ECDC Advisory Forum

Minutes of the Sixty-third meeting of the ECDC Advisory Forum

15 December 2020 (via audio conference)

Contents

Opening and adoption of the programme

1. Andrea Ammon, ECDC Director, welcomed the participants to the 63rd meeting of the Advisory Forum which was taking place via audioconference.

2. Mike Catchpole, Chief Scientist, ECDC welcomed the participants, in particular Ingrid Keller from DG SANTE, European Commission, and Danilo Lo Fo Wong, WHO's Regional Office for Europe, the new focal point for ECDC coordination. Apologies had been received from Iceland, the Netherlands and Aura Timen of EUPHA.

3. Mike Catchpole mentioned that, sadly, this would be the last Advisory Forum meeting for Kåre Mølbæk, AF Member for Denmark, who was retiring as Vice President of Statens Serum Institut in Denmark and thereby leaving the AF. Kåre had been a member of the AF since the very beginning of ECDC, and his input had been hugely valued, so on behalf of the AF and ECDC he thanked him for all his contributions over the years, and noted that he would be hugely missed.

4. The programme was adopted with no changes and there were no conflicts of interest.

Adoption of the draft minutes of the 62nd meeting of the Advisory Forum 24 September 2020

5. Mike Catchpole, Chief Scientist, ECDC, said that amendments to the draft minutes had been requested by France on Point 12, Hungary on Point 40 and Portugal on Points 10, 48 and 62, and these had been taken into account in the draft circulated.

6. Frode Forland, AF Member, Norway said that he had meant to say that in September it was estimated that around 50% of the cases were *detected* in Norway, compared to 10% of the cases in spring 2020.

7. The minutes of the 62nd meeting were adopted.

Update on COVID-19 followed by exchange of information

8. Andrea Ammon, ECDC Director, gave a short update, highlighting a number of issues.

9. Mike Catchpole, Chief Scientist, ECDC, pointed out that, given the news from the UK about a new strain of the virus, suggesting higher rates of transmission, it was important for ECDC to reiterate and make clear its advice regarding avoidance of non-essential travel.

10. Mika Salminen, AF Member, Finland thanked ECDC for its joint guidance with EASA on air travel [chat comment].

11. Kåre Mølbæk, AF Member, Denmark, referring to the strain identified in the UK, said that there had been nine cases in Denmark so the strain was not limited to the UK. It appeared to be two clusters in two different parts of the country. They were checking to see if the cases had any recent travel history or if there were any specific issues in terms of clinical patterns. They had also checked the GISAID database and it appeared to be only UK and Denmark that were affected so far. He also suggested that in the longer term there should be some discussion in the AF on the role of sequencing and how this could provide added value in terms of public health.

12. Mika Salminen said that in Finland a mutation had been seen in some smaller-scale outbreaks which had then spread, but it was difficult to identify any kind of direct effect from this.

13. Mike Catchpole pointed out that the reason the media had picked up on this in the UK was that the strain had been found in areas where the infection rate seemed to be increasing more quickly although it was uncertain whether the two factors were connected. Referring to the likely prevalence of COVID-19 among air travellers, he asked AF members to share any relevant experiences with regard to the testing of returning travellers.

14. Kåre Mølbæk said that as of 3 December 2020 the antigen test had become part of the ECDC case definition, and he wondered whether cases confirmed using antigen testing were being included in TESSy or whether there was a hidden number of cases that escaped surveillance because of the extensive use of antigen testing, meaning that the testing was not being carried out in laboratories. So far in Denmark these tests had not been included, but he was keen to hear how other countries were handling the issue.

15. Osamah Hamouda, AF Member, Germany said that in Germany antigen tests conducted in laboratories were reportable but they were not counted as cases. The German case definition was still restricted to PCR cases. However, antigen tests were being rolled out in homes for the elderly and there were also plans to roll them out in schools. This would be a problem because local health authorities would not receive the results of these tests so they were trying to change the law to ensure that anyone performing rapid antigen tests had a responsibility for reporting the results to their local health authority. However, he was still reluctant to include antigen tests in the case definition due to the very high false positive rate and therefore they were still waiting to have a better understanding of the extent of this. If antigen tests were included they would probably only link them to symptomatic cases although this was still under discussion.

16. Bruno Coignard, AF Member, France, said that in France they had made the switch during the previous week, and now treated the results of antigen tests in the same way as PCR tests and had incorporated them into the indicators for monitoring the outbreak and adapting the case definition. They had also informed ECDC of this change. With regard to the issue of how to capture the information on antigen tests from outside of laboratories, he explained that this was regulated and that those performing the tests had to record the results in a nationwide live database of results otherwise they would not be reimbursed. There were two mass screening operations currently taking place in France, one in Le Havre and one in Charleville-Mézières, so it would be interesting to see how well the data from those was captured. However, to date, they were quite confident that the information provided on antigen tests from pharmacies was reliable, the only difficulty being that it had to be entered manually into the national monitoring system.

17. Mika Salminen, referring to air travellers, said that so far in Finland they had used a risk-based system at major airports, identifying flights coming from places with a probable high incidence in the population and offering voluntary testing for everyone arriving on those flights. The take-up rate had been around 50% but traveller numbers were small (5% of the normal travel schedule). The average rate for travellers testing positive was around 1% or less, although there had been several examples of flights with a much higher prevalence. This meant that they were considering antigen testing as one strategy for risk mitigation if travel increased, although it was highly resource-intensive so they could not cover all their borders with the current system. Under the Finnish system, anyone wishing to set up point-of-care testing in the community or at a facility had to have licensed staff and was also responsible for ensuring that all test results were reported to the national system. Antigen testing had been made part of the case definition and in certain regions such as the North, where there was no local access to labs, there was extensive use of antigen testing (with some being followed up with PCR). In Finland they were also keen to use antigen tests for hard-to-reach populations such as migrant groups and homeless people.

18. Mike Catchpole wondered whether it had been possible to predict those flights into Finland with much higher prevalence and whether the prevalence was based on numbers in the countries of departure.

19. Frode Forland, AF Member, Norway, said that during the autumn migrant workers coming from EU countries had been a problem in Norway and had been the main cause of the second wave in Norway. They had been trying to control this by offering testing at the airport and asking travellers to go into quarantine for 10 days. A new large influx of workers was now expected for the winter fishing season in the north of Norway which could also possibly create the risk of further outbreaks. With regard to rapid tests, a validation study of 5 000 tests matched against PCR tests showed them to have an 80% sensitivity when symptoms were present. Antigen tests could therefore be useful in some circumstances and in Norway they had been discussing using them for border controls and for entry to nursing homes. Antigen tests were now being counted and included in national figures where possible.

20. Sylvia Declich, AF Member, Italy, said that there were some regions in Italy that had started mass screening (e.g. Bolzano.) The problem was that the tests had not been validated. Test specificity varied considerably depending on the population where the mass screening was being done and this was not understood. She therefore wondered whether ECDC was thinking of issuing guidelines in relation to this issue, particularly since the mass testing was being considered as a solution ahead of the opening of ski resorts for the winter season.

21. Mike Catchpole said that this could be considered, although he was not sure of the value of doing this. He asked the AF members for their opinions on whether recommendations from ECDC on mass screening would be useful.

22. Fernando Simón Soria, AF Member, Spain, sharing insights into Spain's testing strategy, said that antigen tests had been used since mid-September by autonomous regions and health services. Usually the sensitivity (90%) and specificity (99%) was high in symptomatic people although the sensitivity was lower in asymptomatic people. Two validation exercises had been carried out to test this in asymptomatic people, and one had shown 50% and one 55% sensitivity, so in Spain antigen tests were being used to test symptomatic people in primary healthcare. This was working well and helping to improve compliance with quarantine and isolation and offered much faster results than PCR. All antigen tests were included in laboratory databases. Around 35-40% of all testing in Spain was now antigen testing and these results were being included in national statistics. Rapid antigen tests were not used in Spain for mass screening as such screening was not being done. They preferred to focus testing on areas where there was evidence of transmission. So antigen tests were mainly used for contact tracing of the close contacts of confirmed cases and targeted testing in areas of very high incidence. All positive results had to be confirmed by PCR to prevent people being forced into isolation due to false positive results. In Spain antigen testing was being used to test travellers arriving without evidence of a PCR test certificate. However, travellers were a low-incidence group and to date they had only found around one positive case in 10 000. During the first week of rapid antigen tests being introduced for all travellers under a new policy, they had performed 400 rapid antigen tests and only found 2-4 positive cases.

23. Kåre Mølbæk supported the idea of ECDC producing some guidelines on mass screening as it was counter-intuitive for mass screening to have an impact unless it was being followed up with quarantine and isolation. In addition, there were people who would test negative but who were incubating the disease. Therefore, in terms of controlling the epidemic, mass screening would have little effect. Having some guidance would also make it possible to prevent significant expenditure on politically-motivated mass screening.

24. Isabel De La Fuente Garcia, AF Member, Luxembourg, said that in Luxembourg they were carrying out mass screening at a rate of around 10% of the population per day (70 000 PCR tests per week). To date around 15% of cases had been diagnosed in this way so for Luxembourg it was a part of the strategy for controlling the pandemic that was considered very useful. Rapid antigen tests was also now available in the country but discussions were still ongoing on how to use them, in order to retain as much capacity as possible for PCR.

25. Jan Kynčl, AF Member, Czech Republic, asked about the possibility of ECDC making a slight amendment or update to the case definition.

26. Franz Allerberger, AF Alternate, Austria, said that mass testing had been carried out in Vienna and one third of the population had been tested in one week. Self-testing with anterior nasal swab had been offered to those who were unable to take nasopharyngeal swab samples. This had worked surprisingly well, which also confirmed the results of a recent publication by Christian Drosten. The US CDC was already accepting this alternative. In his opinion, the anterior nasal swab was a game changer which would make it possible to carry out many more tests and to test much more quickly. In fact, some companies were already changing the instructions in their test kits (e.g. Roche) to take this into account.

27. Bruno Ciancio, Head of Section, Surveillance, ECDC, commenting on the links he had posted in the chat, said that ECDC had seen the potential of population-wide testing last summer in the light of Luxembourg's experience with this. ECDC had published a guidance on the subject, including limitations, such as the need for all those identified to be isolated and contact tracing to be carried out. However, where feasible, population-wide testing did offer the potential to detect all those infected at a given time in order to interrupt the chain of transmission. He had also posted a link to ECDC's testing strategy published in September. In response to the question regarding inclusion of antigen testing in the case definition used for COVID-19, he said that ECDC had published a new definition about 10 days previously which also now encompassed the possibility to include antigen-test-positive cases in reporting to ECDC. ECDC had discussed the case definition extensively with the COVID network and it had been accepted by all and ECDC would now start collecting data based on antigen tests. There were, however, several caveats on how to interpret the results in the light of validation studies of the specificity and sensitivity of the assays, and also based on the expected frequency of disease in the targeted population because this would have an impact on the positive and negative predicted value.

Strategy and framework for COVID-19 vaccination in the EU/EEA with a focus on ECDC activities

28. Lucia Pastore Celentano, Head of Disease Programme, VPD and Immunisation, Disease Programmes Unit, ECDC, gave a short presentation and the floor was opened for discussion.

29. Anders Tegnell, AF Member, Sweden, said that to date there were lots of plans relating to monitoring but he had not seen any practical information on how data would actually be collected. He wondered when ECDC would be able to provide data on the efficacy of the actual vaccines.

30. Rebecca Moore, AF Member, EIWH, asked whether ECDC was planning as part of the joint monitoring, to monitor vaccination of pregnant women and to check whether vulnerable populations would be receiving the vaccine to the same extent as other groups.

31. Kåre Mølbæk, AF Member, Denmark, asked whether there were any countries considering a one dose strategy where the vaccine was in short supply.

32. Lucia Pastore Celentano, responding to the question on monitoring vaccine effectiveness, said that ECDC would be developing protocols on efficacy in collaboration with the Member States and WHO that could be used in the countries. There would also be a specific study using EU data on hospital and healthcare workers as soon as the vaccine was on the market, along with a feasibility study relating to long-term healthcare facilities. A letter would be sent to all Member States the following week to explain how the studies would be performed, and to ask whether they would like to participate. In the new year, there would also be involvement of the neighbouring countries on a voluntary basis. For the first year, ECDC had funds of EUR 1,680 000 available so although it was not certain that they could cover all the countries, the objective of the long-term plan under the new Health Programme was to be as inclusive as possible, and to help countries with capacity building in safety and effectiveness monitoring. New data would be available sometime between June and September, depending on how many vaccines were on the market, dosage, coverage, etc. In parallel, there would also be studies done by the pharmaceutical industry in collaboration with the European Medicines Agency, and DG Research was also organising a network for post-marketing clinical trials. ECDC was in contact with them to understand what type of studies they would be doing. For the moment, the only vaccine that was on the market was not recommended for pregnant women. Vulnerable populations were quite a broad group and the problem was that this group did not just include vulnerable people but also other risk groups specific to COVID-19. At the moment, for the first phase in agreement with WHO and UNICEF the plan was to vaccinate the elderly and healthcare workers first because age was the most important risk factor for death and severe cases. In the second phase, once more was known about the side effects of the vaccination, it would be offered to vulnerable individuals, although the UK had identified small groups of vulnerable people that would be vaccinated immediately along with the elderly. The one-dose strategy has not been considered so far. ECDC's model considered two doses to provide full immunity.

33. Anders Tegnell said that it looked as though most of the population in Sweden would have been offered the vaccine by June so the first phase of the program would be over by then so it sounded very late for results.

34. Lucia Pastore Celentano said that this implied that every country had implemented post marketing surveillance and monitoring. ECDC was simply facilitating a task which was the responsibility of the countries and making it possible to have one common protocol and be able to pool the results. This was more difficult for countries to do in isolation and it simply increased the sample size. The first phase would depend on the countries but they would only cover a small percentage of their population. In theory, countries should cover 10–20% of the vaccination requirement, according to the doses that they had each been allocated. The first phase would make it possible to better understand how the vaccine worked and whether it could prevent infection and transmission. Without knowing how the vaccine worked there was no indication that vaccinating 70% of the population would bring about the end of the pandemic. Therefore, it was not just important to get results in three months but more to build a system that could monitor everything, with the first priority being safety.

35. Nerija Kuprevičienė, AF Alternate, Lithuania, noted that it would be useful to have information on vaccination for those who had previously been infected and asked if ECDC planned to collect this.

36. Lucia Pastore Celentano said that ECDC was currently developing the protocols for the variables but that at present the focus was on the severity of the disease and protection of frontline healthcare

workers. Regarding the question from the AF Alternate for Lithuania, so far the indication from WHO was that everyone should be vaccinated, irrespective of whether they had previously been infected, but for healthcare workers the plan was to conduct serology tests first.

37. Kåre Mølbæk said that many of the points raised by Lucia about studying the science in the medium-term were very valid. However, there was a desire to gain rapid vaccine effectiveness information and for those countries with good immune registries which could be linked to other healthcare databases it would be possible to obtain almost real-time estimates of this information. This would be useful as guidance when developing protocols. Denmark had had good experience from the I-MOVE projects using test negative case control designs and that could also be applied. He believed that with this information it might be possible to have estimates as early as March.

38. Lucia Pastore Celentano said that this was exactly what was planned, and that of course those countries with databases, including the Nordic countries, would make it feasible to have early preliminary results. But to have results by brand, ECDC believed that the population coverage would not be enough. Databases were available in one third of the EU Member States and the others would need to set up an ad-hoc system, which was why a protocol could be very useful in that situation.

Discussion on recommendations arising from the strategic review of the ECDC response to the COVID-19 pandemic

39. Andrea Ammon, Director, ECDC, gave an overview of the recommendations and the floor was opened for discussion.

40. Anders Tegnell, AF Member, Sweden, said that any crisis would put pressure on an organisation, as had been seen recently. However, in the report it was not apparent how ECDC's role during a crisis could be better defined. This role was not clear to everyone – for example the areas in which ECDC worked and those in which the Commission and the Health Security Committee worked. With regard to a better understanding of national health systems, he pointed out that this would be very difficult as they were all so different and complicated. Instead of the proposal to outpost staff to countries, he would recommend establishing more regular communication with countries in smaller groups. He also did not see EU-added value mentioned in the report and felt that this should probably be included.

41. Mika Salminen, AF Member, Finland, supported the view that there should be a division between ECDC and WHO Europe, because issues within the EU region could be quite different from those in the wider WHO European Region. He agreed with the AF Member for Sweden regarding national health systems which were very difficult to understand. However, it had been noted that once the pandemic began it would have been useful to obtain better information from hospital systems earlier on, and he hoped that this was an area ECDC could work on in the future.

42. Franz Allerberger, AF Alternate, Austria, said that WHO was difficult to contact and therefore it was impossible to give feedback on ideas or suggestions. If he wished to give feedback to ECDC or if he had a question, he could obtain an answer within a few hours and always had a contact person to go to. However, WHO was a very different institution.

43. Fernando Simón Soria, AF Member, Spain, agreed that better coordination with WHO would be useful for everyone, and felt that it was important to support WHO. ECDC should be more present in the countries, with bilateral dialogues, and possibly a key person at operational level within ECDC who understood the national health system in each country. The pandemic had shown that it was not only about infectious diseases – it was about healthcare, policy, research, and many other factors. It would involve knowing enough about the whole system to understand how the different bodies were coordinated and how they could be influenced. ECDC needed to spend more time on country visits and its recommendations were sometimes either too late or, in some cases contradictory. A great deal had been learned during the pandemic and this had also shown that it was very easy to move too quickly or too slowly.

44. Lorraine Doherty, AF Member, Ireland said that it had been a difficult period for all of Europe. The remit of WHO and ECDC needed to be clear. In Ireland they had looked at guidance from both organisations and tried to work out what suited them best. She also asked about the role of the AF during a pandemic and how frequently it should meet. She suggested that a forum should be found to facilitate communication across Europe on regular fixed basis, rather than as an ad-hoc arrangement. A more regular working arrangement across institutions in Europe might facilitate a better understanding of one another's systems.

45. Kåre Mølbæk, AF Member, Denmark said that the report had too many recommendations and would therefore be difficult to follow up on. He saw the report as a stepping stone because there was still a lot to be learned about how ECDC and the Member States could interact. He also agreed that it was important to look at the role of the AF. The countries needed a strong WHO and the organisation had been under enormous pressure due to the US position. It was therefore important for ECDC to work together with WHO, particularly during the current global crisis. Since ECDC was only focussing on Europe, it should be more proactive and move more quickly. The EU countries needed to know more about healthcare capacity and infection control so it would be useful for ECDC to learn more about the countries' systems in those specific areas, but not the complete systems.

46. Frode Forland, AF Member, Norway, following up on the comment from the AF Member for Ireland on more frequent meetings, said that the Nordic countries had been meeting every two weeks and he suggested that something similar could be organised at group level for other sets of countries. However, it was quite easy for Sweden, Norway and Denmark to do this as their healthcare systems were similar.

47. Andrea Ammon, Director, ECDC, responding to the issue of collaboration between WHO and ECDC, said that the AF comments reflected what had been said by the Management Board. Of course there might be situations where circumstances in the EU were different to those in the rest of Europe, which might give rise to the need to move earlier or faster, but in general the desire was expressed for ECDC to align itself with WHO. ECDC's collaboration with WHO's Regional Office for Europe had always been very good and continued to be so. With regard to national health systems, she pointed out that in the revised version of ECDC's founding regulations there was a proposal to collect system parameters for obtaining information on capacity and response capability. This offered an opportunity to discuss how to set up monitoring that could be used both in crisis and non-crisis situations, with the parameters included in common digital solutions. With regard to collaboration with countries, ECDC now had a good opportunity to shape this area and to work more closely with the countries in smaller groups or on certain topics. ECDC was still discussing this and hoped that it could be placed on the agenda of the Joint Strategy Meeting for 2021. Regarding the comment on the report having too many recommendations, ECDC planned to focus on those where it could immediately make a change (e.g. interaction with the countries), while some others would require longer-term solutions. Any such changes could involve an update of ECDC's paper on Competent Bodies and the way in which it worked with them. She thanked the AF Members for their comments and feedback.

Long-term surveillance framework 2021-2027

48. Vicky Lefevre, Head of Unit, Public Health Functions, ECDC gave a short presentation.

49. Andrea Ammon, Director, ECDC, stressed that there were still a number of issues to be discussed; however, there were some aspects that it might already be possible to agree on. The proposals were similar to those for proposed changes to ECDC's mandate. She had heard that Member States had noted in the Council meeting that they still needed time to reach a conclusion, but it was important to discuss the issue anyway, even though the conclusion was still pending.

50. Anders Tegnell, AF Member, Sweden said that the proposals were very ambitious but also very good in terms of method. However, the difference between the EU and Member State level surveillance was unclear and needed to be clarified.

51. Bruno Coignard, AF Member, France, said that he could see these plans involving an increase in data requests and that it was important not just to focus on Member States as data providers but more to focus on how the data could be used together for the benefit of everyone. With the increased workload, it would be important to find the correct balance between EU analysis and Member State analysis.

52. Lorraine Doherty, AF Member, Ireland, said that in Ireland they would struggle to meet all the requirements in terms of digital technology which would need extensive resources. With regard to standards, she asked how this would work with those Member States who could not meet the standards set by ECDC because sometimes this was challenging. She also wondered about access to electronic healthcare records in relation to data protection requirements. Overall, she thought the proposals were quite ambitious and that it would be necessary to look at the feasibility of some aspects.

53. Ágnes Hajdu, AF Alternate, Hungary, asked whether ECDC could facilitate that further digitalisation of surveillance systems in a harmonised manner across the EU, not only in terms of

minimum surveillance datasets, but also IT standards and good operational IT practices to support public health.

54. Vicky Lefevre, Head of Unit, Public Health Functions, ECDC, pointed out that there would be no duplication of EU Member State systems and she hoped that this was not the impression gained from the document. This draft framework focusses on EU/EEA surveillance which builds upon national surveillance systems and enhances them with common EU objectives and supranational coordination. She fully agreed with the AF Member for France, that there should be no extra burden placed on Member States to report (although the framework foresees other types of data to be collected it also includes review of the diseases under EU surveillance and further digitalisation and process automation) and that the new framework should be for the benefit of the whole of Europe. With regard to the use of data from electronic health records for EU surveillance purposes, she was aware that setting this up would be challenging and data protection requirements needed to be taken into account. So ECDC was considering this more as a longer term initiative and would conduct some proof of concept studies in the first instance. Regarding the comment by the AF Member for Ireland on resources, ECDC was fully aware that it would not be possible to enhance digitalisation of surveillance systems without EU support, which was why she had mentioned tapping into different EU funding mechanisms. This would help ECDC to gain a better picture of national surveillance systems in order to have a targeted approach to filling the gaps. She was aware that the project was quite ambitious, but this was necessary in order to move forward. The pandemic had revealed some shortcomings in the current EU surveillance system and it was now time to try and take a step forward and address them.

Advisory Forum views on the implementation of proposed changes to the ECDC mandate

55. Andrea Ammon, Director, ECDC, giving a rough outline of the proposal, pointed out that, in addition to changes to ECDC's mandate, there were also proposals to change the serious cross border health threat mandate, and that of the European Medicines Agency. The proposals had attempted to address major issues that have been observed both in the past and during the current pandemic. The proposal for revisions to ECDC's mandate did not extend beyond the realm of infectious diseases. One of the main areas concerned by the revisions was surveillance – finding digital solutions, adding modelling to the toolbox, looking at additional data sets and health system capacities for preparedness and response. She agreed with the AF Member for France that there was an increasing demand for Member States to prepare data and send it to ECDC, but the same demands were also being made on ECDC. She was aware that the changes would have to be made in a phased approach and that it would depend on the country capacity. The other main area was preparedness and response. ECDC's tasks in relation to preparedness were currently not so clearly defined. The idea was to have a better overview of how prepared countries were. There would be a task force which could be deployed in Member States during outbreaks and, when not deployed, could support Member States in improving preparedness and obtaining further knowledge about the Member States' health system. Training was also an important aspect which complemented preparedness. The international dimension would be much more pronounced than in the current founding regulation, and it was also important to take into account aspects such as support to neighbouring countries and the network of global CDCs. There was a proposal to have a network of European reference laboratories although the details were as yet unclear. The Advisory Forum had spent quite a lot of time during the last year discussing the validity of tests, etc. and therefore a European reference laboratory would make it possible to perform and rely on the validity of tests rather than having to ask the Member States to do this themselves. Finally, there was a new task for ECDC in the revised mandate (pending legislation) and this was in the area of substances of human origin.

56. Bruno Coignard, AF Member, France, asked for further information on the subject of the future European reference laboratory.

57. Andrea Ammon said that there was a catalogue of tasks for the European reference laboratories in the proposal. The laboratories, which would be appointed by the Commission, would carry out all the types of standardisation tasks that would have been so useful over the past few months for COVID-19.

58. Frode Forland, AF Member, Norway said that although Norway was not in the EU it was a part of the European Economic Area and he therefore wondered if the proposals would apply to Norway. He thought that proposals were very good. With regard to preparedness, it would require further institutions in each country being involved with ECDC, not just the public health institutions. He was

pleased to see the international dimension being taken into account (after all, the pandemic was global). One area that he felt was not addressed was that of rapid systematic reviews of knowledge and he saw this as a potential role for ECDC in the future in close cooperation with Cochrane and WHO.

59. Lorraine Doherty, AF Member, Ireland, referring to ECDC's revised role in terms of emergency preparedness, said it was not quite clear where ECDC would fit into this. She asked whether it would it be a larger role for ECDC or more of a partnership.

60. Jan Kynčl, AF Member, Czech Republic, stressed the pressure on Member States who would have to provide the data and perform additional tasks. This would be difficult for some countries who had still not been able to respond to the requirements of the cross-border 'umbrella' system from some years ago. He suggested that this issue should be made as simple as possible so that countries could deal with it. For example, by ensuring that tasks were coordinated where possible and that it was clear which agency was dealing with different issues.

61. Kåre Mølbæk, AF Member, Denmark, referring to risk management, said that the new mandate appeared to give ECDC a broader role in this area but he would be reluctant to move in that direction as it was a national issue.

62. Andrea Ammon agreed that it would probably be necessary to expand the range of institutions that ECDC cooperated with in the Member States, and it would be necessary to discuss how to do this. This would also be the case with the substances of human origin as the authorities responsible for blood were not necessarily part of the public health authorities. It would be the task of HERA – the Health Emergency Response Authority – to look at preparedness and to help with stockpiling, joint procurement, etc. As yet, there was no detailed proposal in this area and the plan was to have this by end of 2021 so there was still some opportunity for discussion. She understood the concerns of the AF Member for the Czech Republic and was aware that ECDC's tasks would also increase, as the experience of the past year had shown. As with digital solutions, it was necessary to look at how to lighten the burden. In the long term standardisation would be a way forward to ensure that changes were not happening continuously. She also pointed out that it would be important to include lessons learning in each country as the proposals were currently based on learning at EU level. With regard to the vaccine monitoring platform, this would look at different areas – safety, effectiveness, impact of vaccine coverage, etc. Safety monitoring would be the remit of EMA, effectiveness monitoring would be that of ECDC. The two agencies would collaborate but the tasks were clearly split. This tied into discussions that had gone on in the past on how to ensure that such studies could be undertaken without industry involvement and hopefully would solve this issue. With regard to risk management, ECDC would not only give options for response but also non-binding recommendations. However, this was not really risk management in the true sense as risk management required a knowledge of local content that could never be achieved at the European level. She saw this as an opportunity to look at past experience and see what could have been done better at European level in order to incorporate added value into such recommendations, which could then be passed on to the Member States.

Any other business

63. Kåre Mølbæk, AF Member, Denmark wished to say goodbye as this would be his last AF meeting before retirement. He had been involved right from the beginning, when ECDC had held its first ever AF meeting at Solna town hall, through its years at Tomteboda school before moving to the new premises. However, the scientific journey had been even more impressive than the physical one. He stressed that the voice of ECDC was heard and that the organisation had really made a difference in Europe, and for this congratulations everywhere well deserved. It had been a pleasure to provide ECDC with advice along the way. He felt that it was important for ECDC to bear in mind the perspective of what ECDC could do for Europe and the world rather than what the Member States could do for ECDC. It was also important for ECDC to keep the balance between tradition and innovation in mind – the tradition of field epidemiology and intervention epidemiology and public health specialists working closely together to solve problems systematically alongside more innovative solutions involving new data sources, data from social media and the recognition that European issues were also global issues. Although it was good to embrace innovation it was also important to remember the proud tradition that Europe had in public health training which was where ECDC played an important role. These were his two pieces of advice to ECDC for the future.

64. Andrea Ammon, Director, ECDC, thanked the AF Member for Denmark for his messages and noted that throughout the long journey, his candour and openness had always been highly appreciated.

She hoped that it would be possible to meet again in the future under more normal circumstances. She wished him a happy retirement.

65. Mike Catchpole, Chief Scientist, ECDC, also thanked the AF Member for Denmark and said that it had been an honour working with him. He also hoped that it would be possible to arrange a physical meeting with him in the future. The next AF meeting was scheduled to take place via audioconference on 18 February 2021; for this meeting, ECDC would be using the ECDC stakeholder relationship system (SRM) for electronic registration. Individual invitations would be sent out for this and accepted electronically. Lastly, he thanked the AF for its useful comments and feedback, and wished everyone all the best for the holiday season.

List of participants

Member State	Representative	Status
Austria	Franz Allerberger	Alternate
Croatia	Sanja Kurečić Filipović	Member
Czech Republic	Jan Kynčl	Member
Denmark	Kåre Mølbak	Member
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