EUROPEAN COMMISSION
DIRECTORATE-GENERAL FOR HEALTH AND FOOD SAFETY

Public health
HealthSecurity and Vaccination

Luxembourg, 24 September 2020

Health Security Committee

Audio meeting on the outbreak of COVID-19

Summary Report

Chair: Wolfgang Philipp, European Commission, DG SANTE C3

Audio participants: AT, BE, BG, CZ, DE, DK, EE, ES, FI, FR, HR, HU, IE, IT, LT, LU, LV, MT, NL, PT, RO, SE, SI, SK, NO, CH, UK, AL, ME, RS, XK, UA, MD, DG SANTE, DG CNECT, DG ECHO, DG HR, EMA, ECDC, WHO

Key Conclusions

1. ESI – Disinfection robots *(information from the Commission)*

The Chair opened the meeting referring to a background document that was circulated to the HSC on disinfection robots. DG CNECT further introduced the topic. In the context of the COVID-19 pandemic, disinfection robots could help limit the spread of the virus and protect medical staff and patients, while relieving cleaning staff from the risky activity of disinfection. Based on information collected from media reports and disinfecting robot manufacturers, the demand for disinfection robots has spiked since the start of the COVID-19 pandemic. The need for such robots was also confirmed by more than 500 hospitals across the EU and from the UK that replied positively to an online survey launched by the Commission in June.

On 23 July, the Commission launched an action under the Emergency Support Instrument to support the distribution of disinfection robots[1]. The Commission plans to purchase about 200 disinfection robots to be donated to hospitals across Europe. The selection of the beneficiaries of these donations will be based on criteria prioritising the hospitals most in needs. To proceed with the implementation of this action, the input and the contribution of Member States is needed to better assess the needs at national level, select target hospitals and help liaising with them.

Members of the HSC were therefore asked the following questions: (1) How many hospitals could make useful use of such robots in your country? (2) How would you suggest to select/prioritise hospitals in your country? And (3) Would you be ready to help the Commission with the selection of hospitals and the information towards selected hospitals about the modalities of implementation of this action (including notably the signature of a donation agreement between the EC and each hospital receiving a disinfection robot)?

[1] See Commission Decision C(2020) 5162

Following questions from the HSC, DG CNECT clarified that the purpose of the robots presented today is disinfection, and not cleaning. Moreover, the robots use UV light sources of sufficient intensity instead of chemical spray or vapour, which allows the room to be used again immediately after the completion of the disinfection process. The disinfecting routine is under the remote control and monitoring of an operator, thus avoiding accidents and harm to people from the UV light. Neither the operator, nor anyone else, is in the room at the time of disinfection.

SE noted that, until now, it has not seen any studies on the effectiveness of these specific robots. Hydrogen peroxide disinfection robots have previously been assessed in Sweden, but health authorities did not consider these to be meaningful. SE asked if further documentation could be provided on the practical use of the robots.

DE added that they have not ordered any of the disinfection robots until now, as they also have doubts about their effectiveness and would also appreciate to receive further data and details. Moreover, as the robots use UV light, which can damage the skin and eyes and which has proven to be carcinogenic, DE is reluctant to use the robots. DG CNECT clarified that the disinfection robots can be fully operated from outside the room, and therefore the operator will not be exposed to the UV light.

FR requested to receive further details on the French hospitals that had positively replied to the survey circulated by DG CNECT. Several other countries (IT, EE, DE, LV) indicated that they would also be interested in receiving details on the hospitals in their countries that had positively replied to the questionnaire.

As regards next steps, DG CNECT explained that they would like to start deploying the robots from November onward, and that they foresee to distribute up to 50 robots per month.

Follow-up:

- *DG CNECT will check internally if, also in line with data protection rules, details on the hospitals that responded to the questionnaire can be shared with the HSC members of the related countries.*
- *DG CNECT will collect further information and details on the use and effectiveness of the disinfection robots, which will be circulated to the HSC as it will facilitate decision-making processes in the countries.*
- *Based on the additional information that will be circulated and, if indeed possible, details on the hospitals in each country that expressed interest in the robots, the HSC members will inform the Commission (via the HSC mailbox)* ***by 5 October*** *if they are interested in taking the initiative forward.*

2. Rapid risk assessment COVID-19

ECDC presented the 12th update of the Rapid Risk Assessment regarding COVID-19 in the EU/EEA and the UK[2].

ECDC explained that the rationale for the release of a new update were the latest epidemiological developments. COVID-19 case notification rates have increased steadily across the EU/EEA and the UK since August 2020, but this is not having the same impact in all countries. In several countries the observed upsurge correlates with increased testing rates and intense transmission among individuals between 15 and 49 years of age. In such countries

[2] Available at : https://www.ecdc.europa.eu/en/publications-data/covid-19-risk-assessment-increased-transmission-twelfth-update

most detections concern mild or asymptomatic cases. However, in a number of other countries, the upsurge coincides with high or increasing notification rates in older individuals and, consequently, an increased proportion of hospitalised and severe cases. The observed increased transmission levels indicate that the non-pharmaceutical interventions in place have not achieved the intended effect, either because adherence to the measures is not optimal or because the measures are not sufficient to reduce or control exposure.

The current epidemiological situation in many countries is concerning as it poses an increasing risk of infection for vulnerable individuals and calls for focused public health actions tailored at controlling transmission among older children and adults younger than 50 years of age, protecting medically vulnerable individuals, and protecting healthcare workers, particularly those involved in providing primary care. Moreover, based on the latest epidemiological data available, ECDC has categorised EU/EEA countries and the UK as countries with 'stable trends', 'concerning trends' or 'trends of high concern'. ECDC added that, as also stressed in the recent testing document published by the HSC and ECDC, that more widespread testing is key. Easy access to testing and timeliness of testing is critical for the effectiveness of measures such as contact tracing and isolation of cases.

Concerning quarantine, ECDC recommends a 14-day quarantine for persons who have had contact with confirmed COVID-19 cases, but this can be shortened to 10 days, if a PCR test at day 10 is negative. Finally, reduced compliance by younger people to protective measures is of increasing concern and targeted communication campaigns are required that specifically target young people. The need for protecting the mental health of people who have had COVID-19 is another issue of concern.

The Commission raised multiple questions, including on the latest developments regarding the classification of countries and trends at regional level; timelines and priorities regarding the options for responses set out in the assessment; specific advice on how to operationalize recommendations to focus communication efforts on young people; the impact of non-pharmaceutical interventions and corrective measures needed; questions of immunity, and availability of data from Member States concerning reinfection, and information on coordination the implementation of COVID-19 measures between national and subnational levels.

Follow-up:

- *A detailed discussion on the 12th Rapid Risk Assessment of COVID-19 by ECDC will be held at the next HSC meeting, and members are encouraged to have a detailed look and carefully assess the document ahead of this meeting.*
- *As a basis for this discussion, DG SANTE will circulate a set of main points and questions that arose on the Commission's side after receiving the latest update of the COVID-19 RRA.*

3. Quarantine period for COVID-19 *(for discussion)*

In light of the wide variety of national quarantine approaches taken in response to the COVID-19 pandemic, a further discussion on this topic was initiated. The Chair reiterated that, as set out in the latest RRA, ECDC recommends a 14-days quarantine for persons who have had contact with confirmed SARS-CoV-2 cases, and that this can be shortened to 10 days after exposure, if a PCR test at day 10 is negative. Moreover, the advice given by the CDC in the United States is that people with COVID-19 should be isolated for at least 10 days after symptom onset and until 24 hours after their fever subsides without the use of fever-reducing medications. Looking at the measures implemented by countries across Europe, based on the

latest information provided in response to the ISAA questionnaire, several Member States are implementing a 14-days period, but an increasing number of countries are applying shorter periods of isolation/quarantine. Some countries also apply different rules for confirmed cases and contacts of different categories (e.g. symptomatic or asymptomatic cases).

The Chair asked the HSC members to give an update of the latest isolation and quarantine measures applied in their countries, including the underlying reasoning and scientific evidence on which these are based. Moreover, he asked for interest of developing a common position by the HSC on the issue.

SE explained that the country does not have any mandatory quarantine measures in place for incoming travellers wishing to enter the Swedish territory.

ES referred to a recently published new COVID-19 strategy on early diagnosis and detection of the coronavirus, which changed the duration of quarantine from 14 to 10 days. The strategy document recommends that a RT-PCR or antigen test is taken 10 days after the last contact. The period of 10 days is thus a national recommendation, and it is up to the regions in Spain to decide if they will follow this proposal or if they will implement different measures, also taking into consideration the regional epidemiological situation and available testing capacities. The period of 10 days was chosen as the latest evidence shows that this way the vast majority of COVID-19 cases will be caught. Only 5% will become symptomatic after this period. ES applies the same period of 10-days for isolation measures of mild cases. The period for isolation is 3 days in case people do not develop symptoms and 14 days for severe cases after their discharge from the hospital.

BE added that the country has reduced the quarantine period to 7 days, and that this was a political decision based on scientific advice. A test is required at day 7.

FR explained that they apply different measures according to the situation (e.g. close contacts or symptomatic cases). She added that the decision on the duration of quarantine and isolation measures is often a balanced decision between scientific evidence and behaviour of the general population. By reducing the quarantine or isolation measures, you may miss out on a certain percentage of positive cases, yet the willingness among the population to adhere to the imposed measures will be higher. This is a key aspect to take into consideration.

NL has also reduced its quarantine period from 14 to 10 days, and this decision was based on contact tracing data and information on index cases received by the public health institute. In line with the data put forward by ES, only 5% of the index cases will develop symptoms 6 days after the last contact. Some literature states that 97.5% of all cases are caught when reducing the quarantine to 10 days.

DE added that many discussions and calculations are ongoing concerning the duration of quarantine and isolation measures, and that this very much depends on the specific context. DE is currently considering to shorten the period, in general, from 14 to 10 days, and to give travellers from high-risk areas the possibility to be tested after 5 days. DE agreed with FR that it is important to consider the overall willingness among the population to comply with the quarantine measures. The Robert Koch Institute provided an easy and user-friendly overview of how many positive cases you will miss out on when shortening the quarantine period to certain days.

In IT, the quarantine period is 14 days and they will consider the recent advice published by ECDC.

LU follows the same approach as NL, and, based on data analysed provided by the contact tracing unit, the government recently decided to shorten the isolation period from 14 to 10 days. Quarantine is 7 days and a test is offered at day 6 (this was at day 5 before).

HR has shortened the isolation duration from 14 to 10 days for asymptomatic cases or people showing mild/medium symptoms. In case the clinical picture is severe or the person is immunocompromised, the isolation period can be longer. Currently, the country is experiencing difficulties in terms of compliance with quarantine measures by the population. Moreover, HR raised the question on what type of medical documentation should be required for people who had COVID-19 during the past 3 months and who wish to travel to another EU country.

Follow-up:

- *HSC members are encouraged to provide further details in writing on their national isolation and quarantine measure in place to the HSC mailbox.*
- *The Commission will put together a matrix of the isolation and quarantine measures put in place across the EU, and share with the HSC for further alignment.*
- *At the next HSC meeting, discussions will continue on the possibility for a common HSC position on quarantine and isolation measures, including an agreement on common denominators.*

4. Follow-up to the Commission Communication on short-term preparedness for COVID-19 *(update from countries and discussion)*

The Chair invited the HSC to share updates on the status of implementation of the Communication.

For this meeting, the Action areas discussed were support to vulnerable groups, supply of essential products and seasonal influenza. For support to vulnerable groups, 2 actions were raised: on the design and implementation of specific high density, low threshold testing strategies for vulnerable groups and settings (most of the responding countries have informed that testing strategies for vulnerable groups are in place) and on sharing of best practices on provision of mental health and psychosocial support to vulnerable prone to COVID-19 (while not responding directly to the action item, most of the responding countries have noted that mental health and psychosocial support to vulnerable groups is in place at national level). The Chair enquired about specific testing strategies for vulnerable groups and settings and on provision of mental support to vulnerable groups.

SE informed that they do not have specific testing strategies for vulnerable groups. They are included in the same way as anyone else.

BE noted that currently, their testing strategy includes close contacts, people living in collectivities and staff from nursing homes, hospitalised patients and travellers from high risk areas. With regards to mental support, front line psychologists arranged to meet specific needs for COVID-19, by providing consultations by video conference, and expansion of target groups to include senior, children and young people. No best practices have been developed.

DE informed they are in the middle of revising their testing strategy and are considering to use antigen test for medical care workers and workers in care homes. They intend to implement more often screening to protect these vulnerable groups. No specific provisions of mental health are to note, but DE will share more information, if any.

With regards to supply of essential products, action points aimed to be discussed were the establishment of overview on needs for medical supplies, national production capacities and stockpiles of essential equipment, map of flexible production capacities and conversion possibilities, as well as support of an EU coordinated approach for the planning and implementation of large-scale COVID-19 clinical trials in Europe. No Member States provided inputs on this agenda point.

The last action area discussed was on seasonal influenza. The Chair asked the HSC for any updates regarding vaccination campaigns, supply of vaccines and adaptation of vaccination infrastructures to the COVID-19 pandemic.

ECDC raised the notion of "twindemic" and the importance of preventing this event.

DE mentioned they will start the campaign and are considering the implementation of fever clinics – which are fever focused practices.

IT informed that the Ministry of Health is monitoring any management constraints and further supply. The vaccination campaign will start earlier (October) will target health workers, fragile people, people older than 60 and children between 6 months and 6 years. Vaccines will be made available also in pharmacies and a communication campaign is in preparation at Ministerial level.

PT noted that vaccination campaigns for seasonal influenza vaccination will be launched and that high coverage for influenza vaccine is expected.

NL is giving extra attention to influenza vaccination, with specific attention vaccination coverage in health care setting and workers. More vaccines have been made available, with expectation of a higher turnout. Advice for safer vaccination infrastructures have been developed.

Follow-up:

- *The Commission is finalising the implementation report and will share with the HSC for review.*

5. Recognition of COVID-19 tests in the EU *(for discussion – DE)*

The Chair explained that the issue of mutual recognition of COVID-19 test results, particularly in the context of arriving travellers, was brought up in the IPCR. At the IPCR meeting, 10 MS and Norway mentioned that mutual recognition of test results would be a useful measure to pursue. In this context, a short survey was circulated among the HSC, to which 6 MS and the UK replied. Of these, countries indicated that overall, they are currently not experiencing any problems with the acceptance of test results. This applied both in the case of countries that do not require incoming travellers to have a test result with them as well as those that do require a proof of a negative RT-PCR test upon entry into their territory. However, the countries indicated that a better coordination in this area would be welcome, and concrete suggestions were provided concerning the development of a digital platform. The Chair opened the floor, asking the HSC if they experience any difficulties in this regard and whether there is a need for a coordinated approach.

DE indicated that their COVID-19 test results are signed by medical doctors and that they don't experience any problems with the recognition of test results of incoming travellers. In the beginning, language was an issue but the country now recognises test results in either German or English.

Currently, EE does not require incoming travellers to have a negative RT-PCR test result with them nor do they experience any difficulties in this regard. However, the country proposed that the issue will be discussed further and it believes that the creation of a digital platform could be beneficial. A reference was made to a pilot project that just started with WHO, during which an Estonian company will be developing a digital platform for the verification of vaccination results. Technically it would be rather easy to copy this concept and use the same type of platform for the recognition of COVID-19 test results across Europe.

IT is not aware of any problems regarding the recognition of COVID-19 test results.

The same applies to BG, who informed the other participants that the country is also not having any problems with the recognition of RT-PCR test results. The country does not require incoming travellers to have a negative test result with them. Regarding the test result provided to BG citizens, it shows the name and issuing entity (the list of accredited labs is publicly available).

FR does not require incoming travellers from other European countries to provide a negative test result. However, some problems occurred in relation to the French language used to describe the test results carried by French people travelling to other Member States. This was not recognised in Belgium and Germany. FR is in favour of a system that would support the mutual recognition of test results at EU level, in particular at borders, in order to facilitate the free movement of people between Member States. In this context, FR brought up the following aspects and issues that are relevant for consideration:

- Firstly, would all types of tests be mutually recognised or only RT-PCR (for the moment)? RT-PCRs tests are currently the reference technique but other tests are being deployed or considered for implementation (as it would be less time-consuming, reduce the testing burden on laboratories and facilitate free movement between MS).
- What would be Europe's doctrine regarding antigenic tests? In the United States these are considered as virological tests, but this is not the case in Europe where, depending on the devices, a confirmatory RT-PCR is requested.
- How can the legitimacy of the test result be ensured? For example, is there a need to publish, for each MS, a list setting out the entities authorised at national level for carrying out COVID-19 tests?
- Should the tests be CE marked, and if so, can/should all CE marked tests be recognised? This would not apply for all MS, as in FR, for example, RT-PCR test results are accepted with unlabelled reagents that have been validated by the CNR, as it speeds up the use of devices that are in the process of being labelled, while ensuring that they have satisfactory performance. Moreover, distinguishing between CE and non-CE marked tests may be quite a complex task to carry out at the border.
- What type of criteria should be defined for the mutual recognition and verification of the legitimacy of the test results at borders? For instance, identity of the person, laboratory and country that carried out the test, type of test carried out, result (question of language here as well), chronology of carrying out the test.

The Chair responded that the question in relation to the recognition of rapid antigen test results is very relevant, as these types of tests are increasingly circulating, and depending on their performance could play a pivotal role in the response to Covid-19. It would be helpful to have an overview of country's position and use of rapid antigen tests.

Follow-up:

- *The Commission will circulate a short survey consisting of two parts: one part on the mutual recognition of COVID-19 test results, addressing the points raised by FR; and one part on the current use of rapid antigen tests by European countries.*
- *Discussions will continue at next HSC meetings to identify if, for example, a HSC statement on minimum requirements for recognition of RT-PCR test results would be desirable and if the development of an EU platform would be useful and realistic.*

6. AOB

6.1 Communication (Commission)

HSC ComNet held its last meeting on 17 September to discuss the topics of schools and plans on seasonal flu campaigns. The Chair informed participants that the attendance of the meeting was very low (5 MS), and encouraged HSC members to urge their colleagues to participate in the next ComNet meeting, Particularly in light of the recent update to the COVID-19 RRA, communication is a very important aspect in the context of the pandemic. If the HSC ComNet is not functioning well, discussions on communication may be moved to the general HSC meeting to have a larger platform.

6.2 COVID-19 and mink farms (NL)

NL provided an update regarding COVID-19 outbreaks at the country's mink farms. As the virus has been detected on 55 farms in different regions across the country and humans got infected via mink too, it was decided to terminate all mink farms in NL before the end of the year. NL asked if any other Member State was taking measures regarding mink farms becoming a course of COVID-19 infection.

6.3 Contact tracing data (ECDC)

ECDC referred to discussions held through the HSC meeting, and references made to data that is available from national contact tracing operations. At the moment, ECDC has limited data on contact tracing and if possible, it would appreciate it if countries could share this data.

6.4 Schools (FR)

FR informed the participants that the health protocols in place for schools were changed last week based on the advice provided by the French High Council of Public Health. Taking into consideration that children are at low risk of developing COVID-19 and don't play an active role in transmission, a new case definition was formulated. From now on, contact tracing measures at elementary schools will only implemented if the index case (symptomatic or not) is a supervising adult that was not wearing a mask, or if three children from different families in the same class are COVID-19 positive. Before this was 1 child being positive in a class. FR expects that these new measures will reduce the number of schools that need to be closed.

6.5 Remdesivir (Commission)

The Chair explained that the shipment of the third instalment is expected for next week, and that the Commission will increase the volume by an additional 20.000 vials. This way, the Commission can bridge between the period of Veklury delivery under ESI and the delivery that will be linked to the Framework Contract signed under the Joint Procurement. A meeting of the Veklury Steering Committee will be organised on 29 September and the Framework Contract will be uploaded on CIRCABC so that Member States can scrutinise the document.

Follow-up:

- *To ensure that they are included in the Framework Contract, Albania should send the required information of their contracting authority by 25 September.*