

Minutes of Meeting

26-27 May 2025

Meeting of the EARS-Net Disease Network Coordination Committee

Meeting called by	Hanna MERK, Pete KINROSS, Diamantis PLACHOURAS
Facilitator	Hanna MERK
Note taker	Hanna MERK
Attendees	DNCC Members: Tim ECKMANN (27 May), Vera MANAGEIRO (26 May), Stephen MURCHAN, Carolien RUESEN, Gunnar SKOV SIMONSEN (DNCC Chair), Dorota ŻABICKA, Helena ŽEMLIČKOVÁ (Deputy Chair); DNCC Observers: Carlo GAGLIOTTI (ECDC contractor) (<u>Presenter</u>), Marcello GELORMINI (WHO Regional Office for Europe), Christian GISKE (EUCAST) (27 May), Antonio OLIVER (ESGARS) (26 May). ECDC (presenters): Pete KINROSS, Hanna MERK (<u>Chair and Minutes</u>), Diamantis PLACHOURAS (26 May). ECDC (other attendees): Holger HASTÉN (<u>Support</u>), Vivian LEUNG.

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Scope and purpose

The purpose of this meeting is to update and ask the Members of the European Antimicrobial Resistance Surveillance Network (EARS-Net) Disease Network Coordination Committee (DNCC) for advice on activities that were conducted in 2024 and 2025 so far and that are planned for the remainder of 2025 and onward; including the EARS-Net data call, and the further development of the EARS-Net surveillance.

Agenda

Monday, 26 May 2025

12:30 – 13:00	Virtual room opened
13:00 – 13:10	Welcome and housekeeping meeting day 1 (<i>Hanna Merk, ECDC</i>)
13:10 – 13:30	Update on ECDC and ARHAI (<i>Diamantis Plachouras, ECDC</i>)
13:30 – 14:00	EARS-Net update – standard activities (<i>Hanna Merk, ECDC</i>)
14:00 – 15:00	Surveillance of additional sample types – Council recommendation (<i>Hanna Merk, ECDC</i>) – Examples and pros and cons in the literature (<i>Carlo Gagliotti, ECDC contractor</i>)
15:00 – 15:15	Break
15:15 – 15:55	Surveillance of additional sample types – National and EU/EEA aspects (<i>Hanna Merk, Pete Kinross, ECDC</i>)
15:55 – 16:00	Closing of meeting day 1 (<i>Hanna Merk, ECDC</i>)

Tuesday, 27 May 2025

12:30 – 13:00	Virtual room opened
13:00 – 13:05	Welcome and housekeeping meeting day 2 (<i>Hanna Merk, ECDC</i>)
13:05 – 13:45	Surveillance of additional sample types (continued) – Summary of DNCC advice and additional DNCC advice (<i>Hanna Merk, ECDC</i>)
13:45 – 14:15	EARS-Net data collection timeline (<i>Hanna Merk, ECDC</i>)
14:15 – 14:30	Upcoming legislation on 'Surveillance standards' – options for EARS-Net (<i>Hanna Merk, ECDC</i>)
14:30 – 14:45	Break
14:45 – 15:15	Representativeness of EARS-Net data (<i>Hanna Merk, ECDC</i>)
15:15 – 15:30	Topics for next meeting (<i>Hanna Merk, ECDC</i>)
15:30 – 15:55	AOB (<i>Hanna Merk, ECDC</i>)
15:55 – 16:00	Closing of meeting (<i>Hanna Merk, ECDC</i>)

Agenda items

Welcome and housekeeping

Attachment 1: Day1_A – EARS-Net_DNCC_meeting.pdf

ECDC opened the meeting. No objections were raised to **recording** of the meeting for minutes-taking purposes (neither on day 1 nor day 2 of the meeting). The scope of the meeting was to provide updates and seek advice from the EARS-Net DNCC Members on the activities conducted in 2024 and 2025 so far and those planned for the remainder of 2025 and onwards. The meeting **agenda** was presented. Several DNCC Members/Observers submitted **annual declarations of interest** (ADoIs) that contained potential conflicts of interest (CoIs). DNCC Members and Observers participating in the meeting were asked to raise any points in their ADoI that they considered relevant to the agenda, and to report any relevant updates to their ADoI. None were raised by the participants (neither on day 1 nor day 2 of the meeting). ECDC informed that declared interests do not automatically imply a CoI. However, the presence of a CoI always leads to mitigation measures. For example, such measures may include not inviting a participant to attend the entire meeting or a particular agenda item, and/or inviting a meeting participant to state their CoIs at the start of the meeting.

Update on ECDC and ARHAI

Attachment 2: Day1_B - Update on ECDC and ARHAI.pdf

Diamantis PLACHOURAS (DiPI), Acting Head of the Antimicrobial Resistance (AMR) and Healthcare-Associated Infections (HAIs) (ARHAI) Section and Acting Group Leader AMR/antimicrobial consumption (AMC), provided an update on the ECDC reorganisation and activities relevant to the EARS-Net DNCC.

Dominique MONNET (DoMo) would retire from ECDC on 1 June and was on leave.

The new **ECDC organisational structure** effective as of 1 June 2025 was shared. The reasons for the reorganisation were to achieve (a) greater integration of public health functions (e.g. surveillance, microbiology, response, training, modelling, data science) with disease specific work; (b) an increase in disease specific knowledge and resources while maintaining the required level of horizontal coordination and generic public health function; and (c) more and smaller scientific units manageable in terms of size. The Unit for Disease Programmes (DPR), which the ARHAI Section belongs to would be split into two units (1) Directly transmitted and Vaccine-preventable Diseases (VPD) (DVD) and (2) One Health related Diseases (OHD). DVD would have sections for 'Respiratory viruses', 'STI, Blood-borne viruses and TB' and 'VPD and immunisation'. OHD would consist of ARHAI with DiPI as acting head of section for ARHAI, and 'Food-, Water-, Vector-borne and Zoonotic Diseases'. The head of OHD would be Ole HEUER. As part of the reorganisation ARHAI **staff** would continue working for ARHAI and be joined by five new colleagues who had previously worked on the carbapenem- and/or colistin-resistant Enterobacterales (CCRE) survey, modelling, ECDC strategy, and preparedness and response in healthcare systems. A new head of unit for ARHAI would likely be recruited during the summer in 2025. ARHAI consisted of two groups, and it would be discussed whether this would change after the implantation of the new ECDC organisational structure.

For ARHAI the following **priorities for 2026-2027** were shared: a) provide robust data; b) strengthen genomic AMR surveillance, c) support the implementation of EU infection prevention and control (IPC) guidelines to be published in June 2026, and d) maintain the one health approach on AMR through inter-EU agency collaboration.

Main **ECDC ARHAI outputs** included the 'Scientific Report on the impact of the use of azole fungicides, other than as human medicines, on the development of azole-resistant *Aspergillus* spp.' published 30 January 2025; the EFSA/BIOHAZ scientific opinion on the 'Current status of the occurrence and spread of carbapenemase-producing Enterobacterales in the food chain in the EU/EFTA. Part 1: 2013-2025' published March 2025; and the 'Report on the 4th point prevalence survey of healthcare-associated infections and antimicrobial use in long-term care facilities (2023-2024 data)' published 5 May 2025. As well as the upcoming outputs: the EARS-Net Annual Epidemiological Report (AER) with 2024 data to be published November 2025; the ESAC-Net AER (2024 data) to be published November 2025; the EURGen-Net report on genomic-based surveillance of carbapenem resistant and/or colistin-resistant Enterobacterales at EU level; the AERs on surgical site infections, HAIs in ICUs, and *Clostridioides difficile* infections; and the '5th joint report on the integrated analysis of the antimicrobial agent consumption and occurrence of antimicrobial resistance in bacteria from humans and food-producing animals in the EU/EEA' (JIACRA) to be published in 2026.

The **European Commission (EC)** had moved AMR in part from DG SANTE B2 to DG SANTE A1. This would have implications for how ARHAI works with the EC.

DG SANTE A1, covering AMR and human nutrition, had requested the setting up of **an interagency working group** to reinforce the One Health approach and to enhance cooperation among the following agencies: ECDC, European Chemicals Agency (ECHA), European Environment Agency (EEA), European Food Safety Authority (EFSA), and European Medicines Agency (EMA). The working group objectives would be to a) provide an effective platform to ensure exchange of information on AMR and discuss upcoming requests and mandates and b) work toward an integration of AMR surveillance

data across sectors. This group would be established in the coming six months, with a kick-off meeting planned for October 2025.

ARHAI has been continuing to contribute to **country visits**. Public Health Emergency Preparedness Assessment (PHEPA) country visits (under Article 8 of the Regulation on serious cross-border threats to health). Thirteen out of the 30 visits that need to be completed by the end of 2026 had been planned for 2025. In 2025, the following PHEPA visits had been completed: the Netherlands 27-31 January, Norway 3-7 February, Portugal 3-7 March, and Latvia 17-21 March. The following upcoming PHEPA visits were foreseen in 2025: Iceland 2-6 June, France 23-27 June, Croatia 1-5 September, Lithuania 15-19 September, Slovakia 29 September-3 October, Italy 20-24 October, Cyprus 1-5 December, Greece 8-12 December. Moreover, under the Instrument for Pre-Accession (IPA) 6 a country visit to Serbia had taken place, 24-28 February 2025. However, IPA 6 had now ended. Further IPA country visits would depend on the launch of IPA 7.

ECDC supported the EC and the Health Security Committee (HSC) in producing the '**Opinion of the Health Security Committee (HSC) on rapidly increasing incidence of carbapenem-resistant Enterobacterales (CRE) in healthcare settings**' which was adopted 13 May 2025. It includes the AMR target indicators from the '**Council Recommendation on stepping up EU actions to combat antimicrobial resistance in a One Health approach**'. The latter also includes the recommendation to expand AMR surveillance of additional sample types which would be discussed during the DNCC meeting.

The results from **the point prevalence survey (PPS) of HAIs and antimicrobial use in European long-term care facilities (2023-2024)** published on 5 May had among other results highlighted that of the HAIs few (20%) had a positive microbiological result and among these 23% were resistant bacteria.

DNCC feedback

The DNCC Chair asked whether ECDC had assessed the impact of the multitude of outputs that ECDC produces. ECDC replied that this was important but challenging. However, assessments have been made before the COVID-19 pandemic as part of the evaluation of EU/EEA public health surveillance systems (EPHESUS) project. More recently, outputs have impacted policy making at EU-level and consequently nationally – e.g. the EFSA/BIOHAZ scientific opinion and the Council Recommendation.

EARS-Net update – standard activities

Attachment 3: *Day1_C - EARS-Net update.pdf*

Hanna MERK (HaMe) gave a presentation on the current **EARS-Net DNCC** with a mandate from 2025 to 2028 with the following Members: Tim ECKMANN (TiEc) – Germany, Vera MANAGEIRO (VeMa) – Portugal, Stephen MURCHAN (StMu) – Ireland, Marie-Cécile PLOY – France, Helena RIBIČ – Slovenia, Carolien RUESEN (CaRu) – Netherlands, Gunnar SKOV SIMONSEN – Norway (DNCC Chair), Arjana TAMBIĆ – Croatia, Dorota ŻABICKA (DoZa) – Poland, and Helena ŽEMLIČKOVÁ (HeZe) – Czechia (DNCC Deputy Chair); and the following Observers: Carlo GAGLIOTTI (CaGa) – ECDC contractor, Marcello GELORMINI (MaGe) – WHO Regional Office for Europe, Christian GISKE – EUCAST, Antonio OLIVER (AnOl) – ESGARS. ECDC welcomed VeMa, CaRu, MaGe and AnOl.

The **ECDC EARS-Net team** currently consisted of DiPl as acting Group leader while DoMo was on leave, and Pete Kinross (PeKi) and HaMe.

The **main achievements** of EARS-Net so far in **2025** were presented:

- Metadata changes implemented in Q1 2025 – including the piloting of new antibiotics
- Transition to EpiPulse Cases with preparations, including WHONET adjustments.
 - EpiPulse Cases was launched 28 April 2025.
 - Training sessions completed: 14 April, 24 April and 7 May.
 - Training sessions planned: 10 June 10:00-12:00 CET.
- Contributions to PHEPAs: 1 (Norway).
- A survey of EARS-Net laboratories on new antibiotics had been conducted.
- EARS-Net DNCC Members and Observers had been appointed.
- The **EARS-Net reporting protocol** had been updated and published 28 April 2025.
- The EARS-Net data call email had been sent to countries on 13 May 2025.
- The EQA framework contract with the Technical University of Denmark (DTU) had been completed.
- Coordination with the EU reference laboratory for public health for AMR (EURL-PH-AMR) had taken place.
- EARS-Net External Quality Assessment (EQA) preparations had continued, including DNCC consultations.
- Meetings:
 - DNCC meetings:
 - 12 February 2025 – virtual, meeting minutes had been distributed.
 - 26-27 May 2025 – virtual, ongoing.
- Reports and products:

- The ECDC Rapid Risk Assessment "Carbapenem-resistant Enterobacterales – third update", had been published in February 2025.

Planned work for 2025 was presented:

- The 2025 EARS-Net data call – was planned for late spring/summer 2025. European Antibiotic Awareness Day (EAAD) output production would require adherence to deadlines.
- The 2025 EARS-Net EQA – was planned for summer 2025, with the EURL-PH-AMR.
- Reports and products (chronological order):
 - The EARS-Net EQA report – 2024 data – to be published October 2025.
 - The EARS-Net multi-annual EQA report – to be published October 2025.
 - The 2024 data publication in the ECDC Surveillance Atlas – to be published ahead of EAAD 2025.
 - The EARS-Net AER – 2024 data – to be published on EAAD 2025.
 - The 2024 data joint ECDC-WHO/Europe summary – to be published on EAAD 2025.
- Data sharing with WHO/Europe for GLASS purposes would be carried out within the data sharing agreement, and ECDC routines.
- Meetings:
 - Resources permitting – additional meetings remained to be determined.
- Activities related to the [EU Regulation on serious cross-border threats to health \(EU/2022/2371\)](#):
 - PHEPA visits (N=12): The Netherlands (January); Norway (February); Portugal (March); Latvia (March); Iceland, France (June); Croatia, Lithuania, Slovakia (September); Italy (October); Cyprus, and Greece (December). With the EARS-Net team contributing by a team member going on the visits to Norway and Iceland.
 - Development of 'Surveillance standards'.
- Activities related to the EU Council Recommendation on AMR, 2023 (2023/C 200/01).
- JIACRA V (covering 2022–2024) to be published by December 2026.
- Resources permitting:
 - Revision of criteria for adding new antibiotics under surveillance.
 - Report on blood culture set definition update.
- Manuscripts – ongoing:
 - EARS-Net surveillance data before, during & after COVID-19 interventions (time-series analysis using monthly data).
 - Scoring for multi-country EQAs of antimicrobial susceptibility testing (AST).
- Manuscripts – under consideration:
 - Descriptive summary of the European Antimicrobial Resistance Surveillance System (EARSS) and EARS-Net activity.
 - EARS-Net estimated incidence rates – methodology and results – improving surveillance.
 - EARS-Net 2024 data findings.
 - EARS-Net EQAs 2021-2024.

For the **upcoming data call**, the WHONET and ECDC data management team would be available for support. EAAD output production would require adherence to the following deadlines:

- 1 July 2025: EARS-Net data call closes. All data must be reported and approved in EpiPulse Cases by this date.
- July-15 August 2025: Validation of submitted data continues.
- 16 August 2025: The EARS-Net database would be frozen for analysis. All data corrections must be completed before this date. Data available in EpiPulse Cases at this date would be included in the ECDC analyses.

In 2025, **EAAD** (18 November) is on a Tuesday and ECDC EAAD activities will take place on Tuesday 18 November 2025.

Plans for **contracts and grants** were presented: a) within the WHONET support framework contract, a fourth specific contract was ongoing in 2025; b) within the EARS-Net support framework contract, a third specific contract was ongoing in 2025; c) the EARS-Net EQA exercise would be conducted by the EURL-PH-AMR, with Statens Serum Institut (SSI) as the designated consortium lead for 7 years, as part of a grant awarded in 2025.

The DNCC Members and Observers were informed that the current **planned DNCC input requests** for the remainder of 2025 include feedback on the 2024 EARS-Net EQA report; the Joint Summary 2024 data - EU/EEA section; the 2024 EARS-Net AER; the next EARS-Net EQA panel, process and material; the EARS-Net reporting protocol and analysis changes; and the EARS-Net EQA multi-annual report. Moreover, resources permitting, this could also include work on a blood culture set definition technical report and a Digital EQA (DEQA) exercise.

A short update on Article 17 on '**Urban wastewater surveillance**' in the revised Urban Wastewater Treatment Directive was provided. ECDC was aware of the obligation of Member States to implement wastewater-based surveillance for AMR for research purpose. Work on wastewater-based surveillance was ongoing at ECDC, however ECDC was planning pilot projects that did not involve AMR.

DNCC feedback

The DNCC Chair asked whether the DNCC would be involved in the manuscripts that were ongoing or under consideration. ECDC clarified that the network and therefore the DNCC would be involved in this work.

Surveillance of additional sample types

Attachment 4: *Day1_D1 & D3 - Surveillance of additional sample types.pdf*

Attachment 5: *Day1_D2 - Carlo Surveillance of additional sample types.pdf*

Attachment 6: *Day2_B - Surveillance of additional sample types – continued.pdf*

HaMe provided a short **background** referring to the first section in the recommendation on Surveillance and monitoring of AMR and AMC in the 'Council Recommendation on stepping up EU actions to combat antimicrobial resistance in a One Health approach' which stated:

"HEREBY ENCOURAGES MEMBER STATES TO:

5. Close existing surveillance and monitoring gaps and ensure completeness of data, including real-time data and timely access to data where appropriate by 2030, on both AMR and AMC at all levels (e.g. community, hospitals and long-term care facilities) to support the prudent use of antimicrobials in human health, by: a. ensuring, in coordination with ECDC, that surveillance of AMR in bacteria from humans encompasses not only bloodstream and cerebrospinal fluid isolates (invasive isolates) but also all other isolates from clinical microbiology laboratories, and that the corresponding data are regularly reported to the ECDC to rapidly detect and better gauge the scale and spread of antimicrobial resistant pathogens within and across Member States;"

Opportunities and risks related to this paragraph had been identified. For example, the opportunity to achieve the Council Recommendations (EU/EEA Health ministers) developing EARS-Net vs. the need for acceptable and feasible surveillance objectives, and the efficient use of resources, at EU and national level; better assessment of the EU/EEA situation vs. the generation of less comparable data than data on blood stream infections (BSIs), and it would divert focus from improving BSI and cerebrospinal fluid (CSF) surveillance; comparison of national AMR percentages and estimated incidence vs. the national differences in propensity to test; comparison of annual trends within national reports vs. a questionable added benefit over surveillance of invasive infections; harmonisation/improvement of national AMR surveillance vs. lack of human and other resources for new tasks nationally; the potential to utilise EARS-Net's laboratory network vs. the workload for EARS-Net laboratories, and the impact on BSI surveillance; the volume of new information for action vs. whether there already is enough information for action at EU/EEA level and insufficient resources, e.g. staff and infrastructure; and that it could guide additional national/local actions vs. the difficulty for the EU/EEA-level to influence local activities.

As the current default situation, it was mentioned that there already was a) the point prevalence surveys (PPSs) of healthcare-associated infections and antimicrobial use in European acute care hospitals, although not continuously performed, as well as b) the event-based surveillance consisting of EpiPulse Events, Early Warning and Response System (EWRS) and International Health Regulations (IHR) which provided ad hoc alerts from countries.

CaGa presented **examples of surveillance of additional sample types including pros and cons identified in the literature.**

- The Global Antimicrobial Resistance and Use Surveillance System (GLASS) covers four infectious syndromes (bloodstream, gastrointestinal, gonorrhoea, urinary tract) and of the 2020 data reported to GLASS 82% were on bacteriologically confirmed urinary tract infections (UTIs). However, more countries contribute BSI data than UTI data. GLASS data quality issues included that few EQAs were performed and the frequently observed low AMR rates in countries with high coverage could be due to selection bias.
- DANMAP (use of antimicrobial agents and occurrence of AMR in bacteria from food animals, food and humans in Denmark) covered both invasive and urine samples. Interestingly in these data reductions in AMR for invasive and urine samples mirrored each other over time.
- NORM/NORM-VET (usage of Antimicrobial Agents and Occurrence of AMR in Norway) was already covering several sample types other than BSI (respiratory tract infections, wound infections, and UTIs).
- UKHSA (English surveillance programme for antimicrobial utilisation and resistance) also covers AMR in *Escherichia coli* in urine in its local AMR indicators.
- When focussing on isolates from urine and the potential and limitations of laboratory-based AMR surveillance the following was noted: a) the proportion tested in laboratory-based surveillance requires comparison with population-based surveillance to assess the results from the laboratory-based surveillance; b) whereas BSIs indicate true infection, bacteria in urine may not be due to an infection, however surveillance of urine samples could be useful to detect emerging resistance; c) since UTIs often result in empirical treatment, urine cultures tend to be carried out when the treatment fails, leading to overestimation of AMR in the surveillance; d) a study in Indonesia had shown that laboratory-based surveillance may not show the true bacterial species distribution, and in addition, it overestimated AMR in outpatients; e) the need for comparison with population-based data required substantial resources, however it had been suggested that threshold surveys could be a solution to this challenge; f) however, in England, laboratory-based AMR surveillance had been shown to match population-based surveillance well; g) local data on AMR in UTIs had been shown to be relevant to local empirical treatment guidelines; and h) in the Netherlands a study had found that AMR proportions were similar in laboratory and population-based surveillance.
- Overall, it was concluded that different settings could generate different surveillance results, however it seemed that AMR in BSIs can be extrapolated to other sample types. Additional sample types could affect

local guidelines, provide data on antibiotics not included in BSI surveillance and provide indications of emerging AMR. However, given the required number of isolates and related workload, the need to conduct surveys to validate the data, and the bias affecting the data - laboratory-based surveillance of urine samples may not be the most efficient way of detecting emerging resistance.

HaMe asked the DNCC for advice on the **primary objective for the surveillance of additional sample types** – primarily at EU/EEA level.

PeKi presented the **maximum option** of surveillance of additional sample types for AMR – assuming unlimited workforce and funds. This would include establishment of EU/EEA coordinated surveillance by a) generation of 1-2 protocols for a pilot survey; b) conducting pilot surveillance; c) reporting on the pilot(s) and revising the protocol(s); d) establishing the surveillance and publishing its report; and e) validating data through 'data corroboration studies'. To do this by 2030, could require a) and b) in 2027; c) in 2028; followed by d) and e) in 2029-2030. Ahead of the establishment of this surveillance, there would need to be planning in 2026-2027 which would include defining objectives and intended usefulness for national and EU/EEA levels, defining the scope of the surveillance – including the unit of analysis sample types and comprehensiveness, defining the recommended AST panel, defining a minimal dataset, mapping available e-surveillance opportunities, and preparing the IT infrastructure. In addition, in 2026-2027, mapping of current national surveillance activities which would include a survey of current surveillance of urine samples and its uses, description of the content and similarities and differences for the activities, recommendation of which data countries could report with minimal adjustment and identification of minimal additional variables that would permit for example extrapolation by ECDC. PeKi also highlighted that it had previously been raised that at least two countries had found validation of urine sample surveillance challenging. Planning of the surveillance was considered quite resource intensive. In addition, it would need to be explored if ECDC could handle the amount of data that this type of surveillance would generate. Already at this stage, AMR data generated the largest data volume at ECDC. PeKi also suggested that there were four main options that could be considered as medium to maximum options of the surveillance: a) to collect the available national data centrally; b) to collect the available national data centrally and provide a protocol to countries without national data; c) not to collect the available national data but provide the same protocol to all countries; and d) to collect the available national data centrally and provide a protocol to all countries. Moreover, PeKi presented that the **preparation of the Council Recommendation** had included experts from 27 Member States providing input, this had included 19 Member States providing suggestions and 22 Member States voting to select the top priorities for the Council Recommendation.

DNCC feedback

Overall, expansion of AMR surveillance to additional sample types was met by the DNCC by a mix of concerns and optimism, as well as advice on aspects to consider based on the EARS-Net surveillance history, surveillance already conducted at ECDC and considerations for potential next steps on this topic.

StMu and HeZe voiced that the **work on the Council Recommendation** had not been discussed with the relevant national experts and that several practical aspects to it had perhaps not been considered yet.

HeZe raised that AMR surveillance of other sample types is also covered by **other ECDC surveillance** carried out by the sexually transmitted infections (STI) group, the food and waterborne diseases (FWD) group and the European Antimicrobial Resistance Genes Surveillance Network (EURGen-Net). Increasing cooperation with e.g. the FWD group on carbapenem-resistant Enterobacterales could be useful, as this would make use of data already collected rather than increasing the data collection in EARS-Net. The DNCC Chair raised that the **PPS** does not cover primary care, questioned whether PPS was a viable solution in the long term, and suggested that PPS may not be a good option for AMR surveillance of additional sample types. Instead, automated surveillance was likely a better solution.

ECDC replied that PPS will likely be continued for the foreseeable future.

AnOI suggested that ECDC instead could consider improving the current BSI and CSF surveillance, e.g. by increasing the number of **pathogens** included in the BSI and CSF surveillance carried out by EARS-Net.

In response to the **maximum surveillance option** presented by PeKi, both the DNCC Chair and AnOI raised that the planning would also need to include defining the **pathogens** to include in the surveillance as they would vary by sample type. AnOI also foresaw that expanding AMR surveillance to additional sample types would require changes to the **antibiotic panel** and that different countries would have different panels. AnOI moreover suggested that possibly one could focus the surveillance on *E. coli* in urine samples. The DNCC Chair agreed that there would be a need to identify a few core species for each sample type, e.g. *Klebsiella pneumoniae* and *E. coli* for urine, and *Staphylococcus aureus* for wound material. DoZa raised that it would be important to know why the surveillance data were collected. Moreover, if it were collected it would require good surveillance protocols, likely **sentinel surveillance**, and should also include **microbiological evaluation**. When ECDC asked whether any of the envisaged aspects of the maximum surveillance option could be dropped, the DNCC did not provide any suggestions.

AnOI raised that uploading all data was not possible with the current level of **automation** and that increasing surveillance would increase the **workload** for laboratories. StMu also highlighted that both data automation and **resources** vary across countries and that collecting additional data would be challenging. In addition, already with the current EARS-Net pathogens there are variations across countries. Moreover, work on AMR surveillance of additional sample types would

need to consider both the local and the national levels. Furthermore, the **2030 timeline** would be problematic. StMu concluded that when setting up AMR surveillance of additional sample types it would be good if the disparate surveillance across Europe could be considered, if the surveillance could be made less labour intensive, and if resources could be provided to Member States enable surveillance of AMR in additional sample types. However, the DNCC Chair raised that the focus should be less on the challenges of the AMR surveillance expansion and more on the opportunities it presented. DoZa also raised that GLASS would be focussing on isolate-level data going forward, but that collection of **aggregated data** might be more feasible. The DNCC Chair also suggested that ECDC consider whether aggregated data could be enough to report at an EU/EEA level. However, related to the level of aggregation DoZa advised ECDC to consider how to avoid duplication of work in relation to GLASS.

However, the DNCC chair recognised that the **comparability** of the surveillance results across countries was an issue due to differing treatment guidelines. CaRu agreed with the DNCC Chair and raised that culture rates vary by sample types and highlighted the risk of overestimation of AMR. Moreover, CaRu warned against comparing data across countries due to the differences between them e.g. in healthcare systems. Nonetheless, the DNCC Chair advised that there was a need to collect data on more sample types.

The DNCC Chair suggested that the **primary surveillance objective** could be to inform empirical treatment guidelines, and as a secondary objective the DNCC Chair suggested keeping track of the AMR development with the aim to find emerging resistance early. The DNCC chair added that for AMR data to have an impact it needed to impact IPC and antimicrobial use. In Norway, it had been concluded that both respiratory and urine samples were needed to inform treatment guidelines. TiEc then advised that primary objectives for surveillance of additional sample types should be guided by what is necessary rather than the wording in the Council Recommendation. In addition, if the objective is to gather data for local guidelines, then this did not constitute a satisfactory objective at EU/EEA level as EU/EEA data would not be needed for local guidelines. HeZe, agreed with TiEc that legislation rather than the Council Recommendation should guide the surveillance and asked whether the objective could be to capture more on AMR at **community level**, although this was not at present covered well by ECDC. In Czechia, although coverage of respiratory samples was good, it was challenging to gather data from urine samples, especially from uncomplicated UTIs. ECDC raised that ESAC-Net collects community sector data and information from stewardship programmes to facilitate sharing of experiences. The DNCC Chair favoured the suggestion to move towards collection of more AMR data at community level. StMu raised that data should be collected as **data for action**. Moreover, data from blood may not be sufficient at local and national level. In Ireland data on e.g. carbapenem-resistant Enterobacterales was collected for all sample types. CaGa suggested that the objectives may **differ at national and EU/EEA level**.

TiEc advised that more **timely** surveillance was not indicated as AMR is a slow pandemic. In addition, StMu advised that more thought was needed on this topic e.g. regarding increasing the number of sample types and pathogens and the real-time aspect of the Council Recommendation as it seemed to be based on a wish rather than what might be feasible. As it was, StMu indicated that annual EARS-Net data collection was feasible but that the resources were not available for e.g. quarterly collection. However, at a laboratory and hospital level, data needed to be followed continuously and feedback needed to be sent to both laboratories and hospitals so that action could be taken. The frequency of this work likely varied across countries. The DNCC Chair agreed that timeliness should not be a concern for EARS-Net as it describes the slow AMR development at EU/EEA level. Timeliness would however be a concern at a national level. ECDC raised, that for outbreak detection, timeliness was an important aspect. Moreover, CaGa raised that if timely data was part of the objective, then at EU/EEA level EpiPulse Events may be the answer rather than EpiPulse Cases.

The DNCC Chair also suggested that unless data were **requested at EU/EEA level** they may not be collected at national level. The DNCC Chair raised that the main point of EU/EEA AMR surveillance was to champion AMR surveillance across the EU/EEA countries. To achieve this the DNCC Chair suggested to pick one or two pathogens for urine, respiratory and wound samples, respectively, for surveillance. Although these data would not be comparable across EU/EEA countries, they would help promote surveillance in the countries. Another argument in favour of this was that the current blood and CSF surveillance data also were not very good. However, TiEc considered the current blood culture surveillance data as good, moreover, increasing the AMR surveillance to additional sample types would require more effort. CaRu agreed with the advocacy aspect raised by the DNCC Chair, and that adding sample types to the AMR surveillance could boost surveillance, including surveillance of blood and CSF. However, CaRu highlighted that such an expansion of the surveillance also gave rise to a risk of bias. TiEc and StMu agreed with HeZe that AMR data collected on additional sample types could allow identification of countries with higher and lower levels of AMR and this could enable countries to learn from one another.

The DNCC Chair and StMu also raised that it might be preferable to start the surveillance based on what was already collected and encourage more countries to report, in the **same way as EARS-Net had once started**.

In addition, the DNCC Chair asked whether ECDC knew **which countries conducted UTI AMR surveillance** nationally. The DNCC Chair also advised to check how many countries can provide the data and whether it could be provided at isolate or aggregated level.

ECDC action

Consider

- conducting a survey of what surveillance of additional sample types is being conducted by the EU/EEA countries. **AFTER THE MEETING IT WAS NOTED BY ECDC: EU-JAMRAI-2 IS CONDUCTING SUCH A SURVEY.**
- whether data collected by EURGen-Net as well as the FWD and STI groups at ECDC could contribute to the AMR surveillance of additional sample types.
- if expanding the surveillance, to start small and use it as a form of encouragement to countries to conduct the surveillance.
- that the surveillance method and objective could differ by local, national and EU/EEA level.
- if collecting aggregate data may be preferable over isolate-level data at EU/EEA level.
- collecting community level and additional sample type data as a form of advocacy for AMR surveillance in EU/EEA countries.

EARS-Net data collection timeline

Attachment 7: Day2_C - EARS-Net data collection timeline.pdf

HaMe presented the current timeline for the EARS-Net data call and clarified that it would be the one applied in 2025. The timeline included the data call closing 1 July, additional validation of data being possible in July-15 August, and that the database would be frozen 16 August. After this, analyses including checks; interpretation and writing; review, adjustments and approval by ECDC, the EARS-Net DNCC and the reporting countries would follow. By mid-October the aim was to publish the validated results in the ECDC Surveillance Atlas of Infectious Diseases.

The DNCC were then asked **whether future data collection timelines could be adjusted**. Specifically, if a) the data call could be closed earlier than 1 July, and if so before 15 May/1 June/15 June, and b) whether the validation period (July-15 August) could be shortened, and if so to before 1 June/15 June/30 June/15 July/ 31 July.

DNCC feedback

StMu advised that adequate **notice** of a change in timeline would be needed for the countries.

TiEc advised that for **large countries** a substantial amount of data needed validating before submission. The DNCC Chair and HeZe advised to listen to the larger EU/EEA countries since it was likely easier to adjust the timeline for smaller countries. The DNCC Chair suggested that reaching out to e.g. Italy, France and Germany asking about the feasibility of adjusting the timeline might be a good next step.

DoZa raised that an adjustment to the validation period would also depend on **ECDC resources** to validate.

Regarding the **feasibility** for specific countries some indicated that an adjustment would be a considerable challenge whereas others considered it feasible. TiEc indicated that, in 2026, it would **not be feasible** for Germany to adjust the deadlines. However, if it should turn out that all other countries would share their data before 15 June then Germany would do its best to follow suit. CaRu indicated that an adjustment of the timeline could be challenging and needed to check internally about whether it would be feasible for the Netherlands to have an earlier deadline for the data call, although likely the validation period could be shortened. DoZa suggested that an adjusted timeline would be difficult for Poland since data were available in Poland at the end of April and then May and June were needed to validate and prepare data. However, possibly a data call deadline of **15 June** might be feasible. StMu suggested that for Ireland it might be feasible for the data call to be closed on **15 May** and the validation period to end before 1 June. HeZe suggested that for Czechia the data call could be closed on **15 May**.

ECDC action

Consider

- contacting large EU/EEA countries about the feasibility of moving the data collection timeline forward.

Upcoming legislation on 'Surveillance standards' – options for EARS-Net

Attachment 8: Day2_D - Upcoming legislation on 'Surveillance standards' – options for EARS-Net.pdf

HaMe presented that according to the 'Regulation (EU) 2022/2371 of the European Parliament and of the Council of 23 November 2022 on serious cross-border threats to health' Article 13: "6. The Commission and the Member States shall work together to strengthen the data collection and sharing capacity of Member States and to define disease-specific European **surveillance standards** based on the proposal of the ECDC, in consultation with the relevant surveillance networks." And "7. The ECDC shall monitor and evaluate the epidemiological surveillance activities of dedicated networks on surveillance, including adherence to the surveillance standards referred to in paragraph 6; support Member States with scientific and technical advice to improve the timeliness, completeness and quality of the surveillance data reported; and

share regular monitoring reports with the HSC and the Commission. The ECDC shall also, where applicable and in accordance with Regulation (EC) No 851/2004, make available its expertise on epidemiological surveillance to third countries." And "The ECDC shall regularly provide an overview to the HSC on the timeliness, completeness and quality of the surveillance data reported to it." In line with this, ECDC had started some work which included preparation of a disease/health issue surveillance standards template. The **template** would likely include a) surveillance objectives, including indicators, mandatory information, resolution, reporting frequency and comprehensiveness; b) rationale for the surveillance; c) surveillance outputs; and d) a template for monitoring. The ECDC work would include filling in the template for EARS-Net in **consultation** with the EARS-Net network. In 2025-2026 the ECDC EARS-Net team expected to work with the network on the surveillance **objectives** for EARS-Net. As a step in this direction ECDC asked the DNCC for some initial advice for ECDC to consider when revising the EARS-Net a) objectives and b) surveillance standards. As background the current EARS-Net objectives were also shown: • collect comparable, representative and accurate AMR data; • analyse temporal and spatial trends of AMR in Europe; • provide timely AMR data for policy decisions; • encourage the implementation, maintenance and improvement of national AMR surveillance programmes; and • support national systems in their efforts to improve diagnostic accuracy by offering annual EQAs. ECDC also clarified that the current EARS-Net objectives may be updated, and that other ECDC teams were discussing this topic with their respective networks. Aspects that would be good to hear more from the DNCC on included whether the effect of specifying what Member States should do would risk that only the specified details would be carried out by Member States, and whether to focus the work with the EU/EEA or the national level in mind.

DNCC feedback

The DNCC Chair and StMu advised that the current **EARS-Net objectives** were fine. The DNCC Chair furthermore suggested that representativeness of data was more important than completeness.

TiEc indicated that **mandatory variables** would be welcome since it would generate leverage at the national level and essentially act as a form of advocacy for AMR surveillance.

StMu and HeZe asked what the consequences would be of not reporting mandatory indicators to ECDC. Related to this, StMu raised that if a Member State was not able to report but had to would this not risk generating incomparable data. ECDC replied that a report on the indicators would be generated by ECDC and shared with the HSC, and that ECDC was internally looking into what the consequences might be.

CaRu raised that for mandatory indicators, countries would need to know what the data would be used for.

HeZe and DoZa also suggested that **consulting** the DNCC on the draft indicators would be a good idea, especially since some countries might struggle with the indicators. DoZa also favoured consulting with the entire EARS-Net network, if possible.

ECDC action

Consider

- basing new EARS-Net objectives on the old ones.
- carefully the impact of mandatory indicators/variables, including the consequences of not reporting on them.
- consulting the DNCC and, if possible, the entire network, on the standards.

Representativeness of EARS-Net data

Attachment 9: Day2_E - Representativeness of EARS-Net data.pdf

HaMe presented **representativeness data** included in the latest EARS-Net AER; table 1 based on AMRCOVER data showing 'Population and hospitals contributing data: coverage, representativeness and blood culture rate, EU/EEA, 2023' and maps with intensive care unit (ICU) proportion in 2023 based on 'Hospital department data' that are shown in table format in the respective country profiles in the AER annex. The DNCC were then asked about aspects for ECDC to include ahead of discussion in upcoming DNCC meetings, as well as reflections and advice on the analyses, outputs, actions and any other aspects.

DNCC feedback

TiEc raised that **uniform definitions** for the representativeness data would be good to implement across the countries, and shared that this was an aspect that was being criticised by colleagues. Moreover, TiEc suggested that it would be good to explore the **ICU proportion correlation with the blood culture rates**, and although the shown maps were not necessary to include in the AER it would be useful to explore **how comparable the data are** and comment on this either in the AER or in a manuscript. The DNCC Chair agreed that it was a good idea to explore the representativeness data. The DNCC Chair indicated that data on hospital level and ICU proportion could be helpful for comparisons. This could then be used to **normalise the resistance incidence**. These results could also be **compared to the representativeness** data that is collected by EARS-Net. However, it was clarified by ECDC, CaGa and StMu that hospital level data was not available in EARS-Net data anymore. In addition, StMu suggested that it could be found in the PPS data, but StMu considered the data to be problematic. CaRu raised that in the GLASS report there were comparisons between the **blood culture rates and the resistance rates**. This could be interesting to explore in EARS-Net data.

However, the DNCC Chair suggested that one should be sceptical towards the reported blood culture rates, and referred to the difference between Norway, Denmark and Spain in the reported blood culture rates. The DNCC Chair therefore suggested to focus on ICU and hospital department data rather than the blood culture rate. ECDC replied that the differences in blood culture rate likely stemmed from differences in definitions and that the results were raised with the countries that then validated and approved the results. CaGa suggested that the ICU proportion could be explored, moreover it could be shown e.g. as the median by country and pathogens.

Nonetheless, both TiEc and the DNCC chair thought that a **manuscript** on the representativeness topic would be advisable and preferred this to a report by ECDC. ECDC suggested that a report may be a better way forward for some Member States.

ECDC action

Consider exploring a report or manuscript on representativeness, possibly with a focus on ICU proportion.

Topics for next meeting

Attachment 10: *Day2_F - Topics for next meeting.pdf*

HaMe asked the DNCC about **topics for the next DNCC meeting**, e.g. new topics not covered during the ongoing DNCC meeting, or topics that could benefit from being added to the agenda again.

DNCC feedback

TiEc suggested a discussion on the **specific pathogens** that is being placed under event-based surveillance that had been brought to TiEc attention as being part of the 'Regulation (EU) 2022/2371 of the European Parliament and of the Council of 23 November 2022 on serious cross-border threats to health'.

The DNCC Chair agreed with TiEc that a discussion with focus on **EpiPulse Cases Events** would be a good idea.

ECDC action

Consider adding expansion of pathogens under surveillance and event-based surveillance to a future EARS-Net DNCC meeting agenda.

AOB

Attachment 11: *Day2_GH - AOB Closing of the meeting.pdf*

HaMe asked the DNCC about **any other business** that the DNCC would like to raise.

DNCC feedback

TiEc raised that online meetings were good but that it would be appreciated if the DNCC could have an **in-person meeting**, e.g. at ESCMID Global. Moreover, TiEc offered to help arrange a meeting room at the next ESCMID Global that would be taking place in Munich.

ECDC (PeKi) suggested to, as part of the surveillance standards, discuss a) the **completeness of data** e.g. on PatientType and b) whether to use a **hospital identifier** in EARS-Net that would be harmonised with other efforts e.g. the PPS and EURGen-Net. StMu indicated that different identifier codes are used in different efforts, and that the reporting entities were not reporting identifiers as requested. Nonetheless, at national level, it was possible to map the data. Regarding PatientType, StMu indicated that this type of data was problematic for Ireland.

StMu suggested to **explore with countries challenges faced by the countries when collecting data**, with the aim that the countries could learn from one another.

ECDC action

Consider

- having a face-to-face EARS-Net DNCC meeting.
- adding the following topics to future DNCC agenda: data completeness and hospital identifiers.
- exploring together with countries challenges faced by the countries when collecting data.

Closing of the meeting

Attachment 11: *Day2_GH - AOB Closing of the meeting.pdf*

HaMe **closed the meeting** and thanked all for their contribution to the meeting. ECDC would be sharing minutes with the DNCC and the date for the next DNCC meeting remained to be determined.

ECDC action

Produce draft minutes and share with the DNCC for review.

Attachments

The following attachments are provided in the EARS-Net DNCC sftp server.

Attachment 1: Day1_A – EARS-Net_DNCC_meeting.pdf

Attachment 2: Day1_B - Update on ECDC and ARHAI.pdf

Attachment 3: Day1_C - EARS-Net update.pdf

Attachment 4: Day1_D1 & D3 - Surveillance of additional sample types.pdf

Attachment 5: Day1_D2 - Carlo Surveillance of additional sample types.pdf

Attachment 6: Day2_B - Surveillance of additional sample types – continued.pdf

Attachment 7: Day2_C - EARS-Net data collection timeline.pdf

Attachment 8: Day2_D - Upcoming legislation on 'Surveillance standards' – options for EARS-Net.pdf

Attachment 9: Day2_E - Representativeness of EARS-Net data.pdf

Attachment 10: Day2_F - Topics for next meeting.pdf

Attachment 11: Day2_GH - AOB Closing of the meeting.pdf

Attachment 12: Day1_E - Closing of meeting_day1.pdf

Attachment 13: Day2_A - EARS-Net_DNCC_meeting.pdf

Annex 1. EARS-Net Disease Network Coordination Committee

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NFP, National Focal Point; OCP, Operational Contact Point; AMR, Diseases Caused by Antimicrobial-Resistant Microorganisms.

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