Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Health Technology Assessment (HTA) Expert Advisory Group Meeting (NPHET COVID-19 Support)		
Meeting no. 21 : Wednesday 13th October 2021 at 10:30		
(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 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 John Cuddihy	Specialist in Public Health Medicine & Interim Director, HSE- Health Protection Surveillance Centre (HPSC)
	Dr Cillian de Gascun	Consultant Virologist & Director of the National Virus Reference Laboratory, University College Dublin
	Ms Josephine Galway	National Director of Nursing Infection Prevention Control and Antimicrobial Resistance AMRIC Division of Health Protection and Surveillance Centre
	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
	Dr John Murphy	Consultant Paediatrician & Co-National Clinical Lead, HSE Paediatric/Neonatology Clinical Programme
	*Dr Eamon O'Murchu	Medical Officer, HPRA
	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
	*Prof. Siobhán O' Sullivan	Chief Bioethics Officer, Department of Health
	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
In attendance	Jingjing Jiang	HTA Analyst, HTA Directorate, HIQA
	Dr Louise Larkin	HTA Programme Manager, HTA Directorate, HIQA
	Mark O'Loughlin	Fellow in clinical leadership in public health, HTA Directorate, HIQA
	Dr Kieran Walsh	Senior HTA Analyst, HTA Directorate, HIQA

Secretariat	Ms Debra Spillane	PA to Dr Máirín Ryan, HIQA
Apologies	Ms Avril Aylward	IVD Operations Manager, Medical Devices Department, Health Products Regulatory Authority
	Prof Máire Connolly	Specialist Public Health Adviser, Department of Health and Professor of Global Health and Development, National University of Ireland, Galway
	Dr Lorraine Doherty	National Clinical Director Health Protection, HSE- Health Protection Surveillance Centre (HPSC)
	Dr Vida Hamilton	Consultant Anaesthetist & National Clinical Advisor and Group Lead, Acute Hospital Operations Division, HSE
	Dr David Hanlon	General Practitioner & National Clinical Advisor and Group Lead, Primary Care/Clinical Strategy and Programmes, HSE
	Dr Patricia Harrington	Deputy Director, HTA Directorate, HIQA
	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
	Ms Sarah Lennon	Executive Director, SAGE Advocacy
	Dr Michele Meagher	Medical Officer, Health Products Regulatory Authority
	Dr Eavan Muldoon	Consultant in Infectious Diseases, Mater Misericordiae University Hospital, National Clinical Lead for CIT and OPAT programmes & HSE Clinical Programme for Infectious Diseases
	Dr Deirdre Mulholland	Consultant in Public Health, National Clinical Lead for Knowledge, Evidence and Quality Improvement, Office of the National Clinical Director of Health Protection
	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
	Dr Michael Power	Consultant Intensivist, Beaumont Hospital & Clinical Lead, National Clinical Programme for Critical Care, HSE

* Ad hoc member for this meeting only

Proposed Matters for Discussion:

1. Welcome

The Chair welcomed all EAG members. MR noted two ad-hoc members Eamon O Murchu (Medical Officer HPRA, former project lead for this topic in HTA) and Siobhan O Sullivan (Chief Bioethics Officer, Department of Health).

Apologies recorded as per above.

2. Conflicts of Interest

No new conflicts of interest raised in advance of this meeting.

3. Minutes

No changes to minutes from previous EAG meeting on the 23 August 2021. Minutes were approved as an accurate reflection of the discussions involved.

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	Reinfection rate post infection with SARS-CoV-2 (update)	For discussion	18 October 2021
2	Duration of immunity post vaccination	Ongoing	
3	Nursing home analysis	Ongoing	
	Database	Ongoing - weekly	
	Public health guidance: - vulnerable groups - LTCFs	Ongoing -biweekly -monthly	

5. Presentation on 'Reinfection rate post infection with SARS-CoV-2 (update)' (KW for discussion)

The EAG were reminded that NPHET had requested that HIQA conduct an evidence summary and formulate advice with input from the EAG to address the following policy topics:
"How long does protective immunity (that is, prevention of antigen or RT-PCR confirmed reinfection) last in individuals who were previously infected with SARS-CoV-2 and subsequently recovered?"

<u>The following points were raised for clarification following this presentation:</u>

- Clarification was sought on whether the rate of infection in the population not previously infected and not vaccinated was available to give context to the reinfection rate for the report. It was clarified that there was huge variability in the rate of infection in the population not previously infected across studies given differences in exposure risk and so direct comparisons are challenging. However, in each study the rates were always higher in those previously infected compared with those who were not previously infected.

- It was highlighted that there should not be concern for low number of studies with whole genome sequencing as information can be inferred from the broader surveillance data within each country. Due to the dominance of different variants at different time points, and the speed at which this can occur, it is possible to infer that a person is likely reinfected with a different strain of the virus by considering the time periods involved.

6. Confirmed COVID-19 cases identified with a reinfection in Ireland (Dr John Cuddihy (Interim Director HPSC))

There were no queries on the presentation.

7. Advice: 'Reinfection rate post infection with SARS-CoV-2 (update)' (MO'N) (*for discussion*)

The following points were raised for discussion following this presentation:

- Communication around messaging of the report was felt to be particularly important. A point was raised that vaccination should still be advocated for regardless of any advice regarding the duration of presumed protective immunity post-infection. People should be encouraged to get vaccinated instead of deferring until the end of the period of presumed protective immunity.

- The public's understanding of immunity is important to consider. It was emphasised that there should be clear messaging that prior infection does not provide absolute protection from reinfection, that is, it does not provide sterilising immunity. While there is a risk people can get reinfected following recovery from prior infection, they may not experience clinically impactful symptoms.

- Based on what is seen in practice, concerns were raised about extending the duration of presumed protective immunity post-infection to longer than nine months. Unpublished Irish data from the HPSC would appear to suggest that reinfections, while still uncommon in absolute terms, are becoming relatively more frequent.

- National and international data indicate that healthcare workers (HCW) are disproportionately affected by reinfections due to the increased risk of exposure. Thus, the most significant impact of a policy decision to increase the presumed period of protective immunity from nine to 12 months would likely be in healthcare settings. While HCW at the tail-end of their period of presumed protective immunity may get reinfected, they may only develop mild or asymptomatic COVID-19. However the concern remains that they can transmit the virus to colleagues and patients. This potential for the spread of virus amongst unvaccinated HCWs, and to their patients, should be to the fore of any decision to extend the duration of presumed protective immunity.

- An extension of the duration of presumed protective immunity may also have unintended negative implications at a population level.

- With regards to the studies included in the review, it was noted that the follow-up is less than nine months in a large number of studies. Concerns were also raised regarding the US study which found that almost 6% of HCWs were reinfected, and also with regard to the limited data on the impact of the Delta variant on the reinfection risk.

- The observational nature of all included studies was noted and thus the potential for residual confounding. The context of the included studies was also highlighted: the majority of the evidence is based on time periods when restrictive public health measures were in place, and so when the risk of infection was likely lower. For example, reinfection rates could have been artificially lowered by people wearing masks and socially distancing. It is therefore unclear how generalisable the evidence would be to situations where all measures are relaxed.

- UK seroprevalence (antibody) studies show high seroprevalence rates across the UK. Despite this, the current force of infection is contributing to the ongoing spread of SARS-CoV-2 in the community.

- While the research evidence regarding the low risk of reinfection was found to be encouraging, concerns were raised regarding the timing of a change in policy. Given the current high prevalence of infection and hence a greater level of exposure to the virus, extending the duration of presumed protective immunity from nine months may raise the risk of reinfection.

- There was support to take a cautious approach and to leave the advice unchanged at nine months duration of presumed protective immunity. It was noted that for other seasonal coronaviruses, the duration of protective immunity is usually around 12 months. The Delta variant is currently dominant in Ireland, leading to a high viral load in those infected and an abnormally high burden of infection in the population. The risk of reinfection needs to be considered under the current conditions of a significant amount of circulating virus in the population. Therefore, extrapolating evidence from studies - which were predominantly conducted prior to the dominance of the Delta variant - to the current setting of high community prevalence was not felt to be appropriate.

- There was agreement that any advice regarding natural immunity (that is, immunity due to prior infection) should not be nuanced around any particular subgroups, as to do so would not be practical. Advice needs to be applied equally to everyone who has been previously infected, but other advice around booster or additional vaccine doses may be offered, where appropriate.

- It was suggested that the question should be kept under review as further evidence may provide greater certainty regarding the presumed duration of protective immunity post-infection.

- Due to the wider context of significant changes to public health restrictions, along with increasing levels of international travel and the high levels of virus currently circulating in the community, there was consensus that due to these factors, the presumed duration of protective immunity post-infection should not be extended.

- The Chair thanked Dr Eamon O Murchu for his assistance with the report and Dr John Cuddihy for presenting.

8. Meeting Close

a) AOB
   Updated on the Duration of immunity post vaccination report. NPHET have asked for a further update to ensure currency of evidence for NIAC. EAG Fri 15 Oct postponed until report ready.
b) Date of next meeting: TBD

Meeting closed at 11.39am.