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. 13 : Tuesday 30th March 2021 at 9am		
(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
	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 Lorraine Doherty	National Clinical Director Health Protection, 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 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 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)
	Ms Rachel Kenna*	Chief Nursing Officer, Department of Health
	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 John Murphy	Consultant Paediatrician & Co-National Clinical Lead, HSE Paediatric/Neonatology Clinical Programme

	Dr Gerard O'Connor	Consultant in Emergency Medicine, Mater Misericordiae University Hospital HSE Clinical Programme for Emergency Medicine
	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 Siobhán O'Sullivan*	Chief Bioethics Officer, Department of Health.
	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 Lelia Thornton	Specialist in Public Health Medicine, HSE- Health Protection Surveillance Centre (HPSC)
	Dr Conor Teljeur	Chief Scientist, HTA Directorate, HIQA
In attendance	Dr Eamon O Murchu	Senior HTA Analyst, HTA Directorate, HIQA
	Dr Kieran Walsh	Senior HTA analyst, HTA Directorate, HIQA
	Dr Paula Byrne	Health Services Researcher,, HTA Directorate, HIQA
	Dr Christopher Fawsitt	Senior Health Economist, HTA Directorate, HIQA
Apologies	Dr Niamh Bambury	Specialist Registrar in Public Health Medicine, HSE- Health Protection Surveillance Centre (HPSC)
	Dr Siobhán Kennelly	Consultant Geriatrician & National Clinical & Advisory Group Lead, Older Persons, HSE
	Prof Paddy Mallon	Consultant in Infectious Diseases, St Vincent's University Hospital & HSE Clinical Programme for Infectious Diseases
	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 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
	Prof Martin Cormican	Consultant Microbiologist & National Clinical Lead, HSE Antimicrobial Resistance and Infection Control Team
	Dr Vida Hamilton	Consultant Anaesthetist & National Clinical Advisor and Group Lead, Acute Hospital Operations Division, HSE
	Prof Mary Keogan	Consultant Immunologist, Beaumont Hospital & Clinical Lead, National Clinical Programme for Pathology, HSE

* Ad hoc member for this meeting

Proposed Matters for Discussion:

1. **Welcome**

The Chair welcomed all members. Apologies recorded as per above. Noted that two additional individuals joined the EAG for this topic, namely Dr Siobhán O'Sullivan and Ms Rachel Kenna.

2. Conflicts of Interest

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

3. Minutes

The minutes of 02 March 2021 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	Review of international public policy response for update	Ongoing	TBC April 2021
2	Policies relating to healthcare personnel who do not avail of COVID-19 vaccination: an international review	Drafted	1 April 2021
3	Update – Duration of protective immunity (protection from reinfection) following SARS-CoV-2 infection	Drafted	1 April 2021
4	Serial RADT testing- meat processing plants	Ongoing	8 April 2021
5	Facemask use by children -update	Ongoing	8 April 2021
6	Preventive interventions pre infection with SARS-CoV-2	Ongoing	22 April 2021
	Database	Ongoing - weekly	
	Public health guidance: - vulnerable groups - LTCFs	Ongoing	

5. Presentation on Policies relating to healthcare personnel who do not avail of COVID-19 vaccination: an international review (E'OM)

The EAG were reminded that NPHET had requested that the HIQA conduct an evidence summary and formulate advice with input from the EAG 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.

The following points were raised for clarification following this presentation:

- From previous evidence summaries, it was found that one of the strongest motivators for healthcare workers to get vaccinated was protection of self or loved ones. It was suggested that this finding could be drawn out a little more in the current report.
- It was acknowledged that the current review was perhaps premature in terms of finding international policies in relation to COVID-19 vaccination. It was suggested that the current review could be re-examined at a later date, when Irish data on uptake rates are available.
- It was noted that any policy requiring healthcare workers to be tested can be problematic. There are no data currently to confirm if there is overlap between those who do not (or who will not) avail of vaccination and those who do not avail of serial testing.
- It was clarified that no evidence was identified during the course of this review regarding the acceptability to patients of being treated by a healthcare worker who has not been vaccinated for COVID-19.
- A point was raised that campaigns have highlighted the importance of asking healthcare workers if have they washed their hands, and whether a precedent has been set where patients might feel it was reasonable to also question all healthcare workers on their vaccination status. It was suggested however that asking whether someone has washed their hands is not the same as asking for personal health information.

6. Advice: Policies relating to healthcare personnel who do not avail of COVID-19 vaccination: an international review (MO'N) *(for discussion)*

The following points were raised for discussion following this presentation:

- Developing policy for unvaccinated healthcare personnel was acknowledged as a particular challenge as it deals with complex professional and employer-employee relationships and has important ethical implications.
- The ethical issues were discussed, with a focus on the balancing of rights between healthcare workers and patients. Healthcare workers have a right to bodily integrity, autonomy and confidentiality. However it was noted that these rights are not absolute nor unfettered; limits can be put in place if there is the potential for harming others.
- While a patient can ask about a healthcare worker's vaccination status, it was clarified that the healthcare worker does not have to disclose this sensitive personal health information. There is an obligation on the employer to uphold a healthcare worker's privacy and confidentiality. It is the responsibility of the employer that the employee's role is appropriate and that tasks are safe for them to undertake, in light of their vaccination status. This can be facilitated through a comprehensive risk assessment and implementation of risk mitigation strategies.
- Public health ethics are based on the principle of least infringement, leading to the principle of the least restrictive alternative to achieving the same aim. The intervention ladder developed by the Nuffield Bioethics Council in the UK was agreed by EAG members as a useful framework for developing national guiding principles. The ladder includes different

kinds of government intervention that may be used to promote public health, from the least to the most coercive or intrusive measures. Early steps on the ladder include providing information and enabling choice, while measures at the top of the ladder include restricting and eliminating choice (for example, regulations to require mandatory vaccination). The further up the ladder the State climbs, the stronger the justification has to be. Less restrictive steps that could be included on the ladder are use of nudges, to influence people's choices. More restrictive steps could include guiding choice through disincentives and the restriction of choice, for example through redeployment. Mandatory vaccination sits at the top of the ladder as the most intrusive step. The decision to step up the ladder should be influenced by the level of risk to patients from unvaccinated healthcare personnel posed by increased levels of community transmission. The need for specific guidance as to what those steps on the ladder might be and who might be exempted was emphasised.

- Some members of the EAG stated that there may be an expectation among the public that healthcare workers should be vaccinated and that there may be a degree of discontent if they believe that the person providing them with care is not vaccinated.
- Mitigation of risk to both patients and healthcare workers was felt to be essential. The importance of the setting was also discussed with certain certain vulnerable populations (for example, nursing home residents) seen to be a greater risk from unvaccinated healthcare workers. Additionally, in some settings redeployment was not felt to be a viable option (for example, general practice).
- The evidence of the effectiveness of one-to-one conversions between line management or trusted peers and those who may be hesitant to take the vaccine as a means of improving uptake rates was highlighted as important by EAG members. Any recommendation for one-to-one conversations should be supplemented with sufficient guidance which can be consistently operationalised across the healthcare system. Supports and tools should be developed and made available, taking into consideration the wide range of settings in which health and social care workers operate.
- The precedence for mandatory vaccination against other pathogens was discussed. As a specific example, it was discussed how refusal to get vaccinated for Hepatitis B could prevent surgeons from conducting certain high risk operations.
- There was a general consensus that mandating COVID-19 vaccination at this time may not be appropriate as this may act as a deterrent. Additionally, such a measure may be perceived as being overly harsh on a workforce that have had a particularly traumatic year. If all lesser restrictive measures have been exhausted and there is still low uptake, consideration may be given to mandatory vaccination in the future. However, caution was expressed with regards to how far one should go to ensure high levels of vaccination, and the potential creation of a negative work environment.
- EAG members were generally in favour of a 'support and encourage model' whereby staff are facilitated to make the decision to become vaccinated in a supportive environment.
- The Professional Bodies (such as. the Medical Council of Ireland, Nursing and Midwifery Board or Ireland and Pharmaceutical Society of Ireland) may have a critical role in outlining the duty of members of the professions in terms of vaccination. Trade unions and third level institutions may also play an important role in encouraging COVID-19 vaccination.
- The potential for 'nudges' to improve COVID-19 vaccination uptake behaviour was discussed with examples such as wearing badges or stickers. However, there is a need to be careful

that this is not done in a way that stigmatises or discriminates against those who do not avail of the vaccine for whatever reason.

- Collection of data on uptake, reasons for refusal, ethnicity and setting was considered critical, in order to ascertain where refusals may be higher than usual and any associated factors, so that appropriate supports could be put in place. It was clarified that there is a data reconciliation project ongoing in Ireland which will facilitate the estimation of uptake rates among healthcare workers. Anecdotally, uptake and demand for COVID-19 vaccine among healthcare workers are currently high.
- As there are a range of COVID-19 vaccines currently available, the selection of an alternative vaccine by the healthcare worker may be a possibility on a case-by-case basis if there are particular clinical considerations. However, such an approach would require further consideration and it would have policy implications beyond healthcare workers.
- Evidence relating to presumptive immunity due to a previous infection with SARS-CoV-2 and how this might impact on a healthcare worker's decision to become vaccinated was discussed. There is currently no international standard for the threshold of SARS-CoV-2 antibody titres that can reliably predict immunity to reinfection. However, with additional data this could theoretically be a possibility in the future.
- There was an acknowledgement that there needs to be early engagement with the various trade unions and professional bodies and organisations to discuss how any potential redeployment due to declination of the COVID-19 vaccine vaccine (in cases where other less restrictive options have failed) might work.
- Given the critical role that trusted healthcare workers such as GPs and pharmacists play in encouraging vaccine uptake, vaccine hesitancy or declination by healthcare workers may have a wider influence on the public. There needs to be clear advice against healthcare workers spreading misinformation. It was noted that visible uptake of vaccine by healthcare workers (for example, stickers/badges indicating vaccination status) provides reassurance and strongly influences patients' perceptions of vaccine safety and importance.
- It was confirmed that HIQA will not be writing any policy on dealing with healthcare workers who do not avail of COVID-19 vaccination, but rather HIQA will be providing advice to the policymakers based on the evidence review that has been undertaken and the main considerations arising from expert public health and clinical interpretation of the review by the EAG.

7. **Duration of protective immunity (protection from reinfection) following SARS-CoV-2 infection**

The EAG were reminded that this item NPHET was a planned update of the advice provided to NPHET in March 2021. The evidence summary and advice (with input from the EAG) addressed the following specific research question:

> 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?

This evidence summary and advice is expected to inform a range of policy questions relating to the duration of protective immunity following infection with SARS-CoV-2. In addition to the

evidence summary, it had been noted that Irish data on reinfection would provide important context. The HPSC representative presented preliminary data on reinfection in Ireland.

- Of 232,738 confirmed cases of COVID-19 notified between 2 March 2020 and 23 March 2021, 514 (0.2%) were potentially reinfections, based on the criteria of more than 84 days between notification dates or specimen dates.
- A short discussion followed regarding the anomalous rate of reinfection during July 2020. This could be a product of lower numbers of circulating infections, or differences in rate of testing at the time.

Presentation on Duration of protective immunity (protection from reinfection) following SARS-CoV-2 infection (E'OM)

The following points were raised for clarification following this presentation:

- The group were in agreement that these findings of low risk of reinfection up to 10 months are reassuring. These data are consistent with a recent ECDC review on the risk of reinfection following prior infection or vaccination (29 March 2021). It was acknowledged that the ECDC review incorporated evidence from HIQA's previously published evidence summary (8 March 2021). In addition, the ECDC incorporated HIQA's search strategy in their database search, as published in the HIQA protocol (16 February 2021).
- It was clarified that none of the included studies reported disaggregated data on those with comorbidities or those who are immunocompromised.
- It was clarified that no cohort studies were identified from Brazil. However, included in the Appendix are a number of individual case reports pertaining to transmission of the P.1 variant in the State of Amazonas, Brazil.
- It was noted by EAG members that serial testing programmes have not been altered despite rising levels of vaccination, such as among nursing home staff and residents. Going forward, the approach to testing may change to a surveillance approach when this population is fully vaccinated.

Advice: Duration of protective immunity (protection from reinfection) following SARS-CoV-2 infection (PH) *(for discussion)*

The following points were raised for discussion following this presentation:

- The evidence regarding immunity up to 10 months post-infection was felt to be reasonably robust. HIQA clarified that nine of the eleven included studies followed participants for ≥7 months, six for ≥8 months, five for ≥9 months and three for ≥10 months. However, the median follow-up was significantly shorter than the maximum in all studies. While the maximum follow up extended beyond 10 months, median follow-up ranged from 1.8 to 7 months across studies.
- The current advice is to assume immunity up to six months post-infection. The findings of the review were felt to strengthen the recommendation of an assumption of immunity for six

months. While an incremental increase in this timescale could be made, the advice should be to retain the current six month cut-off for practical reasons and for reasons of clarity.

- The impact of changing this assumption on protocols for testing, definition of close contacts, and other areas of policy should be considered, as well as how changes could introduce confusion into established policies. It might be useful to decide what the next incremental change in the advice should be, for example, an assumption of nine months immunity post-infection could be considered as the next step (previously, 3-month increments have been considered).
- The next version of this report should be scheduled before June 2021, so as to inform any changes before the large cohort infected during the third wave are considered to no longer have protective immunity. Subsequent reviews may consider protective immunity in both unvaccinated and vaccinated populations.
- It was acknowledged that there are limited data on older adults, children, populations with comorbidities, those who are immunocompromised, as well new variants. It was suggested that in the next update, more information will have accrued which will result in stronger recommendations for policy changes relating to the duration of presumptive immunity.
- It was clarified that none of the included studies were confounded by the inclusion of vaccinated participants. Only one included study, conducted among a population of aged UK care home residents, coincided with vaccination roll-out. However, this study explicitly excluded vaccinated individuals from their analyses.
- It was acknowledged that extending the duration of presumptive immunity from six to nine months at this point in time may have a limited impact as it would mostly apply to those infected after the first wave at the beginning of the pandemic, and before the widespread transmission during the third wave. It was acknowledged that confounding due to vaccine rollout will likely be problematic in future studies.

8. Meeting Close

The Chair thanked the EAG members and individuals for their presentations and for their contributions, acknowledging the short turnaround times and notice provided.

Date of next meeting: 6 April 2021

Meeting closed at 10.46 am.