



UK Health
Security
Agency

Weekly national Influenza and COVID-19 surveillance report

Week 17 report (up to week 16 data)

28 April 2022

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For additional information including regional data on COVID-19 and other respiratory viruses, COVID-19 in educational settings, co- and secondary infections with COVID-19 and other data supplementary to this report, please refer to the [accompanying graph pack](#).

Executive summary

This report summarises the information from the surveillance systems which are used to monitor coronavirus (COVID-19), influenza, and other seasonal respiratory viruses in England. References to COVID-19 represent the disease name and SARS-CoV-2 represent the virus name. The report is based on data from week 16 (between 18 April 2022 and 24 April 2022) and for some indicators daily data up to 26 April 2022.

Surveillance indicators suggest that at a national level COVID-19 activity decreased in week 16 of 2022. Surveillance indicators suggest influenza activity is low and decreased in week 16 after recent increases in most indicators.

Since 1 April 2022, free universal symptomatic and asymptomatic testing for the general public in England is no longer available, as outlined in the plan for [living with COVID-19](#). As such, there will be a reduction in the reporting of data obtained through Pillar 2 from April 2022 onwards. Data in this report should be interpreted in the context of this change to testing. [Public health guidance](#) remains in place for cases and their close contacts.

COVID-19 case rates through Pillar 1 decreased in week 16. Case rates decreased slightly in all age groups, regions and ethnic groups. Overall Pillar 1 positivity decreased compared to the previous week.

The overall number of reported acute respiratory incidents decreased in the past week. SARS-CoV-2 was identified in the majority of these.

COVID-19 hospitalisations decreased in week 16. Deaths with COVID-19 decreased in the most recent week.

COVID-19 vaccine coverage for all ages was 69.9% for dose 1 and 65.7% for dose 2 at the end of week 16. COVID-19 vaccine coverage for all ages for dose 3 was at 51.3% at the end of week 16, reaching over 80% in all cohorts over the age of 60.

Through Respiratory Datamart, influenza positivity remained low and decreased to 2.6% in week 16. Other indicators for influenza such as hospital admissions and GP influenza-like illness consultation rates remain low. Respiratory syncytial virus (RSV) positivity remained low overall at 1.9%, with an increase in the under 5 year olds to 9.4% in week 16. Rhinovirus positivity increased to 7.9%. Adenovirus positivity increased to 4.5% overall and 12.5% in under 5 year olds. Parainfluenza positivity also increased to 4.6%, while human metapneumovirus (hMPV) positivity remained low at 0.7% in week 16.

Laboratory surveillance

Confirmed COVID-19 cases (England)

From 1 April 2022, the Government ended provision of free universal symptomatic and asymptomatic testing for the general public in England, as outlined in the plan for [living with COVID-19](#). From week 15 2022, confirmed COVID-19 episodes and positivity through Pillar 1 are presented in this report, with Pillar 2 data available in the accompanying graph pack.

As of 9am on 26 April 2022, a total of 1,591,244 episodes have been confirmed for COVID-19 in England under Pillar 1, and 16,911,142 episodes have been confirmed for COVID-19 in England under Pillar 2, since the beginning of the pandemic.

COVID-19 case rates through Pillar 1 decreased in week 16. Case rates decreased slightly in all age groups, regions and ethnic groups. Overall Pillar 1 positivity decreased compared to the previous week.

* Changes to testing policies over time may affect positivity rates and incidence rates, and should be interpreted accordingly.

* From 31 January 2022, UK Health Security Agency (UKHSA) moved all COVID-19 case reporting in England to use a new episode-based definition which includes possible reinfections. Each infection episode is counted separately if there are at least 91 days between positive test results (polymerase chain reaction (PCR) or lateral flow device (LFD)). Each infection episode begins with the earliest positive specimen date. Further information can be found on the [UK COVID-19 dashboard](#).

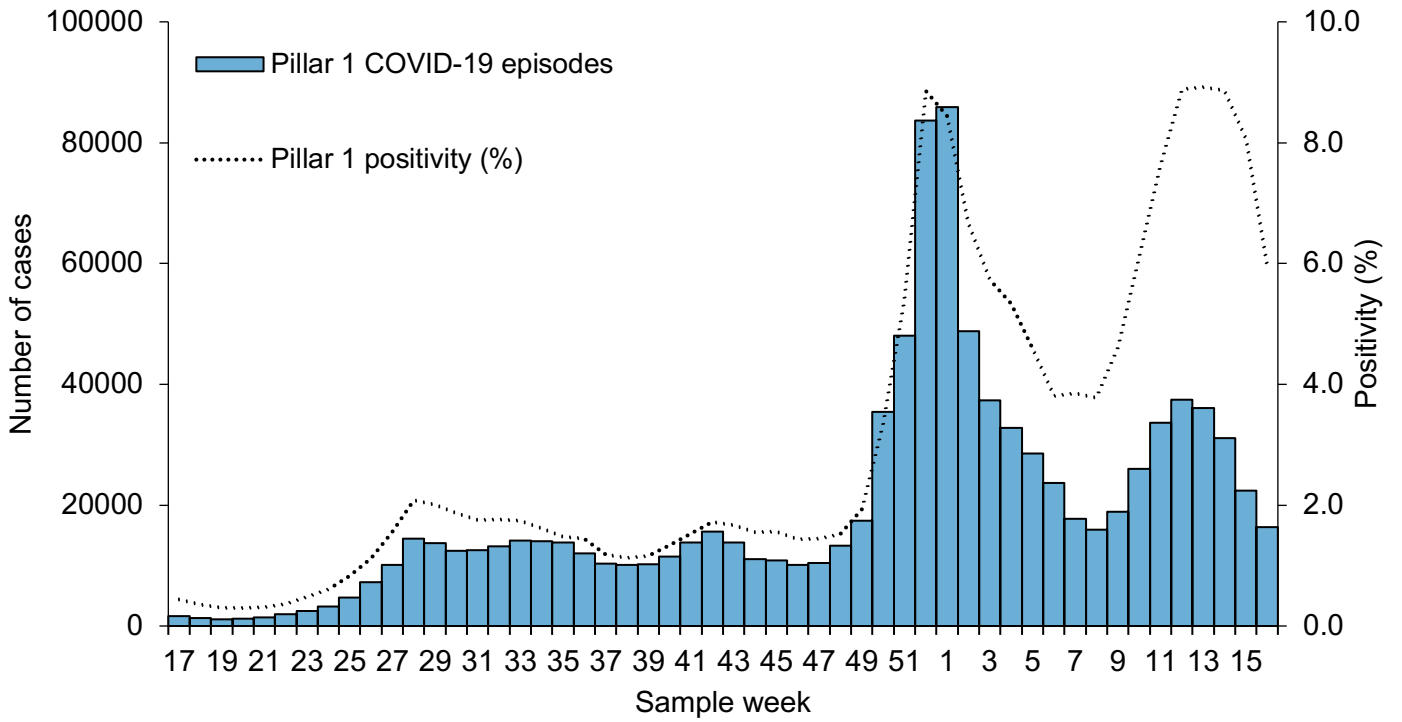
* From the week 32 2021 report onwards, case rates have been updated to use the latest Office for National Statistics (ONS) population estimates for mid-2020. Previously case rates were calculated using the mid-2019 population estimates. Rates by ethnicity and Indices of Multiple Deprivation (IMD) quantile will continue to be presented using the mid-2019 estimates, until the mid-2020 estimates become available.

* Please note that positivity is presented as positivity by PCR testing only. Positivity is calculated as the number of individuals testing positive during the week divided by the number of individuals tested during the week through PCR testing

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

* Data source: Second Generation Surveillance System (SGSS)

Figure 1: Confirmed COVID-19 episodes tested under Pillar 1, based on sample week with overall weekly PCR positivity for Pillar 1 (%)



Age and sex

Figure 2: Weekly confirmed COVID-19 case rates per 100,000, by episode, tested under Pillar 1, by sex

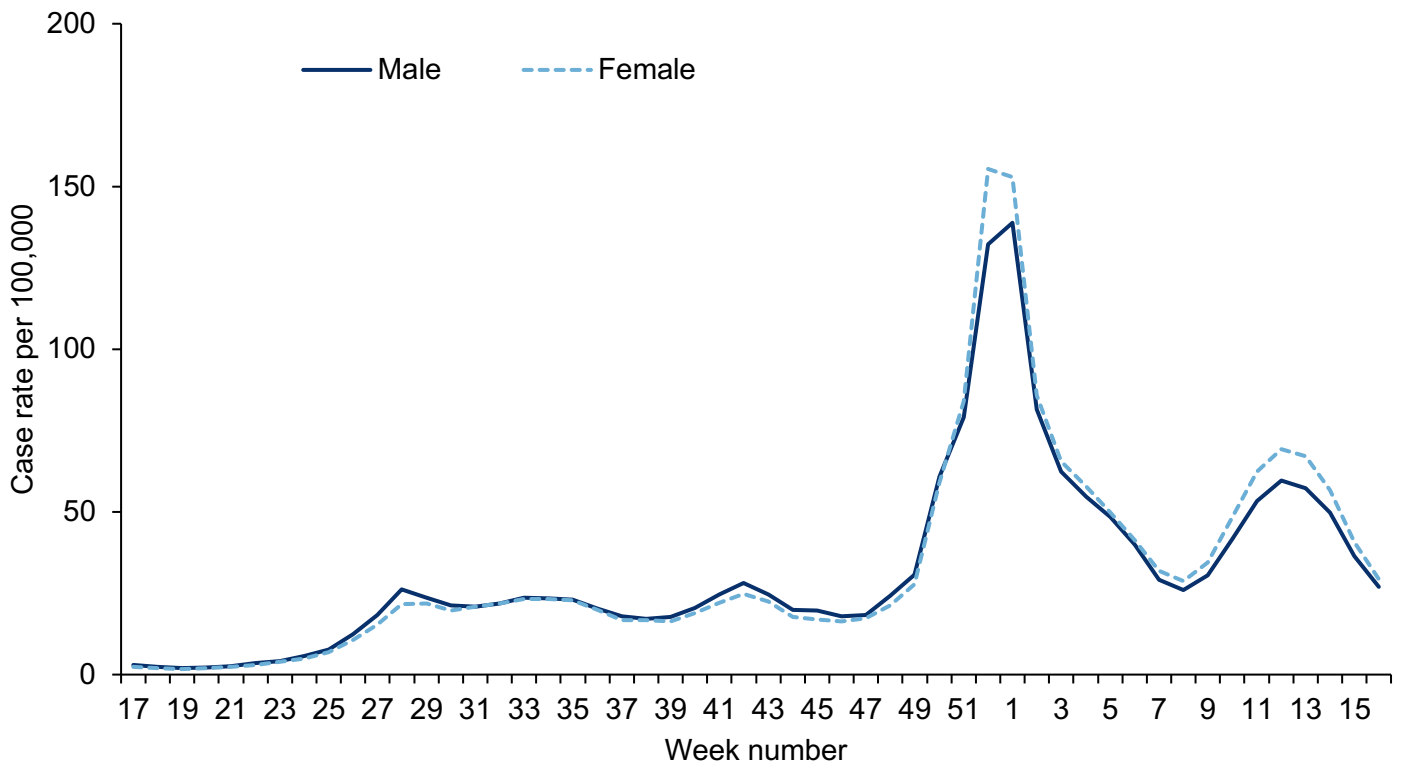


Figure 3: Weekly confirmed COVID-19 case rates per 100,000, by episode, tested under Pillar 1, by age group

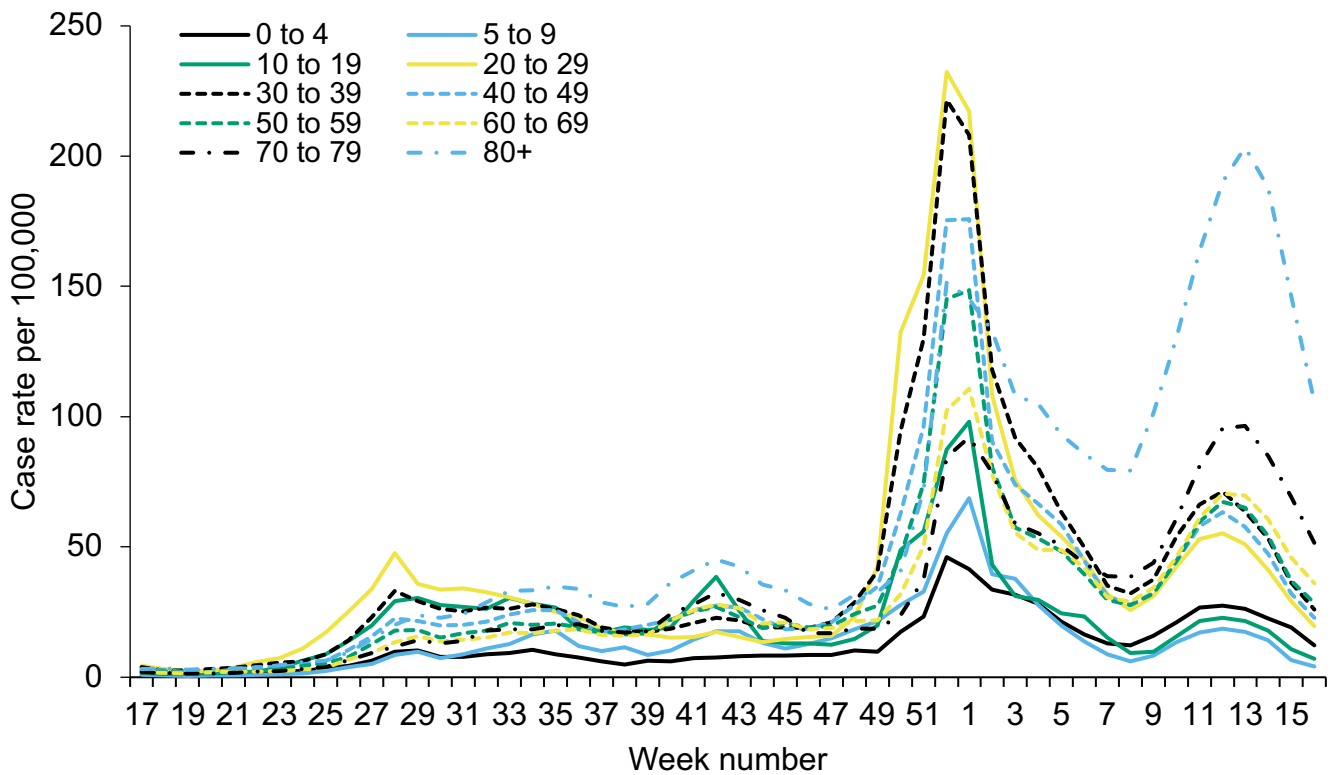


Figure 4: Weekly PCR positivity (%) of confirmed COVID-19 cases tested overall and by sex under Pillar 1

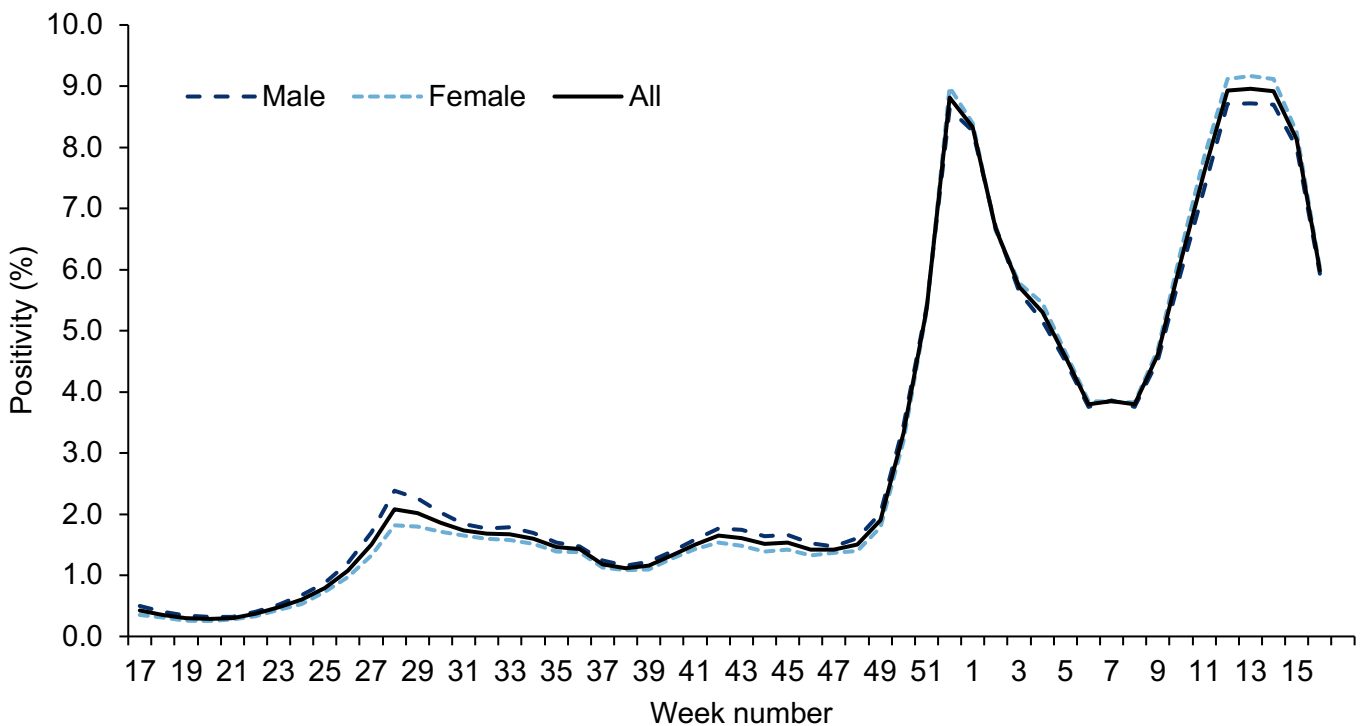
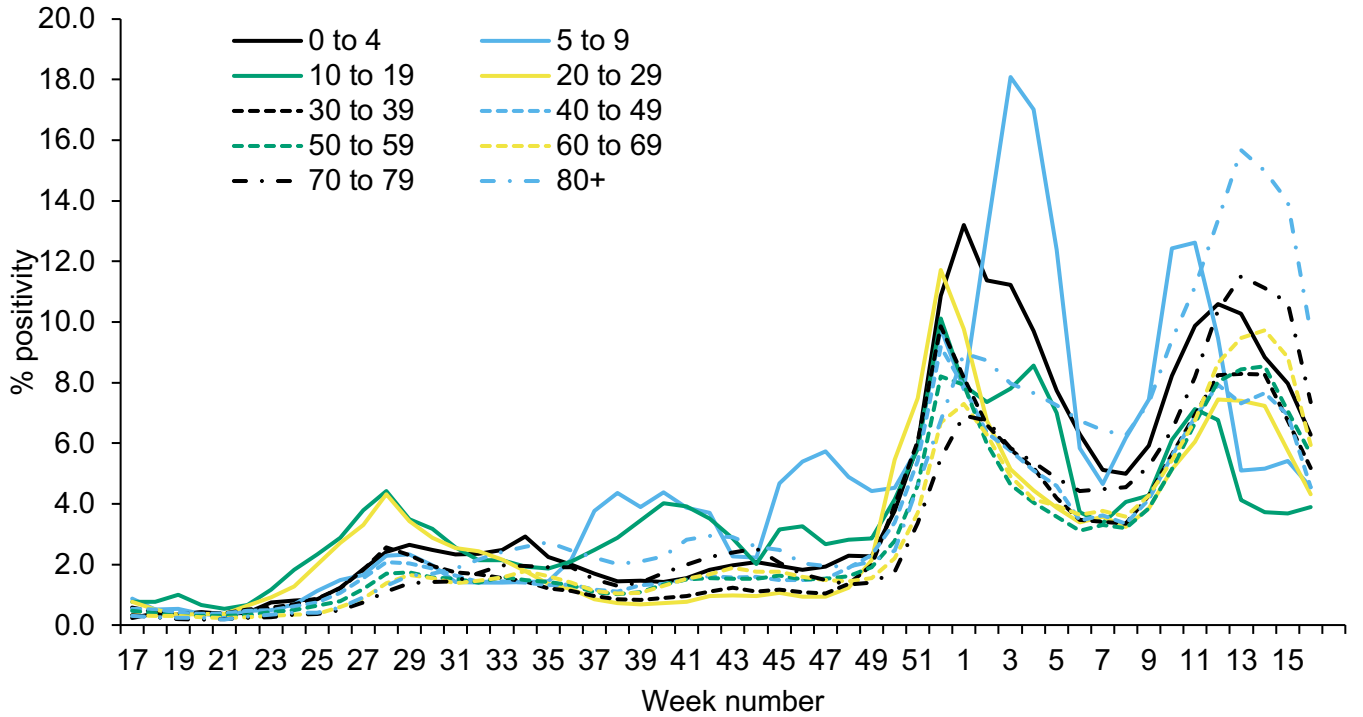
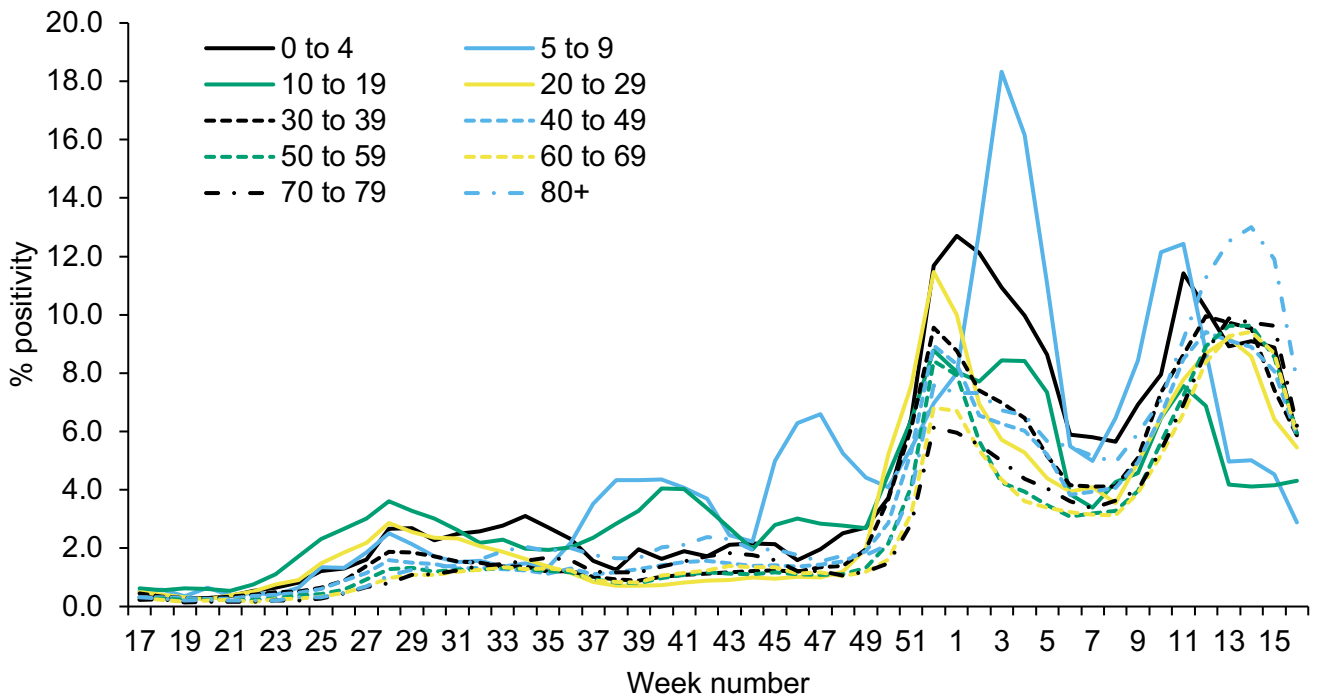


Figure 5: Weekly PCR positivity (%) of confirmed COVID-19 cases tested under Pillar 1, (a) by male and age group and (b) by female and age group

(a) Pillar 1 - Male



(b) Pillar 1 - Female



Geography

Figure 6: Weekly confirmed COVID-19 case rates by episode, per 100,000 population (Pillar 1), by UKHSA Centres and sample week

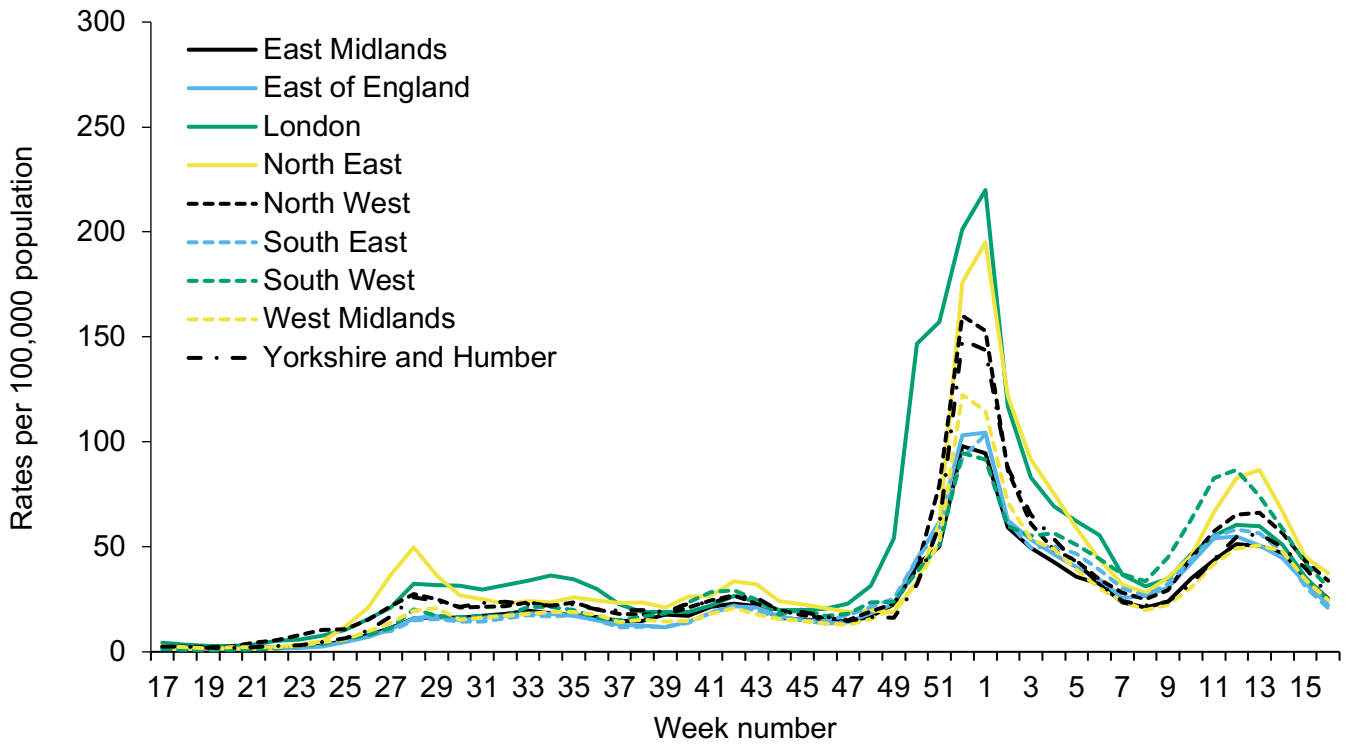


Figure 7: Weekly PCR positivity of confirmed COVID-19 cases tested under Pillar 1 (%) by UKHSA Centres and sample week

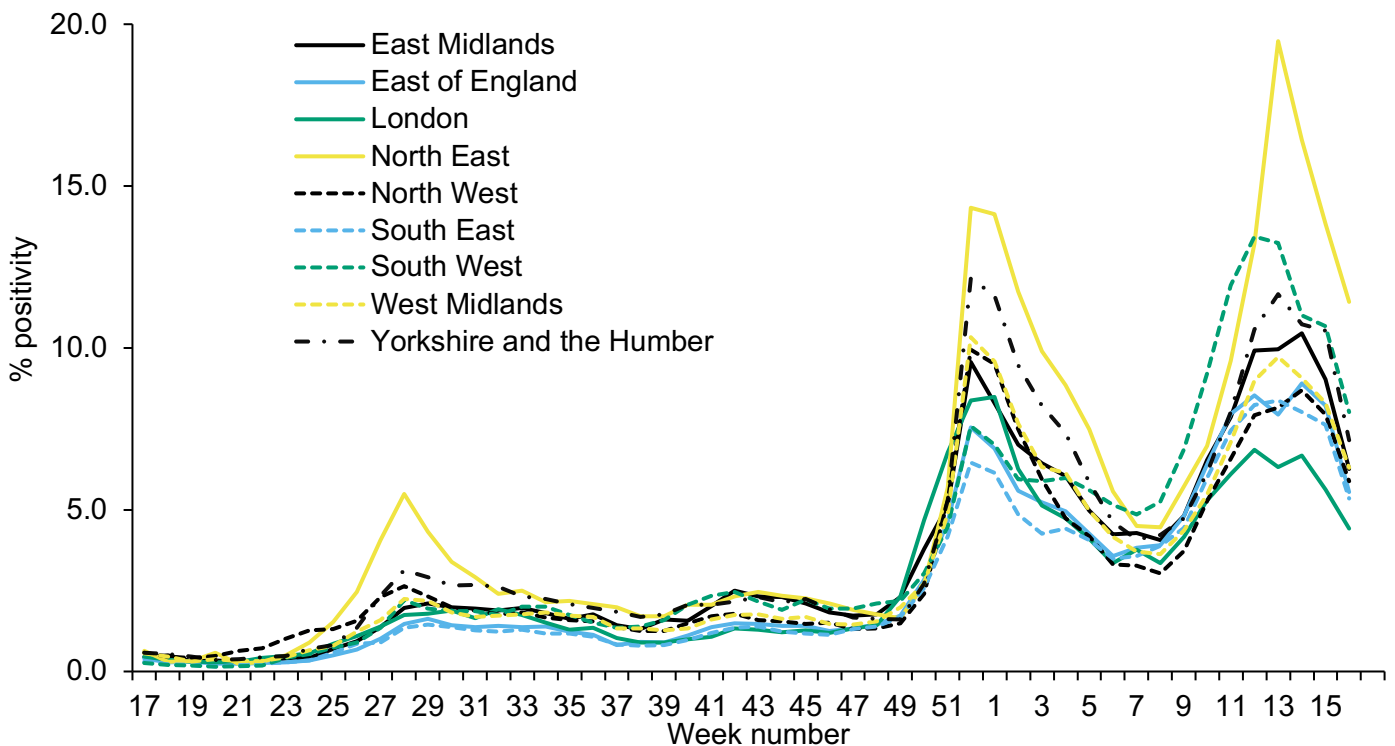
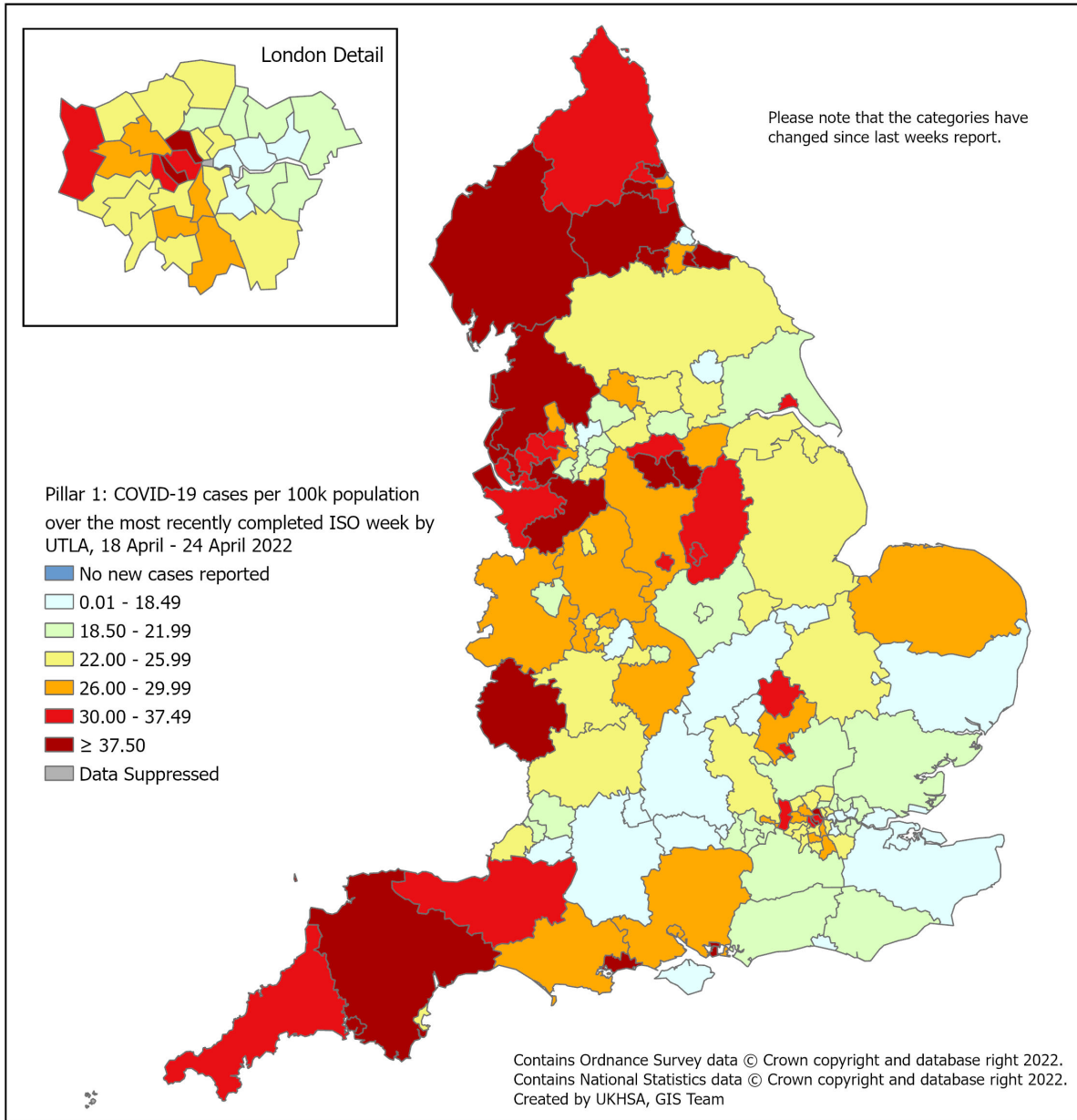
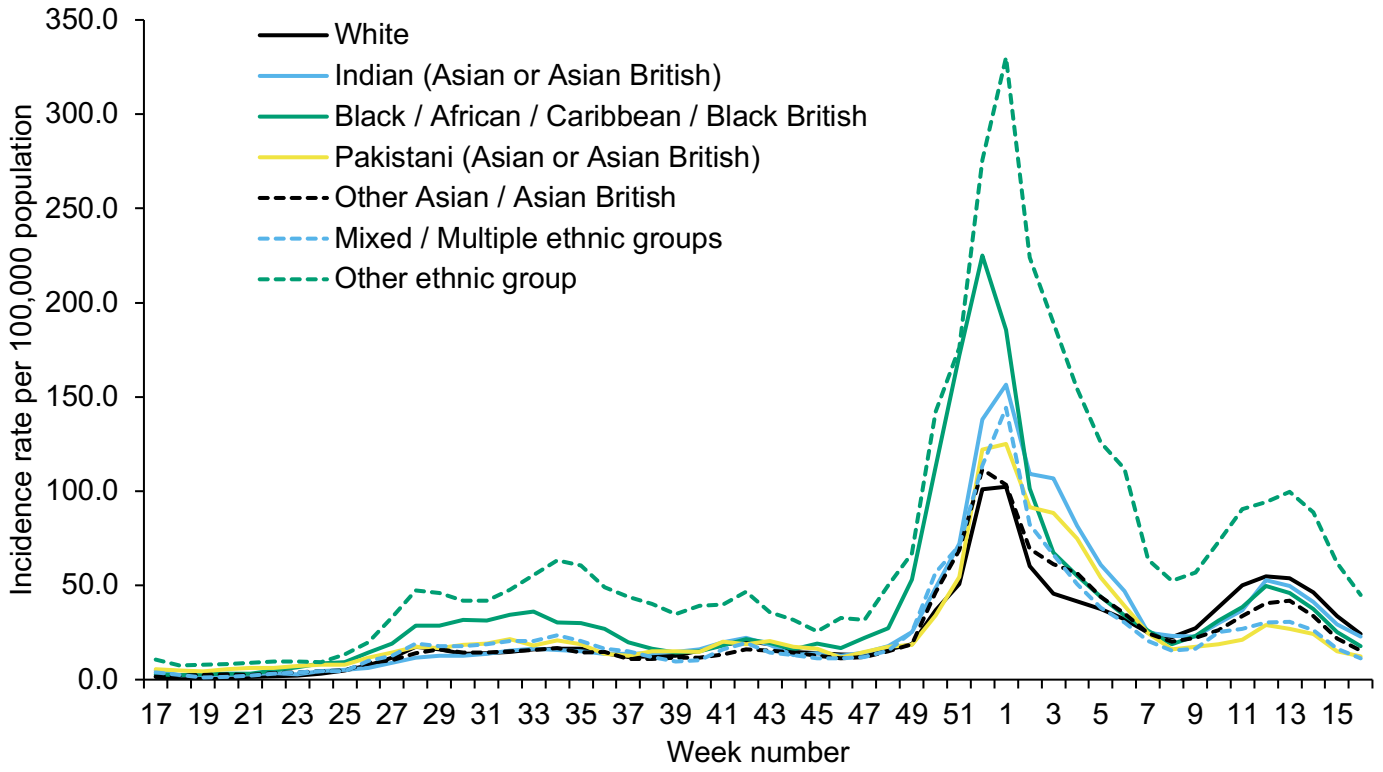


Figure 8: Weekly rate of COVID-19 episodes per 100,000 population (Pillar 1), by upper-tier local authority, England (box shows enlarged map of London area)



Ethnicity

Figure 9: Weekly incidence per 100,000 population by ethnicity (Pillar 1), England



*the incidence rates on Figure 9 have been calculated using the mid-2019 ONS population estimates

Possible SARS-CoV-2 reinfection in England

This is the final publication of this section in the current format. The value of continuing with a regular update of SARS-CoV-2 reinfections will be reviewed in the light of proposed changes to SARS-CoV-2 testing availability and data collection from 1 April 2022. This update presents data to 31 March 2022 or to end week 13 (3 April 2022) where weekly data are presented.

The following figures present population level reinfections based on the first time that individuals tested positive for SARS-CoV-2 through PCR and/or lateral flow device testing in England together with those who have tested positive for SARS-CoV-2 through PCR and/or lateral flow testing with an interval of at least 90 days between two consecutive positive tests. From 31 January 2022, UKHSA COVID-19 case reporting has changed to an episode-based definition which includes possible reinfections (see [What's new | Coronavirus in the UK](#)). Reinfection summaries have been based on these data from report 5, 2022 onwards.

Data has been processed to week 13, 2022 (ending 3 April 2022, extracted 13 April 2022). Based on provisional figures to 31 March 2022, 890,575 reinfection episodes have been identified in England since the beginning of the pandemic, of which 10,315 are third episodes and 98 are fourth episodes; 17.0 million first positives or primary infection episodes are included in the figures. There were 41,913 reinfection episodes identified in updated provisional figures for week 13 (ending 3 April 2022), accounting for 11.6% of all first or reinfection episodes with SARS-CoV-2 that week. Information on Omicron reinfections has been published in the [UKHSA SARS-CoV-2 variants of concern and variants under investigation in England](#) technical briefings.

For a possible reinfection to be categorised as confirmed it requires sequencing of a specimen at each episode and for the later specimen to be genetically distinct from that sequenced from the earlier episode. Availability of such dual sequencing is currently very low for several reasons; sequencing was not widely undertaken early in the pandemic; LFD test results do not allow sequencing and some PCR samples have a low viral load where sequencing cannot be undertaken. To meet the definition of a probable reinfection requires sequencing at the later episode that identifies a variant that was not circulating at the time of the earlier episode.

It is important to consider reinfections in the context of first infections and there is a 90-day delay before people with a first infection can become eligible for reinfection.

Table 1 summarises the definitions of different categories of COVID-19 infection accompanied by totals generated to 31 March 2022 and review of 890,541 possible reinfections to 13 April 2022. These data are affected by the limited availability of sequencing data, particularly in the early months of the pandemic.

Table 1: Different categories of COVID-19 infection with current totals generated by episode-based reporting* in England, to 31 March 2022

Infection type	Definition	Current totals
Primary infection/ first positive	the first positive PCR/ LFD test result for an individual	17.0 million first positives
Possible reinfection	identified based on two sequential positive test results (PCR or LFD) at least 90 days apart	890,541 possible reinfections*
Probable reinfection	where only reinfection sample is available, and this is congruent with contemporaneous phylogeny OR the second event identifies a variant which was not in circulation at the time of first infection	3,575 classified as probable*
Confirmed reinfection	sequencing of a specimen at each episode of a possible reinfection with the later specimen genetically distinct from that sequenced at first episode	8,098 confirmed reinfections*
Persistent infection	Nominally repeat test positives at between 14 and <90-day intervals (likely associated with immunosuppression)	Unquantified

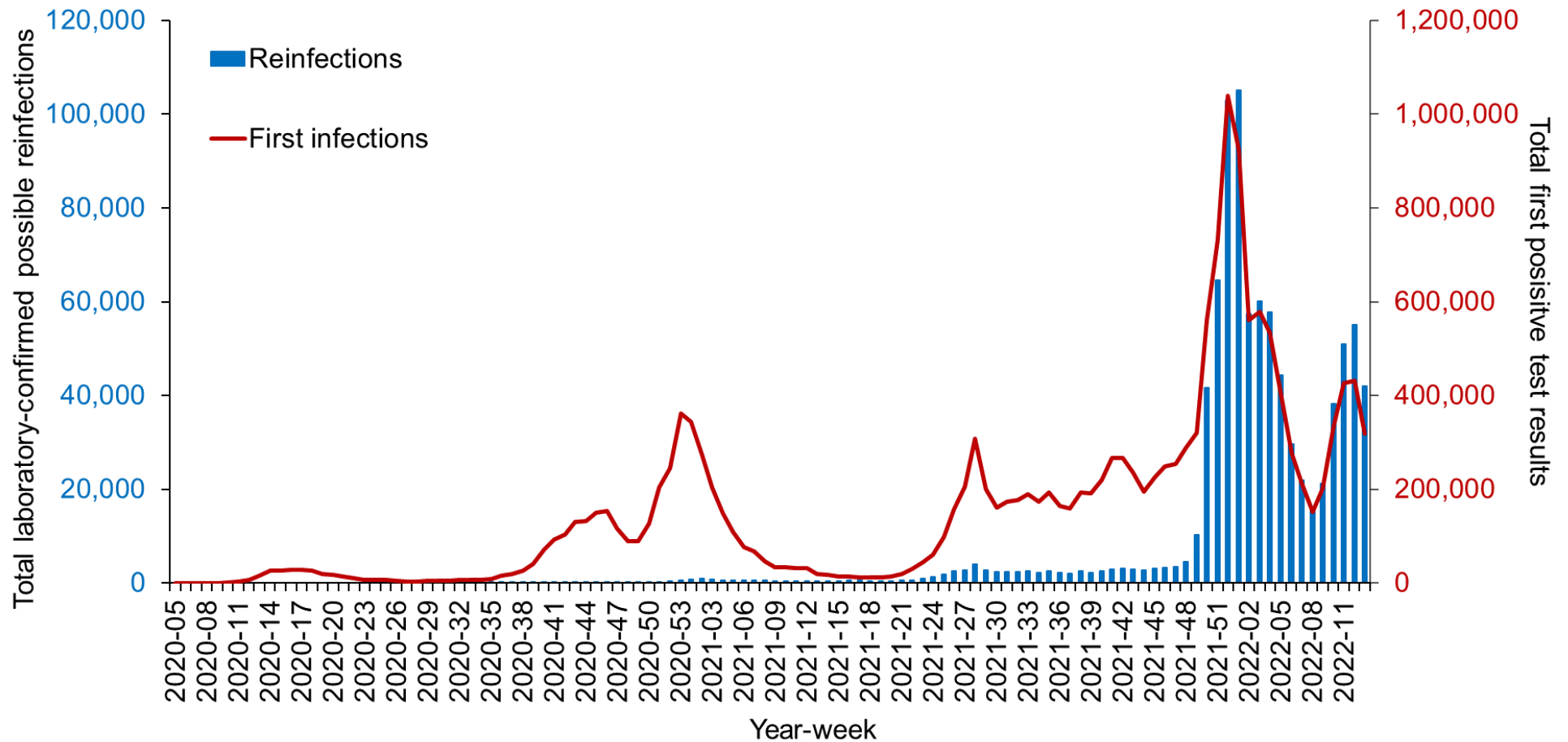
*These totals are generated using the national episode level dataset to 31 March 2022. Some reinfection episodes have not yet been classified and so the total of possible, probable and confirmed will not equal all identified reinfection episodes for the same period. Many possible reinfections do not have sequencing data available at one or other episode and so cannot be further classified.

Figure 10 shows weekly numbers of reinfection episodes and primary infections on the secondary Y-axis.

Figure 11 shows the weekly rates of reinfection episodes per 1000 first infection episodes based on a cumulative denominator derived from total individuals with a first SARS-CoV-2 positive test result at a point 13 weeks (91 days) before the next positive test result together with the cumulative total of first infections (secondary Y-axis) by week of onset.

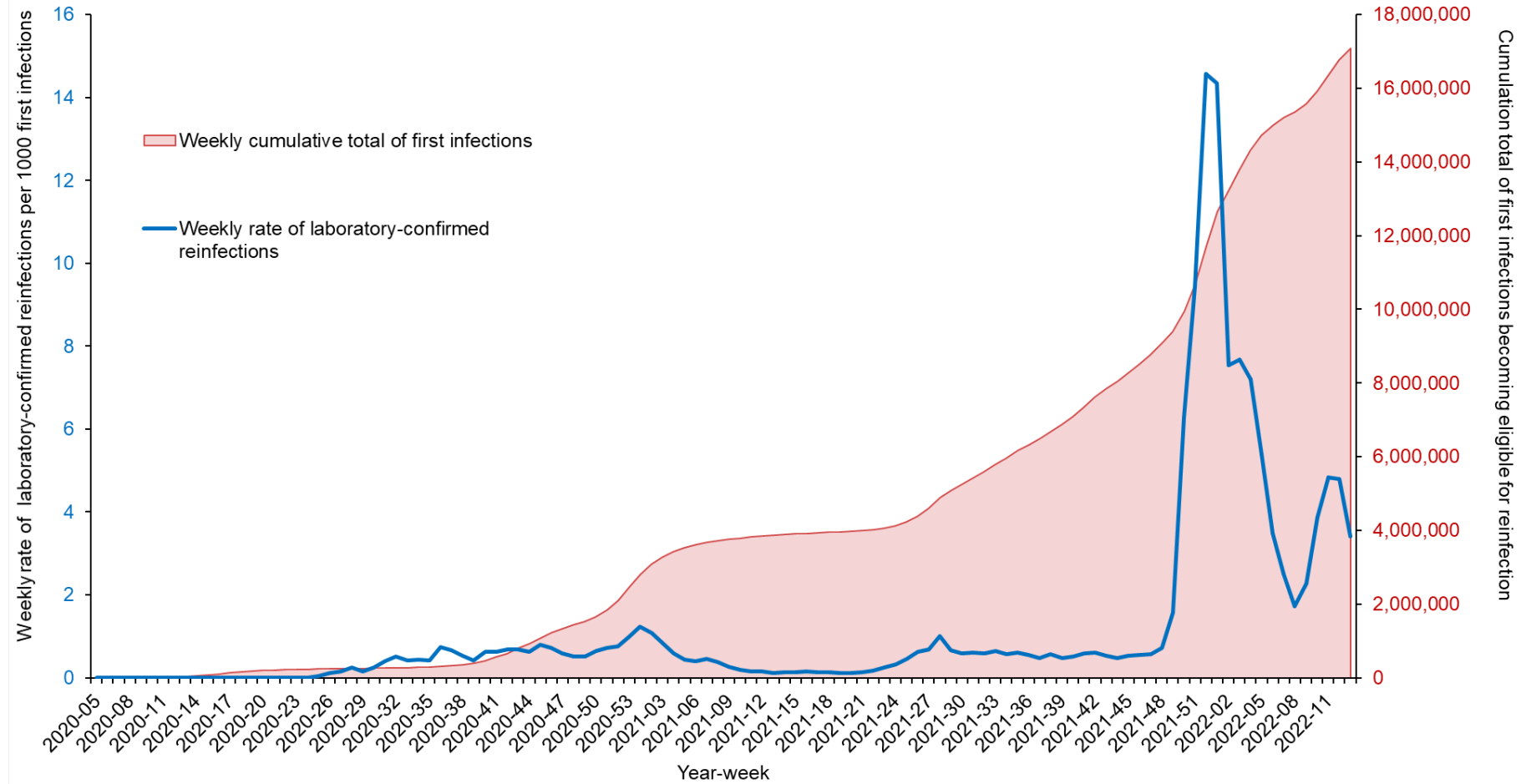
Figures 12a and 12b show weekly rates of reinfection episodes per 1000 first infections based on a cumulative denominator derived from total individuals with a first SARS-CoV-2 positive test result at a point 13 weeks (91 days) broken down by age group into those under 30 years of age and those older than 30 years. The figure also shows weekly first infections in those under 30 years of age and those older than 30 years (secondary Y-axis). Both figures include provisional data to week 13 (ending 3 April 2022).

Figure 10: The weekly total of possible COVID-19 reinfections and first infections* (England only to week 13 2022, provisional early data^Δ)



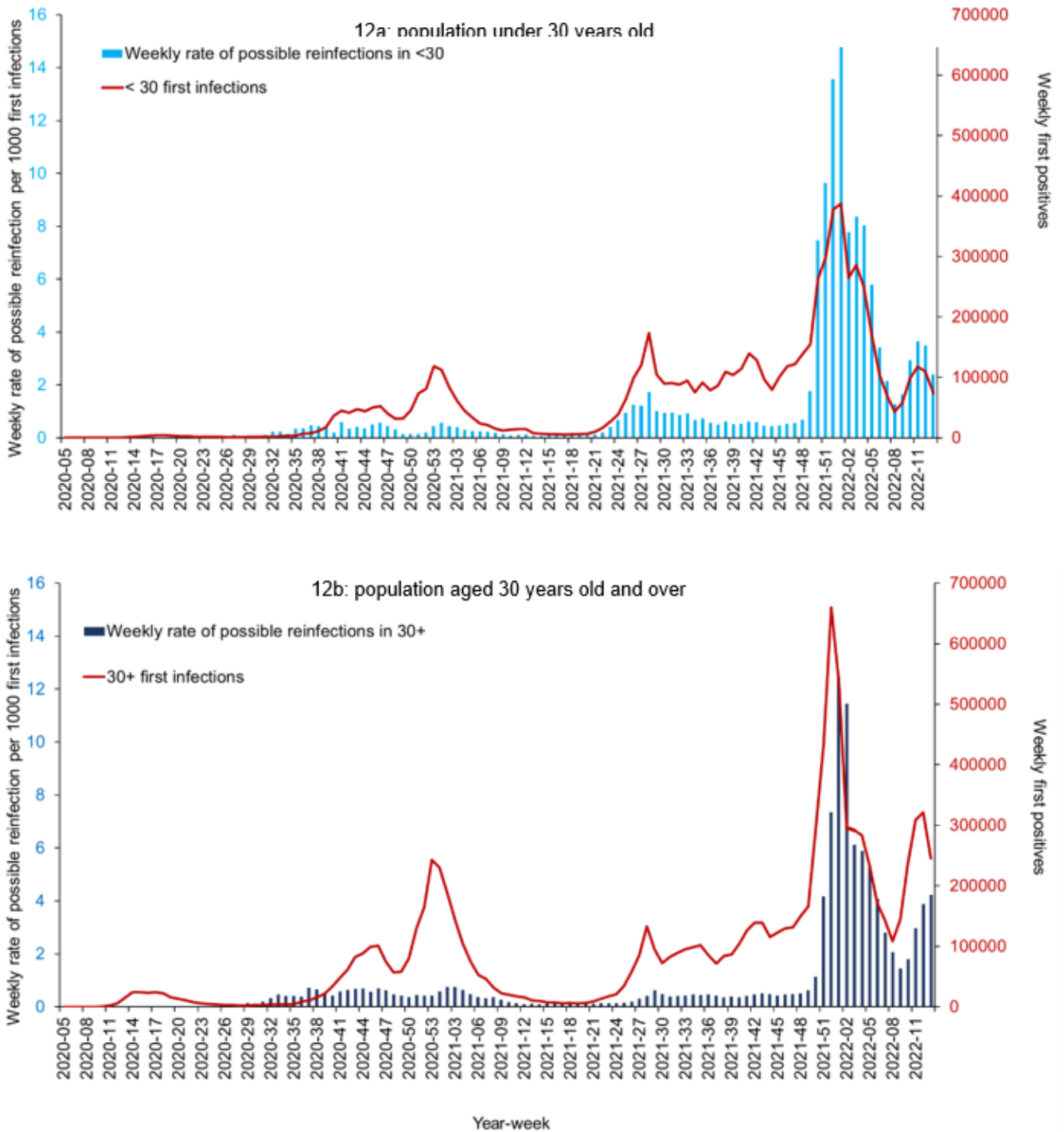
^Δ Data in week 13 includes a part-week after changes to SARS-CoV-2 testing in England were introduced from 1 April 2022

Figure 11: The weekly rate of possible COVID-19 reinfections with cumulation of first infections becoming eligible for reinfection * (England only to week 13 2022, provisional early data^Δ)



^Δ Data in week 13 includes a part-week after changes to SARS-CoV-2 testing in England were introduced from 1 April 2022

Figure 12 (a and b): First COVID-19 positive tests results* & weekly rate of possible COVID-19 reinfections in England to week 13 2022, provisional data^Δ



^Δ Data in week 13 includes a part-week after changes to SARS-CoV-2 testing in England were introduced from 1 April 2022

Respiratory DataMart system (England)

The Respiratory Datamart system began during the 2009 influenza pandemic to collate all laboratory testing information in England. It is now used as a sentinel laboratory surveillance tool, monitoring all major respiratory viruses in England. Seventeen laboratories in England will be reporting data for this season. As this is based on a sample of labs - SARS-CoV-2 positivity figures quoted here will differ from those quoted in the Confirmed COVID-19 cases section, however, they are included to allow comparison with data on other respiratory viruses.

In week 16 of 2022, out of the 63,637 respiratory specimens reported through the Respiratory DataMart System (based on data received from 12 out of 17 laboratories), 2,980 samples were positive for SARS-CoV-2 with an overall positivity of 4.7%. The highest positivity was noted in the 65 year olds and over at 5.0% in week 16.

The overall influenza positivity remained low and decreased to 2.6% in week 16. In week 16, 161 of the 6,133 samples tested positive for influenza (including 53 influenza A(H3N2), 11 fluA(H1N1)pdm09, 93 influenza A(not subtyped) and 4 influenza B).

Respiratory syncytial virus (RSV) positivity remained low at 1.9% in week 16, with the highest positivity in the under 5 year olds at 9.4%. Rhinovirus positivity increased to 7.9% overall and 17.9% in under 5 year olds. Adenovirus positivity increased to 4.5% overall and 12.5% in under 5 year olds. Parainfluenza positivity also increased to 4.6%, while human metapneumovirus (hMPV) positivity remained low at 0.7% in week 16 (Figure 15).

Figure 13: Respiratory DataMart samples positive for influenza and weekly positivity (%) for influenza, England

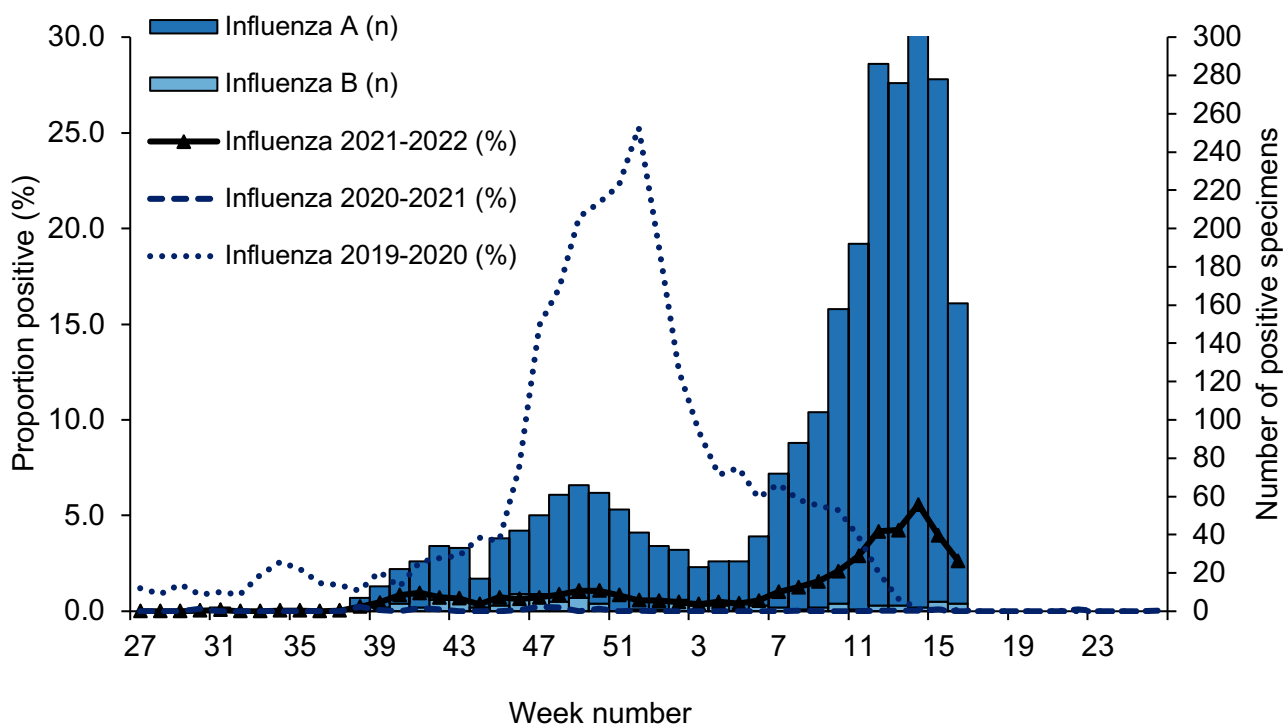


Figure 14: Respiratory DataMart weekly positivity (%) for SARS-CoV-2, England

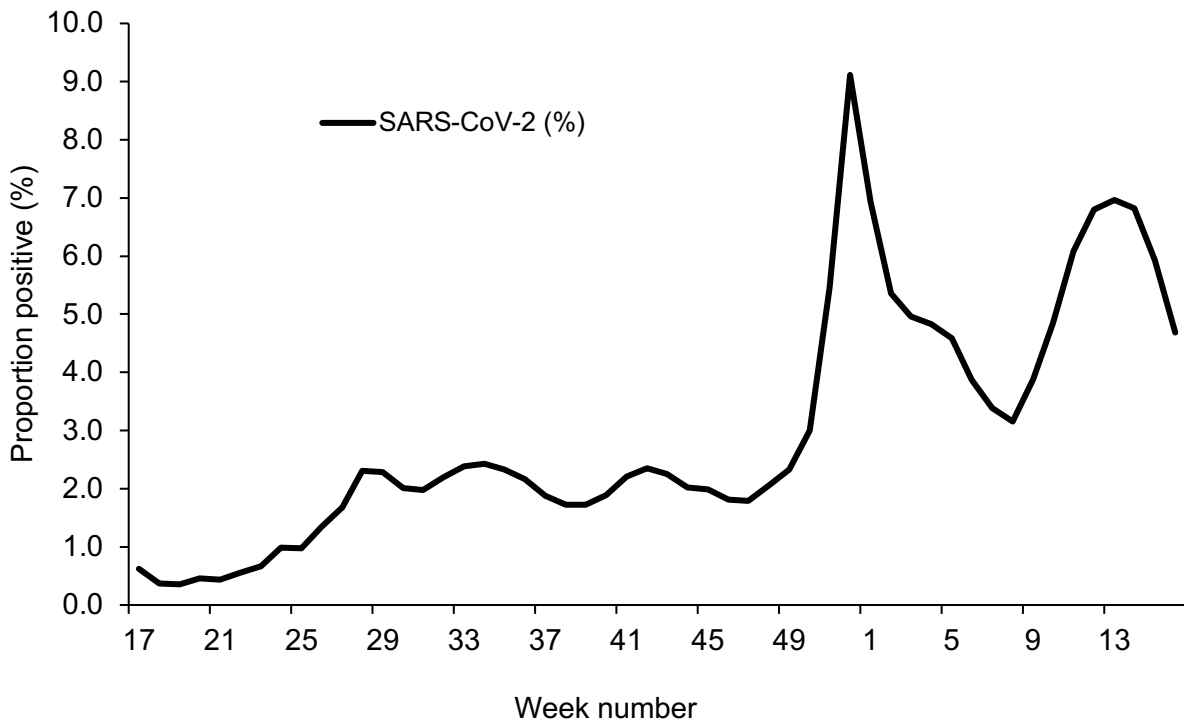


Figure 15: Respiratory DataMart weekly positivity (%) for other respiratory viruses, England

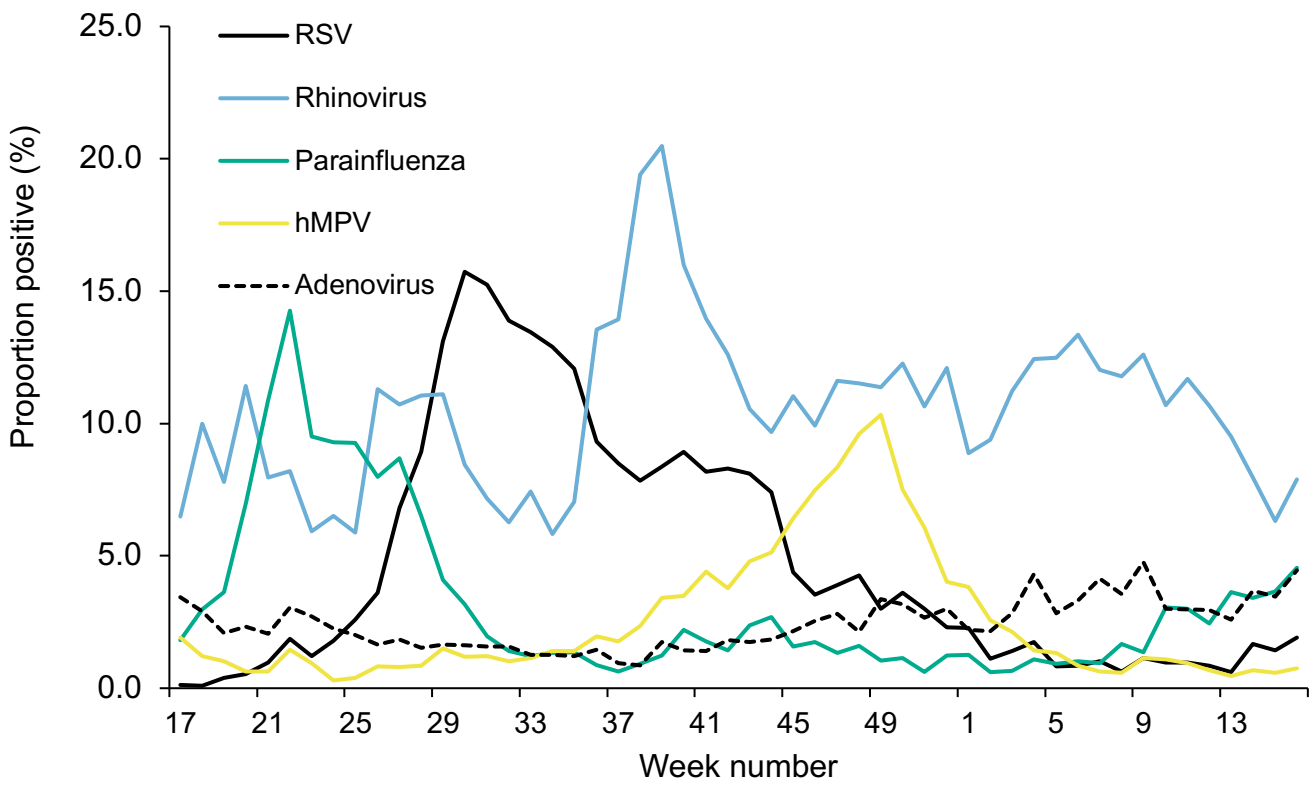


Figure 16: Respiratory DataMart weekly positivity (%) for adenovirus by age, England

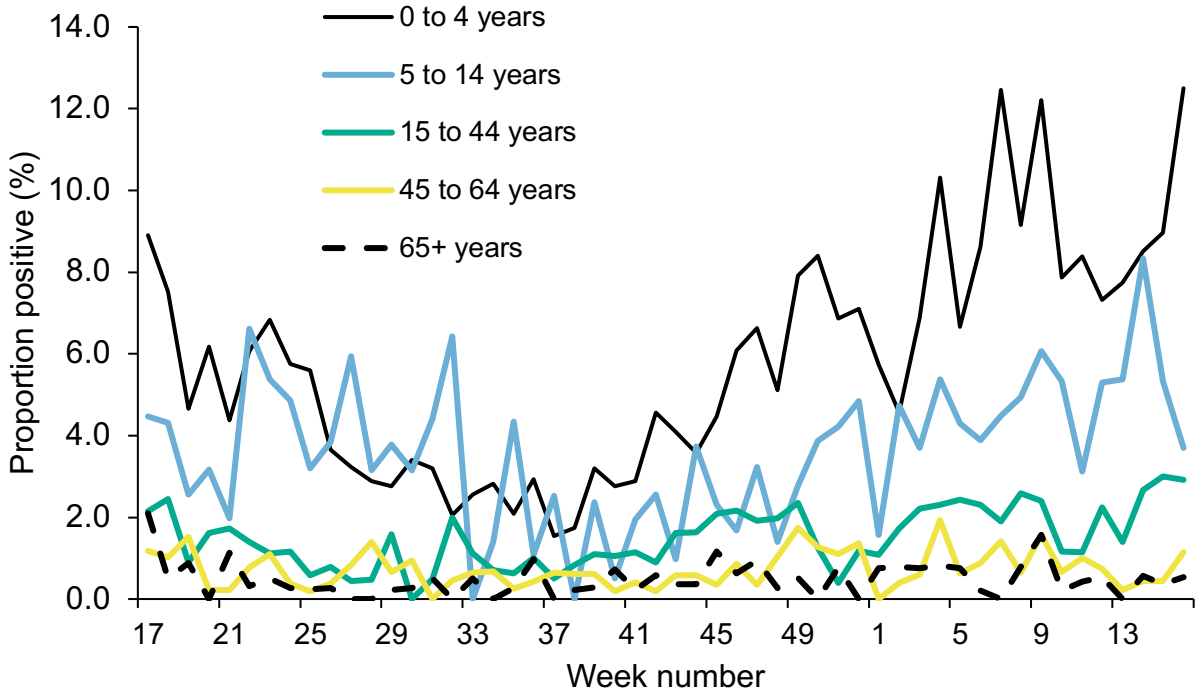


Figure 17: Respiratory DataMart weekly positivity (%) for rhinovirus by age, England

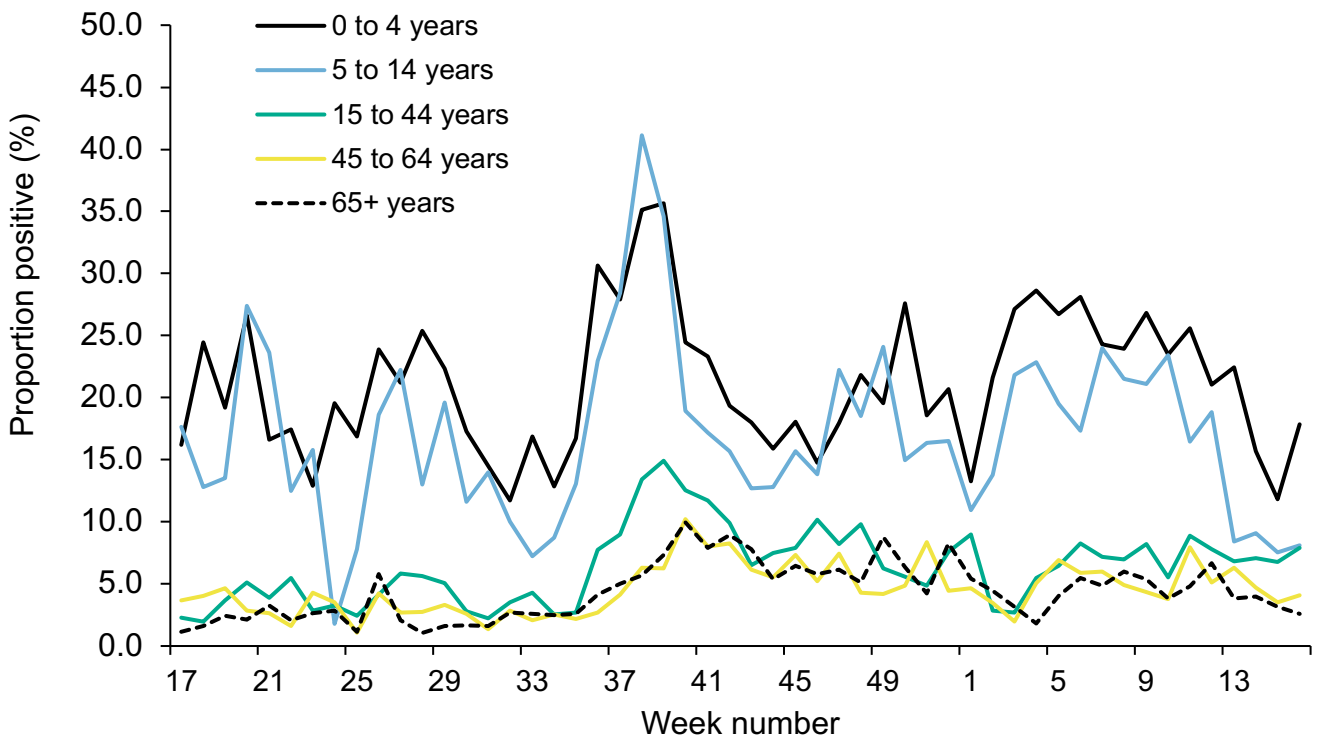
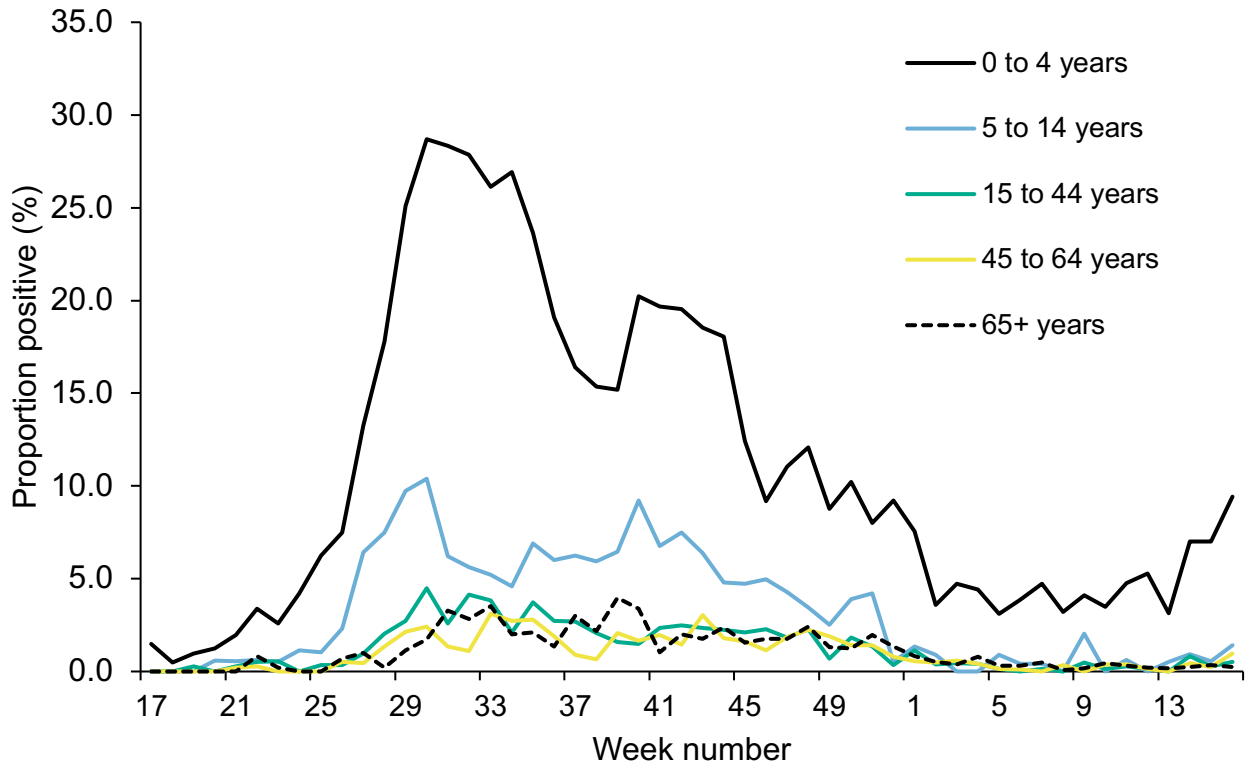


Figure 18: Respiratory DataMart weekly positivity (%) for RSV by age, England



Community surveillance

Acute respiratory infection incidents

Here we present data on acute respiratory infection (ARI) incidents in different settings that are reported to UKHSA Health Protection Teams (HPTs) and entered onto an online web-based platform called HPZone. Incidents are suspected outbreaks of acute respiratory infections linked to a particular setting. All suspected outbreaks are further investigated by the HPT in liaison with local partners. A subset of these will meet the criteria of a confirmed outbreak, that is, where 2 or more laboratory confirmed cases (SARS-CoV-2, influenza or other respiratory pathogens) are linked to a particular setting. Incidents where suspected cases test negative for COVID-19 or other respiratory pathogens, or cases are subsequently found not to have direct links to the setting are discarded.

The number of ARI incidents in each setting with at least one laboratory confirmed case of COVID-19 (or other respiratory pathogen) are reported below. As outlined above, only a subset of these will go on to be confirmed as outbreaks.

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

Data caveats:

1. The incidents captured on HPZone represent a subset of all ongoing ARI clusters and outbreaks in England rather than an exhaustive listing. A variety of arrangements are in place across UKHSA Centres, with local authorities and other stakeholders supporting HPTs in outbreak investigation in some areas without HPZone reporting. As a result, the number of outbreaks reported for some of the regions are underestimates.
2. For this academic year (2021 to 2022) the thresholds for reporting an outbreak in an educational setting have been revised. Clusters and outbreaks are now reported to the Health protection Team if any of the following criteria are met:
 - 5 cases or 10% test-confirmed cases of COVID-19 within 10 days (whichever is reached first), among students or staff
 - Evidence of severe illness for example students or staff members admitted to hospital or a death as a result of a COVID-19 infection
 - For special education needs schools, residential schools and settings that operate with 20 or fewer children, pupils, students and staff at any one time, clusters and outbreaks are reported if the following criteria is met:
 - 2 children, pupils, students and staff, who are likely to have mixed closely, test positive for COVID-19 within a 10-day period

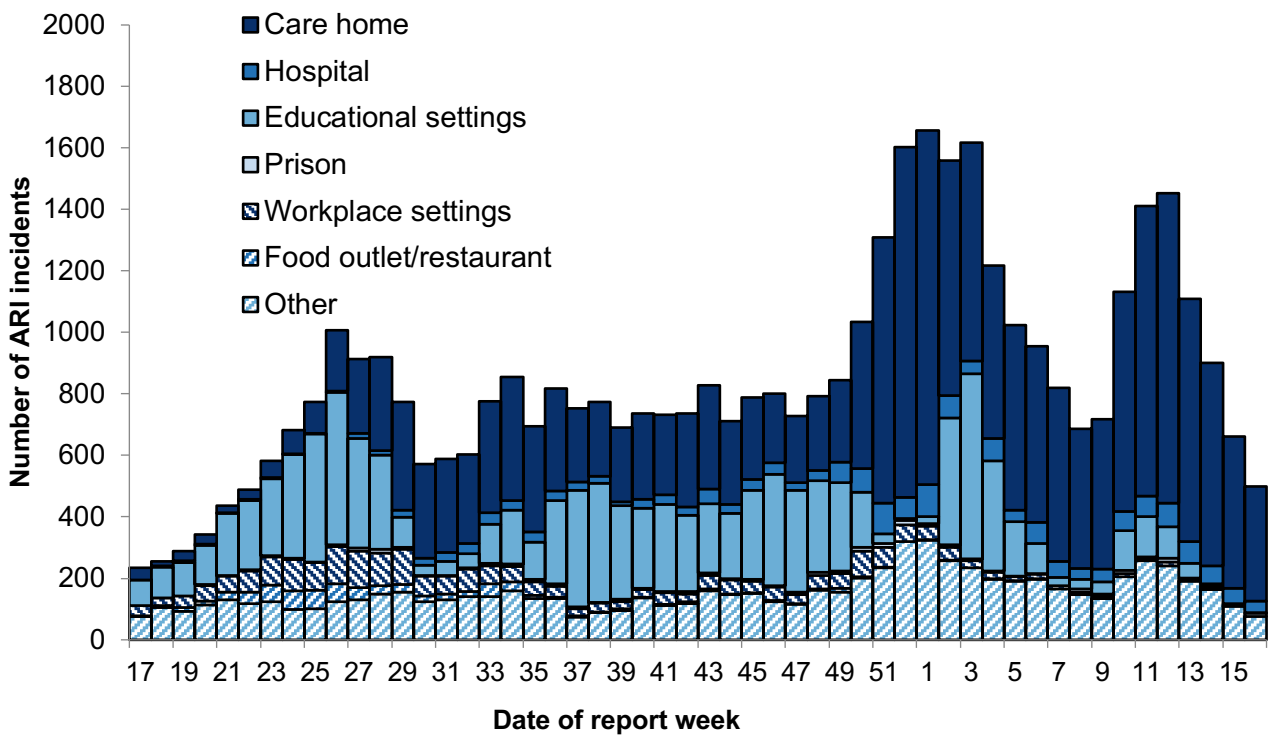
For more information on managing COVID-19 in educational settings please refer to the [framework](#). This should be taken into consideration when comparing 2021 to 2022 season data against 2020 to 2021 season data.

3. It should be noted that the denominator for the different settings will vary significantly. For example, there are fewer hospitals than workplaces. In addition, the propensity to report incidents to UKHSA also varies significantly by setting. This needs to be taken into account when interpreting the weekly number of reported incidents by setting and caution should be used when making comparisons between settings.
4. In light of the above, comparisons between Regions and settings are not advised as they may be misleading.

499 new ARI incidents have been reported in week 16 in the UK (Figure 19):

- 372 incidents were from care homes where 272 had at least one linked case that tested positive for SARS-CoV-2, 1 tested positive for influenza A(not subtyped) and 1 for rhinovirus
- 2 incidents were from educational settings with no test results available
- 39 incidents were from hospitals, where 14 had at least one linked case that tested positive for SARS-CoV-2
- No incidents were from workplace settings
- 10 incidents were from prisons and 8 had at least one linked case testing positive for SARS-CoV-2
- No incidents were from a food outlet or restaurant setting
- 76 incidents were from other settings where 48 had at least one linked case that tested positive for SARS-CoV-2

Figure 19: Number of acute respiratory infection (ARI) incidents by setting, UK



*Excludes data from Wales

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

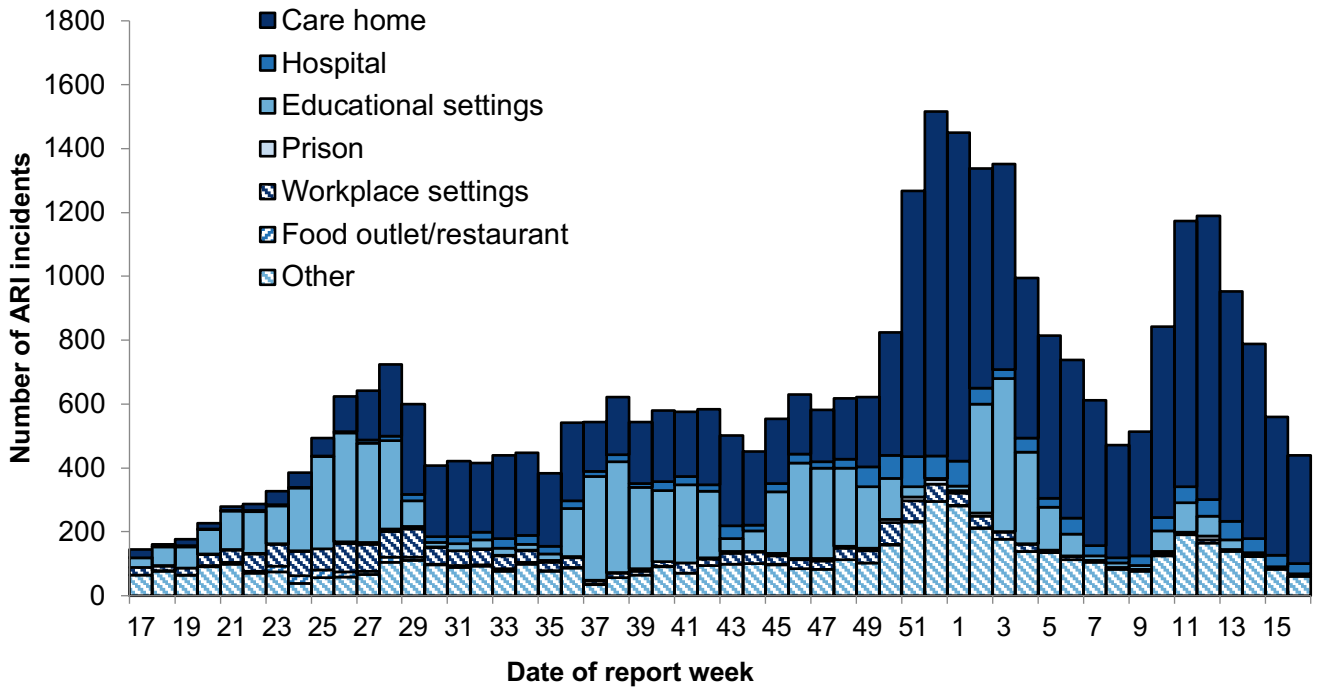


Figure 21: Number of acute respiratory infection (ARI) incidents in care homes by virus type, England

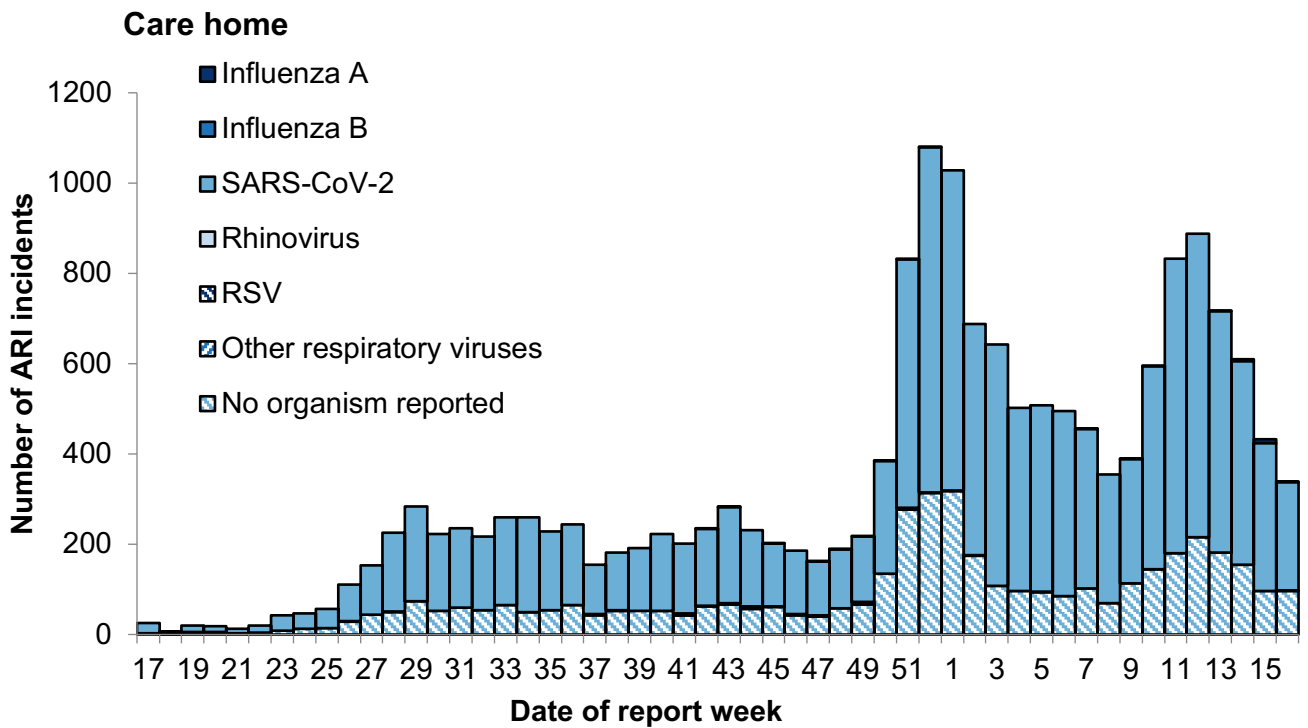


Figure 22: Number of acute respiratory infection (ARI) incidents in hospitals by virus type, England

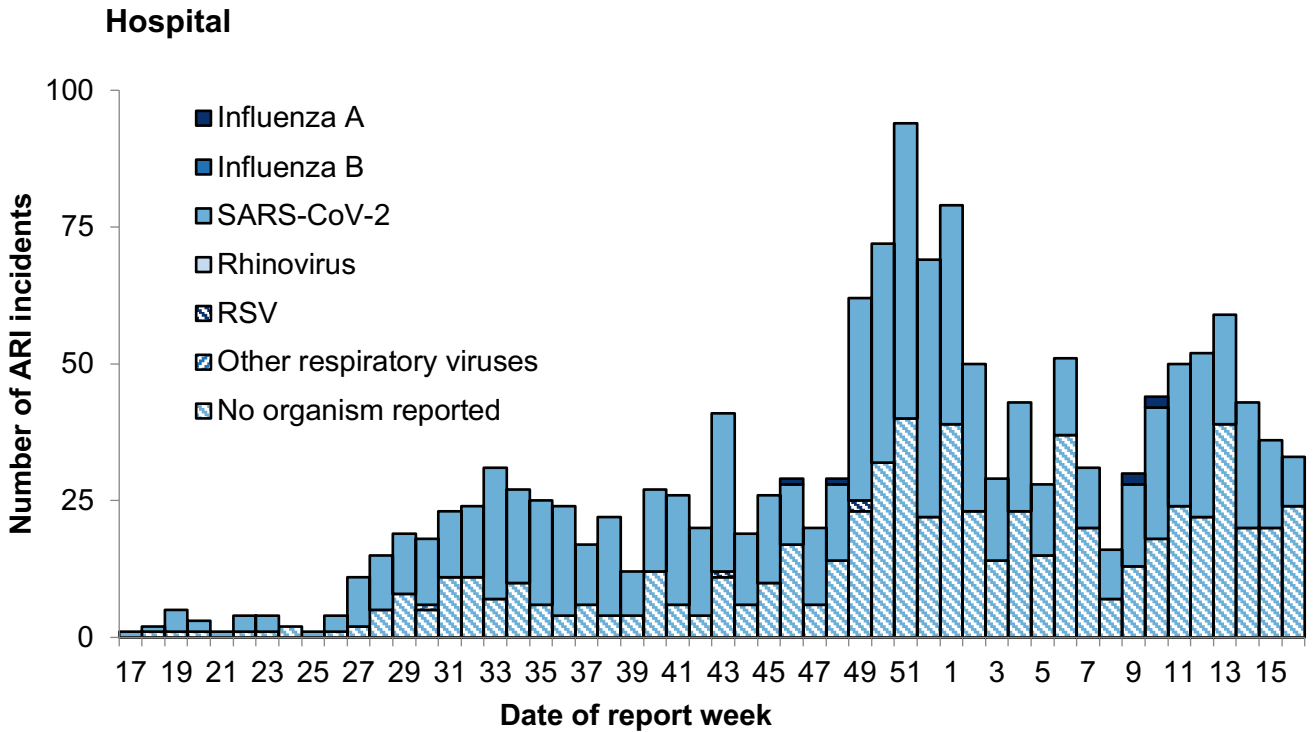


Figure 23: Number of acute respiratory infection (ARI) incidents in educational settings by virus type, England

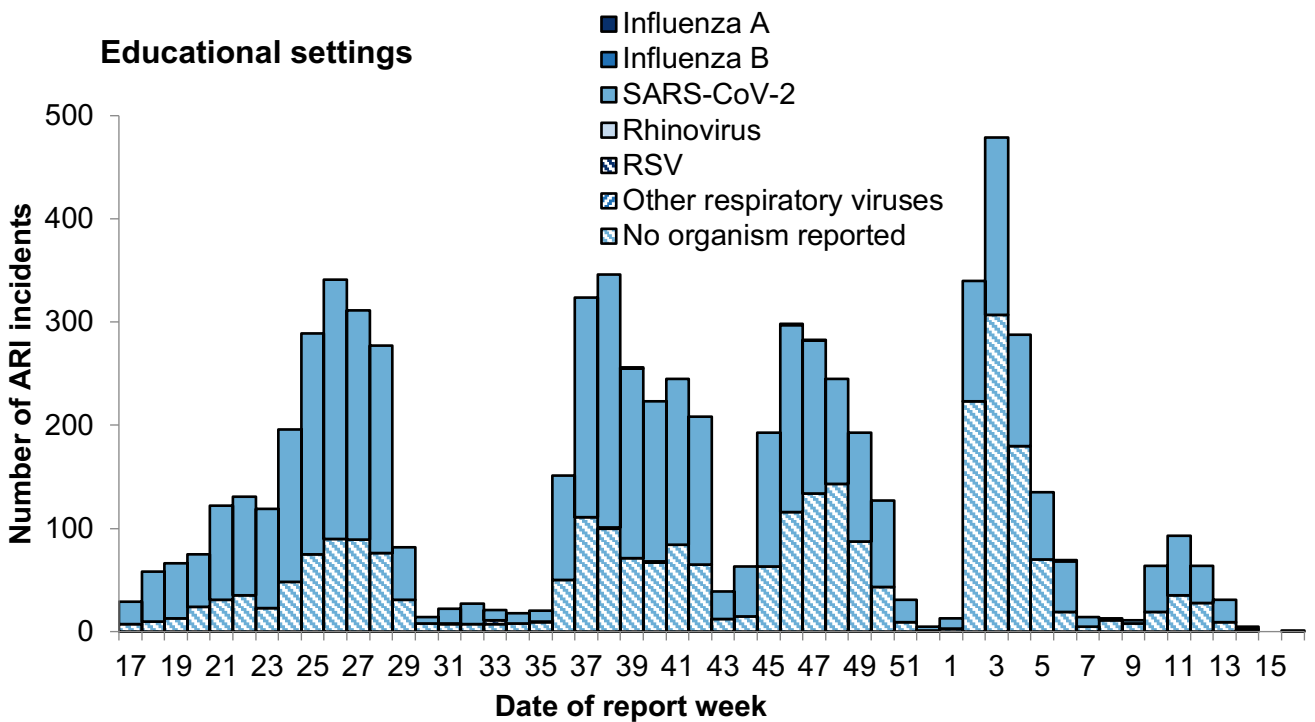


Figure 24: Number of acute respiratory infection (ARI) incidents in prisons by virus type, England

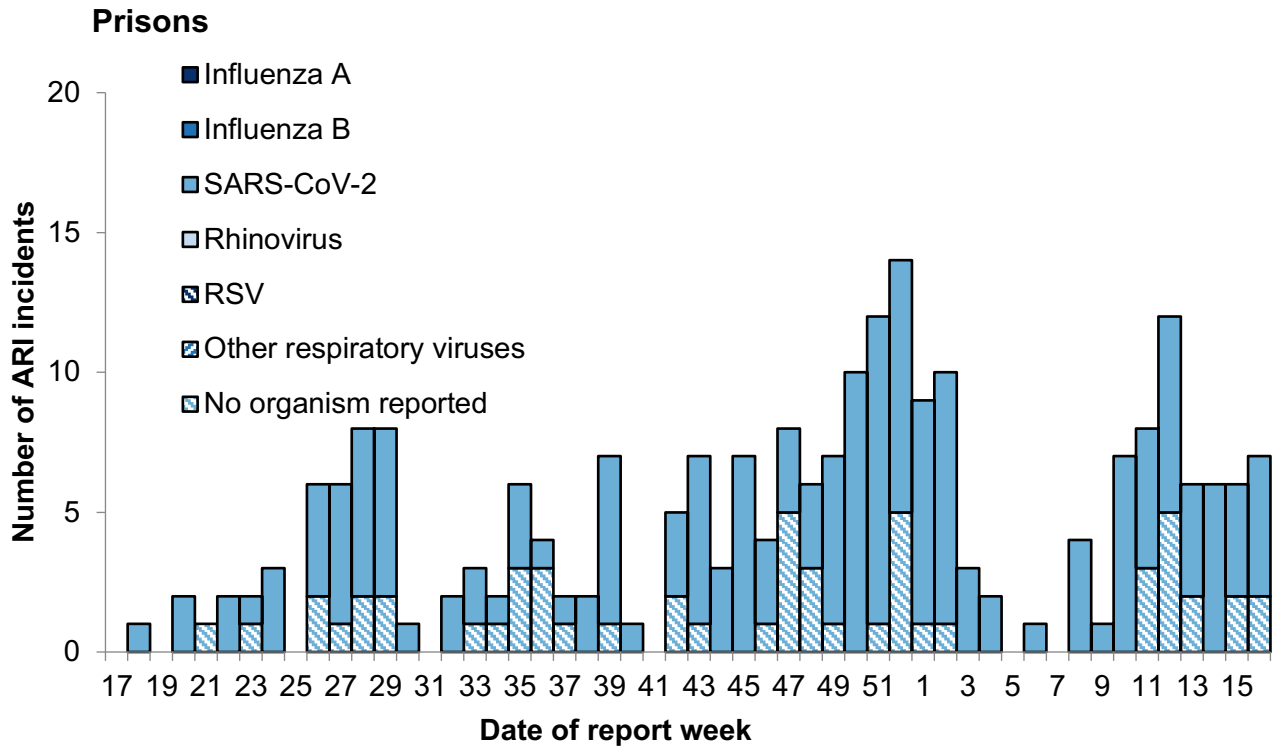


Figure 25: Number of acute respiratory infection (ARI) incidents in workplace settings by virus type, England

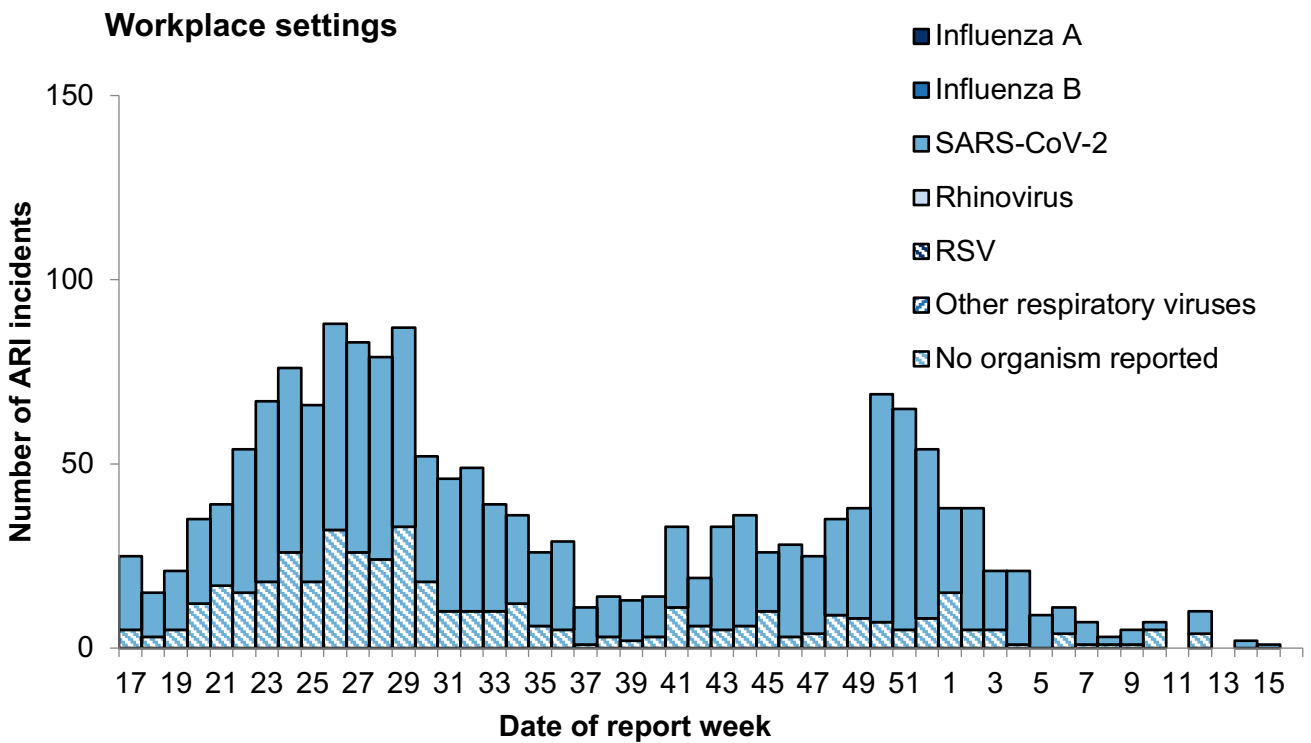


Figure 26: Number of acute respiratory infection (ARI) incidents in food outlet or restaurant settings by virus type, England

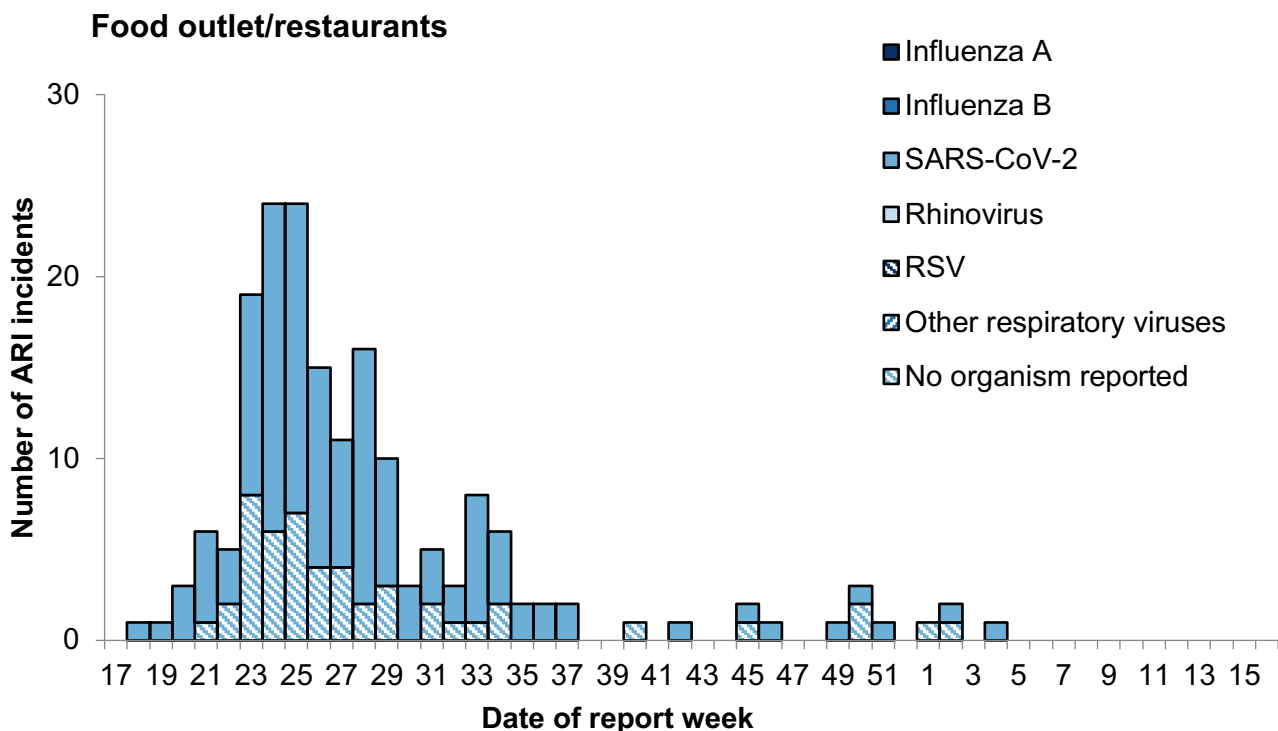


Figure 27: Number of acute respiratory infection (ARI) incidents in other settings by virus type from, England

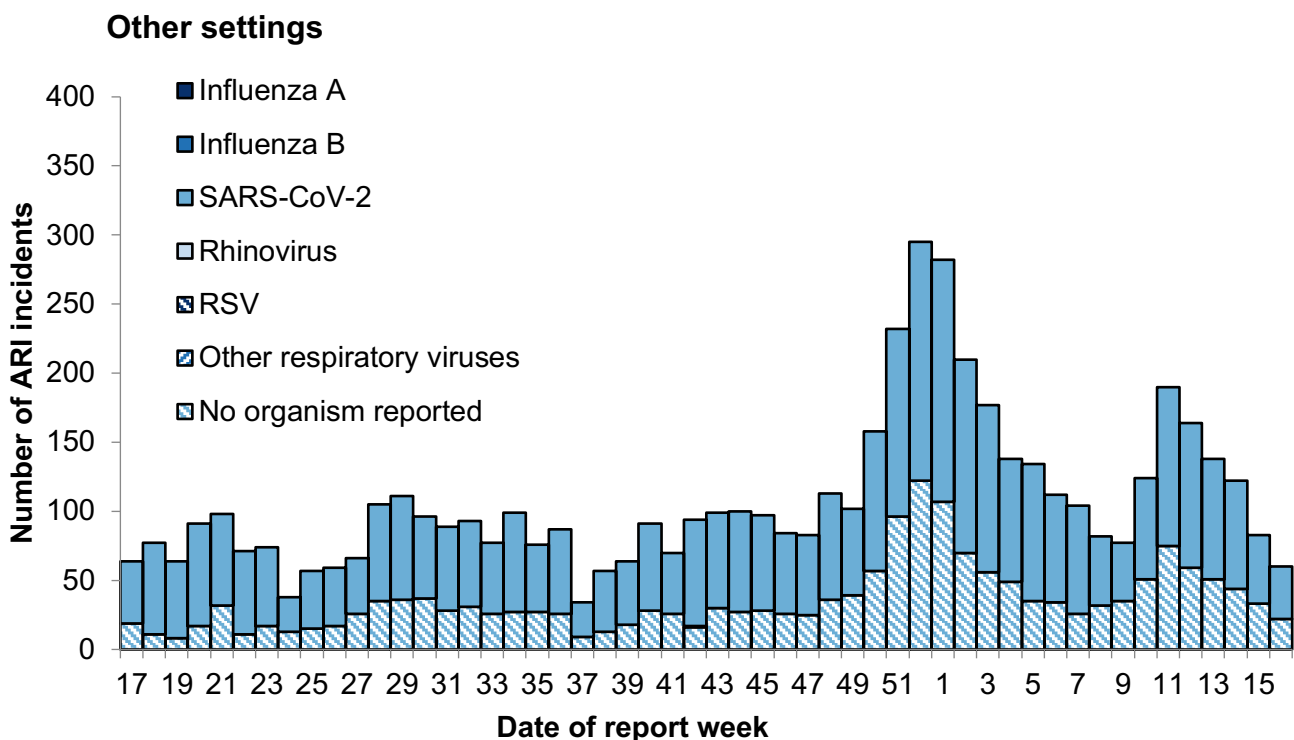


Table 2: Total number of situations and incidents by institution and UKHSA Centres over the past 4 weeks with the total number in the last week in brackets

UKHSA Centres	Care home	Hospital	Educational settings	Prisons	Workplace settings	Food outlet/ restaurant settings	Other settings	Total
East of England	211(40)	4(1)	0(0)	5(2)	0(0)	0(0)	92(13)	312(56)
East Midlands	278(44)	17(3)	6(0)	2(1)	0(0)	0(0)	75(13)	378(61)
London	133(17)	120(27)	9(1)	3(0)	1(0)	0(0)	46(6)	312(51)
North East	89(12)	4(0)	1(0)	0(0)	0(0)	0(0)	16(1)	110(13)
North West	133(28)	6(1)	3(0)	0(0)	0(0)	0(0)	44(2)	186(31)
South East	390(47)	9(1)	2(0)	4(0)	0(0)	0(0)	41(3)	446(51)
South West	581(102)	1(0)	12(0)	1(0)	0(0)	0(0)	20(6)	615(108)
West Midlands	50(9)	7(0)	3(0)	5(1)	0(0)	0(0)	12(3)	77(13)
Yorkshire and Humber	235(40)	3(0)	1(0)	5(3)	2(0)	0(0)	57(13)	303(56)
Total	2100(339)	171(33)	37(1)	25(7)	3(0)	0(0)	403(60)	2739(440)

FluSurvey

An internet-based surveillance system has been developed based on FluSurvey. FluSurvey is a web tool survey designed to monitor trends of influenza-like illness (ILI) in the community using self-reported respiratory symptoms from registered participants. The platform has been adapted to capture respiratory symptoms, exposure risk and healthcare seeking behaviours among registered participants to contribute to national surveillance of COVID-19 activity as well as influenza activity since week 44 2020.

Note: 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.

A total of 2,440 participants completed the weekly surveillance survey in week 16, of which 190 (7.8%) reported fever or cough and 48 (2.0%) reported ILI. The most commonly used healthcare services reported by respondents remains telephoning a GP practice (Figure 28).

Self-reported daily social contact patterns are also reported. A contact is defined as a person outside the household who is approached at a distance of less than one metre, on the day prior to survey completion.

Figure 28: FluSurvey participants self-reporting fever or cough and ILI symptoms, and trends in healthcare seeking behaviour among these participants, England

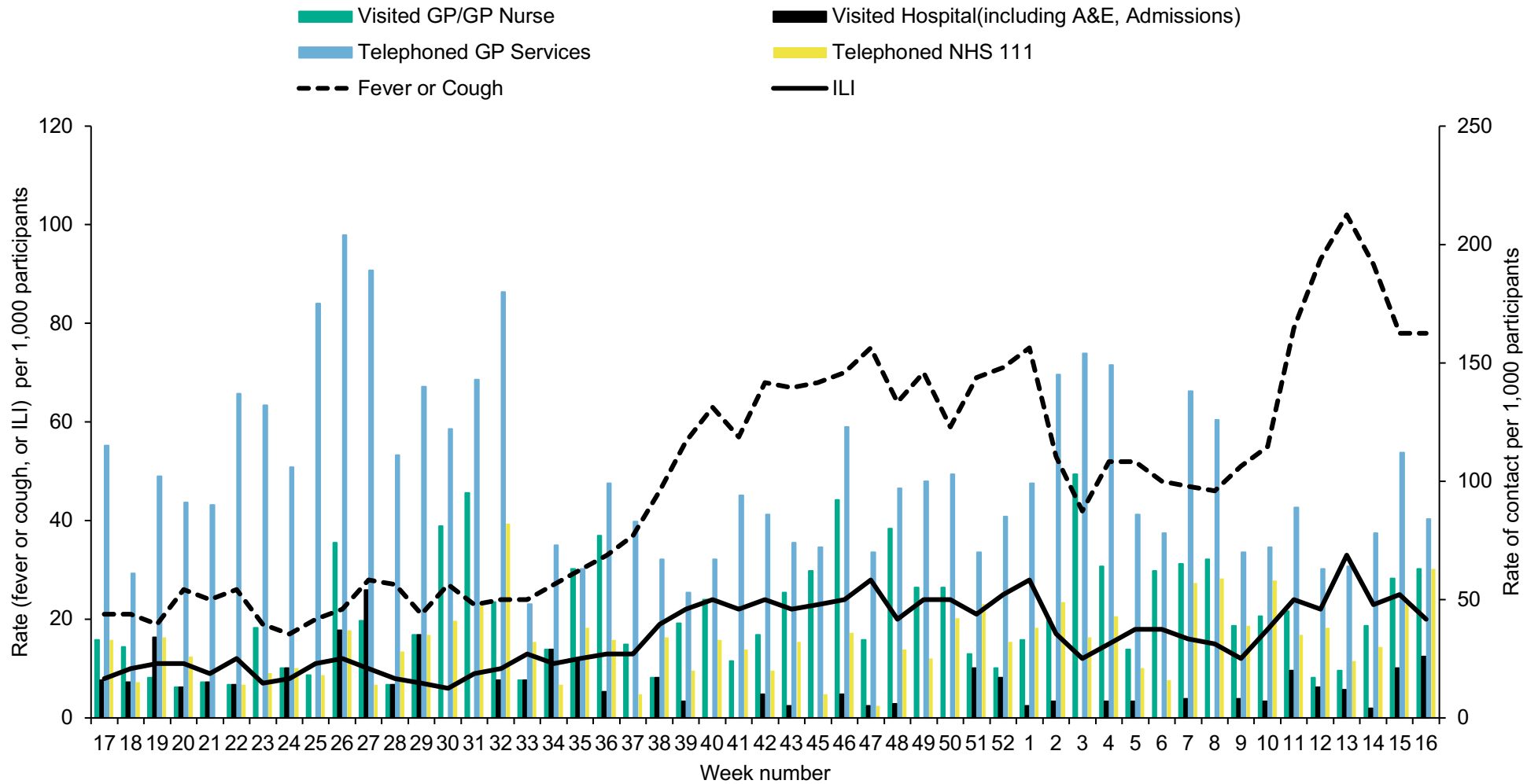
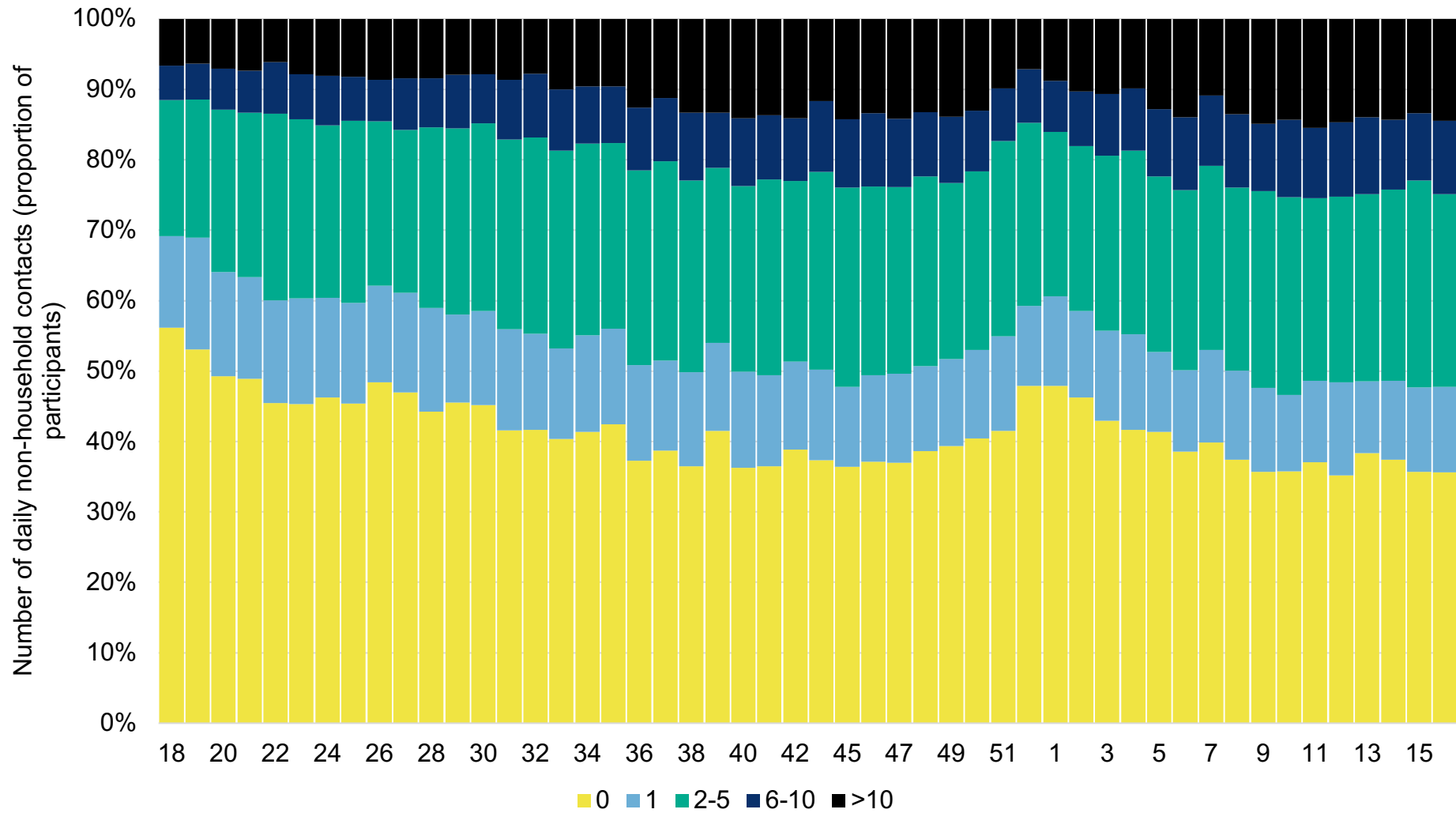


Figure 29: FluSurvey participants' self-reported number of social contacts outside the household



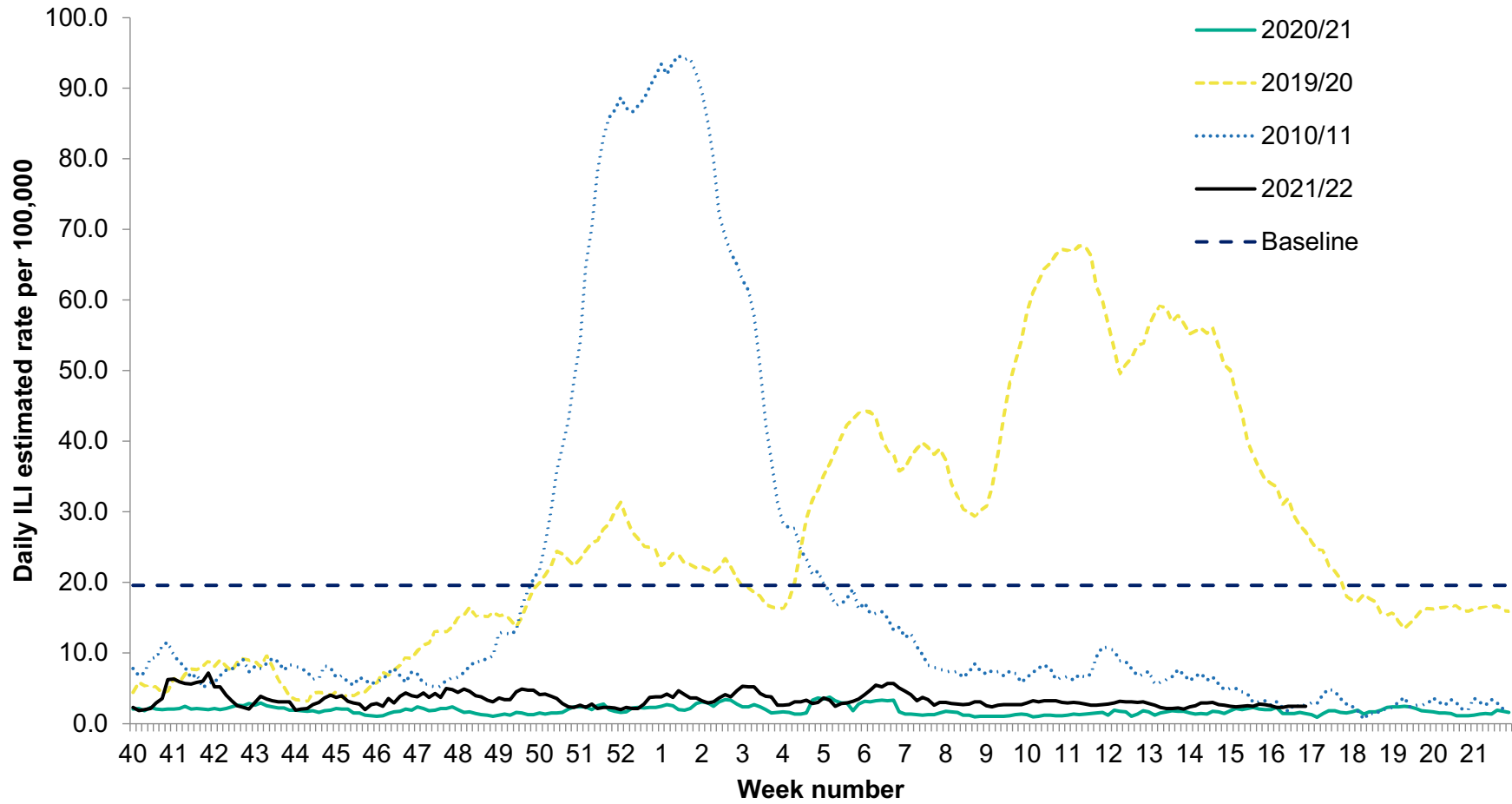
FluDetector

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

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

For week 16, the daily ILI rate remained low and below the baseline threshold of 19.6 per 100,000 for the 2021 to 2022 season (Figure 30).

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

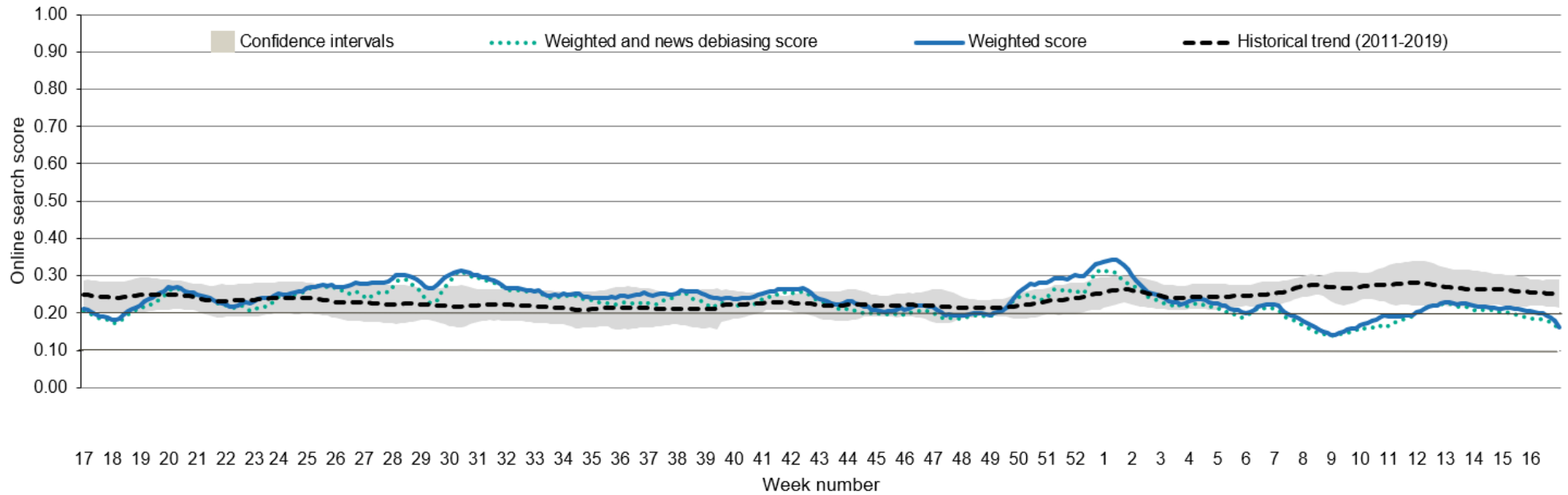


Google search queries

This is a web-based syndromic surveillance system which uses daily search query frequency statistics obtained from the Google Health Trends API. 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 16, the overall and media-debiasing weighted Google search decreased (Figure 31).

Figure 31: Normalised Google search score for COVID-19 symptoms, with weighted score for media-debiasing and historical trend, England



NHS 111

Please note that different syndromic surveillance indicators (NHS 111, GP in hours, GP out of hours and emergency department attendances) are presented here than have been included in previous versions of this report. All indicators previously presented will continue to be published in the [Syndromic Surveillance bulletins](#).

The [NHS 111 service](#) monitors daily trends in phone calls made to the service in England, to capture trends in infectious diseases such as influenza and norovirus.

Up to 24 April, NHS 111 calls for cold or flu decreased. Calls for cold or flu are still above expected levels for this time of year (Figure 32 and 33).

Please note that NHS 111 callers (from 11 May 2020) who are assessed as having probable COVID-19 symptoms are now triaged using symptom specific pathways such as cold or flu, which are included in routine syndromic indicators.

Further information about these caveats is available from the [Remote Health Advice Syndromic Surveillance bulletin](#).

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

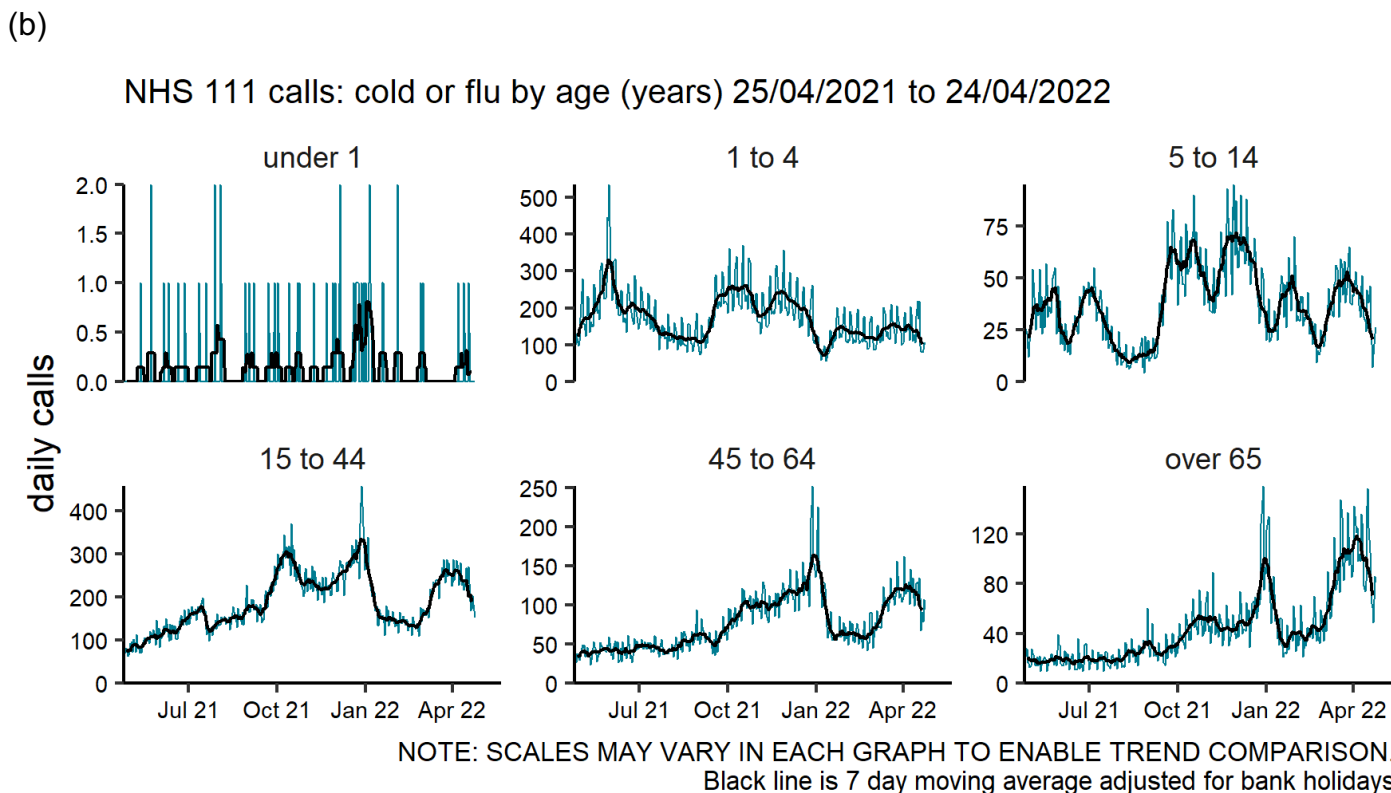
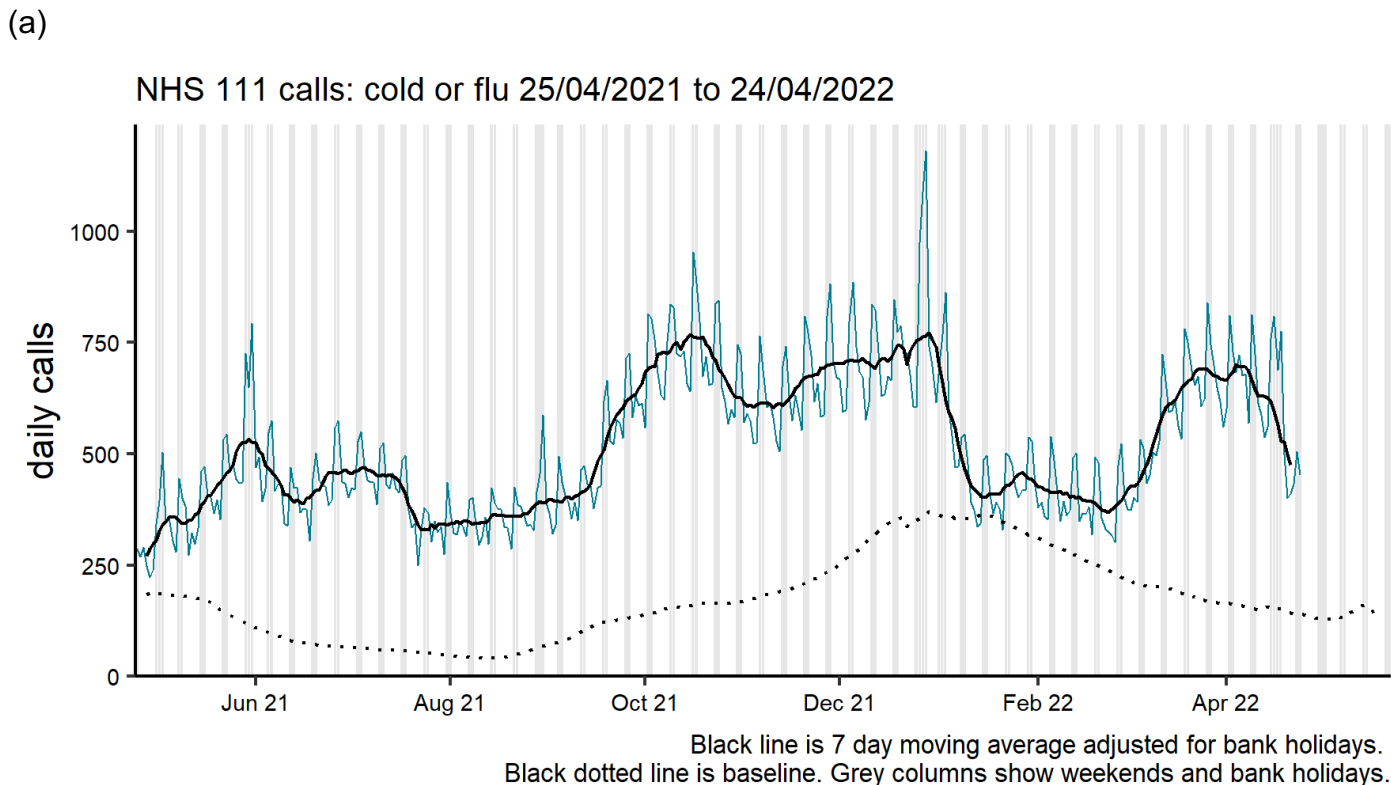
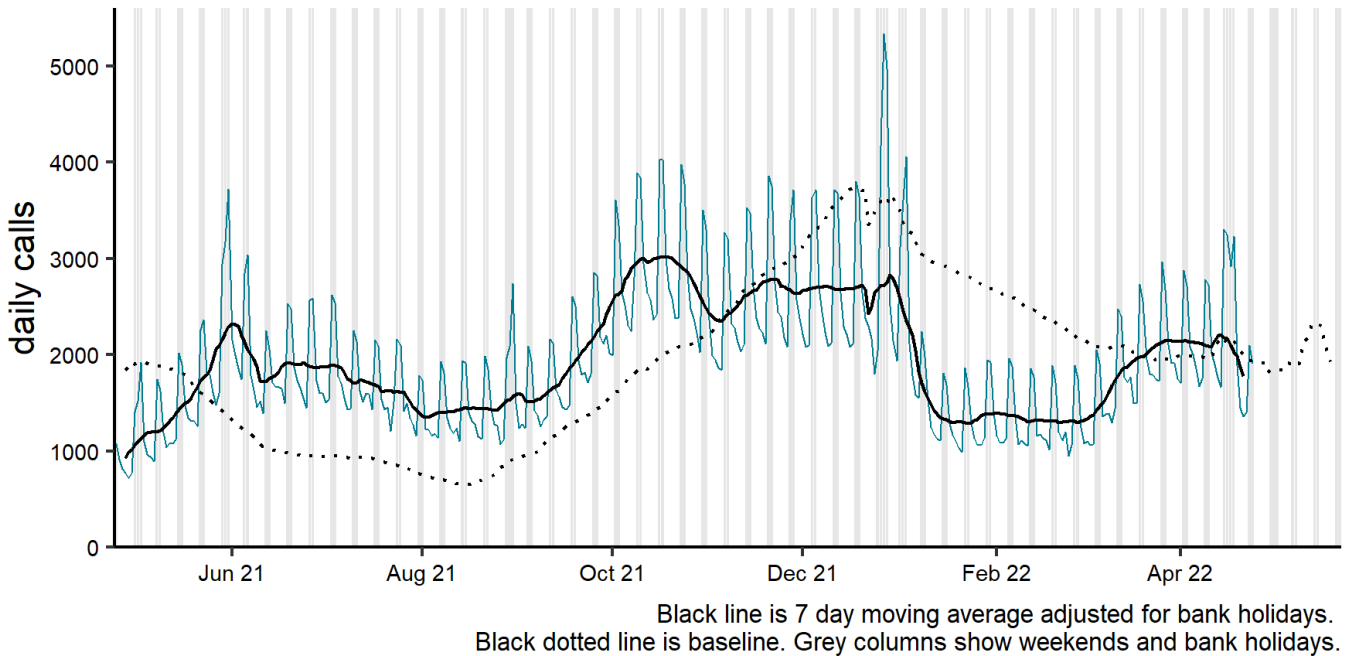


Figure 33: NHS 111 telephony indicators (and 7-day moving average) for number of daily cough calls, England (a) nationally and (b) by age group

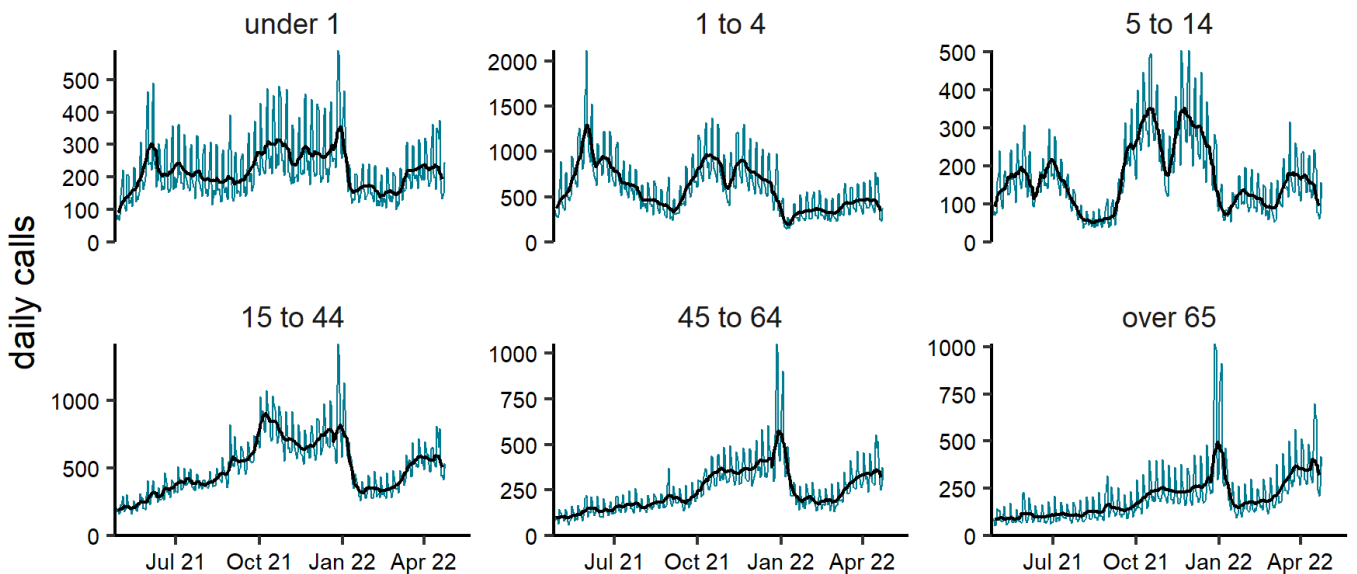
(a)

NHS 111 calls: cough 25/04/2021 to 24/04/2022



(b)

NHS 111 calls: cough by age (years) 25/04/2021 to 24/04/2022



NOTE: SCALES MAY VARY IN EACH GRAPH TO ENABLE TREND COMPARISON.
Black line is 7 day moving average adjusted for bank holidays.

Primary care surveillance

RCGP (England)

The weekly ILI consultation rate through the RCGP surveillance was 1.5 per 100,000 registered population in participating GP practices in week 16 compared to 1.4 per 100,000 in the previous week. This is below the baseline threshold (12.2 per 100,000) (Figure 34). By age group, the highest rates were seen in the 75 year olds and over (2.3 per 100,000). The Lower Respiratory Tract Infections (LRTI) consultation rate was at 40.5 per 100,000 in week 16, compared to the rate of 41.3 per 100,000 in the previous week. The COVID-19 indicator rate was at 137.2 per 100,000 in week 16 compared to a rate of 142.8 per 100,000 in the previous week (Figure 35).

Figure 34: RCGP ILI consultation rates, all ages, England

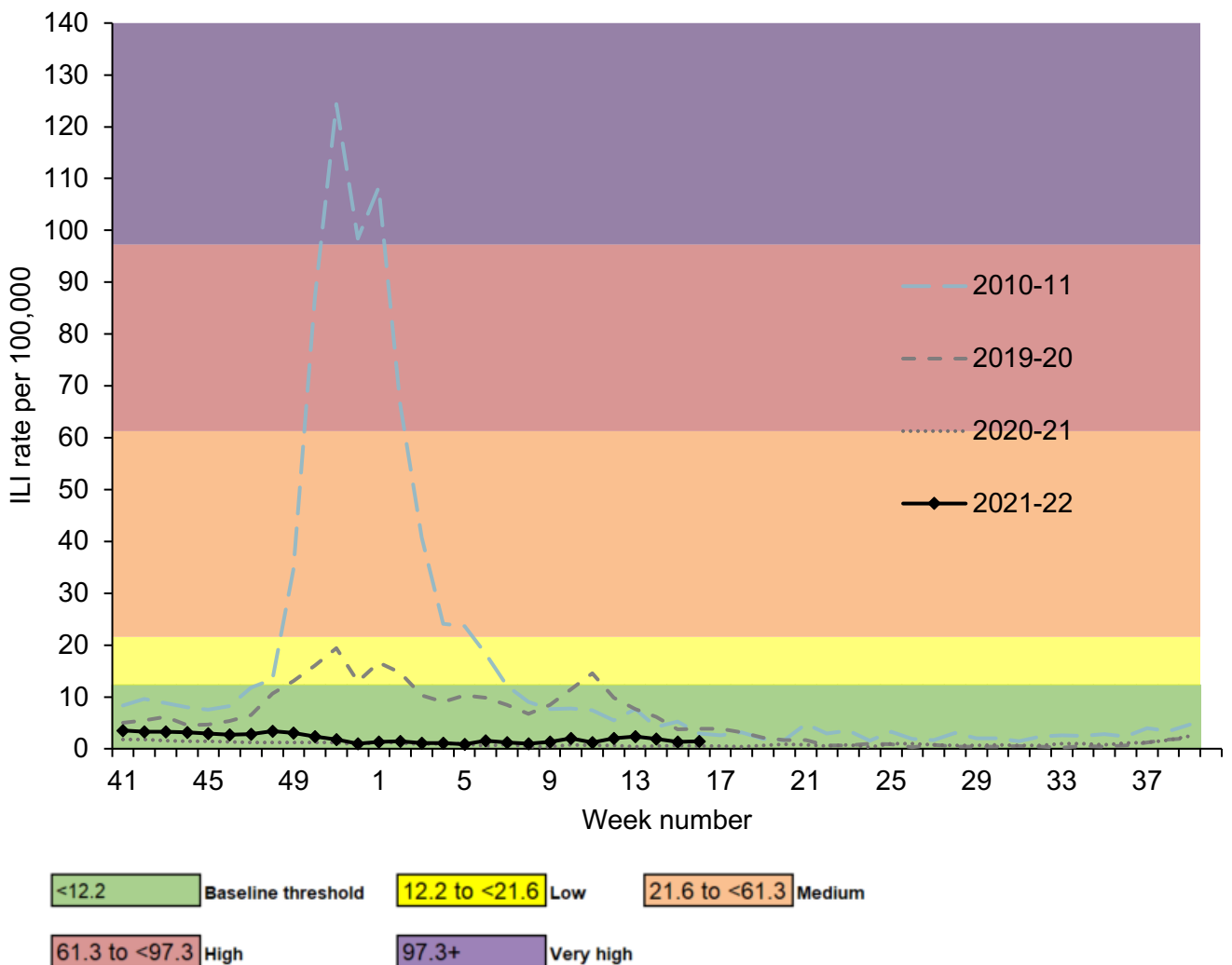
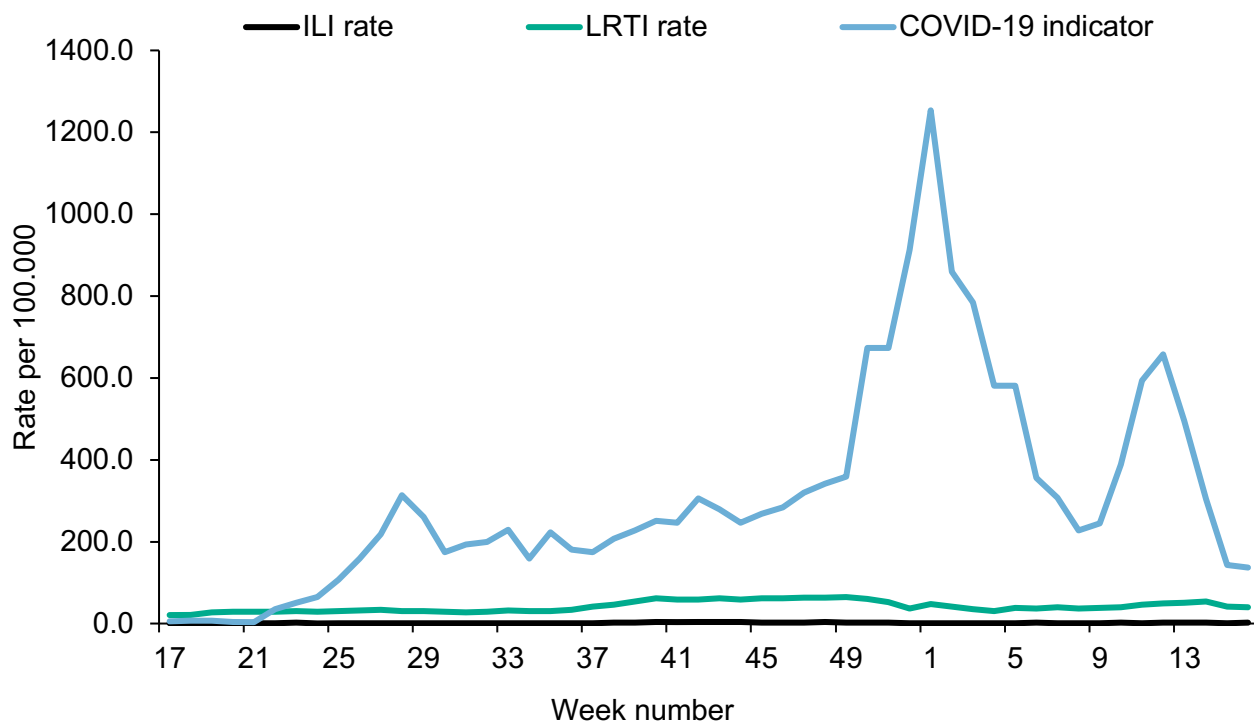


Figure 35: RCGP ILI, LRTI and COVID-19 indicator rates, England



UK

Overall, weekly ILI consultations rates were below baseline levels in all UK schemes (Table 3).

By age group, the highest rates were seen in the 75 year olds and over in Scotland (2.9 per 100,000) and in the 1 to 4 year olds in Northern Ireland (2.4 per 100,000).

Table 3: GP ILI consultations in the UK for all ages with MEM thresholds applied

GP ILI consultation rates (all ages)	Week number															
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
England (RCGP)	1.3	1.4	1.1	1.0	0.9	1.6	1.2	1.0	1.3	2.0	1.2	2.0	2.4	1.8	1.4	1.5
Wales	1.2	0.7	0.5	0.7	1.7	1.8	0.8	1.2	3.0	0.7	2.3	1.9	2.0	1.7		
Scotland	0.6	0.9	0.6	0.7	0.5	0.5	0.7	0.8	0.9	2.6	3.3	1.4	2.8	4.1	0.8	0.9
Northern Ireland	1.5	1.3	1.3	0.8	0.8	0.9	1.3	0.9	1.0	1.0	0.7	1.3	1.4	0.7	0.9	0.5

Baseline threshold

Low

Medium

High

Very high

The Moving Epidemic Method (MEM) has been adopted by the European Centre for Disease Prevention and Control to calculate thresholds for GP ILI consultations for the start of influenza activity (based on 10 seasons excluding 2009 to 2010), in a standardised approach across Europe. For MEM threshold values for each country, please visit the webpage [Sources of UK flu data: influenza surveillance in the UK](#).

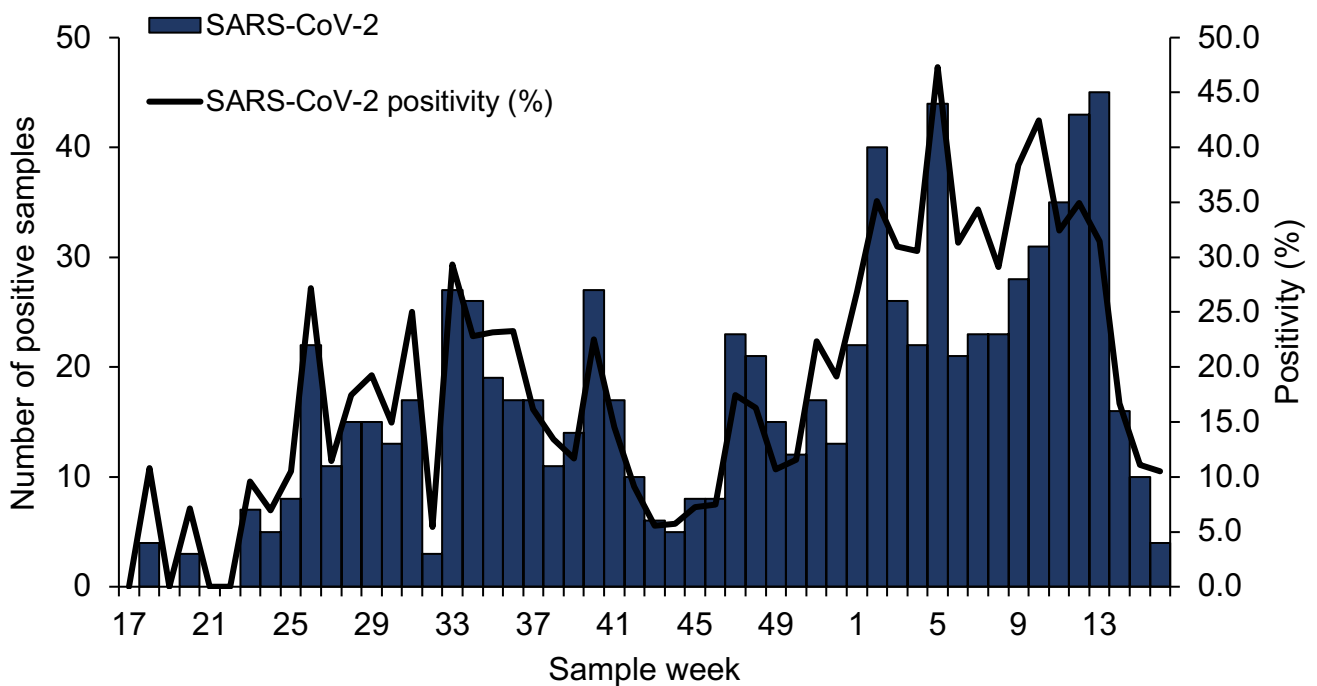
Sentinel swabbing scheme in the UK

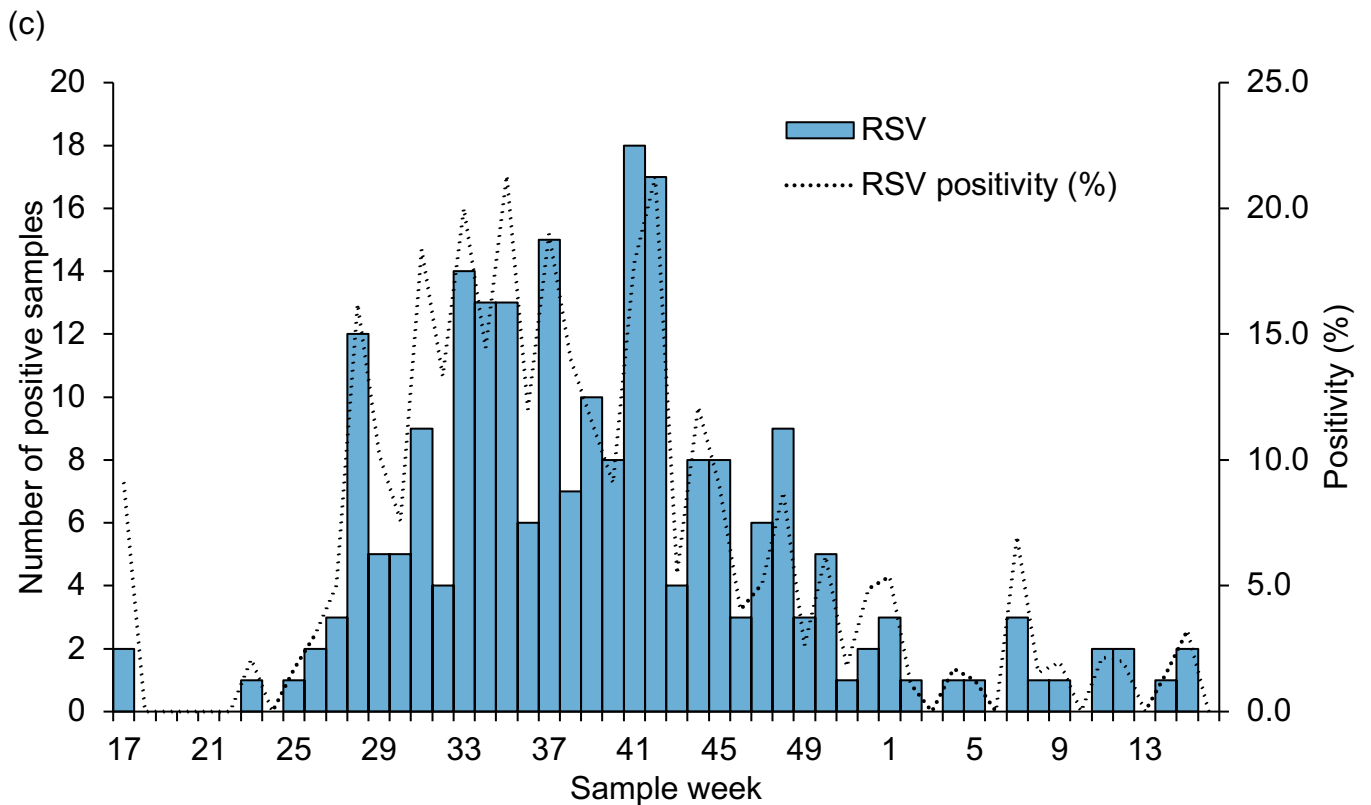
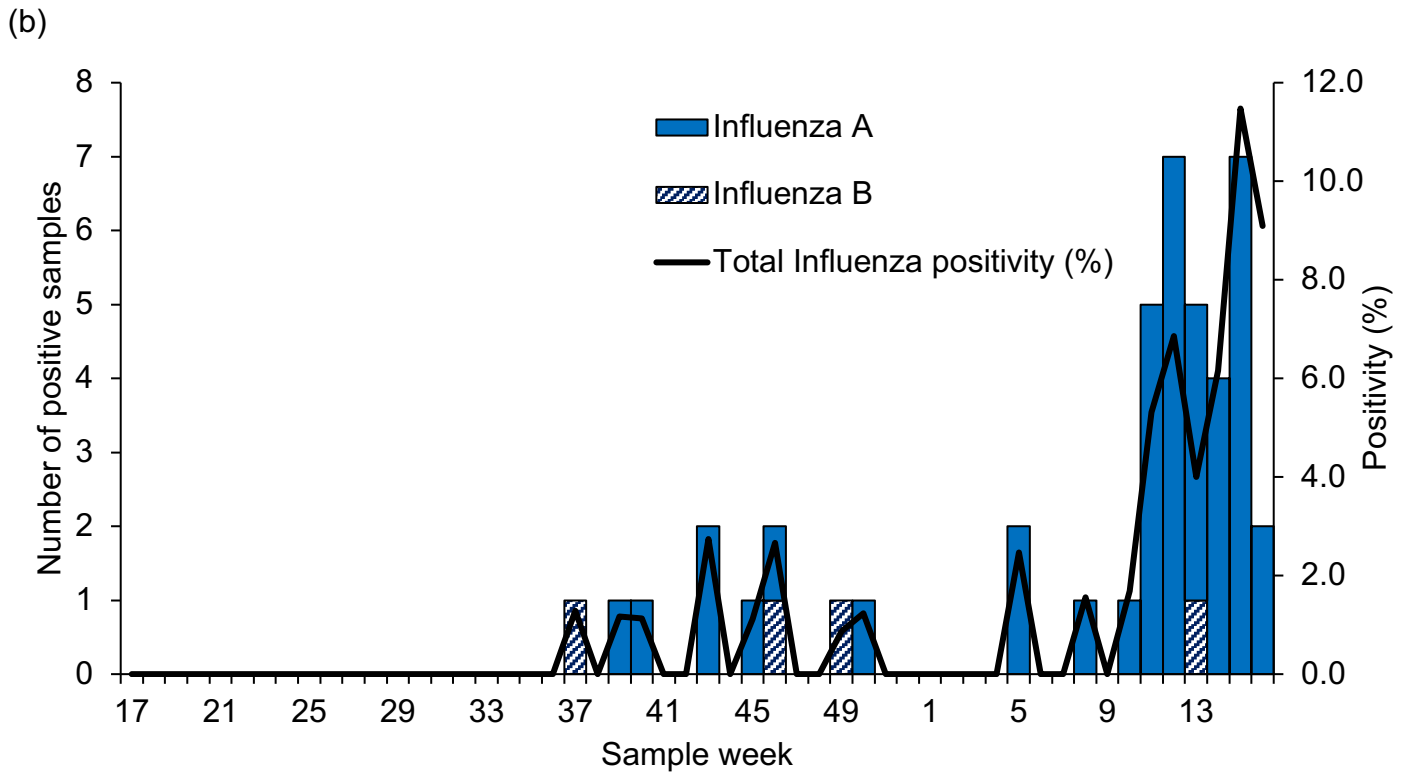
In week 16 2022, 4 samples tested positive for SARS-CoV-2 with an overall positivity of 10.5% (4 out of 38) through the UK GP sentinel swabbing schemes (Figure 36).

In week 16, 2 samples tested positive for influenza in England through the GP sentinel swabbing scheme with an overall positivity of 9.1% (2 out of 22), and no samples tested positive for RSV in England, with an overall positivity of 0.0% (0 out of 22).

Figure 36: Number of positive samples and weekly positivity (%) for (a) COVID-19 and (b) Influenza and (c) RSV, GP sentinel swabbing scheme

(a)





*For the most recent week, more samples are expected to be tested therefore the graphs in Figure 36 should be interpreted with caution

*Positivity (%) is not calculated when the total number tested is less than 10

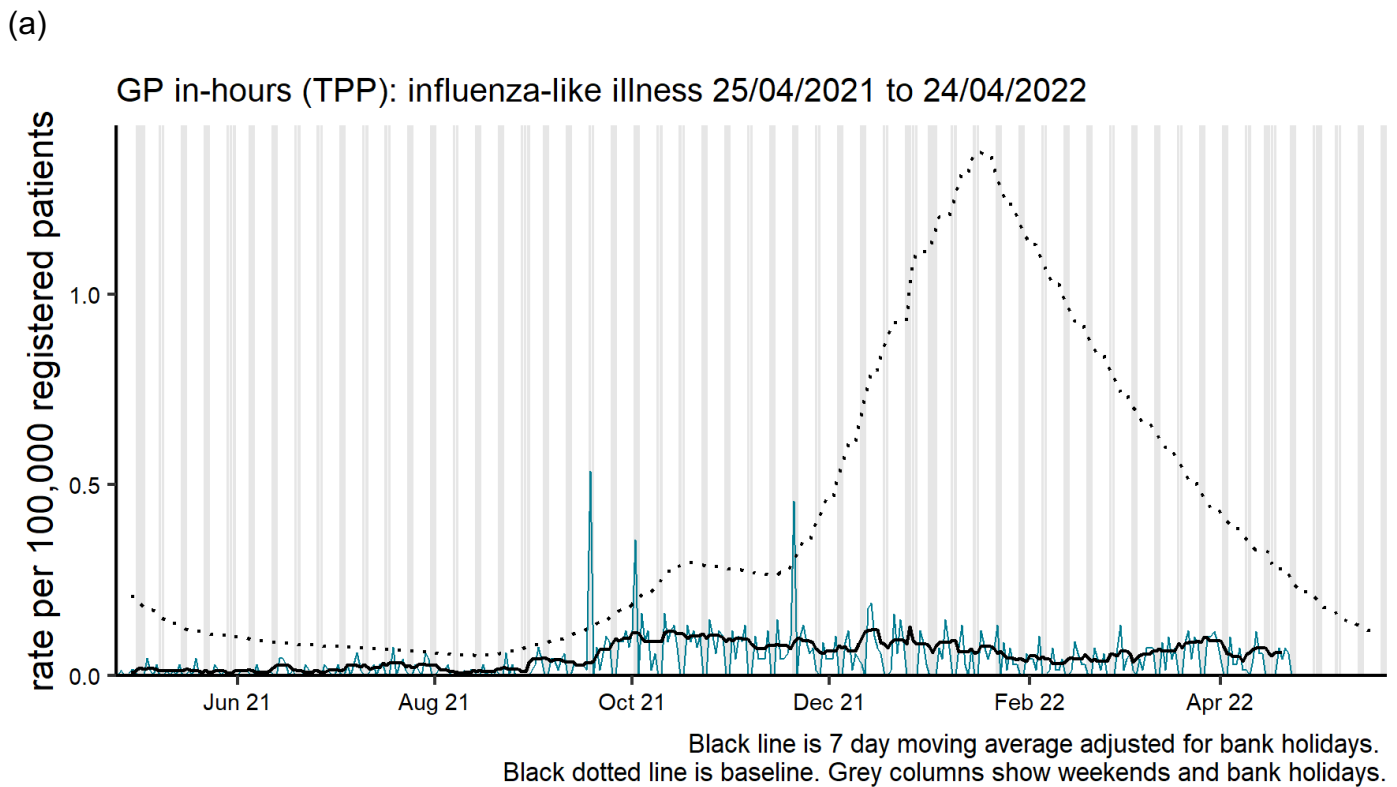
GP In Hours, Syndromic Surveillance

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

Up to 24 April, GP in-hours consultations for influenza-like illness remained stable and below seasonal baselines (Figure 37).

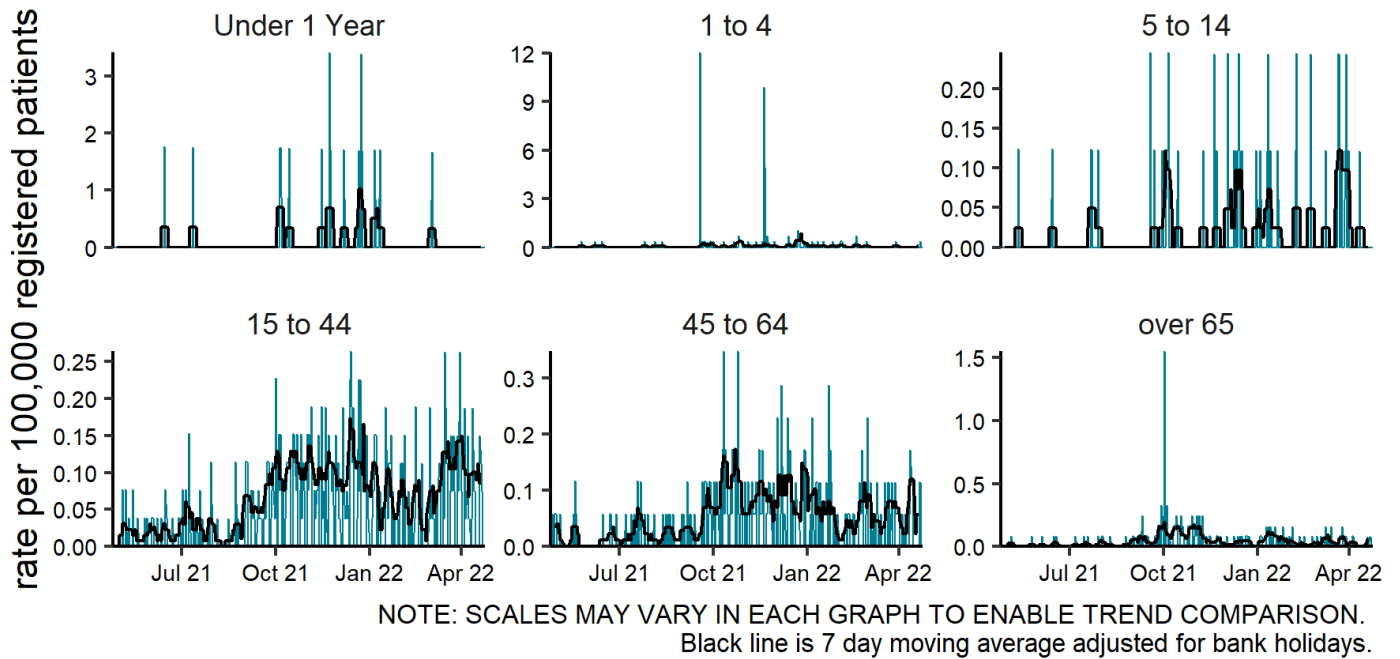
Further indicators and information about caveats are available from the [GP In Hours Syndromic Surveillance bulletin](#).

Figure 37: GPIH clinical indicators for influenza-like illness GP consultations, England (a) nationally, (b) by age group and (c) by UKHSA Centre



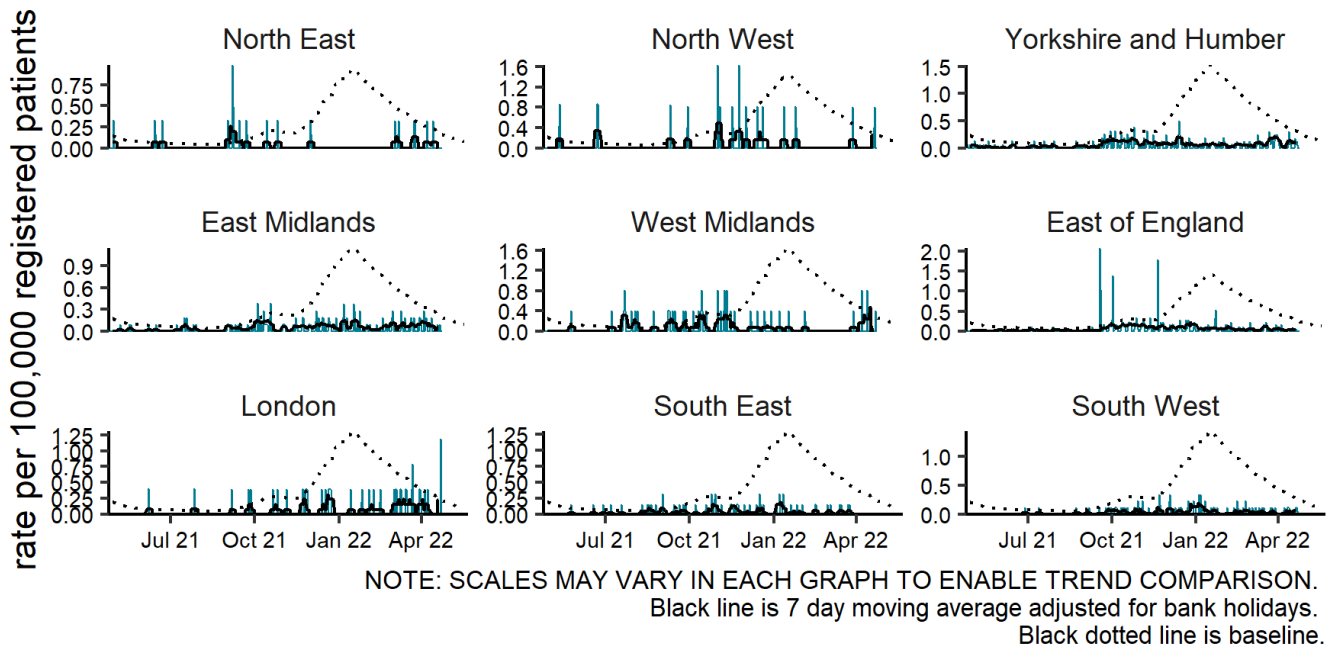
(b)

GP in-hours (TPP): influenza-like illness by age (years) 25/04/2021 to 24/04/2022



(c)

GP in-hours (TPP): influenza-like illness by region 25/04/2021 to 24/04/2022



GPIH Baselines are modelled from historical data to give current seasonally expected levels. GP consultations rates decreased during 2020 due to changes in guidance on accessing health care, therefore separate modelled estimates are provided to show seasonally expected levels pre-COVID-19.

GP Out of Hours, Syndromic Surveillance

The GP Out of Hours (GPOOH) syndromic surveillance system monitors the numbers of daily unscheduled visits and calls to GPs during evenings, overnight, on weekends and on public holidays. This system covers around 55% of England’s out of hour activity.

Up to 24 April, GP out-of-hours and unscheduled care consultations for influenza-like-illness remained stable but above seasonally expected levels. GP-out-of-hours national daily contacts for acute respiratory infection decreased (Figures 38 and 39).

Figure 38: GPOOH number of daily contacts for all ages for influenza-like illness, England

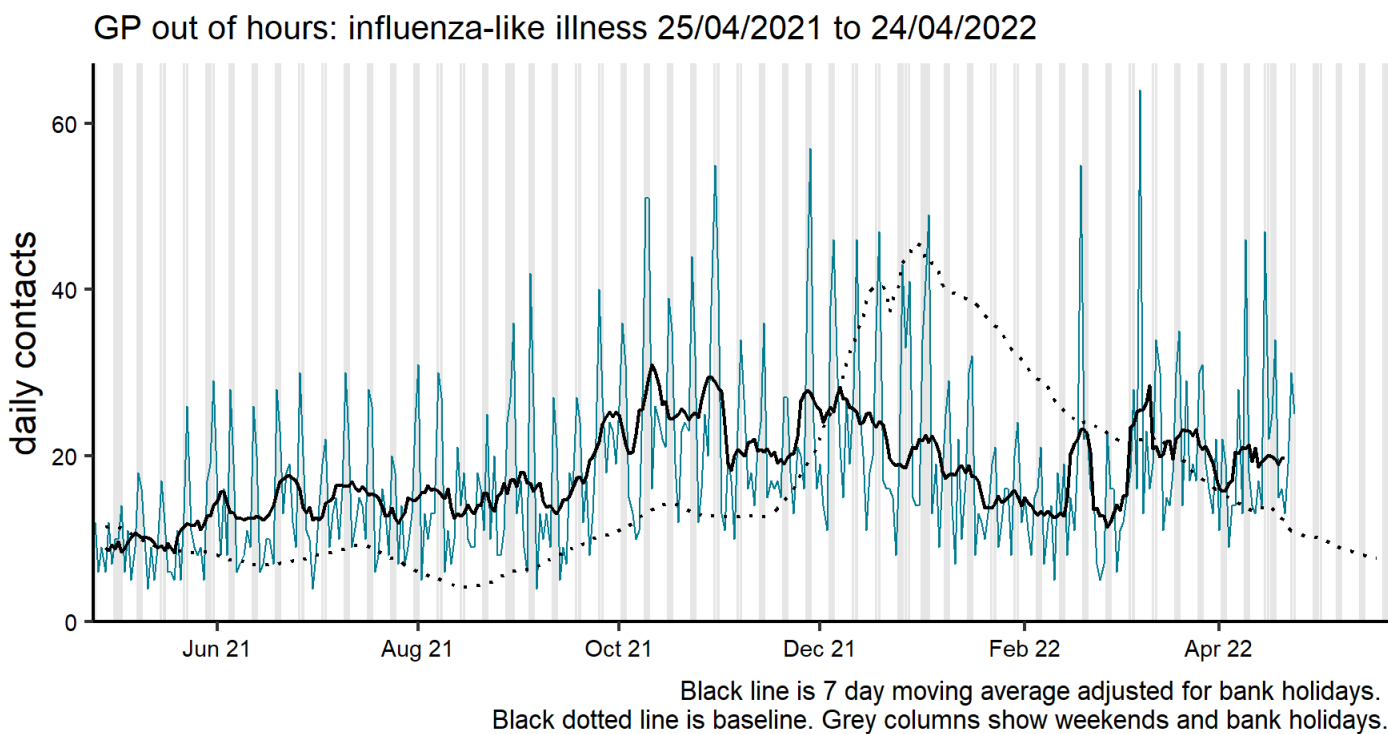
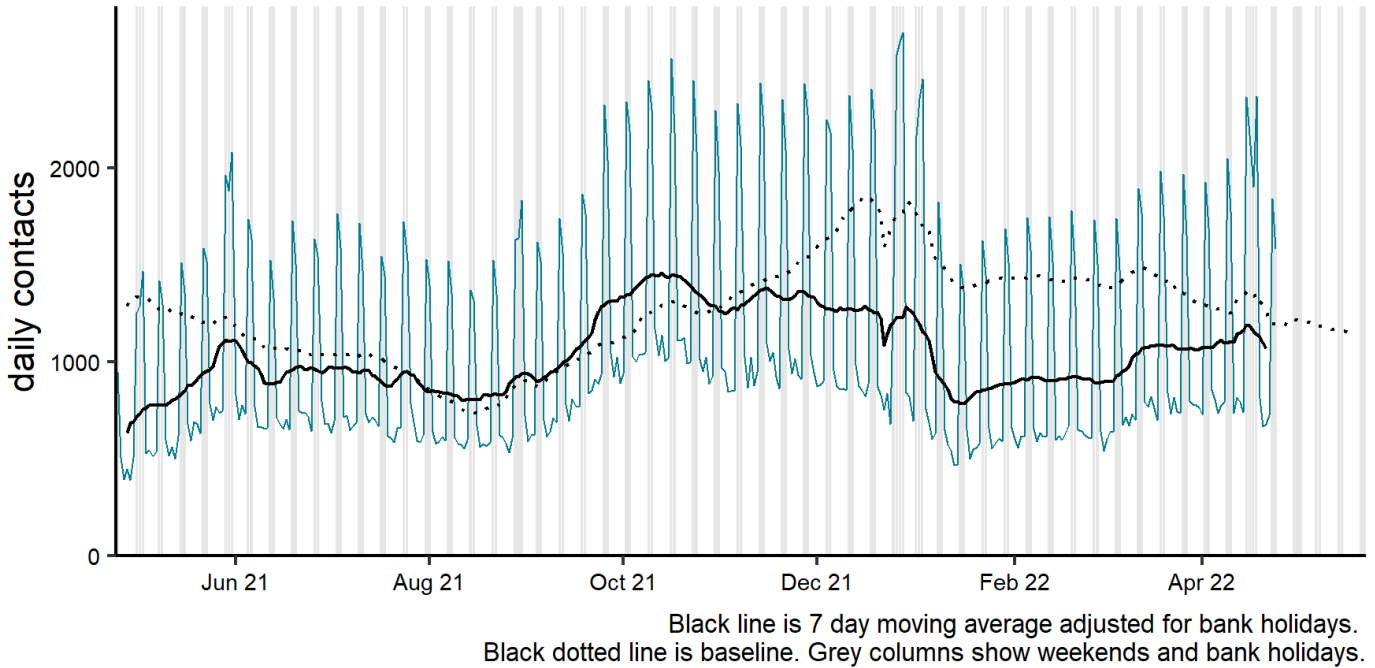


Figure 39: GPOOH number of daily contacts for acute respiratory infections, England (a) nationally and (b) by age group

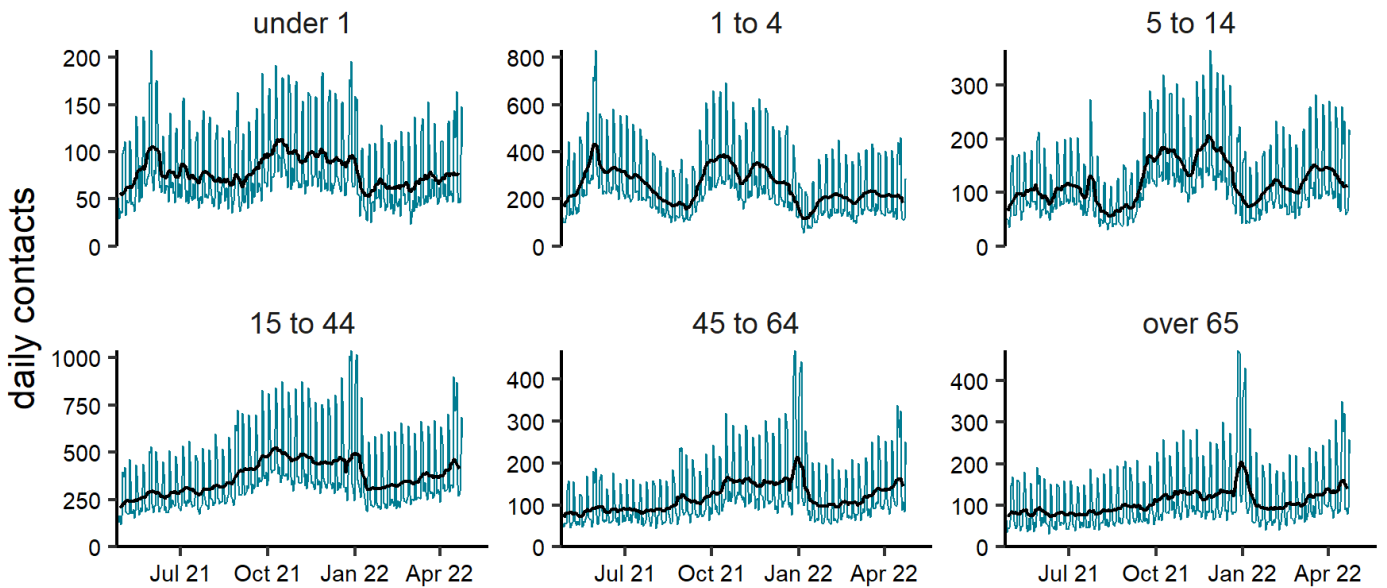
(a)

GP out of hours: acute respiratory infection 25/04/2021 to 24/04/2022



(b)

GP out of hours: acute respiratory infection by age (years) 25/04/2021 to 24/04/2022



NOTE: SCALES MAY VARY IN EACH GRAPH TO ENABLE TREND COMPARISON. Black line is 7 day moving average adjusted for bank holidays.

Secondary care surveillance

SARI Watch

The Severe Acute Respiratory Infection (SARI) Watch surveillance system was established in 2020 to report the number of laboratory-confirmed influenza and COVID-19 cases admitted to hospital and critical care units (ICU and HDU) in NHS acute trusts across England. This has replaced the UK Severe Influenza Surveillance Schemes (USISS) Mandatory and Sentinel data collections for influenza surveillance used in previous seasons, and the COVID-19 hospitalisations in England surveillance system (CHESS) collections for COVID-19 surveillance.

The weekly rate of new admissions of COVID-19, influenza and RSV cases is based on the trust catchment population of those NHS Trusts who made a new return. This may differ from other published figures such as the total number of people currently in hospital with COVID-19.

The Moving Epidemic Method (MEM) thresholds for influenza hospital and ICU or HDU admissions are calculated based on the 2014 to 2015 to the 2018 to 2019 seasons (data from 2019 to 2020 was excluded due to the COVID-19 pandemic). These thresholds have been applied to data from the 2019 to 2020 season onwards.

Trends in hospital and critical care admission rates need to be interpreted in the context of testing recommendations.

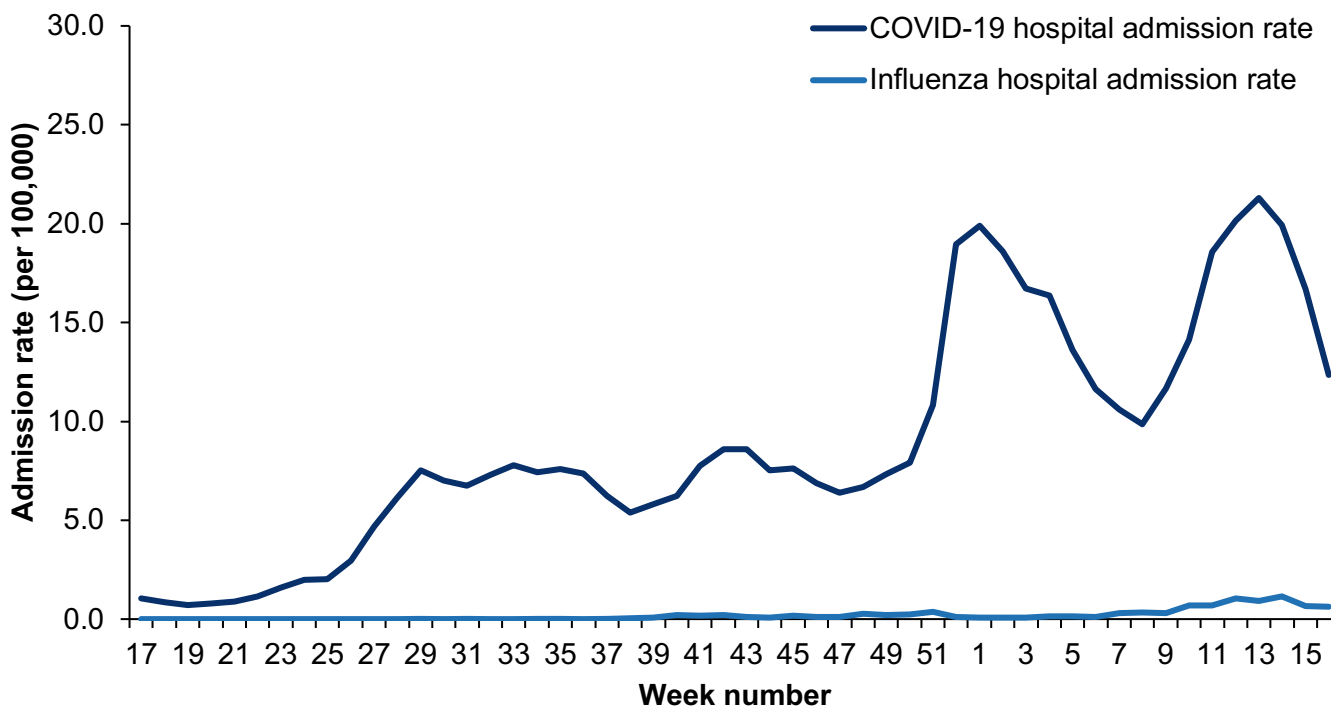
Hospitalisations, SARI Watch

In week 16, the overall weekly hospital admission rate for COVID-19 decreased. The hospitalisation rate for COVID-19 was at 12.35 per 100,000 in week 16 compared to 16.70 per 100,000 in the previous week.

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

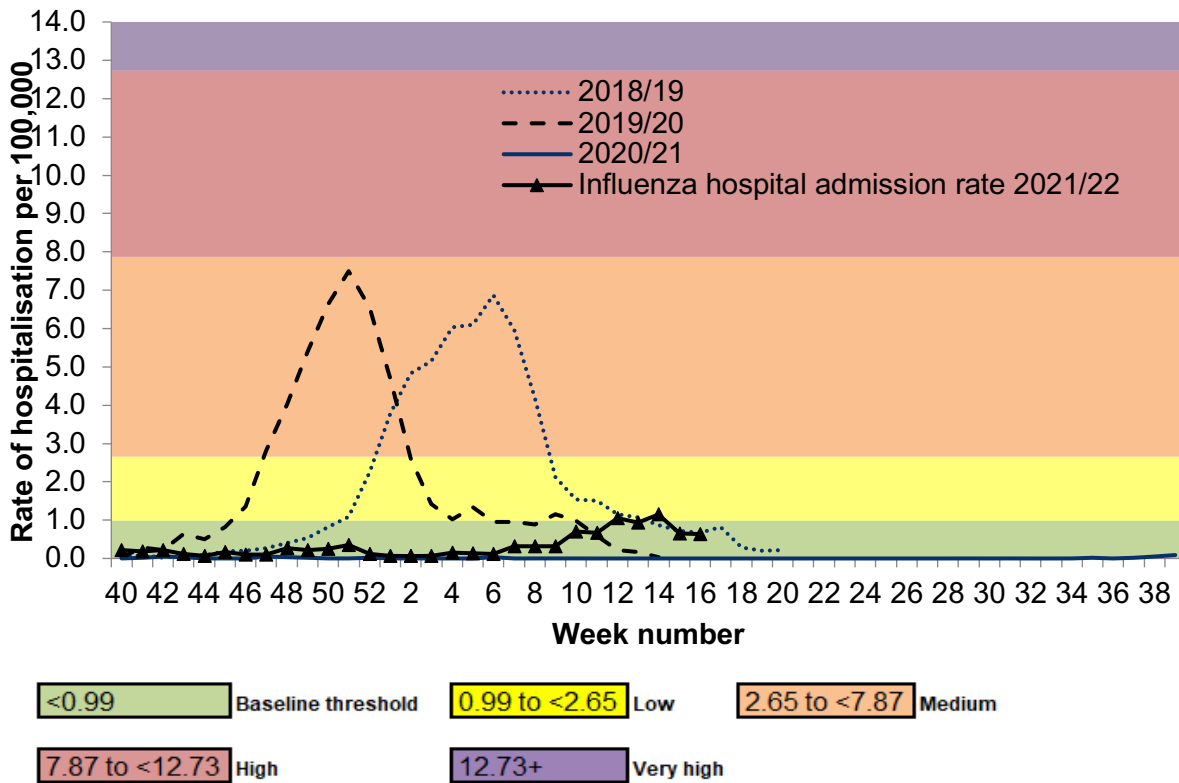
The hospitalisation rate for influenza was at 0.64 per 100,000 in week 16 compared to 0.66 per 100,000 in the previous week. There were 67 new hospital admissions to sentinel Trusts for influenza (22 influenza A(H3N2), 5 influenza A(H1N1)pdm09, 40 influenza A(not subtyped)) in week 16.

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



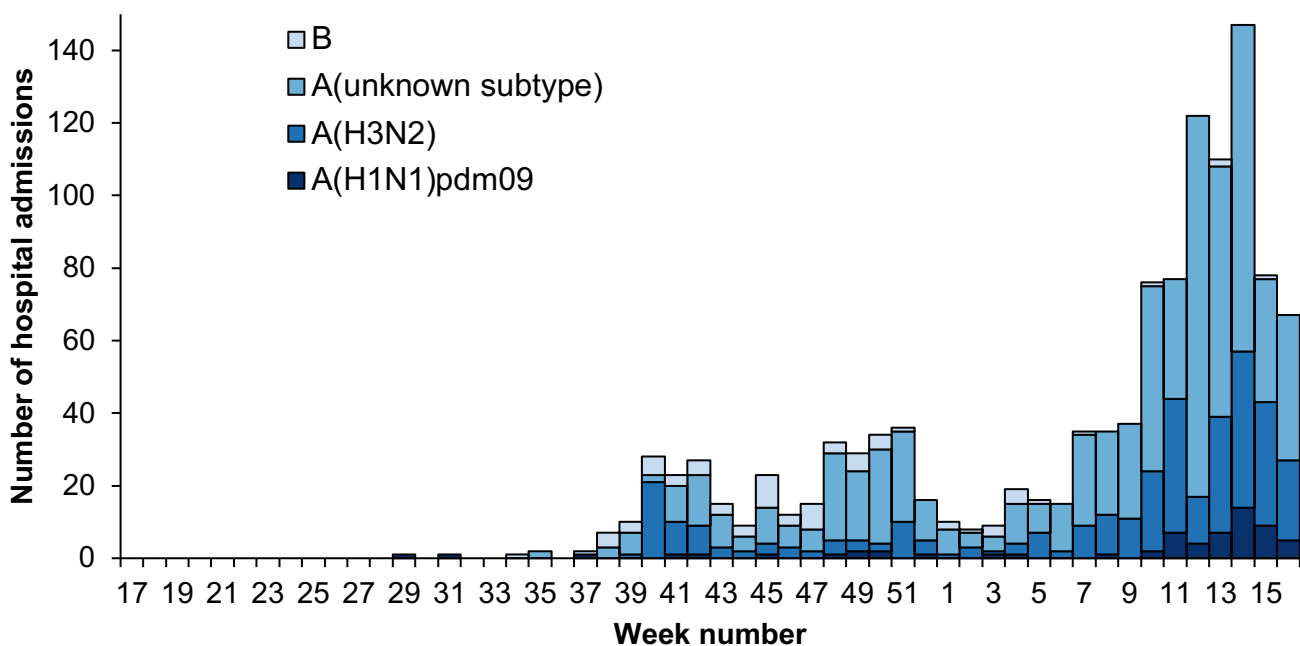
- * influenza hospital admission rate is reported from week 17 2021 onwards
- * influenza hospital admission rate based on 24 sentinel NHS trusts for week 16
- * COVID-19 hospital admission rate based on 106 NHS trusts for week 16
- * SARI Watch data is provisional

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



* MEM thresholds are based on data from the 2014 to 2015 to the 2018 to 2019 seasons (data from 2019 to 2020 was excluded due to the COVID-19 pandemic).

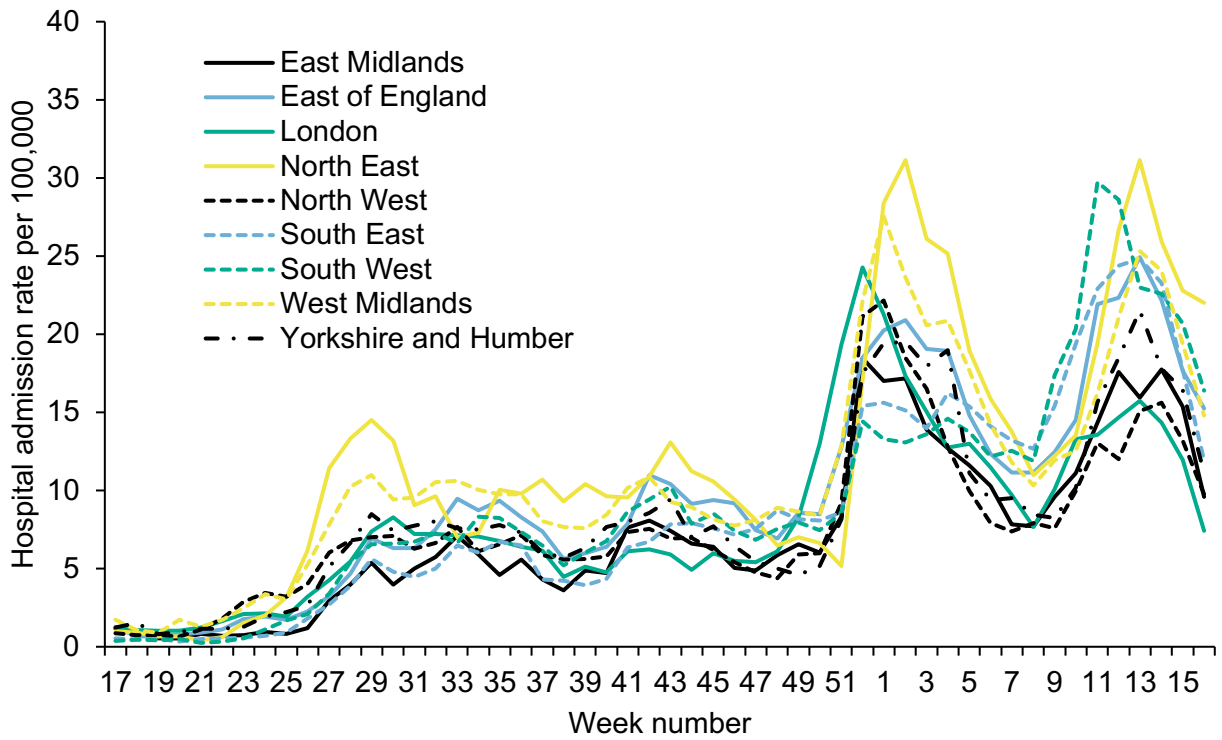
Figure 42: Weekly influenza hospital admissions by influenza type, SARI Watch, England



*number of influenza hospital admissions based on sentinel NHS trusts

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

(a)



(b)

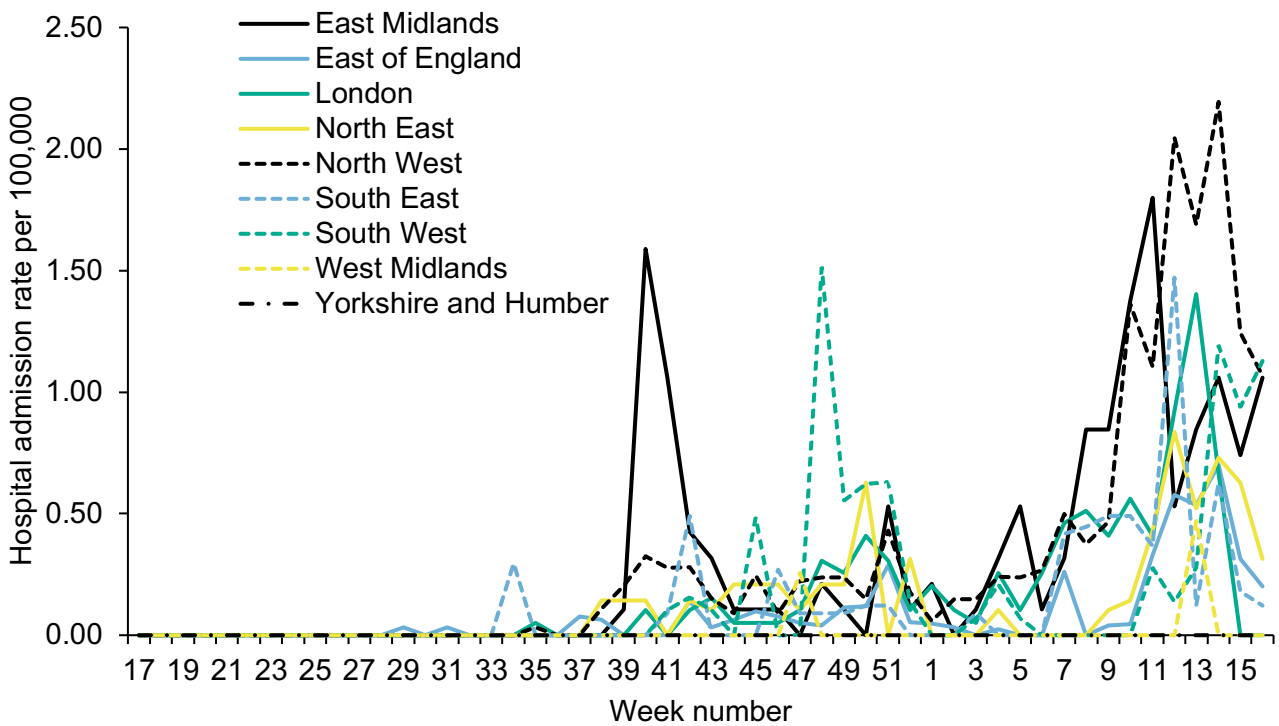
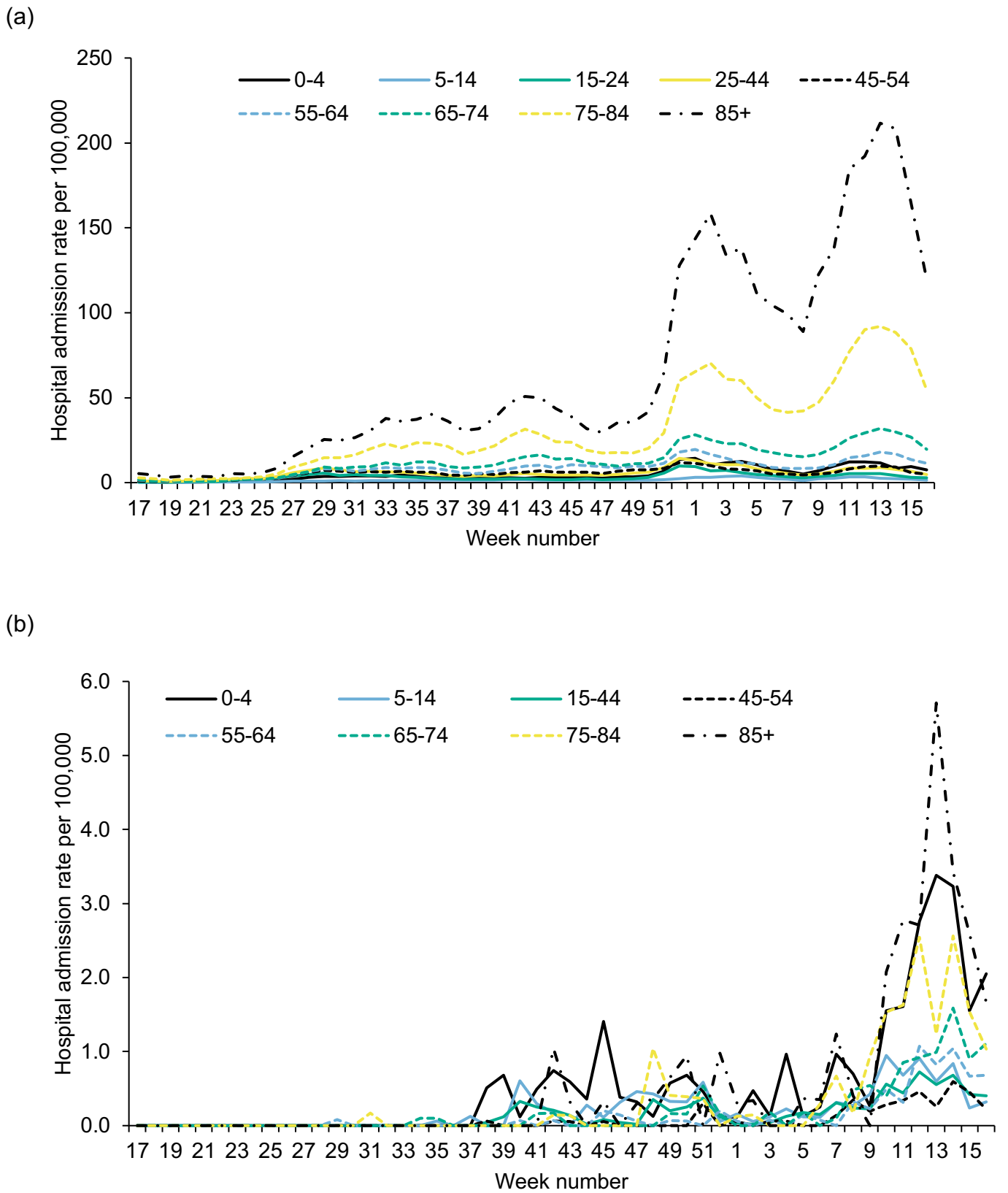


Figure 44: Weekly hospital admission rate by age group for new (a) COVID-19 positive cases and (b) influenza reported through SARI Watch



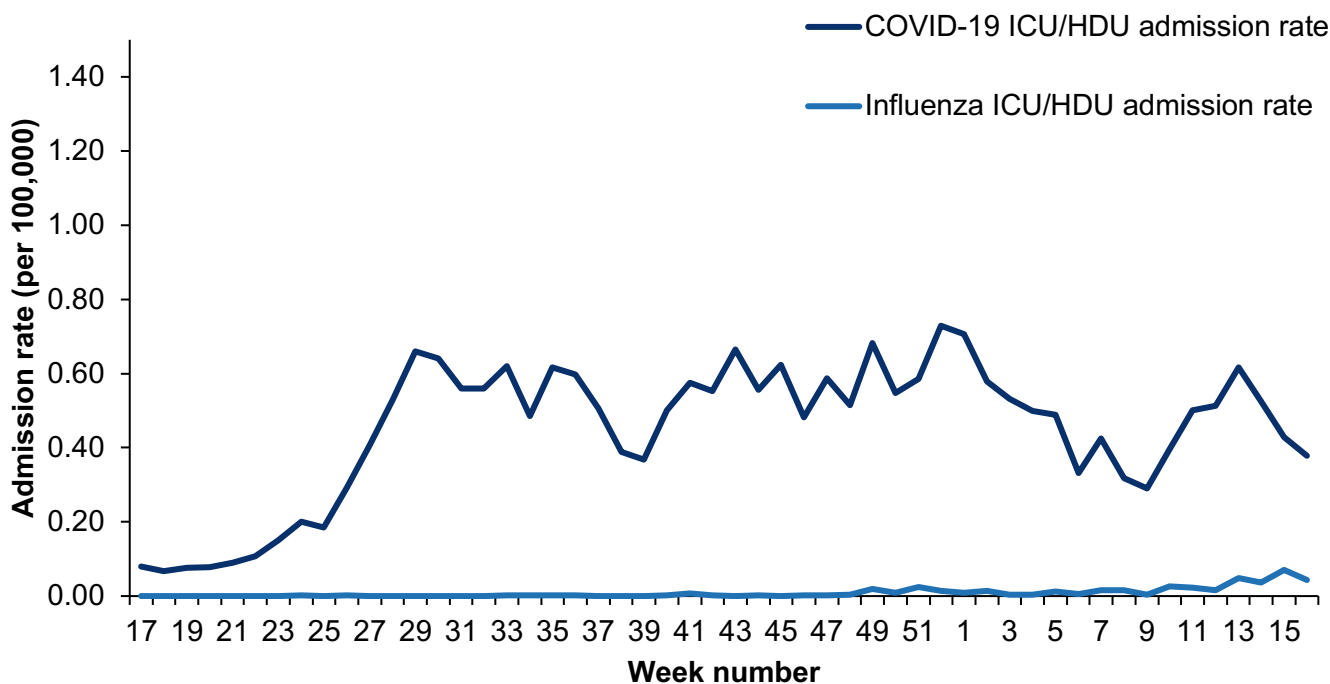
ICU or HDU admissions, SARI Watch

In week 16, the overall weekly ICU or HDU admission rates for COVID-19 decreased. The ICU or HDU rate for COVID-19 was at 0.38 per 100,000 in week 16 compared to 0.43 per 100,000 in the previous week.

By UKHSA Centre, the highest ICU or HDU admission rates for COVID-19 were observed in the North West. By age groups, the highest ICU or HDU admission rates for COVID-19 were observed in the 75 to 84 year olds.

The ICU or HDU rate for influenza was at 0.04 per 100,000 in week 16 compared to 0.07 per 100,000 in the previous week. There were 16 new case reports of ICU or HDU admissions for influenza (1 influenza A(H3N2) and 15 influenza A(not subtyped)) in week 16.

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



* influenza ICU or HDU admission rate is reported from week 17 2021 onwards

* influenza ICU or HDU admission rate based on 90 NHS trusts for week 16

* COVID-19 ICU or HDU admission rate based on 99 NHS trusts for week 16

* SARI Watch data is provisional

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

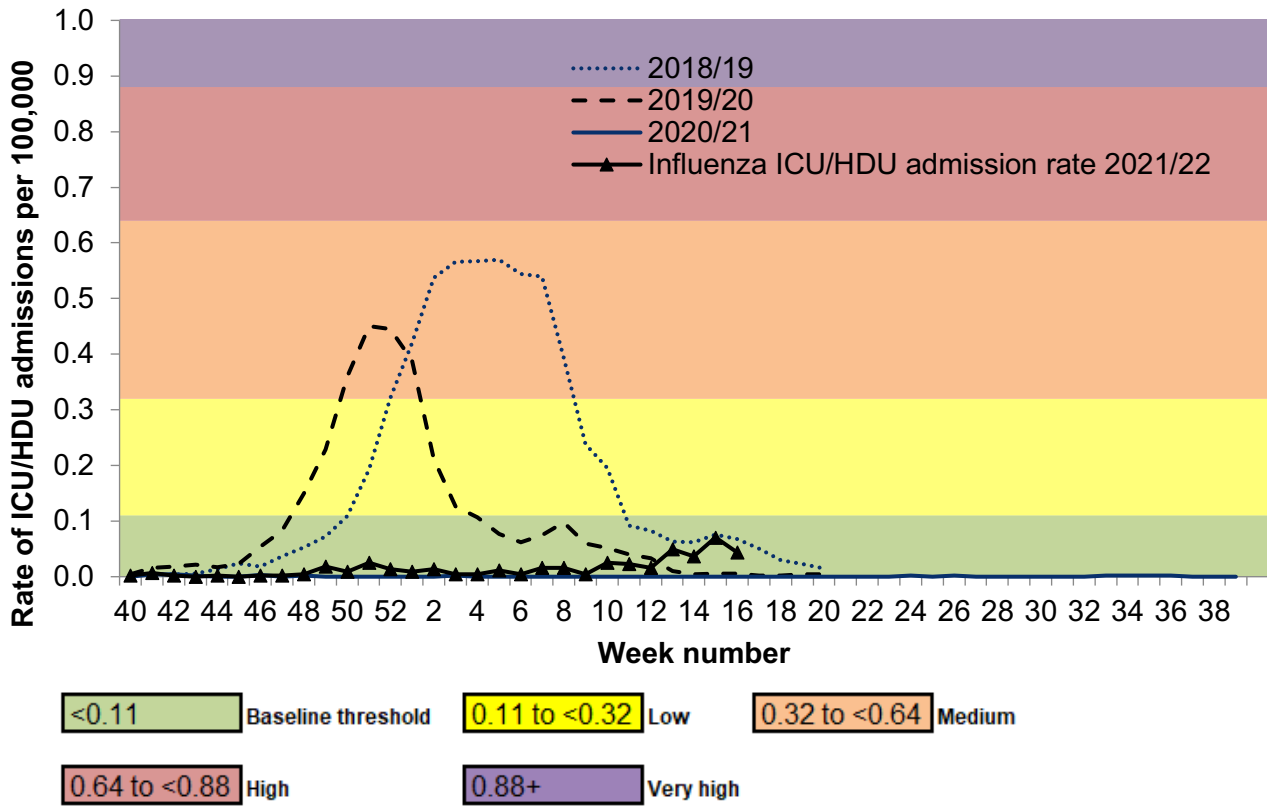


Figure 47: Weekly influenza ICU or HDU admissions by influenza type, SARI Watch, England

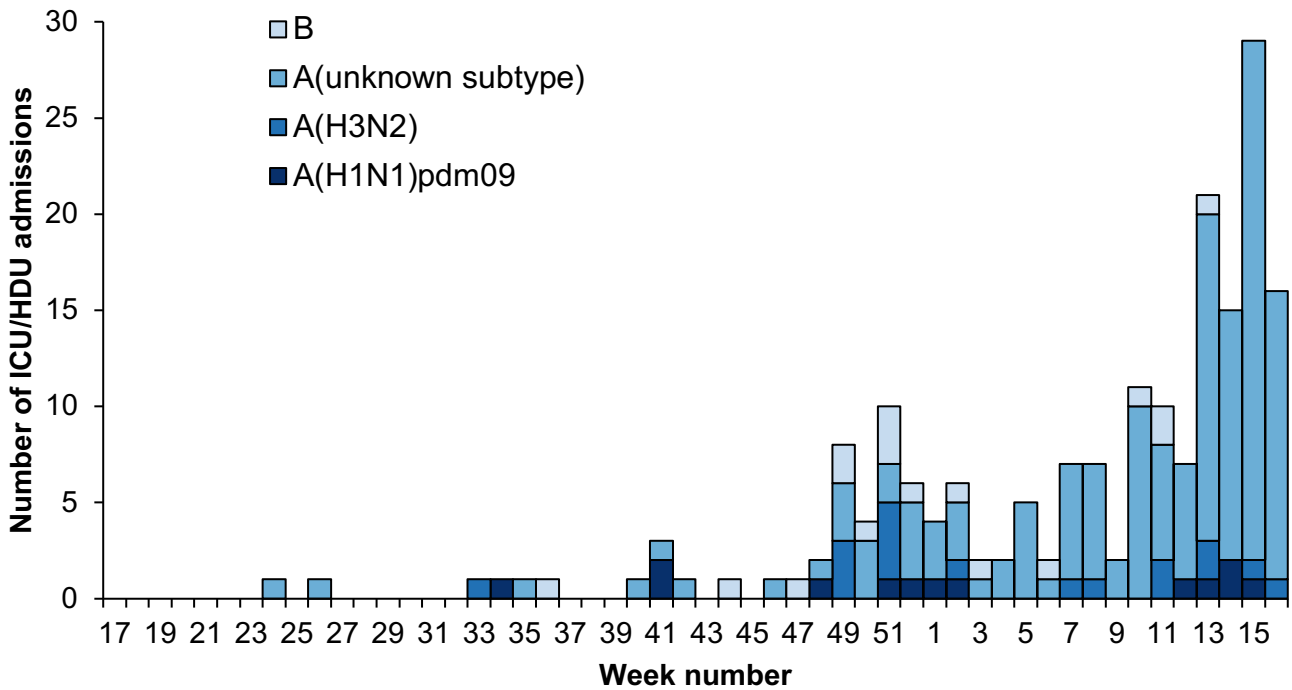
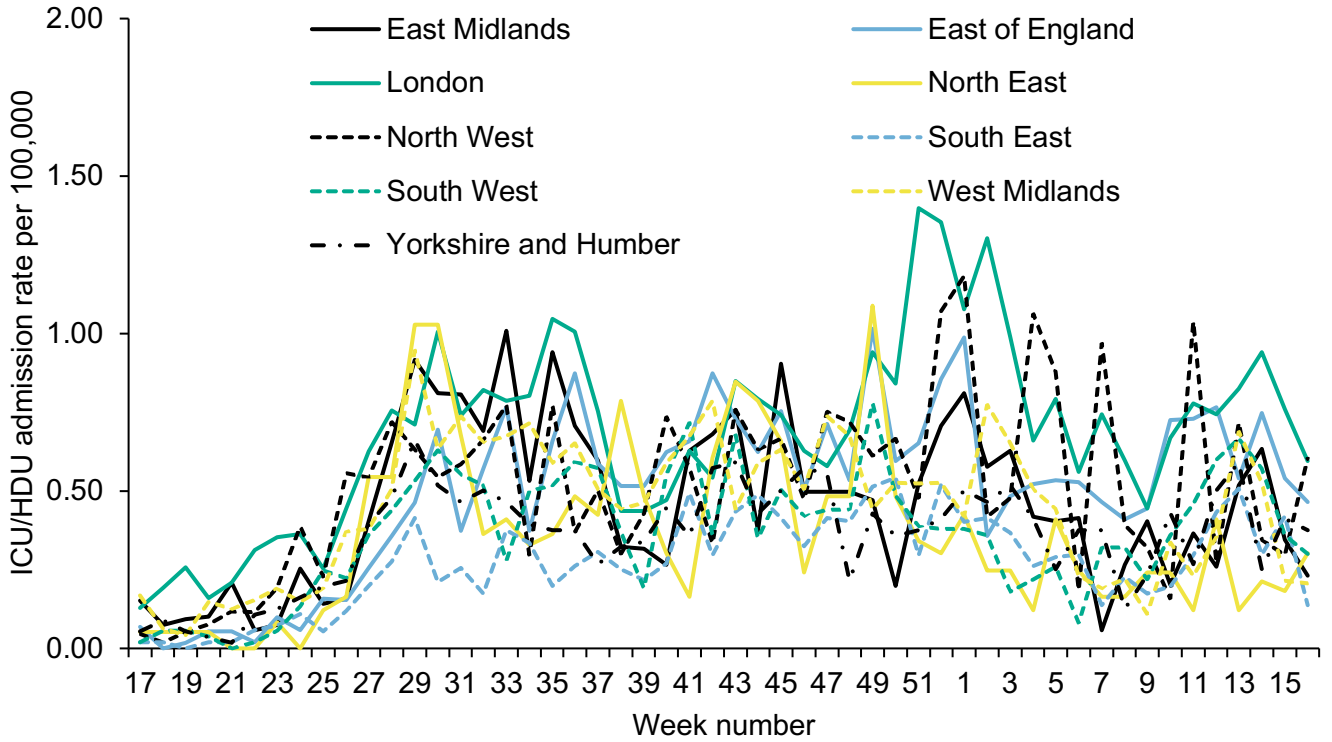


Figure 48: Weekly ICU or HDU admission rate by UKHSA Centre for new (a) COVID-19 positive cases and (b) influenza, reported through SARI Watch

(a)



(b)

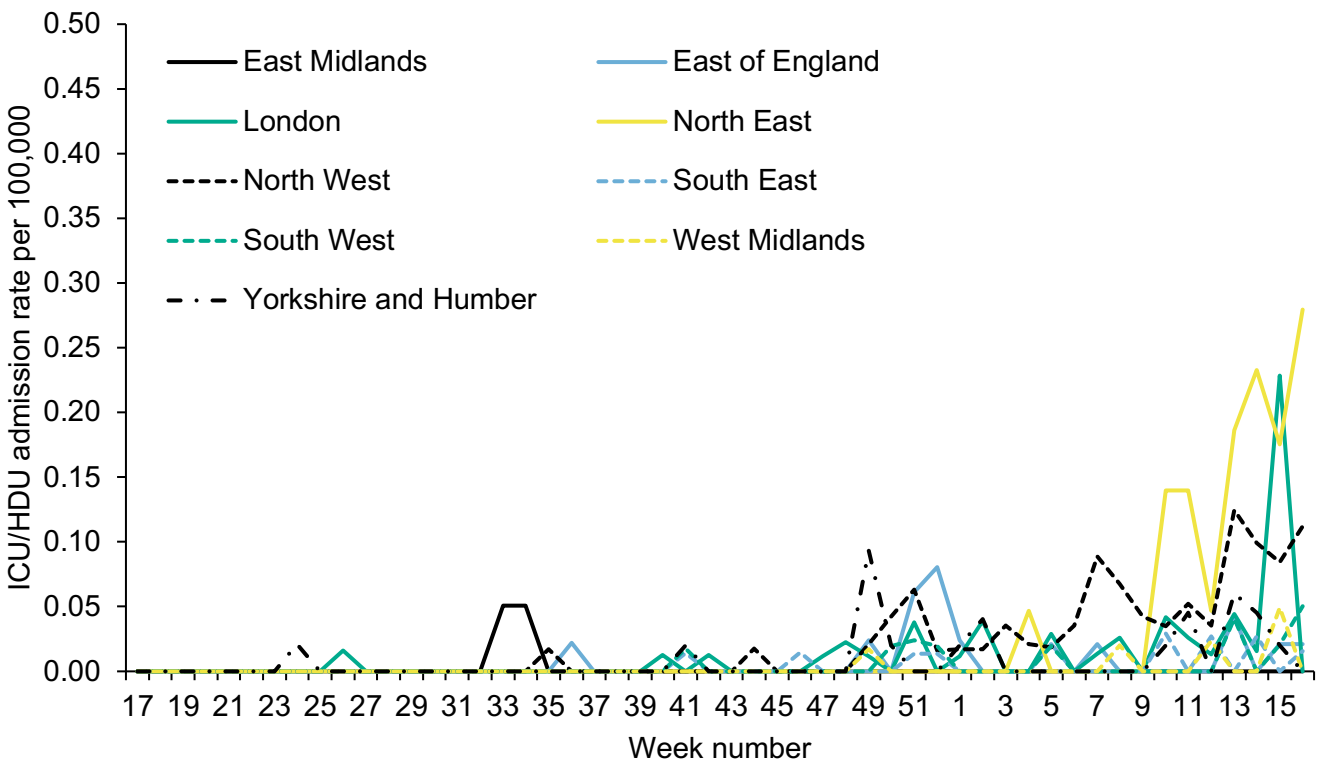
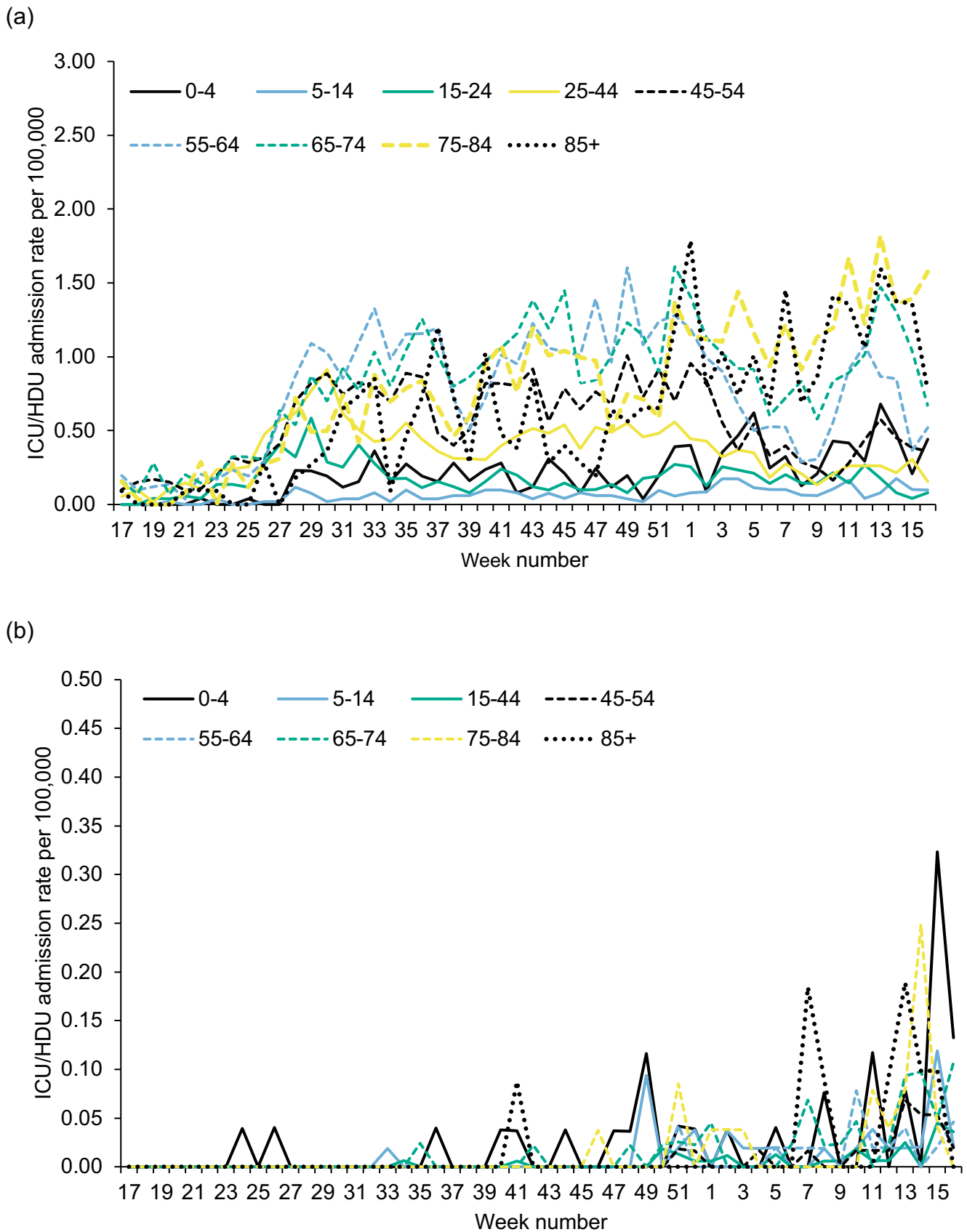


Figure 49: Weekly ICU or HDU admission rate by age group for new (a) COVID-19 positive cases and (b) influenza, reported through SARI Watch

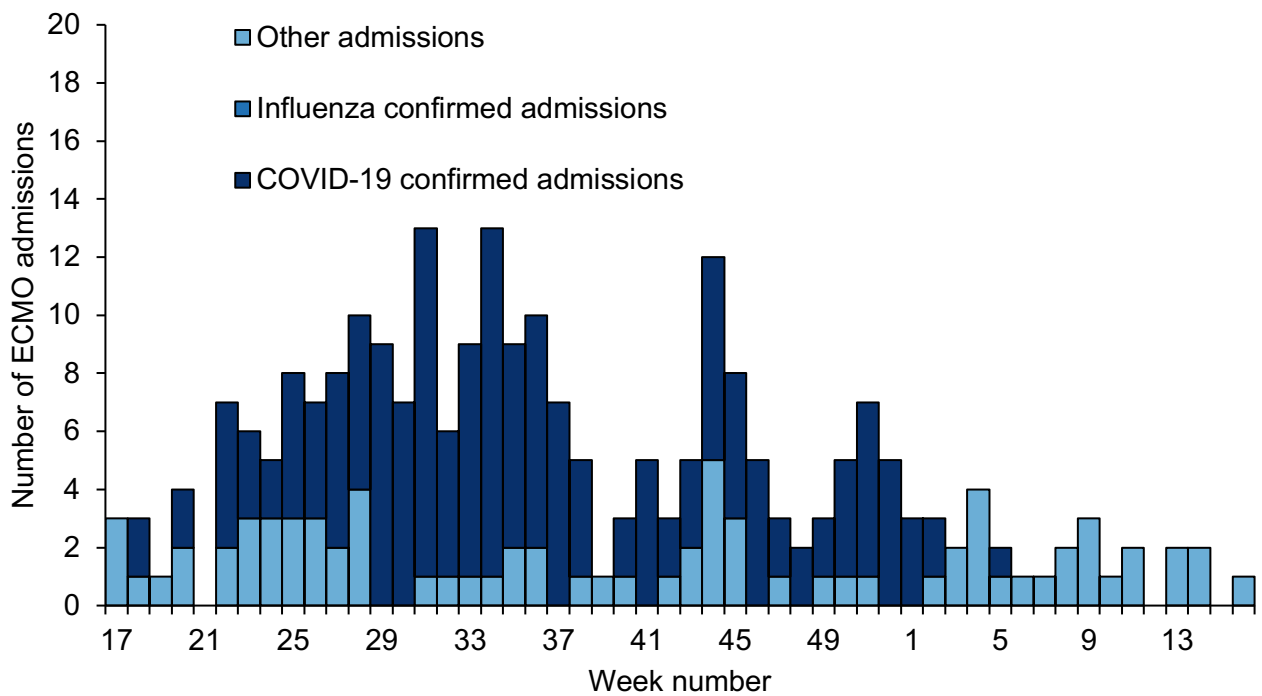


ECMO, SARI Watch

From week 17 2021, a total of 170 laboratory confirmed COVID-19 admissions have been reported from the 6 Severe Respiratory Failure (SRF) centres in the UK.

There were no new laboratory confirmed COVID-19 or influenza admissions reported in week 16 (Figure 50).

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

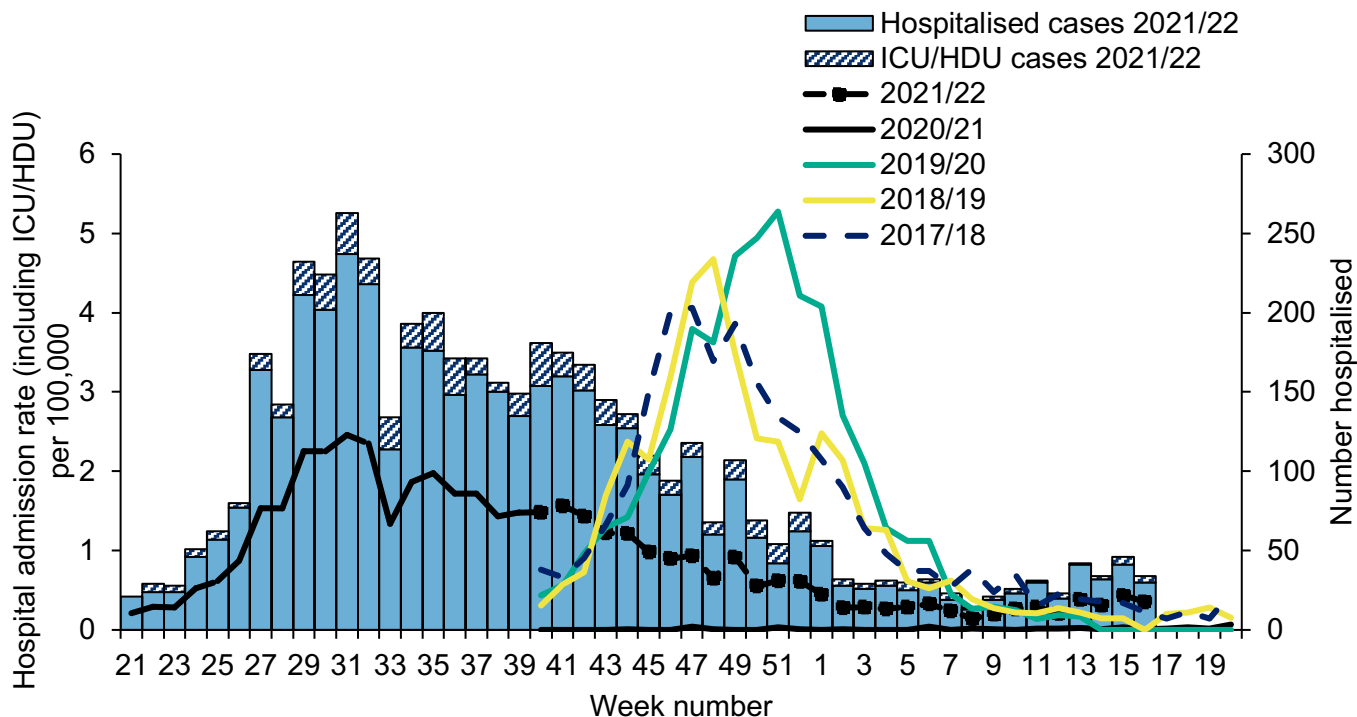


* SARI Watch data is provisional

RSV admissions, SARI Watch

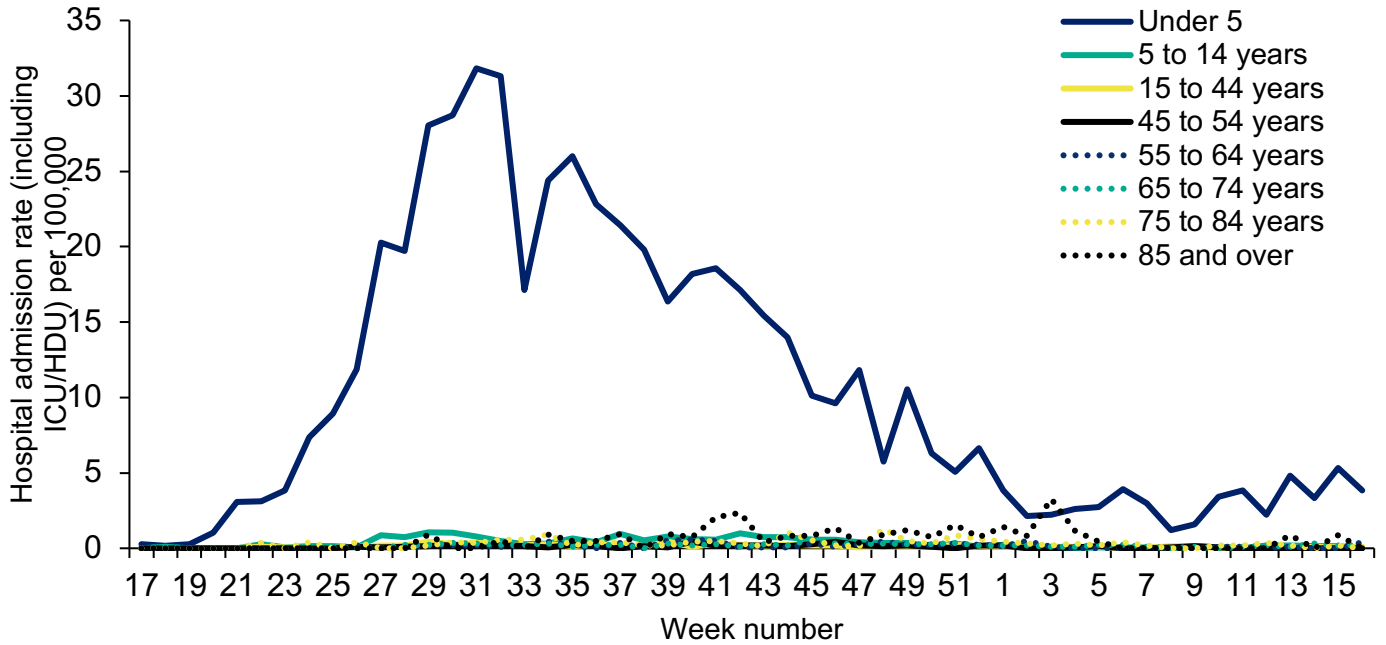
Data on hospitalisations, including ICU or HDU admissions, with Respiratory Syncytial Virus (RSV) are shown below. RSV SARI Watch surveillance is sentinel.

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



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

Figure 52: Weekly hospitalisation (including ICU or HDU) admission rates by age group for new RSV cases reported through SARI Watch in 2021 to 2022, England



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

* SARI Watch data is provisional

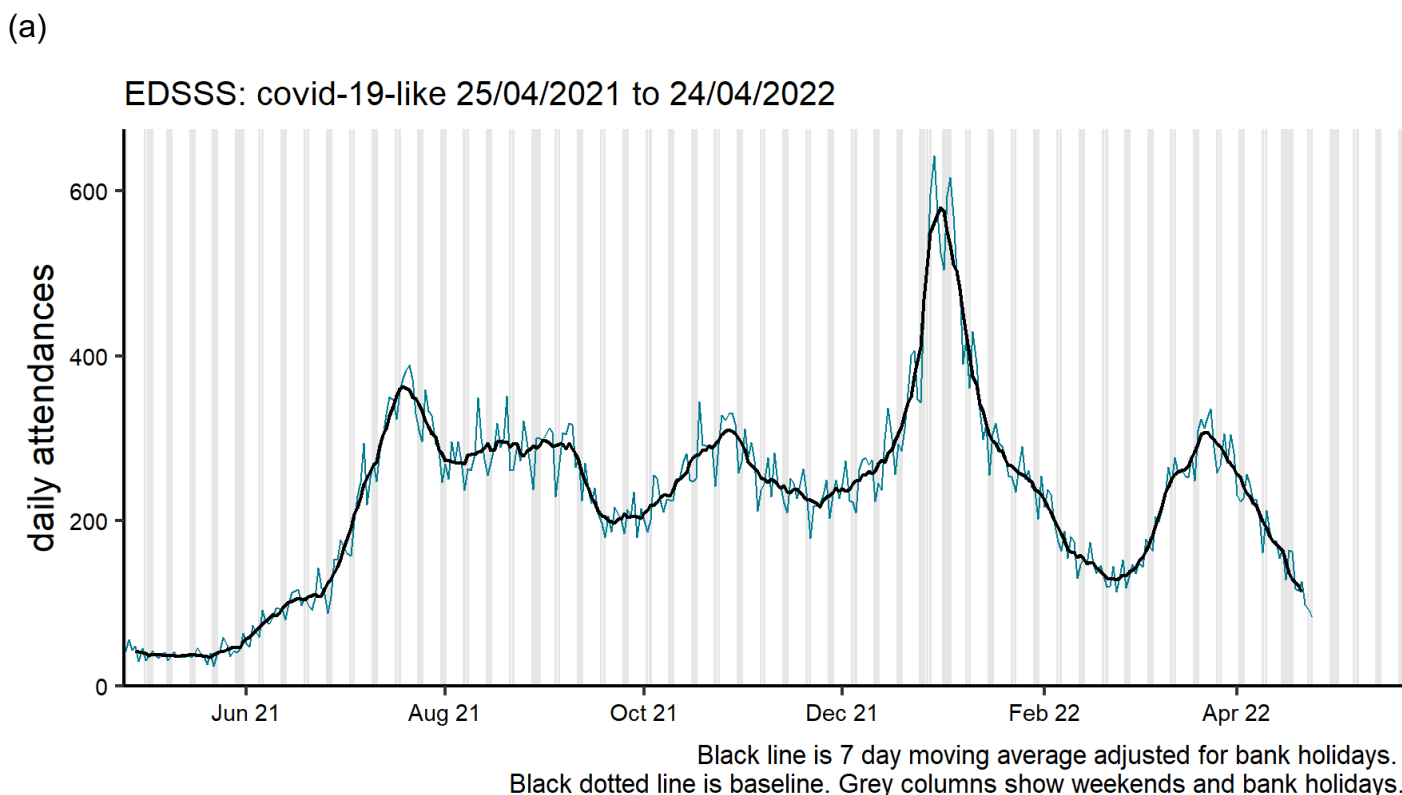
Emergency Department attendances, Syndromic surveillance

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

Up to 24 April, the daily number of Emergency Department (ED) attendances as reported by 117 EDs for COVID-19 and ARI decreased. For ARI these remained above baseline (Figure 53).

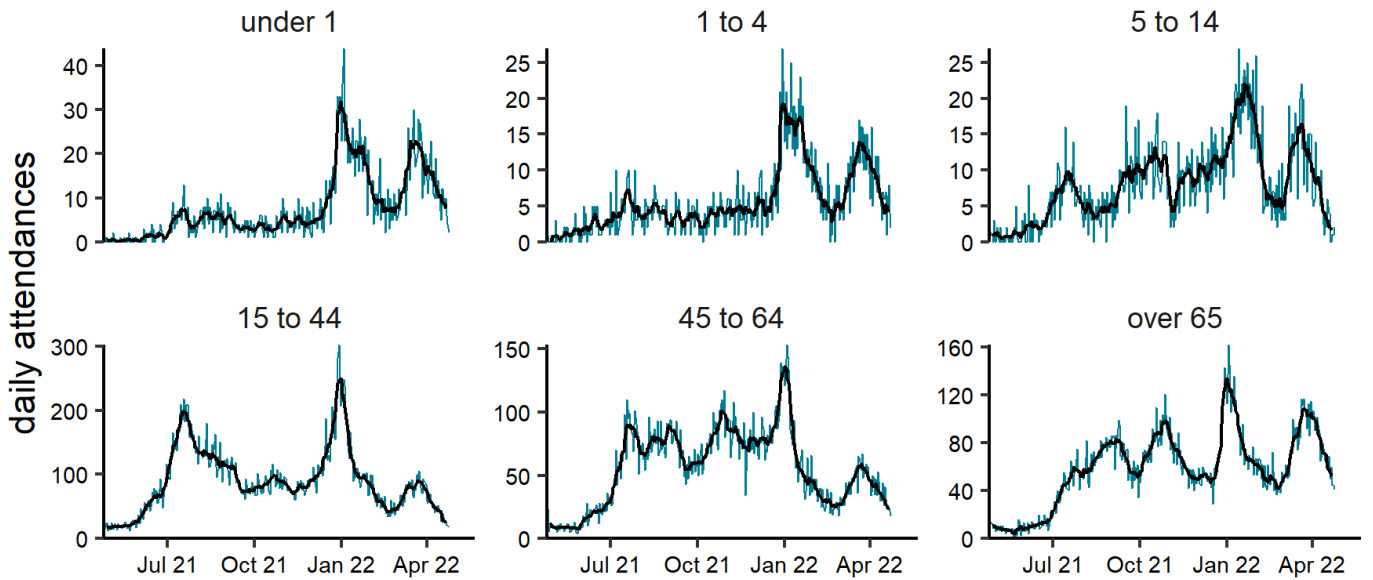
Please note: the COVID-19-like ED indicator is an underestimation of the number of COVID-19 attendances as it only includes attendances with a COVID-19-like diagnosis as their primary diagnosis. The EDSSS COVID-19-like indicator should therefore be used to monitor trends in ED attendances and not to estimate actual numbers of COVID-19 ED attendances. Further information about these caveats is available from the [Emergency Department Syndromic Surveillance](#) bulletin.

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



(b)

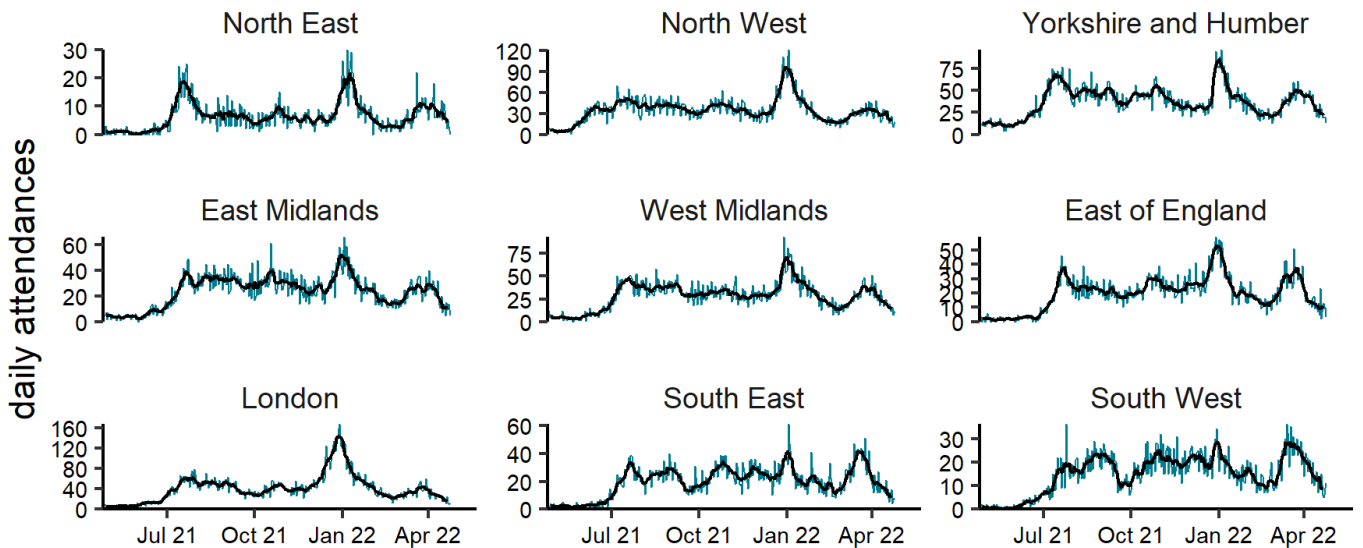
EDSSS: covid-19-like by age (years) 25/04/2021 to 24/04/2022



NOTE: SCALES MAY VARY IN EACH GRAPH TO ENABLE TREND COMPARISON.
Black line is 7 day moving average adjusted for bank holidays.

(c)

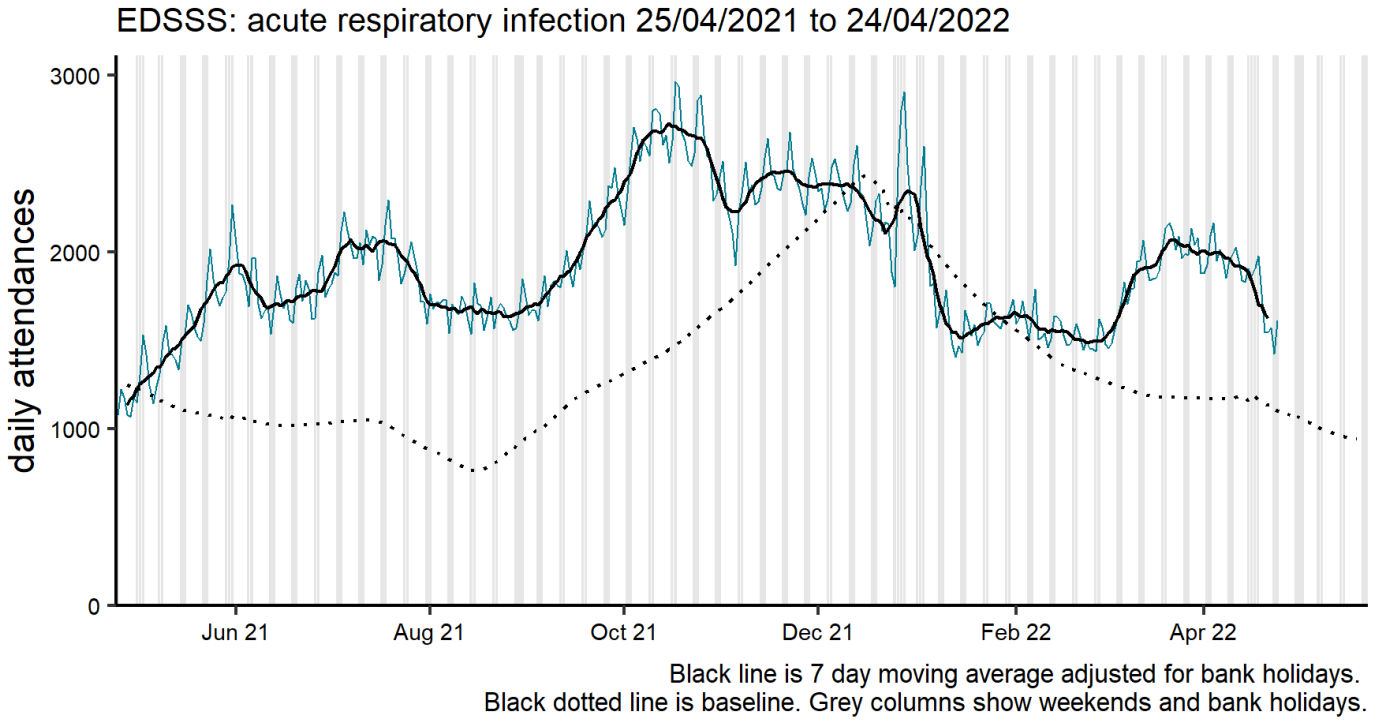
EDSSS: covid-19-like by region 25/04/2021 to 24/04/2022



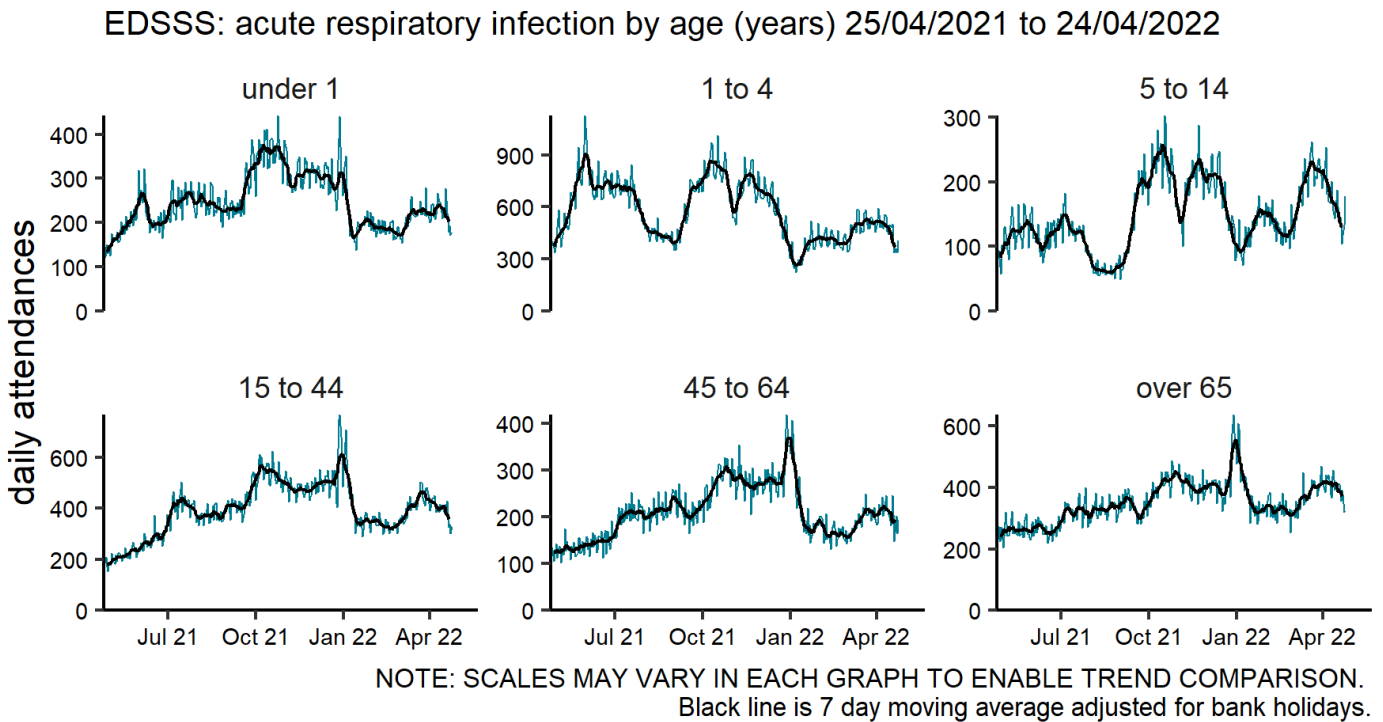
NOTE: SCALES MAY VARY IN EACH GRAPH TO ENABLE TREND COMPARISON.
Black line is 7 day moving average adjusted for bank holidays.
Black dotted line is baseline.

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

(a)

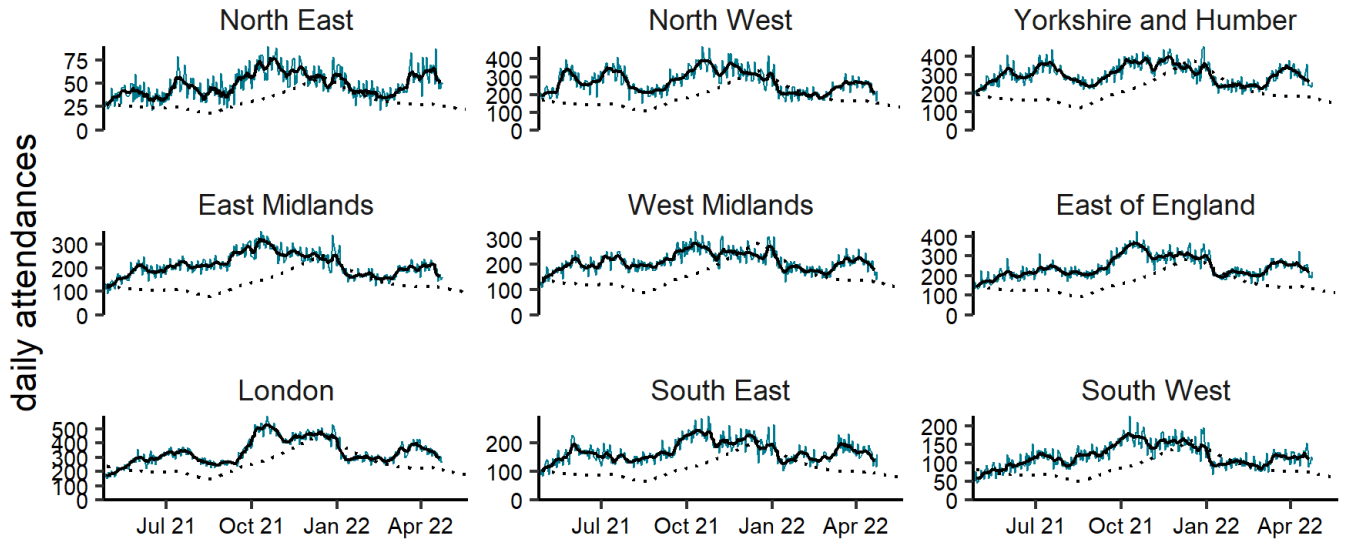


(b)



(c)

EDSSS: acute respiratory infection by region 25/04/2021 to 24/04/2022



NOTE: SCALES MAY VARY IN EACH GRAPH TO ENABLE TREND COMPARISON.
Black line is 7 day moving average adjusted for bank holidays.
Black dotted line is baseline.

Mortality surveillance

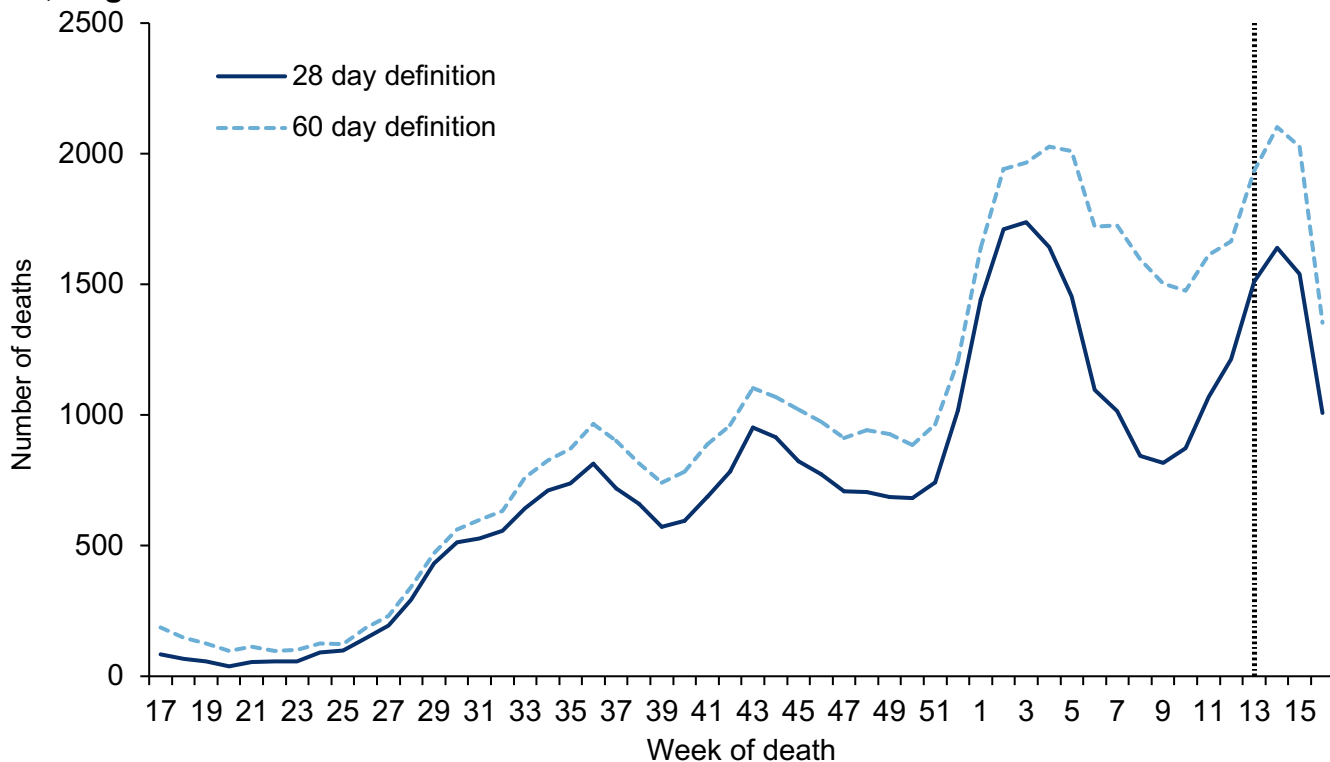
COVID-19 deaths

Changes to the definitions of COVID-19 related deaths in England are described in more detail in an accompanying [technical summary](#).

The current definitions used for mortality surveillance of COVID-19 in England are:

- (a) 28 day definition: A death in a person with a positive COVID-19 test and died within (equal to or less than) 28 days of the most recent episode of infection
- (b) 60 day definition: A death in a person with a positive COVID-19 test and either: died within 60 days of the episode specimen date OR died more than 60 days after the episode specimen date only if COVID-19 is mentioned on the death certificate

Figure 55: Number of deaths by week of death and time since a positive COVID-19 test, England

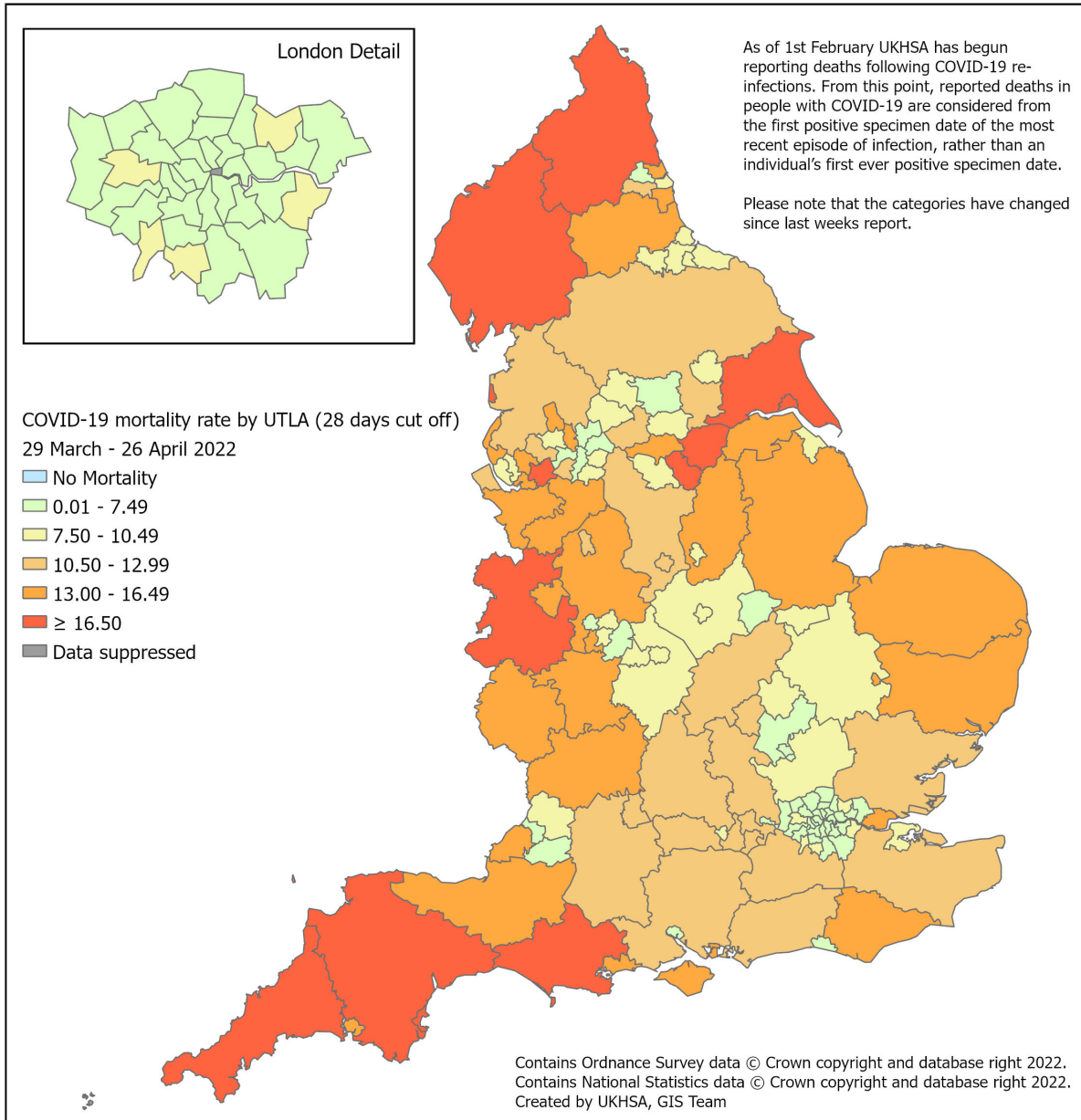


* Vertical dotted line indicates the end of provision of free universal testing for the general public in England, as outlined in the plan for [living with COVID-19](#)

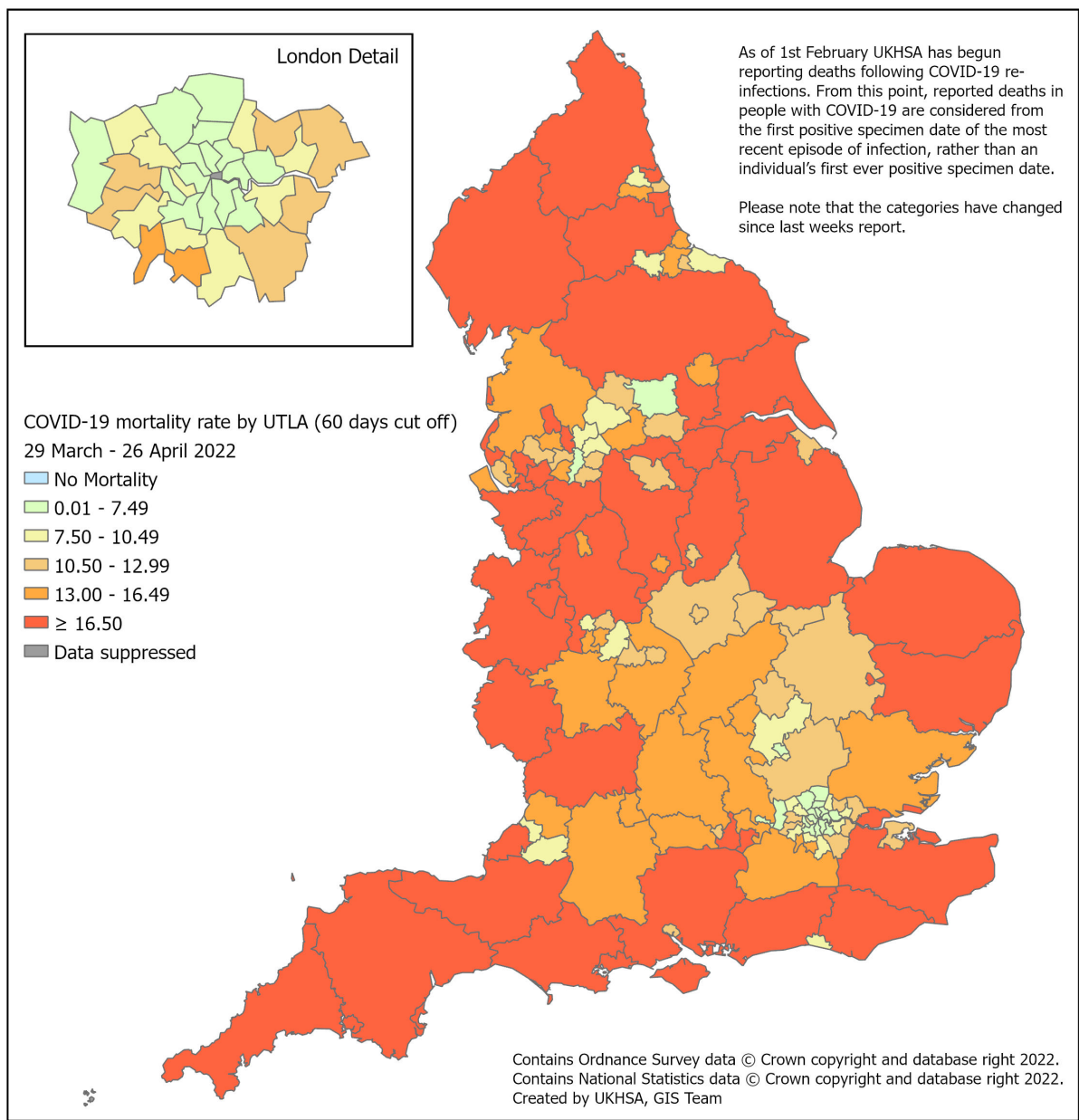
* Data is shown by the week of death. This gives the most accurate analysis of this time progression, however, for the most recent weeks' numbers more deaths are expected to be registered therefore this should be interpreted with caution

Figure 57: Cumulative mortality rate of COVID-19 cases per 100,000 population tested under Pillars 1 and 2 for the past 4 weeks by (a) 28 day definition and (b) 60 day definition

(a)



(b)



Daily excess all-cause mortality (England)

Please note that this data may be subject to delays due to the Easter Bank Holidays and should be interpreted with caution.

Deaths occurring from 1 January 2020 to 13 April 2022 were assessed to calculate the daily excess above a baseline using age-group and region specific all cause deaths as provided daily by the General Register Office (GRO). The deaths were corrected to allow for delay to registration based on past data on these delays and the baseline was from the same day of the year in the previous 5 years plus or minus 7 days with an extrapolated time trend, and with 2 and 3 standard deviation (SD) limits shown (Figure 58).

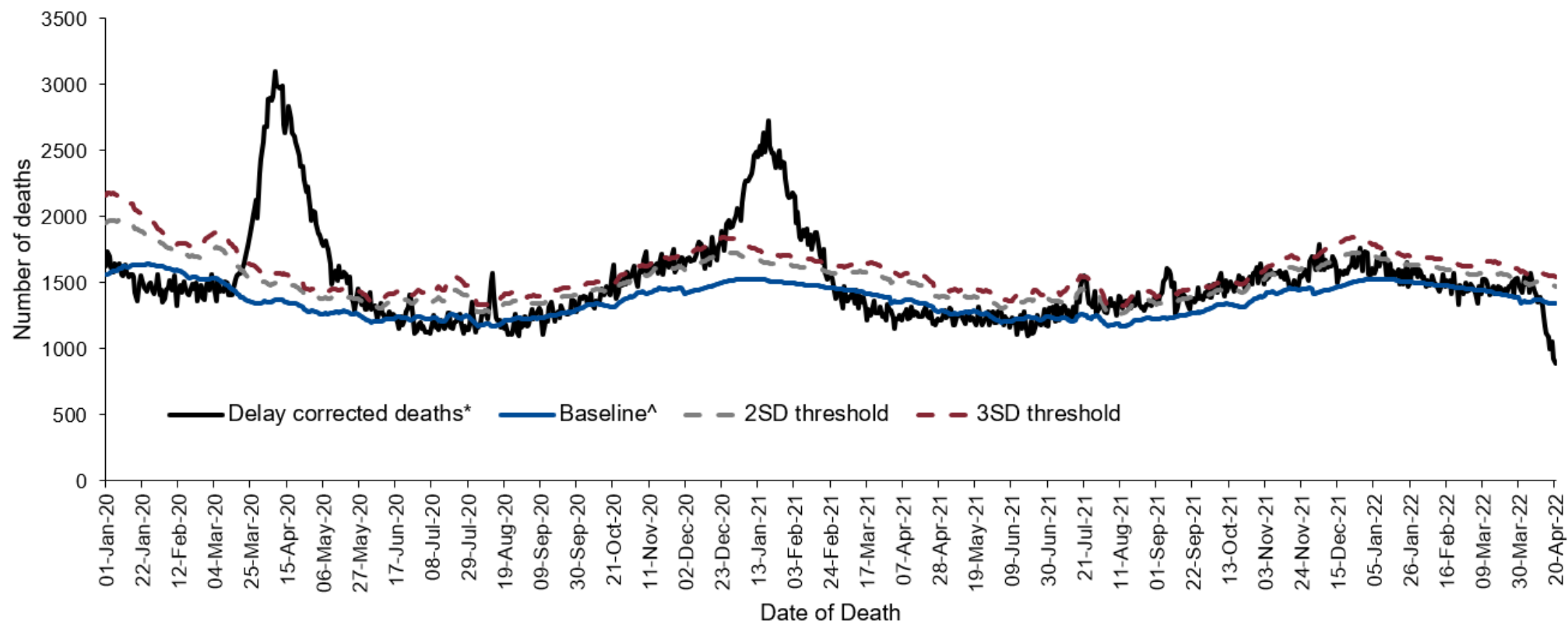
Weeks in which at least 2 days exceeded the 3SD threshold are shown in Table 4 and the daily difference from the baseline by age and region is given in Figure 59.

Note that as this data is by date of death with delay corrections, numbers are subject to change each week, particularly for more recent days.

The current week's model supersedes models presented in previous week.

No excess all-cause mortality was observed in week 15 overall, by age or sub-nationally. Week 36 of 2021 included a heatwave period of 3 days with high temperatures (mean Central England Temperature >20c) which may have contributed to the excess seen in this week. The excess mortality noted in week 33 of 2020 and week 29 of 2021 coincide with heat waves (Figure 58, 59 and Table 4).

Figure 58: Daily excess all-cause deaths in all ages, England, 1 January 2020 to 13 April 2022



^Baseline calculation:

January to November 2020: same day in previous 5 years plus or minus 1 week with a linear trend.

December 2020 to March 2021: past 3 low flu years plus or minus 2 weeks, no trend.

March 2021 onwards: same baseline as 2020

* corrected for delay to registration from death

Other measures of excess mortality published by UKHSA are the [Fingertips excess mortality in England report](#), which uses ONS death registration data; and [the all-cause mortality surveillance report](#), which uses the EuroMOMO model to measure excess deaths.

Table 4: Excess all-cause deaths by (a) age group and (b) UKHSA centres, England

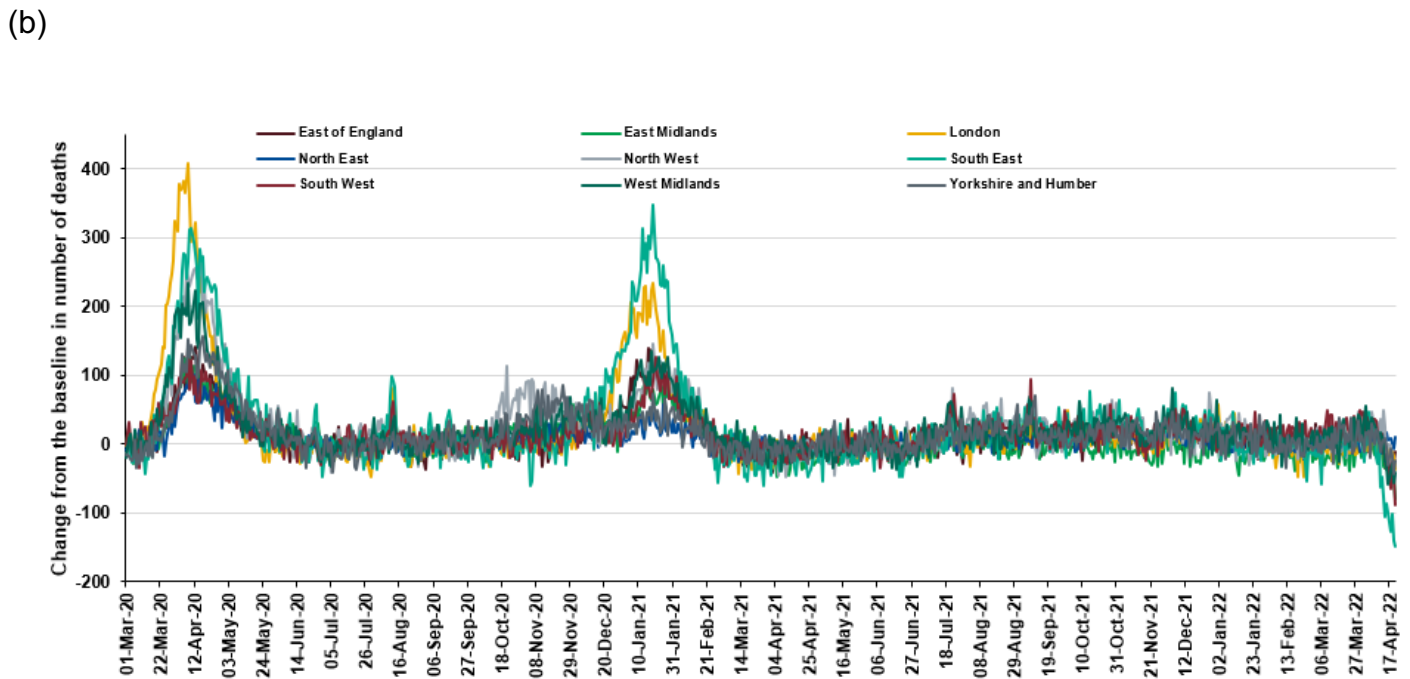
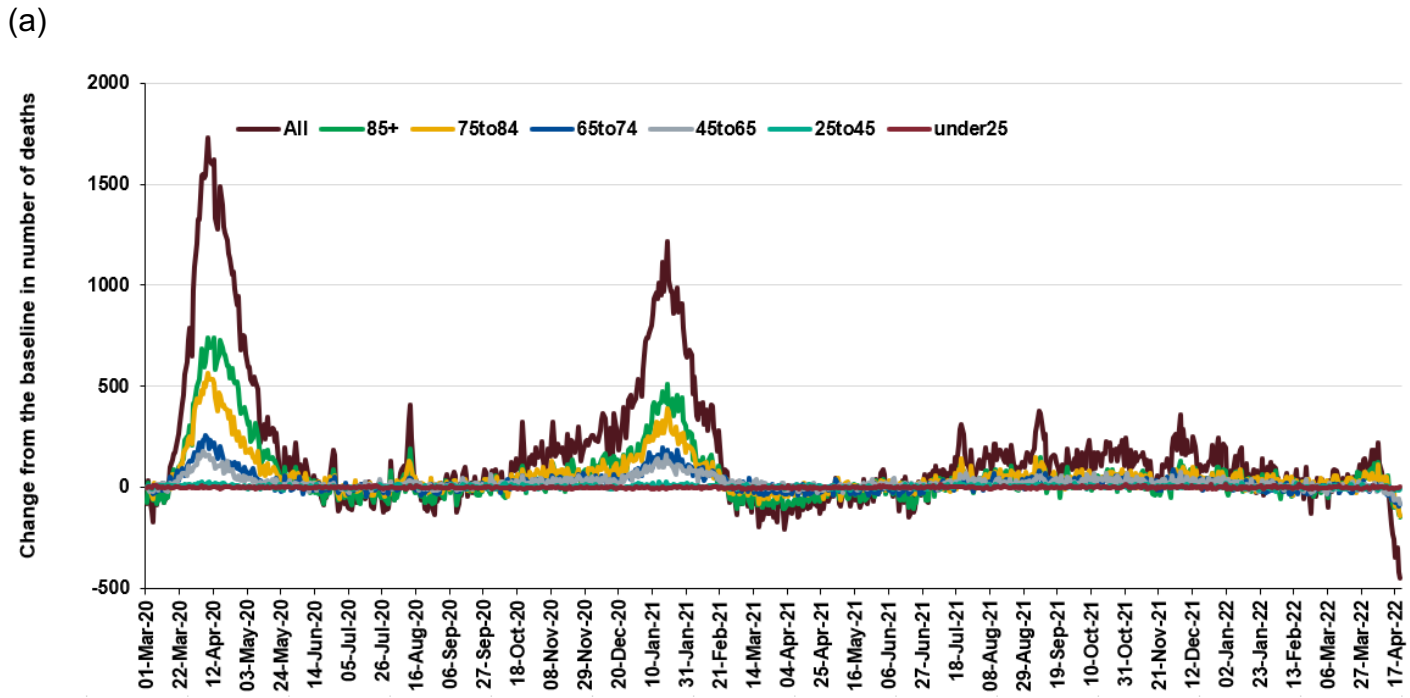
(a)

Age Group	Excess detected in week 15 2022?	Weeks in excess from week 10 to 53 2020	Weeks in excess from week 1 to 52 2021	Weeks in excess from week 1 2022
All	x	13 to 21, 33, 43, 45, 50, 52 to 53	01 to 07, 31 to 32, 35 to 36, 40 to 43, 48	None
under 25	x	None	None	None
25 to 44	x	14 to 16	None	None
45 to 64	x	12 to 19, 49 to 50, 52 to 53	01 to 08, 23, 29, 36, 40 to 44, 48	None
65 to 74	x	13 to 19, 46, 48, 52 to 53	01 to 07, 36, 43, 48	None
75 to 84	x	13 to 21, 33, 45, 49, 52 to 53	01 to 07, 32, 36, 40	None
85+	x	13 to 21, 33, 53	01 to 07, 31, 36	None

(b)

UKHSA Centres	Excess detected in week 15 2022?	Weeks in excess from week 10 to 53 2020	Weeks in excess from week 1 to 52 2021	Weeks in excess from week 1 2022
East of England	x	14 to 19, 52 to 53	01 to 07	None
East Midlands	x	13 to 19, 48	01 to 07	None
London	x	12 to 19, 33, 52 to 53	01 to 06, 36	None
North East	x	14 to 21	02 to 04	None
North West	x	13 to 19, 33, 42 to 47	01 to 07, 31 to 32, 36, 43	None
South East	x	13 to 21, 33, 50 to 53	01 to 07, 36	None
South West	x	13 to 19, 33	02 to 07, 29, 36	None
West Midlands	x	13 to 20, 45, 48	01 to 07, 29, 36, 40, 48	13
Yorkshire and Humber	x	14 to 21, 23, 43 to 50	02 to 04, 32, 35 to 36	None

Figure 59: Daily excess all-cause deaths by (a) age group and (b) UKHSA centres, England, 1 March 2020 to 13 April 2022



Microbiological surveillance

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.

The UKHSA Respiratory Virus Unit has genetically characterised 320 influenza A(H3N2) viruses, collected since week 40 of 2021. Of the characterised influenza A(H3N2) viruses where the age of the individual sampled is known, 54% are from individuals in age groups that would not normally be eligible for influenza vaccination.

Sequencing of the haemagglutinin (HA) gene shows that these A(H3N2) viruses belong in genetic subclade 3C.2a1b; 310 within a cluster designated 3C.2a1b.2a.2. The Northern Hemisphere 2021/22 influenza A(H3N2) vaccine strain (an A/Cambodia/e0826360/2020-like virus) also belongs in genetic subclade 3C.2a1b, within the 2a.1 genetic group. Ten A(H3N2) viruses collected in weeks 50 of 2021 to week 4 of 2022, fall within a cluster designated 3C.2a1b.1a. Viruses within this genetic cluster have been detected in recent months in West and South Africa.

Eleven influenza B viruses, collected since the start of the season in week 40/2021 have been genetically characterised and belong in genetic clade 1A.3 of the B/Victoria lineage, characterised by deletion of three amino acids in the haemagglutinin (HA), in a subgroup designated 1A.3a.2. The N. Hemisphere 2021/22 B/Victoria-lineage quadrivalent and trivalent vaccine component virus (a B/Washington/02/2019-like virus) belongs in genetic clade 1A.3.

Seventeen influenza A(H1N1)pdm09 viruses have been characterised to date this season, belonging in genetic subgroup 6B.1A.5a. Four fall within a cluster designated 6B.1A.5a.1, with two collected from returning travellers. Thirteen A(H1N1)pdm09 viruses also belong in genetic subgroup 6B.1A.5a, within a cluster designated 6B.1A.5a.2. The Northern Hemisphere 2021/22 influenza A(H1N1)pdm09 vaccine strain (an A/Victoria/2570/2019-like virus) also belongs in genetic subclade 6B.1A.5a, within the 6B.1A.5a.2 cluster.

The detection of circulating A(H3N2) and influenza B viruses is in accordance with predominant detections internationally over the period of August and September 2021, and from week 40 to date.

The Respiratory Virus Unit has confirmed by genome sequencing the detection of live attenuated influenza vaccine (LAIV) viruses in 39 influenza A and/or influenza B positive samples collected since week 37 of 2021, from children aged 2 to ≤16 years of age.

Antiviral susceptibility

Influenza positive samples are 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 2021 and 8 of 2022 have been analysed. No viruses with known markers of resistance to neuraminidase inhibitors were detected in 253 A(H3N2), 11 A(H1N1)pdm09 and 9 B/Victoria-lineage neuraminidase gene sequences. No viruses with known markers of resistance to baloxavir marboxil were detected in 8 A(H1N1)pdm09 and 8 B/Victoria-lineage PA gene sequences (cap-dependent endonuclease). Of 222 A(H3N2) PA gene sequences, 220 had no markers of resistance to baloxavir, however 2 sequences were identified with an E199G amino acid substitution

The E199G substitution has been reported previously as causing a minor reduction in baloxavir susceptibility (4.4-fold) in vitro, detected post treatment in a phase 2 paediatric study. For the two viruses identified with this substitution, the first was present as a mixed population (37% E199G) in a sample taken from a child in mid-January. The second virus had the E199G substitution present at 100% and was detected in an adult. No clinical details are available yet, with investigations ongoing.

Table 5: Antiviral susceptibility of influenza positive samples tested at UKHSA-Respiratory Virus Unit (RVU)

(Sub)type	Neuraminidase Inhibitors		Baloxavir	
	Susceptible	Reduced Susceptibility	Susceptible	Reduced Susceptibility
A(H3N2)	253	0	220	2
A(H1N1)pdm09	11	0	8	0
B/Victoria-lineage	9	0	8	0

SARS-CoV-2 variants

UKHSA conducts surveillance of SARS-CoV-2 variants. Further information including an overview of variants, information on new variants and [detailed surveillance of particular variants of concern](#) can be found on GOV.UK and in the [latest technical briefing](#).

Antimicrobial susceptibility

Table 6 shows in the 12 weeks up to week 16 2022, the proportion of all lower respiratory tract isolates of *Streptococcus pneumoniae*, *Haemophilus influenzae*, *Staphylococcus aureus*, MRSA and MSSA tested and susceptible to antibiotics. These organisms are the key causes of community-acquired pneumonia (CAP) and the choice of antibiotics reflects the British Thoracic Society empirical guidelines for management of CAP in adults.

Table 6: Antimicrobial susceptibility surveillance in lower respiratory tract

Organism	Antibiotic	Specimens tested (N)	Specimens susceptible (%)
<i>S. pneumoniae</i>	Penicillin	1,219	87
	Macrolides	1,392	84
	Tetracycline	1,412	84
<i>H. influenzae</i>	Amoxicillin/ampicillin	5,876	51
	Co-amoxiclav	6,375	54
	Macrolides	1,997	5
	Tetracycline	6,606	98
<i>S. aureus</i>	Methicillin	2,920	94
	Macrolides	3,469	69
MRSA	Clindamycin	132	30
	Tetracycline	163	69
MSSA	Clindamycin	2,077	76
	Tetracycline	2,574	92

* Macrolides = erythromycin, azithromycin and clarithromycin

Data source: UKHSA’s SGSS Antimicrobial Resistance (AMR) module, please note that this is different to the data source used in the reports published between weeks 41 2020 to 05 2021

inclusive of the 2020 to 2021 influenza season when the SGSS Communicable Disease Report (CDR) module was used instead due to a UKHSA SGSS AMR data infrastructure issue which has now been resolved. Therefore, the above results are not directly comparable to the results reported between weeks 41, 2020 and 5, 2021. The AMR module of SGSS was used during the 2019 to 2020 influenza season. There has been a reduction in the total number of bacterial positive lower respiratory tract clinical samples reported to UKHSA since mid-March 2020.

COVID-19 sero-prevalence surveillance

Since week 42 2021, updates on COVID-19 sero-prevalence estimates have been published in the weekly [COVID-19 vaccine surveillance report](#).

Influenza vaccination

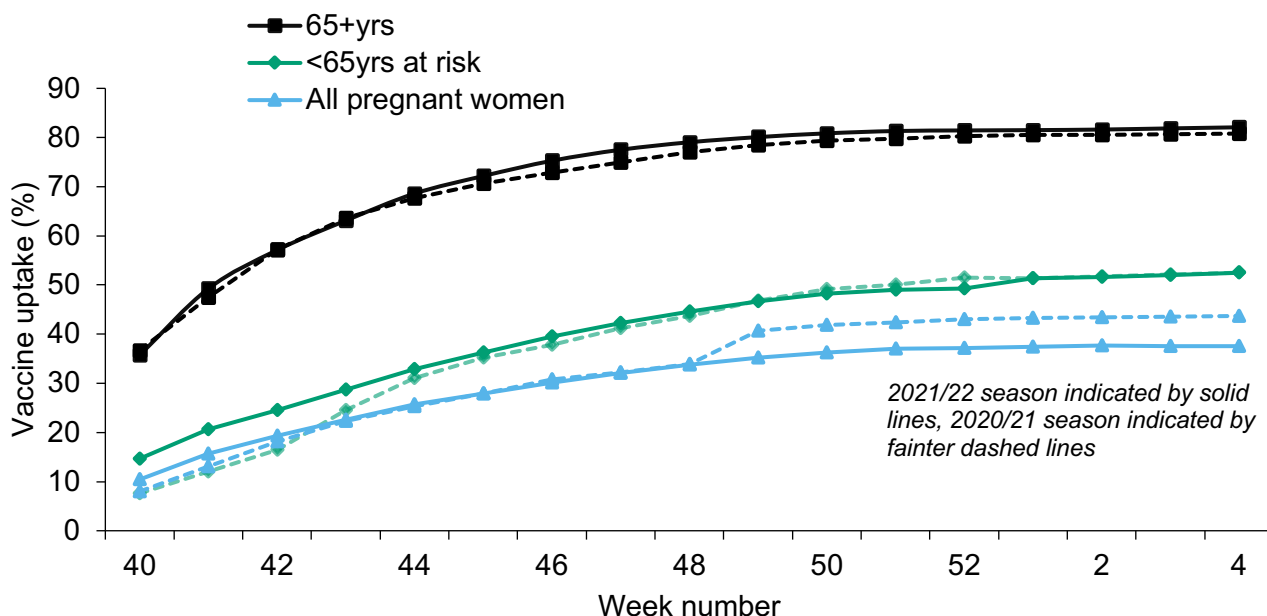
Influenza vaccine uptake in GP patients

The last publication of weekly vaccine uptake data for the 2021 to 2022 season was on 3 February 2022. That data showed that up to week 4 2022, in 87.6 % of GP practices reporting weekly to ImmForm for the main collection, the provisional proportion of people in England who had received the 2021 to 2022 influenza vaccine in targeted groups was as follows:

- 52.5% in under 65 years in a clinical risk group
- 37.6% in all pregnant women
- 82.1% in all 65 year olds and over
- 85.1% in 65 year olds and over and in a clinical risk group
- 45.5% in those aged 50 to 64 who are not in a clinical risk group

Weekly vaccine coverage data is provisional. The sample of GP practices included in the data may change from week to week, resulting in changes to reported cumulative uptake.

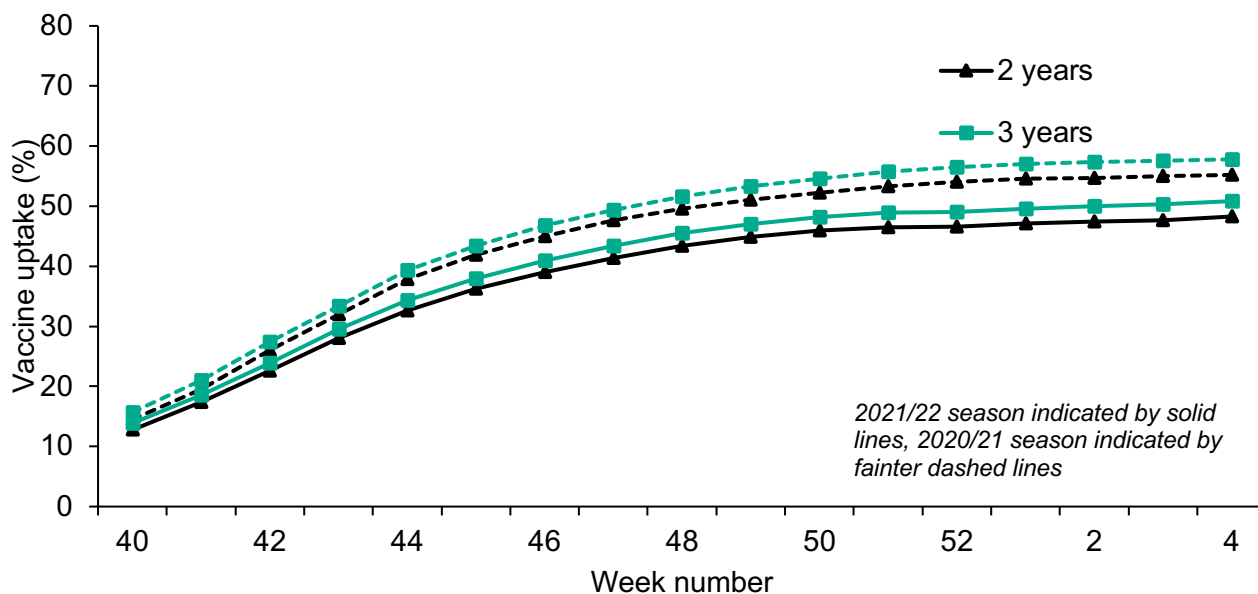
Figure 60: Cumulative weekly influenza vaccine uptake by target group in England



In 2021 to 2022, all 2 and 3 year olds continue to be eligible for influenza vaccination through their GPs. Up to week 4 2022, in 88.1% of GP practices reporting weekly to ImmForm for the childhood collection, the provisional proportion of children in England who had received the 2021 to 2022 influenza vaccine in targeted groups was as follows:

- 48.3% in all 2 year olds
- 50.8% in all 3 year olds

Figure 61: Cumulative weekly influenza vaccine uptake in 2 and 3 year olds, in England



As in previous seasons week 4 data is the last weekly publication during the Influenza season. [Monthly data](#) covering vaccinations that were given between 1 September and 28 February 2022 has been published. This is the sixth publication of monthly data this season and comparator data is available for previous seasons. The monthly GP report includes ethnicity data for at-risk groups, pregnant women and for the first time, 65 years and over.

Influenza vaccine uptake in school age children

Provisional [monthly data](#) on influenza vaccine uptake in children of school years Reception to Year 11 has been published, showing the provisional proportion of children who received the 2021 to 2022 influenza vaccine via school, pharmacy or GP practice between 1 September and 31 January 2022.

Influenza vaccine uptake in healthcare workers

Provisional [monthly data](#) on influenza vaccine uptake in frontline healthcare workers has been published, showing vaccine uptake at national, commissioning region, and Trust level, and by staff group, between 1 September and 28 February 2022.

COVID-19 vaccination

COVID-19 vaccine uptake in England

COVID-19 vaccinations began in England on 8 December 2020 during week 50 2020 (week ending 13 December 2020). Cumulative data up to week 16 2022 (week ending 24 April 2022) was extracted from the National Immunisation Management Service (NIMS). The data presented this week is the provisional proportion of living people in England who had received at least one dose, 2 doses and 3 doses of a COVID-19 vaccination by age group. The overall vaccine uptake in the population for those with at least dose 1 was 69.9%, 65.7% for dose 2 and 51.3% for dose 3. The breakdown by sex showed vaccine uptake in males was 67.4% and 72.2% in females for dose 1. For dose 2 vaccine uptake by sex was 63.2% in males and 68.2% in females. For dose 3 vaccine uptake by sex was 48.7% in males and 54.3% in females. The vaccine uptake rate in adults aged 18 and over was 81.7% (41,405,474/50,680,468) for dose 1; 78.7% (39,875,886/50,680,468) for dose 2 and 63.7% (32,266,230/ 50,680,468) for dose 3.

Table 7: Provisional cumulative COVID-19 vaccine uptake by age in England

NATIONAL	People in NIMS cohort	Vaccinated with at least 1 dose		Vaccinated with at least 2 doses		Vaccinated with at least 3 doses	
		Number vaccinated	% vaccine uptake	Number vaccinated	% vaccine uptake	Number vaccinated	% vaccine uptake
Over 80	2,924,914	2,798,248	95.7	2,780,057	95.0	2,690,156	92.0
75 to under 80	2,316,851	2,219,818	95.8	2,204,553	95.2	2,145,394	92.6
70 to under 75	2,784,932	2,629,823	94.4	2,607,219	93.6	2,516,178	90.3
65 to under 70	2,974,327	2,750,103	92.5	2,718,395	91.4	2,573,103	86.5
60 to under 65	3,600,961	3,271,746	90.9	3,225,600	89.6	2,961,459	82.2
55 to under 60	4,164,522	3,712,999	89.2	3,650,125	87.6	3,262,000	78.3
50 to under 55	4,245,824	3,682,542	86.7	3,604,860	84.9	3,113,513	73.3
45 to under 50	3,957,512	3,254,059	82.2	3,161,946	79.9	2,570,717	65.0
40 to under 45	4,313,637	3,337,749	77.4	3,211,605	74.5	2,447,051	56.7
35 to under 40	4,652,398	3,388,951	72.8	3,221,558	69.2	2,265,855	48.7
30 to under 35	4,878,482	3,407,425	69.8	3,191,029	65.4	2,077,070	42.6
25 to under 30	4,549,379	3,111,713	68.4	2,870,936	63.1	1,738,777	38.2
20 to under 25	3,931,071	2,824,281	71.8	2,539,621	64.6	1,449,268	36.9
18 to under 20	1,385,658	1,016,017	73.3	888,382	64.1	455,690	32.9
16 to under 18	1,384,022	909,428	65.7	665,447	48.1	153,041	11.1
12 to under 16	2,928,947	1,577,034	53.8	933,115	31.9	10,285	0.4
5 to under 11	5,072,646	241,504	4.8	6,222	0.1	11	0.0
Total*	63,161,362	44,134,347	69.9	41,481,067	65.7	32,429,787	51.3

*Caution should be exercised when summing the regional or age figures as the sum of these will not equal the England total. This is due to individuals vaccinated in England who have a registered address in Scotland or Wales or where their address is unknown. There were also vaccinations where the individual had an unknown region and age group or where age is less than 5 years old.

Data is provisional and subject to change following further validation checks. Any changes to historic figures will be reflected in the most recent publication. Please note that numbers published by UKHSA are for public health surveillance purposes only.

Immunity derived from vaccination declines over time and many of the oldest adults received their most recent vaccine dose in September or October 2021. These individuals are at much higher risk of severe coronavirus (COVID-19). Therefore, as a precautionary strategy to maintain high levels of immunity, an extra spring dose is advised around six months and provided there is at least three months from the previous dose for adults aged 75 years and over, residents in a care home for older adults, and individuals aged 12 years and over who are immunosuppressed, as defined in in the COVID 19 healthcare guidance [Green Book](#).

By the end of week 16 (week ending 24 April 2022), 42.9% (2,249,464/5,241,765) of all people aged 75 and over had been vaccinated with a spring booster dose since 21 March 2022, Table 8. Table 9 provides contextual information on how recently people aged 75 and over have been vaccinated, with 32.4% (1,700,695/5,241,765) having been last vaccinated at least six months ago and a further 18.0% (943,208/5,241,765) last vaccinated between 3 and 6 months ago.

Table 8: Provisional cumulative people vaccinated with at least 3 doses of COVID-19 vaccine since the start of the Spring booster campaign that began on the 21 March 2022 by age in England.

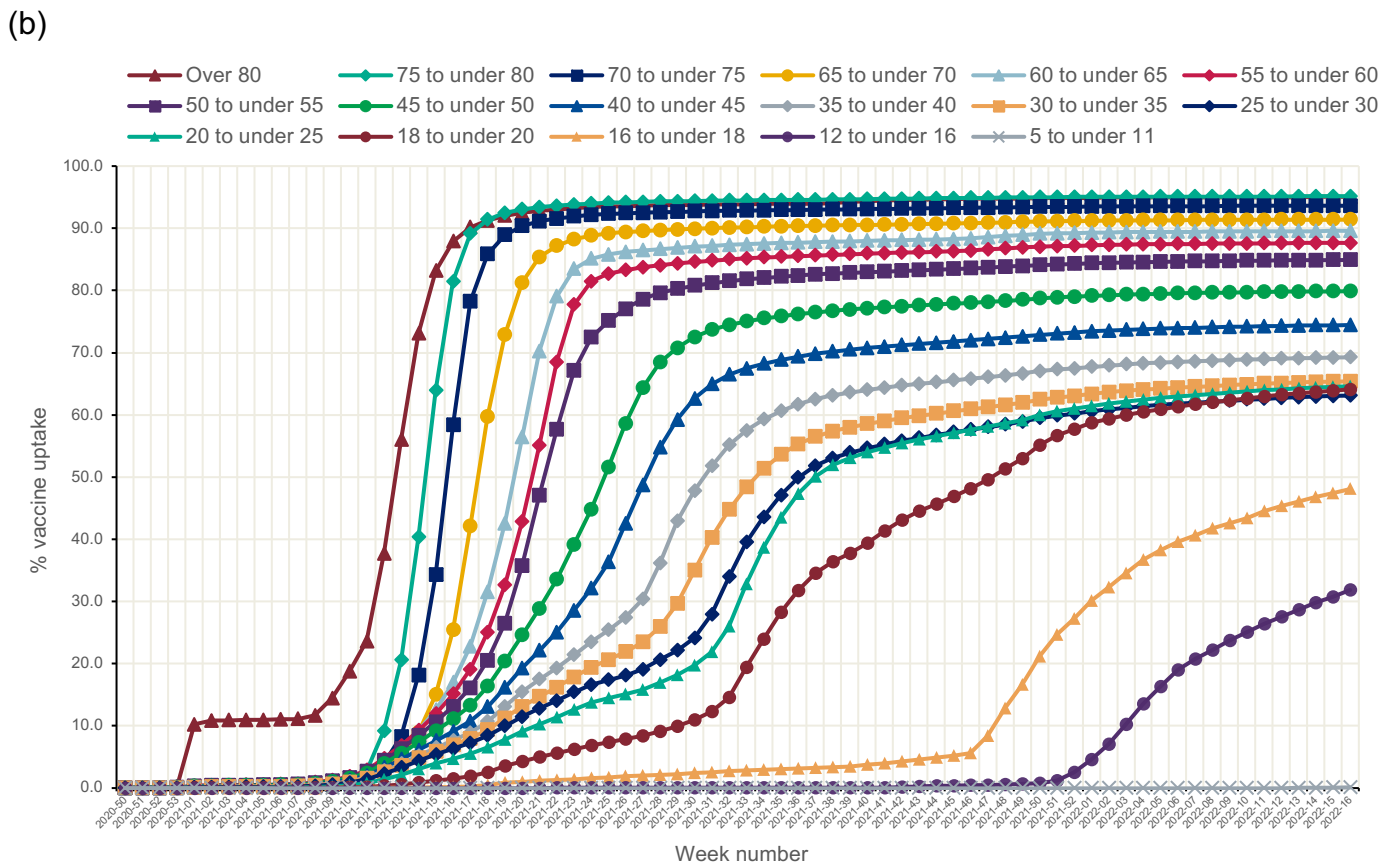
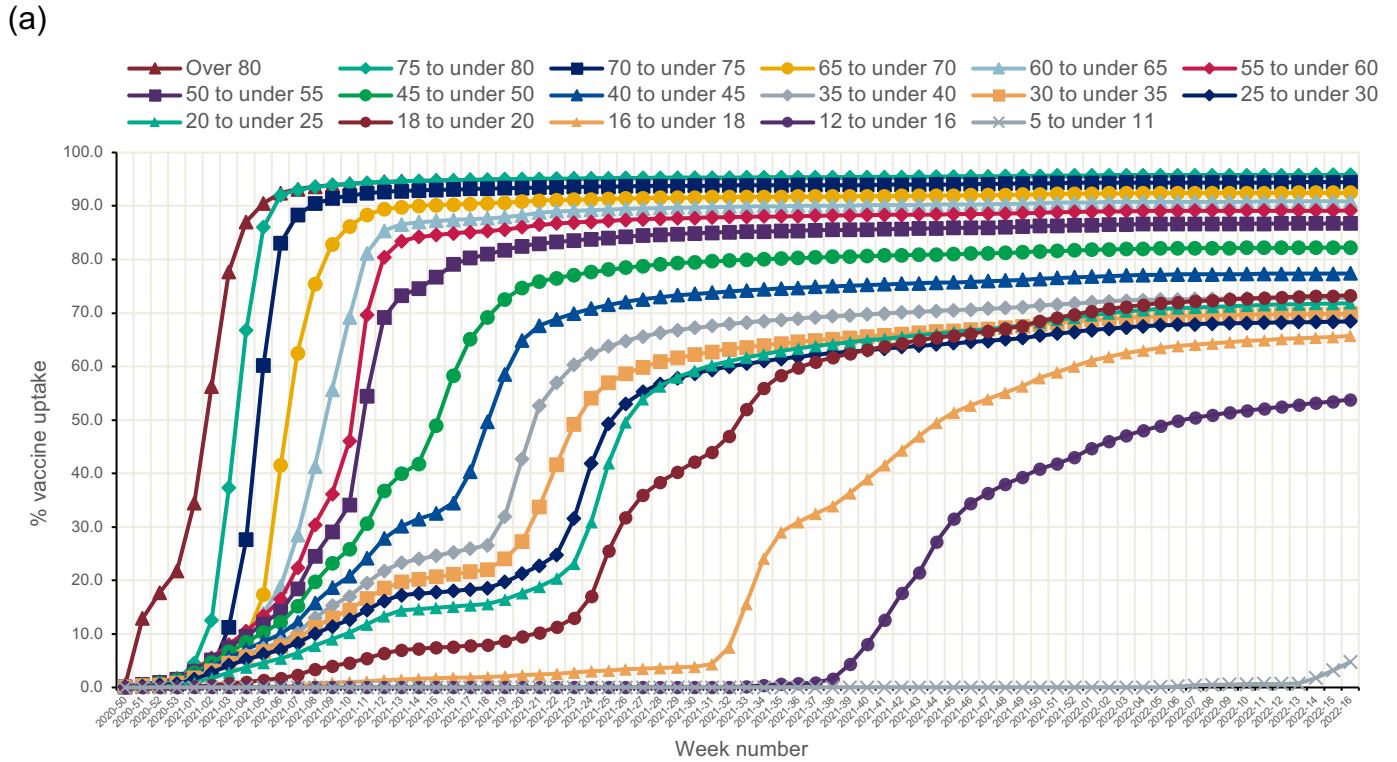
NATIONAL	People in NIMS cohort	Vaccinated with at least 3 doses since 21 March 2022 (spring booster)	Percentage vaccine uptake
Over 80	2,924,914	1,308,390	44.7
75 - 79	2,316,851	941,074	40.6
75 and over	5,241,765	2,249,464	42.9

These tables present coverage as measured against the total population of people aged 75 and over (so includes people who are not yet due to have their spring booster).

Table 9: 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	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	2,924,914	1,376,657	47.1	474,937	16.2	946,655	32.4
75 - 79	2,316,851	997,507	43.1	468,271	20.2	754,040	32.5
75 and over	5,241,765	2,374,164	45.3	943,208	18.0	1,700,695	32.4

Figure 62: Cumulative weekly COVID-19 vaccine uptake by age in England for (a) Dose 1, (b) Dose 2 and (c) Dose 3 (please note the data for this graph is shown from week 35 (week ending 5 September 2021))



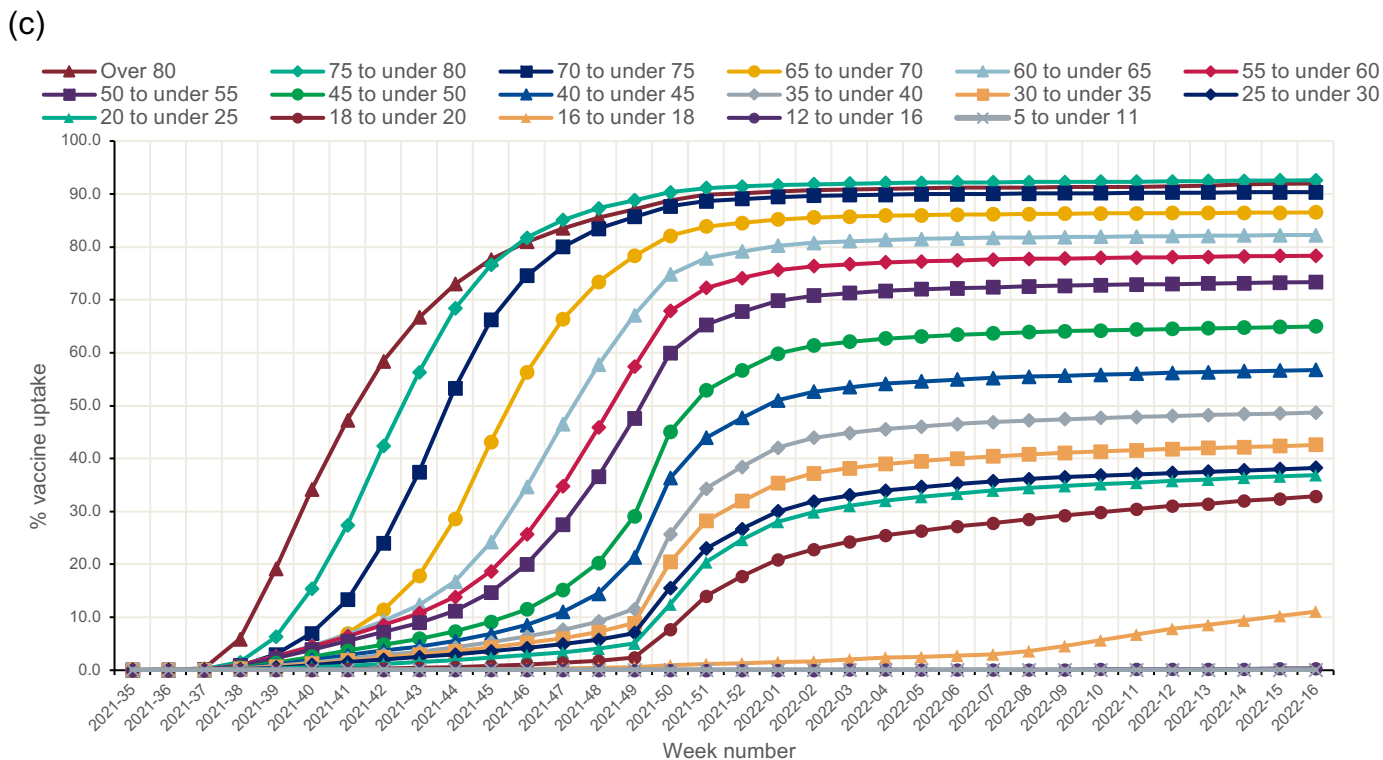


Figure 63: Age-Sex pyramid for COVID-19 vaccine uptake by age in England for Dose 1

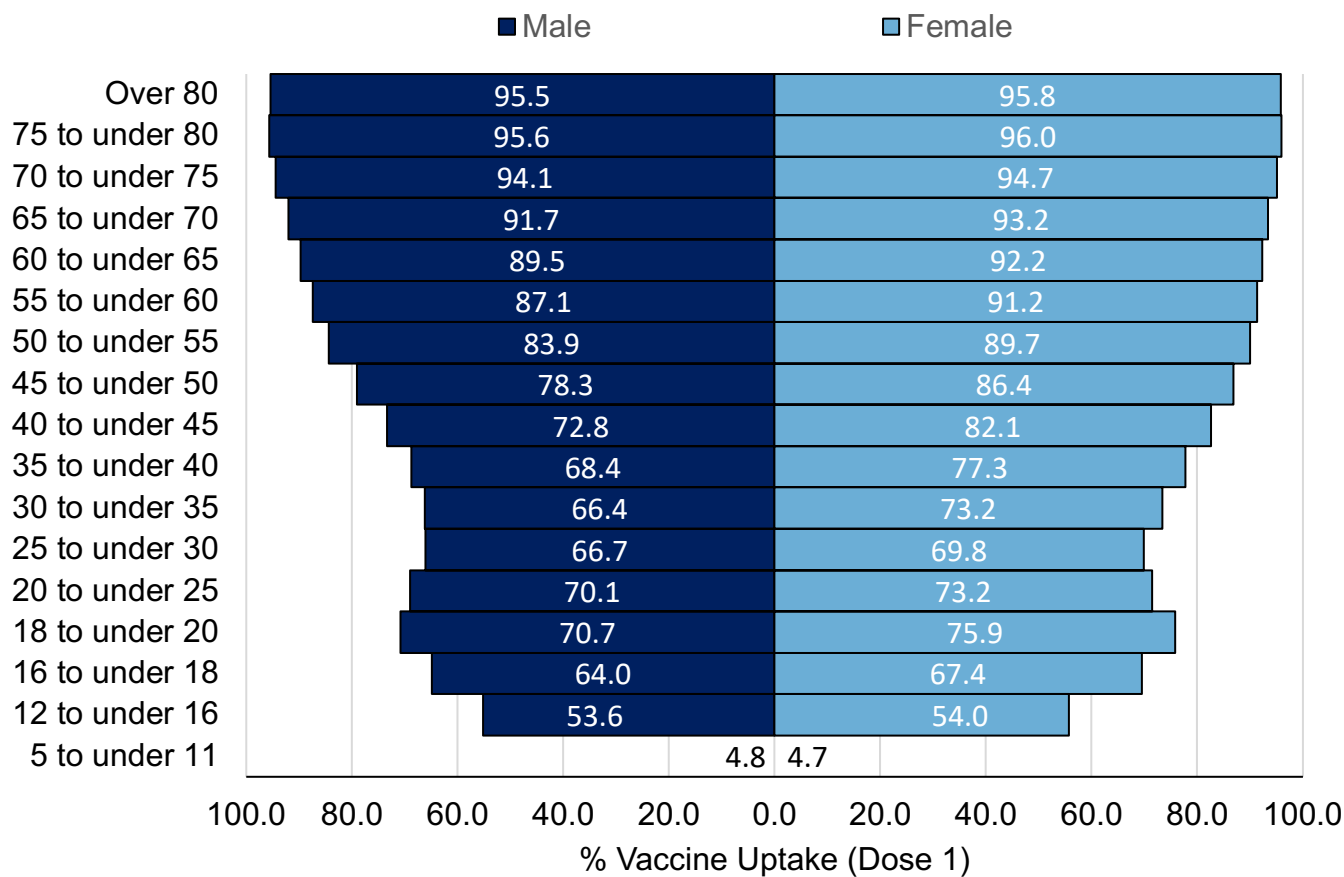


Figure 64: Age-Sex pyramid for COVID-19 vaccine uptake by age in England for Dose 2

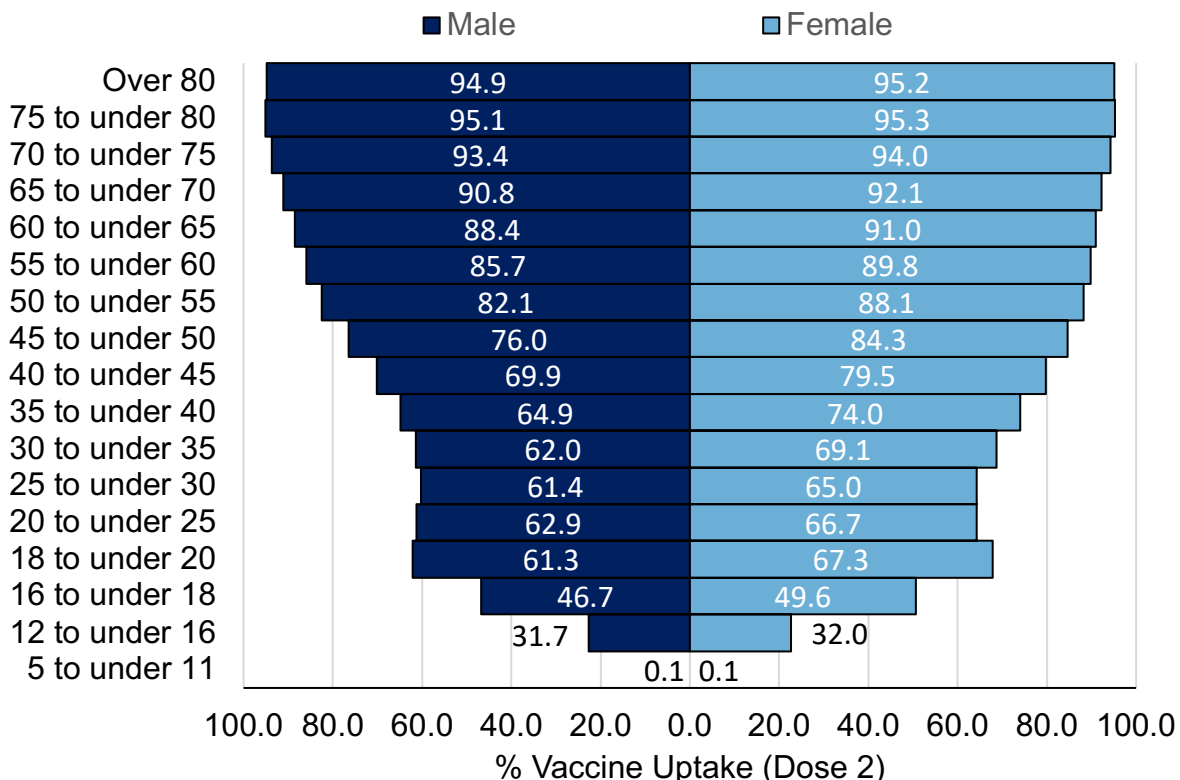
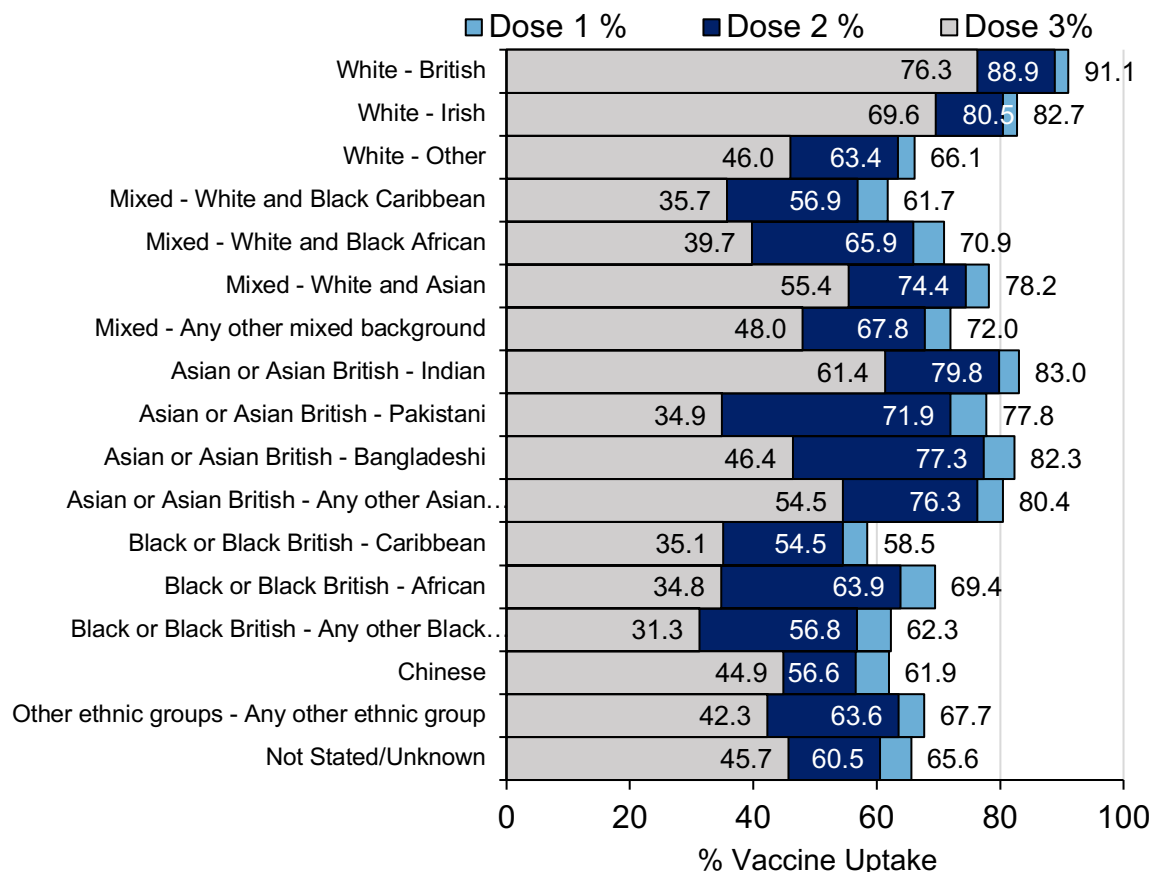


Figure 65: Cumulative weekly COVID-19 vaccine uptake by ethnicity in those living and resident in England, aged 18 and over.



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

From the 6 January 2021 (week 1 of 2021), the Joint Committee on Vaccination and Immunisation (JCVI) advised initially prioritising delivery of the first vaccine dose to maximise the public health impact in the short term and reduce the number of preventable deaths from COVID-19. [See statement](#).

From 18 November 2021, UKHSA have started to report on those in the population with at least 3 doses of COVID-19 vaccine. These figures count the number of doses a person has had in chronological order and include vaccinations given before the start of the programme where data is available to provide a more complete record of the population coverage estimates.

Age was previously calculated as age on the 31 August 2021 (academic cohort for all ages). Please note that from 14 January 2022 (week15 2022), age is calculated on the date data is extracted. The weekly vaccine coverage data is extracted on a Tuesday with data capped to the previous Sunday and all backing data is updated each week going back to the start of the programme. While this change will have an initial impact on vaccine uptake data by age, it is a positive change ensuring more accuracy and consistency in the data moving forwards.

For UK COVID-19 daily counts of vaccinations, please see the [Vaccinations' section of the UK COVID-19 dashboard](#).

For COVID-19 management information on the number of COVID-19 vaccinations provided by the NHS in England, please see the [COVID-19 vaccinations](#) webpage.

International update

Global COVID-19 update

Globally, up to 26 April 2022, a total of 508,968,152 cases of COVID-19 infection have been reported worldwide, including 6,220,002 COVID-19 related deaths.

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

Figure 66: Global map of cumulative COVID-19 cases

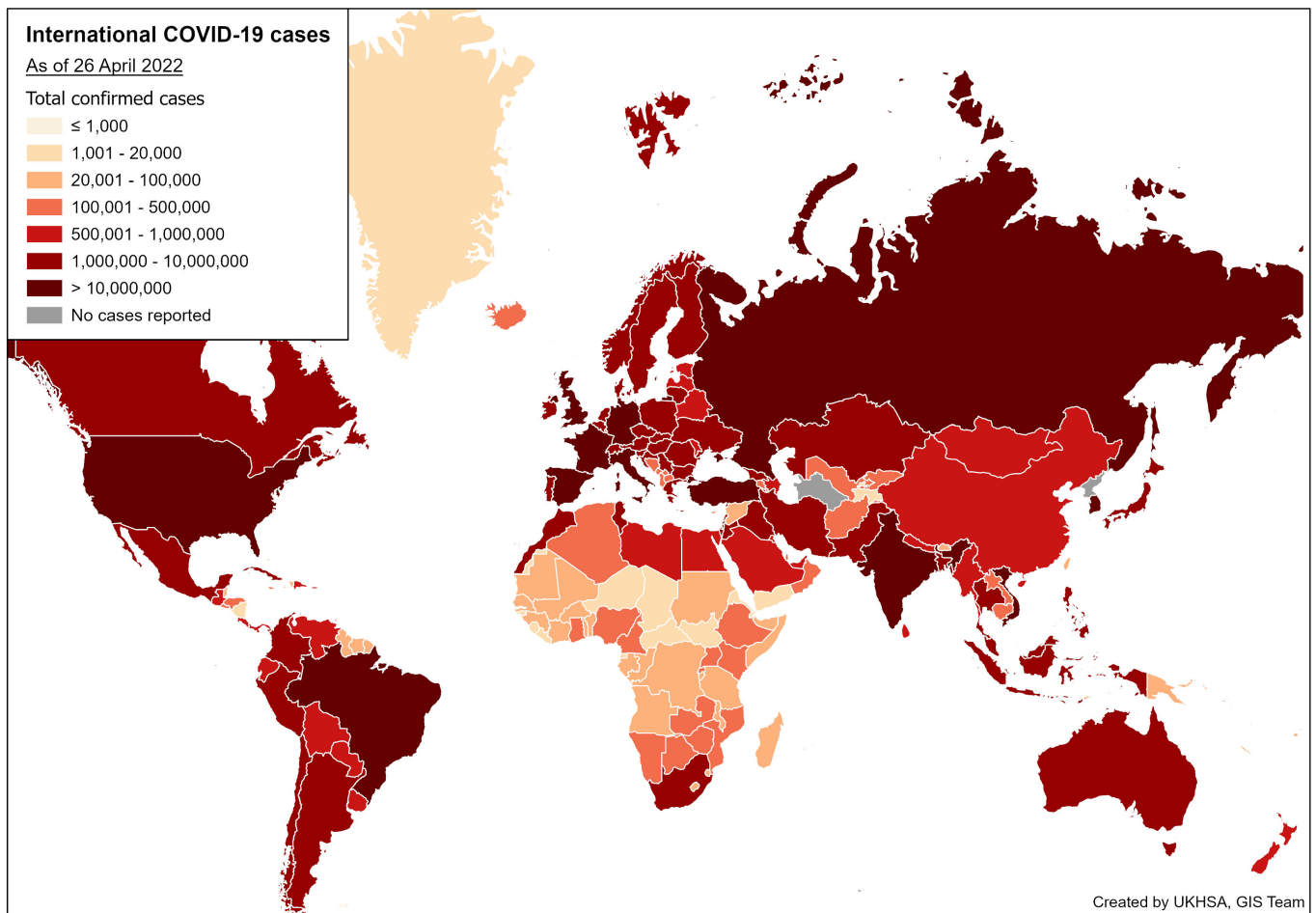


Figure 67: Global map of percentage change in weekly COVID-19 case incidence rate per 100,000 population compared to the previous week

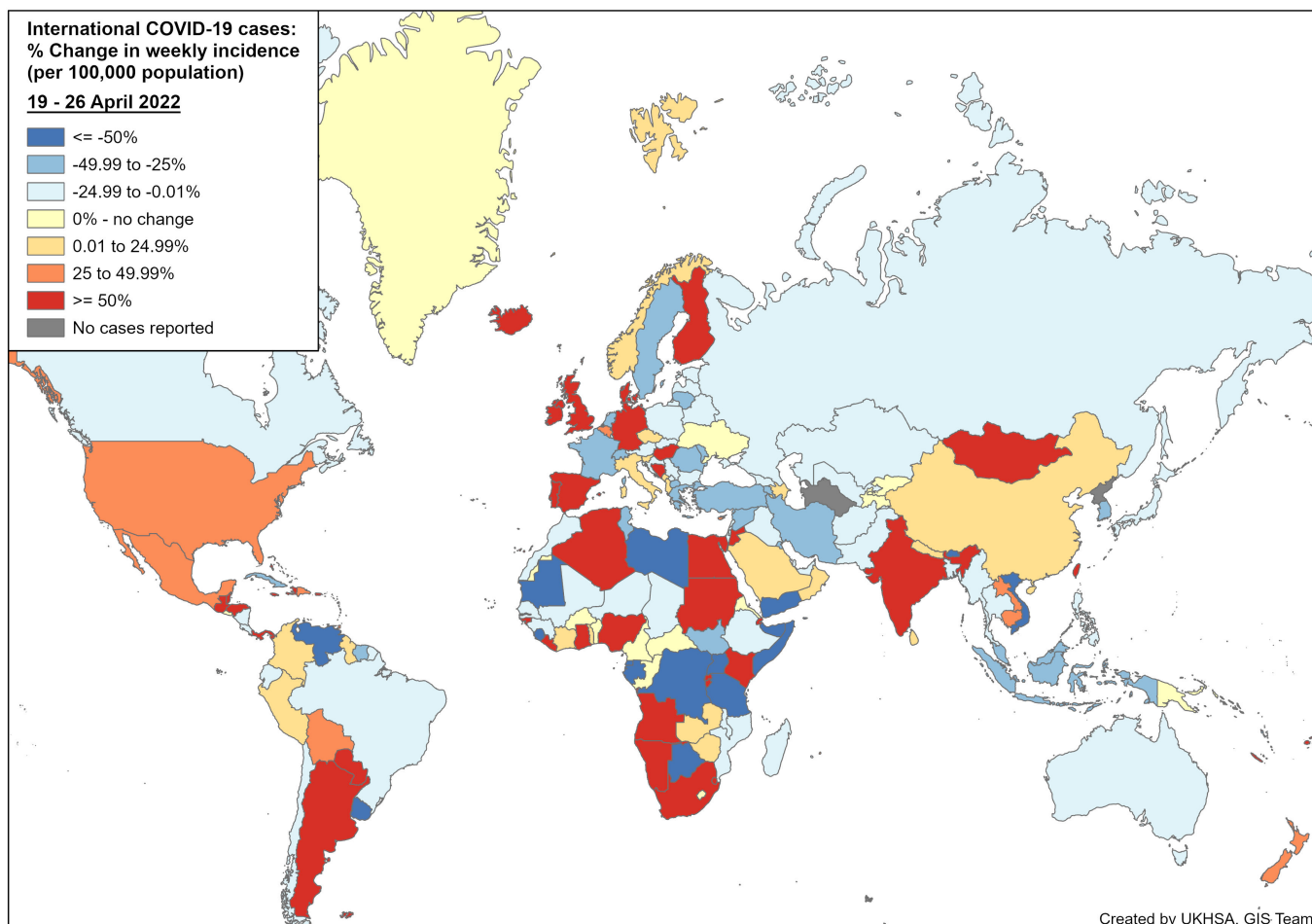
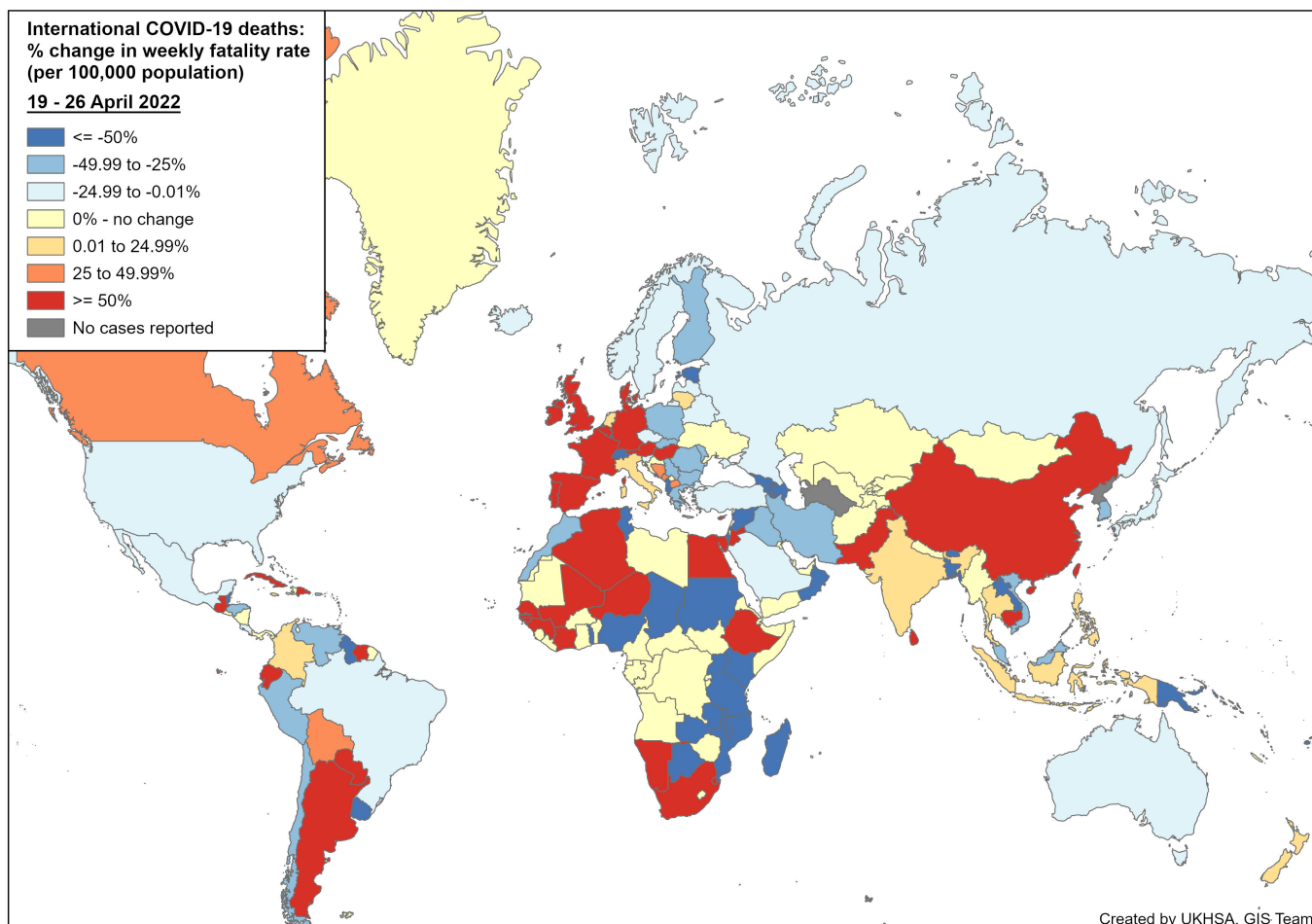


Figure 68: Global map of percentage change in weekly COVID-19 fatality rate per 100,000 population compared to the previous week



Global influenza update

Updated on 18 April 2022 (based on data up to 3 April 2022) ([WHO website](#)).

In the temperate zones of the northern hemisphere, influenza activity increased or remained stable, except in East Asia where detections decreased. Detections were mainly influenza A(H3N2) viruses and B/Victoria lineage viruses. In the temperate zones of the southern hemisphere, influenza activity remained low overall, although detections of influenza A viruses (with A(H3N2) predominant among the subtyped viruses) continued to be reported in some countries in temperate South America and South Africa.

In North America, influenza activity continued to increase in recent weeks but remained lower than pre-COVID-19 pandemic levels at this time of the year and was predominantly due to influenza A viruses, with A(H3N2) predominant among the subtyped viruses.

In Europe, overall influenza activity has stabilised with influenza A(H3N2) predominant.

In East Asia, influenza activity with mainly influenza B/Victoria lineage detections appeared to decrease in China. ILI rate and pneumonia hospitalizations remained elevated in Mongolia. Elsewhere, influenza illness indicators and activity remained low.

In Northern Africa, increasing detections of influenza A(H3N2) were reported in Tunisia.

In Western Asia, influenza activity was low across reporting countries, with the exception of Georgia where increased detections of influenza A(H3N2) were reported.

In the Caribbean and Central American countries, low influenza activity was reported with influenza A(H3N2) predominant.

In tropical South America, low influenza activity was reported with influenza A(H3N2) predominant.

In tropical Africa, influenza activity was reported mainly from Eastern Africa with influenza A(H3N2) predominating followed by influenza B/Victoria lineage viruses.

In Southern Asia, influenza virus detections were at low levels with influenza A(H1N1)pdm09 and A(H3N2) viruses detected.

In South-East Asia, influenza detections were at low levels except in Timor-Leste with influenza A(H3N2) predominant.

The WHO Global Influenza Surveillance and Response System (GISRS) laboratories tested more than 351,420 specimens during the period 21 March 2022 to 3 April 2022. A total of 36,312 specimens were positive for influenza viruses, of which 35,040 (96.5%) were typed as influenza A and 1,272 (3.5%) as influenza B. Of the sub-typed influenza A viruses, 275 (5.5%) were influenza A(H1N1)pdm09 and 4,682 (94.5%) were influenza A(H3N2). Of the characterized B viruses, 1 (0.1%) belonged to the B-Yamagata lineage and 1,005 (99.9%) to the B-Victoria lineage.

Influenza in Europe

Updated on 27 April 2022, up to week 15 of 2022 ([Joint ECDC-WHO Europe Influenza weekly update](#))

For the region as a whole influenza activity is increased and remains well above what was seen in 2020-2021 but is still at lower levels compared to seasons prior to the COVID-19 pandemic.

Influenza activity, based on sentinel primary care specimens from patients presenting with ILI or ARI symptoms, first peaked in week 52 of 2021 (when it reached 19% positivity), declining thereafter until week 4 of 2022, when it increased again reaching a plateau phase (25-30%) since week 10 of 2022.

For week 15 of 2022, of 36 countries and areas reporting on intensity of influenza activity, 15 reported baseline-intensity (across the region), 15 reported low-intensity (across the region), 4 reported medium-intensity (Denmark, Iceland, Lithuania and Romania), 1 reported high-intensity (Estonia) and 1 reported very high-intensity (Luxembourg).

Of 37 countries and areas reporting on geographic spread of influenza viruses, 5 reported no activity (Belarus, Kosovo, North Macedonia, Poland and Ukraine), 11 reported sporadic spread (across the Region), 5 reported local spread (Austria, Czechia, Germany, Malta and Slovakia), 4 reported regional spread (Lithuania, Republic of Moldova, Romania and Serbia) and 12 reported widespread activity (northern, southern and western areas).

For week 15 of 2022, of 1,129 sentinel specimens tested for influenza viruses, 286 were positive. So far in the 2021 to 2022 influenza season, of 50,208 sentinel specimens tested for influenza viruses, 5,875 were positive.

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](#).

Other respiratory viruses

Avian influenza and other zoonotic influenza

[Latest WHO update on 7 April 2022](#)

Since the previous WHO update on 1 March 2022, 3 human cases of infection with avian influenza A(H5N6) viruses and 2 human cases of infection with avian influenza A(H9N2) viruses were reported officially.

Middle East respiratory syndrome coronavirus (MERS-CoV)

From September 2012 to 28 February 2022, a total of 2,585 laboratory-confirmed cases of MERS-CoV and 891 associated deaths were reported globally to WHO under the International Health Regulations (IHR 2005).

[WHO update – 7 April 2022](#)

Between 1 August 2021 to 28 February 2022, six additional cases of MERS-CoV infections, including four associated deaths were reported to WHO from the Kingdom of Saudi Arabia

[WHO update - 17 November 2021](#)

Up to 17 August 2021, 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 the on-going surveillance since September 2012.

On 2 February 2021, the National IHR Focal Point of the United Arab Emirates (UAE) notified WHO of one laboratory-confirmed case of MERS-CoV (WHO website).

Between 12 March and 31 July 2021, the National IHR Focal Point of Saudi Arabia reported 4 additional cases of Middle East Respiratory Syndrome Coronavirus (MERS-CoV) infection, including one associated death. (WHO website).

On 17 November 2021, the National IHR Focal Point of the United Arab Emirates (UAE) notified WHO of one laboratory-confirmed case of Middle East respiratory syndrome coronavirus (MERS-CoV) in UAE (WHO website).

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](#)

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

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

About the UK Health Security Agency

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

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