ECDC Advisory Forum

Minutes of the 39th meeting of the Advisory Forum

Stockholm, 24-25 September 2014

Contents

Item 1 – Opening and adoption of the agenda (and noting the Declarations of Interest and Specific Declarations of Interest, if any) *(Documents AF39/2 Rev.2; AF39/3 Rev.1)*

1. Johan Giesecke, Chief Scientist and Chair, welcomed members of the Advisory Forum (AF) to the Thirty-ninth meeting. He also warmly welcomed Anne Glover, Chief Scientific Adviser of the President (European Commission's Bureau of European Policy Advisers). The Chair then welcomed Outi Lyytikäinen, alternate from Finland attending for the first time and Frank Van Loock and Cornelius Schmaltz from the European Commission.

2. Apologies had been received from Belgium, Cyprus, France, Greece, Latvia, Liechtenstein, Malta, Montenegro, Poland, Serbia and the Former Yugoslav Republic of Macedonia, as well as from the Standing Committee of European Doctors, European Public Health Association, European Patients' Forum and World Health Organization.

3. In reference to declarations of interests, Austria noted the country's participation in the molecular surveillance pilot project.

4. The agenda was adopted with a caveat of an addition requested by Ireland.

Item 2 – Adoption of the draft minutes of the 38th meeting of the Advisory Forum *(Document AF39/4)*

5. The draft minutes from the Thirty-eighth meeting of the AF had been previously circulated to the Members. Comments were received ahead of the meeting from the Netherlands proposing a change of wording in relation to Lyme disease diagnosis. Additional comments were received from Ireland regarding the guidance on antibiotic treatment and Slovenia in reference to the Lyme disease. It was requested to submit the comments in writing to the Corporate Governance Secretariat.

Item 3 – Update from ECDC on the main activities since the last Advisory Forum meeting *(Document AF39/Info Note 1)*

6. Marc Sprenger, ECDC Director, provided an update on the main activities since the last AF meeting highlighting some of the main events, visits and meetings.[1]

7. In relation to the Ebola outbreak, the ECDC Director acknowledged that most of the AF members have been involved in the outbreak one way or the other, for example as part of the Health Security Committee (HSC). He also highlighted the efforts made by the international community to provide experts. ECDC has been participating actively and the HSC is now taking place every week. As a technical agency, ECDC is working according to its mandate in the field of risk assessment. It was also added that relevant information regarding the outbreak and the Centre's Public Health Emergency (PHE) activities has been (and will continuously be) communicated to the AF members.

8. In reference to the launch of the Surveillance Atlas of infectious diseases, the AF members were invited to visit the ECDC website and produce their own graphs.

9. The challenges related to Centre's budget were also brought out.

10. Haraldur Briem, Member, Iceland, thanked the ECDC Director for the visit to Iceland and expressed his hope that the issue of environment contamination due to current volcano explosion will not become a cross border issue in the future.

11. Silvia Declich, Member, Italy, requested for more details regarding the budget, in particular regarding the sectors that have been impacted. In his response, the Director noted that all details

[1] Item 3 - Update on ECDC main activities (M Sprenger)

have not yet been finalised and ECDC is currently waiting for an official letter from the Commission.[2] The AF Members were assured that they will receive further information regarding projects which will continue or be cut as soon as the situation is cleared.

12. Isabel Noguer Zambrano, Alternate, Spain, regretted that the project on burden of diseases has been cut and outlined that Spain would like to express its support for that issue. It was noted by the ECDC Director that unfortunately these cuts have been agreed at an EU level, however, the good news is that the project on the burden of disease will not be totally cancelled and ECDC will do its best to support Member States in their needs.

Item 5 – Keynote address: gaps and links to be assessed in the EU policy cycle

13. Anne Glover, Chief Scientific Adviser of the President, Bureau of European Policy Advisers, thanked ECDC for the kind invitation to attend the AF meeting and provided a keynote presentation, starting by introducing the policy process in the Commission and the role of scientific advice in policy-making.[3] It was added that it will be up for the new Commission to decide how prominent this role will be in the future.

14. Scientific advice will inform policy anticipation (e.g. in the field of climate change). The role of the Chief Scientific Adviser is to deliver expert advice and translate this to non-scientists. In addition, the Chief Scientific Adviser needs to make sure to have robust evidence and transparency. He/she will also act as a watchdog of proper use of scientific evidence and provide guidance on the interpretation of evidence in presence of uncertainty. He/she will stimulate cooperation among different services and Commission's DGs and promotes the European culture of dialogue.

15. The Chief Scientific Adviser reports directly to president Barroso and is advised by the Joint Research Centre, ECDC or other EU agencies and by the Science and Technology Advisory Council. A formal network has been created and that should continue in the new commission.

16. On the 1 November 2014 when the new president of the European Commission, Jean-Claude Juncker, will be taking over, he will have to take a decision regarding the role of scientific adviser. Anne Glover will leave the Commission at the end of January 2015.

17. Mike Catchpole, Member, United Kingdom, noted that the real challenge is to express science in a language to actually make it easier for the elected individuals to make choices and promote legislation. Anne Glover agreed with these comments and added that it needs to be understood where scientists can be 'less exact' in their communication. She also added that in general, EU agencies should be used in a much more effective manner. The existing agencies' network of science advisors (that have already met 4 times) is a very valuable forum. She added also that there is much more potential from ECDC that could be delivered. The Commission should think how the agencies' advice should be better integrated.

Item 4 – Update on the Italian Presidency of the Council of the European Union

18. Silvia Declich, Member, Italy, provided an update on the Italian EU Presidency's priorities in the field of Health.[4] Together with the other two countries (Latvia and Luxembourg) forming the "trio", the general approach is in line with Europe 2020 "Health in all policies". The Italian EU Presidency programme details are available under www.salute.gov.it.

[2] ECDC received the above noted letter from the Commission on 2 October 2014 with the good news that the Commission has approved ECDC's plans for 2 million euros of activities which means that the Centre can now carry out many of the activities which had to be cancelled earlier in the summer.
[3] Item 5 - Keynote presentation (Anne Glover)
[4] Item 4 - Italian Presidency update (S Declich)

Item 6 – Scientific advice: update on assessments, reviews and guidance:

Item 6a – Update on the selection of Coordination Committees of Disease Networks

19. Piotr Kramarz, Deputy Chief Scientist, provided an update on the selection of Coordination Committees of Disease Networks.[5] The work done so far fits into the structure of the CCBs.

20. The work procedures and election procedures were reviewed through examples of different disease programmes and the AF Members were asked how ECDC can further improve or simplify the elections of the members of the coordination committees.

21. Silvia Declich, Member, Italy, said that the process seems to work reasonably; she asked how long members will be appointed for and if the expressions of interest received provide a balanced representation of the countries. It was noted that the members will be appointed for 3 years, with the possibility of re-appointment. The balance is ok, but it is true that some regions are not fully represented.

22. Darina O'Flanangan, Member, Ireland, requested to know whether the AF Members could have a list of appointed members. ECDC prepared such a list and circulated it after the meeting.[6]

Item 6b – The future of Clostridium difficile infection (CDI) surveillance in the EU (Document AF39/5 Rev.1)

23. Carl Suetens, Senior Expert Healthcare-Associated Infections, Surveillance and Response Support Unit, provided a presentation on the future of *Clostridium difficile* infection surveillance in the EU[7]. At the end of his presentation the AF was asked to answer a set of questions, given that important progress has been made regarding diagnosis and typing of CDI in EU/EEA Member States, with respect to the EU standardised protocol for continuous or periodical (minimum 3 months) hospital-based surveillance of CDI that is now available for implementation:

1) Question 1. Should ECDC consider starting up EU-level hospital-based surveillance of CDI? Yes/No

2) Question 2. If Yes to Question 1:

A. ECDC should initiate epidemiological surveillance only (incidence of healthcare-associated CDI), using at least the minimal protocol (aggregated numerator data) or the light protocol (case-based numerator data), or

B. ECDC should initiate all components of the agreed surveillance protocol (i.e. minimal protocol or light protocol and enhanced protocol), including the option for submission of epidemiologically-linked microbiological data (PCR ribotype and antimicrobial susceptibility data)?

24. Out of 15 Members that spoke, four supported option 2A, ten supported 2B and one (Sweden) neither supported nor rejected any of the options.

25. Following Members supported the option 2A: Germany, Slovenia, Spain and France[8]. Following Members supported the option 2B: Ireland, the Netherlands (if sufficient resources, otherwise 2A), Italy, the United Kingdom, Portugal, the Czech Republic, Austria, Hungary,

[5] Item 6a - Coordination Committees (P Kramarz)
[6] The document on Membership of DN Coordination Committees 2014 is available on the AF Extranet, under the AF39 meeting documentation (Presentations folder)
[7] Item 6b - Future of *Clostridium difficile* infection (CDI) surveillance in the EU (C Suetens)
[8] France was unable to attend the meeting, however, comments related to the matter had been submitted to the Chair in writing ahead of the meeting

Luxembourg and Denmark (including an evaluation to assess the European added value). A Yes to Question 2B means that ECDC will include CDI in the proposed 2015 revision of the "The ECDC strategy and roadmap for integration of molecular typing into European level surveillance and epidemic preparedness" to consider making it a priority pathogen in the revised roadmap.

26. Silvia Declich, Member, Italy, added that Italy is moving in the direction of option 2B as a proposal for national surveillance in Italy has just been finalised. They will perform surveillance of all epidemiological cases, not only in hospitals but also in residential homes. However, Italy is unlikely to be ready for 2B in 2015.

27. Mike Catchpole, Member, United Kingdom, supported 2B, noting that EU-added value would only be achieved through 2B as subtyping would aid identification of specific cross-border threats and effective interventions. The experience of the UK's mandatory hospital reporting system is that surveillance outputs must clearly indicate cases for which transmission is likely to have occurred outside of the reporting hospital. He added that a long-term objective could be to perform surveillance of community cases, also in terms of antibiotic stewardship. The Netherlands, Austria and Hungary supported this long-term goal; Austria will start surveillance in long-term care facilities next year.

28. Osamah Hamouda, Member, Germany, stated that Germany would like to support option 2B, but it is not possible for them to provide typing data (2B) at this stage considering hospital surveillance at a national level at this stage. This position was shared by Slovenia and Sweden. He also questioned whether the reported workload results from the pilot study included the time needed for coordination (*note: it did not*) and suggested exploration of how mandatory reporting systems in some countries could be used to complement or collect typing data.

29. Ana Maria Correia, Alternate, Portugal, stated that Portugal is in the position to provide information for option 2B, even though reporting is not mandatory. In 2013, Portugal implemented a laboratory-based surveillance system with quarterly reporting of cases to the National Institute of Health and the General Directorate of Health, with strains sent to the National Institute of Health for typing.

30. Isabel Noguer Zambrano, Alternate, Spain, stated that Spain would be willing to support this new EU initiative, given that CDI is included in the new national guidelines on healthcare-associated infections. However, since CDI surveillance involves decisions of the different autonomous regions in Spain, they would start with only aggregated country data and/or possibly a sentinel surveillance system as resources at the level of the national institute are limited. Linking microbiological and epidemiological data is currently difficult, but work is being done on this issue and they hope to see some progress in the coming year.

31. The importance of the disease in the community was reinforced, and it was pointed out that the surveillance protocol differentiates hospitalised community-acquired cases from hospital-acquired cases. On the basis of the discussions, ECDC will revise the indications for strain typing and explore alternatives for the first 10 strains, while, if possible, maintaining the objective of having a representative epidemiological picture. Option 2B can also be optional for Member States; all participating countries would then report at least 2A.

32. Frank van Loock, European Commission, added that the Commission was pleased to hear the wide support of the Members, also adding that it cannot be afforded that in 2015 countries do not engage in some kind of CDI activity. The EU added value and the burden of CDI has been noted and should also be made clear to the 28 senior policy makers. The Commission welcomes that this disease is put high on the agenda as the problem is big enough for the EU to take this very seriously.

Item 6c – ECDC Microbiology Section (Documents AF39/6 and AF39/7)

a) Proposed strategy for molecular surveillance of invasive meningococcal disease

33. Assimoula Economopoulou, Seconded National Expert, Surveillance and Response Support Unit, presented the proposed strategy for molecular surveillance of invasive meningococcal disease, on behalf of the molecular surveillance working group.[9] The AF was asked whether they agree with the objectives and the outline of data analysis and reporting strategy for molecular surveillance of invasive meningococcal disease in EU/EEA countries.

34. The proposal was overall supported by the AF. Isabel Noguer Zambrano, Alternate, Spain, pointed out that the objective of the project should also be the detection of international outbreaks.

35. Silvia Declich, Member, Italy, queried which kind of agreements there are between ECDC and EMERT. It was clarified that the participation with the EMERT database is voluntary – it is a consortium of national reference laboratories that are also taking part the Invasive Bacterial Diseases Laboratory Network (IBD LabNet) which ECDC coordinates.

b) Strategic direction and plan for revision of the molecular surveillance Roadmap to ensure optimal EU-added value

36. In connection with the mid-term roadmap for molecular surveillance, Marc Struelens, Chief Microbiologist, Office of the Chief Scientist, pointed out that next generation sequencing costs for whole-genome-based analysis were constantly declining and molecular genomics had become a viable option. ECDC have discussed this and other questions with the microbiology focal points in order to decide which types of data should become part of molecular surveillance/molecular genomics. So far, twelve potential disease targets have been identified, and four have are already being pilot tested.

37. ECDC proposed to renew the roadmap annually with a task force from NMFP and NSFP, thus reducing the burden for Member States. It was proposed to suggest a call of interest on a new task force for priority ratings on molecular surveillance topics, examining the Member States' opinion on whole-genome-based solutions in Europe, in collaboration with EFSA and initiatives by the Directorate-General for Research and Innovation on the same topic. In response to the question of whether the AF agreed with the suggested revision process for the molecular surveillance roadmap, there were no objections from the AF was and as such tacit approval was duly noted by the Chair.

38. Frank Van Loock, European Commission, expressed strong support for the proposal to move to molecular genomics.

Item 7 – Epidemic intelligence: update on recent threats in Europe

39. Denis Coulombier, Head of Surveillance and Response Support, provided a brief overview of the topics to be covered during this session, mainly the enterovirus 68 epidemic in the USA and Canada, as well as the Ebola outbreak in West Africa.

Item 7a – Enterovirus 68 epidemic in the USA and Canada

40. Eeva Broberg, Influenza and Other Respiratory Illnesses Programme, outlined the history of the enterovirus 68 epidemic, covering spread, distribution, clinical symptoms, and surveillance.[10] It was also mentioned that recent research suggested a change in the antigenicity and receptor

[9] Item 6c - Strategy for EU molecular surveillance of invasive meningococcal disease (A Economopoulou)
[10] Item 7a - Human enterovirus 68 epidemic in the USA and Canada (E Broberg)

properties of EV-D68, which now preferably binds to upper respiratory tract sialic acid receptors as opposed to the earlier lower respiratory tract binding.

41. The discussion focussed on the question whether ECDC needs to strengthen the surveillance of non-polio enteroviruses.

42. Darina O'Flanagan, Member, Ireland, said that enteroviruses were not normally typed in Ireland. ECDC should assess the circulation more thoroughly, but also promote further typing of enteroviruses. As to the likely cost implications, Member States would need to discuss this with the laboratories to determine the actual costs.

43. Jaap van Dissel, Member, Netherlands, reported that up to 5% of the respiratory tract infections in the Netherlands were caused by enterovirus 68, but that at present there was no increase on previous years.

44. Mike Catchpole, Member, United Kingdom, added that in the United Kingdom 3 cases had been identified this year — not at all exceptional in terms of disease or severity.

45. Franz Allerberger, Alternate, Austria, suggested that ECDC should draw on the Austrian polio reference laboratory and make use of its enterovirus competence, equipment and infrastructure. He also recommended a point prevalence study.

Item 7b – Ebola outbreak in West Africa

46. Denis Coulombier, Head of Surveillance and Response Support, gave an update on the Ebola outbreak in West Africa.[11] The AF was asked how ECDC could provide better support to the Member States in this area: what deliverables, guidance, preparedness would be particularly helpful?

47. ECDC Director informed the AF of his visit to Peter Piot, Director of the London School of Hygiene and Tropical Medicine, who said that the situation was "far worse than 30 years ago". The Director also noted the urgent need for "extremely well-trained healthcare workers" to be sent to West Africa. According to the Director, several EPIET fellows were out in the field (please refer to laboratory Support Mission: Fighting Ebola in Guinea, available from http://ecdc.europa.eu/en/epiet/postcards/Pages/Laboratory-Support-Mission-Fighting-Ebola-Guinea.aspx). A substantial part of the problem, the Director said, was due to the fact that many West African countries were not able to develop an adequate health system, and that over the years the international community had provided very little help in this respect. Overall, he said, the situation in West Africa was difficult to assess because surveillance figures were often no more than educated guesses, tracking people for administrative purposes was problematic, and even basic bookkeeping was impossible, so surveillance data are very flawed. The visit of Thomas R Frieden, Director of the US Centers for Disease Control and Prevention, had been instrumental in making the world aware of what is happening in West Africa.

48. Most AF members agreed that case numbers were probably "dreadfully underestimated". AF Members relayed several stories from co-workers returning from West Africa who reported a "total breakdown of the health services". An unnamed CDC source said that the "epicentre in Guinea is out of control".

49. Member State representatives asked for guidance on topics ranging from waste incinerators for dangerous medical waste[12] (Ireland) to Ebola aerosolisation and rumours of potential airborne transmission (Iceland) to modelling/prediction of future case numbers (Denmark) to hands-on training on protective clothing and guidance and supervision for healthcare workers (Spain, Ireland) to media overreaction (Italy).

50. Franz Allerberger, Alternate, Austria, cautioned that the public health community should not get caught up in a panic that focuses on Ebola, neglecting other diseases which are more relevant.

[11] Item 7 - Ebola epidemic graph of reported and predicted cases (D Coulombier)

[12] Recommended reading on this topic: Department of Health. Health Technical Memorandum 07-01: Safe management of healthcare waste. London: DH; 2013. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167976/HTM_07-01_Final.pdf

Every year, about 1000 malaria-infected Africans from Guinea, Liberia and Sierra Leone are admitted to EU hospitals. Several Member States expressed concerns that these people would experience major delays in treatment because they would be tested for Ebola first.

51. Johan Giesecke, Chair, informed that ESCAIDE would feature a session on Ebola.

Item 8 – Lyme borreliosis: on-going ECDC activities, plans for the future with timelines for deliverables

52. Wim Van Bortel, Entomologist, Emerging and Vector-borne Diseases Programme, reported on Lyme borreliosis and related EU–ECDC initiatives targeting the disease.[13]

53. Darina O'Flanagan, Member, Ireland, said that Ireland chose neuroborreliosis as a key indicator, not erythema migrans, which her institute considered as "too soft" as an indicator.

54. Kåre Mølbak, Member, Denmark, said that Denmark adopted lab-based reporting of neuroborreliosis, which significantly improved surveillance.

55. Haraldur Briem, Member, Iceland, reported that Iceland was tick-free, but that migratory birds carried ticks to Iceland, which is why public health authorities feel they need surveillance.

56. In response to Frank Van Loock, European Commission, ECDC confirmed that the Centre shared the concerns voiced by the Commission. Regarding disease epidemiology, ECDC was primarily looking at space-time trends, making sure not to overburden the Member States and their systems when collecting information on the disease.

57. Hanne Nøkleby, Member, Norway, and Jaap van Dissel, Member, Netherlands, pointed out that Lyme borreliosis was very much in the public eye. In Norway, a significant number of people with health anxieties claimed to have borreliosis, while in the Netherlands an RIVM co-sponsored website (http://www.tekenradar.nl) and a call to mail in tick samples proved to be extremely popular. Norway is currently assessing the disease risk by gathering ticks all over the country.

58. Osamah Hamouda, Member, Germany, pointed out that it was difficult to gain a clear picture because prevalence differed massively from region to region.

59. An unreservedly positive statement came from Mira Kojouharova, Member, Bulgaria, where notification of borreliosis is already mandatory. According to the Bulgarian Member, patient rights organisations were satisfied, and communication between all involved organisations was both cooperative and effective.

60. In summary three items were highlighted to follow up upon: notafiability, a good communication strategy, and a systematic review of laboratories.

Item 9 – Moving forward with Congenital Rubella Infection surveillance in the EU *(Document AF39/8)*

61. Tarik Derrough, Expert Vaccine-Preventable Diseases, Surveillance and Response Support Unit, updated the AF on on-going and completed actions on congenital rubella syndrome in support to its prevention.[14] Cases of congenital rubella syndrome (CRS) are reported to WHO as part of the annual Joint Reporting form but not included in TESSy in order not to disrupt an existing and well-functioning reporting scheme. On 22 April 2014, ECDC published a progress report for the ECDC measles and rubella action plan. The presentation focused in particular on activities related to rubella screening for pregnant woman or women planning a pregnancy and in exploring additional sources of data to document the burden of CRS in Member States (e.g. EUROCAT). A list of all activities conducted by ECDC on CRS prevention was distributed to the AF members ahead of the meeting.

[13] Item 8 - LB project (W Van Bortel)
[14] Item 9 - Moving forward with CRS (T Derrough)

62. Mira Kojouharova, Member, Bulgaria, thanked ECDC for the presentation and expressed her support for all activities related to rubella elimination.

63. Silvia Declich, Member, Italy, welcomed guidance from ECDC around antenatal care and the importance of rubella screening. Isabel Noguer Zambrano, Alternate, Spain, added that Spain would appreciate information on best practices and additional guidance addressing immigrant populations that may be susceptible to rubella when pregnant. It was also highlighted for midwives and gynaecologists to be consulted in addition to rubella focal points for a future guidance document.

64. Emese Szilágyi, Alternate, Hungary, told the AF that Hungary operated a congenital anomaly surveillance system and that additional guidance on screening would be helpful.

65. According to Hanne Nøkleby, Member, Norway, general screening in Norway was replaced by targeting people who have a clear risk of infection during pregnancy.

66. Osamah Hamouda, Member, Germany, said that CRS prevalence in Germany was low – less than one case/year – so investing additional resources would have to be carefully considered. As in Norway, universal screening has been discontinued. He emphasised that timing was essential: there needed to be clear indicators that allow public health authorities to discontinue rubella screening during pregnancy; at the same time, specific populations at risk still had to be screened. ECDC work would therefore be very relevant.

67. When asked about vaccination options for unvaccinated adults, reference was made to trivalent measles-mumps-rubella vaccines and national vaccination guidelines to be followed.

68. There was agreement for rubella operational contact point to be consulted directly in order to share the outcome of on-going CRS activities.

Item 10 – Proposed surveillance systems – next steps

69. It was agreed that this item should be skipped since discussions the previous day had revealed a general consensus on the issue.

Results of the Advisory Forum Working Group sessions

Working Group A: ECDC Expert Directory

70. Osamah Hamouda, Member, Germany, presented the results of Working Group A on the ECDC expert directory (a tool to facilitate selection of experts for specific tasks).[15] The objectives had been to discuss the principles for using the database. Experts were currently recruited through the Competent Bodies but this was a potential problem in certain situations, for example when the specific expertise was not available, when national interests were involved or when rapid input was required. In answer to the question as to what criteria should be applied for the inclusion of experts, the group agreed that anyone could apply, but that all experts would be approved by ECDC, depending on their education, publications, area of expertise, a declaration of interest and English language ability. The selection process would involve criteria being defined for each individual project. Those involved in the project would be able to access the database and define the fields of expertise required as search criteria. The database would provide a list of potential candidates and a balanced group would be selected. Since the Advisory Forum also wished to have some degree of control over the process, terms of reference would be presented to the Forum with the opportunity to comment.

71. Jaap Van Dissel, Member, Netherlands, asked whether the timeline for retaining experts' details in the directory had been discussed. It was confirmed that it had not been discussed and that the project was still on-going.

[15] Working Group A

72. Rodrigo Filipe, Database Analyst, Office of the Chief Scientist, explained that the system automatically re-sent updates to registered members of the database once a year asking them to reconfirm their availability. If they did not reply they would be automatically removed.

73. The Chair clarified that although Member States would be consulted, the experts were not country representatives. Therefore if, following consultation, there were objections by a Member State to a specific expert from that country, the next expert selected from the list would not necessarily also be from the same Member State.

Working Group B: Discussion on content of Risk Assessments

74. Kåre Mølbak, Member, Denmark, summarised the discussions of Working Group B on the content of ECDC risk assessments.[16] The group had agreed that a risk assessment would always depend on the specific objectives and the situation. The assessment of a situation was an iterative process which began by outlining the threat and then moving to more in-depth assessment. ECDC's role did not involve an impact assessment but more an evaluation of the various options available and any new evidence. The group then conducted a 'tour de table' to canvass the opinions of individual representatives. The general opinion was that ECDC rapid risk assessments were highly valued, particularly by the smaller countries, but that they could be more timely. It was agreed that the process should be transparent, the risk assessment should be publicly available and there should be a quick turnaround of any peer review. The risk assessment should offer options for management of the risk, but not make recommendations. The conclusions of the Working Group were that an ECDC risk assessment should not be restricted to the assessment of the risk; that a risk assessment should offer different management options for the risk depending on available evidence; that a risk assessment should not identify priority options for response and that it should not provide recommendations.

75. Mike Catchpole, Member, United Kingdom, added that if risk assessments did not mention options for management they would not be credible.

76. ECDC Director noted that this was a difficult issue which depended on the circumstances. For example, ordinarily ECDC would not give travel advice in a risk assessment, although in its most recent rapid risk assessment on the outbreak of Ebola virus in West Africa, ECDC had included advice on not travelling to the affected area.

77. Denis Coulombier, Head of Surveillance and Response Support Unit, thanked the Working Group for its input and pointed out that the latest risk assessment produced by ECDC had highlighted options rather than making recommendations. Referring to the issue of timeliness, he noted that it was a struggle to produce a risk assessment in a minimum amount of time. Another question raised was how to determine when a risk assessment was required. He suggested that Member States should inform ECDC when they thought there was a need for a risk assessment as, despite daily monitoring, it was sometimes not obvious that the situation was acute.

78. Darina O'Flanagan, Member, Ireland, noted that ECDC's risk assessments were extremely valuable for the Member States in their day-to-day work. Although she agreed that the issue of timeliness was important there were also situations where an extensive risk assessment was not necessary, just some basic facts. She was aware of the pressure on ECDC staff to produce rapid risk assessments and appreciated the work done. She pointed out the need to balance presentation of the information with available resources.

Working Group C: Feasibility Study for EU level Training in Infection Control/Hospital Hygiene

79. Florin Popovici, Member, Romania, presented the results of Working Group C on a feasibility study for EU-level training in infection control and hospital hygiene.[17] The objectives of the Working

[16] Working Group B
[17] Working Group C

Group were to investigate what training was available in infection control and hospital hygiene at EU level; to become familiar with the feasibility study on developing EU-level training in infection control and hospital hygiene and to advise on the logic model for the feasibility study and TRICE IS questionnaire which had been sent to the Member States two days before. The aim of such a feasibility study would be to explore the development of EU-level training for healthcare professionals in EU Member States and to investigate the best format for this training. The Working Group concluded that it was important to address the topics of healthcare-associated infections and antimicrobial resistance at the EU level and that training was necessary. The Group endorsed the TRICE-IS questionnaire and encouraged NFPs to complete the questionnaire as thoroughly as possible.

80. Silvia Declich, Member, Italy, queried why the Working Group had been unable to receive the background material in advance in order to read it before the meeting. She pointed out that for those in the Working Group who were not involved in hospital work discussions had been difficult to follow.

81. The Chair apologised for the late provision of the documents and explained that ECDC preferred not to provide the Working Groups with background papers because it was interested in the group members giving direct opinions and feedback as experts. However, in the case of Working Group C it had been unavoidable.

82. ECDC Director pointed out that from a political perspective, antimicrobial resistance was very high on the healthcare agenda in many countries. He therefore hoped that it would be possible to develop training similar to that for EPIET and EUPHEM to improve infection control in hospitals and to empower those in charge of hospitals to do more about it.

83. Frank Van Loock, European Commission, pointed out that some countries were making more progress on this issue than others and it was therefore hoped that the Advisory Forum would be able to provide guidance. Although the Council of Ministers, the European Parliament and other groups had been pushing for progress on hospital infection, there was still some catching up to be done on the ground. The Commission would therefore be closely monitoring any initiatives resulting from this work.

84. It was then discussed whether the Working Group should have examined infection control and related training in the area of community-acquired infections as part of its remit, given the huge gap between infection control in hospitals and in long-term care in the community.

85. Carl Suetens, Senior Expert Health Care Associated Infections, Surveillance and Response Support, confirmed that although the same principles applied, the same level of control was not implemented in the community (for example in care homes) as in hospitals which meant that infection control in the community was an issue with a much broader scope.

86. Johan Giesecke, Chair, thanked all Working Group participants for their feedback.

Item 13 – Update from the European Commission

Item 13b – Update on research activities and launch of new initiatives: Global Research Collaboration for Infectious Disease Preparedness (GloPID-R) on research preparedness activities

87. Cornelius Schmaltz, European Commission, updated the AF on the work of the DG Research and Innovation.[18]

88. Osamah Hamouda, Member, Germany, asked where the secretariat for the Global Health Security Initiative would be situated. It was explained that the staff of the secretariat would come from the two institutions involved - Fondation Mérieux in Annecy, France, and the University of Oxford in the United Kingdom.

[18] Item 13b - Update from RTD (C Schmaltz)

Item 13a – Serious cross-border threats to health: development of implementing measures

89. Frank Van Loock, European Commission, gave a short presentation on Decision 1082/2013/EU on serious cross-border health threats.[19]

90. Darina O'Flanagan, Member, Ireland, asked for clarification as to whether the request for completion of the template mentioned in the presentation had already been sent out to Member States and this was confirmed.

Item 13c – Update on the future of QUANDHIP

91. Frank Van Loock, European Commission, provided a short clarification on the future of QUANDHIP (Quality Assurance Exercises and Networking on the Detection of Highly Infectious Pathogens).[20]

92. Kåre Mølbak, Member, Denmark, requested clarification on how the nomination would be arranged. It was explained that this had already been done through the Member States.

93. Franz Allerberger, Alternate, Austria, congratulated the Commission on QUANDHIP, pointing out that ten years ago only 40% of the participating European laboratories and institutions had been able to carry out correct diagnostics on all isolates of the highly infectious pathogens sent out for external quality control (e.g. *Yersinia pestis*, *Bacillus anthracis*), but now all of them could do so, even for rarer diseases such as Ebola.

94. Osamah Hamouda, Member, Germany, requested clarification on whether QUANDHIP funding would be extended and if a decision had been taken. It was clarified that the Commission was ready to finance QUANDHIP but needed a minimum level of participation. The greater the number of participants from developing countries in the EU, the more funding would be available. The results of the QUANDHIP consultation would become clear after the submission deadline of 20 October 2014.

Item 11 – Discussion paper on public health training *(Document AF39/9)*

95. Karl Ekdahl, Head of Public Health Capacity and Communication Unit, gave a presentation on public health training in Europe[21], concluded by asking the following questions:

1) Would it be possible to have a standard number of trained specialists in the EU?
2) Should ECDC shift its training resources towards the 'prioritised' Member States with greater training needs?
3) Would the subsequently 'non-prioritised' Member States still be able to access training on a cost sharing basis?
4) Should there be a shift from EU-track to Member State-track fellows in order to expand the programme with the available ECDC budget?

96. Frank Van Loock, European Commission, reminded colleagues that according to the Global Health Security agenda there was a need to have trained specialists at the ratio of 1–200 000 population and wondered whether this requirement was being met. It was important to ensure that a strategy was in place for this. After 2015, the Commission would be prepared to push the European Council and the European Parliament to ensure that capacity was met and that all stakeholders shared the burden.

[19] Item 13a - Decision 1082-2013-EU (F Van Loock)
[20] Item 13c - QUANDHIP and JA HID WP2014 (F Van Loock)
[21] Item 11 - Discussion paper on public health training (K Ekdahl)

97. Osamah Hamouda, Member, Germany, noted that the EPIET programme was one of ECDC's success stories and had fostered the idea of a European identity in public health. In principle, he supported the idea of a standard, but this would need to take into account the size of the population and the structure of the healthcare system in each country. Commenting on the idea of providing training where the need was greatest, he pointed out that the EPIET programme was for specialists who were already trained. He suggested that there could be more training sites but at those training sites with less experienced trainers there could more support from ECDC.

98. Mike Catchpole, Member, United Kingdom, said that although the proposal was very strong, trained specialists were only effective if they were in relevant posts. Support for the programme was required at the highest level in the Member States and the foundations would have to be agreed with the Management Board. Although there would be a need for a shift in terms of the output of the programme, prioritisation did not have to mean a change in training locations.

99. Isabel Noguer Zambrano, Alternate, Spain, said that her country strongly supported the national Spanish FETP programme, but it was difficult for them to maintain it due to lack of resources. Spain was willing to support the programme and would make every effort to do so, both centrally and in the autonomous regions.

100. Jan Kynčl, Member, Czech Republic, stated that he was pleased with the proposal and its prospects. Increasing the number of Member-State tracks would provide an opportunity for countries to be more involved in the process, enabling them to train more people at the same cost. It would also be beneficial because more people would stay and continue to work in national and regional institutions whereas at present only half of the EPIET alumni stayed to work at national and regional level. He did not subscribe to the proposal of having two start dates per year as this would involve an additional workload for the Member States. He was a firm advocate of short courses which were of great benefit to middle-aged career staff who also needed training and who had gained a great deal from the short courses in the past.

101. Kåre Mølbak, Member, Denmark, said that it was important to maintain a balance between EU and Member State tracks. He pointed out that infectious diseases and public health were global issues and by definition this meant that people would move around and work in various countries. It was important to be able to maintain good training sites by listening to the fellows and obtaining their feedback, however this had not been reflected in the questions posed. A decision on whether to prioritise certain Member States depended on the structure of the healthcare system in each country. Another issue that needed to be taken into account was the use of new technologies, such as genome sequencing to facilitate cluster detection and response. Technology of this type would become a priority in the future and the course curriculum would have to be adapted to accommodate this.

102. Darina O'Flanagan, Member, Ireland, said that re-prioritising of Member States would be very difficult as there were many countries that had experienced recessions and resources were stretched. She supported the idea of shifting EU-track to Member-State track as in reality people often went abroad and did not come back. On the other hand, countries also had to encourage people to go and taking two years out of the system at home could also be difficult.

103. ECDC Director noted that an overview of training needs in the Member States would provide ECDC with a better picture of the current situation and make it easier to know what kind of standard to implement. It would also be useful to substantiate calls to Ministries of Health to increase resources on training.

104. Marta Grgič-Vitek, Alternate, Slovenia, said that a minimal standard would be very welcome to help justify the need for training resources. She would appreciate the possibility of being able to access one seat for her country in each new cohort.

105. Karl Ekdahl, Head of Public Health Capacity and Communication Unit, concluded that the paper will be revised in order to reflect the feedback from the AF and then it would be presented to the National Focal Points and the Management Board for discussion. He suggested that a Working Group could be set up to collaborate on this issue over the next six months and invited anyone interested in participating to contact him. It is understood that each country had different needs and ECDC is aware that it might therefore be difficult to obtain a consensus. It was also pointed out that

the figures on costs were only indicative. The AF was invited to come back with written comments after national consultations, as well as declare their interest to participate in the working group.

Item 12 – Update on the second External Evaluation of ECDC

106. Andrew Amato, Head of Disease Programme HIV, Sexually Transmitted Infections and viral Hepatitis, Office of the Chief Scientist, gave a short presentation on the second independent external evaluation of ECDC, carried out in accordance with Founding Regulation 851/2004.[22] He clarified that the results of the evaluation were embargoed until 8 October 2014 when they would be approved by the Management Board ahead of publication.

Item 14 – Confirmation of 2015 and 2016 Advisory Forum meeting dates *(Document AF39/10)*

107. The meeting dates for Advisory Forum meetings in 2015 and 2016 were presented.[23]

Meeting dates 2015		Meeting dates 2016	
AF41	18-19 February	AF45	22-23 February
AF42	12-13 May	AF46	12-13 May
AF43	23-24 September	AF47	19-20 September
AF44	10 December	AF48	12 December

108. The AF approved the meeting dates for 2015 and took note of the dates for 2016.

Item 15 – Any other business

109. Mike Catchpole, Member, United Kingdom, thanked Johan Giesecke for all his work as ECDC's Chief Scientist and wished him every success in the future.

110. Johan Giesecke, Chief Scientist and Chair, thanked the Advisory Forum for the wonderful farewell dinner and presents and wished his successor as ECDC Chief Scientist, Mike Catchpole, the best of luck for the future.

111. Marc Sprenger, ECDC Director, extended a big thank you to the Corporate Governance team for the excellent organisation of the meeting.

112. The next meeting of the Advisory Forum will be held on 10 December 2014 via audio conference.

[22] Item 12 - Update on the second independent external evaluation (A Amato)
[23] Item 14 - AF meeting dates 2015-2016