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

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| **Health Technology Assessment (HTA) Expert Advisory Group Meeting (NPHET COVID-19 Support)** | | |
| **Meeting no. 9: Monday 8th February 2021 at 11:00** | | |
| **(Zoom/video conference)** | | |
| **MINUTES** | | |
| **Attendance:** | | |
| **Chair** | Dr Máirín Ryan | Director of Health Technology Assessment & Deputy Chief Executive Officer, HIQA |
| | Dr Jeff Connell | Assistant Director, UCD National Virus Reference Laboratory, University College Dublin |
| | Prof Máire Connolly | Specialist Public Health Adviser, Department of Health and Professor of Global Health and Development, National University of Ireland, Galway |
| | 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) |
| | Ms Josephine Galway | National Director of Nursing Infection Prevention Control and Antimicrobial Resistance AMRIC Division of Health Protection and Surveillance Centre |
| | 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, Health Technology Assessment, HIQA |
| | Dr Derval Igoe | Specialist in Public Health Medicine, HSE- Health Protection Surveillance Centre (HPSC) |
| | 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 |
| | Dr Sarah M O'Brien | Specialist in Public Health Medicine, Office of National Clinical Advisor & Group Lead (NCAGL) for Chronic Disease |
| | Dr Desmond Murphy | Consultant Respiratory Physician & National Clinical Lead, HSE Clinical Programme for Respiratory Medicine |
| | Dr John Murphy | Consultant Paediatrician & Co-Clinical Lead, Paediatric/Neonatology National Clinical Programme, HSE |

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| | 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 Gerard O'Connor | Consultant in Emergency Medicine, Mater Misericordiae University Hospital & National Clinical Programme for Emergency Medicine, HSE |
| | 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, Health Technology Assessment, HIQA |
| | Ms Anne Tobin | Assessment and Surveillance Manager, Medical Devices, Health Products Regulatory Authority |
| | Dr Lelia Thornton | Specialist in Public Health, HSE- Health Protection Surveillance Centre (HPSC) |
| | Prof Martin Cormican | Consultant Microbiologist & National Clinical Lead, HSE Antimicrobial Resistance and Infection Control Team |
| | Prof Mary Keogan | Consultant Immunologist, Beaumont Hospital & Clinical Lead, National Clinical Programme for Pathology, HSE |
| **In attendance** | Dr Eamon O'Murchu | Senior HTA Analyst, Health Technology Assessment, HIQA |
| | Mr Barrie Tyner | Information Scientist, Health Technology Assessment, HIQA |
| | Dr Christopher Fawsitt | Senior Health Economist, Health Technology Assessment, HIQA |
| | Dr Laura Comber | HTA research analyst, Health Technology Assessment, HIQA |
| | Dr Karen Cardwell | Postdoctoral Researcher HRB-CICER, Health Technology Assessment, HIQA |
| | Dr Kirsty O'Brien | Health Services Researcher, Health Technology Assessment, HIQA |
| | Dr Sinead O'Neill | Epidemiologist/Health Services Researcher, Health Technology Assessment, HIQA |
| | Dr Susan Spillane | Senior HTA Analyst, Health Technology Assessment, HIQA |
| **Secretariat** | Ms Natasha Broderick | HTA analyst, Health Technology Assessment, HIQA |
| **Apologies** | Dr Michael Power | Consultant Intensivist, Beaumount Hospital & National Clinical Lead, HSE Clinical Programme for Critical Care |
| | Prof Paddy Mallon | Consultant in Infectious Diseases, St Vincent's University Hospital & HSE Clinical Programme for Infectious Diseases |
| | Prof Karina Butler | Consultant Paediatrician and Infectious Diseases Specialist, Children's Health Ireland & Chair of the National Immunisation Advisory Committee |
| | Dr Eibhlín Connolly | Deputy Chief Medical Officer, Department of Health |

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| | Dr Cillian de Gascun | Consultant Virologist & Director of the National Virus Reference Laboratory, University College Dublin |
| | Dr Lorraine Doherty | National Clinical Director Health Protection, HSE- Health Protection Surveillance Centre (HPSC) |
| | Dr Muiris Houston | Specialist in Occupational Medicine, Clinical Strategist – Pandemic, Workplace Health & Wellbeing, HSE |
| | Dr Siobhán Kennelly | Consultant Geriatrician & National Clinical & Advisory Group Lead, Older Persons, HSE |

**Proposed Matters for Discussion:**

1. **Welcome**

   The Chair welcomed all members.

2. **Apologies & Introductions**

   Apologies as noted above.

3. **Conflicts of Interest & Meeting Minutes**

   No new conflicts raised in advance of this meeting. Minutes from the previous meeting were not yet available and will be circulated in advance of 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. | Analysis of factors associated with outbreaks of SARS-CoV-2 in nursing homes in Ireland | Drafted | 18 February 2021 for submission to Department of Health |
| 2. | Review of international public policy response for weekly update | Ongoing | Full update 25 February 2021<br>Partial update on antigen testing 11 February 2021 |
| 3. | Measures to support self-isolation and RoM | Drafted | 11 February 2021 |
| 4. | Duration of protective immunity (prevention from reinfection) following SARS-CoV-2 infection | Ongoing | 25 February 2021 |
| | Database | Ongoing | |
| | Public health guidance:<br>- vulnerable groups<br>- LTCFs | Ongoing | |

## 5. Presentation on Analysis of factors associated with outbreaks of SARS-CoV-2 in nursing homes in Ireland

A joint analysis between HIQA and the HPSC was carried out in relation to factors associated with outbreaks of SARS-CoV-2 in nursing homes in Ireland. The context, methods, limitations and key findings of this analysis were presented to the group in detail.

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

- For a study presented in the background information for the analysis, it was queried if nursing home resident data was age matched against the general population looking at incidence or if other were factors included.
- Clarity was sought as to why data in relation to movement of staff, resident transfers etc. were not considered in the analysis, given that they may be significant factors.
    - HIQA explained that data on movement of individuals was not available although it had been identified as relevant in the international literature particularly in terms of staff shared between nursing homes. A way of attempting to account for this was using the proximity of homes to each other as a proxy measure, for example cleaning companies may operate in different nursing homes in the same area.
    - It was noted that number of registered beds was taken as a proxy for occupancy levels. Occupancy data available at a small number of time points during the year does not suggest that occupancy levels vary across homes.
- The limitations in terms of data available are a key finding of this report and should be highlighted and form part of the key points.
    - HIQA agreed but noted that routine collection of data could be onerous and difficult to implement.
- A query was raised in relation to the total number of residents and staff in nursing homes and the skill mix within nursing homes.
    - It was clarified that there are approximately 32,000 beds nationally, with typical occupancy rate approximately 85%. In terms of staffing the ratio of wholetime equivalent staff to residents varies across homes and is dependent on the frailty of the residents in a given home.
- It was queried if the impact of infection, prevention and control (IPC) training was incorporated in the analysis.
    - It was noted that HIQA had looked at compliance with IPC regulations in a sample of nursing homes, excluding those with an outbreak, in May 2020. As only point in time historical data on compliance with regulations, from a sample of homes during the epidemic who were not experiencing outbreaks, were available the inclusion of a covariate regarding this factor was not deemed appropriate.
- In terms of the transfer of nursing homes residents to and from acute care facilities, it was queried if HIPE data could provide discharge data.

- It was clarified that some data would be available from the HIPE system but would not have sufficient coverage or detail for inclusion in this form of analysis.

- A member of the EAG queried what the policy is with regard to transfer of patients from acute hospitals to nursing homes. The current HPSC guidance states if a resident is transferred to a RCF before 14 days from the onset of their symptoms or a positive test they are treated with isolation precautions and only transferred if a detailed risk assessment has been conducted showing that the nursing home can manage the case. It was also noted by a member of the EAG that anyone transferring from an acute hospital to a nursing home (unless they have had a history of COVID-19) is required to have a test three days prior to transferring and regardless of the outcome of the test they are required to restrict their movements for a 14-day period following transfer, in certain circumstances an additional test will be carried out.

## 6. Presentation on Measures to support self-isolation and RoM

The EAG were reminded that NPHET had requested the HIQA evaluation team to undertake a review to address the most recent evidence on the following policy topic on 21 January:

*What measures are being taken internationally to support compliance with self-isolation and restricted movement requirements and is there any evidence as to how effective are these measures?*

In response, HIQA developed a protocol for a rapid evidence summary which was disseminated to the EAG for review in advance.

The following research questions (RQs) were formulated to inform this policy issue:

RQ1. "What public health guidance or measures have been implemented to support those who are in self-isolation or restriction of movements to improve compliance and prevent the spread of SARS-CoV-2?" [An international review]

RQ2. "What evidence is there that measures to support those in self-isolation or restriction of movements improves compliance with these restrictive measures and prevents the spread of respiratory pathogens in a pandemic or an epidemic setting?" [An evidence summary]

A presentation was provided to the EAG of the key findings of the evidence synthesis by the lead analyst. The Chair thanked the members for reviewing the draft rapid evidence summary circulated within a short timeframe. No points were raised as matters for clarification or discussion by the EAG

## 7. Advice: Measures to support self-isolation and RoM

In the context of the background material presented, the EAG was asked for their input in order to formulate the advice.

**The EAG members were asked to take the following key points into consideration:**

- Is there anything from evidence/review to suggest that current measures should continue to be available/no longer be available?
- Are there any additional measures that should be made available?
    - App providing customized information (not just contact tracing)
    - Monitoring/penalties?
- More proactive approach for vulnerable populations
- More targeted communication strategy

**Feedback:**

The EAG highlighted the value of qualitative work, including Irish qualitative data, as being important to understanding factors that might impact compliance, especially in marginalised groups. It was noted that the Economic and Social Research Institute is continuing to undertake research in this area.

The provision of medical masks (and other PPE, where appropriate) has previously been considered, but was not feasible at the time due to logistical challenges to getting masks to individuals in a timely manner. However, the continued high level of transmission within households, as evidenced by the high secondary attack rate and large numbers of household outbreaks, highlights the need for additional measures to support self-isolation and restriction of movements within the home. The provision of medical masks to those who are self-isolating or restricting their movements, particularly to those living in circumstances where adherence to these measures is challenging, should be reconsidered.

It was noted that support is being provided to those who are vulnerable and or cocooning through the Community Call organised via local government, state agencies, community and voluntary groups (for example GAA clubs, religious organisations). Such groups could also have an expanded role in supporting those in self-isolation or restriction of movements. This could include assistance with obtaining essential items such as food, medicines and medical masks.

It was suggested that when case numbers decrease, public health teams could be deployed to outbreaks in the community to provide customised, setting-specific support, in conjunction with clear messaging to ensure the risk of transmission is minimised.

The importance of clear messaging for individuals for whom English is not their first language was also highlighted. It was acknowledged that there are already a substantial number of resources available in different languages in the form of posters, videos and leaflets, but that these groups would still benefit from additional support to ensure they understand the messaging and have the resources to comply with the recommendations.

The wide-spread use of mobile phone applications for contact tracing was acknowledged. It was also noted that some countries have also use web-based applications to support the dissemination of customised information and to help direct individuals to the relevant advice and to the range of resources and supports available to them.

CityWest Hotel and other similar facilities have been successfully used to support those who cannot self-isolate at home. While to date this has been predominantly used by health and social care staff, it is also available to support referred members of the community. Expanded use of these resources could be considered to support individuals who cannot adequately self-isolate or restrict their movements within their own home.

The EAG commented on the use of strict enforcement measures when case numbers are low. For example in Australia and New Zealand universal and comprehensive packages are available and used in conjunction with strict enforcement measures, to support those in self-isolation and restriction of movements. It was acknowledged that although monitoring and penalties have been implemented internationally, the effectiveness of such measures is largely dependent on the context and culture.

**8. How long does protective immunity (that is, prevention of reinfection) last in individuals who were previously infected with SARS-CoV-2 and subsequently recovered? (For information)**

The research question was outlined, and the group were informed that the above research question will be discussed at the next meeting. The approach will consist of a systematic search of literature relating to SARS-CoV-2 infection and a scoping review of the long-term duration of antibody and cell-mediated responses.

**Feedback:**

- The EAG highlighted the particular importance of protective immunity against new variants of concern
    - HIQA emphasised that the study populations, location and follow-up period will be documented, along with any genome sequencing data relating to specific variants.
- The EAG highlighted the fact that whole genome sequencing is not always necessary to determine variants in infected samples; there are alternative tests that can also be used to identify specific variants
    - HIQA will extract and report any data relating to variant identification, noting whether or not full genome sequencing was undertaken.
- The EAG acknowledged the importance of assessing both the infection and reinfection risk among vaccinated cohorts
    - HIQA will assess the evidence of reinfection in any cohort (vaccinated or unvaccinated).
    - The risk of infection following vaccination is out of the scope of the present review.
- The EAG highlighted the importance of reinfection risk among healthcare workers.

- The EAG indicated that there are a number of UK-based studies that have looked at reinfection risk in seropositive individuals.

## 9. Meeting Close

*a) AOB:*

None noted

*b) Date of next meeting:*

Next meeting scheduled for Monday 22nd Feb 2021