ECDC Advisory Forum

Minutes of the Extraordinary Advisory Forum meeting
21 April 2020 (via audio conference)

Contents

Opening and adoption of the programme 2
Update on Situation and Risk Assessment 2
ECDC COVID-19 Rapid Risk Assessment: Update No. 9 2
Exchange of information and experience 5
Closure and next steps 5
Annex: List of participants 6

Opening and adoption of the programme

1. Andrea Ammon, Director, ECDC, opened the meeting and welcomed all the participants to the fifth Extraordinary Meeting of the Advisory Forum dedicated to COVID-19.

2. Mike Catchpole, Chair and Chief Scientist, ECDC, presented the draft programme noting that one purpose of the meeting was to consult with the Advisory Forum members before finalising the 9th update of the Rapid Risk Assessment on COVID-19. The draft programme also included an item on exchange of information and experience, and he invited the AF members to share any concerns they had on the impact of COVID-19 on other public health programmes, such as vaccination programmes, or the surveillance, prevention and control of other diseases.

3. The draft programme was adopted without changes. No specific conflicts of interest were declared with respect to the agenda.

Update on Situation and Risk Assessment

4. Andrea Ammon gave a brief update on the current situation noting that the number of COVID-19 cases in the EU had now passed 1 million, and the number of deaths had exceeded 100 000. She added that 20 countries have seen a decrease in the number of cases in the last 6-11 days; six countries have a very small decrease, while five countries have yet shown a decrease as yet. Deaths however still increase in most countries except for five countries that have not reported new deaths in the last 1-15 days. In addition, data from EuroMOMO show a high or very high levels of excess all-cause mortality in a number of EU countries, primarily in the age group of 65 years and above, but also in the age group of 15-64 years. It is estimated that 7% of hospitalised cased require ICU support, and approximately 14% of hospitalised cases die even if there are variations between the countries. The risk of needing hospitalisation increases from the age of 30 years, and the risk of death with the age of 50 years and above. Men are more likely than women of the same age to be hospitalised, more likely to require ICU or respiratory support, and more likely to die. In several EU countries where data is available it can be seen that 9-26% of all diagnosed COVID-19 cases are in health care workers, not necessarily indicating though that they are all infected in the course of their duties. There are also increasing reports of COVID-19 outbreaks in nursing homes. In some countries these account for a substantial part of all reported deaths, which shows the vulnerability of the elderly in these settings, and the importance of infection control measures for their protection.

5. Referring to the "Joint European Roadmap towards lifting COVID-19 containment measures" put forward by the European Commission and European Council on 15 April, she noted that the roadmap was rather general and there was a need for more detailed guidelines, which was the aim of the next Rapid Risk Assessment. She added that she was regularly participating in telephone- and videoconferences with the EU Ministers of Health chaired by the Health Commissioner or the Presidency as well as with the crisis committee of the Ambassadors of the EU Permanent Representations; from the discussions in these fora it seems clear that the Member States consider it very important to coordinate the de-escalation measures across the EU. All Member States are now scaling up their testing capacity, and only very few countries are now reporting shortages of testing material. One concern is however how this exclusive focus on COVID-19 impacts on other communicable diseases and in particular on vaccination programmes. From the daily ECDC Round Table reports it appears as if no other outbreaks are occurring, but it is more likely that these are not being detected. Lastly, she raised the issue of summer holidays and travelling which had also been brought up in the different committees she was attending and which could be the next element where Europe will drift apart.

ECDC COVID-19 Rapid Risk Assessment: Update No. 9

6. Mike Catchpole presented a summary of the proposed updates in the 9th Rapid Risk Assessment to be published in the next few days. He noted that the next RRA would follow a similar structure as before. The RRA will assess three risk assessment questions; the first two look at the risk of developing severe disease in the general population on one hand, and in vulnerable populations on the other hand. The third question is a new one and considers the risk of resurgence of sustained community transmission in the EU/EEA and the UK in the coming weeks, as a consequence of phasing out the confinement. He asked the AF members whether there were any comments on these three risk assessment questions (*cf.* slide 9 of the PPT shared prior to the meeting). No comments or questions were raised.

7. Mike Catchpole noted that the next slides looked more in detail at the measures that needed to be in place in order to embark on a safe process of de-escalation. The first thing that would need to be in place is an effective monitoring system. As indicated on slide 10, it is recommended to start monitoring at least two weeks before the planned change, and to allow sufficient time after lifting one measure to evaluate its impact before going to the next step. He asked the AF members whether they had any comments on the considerations listed on the slide.

8. Frode Forland, AF Member, Norway, mentioned that the Norwegian authorities were considering a system of gradually opening for instance schools in a randomised way in order to see the effects of the closures, and asked whether there were any similar considerations in other Member States. It would be valuable if ECDC could encourage countries to implement measures in a randomised fashion in order to gain more understanding of the effects of opening and closing the schools for instance.

9. Mike Catchpole agreed that it would indeed be important to make this a learning exercise. In the RRA it is recommended to start lifting measures in small localised geographical areas to be able to assess the effects. He moved to slide 11, which lists a number of proposed methods and indicators for monitoring the situation in different areas of society. Referring to ongoing discussions around the use of mobile apps and telephone surveys to help assess the spread of the virus, he asked whether any Member States had already started to use such apps.

10. Frode Forland, AF Member, Norway, reported that a mobile app had been developed in Norway and was now in the testing phase; 25% of the population had downloaded the app since it was launched. The app records the movements of the user, who is notified if he or she has been in close proximity (less than two metres) to someone infected with the coronavirus for more than 15 minutes. The app does not ask the user to register symptoms, but there is a web based platform available for this purpose (50 000 people have subscribed to this platform).

11. Referring to the analysis of absence from schools, one AF member pointed out that most children seem to be asymptomatic and will therefore continue to go to school. She asked how it can be monitored whether these children are infected, and whether they transmit the disease to others.

12. Mike Catchpole responded that it was reasonable to assume that a constant proportion of children, even if it is a small proportion, do develop symptoms, and thereby changes in this proportion could still provide an indicator of change in disease transmission following relaxation of measures.

13. Lorraine Doherty, AF Member, Ireland, mentioned that she had been asked to develop a plan for a rolling programme of testing in nursing homes in Ireland, and asked whether ECDC was going to recommend testing of these vulnerable groups or only daily health checks as indicated on the slide. Concerning testing of health care workers, there was a need to develop guidance including on the frequency of testing. Lastly, she noted that in order to be able to compare data, all Member States would need to use the same definition of a COVID-19 related death.

14. Bruno Ciancio, Head of Section Surveillance, ECDC, agreed that one of the objectives of this phase was indeed to learn which measures are effective/ineffective, and the question from the AF Member from Norway was very relevant in this context. The purpose of the indicators is to enable countries to immediately detect an increase of cases and take necessary action, or to move forward with the de-escalation measures depending on the situation. Concerning school children, he noted that the RRA will suggest that interventions addressing certain age groups (children under 10 years of age) are lifted first as firstly, evidence shows that there is limited contribution of these groups in the transmission in the general population and secondly, when infected, these age groups rarely develop severe illness. The daily health check for compatible symptoms in nursing homes is motivated by the fact that these groups are particularly vulnerable and therefore already one case is risky which makes effective contact tracing crucial. The importance for staff to be tested will also be mentioned in the RRA. Concerning mortality, he referred to a WHO document published the previous week. Data from EuroMOMO can constitute an extra indicator but cannot be the only one given that this data will be delayed compared to when the incidence of infection starts to increase as a consequence of lifting a measure. Likewise, it is not sufficient to rely completely on existing sentinel surveillance for flu as it only covers 1-5% of the general population.

15. Referring to the question on testing in long-term care facilities, Mike Catchpole clarified that it is suggested as a minimum standard to carry out the screening based on symptomology. Based on the comments, he concluded that the AF members seemed to endorse the content of slide 11. With reference to slide 12 listing the epidemiological criteria, accompanying measures and scenarios that should be considered in the de-escalation phase, he pointed out that it was crucial to have sufficient health system

capacity and resilience in place. This concerns the general capacity, hospital beds, ICU, stocks of PPE and other equipment, etc. A strong risk communication strategy to inform and engage the general public and vulnerable groups should also be considered. He asked whether the AF members had any comments on the two bullet points on the slide.

16. In this context, Andrea Ammon reported that the importance of risk communication had also been emphasised by the EU Ambassadors, who suggested that the communication to the general public will have to be further strengthened in this second phase. Achieving compliance during the lifting of measures was crucial, as well as preparing the general public of the possibility that cases may increase after lifting the measures, which should not be seen as a failure.

17. Mike Catchpole then described the accompanying measures that would need to be in place in terms of monitoring capacity (slide 13): a robust surveillance strategy; a framework for contact tracing as a containment measure, and an extended testing capacity and harmonised testing methodologies. There were no comments or questions on these points. He then moved to slide 14 concerning evidence for policy and practice (mathematical modelling, serosurveys, estimates from mortality data, further delineation of vulnerable groups, evidence on the efficacy of different measures, etc.).

18. Referring to the Joint European Roadmap for lifting containment measures, Frank Van Loock, European Commission, noted that it would be essential to have some ideas on the areas with comparable low circulation of virus; here the European Commission was relying on ECDC in cooperation with Member States to report on these areas.

19. Vicky Lefevre, Acting Head of Unit Public Health Functions, ECDC, clarified that the ECDC Epidemic Intelligence team was currently collecting data at sub-national level for all EU/EEA countries and the UK. It will depend on the country how detailed information can be provided. She added that this information was not yet finalised, but should become available in the coming days.

20. Mike Catchpole agreed that this was an important ongoing task. He reiterated the importance of monitoring the changes that occur in areas where measures are lifted as this information will help to prioritise the relaxation of measures.

21. Andrea Ammon asked the AF members whether there were any particular aspects they felt should be included in future RRAs.

22. Frode Forland mentioned that there was a huge controversy in the Nordic countries about herd immunity, partly triggered by the different strategies followed in Sweden compared to Norway and the other Nordic countries. He asked whether this was a point that ECDC could address in future documents.

23. In response to this comment, Vicky Lefevre referred to slide 5 where it was stated that one of the public health objectives was to limit the virus circulation to manageable levels, while allowing for gradual acquisition of population immunity. She asked whether this was in accordance with the AF views. No objections were raised on this point.

24. Birgitta Lesko, AF Alternate, Sweden, asked for guidance related to the isolation of patients following discharge from ICU noting that health care personnel had raised concerns regarding the requirement that patients need to remain isolated for 14 days.

25. Mike Catchpole responded that he was unable to provide a reply at this stage, but had taken note of this concern and would respond in writing after the meeting.

26. Frank Van Loock asked how it was intended to report on the monitoring system, and with what frequency. He clarified that this was a question addressed to both ECDC and the Member States.

27. Mike Catchpole responded that from ECDC's perspective this will be done via the regular RRAs and other outputs based on information received from the Member States. He recognised that data would need to be shared as rapidly as possible but it of course depended on when Member States would put in place such monitoring systems. He reiterated that it was indeed important to learn from this experience.

28. Franz Allerberger, AF Alternate, Austria, urged ECDC to reconsider the requirement of two negative PCR results within 48 hours as a prerequisite of returning hospitalised patients to nursing homes. Currently there are elderly persons who cannot cope in the hospital setting, but nursing homes are not willing to reaccept them. Concerning the isolation of 14 days, he agreed that it was too long and 10 days would be more than enough. He further suggested including one sentence in the RRA about involvement of police force in contact tracing noting that he had concerns about such an approach. Lastly, he inquired about the ECDC view on the utility of sewage surveillance.

29. Mike Catchpole said ECDC would reflect on these questions. Responding to the question on sewage control as a measure of monitoring, he felt that this was perhaps most valuable at an end stage of the epidemic, but he promised to put this issue on the list of things to look at.

Exchange of information and experience

30. Mike Catchpole mentioned that the purpose of the last item on the agenda was to exchange information and experience, and suggested to keep this is as a standing item of the extraordinary meetings. He invited the AF members to share their views on whether the COVID-19 response has had a significant impact on other public health activities, such as vaccination programmes, or the ability to respond to other infectious disease threats.

31. Ágnes Hajdú, AF Alternate, Hungary, reported that there had been no disruption in the implementation of the mandatory childhood vaccination in January-February; for March-April data was not yet available. However, the HPV vaccination of girls had been cancelled until further notice. For other infections there seemed to be an under-diagnosis due to telemedicine being the recommended method of health-care seeking, but perhaps also due to changes in transmission dynamics as a consequence of social distancing and travel restrictions in place. For ARHAI a gradual decrease has been observed between January and March, and a major drop in April compared to the previous year.

32. Lorraine Doherty reported that there were some concern in Ireland about vaccination programmes, and the immunisation programmes delivered in schools, such as HPV, had stopped due to school closures. There were also some concerns about the impact on cancer screening programmes. An ongoing mumps outbreak seemed to have stopped, perhaps due to social distancing measure. There has also been a significant decrease in notifications on norovirus and other gastrointestinal infections, which could be due to under-reporting or to social distancing.

33. Birgitta Lesko said that there had been no impact on the Swedish childhood vaccination schedule. The same observations as in Ireland had been made for influenza and norovirus, i.e. transmission had dropped several weeks earlier than usually. AMR surveillance shows a clear decrease in the number of reports, perhaps due to reduced testing or improved hygiene and social distancing.

34. Marta Grgič-Vitek, AF Alternate, Slovenia, reported that, in her country, there was some impact on the screening programmes for colon and cervical cancer and many non-urgent health care services have been stopped, such as orthopaedic surgery. Some vaccination programmes were stopped for a month due to shortages of PPE, but were now about to start again. Some routine surveillance activities had slowed down and a number of reports were not published. Other surveillance activities had been put in place, such as SARI surveillance in all acute care hospitals where SARI patients are admitted and surveillance of excess mortality through EuroMOMO.

35. Mike Catchpole concluded that there seemed to be some negative effects in terms of impact on certain vaccination and screening programmes, but also some positive effects due to social distancing which had led to lower spread of some other diseases.

Closure and next steps

36. Mike Catchpole thanked all the participants for their valuable input. He informed the AF members that the next scheduled Advisory Forum meeting will take place on 11 May via audio conference.

37. Andrea Ammon thanked the AF members for their contributions and added that ECDC will get back to the AF again in the coming weeks in in case there are further issues to be discussed.

Annex: List of participants

Member State	Representative	Status
Austria	Franz Allerberger	Alternate
Croatia	Sanja Kurečić Filipović	Alternate
Czech Republic	Kateřina Fabiánová	Alternate
Estonia	Natalia Kerbo	Alternate
France	Bruno Coignard	Alternate
Hungary	Zsuzsanna Molnár	Member
	Ágnes Hajdu	Alternate
Ireland	Lorraine Doherty	Member
Latvia	Jurijs Perevoščikovs	Member
Luxembourg	Isabel De La Fuente Garcia	Member
Netherlands	Susan van den Hof	Alternate
Portugal	Carlos Matias Dias	Member
Slovenia	Marta Grgič Vitek	Alternate
Spain	Marina Pollan Santamaria	Alternate
Sweden	Birgitta Lesko	Alternate
Observers		
Norway	Frode Forland	Member
Non-Governmental Organisations (NGOs)		
European Institute of Women’s Health (EIWH)	Rebecca Moore	Member
European Public Health Association (EUPHA)	Aura Timen	Member

European Commission		
DG SANTE	Franck Van Loock	
WHO		
	Nedret Emiroglou	