MINISTRY OF HEALTH
MANATŪ HAUORA

Minutes

COVID-19 Vaccine and Immunisation Programme Steering Group

Date:	Tuesday, 20 July 2021
	4.30 pm – 6:15 pm
Location:	1 N.3
Chair:	Maree Roberts
Members Attending:	Dr Ashley Bloomfield, Rachel Haggerty (CCDHB/HVDHB), Dr Caroline McElnay, Shona Meyrick, John Whaanga, Deborah Woodley, Shayne Hunter, Dr Ian Town
IIAG:	Keriana Brooking, Co-Chair, Immunisation Implementation Advisory Group
Other Attendees:	Andrew Bailey, Allison Bennett, Jo Gibbs, Dr Tim Hanlon, Jane Hubbard (paper 8), Astrid Koornneef, Rachel Lorimer, Colin MacDonald, Fiona Michel, David Nalder, Mat Parr, Linda Pannekoek (paper 6), Dr Juliet Rumball-Smith, Tamati Sheppard-Wipiiti
Apologies:	Dr Dale Bramley (WDHB), Chris Fleming (SDHB), Wendy Illingworth

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#	Agenda Item
1.	**Introduction and minutes** • The minutes from the previous meeting on 13 July 2021 were approved. • There were no matters arising. • It was noted that following distribution of the agenda, consideration of paper 4 had been deferred until 27 July 2021. **Action tracker consideration** • The meeting considered each of the three action trackers in detail. Changes are reflected within the trackers.
2.	**Operational updates (Jo Gibbs)**
2a.	**Programme Update** *Paper 3: COVID-19 Immunisation Programme Update – 18 July 2021* • Overall numbers vaccinated are tracking ahead of plan. However, the numbers for groups covered by our Equity objective have started to track in the wrong direction. Numbers for Māori have dropped from 10 per cent to 9 per cent this week. • At least seven DHBs are well behind on the equity component of their production plans. This is in spite of all but one DHB being ahead of their overall plan targets.

2b. Process to identify operational impacts of policy proposals

- IIAG members have been receiving papers that including a line 'we will assess operational implications". IIAG noted some queries and cautions about papers being submitted, potentially for approval, when operational implications were not identified.
- Suggestions included clarifying the level at which operational implications would be identified (i.e. provider), who would do the assessment and by when, and how would the Steering Group know when the stated assessment has been completed. What would be the process to manage impacts of implementation was already completed? Who had the systems impact overview?

Group discussion

- Agreed that where the operational implications of paper should ideally by assessed and understood prior to consideration, or they should signal why the assessment had not yet been done.

Action 1: implement a mandatory cover sheet for papers to Steering Group which:
- ***Includes a list of the groups or stakeholders involved in development of/consultation on the paper;***
- ***States whether an assessment of operational impacts has been made; and***
- ***States whether an assessment of the contribution the proposals will make towards achieving the equity objectives has been made.***

3. Standing item on Science and Technical – CV-TAG (Dr Ian Town)

Verbal updates were provided:
- *Myocarditis*: The CV-TAG has had its third and final meeting to discuss events of myocarditis/pericarditis post-vaccination, and related matters. Formal advice will be provided to the Director-General on 21 July 2021.
- Pacific Islands nations using the Pfizer vaccine have sought advice about myocarditis associated with use of this vaccine in younger males, and also the forthcoming advice about use in 12-15 year olds.

4. Risk update (David Nalder)

Paper 5: CVIP Programme risk summary for Steering Group – 20 July 2021

- The 'ultimate' risks of the project are:
  - Loss of public confidence,
  - Lack of equity of access,
  - Low uptake.
- A workshop earlier the same day has themed up the emerging programme risks:
  - Expectation management,
  - Reducing complexity,
  - Legacy and transition.
- A further round of risk profile scoring will be held later in the week.
- Will continue to work with delivery leads on an ongoing basis to ensure risks to the implementation are identified, assessed and managed appropriately.
- As we move into the Assurance Framework, the focus will be the controls around how key risks are addressed.

Group discussion

- A question was asked as to performance risks such as those impacting on achieving equity. While there are many strands to this reporting, it can be hard to get a feel for overall performance and to risks at this level. *(Cont. over)*
- It was noted that generally this would be picked up through assessment against the four dimensions in the Success Framework. Equity was one of these dimensions.

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	• It was agreed that the point at which cumulative risk is such that it impacts on the 'ultimate' risk was not clear. ***Action 2: Apply the Balanced Scorecard as a reporting tool to help show the overall picture of performance. Timeframe – from next Steering Group meeting 27 July 2021.*** **Decisions of the Steering Group** In relation to paper *5 – CVIP Programme risk summary for Steering Group – 20 July 2021,* the Steering Group: **a)** **Noted** the map of inherent risks across the end to end vaccination process design; **b)** **Agreed** that lack of ability to gain early warning of threats to overall performance was a risk; **c)** **Noted** the actions in place to manage and these top risks; and **d)** **Agreed** to implement the Balanced Scorecard as a reporting tool to help show the overall picture of performance.
5.	**Population Data Decision (Linda Pannekoek)**
	Paper 6: Denominator data for vaccine uptake monitoring – 20 July 2021 • CVIP is recommending adopting Health Service Utilisation (HSU) data to use as a denominator for monitoring vaccination uptake. • Historically, the Ministry has used Estimated Population projections from the Census data as the denominator against which health statistics are compared • There are acknowledged differences between this and actual health use data, this is primarily related to the ethnicity recorded in each dataset • The HSU population database has recently been finalised and is ready for use. It is based on numbers enrolled in PHOs and other health service use e.g. filled prescriptions, hospital care). • CVIP wants to be able to publish rates of vaccine uptake for various population groups. • If agreed, this would be implemented promptly. **Group discussion** • CVIP initial data collection re vaccine use has been against the Census. Any reporting against this will need associated communications about denominator, including its limitations. • The Census contains a larger proportion of Māori than does the HSU (by about 1.3%). Care is needed to ensure it is clear that we are trying to present the most accurate data we can about access to vaccine. • Other parts of the Ministry are also interested in the results of any implementation by CVIP. Potential opportunity to update the quality of data in the wider system. **Decisions of the Steering Group** In relation to paper 6, *Denominator data for vaccine uptake monitoring – 20 July 2021,* the Steering Group: **a)** **Agreed** that the CVIP Programme will use the Health Service Utilisation population as the denominator for COVID-19 vaccine uptake monitoring purposes.

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6.	**Progress against milestones** *Paper 7: CVIP Schedule Summary Update – 19 July 2021.* (This paper was noted.)
6a.	**Workforce (Fiona Michel)** *Paper 8: Approach to authorise vaccinators* • The authorised vaccinator process, in place since the 1990s, enables authorised vaccinators across a range of vaccination programmes to administer vaccines without obtaining a prescription. • A provisional vaccinator authorisation process was put in place in 2020. It aimed to allow for a more rapid increase in the numbers of vaccinators (to support measles, influenza and COVID-19 vaccination). • s 9(2)(h) s 9(2)(h) • The CVIP Workforce workstream is confident that vaccinators administering the COVID-19 vaccine have the required qualifications and the necessary skills and competencies to administer the vaccine. • s 9(2)(h) s 9(2)(h) **Decisions of the Steering Group**

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	In relation to paper 8, *Approach to authorise vaccinators*, the Steering Group: a) **Noted** the contents of the paper, b) s 9(2)(h) c) s 9(2)(h)
6b.	**Communications and Engagement (Rachel Lorimer)** *Paper 9: UAC-19 Vaccine – Group 4 campaign planning* • Have developed a flexible framework approach that will apply to communications surrounding the rolling age group announcements regarding access to vaccination. • Key objectives are that it be simple, memorable, apply across media channels, and help to manage expectations. Theme "It's your time to book". • Will use 'profile' people in each age band to 'lead communicate' their story. • Have discussed the approach with Te Puni Kōkiri. It is recognised that the framework does not include comms relating to whanau vaccination. **Group discussion** • It was agreed that this approach would relate well to certain segments of the population, however, it was also unlikely to relate to some groups, including Pacific people. • Noted that an effective approach to whanau will need to be framed quite differently. The by-line was unlikely to resonate with Māori. • The importance of ensuring that appropriate comms were available for Māori and Pacific groups, and that these groups were empowered to develop their own comms messaging, was emphasised.
6c.	**Strategy and All of Government (Mat Parr)** *Paper 10: Interagency collaboration to achieve the aims of the COVID-19 Vaccination and Immunisation Programme – 7 July 2021* • This paper summarised the roles of government agencies in delivering CVIP, and set out opportunities to enhance this as the roll-out gains momentum. It set out a range of areas where support has been provided to date, including policy advice, vaccine purchase negotiation, communications, data, and vaccination service delivery. • As we prepare for scale-up, the CVIP programme needs to know clearly and reliably in what ways government agencies will continue to provide their support. • The concept of a new CVIP Forum, set at deputy chief executive level, was flagged. **Group discussion** • Several government agency groups already exist at chief executive/senior management level. Suggestion made that existing mechanisms be checked for appropriateness before any new group is established at this level. **Decisions of the Steering Group** In relation to paper, Interagency collaboration to achieve the aims of the COVID-19 Vaccination and Immunisation Programme – 7 July 2021, the Steering Group: **a) Noted** the opportunity to increase the contribution of government agencies to the COVID-19 Vaccination and Immunisation Programme; **b) Agreed** in principle to the establishment of a deputy chief executive CVIP Forum, chaired and administered by the Ministry of Health, to support increased government agency collaboration in the CVIP Programme; **c) Agreed** that the memorandum "Interagency collaboration to achieve the aims of the COVID-19 Vaccination and Immunisation Programme" and associated

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	recommendations be shared with the public sector COVID-19 Board, led by DPMC, for endorsement; d) **Agreed** that the memorandum “Interagency collaboration to achieve the aims of the COVID-19 Vaccination and Immunisation Programme” may be shared with other agencies for discussion; and e) **Endorsed** that existing chief executive/senior management level groups should be checked for appropriateness before any new group is established to support increased government agency collaboration in the CVIP Programme.
6c.	**Equity (Tamati Sheppard-Wipiiti)** *Paper 11: Five Point Plan to Disability Action Plan* • We are moving focus from enabling providers to monitoring DHBs. Have agreed performance targets. However some issues are emerging. • Have talked to most of the DHBs about their approach to ensuring the access to and delivery of vaccination services for members of the disability community. A multi-pronged approach is under way: o Leadership: use a profile personality to spearhead public engagement, potentially Hon Carmel Sepuloni (Minister for Disability Issues). o Disability communications fund: EOIs have now been received from parties engaging with the disability community. We expect to negotiate with/fund about 80 per cent of those who applied. o Invitation and accommodations: the national call centre will be able to include site accommodations required to support clients during their vaccination. o Supported decision-making: guidance has been developed however does not appear to be being followed uniformly. IMAC will host a seminar for the sector to build awareness. o Increasing provider flexibility: The Ministry of Social Development has confirmed it is providing flexibility within its own contracting with social services providers to allow them to better focus on vaccination roll-out. However, this message needs to now reach the disability community. • The lack of robust disability data is a recognised national issue. We need to focus on data relating to COVID-19 vaccination roll-out. **Group discussion** • Limitations of having only two weeks’ reporting were noted. • Cautioned that the problem for disability and more widely across equity, was not planning but delivering. We need to ensure that people are accountable for their delivery. • Delivering for equity outcomes means creating the right environment – relieving some current non-COVID-19 vaccination services – ensuring providers have vaccine supply • Noted that using DHBs alone will not achieve the provider diversity required to achieve equity objectives. • Important to both low intensity/high yield AND high intensity/low yield effort concurrently to achieve the desired results. The contribution of primary care sector vaccination is extremely important. ***Action 2: Schedule a discussion on Equity as a key agenda item for next meeting. Discussion to include a rethink of the comms, the plan and the overall approach.***
6d.	**Clinical Safety and Quality (Dr Juliet Rumball-Smith)** *Paper 12 – Early Second Dose – Identified issue and action plan* • Following the signal at last week’s meeting, we have worked with DHBs and identified that about 1,270 people have received their second COVID-19 vaccine prior to 21 days after their first dose. • This is action is considered off-label, or unapproved. A CARM and incident report must be completed for these cases.

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	• We are taking steps to ensure DHBs are aware of and implement the 21-day requirement on every occasion:
	  ○ Technical response – current second booking settings in the booking system and in CIR are considered robust. The booking system does not allow for early second booking. An additional 'early vaccine warning' box is being added to the CIR, effective early August.
	  ○ We are actively engaging with DHB CEOs, clinical leads and quality leads to remind them of the need to ensure the second COVID-19 vaccine dose is administered no earlier than 21-days after the first.
	• An action plan sets out the engagement completed and actions planned (including ongoing weekly reports to DHBs and other vaccination service providers) to ensure requirements relating to the first/second dose interval are met.
	
	Other safety and quality issues discussed
	
	• Mass vaccination events will need careful quality management oversight because of the volumes being handled.
	• Some 'division of tasks' appears to be occurring now in some situations (e.g. drawing up multiple vaccines at a time) which could be contributing to current quality issues and could also transfer into mass event situations.
	• Some issues may simply be data issues and need to be checked. For example, some incorrect expiry information has been identified in CIR.
	
	Decisions of the Steering Group
	
	In relation to discussions about paper *Early Second Dose – Identified issue and action plan Dose and related quality issues,* the Steering Group:
	
	a) **Noted** the contents of the paper *Early Second Dose – Identified issue and action plan,*
	b) **Noted** that several other areas were under consideration from a quality improvement perspective, and
	c) **Requested** that a paper be prepared for the Minister setting out the information on the quality improvement issues identified for CVIP and the actions being taken to address these.
	
	Action 3: draft Health report setting out the information on the quality improvement issues identified for CVIP and the actions being taken to address these. (Dr Juliet Rumball-Smith)

7.	**Any other business** The following papers were noted: • Paper 13 – Communications and engagement support for COVID-19 vaccine rollout • Paper 14 – Readiness update – confirmation of progress on outstanding items • Paper 15 – COVID-19 vaccine roll-out - International comparisons • Paper 16 – Workplace (vaccination) EOI update • Paper 17 – Update on vaccine delivery to Tokelau.
8.	**Next Meeting** Tuesday 27 July 2021, 4.30 p.m. – 6.00 p.m.

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COVID-19 Vaccine and Immunisation Programme Steering Group

Date:	Tuesday, 27 July 2021
	4.30 pm – 6:15 pm
Location:	1 N.3
Chair:	Dr Ashley Bloomfield
Members Attending:	Shayne Hunter, Shona Meyrick, Maree Roberts, Dr Ian Town, Deborah Woodley,
IIAG:	Keriana Brooking (co-Chair), Te Puea Winiata (co-Chair, part-time)
Other Attendees:	Andrew Bailey, Allison Bennett, Michael Dreyer (part time), Luke Fieldes, Jo Gibbs, Caroline Greaney, Dr Tim Hanlon, Chris James, Astrid Koornneef, Fiona Michel, Jason Moses, David Nalder, Mat Parr, Dr Juliet Rumball-Smith, Tamati Sheppard-Wipiiti, Jo Williams
Apologies:	Dr Dale Bramley (WDHB), Chris Fleming (SDHB), Rachel Haggerty (CCDHB/ HVDHB), Wendy Illingworth, Rachel Lorimer, Dr Caroline McElnay, John Whaanga

#	Agenda Item
1.	**Introduction and minutes** • The minutes from the previous meeting on 20 July 2021 were approved. • There were no matters arising. **Action tracker consideration** • The meeting considered each of the three action trackers in detail, updating several items. • Steering Group action [210629-02a] was granted an extension from 3 August to 10 August 2021. • Changes are reflected within the trackers.
2.	**Operational updates (Jo Gibbs/Luke Fieldes)**
2a.	**Programme Update** *Paper 3: COVID-19 Immunisation Programme Update – 25 July 2021* • Significant increase in numbers vaccinated last week – about 40 per cent week on week. However, still about 9 per cent below plan. • Expecting new supply of around 245,000 – 250,000 doses this week. We continue regular engagement with DHBs to ensure they have the ability to deliver to this. • The country's first mass vaccination event will be held 30 July-1 August at the Vodafone Events Centre, Auckland, hosted by MIT. Fully booked at 16,500 slots. Most bookings (12,500) are for Pakeha, non-Māori or non-Pacific people. A wide spread of age banding, however, few older people. This is expected noting that many in this older group have

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	either received their invitation through sequencing, or been vaccinated through Group 2 arrangements. • The event will provide valuable learnings for future events as we scale up.
2b.	**Reporting against the Success Framework** *Paper 4 tabled – COVID-19 Immunisation Programme Success Framework* • The four principles against which the success of the programme will be measured have been agreed by Cabinet (efficiency, equity, safety, experience). • This table is an early effort. It starts to populate the success framework with actual data. It will be updated to the Steering Group every fortnight. • Following the recent decision of the Minister for COVID-19, the denominator data used will be from the HSU rather than NHI. Data can be accessed at DHB level, by dose and overlaid by e.g. age band, ethnicity etc. • This reporting applies only to Group 4 data going forwards. **Group discussion** • IIAG members noted that given the Government commitment towards certain groups, and to then apply age bands in a certain way, the programme needs to be able to present this information clearly. • A question for the future was to understand the point at which it is understood from the data that there is a problem with any given district. • The potential to help to portray booking capacity was noted. ***Action 1: Ministry to run a split of forward bookings by age band and ethnicity (with a particular focus on young people, including those aged under 16 years).***
3.	**Immunisation Implementation Advisory Group update (Keriana Brooking/Te Puea Winiata)**

	• The key issues discussed at the IIAG meeting on 22 July were largely on the agenda for the meeting and could be picked up in detail then:
	  ○ Delivering for equity: specifically DHB delivery against their respective production plans. Noted that these plans do not take into account the cumulative effort made by some DHBs right from the start.
	  ○ Disability: IIAG members had a long discussion about work being done in the disability space, noting with some concern that this is some way off the work done to help meet the needs of Māori and Pacific peoples.
	  ○ Access to vaccination: noted the intention is to push harder into primary care to improve uptake in September/October. However there seems to be a variable approach to commissioning completion and it was felt that not all DHBs would be able to confirm primary care sector readiness.
	  ○ There is a preference from some older Group 3 people to be vaccinated at primary care rather than at mass events.
	  ○ Impact of environmental issues on CVIP delivery - e.g. tired workforce.
	• Concerns were also expressed that increases in the rates of pay for those providing COVID-19 vaccination had flow-on impacts for other vaccination services. In particular these rates may now be higher than rates paid for influenza vaccination. This has implications for the COVID-19 workforce.
	General discussion
	• Ministry officials indicated that at a national level the rates paid to influenza vaccinators were not lower than the rates for COVID-19 vaccinators. However, some providers have some pricing flexibility; the Ministry has little control over this. IIAG representatives were invited to contact Jo Gibbs if they wished to explore this further.

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	• Noted that the Steering Group needed a mechanism to ensure it does not lose sight of issued raised by IIAG and to ensure their resolution. ***Action 2 : Steering Group is to consider actions from future IIAG meetings in the same way as for other groups.*** • IIAG Members also reiterated a concern they had raised at their meeting on 22 July, being that the operational implications of policy proposals coming to the Steering Group often have not been scoped. This impacts on the ability of the Steering Group to make informed decisions. ***Action 3 : The need to ensure operational implications of policy proposals are assessed is to be discussed at the Programme Leadership Group meeting, and those presenting papers to the Steering Group must use the recently developed cover sheet.***
4.	**Equity (Jason Moses)**
4a.	*Paper 5 – Monitoring equity production plans* • Whilst DHBs are broadly meeting wider targets, overall they are performing at 59 per cent of their production plans for Maori. • Noted that delivery to Pacific people is well on track. **Group discussion** • We are now three weeks into Group 4 roll-out. Early performance signals for Māori in particular should be regarded as a red risk flag. The Steering Group did not accept some of the reasons for poor performance provided by DHBs. • The Ministry has done significant work with DHBs to develop their equity production plans. It is reasonable to hold DHBs accountable for the delivery. • In spite of the overall result, some DHBs have delivered to their plans, including Māori in the age sequencing bands. They are keen to commence vaccinating younger Māori, rather than wait for further age band announcements. • Consideration would be given to asking Vaccine Ministers to revisit their decisions to allow scope in operational delivery, delegated to the Ministry of Health **Decisions of the Steering Group** In relation to paper 5 – *Monitoring equity production plans – 27 July 2021,* the Steering Group: a) **Noted** that early indications are that overall, DHBs are not achieving their agreed equity targets; b) **Agreed** that a paper on the plan to improve equity results will be prepared for consideration by Vaccine Ministers at their meeting on 30 July 2021. This paper must take a public health approach and include: • the proportion of under 65 year old population (Māori, non-Māori, Pacific, non-Pacific) who have been vaccinated to date; • discussion on the impact of lowering age bands; • bespoke actions for each under-performing DHB, understanding their specific barriers; and • discussion on how DHBs that are performing well against their equity performance plans would be able to begin vaccinating younger age groups (with an equity focus) out of sequencing. c) **Agreed** that this matter will be discussed with Vaccine Ministers at their meeting on 30 July 2021.

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4b.	*Paper 5a – Update on rollout of COVID-19 vaccination programme for disabled people* • An action plan for increasing the rate of vaccination of people with disabilities was agreed at the previous meeting of the Steering Group. • Concerns have been expressed about data collection at a CVIP programme level. • Strong concerns have also been expressed about the lack of traction made into addressing the potential legacy improvements for nationwide understanding of the disability community into the future. • Concerns were also expressed that many of the CVIP communications are not reflection of the diversity of the disability population. • Concerns are not about funding, but about perceived lack of action. **Decisions of the Steering Group** In relation to paper 5 – *Monitoring equity production plans – 27 July 2021,* the Steering Group: **a) Noted** the issues and mitigations outlined in the paper associated to the disability rollout, ***b)*** **Agreed** that these matters will be discussed at the next meeting of the Programme Leadership Group to identify the most effective and appropriate response.
5.	**COVID-19 – Myocarditis/ Pfizer vaccine for 12-15 year olds/ use of Janssen vaccine** *Paper 6: Consideration of the risk of myocarditis and pericarditis, advice on the Pfizer COVID-19 vaccine for children and use of the Janssen vaccine*
5a.	**Views of Programme** • The paper is compiled following receipt of further advice from CV-TAG on use of the Pfizer vaccine, and receipt of the views of the regulator on these issues. • Noted that on 28 June 2021, Cabinet deferred its consideration of the use of Pfizer vaccine for 12-15 year olds pending further advice being prepared by CV-TAG at the request of the Director-General of Health. • In relation to 12-15 year the paper recommends that at this point, this age group should generally not be vaccinated because of their lower risk of poor health outcomes but suggests consideration could be given to identify a priority 'at risk' group in this age bracket. • In relation to the incidence of myocarditis and pericarditis, the paper suggests that an eight-week gap could be implemented, addressing both this issue and according robust protection from COVID-19. • The paper also notes that because of the certainty of Pfizer supply to New Zealand in 2021, this vaccine should continue to be used in roll-out. There are potential benefits to holding a second vaccine supply (including those who may be unable to receive Pfizer and in a supply shock/outbreak situation). s 9(2)(b)(ii)
5b.	**Views of CV-TAG** *(Myocarditis/pericarditis - Appendix 1 of Paper 6)* • CV-TAG notes that two doses of the Pfizer vaccine are recommended to achieve the maximum level of protection. This is also the basis of Medsafe's provisional approval. • Symptom onsets for myocarditis and/or pericarditis are usually evident within seven days. • A longer interval between doses may reduce some side effects and confer robust protection from COVID-19 (noting that there is an emerging view that delaying the second dose enhances immunogenicity).

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- CV-TAG recommends that people aged 16-29 years receive their second dose of Pfizer at least eight weeks after the first dose.
- People aged 16-29 years who require regular clinical review by a cardiologist should discuss their COVID-19 vaccination situation with their healthcare professional.
- Anyone who develops myocarditis and/or pericarditis after their first Pfizer vaccination should not receive a second dose.
- CV-TAG will continue to monitor this situation and provide advice as evidence becomes available.

*(Use of Pfizer for those aged 12-15 years – Appendix 2 of Pape*r 6)

- This advice is provided within New Zealand's very low prevalence context.
- There is relatively limited amount of data from trial, and limited experience internationally, about vaccination of children.
- Generally, children have a lower risk of poor health outcomes from COVID-19 infection.
- There is a safety signal out about myocarditis in people aged under 30 years receiving mRNA vaccines (such as Pfizer);
- There is no urgent need to move to vaccinating those aged 12-15 years. Consideration can be given to including vaccination of people in this age group if they are high risk.
- CV-TAG will review this situation once it has received expected advice from an external specialist.

Equity

- The paper contemplates several matters that have implications for the achievement of the desired equity results. For example, not extending the use of Pfizer to 12-15 year olds now may impact on uptake for those who might access the vaccine through whānau-based approaches this year.

5c. Views of the Regulator (Medsafe)

Verbal update – Medsafe regulatory update on the safety signal of myocarditis with Comirnaty (Pfizer COVID-19 vaccine)

- The Medsafe information in Paper 6 outlines its regulatory work in this area as well as the expert advice received along the way.
- Medsafe's regulatory view is the data currently available internationally indicates that there is a rarely-reported side effect of myocarditis associated with Pfizer vaccine. The data reported in New Zealand does not currently confirm this signal or if there is a higher risk in under 30s in New Zealand, however, numbers are small so care needs to be taken with interpretation.
- From a regulatory perspective, Medsafe considers the benefits of vaccination with the Pfizer vaccine outweighs the risks as per the approved indication and dosing.
- The emerging data shows the pharmacovigilance system is working well and this issue is an example of what is to be expected when identifying rare adverse reactions that clinical trials would be too small to pick up. The key regulatory objective is to ensure product information is updated and communicated to give consumers and health care professionals information.
- Medsafe has regularly discussed this issue with international regulators and is in line with international colleagues, including Australia. All regulators have added, or are about to add, information to the approved product information (datasheet). The New Zealand update is likely to be published shortly. The planned addition to the datasheet aligns with the communication Medsafe published last week. This was done to provide information to healthcare professionals on this rare side effect reported and what to look for. Noted there was little to no media follow up to Medsafe's alert.
- Regulators are not currently planning to take any other action such as making changes to approved indication or dosing. They maintain regular contact and will continue to update.

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	• Medsafe will continue to monitor this issue as new data becomes available and continue to get expert advice on the clinical significance and benefit risk balance of the vaccine in the approved indication. *Verbal update - Age range change for Comirnaty for 12-15 year olds (Pfizer vaccine)* • Pfizer applied for the indication to be extended to 12 years and over and submitted clinical trial data in support of that. Medsafe assessed that information against internationally agreed criteria and approved the extension of the indication. • The age range was also approved last week (week commencing 19 July 2021) in Australia. It has also been approved in other nations including the EU, the USA and Singapore.
5d.	**Group discussion on Paper 6** • It was observed that there was a close interrelationship between decisions regarding the incidence of myocarditis/pericarditis, and proposals relating to the time lapse between doses. • Noted that few jurisdictions are vaccinating those aged 12-15 years. • Based on current roll-out plans delivery to those aged under 30 years by the end of the year would be challenging. • Noted there is a difference between the programme view and the regulatory view. • Following its concerns raised earlier, the IIAG asked if this paper should have been provided to the Group for prior consultation noting operational implications of some aspects. • The Director-General and the regulator noted that there was a delineation between regulatory decisions and programme decisions. Much of the advice provided in this paper was of a regulatory or technical nature (i.e. from the Regulator and CV-TAG).
5e.	**Steering Group decisions – Paper 6** *In relation to Paper 6 – Consideration of the risk of myocarditis and pericarditis, advice on the Pfizer COVID-19 vaccine for children and use of the Janssen vaccine,* the Steering Group: **a)** **Noted** that CV-TAG has provided its recommendations on the risk of myocarditis and pericarditis in those aged under 30 years following vaccination with the Pfizer vaccine; **b)** **Noted** the perspectives of the Regulator in relation to myocarditis associated with the Pfizer vaccine, and in relation to use of the Pfizer vaccine on those aged 12-15 years; **c)** **Noted** that there are differences between the regulatory view and the proposals for programme delivery; **d)** **Noted** the need to maintain public confidence in COVID-19 vaccination; and **e)** **Agreed** that the issues raised in Paper 6 and their potential impacts will be further considered and a decision taken offline.
6.	**Risk update (David Nalder)**

	Paper 7: CVIP Programme risk summary for Steering Group – 27 July 2021
	
	• The risk profile has not changed. The higher project risks remain:
	    o Embedding equity
	    o Invitation and booking system
	    o Legislative and regulatory compliance
	    o Managing complexity and change.
	• All have established controls in place.
	• Embedding equity remains the key 'red risk'.
	• Actions are under way to manage the legislative and regulatory compliance risk (see Section 7c).

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	Group discussion • Noted that 36 new providers are being onboarded by Capital & Coast by the end of August (equity, invitation and booking system). **Decisions of the Steering Group** In relation to paper 7 – *CVIP Programme risk summary for Steering Group – 27 July 2021*, the Steering Group: **a) Noted** the map of inherent risks across the end to end vaccination process design; and **b) Noted** the actions in place to manage these top risks.
7.	**Progress against milestones** *Paper 9: CVIP Schedule Summary Update – 26 July 2021*. (This paper was noted.)
7a.	**Communications and Engagement (Jo Gibbs for Rachel Lorimer)** *Paper 9: Communications and engagement support for COVID-19 vaccine rollout* • Strong media interest in vaccine arrival two days early during the preceding week. • Public interest in Group 3 vaccinations/invitations. Papers 10 and 10a – *COVID-19 Vaccine 25-30 June 2021 (Horizon Research)* • Respondent sample showed 17.3 per cent of the population aged 16 years and over has been vaccinated (i.e. 705,100 people). This is in line with figures published by the Ministry of Health at 29 June 2021 (705,062). • The number who state they will 'definitely' be vaccinated has not changed from May. • The number who state they 'intend' to be vaccinated has gone down. • The number who state they were 'unlikely' to be vaccinated is 19% (i.e. 650,100 people). **Group discussion** • Noted that as the number of people vaccinated increases, the proportion of people who state they intend to be vaccinated will drop (equity, invitation and booking system).
7b.	**Clinical Safety and Quality (Dr Juliet Rumball-Smith)** *Verbal update* • The Ministry has worked with the service provider who identified an error through the end-of-day vial reconciliation, with five consumers for whom they cannot guarantee they received a vaccination. • The Ministry will work with the provider to agree on the clinical plan and associated communications. • Consideration will be given to prioritising these people for a booster when this becomes available and if it is considered appropriate.
7c.	**Workforce – Authorisation of Vaccinators (Fiona Michel)** *Verbal update* • s 9(2)(h) • The immediate focus is to authorise a group of about 400 vaccinators who applied for authorisation at the time the function was being transferred back to the Ministry. Most of these will be supporting CVIP roll-out. Forty-six authorisations were completed on 22 July and others are being worked through. • The Ministry is using clinical reviewers to provide additional rigour in the re-authorisation process. This will be an ongoing resource requirement.

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	• s 9(2)(h) • The Steering Group will be kept informed on this work.
7d.	**Operations – Stickers to label vaccine syringes and change in syringe supply** *Paper 12: Stickers to label vaccine syringes* • Three incidents of incorrect preparation of the vaccine are being investigated. • Initial findings show that one practice matter (also identified as occurring overseas) is common to all. To address this, it is proposed to change to a syringe brand (Unifix™) that has clearer markings and a more secure and resistant plunger than the brand currently used. • Most COVID-19 vaccines are single-dose vials. As Pfizer is a multi-dose vial, labelling of every syringe dose drawn up is also essential. A label has been developed and approval is sought to procure this. • A decision now will allow early action, noting the procurement and implementation lead times and noting that mass vaccination events are now under way. **Decisions of the Steering Group** In relation to paper 12, *Stickers to label vaccine syringes*, dated 27 July 2021, the Steering Group: **a)** **Noted** that in the future, Unifix™ syringes will be used for vaccination under the COVID-19 Vaccination and Immunisation Programme, **b)** **Approved** the creation, procurement and distribution of Pfizer vaccine stickers, and **c)** **Approved** the addition of the newly created Pfizer vaccine stickers to the consumables packs.
8.	**Any other business** The following papers were noted: • Paper 13: CVIP Outcome Measures – Status update – 26 July 2021. • Paper 14: COVID-19 Vaccination and Immunisation Programme – Privacy and security Assessment – 21 July 2021. • Paper 15: Progress of the COVID-19 Vaccination and Immunisation Programme roll-out.
9.	**Next Meeting** Tuesday 3 August 2021, 4.30 p.m. – 6.00 p.m.

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Minutes

MINISTRY OF HEALTH
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COVID-19 Vaccine and Immunisation Programme Steering Group

Date:	Tuesday, 3 August 2021
Time:	4.30 pm – 6:30 pm
Location:	1 N.3
Chair:	Dr Ashley Bloomfield
Members Attending:	Dr Dale Bramley (WDHB), Chris Fleming (SDHB), Shayne Hunter, Dr Caroline McElnay, Maree Roberts, Dr Ian Town, John Whaanga, Bridget White, Deborah Woodley,
IIAG:	Keriana Brooking (co-Chair)
Other Attendees:	Andrew Bailey, Vince Barry, Allison Bennett, Michael Dreyer, Jo Gibbs, Caroline Greaney, Dr Tim Hanlon, Matt Jones, Astrid Koornneef, Rachel Lorimer, Fiona Michel, Jason Moses, David Nalder, Mat Parr, Jo Williams
Apologies:	Rachel Haggerty (CCDHB/ HVDHB), Wendy Illingworth

#	Agenda Item

1.	**Introduction and minutes**
	• The minutes from the previous meeting on 27 July 2021 were approved with minor amendments.
	
	Late arrival apologies
	• Jason Moses submitted an apology for lateness due to a concurrent meeting.
	
	Matters arising
	• The Steering Group was reminded of the active interest of the Governance Group in the following matters:
	    o Māori Communications Strategy
	    o Effective internally-led assurance.
	• The importance of the associated deliverables meeting their due dates was emphasised.
	
	Action tracker consideration
	• The meeting considered the three action trackers in detail, updating several items. These changes will be reflected in the papers for the next meeting.
	• To recognise the timing of the event debrief and the cycle of PLG consideration of papers to Steering Group, a Vaccine Ministers action – *provide update on lessons learned from the Mass Vaccination Event* - was granted an extension from 6 August to 17 August 2021.
	
	Action 1: Add agenda item to Governance Group meeting for 13 August – Timing of future Assurance activities (David Nalder).

2.	**Operational updates (Jo Gibbs/Astrid Koornneef)**

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2a.	**Programme Update** *Paper 3: COVID-19 Immunisation Programme Update – 1 August 2021* • New Zealand has achieved 2 million vaccinations. Volumes are about 40,000 per day. • About 25 per cent of the population have had their first dose and about 15 per cent are fully vaccinated. • There will be some 'tight' supply points over the next few months. However, currently supply is not restraining any provider and all are receiving the amounts requested.
2b.	*Papers 3a and 3b tabled: 65+ yrs Coverage (booked and vaccinated); 60-64 yrs Coverage (booked and vaccinated)* The tabled papers show the overall numbers of vaccinations booked across DHBs. The data can be split by DHB, ethnicity and age group. • Most DHBs are tracking well across older age groups. • Three DHBs (Southern, Nelson/Marlborough, Lakes) have either completed or significantly completed vaccinating their populations in the sequenced age groups. To keep momentum, and avoid unused capacity, the Ministry proposes to seek ministerial agreement to allow them to begin vaccinating those in the next age band (55 years and over) a few days earlier than announcement. • The Ministry is proactively talking to DHBs needing assistance in reaching some of their groups of people about proactive campaigns (potentially using Whakarongorau) to assist. • Noted that the tables do not show primary care. **General discussion** • The charts help to show DHB capacity to deliver. DHBs are variously booked as far out as November 2021. • Noted that DHBs are all bringing on additional resources to ensure they can get up to their peak delivery. • Considerations for early age band access by some DHBs include ensuring that an equitable coverage is maintained for members of this age group in these DHB regions. • There will be operational implications if some DHBs are approved to move into vaccinating the age bands earlier than others. IT changes will be needed to ensure that the booking system allows them access; the capacity of the national call centre will need to be checked. ***Action 2: The Director-General will discuss early age band access by some DHBs with Hon Hipkins.***
2c.	**First Mass Vaccination Event (Vince Barry)** • The Ministry worked with the Northern Region Health Co-ordination Centre to hold the first mass vaccination event 30 July to 1 August, at the Vodafone Events Centre, Manukau. • Total vaccinated - 15,731 people (target 15,500). • Smooth vaccination and observation processes. St John Ambulance provided observation services. Positive feedback received from attendees. • High-quality clinical, draw-up and cold chain processes were maintained at scale, with clear audit traceability. • Very low levels of vaccine wastage, and a lower than expected number of adverse events reported. • About 15 per cent of bookings did not show; offset by a high number of walk-in bookings. • Some initial opportunities to streamline processes have been identified. A full debrief will be held and the Ministry will update its guidance to DHBs considering mass vaccination events. *Communication from DPMC*

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	• The Director-General noted that he had received a communication from the chief executive of the Department of Prime Minister and Cabinet, congratulating the Ministry on the successful running of the first mass vaccination event in Auckland. • The Director-General added his own personal commendation and thanks to all who had contributed to the success of this event. ***Action 3: Report on lessons learned from the mass vaccination event to be considered by the Steering Group on 17 August.***
3.	**Science and Technical update (Dr Ian Town)**
	• *Myocarditis:* The CV-TAG will circulate its advice regarding myocarditis and pericarditis after vaccination. The advice is precautionary, to the effect that if myocarditis or pericarditis arise, the person should not receive their second vaccine dose. • *Use of Pfizer by 12-15 year olds*: Neither CV-TAG nor the Strategic COVID-19 Public Health Advisory Group (chaired by Sir David Skegg) strongly recommend immediate vaccination of this group. However, young people should be considered if they are 'at risk' (e.g. because they themselves, or those they live with, are immunosuppressed). • *Interval between doses*: CV-TAG will provide advice and talking points for the Director-General about the approaches of other jurisdictions. Noted that internationally, pragmatic decisions are being made because there is, as yet, no evidence to support decision-making. • *Booster vaccination*: Advice about booster vaccines will be completed over the next two or three weeks. • Co-administration of vaccines: CV-TAG is preparing an update of co-administration of the COVID-19 vaccine and the influenza and MMR vaccines in the National Immunisation Programme. • CV-TAG is working with the Behavioural Insights Group to develop approaches to continue to stimulate uptake right across the duration of the programme, including in an environment of high rates of full vaccination. **General discussion** • A question was raised about the use of 'third dose' vaccination to improve protection against COVID-19. There is very little evidence to support this. Trials undertaken show that the antibodies present in a vaccinated person after 12 months were just as high as they were immediately after vaccination. CV-TAG will monitor developments. • Noted that the current priority for New Zealand is to effectively address the risks posed by the changing virus. • Noted that, applying an equity lens to uptake by 12-15 year olds, the expert advice was not 'don't do it' but 'start with these groups'. Agreed that a programme decision will need to balance out protection of individuals and concerns about younger people being 'reservoirs of infection' (per the current Sydney schools outbreak situation). • Further consideration will be given to these issues, noting the interdependencies across the programme.
4.	**Eight week period between vaccinations (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 has done early thinking on how this might be implemented in Aotearoa New Zealand:

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- There are currently 600,000 people who have forward booked their second dose and consideration needs to be given as to the best way to manage these bookings. They could be given the option to change, or a change to the booking system technology could do this automatically and mirror the appointment for six weeks out.
- New bookings could immediately be forward-booked at six weeks.
- Having a thorough understanding of the ability of DHBs to accommodate these changes, including forward booking capacity, is critical.

General discussion

- Clear communications will be essential to retain confidence in the '*Book my Vaccine'* system, particularly for those who have already received both doses.
- A bulk move of current second dose bookings will create spare slots that will 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.
- Need to consider the flow-on impacts for DHB production plans.
- Need to consider the likely impacts on equity. However, it was noted that the delay of the second dose (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.
- Whānau-based initiatives could be given priority for the newly created spare slots.
- Clinical impacts for individual need to be considered. Some people will need to maintain the shorter 'between dose' period to align within their clinical care.
- Noted that from a wider clinical perspective it was considered important not to overstate the U.K. research. However there were no obvious downsides to the approach, noting that New Zealand's three-week period was one of the decisions taken during the initial pandemic period. It was considered the discussion to be had was more about the complexity of operationalising.
- DHBs were comfortable with the timeframe extension, but concerned that the longer the gap between vaccinations, the harder it may be to get people to return if their second vaccine was no longer 'top of mind'.
- DHBs suggested a preference to give those who already have their second appointment booked should be able to choose whether to proceed as booked, or to extend the date.
- Impact on DHB operations and the workforce need to be identified.

Decisions of the Steering Group

In relation to the proposal that there should be an eight week period between the first and second COVID-19 vaccination dose, the Steering Group:

a) Noted that there appear to be good reasons why New Zealand should consider implementing a longer internal between the first and second COVID-19 vaccine doses; and

b) Noted that written advice on the options to implement a longer interval will be provided for consideration by Vaccine Ministers.

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5. 6.	**Update – DHB local activities to reach Māori or Pacific peoples (Jason Moses)** ***and*** **Equity Monitoring Reports (Jason Moses)**
	Paper 4 – Equity Presentation • Māori have a significantly younger population composition than do non- Māori. Under the Sequencing Framework we will start to see Māori being vaccinated at the same rate as non-Māori from the 55+ years band (expected to be late August). The Pacific population has a similar spread. • Mass event – 7 per cent of attendees were Māori; 12 per cent Pacific people. • Most Māori providers are vaccinating now, either under contract to DHB or directly. • DHB vaccination for Pacific people is generally going well (see table page 6) but some areas need better targeting to lift performance. • Working with DHBs to identify what they are doing locally to increase their uptake. This differs by region, but includes marae-based services, festivals, promoting a whānau approach, in some areas (e.g. rural) promoting a community approach, and promoting walk-ins. • Some disability stakeholders have indicated concerns that people with disabilities should have been included in Group 2 or Group 3 sequencing. A discussion will be held with Tātou Whaikaha to make better traction into vaccinating this group. Noted that the vaccination acceptance rate for people with disabilities is 80 per cent. **General discussion** • Important to ensure that Ministers have visibility of the wide range of actions being taken to promote vaccination uptake by Māori, nuanced at a local level. • Both the community approach and whānau approach capture a wide range of people. However, the booking system currently does not provide for either. The Ministry is aware of this and actively looking for ways to support both approaches. • Noted that while current rates for older Māori and Pacific people are low (as expected through the sequencing), the tables generally show a better overall vaccination scenario for these groups than is reflected in public commentary. This data should be published. • Noted that whilst DHBs had targets, we also need to be confident these targets were appropriate. This means understanding where any given DHB's targets sit as a proportion of total Māori or total Pacific in their area, and where they sit compared to other DHBs. • The story that matters is the proportion vaccinated, by age band and ethnicity. • A concern was noted about the use of the HSU as a denominator for reporting performance, when production plans are based on the Statistics NZ denominator, as this affects comparability. The Ministry noted that it would work with DHBs to revise their plans. **Decisions of the Steering Group** In relation to paper 4 – *Equity Presentation* – dated 2 August 2021, the Steering Group: a) **Noted** that breakdowns of vaccination rates for Māori and Pacific people, and for non-Māori and non-Pacific people, by age group, will be published on the Ministry of Health's website from about 6 August 2021, and updated on a regular basis.

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7.	**Support for people who have had a serious AEFI (Dr Juliet Rumball-Smith, Dr Tim Hanlon)**
	Paper 5: Overview of system-level support for consumers who experience serious adverse events following immunisation – 3 August 2021 • Whilst only a small proportion of consumers who report an adverse event following immunisation (AEFI) following COVID-19 immunisation report a serious AEFI (around 4%), due to this being a national vaccination programme, this means that the numbers of consumers reporting a serious AEFI will still be significant (currently >350 consumers). • If this occurs at the vaccination site, initial treatment is managed at the site but may involve transfer to emergency services for assessment or follow-up from a primary care or specialist service provider. Consumers may initiate a treatment Injury claim with ACC. • There is a potential need for a service to support consumers who experience serious AEFIs to help them navigate the health system and to give them confidence that their issues have been acknowledged. • Six options were presented for discussion by the Steering Group. • Noted that putting additional support in place may also help to increase awareness about the nature and incidence of serious AEFIs at a health professional and programme level. **Group discussion** • There is an awareness that, certainly in relation to COVID-19 vaccination, affected consumers want to know that someone in 'the system' is aware of and acknowledges their experience. However, there is no sense that people have wider expectations. • Current approaches differ significantly by region. A centralised and consistently applied response nationally will better support confidence in the roll-out. • Noted that this type of support is not typically an action that would be taken by the Ministry for an adverse event arising from other treatment. Consideration needs to be given to wider application. It was also suggested that the fact that COVID-19 vaccination is free and applies to all New Zealanders may allow for a different approach. **Decisions of the Steering Group** In relation to paper 5 – *Overview of system-level support for consumers who experience serious adverse events following immunisation dated 3 August 2021*, the Steering Group: **a)** **Noted** the current arrangements in place at a system level for consumers who experienced a serious AEFI as a result of COVID-19 vaccination set out in the paper; **b)** **Agreed** that the CVIP would move to implement Option 2 (Extension to Status Quo) as quickly as possible building to Option 5 (website-based information) and Option 6 (a national follow-up co-ordination pathway) as soon as practicable.
8.	**Progress against Milestones (Andrew Bailey)** *Paper 6: CVIP Schedule Summary Update – 2 August 2021.* • No changes to 'traffic light' status over the previous week. • Payments to some primary care providers are causing concern *(see Item 8a. below)*. • Wider system pressures (relating to winter season) have been flagged by DHBs.
8a.	**Improving Access to Vaccination - Primary Care (Dr Joe Bourne/Astrid Koornneef)** *Paper 7: Vaccination Sites – Onboarding – 2 August 2021* • Currently have 361 active primary care sites, of which 113 are pharmacies, 118 are medical centres, and 30 are marae-based or Hauora providers. • 89 sites onboarded in the week to 30 July 2021.

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	• Working with DHBs to understand how they are onboarding primary care over the next few months. Potentially will use a bigger cohort of primary care providers to get to scale. • The programme is getting very good engagement from DHBs. Noted that DHBs are also providing a lot of support to each other. • Key approach differences relate to the ability of the smaller DHBs to cope with the extra workload. • It is important to ensure that DHBs have in place the appropriate contracts with their primary care providers so that these providers can receive funding without delay. The Ministry has written to CFOs of all DHBs to remind them of this. ***Action 4: Add 'Primary Care Roll-out' to the agenda for the Steering Group meeting on 10 August.***

8b.	**Communications and Engagement (Rachel Lorimer)**
	Paper 8: Communications and engagement support for COVID-19 vaccine rollout - 2 August
	• Significant achievements in the past week include:
	  ○ Second vaccination of the Prime Minister;
	  ○ Arrival of the first vaccine shipment into the South Island hub;
	  ○ Vaccination roll-out in Stewart Island;
	  ○ Launch of the 0800 number for people in Group 3;
	  ○ Medsafe approval of AstraZeneca for New Zealand.
	• The Ministry is now doing daily reporting of numbers vaccinated.
	• Focus groups are being held for those aged 60+ yrs. Noted their feedback doesn't quite match with the wider research report, in that the focus group members respond well to current campaign approach. This will be considered further.
	• Consideration being given to how the 'good news stories' can be used in public communications.

9.	**Any other business** ***Vaccinator status (Fiona Michel)*** • Total vaccinators for COVID-19 now over 10,000. Over 2,000 of these are enrolled vaccinators, most of whom are Māori. • Good progress has been made with processing the approximately 400 vaccinators who had applied for authorisation at the time the authorisation function was being transferred back to the Ministry. Most of these are now authorised. The meeting closed at 6.30 p.m.
10.	**Next Meeting** Tuesday 10 August 2021, 4.30 p.m. – 6.00 p.m.

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MINISTRY OF HEALTH
MANATŪ HAUORA

Minutes

COVID-19 Vaccine and Immunisation Programme Steering Group

Date:	Tuesday, 10 August 2021
Time:	4.30 pm – 6:00 pm
Location:	1 N.3
Chair:	Dr Ashley Bloomfield
Members Attending:	Chris Fleming (SDHB), Dr Ian Town, John Whaanga, Bridget White, Deborah Woodley,
Other Attendees:	Vince Barry, Dr Joe Bourne, Luke Fieldes, Michael Dreyer, Jo Gibbs, Caroline Greaney, Dr Tim Hanlon, Wendy Illingworth, Chris James, Matt Jones, Astrid Koornneef, Rachel Lorimer, Colin MacDonald, Rachel Mackay, Fiona Michel, Jason Moses, David Nalder, Dr Juliet Rumball-Smith, Jo Williams
Apologies:	Andrew Bailey, Dr Dale Bramley (WDHB), Keriana Brooking (IIAG co-chair), Rachel Haggerty (CCDHB/HVDHB), Shayne Hunter, Dr Caroline McElnay, Maree Roberts, Te Puea Winiata (IIAG co-chair)

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#	Agenda Item
1.	**Introduction and minutes** • The minutes from the previous meeting on 3 August 2021 were approved. • There were no matters arising. **Matters for meeting focus** • Key areas raised by members for focus at this meeting: o Readiness for extending vaccination to 12-15 year olds o Communications plans o Contingency planning o Age banding o CV-ISMB meeting. **Action tracker consideration** • The meeting considered the three action trackers in detail, updating several items. These changes will be reflected in the papers for the next meeting.
2.	**Operational updates (Jo Gibbs/Astrid Koornneef)**
2a.	**Programme Update** *Paper 3: COVID-19 Immunisation Programme Update – 8 August 2021* • First doses now at 1.37 million, and 816,000 second doses. • All DHB regions are recording increased levels of vaccination.
	2a. Cont.

	• Anticipate that New Zealand will have a million fully vaccinated people in the week commencing 9 August. • Focus on developing guidance on the changes to the interval between doses. • Good data being received through the portal. We have a good system overview of stock in hand and supplies. ***Age banding*** • DHBs raised a concern that there was unused vaccination capacity in the regions because of the age banding constraints. This would become more pronounced with the longer interval between doses. DHBs are very keen to continue to vaccinate to their capacity. • Noted that the next age band announcement was likely to be made a little earlier than originally planned and there was an expectation that age band restrictions may free up significantly in the foreseeable future. • Different DHBs are at different stages. Some of the larger DHBs have solid forward bookings, but some of the smaller DHBs are receiving support (e.g. outwards calling) to fill their booking spaces. • Some regions endeavouring to focus on whānau bookings are encountering some issues with the booking system. The Ministry advised this is something they are aware of and are looking to identify a solution for.
2b.	**COVID-19 Vaccine Independent Safety Monitoring Board (CV-ISMB) (Dr Tim Hanlon)** *Verbal update* • The CV-ISMB met to consider the death of a s 9(2)(a) consumer a few days after first dose vaccination and with a cause of death on post-mortem given as myocarditis. Noted that this case also had s 9(2)(a) . • The forensic pathologist who conducted the post-mortem presented his findings to the board. • The board will now write to the Director-General and CVIP National Director outlining its views and any suggested actions for CVIP. • Some changes to communications to the sector about early detection and treatment of post-vaccination myocarditis are likely. • The Ministry confirmed it is providing support to s 9(2)(a) of this consumer. **Group discussion** • The regulator noted that Medsafe will consider the recommendations from the Board and assess their implications for the content of its Pfizer/Comirnaty safety alert.
3.	**Update from Immunisation Implementation Advisory Group meeting – 5 August 2021 (Caroline Greaney)**
	Key areas of focus and discussion were: • IIAG value proposition: members need to feel that they both add value to COVID-19 vaccination implementation planning and receive value back. Many members are directly involved in service provision and need to be satisfied that their significant time allocation to IIAG is justified. • Commissioning: national consistency for service procurement is essential, particularly as increasing numbers of primary care providers come on board the programme. Members continue to have some concerns about funding adequacy and funding flows, and would like to see if the Ministry can promote more consistency in how DHBs apply their 'special needs' funding. The possibility of a rural adjustor was flagged. • Achieving equity: under IIAG Terms of Reference, members have a strong ongoing interest in equity performance and noted the recent move to use Heath Service Utilisation (HSU) data as a denominator for future reporting. They reinforced the need to

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	ensure that reporting across the wider programme was comparable. (The Ministry confirmed it would work with DHBs to adjust their plans.) • Vaccination for 12-15 year olds – IIAG input included the subsequent comms and engagement challenges that would arise because of the multiple prioritised groups, the interface of this age cohort with other immunisation programmes, the need for a consent process, DHB capability and capacity to incorporate this group into production plans, and the need to consider equity impacts.
4.	**Reporting against the Success Framework (Luke Fieldes, Astrid Koornneef)**
	Paper 4: CVIP Outcome Measures – Status update – 10 August 2021 • At a high level this reporting shows that we are making good progress with a notable increase in uptake dose 1 uptake by those aged 60-64 since 28 July 2021 (roll-out date). For Group 3, there is significantly higher uptake by people with at least one long term condition (LTC) than by those without an LTC. Average waiting times have reduced over the previous week. High vaccine usage rate. • Group 3 faces issues relating to uptake by Māori, irrespective of sequencing. • Noted that Māori, Pacific and Asian groups have a larger proportion of bookings for younger age groups. Other groups are more heavily represented within the older age groups. This is not necessarily unexpected as it coincides with the shape of population distribution. **Group discussion** • Noted that efficiency measures still show performance above plan, however, the plan does not move forwards in equal increments and this can impact on delivery. • Observed that there are a reasonable number of 40-50 year olds in forward bookings who have qualified outside of age banding. • Geospatial work is under way to consider factors influencing attendance at vaccination sites and to help with future modelling. Considerations include population density in the area within a 30 minute drive time of the site, vehicle ownership, and public transport availability.
5.	**Readiness for extending vaccination to 12-15 year olds (Jo Gibbs)**
	Verbal update • This matter is under active consideration. Cabinet will consider advice on options to extend the Pfizer vaccine to 12-15 year olds on 16 August. • A small team has been set up inhouse to consider the implementation approach.
6.	**Māori, Pacific Peoples and Disability communications (Rachel Lorimer)**
	Paper 5: Communications Update: Māori, Pacific and Disability – 10 August 2021 *Papers 6 and 6a: CVIP – Māori Communications Strategy* • The Governance Group has noted its strong focus in being assured that the programme has in place a Māori Communications Strategy to support achievement of the CVIP equity objectives. • The Ministry has allocated funding for engagement with communities to help to remove barriers to uptake of vaccination services. This activity sits alongside 'mainstream' media promotion. • Minister Henare has a clear interest in understanding how a communications plan supports funding allocations to achieve the desired outcomes for Māori.

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	• The Ministry is working with the Cause Collective to help to engage with Pacific communities. • A meeting has been held with Hon Carmel Sepuloni regarding engagement with disability communities. **General discussion** • Noted that in addition to the broader strategy, the Governance Group was also very interested in what was happening at a local level to increase uptake. • Members noted that the draft documents contained strong context, drivers of behaviour, and risk assessment. Noting the Governance Group's focus, some strengthening of actual approaches (at the back of the paper) was needed. **Decisions of the Steering Group** In relation to paper 5 '*Communications Update: Māori, Pacific and Disability'* and papers 6 and 6a '*CVIP – Māori Communications Strategy'* the Steering Group: a) **Noted** the programme of work set out in paper 5 that is being undertaken by the CVIP Programme to facilitate communications and engagement for Māori, Pacific and Disabled Populations, and b) **Requested** that paper 6 and 6a be strengthened to include more detail on the actual approaches that are to be used in the regions to help to support the roll-out of COVID-19 vaccinations for Māori.
7.	**Contingency planning for workforce during Alert Levels 3 and 4 (Fiona Michel)**

	Paper 7: Contingency planning for workforce during Alert Levels 3 and 4 – discussion paper, 10 August 2021
	
	• This discussion paper sought guidance on the focus for policy development for contingency planning to ensure the vaccination workforce had the capacity to meet the likely expected increased demand for vaccination during higher alert levels.
	• Current vaccination workforce about 10,000 though not all are full time.
	• Four options are outlined:
	  ○ option 1 – Using Defence Force personnel;
	  ○ option 2 – reprioritising DHB workforce;
	  ○ option 3 – contracting a 'reserve' vaccination team that can be deployed into affected regions;
	  ○ option 4 – Activating mass vaccination, primary care and drive through models (noting this was an implementation approach rather than being directly a workforce issue).
	
	Group discussion
	
	• Noted that at Alert Level 3 and 4 were quite likely to be applied at a regional rather than national level.
	• Option 1 was not considered a strong option given NZDF was already fully engaged in running managed isolation facilities and associated activities.
	• Option 2 was noted as a stronger option for summer, when the health workforce was not already stretched covering winter illness cases. However, consideration should be given to extending the scope of those included e.g. surgeons and highly trained clinicians could be given prior training as their services all but stopped during AL4. Also consider plunket nurses and other nurse-based services.
	• The need to protect the workforce who would otherwise be required during a high alert level was noted.
	• Noted that this work was an extension of DHB resurgence planning.

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	Decisions of the Steering Group In relation to paper *7: Contingency planning for workforce during Alert Levels 3 and 4 – discussion paper, the Steering Group:* **a)** **Did not agree** to further explore Option 1, noting that the demands on the NZDF workforce are ongoing; **b)** **Agreed** that the Option 2 should be developed to include consideration of how other health service providers who are unlikely to be utilised during high alert levels (e.g. specialists, surgeons, highly trained clinicians, plunket nurses and other nurse-based services) can be redeployed into vaccination during Alert Levels 3 and 4; **c)** **Agreed** to retain and further develop Option 3, noting this appeared to be more of a reallocation of the current workforce; **d)** **Agreed** to retain and further develop Option 4, noting this was a service delivery mechanism; and **e)** **Noted** it would receive an updated paper with detailed policy options and recommendations in early September 2021. • ***Action 1: Prepare a paper with detailed policy analysis and recommendations, for consideration by the Steering Group on 7 September 2021. [Fiona Michel]***
8.	**Amendments to Medicines Regulations 1984**
	Paper 8: Amendments to Medicines Regulations 1984, Schedule 1 • The issues in this paper were outlined and discussed. It was noted that decisions on this matter had implications for service delivery more widely than COVID-19 vaccination. It was decided that this paper would be further considered and decisions taken outside of the Steering Group.
9.	**Risk Update (David Nalder)**
	Paper 9 – CVIP Programme risk summary for Steering Group – 10 August 2021 • The Programme Leadership Group (PLG) continues to review programme risks every fortnight. Current risks relate to delivering to scale, and achieving uptake, with a focus on equitable uptake. • A new risk is added to the high level 'Experience' category risk, being 'public apathy'. This would impact on uptake. • Specific issues to note are the operational implications of any move to change the time between doses where a broad range of issues will need to be considered. These include communications managed, the impact on invitations and bookings, inventory management and digital enablement. **Decisions of the Steering Group** In relation to paper 9*: CVIP Programme risk summary for Steering Group, the Steering Group:* • **Noted** the map of inherent risks across the end-to-end vaccination process design; and • **Noted** the actions in place to manage these risks.

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10.	**Progress against Milestones (Andrew Bailey)** *Paper 10: CVIP Schedule Summary Update – 9 August 2021*
10a.	**Improving access to vaccination – primary care roll-out (Astrid Koornneef)** *Verbal update* • Currently have 386 active primary care sites (up from 361 last week), including pharmacies, medical centres, and marae-based or Hauora providers. • 43 sites onboarded in the week to 8 August (89 in the week to 30 July 2021). • Noted that the Royal New Zealand College of General Practitioners sets accreditation standards for general practice. It believes its Foundation Standard aligns with most of the Covid Vaccine Immunisation Programme Standards. The College is writing to all DHBs setting out where there is alignment and where there are gaps. The aim is to provide a degree of assurance to DHBs so that they can reduce the administrative burden of some of the onboarding process for general practice. However, we are ensuring that DHBs are aware that ensuring services are delivered to an appropriate quality remains their responsibility.

10b.	**Workplace vaccinations update (Rachel Mackay)**
	Verbal update
	
	• EOI for workplace vaccination closed 23 July with 330 responses, primarily from workplaces across a range of sectors. Some interest from service providers.
	• Immediate response process on:
	    o workplaces with over 1,000 workers
	    o smaller workplaces that have a strong focus on Māori, Pacific, disability, or rural groups.
	• The two pilot employers (Mainfreight, Fonterra) will both have completed their first round by 11 August. The Ministry will debrief with both on the learnings from these pilots.
	• Engagement under way with the supermarket sector, as essential service providers. Noted that the Minister will be addressing groups on this and the Ministry has provided talking points.
	• Also working with the Public Service Commission on government agency workplace vaccination planning.

11.	**Any other business** The following papers were noted: • Paper 11 - Update: Communications and engagement support for COVID-019 vaccine rollout. • The meeting closed at 6.00 p.m.
12.	**Next Meeting** Tuesday 17 August 2021, 4.30 p.m. – 6.00 p.m.

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Minutes

MINISTRY OF HEALTH
MANATŪ HAUORA

COVID-19 Vaccine and Immunisation Programme Steering Group

Date:	Tuesday, 17 August 2021
Time:	4.30 pm – 5.05 pm
Location:	4 S.5
Chair:	Maree Roberts for Dr Ashley Bloomfield
Members Attending:	Dr Dale Bramley (WDHB), Chris Fleming (SDHB), Jo Gibbs, Shayne Hunter, Wendy Illingworth, Deborah Woodley,
IIAG:	Keriana Brooking (co-Chair)
Other Attendees:	Dr Joe Bourne, Michael Dreyer, Caroline Greaney, Astrid Koornneef, Rachel Lorimer, Rachel Mackay, Jason Moses, Dr Juliet Rumball-Smith
Apologies:	Dr Ashley Bloomfield, Andrew Bailey, Dr Tim Hanlon, Dr Caroline McElnay, Fiona Michel, Dr Ian Town, John Whaanga, Bridget White

#	Agenda Item
1.	**Introduction and minutes** • The minutes from the previous meeting on 10 August 2021 were approved. **Apologies** • Noted that Chair Dr Ashley Bloomfield and several members had submitted apologies given the concurrent meetings being held to announce and manage the new community case just confirmed in Auckland. **Matters arising** • Cathy O'Malley, General Manager Strategy Primary Community, Nelson/Marlborough DHB has been appointed Chair of the DHB SRO (Senior Responsible Officers) group. She will attend future meetings of the Steering Group in this capacity. The Group thanked Rachel Haggerty (CCDHB/ HVDHB) for covering this role in recent weeks. **Action tracker consideration** • No changes. ***Action 1: Add Cathy O'Malley, Chair of SRO Group, to future meetings of the Steering Group. [Secretariat]***
2.	**Meeting approach**
	• The Acting Chair advised that due to the identification of a new community case in Aotearoa New Zealand and the need for most of the leadership team to be focussed on

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	management of the response, today's meeting would consider only those papers requiring decision: o Papers 5 and 5a – Highbrook incident and management plan; o Paper 6 – Cabinet 'decision to use': the 12-15 year age cohort implementation requirements; o Paper 9 – General Practice and Pharmacy COVID-19 Vaccination Programme.
3.	**Immediate programme response to community case identification (Jo Gibbs)**
	• A formal 'Vaccine IMT' is being set up. • Working on basis that for any region in Alert Level 4, vaccination will stop for a short period to minimise people movement, and allow for planning. (One DHB noted it had already reassigned vaccination staff to swabbing.) • Blueprints for response (including drive through vaccination models) are already developed and will be implemented. • Noted a significant increase in bookings through the national call centre.
4.	**Clinical safety and quality (Dr Juliet Rumball-Smith)**
	Papers 5 and 5a - Highbrook incident and management plan • The Ministry has been working with the NRHCC and the service provider which identified a mismatch of clients and vaccine used through its end-of-day vial reconciliation. It cannot guarantee that five consumers received their full vaccine dose. • The Ministry has done extensive consultation to consider the approaches that could be used, including learnings from Queensland, which has had a similar incident and is offering affected persons a third dose. The Ministry will remain in touch with Queensland authorities to gain any further learnings and their response progresses. • Noted that 'third dose' use has gained some traction overseas, particularly for those who are immunocompromised. **General discussion** • Members strongly supported that affected individuals must be advised of the issue and be given the opportunity to make a decision. • Members also noted that the provider's identification and reporting of this situation demonstrated that the CVIP safety and quality systems that are in place are working. Follow-up actions can now be taken, and relevant improvements to procedural changes can be made to mitigate the risk of future occurrence. • Whilst understanding that the provider was within the NRHCC geographic region, members strongly agreed that management and accountability sat at a CVIP programme level. • New Zealanders must retain confidence in COVID-19 vaccination. Resolution considerations will include relationship management, comms and engagement, and assessing operational implications. **Decisions of the Steering Group** In relation to the paper *Highbrook incident and management plan dated 17 August 2021*, the Steering Group: • **Noted** the contents of the memo and attached incident report; and • **Agreed** that the CVIP programme would lead the management response in relation to this incident, working closely with the Northern Regional Health Co-ordination Centre.
5.	**Implementing vaccination of 12-15 year olds (Astrid Koornneef)**

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	Paper 6 - Cabinet 'decision to use' - the 12-15 year age cohort implementation requirements, 16 August 2021
	
	• Cabinet has agreed that 12-15 year olds will shortly be eligible for COVID-19 vaccination.
	• The paper outlines the key implementation considerations including:
	  ○ Communications;
	  ○ Informed consent;
	  ○ Delivery approaches;
	  ○ Ensuring technology supports the changes.
	• Preferred implementation approach is to start with 12-15 year olds who accompany parents.
	• Working with Crown Law Office to ascertain the informed consent processes necessary to support widened eligibility (i.e. 12-15 year olds who do not accompany parents).
	
	General discussion – implementation readiness
	
	Confirmed as on track for implementation:
	• Technology changes (to CIR and national booking system) expected to be online from 18 August.
	• The national call centre has confirmed it can support from 19 August onwards.
	• Noted that key stakeholders including IMAC are or will soon be contacted re this decision.
	• Next steps include developing a 'change canvas' to provide a high level assessment of the impact of the change on existing programme settings/collateral and to identify any new risks/mitigations.
	
	Decisions of the Steering Group
	
	In relation to the paper *Cabinet 'decision to use': the 12-15 year age cohort implementation requirements dated 16 August 2021*, the Steering Group:
	
	a) Agreed that the roll out of the programme to 12 to 15 year olds will not be through a school-based programme in the first instance;
	b) Noted the implementation plan to ready the programme to vaccinate the 12 to 15 year old cohort from 18 August 2021;
	c) Endorsed the communication plan including the age-appropriate collateral for 12 to 15 year olds;
	d) Noted that work to understand the merits of a national invitation strategy for 12 to 15 year olds will commence in accordance with the Cabinet decision;
	e) Noted the priority availability of the Careerforce training module to include an informed consent process for 12 to 15 year olds,
	f) Noted that a 'change canvas' – a high level assessment of programme impacts – will be completed by 20 August 2021.

6.	**Primary care funding (Dr Joe Bourne) Joe CHECKING on 19/8**
	Paper 9 - General Practice and Pharmacy: COVID-19 Vaccination Programme • CVIP is fundamentally different to other immunisation programmes - size, scope etc. • Most two-dose vaccinations which require client recall are managed through a single setting, e.g. general practice. GP 'per dose' rate therefore includes costs of recall. • Changes were made to the 'per dose' rate for pharmacists in July 2021. • This paper proposes to align GP and pharmacists rates to $36.05 ex GST for ordinary hours, and $48.73 ex GST for 'out of hours' given both do the same job. • Noted that the overall cost is marginal for the programme

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	General discussion • Members understood why these rates were begin applied to COVID-19 related activity at this point. However, they were mindful of the need to consider possible adverse influences on other vaccination programmes into the future and suggested this should be a discussion item for a future Steering Group meeting. • Noted that a single dose vaccine would fundamentally change this model. **Decisions of the Steering Group** In relation to paper 9 - *General Practice and Pharmacy: COVID-19 Vaccination Programme*, the Steering Group: a) **Endorsed** that the Payment Schedule be simplified for General Practice and Pharmacy, with 'per dose' rates for both General Practice and Pharmacy COVID-19 vaccination being: • ordinary hours - $36.05 exc. GST • out of hours - $48.73 exc. GST; b) **Noted** that it is intended to apply two-dose vaccinations through additional settings not historically used for multi-dose vaccinations; and c) **Noted** that work to engage specific providers to encourage people who have not engaged via the national invitation strategy to book their vaccinations, will be scoped at a later date. ***Action 2: Note 'vaccinator role and payment relativity across the sector' for discussion at a future Steering Group meeting. [Secretariat]***
10.	**Next Meeting** Tuesday 24 August 2021, 4.30 p.m. – 6.00 p.m.

Agenda papers not requiring decision that were not considered at this meeting:

Paper 3 – CVIP Programme update – 15 August 2021
Paper 7 – Transition to Future State (Legacy) – 16 August 2021
Paper 8 – CVIP SRO workshop – 5 August 2021
Paper 10 – CVIP Schedule Summary Update – 16 August 2021
Paper 11 – Communications and engagement support for COVID-19 vaccine rollout
Paper 13 – Primary care vaccination sites – 16 August 2021

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Minutes

COVID-19 Vaccine and Immunisation Programme Steering Group

Date:	Tuesday, 31 August 2021
Time:	4.30 pm – 6.00 pm
Location:	Teams Meeting
Chair:	Dr Ashley Bloomfield
Members Attending:	Dr Dale Bramley (WDHB), Chris Fleming (SDHB), Jo Gibbs, Cathy O'Malley (DHB), Wendy Illingworth, Deborah Woodley,
Other Attendees:	Jo Gibbs, Astrid Koornneef, Dr Ian Town, Allison Bennett, Rachel Mackay, Dr Juliet Rumball-Smith, Caroline Greaney, Dr Joe Bourne, Shayne Hunter, Colin MacDonald, Chris James (Medsafe), Dr Tim Hanlon, David Nalder (Risk), Matt Jones, Andrew Bailey, Grant Pollard, Jason Moses, Michael Dreyer
Apologies:	Keriane Brooking (IIAG Co-Chair)

#	Agenda Item
1.	**Introduction and minutes** • The minutes from the previous meeting on 17 August 2021 were approved. **Apologies** • Keriane Brooking **Matters arising** Chair recognised the Members need to focus on the under 12s in the next couple of months. It was noted the Members are aware and have started early work on this. Governance Group meeting recap - No papers were submitted. Discussion on key items; vaccine supply certainty and achieving equity. Actions from the meeting are under way. **Action tracker consideration** Out of scope **Governance Group** • No changes. **Steering Group** • 210817-02 – **Action**: Add vaccinator role and payment relativity across the sector for discussion at a future Steering Group Meeting. **Update:** Vaccinator role has trained employees on staff, most of these are Maori. Numbers to be sent to PM via the Chair. Action Tracker updated. • No changes to other Actions.
2.	**Standing item on Science and Technical (Dr Ian Town)** • There were two items CVIP asked CV-TAG to consider:

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	1. Clinical advice regarding the stand down period between 1st vaccine dose and another vaccine. 2. Discussion about bringing the general vaccination programme together in the future, and potentially offering a range of vaccines in a 'one stop shop' scenario. • Finalised CV TAG advice recommending the intervals between administering the COVID-19 vaccines and other vaccines has been shared with CVIP. Members discussed whether this was something to be considered urgently. Having a gap between vaccines was hardwired into guidelines and pricing so everything else assumes time periods between COVID vaccine and others. Making changes to the existing guidelines and pricing will be a significant piece of work. It was noted that although the second piece of work was to consider all vaccines, this wasn't urgent as flu season was over. It could become urgent in the coming weeks as we ramp up the COVID programme. • Review of Myocarditis communications. Members reported there are concerns from individual clinicians about Myocarditis risk and how this is being communicated to the public. Members decided the CV-TAG section on the website should be updated. • s 9(2)(g)(i), s 6(a). A draft protocol to guide potential extension/third dose, in the context of a missed vaccine incident, was shared with CV TAG, for providing some clinical guidelines for incidents where a vaccination may have been missed. In general, individual incidents will be managed under individualised clinical management plans, however guidelines for larger groups, e.g., 40-50 or more individuals, were discussed. The memo is being updated with feedback from CV TAG. • Members noted they had committed to return to Highbrook people by next Friday 10th September. We are on track to do this and a working plan will sit with the team at NRHCC to operationalise. The timeframe is ed or Thurs next week. • CV Tag endorsed protocol of extension dose for people who experience this event. No age mentioned. Recommendation 6weeks if in community transmission area. 20 weeks if in low or no community transmission area, 6 weeks if person is moderately or severally immune suppressed. • Chair thanked all who worked on this. **Decisions of the Steering Group** a) **Agreed** to update the CV-TAG section of the MOH website regarding Myocarditis communications. b) **Noted** that work to provide Highbrook people with workplan by September 10th is on track. **Action 1: Update CV-TAG section of the MOH website to include information about possible symptoms of myocarditis after COVID-19 vaccination and when to present for medical care. (CVTAG)** **Action 2: Ensure Nicky Turner is informed of first item. (Jo Gibbs)** **Action 3: Return to Highbrook people by 10th September with a working plan. (Juliet Rumball-Smith)**
3.	**Operational update - Immunisation Programme Update (Jo Gibbs)**
	• Modelling shows DHBs can continue uncapped delivery if supply is delivered by 12 September. There is a weekend drop in Pfizer vaccinations. This also assumes we don't increase numbers from the previous 3 weeks. NZ cap is a daily delivery of 90,000 averaged across seven days. Can go above this daily but not weekly. We are way above other country levels. Expecting this wave not to continue as we move into level 2 and people go back to work. It is noted that the work MFAT is doing will increase supply. • Advice has been provided regarding options for front line facing role where vaccinations are required. We are now looking at implications this has for DHBs, including knowing who is and who isn't vaccinated and supporting workers to get vaccinated. • MOH have made system changes as a result of Highbrook and first incidents. Reluctancy to report from some areas regarding incidents, difficult to support stakeholders around reporting timelines. Have yet to solve. The MOH website is being updated with any incidents to inform public asap. 53% 12 and over have had first dose. High numbers daily. 28% fully vaccinated. 67% either booked or in with first dose. Over 80% for over 40s.

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	Decisions of Steering Group a) **Noted** that Ministers are keen for us to commit to protocol when there is an incident that all involved be notified in a timely manner. b) **Noted** incident reporting is an ongoing issue. **Action 1: To discuss at next meeting. Mandating vaccinations for health workers. A paper is being put together. It is complex as employment arrangements to consider. (Secretariat to confirm agenda item for next meeting)**
4.	**Update on vaccine supply (Allison Bennett)**
	• There has been a successful discussion with Europe to secure additional doses. There are a few challenges still involved. Working on regulatory, quality assurance and legalities with crown law and medical council to ensure compliance. On track for first two weeks in September for delivery.
5.	**Policy statement for 12 – 15 year olds (Astrid Koornneef)**
	• Seeking endorsement of policy statements and then upload to Ministry website site supporting message and wider MOH support. **General discussion** • Pacific community is concerned about offering a vaccination without parents knowing. • Discussions around informed consent, competency and formality of consent. Advice being sought to discuss further. • Cautious approach recommended. • Frontline seeing a lot of kids without parents. Encouraging kids to talk to their parents. • Difference noted between school based vaccine programme and community based vaccine programme as a form is sent to parents for consent in school based programme whereas none is required in community based programme. • Noted if running a school based programme then rights of the child still apply. Disability and human rights still prevail over school setting. • At a meeting with Iwi and Ministers there was surprise expressed when notified under 16 year olds can give consent without parents. Have further informed Iwi with guidance of health provider regarding consent 16 year olds can give. • Public may not be aware. If under 12 then assessed at frontline whether can make this decision. We need public communications around this. Fundamental question: Should we require written consent or not? Policy statement seems fine. Quality of communication to health practitioners to enable both worker and child to be protected. • Noting that in clinical setting opportunity to note consultations, side effects available, however in sites outside this setting, not the same level of clinical recording, or ability to match it with clinical record. **Decisions of the Steering Group** a) **Agreed** to communicate expectations with public, including the steps we will take and that we will encourage kids to talk to their parents. b) **Noted** that we trust our health professionals to make an assessment and to record in due fashion.
6.	**Any child under 12 years old receiving a vaccine (Juliet Rumball-Smith)**
	• Have heard under 12 year olds being vaccinated. 2 identified. • Could be kids close to their birthdays. Not the clinical advice. Is a hard line not a choice. Two separate locations. • Both incidents investigated by provider. 1 was a primary carer, 1 unknown. Action to come back to Chair with details.\

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	• MOH has expectations and professionals need to meet these. Standard obligations to disclose as soon as possible. **Action 1: Where was the 2nd incident of an under 12 receiving vaccination. Jo Gibbs**
7.	**Risk update (David Nadler)**
	• One incident management response. Immediate response to risk issue and decisions. • The nature of risk hasn't changed just more prominent, particularly around supply. • Going down through alert levels created complexity on the programme. Speaks to sustainability of being able to operate at current levels. • Risk paper discussed supply and programme resourcing. In last stage of programme. • Risks transitioning from programme to future state when CVIP closes. • Pivot to four separate working groups when back in BAU. • Equity issues have investment, Pacific and Maori have additional funding. • Other equity not discussed yet. • Due to stable platform other risks have been mitigated. Other than delivering to scale, focus is on future state. • We are pressing the equity issues. Focus on reaching out to Pacific and Maori populations. Would like to hear of initiatives. • Maori vaccination numbers doubled in August. Numbers will grow as age groups opened. • Other things happening when contacting Maori such as testing, vaccines, hygiene packs, food packs, stronger focus on DHBs getting information on how they're doing, do they need transport? Will take time to see results but currently numbers are shifting. • Communications to Maori under 40s to be considered as many Iwi and Ministers are providing public, positive messages around COVID and vaccinations. We should be utilising this, and that drive throughs are working. • Great momentum in drive through vaccination events. Paper with Ministers to ramp up funding for COVID response. Maori providers also have a paper with Ministers. **Decisions of the Steering Group** a) **Agreed** to continue monitoring equity numbers as the age groups are now opened.
8.	**Any other business and close** • Memo to Minister Hipkins to agree to original plan of 75% uptake, out to end of October. With little Risk we can update website. • Communications plan. Impacted by alert level changes. Captive audience at home so enormous uptake on channels and people looking for information. Last big broad push and lifting intensity with the last age ranges being opened. Moving into parallel workstreams with our community. • PM asked for Pfizer timeframes last week on paediatric indications on lower age ranges. Still evaluating data from beginning of October. Boosters are in global regulatory discussions and a few differences of opinion. Pfizer submitted approval for three doses, transplant patients and immune compromised people. Interim analysis on general boosters in mid-September. Will inform the Members when know more. • Regarding paediatrics, anticipating volume and considering Delta, be prepared to expedite approval, regulatory and cabinet, and how we implement in the programme. Whilst considering school based need to move sooner. • 5-11 year olds will be included next year, with an amendment to supply agreement. Currently 6 under 1s infected in latest outbreak. Able to scale up because of all the time and work implemented in place already . • Chair recognised the great work the team is doing. Would like to highlight Dr Dale Bramley and Chris Fleming for their involvement as invaluable.
9.	**Next Meeting** Tuesday 7 September 2021. 4:30pm – 6:00pm

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