UK Health Security Agency

Weekly Influenza and COVID-19 Surveillance graphs

UKHSA publishes a weekly national influenza and COVID-19 surveillance report which summaries the information from the surveillance systems which are used to monitor influenza, COVID-19 and other seasonal respiratory viruses in England.

Additional figures based on these surveillance systems are included in this slide set.

The figures presented in this slide set are based on data from week 47 (between 21 November and 27 November 2022).

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Data Information

- From the week 32 report onwards, case rates have been updated to use the latest ONS population estimates for mid-2020. Previously case rates were calculated using the mid-2019 population estimates
- From 11 January 2022 the requirement for confirmatory PCR testing in individuals who test positive using a lateral flow device was temporarily removed.
- Rates by ethnicity and IMD quantile will continue to be presented using the mid-2019 estimates, until the mid-2020 estimates become available.
- From 31 January 2022, UKHSA moved all COVID-19 case reporting in England to use a new episode-based definition which includes possible reinfections. Each infection episode is counted separately if there are at least 91 days between positive test results (PCR or LFD). Each infection episode begins with the earliest positive specimen date. Further information can be found on the UK COVID-19 dashboard.
- Since 1 April 2022, free universal symptomatic and asymptomatic testing for the general public in England is no longer available, as outlined in the plan for living with COVID-19. As such, there will be a reduction in the reporting of data obtained through Pillar 2 from April 2022 onwards. Data in this report should be interpreted in the context of this change to testing. Public health guidance remains in place for cases and their close contacts

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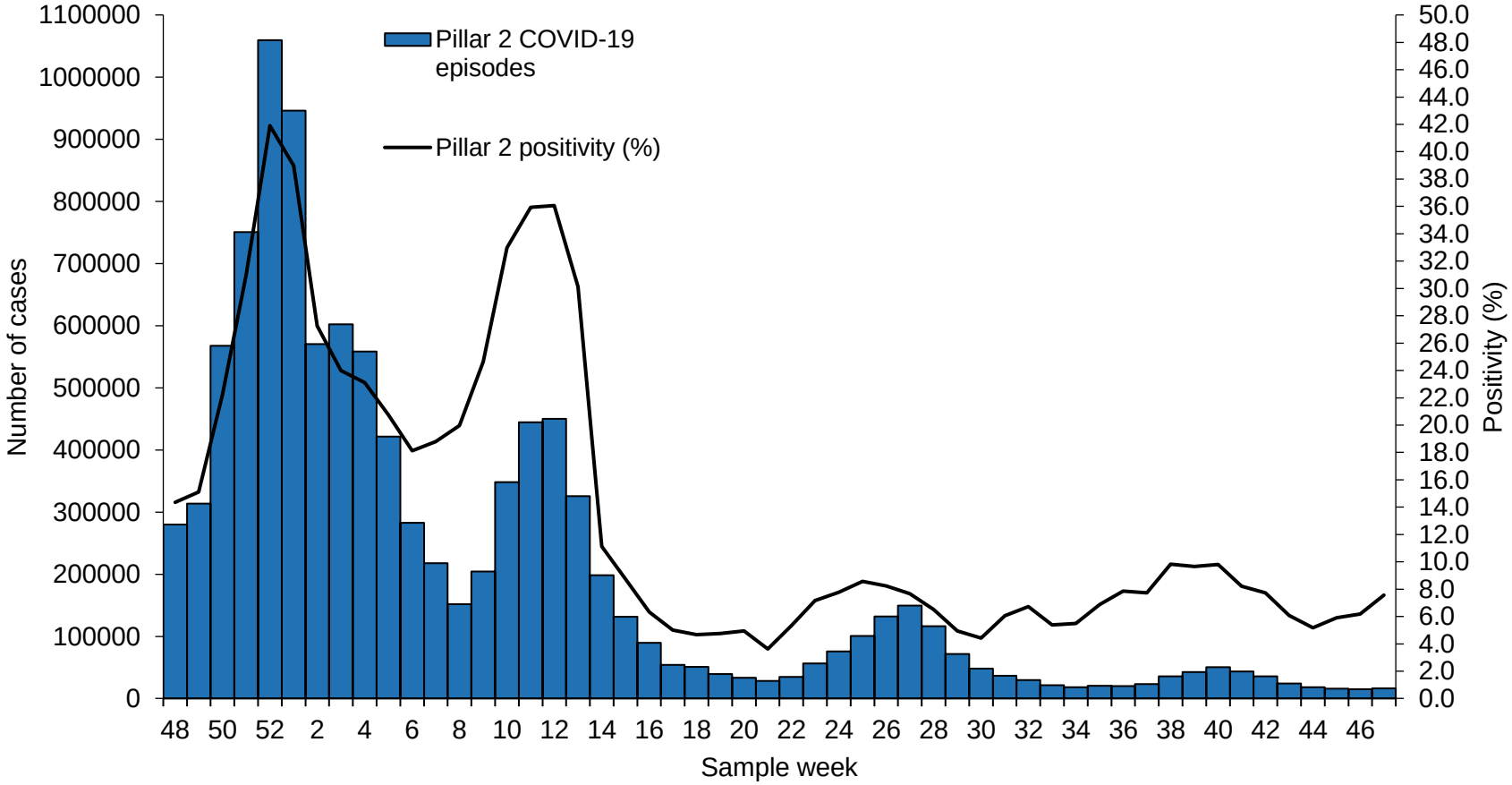
Confirmed COVID-19 episodes tested under Pillar 2, based on sample week with overall weekly PCR positivity for Pillar 2 (%)



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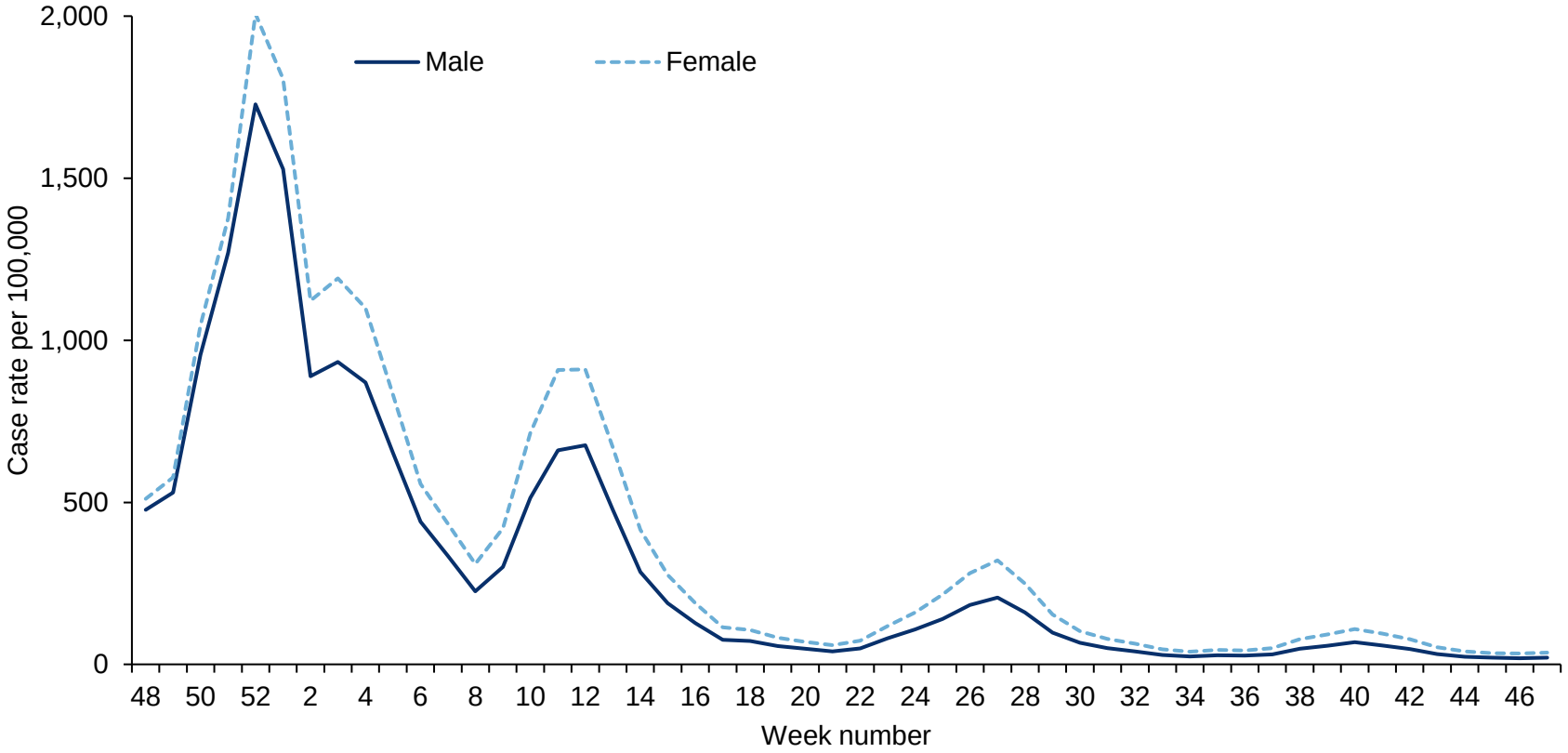
Weekly confirmed COVID-19 case rates per 100,000, by episode, tested under Pillar 2, by sex



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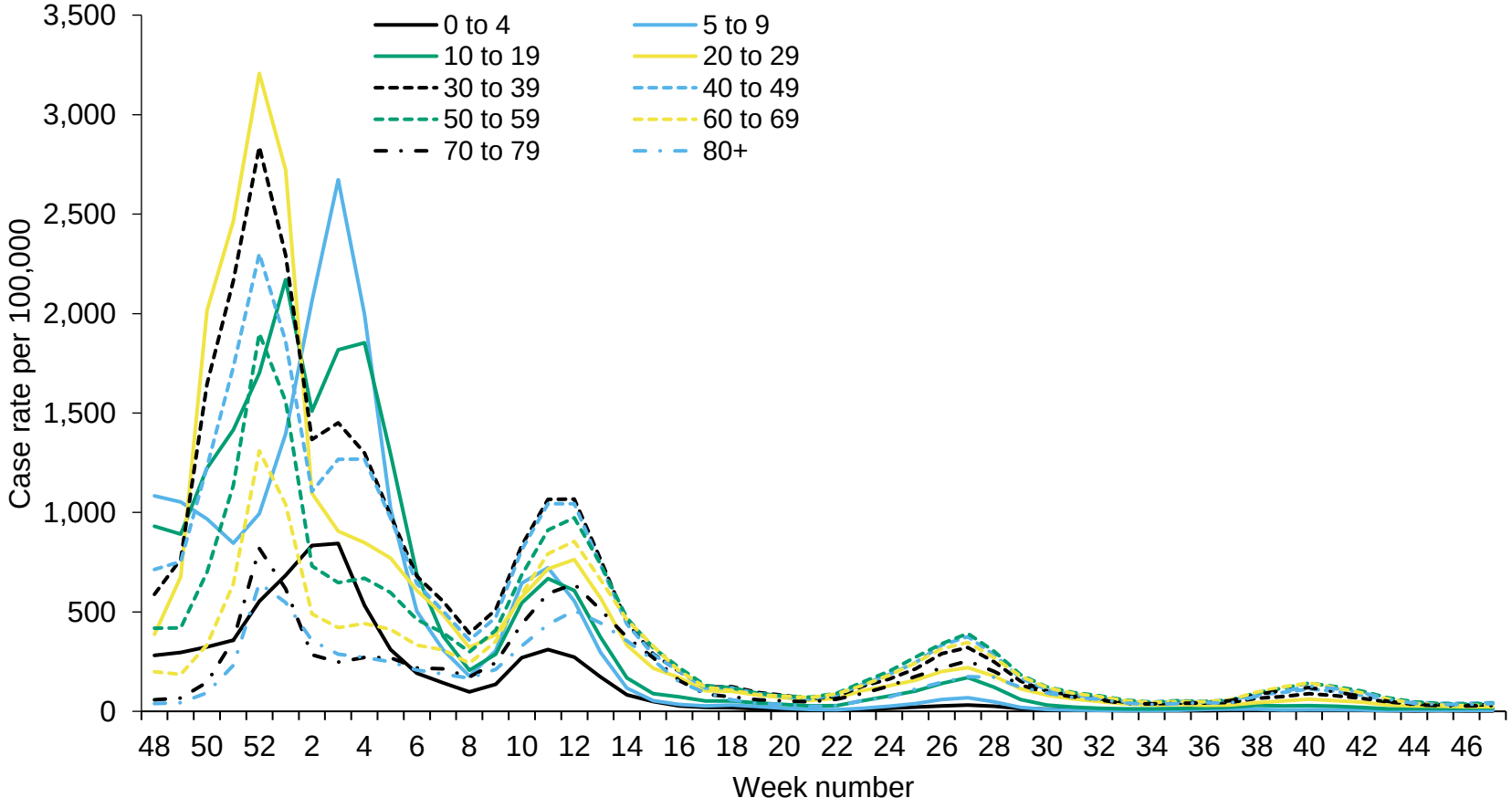
Weekly confirmed COVID-19 case rates per 100,000, by episode, tested under Pillar 2, by age group



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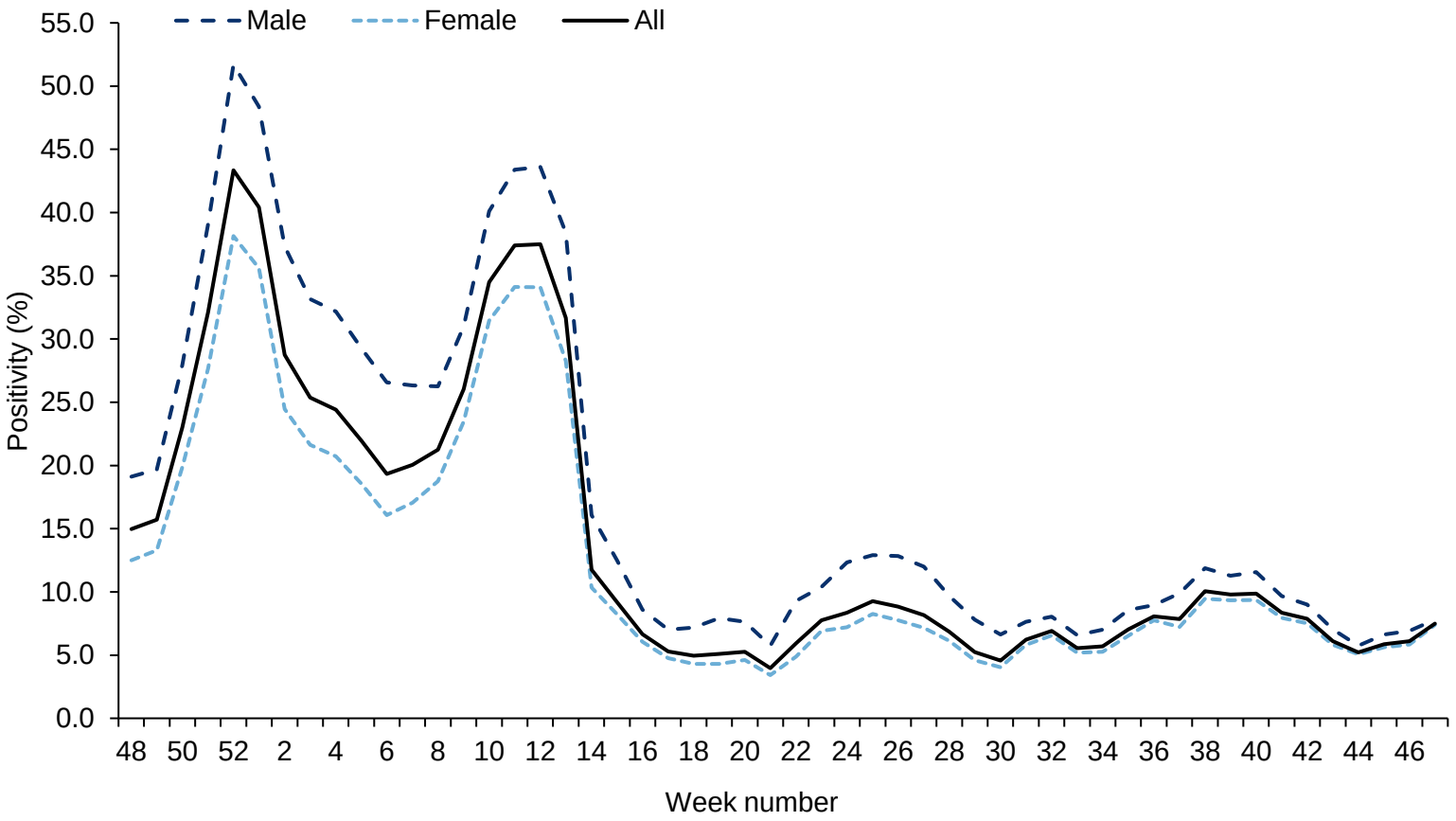
Weekly PCR positivity (%) of confirmed COVID-19 cases tested overall and by sex under Pillar 2



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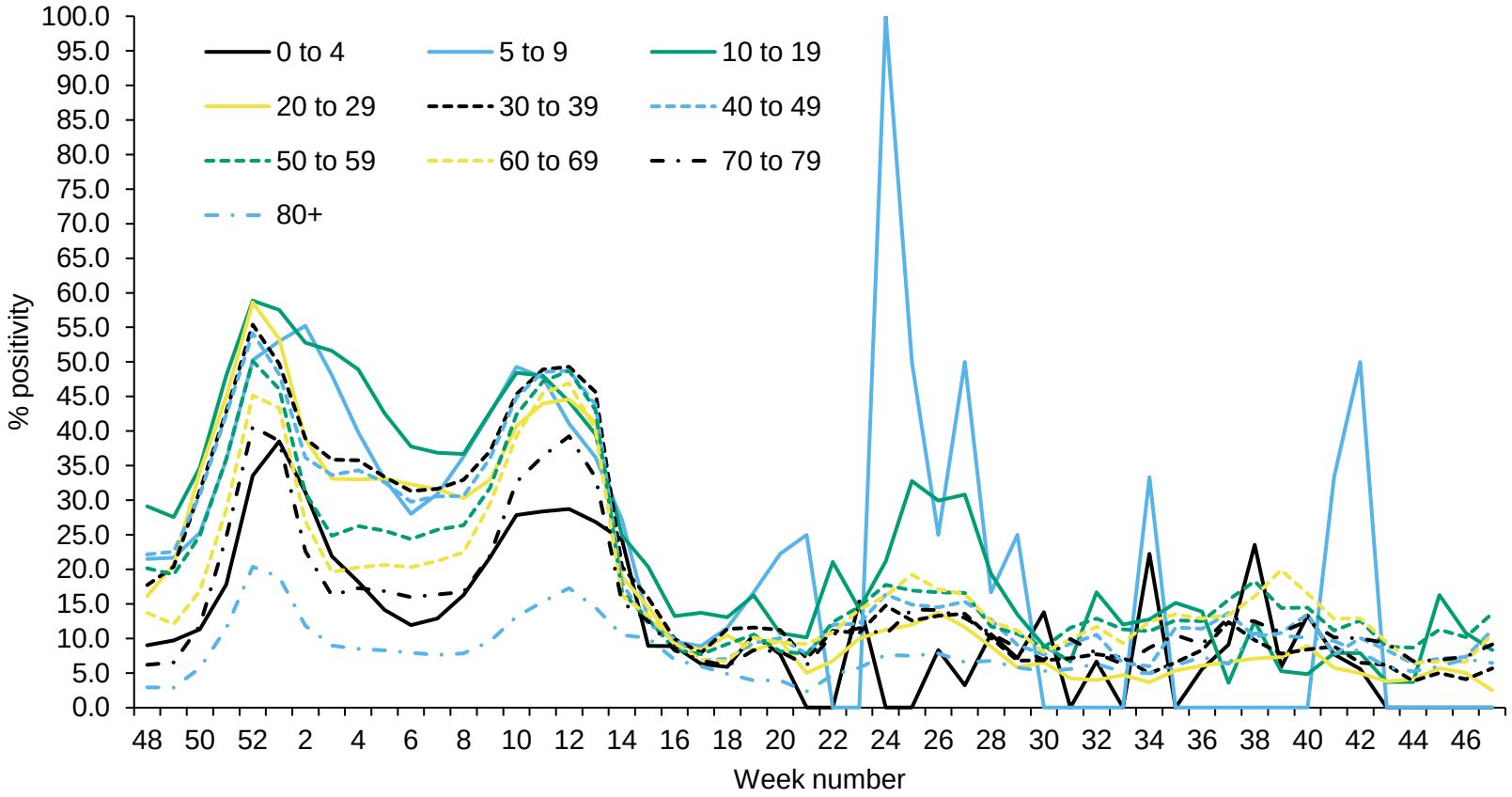
Weekly PCR positivity (%) of confirmed COVID-19 cases tested under Pillar 2, by male and age group



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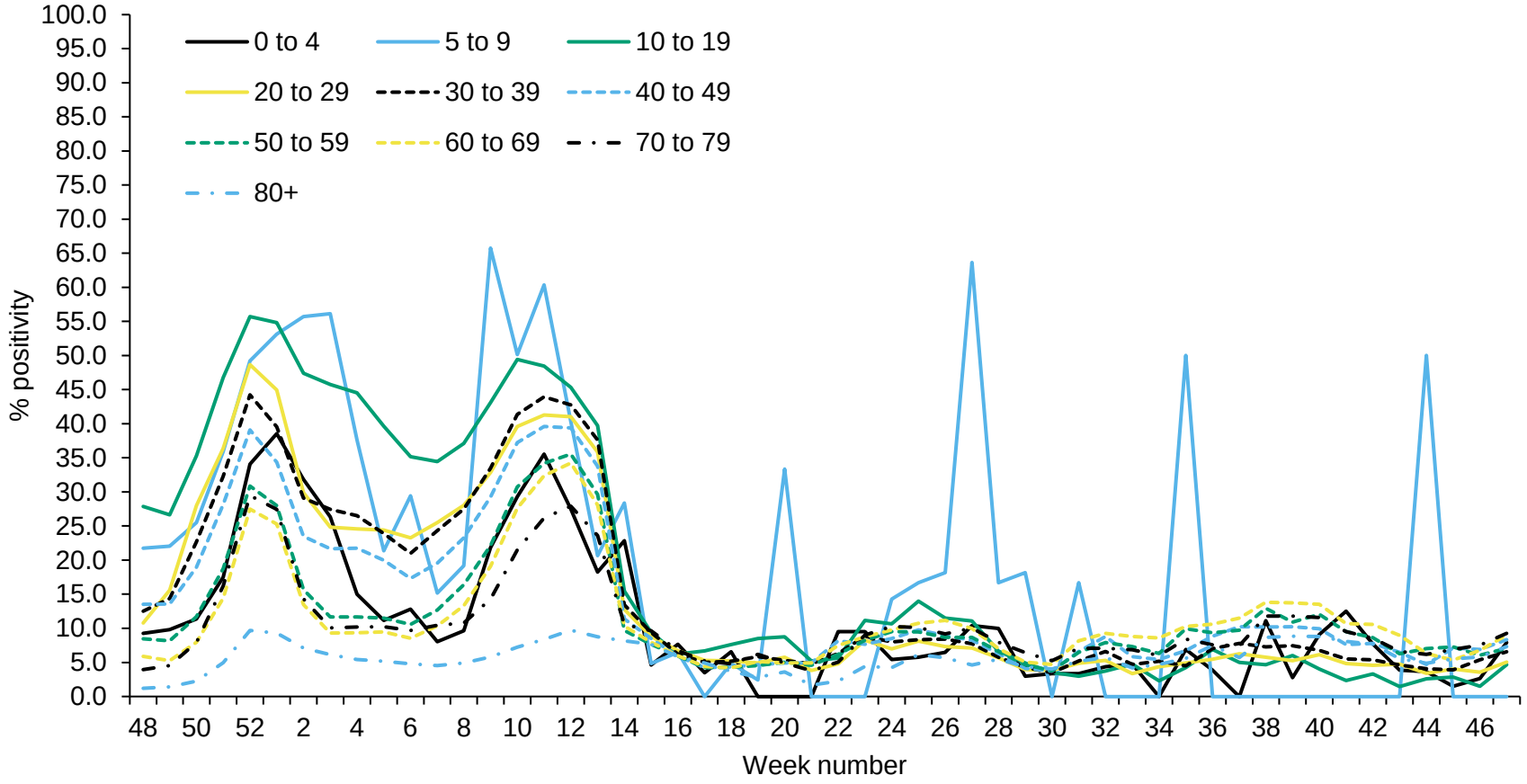
Weekly PCR positivity (%) of confirmed COVID-19 cases tested under Pillar 2, by female and age group



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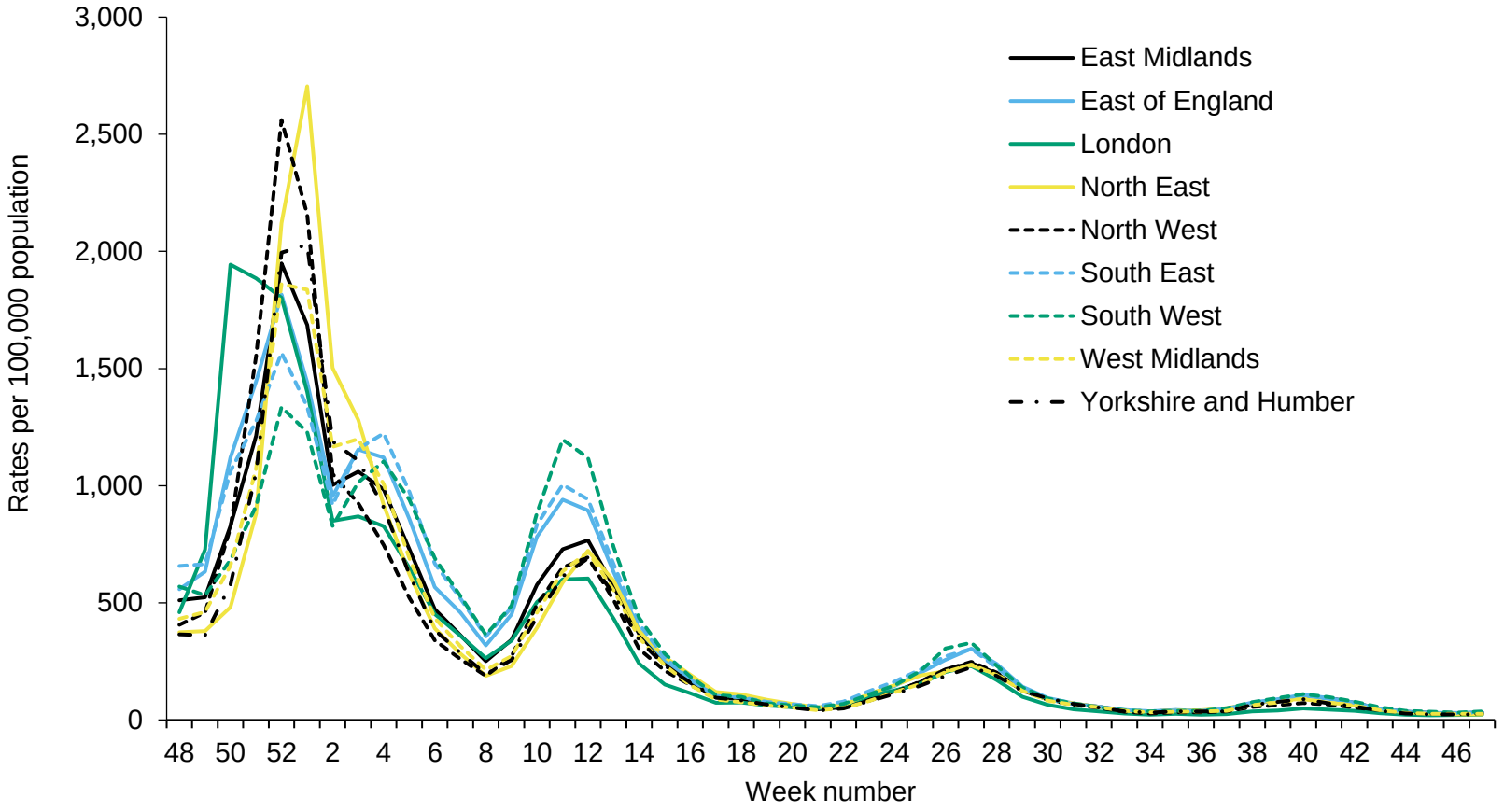
Weekly confirmed COVID-19 case rates by episode, per 100,000 population (Pillar 2), by UKHSA centres and sample week



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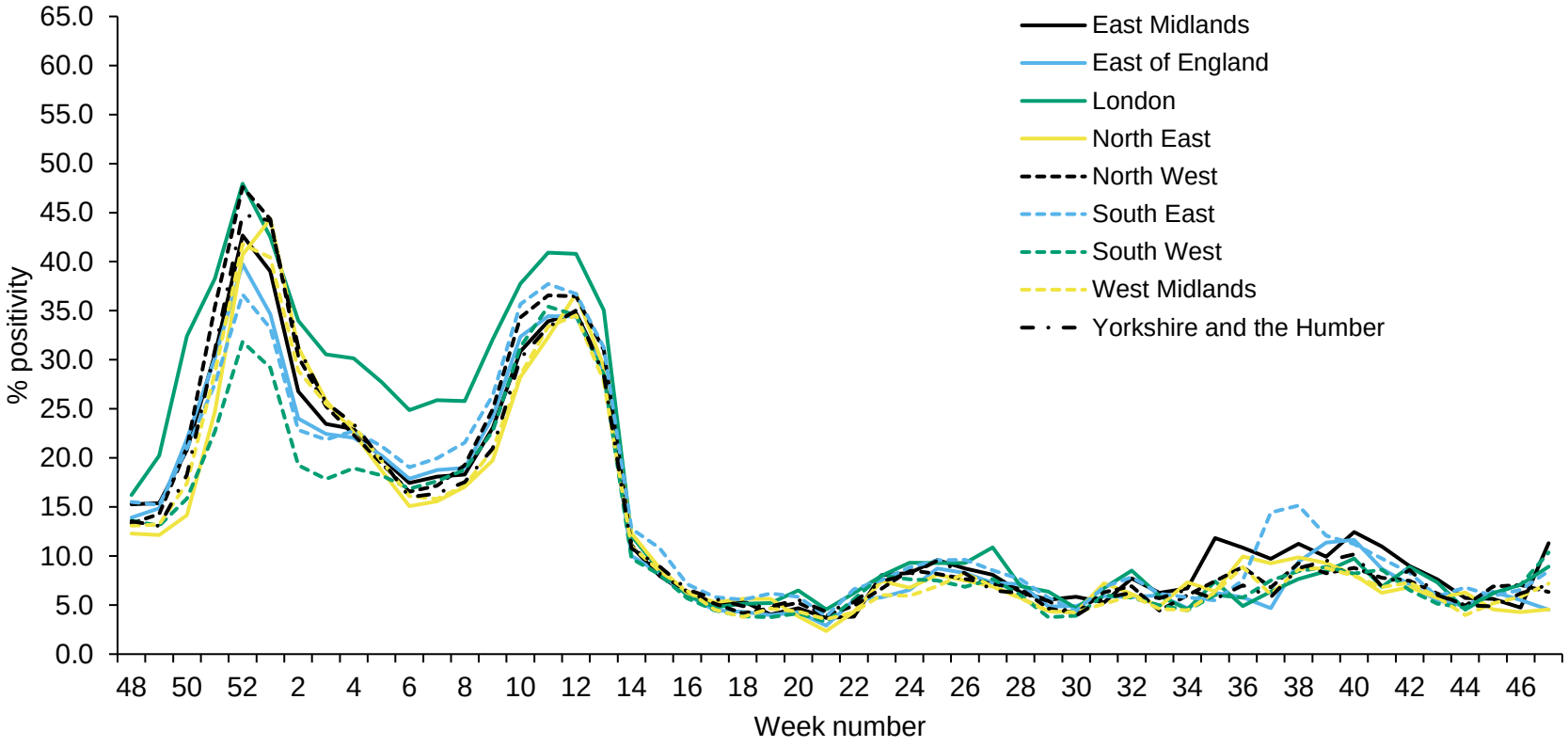
Weekly PCR positivity of confirmed COVID-19 cases tested under Pillar 2 (%) by UKHSA centres and sample week



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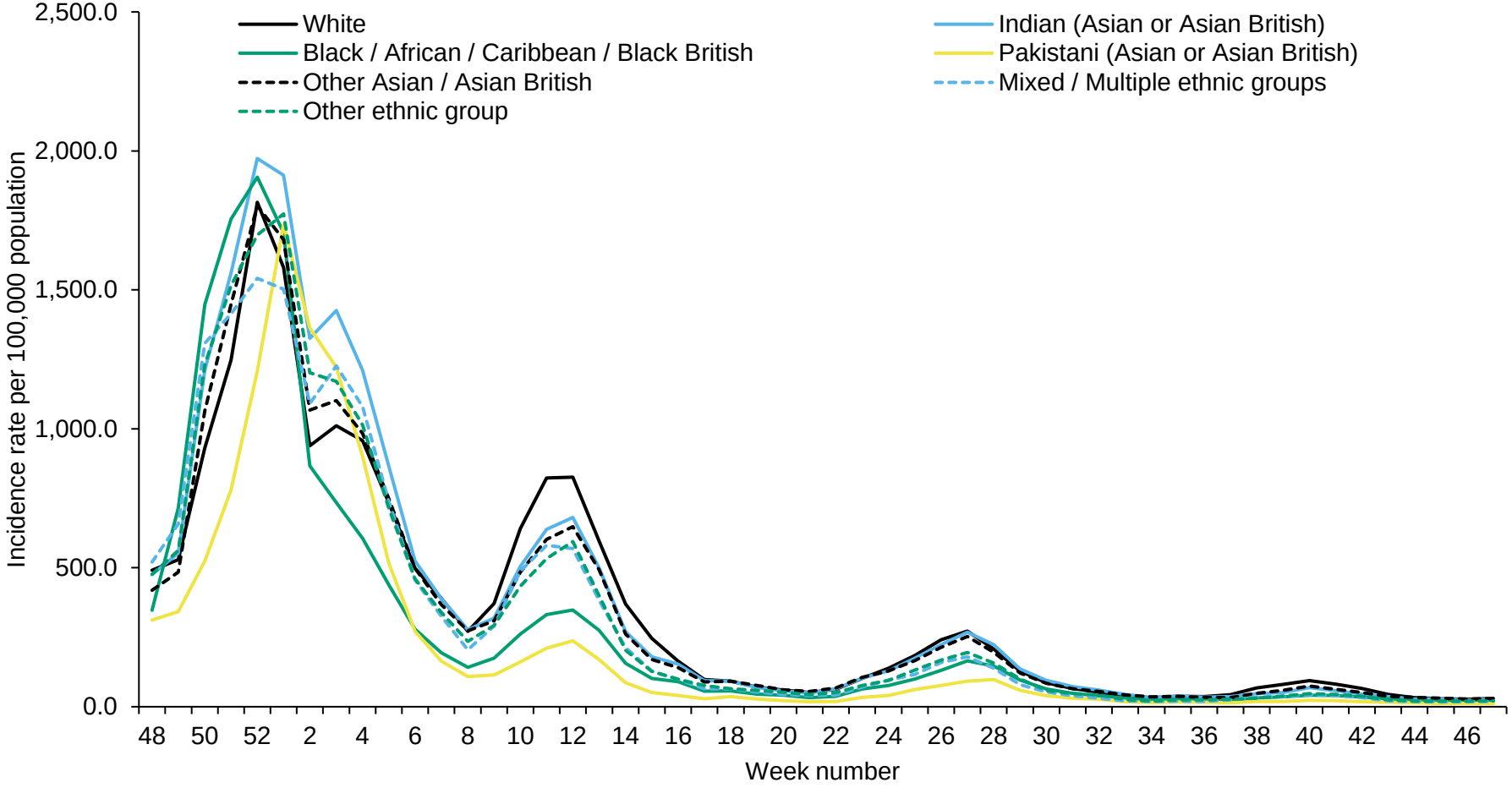
Weekly incidence per 100,000 population by ethnicity (Pillar 2), England



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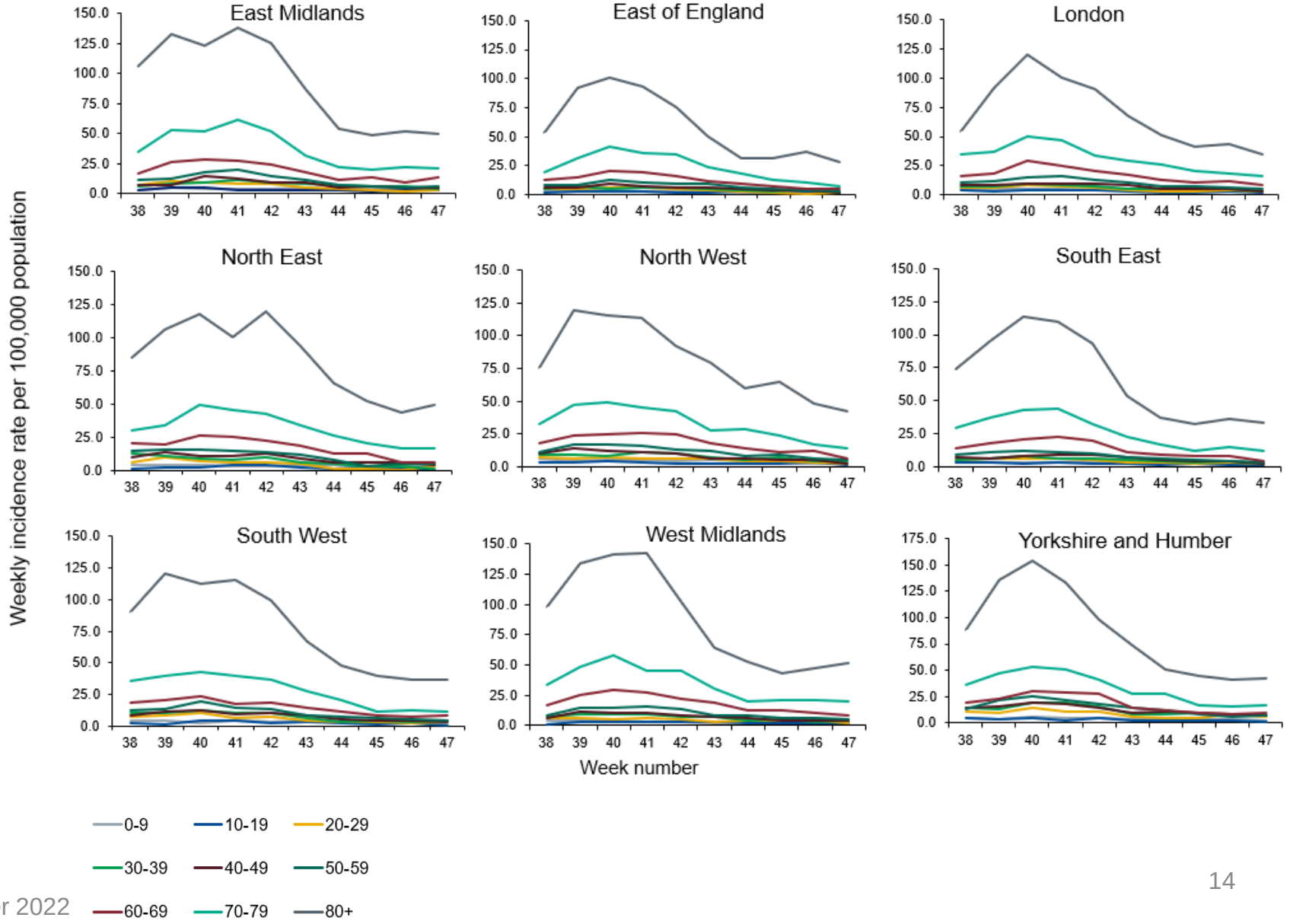
Weekly COVID-19 episodes tested under Pillar 1, per 100,000 population by age group and region, weeks 38 to 47



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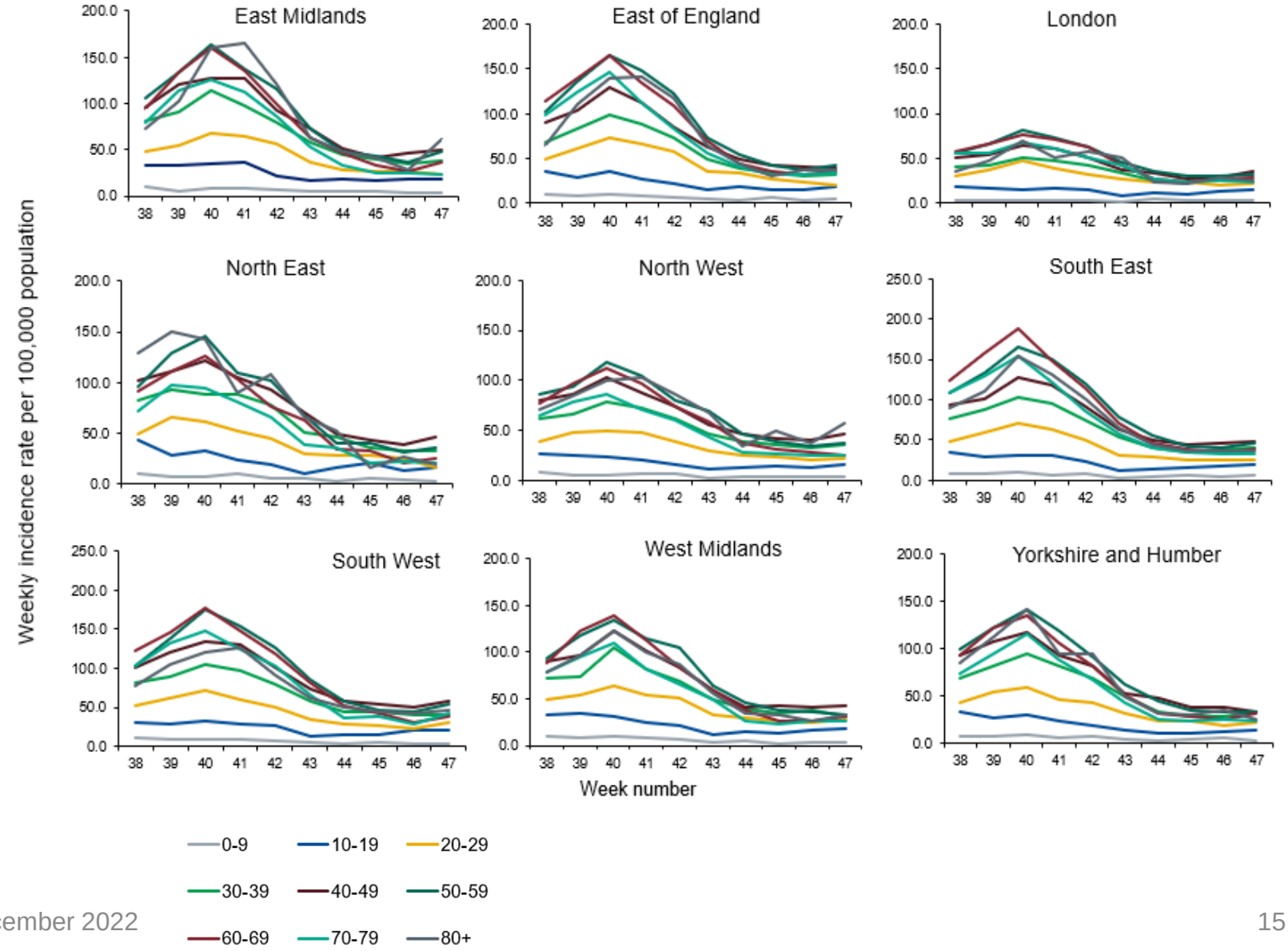
Weekly COVID-19 episodes tested under Pillar 2, per 100,000 population by age group and region, weeks 38 to 47



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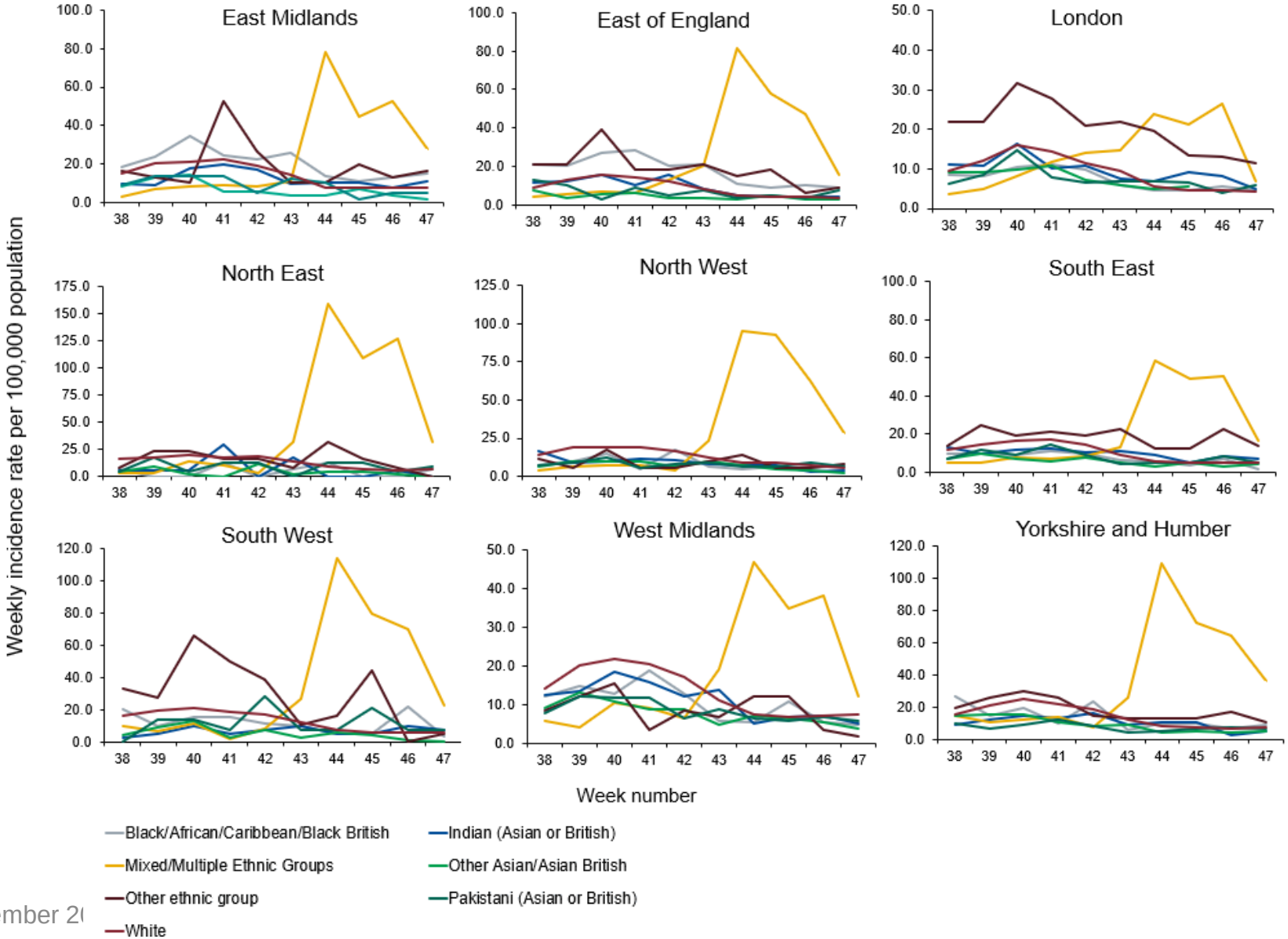
Weekly COVID-19 episodes tested under Pillar 1, per 100,000 population by ethnicity and region, weeks 38 to 47



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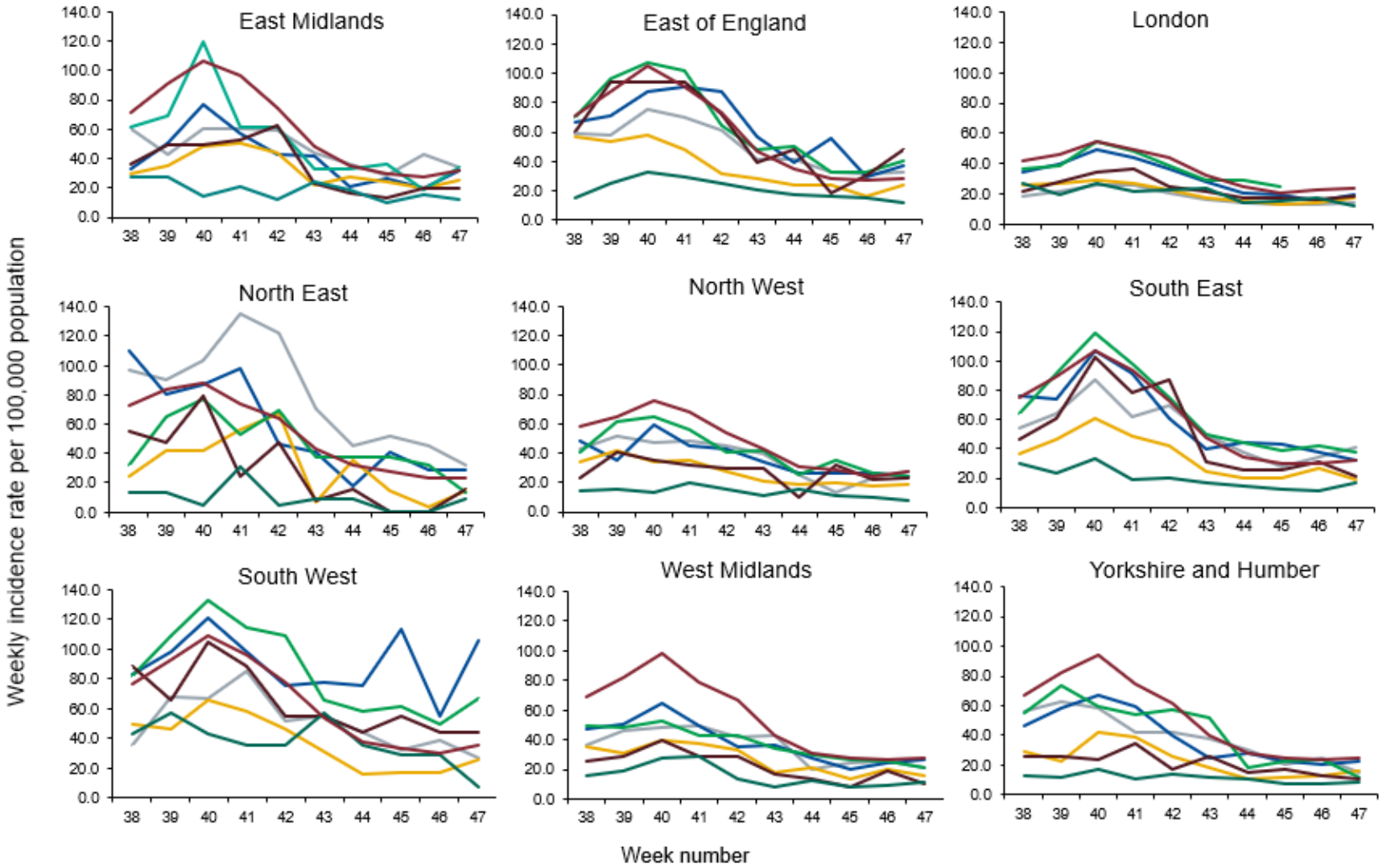
Weekly COVID-19 episodes tested under Pillar 2 per 100,000 population by ethnicity and region, weeks 38 to 47



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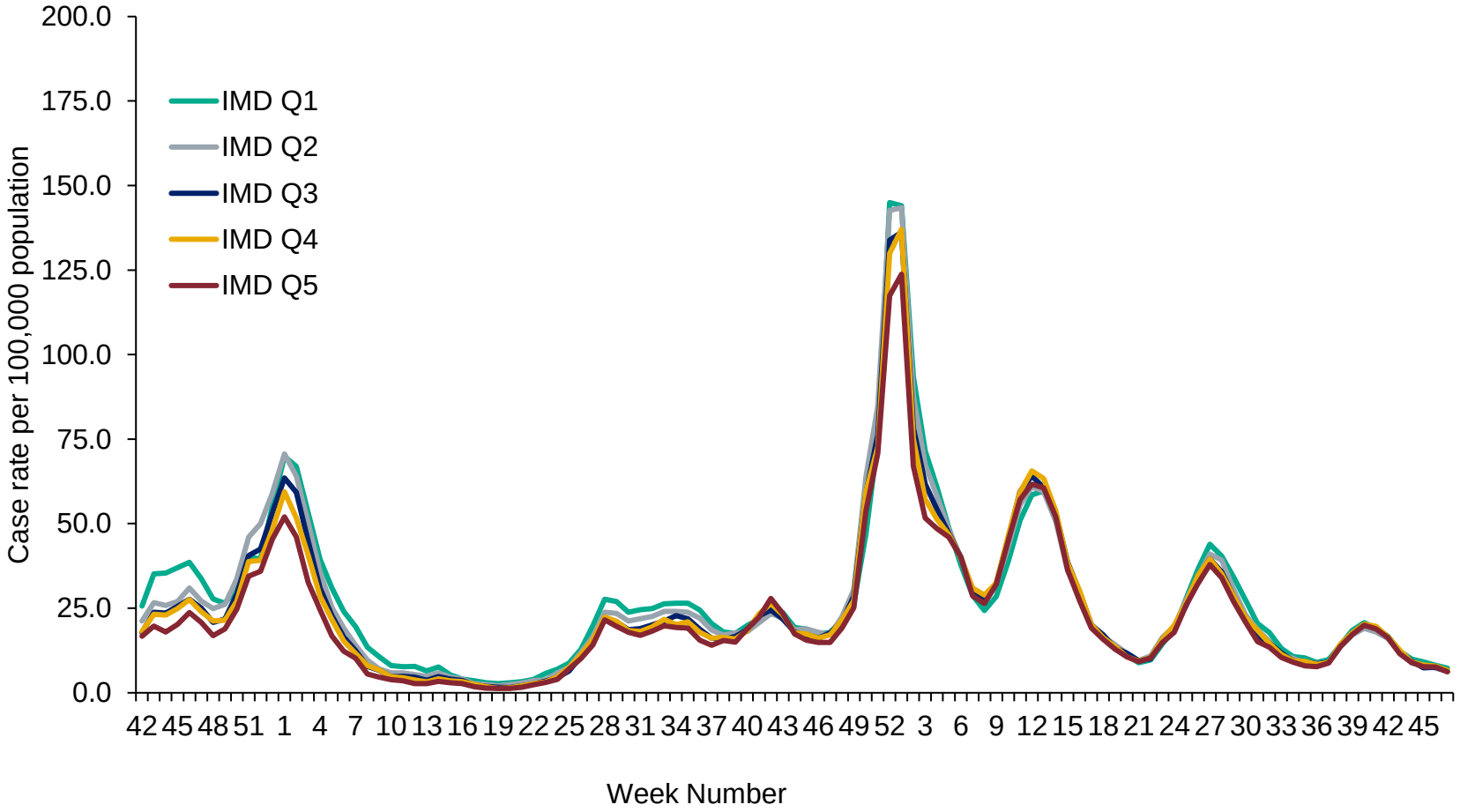
Weekly COVID-19 rate tested under Pillar 1, per 100,000 population by IMD quintile (1 being the most deprived and 5 being the least deprived)



*incidence rates have been calculated using the mid-2019 ONS population estimates

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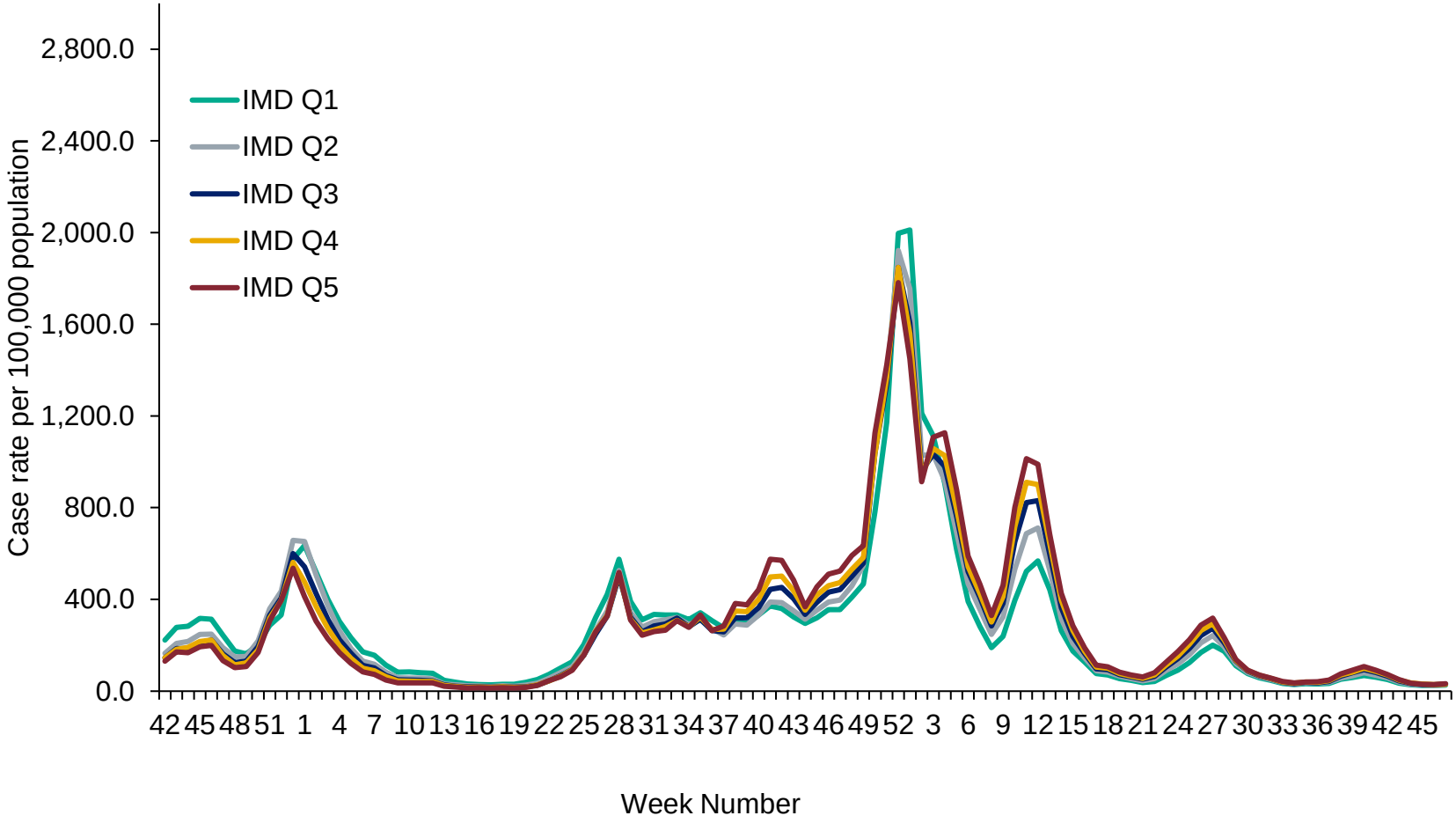
Weekly COVID-19 rate tested under Pillar 2, per 100,000 population by IMD quintile (1 being the most deprived and 5 being the least deprived)



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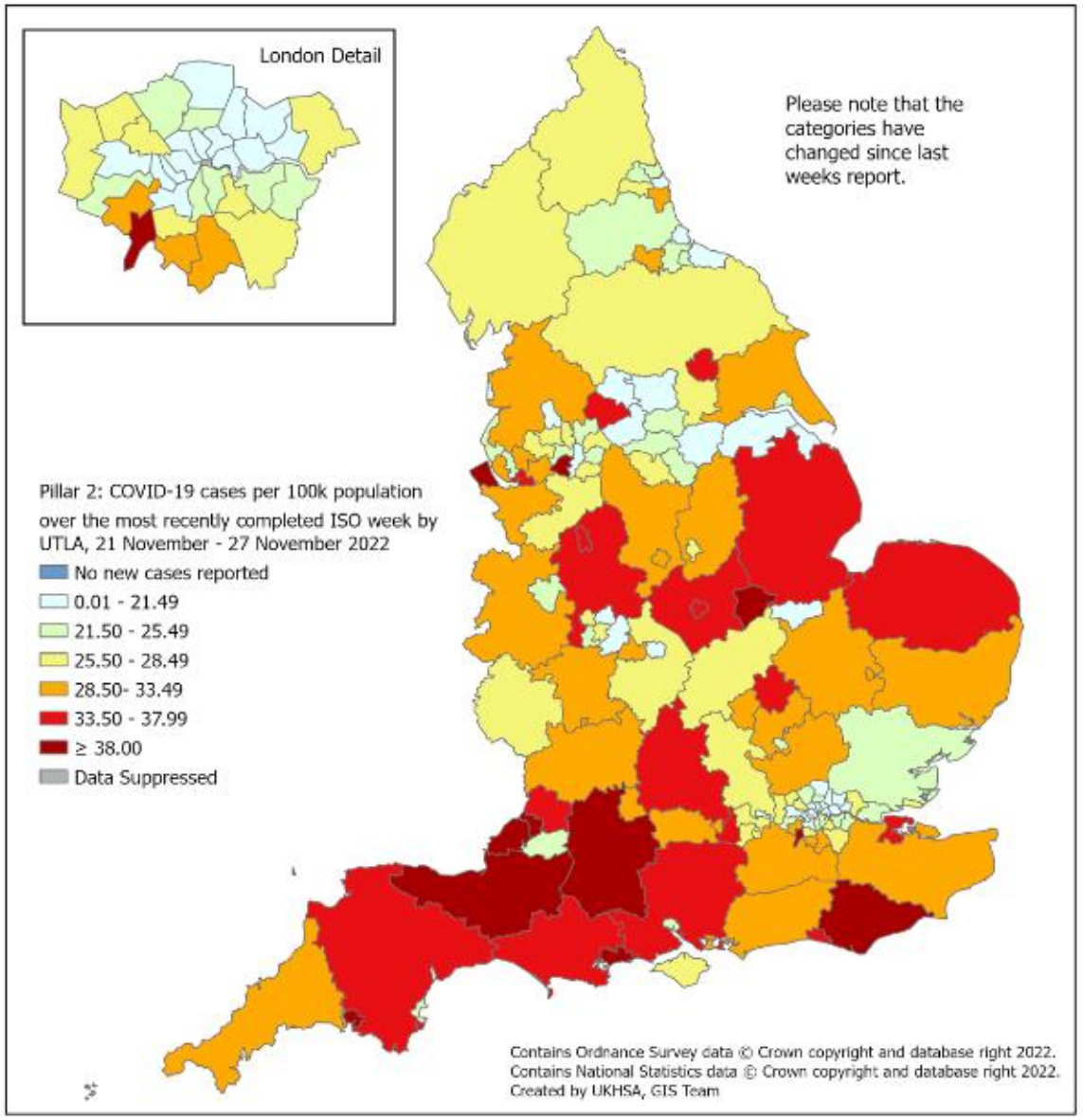
Weekly rate of COVID-19 episodes per 100,000 population (Pillar 2), by upper-tier local authority, England (box shows enlarged map of London area)



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Respiratory Datamart system (England)

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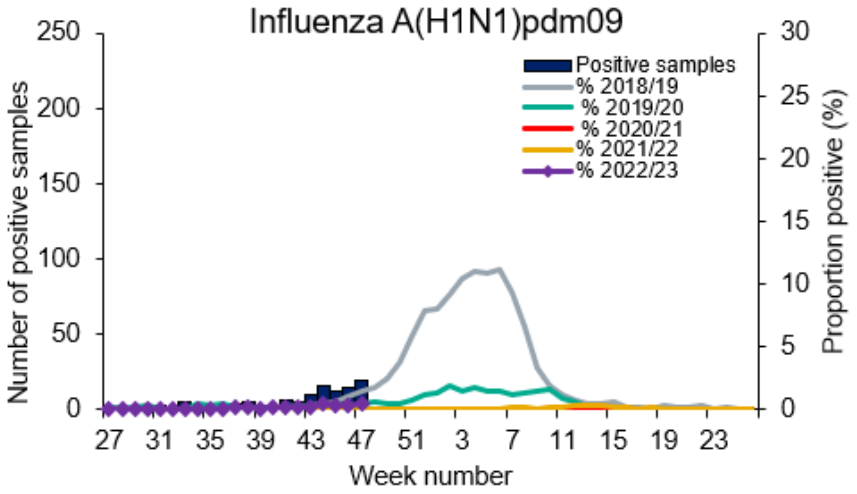
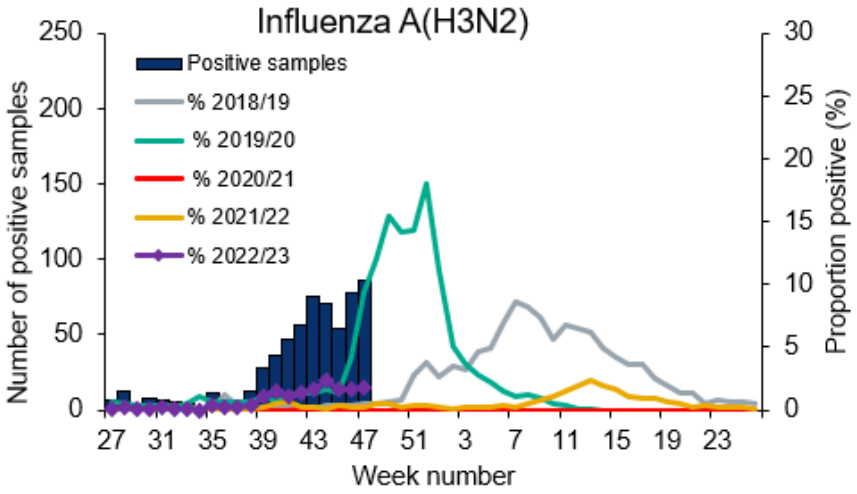
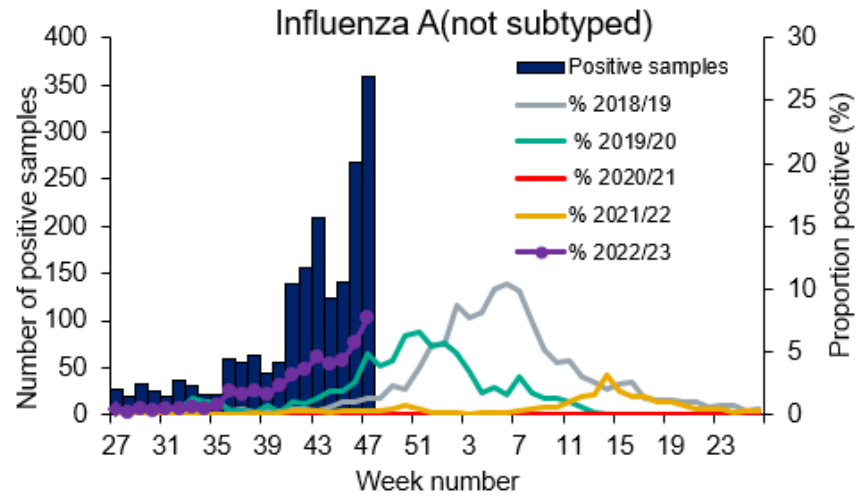
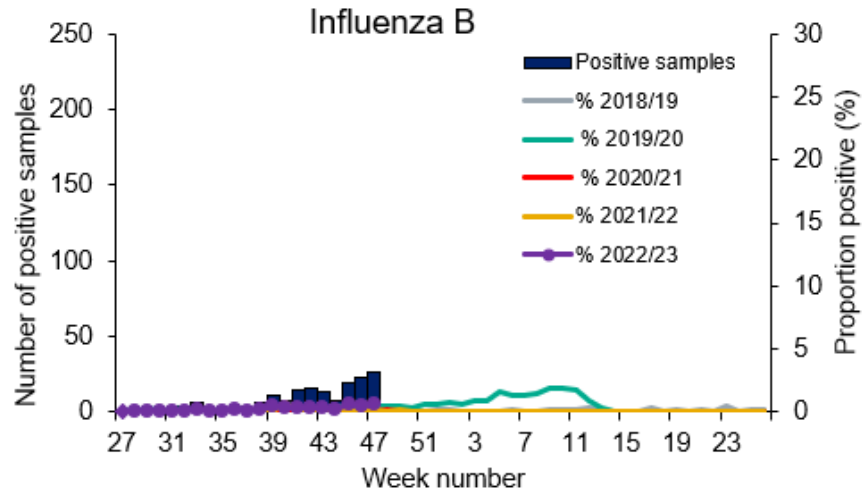
Respiratory DataMart – Influenza subtypes









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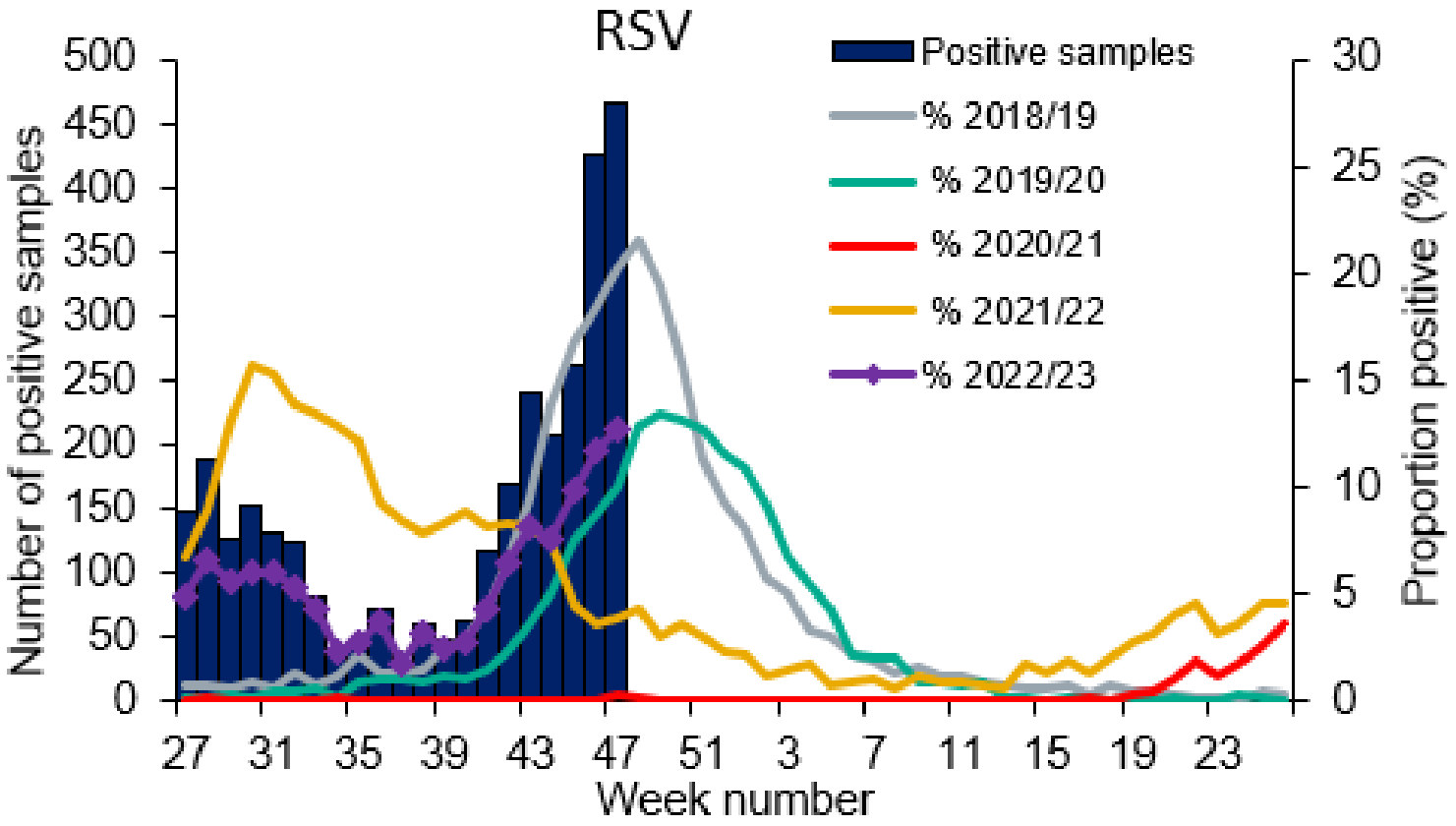
Respiratory DataMart – Respiratory syncytial virus (RSV)



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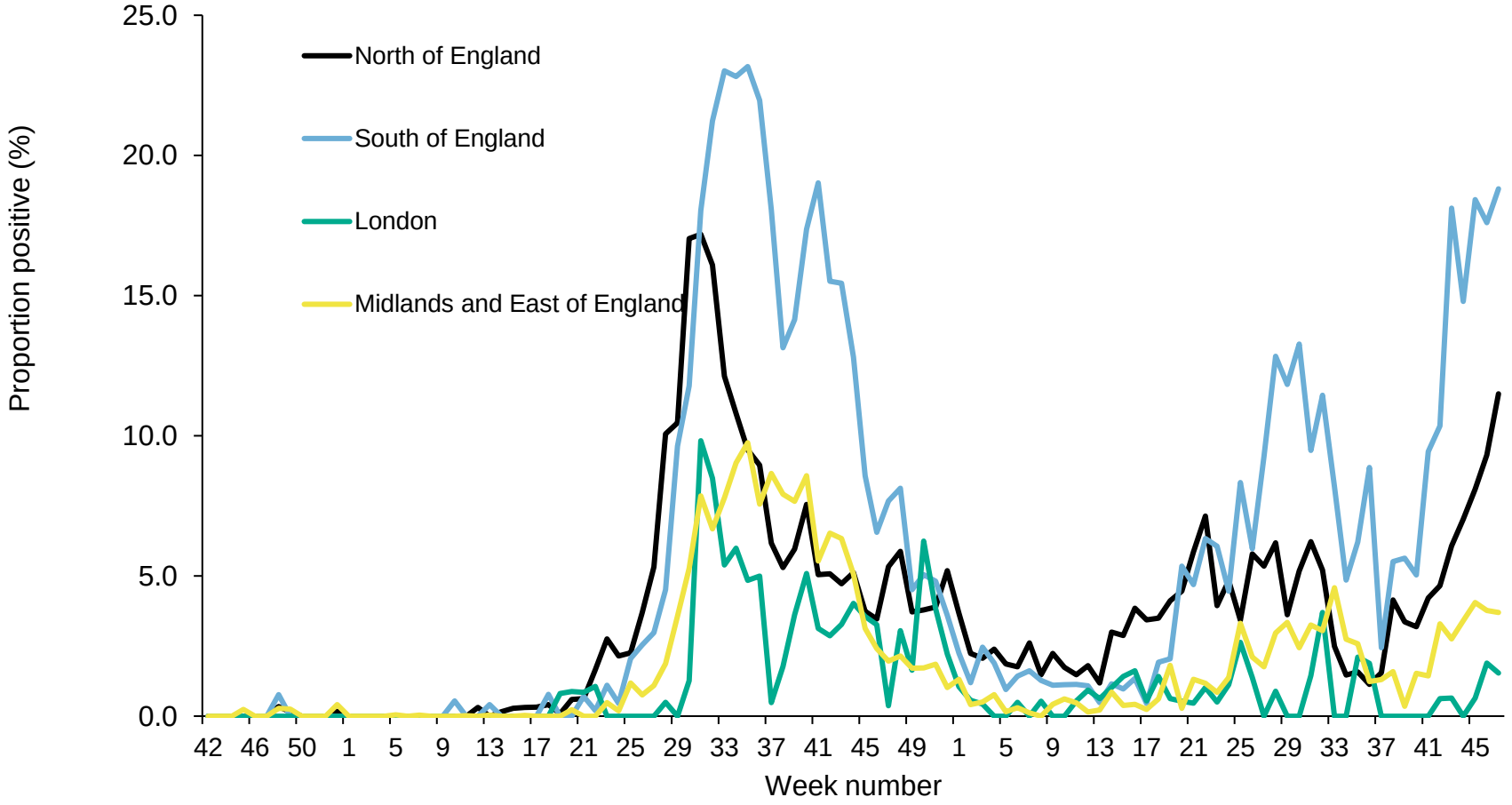
Respiratory DataMart – Respiratory syncytial virus (RSV) weekly positivity by UKHSA region



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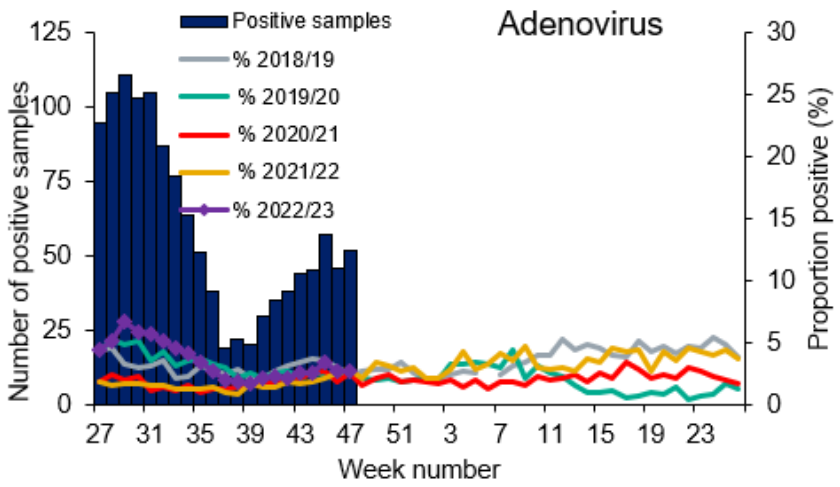
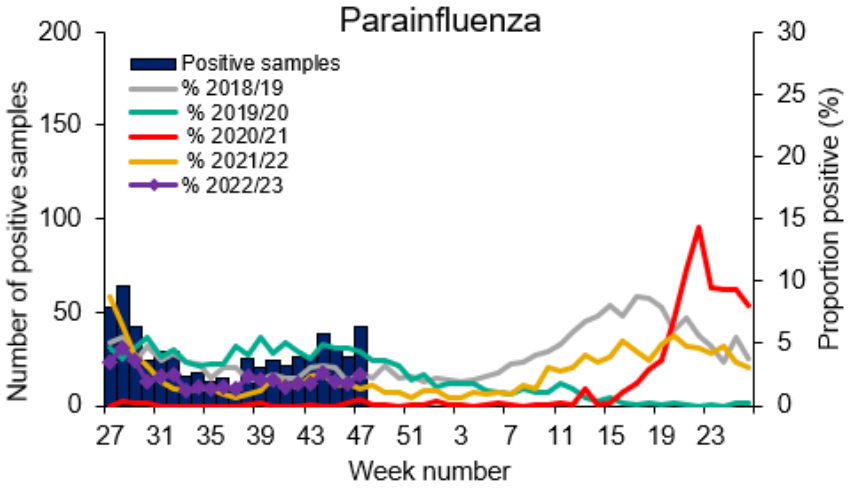
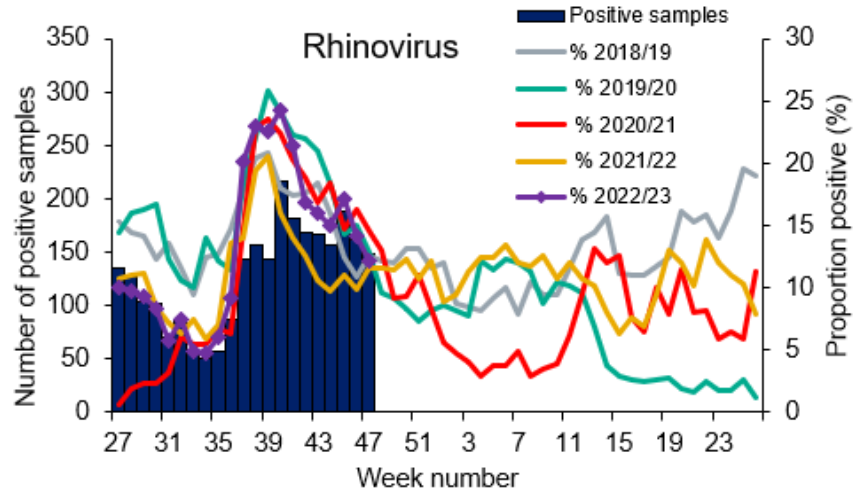
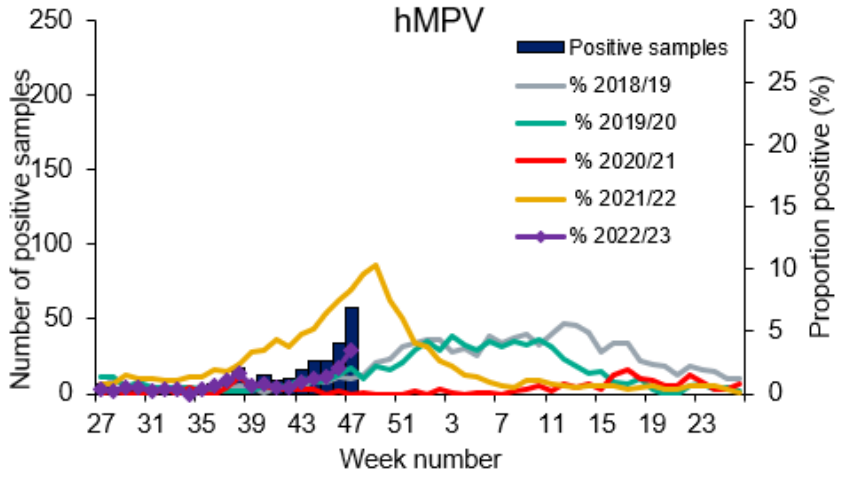
Respiratory DataMart – other respiratory viruses









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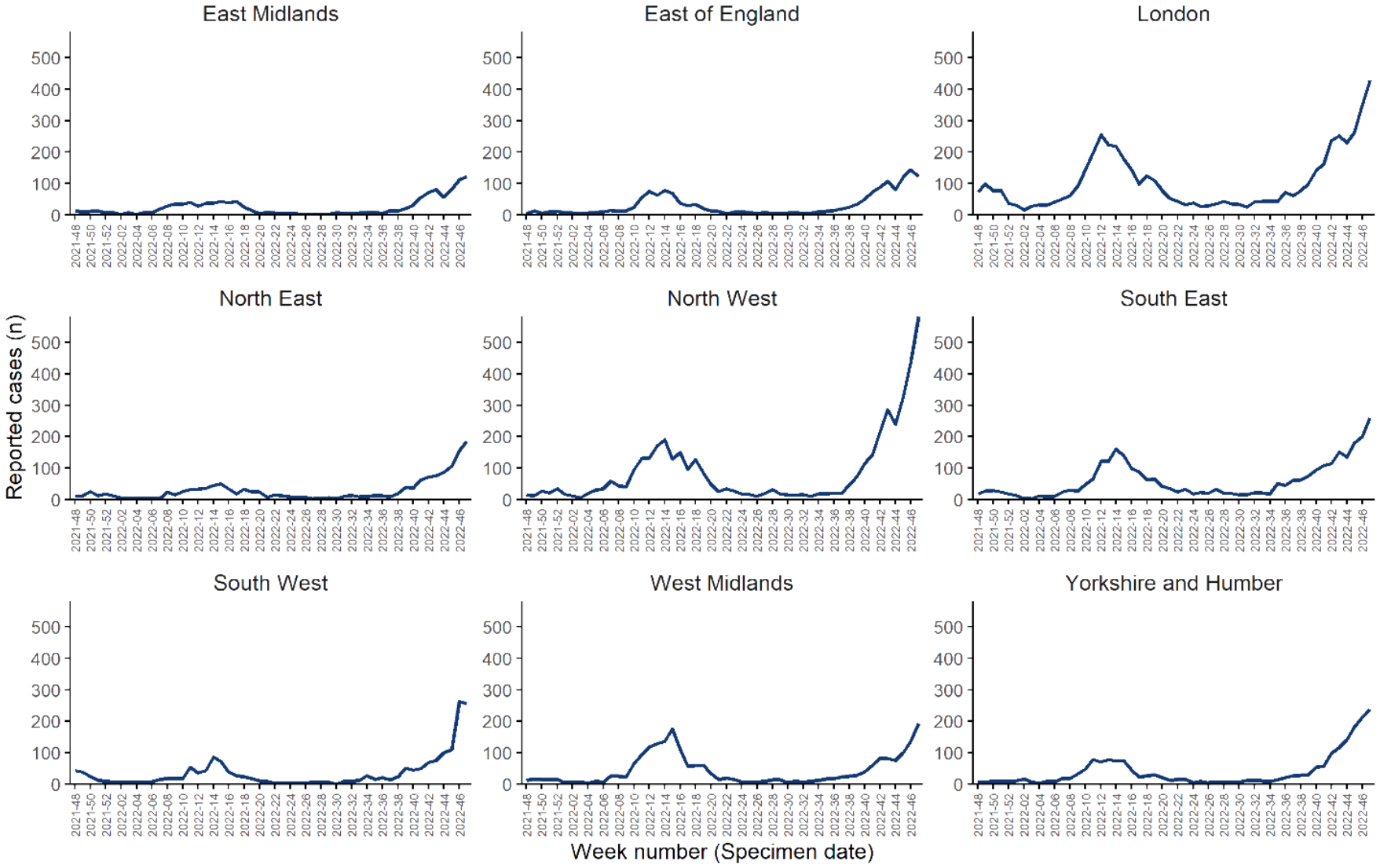
Second generation surveillance system (SGSS)

SGSS reported Influenza A cases by region (all ages)



The presented figures are based on laboratory reports through SGSS. Testing and reporting procedures vary by virus, UKHSA centre and over time, including short-term trends in testing. Therefore comparisons should be done with caution.

Previously, this data was presented by report date however is now presented by specimen date.

SGSS reported Influenza B cases by region (all ages)

The presented figures are based on laboratory reports through SGSS. Testing and reporting procedures vary by virus, UKHSA centre and over time, including short-term trends in testing. Therefore comparisons should be done with caution.
Previously, this data was presented by report date however is now presented by specimen date.

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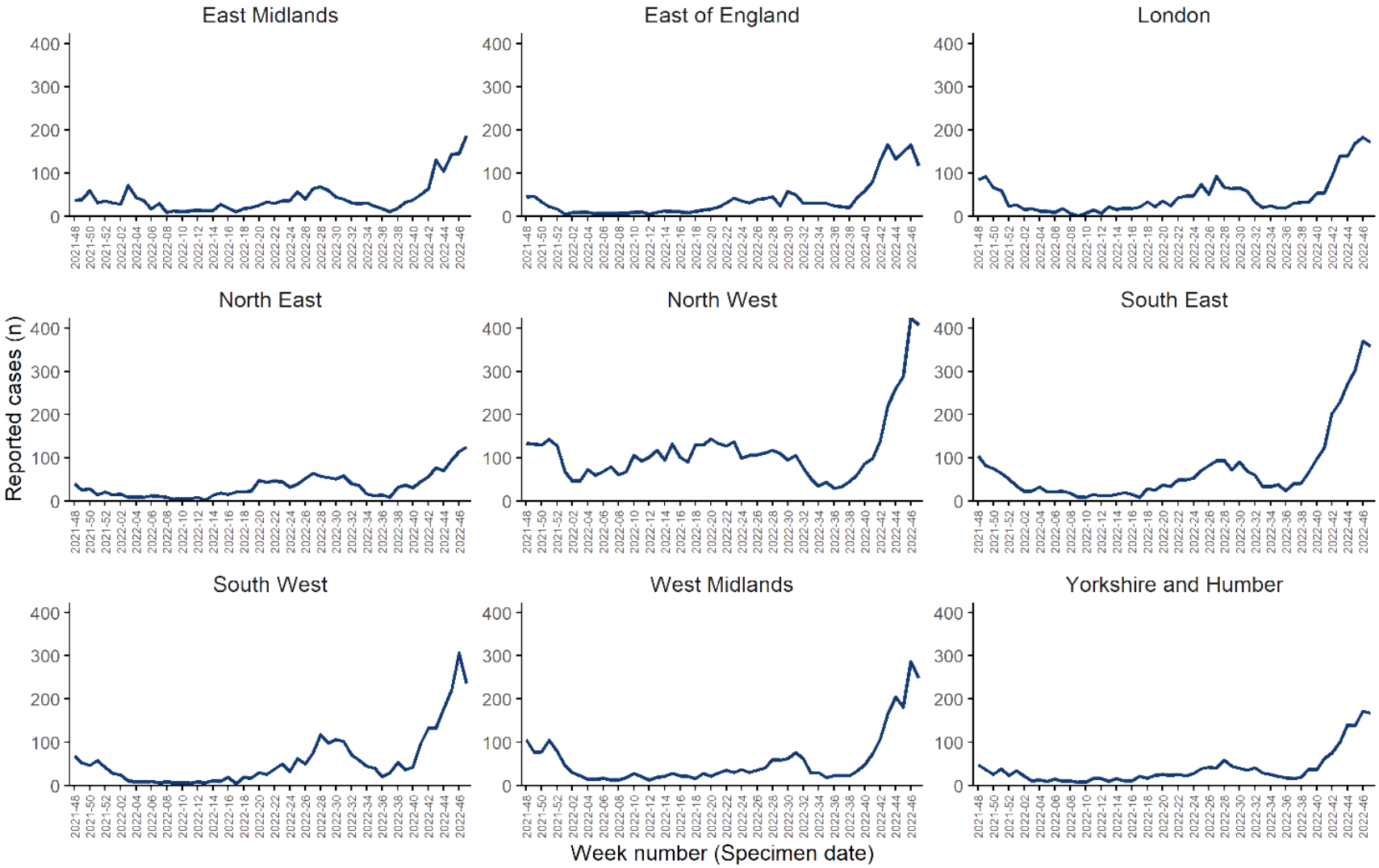
SGSS reported RSV cases by region (all ages)



The presented figures are based on laboratory reports through SGSS. Testing and reporting procedures vary by virus, UKHSA centre and over time, including short-term trends in testing. Therefore comparisons should be done with caution. Previously, this data was presented by report date however is now presented by specimen date.

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SGSS reported Adenovirus cases by region (all ages)

The presented figures are based on laboratory reports through SGSS. Testing and reporting procedures vary by virus, UKHSA centre and over time, including short-term trends in testing. Therefore comparisons should be done with caution.

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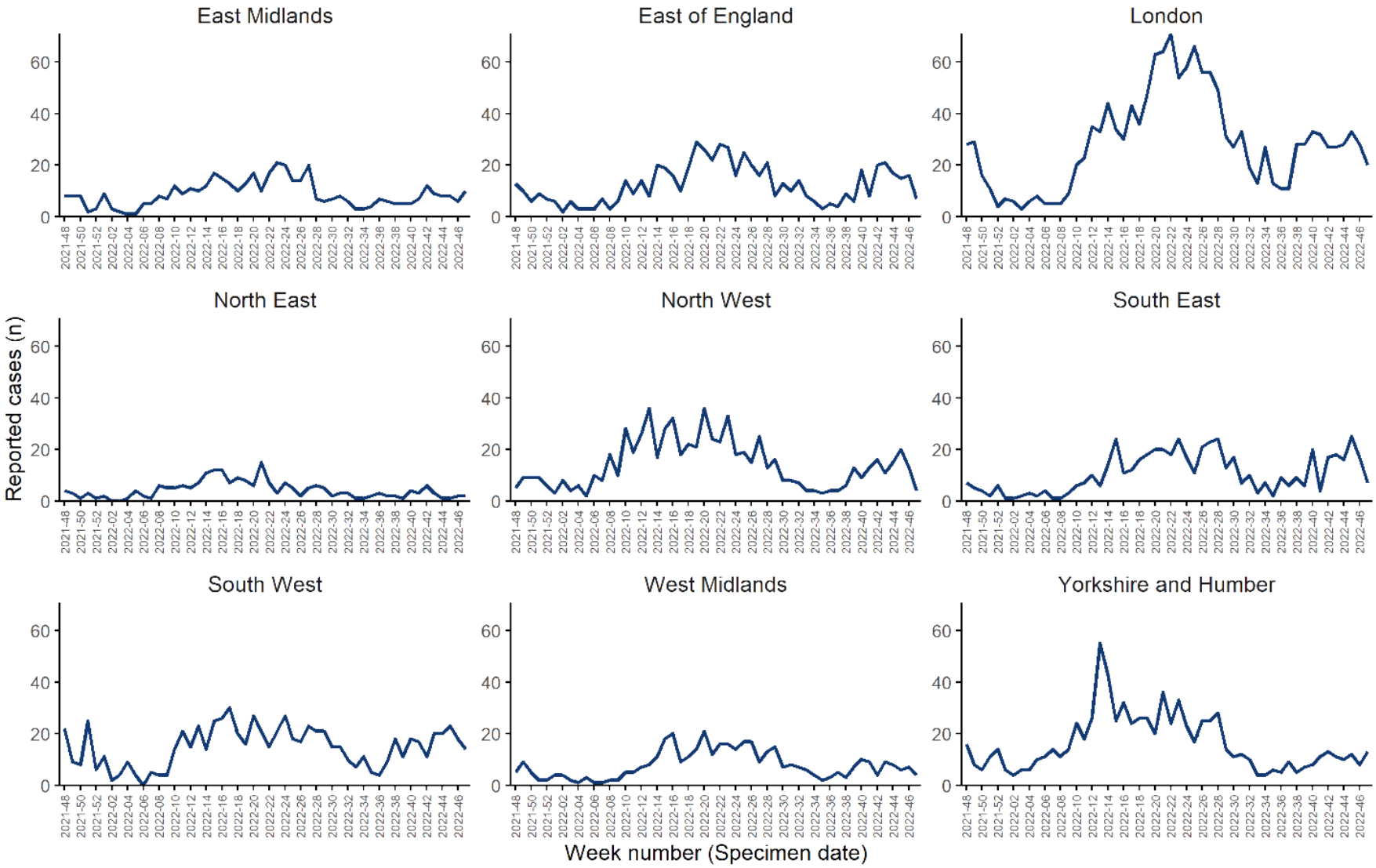
SGSS reported Parainfluenza cases by region (all ages)



The presented figures are based on laboratory reports through SGSS. Testing and reporting procedures vary by virus, UKHSA centre and over time, including short-term trends in testing. Therefore comparisons should be done with caution.

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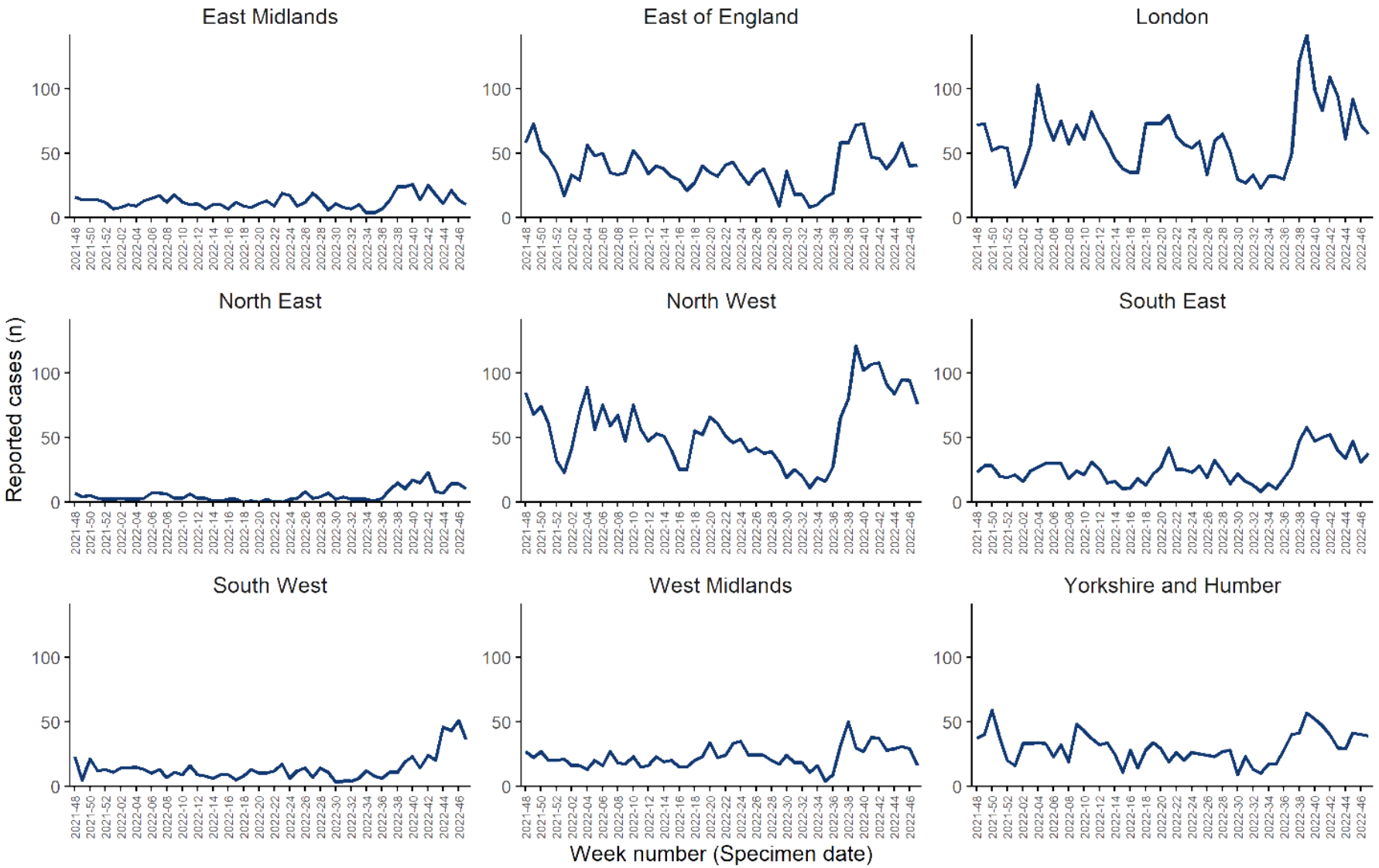
SGSS reported Rhinovirus cases by region (all ages)



The presented figures are based on laboratory reports through SGSS. Testing and reporting procedures vary by virus, UKHSA centre and over time, including short-term trends in testing. Therefore comparisons should be done with caution.

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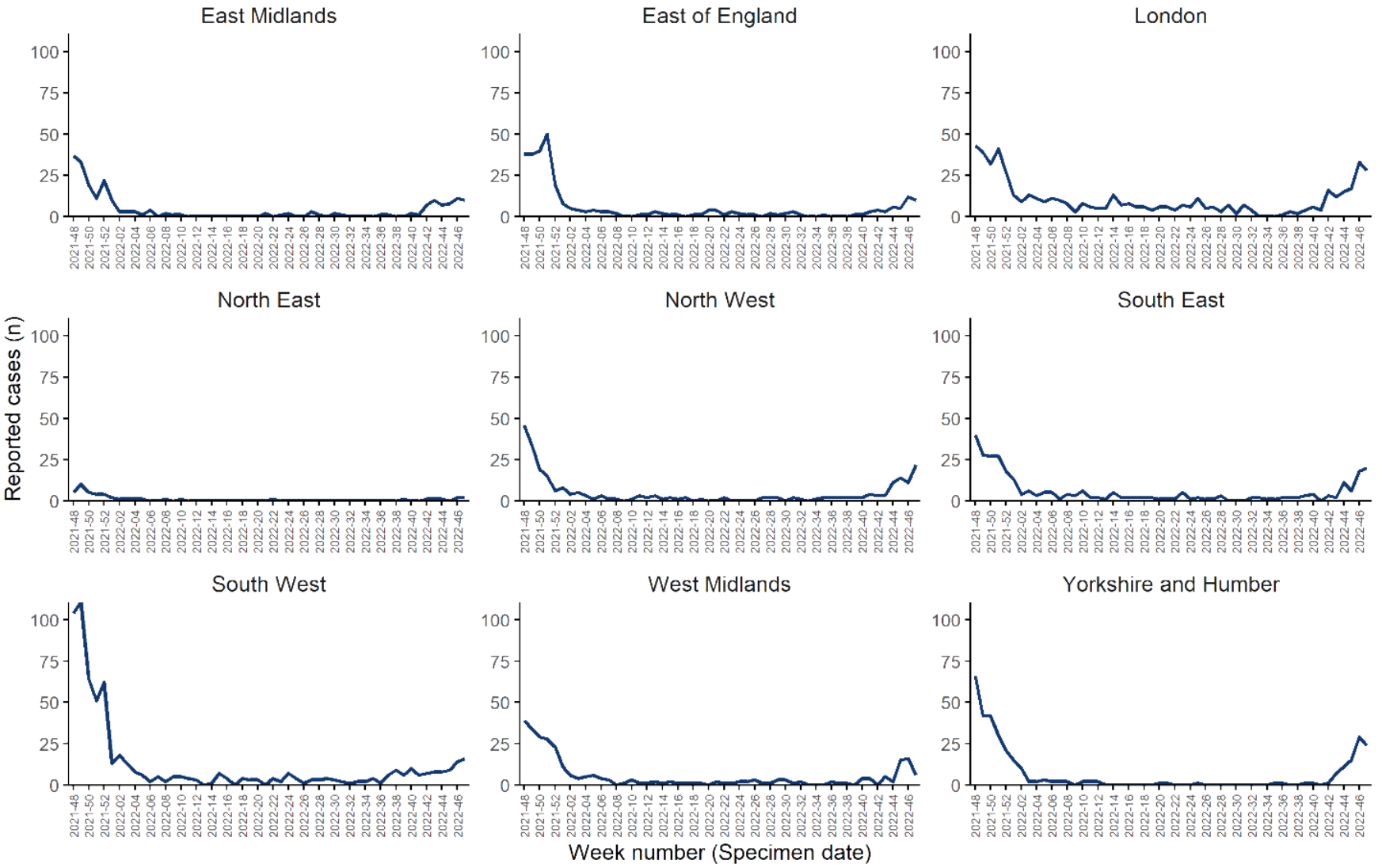
SGSS reported hMPV cases by region (all ages)



The presented figures are based on laboratory reports through SGSS. Testing and reporting procedures vary by virus, UKHSA centre and over time, including short-term trends in testing. Therefore comparisons should be done with caution.

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Community surveillance

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Acute respiratory infection (ARI) outbreaks linked to educational settings

Data Information

- We report on new acute respiratory infection (ARI) incidents reported to UKHSA Health Protection Teams (HPTs) and entered on HPZone in the previous reporting week by setting and locality.

- Daily and weekly aggregated surveillance reports are extracted from HPZone to generate the line listing.

- The weekly extracts include incidents reported in the previous epidemiological week (Monday to Sunday) by locality and context (setting e.g. school)

- The ARI incidents captured on HPZone represent a subset of all ongoing clusters and outbreaks in England rather than an exhaustive listing.

- SARS-CoV2 testing policies and public health guidance for different settings changed over time. This means that any interpretation of seasonal and temporal trends since March 2020 should take this into account.
-
- From week 14 2022 all reported outbreaks are considered suspected, in line with changes in reporting and the implementation of the living with COVID-19 plan. (Prior to this, individual cases notes for situations associated with educational settings were reviewed by an epidemiologist and an assessment made about whether the criteria for a confirmed COVID-19 cluster or outbreak were met).

- The ARI definition includes presentations of both of influenza-like illness (ILI) and other acute viral respiratory infections (AVRI). Causal pathogens can include Influenza A and B, Respiratory Syncytial Virus (RSV), adenovirus, rhinovirus, parainfluenza, human metapneumovirus (hMPV) and SARS-CoV-2.

- For further info please contact: respscidsc@ukhsa.gov.uk

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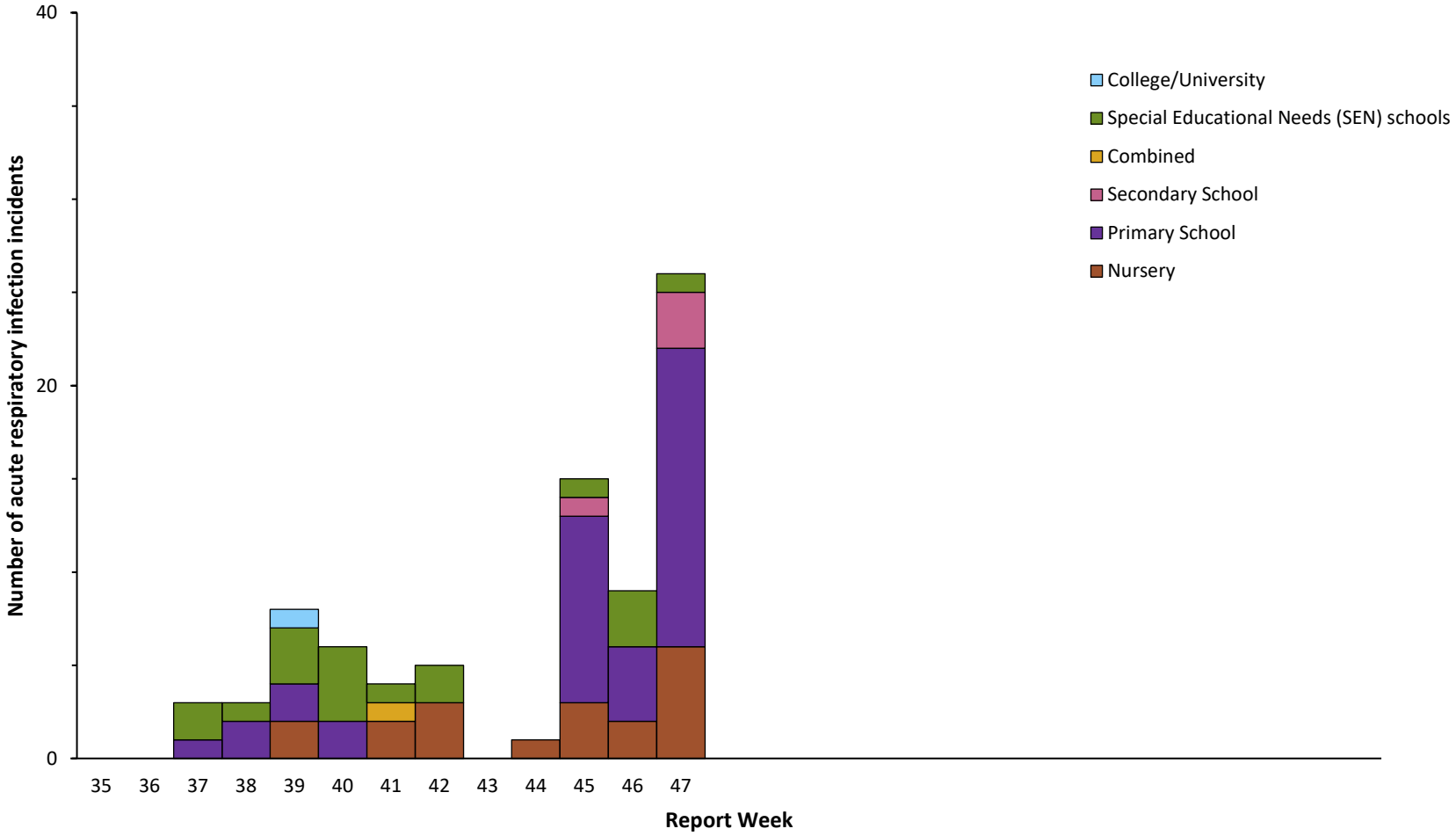
Number of acute respiratory infection outbreaks reported to UKHSA by type of educational setting, England



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Number of acute respiratory infection outbreaks by type of educational setting, England

End of academic year total

Week 35 2021- 34 2022

UKHSA Centres	Cumulative number of suspected acute respiratory infection outbreaks by type of educational setting for the 2021/22 academic year Week 35 2021- 35 2022						
	Nursery	Primary School	Secondary School	Combined	Special Educational Needs (SEN) schools	College University	Total
Total	540	1761	596	161	1306	59	4423

Week 47 2022

Main table

UKHSA Centres	Cumulative number of suspected acute respiratory infection incidents by type of educational setting for the 2022/23 academic year from Week 35 2022						
	Nursery	Primary School	Secondary School	Combined	Special Educational Needs (SEN) schools	College University	Total
East Midlands Centre	3 (1)	2 (0)	0 (0)	0 (0)	1 (0)	0 (0)	**6 (1)**
East of England Centre	0 (0)	0 (0)	0 (0)	0 (0)	1 (0)	0 (0)	**1 (0)**
London Centre	10 (3)	10 (5)	1 (1)	1 (0)	8 (1)	1 (0)	**31 (10)**
North East Centre	3 (1)	2 (2)	0 (0)	0 (0)	0 (0)	0 (0)	**5 (3)**
North West Center	0 (0)	3 (1)	0 (0)	0 (0)	3 (0)	0 (0)	**6 (1)**
South East Centre	0 (0)	1 (1)	1 (0)	0 (0)	0 (0)	0 (0)	**2 (1)**
South West Centre	1 (0)	2 (0)	0 (0)	0 (0)	3 (0)	0 (0)	**6 (0)**
West Midlands Centre	1 (1)	9 (3)	1 (1)	0 (0)	0 (0)	0 (0)	**11 (5)**
Yorkshire & the Humber	1 (0)	8 (4)	1 (1)	0 (0)	2 (0)	0 (0)	**12 (5)**
Total	**19 (6)**	**37 (16)**	**4 (3)**	**1 (0)**	**18 (1)**	**1 (0)**	**80 (26)**

* Number of acute respiratory infection for the most recent week in brackets

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Secondary Care surveillance

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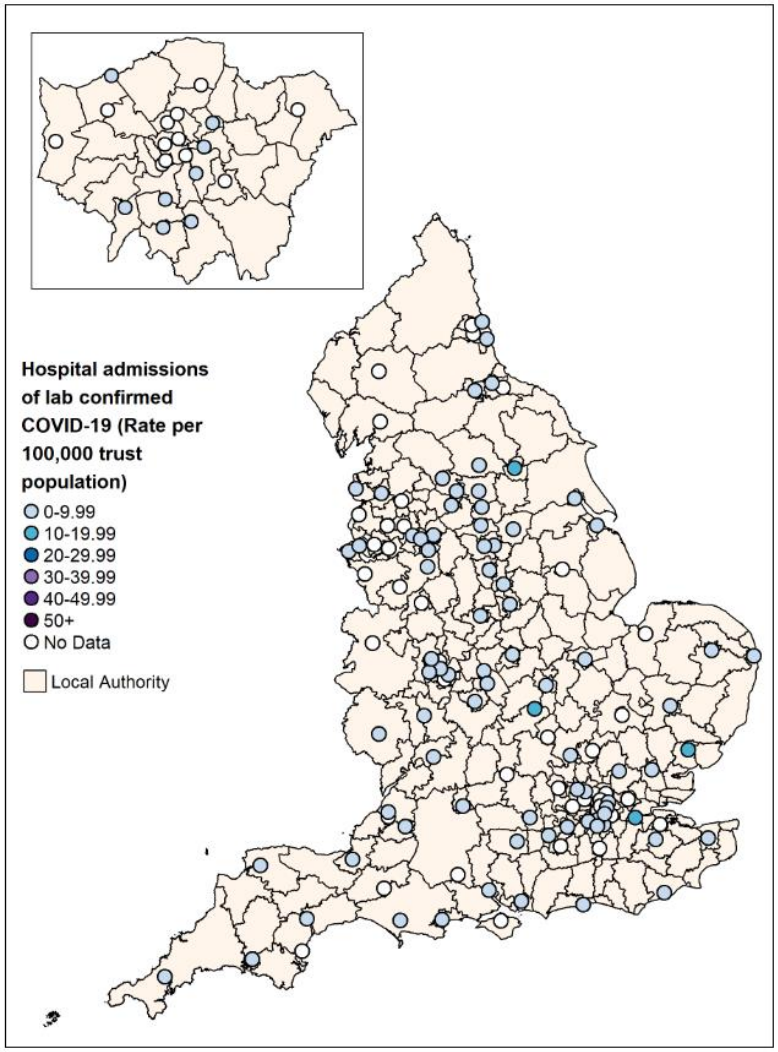
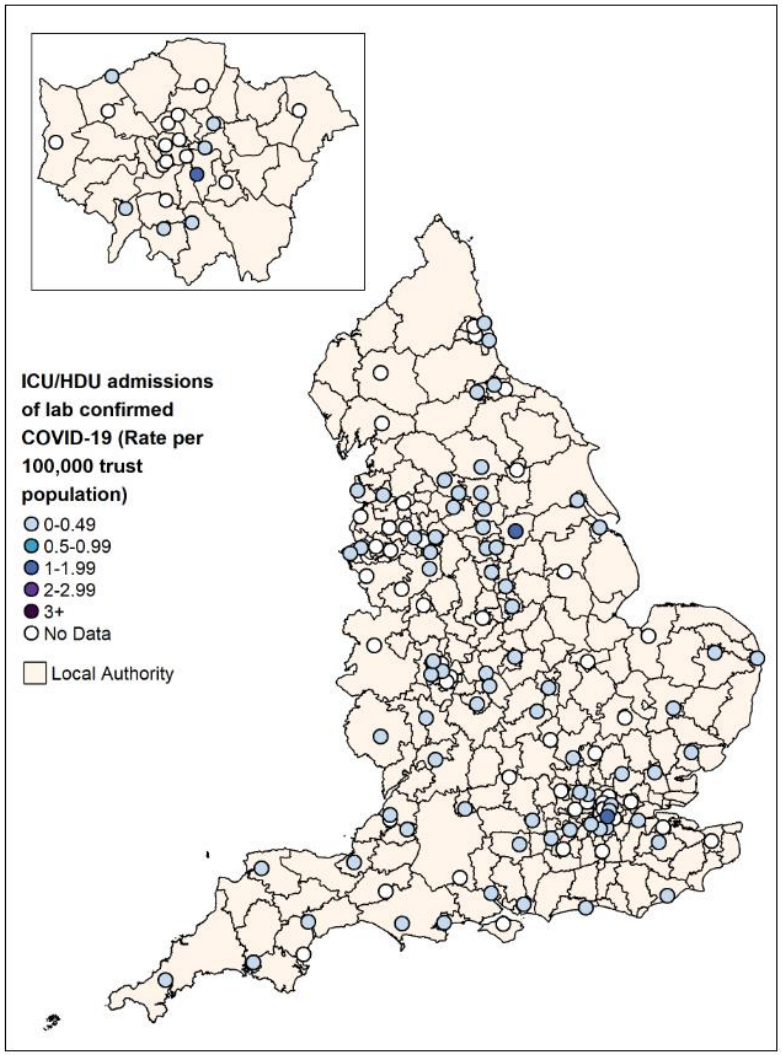
Weekly admission rates for hospital and ICU/HDU laboratory confirmed COVID-19 cases reported through SARI Watch, week 47





Source: UKHSA SARI-Watch (Severe Acute Respiratory Infection-Watch, formerly CHESS).

*Only NHS Acute trusts that have reported **≥1** day in the past week; excludes Specialist trusts. Acute NHS trusts (including Specialist trusts) reporting into SARI-Watch COVID-19 hospitalisation surveillance are typically around 100 per week. This was 90 for the hospitalisation (all levels of care) indicator in week 21 November 2022 to 27 November inclusive and 82 trusts for the ICU/HDU indicator. For the maps, as Specialist trusts are excluded, the number of trusts providing data on COVID-19 hospitalisations in week ending 27 November 2022 was 81 and 74 for ICU/HDU admissions for COVID-19.

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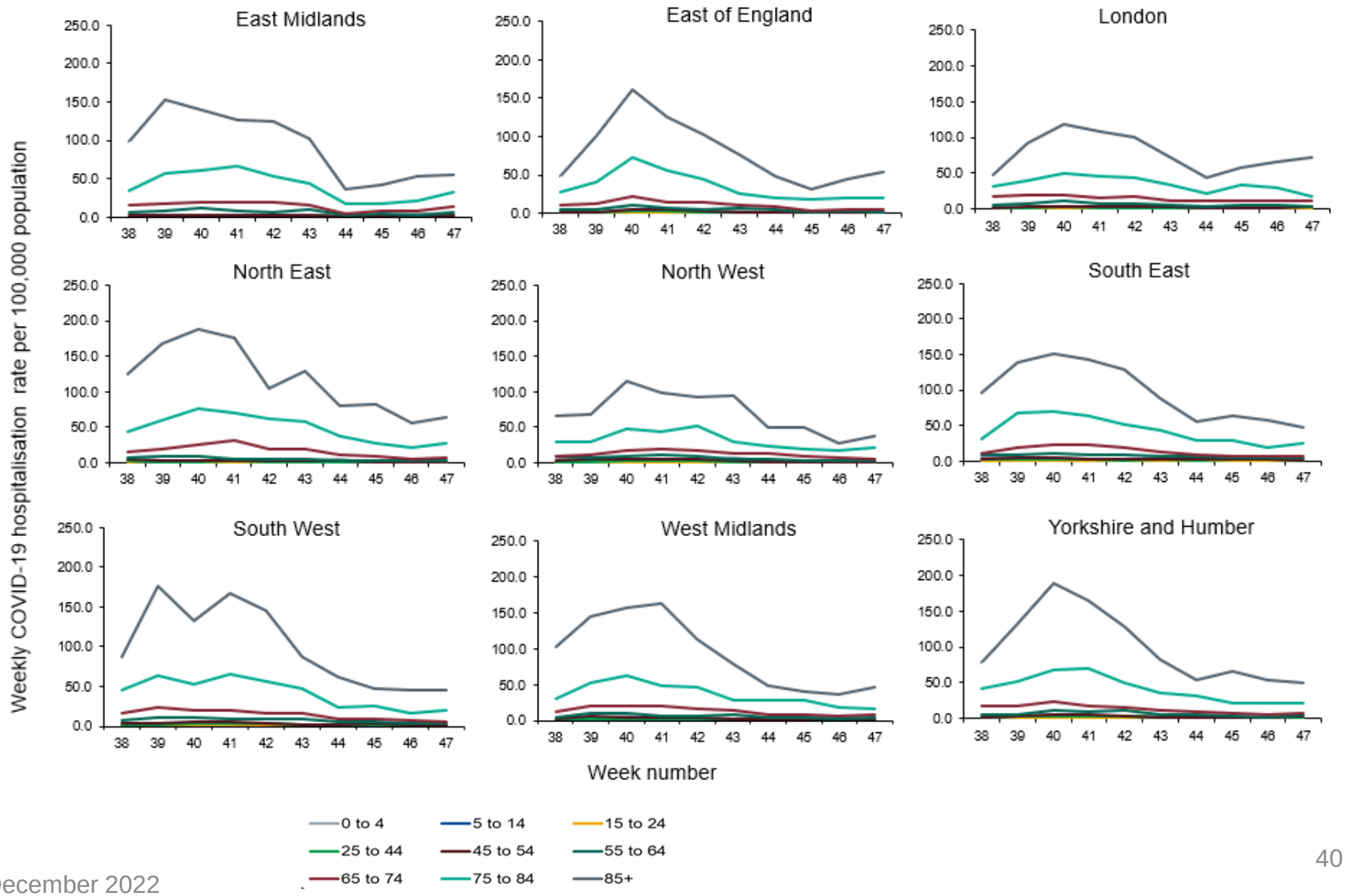
Weekly COVID-19 hospitalisation rate per 100,000 trust catchment population by age group and region, weeks 38 to 47



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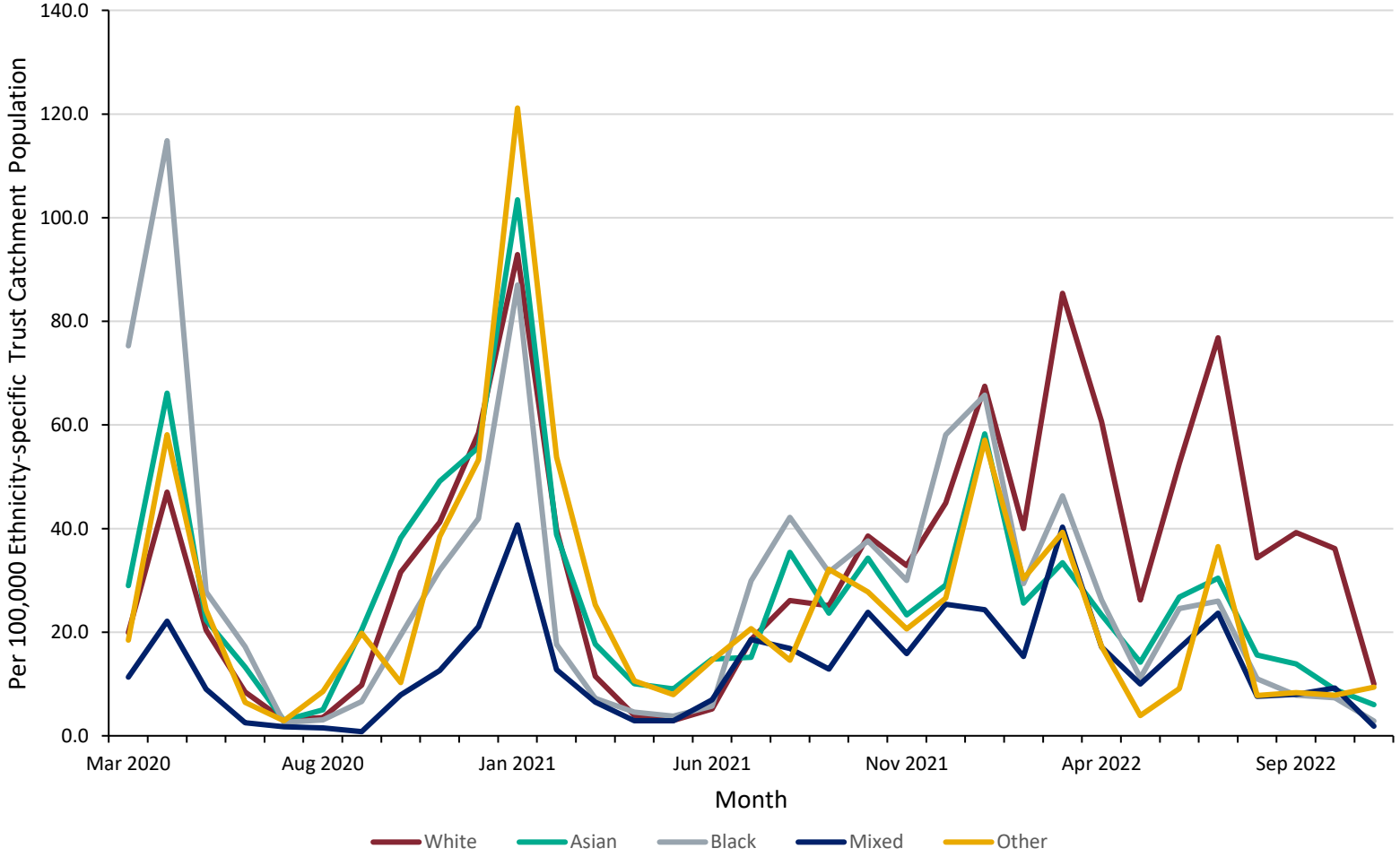
Hospital admission rate (excluding ICU/HDU) by ethnicity per 100,000 trust catchment population, by month



Caveat: From week 24 (2021) the ethnicity analysis is based on a new method for assigning ethnicity, developed by UKHSA. The previous method used the most recent ethnicity recorded through linkage to Hospital Episode Statistics. However, this method led to unfeasibly high rates in the 'Other' ethnic group when applied to COVID-19 cases, hospitalisation or mortality. The new method uses the most frequent ethnicity recorded through linkage to Hospital Episode Statistics, unless the most frequent was 'Other' when the second most frequent was chosen.

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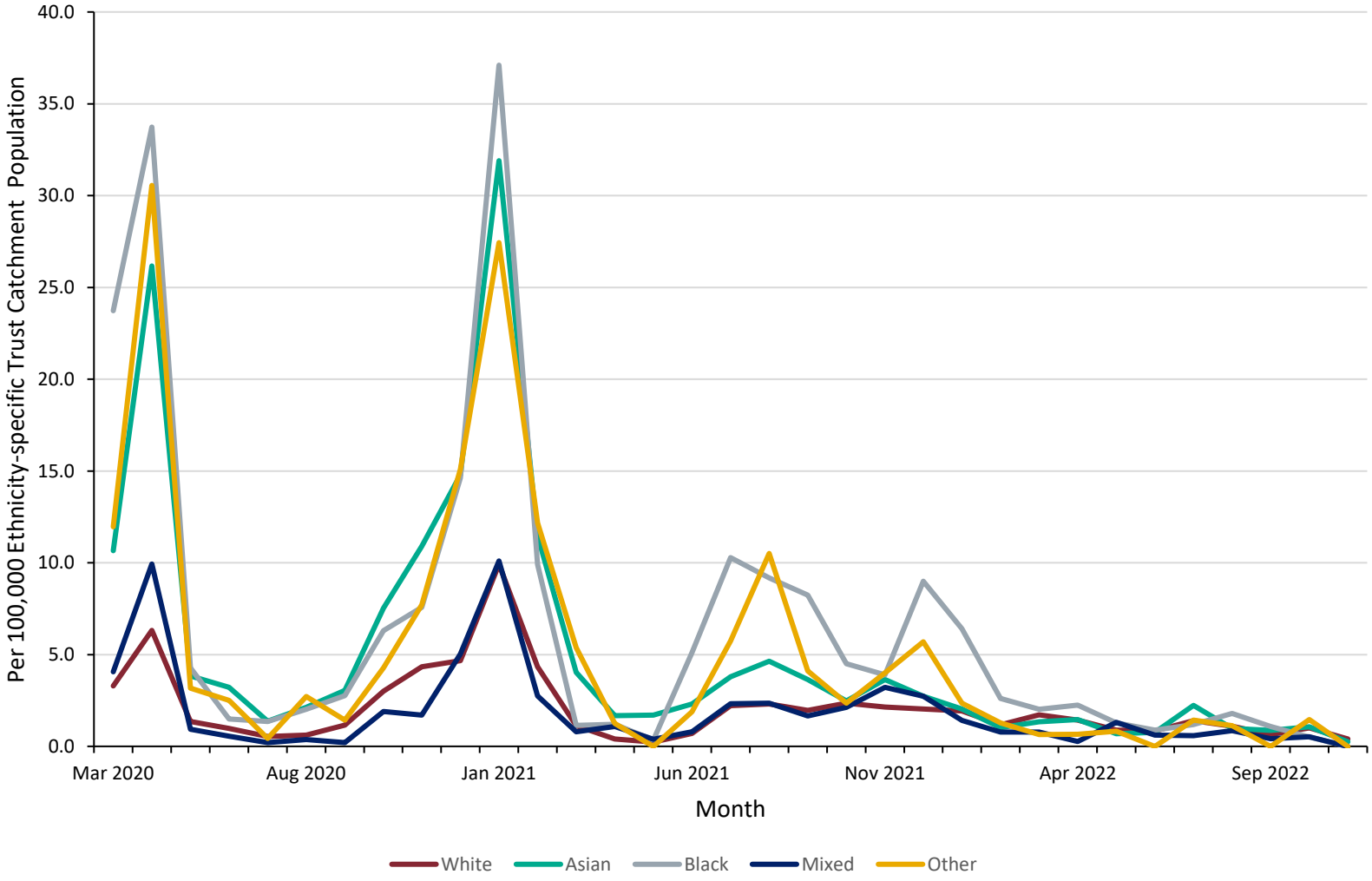
Rate of admission to ICU/HDU by ethnicity, per 100,000 trust catchment population, by month



Caveat: From week (24 2021) the ethnicity analysis is based on a new method for assigning ethnicity, developed by UKHSA. The previous method used the most recent ethnicity recorded through linkage to Hospital Episode Statistics. However, this method led to unfeasibly high rates in the 'Other' ethnic group when applied to COVID-19 cases, hospitalisation or mortality. The new method uses the most frequent ethnicity recorded through linkage to Hospital Episode Statistics, unless the most frequent was 'Other' when the second most frequent was chosen.

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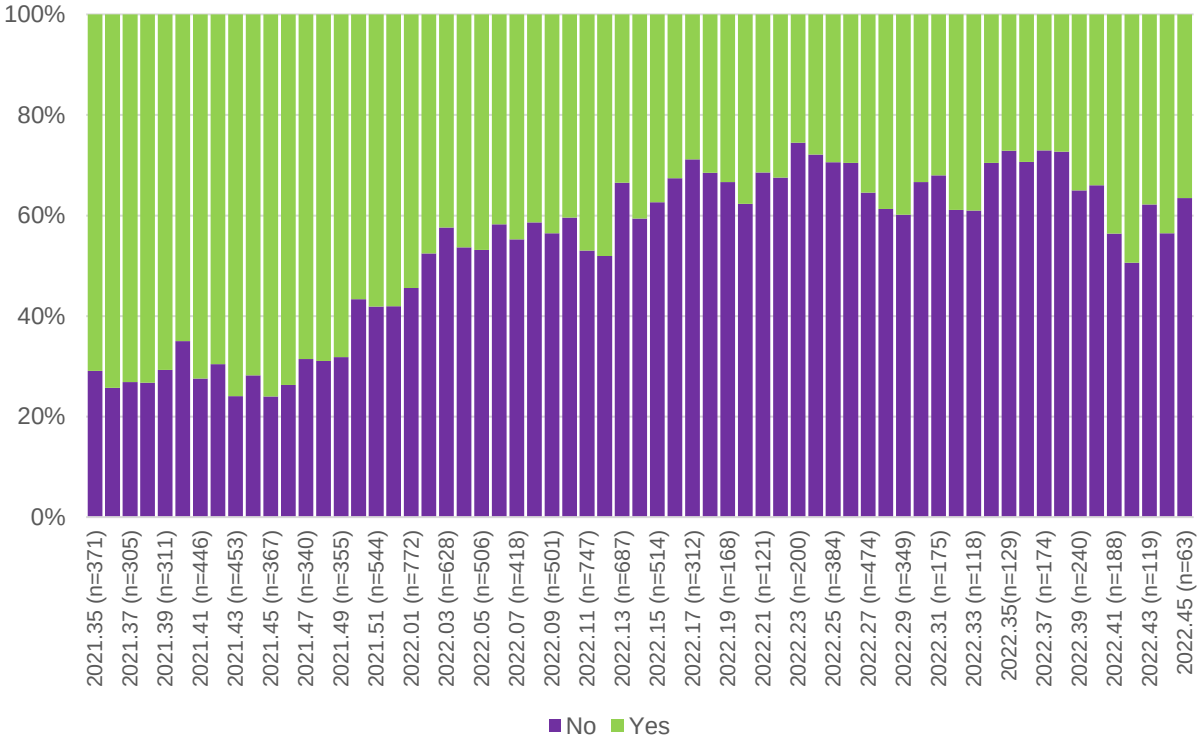
Last updated 17 November 2022

COVID-19 as primary reason for admission among SARS-CoV-2 positive patient by week of admission



Notes

1) Case-level sentinel data from SARI-Watch, form week 35 2021 (commencing 30 August 2021) to week 45 2022 (ending 13 November 2022) inclusive

2) Total 30,166 records in period of analysis, of which 33% (n=10,053) had COVID-19 as primary reason for admission ('Yes').

3) SARS-CoV-2 patients with evidence of COVID-19 treatment but have 'No' or 'Unknown' for COVID-19 as primary reason for admission (n=1,057) are reassigned to COVID-19 as primary reason of admission ('Yes').

4) Reassignment increases COVID-19 as primary reason for admission ('Yes') from 10,053 to 11,110

5) 25% (7,400/30,166) of total records in this period have missing data on the 'Admission due to COVID-19' indicator – these are excluded from analysis

6) Caveats: London trusts under-represented and most recent weeks are subject to retrospective updates

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SARS-CoV-2 Whole Genome Sequencing (WGS) coverage, England

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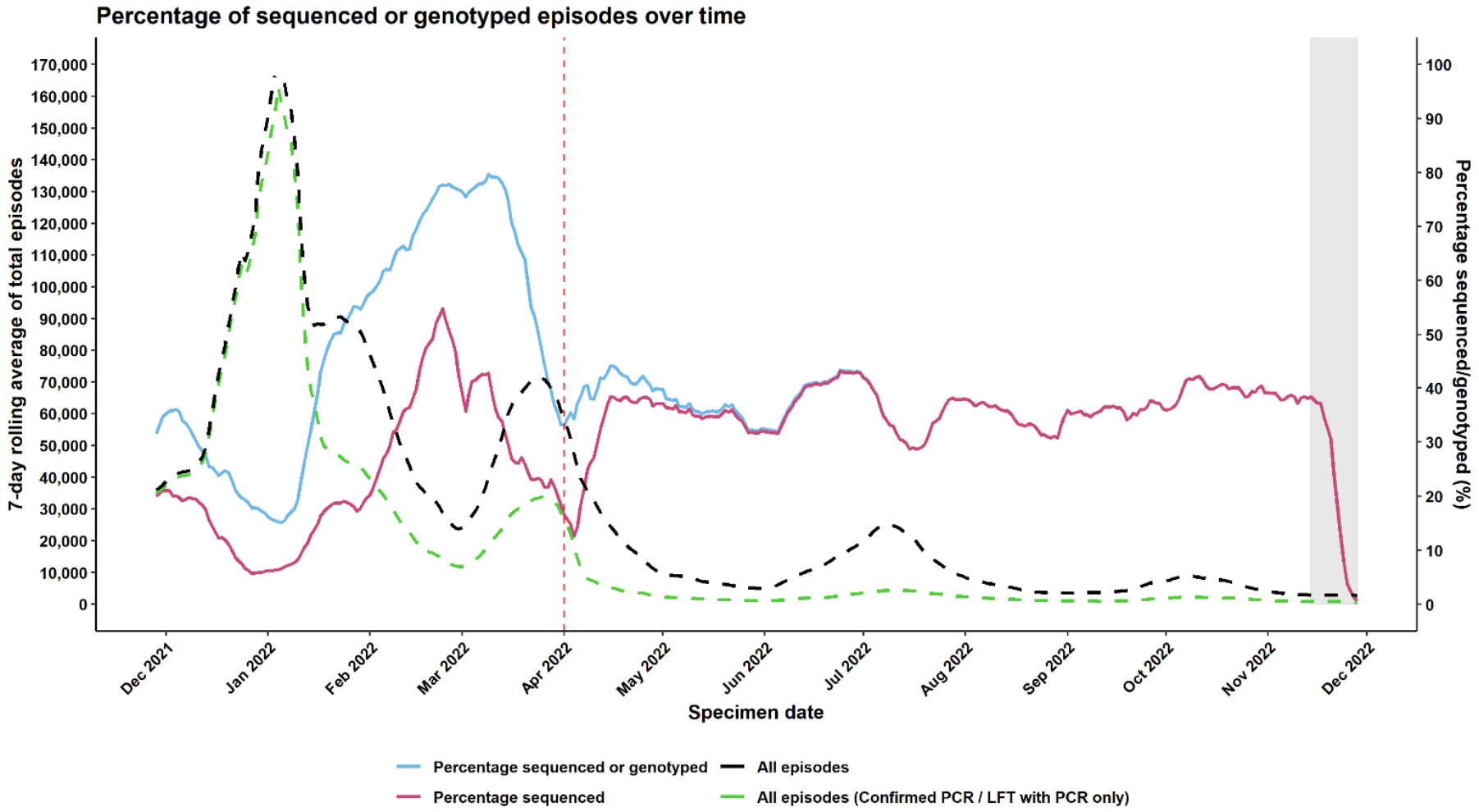
Coverage of sequencing with a valid result and genotyping over time (29 November 2021 to 29 November 2022)

Last updated 1 December 2022



Data extract from 29 November 2022; data from 28 November 2021 to 28 November 2022.
Grey shading was applied to the previous 14 days to account for reporting delays in sequencing data.
Episodes where the individual only tested using a lateral flow device are not included in the percentage denominator.

Episodes where the individual only tested using a lateral flow device are excluded. Grey shading was applied to the previous 14 days to account for reporting delays in sequencing data

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Preceding/co-/secondary infections with COVID-19

Slides for weekly covid flu report

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Preceding/co-/secondary infections with COVID-19

- Caveat - undertesting for other pathogens may result in an underestimate of preceding/co-/secondary infection cases.
- Preceding/co-/secondary infections refers to when a patient has a COVID-19 infection with one or more other pathogen (Please see Appendix 1 – Preceding/co-/secondary infection with COVID-19 definitions.)
  - Preceding infection: SARS-CoV-2 acquired after another pathogen
  - Co-infection: SARS-CoV-2 and other pathogen acquired at the same time
  - Secondary infection: SARS-CoV-2 acquired before another pathogen
- Numbers of preceding/co-/secondary infection remain low across UKHSA surveillance systems.
- For patients with severe respiratory failure requiring Extra Corporeal Membrane Oxygenation (ECMO), analysis of data from five adult ECMO centres in England indicates that among patients with severe respiratory failure due to COVID-19, almost a third of these have co/secondary infections.
- Published data analyses from pandemic wave 1 (W-1) indicates increased mortality associated with COVID-19 and influenza, key bacterial and fungal infections and invasive pneumococcal disease (IPD) in comparison to patients without co/secondary infection.
- Data analysis from W-1 indicates that *Aspergillus* and *candidemia* cases have increased risk of mortality in comparison to patients without co/secondary infection.

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Co/secondary infections among patients with severe respiratory failure requiring Extra Corporeal Membrane Oxygenation (ECMO)

Analysis is based on cumulative data from five adult ECMO centres in England. Surveillance is all year round. Each season commences around October (ISO week 40) ending in September (ISO week 39) in the following year.

Data for the current season (2021-22) is from 4 October 2021 to 2 October 2022 inclusive (week 40 2021 to week 39 2022). This period includes effects from the Delta and Omicron waves of the pandemic. The 2020-21 season is from 28 September 2020 to 3 October 2021 inclusive and includes effects from the Alpha and Delta waves. The 2019-20 season is from 30 September 2019 to 27 September 2020 inclusive and includes effects from the original Wuhan strain.

- In the 2021-22 season, 40% (31/77) of ECMO patients admitted for severe respiratory failure due to laboratory confirmed COVID-19 had clinically significant co/secondary infections. In the previous season (2020-21) this proportion was 33% (134/402). In the 2019-20 season this proportion was 33% (79/236).
- In all three seasons the majority of clinically significant co/secondary infections among respiratory failure COVID-19 cases comprised Gram-negative bacilli from the order Enterobacterales:
  - 45% (14/31) in the current season 2021-22
  - 32% (43/134) in 2020-21 and 46% (36/79) in 2019-20.
  - The decrease in 2020-21 compared to 2019-20 reached borderline significance (p=0.057). No change was detected in other key pathogens between these two time periods.
  - No evidence of change was detected in the proportion of co/secondary infections due to Enterobacterales between 2020-21 and 2021-2022.

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Surveillance of bacterial, fungal and viral infections, in COVID-19 patients in England, Jul 2022 – Nov 2022

HCAI, Fungal, AMR, AMU & Sepsis Division

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Updates

- The following outputs included in this section have been produced via the Unified Infection Dataset (UID), combining previously separate data pipelines
  - Key HCAI bacterial and fungal specimens reported to SGSS and HCAI data capture system
  - Respiratory viral specimens reported to SGSS and Respiratory Datamart
- Data are provisional and subject to change due to possible delayed reporting of microbiological samples
- Free community testing ended 31 March 2022 as part of the government's Living with COVID-19 plan, with asymptomatic testing continuing in some settings. As of 31 August 2022, asymptomatic testing in all settings, including hospitals, has been paused. Please use caution when comparing incidence of bacterial, fungal and viral preceding/co-/secondary infections over time due to these differences in testing strategies.

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Number of COVID-19 patient-episodes with bacterial, fungal or respiratory viral infections in COVID-19 patients diagnosed in England from ISO week 27 of 2022*, by infection type and timing of diagnosis

Bacterial/ fungal/ viral infection by specimen type	COVID-19 patient-episodes with bacterial/ fungal/ viral infection		Timing of bacterial/fungal/viral diagnosis in relation to COVID-19 diagnosis								
			Preceding infection			Coinfection			Secondary infection		
	n	% of COVID cases	n	% infections by site	% of COVID cases	n	% infections by site	% of COVID cases	n	% infections by site	% of COVID cases
Bacterial/fungal bloodstream & lower respiratory infection	33	<0.01	9	27.27	<0.01	6	18.18	<0.01	18	54.55	<0.01
Bacterial/fungal bloodstream infection	3,139	0.35	1,598	50.91	0.18	736	23.45	0.08	805	25.65	0.09
Bacterial/fungal lower respiratory infection	603	0.07	210	34.83	0.02	103	17.08	0.01	290	48.09	0.03
Clostridioides difficile infection	374	0.04	176	47.06	0.02	46	12.30	0.01	152	40.64	0.02
Other respiratory virus infection	750	0.08	131	17.47	0.01	482	64.27	0.05	137	18.27	0.02
Any site†	**4,917**	**0.55**	**2,135**	**43.42**	**0.24**	**1,374**	**27.94**	**0.15**	**1,408**	**28.64**	**0.16**

Key findings:

- 0.5% of COVID-19 patient-episodes had a bacterial, fungal or other respiratory viral infection detected in either the 28 days prior or following their COVID-19 diagnosis.
- Most infections with key organisms were categorised as preceding infections (43.4%).

Please see appendix 1 for pre-/co-/secondary infection definitions with SARS-CoV-2
Please note patients can have multiple COVID-19 infection-episodes, numbers here do not reflect the number of patients.
***SARS-CoV2 specimen dates from 4 July 2022 to 16 Oct 2022 (N=896,484). Last updated 19 Nov 2022.**
† other sites not listed in table but included in total: Bacterial/fungal bloodstream & *Clostridioides difficile* infection (9 preceding, 1 coinfection & 4 secondary) & Bacterial/fungal lower respiratory & *Clostridioides difficile* infection (2 preceding & 2 secondary)
Please note, the MRL pipeline has been suspended due to delayed reporting since March 2022. Fungal infections from SGSS will only be reported (HCAI pipeline) until the MRL pipeline is resumed.

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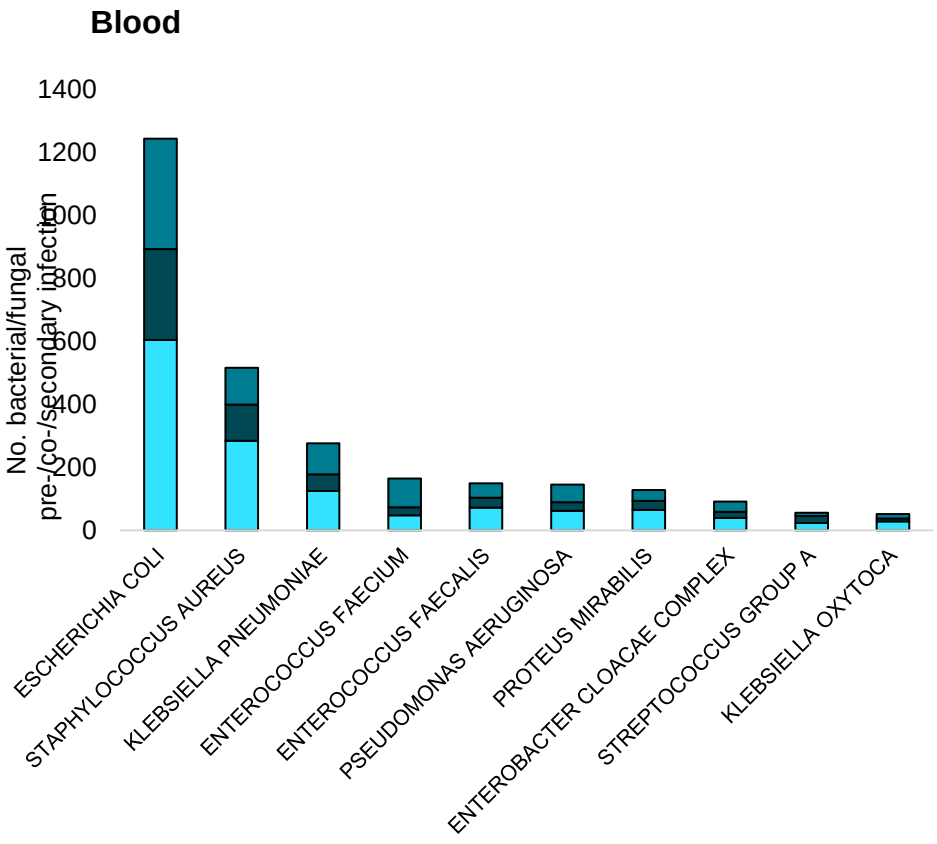
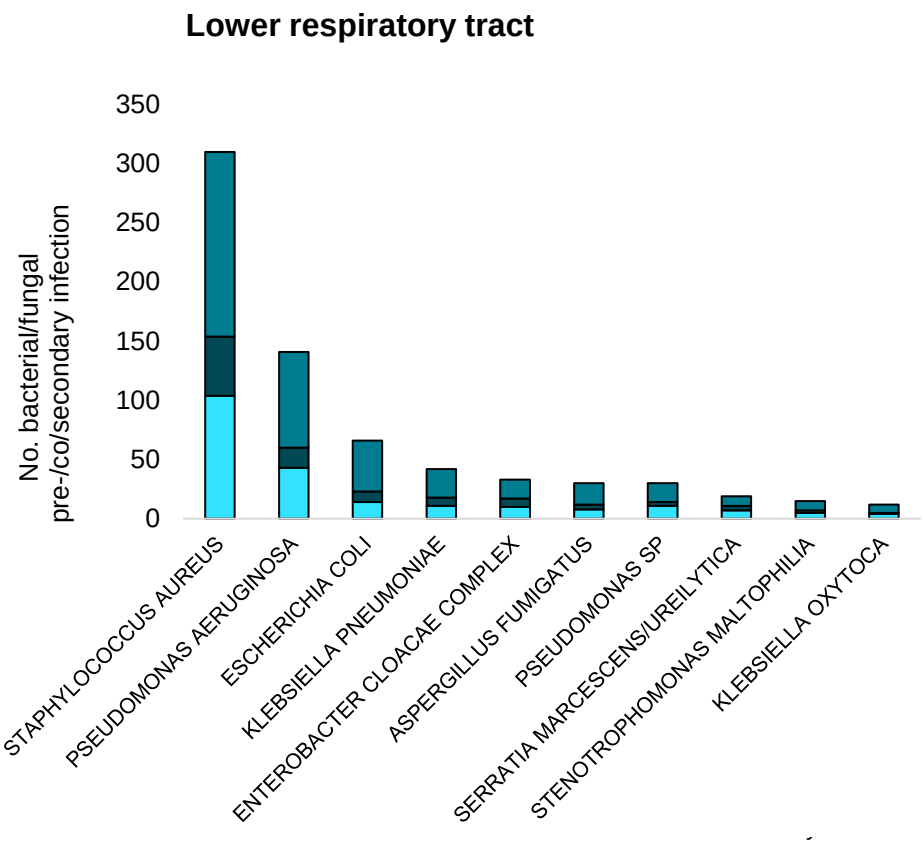
Most frequent bacterial/fungal species in blood or lower respiratory tract specimens, by timing of diagnosis, in COVID-19 patients diagnosed in England from ISO week 27 of 2022





Key findings:

In wave 3, the most frequent bacterial/fungal organisms identified from blood specimens were *Escherichia coli*, *Staphylococcus aureus* and *Klebsiella pneumoniae* and from respiratory specimens were *S. aureus, Pseudomonas aeruginosa* and *E. coli*.

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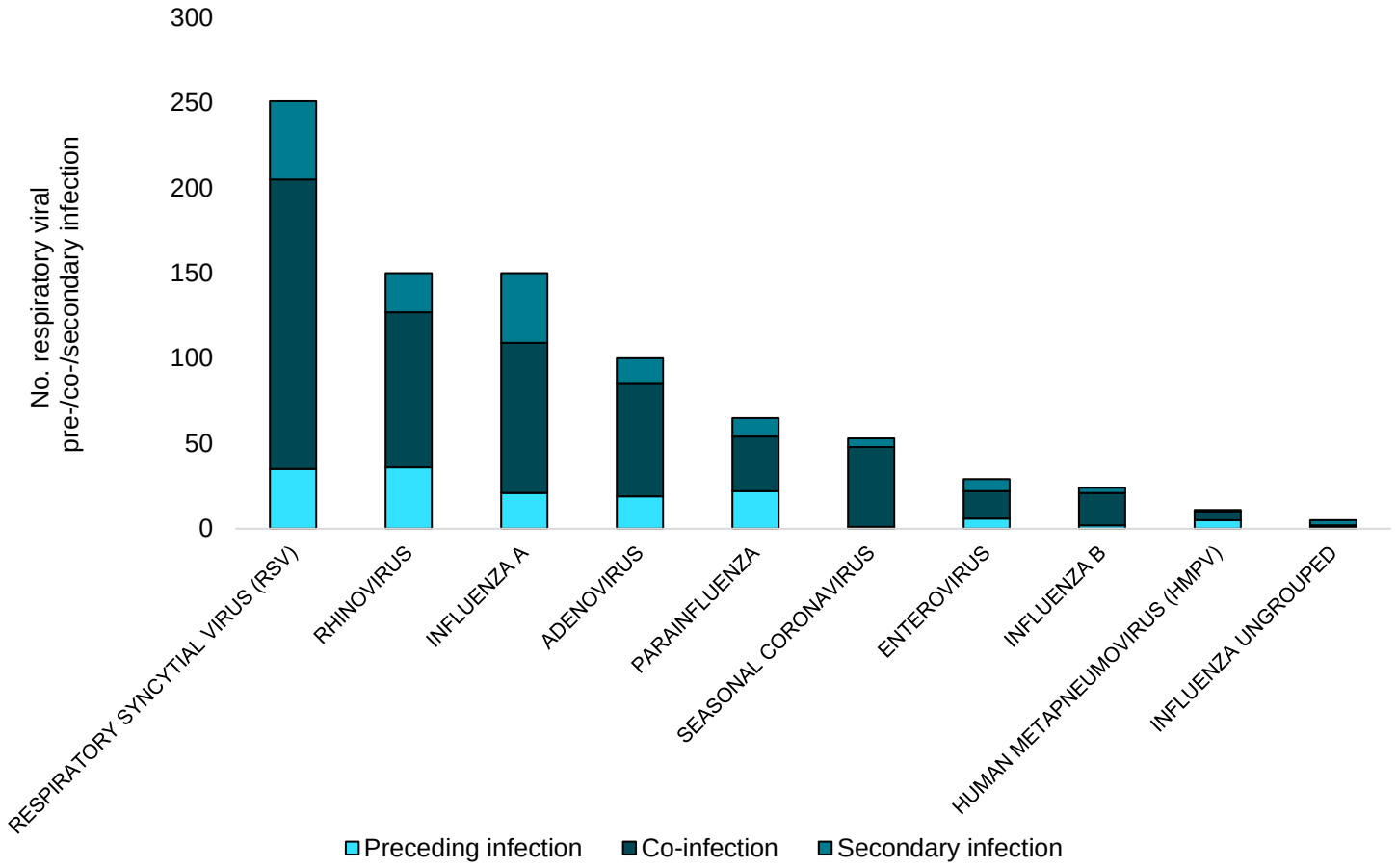
Most frequent viral specimens, by timing of diagnosis, in COVID-19 patients diagnosed in England from ISO week 27 of 2022



Key findings:

In wave 3, the most frequent viral organisms identified from respiratory specimens were RSV, rhinovirus and influenza A.

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Appendix 1: Pre-/co-/secondary infection definitions with COVID-19

The day pertains to the date of the sample collection that yielded a positive result. These definitions do not apply to persistent COVID-19 patients. Patients with persistent COVID-19 require independent clinical assessment.

Organism	Definition co-infection with SARS-CoV-2 †	Definition of infection pre-SARS-CoV-2 infection (other pathogen is primary infection) or Definition of post SARS-CoV-2 secondary infection (SARS-CoV-2 is primary infection)
Influenza A	+/- 1d	2-28d^
Influenza B	+/- 1d	2-28d^
RSV	+/- 1d	2-28d
Adenovirus	+/- 1d	2-28d
Enterovirus	+/- 1d	2-28d
Human metapneumovirus	+/- 1d	2-28d
Parainfluenza (any subtype)	+/- 1d	2-28d
Seasonal coronavirus	+/- 1d *	2-28d
Rhinovirus	+/- 1d	2-28d
Co-infections in ECMO patient (patients with most severe clinical respiratory signs)		
ECMO patients	Individual case review	Individual case review
Blood stream and respiratory infections (bacterial and fungal)		
Achromobacter xylosoxidans	+/- 1d	2-28d
Acinetobacter spp.,	+/- 1d	2-28d
Aspergillus	+/- 1d	2-28d (pre) 2-60d (post, continually hospitalised patients only)
Bordetella pertussis	+/- 28 d Culture/PCR (based on pertussis sample date) +/- 28 Serology/Oral fluid (anti-pertussis toxin Ig) (based on pertussis symptom onset date, excluding cases without onset date)	N/A (Pertussis presentation is often delayed)
Burkholderia cepacia	+/- 1d	2-28d
Candida spp	+/- 1d	2-28d (pre) 2-60d (post, continually hospitalised patients only)
Chlamydia pneumoniae	0-7d PCR	PCR within 14-28 d (8-13d PCR*)
Enterobacter spp.,	+/- 1d	2-28d
Enterococcus spp.	+/- 1d	2-28d
E. coli	+/- 1d	2-28d
Haemophilus influenzae	+/- 2d	3-28d

Continued overleaf

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Appendix 1 continued: Pre-/co-/secondary infection definitions with COVID-19

The day pertains to the date of the sample collection that yielded a positive result. These definitions do not apply to persistent COVID-19 patients. Patients with persistent COVID-19 require independent clinical assessment.

Organism	Definition co-infection with SARS-CoV-2 †	Definition of infection pre-SARS-CoV-2 infection (other pathogen is primary infection) or Definition of post SARS-CoV-2 secondary infection (SARS-CoV-2 is primary infection)
Blood stream and respiratory infections (bacterial and fungal)		
Klebsiella spp.	+/- 1d	2-28d
Legionella pneumophila/species	Individual case review	Individual case review
Mycoplasma pneumoniae	0-7d PCR, IgM serology 0-21d <16y	PCR within 14-28 d (8-13d PCR*)
Neisseria meningitidis	+/- 2d	3-28d
Pseudomonas spp.,	+/- 1d	2-28d
Serratia spp.,	+/- 1d	2-28d
Staphylococcus aureus	+/- 1d	2-28d
Coag-neg Staphylococcus (*S. haemolyticus*)	+/- 1d	2-28d
Stenotrophomonas spp., (*S. maltophilia)*	+/- 1d	2-28d
Streptococcus spp. ‡	+/- 1d	2-28d
Streptococcus pneumoniae	+/- 2d	3-28d
Tuberculosis		
Mycobacterium tuberculosis	Individual case review	Individual case review
Pathogens of the immunocompromised (eg HIV)		
HIV	Individual case review	Individual case review
Gastrointestinal infections		
Listeria	0-5d *	Individual case review
Campylobacter	0-5d *	Individual case review
Shiga toxin-producing *E. coli* (STEC)	0-5d *	Individual case review
Norovirus	0-5d *	Individual case review
Salmonella	0-5d *	Individual case review
Shigella	0-5d *	Individual case review
Anaerobes		
C. difficile	+/- 1d	2-28d
Bacteroides sp. (*B. fragilis* and non-fragilis Bacteroides)	+/- 1d	2-28d

See next slides for notes

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Appendix 1 continued: Pre-/co-/secondary infection definitions with COVID-19

Notes

† From the first specimen date of a SARS-CoV-2 patient episode.

* Additional data check required. (Resistance is not detailed, data for MERS is not currently available).

^ Definition post- SARS-CoV-2 secondary infection (SARS-CoV-2 is primary infection).This has been extended from prior 14d secondary infection definition for influenza used by UKHSA to account for disparities in testing throughout the 28d period after SARS-CoV-2 detection.

‡ Streptococcus species includes the following groups and species:

Group	**Species/other names**
Anginosus Group	*Streptococcus anginosus; Streptococcus constellatus (Streptococcus constellatus subspecies constellatus Streptococcus constellatus subspecies pharynges); Streptococcus* Group F; *Streptococcus intermedius; Streptococcus milleri* group; *Streptococcus sinensis*
Bovis Group	*Streptococcus alactolyticus; Streptococcus bovis* untyped; *Streptococcus equinus; Streptococcus gallolyticus subspecies gallolyticus (Streptococcus bovis* biotype I); *Streptococcus infantarius (Streptococcus infantarius sp infantarius; Streptococcus bovis* biotype II); *Streptococcus lutetiensis; Streptococcus infantarius subspecies coli (Streptococcus bovis* biotype II); *Streptococcus pasteurianus (Streptococcus bovis* biotype II)
Closely Related Genera	*Abiotrophia spp.; Aerococcus spp.; Faklamia spp.; Gemella* spp.; *Globicatella sanguinis; Granulicatella* spp.; *Leuconostoc* spp.; *Pedicoccus* spp.; *Peptostreptococcus* spp.
Mitis Group	*Streptococcus cristatus; Streptococcus mitior; Streptococcus mitis; Streptococcus oralis; Streptococcus pseudopneumoniae; Streptococcus infantis; Streptococcus peroris*
Mutans Group	*Streptococcus mutans; Streptococcus sobrinus*
Other streptococci (including but not limited to)	Anaerobic streptococcus; *Streptococcus acidominimus; Streptococcus* spp., other named/not fully identified; *Streptococcus suis; Streptococcus uberis*
Salivarius Group	*Streptococcus vestibularis; Streptococcus thermophilus*
Sanguinis Group	*Streptococcus gordonii; Streptococcus massiliensis; Streptococcus parasanguinis; Streptococcus sanguinis*
Streptococcus Group A	Group A; *Streptococcus pyogenes; Streptococcus dysgalactiae* subspecies *equisimilis*
Streptococcus Group B	Group B; *Streptococcus agalactiae*
Streptococcus Group C	Group C; *Streptococcus dysgalactiae* subspecies *equisimilis; Streptococcus equi* subspecies *zooepidemicus*
Streptococcus Group G	Group G; *Streptococcus canis; Streptococcus dysgalactiae* subspecies *equisimilis*