Health Technology Assessment (HTA) Expert Advisory Group Meeting (NPHET COVID-19 Support)		
Meeting no. 12 : Monday 22nd March 2021 at 11:00		
(Zoom/video conference)		
(DRAFT) MINUTES		
Attendance:		
Chair	Dr Máirín Ryan	Director of Health Technology Assessment (HTA) & Deputy Chief Executive Officer, HIQA
Members via video conference	Prof Karina Butler	Consultant Paediatrician and Infectious Diseases Specialist, Children's Health Ireland & Chair of the National Immunisation Advisory Committee
	Dr Jeff Connell	Assistant Director, UCD National Virus Reference Laboratory, University College Dublin
	Dr Eibhlín Connolly	Deputy Chief Medical Officer, Department of Health
	Prof Máire Connolly	Specialist Public Health Adviser, Department of Health and Professor of Global Health and Development, National University of Ireland, Galway
	Prof Martin Cormican	Consultant Microbiologist & National Clinical Lead, HSE Antimicrobial Resistance and Infection Control Team
	Ms Sinead Creagh	Laboratory Manager at Cork University Hospital & Academy of Clinical Science and Laboratory Medicine
	Dr Ellen Crushell	Consultant Paediatrician, Dean, Faculty of Paediatrics, Royal College of Physicians of Ireland & Co-National Clinical Lead, HSE Paediatric/Neonatology Clinical Programme
	Dr John Cuddihy	Specialist in Public Health Medicine & Interim Director, HSE- Health Protection Surveillance Centre (HPSC)
	Dr Margaret Fitzgerald*	National Public Health Lead, HSE National Social Inclusion Office
	Ms Josephine Galway	National Director of Nursing Infection Prevention Control and Antimicrobial Resistance AMRIC Division of Health Protection and Surveillance Centre
	Dr Patrcia Garvey*	Surveillance Scientist, Health Protection Surveillance Centre
	Dr Cillian de Gascun	Consultant Virologist & Director of the National Virus Reference Laboratory, University College Dublin
	Dr James Gilroy	Medical Officer, Health Products Regulatory Authority
	Dr Vida Hamilton	Consultant Anaesthetist & National Clinical Advisor and Group Lead, Acute Hospital Operations Division, HSE
	Dr Patricia Harrington	Deputy Director, HTA Directorate, HIQA
	Ms Sarah Lennon	Executive Director, SAGE Advocacy
	Mr Andrew Lynch	Business Manager, Office of the National Clinical Advisor and Group Lead - Mental Health, HSE
	Dr Gerry McCarthy	Consultant in Emergency Medicine, Cork University Hospital & National Clinical Lead, HSE Clinical Programme for Emergency Medicine
	Ms Jane-Ann McKenna*	HSE National Social Inclusion Office
	Prof Paddy Mallon	Consultant in Infectious Diseases, St Vincent's University Hospital & HSE Clinical Programme for Infectious Diseases
	Dr Des Murphy	Consultant Respiratory Physician & Clinical Lead, National Clinical Programme for Respiratory Medicine, HSE

	Dr John Murphy	Consultant Paediatrician & Co-National Clinical Lead, HSE Paediatric/Neonatology Clinical Programme
	Ms Michelle O'Neill	Deputy Director, HTA Directorate, HIQA
	Dr Margaret B. O'Sullivan	Specialist in Public Health Medicine, Department of Public Health, HSE South & Chair, National Zoonoses Committee
	Dr Lynda Sisson	Consultant in Occupational Medicine, Dean of Faculty of Occupational Medicine, RCPI & HSE National Clinical Lead for Workplace Health and Well Being
	Prof Susan Smith	Professor of Primary Care Medicine, Royal College of Surgeons in Ireland
	Dr Patrick Stapleton	Consultant Microbiologist, UL Hospitals Group, Limerick & Irish Society of Clinical Microbiologists
	Dr Conor Teljeur	Chief Scientist, HTA Directorate, HIQA
	Dr Lelia Thornton	Specialist in Public Health Medicine, HSE- Health Protection Surveillance Centre (HPSC)
In attendance	Dr Karen Cardwell	Postdoctoral Researcher HRB-CICER, HTA Directorate, HIQA
	Dr Laura Comber	HTA Research Analyst, HTA Directorate, HIQA
	Dr Christopher Fawsitt	Senior Health Economist, HTA Directorate, HIQA
	Dr Eamon O'Murchu	Senior HTA Research Analyst, HTA Directorate, HIQA
	Mr Barrie Tyner	Information Scientist, HTA Directorate, HIQA
Secretariat	Ms Debra Spillane	PA to Dr Máirín Ryan, HIQA
Apologies	Dr Niamh Bambury	Specialist Registrar in Public Health Medicine, HSE- Health Protection Surveillance Centre (HPSC)
	Dr Lorraine Doherty	National Clinical Director Health Protection, HSE- Health Protection Surveillance Centre (HPSC)
	Dr David Hanlon	General Practitioner & National Clinical Advisor and Group Lead, Primary Care/Clinical Strategy and Programmes, HSE
	Dr Derval Igoe	Specialist in Public Health Medicine, HSE- Health Protection Surveillance Centre (HPSC)
	Dr Siobhán Kennelly	Consultant Geriatrician & National Clinical & Advisory Group Lead, Older Persons, HSE
	Prof Mary Keogan	Consultant Immunologist, Beaumont Hospital & Clinical Lead, National Clinical Programme for Pathology, HSE
	Dr Sarah M. O'Brien	Specialist in Public Health Medicine, Office of National Clinical Advisor & Group Lead (NCAGL) for Chronic Disease
	Dr Michael Power	Consultant Intensivist, Beaumont Hospital & Clinical Lead, National Clinical Programme for Critical Care, HSE
	Dr Des Murphy	Consultant Respiratory Physician & Clinical Lead, National Clinical Programme for Respiratory Medicine, HSE
	Dr Sarah M. O'Brien	Specialist in Public Health Medicine, Office of National Clinical Advisor & Group Lead (NCAGL) for Chronic Disease

* Ad hoc member, for this meeting only.

Proposed Matters for Discussion:

1. **Welcome**

The Chair welcomed all members. Apologies recorded as per above. Noted that three additional individuals joined the meeting for this topic, Margaret Fitzgerald, the National Public Health lead in the National Social Inclusion office in the HSE, Jane-Ann McKenna also from the

National Social Inclusion office and Dr Patricia Garvey, senior surveillance scientist in the HPSC.

2. Conflicts of Interest

No new conflicts raised in advance of or during this meeting.

3. Minutes

The minutes was deferred until the next meeting.

4. Work Programme

The group was provided with an overview of the current status of the work programme including:

No.	Review Questions	Status of work	NPHET date
1	Review of international public policy response for weekly update	Ongoing	TBC April 2021
2	Vaccination Priority Group 9 – are groups appropriate	Drafted	25 March 2021
3	Vaccination of HCWs - consideration in the event of HCW not taking vaccination	Ongoing	1 April 2021
4	Preventive interventions pre infection with SARS-CoV-2	Ongoing	15 April 2021
5	Serial RADT testing- meat processing plants	Ongoing	1 April 2021
6	Facemask use by children -update	To begin 29-March	8 April 2021
7	- Preventive interventions pre infection with SARS-CoV-2 (including modifiable risk factors)	Ongoing	22 April 2021
	Public health guidance: - vulnerable groups - LTCFs	Ongoing	

5. Presentation on Vaccination Priority Group 9 – are groups appropriate (LC)

The EAG was informed that this particular report would not be submitted as advice to NPHET, but rather it would be submitted to NIAC for their consideration as it is their remit to provide advice on vaccine policy to the CMO.

The HIQA evaluation team undertook this rapid evidence synthesis to address the following policy question:

"Groups at increased risk of COVID-19 due to crowded living and or working conditions may include Travellers, Roma, international protection applicants, homeless, prisoners and those working in food processing plants. Based on the available national and international evidence in relation to the increased risk of infection with COVID-19, and the increased risk of severe disease from COVID-19 (including hospitalisation, ICU admission and death), is the above list complete and appropriate?"

The Chair acknowledged the considerable support received with this report, Dr Patricia Garvey for help with access to the data interpretation, Dr Margaret Fitzgerald and Jane-Ann McKenna for assisting with the context and access to data, also colleagues in the Department of Health and colleagues across a range of other government departments and other NGOs that provided the evaluation team with data.

The following points were raised as matters for clarification or discussion by the EAG:

- It was emphasised that Traveller life expectancy was much lower than the general population, with only 3% estimated to live beyond 65 years, therefore the use of chronological age groupings in the vaccine allocation plan may not reflect the physiological age of this population.
- It was highlighted that ascertainment bias likely exists for a number of the groups identified in terms of access to and engagement with test and trace processes. The Roma community in particular were noted to be associated with low engagement with test and trace processes.
- Given the counts of severe outcomes was low for a number of the groups a composite measure could be generated; however, as the groups are unlikely to be mutually exclusive and also unlikely to be directly comparable this may not be appropriate.
- It was emphasised that in the context of limited vaccine supplies, that the current vaccine policy prioritises those at highest risk of severe disease or hospitalisation and the protection of the health service. It is important that decisions around vaccine allocation are evidence based and can be justified, as prioritising one group means denying others. Age was noted to be the single most important risk factor. It was suggested that there is insufficient evidence yet on transmission to pivot the strategy to targeting those who are most at risk of transmission.
- The timing of the data was acknowledged as important given the influence of the now dominant and more transmissible B.1.1.7 variant of concern. While samples are likely too small to enable comparisons across waves, it is a consideration that should be acknowledged.
- It was highlighted that for the specific groups, there is a risk of outbreaks seeding cases in the wider community. This risk should be considered alongside the case numbers and risk within each group.
- It was noted that outbreaks in a number of the groups were well managed up to the third wave; however, the third wave has presented considerably greater difficulties in managing outbreaks overall.
- It was noted that those living in direct provision and those working in meat processing factories, despite typically being younger, may have underlying conditions placing them at increased risk of severe disease.
- It was highlighted that the limited number of cases seen in prisons is likely attributed to the restrictive measures in place. These measures are not considered to be sustainable in the long term in terms of the isolation for prisoners. There are also specific ethical concerns regarding consent when considering prisoners, as they are deprived of their freedom by society. The additional risk they may accrue from being confined to prison is not one over

which they have any control and authority, but rather because society requires them to be there.

- The very focused work of social inclusion partners in assisting people in vulnerable groups was acknowledged resulting in very low incidence among some of these groups. However, it was further emphasised that Public Health teams are increasingly strained in terms of resources to deal with outbreaks in certain groups. It was further acknowledged however, that there are social and ethical considerations with some of the public health measures (for example, closure of canteen facilities in some service for the homeless) that have increased social isolation, so there are challenges with their long term sustainability
- It was acknowledged that for a number of the groups identified, the feasibility and practicality of the vaccination process needs to be considered. For example, vaccinating only certain age bands when engaging with groups may be counterproductive in terms of access and engagement. The potential for discretionary and opportunistic vaccination within certain groups was discussed.
- While not within the scope of the current report, it was noted that a number of Black and Asian minority ethnic groups have been identified internationally as being at increased risk of severe disease. There is a difficulty with how these groups will be identified given high proportions of undocumented individuals. They are largely concentrated in urban settings with the north inner city CHO9 having the highest concentration of ethnic minorities in the whole country. Many of these people also live in challenging circumstances. Outreach is achieved through inclusion health settings and homeless clinics. Consideration also could be given to strategies that have been adopted elsewhere, such as vaccination of everyone within a region. It was noted that single dose vaccines could prove more useful in certain groups identified where access and engagement may be problematic.
- NGOs and community groups were keen to assist particularly in metropolitan areas with identifying individuals for vaccination to assist NIAC and the Chief Clinical Officer with advice on approach.
- It was highlighted that there are incidences of crowded accommodation that are outside the groups considered within the report. It was noted that Wales has opportunistic vaccination that is at the discretion of medical professionals. It was suggested that a similar approach could be adopted for individuals at risk in general practice, in the community, or even in hospital settings, that is, permission to vaccinate these individuals without breaching a sequence.
- Flexibility in terms of vaccination for certain groups is required. For some groups, GPs or vaccination centres will be appropriate; however, for others, such as very mobile populations, those with notably reduced engagement, and those who may have language barriers, there is likely a need to go to these groups and offer vaccination.
- There was a challenging communication issue in relation to this proposal in avoiding stigma. There is a need to be very clear what a vulnerable group is and describe in an evidence-based way why they are described as such. Prioritising someone for vaccination based on the fact that they are a member of a particular group might be quite challenging given that we normally prioritise those for a treatment based on their individual risk. Whilst there appears to be rationale from the evidence and the epidemiological data, there is a need to consider whether that prioritisation can be more of an individual assessment.

- It was highlighted that a proportion of each group will be made up of individuals who meet criteria in preceding vaccine allocation groups, for example based on age or based on medical risk, with concerns raised about how accurately these populations within certain groups are being identified currently.

6. Updated Protocol - preventive interventions pre-infection with SARS-CoV-2 (KC) ***(for discussion)***

The EAG were informed that the scope around the particular question was extended, the original policy question was:

"What is the emerging evidence in relation to (i) pharmaceutical interventions, and (ii) lifestyle interventions prior to diagnosis of COVID-19 in the community aimed at preventing or minimising progression to severe disease?"

The added *scope:*

"With respect to COVID-19, what potentially modifiable lifestyle factors are associated with a reduction in risk of infection and or progression to severe disease?"

The following points were raised as matters for clarification or discussion by the EAG:

- It was clarified that this review relates only to individuals in the community prior to a diagnosis of COVID-19.
- It was noted that any relevant studies in relation to proton pump inhibitors, corticosteroid inhalers and ivermectin should be picked up given the search strategy that has been developed.
- The importance of considering lifestyle intervention and to look at comorbid conditions such as obesity was highlighted. It was suggested that an age-adjusted, behaviour-adjusted approach may be useful.
- Important to include different health care system strategies, and to look at countries or areas that have been more effective in preventing transmission within their communities, and how they went about and what was effective for them.

7. Protocol Vaccination of HCWs - consideration in the event of HCW not taking vaccination (E'OM) (for discussion)

The EAG was informed that NPHET had requested the HIQA evaluation team undertake a review to address the following policy topic:

"What policies, mitigation actions or initiatives have been implemented internationally relating to healthcare workers who do not avail of COVID-19 vaccination that could be considered by the Irish Health Service?"

The request originated from the HSE Chief Clinical Officer. This policy question was used to formulate the following specific research question:

"What international policies and guidelines exist relating to HCWs who do not avail of COVID-19 vaccination?"

The Chair acknowledged the assistance received from Dr Lynda Sisson and Dr Muiris Houston for their advice around the search strategy.

8. Protocol Serial RADT testing- meat processing plants (CT) (for discussion)

The EAG was informed that NPHET had requested the HIQA evaluation team undertake a review to address the following policy topic:

What is the impact on transmission risk and resource requirements of different approaches to serial testing using rapid antigen detection tests (RADTs) in meat processing plants?"

This policy question was used to formulate the following specific research question:

1. To what extent do alternative scenarios to serial testing using RADTs impact the risk of transmission in meat processing plants?
2. How do these scenarios differ in terms of the following outcomes:
    - probability of undetected cases being present in the setting while potentially infectious
    - potential number of infections arising within the setting
    - number of tests (serial RADT and confirmatory PCR) that must be carried out
    - number of false positives
    - resource requirements in terms of support staff to manage or supervise testing
    - total number of staff days in self-isolation or restriction of movement.

The following points were raised as matters for clarification or discussion by the EAG:

- It was agreed that there is considerable variation in the performance of the commercially available RADTs. In terms of the data to inform the model, it was noted that the evaluation team will leverage off the data (performance, uptake, logistics) obtained from the large validation studies of a number of different RADTs undertaken by the HSE. The validation studies include a comparison with RT-PCR in the meat processing plants (MPP).
- It was clarified that the testing uptake will be considered in the model given that testing is voluntary. It was noted that the model will assume RADT testing is based on a mid-turbinate nasal swab obtained by supervised self-sample. Data from the validation studies undertaken in the MPP will be used.
- In terms of transmission risk, it was reiterated that there are issues when comparing with RT-PCR where estimates of sensitivity and specificity are based on data that include high Ct values. It was acknowledged that Ct values are not constant and that there is uncertainty regarding the viral load cut-off for infectivity, but that the chances of recovery of culturable virus are very low at low viral loads, so these may not be associated with significant transmission risk. The model will try to capture uncertainty in this regard.

- It was agreed that community incidence in the vicinity of the MPP may impact the probability of an outbreak occurring. The model will consider available data from the last several months as an indicator of the likelihood of an outbreak occurring. It may be possible to do some sensitivity analysis around lower or higher probabilities of outbreaks, to see if there is a threshold or a cut-off beyond which it is no longer sensible to do any sort of serial testing, or both.

9. Duration of protective immunity (protection from reinfection) following SARS-CoV-2 infection (EOM) (for discussion)

The evaluation team updated the EAG regarding the approach that is being adopted for updating the immunity review (published 8 March 2021), the search for which was completed 5 February 2021. Additional studies published since that date will be included. The team will liaise with the HPSC to incorporate available Irish data on reinfection cases as contextual information. Authors of the previously identified studies have been contacted for disaggregated data on younger and older groups, if available. The evidence summary will be considered at the meeting on 29 March 2021.

10. Meeting Close

The Chair thanked the EAG members for their contributions and highlighted the meeting on 6 April would be on a Tuesday due to the Public Holiday.

Date of next meeting: 29 March 2021

Meeting closed at 11.10am.