



Public Health
England

Protecting and improving the nation's health

Weekly national Influenza and COVID-19 surveillance report

Week 3 report (up to week 2 data)
21 January 2021

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 2 (between 11 and 17 January 2021) and for some indicators daily data up to 19 January 2021.

Surveillance indicators suggest that at a national level COVID-19 case rates have declined in week 2 of 2021, while there was some indication that hospital and ICU admissions began to stabilise. There is currently limited testing for other respiratory viruses, however, laboratory indicators suggest that influenza activity is low.

Further national social and physical distancing measures, including school closures, were introduced in week 1.

Overall case rates and Pillar 2 positivity decreased in week 2. There was a slight increase in Pillar 1 positivity. The highest case rates continued to be seen in London in week 2, however a decrease was observed. Case rates were highest amongst the 20 to 59 year olds in week 2, however declines in case rates were noted in the majority of age groups. By ethnicity, case rates remain highest in other ethnic groups.

Through Respiratory Datamart, there were no influenza positive sample detected in week 2.

The overall number of acute respiratory infection incidents reported to PHE Health Protection Teams has increased from 1627 in the previous week to 1790 in week 2 across all settings in England. In the majority of reported incidents SARS-CoV-2 has been detected. Increases in incidents were noted in educational settings and other settings. 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 remained stable or began to decrease during week 2. General practice (GP) influenza-like illness (ILI) consultations remained low in all UK schemes.

The overall COVID-19 confirmed hospital and ICU/HDU admission rates remained stable in week 2. The overall influenza confirmed hospital and ICU/HDU admission rates remained low.

Emergency department attendances for COVID-19 like diagnosis and acute respiratory infections increased further in week 2.

The number of deaths among confirmed COVID-19 cases increased in week 1. Overall excess all-cause mortality was observed in week 1.

The most recent overall estimated national seroprevalence based on blood donor samples was 9.0% with the highest seroprevalence by region seen in the North West and London regions and by age group in young adults.

Influenza vaccine uptake is above 80% (80.6%) in people aged 65 years and over which is the highest uptake ever achieved. Uptake in 2 and 3 year children is also the highest ever recorded. For those in clinical risk groups uptake is over 51% 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 30.9% 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

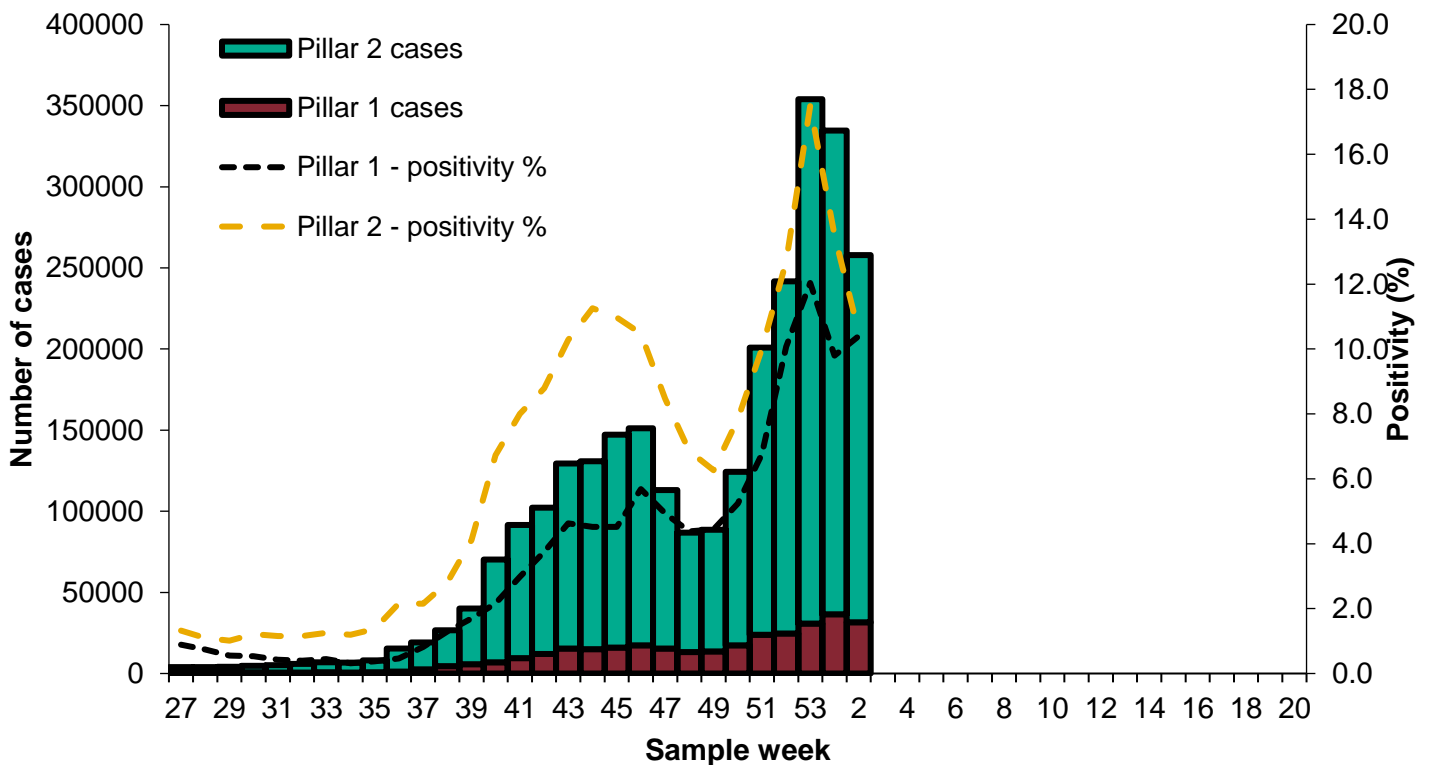
Confirmed COVID-19 cases (England)

As of 09:00 on 19 January 2021, a total of 3,022,609 have been confirmed positive for COVID-19 in England under Pillars 1 and 2.

Overall case numbers and Pillar 2 positivity decreased in week 2. There was a slight increase in Pillar 1 positivity. The highest case rates were seen in the 20 to 29 and 30 to 39 year olds in Pillars 1 and 2. Decreases in positivity rates were noted across the majority of age groups in week 2. Cases rates remain highest in London, although decreases were noted.

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.

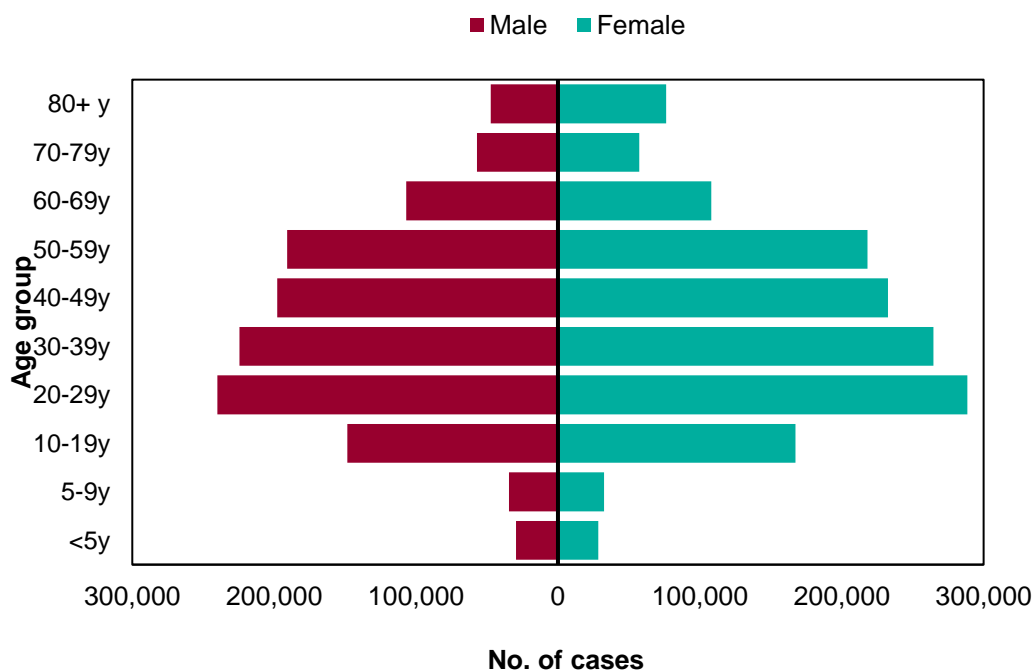
* Positivity is calculated as the number of individuals testing positive during the week divided by the number of individuals tested during the week based on PCR testing.

* 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=2,750,965), and (b) in weeks 1 and 2 (n=589,611)

(a)



(b)

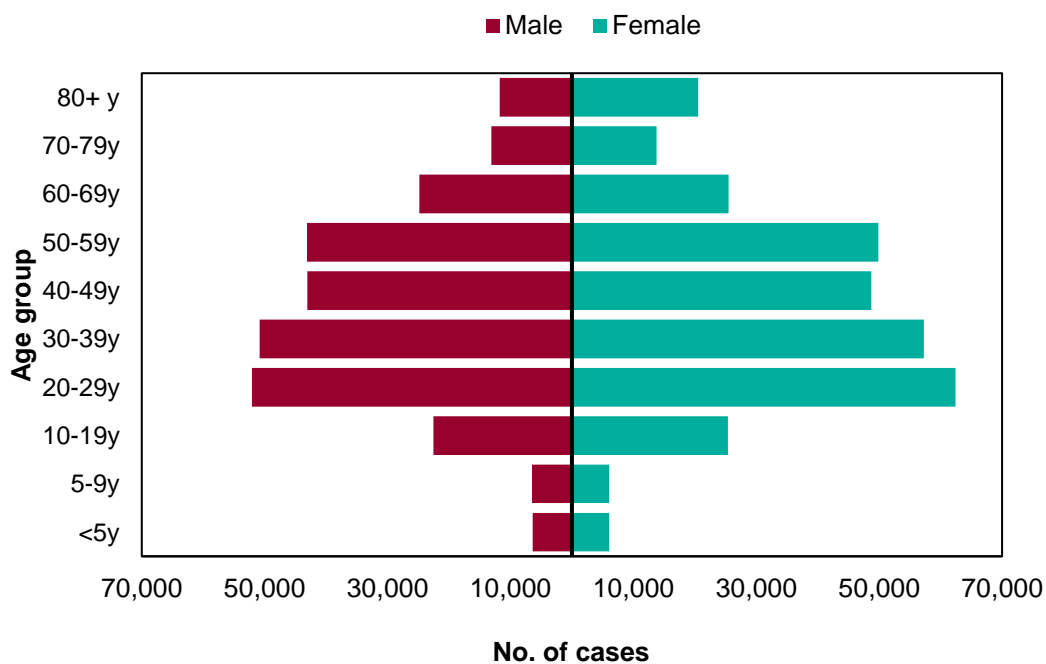


Figure 3: Weekly laboratory confirmed COVID-19 case rates per 100,000, tested under Pillar 1 and Pillar 2, by sex

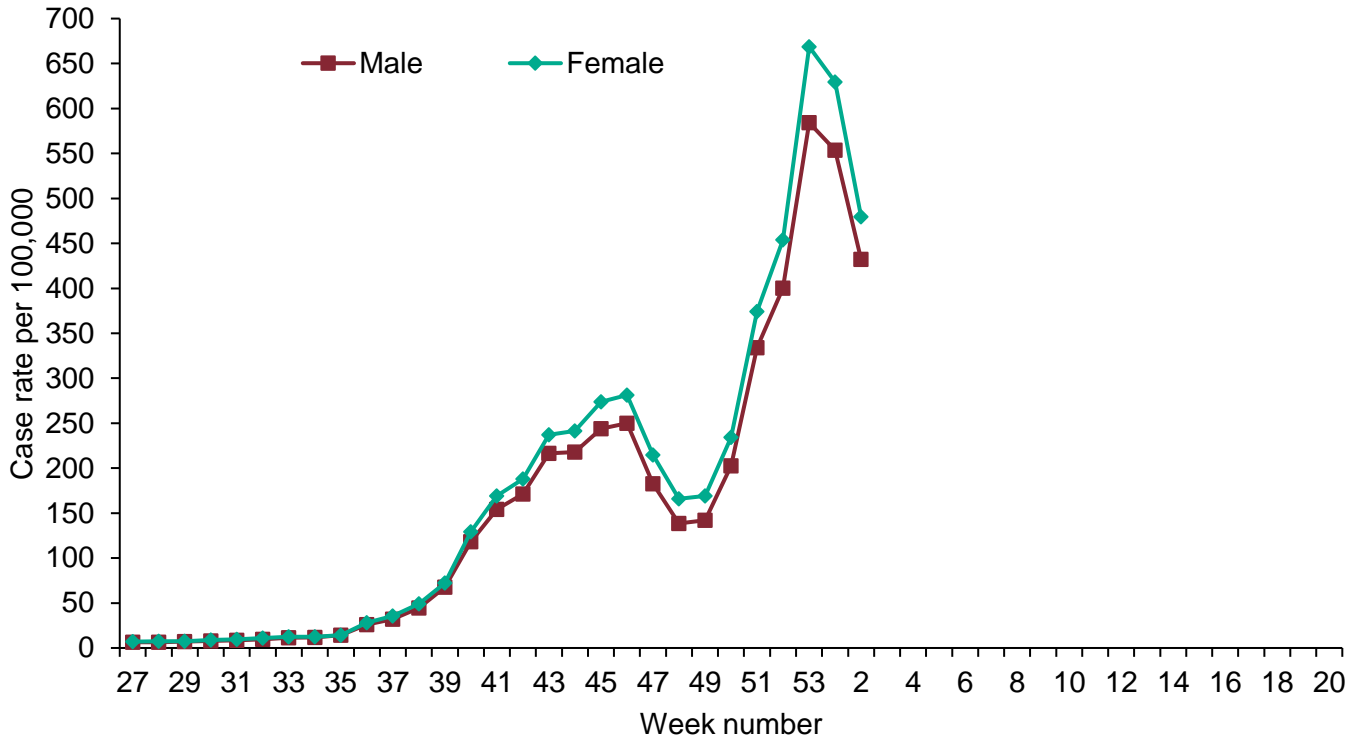


Figure 4: Weekly laboratory confirmed COVID-19 case rates per 100,000, tested under Pillar 1 and Pillar 2, by age group

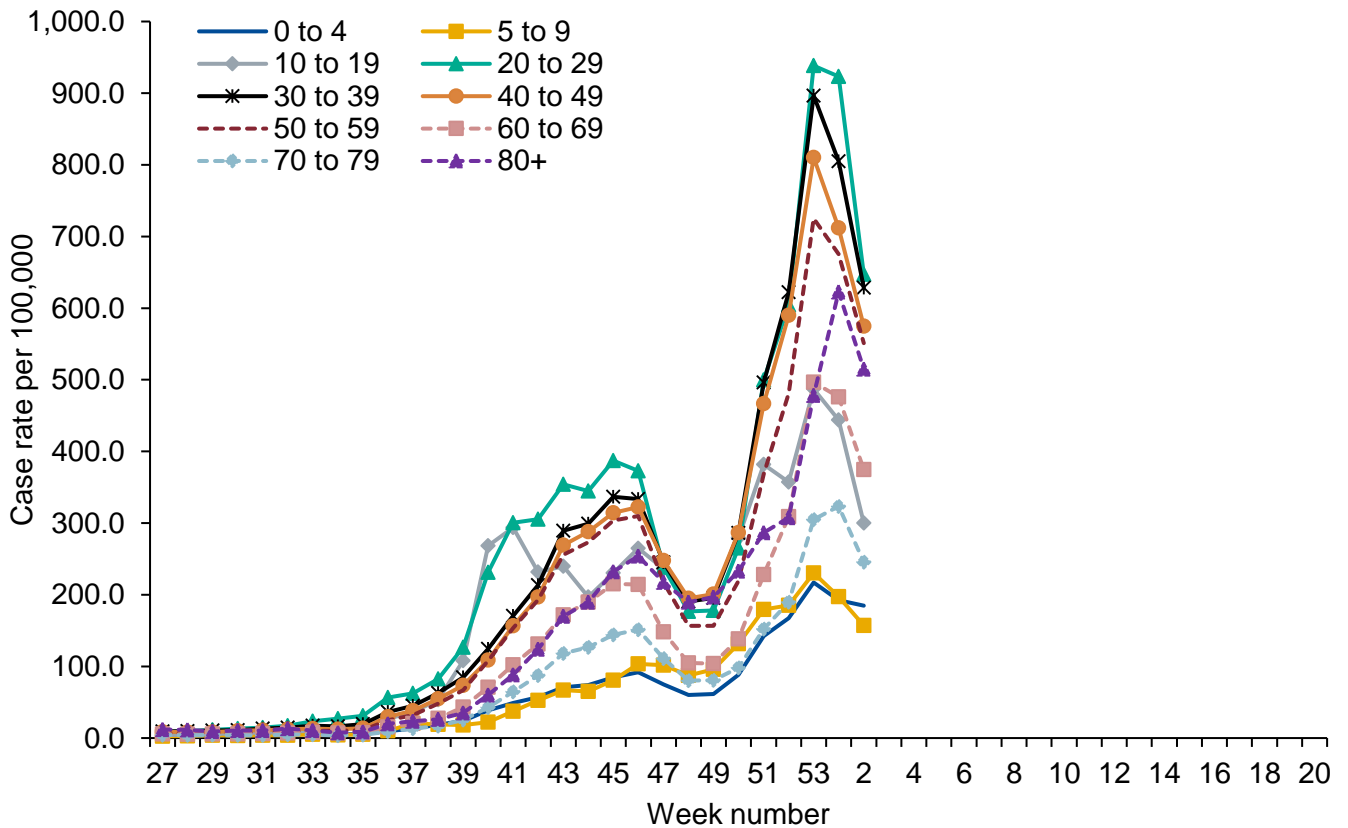


Figure 5: Weekly positivity (%) of laboratory confirmed COVID-19 cases tested overall and by sex under (a) Pillar 1 and (b) Pillar 2, (SGSS and Respiratory DataMart)

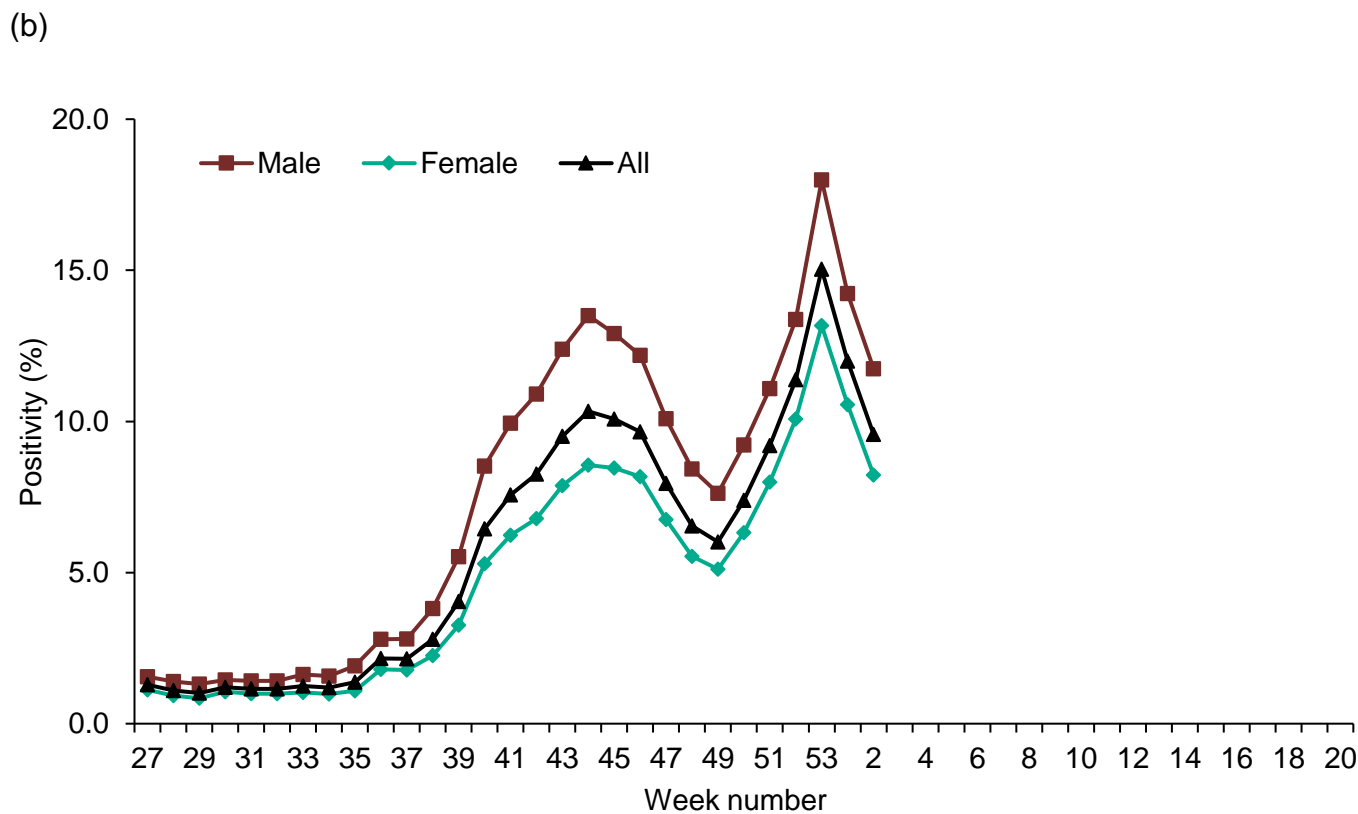
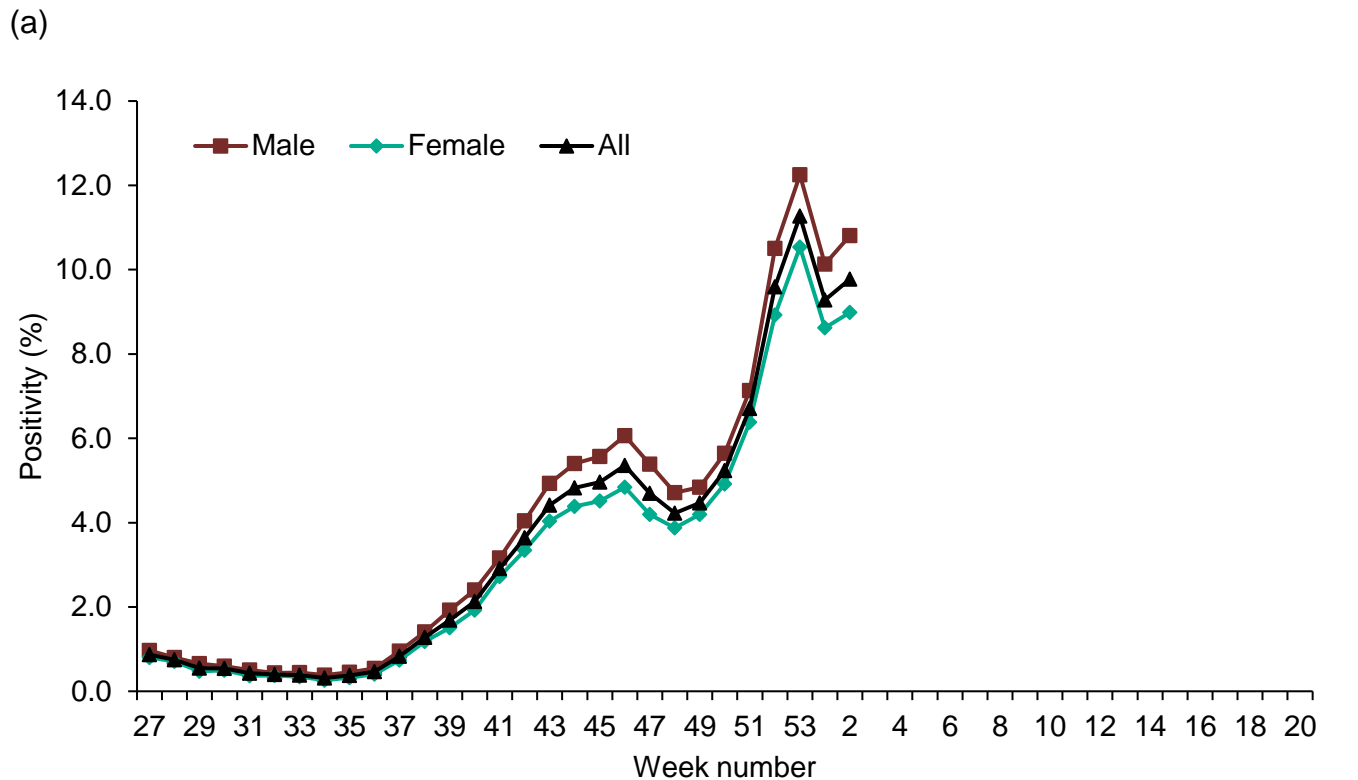
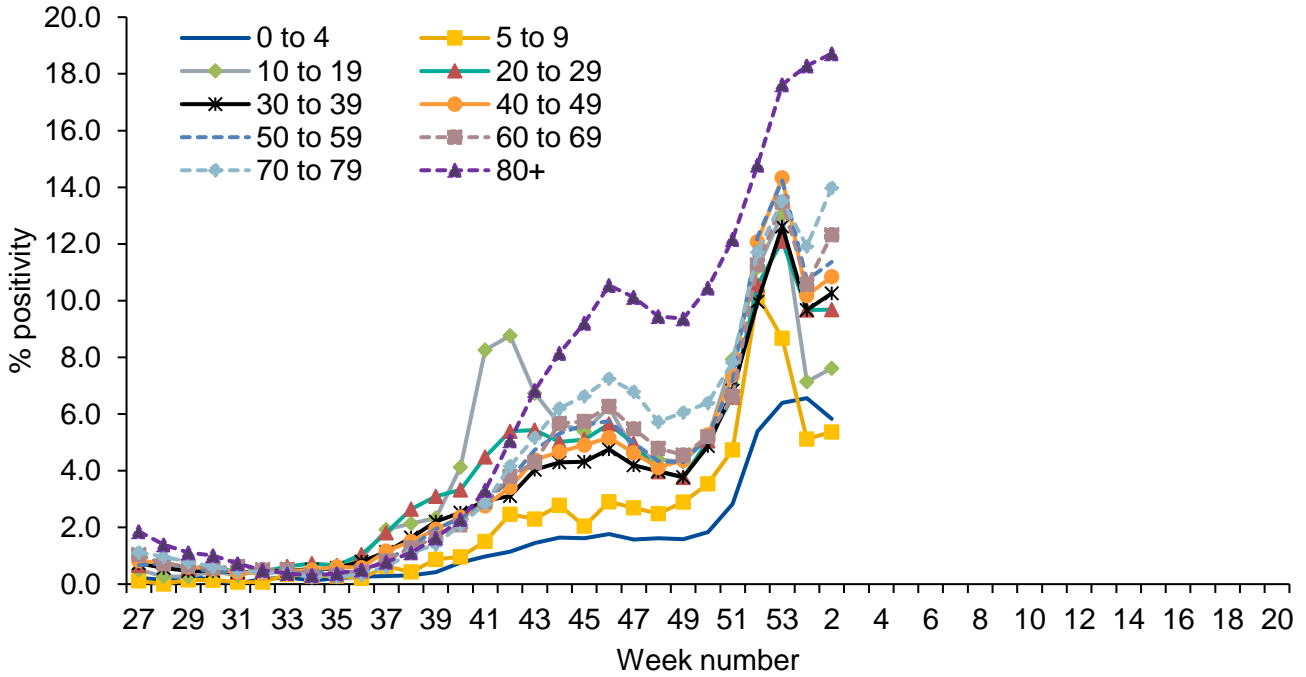
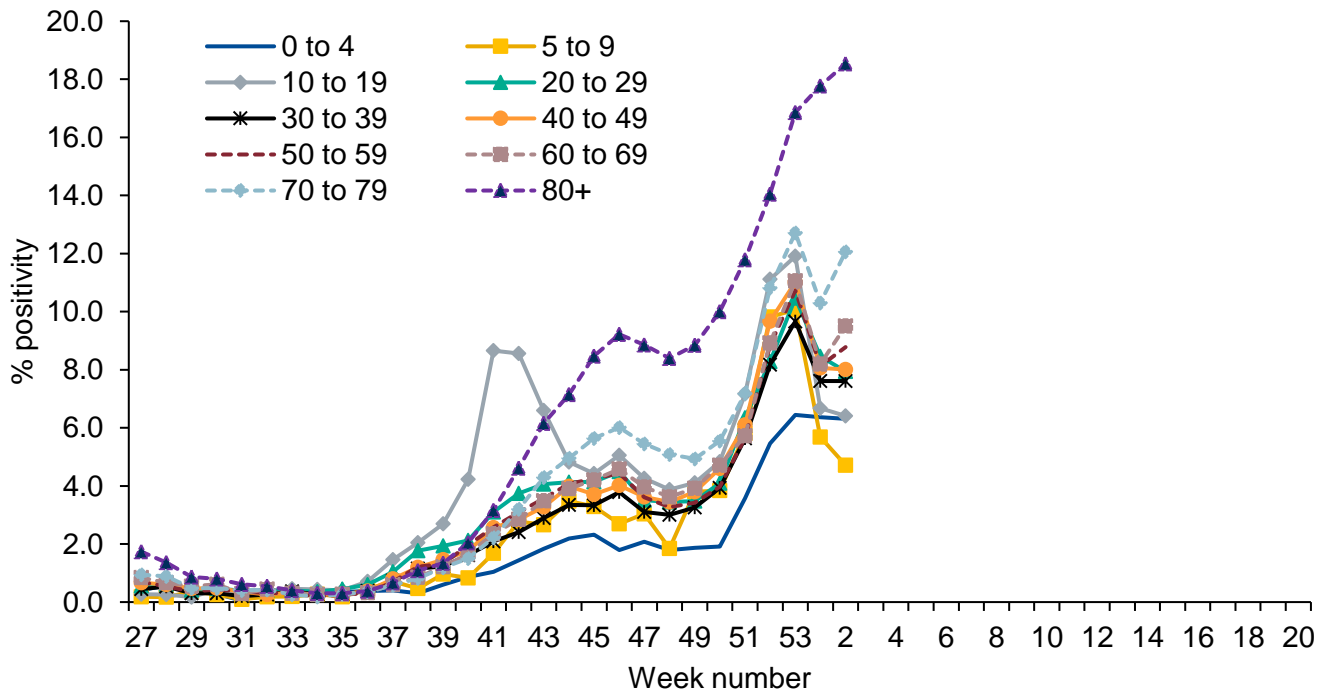


Figure 6: Weekly positivity (%) of laboratory confirmed COVID-19 cases tested under Pillar 1, (a) by male and age group and (b) by female and age group and; under Pillar 2, (c) by male and age group and (d) by female and age group, (SGSS and Respiratory DataMart)

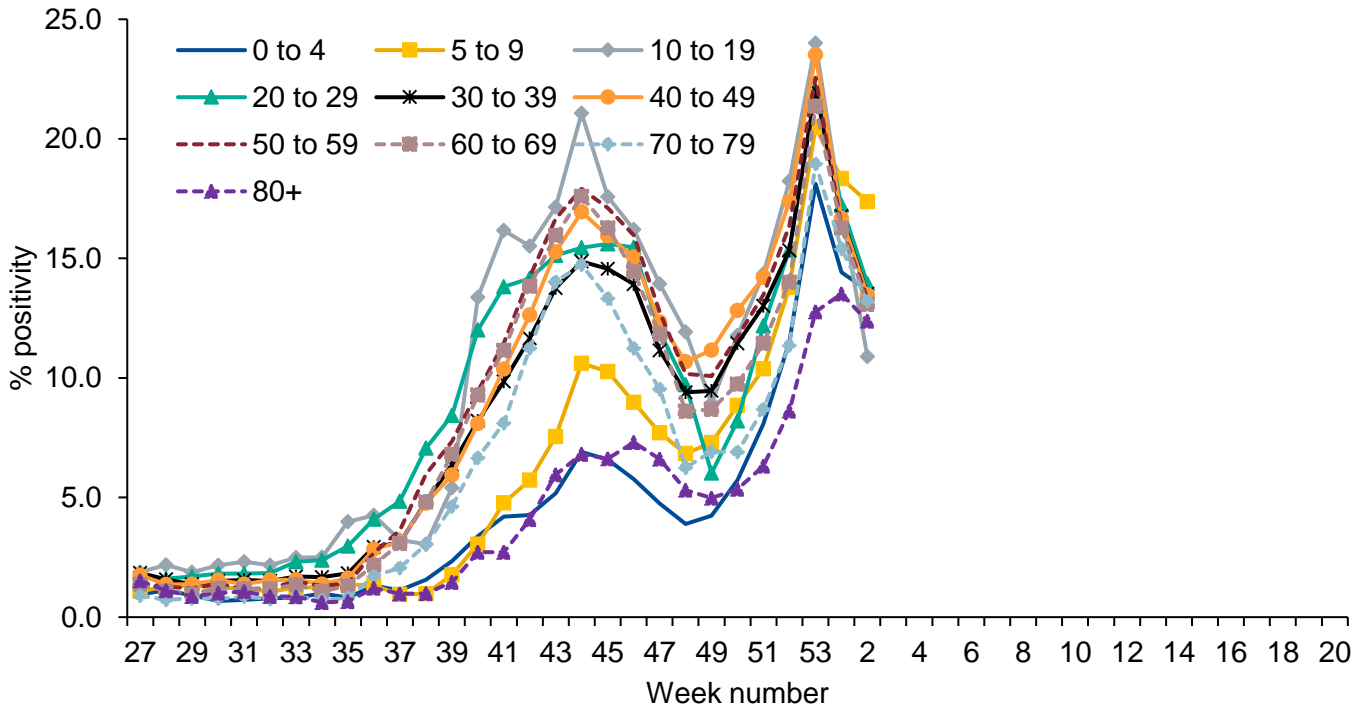
(a) Pillar 1 - Male



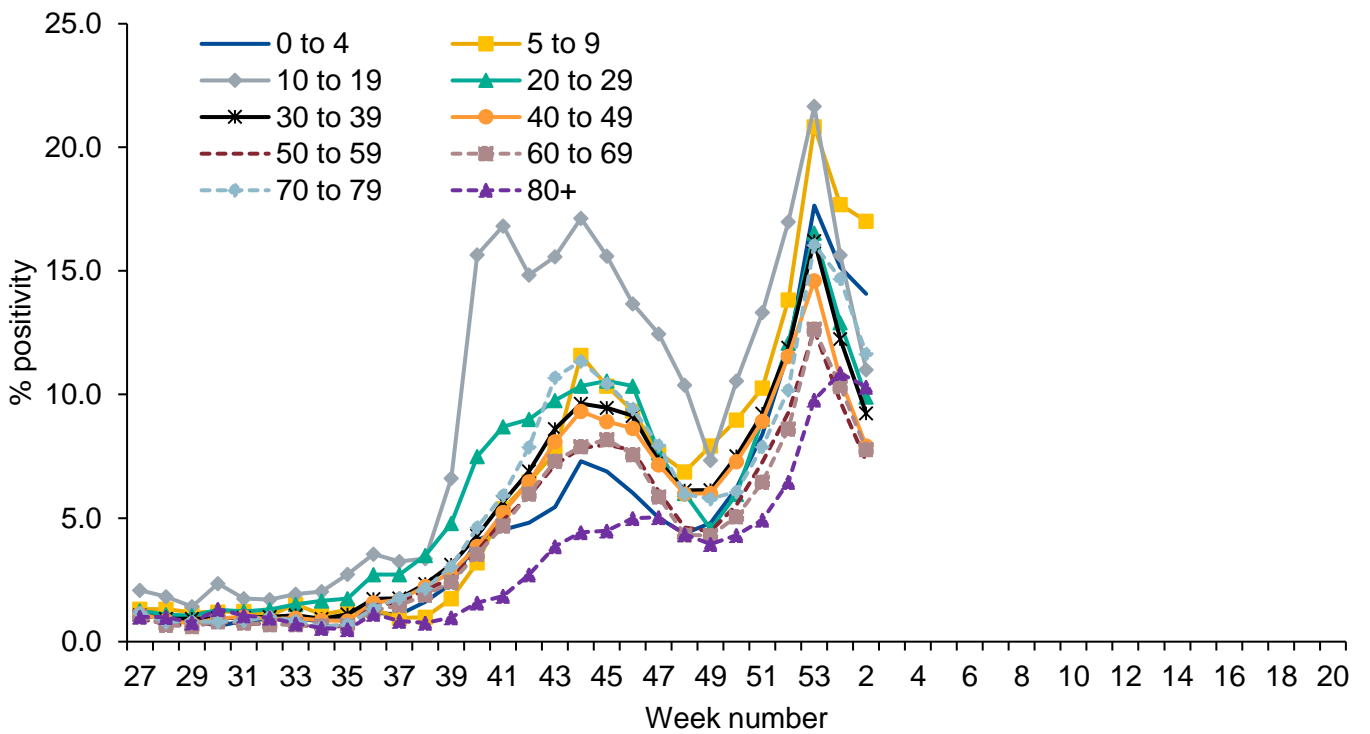
(b) Pillar 1 - Female



(c) Pillar 2 - Male



(d) Pillar 2 - Female



Geography

Table 1: Cumulative number of cases under Pillars 1 and 2 (n=2,992,638) and cumulative number of cases since week 27 under Pillar 1 and 2 (2,757,689)

PHE Centres	Cumulative Pillar 1 + 2 cases	Cumulative since week 27, Pillar 1 + 2 cases
North East	152,113	137,077
North West	479,569	437,292
Yorkshire and Humber	299,765	271,077
West Midlands	322,166	297,012
East Midlands	242,463	221,816
East of England	319,968	295,840
London	591,214	557,583
South East	416,195	383,491
South West	169,185	156,501

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

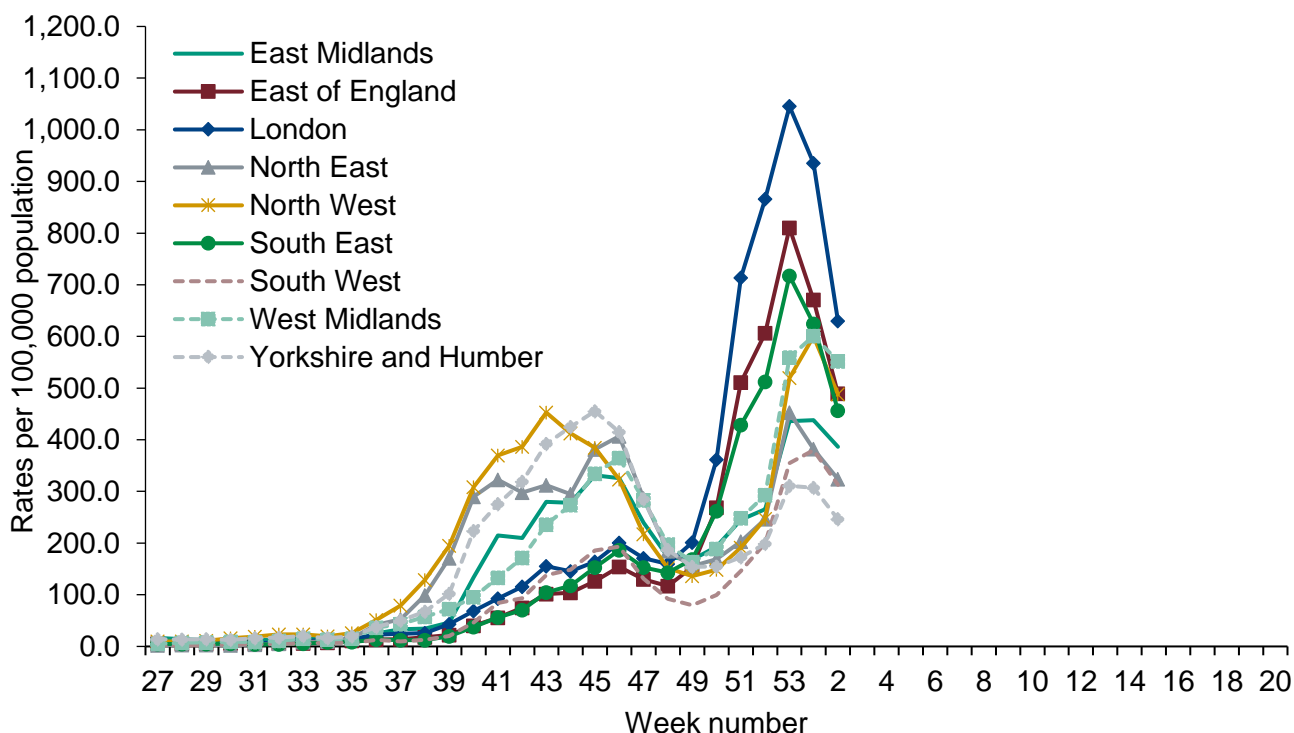
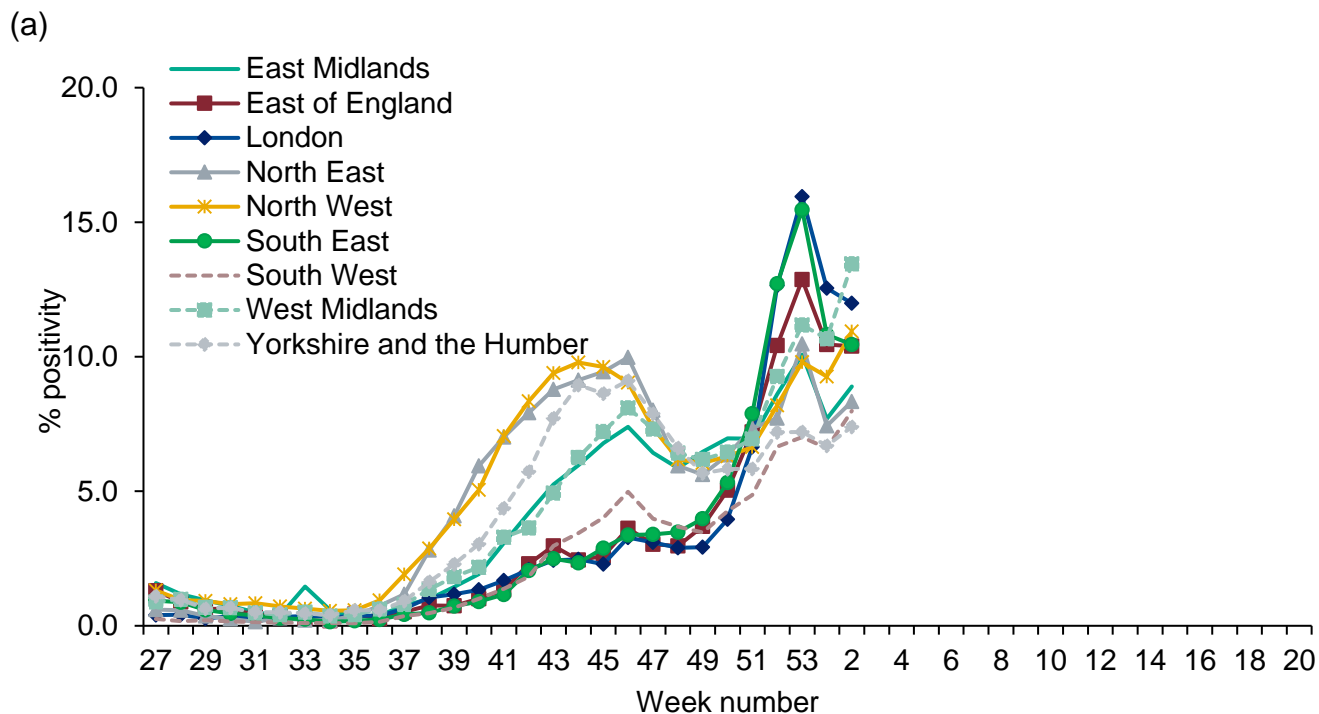


Figure 8: Weekly positivity of laboratory confirmed COVID-19 cases tested under (a) Pillar 1 (%) and (b) Pillar 2 (%), by PHE Centres and sample week, (SGSS and Respiratory DataMart)



Please note, an error occurred in the Pillar 1 positivity by PHE Centre graph in last weeks report. This has now been rectified in this weeks report.

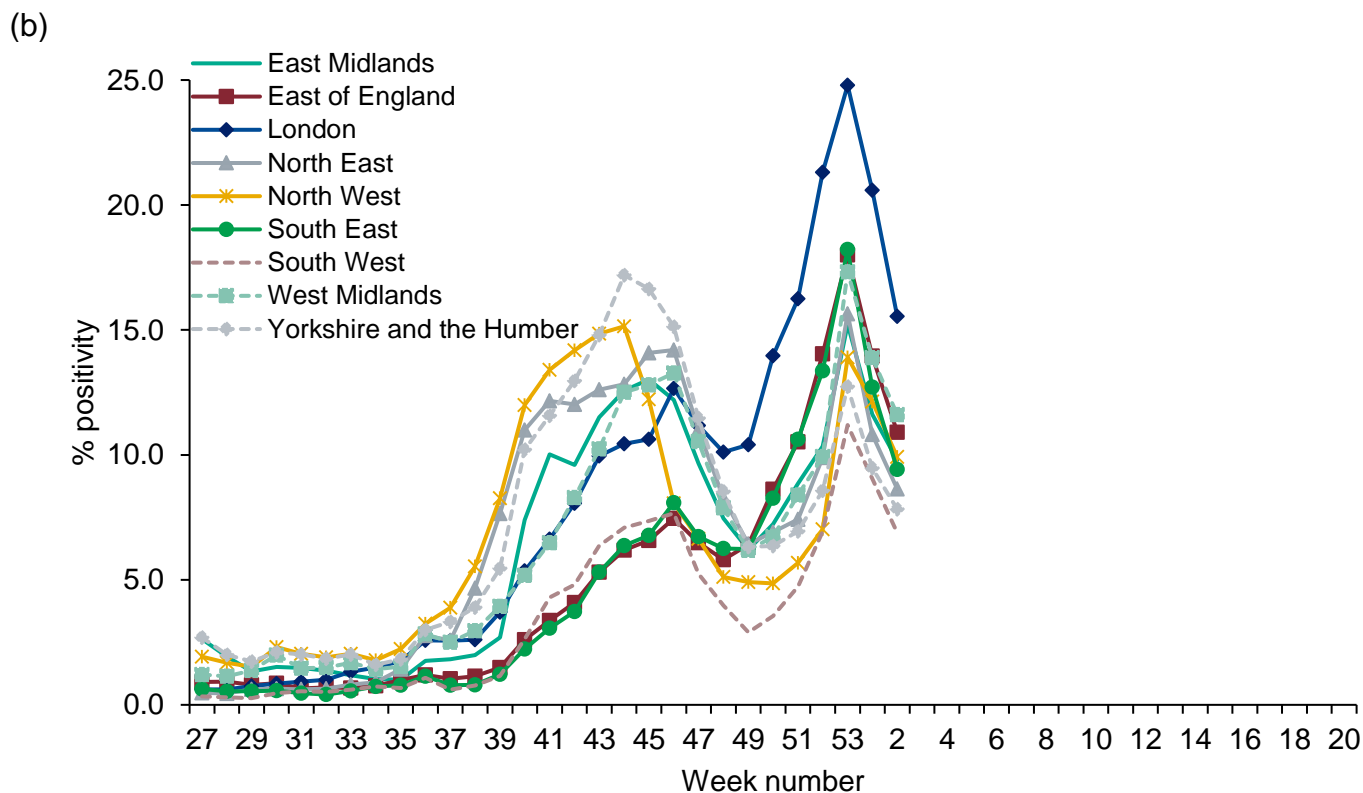
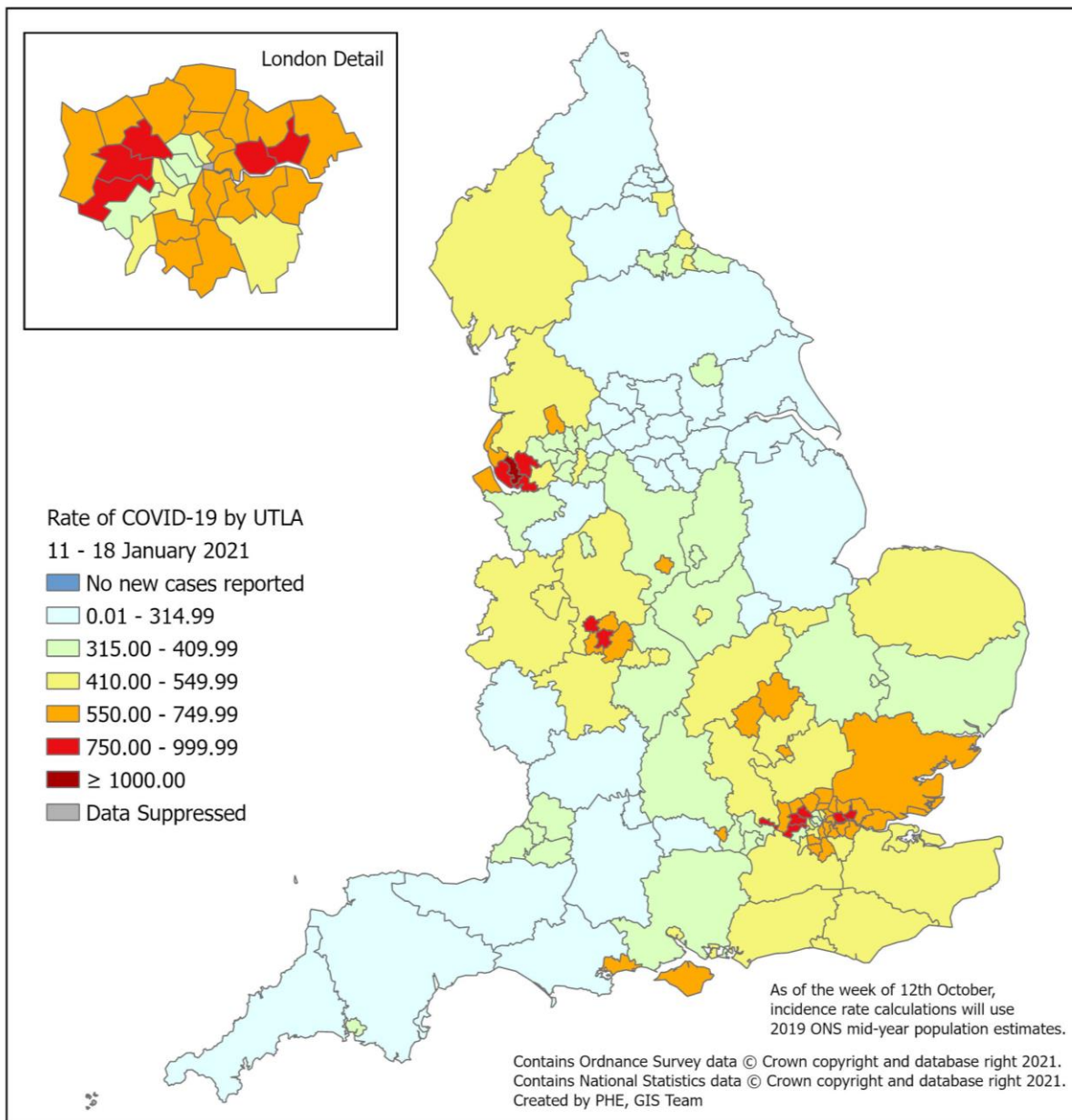
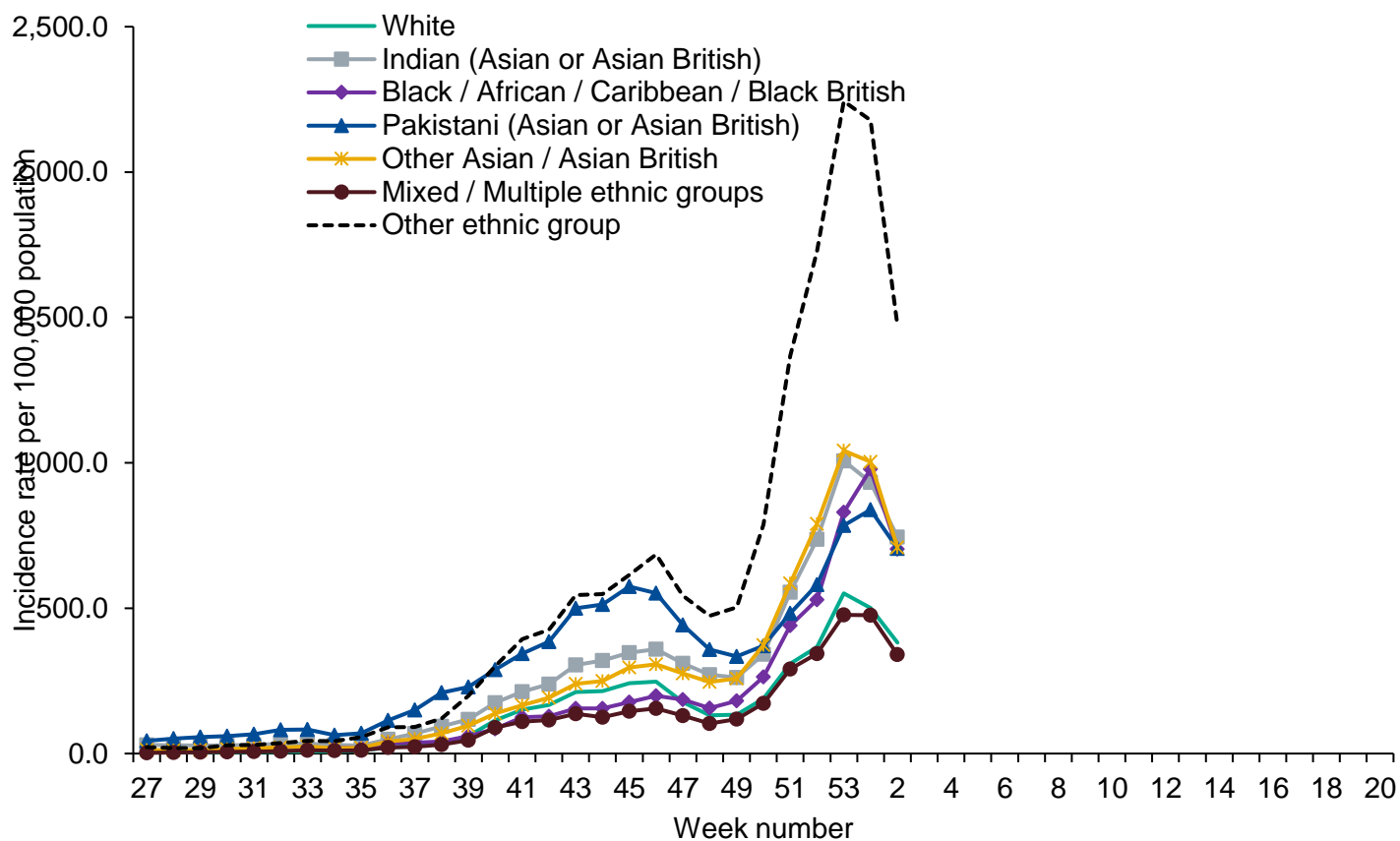


Figure 9: Weekly rate of COVID-19 cases per 100,000 population (Pillar 1 and 2), by upper-tier local authority, England (box shows enlarged map of London area)



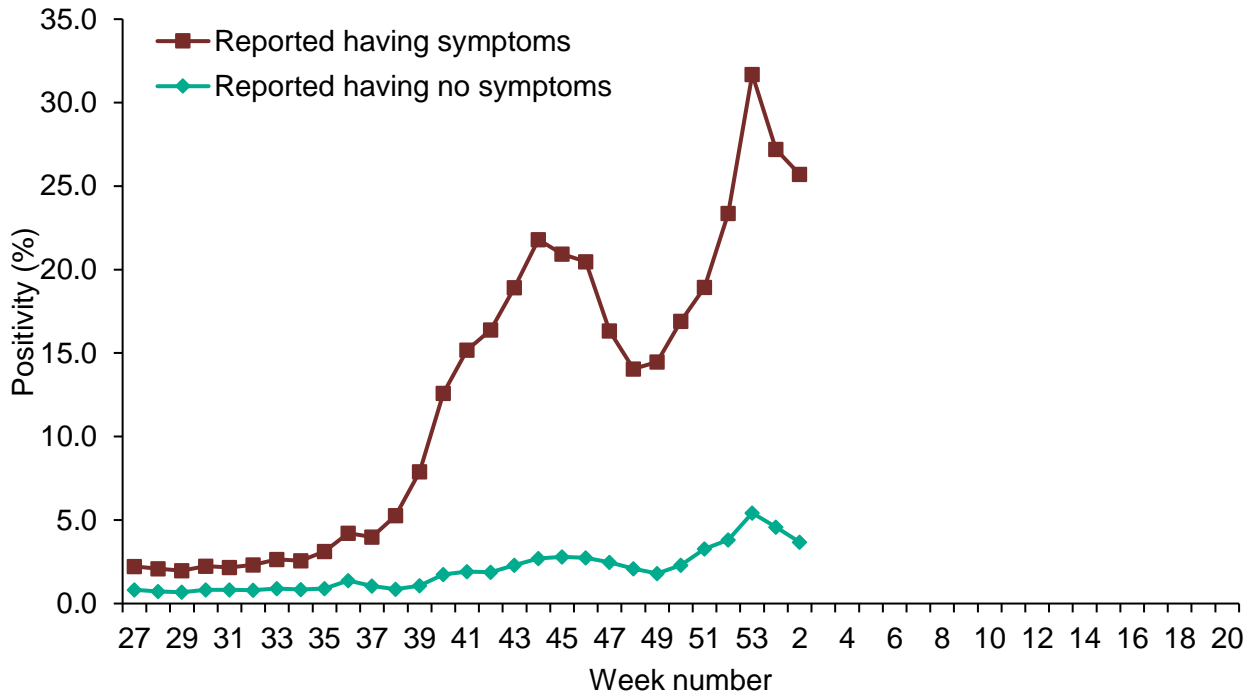
Ethnicity

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



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 2 2021, out of the 127,054 respiratory specimens reported through the Respiratory DataMart System (based on data received from 14 out of 16 laboratories), 13,045 samples were positive for SARS-CoV-2 with an overall positivity of 10.3%. The highest positivity was noted in the 65+ year olds at 12.8% in week 2. The overall influenza positivity remained very low at 0.0% in week 2, with none of 1894 samples testing positive for flu (Figure 12).

Rhinovirus positivity decreased at 5.1% in week 2 compared to 5.6% in the previous week (Figure 13). The highest positivity by age group for rhinovirus was the under 5 year olds in week 2 (Figure 14). Respiratory syncytial virus (RSV), adenovirus, parainfluenza and human metapneumovirus (hMPV) positivity all remained low at 0.0%, 1.3%, 0.0% and 0.1% respectively in week 2 (Figure 13).

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

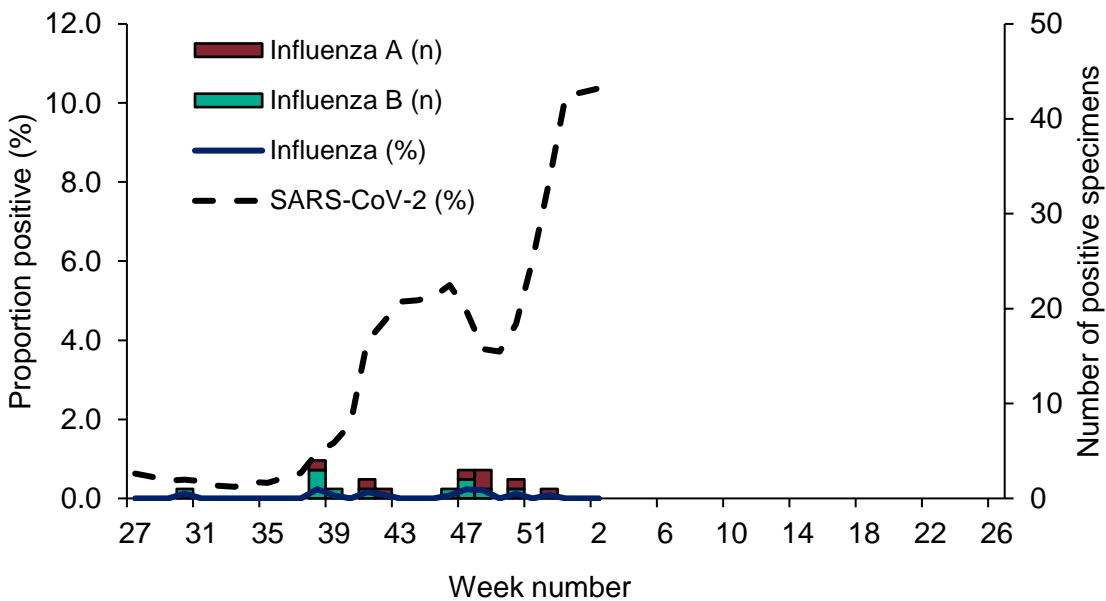


Figure 13: DataMart weekly positivity (%) for other respiratory viruses, England

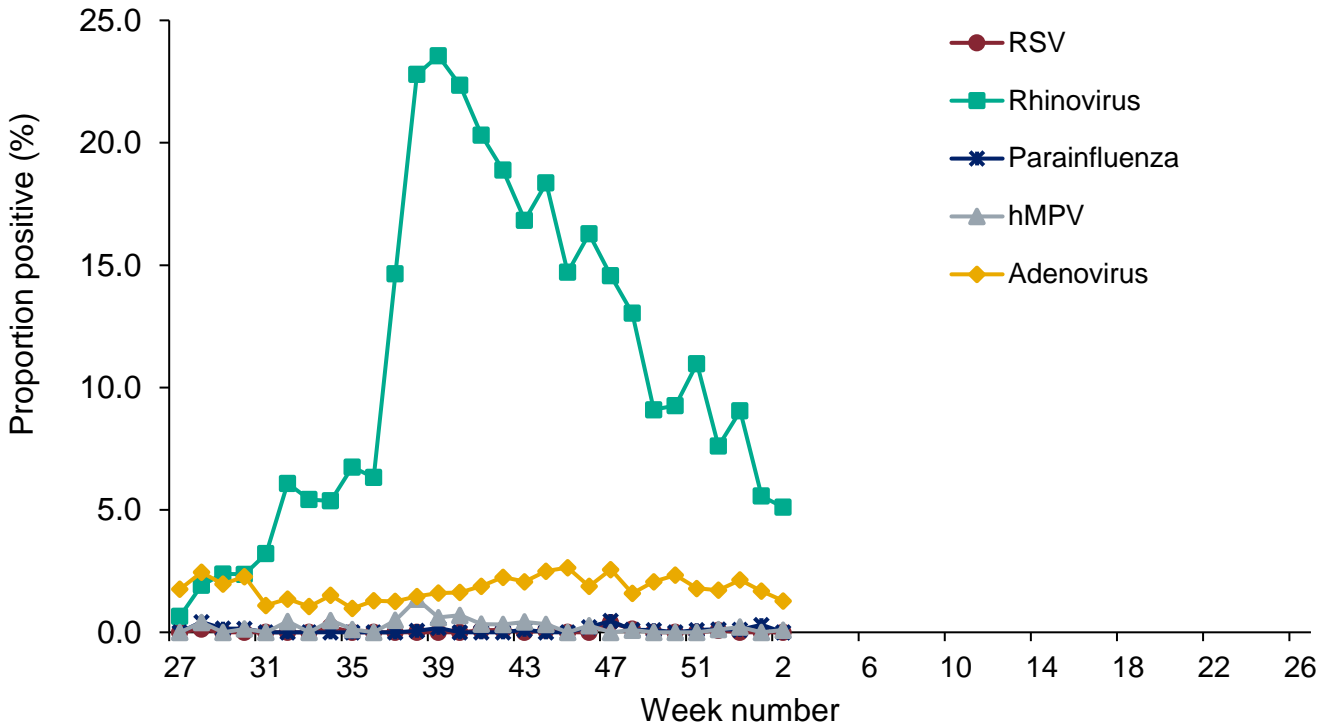
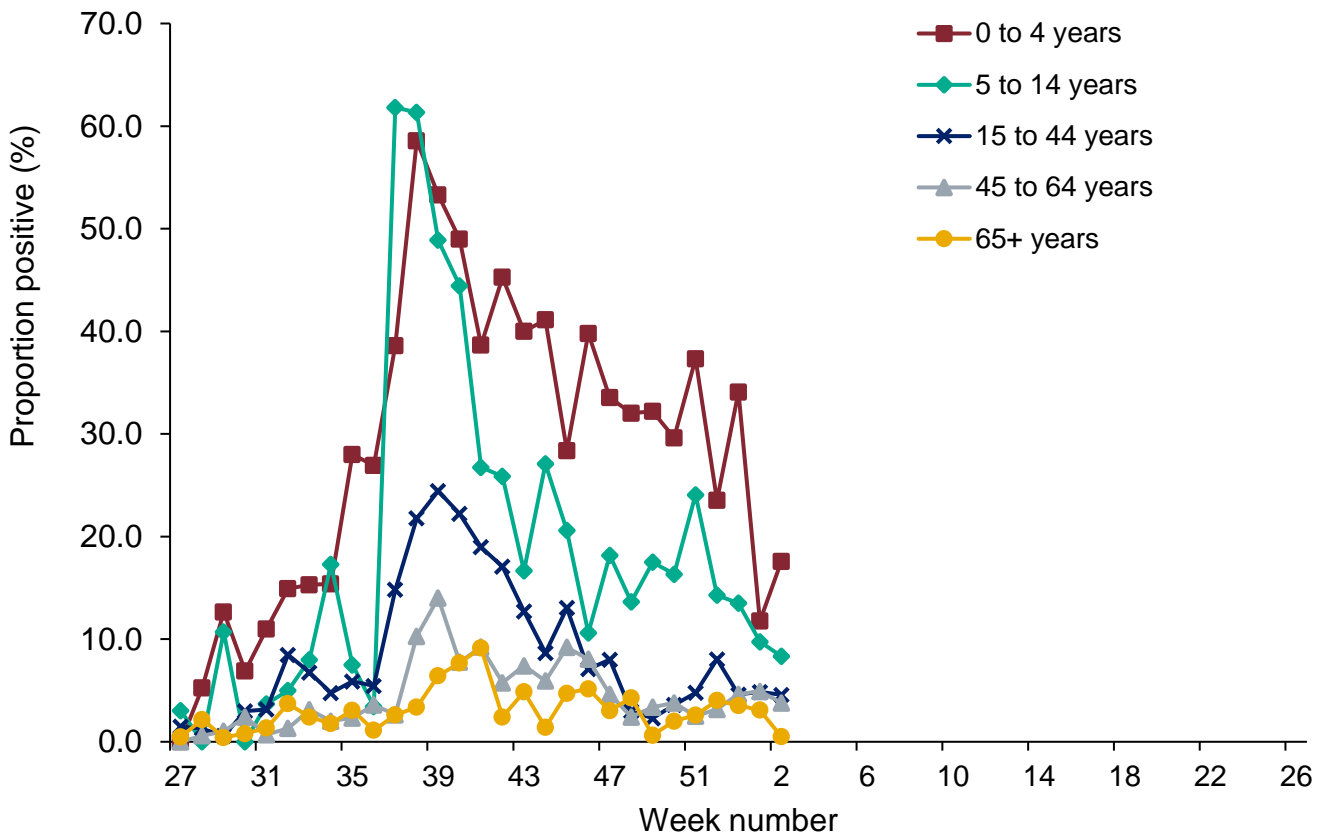


Figure 14: DataMart weekly positivity (%) for rhinovirus by age, England



Community surveillance

Acute respiratory infection incidents

Here we present data on acute respiratory infection (ARI) incidents in different settings that are reported to PHE 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 i.e. where two 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 COVID19 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 COVID19 (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.

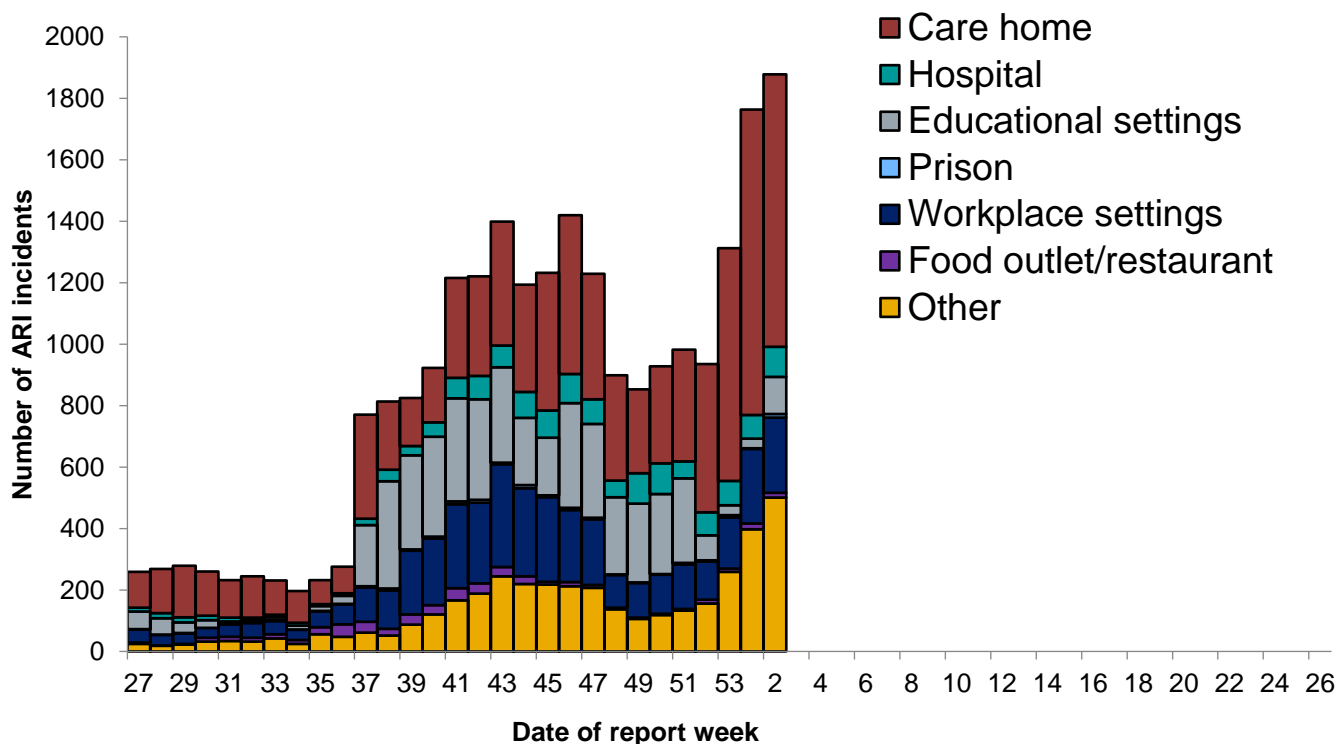
Data caveats:

- 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 PHE 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.
- 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.
- 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 PHE 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.
- In light of the above, comparisons between Regions and settings are not advised as they may be misleading.

1878 new ARI incidents have been reported in week 2 in the UK (Figure 15):

- 887 incidents were from care homes where 670 had at least one linked case that tested positive for SARS-CoV-2 where test results were available
- 120 incidents were from educational settings where 87 had at least one linked case that tested positive for SARS-CoV-2
- 98 incidents were from hospitals where 84 had at least one linked case that tested positive for SARS-CoV-2
- 12 incidents were from prisons where 11 had at least one linked case that tested positive for SARS-CoV-2
- 245 incidents were from workplace settings where 189 had at least one linked case that tested positive for SARS-CoV-2
- 15 incidents were from food outlets/restaurants where 9 had at least one linked case that tested positive for SARS-CoV-2
- 501 incidents were from other settings where 336 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

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

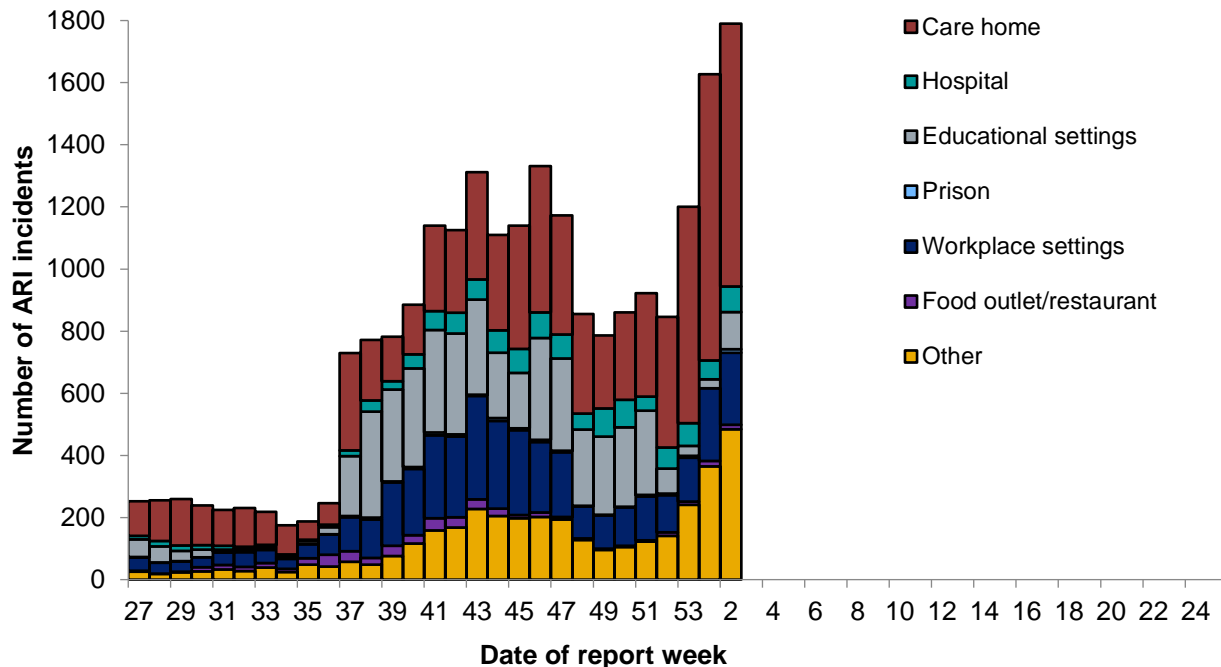


Figure 17: Number of acute respiratory infection (ARI) incidents in care homes by virus type from week 27, England

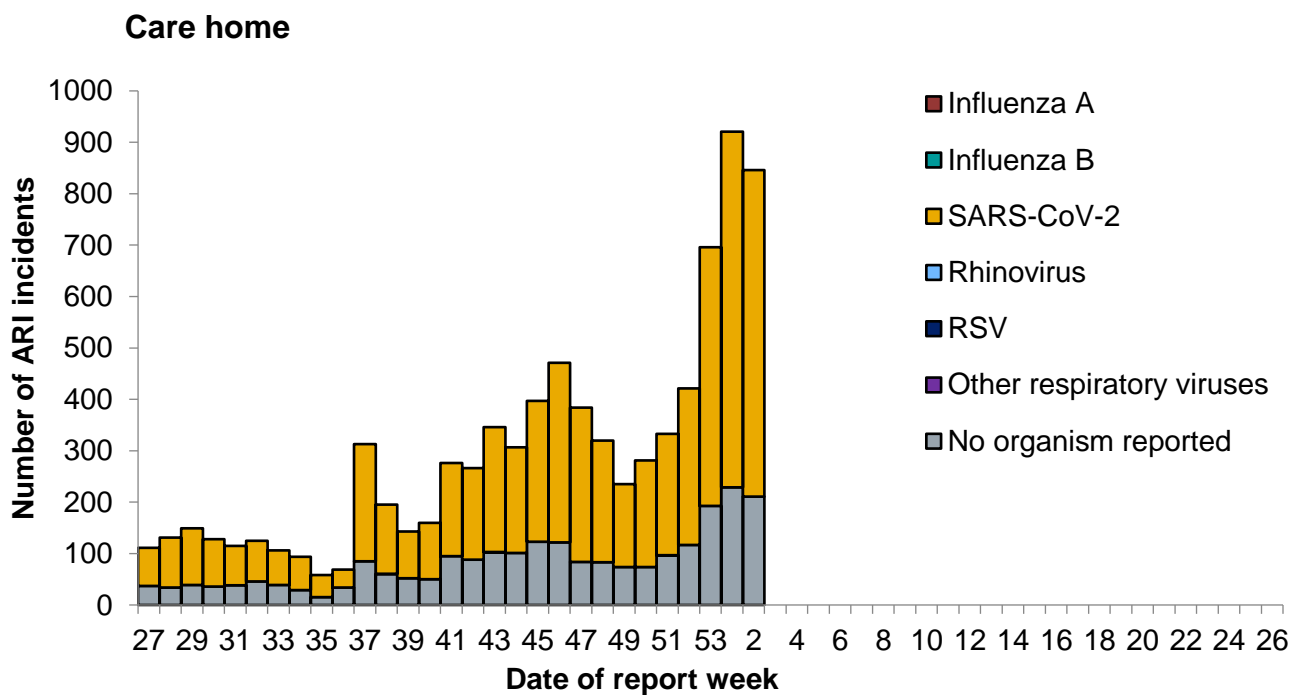


Figure 18: Number of acute respiratory infection (ARI) incidents in hospitals by virus type from week 27, England

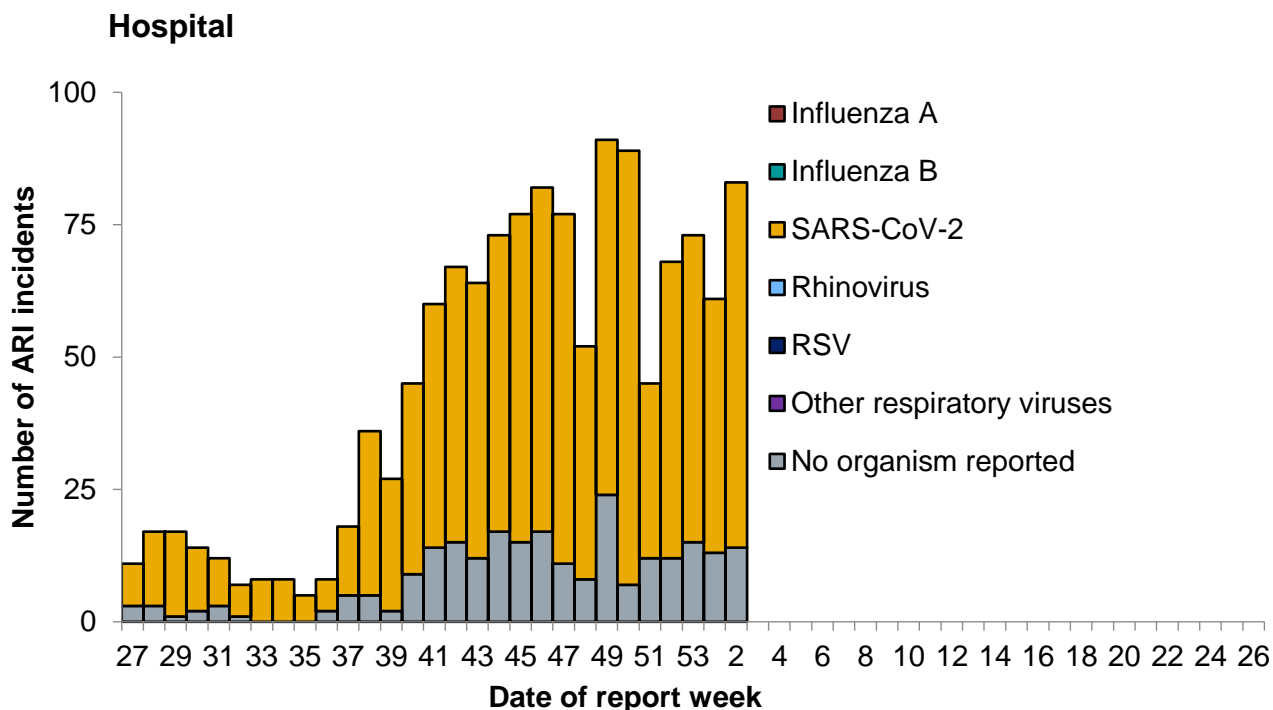


Figure 19: Number of acute respiratory infection (ARI) incidents in educational settings by virus type from week 27, England

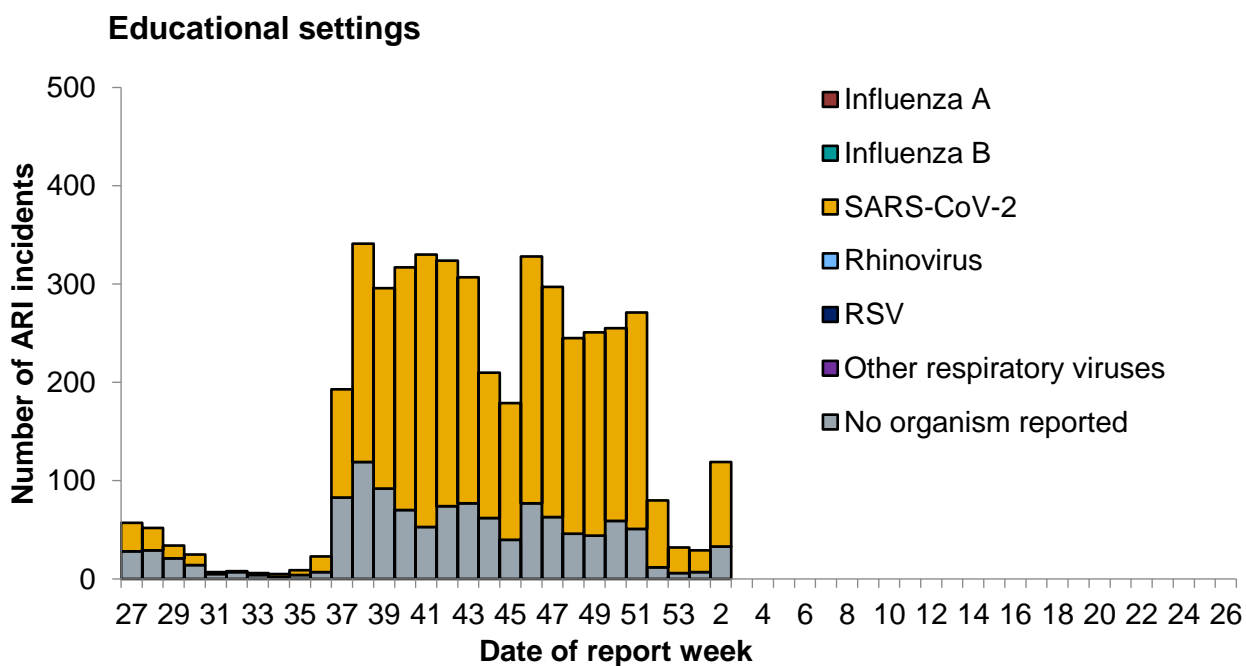


Figure 20: Number of acute respiratory infection (ARI) incidents in prisons by virus type from week 27, England

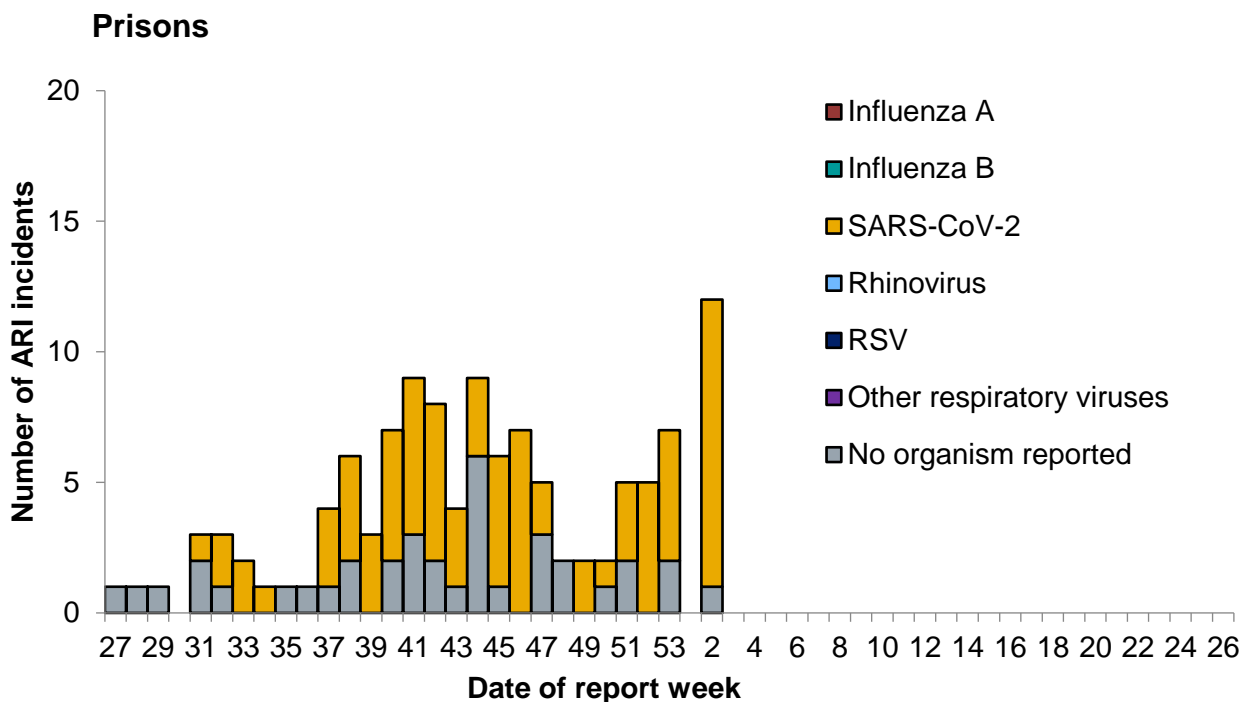


Figure 21: Number of acute respiratory infection (ARI) incidents in workplace settings by virus type from week 27, England

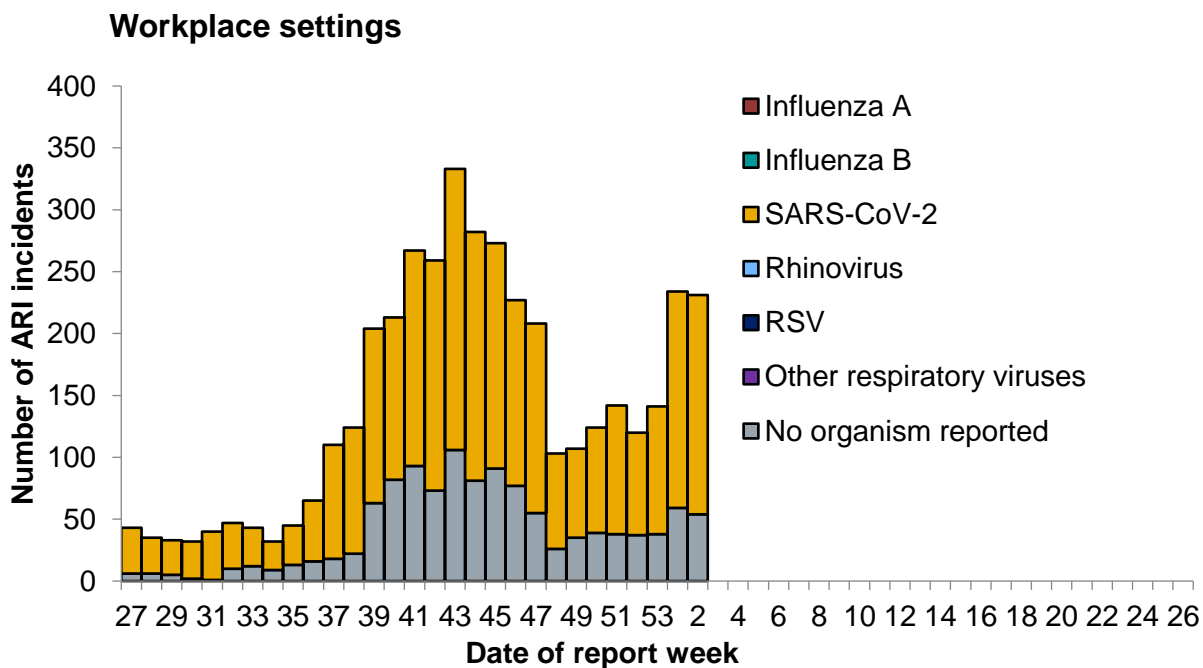


Figure 22: Number of acute respiratory infection (ARI) incidents in food outlet/restaurants settings by virus type from week 27, England

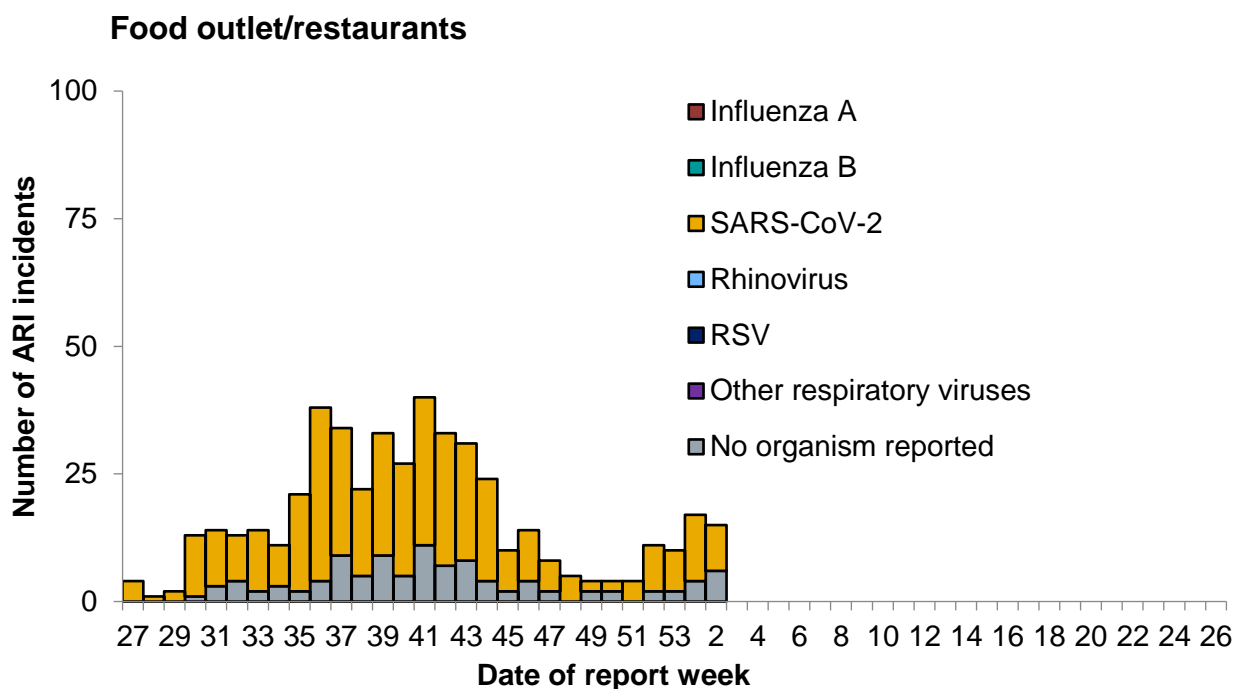


Figure 23: Number of acute respiratory infection (ARI) incidents in other settings by virus type from week 27, England

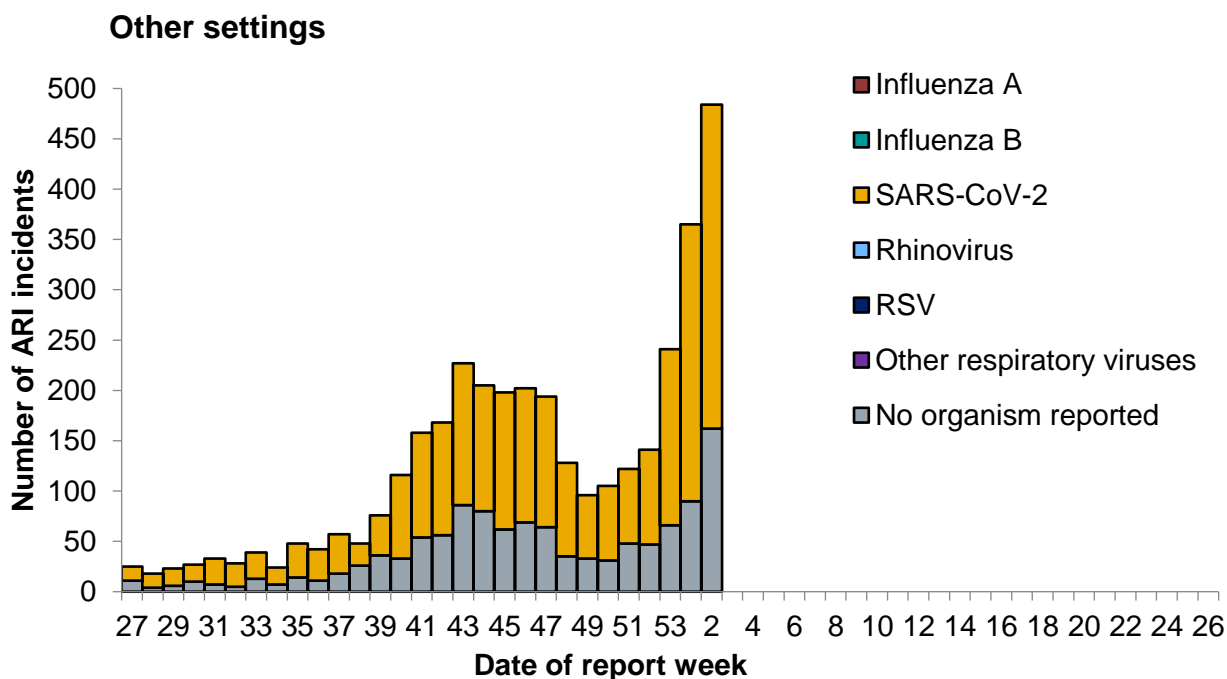


Table 2: Total number of situations/incidents by institution and PHE Centres over the past four weeks with the total number in the last week in brackets

PHE Centres	Care home	Hospital	Educational settings	Prisons	Workplace settings	Food outlet/restaurant settings	Other settings	Total
East of England	403(132)	17(9)	1(0)	1(0)	47(15)	1(0)	157(56)	627(212)
East Midlands	204(73)	54(12)	28(14)	2(1)	78(30)	2(0)	104(38)	472(168)
London	399(96)	104(23)	46(12)	4(2)	45(2)	7(0)	172(73)	777(208)
North East	126(31)	1(0)	3(2)	0(0)	3(1)	0(0)	41(14)	174(48)
North West	190(52)	29(9)	29(13)	4(3)	147(67)	8(1)	132(58)	539(203)
South East	664(176)	36(11)	59(24)	8(3)	156(27)	9(3)	237(77)	1169(321)
South West	409(133)	11(3)	24(12)	1(1)	85(21)	6(1)	88(38)	624(209)
West Midlands	316(110)	26(15)	36(21)	3(2)	121(49)	18(9)	212(95)	732(301)
Yorkshire and Humber	173(43)	7(1)	34(21)	1(0)	44(19)	2(1)	88(35)	349(120)
Total	2884(846)	285(83)	260(119)	24(12)	726(231)	53(15)	1231(484)	5463(1790)

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 2, 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	week50	week51	week52	week53	week01	week02
Residential dwelling (including houses, flats, sheltered accommodation)	91.7	91.7	93.6	93.2	91.6	90.3
Undetermined	3.3	4.7	3.1	3.5	3.2	3.6
Care/Nursing home	3.2	2.2	2.0	2.2	3.5	4.0
Residential institution (including residential education)	0.2	0.1	0.2	0.1	0.2	0.3
Other property classifications	0.5	0.5	0.5	0.4	0.6	0.6
House in multiple occupancy (HMO)	0.4	0.4	0.4	0.4	0.5	0.6
Medical facilities (including hospitals and hospices, and mental health)	0.2	0.1	0.1	0.1	0.2	0.2
Prisons, detention centres, secure units	0.5	0.3	0.2	0.1	0.2	0.5
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 due to national school closures.

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

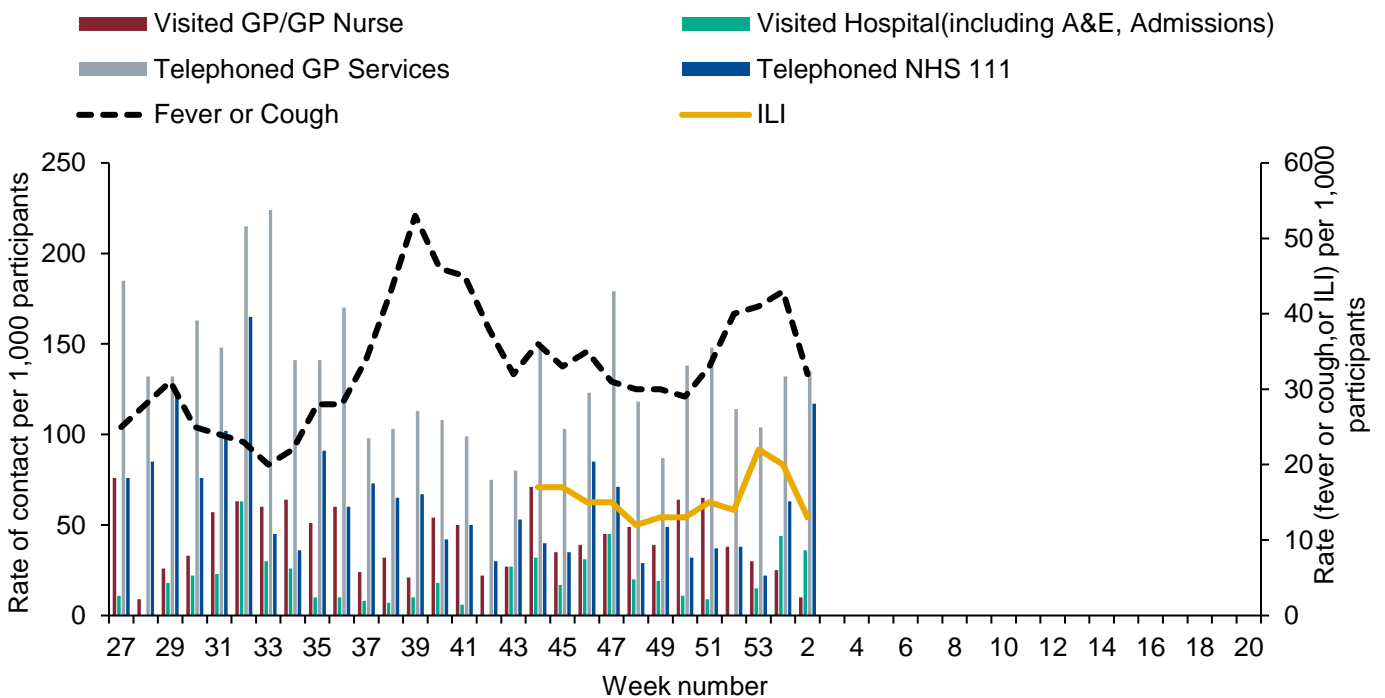
FluSurvey

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 3,487 participants completed the weekly COVID-19 surveillance survey in week 2, of which 111 (3.2%) reported fever or cough and 46 (1.3%) reported influenza like illness (ILI). 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



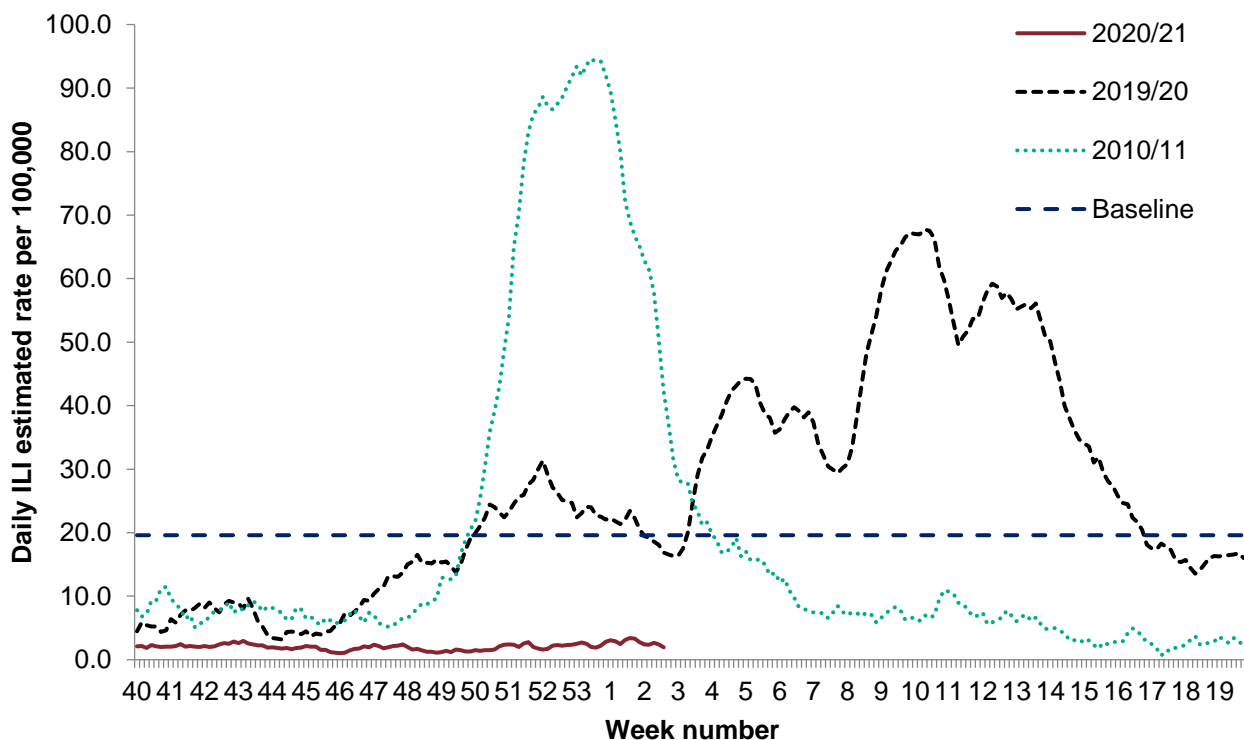
FluDetector

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 2, 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

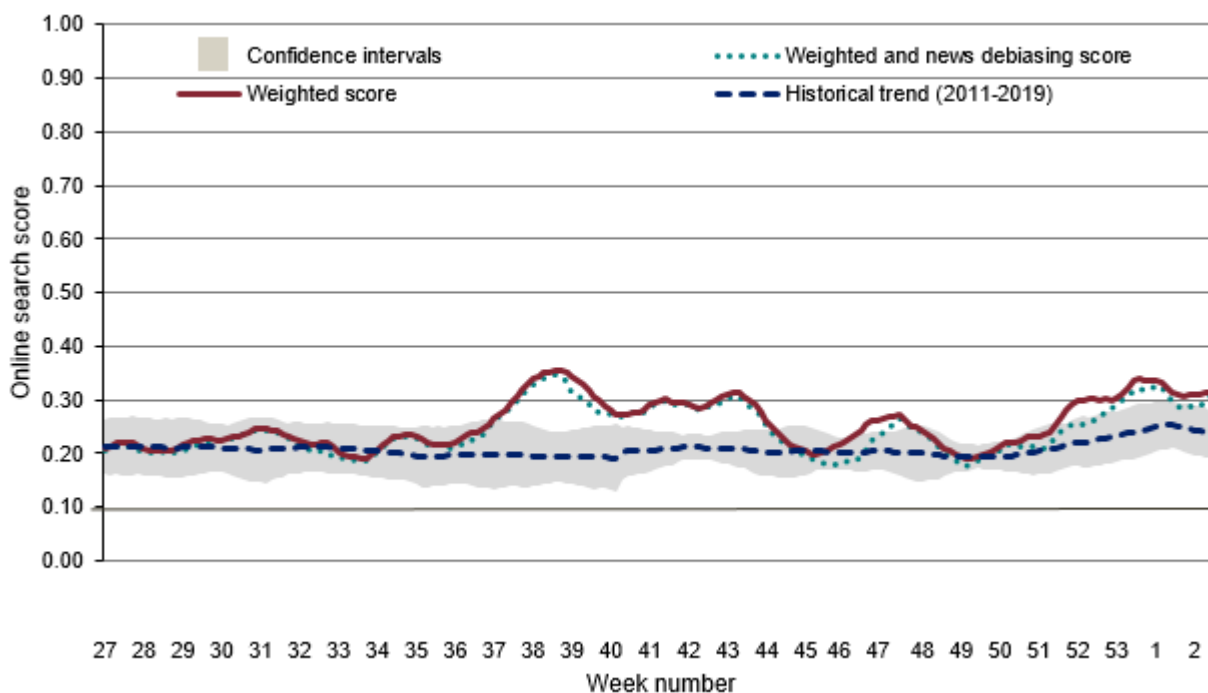


Google search queries

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.

Data for Google search queries were only available up to 15 January (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.

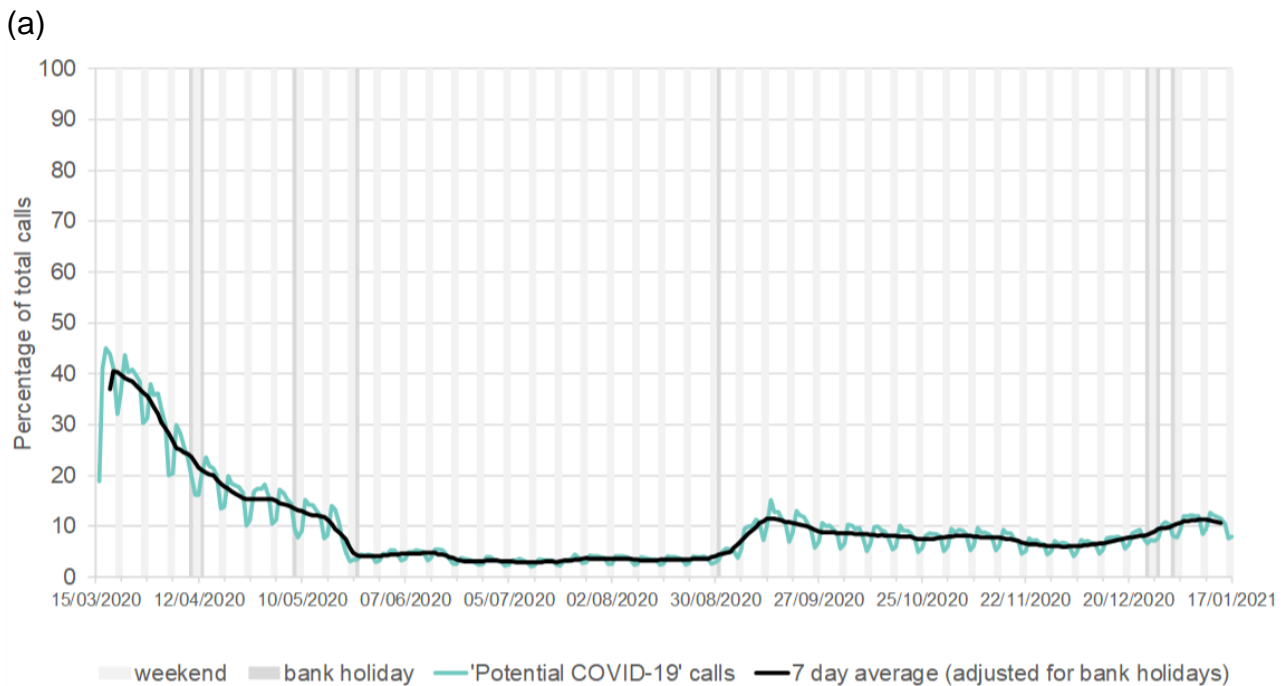
Up to 17 January NHS 111 calls for cold/flu remained stable and online assessments decreased. Calls and online assessments for potential COVID-19 decreased. Calls for loss of taste or smell and online assessments decreased (Figure 27 and 28).

Increases were also noted in calls for difficulty breathing. See the syndromic surveillance bulletin for this indicator.

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



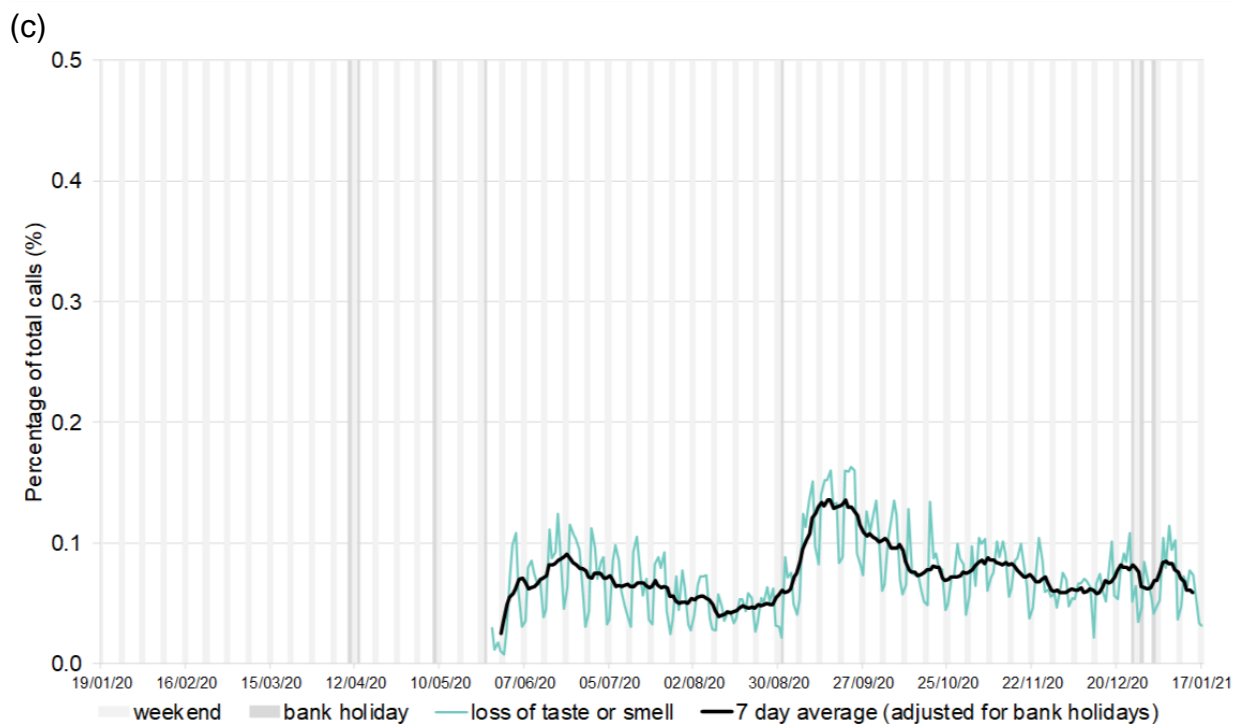
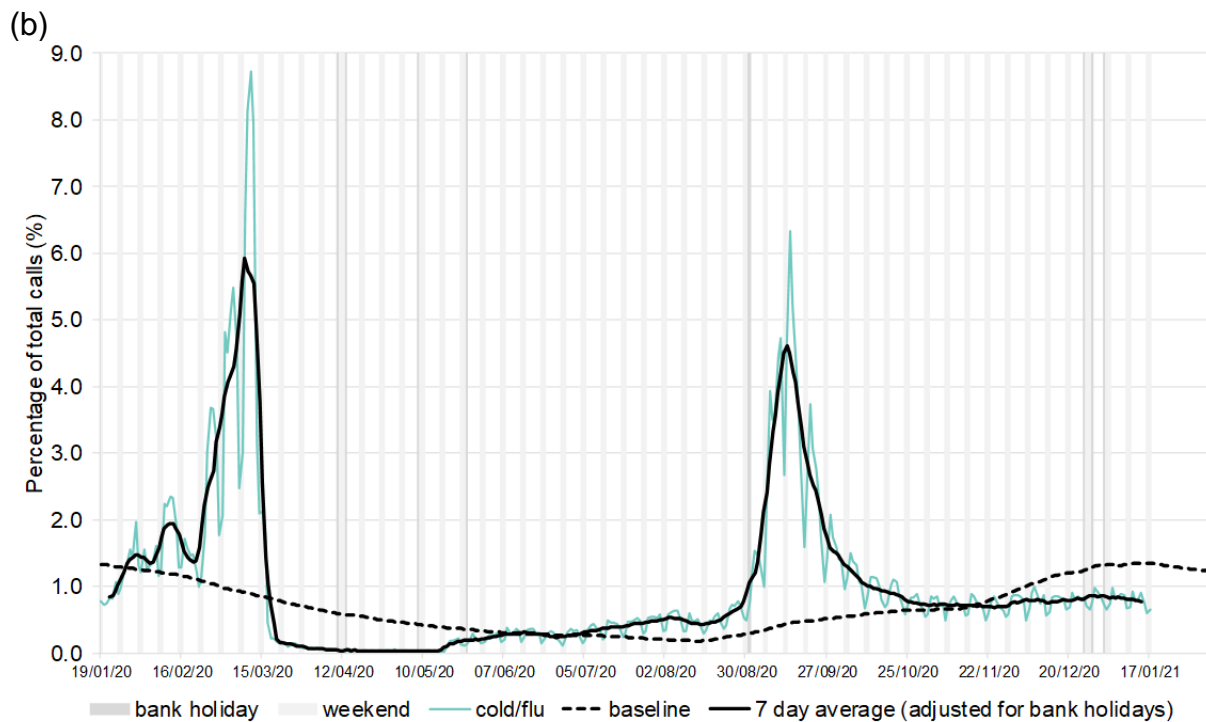
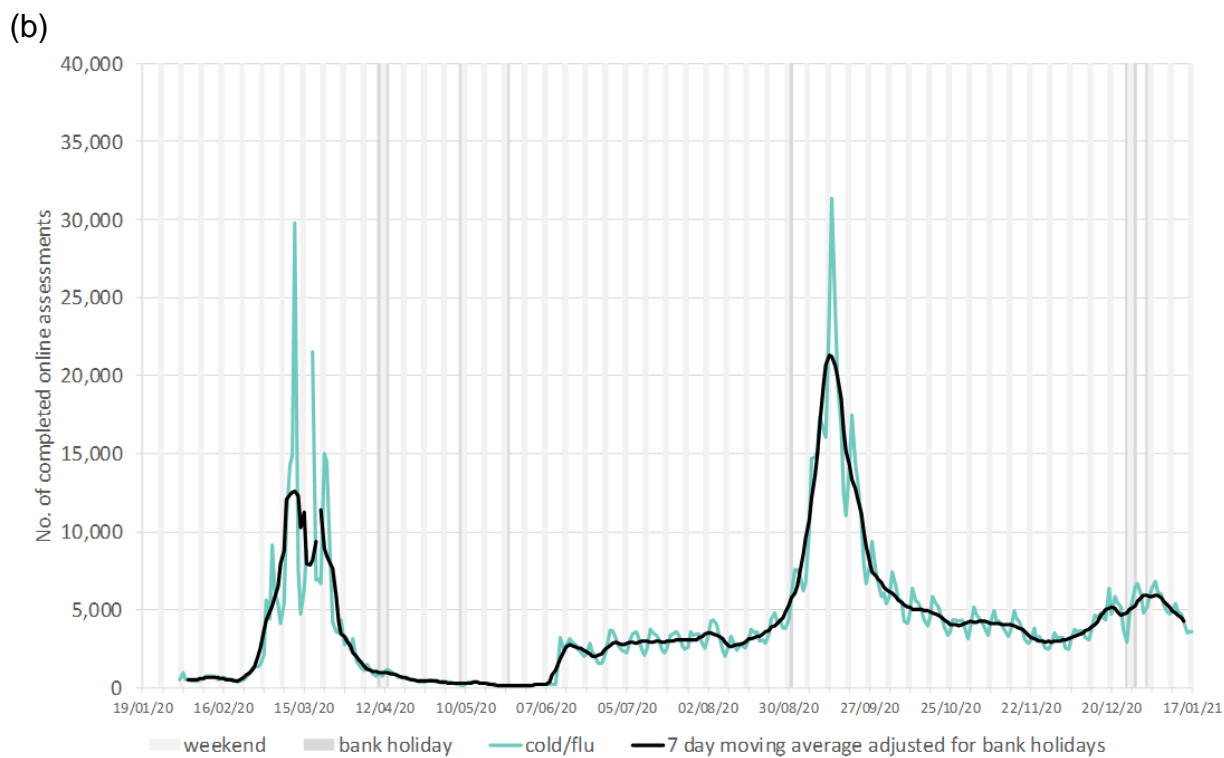
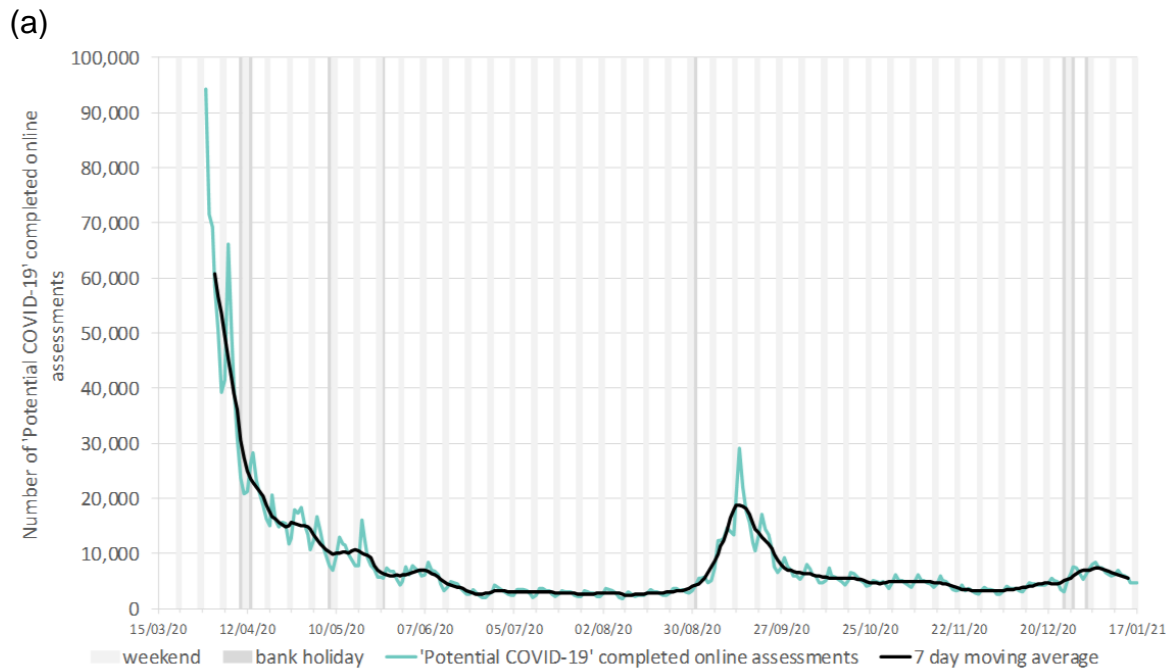
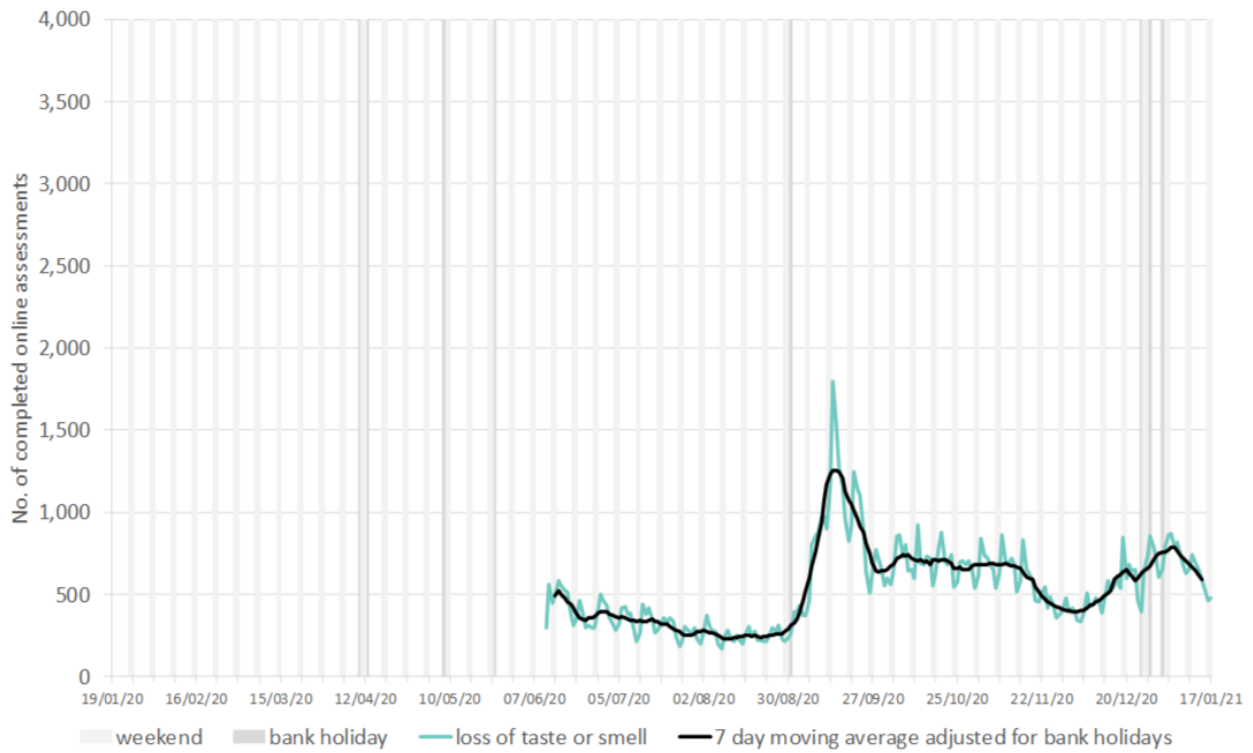


Figure 28: NHS 111 completed online assessments (and 7-day moving average) for (a) daily potential COVID-19 online assessments, (b) daily cold/flu online assessments and (c) daily loss of taste or smell online assessments, as the number of completed online assessments for all ages, England



(c)



Primary care surveillance

RCGP (England)

The weekly ILI consultation rate through the RCGP surveillance was 1.1 per 100,000 registered population in participating GP practices in week 2 compared to the 1.3 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 under 1 year olds (2.9 per 100,000). The Lower Respiratory Tract Infections (LRTI) consultation rate was at 18.7 per 100,000 in week 2, which is a slight decrease compared to the rate of 20.6 per 100,000 from the previous week. The COVID-19-like indicator consultation rate was at 288.7 per 100,000 in week 2 compared to a similar rate of 304.1 per 100,000 in the previous week (Figure 30).

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

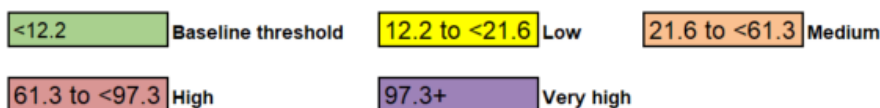
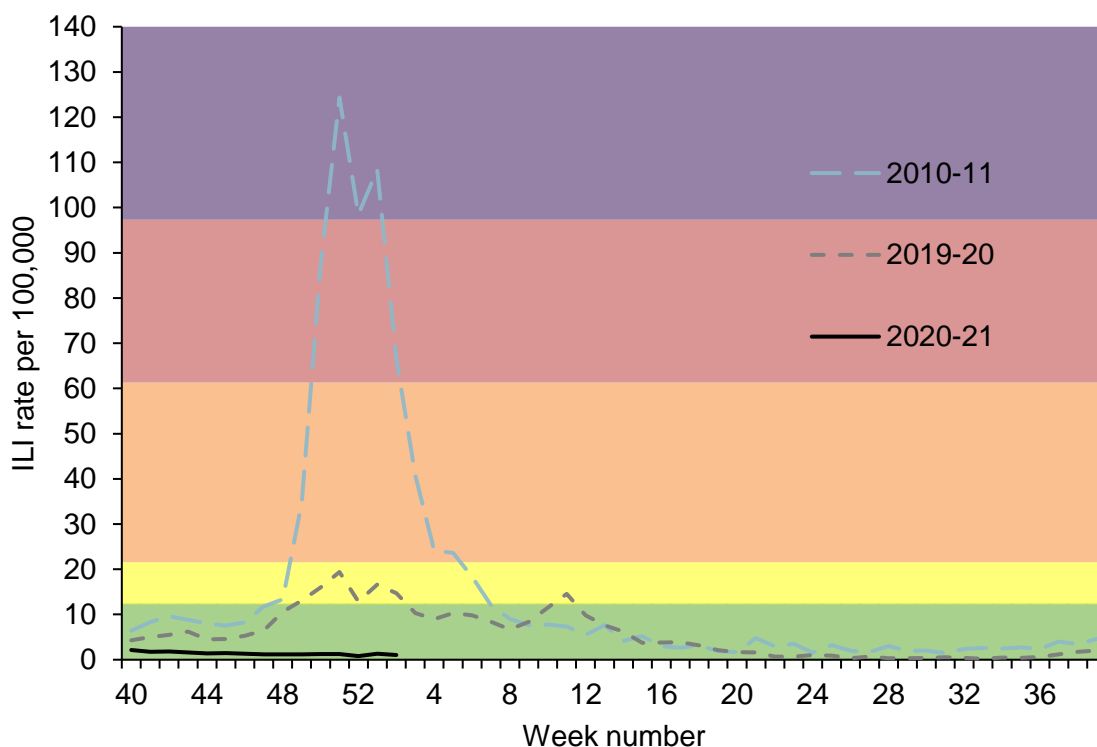
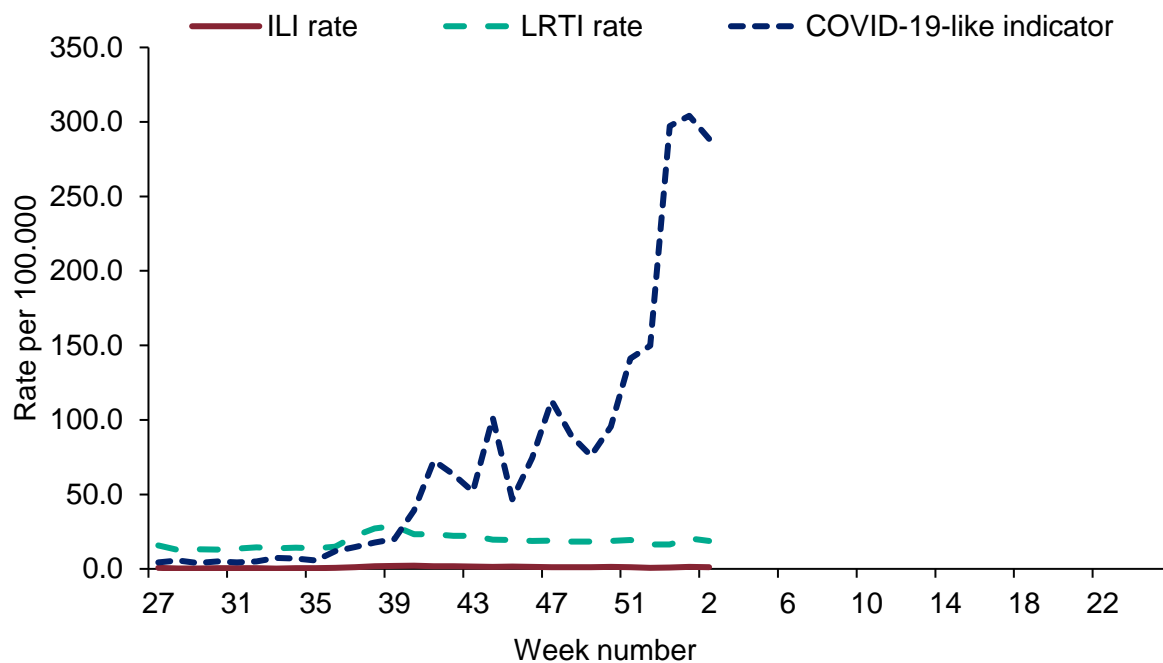


Figure 30: RCGP ILI, LRTI and COVID-19-like indicator consultation rates, England



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 45 to 64 year olds in Scotland (0.7 per 100,000), 65 to 74 year olds in Wales (4.3 per 100,000) and the 45 to 64 year olds in Northern Ireland (3.9 per 100,000).

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	53	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	0.9	1.3	1.1		
Wales	1.0	1.0	1.0	0.8	0.5	0.5	0.5	0.5	0.5	1.6	1.3	1.0	0.8	0.0	0.5	1.0		
Scotland	0.5	0.7	0.5	0.5	0.7	0.8	0.9	0.7	0.6	0.4	0.6	0.4	0.2	0.4	0.5	0.5		
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	2.2	3.4	2.4		

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

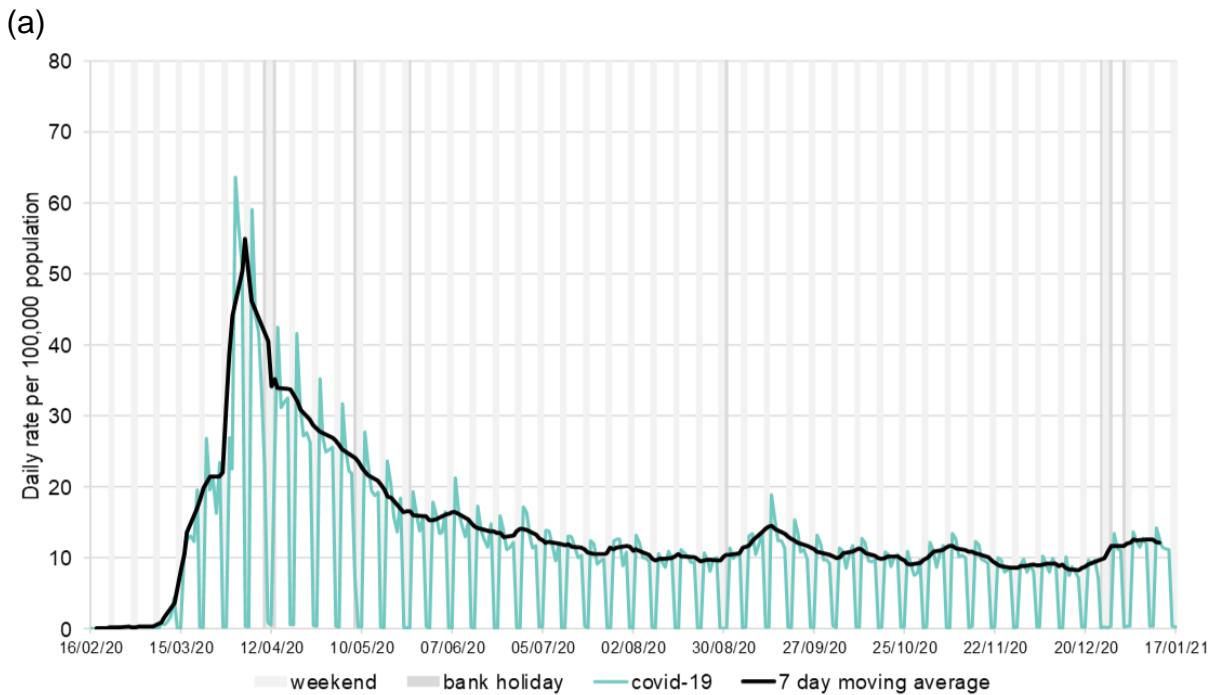
The GP In Hours (GPIH) syndromic surveillance system monitors the number of GP visits during regular hours of known clinical indicators.

Up to 10 January GP in-hours consultations for influenza-like-illness remain below baseline and for COVID-19 remained stable (Figure 31b).

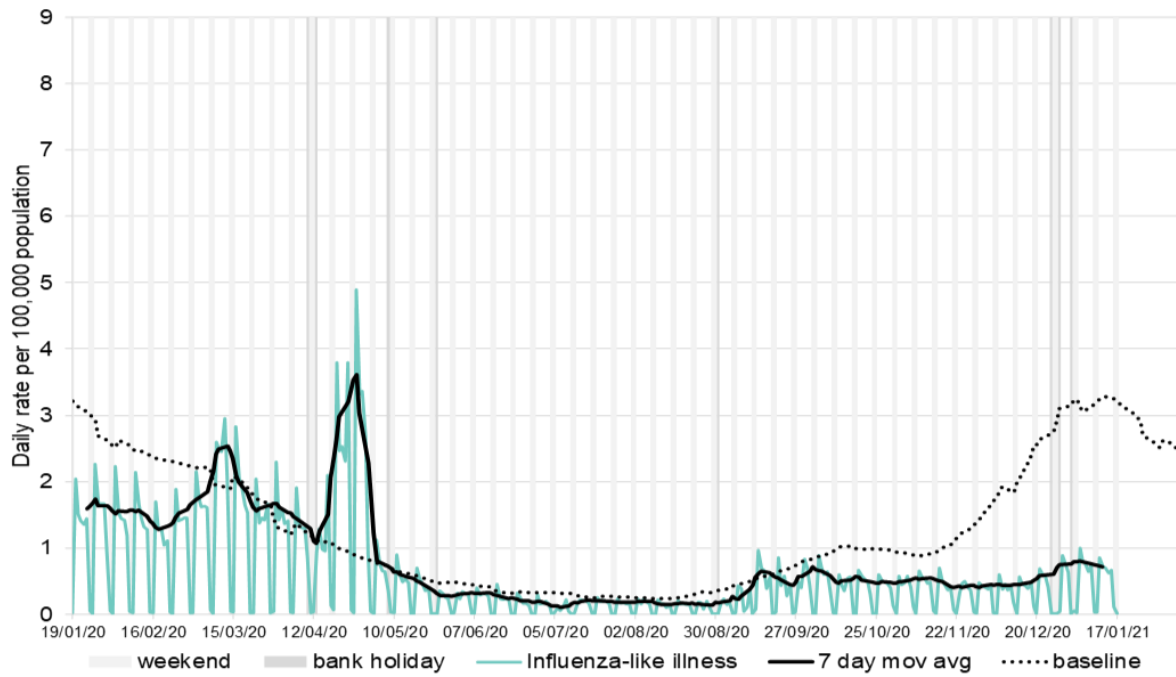
Please note that currently COVID-19-like GP consultations are included from one GP syndromic data provider only and as a result have a smaller population denominator than other indicators (which remain unaffected).

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



(b)

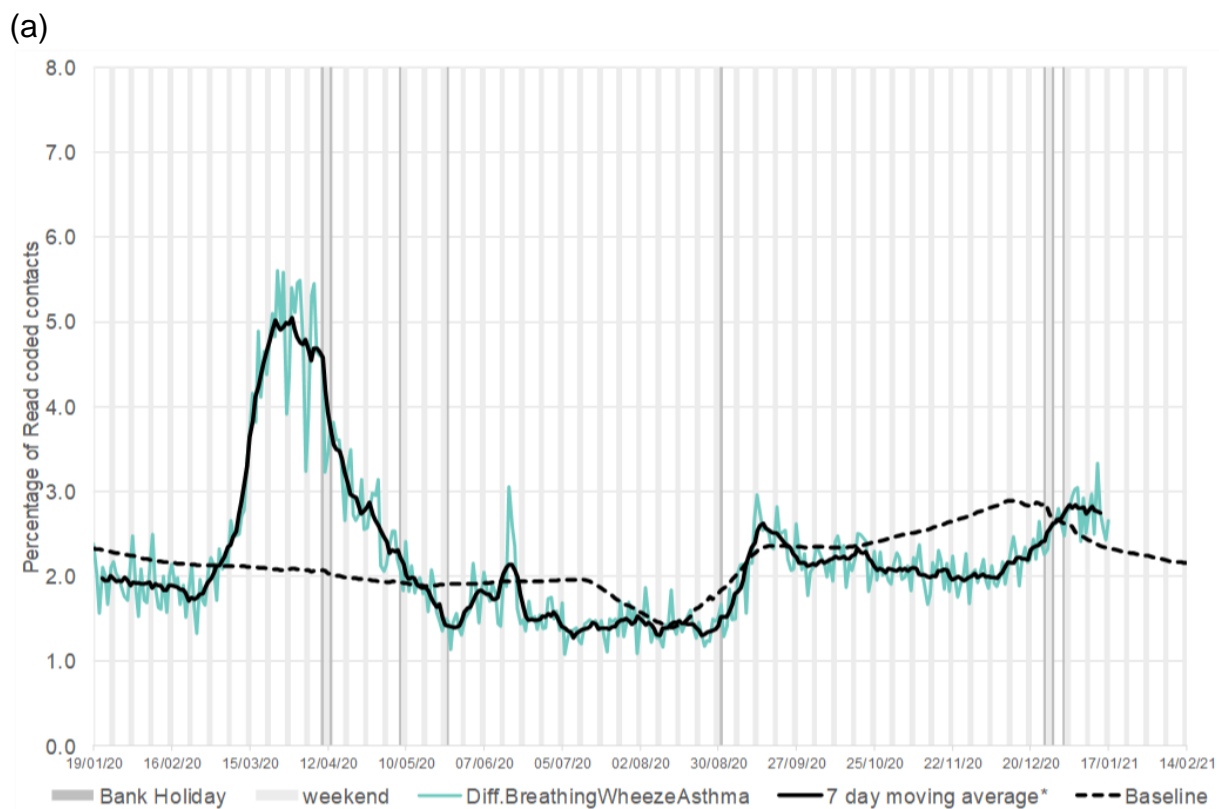


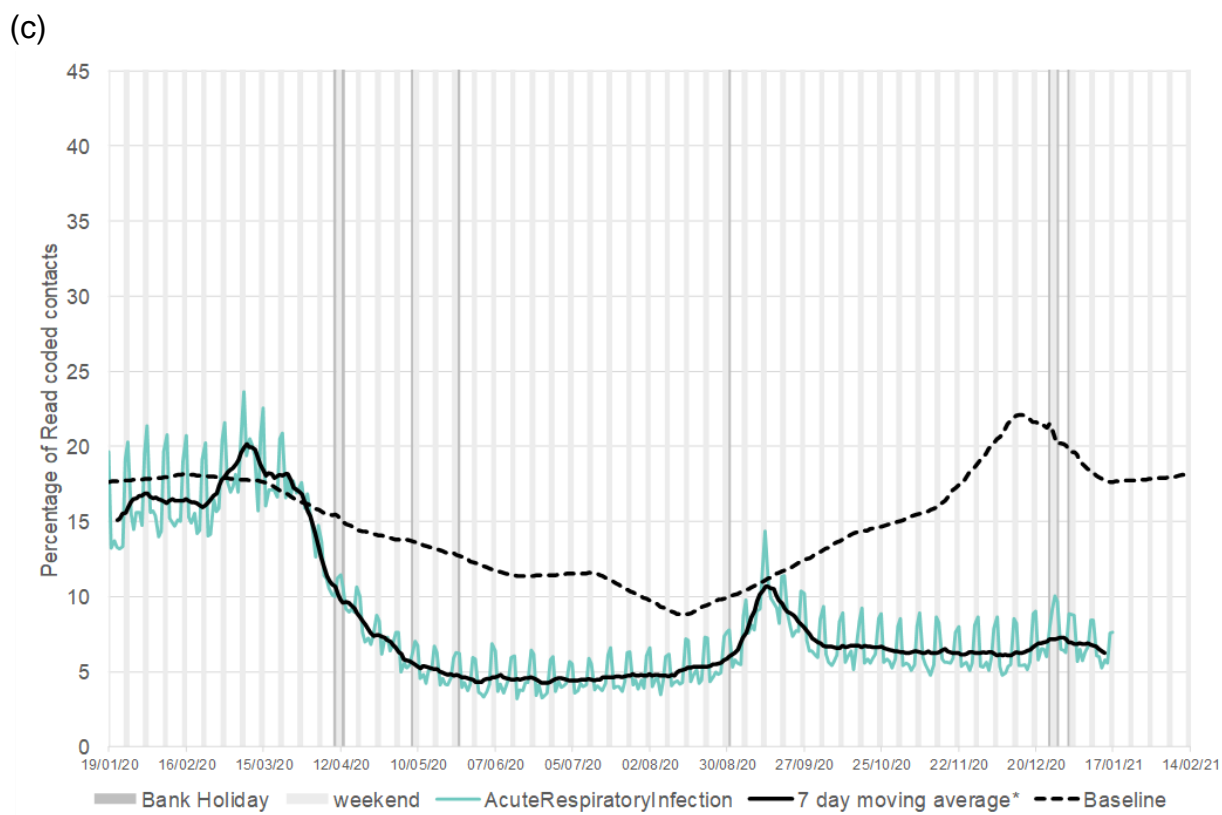
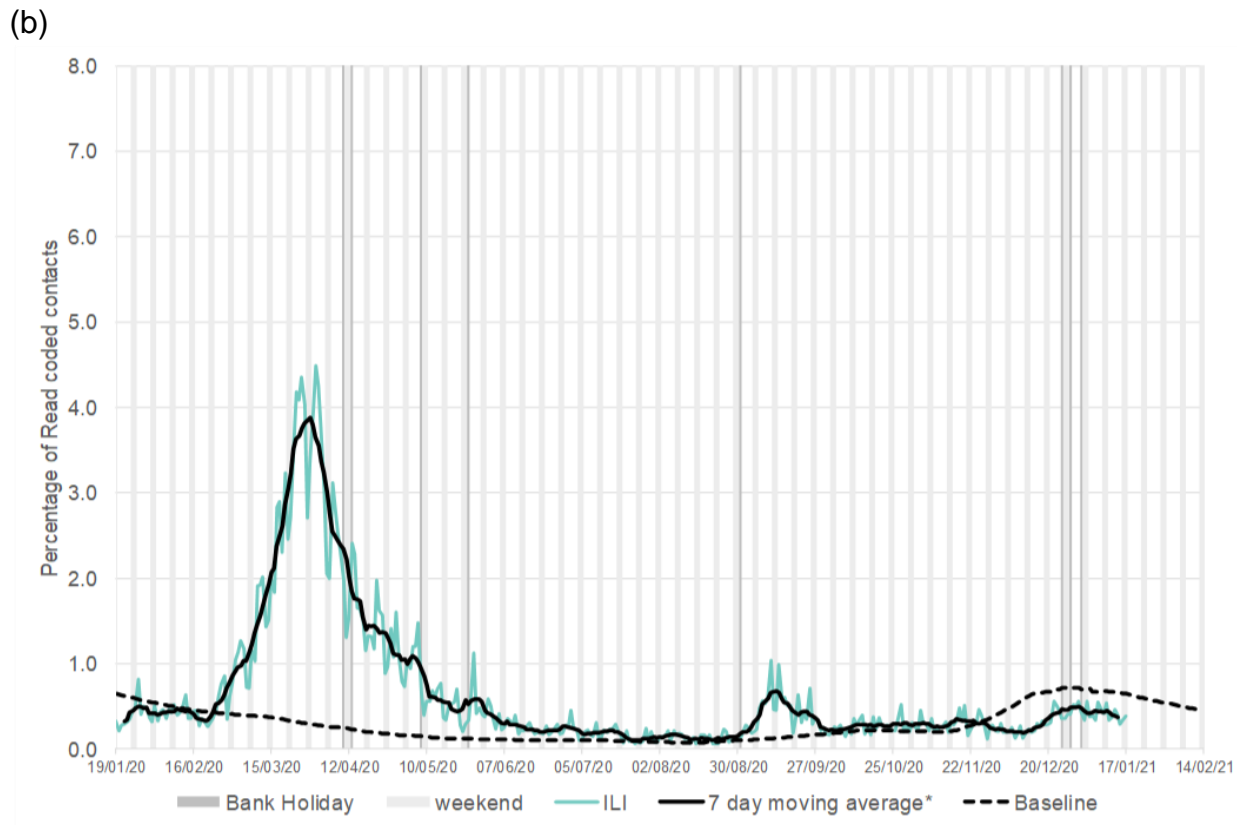
GP Out of Hours, Syndromic Surveillance

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 17 January GP out-of-hours and unscheduled care consultations for acute respiratory infections, influenza-like illness and difficulty breathing/asthma/wheeze increased remained stable (Figure 32).

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



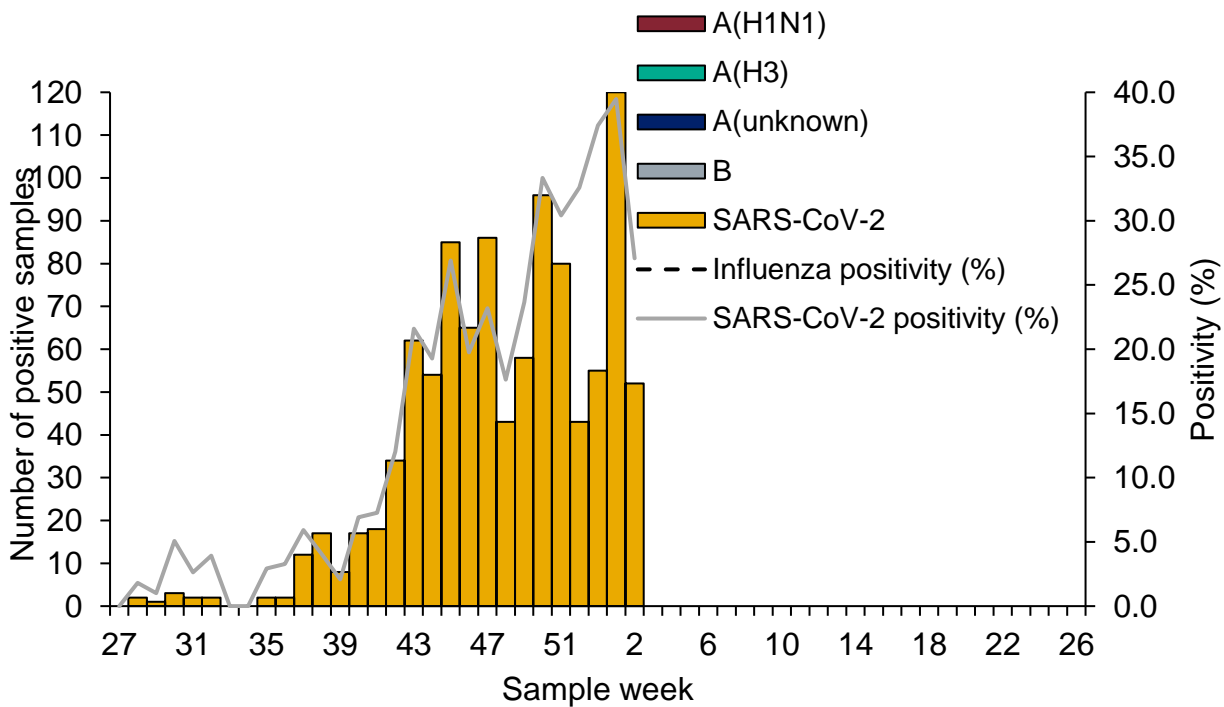


Sentinel swabbing scheme in the UK

In week 2 2021, 52 samples tested positive for SARS-CoV-2 with an overall positivity of 27.1% (52/192) compared to 39.5% (120/304) 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

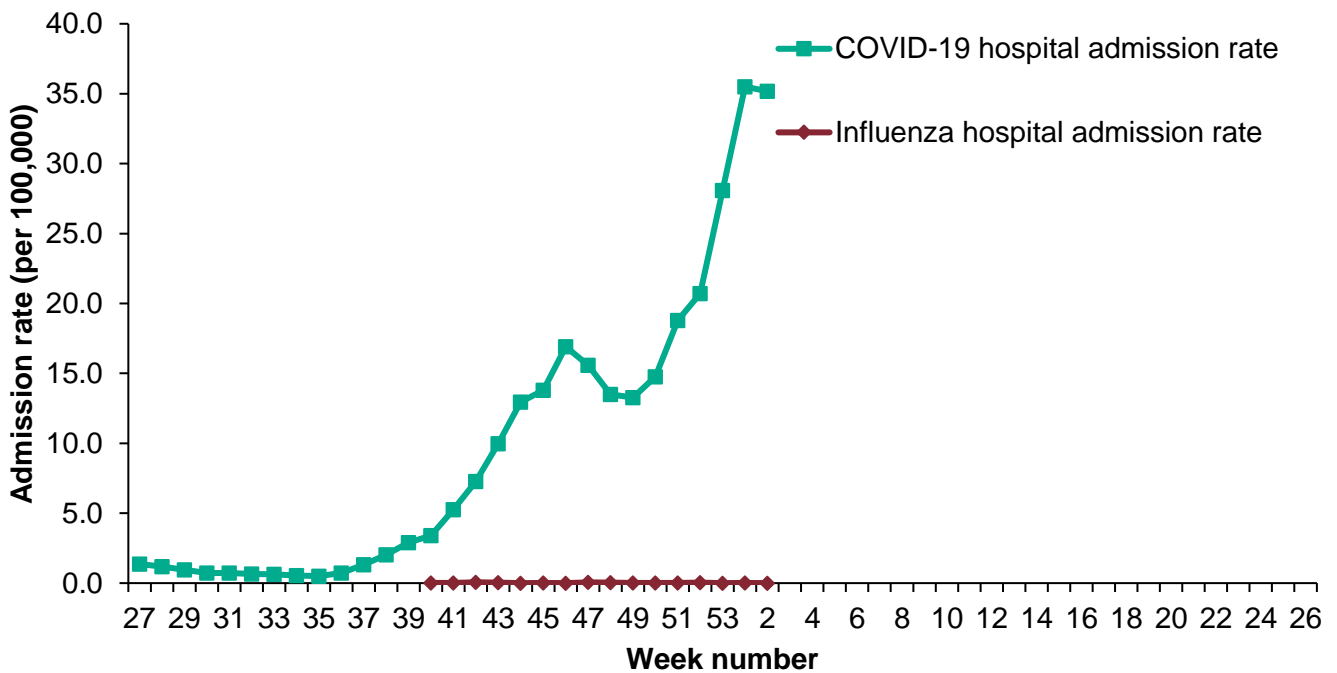
In week 2, the weekly hospital admission rate for COVID-19 remained stable. There was no new hospital admissions for influenza in week 2.

The hospitalisation rate for COVID-19 was at 35.50 per 100,000 in week 2 compared to 35.50 per 100,000 in the previous week.

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

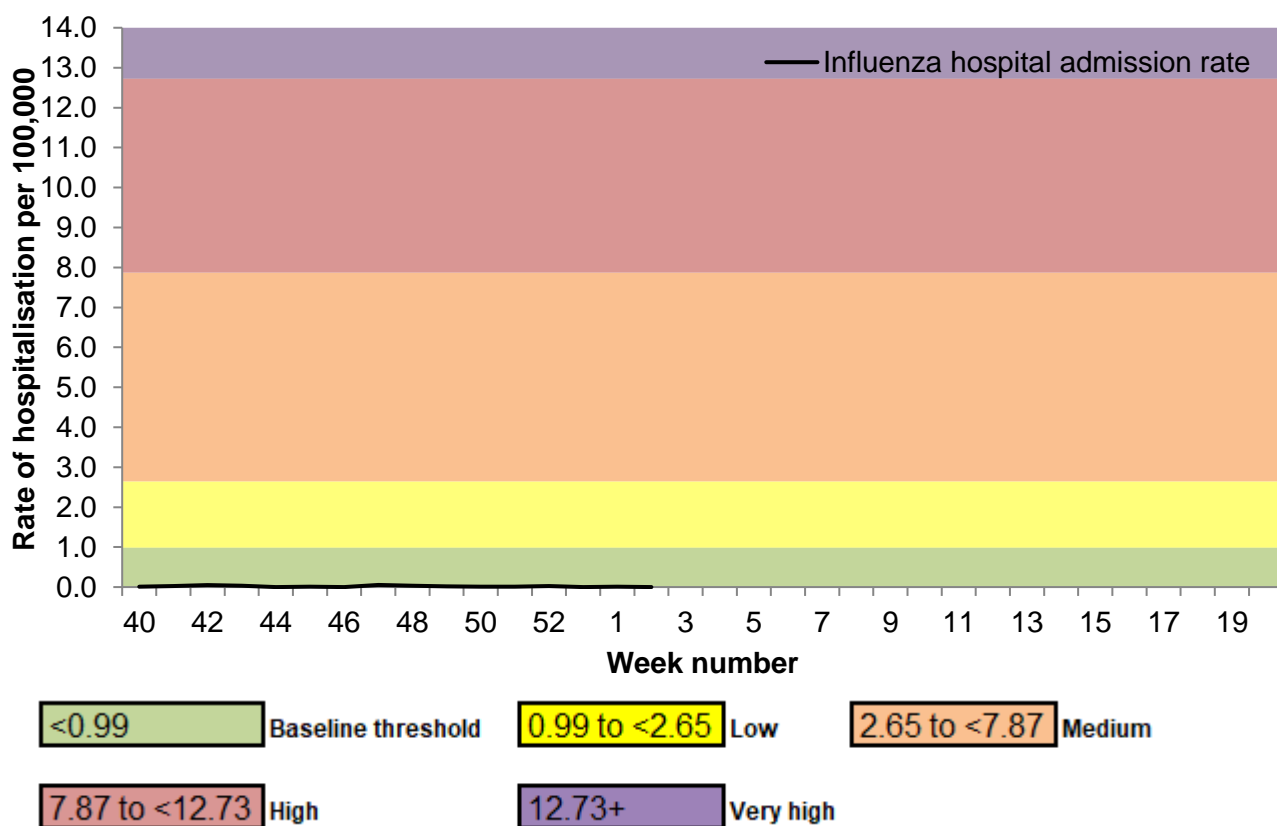
Please note, from this week’s report 2018 trust catchment populations are used to calculate hospital and ICU/HDU admission rates for SARI Watch.

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 28 sentinel NHS trusts for week 2
- * COVID-19 hospital admission rate based on 116 NHS trusts for week 2

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

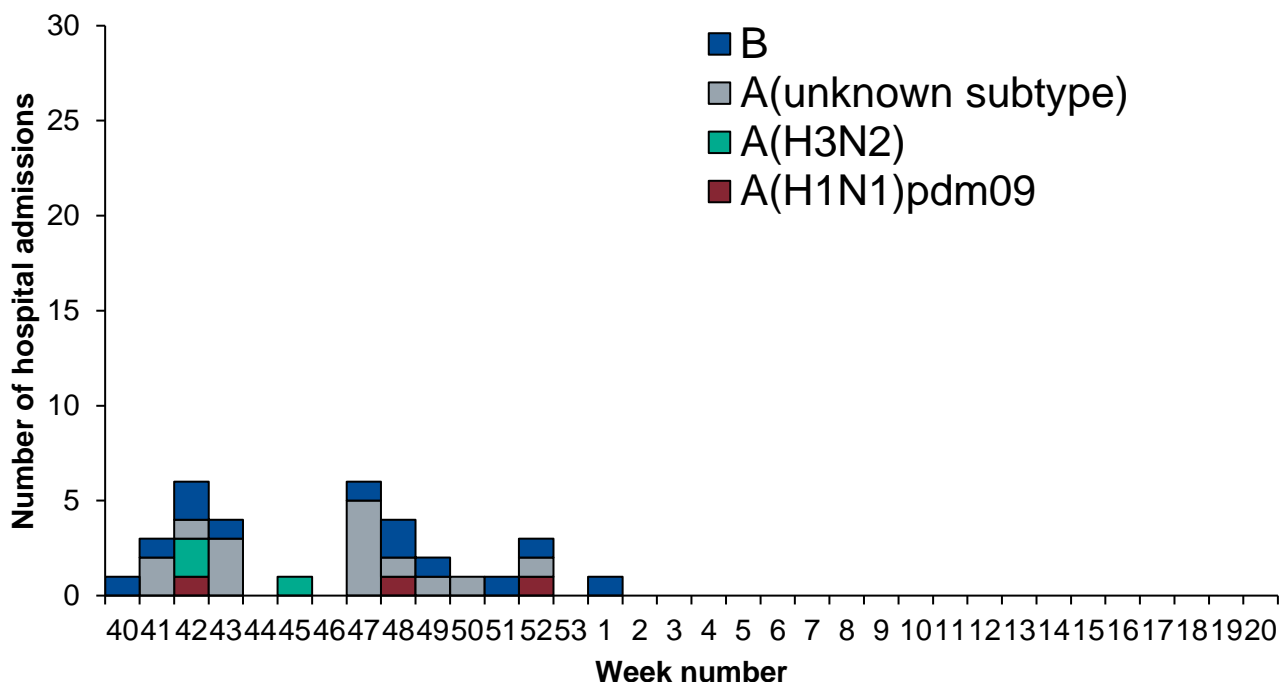


Figure 37: Weekly hospital admission rate by PHE Centre for new (a) COVID-19 positive cases and (b) influenza reported through SARI Watch

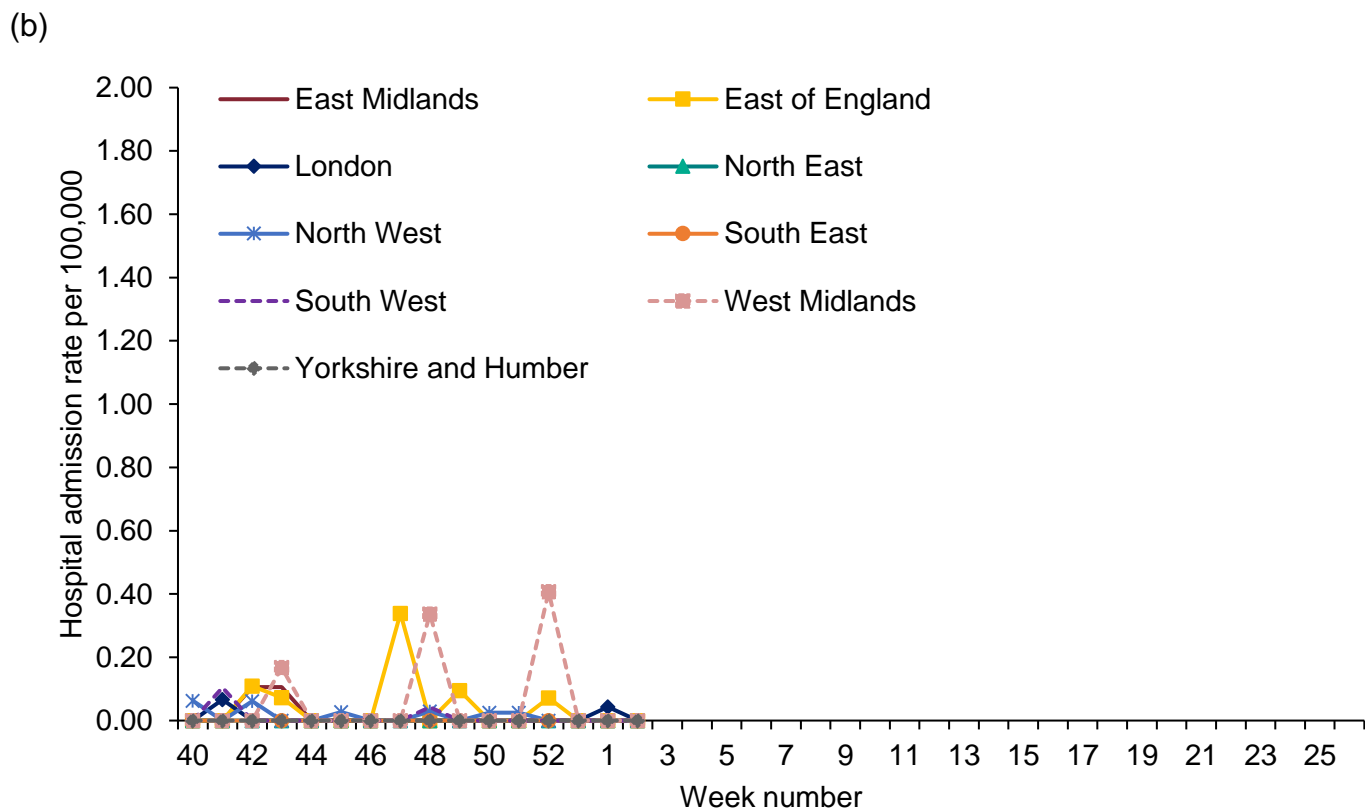
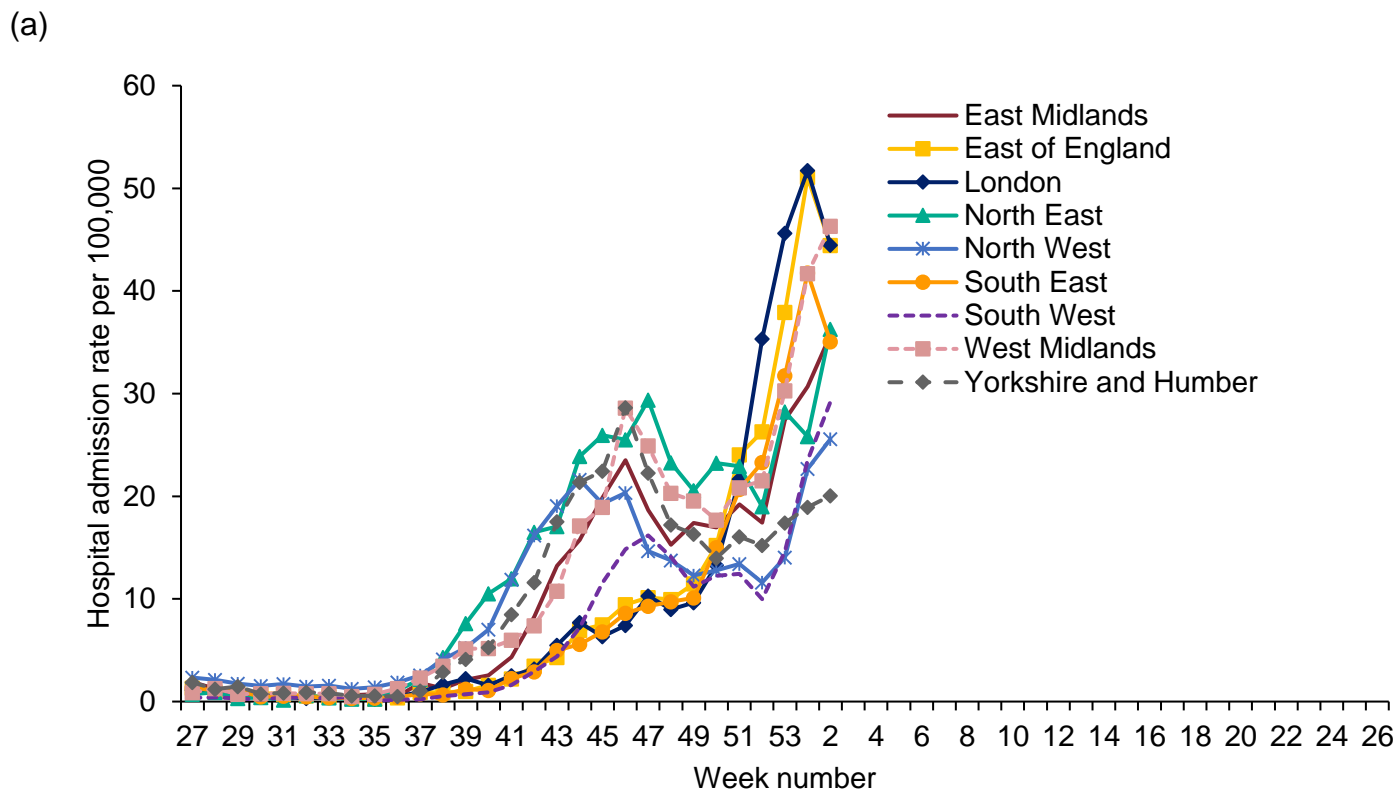
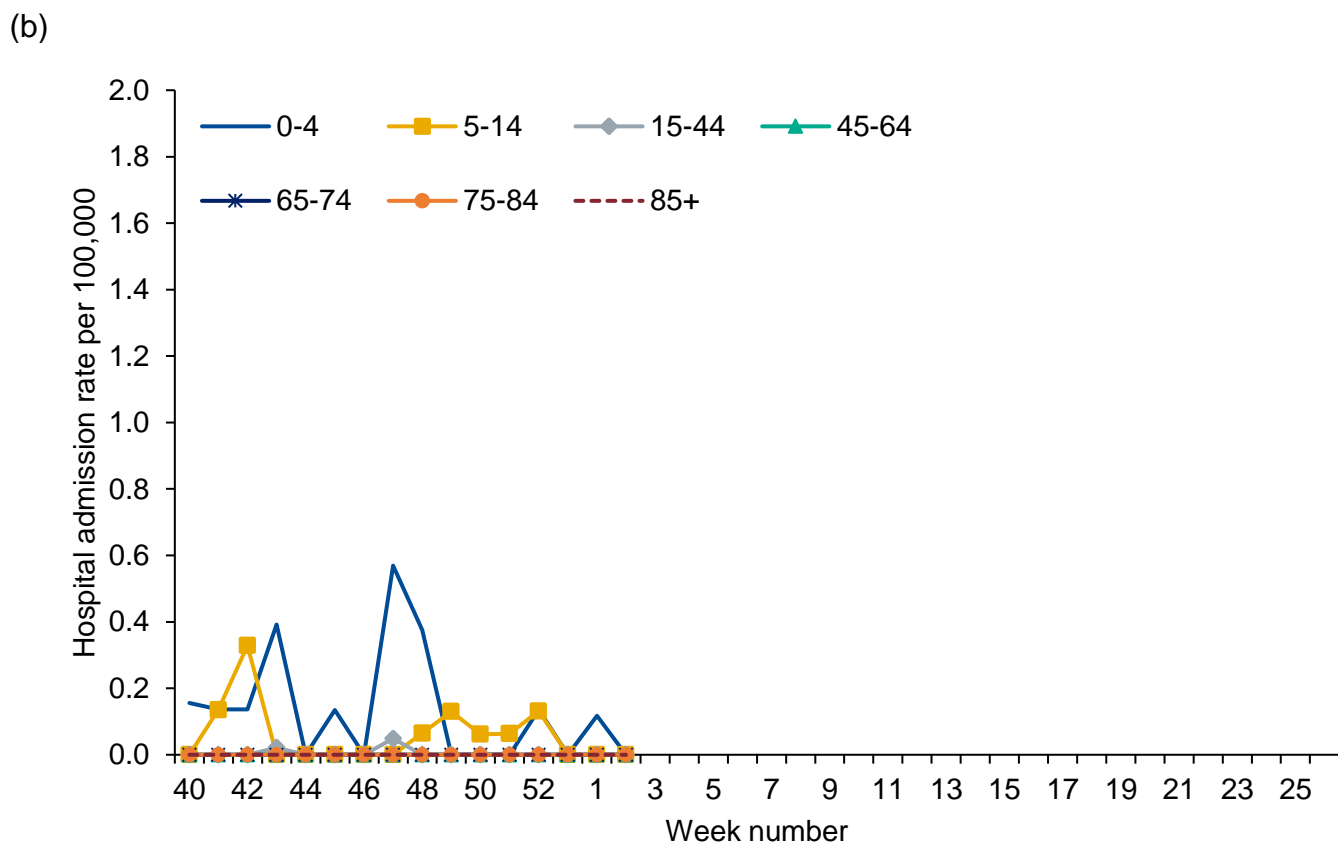
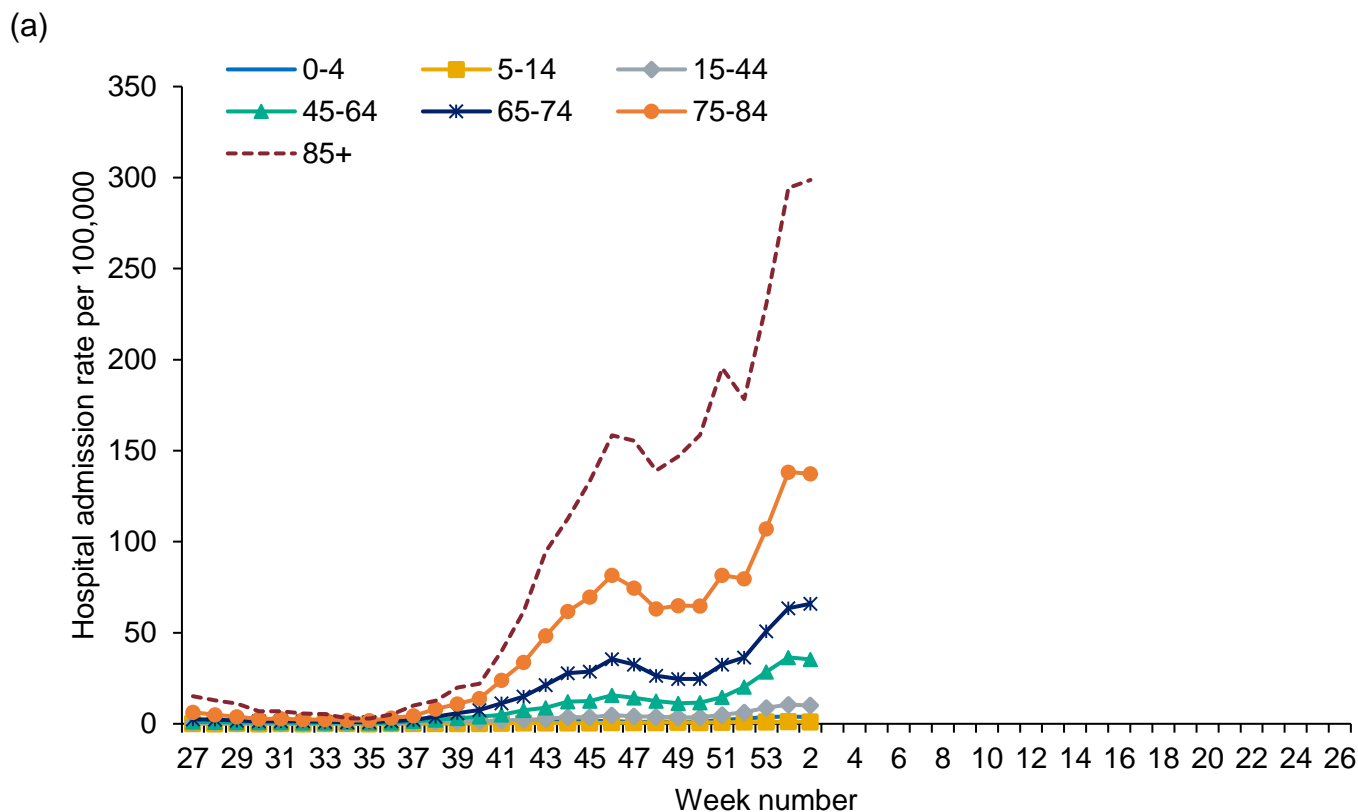


Figure 38: Weekly hospital admission rate by age group for new (a) COVID-19 positive cases and (b) influenza reported through SARI Watch



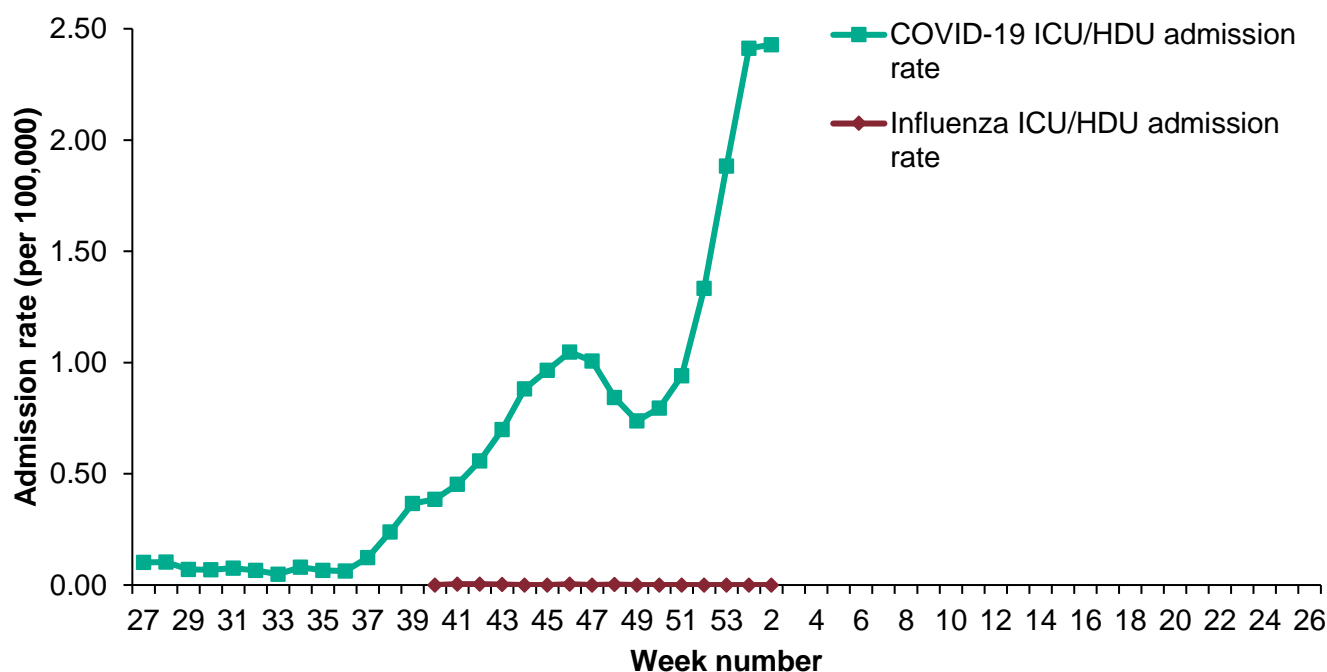
ICU/HDU admissions, SARI Watch

In week 2, the weekly ICU/HDU admission rates for COVID-19 remained stable whilst the ICU/HDU admission rate remained low for influenza.

The ICU/HDU rate for COVID-19 was at 2.43 per 100,000 in week 2 (based on data reported from 115 NHS Trusts) compared to at 2.41 per 100,000 in the previous week. There was no new influenza admission to ICU/HDU in week 2.

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 107 NHS trusts for week 2
- * COVID-19 ICU/HDU admission rate based on 115 NHS trusts for week 2

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

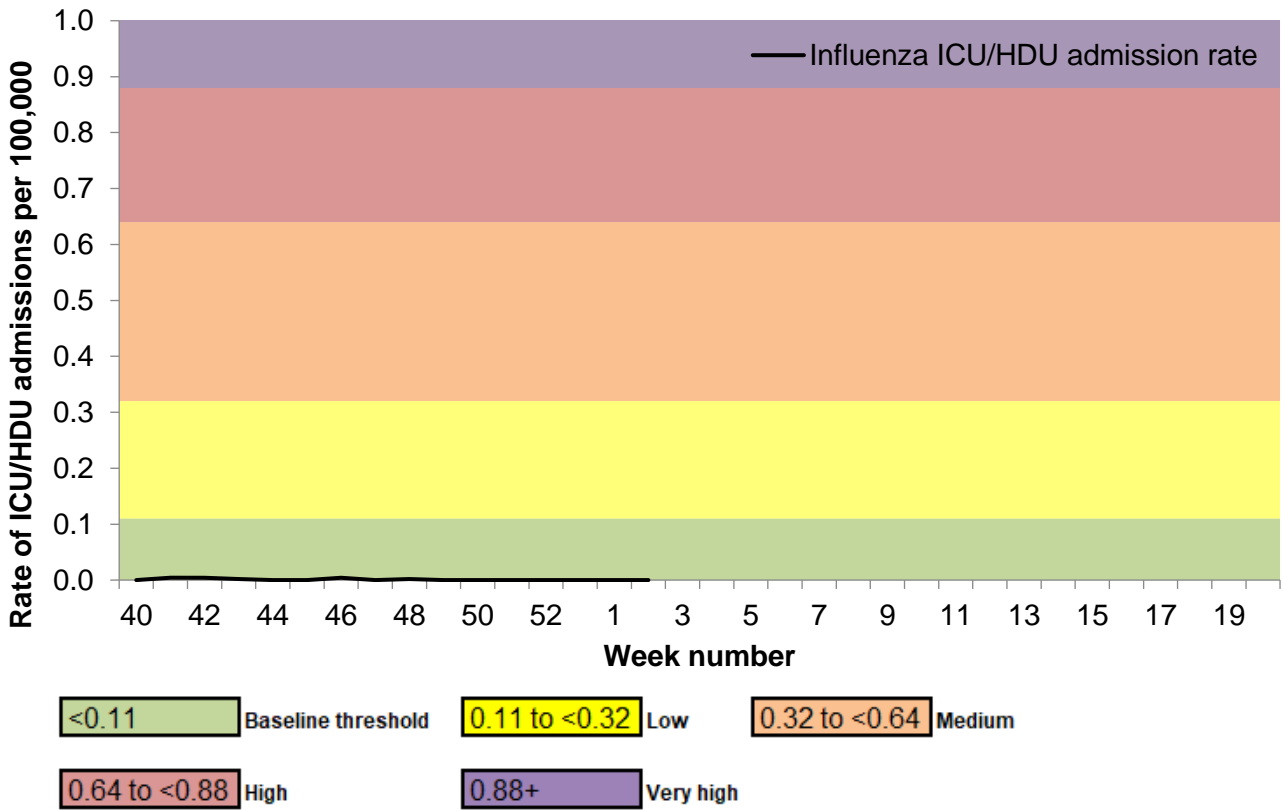


Figure 41: Weekly influenza ICU/HDU admissions by influenza type, SARI Watch, England

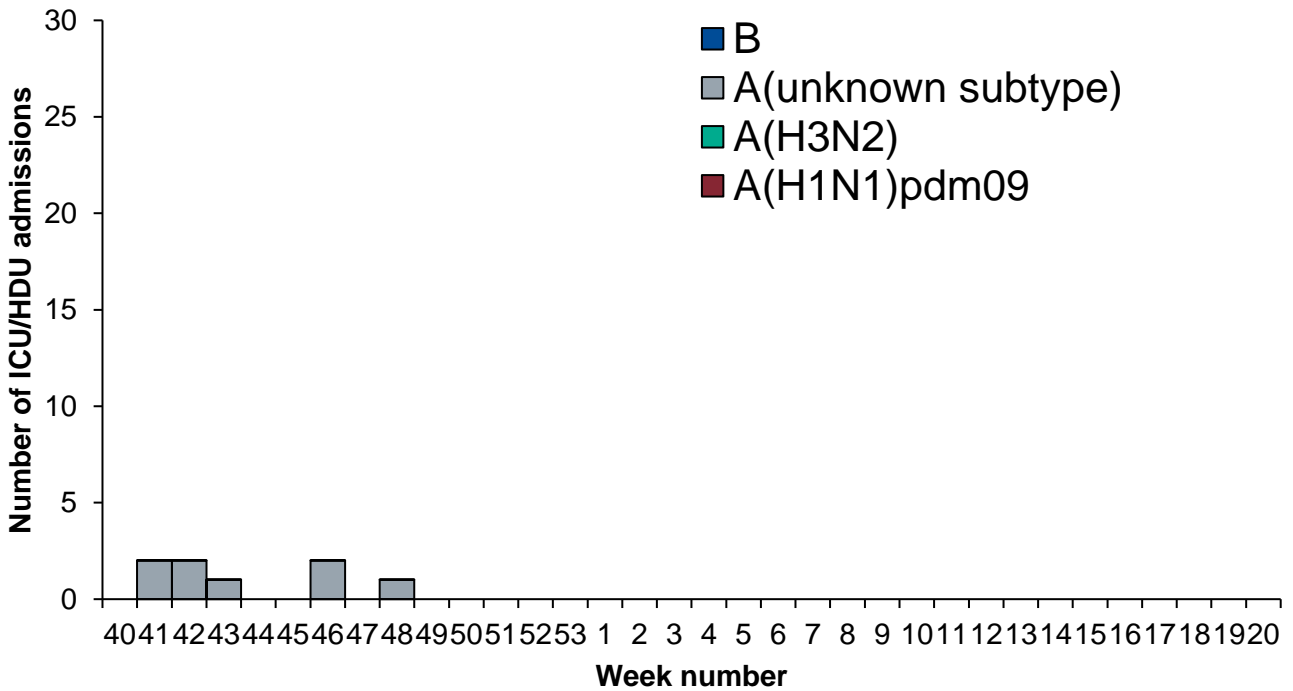


Figure 42: Weekly ICU/HDU admission rate by PHE Centre for new (a) COVID-19 positive cases and (b) influenza reported through SARI Watch

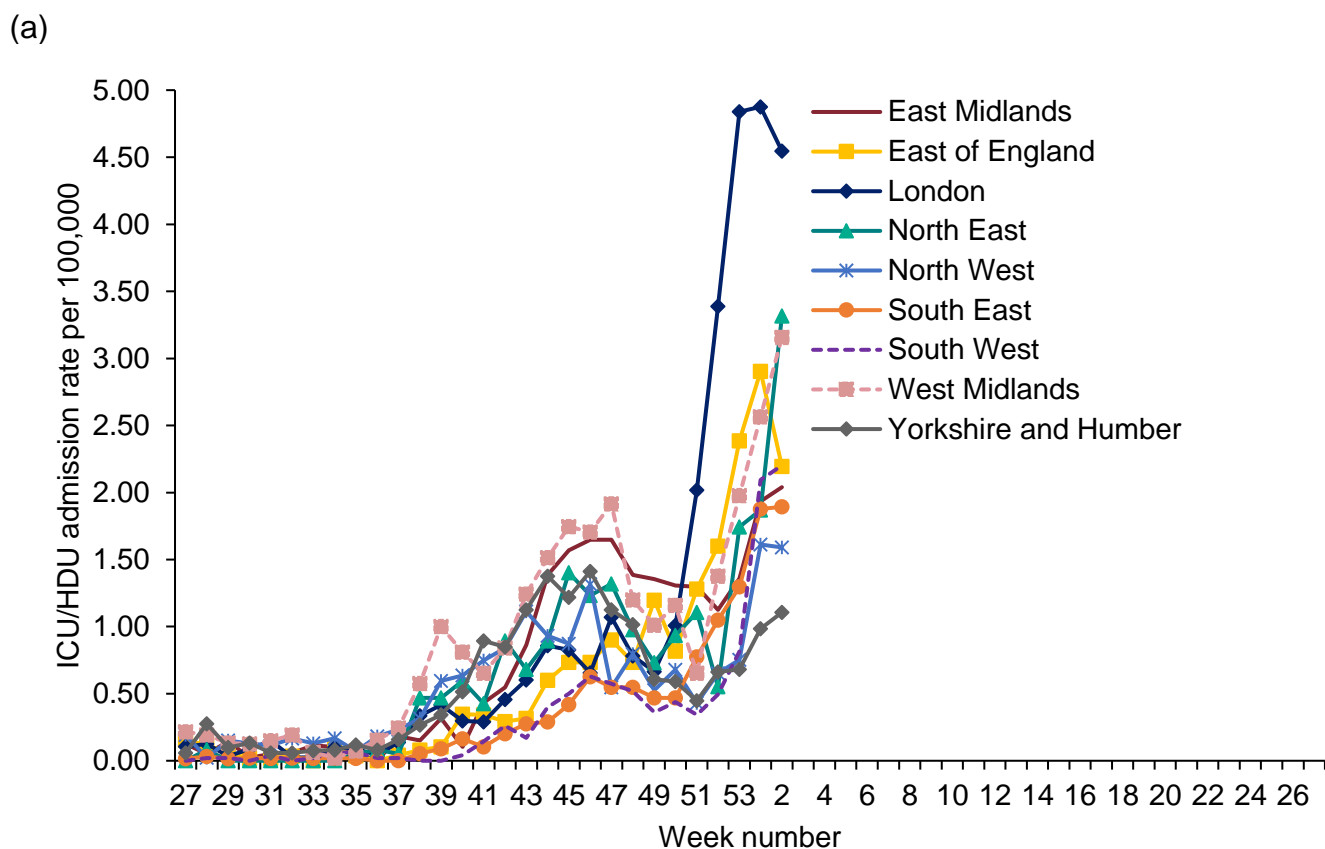
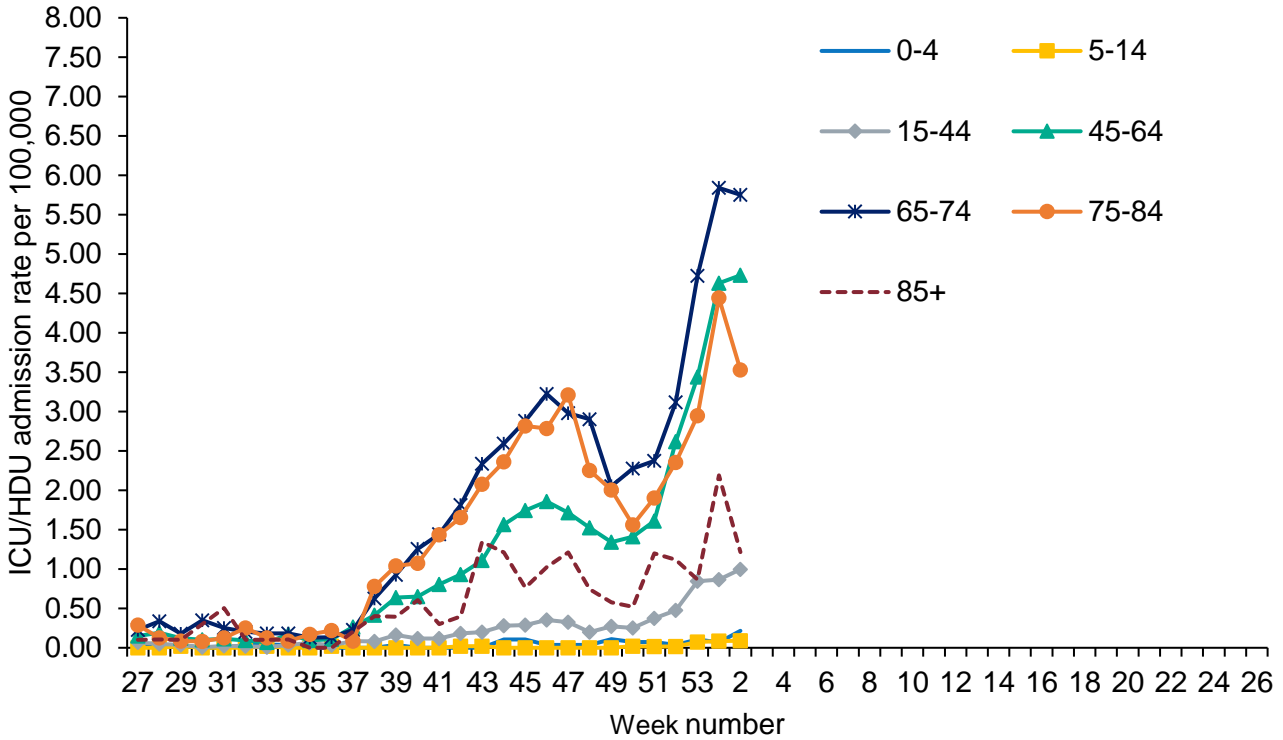
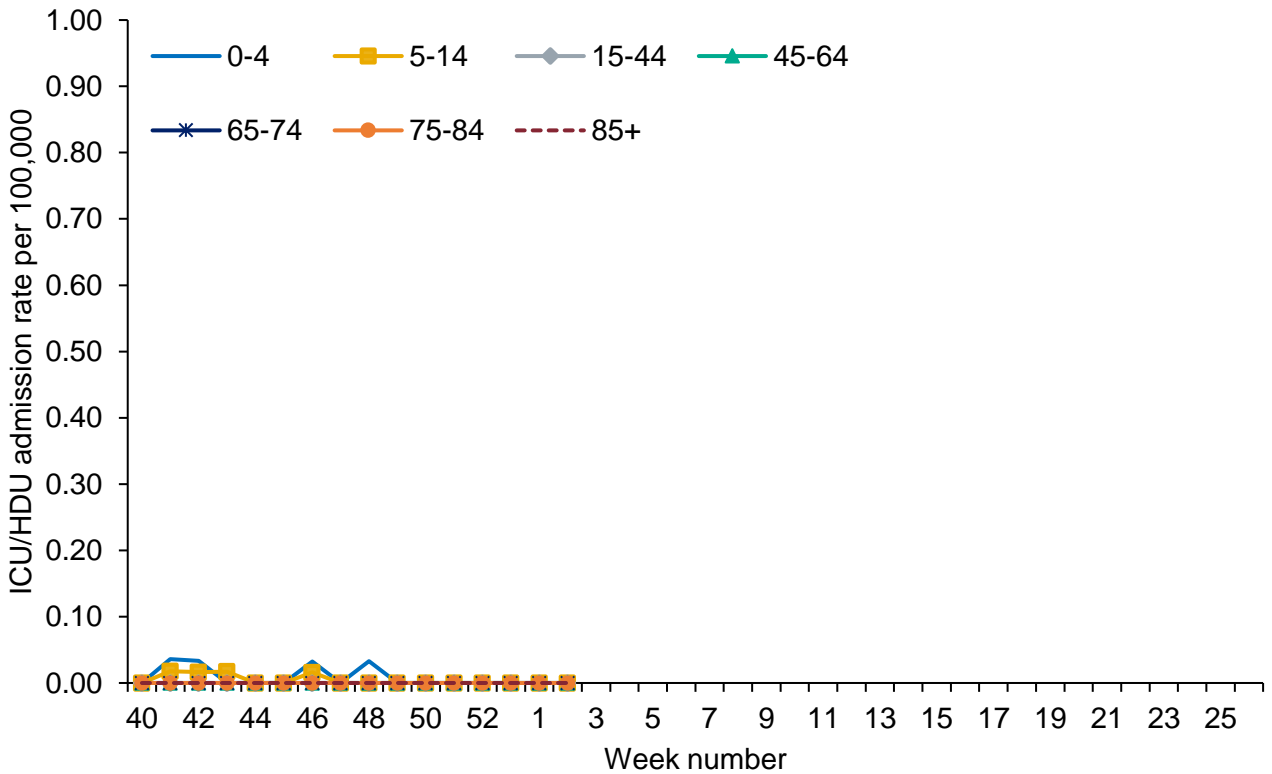


Figure 43: Weekly ICU/HDU admission rate by age group for new (a) COVID-19 positive cases and (b) influenza reported through SARI Watch

(a)



(b)

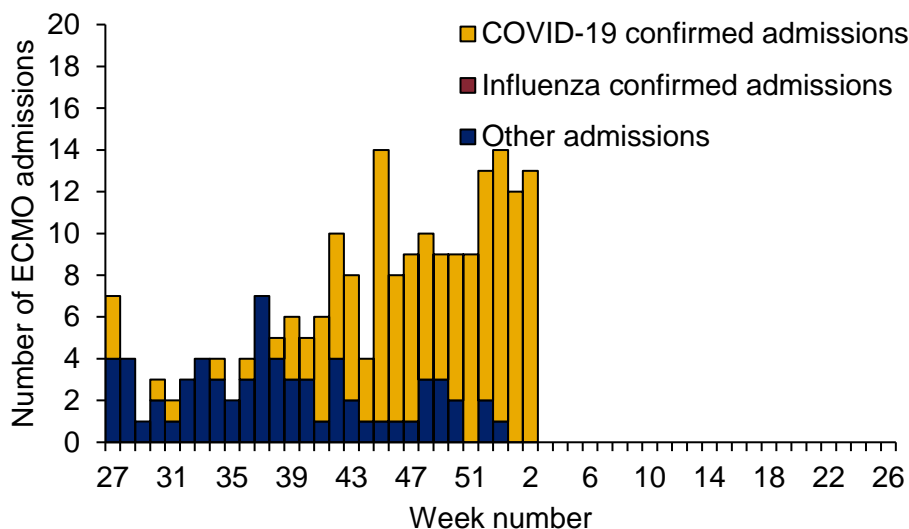


ECMO, SARI Watch

From week 27 2020, a total of 139 laboratory confirmed COVID-19 admissions have been reported from the 6 Severe Respiratory Failure (SRF) centres in the UK.

There were 13 new laboratory confirmed COVID-19 admissions reported in week 2 (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

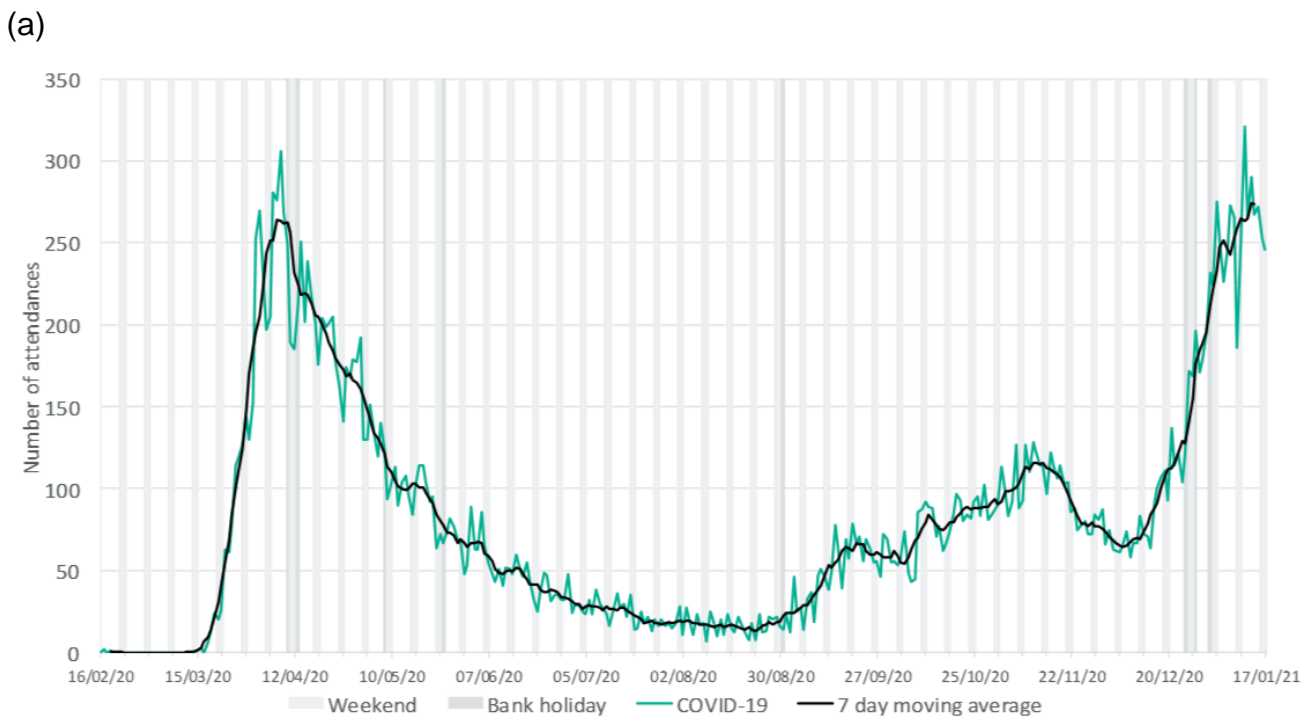
The Emergency Department Syndromic Surveillance System (EDSSS) monitors the daily visits in a network of emergency departments across England.

Up to 17 January 2021, the daily number of ED attendances for all ages as reported by 45 EDs, for COVID-19-like and acute respiratory infection increased (Figure 45).

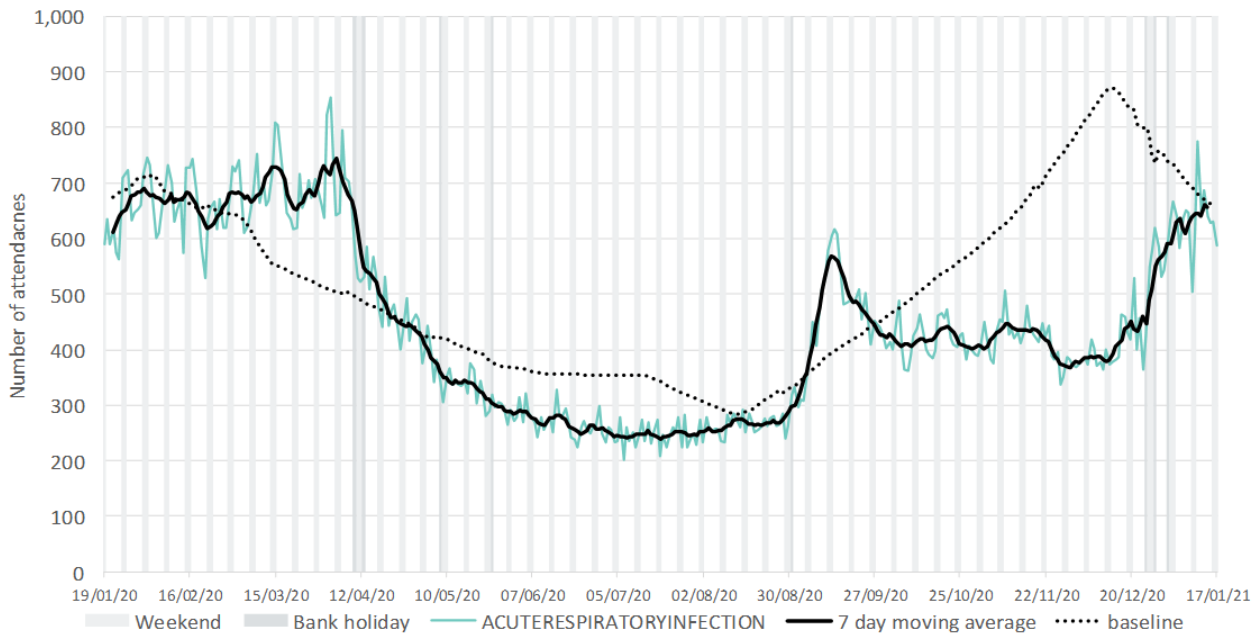
Due to a data transfer issue we are able to include a smaller than usual number of EDs and have incomplete data for 9-11 January.

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



(b)



Mortality surveillance

Cumulative COVID-19 deaths

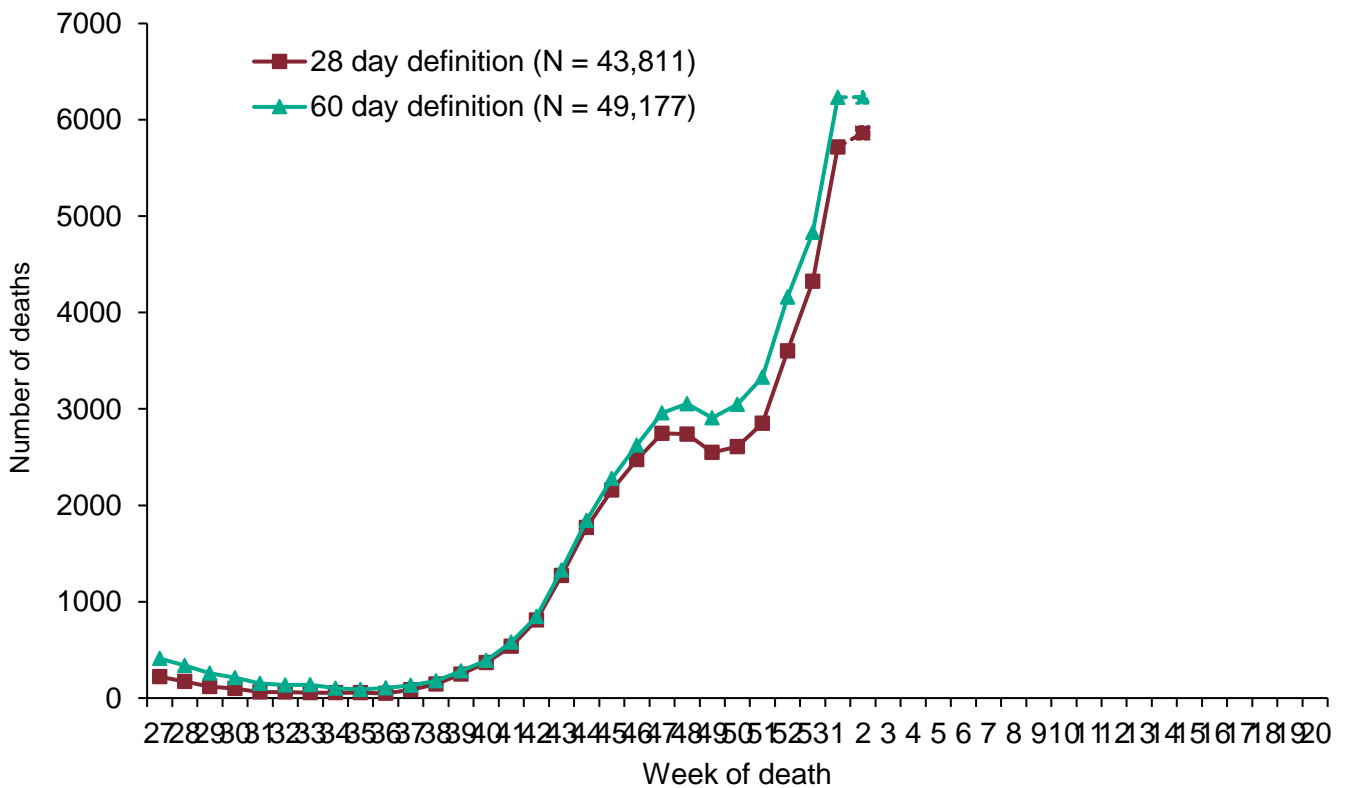
Changes to the definitions of COVID-19 related deaths in England are described in more detail in an accompanying PHE technical summary.

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 46 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

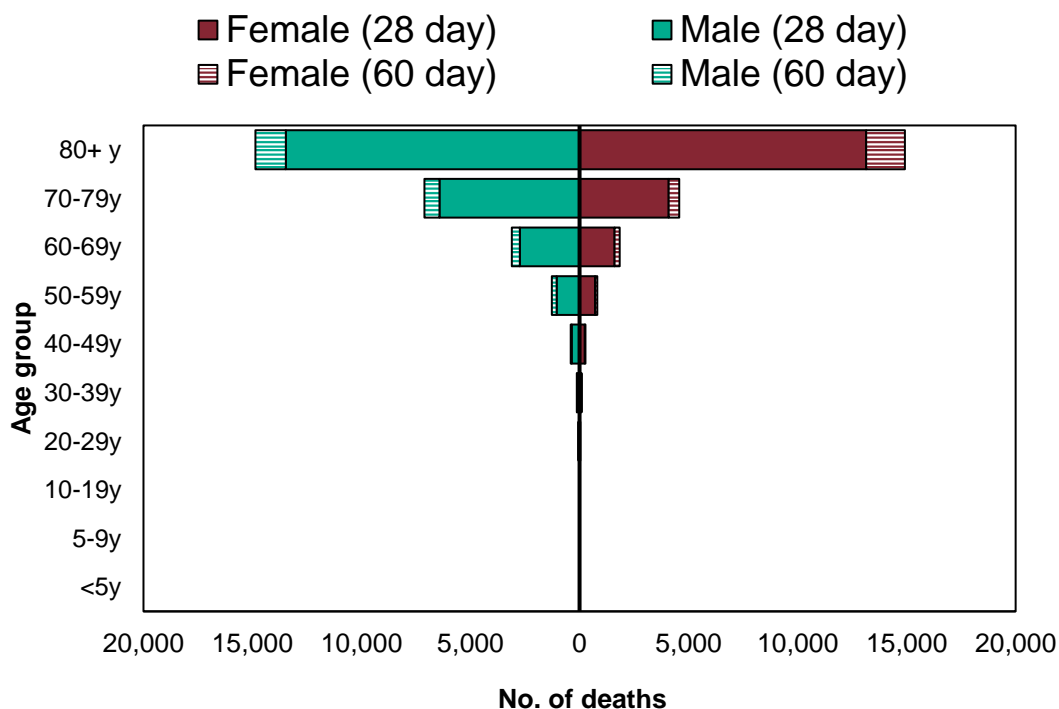


Table 5: Ethnic group (%) of COVID-19 deaths and time since laboratory confirmation of COVID-19, England

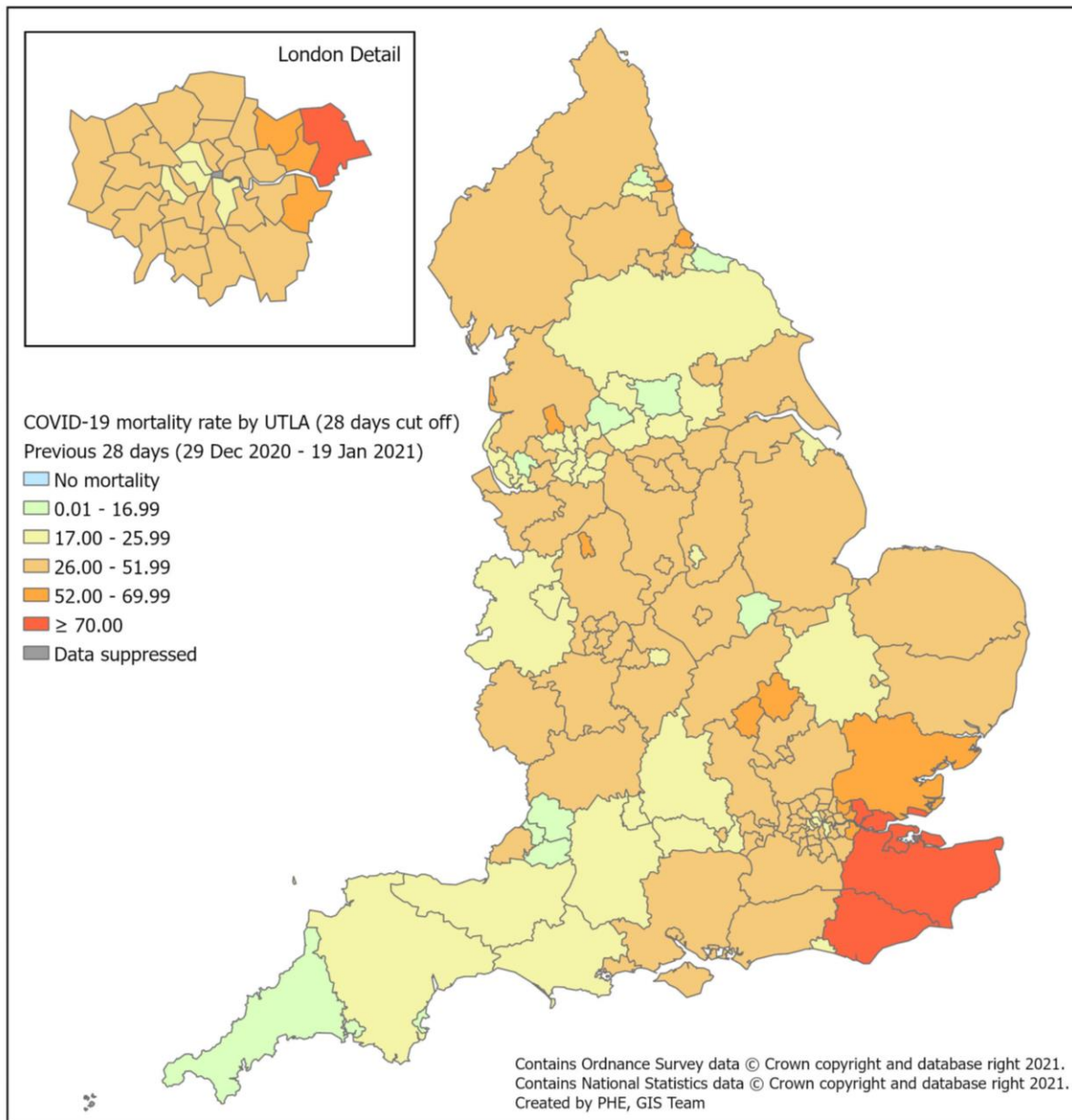
Ethnicity	28 day definition	60 day definition
White	88.9	89.1
Asian / Asian British	7.1	6.9
Black / African / Caribbean / Black British	2.2	2.1
Mixed / Multiple ethnic groups	0.4	0.4
Other ethnic group	1.4	1.4

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

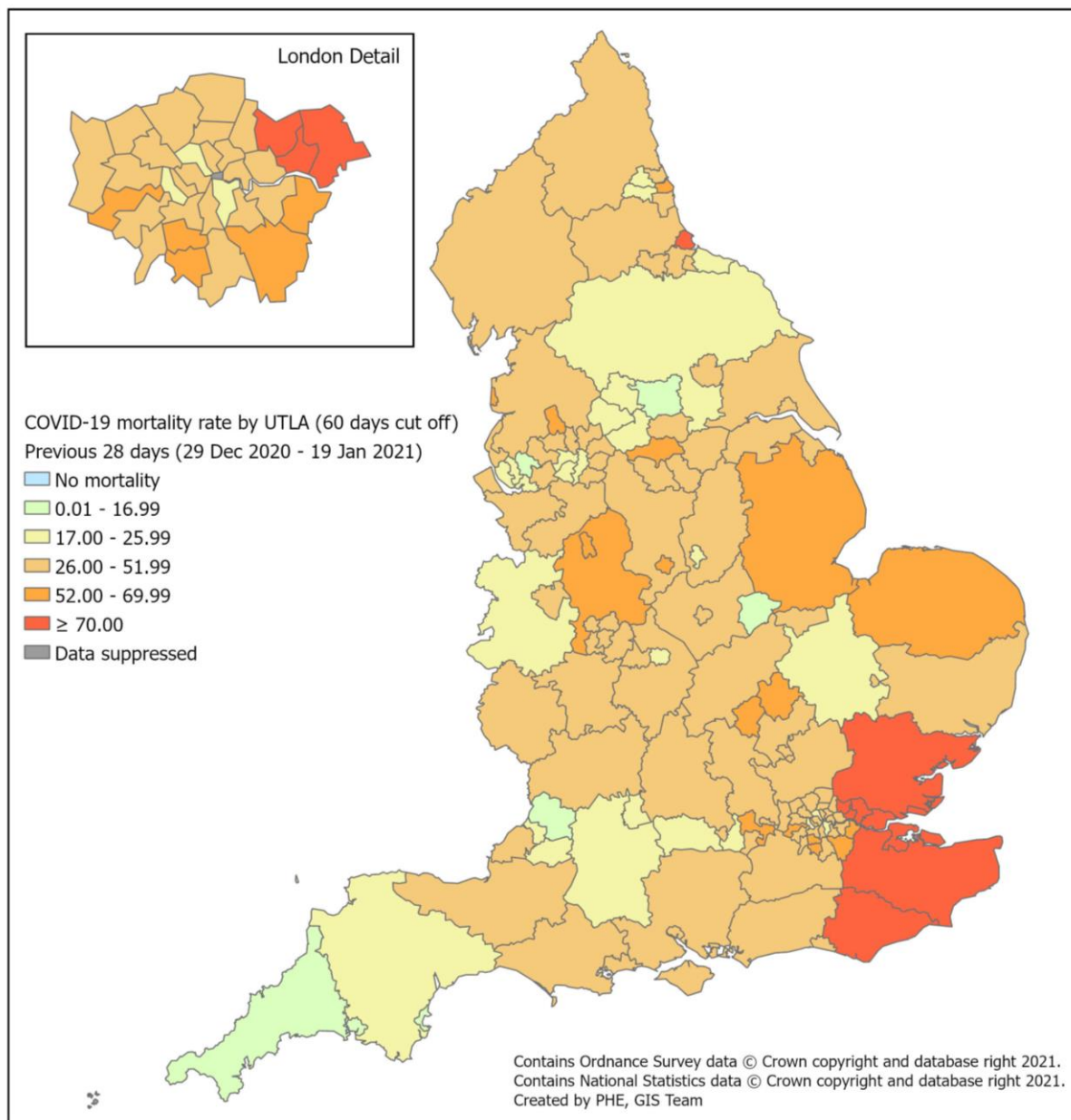
PHE Centres	28 day definition	60 day definition
North East	2,567	2,934
North West	7,467	8,617
Yorkshire & Humber	5,081	5,834
West Midlands	5,063	5,730
East Midlands	4,292	4,846
East of England	4,962	5,441
London	5,270	5,771
South East	6,517	7,179
South West	2,438	2,678

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)



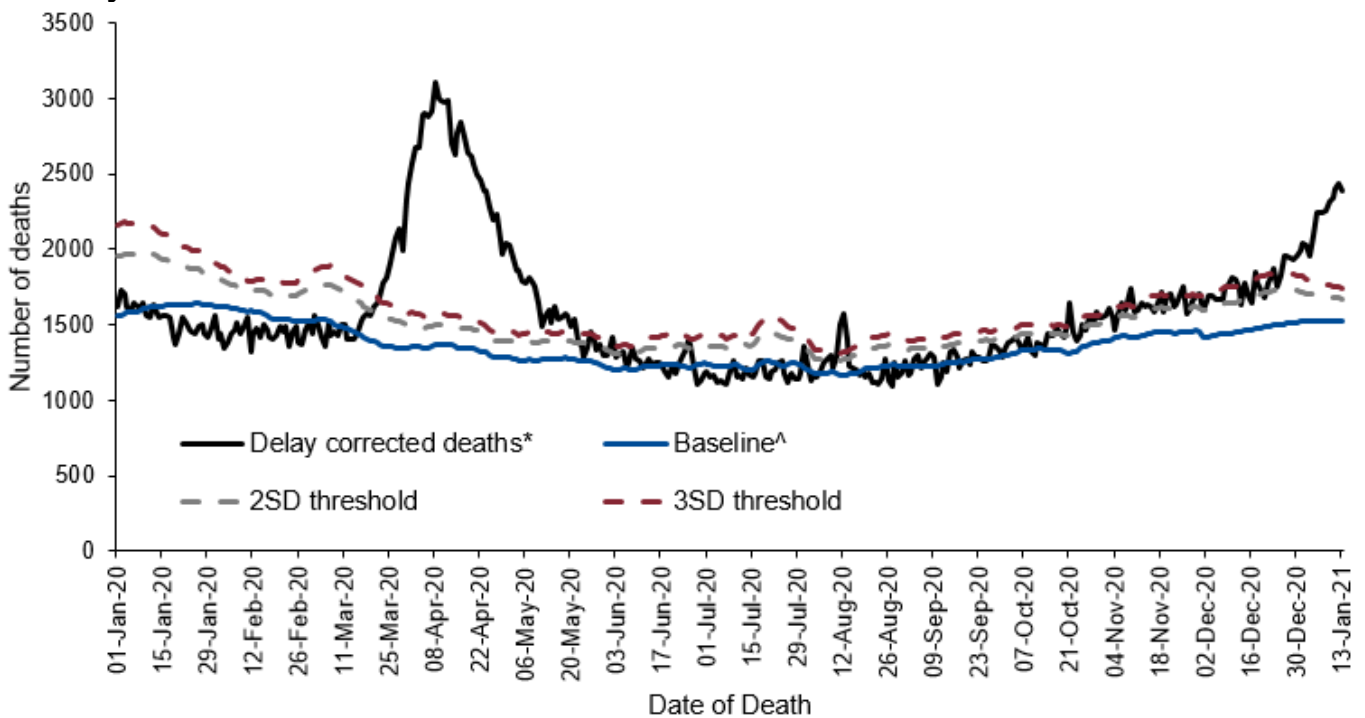
Daily excess all-cause mortality (England)

Deaths occurring from 1 January to 13 January 2021 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.

Significant excess all-cause mortality was observed in week 1 overall, by age group in the 45 to 64, 65 to 74, 75 to 74 and 85 plus year olds; and sub-nationally in East of England, East Midlands, London, North East, North West, South East and West Midlands. The excess noted in week 33 coincides with a heat wave (Figure 49, 50 and Table 7).

Figure 49: Daily excess all-cause deaths in all ages, England, 1 January 2020 to 13 January 2021



^ 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

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

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

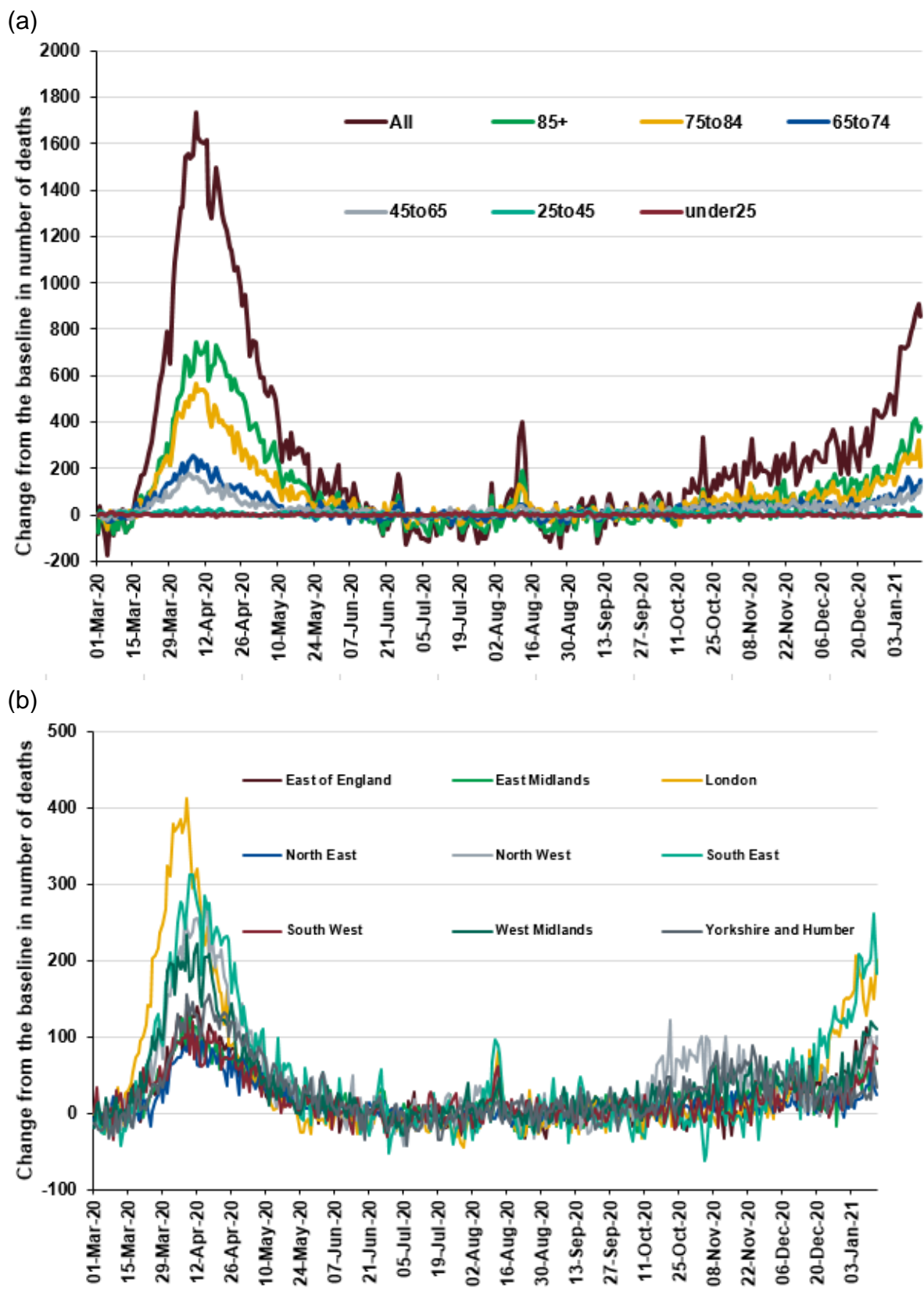
(a)

Age Group	Excess detected in week 1 2020?	Weeks in excess since week 10 2020
All	✓	13 to 21, 33, 43, 45 to 48, 50, 52 to 01
under 25	x	None
25 to 44	x	14 to 16, 38, 43
45 to 64	✓	12 to 19, 44 to 46, 48 to 49, 52 to 01
65 to 74	✓	13 to 19, 46, 53 to 01
75 to 84	✓	13 to 21, 33, 45, 49, 52 to 01
85+	✓	13 to 21, 33, 52 to 01

(b)

PHE Centres	Excess detected in week 1 2020?	Weeks in excess since week 10 2020
East of England	✓	14 to 19, 52 to 01
East Midlands	✓	13 to 19, 53 to 01
London	✓	12 to 19, 33, 51 to 01
North East	✓	14 to 21, 01
North West	✓	13 to 20, 33, 42 to 47, 01
South East	✓	13 to 21, 33, 50 to 01
South West	x	13 to 19, 33
West Midlands	✓	13 to 20, 45 to 48, 53 to 01
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 13 January 2021



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 2, 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 2, no influenza viruses were tested for antiviral susceptibility.

Antimicrobial susceptibility

Table 8 shows in the 12 weeks up to week 2 2021, 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	740	83
	Macrolides	820	74
	Tetracycline	807	76
<i>H. influenzae</i>	Amoxicillin/ampicillin	3,086	60
	Co-amoxiclav	3,435	70
	Macrolides	709	7
	Tetracycline	3,481	97
<i>S. aureus</i>	Methicillin	2,929	93
	Macrolides	3,223	71
MRSA	Clindamycin	141	41
	Tetracycline	179	74
MSSA	Clindamycin	1,903	77
	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

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 2020 and week 1 2021 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 2020 and week 1 2021 are summarised. 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 9.0% (95% CI 8.0% - 10.0%) for the period 14th Dec– 8rd January (week 51 2020 - week 1 2021). Estimates are based on 4420 samples, of which 365 were positive. This compares with 7.0% (95% CI 6.4% - 7.7%) for the period of 16th November – 13th December (weeks 47-50 2020).

Changes in seropositivity are likely to reflect the net effect of increases due to recent transmission and decreases due to antibody waning.

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.

Testing from the latest two weeks was incomplete for all regions except the South West. Recent seropositivity estimates from regions with incomplete testing are drawn from a smaller sample and should be interpreted with caution. These will be updated in future reports as testing is completed.

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. Recently there has been a rise in seropositivity to 14.2% (95% CI 11.5% - 17.3%) in week 51 2020 - week 1 2021, an increase from 9.3% (95% CI 7.8% - 11.0%) in weeks 47-50 2020. 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. The recent increases in London are likely to reflect increases in transmission which is consistent with other data sources.

Data from the North West show that seropositivity increased from 10.4% (95% CI 8.5% - 12.7%) in weeks 47-50 to 12.2% (95% CI 9.6% - 15.3%) in in week 51 2020 - week 1 2021.

In the East of England seropositivity has remained stable at 5.8% (95% CI 4.1% - 8.1%) in weeks 47-50 to compared to 5.8% (95% CI 4.2% - 8.0%) in the most recent data (week 51 2020 - week 1 2021).

Seropositivity in the South East region increased from 4.9% (95% CI 3.7% - 6.4%) for weeks 47-50 to 5.8% (95% CI 3.6% - 9.2%) in week 51 2020 - week 1 2021.

Seropositivity in the South West region increased from 3.0% (95% CI 2.1% - 4.3%) in weeks 47-50 to 5.4% (3.9% - 7.4%) in week 51 2020 - week 1 2021.

Seropositivity in the North East and Yorkshire NHS region increased from 7.4% (95% CI 5.8% - 9.4%) in weeks 47-50 to 8.5% (95% CI 6.1% - 11.6%) in week 51 2020 - week 1 2021.

Data from the Midlands show the proportion seropositive has increased from 7.1% (95% CI 5.6% - 9.1%) in weeks 47-50 to 9.3% (7.2% - 11.9%) in week 51 2020 - week 1 2021.

The variation in proportion seropositive observed in some regions is likely to be driven by changes in the precise locations of sample collection. Testing of samples was incomplete in all regions other than the South West. Despite this, the recent increases observed across most 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. As of late December, a small proportion of donors are likely to have been vaccinated, although it is not expected to affect the results yet due to the lag time to produce a serological response.

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 10.8% (95% CI 9.1% - 12.9%) in weeks 47-50 to 13.4% (95% CI 10.6% - 16.8%) in weeks 51-2021 - 01. Seropositivity has increased in recent weeks across all age groups except the 60-69 year olds.

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

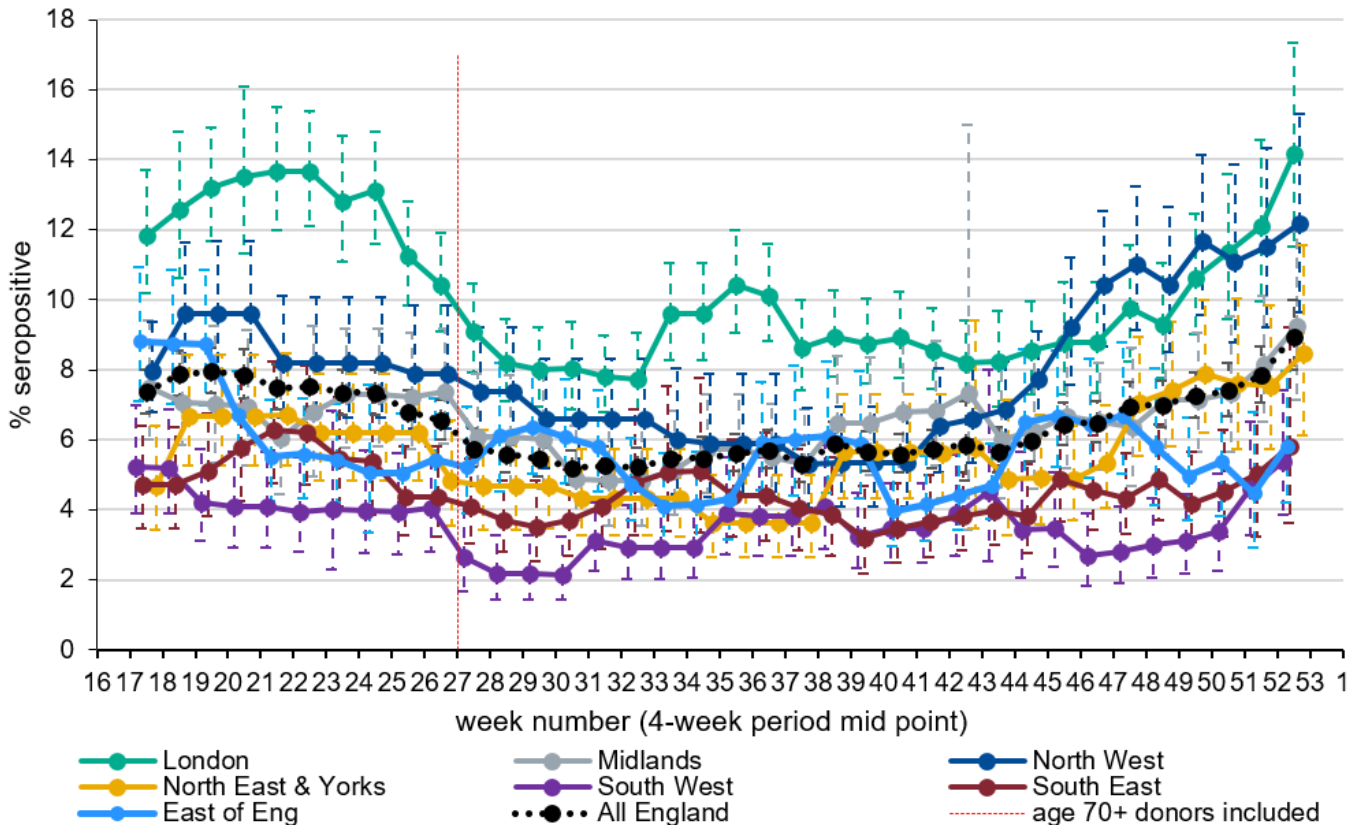
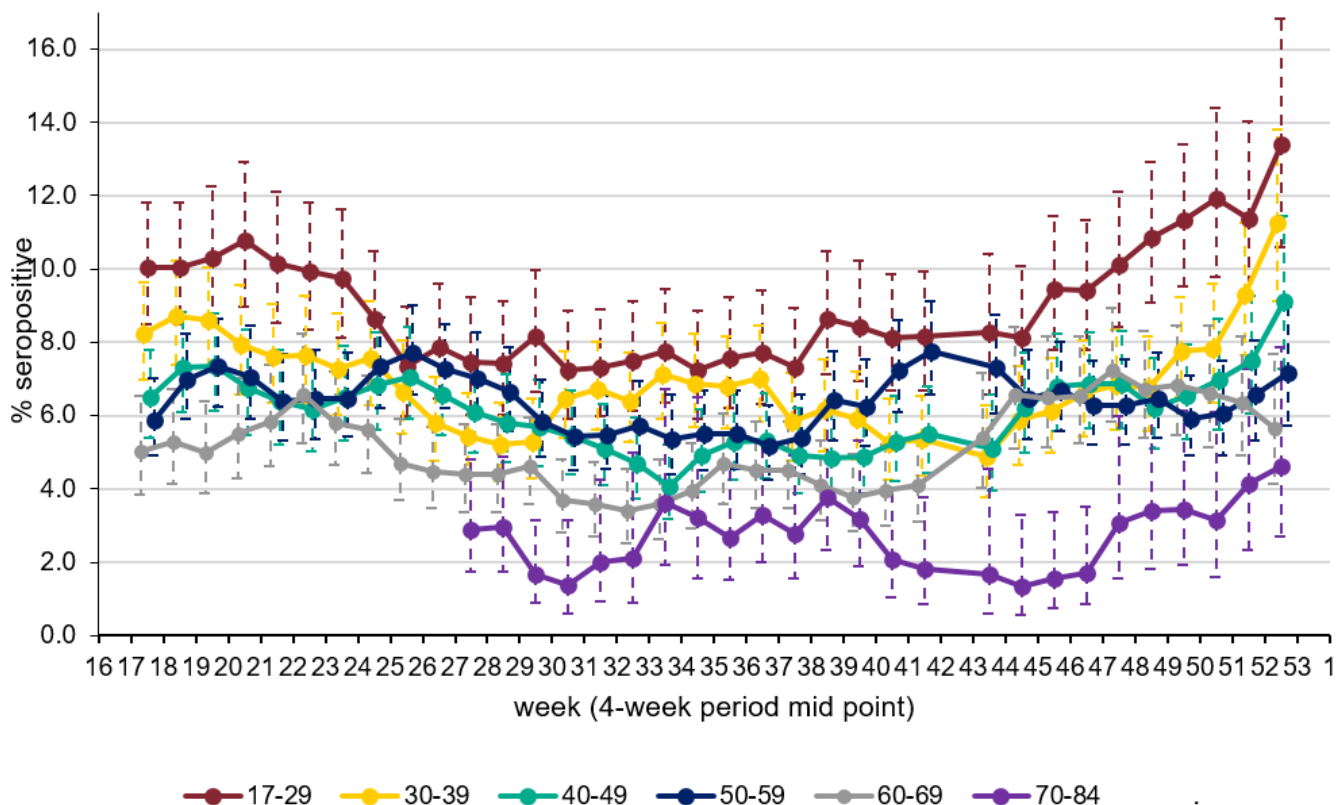


Figure 52: Population weighted 4-weekly rolling SARS-CoV-2 antibody seroprevalence (% seropositive) in blood donors by age group, using Euroimmun test; error bars show 95% confidence intervals



Influenza vaccination

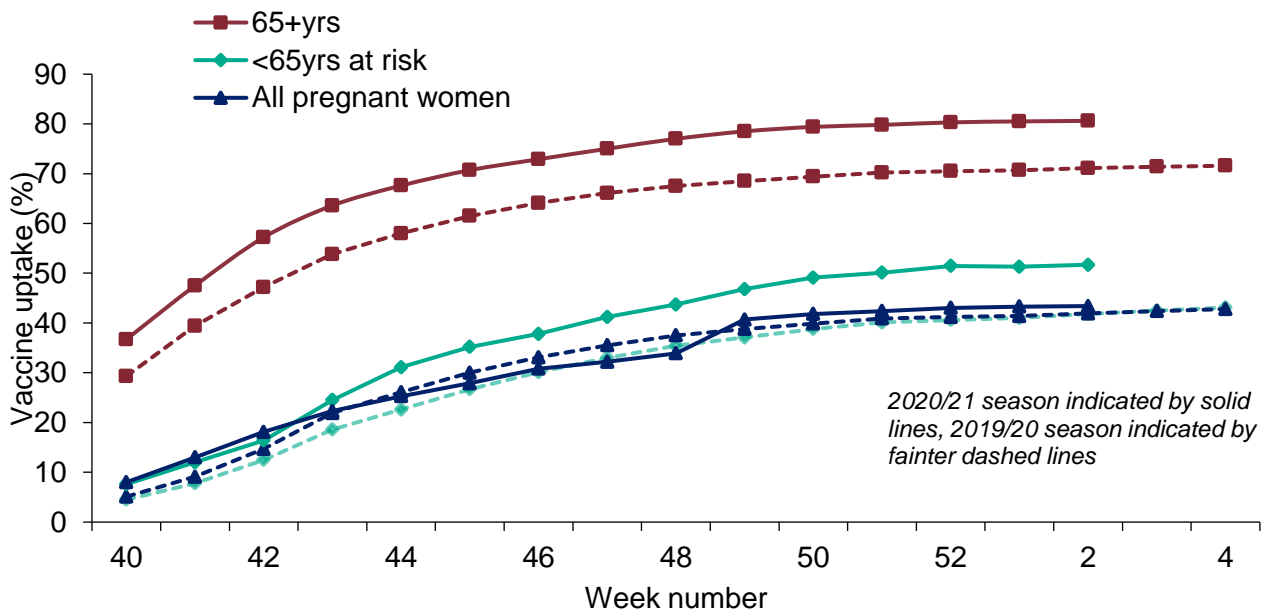
Influenza vaccine uptake in GP patients

Up to week 2 2021 in 95.6% 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):

- 51.7% in under 65 years in a clinical risk group
- 43.4% in pregnant women
- 80.6% in 65+ year olds
- 30.9% in those aged 50-64 who are not in a clinical risk group

There has been an issue with the denominator data submitted for the clinical risk groups by one of the GP system suppliers. This is likely leading to a slight underestimation of coverage for the under 65 at risk cohort this week. This is being investigated and will be corrected as soon as possible

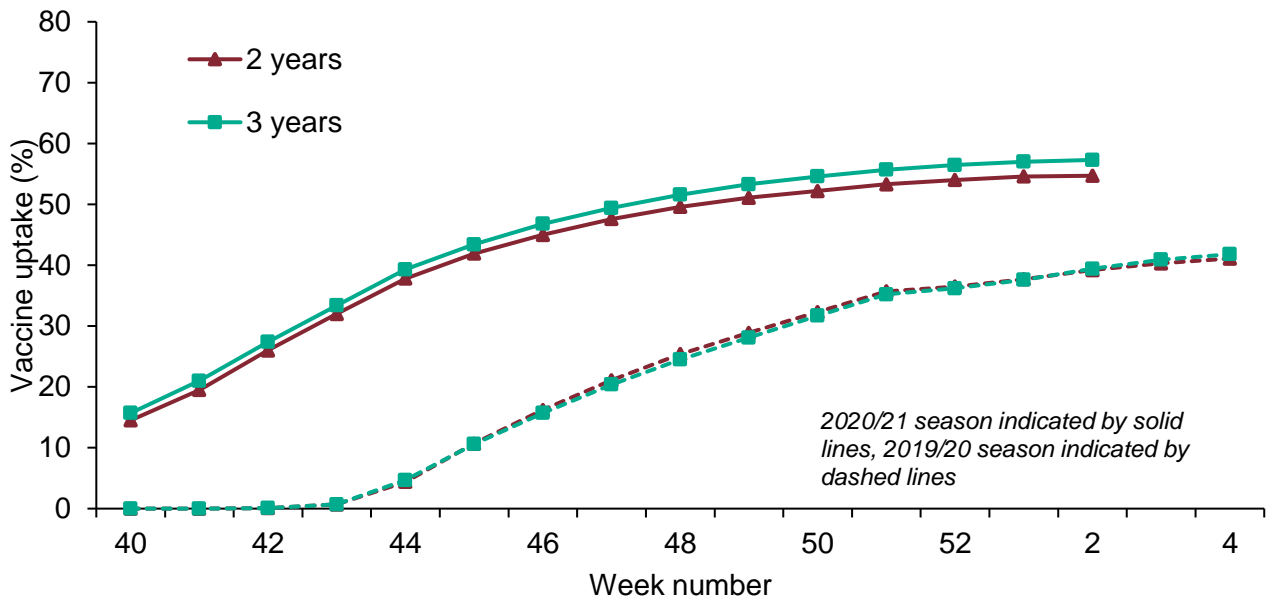
Figure 53: Cumulative weekly influenza vaccine uptake by target group in England



In 2020/21, all 2 and 3 year olds continue to be eligible for influenza vaccination through their GPs. Up to week 2 2021, in 95.6% 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):

- 54.7% in 2 year olds
- 57.3% 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 30 November)	
	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 19 January 2021, 95,651,364 cases of COVID-19 infection have been reported worldwide, including 2,039,034 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

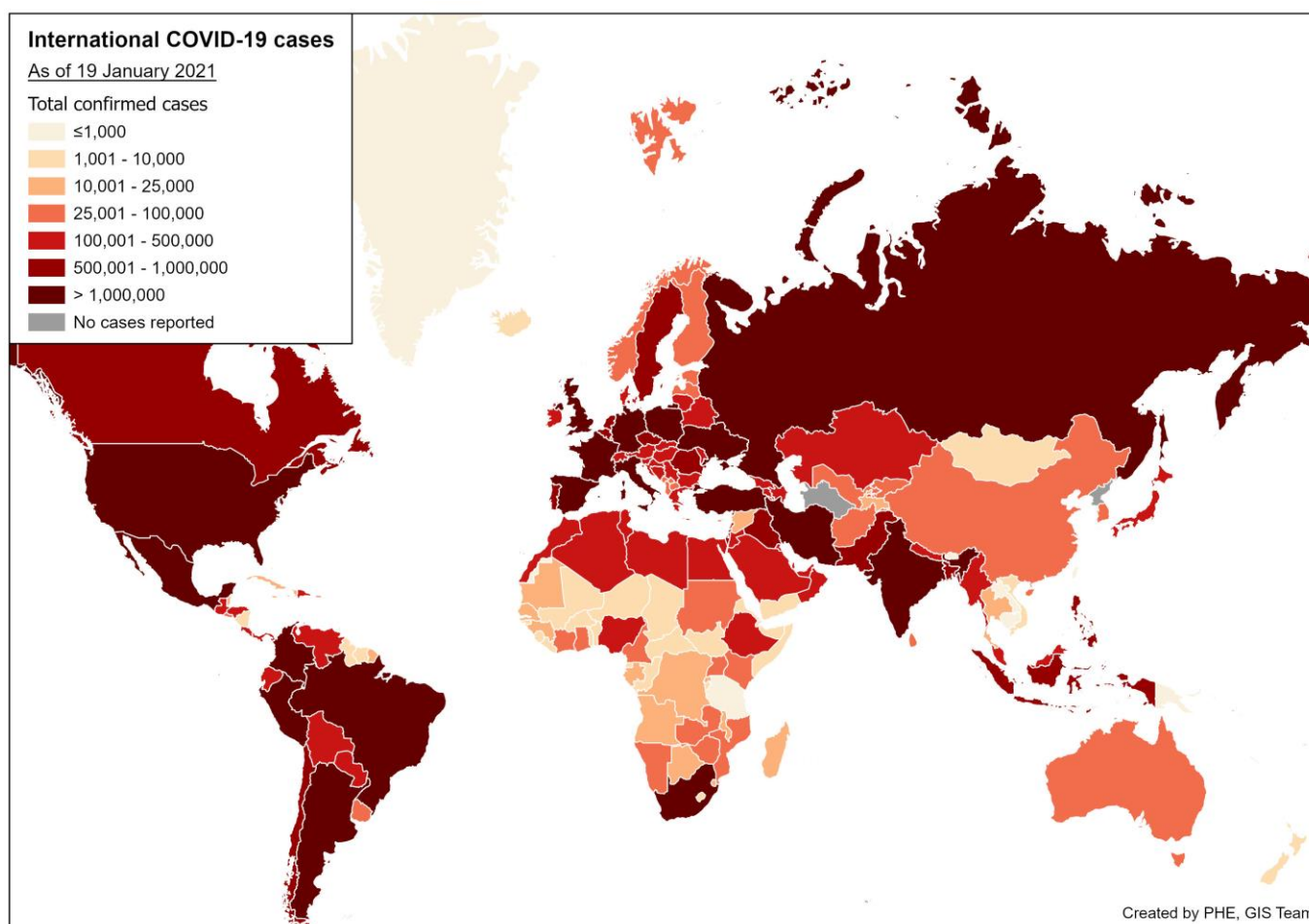
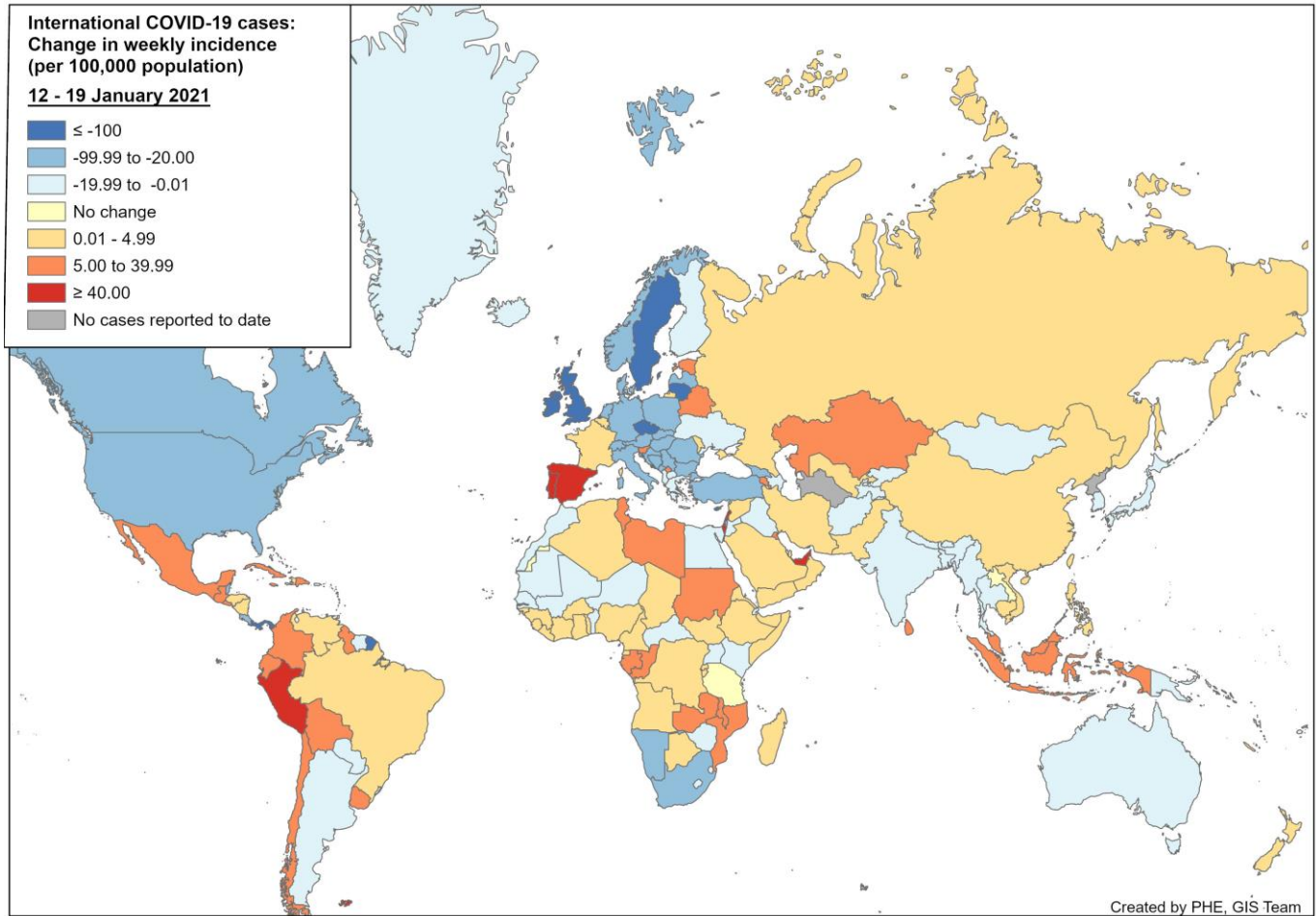


Figure 56: Global map of change in weekly COVID-19 case incidence rate per 100,000 population compared to the previous week



Please note, this map replaces the global map of weekly incidence rates per 100,000 which was presented in previous reports.

Global influenza update

Updated on 12 January 2021 (based on data up to 20 December 2020) ([WHO website](#))

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 B detections accounted for the majority of the very low numbers of detections reported.

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, no influenza detections were reported across reporting countries.

In Northern Africa, there were no influenza reports for this period.

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, no influenza detections were reported.

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

In tropical Africa, influenza activity continued to be reported in Western Africa.

In Southern Asia, sporadic influenza detections were reported in India.

In South East Asia, influenza detections of predominately influenza A(H3N2) continued to be reported in Lao People's Democratic Republic (PDR) and Viet Nam.

The WHO GISRS laboratories tested more than 188,383 specimens between 7 December 2020 and 20 December 2020. A total of 379 specimens were positive for influenza viruses, of which 141 (37.2%) were typed as influenza A and 238 (62.8%) as influenza B. Of the sub-typed influenza A viruses, 8 (13.6%) were influenza

A(H1N1)pdm09 and 51 (86.4%) were influenza A(H3N2). Of the characterized B viruses, 1 (1.5%) belonged to the B-Yamagata lineage and 64 (98.5%) to the B-Victoria lineage.

Influenza in Europe

Updated on 19 January 2021 ([Joint ECDC-WHO Europe Influenza weekly update](#))

For week 1 2021, influenza activity remained at interseasonal levels throughout Europe.

Of 36 countries and areas that reported on the intensity of activity indicator, 31 reported activity at baseline levels, and 5 (Azerbaijan, Estonia, Lithuania, Serbia, and Slovakia) reported low intensity for week 01 2021. Of 37 countries and areas that reported on geographic spread, 32 reported no activity and 5 (Azerbaijan, Denmark, Lithuania, Portugal, and Slovakia) reported sporadic spread for week 01 2021.

For week 01 2021, of 872 sentinel specimens tested for influenza viruses, none were positive. Since the start of the season, of 14 004 sentinel-source specimens that have been tested for influenza viruses, 8 were positive: 2 type A and 6 type B viruses.

There were no hospitalized laboratory-confirmed influenza cases in ICUs reported for week 01 2021. Since the start of the season, there have been 10 hospitalized laboratory-confirmed influenza cases in ICUs

There were no laboratory-confirmed influenza cases in wards outside ICUs reported for week 01 2021.

Influenza in the Northern Hemisphere

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 19 January 2021 ([WHO website](#))

Up to 19 January 2021, 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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Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-leading science, research, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health and Social Care, and a distinct delivery organisation with operational autonomy. We provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific and delivery expertise and support.

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