



UK Health
Security
Agency

National Influenza and COVID-19 surveillance report

Week 31 report (up to week 30 data)

3 August 2023

Correction

19 September 2023: due to a transcription error zero counts were imported for influenza subtypes A(H3N2) and not subtyped samples in figure 4. This has now been amended in figure 4 and in the datafile. This does not alter the numbers written in this report.

Contents

Executive summary	5
Laboratory surveillance	7
Confirmed COVID-19 cases (England).....	7
Respiratory DataMart system (England).....	9
Community surveillance	11
Acute respiratory infection incidents	11
Syndromic surveillance.....	13
Primary care surveillance.....	14
RCGP Clinical Indicators (England).....	14
RCGP sentinel swabbing scheme in England	15
Secondary care surveillance	19
Hospitalisations, SARI Watch	19
ICU or HDU admissions, SARI Watch	21
ECMO, SARI Watch	24
RSV admissions, SARI Watch.....	25
Mortality surveillance	26
COVID-19 deaths	26
Daily excess all-cause mortality (England)	26
Microbiological surveillance	27
SARS-CoV-2 variants.....	27
COVID-19 vaccination.....	29
COVID-19 vaccine uptake in England	29
International update	30
Global COVID-19 update.....	30
Global influenza update.....	30
Other respiratory viruses	33
Related links	35
About the UK Health Security Agency	36

National Influenza and COVID-19 Report: week 31 report (up to week 30 data)

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](#).

For additional information regarding data source please refer to [Sources of surveillance data for influenza, COVID-19 and other respiratory viruses](#)

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 30 (between 24 July and 30 July 2023) and for some indicators daily data up to 31 July 2023.

Overall

In week 30, from most indicators, influenza activity remained low and stable and COVID-19 activity increased across most indicators.

COVID-19

COVID-19 case rates and positivity rates through Pillar 1 increased in all age groups, regions and most ethnic groups in week 30.

Through Respiratory Datamart, SARS-CoV-2 positivity increased slightly to 5.4%.

The overall number of reported SARS-CoV-2 confirmed outbreaks decreased slightly compared to the previous week. 17 SARS-CoV-2 confirmed outbreaks were reported in week 30 in England.

Overall, COVID-19 hospitalisations increased in week 30 compared to the previous week. Hospitalisations were highest in the 85 years and over age group.

Through syndromic surveillance indicators, emergency department attendances for covid-like illness increased nationally.

Influenza

In week 30, influenza positivity rates remained low and stable at 0.8%, with the highest positivity seen in children younger than 5 years of age at 0.9%.

Through primary care surveillance, the influenza-like-illness consultations indicator remained stable in week 30 compared to the previous week and was within the baseline activity level range.

There were no influenza confirmed outbreaks reported in England in week 30.

There were no Influenza ICU admissions in weeks 29 and 30, and thus remained within the baseline range of activity.

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

RSV

The overall positivity for RSV remained low at 0.3%, with the highest positivity in those aged under 5 years old at 1.4%. Emergency department attendances for acute bronchiolitis remained stable nationally, although there was a slight increase in children under one year of age.

Other viruses

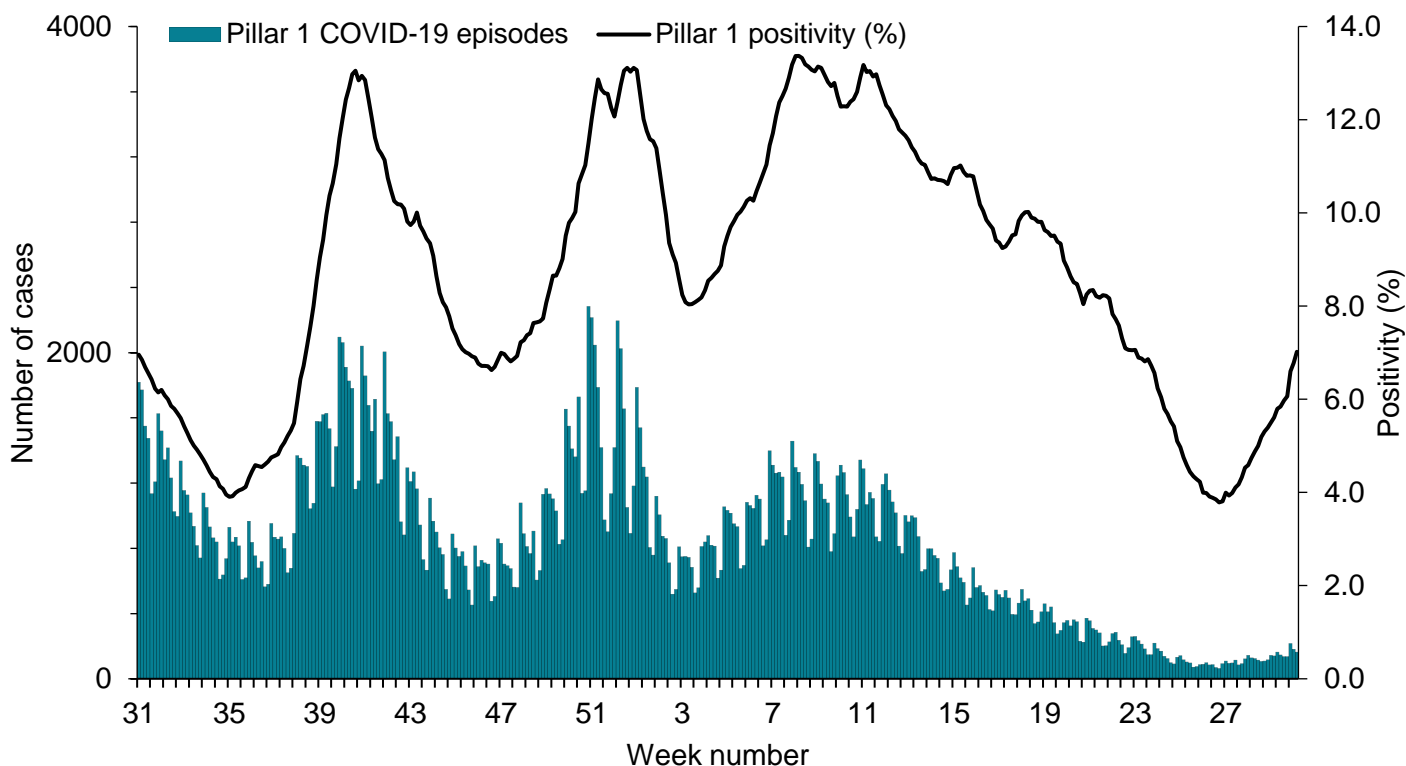
Adenovirus positivity increased slightly to 3.5%, with the highest positivity in children aged 5 to 14 years old age group at 8.6%. Human metapneumovirus (hMPV) positivity remained low at 0.5%, with the highest positivity in children below 5 years of age at 1.2%. Parainfluenza positivity remained stable at 3.5%, with the highest positivity in children below 5 years of age at 5.6%. Rhinovirus positivity decreased slightly to 15.0% overall, with the highest positivity in those aged under 5 years old at 32.4%.

Laboratory surveillance

Confirmed COVID-19 cases (England)

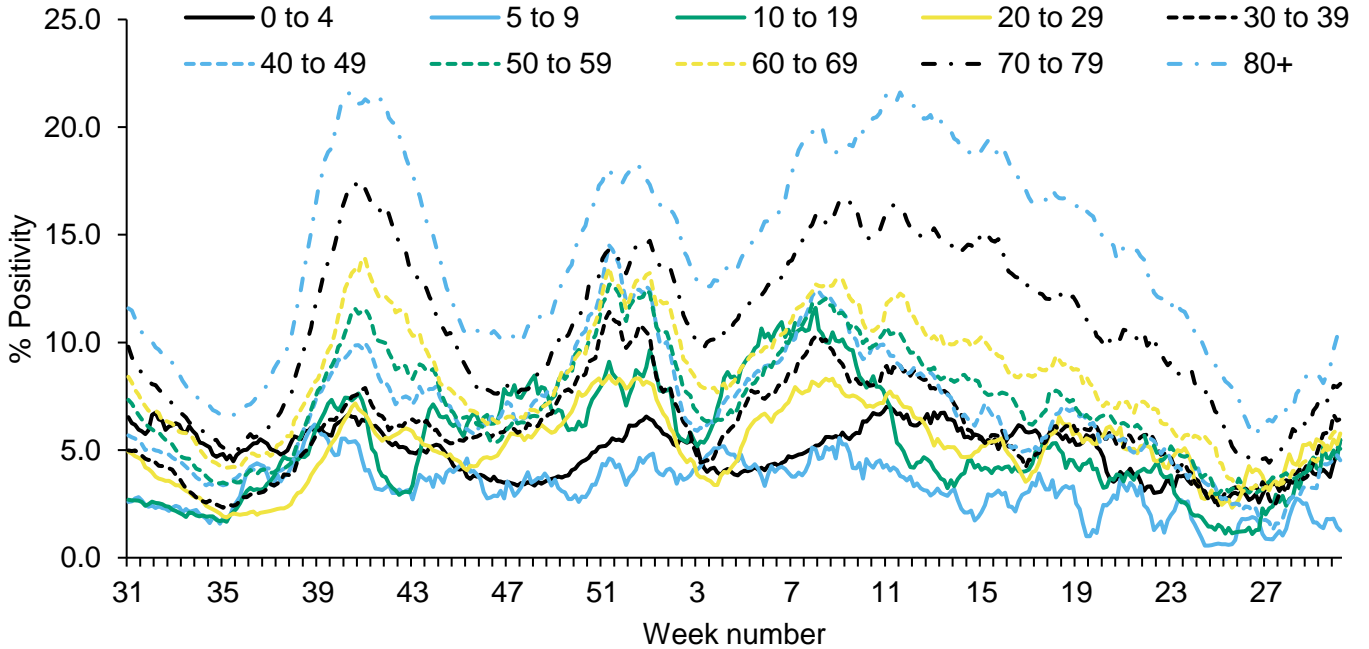
As of 9am on 31 July 2023, a total of 2,108,107 episodes have been confirmed for COVID-19 in England under Pillar 1, and 18,753,619 episodes under Pillar 2, since the beginning of the pandemic. COVID-19 case rates through Pillar 1 increased in all regions and most ethnic groups in week 30.

Figure 1: Confirmed COVID-19 episodes tested under Pillar 1, based on sample day with overall seven-day rolling average PCR positivity for Pillar 1 (%)



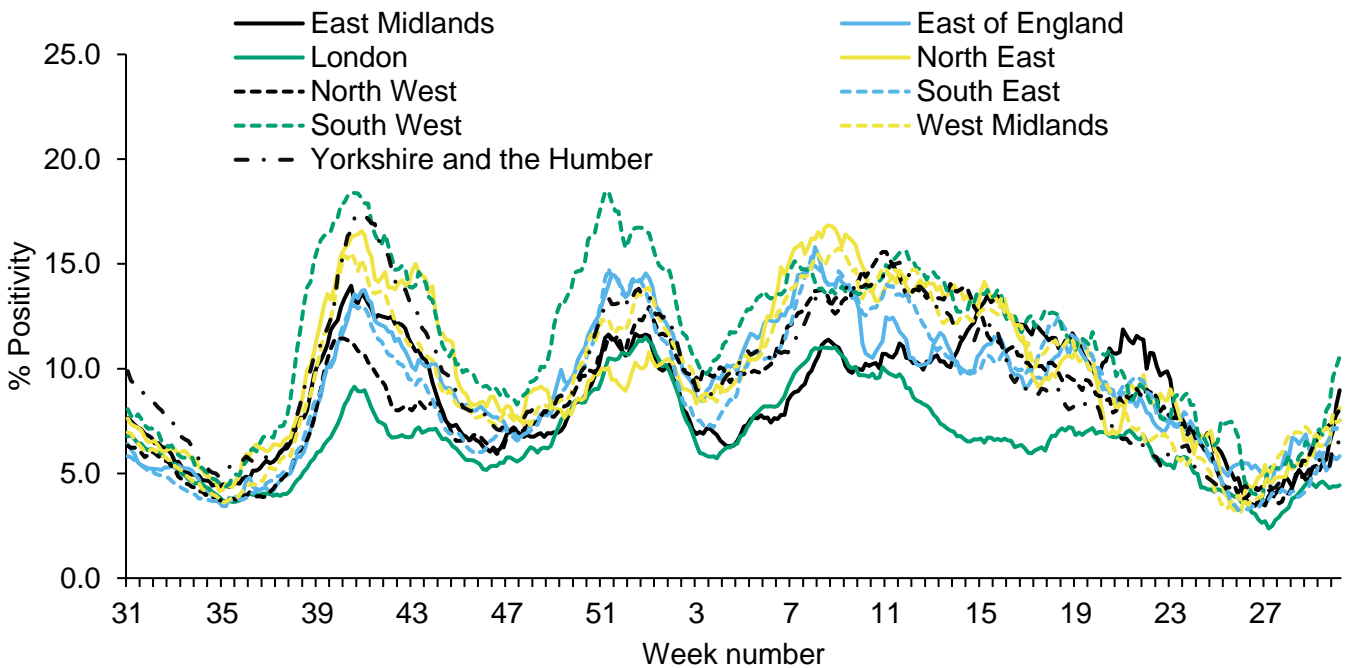
Age

Figure 2: Seven-day rolling average PCR positivity (%) of confirmed COVID-19 cases tested under Pillar 1 by age group



Geography

Figure 3: Seven-day rolling average PCR positivity (%) of confirmed COVID-19 cases tested under Pillar 1 by UKHSA centres



Respiratory DataMart system (England)

In week 30, data is based on reporting from 11 out of the 16 sentinel laboratories.

In week 30, 4,396 respiratory specimens reported through the Respiratory DataMart System were tested for SARS-CoV-2. 238 samples were positive for SARS-CoV-2 with an overall positivity of 5.4%, which increased slightly compared to the previous week. The highest positivity was seen in adults older than 65 years of age at 6.6%.

In week 30, 2,677 respiratory specimens reported through the Respiratory DataMart System were tested for influenza. 22 samples tested positive for influenza; nine influenza A(not subtyped), nine influenza A(H3N2) and four were influenza B (Figure 4). Overall, influenza positivity remained low at 0.8% in week 30 compared to 0.9% in the previous week, with the highest positivity seen in children younger than 5 years of age at 0.9%.

Adenovirus positivity increased to 3.3%, with the highest positivity in children aged 5 to 14 years old age group at 8.6%.

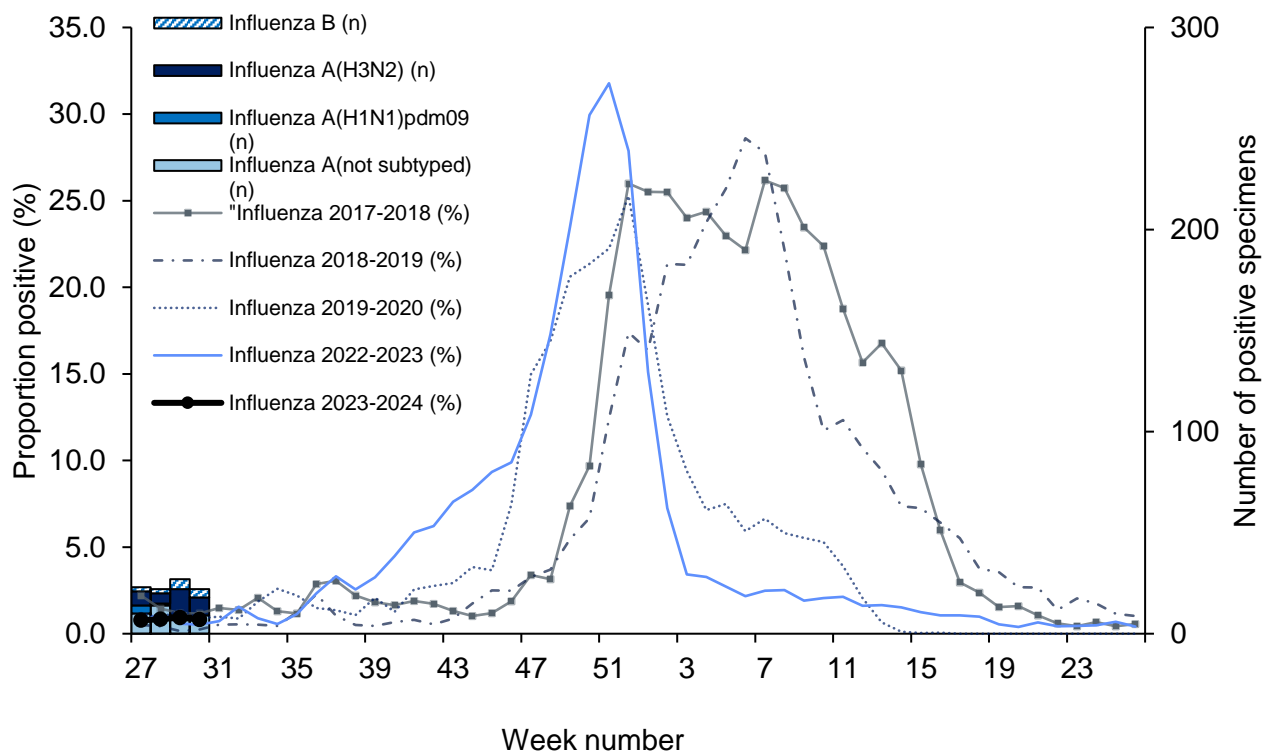
Human metapneumovirus (hMPV) positivity remained low at 0.5%, with the highest positivity in children younger than 5 years of age at 1.2%.

Parainfluenza positivity remained stable at 3.6%, with the highest positivity in children below 5 years of age at 5.6%.

Rhinovirus positivity decreased slightly to 15.0% overall, with the highest positivity in those aged under 5 years old at 32.4%.

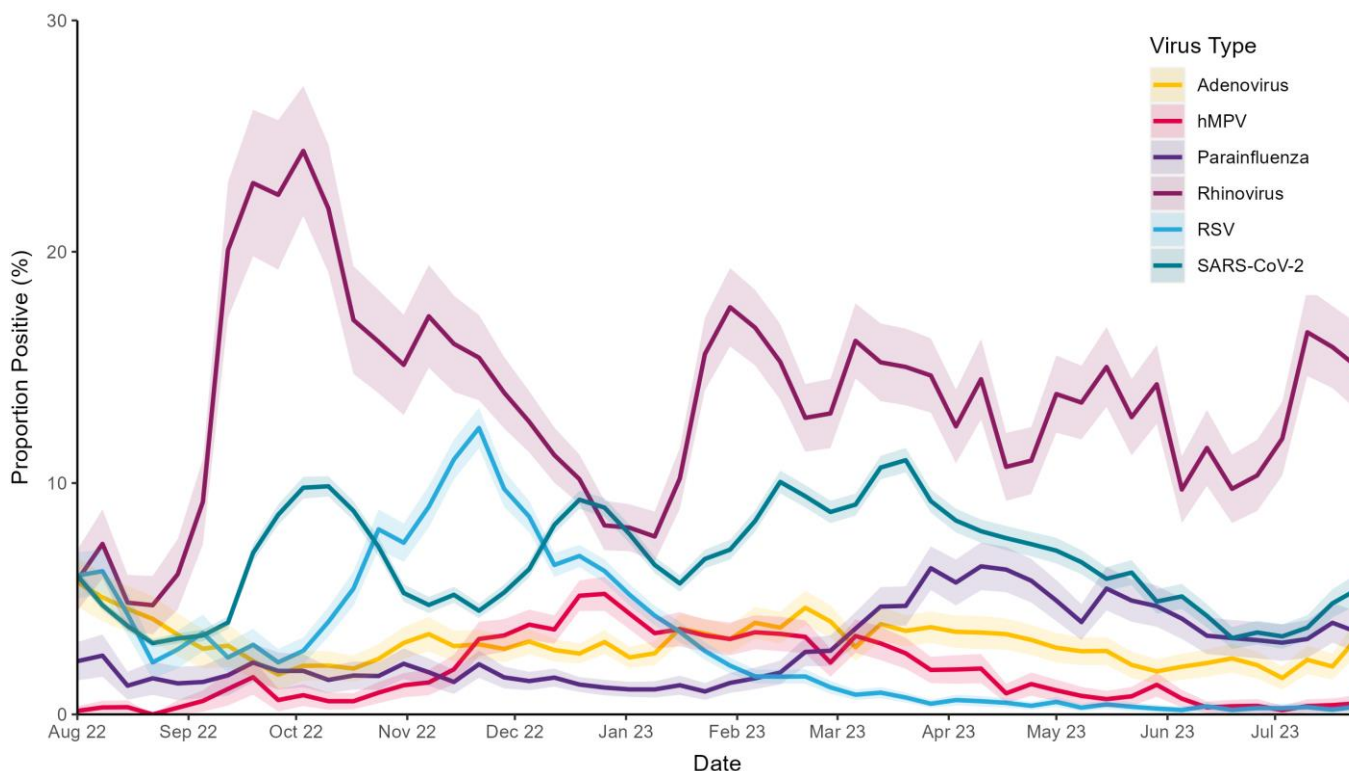
The overall positivity for RSV remained low at 0.3%, with the highest positivity in those aged under 5 years old at 1.4%.

Figure 4: Respiratory DataMart samples positive for influenza and weekly positivity (%) for influenza, England



Please note data from seasons 2020-21 and 2021-22 has been removed as there was low activity throughout.

Figure 5: Respiratory DataMart weekly positivity (%) for other viruses, 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).

76 new ARI incidents have been reported in week 30 in the UK:

- 53 incidents were from care homes, where 24 had at least one linked case that tested positive for SARS-CoV-2
- 15 incidents were from hospitals, where 10 had at least one linked case that tested positive for SARS-CoV-2
- Two incidents were from prisons, where one had at least one linked case that tested positive for SARS-CoV-2
- One incident was from an educational setting, where there was no positive test result available
- Five incidents were from other settings, where two had at least one linked case that tested positive for SARS-CoV-2

Figure 6: Number of acute respiratory infection (ARI) incidents by setting, England

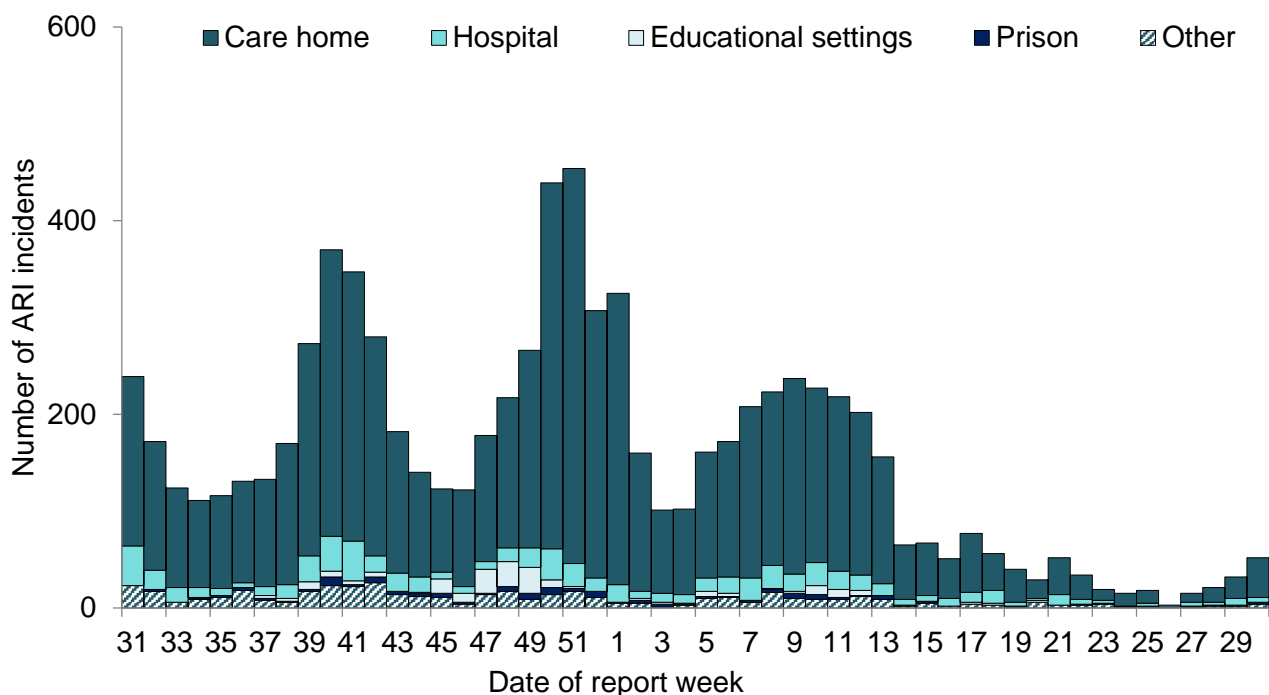
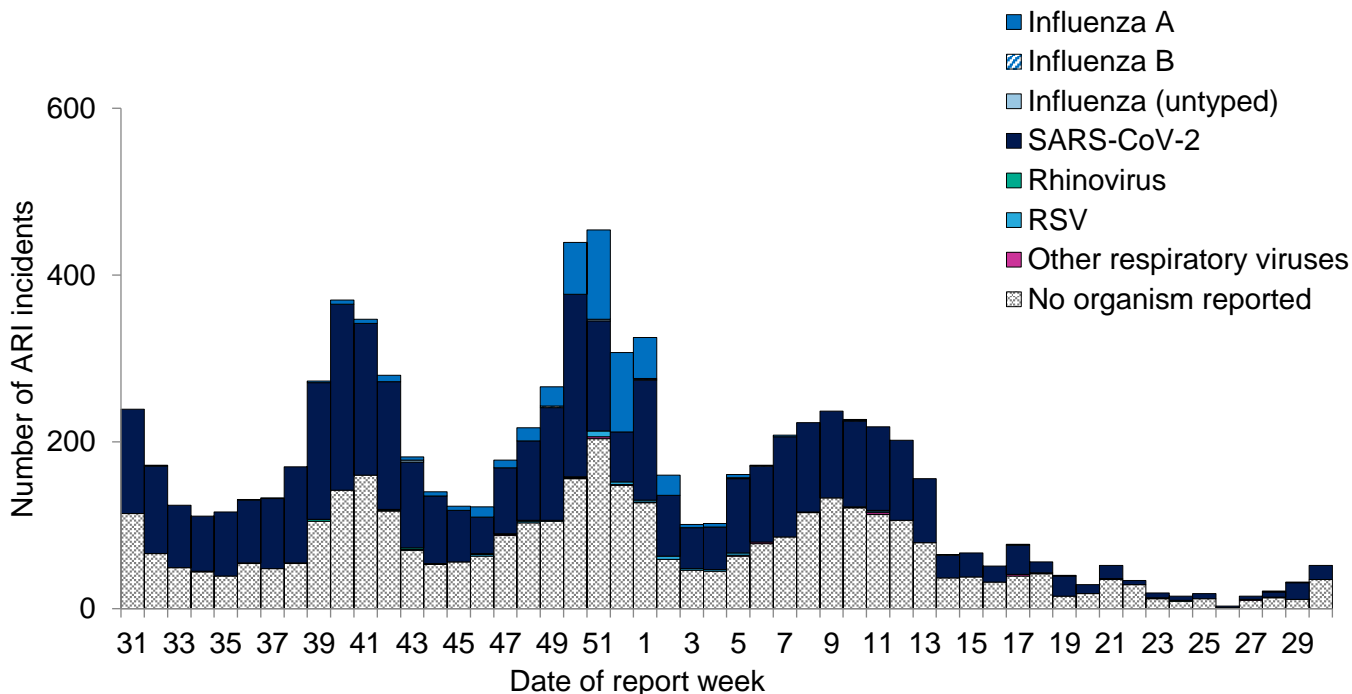


Figure 7: Number of acute respiratory infection (ARI) incidents in all settings by virus type, England



Syndromic surveillance

During week 30, NHS 111 calls for cold or flu and cough remained stable overall and similar to baseline levels. GP in hours consultation rates for influenza-like illness were stable and similar to baseline levels. Emergency department attendances (ED) for influenza-like illness remained stable nationally and similar to baseline levels. ED attendances for acute respiratory infection increased slightly but were similar to baseline levels. ED attendances for acute bronchiolitis overall remained within baseline levels with a slight increase in children aged under one year. ED for covid-19-like illness increased nationally, particularly in adults aged older than 45 years of age.

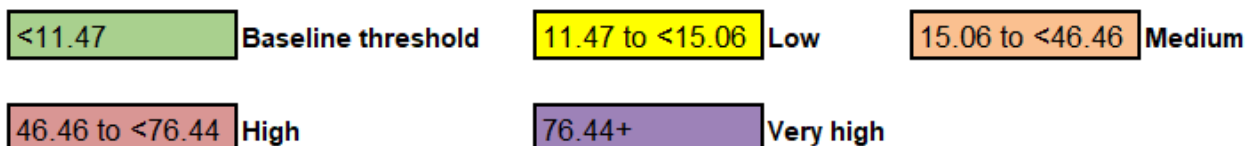
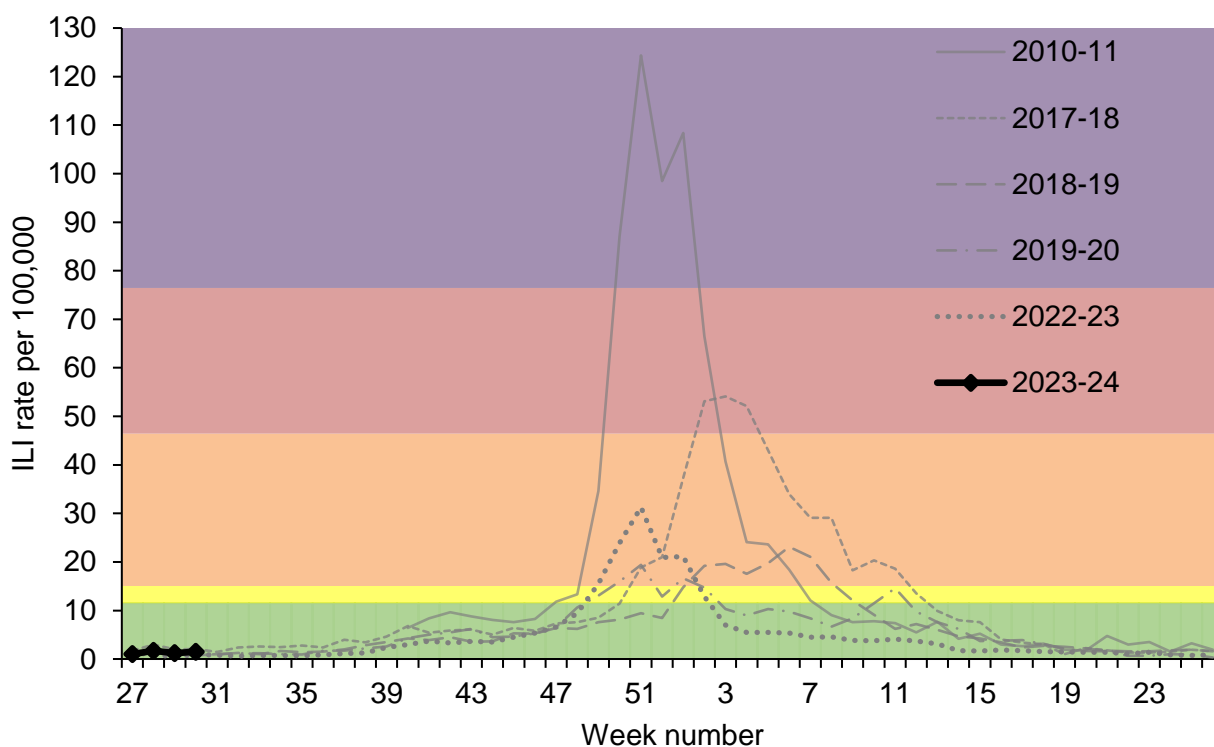
For further information on syndromic surveillance please see the [Syndromic Surveillance: weekly summaries](#).

Primary care surveillance

RCGP Clinical Indicators (England)

The weekly Influenza-like-illness (ILI) consultation rate through the RCGP surveillance increased slightly to 1.5 per 100,000 registered population in participating GP practices in week 28 from 1.2 per 100,000 in week 17. This is within baseline activity levels (less than 11.47 per 100,000) (Figure 8). Data for influenza seasons 2020/21 and 2021/22 are removed as there was low activity throughout.

Figure 8: RCGP influenza-like illness (ILI) consultation rates, all ages, England



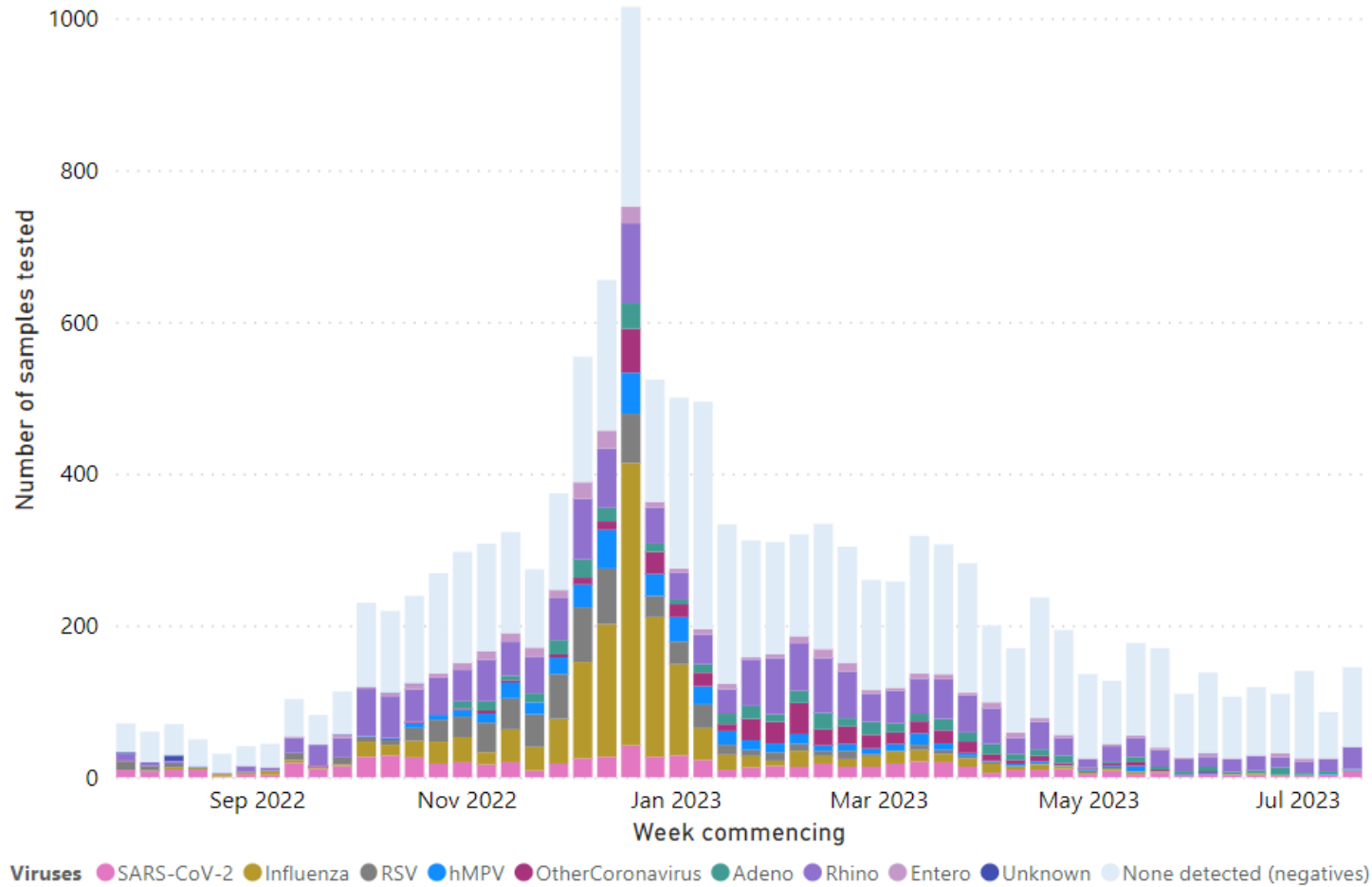
RCGP sentinel swabbing scheme in England

Due to connectivity issues there has been a delay in processing swab results in the last week. Therefore, there are no data for week 30. These will be updated retrospectively.

Based on the date samples were received in the reference laboratory, in week 29 2023 (week commencing 17 July 2023) 145 samples were tested through the GP sentinel swabbing scheme in England, of which 18 samples tested positive (Figure 9). Among all positive samples, 72.5% were positive for rhinovirus, 20% for SARS-CoV-2, 2.5% for adenovirus, 2.5% for RSV and 2.5% for hMPV (Figure 10).

Based on the date samples were taken, positivity for RSV was 0.9%, for influenza 0% and SARS-CoV-2 was 4.7%% in week 29 (Figure 11) from 106 samples.

Figure 9: Number of samples tested for SARS-CoV-2, influenza, and other respiratory viruses in England by week, GP sentinel swabbing

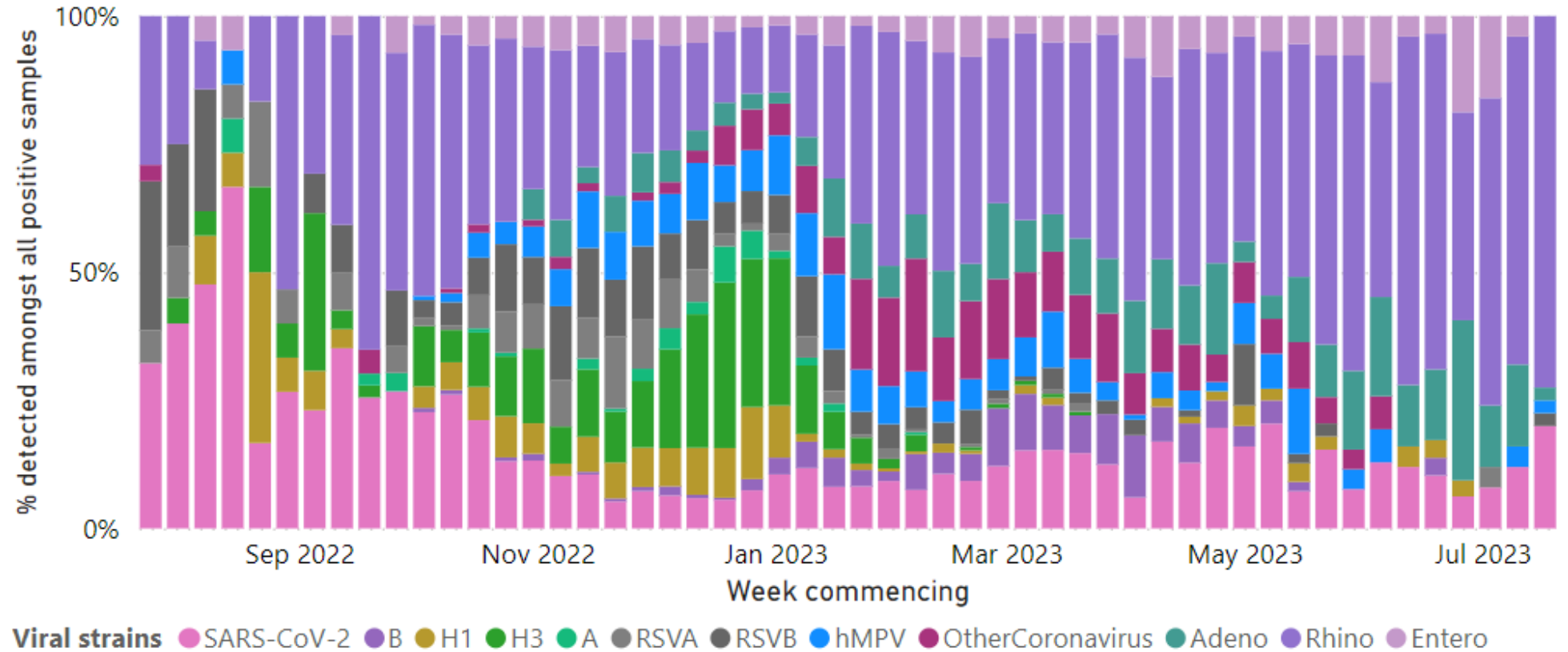


Unknown category corresponds to samples with no result yet.

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

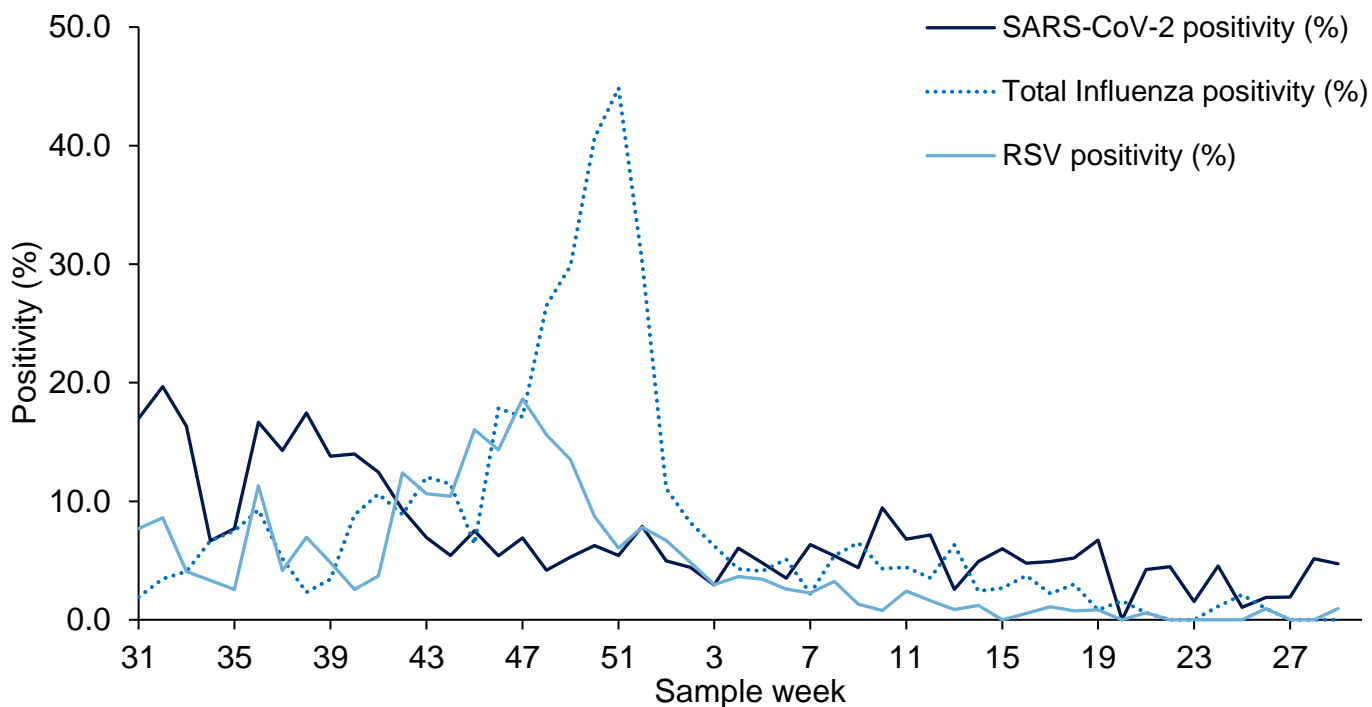
Figure 10: Proportion of detections of SARS-CoV-2, influenza, and other respiratory viral strains amongst virologically positive respiratory surveillance samples in England by week, GP sentinel swabbing scheme

% of positive samples by viral strain, by week



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

Figure 11: Weekly positivity (%) for COVID-19, Influenza and RSV in England by week, GP sentinel swabbing



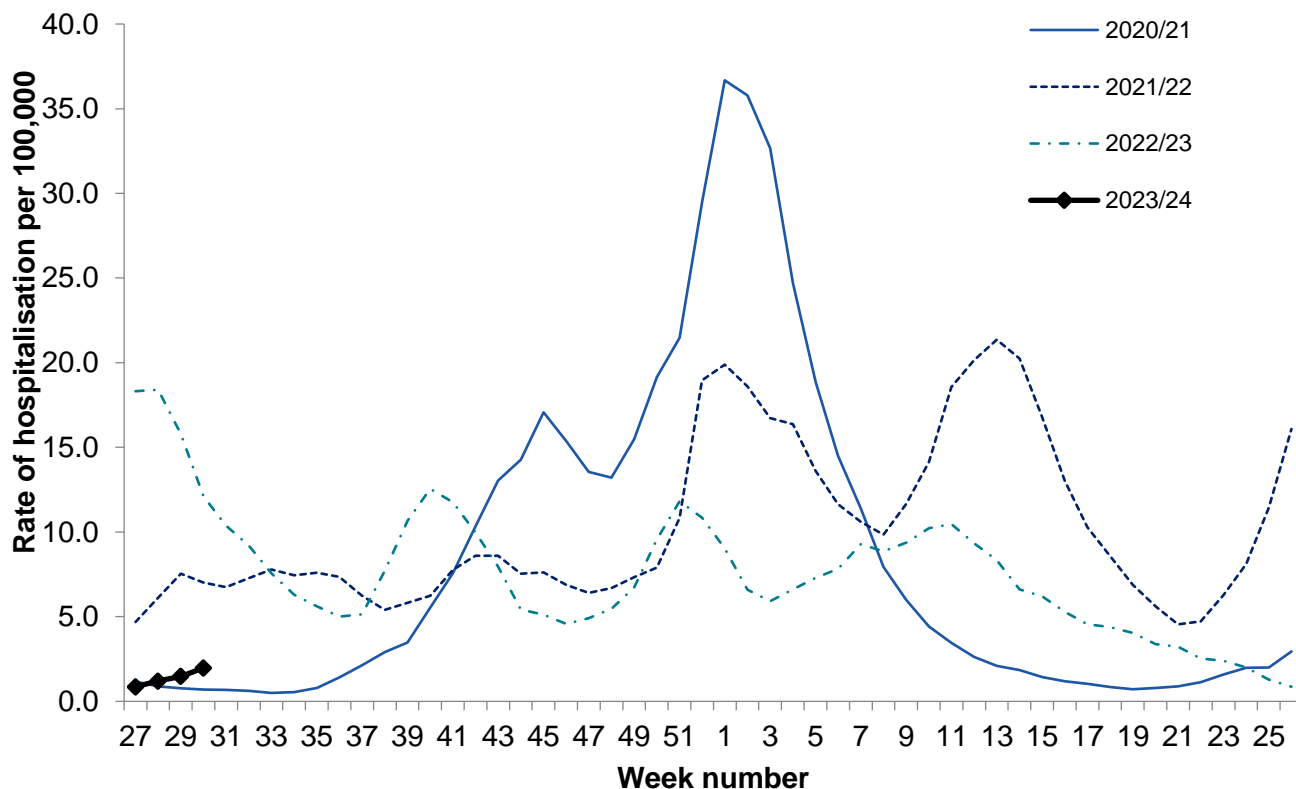
Secondary care surveillance

Hospitalisations, SARI Watch

In week 30 (ending 30 July 2023), the overall weekly hospital admission rate for COVID-19 increased to 1.97 per 100,000 compared to 1.47 per 100,000 in the previous week.

By UKHSA centre, the highest hospital admission rate for COVID-19 was observed in the South West. By age group, the highest hospital admission rate for confirmed COVID-19 continues to be in those aged 85 years old and over.

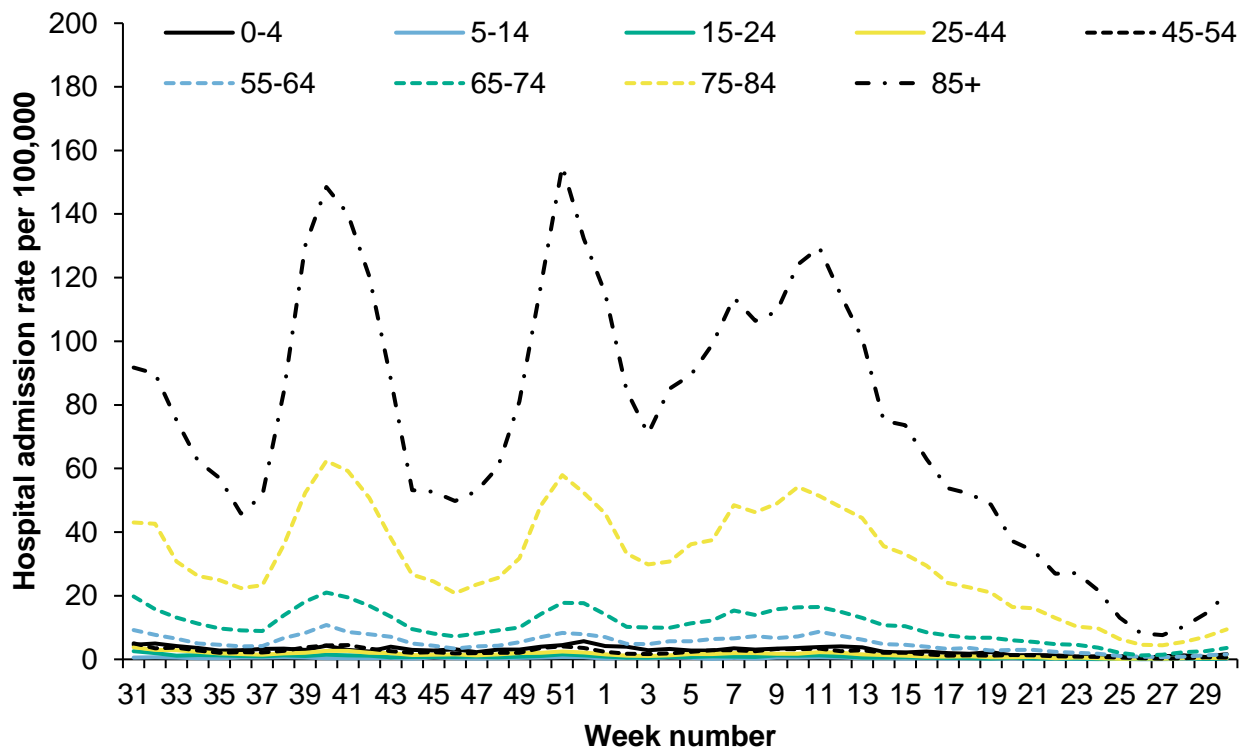
Figure 12: Weekly overall COVID-19 hospital admission rates per 100,000 trust catchment population, SARI Watch, England



* COVID-19 hospital admission rate based on 79 NHS trusts for week 30

* SARI Watch data is provisional and subject to retrospective updates

Figure 13: Weekly hospital admission rate by age group for new COVID-19 positive cases

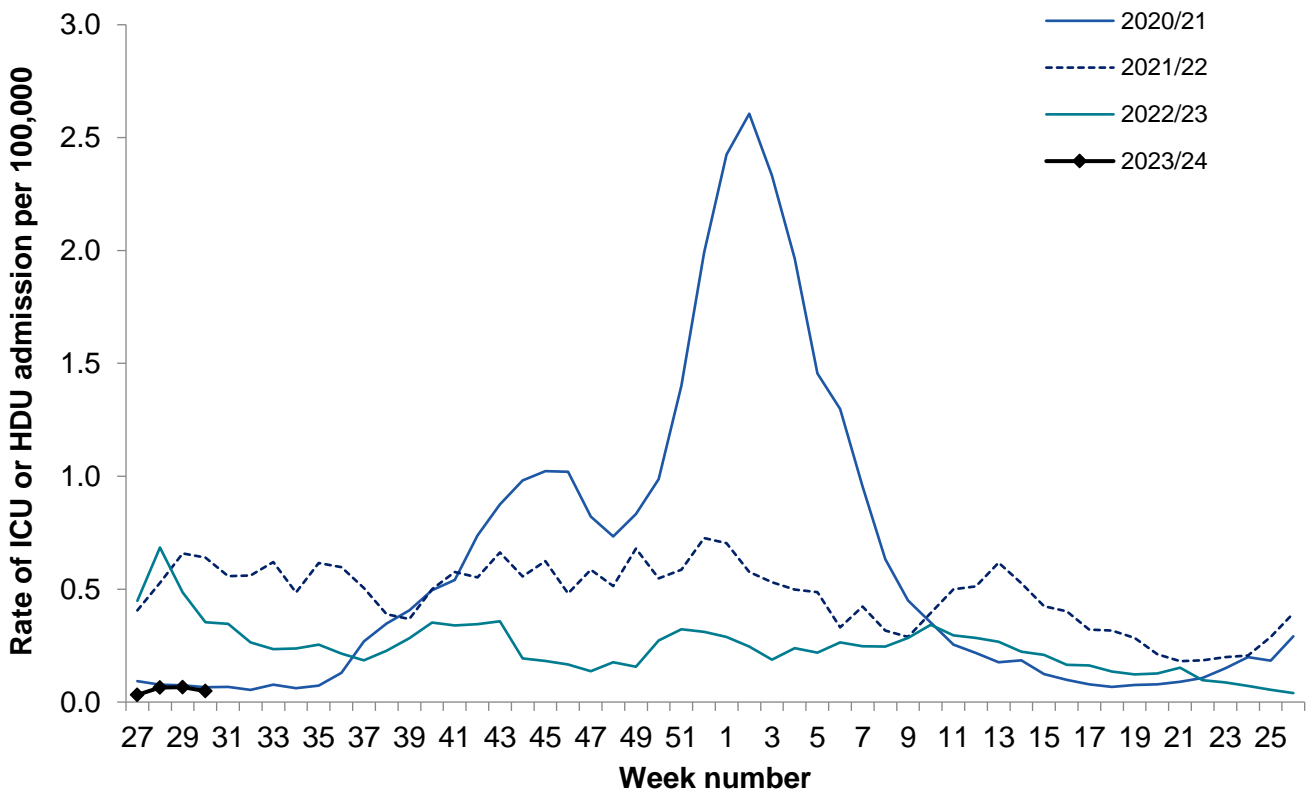


ICU or HDU admissions, SARI Watch

In week 30 (ending 30 July 2023), the overall weekly ICU or HDU admission rate for COVID-19 remained very low and is fluctuating at low levels at 0.05 per 100,000, compared to 0.07 per 100,000 in the previous week. Note that ICU or HDU admission rates may represent a lag from admission to hospital to an ICU or HDU ward.

In weeks 28, 29 and 30 there were no reported ICU or HDU admissions for influenza.

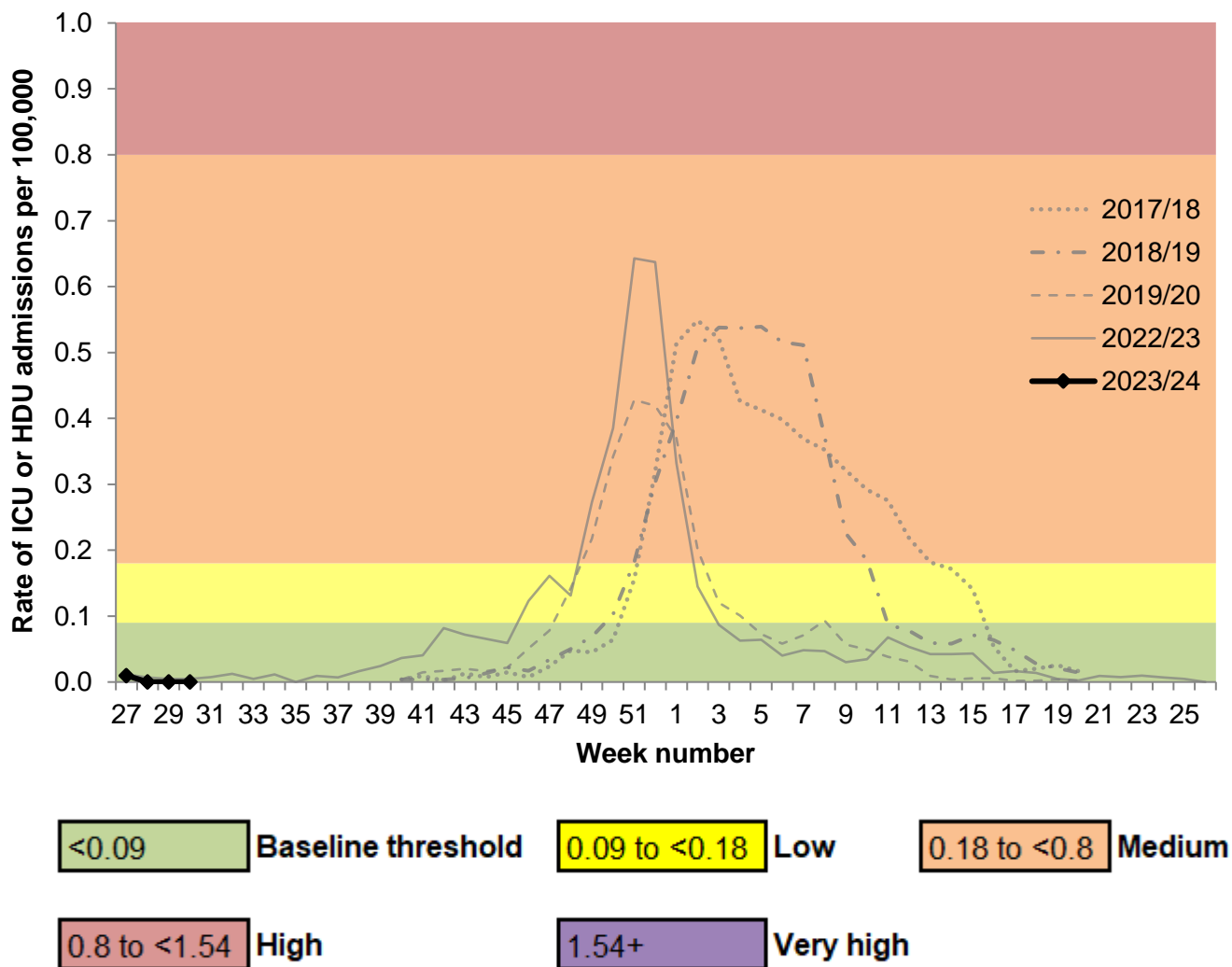
Figure 14: Weekly overall COVID-19 ICU or HDU admission rates per 100,000 trust catchment population, SARI Watch, England



* COVID-19 ICU or HDU admission rate based on 71 NHS trusts for week 30

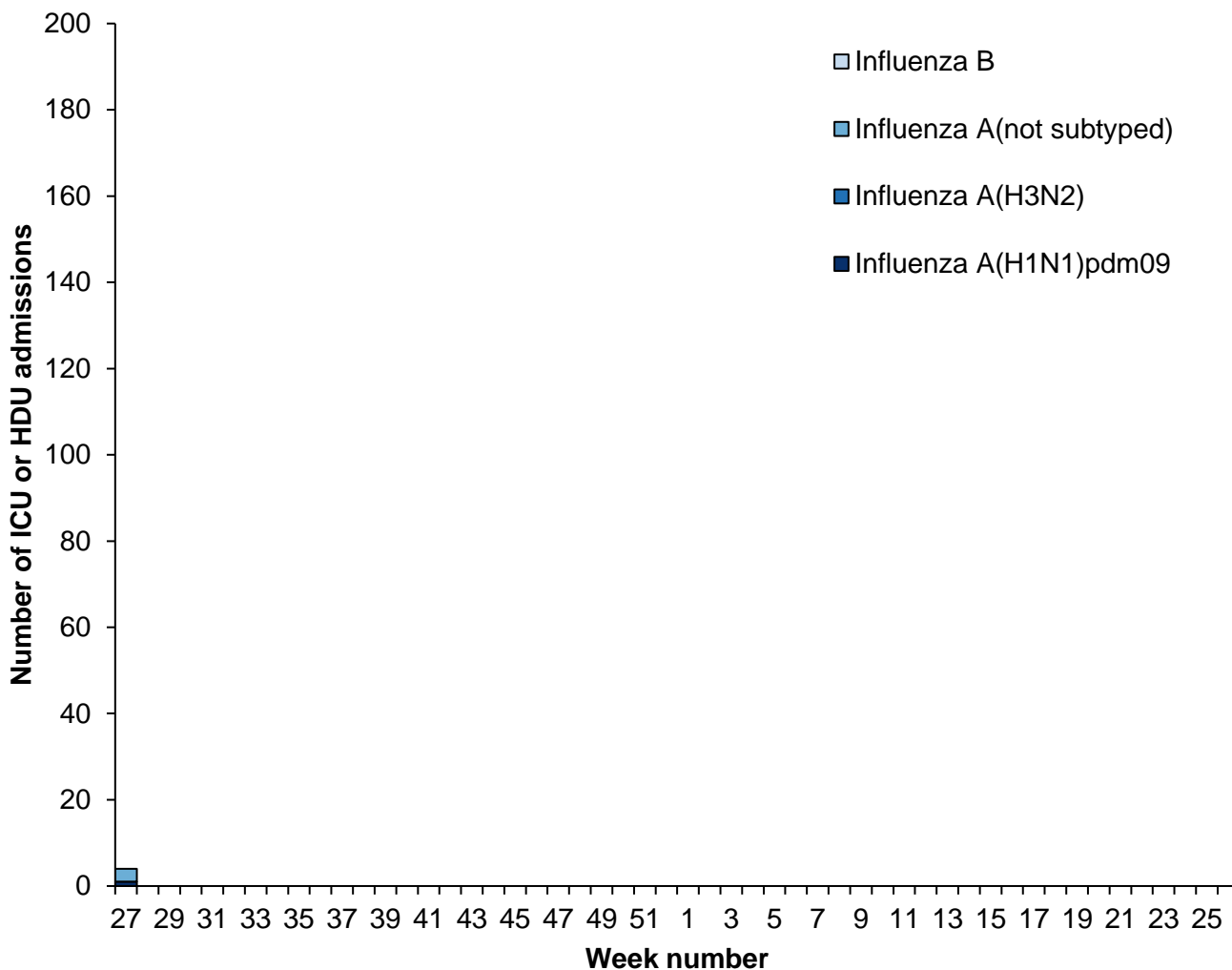
* SARI Watch data is provisional and subject to retrospective updates

Figure 15: Weekly overall influenza ICU or HDU admission rates per 100,000 trust catchment population with MEM thresholds, SARI Watch, England



Data for influenza seasons 2020/21 and 2021/22 have been removed as there was low activity throughout these seasons.

Figure 16: Weekly influenza ICU or HDU admissions by influenza type, SARI Watch, England



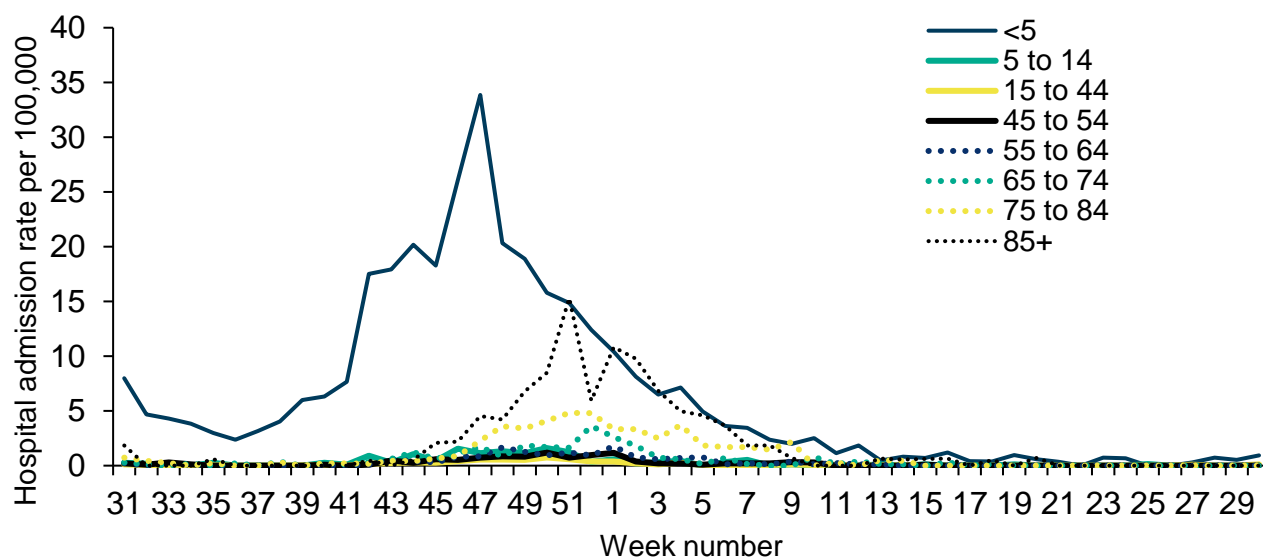
ECMO, SARI Watch

There were seven new ECMO admissions reported in weeks 29 and 30 from the 7 Severe Respiratory Failure (SRF) centres in the UK. None were due to confirmed respiratory viruses.

RSV admissions, SARI Watch

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

Figure 17: 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

Mortality surveillance

COVID-19 deaths

For further information on COVID-19 related deaths in England please see the [COVID-19 dashboard for death](#).

Daily excess all-cause mortality (England)

For further information on excess all-cause mortality in England please see 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.

Microbiological surveillance

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.

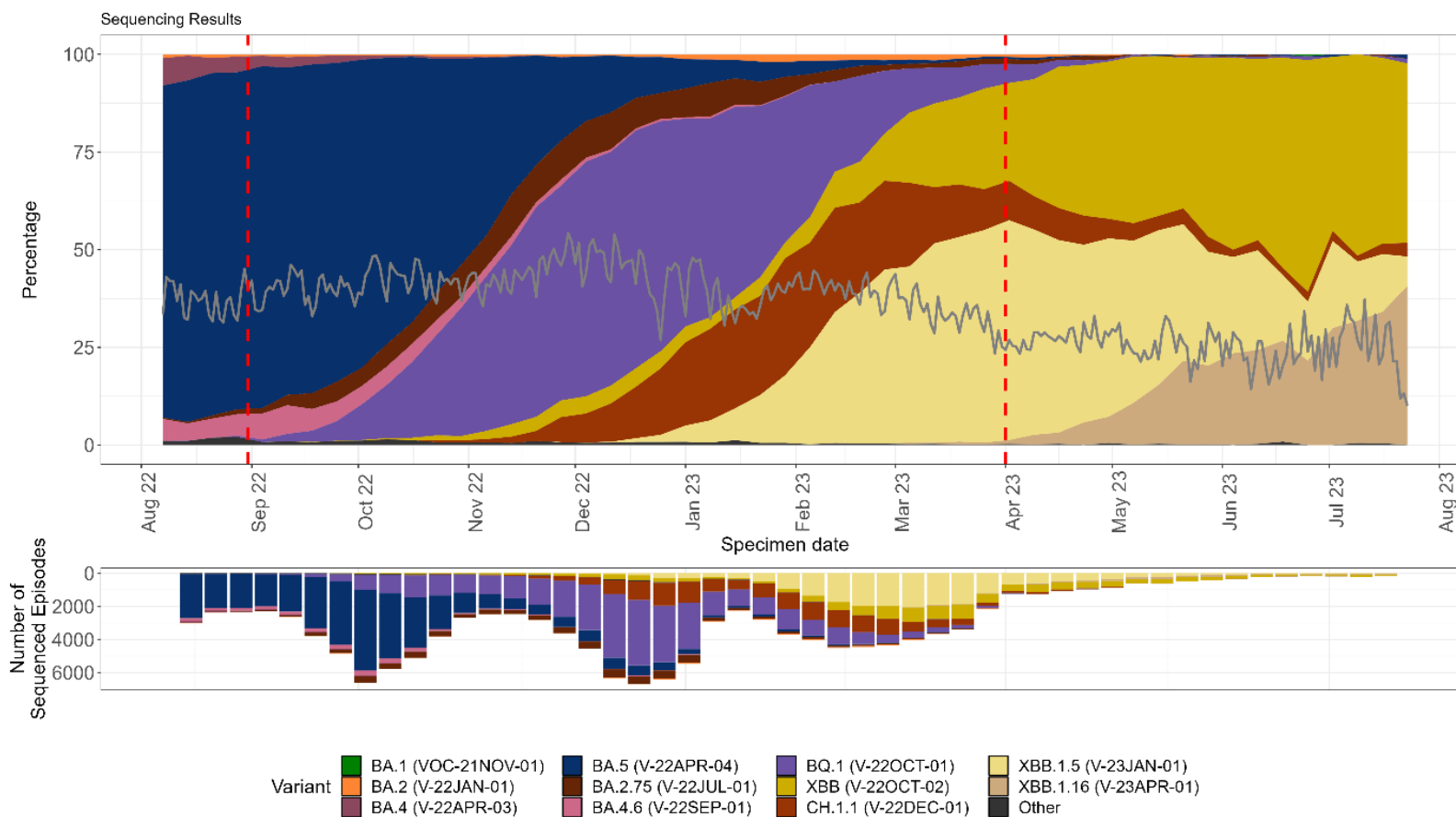
The prevalence of different UKHSA-designated variants amongst sequenced episodes is presented in Figure 18.

Variants may include many sub-lineages that have not been individually designated e.g. XBB.1.9.2 within XBB (V-22OCT-02). As a result, prevalence of that variant appears to be increasing as a whole, masking the effect of one or more growing sublineages. Once a sublineage meets required thresholds to be declared a variant, it will be designated as a variant and prevalence of this sublineage in positive cases will then be identifiable in the data.

To account for sequencing delays, we report the proportion of variants from sequenced episodes between 10 July 2023 and 16 July 2023. Of those sequenced in this period, 33.6% were classified as XBB.1.16 (V-23APR-01), 14.8% as XBB.1.5 (V-23JAN-01), 47.5% as XBB (V-22OCT-02), 2.7% as CH.1.1 (V-22DEC-01), 0.04% for both BA.2.75 (V-22JUL-01) and BQ.1 (V-22OCT-01).

Since 29 May 2023, there has been an average 243 confirmed sequenced cases per week. Due to the small absolute numbers of confirmed sequenced cases, changes in variant proportions appear more pronounced in Figure 18.

Figure 18: Prevalence of SARS-CoV-2 variants amongst available sequences episodes for England from 7 August 2022 to 23 July 2023



The grey line indicates proportion of cases sequenced.

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

- Line 1: End of August 2022 denotes the change in asymptomatic testing
- Line 2: April 2023 denotes changes in PCR testing in social care and hospital settings

Note: Recombinants such as XD, are not specified but are largely within the 'Other' group currently as numbers are too small.

COVID-19 vaccination

COVID-19 vaccine uptake in England

The 2023 spring booster campaign has been completed and there will be no further updates to this section from week 28 until [initiation of the 2023 autumn booster campaign](#).

By the end of week 26 2023 (week ending 2 July 2023), 71.1% (3,856,204 out of 5,423,074) of all people aged over 75 years old who are living and resident in England had been vaccinated with a Spring 2023 booster dose since 3 April 2023.

By the end of week 26 2023 (week ending 2 July 2023), 41.2% (915,421 out of 2,223,120) of all people aged 5 years and over who are immunosuppressed and living and resident in England had been vaccinated with a Spring 2023 booster dose since 3 April 2023

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 24 July 2023 (based on data up to 9 July 2023) ([WHO website](#)).

Globally, influenza detections remained low, but in the southern hemisphere, some countries reported increased influenza detections in recent weeks while detections in other countries seemed to have peaked.

In Oceania, influenza activity continued to increase with influenza A viruses predominant.

In South Africa, influenza activity of predominately influenza A(H3N2) viruses continued to decrease after peaking in early June.

In temperate South America, influenza detections continued to decrease with A(H1N1)pdm09 viruses most frequently detected followed by B viruses across all countries. Severe acute respiratory infections (SARI) activity remained elevated in a few countries.

In the Caribbean countries, influenza activity remained low overall. In the Central American countries, influenza activity decreased overall with A(H1N1)pdm09 most frequently detected followed by B/Victoria lineage viruses.

In the tropical countries of South America, overall influenza activity was low with detections of predominantly A(H1N1)pdm09 and B viruses.

In tropical Africa, influenza detections remained low in reporting countries with influenza A(H1N1)pdm09 viruses predominantly detected.

In Southern Asia, influenza activity remained low overall except for Bangladesh and Iran (Islamic Republic of) where detections increased in recent weeks.

In South-East Asia, influenza activity remained stable in most reporting countries, with continued reporting of predominantly A(H1N1)pdm09 and A(H3N2) virus detections overall.

In the temperate zones of the northern hemisphere, influenza activity was reported at low levels or below seasonal threshold in most reporting countries. Detections were predominantly influenza A(H1N1)pdm09 followed by influenza A (H3N2) and B viruses.

The WHO GISRS laboratories tested more than 240,286 specimens during that time period. 5,813 were positive for influenza viruses, of which 3,984 (68.54%) were typed as influenza A and 1,829 (31.46%) as influenza B. Of the sub-typed influenza A viruses, 1,565 (66.20%) were influenza A(H1N1)pdm09 and 799 (33.80%) were influenza A(H3N2). Of the type B viruses for which lineage was determined, all (444) belonged to the B/Victoria lineage.

Influenza in Australia

Updated 28 July 2023 (based on data up to fortnight ending 23 July 2023) ([Australian Government website](#)).

Australia monitors influenza through a number of complementary systems. The Australian government advises caution in the interpretation of data reported from various influenza surveillance systems due to the effects of COVID-19, particularly when making inter-season comparisons. Caution should also be applied in assessing the implications of influenza activity in Australia to the UK. It is not possible to reliably predict the course of the 2023 southern hemisphere influenza season or the implications for the following 2023 to 2024 northern hemisphere season, such as the timing, activity and impact of the 2023 to 2024 influenza season in the UK. Australia is one of many countries from which flu may arrive in the UK, including other countries which are more populous and or have more frequent inbound travel. Australia's influenza activity reflects its specific epidemiological circumstance and has no bearing on the local persistence of influenza in the UK in our inter-seasonal period.

Influenza-like-illness (ILI) activity in the community reported to FluTracking has decreased in the last fortnight, while ILI presentations to ASPREN sentinel general practitioners (GPs) have been stable. In the year-to-date (1 January to 23 July 2023), there have been 174,898 notifications reported to the National Notifiable Diseases Surveillance System (NNDSS) in Australia, of which 22,436 notifications had a diagnosis date this fortnight.

There is currently not enough information to comprehensively assess the potential severity of the 2023 influenza season at this time. In the year-to-date, of the 174,898 notifications of laboratory-confirmed influenza, 162 influenza-associated deaths have been notified to the NNDSS. Since seasonal surveillance commenced in April 2023, there have been 1,991 sentinel hospital admissions, of which 137 (6.88%) were admitted directly to ICU.

In the year-to-date, 62.6% of notifications of laboratory-confirmed influenza reported to the NNDSS were influenza A, of which 95.1% were influenza A(untyped); 4.4% were influenza A(H1N1); and 0.52% were influenza A(H3N2). Influenza B accounted for 35.2% of notifications; influenza A&B accounted for 0.3% of notifications; and 1.9% of influenza notifications were untyped.

Of the 2,296 samples referred to the WHOCC in the year-to-date, 97.5% of influenza A(H1N1) isolates, 81.2% of influenza A(H3N2) isolates and 99.2% of influenza B/Victoria isolates characterised were antigenically similar to the corresponding vaccine components. It is too early to assess vaccine effectiveness for this season.

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 14 July 2023](#)

From 1 June to 14 July 2023, one human case of infection with an influenza A(H1N1) variant virus, two human cases with positive influenza A(H5N1) detections, one human case of infection with an influenza A(H5N6) virus, and one human case of infection with an influenza A(H9N2) virus were 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.

UKHSA has detected influenza A(H5) virus in two poultry workers, following the introduction of an asymptomatic testing programme for people who have been in contact with infected birds. See the [UKHSA press release 16 May 2023](#) for more information.

[Latest UKHSA avian influenza technical briefing 4 July 2023](#)

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

Middle East respiratory syndrome coronavirus (MERS-CoV)

On 10 July 2023, the United Arab Emirates (UAE), [notified WHO of a case of Middle East Respiratory Syndrome Coronavirus \(MERS-CoV\)](#) in a 28-year-old male from Al Ain city in Abu Dhabi. Since July 2013, when the UAE reported the first case of MERS-CoV, 94 confirmed cases (including this new case) and 12 deaths have been reported.

From April 2012 to July 2023, a total of 2,605 laboratory-confirmed cases of MERS-CoV and 936 associated deaths were reported globally to WHO under the International Health Regulations (IHR 2005). [WHO publishes monthly updates.](#)

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.

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