New autumn COVID-19 spike as UK government continues to limit access to free vaccines

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6 October 2025

The UK is experiencing a new spike in COVID-19 infections driven by two recently emergent Omicron subvariants dubbed “Stratus” and “Nimbus”. Together these now account for the majority of cases in the UK, with genomic surveillance indicating that roughly 63 percent of analysed cases were Stratus and 25 percent were Nimbus by late September.

The World Health Organization (WHO) has classified Stratus as a “variant under monitoring,” noting it showed the highest global growth advantage in mid-2025, even outpacing Nimbus. Despite their similar overall impact, Stratus and Nimbus have each been linked to some unusual symptoms, reflecting subtle differences in how these variants affect patients.

Doctors have noted that both can cause an extremely painful sore throat—described by some sufferers as a “razor blade” sensation—often leading to a hoarse or croaky voice. Stratus infections in particular have been associated with a persistent dry cough, fatigue and fever, while Nimbus is noted to be highly transmissible due to an enhanced ability to bind to human cells.

In July, the WSWS drew attention to the 11th wave of mass COVID-19 infection sweeping across the United States and other countries, driven by new highly transmissible variants.

Due to far fewer people now testing for COVID-19, it has become difficult to gauge the true spread of infection in Britain. Official case counts are a severe undercount of actual infections. But it is clear that after a summer “lull” in infections—during which around 800 people still died with COVID-19 on the death certificate—indicators are once again trending upward as autumn begins.

Over the month of September, reported infections and hospital admissions have risen steadily. In England, lab test positivity increased from 7.6 percent to 8.4 percent in mid-September. The UK Health Security Agency (UKHSA) surveillance report noted that COVID-19 activity, while still at a “low” baseline level, “increased slightly” heading into October.

The limited testing that is done suggests a few thousand cases are being identified per week—around 1,995 cases were recorded in the week of September 10–17, a 14.3 percent rise from the previous week. By comparison, data available for August showed about 1,162 people admitted with COVID-19 in the entire month—which was already up 15.6 percent from July.

All these figures greatly understate reality. With the government having shut down free mass testing and scaled back surveillance, official case numbers are far lower than they were a few years ago, capturing only a fraction of infections (primarily those tested in hospitals). Even UKHSA officials acknowledge that it is “increasingly difficult for experts to track infections”. Workers are left in the dark about the true extent of COVID spread in their communities.

Even the incomplete data shows a concerning rise in illness “so early in autumn”, as one medical expert told the *BMJ* (formerly, *British Medical Journal*). Hospitalisations are climbing alongside cases. The UKHSA reports that weekly COVID hospital admission rates in England jumped from 2.0 per 100,000 population to about 2.73 in mid-September—an increase of 37 percent in a week.

Under the bipartisan policy of “living with the virus”, the wearing of masks, isolation, contact-tracing, and other public health mitigation measures have been eliminated. The result is that, outside of individual

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choice, there are effectively no barriers to COVID-19 spreading through the UK's schools, workplaces, and public venues.

The official guidance remains that if someone feels unwell with respiratory symptoms or fever, they "should avoid contact with vulnerable people and stay at home if possible", but this is purely advisory. In reality, many cannot afford to isolate due to work pressures or may not even realize they have COVID because testing is so scarce. This laissez-faire approach virtually guarantees continued mass infection, which in turn means more illness and the potential for further variants to emerge.

One of the few remaining pillars of the pandemic response is vaccination, but this too has been drastically scaled back. As of autumn 2025, the National Health Service (NHS) is offering a COVID booster only to a very limited high-risk group: adults aged 75 and over, residents of care homes for older adults, and individuals with weakened immune systems (6 months+).

This is an even narrower criterion than the previous year which also included adults aged 65-74 and people in clinical risk groups, both dropped from free eligibility in 2025.

In other words, millions of people who once qualified for free COVID vaccination are now excluded. They must either pay out-of-pocket for a private vaccine or go without. The price of a private COVID jab in the UK is between £75–£105, making it unaffordable for many already devastated by a years-long and worsening cost of living crisis.

Unsurprisingly, uptake has fallen, with vast numbers of Britons, even those medically vulnerable, having not received any booster in the last year. This situation is also a result of the systematic attack on public awareness of the continued danger posed by the disease. Many workers, misled into thinking COVID is "over", do not get another shot.

Health officials still emphasize that vaccines are crucial. UKHSA data from last winter showed those who got the booster were 43 percent less likely to be hospitalized with COVID compared to the unvaccinated. The agency is urging everyone who is eligible this autumn to come forward for both the COVID and flu vaccines ahead of winter. "The most important thing is for those eligible to get their vaccination when it is due," officials insist. However, this messaging rings hollow given that the majority of the population is deemed ineligible for free COVID boosters.

Past waves of infection have already left a devastating impact on the working class in the form of Long-COVID. According to the most recent Office for National Statistics /UKHSA estimates—published in April 2024—2 million people (3.3 percent of the population in private households in England and Scotland) report Long-COVID symptoms. Of these, 75 percent said their daily activities were limited, and 19 percent said they were "limited a lot." Half reported symptoms lasting for two years; about 31 percent for three years.

Despite this lasting damage, NHS England ended ring-fenced funding for specialist Long-COVID services on April 1 this year. Many clinics are closing or scaling back services.

According to "The Sick Times" website, dedicated to chronicling the Long-COVID crisis, out of a peak figure of 120 Long-COVID services nationwide, only 46 confirmed they would remain open by July 2025. This has created a postcode lottery, with workers living in some Integrated Care Board (ICB) areas, such as Northeast London and Lancashire and South Cumbria, having no access to Long-COVID care under the NHS.

Workers in the UK and internationally must oppose their governments' slashing of resources to fight the ongoing COVID-19 pandemic and fight for a policy of eliminating the virus to protect themselves and wider society from this devastating disease. Such a strategy must be funded by the hoarded wealth of the corporations and the super-rich, and organised democratically and scientifically, not subordinated to the demands of the capitalist oligarchy.

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