This is an Experimental Statistics publication

Experimental statistics are official statistics which are published in order to involve users and stakeholders in their development and as a means to build in quality at an early stage. It is important that users understand that limitations may apply to the interpretation of this data, further details of which are presented in this report.

All official statistics should comply with the UK Statistics Authority’s Code of Practice which promotes the production and dissemination of official statistics that inform decision making. Once the evaluation is completed and an enhanced report is developed that meets the needs of users and stakeholders, the Experimental label will be removed.

Find out more about the Code of Practice at: https://www.statisticsauthority.gov.uk/osr/code-of-practice/

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Introduction

Surveillance of influenza infection is a key public health activity as it is associated with significant morbidity and mortality during the winter months, particularly in those at risk of complications of flu e.g. the elderly, those with chronic health problems and pregnant women.

The spectrum of influenza illness varies from asymptomatic illness to mild/moderate symptoms to severe complications including death. In light of the spectrum of influenza illness there is a need to have individual surveillance components which provide information on each aspect of the illness.

There is no single flu surveillance component that can describe the onset, severity and impact of influenza or the success of its control measures each season across a community. To do so requires a number of complimentary surveillance components which are either specific to influenza or its control, or which are derived from data streams providing information of utility for other HPS specialities (corporate surveillance data). Together, the influenza surveillance components provide a comprehensive and coherent picture of ILI/ARI activity on a timely basis throughout the flu season.

In its Global Epidemiological Surveillance Standards for Influenza (2014), WHO proposes the following set of influenza surveillance functions:

- Describe the seasonality, start, peak and end of the influenza season.
- Identify and monitor groups at high risk of severe disease and mortality.
- Establish baseline levels of activity for influenza and severe influenza-related disease with which to evaluate the impact and severity of each season and of future pandemic events.
- Determine influenza burden to help decision-makers prioritize resources and plan public health interventions;
- Identify locally circulating virus types and subtypes and their relationship to global and regional patterns;
- Assist in developing an understanding of the relationship of virus strains to disease severity;
- Evaluate vaccine and other interventions effectiveness;
- Facilitate vaccine strain selection;
- Detect unusual and unexpected events such as outbreaks of influenza outside the typical season, severe influenza among healthcare workers, or clusters of vaccine failures that may herald novel influenza virus or lower vaccine effectiveness.
Main Points

**Overall assessment:**
- Influenza activity is increasing and there is evidence of circulation of influenza within the community and closed settings.
- A Scottish addendum to the Public Health England guidance on use of antiviral agents for the treatment and prophylaxis of seasonal influenza has been published on the [HPS website](https://www.hps.org.uk).

**In week 48:**
- The rate of influenza-like illness (ILI) was at **Baseline** activity level (12.2 per 100,000).
- The proportion of NHS24 respiratory calls was at **Moderate** activity level (22.3%).
- The swab positivity of influenza in primary care was at **Moderate** activity level (56.5%, 13/23).
- The swab positivity of influenza in secondary care was at **Moderate** activity level (20.6%, 109/529).
- The incidence rate of influenza in secondary care was at **Baseline** activity level (2.1 per 100,000 population).
- Respiratory syncytial virus (RSV) was at **Low** activity level. This was lower than the activity level retrospectively assigned to week 47 (Extraordinary).
- Human Metapneumovirus (HPMV) and Rhinovirus were at **Low** activity level. The rest of the non-flu respiratory pathogens were at **Baseline** activity levels.
- There were 2 new acute respiratory illness outbreaks reported (**Baseline** activity level).
- There were 3 new cases reported of laboratory confirmed influenza with severe acute respiratory infection (SARI) requiring intensive care management (**Baseline** activity level).
- There were no SARI deaths reported.
- The all-cause mortality excess was at **Low** activity level in week 46.
Results and Commentary

GP consultations for influenza-like illness (ILI)

• The overall rate of GP consultations for influenza-like illness (ILI) was at **Baseline** activity level in week 48 (12.2 per 100,000) (1). This was similar to the ILI rate in week 47 (11.8 per 100,000 population) (Figure 1).

• By age group, the highest rates were seen in those aged 15-44 years (15.1 per 100,000 population, **Baseline** activity level) and those aged 45-64 years (12.9 per 100,000 population, **Baseline** activity level).

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1 Activity levels for GP consultation rates for ILI (Baseline: 0 < 26.7; Low: 26.7 < 37.2; Moderate: 37.2 < 154.4; High: 154.4 < 289.7; Extraordinary: >= 289.7 per 100,000 population).
NHS24 respiratory calls

- The proportion of NHS24 respiratory calls was at **Moderate** activity level (22.3%) in week 48 (2). This was similar to the proportion of respiratory calls in week 47 (22%). The proportion for week 48 was higher than the same week last season (20.5%).
- By age group, the highest proportion of NHS24 respiratory calls was seen in those aged 1-4 years (56.7%, **Moderate** activity level) and those aged under 1 year (54.4%, **Moderate** activity level).

Microbiological surveillance

Influenza in primary care (GP sentinel swabbing scheme - GPSSS)

- A total of 13 participating practices submitted samples (31.7%, 13/41). This was lower than the number of participating practices in week 47 (this has retrospectively been updated to 41.5%, 17/41).
- The swab positivity in primary care was at **Moderate** activity level (56.5%, 13/23) (3). This was higher than the swab positivity in week 47 (this has retrospectively been updated to 24.2%, 8/33 - Baseline activity level).
- There were 13 influenza detections (1 influenza (H1N1), 7 influenza A(H3N2), 5 influenza A (untyped), 0 influenza B and 0 co-infections).

Influenza in secondary care (ECOSS)

- The swab positivity in secondary care was at **Moderate** activity level (20.6%, 109/529) (4). This was higher than the swab positivity in week 47 (this has retrospectively been updated to 15.7%%, 190/1,214 - Low activity level).
- The incidence rate of influenza in secondary care was at **Baseline** activity level (2.1 per 100,000 population) (5). This was lower than the incidence rate in week 47 (this has retrospectively been updated to 3.5 per 100,000 population - Low activity level).
- There were 114 influenza detections (5 influenza (H1N1), 59 influenza A(H3N2), 47 influenza A (untyped), 3 influenza B and 0 co-infections).

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2 Activity levels for NHS24 respiratory calls (Baseline: 0% < 17.1%; Low: 17.1% < 21.4%; Moderate: 21.4% < 30.2%; High: 30.2% < 35.1%; Extraordinary: >= 35.1%).

3 Activity levels for GPSSS swab positivity (Baseline: 0% < 25.6%; Low: 25.6% < 40.3%; Moderate: 40.3% < 66.9%; High: 66.9% < 83.7%; Extraordinary: >= 83.7%).

4 Activity levels for ECOSS swab positivity (Baseline: 0% < 7.4%; Low: 7.4% < 19.5%; Moderate: 19.5% < 38.3%; High: 38.3% < 51.7%; Extraordinary: >= 51.7%).

5 Activity levels for ECOSS incidence rate of influenza (Baseline: 0 < 2.8; Low: 2.8 < 4.6; Moderate: 4.6 < 16.6; High: 16.6 < 29.4; Extraordinary: >= 29.4).
• The predominant influenza type was influenza A. Among those viruses that have been subtyped, the predominant influenza subtype was influenza A(H3N2).

Influenza genetic characterisation

Each year the West of Scotland Specialist Virology Centre (WOSSVC) conducts genetic characterisation of a small number of influenza samples. These include samples from influenza outbreaks, individuals seriously ill, individuals who have died due to influenza and individuals with suspected vaccine failure. The genetic characterisation data are used to 1) examine if the circulating influenza strains match those included in the seasonal influenza vaccine; and to 2) monitor for changes in circulating influenza viruses.

• Since week 40, a total of 58 samples were genetically characterised:
  – 6 influenza A(H1N1) subclade 6B1.A5A. The Northern Hemisphere 2019/20 influenza A(H1N1) vaccine strain belongs to genetic subclade 6B1.A.
  – 39 influenza A(H3N2) subclade 3C.3a. The Northern Hemisphere 2019/20 influenza A(H3N2) vaccine strain belongs to genetic subclade 3C.3a.
  – 6 influenza A(H3N2) subclade 3C.2a1b.
  – 1 influenza B/Victoria lineage belonging to a group with a double deletion mutation (B/Colorado/06/2017). The Northern Hemisphere 2019/20 influenza B vaccine strain belongs to this group.
  – 6 influenza B/Victoria lineage belonging to a group with a triple deletion mutation (B/Washington/02/2019).

• Further information on genetic characterisation will be provided throughout the season when more data are available.

Non-influenza respiratory pathogens

• Adenovirus was at Baseline activity level. This was lower than the activity level retrospectively assigned to week 47 (Low).
• Coronavirus was at Baseline activity level. This was similar to the activity level retrospectively assigned to week 47 (Baseline).
• Human Metapneumovirus (HPMV) was at Low activity level. This was similar to the activity level retrospectively assigned to week 47 (Low).
• Mycoplasma pneumoniae (MPN) was at Baseline activity level. This was lower than the activity level retrospectively assigned to week 47 (Low).
• Parainfluenza virus was at Baseline activity level. This was lower than the activity level retrospectively assigned to week 47 (Low).
• Rhinovirus was at **Low** activity level. This was similar to the activity level retrospectively assigned to week 47 (Low).

• Respiratory syncytial virus (RSV) was at **Low** activity level. This was lower than the activity level retrospectively assigned to week 47 (Extraordinary). The typical RSV season lasts approximately 12 weeks and usually peaks between week 49 and week 52. The large majority of RSV detections thus far have been in those aged under 5 years.

**Acute Respiratory Illness (ARI) outbreaks**

• There were 2 new acute respiratory illness outbreaks reported in week 48 (**Baseline** activity level).

• Since week 40 2019, there was a total of 12 ARI outbreaks reported to HPS:
  – 6 were reported from care homes (2 due to influenza A(untyped));
  – 4 was reported from a hospital (1 due to influenza A(H1N1) and 1 due to influenza A(untyped));
  – 2 were reported from a school (0 due to influenza);

• These were geographically spread throughout Scotland: 33.3% in the North, 50% in the East and 16.7% in the West (6).

**Severe Acute Respiratory Illness (SARI)**

• There were 3 new cases of laboratory confirmed influenza with severe acute respiratory infection (SARI) requiring intensive care management reported in week 48 (**Baseline** activity level).

• Since week 40 2019, there were a total of 3 SARI cases reported to HPS.
  – Influenza type: 2 were due to influenza A(H1N1) and 1 due to influenza B;
  – Age group: 1 among 15-44 years; 1 among 45-64 years and 1 among 65-74 years of age;
  – Week of admission: 2 in week 47 and 1 in week 48;

• These were geographically spread throughout Scotland: 33.3% in the North, 0% in the East and 66.7% in the West (6).

Influenza-associated mortality

SARI mortality

- There were no SARI deaths reported in week 48.
- Since week 40 2019, there were no SARI deaths reported to HPS.

Excess all-cause mortality

- The all-cause mortality excess was at Low activity level in week 46 (7). This excess was observed in those 65 years and above.
- Please note that HPS will only publish information on all-cause mortality two weeks after the week of the occurrence of the deaths to allow for reporting delay.

7 Baseline activity level for all ages all-cause mortality excess (EUROMOMO z-score < 2).
Vaccine uptake

- Influenza vaccine uptake is estimated in-season with electronic extracts that come direct from general practice. These extracts run from week 40 to week 15 and data presented in this report is provisional. Vaccine uptake data is verified later in the year using general practice claims for payment data. Influenza vaccine uptake will be reported on a 4-weekly basis.

- A software issue affecting the vaccine uptake submission from EMIS practices has now been solved and the vaccine uptake estimates below have been derived from both EMIS and INPS Vision practices (accounting for > 95% of Scottish GP practices).

- Provisional data for week 47 suggests uptake rates of:
  - 66.2% in people aged 65 years and over, compared with 63.4% in 2018-19;
  - 34.0% in under 65 years at-risk, compared with 33.9% in 2018-19;
  - 47.4% in pregnant women (with other risk factors), compared with 47.8% in 2018-19;
  - 37.0% in pregnant women (without other risk factors), compared with 38.2% in 2018-19;
  - 28.3% in preschool children (2 to under 5 years), compared with 43.8% in 2018-19;
  - 67.3% in primary school children, compared with 72.3% in 2018-19.

- The next update of vaccine uptake data will be available in report of week 52 2019 (published on Friday 3 January 2020).

- In Scotland, a new programme named The Vaccination Transformation Programme (VTP) is underway to redesign and modernise the delivery of local vaccination services. The VTP began on 1 April 2018 and will run for three years. Each Health Board is progressing with the roll-out of VTP at different stages with some boards delivering their vaccines outwith the GP and therefore not recorded on these systems in a timely manner.

- Please note that due to changes in delivery of influenza vaccinations as a result of the Vaccine Transformation Programme and a more phased or later availability of Fluenz stocks than last year, vaccine uptake estimates for some groups and boards may initially be lower than expected. It is anticipated that this will be resolved over the course of the programme as the data becomes more complete.
Further information

Influenza surveillance in Scotland

- For further information on influenza and the influenza surveillance system in Scotland, please visit the influenza page on the HPS website.
- For caveats and notes explaining the data and the methodologies used in this report, please see HPS Weekly National Seasonal Respiratory Report - Notes and Caveats.
- Scottish Vaccine Update
- Historical end of season influenza vaccine uptake
- The technical document on reporting rates of influenza-like illness (ILI) consultations from General Practitioners in Scotland has been published on HPS Website. This report provides background to reporting of primary care consultation rates for ILI in Scotland plus 1) a description of the 2017/18 data issues and end of season revision of ILI consultation rates; and 2) the application of the Moving Epidemic Method (MEM) to Scottish ILI consultation rate data.
- A Scottish addendum to the Public Health England guidance on use of antiviral agents for the treatment and prophylaxis of seasonal influenza has been published on the HPS website.

Vaccine effectiveness

- The UK end-of-season 2017/18 influenza vaccine effectiveness results have now been published in Eurosurveillance.
- The interim 2018/19 influenza vaccine effectiveness estimates from six European studies was published in Eurosurveillance.
- The 2018/19 end-of-season vaccine effectiveness results have been published in Vaccine

Vaccine composition

- The WHO have published the recommended composition of influenza virus vaccines for use in the 2019/20 northern hemisphere influenza season.

UK and international influenza reports

- PHE Weekly national flu report
- Flu News Europe website
- WHO influenza update
- EuroMOMO website
## Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>All-cause mortality</td>
<td>Vital statistics of total number of deaths, regardless of cause.</td>
</tr>
<tr>
<td>Antiviral medication</td>
<td>Antiviral drugs are prescription medicines that fight against flu viruses. Antivirals work by stopping the flu virus from multiplying in the body. They won’t cure flu, but they may help slightly reduce the length of the illness and relieve some of the symptoms.</td>
</tr>
<tr>
<td>Acute respiratory illness (ARI) outbreak</td>
<td>The surveillance definition of an ARI outbreak is: two or more cases in a closed institution (e.g. school, care home, hospital) with onset within 7 days of each other) of acute respiratory infections (whether virologically confirmed or not).</td>
</tr>
<tr>
<td>Activity level</td>
<td>In the context of the Moving Epidemic Method (MEM), the epidemiological activity can be defined into 5 activity levels. The activity levels based on the MEM uses 4 thresholds (Epidemic, Medium, High and Very high) and are categorised as: baseline activity (when activity is below epidemic threshold); low activity (when activity is between epidemic and medium thresholds); moderate activity (when activity is between medium and high thresholds); high activity (when activity is between high and very high thresholds); Extraordinary activity (when activity is above very high threshold). Knowing influenza activity levels allows comparisons over time and across countries.</td>
</tr>
<tr>
<td>Case-fatality rate (CFR)</td>
<td>The CFR is measure of the severity of a disease and is defined as the proportion of deaths within a defined population of cases.</td>
</tr>
<tr>
<td>Electronic Communication of Surveillance in Scotland (ECOSS)</td>
<td>National laboratory surveillance system that captures laboratory results from diagnostic and reference laboratories in Scotland</td>
</tr>
<tr>
<td>Excess mortality</td>
<td>Excess mortality is defined as a statistically significant increase in the number of deaths reported over the expected number for a given point in time. This calculation allows for a weekly variation in the number of deaths registered and takes account of deaths registered retrospectively. There is no single cause of ‘additional’ deaths in the winter months but they are often attributed in part to cold weather (e.g. directly from falls, fractures, road traffic accidents), through worsening of chronic conditions.</td>
</tr>
<tr>
<td><strong>Medical Conditions</strong></td>
<td>medical conditions, e.g. heart and respiratory complaints and through respiratory infections including influenza.</td>
</tr>
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<td>------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Incidence rate</strong></td>
<td>Number of new laboratory positive test results expressed as a rate per 100,000 Scottish population. Virological data is dynamic, therefore, the incidence rate will change retrospectively week to week as more data becomes available.</td>
</tr>
<tr>
<td><strong>Influenza-like illness (ILI)</strong></td>
<td>Influenza virus infections can cause a range of symptoms which are non-specific and resemble the clinical picture of a variety of other pathogens. A clinical diagnosis is often referred as influenza-like illness (ILI) by General Practitioners (GP). In Scotland, the recommended surveillance case definition for ILI is an individual presenting in primary care with an acute respiratory illness with physician-diagnosed fever or complaint of feverishness in the previous 7 days. It is important to note that: the surveillance case definition for ILI is not necessarily intended to capture all cases but to describe trends over time; the individual diagnosis and clinical electronic recording of ILI is at clinical discretion of the GP; ILI is not the same as a laboratory confirmation of influenza and any clinical diagnosis based on signs and symptoms will miss some influenza infections and include some non-influenza infections.</td>
</tr>
<tr>
<td><strong>Influenza</strong></td>
<td>Influenza (flu) is a contagious respiratory illness caused by influenza viruses. There are two main types of influenza virus: Types A and B. The influenza A and B viruses that routinely spread in people (human influenza viruses) are responsible for seasonal flu epidemics each year. Current subtypes of influenza A viruses found in people are influenza A(H1N1) and influenza A(H3N2) viruses. Currently circulating influenza B viruses belong to one of two lineages: B/Yamagata and B/Victoria.</td>
</tr>
<tr>
<td><strong>Moving Epidemic Method (MEM)</strong></td>
<td>MEM is a methodology used for setting thresholds and classifying epidemiological activity levels. This methodology has adopted by the UK, the European Centre for Disease Prevention and Control (ECDC) and World Health Organisation (WHO) to define influenza activity levels.</td>
</tr>
<tr>
<td><strong>Severe Acute Respiratory Infection (SARI)</strong></td>
<td>The surveillance definition of a SARI case in Scotland is: a patient receiving intensive care management (level 3 care) who also had a laboratory confirmed influenza positive result at that time.</td>
</tr>
</tbody>
</table>
### Sentinel swabbing scheme

Sentinel surveillance system where a number of patients with influenza-like illness (ILI) or acute respiratory infection (ARI) are swabbed, i.e. have an upper respiratory sample collected. The primary purpose of the swabbing scheme is to determine the start, peak and duration of influenza in the community whilst identifying the contribution of other respiratory viruses to respiratory burden. A secondary purpose of the swabbing results from your practice is that it also allows Scotland to contribute pro-rata to an annual UK-wide assessment of flu vaccine effectiveness which informs the World Health Organisation (WHO) strain selection for inclusion in future vaccines.

### Swab positivity

Proportion of positive laboratory results among a defined number laboratory tested samples, i.e. number of positives divided by total number of laboratory tests done. Virological data is dynamic, therefore, the swab positivity will change retrospectively week to week as more data becomes available.

### Threshold

In the context of influenza surveillance, thresholds help to 1) to characterise influenza activity levels, 2) to indicate when the influenza season has begun and 3) to detect periods of increased activity or atypical activity.
Contact

<table>
<thead>
<tr>
<th>Jim McMenamin</th>
<th>Arlene Reynolds</th>
<th>Diogo Marques</th>
</tr>
</thead>
<tbody>
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<td>Epidemiologist</td>
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<td>0141 300 1422</td>
<td>0141 300 1422</td>
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<tr>
<td><a href="mailto:nss.hpsflu@nhs.net">nss.hpsflu@nhs.net</a></td>
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Next publication
The next release of this publication will be 12 December 2019.

Rate this publication
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# Appendices

## Appendix 1 - Publication Metadata

<table>
<thead>
<tr>
<th>Metadata Indicator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Publication title</td>
<td>HPS weekly national seasonal respiratory report</td>
</tr>
<tr>
<td>Description</td>
<td>Summary epidemiological information on seasonal influenza and other seasonal respiratory infections activity in Scotland.</td>
</tr>
<tr>
<td>Theme</td>
<td>Infections in Scotland</td>
</tr>
<tr>
<td>Topic</td>
<td>Information on seasonal influenza and other seasonal respiratory infections</td>
</tr>
<tr>
<td>Format</td>
<td>PDF</td>
</tr>
<tr>
<td>Data source(s)</td>
<td>This report includes a number of data sources: 1) GP consultations for influenza-like illness (ILI); 2) NHS24 respiratory calls, 3) Primary care virology (GP Sentinel Swabbing Scheme), 4) Secondary care virology (ECOSS); 5) Acute Respiratory Illness (ARI) outbreaks; 6) Severe Acute Respiratory Infection (SARI); 7) Excess all-cause mortality (obtained from National Records Scotland); 8) Influenza vaccine uptake. Detailed explanation on the data sources can be found on the HPS website.</td>
</tr>
<tr>
<td>Date that data are acquired</td>
<td>Up to the Tuesday prior to release date.</td>
</tr>
<tr>
<td>Release date</td>
<td>05 December 2019</td>
</tr>
<tr>
<td>Frequency</td>
<td>Weekly from week 40 2019 to week 20 2020 and four-weekly from week 21 2020 to week 39 2020.</td>
</tr>
<tr>
<td>Timeframe of data and timeliness</td>
<td>This is up to date data.</td>
</tr>
<tr>
<td>Continuity of data</td>
<td>Data is produced weekly from week 40 2019 to week 20 2020 and four-weekly from week 21 2020 to week 39 2020.</td>
</tr>
<tr>
<td>Revisions statement</td>
<td>These data are not subject to planned major revisions. However, HPS aims to continually improve the interpretation of the data and therefore analysis methods are regularly reviewed and may be updated in the future.</td>
</tr>
<tr>
<td>Revisions relevant to this publication</td>
<td>This publication has no revisions.</td>
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<tr>
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</tr>
<tr>
<td>Concepts and definitions</td>
<td>See Glossary.</td>
</tr>
<tr>
<td>Relevance and key uses of the statistics</td>
<td>The data are used to gauge the start, peak and duration of the influenza season and describe the current impact and the severity of the influenza season in Scotland each winter. Such information allows comparison with prior influenza seasons and with current activity across the UK, Europe and globally.</td>
</tr>
<tr>
<td>Accuracy</td>
<td>1) GP Consultations for ILI received by HPS as weekly automated aggregated data extracts from the GP practice systems. These data are subject to limited data quality assurances. The ILI data are subject to adjustment by statistical methods to allow comparison between seasons – these methods are outlined in a separate technical document. 2) NHS 24 respiratory calls are identified through selected key words to represent chosen syndromes. This is regularly reviewed and monitored by NHS24. 3) Primary care virology (GP Sentinel Swabbing Scheme) – Data is representative at Scottish level but data from beginning and end of season may need to be interpreted with caution due to low number of samples submitted. Virological data is dynamic, therefore, the swab positivity and absolute numbers will change retrospectively week to week as more data becomes available. 4) Secondary care virology (ECOSS) data is subject to a data quality and assurance processes. 5) Acute Respiratory Illness (ARI) outbreaks data is monitored by HPS and followed up with local HPTs to ensure its accuracy. Virological data is dynamic, therefore, the swab positivity and absolute numbers will change retrospectively week to week as more data becomes available. 6) Severe Acute Respiratory Infection (SARI) data is monitored by HPS and followed up with local HPTs to ensure its accuracy. 7) All-cause mortality (obtained from National Records Scotland) is information provided for management purposes and quality assured by NRS. 8) Influenza vaccine uptake data are received by HPS as four-weekly automated aggregated data extracts from the GP practice systems. These data are subject to limited data quality assurances.</td>
</tr>
<tr>
<td>Completeness</td>
<td>1) GP consultations for influenza-like illness (ILI) – approximately 98% (923/940) of GP practices routinely report to HPS. 2) NHS24 respiratory calls – HPS receives 100% of NHS24 calls. 3) Primary care virology (GP Sentinel Swabbing Scheme) – practices invited to participate account for approximately 6% of Scottish population.</td>
</tr>
</tbody>
</table>
Number of practices submitting samples may vary from week to week. Virological data is dynamic, therefore, the swab positivity and absolute numbers will change retrospectively week to week as more data becomes available. 4) Secondary care virology (ECOSS) – all Scottish laboratories submit positive results. Currently only 5 main laboratories submit influenza negative results. Virological data is dynamic, therefore, the swab positivity and absolute numbers will change retrospectively week to week as more data becomes available. 5) Acute Respiratory Illness (ARI) outbreaks – ad-hoc reporting, completeness compared against other sources of information (e.g. HPzone, Hospital outbreak registers). 6) Severe Acute Respiratory Infection (SARI) – ad-hoc reporting, completeness compared against other sources of information (e.g. HPzone, ECOSS). 7) All-cause mortality - data reported 2 weeks in retrospect. 8) Influenza vaccine uptake – approximately 99% (939/940) of GP practices routinely report to HPS. A software issue has delayed the vaccine uptake submission from EMIS practices. The vaccine uptake estimates have been derived from INPS Vision practices only (accounting for 50% of Scottish GP practices) and are compared to vaccine uptake estimates for INPS Visions practices only for previous season at the same point in time. In addition to this, changes being made under the VTP means that uptake information from settings other than general practice may not be available in a timely manner as part of the routine monthly GP data extracts.

Comparability
Public Health England, weekly national influenza report:
Joint ECDC WHO-Euro influenza weekly report:
https://flunewseurope.org/

Accessibility
It is the policy of HPS Scotland to make its web sites and products accessible according to published guidelines.

Coherence and clarity
The report includes detail on the background to the influenza-like illnesses in Scotland as well as analysis results. The report has been produced using the standard HPS publications template and is available as a PDF file.

Value type and unit of measurement
1) GP consultations for influenza-like illness (ILI) are presented as rates per 100,000 population. 2) NHS24 respiratory calls are presented as proportion (%) among all NHS24 calls. 3) Primary care virology (GP Sentinel Swabbing Scheme) data are presented as numbers of influenza detections and proportion of positive samples (%), i.e. swab positivity. 4) Secondary care virology (ECOSS) data for influenza are presented as numbers of laboratory detections, proportion of positive
samples (%), i.e. swab positivity and incidence rate of influenza (rate per 100,000 Scottish population). The number of laboratory detections of other non-influenza respiratory pathogens are presented as activity levels per pathogen. 5) Acute Respiratory Illness (ARI) outbreaks data are presented as counts of outbreaks, proportion of outbreaks by influenza type and geographical region (%). 6) Severe Acute Respiratory Infection (SARI) data are presented as counts of SARI cases, proportion of SARI cases by influenza type and geographical region (%). SARI mortality data are presented as proportion of deaths among SARI cases (%), i.e. case fatality rate (CFR). 7) Excess all-cause mortality data are presented as all-cause mortality excess activity levels (based on EUROMOMO model z-scores) and number of weeks where excess was observed. Data is presented two weeks in retrospect to allow for data delays. 8) Influenza vaccine uptake data are presented as proportion of individuals vaccinated (%) per vaccination target group.

<table>
<thead>
<tr>
<th>Disclosure</th>
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Appendix 3 - Early access details

Pre-Release Access

Under terms of the “Pre-Release Access to Official Statistics (Scotland) Order 2008”, HPS is obliged to publish information on those receiving Pre-Release Access ("Pre-Release Access" refers to statistics in their final form prior to publication). The standard maximum Pre-Release Access for Experimental Official Statistics is 24 hours. Shown below are details of those receiving standard Pre-Release Access.

Standard Pre-Release Access:

- Scottish Government Health Department (health protection policy and winter planning teams)
- NSS Media Relations team
- NHS Board Chief Executives
- NHS Board Communication leads
Appendix 4 - HPS and Official Statistics

About HPS

HPS is a division of NHS National Services Scotland which works at the very heart of the health service across Scotland, delivering services critical to frontline patient care and supporting the efficient and effective operation of NHS Scotland. HPS was established by the Scottish Government in 2005 to strengthen and coordinate health protection in Scotland. It is organised into three specialist groups with expertise provided by a multi-disciplinary workforce which includes doctors, nurses, scientists and information staff, all of whom are supported by core business teams. The specialist groups are:

• Antimicrobial Resistance Healthcare Associated Infections;
• Blood Borne Viruses and Sexually Transmitted Infections, Immunisation, and Respiratory and Vaccine Preventable Diseases;
• Environmental Public Health, Gastrointestinal and Zoonoses, Travel and International Health.

Official Statistics

Our official statistics publications are produced to a high professional standard and comply with the Code of Practice for Official Statistics. The Code of Practice is produced and monitored by the UK Statistics Authority which is independent of Government. Under the Code of Practice, the format, content and timing of statistics publications are the responsibility of professional staff working within NHS National Services Scotland. Our statistical publications are currently classified as one of the following:

• National Statistics (i.e. assessed by the UK Statistics Authority as complying with the Code of Practice)
• National Statistics (i.e. legacy, still to be assessed by the UK Statistics Authority)
• Official Statistics (i.e. still to be assessed by the UK Statistics Authority)
• Other (not Official Statistics)

Further information on NHS National Services Scotland’s statistics, including compliance with the Code of Practice for Official Statistics, and on the UK Statistics Authority, is available on the ISD website.