



UK Health
Security
Agency

Weekly national Influenza and COVID-19 surveillance report

Week 40 report (up to week 39 data)

6 October 2022

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For additional information including regional data on COVID-19 and other respiratory viruses, COVID-19 in educational settings, co- and secondary infections with COVID-19 and other data supplementary to this report, please refer to the [accompanying graph pack](#).

Executive summary

This report summarises the information from the surveillance systems which are used to monitor coronavirus (COVID-19), influenza, and other seasonal respiratory viruses in England. References to COVID-19 represent the disease name and SARS-CoV-2 represent the virus name. The report is based on data from week 39 (between 26 September to 2 October 2022) and for some indicators daily data up to 4 October 2022.

At a national level, COVID-19 activity increased in most indicators in week 39 of 2022. Surveillance indicators suggest low levels of influenza activity, with increases seen in some indicators.

Overall COVID-19 case rates through Pillar 1 increased in week 39, in some age groups, regions and ethnic groups. Overall Pillar 1 positivity increased compared to the previous week. Routine asymptomatic testing through NHS settings has been paused from 31 August, this will have an impact on Pillar 1 case rates and positivity rates.

Through Respiratory Datamart, influenza positivity was low but increased to 2.8% in week 39. SARS-CoV-2 positivity increased to 8.3%. Respiratory syncytial virus (RSV) positivity decreased to 2.9% in week 39, while there was an increase in the under 5 year olds at 11.0%. Adenovirus positivity remained stable at 1.8%. Rhinovirus positivity decreased to 18.7% overall. Parainfluenza positivity decreased to 1.2%, while human metapneumovirus (hMPV) positivity remained low at 1.1% in week 39.

The overall number of reported acute respiratory incidents increased compared to the previous week, with the highest number of incidents continuing to be in care homes. SARS-CoV-2 was identified in the majority of these. Through NHS 111, increases in calls for flu/cold and cough were observed.

Through primary care surveillance, influenza like illness consultations remain low, while lower respiratory tract infection and COVID-19 like consultations have increased. Through sentinel GP swabbing, SARS-CoV-2 positivity remained stable.

COVID-19 hospitalisations and ICU or HDU admissions with COVID-19 increased in week 39 and particularly noted in older age groups. Influenza hospital admissions remain at baseline. The RSV hospitalisation rate increased in the under 5 year olds. Increases in emergency department attendances for COVID-19 and acute respiratory infections were also noted.

Deaths with COVID-19 increase slightly in week 38.

COVID-19 vaccine coverage for all ages was 70.9% for dose 1 and 67.4% for dose 2 at the end of week 39. COVID-19 vaccine coverage for all ages for dose 3 was at 53.1% at the end of week 39. The COVID-19 Autumn booster vaccination campaign commenced in early September. By the end of week 39 19.7% of all people aged over 50 years old had been vaccinated with an Autumn booster dose.

Laboratory surveillance

Confirmed COVID-19 cases (England)

From 1 April 2022, the government ended provision of widespread community testing in England, as outlined in the plan for [living with COVID-19](#). From week 15 2022, confirmed COVID-19 episodes and positivity through Pillar 1 are presented in this report, with Pillar 2 data available in the accompanying graph pack. Routine asymptomatic testing through NHS settings has been paused from 31 August, this will have an impact on Pillar 1 case rates and positivity rates.

As of 9am on 4 October 2022, a total of 1,859,331 episodes have been confirmed for COVID-19 in England under Pillar 1, and 18,148,906 episodes have been confirmed for COVID-19 in England under Pillar 2, since the beginning of the pandemic.

Overall COVID-19 case rates through Pillar 1 increased in week 39, in some age groups, regions and ethnic groups. Overall Pillar 1 positivity increased compared to the previous week.

* Changes to testing policies over time may affect positivity rates and incidence rates and should be interpreted accordingly.

* From 31 January 2022, UK Health Security Agency (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 (polymerase chain reaction (PCR) or rapid lateral flow device). Each infection episode begins with the earliest positive specimen date. Further information can be found on the [UK COVID-19 dashboard](#).

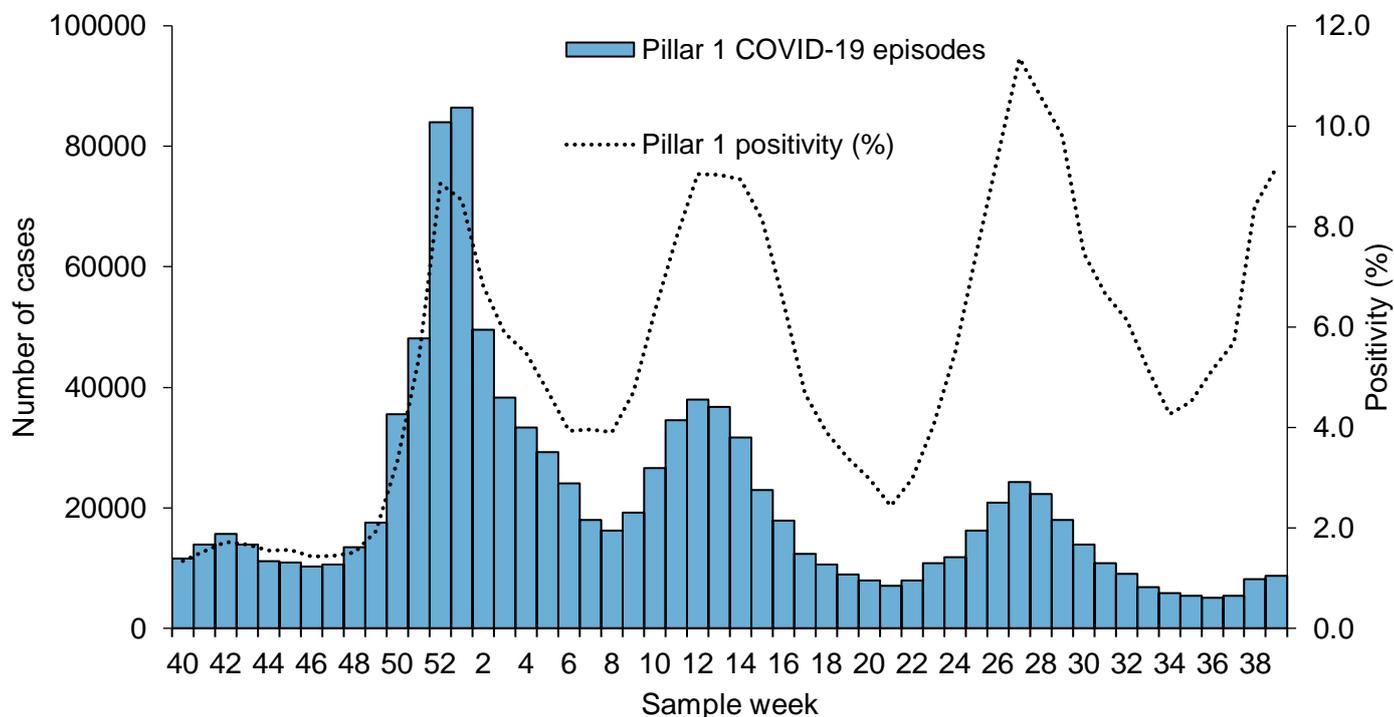
* From the week 32 2021 report onwards, case rates have been updated to use the latest Office for National Statistics (ONS) population estimates for mid-2020. Previously case rates were calculated using the mid-2019 population estimates. Rates by ethnicity and Indices of Multiple Deprivation (IMD) quantile will continue to be presented using the mid-2019 estimates, until the mid-2020 estimates become available.

* Please note that positivity is presented as positivity by PCR testing only. Positivity is calculated as the number of individuals testing positive during the week divided by the number of individuals tested during the week through PCR testing

* Data is shown by the week the specimen was taken from the person being tested. This gives the most accurate analysis of this time progression, however, for the most recent week results for more samples are expected therefore this should be interpreted with caution

* Data source: Second Generation Surveillance System (SGSS)

Figure 1: Confirmed COVID-19 episodes tested under Pillar 1, based on sample week with overall weekly PCR positivity for Pillar 1 (%)



Age and sex

Figure 2: Weekly confirmed COVID-19 case rates per 100,000, by episode, tested under Pillar 1, by sex

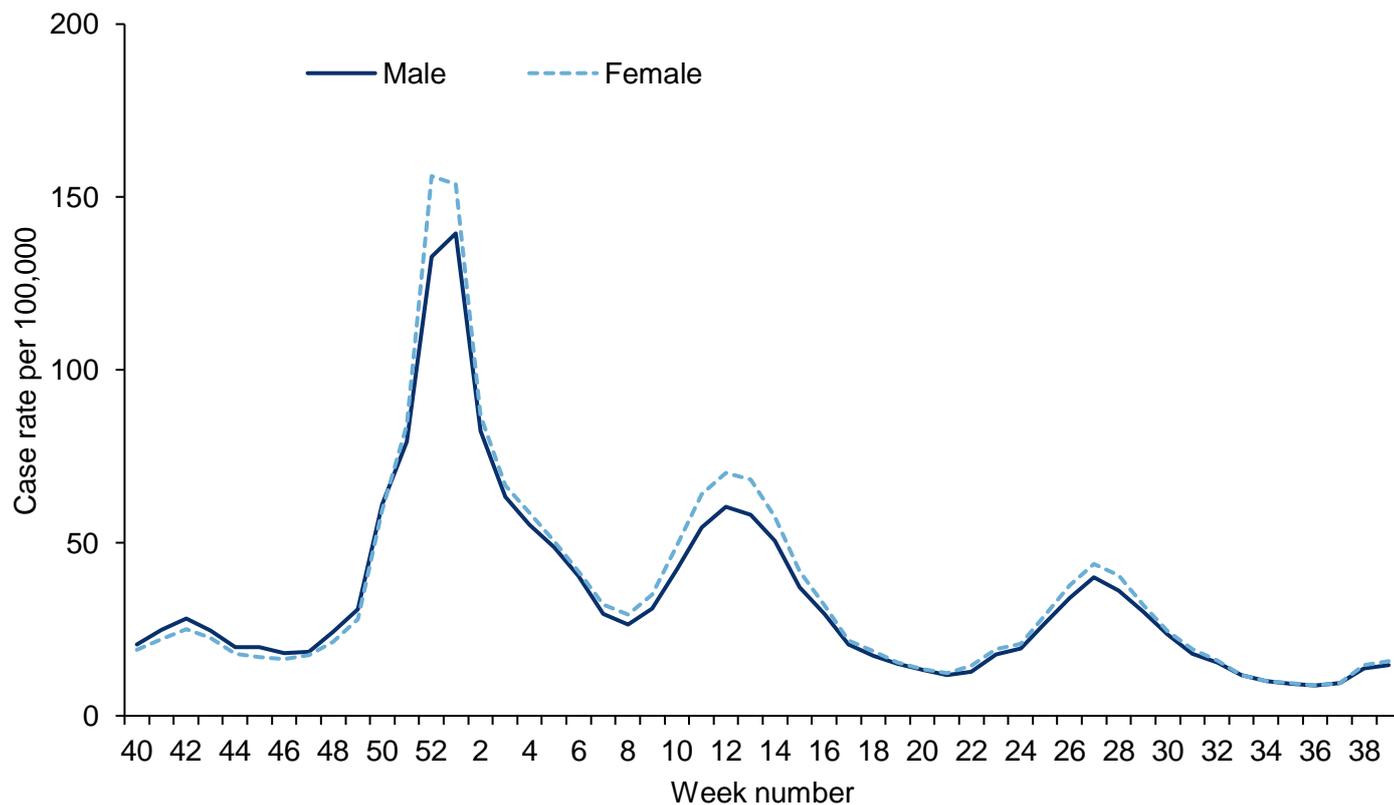


Figure 3: Weekly confirmed COVID-19 case rates per 100,000, by episode, tested under Pillar 1, by age group

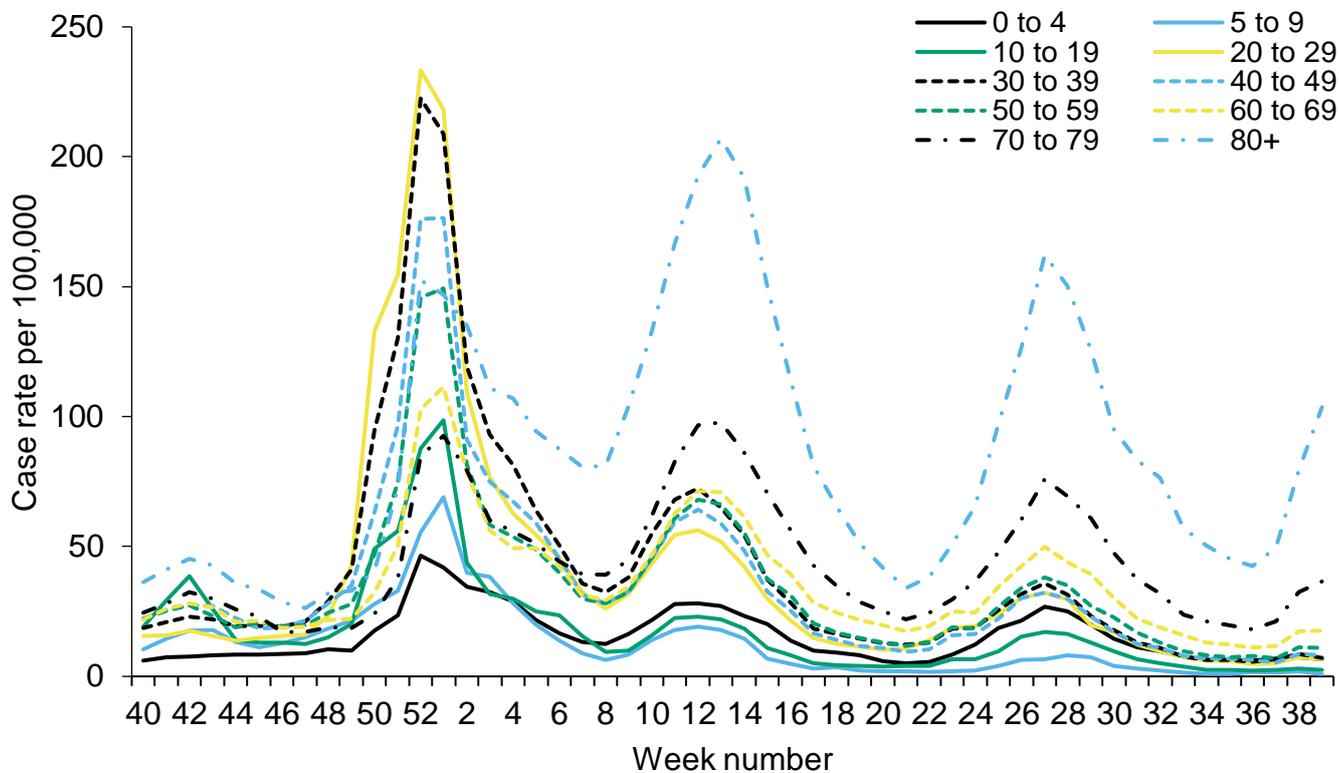


Figure 4: Weekly PCR positivity (%) of confirmed COVID-19 cases tested overall and by sex under Pillar 1

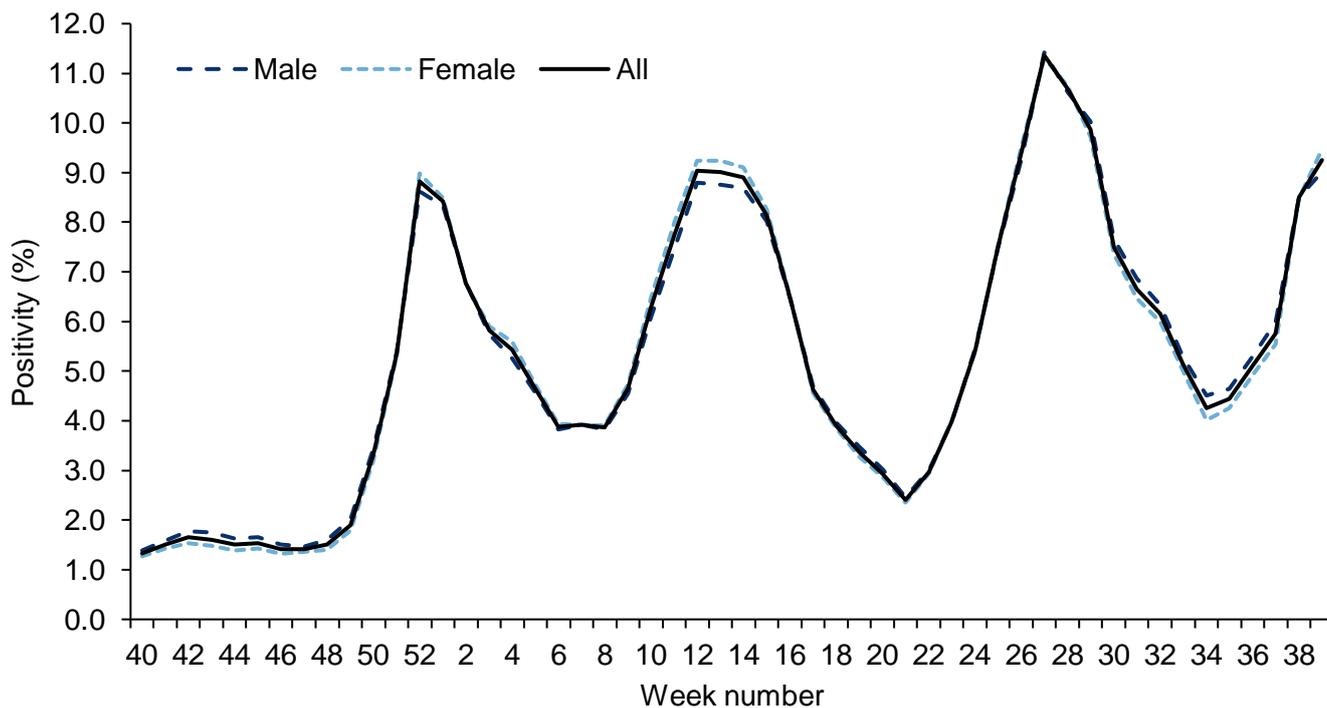
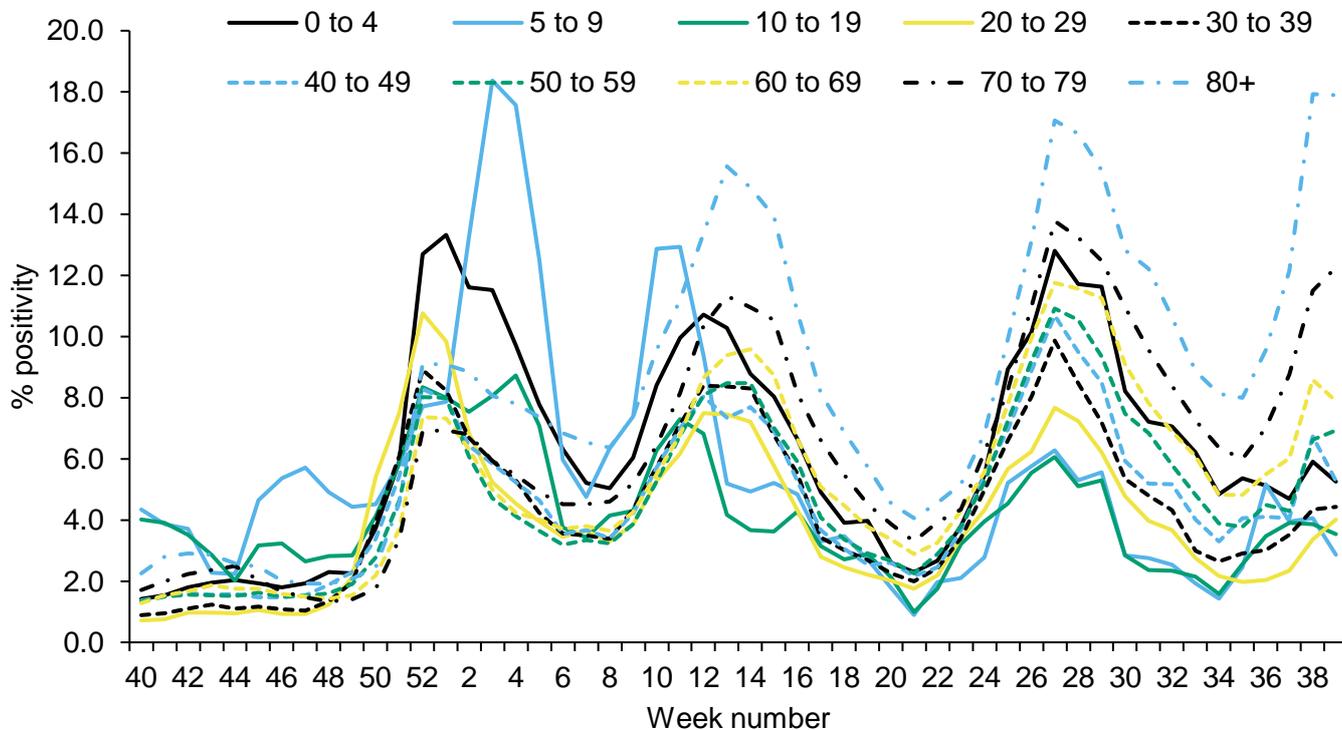
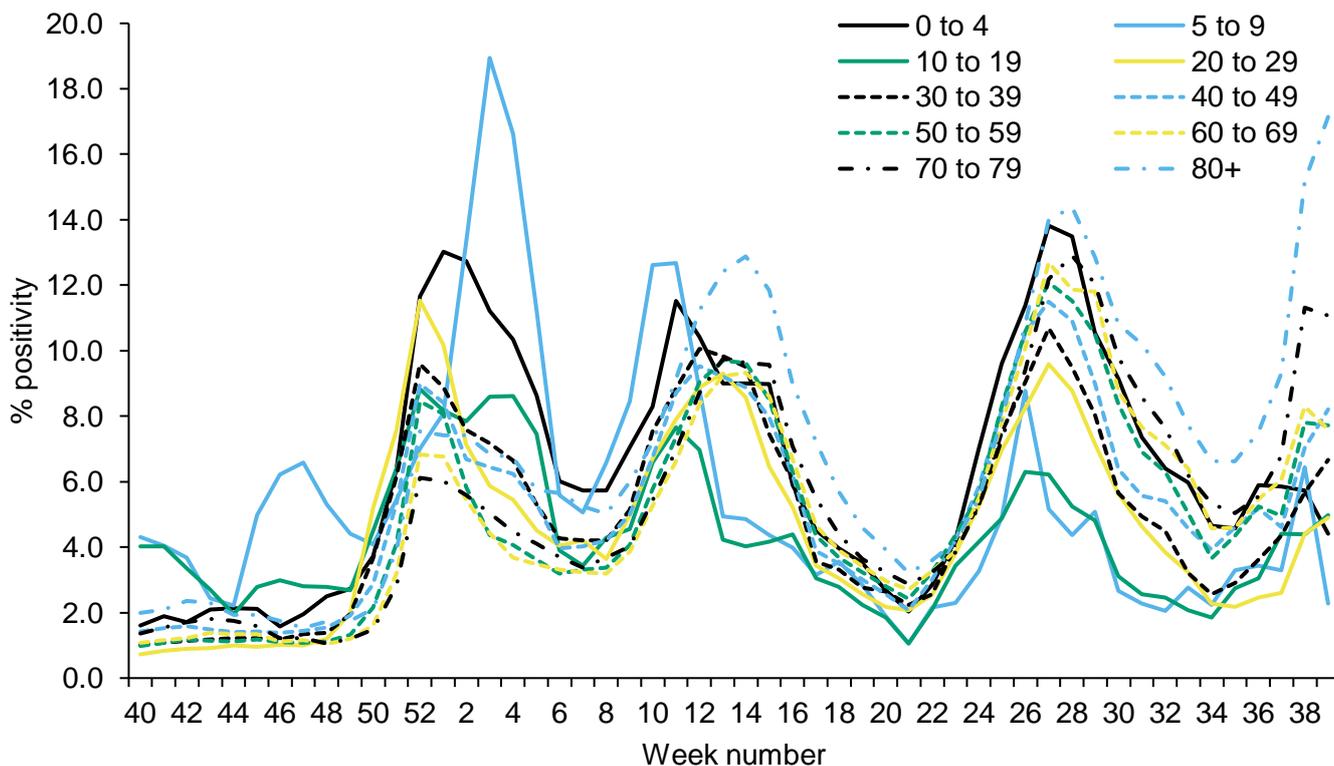


Figure 5: Weekly PCR positivity (%) of confirmed COVID-19 cases tested under Pillar 1, (a) by male and age group and (b) by female and age group

(a) Pillar 1 - Male



(b) Pillar 1 - Female



Geography

Figure 6: Weekly confirmed COVID-19 case rates by episode, per 100,000 population (Pillar 1), by UKHSA centres and sample week

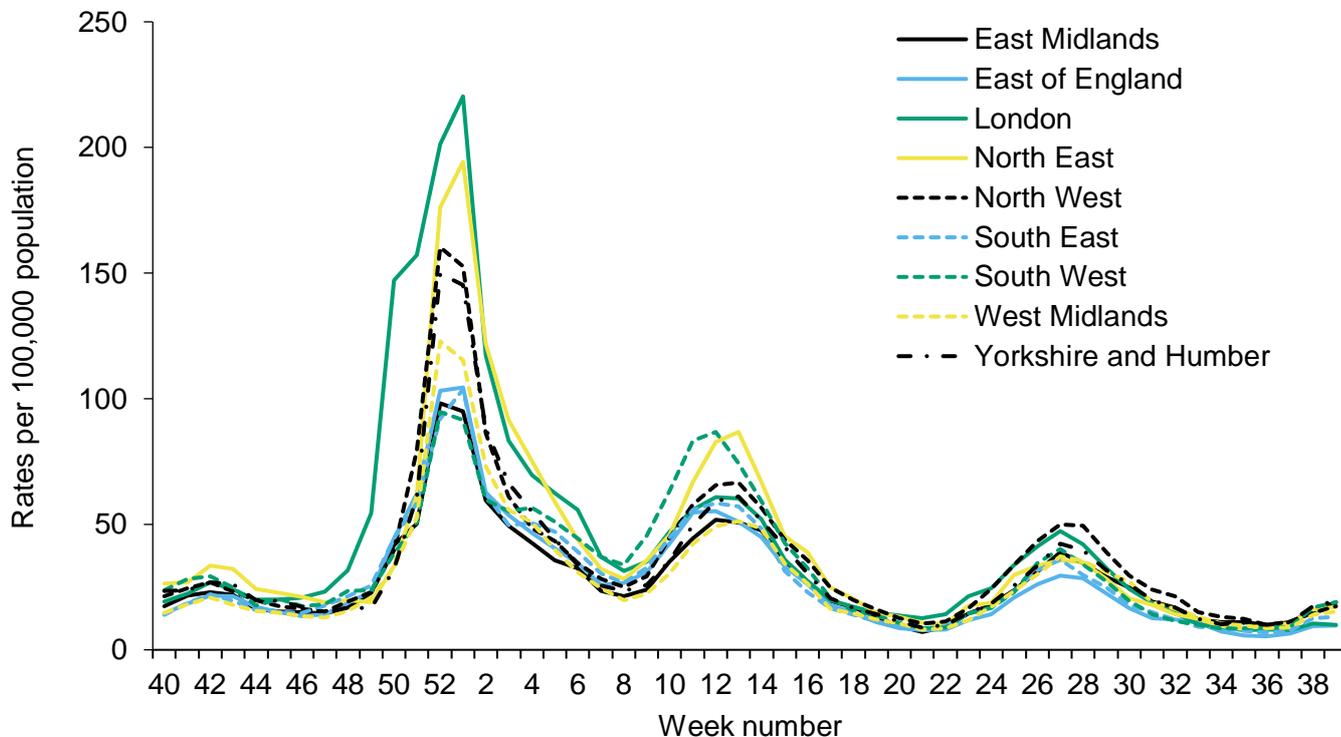


Figure 7: Weekly PCR positivity of confirmed COVID-19 cases tested under Pillar 1 (%) by UKHSA centres and sample week

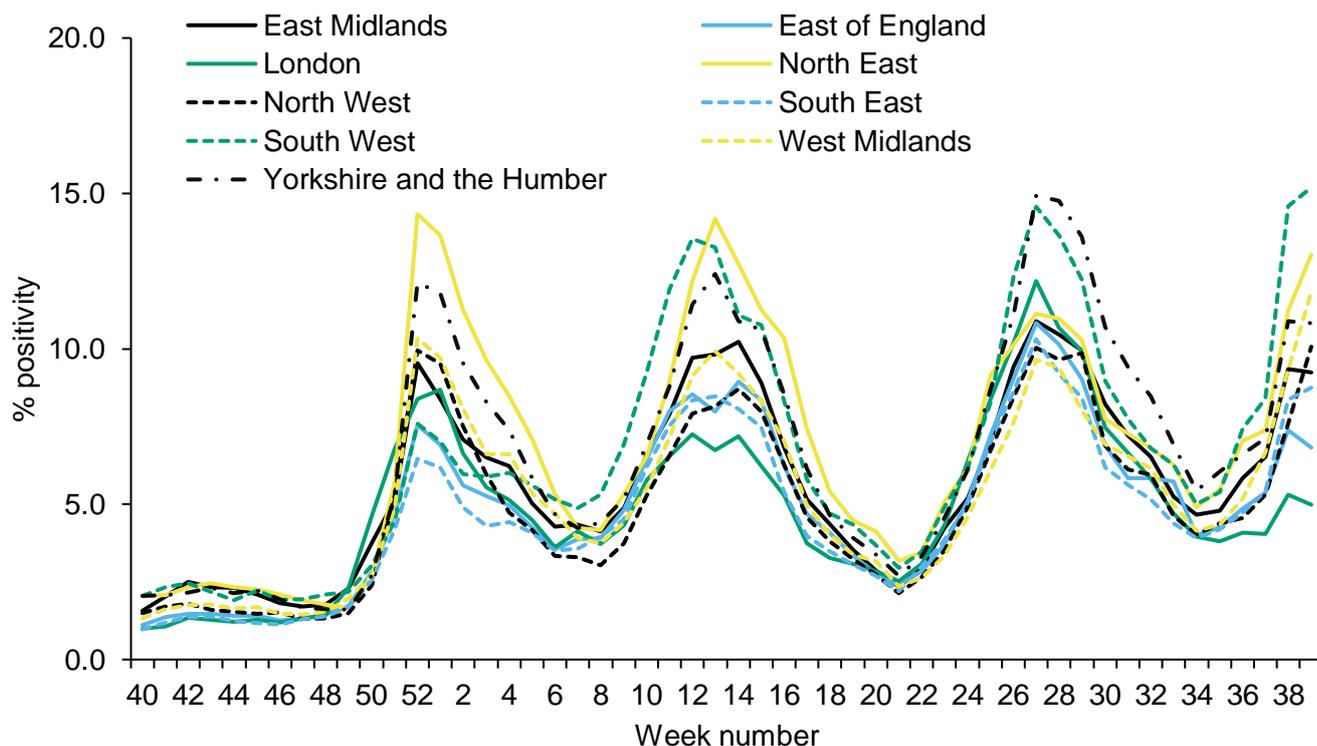
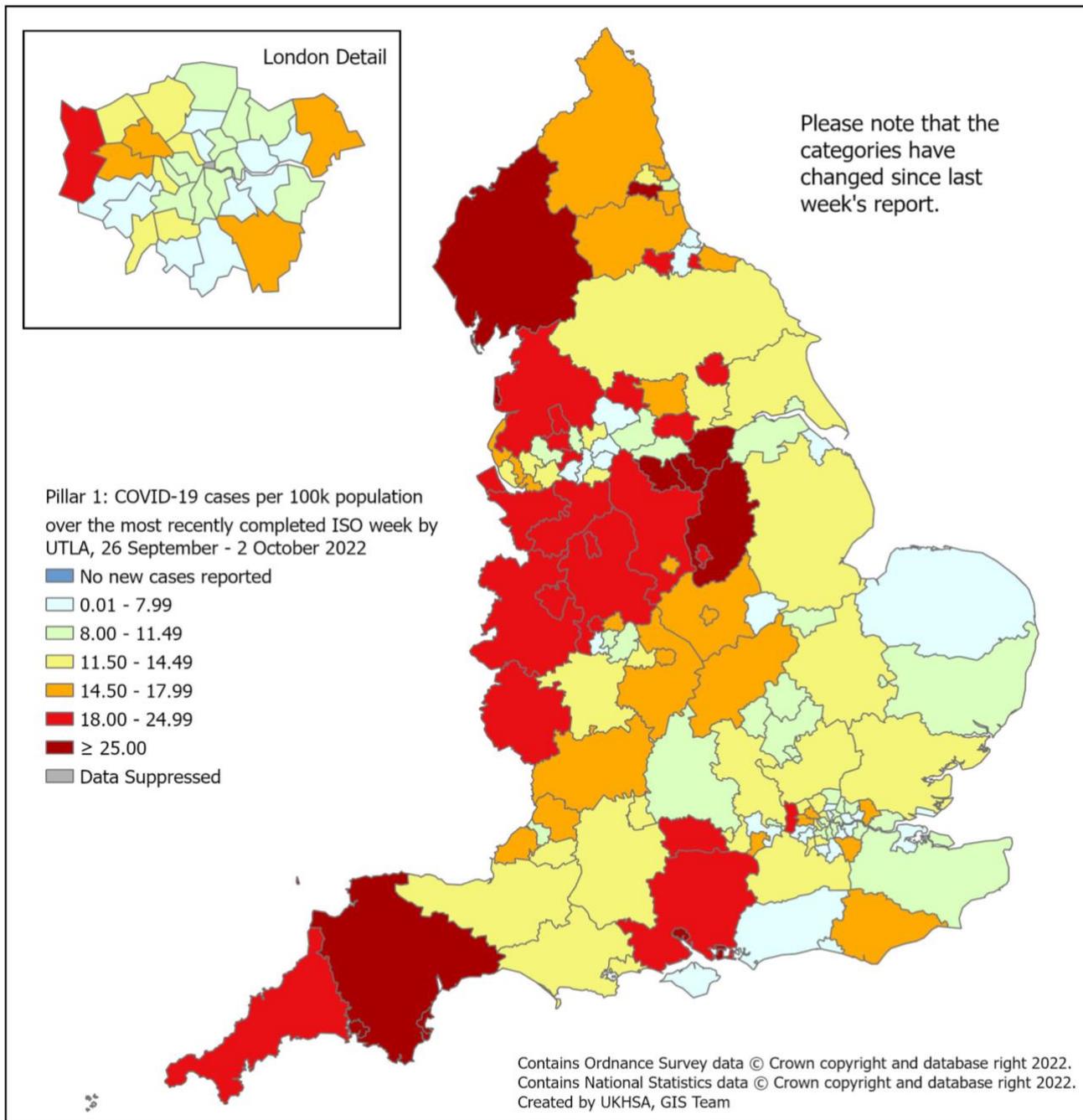
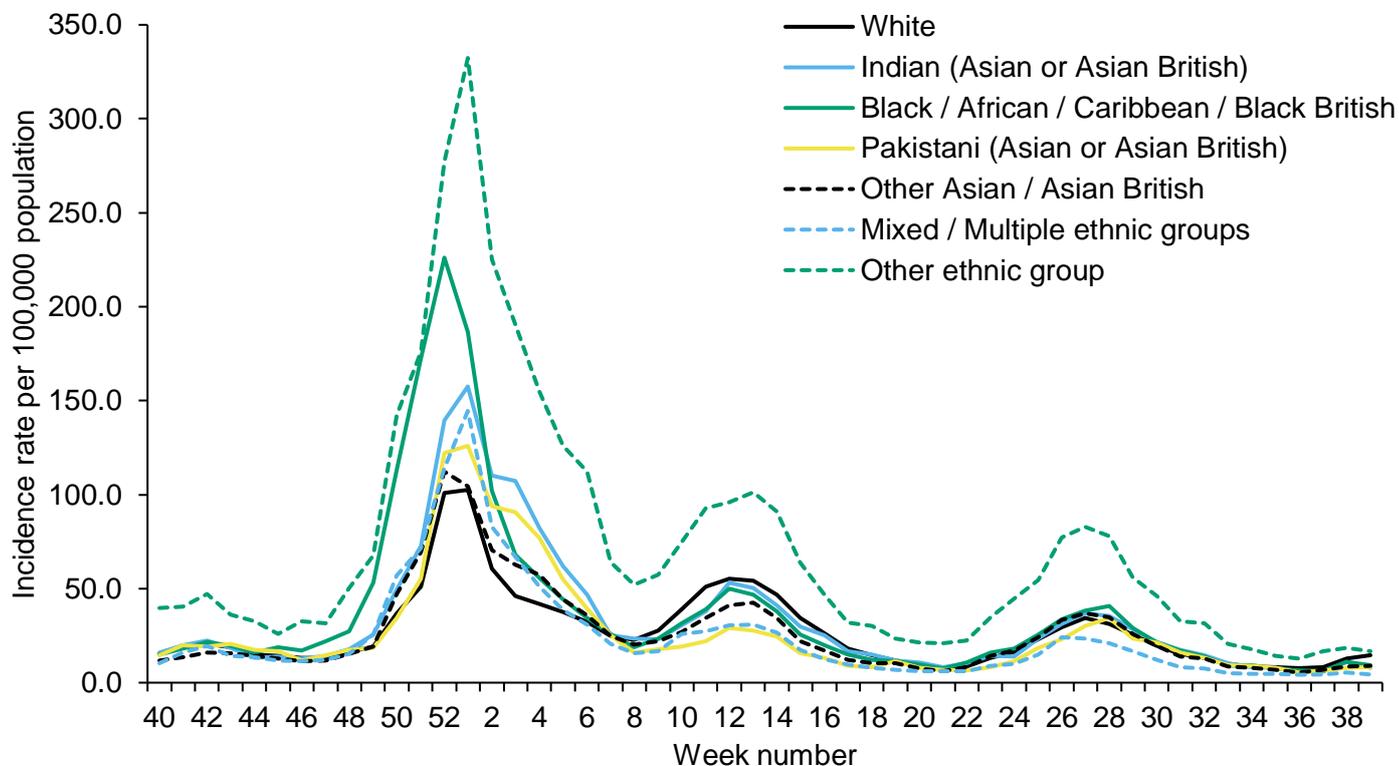


Figure 8: Weekly rate of COVID-19 episodes per 100,000 population (Pillar 1), by upper-tier local authority (UTLA), England (box shows enlarged map of London area)



Ethnicity

Figure 9: Weekly incidence per 100,000 population by ethnicity (Pillar 1), England



*the incidence rates on Figure 9 have been calculated using the mid-2019 ONS population estimates

Possible SARS-CoV-2 reinfection in England

SARS-CoV-2 reinfections data is not currently being published. For previous updates please see previous editions of this report.

Respiratory DataMart system (England)

The Respiratory Datamart system began during the 2009 influenza pandemic to collate all laboratory testing information in England. It is now used as a sentinel laboratory surveillance tool, monitoring all major respiratory viruses in England. Seventeen laboratories in England will be reporting data for this season. As this is based on a sample of labs, SARS-CoV-2 positivity figures quoted here will differ from those quoted in the Confirmed COVID-19 cases section, however, they are included to allow comparison with data on other respiratory viruses.

In week 39 of 2022, out of the 12,863 respiratory specimens reported through the Respiratory DataMart System (based on data received from 14 out of 17 laboratories), 1069 samples were positive for SARS-CoV-2 with an overall positivity of 8.3%, which has been increasing since week 36. The highest positivity was noted in the 65 year olds and over at 1.3%.

The overall influenza positivity was low but increased to 2.8% in week 39, with 66 samples testing positive for influenza (including 2 influenza A(H1N1)pdm09, 10 influenza A(H3N2), 46 influenza A(not subtyped) and 8 influenza B).

Respiratory syncytial virus (RSV) positivity decreased to 2.9% in week 39, while there was an increase in the under 5 year olds at 11.0%.

Adenovirus positivity remained stable at 1.8%. Rhinovirus positivity decreased to 18.7% overall. Parainfluenza positivity decreased to 1.2%, while human metapneumovirus (hMPV) positivity remained low at 1.1% in week 39 (Figure 12).

Figure 10: Respiratory DataMart samples positive for influenza and weekly positivity (%) for influenza, England

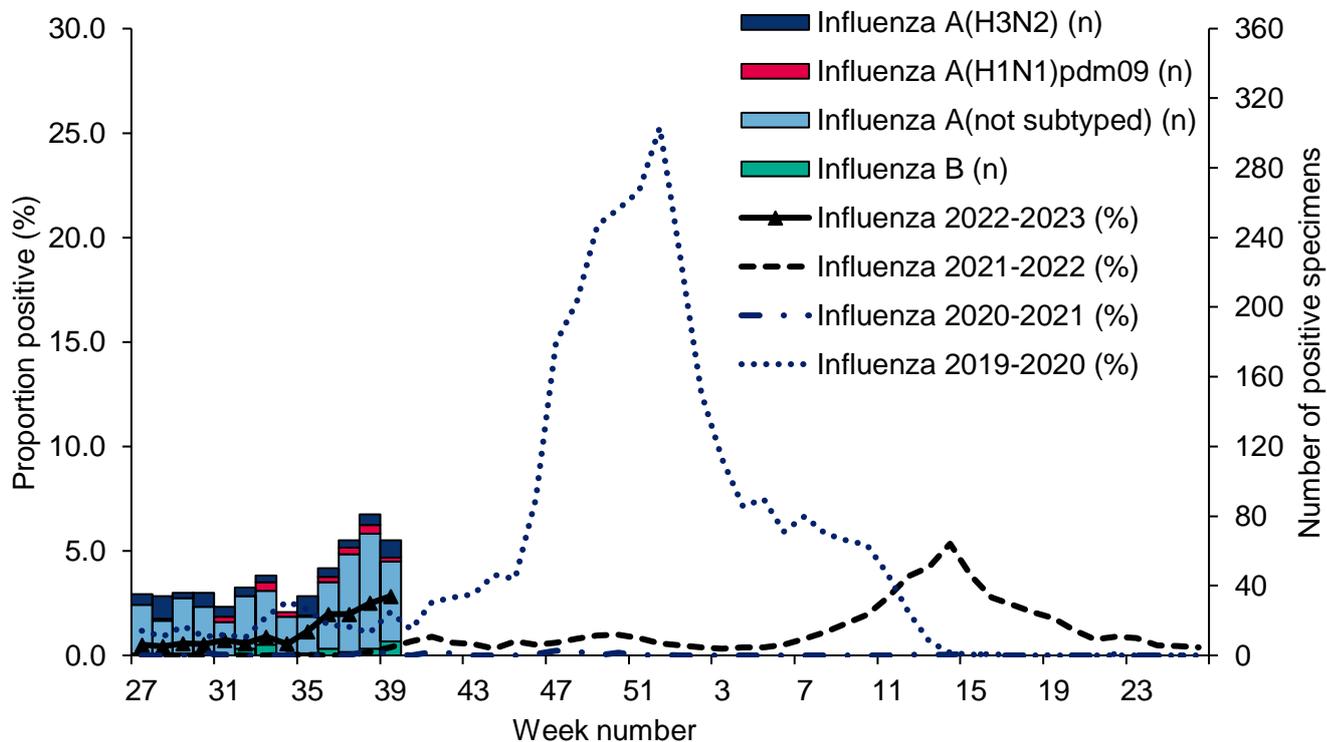


Figure 11: Respiratory DataMart weekly positivity (%) for SARS-CoV-2, England

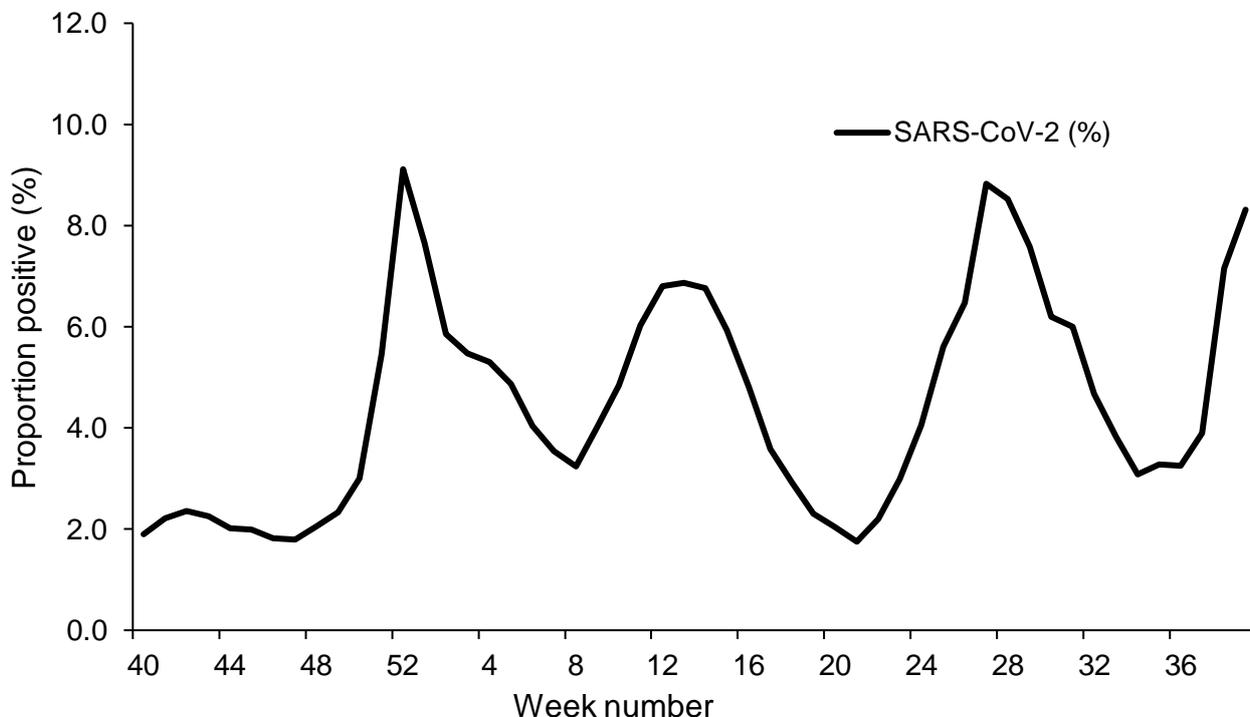


Figure 12: Respiratory DataMart weekly positivity (%) for other respiratory viruses, England

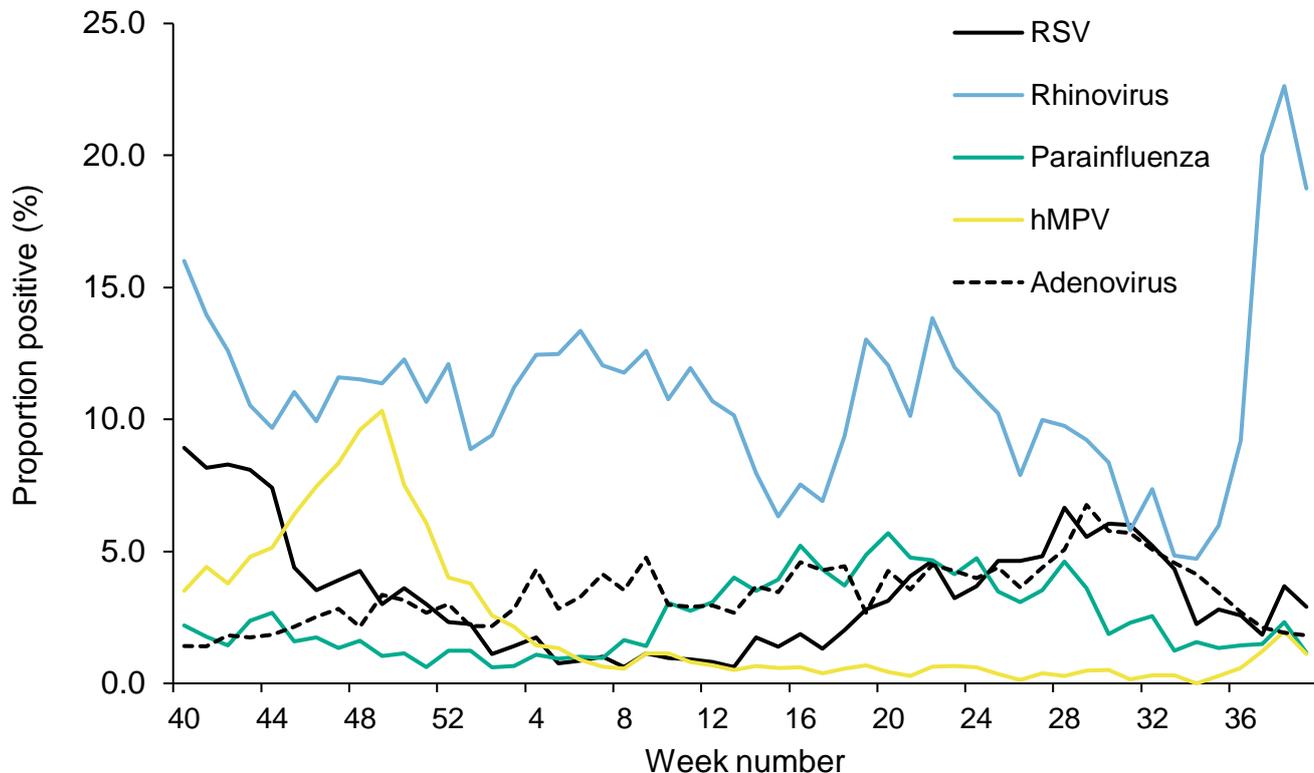


Figure 13: Respiratory DataMart weekly positivity (%) for adenovirus by age, England

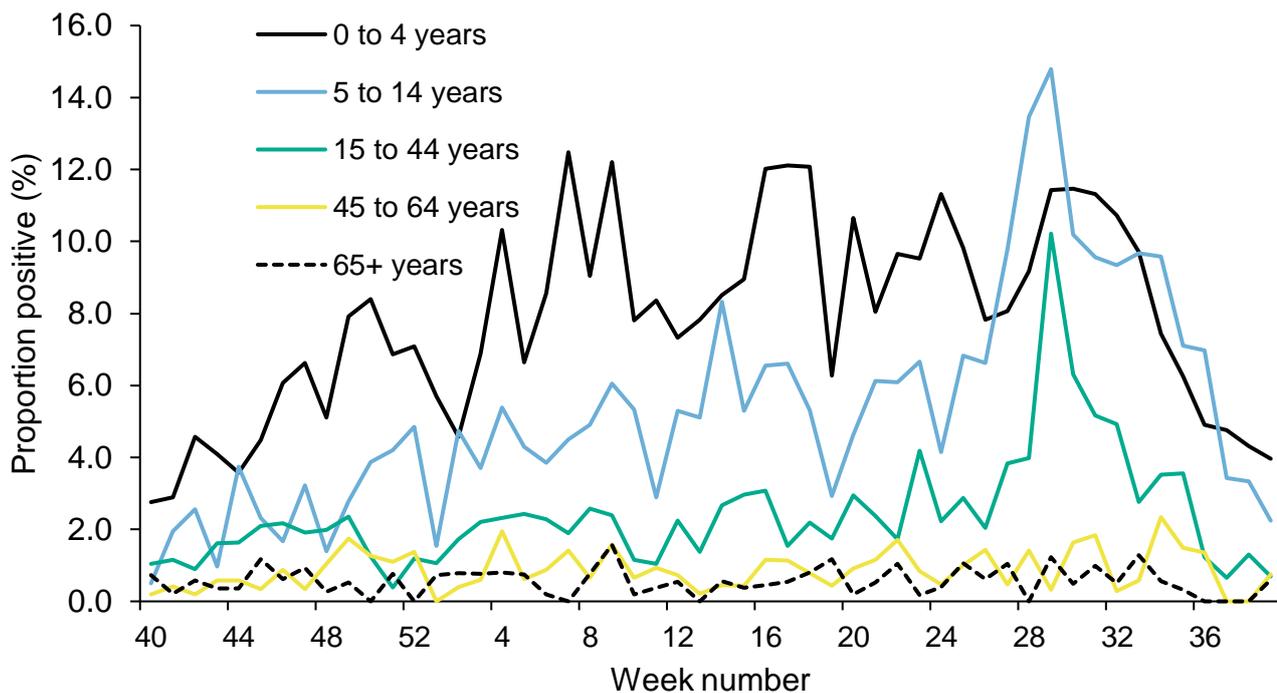


Figure 14: Respiratory DataMart weekly positivity (%) for rhinovirus by age, England

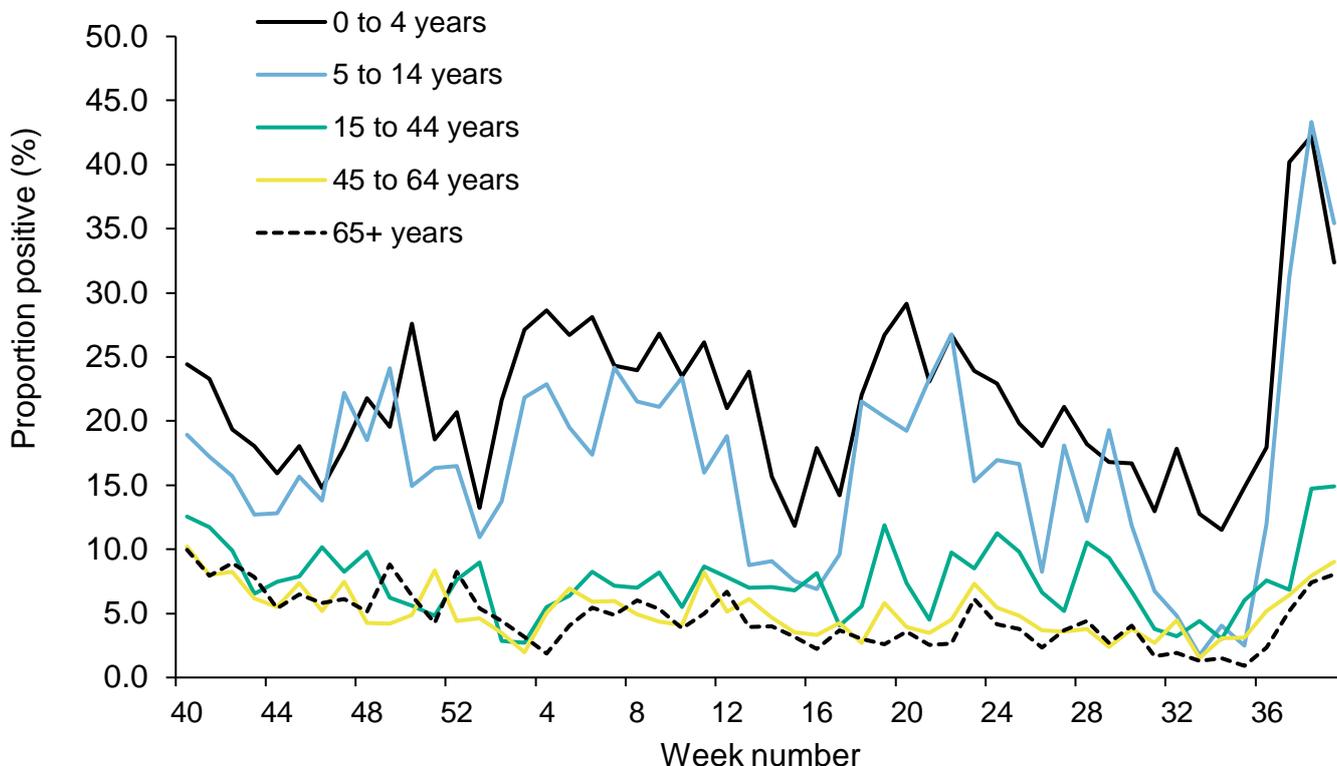
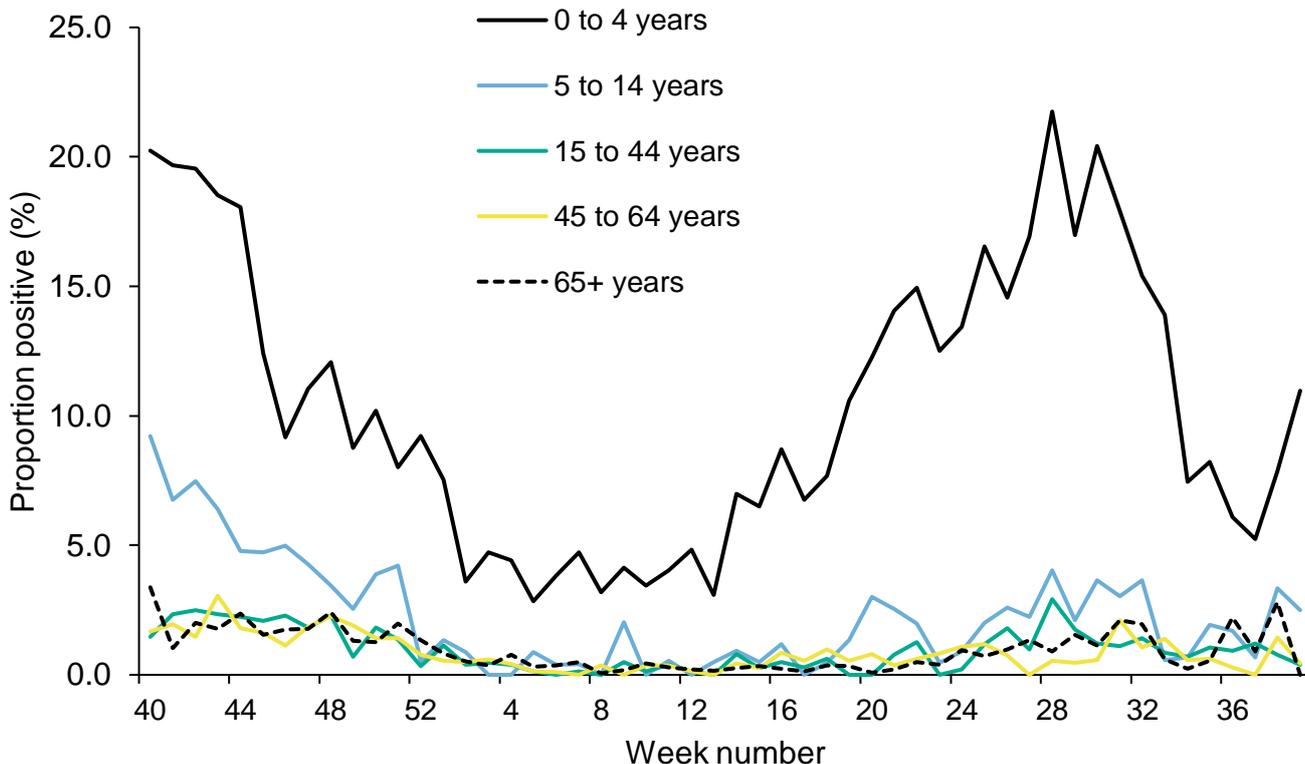


Figure 15: Respiratory DataMart weekly positivity (%) for RSV by age, England



Community surveillance

Acute respiratory infection incidents

Here we present data on acute respiratory infection (ARI) incidents in different settings that are reported to UKHSA Health Protection Teams (HPTs) and entered onto an online web-based platform called HPZone. Incidents are suspected outbreaks of acute respiratory infections linked to a particular setting. All suspected outbreaks are further investigated by the HPT in liaison with local partners.

Data for England, Scotland and Northern Ireland are included in the UK figures.

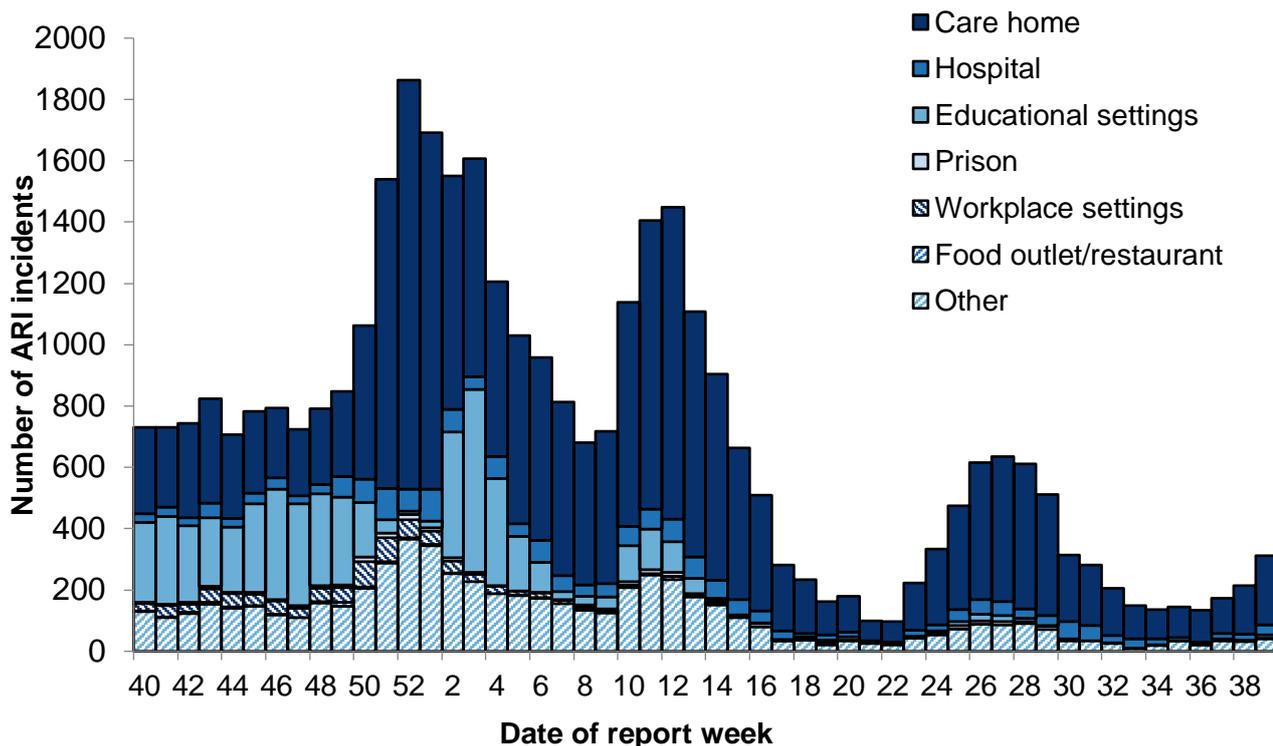
Data caveats:

1. The incidents captured on HPZone represent a subset of all ongoing ARI clusters and outbreaks in England rather than an exhaustive listing. A variety of arrangements are in place across UKHSA centres, with local authorities and other stakeholders supporting HPTs in outbreak investigation in some areas without HPZone reporting. As a result, the number of outbreaks reported for some of the regions are underestimates.
2. It should be noted that the denominator for the different settings will vary significantly. For example, there are fewer hospitals than workplaces. In addition, the propensity to report incidents to UKHSA also varies significantly by setting. This needs to be considered when interpreting the weekly number of reported incidents by setting and caution should be used when making comparisons between settings.
3. Considering the above, comparisons between regions and settings are not advised as they may be misleading.

312 new ARI incidents have been reported in week 39 in the UK (Figure 16):

- 226 incidents were from care homes where 145 had at least one linked case that tested positive for SARS-CoV-2 and one for influenza A(not subtyped) and 2 for rhinovirus
- 33 incidents were from hospitals, where 20 had at least one linked case that tested positive for SARS-CoV-2 and 1 for influenza A(not subtyped)
- 10 incidents were from educational settings, where 2 had at least one linked case that tested positive for SARS-CoV-2
- 1 incident was from prison and had at least one linked case that tested positive for SARS-CoV-2
- No incidents were from workplace settings
- No incidents were from a food outlet or restaurant setting
- 41 incidents were from other settings where 20 had at least one linked case that tested positive for SARS-CoV-2, 2 for influenza A(not subtyped) and 1 for RSV

Figure 16: Number of acute respiratory infection (ARI) incidents by setting, UK



*Excludes data from Wales

Figure 17: Number of acute respiratory infection (ARI) incidents by setting, England

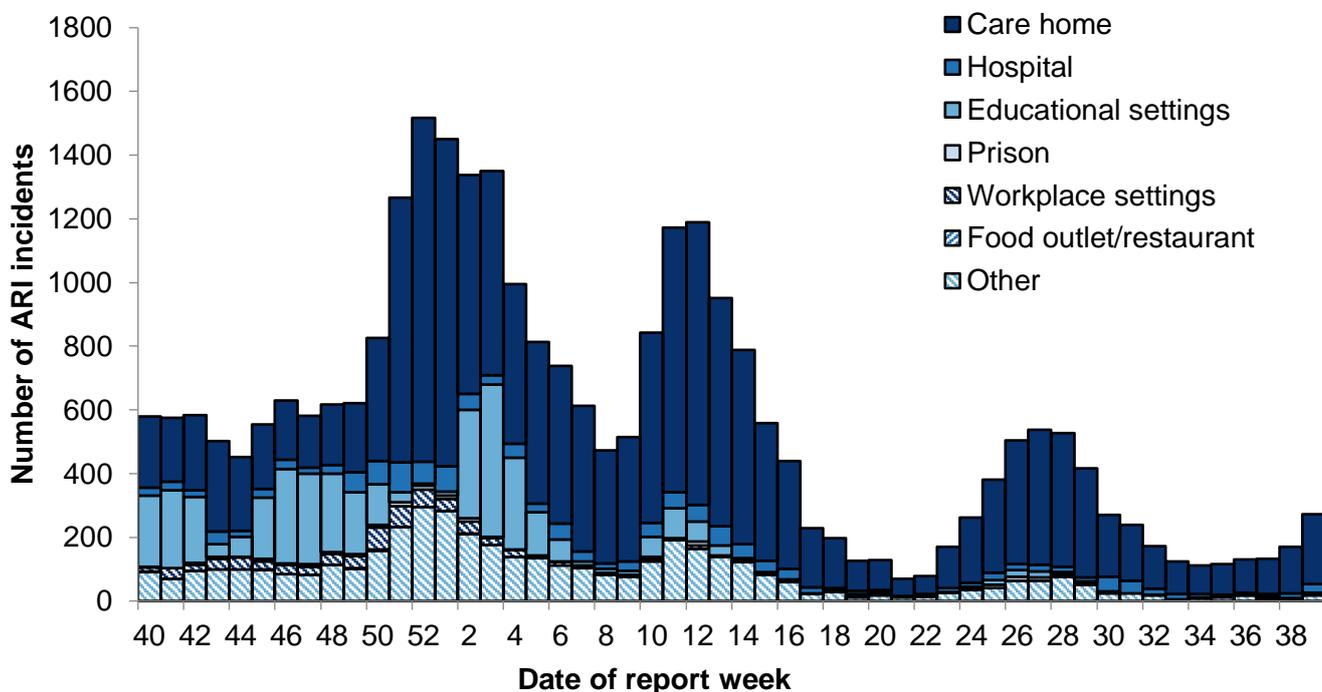


Figure 18: Number of acute respiratory infection (ARI) incidents in care homes by virus type, England

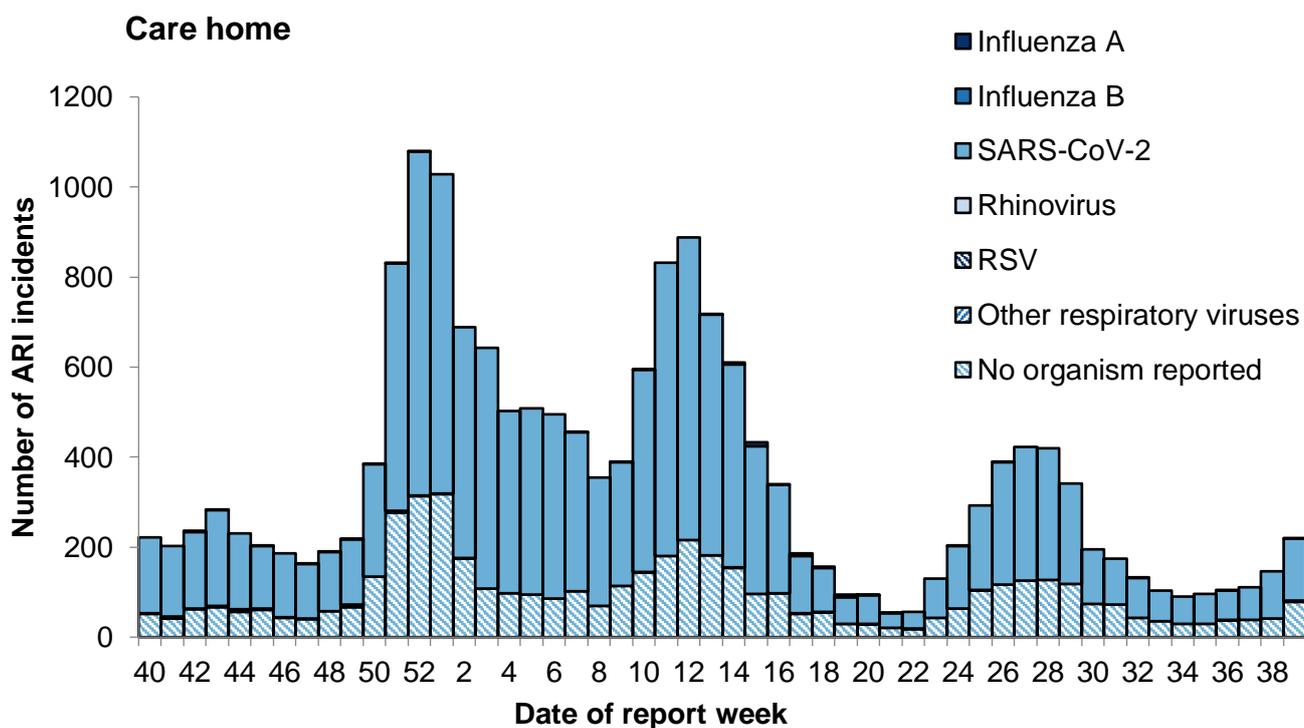


Figure 19: Number of acute respiratory infection (ARI) incidents in hospitals by virus type, England

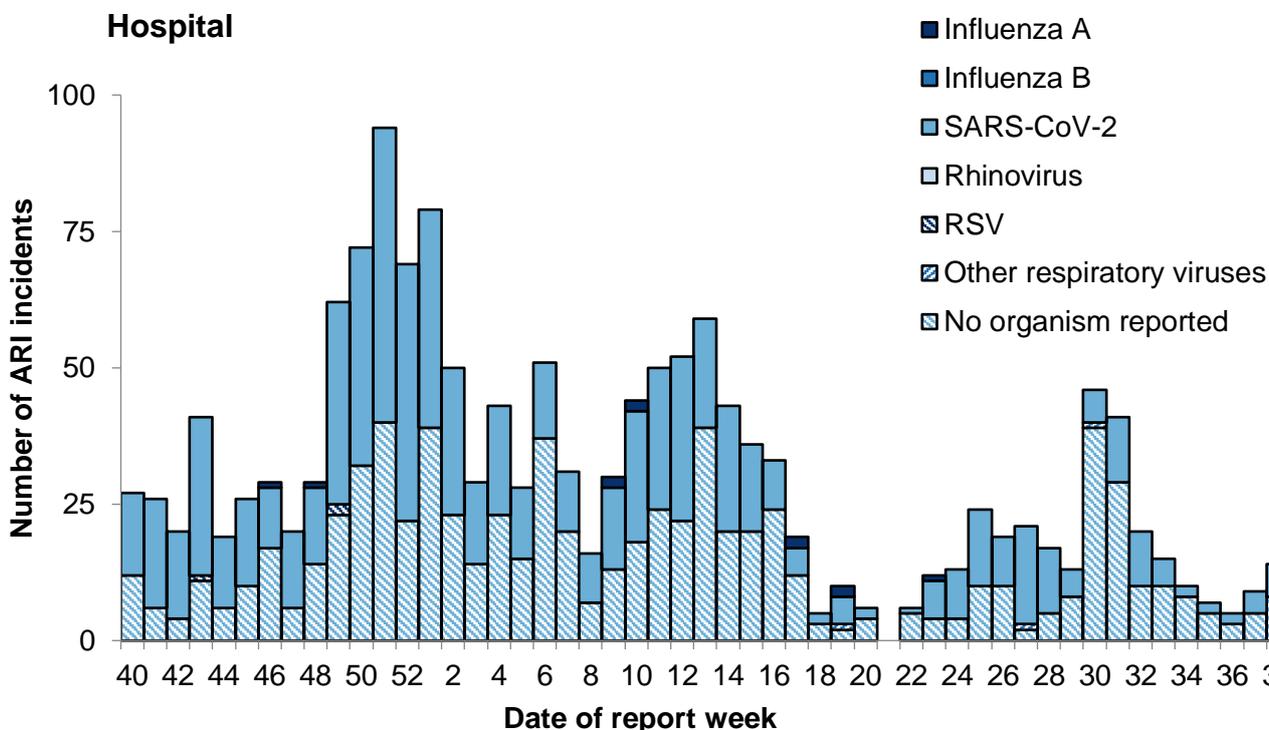


Figure 20: Number of acute respiratory infection (ARI) incidents in educational settings by virus type, England

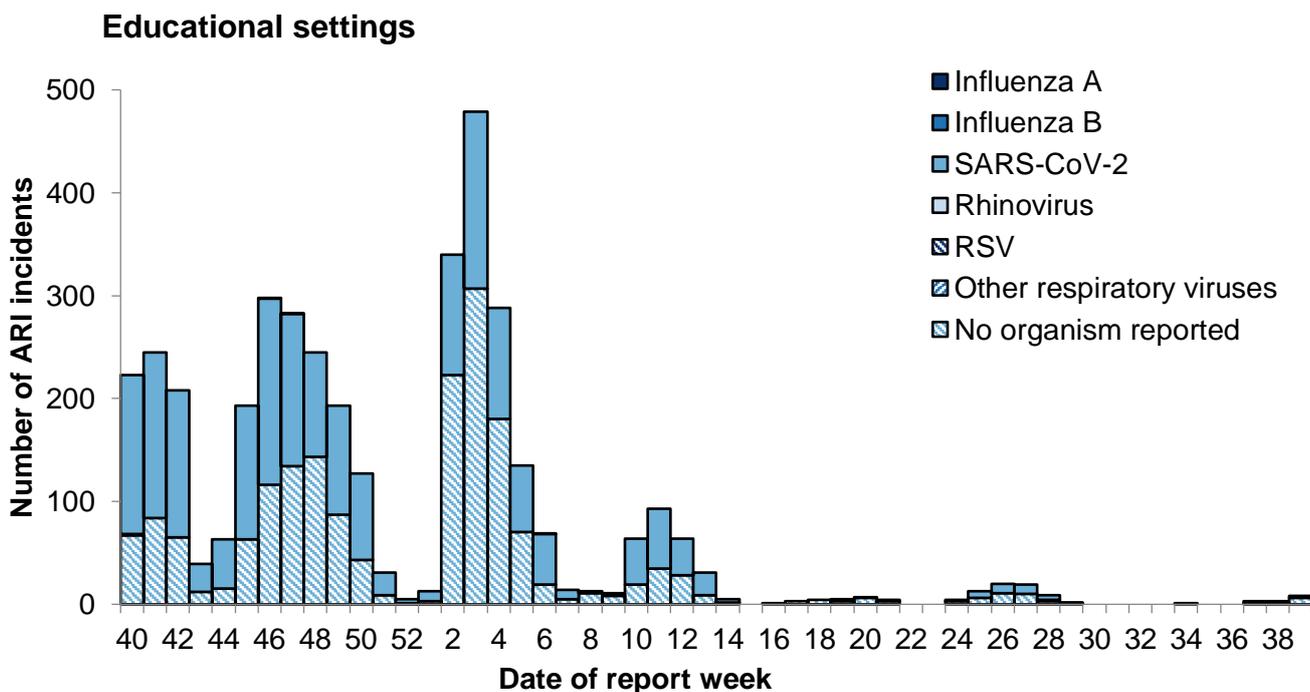


Figure 21: Number of acute respiratory infection (ARI) incidents in prisons by virus type, England

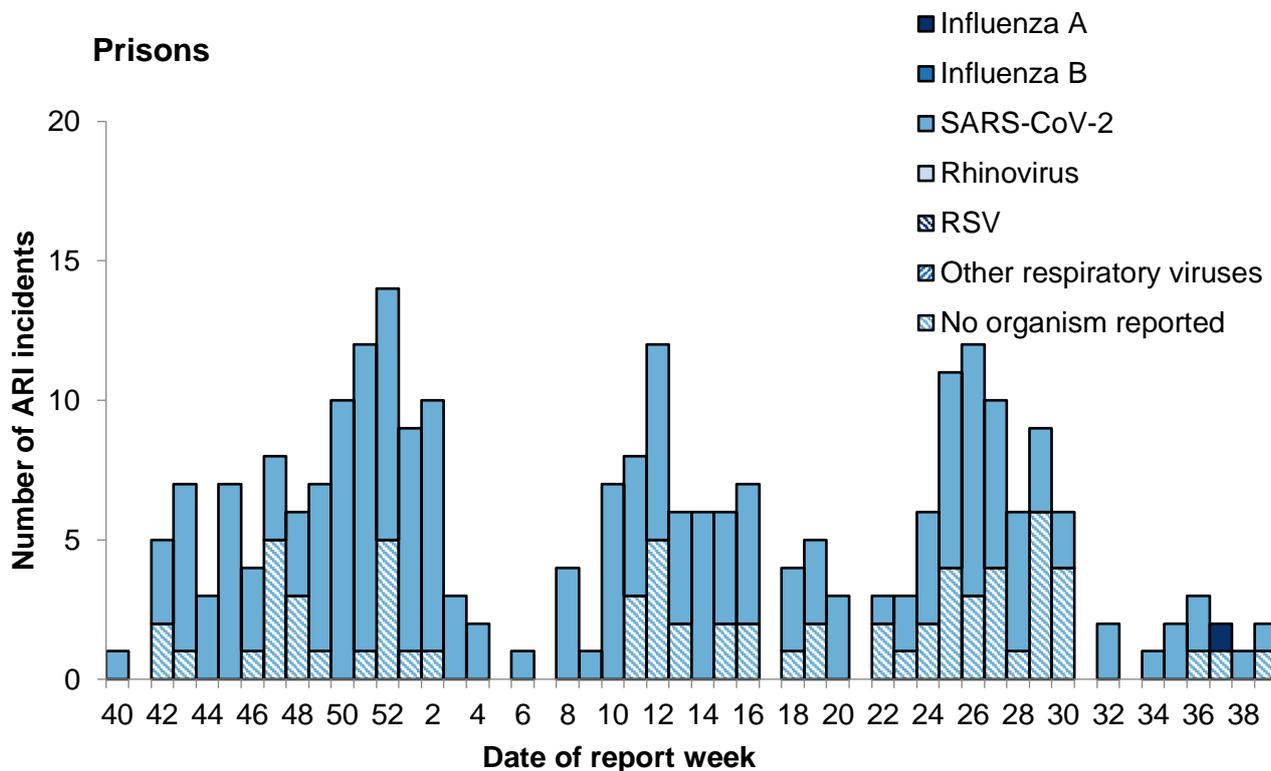


Figure 22: Number of acute respiratory infection (ARI) incidents in workplace settings by virus type, England

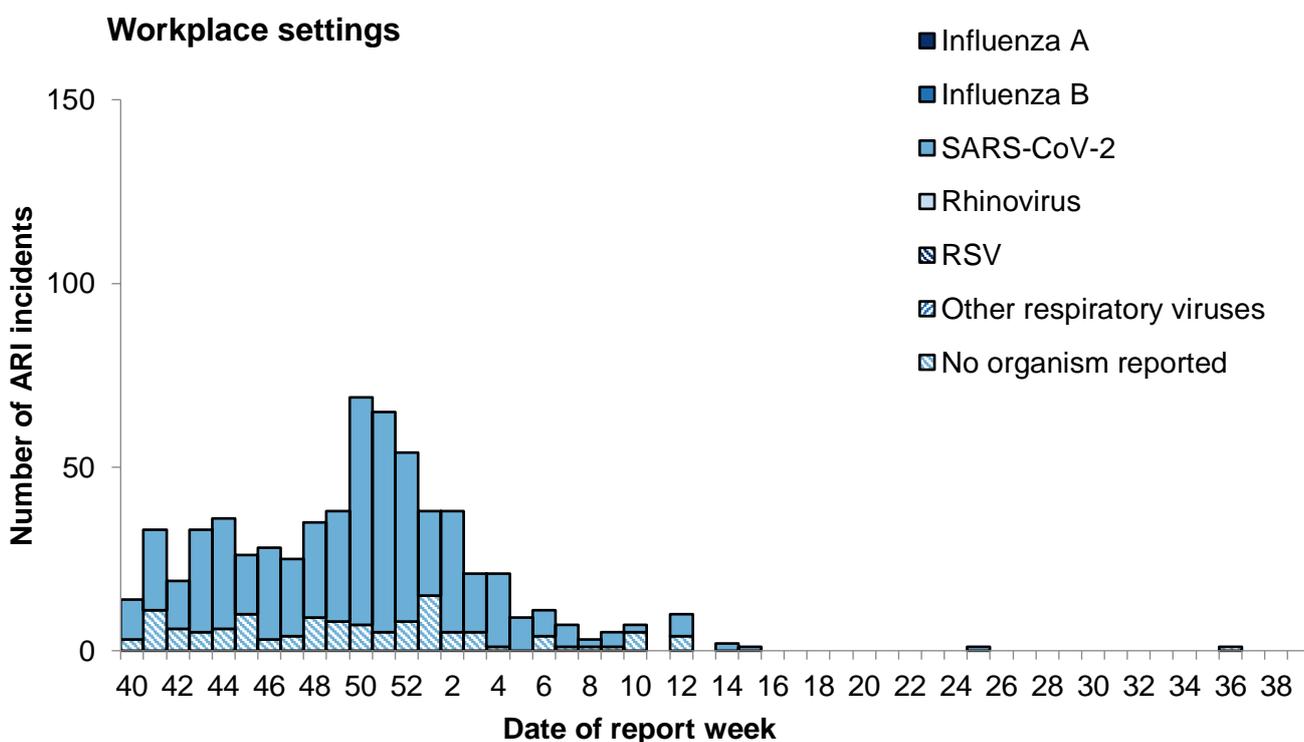


Figure 23: Number of acute respiratory infection (ARI) incidents in food outlet or restaurant settings by virus type, England

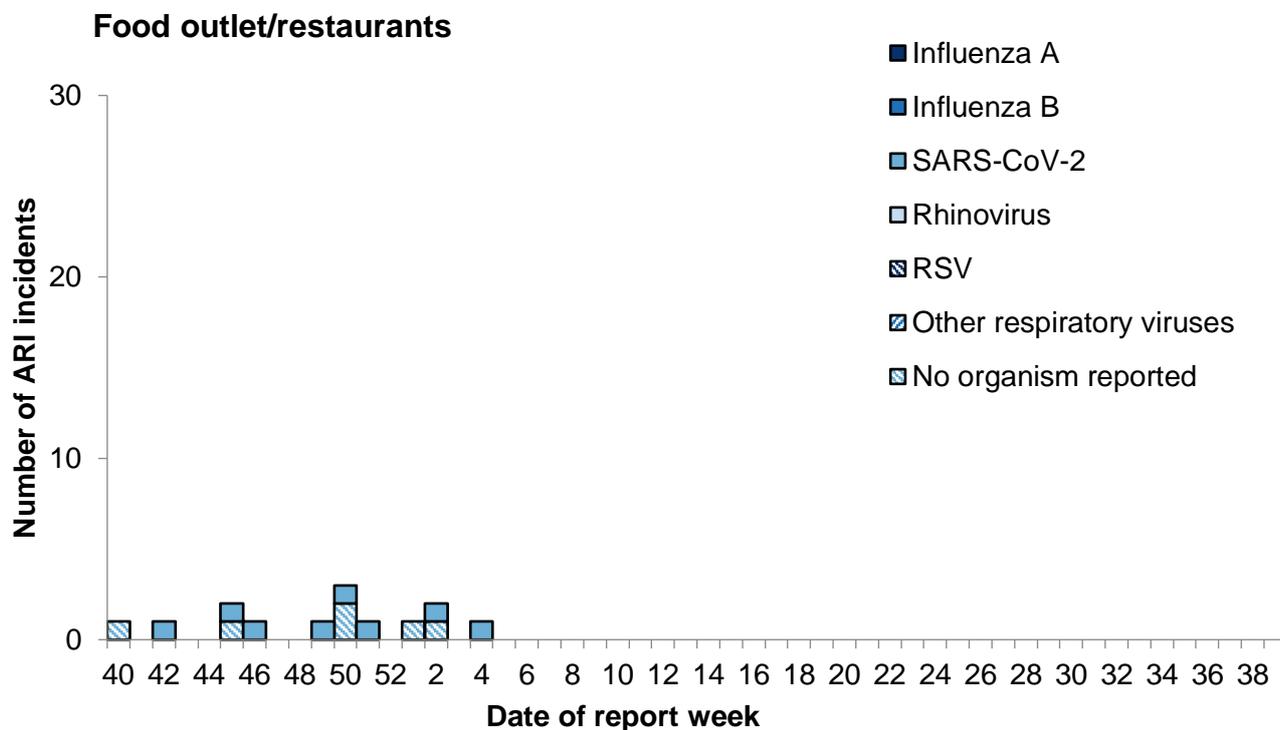


Figure 24: Number of acute respiratory infection (ARI) incidents in other settings by virus type from, England

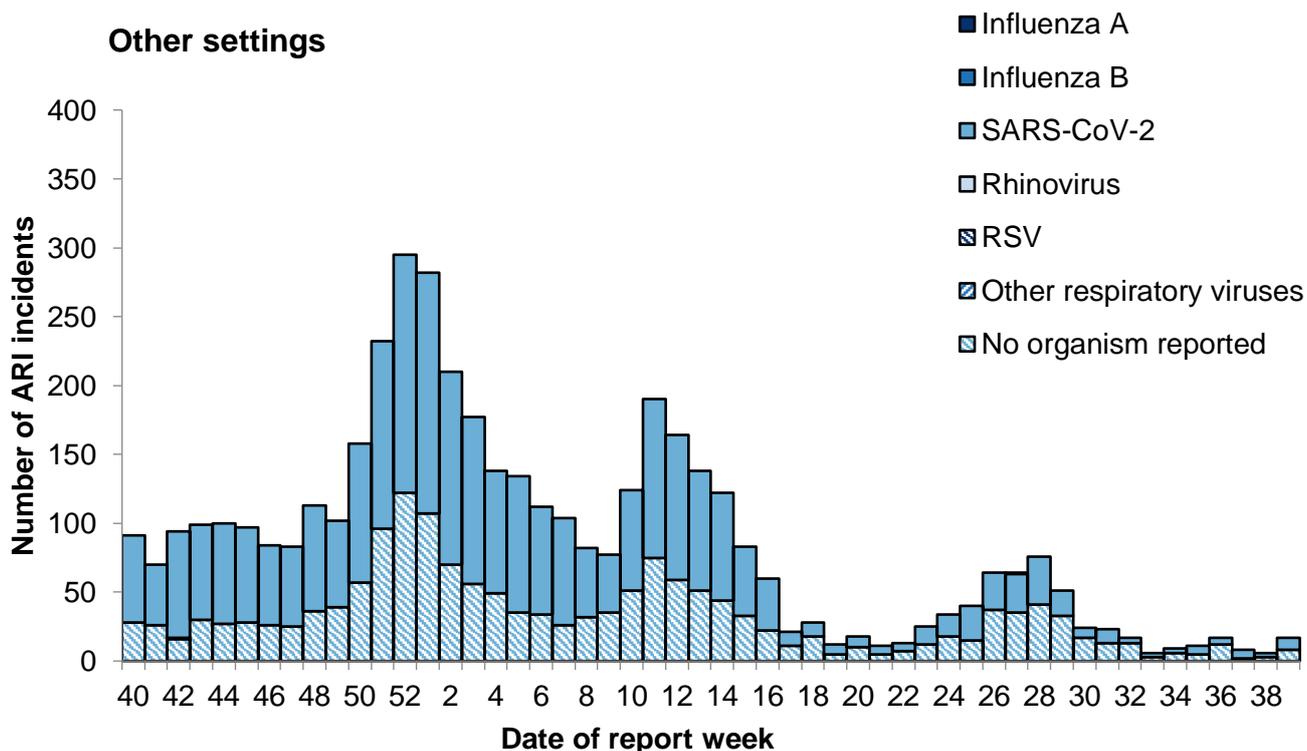


Table 1: Total number of situations and incidents by institution and UKHSA centres over the past 4 weeks with the total number in the last week in brackets

UKHSA Centres	Care home	Hospital	Educational settings	Prisons	Workplace settings	Food outlet/ restaurant settings	Other settings	Total
East of England	63(33)	1(0)	0(0)	1(0)	0(0)	0(0)	6(1)	71(34)
East Midlands	71(20)	2(0)	3(2)	2(1)	1(0)	0(0)	5(0)	84(23)
London	51(18)	29(15)	5(5)	0(0)	0(0)	0(0)	8(3)	93(41)
North East	85(30)	0(0)	0(0)	1(0)	0(0)	0(0)	5(3)	91(33)
North West	24(10)	2(2)	1(0)	0(0)	0(0)	0(0)	7(5)	34(17)
South East	9(4)	11(5)	0(0)	2(1)	0(0)	0(0)	0(0)	22(10)
South West	220(79)	1(0)	4(1)	0(0)	0(0)	0(0)	11(3)	236(83)
West Midlands	19(9)	7(4)	1(0)	1(0)	0(0)	0(0)	3(1)	31(14)
Yorkshire and Humber	39(16)	2(1)	0(0)	1(0)	0(0)	0(0)	3(1)	45(18)
Grand Total	581(219)	55(27)	14(8)	8(2)	1(0)	0(0)	48(17)	707(273)

FluSurvey

An internet-based surveillance system has been developed based on FluSurvey. FluSurvey is a web tool survey designed to monitor trends of influenza-like illness (ILI) in the community using self-reported respiratory symptoms from registered participants. The platform has been adapted to capture respiratory symptoms, exposure risk and healthcare seeking behaviours among registered participants to contribute to national surveillance of COVID-19 activity as well as influenza activity since week 44 2020.

Note that ILI is defined as sudden onset of symptoms with at least one of fever (chills), malaise, headache, muscle pain and at least one of cough, sore throat, shortness of breath.

A total of 2,233 participants completed the weekly surveillance survey in week 39, of which 220 (9.9%) reported fever or cough and 64 (9.9%) reported ILI. Both COVID-19 related symptoms and influenza like illness (ILI) have been increasing since week 36 amongst respondents completing the survey during the reporting period. Healthcare seeking behaviour amongst participants reporting respiratory symptoms relating to COVID-19 (cough, fever or loss of smell) showed that participants were more likely to telephone their GP provider as a result of their symptoms when compared to other healthcare services (Figure 25).

Self-reported daily social contact patterns are also reported. A contact is defined as a person outside the household who is approached at a distance of less than one metre, on the day prior to survey completion.

Figure 25: FluSurvey participants self-reporting fever or cough and ILI symptoms, and trends in healthcare seeking behaviour among these participants, England

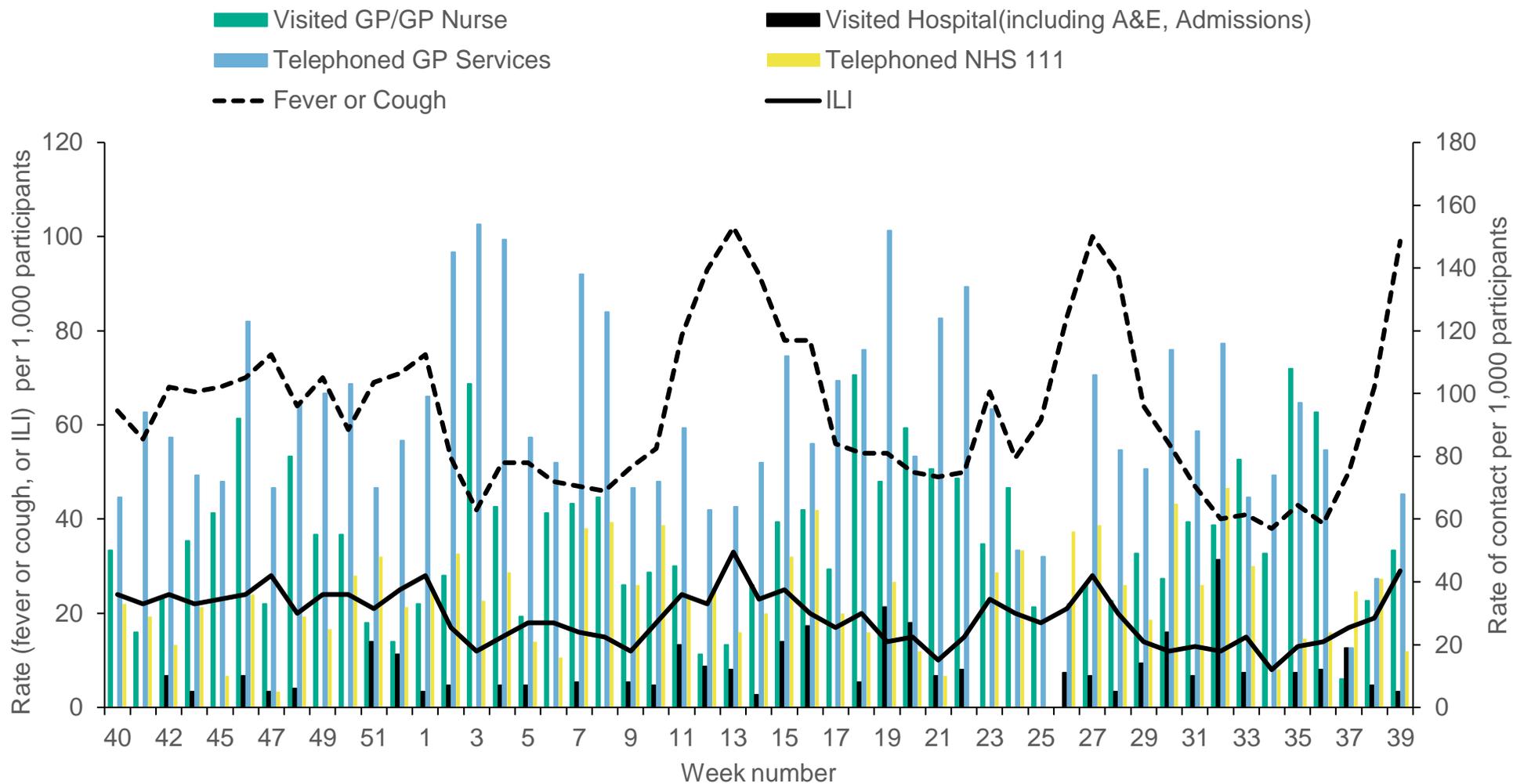
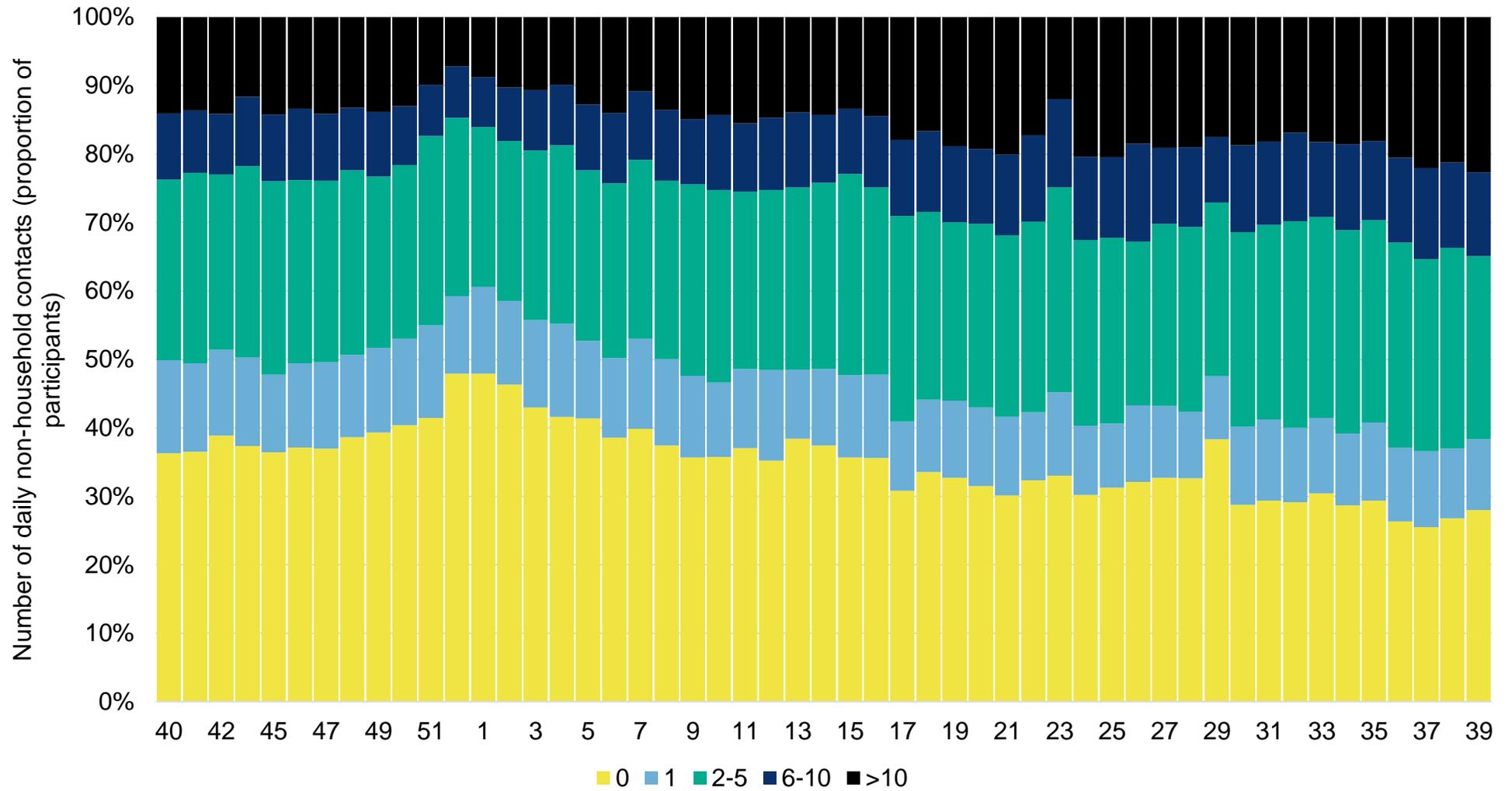


Figure 26: FluSurvey participants' self-reported number of social contacts outside the household

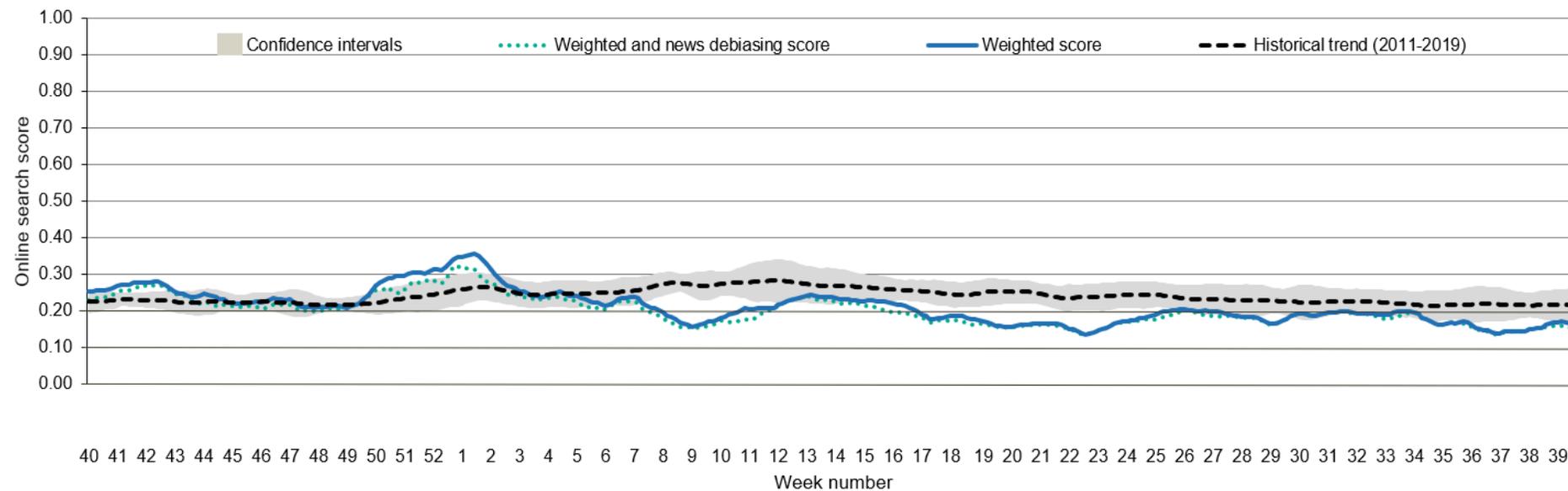


Google search queries

This is a web-based syndromic surveillance system which uses daily search query frequency statistics obtained from the Google Health Trends API (Application Programming Interface). This model focuses on search queries about COVID-19 symptoms as well as generic queries about 'coronavirus' (for example 'COVID-19'). The search query frequency time series is weighted based on symptom frequency as reported in other data sources. Frequency of searches for symptoms is compared with a baseline calculated from historical daily data. [Further information on this model](#) is available online.

During week 39, the overall and media-debiasing weighted Google search scores decreased slightly compared to the previous week (Figure 27).

Figure 27: Normalised Google search score for COVID-19 symptoms, with weighted score for media-debiasing and historical trend, England



NHS 111

Please note that different syndromic surveillance indicators (NHS 111, GP in hours, GP out of hours and emergency department attendances) are presented here than have been included in previous versions of this report. All indicators previously presented will continue to be published in the [Syndromic Surveillance bulletins](#).

The [NHS 111 service](#) monitors daily trends in phone calls made to the service in England, to capture trends in infectious diseases such as influenza and norovirus.

Please note that the number of NHS 111 calls are still lower than usual due to widely publicised disruption faced by a clinical software system. The NHS 111 call data presented in this report should therefore be interpreted with some caution.

Up to 2 October the number of calls for cough and cold or flu increased nationally (Figure 28 and 29).

Please note that NHS 111 callers (from 11 May 2020) who are assessed as having probable COVID-19 symptoms are now triaged using symptom specific pathways such as cold or flu, which are included in routine syndromic indicators.

Further information about these caveats is available from the [Remote Health Advice Syndromic Surveillance bulletin](#).

Figure 28: NHS 111 telephony indicators (and 7-day moving average) for number of daily cold or flu calls, England (a) nationally and (b) by age group

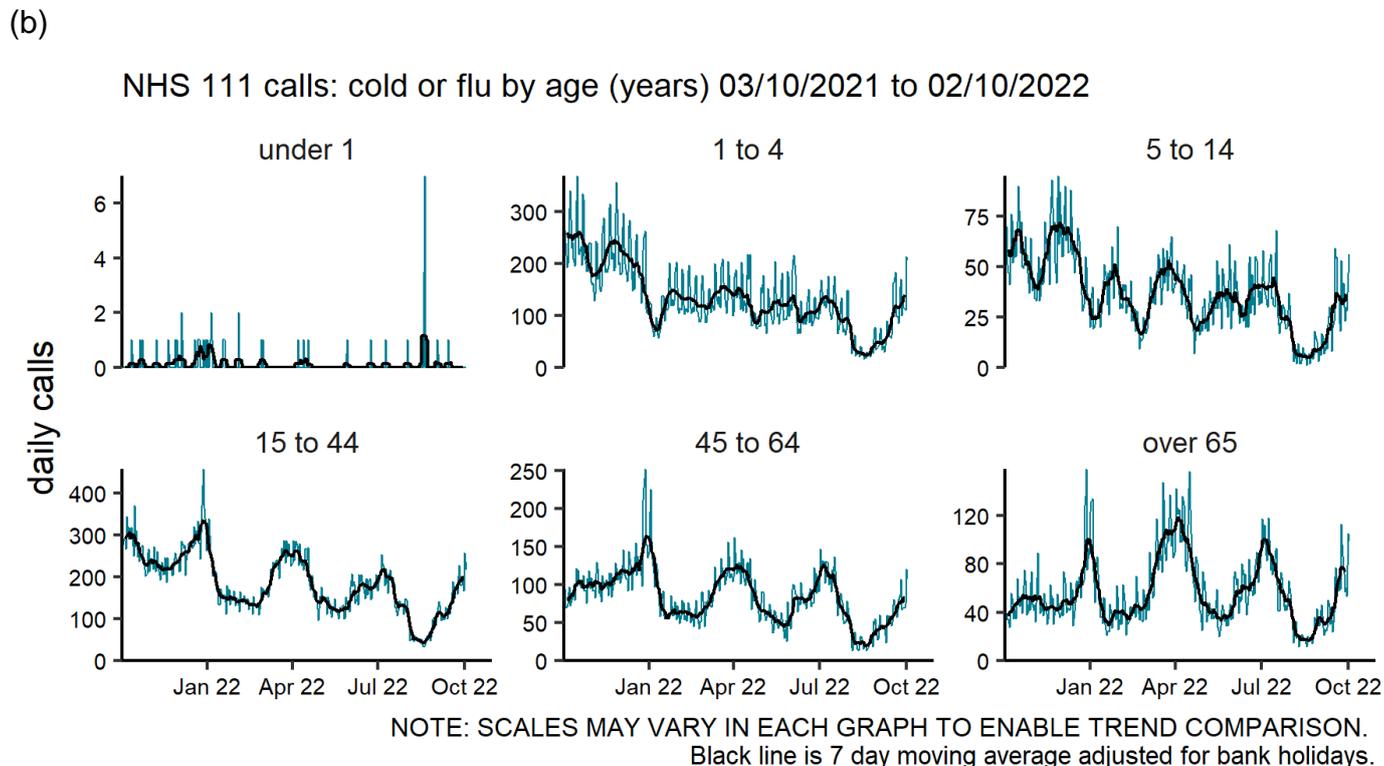
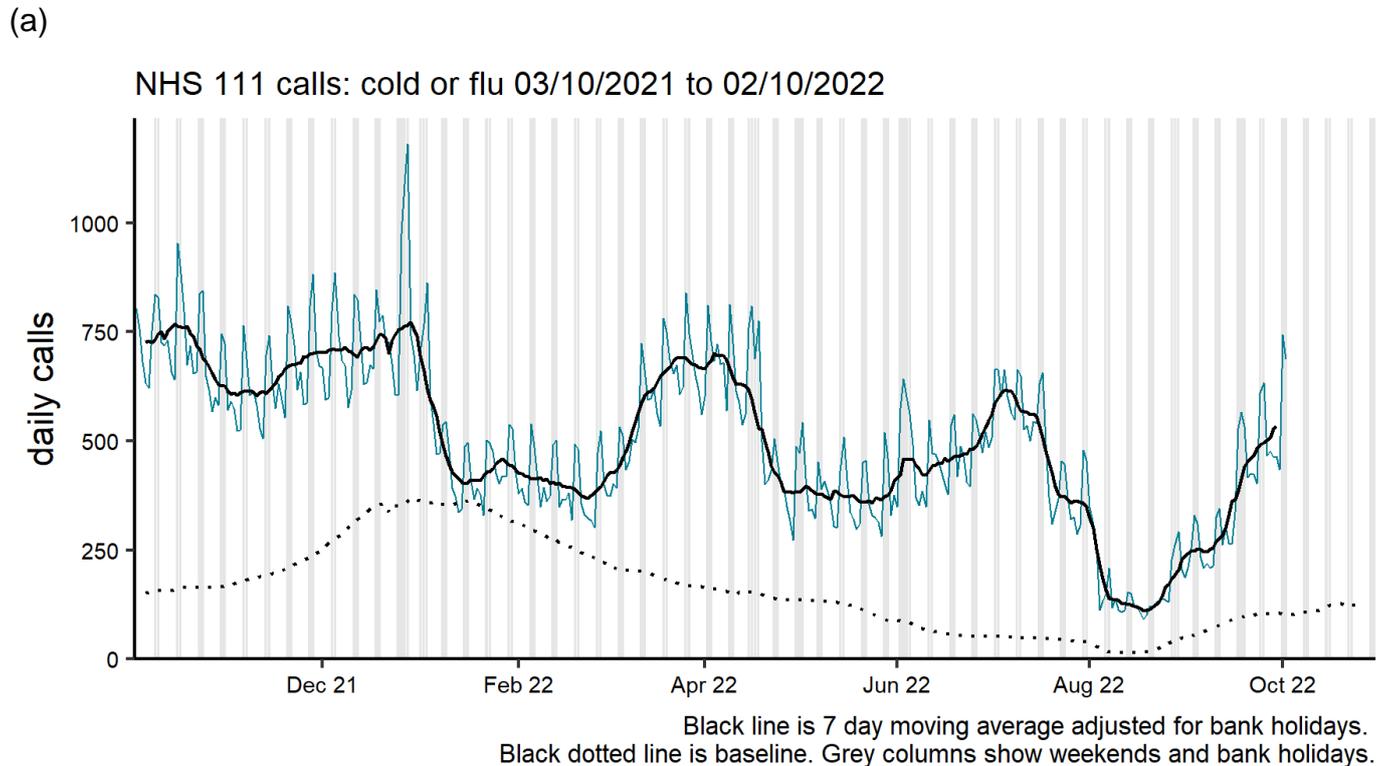
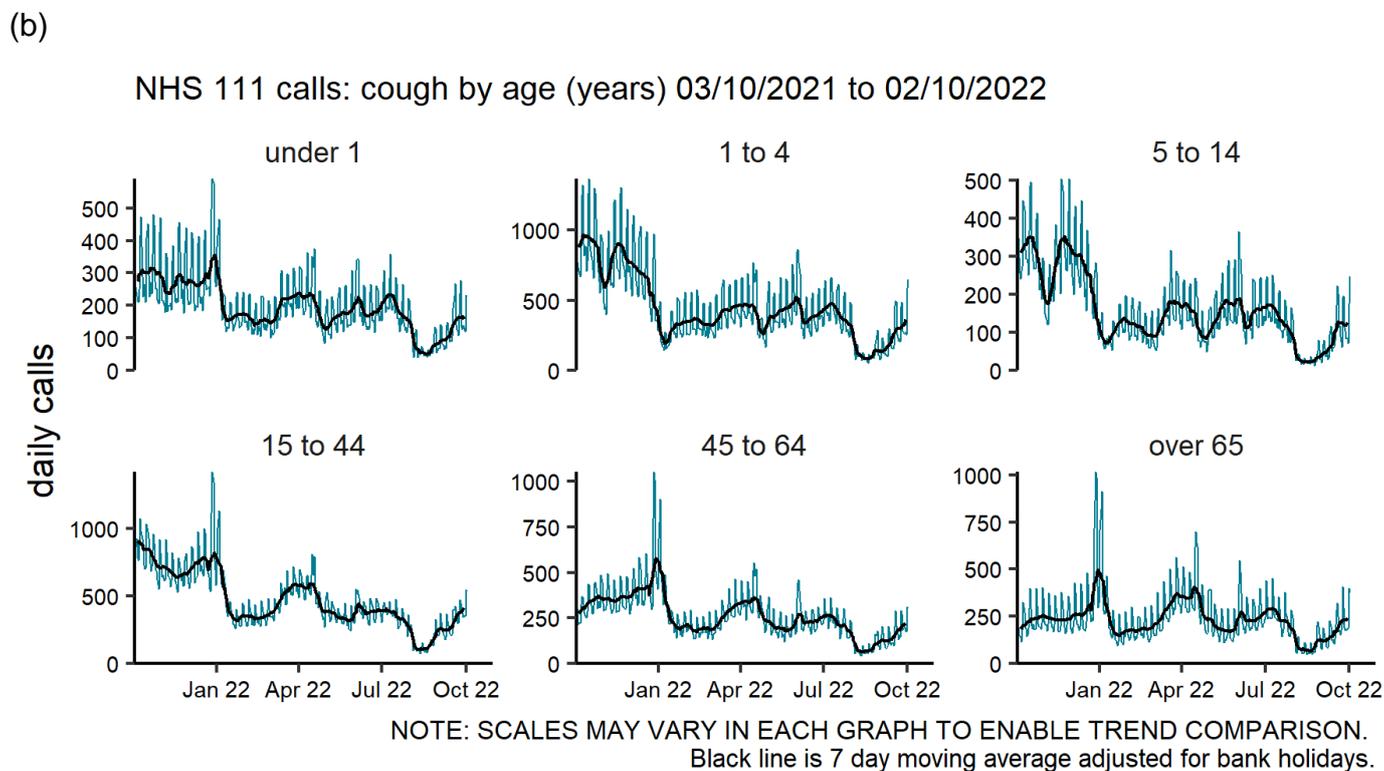
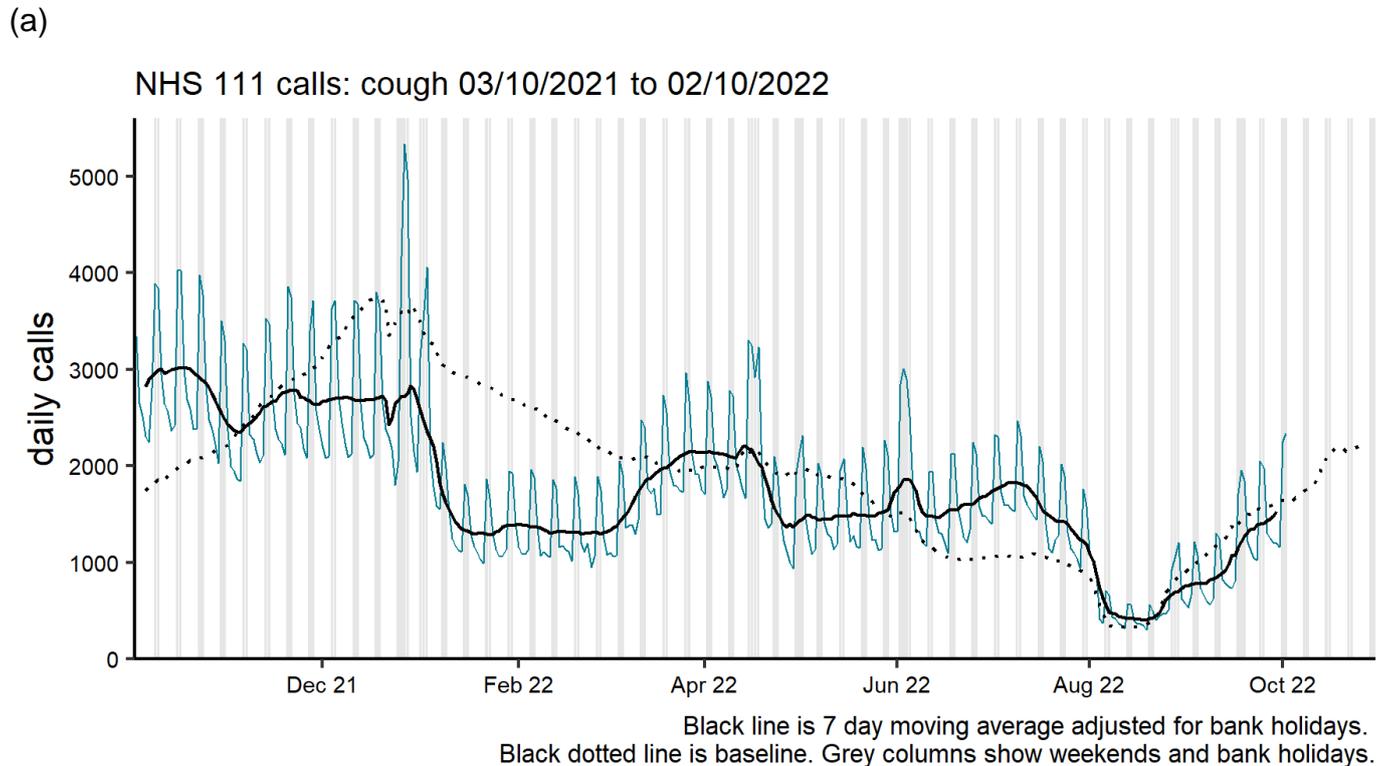


Figure 29: NHS 111 telephony indicators (and 7-day moving average) for number of daily cough calls, England (a) nationally and (b) by age group



Primary care surveillance

RCGP (England)

The weekly ILI consultation rate through the RCGP surveillance was 2.4 per 100,000 registered population in participating GP practices in week 39 compared to 1.3 per 100,000 in the previous week. This is below the baseline threshold (12.2 per 100,000) (Figure 30). By age group, the highest rates were seen in the 45 to 64 year olds (3.3 per 100,000). The lower respiratory tract infections (LRTI) consultation rate was at 59.7 per 100,000 in week 39, compared to the rate of 40.0 per 100,000 in the previous week. The COVID-19 indicator rate was at 73.2 per 100,000 in week 39 compared to a rate of 61.1 per 100,000 in the previous week (Figure 31).

Figure 30: RCGP ILI consultation rates, all ages, England

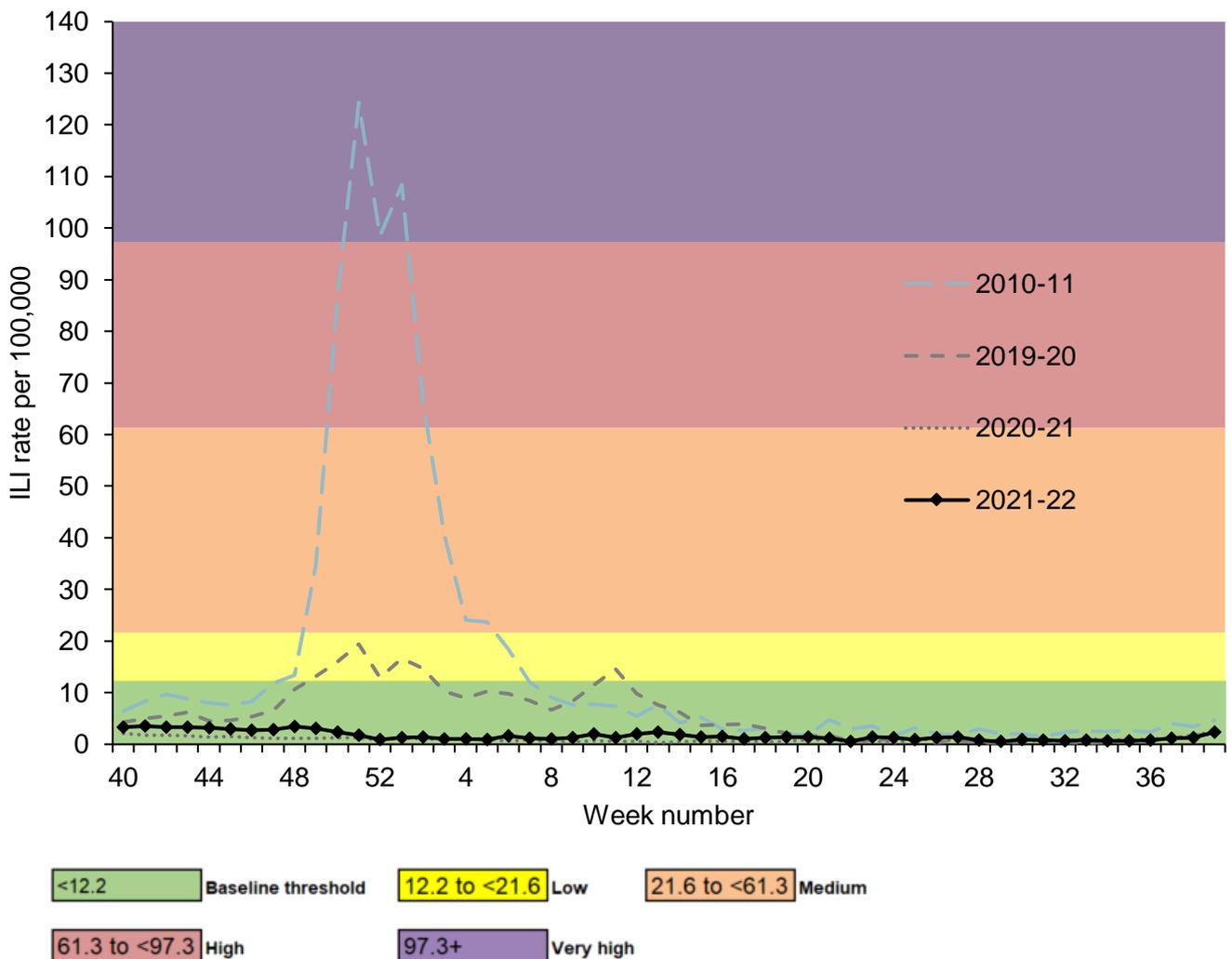
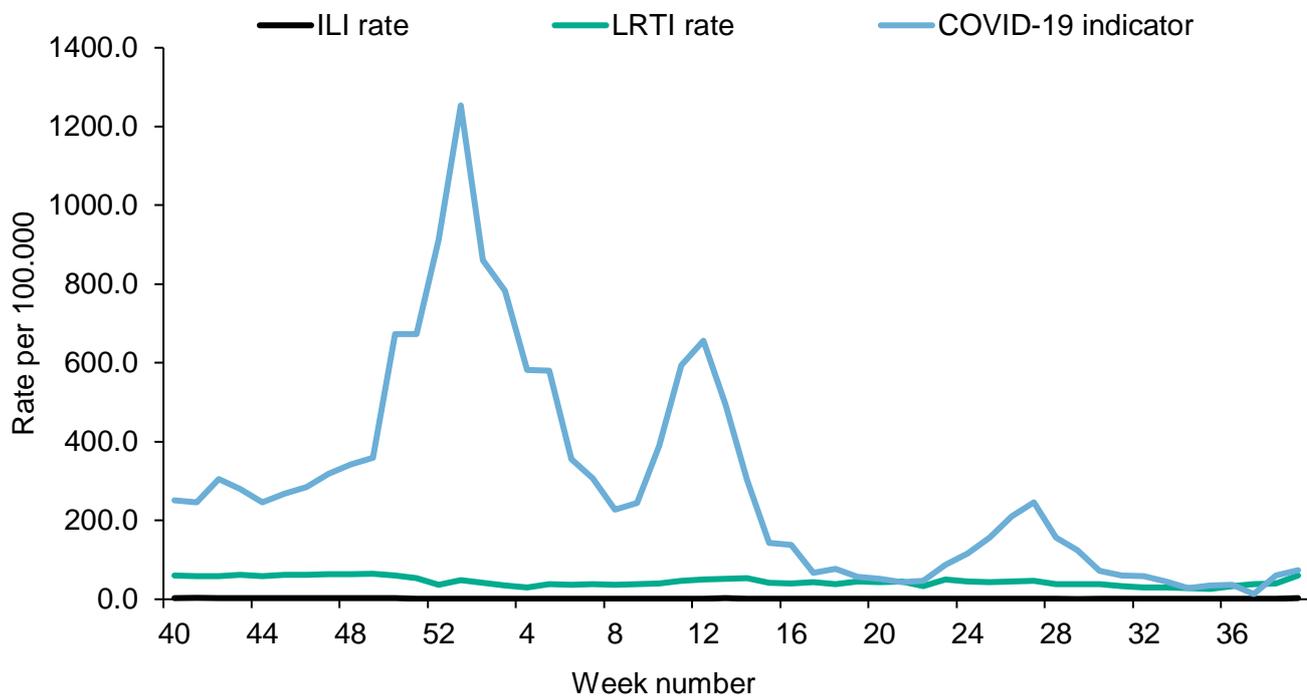


Figure 31: RCGP ILI, LRTI and COVID-19 indicator rates, England



UK

Overall, weekly ILI consultations rates were below baseline levels in all UK schemes (Table 2).

By age group, the highest incidence age groups were in the 75 plus year olds and over in Scotland (7.1 per 100,000), in the 15 to 44 year old in Northern Ireland (2.4 per 100,000) and the 45 to 64 year olds in Wales (5.7 per 100,000).

Table 2: GP ILI consultations in the UK for all ages with MEM (Moving Epidemic Method) thresholds applied

GP ILI consultation rates (all ages)	Week number														
	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39
England (RCGP)	0.9	1.3	1.4	0.9	0.5	0.9	0.8	0.6	0.7	0.7	0.6	0.8	1.2	1.3	2.4
Wales	1.5	2.0	1.0	1.0	0.0	0.5	0.3	0.3	1.5	1.3	0.3	1.5	2.2	2.0	2.8
Scotland	0.8	0.7	0.6	0.7	0.6	0.6	0.4	0.5	0.5	0.6	0.8	1.3	1.3	2.1	3.3
Northern Ireland	0.8	1.0	1.3	0.4	0.2	0.8	0.3	0.2	0.2	0.7	0.8	0.8	0.8	0.7	1.7

The Moving Epidemic Method (MEM) has been adopted by the European Centre for Disease Prevention and Control to calculate thresholds for GP ILI consultations for the start of influenza activity (based on 10 seasons excluding 2009 to 2010), in a standardised approach across Europe. For MEM threshold values for each country, please visit the webpage [Sources of UK flu data: influenza surveillance in the UK](#).

Sentinel swabbing scheme in England

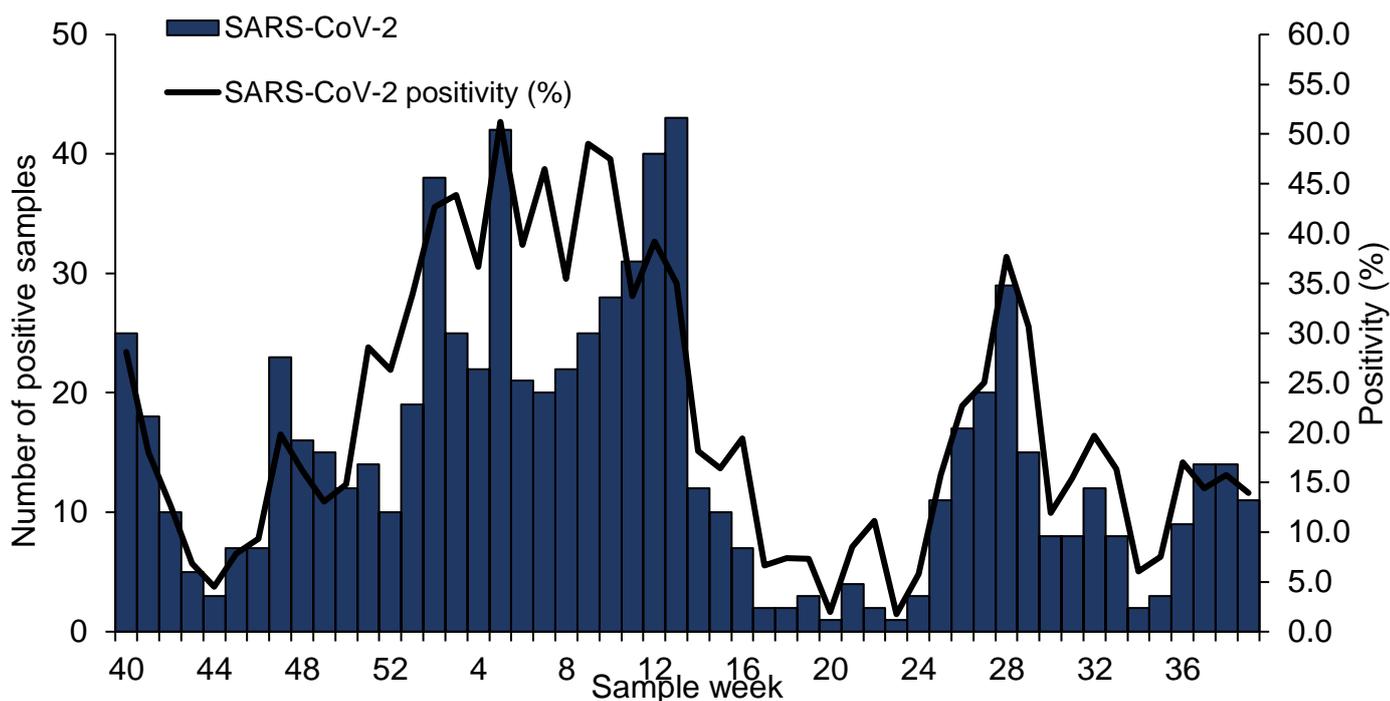
In week 39 2022, 11 samples tested positive for SARS-CoV-2 through the GP sentinel swabbing scheme in England (Figure 32).

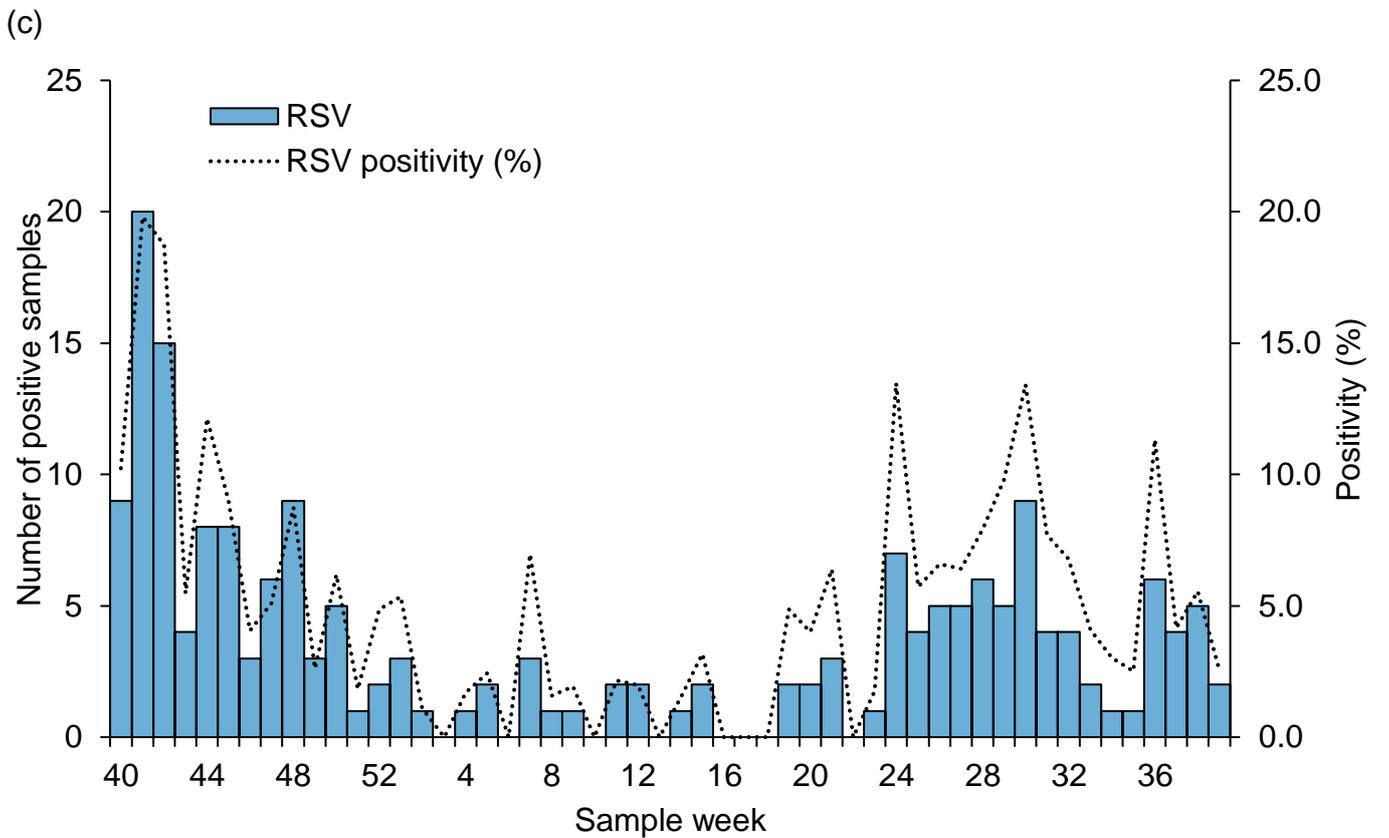
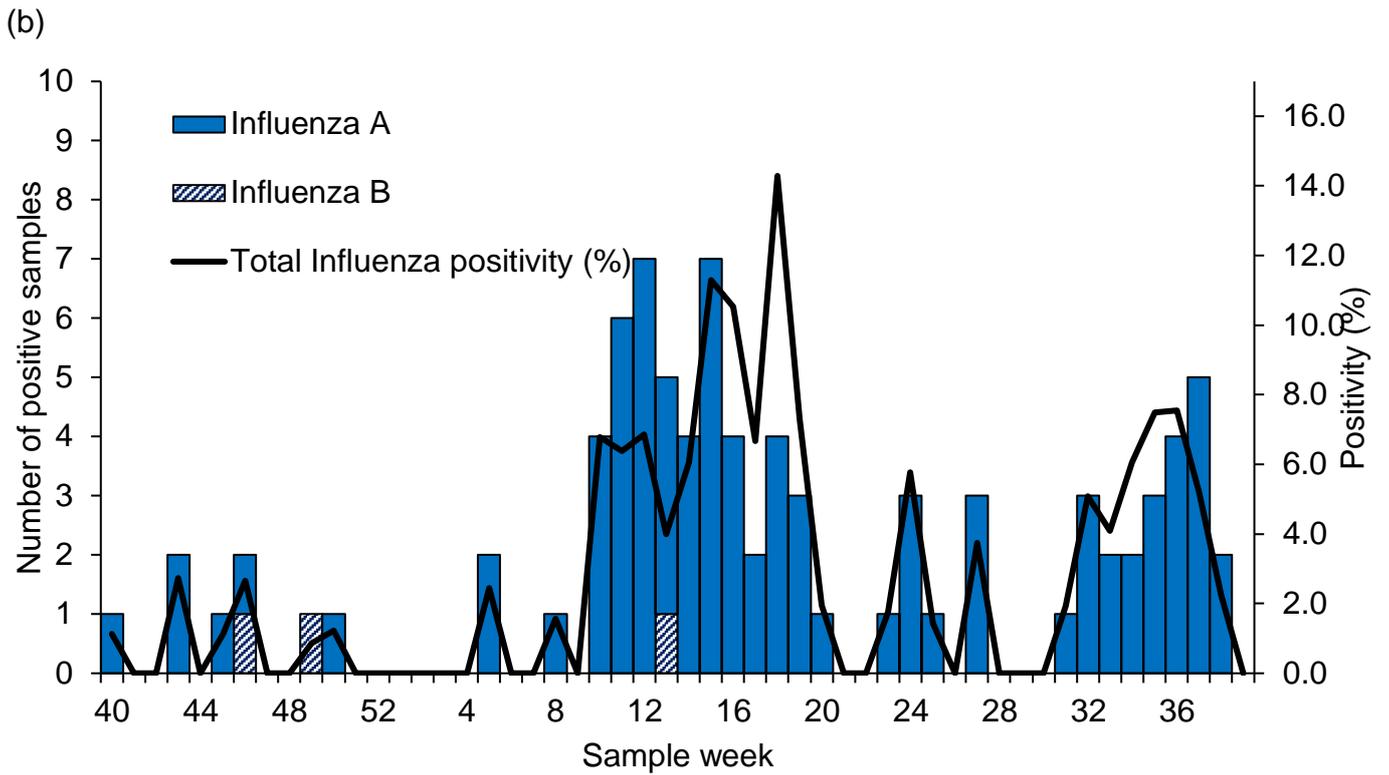
In week 39, 2 samples tested positive for RSV and no samples tested positive for influenza in England through the GP sentinel swabbing scheme.

* Please note that due to lower sample numbers data from week 14 of 2022 onwards should be interpreted with caution.

Figure 32: Number of positive samples and weekly positivity (%) for (a) COVID-19 and (b) Influenza and (c) RSV, GP sentinel swabbing scheme

(a)





*For the most recent week, more samples are expected to be tested therefore the graphs in Figure 32 should be interpreted with caution

*Positivity (%) is not calculated when the total number tested is less than 10

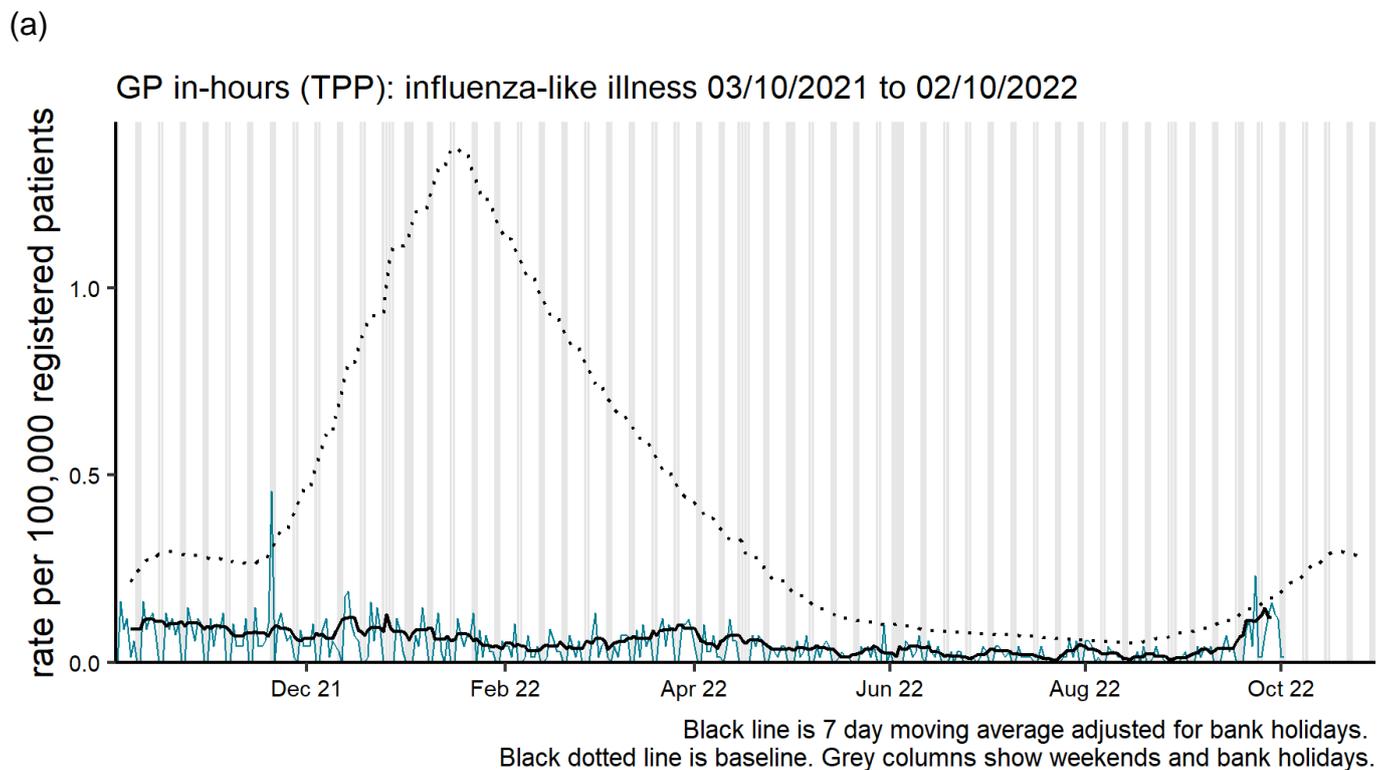
GP In Hours, Syndromic Surveillance

The GP In Hours (GPIH) syndromic surveillance system monitors the number of GP visits during regular hours of known clinical indicators.

Up to 2 October, GP in-hours consultations for influenza-like illness decreased (Figure 33).

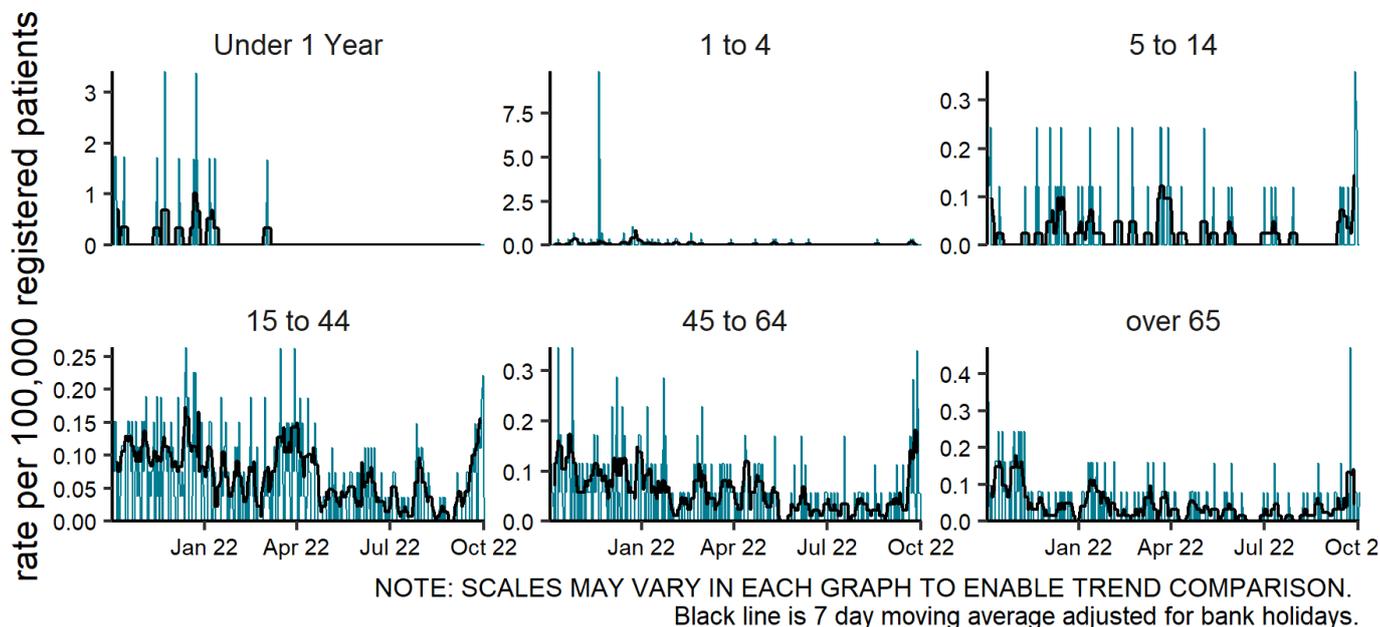
Further indicators and information about caveats are available from the [GP In Hours Syndromic Surveillance bulletin](#).

Figure 33: GPIH clinical indicators for influenza-like illness GP consultations, England (a) nationally, (b) by age group and (c) by UKHSA centre



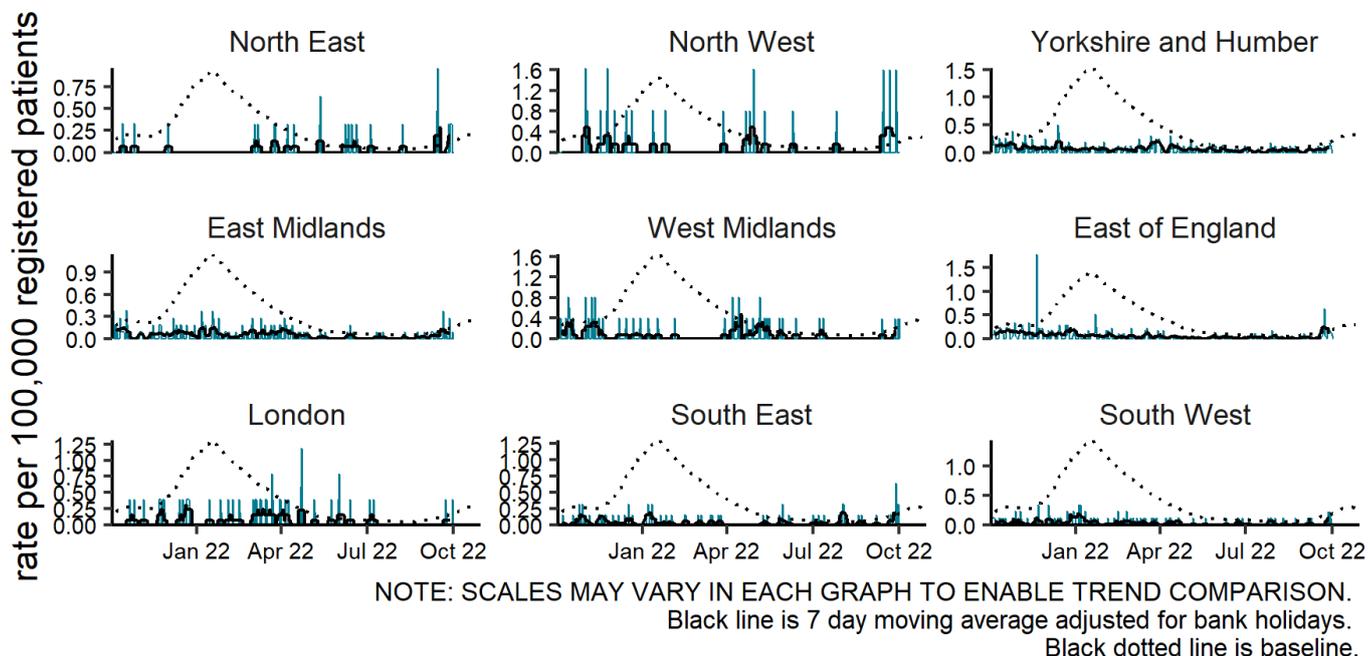
(b)

GP in-hours (TPP): influenza-like illness by age (years) 03/10/2021 to 02/10/2022



(c)

GP in-hours (TPP): influenza-like illness by region 03/10/2021 to 02/10/2022



GPIH Baselines are modelled from historical data to give current seasonally expected levels. GP consultations rates decreased during 2020 due to changes in guidance on accessing health care, therefore separate modelled estimates are provided to show seasonally expected levels pre-COVID-19.

GP Out of Hours, Syndromic Surveillance

The GP Out of Hours (GPOOH) syndromic surveillance system monitors the numbers of daily unscheduled visits and calls to GPs during evenings, overnight, on weekends and on public holidays. This system covers around 55% of England’s out of hour activity.

Please note that due to a disruption with a GPOOH clinical software system provider, GPOOH data from 4 August onwards is not currently available (Figures 34 and 35).

Figure 34: GPOOH number of daily contacts for all ages for influenza-like illness, England

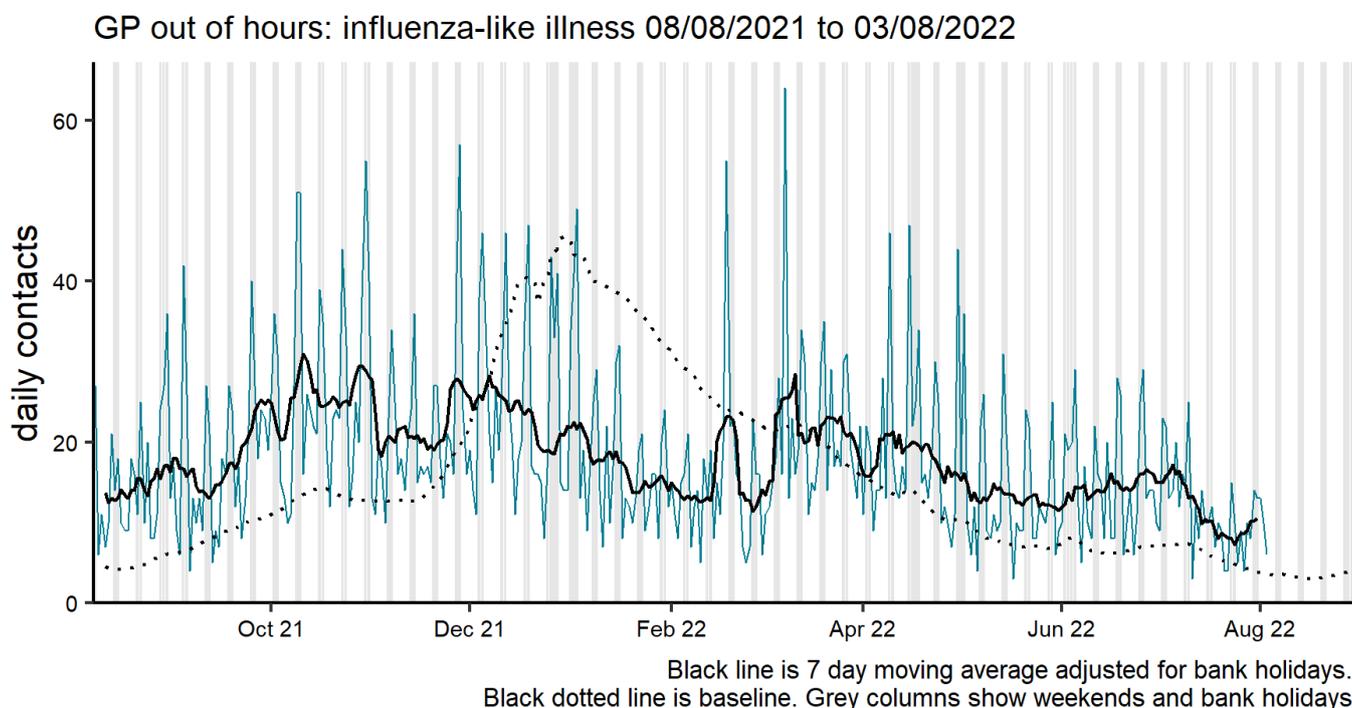
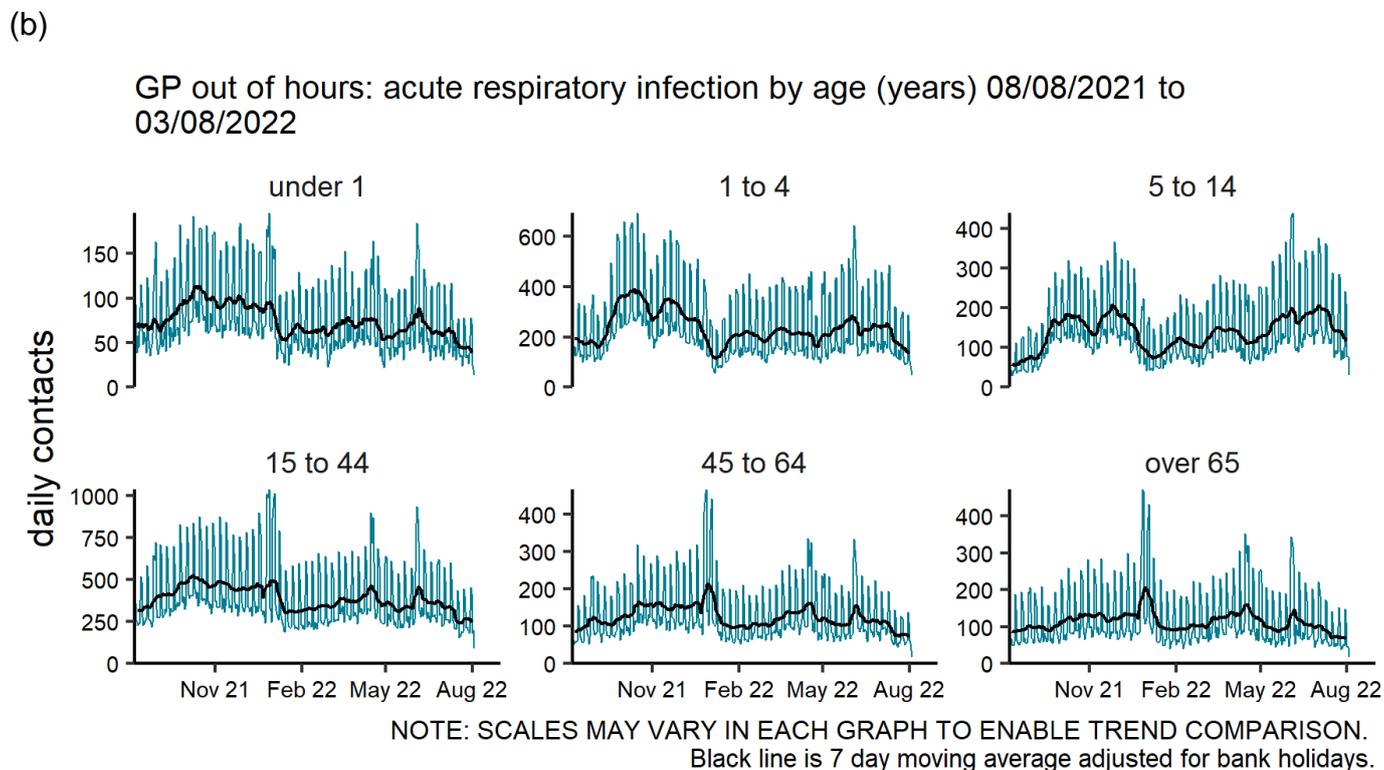
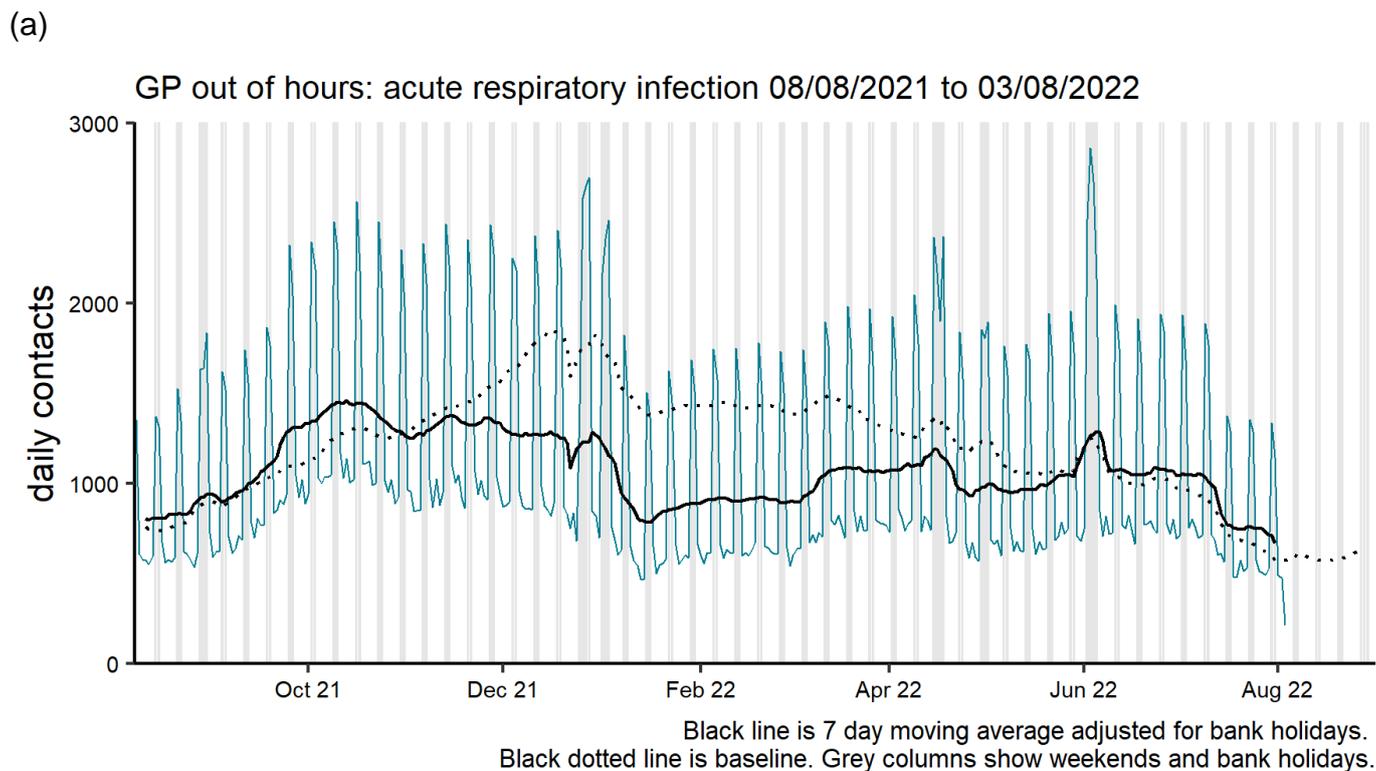


Figure 35: GPOOH number of daily contacts for acute respiratory infections, England (a) nationally and (b) by age group



Secondary care surveillance

SARI Watch

The Severe Acute Respiratory Infection (SARI) Watch surveillance system was established in 2020 to report the number of laboratory-confirmed influenza and COVID-19 cases admitted to hospital and critical care units (ICU and HDU) in NHS acute trusts across England. This has replaced the UK Severe Influenza Surveillance Schemes (USISS) Mandatory and Sentinel data collections for influenza surveillance used in previous seasons, and the COVID-19 hospitalisations in England surveillance system (CHESS) collections for COVID-19 surveillance.

The weekly rate of new admissions of COVID-19, influenza and RSV cases is based on the trust catchment population of those NHS Trusts who made a new return. This may differ from other published figures such as the total number of people currently in hospital with COVID-19.

The Moving Epidemic Method (MEM) thresholds for influenza hospital and ICU or HDU admissions are calculated based on the 2014 to 2015 to the 2018 to 2019 seasons (data from 2019 to 2020 was excluded due to the COVID-19 pandemic). These thresholds have been applied to data from the 2019 to 2020 season onwards.

Trends in hospital and critical care admission rates need to be interpreted in the context of testing recommendations. Please note that routine asymptomatic testing through NHS settings has been paused from 31 August 2022, therefore SARI-Watch data should be interpreted with this in mind.

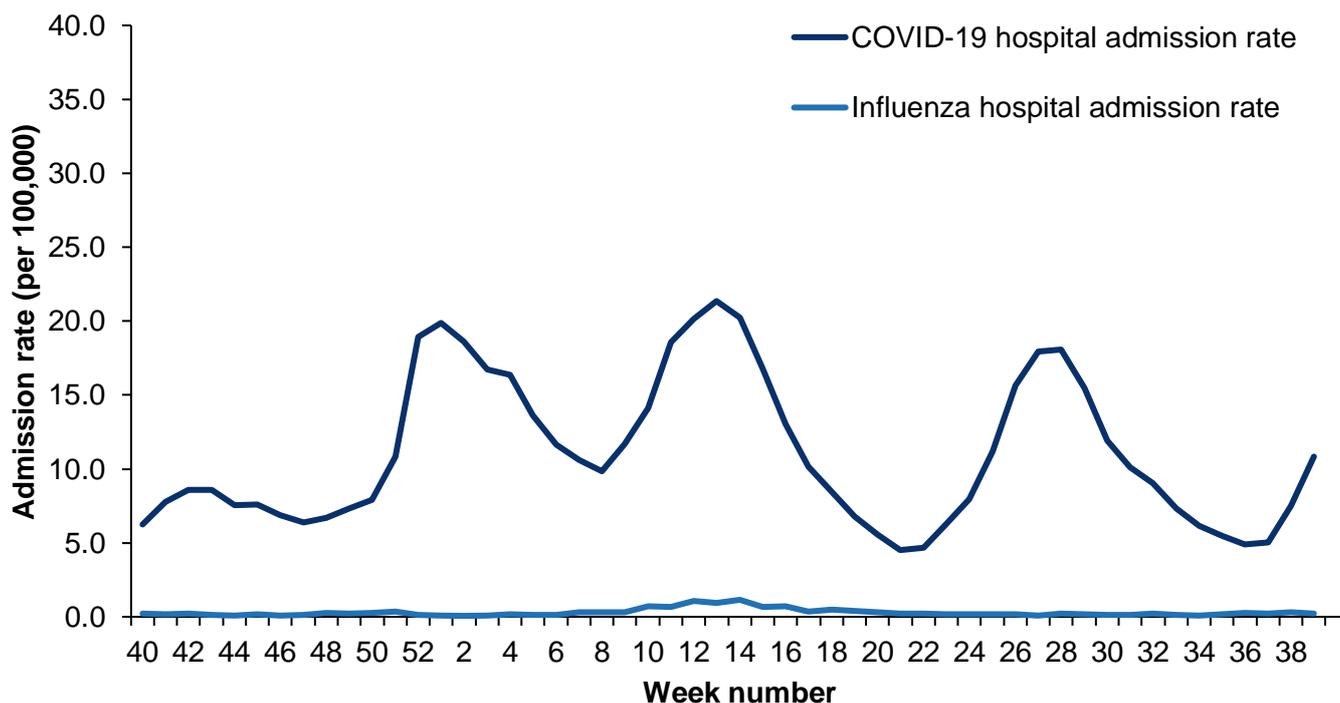
Hospitalisations, SARI Watch

In week 39, the overall weekly hospital admission rate for COVID-19 increased to 10.83 per 100,000 in week 39 compared to 7.49 per 100,000 in the previous week.

By UKHSA centre, the highest hospital admission rate for COVID-19 was observed in the South West. By age group, the highest hospital admission rate for confirmed COVID-19 was in the 85 year olds and over.

The hospitalisation rate for influenza was at 0.23 per 100,000 in week 39 compared to 0.29 per 100,000 in the previous week. There were 20 new hospital admissions to sentinel Trusts for influenza (3 influenza A(H1N1)pdm09, 4 influenza A(H3N2), 11 influenza A(not subtyped) and 2 influenza B) in week 39.

Figure 36: Weekly overall hospital admission rates of new COVID-19 and influenza positive cases per 100,000 population reported through SARI Watch, England



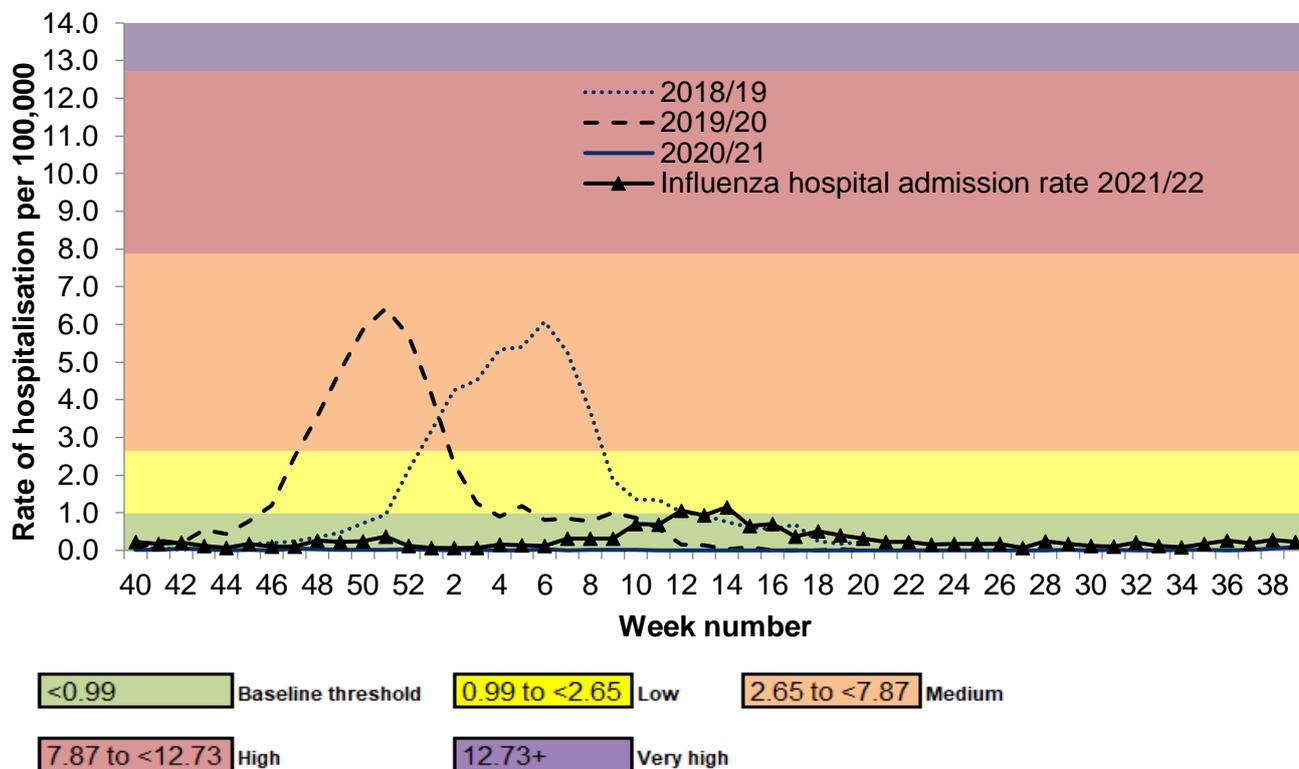
* hospital admission rate is reported from week 39 2021 onwards

* influenza hospital admission rate based on 22 sentinel NHS trusts for week 39

* COVID-19 hospital admission rate based on 90 NHS trusts for week 39

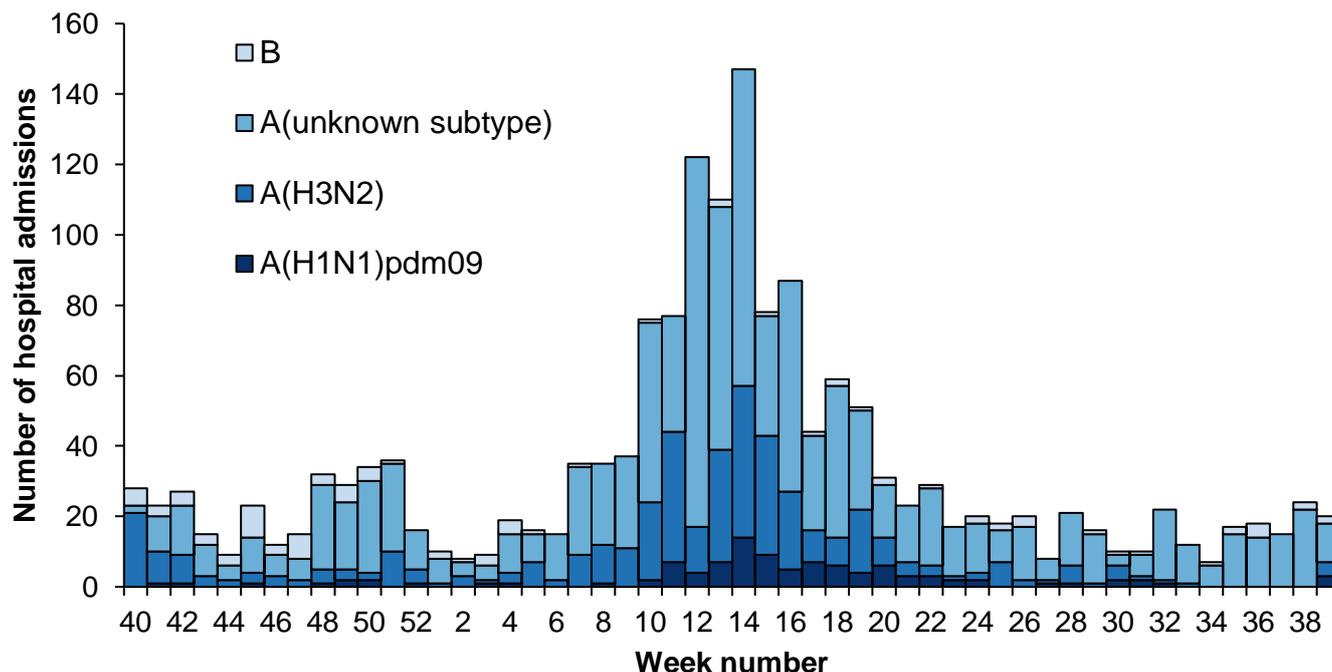
* SARI Watch data is provisional

Figure 37: Weekly overall influenza hospital admission rates per 100,000 trust catchment population with MEM thresholds, SARI Watch, England



* MEM thresholds are based on data from the 2014 to 2015 to the 2018 to 2019 seasons (data from 2019 to 2020 was excluded due to the COVID-19 pandemic).

Figure 38: Weekly influenza hospital admissions by influenza type, SARI Watch, England



*number of influenza hospital admissions based on sentinel NHS trusts

Figure 39: Weekly hospital admission rate by UKHSA centre for new (a) COVID-19 positive cases and (b) influenza reported through SARI Watch

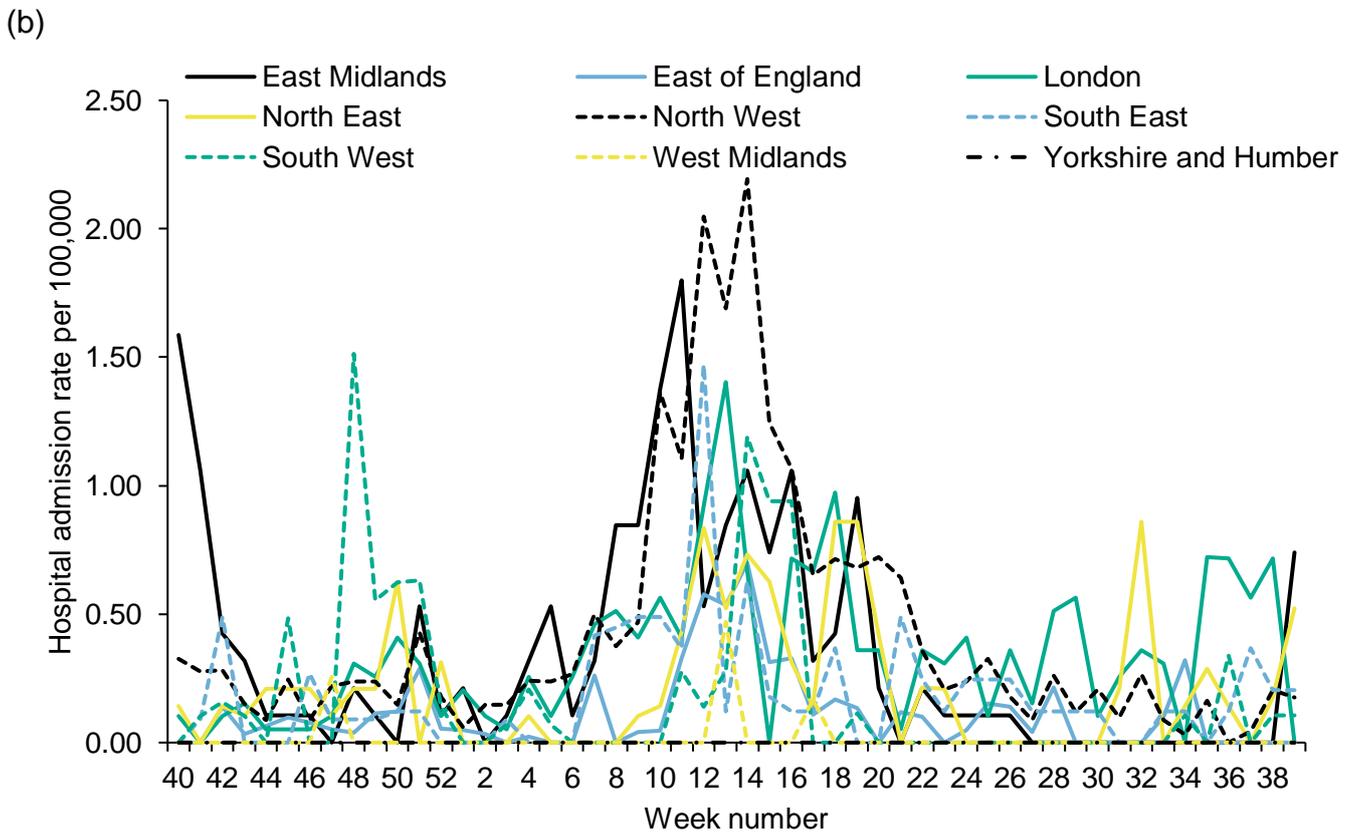
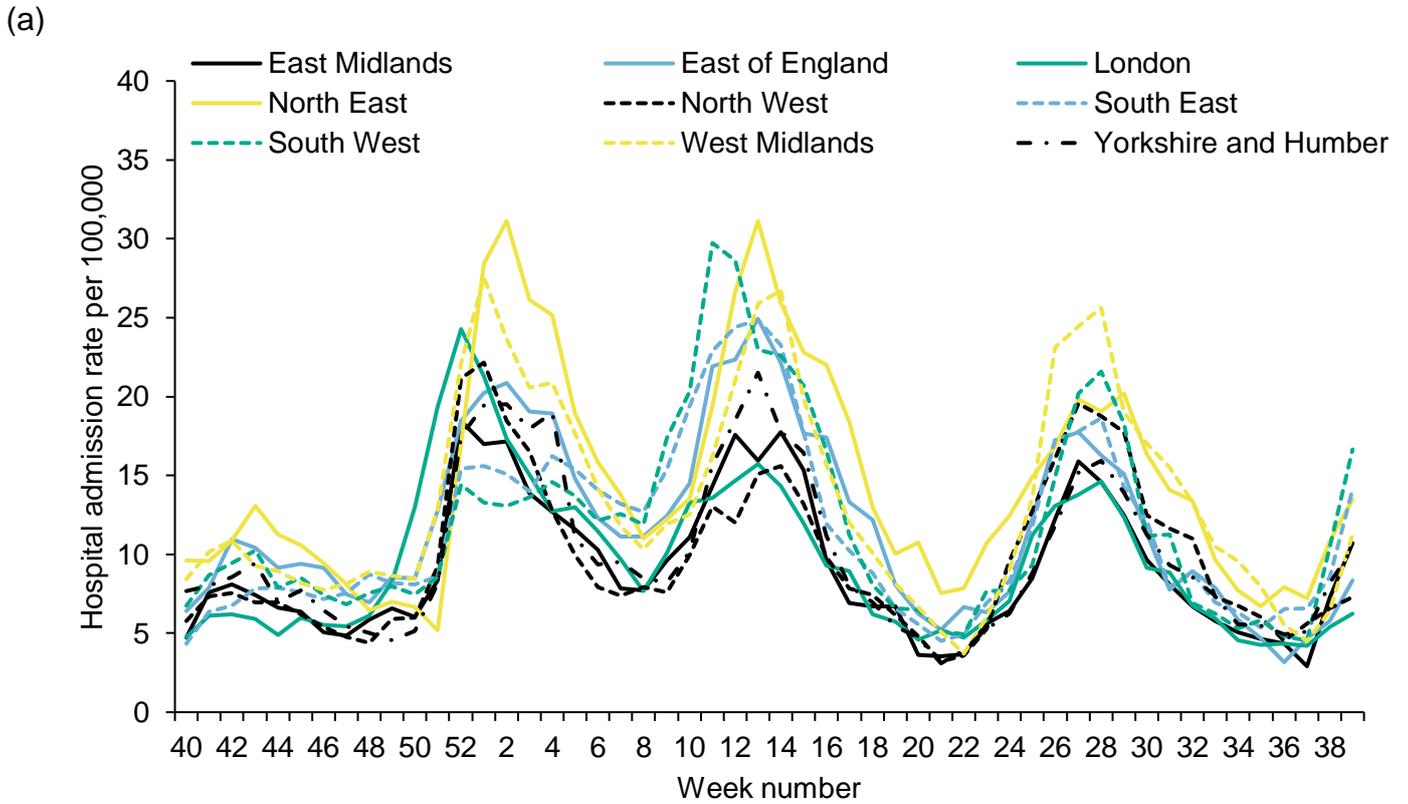
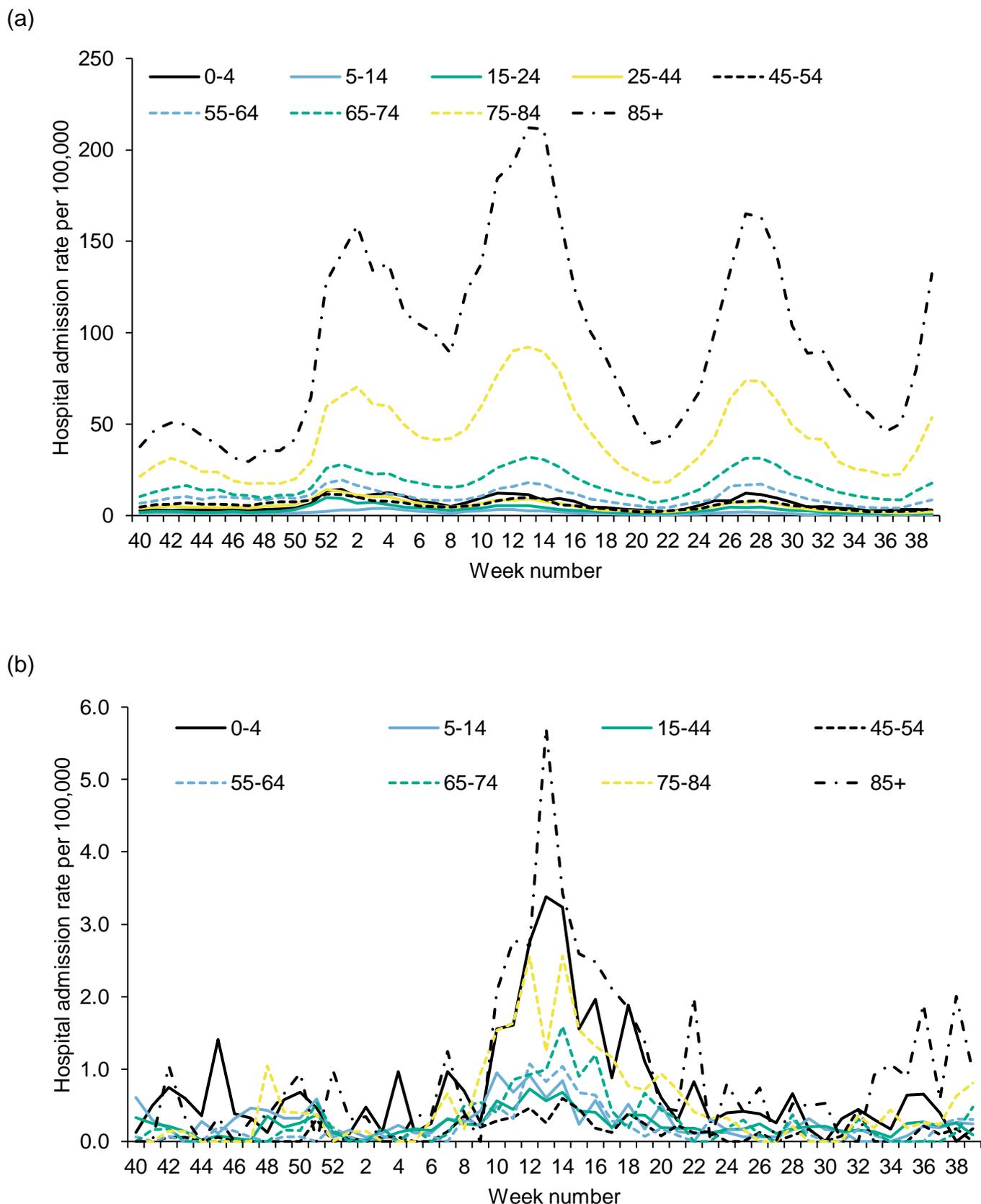


Figure 40: Weekly hospital admission rate by age group for new (a) COVID-19 positive cases and (b) influenza reported through SARI Watch



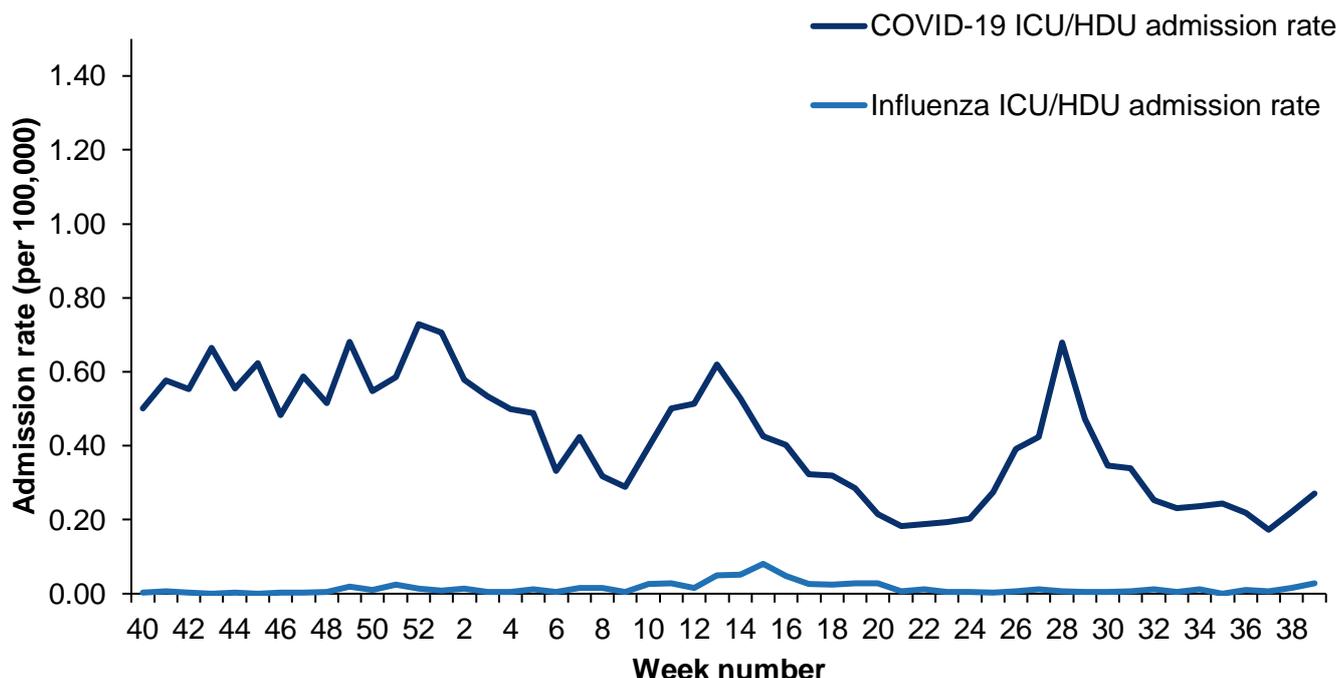
ICU or HDU admissions, SARI Watch

In week 39, the overall weekly ICU or HDU admission rates for COVID-19 remained low, at 0.27 per 100,000 in week 39 compared to 0.22 per 100,000 in the previous week. Note that ICU or HDU admissions rates may represent a lag from admission to hospital to an ICU or HDU ward.

By UKHSA centre, the highest ICU or HDU admission rates for COVID-19 were observed in London. By age groups, the highest ICU or HDU admission rates for COVID-19 were observed in the 75 to 84 year olds.

The ICU or HDU rate for influenza was at 0.03 per 100,000 in week 39 compared to 0.01 per 100,000 in the previous week. There were 11 new case report of an ICU or HDU admission for influenza in week 39 (9 influenza A(not subtyped) and 2 influenza B).

Figure 41: Weekly overall ICU or HDU admission rates of new COVID-19 and influenza positive cases per 100,000 population reported through SARI Watch, England



- * ICU or HDU admission rate is reported from week 39 2021 onwards
- * influenza ICU or HDU admission rate based on 91 NHS trusts for week 39
- * COVID-19 ICU or HDU admission rate based on 84 NHS trusts for week 39
- * SARI Watch data is provisional

Figure 42: Weekly overall influenza ICU or HDU admission rates per 100,000 trust catchment population with MEM thresholds, SARI Watch, England

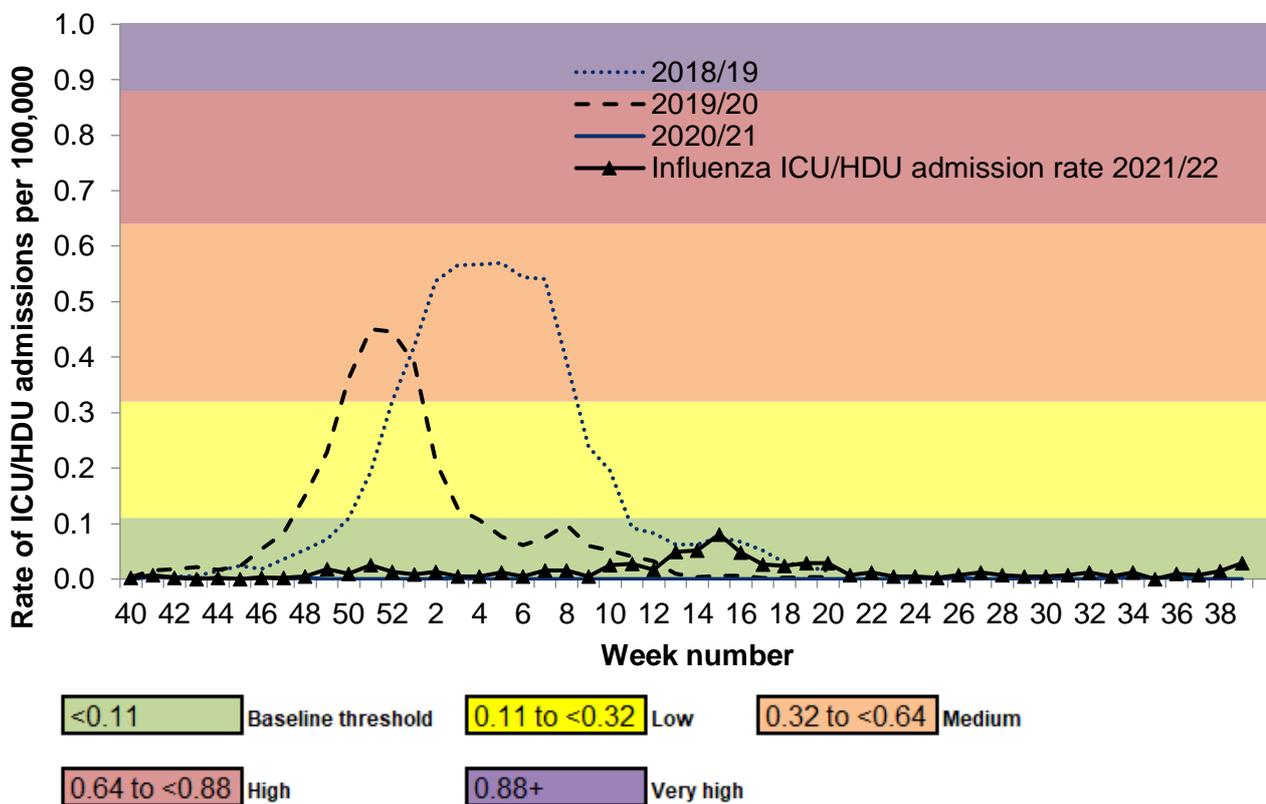


Figure 43: Weekly influenza ICU or HDU admissions by influenza type, SARI Watch, England

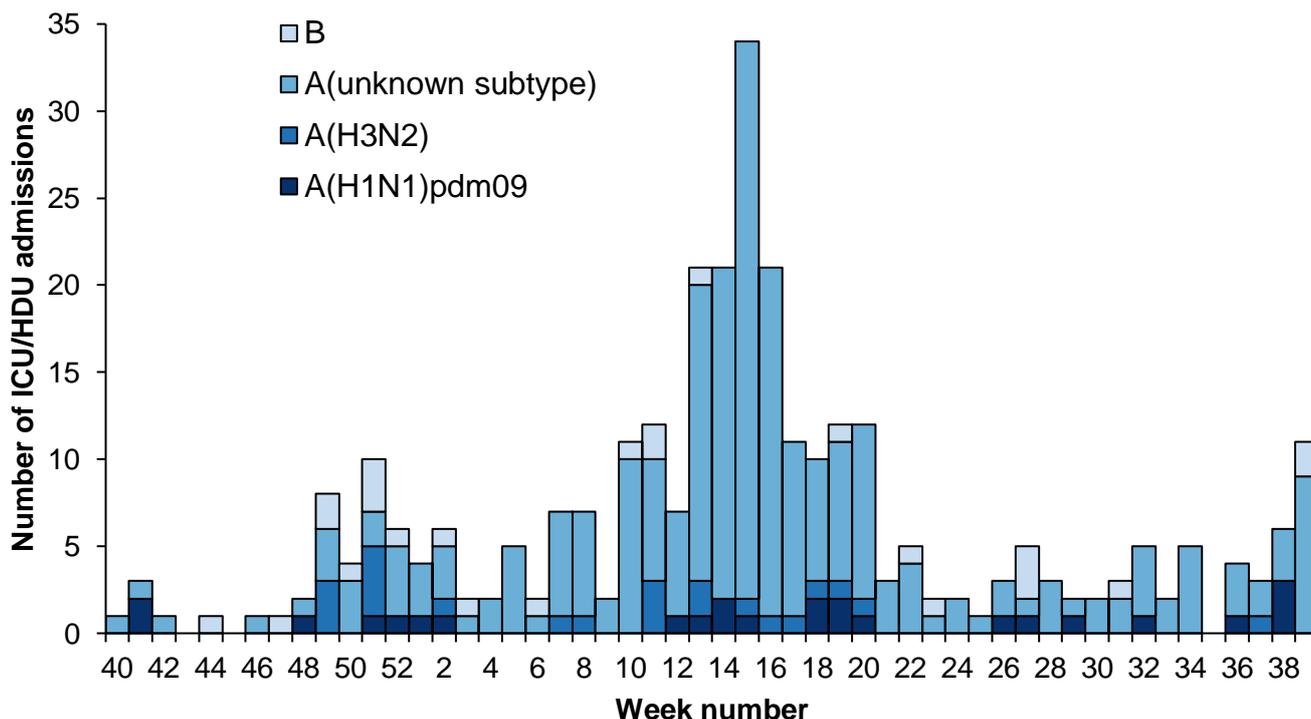


Figure 44: Weekly ICU or HDU admission rate by UKHSA centre for new (a) COVID-19 positive cases and (b) influenza, reported through SARI Watch

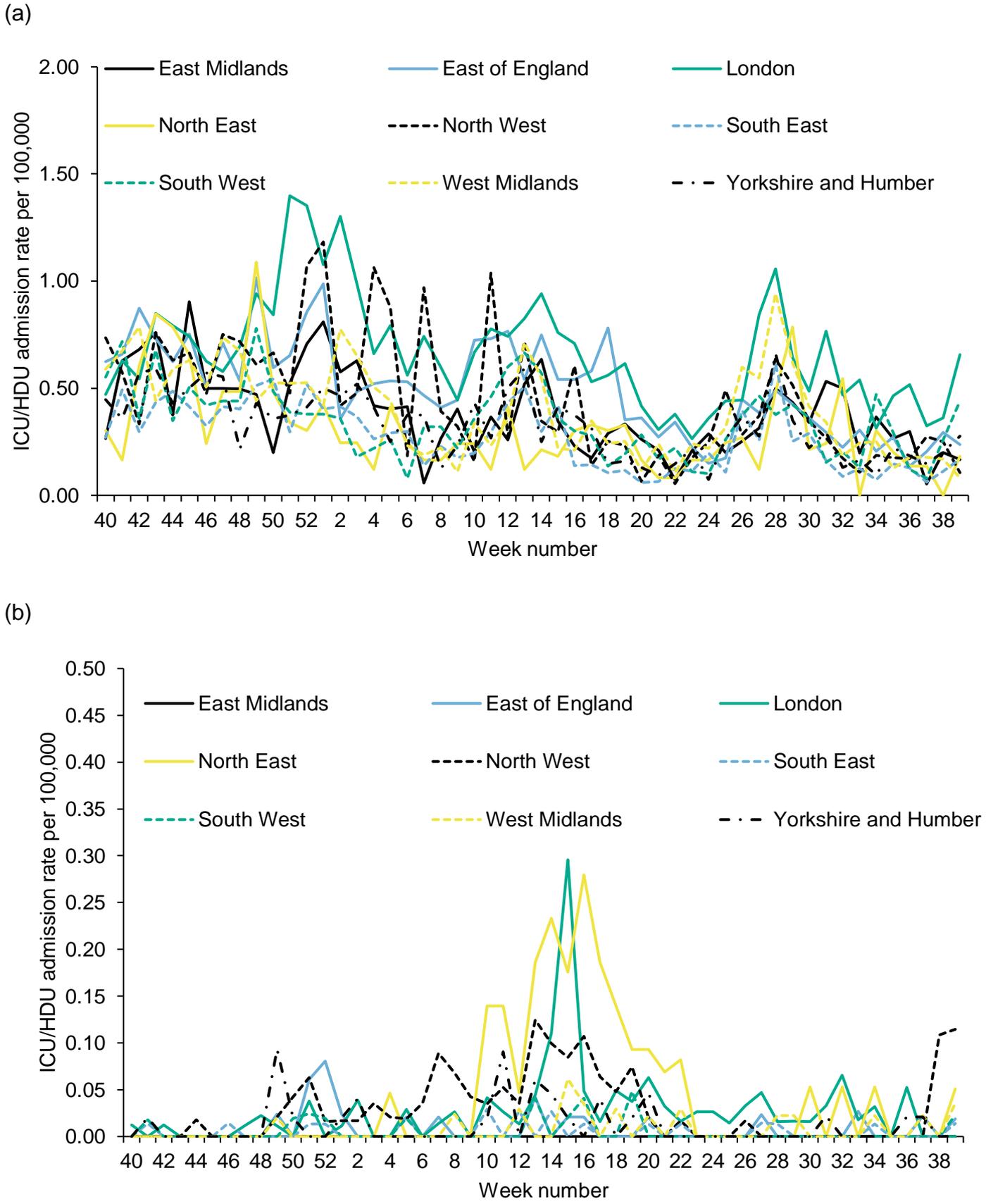
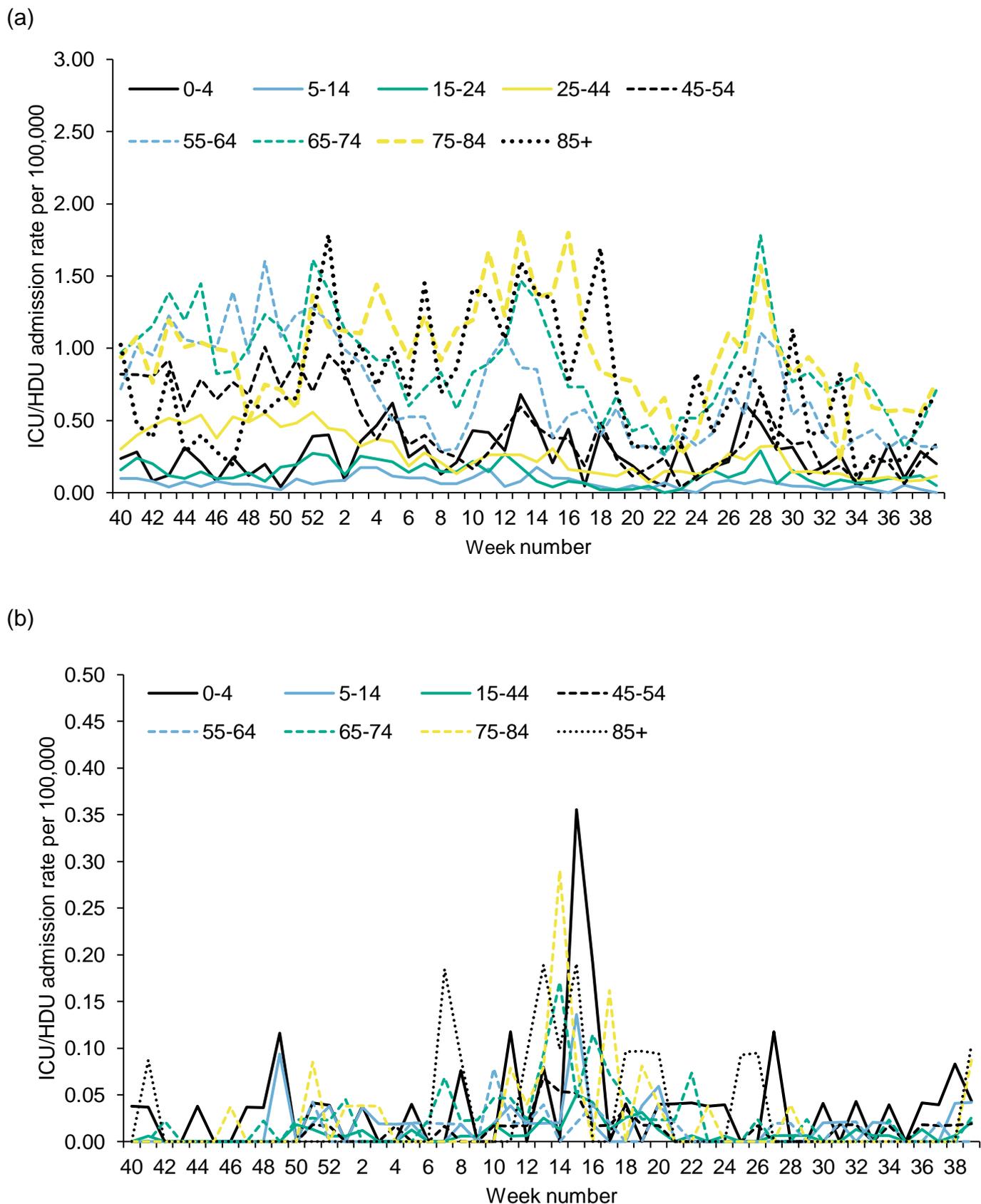


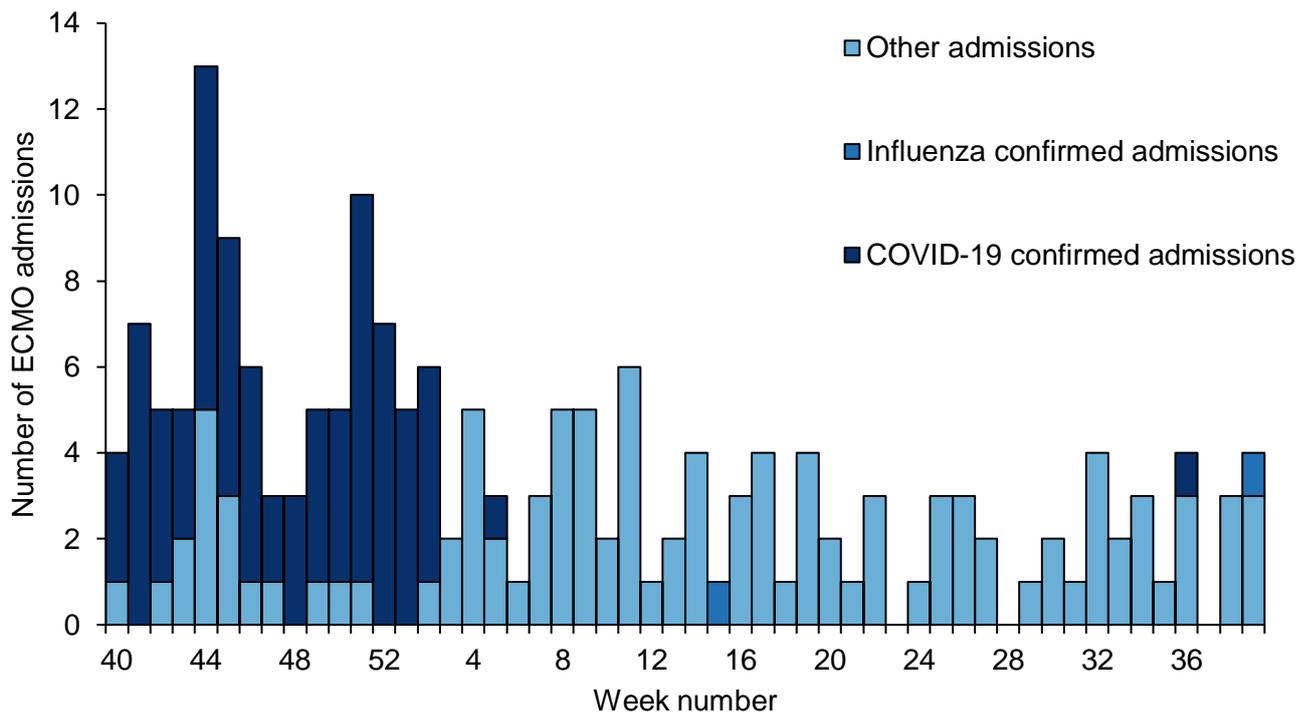
Figure 45: Weekly ICU or HDU admission rate by age group for new (a) COVID-19 positive cases and (b) influenza, reported through SARI Watch



ECMO, SARI Watch

There was one new laboratory confirmed influenza admission reported in week 39 from the 6 Severe Respiratory Failure (SRF) centres in the UK (Figure 46).

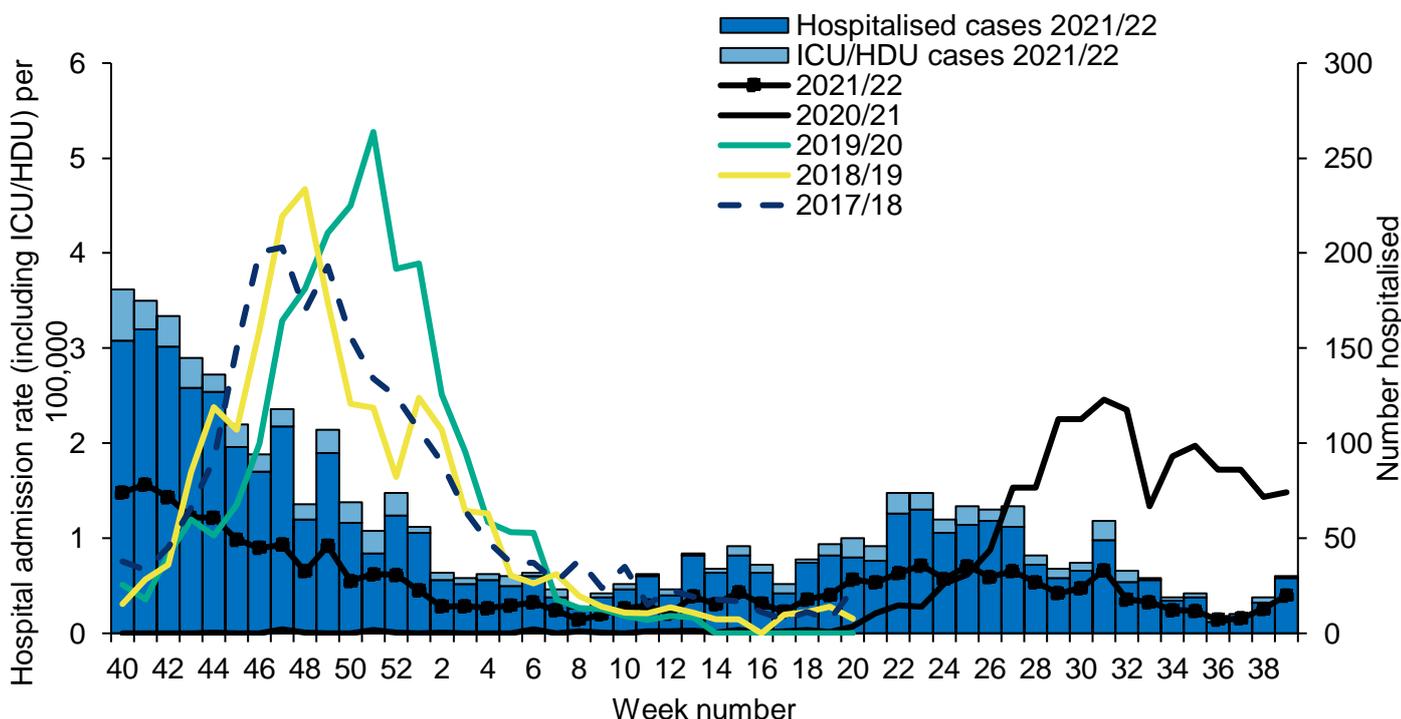
Figure 46: Laboratory confirmed ECMO admissions (COVID-19, influenza and non-COVID-19 confirmed) to Severe Respiratory Failure centres in the UK



RSV admissions, SARI Watch

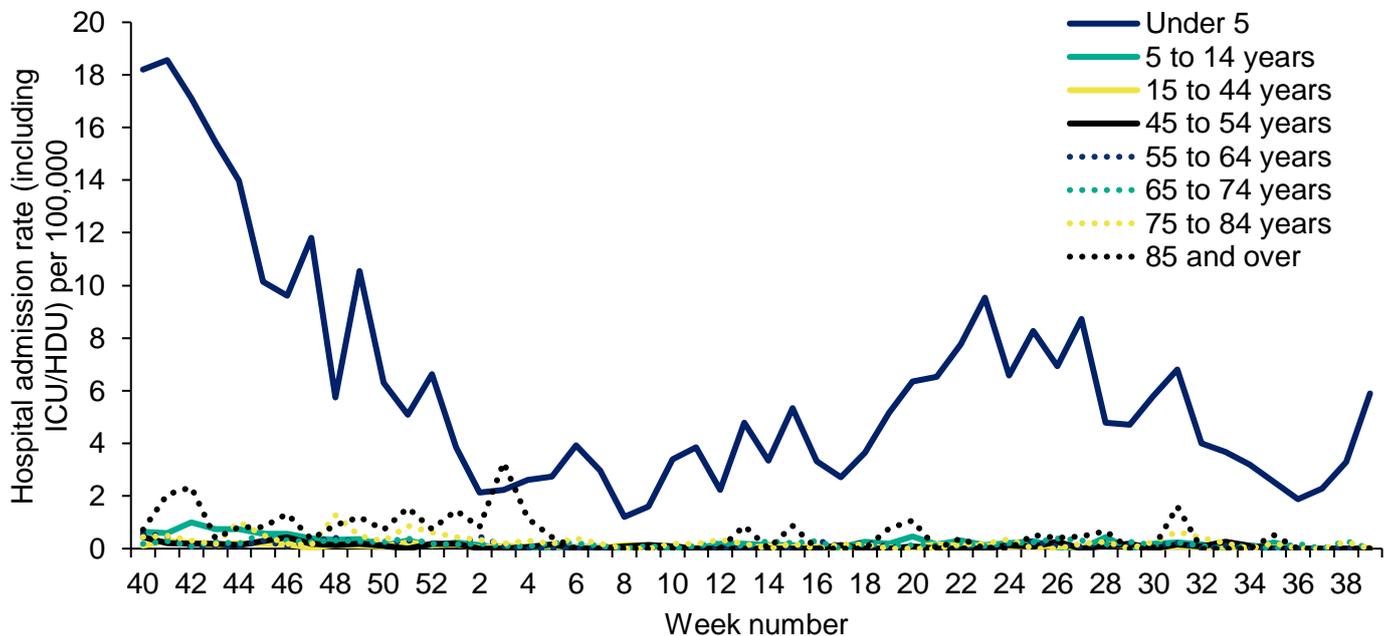
Data on hospitalisations, including ICU or HDU admissions, with respiratory syncytial virus (RSV) are shown below. RSV SARI Watch surveillance is sentinel.

Figure 47: Weekly overall hospital admission rates (including ICU or HDU) of RSV positive cases per 100,000 population reported through SARI Watch, England



* Please note that in previous seasons, RSV SARI Watch surveillance has run from week 40 to week 20. In the 2020 to 2021 season this was extended to run throughout the year, to allow for surveillance of out-of-season trends

Figure 48: Weekly hospitalisation (including ICU or HDU) admission rates by age group for new RSV cases reported through SARI Watch in 2021 to 2022, England



* Please note that rates are based on the number of hospitalised cases divided by the Trust catchment population, multiplied by 100,000

* SARI Watch data is provisional

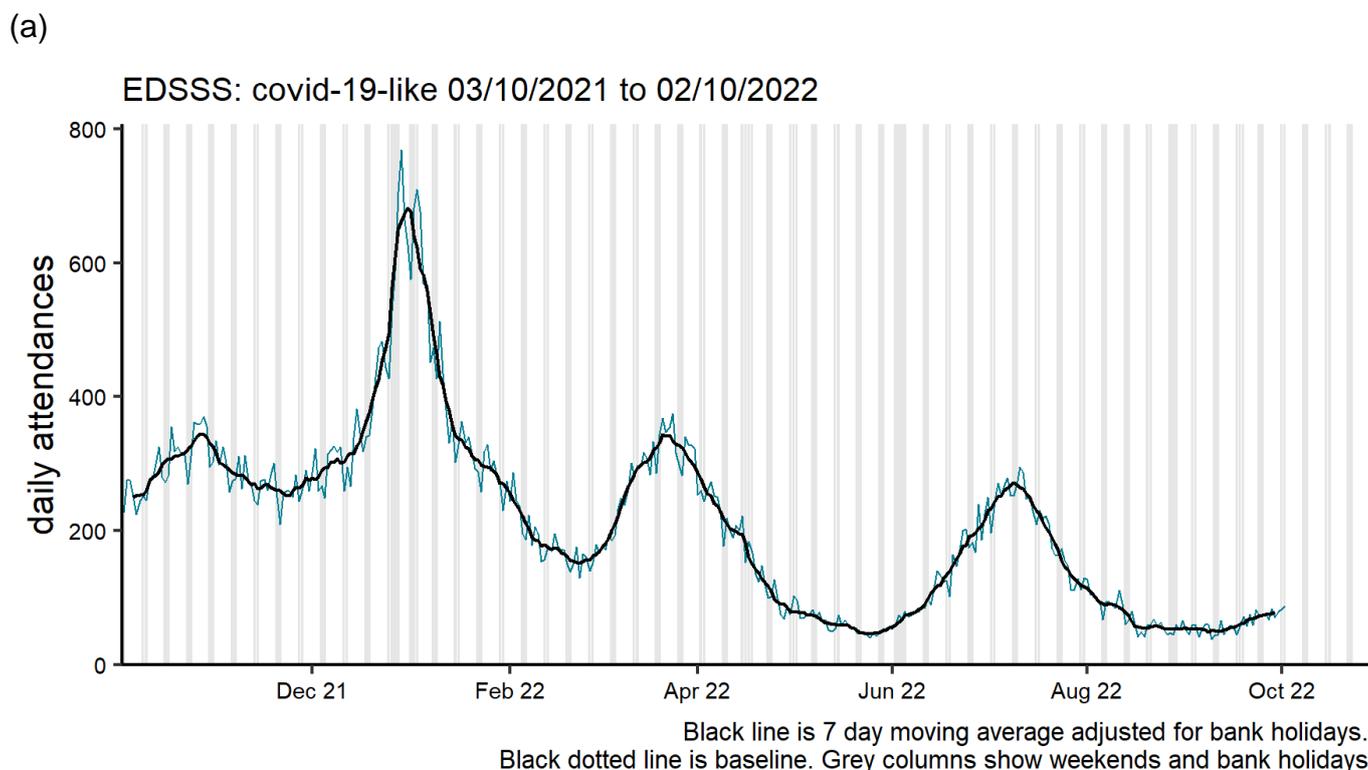
Emergency Department attendances, Syndromic surveillance

The [Emergency Department Syndromic Surveillance System \(EDSSS\)](#) monitors the daily visits in a network of emergency departments across England.

Up to 2 October ED attendances as reported by 135 EDs for acute respiratory infection increased nationally. ED attendances for COVID-19-like increased nationally, mostly among those over 65 years old (Figures 49 and 50).

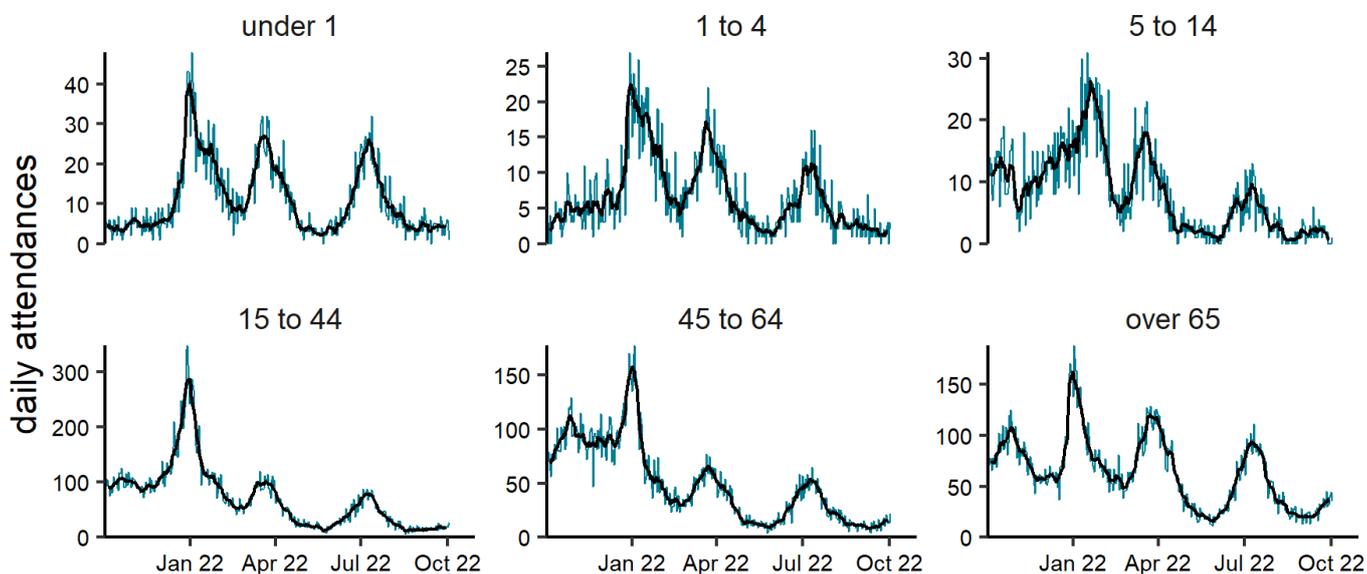
Please note: the COVID-19-like ED indicator is an underestimation of the number of COVID-19 attendances as it only includes attendances with a COVID-19-like diagnosis as their primary diagnosis. The EDSSS COVID-19-like indicator should therefore be used to monitor trends in ED attendances and not to estimate actual numbers of COVID-19 ED attendances. Further information about these caveats is available from the [Emergency Department Syndromic Surveillance](#) bulletin.

Figure 49: Daily ED attendances for COVID-19-like infections, England (a) nationally, (b) by age group and (c) by UKHSA centre



(b)

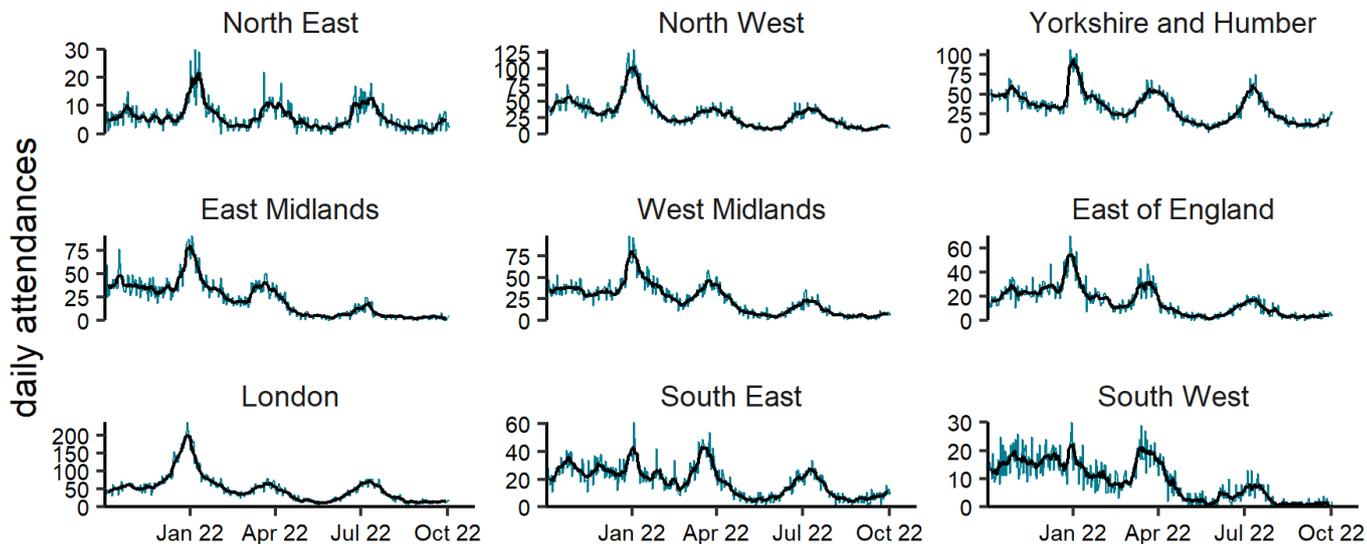
EDSSS: covid-19-like by age (years) 03/10/2021 to 02/10/2022



NOTE: SCALES MAY VARY IN EACH GRAPH TO ENABLE TREND COMPARISON.
Black line is 7 day moving average adjusted for bank holidays.

(c)

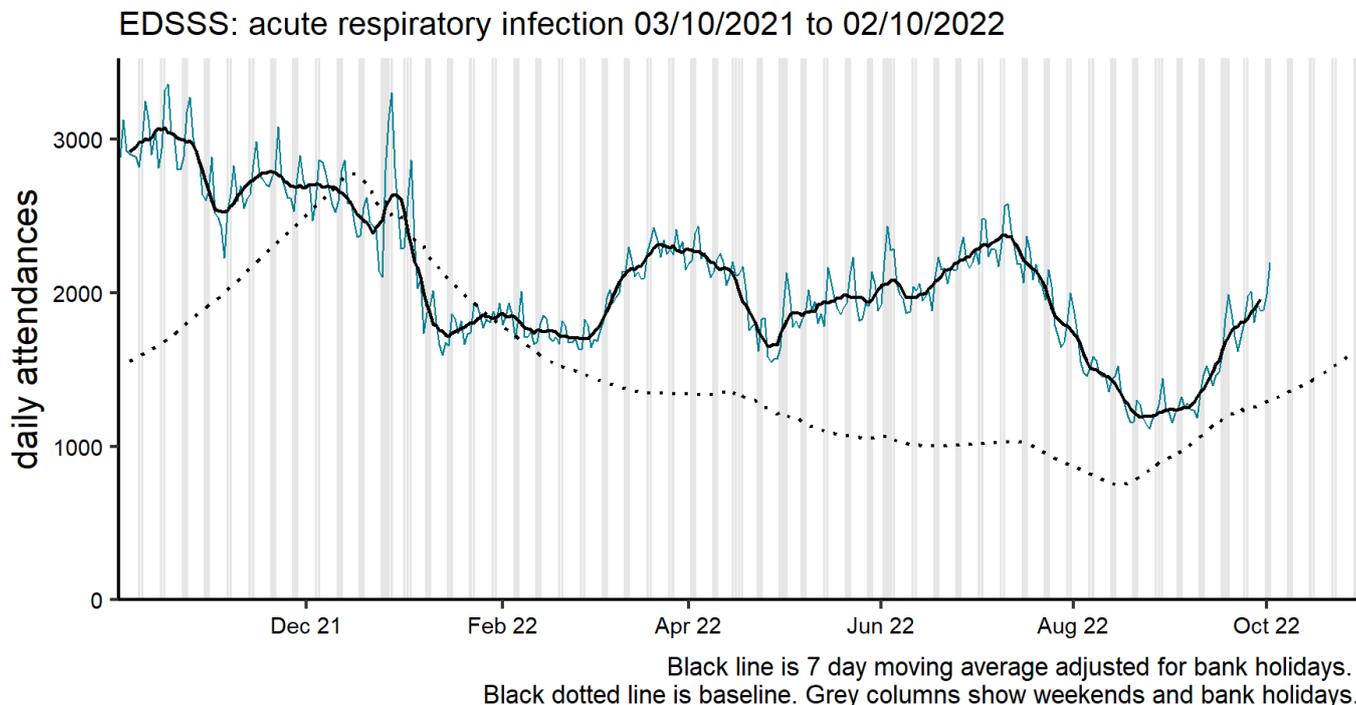
EDSSS: covid-19-like by region 03/10/2021 to 02/10/2022



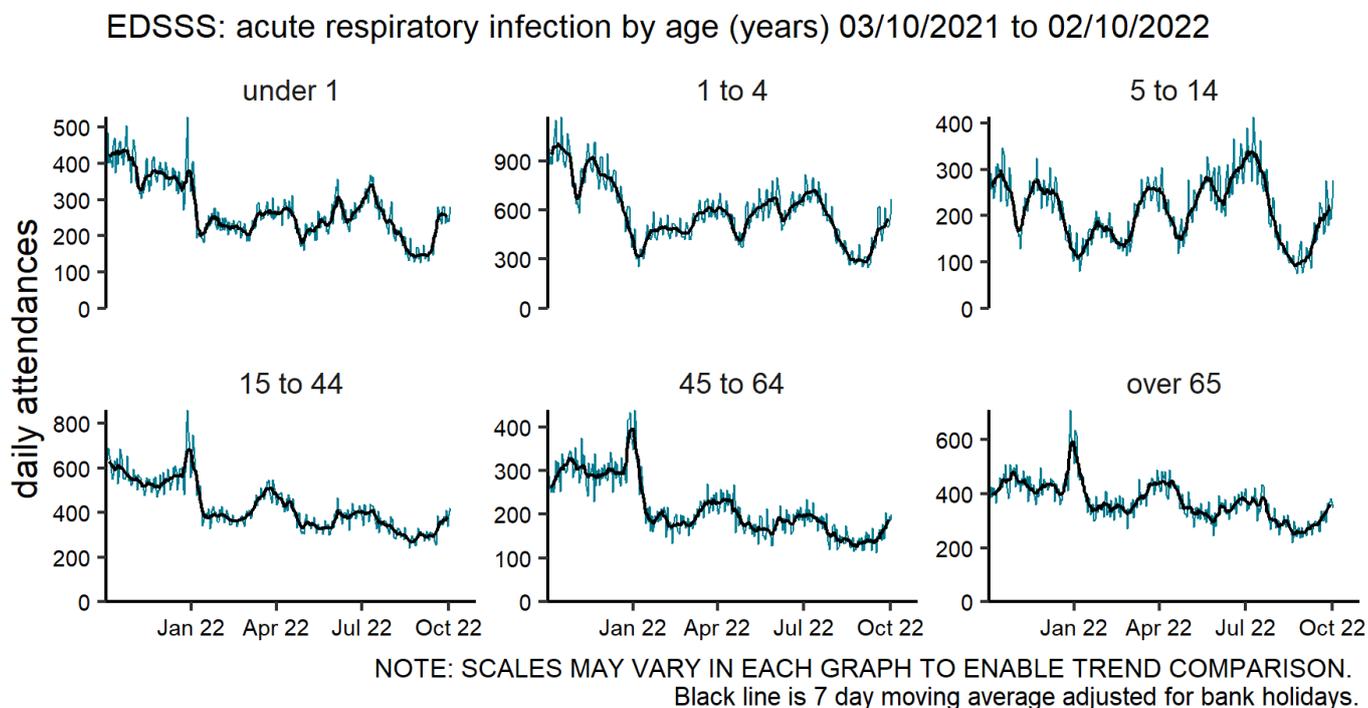
NOTE: SCALES MAY VARY IN EACH GRAPH TO ENABLE TREND COMPARISON.
Black line is 7 day moving average adjusted for bank holidays.
Black dotted line is baseline.

Figure 50: Daily ED attendances for acute respiratory infections, England (a) nationally, (b) by age group and (c) by UKHSA centre

(a)

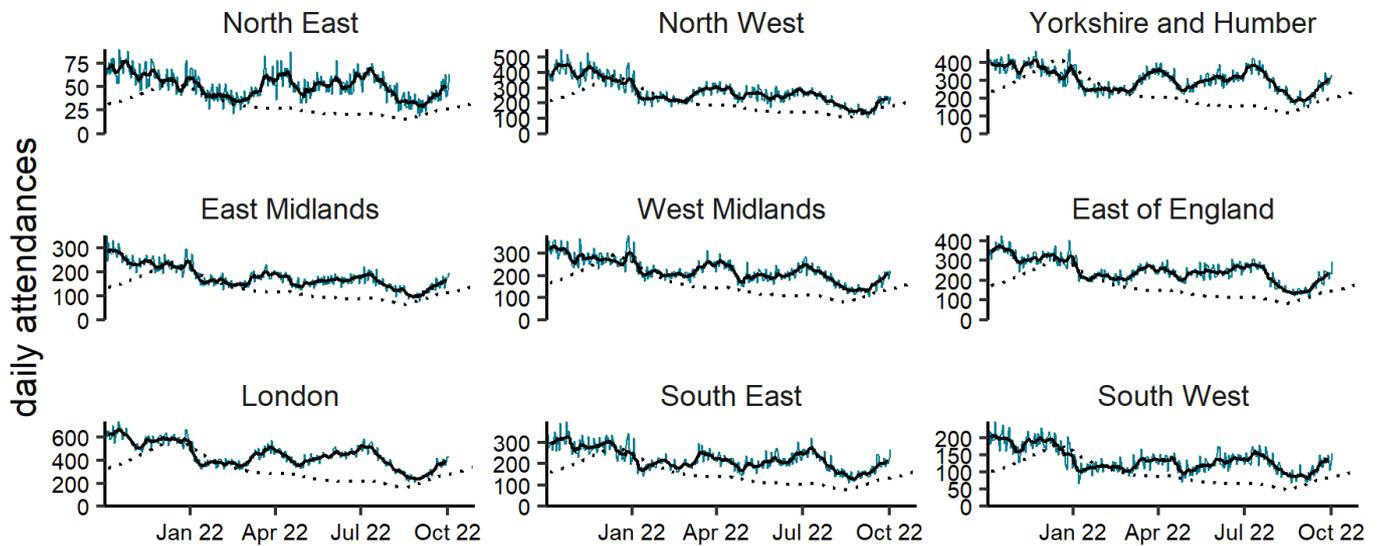


(b)



(c)

EDSSS: acute respiratory infection by region 03/10/2021 to 02/10/2022



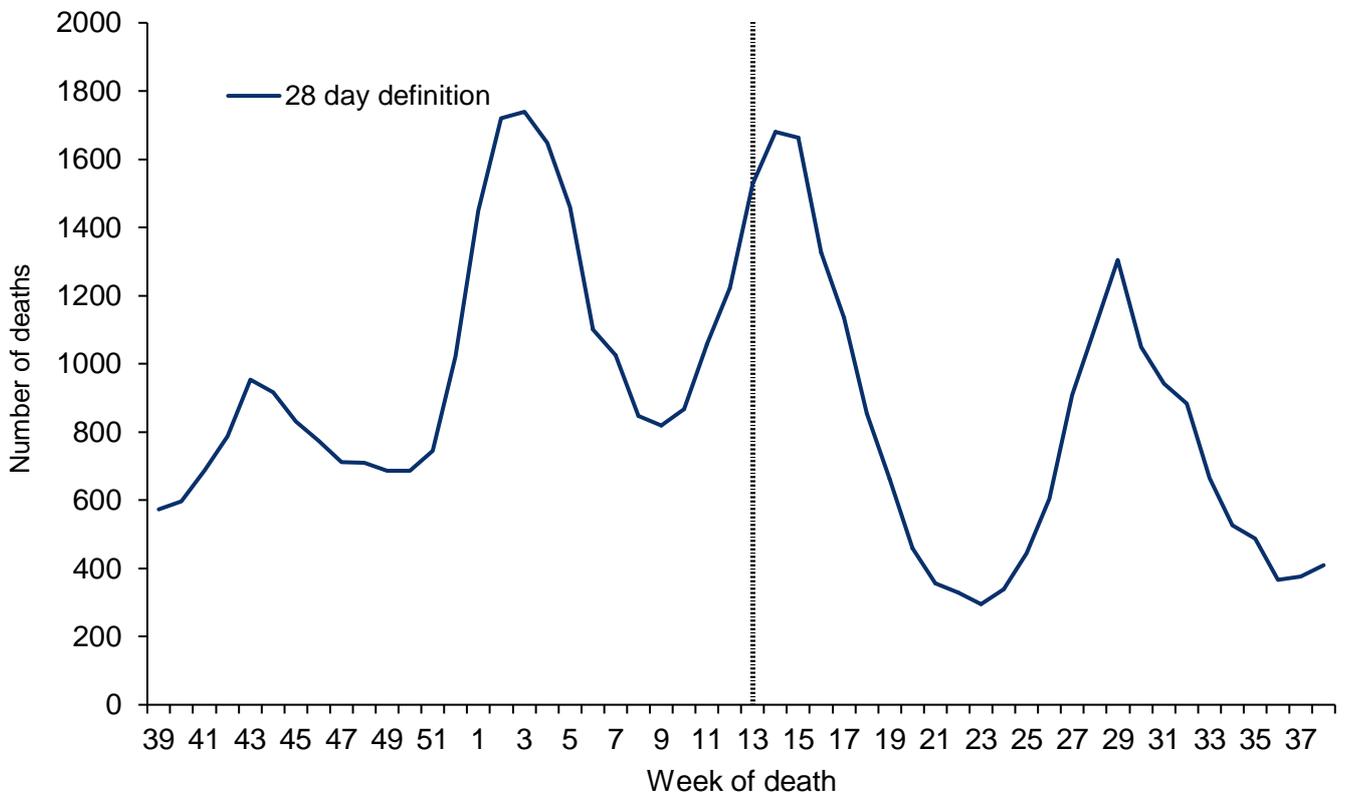
NOTE: SCALES MAY VARY IN EACH GRAPH TO ENABLE TREND COMPARISON.
Black line is 7 day moving average adjusted for bank holidays.
Black dotted line is baseline.

Mortality surveillance

COVID-19 deaths

COVID-19 related deaths by the 28 day definition are reported below. This metric includes a death in a person with a positive COVID-19 test who died within (equal to or less than) 28 days of the first positive specimen date in the most recent episode of infection.

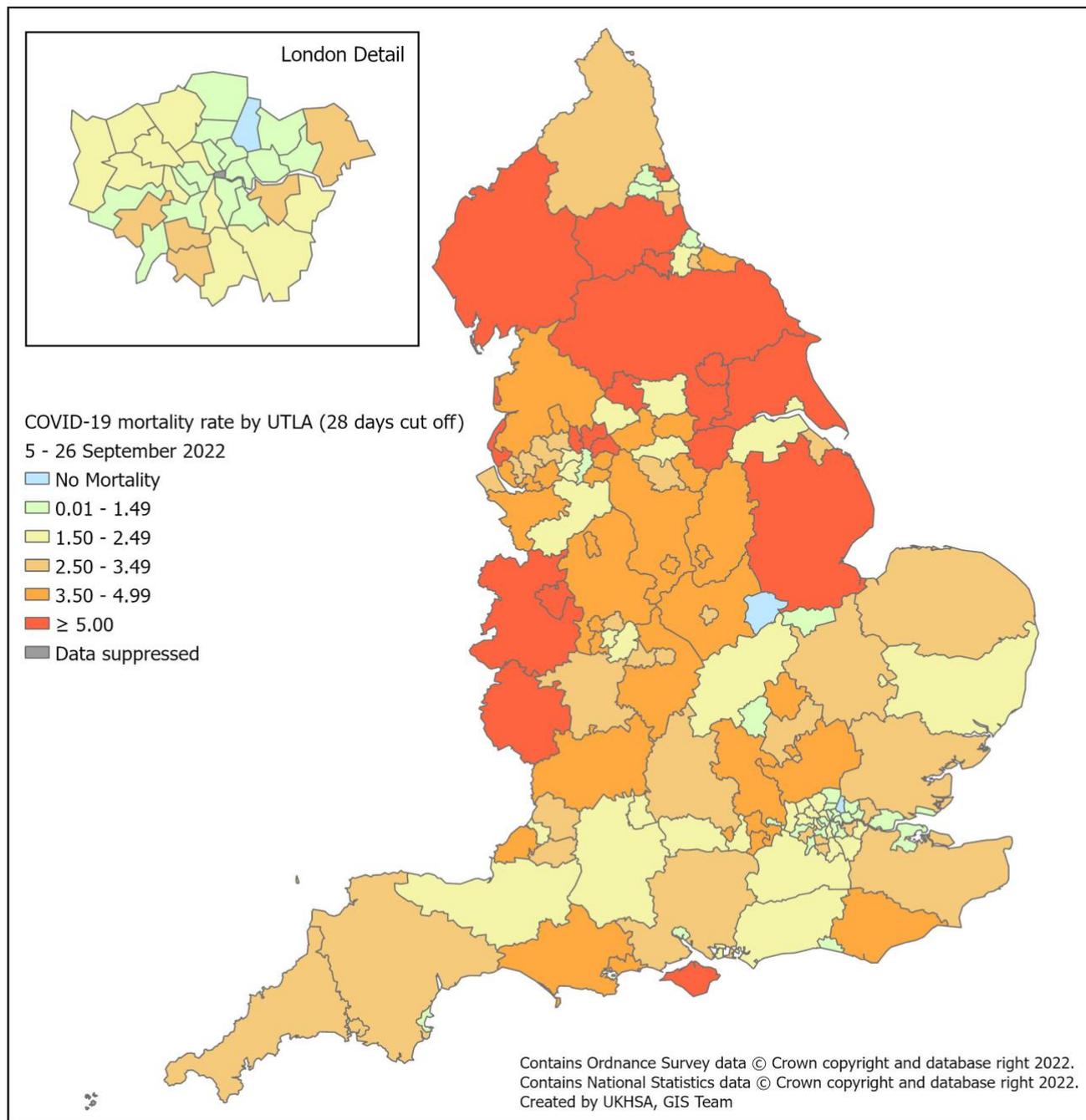
Figure 51: Number of deaths by week of death and time since a positive COVID-19 test (28 day definition), England



* Vertical dotted line indicates the end of provision of free universal testing for the general public in England, as outlined in the plan for [living with COVID-19](#).

* Data is shown by the week of death. This gives the most accurate analysis of this time progression, however, for the most recent weeks' numbers more deaths are expected to be registered therefore this should be interpreted with caution

Figure 52: Cumulative mortality rate of COVID-19 cases per 100,000 population tested under Pillars 1 and 2 for the weeks 35 to 38 by 28 day definition



Daily excess all-cause mortality (England)

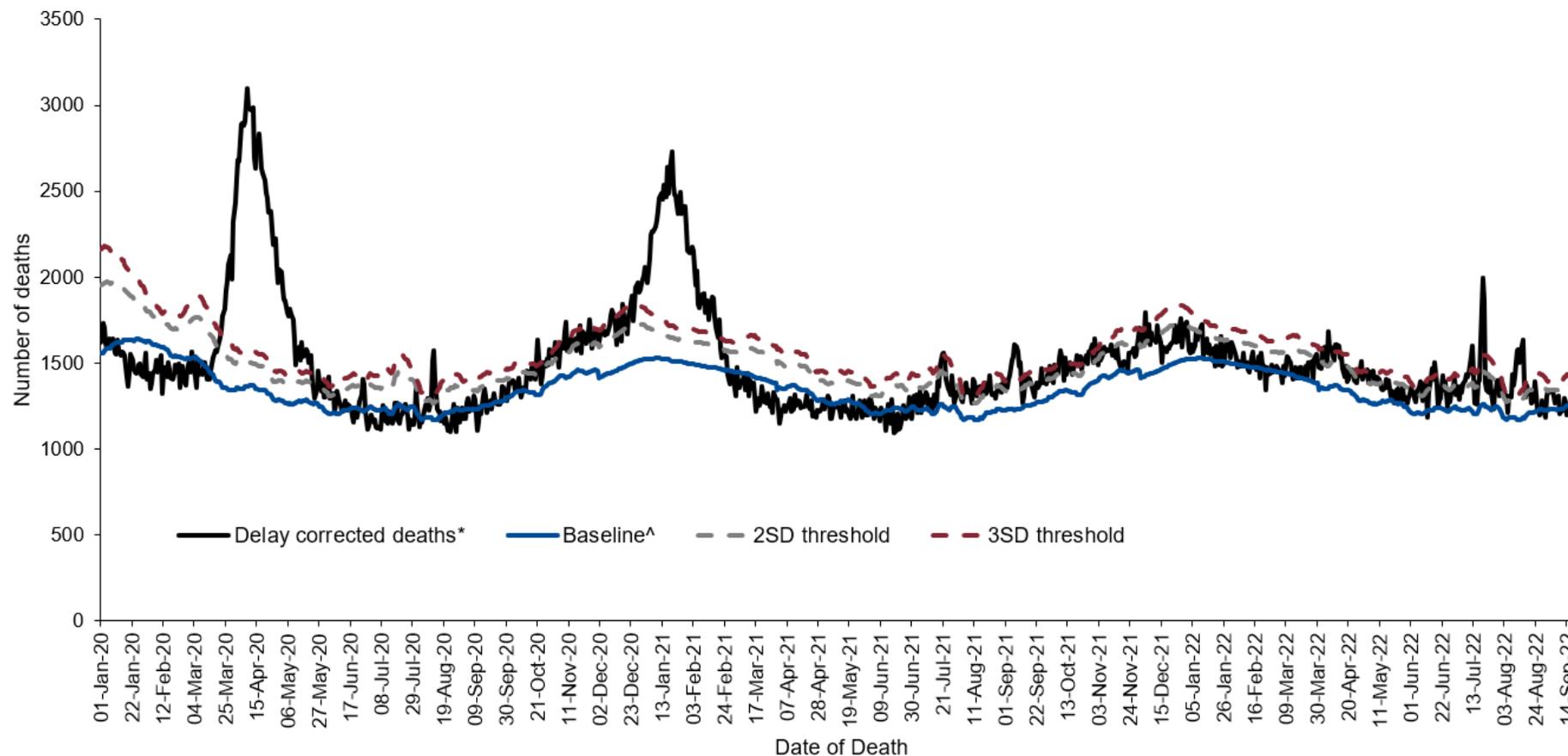
Deaths occurring from 1 January 2020 to 28 September 2022 were assessed to calculate the daily excess above a baseline using age-group and region specific all cause deaths as provided daily by the General Register Office (GRO). The deaths were corrected to allow for delay to registration based on past data on these delays and the baseline was from the same day of the year in the previous 5 years plus or minus 7 days with an extrapolated time trend, and with 2 and 3 standard deviation (SD) limits shown (Figure 53).

Weeks in which at least 2 days exceeded the 3SD threshold are shown in Table 3 and the daily difference from the baseline by age and region is given in Figure 54.

Note that as this data is by date of death with delay corrections, numbers are subject to change each week, particularly for more recent days. The current week's model supersedes models presented in previous week.

No excess all-cause mortality was observed in week 38 overall. Note that level 3 heat-health alerts were issued for June 17 to 18, July 11 to 21, and August 9 to 16 2022, and a level 4 heat-health alert issued for July 18 to 19 2022.

Figure 53: Daily excess all-cause deaths in all ages, England, 1 January 2020 to 28 September 2022



^Baseline calculation:

January to November 2020: same day in previous 5 years plus or minus 1 week with a linear trend.

December 2020 to March 2021: past 3 low flu years plus or minus 2 weeks, no trend.

March 2021 onwards: same baseline as 2020

* corrected for delay to registration from death

Other measures of excess mortality published by UKHSA are the [Fingertips excess mortality in England report](#), which uses ONS death registration data and [the all-cause mortality surveillance report](#), which uses the EuroMOMO model to measure excess deaths.

Table 3: Excess all-cause deaths by (a) age group and (b) UKHSA centres, England

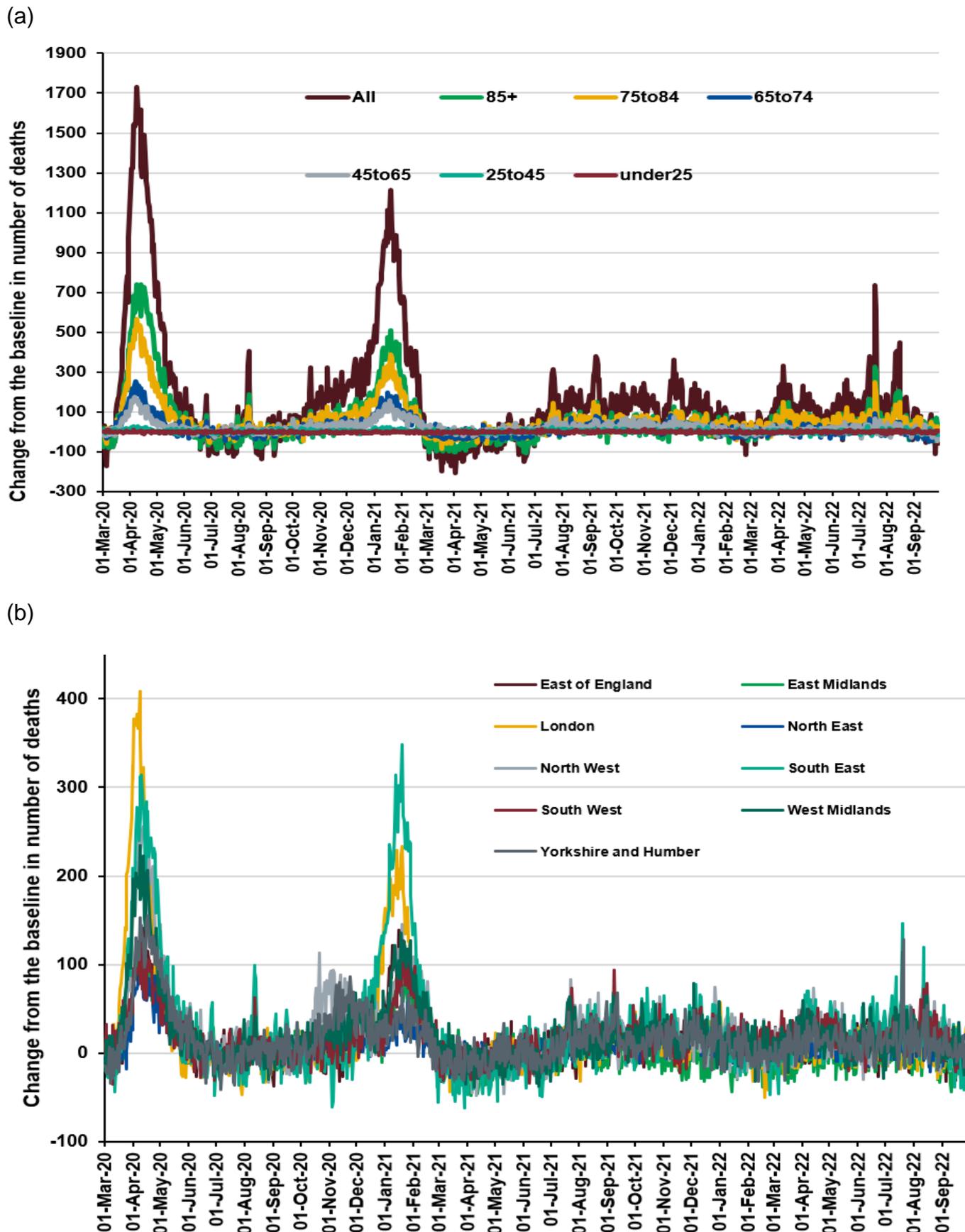
(a)

Age Group	Excess detected in week 38 2022?	Weeks in excess from week 10 to 53 2020	Weeks in excess from week 1 to 52 2021	Weeks in excess from week 1 2022
All	x	13 to 21, 33, 43, 45, 50, 52 to 53	01 to 07, 29, 31 to 32, 35 to 36, 40 to 44, 48	14 to 15, 18, 23 to 24, 27 to 29, 32 to 33
under 25	x	None	None	None
25 to 44	x	14 to 16	None	None
45 to 64	x	12 to 19, 49 to 50, 52 to 53	01 to 08, 23, 29 to 30, 36, 40 to 44, 48 to 49	29
65 to 74	x	13 to 19, 46, 48, 52 to 53	01 to 07, 36, 43, 48	None
75 to 84	x	13 to 21, 33, 45, 49, 52 to 53	01 to 07, 32, 36, 40	14 to 19, 22 to 24, 27 to 29, 31 to 32
85+	x	13 to 21, 33, 53	01 to 07, 31, 36	28 to 29, 32

(b)

UKHSA Centres	Excess detected in week 38 2022?	Weeks in excess from week 10 to 53 2020	Weeks in excess from week 1 to 52 2021	Weeks in excess from week 1 2022
East of England	x	14 to 19, 52 to 53	01 to 07	27, 29
East Midlands	x	13 to 19, 48	01 to 07	29
London	x	12 to 19, 33, 52 to 53	01 to 06, 36	32
North East	x	14 to 21	02 to 04	None
North West	x	13 to 19, 33, 42 to 47	01 to 07, 31 to 32, 36, 43	14 to 15, 29 to 30, 32
South East	x	13 to 21, 33, 50 to 53	01 to 07, 36, 41, 49	14, 32
South West	x	13 to 19, 33	02 to 07, 29, 36	29, 32, 34
West Midlands	x	13 to 20, 45, 48	01 to 07, 29, 36, 40, 48	13 to 14, 28 to 29, 32
Yorkshire and Humber	x	14 to 21, 23, 43 to 50	02 to 04, 32, 35 to 36	29, 32

Figure 54: Daily excess all-cause deaths by (a) age group and (b) UKHSA centres, England, 1 March 2020 to 28 September 2022



Microbiological surveillance

Virus characterisation

UKHSA characterises the properties of influenza viruses through one or more tests, including genome sequencing (genetic analysis) and haemagglutination inhibition (HI) assays (antigenic analysis). These data are used to compare how similar the currently circulating influenza viruses are to the strains included in seasonal influenza vaccines, and to monitor for changes in circulating influenza viruses. The interpretation of genetic and antigenic data sources is complex due to a number of factors, for example, not all viruses can be cultivated in sufficient quantity for antigenic characterisation, so that viruses with sequence information may not be able to be antigenically characterised as well. Occasionally, this can lead to a biased view of the properties of circulating viruses, as the viruses which can be recovered and analysed antigenically, may not be fully representative of majority variants, and genetic characterisation data does not always predict the antigenic characterisation.

Information on virus characterisation for the 2021 to 2022 season is available in [previous reports](#).

Antiviral susceptibility

Influenza positive samples are screened for mutations in the virus neuraminidase (NA) and the cap-dependent endonuclease (PA) genes known to confer neuraminidase inhibitor or baloxavir resistance, respectively. The samples tested are routinely obtained for surveillance purposes, but diagnostic testing of patients suspected to be infected with antiviral-resistant virus is also performed.

Information on antiviral susceptibility for the 2021 to 2022 season is available in [previous reports](#).

SARS-CoV-2 variants

This section is updated fortnightly. The last update was in week 40 2022 report.

UKHSA conducts genomic surveillance of SARS-CoV-2 variants.

This section provides an overview of new and current circulating variants in England.

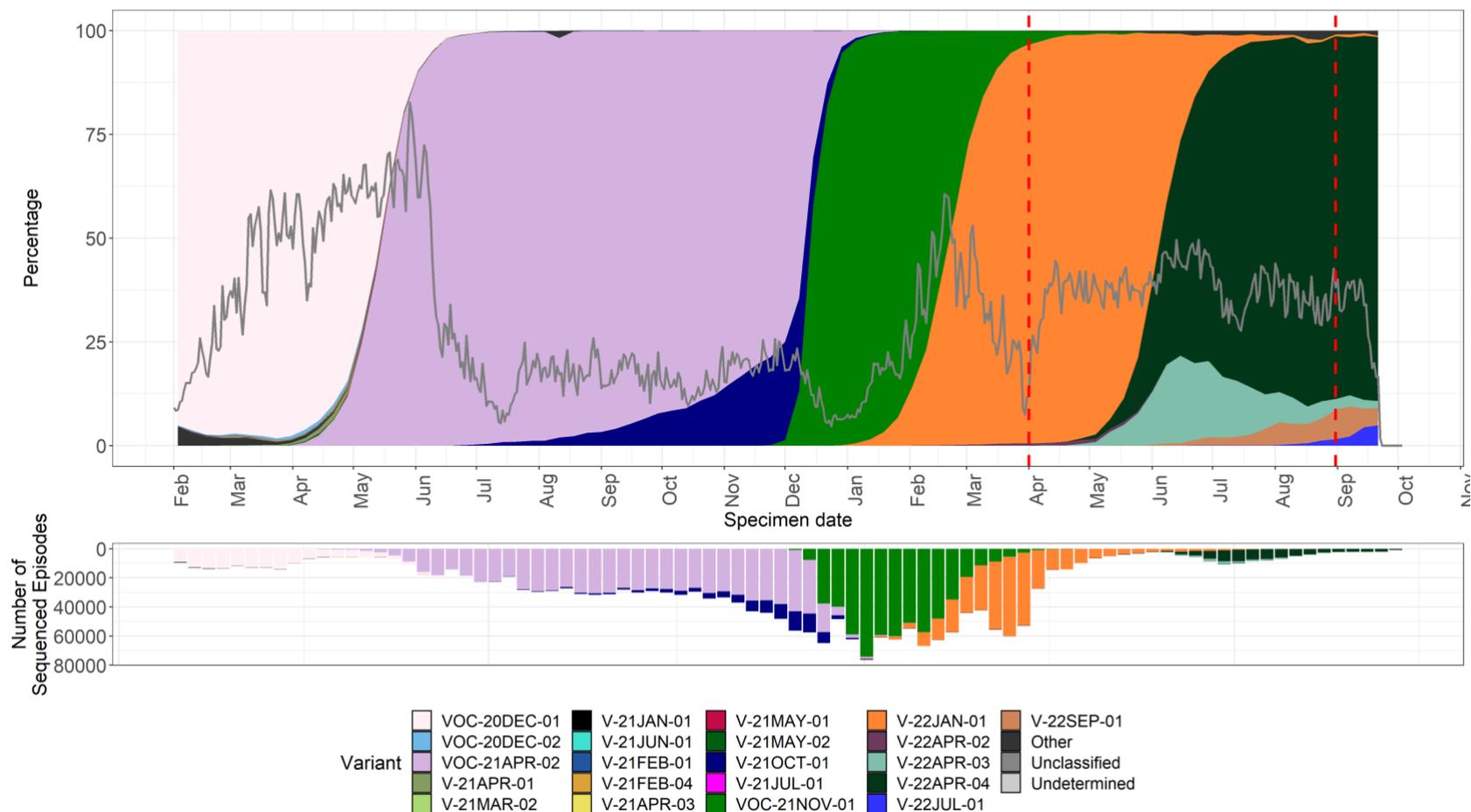
Detailed surveillance of particular variants of concerns can be found in recent [technical briefings](#).

Information on whole genome sequencing coverage can be found in the accompanying slide set.

The prevalence of different UKHSA-designated variants amongst sequenced episodes is presented in Figure 55.

Of the sequenced episodes from 01 February 2022 to 04 October 2022 0.4% were BA.2 (V-22JAN-01), 2.0% were BA.4 (V-22APR-03), 4.0% were BA.4.6 (V-22SEP-01), 88.0% were BA.5 (V-22APR-04), 5.0% were BA.2.75 (V-22JUL-01), and 1.0% were classified as other.

Figure 55. Prevalence of SARS-CoV-2 variants amongst available sequences episodes for England from 1 February, as of 04 October 2022



The grey line indicates proportion of cases sequenced.

The vertical dashed lines (red) denote changes in policies:

- April line denotes the start of England's 'Living with COVID' Plan.
- End of August line denotes the change in asymptomatic testing

Note recombinants such as XD, are not specified but are largely within the 'other' group currently as numbers are too small.

As of week 39 2022, BA.5 continues to be the predominant circulating variant in England (Table 4).

Table 4. Total distribution of SARS-CoV-2 variants detected in England in the last 12 weeks, up to week 39 (week ending 02 October 2022)

Variant	Other names by which this variant is known	Total confirmed (sequencing) cases in the last 12 weeks	Last reported specimen date
VOC-21APR-02	Delta	3	15-08-2022
VOC-21NOV-01	Omicron BA.1	24	13-09-2022
V-22JAN-01	Omicron BA.2	1,189	21-09-2022
V-22APR-02	Omicron XE	2	30-07-2022
V-22APR-03	Omicron BA.4	5,186	21-09-2022
V-22APR-04	Omicron BA.5	46,613	23-09-2022
V-22JUL-01	Omicron BA.2.75	324	23-09-2022
V-22SEP-01	Omicron BA.4.6	2,067	23-09-2022

*Sequencing data has a lag of approximately two weeks therefore the presented numbers should be interpreted in this context

*Cumulative numbers may be revised up or down as a results of reclassification of results, re-infections and changes to diagnostic tests, new variants or public health management levels

*Confirmed individuals are confirmed COVID-19 cases with a validated sequencing result meeting the confirmed case definitions.

Antimicrobial susceptibility

Table 5 shows in the 12 weeks up to week 39 2022, the proportion of all lower respiratory tract isolates of *Streptococcus pneumoniae*, *Haemophilus influenzae*, *Staphylococcus aureus*, MRSA (Methicillin-resistant *Staphylococcus aureus*) and MSSA (methicillin-susceptible *Staphylococcus aureus*) tested and susceptible to antibiotics. These organisms are the important causes of community-acquired pneumonia (CAP) and the choice of antibiotics reflects the British Thoracic Society empirical guidelines for management of CAP in adults.

Table 5: Antimicrobial susceptibility surveillance in lower respiratory tract

Organism	Antibiotic	Specimens tested (N)	Specimens susceptible (%)
<i>S. pneumoniae</i>	Penicillin	1,471	86
	Macrolides	1,644	81
	Tetracycline	1,624	82
<i>H. influenzae</i>	Amoxicillin/ampicillin	7,486	47
	Co-amoxiclav	8,685	50
	Macrolides	1,859	6
	Tetracycline	8,947	98
<i>S. aureus</i>	Methicillin	7,486	47
	Macrolides	8,685	50
MRSA	Clindamycin	215	50
	Tetracycline	268	73
MSSA	Clindamycin	2,891	76
	Tetracycline	3,597	93

* Macrolides = erythromycin, azithromycin and clarithromycin

Data source: UKHSA's SGSS Antimicrobial Resistance (AMR) module, please note that this is different to the data source used in the reports published between weeks 41, 2020 to 5, 2021 inclusive of the 2020 to 2021 influenza season when the SGSS Communicable Disease Report (CDR) module was used instead due to a UKHSA SGSS AMR data infrastructure issue which has now been resolved. Therefore, the above results are not directly comparable to the results reported between weeks 41, 2020 and 5, 2021. The AMR module of SGSS was used during the 2019 to 2020 influenza season. There has been a reduction in the total number of bacterial positive lower respiratory tract clinical samples reported to UKHSA since mid-March 2020.

COVID-19 sero-prevalence surveillance

Since week 42 2021, updates on COVID-19 sero-prevalence estimates have been published in the weekly [COVID-19 vaccine surveillance report](#).

COVID-19 vaccination

COVID-19 vaccine uptake in England

COVID-19 vaccinations began in England on 8 December 2020 during week 50 2020 (week ending 13 December 2020). Cumulative data up to week 39 2022 (week ending 2 October 2022) was extracted from the National Immunisation Management Service (NIMS). The data presented this week is the provisional proportion of living people resident in England who had received at least one dose, 2 doses and 3 doses of a COVID-19 vaccination by age group. The overall vaccine uptake in the living and resident population for those with at least dose 1 was 70.9%, 67.4% for dose 2 and 53.1% for dose 3. The breakdown by sex showed vaccine uptake in males was 68.4% and 73.4% in females for dose 1. For dose 2 vaccine uptake by sex was 64.8% in males and 70.0% in females. For dose 3 vaccine uptake by sex was 50.3% in males and 56.1% in females. The vaccine uptake rate in adults aged 18 and over was 82.5% (41,141,405 out of 49,853,385) for dose 1; 79.8% (39,773,849 out of 49,853,385) for dose 2 and 65.8% (32,804,493 out of 49,853,385) for dose 3.

Table 6: Provisional cumulative COVID-19 vaccine uptake by age in England

NATIONAL	People in NIMS cohort who are living and resident in England	Vaccinated with at least 1 dose		Vaccinated with at least 2 doses		Vaccinated with at least 3 doses	
		Number vaccinated	% vaccine uptake	Number vaccinated	% vaccine uptake	Number vaccinated	% vaccine uptake
Over 80	2,938,188	2,832,029	96.4	2,816,733	95.9	2,752,393	93.7
75 to under 80	2,370,674	2,284,040	96.3	2,270,373	95.8	2,220,142	93.7
70 to under 75	2,711,164	2,574,317	95.0	2,553,287	94.2	2,472,476	91.2
65 to under 70	2,963,503	2,761,829	93.2	2,731,948	92.2	2,595,763	87.6
60 to under 65	3,592,913	3,292,272	91.6	3,249,400	90.4	2,999,180	83.5
55 to under 60	4,118,935	3,694,849	89.7	3,636,731	88.3	3,273,862	79.5
50 to under 55	4,174,788	3,642,034	87.2	3,570,574	85.5	3,111,202	74.5
45 to under 50	3,874,043	3,198,606	82.6	3,113,803	80.4	2,563,851	66.2
40 to under 45	4,280,765	3,335,385	77.9	3,218,340	75.2	2,499,969	58.4
35 to under 40	4,581,893	3,369,795	73.5	3,217,259	70.2	2,329,254	50.8
30 to under 35	4,741,908	3,355,621	70.8	3,163,257	66.7	2,145,116	45.2
25 to under 30	4,341,117	3,047,755	70.2	2,838,071	65.4	1,823,866	42.0
20 to under 25	3,790,853	2,756,733	72.7	2,515,779	66.4	1,558,812	41.1
18 to under 20	1,372,641	996,140	72.6	878,294	64.0	458,607	33.4
16 to under 18	1,389,817	899,619	64.7	712,198	51.2	193,466	13.9
12 to under 16	2,932,180	1,511,466	51.5	1,124,726	38.4	25,750	0.9
5 to under 12	5,005,847	555,341	11.1	289,197	5.8	1,069	0.0
Total*	62,187,225	44,107,965	70.9	41,899,983	67.4	33,024,781	53.1

*Caution should be exercised when summing the age figures as the sum of these will not equal the England total. This is due to individuals vaccinated in England where the individual had an unknown age

group or where age is less than 5 years old. Individuals vaccinated in England who have a registered address outside of England or where their address is unknown have been excluded.

From 18 November 2021 (week 46 2021) UKHSA started to report on those in the population with at least 3 doses of COVID-19 vaccine. These figures count the number of doses a person has had in chronological order and includes vaccinations given before the start of the programme where data is available to provide a more complete record of the population coverage estimates.

Age was previously calculated as age on the 31 August 2021 (academic cohort for all ages). Please note that from 14 April 2022 (week 15 2022), age is calculated on the date data is extracted. The weekly vaccine coverage data is extracted on a Tuesday with data capped to the previous Sunday and all backing data is updated each week going back to the start of the programme.

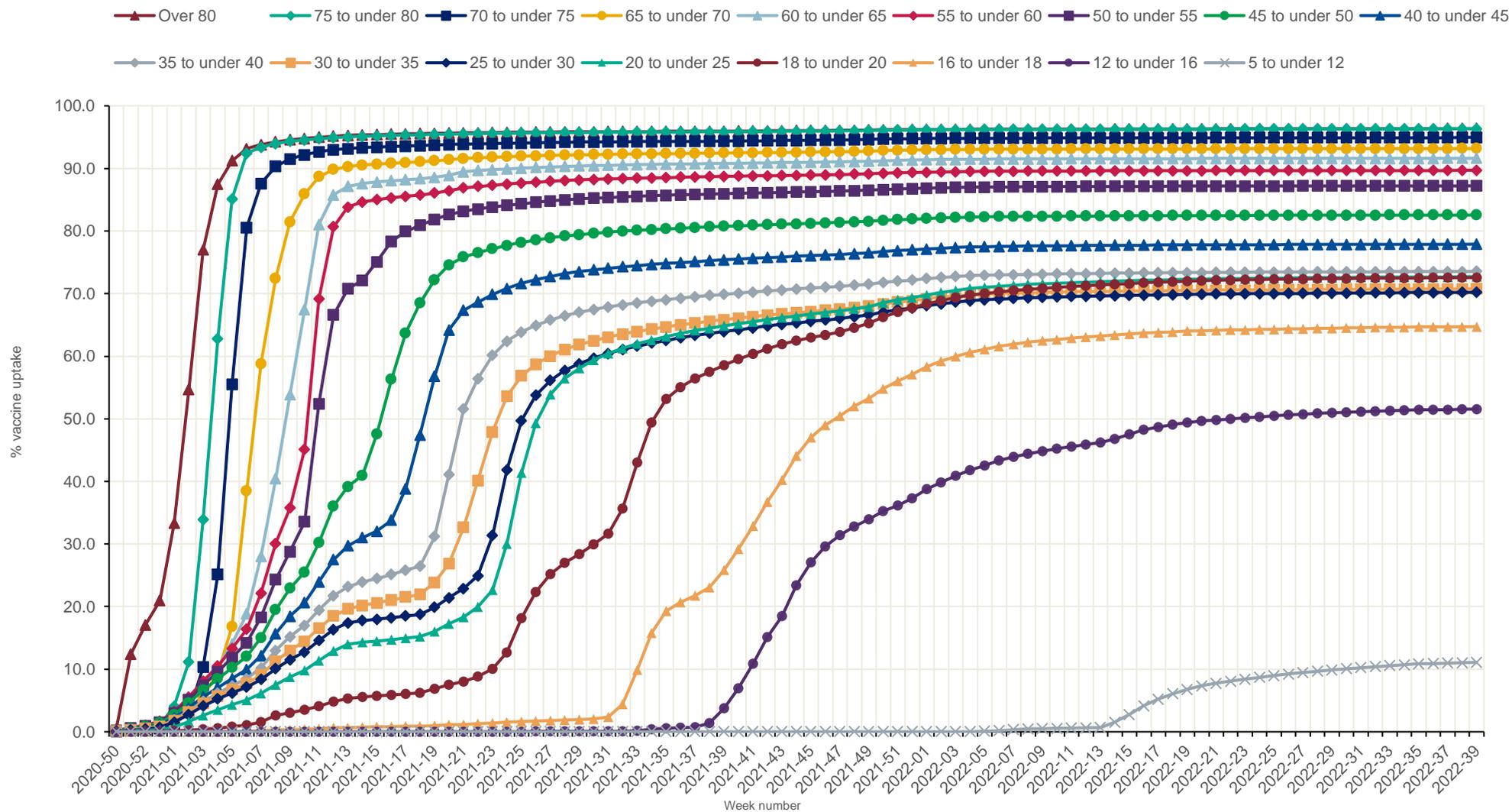
From 1 September 2022 (week 35 2022), the definition used in the table looking at eligibility by month for the spring booster campaign was changed from '6 months since the last dose' to '3 months since the last dose' to account for the earliest time a person can become eligible for the campaign. Eligibility table for the autumn booster campaign are calculated using the same method where a person is eligible after a 2 dose primary course provided there is an interval of at least 3 months since their last dose.

From 6 October 2022 (week 40 2022), all England coverage figures are of living people who are resident in England. Individuals vaccinated in England who have a registered address outside of England or where their address is unknown have been excluded.

Data is provisional and subject to change following further validation checks. Any changes to historic figures will be reflected in the most recent publication. Please note that numbers published by UKHSA are for public health surveillance purposes only.

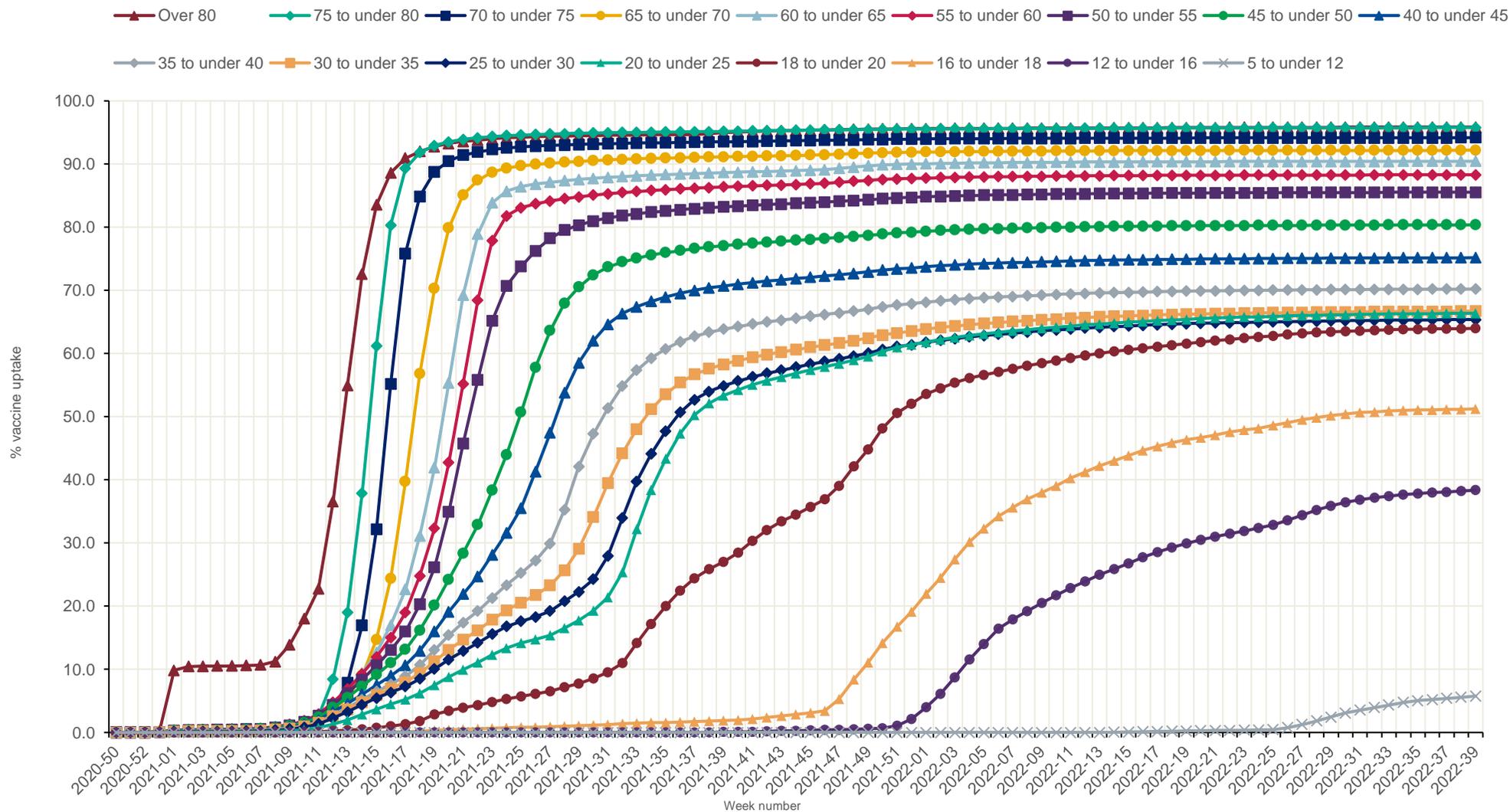
Figure 56: Cumulative weekly COVID-19 vaccine uptake by age in those who are living and resident in England for (a) Dose 1, (b) Dose 2 and (c) Dose 3 (please note the data for this graph is shown from week 39 (week ending 2 October 2022))

(a)



Weekly National Influenza and COVID-19 Report: week 40 report (up to week 39 data)

(b)



From the 6 January 2021 (week 1 of 2021), the Joint Committee on Vaccination and Immunisation (JCVI) advised initially prioritising delivery of the first vaccine dose to maximise the effect on public health in the short term and reduce the number of preventable deaths from COVID-19.

Table 7: Provisional cumulative people vaccinated with any dose of COVID-19 vaccine in the last 3 months, 3 to 6 months and vaccinated more than 6 months ago

National	People in NIMS cohort who are living and resident in England	Vaccinated in the last 3 months (84 days)		Vaccinated 3 to 6 months ago (85 to 168 days)		Vaccinated 6 months ago (169 or more days)	
		Numbers vaccinated	Percentage vaccinated	Numbers vaccinated	Percentage vaccinated	Numbers vaccinated	Percentage vaccinated
Over 80	2,938,188	1,244,526	42.4	777,238	26.5	819,882	27.9
75 to under 80	2,370,674	1,034,842	43.7	646,168	27.3	610,986	25.8
70 to under 75	2,711,164	920,339	33.9	83,635	3.1	1,581,260	58.3
65 to under 70	2,963,503	778,468	26.3	65,315	2.2	1,933,743	65.3
60 to under 65	3,592,913	308,826	8.6	68,366	1.9	2,937,269	81.8
55 to under 60	4,118,935	255,411	6.2	69,045	1.7	3,396,536	82.5
50 to under 55	4,174,788	204,178	4.9	68,213	1.6	3,396,957	81.4
45 to under 50	3,874,043	132,568	3.4	67,088	1.7	3,026,418	78.1
40 to under 45	4,280,765	115,328	2.7	81,439	1.9	3,174,671	74.2
35 to under 40	4,581,893	109,295	2.4	103,051	2.2	3,204,336	69.9
30 to under 35	4,741,908	107,539	2.3	129,501	2.7	3,177,544	67.0
25 to under 30	4,341,117	100,392	2.3	146,451	3.4	2,868,778	66.1
20 to under 25	3,790,853	92,488	2.4	171,864	4.5	2,552,827	67.3
18 to under 20	1,372,641	43,897	3.2	105,336	7.7	863,419	62.9
16 to under 18	1,389,817	68,080	4.9	152,260	11.0	683,667	49.2
12 to under 16	2,932,180	154,326	5.3	273,170	9.3	1,091,277	37.2
5 to under 12	5,005,847	315,680	6.3	205,435	4.1	37,502	0.7

Table 7 is presented to provide an overview of how recently a person has been vaccinated either through the primary vaccination campaign or subsequent booster campaigns. This helps us understand the data in the context of vaccine waning across the whole COVID-19 programme. Breakdowns by Ethnicity, and IMD, by age can be found in the backing tables

Figure 57: Provisional cumulative people vaccinated with any dose of COVID-19 vaccine in the last 3 months, 3 to 6 months and vaccinated more than 6 months ago

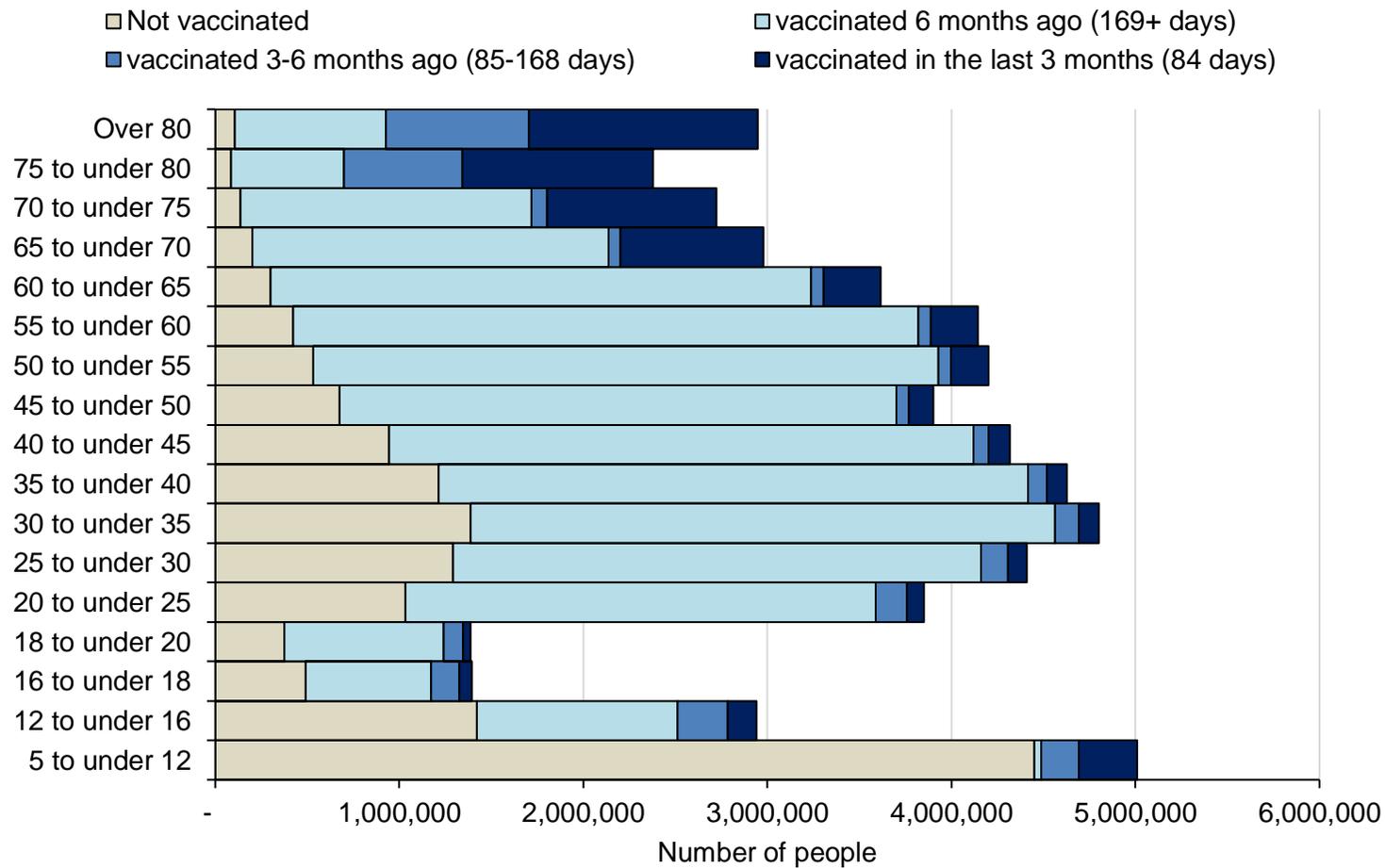


Figure 58: Age-Sex pyramid for COVID-19 vaccine uptake by age in those living and resident in England for dose 1

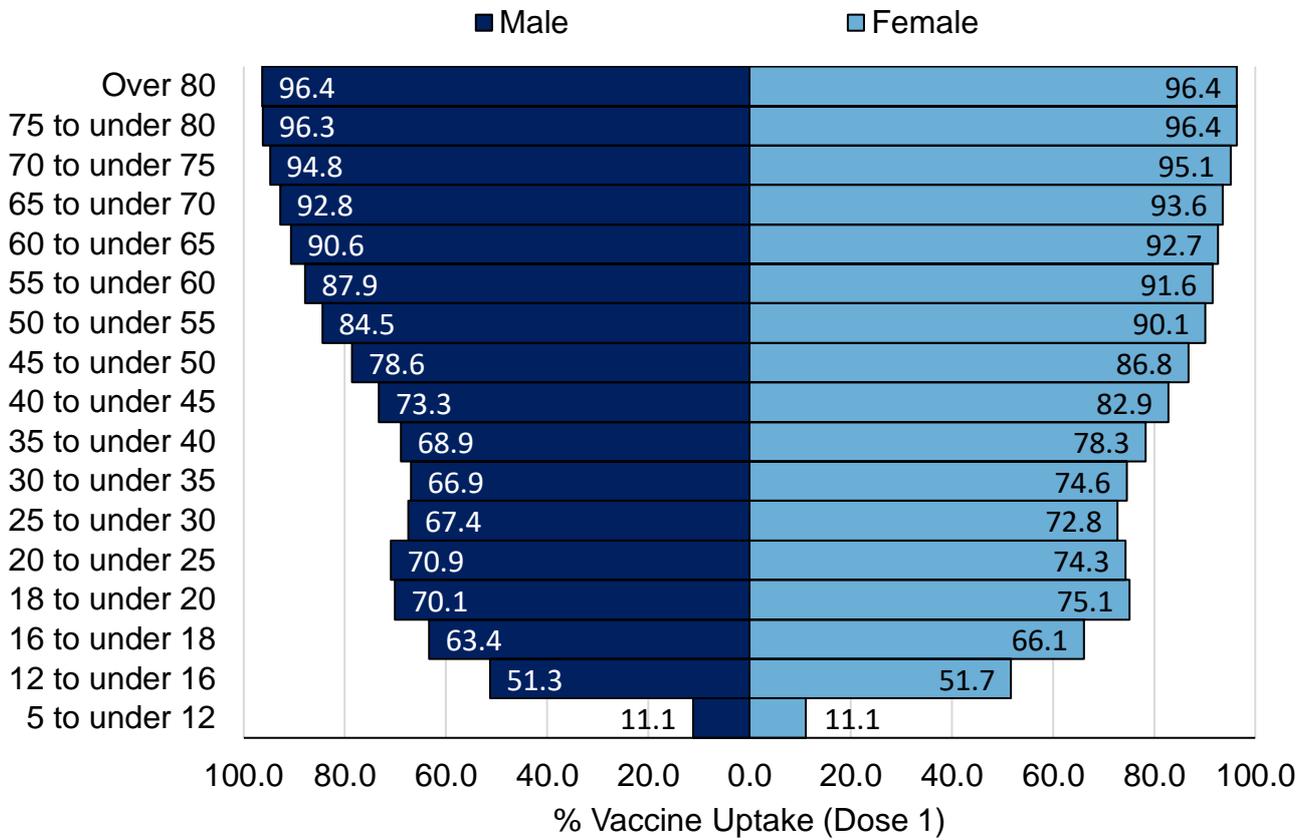


Figure 59: Age-Sex pyramid for COVID-19 vaccine uptake by age in those living and resident in England for dose 2

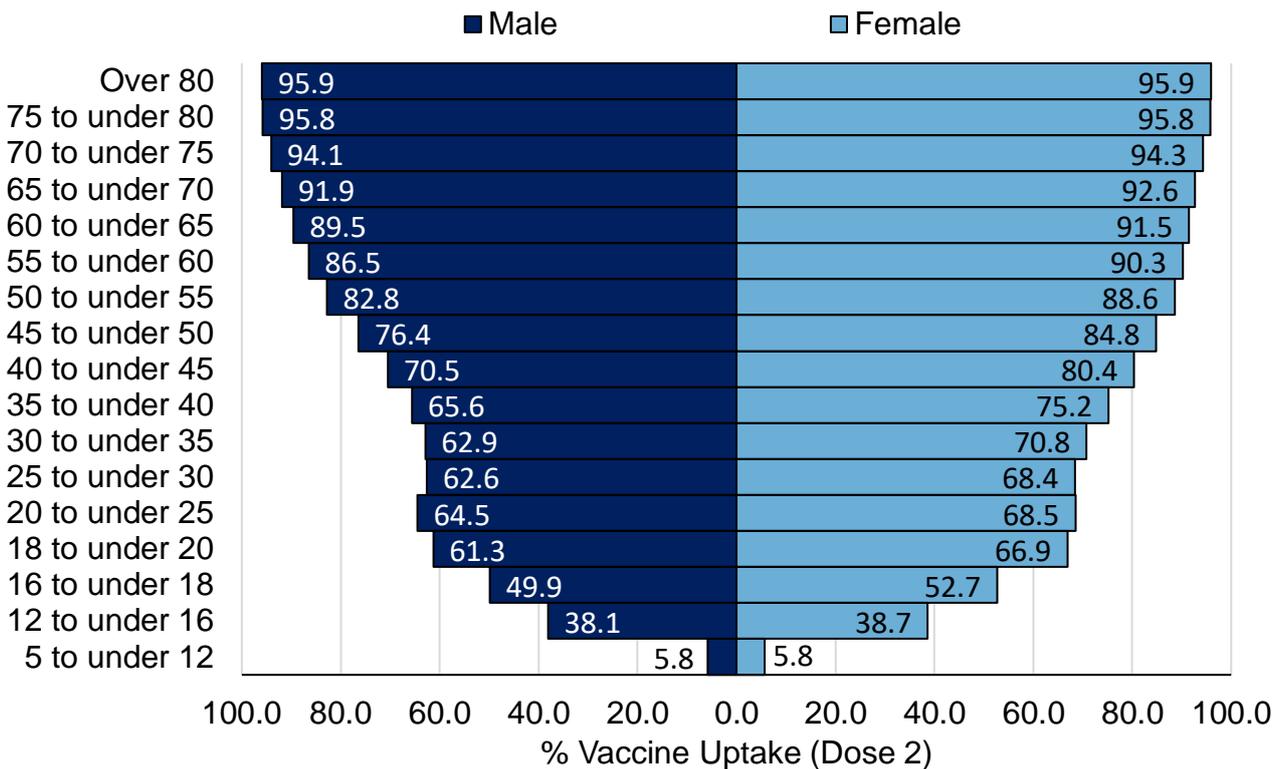
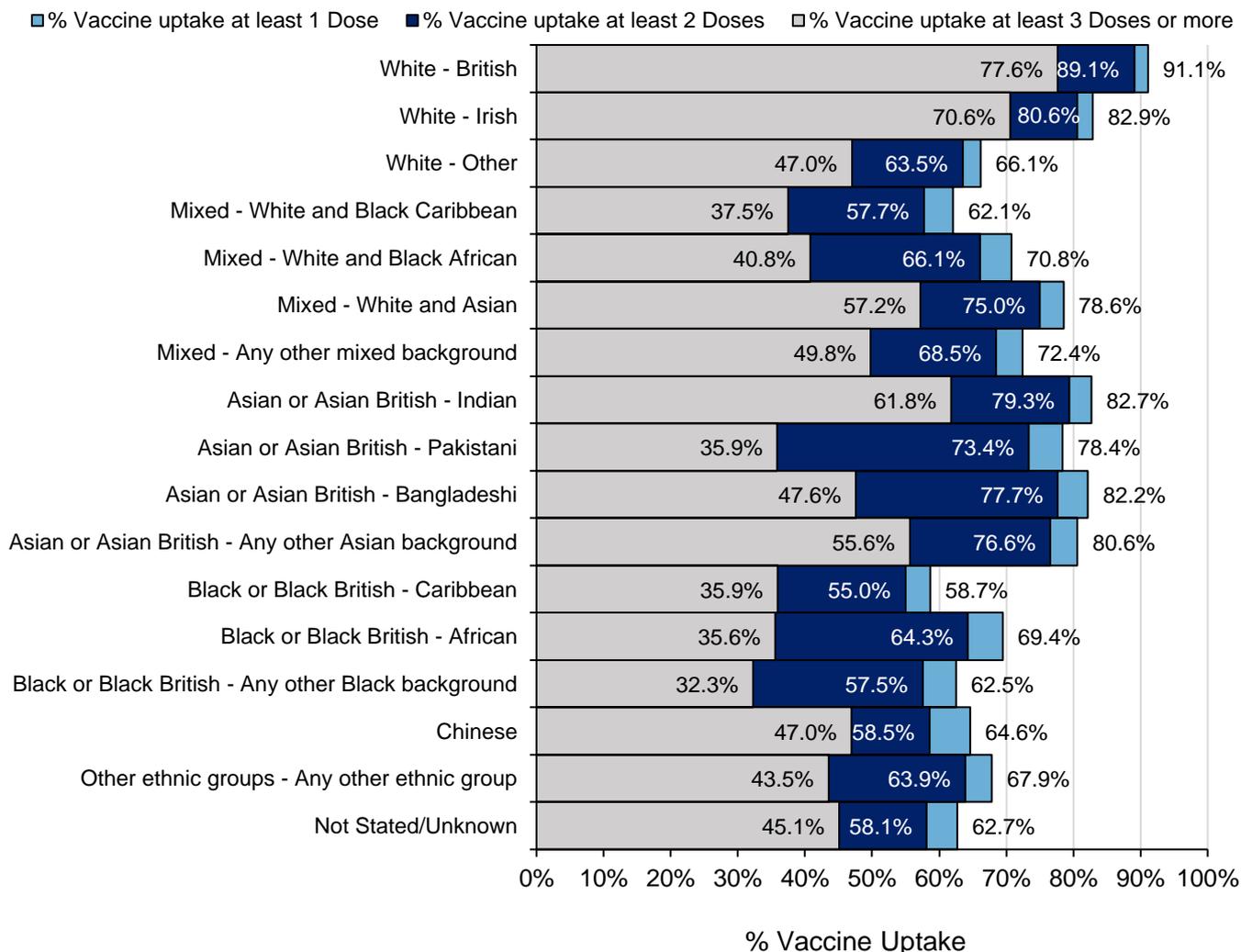


Figure 60: Cumulative weekly COVID-19 vaccine uptake by ethnicity in those living and resident in England, aged 18 and over



For a regional breakdown of the ethnicity data, please see the data file that accompanies this report.

Autumn Booster Campaign

Immunity derived from vaccination declines over time and following on from the Spring campaign, the JCVI has recommended an Autumn Booster campaign with the primary objective to boost immunity in those at higher risk from COVID-19 and thereby optimise protection against severe COVID-19, specifically hospitalisation and death, over winter 2022 to 2023.

The Autumn booster data reported below covers any booster dose administered from the 1 September 2022 provided there is at least 3 months from the previous dose. Eligible groups for the Autumn booster campaign are defined in the COVID-19 healthcare guidance [Green Book](#) and include residents in a care home for older adults, staff working in care homes for older adults, frontline health and social care workers, all adults aged 50 years and over, persons aged 5 to 49 years in a clinical risk group, household contacts of people with immunosuppression, and carers.

Table 8 presents coverage as measured against the total population and includes people who are not yet due to have their Autumn booster. It is important that unvaccinated individuals, especially vulnerable adults, receive a primary course of vaccination, irrespective of whether individuals have had previous infection. Table 8 should be interpreted in the context of Table 7 which shows how recently a person who is living and resident in England has been vaccinated either through the primary vaccination campaign or a subsequent booster campaign. This helps us understand the data in the context of vaccine waning across the whole COVID-19 programme.

By the end of week 39 (week ending 2 October 2022), 19.7% (4,502,303 out of 22,870,165) of all people aged over 50 years old had been vaccinated with an Autumn booster dose since 1 September 2022, Table 8.

Table 8: Provisional cumulative people vaccinated by age with a booster of COVID-19 vaccine from the 1 September 2022 as part of the Autumn booster campaign in England

National	People in NIMS cohort who are living and resident in England	Vaccinated with an Autumn booster since 1 September 2022*	Percentage vaccine uptake
Over 80	2,938,188	1,185,005	40.3
75 to under 80	2,370,674	971,206	41.0
70 to under 75	2,711,164	892,733	32.9
65 to under 70	2,963,503	755,117	25.5
60 to under 65	3,592,913	285,827	8.0
55 to under 60	4,118,935	232,014	5.6
50 to under 55	4,174,788	180,401	4.3
Total aged 50 and over	22,870,165	4,502,303	19.7

*autumn booster defined as any additional dose of vaccine after a 2 dose primary course provided there is an interval of at least 3 months and it is given since the 1 September 2022

Table 9: Provisional cumulative people vaccinated with an autumn booster COVID-19 vaccine against those eligible by the end of December 2022

Age at end of December	Eligible by the end of December	Of those eligible by the end of December, numbers vaccinated	Percentage vaccine uptake eligible end of December
Over 80	2,908,360	1,221,347	42.0
75 to under 80	2,316,294	979,833	42.3
70 to under 75	2,555,763	883,294	34.6
65 to under 70	2,766,822	735,152	26.6
60 to under 65	3,291,370	282,016	8.6
55 to under 60	3,664,182	229,308	6.3
50 to under 55	3,583,193	177,611	5.0
Total aged 50 and over	21,085,984	4,508,561	21.4

Table 9 looks at people aged 50 and over at the end of December 2022 who are eligible for an autumn booster if they have completed a primary course of 2 doses and are at least 3 months from their previous dose.

Please note that this uses a different age cut off definition to the rest of the report and is therefore not a subset of other tables. Eligible population figures in this table do not include those who are aged 50 and over and have not been vaccinated; unvaccinated people are taken into consideration in the coverage tables above. This table is based on those who have been vaccinated and may include those who are no longer resident in England or have an unknown address.

Immunosuppression

Provisional vaccine uptake data in living and resident people identified as immunosuppressed in England to the end of week 38 (week ending 2 October 2022) can be found in Table 10. This shows that vaccine uptake in the 501,251 identified as immunosuppressed was 95.7% for at least dose 1, 94.7% for at least 2 doses and 89.1% for at least 3 doses.

Table 10: Vaccine uptake in people identified as immunosuppressed in England

Immuno-suppression	People in NIMs Cohort who are living and resident in England	Numbers vaccinated with at least 1 dose	Percentage vaccine uptake with at least 1 dose	Numbers vaccinated with at least 2 doses	Percentage vaccine uptake with at least 2 doses	Numbers vaccinated with at least 3 doses	Percentage vaccine uptake with at least 3 doses
England	501,251	479,703	95.7	474,441	94.7	446,478	89.1

Table 11: Vaccine uptake in people identified as immunosuppressed in England with a booster of COVID-19 vaccine from the 1 September 2022 as part of the Autumn booster campaign*

Immuno-suppression	People in NIMS cohort who are living and resident in England	Vaccinated with an autumn booster since 1 September 2022*	Percentage vaccine uptake
England	501,251	109,503	21.8

*autumn booster defined as any additional dose of vaccine after a 2 dose primary course provided there is an interval of at least 3 months and it is given since the 1 September 2022

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Tables 10 and 11 present coverage as measured against the total population of people identified as immunosuppressed. The current uptake of the autumn booster in people identified as immunosuppressed is 13.4%. Many people in this group have been vaccinated more recently and are still becoming eligible for their autumn booster. This can be seen in Table 12, in which 51.1% of people identified as immunosuppressed are covered by a vaccine given in the last 6 months.

Table 12: People identified as immunosuppressed in England vaccinated with any dose of COVID-19 vaccine in the last 3 months, 3 to 6 months and vaccinated more than 6 months ago

Immuno-suppression	People in NIMS cohort who are living and resident in England	Vaccinated in the last 3 months (84 days)		Vaccinated 3 to 6 months ago (85 to 168 days)		Vaccinated 6 months ago (169 or more days)	
		Numbers vaccinated	Percentage vaccinated	Numbers vaccinated	Percentage vaccinated	Numbers vaccinated	Percentage vaccinated
England	501,251	143,512	28.6	128,114	25.6	208,077	41.5

Table 12 is presented to provide an overview of how recently a person identified as immunosuppressed has been vaccinated either through the primary vaccination campaign or a subsequent booster campaign. This helps us understand the data in the context of vaccine waning across the whole COVID-19 programme and shows that most people identified as immunosuppressed have been recently vaccinated.

Detailed information on the NHS Digital characterisation of the immunosuppressed group can be found on the [NHS Digital website](#).

For COVID-19 data on the real-world effectiveness of the COVID-19 vaccines, and on COVID-19 vaccination in pregnancy, please see [the COVID-19 vaccine surveillance reports](#).

For COVID-19 management information on the number of COVID-19 vaccinations provided by the NHS in England, please see the [COVID-19 vaccinations](#) webpage.

For UK COVID-19 daily counts of vaccinations, please see the [Vaccinations' section of the UK COVID-19 dashboard](#).

International update

Global COVID-19 update

For further information on the global COVID-19 situation please see the [World Health Organisation \(WHO\) COVID-19 situation reports](#).

Global influenza update

Updated on 3 October 2022 (based on data up to 18 September 2022) ([WHO website](#)).

Globally, influenza activity remained low with influenza A(H3N2) viruses predominately detected. In the temperate zones of the southern hemisphere, overall influenza activity appeared to further decrease this reporting period, except in South Africa where activity increased.

In Oceania, influenza detections of primarily influenza A(H3N2) and influenza-like activity (ILI) activity were at low levels overall.

In Southern Africa, there was an increase in influenza activity with mainly influenza B viruses reported.

In temperate South America, influenza activity remained low. Influenza A(H3N2) viruses predominated among subtyped viruses.

In the Caribbean and Central American countries, low influenza activity was reported with influenza A(H3N2) most frequently detected.

In the tropical countries of South America, influenza detections were low and A(H3N2) detections predominated.

In tropical Africa, influenza activity remained low with influenza A(H3N2) viruses predominant among the reported detections.

In Southern Asia, influenza detections were predominantly A(H1N1)pdm09 viruses, with influenza A(H3N2) and influenza B viruses also reported.

In South-East Asia, influenza activity decreased a little, with influenza A(H3N2) viruses predominant.

In the countries of North America, influenza activity remained at inter-seasonal levels as typically observed at this time of year. Influenza A(H3N2) was predominant among the few subtyped viruses.

In Europe, overall influenza activity remained at inter-seasonal levels with influenza A(H3N2) detections increasing in a few countries.

In Central Asia, no influenza detections were reported.

In Northern Africa, no influenza detections were reported.

In East Asia, influenza activity of predominantly influenza A(H3N2) continued to decrease in China. Elsewhere, influenza illness indicators and activity were low.

In Western Asia, detections of influenza slightly increased in some countries of the Arab Peninsula.

The WHO Global Influenza Surveillance and Response System (GISRS) laboratories tested more than 118,327 specimens during the period 5 to 18 September 2022. A total of 4,123 were positive for influenza viruses, of which 3,650 (88.5%) were typed as influenza A and 473 (11.5%) as influenza B. Of the sub-typed influenza A viruses, 369 (13%) were influenza A(H1N1)pdm09 and 2,463 (87%) were influenza A(H3N2). Of the characterized B viruses, 169 (100%) belonged to the B Victoria lineage.

Influenza in Europe

Updated for data between week 31 to week 35, 2022 ([Joint ECDC-WHO Europe Influenza weekly update](#)).

For the Region as a whole, influenza activity reached levels well above those observed in the 2020/21 season.

Influenza activity, based on sentinel primary care specimens from patients presenting with ILI or ARI symptoms, first peaked in week 52 of 2021 (when it reached 19% positivity), declining thereafter until week 4 of 2022, when it increased again reaching a plateau phase (25 to 30% positivity) between weeks 10 and 15 of 2022 (this represents late activity compared to most previous seasons) followed by a subsequent 8 week decline to 10% in week 20 of 2022.

Between weeks 26 to 30 of 2022, influenza activity has increased but remains at inter-seasonal levels. In the 2021 to 2022 influenza season up to week 35, of 80,189 sentinel specimens tested for influenza viruses, 7,960 were positive with the most dominant strain being A(H3).

Influenza in North America

For further information on influenza in the United States of America please see the [Centre for Disease Control weekly influenza surveillance report](#). For further information on influenza in Canada please see the [Public Health Agency weekly influenza report](#).

Australian Influenza Surveillance Report and Activity Updates

Australia monitors influenza through a number of complimentary systems. The Australian government advises caution is required in interpretation of these due to the effects of COVID-19, particularly inter-year comparisons. Caution should also be applied in assessing the implications of influenza activity in Australia to the UK. It is not possible to reliably predict the course of the 2022 southern hemisphere influenza season or the implications for the following 2022 to 2023 northern hemisphere season, such as the timing, activity and impact of the 2022 to 2023 influenza season in the UK. Australia is one of many countries from which flu may arrive in the UK, including other countries which are more populous and or have more frequent inbound travel. Australia's influenza activity reflects its specific epidemiological circumstance and has no bearing on the local persistence of influenza in the UK in our inter-seasonal period.

For further information on influenza in Australia please see the [Australian Influenza Surveillance Report and Activity Updates](#).

Other respiratory viruses

Avian influenza and other zoonotic influenza

[Latest WHO update on 30 August 2022](#)

Since the previous WHO update on 27 June 2022, 1 human case of infection with an avian influenza A(H5N6), 1 human case of infection with an avian influenza A(H9N2) virus, 1 human case of infection with an influenza A(H1N2) variant virus and 1 human case of infection with an influenza A(H3N2) variant virus were reported officially. Additionally, 1 human case of infection with an influenza A(H1N2) variant virus and 2 human cases of infection with influenza A(H3N2) variant viruses were detected.

The overall public health risk from currently known influenza viruses at the human-animal interface has not changed, and the likelihood of sustained human-to-human transmission of these viruses remains low. Human infections with viruses of animal origin are expected at the human-animal interface wherever these viruses circulate in animals.

Middle East respiratory syndrome coronavirus (MERS-CoV)

From September 2012 to 15 May 2022, a total of 2,591 laboratory-confirmed cases of MERS-CoV and 894 associated deaths were reported globally to WHO under the International Health Regulations (IHR 2005).

On 28 April 2022, the National IHR Focal point of Oman notified WHO of one case of MERS-CoV in Oman ([WHO website](#)).

Between 22 March and 3 April 2022, the National IHR Focal Point of Qatar reported 2 laboratory-confirmed cases of Middle East respiratory syndrome coronavirus (MERS-CoV) infection to the WHO ([WHO website](#)).

Up to 17 August 2021, a total of 5 cases of Middle East respiratory syndrome coronavirus, MERS-CoV, (3 imported and 2 linked cases) have been confirmed in the UK through ongoing surveillance since September 2012.

[Further information on management and guidance of possible cases](#) is available online. The latest [ECDC MERS-CoV risk assessment](#) highlights that risk of widespread transmission of MERS-CoV remains very low.

Related links

[Previous national COVID-19 reports](#)

[Previous weekly influenza reports](#)

[Annual influenza reports](#)

[COVID-19 vaccine surveillance reports](#)

[Previous COVID-19 vaccine surveillance reports](#)

[Public Health England \(PHE\) monitoring of the effectiveness of COVID-19 vaccination](#)

[Investigation of SARS-CoV-2 variants of concern: technical briefings](#)

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