Health Technology Assessment (HTA) Expert Advisory Group Meeting (NPHET COVID-19 Support)		
Meeting no. 23: Thursday 10 March 2022 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
	Ms Sinead Creagh	Laboratory Manager at Cork University Hospital & Academy of Clinical Science and Laboratory Medicine
	Dr Lisa Domegan*	Surveillance Scientist, HSE- Health Protection Surveillance Centre (HPSC)
	Prof. 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
	Dr Patricia Garvey*	Surveillance Scientist, HSE- Health Protection Surveillance Centre (HPSC)
	Dr Patricia Harrington	Deputy Director, HTA Directorate, HIQA
	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 John Murphy**	Consultant Paediatrician & Co-National Clinical Lead, HSE Paediatric/Neonatology Clinical Programme
	Mr Ronan O'Kelly*	Statistician, Statistics and Analytics unit, Department of Health (DOH)
	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 Michael Power	Consultant Intensivist, Beaumont Hospital & Clinical Lead, National Clinical Programme for Critical Care, HSE
	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	Mr Paul Carty	Senior HTA Analyst, HTA Directorate, HIQA
	Mr Fearghal Comaskey	HTA Analyst, HTA Directorate, HIQA
	Ms Jiang Jingjing	HTA Analyst, HTA Directorate, HIQA
	Dr Louise Larkin	HTA Programme Manager, HTA Directorate, HIQA
Apologies	Dr Susan Spillane	Head of Assessment, HTA Directorate, HIQA
	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)
	Dr Vida Hamilton	National Clinical Advisor and Group Lead, Acute Hospitals
	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

* Ad hoc member for this meeting only. ** Alternate nominee for programme and or association.

Proposed Matters for Discussion:

1. Welcome (MR)

The Chairperson welcomed the EAG members. MR welcomed a number of additional members (Dr Lisa Domegan, Dr Patricia Garvey, Dr Michele Meagher and Mr Ronan O'Kelly) who were invited for this meeting on the basis of their specific expertise relevant to the topics being discussed.

Apologies recorded as per above.

2. Conflicts of Interest (MR)

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

3. Minutes (MR)

No changes to minutes from previous EAG meeting on the 15 November 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	Target date
1	Descriptive analysis of COVID-19 epidemiological indicators and associated contextual factors in European countries	Drafted	

2	High level review of configuration and reform of Public Health systems in selected countries	Ongoing	To be provided to Public Health Reform Expert Advisory Group in two parts (28 March and 25 April 2022)
3	Analysis of consultation on the public health system in Ireland	Commences 22 March 2022	25 April 2022, although dependent on response rate
4	Nursing home analysis	Complete	

5. **Presentations on key factors to consider for the use of 'Descriptive analysis of COVID-19 epidemiological indicators and associated contextual factors in European countries' (Paul Carty)** *(for discussion)*

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

- It was queried whether the scope of the epidemiological analysis could be expanded to have a global focus. The Chair noted that the scope of this project, as requested by the Department of Health, was specifically focused on the burden of COVID-19 in Europe.

- It was suggested that National Office of Clinical Audit (NOCA) would be able to provide data on ICU capacity and occupancy rates in Ireland during the pandemic. How hospital capacity is used was noted to be important, with potential to maximise the use of the available capacity through, for example, increased use of inter-hospital transfers. It was agreed that HIQA's Evaluation Team would contact NOCA for these data.

- It was queried whether there was a simple measure that could represent population dispersion along with population density. It was clarified that there are no available European data for such a measure. An alternative suggestion was to consider using a metric of urbanisation (that is, the percentage of people that live in urban areas).
- The mismatch between COVID-19 deaths and excess mortality was noted, with Ireland being one of the few countries where reported COVID-19 deaths exceeded excess mortality. It was highlighted that Ireland uses the WHO definition on COVID deaths (last updated in 2020) which provides a broad definition of COVID deaths. Other countries have taken a different approach to capturing COVID-19 deaths, particularly the UK (which may have under-captured deaths) and France. Differences in definition limit the ability to make comparisons between countries.
- It was requested that the total cumulative deaths over the study period in the population aged 65 years or over be added to the report. The HPSC noted that the data they capture for EUROMOMO are available by subgroups in those over 65 years of age. It was agreed that these data would be added to the report.
- It was noted that, in contrast to some European countries, Ireland had low excess mortality in those age groups under 65 years. However, due to the variety of reasons described in the report, it is difficult to compare excess deaths across Europe.

- It was suggested that the sex distribution of the population aged over 65 years could be worth exploring, as there is evidence to indicate that males have a greater chance of mortality due to COVID-19. It was noted however that these data were not readily available, and would need to be collated from each country individually if they were to be included.
- Page 7 of the report indicates that the second COVID peak occurred in February 2021 – it was suggested that while this may have reflected peak test positivity. From the healthcare system perspective, the peak actually occurred in January 2021, as reflected in the intensity of the wave on the hospital system at that time.
- It was noted that there was a dip in confirmed cases following the introduction of Level 5 restrictions, contradicting page 23 of the report that mentions confirmed cases gradually increasing from October onwards.
- It was noted that at one point, Ireland had the highest incidence rate of COVID-19 in the world, but that this was not highlighted in the report. It was suggested that wave intensity could be considered in the report to emphasise pressure points on the healthcare system.

6. **Discussion: 'Descriptive analysis of COVID-19 epidemiological indicators and associated contextual factors in European countries (Michelle O'Neill)** *(for discussion)*

The COVID-19 EAG engaged in a facilitated discussion based on the presentation described above. The EAG noted that they were satisfied that the key findings of the draft report reflected the data analysis. The following additional points were raised:

- It was acknowledged that throughout the European countries, public health policies changed substantially over the course of the pandemic with variation also between countries. Policies within Ireland also varied throughout the course of the pandemic.
- With regard to test positivity, it should be acknowledged that testing capacity and the testing strategy that are in place in a country are key factors in interpreting this contextual factor and also impact reported incidence rates. Capacity and strategies changed over time with capacity noted to be particularly limited in the first wave. In terms of strategies, Ireland's close contact testing changed at times, and there was serial testing resulting in lower positivity rates. Therefore, case counts between waves are not directly comparable.
- There was a wide variation in the definition of mortality from COVID (confirmed and probable) across countries. The definition used in Ireland was broader than in most countries thus we are including more deaths than most European countries. However, it was noted that while a broad definition was used In Ireland, when observing all COVID-19 deaths notified to date, 95.7% were lab-confirmed cases, 1.5% were probable cases and 2.8% were 'possible'. Only 185 COVID-19 deaths were not lab confirmed.
- Ireland's high stringency index and approach to vaccination rollout placed a greater emphasis on protecting the elderly population, and lead to a lower burden of death. Despite these actions, it was highlighted that over 90% of deaths in Ireland occurred in the over 65 population and this may warrant further research.
- It was noted that important contextual factors such as socio-economic status and ethnicity are not included within the report, but could be commented on as part of the discussion.

- It is worth highlighting that Ireland experienced shorter periods of time in excess mortality with seven weeks in the first wave and seven to eight weeks in the second wave. In comparison, some EU countries had extensive and long periods of excess deaths.
- Noted that the number of expected deaths is an estimate and will differ depending on the periods of time chosen.
- The calculated EU-27 averages were limited by variation in the timing of waves experienced across countries in Europe. It was suggested that it might be useful to split the analysis' time span into separate time points and analyse according to days from the initiation of the wave in each country. However, the key limitation to this approach is that there is no universal way of defining the beginning and ending of waves. Therefore, it was agreed that this analysis would not be pursued.
- The absence of a direct comparison between Ireland and the UK in the report was noted. While recognising that the UK and Ireland share a lot of infrastructure and the force of the infection in the UK had a direct impact on incidence in Ireland it was agreed that direct comparisons are limited by a large number of contextual factors (such as population size) and also differences in definitions used, for example of COVID-19 deaths.
- There was agreement that the cumulative figures for both cases and deaths are useful information and could be brought into the discussion.
- It was suggested that the discussion should include commentary on the potential impact of a particularly substantial wave of COVID-19 (during which a lot of the population were infected) on subsequent COVID-19 waves; this should include consideration of whether subsequent peaks may be lower due to higher levels of immunity.
- It was suggested that population dispersion and percentage of urbanisation could be considered. Limitations of using population density as a contextual factor to explain the incidence of COVID-19 were highlighted; areas with high population density typically have better public health measures and better testing systems in place although it was noted that experience of New York showed this is not always the case.
- While acknowledging that capacity limitations impact decisions around hospital admissions and discharge, without evidence it is not possible to infer that this impacted outcomes.
- The importance of highlighting the impact on non-COVID patients was noted. It was highlighted that across the acute hospital system, COVID-19 displaced both non-COVID-19 scheduled and unscheduled care.
- The EAG agreed that the report highlights the value of data sharing worldwide and its applicability to policy evaluation. This should be noted in the report.
- It was suggested that, across the epidemiological indicators, the Irish peaks were typically shorter and lower than those experienced in other European countries. It should be highlighted that the nature of public health response in totality is likely an important conclusion.
- A potential limitation was raised with regard to the stringency index data, which did not incorporate all public health measures, such as guidance on ventilation of buildings and antigen testing. It should be noted that there were variations in how the measures were implemented in different countries.

7. Meeting Close

a) AOB: Nil
b) Date of next meeting: TBD

Meeting closed at 12.30