



Public Health
England

Protecting and improving the nation's health

Weekly national Influenza and COVID-19 surveillance report

**Week 53 report (up to week 52 data)
31 December 2020**

Executive summary

This report summarises the information from the surveillance systems which are used to monitor Coronavirus Disease 2019 (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 52 (between 21 December and 29 December 2020) and for some indicators daily data up to 29 December 2020.

Data over the Christmas period may be subject to delays and should be interpreted with caution.

Surveillance indicators suggest that COVID-19 activity at a national level has continued to increase during week 52. There is currently limited testing for other respiratory viruses, however, laboratory indicators suggest that influenza activity is low.

Since week 45, mass asymptomatic testing has been rolled out in parts of the country (<https://www.gov.uk/government/news/more-rapid-covid-19-tests-to-be-rolled-out-across-england>). This is likely to impact on some surveillance indicators.

Detections of COVID-19 cases in England increased further in week 52. Overall positivity rates also increased in both Pillar 1 and 2. The highest case rates and positivity continued to be seen in London, South East and East of England in week 52, while smaller increases were observed in all other regions. Cases rates were highest amongst the 20 to 49 year olds in week 52. By ethnicity, there continues to be a notable increase in other ethnic groups. Positivity has increased and remains much higher in individuals who have reported having symptoms.

Through Respiratory Datamart, there were one influenza positive sample (1 influenza A not subtyped) detected in week 51. Rhinovirus activity decreased slightly in week 52.

The overall number of acute respiratory infection incidents reported to PHE Health Protection Teams has decreased from 922 in the previous week to 846 in week 52 across all settings in England. In the majority of reported incidents SARS-CoV-2 has been detected. It is important to note that an increasing number of outbreaks are being managed through other routes outside of Health Protection Teams.

The majority of community and syndromic indicators have remained stable or increased slightly during week 51. General practice (GP) influenza-like illness (ILI) consultations remained low in all UK schemes.

Through the UK GP swabbing scheme, SARS-CoV-2 positivity among patients contacting their GP with influenza like illness or lower respiratory tract infection symptoms increased slightly from 30.6% (76/248) in week 51 to 33.0% (29/88) in week 52.

The overall COVID-19 confirmed hospital rate decreased slightly whilst that of COVID-19 confirmed ICU/HDU admission rates increased slightly. The overall influenza confirmed hospital and ICU/HDU admission rates remained low.

Emergency department attendances for COVID-19 like diagnosis increased further and whilst attendances for acute respiratory infections have remained stable in week 52.

The number of deaths among confirmed COVID-19 cases decreased in week 52. No overall excess all-cause mortality was observed in week 51.

The most recent overall estimated national seroprevalence based on blood donor samples was 6.9% with the highest seroprevalence by region seen in the North West and by age group in young adults. There have been notable increases in seroprevalence in the North-West and North East in recent weeks which is likely to reflect the high levels of COVID-19 activity in this region in recent months.

Influenza vaccine uptake is now above 80% (80.2%) in people aged 65 years + which is the highest uptake ever achieved. Uptake in 2 and 3 year children is the highest ever recorded. For those in at-risk groups uptake is 51.3% and higher than the same time in the last seven seasons. For pregnant women uptake is higher than the same time last season. All 50-64 year olds became eligible for vaccination on 1 December and 25.7% have taken it up so far (this excludes patients in this age band who are in a clinical risk group). Weekly vaccine coverage data are provisional.

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Laboratory surveillance

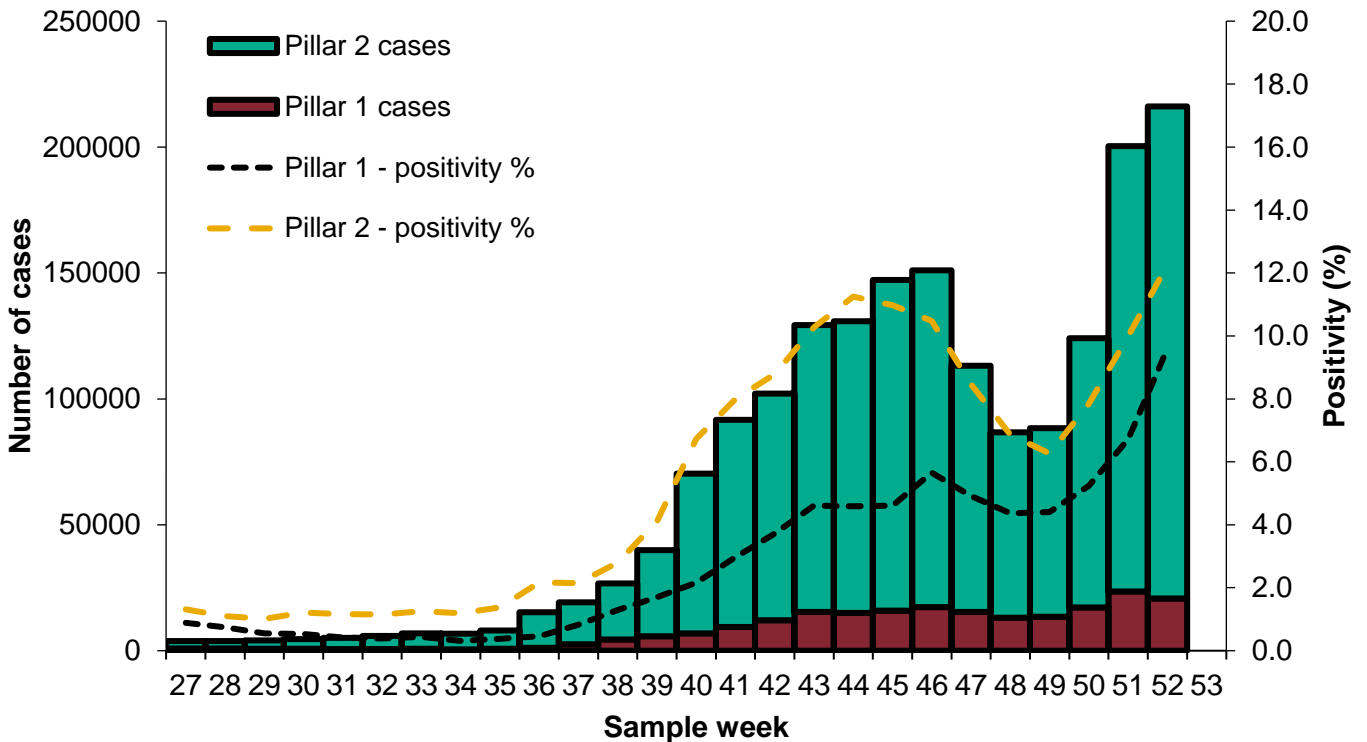
Confirmed COVID-19 cases (England)

As of 09:00 on 29 December 2020, a total of 2,046,892 have been confirmed positive for COVID-19 in England under Pillars 1 and 2.

Overall case numbers and positivity in both Pillar 1 and 2 continued to increase in week 52. The highest case rates were seen in the 30 to 39 and 20 to 29 year olds in Pillars 1 and 2. Increases in positivity rates were noted across the majority of age groups. Cases rates remain highest in London, East of England and South East regions, with smaller increases in other regions.

From the week 42 report onwards, case rates in Figures 3,4,7 and 9 have been calculated using mid-2019 ONS population estimates.

Figure 1: Laboratory confirmed COVID-19 cases tested under Pillar 1 and Pillar 2, based on sample week with overall weekly positivity for Pillars 1 and 2 (%)



*The data are 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.

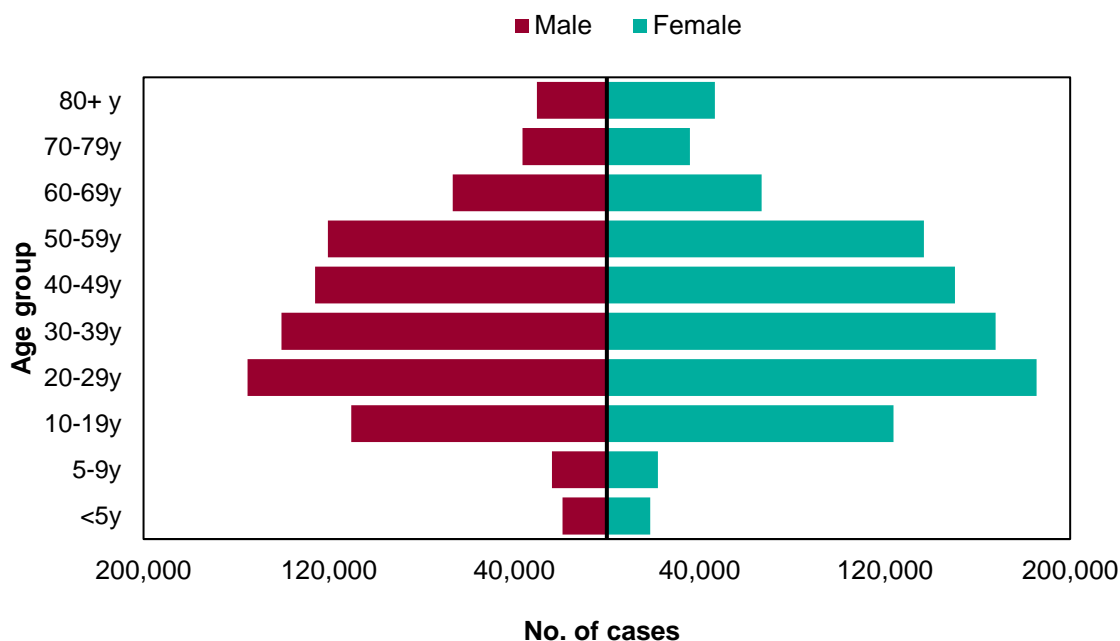
* Positivity is calculated as the number of individuals testing positive during the week divided by the number of individuals tested during the week based on PCR testing.

* As of 16 November 2020, the methodology for allocating geographies for cases has been updated to include alternate postcodes where applicable. This change has been applied for cases reported since 1 September 2020. Cases reported prior to 1 September 2020 will not be allocated alternate postcode geographies.

Age and sex

Figure 2: Age/sex pyramids for laboratory confirmed COVID-19 cases tested under Pillars 1 and 2 (a) cumulative number since week 27 (n=1,782,239), and (b) in weeks 51 and 52 (n=414,369)

(a)



(b)

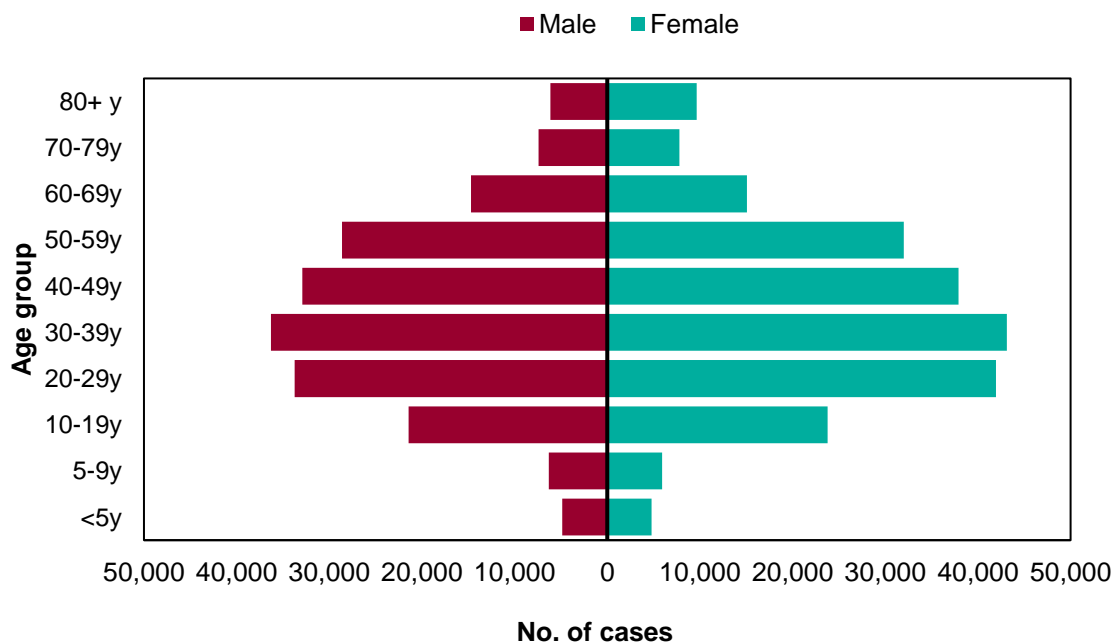


Figure 3: Weekly laboratory confirmed COVID-19 case rates per 100,000, tested under Pillar 1 and Pillar 2, by sex

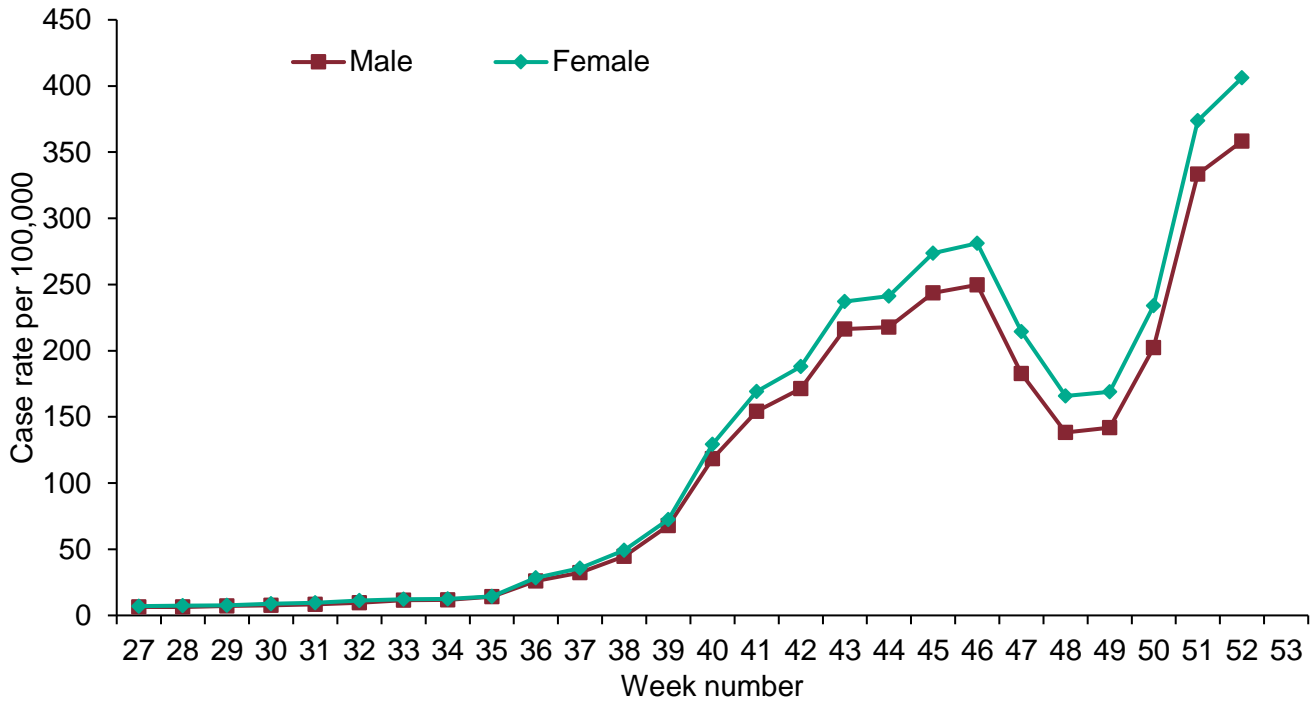


Figure 4: Weekly laboratory confirmed COVID-19 case rates per 100,000, tested under Pillar 1 and Pillar 2, by age group

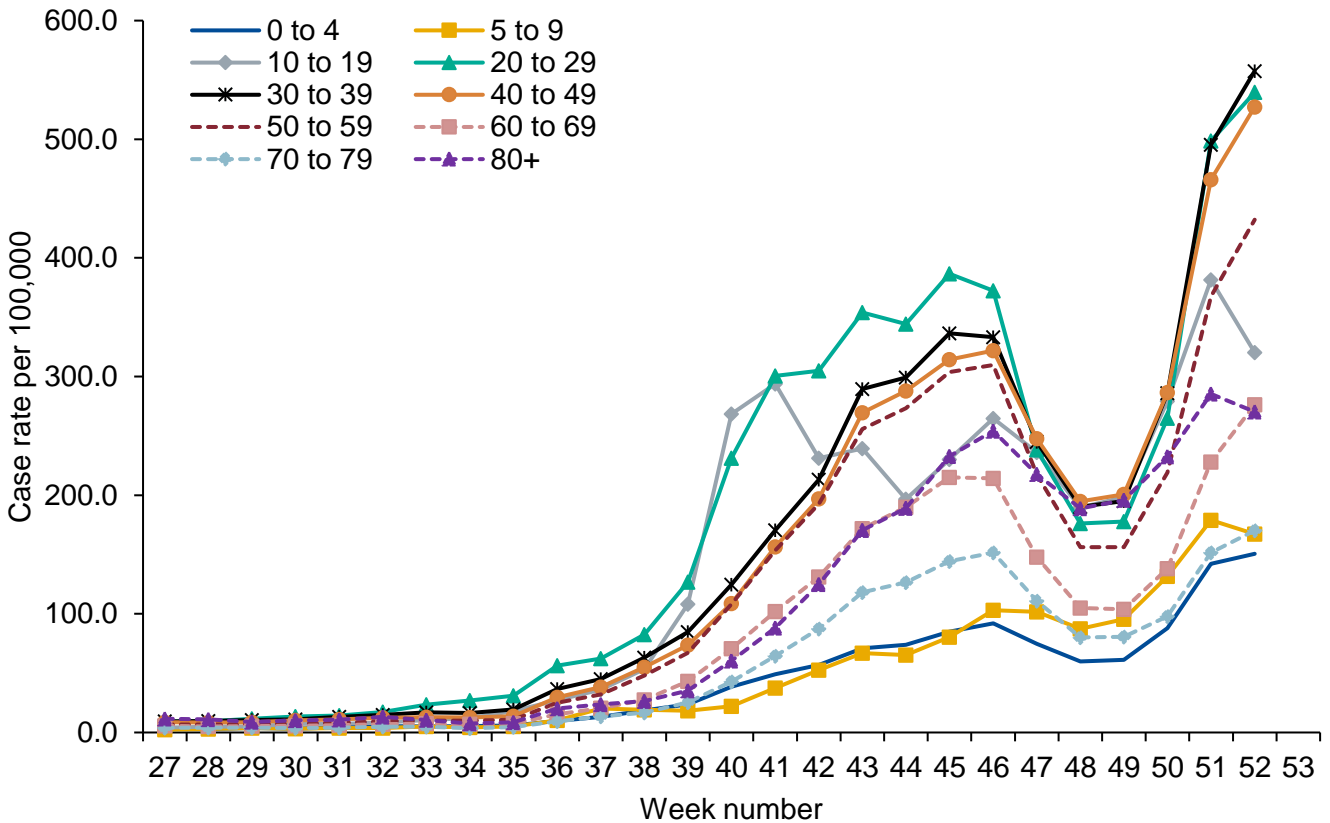
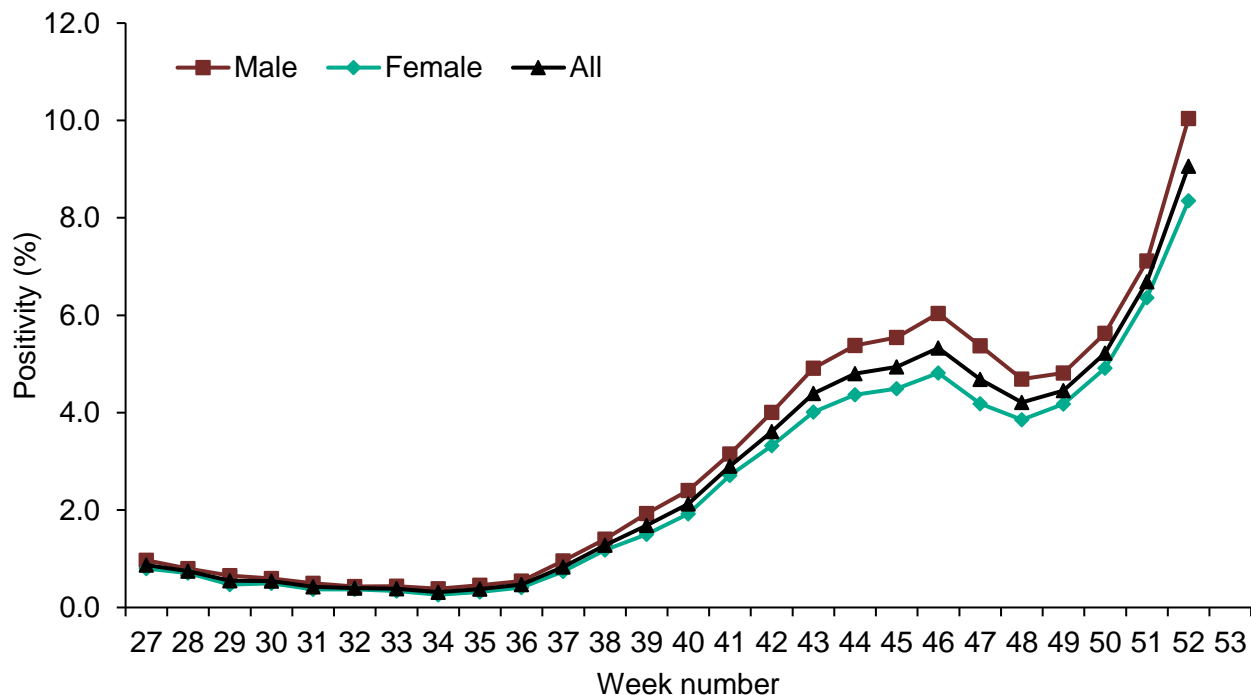


Figure 5: Weekly positivity (%) of laboratory confirmed COVID-19 cases tested overall and by sex under (a) Pillar 1 and (b) Pillar 2, (SGSS and Respiratory DataMart)

(a)



(b)

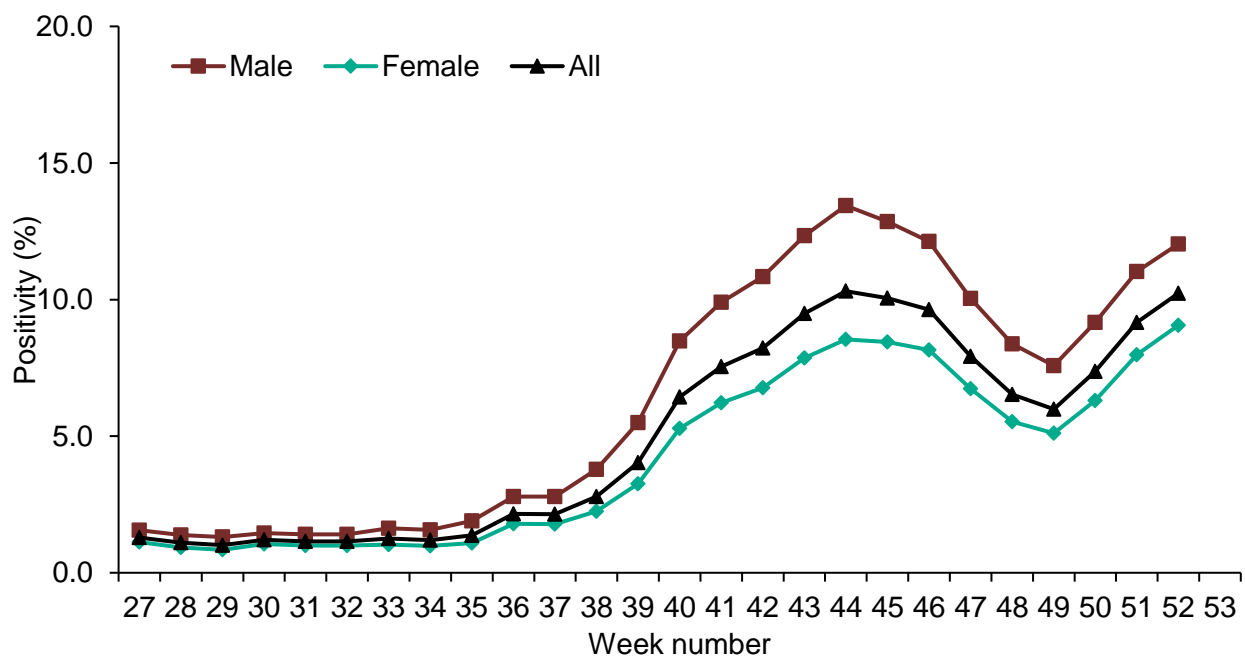
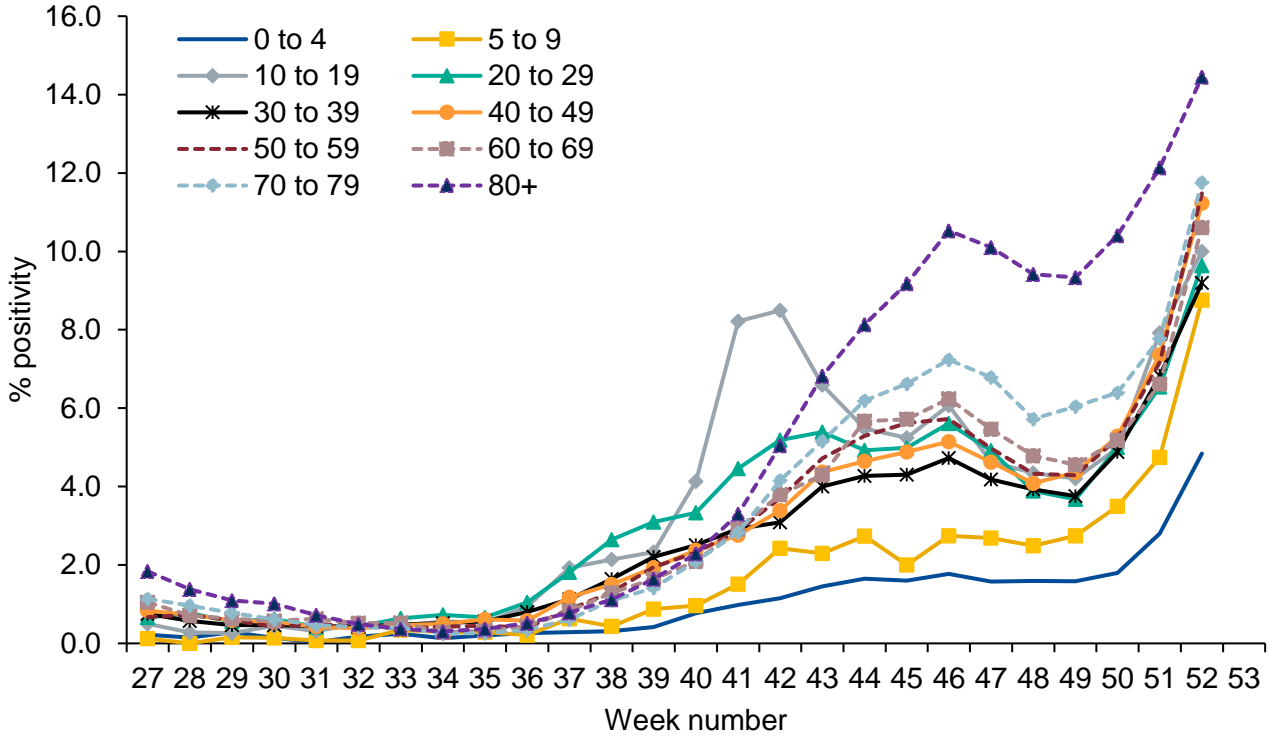
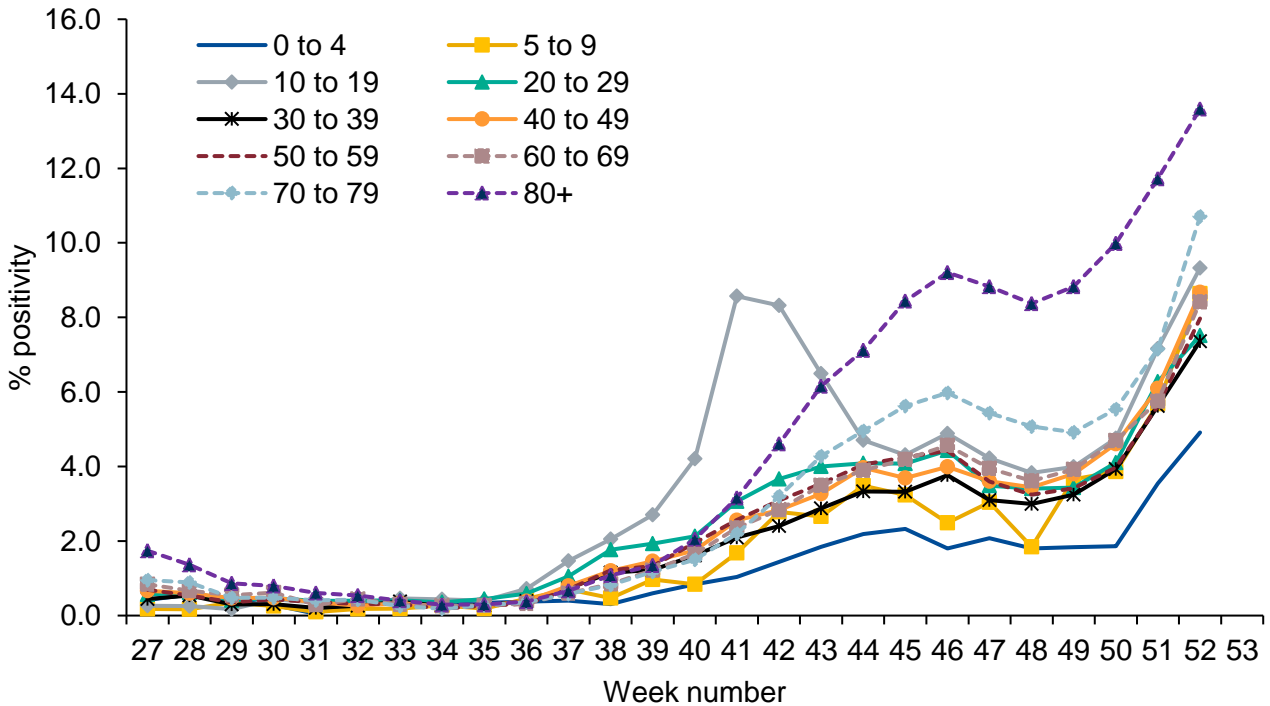


Figure 6: Weekly positivity (%) of laboratory confirmed COVID-19 cases tested under Pillar 1, (a) by male and age group and (b) by female and age group and; under Pillar 2, (c) by male and age group and (d) by female and age group, (SGSS and Respiratory DataMart)

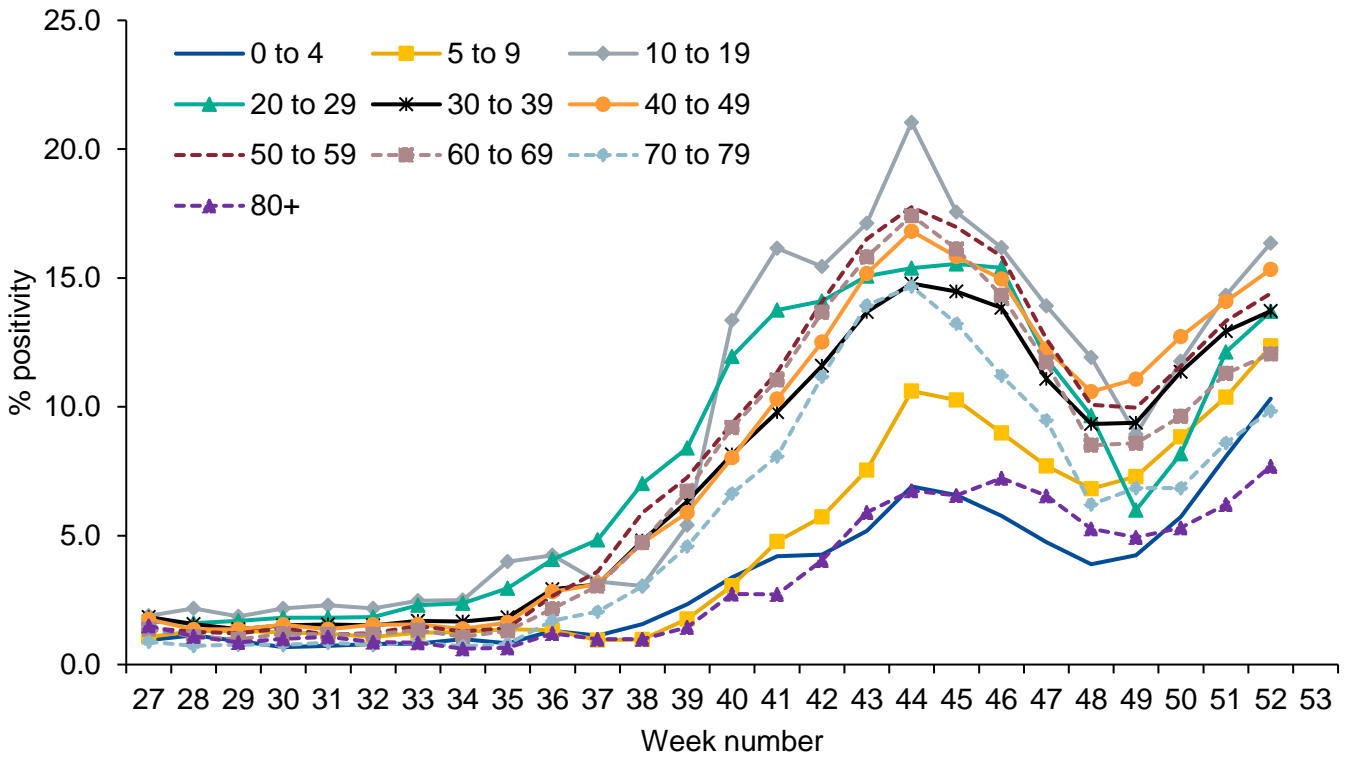
(a) Pillar 1 - Male



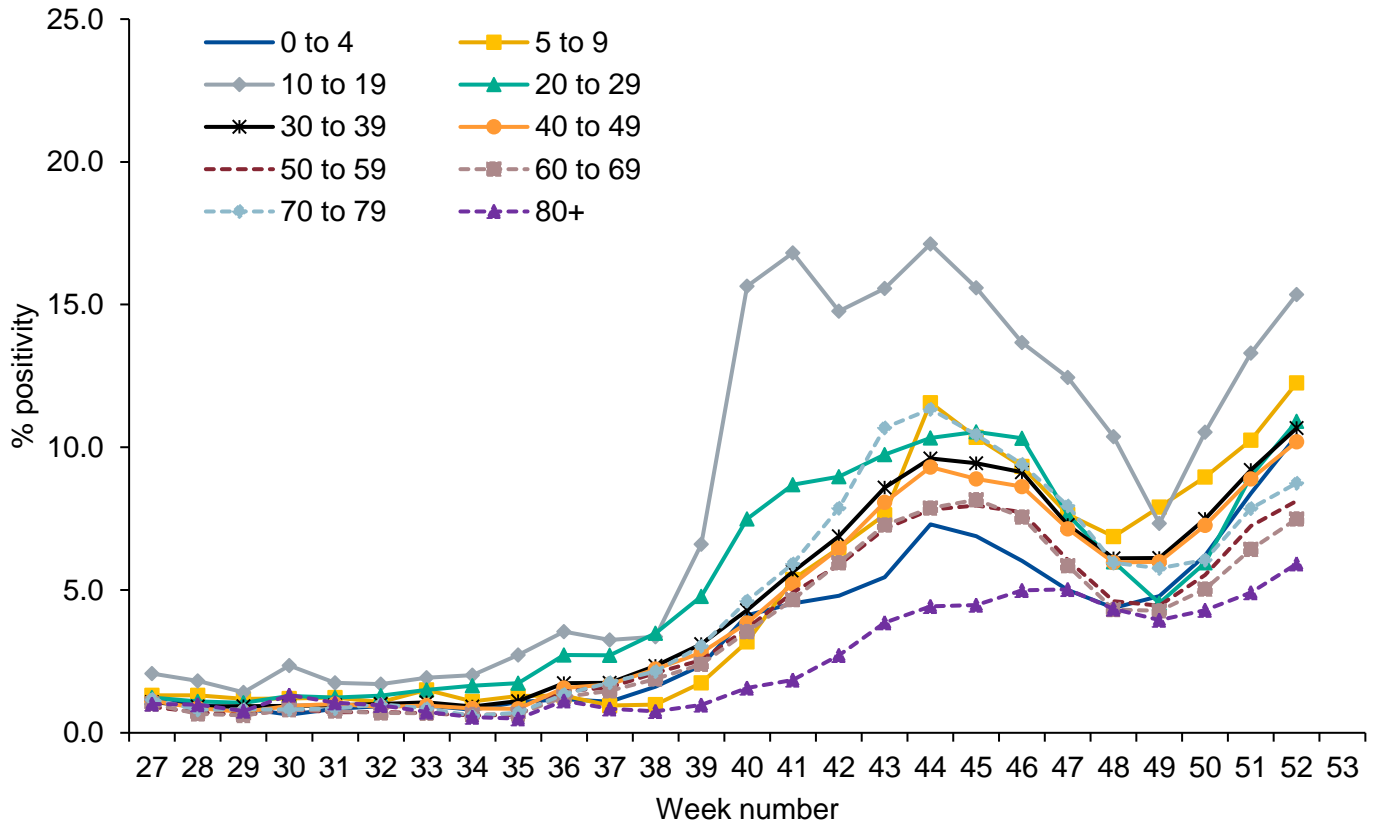
(b) Pillar 1 - Female



(c) Pillar 2 - Male



(d) Pillar 2 - Female



Geography

Table 1: Cumulative number of cases under Pillars 1 and 2 (n=2,023,379) and cumulative number of cases since week 27 under Pillar 1 and 2 (n=1,788,434)

PHE Centres	Cumulative Pillar 1 + 2 cases	Cumulative since week 27, Pillar 1 + 2 cases
North East	120,414	105,378
North West	360,281	318,032
Yorkshire and Humber	251,525	222,829
West Midlands	219,065	193,908
East Midlands	180,346	159,706
East of England	187,637	163,509
London	344,714	311,069
South East	249,845	217,145
South West	109,552	96,858

Figure 7: Weekly laboratory confirmed COVID-19 case rates per 100,000 population (Pillar 1 and Pillar 2), by PHE Centres and sample week

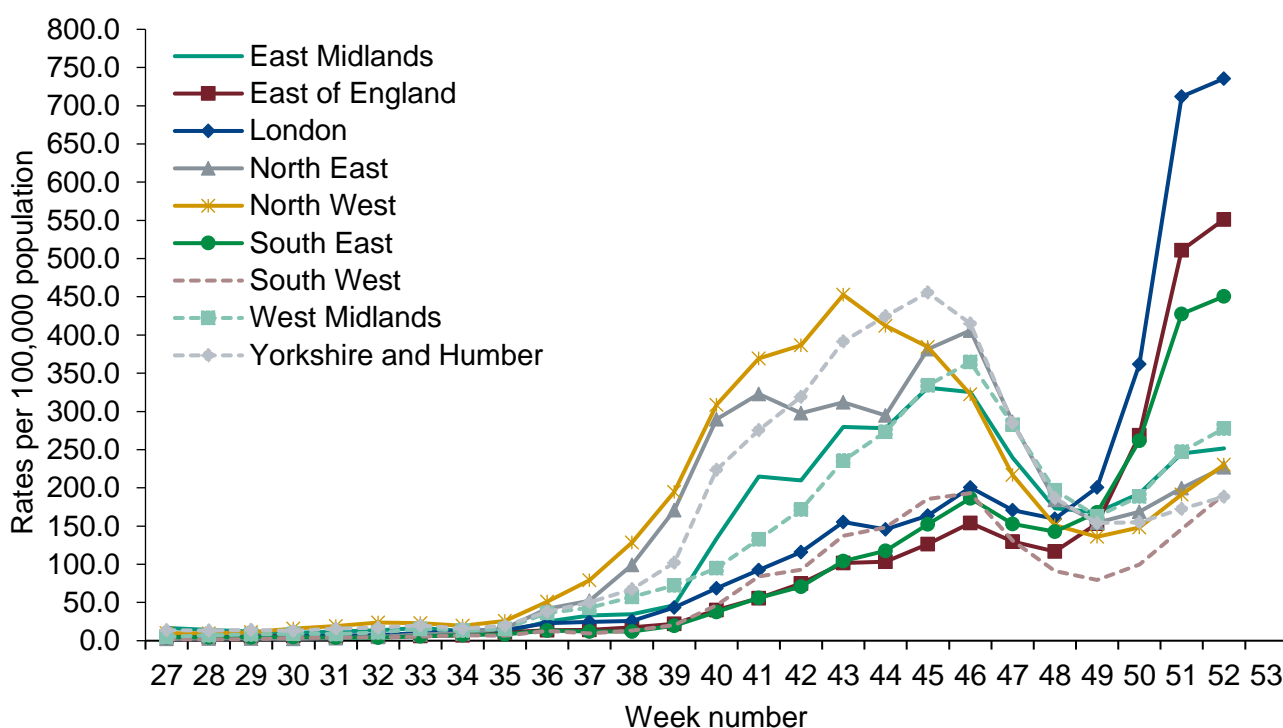


Figure 8: Weekly positivity of laboratory confirmed COVID-19 cases tested under (a) Pillar 1 (%) and (b) Pillar 2 (%), by PHE Centres and sample week, (SGSS and Respiratory DataMart)

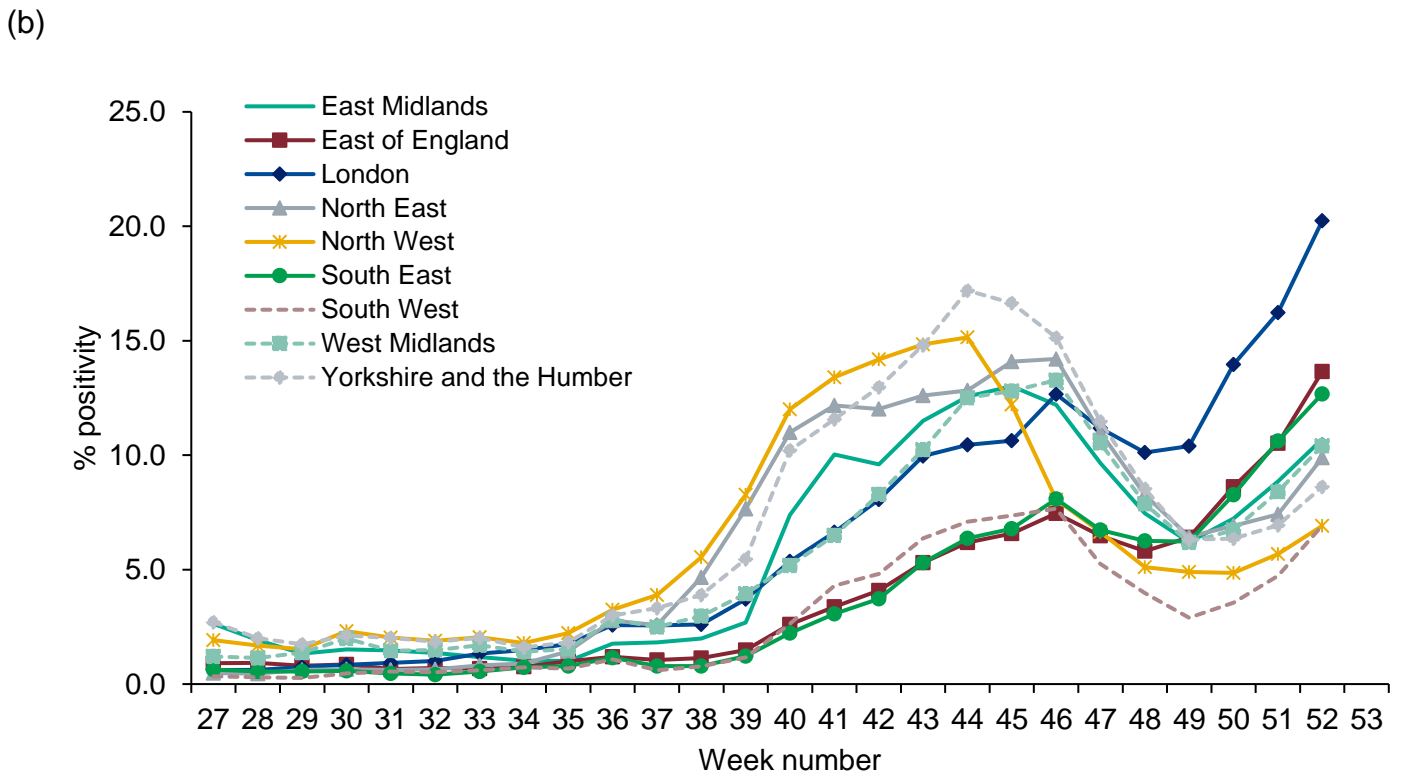
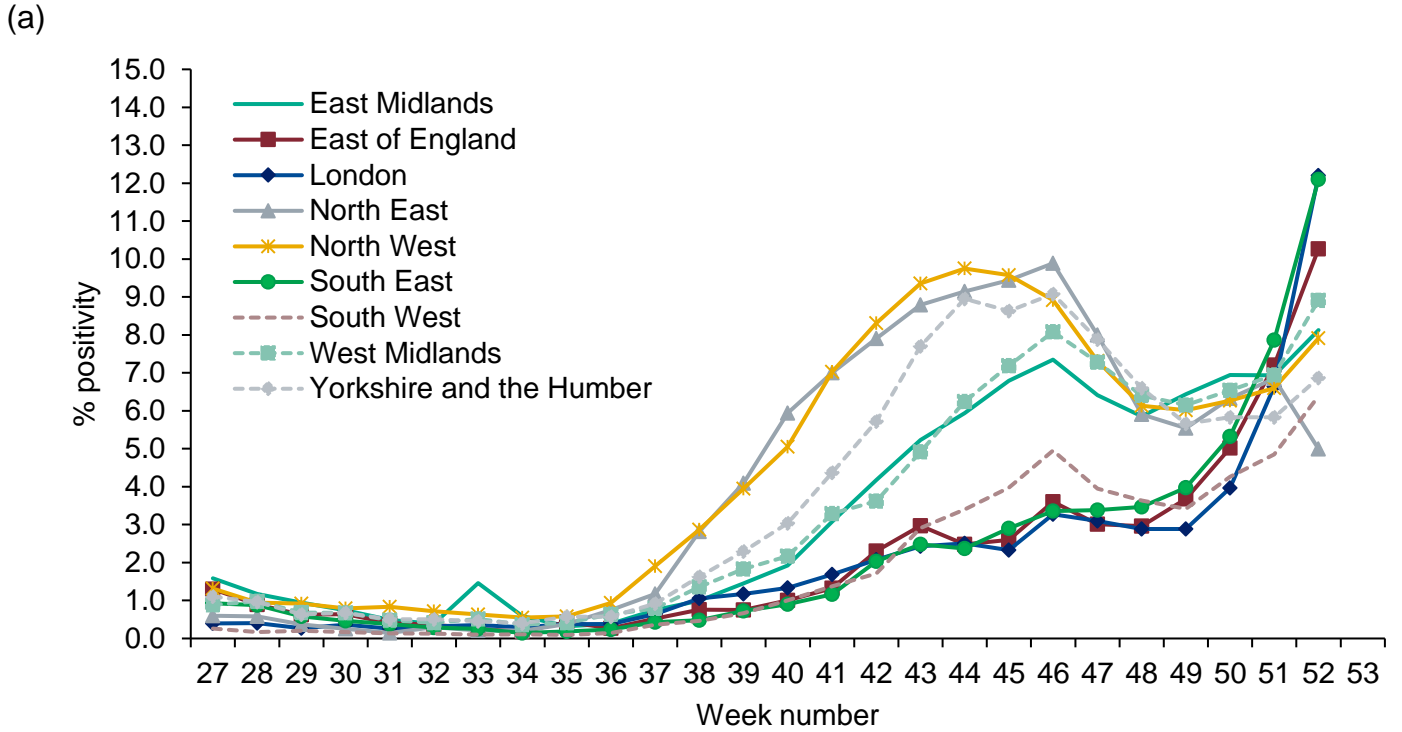
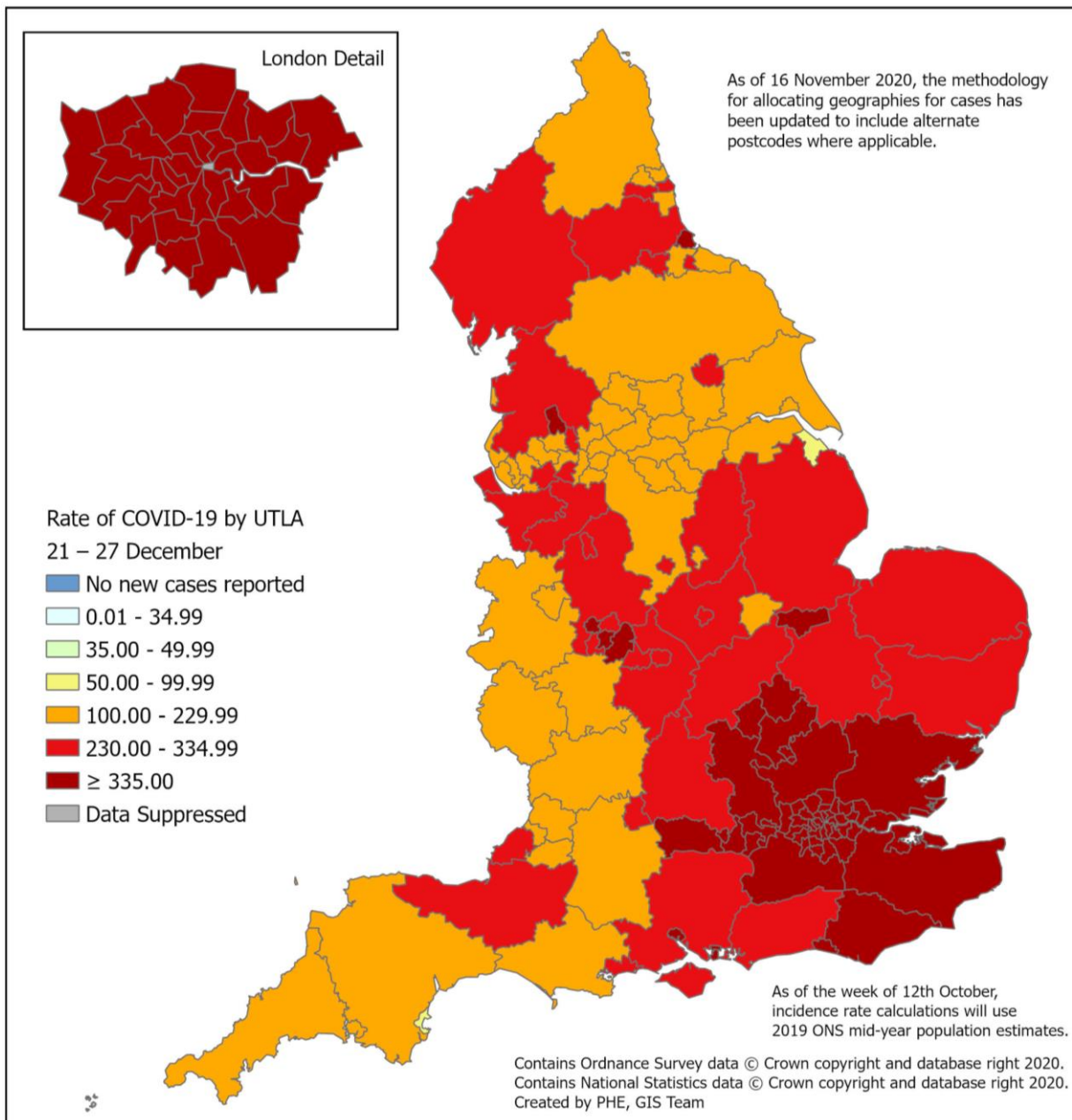
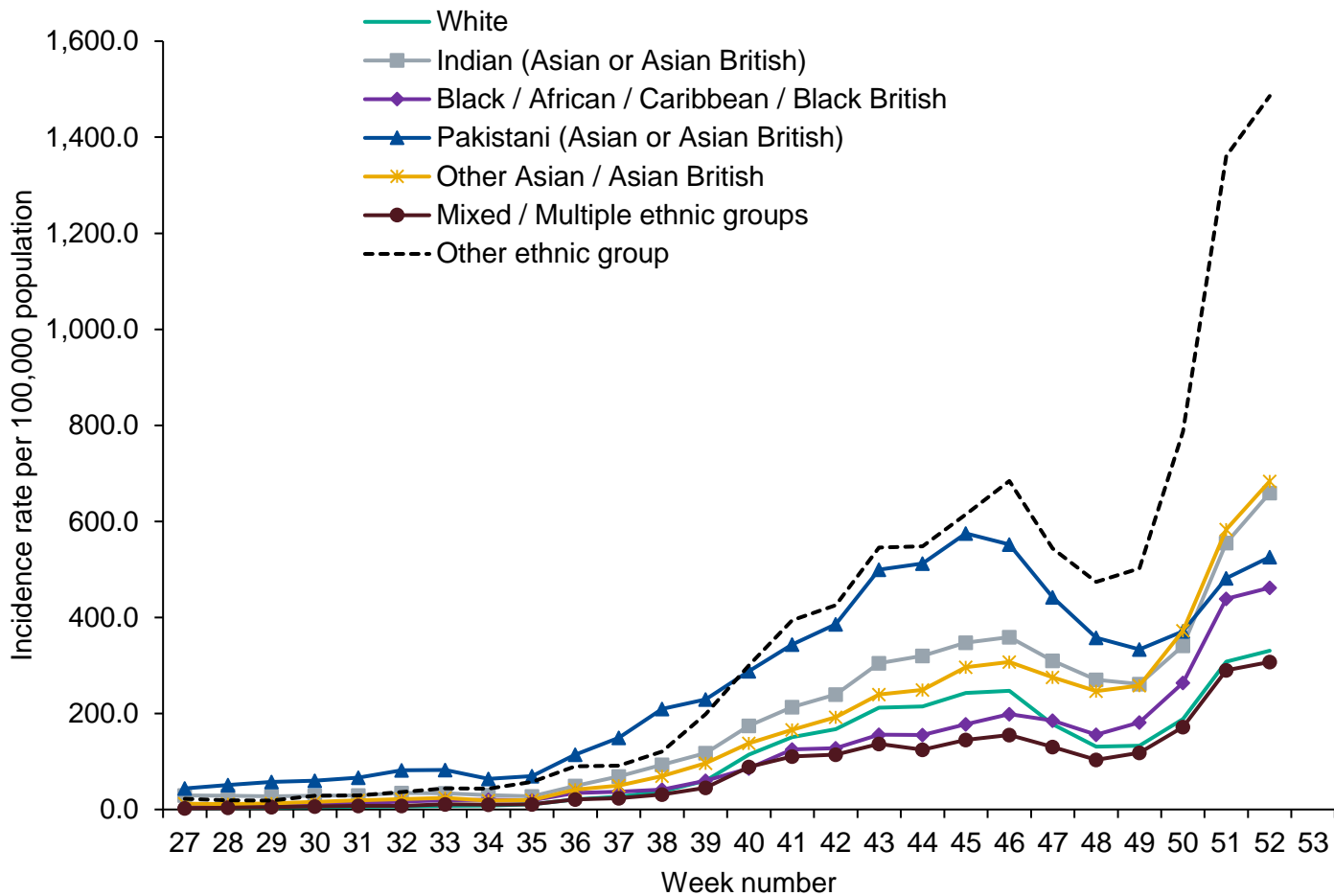


Figure 9: Weekly rate of COVID-19 cases per 100,000 population (Pillar 1 and 2), by upper-tier local authority, England (box shows enlarged map of London area)



Ethnicity

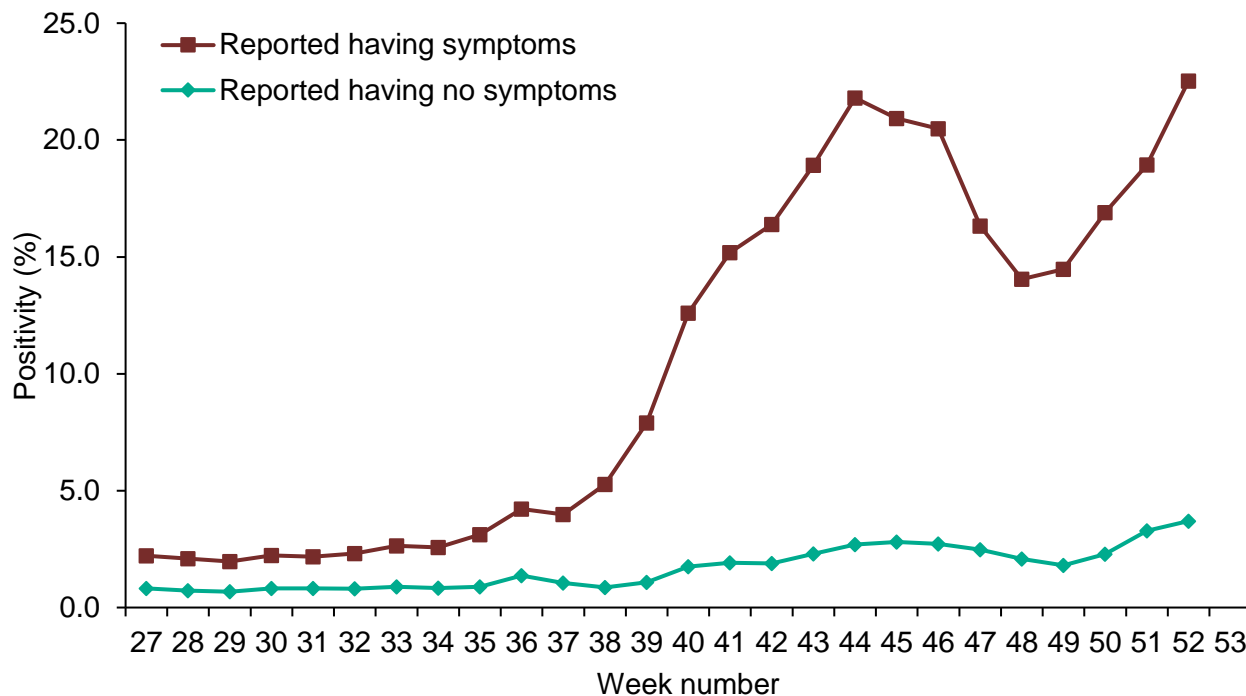
Figure 10: Weekly incidence per 100,000 population by ethnicity, England



*the incidence rates on Figure 10 have been calculated using the mid-2018 ONS population estimates

Positivity by symptoms

Figure 11: Weekly positivity of laboratory confirmed COVID-19 cases by symptoms reported on Pillar 2 test request, (SGSS and Respiratory DataMart)



Respiratory DataMart system (England)

The Respiratory Datamart system was initiated 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. 16 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 facilitate comparison with data on other respiratory viruses.

In week 52 2020, out of the 87,561 respiratory specimens reported through the Respiratory DataMart System (based on data received from 14 out of 16 laboratories), 6680 samples were positive for SARS-CoV-2 with an overall positivity of 7.6%. The highest positivity was noted in the 65+ year olds at 8.6% in week 52. The overall influenza positivity remained very low at 0.1% in week 52, with 1 of 1075 samples testing positive for flu (1 influenza A not subtyped) (Figure 12).

Rhinovirus positivity increased slightly at 7.6% in week 52 compared to 11.0% in the previous week (Figure 13). The highest positivity by age group for rhinovirus remained in the under 5 year olds in week 52 (Figure 14). Respiratory syncytial virus (RSV), adenovirus, parainfluenza and human metapneumovirus (hMPV) positivity all remained low at 0.1%, 1.3%, 0.1% and 0.0% respectively in week 52 (Figure 13).

Figure 12: DataMart samples positive for influenza and weekly positivity (%) for influenza and SARS-CoV-2, England

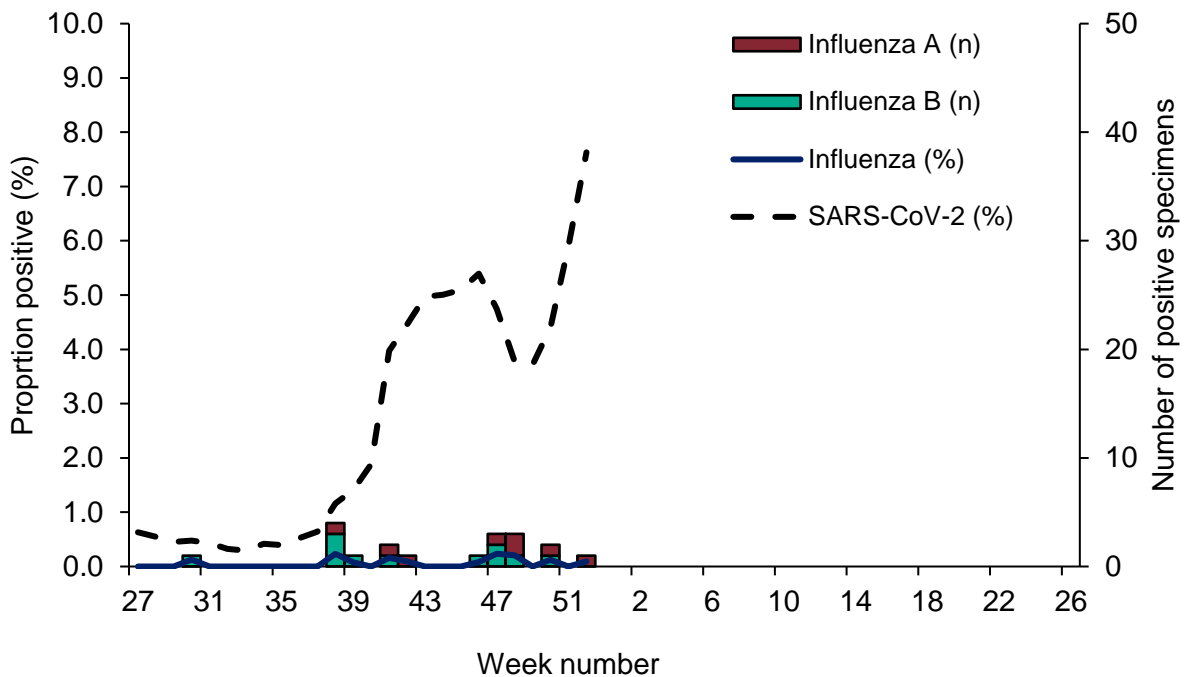


Figure 13: DataMart weekly positivity (%) for other respiratory viruses, England

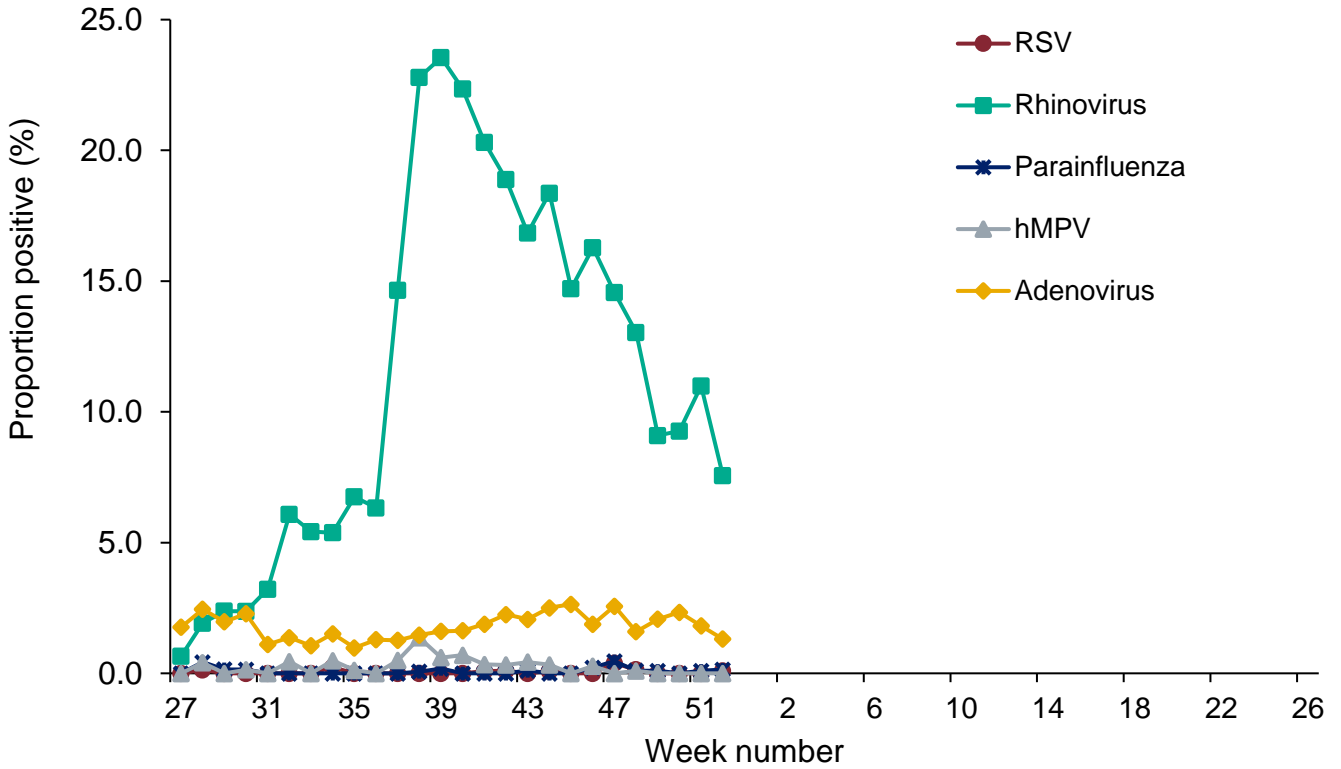
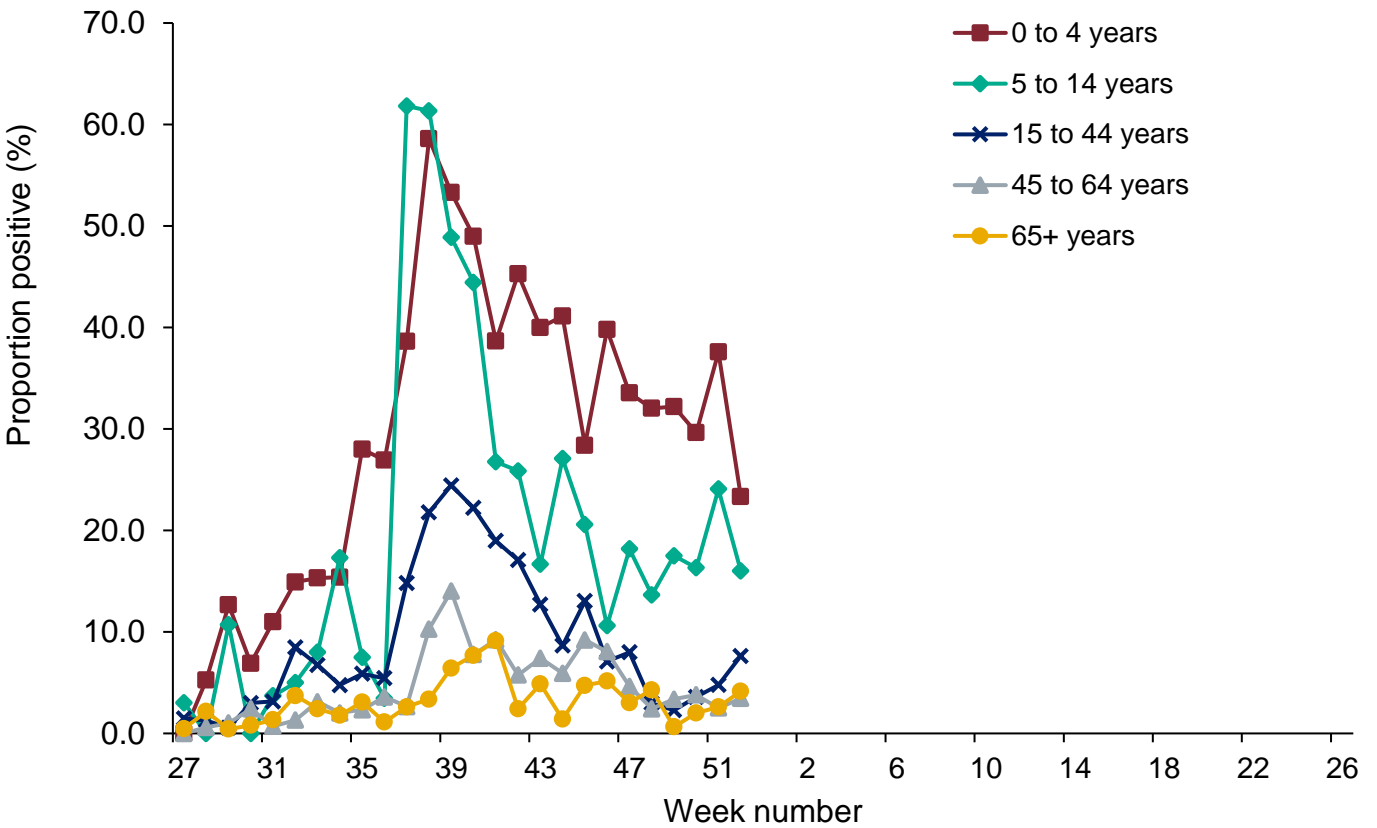


Figure 14: DataMart weekly positivity (%) for rhinovirus by age, England



Community surveillance

Acute respiratory infection incidents

Information on acute respiratory infection (ARI) incidents is based on situations reported to PHE Health Protection Teams (HPTs). These include:

- confirmed outbreaks of acute respiratory infections ie two or more laboratory confirmed cases (SARS-CoV-2, influenza or other respiratory pathogens) linked to a particular setting
- setting situations where an outbreak is suspected

All suspected outbreaks are further investigated by the HPT in liaison with local partners and a significant proportion do not meet the criteria of a confirmed outbreak. For example, if suspected cases test negative for COVID19 or other respiratory pathogens, or cases are subsequently found not to have direct links to the setting. Since Pillar 2 testing became open to everyone during week 21 more incidents of mild disease have been detected in settings with healthy young populations.

Processes for reporting ARI incidents vary between PHE Centres.

The situations captured on HPZone represent a subset of all ongoing clusters and outbreaks in England rather than an exhaustive listing. A variety of arrangements are in place with local authorities and other stakeholders supporting HPTs, however data are not routinely documented on HPZone. As a result, the number of outbreaks reported for some of the regions are underestimates.

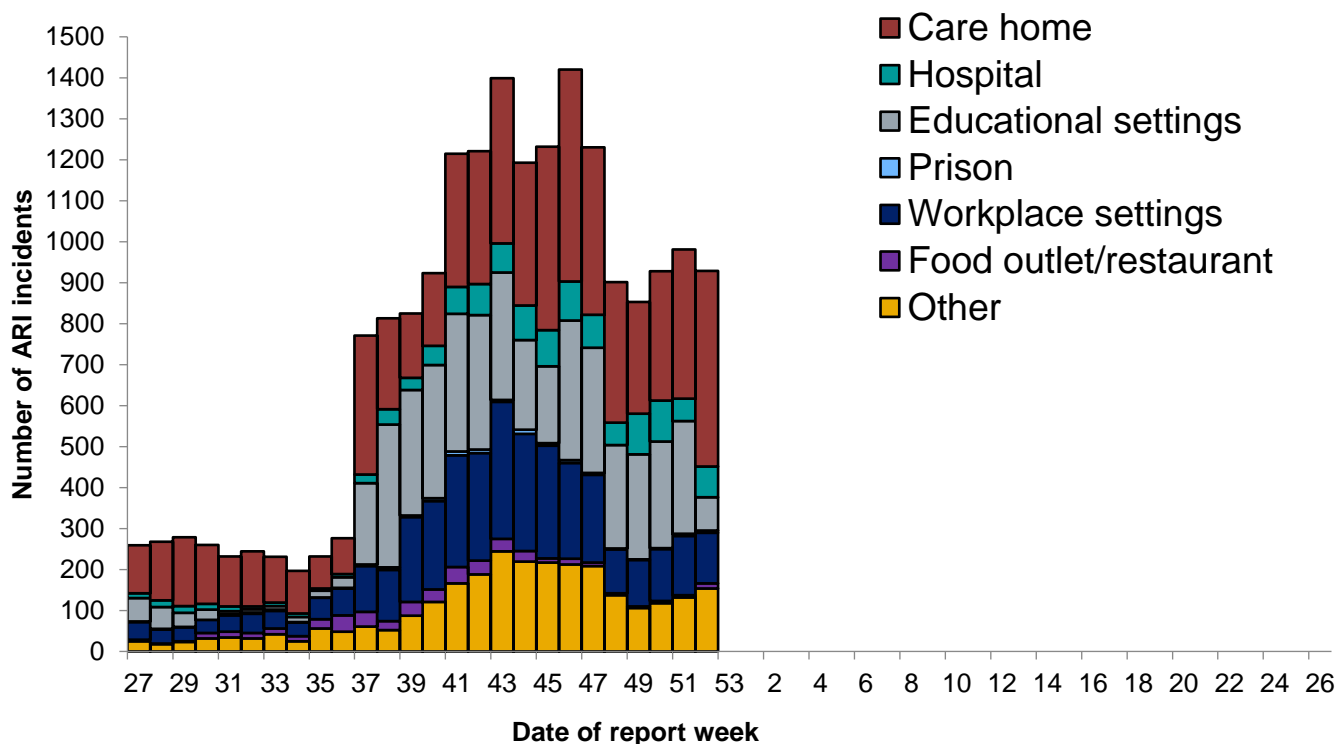
The denominator (the overall number of settings in each category) will differ by the setting category, for example there are fewer hospitals than workplaces, as will the propensity to report incidents to PHE. Therefore, these data are more useful for monitoring trends over time than making comparisons across setting categories.

The number of incidents in each setting with at least one laboratory confirmed case of COVID19 are reported below. A national school helpline started operating on 17 September 2020 and a Universities helpline started operating on 7 October. This is likely to have had an impact on the number of situations/outbreaks being reported to HPTs in these settings

929 new ARI incidents have been reported in week 52 in the UK (Figure 15):

- 478 incidents were from care homes where 341 had at least one linked case that tested positive for SARS-CoV-2 where test results were available
- 81 incidents were from educational settings where 69 had at least one linked case that tested positive for SARS-CoV-2
- 75 incidents were from hospitals where 63 had at least one linked case that tested positive for SARS-CoV-2
- 5 incidents were from prisons where all had at least one linked case that tested positive for SARS-CoV-2
- 124 incidents were from workplace settings where 86 had at least one linked case that tested positive for SARS-CoV-2
- 12 incidents were from food outlets/restaurants where 10 had at least one linked case that tested positive for SARS-CoV-2
- 154 incidents were from other settings where 102 had at least one linked case that tested positive for SARS-CoV-2

Figure 15: Number of acute respiratory infection (ARI) incidents by institution, UK



*excludes data from Wales & NI

Figure 16: Number of acute respiratory infection (ARI) incidents by institution, England

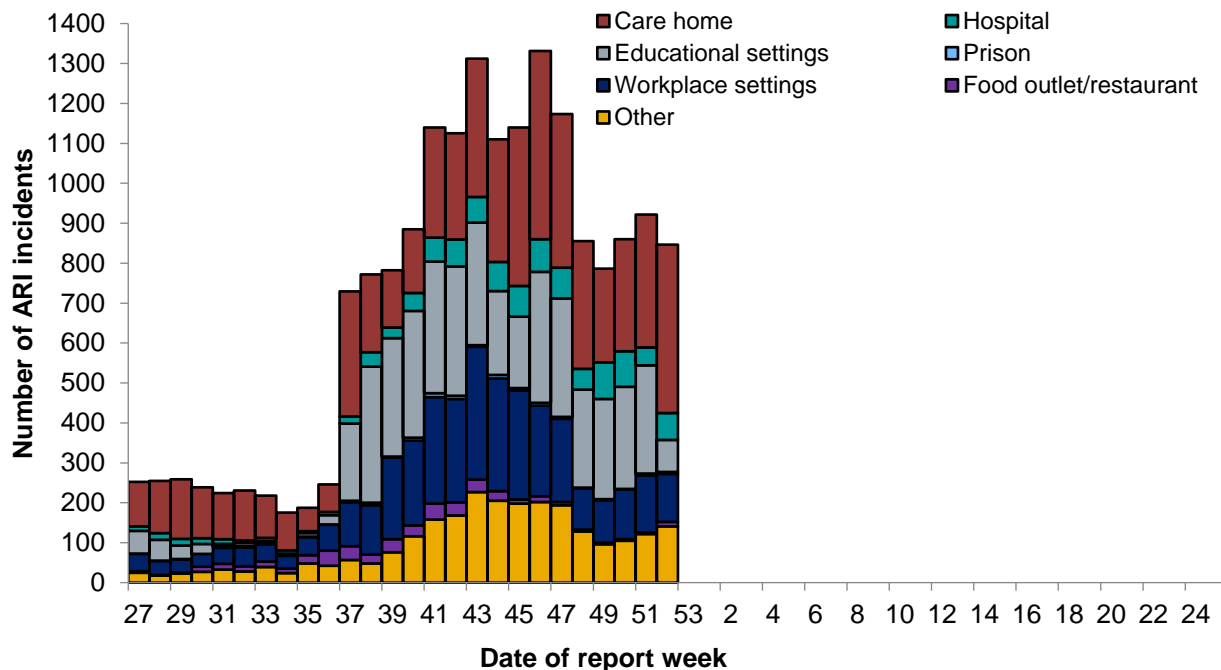


Figure 17: Number of acute respiratory infection (ARI) incidents in care homes by virus type from week 27, England

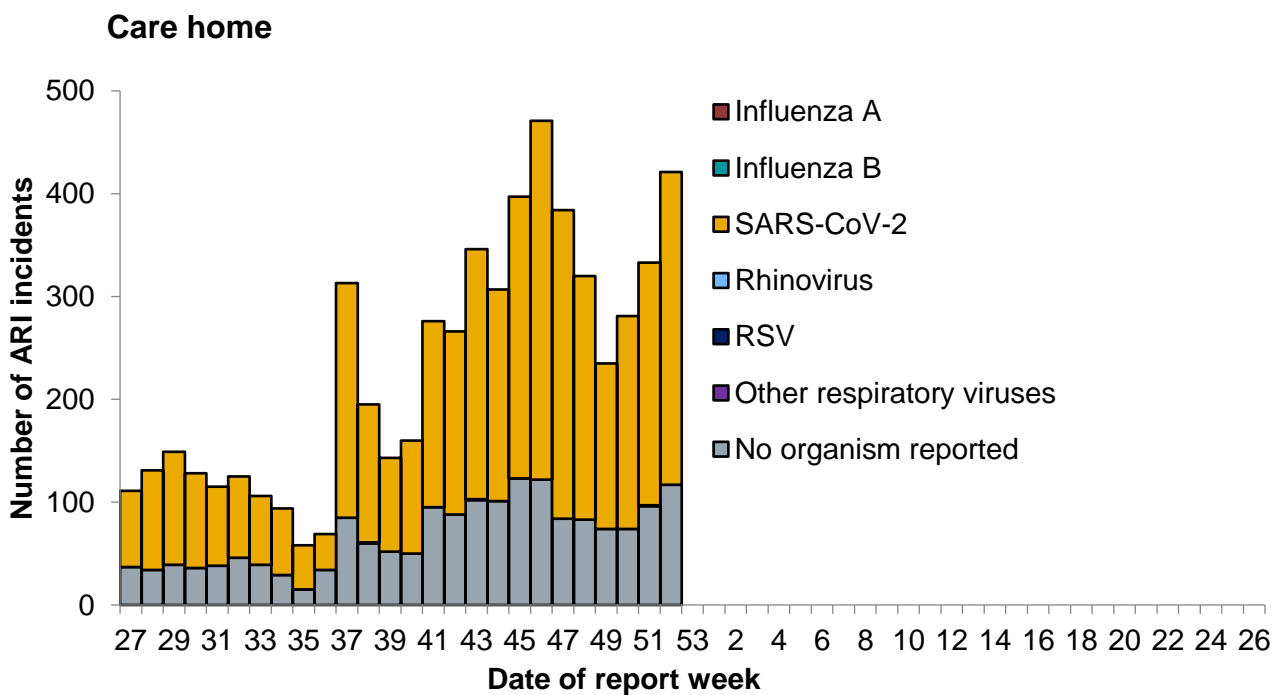


Figure 18: Number of acute respiratory infection (ARI) incidents in hospitals by virus type from week 27, England

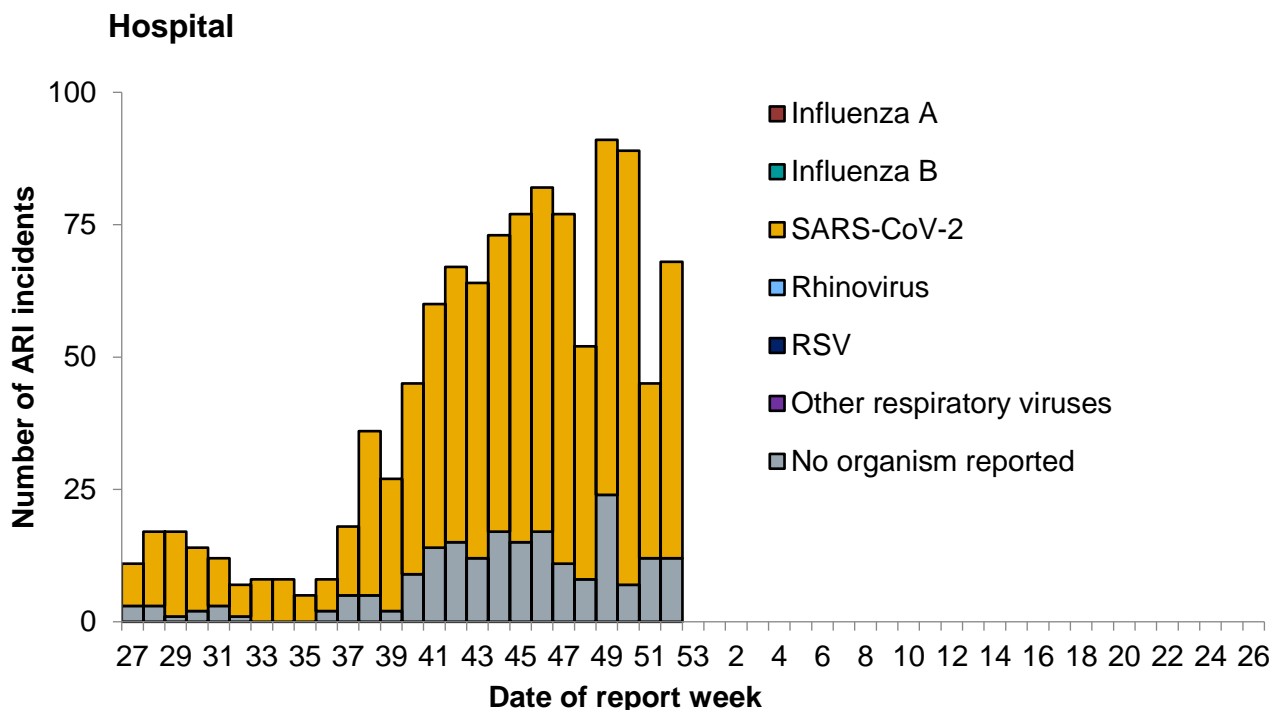


Figure 19: Number of acute respiratory infection (ARI) incidents in educational settings by virus type from week 27, England

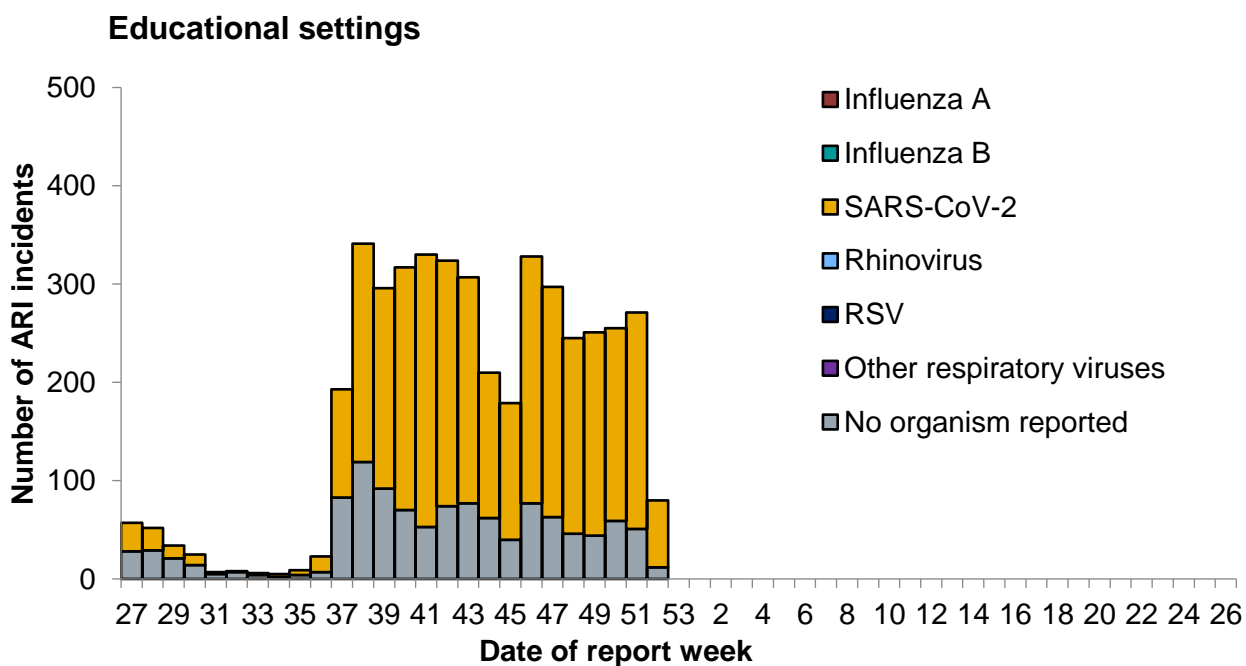


Figure 20: Number of acute respiratory infection (ARI) incidents in prisons by virus type from week 27, England

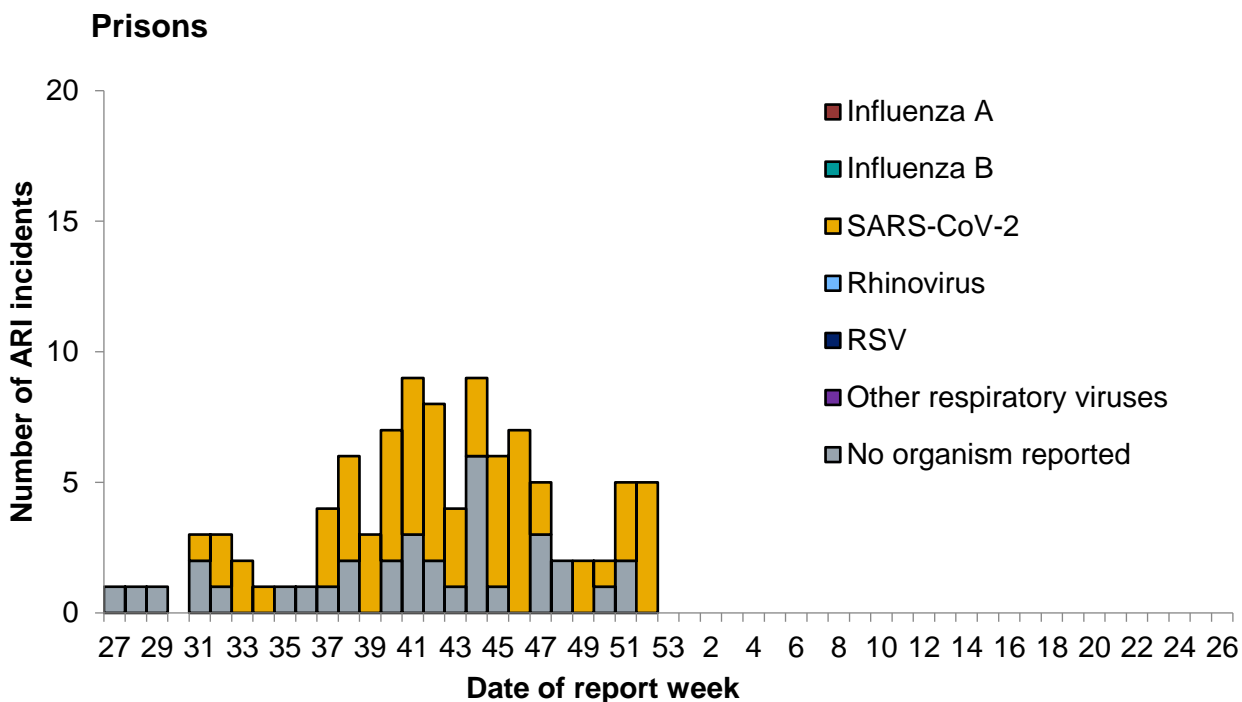


Figure 21: Number of acute respiratory infection (ARI) incidents in workplace settings by virus type from week 27, England

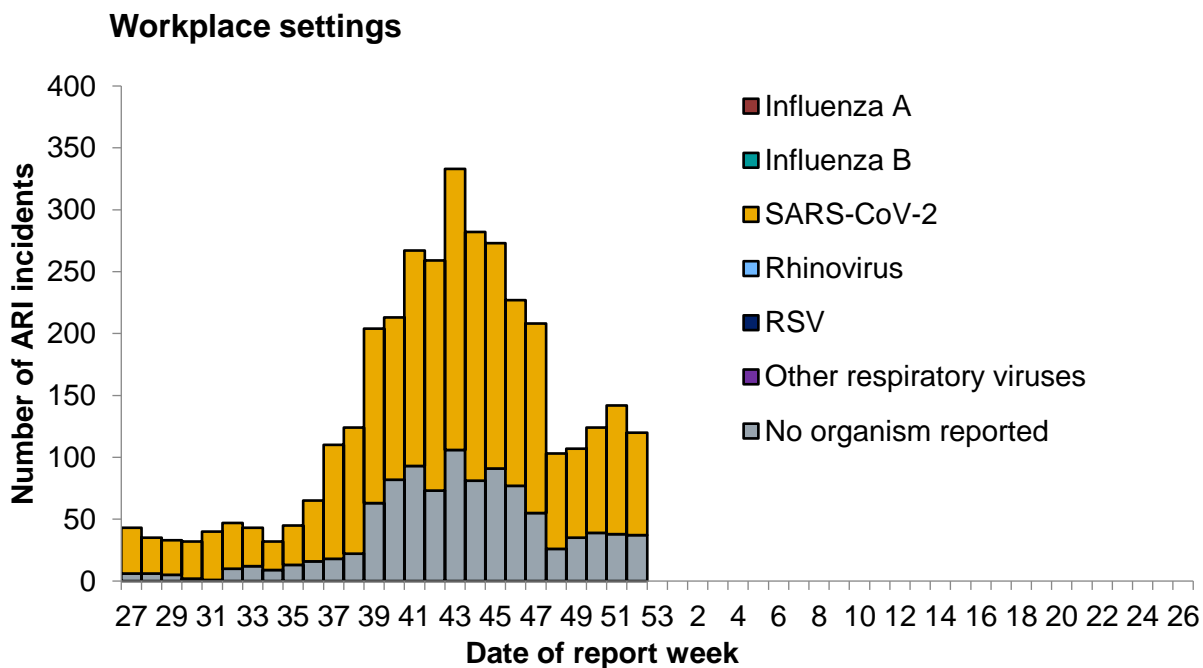


Figure 22: Number of acute respiratory infection (ARI) incidents in food outlet/restaurants settings by virus type from week 27, England

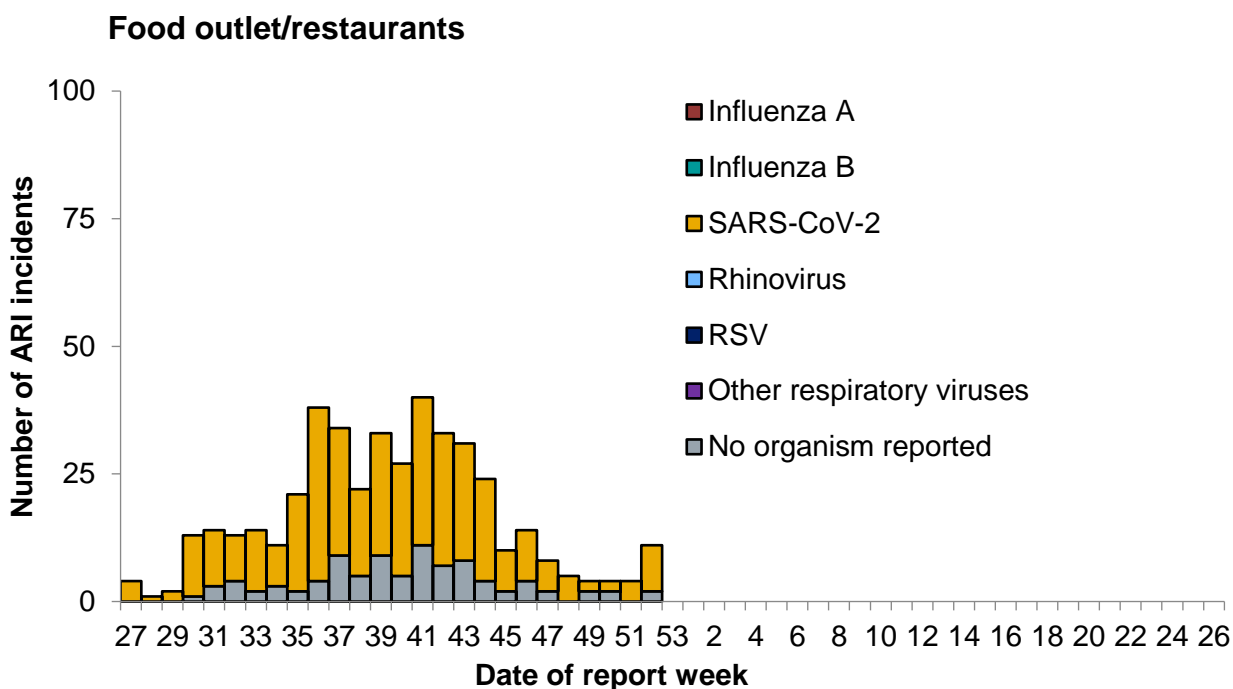


Figure 23: Number of acute respiratory infection (ARI) incidents in other settings by virus type from week 27, England

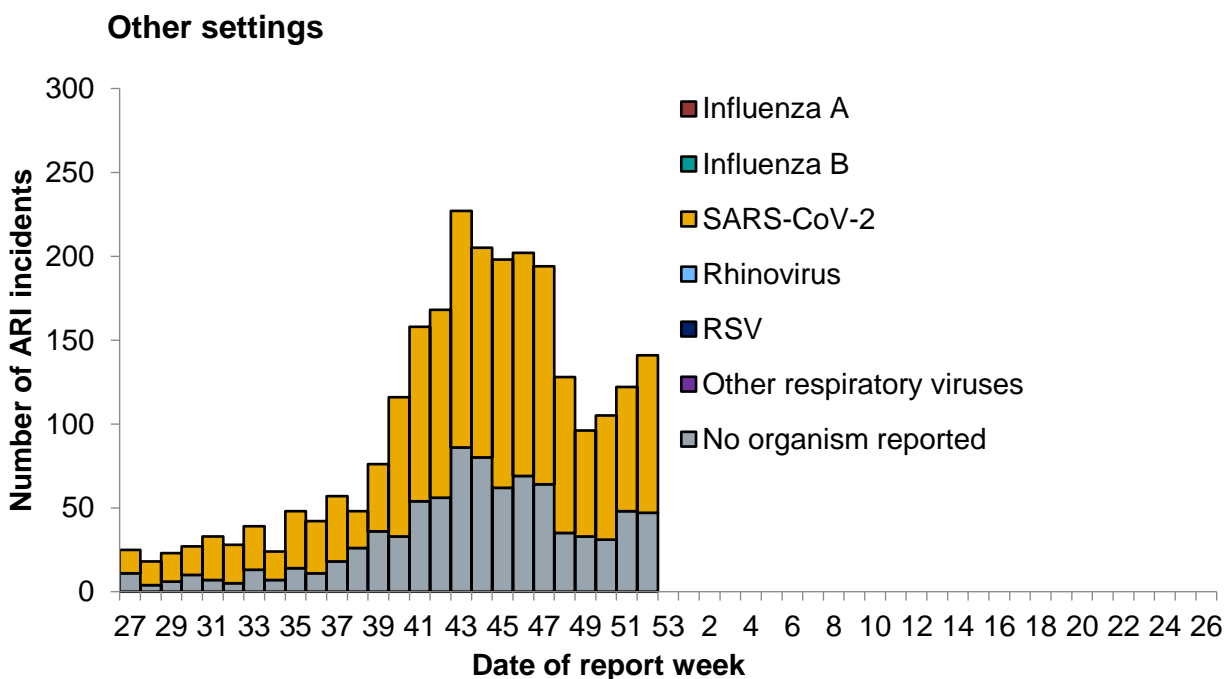


Table 2: Total number of situations/incidents by institution and PHE Centres over the past four weeks with the total number in the last week in brackets

PHE Centres	Care home	Hospital	Educational settings	Prisons	Workplace settings	Food outlet/restaurant settings	Other settings	Total
East of England	139(58)	21(3)	9(0)	1(1)	37(7)	0(0)	62(17)	269(86)
East Midlands	84(18)	50(9)	31(3)	0(0)	52(18)	1(1)	37(18)	255(67)
London	166(57)	123(35)	345(24)	4(0)	64(6)	3(2)	59(19)	764(143)
North East	70(27)	1(0)	4(0)	1(0)	6(0)	0(0)	22(4)	104(31)
North West	113(32)	32(7)	26(4)	0(0)	68(20)	4(1)	61(20)	304(84)
South East	312(116)	20(5)	273(22)	5(2)	133(37)	9(5)	83(25)	835(212)
South West	144(44)	11(5)	48(10)	0(0)	35(10)	1(0)	28(5)	267(74)
West Midlands	128(36)	20(1)	72(7)	2(1)	59(13)	4(2)	63(20)	348(80)
Yorkshire and Humber	114(33)	15(3)	49(10)	1(1)	39(9)	1(0)	49(13)	268(69)
Total	1270(421)	293(80)	857(80)	14(5)	493(120)	23(11)	464(141)	3414(846)

COVID-19 cases by type of residence

Table 3 shows the proportion of confirmed COVID-19 cases according to their type of residence. Property classifications are derived from Ordnance Survey AddressBase and are matched to address details within the laboratory data. Properties are identified by unique property reference number (UPRN) and basic land property unit (BLPU). Cases with poor or no address data which failed the address matching and are classed as 'undetermined'. No fixed abode and overseas addresses identified by recording in the laboratory data.

In week 52, the highest percentage of confirmed COVID-19 cases by type of residence was seen in residential dwelling (Table 3).

Table 3: Type of residence of confirmed COVID-19 cases by percentage of total weekly cases

Type of residence	week47	week48	week49	week50	week51	week52
Residential dwelling (including houses, flats, sheltered accommodation)	90.1	90.7	90.5	93.2	93.1	94.4
Undetermined	4.5	3.4	3.5	1.8	3.3	2.3
Care/Nursing home	3.5	4.0	4.3	3.3	2.2	2.0
Other property classifications	0.7	0.7	0.6	0.5	0.5	0.5
Residential institution (including residential education)	0.3	0.2	0.2	0.2	0.1	0.1
House in multiple occupancy (HMO)	0.4	0.4	0.3	0.4	0.4	0.4
Medical facilities (including hospitals and hospices, and mental health)	0.2	0.2	0.2	0.1	0.1	0.1
Prisons, detention centres, secure units	0.4	0.4	0.4	0.5	0.3	0.2
Overseas address	0.0	0.0	0.0	0.0	0.0	0.0
No fixed abode	0.0	0.0	0.0	0.0	0.0	0.0

Medical Officers of Schools Association (MOSA) & PHE surveillance scheme

Boarding schools in England within the MOSA network are recruited each season to report various respiratory related illnesses including influenza like illnesses (ILI). For the 2020 to 21 season, 6 MOSA schools have agreed to participate in the scheme, including a total of 4,138 pupils.

The overall ILI rate (all school years) for week 50 was 0.0 per 1,000 students compared to 1.65 per 1,000 students in the previous week. The overall ILI rate (all staff) for week 50 was 0.0 per 1,000 staff compared to 0.61 per 1,000 staff in the previous week.

The overall laboratory confirmed COVID-19 rate (all school years) for week 50 was 0.0 per 1,000 students compared to 6.04 per 1,000 students in the previous week.

The overall laboratory confirmed COVID-19 (all staff) for week 50 was 0.0 per 1,000 staff compared to 3.65 per 1,000 staff in the previous week.

There is no further update in week 52.

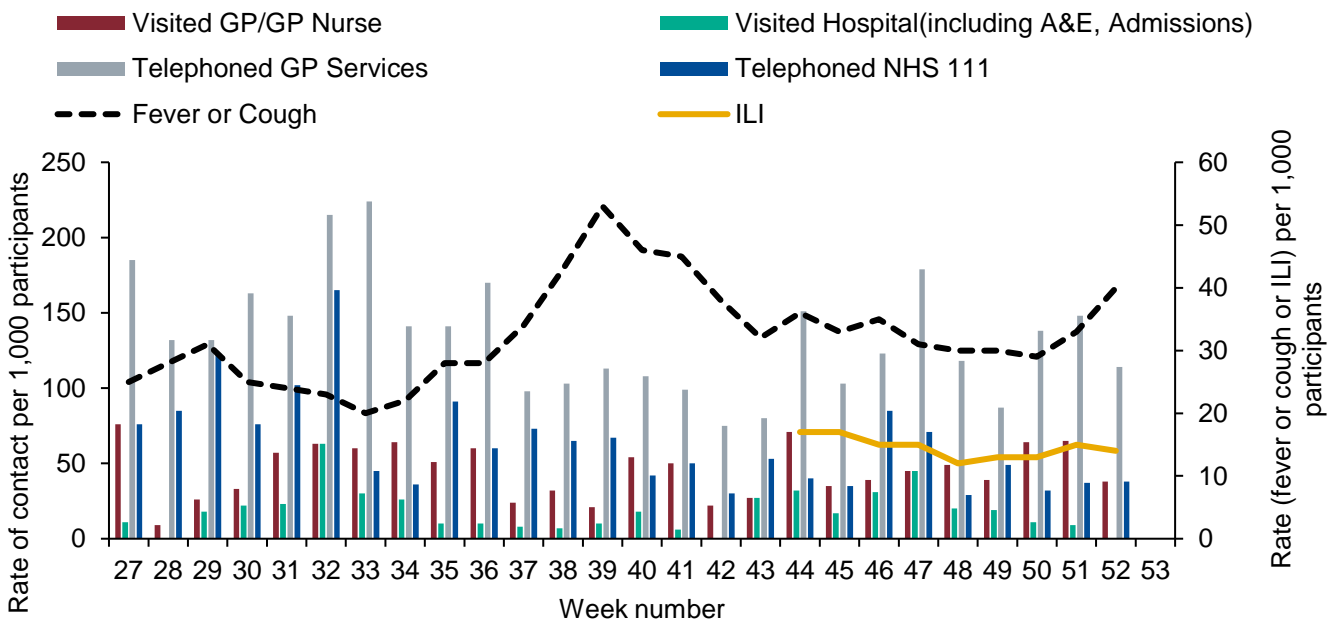
If you are a MOSA school and would like to participate in this scheme, please email mosa@phe.gov.uk for more information.

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. 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 3,330 participants completed the weekly COVID-19 surveillance survey in week 52, of which 132 (1.02%) reported fever or cough and 46 (1.4%) reported influenza like illness (ILI). The proportion of participants reporting Covid19 related symptoms (cough, fever or loss of smell) have increased while number of people reporting ILI symptoms has remained low. The most commonly used healthcare services reported by respondents remains telephoning a GP practice (Figure 24).

Figure 24: Rate of contact with different healthcare services among FluSurvey participants reporting fever or cough symptoms, England



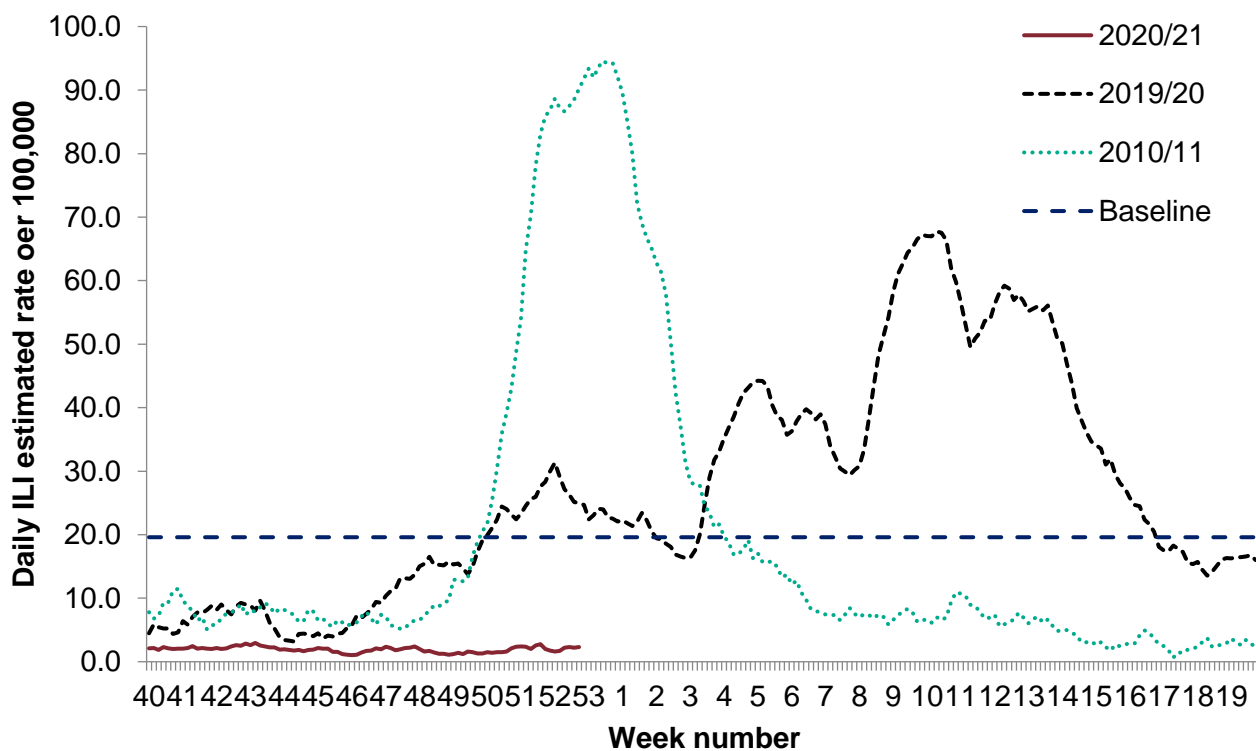
FluDetector

FluDetector is a web-based model which assesses internet-based search queries for influenza-like illness (ILI) in the general population.

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

For week 52, the daily ILI rate remained low and below the baseline threshold of 19.6 per 100,000 for the 2020 to 2021 season (Figure 25).

Figure 25: Daily estimated ILI Google search query rates per 100,000 population, England

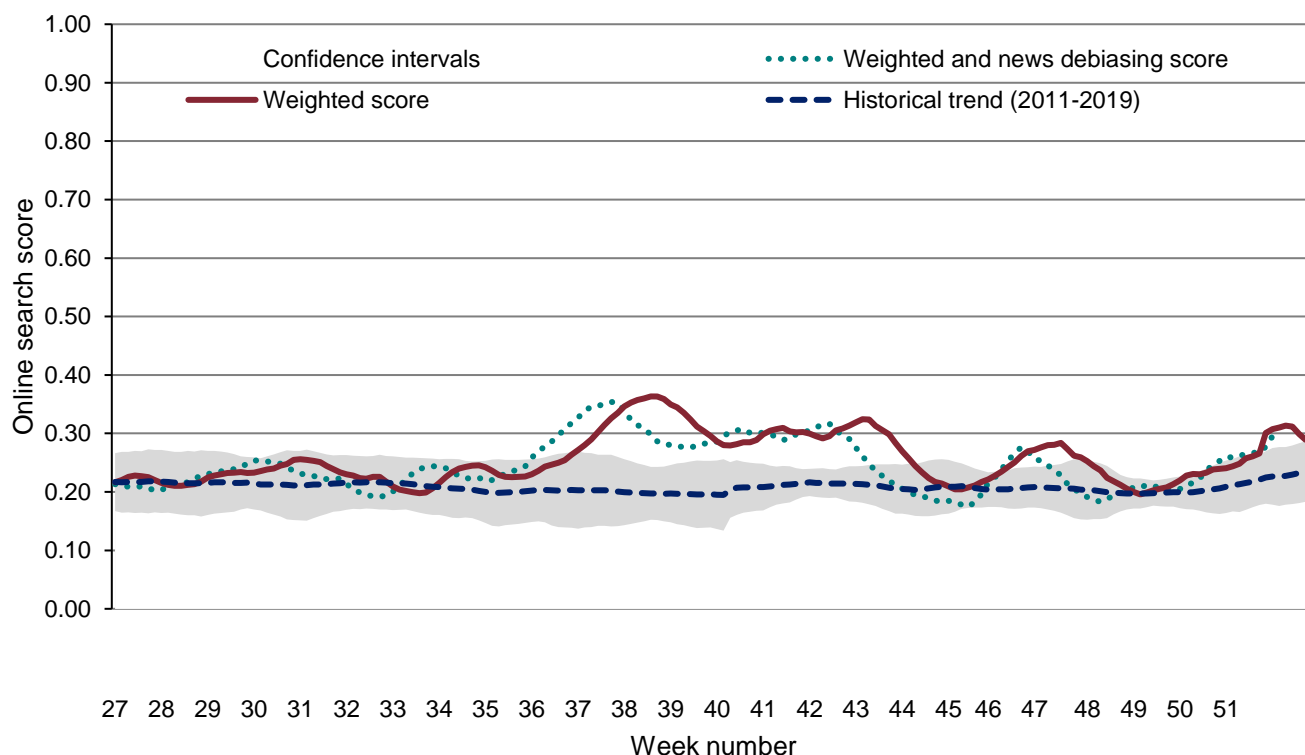


Google search queries

This is a web-based syndromic surveillance system which uses daily search query frequency statistics obtained from the Google Health Trends API [1]. This model focuses on search queries about COVID-19 symptoms as well as generic queries about “coronavirus” (e.g. “covid-19”). The search query frequency time series has been 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.

During week 52, the overall and media-debiasing weighted Google search scores continued to increase (Figure 26).

Figure 26: Normalised Google search score for COVID-19 symptoms, with weighted score for media-debiasing and historical trend, England



NHS 111

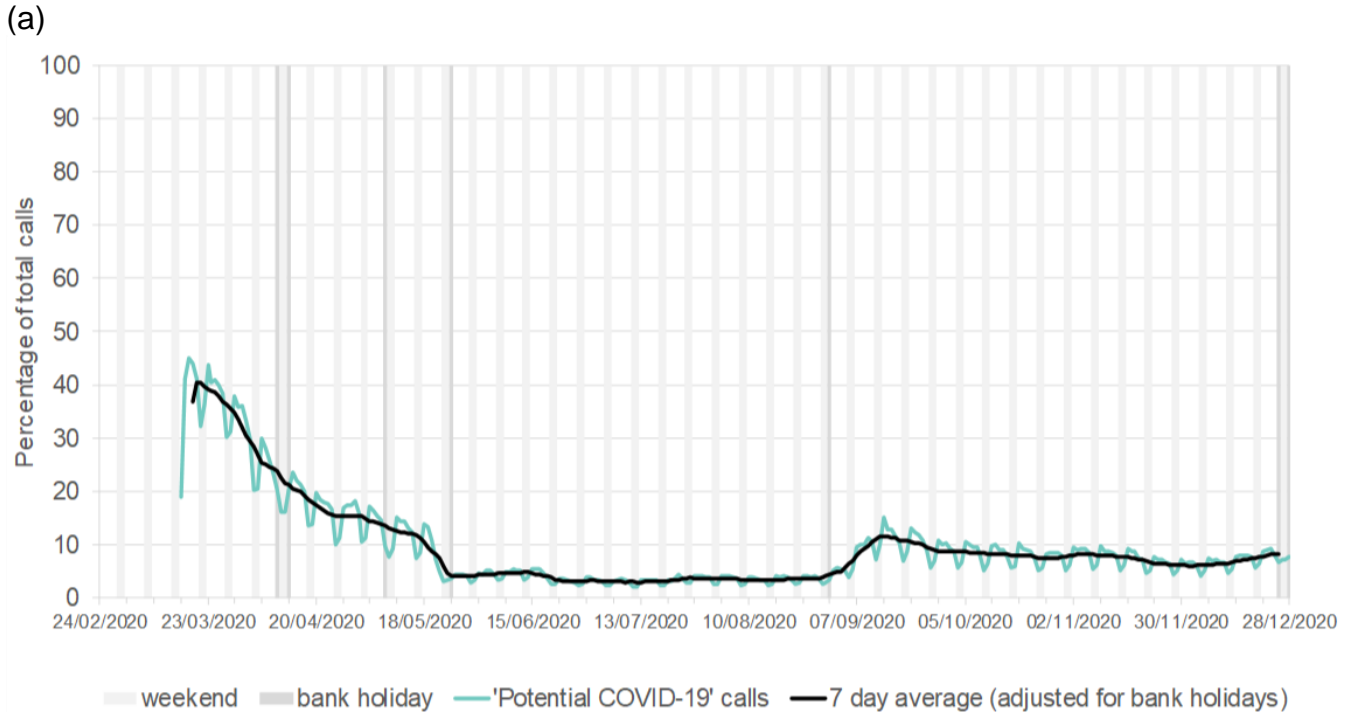
The NHS 111 service monitors daily trends in phone calls made to the service in England, to capture trends in infectious diseases such as influenza and norovirus.

Up to 28 December NHS 111 calls and online assessments for cold/flu remained stable. Calls and online assessments for potential COVID-19 increased. Calls for loss of taste or smell and online assessments increased (Figure 27 and 28).

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

Further information about these caveats is available from the PHE Remote Health Advice Syndromic Surveillance bulletin.

Figure 27: NHS 111 telephony indicators (and 7-day moving average) for (a) daily potential COVID-19 calls, (b) daily cold/flu calls and (c) daily loss of taste or smell calls, as a percentage of total calls for all ages, England



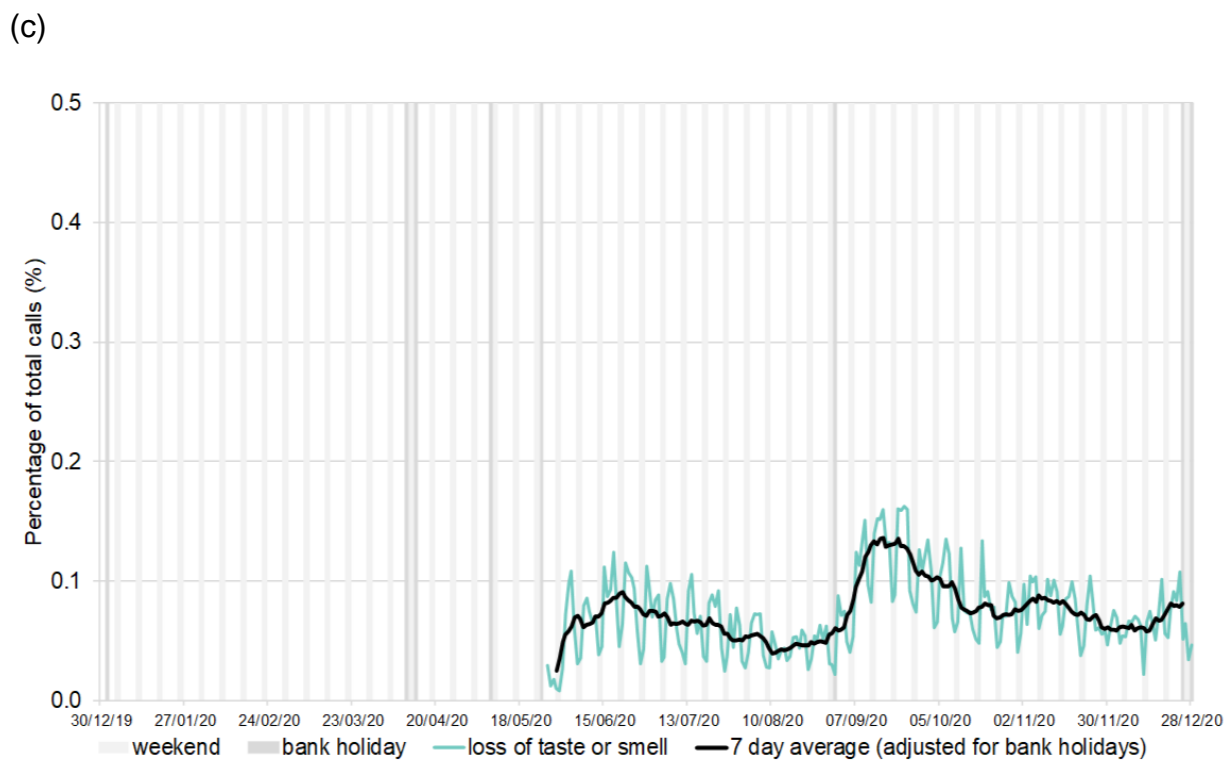
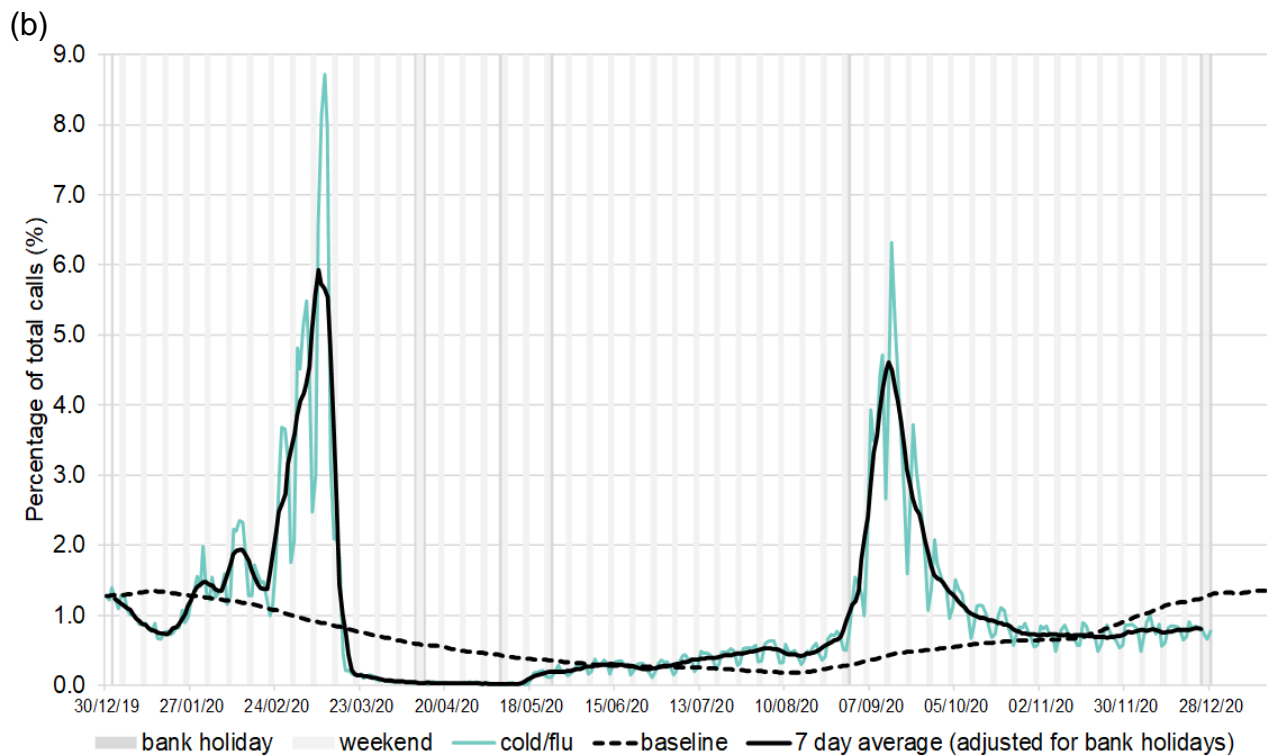
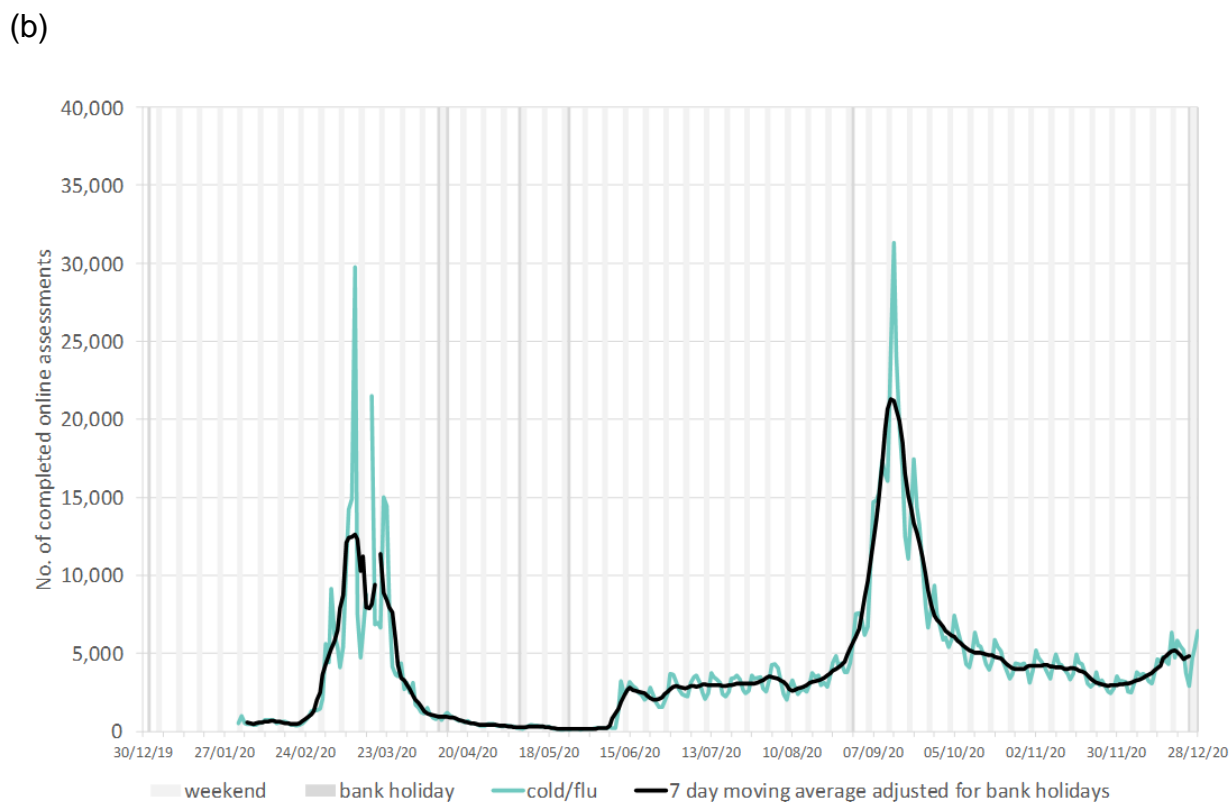
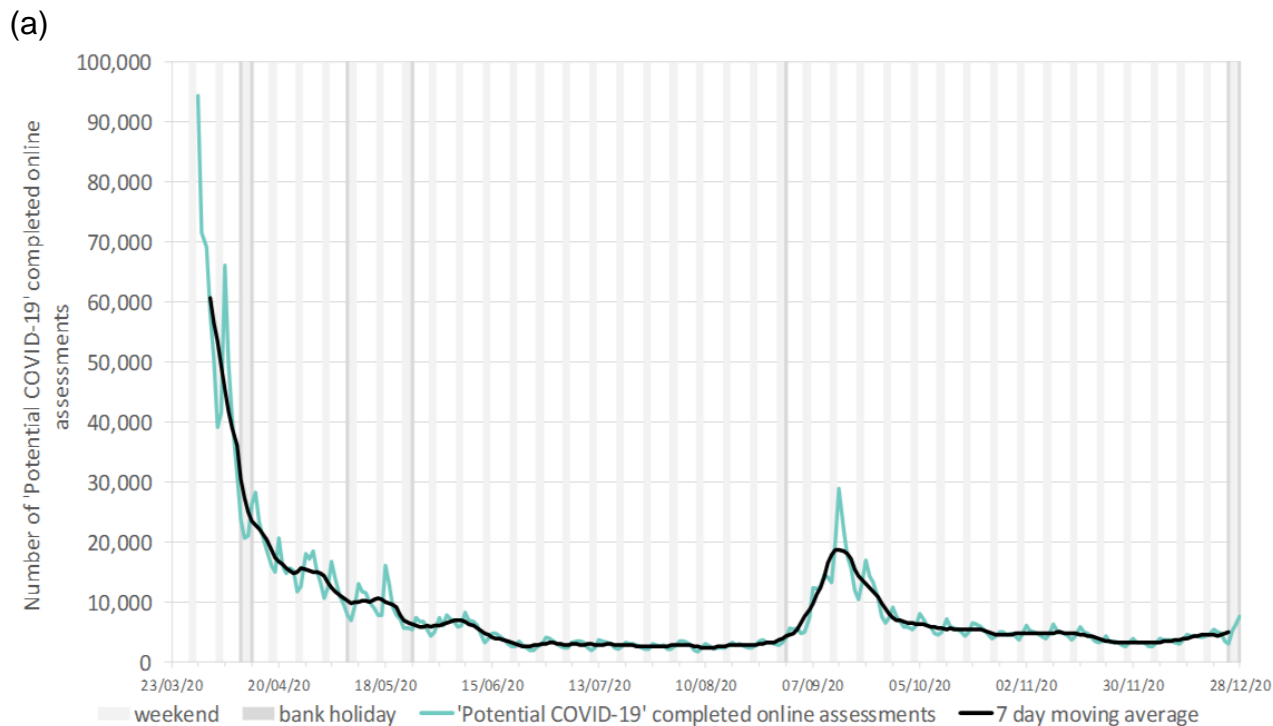
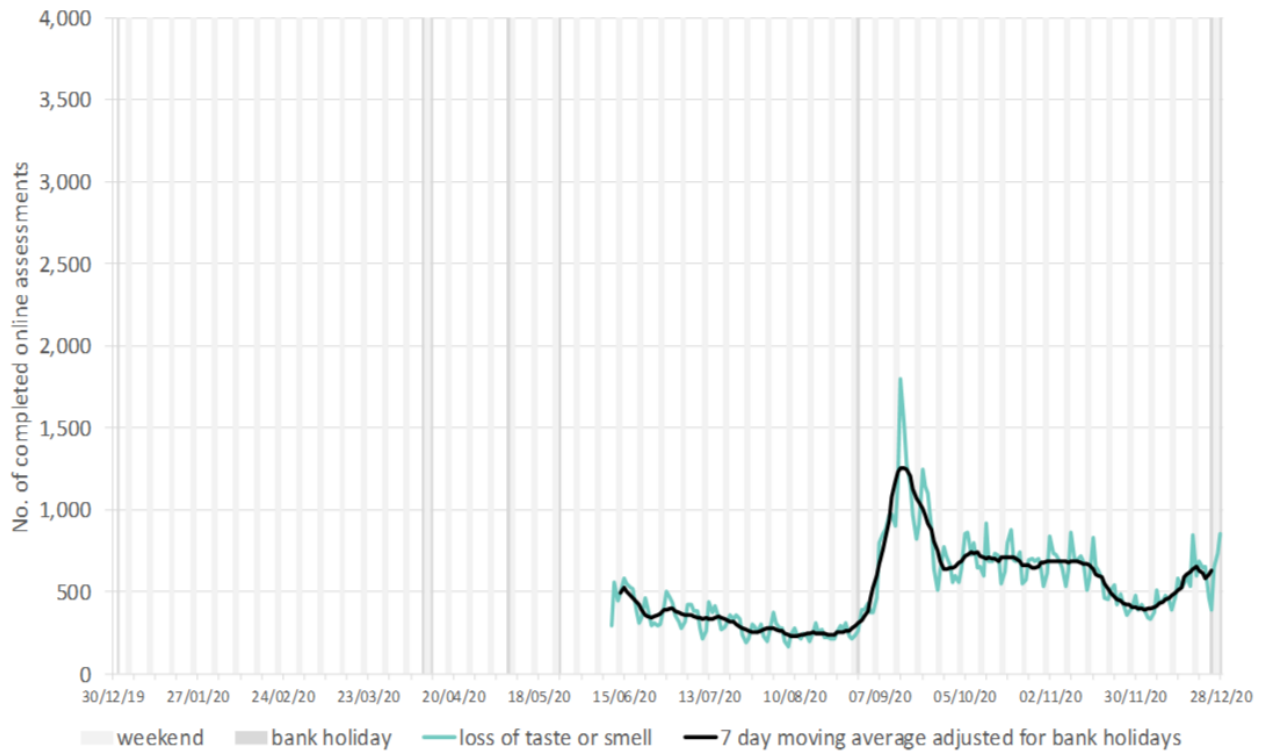


Figure 28: NHS 111 completed online assessments (and 7-day moving average) for (a) daily potential COVID-19 online assessments, (b) daily cold/flu online assessments and (c) daily loss of taste or smell online assessments, as the number of completed online assessments for all ages, England



(c)



Primary care surveillance

RCGP (England)

The weekly ILI consultation rate through the RCGP surveillance was 0.7 per 100,000 registered population in participating GP practices in week 52 compared to the 1.2 per 100,000 in the previous week. This is below the baseline threshold (12.2 per 100,000) (Figure 29). By age group, the highest rates were seen in the 75+ year olds (0.9 per 100,000). The Lower Respiratory Tract Infections (LRTI) consultation rate was at 16.3 per 100,000 in week 52, which was a decrease to the rate of 19.4 per 100,000 from the previous week. The COVID-19-like indicator consultation rate was at 149.7 per 100,000 in week 52 compared to a similar rate of 141.2 per 100,000 in the previous week (Figure 30).

Figure 29: RCGP ILI consultation rates, all ages, England

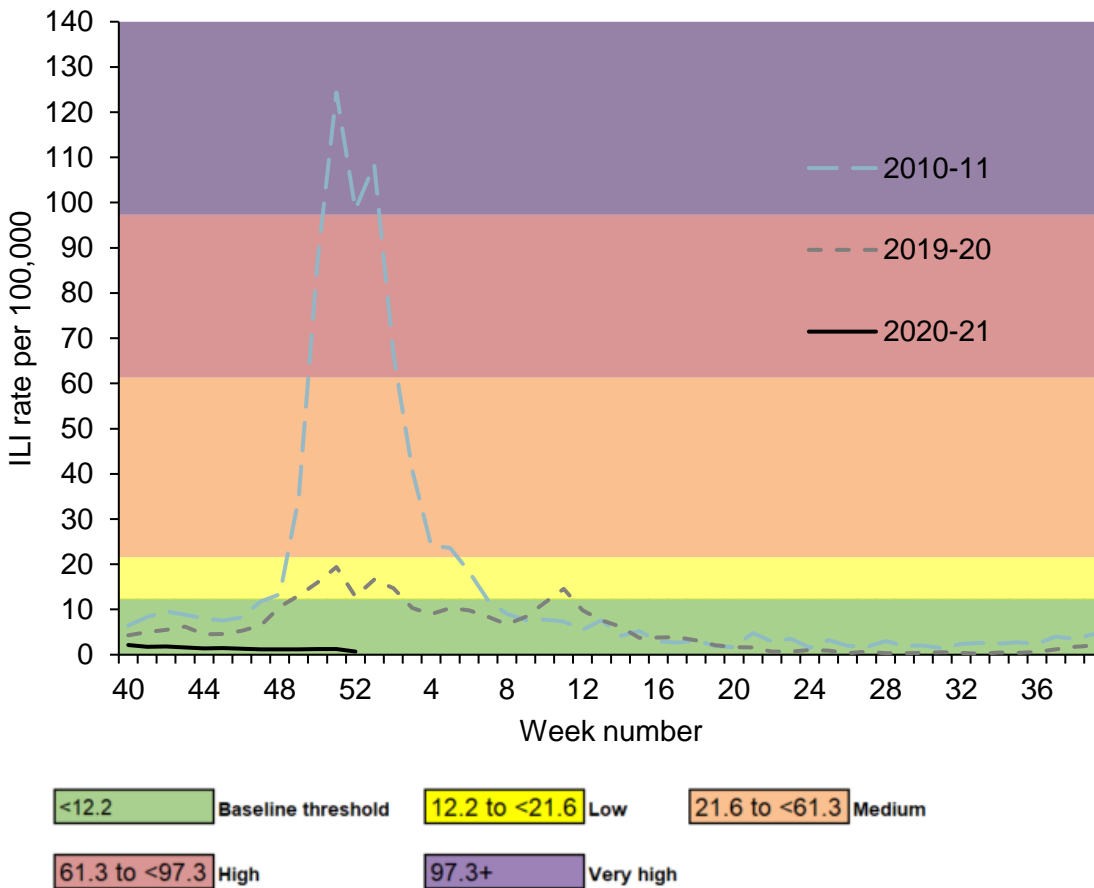
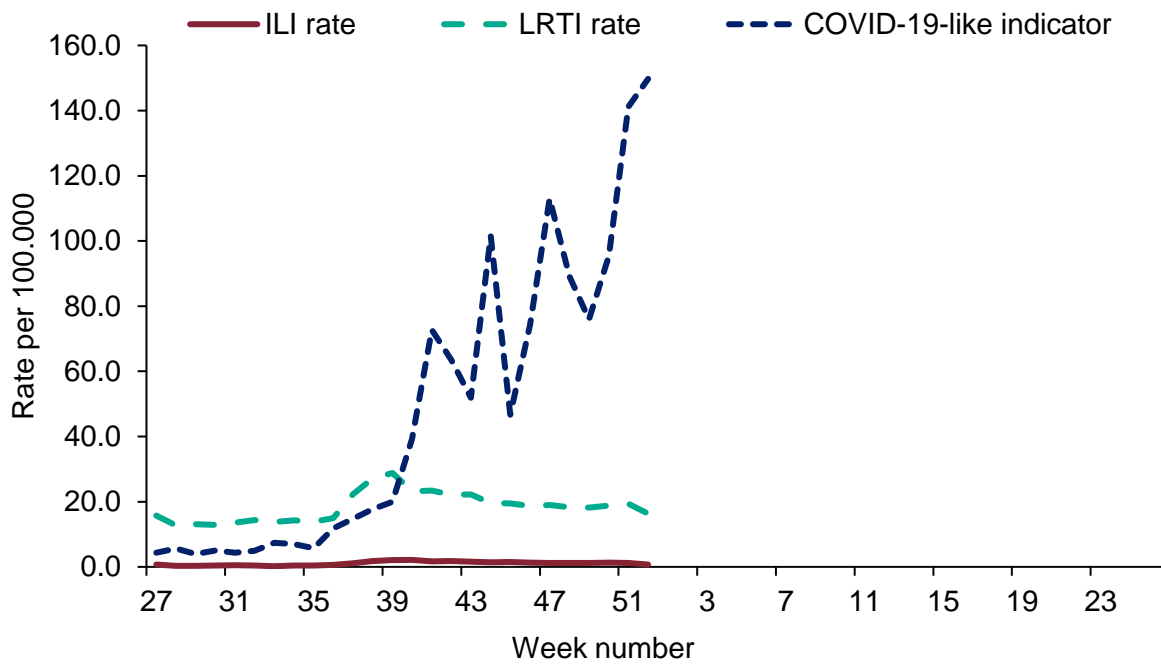


Figure 30: RCGP ILI, LRTI and COVID-19-like indicator consultation rates, England



UK

Overall, weekly ILI consultations rates were below baseline levels in all UK schemes (Table 4).

By age group, the highest rates were seen in the 65 to 74 year olds in Northern Ireland (1.3 per 100,000). Data was not available from Wales and Scotland for weeks 51 and 52.

Table 4: GP ILI consultations in the UK for all ages with MEM thresholds applied

GP ILI consultation rates (all ages)	Week number																
	40	41	42	43	44	45	46	47	48	49	50	51	52	1	2	3	4
England (RCGP)	2.1	1.7	1.8	1.6	1.4	1.5	1.3	1.2	1.2	1.2	1.3	1.2	0.7				
Wales	1.0	1.0	1.0	0.8	0.5	0.5	0.5	0.5	0.5	1.6	1.3						
Scotland	0.5	0.7	0.5	0.5	0.7	0.8	0.9	0.7	0.6	0.5	0.6						
Northern Ireland	1.3	1.5	2.2	1.4	1.6	1.8	1.8	1.9	1.7	1.2	1.5	1.7	0.7				

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 2009/10), in a standardised approach across Europe. For MEM threshold values for each country, please visit:

<https://www.gov.uk/guidance/sources-of-uk-flu-data-influenza-surveillance-in-the-uk#clinical-surveillance-through-primary-care>

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.

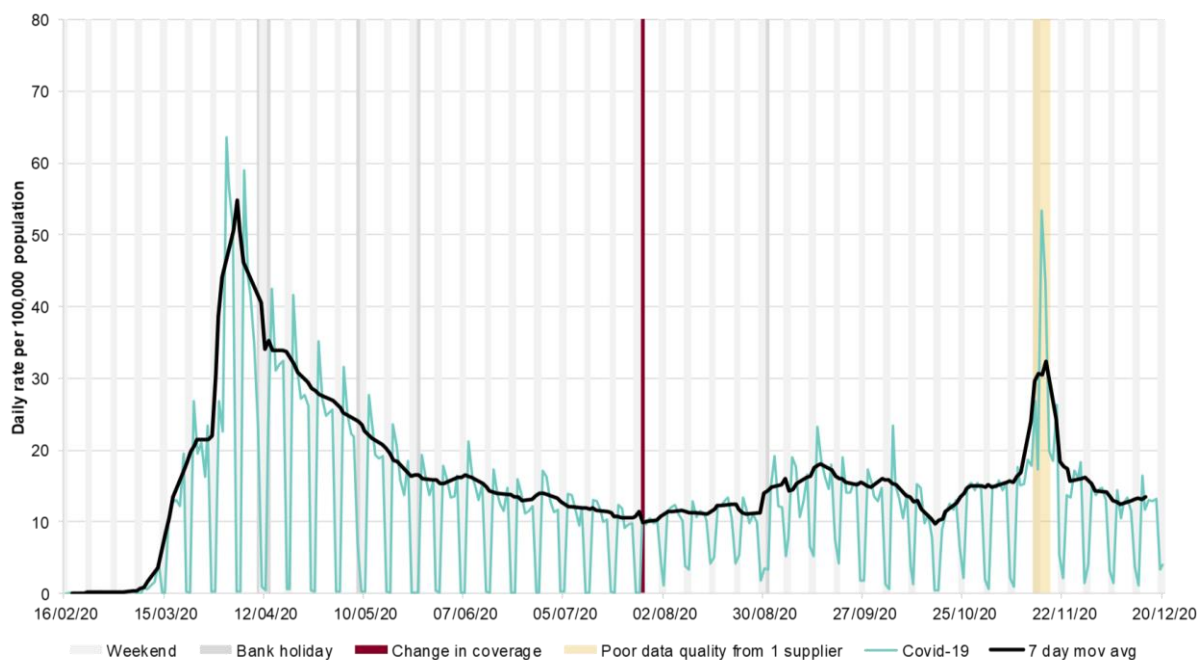
Up to 27 December GP in-hours consultations for influenza-like-illness increased slightly (Figure 31b). Due to a technical problem at one of our data providers which has resulted in over-reporting of daily COVID consultations it has not been possible to update Figure 31a this week.

Data quality issues in the reporting of GP consultations for COVID-19 from one syndromic GP data supplier during week 47 caused artificially high rates of COVID-19 attendances as indicated in Figure 31.

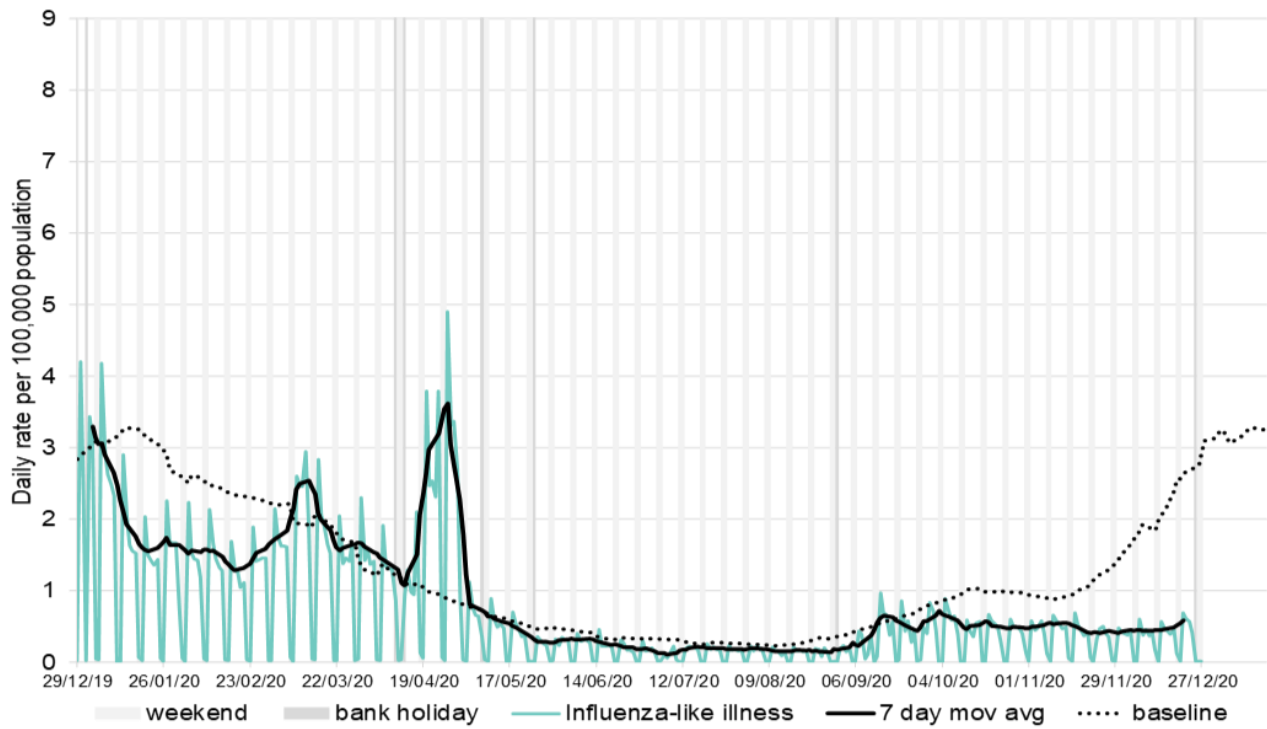
Please note GP data should be interpreted with caution due to changes in advice regarding accessing GP surgeries due to COVID-19. Further information about these caveats is available from the PHE GP In Hours Syndromic Surveillance bulletin.

Figure 31: GPIH clinical indicators for (a) potential COVID-19 GP consultations and (b) influenza-like illness GP consultations, England

(a)



(b)



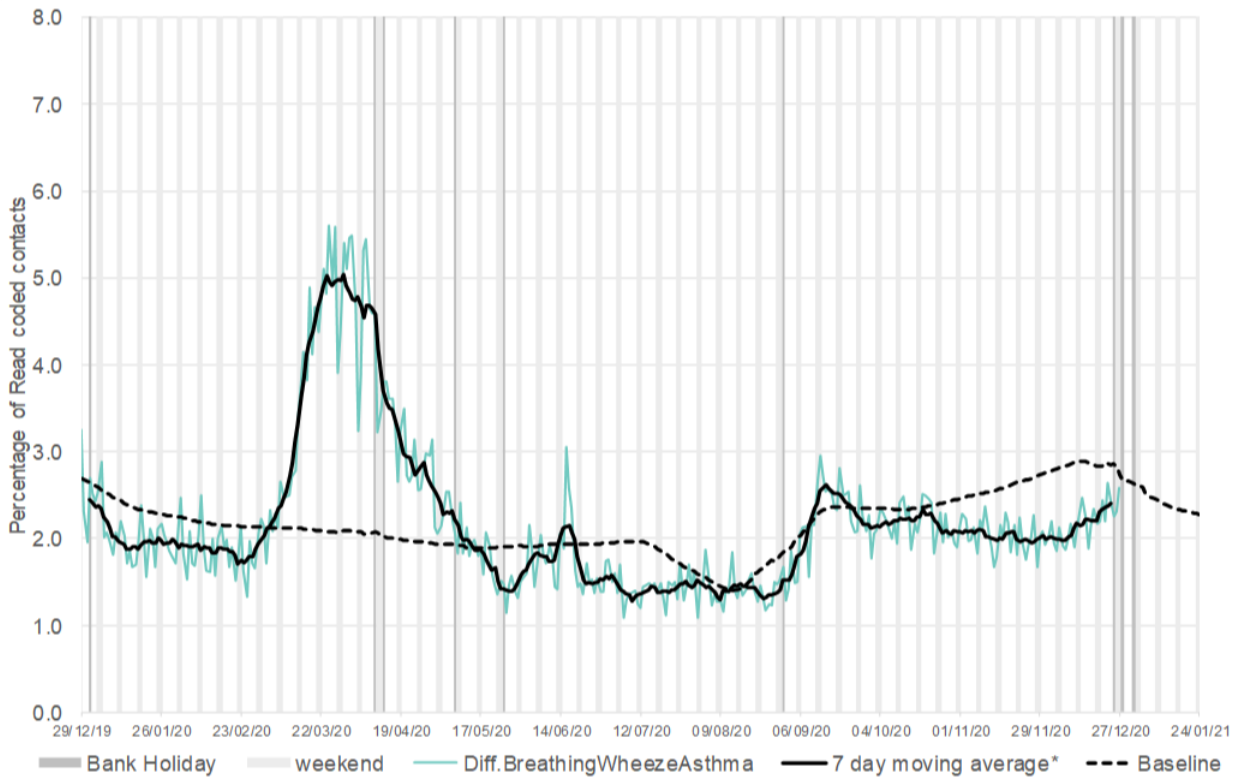
GP Out of Hours, Syndromic Surveillance

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 cover around 70% of England’s out of hour activity.

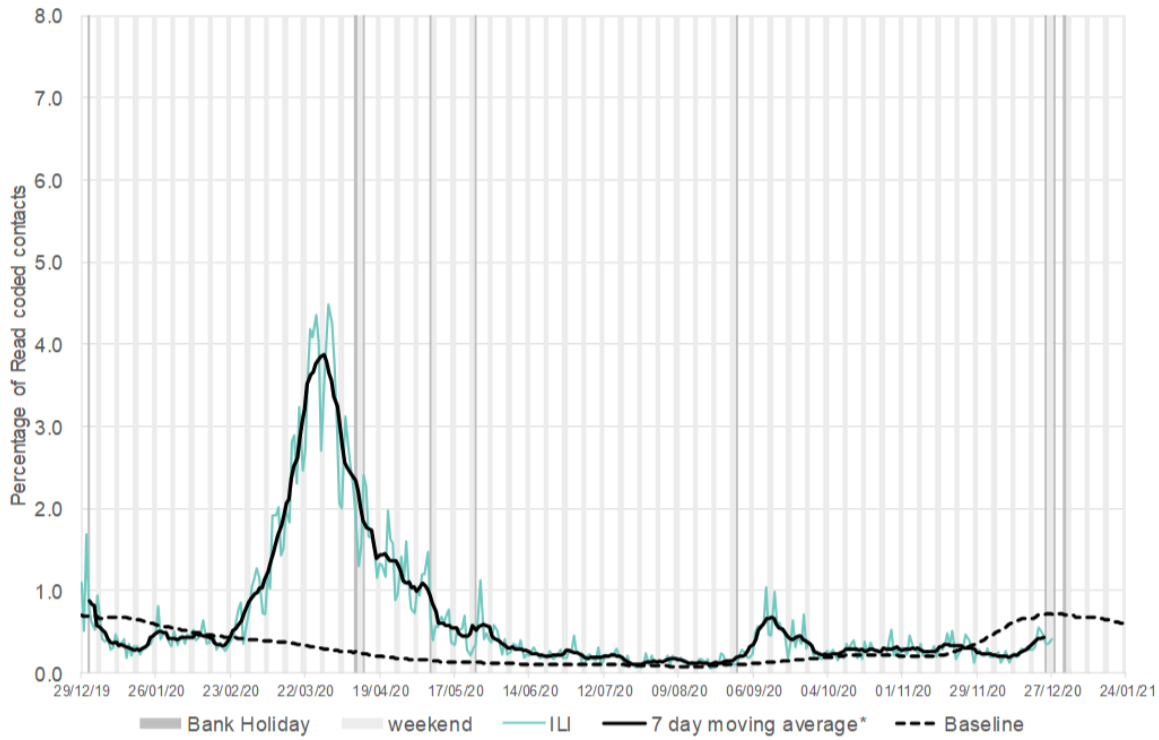
Up to 27 December GP out-of-hours and unscheduled care consultations for acute respiratory infections, influenza-like illness and difficulty breathing/asthma/wheeze increased (Figure 32).

Figure 32: GPOOH daily contacts (%) for (a) difficulty breathing/wheeze/asthma, (b) influenza-like illness and (c) acute respiratory infections, England

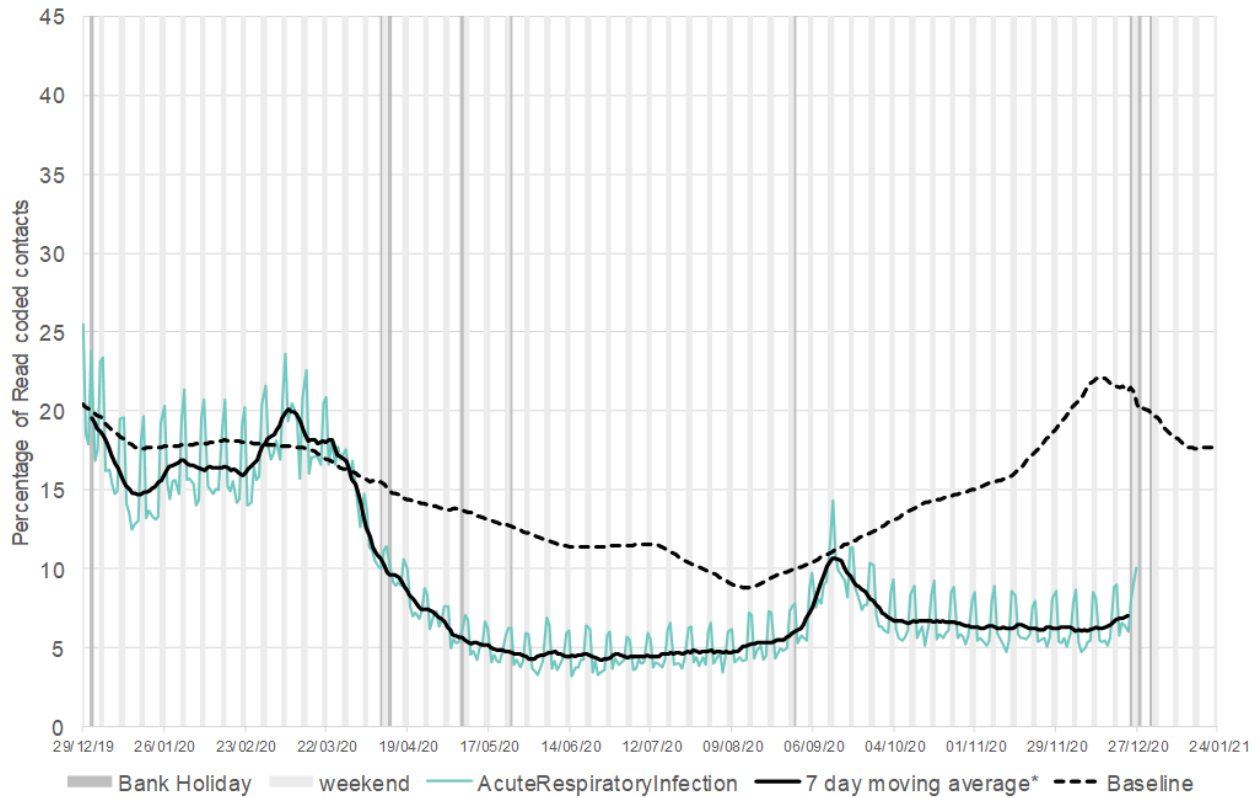
(a)



(b)



(c)

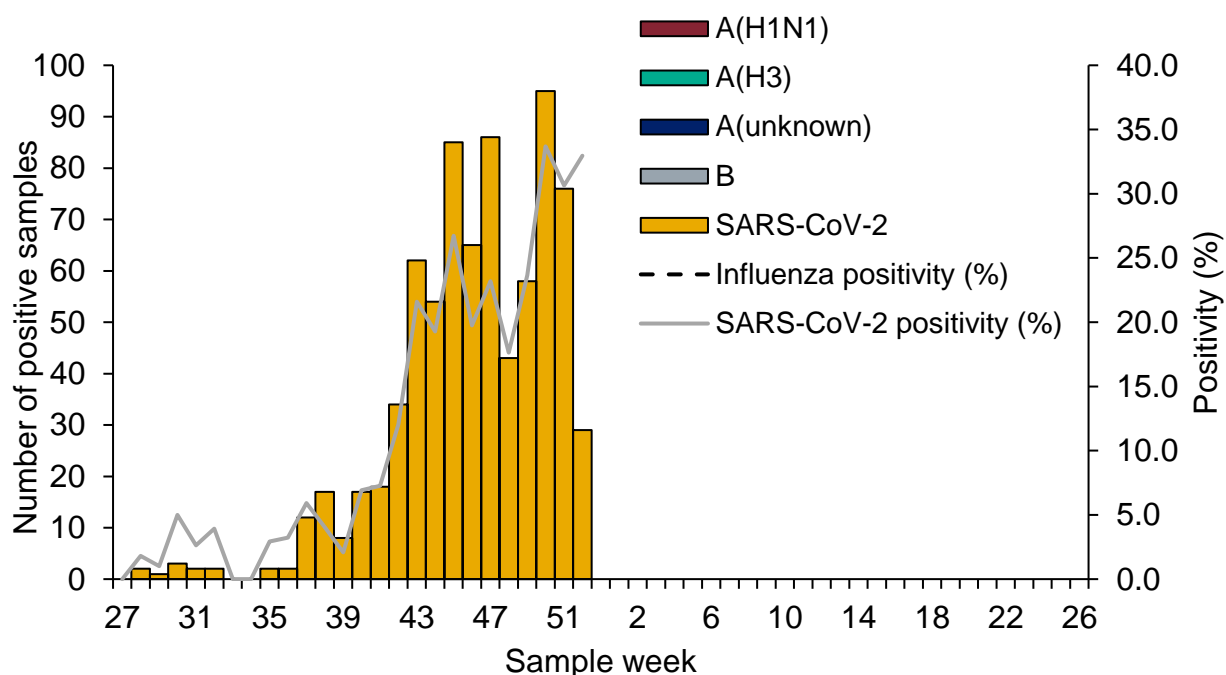


Sentinel swabbing scheme in the UK

In week 52 2020, 29 samples tested positive for SARS-CoV-2 with an overall positivity of 33.0% (29/88) compared to 30.6% (76/248) in the previous week, through the UK GP sentinel swabbing schemes (Figure 33).

Samples up to week 41 were only tested for SARS-CoV-2.

Figure 33: Number of influenza and COVID-19 positive samples and weekly positivity (%), UK GP sentinel swabbing scheme



*For the most recent week, more samples are expected to be tested therefore the graph in Figure 33 should be interpreted with caution

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

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/HDU) in NHS acute trusts across England. This has replaced the 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 and influenza 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.

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

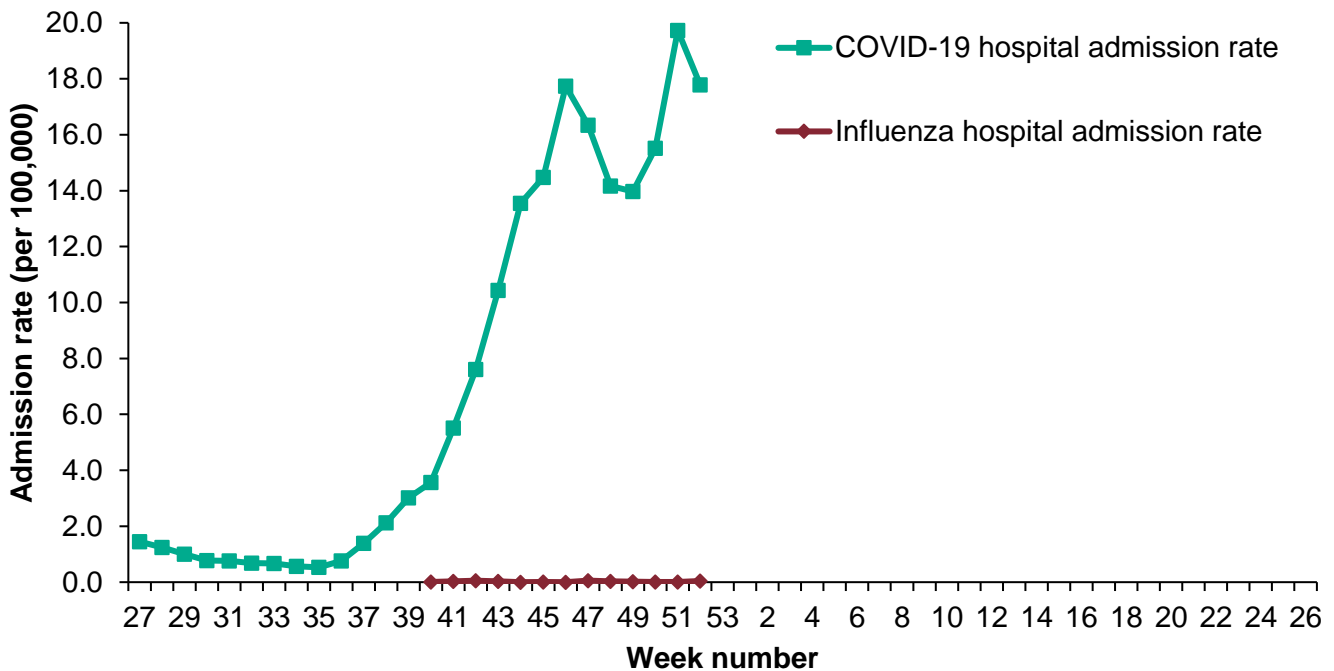
Hospitalisations, SARI Watch

In week 52, the weekly hospital admission rate for COVID-19 decreased slightly in comparison to that observed in week 51. The hospital admission rate remained low for influenza. However, it is likely that data was not complete for week 52 due to the holiday period since some trusts reported unexpectedly low numbers of cases.

The hospitalisation rate for COVID-19 was at 17.78 per 100,000 in week 52 compared to 19.78 per 100,000 in the previous week. The hospitalisation rate for influenza was at 0.04 per 100,000 in week 52 compared to 0.01 per 100,000 in the previous week; and there were three new confirmed influenza (1 influenza A(H1N1)pdm09, 1 influenza A(unknown subtype) and 1 influenza B) hospital admissions reported.

By PHE centre, the highest hospital admission rate for COVID-19 was observed in the London and in the West Midlands for influenza. By age groups, the highest hospital admission rate for confirmed COVID-19 was in the 85+ year olds and for influenza in the 5 to 14 year olds.

Figure 34: Weekly overall hospital admission rates per 100,000 of new COVID-19 and influenza positive cases reported through SARI Watch, England

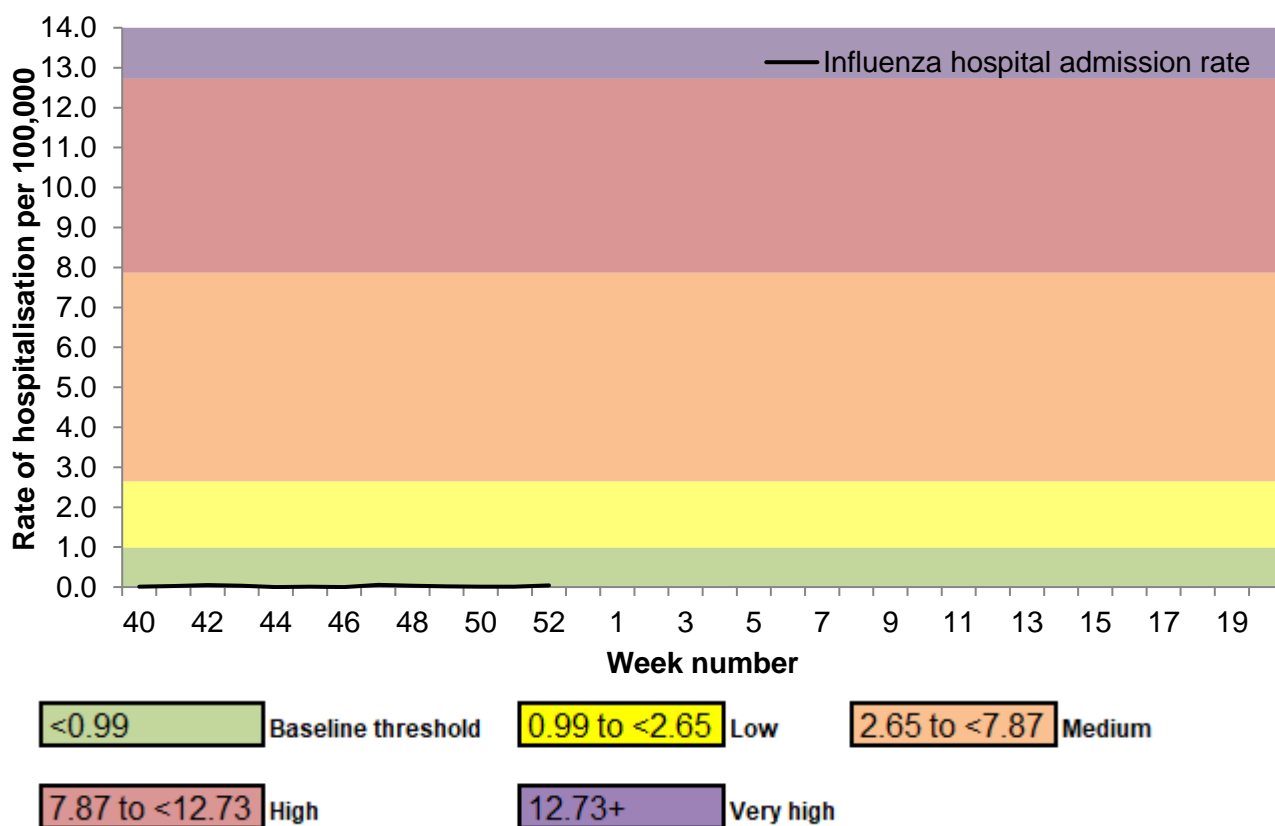


* influenza hospital admission rate is reported from week 40 2020 onwards

* influenza hospital admission rate based on 22 sentinel NHS trusts for week 52

* COVID-19 hospital admission rate based on 119 NHS trusts for week 52

Figure 35: Weekly overall influenza hospital admission rates per 100,000 trust catchment population with MEM thresholds, SARI Watch, England



* the MEM thresholds used are those from the 2019/20 season due to the pandemic

Figure 36: Weekly influenza hospital admissions by influenza type, SARI Watch, England

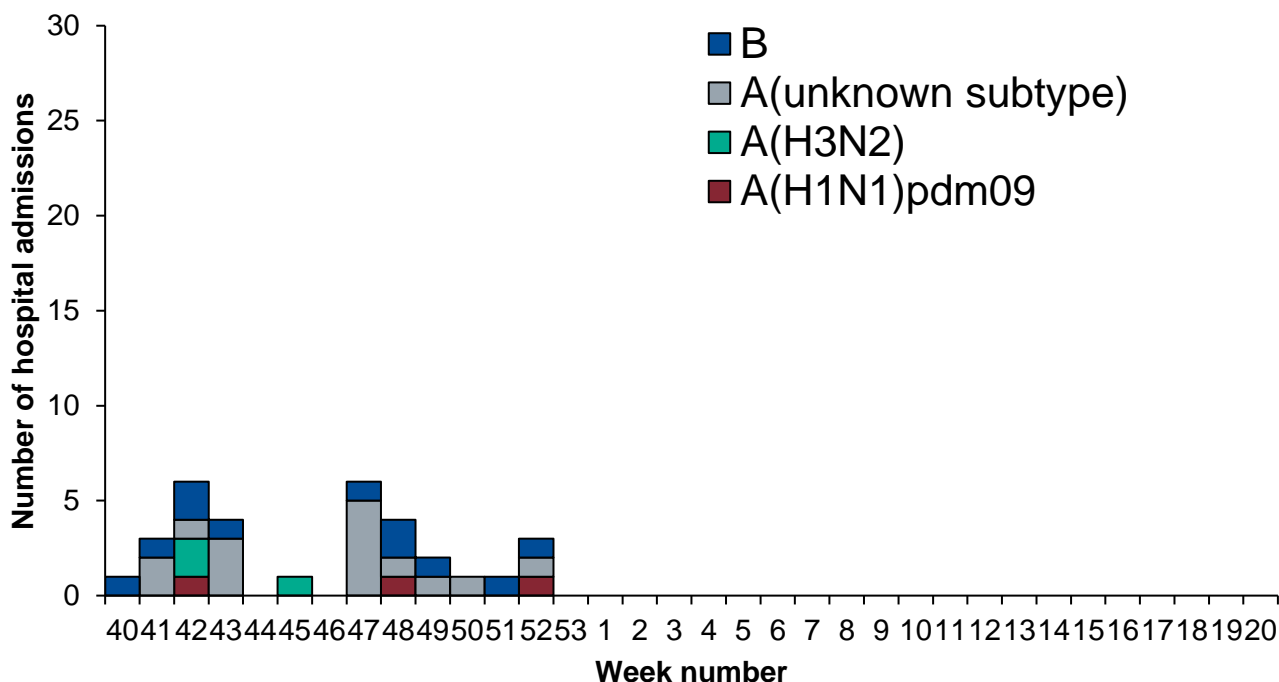


Figure 37: Weekly hospital admission rate by PHE Centre for new (a) COVID-19 positive cases and (b) influenza reported through SARI Watch

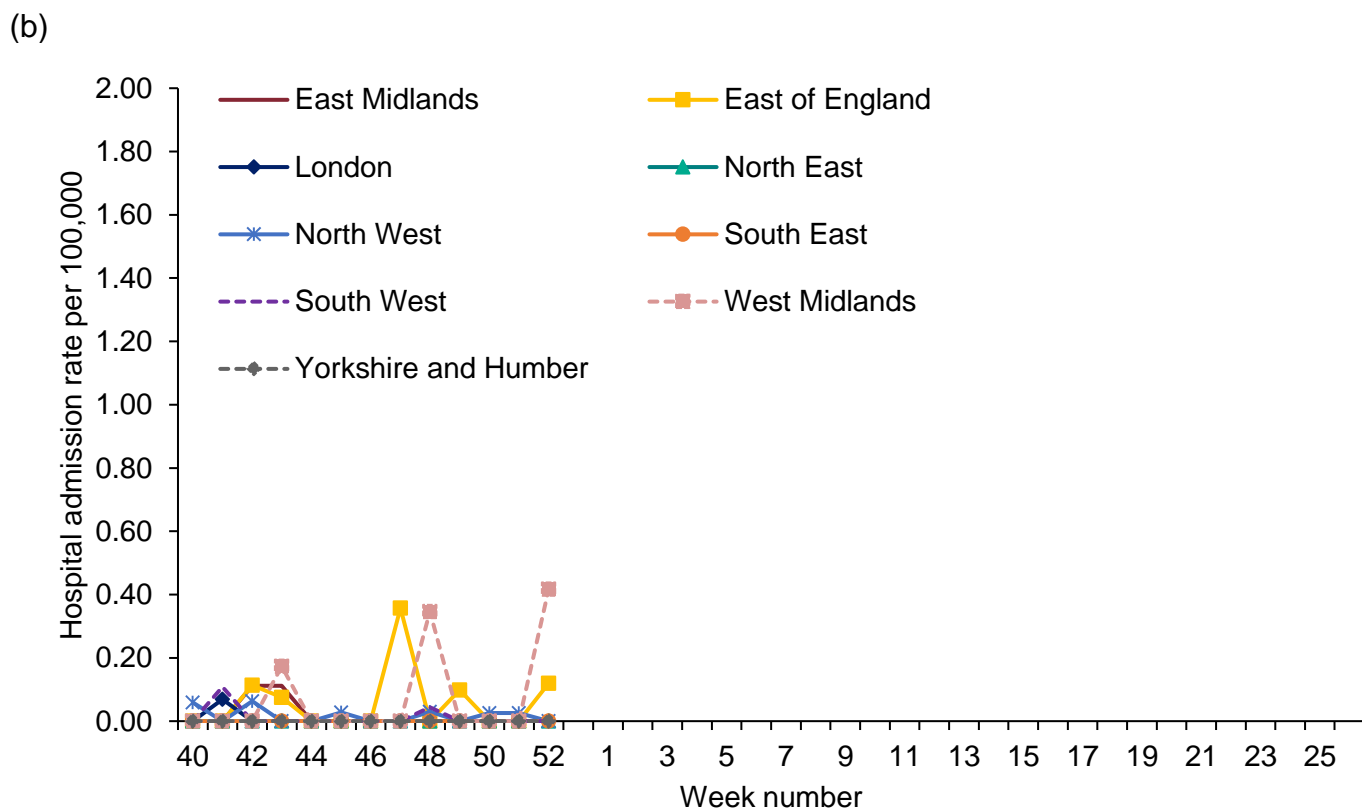
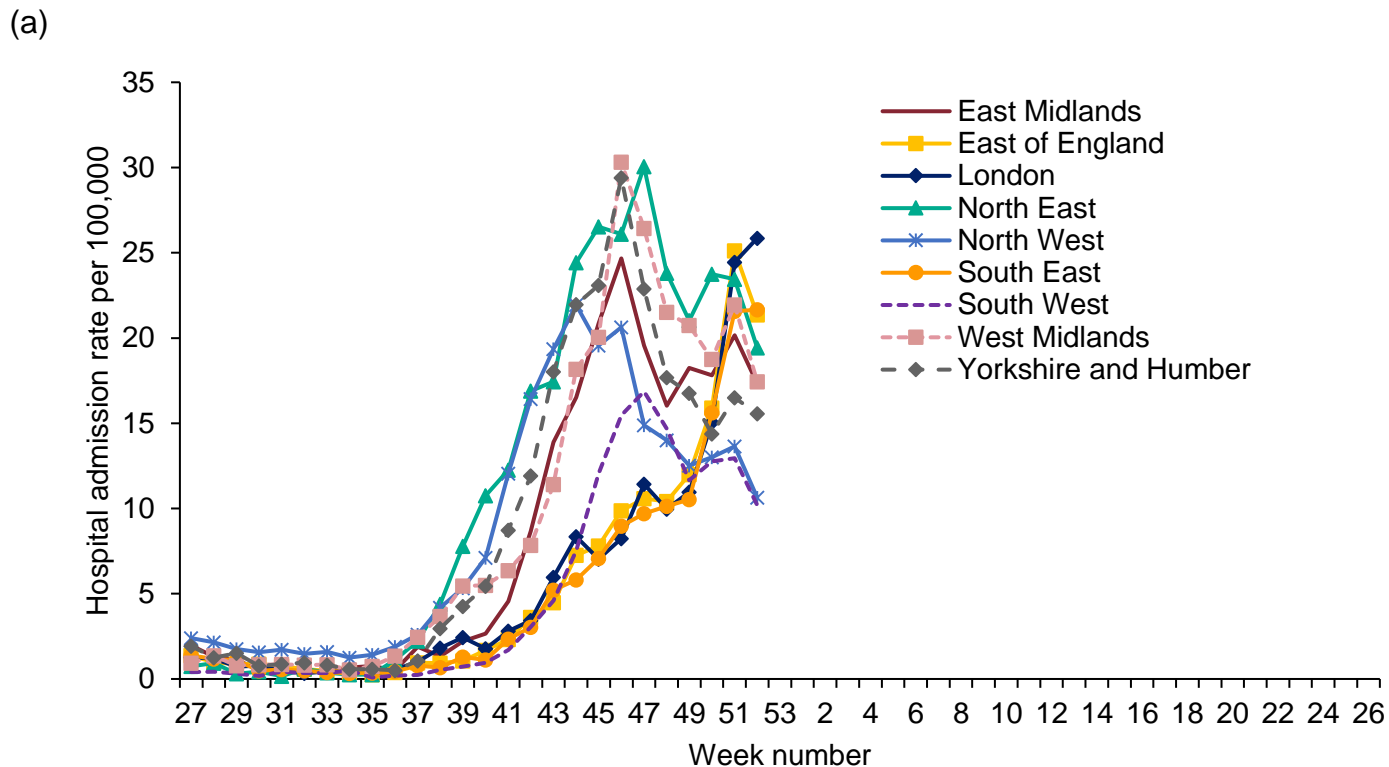
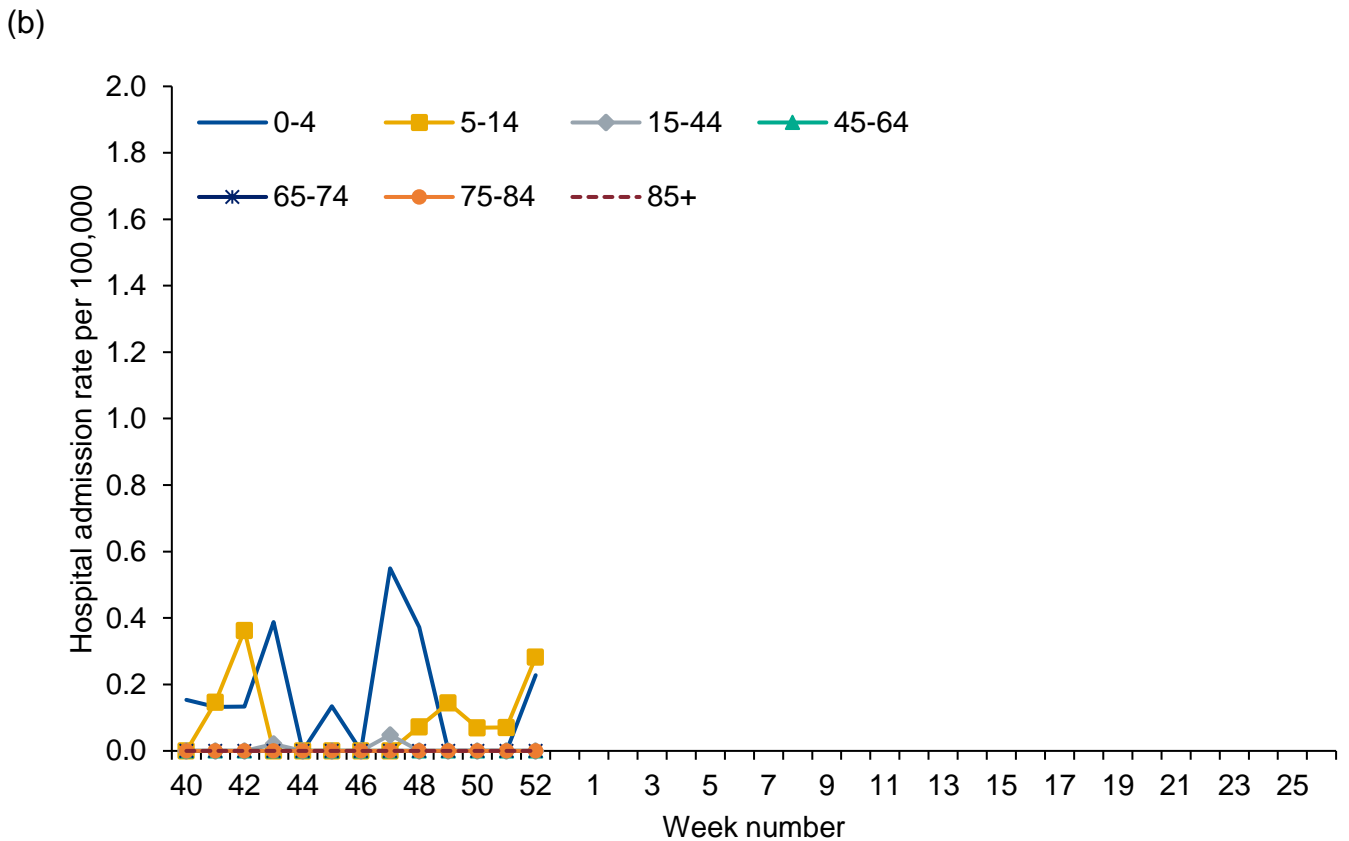
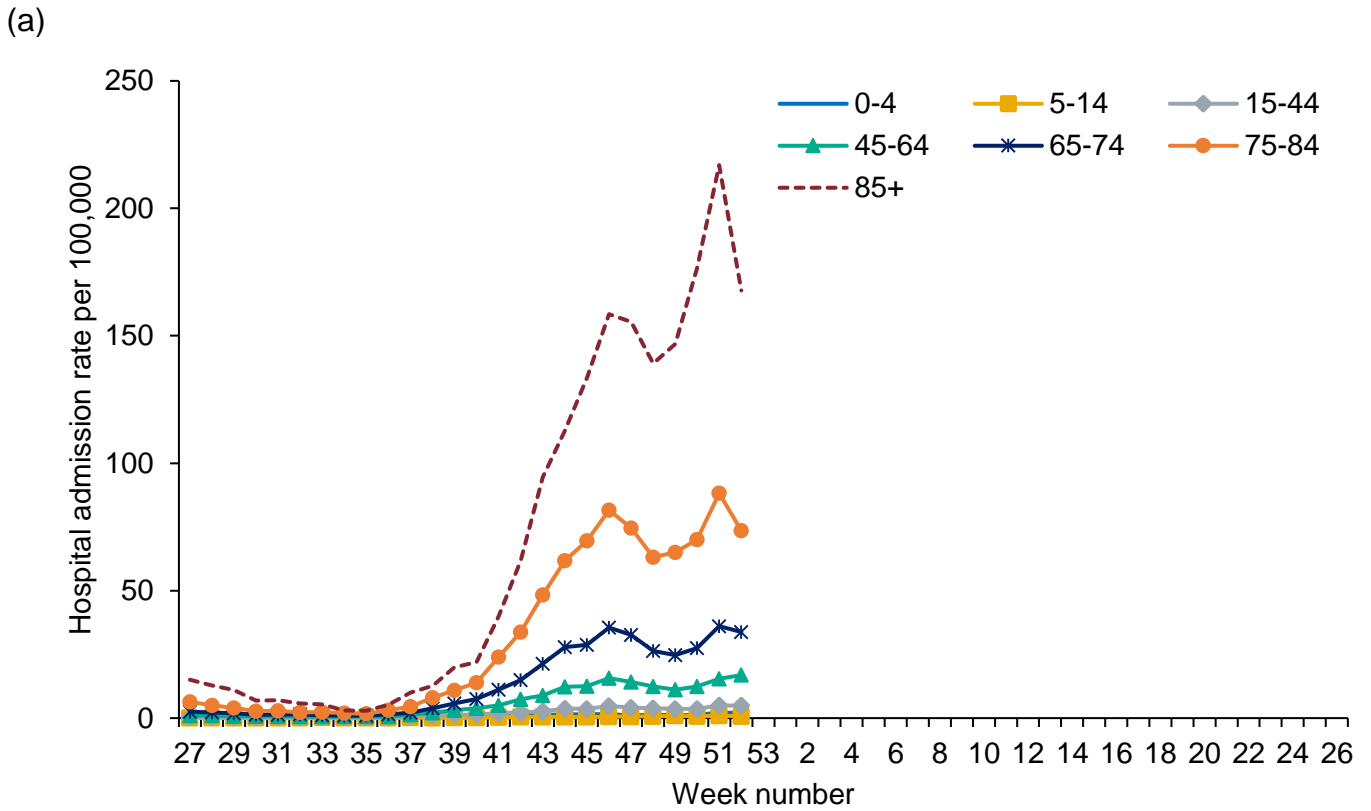


Figure 38: Weekly hospital admission rate by age group for new (a) COVID-19 positive cases and (b) influenza reported through SARI Watch



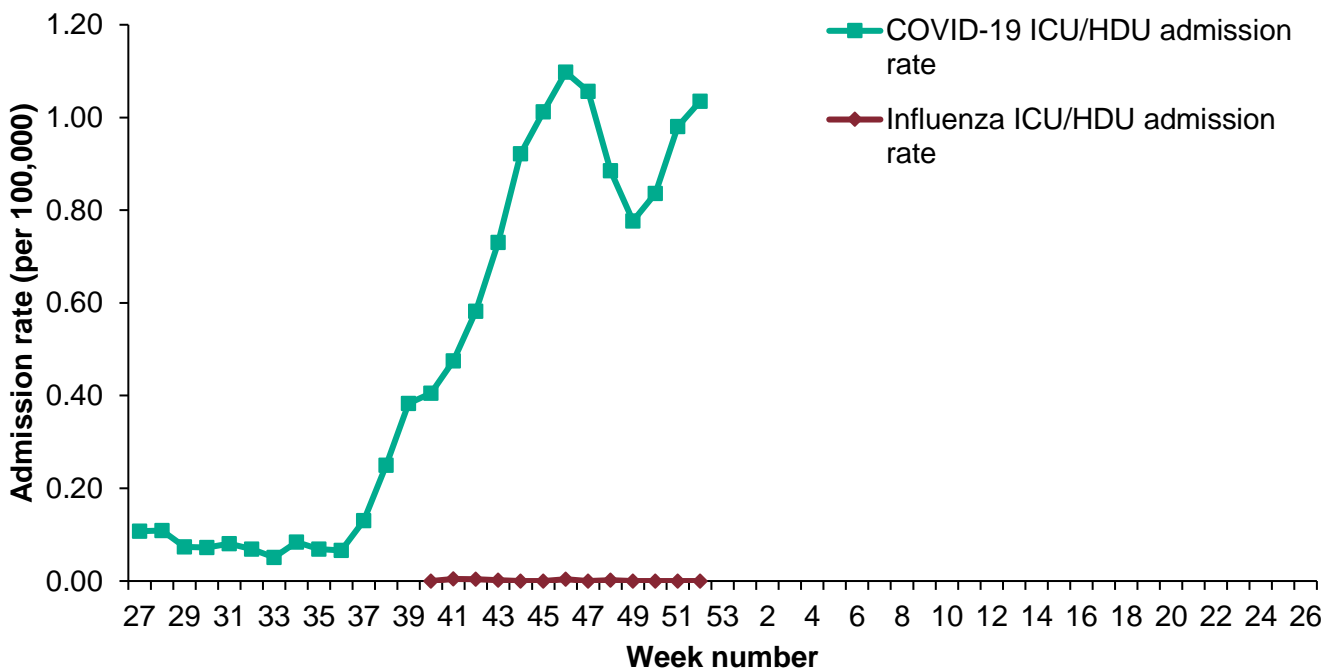
ICU/HDU admissions, SARI Watch

In week 52, the weekly ICU/HDU admission rates for COVID-19 increased whilst the ICU/HDU admission rate remained low for influenza.

The ICU/HDU rate for COVID-19 was at 1.03 per 100,000 in week 52 (based on data reported from 115 NHS Trusts) compared to at 0.98 per 100,000 in the previous week. There was no new influenza admission to ICU/HDU in week 52.

By PHE Centre, the highest ICU/HDU admission rates for COVID-19 were observed in London. By age groups, the highest ICU/HDU admission rates for COVID-19 were observed in the 65 to 74 year olds.

Figure 39: Weekly overall ICU/HDU admission rates per 100,000 of new COVID-19 and influenza positive cases reported through SARI Watch, England



- * influenza ICU/HDU admission rate is reported from week 40 2020 onwards
- * influenza ICU/HDU admission rate based on 95 NHS trusts for week 52
- * COVID-19 ICU/HDU admission rate based on 115 NHS trusts for week 52

Figure 40: Weekly overall influenza ICU/HDU admission rates per 100,000 trust catchment population with MEM thresholds, SARI Watch, England

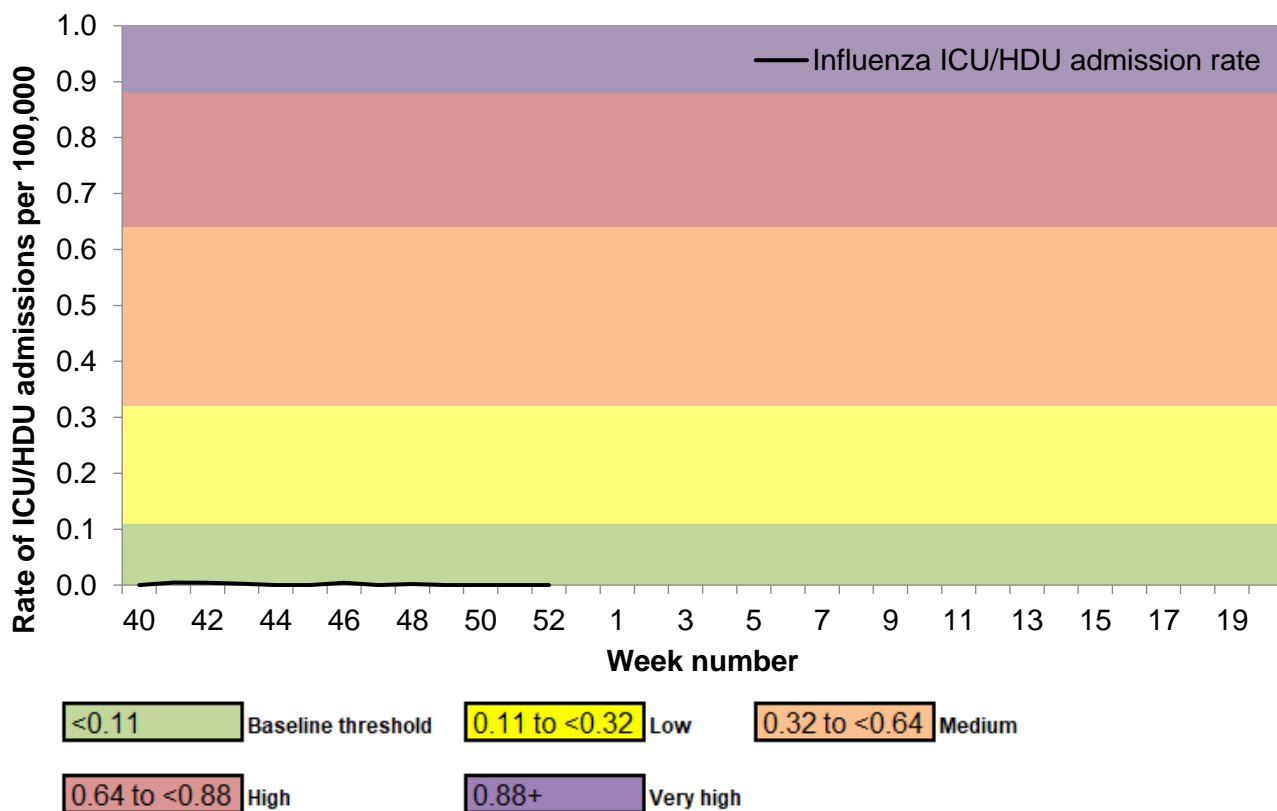


Figure 41: Weekly influenza ICU/HDU admissions by influenza type, SARI Watch, England

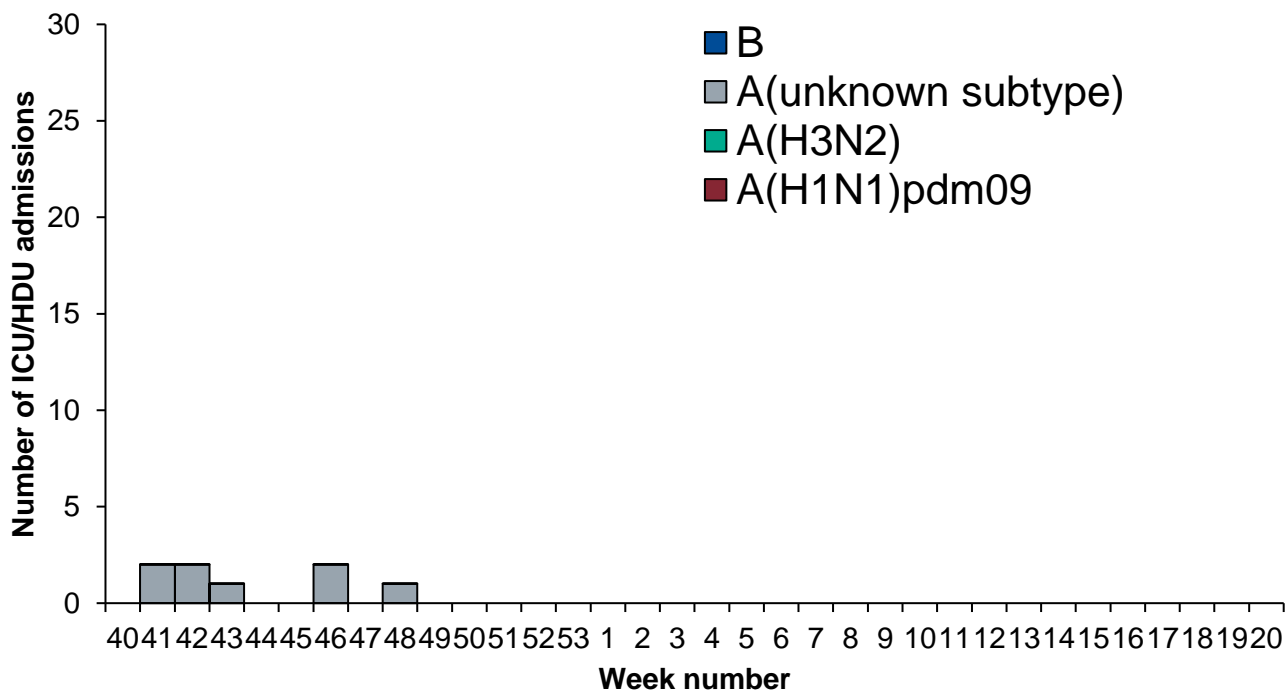


Figure 42: Weekly ICU/HDU admission rate by PHE Centre for new (a) COVID-19 positive cases and (b) influenza reported through SARI Watch

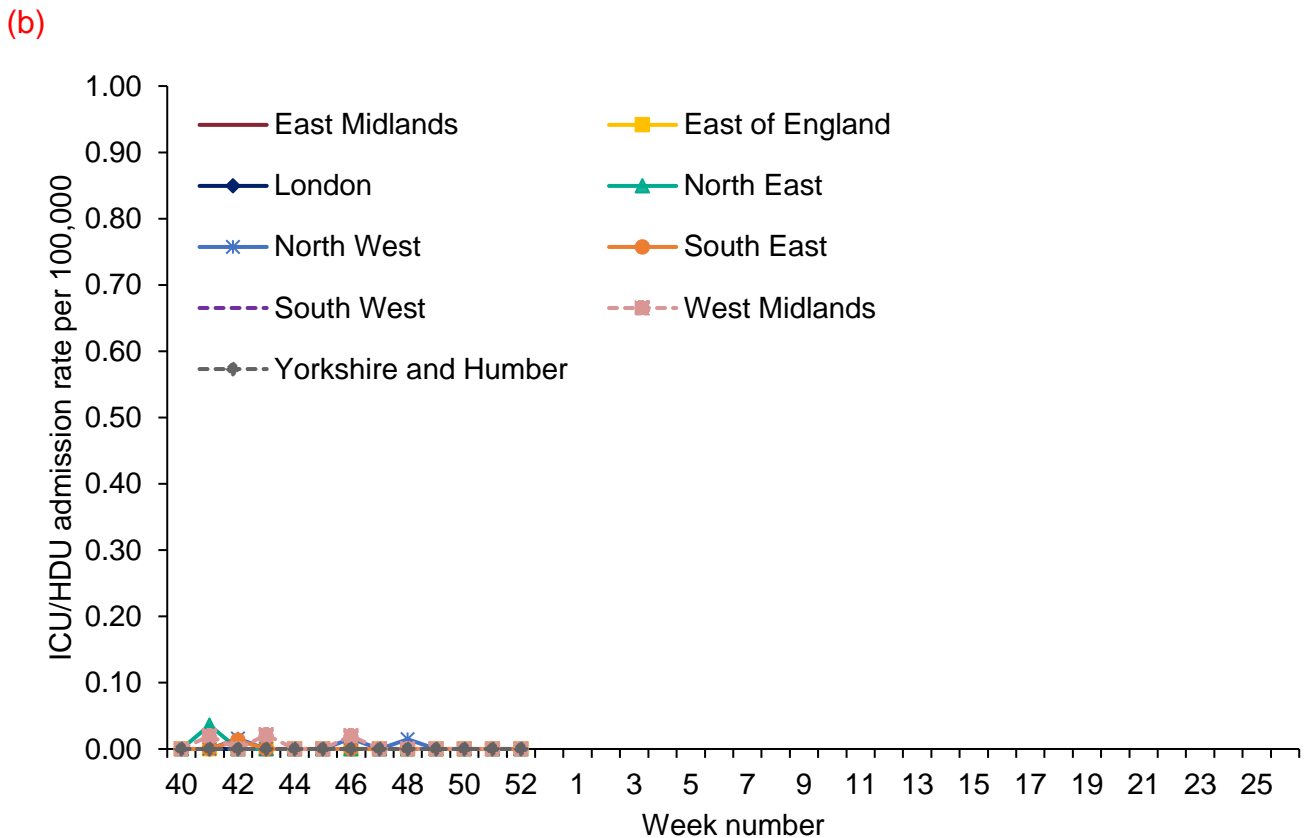
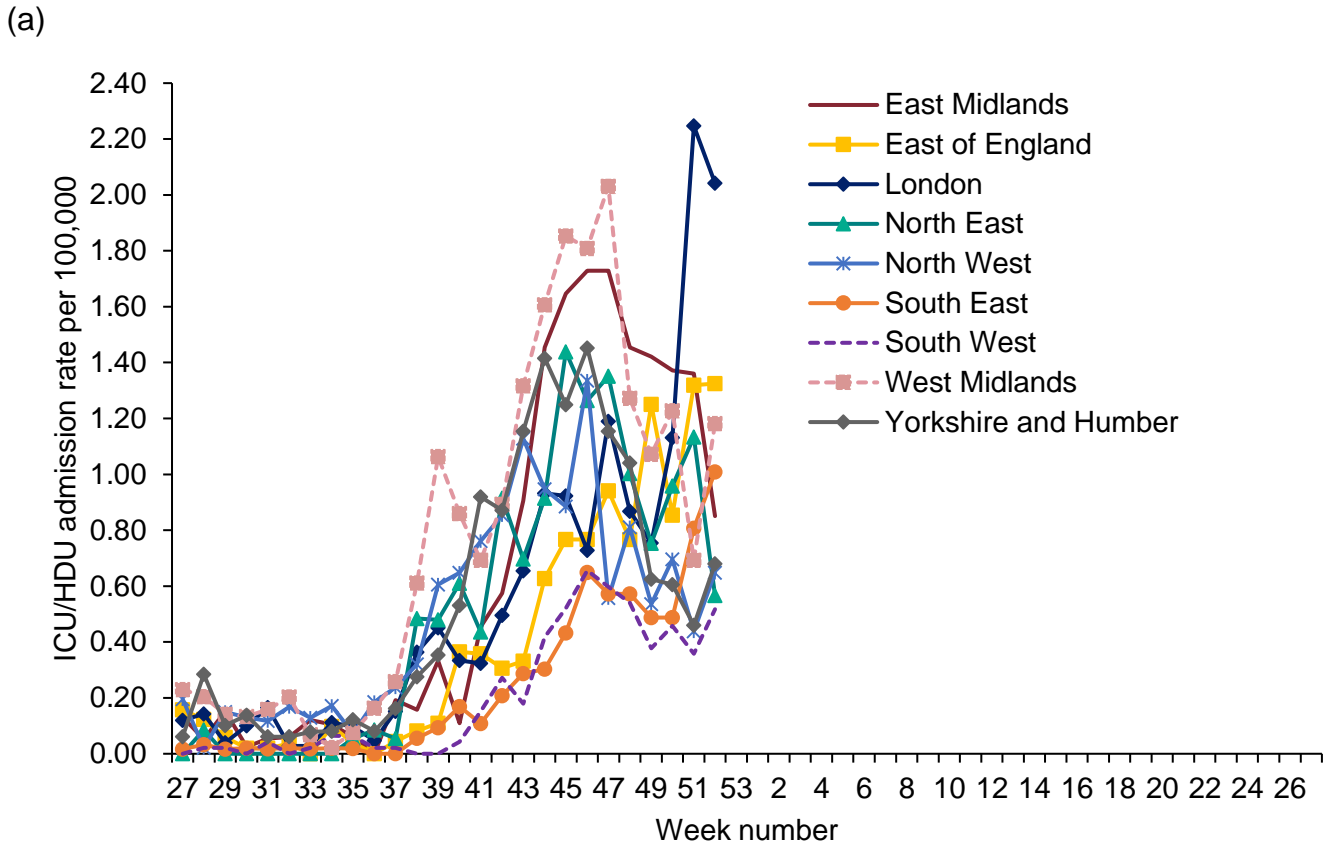
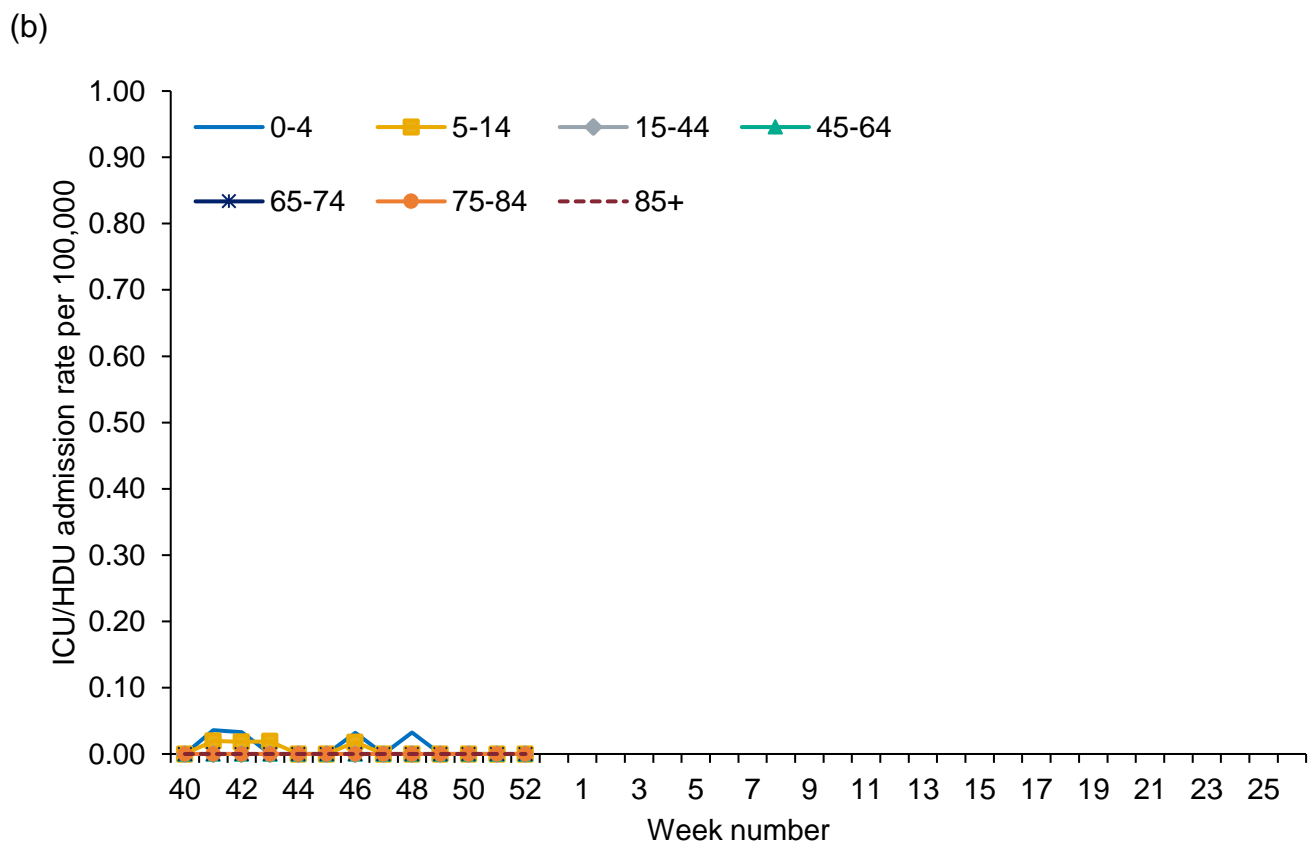
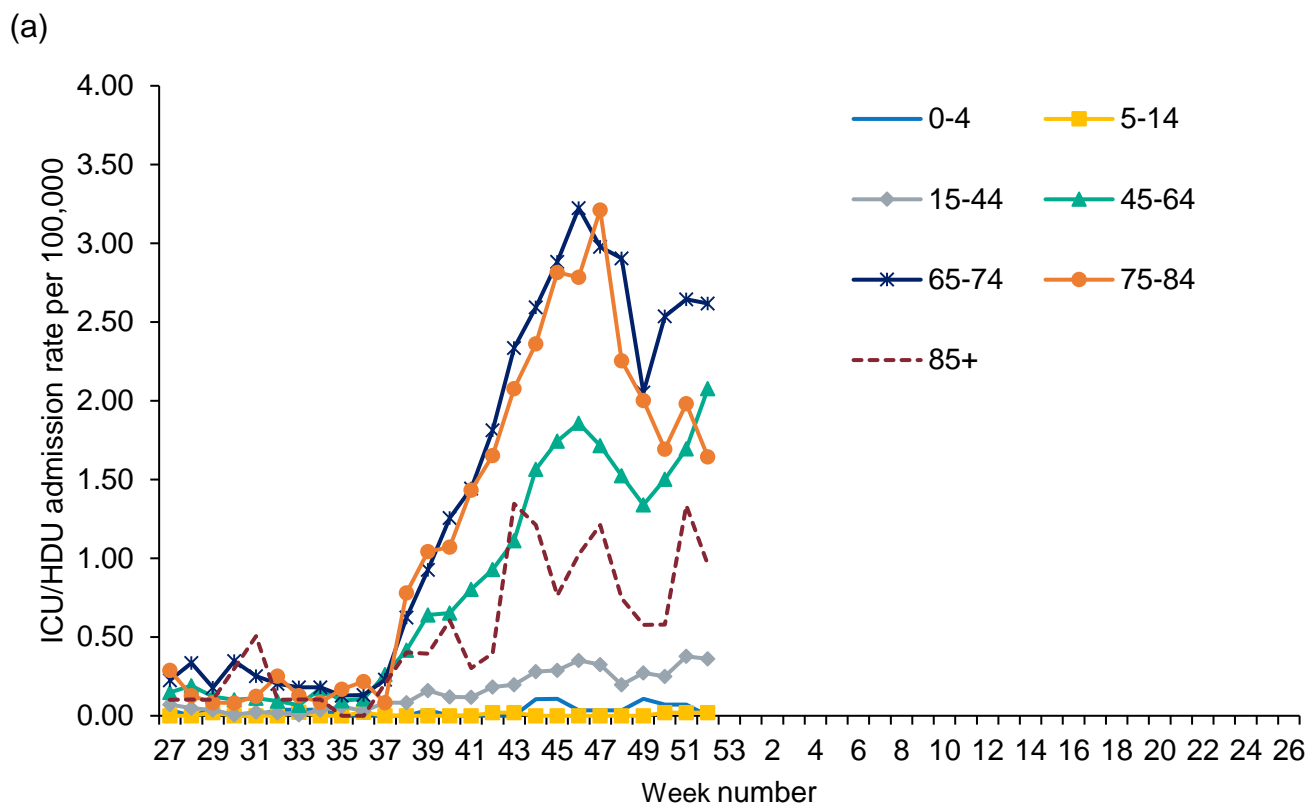


Figure 43: Weekly ICU/HDU admission rate by age group for new (a) COVID-19 positive cases and (b) influenza reported through SARI Watch

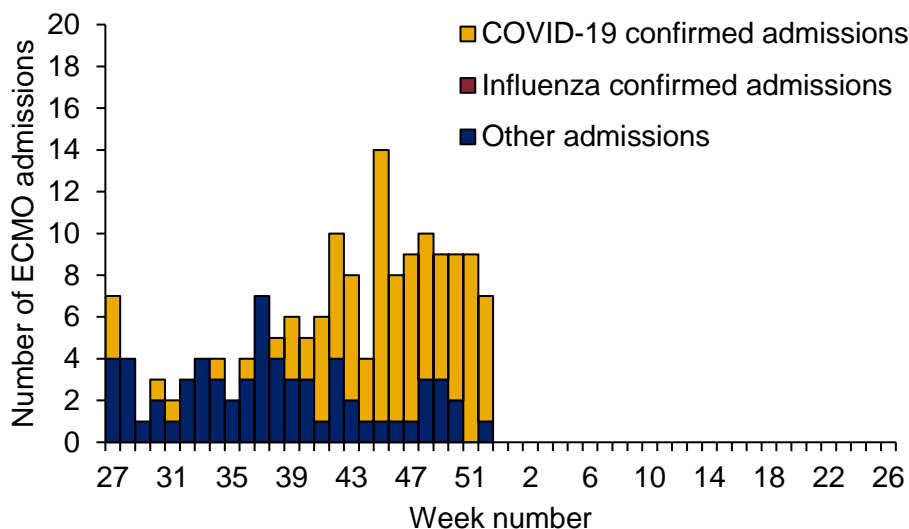


ECMO, SARI Watch

From week 27 2020, a total of 96 laboratory confirmed COVID-19 admissions have been reported from the 6 Severe Respiratory Failure (SRF) centres in the UK.

There were 6 new laboratory confirmed COVID-19 admissions reported in week 52 (Figure 44).

Figure 44: Laboratory confirmed ECMO admissions (COVID-19, influenza and non-COVID-19 confirmed) to Severe Respiratory Failure centres in the UK



*From the week 45 report (this report), data on ECMO admissions is being presented for the UK (including retrospective data from week 27 onwards).

Emergency Department attendances, Syndromic surveillance

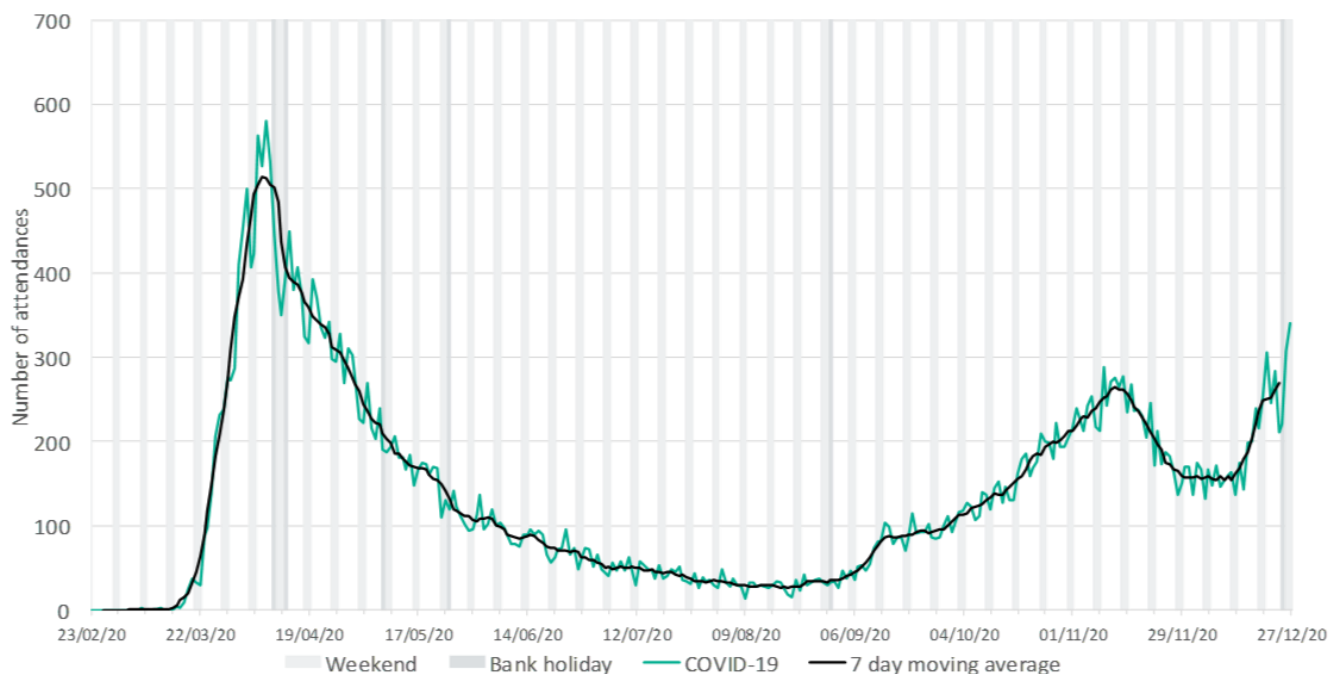
The Emergency Department Syndromic Surveillance System (EDSSS) monitors the daily visits in a network of emergency departments across England.

Up to 27 December 2020, the daily number of ED attendances for all ages as reported by 86 EDs, for COVID-19-like increased (Figure 45).

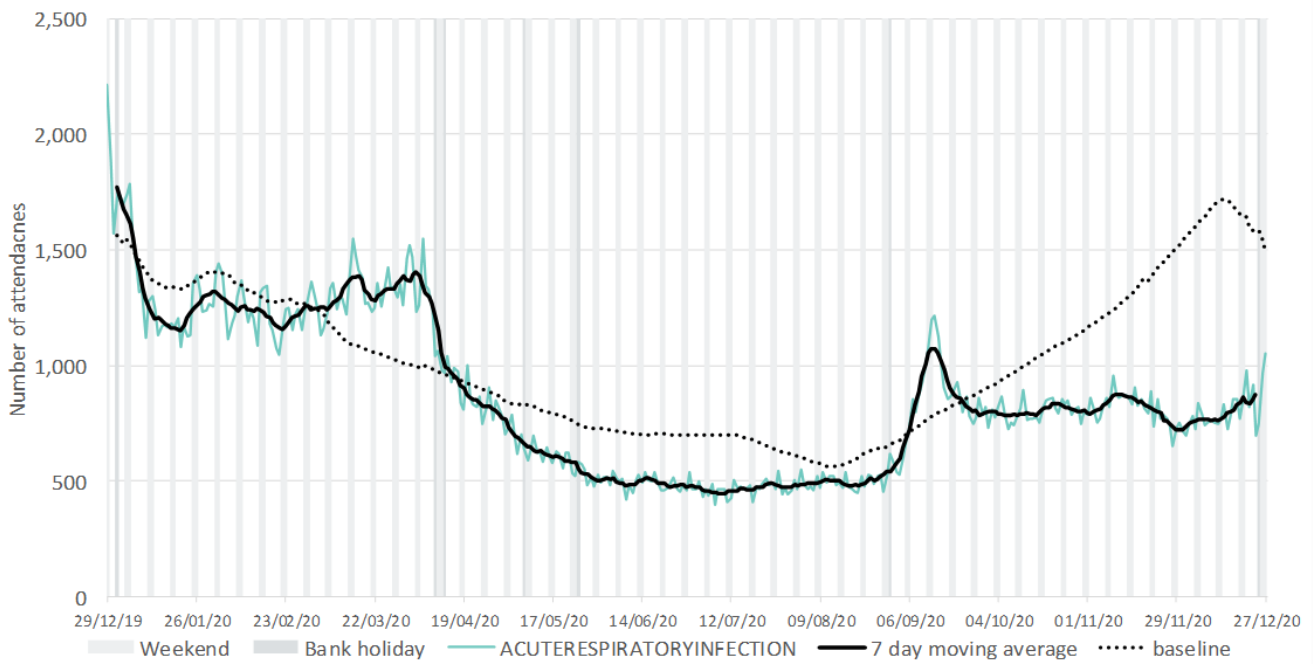
Please note: the COVID-19-like ED indicator is an underestimation of the number of COVID-19 attendances as it only includes attendances with a COVID-19-like diagnosis as their primary diagnosis. The EDSSS COVID-19-like indicator should therefore be used to monitor trends in ED attendances and not to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

Figure 45: Daily ED attendances for (a) COVID-19-like and (b) acute respiratory infections, all ages, England

(a)



(b)



Mortality surveillance

Cumulative COVID-19 deaths

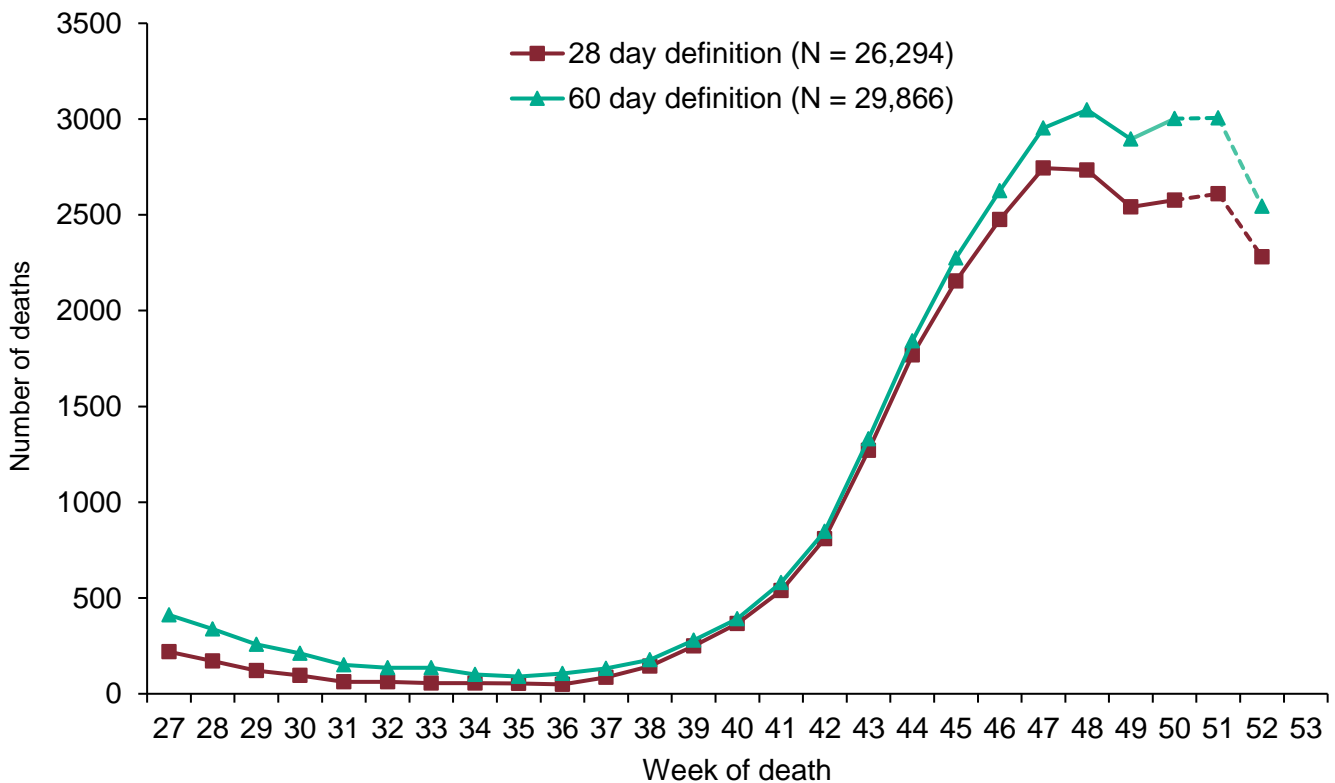
Changes to the definitions of COVID-19 related deaths in England are described in more detail in an accompanying PHE technical summary.

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

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

The introduction of these definitions will affect the numbers which have been presented in past reports and therefore Figure 45 represents these differences by definition.

Figure 46: Number of deaths since week 27 by week of death and time since laboratory confirmation of COVID-19, England



*The data are 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 47: Age/sex pyramid of laboratory confirmed COVID-19 deaths, since week 27

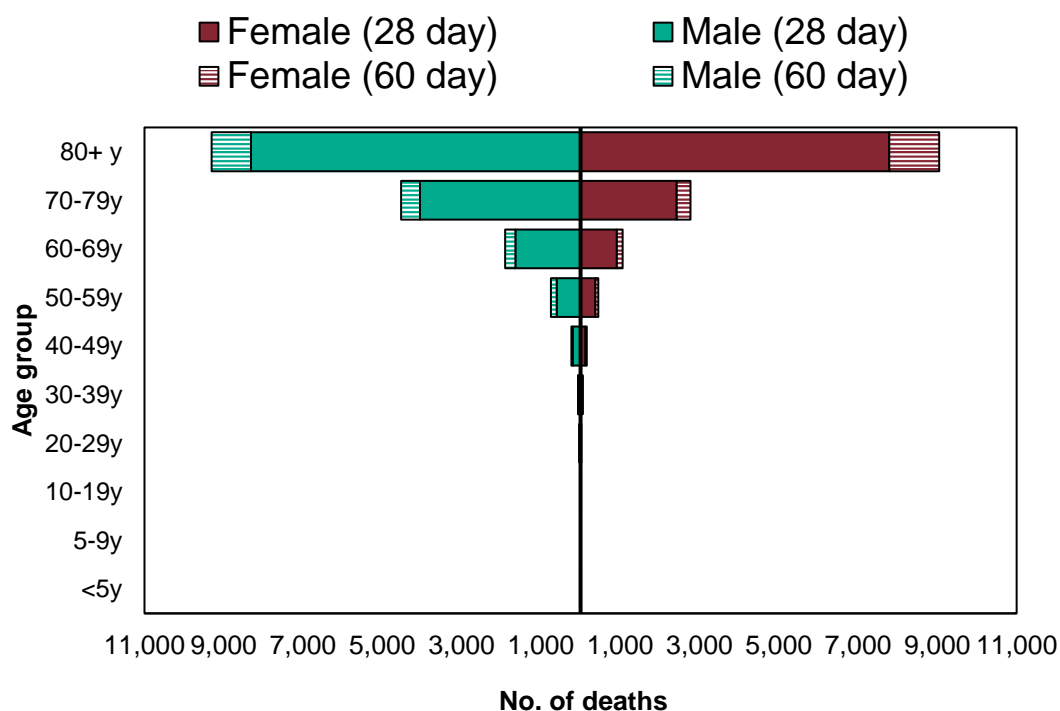


Table 5: Ethnic group (%) of COVID-19 deaths and time since laboratory confirmation of COVID-19, England

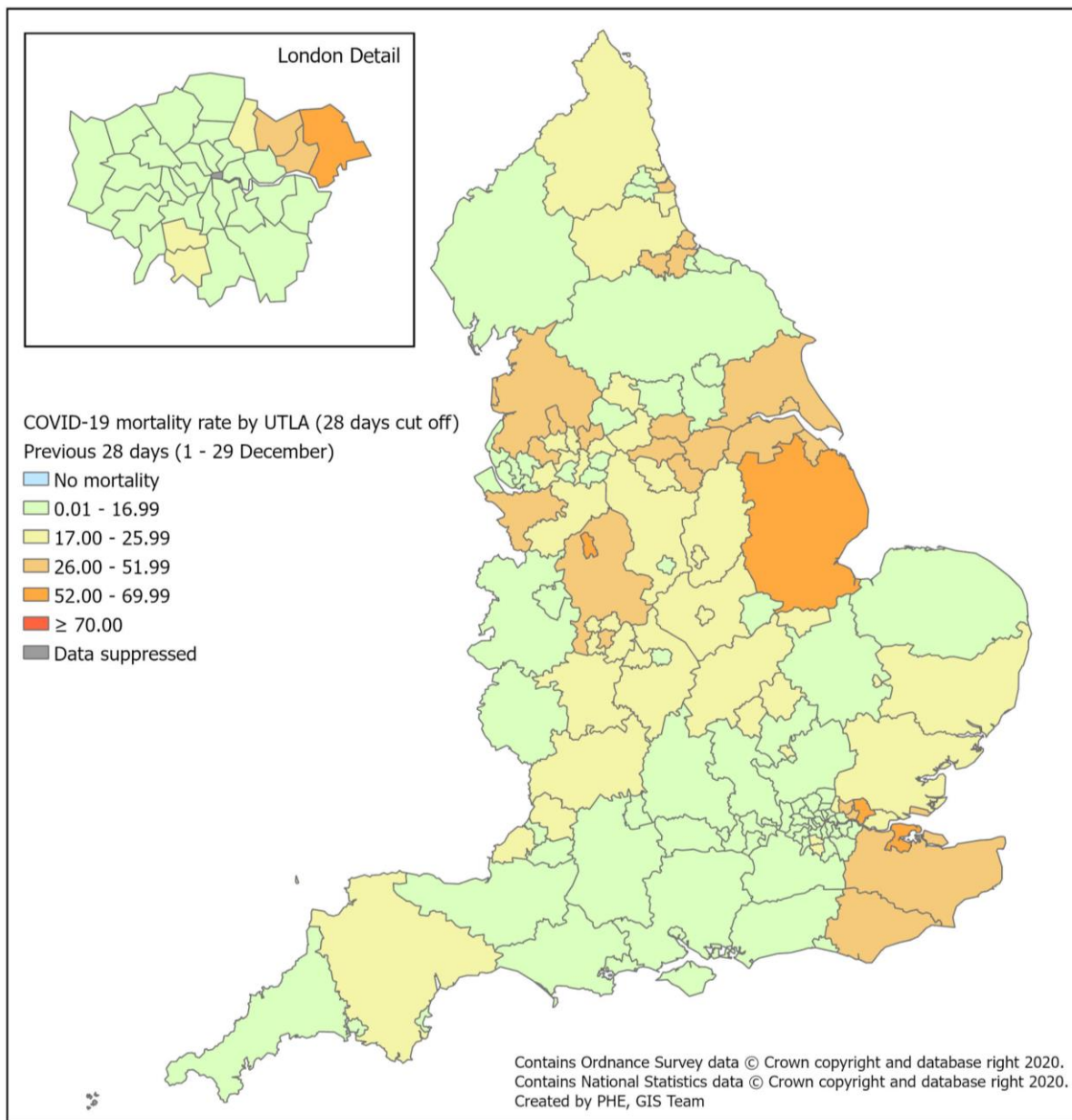
Ethnicity	28 day definition	60 day definition
White	90.4	90.3
Asian / Asian British	6.6	6.7
Black / African / Caribbean / Black British	1.6	1.5
Mixed / Multiple ethnic groups	0.4	0.4
Other ethnic group	1.1	1.1

Table 6: Cumulative number of COVID-19 deaths since week 27 and time since laboratory confirmation of COVID-19 by PHE Centres

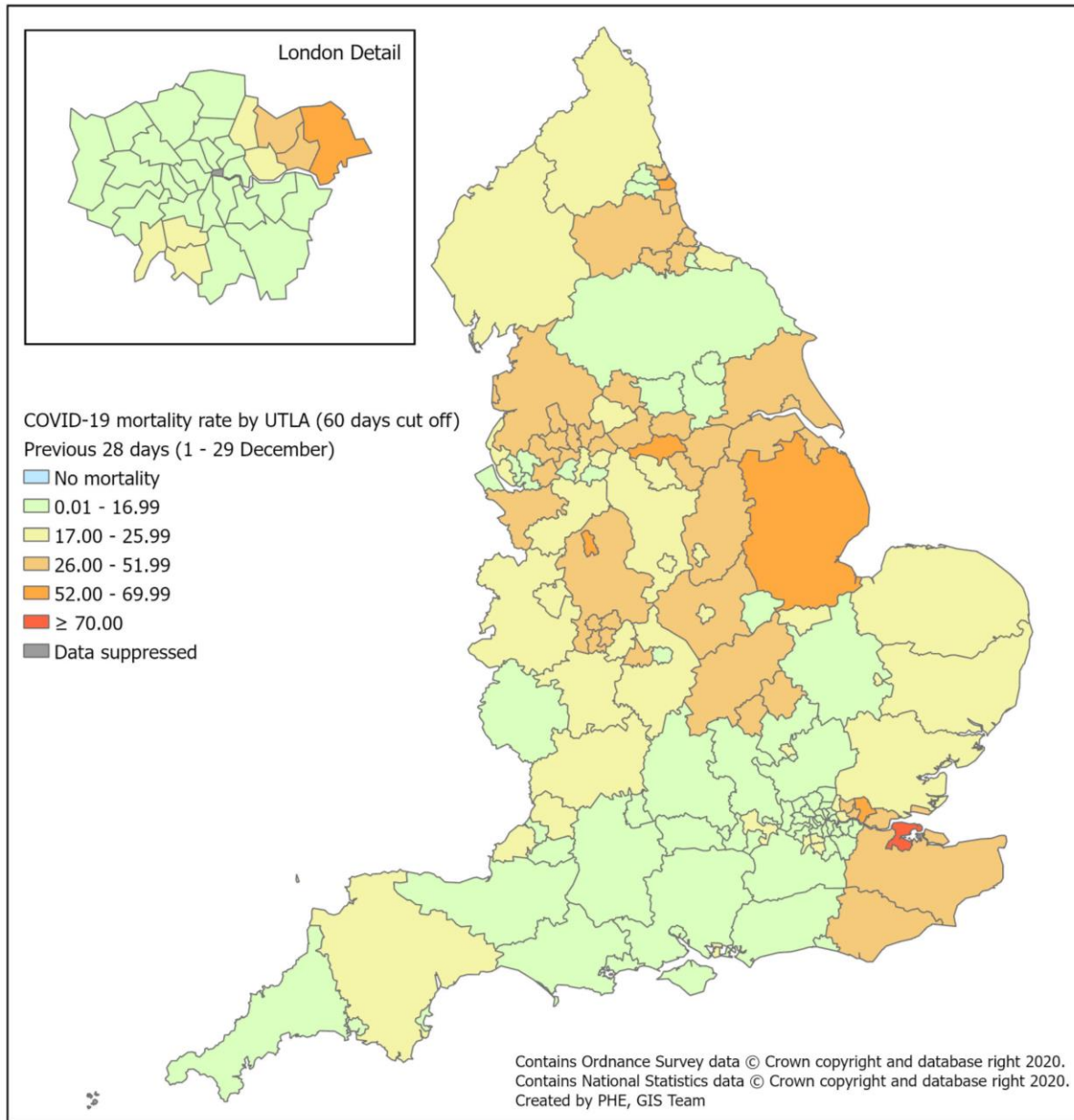
PHE Centres	28 day definition	60 day definition
North East	1,885	2,170
North West	5,701	6,600
Yorkshire & Humber	3,976	4,513
West Midlands	3,309	3,749
East Midlands	2,938	3,308
East of England	2,116	2,453
London	2,064	2,365
South East	2,888	3,333
South West	1,414	1,574

Figure 48: Cumulative mortality rate of COVID-19 cases per 100,000 population tested under Pillars 1 and 2 for the past four weeks by (a) 28 day definition and (b) 60 day definition

(a)



(b)



* Figure 48 has been calculated using mid-2019 ONS population estimates

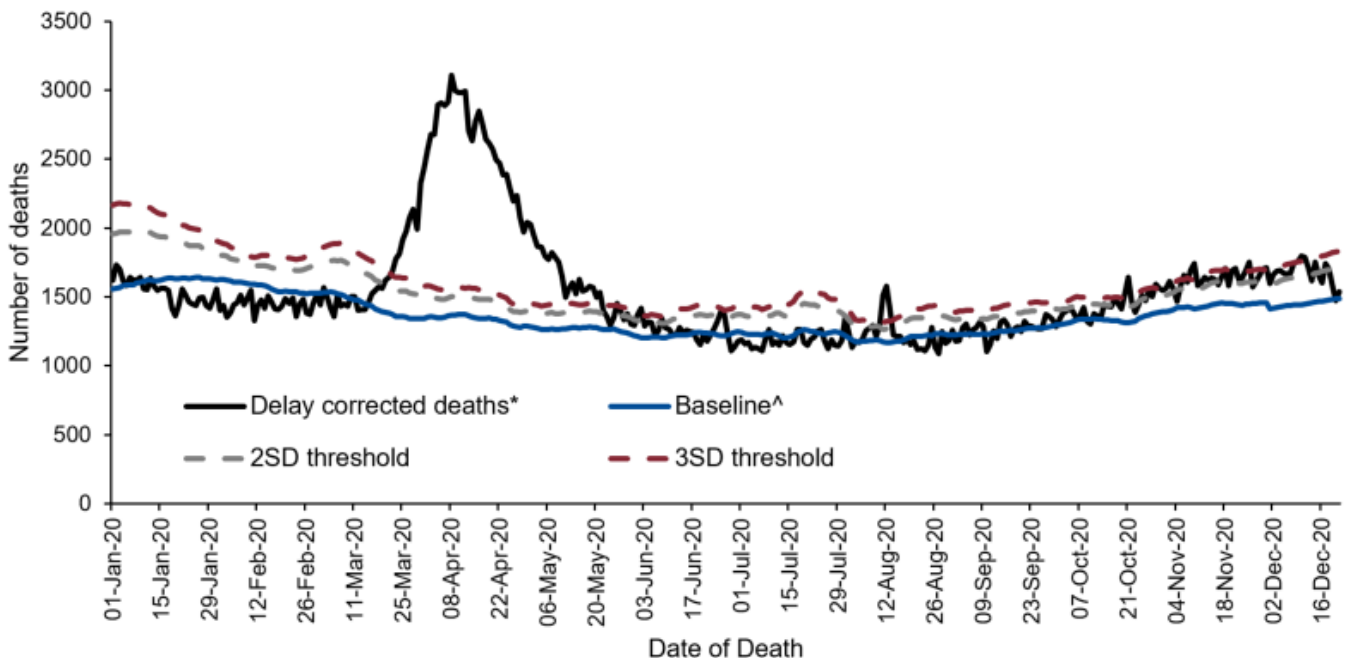
Daily excess all-cause mortality (England)

Deaths occurring from 1 January to 21 December 2020 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 +/- 7 days with an extrapolated time trend, and with 2 and 3 standard deviation (SD) limits shown (Figure 49).

Weeks in which at least 2 days exceeded the 3SD threshold are shown in Table 7 and the daily difference from the baseline by age and region is given in Figure 49. Note that as these data are by date of death with delay corrections, numbers are subject to change each week, particularly for more recent days.

No significant excess all-cause mortality was observed in week 51 overall, by age group and subnationally. The excess noted in week 33 coincides with a heat wave (Figure 49, 50 and Table 7). The most recent estimates should be interpreted with caution due to the delays in registrations over the Christmas period.

Figure 49: Daily excess all-cause deaths in all ages, England, 1 January 2020 to 21 December 2020



^ based on same day in previous 5 years +/- 1 week with a linear trend projected or for December to February past 3 low flu years +/-2 weeks, no trend

* corrected for delay to registration from death

Table 7: Excess all-cause deaths by (a) age group and (b) PHE centres, England

(a)

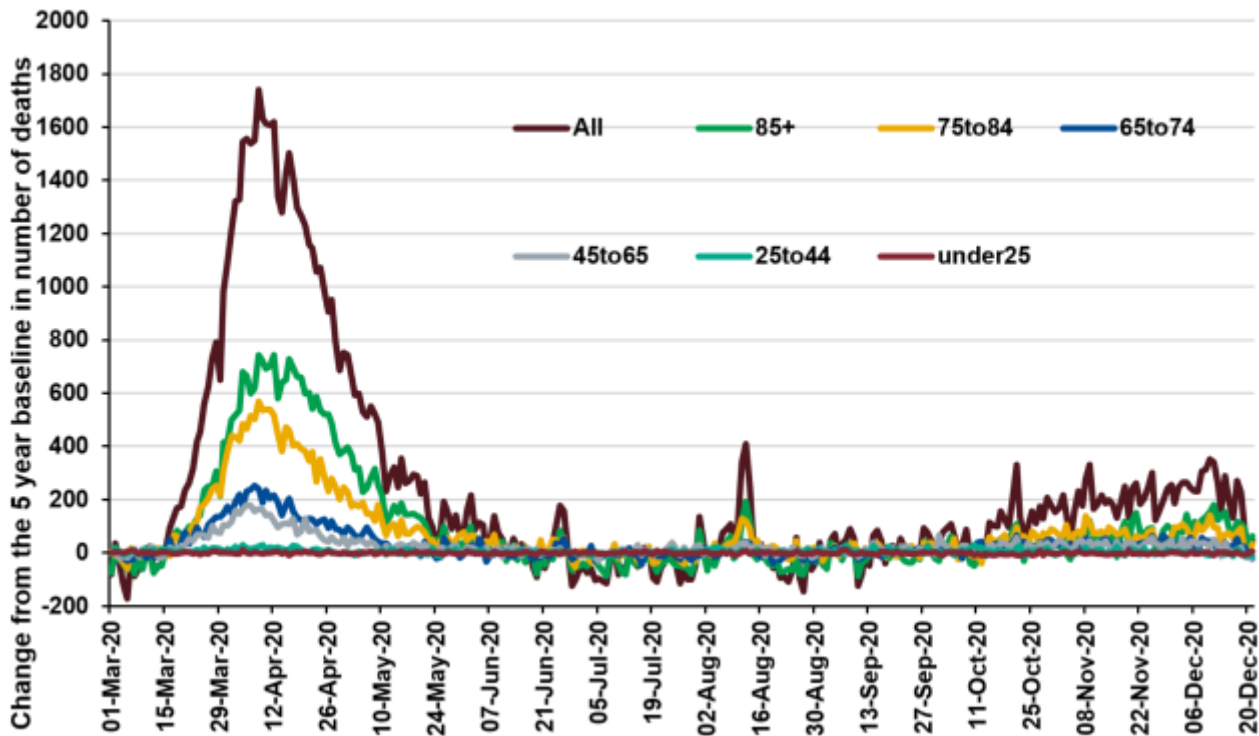
Age Group	Excess detected in week 51 2020?	Weeks in excess since week 10 2020
All	x	13 to 21, 33, 43 to 45, 47 to 48, 50
under 25	x	None
25 to 44	x	14 to 16, 32,38
45 to 64	x	12 to 19, 45 to 46
65 to 74	x	13 to 19
75 to 84	x	13 to 21, 33, 43, 45, 49 to 50
85+	x	13 to 21, 33

(b)

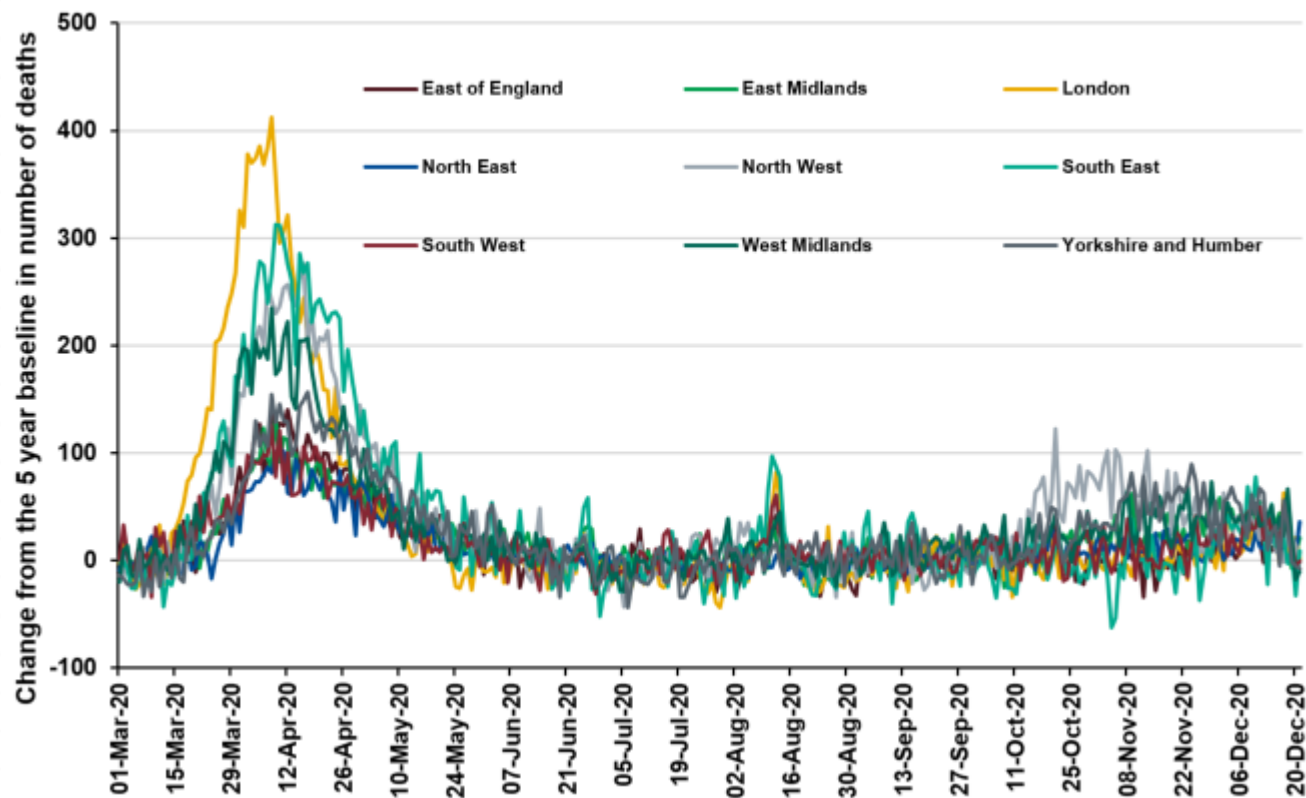
PHE Centres	Excess detected in week 51 2020?	Weeks in excess since week 10 2020
East of England	x	14 to 19
East Midlands	x	13 to 19
London	x	12 to 19, 33
North East	x	14 to 21
North West	x	13 to 20, 33, 42 to 47
South East	x	13 to 21, 33, 50
South West	x	13 to 19, 33
West Midlands	x	13 to 20, 45 to 48
Yorkshire and Humber	x	14 to 21, 23, 43 to 50

Figure 50: Daily excess all-cause deaths by (a) age group and (b) PHE centres , England, 1 March 2020 to 21 December 2020

(a)



(b)



Microbiological surveillance

Virus characterisation

PHE 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.

In week 52, no influenza viruses were characterised by PHE Respiratory Virus Unit (RVU).

Antiviral susceptibility

Influenza positive samples are screened for mutations in the virus neuraminidase gene known to confer oseltamivir and/or zanamivir resistance. Additionally, testing of influenza A(H1N1)pdm09, A(H3N2), and influenza B virus isolates for neuraminidase inhibitor susceptibility (oseltamivir and zanamivir) is performed at PHE-RVU using a functional assay. The data summarized below combine the results of both testing methods. The samples tested are routinely obtained for surveillance purposes, but diagnostic testing of patients suspected to be infected with neuraminidase inhibitor-resistant virus is also performed.

In week 52, no influenza viruses were tested for antiviral susceptibility.

Antimicrobial susceptibility

Table 8 shows in the 12 weeks up to week 52 2020, 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 8: Antimicrobial susceptibility surveillance in lower respiratory tract

Organism	Antibiotic	Specimens tested (N)	Specimens susceptible (%)
<i>S. pneumoniae</i>	Penicillin	818	85
	Macrolides	896	74
	Tetracycline	888	77
<i>H. influenzae</i>	Amoxicillin/ampicillin	3,452	61
	Co-amoxiclav	3,836	71
	Macrolides	781	7
	Tetracycline	3,896	97
<i>S. aureus</i>	Methicillin	2,944	93
	Macrolides	3,222	70
MRSA	Clindamycin	138	38
	Tetracycline	177	75
MSSA	Clindamycin	1,898	76
	Tetracycline	2,648	93

* Macrolides = erythromycin, azithromycin and clarithromycin

Data source: PHE's SGSS CDR module. Please note that this is different to the data source used during the 2019/20 influenza season when the SGSS AMR module was used, and so the results are not directly comparable.

There has been a reduction in the total number of bacterial positive lower respiratory tract clinical samples reported to PHE since mid-March 2020

COVID-19 sero-prevalence surveillance

Due to the holiday period, this section has not been updated for week 53.

The results from testing samples provided by healthy adult blood donors aged 17 years and older, supplied by the NHS Blood and Transplant (NHS BT collection) between weeks 17-50 are summarised. This programme has previously involved testing approximately 1000 donor samples from two different NHS regions each week. In this week's report, the data presented reflects a change in the sampling strategy as of week 44, with approximately 250 samples from each geographic NHS region being tested each week. Since week 26, an exclusion of donors aged 70 years and older donating throughout lockdown was lifted, and therefore data since then include donors in this older age group.

Seroprevalence in Adults aged 17 years and older (Blood Donors)

The results presented here are based on testing using the Euroimmun assay for blood donor samples collected between weeks 17-50. This report presents seropositivity estimates using a 4-week rolling prevalence for national and regional estimates. Seroprevalence estimates reported are based on seropositivity which are unadjusted for the sensitivity and specificity of the assays used. This is because assay sensitivity will change according to the time since infection in these cohorts due to waning of antibodies.

National prevalence

Overall population weighted (by age group, sex and NHS region) antibody prevalence using the Euroimmun assay among blood donors aged 17 years and older in England was 6.9% (95% CI 6.3% - 7.6%) for the period 16th November– 13th December (weeks 47-50). Estimates are based on 7388 samples, of which 505 were positive. This compares with 6.0% (95% CI 5.4% - 6.6%) for the period of 21st October – 13th November (weeks 43-46).

Changes in seropositivity are likely to reflect the net effect of increases due to recent transmission and decreases due to antibody waning. Demographic changes in the donor population also need to be considered, such as when donors aged 70 years and older were excluded from donating during the first national lockdown.

Regional prevalence over time

Seropositivity (weighted by age group and sex) vary across the country and over time. Figure 51 shows the overall 4-weekly rolling proportion seropositive in each region over time. Seropositivity estimates are plotted weekly using the mid-point of a rolling 4-weekly period.

In London, the 4-weekly rolling seropositivity increased from 11.8% (week 16-19) to 13.7% (weeks 20-23). From week 24 seropositivity declined and plateaued with estimates at 7.8% in

weeks 30-33. This was then followed by a rise in seropositivity to 10.4% (95% CI 9.1% - 12%) in weeks 34-37 and has plateaued at 9.3% (95% CI 7.8% - 11.1%) in weeks 47-50. Contributory factors to this fluctuation are likely to include variability in the precise locations of sampling within London and changes in exposure of donors. Increases in seropositivity observed in weeks 34-37 in part may reflect samples being tested from donors who were likely to be returning to donate having donated in earlier parts of the epidemic when incidence was high.

Data from the North West show that seropositivity increased from 7.7% (95% CI 6.6% - 9.1%) in weeks 43-46 to 10.3% (95% CI 8.3% - 12.6%) in weeks 47-50. The North West currently has the highest seropositivity of any English region.

In the East of England seropositivity decreased from 6.5% (95% CI 4.9% - 8.6%) in weeks 43-46 to 5.8% (95% CI 4.1% - 8.1%) in the most recent data (weeks 47-50).

Seropositivity in the South East region increased from 3.8% (95% CI 2.7% - 5.3%) for weeks 43-46 to 4.9% (95% CI 3.7% - 6.4%) in weeks 47-50.

Seropositivity in the South West region decreased from 3.4% (95% CI 2.1% - 5.7%) in weeks 43-46 to 3.0% (2.1% - 4.3%) in weeks 47-50.

Seropositivity in the North East and Yorkshire NHS region increased from 4.9% (95% CI 3.6% - 6.7%) in weeks 43-46 to 7.5% (95% CI 5.9% - 9.5%) in week 47-50.

Data from the Midlands show the proportion seropositive has been stable at 6.8% (95% CI 5.3% - 8.7%) in weeks 47-50. This compares with 6.2% (4.6% - 8.4%) in weeks 43-46.

The change in proportion seropositive observed in some regions is likely to be driven by changes in the precise locations of sample collection. However, the most recent increases observed in the North West and North East and Yorkshire regions are likely to reflect increased transmission, consistent with other surveillance data. Increases in seropositivity reflect transmission occurring at least two to three weeks previously given the time taken to generate an antibody response following infection.

Prevalence by age group

Population weighted antibody prevalence (unadjusted) estimates have remained highest in donors aged 17-29 and has generally declined with age, with lowest prevalence in donors aged 70-84. Donors aged 70-84 years were only included from week 26 onward as this age group, who were advised to not to donate during the first national lockdown, have been able to return to donor clinics since then (Figure 52).

Prevalence for all age groups for weeks 41-44 has been excluded due to a change in sampling strategy from week 44 which resulted in a small number of samples from older age groups in some regions which makes interpretation of trends for this period difficult. The largest variation in seropositivity over time has been observed in those aged 17-29; prevalence has increased in recent weeks from 8.1% (95% CI 6.5% - 10.1%) in weeks 43-46 to 10.6% (95% CI 8.8% - 12.6%) in weeks 47-50. Whilst prevalence in donors aged 70-84 remains the lowest across all age groups, seropositivity in this age group

has also increased recently from 1.4% (95% CI 0.5 – 3.3%) in weeks 43-46 to 3.4% (95% CI 1.8% - 6.3%) in weeks 47-50.

Figure 51: 4-weekly rolling SARS-CoV-2 antibody seroprevalence (% seropositive) in blood donors by region, using Euroimmun test; error bars show 95% confidence intervals

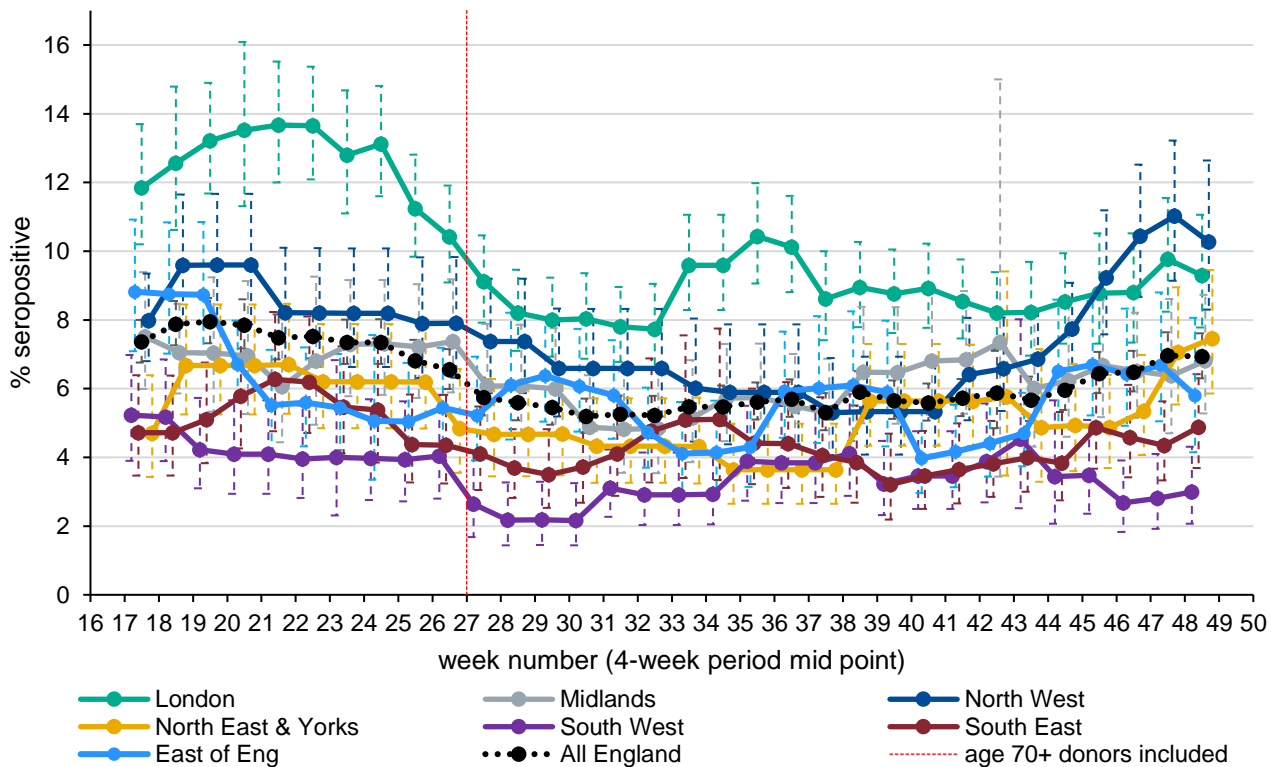
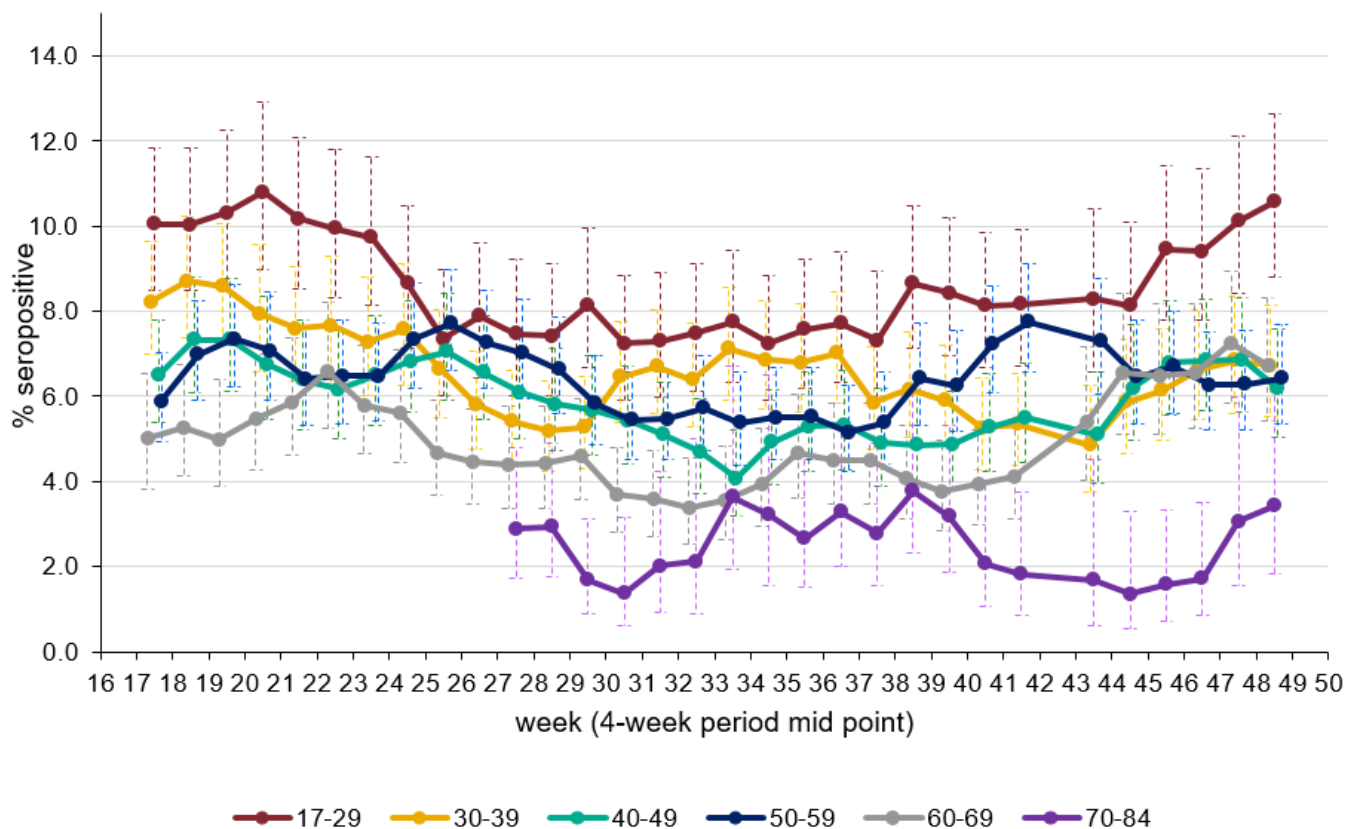


Figure 52: Population weighted 4-weekly rolling SARS-CoV-2 antibody seroprevalence (% seropositive) in blood donors by age group, using Euroimmun test; error bars show 95% confidence intervals



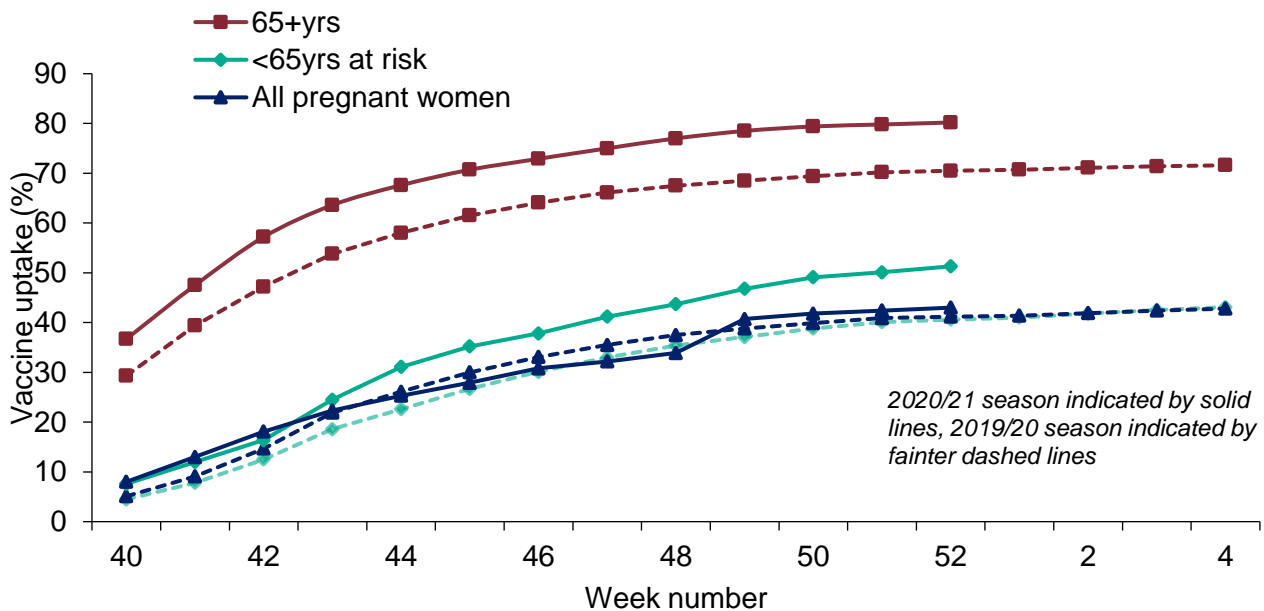
Influenza vaccination

Influenza vaccine uptake in GP patients

Up to week 52 2020 in 95.1% of GP practices reporting weekly to Immform for the main collection, the provisional proportion of people in England who had received the 2020/21 influenza vaccine in targeted groups was as follows (Figure 53):

- 51.3% in under 65 years in a clinical risk group
- 43.0% in pregnant women
- 80.2% in 65+ year olds
- 25.7% in those aged 50-64 who are not in a clinical risk group

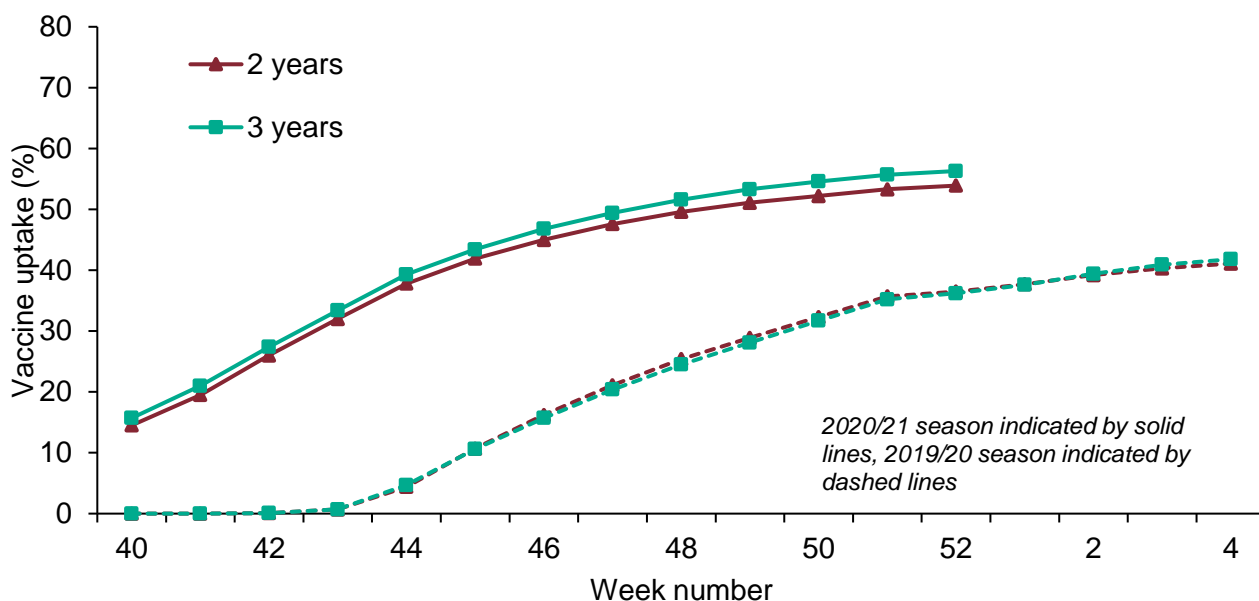
Figure 53: Cumulative weekly influenza vaccine uptake by target group in England



In 2020/21, all 2 and 3 year olds continue to be eligible for influenza vaccination through their GPs. Up to week 52 2020, in 94.6% of GP practices reporting weekly to Immform for the childhood collection, the provisional proportion of children in England who had received the 2020/21 influenza vaccine in targeted groups was as follows (Figure 54):

- 53.9% in 2 year olds
- 56.3% in 3 year olds

Figure 54: Cumulative weekly influenza vaccine uptake in 2 and 3 year olds, in England



Monthly data which cover vaccinations that were given between 1 September and 30 November 2020 was published on 22 December 2020 and includes ethnicity data for at-risk groups and pregnant women. For at risk groups aged 16 to under 65 years when grouped by ethnicity, the highest vaccine uptake was seen in some Asian and White ethnicities with the lowest uptake was seen in Black and mixed White and Black ethnicities. For pregnant women, when grouped by ethnicity, the highest vaccine uptake was seen in Chinese ethnicity and some White and Asian ethnicities, with the lowest uptake seen in Black and mixed White and Black ethnicities.

Influenza vaccine uptake in school age children

Provisional data from the first monthly collection of influenza vaccine uptake for children of school years Reception to Year 7 (from a sample of 98.0% of all Local Authorities in England) show the provisional proportion of children in England who received the 2020/21 influenza vaccine via school, pharmacy or GP practice by 30 November 2020 in targeted groups in Table 9.

Table 9: Provisional cumulative influenza vaccine uptake in children in school years Reception to Year 7, up to 30 November 2020 and 2019, England

School Year	% Vaccine uptake (up to 31 October)	
	2020/21	2019/20
Reception (4-5 years)	49.3	46.4
Year 1 (5-6 years)	49.5	45.8
Year 2 (6-7 years)	49.0	45.0
Year 3 (7-8 years)	48.8	43.7
Year 4 (8-9 years)	47.6	43.2
Year 5 (9-10 years)	47.2	41.3
Year 6 (10-11 years)	45.6	39.7
Year 7 (11-12 years)	43.0	-

* Year 7 were not part of the programme in 2019/20

Influenza vaccine uptake in healthcare workers

Provisional data from the second monthly collection of the influenza vaccine uptake by frontline healthcare workers show 70.6% were vaccinated by 30 November 2020 from 96.1% of all organisations, compared to 61.5% vaccinated in the previous season by 30 November 2019. The report provides uptake at national, NHS region, Sustainability and Transformation Partnerships (STP) and Trust-level.

International update

Global COVID-19 update

Globally, up to 29 December 2020, 81,382,731 cases of COVID-19 infection have been reported worldwide, including 1,772,737 COVID-19 related deaths.

For further information on the global COVID-19 situation please see the WHO COVID-19 situation reports.

Figure 55: Global map of cumulative COVID-19 cases

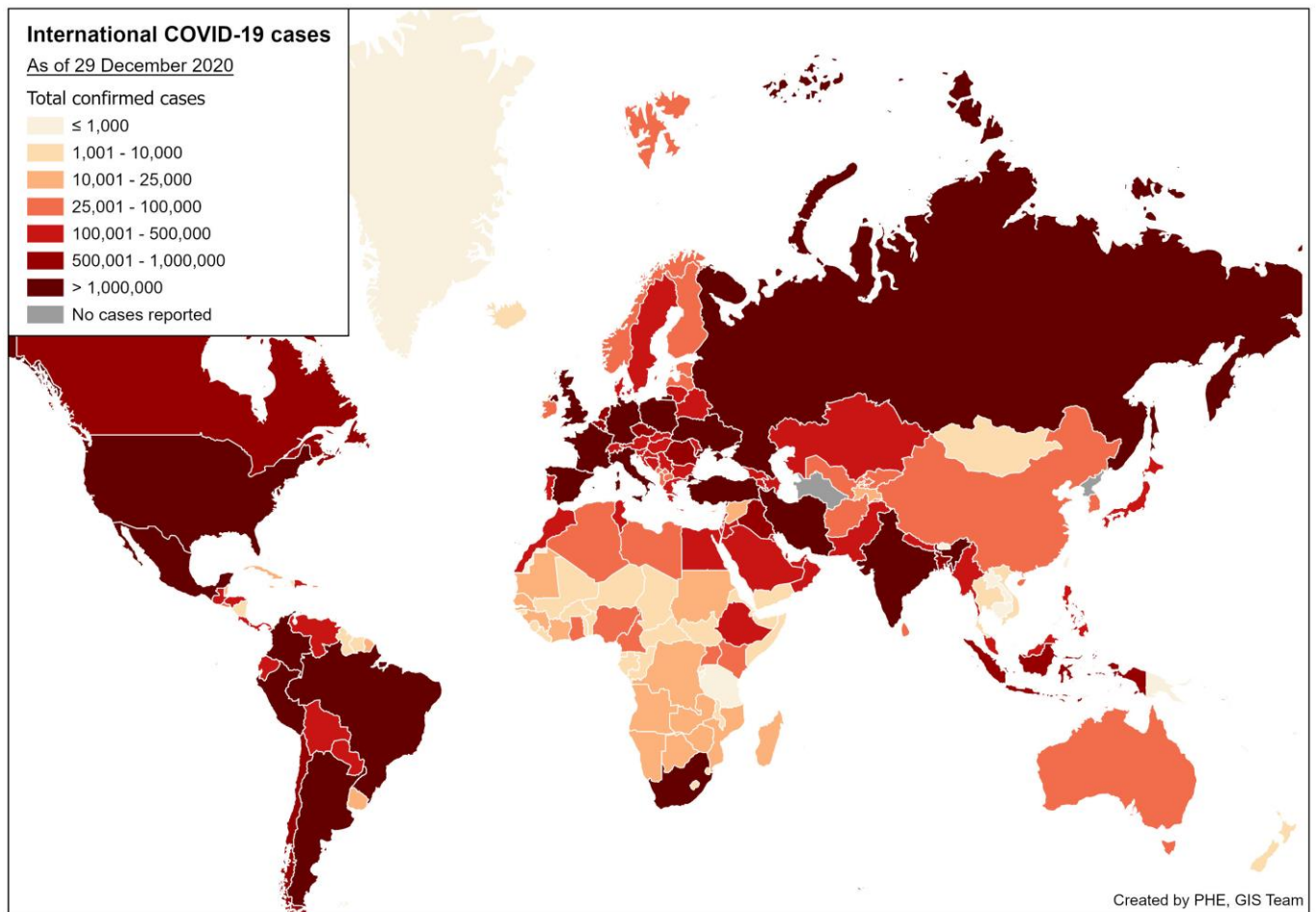
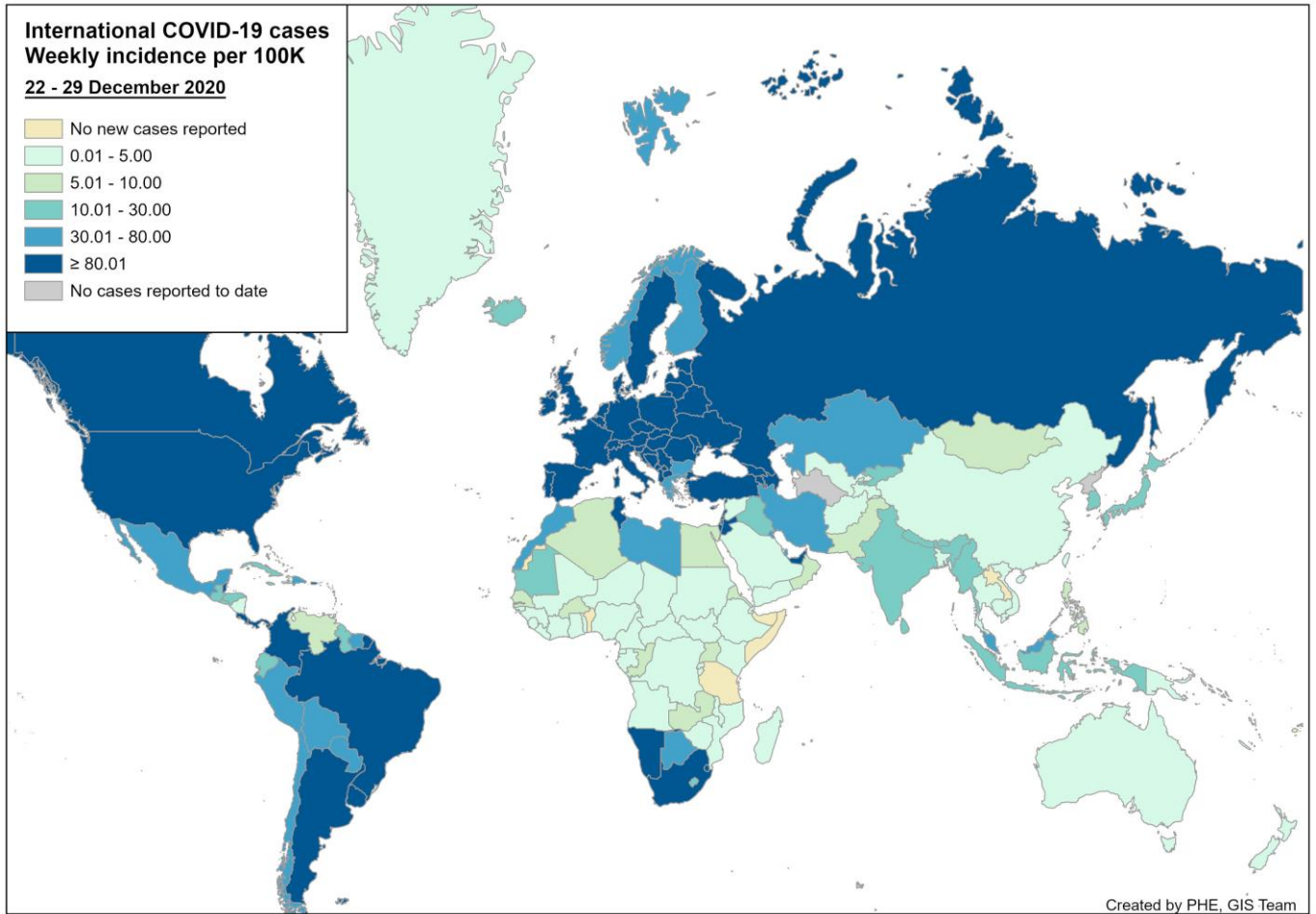


Figure 56: Global map of weekly COVID-19 case incidence rate per 100,000, week 52 2020



Global influenza update

Updated on 21 December 2020 (based on data up to 06 December 2020) (WHO website)

The current influenza surveillance data should be interpreted with caution as the ongoing COVID-19 pandemic has influenced to varying extents health seeking behaviours, staffing/routines in sentinel sites, as well as testing priorities and capacities in Member States.

In the temperate zone of the northern hemisphere, influenza activity remained below interseasonal levels, though sporadic detections of influenza A and B viruses were reported in some countries. In the temperate zone of the southern hemisphere, influenza activity was reported at interseasonal level. Worldwide, influenza A and B viruses were detected in similar proportions.

In the countries of North America, influenza activity indicators, including the percent of tests positive for influenza, were at very low levels.

In Europe, influenza activity remained at inter-seasonal levels though sporadic detections of influenza A and B viruses were reported across reporting countries.

In Central Asia, sporadic influenza B detections were reported across reporting countries.

In Western Asia, influenza activity remained at inter-seasonal level and ILI activity remained low overall.

In East Asia, influenza illness indicators and influenza activity remained at inter-seasonal levels in most reporting countries.

In the Caribbean and Central American countries, sporadic influenza B detections were reported in Mexico.

In tropical South America, there were no influenza detections in this reporting period.

In Western Africa, co-circulation of influenza A(H3N2) and B-Victoria lineage viruses continued to be reported in Côte d'Ivoire, whereas there were no influenza updates in Middle and Eastern Africa.

In Southern Asia, there were no influenza detections for this reporting period. ILI and SARI rates continued to increase in Afghanistan. ILI levels remained elevated also in Bangladesh.

In South East Asia, influenza activity of predominately influenza A(H3N2) continued to be reported across reporting countries. In Lao PDR, ILI and SARI rates remained elevated and influenza detections continued to be reported. Influenza detections were reported in TimorLeste in recent weeks.

In Oceania, ILI and other influenza activity indicators remained very low, despite continued testing.

The WHO GISRS laboratories tested more than 204,150 specimens between 23 November 2020 and 06 December 2020. A total of 385 specimens were positive for influenza viruses, of which 189 (49.1%) were typed as influenza A and 196 (50.9%) as influenza B. Of the sub-typed influenza A viruses, 16 (19.3%) were influenza A(H1N1)pdm09 and 67 (80.7%) were influenza A(H3N2). Of the characterized B viruses, 3 (10.3%) belonged to the B-Yamagata lineage and 26 (89.7%) to the B-Victoria lineage.

Influenza in Europe

Updated on 29 December 2020 (Joint ECDC-WHO Europe Influenza weekly update)

For week 51 2020, influenza activity remained at interseasonal levels throughout Europe.

Of 35 countries and areas that reported on the intensity of activity indicator, 31 reported activity at baseline levels, and 4 (Azerbaijan, Lithuania, Serbia and Slovakia)) reported low intensity for week 51 2020. Of 36 countries and areas that reported on geographic spread, 28 reported no activity, 7 reported sporadic spread (in eastern, northern and western areas) and Estonia reported local spread for week 51 2020.

For week 51 2020, of 786 sentinel specimens tested for influenza viruses, none were positive. Since the start of the season, of 11 060 sentinel-source specimens that have been tested for influenza viruses, seven were positive: 2 type A and 5 type B viruses.

There were no hospitalised laboratory-confirmed influenza cases in ICUs reported for week 51 2020. Since the start of the season, there have been 10 hospitalised laboratory-confirmed influenza cases in ICUs.

There were no laboratory-confirmed influenza cases in wards outside ICUs reported for week 51 2020.

Influenza in the Northern Hemisphere

Influenza activity remains low in the United States of America and in Canada.

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

Latest update on 9 December 2020 (WHO website)

Influenza A(H5) viruses:

Between 24 October and 09 December 2020, one new laboratory-confirmed human case of influenza A(H5N1) virus infection was reported to WHO from Lao People's Democratic Republic (PDR) on 31 October 2020.

Influenza A(H7N9) viruses:

There have been no publicly available reports from animal health authorities in China or other countries on influenza A(H7N9) virus detections in animals in recent months.

Influenza A(H9N2) viruses:

Between 24 October and 09 December 2020, one laboratory-confirmed human case of influenza A(H9N2) virus infection was reported from China to WHO on 18 October 2020 and was not included in the previous update.

Middle East respiratory syndrome coronavirus (MERS-CoV)

Latest update on 29 December 2020 (WHO website)

Up to 29 December 2020, a total of five cases of Middle East respiratory syndrome coronavirus, MERS-CoV, (three imported and two linked cases) have been confirmed in the UK through the on-going surveillance since September 2012.

From 1 April to 31 May 2020, the National IHR Focal Point of Saudi Arabia reported 9 new cases of MERS-CoV infection, including five deaths.

Globally, since September 2012, WHO has been notified of 2,562 laboratory-confirmed cases of infection with MERS-CoV, including 881 related deaths. Further information on management and guidance of possible cases is available online. The latest ECDC MERS-CoV risk assessment can be found [here](#), where it is highlighted 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](#)

[Sources of influenza surveillance data](#)

[Sources of COVID-19 surveillance data](#)

PHE 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 <http://www.legislation.gov.uk/uksi/2002/1438/regulation/3/made>. 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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