



UK Health
Security
Agency

Epidemiology Modelling Review Group: consensus statement on COVID-19

Date: 16 March 2022

Introduction

The UK Health Security Agency (UKHSA) Epidemiology Modelling Review Group (EMRG) shares this consensus statement on coronavirus (COVID-19) with acknowledgment to SPI-M-O, who have developed and shared modelling methodologies and contribute model outputs to these combined estimates.

All probability statements are in line with the framework given in [Annexe A](#).

Summary

1. UKHSA's best estimate for R in England is between 1.1 and 1.4. R is estimated to be between 1.0 and 1.3 for Wales, 1.0 and 1.3 for Scotland, and 0.9 and 1.2 for Northern Ireland ([Figure 1](#)). These estimates are based on models¹ fit to data available up to 14 March 2022 where feasible,² including hospitalisations, deaths, testing, wastewater samples and longitudinal studies.
2. Case numbers are increasing in England, Scotland and Wales despite the context of changes to testing guidelines (suspension of confirmatory PCR testing),³ which may be affecting testing behaviour, with a decrease in propensity to seek a test, to an uncertain degree. New policy changes⁴ add to this, further affecting data flows.
3. Estimates lag changes in transmission by 2 to 3 weeks, due to the time required to see changes in data streams. It is an average over time, geographies, viral variants, and communities.
4. Combined estimates⁵ show that the incidence⁶ is between 100,000 and 206,000 new infections per day in England.

¹ Model estimates are required as quantities such as the Reproduction Number (R) are not directly observable. Instead, a variety of independently produced models are used to interpret the data and estimate R. The combination of models able to be included can change between weeks and therefore care should be taken when drawing week-on-week comparisons.

² Due to a technical issue, data from Scotland for multiple data streams were only available up to 9 March 2022

³ [Confirmatory PCR tests to be temporarily suspended for positive lateral flow test results](#)

⁴ [COVID-19 Response: Living with COVID-19 - GOV.UK](#)

⁵ Different nations and regions may use different sets of models for these estimates; hence caution should be applied in drawing direct comparisons. For example, fewer models produce estimates for Wales and Northern Ireland.

⁶ The number of new infections per day.

Incidence and prevalence

5. During its most recent week (ending 12 March 2022), the ONS COVID-19 Infection Survey estimates⁷ that an average of 2,653,200 people had COVID-19 in the community in England (95% credible interval 2,571,500 to 2,739,700). The survey does not include people in care homes, hospitals or prisons. Estimates from across the 4 nations of the UK are:
- England 2,653,200 (95% credible interval 2,571,500 to 2,739,700)
 - Scotland 376,300 (95% credible interval 345,400 to 409,900)
 - Wales 125,400 (95% credible interval 108,100 to 144,900)
 - Northern Ireland 130,600 (95% credible interval 113,100 to 149,100)

Growth rate and reproduction number

For small daily changes, the growth rate is approximately the proportion by which the number of infections increases or decreases per day, that is, the speed at which an epidemic is growing or shrinking. However, at very high growth rates, this relationship does not hold.⁸

6. The EMRG's consensus estimates for the growth rates in the 4 nations are (90% credible interval):
- England is between +2% to +6% per day
 - Wales is between -1% to +3% per day
 - Scotland is between -1% to +3% per day
 - Northern Ireland is between -2% to +2% per day

National estimates of growth rates are summarised in [Figure 2](#).

7. The reproduction number (R) is the average number of secondary infections produced by a single infected individual; it is an average over time, geographies, viral variants, and communities.
8. UKHSA's best estimate for R in England is 1.1 and 1.4. R is estimated to be between 1.0 and 1.3 for Wales, 1.0 and 1.3 for Scotland, and 0.9 and 1.2 for Northern Ireland. UKHSA's agreed national and regional R estimates are summarised in [Table 1](#), [Table 2](#) and individual model estimates are illustrated in [Figure 1](#), and [Figure 3](#).
9. Case numbers are increasing in England, Scotland and Wales despite the context of changes to testing guidelines (suspension of confirmatory PCR testing),⁹ which may be

⁷ These estimates can be subject to revision as further information is available and modelled.

⁸ Further Technical Information on the growth rate can be found in Plus Magazine: [The growth rate of COVID-19 | plus.maths.org](#).

⁹ [Confirmatory PCR tests to be temporarily suspended for positive lateral flow test results](#)

affecting testing behaviour, with a decrease in propensity to seek a test, to an uncertain degree. New policy changes¹⁰ add to this, further affecting data flows.

10. R is an indicator that lags changes in transmission by 2 to 3 weeks,¹¹ due to the time required for changes to be seen in data streams. Therefore, while epidemic estimates for R and other metrics such as growth rate, use the latest data available up to 14 March 2022, where feasible,¹² the estimates reported here represent the epidemic situation as at 1 March 2022.
11. Estimates of R and the growth rates per day become less useful in determining the state of the epidemic when there is a high degree of immunity to the circulating variant in the population. Particular care should be taken when interpreting these estimates.
12. In addition, changes in population immunity can impact data streams, with alterations to the relationship between cases and health outcomes, such as hospital admissions. These relationships will continue to change depending on the degree of immune protection to variant(s) in circulation.
13. R and growth rate estimates indicate the magnitude of growth or decay of the epidemic. However, these indicators should be considered alongside other measures of the epidemic, such as incidence,¹³ and prevalence.¹⁴ When prevalence is very high, even if R is at, or below, 1, the absolute number of new cases will be very high.

¹⁰ [COVID-19 Response: Living with COVID-19](#)

¹¹ Different data-streams and different models are expected to be lagged in their estimates by different amounts when compared with the true underlying epidemiological situation. This is due to multiple lags such as reporting and delays in the infection processes.

¹² Different models fit to different windows of time using different methodologies, hence not all models will fit up to this precise date.

¹³ The number of individuals who develop the disease within a specified time period

¹⁴ The proportion of the population with the disease at a given point in time

Table 1. Combined estimates of R values growth rates and doubling times in the 4 nations of the UK (90% credible interval)

Nation	R	Daily growth rate	Doubling time ¹⁵
England	1.1 to 1.4	+2% to +6%	12 to 31 days
Wales	1.0 to 1.3	-1% to +3%	24 days to flat
Scotland	1.0 to 1.3	-1% to +3%	33 days to flat
Northern Ireland	0.9 to 1.2	-2% to +2%	Flat

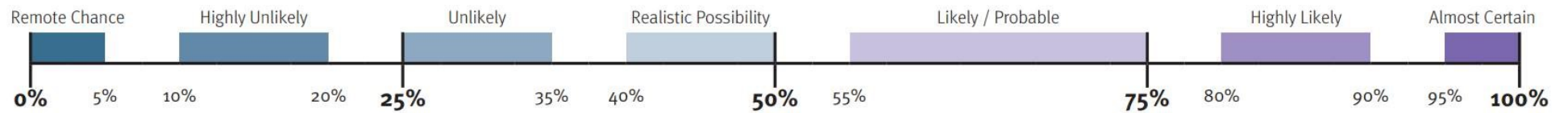
Table 2. Combined estimates of R values growth rates and doubling times in the NHS England regions (90% credible interval)

NHS England region	R	Daily growth rate	Doubling time ¹⁵
England	1.1 to 1.4	+2% to +6%	12 to 31 days
London	1.1 to 1.4	+2% to +7%	11 to 32 days
East of England	1.1 to 1.4	+2% to +7%	11 to 30 days
Midlands	1.0 to 1.3	+1% to +6%	12 to 36 days
North East & Yorkshire	1.0 to 1.3	+1% to +5%	15 days to flat
North West	1.1 to 1.4	+2% to +6%	11 to 32 days
South East	1.0 to 1.4	+1% to +6%	12 to 40 days
South West	1.0 to 1.4	+1% to +6%	12 days to flat

¹⁵ Any estimates with a halving or doubling time of more than 40 days have been described as flat. Negative values of doubling time indicate a halving time (the time expected for cases to fall by 50%). Doubling time here is calculated using the growth rate.

Annexe A. PHIA framework of language for discussing probabilities

The yardstick splits the probability scale into 7 ranges from remote chance (0 to 5% probability) to almost certain (95% to 100% probability).



Acknowledgements

UKHSA takes responsibility for this consensus statement and its contents. However, UKHSA would like to acknowledge the work of SPI-M-O and academic partners in developing methodologies and sharing these, as well as continuing to contribute model outputs to the combined estimates. These estimates include contribution from LSHTM ([1](#), [2](#)), Imperial College London ([3](#), [8](#)), University of Warwick ([4](#), [5](#)), University of Exeter and University of Bristol ([6](#)), Lancaster University ([7](#)), University of Manchester and University of Cambridge ([9](#)). UKHSA would also like to thank the European Bioinformatics Institute ([10](#)), University of Oxford ([11](#), [12](#)), University of Liverpool ([13](#)), and the Institute of Disease Modeling ([14](#)) for contributing model outputs. UKHSA also acknowledges the work developing combination estimates from Defence and Science Technology Laboratory ([15](#)). UKHSA also thanks and acknowledges the support and collaboration of the SPI-M-O Secretariat and co-Chairs, as well as colleagues across the 4 nations.

References

1. Abbott, Hellewell and others '[Estimating the time-varying reproduction number of SARS-CoV-2 using national and subnational case counts](#)'. Wellcome Open Research, 8 December 2020
2. Sherratt and others. '[National and Subnational estimates for the United Kingdom](#)'
3. Knock and others. '[Key epidemiological drivers and impact of interventions in the 2020 SARS-CoV-2 epidemic in England](#)'. Science Translational Medicine, 14 July 2021
4. Keeling and others. '[Predictions of COVID-19 dynamics in the UK: Short-term forecasting and analysis of potential exit strategies](#)'. PLOS Computational Biology, 22 January 2021
5. Keeling and others. '[Fitting to the UK Covid-19 outbreak, short-term forecasts and estimating the reproductive number](#).' MedRxiv: 29 September 2020
6. Challen and others. '[Estimates of regional infectivity of COVID-19 in the United Kingdom following imposition of social distancing measures](#).' Philosophical Transactions of the Royal Society B: 31 May 2021
7. Jewell and others. '[Bayesian stochastic model-based forecasting for spatial COVID-19 risk in England Technical Concept Note](#).' Github: 22 September 2020
8. Cori and others. '[A New Framework and Software to Estimate Time-Varying Reproduction Numbers During Epidemics](#).' American Journal of Epidemiology: 1 November 2013
9. Birrell and others. '[Real-time Nowcasting and Forecasting of COVID-19 Dynamics in England: the first wave?](#)' Philosophical Transactions of the Royal Society B: Biological Sciences, 31 May 2021
10. Vöhringer and others. '[Genomic reconstruction of the SARS-CoV-2 epidemic across England from September 2020 to May 2021](#)'. MedRxiv, 26 May 2021
11. Teh and others. '[Efficient Bayesian Inference of Instantaneous Reproduction Numbers at Fine Spatial Scales, with an Application to Mapping and Nowcasting the Covid-19 Epidemic in British Local Authorities](#).' LocalCovid.info: 19 April 2021
12. Panovska-Griffiths and others. '[Modelling the impact of reopening schools in early 2021 in the presence of the new SARS-CoV-2 variant and with the roll out of vaccination against COVID-19](#)'. MedRxiv: 9 February 2021
13. Moore and Phillips. '[Liverpool Covid Model: Model Overview](#).' Github: 10 March 2021
14. Kerr and others. '[Covasim: an agent-based model of COVID-19 dynamics and interventions](#).' MedRxiv: 1 April 2021
15. Maishman and others. '[Statistical methods used to combine the effective reproduction number, \$R\(t\)\$, and other related measures of COVID-19 in the UK](#).' arXiv preprint, 3 March 2021

Figure 1a. Estimates of R in the 4 UK nations (90% credible intervals) as at 1 March 2022

Bars represent different independent estimates. The grey shaded areas represent the combined numerical range and the black bars are the combined range after rounding outwards to one decimal place.

England

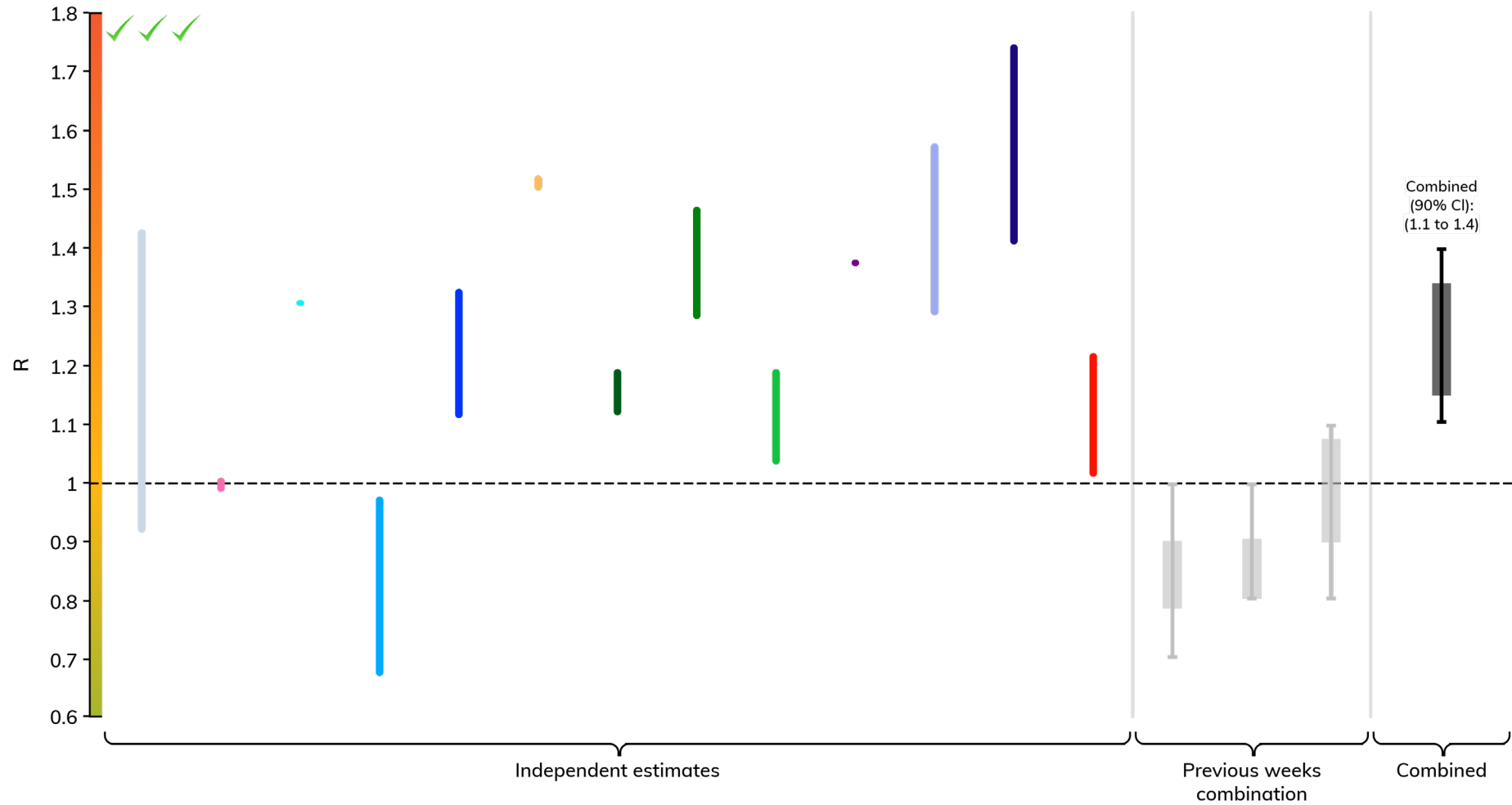


Figure 1b. Estimates of R in the 4 UK nations (90% credible intervals) as at 1 March 2022

Bars represent different independent estimates. The grey shaded areas represent the combined numerical range and the black bars are the combined range after rounding outwards to one decimal place.

Wales

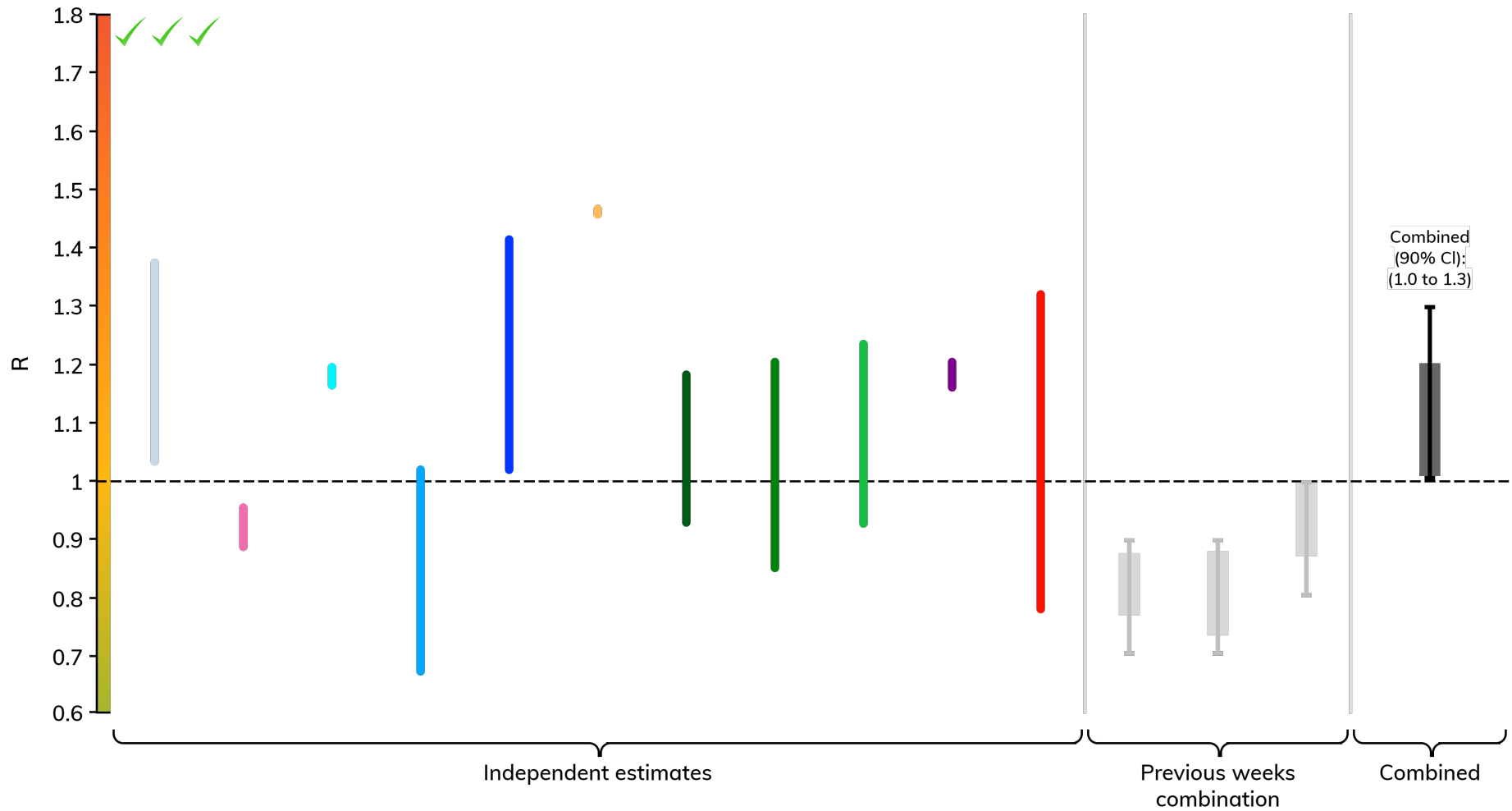


Figure 1c. Estimates of R in the 4 UK nations (90% credible intervals) as at 1 March 2022

Bars represent different independent estimates. The grey shaded areas represent the combined numerical range and the black bars are the combined range after rounding outwards to one decimal place.

Scotland

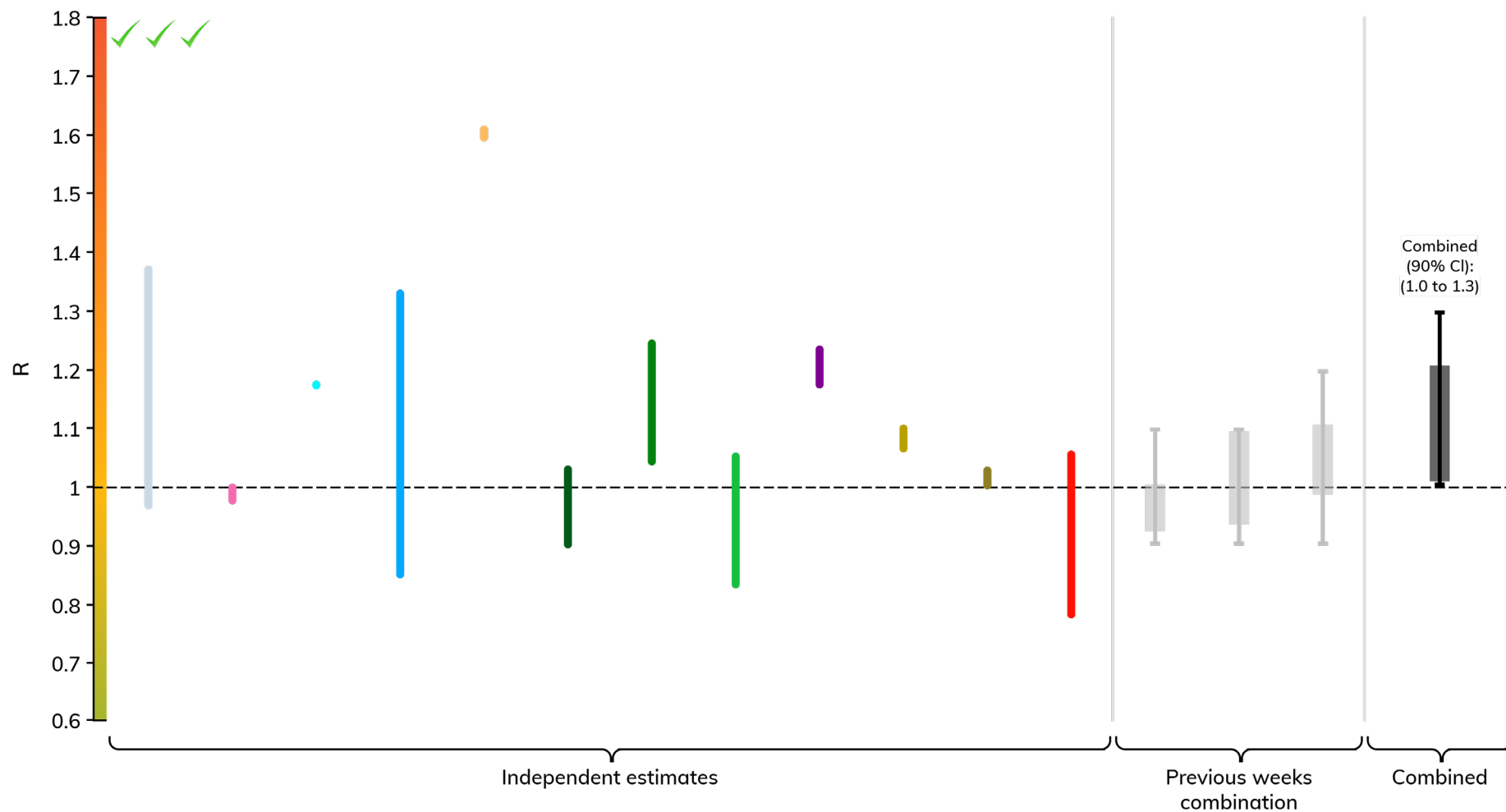


Figure 1d. Estimates of R in the 4 UK nations (90% credible intervals) as at 1 March 2022

Bars represent different independent estimates. The grey shaded areas represent the combined numerical range and the black bars are the combined range after rounding outwards to one decimal place.

Northern Ireland

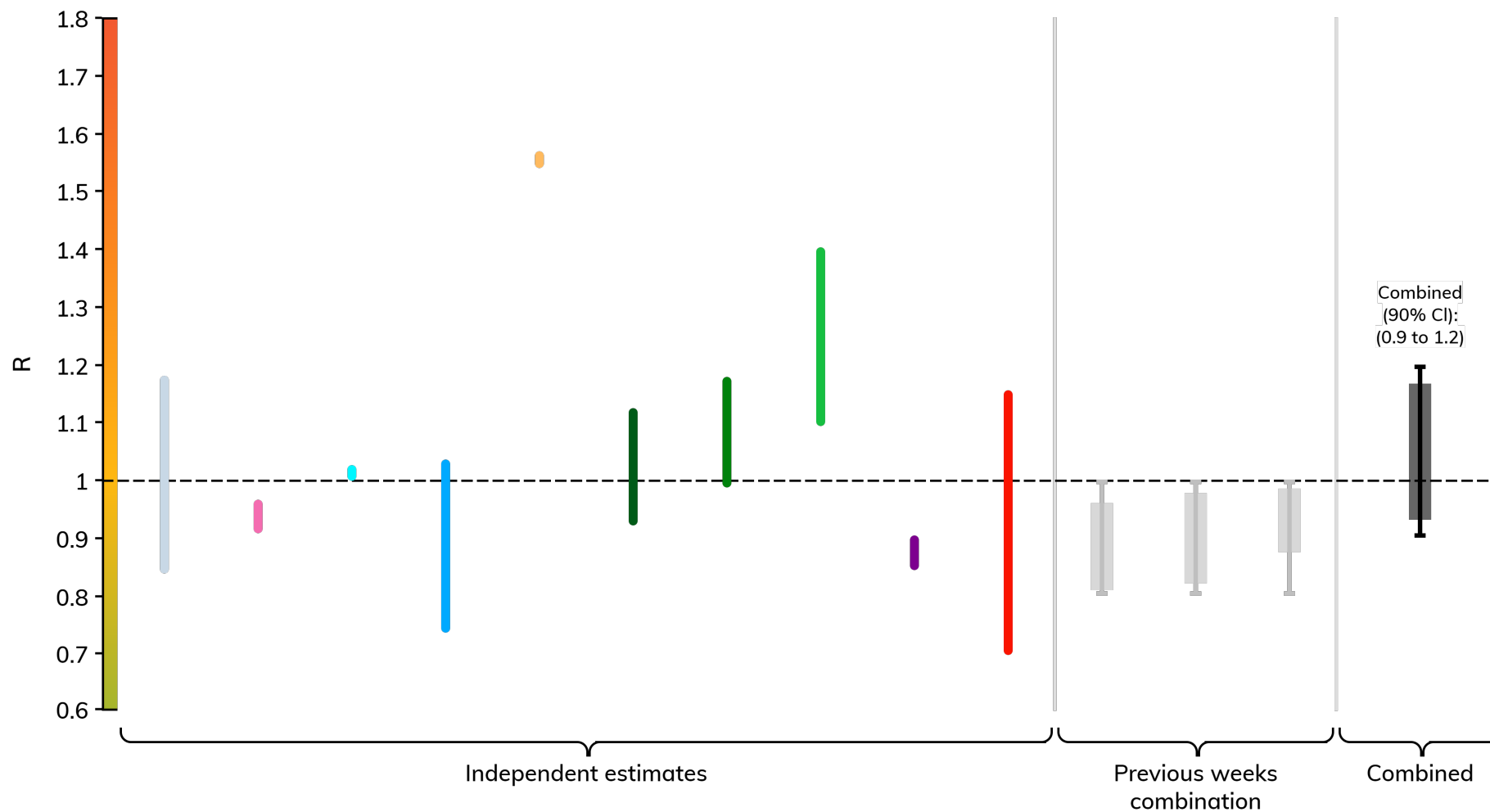


Figure 2a. Estimates of the growth rate in the 4 UK nations, including 90% credible intervals as at 1 March 2022

Bars represent different independent estimates. The grey shaded areas represent the combined numerical range and the black bars are the combined range after rounding outwards to the nearest per cent.

England

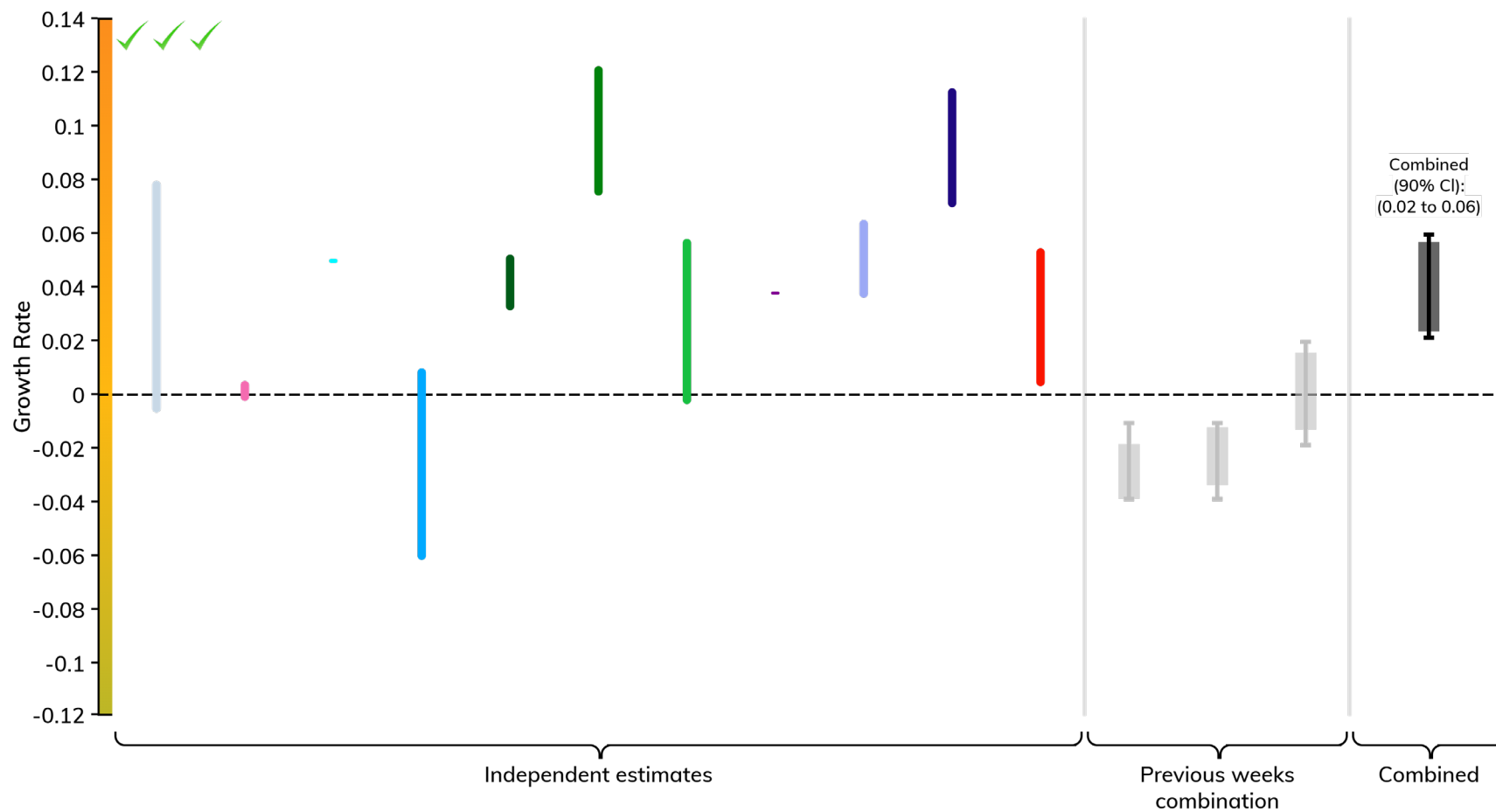


Figure 2b. Estimates of the growth rate in the 4 UK nations, including 90% credible intervals as at 1 March 2022

Bars represent different independent estimates. The grey shaded areas represent the combined numerical range and the black bars are the combined range after rounding outwards to the nearest per cent.

Wales

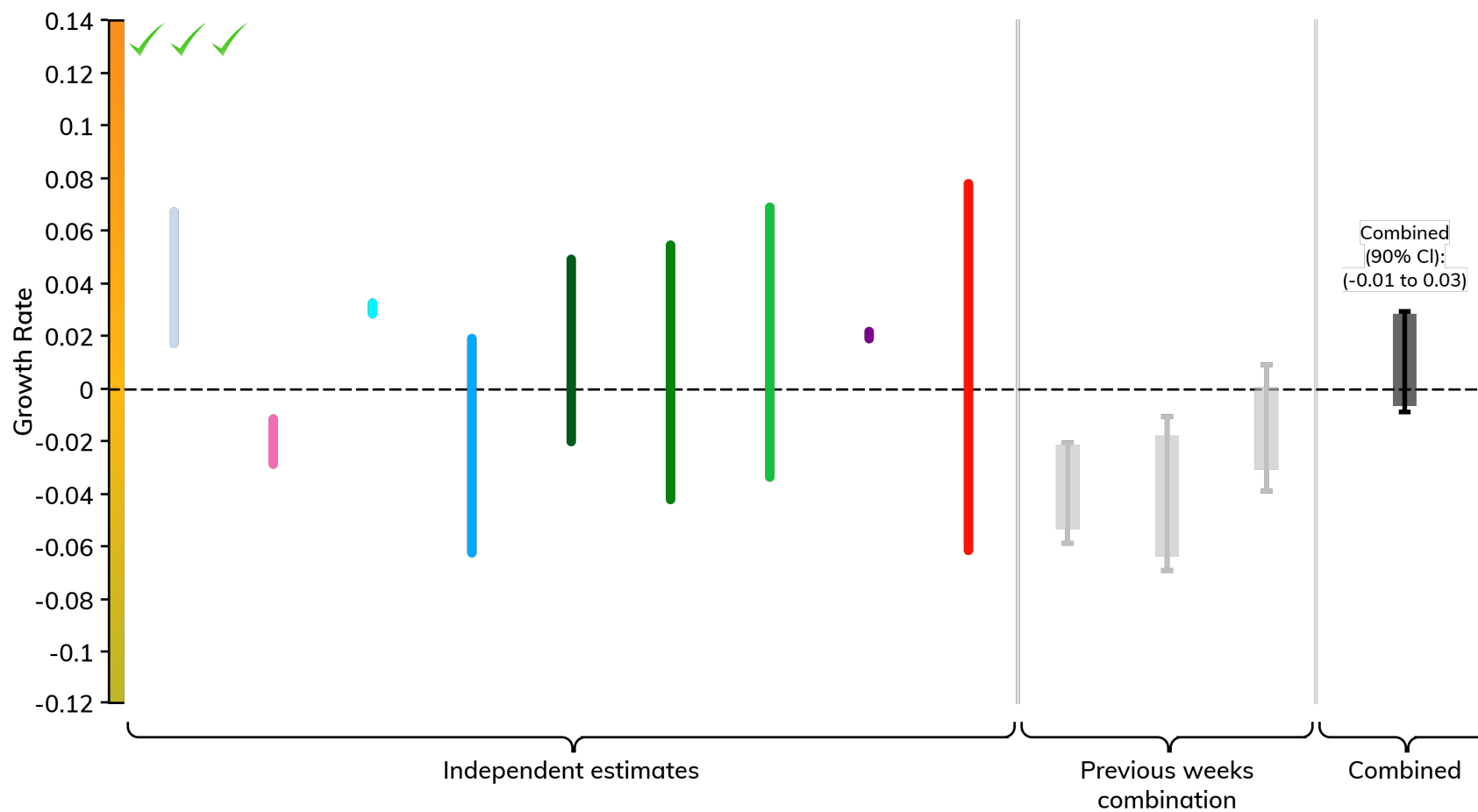


Figure 2c. Estimates of the growth rate in the 4 UK nations, including 90% credible intervals as at 1 March 2022

Bars represent different independent estimates. The grey shaded areas represent the combined numerical range and the black bars are the combined range after rounding outwards to the nearest per cent.

Scotland

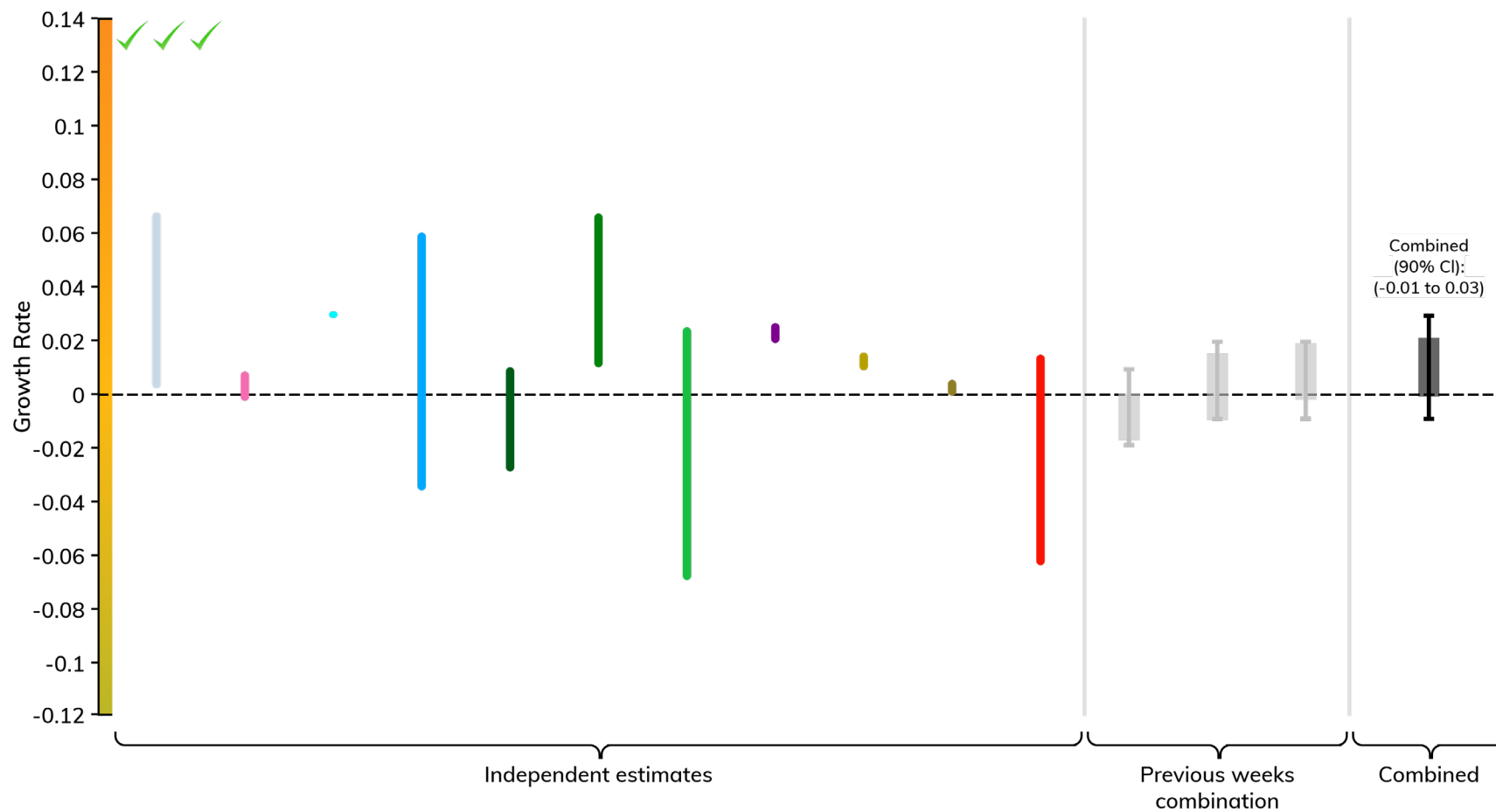


Figure 2d. Estimates of the growth rate in the 4 UK nations, including 90% credible intervals as at 1 March 2022

Bars represent different independent estimates. The grey shaded areas represent the combined numerical range and the black bars are the combined range after rounding outwards to the nearest per cent.

Northern Ireland

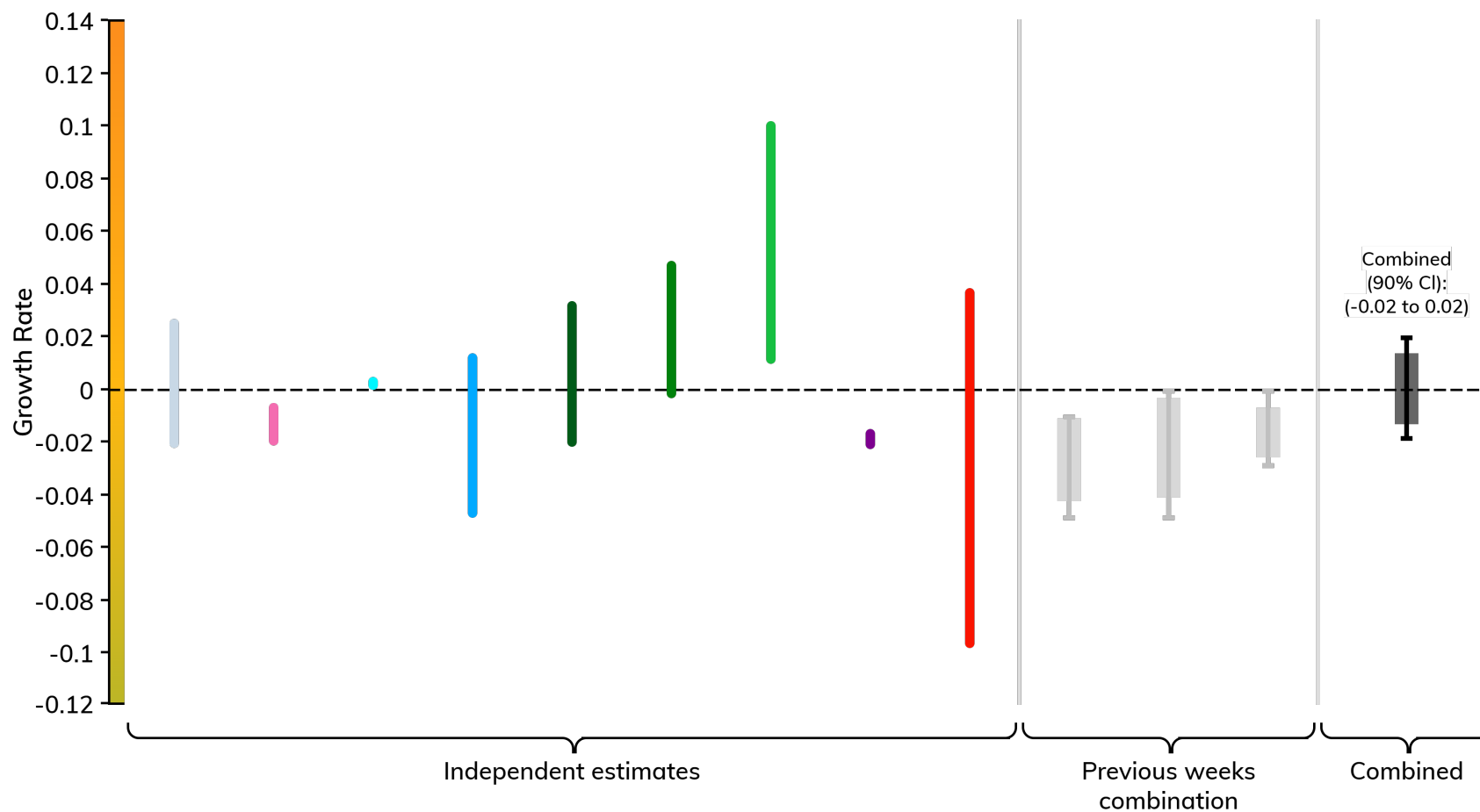


Figure 3a. Estimates of R in the NHS England regions, including 90% credible intervals as at 1 March 2022

Bars represent different independent estimates. The grey shaded areas represent the combined numerical range and the black bars are the combined range after rounding outwards to one decimal place.

London

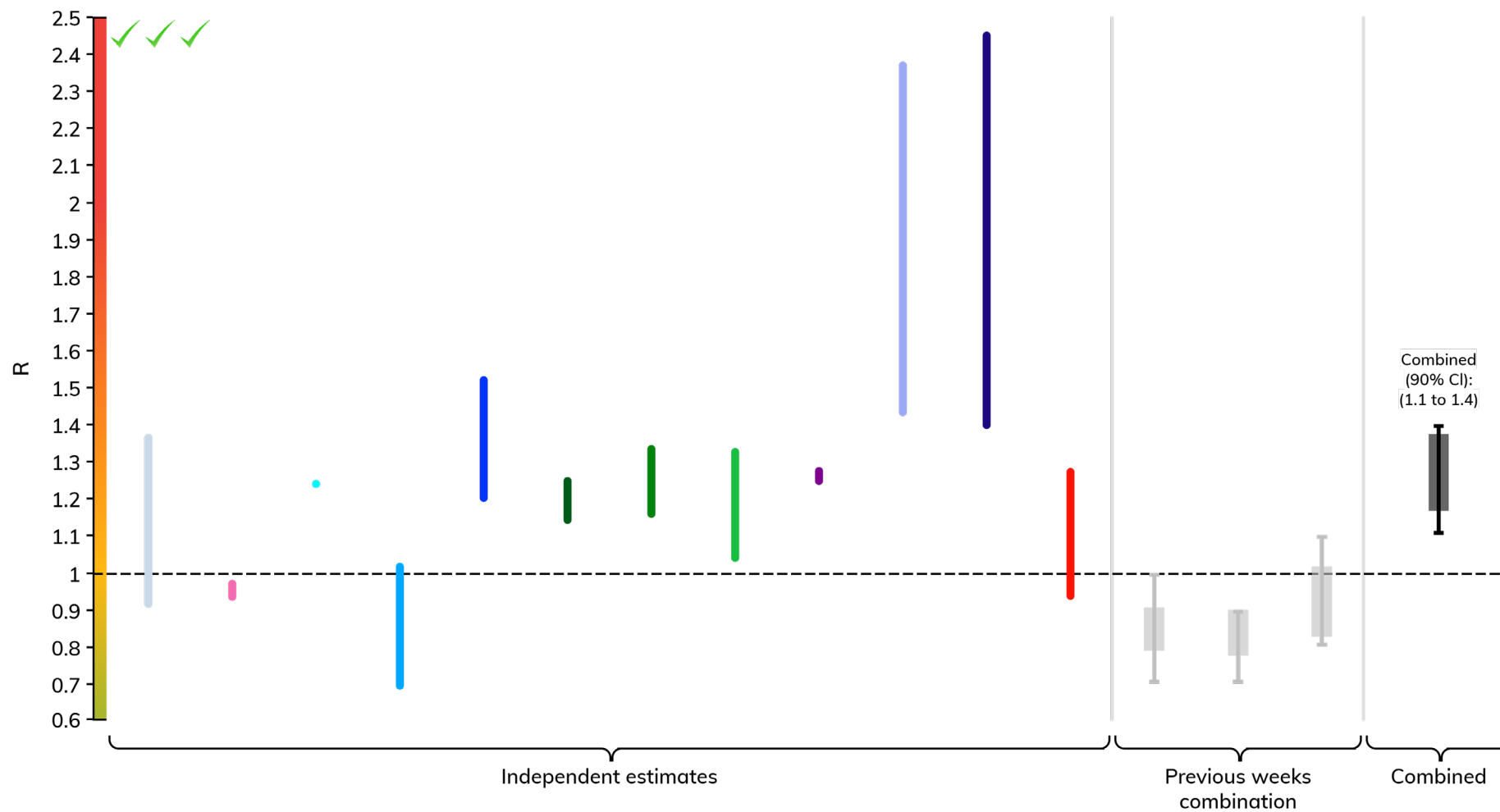


Figure 3b. Estimates of R in the NHS England regions, including 90% credible intervals as at 1 March 2022

Bars represent different independent estimates. The grey shaded areas represent the combined numerical range and the black bars are the combined range after rounding outwards to one decimal place.

East of England

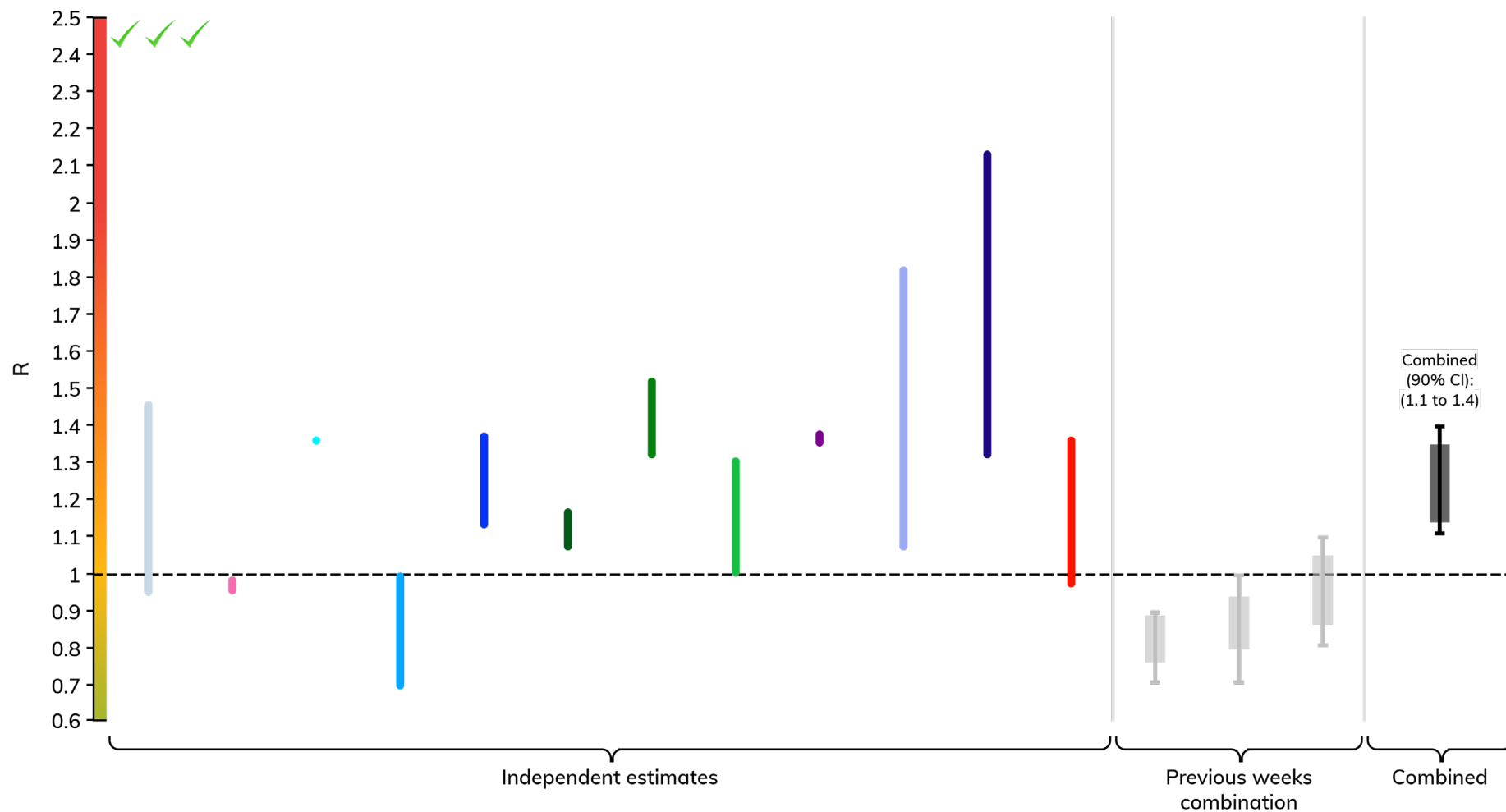


Figure 3c. Estimates of R in the NHS England regions, including 90% credible intervals as at 1 March 2022

Bars represent different independent estimates. The grey shaded areas represent the combined numerical range and the black bars are the combined range after rounding outwards to one decimal place.

Midlands

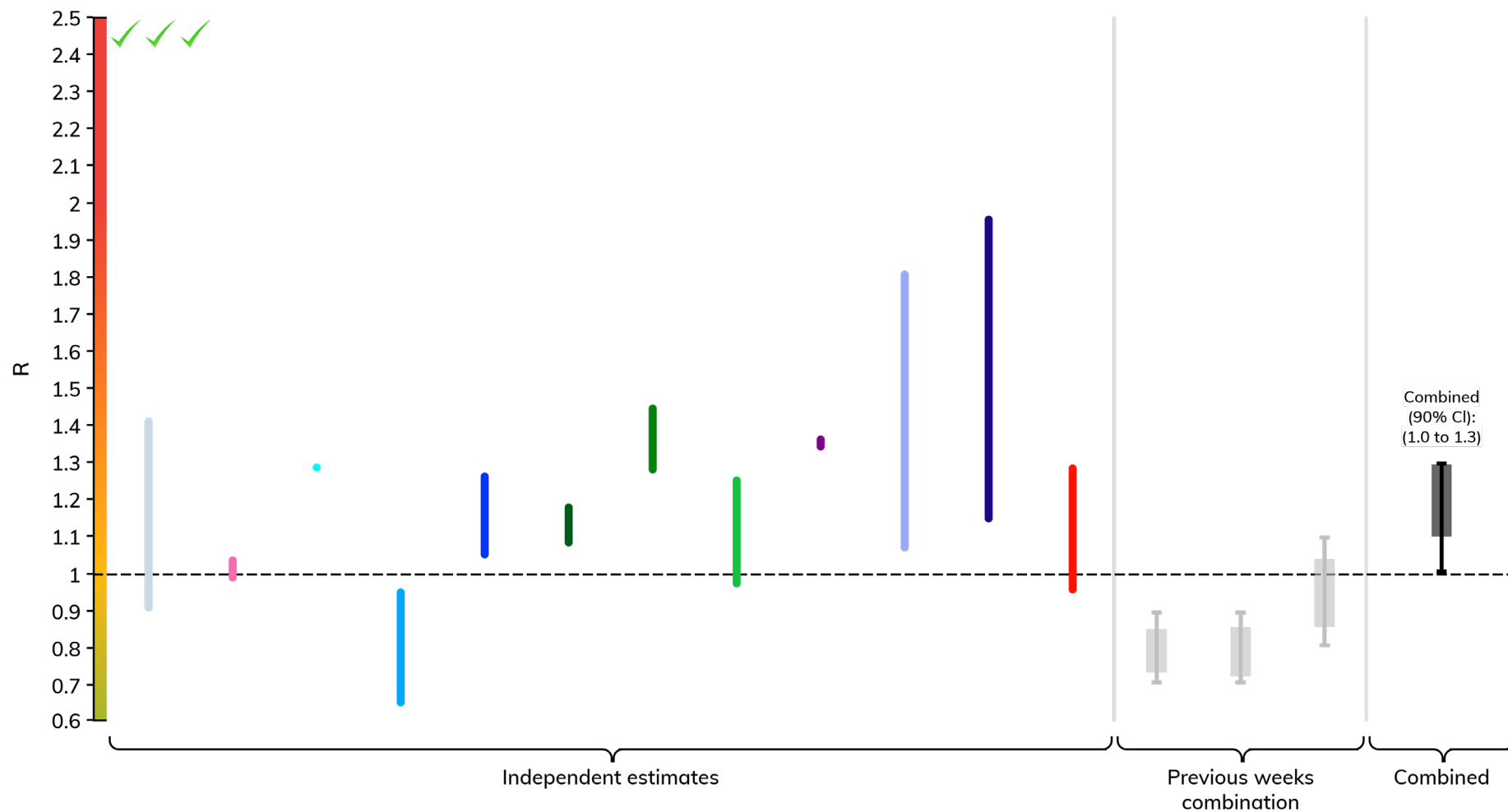


Figure 3d. Estimates of R in the NHS England regions, including 90% credible intervals as at 1 March 2022

Bars represent different independent estimates. The grey shaded areas represent the combined numerical range and the black bars are the combined range after rounding outwards to one decimal place.

North East and Yorkshire

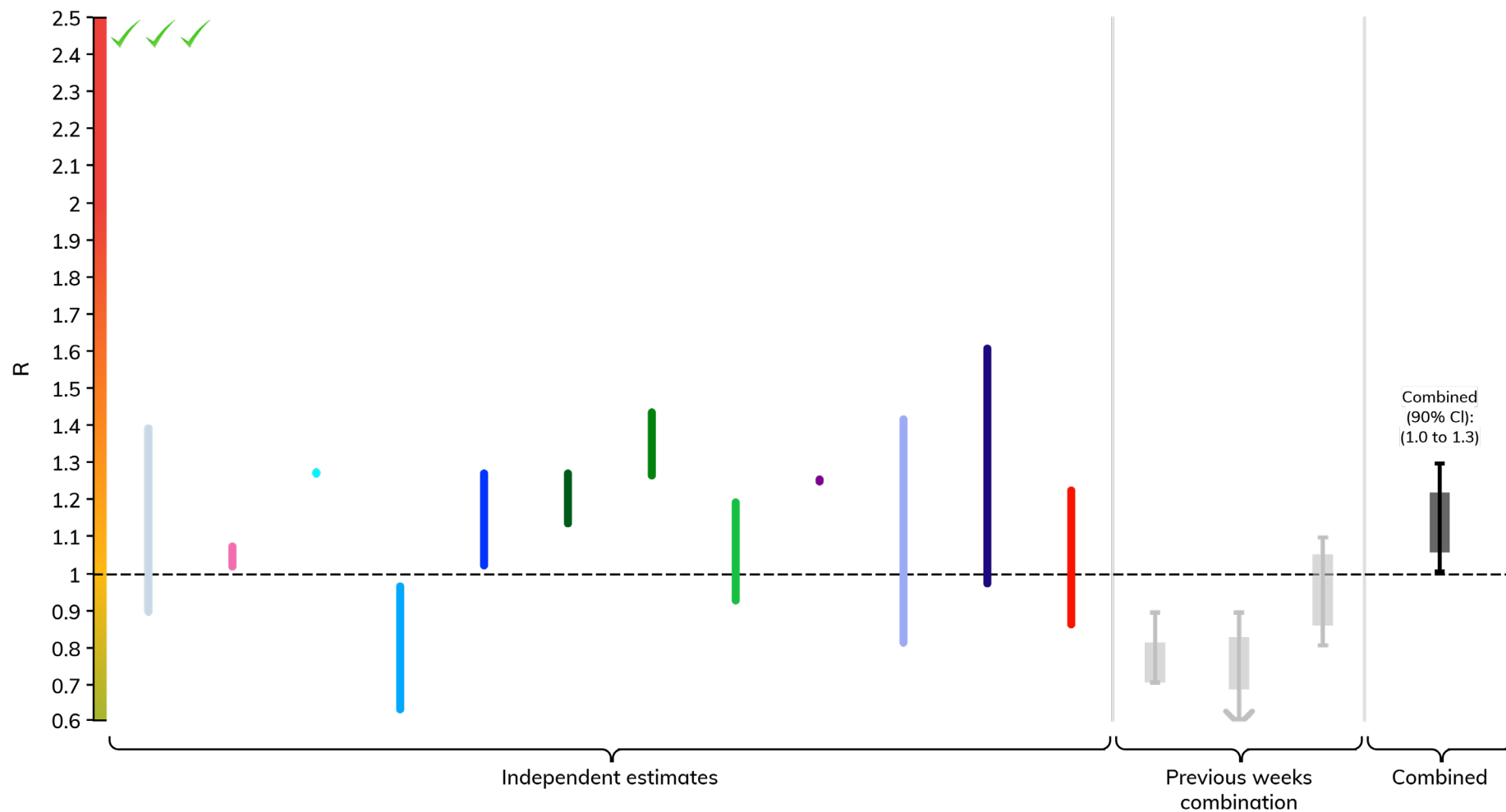


Figure 3e. Estimates of R in the NHS England regions, including 90% credible intervals as at 1 March 2022

Bars represent different independent estimates. The grey shaded areas represent the combined numerical range and the black bars are the combined range after rounding outwards to one decimal place.

North West

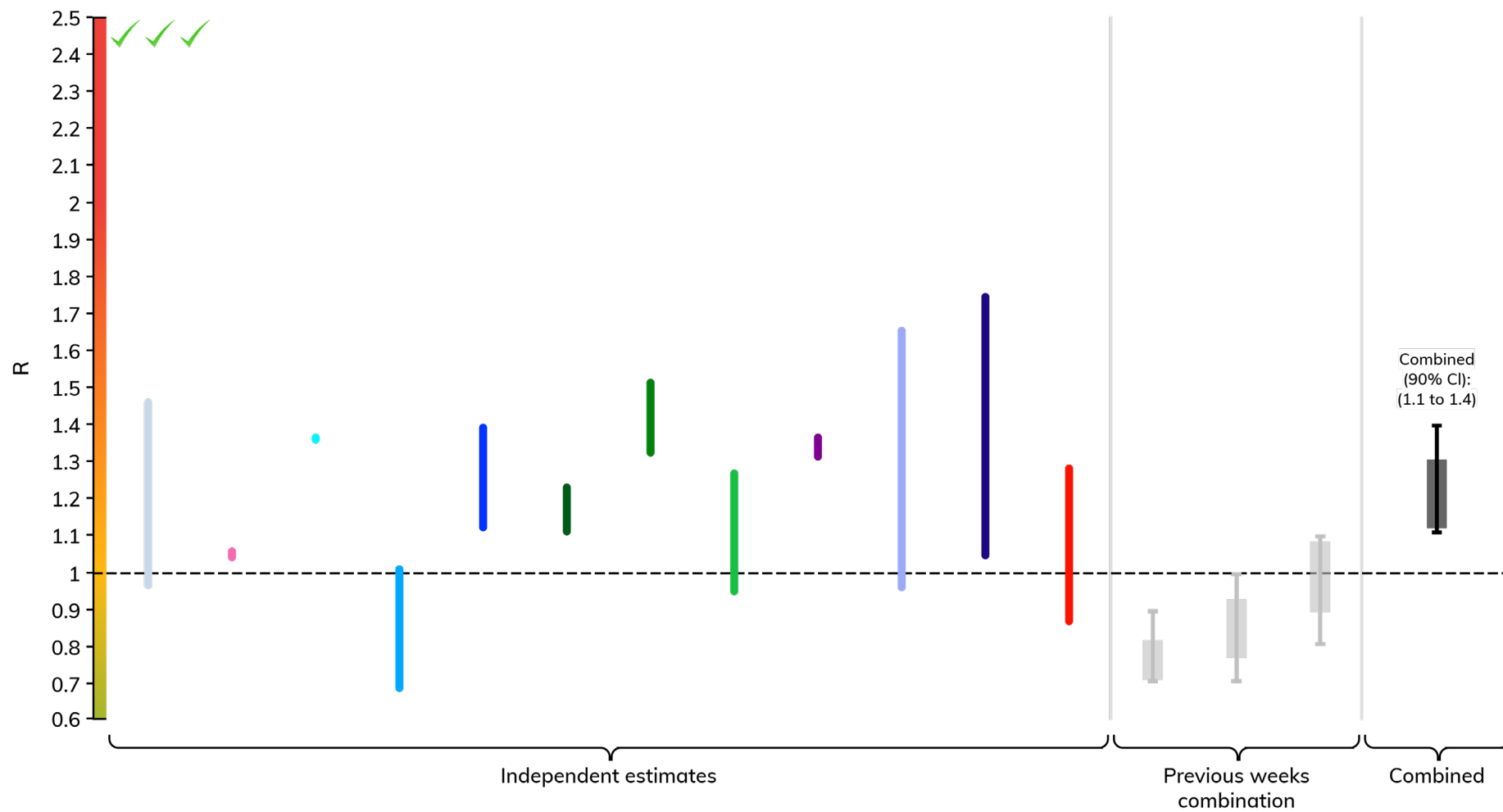


Figure 3f. Estimates of R in the NHS England regions, including 90% credible intervals as at 1 March 2022

Bars represent different independent estimates. The grey shaded areas represent the combined numerical range and the black bars are the combined range after rounding outwards to one decimal place.

South East

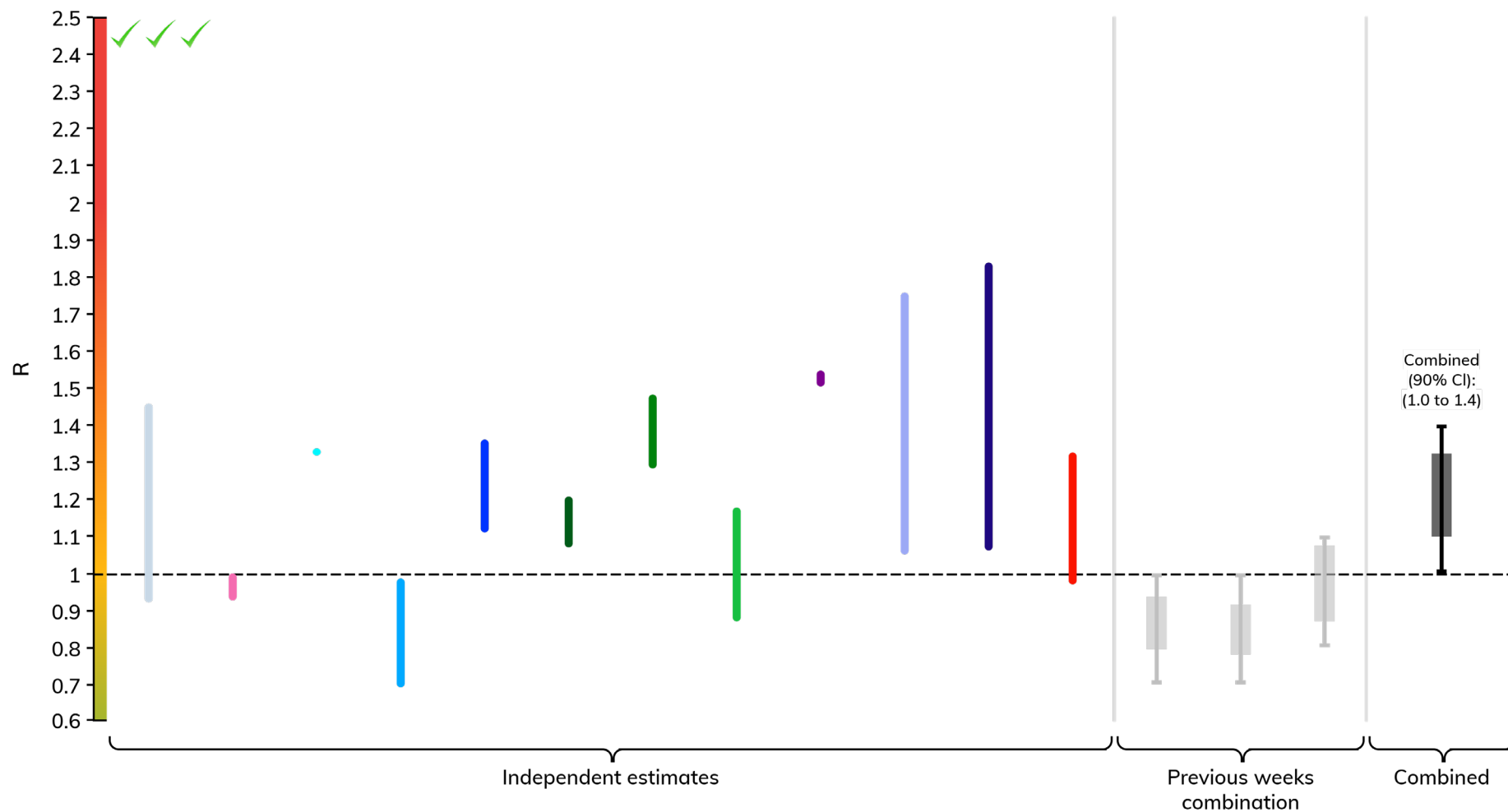
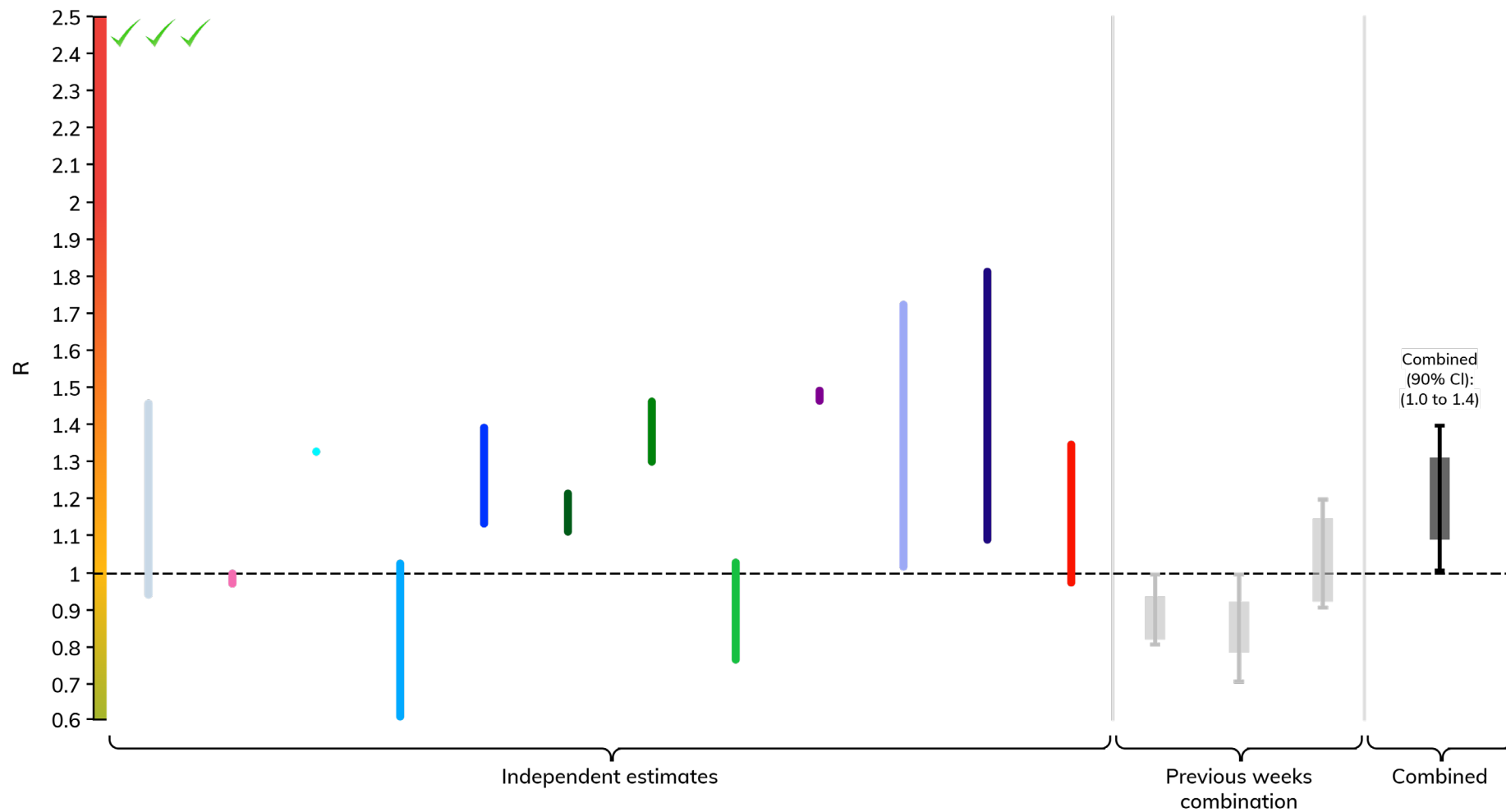


Figure 3g. Estimates of R in the NHS England regions, including 90% credible intervals as at 1 March 2022

Bars represent different independent estimates. The grey shaded areas represent the combined numerical range and the black bars are the combined range after rounding outwards to one decimal place.

South West



About the UK Health Security Agency

The [UK Health Security Agency](#) is an executive agency, sponsored by the [Department of Health and Social Care](#).

© Crown copyright 2022

Published: April 2022

Gateway number: GOV-11876



You may re-use this information (excluding logos) free of charge in any format or medium, under the terms of the Open Government Licence v3.0. To view this licence, visit [OGL](#). Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.



UKHSA supports the UN
Sustainable Development Goals

