



UK Health
Security
Agency

Weekly national Influenza and COVID-19 surveillance report

Week 10 report (up to week 9 data)

09 March 2023

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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 9 (between 27 February and 5 March 2023) and for some indicators daily data up to 7 March 2023.

Overall

In week 9, from most indicators, influenza activity decreased compared with week 8. COVID-19 activity showed a mixed picture – with some indicators, most notably hospitalisations and primary care surveillance, suggesting a slight increase in activity.

COVID-19

COVID-19 case rates through Pillar 1 decreased overall, across all age groups, most regions, and most ethnic groups.

Through Respiratory Datamart, SARS-CoV-2 positivity decreased to 9.1% compared with 9.5% the previous week.

Through primary care surveillance, COVID-19 indicators increased slightly compared with week 8.

The overall number of reported COVID-19 confirmed outbreaks remained stable compared with the previous week. The highest number of incidents continue to be in care homes, with 93 COVID-19 confirmed outbreaks occurring in England in week 9 compared with 96 in week 8.

Overall, COVID-19 hospitalisations increased slightly, and ICU admissions remained stable in week 9 compared with week 8. Hospitalisations were highest in the 85 years and over age group. Through syndromic surveillance indicators, emergency department attendances for covid-like illness remained stable nationally but increased slightly in those aged 65 years and over and continued to increase in the West Midlands and East of England regions.

Deaths with COVID-19 decreased in week 9.

The COVID-19 Autumn booster vaccination campaign commenced in early September. By the end of week 9, 65.8% of all people aged over 50 years old who are living and resident in England had been vaccinated with an Autumn booster dose.

Influenza

In week 9, influenza positivity decreased slightly to 1.8% compared with 2.5% in week 8, with highest positivity seen in the 15 to 44 years old age group at 4.6%. This is a decrease from 6.8% in week 8. Influenza B positivity decreased to 1.3% in week 9 compared with 1.7% in week 8.

Through primary care surveillance, the influenza-like-illness consultations indicator decreased in week 9 compared with the previous week and was within the baseline activity level range.

No influenza confirmed outbreaks were reported in week 9 in England.

Influenza hospital admissions decreased in week 9 compared with the previous week. The rates from week 4 2023 onwards were revised due to further retrospective updates from trusts. The rate in the latest week has returned to baseline activity levels. By UKHSA Centre, the highest hospitalisation rate was observed in London (3.03 per 100,000). By age group, the highest hospital admission rate for influenza was in those under 5 years old (3.13 per 100,000). Influenza ICU admissions decreased in week 9 and remained within the baseline range of activity.

Emergency department attendances for influenza-like illness remained stable nationally.

The majority of influenza detections in the most recent week have been influenza B across a number of surveillance systems.

RSV

The overall positivity for RSV remained low at 1.1%, with the highest positivity in those aged under 5 years old at 4.0%. In week 9, the overall hospital admission rate for RSV remained stable at 0.40 per 100,000. Emergency department attendances for acute bronchiolitis remained stable nationally.

Other viruses

Adenovirus positivity decreased slightly to 3.9%, with the highest positivity in those aged under 5 years old at 11.4%. Human metapneumovirus (hMPV) positivity remained stable at 2.5%, with the highest positivity in those aged under 5 years old at 3.9%. Parainfluenza positivity remained stable at 2.6%, with the highest positivity in those aged under 5 years old at 7.0%. Rhinovirus positivity decreased slightly to 11.5% overall, with the highest positivity in those aged under 5 years old at 22.5%. The overall positivity for RSV remained low at 1.1%, with the highest positivity in those aged under 5 years old at 4.0%.

Other indicators

During week 9, NHS 111 calls for cough decreased nationally. Calls for cold or flu increased slightly nationally, with small increases in those aged 1 to 4 years and 15 to 44 years old.

The primary care lower respiratory tract infection rate decreased in week 9.

Emergency department attendances for acute respiratory infection remained stable nationally.

No excess deaths (from all causes) were observed in week 8.

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 effect on Pillar 1 case rates and positivity rates.

As of 9am on 5 March 2023, a total of 2,025,172 episodes have been confirmed for COVID-19 in England under Pillar 1, and 18,618,092 episodes under Pillar 2, since the beginning of the pandemic. COVID-19 case rates through Pillar 1 decreased in week 9, in all age groups, most regions, and most ethnic groups. The number of Pillar 1 COVID-19 episodes decreased to 5,315 in week 9 compared with 7,527 in week 8.

Data notes:

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.

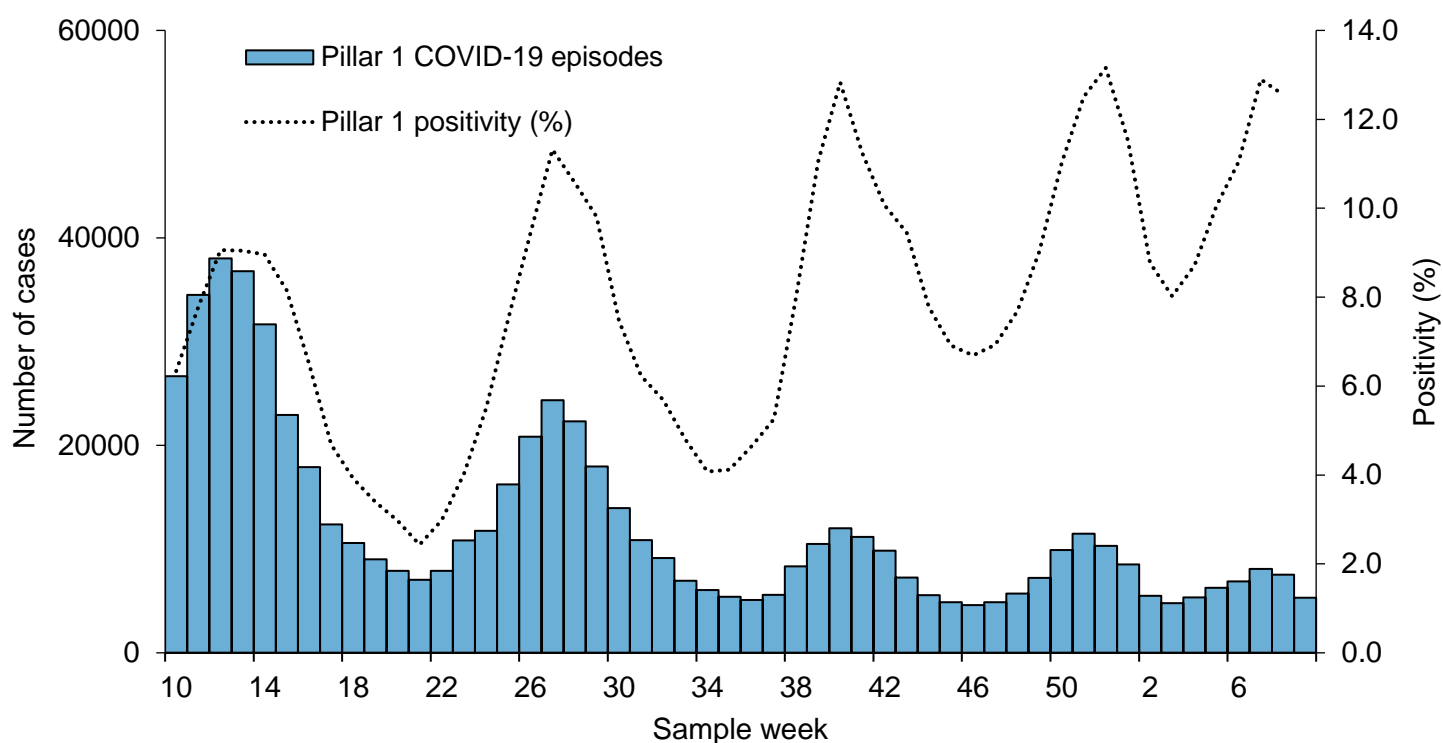
Data is shown by the week the specimen was taken from the person being tested. This gives the most accurate analysis of this time progression. However, for the most recent week results for more samples are expected therefore this should be interpreted with caution.

Data from the most recent week is subject to reporting lags and may change in future iterations.

Pillar 1 positivity metrics for the most recent week have been omitted due to a possible data processing issue which is being investigated. Please refer to the DataMart data on SARS-CoV2 positivity in figure 11.

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

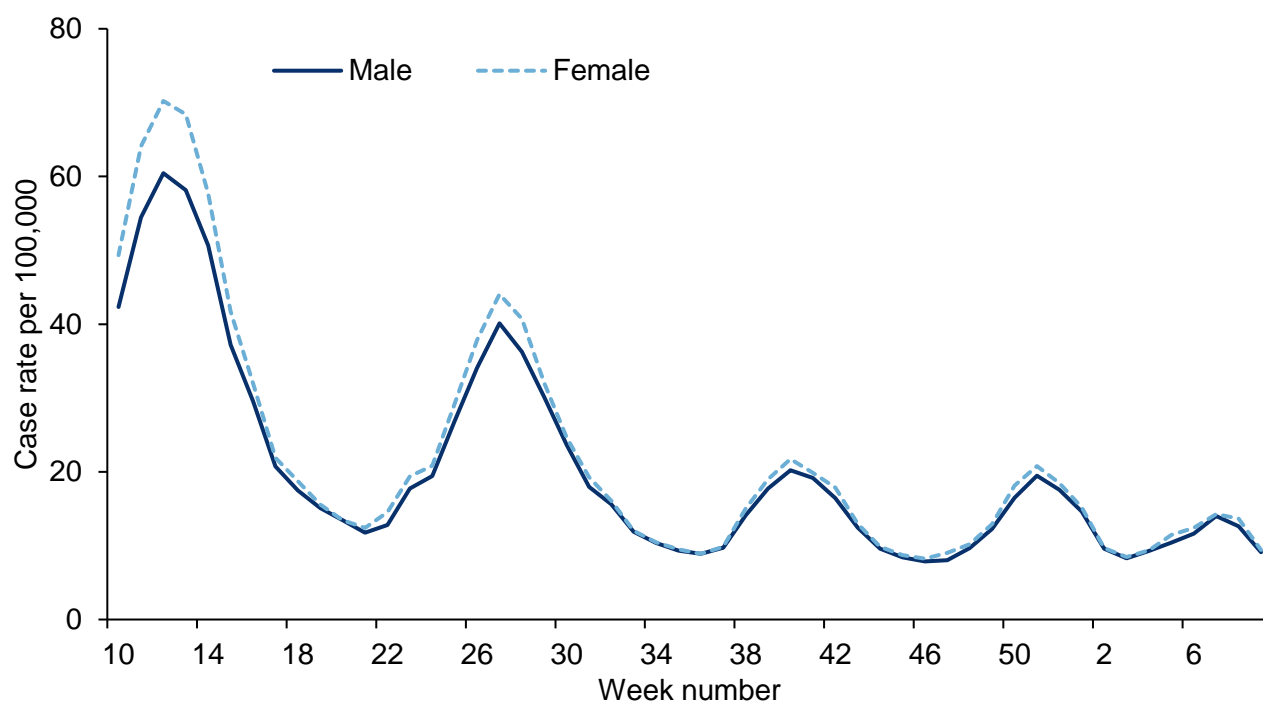


Figure 3: Weekly confirmed COVID-19 case rates per 100,000, by episode, tested under Pillar 1, by age group

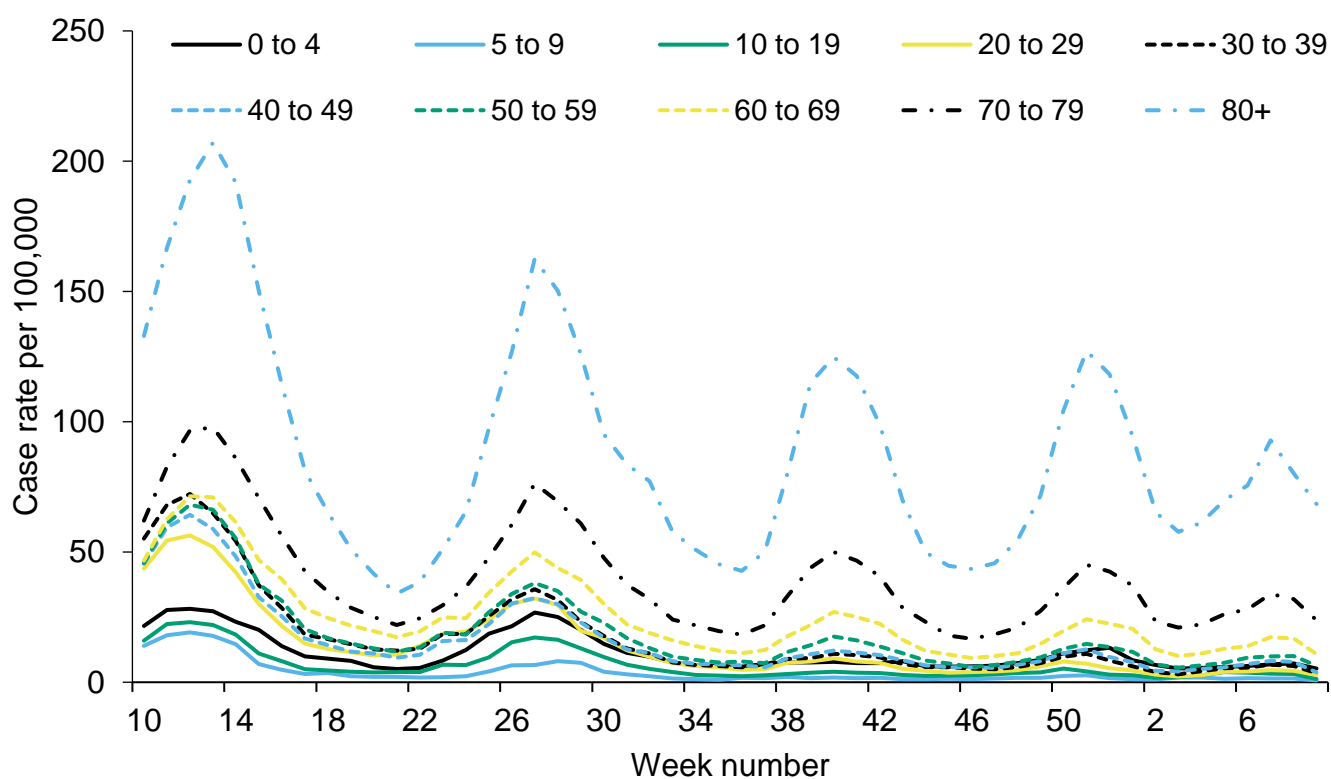


Figure 4: Weekly PCR positivity (%) of confirmed COVID-19 cases tested overall and by sex under Pillar 1

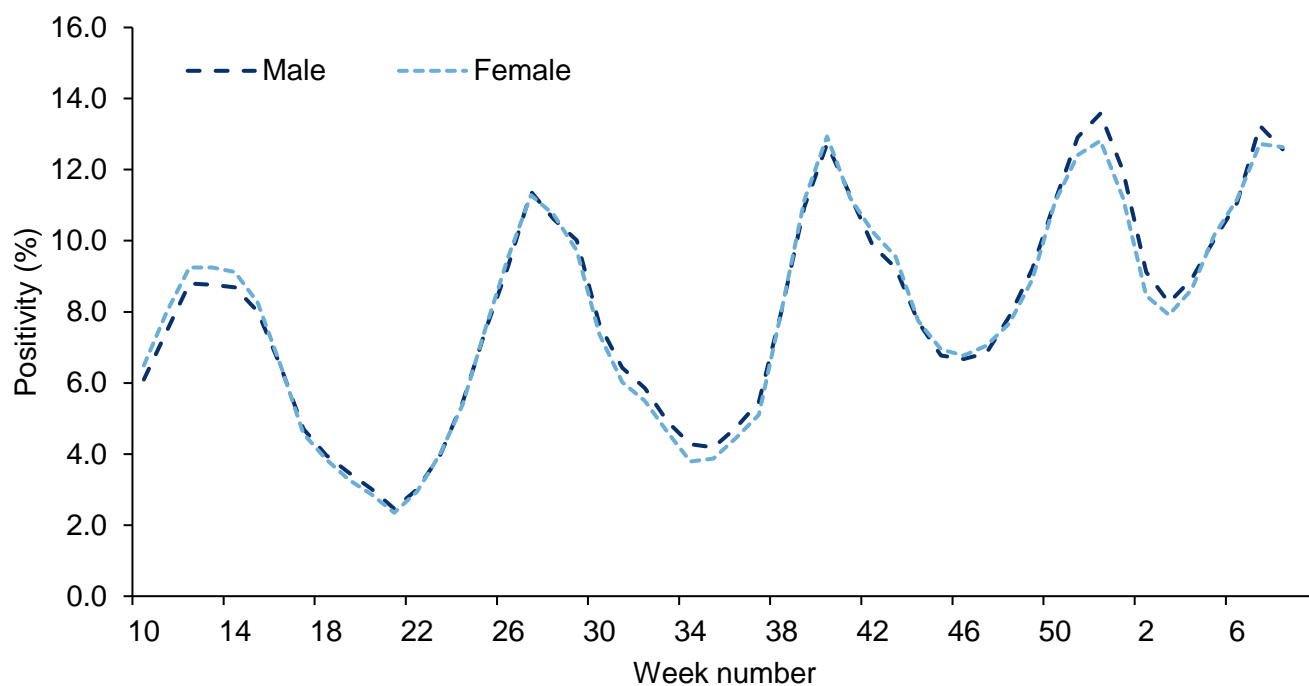
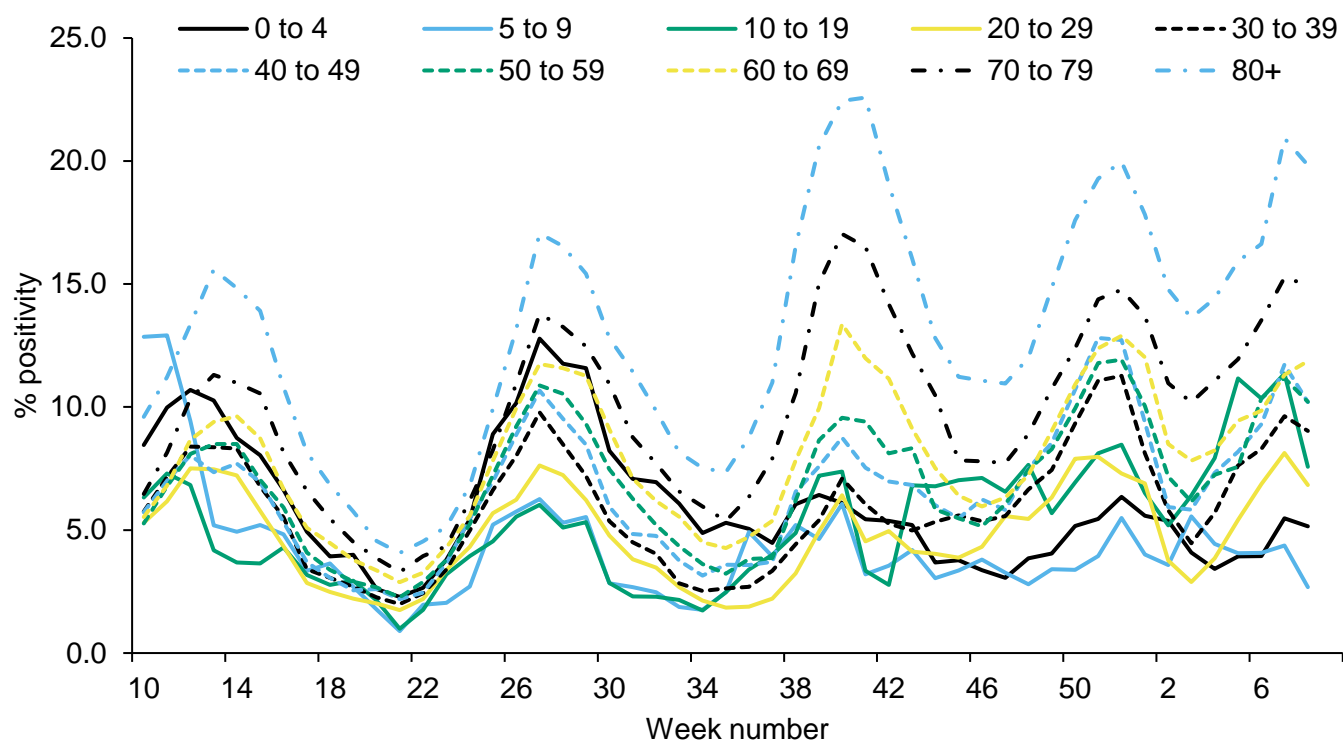
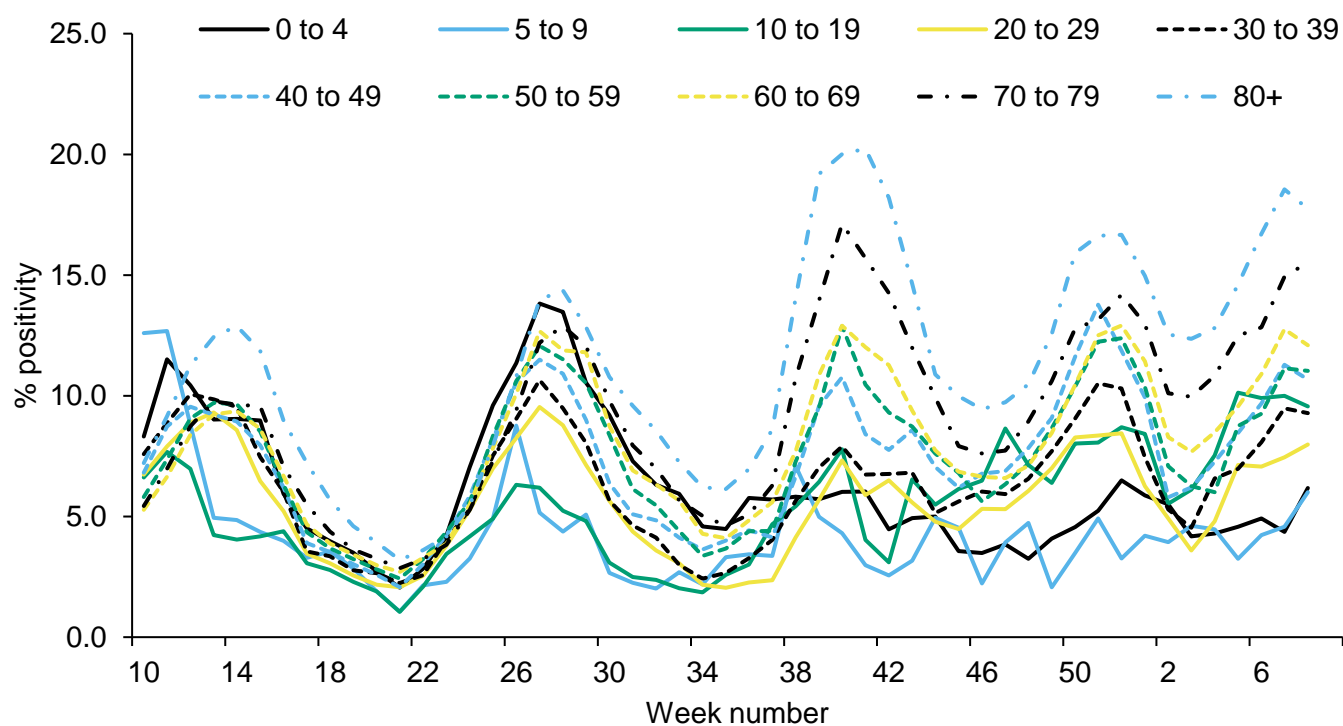


Figure 5: Weekly PCR positivity (%) of confirmed COVID-19 cases tested under Pillar 1, (a) by male and age group and (b) by female and age group

(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

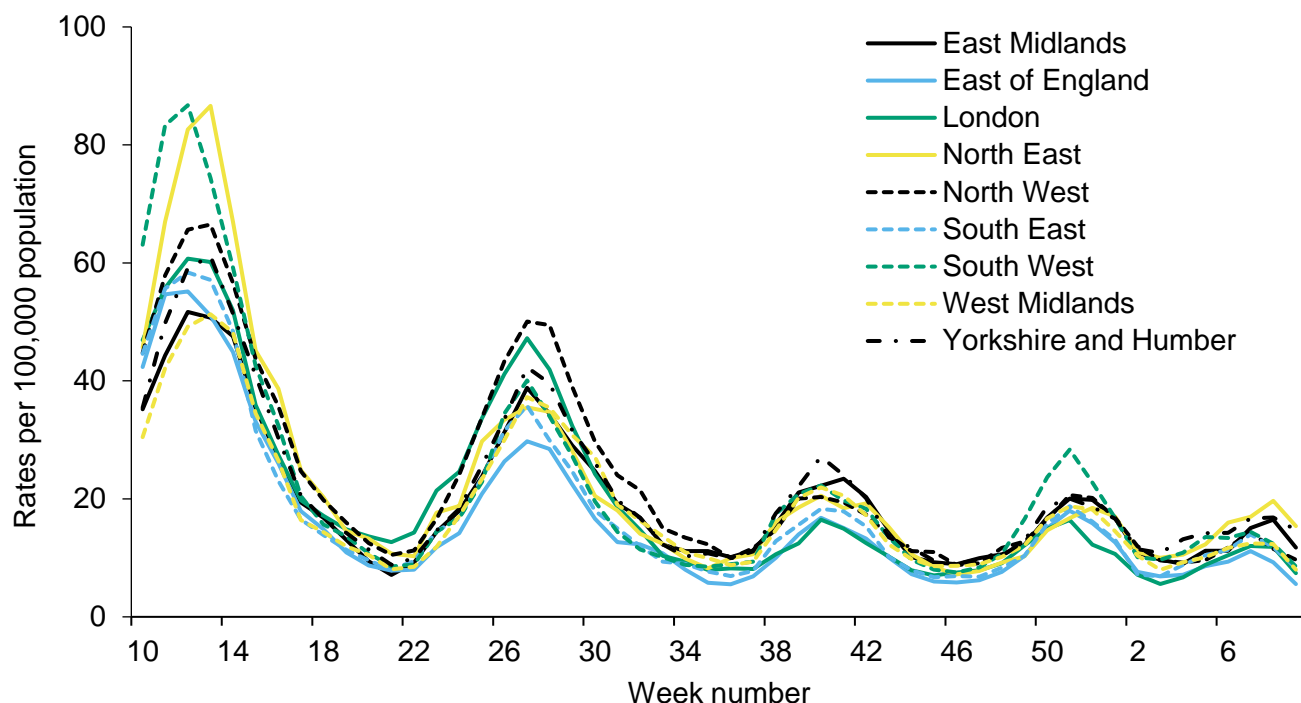


Figure 7: Weekly PCR positivity of confirmed COVID-19 cases tested under Pillar 1 (%) by UKHSA centres and sample week

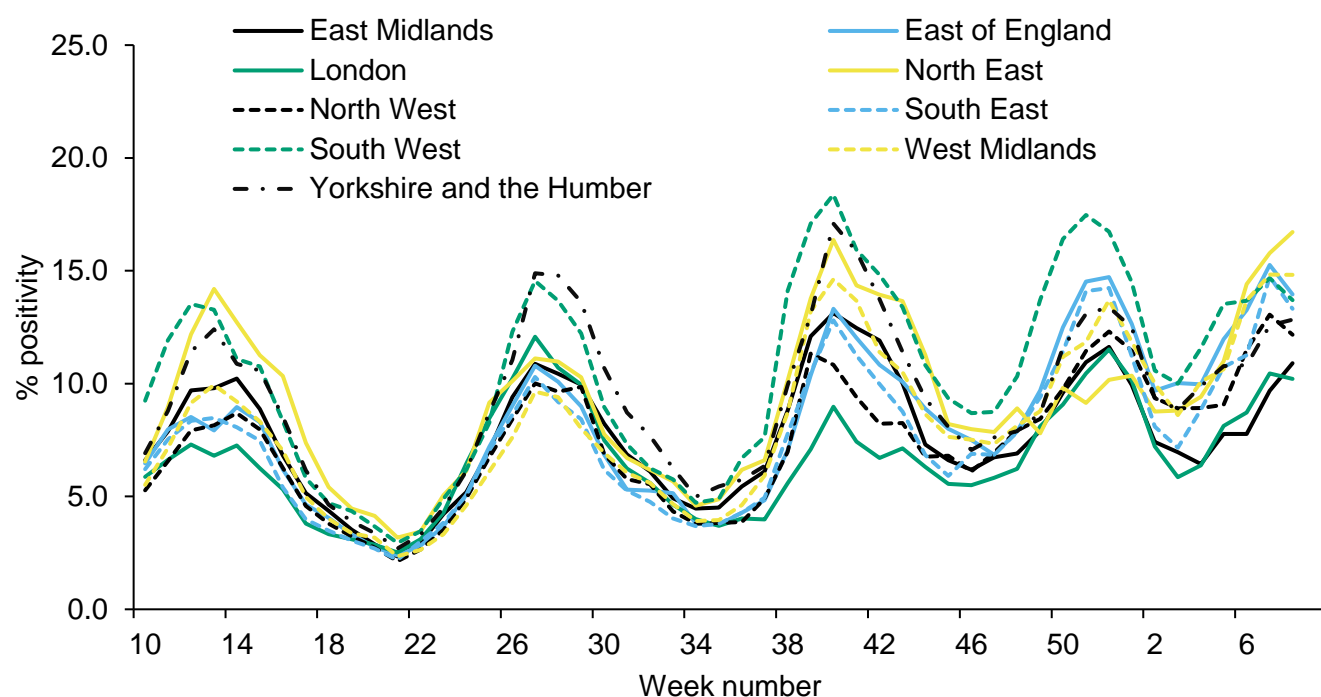
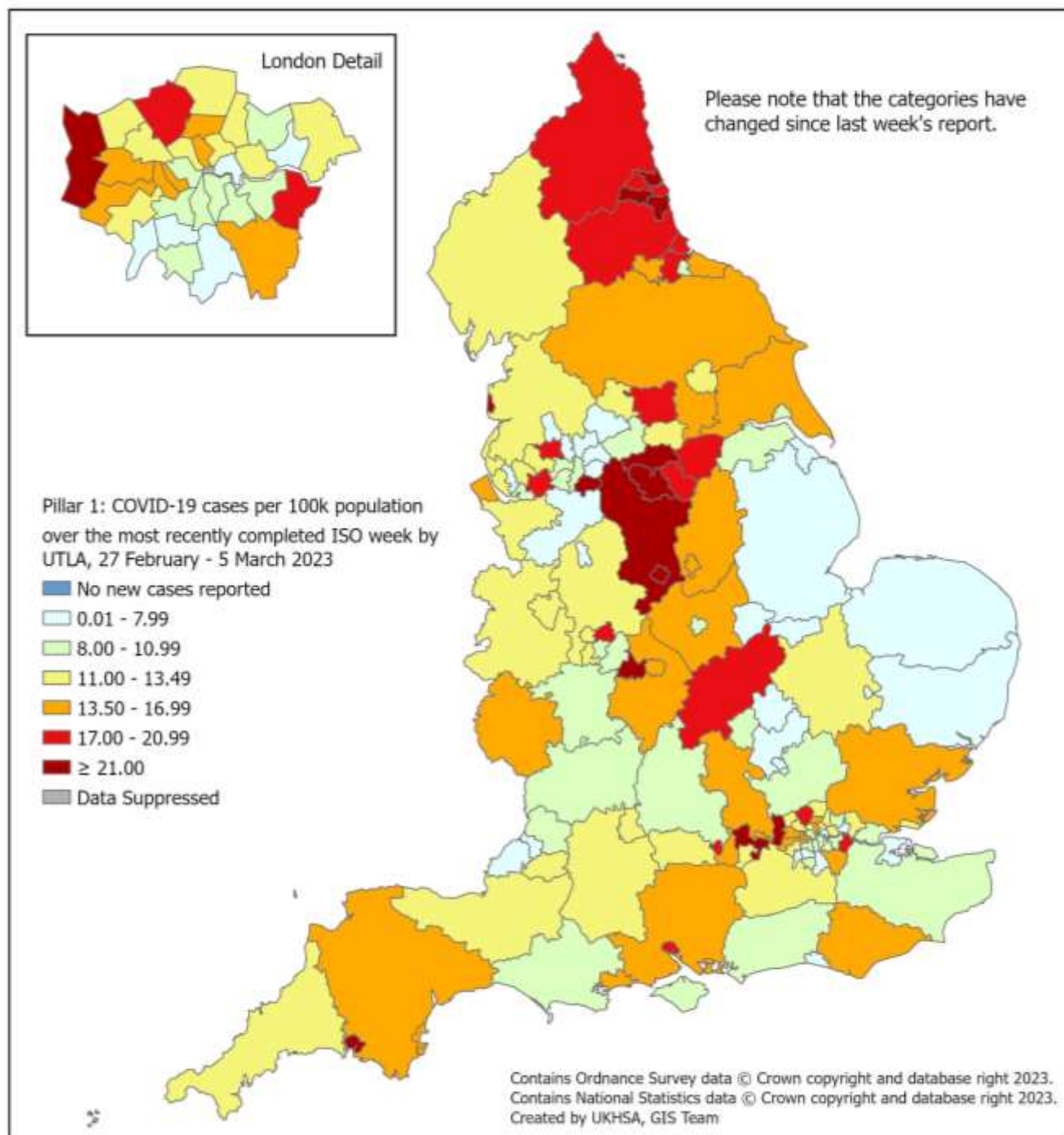
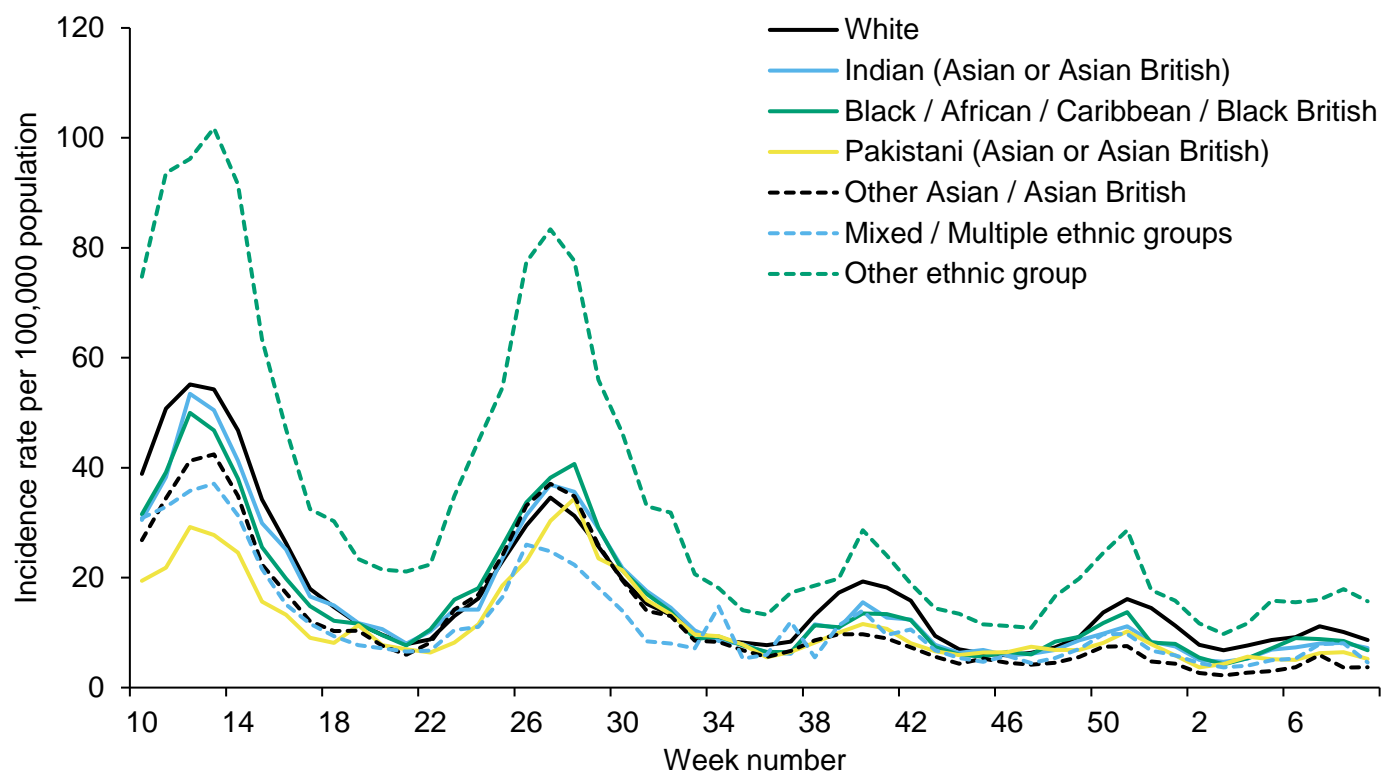


Figure 8: Weekly rate of COVID-19 episodes per 100,000 population (Pillar 1), by upper-tier local authority (UTLA), England (box shows enlarged map of London area)



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. Data from one reporting laboratory has been removed from week 43 onwards due to data quality issues.

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. Sixteen 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 9, data is based on reporting from 12 out of the 16 sentinel laboratories.

In week 9, 10,849 respiratory specimens reported through the Respiratory DataMart System were tested for SARS-CoV-2. 985 samples were positive for SARS-CoV-2 with an overall positivity of 9.1%, which decreased slightly from 9.5% the previous week. The highest positivity was seen in the 65 year olds and over at 12.1%.

In week 9, 5,481 respiratory specimens reported through the Respiratory DataMart System were tested for influenza. 99 samples tested positive for influenza; 8 influenza A(H3), 2 influenza A(H1N1)pdm09, 17 influenza A(not subtyped) and 72 influenza B (Figure 12). Overall, influenza positivity decreased slightly to 1.8% in week 9 compared with 2.5% in week 8, with highest positivity seen in the 15 to 44 year old age group at 4.6%, a decrease from 6.8% in week 8. Influenza B positivity decreased to 1.3% in week 9 compared with 1.7% in week 8. Influenza A(H3N2) positivity decreased slightly to 1.1% in week 9 compared with 1.3% in week 8. Influenza A(H1N1)pdm09 positivity remained low at 0.0%.

Adenovirus positivity decreased slightly to 3.9%, with the highest positivity in those aged under 5 years old at 11.4%.

Human metapneumovirus (hMPV) positivity remained stable at 2.5%, with the highest positivity in those aged under 5 years old at 3.9%.

Parainfluenza positivity remained stable at 2.6%, with the highest positivity in those aged under 5 years old at 7.0%.

Rhinovirus positivity decreased slightly to 11.5% overall, with the highest positivity in those aged under 5 years old at 22.5%.

The overall positivity for RSV remained low at 1.1%, with the highest positivity in those aged under 5 years old at 4.0%.

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

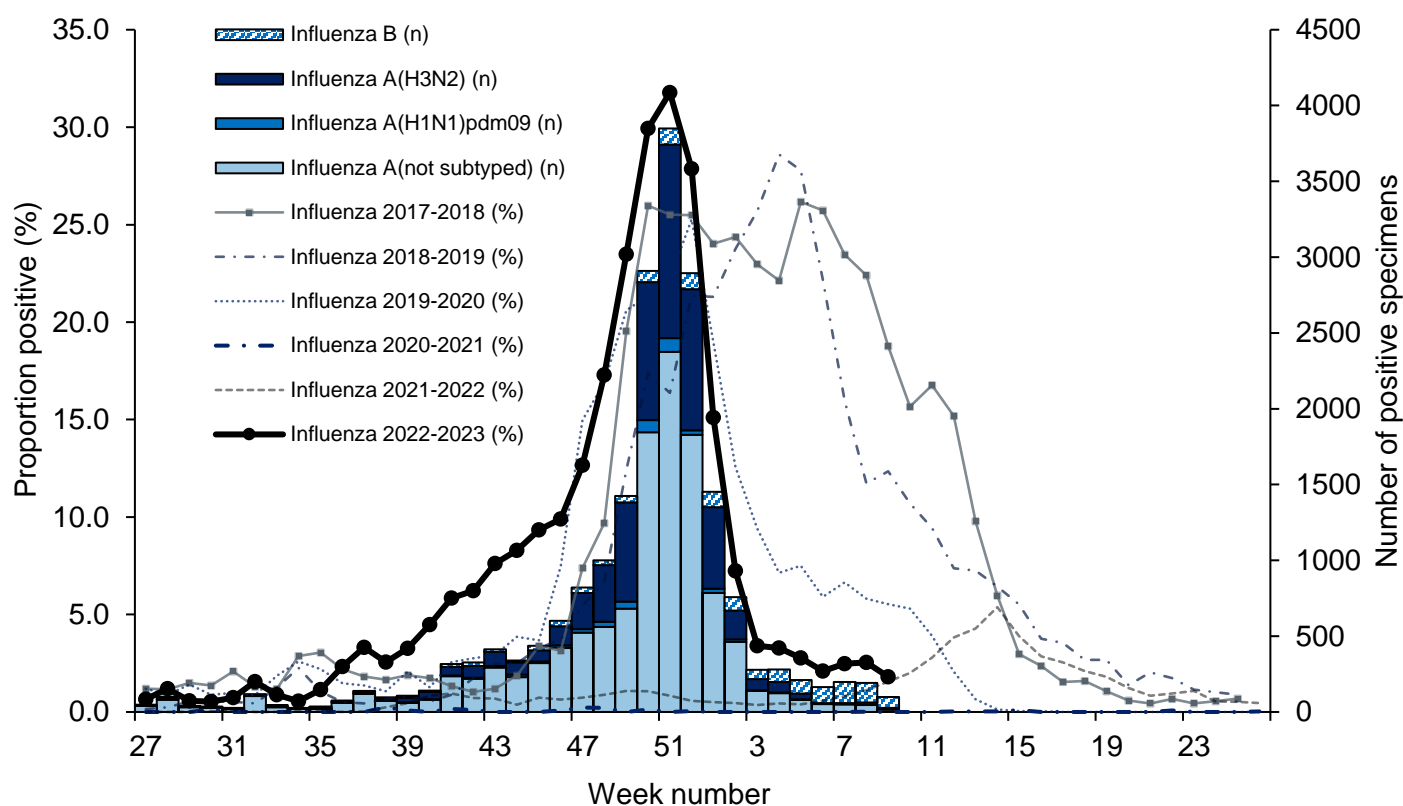


Figure 11: Respiratory DataMart weekly positivity (%) for SARS-CoV-2, England

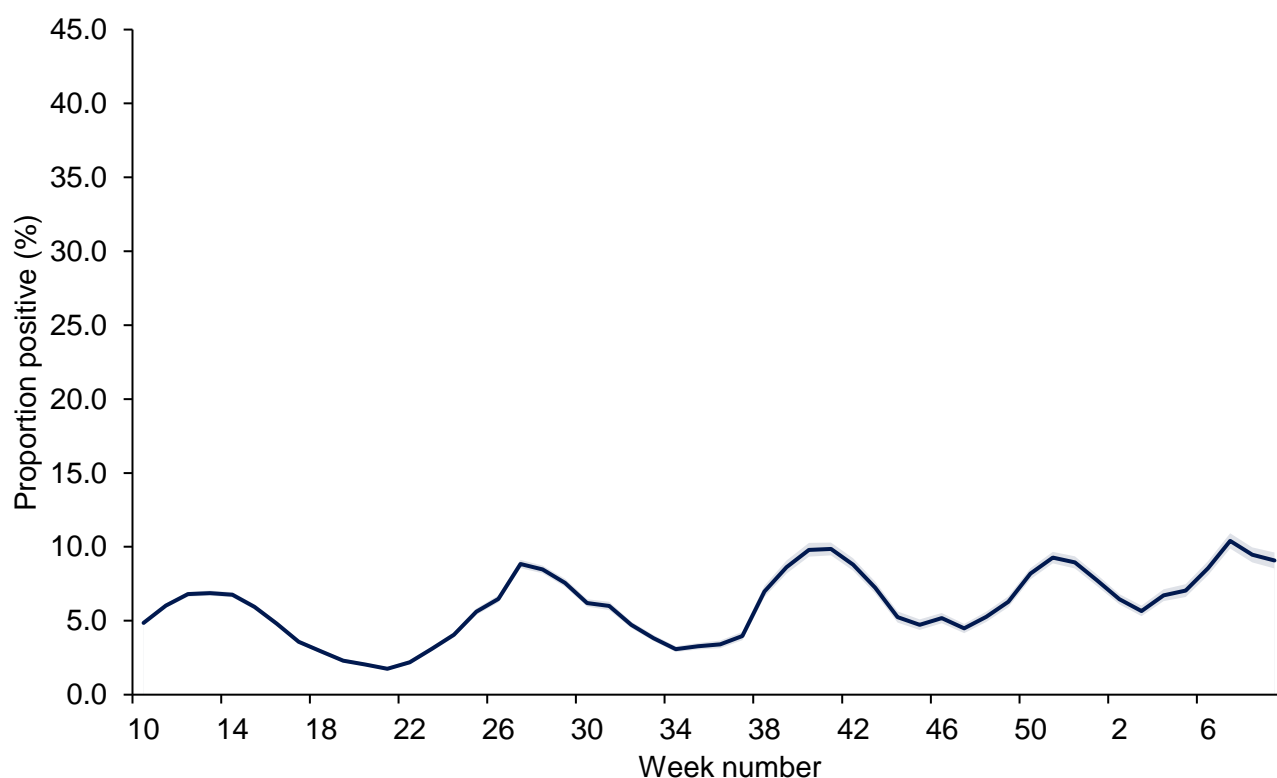


Figure 12: Respiratory DataMart weekly positivity (%) for influenza, England

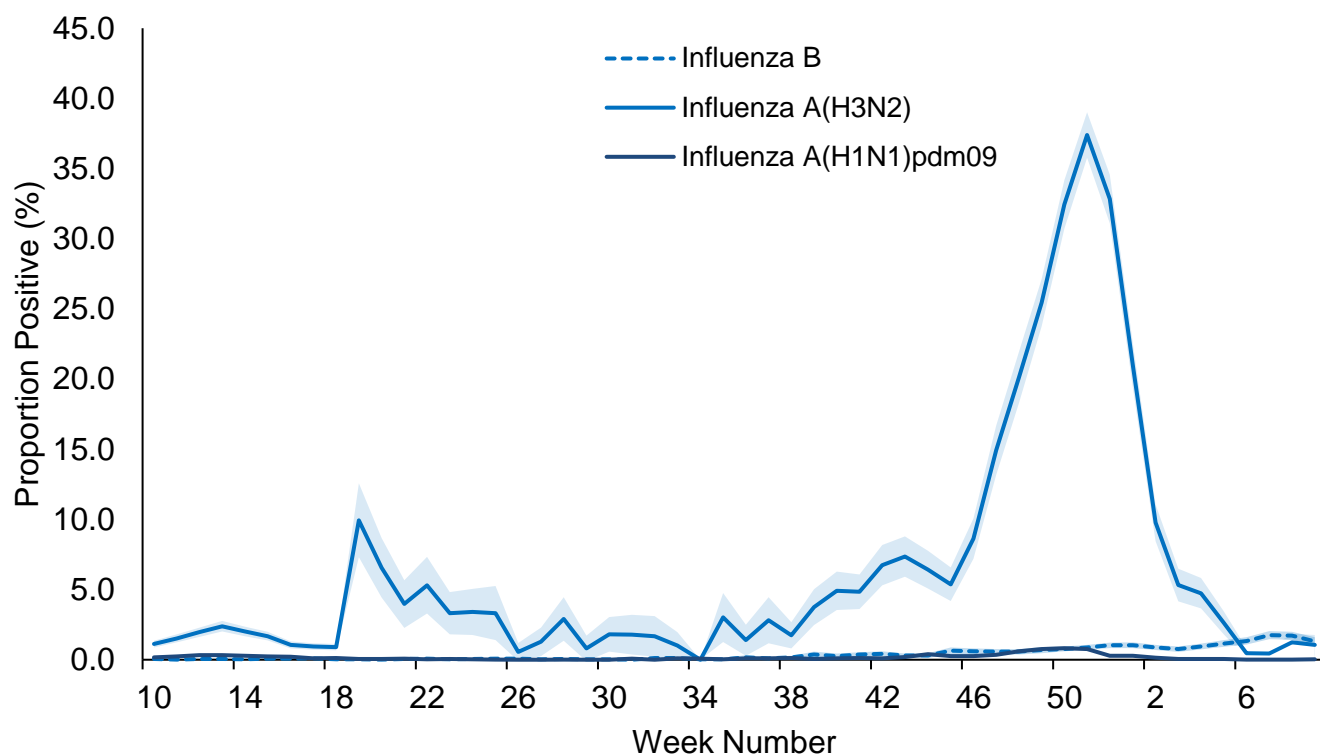


Figure 13: Respiratory DataMart weekly positivity (%) for influenza by age, England

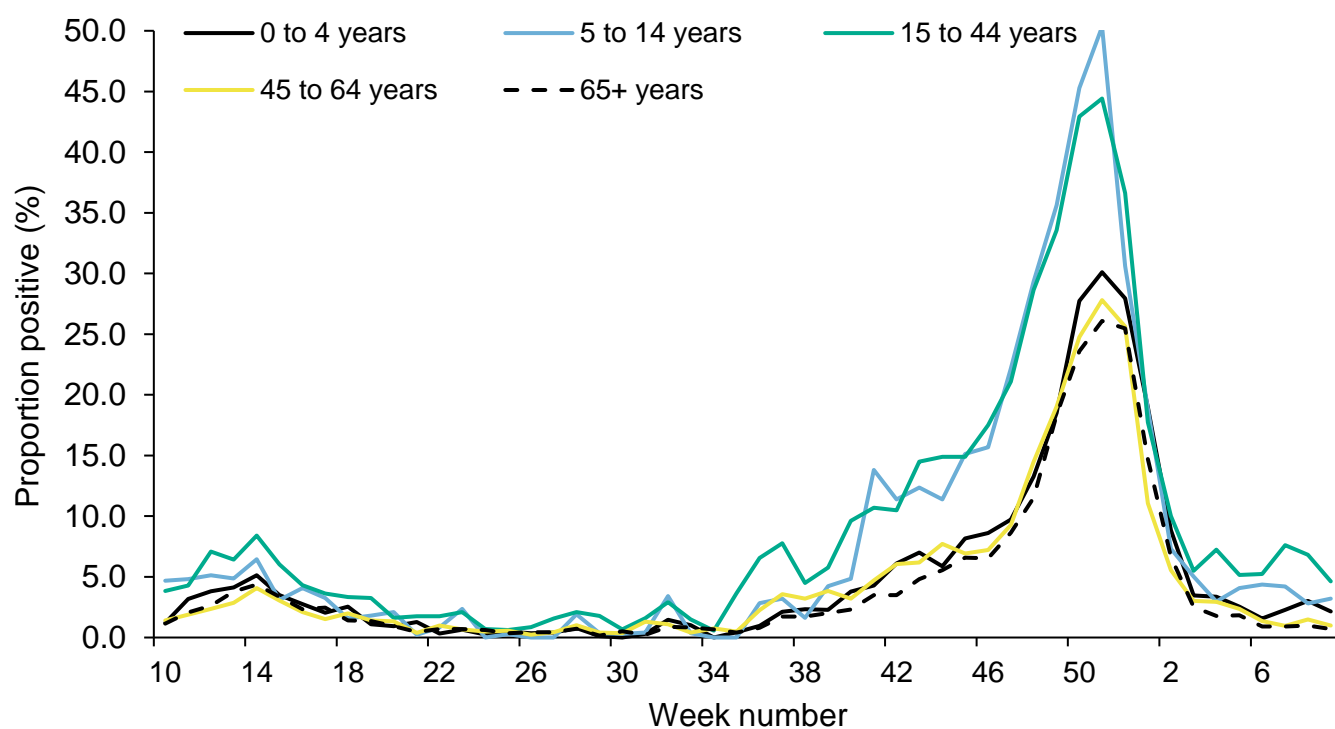


Figure 14: Respiratory DataMart weekly positivity (%) for other viruses, England

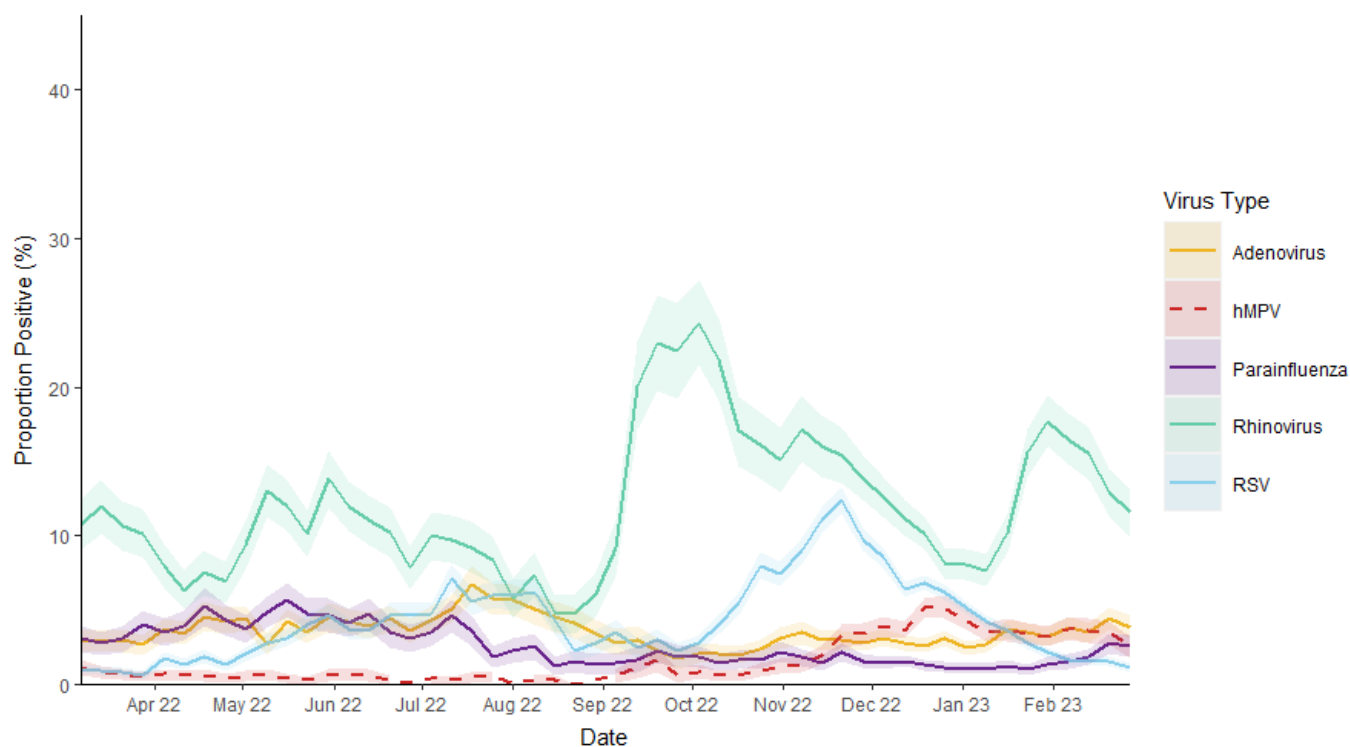


Figure 15: Respiratory DataMart weekly positivity (%) for adenovirus by age, England

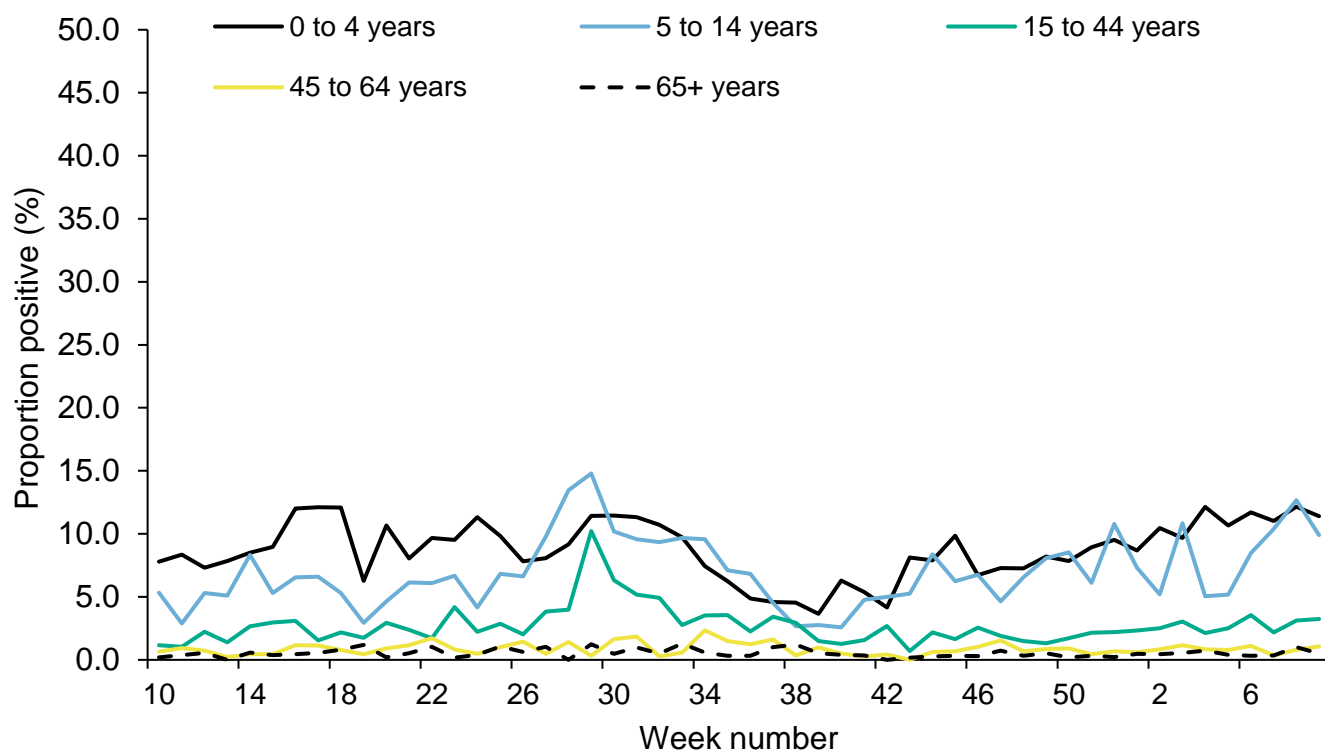


Figure 16: Respiratory DataMart weekly positivity (%) for hMPV by age, England

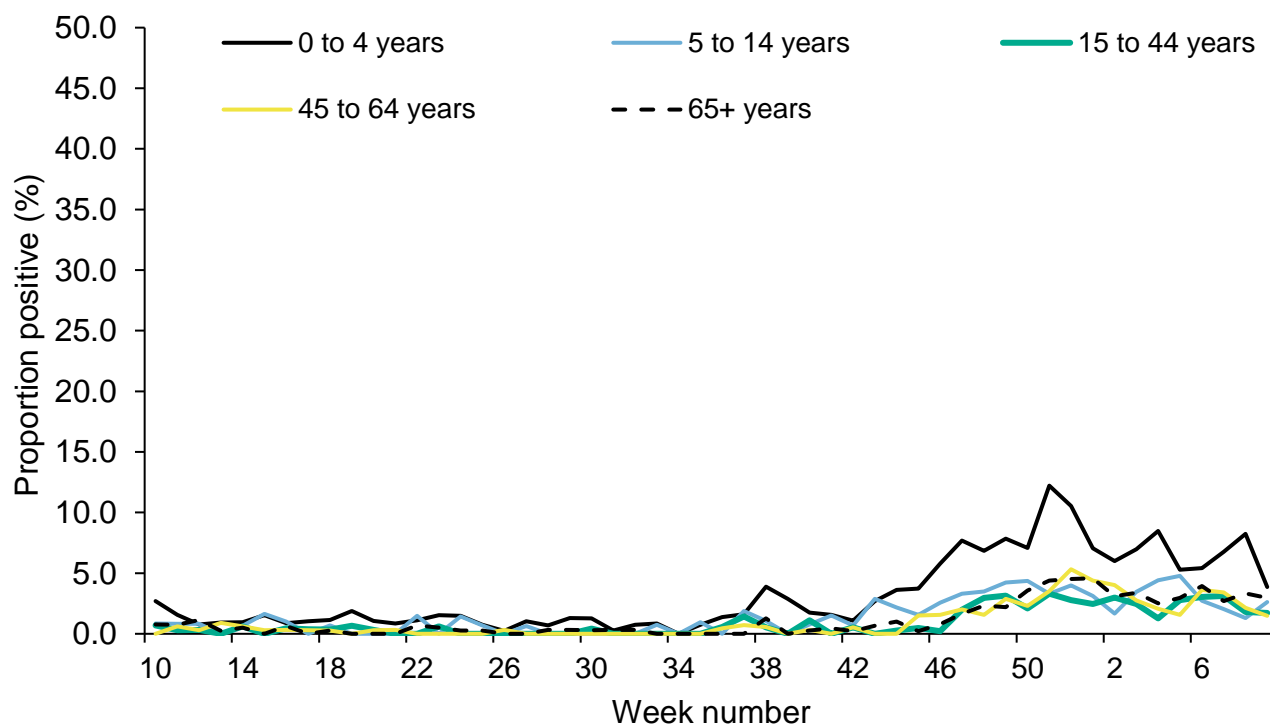


Figure 17: Respiratory DataMart weekly positivity (%) for parainfluenza by age, England

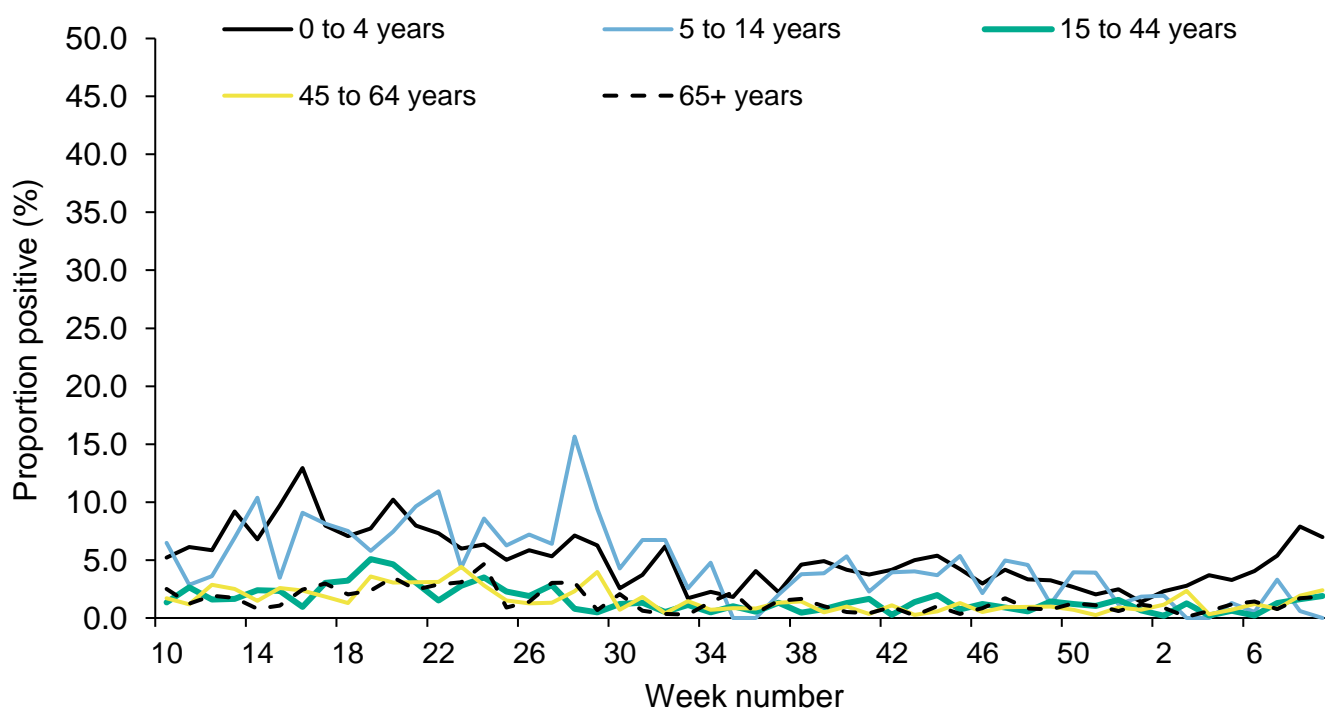


Figure 18: Respiratory DataMart weekly positivity (%) for rhinovirus by age, England

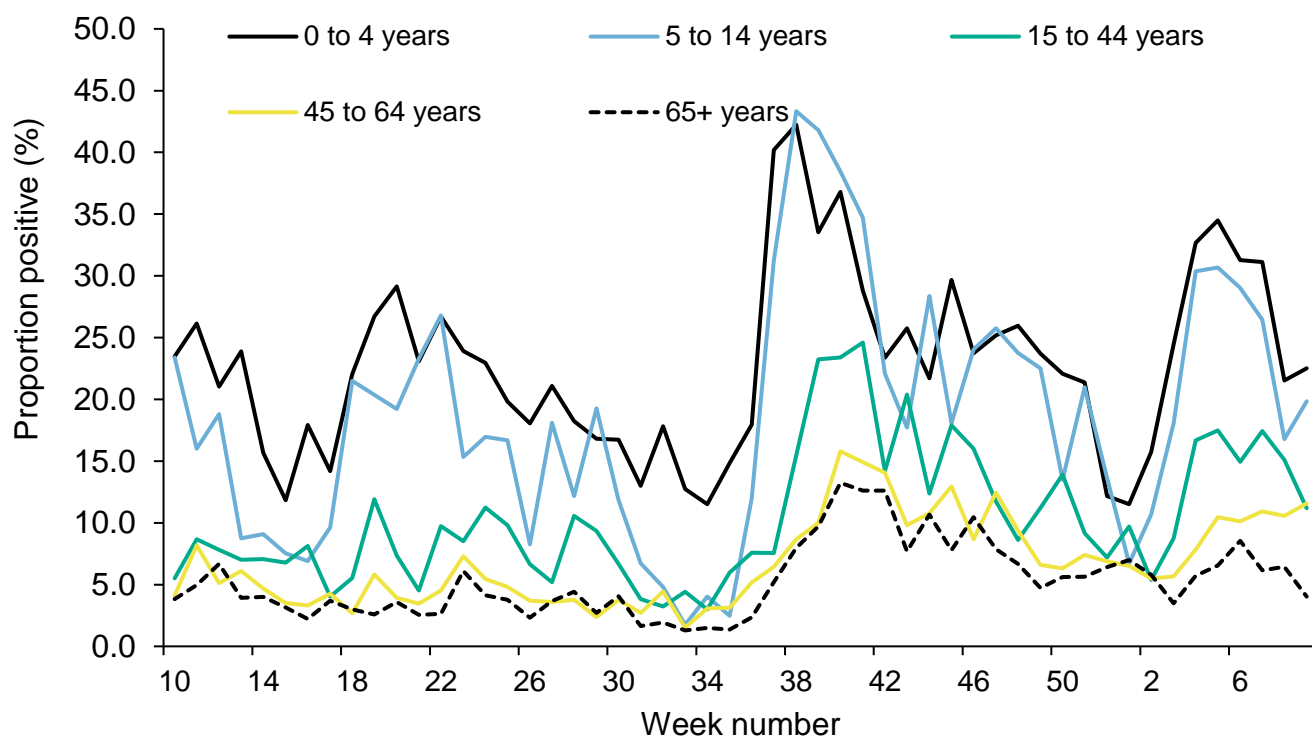
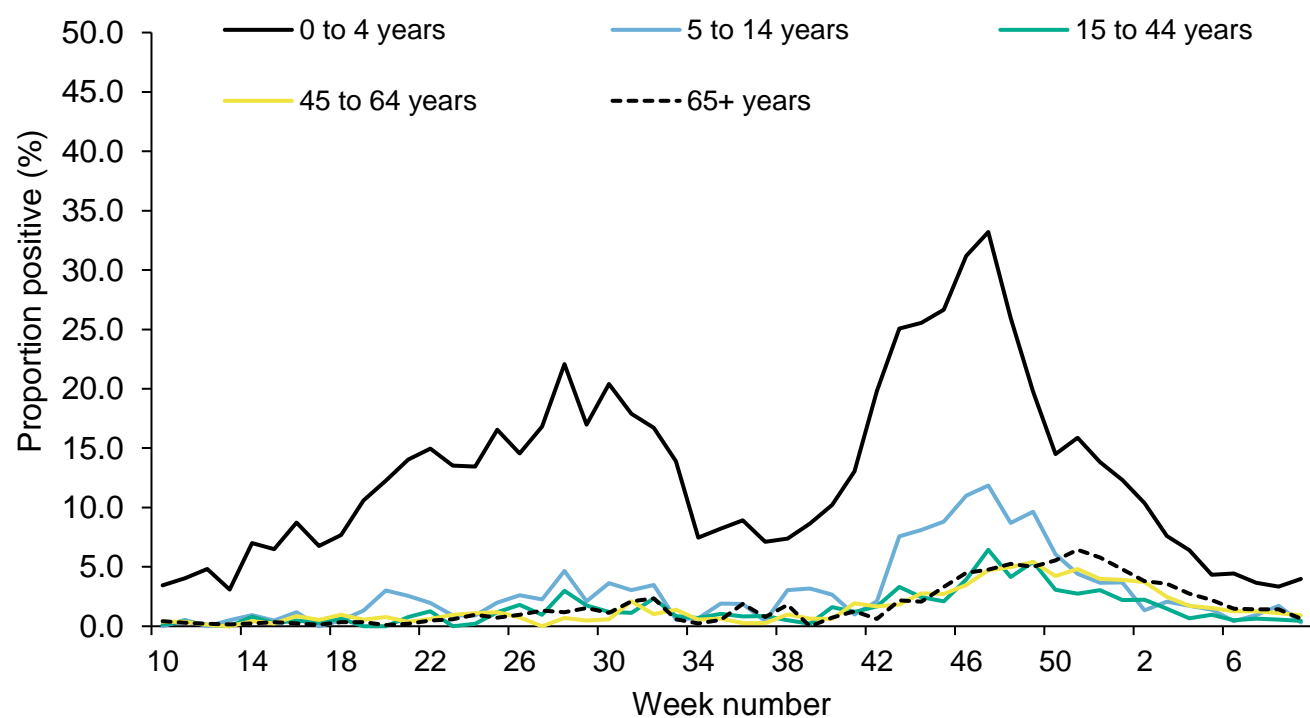


Figure 19: Respiratory DataMart weekly positivity (%) for RSV by age, England



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.

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

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

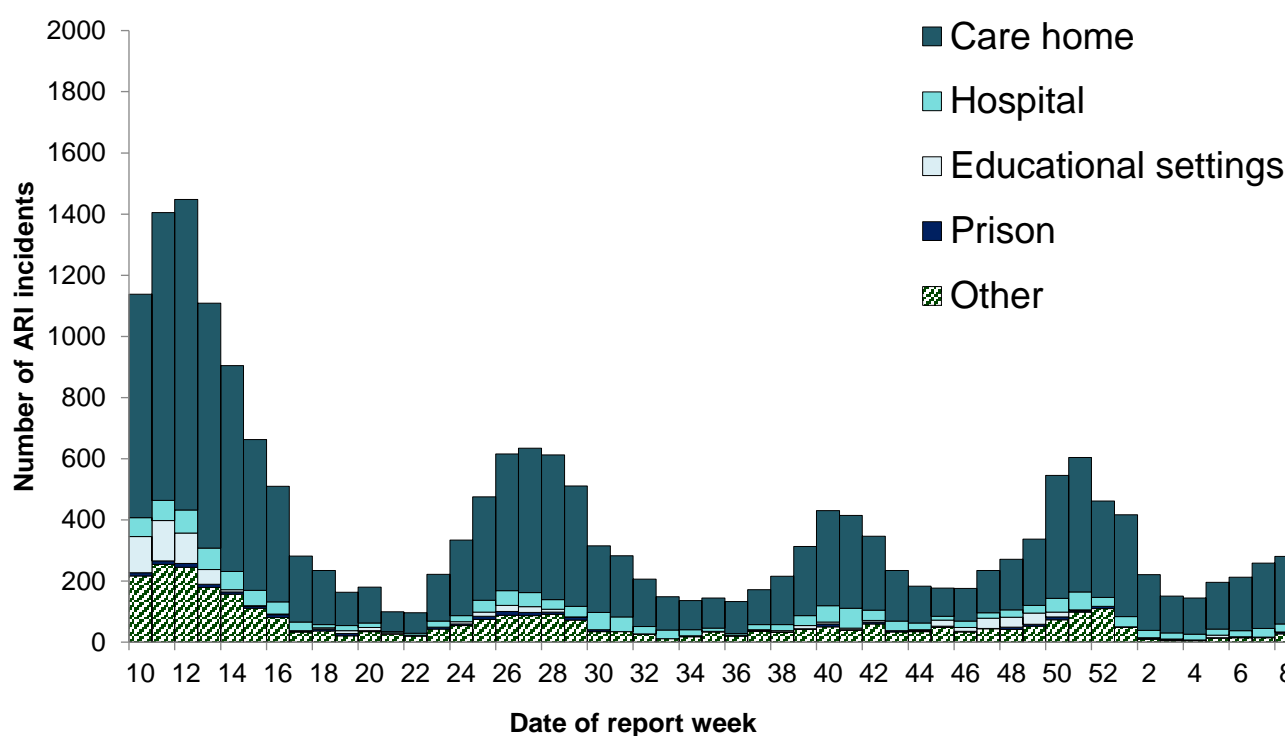
Data caveats:

1. The incidents captured on HPZone represent a subset of all ongoing ARI clusters and outbreaks in England rather than an exhaustive listing.
2. In addition, SARS-CoV-2 testing policies and public health guidance for different settings changed over time. This means that any interpretation of seasonal and temporal trends since March 2020 should take this into account.
3. 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.
4. Considering the above, comparisons between regions and settings are not advised as they may be misleading.

286 new ARI incidents have been reported in week 9 in the UK (Figure 20):

- 236 incidents were from care homes, where 110 had at least one linked case that tested positive for SARS-CoV-2 and 1 for Influenza A(not subtyped)
- 24 incidents were from hospitals, where 8 had at least one linked case that tested positive for SARS-CoV-2 and 1 for Influenza B
- 5 incidents were from prisons, where 3 had at least one linked case that tested positive for SARS-CoV-2
- 4 incidents were from educational settings, where no test result was available
- 1 incident was from a workplace setting, which had at least one linked case that tested positive for SARS-CoV-2
- 16 incidents were from other settings, where 7 had at least one linked case that tested positive for SARS-CoV-2

Figure 20: Number of acute respiratory infection (ARI) incidents by setting, UK



*Excludes data from Wales

Figure 21: Number of acute respiratory infection (ARI) incidents by setting, England

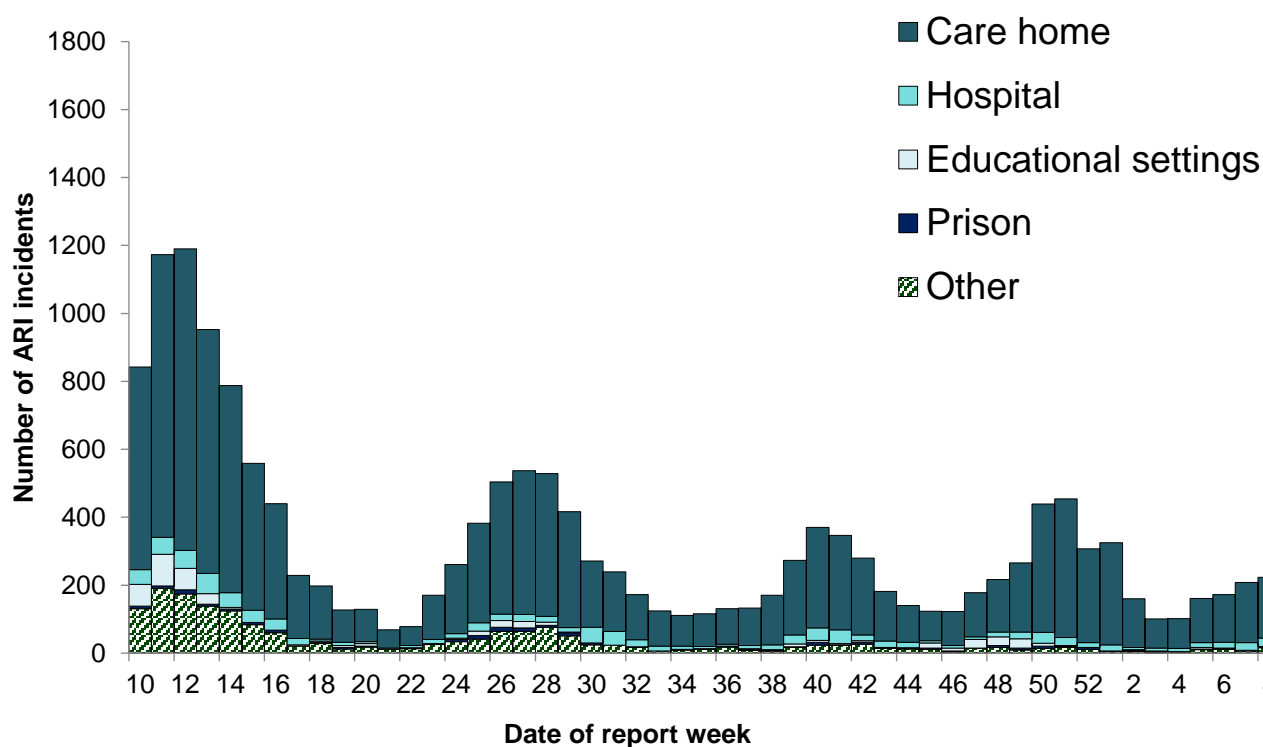


Figure 22: Number of acute respiratory infection (ARI) incidents in care homes by virus type, England

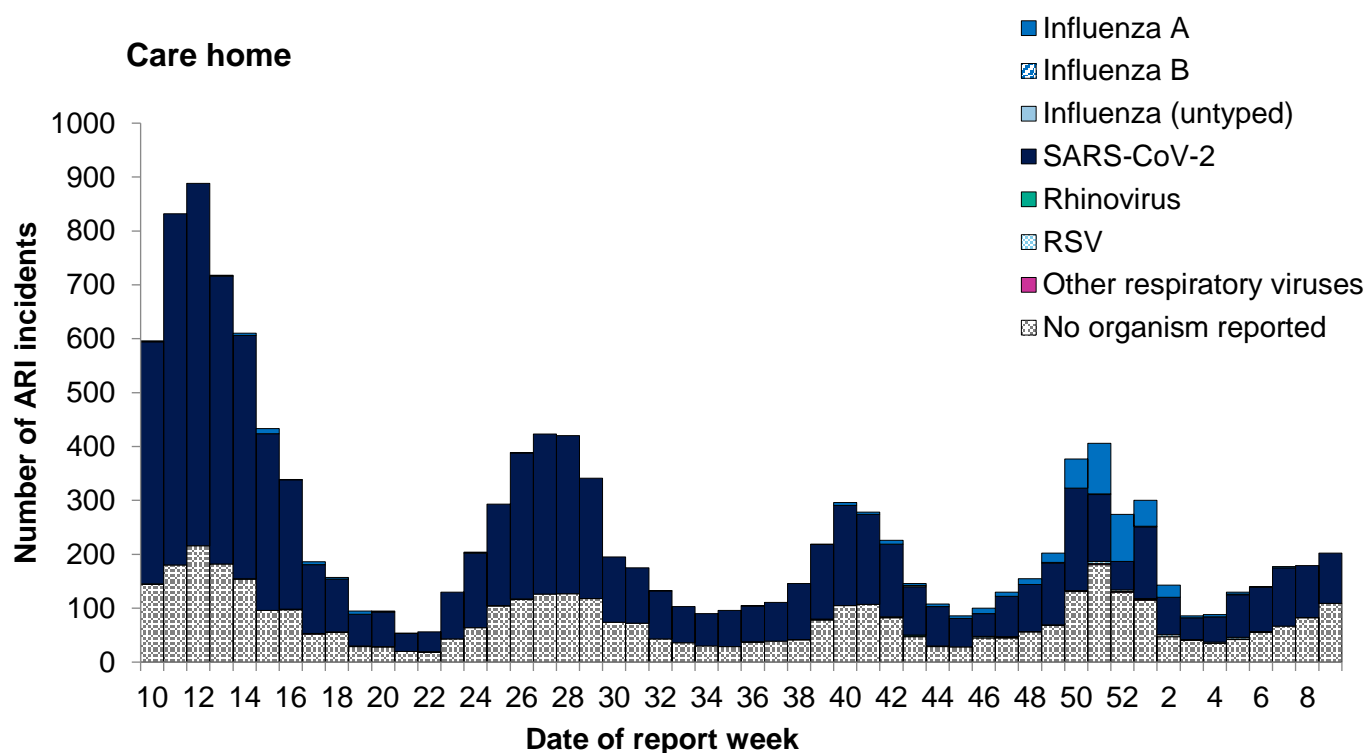


Figure 23: Number of acute respiratory infection (ARI) incidents in hospitals by virus type, England

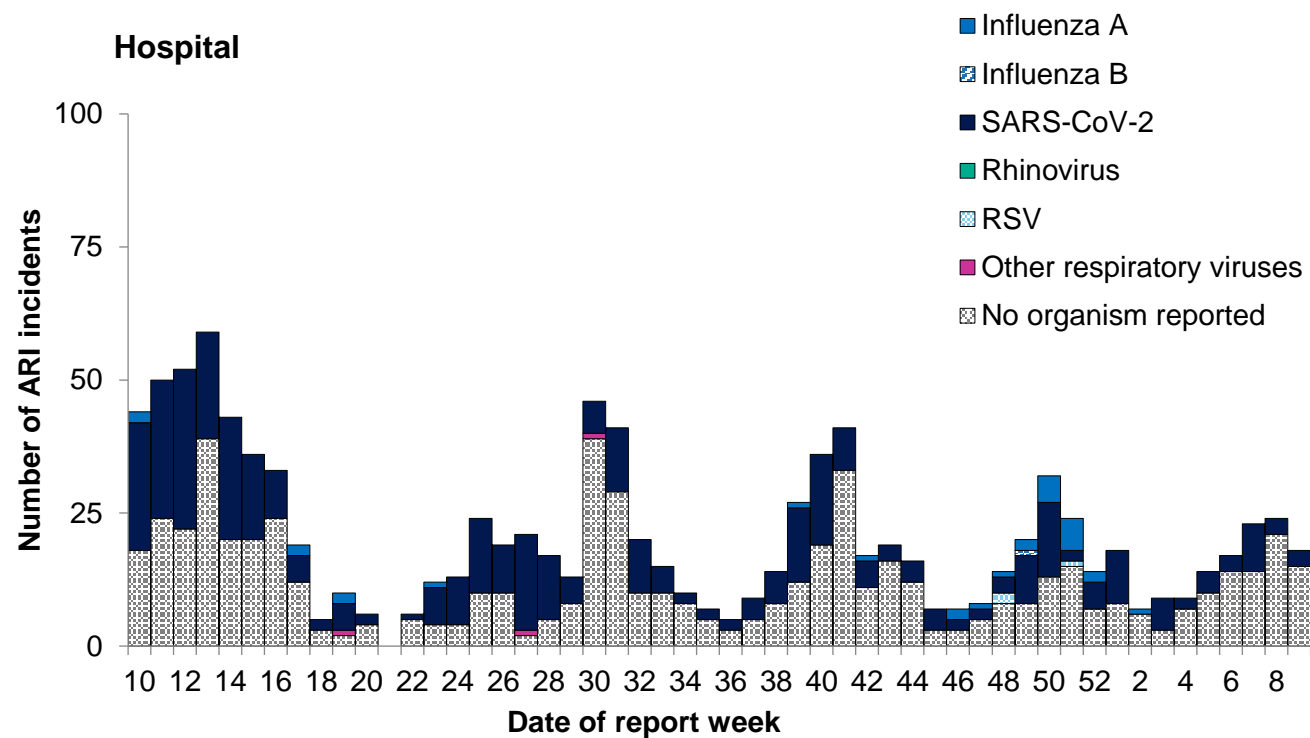


Figure 24: Number of acute respiratory infection (ARI) incidents in educational settings by virus type, England (a) for the weeks 10 2022 to 9 2023 and (b) for the 2022 to 23 academic year

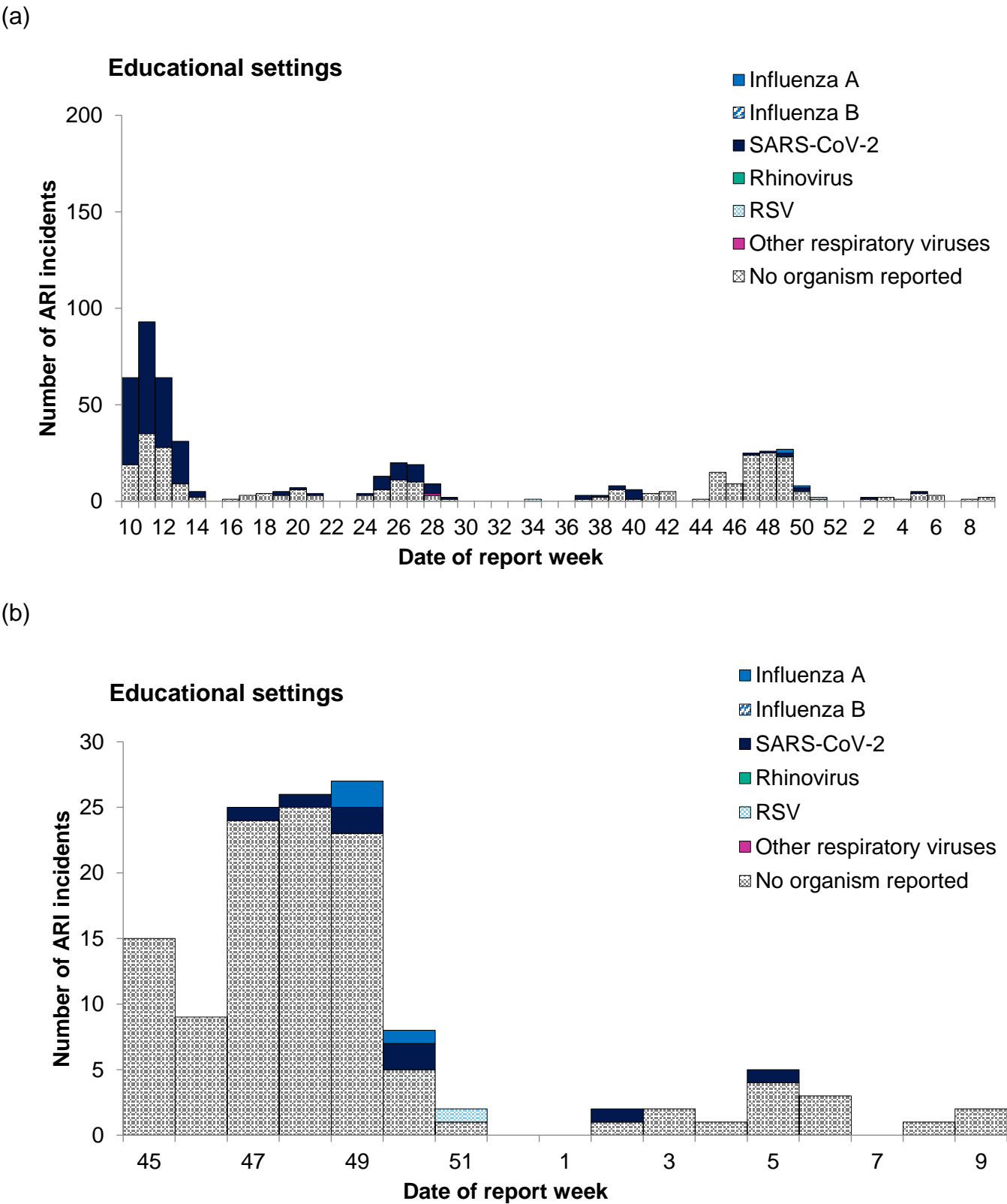


Figure 25: Number of acute respiratory infection (ARI) incidents in prisons by virus type, England

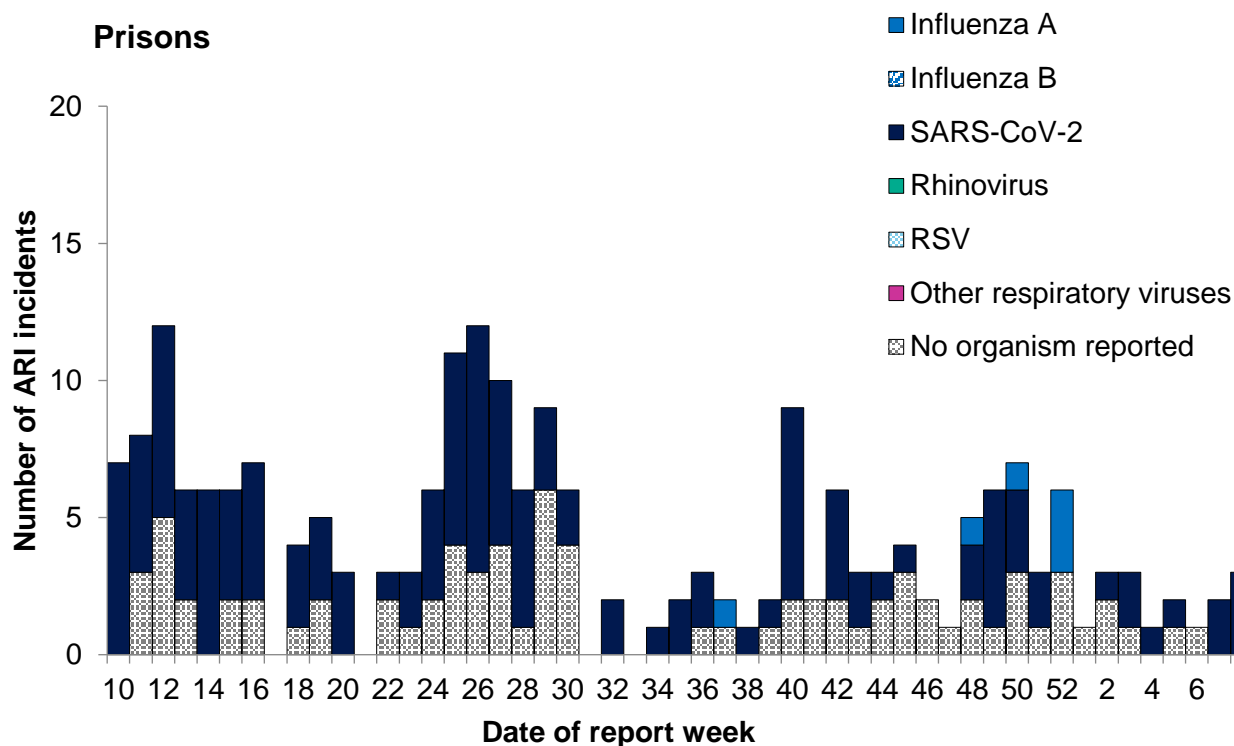


Figure 26: Number of acute respiratory infection (ARI) incidents in other settings by virus type from, England

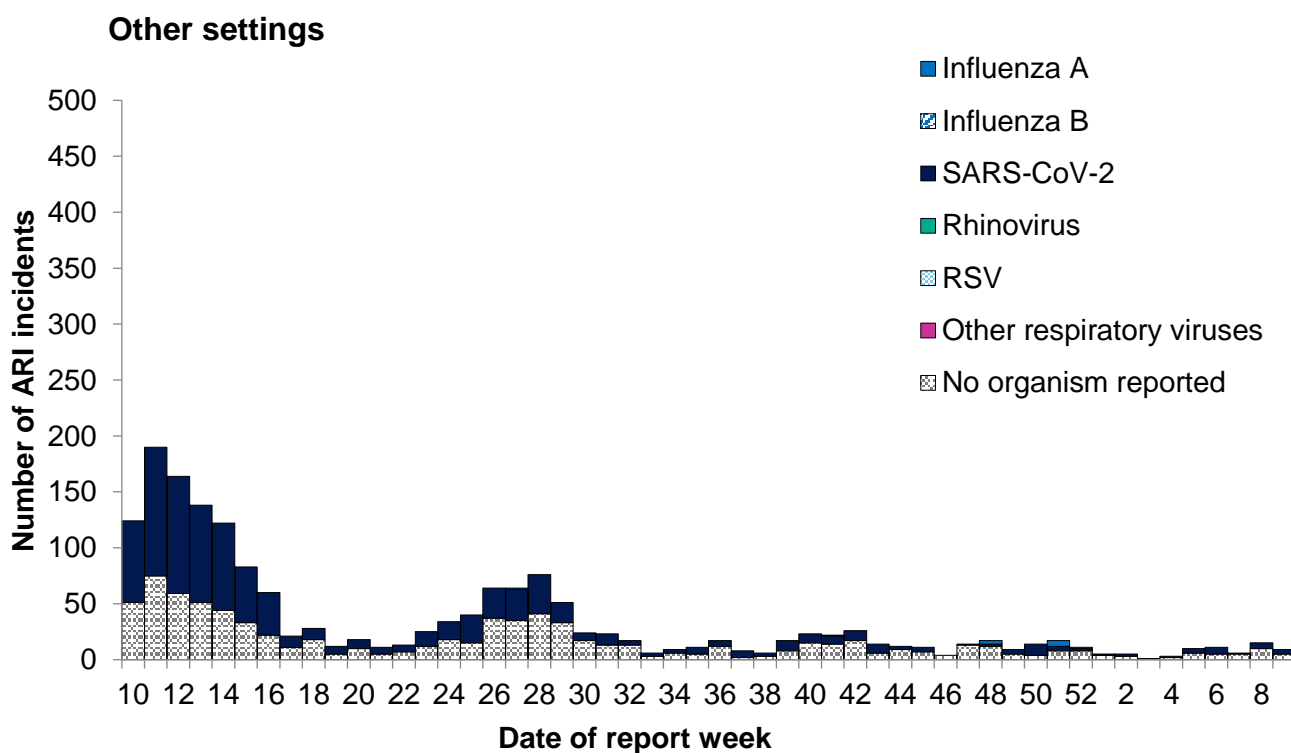


Table 1: Total number of situations and incidents by institution and UKHSA centres over the past 4 weeks with the total number in the last week in brackets

UKHSA Centres	Care Home	Hospital	Educational Setting	Prison	Workplace	Other	Grand Total
East of England	46(15)	0(0)	0(0)	0(0)	0(0)	1(0)	47(15)
East Midlands	14(2)	1(0)	0(0)	2(1)	0(0)	1(0)	18(3)
London	110(30)	70(17)	4(1)	1(0)	2(1)	16(4)	203(53)
North East	94(41)	0(0)	0(0)	0(0)	0(0)	1(1)	95(42)
North West	16(4)	1(0)	0(0)	0(0)	0(0)	1(0)	18(4)
South East	7(2)	0(0)	0(0)	6(3)	0(0)	0(0)	13(5)
South West	287(71)	0(0)	0(0)	0(0)	0(0)	8(1)	295(72)
West Midlands	38(14)	9(1)	2(1)	1(1)	0(0)	4(0)	54(17)
Yorkshire and Humber	86(23)	1(0)	0(0)	1(0)	0(0)	9(3)	97(26)
Grand Total	698(202)	82(18)	6(2)	11(5)	2(1)	41(9)	840(237)

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.

During week 9, there were 2,071 participants completing the weekly symptoms questionnaire of which 188 (9.1%) reported fever or cough and 47 (2.3%) reported influenza like illness (ILI).

In participants completing the weekly symptoms survey both COVID-19 and ILI related symptoms increased slightly compared with week 8.

Healthcare seeking behaviour amongst participants reporting respiratory symptoms relating to COVID-19 (cough, fever or loss of smell) showed that participants reporting symptoms were more likely to telephone their GP provider (Figure 27).

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. There remains variation on social mixing patterns amongst participants as people are meeting more individuals outside of their households (Figure 28).

Figure 27: FluSurvey participants self-reporting fever or cough and ILI symptoms, and trends in healthcare seeking behaviour among these participants, England

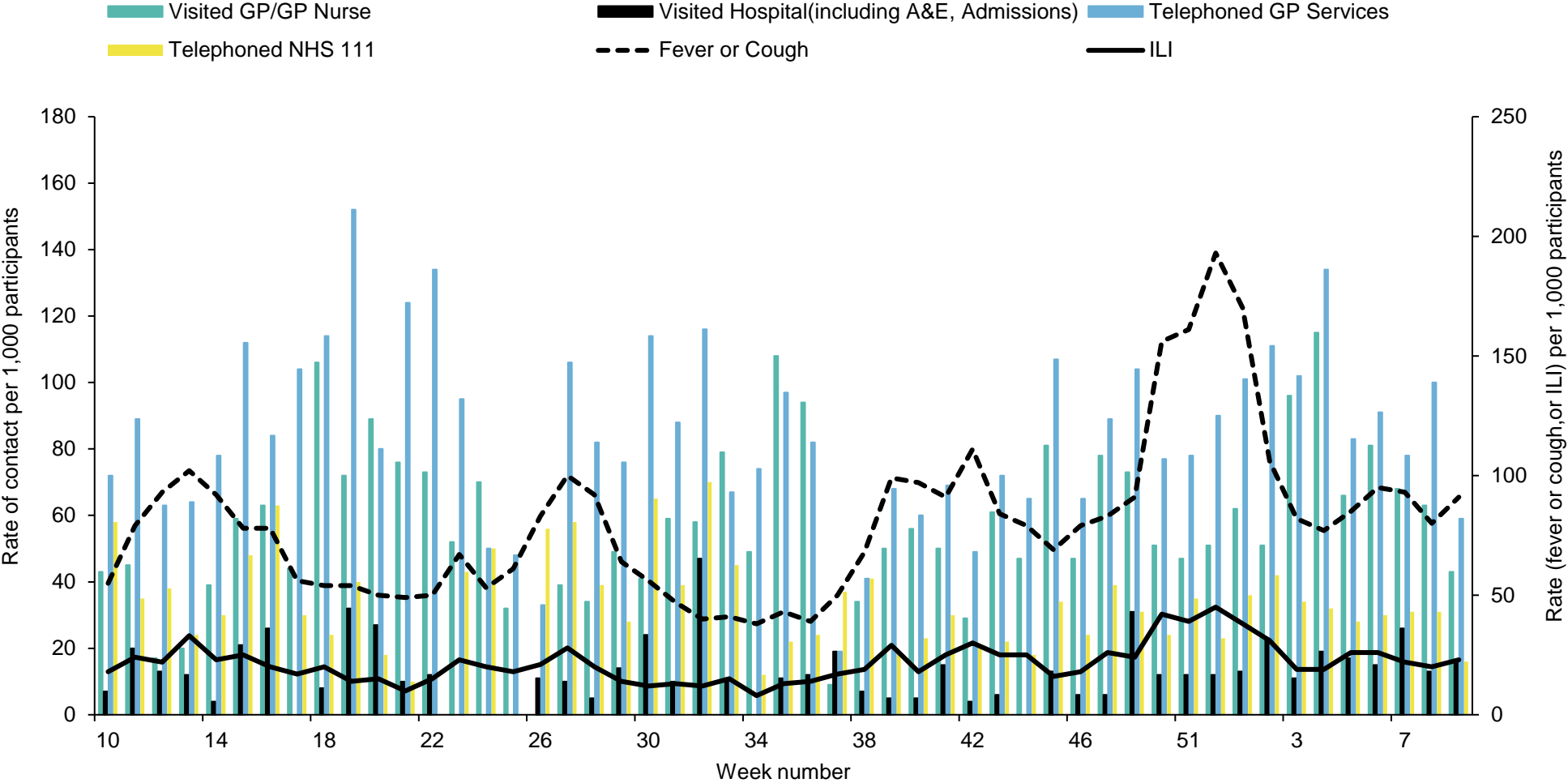
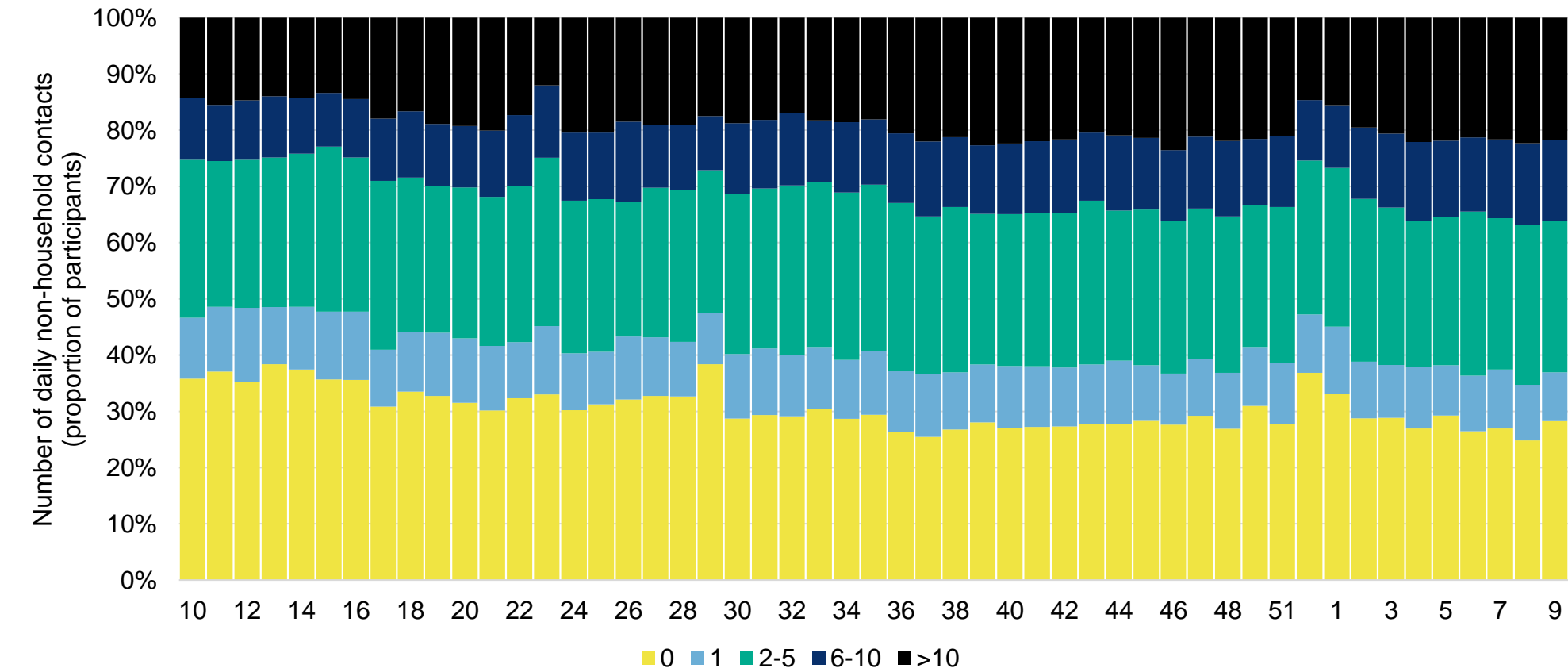


Figure 28: FluSurvey participants’ self-reported number of social contacts outside the household

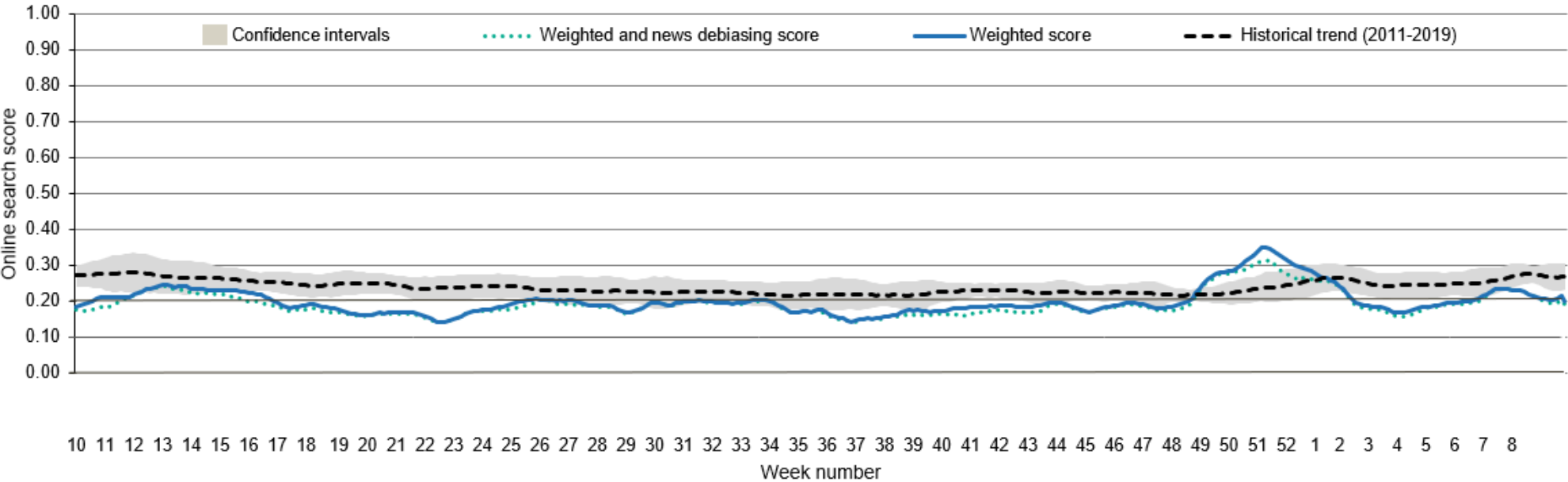


Google search queries

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 9, the overall and media-debiasing weighted Google search scores remained fairly stable compared with week 8 (Figure 29).

Figure 29: Normalised Google search score for COVID-19 symptoms, with weighted score for media-debiasing and historical trend, England



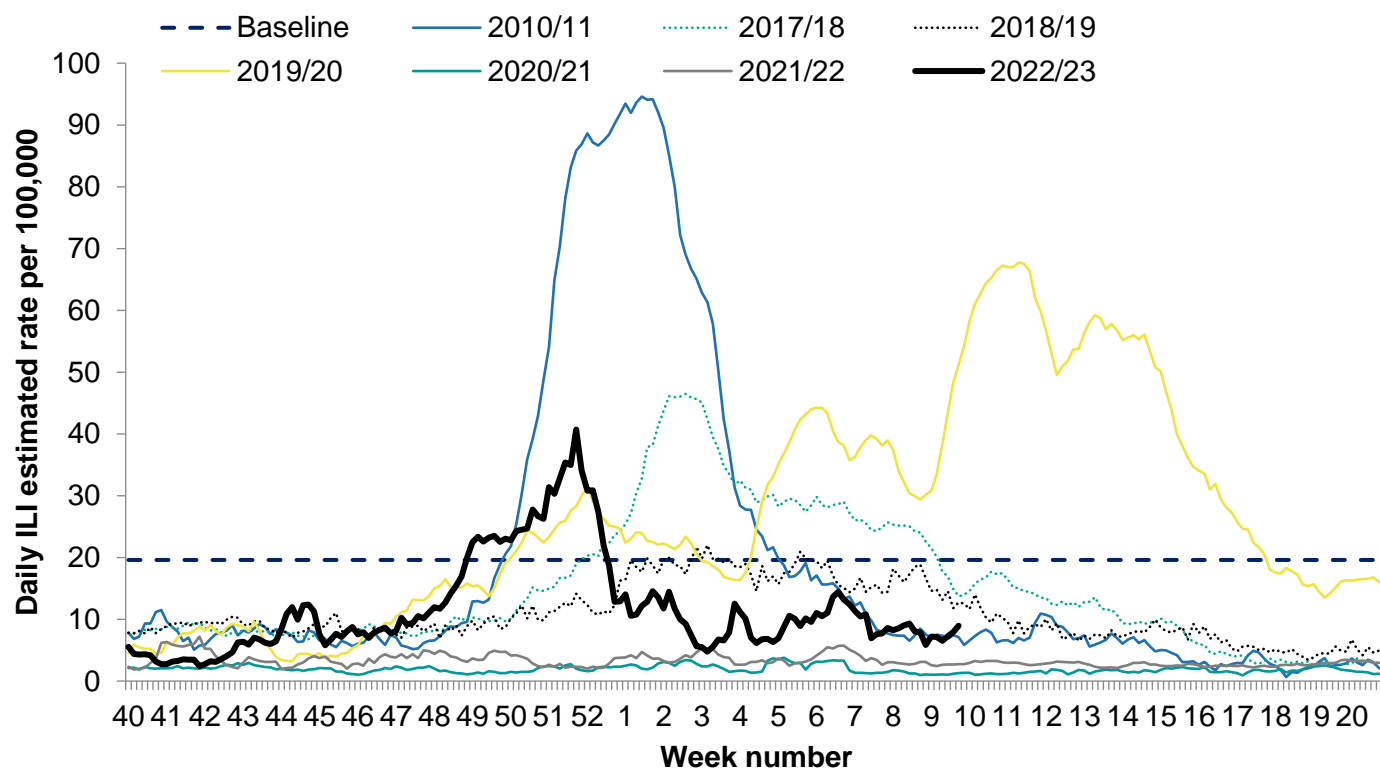
Flu Detector

FluDetector is a web-based model which assesses internet-based search queries for ILI in the general population.

Daily ILI rate estimates are based on uniformly averaged search query frequencies for a week-long period (including the current day and the 6 days before it).

For week 9, the daily ILI rate decreased slightly in week 9 compared with week 8 and remained below the baseline threshold of 19.6 per 100,000 for the 2022 to 2023 season (Figure 30).

Figure 30: Daily estimated ILI Google search query rates per 100,000 population, England



NHS 111

Please note that different syndromic surveillance indicators (NHS 111, GP in hours, GP out of hours and emergency department attendances) presented here 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.

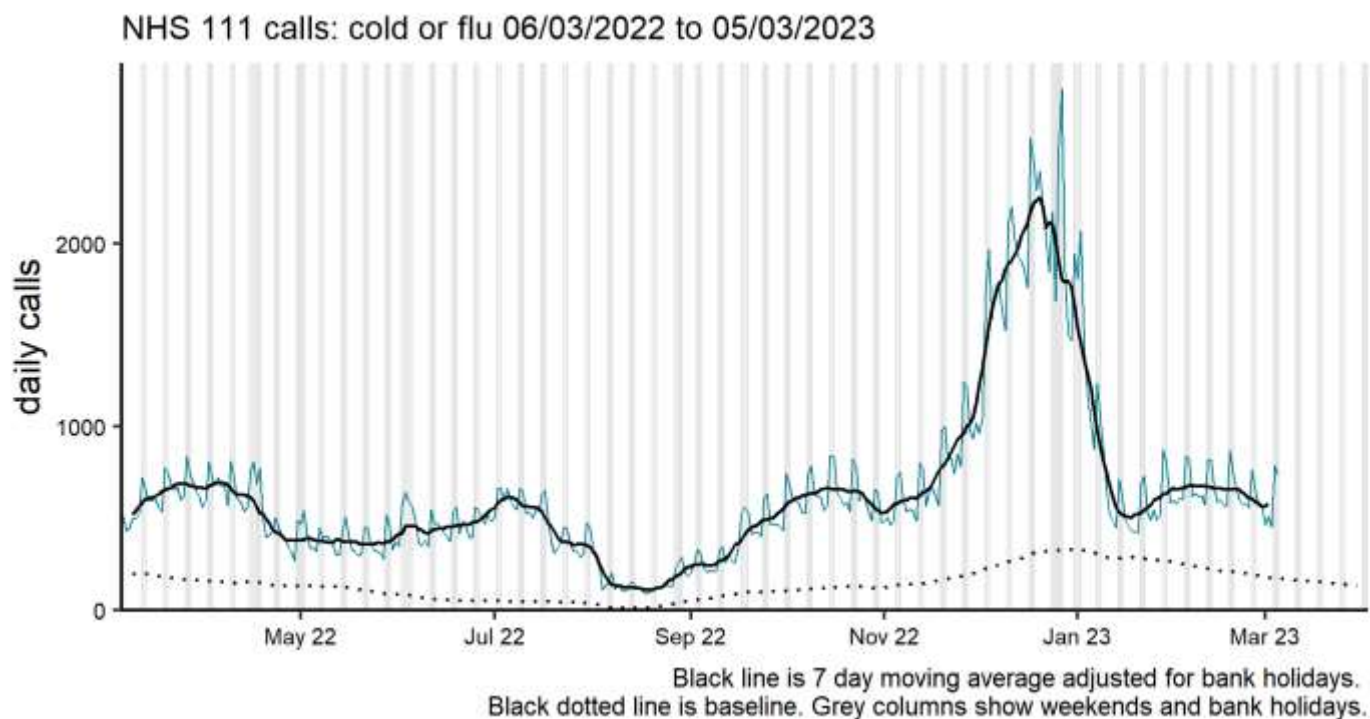
During week 9, NHS 111 calls for cough continued to decrease nationally. Calls for cold or flu increased slightly nationally, with small increases in those aged 1 to 4 years and 15 to 44 years (Figure 31 and 32).

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 31: 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

(a)



(b)

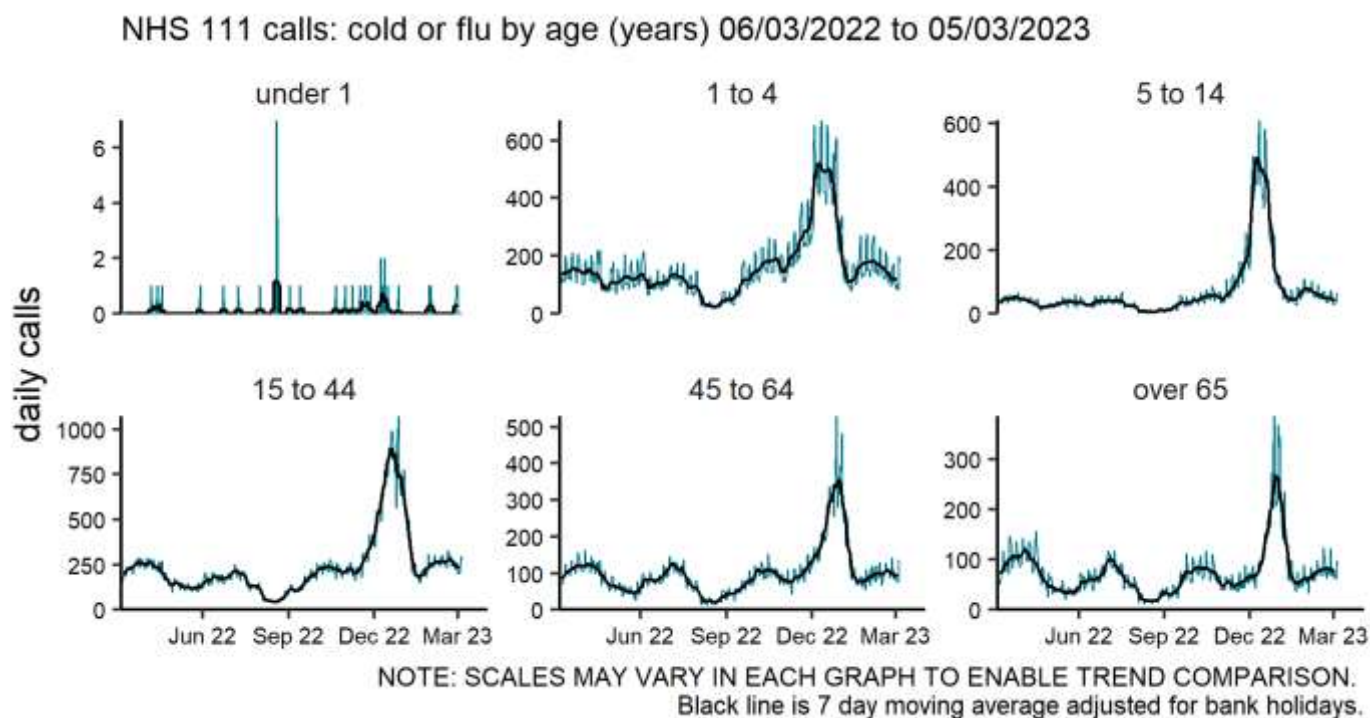
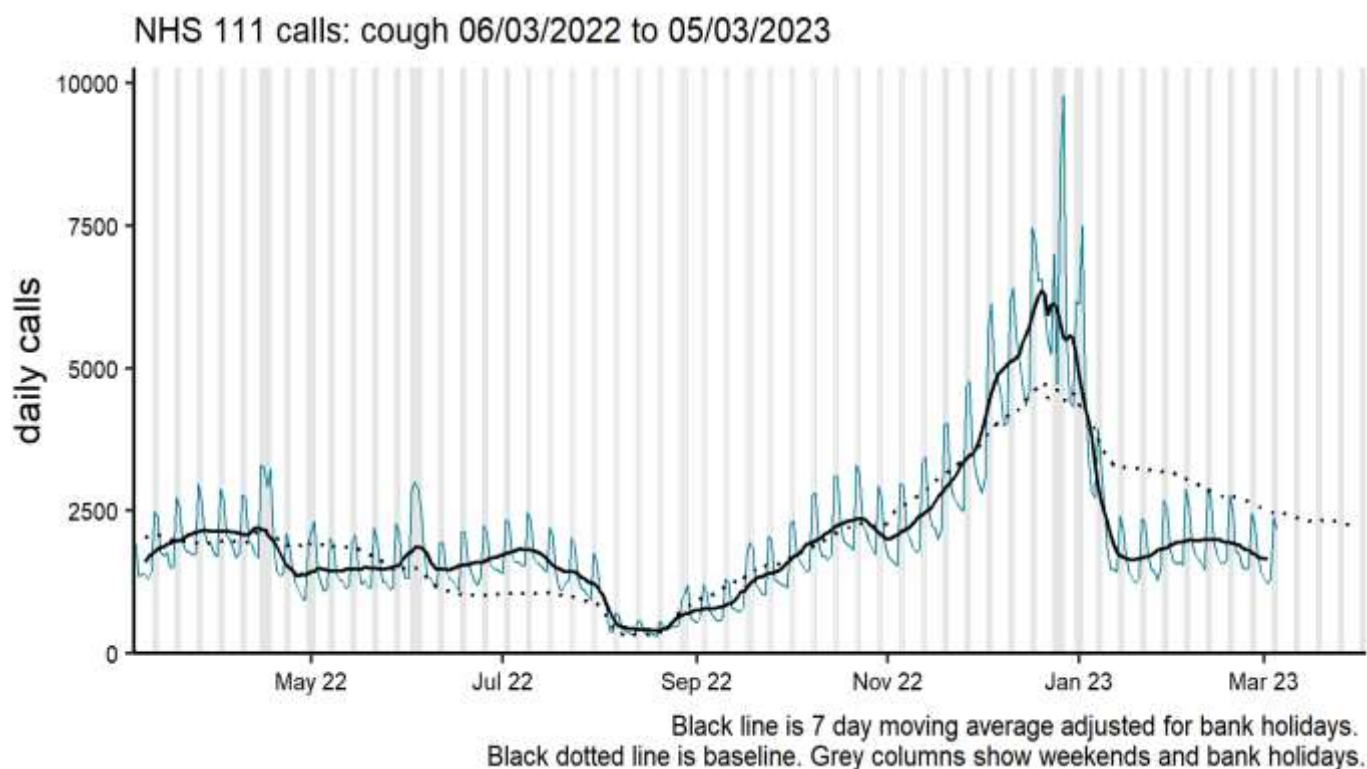
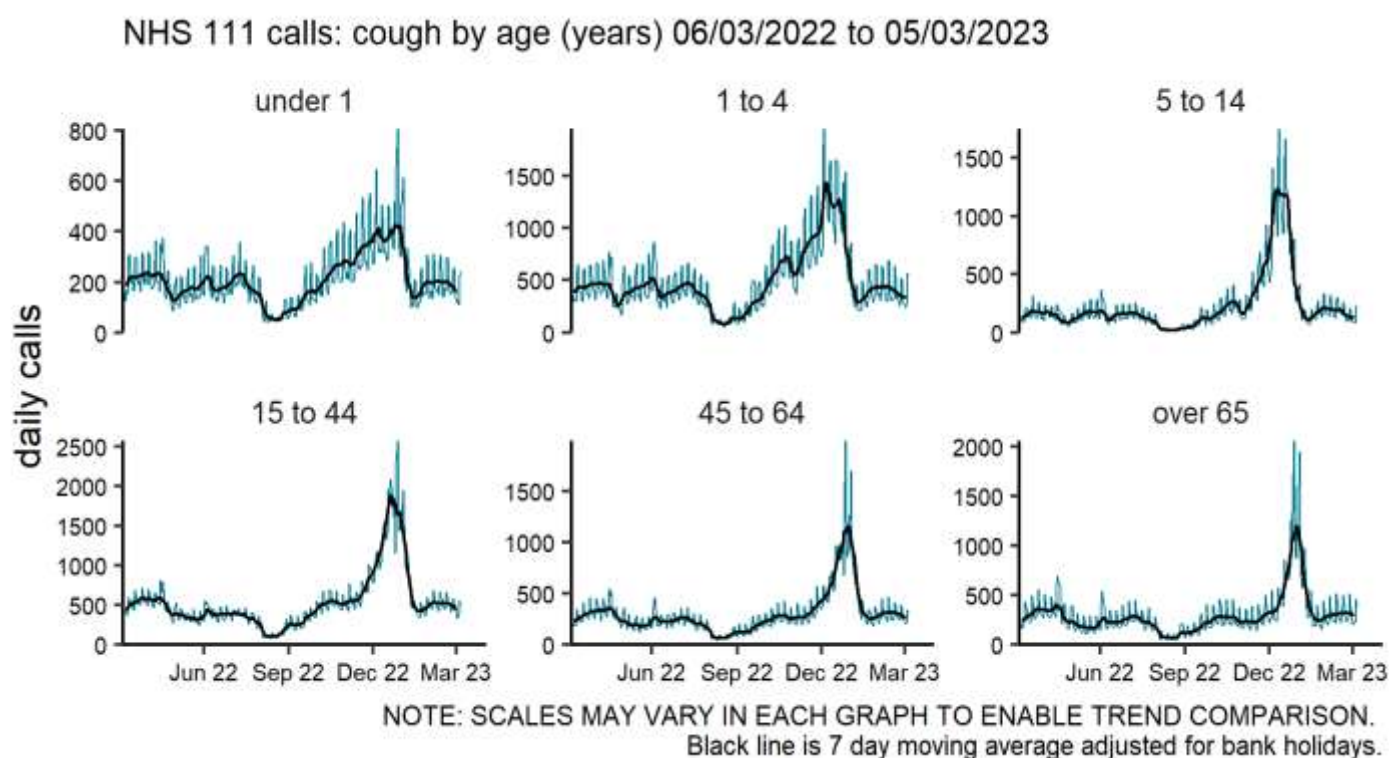


Figure 32: NHS 111 telephony indicators (and 7-day moving average) for number of daily cough calls, England (a) nationally and (b) by age group

(a)



(b)



Primary care surveillance

RCGP (England)

The weekly ILI consultation rate through the RCGP surveillance was 3.8 per 100,000 registered population in participating GP practices in week 9, compared with 4.6 per 100,000 in the previous week and remained within baseline activity levels (less than 11.47 per 100,000) (Figure 33). By age group, the highest rates were seen in 15 to 44 year olds (4.6 per 100,000) followed by 45 to 64 year olds (4.5 per 100,000). The lower respiratory tract infections (LRTI) consultation rate decreased to 63.7 per 100,000 in week 9 compared with 69.4 per 100,000 the previous week. The COVID-19 indicator rate increased to 36.3 per 100,000 in week 9 compared with 33.1 per 100,000 in the previous week (Figure 34).

Figure 33: RCGP influenza-like illness (ILI) consultation rates, all ages, England

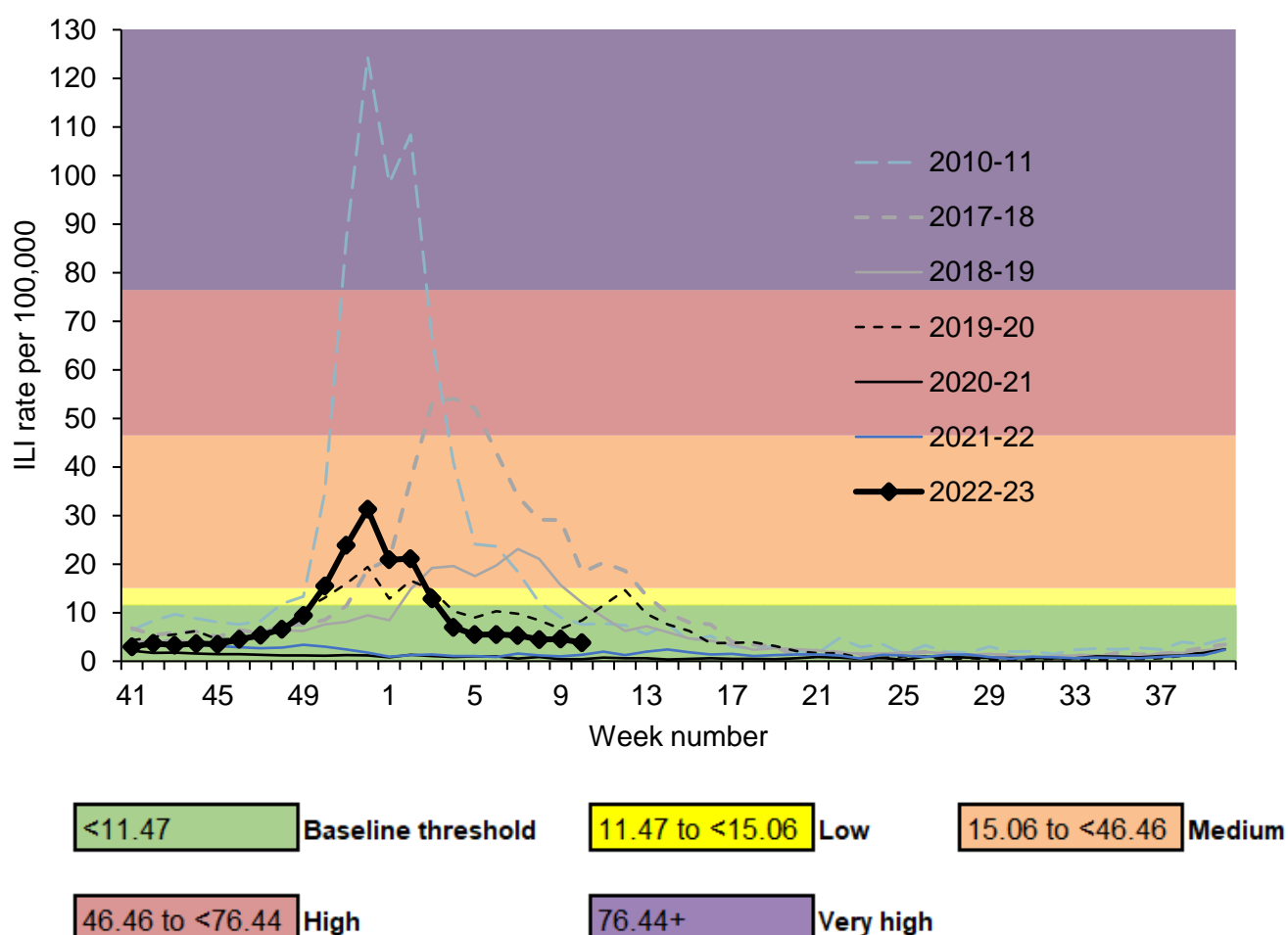
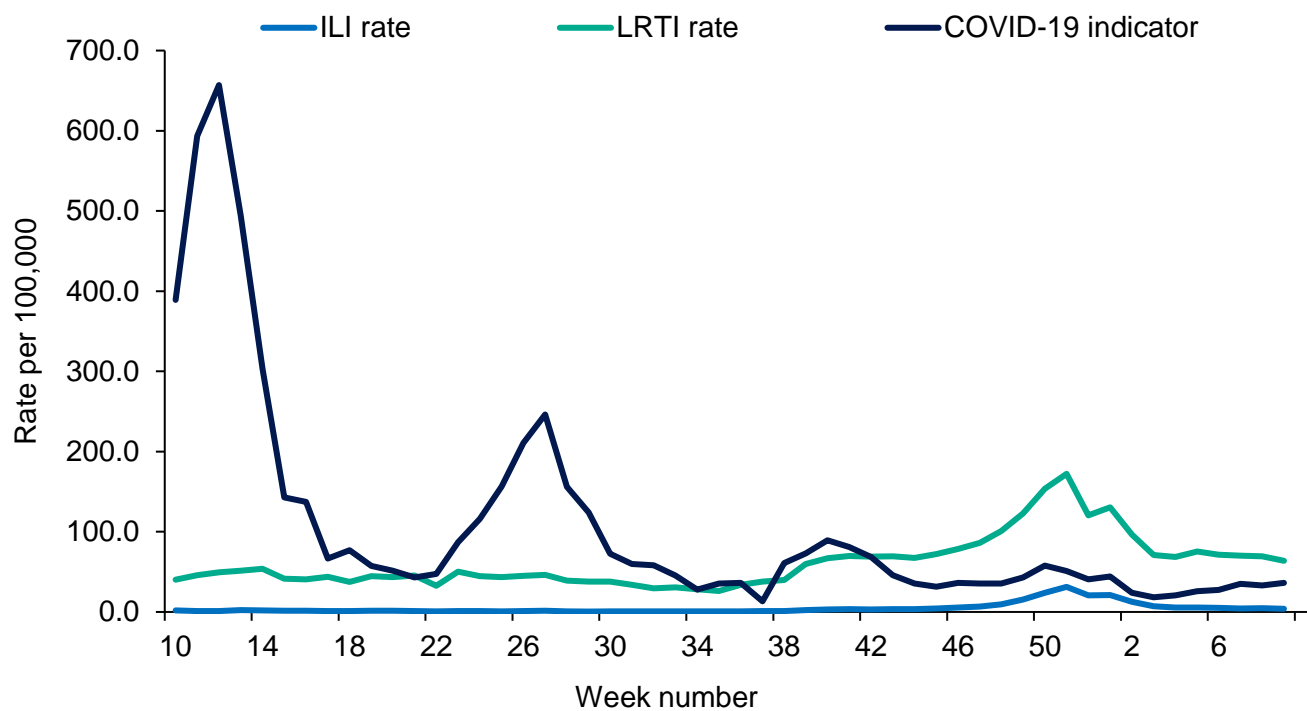


Figure 34: RCGP ILI, LRTI and COVID-19 indicator rates, England



UK

Overall, weekly ILI consultations remained at baseline activity levels in all devolved administrations.

By age group, the highest incidence was in people aged 15 to 44 years old in England (4.6 per 100,000), in children under 1 year old in Scotland (4.8 per 100,000), in children under 1 year old in Northern Ireland (13.1 per 100,000) and in children aged between 1 and 4 years old in Wales (6.8 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																					
	40	41	42	43	44	45	46	47	48	49	50	51	52	1	2	3	4	5	6	7	8	9
England (RCGP)	3.0	3.7	3.3	3.6	3.5	4.5	5.3	6.6	9.4	15.5	23.9	31.3	20.9	21.1	12.9	7.0	5.5	5.5	5.3	4.5	4.6	3.8
Wales	3.5	2.8	3.9	4.8	6.3	7.0	3.5	4.3	7.8	14.1	24.2	39.1	34.8	22.8	14.3	6.8	3.3	5.2	4.9	4.5	3.2	3.9
Scotland	2.1	1.8	4.0	3.8	3.5	4.8	4.1	3.1	5.9	7.2	11.1	20.2	31.9	20.7	15.9	9.7	5.7	3.8	6.1	3.9	5.9	3.0
Northern Ireland	1.3	2.2	1.8	3.5	3.0	3.7	3.5	4.9	5.0	6.0	9.4	17.8	14.0	17.7	10.3	6.4	3.3	4.2	3.4	2.6	3.3	2.7

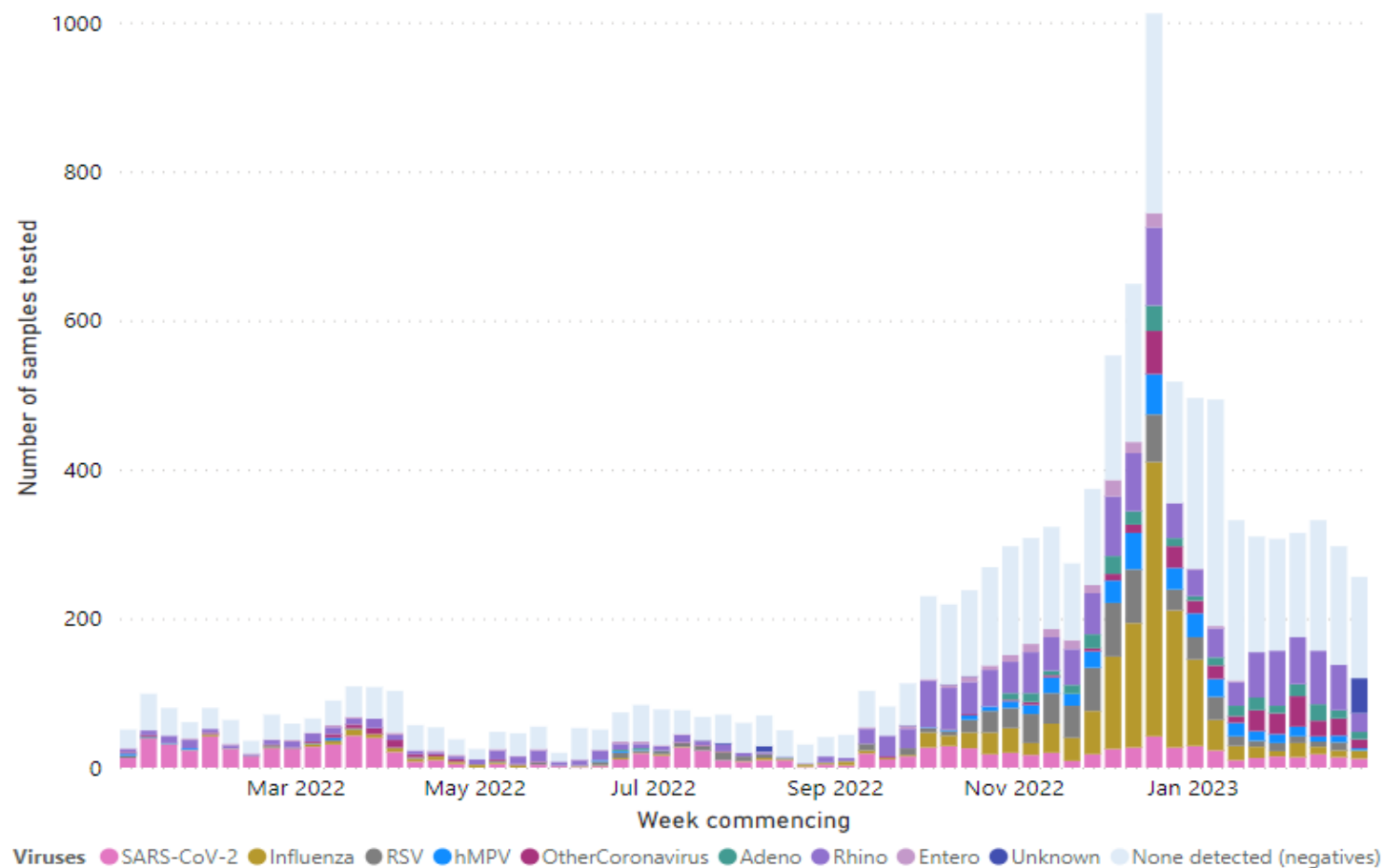
The Moving Epidemic Method (MEM) has been adopted by the European Centre for Disease Prevention and Control to calculate thresholds for GP ILI consultations for the start of influenza activity (based on 10 seasons excluding 2020 to 2021), in a standardised approach across Europe.

Sentinel swabbing scheme in England

Based on the date samples were received in the reference laboratory, in week 9 2023 (week commencing 27th February 2023) 250 samples were tested through the GP sentinel swabbing scheme in England, of which 136 samples tested positive (Figure 35). Among all positive samples, 34.3% were for rhinovirus, 16.4% for SARS-CoV-2, 16.4% for seasonal coronaviruses, 15.1% for influenza, 13.7% for adenovirus and 4.1% for hMPV (Figure 36).

Based on the date samples were taken, influenza positivity decreased, SARS-CoV-2 positivity increased, and RSV positivity remained stable in week 9 (Figure 38). Data for the most recent week will be updated retrospectively. Positivity (%) is not calculated when the total number tested is less than 20 (Figure 38).

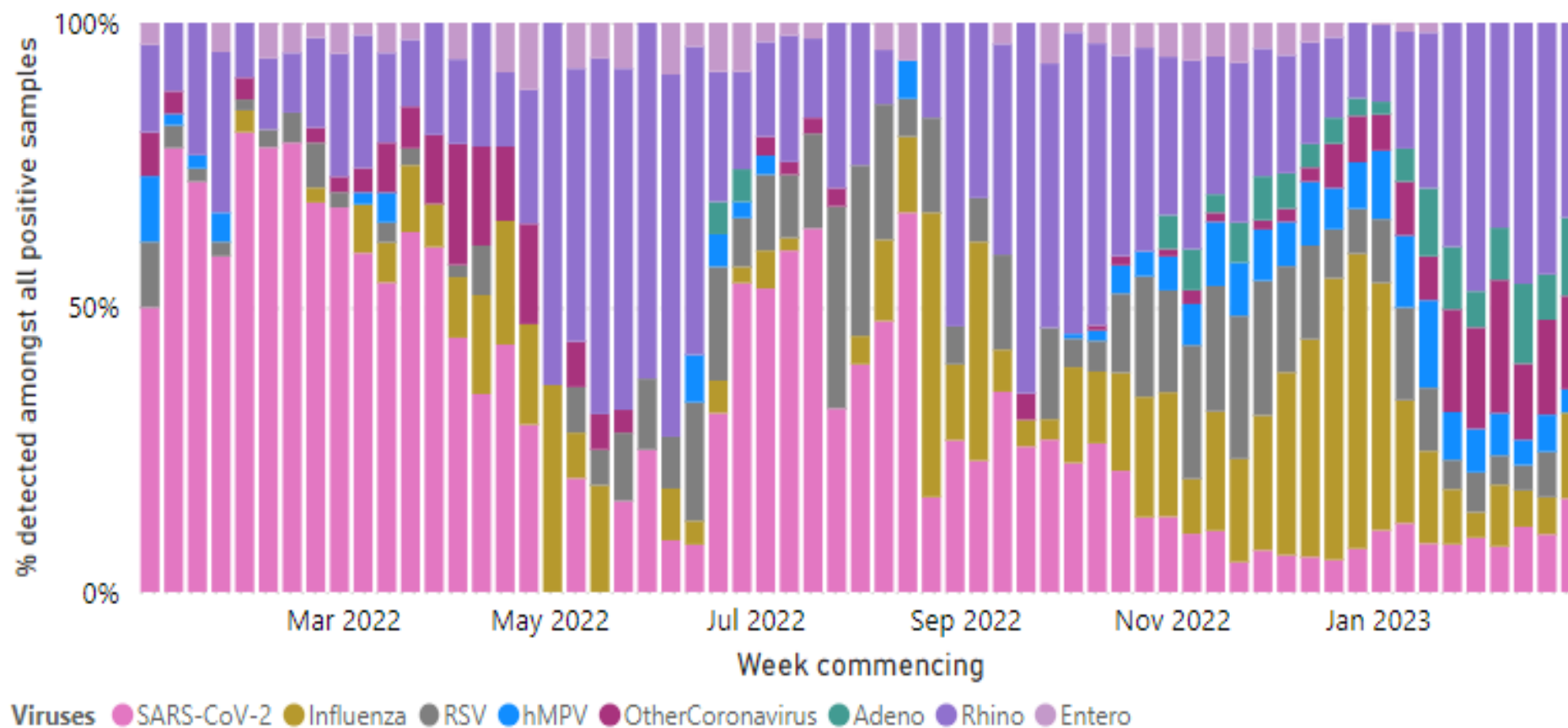
Figure 35: Number of samples tested for SARS-Cov-2, influenza, and other respiratory viruses in England by week, GP sentinel swabbing



Unknown category corresponds to samples with no result yet.

Source: RCGP Research and Surveillance Centre sentinel primary care practices ([RCGP Virology Dashboard](#))

Figure 36. Proportion of detections of SARS-CoV-2, influenza, and other respiratory viruses amongst virologically positive respiratory surveillance samples in England by week, GP sentinel swabbing scheme



Source: RCGP Research and Surveillance Centre sentinel primary care practices ([RCGP Virology Dashboard](#))

Figure 37: Number of positives samples for influenza A (by subtype) and B in England by week, GP sentinel swabbing

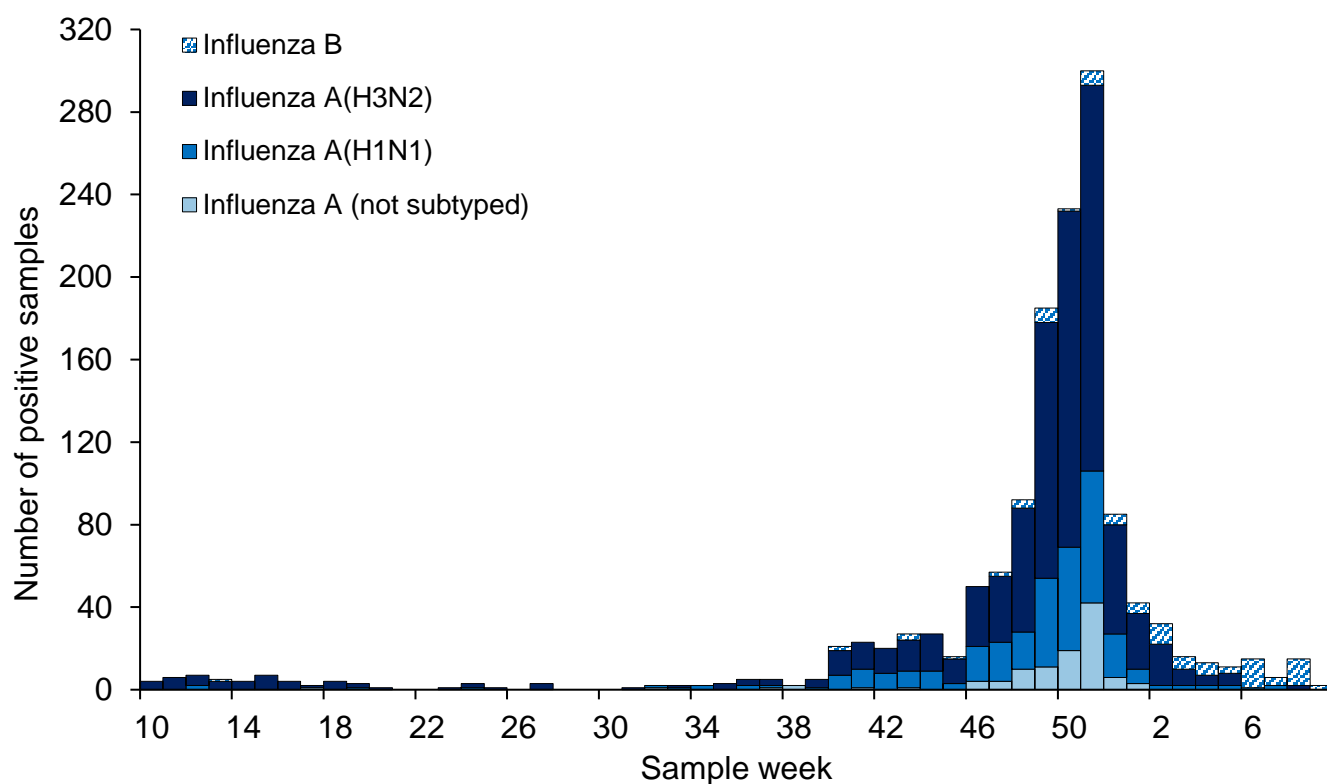
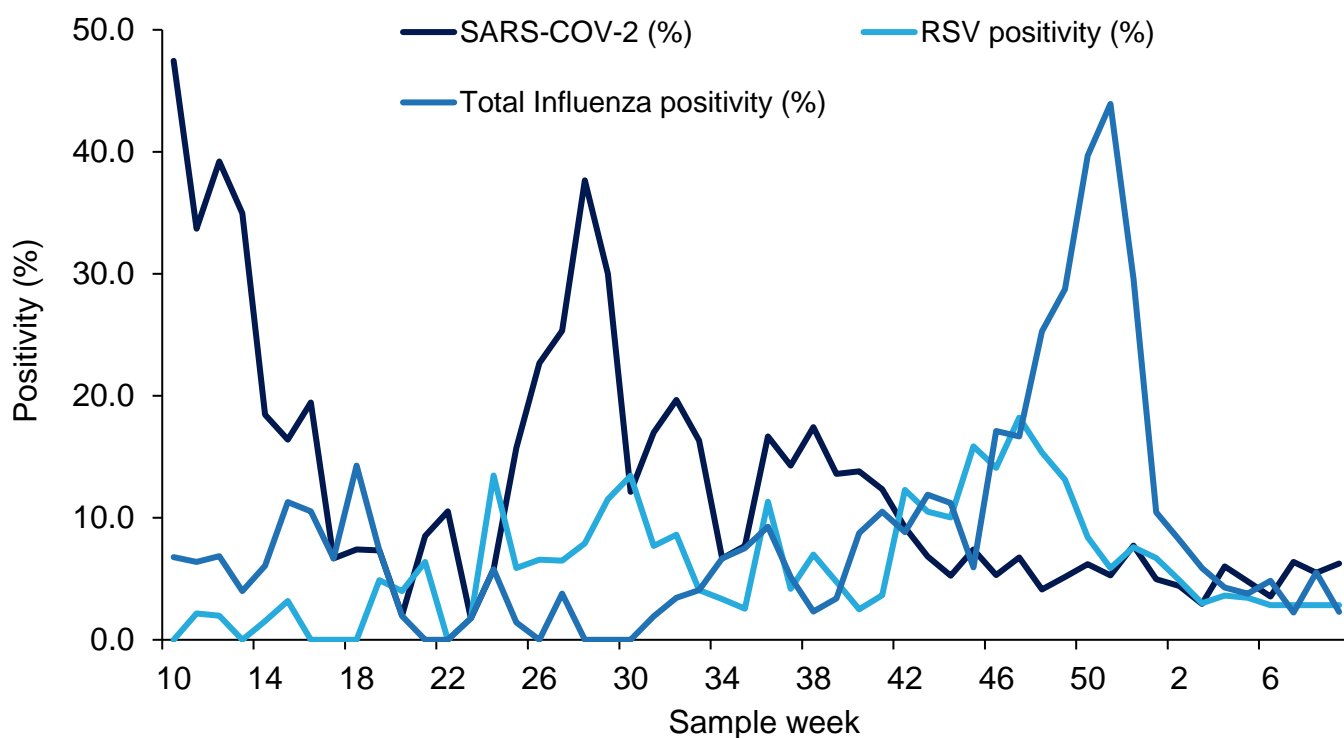


Figure 38: Weekly positivity (%) for COVID-19, Influenza and RSV in England by week, GP sentinel swabbing



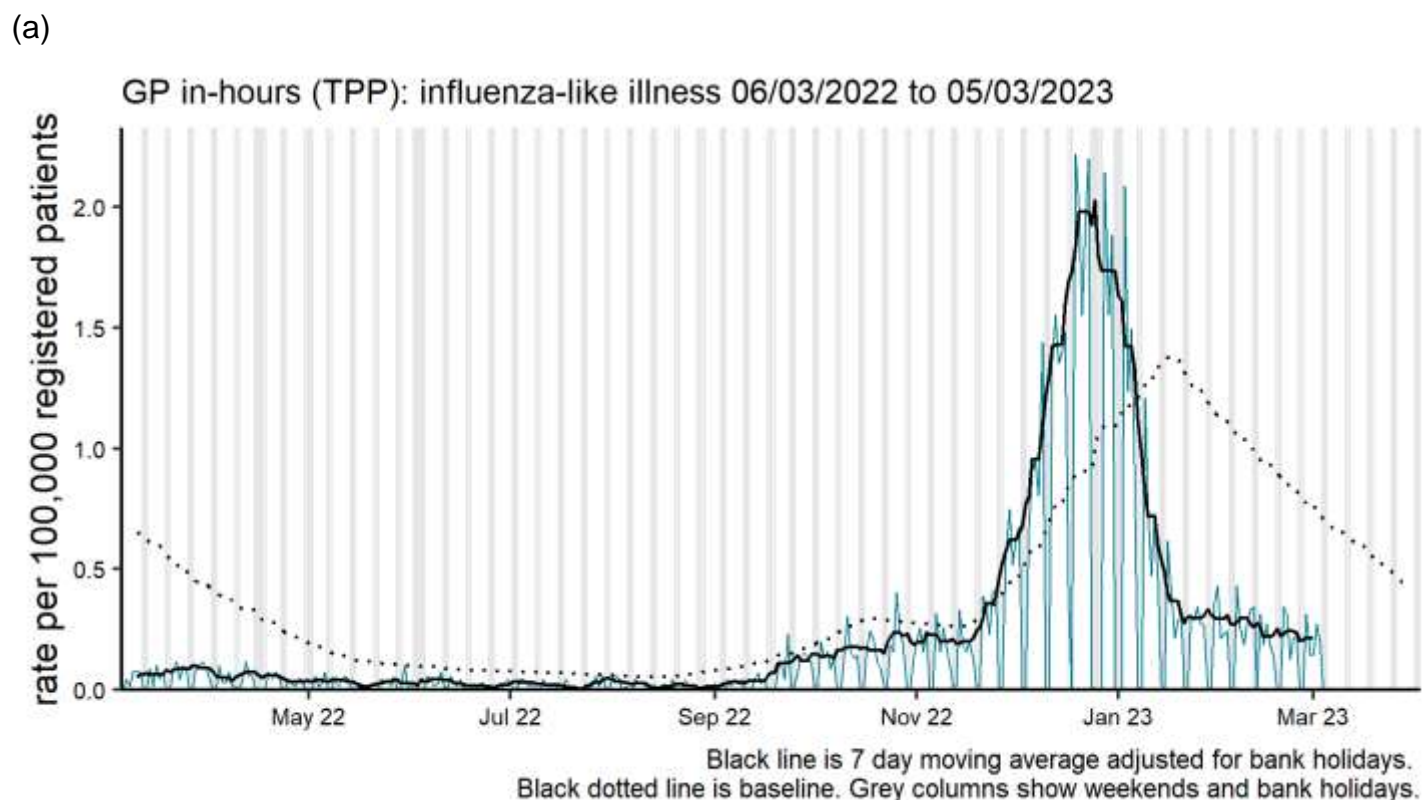
GP In Hours, Syndromic Surveillance

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

During week 9, the rate of GP in hours consultations for influenza-like illness remained stable and below the baseline levels (Figure 39).

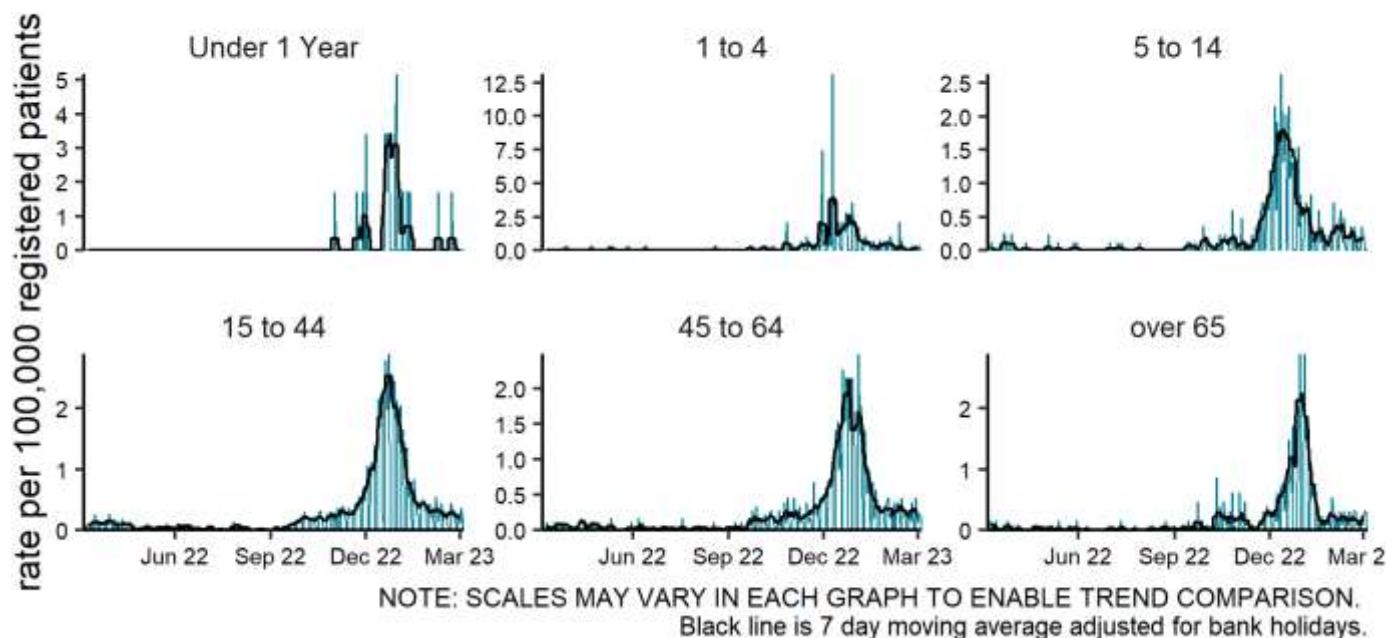
Further indicators and information about caveats are available from the [GP In Hours Syndromic Surveillance bulletin](#).

Figure 39: GPIH clinical indicators for influenza-like illness GP consultations, England (a) nationally, (b) by age group and (c) by UKHSA centre



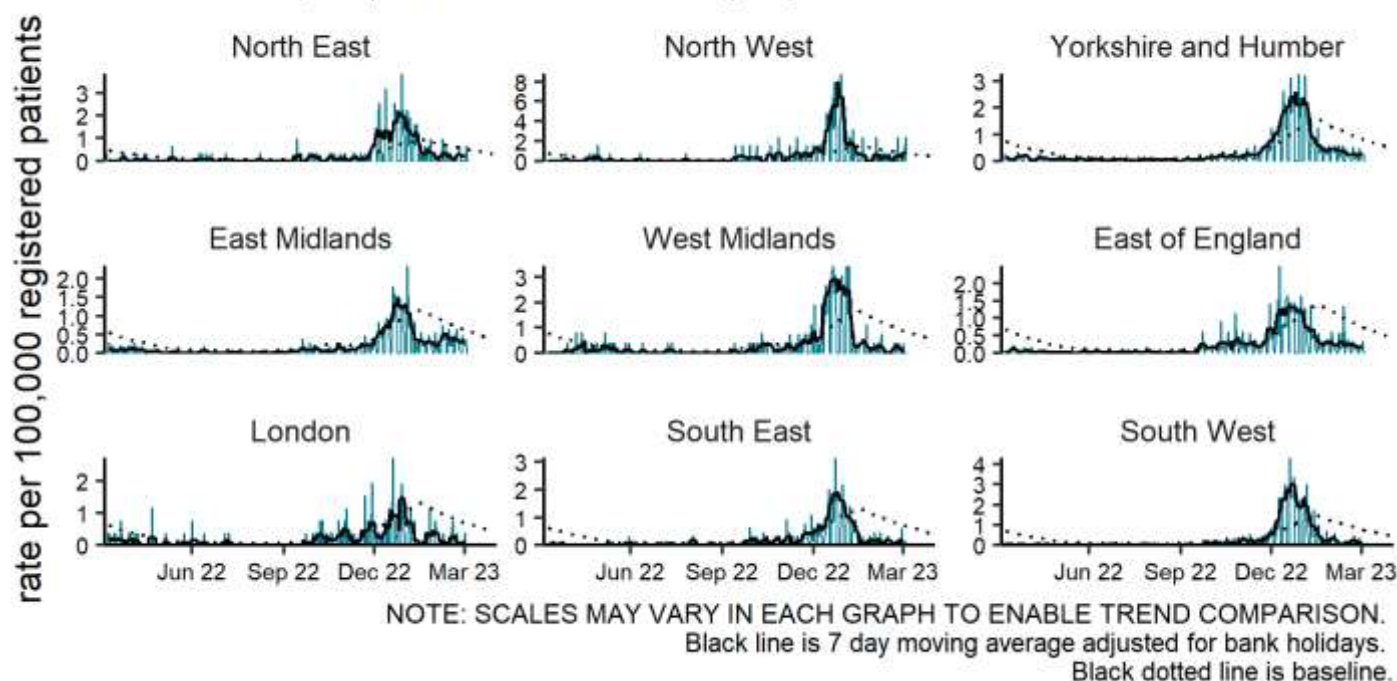
(b)

GP in-hours (TPP): influenza-like illness by age (years) 06/03/2022 to 05/03/2023



(c)

GP in-hours (TPP): influenza-like illness by region 06/03/2022 to 05/03/2023



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.

Due to a disruption with a GPOOH clinical software system provider, GPOOH data from 4 August onwards is not currently available. Data from GPOOH systems will be added back into this report once available. The most recent data is available in [previous reports](#).

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 2016 to 2017 to the 2021 to 2022 seasons (data from 2020 to 2021 was excluded due to the COVID-19 pandemic). These thresholds have been applied to data from the 2022 to 2023 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 for SARS-CoV-2 through NHS settings has been paused from 31 August 2022, therefore SARI-Watch data should be interpreted with this in mind.

Similarly trends in influenza hospitalisation and critical care admission should be interpreted in the context of testing practices. In recent years there has been wider implementation of rapid molecular point of care tests for influenza in hospital settings. From a public health surveillance perspective it is important to consider a step change in influenza case ascertainment in more recent years.

On 16 February 2023, UKHSA issued a reminder to acute Trusts that influenza A samples from critical care should be subtyped in line with existing guidance. This may impact on the ratio of subtyped to unsubtyped in surveillance data.

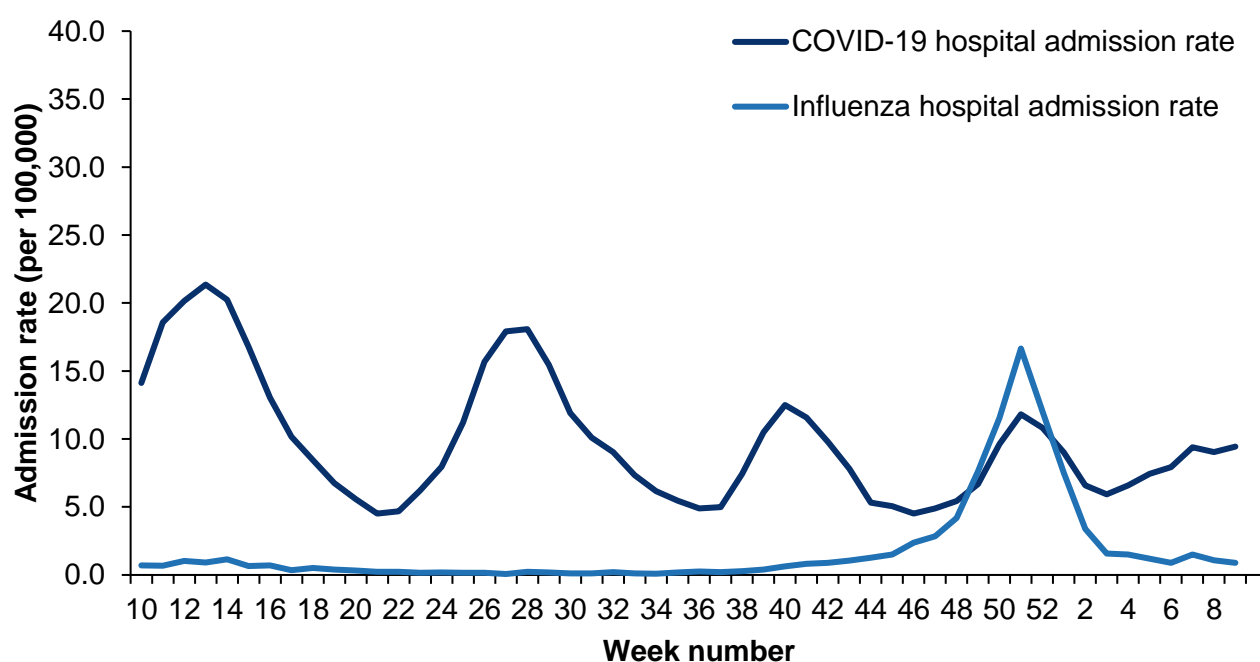
Hospitalisations, SARI Watch

In week 9 (ending 5 March 2023), the overall weekly hospital admission rate for COVID-19 increased slightly to 9.44 per 100,000 compared with 9.03 per 100,000 in the previous week.

By UKHSA centre, the highest hospital admission rate for COVID-19 was observed in the North East. By age group, the highest hospital admission rate for confirmed COVID-19 continues to be in those aged 85 year olds and over.

In week 9 (ending 5 March 2023), the overall weekly hospital admission rate for influenza decreased to 0.89 per 100,000 compared with 1.07 per 100,000 in the previous week. The rates from week 4 2023 onwards were revised due to further retrospective updates from trusts. The rate in the latest week has returned to baseline activity levels. By UKHSA Centre, the highest hospitalisation rate was observed in London (3.03 per 100,000). By age group, the highest hospital admission rate for influenza was in the under 5 years old age group (3.13 per 100,000). There were 80 new hospital admissions to sentinel Trusts for influenza (10 influenza A(not subtyped) and 70 influenza B) in week 9.

Figure 40: Weekly overall hospital admission rates of new COVID-19 and influenza positive cases per 100,000 population reported through SARI Watch, England

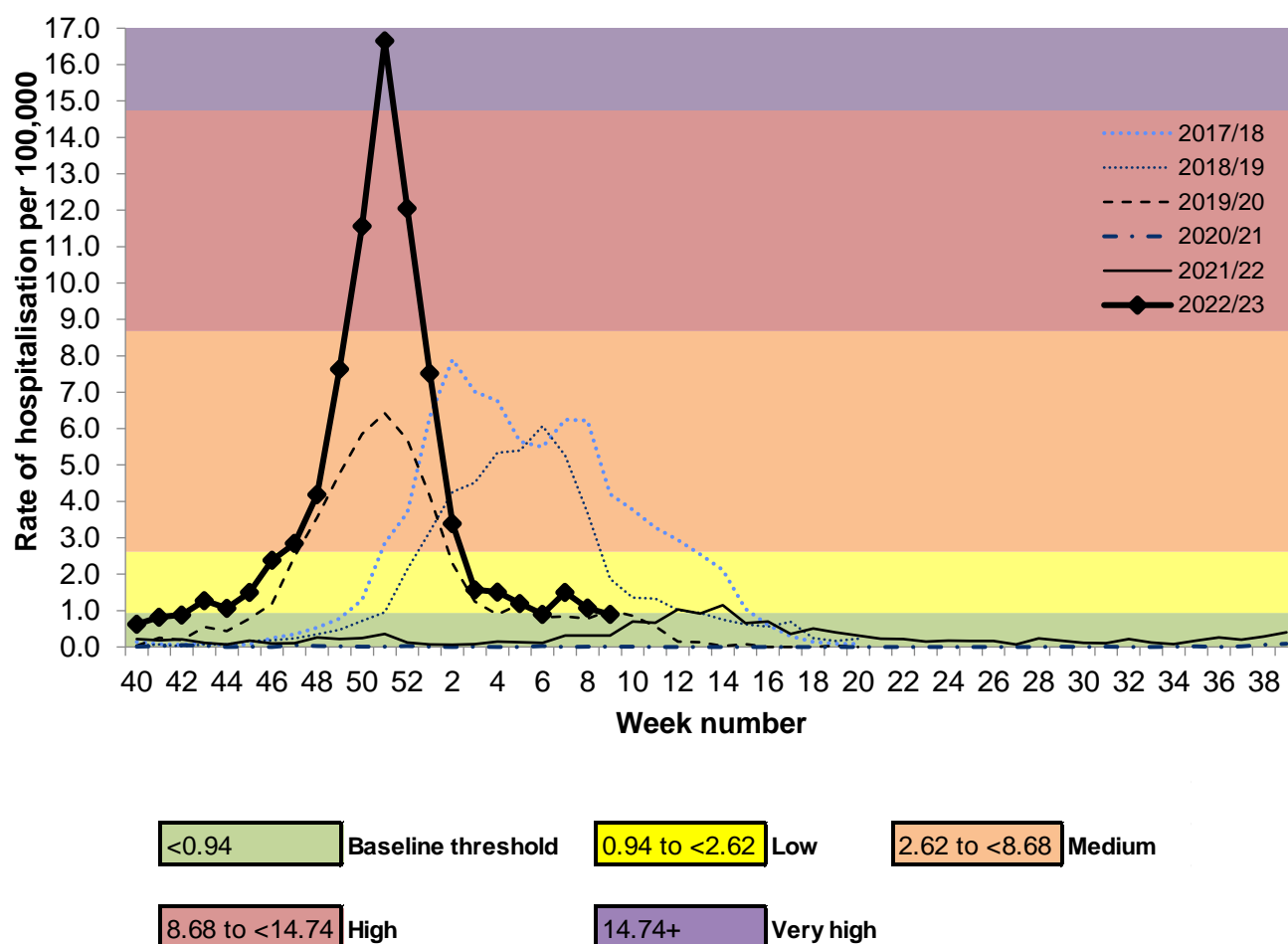


* Influenza hospital admission rate based on 21 sentinel NHS trusts for week 9

* COVID-19 hospital admission rate based on 88 NHS trusts for week 9

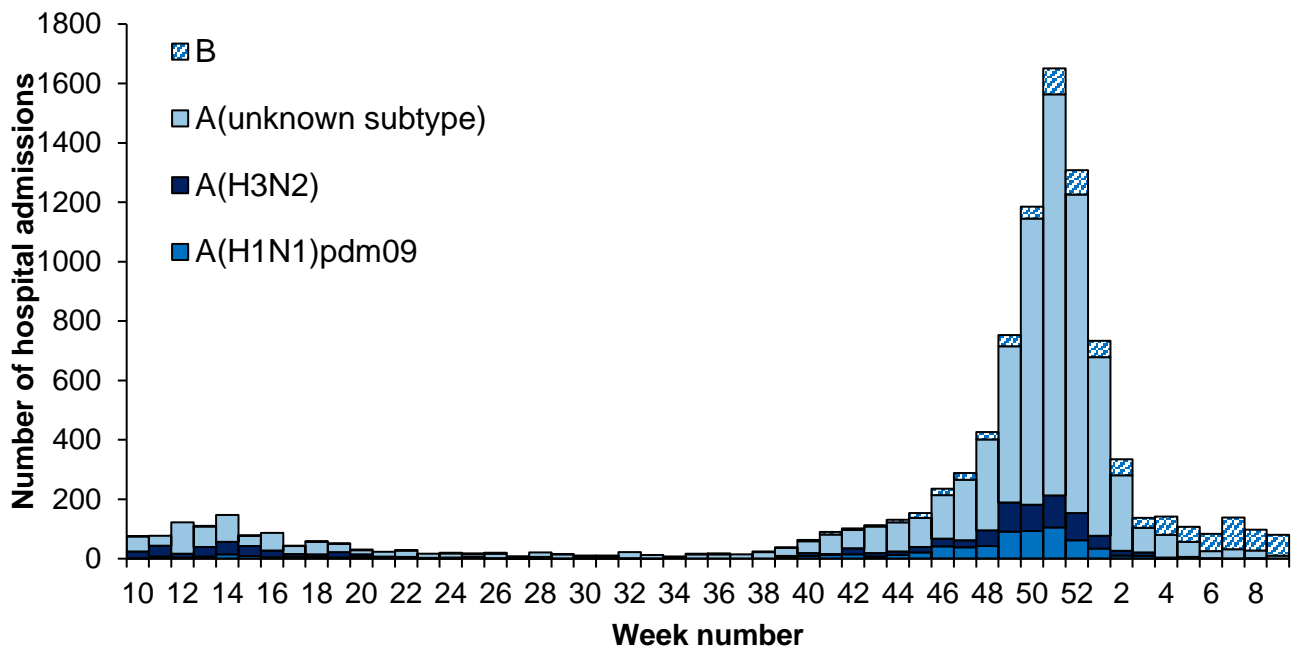
* SARI Watch data is provisional

Figure 41: Weekly overall influenza hospital admission rates per 100,000 trust catchment population with MEM thresholds, SARI Watch, England



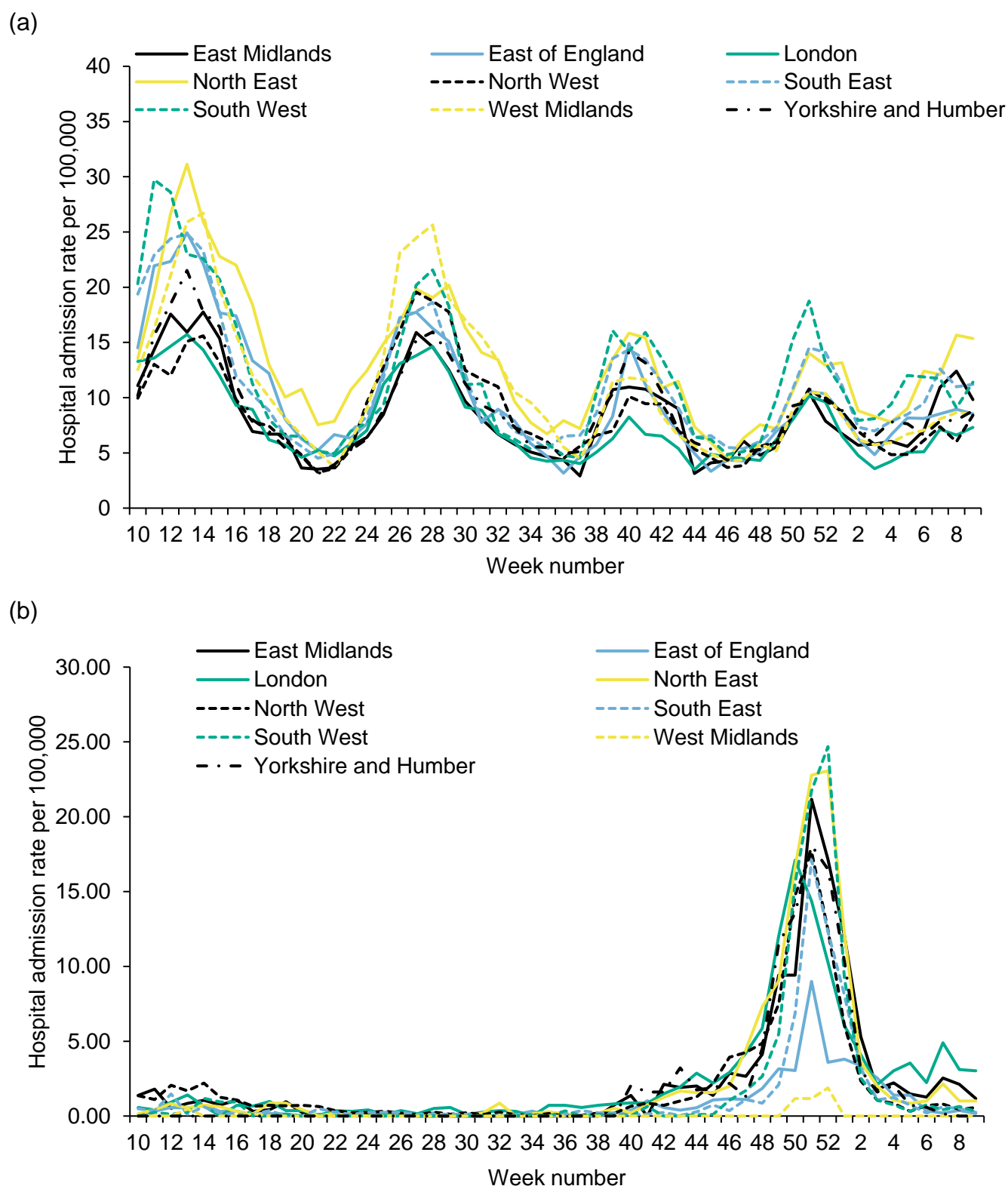
* MEM thresholds are based on data from the 2016 to 2017 to the 2021 to 2022 seasons (data from 2020 to 2021 was excluded due to the COVID-19 pandemic).

Figure 42: Weekly influenza hospital admissions by influenza type, SARI Watch, England



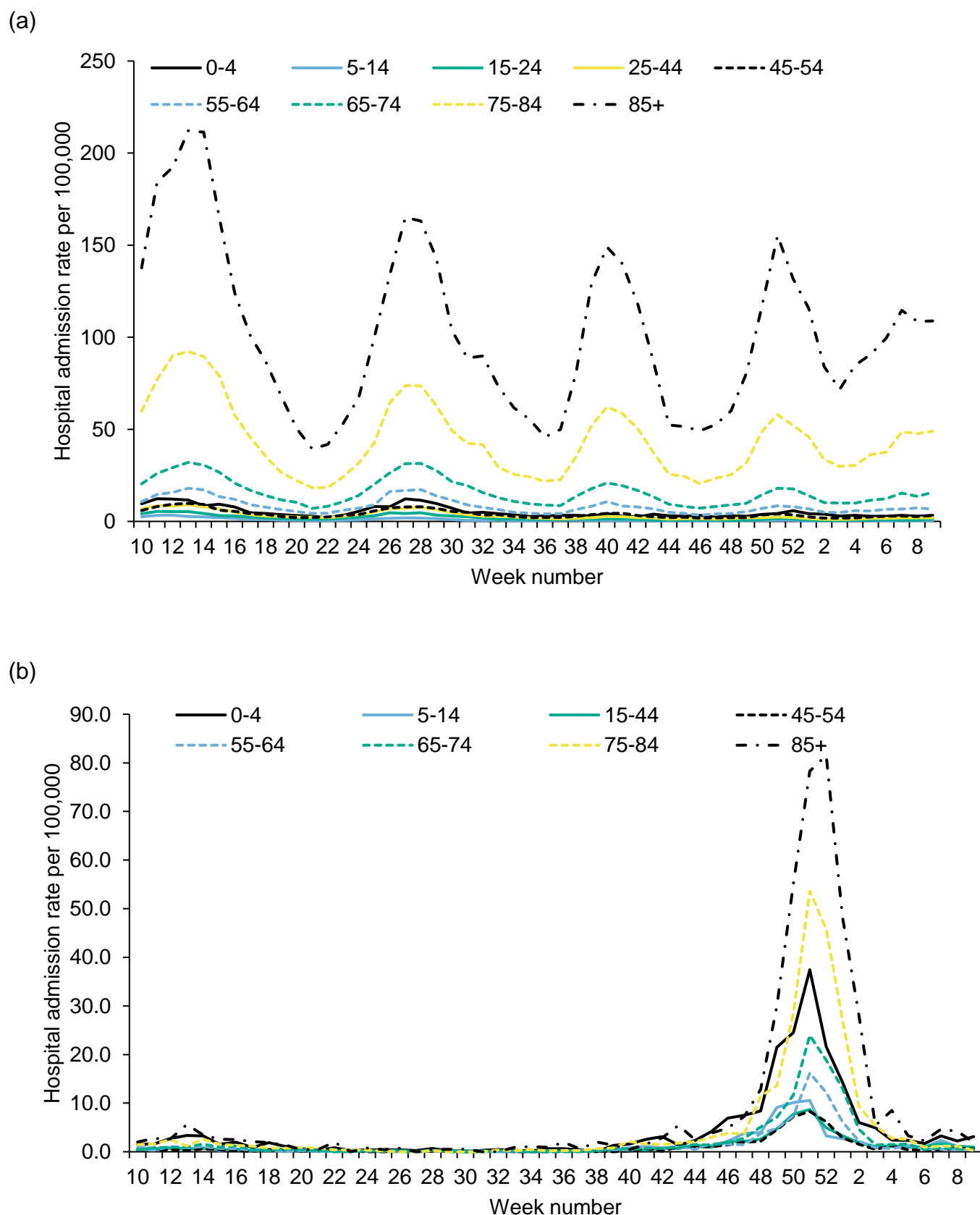
*Number of influenza hospital admissions based on sentinel NHS trusts

Figure 43: Weekly hospital admission rate by UKHSA centre for new (a) COVID-19 positive cases and (b) influenza reported through SARI Watch*



* Rates in some regions may not include all influenza surveillance sentinel sites from week to week

Figure 44: Weekly hospital admission rate by age group for new (a) COVID-19 positive cases and (b) influenza reported through SARI Watch



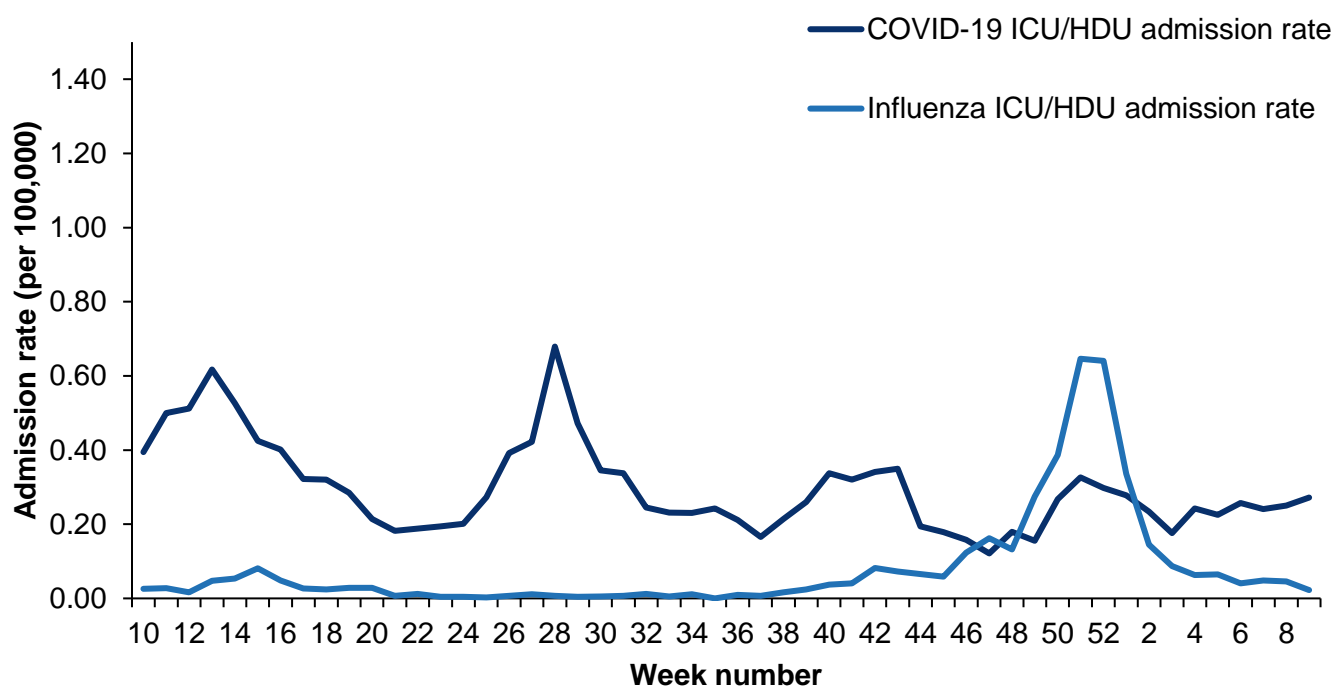
ICU or HDU admissions, SARI Watch

In week 9 (ending 5 March 2023), the overall weekly ICU or HDU admission rates for COVID-19 remained low although increased slightly to 0.27 per 100,000, compared with 0.25 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 group, the highest ICU or HDU admission rates for COVID-19 were observed in the 75 to 84 year olds.

In week 9, the overall ICU or HDU rate for influenza decreased to 0.02 per 100,000 compared with 0.05 per 100,000 in the previous week. The rate in the latest week remained at baseline activity levels. There were 9 new case reports of an ICU or HDU admission for influenza in week 9 (1 influenza A(not subtyped) and 8 influenza B).

Figure 45: Weekly overall ICU or HDU admission rates of new COVID-19 and influenza positive cases per 100,000 population reported through SARI Watch, England



* Influenza ICU or HDU admission rate based on 93 NHS trusts for week 9

* COVID-19 ICU or HDU admission rate based on 83 NHS trusts for week 9

* SARI Watch data is provisional

Figure 46: Weekly overall influenza ICU or HDU admission rates per 100,000 trust catchment population with MEM thresholds, SARI Watch, England

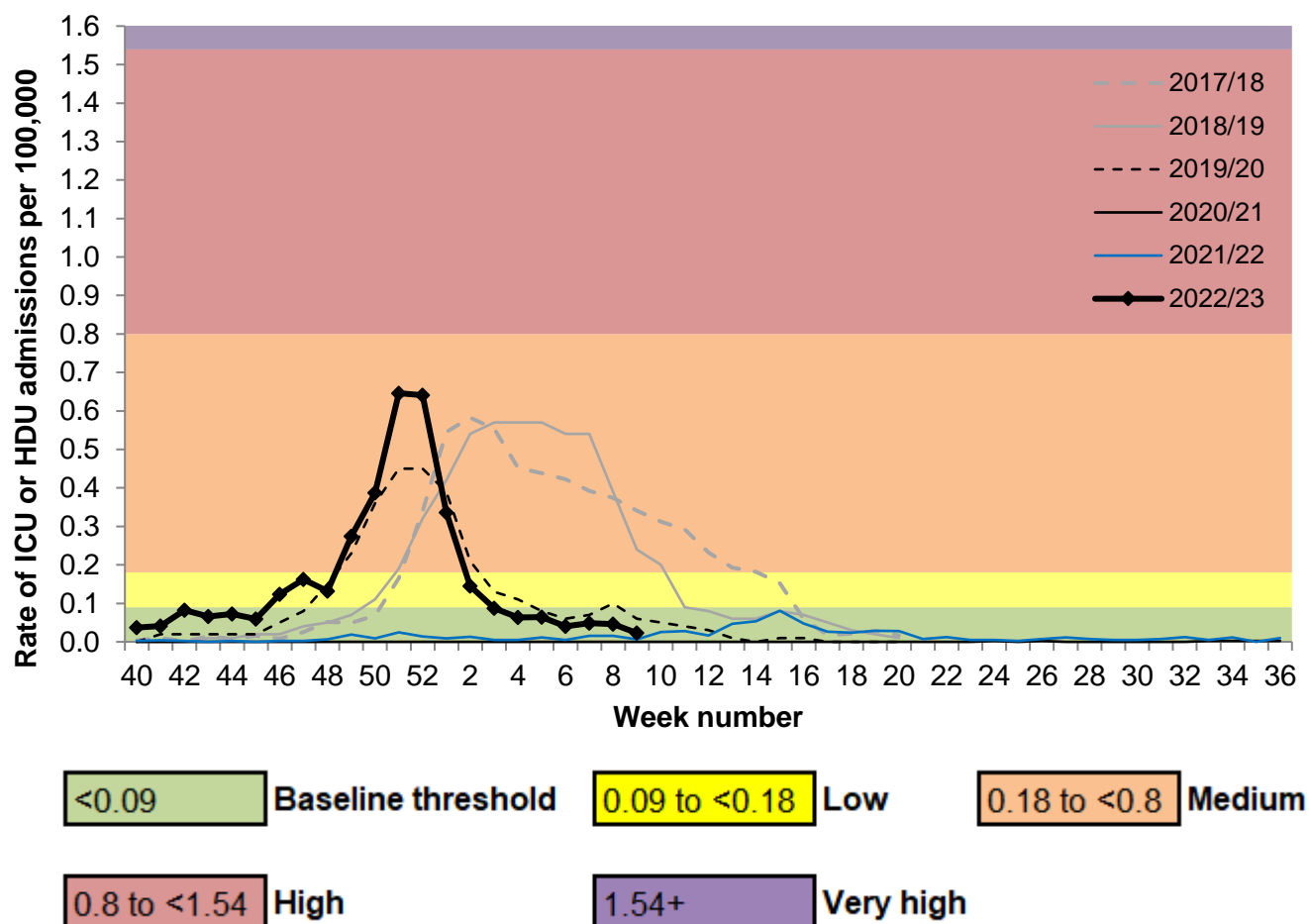


Figure 47: Weekly influenza ICU or HDU admissions by influenza type, SARI Watch, England

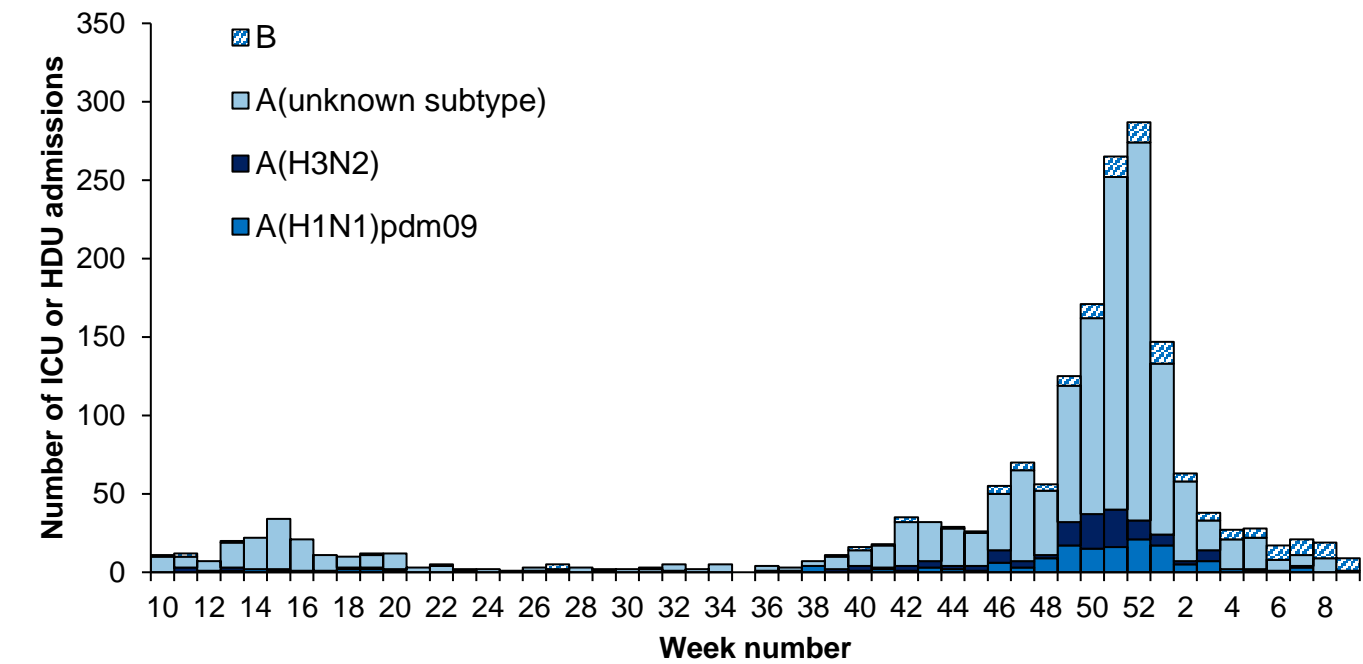
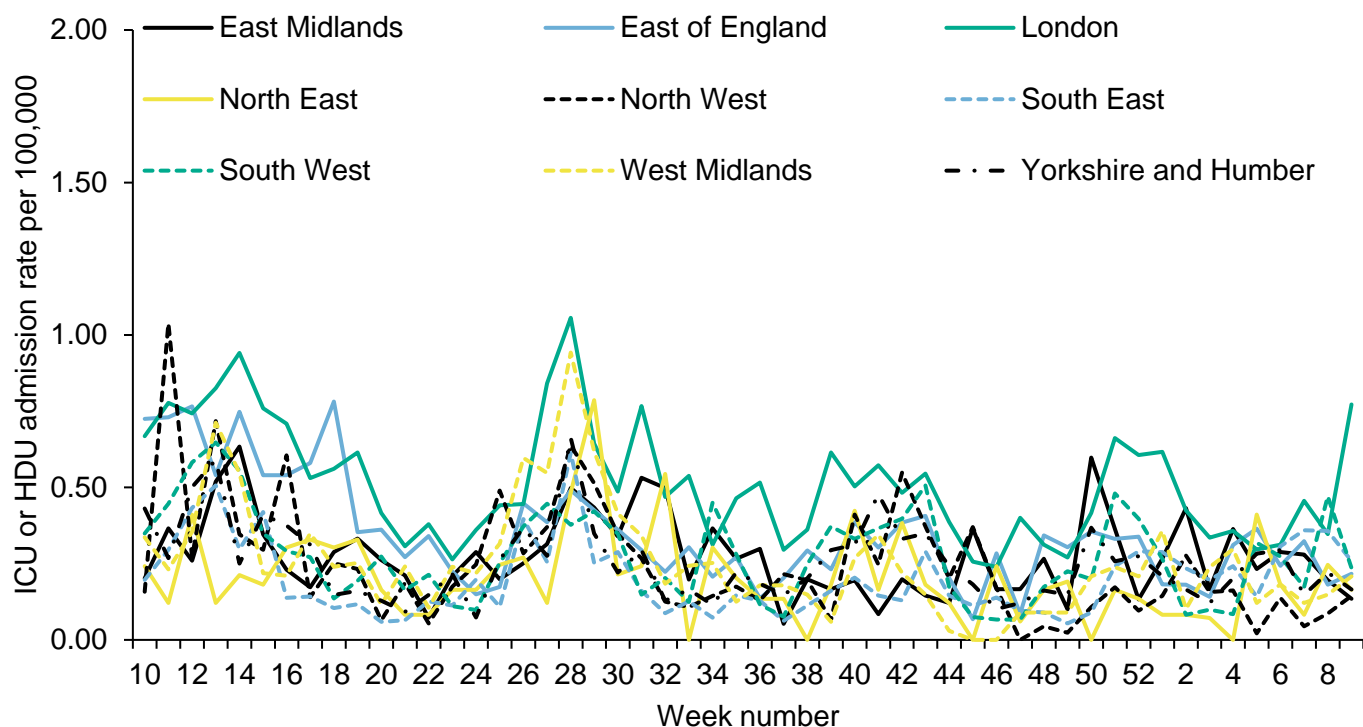


Figure 48: Weekly ICU or HDU admission rate by UKHSA centre for new (a) COVID-19 positive cases and (b) influenza, reported through SARI Watch

(a)



(b)

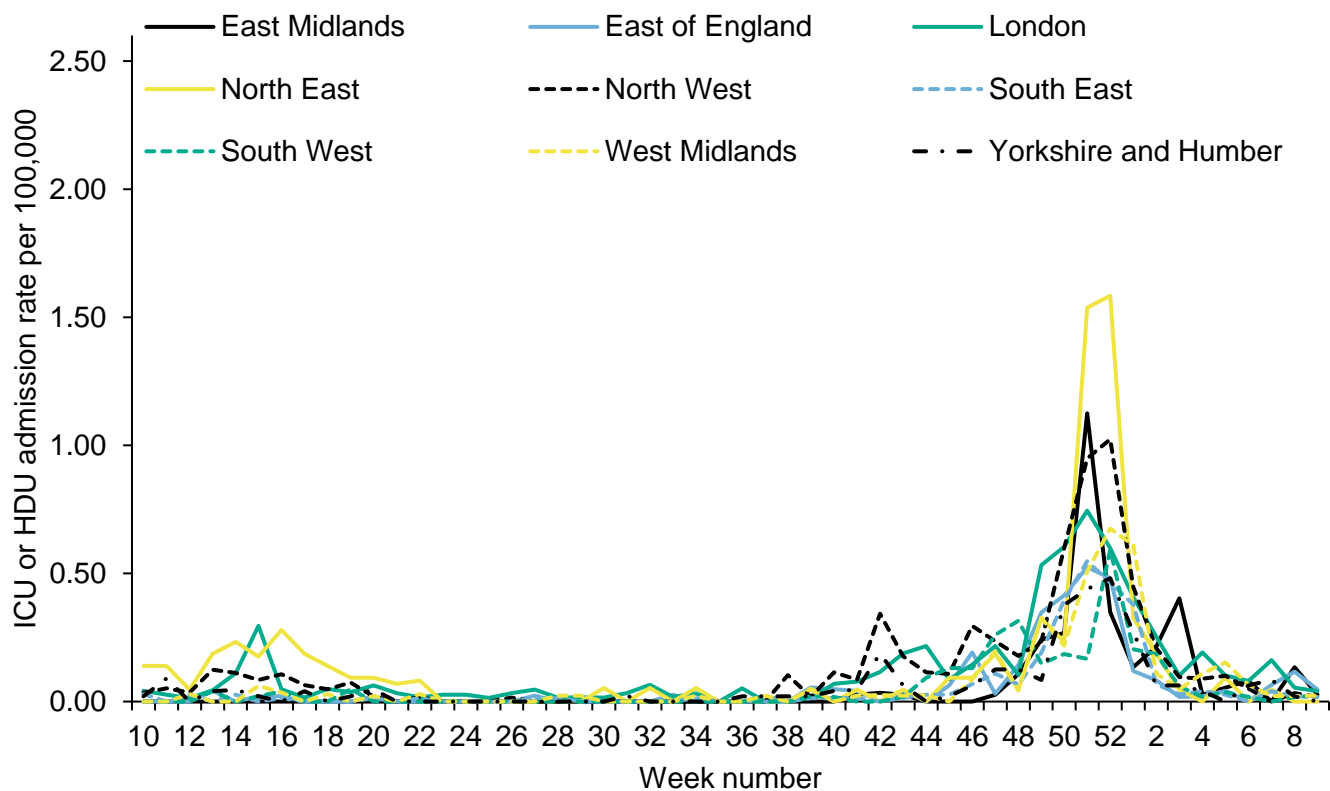
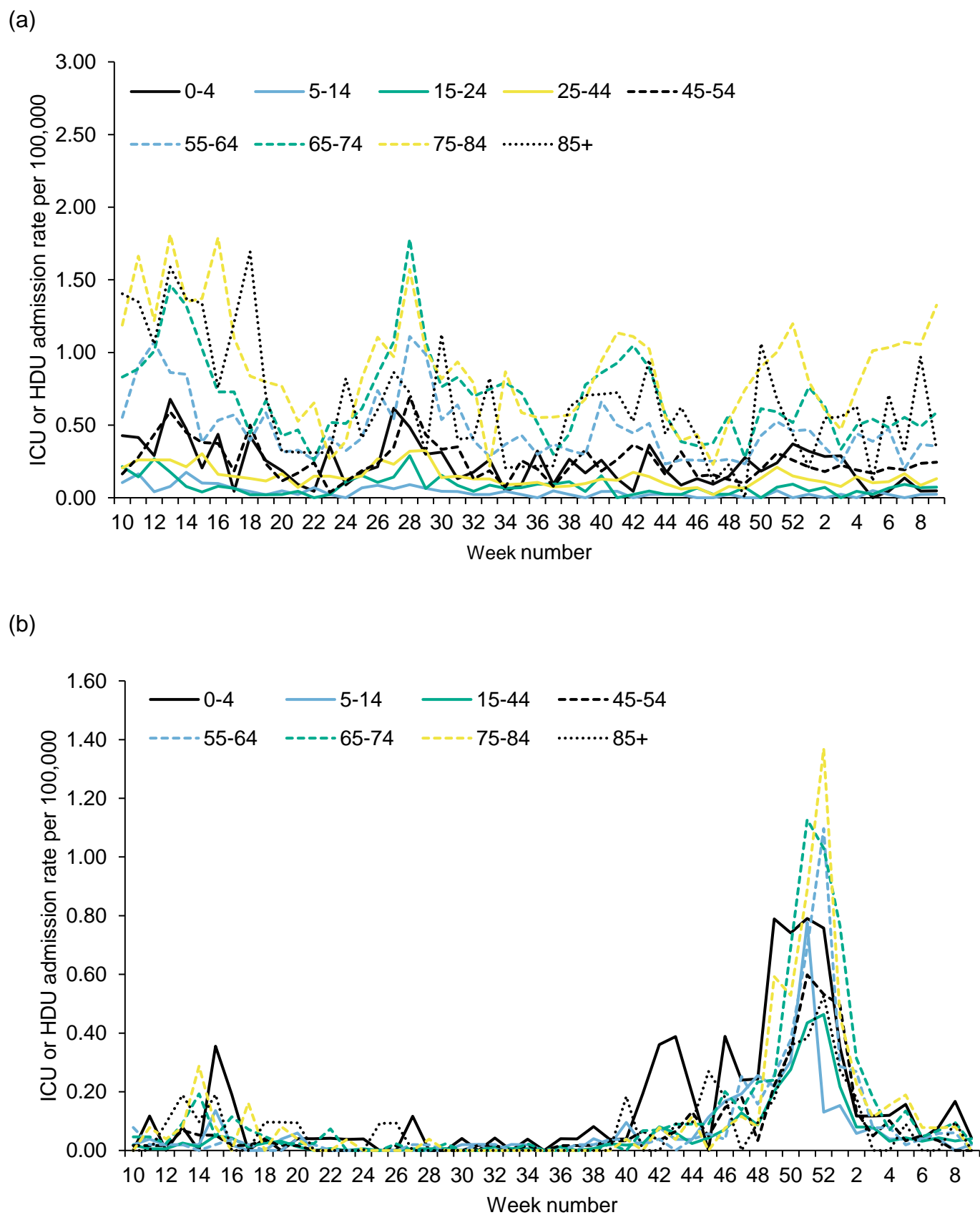


Figure 49: Weekly ICU or HDU admission rate by age group for new (a) COVID-19 positive cases and (b) influenza, reported through SARI Watch

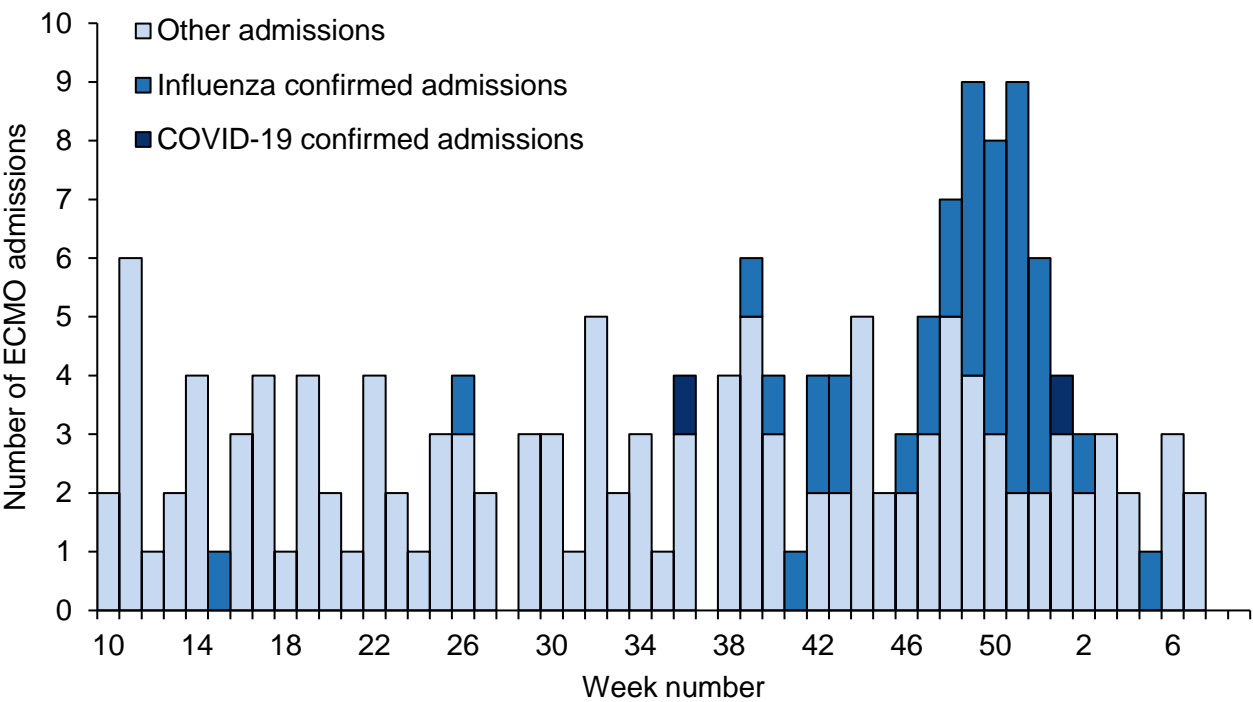


ECMO, SARI Watch

There were no new ECMO admissions reported in week 9 from the 7 Severe Respiratory Failure (SRF) centres in the UK (Figure 50).

Figure 50: Laboratory confirmed ECMO admissions (COVID-19, influenza and non-COVID-19 confirmed) to Severe Respiratory Failure centres in the UK

* SARI Watch data is provisional

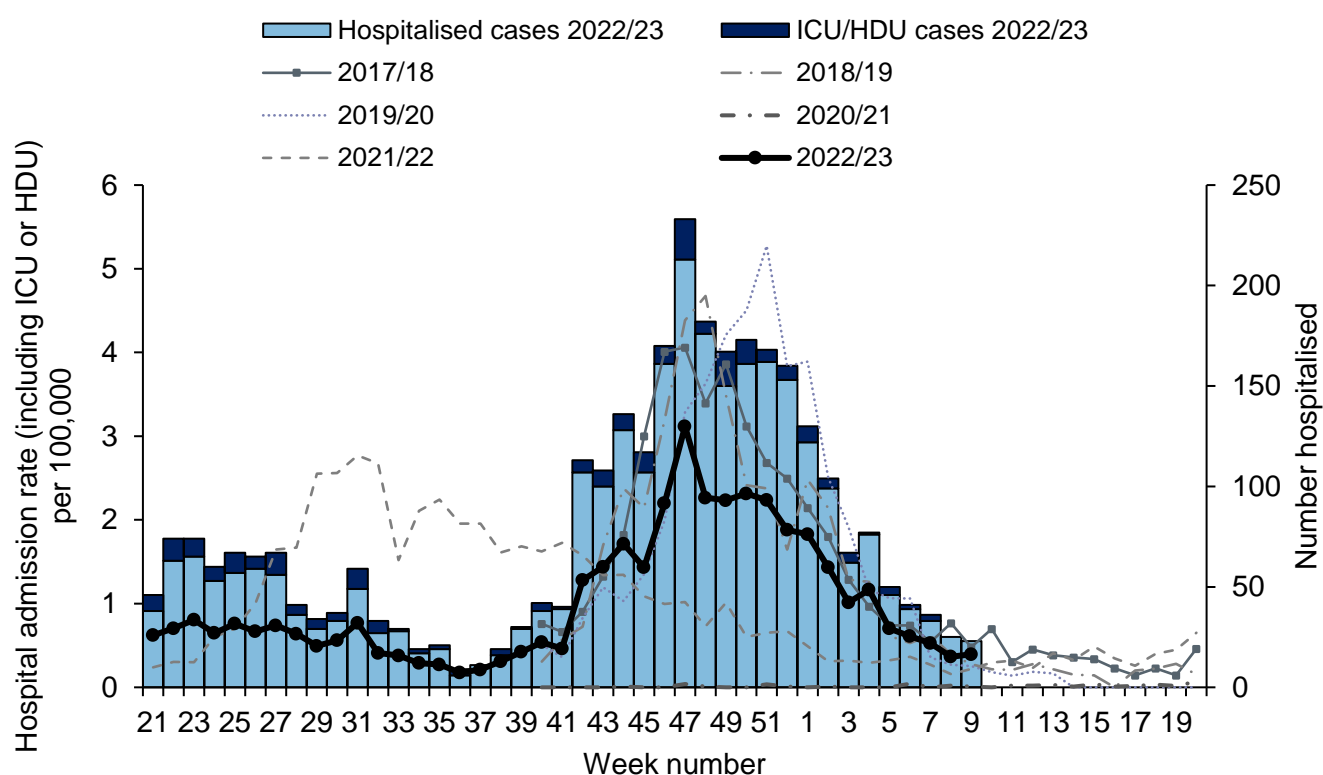


RSV admissions, SARI Watch

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

In week 9, the overall hospital admission rate for RSV remained stable at 0.40 per 100,000 compared with 0.37 per 100,000 in the previous week. The highest rate was seen in the under 5 year olds at 2.20 per 100,000, with rates remaining low across all age groups.

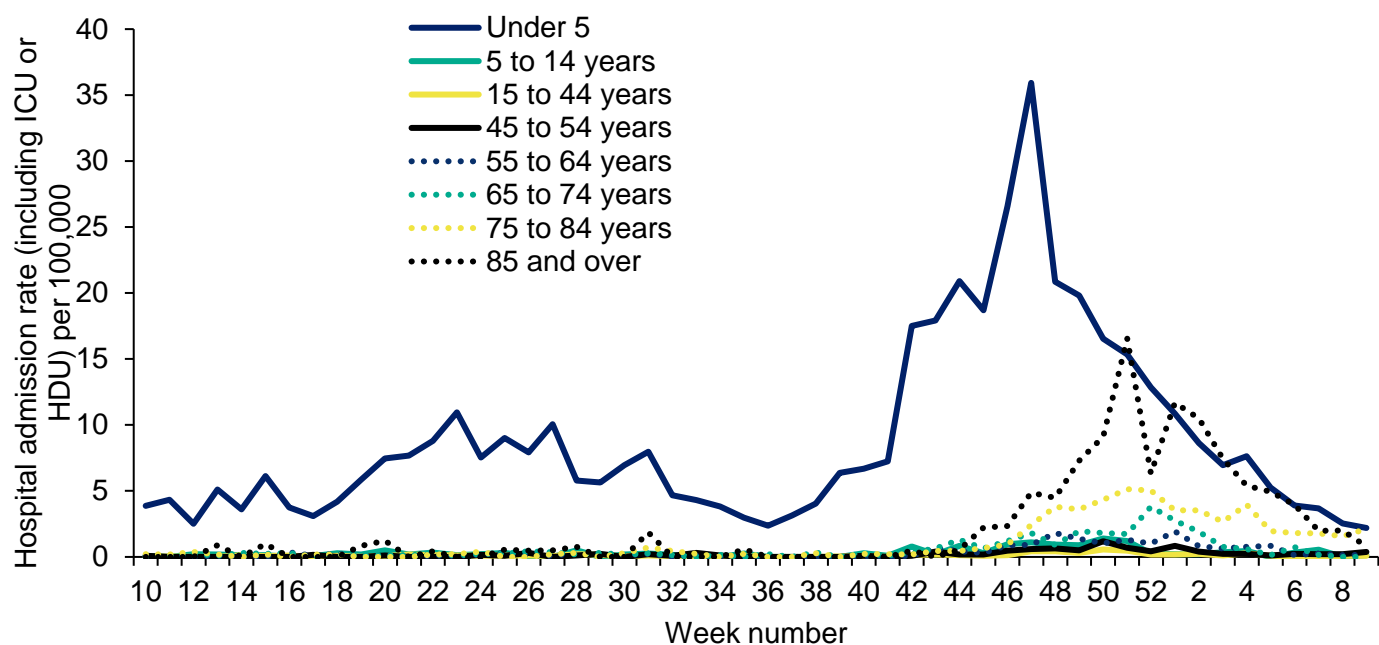
Figure 51: Weekly overall hospital admission rates (including ICU or HDU) of RSV positive cases per 100,000 population reported through SARI Watch, England



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

Figure 52: Weekly hospitalisation (including ICU or HDU) admission rates by age group for new RSV cases reported through SARI Watch, England

* SARI Watch data is provisional



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

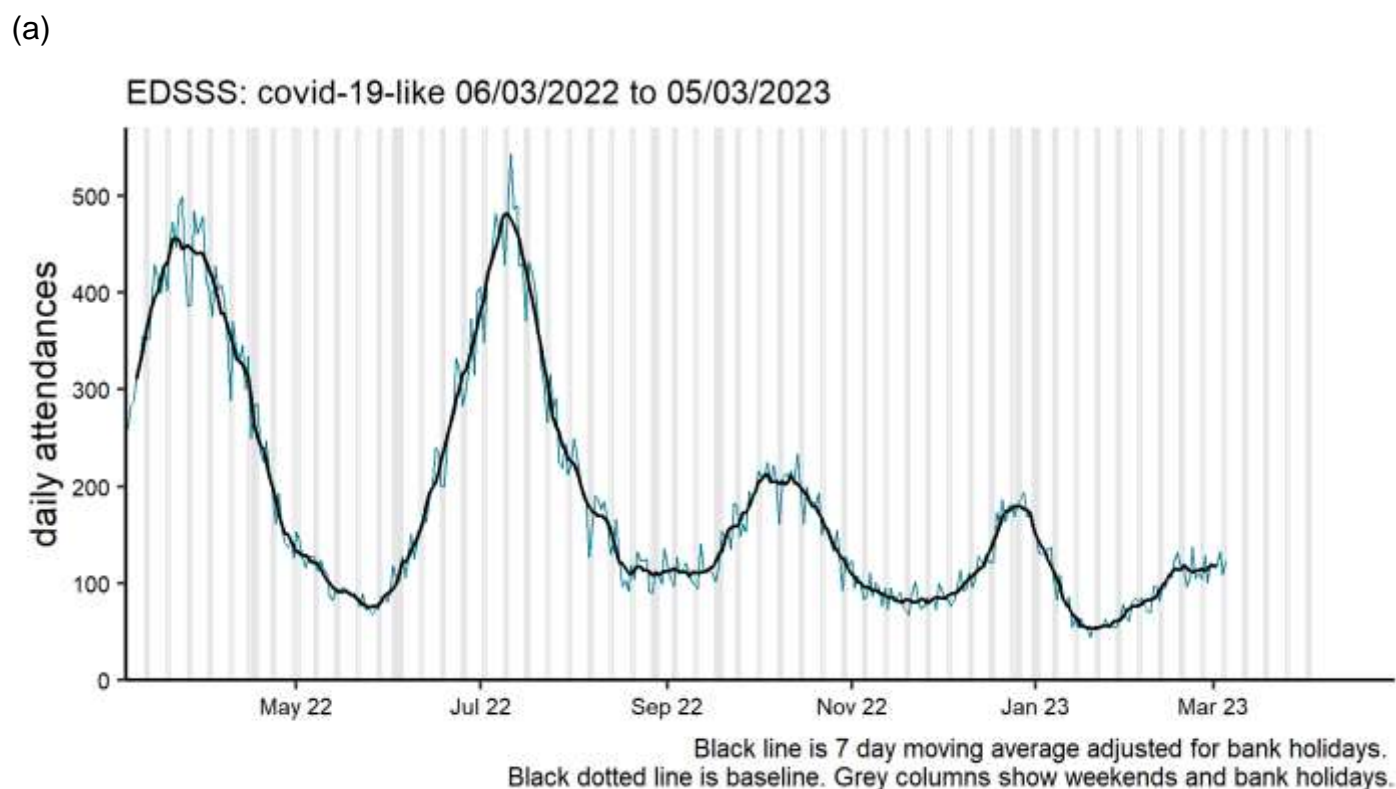
Emergency Department attendances, Syndromic surveillance

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

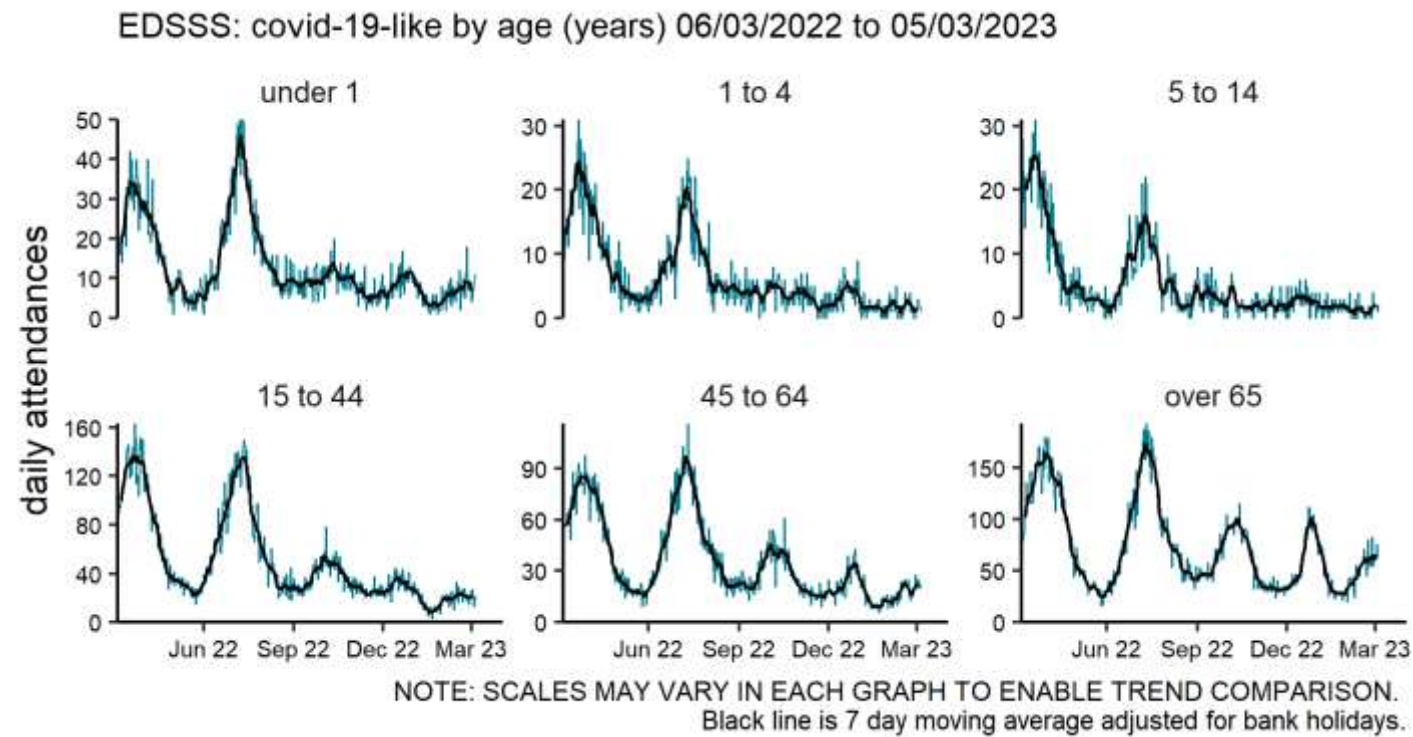
During week 9, attendances for covid-like illness remained stable nationally but increased slightly in those aged 65 years and over and continued to increase in the West Midlands and East of England regions (Figure 53). Attendances for acute respiratory infection, influenza-like illness and acute bronchiolitis remained stable nationally and similar to levels expected for this time of year (Figures 54, 55 and 56).

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. Remodelled EDSSS baselines have been refitted during week 6 to account for post-COVID-19 changes in health care seeking behaviour. Further information about these caveats is available from the [Emergency Department Syndromic Surveillance](#) bulletin.

Figure 53: Daily ED attendances for COVID-19-like infections, England (a) nationally, (b) by age group and (c) by UKHSA centre



(b)



(c)

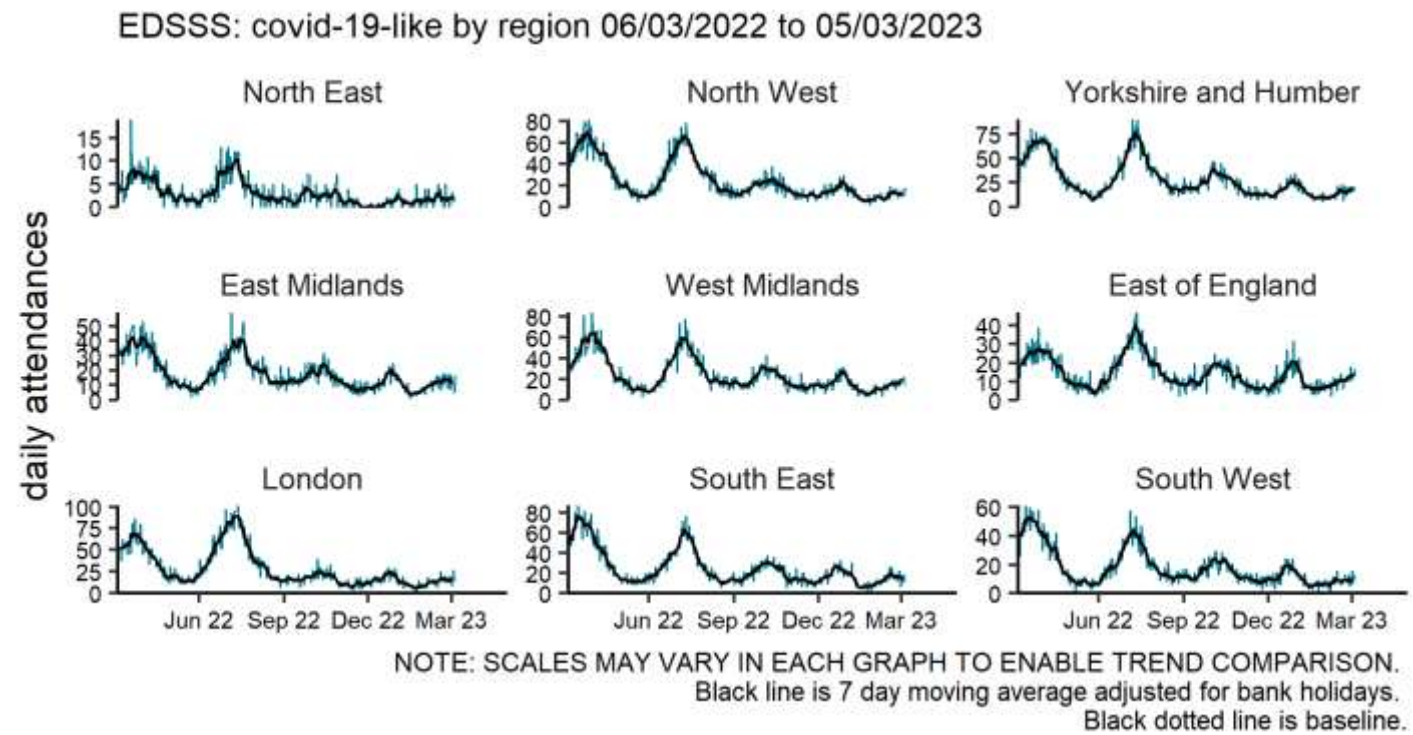
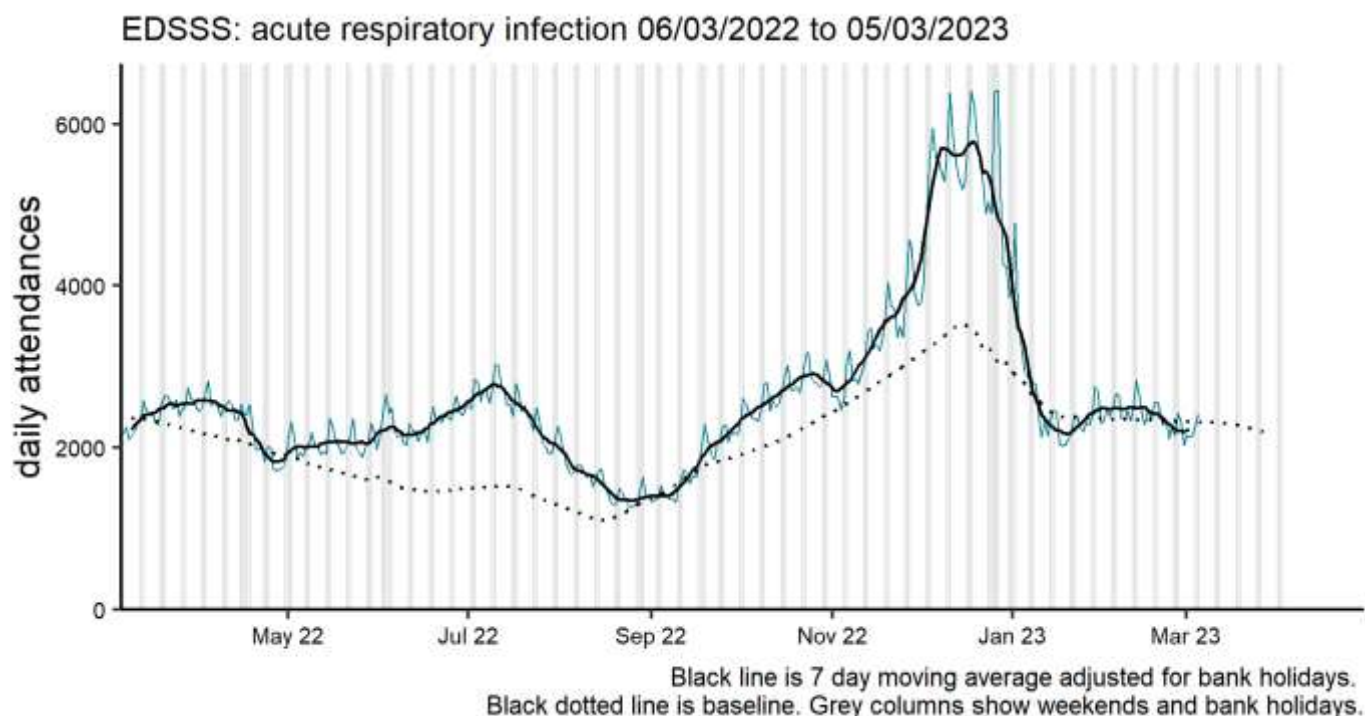
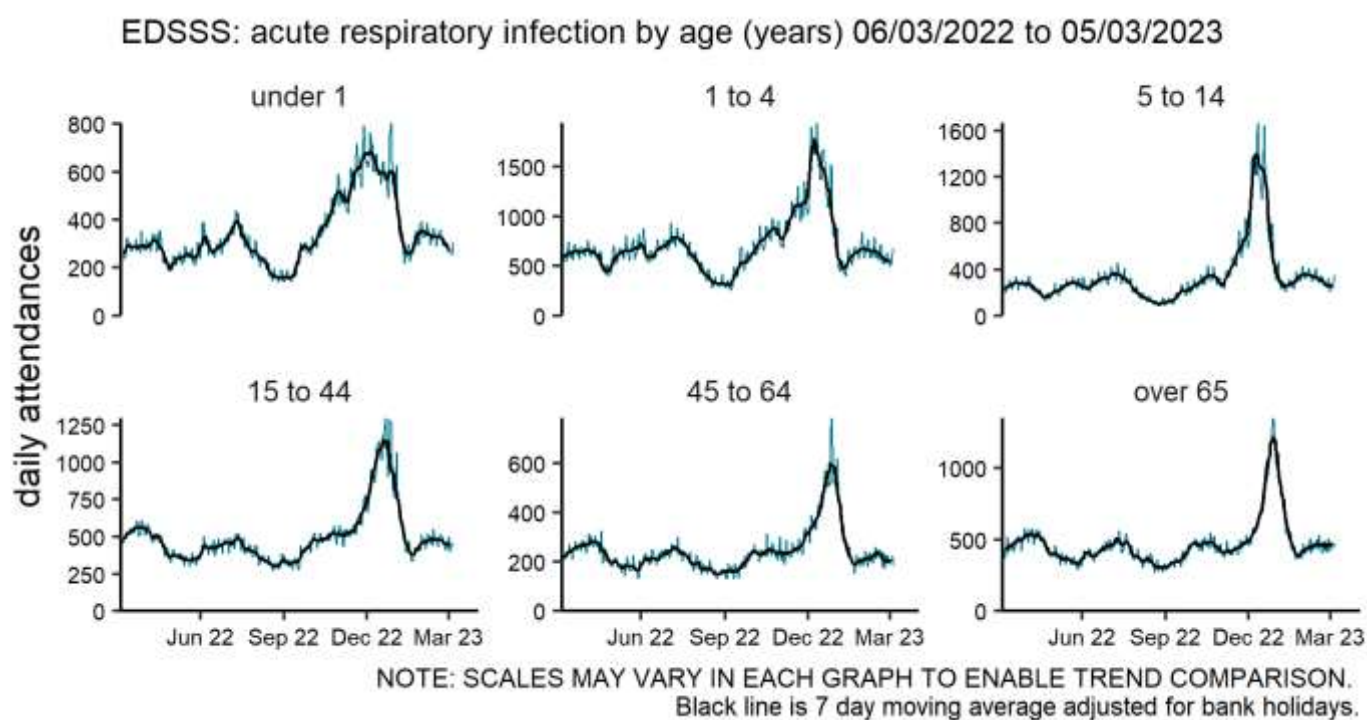


Figure 54: Daily ED attendances for acute respiratory infection, England (a) nationally, (b) by age group and (c) by UKHSA centre

(a)



(b)



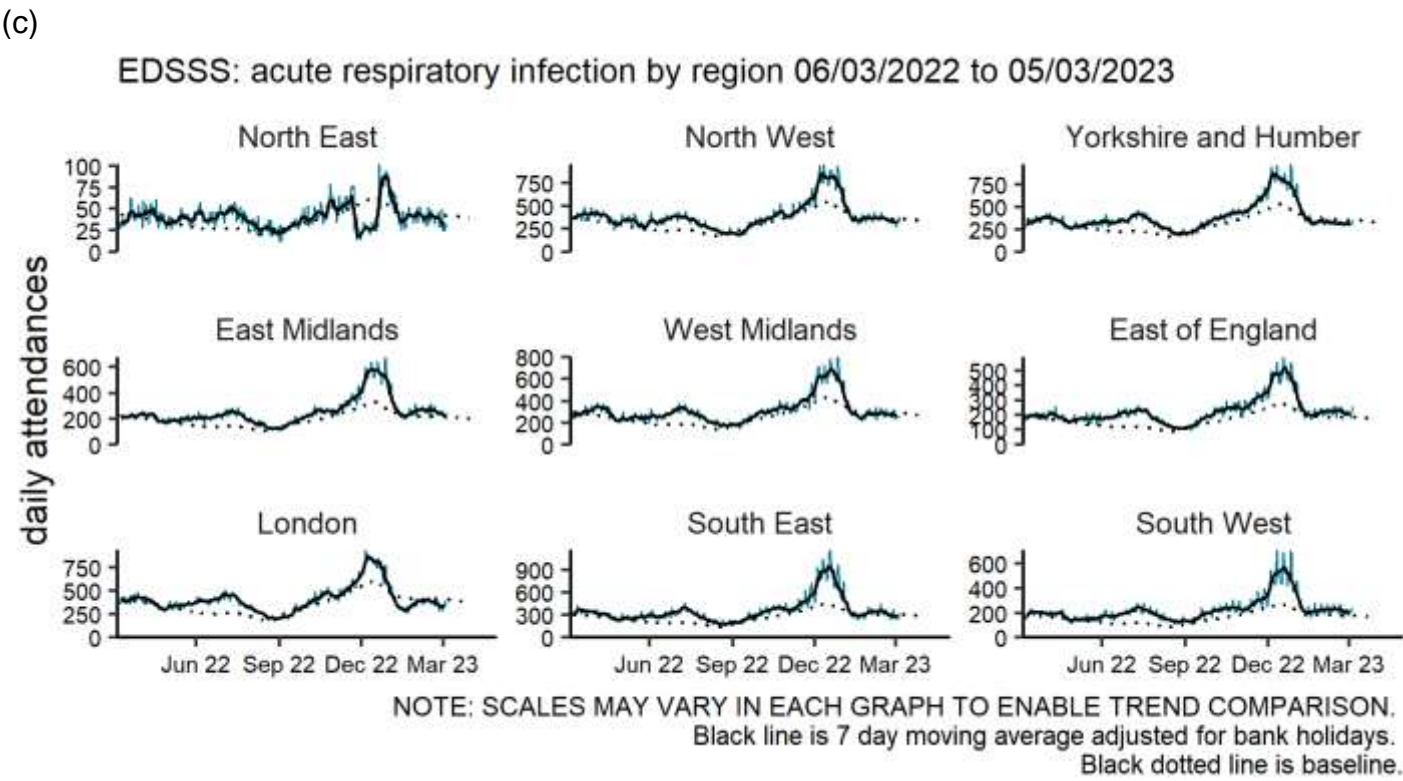
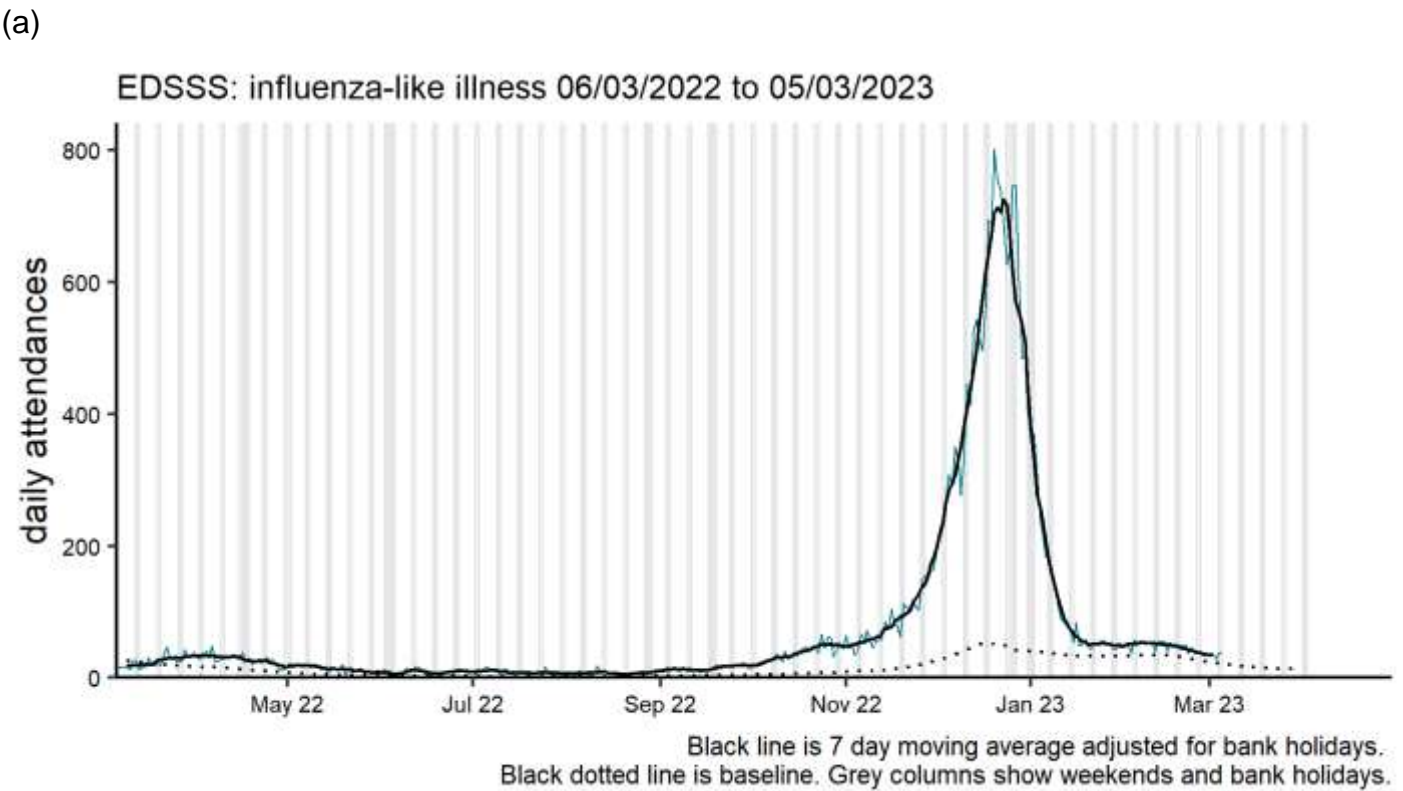
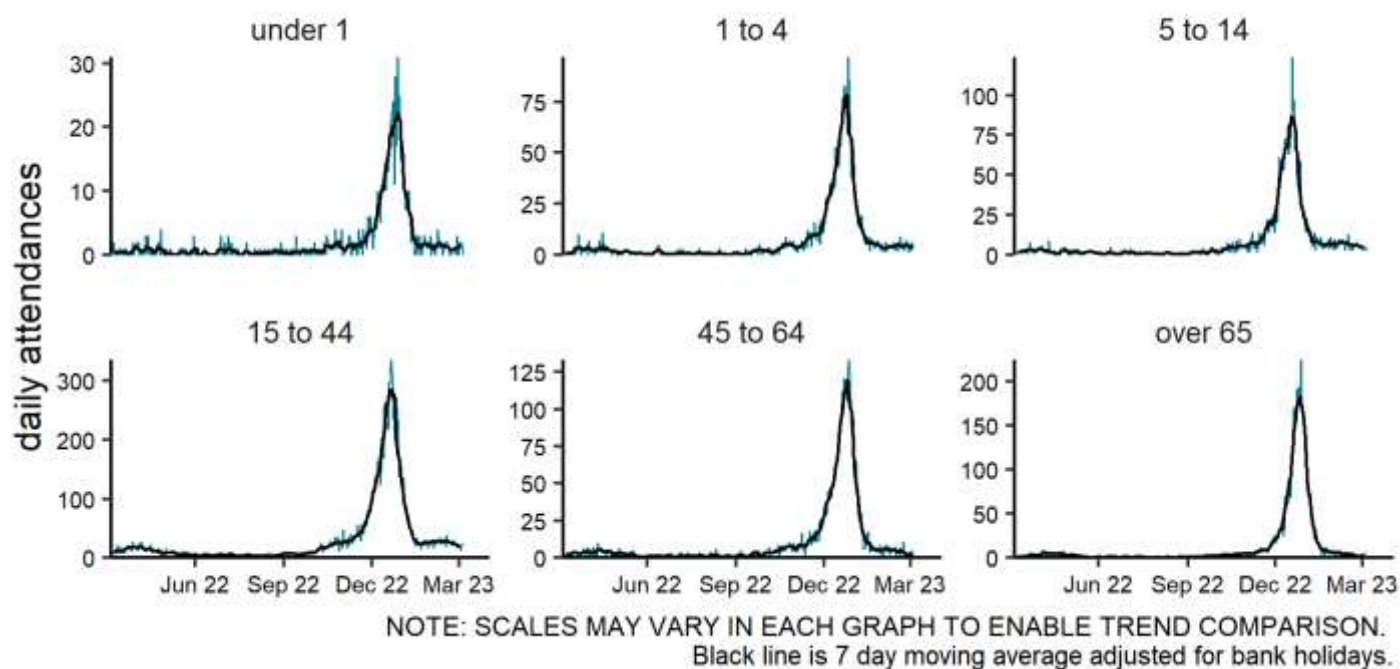


Figure 55: Daily ED attendances for influenza-like illness, England (a) nationally, (b) by age group and (c) by UKHSA centre



(b)

EDSSS: influenza-like illness by age (years) 06/03/2022 to 05/03/2023



(c)

EDSSS: influenza-like illness by region 06/03/2022 to 05/03/2023

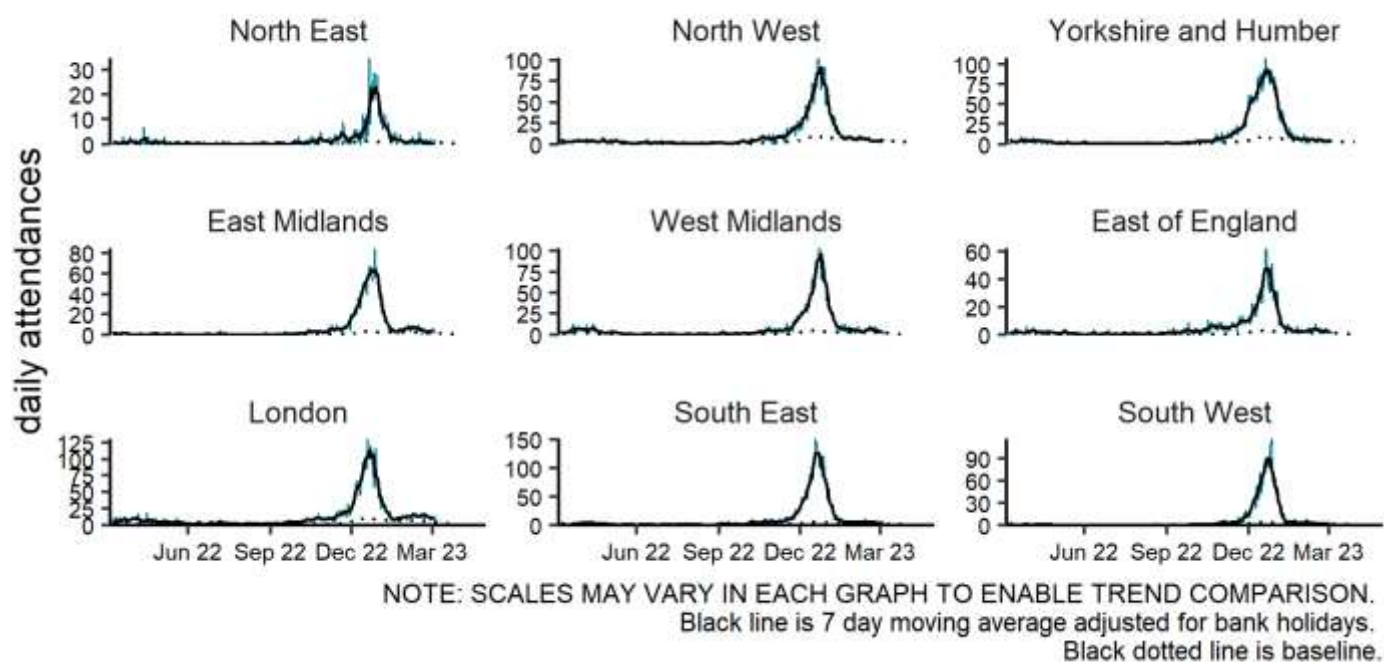
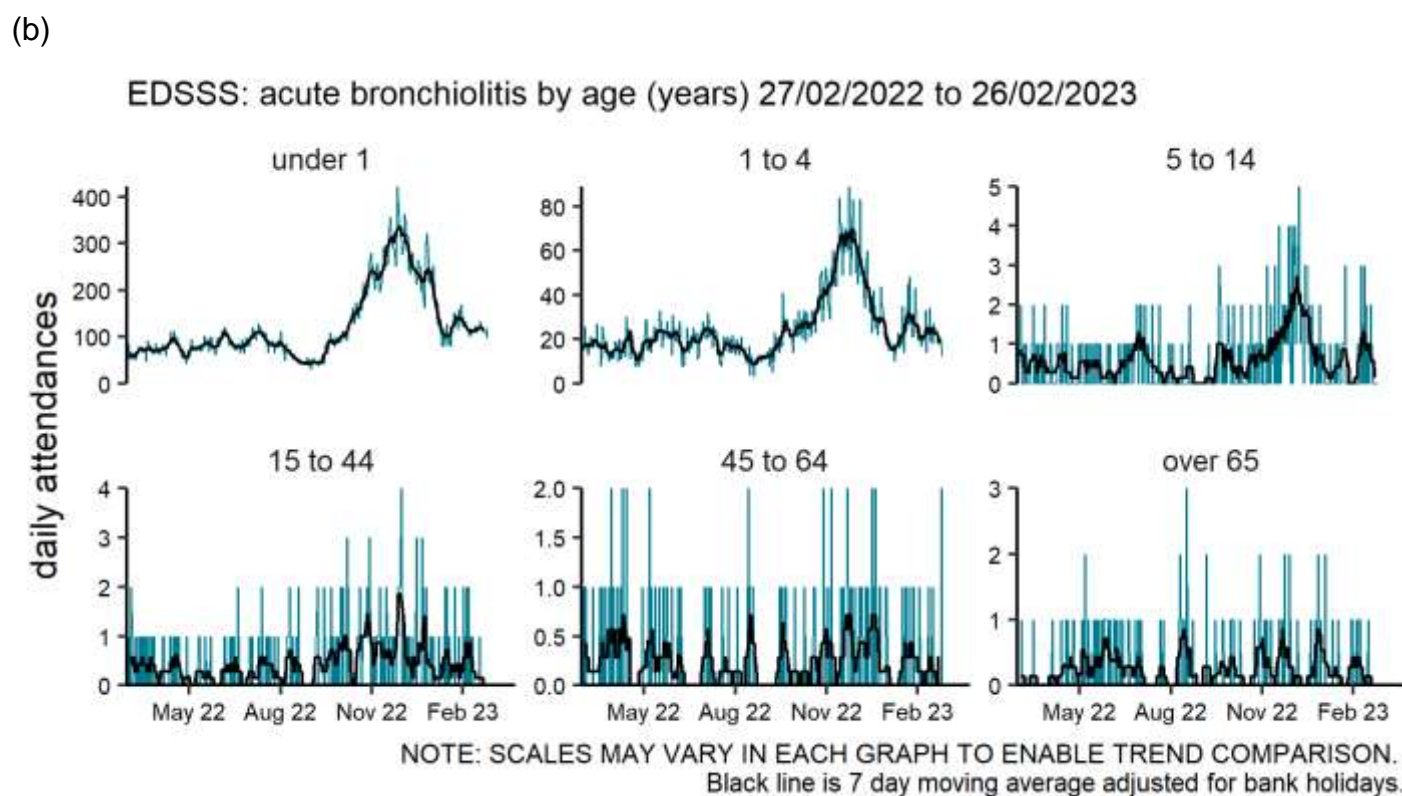
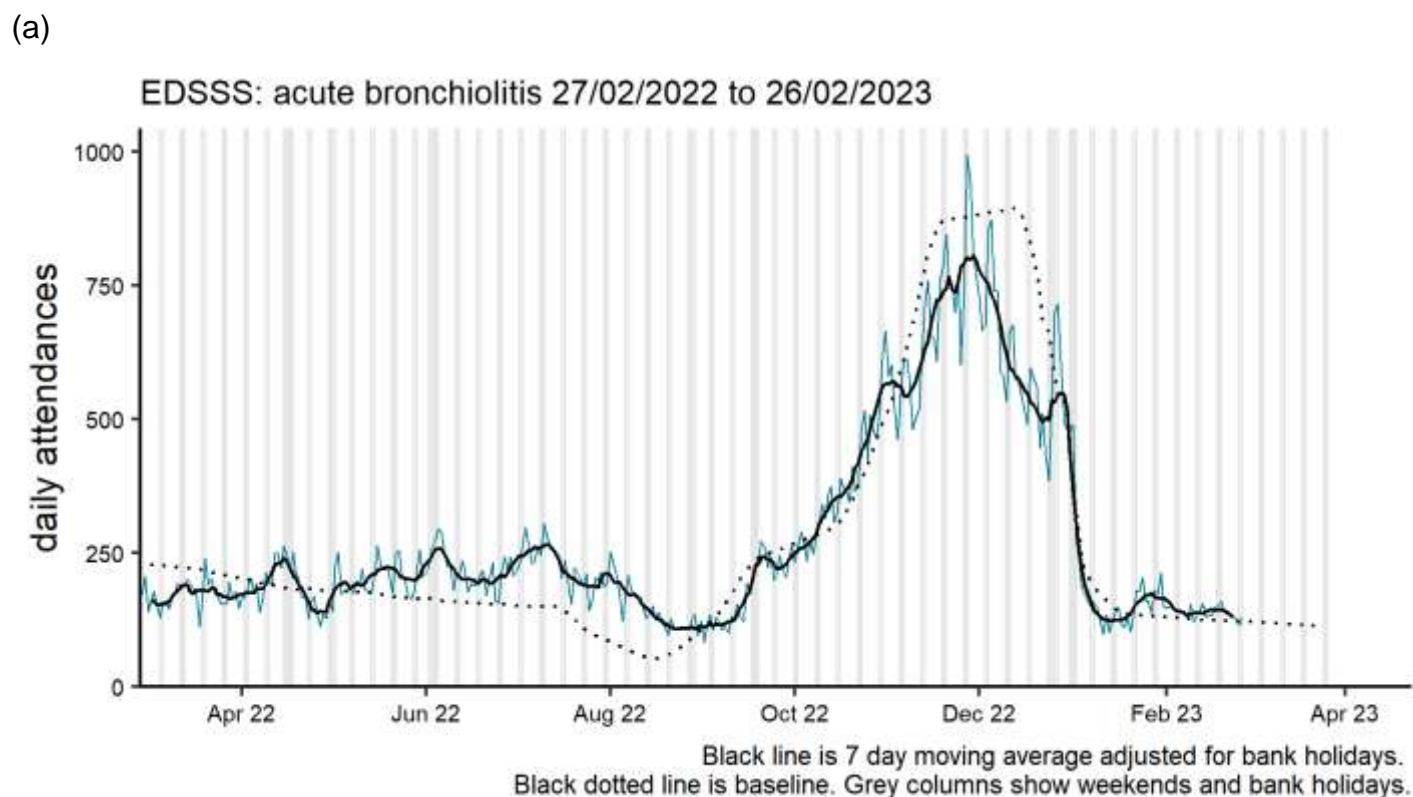
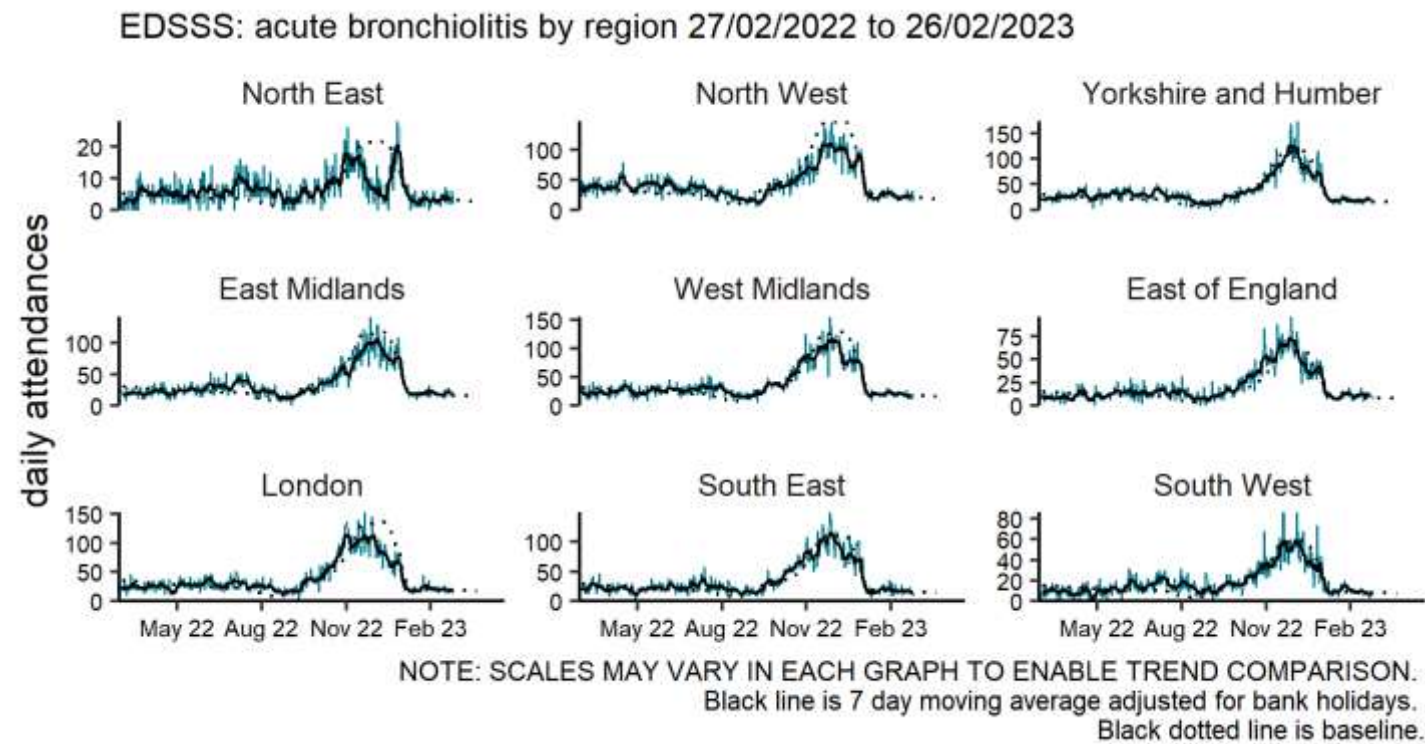


Figure 56: Daily ED attendances for acute bronchiolitis, England (a) nationally, (b) by age group and (c) by UKHSA centre



(c)

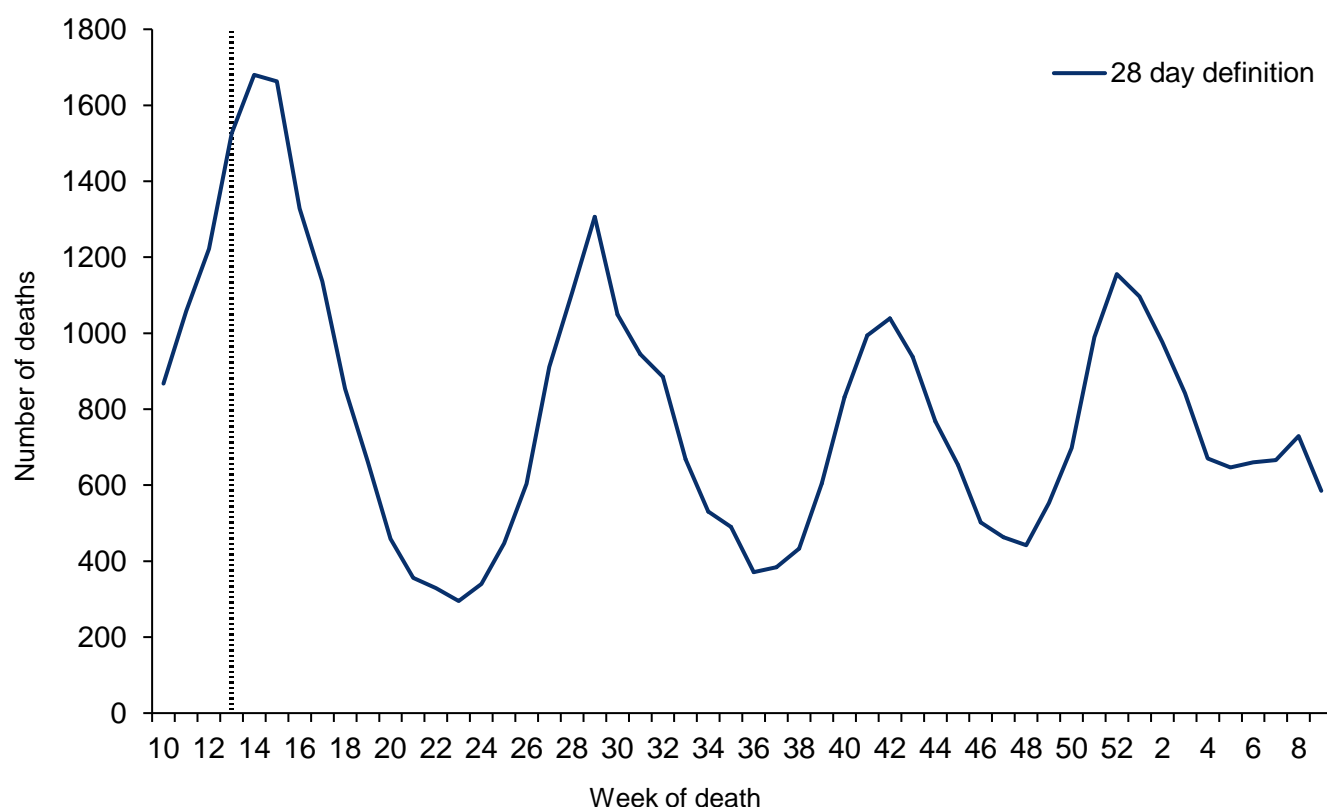


Mortality surveillance

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.

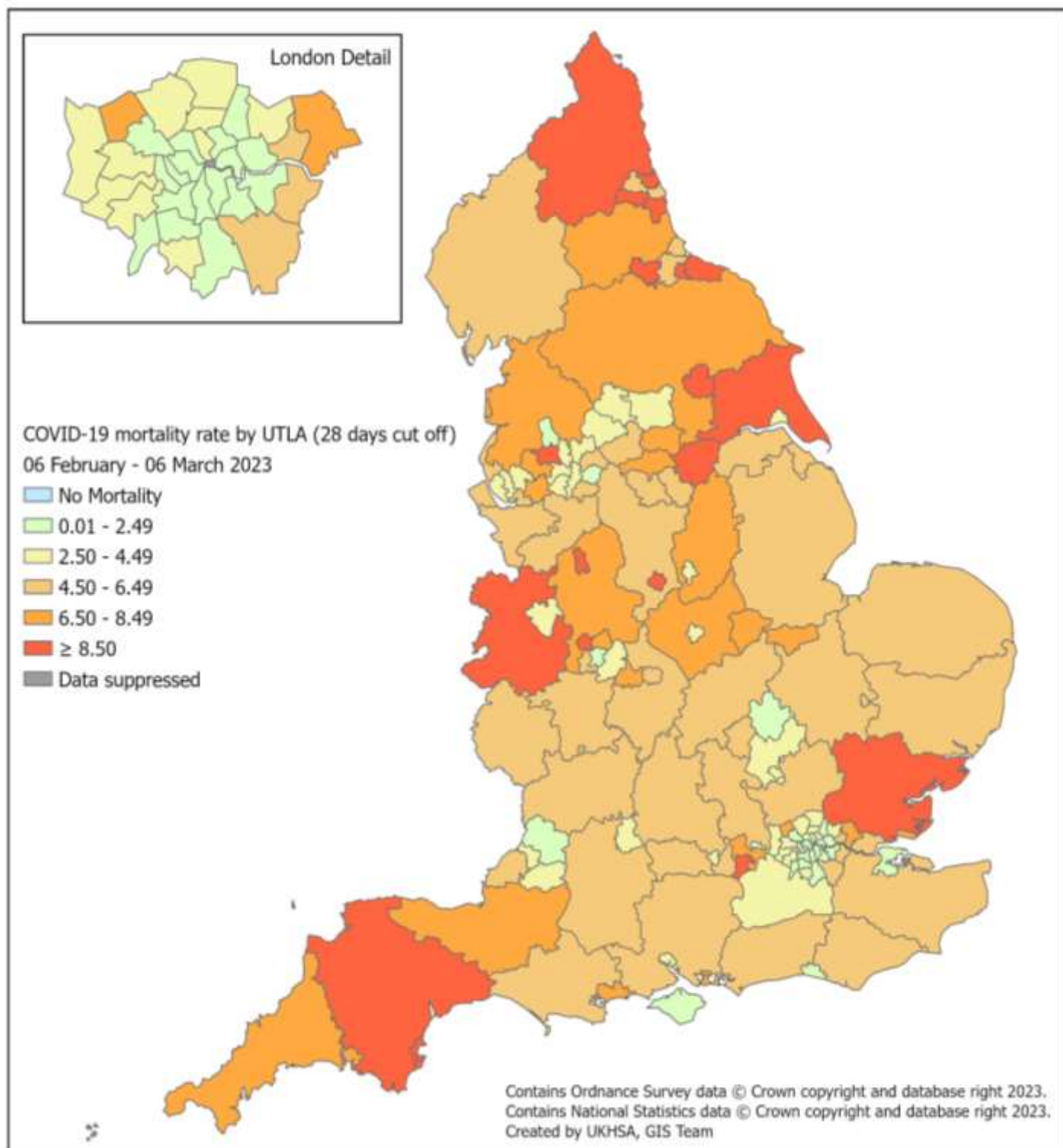
Figure 57: Number of deaths by week of death and time since a positive COVID-19 test (28 day definition), England



* 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 58: Cumulative mortality rate of COVID-19 cases per 100,000 population tested under Pillars 1 and 2 for the weeks 6 to 9 by 28 day definition



Daily excess all-cause mortality (England)

Deaths occurring from 1 January 2020 to 1 March 2023 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. The baseline until November 2020 was from the same day of the year in the previous 5 years plus or minus 7 days with an extrapolated time trend. The baseline from December 2020 to March 2021 only uses the same days +/- 7 days from the past 3 low flu years with no trend, and the baseline from April 2021 onwards is set to be the same as the previous years baseline. Along with the baseline 2 and 3 standard deviation (SD) limits shown (Figure 59).

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 Figures 60 and 61.

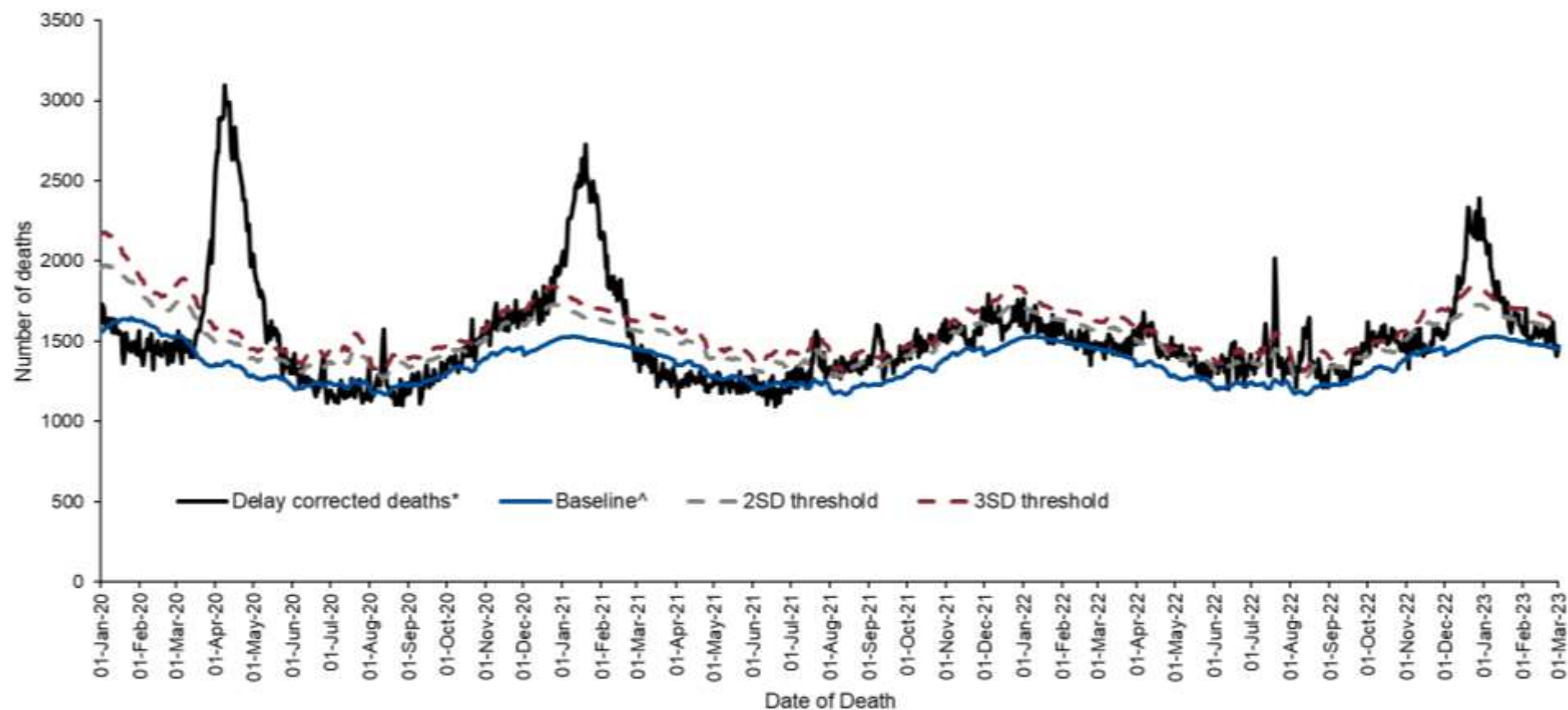
Note that as this data is by date of death with delay corrections, numbers are subject to change each week, particularly for more recent days. The current week's model supersedes models presented in previous week.

No excess all-cause mortality was observed in week 8.

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.

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.

Figure 59: Daily excess all-cause deaths in all ages, England, 1 January 2020 to 1 March 2023



^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.

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

(a)

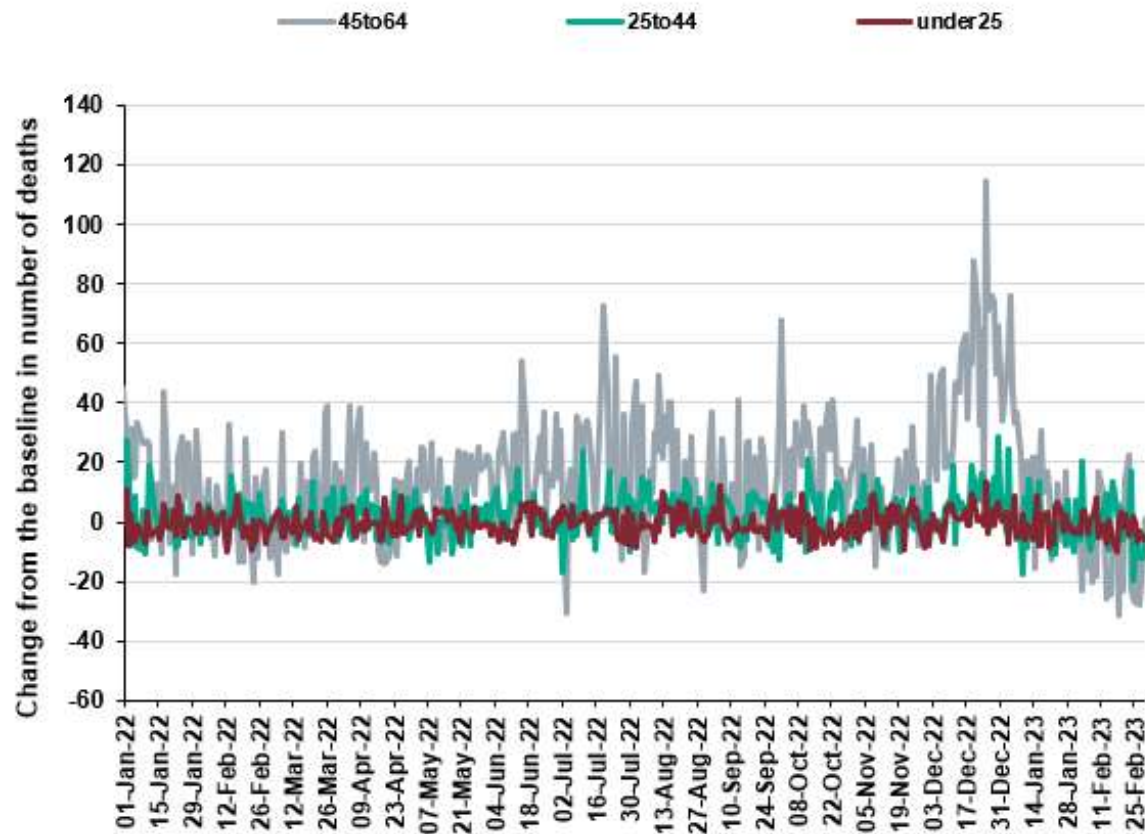
Age Group	Excess detected in week 7 2023	Weeks in excess from week 10 to 53 2020	Weeks in excess from week 1 to 52 2021	Weeks in excess from week 1 to 52 2022	Weeks in excess from week 1 2023
All	No	13 to 21, 33, 43, 45, 50, 52 to 53	01 to 07, 29, 31 to 32, 35 to 36, 40 to 44, 48	14 to 15, 17 to 18, 23 to 24, 27 to 29, 31 to 33, 39 to 42, 49 to 52	01 to 02
under 25	No	None	None	None	None
25 to 44	No	14 to 16	None	None	None
45 to 64	No	12 to 19, 49 to 50, 52 to 53	01 to 08, 23, 29 to 30, 36, 41 to 44, 48 to 49	29, 49 to 52	01
65 to 74	No	13 to 19, 46, 48, 52 to 53	01 to 07, 36, 43, 48	32, 50 to 52	01
75 to 84	No	13 to 21, 33, 45, 49, 52 to 53	01 to 07, 32, 36, 40, 42	14 to 18, 22 to 25, 28 to 29, 31 to 32, 38 to 42, 49 to 52	01 to 02, 04
85+	No	13 to 21, 33, 53	01 to 07, 31, 36	23, 28 to 29, 32, 39, 50 to 52	01 to 02

(b)

UKHSA Centres	Excess detected in week 7 2023	Weeks in excess from week 10 to 53 2020	Weeks in excess from week 1 to 52 2021	Weeks in excess from week 1 to 52 2022	Weeks in excess from week 1 2023
East of England	No	14 to 19, 52 to 53	01 to 07	27, 29, 50 to 52	None
East Midlands	No	13 to 19, 48	01 to 07	29, 52	None
London	No	12 to 19, 33, 52 to 53	01 to 06, 36	29, 50 to 52	None
North East	No	14 to 21	02 to 04	52	01
North West	No	13 to 19, 33, 42 to 47	01 to 07, 31 to 32, 36, 43	14 to 15, 29 to 30, 32, 39, 42, 50 to 52	01 to 02
South East	No	13 to 21, 33, 50 to 53	01 to 07, 36, 41, 49	14, 28, 32, 40 to 42, 49 to 52	01 to 02
South West	No	13 to 19, 33	02 to 07, 29, 36	17 to 18, 29, 32 to 34, 39, 50 to 52	01, 06
West Midlands	No	13 to 20, 45, 48	01 to 07, 29, 36, 40, 48	13, 28 to 29, 32, 41 to 42, 51 to 52	01
Yorkshire and Humber	No	14 to 21, 23, 43 to 50	02 to 04, 32, 35 to 36	15, 29, 32, 42, 50 to 52	01

Figure 60: Daily excess all-cause deaths by age group, England, 1 January 2022 to 1 March 2023

(a)



(b)

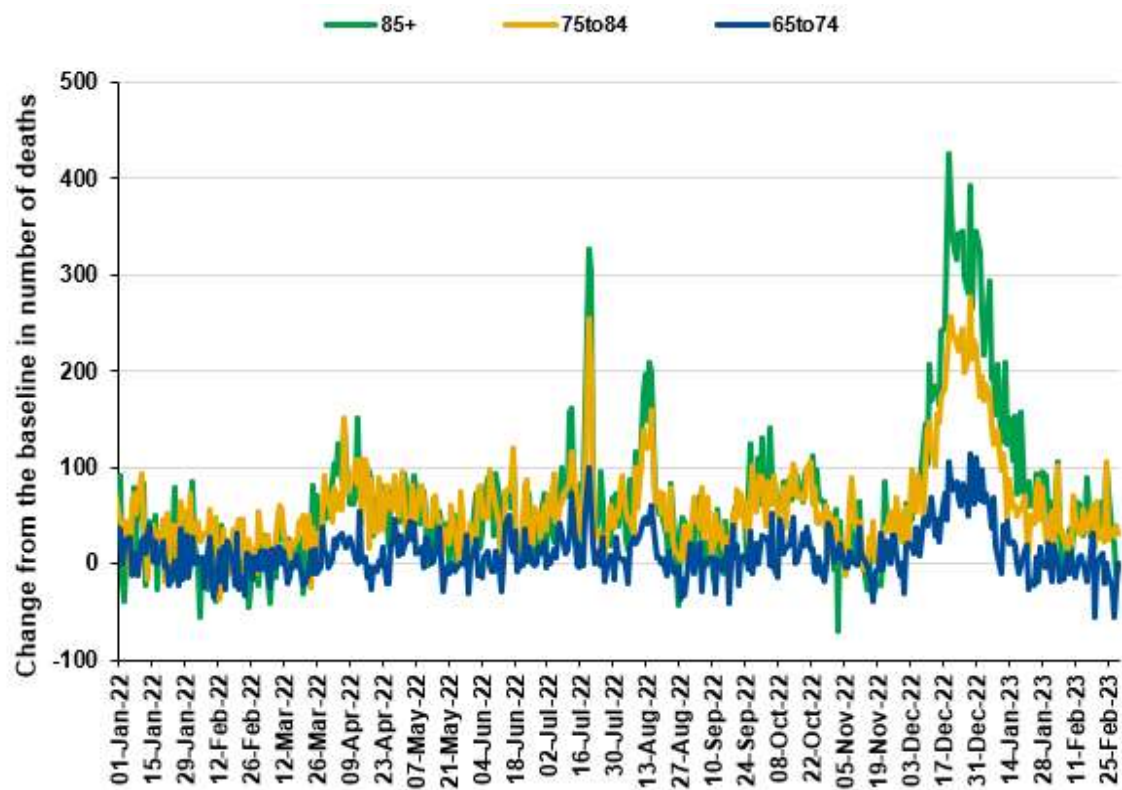
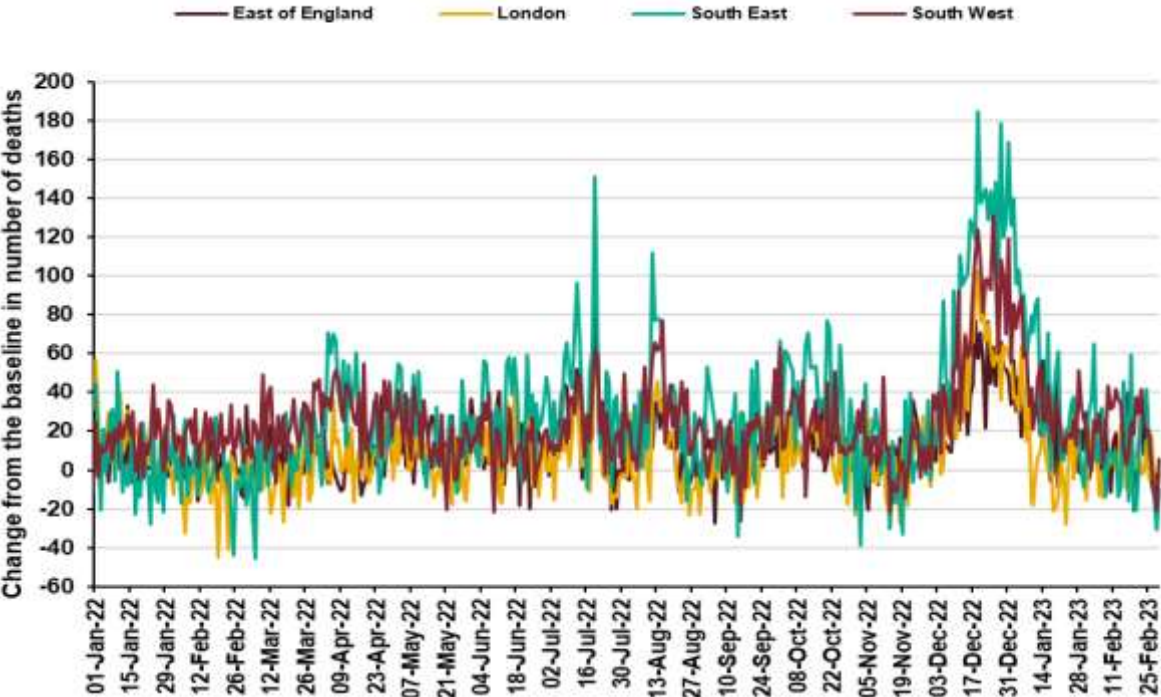
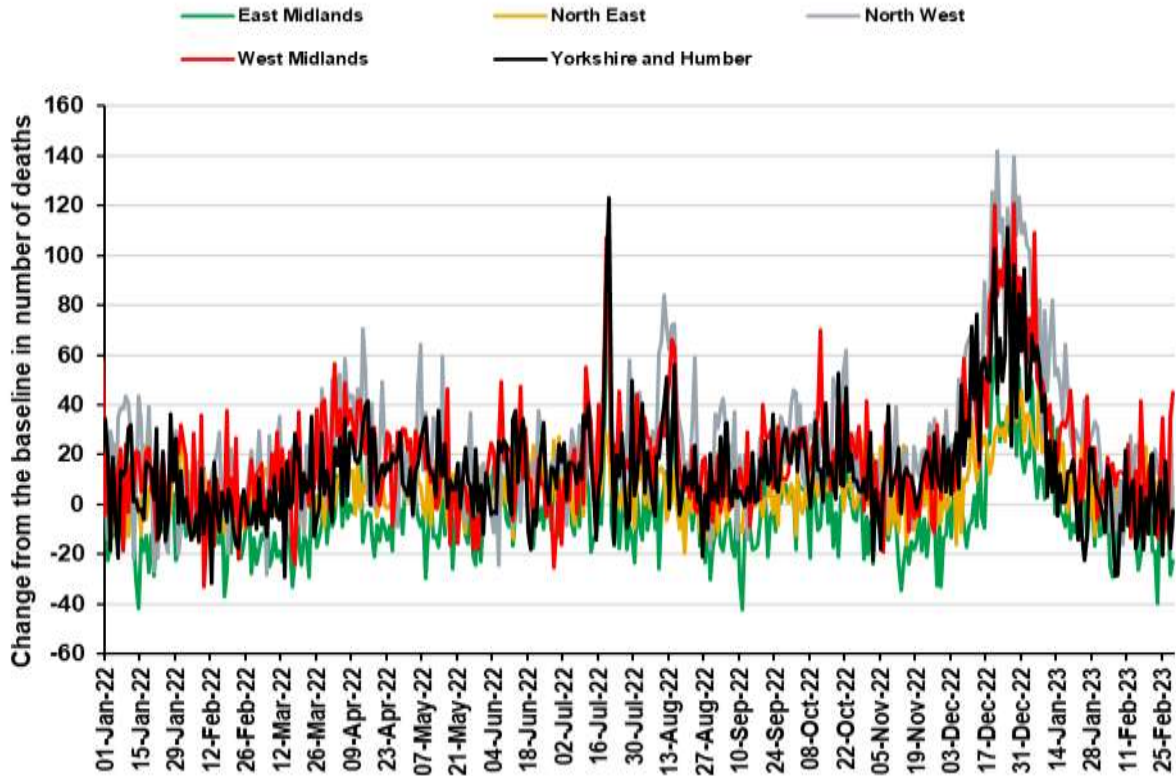


Figure 61: Daily excess all-cause deaths by UKHSA centre, England, 1 January 2022 to 1 March 2023

(a)



(b)



Microbiological surveillance

Influenza 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.

Between week 40 2022 and week 10 2023, the UKHSA Respiratory Virus Unit have genetically characterised, by sequencing of the haemagglutinin (HA) gene, 2,527 influenza A viruses (1,673 A(H3N2) and 854 A(H1N1)pdm09 viruses) and 89 influenza B viruses.

The 1,673 influenza A(H3N2) viruses genetically characterised, all belong in the genetic subclade 3C.2a1b.2a.2. The Northern Hemisphere 2022-23 influenza A(H3N2) vaccine strain (an A/Darwin/9/2021-like virus) also belongs in this 3C.2a1b.2a.2 genetic subclade.

The 854 influenza A(H1N1)pdm09 viruses characterised to date this season, all belong in genetic subgroup 6B.1A.5a.2. The Northern Hemisphere 2022-23 influenza A(H1N1)pdm09 vaccine strain (an A/Victoria/2570/2019-like virus) also belongs in genetic subclade 6B.1A.5a, within the 6B.1A.5a.2 cluster.

The 89 influenza B/Victoria lineage viruses have been genetically characterised, all belonging in subclade V1A3, within the subgroup V1A3a.2. The Northern Hemisphere 2022-23 influenza B/Victoria lineage vaccine strain (a B/Austria/1359417/2021-like virus) also belongs in this V1A3a.2 subclade/group.

The Respiratory Virus Unit has confirmed by genome sequencing the detection of live attenuated influenza vaccine (LAIV) viruses in 2 influenza A positive samples and 9 influenza B positive samples collected since week 40, all from children aged between 2 and 16 years old.

Influenza antiviral susceptibility

Influenza positive samples are genome sequenced and 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.

Influenza virus sequences from samples collected between weeks 40 2022 and week 10 2023 have been analysed. Analysis of 1,474 A(H3N2) viruses by sequencing found one oseltamivir resistant virus with an E119V amino acid substitution present as a mixed population (80% E119V). The sample was collected from an adult, post-oseltamivir treatment, in January 2023. Of 794 A(H1N1)pdm09 NA sequences analysed, 1 oseltamivir resistant virus with an H275Y amino acid substitution present as a mixed population (80% H275Y) was detected. The sample was collected from an immune compromised adult, post oseltamivir treatment, in December 2022. No viruses with known markers of resistance to neuraminidase inhibitors were detected in 86 influenza B NA sequences analysed.

No viruses with known markers of resistance to baloxavir marboxil were detected in 1,185 A(H3N2), 599 A(H1N1)pdm09 and 69 influenza B PA sequences analysed.

Table 4: Antiviral susceptibility of influenza positive samples tested at UKHSA-RVU

(Sub)type	Neuraminidase Inhibitors		Baloxavir	
	Susceptible	Reduced Susceptibility	Susceptible	Reduced Susceptibility
A(H3N2)	1,473	1	1,185	0
A(H1N1)pdm09	793	1	599	0
B/Victoria-lineage	86	0	69	0

SARS-CoV-2 variants

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

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

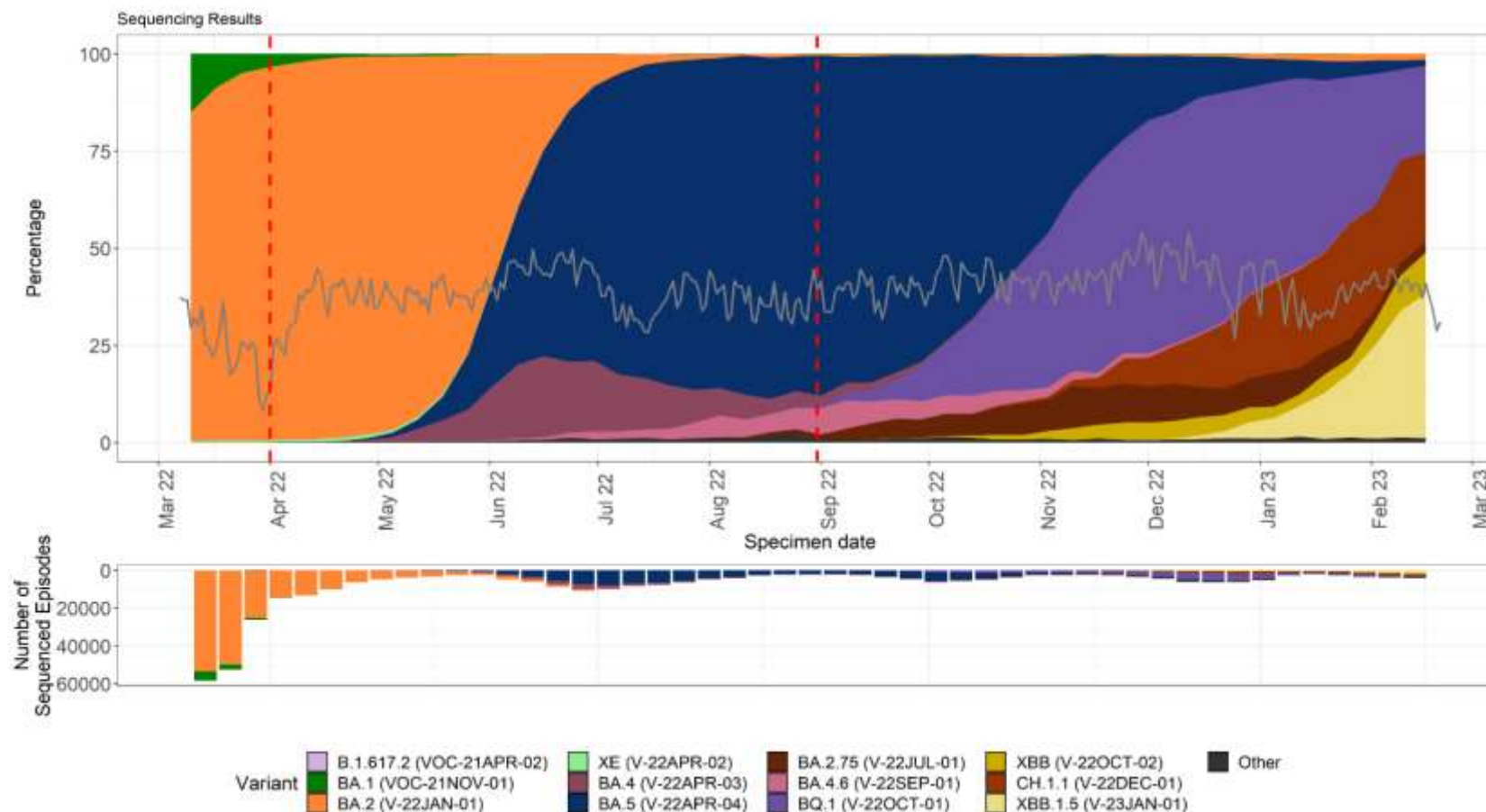
Detailed surveillance of particular variants of concerns can be found in recent [technical briefings](#).

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 62.

To account for sequencing delays, we report the proportion of variants from sequenced episodes between 20 February 2023 and 26 February 2023. Of those sequenced in this period, 40.6% were classified as XBB.1.5 (V-23JAN-01), 25.8% as CH.1.1 (V-22DEC-01), 17.1% as BQ.1 (V-22OCT-01), 9.9% as XBB (V-22OCT-02), 1.7% as BA.2.75 (V-22JUL-01), 1.5% as BA.2 (V-22JAN-01), 1.3% as BA.5 (V-22APR-04), and 2.1% as Other.

Figure 62. Prevalence of SARS-CoV-2 variants amongst available sequences episodes for England from 1 February 2022 to 26 February 2023



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 8 2023, XBB.1.5 was the most commonly circulating variant in England (Table 5).

Table 5. Total distribution of SARS-CoV-2 variants detected in England in the last 12 weeks, up to week 8 (week ending 19 February 2023)

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	1	26-12-2022
VOC-21NOV-01	Omicron BA.1	8	22-01-2023
V-22JAN-01	Omicron BA.2	606	26-02-2023
V-22APR-03	Omicron BA.4	19	16-02-2023
V-22APR-04	Omicron BA.5	3,391	26-02-2023
V-22JUL-01	Omicron BA.2.75	3,132	26-02-2023
V-22SEP-01	Omicron BA.4.6	181	21-02-2023
V-22OCT-01	Omicron BQ.1	23,524	26-02-2023
V-22OCT-02	Omicron XBB	2,869	26-02-2023
V-22DEC-01	Omicron CH.1.1	10,886	26-02-2023
V-23JAN-01	Omicron XBB.1.5	6,938	26-02-2023

*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 6 shows in the 12 weeks up to week 9 2023, 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 6: Antimicrobial susceptibility surveillance in lower respiratory tract

Organism	Antibiotic	Specimens tested [‡] (N)	Specimens susceptible (%)
<i>S. pneumoniae</i>	Penicillin	3,485	88
	Macrolides	3,906	84
	Tetracycline	3,672	83
<i>H. influenzae</i>	Amoxicillin/ampicillin	21,018	39
	Co-amoxiclav	25,136	46
	Macrolides	4,935	4
	Tetracycline	24,705	98
<i>S. aureus</i>	Methicillin	6,903	93
	Macrolides	8,162	70
MRSA	Clindamycin	365	52
	Tetracycline	456	73
MSSA	Clindamycin	4,708	76
	Tetracycline	5,584	93

* Macrolides = erythromycin, azithromycin and clarithromycin

[‡] Specimen types = lower respiratory tract, bronchial, lung, alveolar lavage, pleura, chest, sputum, endotracheal aspirate, and pleural fluid

Data source: UKHSA's SGSS AMR module, please note that this is different to the data source used in the reports published between weeks 41 2020 to 05 2021 inclusive of the 2020/21 influenza season when the SGSS CDR module was used instead due to a PHE (now 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 05 2021. The AMR module of SGSS was used during the 2019/20 influenza season.

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 09 2023 (week ending 5 March 2023) 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 COVID-19 vaccinations. Individuals vaccinated in England who have a registered address outside of England or where their address, age, or sex is unknown have been excluded. Due to changes in GP practice lists, in order to include newly registered patients and remove those who are no longer resident, there will be slight variation to the figures to reflect those who are currently resident in England.

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.

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.

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 7 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. To understand the data in the context of vaccine waning across the whole COVID-19 programme, we present Table 8 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. Now that the Autumn booster campaign has come to a close, we have removed tables related to the eligible population at the

end of December 2022, and the immunosuppression cohort. We will provide new data on the anticipated Spring booster campaign when data becomes available.

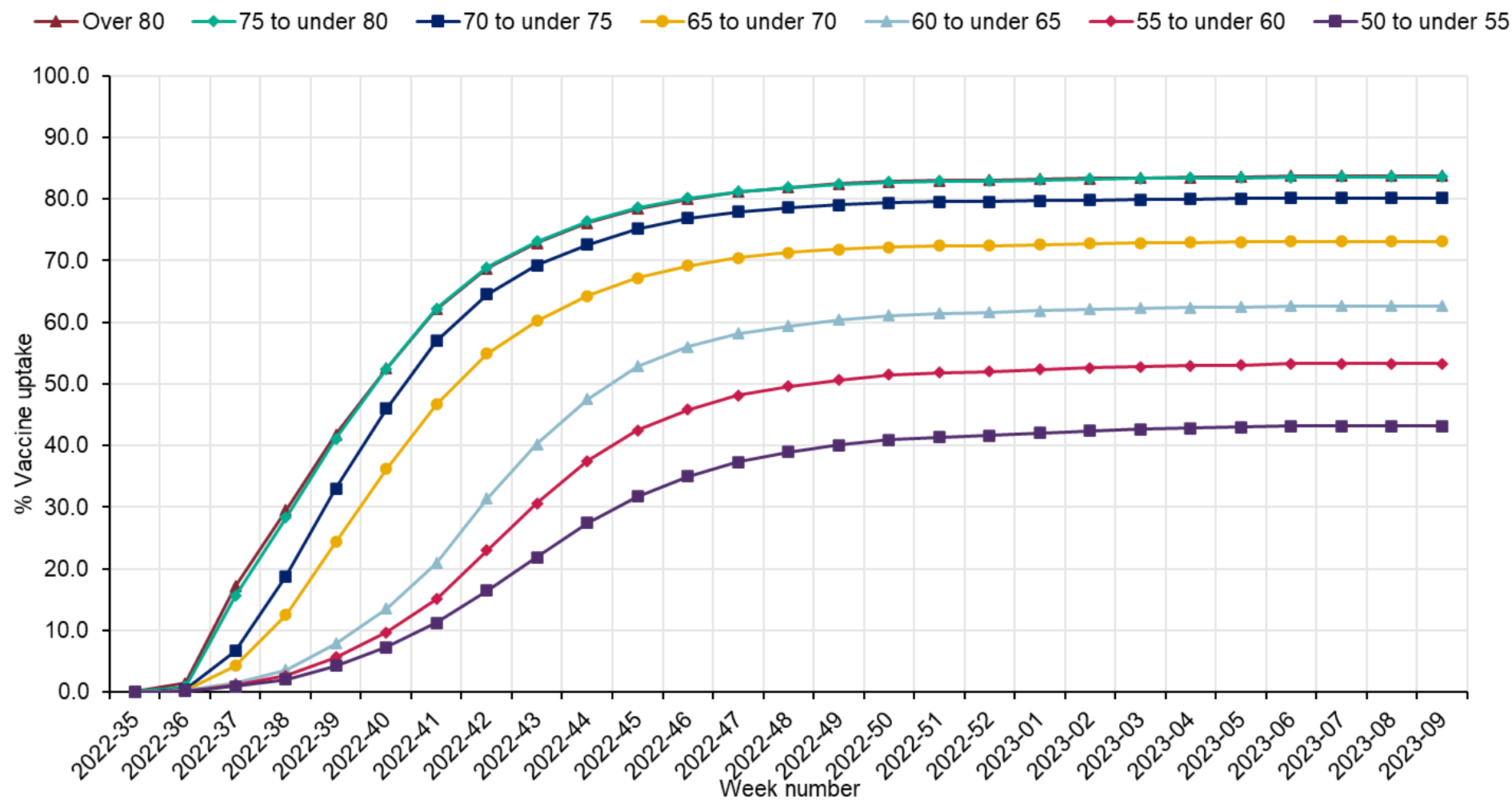
By the end of week 9 2023 (week ending 5 March 2023), 65.8% (15,103,465 out of 22,965,856) of all people aged over 50 years old who are living and resident in England who had been vaccinated with an Autumn booster dose since 1 September 2022, Table 7 and Figure 63. Vaccine uptake of those aged over 80 years old was 83.8% (2,468,409 out of 2,947,300).

Table 7: 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	2,947,300	2,468,409	83.8
75 to under 80	2,413,269	2,016,525	83.6
70 to under 75	2,682,688	2,149,943	80.1
65 to under 70	2,996,203	2,191,890	73.2
60 to under 65	3,634,846	2,278,616	62.7
55 to under 60	4,130,203	2,200,289	53.3
50 to under 55	4,161,347	1,797,793	43.2
Aged 50 and over	22,965,856	15,103,465	65.8

*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.

Figure 63: Cumulative weekly COVID-19 vaccine uptake by age in those who are living and resident in England for those vaccinated with an Autumn booster since 1 September 2022



Proportion of people vaccinated by time since last vaccination

Table 8: 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	Numbers vaccinated
Over 80	2,947,300	41,274	1.4	1,962,544	66.6	838,919	28.5
75 to under 80	2,413,269	32,550	1.3	1,644,172	68.1	648,088	26.9
70 to under 75	2,682,688	33,769	1.3	1,967,667	73.3	543,631	20.3
65 to under 70	2,996,203	44,341	1.5	2,044,581	68.2	701,847	23.4
60 to under 65	3,634,846	87,181	2.4	2,150,717	59.2	1,090,121	30.0
55 to under 60	4,130,203	113,715	2.8	2,051,080	49.7	1,534,899	37.2
50 to under 55	4,161,347	137,771	3.3	1,633,380	39.3	1,846,137	44.4
45 to under 50	3,869,065	51,579	1.3	502,121	13.0	2,617,597	67.7
40 to under 45	4,351,766	42,544	1.0	394,057	9.1	2,923,455	67.2
35 to under 40	4,655,890	39,027	0.8	327,643	7.0	3,021,475	64.9
30 to under 35	4,783,154	37,440	0.8	275,348	5.8	3,028,371	63.3
25 to under 30	4,403,131	30,827	0.7	204,512	4.6	2,806,817	63.7
20 to under 25	3,824,044	23,484	0.6	139,322	3.6	2,565,327	67.1
18 to under 20	1,398,587	11,460	0.8	41,661	3.0	925,201	66.2
16 to under 18	1,410,804	18,126	1.3	45,604	3.2	824,345	58.4
12 to under 16	2,971,194	23,526	0.8	74,544	2.5	1,306,724	44.0
5 to under 12	5,012,534	39,630	0.8	115,534	2.3	379,662	7.6

Table 8 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 64: 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

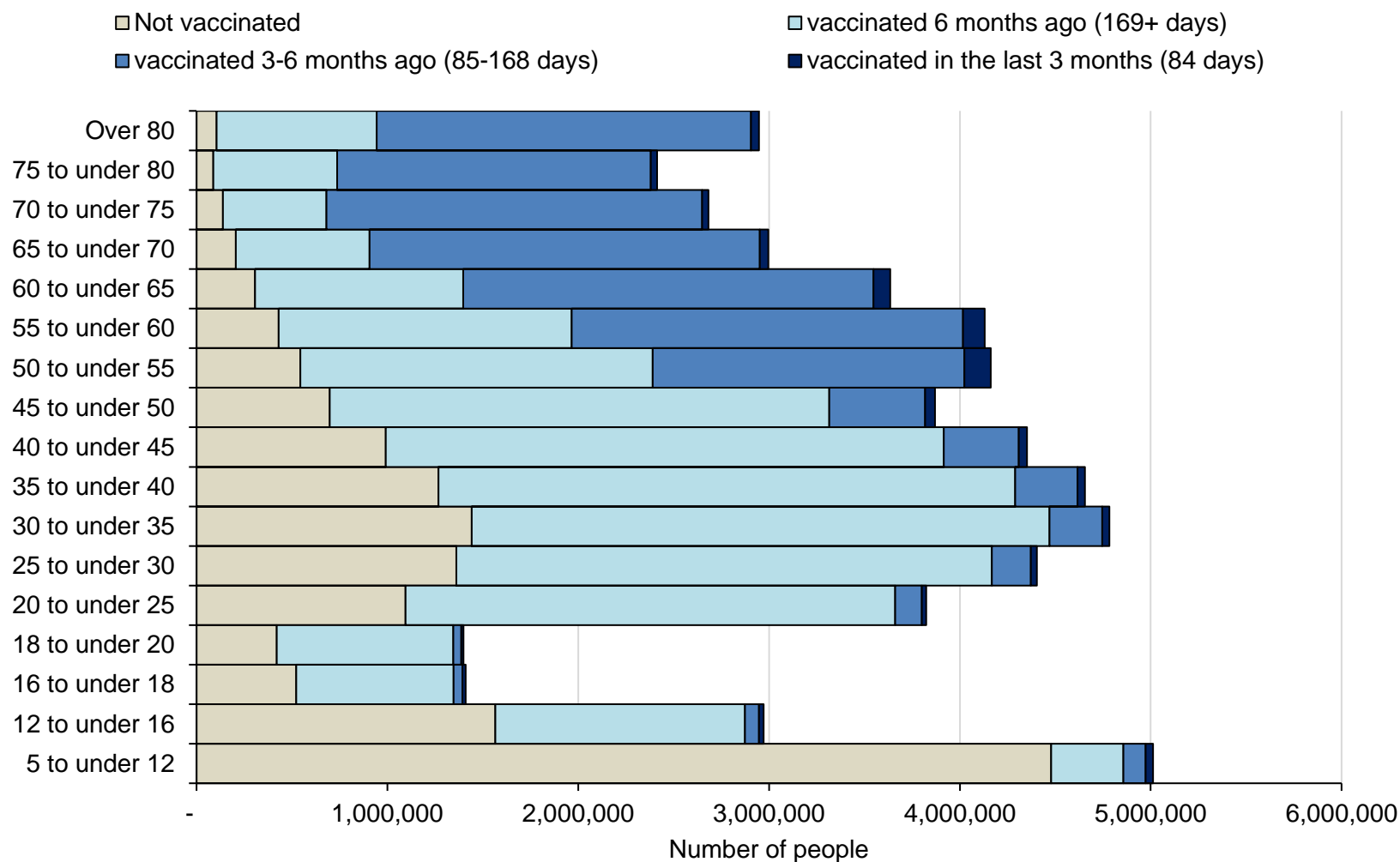


Figure 65: Provisional data on the proportion of people vaccinated with any dose of COVID-19 vaccine in the last 3 months, 3 to 6 months and vaccinated more than 6 months ago by ethnicity in those living and resident in England, aged 50 and over

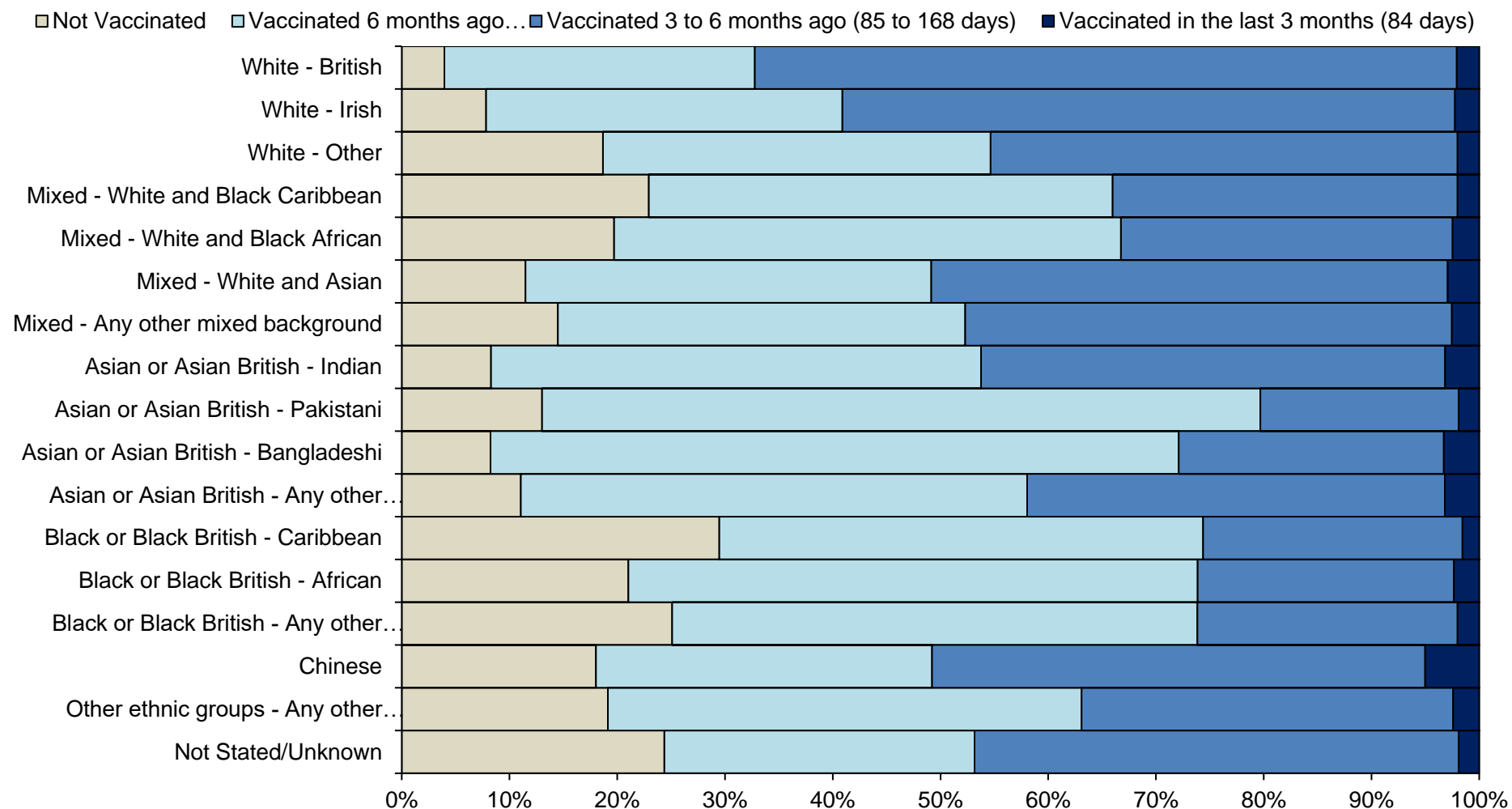
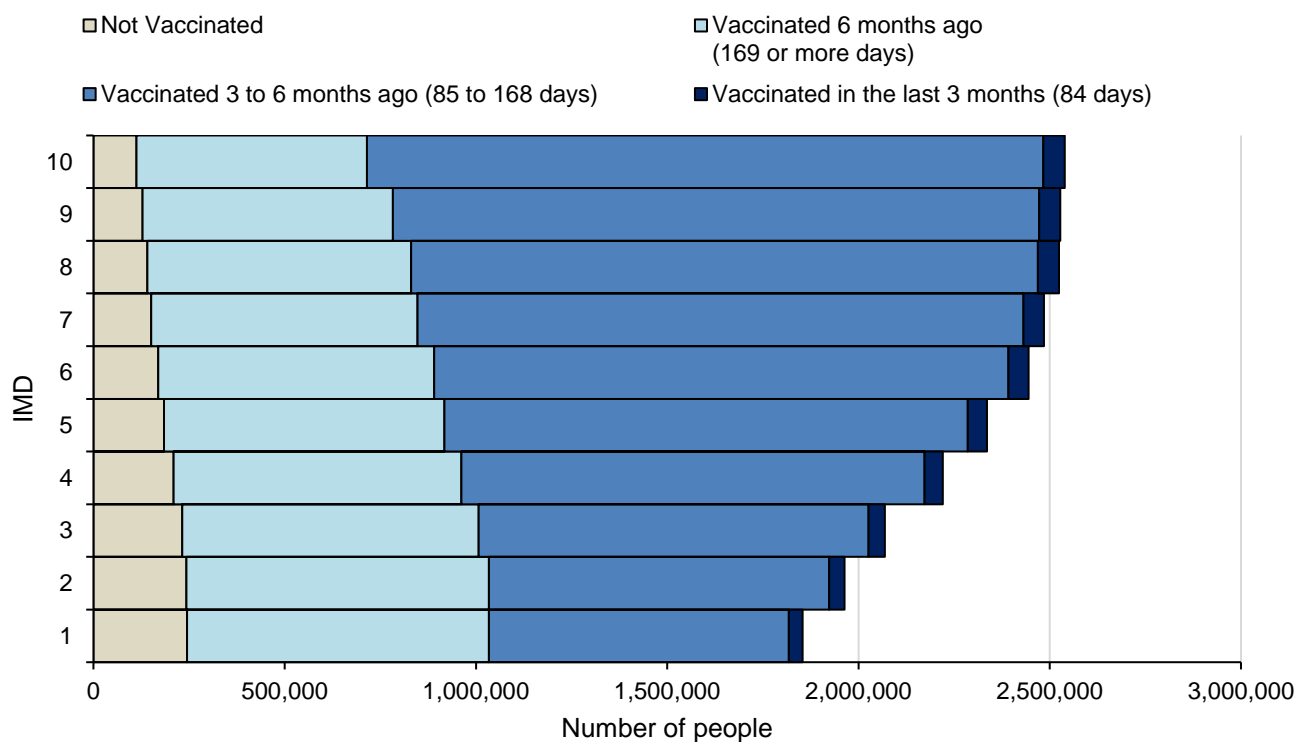


Figure 66: Provisional cumulative people vaccinated with any dose of COVID-19 vaccine in the last 3 months, 3 to 6 months and vaccinated more than 6 months ago by indices of multiple deprivation (IMD)* in those living and resident in England, aged 50 and over



*Decile 1 represents the most deprived 10% (or decile) of small areas in England and Decile 10 represents the least deprived 10% (or decile) of small areas in England.

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

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 vaccination figures and definitions, please see the [Vaccinations' section of the UK COVID-19 dashboard](#)

The population coverage data representing the evergreen offer of doses 1, 2, and 3 has changed little in recent months and are no longer presented in both the UKHSA weekly flu and COVID-19 surveillance reports and in the UK COVID-19 Dashboard. Both the UKHSA weekly flu and COVID-19 surveillance reports and in the UK COVID-19 Dashboard now highlight data on the most recent vaccination campaign in those at higher risk from COVID-19 as immunity derived from vaccination declines over time. The overall vaccine uptake in the living and resident population for those with at least dose 1, 2 and 3 doses is still available within the backing tables for this section and in the dashboard APIs.

For a summary of the differences in denominators used to present administrative vaccine uptake by NHS England and vaccine coverage by UKHSA since the start of the COVID-19 programme, please see explainer [here](#). Please note that some administrative vaccine uptake data uses an ONS mid-year estimate as a denominator because not all devolved administrations have a national vaccine register. Please note that not everyone in the numerator will be in the denominator for administrative vaccine uptake where ONS mid-year estimates are used

International update

Global COVID-19 update

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

Global influenza update

Updated 6 March 2023 (based on data up to 19 February 2023) ([WHO website](#)).

Globally, influenza activity continued to decrease following the peak in late 2022. Influenza A viruses predominated with a slightly larger proportion of A(H1N1)pdm09 viruses detected among the subtyped influenza A viruses. The proportion of influenza B virus detections increased during this reporting period.

In the countries of North America, most indicators of influenza activity decreased to levels similar or below levels typically observed towards the end of the season. Influenza A viruses predominated and influenza A(H3N2) accounted for the majority of subtyped influenza A viruses in the United States of America (USA), whereas A(H1N1)pdm09 accounted for the majority of subtyped influenza A viruses in Canada.

In Europe, overall influenza detections remained stable and influenza positivity from sentinel sites increased in the most recent week, remaining above the epidemic threshold at the regional level. Out of 39 countries, 18 reported high or moderate intensity, and over half continued to report widespread activity. Overall, influenza A and B viruses were detected at similar proportions in both sentinel and non-sentinel surveillance. The proportion of influenza B viruses increased in recent weeks. Other indicators of influenza activity remained stable or decreased in most countries while a few countries reported increases.

In Central Asia, influenza activity decreased overall.

In Northern Africa, activity driven by all seasonal influenza subtypes was low and continued to decrease in Morocco and Tunisia.

In Western Asia, influenza activity continued to be reported in some countries with detections of all seasonal influenza subtypes.

In East Asia, influenza activity of predominantly A(H1N1)pdm09 steeply increased in China but decreased in the other reporting countries.

In the Caribbean and Central American countries, influenza activity of mainly influenza A(H3N2) and B viruses continued to decrease.

In the tropical countries of South America, influenza remained low with all seasonal subtypes co-circulating and influenza B/Victoria predominant

In tropical Africa, influenza activity was highest in eastern Africa but remained low overall with detections of all seasonal influenza subtypes reported.

In Southern Asia, influenza activity remained low with all seasonal influenza subtypes detected.

In South-East Asia, detections of predominantly influenza B viruses remained elevated, mainly due to continued detections in Malaysia.

In the temperate zones of the southern hemisphere, influenza activity remained at interseasonal levels.

The WHO GISRS laboratories tested more than 452,053 specimens during that time period. 31,912 were positive for influenza viruses, of which 18,760 (58.8%) were typed as influenza A and 13,152 (41.2%) as influenza B. Of the sub-typed influenza A viruses, 4,159 (66.2%) were influenza A(H1N1)pdm09 and 2,144 (33.8%) were influenza A(H3N2). Of the characterized B viruses, 100% (1,094) belonged to the B/Victoria lineage.

Influenza in Europe

Updated data for week 8 2023 ([Joint ECDC-WHO Europe Influenza weekly update](#)).

The percentage of all sentinel primary care specimens from patients presenting with ILI or ARI symptoms that tested positive for an influenza virus decreased from 28% in the previous week to 25% in week 8 2023 which remains above the epidemic threshold (10%). Influenza activity had been decreasing across the Region until week 4 2023, however an increase in positivity was noted between week 5 and 7 2023 related to increased type B virus circulation. Countries are experiencing a mixed distribution of circulating viruses with increasing circulation of A(H1)pdm09 and type B viruses.

For week 8 2023, of 38 countries and areas reporting on intensity of influenza activity, 6 reported baseline-intensity (Germany, Netherlands, Ukraine, United Kingdom (Northern Ireland), United Kingdom (Scotland) and Uzbekistan), 11 reported low-intensity (across the Region), 19 reported medium-intensity (across the Region) and 2 reported high-intensity (Bosnia and Herzegovina, and Croatia).

Of 37 countries and areas reporting on geographic spread of influenza viruses, 4 reported sporadic spread (Azerbaijan, Kazakhstan, United Kingdom (Northern Ireland) and Uzbekistan), 4 reported local spread (Kyrgyzstan, Lithuania, Malta and Slovakia), 8 reported regional spread (Austria, Czechia, Georgia, North Macedonia, Moldova, Serbia, United Kingdom (Scotland) and Kosovo) and 21 reported widespread activity (across the Region).

For week 8 2023, 836 (25%) of 3,306 sentinel specimens tested positive for an influenza virus; 30% were type A and 70% were type B. Of 159 subtyped A viruses, 87% were A(H1)pdm09 and 13% A(H3). All 136 type B viruses ascribed to a lineage were Victoria lineage.

Of 30 countries and areas across the Region that each tested at least 10 sentinel specimens in week 8 2023, 22 reported a rate of influenza virus detections at or above 10%: Sweden (73%), Slovenia (50%), Netherlands (48%), France (42%), Slovakia (41%), Romania (36%), Denmark (36%), Switzerland (35%), Spain (34%), Moldova (32%), Ukraine (31%), Armenia (30%), Luxembourg (26%), Poland (25%), Belgium (25%), Norway (23%), Italy (22%), Austria (20%), Kosovo (17%), Germany (16%), Estonia (12%) and Bulgaria (10%).

For the season to date, 21,064 (24%) of 89,424 sentinel specimens tested positive for an influenza virus. More influenza type A (n=17,415, 83%) than type B (n=3,649, 17%) viruses have been detected. Of 14,251 subtyped A viruses, 9,668 (68%) were A(H3) and 4,583 (32%) were A(H1)pdm09. All 1,049 influenza type B viruses ascribed to a lineage were Victoria lineage (71% of type B viruses were reported without a lineage).

For week 8 2023, 7,641 of 59,752 specimens from non-sentinel sources (such as hospitals, schools, primary care facilities not involved in sentinel surveillance, or nursing homes and other institutions) tested positive for an influenza virus; 3,484 (46%) were type A and 4,157 (54%) were type B. Of 506 subtyped A viruses, 360 (71%) were A(H1)pdm09 and 146 (29%) A(H3). Of 198 type B viruses ascribed to a lineage, all were Victoria lineage.

For the season to date, more influenza type A (n=176,001, 84%) than type B (n=33,950, 16%) viruses have been detected. Of 52,424 subtyped A viruses, 28,514 (54%) were A(H1)pdm09 and 23,910 (46%) were A(H3). Of 2,322 influenza type B viruses ascribed to a lineage, all were B/Victoria (93% of type B viruses were reported without a lineage).

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](#).

Influenza in Australia

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 26 January 2023](#)

From 6 January 2023 to 26 January 2023, one human case of infection with an influenza A(H5) virus was reported officially.

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.

[Latest UKHSA avian influenza technical briefing 23 February 2023](#)

See also the [WHO Disease Outbreak News Reports](#) for more information.

Middle East respiratory syndrome coronavirus (MERS-CoV)

From April 2012 to January 2023, a total of 2,603 laboratory-confirmed cases of MERS-CoV and 935 associated deaths were reported globally to [WHO](#) under the International Health Regulations (IHR 2005).

Between 29 December 2021 and 31 October 2022, four laboratory-confirmed cases of MERS-CoV were reported to WHO by the Ministry of Health of the Kingdom of Saudi Arabia. No deaths were reported ([WHO website](#)).

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](#)).

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](#)

[Sources of surveillance data for influenza, COVID-19 and other respiratory viruses](#)

UKHSA has delegated authority, on behalf of the Secretary of State, to process Patient Confidential Data under Regulation 3 The Health Service (Control of Patient Information) Regulations 2002

Regulation 3 makes provision for the processing of patient information for the recognition, control and prevention of communicable disease and other risks to public health.

About the UK Health Security Agency

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

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