manual booking systems. Jo has contacted Healthline and Andrew Slater about providing resourcing. • DHBS are struggling to book numbers to escalate. Some DHBs have been asking for specific help, members of the team doing site visits in Wanganui and Canterbury. Astrid gave more specific details on numbers • Model numbers set at 39k, DHB plans make provision for 31k. This is part of an ongoing conversation about how we support them to get numbers up. • Next plans coming in after Easter, Jo and Astrid will be meeting with SROs, leads and CEs to get deeper understanding of plans. • Inventory orders show a 30% shortfall on DHB plans and 40% shortfall on model, it is not possible to close that gap but they are working to narrow it. • Risk is going further down into programme i.e. winter flu, staffing, critical capacity in ED. CVIP needs to be priority. • Rachel Haggerty brought up national vs local deliverables. Nationwide system availability and decision-making needs to line up with DHBs. Jo Gibbs stated that rebasing will be a difficult conversation; how can we know potential plans will be delivered. *Paper considered: Early Vaccine Access Application and Approval Process* • We need a mechanism in place for EVA as soon as possible. • It was anticipated that regional transport exemption system would support this, but it is insufficient. • Interim process will be manual email case-by-case and will be in place for about a week. Working securing on surge capacity from the Ministry of Justice. • Criteria for compassionate EVA is tight, sports exemptions will be easier to manage. • Expecting surge, need to ensure everyone in MOH knows where to steer. There is only a week turnaround due to vaccine schedule.

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5.	**Update on privacy and assurance in light of Canterbury DHB privacy incident** (Matt Lord, Michael Dreyer, Geoff Gwyn) *Paper considered: IT Security Incident – CDHB – 26 March 2021* • Canterbury is looking at new options to get by that are not paper-based. • The Ministry team have gone to DHBs to find out if they are using implicated system, all booking systems used by DHBs will have to be security checked. • MIQ system being checked again. • Team has prepared advisory notice and is sending out further guidance. • National system will be checked before release. • There is no evidence of malicious infiltration, however investigations will take place, an official letter has been sent to vendor. ***Action 6: Set expectations on who DHBs should be using for booking systems***
	Design and build
6.	**Operational contingency planning in the event of an outbreak** (Mat Parr, Andrew Old) *Paper considered: Contingency planning in an outbreak scenario* There was a workshop session in Auckland that pulled together discussion paper seeking steer. • Time period consideration: this planning is only relevant up until June/July before general population is vaccinated. • If there is an outbreak, workforce will pulled into contact tracing, and it is likely an out-of-region workforce will need to be utilised which is a planning consideration. MOH must be cognisant of planning load on DHBs. • Andrew brought up the considerations around physical sites which would need to established similar to testing infrastructure, that can stand up quickly. • Quite a dynamic issue that we will have revisit regularly. Regular planning can also inform scenario 2 and 3. • Ring vaccination may be still required, on a small scale. Need agility in outbreak scenario. Discussion was had around whether planning be focused on ring vaccination as more likely scenario, still likely to need surge workforce. Look at sites and infrastructure set up now, bring in capability for response. ***Action 7: Focus planning on most likely scenario i.e. ring vaccinating***
7.	**Comms and engagement update** (John Walsh) *Paper considered: Communications and engagement support for COVID-19 vaccine rollout* John gave a brief update on staffing, they are onboarding in excess of 20 new staff into the team to produce necessary collateral and support the national campaign. • Additional resources will also support sector comms and engagement, particularly to clarify timings of vaccine rollout and where responsibilities lie within the sector. National campaign is advancing well. Planning to launch week beginning 19th April and it will be a significant presence in the market.
8.	**Disability Communications Campaign Funding** (Ray Finch) *Paper considered: Disability Communications Campaign Funding*

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	• There is a need for a codesign process with the comms team for targeted audience, this will align and land well with programme equity approach. • John Walsh has engaged with the paper and is supportive, has resources standing by to support. • Ashley wants clarity on shared governance with DPOs to ensure accountability and alignment with broader comms. • Ray assured that disability comms will include learning disabilities and mental health. ***Action 8: Funding agreed in principle, Ray to work with John Walsh and DHBs/ DPOs on co-governance and utilisation.***
9.	**Workforce resourcing update** (Fiona Michel, Jo Gibbs) *Paper considered: Workforce strategy and plan.* Fiona gave an update on key issues and gave a summary of forecasting: • Design and build team have been working on forecasting how many people are theoretically required, now work must be done on how that matches to available workforce. • Piece of work ongoing around codifying population of workforce and progress through training, surge database etc and where they are. • Aim to have weekly/ regular report from DHBs on workforce. DHBs have done elements of this planning already, plan is to pull that work first, reconciliate it and work on a template and reporting process based on existing plans. • Confidence workforce is progressing well, there is data and engagement, and is on the path to routine reporting. • She highlighted process map for database but needs technical resources to build it. • Planning done on how to secure contingent workers, have had discussions with providers, i.e MedPro and SROs about building a bank of vaccinators • There are concerns across the sector about workforce poaching, will have to work on getting an exemption process for procurement. Ashley assured that this process can be expedited. Next step is to get monthly plans and contracts in place, continuing to build workforce team and working on the non-regulated training programme. • She gave assurance that have enough people in NZ to complete vaccination programme we just need to corral and organise them. • Caroline brought up that there are a number authorisation issues to work through but they not insurmountable. • A lot of good traction this week from Ras. ***Action 9: Fiona to work on getting contracts in place and give information to DG by end of the week***
10	**Approach to managing misinformation** (Mat Parr) *Paper considered: Resilience to Mis/disinformation.* Work is underway from all-of-government, the normal MOH approach to misinformation is relatively passive: • Discussion focused on question of if MOH should take a more proactive approach, it was decided this issue needs more consideration and work as it would set a precedent, not just in MOH but across all government departments.

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	• Will use international learnings from immunisation misinformation. ***Action: Look at international policy on vaccine misinformation and have discussion with comms and other government agencies.***
11.	**Any other business** • Funding to be discussed offline

Item	*Action*	*Who*	*Due date*	*Status*
Tuesday 23 March				
1	At SG on 30 March 2021, move for agreement to the minutes of meeting held 16 March 2021.	Chair	30 March	Complete
2	CEs of DHBs that have not provided plans, or are not meeting their roll-out plan targets to be contacted if required.	Jo Gibbs	30 March	Complete
3	A group to be established which is dedicated to identifying the denominator numbers.	Mat Parr	6 April	Complete
4	Update the critical path for the Governance Group session on Friday 26 March, particularly to show the volume change over time and the number of sites of which type would need to be in place over time ahead of 1 July.	Matt Jones Shayne Hunter	26 March	Complete
5	Secure written agreements with NZDF on the use of their workforce following completion of their programme	Fiona Michel	6 April	Complete
6	Finalise the model and develop approach for delivery at next meeting.	Simon Everitt	30 March	Complete
7	Pillar leads and delivery leads to ensure absolute clarity of the products that will be delivered to support timeframes in the critical path.	Matt Jones Mat Parr	30 March	Complete
8	Risk paper to identify risks and actions that address the risks in the critical path	David Nalder	30 March	Complete
Tuesday 30 March				
1	Talk to CEs about Easter plans at 6:30pm meeting	Chair and Sue Gordon	30 March	Complete
2	Have a strawman plan for integrated programme created by 7th April, in time for governance group on Friday 9th April	Mat Par	7 April	In progress
3	Follow up on ensuring local clinical governance arrangements are in place, and feedback on Juliet's work.	Ian Town	8 April	In progress
4	CV-TAG to provide advice on use of vaccine in any scenario whether it is alongside the use of flu, MMR, prophylactic etc.	Ian Town	6 April	In progress
5	Proposal to put out science publicly, this needs to be signed out through comms and public health.	Ian Town	6 April	In progress

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6	Set expectations on who DHBs should be using for booking systems	Geoff Gwyn, Matt Lord, Michael Dreyer	6 April	In progress
7	Focus contingency planning on most likely scenario i.e. ring vaccinating	Mat Parr, Andrew Old	6 April	In progress
8	Funding agreed in principle, Ray will work with John Walsh and DHBs/ DPOs on co-governance and utilisation.	Ray Finch	6 April	In progress
9	Fiona to work on getting contracts in place and give information to DG by end of the week	Fiona Michel	1 April	In progress
10	Look at international policy on vaccine misinformation and have discussion with comms and other government agencies.	Mat Parr	6 April	In progress

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