UK Health Security Agency

National influenza and COVID-19 surveillance report

Week 39 report (up to week 38 2024 data)

26 September 2024

Contents

For additional information including regional data on COVID-19 and other respiratory viruses, 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 severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)), influenza, and diseases caused by seasonal respiratory viruses in England. This report is based on data from week 38 of 2024 (between 16 and 22 September 2024).

Overall

In week 38, influenza remained at interseasonal levels and COVID-19 activity increased. There was an increase in rhinovirus activity and a small increase in respiratory syncytial virus (RSV) activity through Respiratory DataMart.

Influenza

Through Respiratory DataMart, influenza positivity remained stable at 1.6% in week 38 compared with 1.4% in the previous week.

COVID-19

Through Respiratory DataMart, SARS-CoV-2 positivity increased to 11.8% compared with 9.1% in the previous week.

Overall, COVID-19 hospital admissions increased to 3.71 per 100,000 compared with 2.56 per 100,000 in the previous week. Hospitalisations were highest in those aged 85 years and over. COVID-19 intensive care unit (ICU) admissions remained low and increased slightly to 0.11 per 100,000 in week 38 compared with 0.09 per 100,000 in the previous week.

Other viruses

Through Respiratory DataMart, respiratory syncytial virus (RSV) positivity increased slightly to 0.8%, with the highest positivity in those aged under 5 years at 4.2%. Adenovirus positivity increased slightly to 2.2%, with the highest positivity in those aged under 5 years at 5.1%. Human metapneumovirus (hMPV) positivity remained low at 0.6%, with the highest positivity in those aged over 65 years at 1.1%. Parainfluenza positivity increased slightly to 1.0%, with the highest positivity in those aged between 5 and 14 years at 4.7%. Rhinovirus positivity increased to 14.0% overall, with the highest positivity in those aged under 5 years at 37.4%.

Laboratory surveillance

Respiratory DataMart system (England)

In week 38, data is based on reporting from 11 out of the 16 sentinel laboratories.

In week 38, 3,896 respiratory specimens reported through the Respiratory DataMart System were tested for influenza. There were 63 positive samples for influenza; 28 influenza A(not subtyped), 22 influenza A(H3N2), 1 influenza A(H1N1)pdm09, and 12 influenza B. Overall, influenza positivity remained stable at 1.6% in week 38 compared with 1.4% in the previous week.

In week 38, 3,774 respiratory specimens reported through the Respiratory DataMart System were tested for SARS-CoV-2. There were 445 positive samples for SARS-CoV-2 with an overall positivity of 11.8%, which increased in comparison with 9.1% in the previous week. The highest positivity was seen in adults aged over 65 years at 16.5%.

RSV positivity increased slightly to 0.8%, with the highest positivity in those aged under 5 years at 4.2%.

Adenovirus positivity increased slightly to 2.2%, with the highest positivity in those aged under 5 years at 5.1%.

Human metapneumovirus (hMPV) positivity remained low at 0.6%, with the highest positivity in those aged over 65 years at 1.1%.

Parainfluenza positivity increased slightly to 1.0%, with the highest positivity in those aged between 5 and 14 years at 4.7%.

Rhinovirus positivity increased to 14.0% overall, with the highest positivity in those aged under 5 years at 37.4%.

DataMart data is provisional and subject to retrospective updates.

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

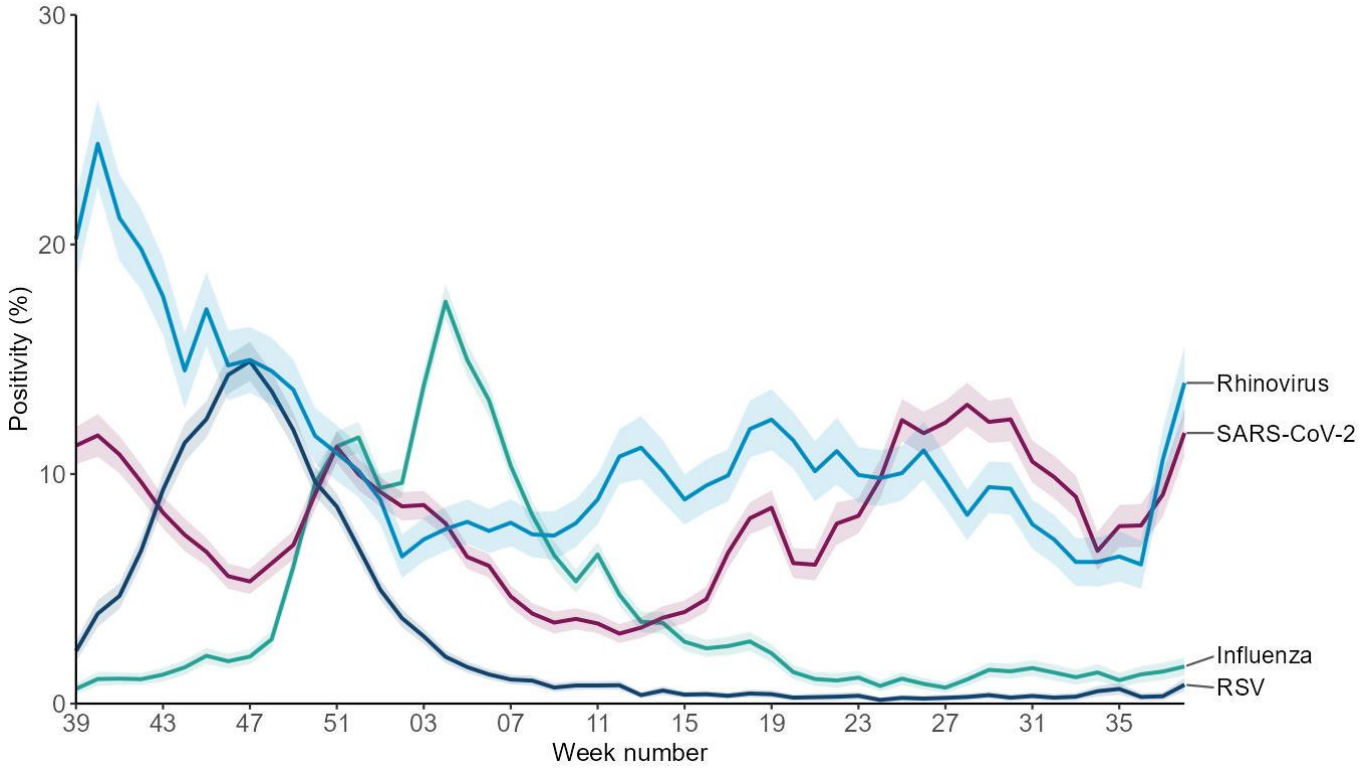
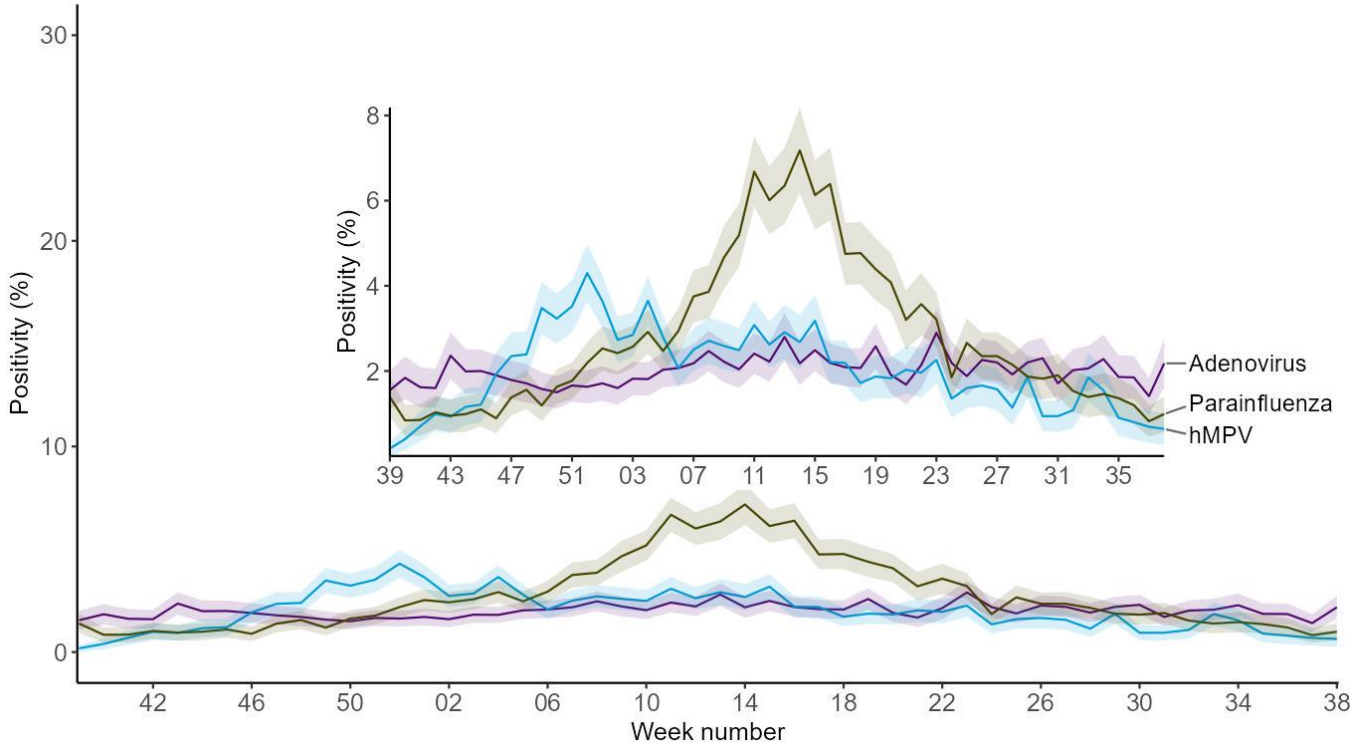


Figure 1b. Respiratory DataMart weekly positivity (%) for adenovirus, hMPV and parainfluenza, England



Primary care surveillance

RCGP sentinel swabbing scheme in England

Based on the date that samples were taken, in week 37 of 2024 (week commencing 9 September 2024) 305 samples were received through the GP sentinel swabbing scheme in England. 4 of these samples tested positive (Figure 2). Please note that rhinovirus and enterovirus testing has been delayed from week 51 2023 and therefore some samples which are currently reported as negative may subsequently be reported as rhinovirus or enterovirus. Furthermore, among the positive results, the relative contribution of different pathogens is likely to reduce as rhinovirus and enterovirus positive results are added.

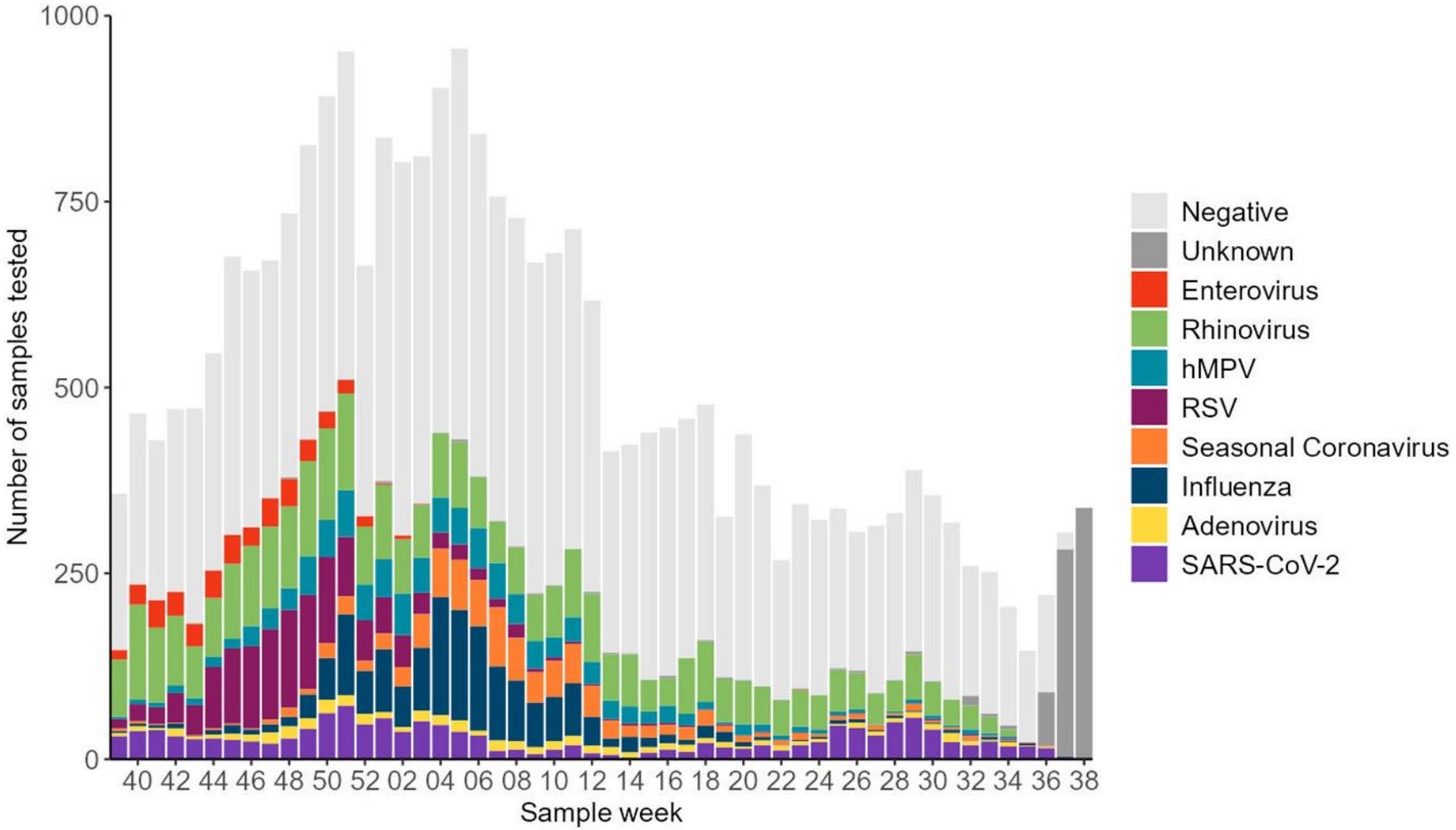
There were no available results for week 38. The proportion of detections among all positive samples is not calculated when the number of samples with a result is fewer than 50. Therefore, no positivity is reported for both weeks 37 and 38.

In previous reports, Figure 2 was produced based on the date samples were received in the reference laboratory. From 23 November 2023 (week 47 report) this figure has been updated to be based on the date samples were taken.

From 27 November 2023, swabbing was temporarily 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.

More extensive data can be found on the RCGP virology dashboard.

Figure 2. Number of samples tested for SARS-CoV-2, influenza, and other respiratory viruses in England by week, GP sentinel swabbing [note 1]



[note 1] Unknown category corresponds to samples with no result yet.

Secondary care surveillance

COVID-19, SARI Watch

Surveillance of COVID-19 hospitalisations to all levels of care and surveillance of admissions to ICU or high-dependency unit (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 38 (ending 22 September 2024), the overall weekly hospital admission rate for COVID-19 increased to 3.71 per 100,000 compared with 2.56 per 100,000 in the previous week. By UKHSA region, the highest hospital admission rate for COVID-19 was observed in the North East (increasing to 5.80 per 100,000 from 4.18 per 100,000 in the previous week). Increases occurred in the remaining 8 regions. By age group, the highest hospital admission rate for confirmed COVID-19 continued to be in those aged over 85 years, increasing to 37.18 per 100,000 compared with 25.11 in the previous week. An increase occurred in most of the remaining age groups including in those aged 65 to 74 years and those aged 75 to 84 years.

In week 38 (ending 22 September 2024), the overall weekly ICU or HDU admission rate for COVID-19 remained low, yet increased slightly to 0.11 per 100,000. This was compared with 0.09 per 100,000 in the previous week. Note that with very low rates in critical care, small random fluctuations may occur. 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 centre or by age group is currently fluctuating at low levels due to low underlying numbers.

Figure 3. Weekly overall COVID-19 hospital admission rates per 100,000 trust catchment population, reported through SARI Watch mandatory surveillance, England

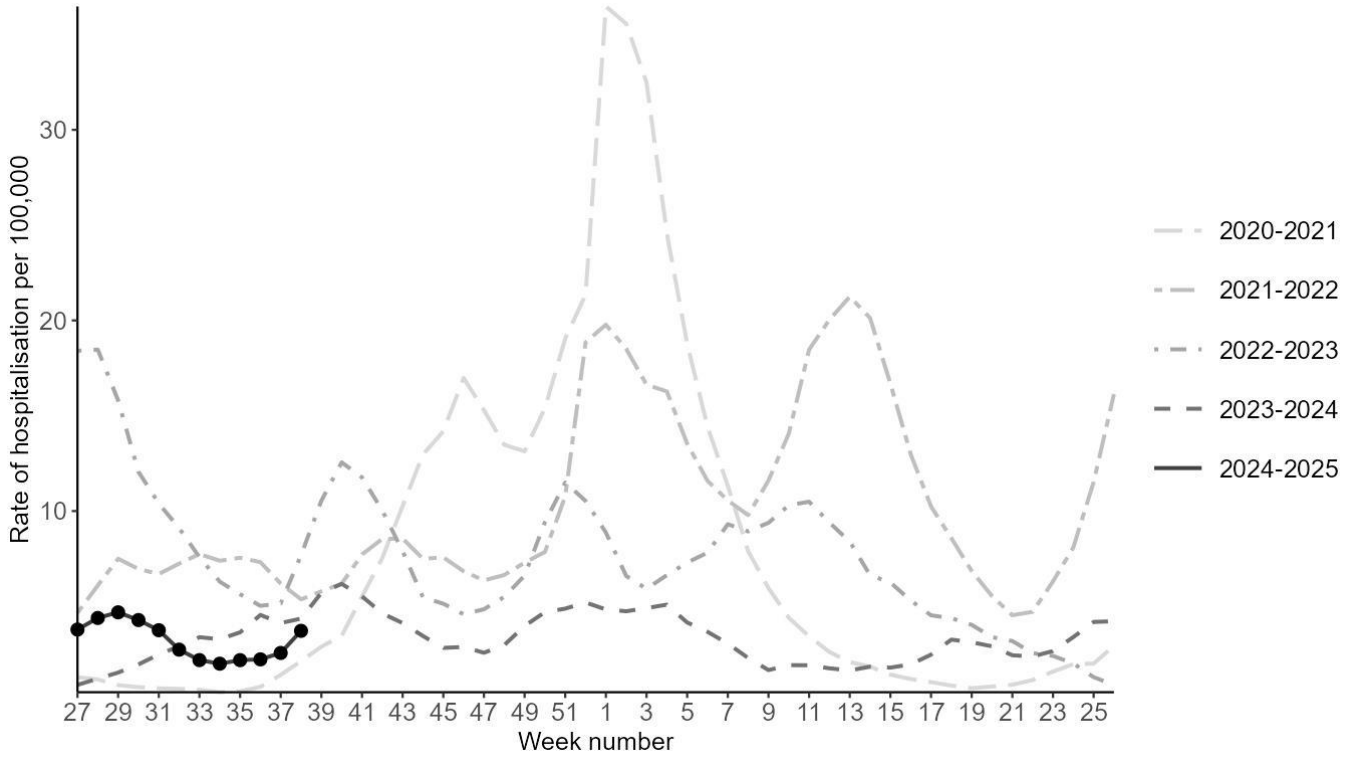
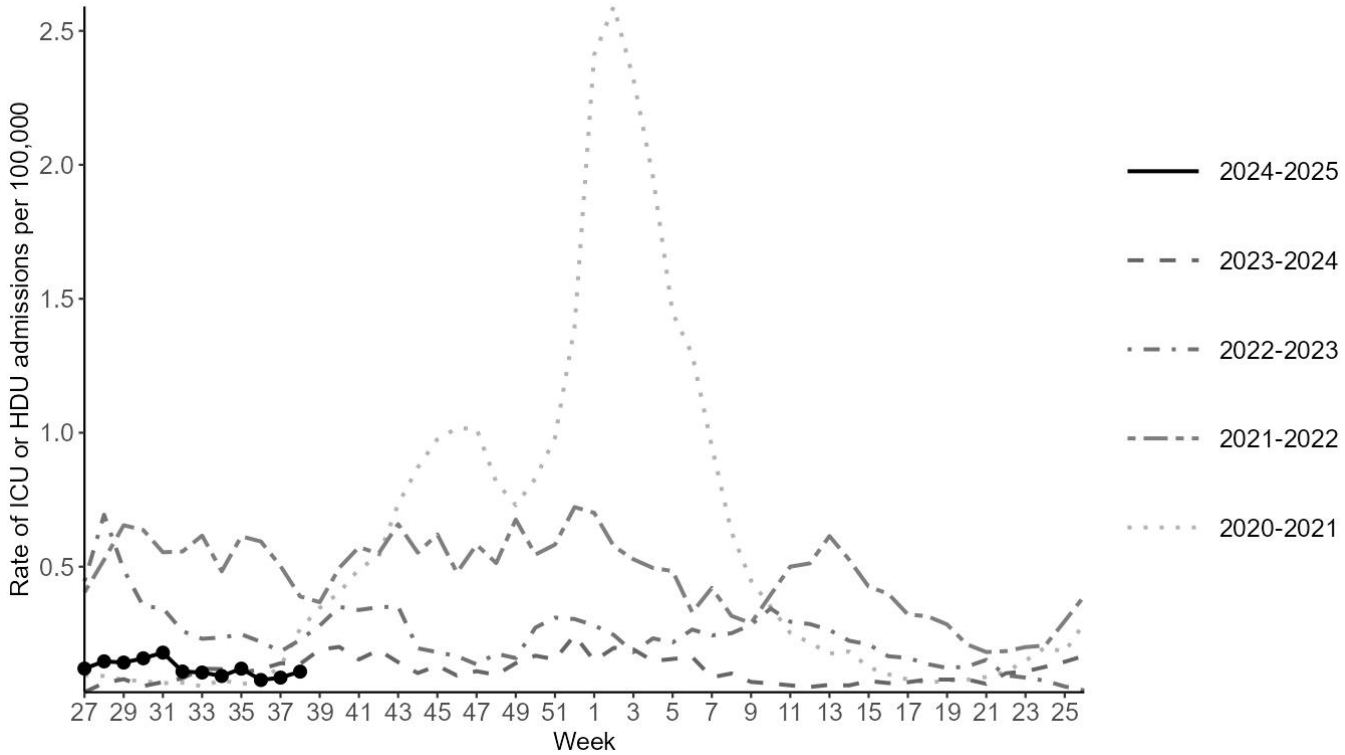


Figure 4. Weekly overall COVID-19 ICU or HDU admission rates per 100,000 trust catchment population, reported through SARI Watch mandatory surveillance, England



ECMO, SARI Watch

There was one new extra corporeal membrane oxygenation (ECMO) admission in adults (due to an acute respiratory infection (ARI) without an identified pathogen) reported in week 38 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 and trauma) and sepsis of non-respiratory origin.

SARI Watch data is provisional and subject to retrospective updates.

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 and South America

For further information on influenza in the American continent please see the Pan American Health Organisation influenza surveillance report. 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 and the latest UKHSA avian influenza technical risk assessment updated 25 July 2024.

Middle East respiratory syndrome coronavirus (MERS-CoV)

For further information please see the WHO disease outbreak news reports and the WHO monthly updates.
Further information on management and guidance of possible cases is available online. The latest highlights that risk of widespread transmission of MERS-CoV remains very low.

Additional surveillance sources

COVID-19 deaths

For further information on COVID-19 related deaths in England please see the COVID-19 dashboard for death.

All-cause mortality assessment (England)

For further information on all-cause mortality in England please see the Excess mortality within England: post-pandemic method report, which uses Office for National Statistics (ONS) death registration data, the all-cause mortality surveillance report, which uses the European mortality monitoring (EuroMOMO) model to identify weeks with higher than expected mortality and the ONS all-cause excess mortality report.

Flu Detector

For further information on syndromic surveillance please see the daily influenza-like illness rates.

Syndromic surveillance

For further information on syndromic surveillance please see the syndromic surveillance: weekly summaries.

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.

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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.

UKHSA is an executive agency, sponsored by the Department of Health and Social Care.

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