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11 August 2021

9(2)(a)



RE Official Information Act request CDHB 10642

I refer to your email received 23 June 2021 requesting the following information under the Official Information Act from Canterbury DHB. Specifically:

- **Can you provide all correspondence with and reporting to the Ministry of Health in relation to the determination of targets for the vaccination roll-out. I understand this will be done under the OIA).**

Please refer to **Appendix 1** (attached), which contains correspondence and reporting with the Ministry of Health in relation to the determination of targets for the COVID-19 vaccination rollout.

Please note: we have redacted information pursuant to sections 9(2)(a) and 9(2)(c) of the Official Information Act, i.e. to “*protect the privacy of natural persons...*” and to “*avoid prejudice to measures protecting the health and safety of members of the public...*”

In addition to the attached Appendix, some correspondence relating to this subject has already been released and has been made available to the public via our website. Please read and refer to previous OIA response CDHB 10576 via the link below:

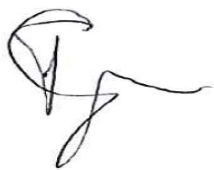
<https://www.cdhb.health.nz/about-us/document-library/cdhb-10576-covid-vaccinations-rollout/>

I trust that this satisfies your interest in this matter.

You may, under section 28(3) of the Official Information Act, seek a review of our decision to withhold information by the Ombudsman. Information about how to make a complaint is available at www.ombudsman.parliament.nz; or Freephone 0800 802 602.

Please note that this response, or an edited version of this response, may be published on the Canterbury DHB website after your receipt of this response.

Yours sincerely

A handwritten signature in black ink, appearing to be 'Tracey Maisey', with a stylized, flowing script.

Tracey Maisey
Executive Director
Planning, Funding & Decision Support

133 Molesworth
Street
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Wellington 6140
New Zealand

9(2)(a)

16 December 2020

To: DHB Chief Executives

Cc: GM Planning and Funding

Tēnā koutou katoa

COVID-19 Vaccine and Immunisation Programme

Thank you for your continued work to coordinate the efforts of the health system in response to COVID-19 this year. I want to acknowledge the dedication and hard work that has, and continues to be, put into responding to the new challenges that COVID-19 has presented in 2020 on top of providing a full range of health services to New Zealanders.

This letter is the first formal engagement with DHBs on the Covid-19 immunisation programme and provides foundational information on the overall programme structure and foundational pillars that make up the programme of work.

COVID Vaccine and Immunisation Programme

As you will be aware, the Government has been proactive in procuring and planning for the delivery of a COVID-19 vaccine. A national programme, the COVID-19 Vaccine and Immunisation Programme, has been established in the Ministry of Health to manage the associated strategy, design and implementation of the immunisation programme. With the Government recently confirming its immunisation policy and approach, the programme has an increasing focusing on implementation.

The COVID-19 Vaccine and Immunisation programme will be the most significant immunisation event in New Zealand history. The Government has options to purchase sufficient vaccines to immunise the entire population of New Zealand, and we have also supported some Pacific countries by purchasing vaccines on their behalf. Implementation throughout the country will require significant workforce development and coordination, new service delivery models and approaches, as well as leveraging the strengths of the current system.

The Ministry of Health is committed to partnering with DHBs throughout this process, recognising the expertise in coordination and commissioning in each local DHB context.

Te Tiriti o Waitangi and Equity

Te Tiriti o Waitangi and equity are the overarching principles of the immunisation strategy. These principles are integrated across the pillars and enablers of the strategy. To support the success of this strategy we are also asking DHBs to have these principles at the core of all your decisions and actions.

Upholding and honouring Te Tiriti requires embedding the five Te Tiriti principles from Wai 2575 Hauora report: Tino rangatiratanga, equity, active protection, options, and partnership. This may include partnering with your respective Iwi, Māori Relationship Boards, Māori providers and communities to develop, design, implement, and monitor the vaccination programme. Other considerations may also include data sovereignty principles, Māori models of care, and resourcing Māori providers and communities.

Equity is focused on achieving equitable outcomes for Māori, Pacific peoples, and disabled peoples. This will require specific action to meet the needs of these identified groups, resourcing and implementing those actions, and monitoring and tracking the results for the identified groups. This may also mean adopting new approaches for delivering the immunisation programme, and tailored methods of distributing information to meet their needs. DHBs are encouraged to work directly with Māori, Pacific, and disabled peoples to develop their immunisation programmes and communication strategies.

Further advice and guidance are being developed with the Immunisation Implementation Advisory Group (IIAG), who is advising the COVID-19 Vaccine and Immunisation Programme, and will be shared when available.

Role of Ministry and DHBs in the response

The Ministry of Health will play a central role in administering and coordinating the programme. The Ministry of Health will administer the overall programme nationally with common tools, processes and data to ensure there is visibility of performance and progress.

The Ministry of Health will be prescriptive on, and establish expected models of care, operational policies, standard operating procedures, workforce approaches, vaccine management and logistics, reporting requirements, funding for the programme, and timeframes for vaccine delivery. Core enablers such as technology, data and reporting will be developed and directed by the Ministry of Health. As much as possible, the use of existing processes will be used to minimise disruption.

The Ministry of Health will partner with DHBs who will provide the local system coordination and operationalisation of the programme. DHBs will meet the requirements of the vaccination programme, identifying how they will meet these service requirements, providing the service and population coverage and the setting they will use to deliver vaccinations. In the planning for the programme, there is nothing to preclude DHBs from planning and working regionally such as the approach used by the Northern DHBs. It is important that we move with urgency on the collaborative design of the service delivery and associated implementation

requirements, while acknowledging there is uncertainty of some aspects of the programme.

The Ministry will take a central role in public communications. We are preparing a wide-ranging communications campaign that is intended to help address key questions and concerns, provide assurance and confidence in the safety of any vaccines, and support people to make a positive, informed choice regarding immunisation. This campaign is expected to have multiple streams – with dedicated, separate areas of focus for engagement with Māori, Pacific peoples, and supporting the health workforce. As the approach begins to take shape we will look to share any early stage thinking and we welcome feedback on how the approach could best be configured to support DHB engagement with your communities. We would welcome your thoughts on how best to engage with you on this process.

We are considering other regular information mechanisms (such as fortnightly e-newsletter-style updates) and contributing to online information and resources to support the health workforce communicating with their patient communities. Your advice on any other mechanisms and approaches you would like to see in place that would help support your teams to stay informed and feel confident and connected to the vaccine progress as we prepare for the expected rollout in 2021 is appreciated.

Implementation Planning

It remains uncertain exactly when vaccines will be available for public use, but we are working to ensure the systems and processes are in place to support a potential rollout from March 2021. We are moving swiftly but we are being careful not to rush, nor will we compromise safety (Medsafe approval for vaccine safety and efficacy is required). Once approved, we expect COVID-19 vaccines to become available in stages throughout 2021 and we are planning for a range of different scenarios to help ensure the initial supply of vaccines goes where it is needed most to protect our communities. Ensuring equity of outcomes, especially for Māori and Pacific peoples, and appropriate protection for our most vulnerable, are key priorities in this planning.

At present, the programme is currently planning for delivery of 225,000 courses of a two-dose vaccine (Pfizer) from March 2021. Recipients will be determined by the sequencing framework, with border and Managed Isolation and Quarantine (MIQ) workers as priority populations should we remain in a low or no community transmission environment. The timing of subsequent deliveries is less certain, and we will update you as timings firm up.

It is important that the delivery of the COVID vaccine minimises the impact on existing health services, while maximising the value of existing people, systems and processes.

A funding model is being developed that aims to reflect the full cost of delivering the vaccine, including workforce and overhead across a range of settings and scenarios.

DHB Representation and Engagement

DHBs are represented at the programme Steering Group by Chris Fleming and Dr Dale Bramley (see Appendix 1 for an overview of the governance arrangements).

Dame Dr Karen Poutasi is the Chair of the Governance Group, which provides oversight and assurance of the overall programme.

From 11 January our stakeholder engagement team will be fully on board, with dedicated resource to support our engagement and collaboration with DHBs and the wider health sector. We will be working with Dr Dale Bramley and Chris Fleming, as our Steering Group representatives, and we will keep DHB CEs fully informed at a strategic level.

The programme team will continue to engage directly with the National GMs Planning and Funding and their nominated working group. We are also communicating regularly through the DHB Communications Managers forum.

Information Pack

Attached to this letter is a pack of preliminary information across the 'pillars' of the programme, and other key information such as funding and communications, and a series of considerations and areas where the Ministry will require further information or actions from you. In the New Year we will run a series of virtual sessions to provide further information, detailed planning advice, and seek your feedback.

We are sharing this information in confidence to enable you to commence planning in line with what is currently known about the strategy, requirements and timing. Much of the information will be communicated in a public announcement by the Prime Minister on the 17th of December and we ask that you do not share the information until these announcements have been made.

The COVID-19 vaccine will complement our Elimination Strategy as we continue to protect New Zealanders, and support the wider social, cultural and economic wellbeing of New Zealand. Ensuring that we have the means to provide a free and safe vaccine to New Zealanders is critical. We look forward to working closely with you on this important work.

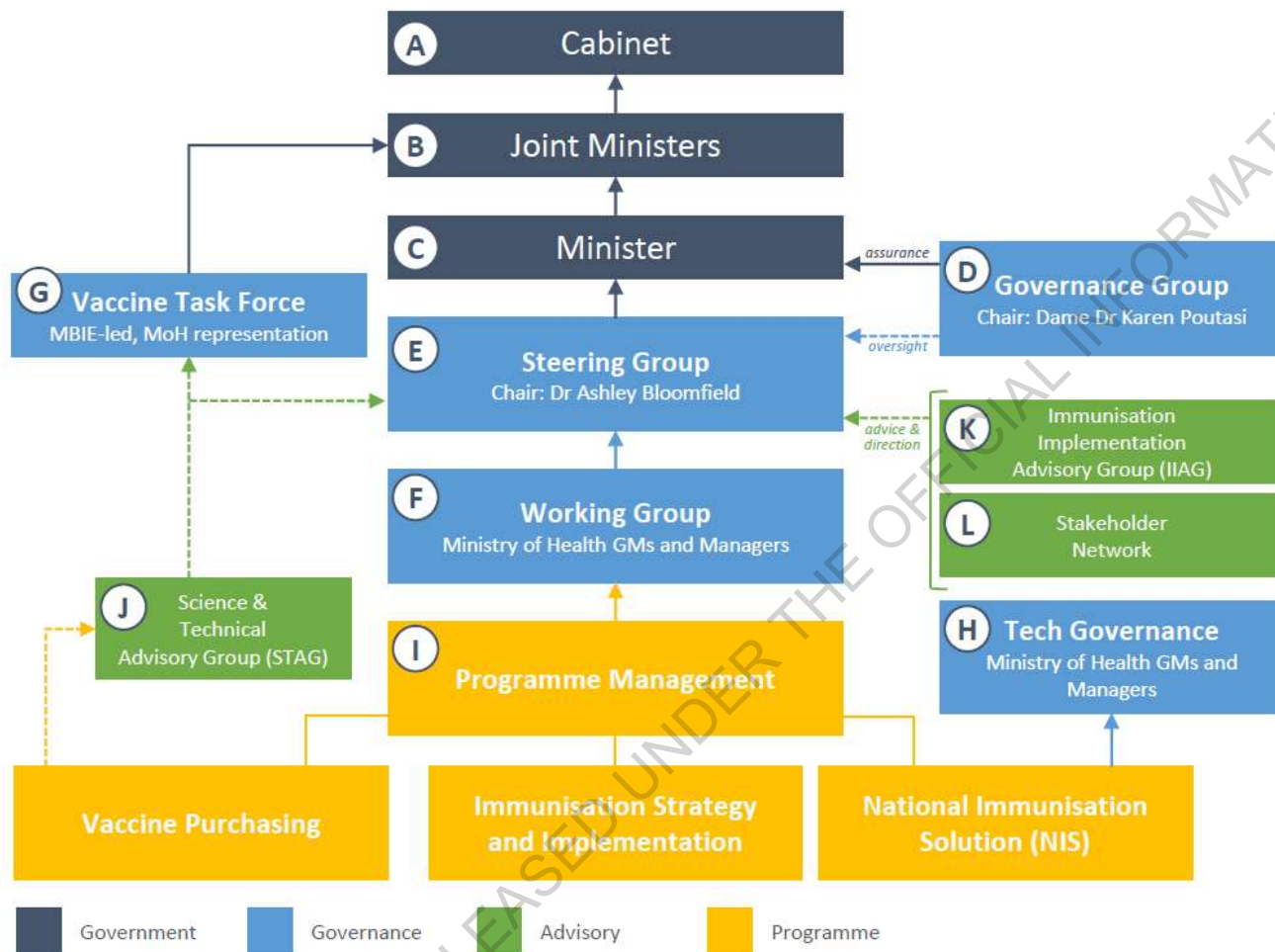
Yours sincerely

Dr Ashley Bloomfield
Te Tumu Whakarae mō te Hauora
Director-General of Health

List of Appendices

1. Programme Governance and DHB engagement mechanisms
2. Programme Blueprint
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4. Pillar 2: Sequencing Framework and Scenario Planning (Embargoed until Prime Minister's announcement)
5. Pillar 3: Distribution and Inventory Management
6. Pillar 4: Vaccine Workforce
7. Pillar 5: Provider Engagement
8. Pillar 6: Immunisation Event: Before, During & After
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10. Funding
11. Communications strategy
12. Actions and Next Steps

1. Programme Governance and DHB Engagement



A: Cabinet; B: Joint Ministers; C: Minister
Approval on strategy; Funding decisions; Decision to use vaccine and sequencing of distribution

D: Governance Group
Oversight and assurance; Domain expertise

E: Steering Group
Programme decision making; Strategic risk and issue management; Overall programme direction

F: Working Group
Operational risk and issue management; Design Authority for business processes; Review and advice on options before presentation to Steering Group

G: Vaccine Task Force
MBIE-led. Decisions on vaccine purchasing.

H: Technology Governance
Technology assurance, including: architecture Design Authority; security; privacy

I: Programme Management
Support and co-ordination

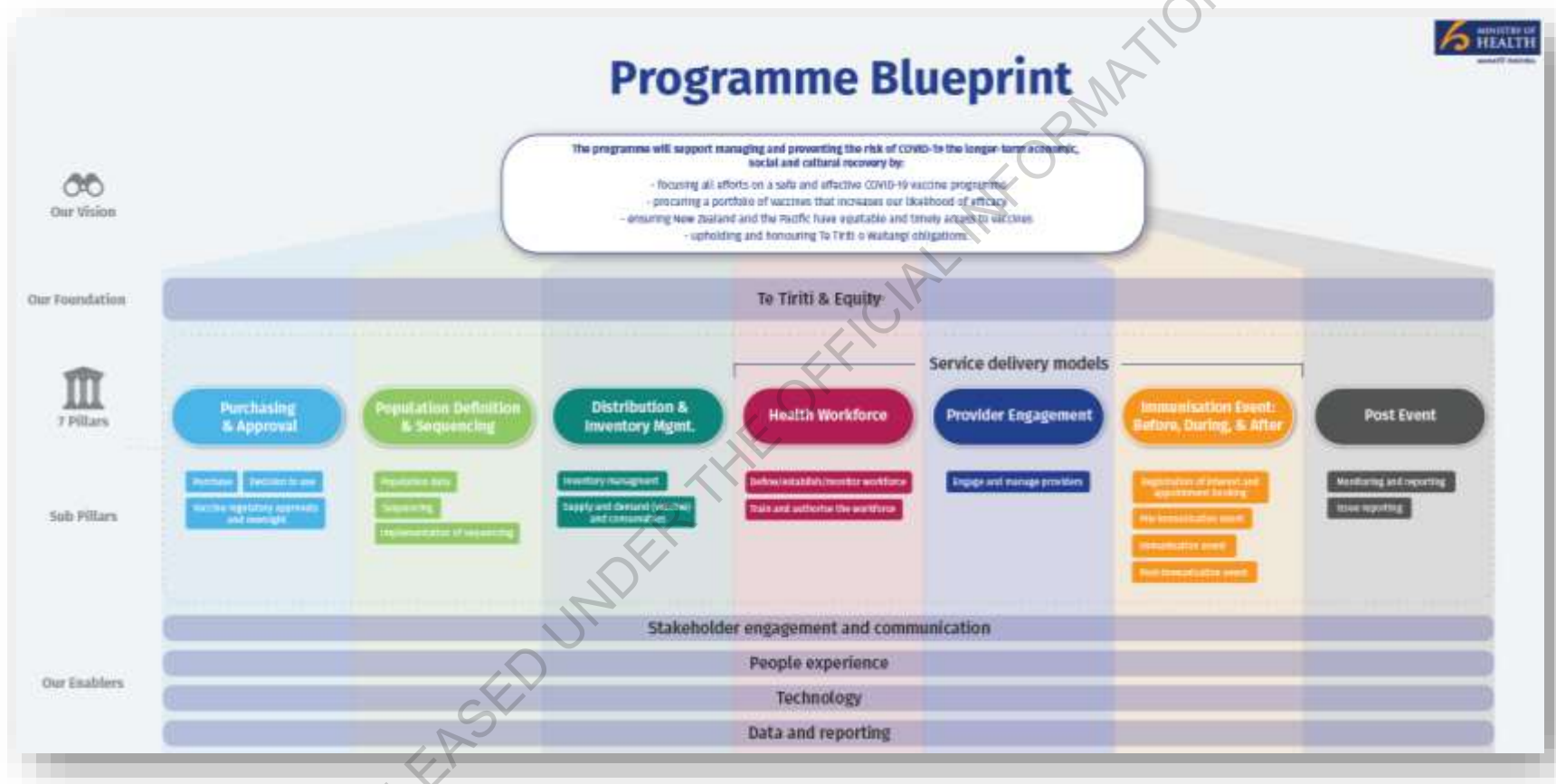
J: Science and Technical Advisory Group (STAG)
Science and technical advice and direction

K: Immunisation Implementation Advisory Group
Health sector and implementation advice and direction

L: Stakeholder Network
Industry, health, social services network

2. Programme Delivery Blueprint

We have structured the programme into seven delivery pillars that organise the work to align cross-functional delivery teams. We are continuing to evolve the service delivery models and require input from you to help design the most efficient and practical models.



Core enablers, such as communications, technology and data and reporting will be directed nationally by the programme. Where possible, technology and data and reporting will leverage existing processes to minimise disruption.

3. Pillar 1: Purchasing and Regulatory Approval

The first stage of the programme is focused on the purchasing process to secure sufficient quantities of safe and effective vaccines, which was led by a Vaccine Taskforce. This has been coordinated by the Ministry of Business, Innovation and Employment, and had input from the Ministry of Health, Ministry of Foreign Affairs and Trade, Treasury, PHARMAC, and other government agencies.

New Zealand has negotiated several options to purchase a portfolio of vaccines through advance purchase agreements (APAs) with pharmaceutical suppliers. To date, options to purchase Pfizer/BioNTech and Janssen vaccines have been confirmed. Subsequent vaccine option to purpose will be announced in future.

Medsafe will provide independent regulatory approval of any vaccine before it can be administered in New Zealand. Medsafe is streamlining the assessment process and prioritising the vaccine approval over other medications to ensure the process is both robust and timely.

There will be a public announcement by the Prime Minister on 17 December outlining further detail on the above.

4. Pillar 2: Population Definition and Sequencing

As quantities of the vaccine will be limited when it first arrives in New Zealand, the Ministry of Health will need to sequence delivery so that it goes first to population groups who need it most, depending on the status of New Zealand community transmission at the time. This is to ensure that the best protection to population groups who are at a higher risk of poor outcomes from COVID-19 are considered.

The Ministry of Health developed the Sequencing Framework in collaboration with the Immunisation Implementation Advisory Group, and Cabinet has approved it. The Sequencing Framework seeks to respond to three different scenarios for rolling out the vaccine and will change as new information comes to light and be shared with the public.

Scenario 1: Low/no transmission scenario

In a no/low transmission scenario, the objective is to prevent transmission. Vaccinating those who are at most at risk of exposure to COVID-19 – those working at the border or who would have increased contact with cases – will provide the best protection for the whole population, including Māori, Pacific peoples, disabled people and older people.

Initially, border, managed isolation and quarantine (MIQ) workers, highest-risk front-line health care workers, and their household contacts are expected to be prioritised as a tier one category. Tier two within this group is expected to include the rest of the high-risk health workforce, and high risk people in the public sector and emergency services. Tier three includes people in the community who are most vulnerable to serious illness such as older people, as well as at-risk health and social services workforce.

Once all three tiers are vaccinated, vaccination will roll out to the broader population in line with Medsafe recommendations on the age groups the vaccine is registered for.

Scenario 2: Clusters and controlled outbreaks

Where clusters exist in the community and we have small, local outbreaks, the priority continues to be protecting those who work at the border and highest risk health care workers. However, an added priority would be to protect those in the communities who are affected by the outbreaks

Scenario 3: Widespread community transmission scenario

Where community transmission is widespread, the objective becomes protecting those most at risk of serious health outcomes as well as the groups that are most likely to infect them.

COVID-19 Sequencing Framework

This diagram shows who will receive the vaccine under different scenarios to ensure the right people are vaccinated at the right time, when vaccine supply is constrained.

Scenario	Scenario One Low/no community transmission Aim: Prevent transmission	Scenario Two Clusters and controlled outbreaks Aim: Reduce transmission and protect people in close contact	Scenario Three Widespread community transmission Aim: Protect those most vulnerable to prevent illness and mortality
Group One First group of people to receive the vaccine in each scenario	<ul style="list-style-type: none"> Border and managed isolation & quarantine workforce Health workforce at highest risk of exposure to COVID-19 Household contacts of the above two groups 	<ul style="list-style-type: none"> Border and managed isolation & quarantine workforce Health workforce at highest risk of exposure to COVID-19 Household contacts of the above two groups Population affected by the outbreak 	<ul style="list-style-type: none"> Older people (aged care residents, Māori and Pacific people, then others aged over 65 years) People under 65 with underlying conditions People living in long-term residential care settings
Group Two Second group of people to receive the vaccine in each scenario	<ul style="list-style-type: none"> High risk frontline health workforce High risk frontline public sector and emergency services 	<ul style="list-style-type: none"> High risk frontline health workforce High risk frontline public sector and emergency services 	<ul style="list-style-type: none"> High risk frontline health workforce High risk frontline public sector and emergency services Remaining frontline health workforce
Group Three Third group of people to receive the vaccine in each scenario	<ul style="list-style-type: none"> People in the community, including: <ul style="list-style-type: none"> Older people People with underlying conditions At risk health and social services workforce 	<ul style="list-style-type: none"> People in the community, including: <ul style="list-style-type: none"> Older people People with underlying conditions At risk health and social services workforce 	<ul style="list-style-type: none"> Remaining health and public sector workforce Other population groups

5. Pillar 3: Distribution and Inventory Management

The programme will take a centralised role in securing the total range of vaccines and consumables required to prepare and administer the vaccine, with the objective that they will be available in sufficient quantities to ensure the delivery of a safe and effective vaccine. The programme is currently anticipating the initial vaccine to be a limited delivery of 225,000 courses of the Pfizer vaccine arriving in Q1 2021. This will require a fully effective distribution and inventory management system with ultra-low temperature (ULT) capability to be managed in line with the sequencing and scenario planning. The approach has built upon the existing PPE distribution and inventory management, and lessons learnt from the 2020 Influenza campaign as identified by the Review.

The Ministry will be responsible for procuring and distributing:

- Preparation consumables: PPE, ultra-low temperature (ULT) related PPE, swabs, needles, syringes, saline; and
- Administration: gauze strips, needles, syringes, sharps bins, waste disposal, biobags.

Distribution Infrastructure

To set up a distribution network to support delivery of the vaccine and consumables throughout the sequencing framework requires:

- Cold storage infrastructure at the right places and sufficient capacity at distribution points throughout New Zealand;
- At the regional and national layer distribution point, sufficient logistical capability and capacity to coordinate the delivery of the vaccine and consumables;
- Transport to support the movement the vaccine and consumables from the national storage point to the provider/vaccinator with visibility from point to point; and
- Appropriate security while in warehouses and in transit.

Inventory Management

Inventory will be managed by the Ministry of Health to enable the end-to-end tracking and tracing of the vaccine to the consumer. There will be a sector-wide demand planning and inventory management system which maintains high level of visibility and coordination capability of vaccines and consumables to support vaccine delivery in New Zealand to enable:

- planned supply of vaccine and consumables from national storage to providers;
- forecasting and managing future changes in demand for each vaccine with forecast supply;
- preventing delays and wastage through the incorrect distribution of vaccines and consumables; and
- coordinating supply to meet a range of targeted scenarios (regional or locational specific outbreaks).

The inventory management system will use existing DHB processes to manage the data flow. This will require DHB input and will be an ongoing and iterative process. The inventory management system will be piloted using PPE data starting early in

2021, with go live in March. DHBs will be required to provide data for PPE which will involve supplying information regarding stock on hand for PPE as you currently provide with minor changes to take advantage of the new system tools.

What we need from DHBs?

The programme is currently working with DHB contacts for the PPE data flows and will continue to engage with this group. Further information associated with current capabilities to manage an ULT vaccine will support the planning of possible distribution mechanisms. Key questions we would like you to answer include:

1. Does your DHB or region have the physical capability to store and handle the Pfizer vaccine noting the requirements to store in -70 degrees?
2. What is your DHBs capacity to manage changes in the Pfizer vaccine expiry date? i.e. up to 6 months at -70 degrees, once thawed expiry is up to 5 days.
3. Does your DHB or region have Medsafe wholesale licences to store and distribute vaccines outside of the DHB to other providers?

6. Pillar 4: Vaccine Workforce

The Ministry of Health has developed a workforce strategy as a key part of the COVID – 19 Immunisation Strategy. The vision is to engage a workforce that is capable and ready to deliver a COVID-19 immunisation programme when a vaccine is available.

The principles below underpin the Immunisation Strategy, and are also applicable to the strategy we will apply across the workstream:

Principle	Application
Equity	<i>Equity</i> – the workforce is culturally competent and representative of the people they are immunising, and equity is embedded into the approach taken by the workforce
	<i>Equal concern</i> – a safety conscious workforce will deliver the vaccine to everyone, and treat them as equals
Wellbeing	<i>Minimising harm</i> – a workforce is focused on promoting accessibility and will be responsive to the needs of the population
	<i>Regional responsibility</i> – we will plan for administering the vaccine in the Pacific and advocate for our Pacific neighbours
Stewardship	<i>Value</i> – the workforce will maximise effectiveness to reduce wastage, and understand the wider impact of their actions
	<i>Legitimacy</i> – a workforce will build public confidence in a vaccine as the main point of contact for those who are immunised

Workforce Approach

There are approximately 11,000 health professionals in New Zealand that are authorised or able to deliver vaccinations, including nurses, pharmacists, general practitioners. It was considered that it would be (theoretically) feasible to vaccinate the entire population with this workforce, when assuming they have only 10 – 20 % capacity available to deliver COVID-19 vaccines.

However, there is recognition that the workforce is already stretched, and that it is vital that core health and disability services and immunisation programmes are not impacted by delivery of a COVID-19 vaccine. As such, a range of options were considered, each reflecting vaccinating the population over various timeframes and utilising a workforce in different ways. The options were assessed against the principles in the workforce strategy to ensure the workforce considered equity, wellbeing, and stewardship.

A mixed-model approach to the workforce

The Ministry supports a mixed model approach where the existing vaccinating workforce will be augmented with a newly trained vaccinator workforce of non-practicing health professionals. The Ministry's preferred option is to train an additional 2,000 – 3,000 non-practicing health professionals (with a related qualification) that will likely be sourced from a range of groups:

- the already identified COVID-19 surge workforce (~3,400 people)
- non-practicing nurses without a current practicing certificate (currently numbering ~14,000 people)
- nursing and pharmacy students (with clinical oversight)
- non-practising pharmacists
- non-practicing doctors.

The Ministry of Health (based on initial discussions with the sector to date), acknowledges that the existing workforce wants and expects to be involved in delivering a COVID-19 vaccine. The existing workforce also provides a source of clinical oversight, enabling less experienced vaccinators to have appropriate support when delivering vaccines.

The mixed-model approach includes carrying out vaccination via primary care (including general practice and urgent care), community pharmacy, community health providers (including Māori and Pacific health providers) and could include utilising Aged Residential Care and Home and Community Support Providers. These groups will need to be supported to access additional workforce to enable increased capacity and to ensure accessibility to a vaccine.

Other workforce options were considered, however, the Medicines Regulations 1984 does not support a non-health professional to deliver a vaccine. For a vaccinator to be authorised, for example, the regulations requires a written application by the applicant with documentary evidence that satisfies the Director-General or a Medical Officer of Health and proves the person has the relevant competency, skills, and knowledge to carry out vaccination services (e.g. basic emergency techniques, knowledge of safe and effective handling of immunisation products and equipment, clinical interpersonal skills, knowledge of relevant diseases and ability to explain vaccination to patients). In practice, this includes a relevant practicing certificate.

The Ministry is working with regulatory authorities to implement a process for non-practicing health professionals to gain a relevant practicing certificate. The authorities have agreed that an approach which is similar to that used for the COVID-19 surge workforce can be used for COVID-19 vaccinators. More information will be available about how these practicing certificates can be gained early next year.

Workforce training and coordination

The Ministry has partnered with IMAC to deliver training and support services for the COVID-19 vaccines. This includes general vaccine training and education, training for each vaccine that will be available, training that reflects Māori and Pacific cultural competencies, and training in the new immunisation technology solution that is in development. IMAC are engaging regional advisors and local coordinators to support

you to build capacity and capability within your areas. Training will be available from February 2021 and is fully funded by the Ministry.

The Ministry is playing an overall coordination role in building workforce capacity across the system. This includes working with regulatory authorities to reach out to potential vaccinators within their networks and utilising the COVID-19 Surge Workforce database. We will work with DHBs to link them with the available workforce to build capacity in each area.

Workforce Modelling Information

The Ministry of Health has completed initial modelling to deliver Scenario 1, Tier 1 from the Sequencing Framework (which assumes no or low transmission) and estimates an additional 400-500 FTE nationally is required to deliver the anticipated Pfizer vaccine (and excludes other vaccines). This workforce modelling assumes 100% of the vaccine is delivered against the following delivery schedule: 450,000 doses in March 21, 600,000 doses 1 June 2021 and 450,000 doses 1 September 2021.

The following table provides a summary of the Ministry's working estimation of FTE workforce required nationally. This workforce could take the form of new FTEs or could include existing vaccinators¹. Due to a high level of uncertainty, the estimated workforce requirements are our *current best estimate* and based on the information currently available:

Lower and upper estimates of FTE required for first delivery of Pfizer vaccine 1 March 2021

	<i>Lower FTE estimate</i>	<i>Upper FTE estimate</i>	<i>Doses to deliver (approximate)</i>
<i>National</i>	400	750	450k

Our modelling is developing alongside progression of other fundamental pieces of the delivery framework, such as sequencing, and we are working to provide a more detailed estimate of the workforce requirement **by region** before the end of January 2021.

Note that the table above shows the expected workforce required for delivery of the first vaccine only. There are further and larger vaccine deliveries expected in the months following March and the workforce in each DHB will need to scale in line with these. We are working to provide a more detailed estimate of the workforce requirements **beyond** March 2021 before the end of January 2021 and as more information becomes available.

¹ Workforce capacity to vaccinate while maintaining BAU should be considered – 10 existing vaccinators that can each vaccinate 10% of the time would be equivalent to one FTE for example.

What do we need from DHBs?

Noting the Ministry's preference for a mixed model approach the Ministry is seeking DHBs views on the items below. Note: this should assume delivery of 225k courses of the two-dose vaccine A in a low or no community transmission environment.

4. Please provide comment on your DHB vaccinator workforce capability and capacity noting existing commitments for MMR and Influenza vaccinations.
5. Noting the MOH will be providing assistance with accessing new vaccinator workforce through regulatory bodies and surge workforce, please identify what other options your DHB or region might engage to increase its vaccinator workforce?
6. Please provide a view on key delivery parameters that you feel should be factored into the workforce modelling, such as your view on the average time to deliver each vaccine and your view on the expected uptake of the vaccine within the sequenced cohorts in your region i.e. MIQ, Border, frontline health workers etc.
7. What preferred service delivery model will you implement to reach the four priority populations MIQ, border workers, high risk household contacts and front-line health care workers noting the logistical challenges of the first vaccine (including -70 temp, 2-5 day shelf life once thawed etc).

7. Pillar 5: Provider Engagement

The Ministry of Health is engaging with DHBs, providers and partners to enable delivery of the COVID-19 vaccine across communities in New Zealand. DHBs play a key role in the local co-ordination and commissioning of health services within their region so are well placed to deliver the programme in partnership with the Ministry of Health. DHBs have an existing and extensive network of providers across their region which can be leveraged, while also working with the Ministry to grow a new vaccination workforce and service delivery models.

Focus for the next stages of implementation is now to work with DHBs around the planning for the implementation and delivery of the vaccination to the prioritised population as part of Scenario 1, Tier 1, low or no community transmission.

There are other workforce groups beyond DHBs and a wider engagement plan is being developed. This will include engaging with national entities such as GPNZ and the Primary Healthcare Alliance to ensure that other professional and health workforce representative groups are engaged in the immunisation rollout. Further work in this space will commence in the New Year, which we will advise DHBs of as planning progresses.

What do we need from DHBs?

8. Consistent with the advice provided on sequencing, workforce and the current epidemiological context, DHBs or regions are asked to start engaging with their provider networks now i.e. Primary Care, ARC, Maori and Pacific providers, NGO providers etc.

8. Pillar 6: Immunisation Event: Before, During & After

Detailed planning is underway to map out and plan the registration and booking, pre immunisation event and immunisation event and the enablers that are needed to ensure the consumer has a successful immunisation experience.

The Ministry of Health is developing a new technology solution that ensures all COVID-19 vaccination events are captured accurately and completely in a manner that is simple and efficient. We are building this solution so it will look and feel like the other recent COVID-19 technologies e.g. National Contact Tracing Solution and the National Border Solution.

It is important to know that the new Covid-19 Immunisation Register is being developed iteratively. Not only does this mean that we will continue to develop it over time adding more capabilities as we go but it gives us the opportunity to improve things that we have previously released. Your feedback will be important throughout.

Finally, the COVID-19 Immunisation Register will be used for COVID-19 vaccinations only while the NIR will be used for all other vaccinations as per normal. Later in 2021, the technology programme will pivot to developing the new National Immunisation System to replace the NIR by March 2022.

9. Pillar 7: Post Event

Post Event refers to the monitoring and mitigation of risks and issues with the process of vaccination at the individual and cohort levels, alongside risk management approaches across the other six pillars. Within this pillar we acknowledge that:

- Vaccines and immunisation are not without risks and;
- Adverse events can and do occur, both causally and correlatively with the process of vaccination; and
- The effectiveness of an immunisation programme is likewise affected by many factors.

Medsafe are working closely with the programme to ensure that the critical path for their regulatory role in safety monitoring is upheld, while key pharmacovigilance functions are upgraded for scale, pace, and functionality.

The three components of the Post Event pillar provide the structure for the following areas of work:

- Vaccine safety – adverse event monitoring (passive and active) and signal detection; causation assessment and clinical case review; monitoring of international trends and warnings; regulation of vaccines and guidance for safe use.
- Vaccine effectiveness – immunogenicity monitoring and research, from New Zealand data and international insights.
- Immunisation programme effectiveness – vaccine coverage and uptake across the population; monitoring, analysis, and reporting on impact of the programme on key indicators of safety, protection, and effect on public health.

10. Funding

A funding model is being developed that aims to reflect the full cost of delivering the vaccine, including workforce and overhead across a range of settings and scenarios.

For providers, the funding approach to commissioning should reflect the costs of delivering the service, and incentivise:

- Completed immunisation course for each individual (pay more for the delivery of the second dose);
- Additional and targeted resourcing focussing on Māori, Pacific and high needs communities;
- Establishment of a dedicated and appropriately trained workforce;
- Effective recording of immunisation in the technology solution;
- Minimisation of vaccine waste; and
- Positive customer experience (communications with customers, service on the day, minimal wait time etc).

Therefore, a funding arrangement that distinguishes between different elements of the delivery requirements is proposed:

- The administration of the vaccine to clients will be contracted a fee-for service model, where the second vaccination is priced higher than the first to incentivise completed course of immunisation;
- Payment for each vaccination will be made on registration of the vaccination in NIS;
- Funding for the recruitment and training of the dedicated vaccination workforce;
- A financial disincentive for wasted doses; and
- An input-based fee for the establishment and operation of community pop-up hubs, if required.

11. Communications Strategy

High Level Campaign Approach

We are beginning to prepare for the wider public information campaign to support the immunisation rollout and encourage uptake of COVID-19 vaccines. We are approaching the campaign in four phases.

Our intention is to approach the campaign through four separate streams, each with its own dedicated resources and strategy. The four streams are:

- **All of Aotearoa NZ** – *working with a mainstream provider to support the broad-based public information for all audiences.*
- **Dedicated engagement with Māori** – *working with Māori providers, iwi and communities to support Māori uptake and engagement.*
- **Dedicated engagement with Pacific** – *working with Pacific providers, networks and leaders to support engagement and uptake for Pacific peoples.*
- **Dedicated support for the Health Workforce** – *a dedicated stream of activity with its own resources to support the needs of our health workforce.*

Co-designing the approach: We are looking to work closely with Māori, Pacific, and Health Workforce networks and representatives to co-design the campaign approach as much as possible – supporting the process with consistent national messaging but tailored for local contexts.

CAMPAIGN PHASES

FOUR KEY PHASES			
By End of 2020	SUMMER – QUARTER 1 2021	APRIL – DECEMBER 2021	2022
<p>Aim: To ensure information is available to the public and the health workforce re progress of vaccine programme.</p> <p>Key topics: purchasing progress, safety assurance.</p>	<p>Aim: To address key questions and concerns people may have regarding potential vaccines, help clarify NZ's context (in contrast to the emergency settings our international peers need to manage), and indications of likely timeframes and sequencing.</p> <p>Key topics: safety of vaccines, approval processes, sequencing strategies, which vaccines NZ is purchasing, how vaccination protects us, NZ's context.</p>	<p>Aim: Encourage uptake, support access to vaccines, and address any remaining questions and barriers. Support any innovative outreach approaches and service design activities.</p> <p>Key topics: encouragement to vaccinate, how and where to access, address any remaining questions.</p>	<p>Note: <i>It may be that vaccines have a limited protection and we need to drive a further round of immunisations in 2022.</i></p> <p><i>It may also be there other vaccines come online at different times so we need to support a staggered rollout.</i></p> <p><i>We will allow for these and other factors with some high-level planning for the 2022 period.</i></p>

12. Actions and Next Steps

This table provides a summary of the actions we are requiring of DHBs to assist in the planning and preparation of the COVID-19 Vaccine and Immunisation Programme. As already stated, the Ministry is working to a date of the 1st March 2021 for sector readiness for the Pfizer vaccine.

In the planning, there is nothing to preclude DHBs from planning and working regionally such as the approach used by the Northern DHBs.

The following table provides a summary of the information request or actions the Ministry is seeking from DHBs. This will be an iterative process over the coming months as we jointly work towards vaccine readiness on 1 March 2021.

Please send all responses to 9(2)(a) by **22 January 2021**.

Pillar	Information Request / Action
Distribution and inventory management	<ol style="list-style-type: none"> Does your DHB or region have the physical capability to store and handle the Pfizer vaccine noting the requirements to store in -70 degrees? What is your DHBs capacity to manage changes in the Pfizer vaccine expiry date? i.e. up to 6 months at -70 degrees, once thawed expiry is up to 5 days. Does your DHB or region have Medsafe wholesale licences to store and distribute vaccines outside of the DHB to other providers?
Workforce	<ol style="list-style-type: none"> Please provide comment on your DHB vaccinator workforce capability and capacity noting existing commitments for MMR and Influenza vaccinations. Noting the MOH will be providing assistance with accessing new vaccinator workforce through regulatory bodies and surge workforce, please identify what other options your DHB or region might engage to increase its vaccinator workforce? Please provide a view on key delivery parameters that you feel should be factored into the workforce modelling, such as your view on the average time to deliver each vaccine and your view on the expected uptake of the vaccine within the sequenced cohorts in your region i.e. MIQ, Border, frontline health workers etc.

	<p>7. What preferred service delivery model will you implement to reach the four priority populations MIQ, border workers, high risk household contacts and front-line health care workers noting the logistical challenges of the first vaccine (including. - 70 temp, 2-5 day shelf life once thawed etc).</p>
Provider Engagement	<p>8. Consistent with the advice provided on sequencing, workforce and the current epidemiological context, DHBs or regions are asked to start engaging with their provider networks now i.e. Primary Care, ARC, Maori and Pacific providers, NGO providers etc.</p>

133 Molesworth
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New Zealand

9(2)(a)

20 January 2021

To: DHB Chief Executives

CC: GMs Planning and Funding; Chief Medical Officers, Vaccine Lead Group; DHB Vaccine Working Group; Public Health Unit Leadership; Primary Health Organisation CEs; 9(2)(a), Chair Immunisation Implementation Advisory Group

Tēna koutou katoa,

Update on COVID-19 Vaccine and Immunisation Programme

Engagement so far in 2021

Thank you for your continued support and engagement on the COVID-19 Vaccine and Immunisation Programme. Things are moving at pace and we appreciate your teams' engagement to date; the feedback, questions and conversations have been invaluable.

We held two open book online sessions recently to walk through information on sequencing, health workforce, funding, and logistics and distribution. A summary of the questions asked in these sessions, and responses, are summarised and attached.

Response to 16 December letter

We are looking forward to receiving your reply to the letter from the Director-General dated 16 December. Your feedback, suggestions and answers to the questions are vital to our ongoing planning for the vaccine delivery. Please make sure your DHB has sent your responses to the eight key questions and actions in this letter to 9(2)(a) by 22 January 2021. The letter is attached for reference.

Following this, we will come back to you with more programme details and information that will be specific to each DHB. We will provide details around expected volume by population cohort in line with the sequencing framework for your DHB, estimates of the workforce requirements and an update on the funding arrangements. Following this we will be aiming to confirm service coverage and delivery arrangements with DHBs for the initial populations.

We are progressing the development of Māori and Pacific immunisation delivery strategies, including targeted funding for communications, workforce and Māori and Pacific providers, and expect to be able to share this detail in the coming weeks.

Thank you again for your engagement with this iterative process as we work jointly towards being operationally ready to deliver COVID-19 vaccines. Please continue to let

us know how we can build on our engagement with DHBs and sector partners over the coming weeks, and send questions or suggestions to covid-19vaccine@health.govt.nz.

We are looking at how we provide regular information to keep your Boards informed and will work with you on that.

Yours sincerely,



Sue Gordon, **Deputy Chief Executive COVID-19 Health System Response, Ministry of Health**

9(2)(a) [REDACTED], Waitematā DHB

9(2)(a) [REDACTED], Southern DHB

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Appendix 1: Workforce considerations and accessing the surge workforce database

The Ministry of Health has been engaging with DHB GMs HR regarding workforce considerations, roles and responsibilities with Immunisation Advisory Centre (IMAC), and joint workforce planning for the new vaccinator workforce.

The Ministry of Health has utilised the COVID-19 Surge Workforce database as a means of recording the names and details of people who have signalled they are available to be employed as vaccinators.

As we continue engagement across the sector, we expect the numbers of people on the database to grow. The database is available to support District Health Boards to employ additional capacity as the roll out of COVID-19 vaccines ramps up over 2021, in addition to any other initiatives that you may establish within your areas.

Information on the COVID-19 surge workforce database can be found on the Ministry website at: 9(2)(a) [REDACTED]

To access the database, a request needs to be submitted via the registration link on that page, under the heading 'Employer workforce requests' or here.

Beyond Recruitment are managing the portal on behalf of the Ministry. If there are any queries around the process to access the database, or around how many vaccinators have registered their interest, they can be contacted via the Work Force Response email 9(2)(a) [REDACTED]

Appendix 2: Questions and answers from open book sessions

Population Definition and Sequencing

Q: Do border workers include maritime workers and airline staff?

A: Yes.

Q: What about PHUs?

A: As a front-line health work force they will be considered priority.

Q: Would it be possible to send out estimated numbers for the various tiers (and subgroups within tiers) for each DHB?

A: We are working on these numbers and will send them out when they are firmed up.

Q: What is the current thinking on the definition of critical health workforce?

A: We have a working definition of the target workforce. We will share this and get your input before it is confirmed.

Q: What is the definition of 'household' in terms of identifying who is eligible in Tier 1, and how big is each household?

A: We are still working on this definition for 'household'. Sizes will vary but for planning purposes we are assuming the size of a household to be three people for the time being.

Q: When will the groups of higher risk be further defined and when will we know how much vaccine from the first tranche each DHB will be allocated?

A: We are working with interim definitions for the higher risk groups and have suitable allocation assumptions for these. Once these are firmed up, we will send them to Cabinet for approval. We expect this to happen in the first half of February.

Q: Which of the current internationally approved vaccines will be deployed?

A: All vaccines will need to go through the New Zealand Medsafe process before being distributed. International approvals will feed into this approval process.

Q: Why are household contacts included in the high-risk groups, if their link to risk factors is being vaccinated?

A: Vaccines are unlikely to be 100% effective and there is currently no evidence that the vaccine will stop transmission. Immunising both the border workforces and their household contacts seeks to reduce the risk that people with connections to the border contract the virus.

Q: Have we considered delaying flu vaccinations?

A: No, we expect the 2021 Flu campaign to continue as planned.

Q: Can you give both flu and Covid-19 vaccinations at the same time?

A: The planning assumption is that you cannot. As more evidence emerges we will provide further guidance.

Health Workforce

Q: Who are the educators from IMAC for each of the regions/DHBs?

A: We are working with IMAC on this and will provide details when Educators have been confirmed for regions / DHBs.

Q: Will there be additional support for CPR training?

A: We understand that CPR training could be roadblock in some regions and we are looking at this issue in terms of additional capacity that could be secured

Q: Can you let us know which tertiary institutions have taken up the opportunity of providing vaccination training to their students?

A: We will compile and distribute a list of the tertiary institutions who have provided vaccination training.

Q: What is the situation for retirees who wish to become vaccinators?

A: There will be an avenue for retirees who wish to become vaccinators and we are still working on details for this.

Q: Do we anticipate vaccination being under standing orders or an approved vaccination programme?

A: Much of our planning is on the assumption standing orders would be in place.

Q: How long will the vaccine authorisation process take for re-employed staff?

A: Authorisation can be provided by IMAC and we are looking for this process to take approximately three days.

Q: In relation to student vaccinators, is the training of students been balanced with their need to study and qualify?

A: Yes. The training might replace some of the required international experience. Some schools are looking to integrate the training into their courses.

Q: How will clinical assessments be done?

A: There will be four regional co-ordinators to manage the assessments.

Q: Will the clinical assessments also consider delivery of multidose vial vaccines which introduce additional risk of error and infection?

A: Yes, the training for vaccinators will cover this.

Q: Do authorised vaccinators still need Covid-19 training?

A: Yes, a specific Covid-19 module for authorised vaccinators is being developed by IMAC and will be made available online.

Q: What is the training process for people who can't currently vaccinate?

A: There are provisional courses where new vaccinators can train. This course takes around four hours to complete, plus a one hour. Prospective vaccinators who complete this course may then proceed to the specific additional Covid-19 module.

Q: Will support be provided for peer assessment?

A: Yes, IMAC will be responsible for a network of regional Covid-19 advisors, and there will be coordinators to work alongside existing DHB coordinators. IMAC are also looking at running simulation clinics.

Q: Who is doing the recruiting for vaccinators? MoH or DHBs?

A: Our assumption is that DHBs will do this.

Q: Will DHBs have access to the surge workforce database?

A: Yes. Refer to information in this letter.

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Logistics and Distribution

Q: Will there be daily deliveries, i.e. seven days per week? At least six would be good so that Saturday and Monday clinics could run.

A: We will look at what is needed and if required deliveries will be made seven days a week.

Q: Will there be some guidance around using the vaccine doses up if ordered or reconstituted but not used? It seems better to administer it to someone rather than doses being wasted.

A: We are looking at this as part of our sequencing implementation work, noting that there is an efficiency trade-off decision to be made for doses that have been reconstituted or thawed.

Q: How should we reach household contacts?

A: We expect this will need to be coordinated by DHBs, working with employers and employees.

Q: What is the longest transit time for vaccines?

A: The longest road transit time is approximately nine hours. Our processes will take account of the transit time when picking up and packing, i.e. the furthest away will be picked up and dispatched first. We also have the option of flying.

Q: What support will be provided for scheduling?

A: We are still working on this and will keep you informed.

Q: When will we see additional sector comms around this - primary care are expecting to be delivering vaccine and need information.

A: We now have a communications team in place and will set up an information channel to ensure the primary sector gets all the information it needs in a timely fashion.

Q: Will the vaccine and clinical supplies be managed centrally through the two regional sites? Or is there any expectation that DHBs take part in the supply chain management.

A: The vaccine and clinical supplies will be managed centrally through the two regional sites. DHBs will have some responsibility in this to manage and update inventory quantities, ordering, planning, etc. and we will provide guidance on how this is expected to work.

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9(2)(a)

26 January 2021

Tēnā koutou katoa

I am writing to update you on the Government's plans for rolling out a COVID-19 vaccine and how it will involve your workers.

I have also attached an information sheet for you to share with your workforce.

As things currently stand, our border and MIQ workforces will be the first to receive the COVID-19 vaccine. This reflects the critical role they play, standing between us and those who might unwittingly bring the virus into our communities, and the higher risk that represents to their health.

In our current situation, where there is no community transmission, we expect to start vaccinating frontline workers and people they share households with as a priority. We have been working towards a second quarter rollout for this (potentially during March); however, if the vaccine is approved and becomes available earlier, we would look to move as soon as possible. Once the vaccine arrives in New Zealand, we expect to be able to complete vaccinating this group within weeks.

We expect to then make vaccines available for the general public in the second half of the year.

The confirmed timing depends on Medsafe approval of the vaccine, with a decision expected early next week, and when the suppliers can deliver it. We are confident we are well on track for the roll-out but we will keep you informed as this work progresses.

We also plan to offer vaccination to people who share households with border and MIQ workers around the same time to ensure they receive the same level of protection. Although we know the vaccine will protect individuals from the effects of the virus, it is too early for researchers to confirm whether a vaccinated person could still be a carrier and transmit COVID-19 to someone else. Vaccinating household contacts also helps protect against this potential risk. For this reason, mandatory testing of our border and MIQ workforce will still need to continue for the time being.

We will have more detailed conversations with you shortly regarding household contacts as we appreciate there are a number of things to consider there (ie shared custody situations, workers who stay away from home at times as part of their work, etc).

To ensure we are able to efficiently roll out the vaccine following Medsafe's approval, we are now busy putting in place all the necessary systems and processes. This includes working with District Health Boards who will be organising the actual administration of the vaccine, and with employers and other relevant agencies.

The only thing that might change our plan to prioritise vaccination of border and MIQ workers would be a community outbreak of any scale. In that situation, we would need to consider the situation of other groups, such as the elderly and other high-risk groups. If that happens, we will ensure workers and employers are kept informed of any changes to our delivery schedule and what this means for you.

As finer details of the rollout are confirmed, we will keep you updated of progress, including what you and your workers need to know and do. We know workers will have lots of questions and we would ask that you channel these through to 9(2)(a)

We appreciate teams have already been working together. As a follow up to Ashley Bloomfields presentation to border CEOs last week, we would like to invite you to a planning workshop on Monday 1 February 3pm to 4.30pm, where you can raise any questions. We will follow up with details.

For further information about the Ministry of Health's COVID-19 Vaccine planning visit

9(2)(a)

Thank you for your ongoing efforts to keep New Zealand communities free from COVID-19.

Ngā mihi

9(2)(a)

Mathew Parr

Programme Director

COVID-19 Vaccine and Immunisation Programme

Ministry of Health

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Sequencing the Roll out of COVID-19 Vaccines

It is likely that vaccines will become available in stages, which means we will need to consider the best way to sequence their delivery to provide the best protection for those who are at a higher risk of poor outcomes from COVID-19. We are preparing for three different scenarios for rolling out the vaccine, based on whether we are able to keep COVID-19 out of our borders or whether we are dealing with community transmission.

Group One

First group of people to receive the vaccine in each scenario

Group Two




Second group of people to receive the vaccine in each scenario



Group Three



Third group of people to receive the vaccine in each scenario

Scenario One

Low/no community transmission
Aim: Prevent transmission





-  Border and managed isolation & quarantine workforce
-  Health workforce at highest risk of exposure to COVID-19
-  Household contacts of the above two groups



-  High risk frontline health workforce
-  High risk frontline public sector and emergency services



-  People in the community, including:
 - Older people
 - People with underlying conditions
-  At risk health and social services workforce

Scenario Two

Clusters and controlled outbreaks
Aim: Reduce transmission and protect people in close contact




-  Border and managed isolation & quarantine workforce
-  Health workforce at highest risk of exposure to COVID-19
-  Household contacts of the above two groups
-  Population affected by the outbreak




-  High risk frontline health workforce
-  High risk frontline public sector and emergency services



-  People in the community, including:
 - Older people
 - People with underlying conditions
-  At risk health and social services workforce

Scenario Three

Widespread community transmission
Aim: Protect those most vulnerable to prevent illness and mortality

-  Border and managed isolation & quarantine workforce
-  Health workforce at highest risk of exposure to COVID-19
-  Household contacts of the above two groups

-  High risk frontline health workforce
-  High risk frontline public sector and emergency services
-  Remaining frontline health workforce

-  Remaining health and public sector workforce
-  Other population groups

Unite
against
COVID-19

Appendix B: COVID-19 Vaccine Sequencing Framework: Population cohort definitions for Tiers 1 and 2

Scenario One:

SCENARIO & TIER	POPULATION COHORT	DEFINITION
TIER ONE: THE BORDER AND MIQ		
Tier 1	Border workforce, all workers recorded on the official Border Register as per the Border Order.	<p>"Affected persons" at a New Zealand border (airport or marine port) as defined by the COVID-19 Public Health Response (Required Testing) Order 2020¹. Includes only the workforce that qualify for routine COVID testing as recorded on the official Border Register within the following categories:</p> <ul style="list-style-type: none"> - Aircrew members who qualify based on the border order - Flight or ship workers who spend more than 15 minutes in an enclosed space (plane or ship) and qualify based on the border order - Airside government officials - Airside DHB workers - Airside retail, food, beverage workers - Airside cleaners - Airline/airport workers interacting with international passengers and baggage - Other landside workers interacting with international passengers - Pilots, stevedores working on/around, and people who board affected ship - Workers who transport to/from affected ship - Other port workers who interact with people required to be in isolation - Health workers providing COVID-19 testing services to these sites.
	MIQ workforce	<p>"Affected persons" at a New Zealand border (airport or marine port) as defined by the COVID-19 Public Health Response (Required Testing) Order 2020². Includes only the workforce that qualify for routine COVID testing as recorded on the official Border Register within the following categories:</p>

¹ <http://www.legislation.govt.nz/regulation/public/2020/0284/latest/whole.html#LMS426656>

² <http://www.legislation.govt.nz/regulation/public/2020/0284/latest/whole.html#LMS426656>

		<p>This includes:</p> <ul style="list-style-type: none"> - All MIQ workers - MIQ Healthcare workers including medical, nursing and support staff who provide services to these facilities - Workers who transport to/from MIQ.
	Household Contacts of the eligible Border and MIQ workforce	Any person who usually resides in a household or household like setting with (a border or MIQ worker as set out above), regardless of whether they are related or unrelated people; this will include people who may reside part-time in the household including children and partners not permanently resident in the household.
TIER TWO: FRONTLINE WORKFORCES AND AGED RESIDENTIAL CARE		
Tier 2 (a)	Frontline non border health workers potentially exposed to COVID whilst providing care.	<p>The frontline healthcare workforce in healthcare service delivery settings where possible cases will seek healthcare as there is no ability to screen for COVID before the interaction occurs.</p> <p>It includes only staff who are at the front line <u>interacting directly with patients</u> in:</p> <ul style="list-style-type: none"> - COVID-19 testing (taking samples and laboratory analysis) - Administering COVID-19 Testing - Administering COVID-19 Vaccinations - Ambulance services - Emergency Department Front Line Workforces - Emergency response diagnostics (e.g. radiology) and support staff (e.g. orderlies, security, receptionists) who are interacting with patients - Community Midwives and WCTO workers in people's homes - General Practice front line workforce including GPs, nurses and receptionists - Pharmacy front line workforce - NGOs (including whanau ora) providing first response personal health services directly to patients (excludes mental health and addictions, social support services) - Urgent Care Clinics and Accident & Emergency front line staff - Healthcare providers providing treatment services to people in managed isolation. This only includes the four centres with MIQ facilities and only extends to services which receive MIQ patient referrals.

Tier 2 (b)	Frontline healthcare workers and critical workforce (e.g. NZ Police) who may expose more vulnerable people to COVID	<p>The frontline healthcare workforce working in healthcare service delivery settings interacting with patients/clients.</p> <p>Frontline healthcare workers <u>interacting with patients</u>:</p> <ul style="list-style-type: none"> - Inpatient, ambulatory and outpatient publicly funded hospital services including community staff and diagnostics - All residential care workers including mental health and disability - Home care support workers including aged care and disability support - Community diagnostics – radiology, laboratories - All other primary care not included in Tier 2 (a) - Community and home-based services - All NGO and community-based services including iwi-based services, mental health - Community public health teams - Outreach Immunisation staff - COVID Incident Management Teams at each DHB
	ARC workers and residents	Any person who works (in a casual, fixed term, permanent or volunteer position), or usually resides in an Aged Residential Care setting, includes Corrections High Dependency Units .
	Critical Workforces	<p>Other Critical Workforces:</p> <ul style="list-style-type: none"> - NZ Corrections Services - Only those based inside prisons or residential facilities - NZ Police – frontline Police only - Offshore public servants when in New Zealand: Public sector staff (and their families if relevant) who are required to travel offshore on official Government business to high-risk locations, including diplomatic and consular staff. - NZ Defence Force (limited to only frontline responders) - Fire and Emergency New Zealand.

9(2)(a)

From: Kirsten Curry [<mailto:Kirsten.Curry@health.govt.nz>]
Sent: Friday, 5 February 2021 6:55 p.m.
To: GM P&F <GM.PandF.Governance@tas.health.nz>; O365.DLIST.DHB-GMsPlanningandFunding@TAS <DHB-
Subject: RE: update: urgent action required: provision of numbers inside tier2(a) and Tier(b)

CAUTION: This email originated from outside TAS. Please only click on links or open attachments if you are confident the sender is genuine and know the content is safe

Kia ora,

Thank you for your time today.

I have confirmed that the **amendments to the population definitions are not material**. Please find attached. These will also be circulated via the letter being sent out tonight.

We would appreciate the information by COP Thursday 11 February to [9\(2\)\(a\)@health.govt.nz](mailto:9(2)(a)@health.govt.nz). The information is being used to provide information to senior Ministers, including the Prime Minister, and to support inventory planning. Please get in touch if you have any questions or issues with completing within the timeframe.

We have prepared a template based on the definitions, you are welcome to use this or send through in any format that is best for you.

Ngā mihi,
Kirsten

From: GM P&F <GM.PandF.Governance@tas.health.nz>
Sent: Friday, 5 February 2021 1:46 pm
To: GM P&F <GM.PandF.Governance@tas.health.nz>; O365.DLIST.DHB-GMsPlanningandFunding@TAS <DHB-
GMsPlanningandFunding@tas.health.nz>; [9\(2\)\(a\)@tas.health.nz](mailto:9(2)(a)@tas.health.nz);
Cc: [9\(2\)\(a\)@tas.health.nz](mailto:9(2)(a)@tas.health.nz); [9\(2\)\(a\)@tas.health.nz](mailto:9(2)(a)@tas.health.nz); [9\(2\)\(a\)@tas.health.nz](mailto:9(2)(a)@tas.health.nz); [9\(2\)\(a\)@tas.health.nz](mailto:9(2)(a)@tas.health.nz); [9\(2\)\(a\)@tas.health.nz](mailto:9(2)(a)@tas.health.nz); Kirsten Curry <Kirsten.Curry@health.govt.nz>; [9\(2\)\(a\)@tas.health.nz](mailto:9(2)(a)@tas.health.nz);
Subject: update: urgent action required: provision of numbers inside tier2(a) and Tier(b)

Hi All

Following a discussion with the Ministry today, we understand DHBs will receive a letter later today from the Ministry with further refinement of the sequencing framework and definitions. The Ministry has said you can 'stand down' on collating the numbers requested in the email below, until you receive the further communication later today.

Ngā mihi
Rachel



Rachel Mackay
Director, Integrated Community Services

T 9(2)(a)
[Redacted]
www.tas.health.nz

From: GM P&F

Sent: Thursday, 4 February 2021 2:59 PM

To: O365.DLIST.DHB-GMsPlanningandFunding@TAS <DHB-GMsPlanningandFunding@tas.health.nz>

9(2)(a) @tas.health.nz; 9(2)(a) @tas.health.nz; 9(2)(a) @tas.health.nz; 9(2)(a) @tas.health.nz;

Kirsten Curry <Kirsten.Curry@health.govt.nz>; 9(2)(a)

Subject: urgent action required: provision of numbers inside tier2(a) and Tier(b)

Sent on behalf of Rachel Haggerty:

Kia ora koutou

Can you please provide possible numbers inside Tier 2(a) and Tier 2(b) as per the timeframes agreed at GMs Planning & Funding meeting. This may have already occurred but it is an essential deliverable for DHBs. Attached is the latest version of the Sequencing Framework from the Ministry (thanks Kirsten).

Can you please prioritise sending the possible numbers for Tier 2(a) by 3pm Friday 5 February (tomorrow);

Tier2(b) is needed at a later date, suggest Thursday 11 February. Kirsten please let us know if there's a more definitive date you need the information by.

Please send your response to 9(2)(a)

We will also send you feedback to review on the funding model this afternoon.

Ngā mihi nui

Rachel Haggerty

Chair

National GMs Planning & Funding

20 District Health Boards

Director Strategy Planning and Performance | Capital & Coast and Hutt Valley District Health Board

9(2)(a)

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Population Sequencing - Health workforce data collection

DHB Name

Contact person

Tier Two: Frontline workforces and Aged Residential Care

Population

Comments

Tier Two (a): The frontline healthcare workforce in healthcare service delivery settings where possible cases will seek healthcare as there is no ability to screen for COVID-19 before the interaction occurs

COVID-19 testing (taking samples and laboratory analysis)		
Administering COVID-19 testing		
Administering COVID-19 vaccinations		
Ambulance services		
Emergency department front line workforces		
Emergency response diagnostics and support staff interacting with patients		
Community midwives and WCTO workers in peoples homes		
General Practice front line workforce including GP's, nurses and receptionists		
Pharmacy front line workforce		
NGOs (including Whānau Ora) providing first response personal health services directly to patients (excluding mental health and addictions, social support services)		
Urgent Care Clinics and Accident and Emergency front line staff		
Healthcare providers providing treatment services to people in managed isolation (only in four centres with MIQ and services which receive MIQ patient referrals)		

Tier Two (b): The frontline healthcare workforce working in healthcare service delivery settings interacting with patients / clients

Frontline healthcare workers and critical workforces

Inpatient, ambulatory and outpatient publicly funded hospital services including community staff and diagnostics		
All residential care workers including mental health and addictions and disability		
Home care support workers including aged care and disability support		
Community diagnostics - radiology, laboratories		
All other primary care not included in Tier 2 (a)		
Community and home-based services		
All NGO and community-based services including iwi-based services and mental health and addictions		
Community public health teams		
Outreach immunisation staff		
COVID Incident Management Teams at each DHB		

ARC workers and residents

General comments

Canterbury District Health Board CVIP Volumes and Planning - 24 May 2021

DHB Volumes and Planning – Supporting information required for Canterbury DHB	
Demand Planning	
1. Local Invitation Strategy	
1.1 Please provide an overview of the local invitation strategy to bring people into sites for vaccination.	<p>Canterbury DHB will utilise a variety of strategies to invite people to be vaccinated using the strengths of the whole of the Canterbury health system and drawing on the wider community to support invitation processes.</p> <p>Overall principles include:</p> <ul style="list-style-type: none"> • An overriding focus on equity; inviting those most at risk before others. • Developing invitation approaches that meet the needs of the diverse range of people that make up our local communities. • Using invitation approaches that provide a positive initial experience of the vaccination programme to increase uptake. • Providing people with multiple options for invitation and booking via general and targeted strategies. • Utilising culturally appropriate invitation processes, as determined by local community leaders. • Aligning communications to avoid confusing messages. • Streaming invitations over time to not overwhelm capacity to deliver. <p>Primary care will be responsible for a significant component of the invitation process for Groups 3 and beyond as they hold relevant information and contact details for a large part of our communities and can target specific groups in the sequencing framework.</p>

	<p>This will be supplemented by targeted approaches to ensure equitable access for all people, including supported booking processes utilising Māori and Pacific providers, NGOs and community groups who support older people, disabled people and other communities of interest.</p>
1.2 What information datasets will you use to identify and invite people for vaccination?	<p>Primary care practice management systems (PMS) will primarily be utilised to identify and send communications to their enrolled population to invite them to book an appointment to be vaccinated.</p> <p>This will be supplemented by using local Māori / Pacific and other community, social and health providers to identify people and support their booking (mostly via the National Booking System [NBS]).</p>
1.3 What methods will you use to invite people for vaccination? (i.e., email and text)	<p>Primary care will send texts, emails and letters to invite their enrolled populations to book for vaccination.</p> <p>Outbound calls will be used to support invitation in certain circumstances – for example, Ngai Tahu will call people enrolled with them to invite them to attend Māori mobile clinics at marae. He Waka Tapu will work with Nga Hau e Wha Marae to call Māori whanau and invite them to attend the Whanau Ora Designated Clinic.</p> <p>Kaupapa Māori providers will use their staff to link and connect whanau to the range of vaccination services provided.</p> <p>Etu Pasifika will provide a short-term booking and coordination function locally. This function will begin with a focus on Pasifika peoples including the enrolled population of Etu Pasifika. For June through mid-July the intention is for Etu Pasifika to use their MedTech system primarily to text, email Pasifika families, community and church groups. This will be augmented by face-to-face approaches through existing relationship networks.</p> <p>This invitation service will include speakers of a range of Pacific languages starting with Samoan, Tongan, Fijian, Cook Islands Maori. In addition to booking invitations this service will triage to connect people with liaison and support services as required. Along with Etu Pasifika these services will include Pacific clinicians and health workers from Tangata Atumotu Trust, Vaka Tautua and Pegasus, Christchurch and Waitaha PHO's, Canterbury District Health Board and Ministry for Pacific Peoples.</p> <p>Community groups and social sector providers may use face-to-face approaches to invite people to book (for example to a mobile church-based clinic).</p>

<p>1.4 What are your limitations or areas of concern when inviting people for vaccination?</p>	<p>Identified areas of concern include:</p> <ul style="list-style-type: none"> • Capacity of the NBS to cope with the volume of calls for assisted bookings. • The lack of accessibility to the NBS for Pasifika, Culturally and Linguistically Diverse (CALD) communities, people who don't have English as a first language and people who do not have ready access to the internet and/or transport. • The need to stream the invites in such a way as to align with capacity of booking and delivery systems. • The potential for duplicate invites for whanau or communities when a range of invitation strategies are utilised.
<p>1.5 Have you identified any additional invitation strategies that could be considered?</p>	<p>Other possibilities being considered include:</p> <ul style="list-style-type: none"> • Providing community groups with access to the NBS to facilitate invitations to their communities of interest. • Having people in public places (such as libraries and other community facilities) who can book people into the NBS – particularly for those who aren't enrolled in primary care or don't have easy access to text or email or a phone. • Enlisting support from community services providers, NGOs and social sector agencies, such as MSD, to help us connect to vulnerable whanau and communities. • A solution that integrates the national booking system with the localised resources and assets – i.e., a mobile solution that could reach geographic, church and ethnic communities more effectively.
<p>2. Equity</p>	
<p>2.1 Please provide an overview of your approach to working in partnership with your respective Māori, Pacific and disability providers and communities.</p>	<p>Mechanisms for engagement with Māori, Pasifika, CALD, the disability community and other priority groups have been established and the programme is working in partnership to plan and implement delivery models that will enhance access.</p> <p>Our leadership structure has been designed with strategic equity leadership on our Waitaha Covid-19 Vaccination Strategic Group, that is connected to collaboratives of Māori, Pasifika and Disability leaders, including:</p> <ul style="list-style-type: none"> • Te Ohu Urupare, a Māori health leadership response group established to give effect to Te Tiriti responsibilities of the Canterbury health system. Te Ohu Urupare provides a collective Māori voice at the highest level of decision-making in any emergency response from the Canterbury health system and membership includes Manawhenua Ki Waitaha, Te Runanga O Ngai Tahu, Kaupapa Māori NGOs, Māori clinicians, Whanau Ora leaders' researchers/academic, DHB, PHO, community and Te Puni Kokiri.

	<ul style="list-style-type: none"> • Pasifika Health Collective including membership from Etu Pasifika, Tangata Atumotu Trust, Vaka Tautua, Ministry for Pacific Peoples, PHOs and DHB. • Canterbury DHB Disability Steering Group that includes representatives of the disability community, Māori, Pacific, whanau, Canterbury DHB clinical and managerial leads, primary care and Canterbury Clinical Network clinical lead. <p>Dedicated clinical and project leads have been appointed to coordinate and support the work in these areas.</p>																												
2.2 How many vaccines approximately will be needed for both the DHB and the local providers?	<table border="1"> <thead> <tr> <th>Week Starting</th><th>Planned Vaccines Delivered</th></tr> </thead> <tbody> <tr><td>7/05/2021</td><td>23230</td></tr> <tr><td>7/12/2021</td><td>26224</td></tr> <tr><td>7/19/2021</td><td>29110</td></tr> <tr><td>7/26/2021</td><td>35249</td></tr> <tr><td>8/02/2021</td><td>36440</td></tr> <tr><td>8/09/2021</td><td>37574</td></tr> <tr><td>8/16/2021</td><td>37574</td></tr> <tr><td>8/23/2021</td><td>37574</td></tr> <tr><td>8/30/2021</td><td>37574</td></tr> <tr><td>9/06/2021</td><td>37454</td></tr> <tr><td>9/13/2021</td><td>37454</td></tr> <tr><td>9/20/2021</td><td>37454</td></tr> <tr><td>9/27/2021</td><td>37454</td></tr> </tbody> </table> <p>The CDHB delivery plan from 1 July to 30 September plans to deliver 446,000 vaccinations in total. We also expect to deliver another 45,000 from 25 May to 1 July.</p> <p>CDHB over 16 population is approx. 442,000 according to the National Enrolment Service. Therefore, a maximum of 884,000 doses will be needed assuming the age range of vaccination does not change. An uptake rate at the national expected average of 77%* would require 681,000 doses.</p> <p>* At a glance – April 2021: https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-vaccines-archived/covid-19-vaccine-strategy-planning-insights/covid-19-vaccine-research-insights</p>	Week Starting	Planned Vaccines Delivered	7/05/2021	23230	7/12/2021	26224	7/19/2021	29110	7/26/2021	35249	8/02/2021	36440	8/09/2021	37574	8/16/2021	37574	8/23/2021	37574	8/30/2021	37574	9/06/2021	37454	9/13/2021	37454	9/20/2021	37454	9/27/2021	37454
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<p>2.3 What outreach services will be delivered to ensure an equitable uptake of the vaccine in hard to reach communities?</p>	<p>Alongside dedicated clinics at Nga Hau e Wha marae and Etu Pasifika, mobile outreach teams will be utilised to support target groups, locations and hard to reach communities. This will follow the completion of our long-term resident's programme.</p> <p>The mobile outreach programme will be centrally planned and prioritised with the various leadership groups that incorporate Māori, Pasifika, CALD and disability collaboratives and representatives. This will include services provided across Marae, at churches, kura, the refugee centre and other areas as recommended.</p> <p>Targeting of this service will be a process of working with service providers and analysis of CIR data to identify and act on emerging gaps in programme provision.</p>
<p>2.4 What communications, including targeted communications, are being delivered to increase uptake and address hesitancy?</p>	<p>Trusted faces and trusted places</p> <p>Our strategy to increase uptake and reduce hesitancy involves leveraging trusted community leaders, representatives and influencers. These organisations and individuals, supported by us, are delivering targeted, timely, accurate information, using trusted channels and in trusted places.</p> <p>We're setting up our clinics in places where our target communities live, work, worship and play, and using trusted faces from these places and communities to promote them.</p> <p>We're creating content, using faces and voices from target communities, for publications and channels that our target communities watch, read and follow.</p> <p>We're amplifying and sharing messaging about where to find accurate, credible information, and encouraging communities to report mis and dis-information.</p> <p>He tangata, He tangata, He tangata</p> <p>We're supporting and partnering with mana whenua and Pacific communities. We're supporting, enabling and empowering our partners to deliver what's best for their communities to improve health outcomes, at the pace of trust.</p> <p>Together, we're providing safe places; online, in places of worship and celebration and at workplaces, initially, to encourage dialogue, aroha, and to acknowledge communities' very real fears, uncertainties and questions, then to provide accessible,</p>

	<p>safe, welcoming spaces in which individuals can be vaccinated. Supporting communications materials are made available at each step of the journey in languages, formats and on channels that best suit each community and individual.</p> <p>Once hesitant individuals choose to be vaccinated, we'll tautoko, affirm and celebrate their decision by highlighting manaaki tāngata; their choice to protect themselves, their whānau and their community. We'll encourage individuals to share their vaccination journeys, and we'll provide communications and engagement materials that support them to do so, for example, Facebook frames and Instagram filters, stickers, COVID-19 superhero 'selfie' banners.</p>
2.5 Who will be accountable for equity for Māori, Pacific and disabled people across the delivery of the vaccine rollout programme (e.g. an equity-specific role)?	<p>The Waitaha Covid-19 Vaccination Programme is accountable for ensuring equitable access to vaccines for Māori, Pacific and disabled people. The overall aim of our programme is 'to ensure that all eligible people living in Canterbury have the opportunity to receive the COVID-19 vaccine by the end of 2021, in a way that is equitable, acceptable, and accessible'.</p> <p>As described above, our Waitaha Covid-19 Vaccination Strategic Leadership Group includes key Māori, Pasifika and Disability leaders that are connected to Te Ohu Urupare, Pasifika Health Collective and the Canterbury DHB Disability Steering Group. Dedicated project leads are identified across these areas, alongside the Emergency Control Centre Welfare Lead.</p>
2.6 How will providers be included in the planning and delivery of services?	<p>We have established a Waitaha Covid-19 Vaccination Strategic Leadership Group which includes provider/ community leaders from Māori, Pacific, Rural, Aged Care, Mental Health and Disability groups. They have the role of connecting with members of these communities and helping to ensure issues can be raised at a strategic level across the Programme.</p> <p>Providers across these groups have been consulted with throughout the planning and delivery of the programme. They have contributed to, and in many cases designed the services required for their communities. These services will continue to be monitored for effectiveness and adjusted according to need as the programme progresses.</p>
2.7 What equity targets you will have for Māori, Pacific and	<p>The programme office receives daily information on the numbers of Māori and Pacific persons vaccinated, which is reported in the daily SitREP to all Waitaha Covid-19 Vaccination Programme members, clinical leads, local executives across the system. This information is also reported to the Waitaha Covid-19 Vaccination Governance Group on a weekly basis.</p>

<p>disabled people, and how you monitor them in your region?</p>	<p>We will be doing more work with our disability representatives to understand the most effective way of gathering and interpreting data around vaccination rates in the disability community. It is unlikely the CIR will be able to provide the entirety of this data, as this is a diverse community and often under-reported in standard health screening tools at point of access.</p> <p>Vaccination rates in these groups should reflect comparable uptake to the rest of the population, once adjusted for enhanced equity targets.</p>
<h2>Capacity Planning</h2>	
<h3>3. Service Models and Sites</h3>	
<p>3.1 What is your accountability model and operating model for decision making?</p> <ul style="list-style-type: none"> - Please refer to the draft accountability framework for guidance. 	<p>Canterbury DHB is planning and delivering the vaccination rollout through a co-ordinated Vaccination Programme that uses a modified Emergency Coordination Centre (ECC) structure, supported by a governance group and a strategic leadership group.</p> <p>The Canterbury COVID-19 vaccination programme governance group meets weekly and includes CDHB Chair, Canterbury Clinical Network Chair, CDHB CEO, CDHB COVID Clinical Lead and CDHB COVID Executive Lead, ECC Controller and Vaccination Programme Lead, Vaccination Programme Clinical Leads, Māori/Equity Lead and Ministry Regional Director.</p> <p>The strategic leadership group meets fortnightly. This group contributes to and supports decision making and provides guidance on operational procedures pertaining to the delivery of the local vaccination programme, based on current evidence, experience, and international and national guidelines. This group includes membership from people with links to Māori, Pasifika, rural, disability, nursing, pharmacy, primary care, public health, older people, mental health.</p>

	<p>A Quality and Safety Group is also being established, following an initial workshop held on Wednesday 19 May. This will be formalised over the next fortnight.</p> <p>The CDHB ECC was activated on Monday 19 April 2021 as part of the Canterbury DHB's COVID-19 Vaccination Rollout. The ECC is mandated by the CDHB Chief Executive and his Executive Management Team.</p> <p>The ECC ensures a high-level of communication and service continuity across and within the COVID-19 vaccination programme. Its focus is to work with all key stakeholders, identifying gaps, pinch points and areas of concern and addressing these swiftly and appropriately. It also delivers liaison between the Ministry of Health and the CDHB. The ECC will share communications and information across its networks with communities and make timely decisions and action outcomes as soon as possible. It will deliver situation reports, operational reporting and any other documents requested by the Ministry of Health on time and to brief. It will identify obstacles or difficulties to delivering and maintaining agreed service levels and monitor, manage or escalate factors outside its control that are critical to its success. This is facilitated by daily ECC leadership meetings.</p> <p>The ECC is responsible for and works within the geographic boundaries of the CDHB. All key decisions, activities or issues are noted and shared with the Chief Executive as appropriate. Risks or threats to the successful delivery of this programme are detailed in the ECC's risk register.</p>
<p>3.2 What sites are you planning to run and what model (mega sites, GP Hubs)?</p>	<p>The following delivery channels are planned for the period 1 July to 30 September:</p> <p>Mass Vaccination Centres (MVC)</p> <ul style="list-style-type: none"> - The existing site at Orchard Road will increase its current operating capacity (2,400 pw) to 7,105 pw - A new site will be activated at the Princess Margaret Hospital, increasing to a planned capacity of 7,105 pw - Replacement of 9(2)(c) will be achieved with a partnership between CDHB Primary Care to upscale three suitable Primary Care Designated Clinics, providing geographic coverage and access for populations in the East of Christchurch. Three sites with individual capacity of between 1500 and 2200 pw are in various stages of planning at Eastgate Mall, Nga Hau e Wha Marae 9(2)(c). <p>Urban or semi urban Primary Care Designated Clinics.</p>

Designated Clinics are generally operated by General Practice, Community Pharmacy or a local collaboration of primary care providers. These clinics can be centrally booked via the NBS and will provide capacity to support the phased “Invitation process” planned across Canterbury.

The existing cluster of eight Designated Clinics as of 30 June will ramp up to provide a total capacity of 7,100 pw.

Following 1 July, a further 10 Designated Clinics are planned to open providing an additional capacity of 6,100 pw.

Rural Primary Care Designated Clinics

Nine rural Designated Clinics will be established by the programme prior to 30 June. These are relatively small clinics and will provide a total planned capacity of 1,230 pw until the local populations have been fully vaccinated.

Māori and Pasifika Fixed sites

Planned sites include:

- 9(2)(c) [REDACTED]
- Nga Hau e Wha - Pages Rd
- 9(2)(c) [REDACTED]
- 9(2)(c) [REDACTED]

General Practice and Pharmacy

The current production plan does not include General Practice and Pharmacy sites operating as standalone clinics (other than as Designated Clinics). We are currently collaborating with the three Canterbury PHOs to build the operational and clinical process necessary to onboard individual primary care providers at scale. Once these processes and the necessary vaccine supply logistics are in place, we intend to begin onboarding individual primary care sites. Depending on the rate at which these sites can be onboarded we will likely downscale the capacity of our Designated Clinics, effectively substituting one channel for another. Pasifika health collective are working with PHO's to determine focused support services for General Practices and Pharmacies operating as designated clinics and those with significant Pasifika enrolled populations

Māori and Pasifika Mobile Outreach

Mobile teams will visit Marae, Churches and other targeted locations (on a number of occasions) including:

- 9(2)(c) [REDACTED]

	<ul style="list-style-type: none"> • 9(2)(c) • 9(2)(c) • 9(2)(c) <p>Mobile Outreach Services</p> <p>Three mobile teams will complete the tier 2b long-term residential cohort by 31 July. These teams will then be available to support remote rural and other hard to reach populations e.g., CALD and other disabled populations.</p>
<p>3.3 What challenges are you facing on sites and site capacity?</p>	<p>The operational team have identified a range of challenges across vaccination sites, several of which have been addressed already through the programme's focus on continuous quality and process improvement. The challenges below are those that remain difficult to reduce or remove and where there may be an opportunity for the centre to support improvement. They have been grouped into categories, noting that challenges differ depending on the model of vaccination delivery e.g., some challenges identified for mobile clinics provide efficiency when the setting is varied to a fixed site (primary care designated clinic or mass vaccination site) and vice versa.</p> <p>Workforce</p> <ul style="list-style-type: none"> • There is a significant increase of workforce required to ensure that we have the capacity to deliver vaccination at the scale required from August 2021. Identifying and establishing a casual workforce from a limited pool of resources that are already stretched delivering health services while not impacting BAU activity further. • Use of the unregulated workforce (vaccinator assistants) may not increase capacity. It is unlikely that we will identify significant numbers of people who are not already working in health to join this programme. The training of this workforce is proposed to be undertaken by the programme, which will be challenging to place on top of the onboarding requirements that are currently in place for vaccinator, administrative and recovery workforces. Additional centralised support with simple process to support effective recruitment of the unregulated workforce. • Efficient use of existing staffing models could be improved by investing in technician assistance to support vaccine management and undertake drawing up. Technicians could be trained through Pharmacy to assist with this, releasing vaccinator time for increased vaccination. • An effective and scalable model to vaccinate groups 3 & 4 is one that maximises the existing vaccinator workforce and utilises the expertise and geographic coverage of primary care. However, the available capacity within our

workforce is further challenged by the constraints inherent in the current education and onboarding models of CIR, IMAC and the National Booking System.

Demand Management

- Lack of a national booking system to date, has resulted in a complex local solution of a combination of 0800 numbers, online booking system, and local PMS systems. This has created a significant workload for the programme to manage capacity and demand and has reduced the speed with which we can confidently expand our network of sites. A clear transition plan is required to migrate existing systems to the NBS when it becomes widely available.
- Messaging and media communication that is developed and delivered from the centre has not aligned with local delivery capacity and priorities. This has created challenges for managing expectations and significantly increased the workload for our administrative staff, call centre staff and general practice teams. These teams have been subjected at times to frustrated and agitated members of the public.
- Messages that are not aligned to delivery requires crowd control responses to manage unexpected walk-in demand diverting vaccination teams from the timely delivery of vaccination events.
- As the population's understanding of the sequencing framework increases certain people are taking advantage of this knowledge to book appointments out of sequence. This is only apparent when they present for vaccination.
- The establishment of a designated clinic at Etu Pasifika in the central city could create unintended consequences if open to the national booking system. As an equity response Etu Pasifika will initially be focused on Pasifika including their enrolled population. Moving into July/August and beyond will enable a planned transition and widening of Etu Pasifika to serve the general population.

Acceptability

- Achieving high quality service delivery has required the perspectives of all groups receiving vaccination to be considered and responded to. Large scale delivery models can present a challenge to provide a culturally appropriate, inclusive, and accessible response when large volumes of people flow through a centre in a day. In response we have identified and established equity targeted initiatives through specific primary care designated clinics and mobile outreach service delivery. A quality plan, and associated Quality and Safety Steering Group, is in development, which will be user informed and will identify measures to assess our quality performance against.

Location

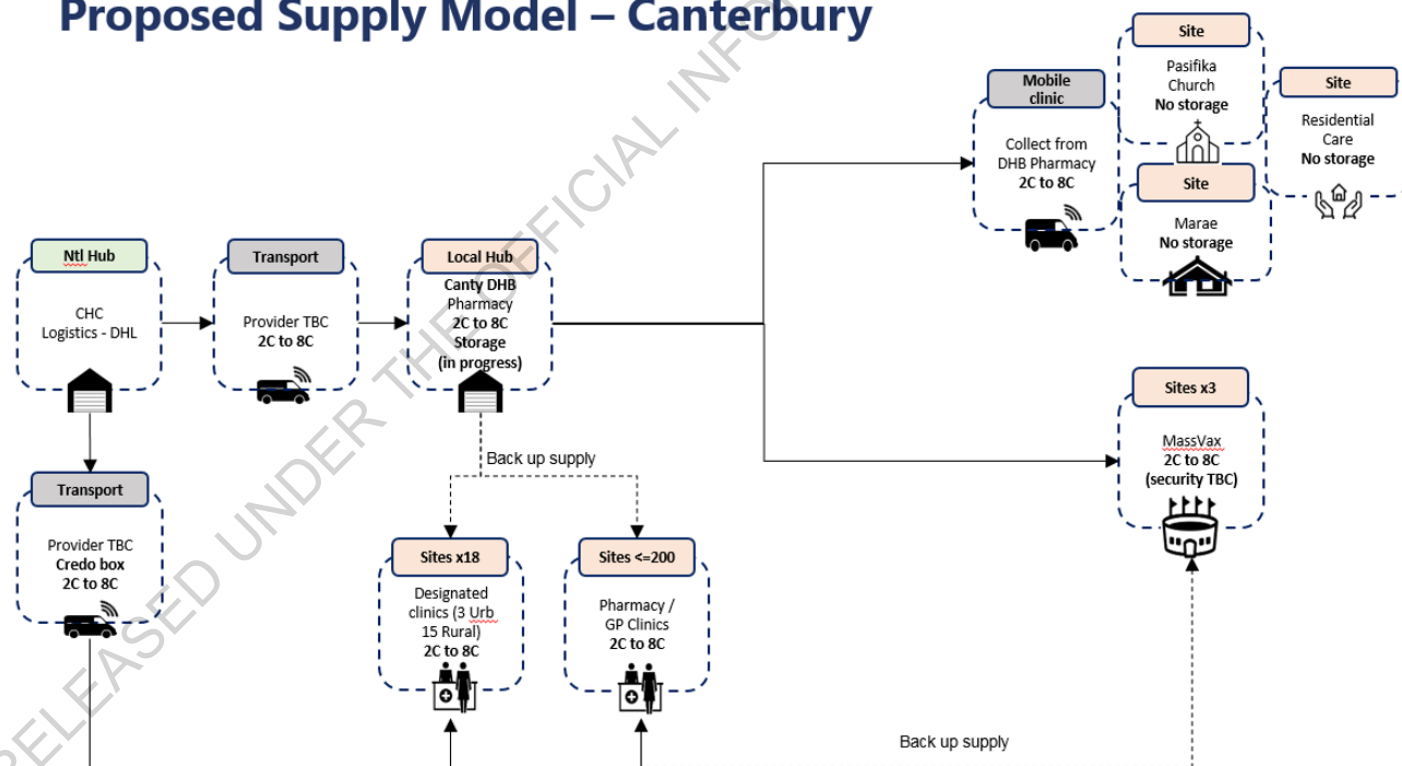
	<ul style="list-style-type: none"> Suitability and availability of facilities to accommodate large scale vaccination does not align well with providing good geographical access for populations. Some sites may be at some distance from workplaces and communities which creates barriers to access. Careful consideration of location alongside a range of transport and accessibility options have been key to ensure reasonable geographical distribution for our mass vaccination centres, alongside a mixed delivery model of smaller designated clinics and mobile outreach services. <p>Daily Operations</p> <ul style="list-style-type: none"> There have been delays in the delivery of Covid-19 related collateral despite significant lead times provided. This has resulted in the diversion of vaccination team members to collect and redistribute across our network. Managing clinic flow when there is a requirement to complete a clinic as paper based. Finding resources to retrospectively upload the information to the CIR has been a challenge. Changes to our operating procedures have removed this issue. Ensuring that there are enough local CIR experts to support onboarding, day to day clinic delivery as well as manage data entry, error correction and ensure that people without NHIs receive one in a timely manner has been challenging for the programme. This can create further inefficiencies in second dose delivery if there has been a delay.
<p>3.4 What are your distribution models to support these sites?</p>	<p>Currently, vaccines are provided to all urban sites from Christchurch Hospital Pharmacy, and all rural sites direct from HCL Auckland via MOH contracted transportation.</p> <p>From July, the Christchurch DHL Hub, contracted by the MOH to store and distribute vaccines, will be operational. Over the next few weeks, distribution to non-DHB urban sites will transition to supply direct from this Hub. DHB sites, including DHB run mobile clinics and mass vaccination centres, will continue to be supplied by Christchurch Hospital Pharmacy as the business-as-usual channel for supplying medicines and vaccines to the DHB facilities.</p> <p>Christchurch Hospital Pharmacy will continue to be a back-up and surge supply as needed for all sites, including non-DHB, enabled by the Licence to Sell Medicines by Wholesale (Wholesale Licence) and the Licence to Operate a Pharmacy both issued by the MOH. Christchurch Hospital Pharmacy will also manage the movement between sites of expiring vaccines to minimise wastage as needed and as allowed by the Wholesale Licence. Additional support and cold chain storage are</p>

available from other CDHB Hospital Pharmacy sites (Burwood and Ashburton), which each have a Wholesale Licence for the purposes of distributing the Pfizer Comirnaty vaccine.

Vaccines will arrive thawed at 2oC to 8oC to all sites, with the Christchurch DHL Hub being the only freezer capacity in the Canterbury region. Christchurch Hospital Pharmacy has a freezer capable of storing vaccines at –20oC if needed.

This model is supported by the purchase of static and mobile cold chain equipment, the recruitment of pharmacy staff to fixed term roles and the provision of transportation to the team.

Proposed Supply Model – Canterbury

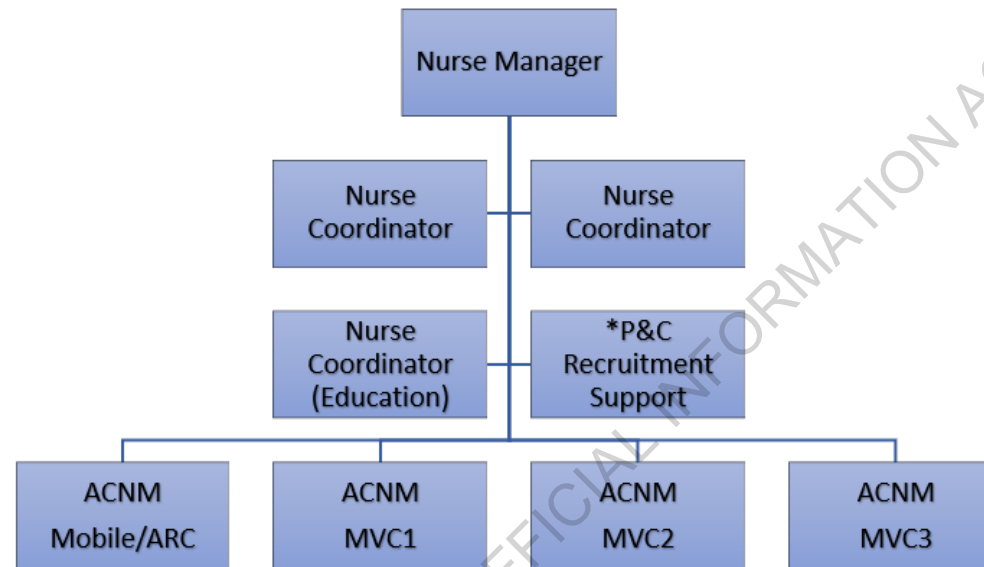


4. Workforce	
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4.1 What are the staffing models that will be applied to different sites?

Clinical Staffing Senior Nursing Structure



Vaccinators - mass vaccination clinic			
Role	Minimum Standard	Ideal Standard	Notes
Allocated to Vaccination station	1 per vaccination station	1 per vaccination station	This is the core role, so the number of vaccination stations scales according to the availability of vaccinators.
Float (includes drawing up and Lead Vaccinator)	1 per 3 vaccination stations	1 per 3 vaccination stations	This is to allow for drawing up, general flexibility for breaks etc and provision for one of these people to be the nominated lead vaccinator / shift lead to provide leadership and oversight.
Observation area	0	1 per observation area	How many Nurses are required depends on the physical layout of the clinic including lines of sight. It is ideal to have this person available, but if not the observers (admin) will need to pull an authorised vaccinator from float or a vaccination station as required.
Total	1.3 vaccinators per station	1.3 vaccinators per station + 1 Observation	Capacity is assumed to be 65 vaccinations per station per day based on 6.5 hours per day multiplied 10 vaccinations per hour.

Administrators – Mass Vaccination Clinics			
Role	Minimum Standard	Ideal Standard	Notes
Welcoming / wayfinding	0 per site	1 per site (provided from float see below)	If other staff such as security are available, they can perform the welcoming / wayfinding role if agreed.
Vaccination support / registration	1 per vaccination station	1 per vaccination station	These administrators are usually positioned on the way in to do patient registration / booking in as there are a <u>number of questions</u> to be completed.
Float	1 per 3 vaccination stations	1 per 3 vaccination stations	One of these float administrators fills the welcoming / wayfinding role if available.
Post-vaccination observation	1 per 4 vaccination stations??	1 per 3 vaccination stations??	At a rate of 10 vaccinations per hour per station a 1:3 ratio means 10 vaccine recipients per administrator in the observation area. This also allows administrators to book second vaccination appointments with patients.
Total	1.6 admin per vaccination station	1.7 admin per vaccination station	

Vaccinators - Mobile Clinic			
Role	Minimum Standard	Ideal Standard	Notes
Vaccinator plus general duties (including monitoring)	1 per 30 people to be vaccinated (minimum 2 vaccinators)	1 per 30 people to be vaccinated (minimum 2 vaccinators)	At least 1 of the Vaccinators in a mobile clinic must be authorised. One of the vaccinators takes on the Team Lead role for each team and takes responsibility for managing the vaccine and overall clinic running.
Clinical Lead	None	1 per 90 people to be vaccinated	Performs site visit ahead of clinic focussing on flow of environment, equipment required and clients who will be vaccinated. On the day oversees the running of the clinic, primarily the monitoring of individual clients while they are waiting before and after their vaccinations. This role is essential in ARC facilities and becomes more intensive in facilities which provide higher levels of care. The role does not necessarily need vaccinator training/qualifications but does require clinical experiences with mental health and dementia patients.
Total	3 vaccinators per 90 people to be vaccinated	4 vaccinators per 90 people to be vaccinated	Capacity is assumed to be 90 per vaccinator per day based on a <u>3 vaccinator</u> team working at a rate of 6 vaccinations per hour multiplied by 5 hours vaccinating time.

Administrators - Mobile clinic			
Role	Minimum Standard	Ideal Standard	Notes
General Admin Support	1 admin per vaccinator	1 admin per vaccinator	The ratio of admin to vaccinator is less in the mobile clinics as the vaccinators need to do more roles and patients are generally more complex so the rate of vaccination is slower.
Offsite Admin support	1 FTE admin per clinic	1 FTE admin per clinic	Due to the patient cohort and potential difficulties around consent these mobile clinics are expected to generate significant paperwork to be entered retrospectively by an offsite administrator
Total	1 admin per vaccinator + 1 offsite	1 admin per vaccinator + 1 offsite	

Primary Care Designated Clinics

The following overview was provided by our primary care co-ordination team:

	<p>Large Primary Care Site – Approx. 600-1200 vaccines/week:</p> <ul style="list-style-type: none"> - 1 dedicated vaccinator per station – 2 stations required. - 1 admin - 1 recovery <p>Medium Primary Care Site – approx. 300-600 vaccines/week:</p> <ul style="list-style-type: none"> - 1 dedicated vaccinator per station – 1-2 stations required depending on number of days vaccines are spread over - 1 admin - 1 recovery <p>Small Primary Care Site – Approx. 30-300 vaccines/week</p> <ul style="list-style-type: none"> - 1 vaccinator/recovery depending on number of days vaccine is spread over, if 30 vaccines/week may opt for vaccinator + recovery to be the same person - 1 admin <p>To convert this into an overall workforce model we have assumed 1 FTE equates to 300 vaccinations per week, for both vaccinators and administration.</p>
4.2 What gaps do you have in your staffing plan?	<p>The planned step up in the capacity of the programme from 1 July will require a significant equivalent increase in the direct and indirect workforce requirements. On top of this, the programme is currently in the process of standing down and replacing staff that were initially seconded to help with the MIQ and Tier 1a vaccinations.</p> <p>As per the attached Production Plan the total vaccination workforce across all distribution channels for Canterbury is estimated as:</p> <ul style="list-style-type: none"> • 240 FTE total vaccinators • 251 FTE total administration • 39 FTE total clinical leads • 39 FTE total site managers

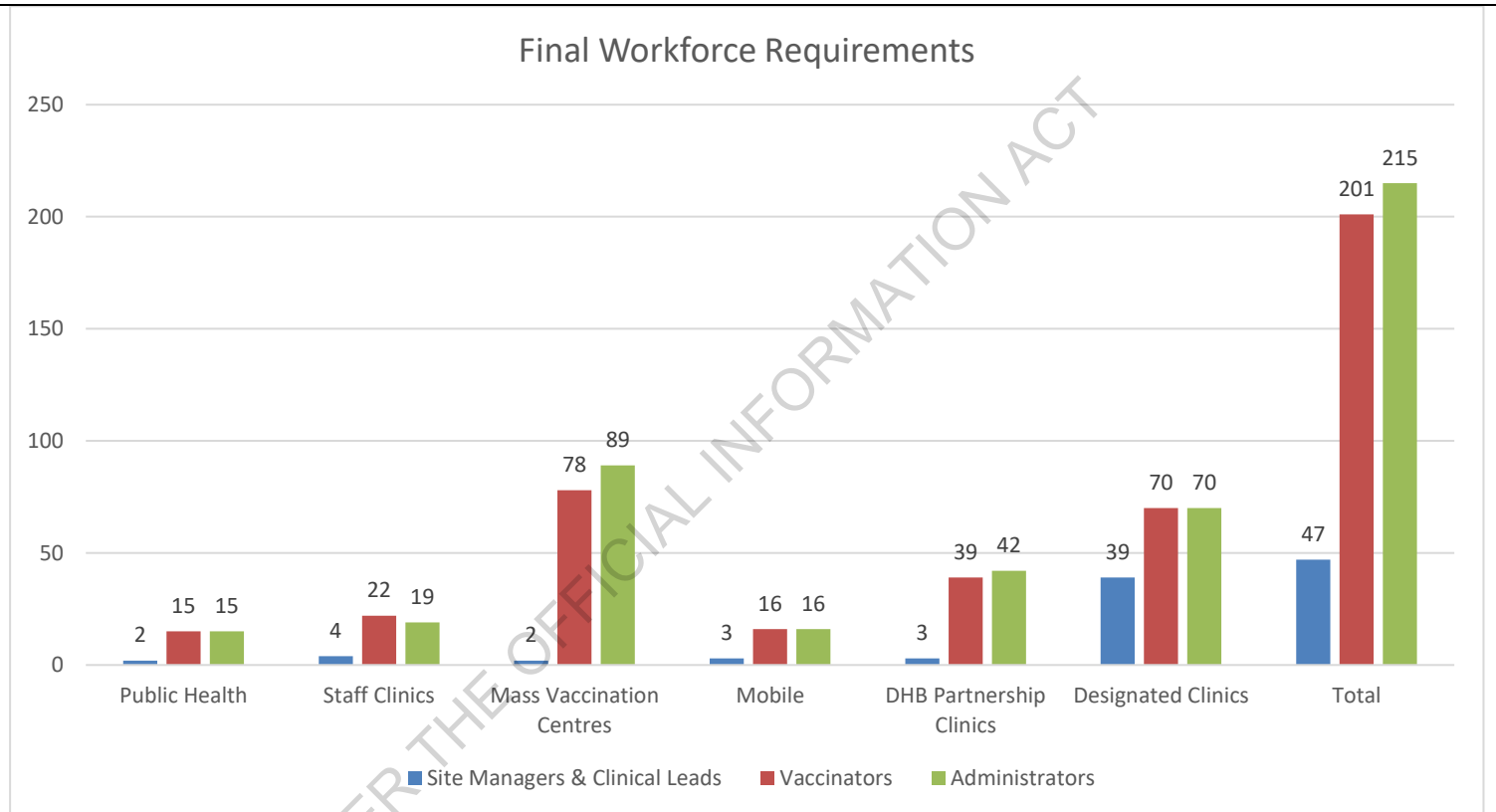


Figure 1: Workforce Requirements – note the total is not the sum of the parts due to phasing of clinics

These roles have been further allocated across the various role types detailed in the Ministry's CVIP Production Plan template for Canterbury e.g., the total vaccinator requirement provided above makes allowance for direct vaccinators, observation leads and vaccinator preparer/cold chain. The total admin requirement allows for admin/registration, consent & clinical assessment, CIR data entry and observation support staff.

We have planned for the Primary Care Designated Clinics to secure their own workforce requirements as part of their own planning and on-boarding process. We expect that DHB Partnership Clinics will primarily source their own workforce, but a centralised casual pool will also be available to these clinics.

	<p>Specific to our planned Mass Vaccination Centres (MVC) and Mobile Outreach Teams, the vaccination workforce is estimated as:</p> <ul style="list-style-type: none"> • 96 FTE total vaccinators – 78 MVC and 16 mobile clinics. • 105 FTE total administration – 89 MVC and 16 mobile clinics. <p>As at 17 May Canterbury has:</p> <ul style="list-style-type: none"> • 195 active vaccinators - those who have administered one or more doses. • 499 trained vaccinators - those who have completed COVID-19 vaccinator and CIR training as reported by IMAC. <p>Currently, the Canterbury DHB has both employed the workforce and used a partnership approach to secure staff from our community partners to deliver the programme requirements up to 30 June. This includes:</p> <ul style="list-style-type: none"> • Employing 17 FTE vaccinators and 44 FTE administrators/recovery roles • Primary care self-resourcing designated clinics • Kaupapa Māori providers • Collaboration with private and community service providers (i.e., Rymans, Florence Nightingale) <p>This level of workforce is sufficient for the current scale of our MVC and Mobile programme; however, we are now ramping up our workforce identification programme as below.</p> <p>The Indirect workforce requirements such as Operations Managers, Clinical Leads, Rostering, Security, Traffic Management, etc) are largely being seconded from across the Canterbury health system, contracted from appropriate agencies, or recruited through an open recruitment process as required.</p>
4.3 How are you planning to address the staffing gap?	<p>The significant increase required in the programme's staffing requirements from July is recognised as a considerable challenge to the programme. There remains uncertainty as to whether our proposed plans will deliver the number of FTE identified. The scale of workforce required when considered against the total workforce available will impact on other health system delivery. We do consider that BAU will be affected in some way by the increasing scale of the vaccination programme.</p> <p>Based on our planned delivery through primary care designated clinics, mass vaccination clinics and mobile teams we are planning to address the workforce gap by drawing on staff through multiple approaches, including:</p>

- **Primary care** – It is planned that Primary Care will ramp up to deliver approximately 60% of programme and the workforce requirements during this period. Initially this will be through the expansion of our Primary Care designated and partnership clinic programme, however we are also working with the Canterbury PHOs and Canterbury Community Pharmacy Group (CCPG) to support and coordinate the onboarding and operationalisation of primary care clinics, alongside enhancing the existing primary care teams with support for training and accreditation.
- **Student workforces** at Ara, University of Otago, University of Canterbury including medical, nursing and allied health students is anticipated to provide between 100 and 200 individuals to contribute. We are liaising with the Student Volunteer Army to identify students who could be recruited into administration roles.
- **Recently retired** health care professionals.
- **Community Based Providers** (including Māori and Pacific providers, community services, aged residential care, private hospitals, MIQF) who have trained workforces.
- **Employers** with furloughed staff, such as airlines will be contacted to identify larger groups of people who could fulfil administrative functions in the programme.
- **Responses to the EOI** issued by the Canterbury DHB and Ministry of Health for vaccinators and admin/recovery staff.
- **Ongoing open recruitment process** for vaccinator and administration/observation staff through the Canterbury DHB.

A number of people from across the Canterbury health system have been seconded into the Vaccination Programme. The resource of the Canterbury Primary Response Group is also being utilised to support substantial delivery via primary care across all of Canterbury.

The programme has fed into the consultation on the use of vaccination assistants and is in discussion with Māori and Pacific providers about people who might fill this role.

5. Equity	
5.1 Please outline your approach to ensuring equity in your workforce planning and site approach.	<p>Canterbury DHB is working with Māori and Pacific Providers who will provide vaccinators and other staff roles into the programme at specific sites.</p> <p>We are also involving people who provide translation services to the DHB as part of the call centre – people who speak English as a second language.</p> <p>Community meetings are being held or are planned for late May and June with the Pacific, Refugee, CALD (Culturally and Linguistically Diverse) Communities and several Disability Groups including mental health. These have been arranged through known community leaders including people in local government.</p> <p>These groups will continue to have the opportunity to recommend sites and /or systems that will assist their communities to access the vaccine e.g., a day at a mass clinic for people who need deaf interpreters.</p>
5.2 What Māori and Pacific providers will you be using?	<p>We are working with the following providers and organisations:</p> <ul style="list-style-type: none"> • He Waka Tapu • Purapura Whetu • Rehua Marae • Te Kakakura Trust • Te Puawaitanga ki Ōtautahi Trust • Te Rūnanga o Ngā Maata Waka • Te Tai o Marokura • Te ha o te ora • Māori/Indigenous Health Institute (MIHI) to lead Māori vaccination service with approval from Te Ohu Urupare and Mana Whenua • He Waka Tapu Whānau Ora community clinic in association with Nga Hau e Wha Marae • Tangata Atumotu Trust • Etu Pasifika • Waitaha PHO

	<ul style="list-style-type: none">• Pegasus PHO• Christchurch PHO
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CVIP - DISTRICT HEALTH BOARD PRODUCTION PLAN

[illegible]

	Security	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Maori Wardens	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Traffic Management	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	TOTAL VACCINATION CAPACITY	349	372	431	477	508	508	508	508	508	504	504	504	504	504

RELEASED UNDER THE OFFICIAL INFORMATION ACT

9(2)(a)

From: Vince Barry <Vince.Barry@health.govt.nz>
Sent: Monday, 24 May 2021 12:52 p.m.
To: Kim Sinclair-Morris
Cc: Peter Bramley
Subject: RE: Canterbury DHB Vaccination Plan July - end September 2021

Outstanding
 Really well done to you all in Canterbury
 Thanks
 Vince

From: Kim Sinclair-Morris <kim.sinclair-morris@ccn.health.nz>
Sent: Monday, 24 May 2021 11:55 am
To: SROs.Covid.Vaccination@tas.health.nz

9(2)(a)

Subject: Canterbury DHB Vaccination Plan July - end September 2021

Kia ora koutou,

Attached is the Canterbury DHB Covid-19 Vaccination Production Plan July - end September 2021, Supporting Information, and a copy of the Waitaha Covid-19 Vaccination Programme Structure.

While we have not utilised the site template, we do have access to all that supporting information in our production plan. We are happy to provide the entire production plan as required.

Ngā mihi

Kim Sinclair-Morris
Canterbury Covid-19 Vaccination Programme Lead

9(2)(a)

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9(2)(a)

From: Vince Barry <Vince.Barry@health.govt.nz>
Sent: Thursday, 17 June 2021 8:25 a.m.
To: Kim Sinclair-Morris
Subject: FW: Revised production plan July to October including equity numbers
Attachments: 210616 Revised DHB Production Plan including equity.xlsx
Importance: High

From: Joe Bourne <Joe.Bourne@health.govt.nz>
Sent: Wednesday, 16 June 2021 6:11 pm

9(2)(a)

Subject: Revised production plan July to October including equity numbers
Importance: High

Kia Ora Koutou

Please find attached our shortened production plan template to capture your adjusted week by week production plan for the 13 weeks from 5th July to 3rd October. We appreciate that this has been a challenging activity as we have had to adjust to changes in vaccine supply. The template requires a weekly total of vaccinations that will be delivered in your DHB area broken down by Maori, Pacific Peoples and others.

We ask that this is completed and returned via 9(2)(a) at TAS by midday **Tuesday 22nd June** – email 9(2)(c)

General instructions

- There is a separate sheet for each DHB. There is no need to go back to your original plan

- Your total vaccinations for the 13 week period needs to equal your original plan submitted at the end of May and signed off by your CE. This is given in a green square. If this number is not correct please contact your Regional Account Lead (RAL) to discuss
- Every DHB has been called this afternoon to explain that due to the timing of the first vaccine delivery from Pfizer for July on the 6th July, your vaccine allocation for the week ending 4th July needs to be spread out to cover 5th and 6th July as well. It is acknowledged that your numbers of vaccines given for the weekend ending 4th July will therefore be lower by the amount you give on 5th and 6th July.
- DHBs must spread that week ending 4th July allocation over the nine days to avoid having days where no vaccinations are taking place.
- Please notify your RAL as soon as possible if you will not be able to honour all existing bookings

Maori and Pacific Peoples Estimations

- Please identify the number of Māori and Pacific People who will be vaccinated each week of the 13 week period. The aim is to ensure that from a planning perspective DHBs are providing enough sites and vaccination slots to meet the needs of those populations
- DHBs are accountable for ensuring an equitable delivery of the vaccination programme in their DHB
- The proportion of Māori and Pacific People in each DHB according to census data is given as a guide
- However, we recommend a more nuanced approach when considering the equity of your vaccine delivery, as the proportion of Maori and Pacifica who experience conditions that make them eligible for Group 3 is disproportionately higher (up to 40% increase in risk).
- The Ministry is working on producing an adjuster that will better inform the numbers that should be in group 3 (recognising the difference in age structure, as well as disease prevalence) but this is not yet completed. It is likely that we will provide a range between which we would expect the proportion of these group to be and this will support future conversations

If you have any questions regarding the completion of the spreadsheet please do not hesitate to contact your Regional Account Lead or Manager.

We will continue to up date you with any variations as early as possible. Many thanks for your help.

Ngā mihi

Joe

Dr Joe Bourne FRNZCGP / MSc (Public Health)
COVID-19 Vaccine & Immunisation Programme

9(2)(a)



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CVIP - DISTRICT HEALTH BOARD - PRODUCTION AND EQUITY PLAN

Canterbury	WEEK ENDING															
	20-Jun-21	27-Jun-21	4-Jul-21	11-Jul-21	18-Jul-21	25-Jul-21	1-Aug-21	8-Aug-21	15-Aug-21	22-Aug-21	29-Aug-21	5-Sep-21	12-Sep-21	19-Sep-21	26-Sep-21	3-Oct-21
Māori	608	698	1,233	1,286	1,496	2,130	2,975	3,461	3,608	3,900	3,900	4,049	4,255	4,404	4,248	4,306
Pacific Peoples	595	547	632	570	542	800	1,158	1,425	1,506	1,654	1,654	1,722	1,729	1,797	1,788	1,851
Other	9,416	9,373	8,753	8,762	8,580	14,844	20,362	26,132	28,009	32,099	32,099	34,982	34,894	37,328	37,117	39,626
TOTAL	10618	10618	10618	10618	10618	17773	24495	31018	33123	37653	37653	40753	40878	43528	43153	45783

Original DHB 13 week production plan total July to October (Doses)	397,000
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Notes for weekending 4th July	Due to the first vaccine delivery in July arriving at 3:30am on 6th July, DHBs will need to spread the dose allocation for weekending 4th July to cover the 5th and 6th July also i.e. a 9 day week. It is acknowledged that when reporting the weekend ending 4th July this will now be below plan
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Instructions
Row 5 - the number of Māori to be vaccinated each week - see table for estimated proportion - from weekending 11 July
Row 6 - the number of Pacifica to be vaccinated each week - see table for estimated proportion - from weekending 11 July
Row 7 - other people to be vaccinated - from weekending 11 July
Row 8 - total to be vaccinated each week
The first 5 weeks are fixed due to vaccine supply - they do not include additional allocations to honour existing bookings
The total number for the 13 week period from week ending 11 July will equal the DHBs previously signed off production plan

Census data to aid equity calculation

People Age 16+						
DHB	Māori	Māori%	Pacific Peoples	Pacific Peoples%	Other	Grand Total
Canterbury	39820	8%	12020	3%	424048	475888

9(2)(a)

From: Vince Barry <Vince.Barry@health.govt.nz>
Sent: Tuesday, 22 June 2021 6:23 p.m.
To: Kim Sinclair-Morris; SROs Covid Vaccination
Cc: 9(2)(a)
 9(2)(a)
Subject: RE: Canterbury DHB Covid-19 Vaccination Production Plan to 3 Oct

Kia ora Kim

Thank you and the team for a superb job bringing this plan together.

We will be in touch in the next couple of days to feed back, but my initial comment is

A really professional job that reflects the excellent relationships that you have developed across the programme

Nga mihi

Vince

From: Kim Sinclair-Morris <kim.sinclair-morris@ccn.health.nz>
Sent: Tuesday, 22 June 2021 3:44 pm
To: SROs Covid Vaccination <SROs.Covid.Vaccination@tas.health.nz>; Vince Barry <Vince.Barry@health.govt.nz>
Cc: 9(2)(a)

Subject: Canterbury DHB Covid-19 Vaccination Production Plan to 3 Oct

Kia ora Vince,

Please find attached the revised Canterbury DHB Covid-19 Vaccination Production Plan to 3 October, including equity targets.

As discussed, key points to note include:

- a whanau-based invitation strategy for Maori and Pasifika will be implemented to enable achievement of our equity targets.
- these vaccination volumes require the onboarding of 100 general practices and community pharmacies over the coming months.

Ngā mihi

Kim Sinclair-Morris
Canterbury Covid-19 Vaccination Programme Lead

9(2)(a)

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