MINISTRY OF HEALTH
MANATŪ HAUORA

133 Molesworth Street
PO Box 5013
Wellington 6140
New Zealand
T+64 4 496 2000

20 December 2021

Scott

By email: fyi-request-15571-da3dea56@requests.fyi.org.nz
Ref: H202114872

Tēnā koe Scott

Response to your request for official information

Thank you for your follow up request under the Official Information Act 1982 (the Act) to the Ministry of Health (the Ministry) on 26 October 2021. You requested:

> *"I would like to request copies of all IIAG meeting minutes dated since the beginning of August.*
>
> *I would also like to request copies of the six contingency plans referred to on page 27 of your most recent release document, namely the CVIP contingency plans for:*
>
> 1. *A community outbreak,*
> 2. *Disruption to the vaccine supply,*
> 3. *Disruption to the COVID-19 vaccination workforce,*
> 4. *Unavailability of IT systems,*
> 5. *A clinical safety issue,*
> 6. *A significant privacy or security breach.*
>
> *Finally, I would like to request copies of the IIAG Terms of Reference and two latest work plans (the work plans for the 3rd and 4th quarters)."*

The Ministry has identified six Immunisation Implementation Advisory Group (IIAG) meeting minutes, six contingency plans and one IIAG Terms of Reference document within scope of your request. All documents are itemised in Appendix 1 to this letter, and copies of the documents are enclosed. Where information is withheld, this is outlined in the Appendix and noted in the document itself. Please note, the reference to 'work plans' do not exist. As such that part of your request is refused under section 18(e) of the Act, as the requested information does not exist.

Please further note where information is withheld under section 9 of the Act, I have considered the countervailing public interest in release in making this decision and consider that it does not outweigh the need to withhold at this time.

I trust this information fulfils your request. Under section 28(3) of the Act, you have the right to ask the Ombudsman to review any decisions made under this request. The Ombudsman may be contacted by email at: info@ombudsman.parliament.nz or by calling 0800 802 602.

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

Astrid Koornneef
Director
National Immunisation Programme

Appendix 1: List of documents for release

#	Date	Document details	Decision on release
1	5 August 2021	IIAG Minutes	Released in full.
2	19 August 2021		
3	3 September 2021		
4	17 September 2021		
5	1 October 2021		
6	15 October 2021		
7	Date last reviewed: 30 November 2021	Contingency Planning: Community Outbreak of COVID-19	Released with some information withheld under the following sections of the Act: • Section 9(2)(a) to protect the privacy of natural persons; • Section 9(2)(c) to avoid prejudice to measures protecting the health or safety of members of the public.
8		Contingency Planning: Disruption to the supply of vaccines, PPE or consumables	
9		Contingency Planning: Disruption to the availability of vaccinator or administrator workforce	
10		Contingency Planning: Unavailability of IT systems	
11		Contingency Planning: Clinical Safety Issue	Released in full.
12		Contingency Planning: Significant Privacy or Security Breach	Released with some information withheld under the following sections of the Act: • Section 9(2)(a) • Section 9(2)(c)
13	5 August 2021	COVID-19 Immunisation Implementation Advisory Group: Term of Reference	Released in full.

IIAG Minutes

Meeting - 5 Here-turi-kōkā 2021

Date:	Thursday 5 August 2021
Time:	1:30 pm – 3:00 pm
Chair:	Keriana Brooking
Members attending	Dr Angela Ballantyne, Taima Campbell, Kevin Pewhairangi, Loretta Roberts, Rhonda Sherriff, Te Puea Winiata
MoH Attendees:	Andrew Bailey, Allison Bennett, Caroline Greaney, Matt Jones, Patricia Joseph, Astrid Koornneef, Angie Lawrie, Rachel Lorimer, Jason Moses, Mathew Parr, Jo Williams
Apologies:	Nicky Birch, Dr Tristram Ingham, Dr Helen Petousis-Harris, Tamati Sheppard-Wipiiti, Dr Apisalome Talemaitoga, Silao Vaisola-Sefo,

Item	Agenda Item
1.	**Introduction and welcome** • Keriana Brooking welcomed members, noting that a number unfortunately had prior commitment clashes. • Keriana opened the meeting with karakia. • The minutes of meeting held 22 Hūrae 2021 were confirmed. • No conflicts of interest were registered. • IIAG members met privately by Zoom from 1.00 p.m. – 1.30 p.m. **Matters arising** • The period of consultation on the draft Terms of Reference dated 1 July 2021, tabled at the 9 July meeting, has now ended. There were no further changes. This version of the Terms of Reference was therefore confirmed as final. ***Ministry Action: Finalise the Terms of Reference and distribute to members.***
2.	**Value proposition of the IIAG (Chair)**
	• In opening the meeting, the Co-Chair reinforced the need for IIAG members to feel that the Group both added value to COVID-19 vaccination implementation planning and received value back. Many members are directly involved in service provision. There are many areas in which they could make meaningful contributions such as information about baselines, evidence and operating structures. They need to be satisfied that their significant time allocation is justified. As a group, the IIAG also needs to be able to see that trade-offs were considered within decision-making.

	• The co-chair indicated that she was expecting written feedback on this issue from members shortly. The co-chairs would probably look to meet with the Ministry once member feedback was received.
3.	**Equity Monitoring (Jason Moses)**
	Paper 4: Equity Presentation – 2 August 2021 • Following the recent decision of the Minister for COVID-19, the denominator used for reporting for Group 4 is from Health Service Utilisation Population (HSU) data rather than from NHI data. This data can be accessed at DHB level, by dose and overlaid by e.g. age band, ethnicity etc. • Group 4 vaccination has been under way for about three weeks. Using HSU data means we have a more accurate representation of vaccination performance across DHBs by age band. • Noted that while current vaccination rates for older Māori and Pacific people are low (as expected through the sequencing), the tables in this paper generally show a better overall vaccination scenario for these groups than is reflected in public commentary and through DHB production planning. • As at 1 August 2021, Māori and Pacific aged over 55 years are being vaccinated at similar or higher rates to non-Māori non Pacific over 55 years. • Some DHBs have delivered to their equity targets under sequencing and the Ministry will discuss with the Minister whether these DHBs could move earlier on the younger age bands. **IIAG perspectives and advice** • Members sought clarification about the use of the HSU as a denominator for reporting performance, when production plans are based on the Statistics NZ denominator. This meant comparisons were difficult. The Ministry noted that it would work with DHBs to revise their plans so that they were aligned. • There are difficulties in making whānau bookings through the national booking system. The Ministry confirmed that the booking system is currently able to accept only single bookings and technology solutions are being sought. For now, alternatives would need to be used such as making group bookings using the national call centre. • Members noted they may consider using some meeting time to identify these types of operational issues and methods to address them so that they did not become roadblocks.
4.	**Commissioning and Funding**
	Verbal update and advice from IIAG – Co-Chairs • Providers want to do the best for their communities, but face many 'on the ground' obstacles. The primary care sector is a critical part of scale-up. Where primary care providers do not come on board, this increases the demands on DHBs and other providers with flow-on effects for roll-out. • Effective national implementation requires a central overview of the commissioning approach across New Zealand. The IIAG saw this as an assurance role for the Ministry. • The IIAG noted that while this matter is raised frequently with DHB SROs, the Group perceives there is a discord between 'intent' and 'execution'. Specific concerns relate to: ○ achieving a level of national consistency (particularly important with a wider range of primary care providers coming on board);

	○ funding adequacy, funding flows and the desire for a greater level of consistency of approach (payment timeframes, 'fee for service' vs 'special needs' funding, the possibility of a rural adjustor); ○ service provision logistics (understanding the requirements of vaccination providers, impact of trade-offs such as allocating secure storage, and technology challenges that constrain achievement of objectives, e.g. inability to make whānau bookings); ○ understanding the quantum of commissioning, their location, their funding status, and overall sufficiency to support scale-up. • The IIAG advises that it is well-placed to identify both the issues and possible actions to address them. **Discussion** • The Ministry acknowledged there had been earlier issues with funding flows for equity performance. The initial funding round saw funds sent directly to providers. Funding through the second round had gone to DHBs to allow them to fund the specific requirements of their communities. • Funding for round three had been by application. This was well subscribed. • The recent adjustments to price per dose had necessitated some changes to current funding arrangements.
5.	**Decision to use Pfizer (12-15 year olds) and Janssen (Allison Bennett)**
	Paper 4: Decision to use considerations for Pfizer (12 to 15s) and Janssen • The Ministry has received technical advice from CV-TAG following the Medsafe 'decision to use' Pfizer for 12-15 year olds. Current thinking is the extension in the first instance could apply to 'at risk' members of this age group. • It was noted that New Zealand was unlikely to secure a supply of Janssen this calendar year and that the pragmatic decision at this point was to continue with one vaccine in the portfolio, noting the reliability of supply from Pfizer. • The Ministry noted that it must provide its advice on these matters in the immediate future. **IIAG perspectives and advice** • Members indicated this was a matter that required robust consideration. Extending vaccination to those aged 12-15 years provided another variation for roll-out which had a number of potential implications: ○ communications and engagement challenges because of multiple messaging relating to groups prioritised for vaccination; ○ equity implications (not covered by Paper 4); ○ the interface of this age cohort with other immunisation programmes; ○ the concerns around myocarditis in younger males. ○ consent processes – can children elect to be vaccinated without parental approval? ○ the unknown level of confidence about this group being able to be incorporated into DHB production plans and delivery; ○ timing of any such vaccination – school holidays. • Consideration could be given to doing scenario modelling to ensure roll-out to this group out of sequencing could be managed. • In respect of the Janssen vaccine, members suggested that there is merit in having a second vaccine in the portfolio, for example some people who declined the two-dose vaccine might accept a one-dose vaccine.

6.	**Strategy to drive high levels of uptake through Q.3 (Mat Parr/Matt Jones)**

	• The critical nine-week peak period for COVID-19 vaccination will occur in September-October 2021. We need to maximise New Zealand's demand during this period.
	• Primary care service providers and mass vaccination events are likely to play the greatest roles.
	• Additional feedback from members is welcomed before the next meeting.
	
	IIAG perspectives and advice
	
	• Driving uptake:
	  ○ Ensure clinical safety remains the key priority.
	  ○ Suggested that careful consideration is given to use of incentives. Noted that a vaccination passport is likely to provide a strong incentive.
	  ○ Note that wider environmental issues may impact on the ability of the workforce to deliver services.
	  ○ Consider other countries' approaches.

7.	***Transition to Future State (Mat Parr/Matt Jones)***
	Paper 6: CVIP Programme – Transition to Future State (Legacy) – 4 August 2021 • A team has been created to focus on the Transition to Future State. • The paper sets out a high level approach to designing for the endemic delivery of COVID-19 vaccinations into the future. • Due to time constraints at the meeting, members wishing to provide feedback can send this to Matt Jones before the next meeting.
8.	***Extension of Dosing Schedule (Astrid Koornneef)***

	Verbal update
	• There is an emerging view (United Kingdom) that increasing the period of time (i.e. to six weeks) between the first and second dose will enhance immunogenicity from COVID-19.
	• The Ministry is considering what this means for implementation in Aotearoa New Zealand:
	  ○ need to consider the likely impacts on equity. However, it was noted that a longer interval between doses (particularly a bulk move) would mean that first dose vaccination would move more quickly into the younger age groups, where Māori are a bigger proportion of the population than are non-Maori.
	  ○ a bulk move of current second dose bookings would create spare slots that would need to be filled. This could be beneficial in allowing for a significant increase in the number of first doses delivered, or to provide added flexibility for walk-ins.
	• The minimum period of time between doses would remain unchanged at 21 days.
	• Need to consider how to manage rebooking those already in the system.
	• Need to consider the impact on those who have already had their second dose.
	• An announcement is likely early in the following week.

Cont.	**IIAG perspectives and advice** • Reinforced the importance of clear communications to support this change, including the benefits. • Messaging to those who have already been vaccinated with a three-week interval between doses needs very careful thinking to reassure and maintain confidence. • Consider if a longer timeframe between doses will impact on awareness/ willingness to be vaccinated for the second dose. • Consider the wider impacts on providers at a local level, who are often called directly by their clients. • Will people have choice?
8.	**General Business** • Members wishing to provide feedback on Paper 10: Interim process on booking approach for people with disabilities, should provide this to Astrid Koornneef. • The following papers were noted: ○ *Paper 8: COVID-19 National Clinical Quality and Safety Forum – Terms of Reference – version 2* ○ *Paper 9: CVIP Outcome Measures – Status update – data as at 26 July 2021* ○ *Paper 10: IIAG work programme to September 2021.*
8.	**Closing/Karakia whakamutunga** – Taima Campbell
9.	**Next meeting** Thursday 27 August 2021 1.00 p.m. – 1.30 p.m. (IIAG member session) 1.30 p.m. – 3.00 p.m. (Full attendance)

Minutes

Immunisation Implementation Advisory Group Meeting – 19 Here-turi-kōkā 2021

Date:	Thursday 19 August 2021
Time:	2:00 pm – 3:00 pm
Co-Chairs:	Keriana Brooking, Te Puea Winiata
Members attending	Dr Angela Ballantyne, Taima Campbell, Dr Helen Petousis-Harris, Kevin Pewhairangi, Rhonda Sherriff,
MoH Attendees:	Dr Joe Bourne, Allison Bennett, Michael Dreyer (item), Caroline Greaney, Matt Jones, Angie Lawrie, Rachel Mackay, Fiona Michel, Charmaine Ngarimu, Mathew Parr, Tamati Sheppard-Wipiiti
Apologies:	Nicky Birch, Dr Tristram Ingham, Jason Moses, Loretta Roberts, Dr Apisalome Talemaitoga, Silao Vaisola-Sefo,
Format:	To ensure compliance with the Alert Level 4 in place across New Zealand at the time of this meeting, all attendees at this meeting joined by Zoom.

Item	Agenda Item
1.	**Introduction and welcome** • Keriana Brooking welcomed members. • Te Puea Winiata opened the meeting with karakia. • The minutes of meeting held 5 Here-turi-kōkā 2021 were confirmed. • No conflicts of interest were registered. • Noted that Jason Moses had submitted an apology due to a concurrent meeting with Minister Henare.
1a.	**Matters arising** • Members noted their increasing concerns that many primary providers have still not been paid by their DHBs for services provided, dating back several months. One member advised that these issues seem to have arisen when payments were integrated with the CIR and that most of the outstanding payments seem to pre-date that timeframe. • Members are concerned that the matter is acknowledged but that there is no clear line of responsibility for addressing it.

1a. Cont.	• The Ministry indicated it has identified a list of the providers it understands have not been paid. ***Ministry Action 1: Fiona Michel will raise this matter with CVIP National Director, and email IIAG members with the proposed approach and details of the person responsible for ensuring this issue is addressed.***
1b.	**Meeting format** • Noted that the meeting focused on a small number of essential matters: o vaccinating in an Alert Level 4 environment, o vaccinating healthcare workers o implementation of a decision to use Pfizer for 12-15 year olds. • This reflected the Alert Level 4 situation applying across Aotearoa New Zealand at the time of the meeting and acknowledged that most IIAG members are directly involved in healthcare service provision.
2.	**Vaccinating in an Alert Level 4 environment**
2a.	• At IIAG's request, the Ministry updated on the status of national vaccination services. Delivery for 19 August was expected to be at about 30 per cent but would start to return to normal from 20 August in many places. This was an extraordinary achievement just two days after the outbreak. Noted that the Auckland region was currently operating at about 50 per cent. • The IIAG noted that in February 2021 it had provided input to policy work led by the Ministry on scenario planning or vaccination in the event of an outbreak. IIAG asked if this had been used in the current situation and suggested that: o consideration be given to formalising this work into guidance for the sector, o review of the scenarios may be timely. ***Ministry Action 2: Mat Parr/Matt Jones to locate/confirm use of scenario planning work to which the IIAG contributed.***
2b.	**Understanding 'what's working'** • The Ministry is keen to hear member views on 'what's working for them for vaccination in this environment so that it can improve its guidance document. For example – issues to consider re vaccinating in cars (access to facilities, traffic management, how to manage the observation period). • Members who wish to provide comments should email: joe.bourne@health.govt.nz
3	**Vaccinating healthcare workers (Allison Bennett)**
	Paper 3: consultation with agencies on potential options to encourage COVID-19 vaccine uptake among healthcare workers – August 2021 • The Ministry is developing policy advice on mandatory vaccination of healthcare workers and on vaccination of this group during AL4 and requested member feedback on this issue. **IIAG perspectives and advice** • Member input included: o the personal beliefs of some workers are not supportive of vaccination;

	○ there can be significant pressures on employers where non-vaccinated workers need to be redeployed and there are limited roles not in the frontline; ○ there are 'good employer' challenges for employers who are trying to balance frontline worker preferences relating to vaccination; ○ consider whether vaccinator assessment and authorisation processes may be unnecessarily delaying vaccinators from coming onstream; and ○ consider interface/alignment with requirements on other similar groups e.g. police. • In response to a question from members, the Ministry advised that it did not currently have a blacklog of applications for the role of COVID-19 Vaccinator awaiting assessment. However, a number of applications have been made with incomplete information and these will be processed when all relevant information is received. The Ministry will be happy to follow up on specific cases that may be causing issues.
4.	**Decision to use Pfizer (12-15 year olds) and Janssen (Allison Bennett)**
	Paper 4: Implementation of 'decision to use' the Pfizer vaccine for 12 to 15 year olds – 16 August 2021 • Following the development of policy advice (see item 5, Minutes 5 August 2021) the Ministry is developing the implementation approach for vaccination of 12-15 year olds. Current thinking is that the initial roll-out would encourage eligible parents/caregivers to book their eligible children in a whānau booking. • As well as messaging and booking logistics, consideration is being given to things such as safety and patient experience and the Ministry is keen to hear members' views. • A pilot for this age group is likely to be held in about a week. **IIAG perspectives and advice** • Member input included: ○ There will be challenges in implementing for this age group in school settings this year, noting the full term 4 calendars of this cohort, ○ If planning to do in schools next year, ensure that receiving the necessary permissions is done at the start of the school year, ○ Local solutions to this age group can also include through primary health care, workplaces, or marae.
5. **5a.**	**General Business** ***Understanding equity performance*** • Members noted the most recent changes to sequencing, with the inclusion of certain 12-15 year olds effectively immediately and the announcement that all eligible people over the age of 12 years will be able to book a vaccination from 1 September 2021. The asked how this impacted on equity performance, noting they are keen to understand the detail of current equity performance at a DHB level. They are also keen to understand performance of those providers who do not use the booking system. • Matt Parr advised that the move to use Health Service Utilisation data for reporting allowed for some very powerful analytics to be extracted by region, by DHB, by ethnicity, by age group etc.

	• The Ministry indicated it would like to work with members to identify interventions for areas needing more focus. • After discussion, it was agreed that this would be an agenda item for the next meeting. ***Ministry Action 3: Allocate solid timeslot on the agenda for the next meeting of the IIAG (on 2 September 2021) to share the data dashboard/do a deep dive of equity performance at DHB level with IIAG members.***
5b.	***Vaccination 'Passports' (Allison Bennett)*** *Paper 6: New Zealand-issued digital vaccination certificates* • This paper provided an update on work under way to develop COVID-19 digital vaccination certificates for people vaccinated in New Zealand, with the primary aim of supporting international travel. • Written input submitted prior to the meeting by one member is reflected below: o good to see New Zealand working to ensure its certification meets global standards - agrees on the importance of interoperability; o ensure there is provision to provide certificates to individuals who cannot be vaccinated for medical reasons, to ensure they are not adversely affected; o does not support vaccination as a condition of entry into New Zealand however thinks it reasonable to use vaccine status as a consideration in terms of quarantining and testing regimes on arrival; o The presumption that vaccination is easily accessible is very important. New Zealand must continue to invest in removing barriers to vaccination. Suggested that domestic use of a vaccine certificate could perhaps be dependent on reaching certain vaccination equity targets? o Might rapid antigen testing be an alternative for a vaccine certificate for domestic use? • As the meeting had reached its allocated timeslot, it was agreed that other members who wish to p ovide comments should email: michael.dreyer@health.govt.nz
6.	**Closing/Karakia whakamutunga** – Dr Joe Bourne

MINISTRY OF HEALTH
MANATŪ HAUORA

Implementation Immunisation Advisory Group – IIAG Minutes

Date:	Friday 3 September 2021
Time:	11:00am - 1:00 pm
Chair:	Keriana Brooking
Members attending	Nicky Birch, Dr Tristram Ingham, Dr Helen Petousis-Harris, Kevin Pewhairangi, Loretta Roberts
MoH Attendees:	Andrew Bailey, Dr Joe Bourne, Astrid Koornneef, Rachel Lorimer, Jason Moses, Mathew Parr, Tamati Sheppard-Wipiiti. Dr Angela Ballantyne, Taima Campbell, Rhonda Sherriff, Silao Vaisola-Sefo,
Apologies:	Te Puea Winiata, Nicky Birch, Dr Apisalome Talemaitoga

Item	Agenda Item
1.	**Introduction and welcome** • Keriana Brooking welcomed members. • The minutes of meeting held 9 Hūrae 2021 were confirmed. • No conflicts of interest were registered. • There were no matters arising from the previous Minutes. • No changes to existing Actions. **Matters Arising** • Maori providers in active communication with providers and DHBs in relation to provider payments. Small number paid more than once. Will carry this conversation over to the next meeting.
2.	**Interactive equity session with a data focus (Tamai Sheperd-Wipiiti, Declan Sue, Patricia Joseph)**
	• Focus on Monitoring and Performance. Looking to disseminate information to DHBs for monitoring and performance, particularly Maori, Pacifica and Disability data. **General Discussion** • Noted that Pacific numbers doing better than Maori. Encouraging given where the outbreak is. • The Members want to make it clear that if there are any supply issues then equinity should continue unabated. • It is noted it's been difficult to get traction on disability issues. Now that we have the Minister involved, she is very proactive and is getting noticeable traction. • There is a lot of data on COVID. As a team we're focussed on creating a framework to korero within GPs, DHBs. Whanau and Iwis with other agencies. • Effort being undertaken to continue momentum of big uptake in August into September and October. • 28 day Northland campaign scheduled for launching in September/October.

	• Every Maori provider primarily government funde3d, able to analyse how many doses, where to open and which days are best. We're gathering data regarding regions with a view to further resourcing and support. • Pacific providers are able to identify issues that are site specific. We're working to capture the provider and which site. • We have invited stakeholders and Maori stakeholders to hui to discuss issues and to look at decisions being made. Flexibility is important and when we respond it is timely and relevant to those communities. • Tracking areas where there are high Maori and Pacific people are enrolled. • When we go into communities, we have targeted communications for each. • Different agencies are focussing on Maori, Pacific and disability people so we're working through supporting these through further funding opportunities. • It is noted that when we are using the data through the booking system for Maori, bookings don't mean they're getting vaccinated. Also, GPs and Maori health p oviders are doing walk-ins and booking system as well. • On the diagram provided we note that some areas of Pacific people are a sea of green through all age groups, and the Red and Orange areas are consistent th oughout the country. • The Members noted it is great to see the level of data presented as there are some good practices captured. 've now opened all age groups and there are good strategies for working out how we spread the sea of green. This data may be used by PHOs in conversations around rationalisation. • The big difference the data has made in enriching korero to have an informed opinion. • It is noted there is a differential uptake across age bands and sequencing framework. A church based approach for Pacific people and eligible whanau enabled an early uptake. There was a high uptake also in areas where seasonal workers were deemed essential workers. • Intelligence is gaining momentum through mainstream media and feedback. Immunisation results from campaigns run in schools produce the highest uptake. Canterbury is willing to take the lead on a school based programme. • Up the coast limited number of vaccinators so provider is helping. Drive throughs are operating. Pharmacies and GPs waiting on contracting requirements from DHB. Vaccinators assigned to CIR is ongoing. • Business address being used for communications with the Ministry. Current process will need to be updated to reflect this otherwise individual contractors will go elsewhere. Exception process will be ramped up as a result as we need to be more flexible • There is an assurance a disability dashboard is coming. • It is noted that the DHBs have access to denominator but may not know those to target. The denominator is 40,000 in the ACC and DSS databases. No systematic data collection for disability throughout the programme. These are not known by their NHI number. Work undertaken by Disability Ministry to work through data policy issues. This is a legacy the programme will work through. • There is work regarding PHOs GPs completing requirements for MSD so they can approach people directly in a soft contact to get vaccinated. • Tamai recognised the great mihi done by Declan, Jason and Tamiti. **IIAG Decisions** **a) Noted: Raise with Ministry that when we get into rationalisation, we will review population and equity distribution of supply. (Tamiti)** **b) Noted: Canterbury is willing to take the lead on a school based programme.** **c) Noted: Personal email exemption process will be ramped up so as to include individual contractor email addresses.** **d) Noted: Legacy of database information for disability people.**
3.	**Booster Dose Update (Allison Bennett)**

	Update on whether third vaccination doses will be required / offered in 2022 • We are grounding decisions for booster programme in evidence provided by science and technical insight. • Regulatory agencies are in discussion whether boosters are need. • Focussing on security of supply. Oct/Nov/Dec committing to delivery if boosters appropriate. • CBT science evidence pending. • Update to Ministers Sept/Oct if concrete enough system to produce programme. Discussion about implementation of booster programme is conceptual at the moment in this phase of the vaccination programme. • There is increasing evidence that while people may need boosters, we will need to include people with specific conditions that might impact their effectiveness of the vaccine. How are we going to identify and proactively locate these people? • At the moment the disability system doesn't know who is disabled and who has a long term condition. Alignment with other vaccination programmes may inform the programme in 2022. Population requiring annualisation of all vaccinati ns will need strategizing to resolve COVID booster process. • Further discussion offline with the Chair advised.
4.	**Vaccine Passports (Michel Dreyer)**
	Update on vaccine passports / vaccine certificates • People will need testing and passports going forward. Travel certificates when coming and going from NZ and considering emerging global expectations. • Fraud and Identity issues to be considered. NZ using European version which is most common and globally accepted. • Passports will need to be digital and other. There is a basic version available for phones in beta testing. • Private and personal information, secure identity through RealMe, health identity to be easily setup online or with GP support. • Opportunity with the identity data users can self-ethnicity, self-determine disability and self-Iwi affiliation. **IIAG Decisions** **a) Noted:** IIAG would like to discuss further as lots of ideas to consider. Including living with COVID and how we manager this with passports. Tabled a topic for next meeting
5.	**Non-Regulated Workforce – Training and Procedures (Fiona Michel)**
	• 12817 Trained COVID vaccinators, 1149 Maori and 411 Pacific people. 50% of trained workforce have vaccinated in the programme so far. Workforce working under supervision is 267 completed training. Largest is 121 Maori, 26 Pacific. 18 people are actively vaccinating from this cohort. 18 people have delivered over 1500 vaccinations. • Disability agency providers and other NGOs are open to doing communications to interact with their population base. • Acknowledged this role is an opportunity to get people into the workforce. There are still regulatory barriers to make this happen. • This role could continue after COVID within the general programme. • It is noted workers can do online training, but workplace training is a requirement. Staff have completed training but not authorised so working through barriers to authorisations. There is no backlog in authorisations just in getting the requests submitted. **Action: Will come back to IIAG with information around breaking barriers to enable the workforce. (Loretta)**

	Action: Will work further to address need to deliver service in other ways, such as carpark delivery. (Loretta)
6.	**Childhood Immunisations (Jared Solloway, Kellie Priest)**
	• Rates are declining around the country specifically Maori and Pacific children. • DHBS submitted plans to address declining rates with equity focus and timelines of achievement. • IIAG to review plans and summary of decisions, and submit comments in its role of providing best practice, accessibility and equity advice. **Action: Disability Advisory Group minutes to IIAG as a standard agenda item. (Tristram)** **Action: Provide summary of decisions in the plans. (Jared)** **Action: Taima agreed to review plans on behalf of IIAG. (Taima)**
7.	**Closing/Karakia whakamutunga**
8.	**Next meeting** Friday 17th September 2021 11.00 a.m. – 11.30 a.m. (IIAG member session) 11.30 p.m. – 1.00 p.m. (Full attendance)

Minutes

Immunisation Implementation Advisory Group Meeting – 17 Mahuru 2021

Date:	Friday 17 September 2021
Time:	11:00am – 1:00pm
Co-Chairs:	Keriana Brooking, Te Puea Winiata
Members attending	Dr Angela Ballantyne, Taima Campbell, Dr Helen Petousis-Harris, Kevin Pewhairangi, Rhonda Sherriff, Silao Vaisola Sefo
MoH Attendees:	Dr Joe Bourne, Allison Bennett, Michael Dreyer, Caroline Greaney, Matt Jones, Rachel Mackay, Fiona Michel Charmaine Ngarimu, Tamati Sheppard-Wipiiti, Jason Moses Christina Nolan (presenting for Astrid Koornneef) Helen Francis (Secretariat)
Apologies:	Dr Tristram Ingham, Nicky Birch, Loretta Roberts

Item	Agenda Item
1.	**Introduction and welcome** • Keriana Brooking welcomed members. • Kevin Pewhairangi opened the meeting with karakia. • The minutes of meeting held 3rd September 2021 were confirmed. • No conflicts of interest were registered. **Apologies** Dr Tristram Ingham, Nicky Birch, Loretta Roberts, Rhonda Sherriff had to leave early due to a scheduling conflict. **Update on Actions** **Action 210819-01:** Raise delay in payments to providers with the National Director, and email IIAG members with the proposed approach, and details of the person responsible for ensuring the issue is addressed. **Update:** Community providers have received first two payments and further payments are progressing. Maori providers are in communication with providers and DHBs. Most GPs have received payments. **(Fiona Michel)** **Action 210805-02:** Bring back population demographics for Pfizer 12 - 15 year olds. **Update:** Raise as agenda item for next meeting. **(Allison Bennett)**

	Action 210805-03: Bring back a list of the risk and how they are being managed for Pfizer 12 - 15 year olds. Update: Raise as agenda item for next meeting. **(Allison Bennet)** **No change to other Actions.** **Matters arising** There are no matters arising.

2.	**Tātou Whaikaha update (Dr Tristram Ingham)**
	This item was not presented as Dr Tristram Ingham was unable to attend the meeting.
3.	**Reaching the unbooked/unvaccinated population (Rachel Lorimer, Petrus Van Der Westhuizen)**

- To summarise there are commentator conversations coming from many areas about what NZ looks like as we consider opening our borders.
- We find ourselves in a time and place where considering redesign and costs of the programme, we are also considering what role the IIAG might take in providing advice into these areas.

3a) Latest Horizon research (Rachel Lorimer)

- The outbreak delayed the July findings, so we have August to consider instead.
- There is an increase in the overall uptake. Under 18s and 45 - 55year old's are the most unsure age groups about being vaccinated.
- There is a paper going to the Vaccine Ministers this afternoon (17 September) where we will share this information.
- We will widely share the data regarding understanding motivations of people not wanting to be vaccinated.
- There is a large group who would like to be vaccinated but would like specific health advice regarding the safety of the vaccine and their individual health circumstances.
- Those that do want to get vaccinated but need answers to their questions first also state they feel unacknowledged
- We have answers to these questions but haven't worked through getting these to those that haven't booked.
- These are key factors now guiding our research.
- We will develop specific campaigns as a result of this research and let people know it is reasonable to have questions and want answers before getting vaccinated.
- Overwhelming feedback from recent events, where there was someone available to answer questions on site, was that it was very helpful and made people feel heard. Having their concerns addressed directly made an immediate difference to whether they would then get vaccinated.
- There were early events like this, where someone attended early morning shift changes at a Port so they could answer any questions from the workforce.
- This is an area the Ministry could run and offer support to those on the ground to facilitate that.
- Doctors and Nurses already in the community could provide this in their local regions.

3b) Geospatial data (Petrus Van Der Westhuizen)

- The Ministry is considering strategies and talking to wider stakeholder groups to use this data to inform public engagement activities.
- The Ministry has published this information on the main website and will be updated weekly. This information includes, equity, demographic, age, gender, ethnicity and will provide base rates for people to download.
- The team is considering website data so people can develop content. They plan to work closely with the reporting team on this.
- Next step is to publish more regular regional statistical data of vaccine uptake through these channels.
- The Ministry will not publish data where individual people can be identified.

- The data is being shared with TPK and they are using it in their platform.

3c) Equity data (Jason Moses)

- Over the last two months there have been daily increases in vaccinations. We see lower rates on Sundays for Māori but not for Pasifika people as they have church on Sundays.
- Under 30s only opened for vaccinations in last two weeks, once we start to see this younger age group come through, we will have a more comprehensive view.
- We're developing targets for Rangatahi and under 40s as these are our biggest concern based on the data.
- The Strategies for uptake item will cover the specific strategies.
- The data does not split age bands, is this due to concerns about privacy and identifiable data?
- The age bands can be split, and If we get into too low numbers, we can suppress the details so not identifiable.
- There are areas where agencies have gone to streets of interest to target households, to ask people about any challenges they have in getting vaccinated.
- There are some cases where whanau have gone to get tested and then have to wait for 12 days before getting vaccinated. Agencies are concerned they may lose connections if there are barriers to getting vaccinated.
- The Ministry would like to use the data to reprioritise efforts. There may be oversupply of vaccine appointments in areas we no longer need. How can we match booking availability to the areas where it is needed?
- Descaling in parts of New Zealand may be appropriate as we meet suburb saturation and diverting capacity into other ways of reaching communities.
- The Ministry is remapping of our efforts to include the wider childhood immunisation programme.

Action: Caroline will raise with Juliet concerns about the length of time between testing and getting vaccinated for further advice. **(Caroline Greaney)**

3d) Strategies for uptake (Fiona Michel)

This is a summary of where the programme is reprioritising for the next three months

- Focusing on optimising our delivery and day to day operations. If the outbreak hadn't occurred, we are achieving above production plan levels.
- Empowering people who know their communities to reach out and support local provider creativity.
- Good ideas through that we will be spreading out as these ideas are not centralised.
- Creating a library of ideas and then aligning those with demographics.
- Where there isn't a solution, working through to find one.
- Great examples of people working together.
- Clarity regarding incentives, enablers, and recognition differences. Incentives are prizes, Enablers is the assistance, Recognition is the thanks.
- Learnings from ideas that are working.
- Research points to incentives not changing the numbers but rewarding those already wanting to be vaccinated.

	• Buses in the community this week. Not new but more to come. • Research into enablers continuing. • DHB funding service providers, to increase delivery method of the provider, as this was proving effective. Should form part of the collective delivery. • Focus should also be on the fundamental of process as being respected, how people feel about their experience. • Employers are finding ways to encourage their employees and the Ministry is not involved. • Online CPR training accepted during lockdown and then expected to do in house. **Action:** Discuss with workstream lead re: CPR training and suitability of trainees. **(Fiona Michel)** **Action:** Presenting to Vaccine Ministers with a view to papers next week. Will involve the IIAG members before the next meeting. **(Fiona Michel)** **Note:** Strategies for Uptake to remain as a standard item on the IIAG agenda.
4.	**Mandatory vaccination of healthcare workers (Mani Crawford, Alison Cossar)**
	In writing this paper for Vaccine Ministers, support and feedback are asked of the IIAG. Concentrating on policy settings for health workers included in vaccinations. • This paper is based on public facing areas, including emergency departments, and the possibility of patients becoming infected if exposed to staff who are not vaccinated. This includes receptionists, janitors, and health workers. • Provisions of support, for unvaccinated people working in small workforces providing services, to be considered, as removing these people may have a detrimental effect on service provision and communities. • As providers we will need to work through what it means to refuse to employ un-vaccinated people and what other roles there may be for those people. • Considerations will need to be made in case colleagues refuse to work with staff because they re not vaccinated. • Clarification is sought regarding two main areas. Paternalistic to protect providers own health and protecting other people. Good data and scientific basis are required on transmissibility to justify the order. • Important to future proof the policy settings. • Advice for businesses, employees, and health and safety regarding integrating into the workplace is being worked on. • Health providers may reflect what is happening in corporations as they are reviewing employment contracts for new staff to be vaccinated. The Chair noted this is a highly sensitive area and includes regulated workforces and/or unions. The Chair recognized there are some operationalizing that will be required for the programme to work through carefully and with respect working with our partners.
5.	**Co-administration of vaccinations – change impact assessment and draft policy statement (Astrid Koornneef, Christina Nolan presented on behalf of Astrid)**
	• There are some in the private sector who are offering incentives to their employees to get vaccinated.

	• There are industries, such as exporting companies, that are working to understand if they will be able to export their products if their workers are not vaccinated. As a result, they are offering incentives to their staff. • Small incentives seem to be providing better results for providers, rather than large items as incentives. • New policy statement advice is to deliver COVID vaccine without time restrictions and with other vaccines. • Updating our website to reflect new advice. • Changes to BookMyVaccine to reflect this. • Standards for COVID and other vaccinations will be the same and our vaccinators trained accordingly. **Note:** Caroline is advising the Ministers on Thursday regarding disincentives **IIAG Decisions:** **Approved:** The Mandatory Vaccination of Healthcare workers paper is approved with amendments as discussed at this meeting.
6.	**Future state of COVID-19 vaccination programme (Matt Jones)**
	• The Ministry will have 5 – 6 million doses available next year. • Only a small per centage of the population may need an extra dose. This includes returnees from overseas as well. The team is expecting only the need for one dose, no sequencing framework, and lower levels next year. • The programme and the health sector have matured over this year and expect to continue on this trajectory. • Any operational constraints that we might see will be dealt with easier as we now have experience from this year.
7.	**Digital certificate update (Michael Dreyer)**
	• Currently we are able to show vaccine and test results and then later in the year certificates We also have potential for use in domestic settings. • DHBs require employment screen testing of individuals. • Individuals will be able to self-identify and view their own vaccination data. • Individuals will be able to provide a certificate to confirm vaccination for employers. • Home based clients have requested viewing vaccination status of support workers before accepting. • The team are piloting access to vaccine data to share with employers digitally and how we can use things created for the programme going forward. • Would like to see data of entire vaccination status. Ability to see when individuals might need boosters would be useful. • There are more legacy and privacy considerations we are working through. • What does NZ summer look like and the future of vaccinations? Domestic use showing vaccination status in the hospitality and other sectors, may emerge as they want to advocate and maximise good numbers for the summer. • The ability to update individual iwi affiliation is going live overnight. **Note:** Michael will add agenda items as new things emerge. The Chair acknowledged the great work Michael and his team have done for the programme.

8.	**Any other business and close**
	There was no further business for discussion.
9.	**Closing/Karakia whakamutunga** – Dr Joe Bourne **The meeting closed at 1pm**

Minutes

Immunisation Implementation Advisory Group Meeting – 1 Oketopa 2021

Date:	Friday 1 October 2021
Time:	11:00am – 1:00pm
Co-Chairs:	Taima Campbell
Members attending	Dr Angela Ballantyne, Dr Helen Petousis-Harris, Kevin Pewhairangi, Rhonda Sherriff, Silao Vaisola-Sefo, Dr Tristram Ingham
MoH Attendees:	Dr Joe Bourne, Allison Bennett, Michael Dreyer, Caroline Greaney, Matt Jones, Rachel Mackay, Fiona Michel Charmaine Ngarimu, Nicky Birch, Loretta Roberts, Adam Dalgleish Jackie Eades, Jim Brown Christina Nolan (presenting for Astrid Koornneef) Kirsten Curry (presenting for Rāwā Keratai) Helen Francis (Secretariat)
Apologies:	Keriana Brooking, Te Puea Winiata, Astrid Koornneef, Tamati Sheppard-Wipiiti, Rāwā Keratai, Adam Dalgleish (presenting for Astrid Koornneef)

Item	Agenda Item
1.	**Introduction and welcome** • Taima Campbell welcomed members. • Kevin Pewhairangi opened the meeting with karakia. • The minutes of meeting held 24th September 2021 were confirmed. • No conflicts of interest were registered. **Update on Actions** **Action 210817-01:** Caroline Greaney to raise with Juliet concerns around the length of time between getting tested and vaccinated for further advice. **Update:** Caroline Greaney has responded to Te Puea Winiata directly. **This Action is Complete.** **Action 210917-02:** Discuss with workstream lead re: CPR training and suitability of trainees. **Update:** Discussion has occurred in the last fortnight. **This Action is Complete.** **Action 210917-03:** Involve IIAG members in the development of the strategies for uptake paper before the next meeting. Paper going to Vaccine Ministers Friday 24th September. **Update:** Feedback has been incorporated into the Paper.

	This Action is Complete. **Action 210903-01:** Come back to the group with information around breaking barriers to enable the vaccinator workforce. **Update:** Good success to date in breaking down barriers. DHBs working towards breaking down further barriers. **This Action is ongoing.** **Action 210903-02:** Work further to address the need to deliver services in other ways, such as carpark delivery. **Update:** Information regarding resource guides on how to vaccinate in outreach settings on the website. **This Action is Complete.** **Action 210903-04:** Provide summary of decisions in the DHB production plans for childhood immunisations. **Update:** Will circulate and discuss at the next meeting. **Action 210903-05:** Review childhood immunisation plans on behalf of IIAG. **Update:** Work in progress. Linking into legacy connections. **This Action is ongoing.** **Matters arising** There is an OIA request for the minutes of the previous IIAG meetings. It is noted that Tātou Whaikaha is a sub-group of the IIAG, and their minutes should be considered as part of the OIA request. **Action:** Clarification requested whether including Tātou Whaikaha minutes is part of the OIA request for IIAG Minutes. **(Caroline Greaney)** Strategy for mental health to access the disability community was requested from the Ministry. **(Taima Campbell)**
2.	**Tātou Whaikaha update (Dr Tristram Ingham)**
	Dr Tristram Ingham provided an update to the IIAG members of the previous Tātou Whaikaha meeting held 28th September 2021.
3.	**Update from Ministry on disability actions (Kirsten Curry, Jackie Eades)**
	Current refresh of the governance, partnership, and engagement with the Ministry and DHBs. **3a) Transport for disabled people (Kirsten Curry)** • Whakarongorau in partnerships with travel agencies as they already have relationships with those providing transport for disabled people. • Continuing to use local community solutions where users can make decisions regarding their options. • Monitoring closely as solutions might be used for other vulnerable groups in communities facing barriers. • In home vaccinations can be self-requested from DHBs by disabled people. • Establishing partnership with both Ministry of Education and Ministry of Health to provide funding to students and those with high health needs. • DHBs working with special schools and education representatives. • Consultation with Ministry of Health and Ministry of Education data governance groups, schools, and the privacy commission underway, regarding non-health related data privacy considerations and users being mostly minors.

	3b) Disability contact centre (Jackie Eades) • Trialing new vaccination disability pathway on the helpline. Currently 120 people have used this. • When dialing Whakarongorau users can speak to disability advocates to assist in providing appropriate support. • Whakarongorau is producing a communications plan for the dedicated Healthline. • Whakarongorau has a dedicated clinical team that callers can be put through to. **Action:** A diagram of Whakarongorau services was requested. Will be sent through to the members after this meeting. **(Jackie Eades)** **Action:** Feedback requested, at the next meeting, of what is happening at Whakarongorau. **(Jackie Eades)** **3c) Monitoring and Evaluation (Kirsten Curry)** • Workshop to be established in the short term to prioritise outcomes and match our ongoing approach. • There are gaps in the disability data, IDI is excellent but still misses some groups, such, as neuro driven and the intellectually disabled. Outreach ideas to reach these communities is a priority.
4.	**Sharing CVIP data from CIP with Whānau Ora Commissioning Agency, Iwi, and non-health providers (Jim Brown)**
	• The purpose of this data is to provide details of who is not vaccinated so we can target outreach services to inform people of vaccination services. • This data is not intended to provide details of who is not vaccinated so those people can be excluded. • Data sharing in this space is a public shift in expectations and requires transparency from the Ministry. • We are ensuring we as a health system appropriately service our national commitment through the population health data. Employee and employer data sharing is a different user case. • The sharing of health data with non-health agencies requires further legal advice. • Providing line of sight for data sharing is important to control the provision of the data when sharing with providers. • Working with office of the privacy commission to agree the text. • Significant interest for data from iwi agencies, including the National Hauora Coalition. • Future proofing data sharing agreements for other activities, including non-COVID activities is a priority. COVID data is not held in the national immunisation registry so the requirements for data sharing are different. • The establishment of a new national immunisation service in 2022 will include data sharing constructs. Work on these constructs is ongoing. • Within the national immunisation service there is no provision for sharing vaccination details of children in care, Oranga Tamariki, data. • There is no provision for sharing vaccination details of those involved with Corrections, staff and inmates combined. • There is interest from the IIAG members regarding the scope of use and how it will be defined, communicated, and monitored to 92 or so organisations.

	Action: Will add feedback to the paper for consideration. **(Jim Brown)** **Action:** Double checking the references in the paper are correct, so the working is unambiguous and provides the correct authority. **(Jim Brown)** **Action:** The IIAG would like to see the paper and any improvements in the gap in datasets that may be available at the next meeting. **(Jim Brown)** **Action:** Details regarding understanding the different clauses in the privacy code relating to the sharing of this information will be sent to members after this meeting. **(Dr Angela Ballantyne)**
5.	**Future of the COVID-19 vaccinator role (Fiona Michel, Sonia McFetridge)**
	This item is asking the IIAG for feedback and confirmation we are moving in the right direction. If approved, a paper will be written for Ministers to make changes to the role so it can do additional tasks. • Want to make the role sustainable for the future. • Want to build the role into the next steps of the organisation. • We have data showing there is diversity in those that are doing the role, they are proving effective in their communities, and we want to make sure employers can use them as their communities need them. • Daily we have more vaccinators coming through to be authorized. • Proven to be effective in bringing Māori into the workforce. • Has the ability to provide staircase into other health roles. • Driven through providers in communities. • The role is proving useful in reaching hard to reach communities. • Opportunities for diversifying training pathway and to be provided by other providers. • Working group to be re-established for the next phase. • Opportunities for this role to be used for other vaccinations, worthwhile to have this role available for other parts of the sector. • The role may be supervised by an accredited employer who may not then employee the person. • Remuneration review completed. Will go out to providers with new suggested higher rate **IIAG Decision** **Approved** direction of the paper to future proof this role. **Action:** Return with the feedback incorporated into the paper. **(Fiona Michel)**
6	**Reaching the unbooked/unvaccinated population (Tamiti Sheppard-Wipiiti, Fiona Michel)**
	Tamiti was unable to present as he was held up in traffic. **6a) Equity data (Tamiti Sheppard-Wipiiti)** • There are conversations ongoing with the data team regarding releasing granulated data and making sure there is strong story telling around the different community-based approaches when releasing regional data. • Framing communications to reflect community successes.

	Action: Domestic use of vaccination passports on IIAG and Tātou Whaikaha next agenda. **(Caroline Greaney)** **Action:** Return to next meeting with feedback on what's working better, or how we're working differently, on strategies regarding equity between Māori and Pacific. **(Tamiti Sheppard-Wipiiti)** **6b) Strategies for Uptake (Fiona Michel)** • We're working on policy and advising Ministers regarding mandatory vaccinations and what the scope means. • Whether employees are vaccinated or not is becoming an issue for employers. • Local groups in in home support areas working collaboratively to create willingness to be vaccinated. • Would like to see how we're targeting age groups before we open to them so we can be better prepared.
7.	**Any other business and close**
	There was no further business for discussion.
8.	**Closing/Karakia whakamutunga** – Dr Tristram Illingham **The meeting closed at 1pm**

Minutes

Immunisation Implementation Advisory Group Meeting – 15 Oketopa 2021

Date:	Friday 15 October 2021
Time:	11:00am – 1:00pm
Co-Chairs:	Taima Campbell, Te Puea Winiata
Members attending	Dr Angela Ballantyne, Dr Helen Petousis-Harris, Kevin Pewhairangi, Rhonda Sherriff, Dr Tristram Ingham, Nicky Birch, Loretta Roberts
MoH Attendees:	Dr Joe Bourne, Allison Bennett, Michael Dreyer, Caroline Greaney, Matt Jones, Rachel Mackay, Fiona Michel, Charmaine Ngarimu, Adam Dalgleish, Jim Brown, Astrid Koornneef, Michael Dreyer, Rachel Mackay, Tamati Shepherd-Wipiiti, Rāwā Keratai Wood-Bodley, Aaron Culver Alexia Black Christina Nolan (presenting for Astrid Koornneef) Kirsten Curry (presenting for Rāwā Keratai Wood-Bodley) Helen Francis (Secretariat)
Apologies:	Keriana Brooking Silao Vaisola-Sefo

Item	Agenda Item
1.	**Introduction and welcome** • Taima Campbell welcomed members. • Te Paati opened the meeting with karakia. • The minutes of meeting held 1st October 2021 were confirmed. • No conflicts of interest were registered. **Update on Actions** All Actions remain the same. **Matters arising** There were no matters arising.
2.	**Tātou Whaikaha update (Dr Tristram Ingham)**
	Dr Tristram Ingham provided an update to the IIAG members of the previous Tātou Whaikaha meeting held 1st October 2021. Things to note:

	• There is no dedicated centrally conceived disability strategy. No specific messaging to date. Operationally there is a lot of variability as disability providers work across multiple DHBs. • Concern growing regarding disabled people and their whanau, who are not on Māori provider lists, getting access to the vaccine. • Super Saturday unfortunately not suitable for everyone. Would like to see dedicated day for people with disabilities so accessibility can be better managed.
3.	**Reaching the unbooked/unvaccinated population (Tamiti Shepherd-Wipiiti, Fiona Michel)**
	3a) Equity data (Tamiti Shepherd-Wipiiti) • Māori numbers are going up. Past 10 days are the highest growing ethnicity. • Clear indication in the data that where there is positive and working partnerships with providers and DHBs things are working well. Where there is not strong relationship with DHBs things are not working as well. Iwis are taking the lead in areas where the relationship is not good. • Data is public at the top level. Level two is public too. Working on the next level and what is appropriate to provide. Unprecedented to share individual data. Ministry is being deliberate about where the data goes and working directly with providers what are most well placed to reach the unvaccinated population and have a specific purpose in reaching them. • Supercharged our transport options so they are now free across the country. • Providers would like to keep the vaccinator roles going and embed them into the wider programme to create a legacy workforce. Pilot underway with pacific providers and Moana research, in conversation with Māori providers who have a few vaccinators. **3b) Strategies for uptake (Fiona Michel)** • Strategies library. Access distributed to DHBs, seeing good uptake. The programme is working with it, seeing what is working and where we might use ideas in other areas. Sharing information with DHBs and looking centrally to see gaps we need to fill. • All efforts focused on Super Saturday and Vaxathon.
4.	**Domestic vaccine certificates (Maria Cotter)**
	This item was not presented due to a scheduling conflict. Will be added to agenda for the next meeting. IIAG concerns regarding discussion of the merits of a vaccine certificate and the ethical and social impacts, not just the legal aspects. Would like to see substantive discussion, not a small group of Ministers making decisions.
5.	**Future state update (Matt Jones)**
	• Planning for next year and next steps is underway. Suggestion to IIAG to provide timing of when to engage with IIAG in appropriate conversations. • Complex landscape of change as the programme reconnects with the world. • Planning for 5–11-year old's is underway, assuming approval next year. • Catch up for childhood immunisations. Discussing how covid vaccinators might be used in school-based programme. • Planning underway for next winter covid and flu vaccinations. • Primary and NGO care will be the focus next year. Collaborative planning with same groups as this year. • Everything discussed is also a foundation for the Māori Health Advisory. Evidence based system to help Māori. There is a need to build Māori and Pacific Health Services around this. • Concerns regarding primary health care in catchup role as people haven't accessed during lockdowns and covid.

	• How are we keeping collaborative doors open from covid experience to ensure communities who have been hard to reach can be reached. Also enabling health services to keep those doors open to identify other needs and can pivot to working differently so we keep that relationship going. • Urgency of pivot into future state and the need to happen now.
6.	**Mental health and addiction services users and COVID-19 vaccination (Arran Culver, Alexia Black)**
	• Vaccination numbers in NGOs and specialist areas are the lowest numbers. Māori mental health and addiction service users more likely to be unvaccinated. • Communities know their own solutions. Ministry should support them to make their own decisions. • Innovation in Equity and Disability spaces could be used in this area also as issues are similar. • Disability and Mental health are not traditionally aligned in DHBs. • Not a mental health issue, is a vaccination issue. 20-year mortality gap with mental health and the general population. Want to highlight strong focus on mental health people accessing addiction services. • Jansseen vaccine may be an alternative for those struggling with more than one dose. • Pharmacies doing regular vaccinations as they have a relationship with this group. • Three weeks ago, no strategy, the Ministry is working ono a paper to go through to Steering Group for funding. • Mental health and Rainbow communities not in terms of reference for the programme at the beginning of the programme. Apologies from the Ministry. These groups are now included.
7.	**Third primary dose policy statement (Christine Nolan)**
	• Third dose is important to immunocompromised people. • Good communications required for those prescribing third doses. • Concern regarding prescriptions. Puts an expectation of prescriber and recipient to take own liability for recommendations. Health literacy can be a burden for people. • Working through if third dose prescribing relies on the prescriber to invite those to have it or s it up to the recipient to self-identify their need for it, or both. • Would be useful to have evidence base for medication dosages as well then come back to due diligence. **IIAG Suggestion:** Have principle-based guidance. Will need to have flexibility for prescriber to determine if needed.
8.	**Update on programme audit tools (Christine Nolan)**
	• Heavy investment programme. 16national providers. Assessment for 20 DHBs. • Providers have been assessed from the beginning of the programme. • Self-assessment approach with DHB provision of vaccine, yes or no questions, light touch to paint a picture.
9.	**Childhood immunisations update (Keelie Priest)**
	• Plan is currently with the Ministry team for review. Informative memo will come back to IIAG at the nest meeting for discussion. • Connects the workforce legacy planning. **Action:** Return to next IIAG meeting with memo regarding childhood immunisation plan that is currently with the Ministry for review. **(Kirsten Curry)**
7.	**Any other business and close**

	There was no further business for discussion.
8.	**Closing/Karakia whakamutunga** – Dr Tristram Illingham The meeting closed at 1pm

COVID-19 Vaccine Immunisation Programme

Contingency Planning

Template Guidance Note:

*A function summary sheet should be completed for each function with a goal recovery timeframe of **one week or less**.*

This summary sheet contains important information that will be used by the response team to prioritise resources and support you to maintain your function.

Scenario Information			
Name:	Community Outbreak of COVID-19	**Risk Level (0-10)**	
Description:	This may have an impact on consumers ability to attend vaccination bookings and require a redistribution of vaccination site staff and administrators to testing or tracing activities. Dependant on the location/s of the outbreak this scenario may impact at a national, regional or local level.		
Exemplar Events:	Level 3 Controls, Auckland Region, August 2020		
Activation Trigger:	This contingency plan can be activated anytime the government announces a move from Alert Level 1 to Alert Level 2, 3, o 4. This may be due, but not limited, to the following: • Limited community transmission could be occurring (Level 2) • Active cluster in more than one region (Level 2) • Multiple active clusters in multiple regions (Level 3) • Multiple cases of community transmission occurring (Level 3) • Widespread outbreak (Level 4) • Sustained and intensive community transmission is occurring (Level 4)		
Impacts:	Potential Impacts: • May require a review of all sites and site configurations by providers (e.g., DHBs) to adhere to social distancing rules and protocols specified by relevant alert level. • Potential slowdown of service delivery for sites that can operate under relevant a ert level protocols e.g., symptom screening. • Potential shutdown of sites which cannot operate under relevant alert level protocols. • Reduced patient flow due to inability to travel and lockdown requirements • Redeployment of vaccinator staff to case investigation or contact tracin work. • Impact on vaccination sites and staff and ensuring that the appropriate resources and service delivery quality is being followed e.g., vaccinator staff wearing PPE. • Increased security and requirements for staff and patient screening before COVID-19 vaccination events. • Increased cost of delivery of vaccinations (PPE, increased space etc). • May require the review the event and impacts of current programme collateral (e.g. Playbooks). • May require the review of Clinical Quality and Safety documentation and communications. • Review the Operating Guidelines based on specified alert level. • Potential workforce constraints due to inability to travel, household commitments, community transmission, personal health issues. • Potential issues in distribution and logistics sta f either nationally, regionally, or locally, to delivery vaccine and consumable stock to DHB • Potential issues in delivery channels (flight, freight, train) due to regional, or national lockdowns. • Ensure that Māori and Pacific vaccination sites and providers can continue to operate (or are prioritised) to ensure the programme remained focused *on the equity of outcomes*.		
Recovery Time Objective:	Within one week of returning to Alert Level 1 Service delivery returned to National Production Plan levels	**Maximum Tolerable Period of Disruption (MTPD):**	4 weeks based on exemplar event.
Function Owner (Business Group):	National Operations Group	**Directorate:**	COVID-19 Vaccine and Immunisation Programme
Key Contacts:	**Name:**	**Role/s:**	**Mobile**
Lead	**Astrid Koornneef**	**GM Operations**	s 9(2)(a)
Alternate/s	Loren Shand	Production and Planning Manager	

Section 1: What do we need?

Critical Resources: *(Without these resources the function cannot continue or be resumed within acceptable timeframes)*				
	Type		**< 1 day**	**< 1 week**
Programme		People	• Key personnel detailed in contacts list need to be available. • Regional Account Managers and Leads (RAM and RAL) to provide support for DHBs • Additional Communications Resources • Qualified personnel to form Incident Management Team (IMT). • Access to Ministers (E.g. Vaccine Ministers).	•
		Facilities / remote working	• Access to 133 Molesworth Street • Access to DHB facilities • Remote working for non-critical staff	• Continued ability for staff to work from home (WFH). • Access to WFH guidance on set-up for new personnel.
		Equipment *Standard = laptop, keyboard, mouse, power cable, workstation (desk, single monitor and chair)*	•	• WFH equipment (Monitors, desks etc)

COVID-19 Vaccine Immunisation Programme

Contingency Planning

		Information Technology *Standard operating environment (SOE) = Lotus Notes (email, calendar & filing), Microsoft Suite (Word, Excel, PowerPoint), remote access, printing, VOIP (telephony), MoH@WK*	• Collaborative tools (e.g. ZOOM, Microsoft Teams) • CIR access • COVID Tracking and Tracing • AEFI	•
Sector (DHB, Occ Health, HCL etc)		People		
		Facilities / remote working		
		Equipment *Standard = laptop, keyboard, mouse, power cable, workstation (desk, single monitor and chair)*		
		Information Technology *Standard operating environment (SOE) = Lotus Notes (email, calendar & filing), Microsoft Suite (Word, Excel, PowerPoint), remote access, printing, VOIP (telephony), MoH@WK*		

	Other critical resources:			
	Type	**Description** ***(Group where appropriate, e.g. IT applications)***	**Timeline**	**Supporting information**
	Facilities (e.g. Incident Management Team)	Incident Management Team suitable alternate location in 133 Molesworth Street as base to coordinate Health response activities/functions.	<4 hours	Incident Management Team SOP for activation, set-up and functions are available [insert locations]
	Equipment (e.g. whiteboard)	IMT equipment, i.e. whiteboards monitors, desk phones, boardroom/planning spaces, etc	<4 hours	See IMT SOP for set-up requirements including requirements for set-up of alternate sites

Section 2: What do we do?

What are the specific notifications, assessments, responses and communications plans that we need to complete to ensure we get to the end trigger as efficiently as possible.

Timeline	**What we need to do**		
	< 1 hour	**< 1 day**	**< 1 week**
Key activities/process required to ensure continuity of the function	**Notification:** • Ministry Op rations workgroup to inform Regional Account Managers (RAMs) and Regional Account Leads (RALs) of change in Alert levels. • Subsequent notification to providers e g., DHBs, Occupational Health. **Assessment:** • RAMs and RALs to support site assessments in affected areas to determine if site(s) can adhere to alert level protocols (e.g. social distancing). • Clinical Lead to work with Quality Manager to complete an impact assessment for the nature, extent and impact of the outbreak from a clinical quality and safety perspective • Logistics workgroup to conduct an assessment to understand the impact to distribution and logistics people, processes, and systems. • Post Event to conduct impact assessment regarding adequate medical assessment processes. For example, an outbreak in Dunedin could impact CARM operations which would disrupt all adverse event monitoring and reporting for the programme (as well as pharmacovigilance support arrangements for Pacific realm countries). • GM Clinical to communicate with and prioritise workstream requests. • GM Clinical to review and support vaccination site quality and safety plans and processes.	**Notification:** • GM Operations to stand up an Incident Management Team within the programme. • Notify NITC and Testing teams regarding outbreak and staff priorities. • Discussion with NITC and Testing Team about DHB staffing priorities. • Director to provide early advice to the Steering Group on impacts and options to maintain and/or re-establish national service delivery. **Assessment:** • Workforce workgroup to conduct national impact assessment to identify if staff are required to be redeployed to other areas e.g., testing. • Workforce and Equity workgroups to conduct impact assessment to identify priority sites and vaccination volumes that need to be resourced. • GM Clinical and GM Post Event to support the stand up IMT to conduct a detailed review of the event and provide advice, including the potential role of vaccination in the affected area/s e.g., targeted vaccination approach.	**Notification:** • Daily online meetings to support key service delivery partners e.g., DHB SROs, PHOs and equity providers. **Assessment:** • Consider the use of alternative single dose vaccines e.g., Jansen in an outbreak. Pending approval by Medsafe late June. • GM Clinical to lead assessments to identify if any DHBs are not able to provide vaccinations safely. • GM Operations to mobilise (if required) NZDF to support vaccinating non-NZDF staff in an outbreak scenario *(this plan requires finalisation with NZDF including agreed triggers and roles and responsibilities).* • GM Clinical to contribute to the wider response review and monitor the clinical risks of the community outbreak. **Response:** • GM Operations to support providers to ensure correct protocols are in place for safe delivery of vaccinations.

COVID-19 Vaccine Immunisation Programme

Contingency Planning

Timeline	What we need to do		
	< 1 hour	**< 1 day**	**< 1 week**
	Response: • Direct DHBs to activate contingency plan across vaccination, testing, and contact tracing deconfliction of workforce • Confirm affected sites specific COVID Tracer App QR Codes • Clinical to contact sites regarding the importance of maintaining current processes and having safe clinical practice. • Workforce workgroup to liaise with providers to understand resourcing constraints on any open sites. • Equity workgroup to liaise with providers to understand resourcing constraints on any open sites. Where possible and safe negotiate exemptions for Māori and Pacific Health providers sites to remain open. • Providers to implement contingency plans related to increase in alert level.	• GM Logistics to conduct detailed assessment to understand impacts on the demand, supply, storage, distribution, consumption and waste plans. • GM Logistics to conduct assessments of PPE and materials required for each provider. • Review booking system management plan for affected areas. • Review the site delivery and receipt process to ensure any changes to transportation are identified and communicated. • Conduct analysis on the daily vaccination requirements (numbers of vaccinations) for each provider. **Response:** • GM Operations to provide key messaging to providers (DHBs, Occ Health etc) on protocols for specified alert levels. • GM Ope ations to support providers with recommended service delivery model settings for specified alert levels e.g., drive through model, mass vaccination event in level 2 as focus on getting large portions of the population vaccinated in short period of time. • GM Post Event to provide clear messaging into the Communications team around the difference between COVID-19 symptoms and vaccine related adverse event symptoms. • Release community media schedules and/or timeline for communications • Engage with Iwi, Pasifika, and disability leaders to understand the impact on their communities to ensure COVID-19 vaccinations continue to reach the “at-risk” populations. • Mitigate risk of transmission from local vaccination sites by following appropriate level procedure. • GM Equity to ensure that populations receiving vaccination are equitable. • GM Operations to assess impact on external call centres e.g., DHBs and Whakarongorau.	• GM Operations to physically support setup of safe vaccination sites in locations which cannot provide vaccinations safely based on alert level requirements. • GM Logistics to enact the required changes to: Demand, supply, storage, distribution, consumption & waste plan based on the impact assessment. • GM P s Event to establish a m chanism to monitor symptoms of COVID-19 in vaccinated patients (real world effectiveness data). Establish and deploy contingency staff workforce to affected areas or locations e.g., occupational health staff, redeployed hospital staff, and/or relocated staff from other centres. • Provide support to providers in the deployment of mobile vaccination centres for priority groups. • Reprioritise vaccinations to “at-risk” and high need populations through bookings and distribution. • GM Post Event to Establish a mechanism to monitor whether people getting sick have been vaccinated (real world effectiveness data) • GM Clinical to support the monitoring of clinical risks and contribute to the review of the remedial action to manage the clinical risks.
Alternatives available			

Communications	What we need to do	
	Internal Communications Plan	**External Communications Plan**
Audience	Cabinet Health and Vaccine Ministers DG Ministry of Health Steering Group CVIP Programme Leadership Group	Localised and targeted outbreak area communication e.g., schools, TV, ads, internet, mail. New Zealand Public Health Sector

COVID-19 Vaccine Immunisation Programme

Contingency Planning

Communications	What we need to do	
	Internal Communications Plan	**External Communications Plan**
	GM Communications COVID-19 Response Team Service Delivery Providers e.g., DHBs, Occupational Health, equity providers.	
Key Message	Our key priority in this situation is managing the outbreak to protect the health of all New Zealanders - unfortunately this means we may need to divert resource and postpone some vaccinations.	Our key priority in this situation is managing the outbreak to protect the health of all New Zealanders - unfortunately this means we may need to divert resource and postpone some vaccinations. There will be regular updates of the situation. If your booking has been affected, we will reschedule it.

Section 3 – Who's involved?

Inter-dependencies	
Who relies on us to continue this function?	**Why do they rely on it?**
Service Providers (e.g., DHBs, PHOs, GPs).	• Provision of planning suppor to ematch demand and supply, particularly in affected areas. • Provision of support to ensure all vaccination sites can meet the requirements of the A ert Level changes. • Provision of alte a ive Service Delivery Model Settings in an outbreak e.g. drive through vaccinations or mass vaccination events. • Prioritisation and re-distribution of vaccines, PPE and consumables. • Prioritisation and re-distribution of workforce. • Provision of national communications messaging and support for local targeted communications.
3PL Partners s 9(2)(c) [redacted]	• Require prioritised supply plan to enable distribution to right vaccination sites.
Ministry senior leaders and programme governance (including Steering Group).	• Require timely advice and options on how to maintain service delivery in the specific context of the outbreak.
Who do we rely on to continue this function?	**Why do we rely on them?**
Service Delivery Providers	• To understand the impacts and options at an individual site level and how service delivery can be maintained in the specific context of the community outbreak. • Require forecast changes to capacity and demand at individual vaccination sites • Require updated forecast consumption and waste plans at individual vaccination sites.
Centre for Adverse Reaction Monitoring (CARM).	• Advice from CARM (via Medsafe) on medical assessment support requirements at national, regional and local levels.
ESR	• To support the analysis of vaccine effectiveness in a community outbreak (real world effectiveness data).
3PL Partners s 9(2)(c) [redacted]	• Delivery of updated distribution and storage plan based on programme re-prioritisation of supply.

COVID-19 Vaccine Immunisation Programme

Contingency Planning

MINISTRY OF HEALTH
MANATŪ HAUORA

Section 4 – What are the key end triggers?

End trigger *(What is going to trigger the end of the contingency plan?)*	
What is the trigger to end the event?	The end trigger to this plan is when New Zealand reaches Alert level 1 meaning: • There is limited / no community transmission • There are no cross-regional clusters

Section 5 – Key contacts?

Function Overview *(Who is the key internal or external person who has a key role in re-establishing this function?)*			
Key Contacts:	**Name**	**Role/s**	**Mobile**
Lead	Jo Gibbs	CVIP Programme Director	s 9(2)(a)
Alternate/s	Astrid Koornneef	GM Operations	9(2)(a)
(e.g. activity lead)	DHB SRO		
	Ian Costello	GM Logistics	s 9(2)(a)
	Mike Stewart	Manager Logistics	
	External Logistics Contacts List	https://mohgovtnz.sharepoint.com/:x:/s/CovidLogisticsOperations-KPMG/EekJiDhPPaJHudWYLuwk6SUB-rlGp23o07NLA4vbNk97fw?e=zJJvqd	
	???	CARM Manager	
	Juliet Rumball-Smith	GM Clinical Quality & Safety	s 9(2)(a)
	???	Medsafe	
	???	ESR	
		CVIP RALs & RAMs	
		Maori Health Directorate	
		Pacific Health Team	
		Disability Directorate	

Section 6 – External Plans and/or Policy Settings?

External Documentation *(What other resources are available to support)*		
Document Name	**Description**	**Location**
"Update on using the COVID-19 Comirnaty (Pfizer/BioNTech) vaccine in an outbreak"	Paper providing advice to The CVIP Steering Group dated 15 June 2021.	

Ministry of Health Emergency Management Response Contingency Planning

Template Guidance Note:

*A function summary sheet should be completed for each function with a goal recovery timeframe of **one week or less**.*

This summary sheet contains important information that will be used by the response team to prioritise resources and support you to maintain your function.

Scenario Information			
Name:	**Disruption to the supply of vaccines, PPE or consumables**	**Risk Level (0-10)**	
Description:	This may have an impact on the number of vaccinations that can occur to meet service delivery targets. This scenario may impact at a national level, e.g. no arrival in country of a vaccine shipment, or at a regional or local level e.g. loss of a distribution hub or a DHB pharmacy.		
Exemplar Events:			
Activation Trigger:	This contingency plan can be activated anytime the supply of vaccine, consumables of PPE is disrupted. This may be due, but not limited, to the following: • Supply of vaccinations and/or consumables not reaching New Zealand due to constrained supply. • Supply of vaccinations and/or consumables not reaching New Zealand due to supply chain delays. • Unforeseen event "act of god" which means vaccines or consumables are not able to be used. • Any vaccines, or consumables are deemed "unusable" e.g. needles on a large scale upon arrival in New Zealand. • Any disruption to the internal distribution network e.g. loss of a national distribution hub and/or a local distribution node e.g. DHB pharmacy.		
Impacts:	Potential Impacts: • Low or no supply of vaccines, consumables or PPE, causing reduced capacity to meet the national production plan. • Reduced capacity to deliver vaccinations impacting on the public's trust and confidence in the programme. • Vaccinator workforce using inappropriate equipment (e.g. needles) to administer vaccinations causing potential adverse reactions (e.g. hypersensitivity AEFI events) or decrease in supply (ability to draw up doses). • Underutilised vaccinator workforce which could then be redeployed to other health sector priorities. • Reduction in individual site operating hours and/or temporary closures. • Risk to safe vaccination practices (including IPC) if PPE not used in a constrained supply situation.		
Recovery Time Objective:	Within three days of returning to normal supply conditions. Service delivery returned to National Production plan levels.	**Maximum Tolerable Period of Disruption (MTPD):**	Estimate will be based on stock inventory at time of disruption.
Function Owner (Business Group):	Logistics and Inventory Group	**Directorate:**	COVID-19 Vaccine and Immunisation Programme
Key Contacts:	**Name:**	**Role/s:**	**Mobile**
Lead	**Ian Costello**	**GM Logistics and Inventory**	s 9(2)(a)
Alternate/s	Kobus Retief	Delivery Lead	

Section 1: What do we need?

Critical Resources: ***(Without these resources the function cannot continue or be resumed within acceptable timeframes)***				
	Type		**< 1 day**	**< 1 week**
Programme		People	• Key personnel detailed in contacts list need to be available including external logistics staff.. • Regional Account Managers and Leads (RAM and RAL) to provide support for DHBs • Qualified personnel to form Incident Management Team (IMT). • Access to vaccine and Health Ministers	
		Facilities / remote working	• Access to 133 Molesworth Street • Remote working for non-critical staff	• Continued ability for staff to work from home (WFH). • Access to WFH guidance on set-up for new personnel.
		Equipment *Standard = laptop, keyboard, mouse, power cable, workstation (desk, single monitor and chair)*		• WFH equipment (Monitors, desks etc)
		Information Technology *Standard operating environment (SOE) = Lotus Notes (email, calendar & filing), Microsoft Suite (Word, Excel, PowerPoint), remote access, printing, VOIP (telephony), MoH@WK*	• Collaborative tools (e.g. ZOOM, Microsoft Teams) • Remote access to Logistics database and services	
Sector (DHB, Occ Health, HCL etc)		People		
		Facilities / remote working		

Ministry of Health Emergency Management Response Contingency Planning

		Equipment *Standard = laptop, keyboard, mouse, power cable, workstation (desk, single monitor and chair)*		
		Information Technology *Standard operating environment (SOE) = Lotus Notes (email, calendar & filing), Microsoft Suite (Word, Excel, PowerPoint), remote access, printing, VOIP (telephony), MoH@WK*		
	Other critical resources:			
	Type	**Description *(Group where appropriate, e.g. IT applications)***	**Timeline**	**Supporting information**
	Facilities (e.g. Incident Management Team)	Incident Management Team suitable alternate location in 133 Molesworth Street as base to coordinate Health response activities/functions.	<4 hours	Incident Management Team SOP for activation, set-up and functions are available [insert locations]
	Equipment (e.g. whiteboard)	IMT equipment, i.e. whiteboards, monitors, desk phones, boardroom/planning spaces, etc	<4 hours	See IMT SOP for set-up requirements including requirements for set-up of alternate sites

Section 2: What do we do?

What are the specific notifications, assessments, responses and communications plans that we need to complete to ensure w get to the end trigger as efficiently as possible.

Timeline	**What we need to do**		
	< 1 hour	**< 1 day**	**< 1 week**
Key activities/process required to ensure continuity of the function	**Notifications:** • GM Logistics to communicate with key stakeholders e.g. s 9(2)(c) [redacted] • GM Clinical to communicate with vaccination sites regarding the importance of maintaining current best practice and clinical saf ty practices in a constrained supply environment. **Assessments:** • Undertake assessment of the use of other vaccin s or consumables in the event of a constrained supply of the Pfizer vaccine. • GM Logistics to commence an impact assessment to understand the implications of the supply disruption (current stocktake and future resupply). • GM Post Event to undertake AEFI assessments to identify if clinical safety procedures continue to be followed in a constrained supply environment. **Responses:** • GM Operations to commence the development of a short-term management plan to enable prioritised service delivery to continue. • GM Operations to stand up an Incident Management Team	**Notifications:** • Director to notify key stakeholders of situation and early assessment of impacts. • Programme (via RAMs/RALs) to inform DHBs and providers of possible delays to supply and therefore future bookings • within the programme. • GM Post Event to notify IMAC of AEFI assessment and impact (e.g. if adrenaline) • GM Logistics to continue communication with 3PL to determine the extent of supply constraints. • Director to provide early advice to the Steering Group on impacts and options to maintain and/or re-establish national service delivery. **Assessments:** • GM Equity to provide advice on how service delivery to equity populations can be maintained in a constrained supply environment. • GM Operations to conduct an assessment to review the event and provide advice. This should include the clinical implications of the event. • GM Logistics to conduct detailed assessment to understand implications on demand, supply, storage, distribution, consumption & waste plans. This should include expected daily volumes of consumers. • GM Post Event to conduct an ongoing assessment of AEFI with IMAC **Responses:** • GM Operations to provide planning support to affected service providers.	**Notification:** • Communications to the general public and key stakeholders regarding the proposed delays. • GM Post Event and GM Clinical to ensure that communications from IMAC re appropriate use of consumables to be disseminated to service providers. **Assessments:** • GM Clinical to support event review. Monitor any emerging clinical risks and develop any remedial actions including change to process or procedure. • Regional Account Managers and Leads (RAM and RAL) to monitor site safety feedback from DHBs. • GM Operations to assess vaccination booking events and ensure supply meets prioritised demand. **Responses:** • GM Logistics provide amended demand, supply, storage, distribution, consumption and waste plans. • Communicate alternative consumables and/or vaccines to service providers. • Complete plan for alternative vaccination delivery setting models (if appropriate). • Redistribution of vaccines, consumable and PPE to at risk, equity or second dose populations.

Ministry of Health Emergency Management Response Contingency Planning

Timeline	What we need to do		
	< 1 hour	**< 1 day**	**< 1 week**
		• Provide clinical advice regarding supply and alternatives to providers • GM Workforce to provide advice to service providers on implications for vaccination staff e.g., underutilised workforce. NOTE: responsibility for workforce rests with employer. • Prioritisation of supply to meet the sequencing framework e.g. equity providers.	
Alternatives available			

Communications	What we need to do	
	Internal Communications Plan	**External Communications Plan**
Audience	Cabinet Health and Vaccine Ministers DG Ministry of Health Steering Group CVIP Programme Leadership Group GM Communications COVID-19 Response Team Service Delivery Providers e.g., DHBs, Occupational Health, equity providers.	Localised and targeted outbreak area communication e.g., schools, TV, ads, internet mail New Zea and Public Health S ctor
Key Message	For PPE or consumables: We are working with [supplier] to look at ways we can sour e additional/different [PPE/consumable]. As soon as we have a better understanding of what is possible, we will let you know. For vaccines: Our key priority is ensuring we use our limited supply for the most at-risk people - unfortunately this means we may need to postpone some vaccinations until we receive additional supplies. There will be regular updates of the situation. Sig al alternative vaccines usage??????	For PPE or consumables: We are working with [supplier] to look at ways we can source additional/different [PPE/consumable]. As soon as we have a better understanding of what is possible, we will let you know. For vaccines: Our key priority is ensuring we use our limited supply for the most at-risk people - unfortunately this means we may need to postpone some vaccinations until we receive additional supplies. There will be regular updates of the situation. If your booking has been affected, we will reschedule it.

Ministry of Health Emergency Management Response Contingency Planning

Section 3 – Who's involved?

Inter-dependencies	
Who relies on us to continue this function?	**Why do they rely on it?**
Service Providers (e.g., DHBs, PHOs, GPs).	• Provision of planning support to rematch demand and supply, particularly in affected areas. • Provision of alternative Service Delivery Model Settings (if applicable) e.g. drive through vaccinations or mass vaccination events. • Prioritisation and re-distribution of vaccines, PPE and consumables. • Advice and access to alternative supplies and/or suppliers e.g., Jansen vaccine. • Advice on re-distribution of workforce. • Provision of national communications messaging and supp rt for local targeted communications.
3PL Partners (HCL, DHL and NZ Post Pace)	• Require prioritised supply plan to enable distribu ion to right vaccination sites. • Require notification of any approved alternative suppliers of vaccines, consumables and PPE.
Ministry senior leaders and programme governance (including Steering Group).	• Require timely advice and options on how to maintain service delivery in the specific context of the outbreak
Who do we rely on to continue this function?	**Why do we rely on them?**
Service Delivery Providers	• To understand the impac s and options at an individual site level and how service delivery can be maintained in the specific context of constrained supply. • Require forecast changes to capacity and demand at individual vaccination sites • Require updated forecast consumption and waste plans at individual vaccination sites.
3PL	• To deliver to the reprioritised supply and distribution plan.
CARM / MedSafe	• Provide ongoing support in the assessment of adverse event reporting.
Immunisation Advisory Committee (IMAC)	• Advice on the appropriate use of consumables and PPE in a constrained supply environment. • Advice and support on the use of alternative vaccines.

Section 4 – What are the key end triggers?

End trigger ***(What is going to trigger the end of the contingency plan?)***	
What is the trigger to end the event?	• Notification by suppliers or third-party logistics (3PL) provider of the resumption of the initial contracted supply of vaccines, consumables, and PPE. • Notification by providers that the distribution and/or storage issue has been resolved e.g. reestablishment of a national distribution hub. • Enough alternative supplies e.g., Jansen vaccine have been distributed to meet the demand required to meet the national production plan.

Section 5 – Key contacts?

Function Overview ***(Who is the key internal or external person who has a key role in re-establishing this function?)***			
Key Contacts:	**Name**	**Role/s**	**Mobile**
Lead	Jo Gibbs	CVIP Programme Director	
Alternate/s	Ian Costello	GM Logistics	s 9(2)(a)
(e.g. activity lead)	Mike Stewart	Manager Logistics	s 9(2)(a)
	Key external contacts for consumables are listed here: https://mohgovtnz.sharepoint.com/:x:/s/CovidLogisticsOperations-KPMG/EekJiDhPPaJHudWYLuwk6SUB-rlGp23o07NLA4vbNk97fw?e=zJJvqd		
	Juliet Rumball Smith.	GM, Clinical Quality & Safety	
		Director, IMAC	
	Rachel Haggerty	Chair DHB SRO	
	Fiona Michel	GM Workforce	
		RAMs & RALs	
	Astrid Koornneef	GM Operations	s 9(2)(a)

Ministry of Health Emergency Management Response Contingency Planning

Section 6 – External Plans and/or Policy Settings?

External Documentation *(What other resources are available to support)*		
Document Name	**Description**	**Location**

Ministry of Health Emergency Management Response Contingency Planning

Template Guidance Note:

*A function summary sheet should be completed for each function with a goal recovery timeframe of **one week or less**.*

This summary sheet contains important information that will be used by the response team to prioritise resources and support you to maintain your function.

Scenario Information			
Name:	**Disruption to the availability of vaccinator or administrator workforce**	**Risk Level (0-10)**	5
Description:	This may have an impact on the number of vaccinations that can occur to meet service delivery targets. The scenario may impact at a national level, e.g. strike, or at a regional or local level, e.g. Civil Defence Emergency.		
Exemplar Events:	National Nurses Strike, Wednesday 9th June 2021		
Activation Trigger:	This contingency plan can be activated anytime a disruption occurs to the vaccinator workforce. This may be due, but not limited to the following: • Reprioritisation of workforce to other national or local health priorities e.g., community outbreak (refer community outbreak contingency plan). • Reduced availability of vaccinator workforce due to national employment relations dispute e.g., strike. • Reduced availability of vaccinator workforce at a regional or local level, e.g. adverse weather events (Ashburton floods). • Temporary closure of vaccination sites due to unavailability of key workforce personnel e.g., clinical leadership. • Workforce forecasting indicates insufficient workforce to open planned vaccination sites safely in a specific geographical location required to meet the relevant DHB production plan.		
Impacts:	Potential Impacts: • Fewer vaccinations administered by service providers. • Increased waiting times and/or rescheduling of consumers vaccination events. • Less vaccinators may lead to unsafe supervision ratios and missed steps around the vaccination process e.g., Infection Prevention Controls, post-observation or incomplete data entry. • Reduced staff numbers could create an unsafe vaccination environment (e.g risk to vaccinator or consumer safety). • Potential increase in vaccinator fatigue if hours are increased to meet booking demand. • Temporary or permanent vaccination site closures due to lack of staff. • Increased ratio of inexperienced vaccinators at worksites if surge staff are required to address short term capacity gaps. This could lead to under or over (cautious approach) reporting of adverse events, or the need for inexperienced staff to undertake higher risk vaccinations. • Potential risk to equitable outcome for New Zealanders if a reduced vaccinator workforce is unable to travel and meet the needs of the high-risk populations.		
Recovery Time Objective:	Within one week. Service delivery returned to National Production Plan levels.	**Maximum Tolerable Period of Disruption (MTPD):**	Estimate will be based on specific circumstances of the disruption.
Function Owner (Business Group):	Sector Engagement, Workforce and Welfare Group	**Directorate:**	COVID-19 Vaccine and Immunisation Programme
Key Contacts:	**Name**	**Role/s**	**Mobile**
Lead	**Fiona Michel**	**Director**	s 9(2)(a)
Alternate/s	Sonia McFetridge	Delivery Lead	+64

Section 1: What do we need?

Critical Resources: *(Without these resources the function cannot continue or be resumed within acceptable timeframes)*				
	Type		**< 1 day**	**< 1 week**
Programme		People	• Key personnel detailed in contacts list need to be available. • Regional Account Managers and Leads (RAM and RAL) to provide support for DHBs • Qualified personnel to form Incident Management Team (IMT). • Access to Ministers (E.g. Vaccine Ministers).	• s 9(2)(c) [redacted]
		Facilities / remote working	• Access to 133 Molesworth Street • Access to DHB facilities • Remote working for non-critical staff	• Continued ability for staff to work from home (WFH). • Access to WFH guidance on set-up for new personnel.
		Equipment *Standard = laptop, keyboard, mouse, power cable, workstation (desk, single monitor and chair)*	•	• WFH equipment (Monitors, desks etc)
		Information Technology *Standard operating environment (SOE) = Lotus Notes (email, calendar & filing), Microsoft Suite (Word, Excel, PowerPoint), remote access, printing, VOIP (telephony), MoH@WK*	• Collaborative tools (e.g. ZOOM, Microsoft Teams). • Hands-up (surge) database	•
		People		

Ministry of Health Emergency Management Response Contingency Planning

Sector (DHB, Occ Health, HCL etc)		Facilities / remote working		
		Equipment *Standard = laptop, keyboard, mouse, power cable, workstation (desk, single monitor and chair)*		
		Information Technology *Standard operating environment (SOE) = Lotus Notes (email, calendar & filing), Microsoft Suite (Word, Excel, PowerPoint), remote access, printing, VOIP (telephony), MoH@WK*		

	Other critical resources:			
	Type	**Description** ***(Group where appropriate, e.g. IT applications)***	**Timeline**	**Supporting information**
	Facilities (e.g. Incident Management Team)	Incident Management Team suitable alternate location in 133 Molesworth Street as base to coordinate Health response activities/functions.	<4 hours	Incident Management Team SOP for activation, set-up and functions are available [insert locations]
	Equipment (e.g. whiteboard)	IMT equipment, i.e. whiteboards, monitors, desk phones, boardroom/planning spaces, etc	<4 hours	See IMT SOP for set-up requirements including requirements for set-up of alternate sites

Section 2: What do we do?

What are the specific notifications, assessments, responses and communications plans that we need to complete to ensure we get to the end trigger as efficiently as possible.

Timeline	**What we need to do**		
	< 1 hour	**< 1 day**	**< 1 week**
Key activities/process required to ensure continuity of the function	**Notifications:** • GM Clinical to communicate with sites regarding the importance of maintaining current best practice and clinical safety practices. • Director Workforce to communicate with service providers to understand the drivers and impact of educed staff numbers. **Assessments:** • Director Workforce to conduct an impact assessment of reduced staff numbers at a national and site-specific level. • GM Workforce assess the SURGE workforce capacity in affected lo ations. • GM Logistics to communicate with key (3PL) stakeholders and conduct an initial impact assessment on supply and demand of vaccines (if applicable) of reduced staff numbers. **Responses:** • Support and provide advice to DHBs in activating surge or contingency workforces.	**Notifications:** • GM Operations to stand up an Incident Management Team within the programme. • Director to provide early advice to the Steering Group on impacts and options to maintain and/or re-establish national service delivery. • GM Operations to develop with providers a management plan to minimise disruption to consumers, including the management of current bookings and taking on new bookings • GM Equity to connect with Māori and Pacific Health providers and DHBs to access the Surge Database **Assessments:** • GM Operations to conduct an initial event review, including clinical implications, and provide early advice to Director. • GM Logistics to conduct detailed assessment to understand impacts on demand, supply, storage, distribution, consumption and waste plans. • GM Post Event to conduct an early and ongoing assessment of AEFI with IMAC for each affected vaccination site. • Director Workforce to conduct an assessment to identify if vaccinator workforce can be relocated to affected sites • Review of forecast of daily volumes of consumers at affected worksites. • GM Equity to ensure all available workforce is active (e.g. IMAC, Hands up / SURGE) • GM Equity to review the impact on Iwi and Pacifica providers.	**Notifications:** • Notify IMAC of AEFI assessments at affected site level. **Assessments:** • Conduct review of the clinical quality and safety of proposed procedures • Monitor clinical risks. • GM Equity to assess impacts on equity populations of reduced service delivery capacity. • Director Workforce to assess the feasibility of consolidating the workforce within the regions affected, or movement of resources between regions • Director Workforce to assess the drivers for reduced workforce availability e.g., vaccinator incentives, working conditions etc. • GM Operations to ensure that reduced vaccination booking events in affected sites aligns to supply to limit wastage. **Responses:** • GM Equity to ensure that the vaccinations are going to priority populations. • GM Clinical to monitor compliance with quality and safety standards at affected worksites. • Director Workforce to consider options for incentivising vaccinator participation at affected sites. • GM Logistics to enact the required changes to demand, supply, storage, distribution, consumption and waste plans.

Ministry of Health Emergency Management Response Contingency Planning

Timeline	What we need to do		
	< 1 hour	**< 1 day**	**< 1 week**
		Responses: • Operationalise all available workforce in the region e.g. SURGE, Hand Up, and IMAC database. • Director Workforce to quantify training capacity available to support the activation of identified yet untrained workforce.	• GM Post Event to fast-track medical assessments at affected sites to ensure these AEFI events are linked to workforce and not the vaccine batch/sub batch • GM Post Event to monitor sites with reduced or surged workforce and the daily management and trends of adverse event reporting. • GM Post Event to re-distribute IMAC practitioners to support vaccinators at af ected sites where increased AEFI reporting events are seen. • Director Workforce to support rapid onboarding of additional vaccinators (if necessary).
Alternatives available			

Communications	What we need to do	
	Internal Communications Plan	**External Communications Plan**
Audience	Cabinet Health and Vaccine Ministers DG Ministry of Health Steering Group CVIP Programme Leadership Group GM Communications COVID-19 Response Team Service Delivery Providers e g., DHBs, Occupational Health, equity providers	Localised and targeted outbreak area communication e.g., schools, TV, ads, internet, mail. New Zealand Public Health Sector
Key Message	The Ministry is aware that many COVID-19 vaccination centres around New Zealand will be temporarily closed today (9 June) because of the industrial action DHBs have been contacting affected people to rebook their vaccinations for another day If someone is booked to have their vaccination today and hasn't heard from their DHB to change their appointment time, they should attend their vaccination as planned We will still be ahead of plan by the end of this week, even with the industrial action taking place.	The Ministry is aware that many COVID-19 vaccination centres around New Zealand will be temporarily closed today (9 June) because of the industrial action DHBs have been contacting affected people to rebook their vaccinations for another day If someone is booked to have their vaccination today and hasn't heard from their DHB to change their appointment time, they should attend their vaccination as planned We will still be ahead of plan by the end of this week, even with the industrial action taking place.

Ministry of Health Emergency Management Response Contingency Planning

Section 3 – Who's involved?

Inter-dependencies	
Who relies on us to continue this function?	**Why do they rely on it?**
Service Providers (e.g., DHBs, PHOs, GPs).	• Provision of planning support to rematch demand and supply, particularly in affected areas. • Provision of clinical advice and support to ensure safe vaccination at sites with a reduced workforce. • Support to identify and operationalise all available workforce in the affected area e.g. SURGE, Hand Up, and IMAC database. • Support to rapidly onboard new vaccinators (if necessary). • Support to prioritisation and re-distribute the available workforce. • Ensure availability of vaccinator training. • Provision of national communications messaging and support for local targeted communications.
3PL Partners (HCL, DHL and NZ Post Pace)	• Require amended distribution and storage plan to enable distribution as a result of reduced demand at affected sites.
IMAC	• Require forecasting of training needs o maintain national workforce capacity.
Ministry senior leaders and programme governance (including Steering Group).	• Require timely advice and options on how to maintain service delivery in the specific context of the outbreak.
Who do we rely on to continue this function?	**Why do we rely on them?**
IMAC	• To provide enough national training to meet the requirements for vaccinator workforce.
Service Providers (e.g., DHBs, PHOs, GPs).	• To understand the impacts and options at an individual site level and how service delivery can be maintained in the specific context of the community outbreak. • Require forecast changes to capacity and demand at individual vaccination sites • Require updated forecast consumption and waste plans at individual vaccination sites.
3PL Partners (HCL, DHL and NZ Post Pace)	Delivery of updated distribution and storage plan based on affected areas amended supply and demand plans.

Section 4 – What are the key end triggers?

End trigger *(What is going to trigger the end of the contingency plan?)*	
What is the trigger to end the event?	The end trigg r to this plan is when: • There are enough vaccinators to support the immediate safe delivery of vaccinations in line with all DHB Production Plans. • There are enough vaccinators to meet short term (one month) forecasted national need. • Vaccination service delivery returns to the levels detailed in the National Production Plan.

Section 5 – Key contacts?

Function Overview *(Who is the key internal or external person who has a key role in re-establishing this function?)*			
Key Contacts:	**Name**	**Role/s**	**Mobile**
Lead	Jo Gibbs	CVIP Programme Director	+s 9(2)(a)
Alternate/s	Fiona Michel	GM Workforce	s 9(2)(a)
e g. activity lead)	Ian Costello	GM Logistics	s 9(2)(a)
		CARM	
		IMAC	
		DHB SROs	
		RALs & RAMs	
	Astrid Koornneef	GM Operations	s 9(2)(a)

Section 6 – External Plans and/or Policy Settings?

External Documentation *(What other resources are available to support)*		
Document Name	**Description**	**Location**
DHB Workforce Plans	Individual DHB Workforce Plans (specify optimum workforce numbers per site per vaccination numbers).	
DHB Production Plans	Individual DHB Production Plans	

Ministry of Health Emergency Management Response Contingency Planning

Template Guidance Note:

*A function summary sheet should be completed for each function with a goal recovery timeframe of **one week or less**.*

This summary sheet contains important information that will be used by the response team to prioritise resources and support you to maintain your function.

Scenario Information			
Name:	**Unavailability of IT systems**	**Risk Level (0-10)**	5
Description:	This may have an impact on the number of bookings, e.g. National Booking System, that can be made or data that can be recorded, e.g. CIR. This scenario is likely to impact at a national level.		
Exemplar Events:	Salesforce Outage (4 hours).		
Activation Trigger:	This contingency plan can be activated anytime critical IT applications are unavailable for a sustained period (>1 day) due to outage. This may be due, but not limited, to the following: Technical Outages • ISP (personal internet) failure. • DHB Internet unavailable. • Failed code release that impacts specific functions within applications. • Platform monitoring services identify technical failures. • Cloud service providers are down affecting the Salesforce platform e.g., CIR and National Booking System (unlikely to meet the >1-day threshold). Criminal Actor (refer to contingency plan for significant privacy and security breach) • Biz disruption – systems offline e.g., ransomware or Denial of Service (DOS) attack • Unauthorised access to system or personal data.		
Impacts:	Potential Impacts: • Loss of trust and confidence in the vaccination programme. • Outages of online recording services (e.g. CIR), will require the manual collection of personal information, increasing the time of each vaccination event and reducing overall throughput. • Outages of booking systems (e.g. NBS) will reduce the ability of consumers to book a vaccination appointment, reducing the throughput at vaccination sites. • Manual reporting of adverse events has the potential to result in underreporting and delays in the analysis of this data. • Potential to impact the provision of clinical advice on quality and safety processes. • At affected vaccinations sites patient clinical information including flags on adverse events will not be available. • Potential for delay in logistics information being received for supply and demand tracking, causing delays in distribution or oversupply leading to wastage. • Potential to cause impact on the management of bookings including the reconciliation between invitations, bookings and identity of consumer (e.g. NIBS, CPIR, Match+ CIR). • Potential to require an increase in administration staff and a reduction in vaccinator staff due to increase in manual inputs and time taken to conduct a vaccination event. • Risks to storing personally identifiable information internally without the correct authorities and/or security (e.g. excel workbooks). • Delay in receiving data from vaccination sites e.g., throughput, adverse event reporting etc.		
Recovery Time Objective:	One day for technical outages	**Maximum Tolerable Period of Disruption (MTPD):**	
Function Owner (Business Group):	Data and Digital Group	**Directorate:**	COVID-19 Vaccine and Immunisation Programme
Key Contacts:	**Name**	**Role/s**	**Mobile**
Lead	**Michael Dreyer**	**GM: Data and Digital**	s 9(2)(a)
Alternate/s	Jeff Brandt	Technical Director	+64

Section 1: What do we need?

Critical Resources: *(Without these resources the function cannot continue or be resumed within acceptable timeframes)*				
	Type		**< 1 day**	**< 1 week**
Programme		People	• Key personnel detailed in contacts list need to be available. • Regional Account Managers and Leads (RAM and RAL) to provide support for DHBs. • Qualified personnel to form Incident Management Team (IMT). • Access to Ministers (E.g. Vaccine Ministers).	•
		Facilities / remote working	• Access to 133 Molesworth Street • Access to DHB facilities • Remote working for non-critical staff	• Continued ability for staff to work from home (WFH). • Access to WFH guidance on set-up for new personnel.
		Equipment *Standard = laptop, keyboard, mouse, power cable, workstation (desk, single monitor and chair)*	•	•

Ministry of Health Emergency Management Response Contingency Planning

		Information Technology *Standard operating environment (SOE) = Lotus Notes (email, calendar & filing), Microsoft Suite (Word, Excel, PowerPoint), remote access, printing, VOIP (telephony), MoH@WK*	• Collaborative tools (e.g. ZOOM, Microsoft Teams) • SOE for logistics in the event of CIR/NIBS outage	•
Sector (DHB, Occ Health, HCL etc)		People		
		Facilities / remote working		
		Equipment *Standard = laptop, keyboard, mouse, power cable, workstation (desk, single monitor and chair)*		
		Information Technology *Standard operating environment (SOE) = Lotus Notes (email, calendar & filing), Microsoft Suite (Word, Excel, PowerPoint), remote access, printing, VOIP (telephony), MoH@WK*		

	Other critical resources:			
	Type	**Description** ***(Group where appropriate, e.g. IT applications)***	**Timeline**	**Supporting information**
	Facilities (e.g. Incident Management Team)	Incident Management Team suitable alternate location in 133 Molesworth Street as base to coordinate Health response activities/functions.	<4 hours	Incident Management Team SOP for activation, set-up and functions are available [insert locations]
	Equipment (e.g. whiteboard)	IMT equipment, i.e. whiteboards, monitors, desk phones, boardroom/planning spac s, etc	<4 hours	See IMT SOP for set-up requirements including requirements for set-up of alternate sites
	Facilities (e.g. IT Major Incident Management Team)	IT Major Incident Management Team suitable alternate location in 133 Molesworth Street as base to coordinate Health response activities/functions.	<4 hours	IT Major Incident Management Team SOP for activation, set-up and functions are available [insert locations]

Section 2: What do we do?

What are the specific notifications, assessments, responses and communications plans that we need to complete to ensure we get to the end trigger as efficiently as possible.

Timeline	**What we need to do**		
	< 1 hour	**< 1 day**	**< 1 week**
Key activities/process required to ensure continuity of the function	**Notifications:** • Notify s rvice delivery providers to move to paper-based reporting. • Notify stakeholder communications detailing the impact to services and users. • Notify DHBs to activate their BCP for IT outages. **Assessments:** • Conduct assessment to understand the extent of the system outage. • Logistics to communicate with key (3PL) stakeholders and understand the impact of the event • Capture "Support Service Desk" issue from 1st level support process • Conduct a grey area diagnostic and raise the issue to level 2 (Ministry or external platform vendor) resolution if required. **Responses:** • Front line services (level 1) attempt to fix the system outage issue • GM Data and Digital to initiate the Ministry's Major Incident Management (MIM) Processes including the standing up of a Major Incident Management Team (if necessary) • Director to ensure that the activities of the IT MIMT are coordinated and aligned to the operational responses to the service delivery impacts.	**Notifications:** • GM Operations to develop process to contact all consumers with an affected booking (if applicable). • Communicate outage with public through communications **Assessments:** • GM Operations to conduct an initial impact assessment of the service delivery implications of the incident. • GM Logistics to conduct an initial assessment to understand the inventory and distribution implications. • GM Clinical to review options for restoration of provider services for clinical and quality needs (if applicable). **Responses:** • GM Operations to stand up a programme Incident Management Team to manage the service delivery impacts of the issue. • GM Operations to develop management plan in line with the operational, logistical and clinical assessment s conducted. • IT Major Incident Management process continues to drive resolution activities (and potentially escalate platform suppliers for assistance).	**Notifications:** • Status notifications to all affected participants of progress in resolving issue. **Assessments:** • GM Data and Digital to conduct a major incident management report (once services restored). • The primary outcome of the report is to identify and address the underlying root cause of the service failure. • GM Operations to review the plans to enter manual information into CIR/databases once IT systems are back online. **Responses:** • IT MIM process continues; once the process finds a fix the fix will be implemented, and all parties involved will be notified regarding the resolution. • GM Clinical to provide clinical quality and safety advice and support to providers. • GM Clinical to contribute to the development of communications messaging to the public and service delivery providers.

Ministry of Health Emergency Management Response Contingency Planning

Timeline	What we need to do		
	< 1 hour	**< 1 day**	**< 1 week**
		• GM Data and Digital to divert technology (knowledge) sources to support resolution to system outage • GM Operations to support providers to transition to manual/hard-copy consumer information based on assessments and management plan. • GM Operations to ensure the secure storage of personal information is considered in all service delivery providers management pans. • Review of expected daily volumes of vaccine recipients • GM Workforce to consider options (including training) to complete post outage data entry. • GM Clinical to review any workaround options to restore provider service deliv ry. From a clinical and safety perspective. • GM Post Event o liaise with Clinical Leads at vaccinator sites to uncover if there have been any serious AEFI events and fast fast-track sending/faxing/emailing of paper documents for medical assessment as required.	• GM Logistics to enact the required changes indicated by the initial assessment to demand, supply, storage, distribution, consumption and waste plan • Post Event to work closely with Digital and Clinical to ensure all high-level AEFI events are being tracked manually and are provided to the appropr ate sources in a timely fashion. • GM Operation to support with ongoing management of manual bookings and ecording of patient information. • GM Operations to ensure sites can manage walk-ins in lieu of bookings (consider site access and traffic management) • GM Operations to ensure the management of confidential information at vaccination sites is appropriate.
Alternatives available			

Communications	What we need to do	
	Internal Communications Plan	**External Communications Plan**
Audience	Cabinet Health and Vaccine Ministers DG Ministry of Health St ering Group CVIP Programme Leadership Group GM Communications COVID-19 Response Team Service Delivery Providers e.g., DHBs, Occupational Health, equity providers.	Localised and targeted outbreak area communication e.g., schools, TV, ads, internet, mail. New Zealand Public Health Sector
Key Message	Key Message We are aware there is an issue with Book my Vaccine, and it is impacting on people's ability to make bookings. We are working with working our IT providers to get a better understanding of the situation and how long it will take to fix. The data in Book my Vaccine is safe and secure, and there have been no data breaches. Our key priority is getting this situation fixed to that people can continue to make vaccine appointments. There will be regular updates of the situation.	Key Message We are aware there is an issue with Book my Vaccine, and it is impacting on people's ability to make bookings. We are working with working our IT providers to get a better understanding of the situation and how long it will take to fix. The data in Book my Vaccine is safe and secure, and there have been no data breeches. Our key priority is getting this situation fixed to that people can continue to make vaccine appointments. There will be regular updates of the situation.

Ministry of Health Emergency Management Response Contingency Planning

MINISTRY OF HEALTH
MANATŪ HAUORA

Section 3 – Who's involved?

Inter-dependencies	
Who relies on us to continue this function?	**Why do they rely on it?**
Service Providers (e.g., DHBs, PHOs, GPs).	• Restoration of critical IT applications that support vaccinations at scale e.g. National Booking System. • Support to clinical leads on how to maintain safe vaccination practices including adverse event reporting in the context of IT system outages. • Provision of planning support to rematch demand and supply, if impacted by reduced throughput. • Provision of support to ensure all vaccination sites can meet the additional administrative requirements of paper-based system. • Amended distribution of vaccines, PPE and consumables where applicable). • Provision of national communications messaging and support for local targeted communications.
3PL Partners s 9(2)(c) [redacted]	• Require any amended supply plan to enable distribution of the right volumes to right vaccination sites.
Ministry senior leaders and programme governance (including Steering Group).	• Require timely advice and options on how to maintain service delivery in the specific context of the outbreak.
Who do we rely on to continue this function?	**Why do we rely on them?**
IT Vendors (e.g. SalesForce)	• In the event of an outage the supplier may be required to help support in getting the service back up and running. • Appropriate level of vendor support contracts with hours of services aligned to the induvial service components. • Integration between service suppliers service desk systems with ability to receiv event and manage event through to resolution.
IMAC	• Timely review of adverse events in a paper-based reporting system.
3PL Partners (HCL, DHL and NZ Post Pace)	• Delivery of updated distribution and storage plan based on amended demand plan.

Section 4 – What are the key end triggers?

End trigger *(What is going to trigger the end of the contingency plan?)*	
What is the trigger to end the event?	• Complete service restoration and post incident review completed, improvements recommended and actioned with the root cause addressed through implementation of the fix. • Vaccination service delivery is back to the required levels within the National Production Plan.

Section 5 – Key contacts?

Function Overview *(Who is the key internal or external person who has a key role in re-establishing this function?)*			
Key Contacts:	**Name**	**Role/s**	**Mobile**
Lead	Jo Gibbs	CVIP Programme Director	s 9(2)(a) [redacted]
Alternate/s	Astrid Koornneef	GM Operations	s 9(2)(a) [redacted]
	Michael Dreyer	GM Data and Digital	s 9(2)(a) [redacted]
(e.g. activity lead)		CARM	
	IT Vendor Support Services		
		DHB SROs	
		GM Workforce	
		RALs & RAMs	
		GM Operations	
	Shayne Hunter	DDG Data and Digital	
	Service Desk Leadership		
	Business Product Owners		
	IMAC		

Ministry of Health Emergency Management Response Contingency Planning

Section 6 – External Plans and/or Policy Settings?

External Documentation *(What other resources are available to support)*		
Document Name	**Description**	**Location**
Ministry IT Major Incident Management Processes		

Ministry of Health Emergency Management Response Contingency Planning

Template Guidance Note:

*A function summary sheet should be completed for each function with a goal recovery timeframe of **one week or less**.*

This summary sheet contains important information that will be used by the response team to prioritise resources and support you to maintain your function.

Scenario Information			
Name:	Clinical Safety Issue	**Risk Level (0-10)**	5
Description:	This may cause service delivery to be paused and a loss of trust and confidence in the immunisation programme, e.g. recalled vaccine batch, increasing number of adverse events, a serious clinical incident or an Independent Safety Monitoring Board stop.		
Exemplar Events:			
Activation Trigger:	This contingency plan can be activated anytime there is an increase in clinical safety and quality risk, or a vaccines approval is suspended. This may be due, but not limited, to the following: • Instance of serious clinical incident e.g. sudden death • Significant number of post event adverse reactions. This could be at a national, regional level or local level. • Significant clinical issues relating to the vaccine being observed overseas. • Safety or quality issues with the vaccine supply e.g., vaccine batch recall. • Independent Safety and Monitoring Board decision to pause or stop based on ongoing review of adverse events.		
Impacts:	Potential Impacts: • Reduction or stoppage in the supply of vaccines to vaccination sites. • Clinical investigation and review of incident/s. • Review of the clinical safety protocols for vaccination service delivery. • Reluctance by consumers to be vaccinated with the specific vaccine under clinical eview. • Temporary closure of vaccinations sites. • Temporary or permanent loss of vaccinator workforce through re-deployment to o her health priorities. • Loss of confidence in vaccinator workforce in the safety and efficacy of the vaccine and their involvement in the programme. • Loss of confidence in the programme, and in the vaccination by the pub ic including those consumers already vaccinated.		
Recovery Time Objective:	Within one week of clinical investigation commencing.	**Maximum Tolerable Period of Disruption (MTPD):**	
Function Owner (Business Group):	Clinical Safety and Quality Group	**Directorate:**	COVID-19 Vaccine and Immunisation Programme
Key Contacts:	**Name**	**Role/s**	**Mobile**
Lead	**Dr. Juliet Rumball Smith**	**GM Clinical Safety and Quality**	
Alternate/s			

Section 1: What do we need?

Critical Resources: *(Without these resources the fun tion cannot continue or be resumed within acceptable timeframes)*				
	Type		**< 1 day**	**< 1 week**
Programme		People	• Key personnel detailed in contacts list need to be available. • Regional Account Managers and Leads (RAM and RAL) to provide support for DHBs • Additional Communications Resources • Qualified personnel to form Incident Management Team (IMT). • Access to Ministers (E.g. Vaccine Ministers).	•
		Facilities / remote working	• Access to 133 Molesworth Street • Access to DHB facilities • Remote working for non-critical staff	• Continued ability for staff to work from home (WFH). • Access to WFH guidance on set-up for new personnel.
		Equipment *Standard = laptop, keyboard, mouse, power cable, workstation (desk, single monitor and chair)*	•	• WFH equipment (Monitors, desks etc)
		Information Technology *Standard operating environment (SOE) = Lotus Notes (email, calendar & filing), Microsoft Suite (Word, Excel, PowerPoint), remote access, printing, VOIP (telephony), MoH@WK*	• Collaborative tools (e.g. ZOOM, Microsoft Teams) • CIR access • COVID Tracking and Tracing • AEFI	•
Sector (DHB, Occ Health, HCL etc)		People		
		Facilities / remote working		
		Equipment		

Ministry of Health Emergency Management Response Contingency Planning

		Standard = laptop, keyboard, mouse, power cable, workstation (desk, single monitor and chair)		
		Information Technology *Standard operating environment (SOE) = Lotus Notes (email, calendar & filing), Microsoft Suite (Word, Excel, PowerPoint), remote access, printing, VOIP (telephony), MoH@WK*		
	Other critical resources:			
	Type	**Description *(Group where appropriate, e.g. IT applications)***	**Timeline**	**Supporting information**
	Facilities (e.g. Incident Management Team)	Incident Management Team suitable alternate location in 133 Molesworth Street as base to coordinate Health response activities/functions.	<4 hours	Incident Mana ement Team SOP for act va ion, set-up and functions are available [insert locat ns]
	Equipment (e.g. whiteboard)	IMT equipment, i.e. whiteboards, monitors, desk phones, boardroom/planning spaces, etc	<4 hours	See IMT SOP for set-up requirements including requirements for set-up of alternate sites

Section 2: What do we do?

What are the specific notifications, assessments, responses and communications plans that we need to complete to ensure we get to the end trigger as efficiently as possible.

Timeline	**What we need to do**		
	< 1 hour	**< 1 day**	**< 1 week**
Key activities/process required to ensure continuity of the function	**Notifications:** • GM Post Event to notify GM Clinical Safety and Quality and Safety of issue. • Post Event to notify key stakeholders e.g., National Director, Chair Independent Safety Monitoring Board and GM Medsafe. • GM Clinical Safety and Quality to notify DHB Clinical Leads and the National Clinical Safety and Quality Forum (to be established) **Assessments:** • GM Clinical to initiate Clinical Quality and Safety assessment of event(s) • GM Logistics workgroup to conduct an assessment to understand the impact to distribution and logistics p ople, processes, and systems. • GM Communications to develop communication plan for internal and external audiences. **Responses:** • GM Clinical Quality and Safety to stand up an Incident Reference Group to establish the facts (who, what and how). • GM Operations to establish an Incident Management Team to manage the service delivery impacts of the incident/s.	**Notifications:** • GM Comms to release communications to internal and external stakeholders regarding status of event • GM Equity and GM Communications to reach out to Māori, Pacific and Disability providers. • GM Equity to notify Iwi and Pasifika leaders. • Director to provide early advice to the Steering Group on impacts and options to maintain and/or re-establish national service delivery. **Assessments:** • GM Operations to conduct an initial impact assessment on service delivery. • GM Logistics to conduct initial assessment to understand impacts on the demand, supply, storage, distribution, consumption and waste plans. • GM Clinical to investigate and review the background to the clinical safety issue. • GM Post Event to obtain evidence surrounding any adverse event for assessment. • GM Workforce to conduct assessment into additional training requirements • GM Operations to support DHBs in the management of inventory and bookings. • GM Equity to conduct assessment on impact to Iwi and Pasifika **Responses:** • GM Clinical to assign the issue to the subject matter expert in the Clinical Quality and Safety Team to investigate. • GM Operations to resource staff to manage the increase in contacts from the public to internal functions e.g., COVID-19 Response.	**Notifications:** • GM Commutations to release updated information / plan / next steps to all external and internal stakeholders. **Assessments:** • GM Clinical Safety and Quality to review investigations and provide recommendations to resume service delivery (if required). Mitigations may include additional clinical controls or a pause pending further investigation. • GM Post Event to source all information from specific adverse events (within 48 hours) to support assessments. Noting this may be delayed if the Coroner is involved. • GM Workforce to review staff training materials and make updates (if required). • GM Operations to review the medication, equipment, and space available to respond to medical emergencies. • GM Operations to review and amend (if required) the operational guidelines and service standards relating to the incident. **Responses:** • GM Clinical Safety and Quality to provide an initial action plan based on their assessment. • GM Logistics to enact the required changes to demand, supply, storage, distribution, consumption and waste plan based on the impact assessment. • GM Post Event to provide advice to providers regarding outcome of impact assessment. • GM Operations to support DHBs in planning a restart of service delivery (if required).

Ministry of Health Emergency Management Response Contingency Planning

Timeline	What we need to do		
	< 1 hour	**< 1 day**	**< 1 week**
		• GM Operations to assess impact on external call centres e.g., DHBs and Whakarongorau.	
Alternatives available			

Communications	What we need to do	
	Internal Communications Plan	**External Communications Plan**
Audience	Cabinet Health and Vaccine Ministers DG Ministry of Health Steering Group CVIP Programme Leadership Group GM Communications COVID-19 Response Team Service Delivery Providers e.g., DHBs, Occupational Health, equity providers.	Localised and targeted outbreak area communication e.g., schools, TV, ads, internet, mail. New Zealand Public Health Sector
Key Message	We are aware that a report has been received by Centre for Adverse Reactions Monitoring (CARM) of a suspected XXXX CARM [and XXX] are currently assessing the situation and with the information we have ava lable right now, we are confident the vaccine roll-out an continue as the investigation takes place. We have no safety concerns with the Pfizer vaccine There will be regular updates of the situation.	We are aware that a report has been received by Centre for Adverse R actions Monitoring (CARM) of a suspected XXXX CARM [and XXX] are currently assessing the situation and with the information we have available right now, we are confident the vaccine roll-out can continue as the investigation takes place. We have no safety concerns with the Pfizer vaccine There will be regular updates of the situation.

Section 3 – Who's involved?

Inter-dependencies	
Who relies on us to continue this function?	**Why do they rely on it?**
Service Providers (e.g., DHBs, PHOs, GPs).	• Provision of planning support to rematch demand and supply, particularly in affected areas (if required). • Provision of clinical advice and support. • Provision of support to ensure all vaccination sites can meet the new requirements of clinical safety protocols and/or operating guidelines (if required). • Provision of national communications messaging and support for local targeted communications.
3PL Partners (HCL, DHL and NZ Post Pace)	• Require amended supply and storage plan for affected sites.
ACC	• Notify ACC of events which may have occurred for their records and tracking of events.
MedSafe	• Notifications of adverse clinical event(s)
Who do we rely on to continue this function?	**Why do we rely on them?**
Centre for Adverse Reaction Monitoring (CARM).	• Receives and analysis all reported adverse events. • Service provider for Medsafe.
Independent Safety Monitoring Board (ISMB)	• Provide expert advice on the safety and efficacy of vaccines. • Assess adverse events of special interest. • Monitor programme performance and post event data including decision to pause or stop.
Immunisation Implementation Advisory Group (IIAG)	• Advice on how to plan and implement the programme. • Positioning equity at the centre of the programme.
Medsafe	• Administer the Medicines Act 1980 and Regulations 1984. • Ensure medicines meet standards of safety, quality and efficacy. • Oversight of manufacture, storage and distribution to ensure that products meet standards until delivered to the end user.
COVID-19 Vaccine Technical Advisory Group (CVTAG)	• Scientific and technical advice on when, how and for whom to use vaccines. • Continued assessment of new and emerging evidence.
National Clinical Quality and Safety Forum (to be established).	• Provide advice on emerging risks including patient safety risks.

Ministry of Health Emergency Management Response Contingency Planning

	• Assess and monitor clinical quality and safety performance of the programme.

Section 4 – What are the key end triggers?

End trigger *(What is going to trigger the end of the contingency plan?)*	
What is the trigger to end the event?	• The vaccine is approved for on-going usage by competent authority e.g. Medsafe, Independent Safety and Monitoring Board or COVID-19 Vaccine Technical Advisory Group. • Implementation of any clinical safety and quality recommendations made by clinical leadership and/or governance, e.g. changes to clinical practice and/or Operating Guidelines. • Service delivery levels return to meet National Production Plan. • Public sentiment surveys return to or above pre-incident levels.

Section 5 – Key contacts?

Function Overview *(Who is the key internal or external person who has a key role in re-establishing this function?)*			
Key Contacts:	**Name**	**Role/s**	**Mobile**
Lead	Jo Gibbs	CVIP Programme Director	
Alternate/s	Juliet Rumball-Smith	Group Manager Clinical Quality and Safety Team	
	DHB Clinical Leads	*CVIP Quality and Safety Framework and Actions paper for Steering Group 25 May 2021 – Appendix 4*	
(e.g. activity lead)		CARM	
		Medsafe	
		IMAC	
		Chief Executives/SROs	
		GM Post Event	
		GM Operations	
		RALs & RAMs	

Section 6 – External Plans and/or Policy Settings?

External Documentation *(What other resources are available to support)*		
Document Name	**Description**	**Location**
CVIP Quality and Safety Framework and Actions paper for Steering Group 25 May 2021	This paper sets out the overarching CVIP Quality and Safety Framework (the F amework) and details the work that has been progressed to strengthen the specific clinical quality and safety quadrant of the Framework by establishing: • an internal CVIP incident review group (IRG) • the National Clinical Quality and Safety Forum (NCQSF) In addition, the CVIP team set out the expectation of the Programme on clinical quality and safety to DHBs. DHBs have provided details of the appropriate people and processes that are in place to support clinical quality and safety and we have confidence that DHBs understand the expectations.	

Ministry of Health Emergency Management Response Contingency Planning

Template Guidance Note:

*A function summary sheet should be completed for each function with a goal recovery timeframe of **one week or less**.*

This summary sheet contains important information that will be used by the response team to prioritise resources and support you to maintain your function.

Scenario Information			
Name:	**Significant Privacy or Security Breach**	**Risk Level (0-10)**	
Description:	This may impact on vaccination service delivery by causing the outage of IT applications, e.g. ransomware, or reducing public trust and confidence in the programme, e.g. personal health consumer information being placed in the public domain.		
Exemplar Events:	Waikato Ransomware, June 2021 Canterbury DHB insecure public facing booking application, April 2021		
Activation Trigger:	This contingency plan can be activated anytime there is an identification of an IT security breach within a programme application or related third party system or a privacy breach has occurred. This may be due, but not limited, to the following: • Significant Outage or loss of service e.g. DOS attack or ransomware • Unauthorised access to system or personal data. • Personal consumer information has been released into the public domain • Website defacing is an attack that often replaces the hosted website with one of the attackers. • Inadvertent or deliberate breach of security protocols or regulations. • Insider threat e.g., disgruntled employee releasing or accessing information.		
Impacts:	Potential Impacts: • Loss of public trust and confidence in the vaccination programme. • Significant outage of IT applications. • Outages of online recording services (e.g. CIR), will require the manual collection of personal information, increasing the time of each vaccination event and reducing overall throughput. • Outages of booking systems (e.g. NBS) will reduce the ability of consumers to book a vaccination appointment, reducing the throughput at vaccination sites. • Manual reporting of adverse events has the potential to result in underreporting and delays in the analysis of this data. • Potential to impact the provision of clinical advice on quality and safety processes. • At affected vaccinations sites patient clinical information including flags on adverse events may not be available. • Potential for delay in logistics information being received for supply and demand tracking, causing delays in distribution or oversupply leading to wastage. • Potential to cause impact on the management of bookings including the reconciliation between invitations, bookings and identity of consumer (e.g. NIBS, CPIR, Match+ CIR). • Potential to require an increase in administration staff and a reduction in vaccinator staff due to increase in manual inputs and time taken to conduct a vaccination event. • Risks to storing personally identifiable information internally without the correct authorities and/or security (e.g. excel workbooks). • Delay in receiving data from vaccination sites e.g., throughput, adverse event reporting etc. • Potential personal data breaches can expose individuals to social engineering hack or a Phishing attack. • Serious harm to an individual or group of people e.g. identity theft.		

Recovery Time Objective:		**Maximum Tolerable Period of Disruption (MTPD):**	
Function Owner (Business Group):	National Operations Group	**Directorate:**	COVID-19 Vaccine and Immunisation Programme
Key Contacts:	**Name**	**Role/s**	**Mobile**
Lead	**Astrid Koornneef**	**GM: Operations**	
Alternate/s			

Section 1: What do we need?

Critical Resources: *(Without these resources the function cannot continue or be resumed within acceptable timeframes)*				
	Type		**< 1 day**	**< 1 week**
Programme		People	• Privacy Expert/Partner • Security Expert/Partner • Clinical Expertise (dependant on nature of system and its purpose). • Key personnel detailed in contacts list available. • RAM and RAL support for DHBs • Qualified personnel to form Incident Management Team (IMT). • Direct access to Ministers (E.g. Vaccine Minister)	• Employee Assistance Programme for affected individuals/staff
		Facilities / remote working	• Access to 133 Molesworth Street • Access to DHB facilities • Remote working for non-critical staff	• Access to WFH material
		Equipment *Standard = laptop, keyboard, mouse, power cable, workstation (desk, single monitor and chair)*	• 5G Wifi pre-paid SIM cards. • Wifi Routers	• WFH equipment (Monitors, desks etc)
		Information Technology	• Collaborative tools (e.g. ZOOM, Microsoft Teams)	

Ministry of Health Emergency Management Response Contingency Planning

		Standard operating environment (SOE) = Lotus Notes (email, calendar & filing), Microsoft Suite (Word, Excel, PowerPoint), remote access, printing, VOIP (telephony), MoH@WK	• Access to SalesForce database	
Sector (DHB, Occ Health, HCL etc)		People		• IT Service Partners Help Desk staff
		Facilities / remote working		
		Equipment *Standard = laptop, keyboard, mouse, power cable, workstation (desk, single monitor and chair)*		• IT Standard Equipment to replace equipment affected by ransomware
		Information Technology *Standard operating environment (SOE) = Lotus Notes (email, calendar & filing), Microsoft Suite (Word, Excel, PowerPoint), remote access, printing, VOIP (telephony), MoH@WK*		• Software licences to re-establish connectivity

	Other critical resources:			
	Type	**Description** ***(Group where appropriate, e.g. IT applications)***	**Timeline**	**Supporting information**
	Facilities (e.g. Incident Management Team)	Incident Management Team suitable alternate location in 133 Molesworth Street as base to coordinate Health response activities/functions.	<4 hours	Incident Management Team SOP for activation, set-up and functions are available [insert locations]
	Equipment (e.g. whiteboard)	IMT equipment, i.e. whiteboards monitors, desk phones, boardroom/planning spaces etc	<4 hours	See IMT SOP for set-up requirements including requirements for set-up of alternate sites
	Facilities (e.g. IT Major Incident Management Team)	IT Major Incident Management Team suitable alternate location in 133 Molesworth Street as base to coordinate Health response activities/functions.	<4 hours	IT Major Incident Management Team SOP for activation, set-up and functions are available [insert locations]

Section 2: What do we do?

s (9)(2)(c), s 9(2)(e)

[redacted]

Ministry of Health Emergency Management Response Contingency Planning

s 9(2)(c), s 9(2)(e)

[redacted]

Ministry of Health Emergency Management Response Contingency Planning

s (9)(2)(c), s 9(2)(e)

[redacted]

Section 4 – What are the key end triggers?

End trigger *(What is going to trigger the end of the contingency plan?)*	
What is the trigger to end the event?	• Complete service restoration and post incident review completed, improvements recommended and actioned with the root cause addressed through implementation of the fix. • Vaccination service delivery is back to the required levels within the National Production Plan.

Section 5 – Key contacts?

Function Overview *(Who is the key internal or external person who has a key role in re-establishing this function?)*			
Key Contacts:	**Name**	**Role/s**	**Mobile**
		D&D Security Team via MITC Service Desk	
		RALs & RAMs	
	Mark Sowden	Chief Government Data Steward	
		GM Operations	
		Office of the Privacy Commissioner	
		GCSB	
		CERT	
	Caitlin Hawkins	Manager Privacy	s 9(2)(a) [redacted]
	Phil Knipe	Chief Privacy and Chief Legal Officer	s 9(2)(a) [redacted]

Section 6 – External Plans and/or Policy Settings?

External Documentation *(What other resources are available to support)*		
Document Name	**Description**	**Location**
National Cyber Security Sector Responses Plan.		
Protective Security Requirements		PSR Website
NotifyUS	OPC Breach Reporting Tool	OPC Website

Document 13

MINISTRY OF HEALTH
MANATŪ HAUORA

COVID-19 Immunisation Implementation Advisory Group

Terms of Reference

Edition 2

Updated 5 August 2021

1. Purpose

The Director-General of Health has established the COVID-19 Immunisation Implementation Advisory Group (IIAG, the Group) to provide independent, expert advice to the Ministry of Health (the Ministry) on designing, planning, preparing and implementing a COVID-19 Vaccination and Immunisation Programme (the Programme) with a focus on achieving equity and meeting Crown obligations under Te Tiriti o Waitangi.

The IIAG is the Ministry's primary advisory group for design thinking and strategy for the Programme.

2. Introduction

These Terms of Reference (ToR) set out for the IIAG:

- context
- the role of IIAG
- consideration of Te Tiriti o Waitangi
- membership and expectations of members
- terms of appointment
- meeting protocol
- liability
- confidentiality
- process for managing conflicts of interest
- remuneration
- the process of review.

This document constitutes the second version of the Group's Terms of Reference. At the IIAG's inaugural meeting on 2 October 2020, it was agreed the Group's ToR would be a living document and may be reviewed and updated as necessary.

3. Context

The World Health Organization (WHO) declared the outbreak of COVID-19 a pandemic on 11 March 2020. COVID-19 is an infectious disease caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). The pandemic has caused extensive global, social and economic disruption

A safe, effective vaccine, available in sufficient quantities to achieve population immunity, appears the most likely route to fully re-opening international borders and achieving national and global recovery from COVID-19.

The Ministry of Health (the Ministry) has established a COVID-19 Vaccination and Immunisation Programme (the Programme) to support the Government reach its objective of offering a COVID-19 vaccination to every eligible person in New Zealand by the end of 2021.

The IIAG's role is to ensure expert implementation advice informs this work, and assessments are made of whether Te Tiriti o Waitangi and equity responsibilities are being met.

Due to the inherent uncertainties of the COVID-19 pandemic, all work related to the Programme, and the IIAG's role in this, will need to be regularly reviewed and change and evolve as required.

4. Role and responsibilities of the IIAG

The Group's role is to develop expert advice and make recommendations to the Ministry on how to design, plan, prepare for and implement a COVID-19 Vaccination and Immunisation Programme including, but not limited to:

- ensuring the Programme is honouring the Crown's obligation under Te Tiriti o Waitangi;
- positioning equity at the centre of the Programme;
- supporting and equipping whānau, hapū, iwi, Māori communities to deliver the Programme to their communities where possible;
- supporting and equipping Pacific communities to deliver the Programme to their communities where possible;
- identifying priority groups for the delivery of the vaccine(s);
- ensuring equitable access to the vaccine(s) for priority groups;
- managing vaccine demand and supply, including distribution;
- public and sector communications to support the immunisation p ogramme rollout;
- workforce requirements, in particular the vaccinator workforce;
- logistics, including management and availability of equipment to support immunisation and cold chain requirements;
- behavioural psychology surrounding vaccines and receiving immunisations;
- data access, use and storage;
- monitoring and evaluation of the Programme.

The Group will consider for endorsement any proposals or plans provided by the Ministry or other advisory groups.

The Group will provide the Ministry with its best advice. This advice is not binding on the Ministry and the Ministry may take a different position.

4.1 Sub-groups and wider consultation

The Group will convene appropriate sub-groups to meet and provide specialist advice when required or requested by the Ministry. The Group will nominate a chair from the Group for each of these sub-groups.

The Group and sub-groups are required to have targeted consultation with Māori health experts. The Group and sub-groups may request expansion of consultation beyond the membership in order to develop robust advice that is fit for purpose. Stakeholder reference groups may be convened with the permission of the co-chairs and the Ministry to capture other wider interests (such as social sector, aged care, education, business) in the shaping of advice.

4.2 Consideration of Te Tiriti o Waitangi

The IIAG will ensure their advice is provided within the context of honouring Te Tiriti o Waitangi.

The principles of Te Tiriti o Waitangi, as articulated by the Courts and the Waitangi Tribunal provide the framework for how the Ministry will meet its obligations under Te Tiriti o Waitangi. The IIAG must apply and adhere to these principles when providing advice:

- **Tino rangatiratanga**

The guarantee of tino rangatiratanga, which provides for Māori self-determination and mana motuhake. This means ensuring Māori are part of decision-making process with regards to the design, delivery and monitoring of the immunisation programme.

- **Equity**

The principle of equity, which requires a commitment to achieving equitable health outcomes for Māori. This means the IIAG will actively ensure equitable access to the vaccine and equitable outcomes for Māori as part of the design and delivery of the immunisation programme.

- **Active protection**

The principle of active protection, which requires the fullest extent practicable is required to achieve equitable health outcomes for Māori. This means the IIAG utilises data, evidence and resources to actively identify and address inequities with regards to immunisation and the protection of Māori health and wellbeing.

- **Options**

The principle of options requires there to be, and properly esourced, kaupapa Māori health and disability services. Furthermore, the Crown is obliged to ensure that all health and disability services, including immunisations, are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.

- **Partnership**

This requires the Crown and Māori to work in partnership in the governance, design, delivery and monitoring of health and disability services. This means ensuring appropriate Māori representation on the IIAG, as well as ensuring the IIAG is partnering with Māori in the design, delivery and monitoring advice they provide for the immunisation programme.

5. Role and responsibilities of the Ministry of Health

The Ministry will provide secretariat and administrative support for Group and sub-group meetings. This will include inviting attendees, arranging conferencing facilities, and developing and circulating agendas, papers and minutes.

The Ministry will provide adequate and timely national and international information and data wherever possible to support the work of the Group.

5.1 Consideration of advice by the Ministry and Programme Steering Group

The IIAG is established by the Director-General of Health to provide expert advice to the Ministry. The Ministry and Director-General of Health will give reasonable consideration to the advice and recommendations of the Group, however, recommendations from the IIAG are not binding on the Ministry and the Ministry may take a different position.

Where the Ministry takes a substantively different position to that recommended by the IIAG, this will be communicated to the IIAG and explained.

The Ministry will provide the outcome of IIAG's considerations to the Programme Steering Group, chaired by the Director-General of Health. This will be by way of the IIAG's meeting minutes at a minimum and may also include any reports or memos the IIAG may produce. The IIAG co-chair representing DHBs will be invited to attend the weekly Steering Group meeting and both co-chairs will present to the Steering Group no less frequently than monthly.

IIAG advice and recommendations will be provided to Ministers at the discretion of the Director-General of Health, either specifically attributed to the IIAG or as part of general advice.

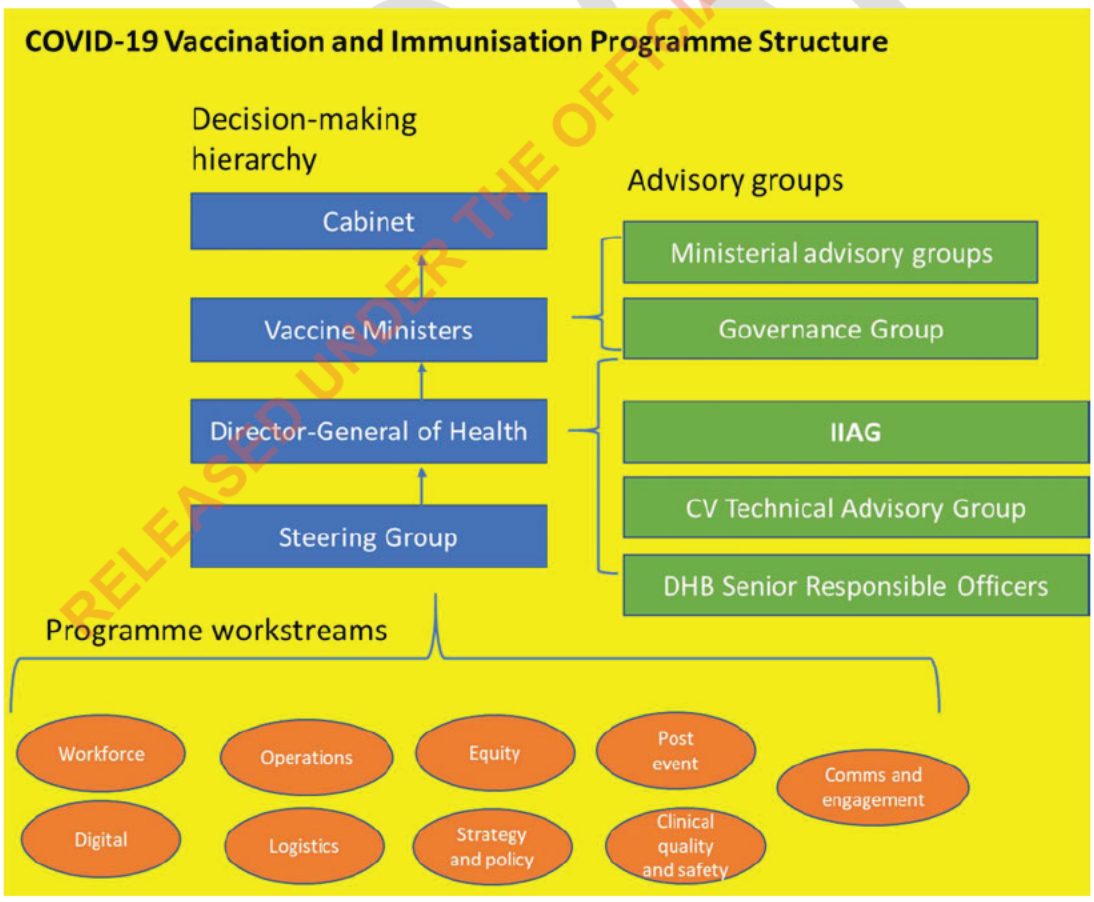
6. Scope of advice

IIAG provides the Ministry with advice on the Programme in the environment of other advisory groups. In particular:

- **COVID-19 Vaccine Technical Advisory Group** – provides science advice and decision to use advice on specific vaccines
- **The Programme Governance Group** – provides oversight and assurance of the Programme, reporting to Vaccine Ministers.
- **The DHB Senior Responsible Officer forum** – provides advice on commissioning of vaccination services.

The IIAG may canvas these areas in providing advice to the Ministry but does not hold specific responsibility for doing so.

An outline of the Programme's decision-making and advisory group structure is provided below.



7. Membership

7.1 Appointment process

Membership of the Group, including the appointment to the role of co-chairperson is through a direct selection appointment process by the Director-General of Health.

Members will be appointed based on their individual skills, knowledge and expertise. In most cases members are not appointed as representatives of organisations and are expected to contribute their own views and perspectives on the practical implementation of the Programme, and together form a system view.

Consideration will be given to have Māori and Pacific representation and tino rangatiratanga (decision making) when appointing members.

The composition of the Group will be revised as the needs from the COVID-19 immunisation programme evolve.

7.2 Group composition

As at 1 August 2021, IIAG members are:

Member	Role/Representation
Keriana Brooking	Co-chair, DHB Chief Executive
Te Puea Winiata	Co-chair, Chief Executive, whānau-based healthcare
Dr Helen Petousis-Harris	Vaccine safety and effectiveness
Dr Angela Ballantyne	Bioethicist
Silao Vaisola-Sefo	Pacific health provider
Dr Apisalome Talemaitoga	GP and pacific health expert
Nicky Birch	Māori communications and engagement specialist
Taima Campbell	Nursing representative
Dr Tristram Ingham	Medical researcher and epidemiologist, disability sector expert
Kevin Pewhairangi	Pharmacy representative
Loretta Roberts	Immunisation specialist
Rhonda Sherriff	Aged residential care sector

7.3 Core responsibilities of the co-chairs

- provide effective leadership and direction to the IIAG
- have a commitment to upholding the principles of Te Tiriti o Waitangi
- have a commitment to ensuring equity of access and equity of health outcome for all New Zealanders, with a particular focus on Māori and Pacific groups
- provide necessary guidance and support to the IIAG members
- approve the meeting minutes in a timely manner.

To ensure IIAG has transparency over the consideration of its advice to the Ministry, the IIAG co-chair representing DHBs will be invited to attend each Steering Group meeting and both co-chairs will present to the Steering Group no less frequently than monthly.

7.4 Core responsibilities of all the members

- have a commitment to upholding the principles of Te Tiriti o Waitangi
- have a commitment to ensuring equity of access and equity of health outcome for all New Zealanders, with a particular focus on Māori and Pacific groups
- have a commitment to work for the New Zealand public
- act in their professional capacity as experts on areas relevant to the COVID-19 immunisation programme
- provide the Group with their own views and insights
- prepare for meetings, including reading any material sent out prior to the meeting
- prioritise attendance at the meetings and in the case of non-attendance, notify the co–chairs (or Secretariat) in advance of the meeting at the earliest possible opportunity. When circumstances prevent them from attending meetings, members will forward any comments, concerns and queries to the co-chairs before the meeting.

7.5 Terms of appointments

Appointments are made for the duration of the Group, unless otherwise determined by the Director-General of Health.

The Director-General, in consultation with the co-chairs, may terminate the appointment of any member at any time by notification in writing.

8. Meeting procedures

IIAG meetings will be held primarily through virtual means. The Secretariat will ensure the appropriate arrangements are made for members.

The meeting schedule will be agreed by co-chairs. Additional meetings may be called by the Secretariat in consultation with the co-chairs on an as required basis.

Draft minutes will be provided to members within **five** working days of the meeting.

Meeting agendas and relevant papers will be provided to attendees at least **three** working days before the meeting. The co-chairs may accept late items and papers at their discretion.

Feedback may be requested on various issues and proposals out of the usual meeting cycle. The Ministry will endeavour to give the Group as much time as possible to consider the information provided and provide feedback.

9. Liability

Members are not liable for any act or omission done or omitted in their capacity as a member, if they acted in good faith, and with reasonable care, in pursuance of the functions of the Group.

10. Confidentiality

Members of the Group will be privy to confidential and commercially sensitive information. It is expected that all information shared and discussed, including the agenda, material and minutes, are confidential. Members must ensure confidentiality is maintained and documents kept

securely. Release of correspondence or papers can only be made with the prior approval of the Ministry.

Members must ensure that any information acquired or created for IIAG consideration is only used for performing duties as a member. Members may not use their knowledge of confidential IIAG issues to provide inequitable benefit, gain or advantage to any individual, private or public agency or group.

Members are free to, and are expected to, express their own views within the context of meetings, or the general business of the IIAG.

Members agree they will not at any time disclose to any person otherwise than necessary for these ToR or as required by law, any information they acquire for the purpose of providing and completing the services. In carrying their functions members of the IIAG, members shall not make public statements of any kind on behalf of the IIAG.

No members will make media statements of any kind on behalf of the IIAG unless requested or approved to do so by the National Director Operations, COVID-19 Vaccine and Immunisation Programme.

All IIAG related agendas, minutes, email and other communication are subject to release under the Official Information Act 1982 unless otherwise excluded for release under the provisions of that Act.

All requirements around confidentially will apply equally to all members, guests and staff supporting the Group.

11. Conflicts of Interest

The IIAG will adhere to the Ministry's guidelines on conflicts of interest for advisory groups (see Appendix 1).

Members should perform their functions in good faith, honestly and impartially and avoid situations that might compromise their integrity or otherwise lead to conflicts of interest. Proper observation of these principles will enable public confidence in the work of the committee to be maintained.

Members must complete a written Declaration of Conflict[1] of interest both on appointment and annually, irrespective of whether they have a conflict of interest.

Any actual, perceived or potential conflicts of interest must be disclosed.

The group will have Conflicts of Interest as a standing item first on the meeting agenda to accommodate verbal disclose and to ensure the Conflicts of Interest register is kept up-to-date and accurate.

Conflict of interest declaration form for

[1]

Conflicts of interest must also be considered with every agenda item, with the extend of any conflict/s assessed and fully documented in the minutes, including action taken to manage the conflict.

12. Fees

Members of the IIAG are entitled to be paid fees for attendance at meetings. Members who are not already paid for their time through wider state sector arrangements are eligible to claim a fee of $895 per day (based on an eight-hour day). The level of attendance fees is set in accordance with Cabinet Office Circular CO (19) 1, Fees framework for members appointed to bodies in which the Crown has an interest.

13. Expense Reimbursements

Members could be entitled to be reimbursed for actual and reasonable travelling and other expenses incurred in carrying out their duties, with prior agreement.

The expectation is that the standards of travel, accommodation, meals and other expenses are modest and appropriate to reflect public sector norms. Airfares and accommodation where funded should be booked through the Ministry.

14. Term of the IIAG and review of the ToR

The IIAG will be disestablished on 31 October 2021, or at any time earlier if the duties of the IIAG have been fulfilled or it is no longer required. The end date for the IIAG will be reviewed in September 2021 for any requirement to further extend the Group's term.

The work and terms of reference of the IIAG may be amended, replaced or revoked by the Ministry at any time, and will be reviewed regularly by the Ministry, in conjunction with the IIAG co-chairs.