



UK Health  
Security  
Agency

# **National Influenza and COVID-19 surveillance report**

Week 3 report (up to week 2 2024 data)  
18 January 2024

# Contents

Executive summary .....	4
User Feedback.....	6
Laboratory surveillance .....	7
Respiratory DataMart system (England).....	7
Confirmed COVID-19 cases (England).....	13
Microbiological surveillance .....	16
SARS-CoV-2 variants.....	16
Influenza virus characterisation .....	19
Influenza antiviral susceptibility .....	21
Community surveillance .....	22
SIREN healthcare cohort study .....	22
Winter COVID-19 Infection study .....	23
Acute respiratory infection incidents (ARI).....	26
FluSurvey .....	29
Google search queries .....	31
Flu Detector.....	32
Syndromic Surveillance .....	33
Primary care surveillance.....	37
RCGP Clinical Indicators (England).....	37
RCGP sentinel swabbing scheme in England .....	38
Secondary care surveillance .....	42
Influenza, SARI Watch .....	42
COVID-19, SARI Watch .....	49
ECMO, SARI Watch .....	54
RSV admissions, SARI Watch.....	55
Mortality surveillance .....	58
COVID-19 deaths .....	58
Daily excess all-cause mortality (England) .....	58
Influenza vaccination .....	59

Influenza vaccine uptake in GP patients.....	59
COVID-19 vaccination.....	61
COVID-19 vaccine uptake in England .....	61
Proportion of people vaccinated by time since last vaccination .....	64
International update .....	66
Global COVID-19 update.....	66
Global influenza update .....	66
Other respiratory viruses .....	66
Related links .....	67
About the UK Health Security Agency .....	68

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 COVID-19 (caused by SARS-CoV-2), influenza, and diseases caused by 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 2 (between 8 January and 14 January 2024).

Please note data for recent weeks should be interpreted with caution in the light of changes in patterns of healthcare use, social mixing and lagged reporting due to the Christmas and New Year's Day holidays.

### Overall

In week 2, influenza activity increased slightly across most indicators. COVID-19 and respiratory syncytial virus (RSV) activity decreased across most indicators.

### Influenza

Through Respiratory DataMart, influenza positivity increased to 10.0% in week 2 compared to 9.7% in the previous week.

Through primary care surveillance, the influenza-like-illness (ILI) consultations indicator increased slightly to 8.0 per 100,000 in week 2 compared to 7.5 per 100,000 in the previous week and remained within the baseline activity level range.

There were 34 influenza confirmed acute respiratory incidents reported in England in week 2.

Overall, influenza hospitalisations increased slightly to 4.35 per 100,000 in week 2 compared to 4.21 per 100,000 in the previous week and remained in the medium impact range. ICU or HDU admissions decreased compared to the previous week and was in the baseline impact range.

Emergency department (ED) attendances for ILI decreased nationally.

Weekly influenza vaccine uptake for the 2023 to 2024 season is reported for week 2 of 2024. Compared to the equivalent week in the 2022 to 2023 season, vaccine uptake is higher for those aged 2 years, comparable for those aged 3 years, and lower for those aged 65 years and over, pregnant women and those aged under 65 years in clinical risk groups.

## COVID-19

Through Respiratory DataMart, SARS-CoV-2 positivity decreased slightly to 9.1% in week 2 compared to 9.6% in the previous week.

COVID-19 case rates and positivity in Pillar 1 decreased, with decreases observed in some age groups, regions, and ethnic groups in week 2.

The overall number of reported SARS-CoV-2 confirmed acute respiratory incidents in week 2 remained stable compared to the previous week. There were 46 SARS-CoV-2 confirmed acute respiratory incidents reported in week 2 in England.

Overall, COVID-19 hospitalisations decreased slightly to 4.6 per 100,000 in week 2 compared to 4.9 per 100,000 in the previous week. Hospitalisations were highest in the 85 years and over age group. COVID-19 ICU admissions increased slightly in week 2 compared to the previous week.

Weekly COVID-19 vaccine update for the 2023 to 2024 season is reported for week 2. Overall, 70.3% of all people aged over 65 years in England had been vaccinated with an autumn 2023 booster dose since 1 September 2023. Compared to the equivalent week in the 2022 to 2023 season, vaccine uptake is lower among all eligible age groups.

## Respiratory Syncytial Virus (RSV)

Through Respiratory DataMart, positivity for RSV decreased to 3.0%, with the highest positivity in those aged under 5 years at 5.7%. ED attendances for acute bronchiolitis continued to decrease. Overall RSV hospitalisations decreased to 1.21 per 100,000 compared to 1.39 per 100,000 in the previous week. In those aged under 5 years, hospitalisation rates decreased to 4.5 per 100,000 compared to 12.5 in the previous week. In those aged 85 years and over, hospitalisations rates decreased to 8.3 per 100,000 compared to 9.7 per 100,000 in the previous week.

## Other viruses

Adenovirus positivity remained low at 1.8%, with the highest positivity in those aged under 5 years at 6.5%. Human metapneumovirus (hMPV) positivity decreased slightly to 3.5%, with the highest positivity in those aged under 5 years at 7.4%. Parainfluenza positivity remained low at 2.3%, with the highest positivity in those aged under 5 years at 4.1%. Rhinovirus positivity decreased to 5.8% overall, with the highest positivity in those aged under 5 years at 13.9%.

## Feedback survey

As part of our ongoing commitment to continuous improvement, we are asking for feedback on the National weekly influenza and COVID-19 surveillance report through [our feedback survey](#). The purpose of this survey is to deepen our understanding of how readers engage with the report, highlighting areas readers find valuable and pinpointing areas for enhancement. The insights obtained from this survey will play a pivotal role in shaping the direction of future report development. The survey will be open until the end of the weekly reporting season.

Scan this QR code using a mobile device:

**National weekly influenza and  
COVID-19 surveillance report  
2023/24 Feedback Survey**



# Laboratory surveillance

## Respiratory DataMart system (England)

In week 2, data is based on reporting from 12 out of the 16 sentinel laboratories.

In week 2, 7,377 respiratory specimens reported through the Respiratory DataMart System were tested for influenza. There were 740 positive samples for influenza; 549 influenza A(not subtyped), 148 influenza A(H3N2), 25 influenza A(H1N1)pdm09, and 18 influenza B (Figure 4). Overall, influenza positivity increased to 10.0% in week 2 compared to 9.7% in the previous week.

In week 2, 6,913 respiratory specimens reported through the Respiratory DataMart System were tested for SARS-CoV-2. There were 626 positive samples for SARS-CoV-2 with an overall positivity of 9.1%, which decreased slightly compared to 9.6% in the previous week. The highest positivity was seen in adults aged over 65 years at 12.0%.

RSV positivity decreased to 3.0%, with the highest positivity in those aged under 5 years at 5.7%.

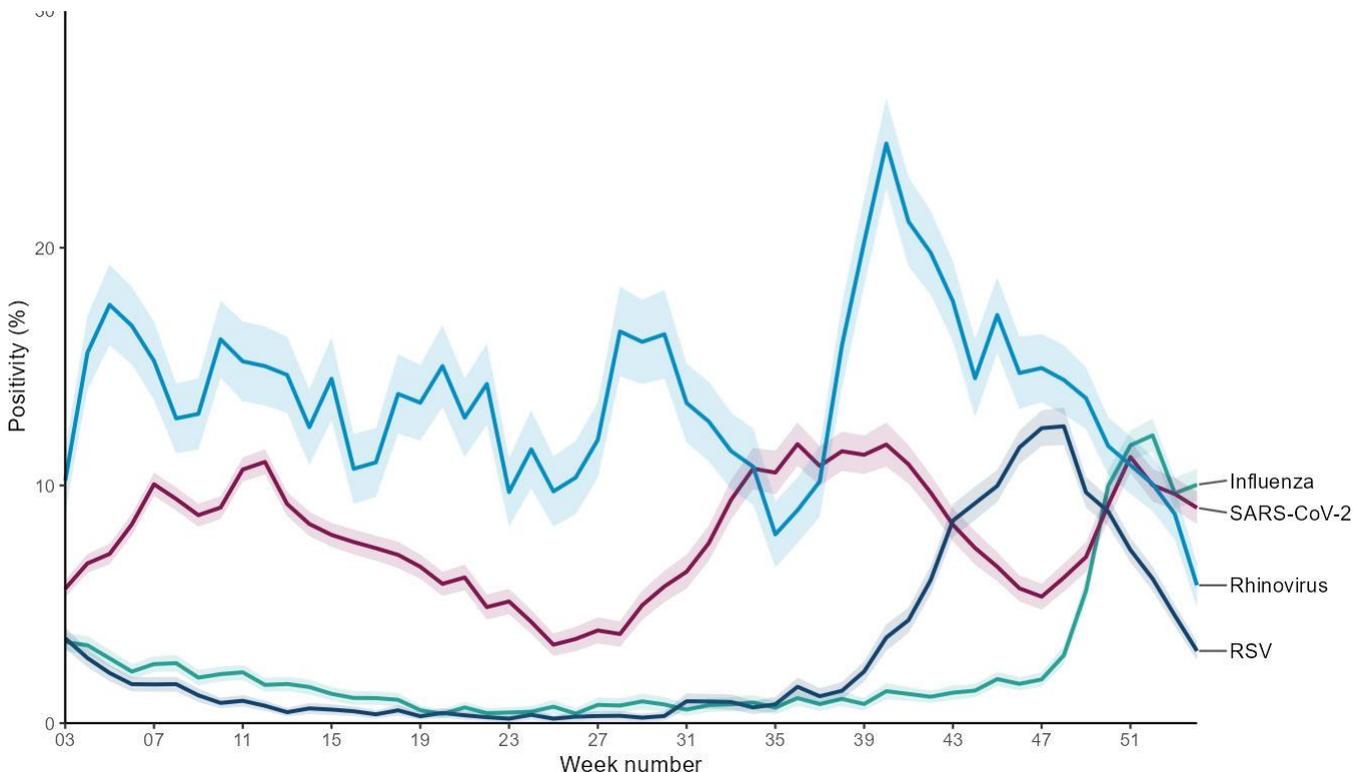
Adenovirus positivity remained low at 1.8%, with the highest positivity in those aged under 5 years at 6.5%.

Human metapneumovirus (hMPV) positivity decreased slightly to 3.5%, with the highest positivity in those aged under 5 years at 7.4%.

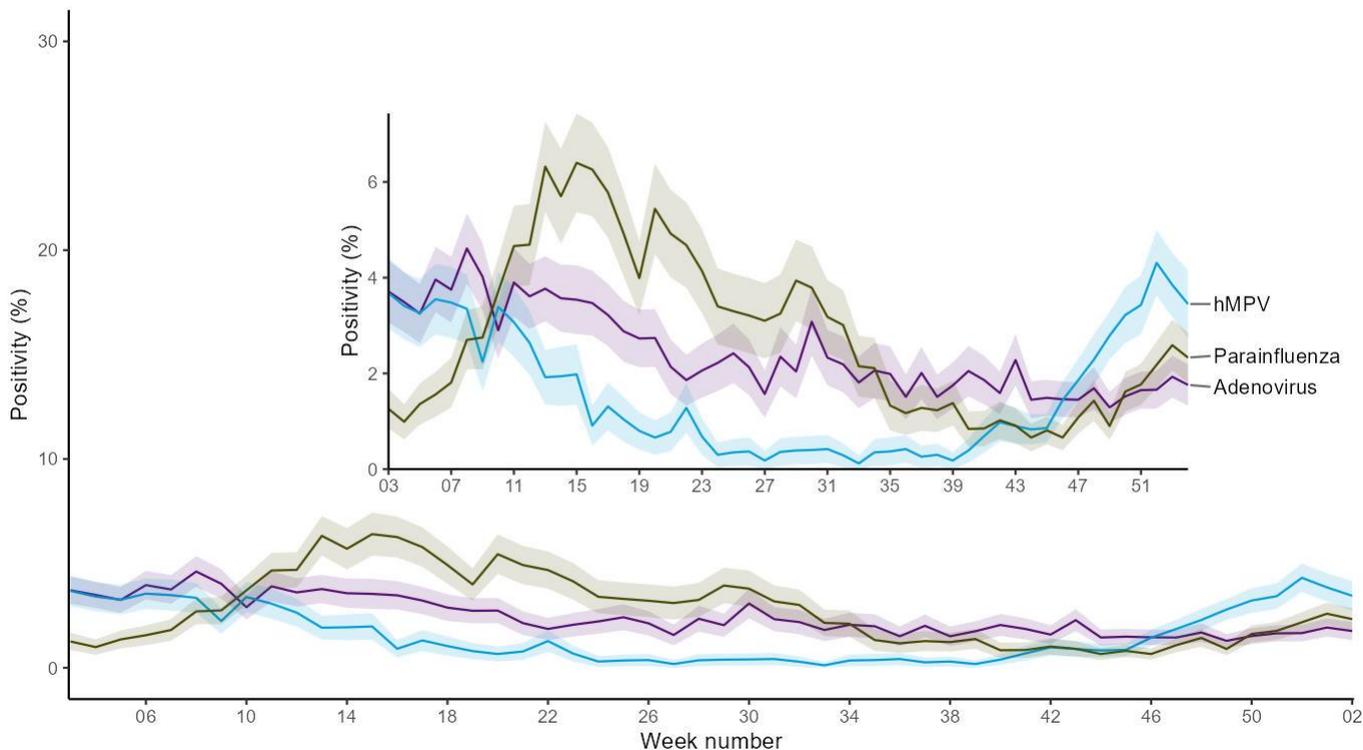
Parainfluenza positivity remained low at 2.3%, with the highest positivity in those aged under 5 years at 4.1%.

Rhinovirus positivity decreased to 5.8% overall, with the highest positivity in those aged under 5 years at 13.9%.

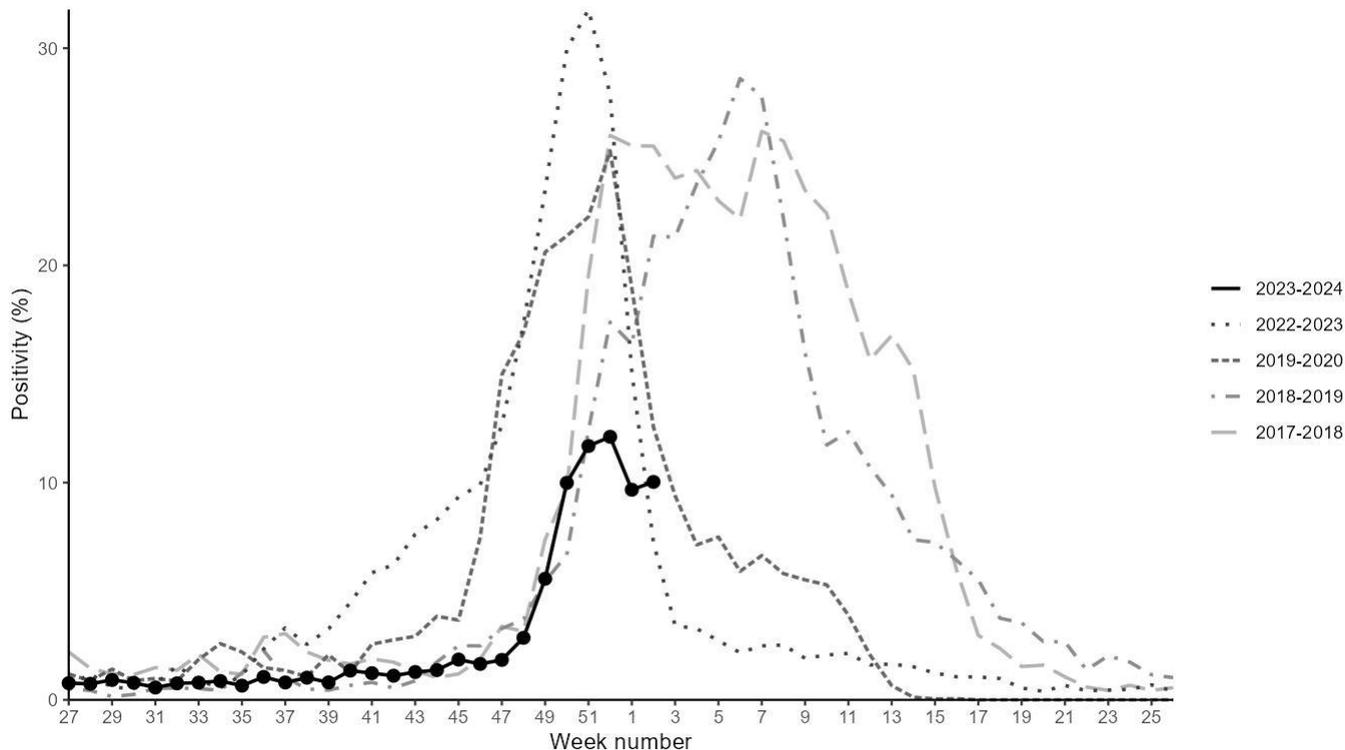
**Figure 1a. Respiratory DataMart weekly positivity (%) for influenza, SARS-CoV-2, RSV and rhinovirus, England**



**Figure 1b. Respiratory DataMart weekly positivity (%) for adenovirus, hMPV and parainfluenza, England**

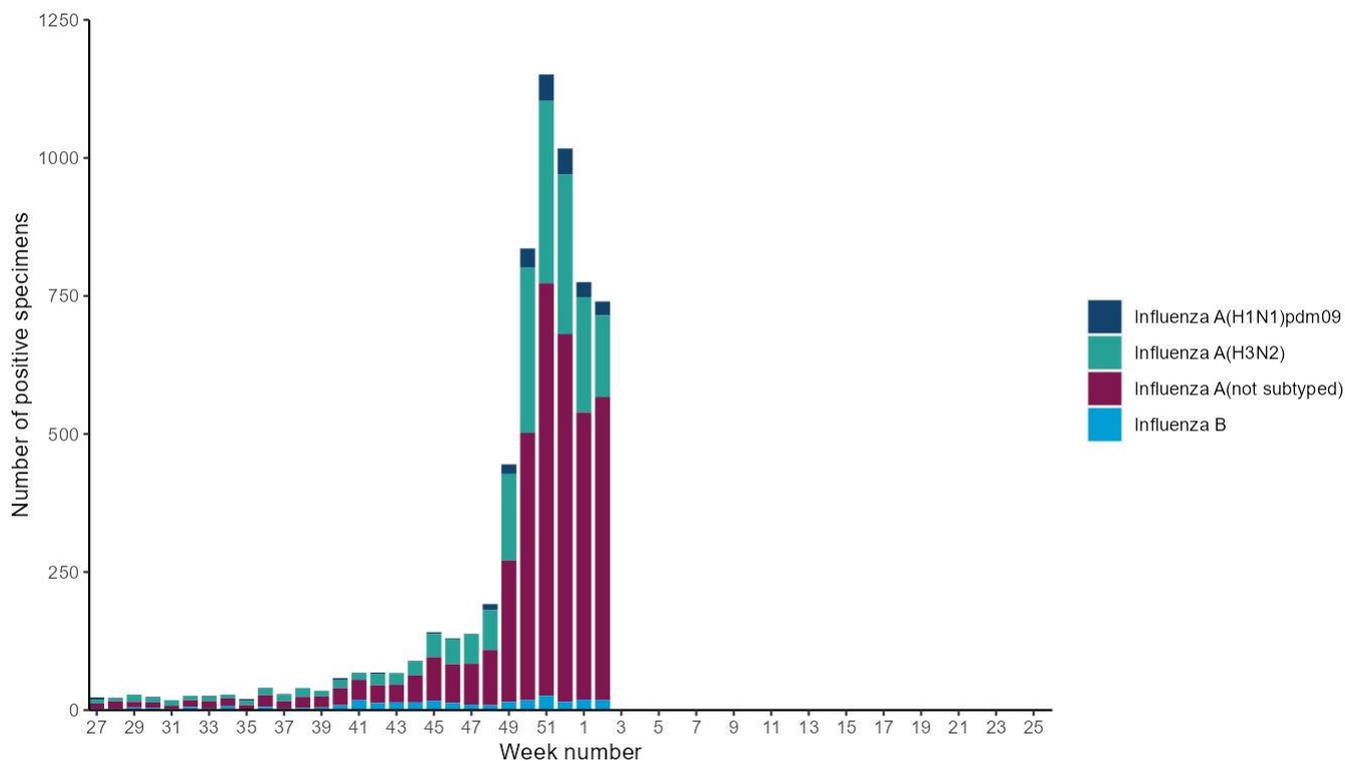


**Figure 2. Respiratory DataMart weekly positivity (%) for influenza by year, England [note 1]**

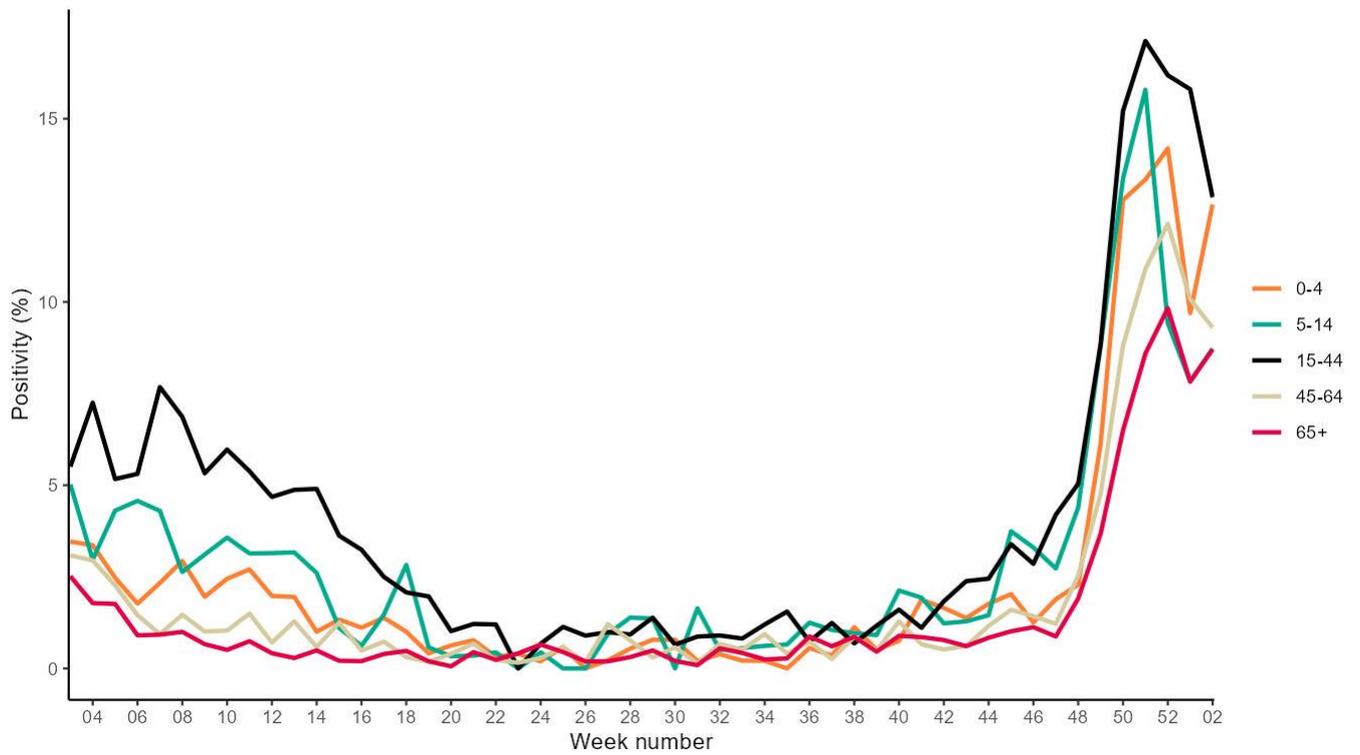


[note 1] Data from seasons 2020 to 2021 and 2021 to 2022 has been removed as there was low activity throughout these seasons.

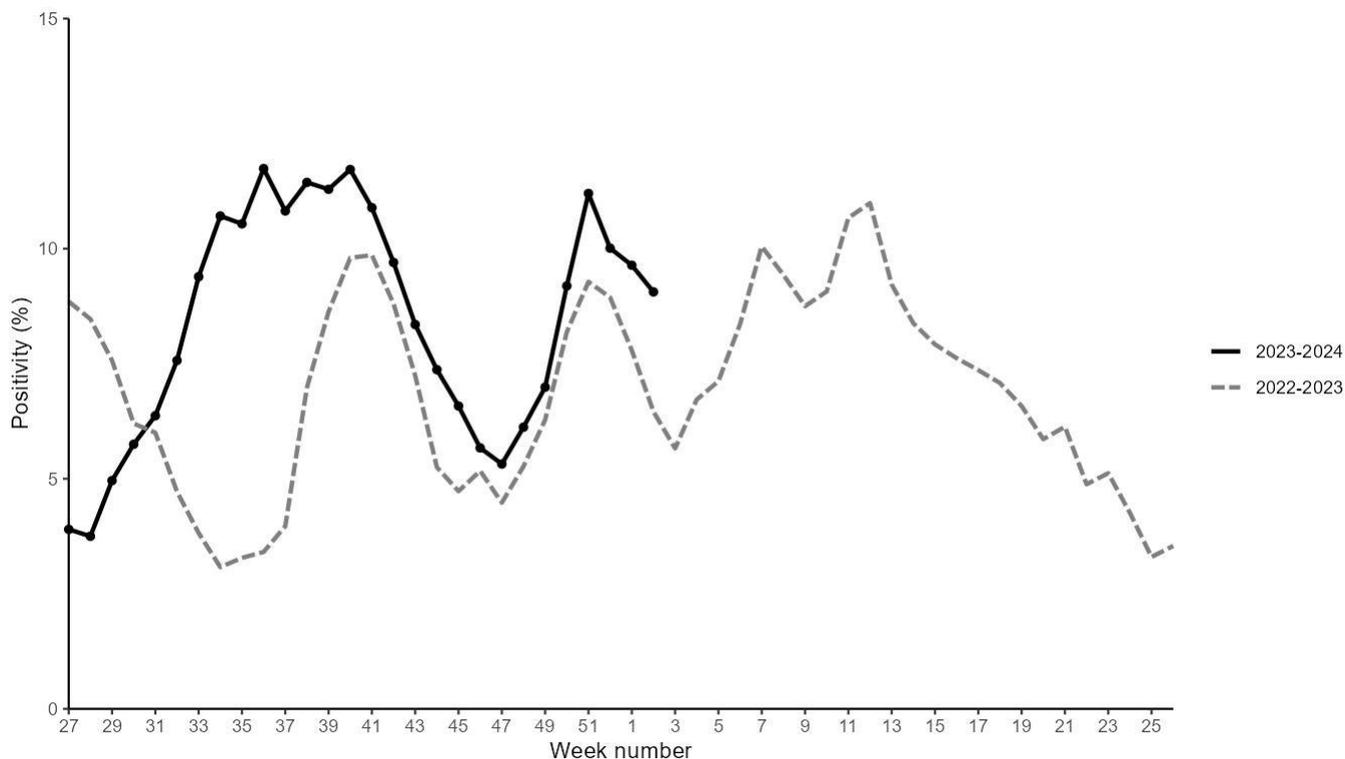
**Figure 3. Respiratory DataMart samples positive for influenza by type and subtype, England**



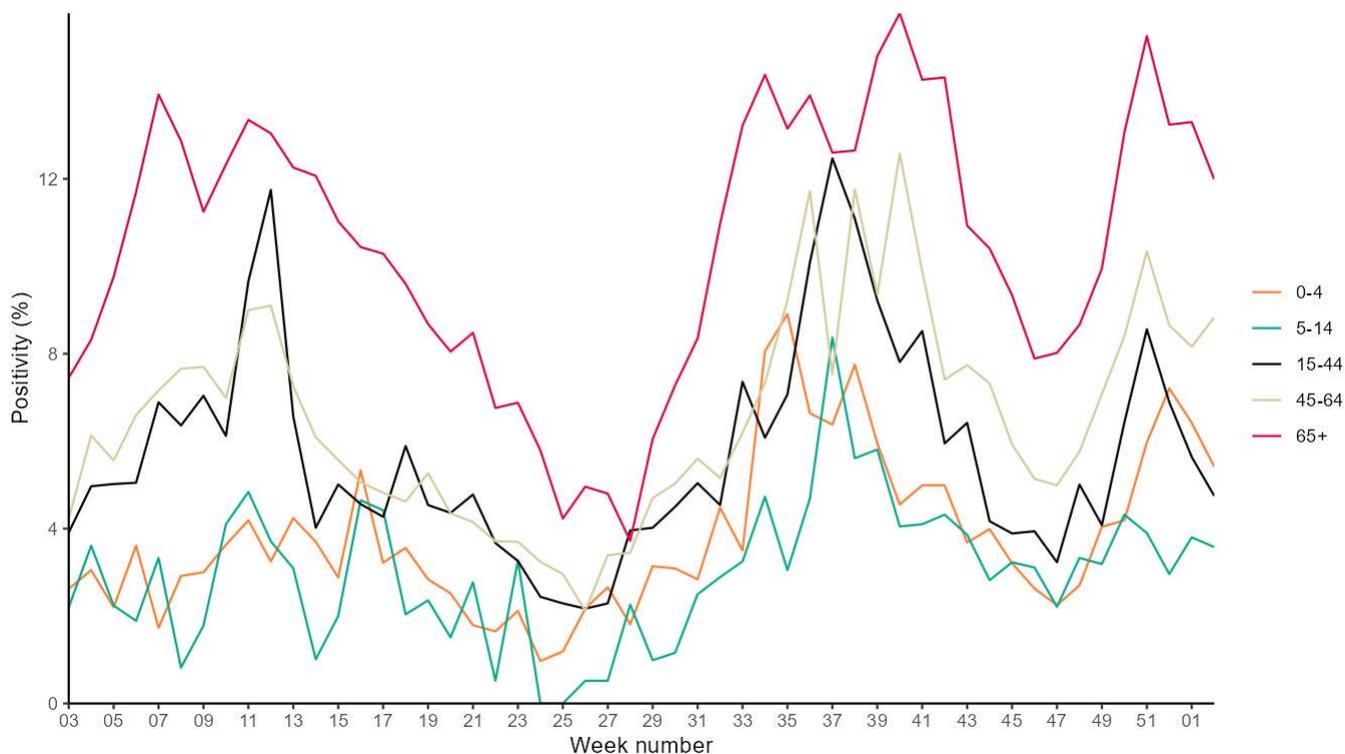
**Figure 4. Respiratory DataMart weekly positivity (%) for influenza by age, England**



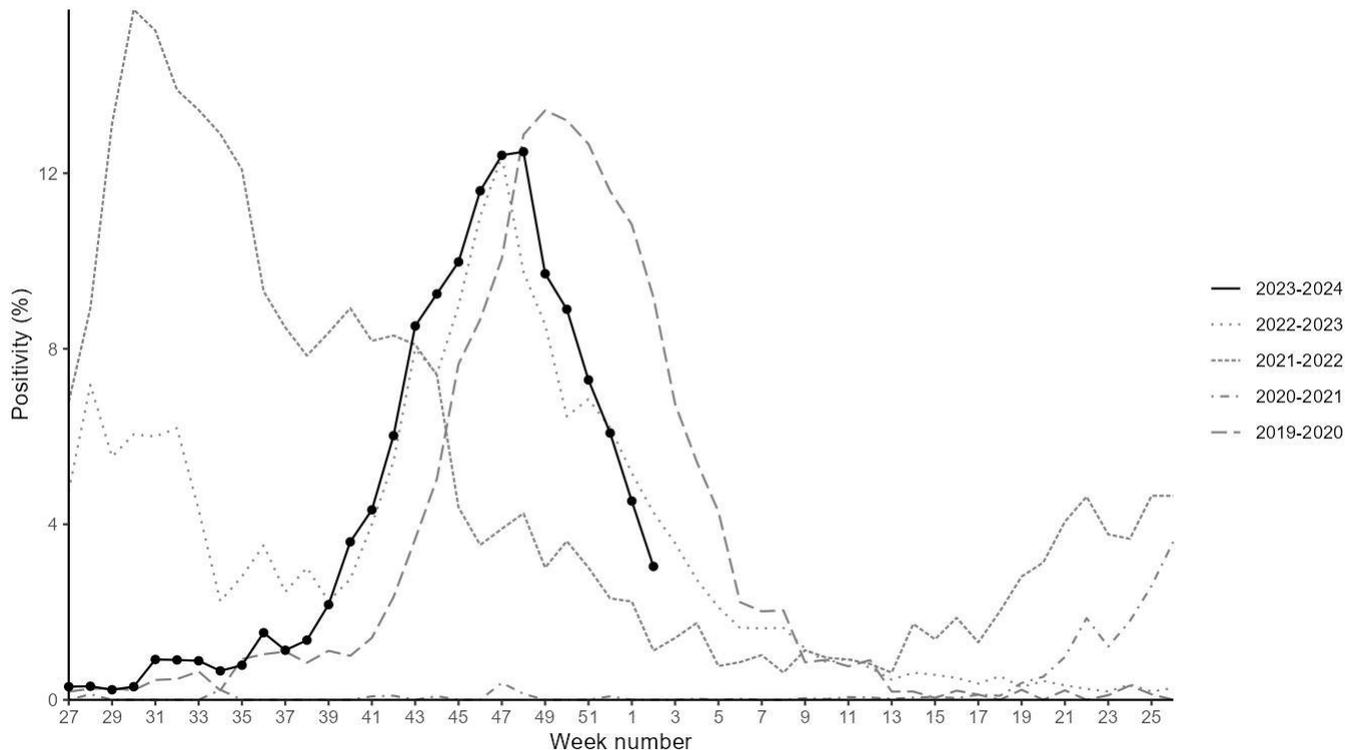
**Figure 5. Respiratory DataMart weekly positivity (%) for SARS-CoV-2 by year, England**



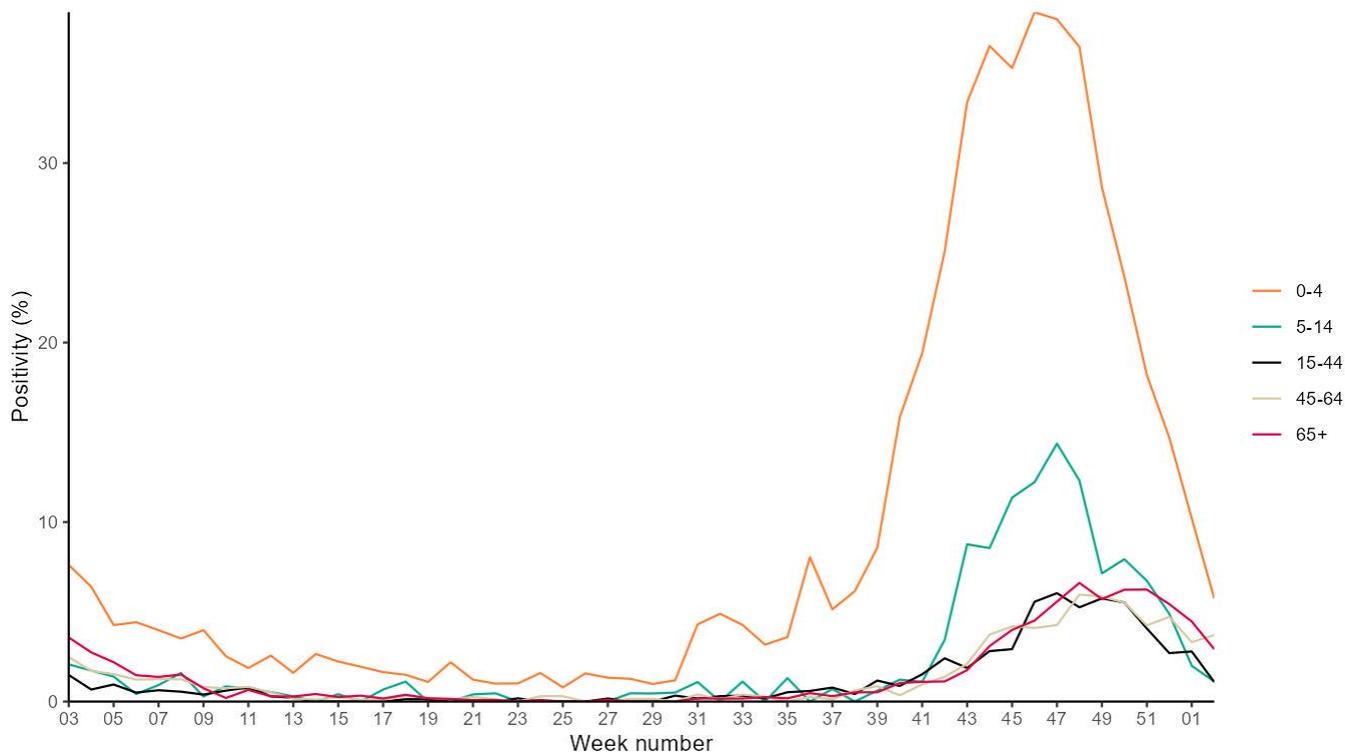
**Figure 6. Respiratory DataMart weekly positivity (%) for SARS-CoV-2 by age, England**



**Figure 7. Respiratory DataMart weekly positivity (%) for RSV by year, England**



**Figure 8. Respiratory DataMart weekly positivity (%) for RSV by age, England**



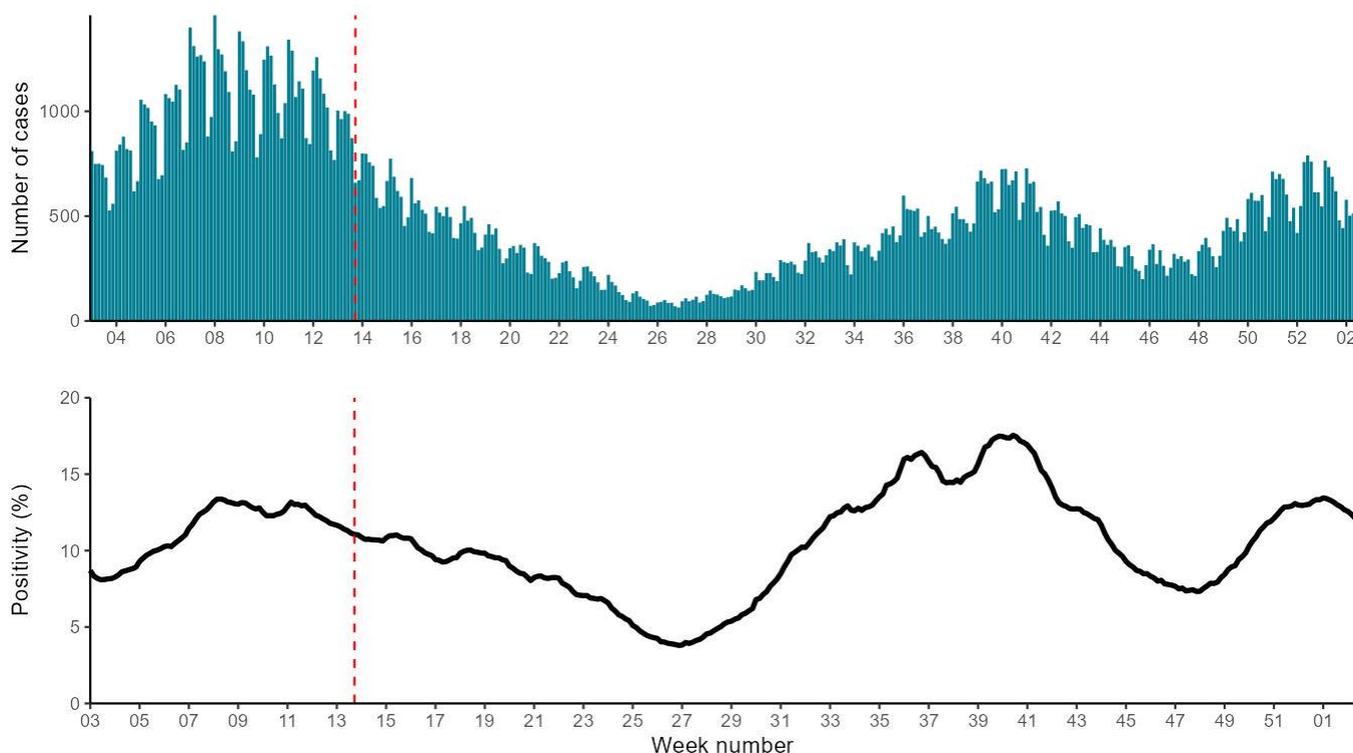
## Confirmed COVID-19 cases (England)

As of 9am on 16 January 2024, there were 3,188 Pillar 1 cases in week 2, a 25.4% decrease from the previous week.

COVID-19 polymerase chain reaction (PCR) positivity for Pillar 1 decreased slightly in week 2, with a weekly mean positivity rate of 12.1% compared to 13.1% in the previous week. Pillar 1 positivity rates were highest in those aged 85 years and over at a weekly mean positivity rate of 18.6% (a decrease from 19.4% in week 1) and in the East Midlands at a weekly mean positivity rate of 13.8% (an increase from 15.1% in week 1).

**Data notes:** Changes to testing policies over time may affect positivity rates and incidence rates and should be interpreted accordingly. COVID-19 case reporting in England uses an episode-based definition which includes possible reinfections, each infection episode is counted separately if there are at least 91 days between positive test results (PCR or rapid lateral flow device). Each infection episode begins with the earliest positive specimen date. Additionally, further changes in [testing policy](#) are in effect since 1 April 2023, which may affect case rates and positivity rates.

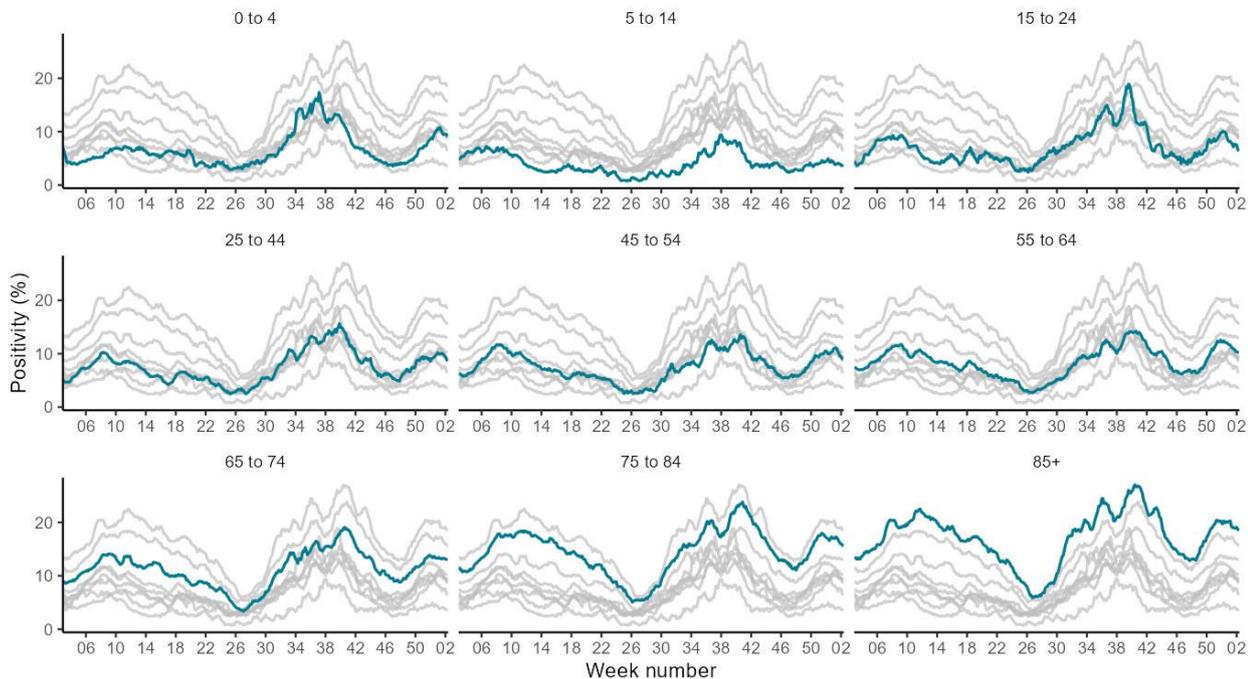
**Figure 9. Confirmed COVID-19 episodes tested under Pillar 1, based on sample date with overall 7-day rolling average PCR positivity for Pillar 1 (%) [note 2]**



[note 2] The vertical dashed line (red) denotes changes in testing policies.

## Age

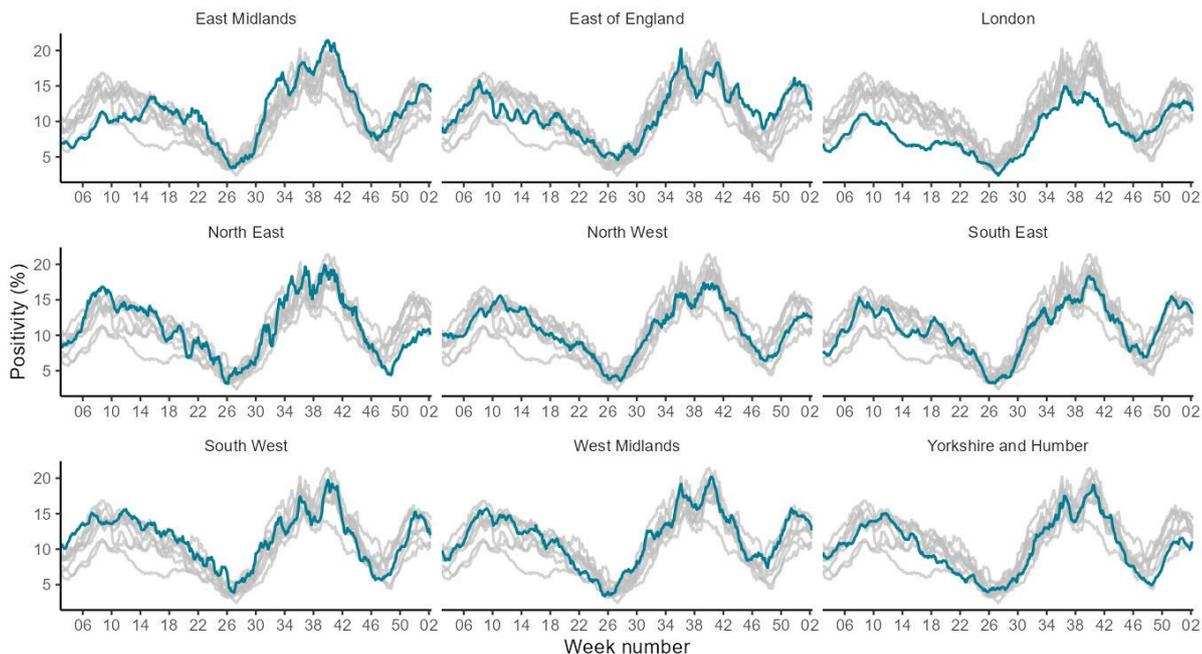
**Figure 10. 7-day rolling average PCR positivity (%) of confirmed COVID-19 cases tested under Pillar 1 by age group [note 3]**



[note 3] The highlighted line corresponds to the age group in the subplot title, grey lines correspond to all other age groups.

## Geography

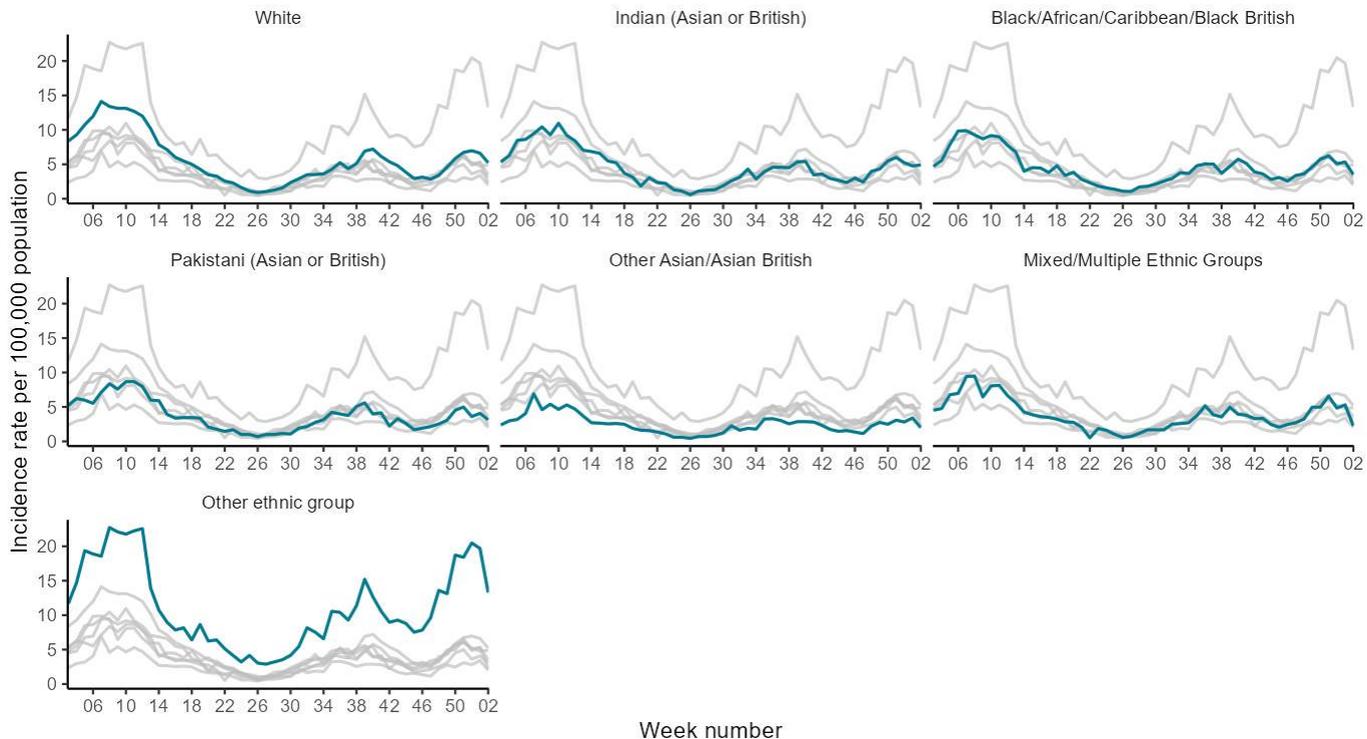
**Figure 11. 7-day rolling average PCR positivity (%) of confirmed COVID-19 cases tested under Pillar 1 by UKHSA region [note 4]**



[note 4] The highlighted line corresponds to the UKHSA region in the subplot title, grey lines correspond to all other regions.

## Ethnicity

**Figure 12: Weekly incidence of confirmed COVID-19 cases per 100,000 population by ethnicity (Pillar 1), England [note 5]**



[note 5] The highlighted line corresponds to the ethnicity in the subplot title, grey lines correspond to all other ethnicities.

# Microbiological surveillance

## SARS-CoV-2 variants

This section is updated fortnightly with an update included in this report.

The UK Health Security Agency (UKHSA) conducts genomic surveillance of SARS-CoV-2 variants.

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

Detailed information on circulating SARS-CoV-2 lineages are published monthly and can be found in the [SARS-CoV-2 genome sequence prevalence and growth rate updates](#).

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

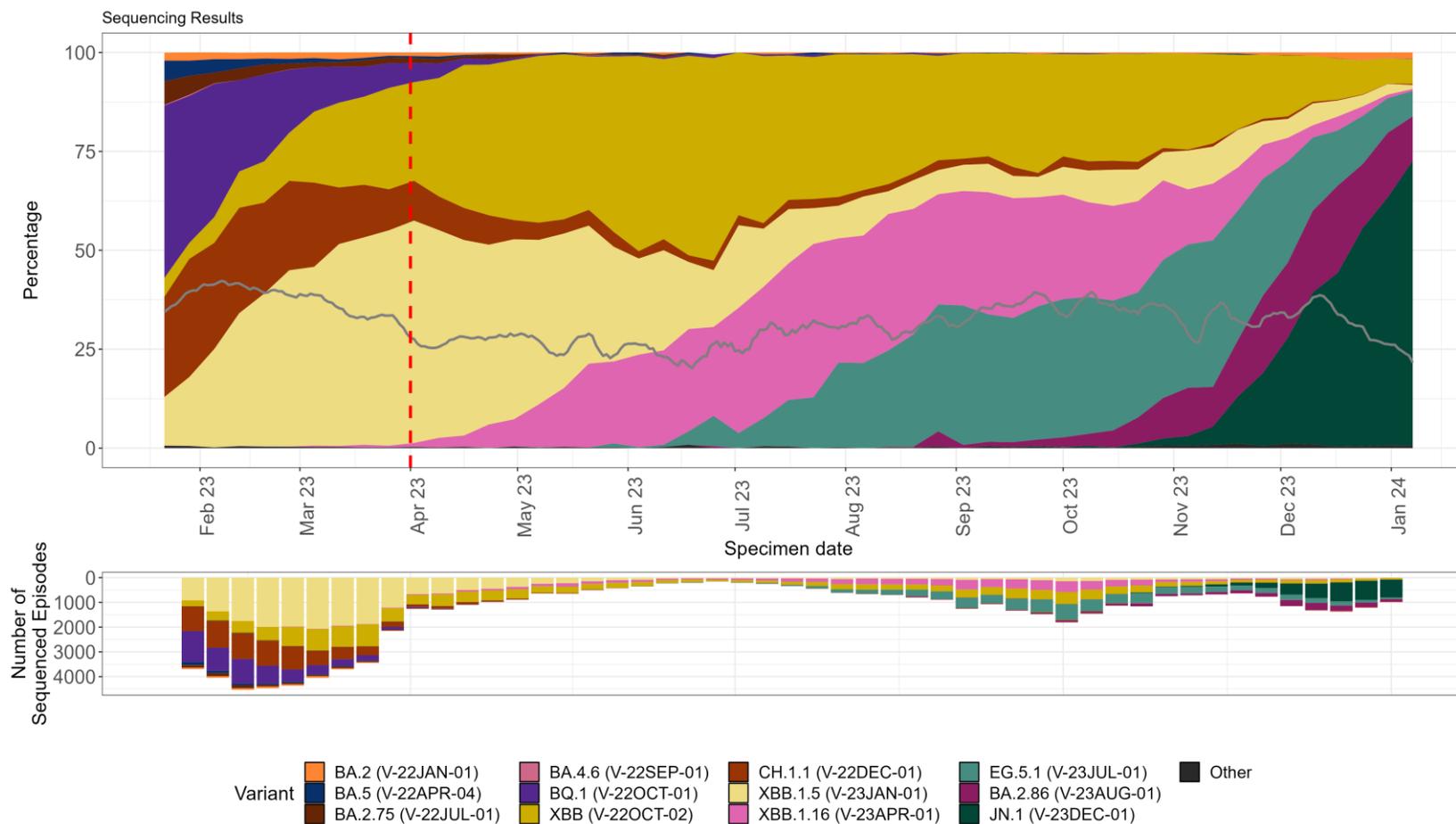
The sequence data used in this report is classified using UKHSA variant definitions (rather than Pangolin lineage assignment, which is commonly used to assign lineages to sequences). UKHSA defines variants based on a set of mutations common to a lineage to allow consistent detection, monitoring and reporting.

Poorer quality sequence data may be classified as a more ancestral variant due to missing data. Furthermore, variants may include sub-lineages that have not been individually designated for example JN.1 within BA.2.86 (V-23AUG-01). Once a sub-lineage meets required thresholds, it will be designated as a variant and prevalence of this sub-lineage in positive cases will then be identifiable in the data. The [UKHSA variant definition repository](#) contains the previous genomic definitions for UKHSA declared variants.

The prevalence of different UKHSA-designated variants amongst sequenced cases is presented in Figure 13.

To account for sequencing delays, we report the proportion of variants from sequenced cases between 1 January 2024 and 7 January 2024. Of those sequenced in this period, 1.6% were classified as BA.2 (V-22JAN-01), 6.2% were classified as XBB (V-22OCT-02), 1.0% were classified as XBB.1.5 (V-23JAN-01), 6.4% were classified as EG.5.1 (V-23JUL-01), 11.2% were classified as BA.2.86 (V-23AUG-01) and 71.9% were classified as JN.1 (V-23DEC-01).

**Figure 13: Prevalence of SARS-CoV-2 variants amongst available sequenced cases for England from 22 January 2023 to 7 January 2024 [note 6]**



The grey line indicates proportion of cases sequenced. The vertical dashed line (red) in April 2023 denotes changes in PCR testing in social care and hospital settings.

[note 6] Recombinants such as XD, are not specified but are largely within the 'Other' group currently as numbers are too small.

**Table 1. Total distribution of SARS-CoV-2 variants detected in England in the last 12 weeks, up to week 2 (week ending 14 January 2024) [note 7]**

<b>Variant</b>	<b>Other names by which this variant is known</b>	<b>Total sequenced cases in the last 12 weeks</b>	<b>Last reported specimen date</b>
V-22JAN-01	Omicron BA.2	113	10-01-2024
V-22OCT-02	Omicron XBB	1,509	08-01-2024
V-23JAN-01	Omicron XBB.1.5	556	09-01-2024
V-23APR-01	Omicron XBB.1.16	749	07-01-2024
V-23JUL-01	Omicron EG.5.1	2,296	08-01-2024
V-23AUG-01	Omicron BA.2.86	1,729	09-01-2024
V-23DEC-01	Omicron JN.1	3,805	10-01-2024

[note 7] Sequenced cases are PCR confirmed COVID-19 cases with a validated sequencing result meeting the case definitions.

Designated variants with 50 or more sequenced cases in the past 12 weeks are presented in the table above.

Sequencing data has a lag of approximately 2 weeks therefore the data presented should be interpreted in this context.

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

## 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.

As of week 2 of 2024, the UKHSA Respiratory Virus Unit (RVU) has genetically characterised 336 influenza A(H3N2) viruses, which had been detected this season (since week 40), with 334 of these belonging in genetic subclade 3C.2a1b.2a.2 in the 2a.3a.1 subgroup. One A(H3N2) virus belonging to the 2a.3 subgroup and one A(H3N2) virus belonging to the 2a.3a subgroup were detected. The Northern Hemisphere 2023/24 influenza A(H3N2) vaccine strain (an A/Darwin/9/2021-like virus) also belongs in genetic subclade 3C.2a1b.2a.2.

In the same period, 334 influenza A(H1N1)pdm09 viruses have been characterised. Sequencing of the haemagglutinin (HA) gene shows that 278 belong in genetic subgroup 6B.1A.5a.2a and 56 in subgroup 6B.1A.5a.2a.1. The Northern Hemisphere 2023/24 influenza A(H1N1)pdm09 vaccine strain (an A/Victoria/4897/2022 (H1N1)pdm09-like virus) also belongs in genetic subclade 6B.1A.5a, within the 6B.1A.5a.2a.1 cluster.

Since week 40, 18 influenza B/Victoria lineage viruses have been genetically characterised belonging in subclade V1A3, 17 within the subgroup V1A3a.2 and one within subgroup V1A3a.2a. The Northern Hemisphere 2023/24 influenza B/Victoria lineage vaccine strain (a B/Austria/1359417/2021-like virus) also belongs in this V1A3a.2 subclade/group.

Different lineages may dominate during the season, and a close watch will be kept on the proportion of different viruses circulating to assist with the evaluation of vaccine effectiveness.

The RVU has confirmed by genome sequencing the detection of live attenuated influenza vaccine (LAIV) viruses in 5 influenza A positive samples and in 6 influenza B positive samples collected since week 40, from children aged between 2 and 16 years.

One influenza A(H1N2)v virus has been genetically characterised belonging in clade 1B 1.1. This is an unusual detection of a variant H1N2 (H1N2v) virus in a human clinical sample. The HA and NA genes as well as internal gene segments from the A(H1N2)v detection show a very close relationship to contemporary 1B.1.1 swine influenza A viruses from the UK.

**Table 2. Number of influenza viruses characterised by genetic and antigenic analysis at the UKHSA Respiratory Virus Unit since week 40 of 2023**

<b>(Sub)type</b>	<b>Genetic group</b>	<b>Number sequenced</b>
A(H3N2)	3C.2a1b.2a.2a.3	1
	3C.2a1b.2a.2a.3a	1
	3C.2a1b.2a.2a.3a.1	334
	Total	336
A(H1N1)pdm09	6B.1A.5a.2a	278
	6B.1A.5a.2a.1	56
	Total	334
B/Victoria-lineage	V1A3a.2	17
	V1A3a.2a	1
	Total	18
A(H1N2)v	1B 1.1	1
	Total	1

## 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 of 2023 and 2 of 2024 have been analysed.

Analysis of 330 A(H3N2) viruses found no viruses with known markers of resistance to neuraminidase inhibitors. Analysis of 333 A(H1N1)pdm09 by sequencing found 3 oseltamivir resistant viruses taken from 2 patients: 2 with a H275Y amino acid substitution (89.5% and 92.3%) taken from the same patient, and 1 with D199E amino acid substitution (99.8%). All 3 samples were collected from immune compromised adult patients who were known to have received oseltamivir treatment.

Analysis of 16 influenza B NA sequences found no evidence of known markers of resistance to neuraminidase inhibitors.

No viruses with known markers of resistance to baloxavir marboxil were detected in 293 A(H3N2), 273 A(H1N1)pdm09 and 13 influenza B PA sequences analysed.

**Table 3. Antiviral susceptibility of influenza positive samples tested at UKHSA-RVU**

<b>(Sub)type</b>	<b>Neuraminidase inhibitors: susceptible</b>	<b>Neuraminidase inhibitors: reduced susceptibility</b>	<b>Baloxavir: susceptible</b>	<b>Baloxavir: reduced susceptibility</b>
A(H3N2)	330	0	293	0
A(H1N1)pdm09	330	3	273	0
B/Victoria-lineage	16	0	13	0

# Community surveillance

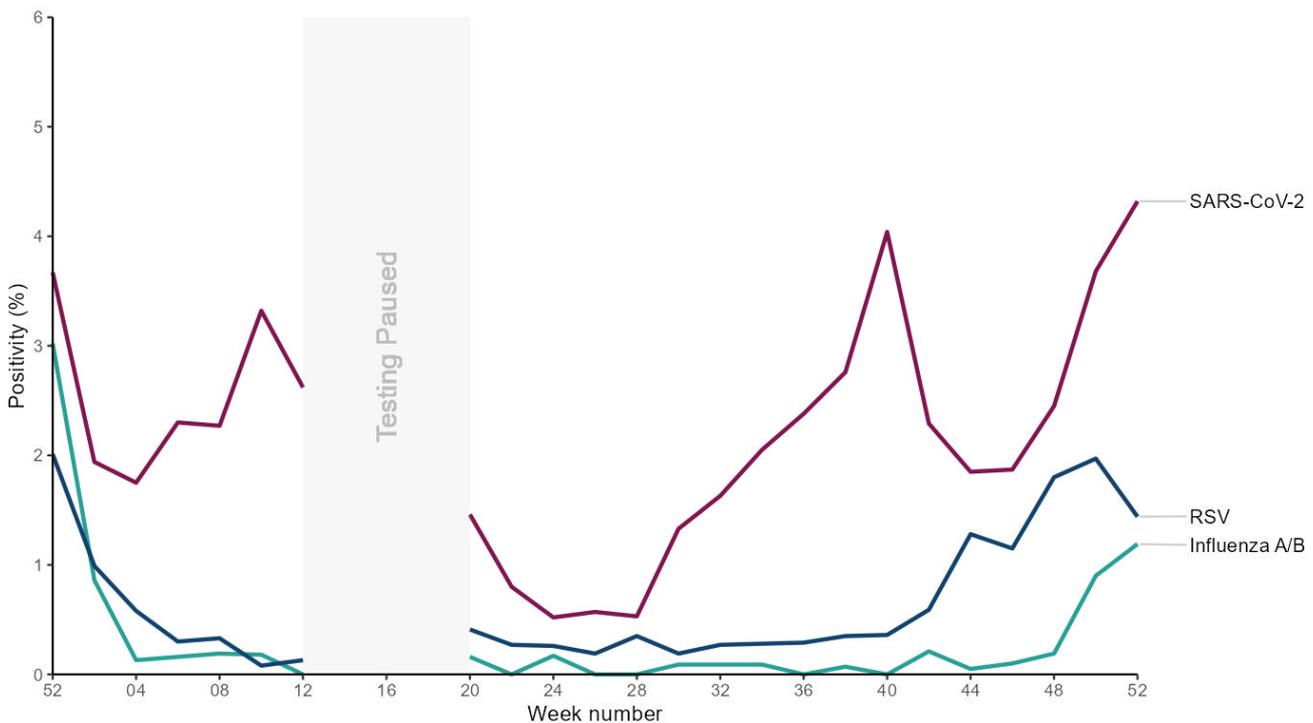
## SIREN healthcare cohort study

This section is updated fortnightly. There is no update included in this report.

The SIREN healthcare cohort study was set up in June 2020 and recruited over 44,500 participants to investigate SARS-CoV-2 infections and immunity among UK healthcare workers. 6,000 participants from the original cohort were re-recruited into the study and undergo fortnightly asymptomatic PCR testing for SARS-CoV-2, Influenza A/B and RSV, to monitor positivity rates and the emergence of new SARS-CoV-2 variants. Participants are distributed across the UK, with a median age of 53 years, and 78% are female.

Figure 14 describes fortnightly positivity rates (per 100 tests) of SARS-CoV-2, Influenza A/B and RSV in the SIREN cohort over the last 12 months. During the fortnight commencing 25 December 2023, 3,877 swabs were returned (66.6% of participants). Influenza positivity has increased since the end of November (1.19% positive compared to 0.90% in previous fortnight). SARS-CoV-2 positivity has also increased since early November (4.32% positive compared to 3.68% in previous fortnight). RSV positivity has increased since the start of October but decreased slightly in the previous fortnight (1.44% swabs positive compared to 1.97% in previous fortnight).

**Figure 14. SIREN study fortnightly PCR positivity (%) for influenza, SARS-CoV-2 and RSV, UK [note 8]**



[note 8] The week number indicates the fortnight commencing.

## Winter COVID-19 Infection study

This section is updated fortnightly with an update included in this report. The Winter Coronavirus (COVID-19) Infection Study aims to understand the impact of COVID-19, particularly over the winter period. The study is run jointly by the Office for National Statistics (ONS) and UKHSA, with data collected via online questionnaire completion and self-reported lateral flow device (LFD) results from previous participants of the COVID-19 Infection Survey.

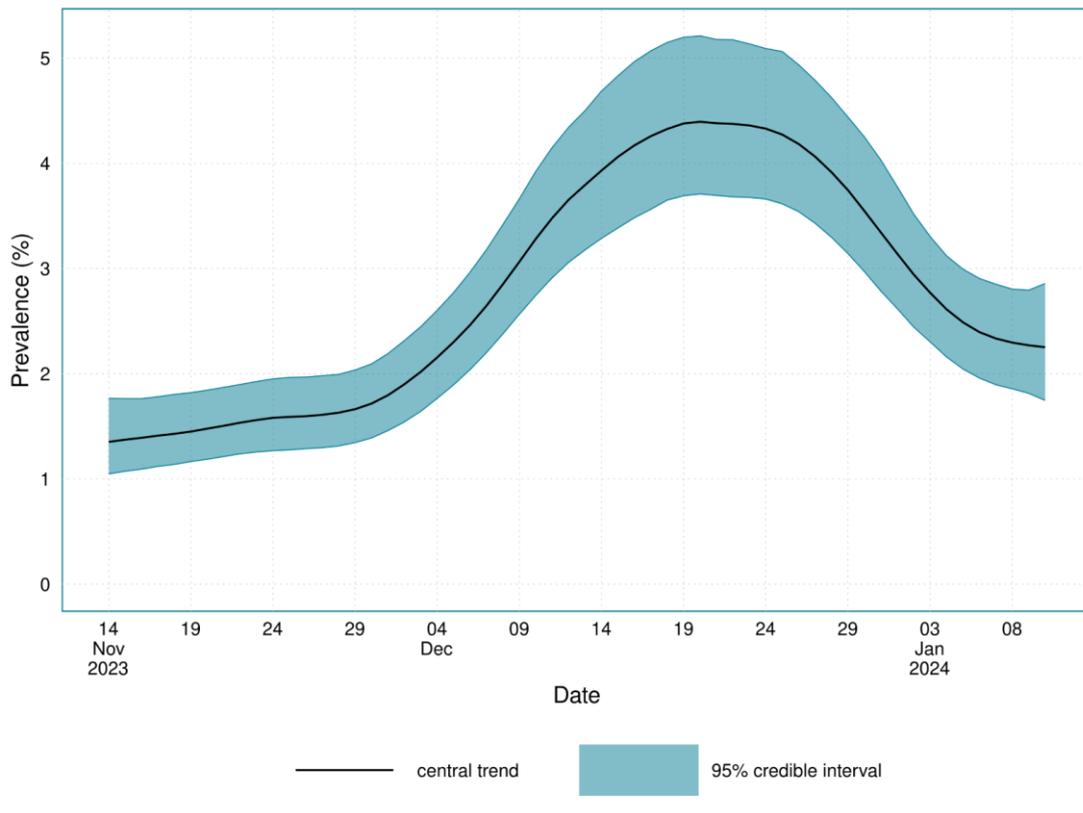
### Modelled prevalence

Prevalence is a modelled estimate of people currently infected with SARS-CoV-2 using percentage of people testing positive (percentage of people infected with SARS-CoV-2) and adjusted to account for lower sensitivity of LFD tests and weighted to be representative of the general population. These data are published by UKHSA ([Winter COVID-19 Infection Study](#)) and are presented as daily estimates.

On 10 January 2024, the estimated prevalence in England and Scotland was 2.3% (95% credible interval (CrI): 1.7% to 2.9%) compared to 2.8% (95% CrI 2.3% to 3.3%) on 3 January 2024 (figure 15). The estimated prevalence on 10 January 2024 corresponds to around 1,352,000 (95% CrI 1,048,000 to 1,715,000) people infected or 1 in 43 people (95% CrI: 1 in 59 to 1 in 34).

Within age groups, the group with the highest prevalence on 10 January 2024 were those aged between 35 and 44 years (prevalence 3.2%, 95% CrI 2.4% to 4.2%) and those aged between 18 and 34 years (prevalence 2.7%, 95% CrI 1.8% to 3.9%). Regionally, the highest prevalence on 10 January 2024 was estimated in South West (prevalence 3.0%, 95% CrI 2.2% to 4.1%). Graphs on prevalence by age and region are shown in the [supplementary slide set](#).

**Figure 15. Estimates of prevalence between 14 November 2023 and 10 January 2024, Winter CIS, England and Scotland**

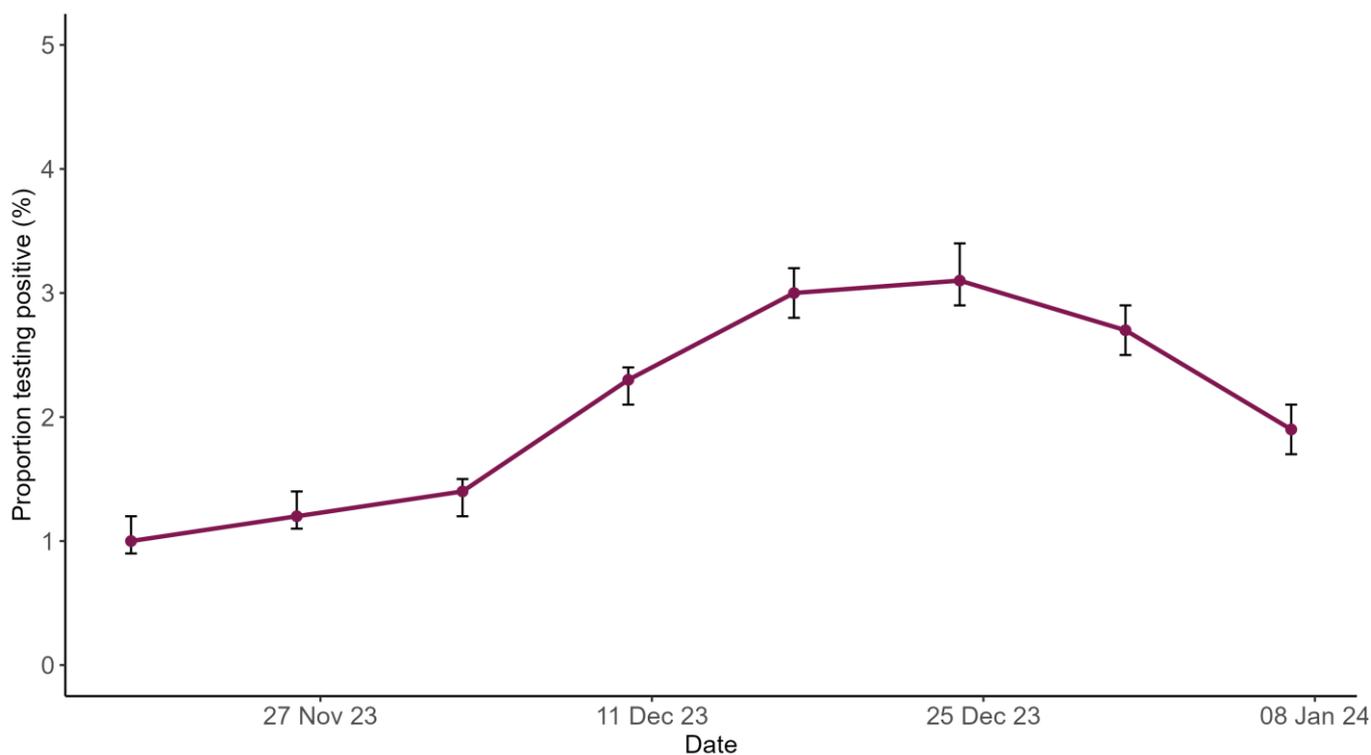


### Percentage testing positive

This section presents the number of people who self-reported a positive LFD result out of those who self-reported an LFD test result in England, as reported by ONS ([Winter Coronavirus \(COVID-19\) Infection Study, England and Scotland](#)). The results are presented by reporting week. In the latest week, 2.7% (95% confidence interval 2.5%-2.9%) of study participants tested positive between 28 December 2023 and 3 January 2024 and 1.9% (95% confidence interval 1.7%-2.1%) between 4 January 2024 and 10 January 2024 (Figure 16).

The age group with the highest positivity in the latest week were in those between 35 and 44 years of age (2.9%, 95% CI of 2.1% to 3.7%). In the latest week, East Midlands was the region with the highest positivity (2.6%, 95% CI of 1.9% to 3.3%). Data on age and region can be found in the [supplementary data file](#).

**Figure 16. Percentage testing positive for COVID-19, Winter COVID-19 infection study, England**



## Acute respiratory infection incidents (ARI)

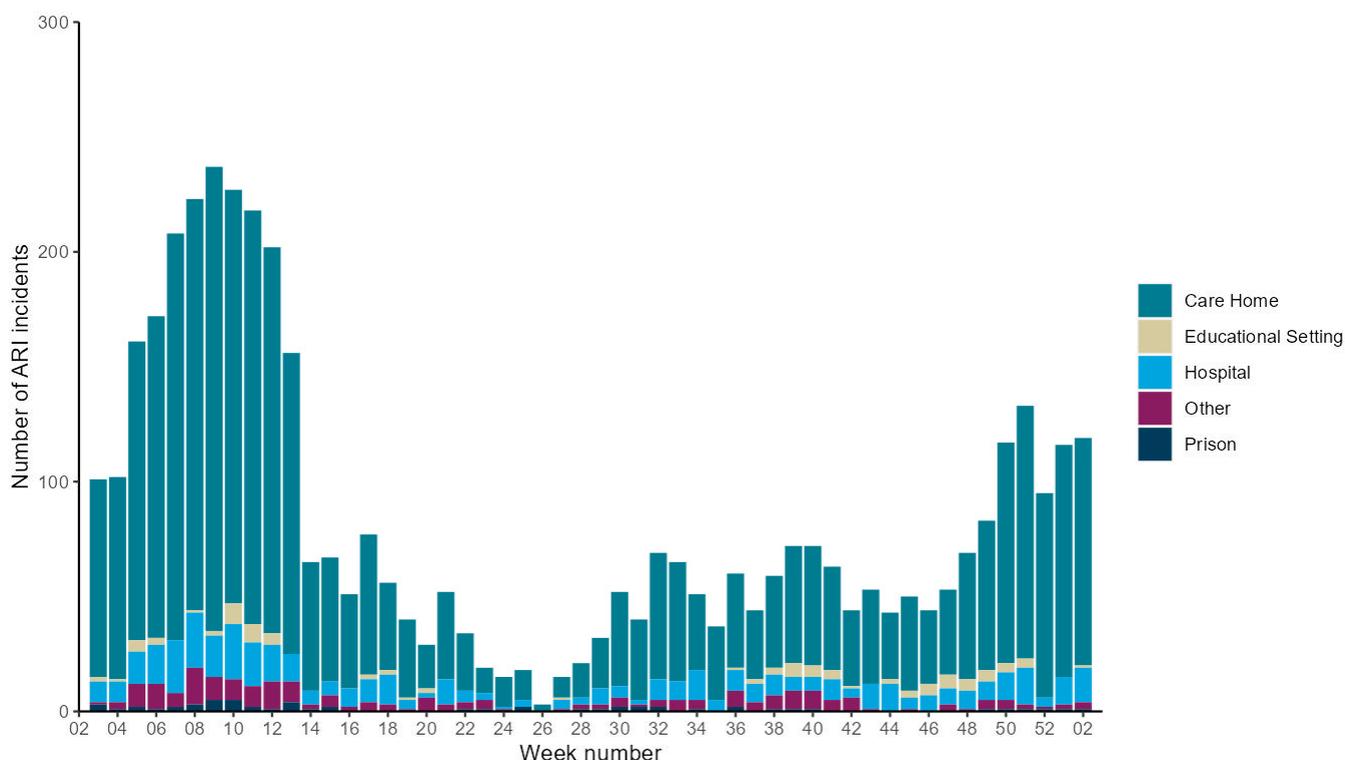
Here we present data on ARI incidents in different settings that are reported to UKHSA Health Protection Teams (HPTs).

There were 119 new ARI incidents reported in week 2 in England. In the latest week, these included:

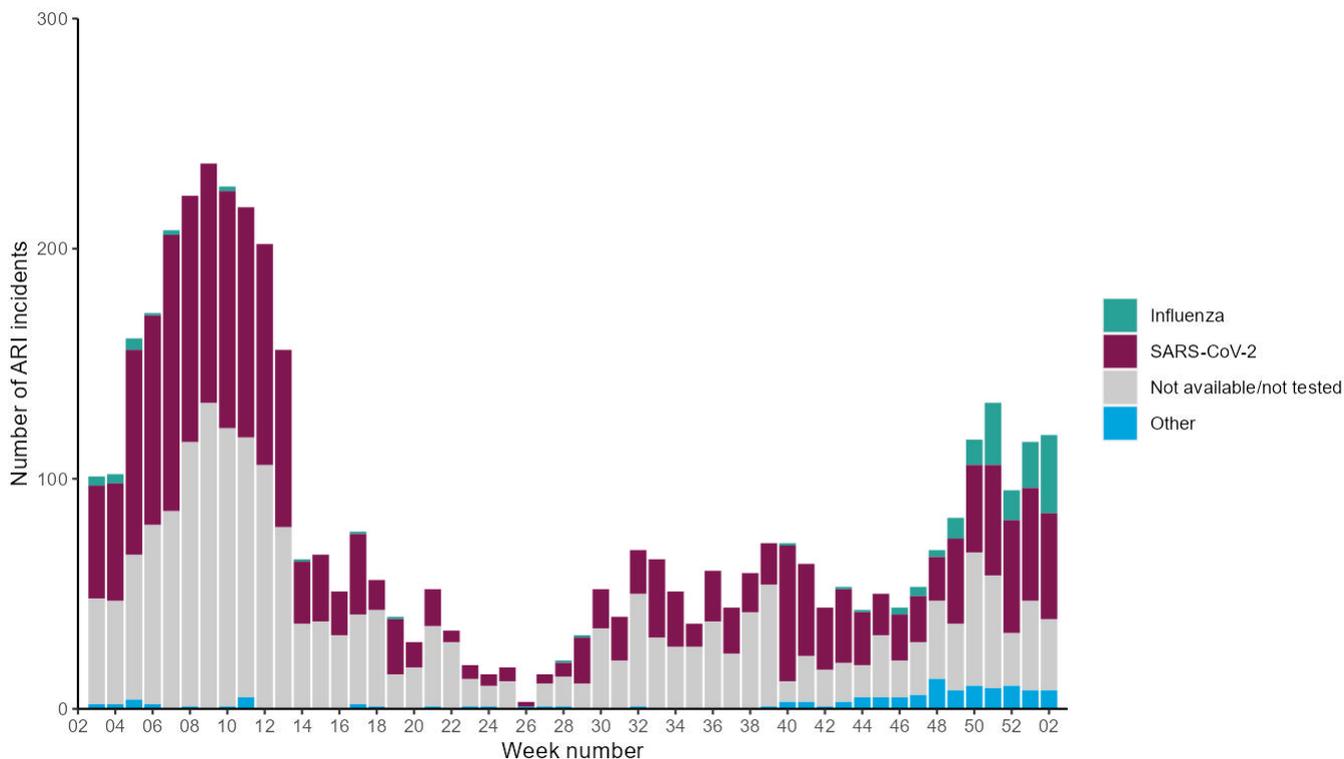
- 99 incidents reported from care homes, of which 31 were laboratory confirmed for SARS-CoV-2, 28 for influenza A(not subtyped), 6 for RSV, 3 for influenza(not typed), 1 for rhinovirus and 1 for SARS-CoV-2 and RSV (mixed infection)
- 15 incidents reported from hospitals, of which 11 were laboratory confirmed for SARS-CoV-2 and 3 for influenza A(not subtyped)
- 1 incident reported from an educational setting, with no test results available
- 1 incident reported from a prison, which was laboratory confirmed for SARS-CoV-2
- 3 incidents reported from other settings, of which 3 was laboratory confirmed for SARS-CoV-2

Please note that data back to week 40 was retrospectively updated following an improvement in the method to assign incidents to an identified pathogen using reports from health protection teams.

**Figure 17. Number of ARI incidents by setting, England**



**Figure 18. Number of ARI incidents in all settings by virus type, England**



**Figure 19. Number of ARI incidents in care homes by virus type, England**

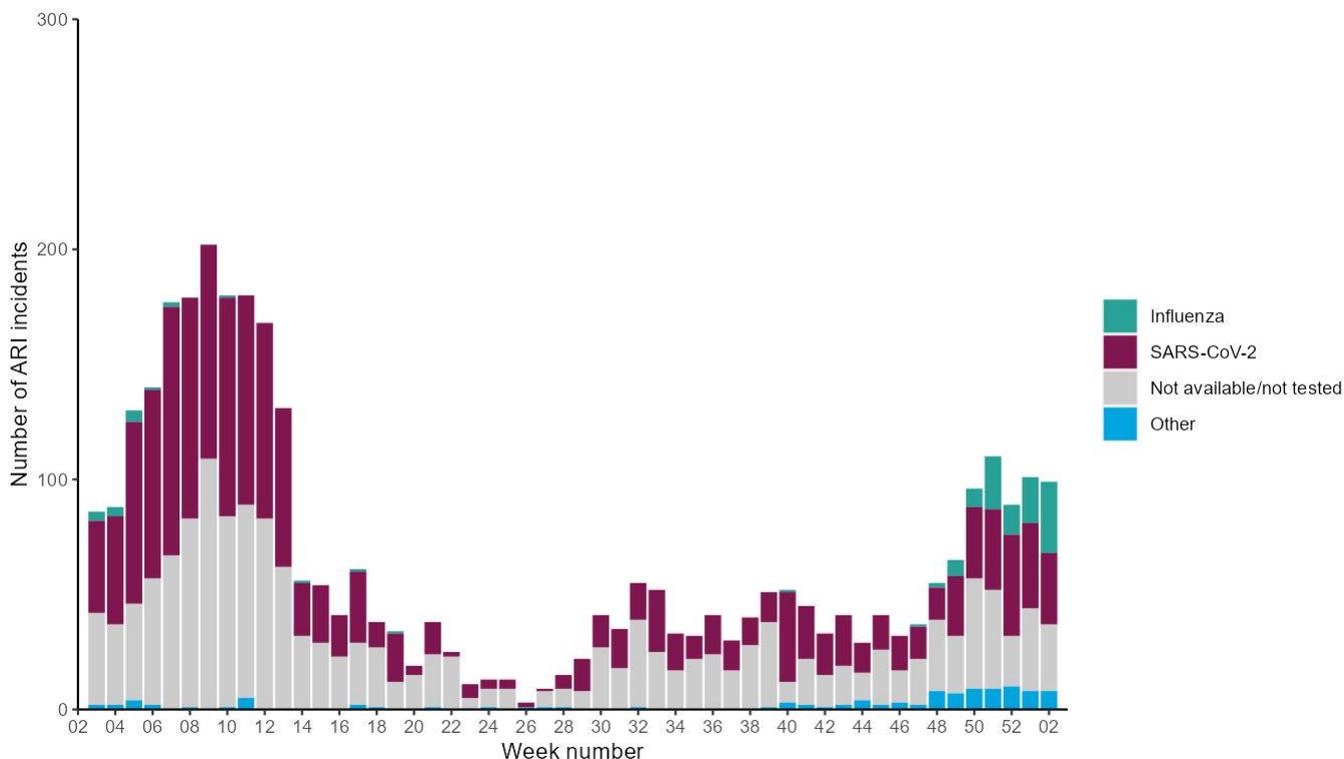
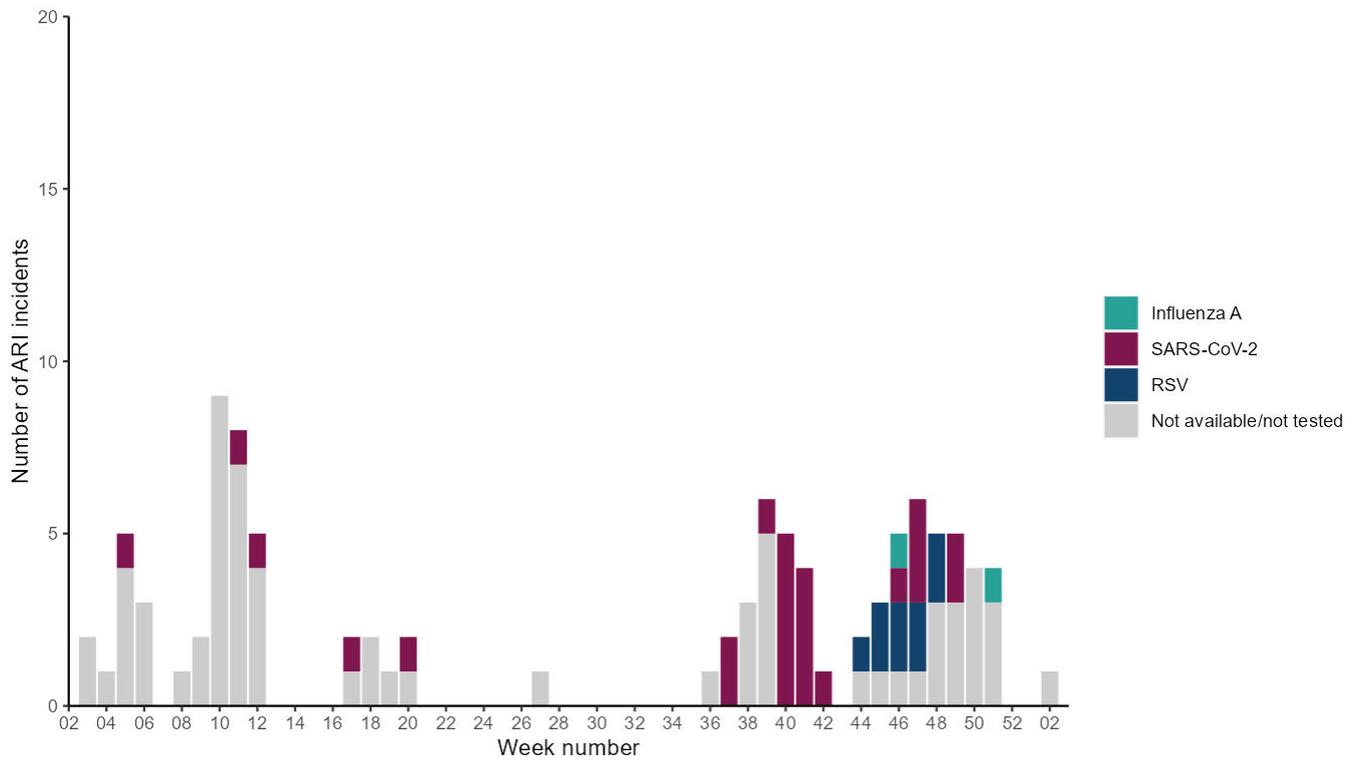


Figure 20. Number of ARI incidents in educational settings by virus type, England



## FluSurvey

[FluSurvey](#) is an internet-based participatory surveillance system based on the InfluenzaNet platform. FluSurvey 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 of 2020.

The survey had a planned pause in summer 2023 (as was the norm prior to COVID-19 emergence) and restarted in autumn 2023 on the FluSurvey 2.0 web platform with a mixture of previous participants and new participants. Therefore, the baseline demographics and level of symptoms may have changed compared to last season, including the possibility that new registrations and re-registrations may have been initiated by recent onset of illness.

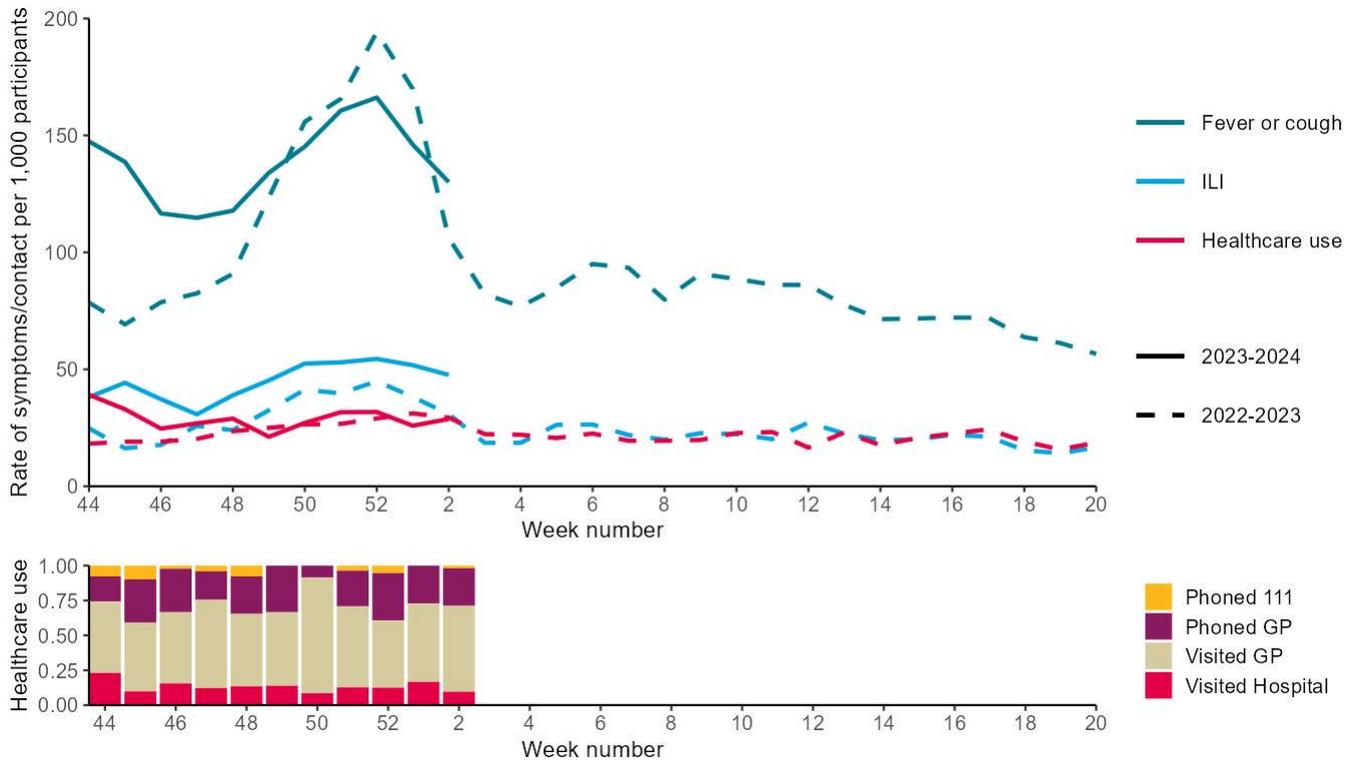
Note that ILI is defined as sudden onset of symptoms with at least one of fever (chills), malaise, headache, muscle pain and at least one of cough, sore throat, shortness of breath.

During week 2, there were 1,807 participants completing the weekly symptoms questionnaire of which 235 (13.0%) reported fever or cough and 86 (4.8%) reported ILI, slight decrease from data reported in week 1. Amongst people reporting at least one respiratory symptoms, the most commonly reported contact with healthcare services was a visit to their GP surgery.

Healthcare use is presented as total use due to reported related symptoms and is classified by the most resource intensive use of health care resource if any is used (hospital being more intensive than physically visiting the general practitioner). Amongst people reporting at least one respiratory symptom, the most reported contact with healthcare services was a visit to their GP surgery.

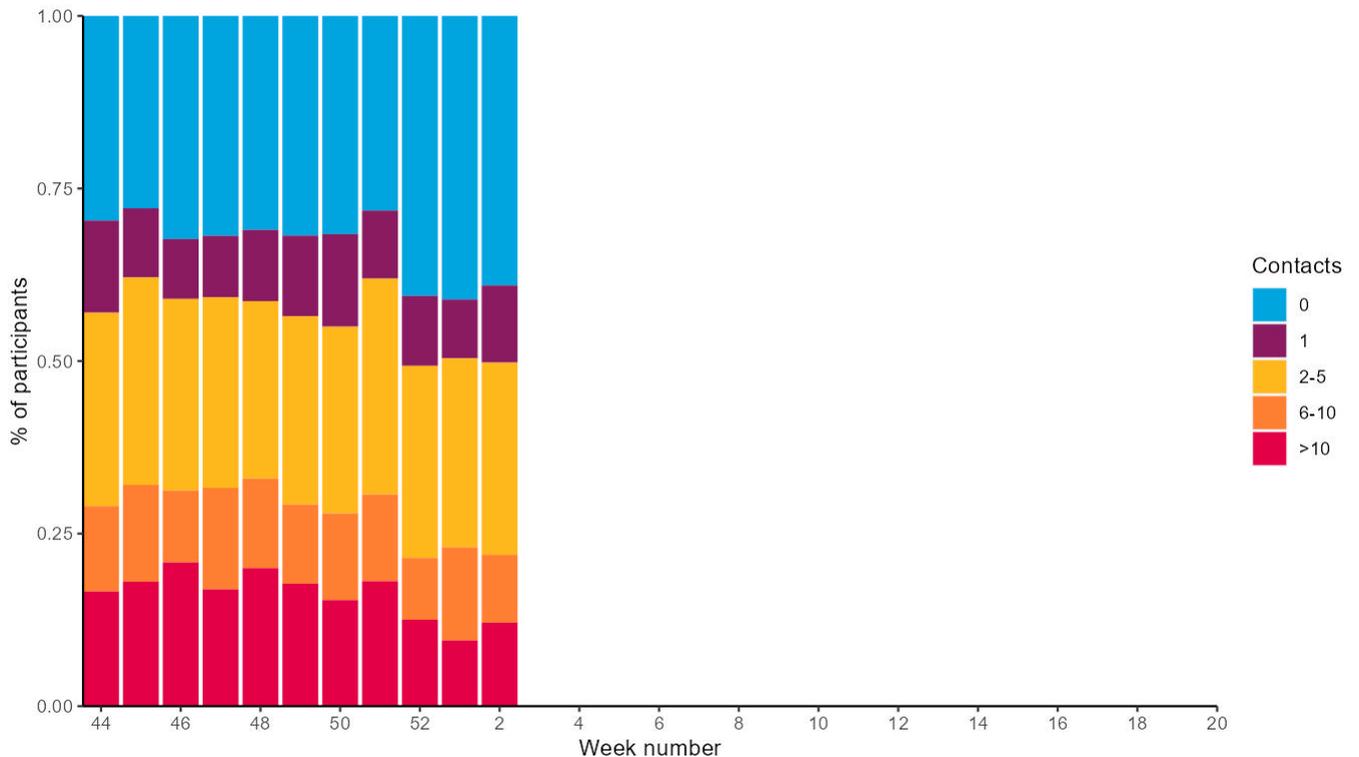
Self-reported daily social contact patterns are also reported. A contact is defined as a person outside the household who is approached at less than one metre, on the day prior to survey completion (Figure 21). There remains variation on social mixing patterns amongst participants with more people reporting not meeting any individual outside of their households during week 1.

**Figure 21. FluSurvey participants self-reporting fever or cough and ILI symptoms, and trends in healthcare seeking behaviour among these participants, England [note 9]**



[note 9] Please note in week 50 of 2022 there was no data available. The lines in the upper panel have been continued using interpolation.

**Figure 22. FluSurvey participants' self-reported number of social contacts outside the household**

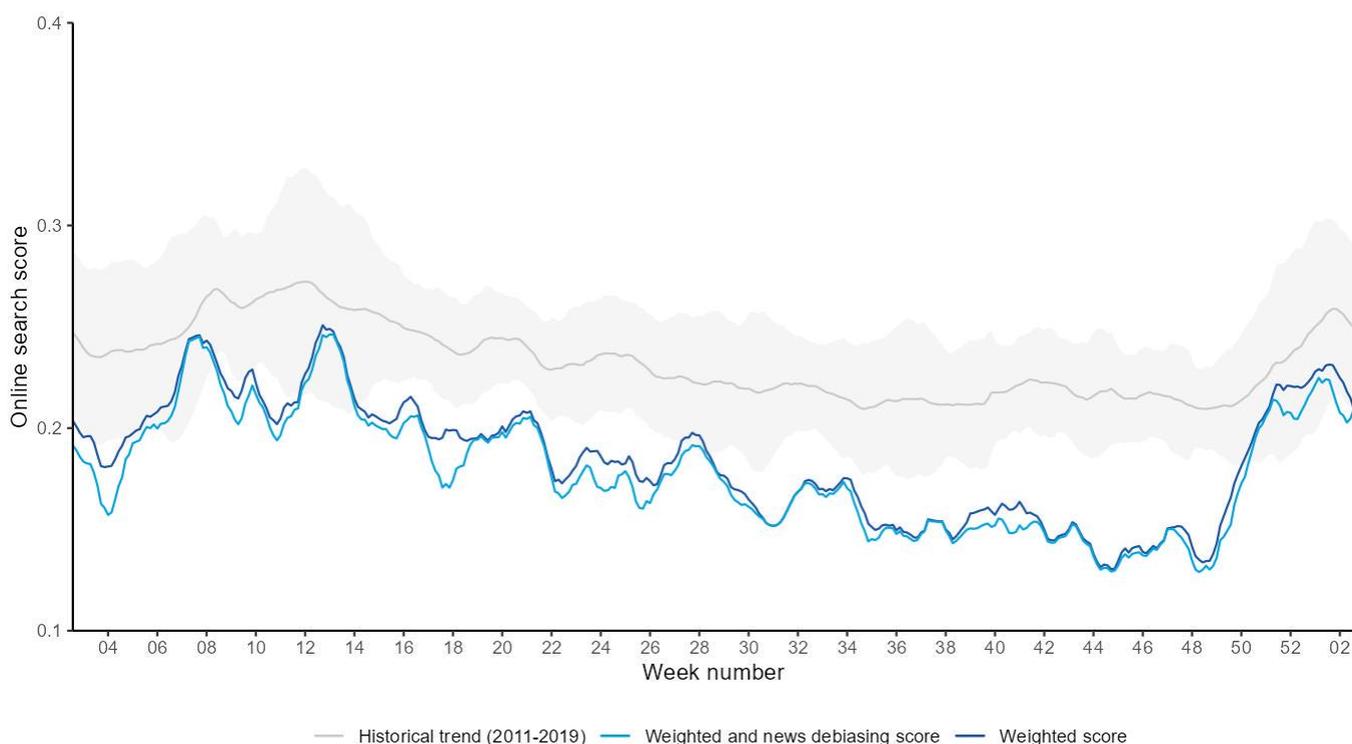


## Google search queries

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 2, the overall and media-debiasing weighted Google search scores decreased compared to the previous week (Figure 23).

**Figure 23. Normalised Google search score for COVID-19 symptoms, with weighted score for media-debiasing and historical trend, England**



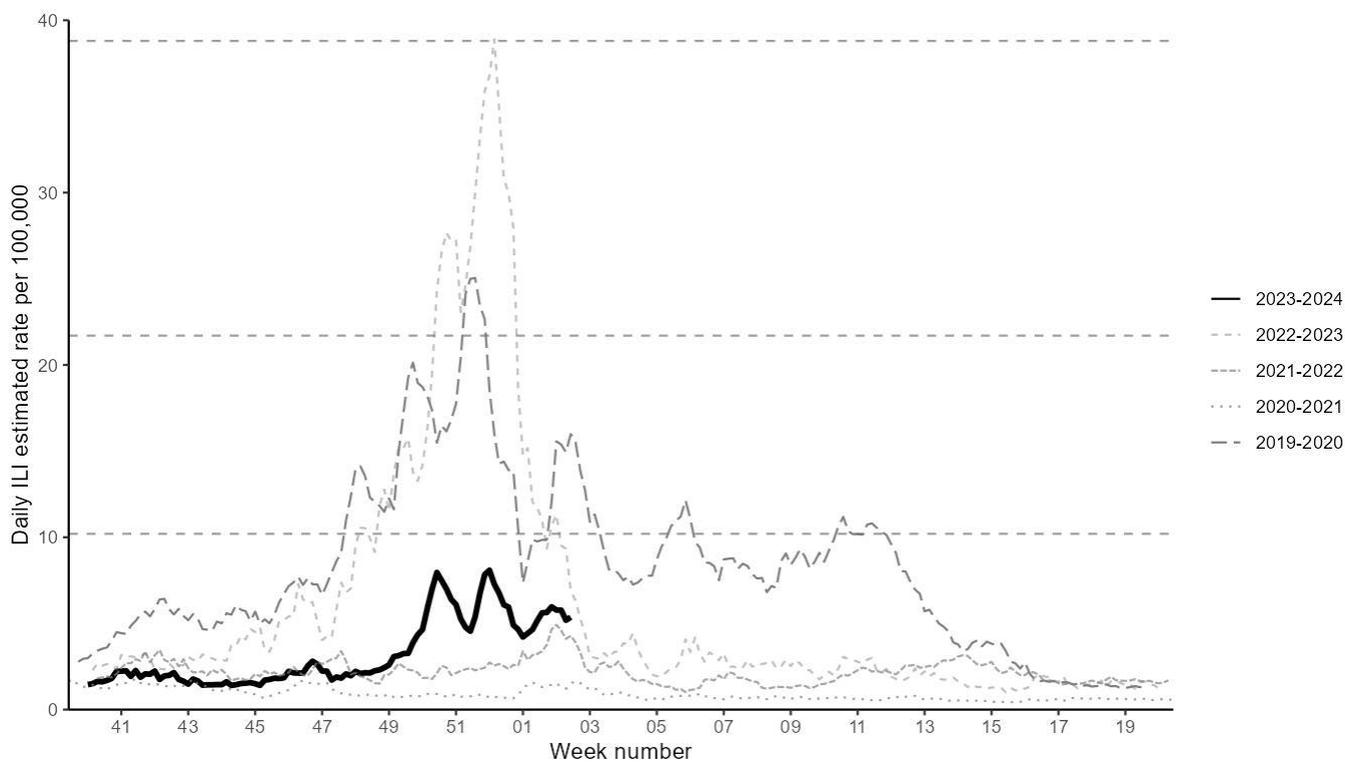
## Flu Detector

FluDetector is a web-based model which assesses internet-based search queries for influenza-like illness (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 2, the daily ILI query rate remained stable and activity remained below baseline activity (Figure 24).

**Figure 24. Daily estimated ILI Google search query rates per 100,000 population, England**

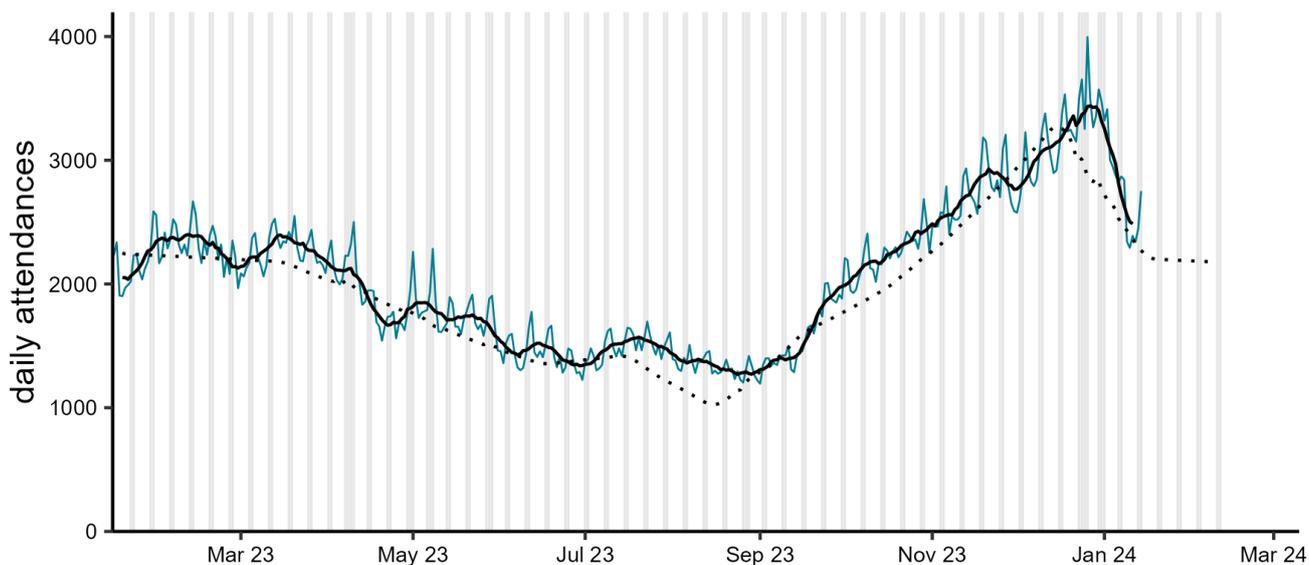


## Syndromic Surveillance

During week 2, NHS 111 calls for cold or flu and calls for cough increased in those aged under 5 years and remained below baseline levels nationally. GP in-hours consultation rates for influenza like illness (ILI) decreased and remained below expected levels. GP out of hours contacts for acute respiratory infection decreased, while ILI remained stable. ED attendances for acute bronchiolitis decreased. Acute respiratory infection and ILI ED attendances decreased across all age groups except children aged between 1 and 14 years. COVID-19-like attendances decreased across all age groups and regions.

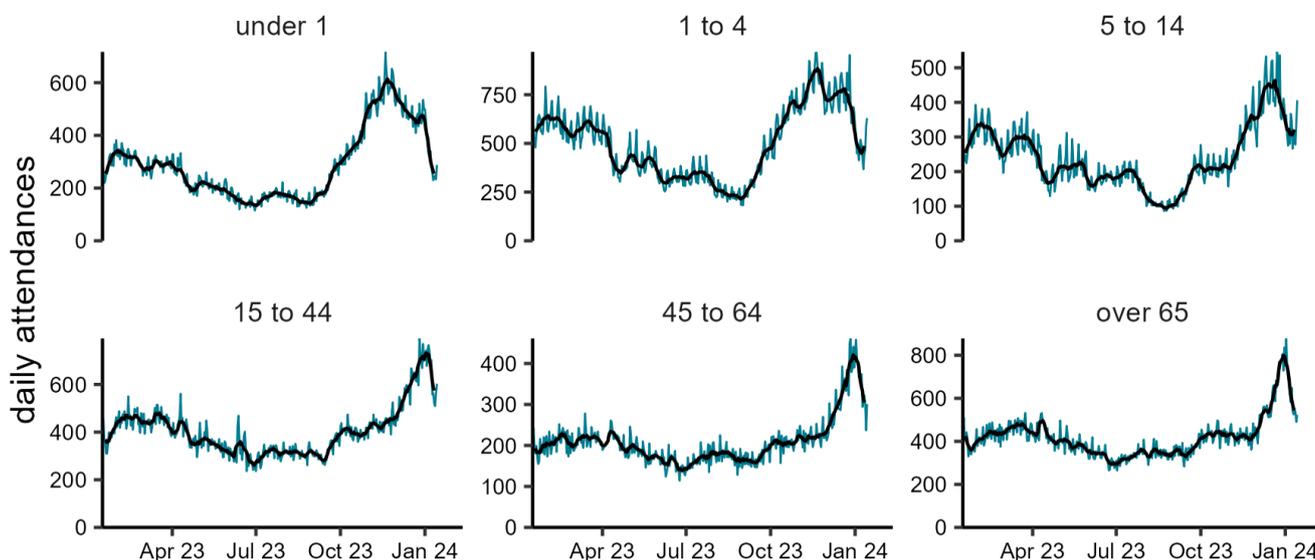
For further information on syndromic surveillance please see the [Syndromic Surveillance: weekly summaries](#).

**Figure 25a. Daily ED attendances for acute respiratory infection nationally, England [note 10]**



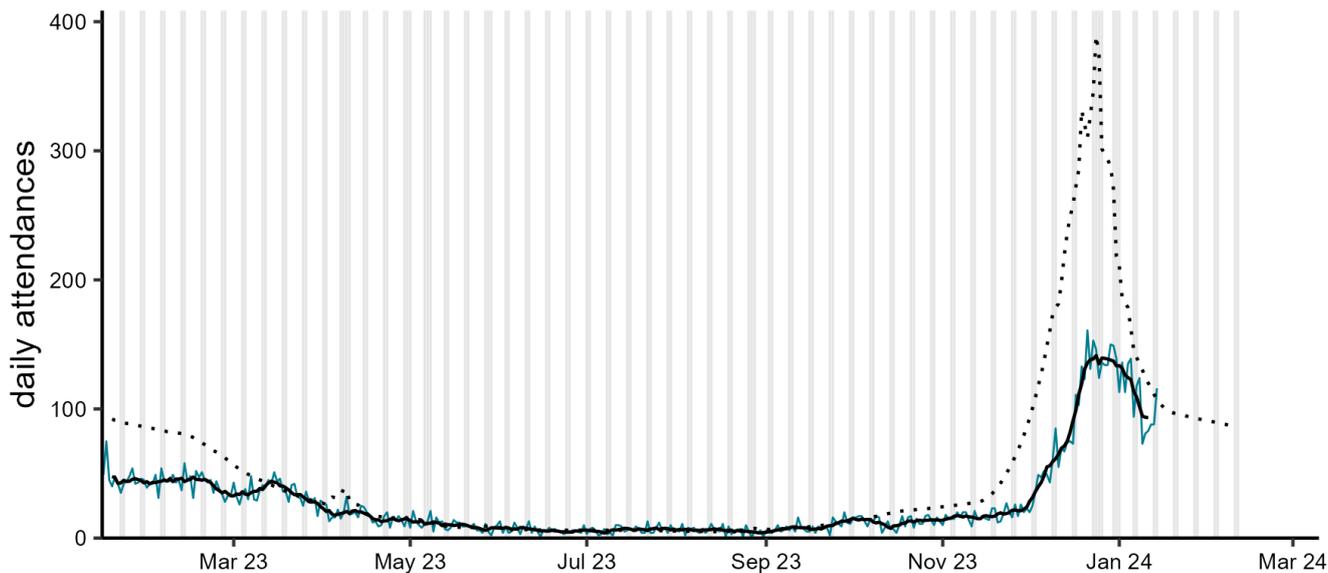
[note 10] The solid black line is a 7-day moving average adjusted for holidays. The solid green line is the daily attendances. The black dotted line is the baseline. The grey columns show weekends and bank holidays.

**Figure 25b. Daily ED attendances for acute respiratory infection by age group, England [note 11]**



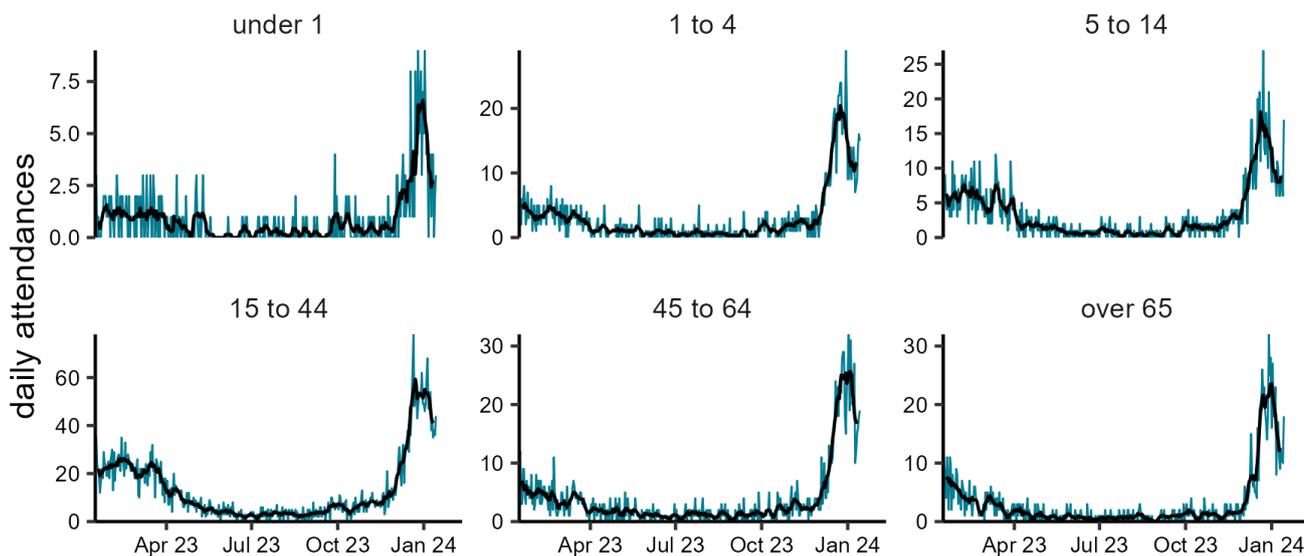
[note 11] The scales may vary in each graph to enable trend comparison. The black line is the 7-day moving average adjusted for bank holidays.

**Figure 26a. Daily ED attendances for influenza-like illness nationally, England [note 10]**



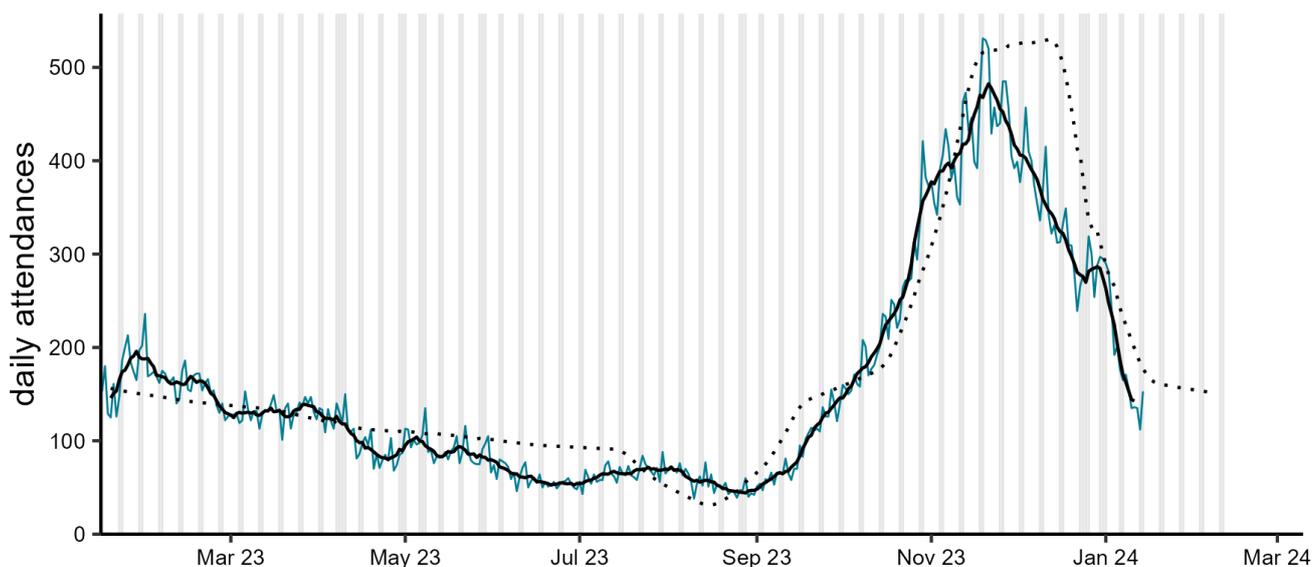
See [note 10] as above.

**Figure 26b. Daily ED attendances for influenza-like illness by age group, England [note 11]**



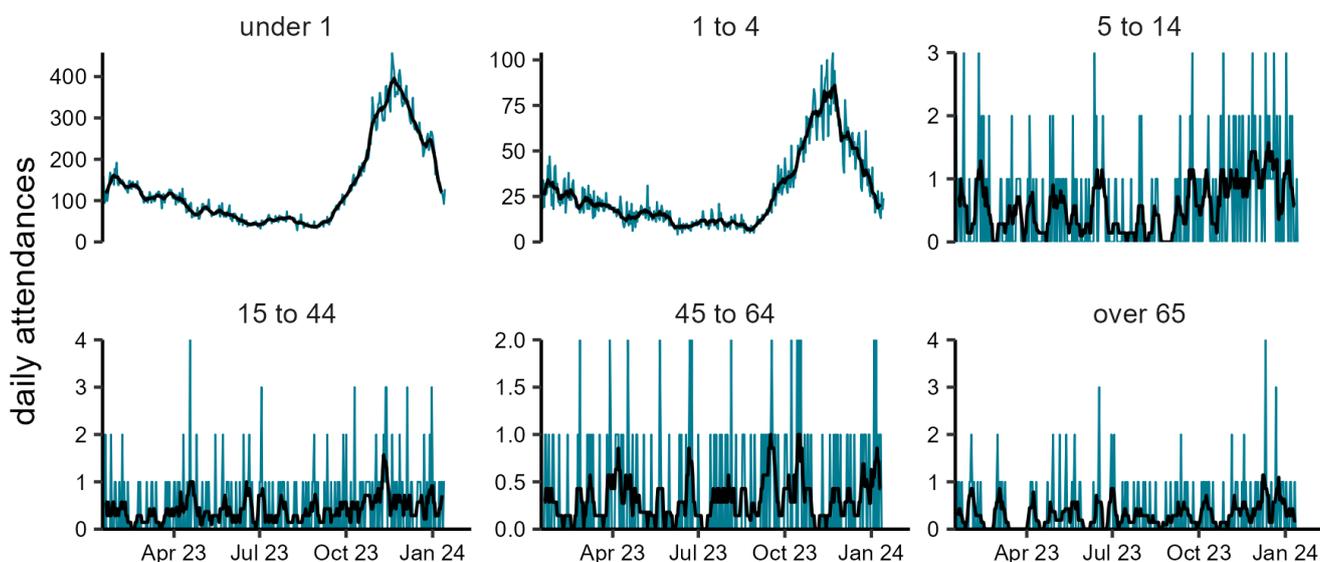
See [note 11] as above.

**Figure 27a. Daily ED attendances for acute bronchiolitis nationally, England [note 12]**



See [\[note 10\]](#) as above.

**Figure 27b. Daily ED attendances for acute bronchiolitis by age group, England [note 12]**



See [\[note 11\]](#) as above.

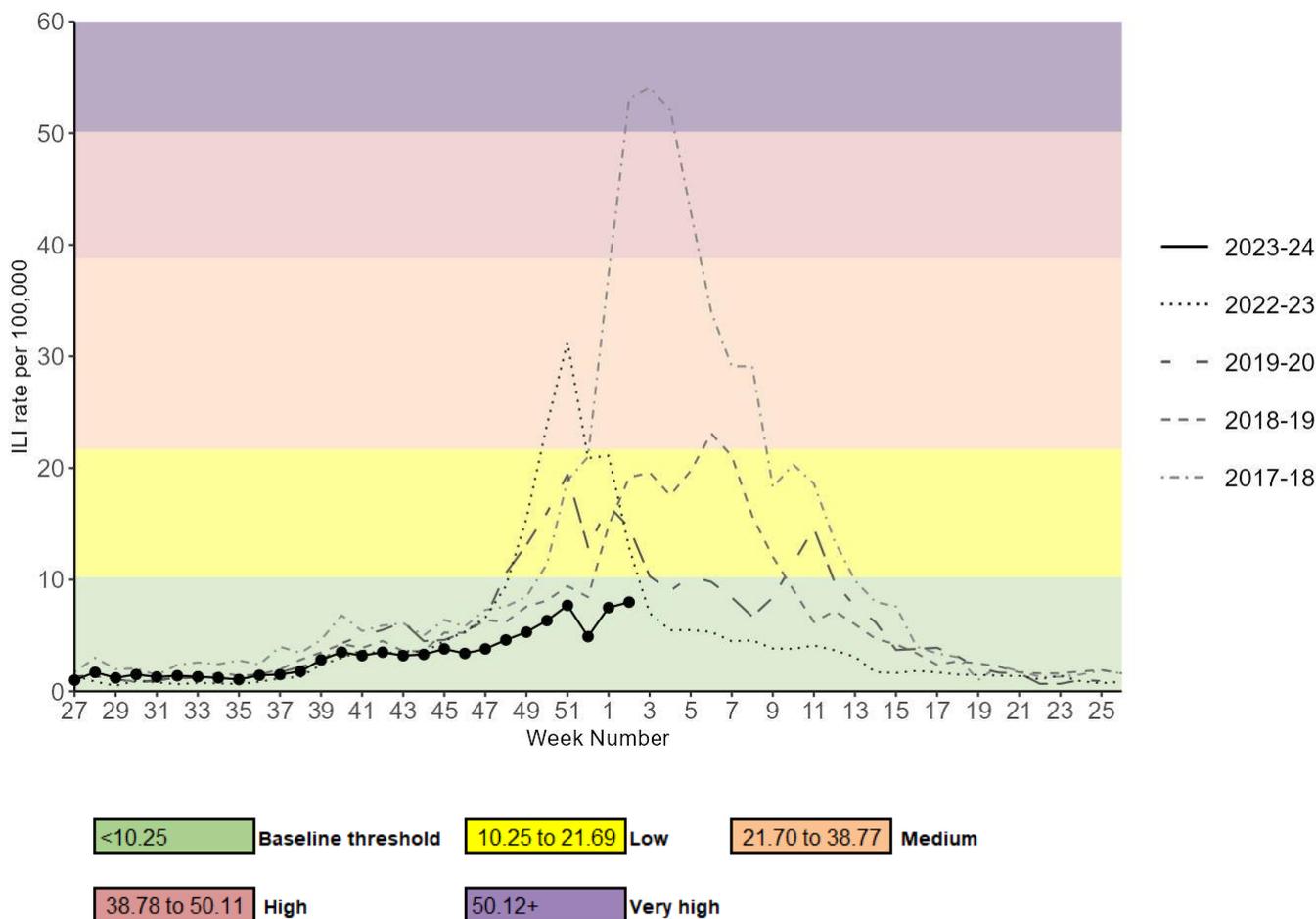
[note 12] Please note, there was no update in week 14 for acute bronchiolitis syndromic surveillance.

# Primary care surveillance

## RCGP Clinical Indicators (England)

The weekly ILI consultation rate through the Royal College of General Practitioners (RCGP) surveillance increased slightly to 8.0 per 100,000 registered population in participating GP practices in week 2 compared to 7.5 per 100,000 in the previous week. This is within baseline activity levels (less than 10.25 per 100,000) (Figure 28). By age group, the highest rates were seen those between 45 and 64 years of age (10.8 per 100,000), followed by those aged over 75 years (8.7 per 100,000). The lower respiratory tract infections (LRTI) consultation rate remained stable at 144.1 per 100,000 in week 2 compared to 144.4 per 100,000 in the previous week.

**Figure 28. RCGP ILI consultation rates, all ages, England**



Moving Epidemic Method (MEM) thresholds are based on data from the 2015 to 2016 season to the 2022 to 2023 season. Please note the 2020 to 2021 and 2021 to 2022 seasons have been removed due to low activity throughout these seasons.

## RCGP sentinel swabbing scheme in England

Due to reporting delays, there were insufficient results of samples taken in week 2 of 2024 to report. These will be included in next week's report. Additionally, starting in week 51 testing for enterovirus and rhinovirus have been delayed.

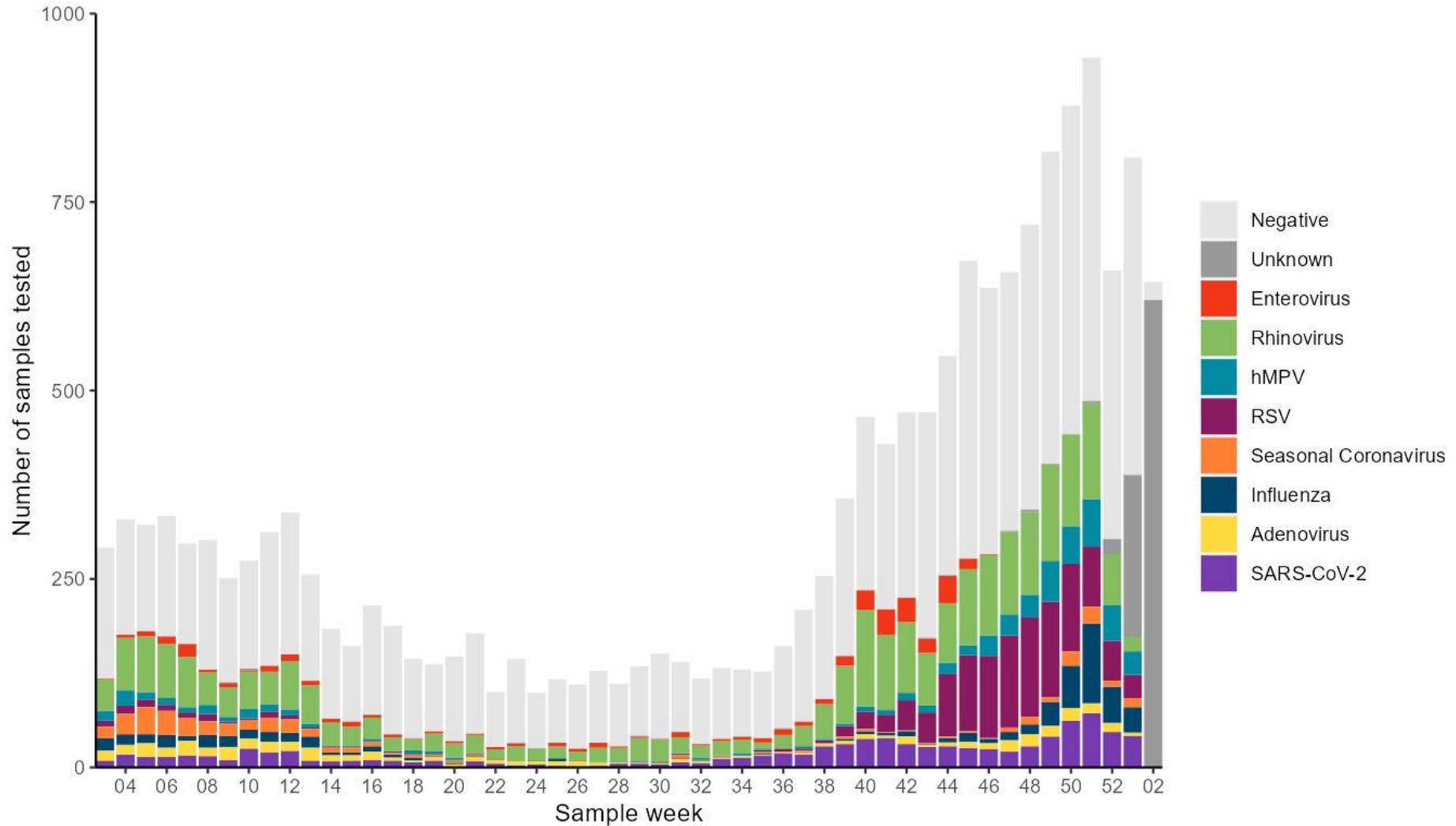
Based on the date samples were taken, in week 1 of 2023 (week commencing 1 January 2024) 803 samples were tested through the GP sentinel swabbing scheme in England of which 173 samples tested positive (Figure 29). Among all positive samples, 24.3% were positive for SARS-CoV-2, 19.7% were positive for influenza, 17.9% were positive for hMPV, 17.9% were positive for RSV, 11.0% for rhinovirus, 6.9% were positive for other seasonal coronaviruses and 2.3% were positive for adenovirus (Figure 30). Due to the number of samples which have not yet been categorised, data should be interpreted with caution when compared to previous weeks. In week 2, there were result for 25 samples, proportion of detections among all positive samples is not calculated when the number of samples with result is less than 50.

In week 1, positivity for SARS-CoV-2 was 7.2%, positivity for influenza was 6.2%, and positivity for RSV was 5.6% (Figure 31). Due to the number of samples which have not yet been categorised, data should be interpreted with caution when compared to previous weeks. In week 2, there were result for 25 samples, positivity (%) is not calculated when the number of samples with result is less than 50.

In previous reports, figure 27 and figure 28 were produced based on the date samples were received in the reference laboratory. From 23 November 2023 (week 47 report) these figures have been updated to be based on the date samples were taken.

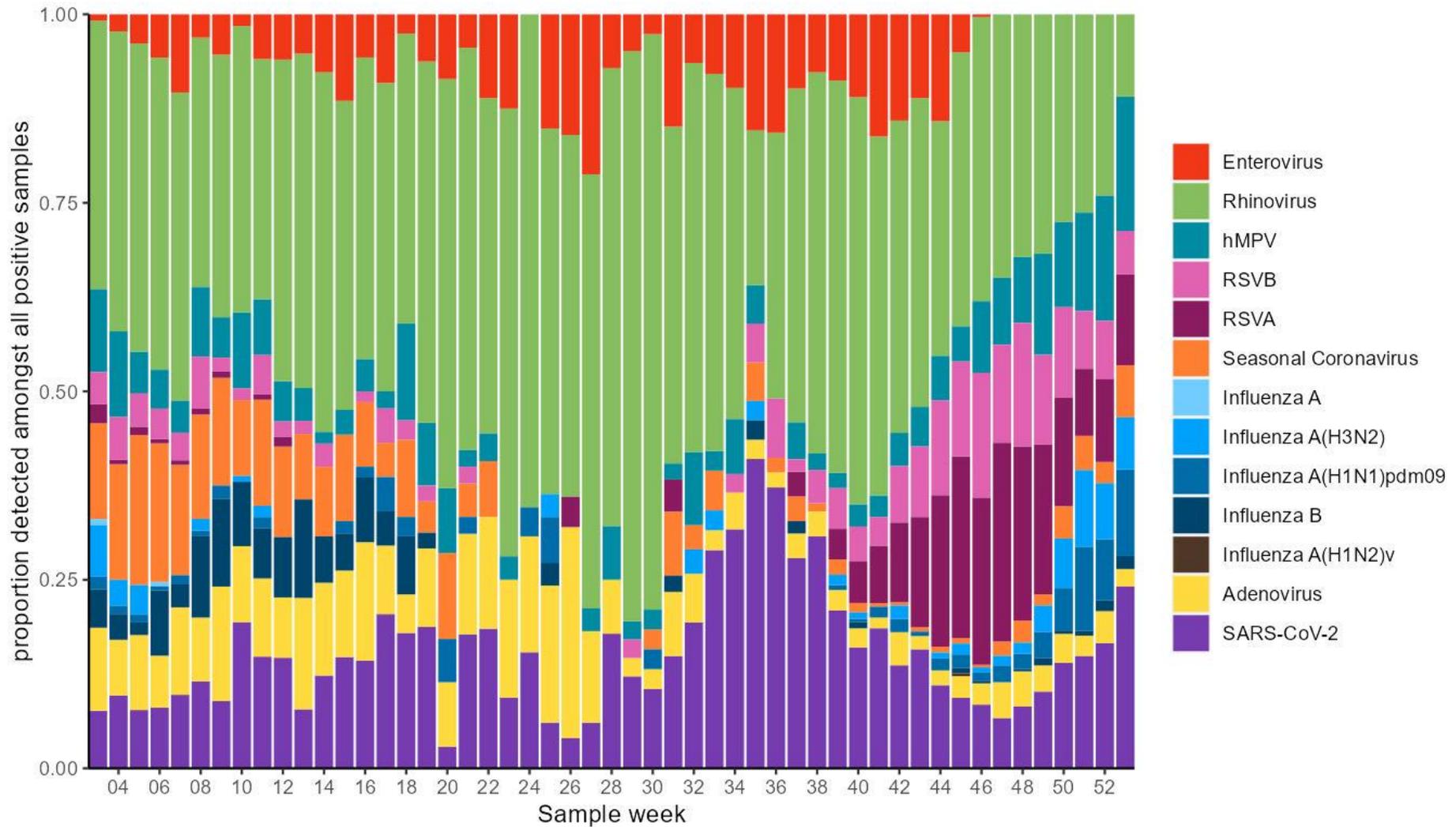
From 27 November 2023, swabbing was increased in the Yorkshire and Humber region in response to the [identification of a case of influenza A\(H1N2\)v](#). This may lead to an over-representation of the Yorkshire and Humber region.

**Figure 29. Number of samples tested for SARS-CoV-2, influenza, and other respiratory viruses in England by week, GP sentinel swabbing [note 13]**



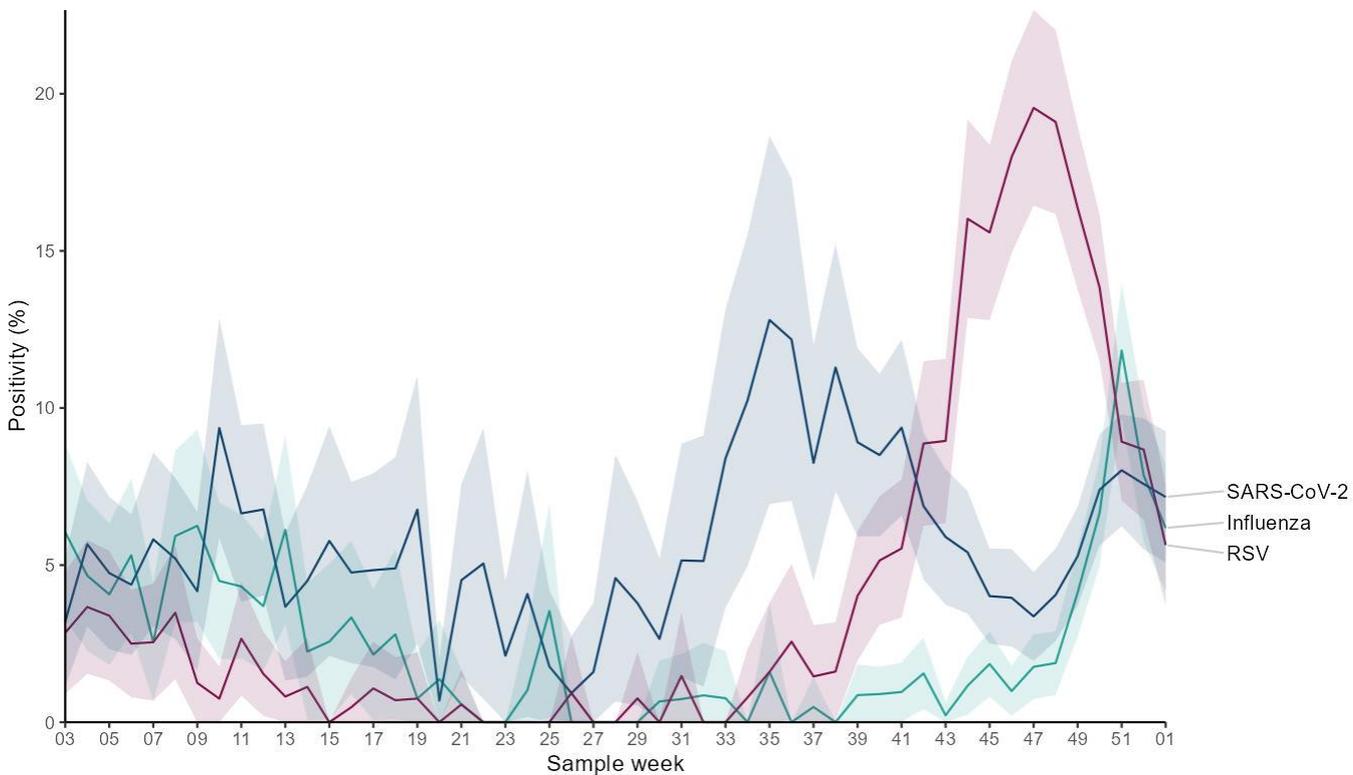
[note 13] Unknown category corresponds to samples with no result yet.

**Figure 30. 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 [note 14]**



[note 14] from week 51 data contains a substantial reduction of test results for enterovirus and rhinovirus due to a delay in testing for these pathogens.

**Figure 31. Weekly positivity (%) for COVID-19, influenza and RSV in England, GP sentinel swabbing**



## Secondary care surveillance

### Influenza, SARI Watch

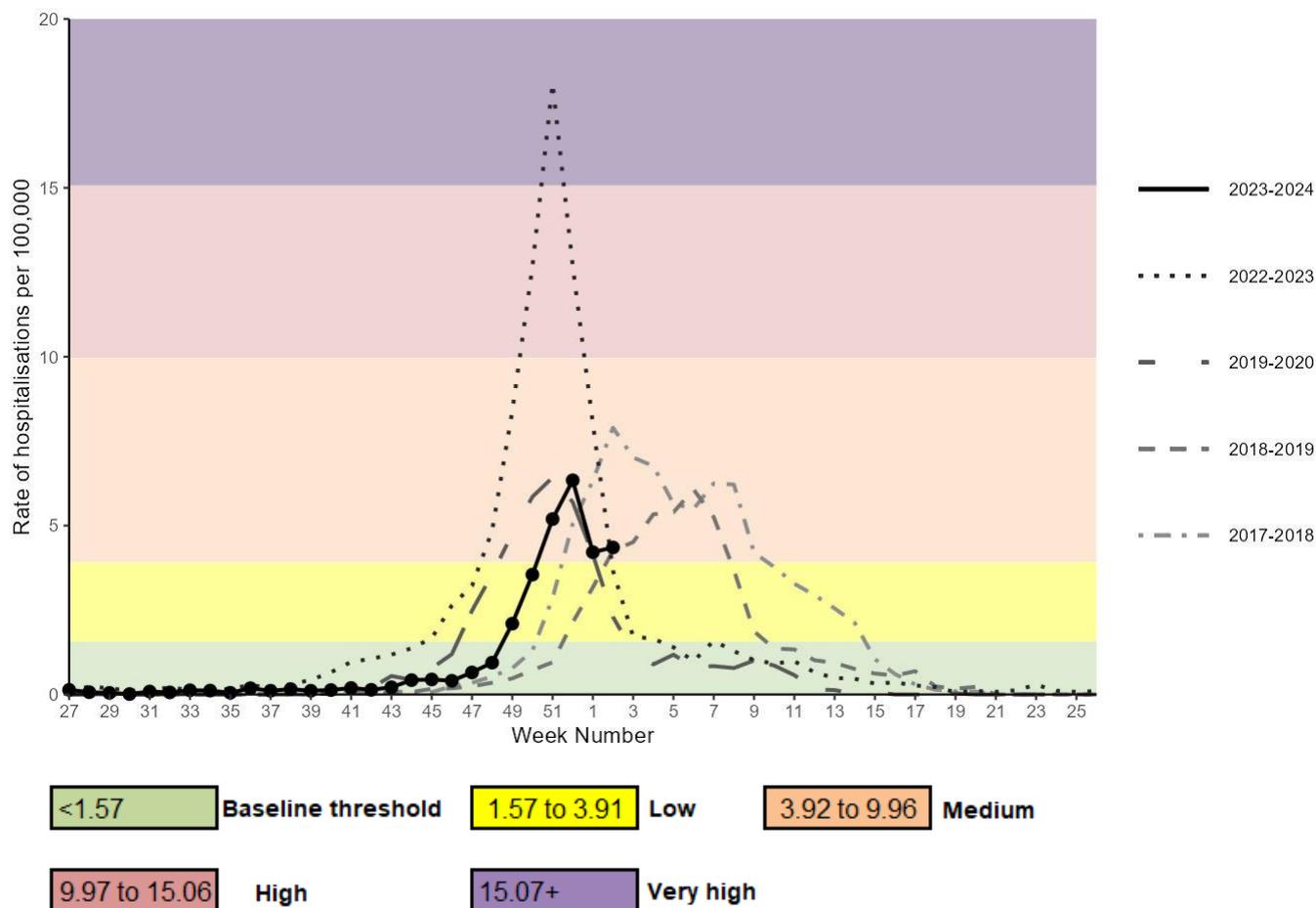
Surveillance of influenza hospitalisations to all levels of care is based on data from a small sentinel network of acute NHS trusts in England. Surveillance of admissions to ICU or HDU for influenza is mandatory with data required from all acute NHS trusts in England. Please note that the SARI Watch rates for 2023 to 2024 use the latest trust catchment population. For consistency the rates have been updated back to October 2020. The population denominator reflects changes in trust reconfiguration, hospital admission activity and population estimates.

In week 2 (ending 14 January 2024), the overall weekly hospital admission rate for influenza increased slightly to 4.35 per 100,000 compared to 4.21 per 100,000 in the previous week. The latest rate remained within the medium impact range (3.92 to 9.96 per 100,000). There were 425 new hospital admissions for influenza (328 influenza A(not subtyped), 67 influenza A(H1N1)pdm09, 24 influenza A(H3N2), and 6 influenza B).

In week 2, the overall ICU or HDU rate for influenza decreased to 0.08 per 100,000 compared to 0.14 per 100,000 in the previous week. The rate in the latest week was within the baseline impact range. There were 32 new case reports of an ICU or HDU admission for influenza in week 2 (28 influenza A(not subtyped), 2 influenza A(H1N1)pdm09, 2 influenza A(H3N2) and 0 influenza B).

One paediatric trust joined the sentinel surveillance on influenza and RSV hospitalisations from week 2 of 2024 and backdated returns to week 48 of 2023.

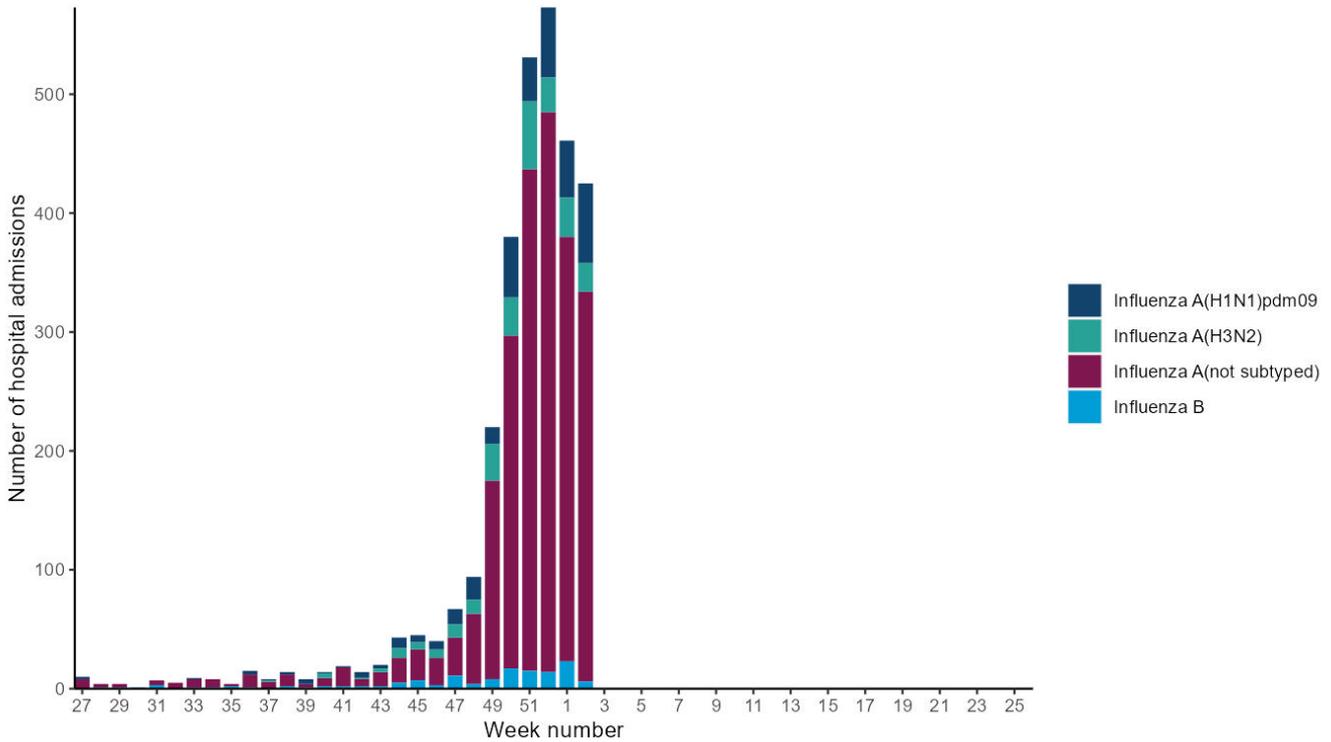
**Figure 32. Weekly overall influenza hospital admission rates per 100,000 trust catchment population with MEM thresholds, reported through SARI Watch sentinel surveillance, England**



MEM thresholds are based on data from the 2015 to 2016 season to the 2022 to 2023 season. Please note the 2020 to 2021 and 2021 to 2022 seasons have been removed due to low activity throughout these seasons.

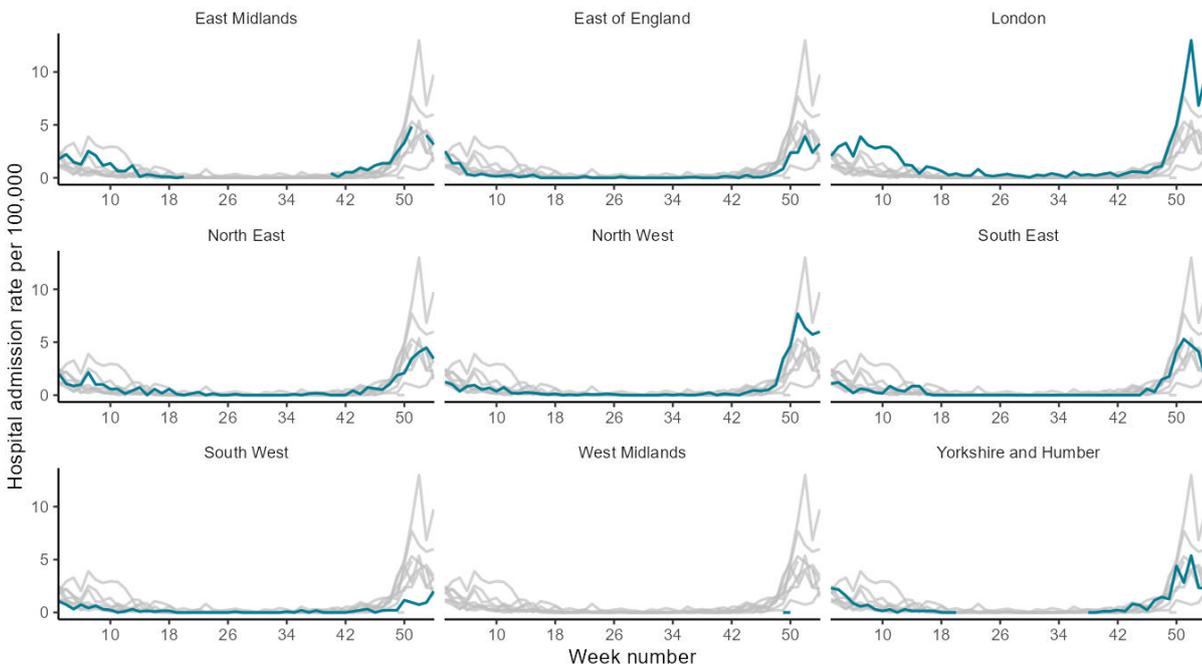
Influenza hospital admission rate based on 24 sentinel NHS trusts for week 2. SARI Watch data is provisional and subject to retrospective updates.

**Figure 33. Weekly influenza hospital admissions by influenza type, reported through SARI Watch sentinel surveillance, England [note 15]**



[note 15] Number of influenza hospital admissions based on sentinel NHS trusts.

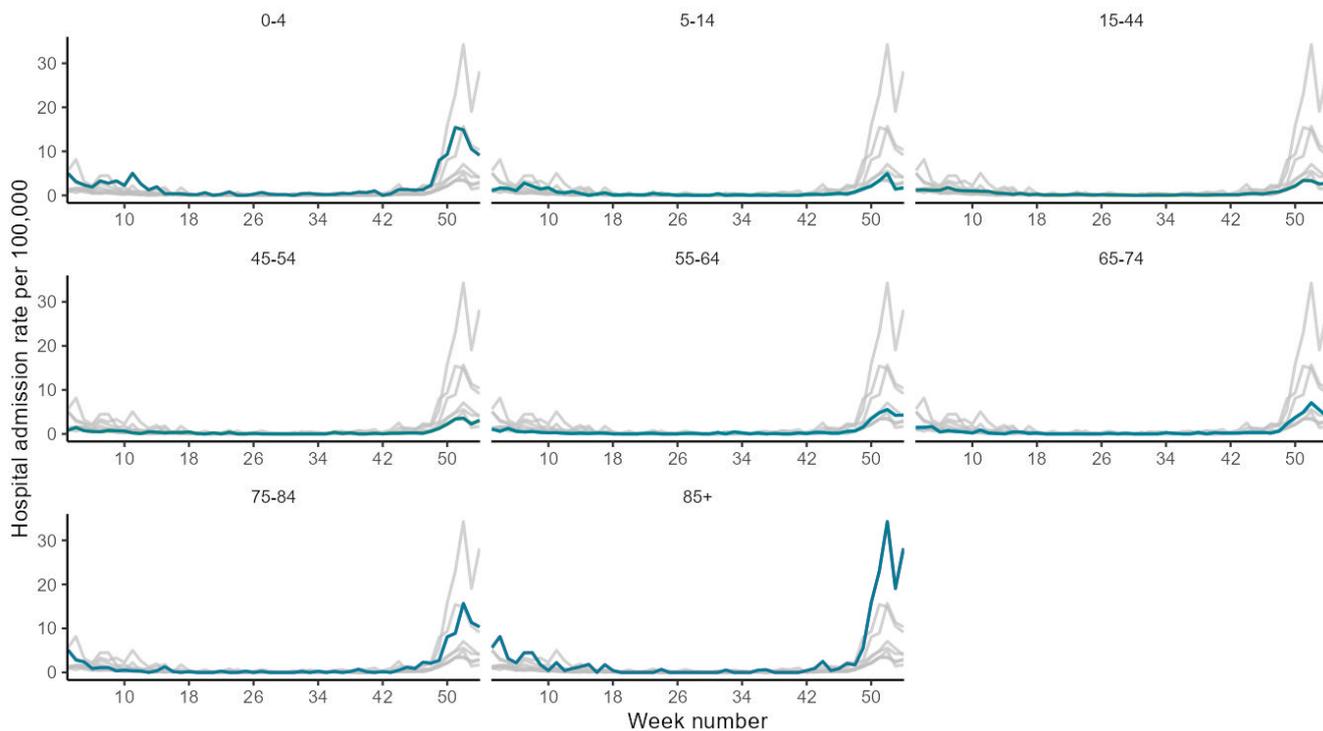
**Figure 34. Weekly hospital admission rate by UKHSA region for new influenza reported through SARI Watch sentinel surveillance [note 4] [note 16]**



[note 16] Rates in some regions may not include all influenza surveillance sentinel trust sites from week to week. This may lead to variation in regional representation hence caution is required in interpreting the weekly data by region.

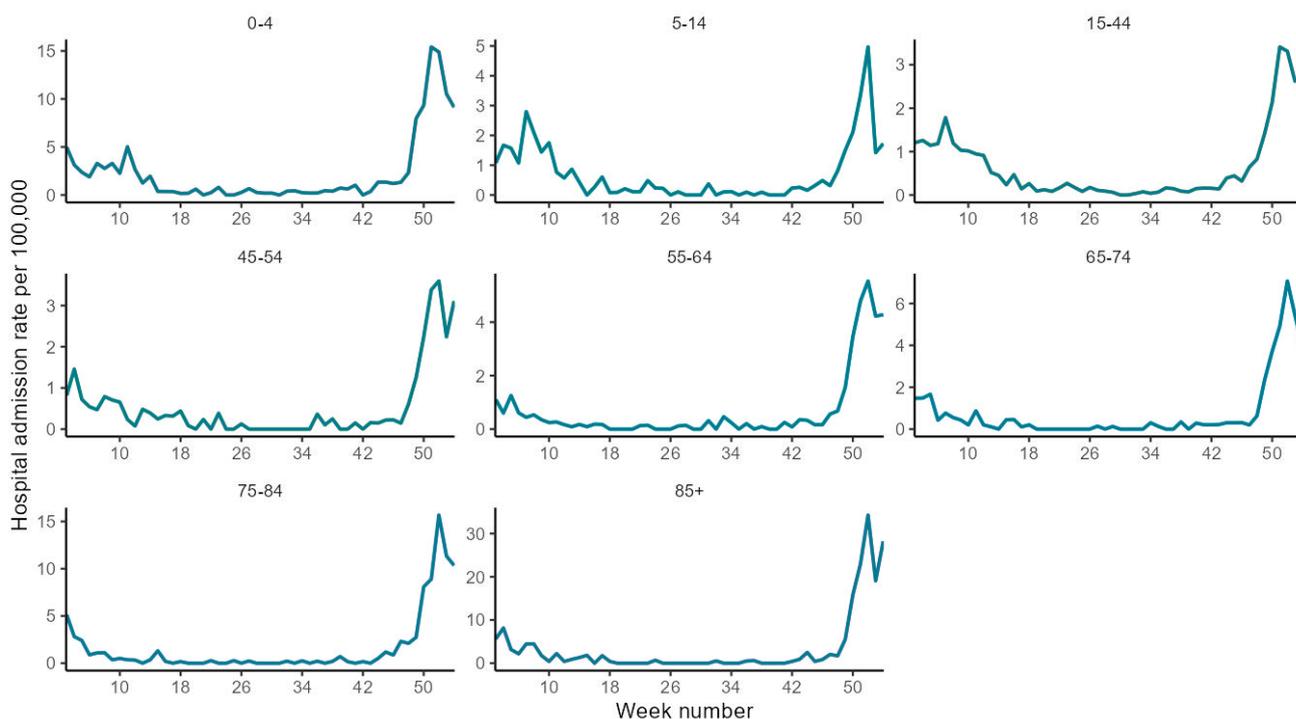
See [note 4] as above

**Figure 35a. Weekly hospital admission rate by age group for new influenza reported through SARI Watch sentinel surveillance - fixed y-axis [note 3]**

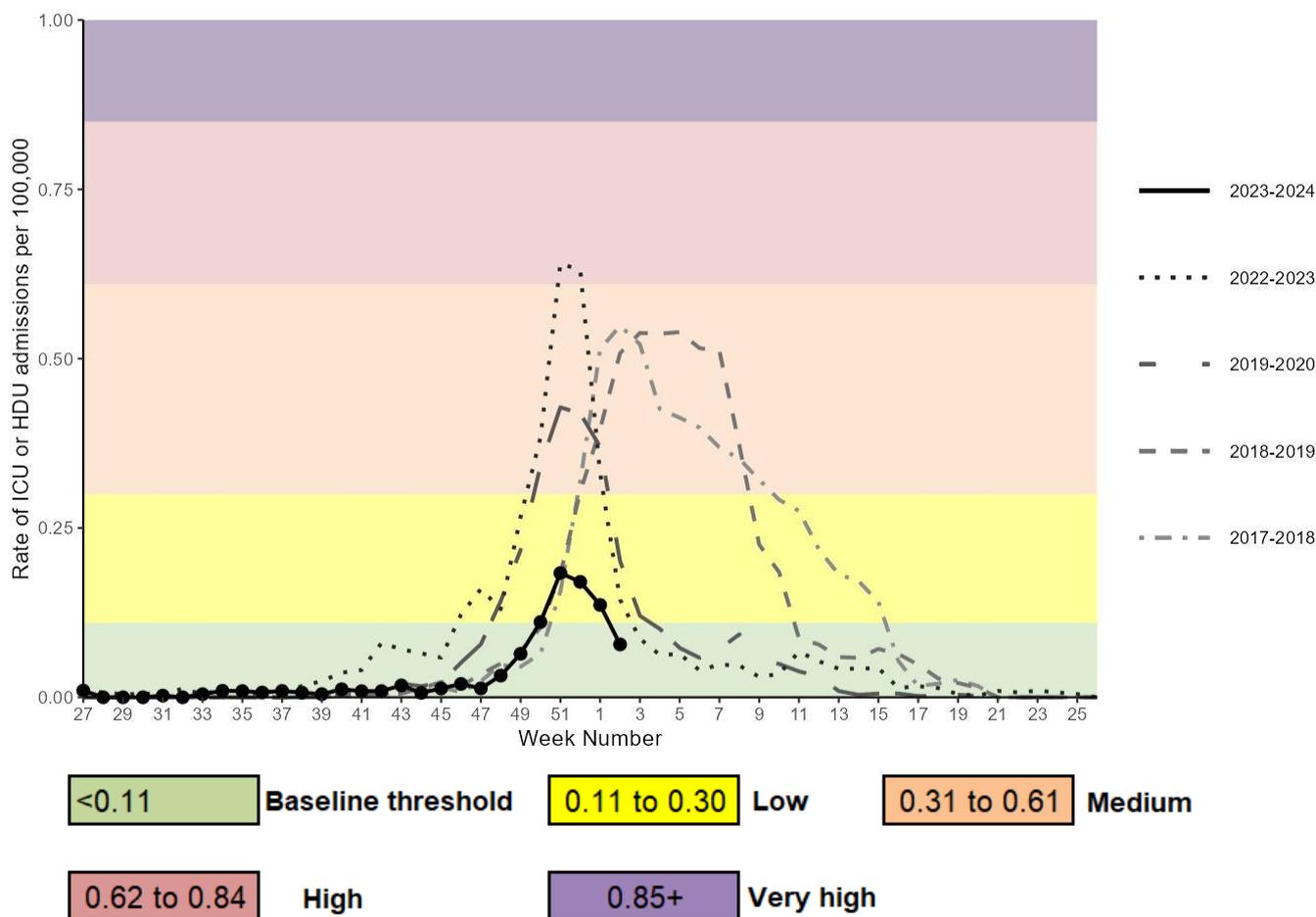


See [note 3] as above.

**Figure 35b. Weekly hospital admission rate by age group for new influenza reported through SARI Watch sentinel surveillance - adjusted y-axis**



**Figure 36. Weekly overall influenza ICU or HDU admission rates per 100,000 trust catchment population with MEM thresholds, reported through SARI Watch, England**

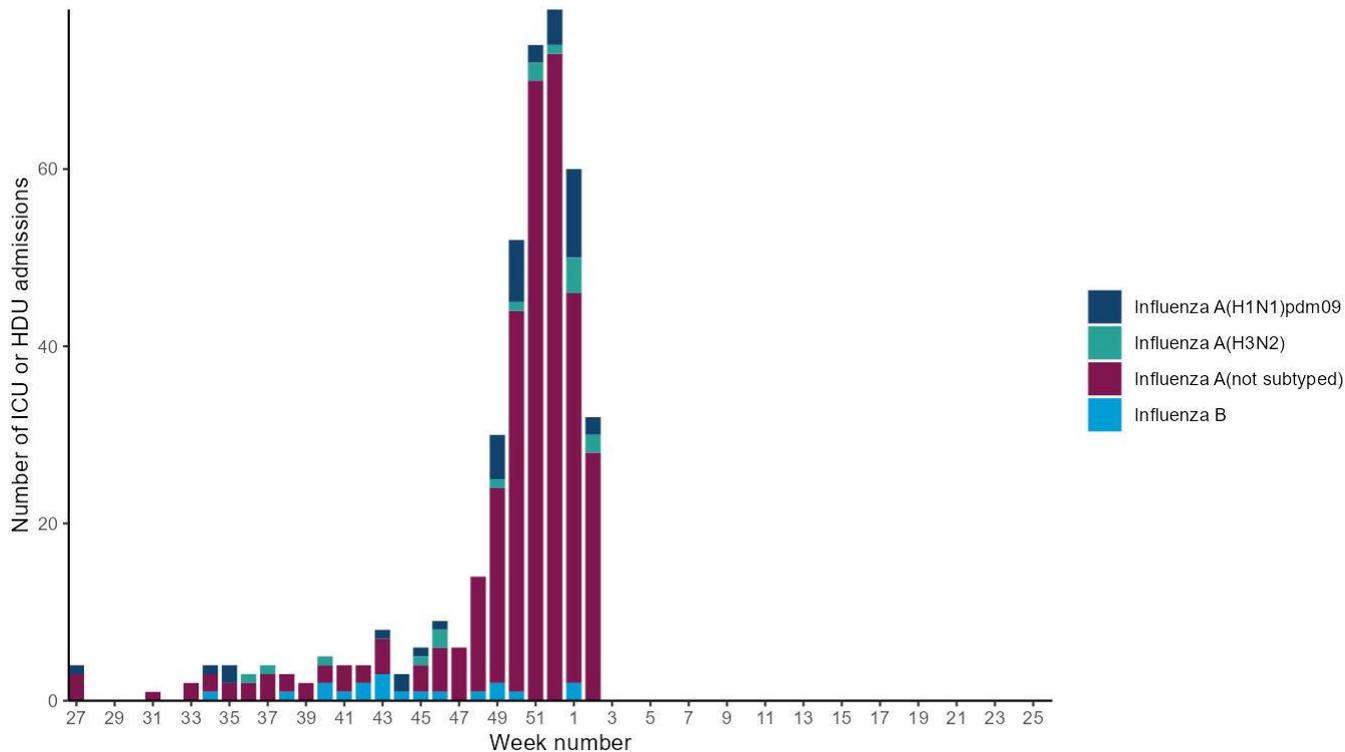


MEM thresholds are based on data from the 2015 to 2016 to the 2022 to 2023 seasons. Please note the 2020 to 2021 and 2021 to 2022 seasons have been removed due to low activity throughout these seasons.

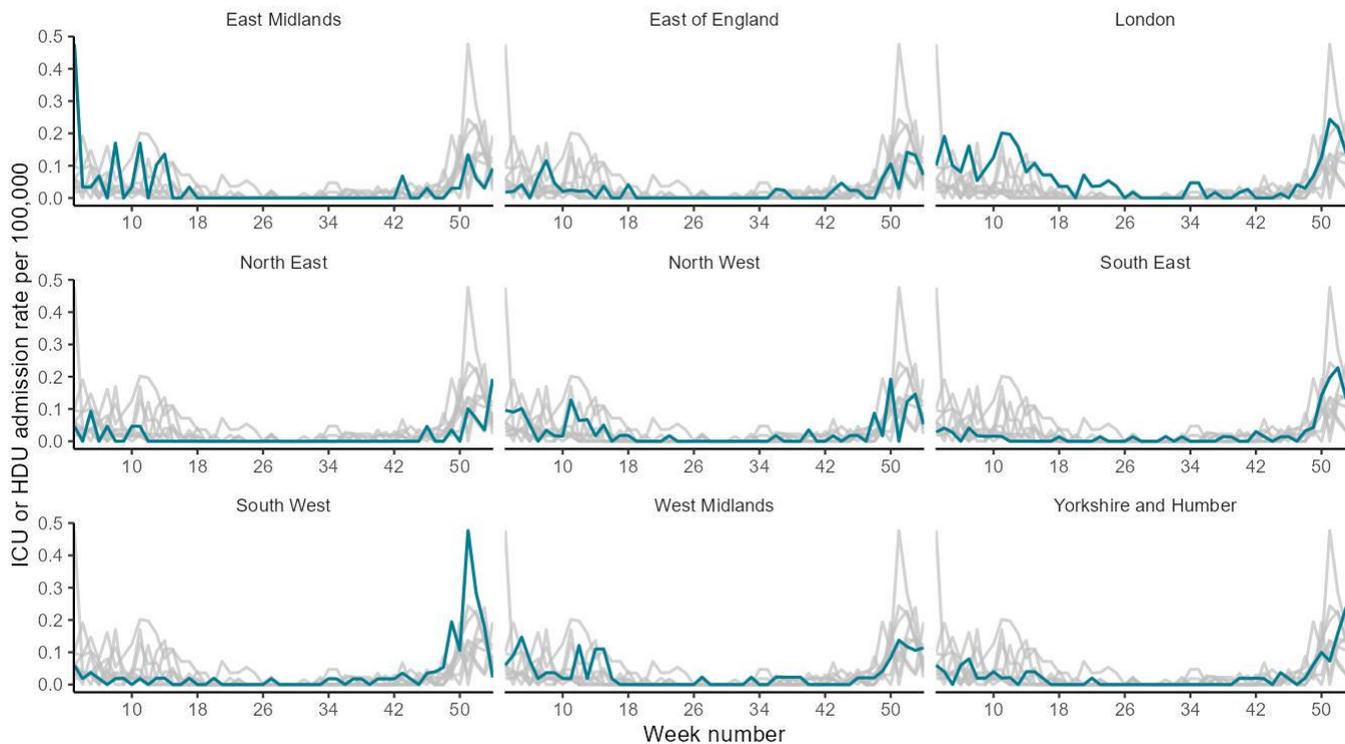
Influenza ICU or HDU admission rate based on 93 NHS trusts for week 2.

SARI Watch data is provisional and subject to retrospective updates.

**Figure 37. Weekly influenza ICU or HDU admissions by influenza type, reported through SARI Watch, England**

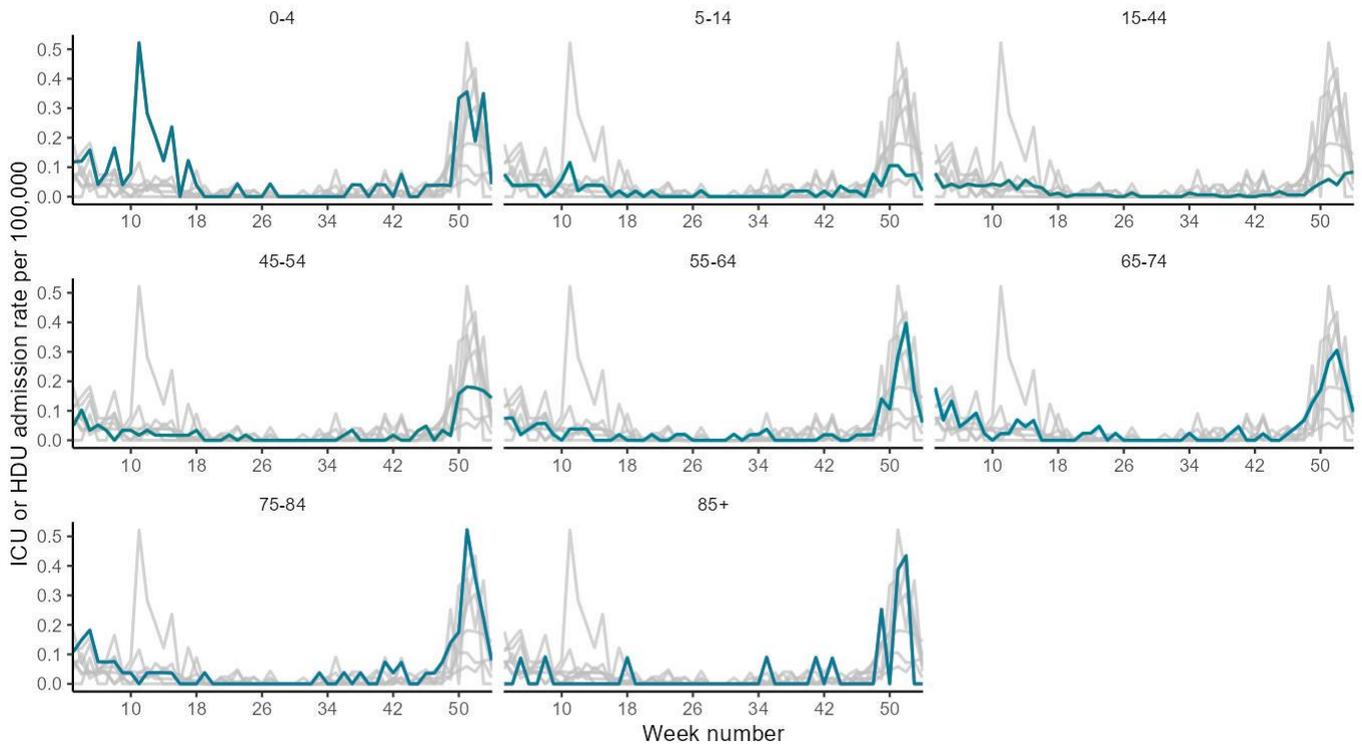


**Figure 38. Weekly ICU or HDU admission rate by UKHSA region for new influenza, reported through SARI Watch [note 4]**



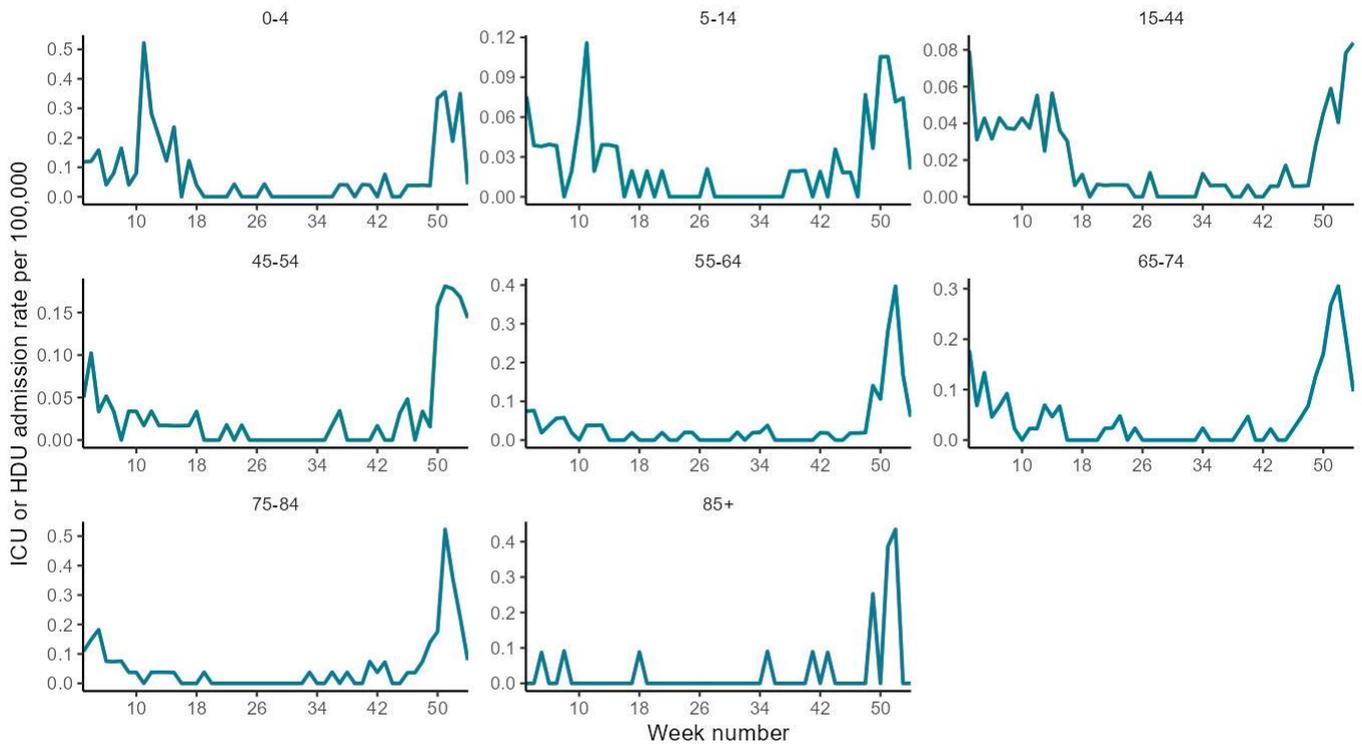
See [\[note 4\]](#) as above

**Figure 39a. Weekly ICU or HDU admission rate by age group for new influenza cases, reported through SARI Watch - fixed y-axis [note 3]**



See [note 3] as above.

**Figure 39b. Weekly ICU or HDU admission rate by age group for new influenza cases, reported through SARI Watch - adjusted y-axis**



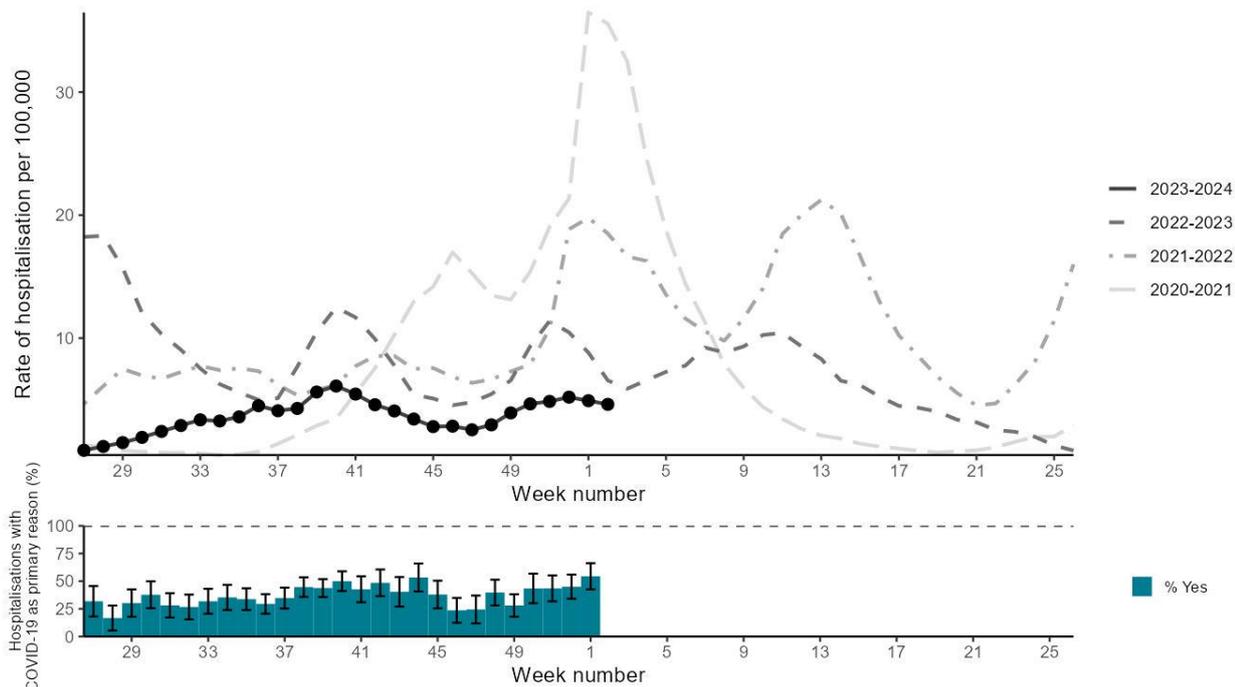
## COVID-19, SARI Watch

Surveillance of COVID-19 hospitalisations to all levels of care and surveillance of admissions to ICU or HDU for COVID-19 are both mandatory with data required from all acute NHS trusts in England. Please note that the SARI Watch rates for 2023 to 2024 use the latest trust catchment population. For consistency the rates have been updated back to October 2020.

In week 2 (ending 14 January 2024), the overall weekly hospital admission rate for COVID-19 decreased slightly to 4.62 per 100,000 compared to 4.91 per 100,000 in the previous week. By UKHSA region, the highest hospital admission rate for COVID-19 was observed in the North West (increasing to 6.48 per 100,000, decreasing in the remaining regions). By age group, the highest hospital admission rate for confirmed COVID-19 continued to be in those aged 85 years and over at 52.99 per 100,000; similar to the previous week with decreases in the remaining age groups.

In week 2 (ending 14 January 2024), the overall weekly ICU or HDU admission rate for COVID-19 increased slightly to 0.18 per 100,000, compared to 0.14 per 100,000 in the previous week. Note that with very low rates in critical care, this increase could be an effect of random fluctuation but will be monitored. Note that ICU or HDU admission rates may represent a lag from admission to hospital to an ICU or HDU ward. The ICU or HDU admission rate for COVID-19 by UKHSA region or by age group fluctuated at low levels in week 2 due to low underlying numbers.

**Figure 40. Weekly overall COVID-19 hospital admission rates per 100,000 trust catchment population, reported through SARI Watch, England**

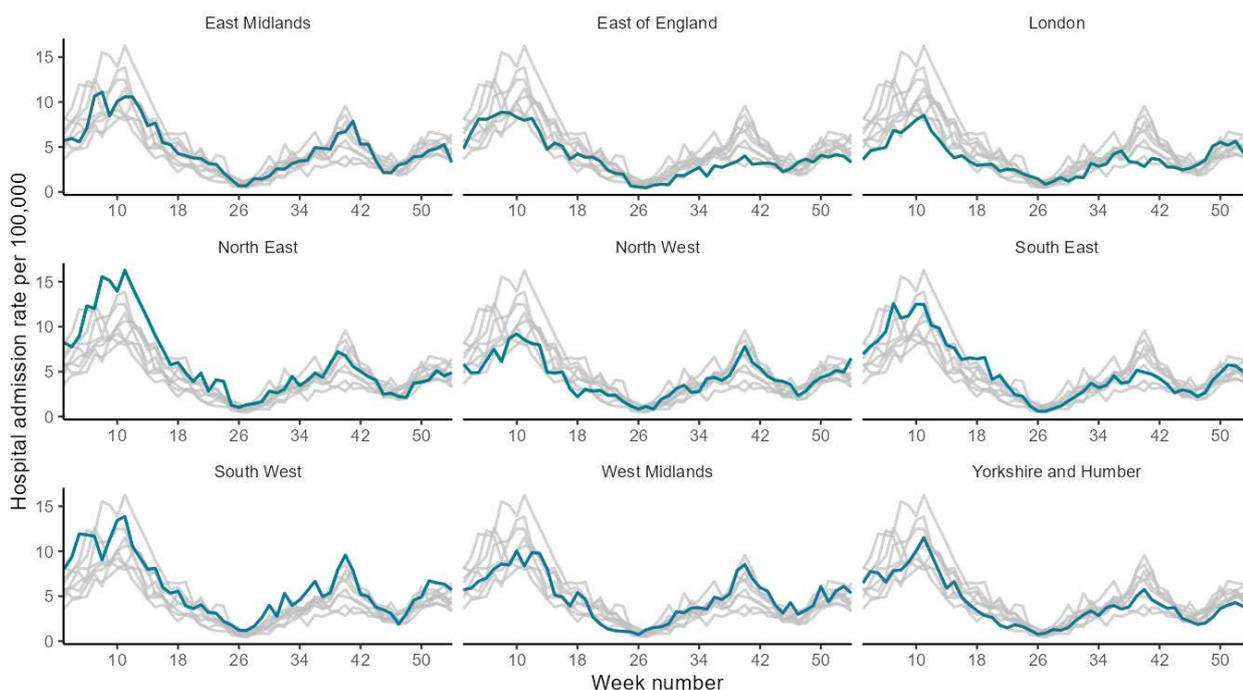


COVID-19 hospital admission rate based on 88 NHS trusts for week 2.

SARI Watch data is provisional and subject to retrospective updates.

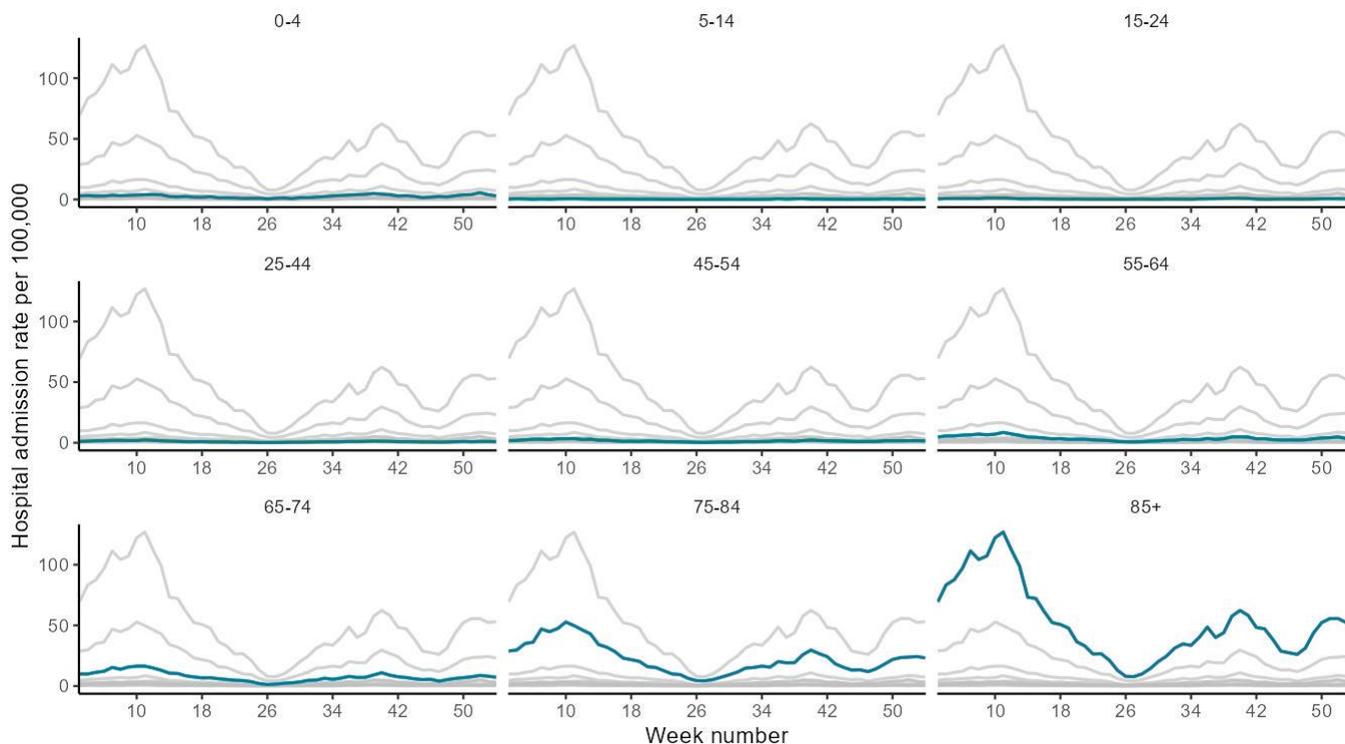
Data on proportions of hospitalisations primarily due to COVID is based on returns from a smaller number of participating trusts in sentinel surveillance and may not be representative of all acute NHS trusts.

**Figure 41. Weekly hospital admission rate by UKHSA region for new COVID-19 positive cases, reported through SARI Watch [note 4]**



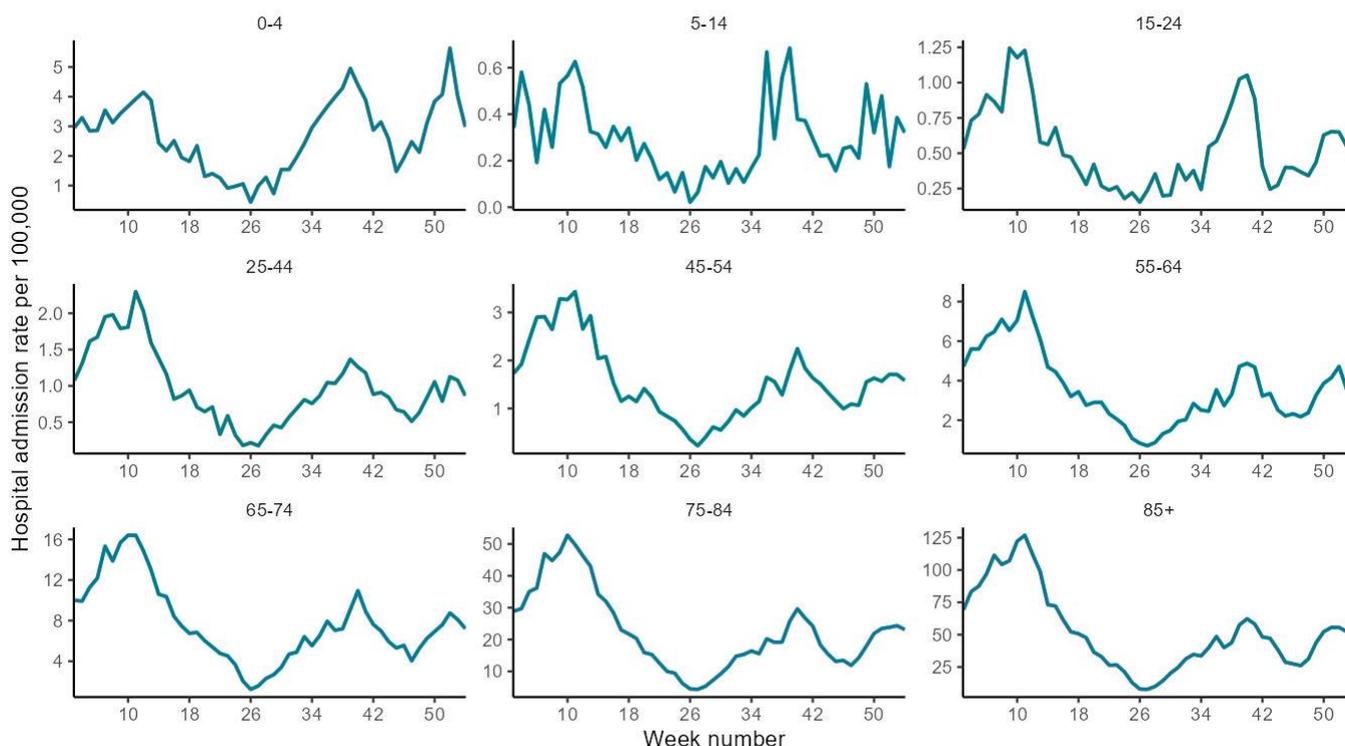
See [\[note 4\]](#) as above.

**Figure 42a. Weekly hospital admission rate by age group for new COVID-19 positive cases reported through SARI Watch - fixed y-axis [note 3]**

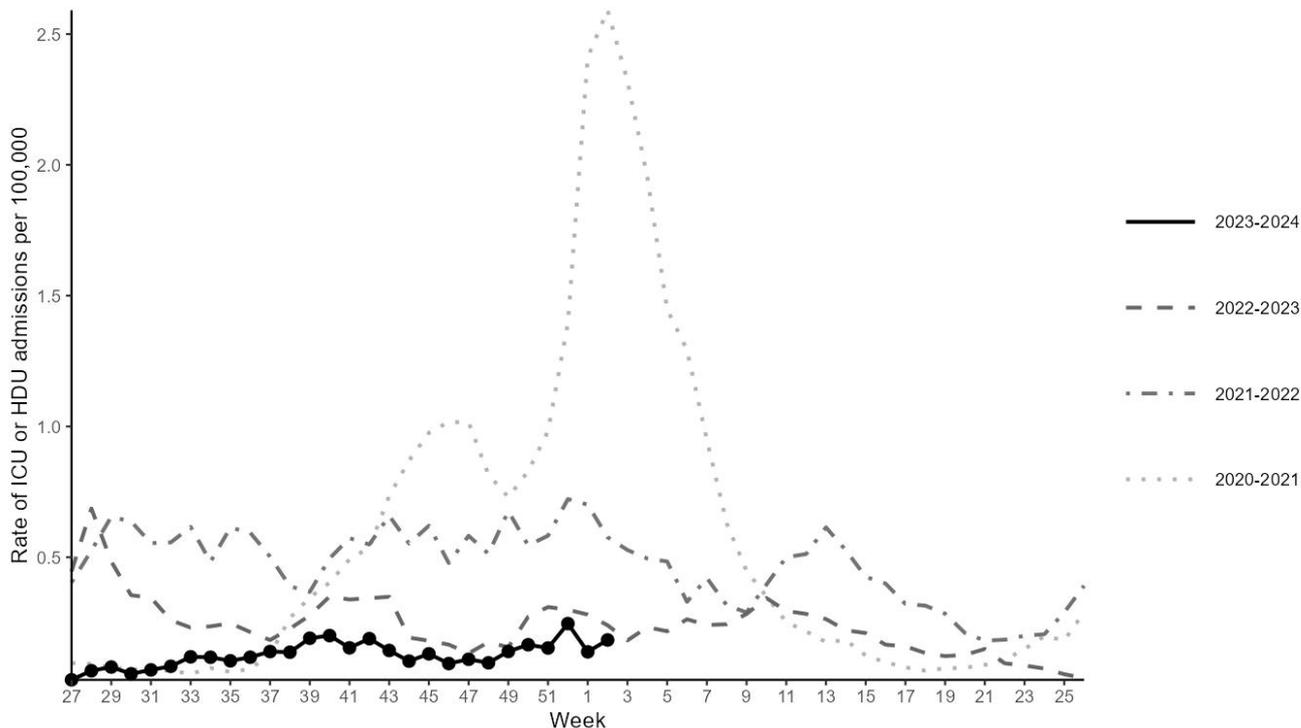


See [note 3] as above.

**Figure 42b. Weekly hospital admission rate by age group for new COVID-19 positive cases reported through SARI Watch - adjusted y-axis**



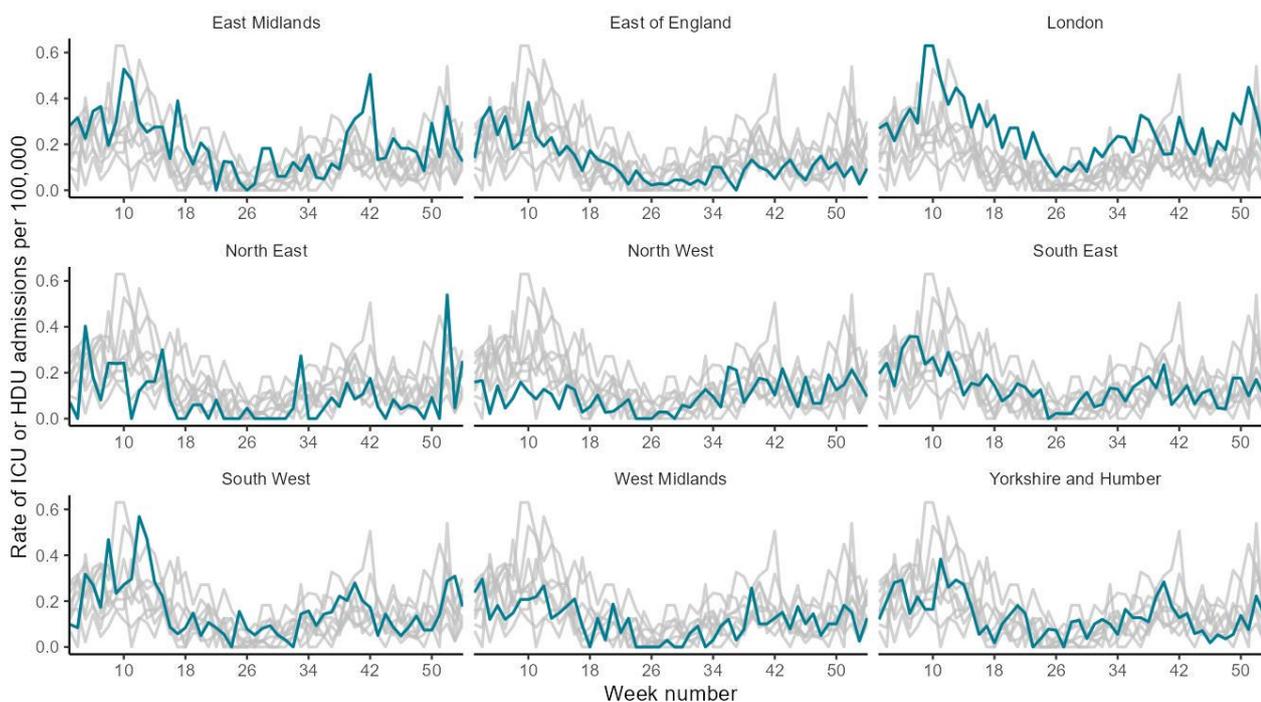
**Figure 43: Weekly overall COVID-19 ICU or HDU admission rates per 100,000 trust catchment population, reported through SARI Watch, England**



COVID-19 ICU or HDU admission rate based on 79 NHS trusts for week 2.

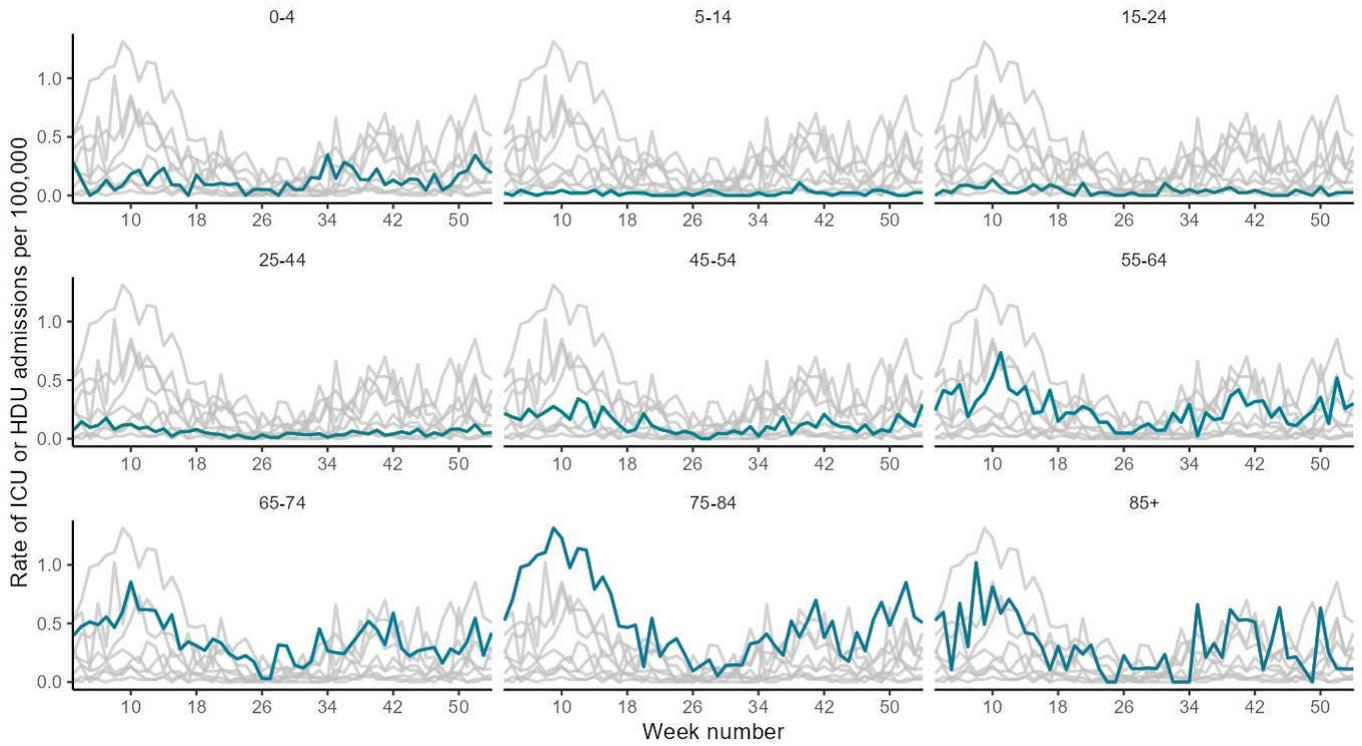
SARI Watch data is provisional and subject to retrospective updates.

**Figure 44: Weekly ICU or HDU admission rate by UKHSA region for new COVID-19 positive cases reported through SARI Watch [note 4]**



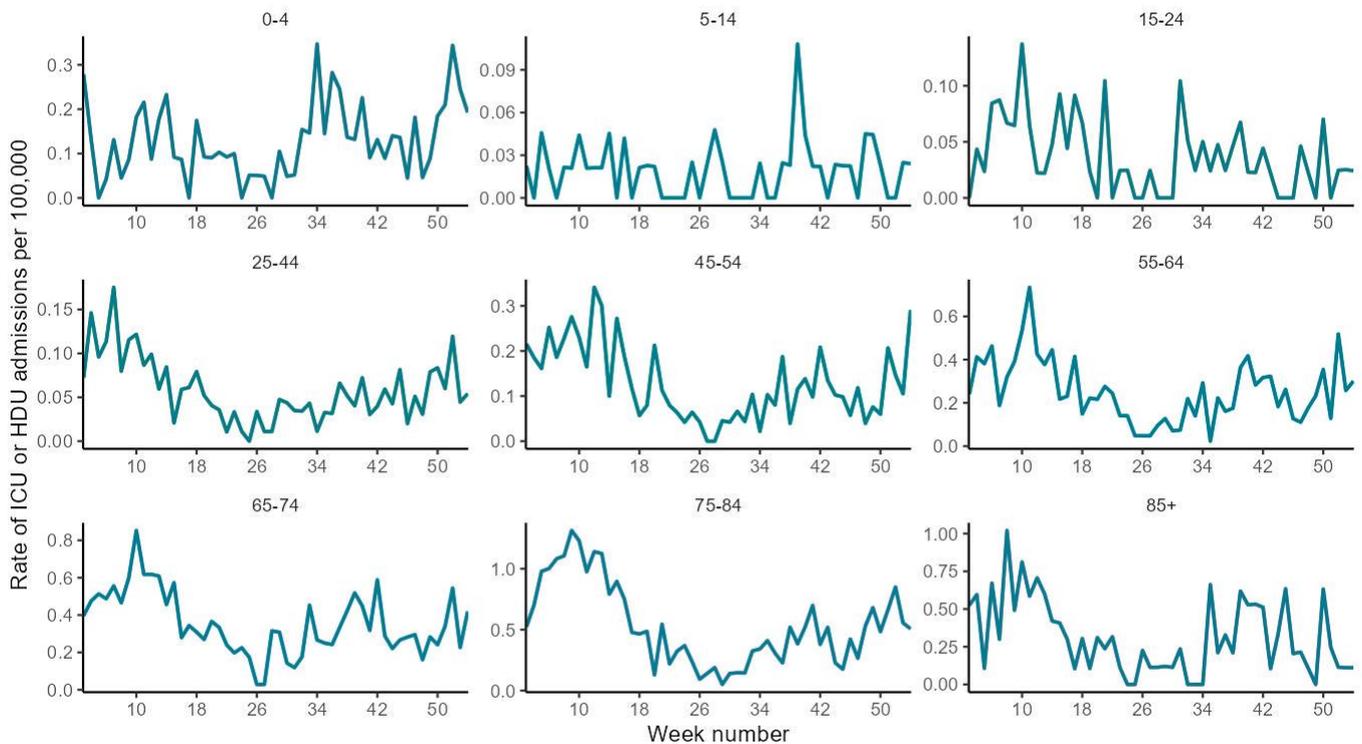
See [note 4] as above

**Figure 45a. Weekly ICU or HDU admission rate by age group for new COVID-19 positive cases reported through SARI Watch - fixed y-axis [note 3]**



See [note 3] as above.

**Figure 45b. Weekly ICU or HDU admission rate by age group for new COVID-19 positive cases reported through SARI Watch adjusted y-axis**

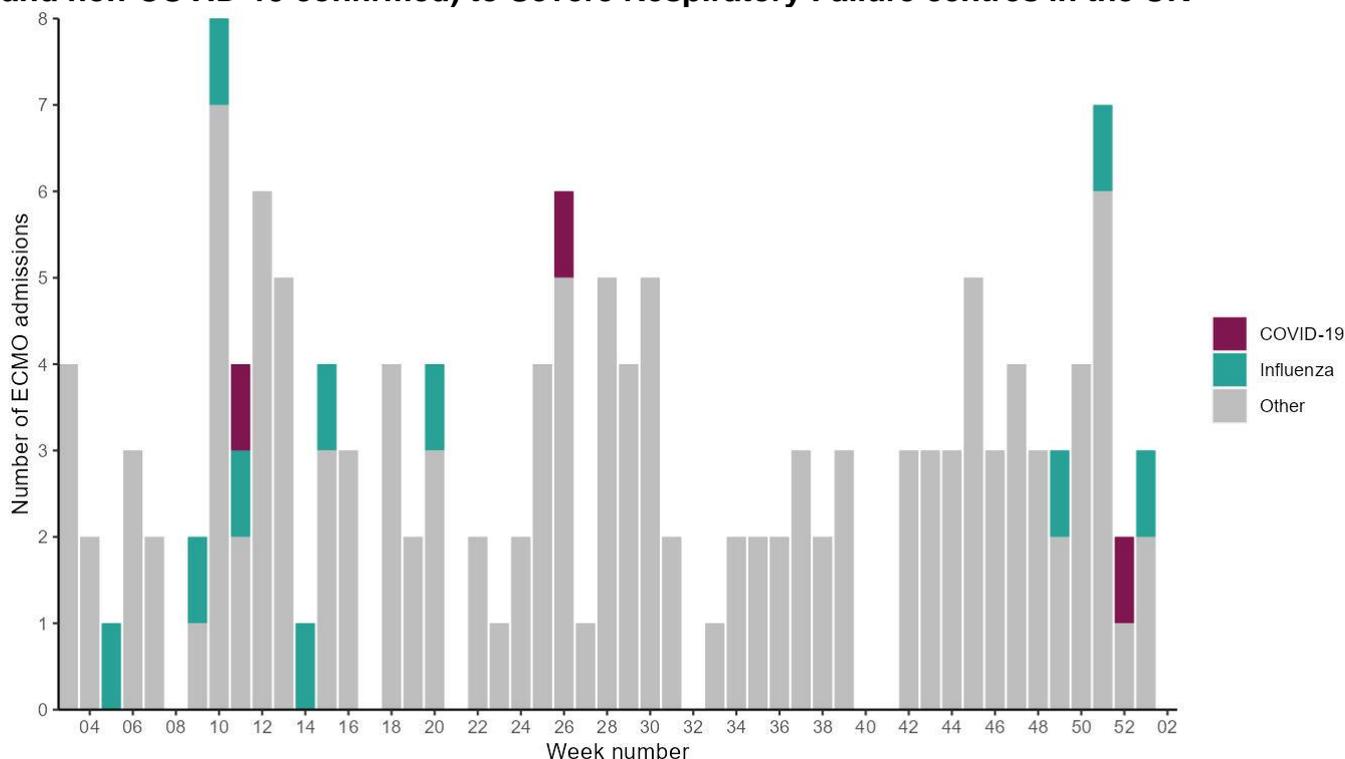


## ECMO, SARI Watch

There were no new extra corporeal membrane oxygenation (ECMO) admissions reported in week 2 from the 7 Severe Respiratory Failure (SRF) centres in the UK.

Please note that the other group includes other viral, bacterial or fungal ARI, suspected ARI, non-infection (such as asthma, primary cardiac, trauma etc.) and sepsis of non-respiratory origin.

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



SARI Watch data is provisional and subject to retrospective updates.

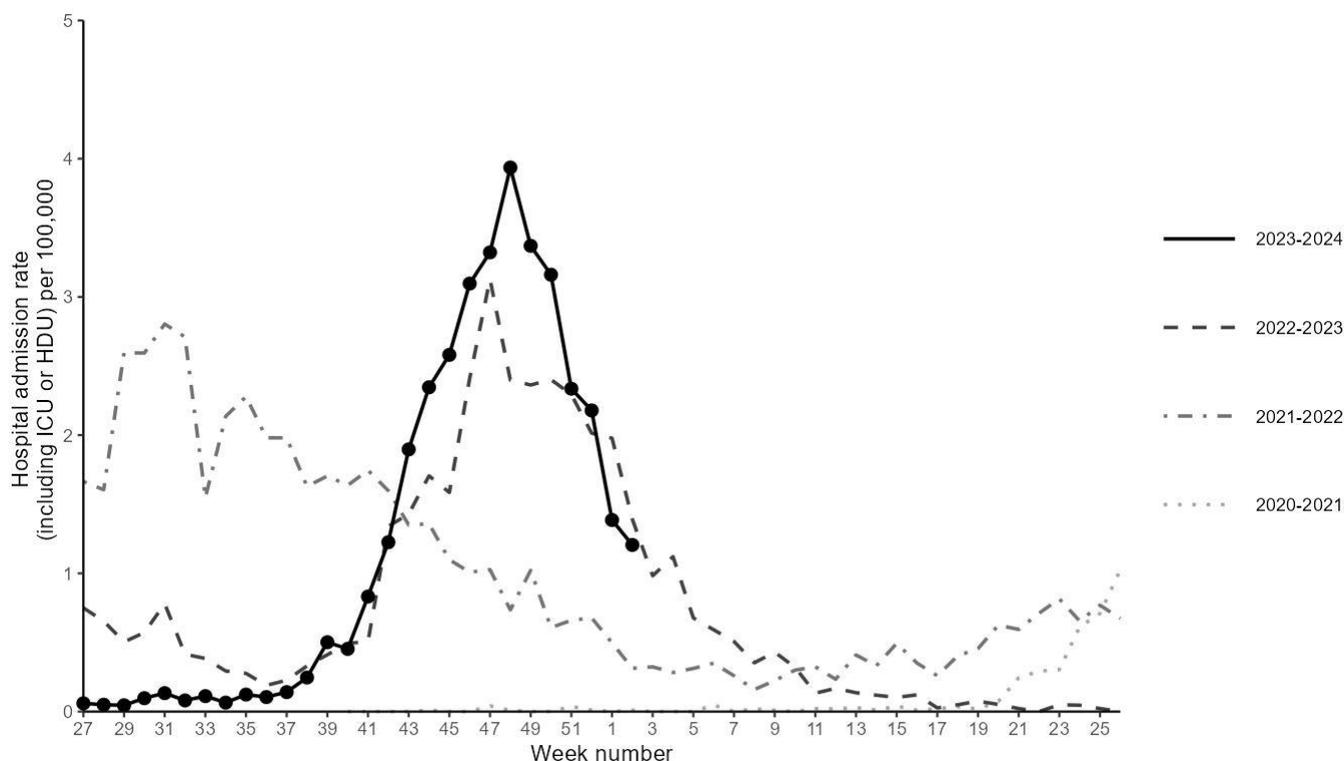
## RSV admissions, SARI Watch

Data on hospitalisations, including ICU or HDU admissions, with respiratory syncytial virus (RSV) are shown below. RSV SARI Watch surveillance is sentinel. Please note that the SARI Watch rates for 2023 to 2024 use the latest trust catchment population. For consistency the rates have been updated back to October 2020. The population denominator reflects changes in trust reconfiguration, hospital admission activity and population estimates.

In week 2, the overall hospital admission rate for RSV decreased to 1.21 per 100,000 compared to 1.39 per 100,000 in the previous week. In children under 5 years of age hospitalisation rates were 4.5 per 100,000, decreasing compared to 12.5 per 100,000 in the previous week. In those aged 85 years and above, RSV hospitalisation rates decreased to 8.3 per 100,000 from 9.7 per 100,000.

One paediatric trust joined the sentinel surveillance on influenza and RSV hospitalisations from week 2 of 2024 and backdated returns to week 48 of 2023.

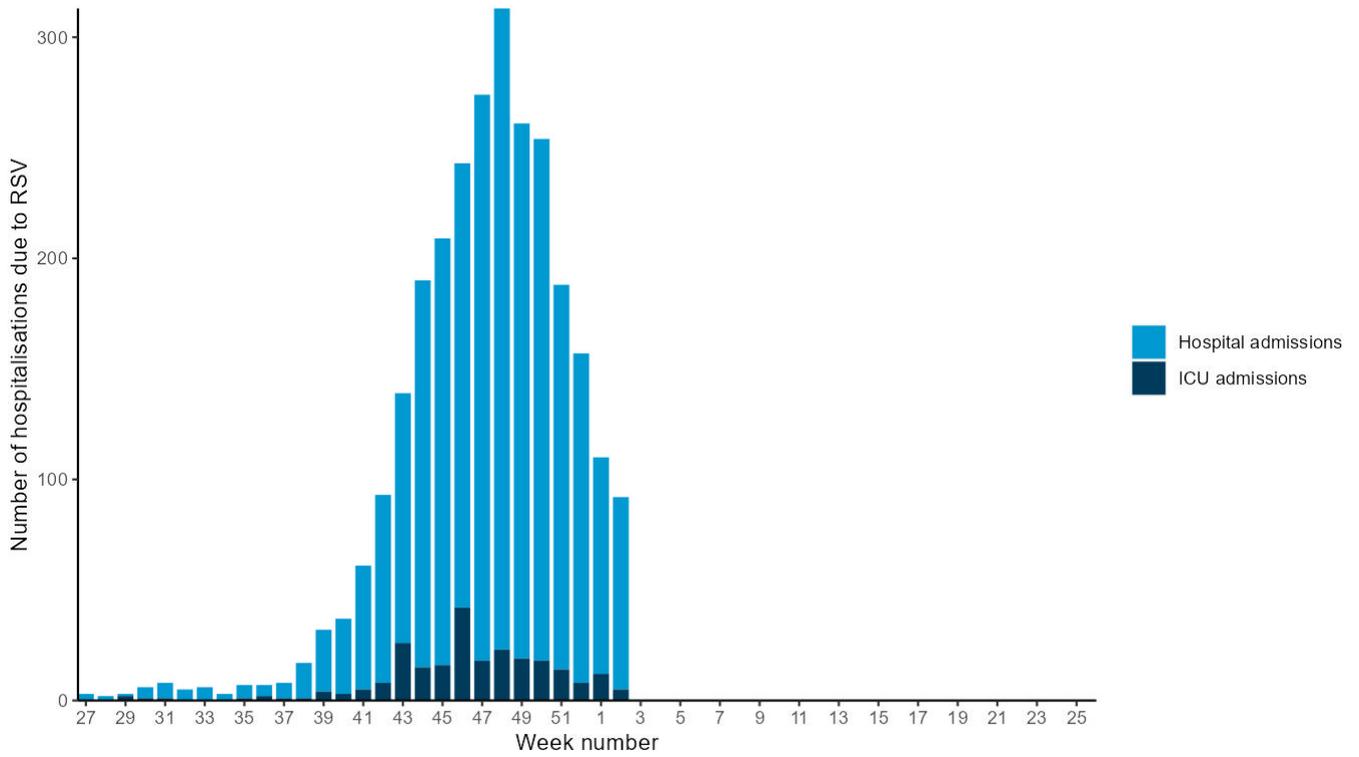
**Figure 47. Weekly overall hospital admission rates (including ICU or HDU) of RSV positive cases per 100,000 population reported through SARI Watch sentinel surveillance, England [note 17]**



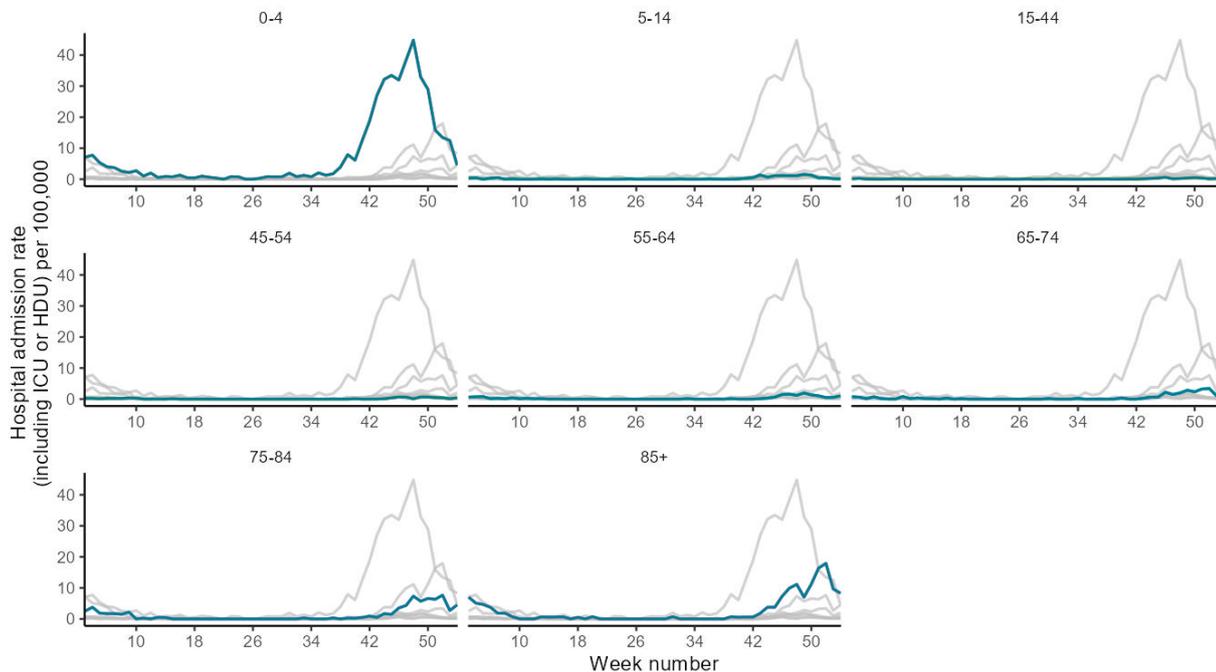
[note 17] Rates are based on the number of hospitalised cases divided by the Trust catchment population, multiplied by 100,000.

RSV admission rate based on 18 NHS trusts for week 2.

**Figure 48: Weekly count hospital admissions of RSV positive cases reported through SARI Watch sentinel surveillance by level of care, England**

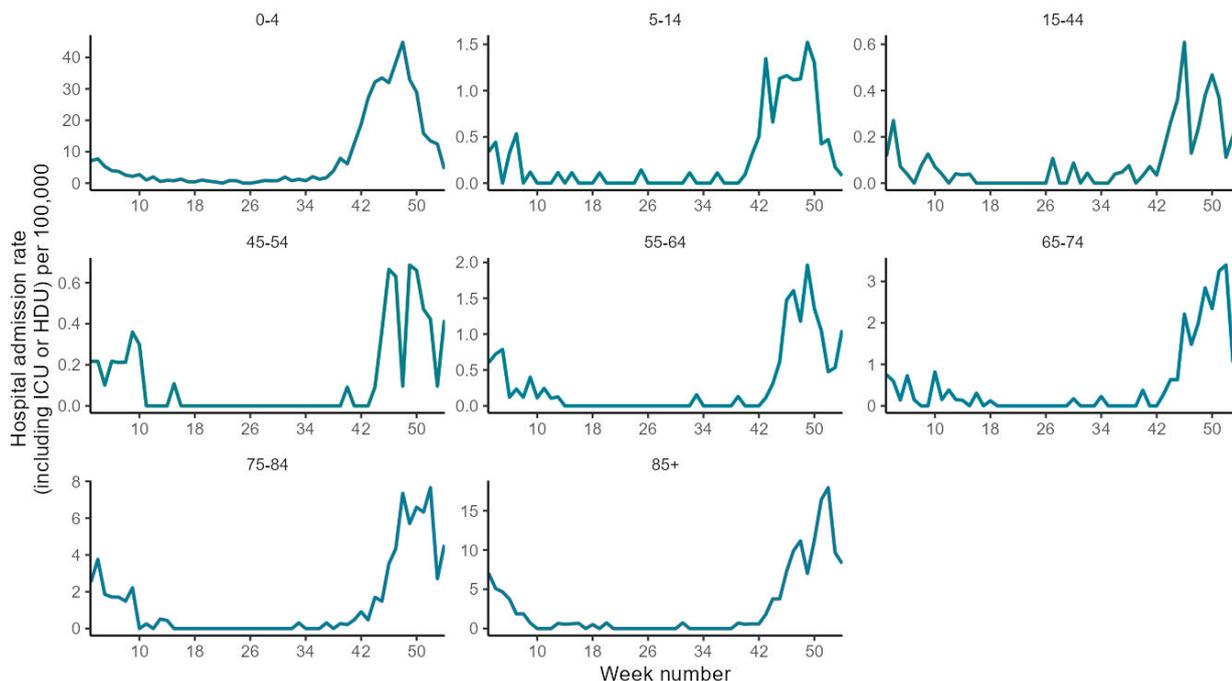


**Figure 49a. Weekly hospitalisation (including ICU or HDU) admission rates by age group for RSV cases reported through SARI Watch sentinel surveillance, England - fixed y-axis [note 3]**



See [note 3] as above.

**Figure 49b. Weekly hospitalisation (including ICU or HDU) admission rates by age group for RSV cases reported through SARI Watch sentinel surveillance, England adjusted y-axis**



SARI Watch data is provisional.

## 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 Office for National Statistics (ONS) death registration data and the [all-cause mortality surveillance report](#), which uses the European mortality monitoring (EuroMOMO) model to identify weeks with higher than expected mortality.

# Influenza vaccination

## Influenza vaccine uptake in GP patients

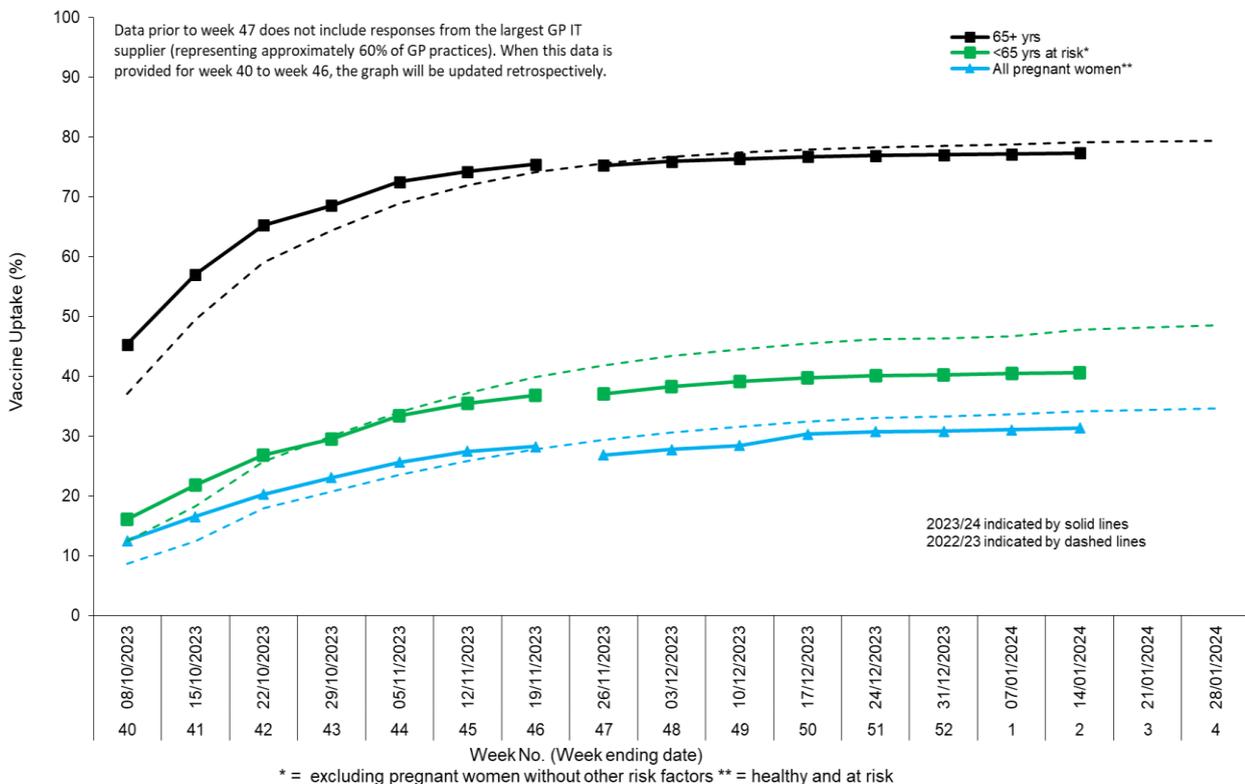
Weekly vaccine coverage data is provisional. Data is presented below for week 2 of 2024.

Up to week 2 of 2024, in 95.5% of GP practices reporting weekly to ImmForm for the main collection, the provisional proportion of people in England who had received the 2023 to 2024 influenza vaccine in targeted groups was as follows:

- 40.6% in those aged under 65 years in a clinical risk group
- 31.3% in all pregnant women
- 77.3% in all those aged 65 years and over

This is the eighth weekly data this season which has included data from all GP IT suppliers for the GP main survey. Data prior to week 47 does not include responses from the largest GP IT supplier (representing approximately 60% of GP practices). When this data is provided for week 40 to week 46, the graph will be updated retrospectively, and a continuous trend line will be plotted for all data points.

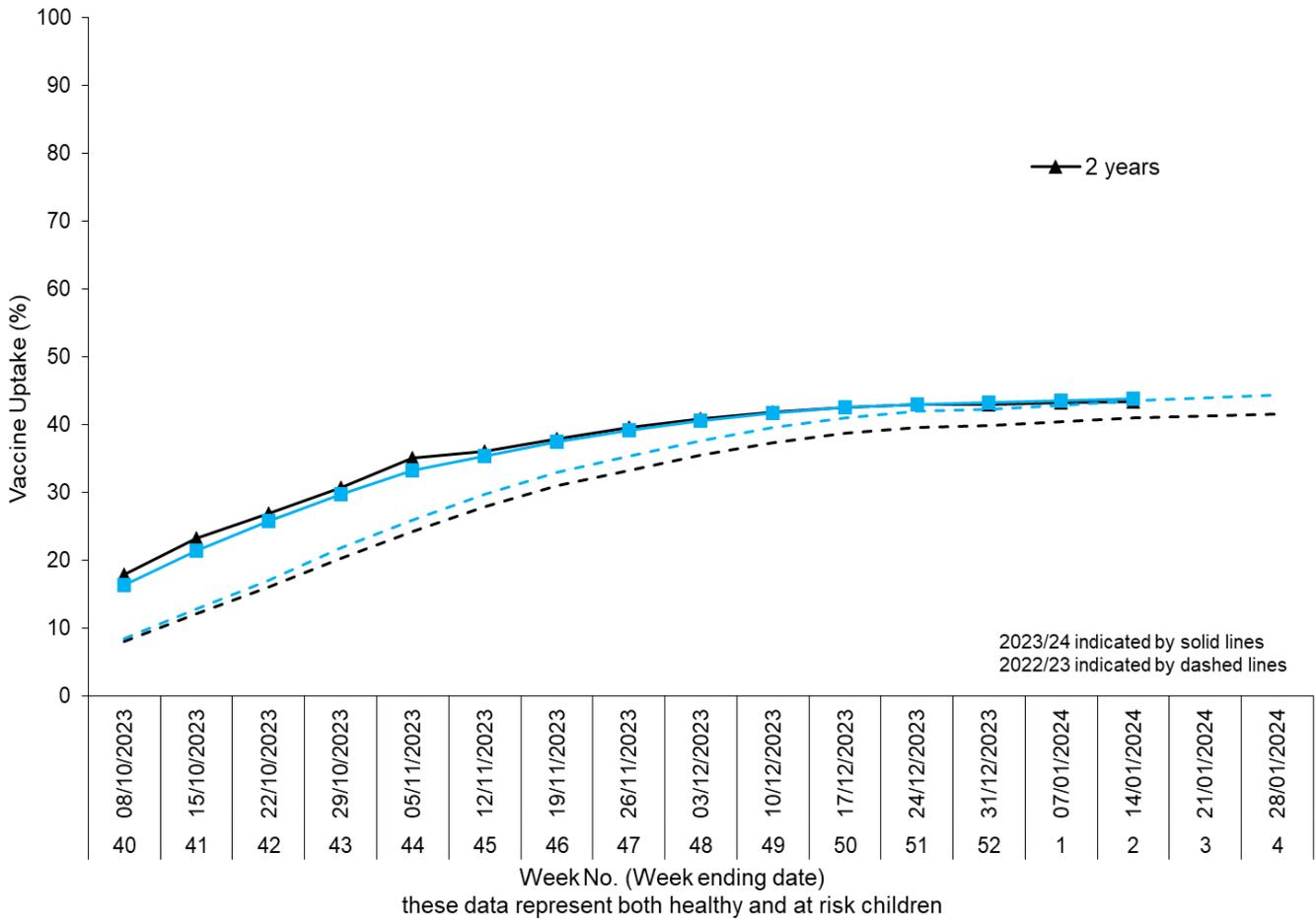
**Figure 50. Cumulative weekly influenza vaccine uptake by target group in England**



In 2023 to 2024, all those aged 2 and 3 years of age continue to be eligible for influenza vaccination through their GPs. Up to week 2 of 2024, in 91.2% of GP practices reporting weekly to ImmForm for the childhood collection, the provisional proportion of children in England who had received the 2023 to 2024 influenza vaccine in targeted groups was as follows:

- 43.4% in all those aged 2 years
- 43.8% in all those aged 3 years

**Figure 51. Cumulative weekly influenza vaccine uptake in those aged 2 and 3 years, in England**



Monthly data which cover vaccinations that were given between 1 September and 31 December 2023 for [GP patients](#), [school aged children](#) and [frontline healthcare workers](#) will be published next week (25 January 2024) for the third time this season.

# COVID-19 vaccination

## COVID-19 vaccine uptake in England

This week we are delaying the publication of additional backing on COVID vaccine coverage pending further review to assure the quality of the data. These will be published as soon as these additional checks are completed.

COVID-19 vaccinations began in England on 8 December 2020 during week 50 of 2020 (week ending 13 December 2020). Cumulative data up to week 2 of 2024 (week ending 14 January 2024) 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 as age on 31 March 2024. From 23 October 2023, data is extracted on a Monday with data capped to the previous Sunday. This change from Tuesday data extraction means that because of data lags, reported coverage for the most recent week will be marginally lower than if data were extracted on Tuesday. This change has been implemented to help ensure timely reporting. 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. There are significant changes being undertaken in the data feeds that provide these statistics. It is therefore necessary to report the autumn campaign on a fixed denominator, the population as at 31 August 2023. 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 2023 Campaign

Immunity derived from vaccination declines over time, the Joint Committee on Vaccination and Immunisation (JCVI) has recommended an autumn 2023 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 in time for winter 2023 to 2024.

The autumn 2023 data reported below covers any dose administered from 1 September 2024 provided there is at least 20 days from the previous dose. Eligible groups for the autumn campaign are defined in the COVID-19 healthcare guidance [Green Book](#)

Table 4 presents coverage as measured against the total population and includes people who are not yet due to have their autumn 2023 booster, specifically those turning aged 65 years by

31 March 2024. 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 5 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.

By the end of week 2 of 2024 (week ending 14 January 2024), 70.3% (7,845,695 out of 11,164,326) of all people aged over 65 years who are living and resident in England who had been vaccinated with an Autumn 2023 booster dose since 1 September 2023, Table 4 and Figure 52.

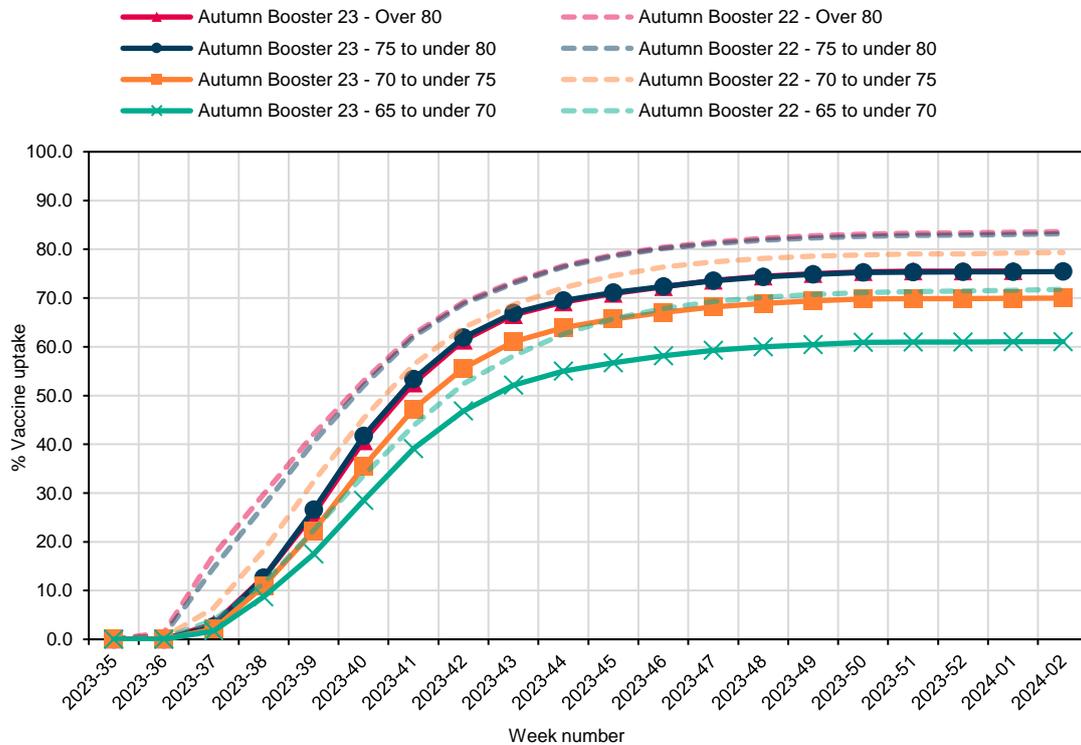
**Table 4. Provisional cumulative people vaccinated by age with a dose of COVID-19 vaccine from 1 September 2023 as part of the autumn 2023 campaign in England**

National	People in NIMS cohort who are living and resident in England	Vaccinated since 1 September 2023 [note 18]	Percentage vaccine uptake
Over 80	3,010,182	2,275,405	75.6
75 to under 80	2,458,682	1,854,181	75.4
70 to under 75	2,672,292	1,870,216	70.0
65 to under 70	3,023,170	1,845,893	61.1
Aged 65 and over	11,164,326	7,845,695	70.3

[note 18] Autumn 2023 booster defined as any dose of vaccine given after 1 September 2023, provided there is an interval of at least 20 days since any previous dose.

Monthly data for frontline healthcare workers will be published next week (25 January 2024) for the third time this season. This will cover vaccinations that were given between 1 September and 31 December 2023 and is available under the [joint flu and COVID-19 vaccine uptake report](#).

**Figure 52. Cumulative weekly COVID-19 vaccine uptake in those who are living and resident in England vaccinated with an autumn 2023 dose since 1 September 2023 [note 19]**



[note 19] This graph shows data for the autumn 2022 campaign and does not correspond to the date axis but is aligned to the current autumn 2023 campaign to allow comparison of the rate of uptake in both campaigns.

## Proportion of people vaccinated by time since last vaccination

**Table 5. Provisional cumulative people vaccinated with any dose of COVID-19 vaccine in the last 3 months, 3 to 6 months and vaccinated more than 6 months ago**

National	People in NIMS cohort who are living and resident in England	Vaccinated in the last 3 months (84 days)		Vaccinated 3 to 6 months ago (85 to 168 days)		Vaccinated 6 months ago (169 or more days)	
		Numbers vaccinated	Percentage vaccinated	Numbers vaccinated	Percentage vaccinated	Numbers vaccinated	Percentage vaccinated
Over 80	3,010,182	440,706	14.6	1,838,416	61.1	628,771	20.9
75 to under 80	2,458,682	341,460	13.9	1,516,115	61.7	511,914	20.8
70 to under 75	2,672,292	394,491	14.8	1,480,475	55.4	658,968	24.7
65 to under 70	3,023,170	442,603	14.6	1,408,700	46.6	963,060	31.9
60 to under 65	3,691,023	370,890	10.0	738,918	20.0	2,264,087	61.3
55 to under 60	4,133,235	298,273	7.2	515,203	12.5	2,882,534	69.7
50 to under 55	4,127,778	218,675	5.3	366,942	8.9	2,986,066	72.3
45 to under 50	3,873,067	135,351	3.5	228,595	5.9	2,785,377	71.9
40 to under 45	4,410,433	111,497	2.5	180,162	4.1	3,081,980	69.9
35 to under 40	4,711,499	94,348	2.0	143,720	3.1	3,154,470	67.0
30 to under 35	4,788,980	82,469	1.7	113,930	2.4	3,108,511	64.9
25 to under 30	4,416,848	60,167	1.4	77,861	1.8	2,875,662	65.1
20 to under 25	3,787,791	38,311	1.0	49,213	1.3	2,596,162	68.5
18 to under 20	1,402,413	9,780	0.7	11,475	0.8	933,809	66.6
16 to under 18	1,430,176	7,298	0.5	5,916	0.4	860,411	60.2
12 to under 16	2,994,199	17,224	0.6	7,290	0.2	1,235,087	41.2
5 to under 12	4,998,730	14,180	0.3	1,796	0.0	460,889	9.2

Table 5 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, for those aged 65 years and over can be found in the supplementary data file.

A regional breakdown of the ethnicity data is available in the accompanying data file for this report.

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

COVID-19 management information on the number of COVID-19 vaccinations provided by the NHS in England is available on the [COVID-19 vaccinations](#) webpage.

UK COVID-19 daily vaccination figures and definitions are available on 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.

## 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

For further information on the global influenza situation please see the [World Health Organization \(WHO\) Influenza update](#).

### Influenza in Europe

For further information on influenza in Europe please see the [European Respiratory Virus Surveillance Summary weekly update](#).

### 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

For further information, please see the [Latest WHO update on 21 December 2023](#) and the [Latest UKHSA avian influenza technical briefing 14 July 2023](#)

### Middle East respiratory syndrome coronavirus (MERS-CoV)

For further information please see the [WHO Disease Outbreak News Reports](#) and the [WHO publishes monthly updates](#).

[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](#)

[RCGP Virology Dashboard](#)

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

UKHSA is responsible for protecting every member of every community from the impact of infectious diseases, chemical, biological, radiological and nuclear incidents and other health threats. We provide intellectual, scientific and operational leadership at national and local level, as well as on the global stage, to make the nation health secure.

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

© Crown copyright 2024

Prepared by: Immunisation and Vaccine Preventable Diseases Division  
For queries relating to this document, please contact: [respdsr.enquiries@ukhsa.gov.uk](mailto:respdsr.enquiries@ukhsa.gov.uk)

Published: 18 January 2024  
Oublishing reference: GOV-16040



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



UKHSA supports the UN  
Sustainable Development Goals

