Public Health England

Protecting and improving the nation's health

Weekly national Influenza and COVID-19 surveillance report

Week 15 report (up to week 14 data)
15 April 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 14 (between 5 and 11 April 2021) and for some indicators daily data up to 13 April 2021.

Rollout of the COVID-19 vaccination programme began in week 50. Social and physical distancing measures, including school closures, were introduced in week 1. Some measures were relaxed in week 10, including reopening schools. School holidays occurred during weeks 13, 14 or 15 for the majority of schools.

Surveillance indicators suggest that at a national level COVID-19 activity decreased in week 14 of 2021. There is currently limited testing for other respiratory viruses, however, laboratory indicators suggest that influenza activity is low.

Please note, from this week's report the way cases are reported has changed, please see page 6 for further details.

Overall case rates continued to decrease in week 14, with decreases in case rates seen in all age groups, regions and ethnic groups. Overall Pillar 1 and Pillar 2 positivity decreased slightly compared to the previous week.

There have been large decreases in reported acute respiratory incidents in over the past 2 weeks. SARS-CoV-2 was identified in the majority of these.

COVID-19 hospitalisations decreased further in week 14 and has been decreasing since week 2. Deaths with COVID-19 decreased further in week 14 and has been decreasing since week 3. This continued decrease is likely to reflect the impact of both social and physical distancing measures and the vaccination programme.

COVID-19 vaccine coverage was 43.8% for dose 1 at the end of week 14, reaching over 90% in all cohorts over the age of 65 years and over 80% in all cohorts over 50 years. COVID-19 vaccine coverage was 10.5% for dose 2 at the end of week 14.

The impact of the vaccination programme is particularly notable in the seroprevalence data which indicates that around 53.7% of the population have antibodies to SARS-CoV-2 from either infection or vaccination, compared to 15% from infection alone. Differences in seropositivity for vaccination or infection versus infection alone are most notable in the older age groups. In the 70-84 years age group around 97.7% had antibodies from either infection or vaccination compared to 4.8% from infection alone.

Through Respiratory Datamart, there was one influenza positive sample detected in week 14, which was an influenza A(H3N2). Other indicators for influenza such as hospital admissions and GP influenza-like illness consultation rates remain low. Decreases in rhinovirus activity were noted this week after increases in activity over the previous 4 weeks.

Contents

Laboratory surveillance

Confirmed COVID-19 cases (England)

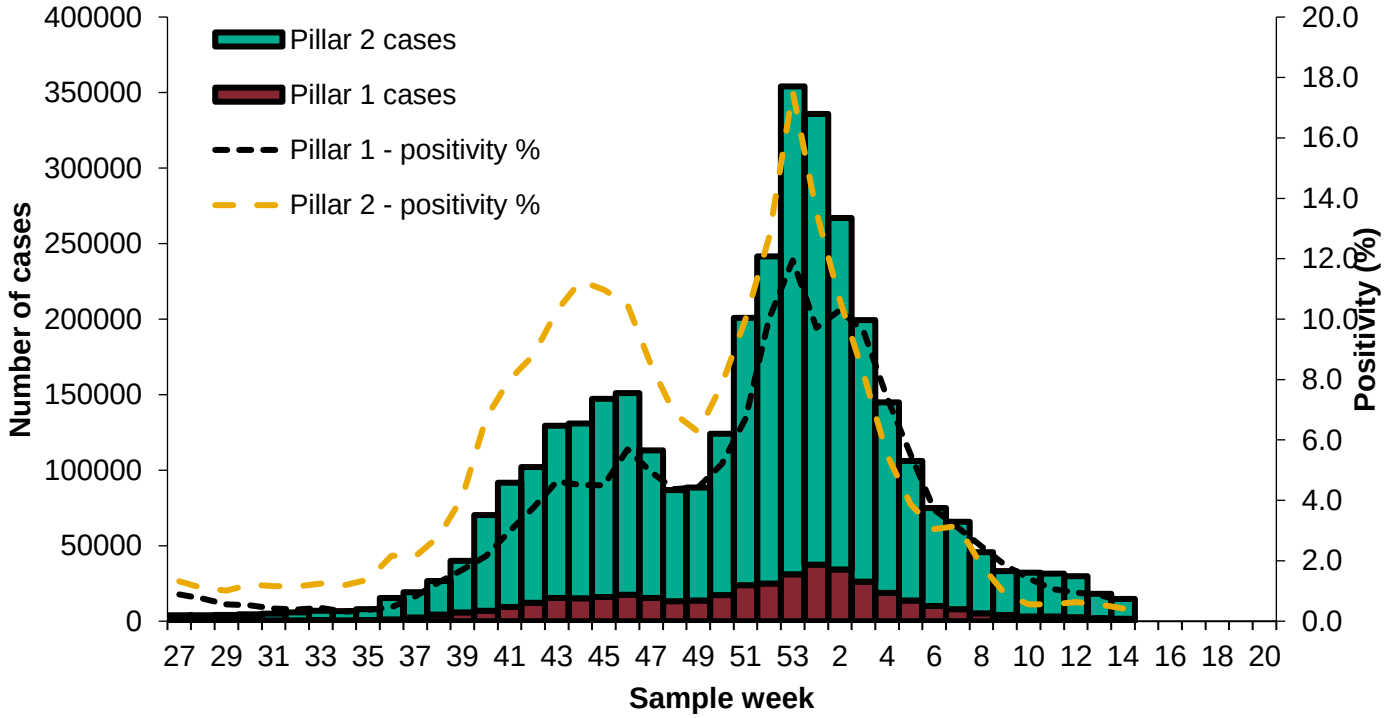
As of 09:00 on 13 April 2021, a total of 3,824,441 have been confirmed positive for COVID-19 in England under Pillars 1 and 2.

Overall case numbers decreased in week 14. Case rates are decreasing in all age groups, regions and ethnic groups. Pillar 1 and Pillar 2 positivity both decreased slightly compared to the previous week.

Data on variants of concern or under investigation are available here and here.

Please note, there has been a change to the way cases are reported from this week's report onwards. Cases that have been identified through a positive rapid lateral flow device (LFD) test will be removed if the individual took Polymerase Chain Reaction (PCR) tests within 3 days that were all negative. This change has been applied retrospectively back to 1 November 2020, so you may notice slight decreases in retrospective figures. From now on, individuals that have positive LFDs with all subsequent PCR tests within 3 days showing negative results will be removed on a rolling basis. This is most likely to impact the case numbers for the most recent week, which may see slight decreases in following weeks' reports. Some changes to earlier weeks might occur based on delayed reporting.

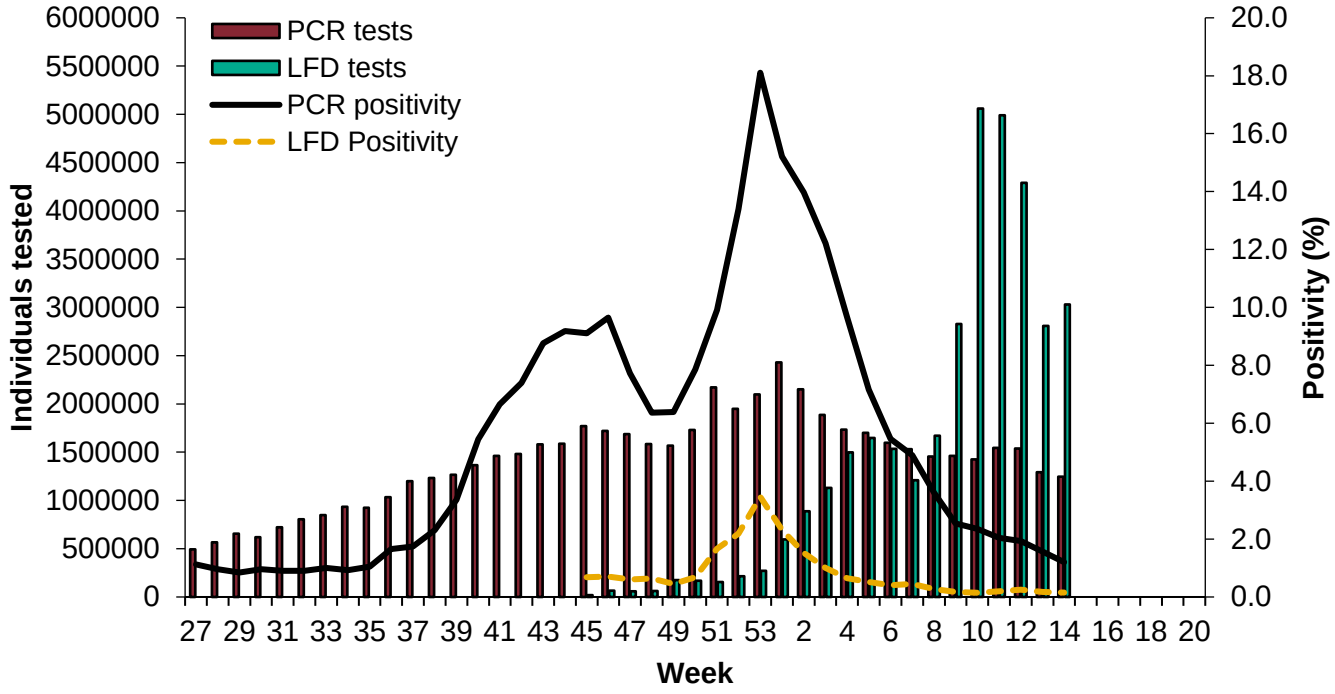
Figure 1: Confirmed COVID-19 cases tested under Pillar 1 and Pillar 2, based on sample week with overall weekly positivity for Pillars 1 and 2 (%)



*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 (excluding Figure 2) 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 and lateral flow device (LFD) testing.

Figure 2: Weekly positivity (%) of confirmed COVID-19 and number of individuals tested by type of test, under Pillar 1 and 2 (SGSS and Respiratory DataMart)

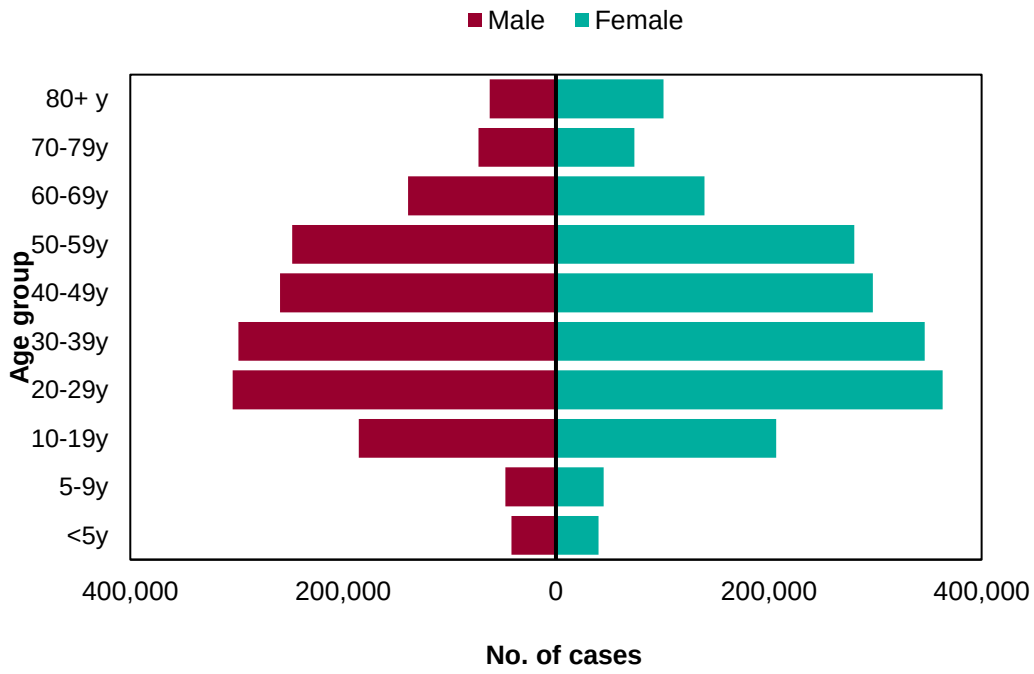


*For Figure 2 positivity is calculated as the number of individuals testing positive using a specific test type during the week, divided by the number of individuals tested using that specific test type during the week.
*Please note that an individual may appear under both PCR and LFD tests if they have been tested using both test types in a given week.

Age and sex

Figure 3: Age/sex pyramids for confirmed COVID-19 cases tested under Pillars 1 and 2 (a) cumulative number since week 27 (n=3,552,283), and (b) in weeks 13 and 14 (n=32,441)

(a)



(b)

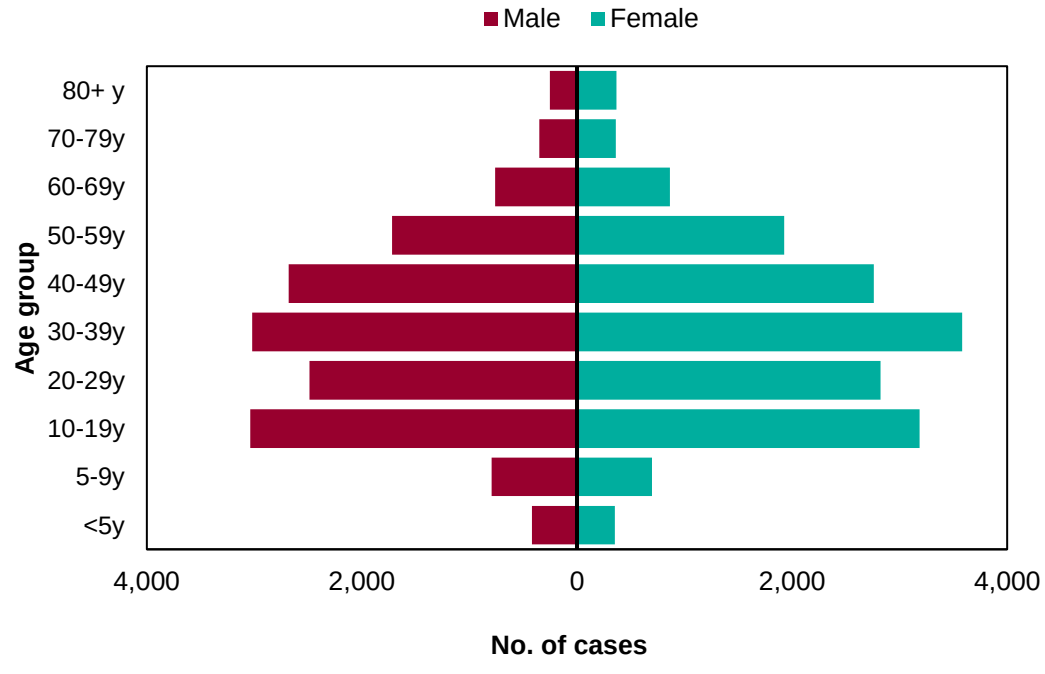


Figure 4: Weekly confirmed COVID-19 case rates per 100,000, tested under Pillar 1 and Pillar 2, by sex

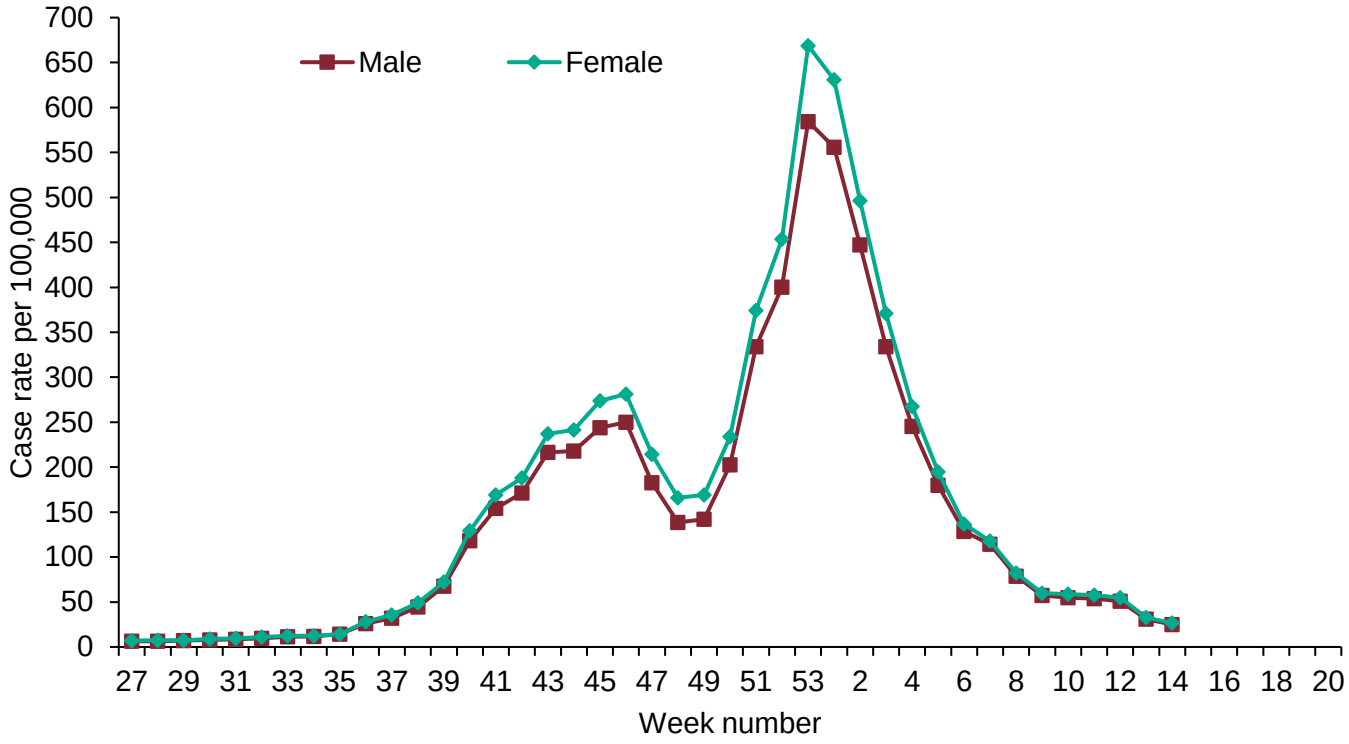


Figure 5: Weekly confirmed COVID-19 case rates per 100,000, tested under Pillar 1 and Pillar 2, by age group

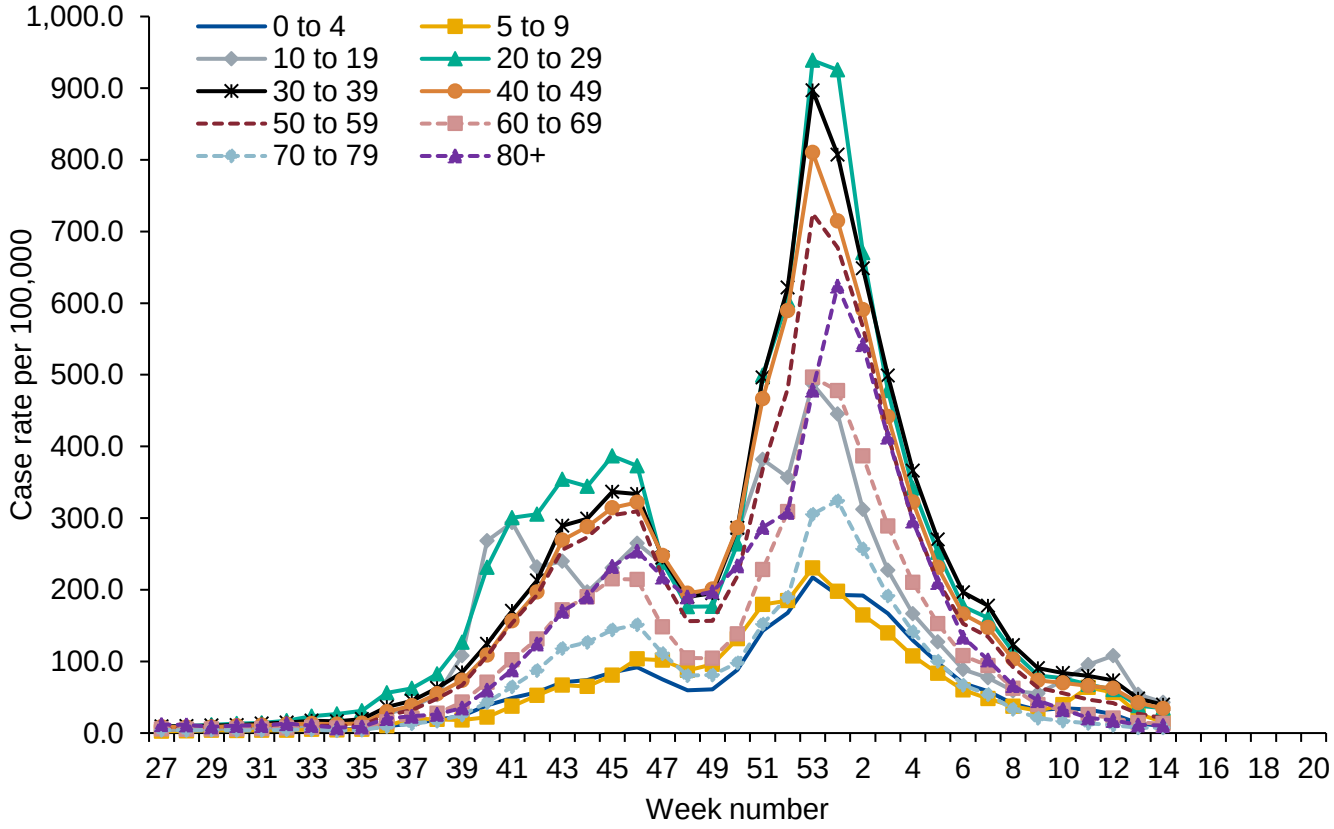
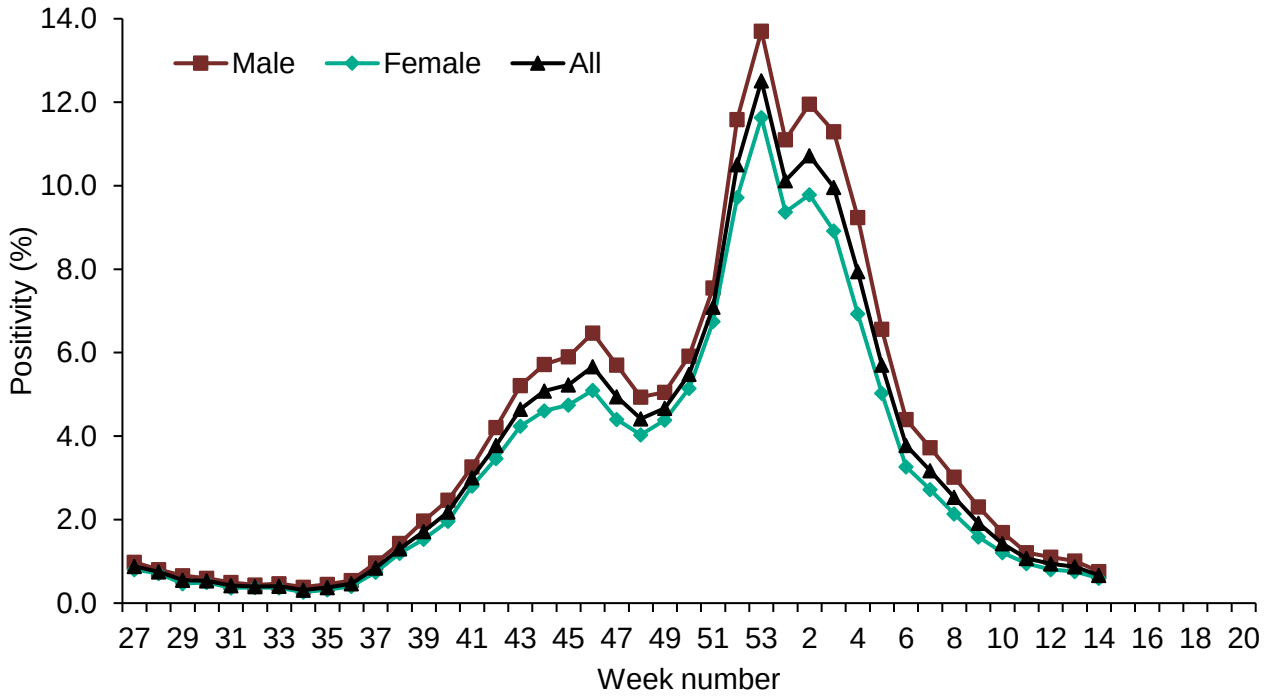


Figure 6: Weekly positivity (%) of confirmed COVID-19 cases tested overall and by sex under (a) Pillar 1 and (b) Pillar 2, (SGSS and Respiratory DataMart)

(a)



(b)

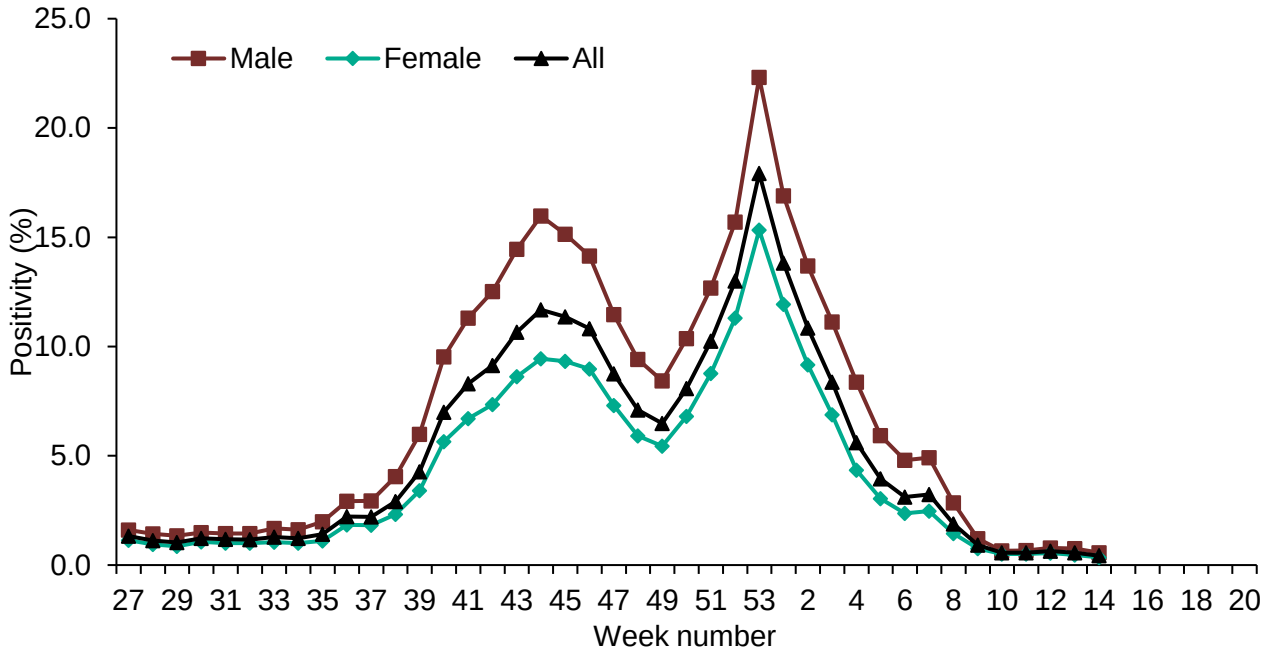
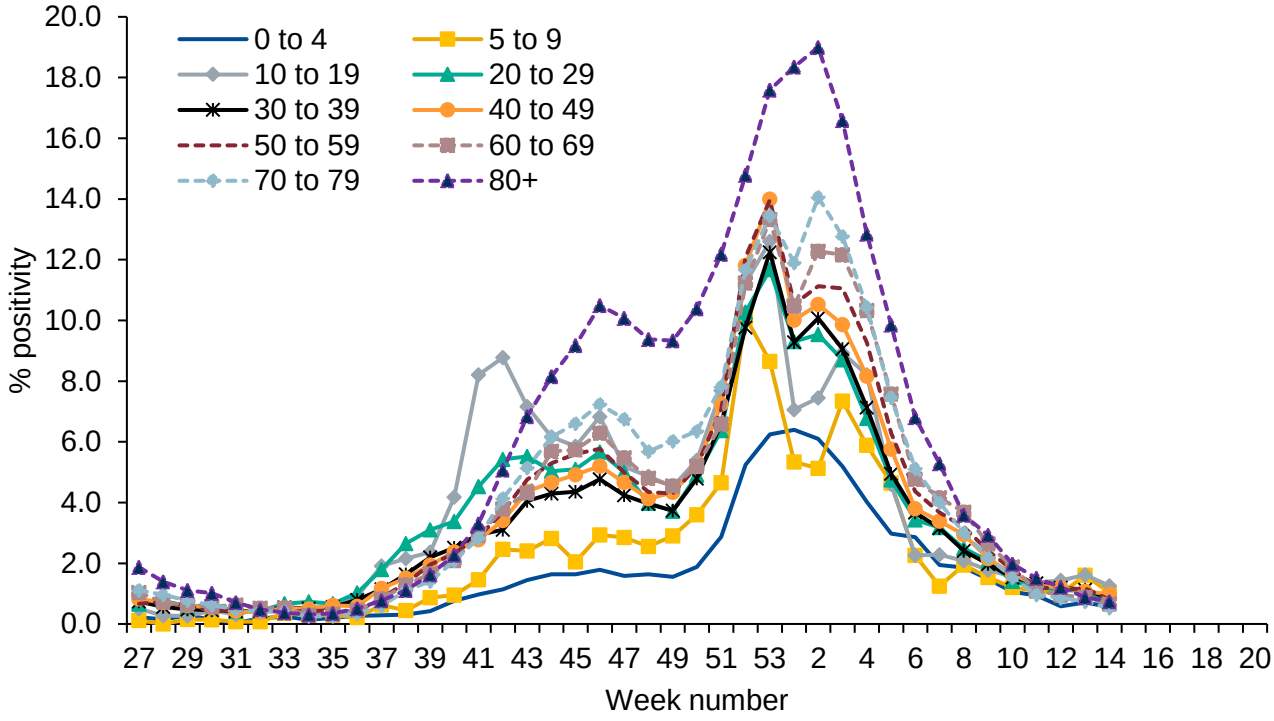
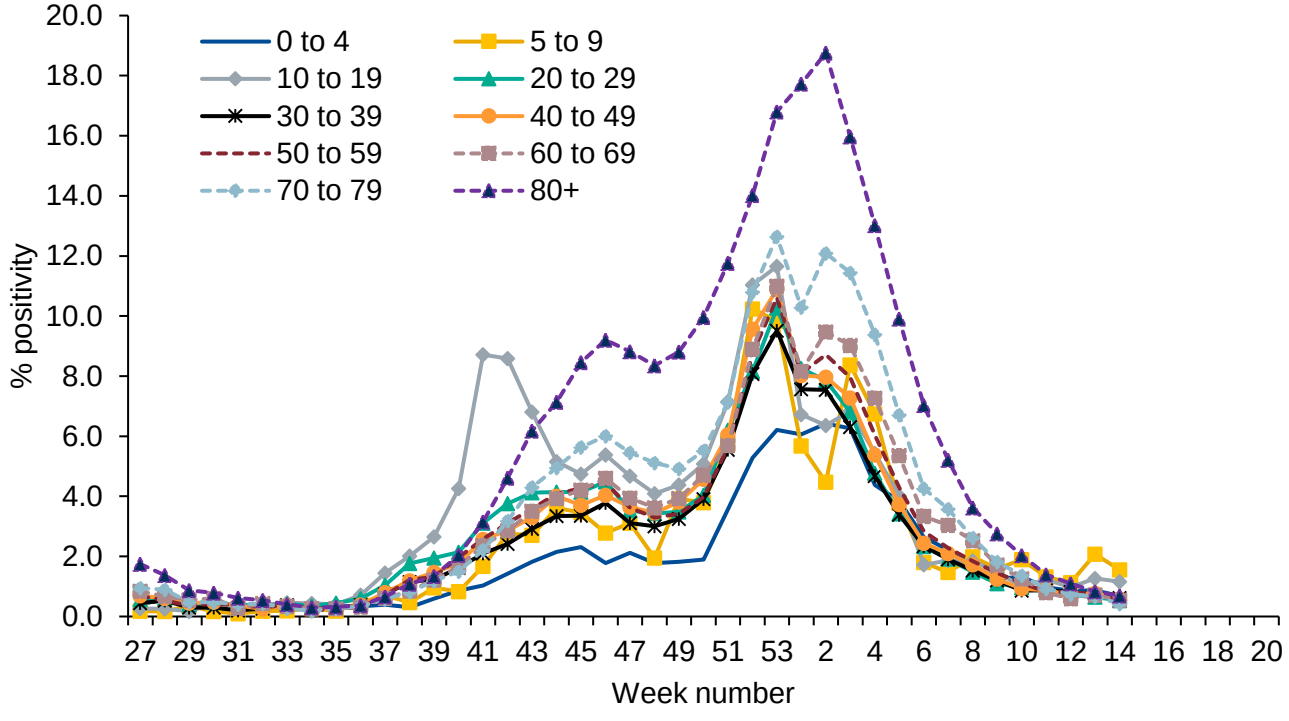


Figure 7: Weekly positivity (%) of confirmed COVID-19 cases tested under Pillar 1, (a) by male and age group and (b) by female and age group and; under Pillar 2, (c) by male and age group and (d) by female and age group, (SGSS and Respiratory DataMart)

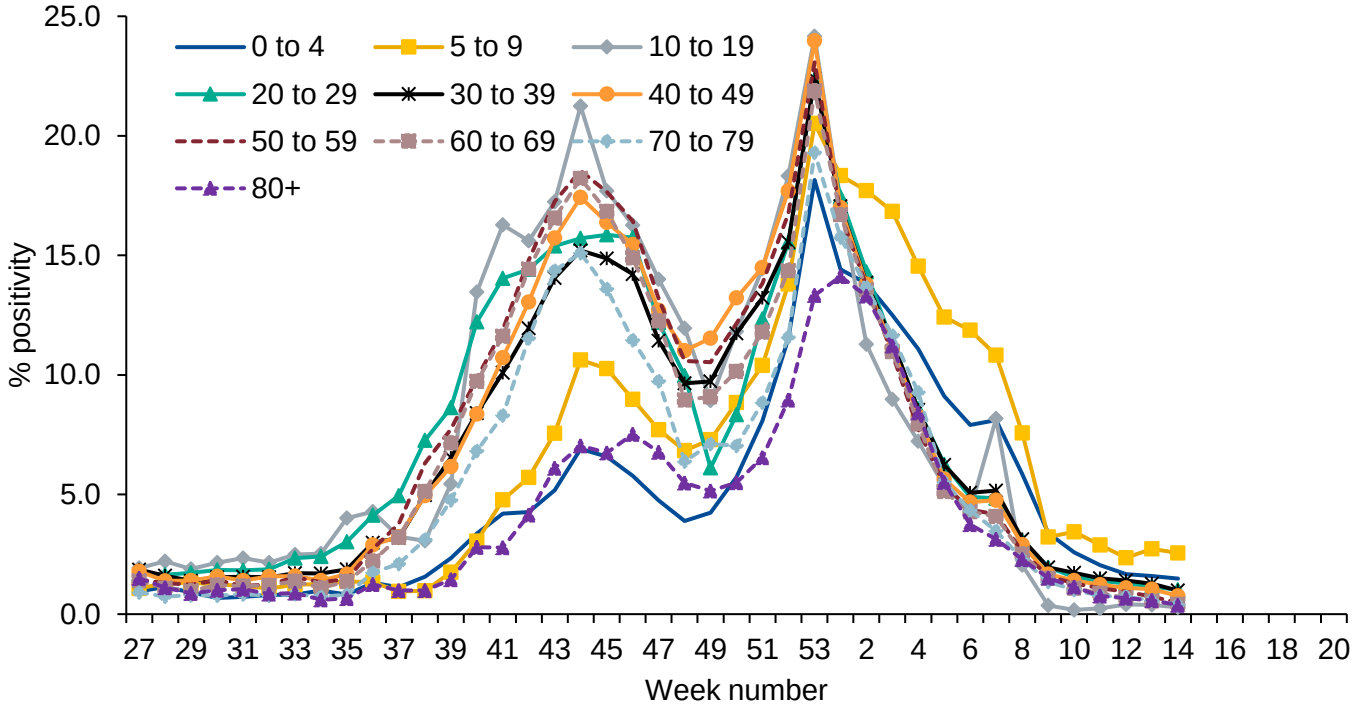
(a) Pillar 1 - Male



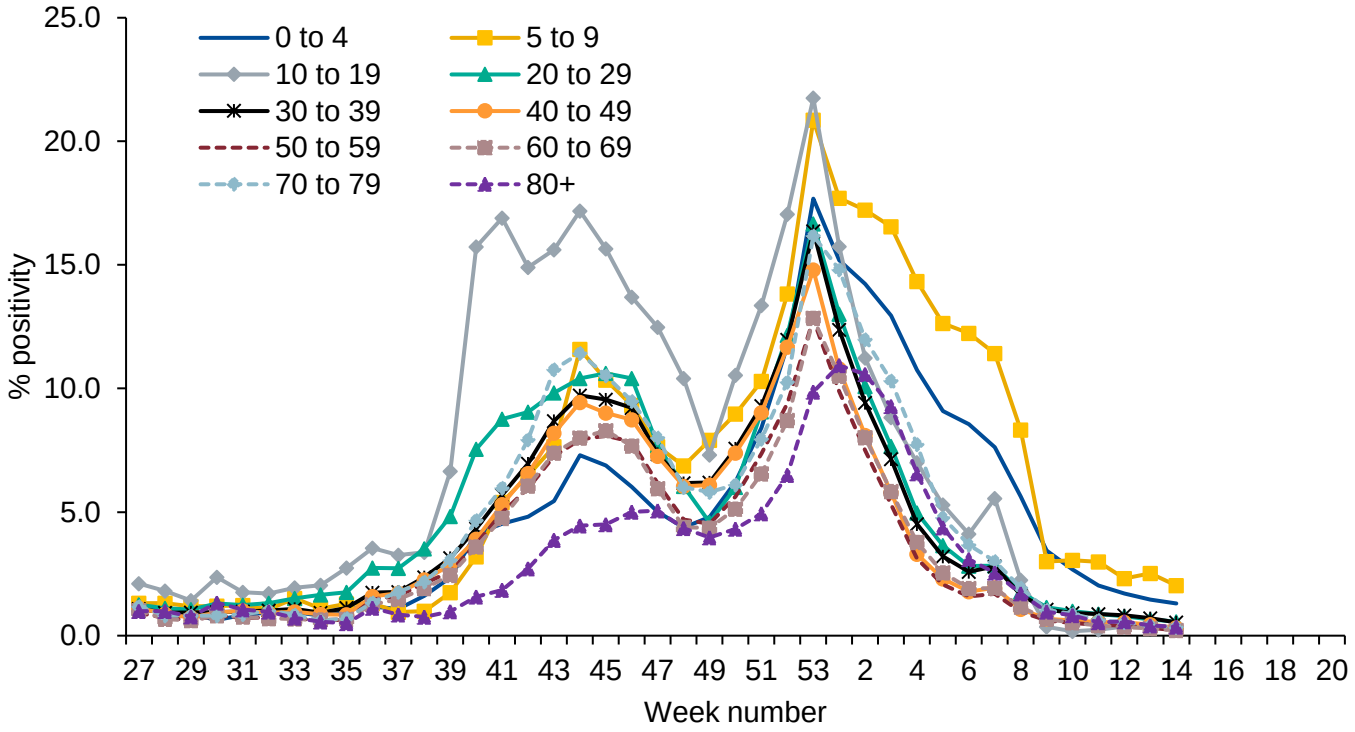
(b) Pillar 1 - Female



(c) Pillar 2 - Male



(d) Pillar 2 - Female



Geography

Table 1: Cumulative number of cases under Pillars 1 and 2 (n=3,788,336) and cumulative number of cases since week 27 under Pillar 1 and 2 (3,553,509)

PHE Centres	Cumulative Pillar 1 + 2 cases	Cumulative since week 27, Pillar 1 + 2 cases
North East	191,713	176,712
North West	602,356	560,100
Yorkshire and Humber	387,374	358,698
West Midlands	426,420	401,271
East Midlands	325,746	305,106
East of England	405,675	381,546
London	714,079	680,476
South East	515,913	483,219
South West	219,060	206,381

Figure 8: Weekly confirmed COVID-19 case rates per 100,000 population (Pillar 1 and Pillar 2), by PHE Centres and sample week

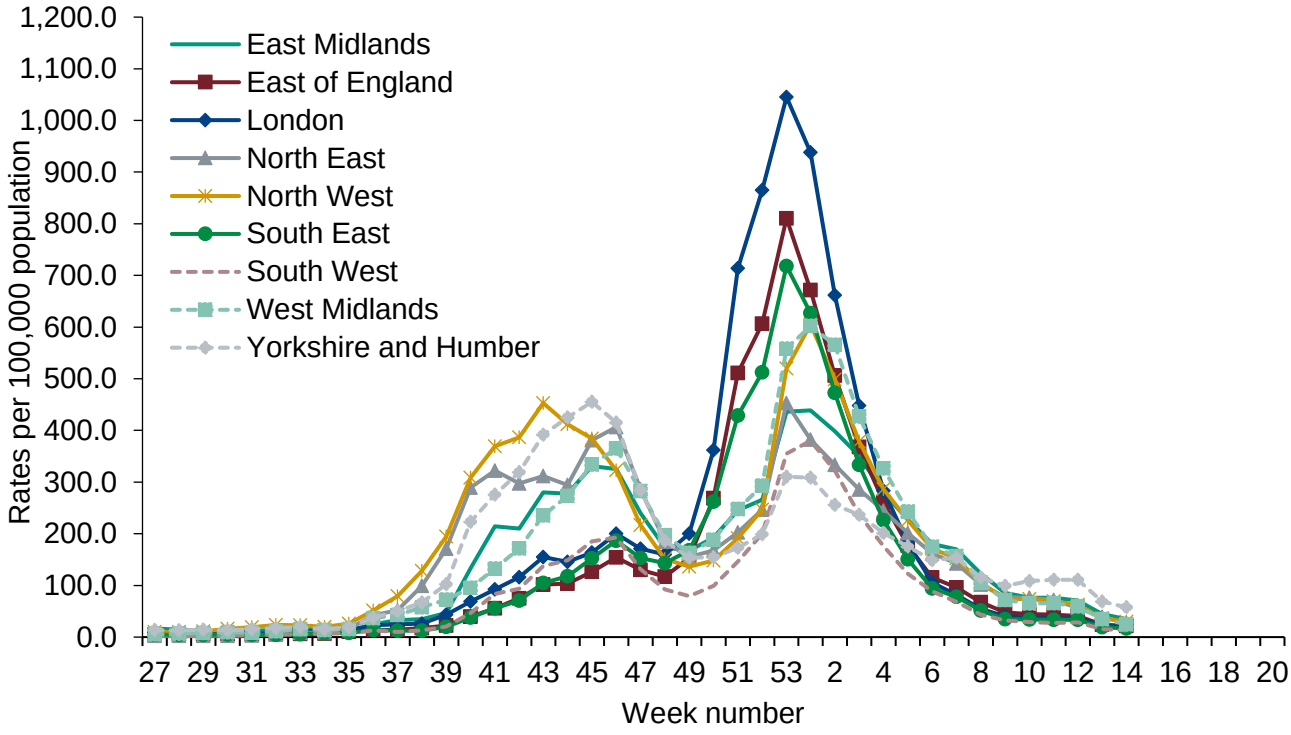
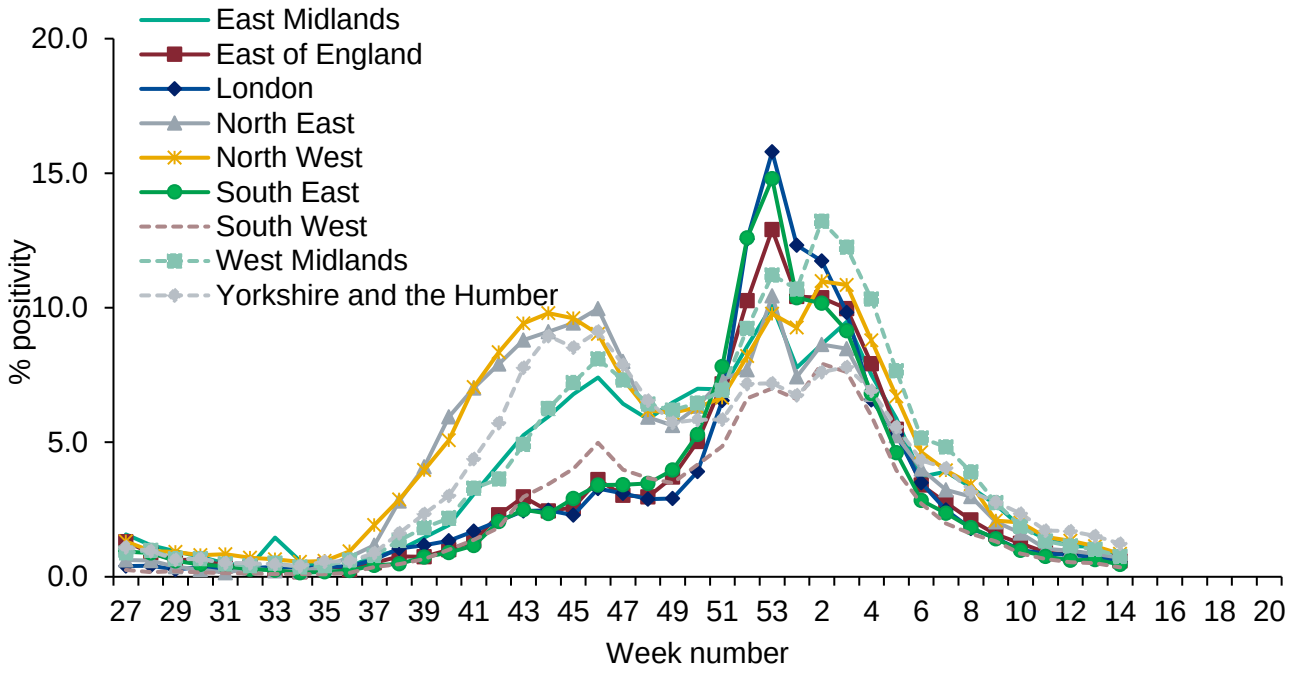


Figure 9: Weekly positivity of confirmed COVID-19 cases tested under (a) Pillar 1 (%) and (b) Pillar 2 (%), by PHE Centres and sample week, (SGSS and Respiratory DataMart)

(a)



(b)

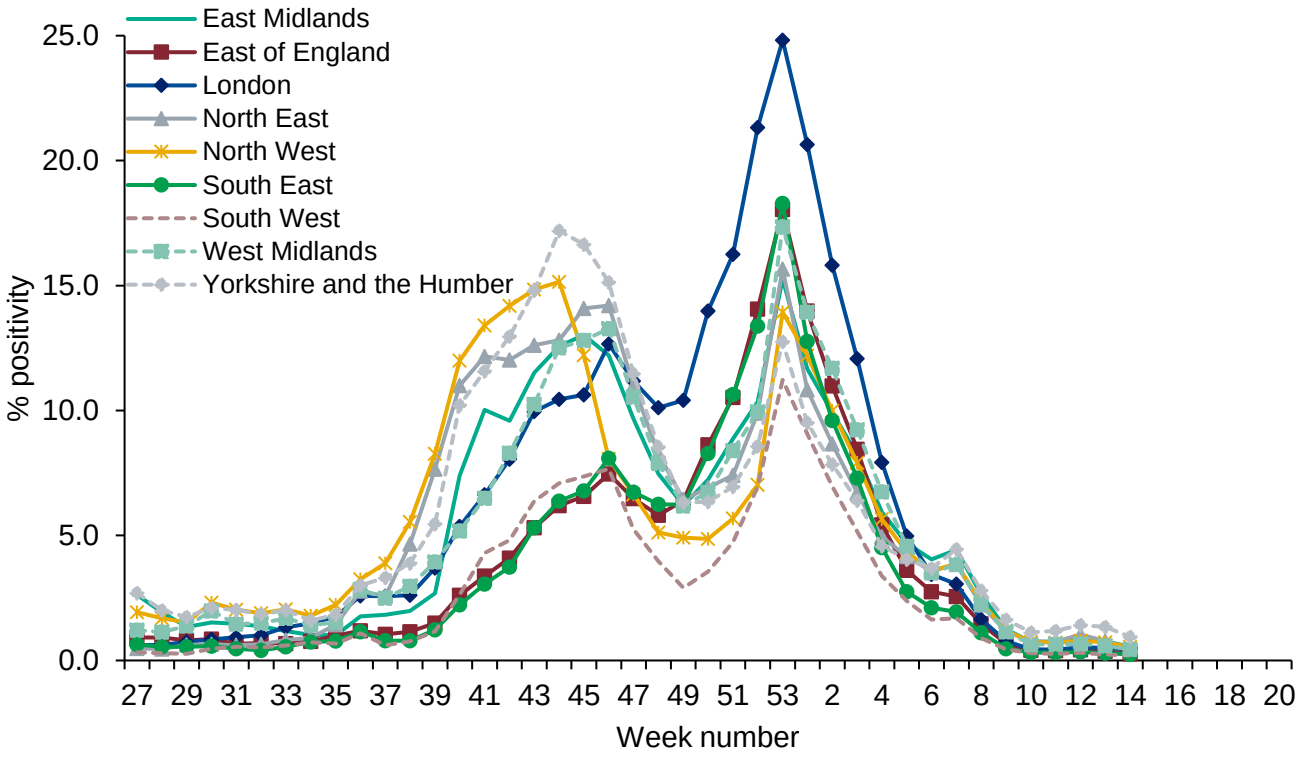
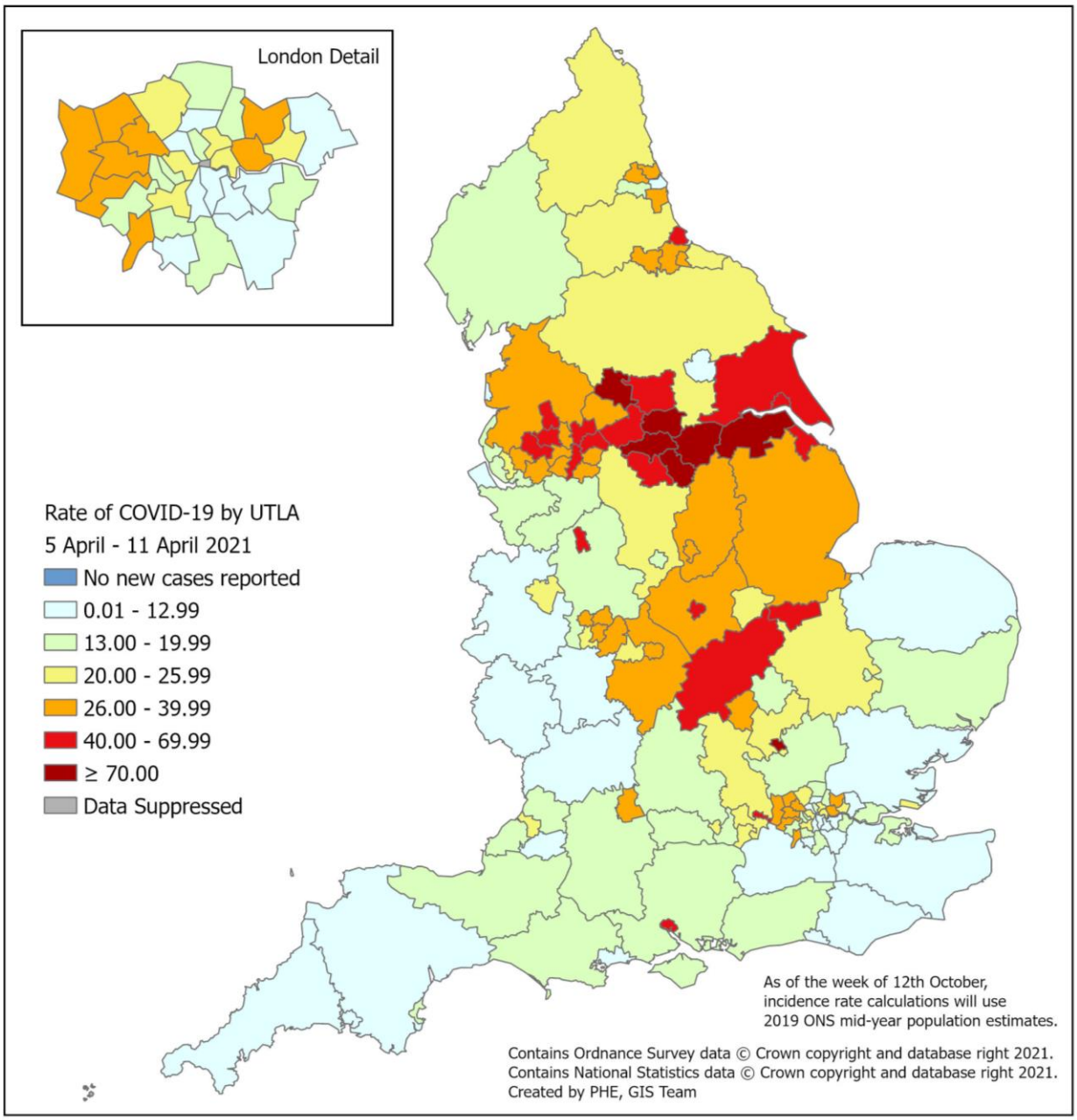
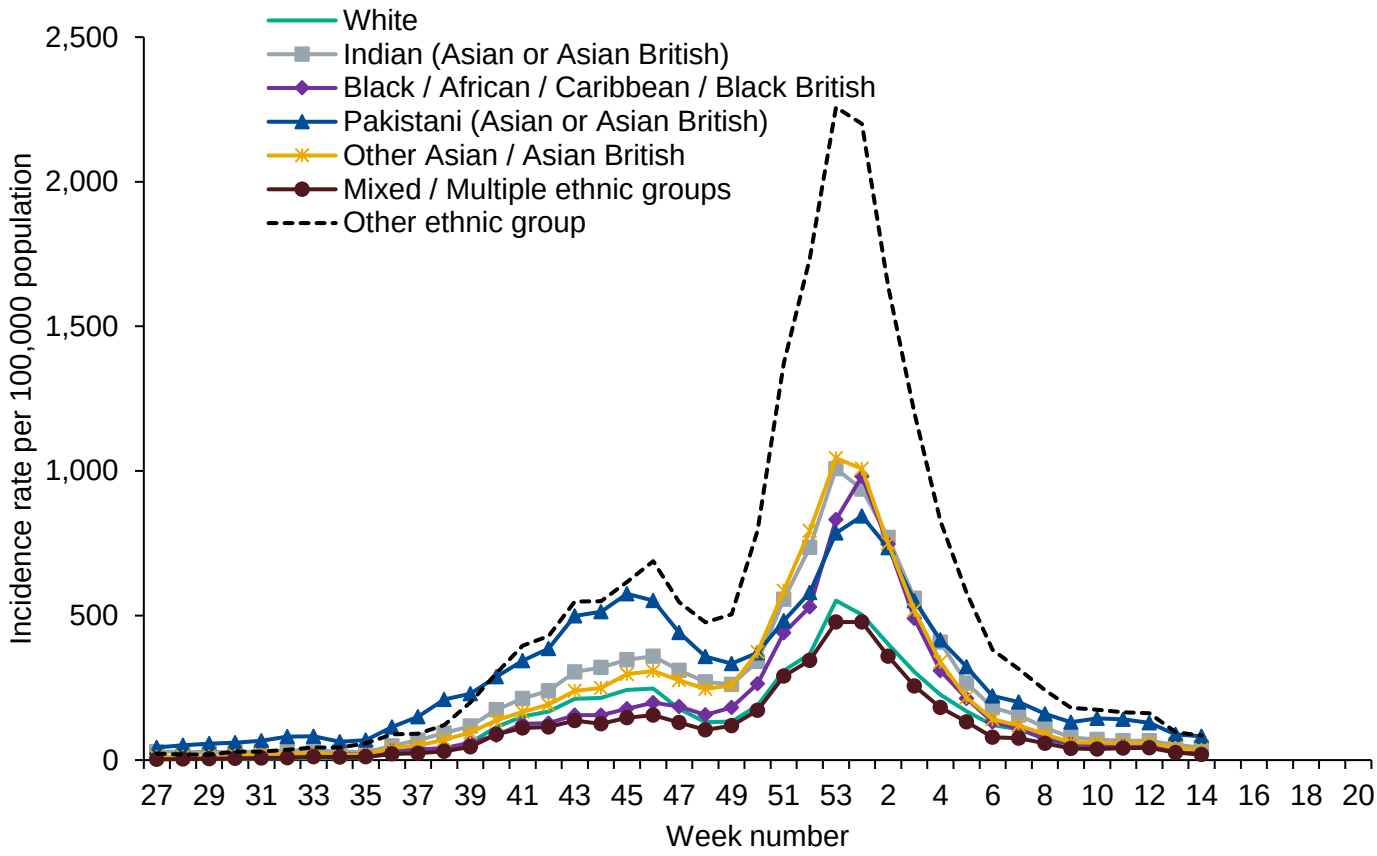


Figure 10: Weekly rate of COVID-19 cases per 100,000 population (Pillar 1 and 2), by upper-tier local authority, England (box shows enlarged map of London area)



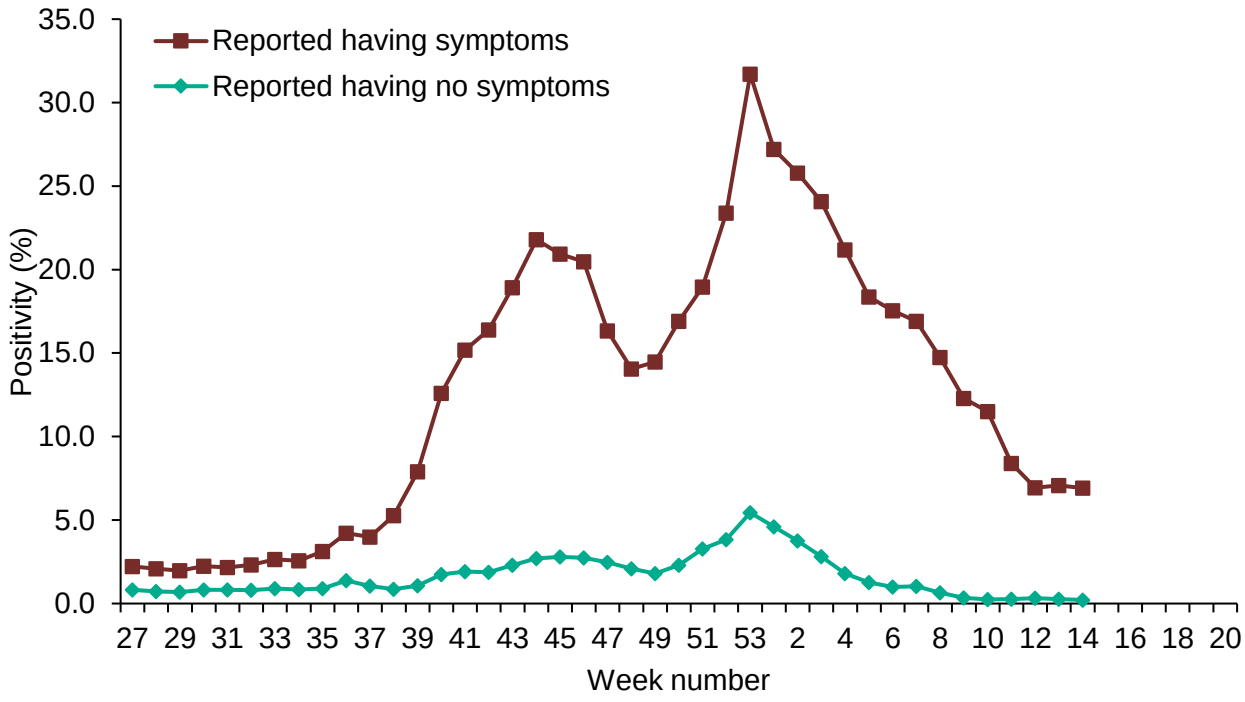
Ethnicity

Figure 11: Weekly incidence per 100,000 population by ethnicity, England



Positivity by symptoms

Figure 12: Weekly positivity of 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 14 2021, out of the 100,998 respiratory specimens reported through the Respiratory DataMart System (based on data received from 15 out of 16 laboratories), 557 samples were positive for SARS-CoV-2 with an overall positivity of 0.6%. The highest positivity was noted in the 5 to 14 year olds at 0.8% in week 14. The overall influenza positivity remained very low at 0.0% in week 13, with one of 3,697 samples testing positive for flu. This was an influenza A(H3N2) (Figure 13).

Rhinovirus positivity increased from 13.2% in week 13 to 11.5% in week 14. Respiratory syncytial virus (RSV), adenovirus, parainfluenza and human metapneumovirus (hMPV) positivity all remained low at 0.0%, 1.0%, 0.2% and 0.6% respectively in week 14 (Figure 14).

Figure 13: DataMart samples positive for influenza and weekly positivity (%) for influenza and SARS-CoV-2, England

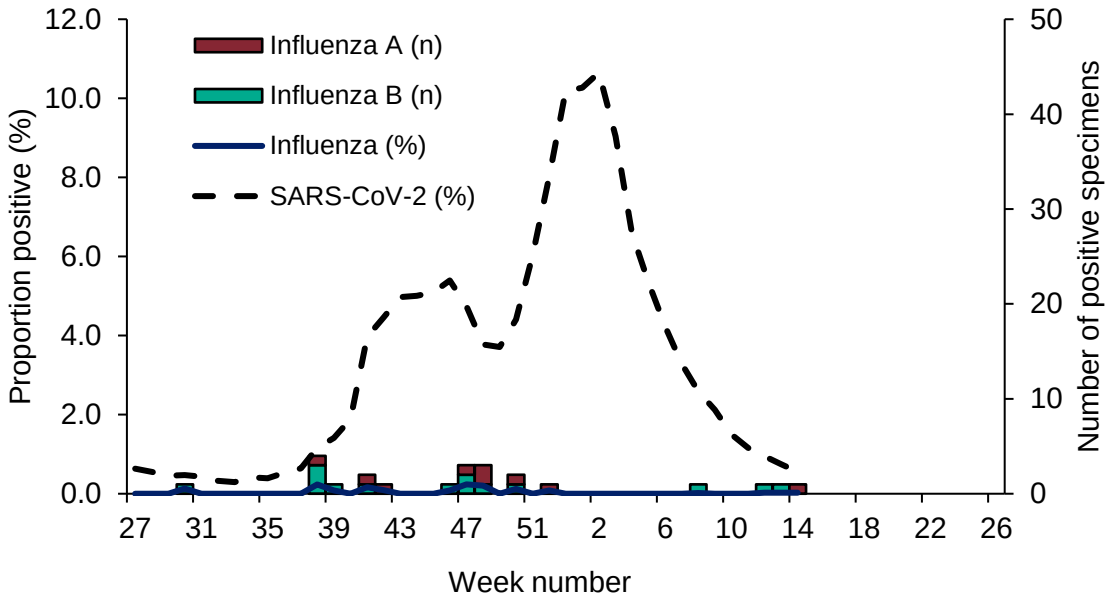


Figure 14: DataMart weekly positivity (%) for other respiratory viruses, England

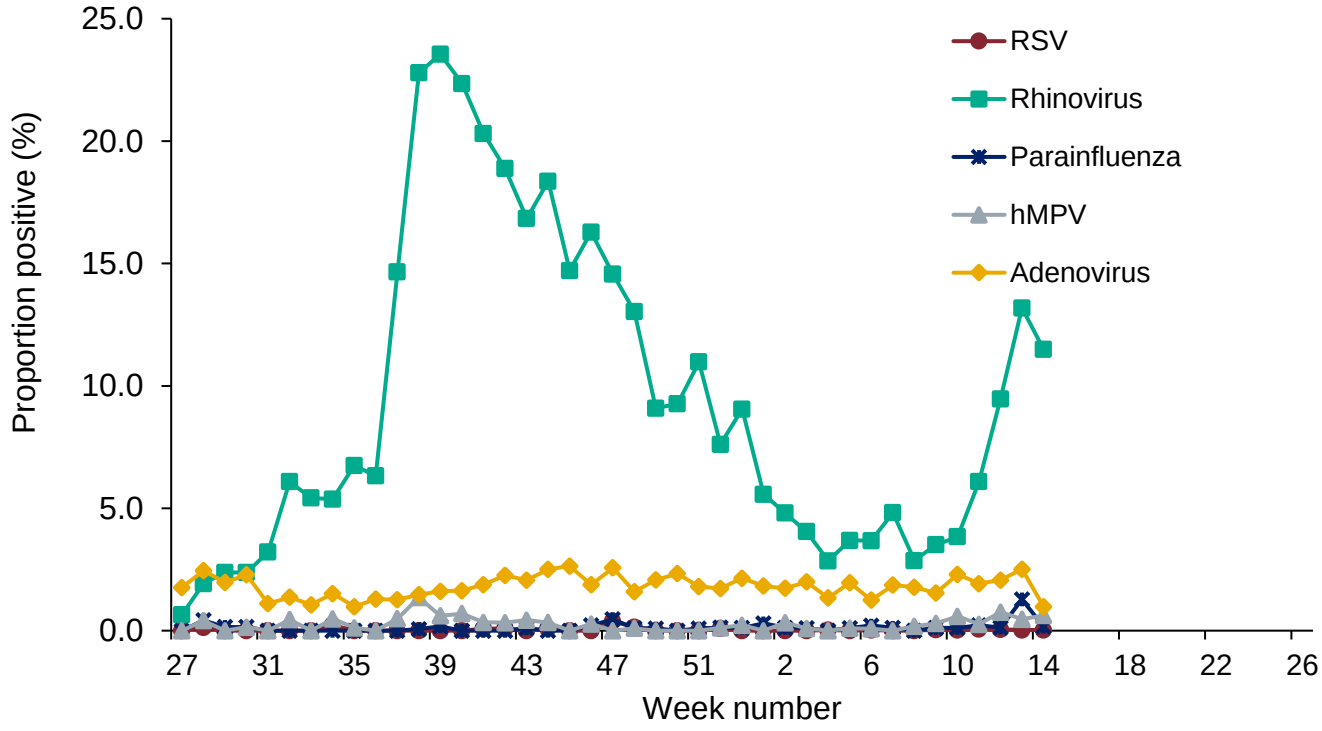
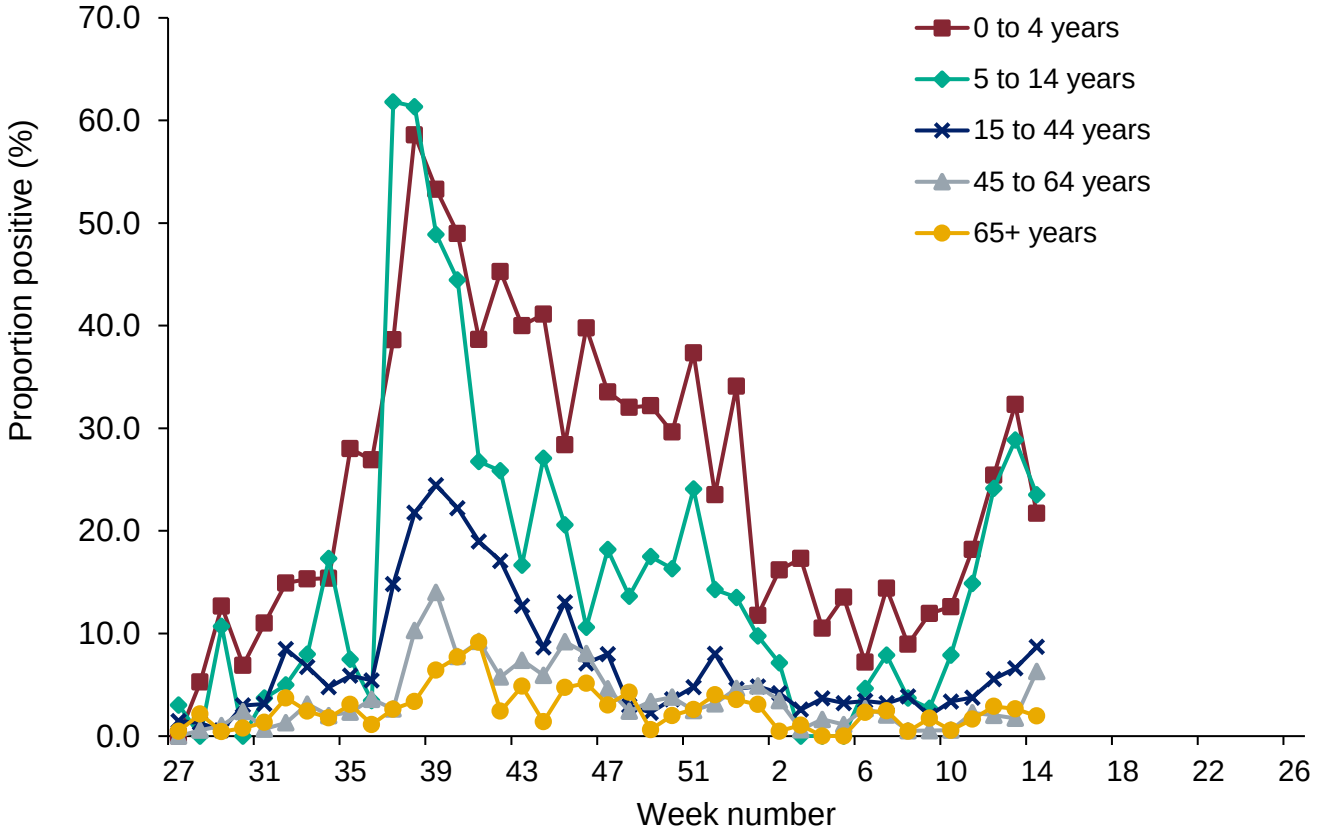


Figure 15: DataMart weekly positivity (%) for rhinovirus by age, England



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.

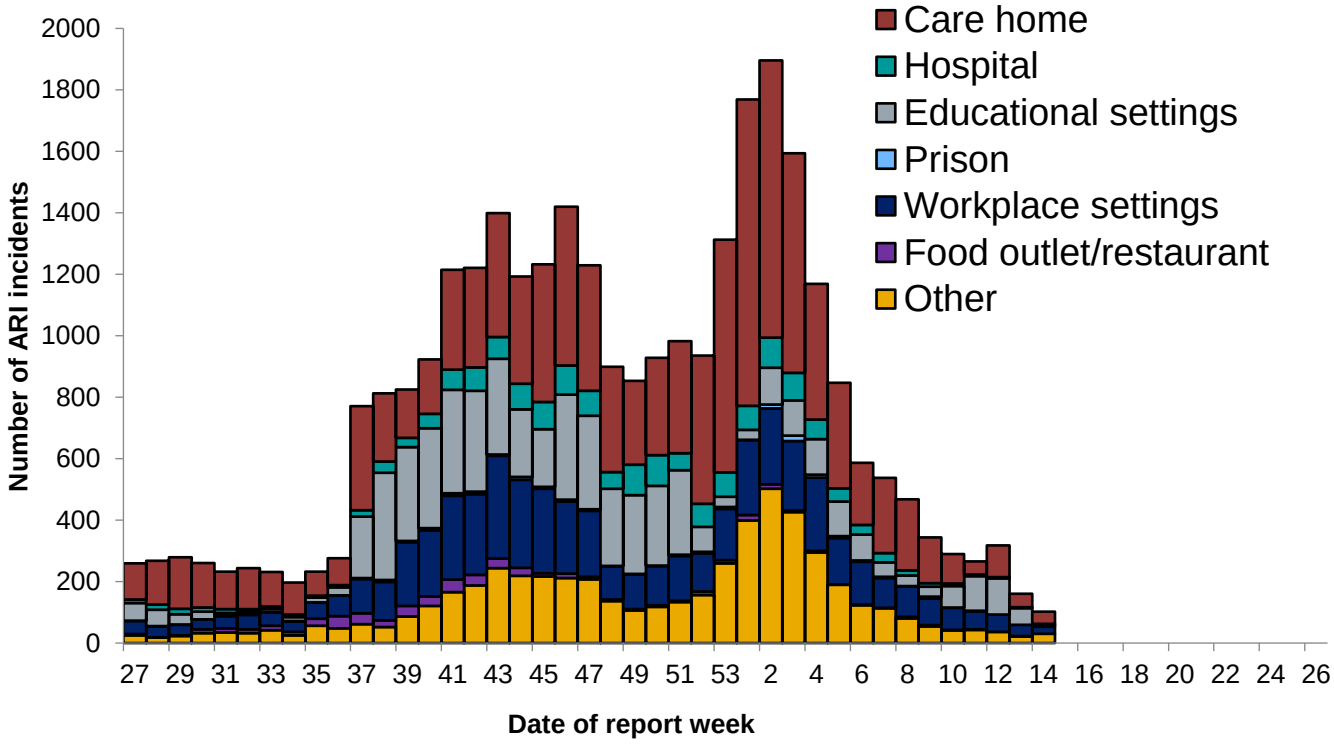
Data caveats:

- 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.

102 new ARI incidents have been reported in week 14 in the UK (Figure 16):

- 39 incidents were from care homes where 27 had at least one linked case that tested positive for SARS-CoV-2 where test results were available
- 6 incidents were from educational settings where 6 had at least one linked case that tested positive for SARS-CoV-2
- 4 incidents were from hospitals where 3 had at least one linked case that tested positive for SARS-CoV-2
- 23 incidents were from workplace settings where 17 had at least one linked case that tested positive for SARS-CoV-2
- 30 incidents were from other settings where 22 had at least one linked case that tested positive for SARS-CoV-2

Figure 16: Number of acute respiratory infection (ARI) incidents by setting, UK



*excludes data from Wales

Figure 17: Number of acute respiratory infection (ARI) incidents by setting, England

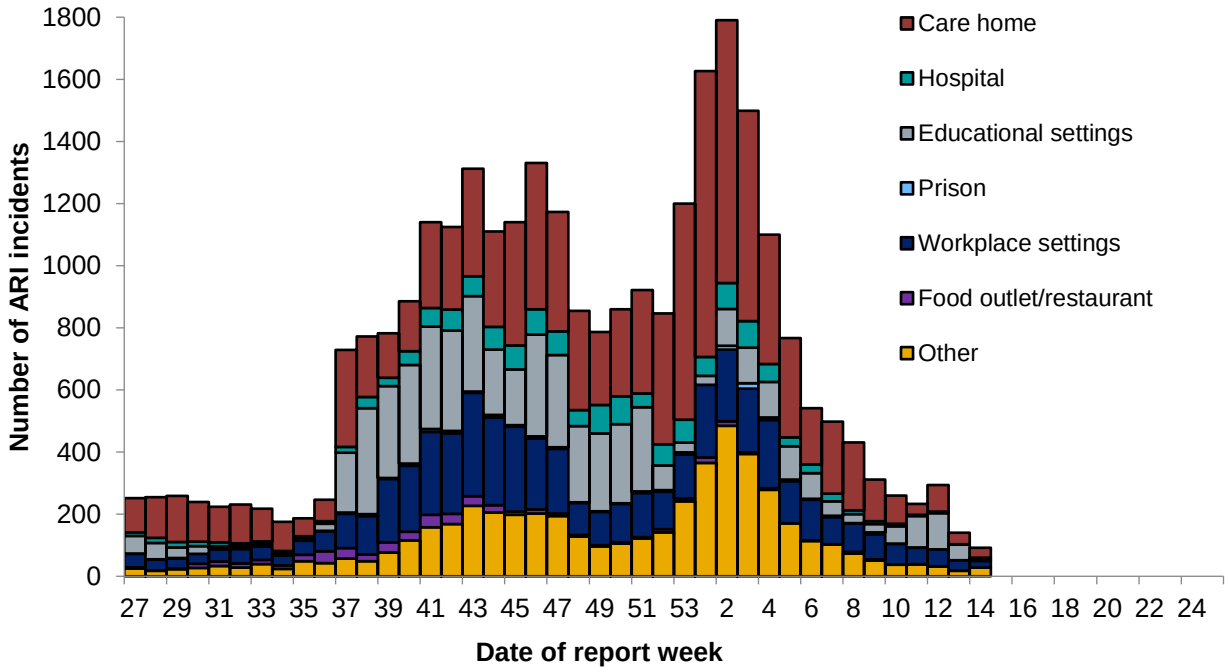


Figure 18: Number of acute respiratory infection (ARI) incidents in care homes by virus type from week 27, England

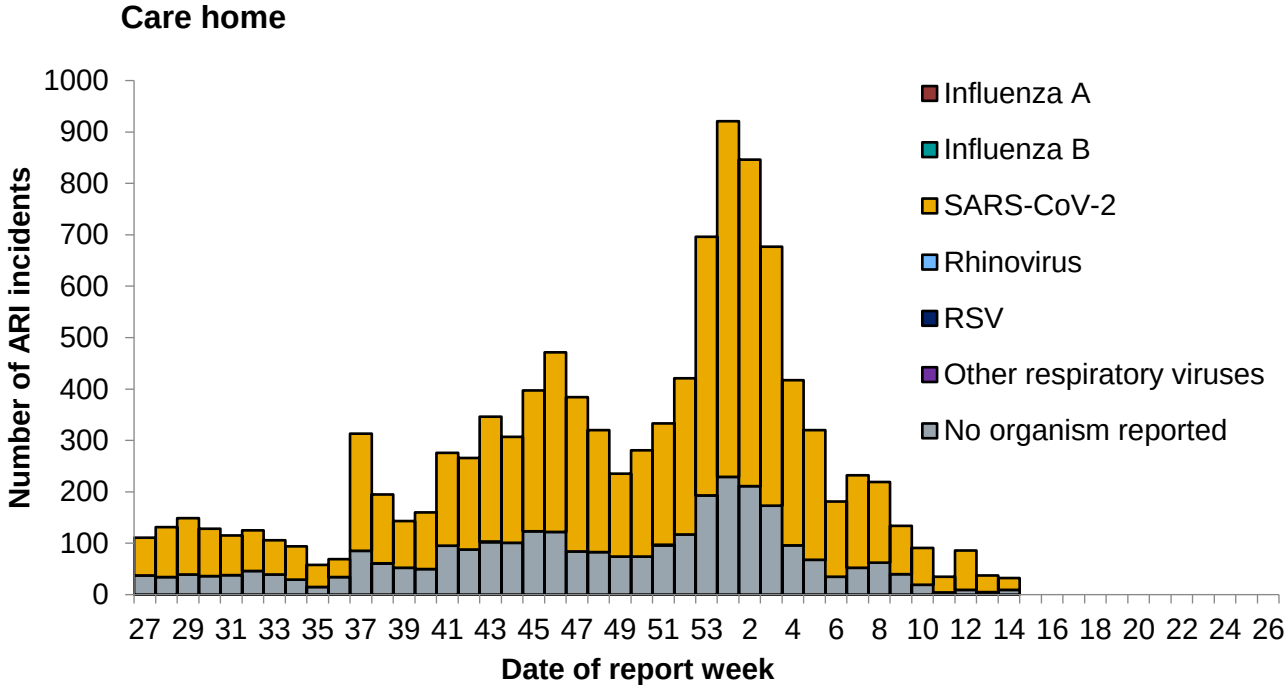


Figure 19: Number of acute respiratory infection (ARI) incidents in hospitals by virus type from week 27, England

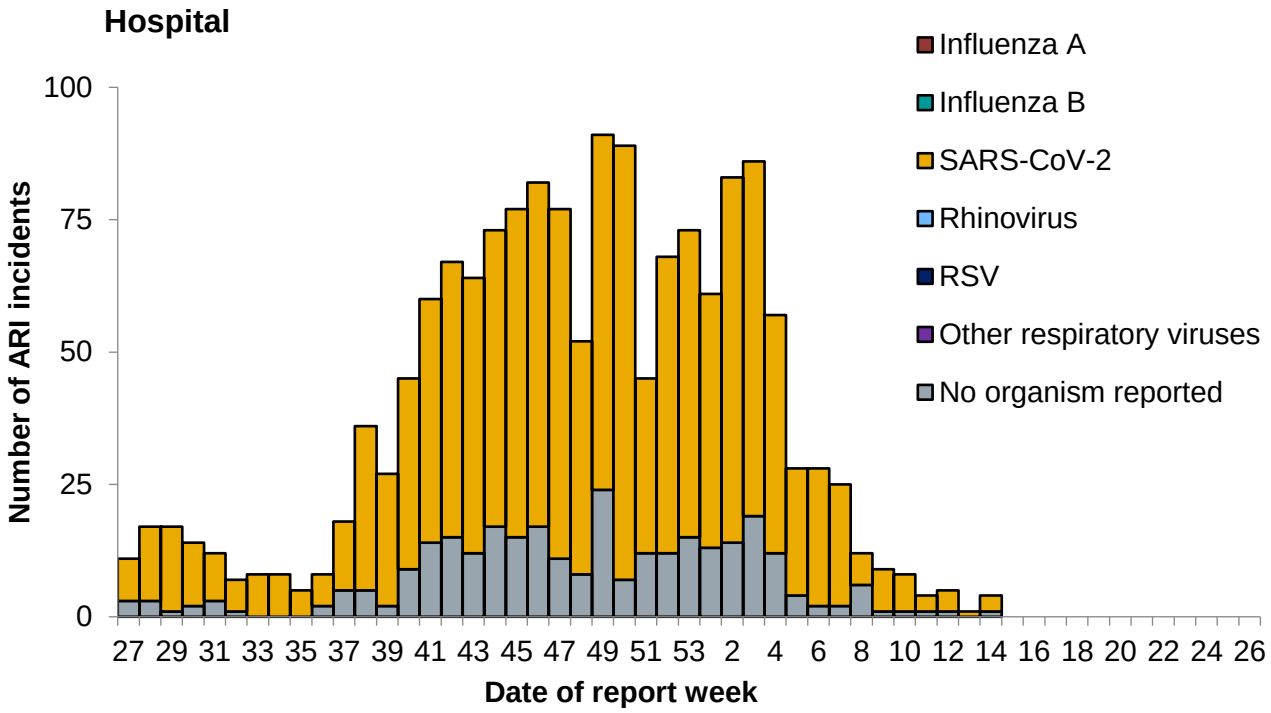


Figure 20: Number of acute respiratory infection (ARI) incidents in educational settings by virus type from week 27, England

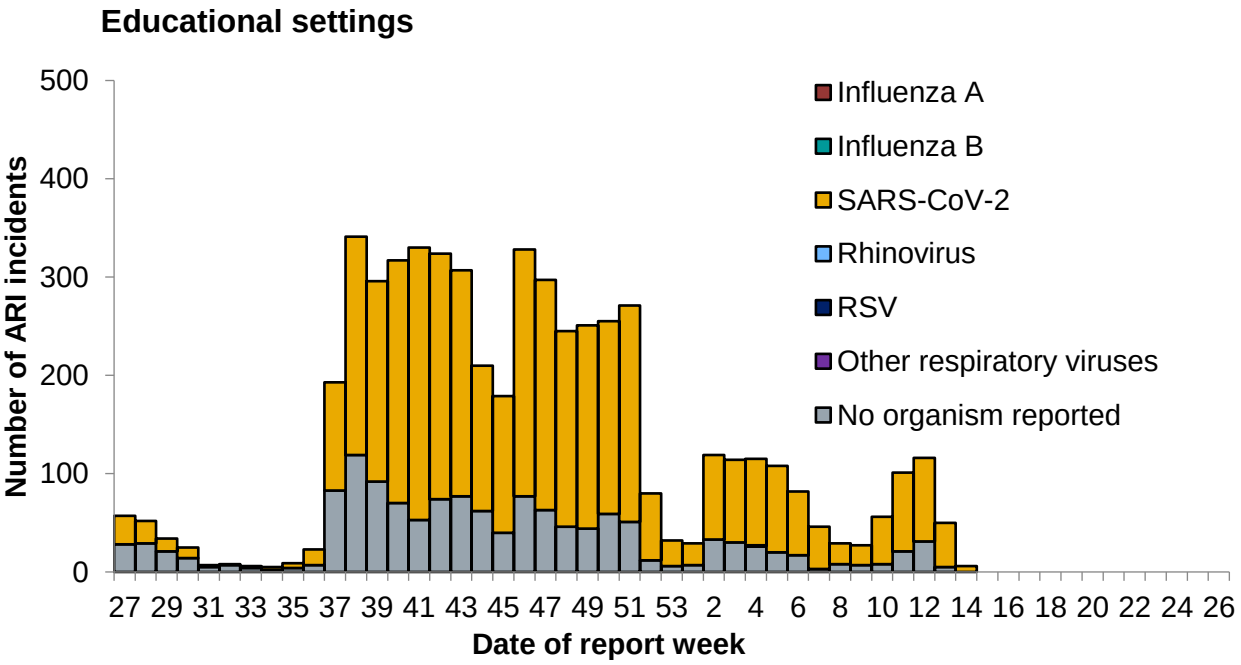


Figure 21: Number of acute respiratory infection (ARI) incidents in prisons by virus type from week 27, England

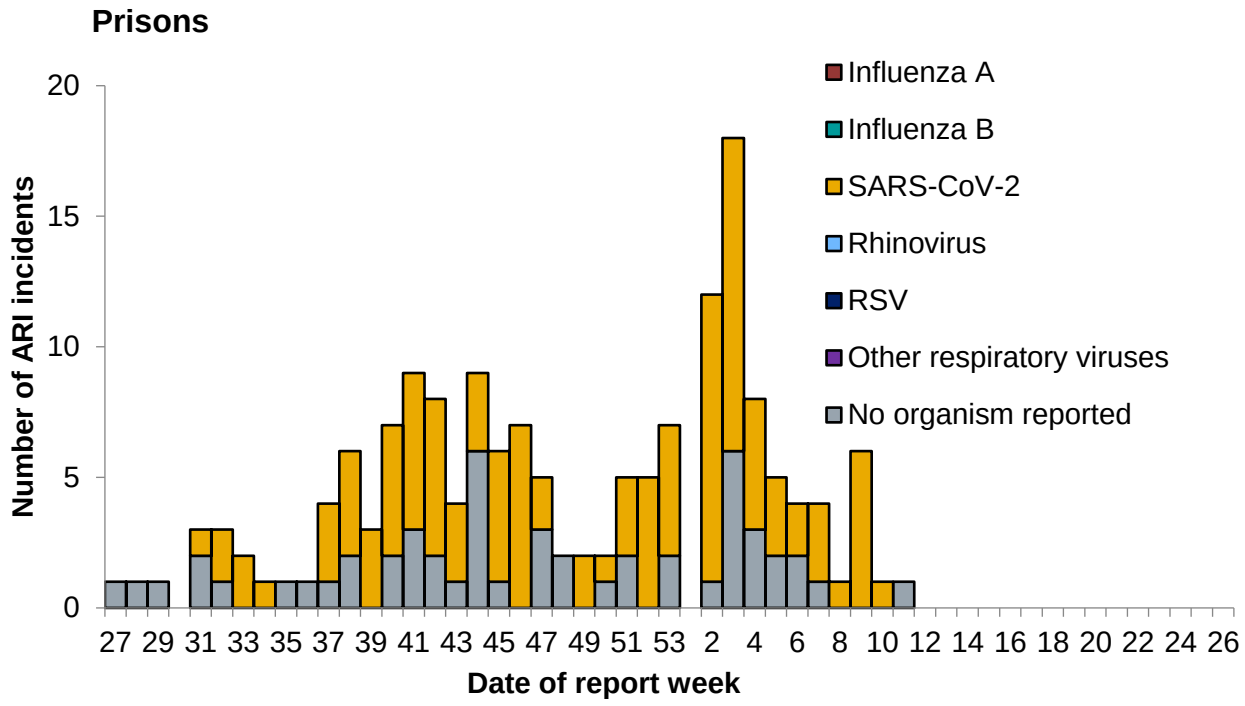


Figure 22: Number of acute respiratory infection (ARI) incidents in workplace settings by virus type from week 27, England

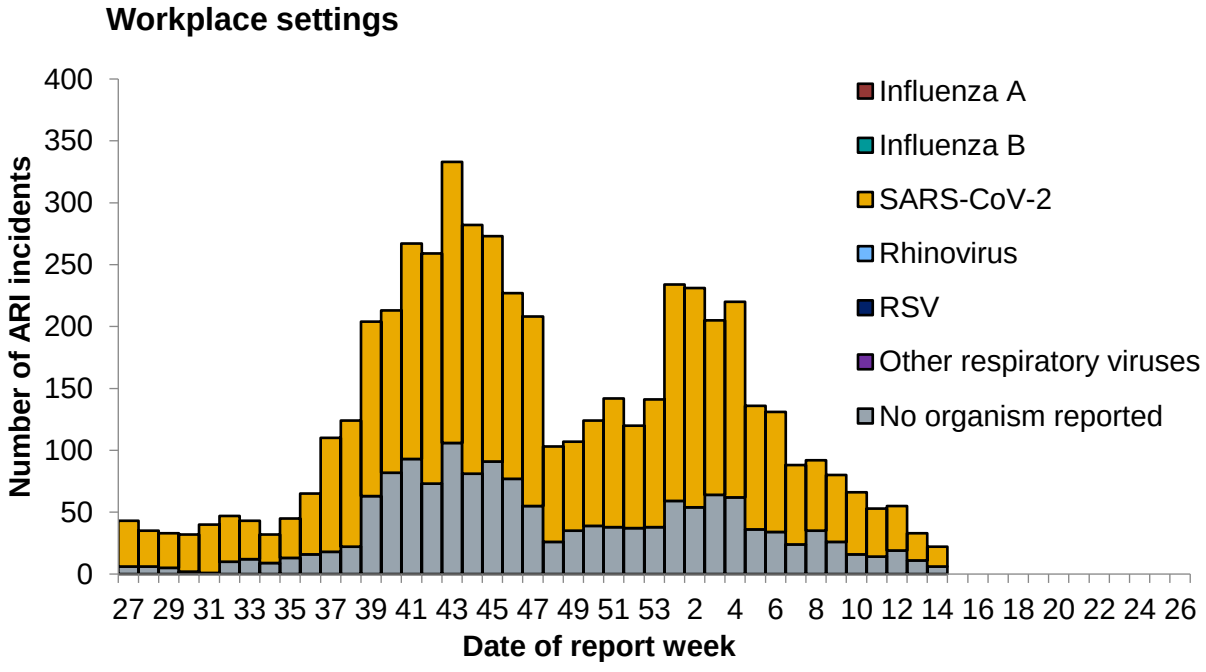


Figure 23: Number of acute respiratory infection (ARI) incidents in food outlet/restaurants settings by virus type from week 27, England

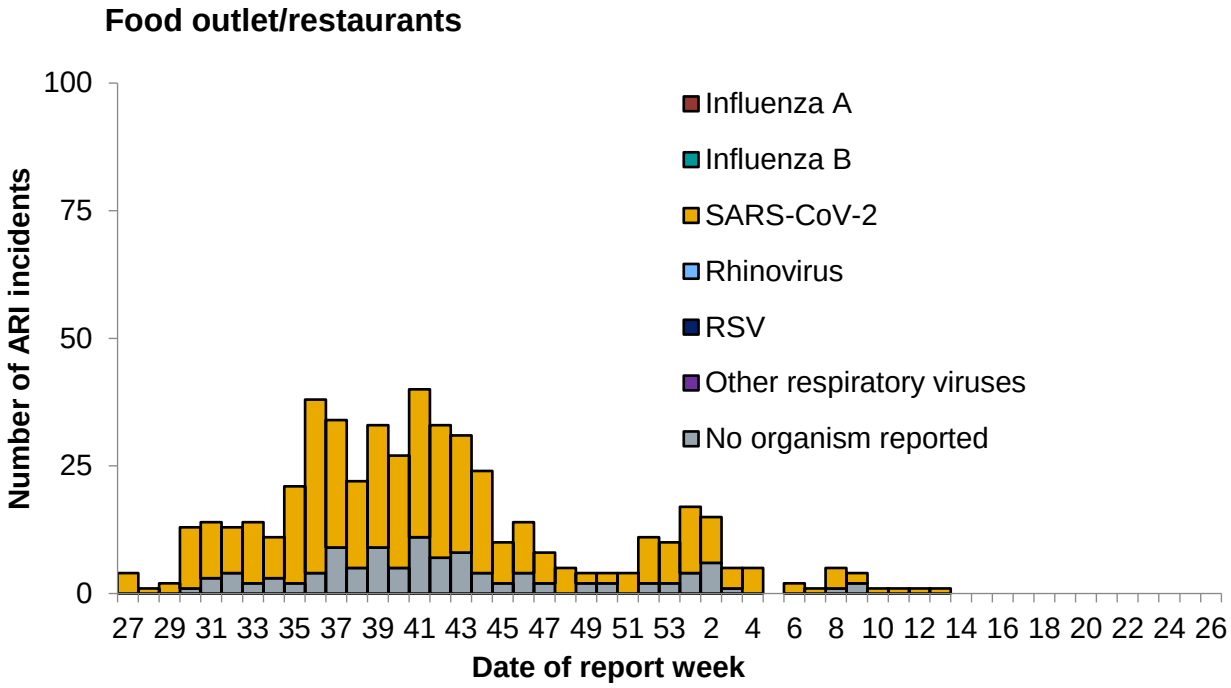


Figure 24: Number of acute respiratory infection (ARI) incidents in other settings by virus type from week 27, England

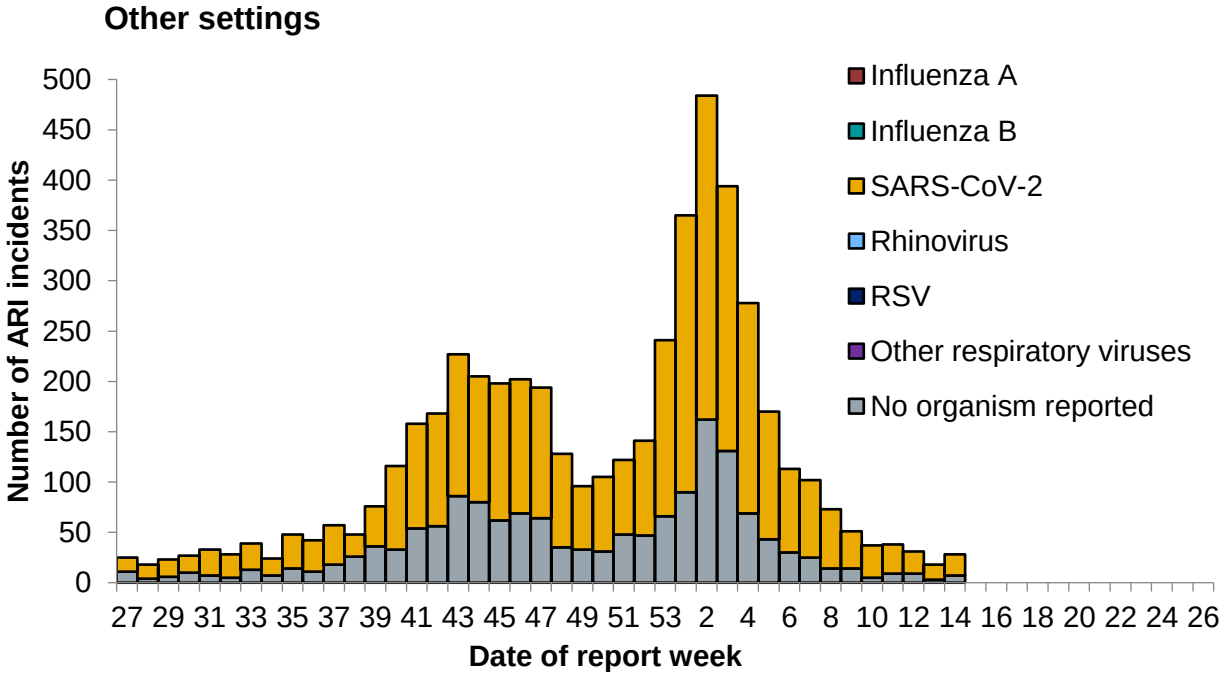


Table 2: Total number of situations/incidents by institution and PHE Centres over the past four weeks with the total number in the last week in brackets

PHE Centres	Care home	Hospital	Educational settings	Prisons	Workplace settings	Food outlet/restaurant settings	Other settings	Total
East of England	12(2)	2(0)	4(0)	0(0)	7(2)	0(0)	2(0)	27(4)
East Midlands	22(3)	5(1)	29(2)	0(0)	23(5)	0(0)	10(0)	89(11)
London	5(3)	2(1)	26(0)	0(0)	3(1)	0(0)	9()1	45(6)
North East	37(2)	0(0)	4(0)	0(0)	0(0)	0(0)	4(0)	45(2)
North West	4(0)	0(0)	19(1)	0(0)	26(4)	0(0)	9(2)	58(7)
South East	20(5)	0(0)	32(0)	0(0)	16(1)	1(0)	18(2)	87(8)
South West	36(7)	1(0)	17(0)	0(0)	12(2)	0(0)	20(9)	86(18)
West Midlands	23(5)	3(2)	76(2)	0(0)	25(1)	2(0)	12(3)	141(13)
Yorkshire and Humber	31(5)	1(0)	66(1)	1(0)	51(6)	0(0)	31(11)	181(23)
Total	190(32)	14(4)	273(6)	1(0)	163(22)	3(0)	115(28)	759(92)

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 14, 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	week9	week10	week11	week12	week13	week14
Residential dwelling (including houses, flats, sheltered accommodation)	91.1	93.1	94.6	94.2	92.9	93.0
Undetermined	3.1	2.6	2.4	2.6	3.3	3.2
Care/Nursing home	2.5	1.7	0.9	0.8	0.9	1.1
Residential institution (including residential education)	0.4	0.4	0.3	0.2	0.2	0.3
Other property classifications	0.6	0.6	0.6	0.6	0.8	0.9
House in multiple occupancy (HMO)	0.4	0.5	0.5	0.5	0.6	0.7
Medical facilities (including hospitals and hospices, and mental health)	0.2	0.1	0.1	0.3	0.9	0.7
Prisons, detention centres, secure units	1.7	1.0	0.7	0.8	0.4	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 due to national school closures.

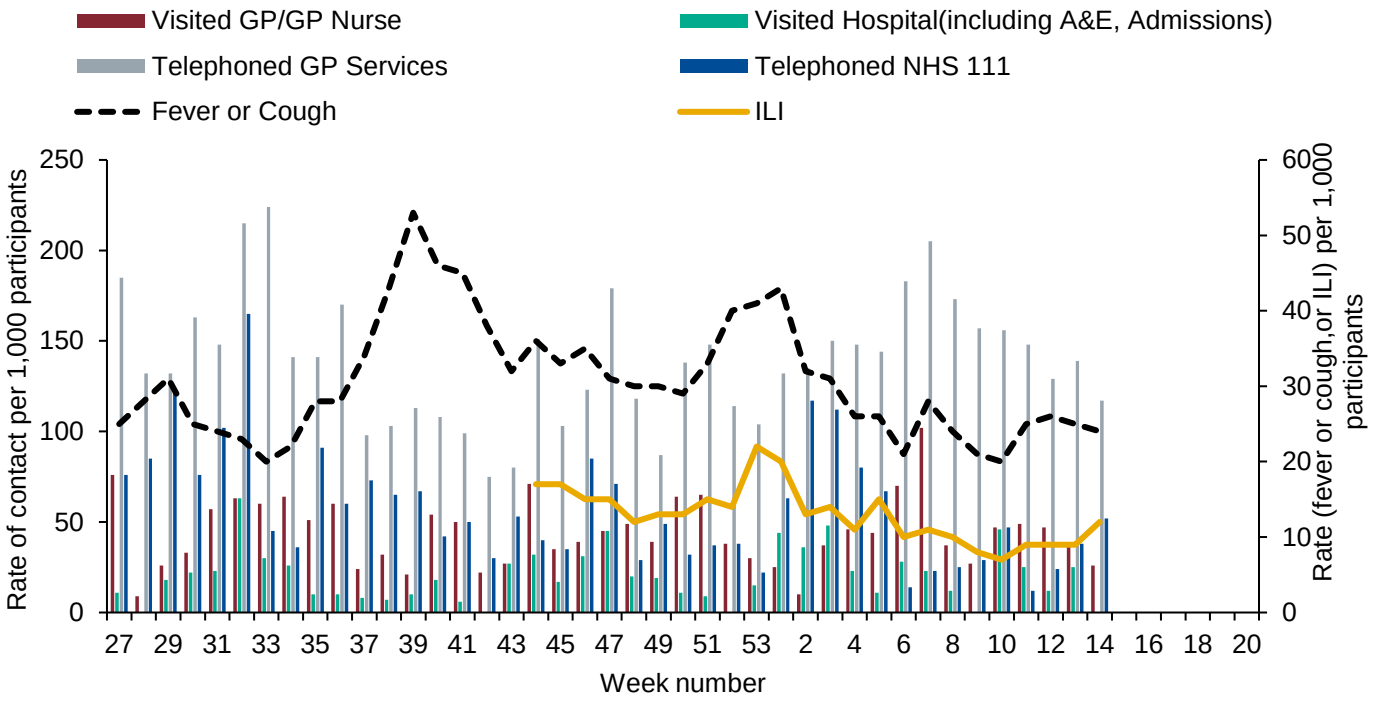
If you are a MOSA school and would like to participate in this scheme, please email mosa@phe.gov.uk for more information.

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 3,261 participants completed the weekly surveillance survey in week 14, of which 77 (2.4%) reported fever or cough and 41 (1.3%) reported influenza like illness (ILI). The most commonly used healthcare services reported by respondents remains telephoning a GP practice (Figure 25).

Figure 25: Rate of contact with different healthcare services among FluSurvey participants reporting fever or cough symptoms, England



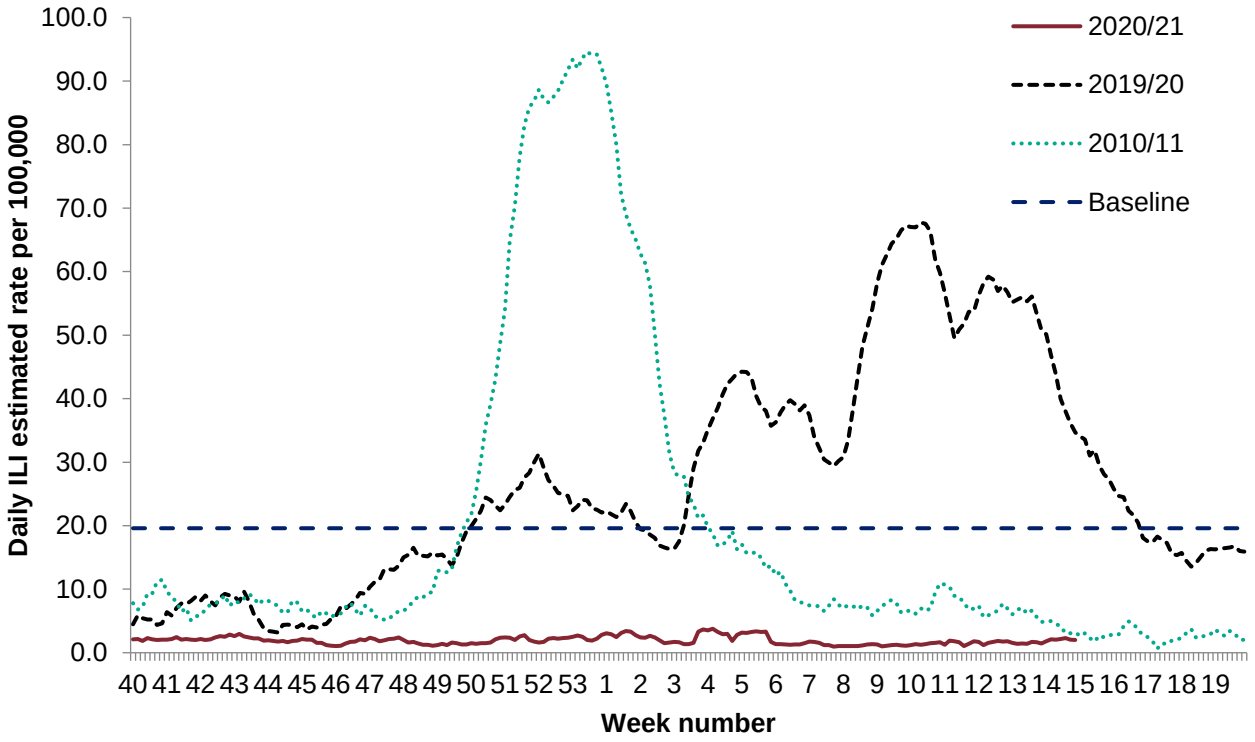
FluDetector

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 14, the daily ILI rate remained low and below the baseline threshold of 19.6 per 100,000 for the 2020 to 2021 season (Figure 26).

Figure 26: Daily estimated ILI Google search query rates per 100,000 population, England

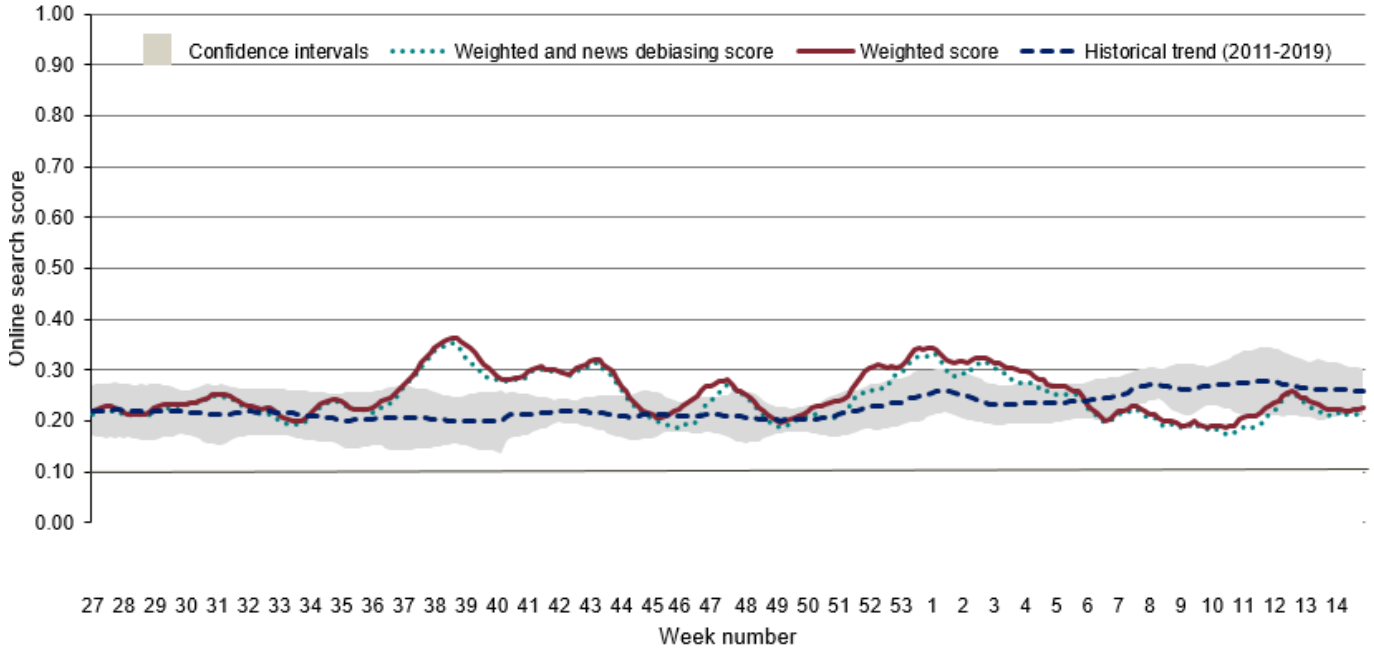


Google search queries

This is a web-based syndromic surveillance system which uses daily search query frequency statistics obtained from the Google Health Trends API. This model focuses on search queries about COVID-19 symptoms as well as generic queries about "coronavirus" (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. Further information on this model is available here: https://www.nature.com/articles/s41746-021-00384-w

During week 14, the overall and media-debiasing weighted Google search scores remained stable (Figure 27).

Figure 27: 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.

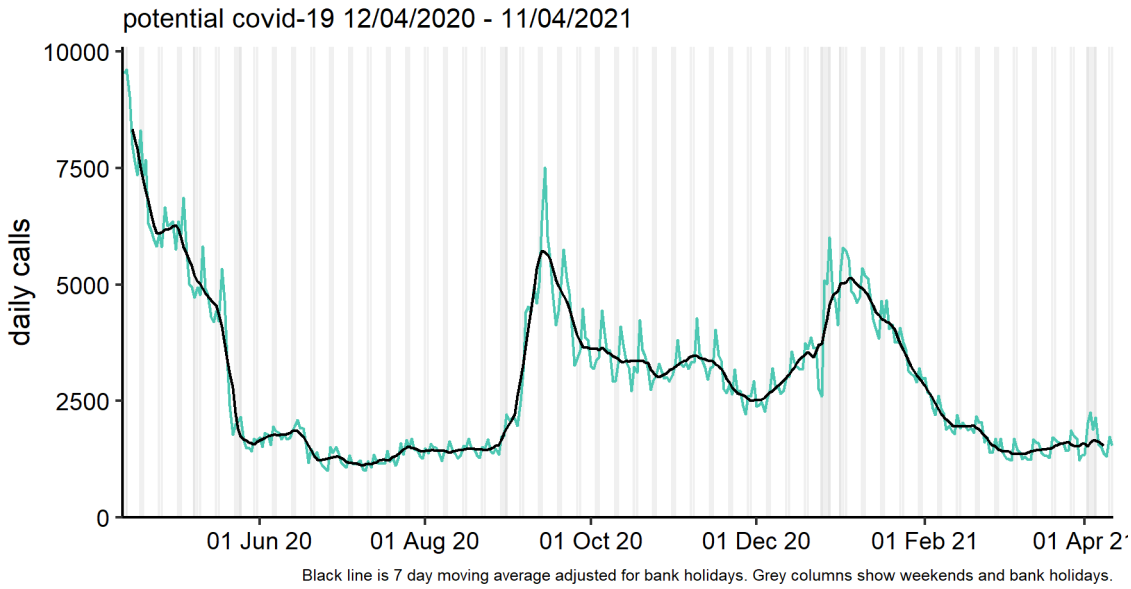
Up to 11 April NHS 111 calls for cold/flu increased while online assessments for remained stable. Calls for potential COVID-19 increased and online assessments remained stable. Calls for loss of taste or smell increased while online assessment remained stable (Figure 28 and 29).

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.

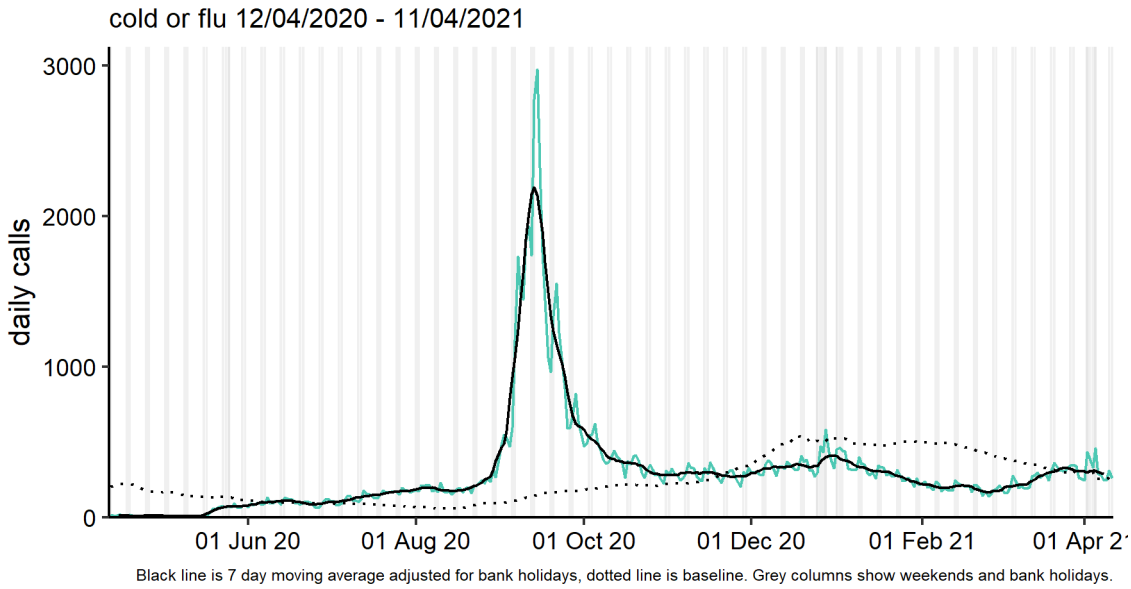
Further information about these caveats is available from the PHE Remote Health Advice Syndromic Surveillance bulletin.

Figure 28: 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

(a)



(b)


cold or flu 12/04/2020 - 11/04/2021
daily calls
3000
2000
1000
0
01 Jun 20
01 Aug 20
01 Oct 20
01 Dec 20
01 Feb 21
01 Apr 2
Black line is 7 day moving average adjusted for bank holidays, dotted line is baseline. Grey columns show weekends and bank holidays.

(c)

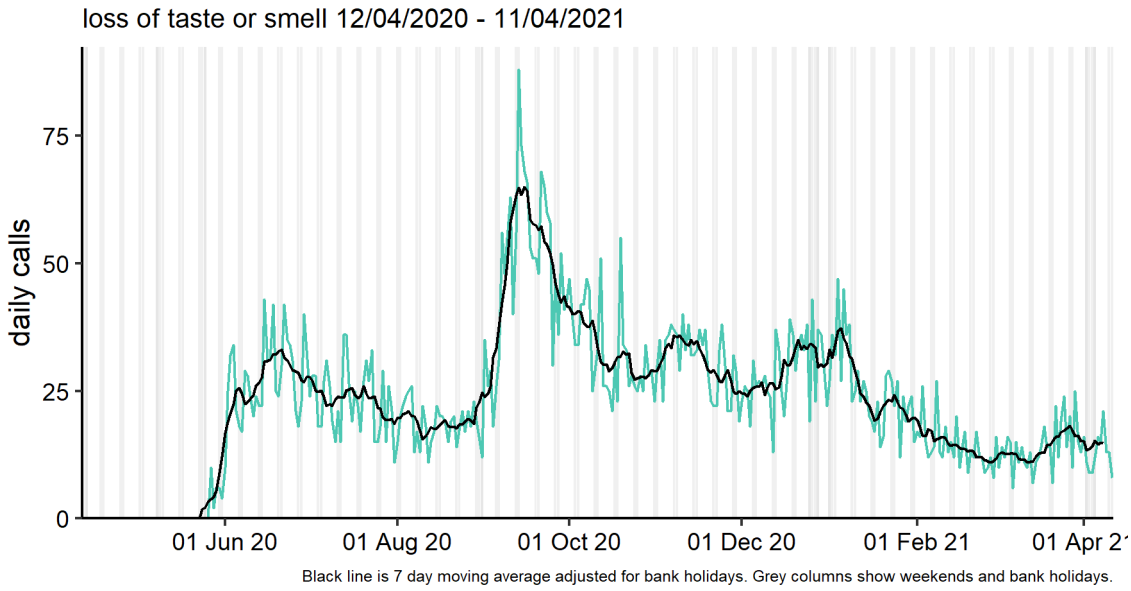
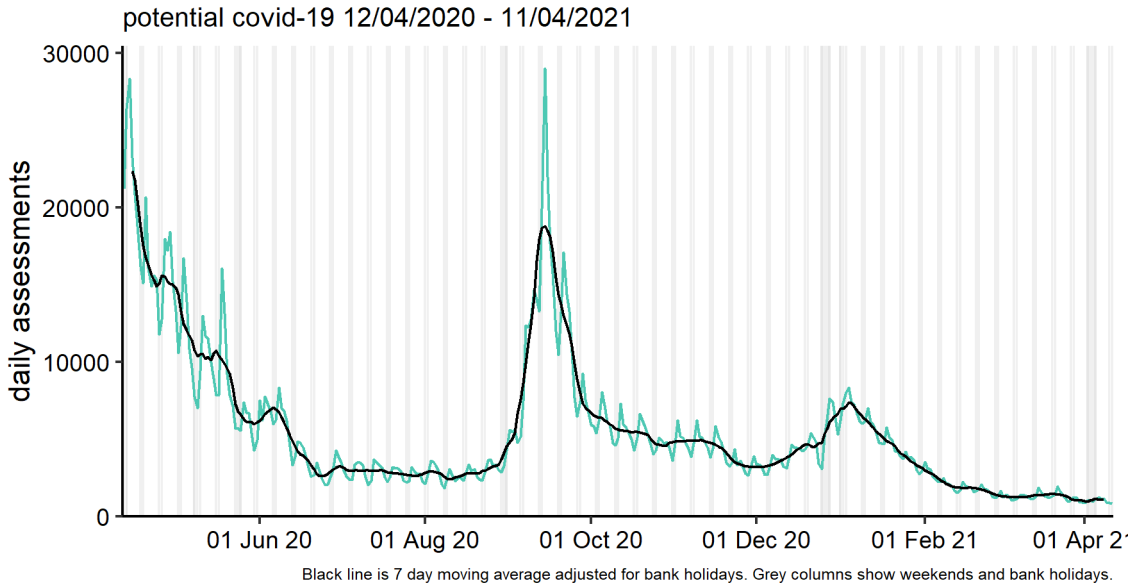
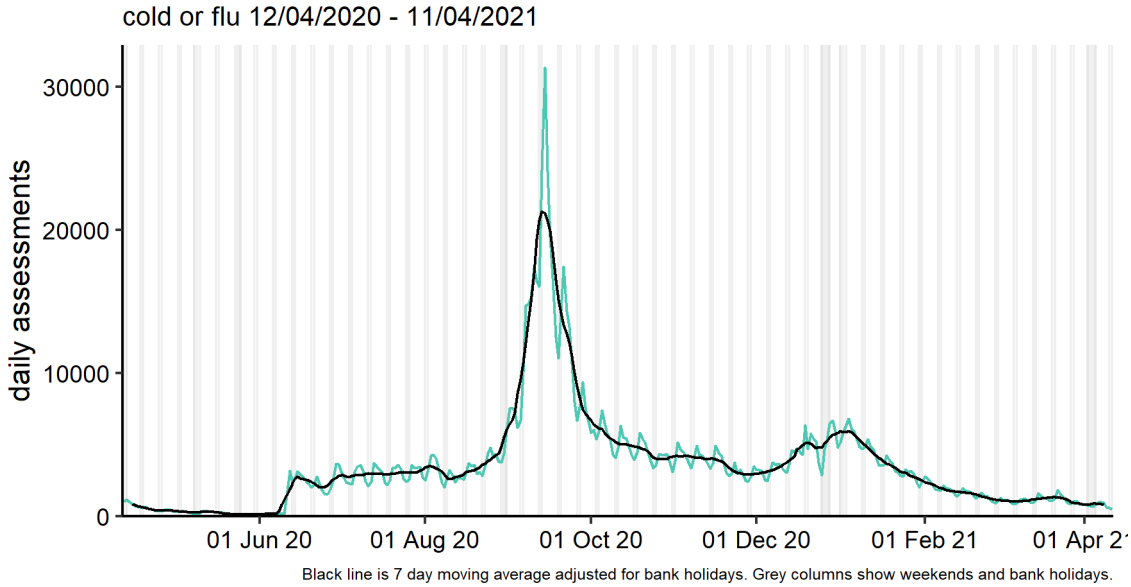

loss of taste or smell 12/04/2020 - 11/04/2021
daily calls
75
50
25
0
01 Jun 20
01 Aug 20
01 Oct 20
01 Dec 20
01 Feb 21
01 Apr 2
Black line is 7 day moving average adjusted for bank holidays. Grey columns show weekends and bank holidays.

Figure 29: 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

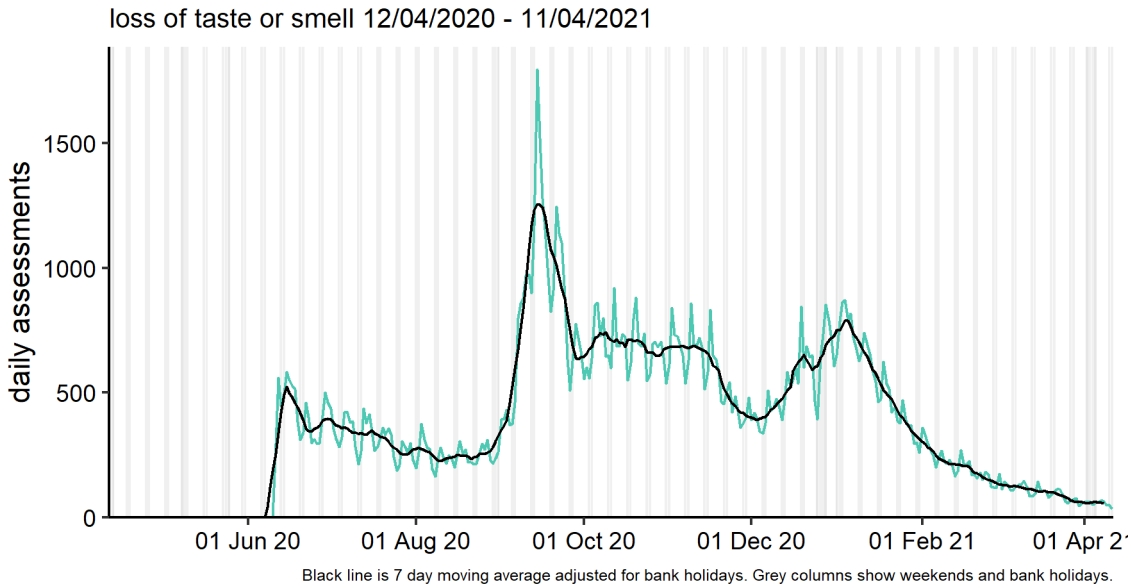
(a)



(b)



(c)


loss of taste or smell 12/04/2020 - 11/04/2021
daily assessments
1500
1000
500
0
01 Jun 20
01 Aug 20
01 Oct 20
01 Dec 20
01 Feb 21
01 Apr 2
Black line is 7 day moving average adjusted for bank holidays. Grey columns show weekends and bank holidays.

Primary care surveillance

RCGP (England)

The weekly ILI consultation rate through the RCGP surveillance was 0.5 per 100,000 registered population in participating GP practices in week 14 compared to the 0.3 per 100,000 in the previous week. This is below the baseline threshold (12.2 per 100,000) (Figure 30). By age group, the highest rates were seen in the 45 to 64 year olds (0.9 per 100,000). The Lower Respiratory Tract Infections (LRTI) consultation rate was at 20.0 per 100,000 in week 14, compared to the rate of 16.8 per 100,000 from the previous week. The COVID-19-like indicator consultation rate was at 12.5 per 100,000 in week 14 compared to a rate of 11.5 per 100,000 in the previous week (Figure 31).

Figure 30: RCGP ILI consultation rates, all ages, England

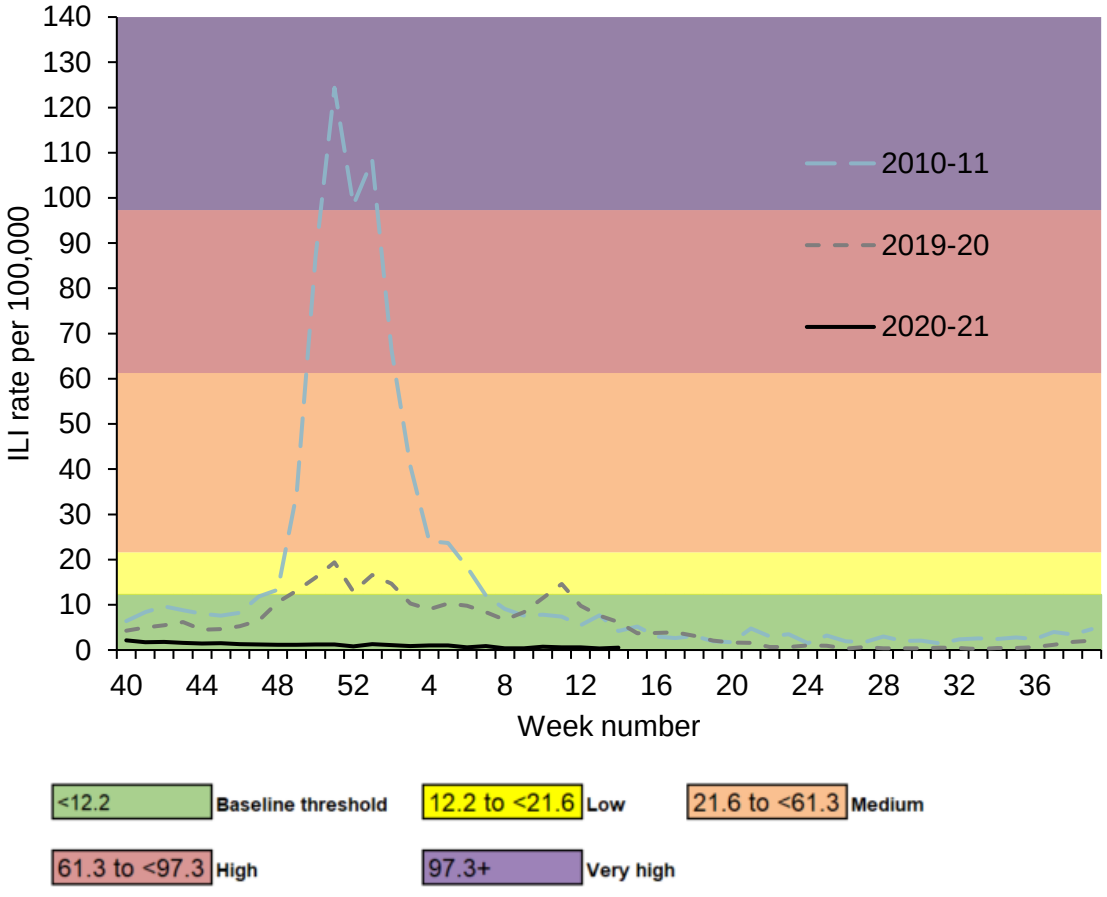
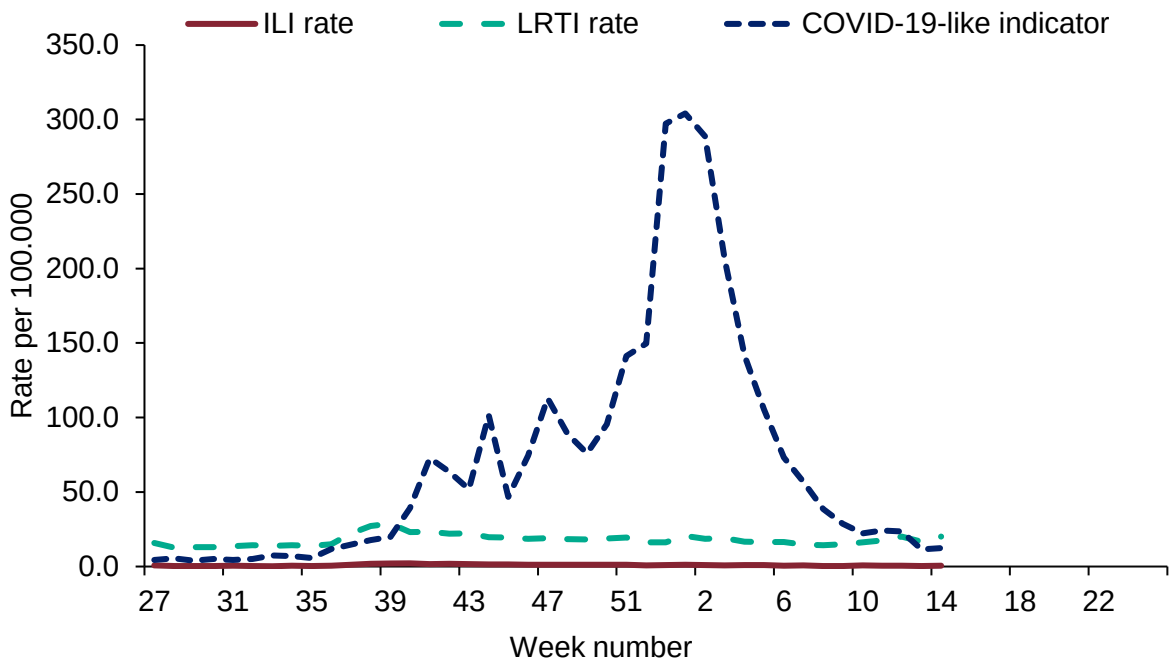


Figure 31: RCGP ILI, LRTI and COVID-19-like indicator consultation rates, England



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 Scotland (0.4 per 100,000) and the 1 to 4 year olds in Northern Ireland (1.3 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	5	6	7	8	9	10	11	12	13	14
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	0.9	1.0	1.0	0.6	0.9	0.4	0.4	0.7	0.6	0.6	0.3	0.5
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	0.8	0.7	0.5	0.3	0.8	0.3	1.0	0.5	0.0	1.0	0.5	0.5
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	0.6	0.5	0.4	0.5	0.4	0.5	0.5	0.3	0.2	0.3	0.4	0.4	0.2
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	2.1	1.0	1.6	0.8	0.8	1.1	0.8	0.7	0.6	0.6	0.4	0.3

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

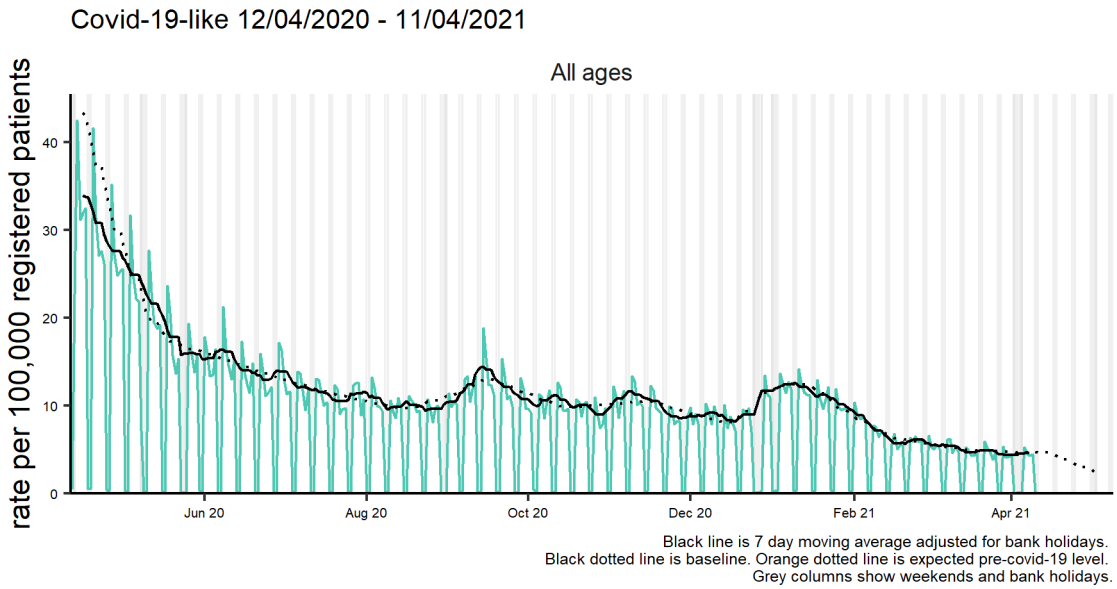
The GP In Hours (GPIH) syndromic surveillance system monitors the number of GP visits during regular hours of known clinical indicators.

Up to 11 April GP in-hours consultations for influenza-like-illness and COVID-19 remained stable (Figure 32).

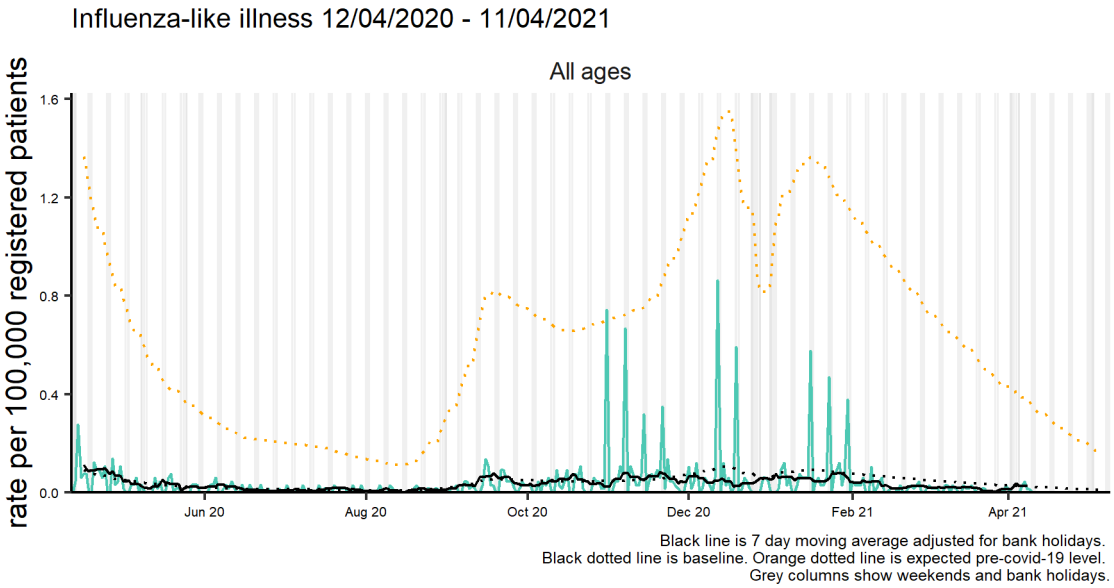
Further information about caveats is available from the PHE GP In Hours Syndromic Surveillance bulletin.

Figure 32: GPIH clinical indicators for (a) potential COVID-19 GP consultations and (b) influenza-like illness GP consultations, England

(a)



(b)



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

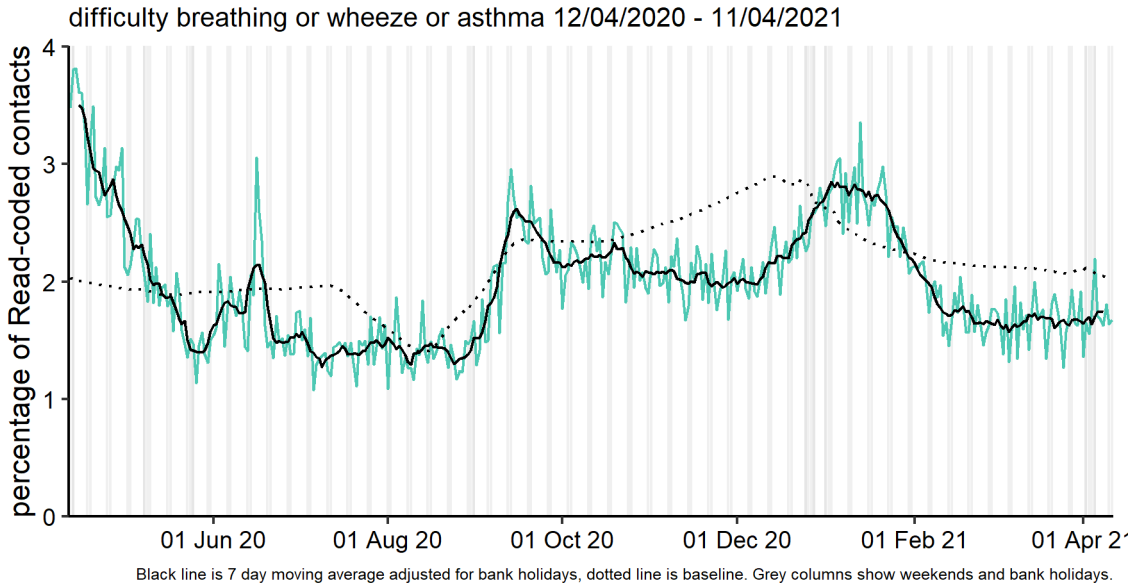
GP Out of Hours, Syndromic Surveillance

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

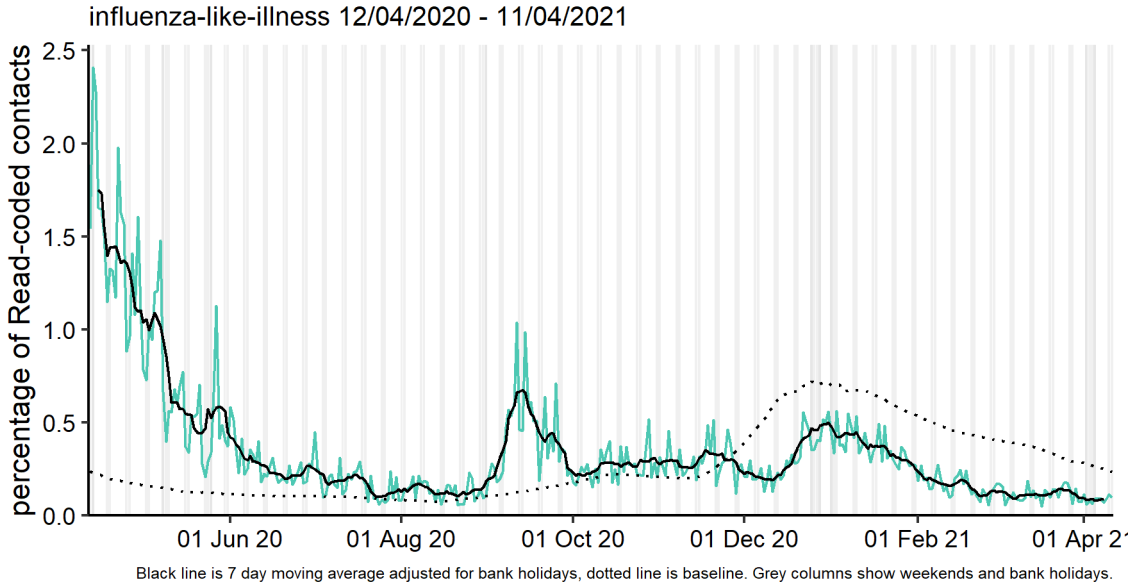
Up to 11 April GP out-of-hours and unscheduled care consultations for acute respiratory infections, influenza-like illness and difficulty breathing/asthma/wheeze remained stable (Figure 33).

Figure 33: GPOOH daily contacts (%) for (a) difficulty breathing/wheeze/asthma, (b) influenza-like illness and (c) acute respiratory infections, England

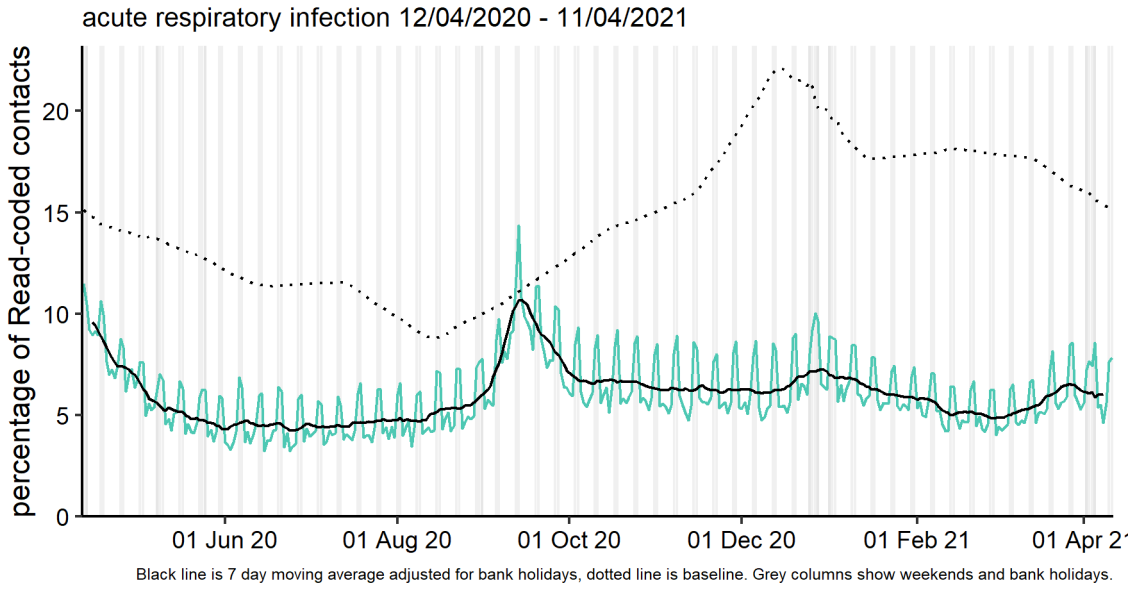
(a)



(b)



(c)

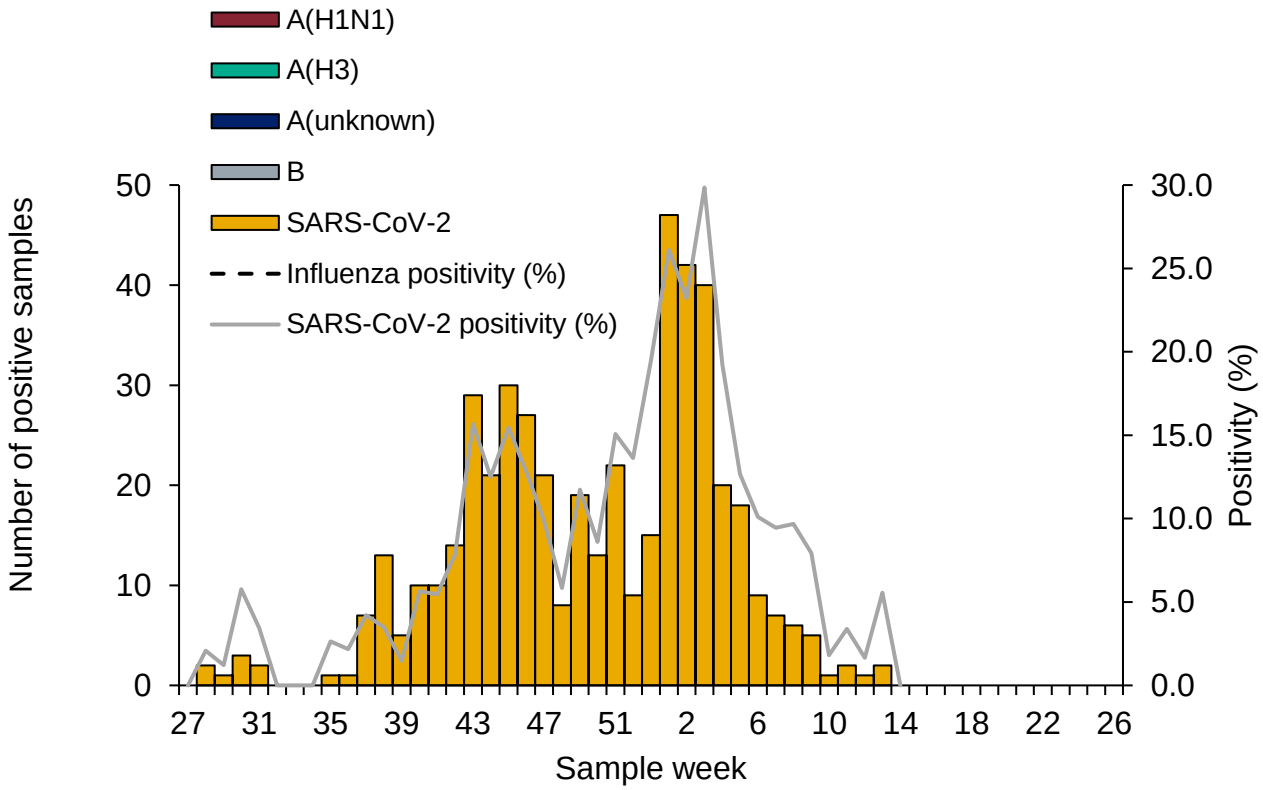

acute respiratory infection 12/04/2020 - 11/04/2021
percentage of Read-coded contacts
0
5
10
15
20
01 Jun 20
01 Aug 20
01 Oct 20
01 Dec 20
01 Feb 21
01 Apr 2
Black line is 7 day moving average adjusted for bank holidays, dotted line is baseline. Grey columns show weekends and bank holidays.

Sentinel swabbing scheme in the UK

In week 14 2021, no samples tested positive for SARS-CoV-2 with an overall positivity of 0.0% (0/33) compared to 5.6% (2/36) in the previous week, through the UK GP sentinel swabbing schemes (Figure 34).

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

Figure 34: 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 34 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.

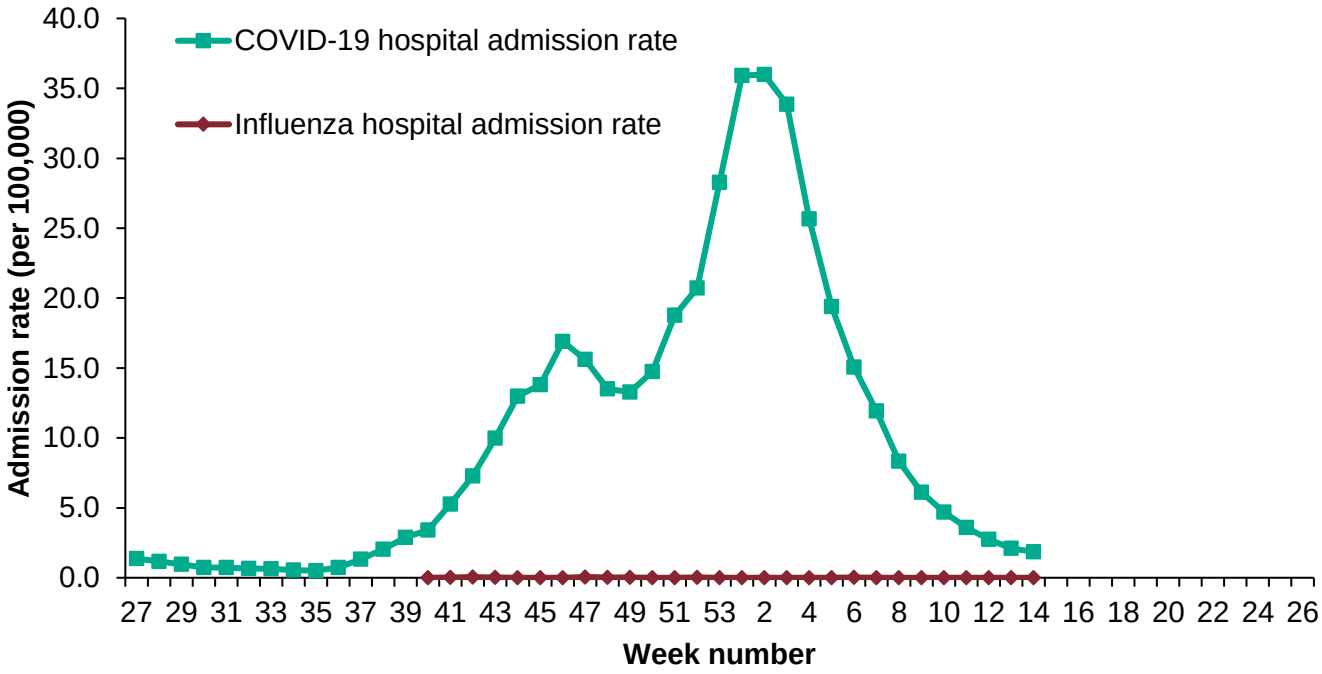
Hospitalisations, SARI Watch

In week 14, the weekly hospital admission rate for COVID-19 continued to decrease. There were no new hospital admissions for influenza in week 14.

The hospitalisation rate for COVID-19 was at 1.85 per 100,000 in week 14 compared to 2.11 per 100,000 in the previous week.

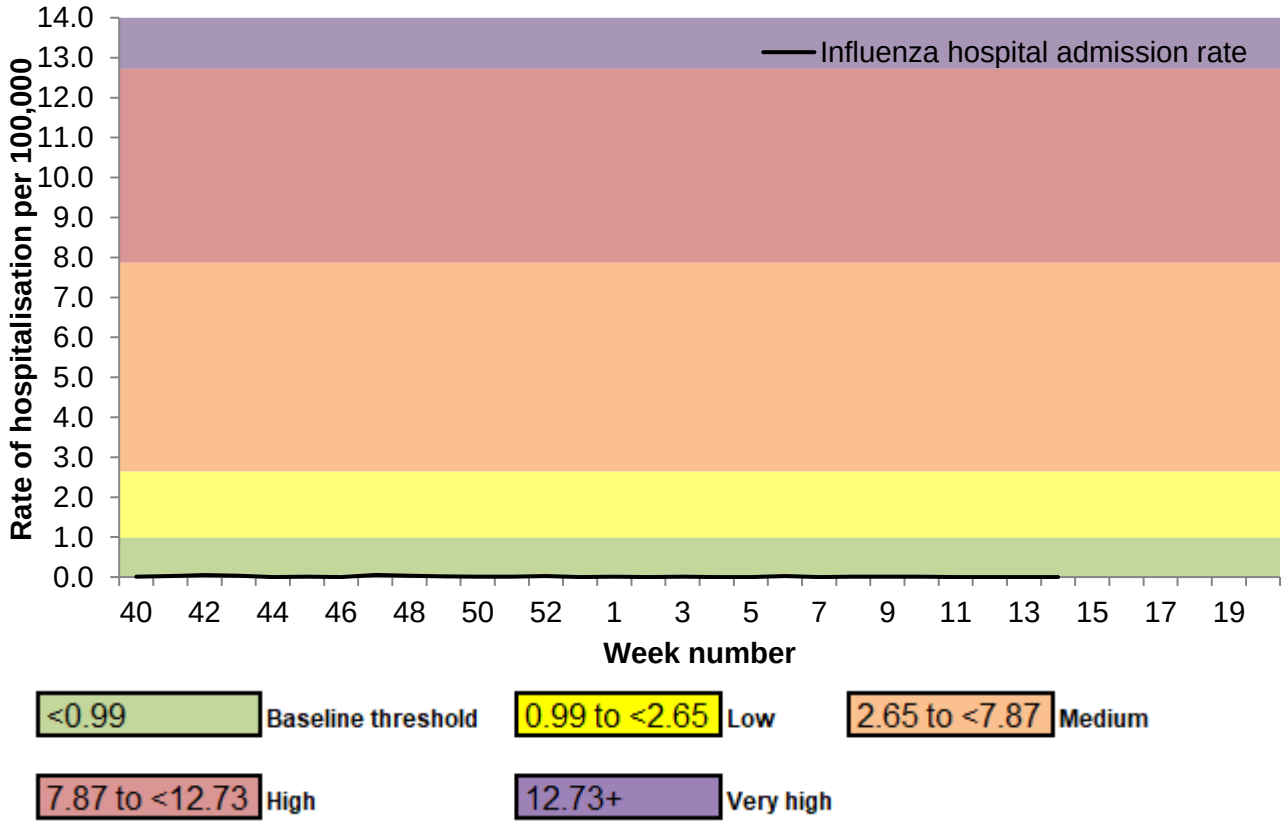
By PHE centre, the highest hospital admission rate for COVID-19 was observed in Yorkshire and Humber. By age groups, the highest hospital admission rate for confirmed COVID-19 was in the 85+ year olds.

Figure 35: 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 24 sentinel NHS trusts for week 14
* COVID-19 hospital admission rate based on 115 NHS trusts for week 14
* SARI Watch data are provisional.

Figure 36: 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 37: Weekly influenza hospital admissions by influenza type, SARI Watch, England

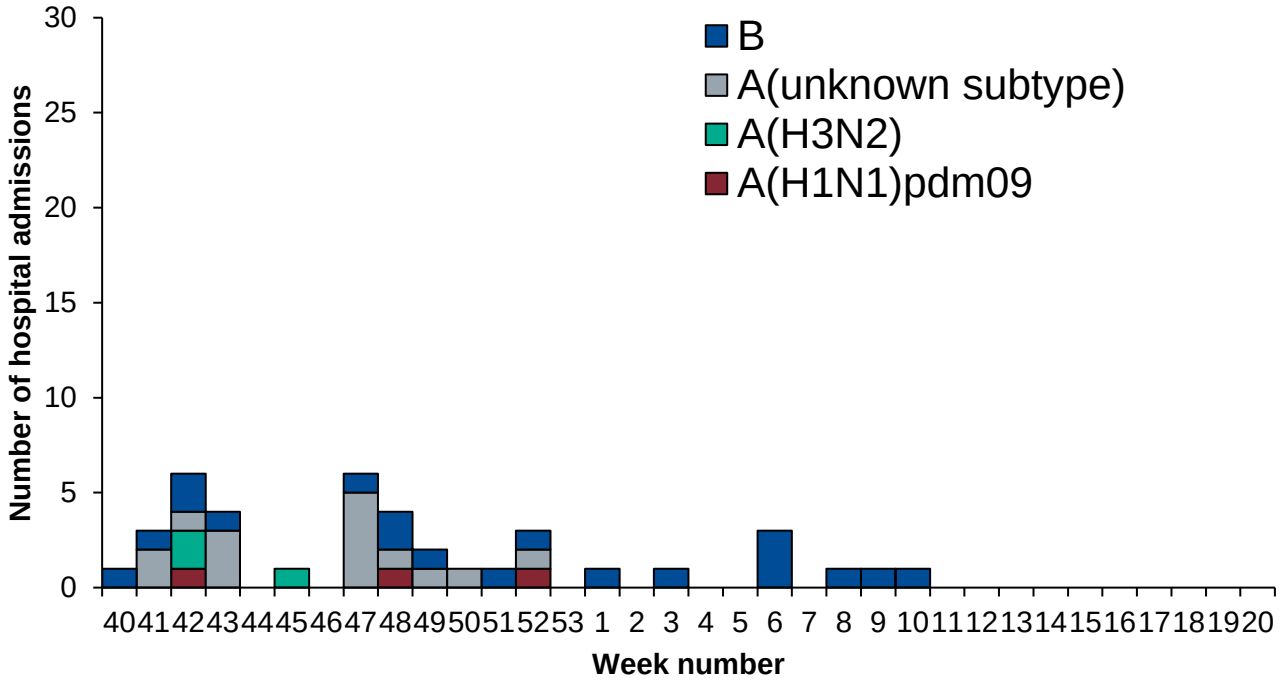
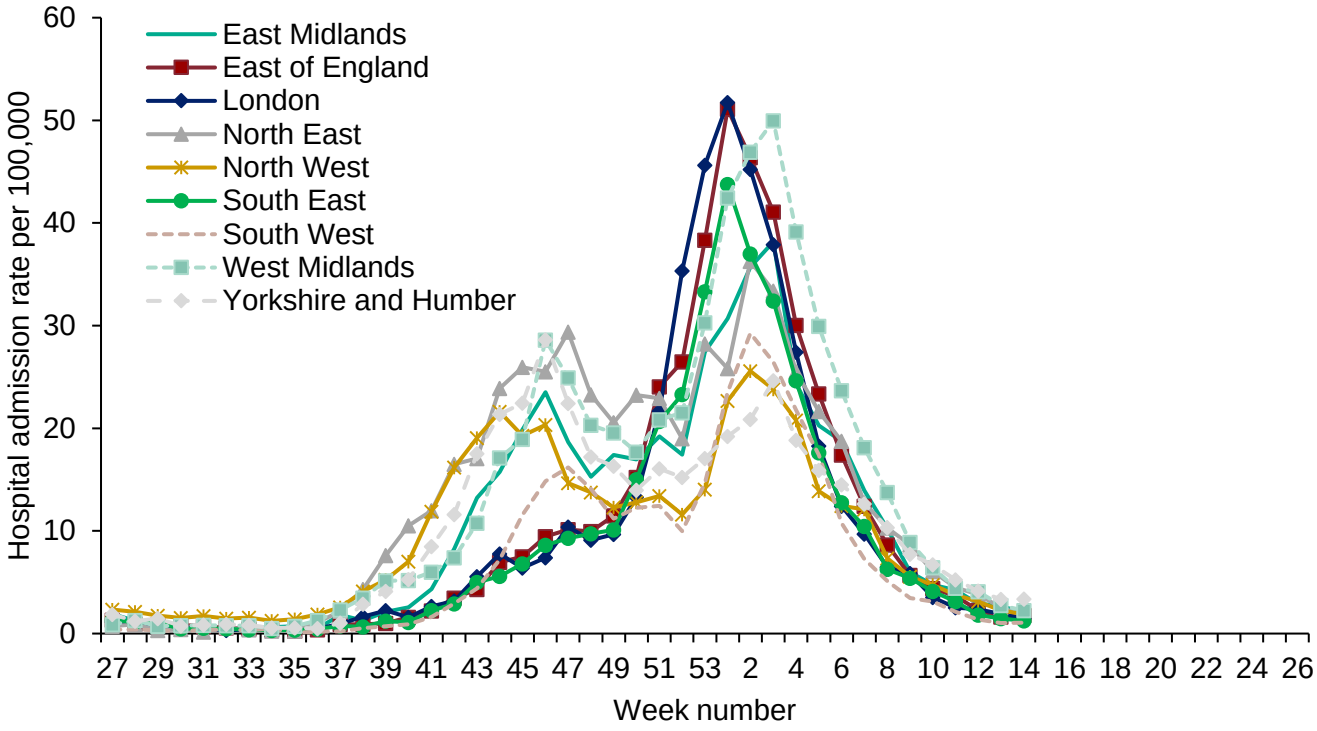


Figure 38: Weekly hospital admission rate by PHE Centre for new (a) COVID-19 positive cases and (b) influenza reported through SARI Watch

(a)



(b)

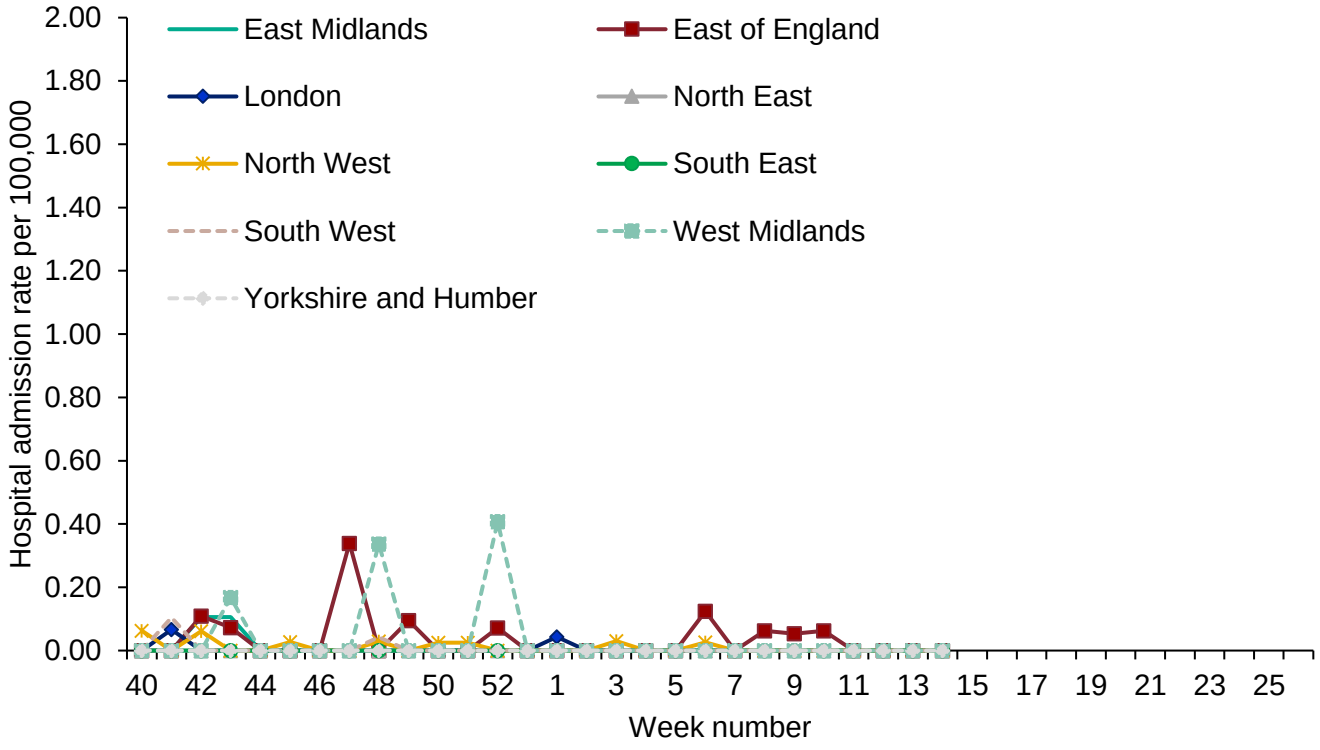
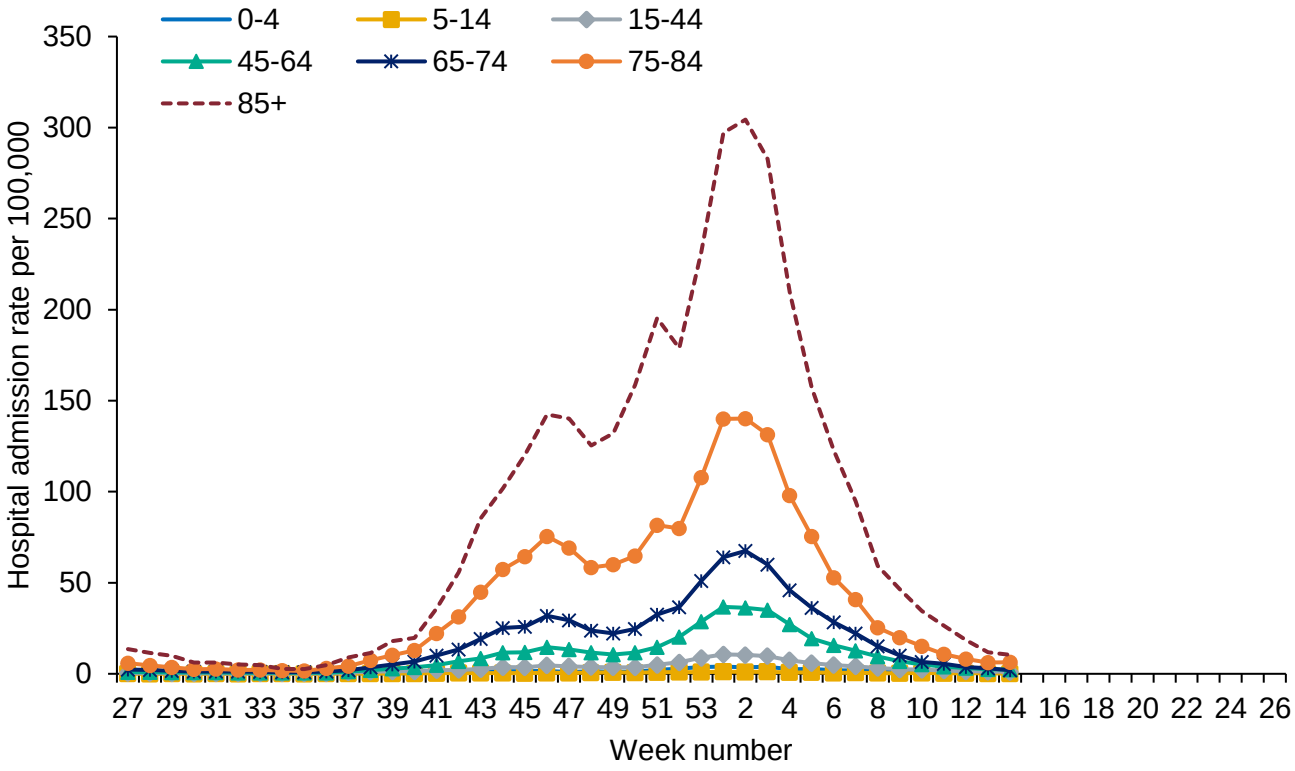
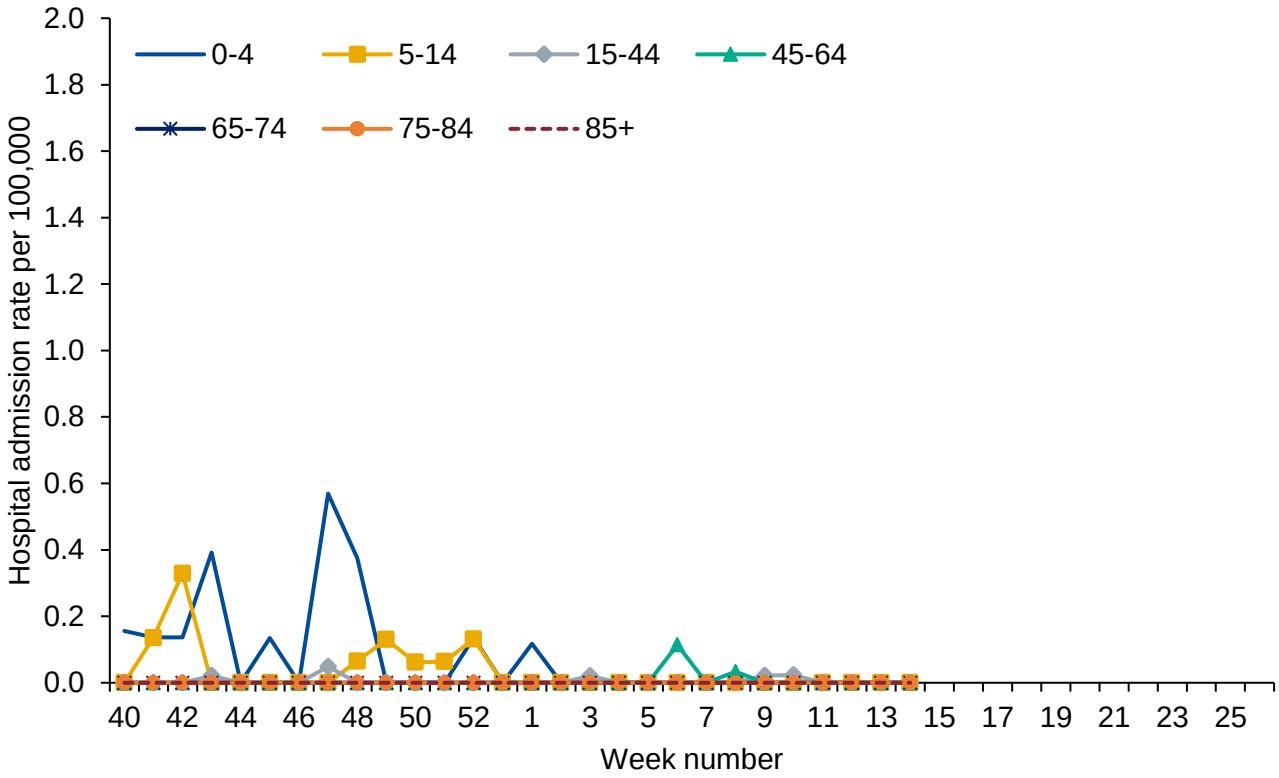


Figure 39: Weekly hospital admission rate by age group for new (a) COVID-19 positive cases and (b) influenza reported through SARI Watch

(a)



(b)



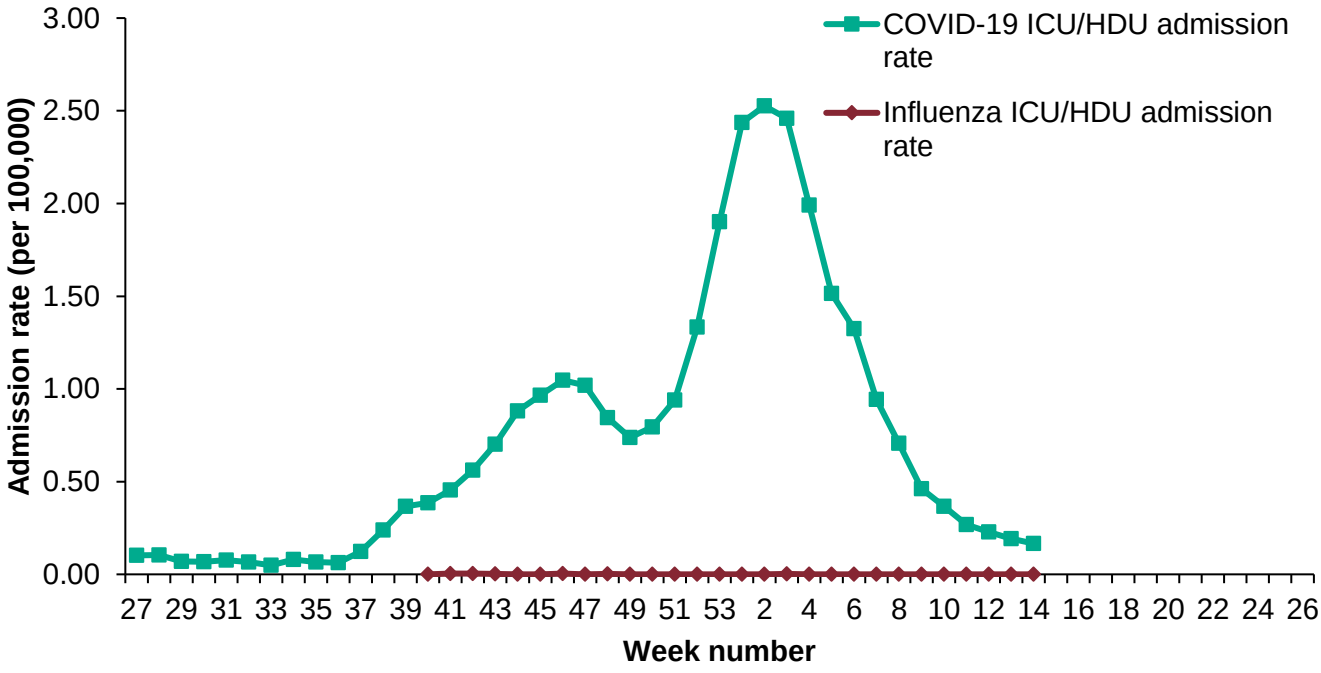
ICU/HDU admissions, SARI Watch

In week 14, the weekly ICU/HDU admission rates for COVID-19 decreased slightly. There was no new ICU/HDU admissions for influenza in week 14.

The ICU/HDU rate for COVID-19 was at 0.17 per 100,000 in week 14 compared to at 0.19 per 100,000 in the previous week.

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 45 to 64 year olds.

Figure 40: 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 94 NHS trusts for week 14
* COVID-19 ICU/HDU admission rate based on 112 NHS trusts for week 14
* SARI Watch data are provisional.

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

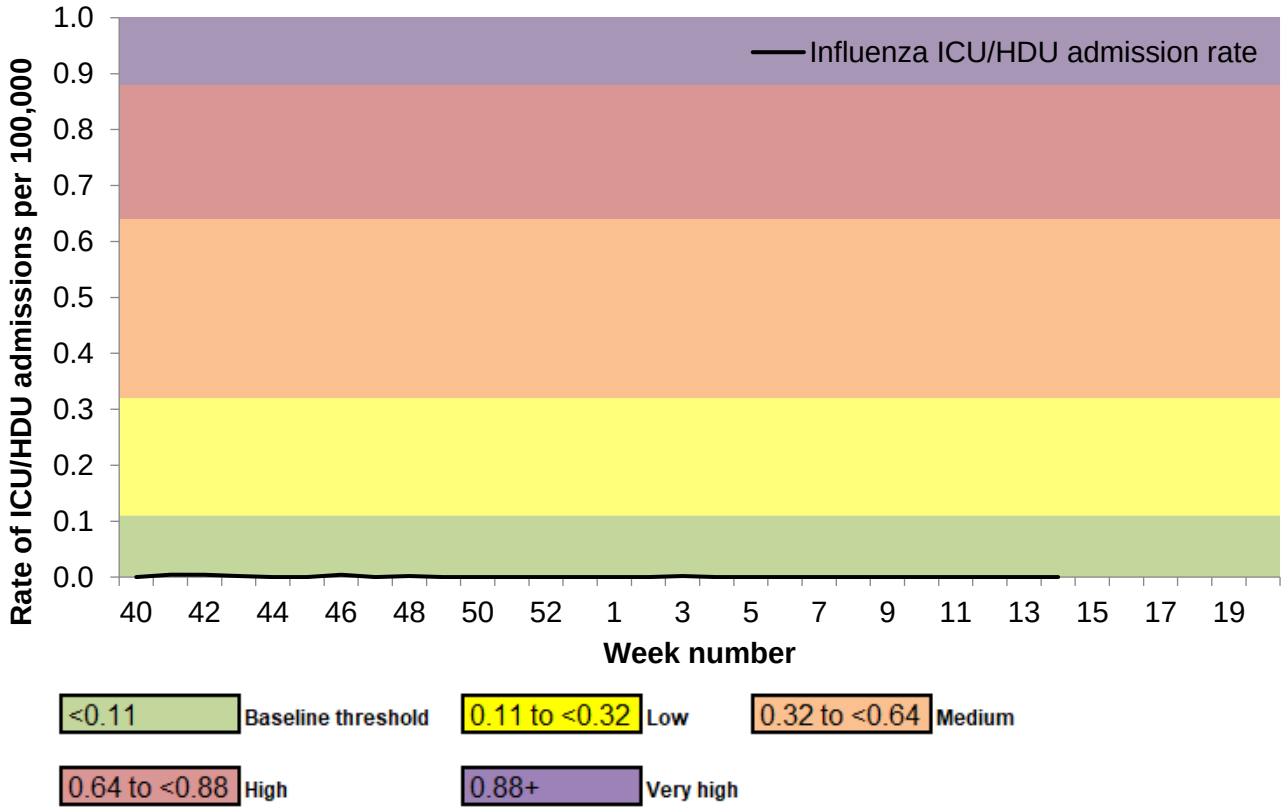


Figure 42: Weekly influenza ICU/HDU admissions by influenza type, SARI Watch, England

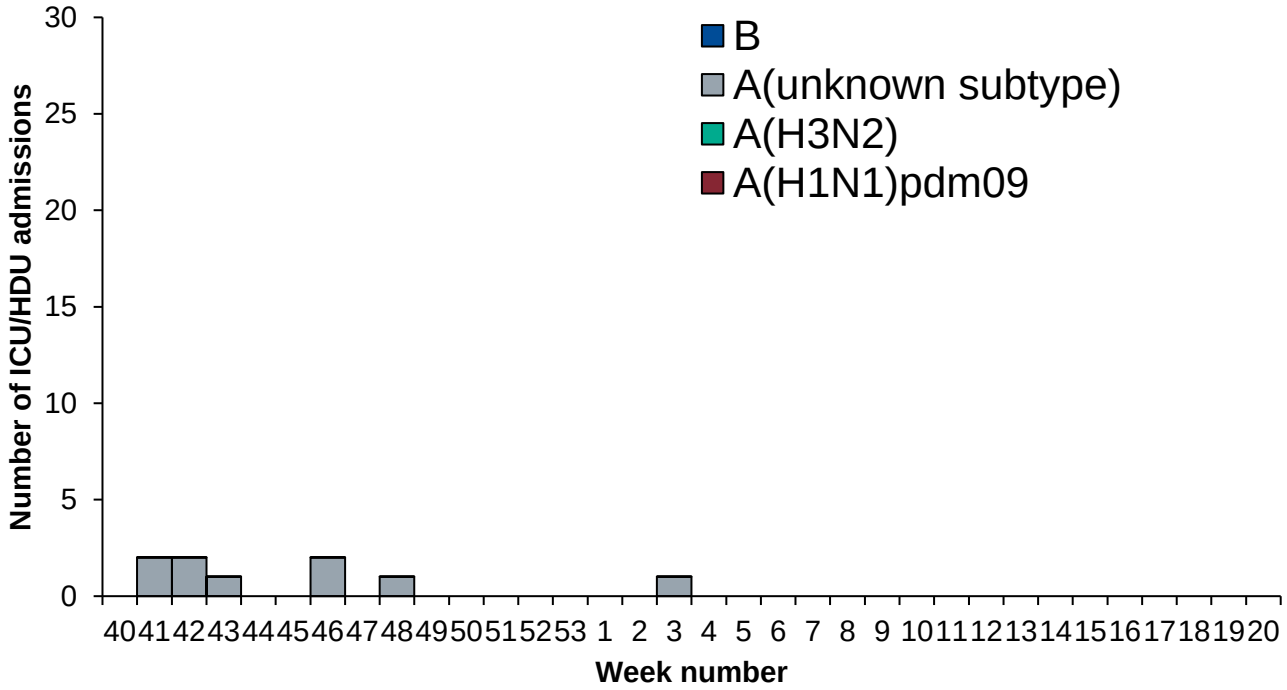
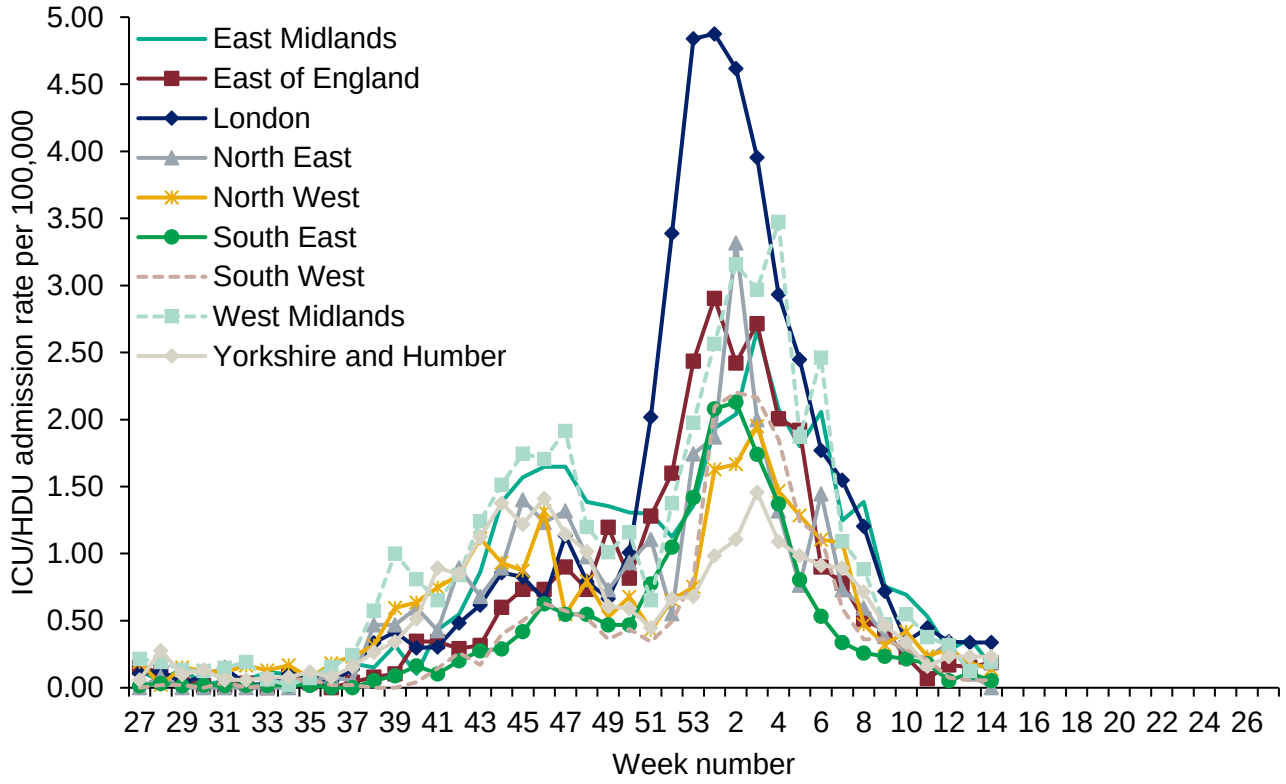


Figure 43: Weekly ICU/HDU admission rate by PHE Centre for new (a) COVID-19 positive cases and (b) influenza reported through SARI Watch

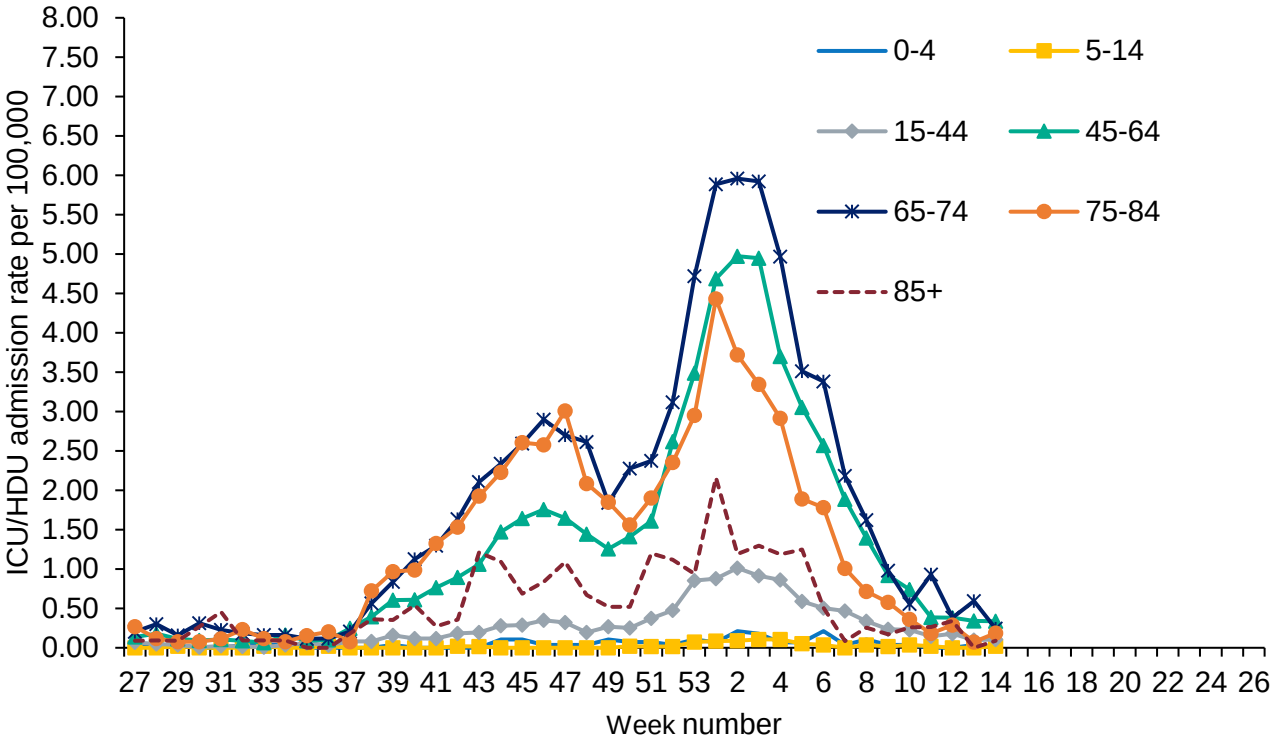
(a)



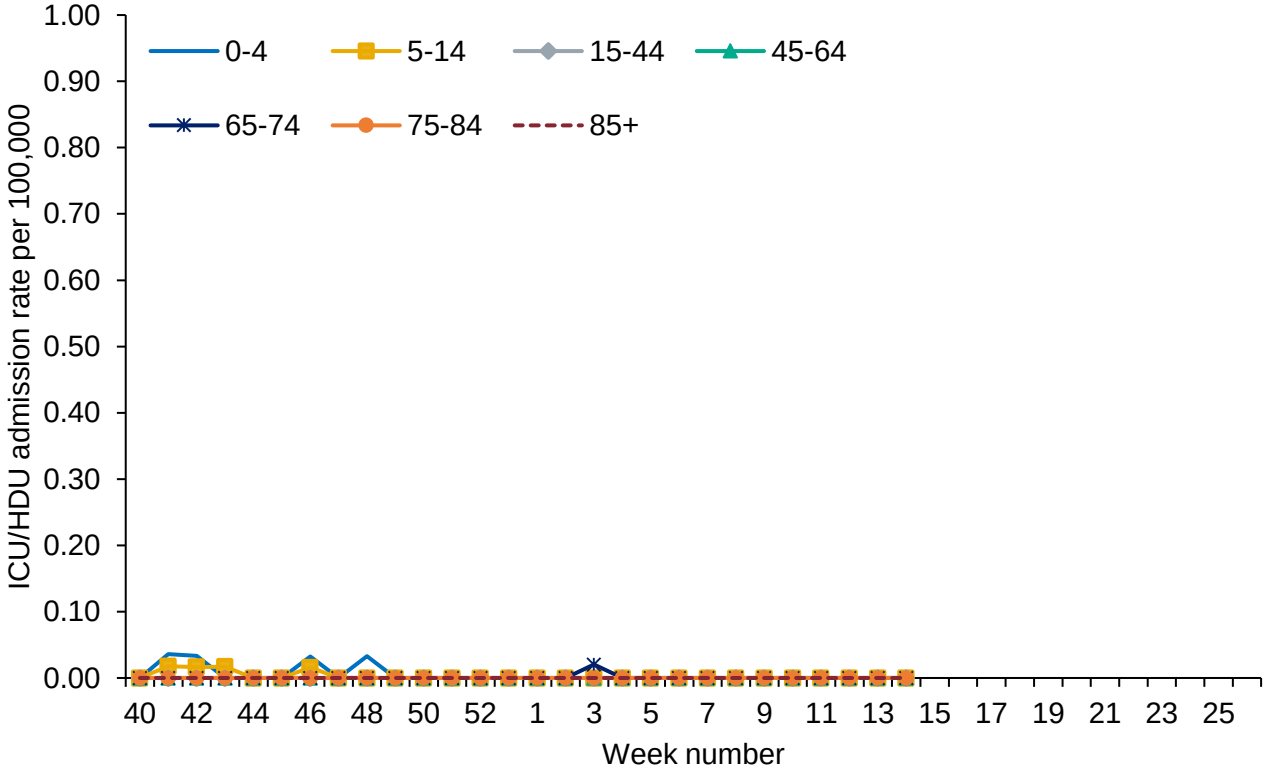
(b)

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

(a)



(b)

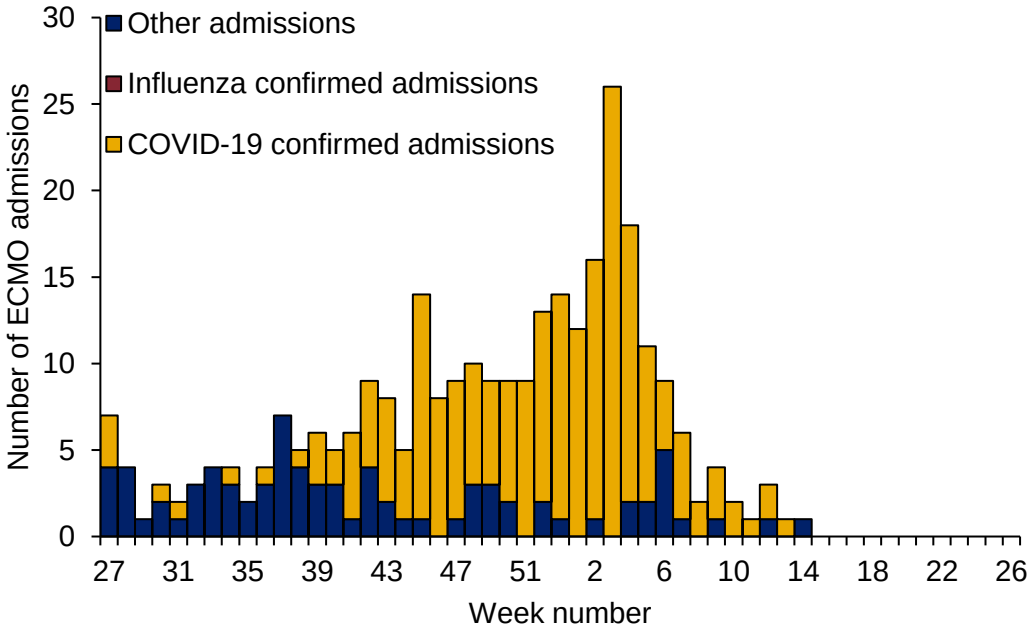


ECMO, SARI Watch

From week 27 2020, a total of 213 laboratory confirmed COVID-19 admissions have been reported from the 6 Severe Respiratory Failure (SRF) centres in the UK.

There were no new laboratory confirmed COVID-19 admissions reported in week 14 (Figure 45).

Figure 45: Laboratory confirmed ECMO admissions (COVID-19, influenza and non-COVID-19 confirmed) to Severe Respiratory Failure centres in the UK



Emergency Department attendances, Syndromic surveillance

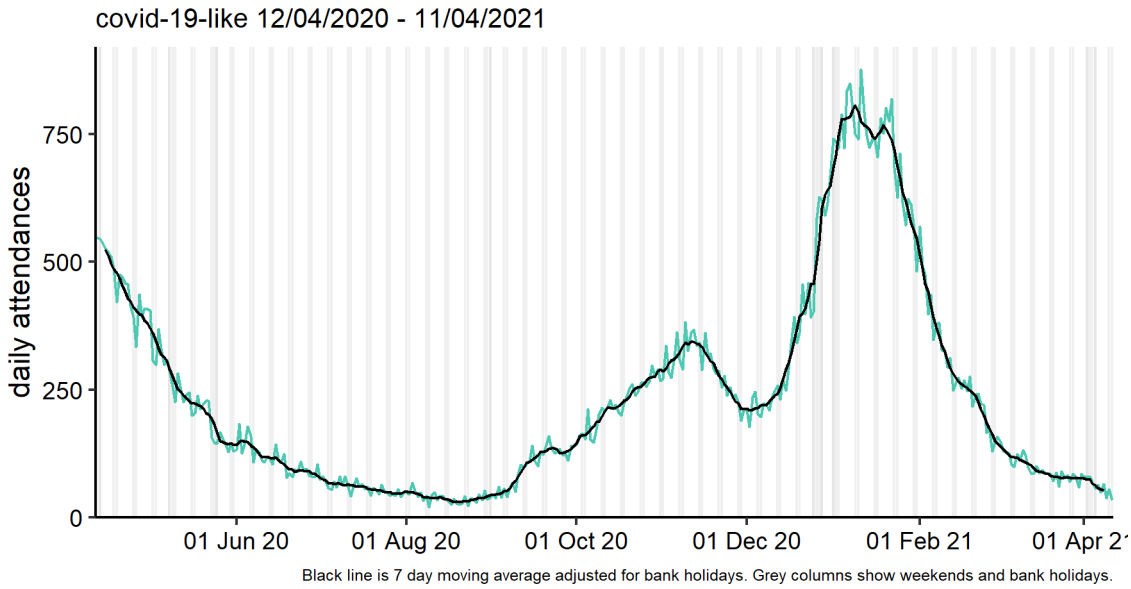
The Emergency Department Syndromic Surveillance System (EDSSS) monitors the daily visits in a network of emergency departments across England.

Up to 11 April 2021, the daily number of ED attendances for all ages as reported by 106 EDs, for COVID-19-like and acute respiratory infection decreased (Figure 46).

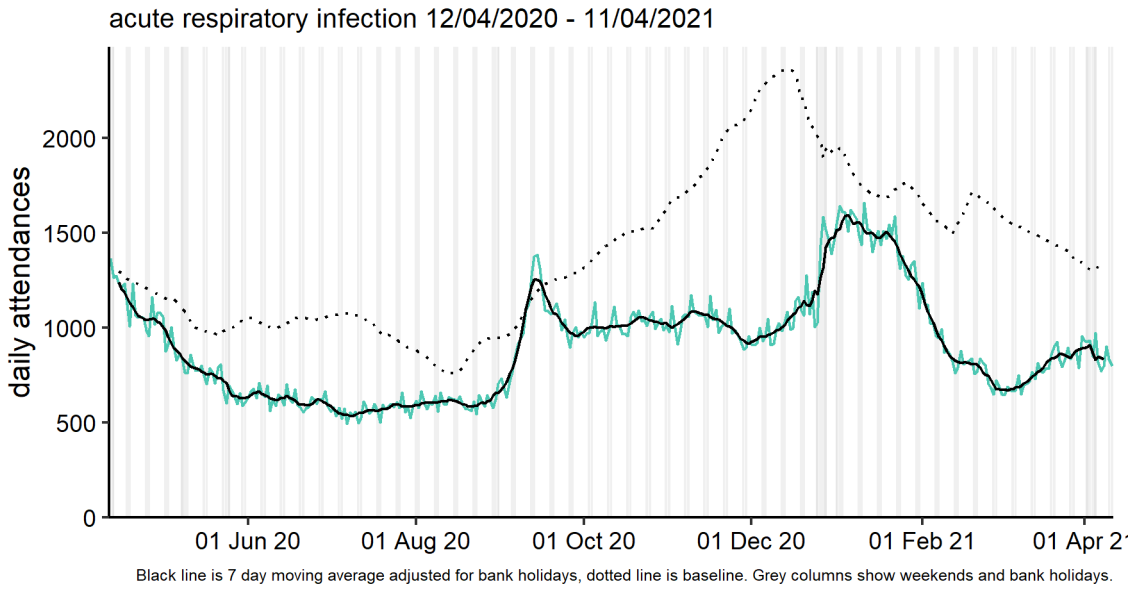
Please note: the COVID-19-like ED indicator is an underestimation of the number of COVID-19 attendances as it only includes attendances with a COVID-19-like diagnosis as their primary diagnosis. The EDSSS COVID-19-like indicator should therefore be used to monitor trends in ED attendances and not to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

Figure 46: Daily ED attendances for (a) COVID-19-like and (b) acute respiratory infections, all ages, England

(a)



(b)


acute respiratory infection 12/04/2020 - 11/04/2021
daily attendances
2000
1500
1000
500
0
01 Jun 20
01 Aug 20
01 Oct 20
01 Dec 20
01 Feb 21
01 Apr 2
Black line is 7 day moving average adjusted for bank holidays, dotted line is baseline. Grey columns show weekends and bank holidays.

Mortality surveillance

Cumulative COVID-19 deaths

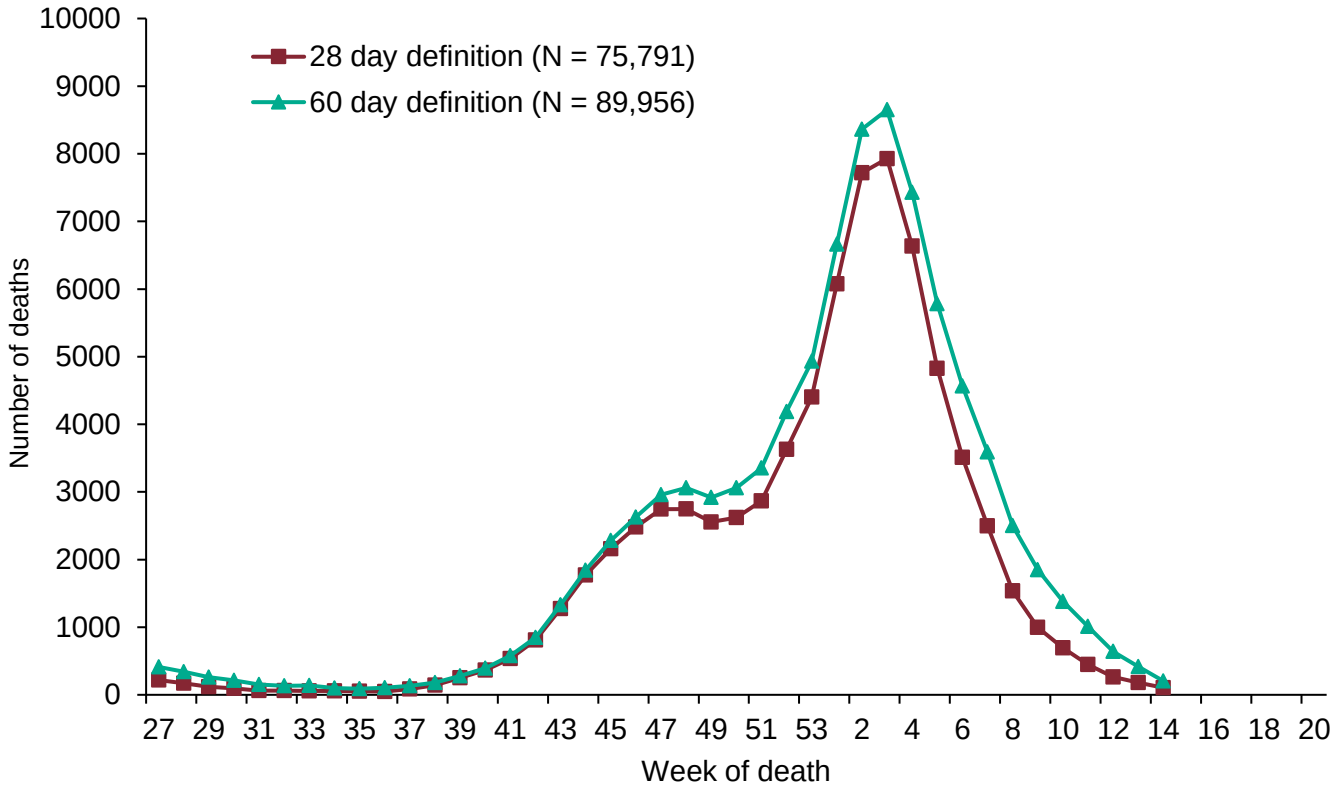
Changes to the definitions of COVID-19 related deaths in England are described in more detail in an accompanying PHE technical summary.

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 47 represents these differences by definition.

Figure 47: 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 48: Age/sex pyramid of laboratory confirmed COVID-19 deaths, since week 27

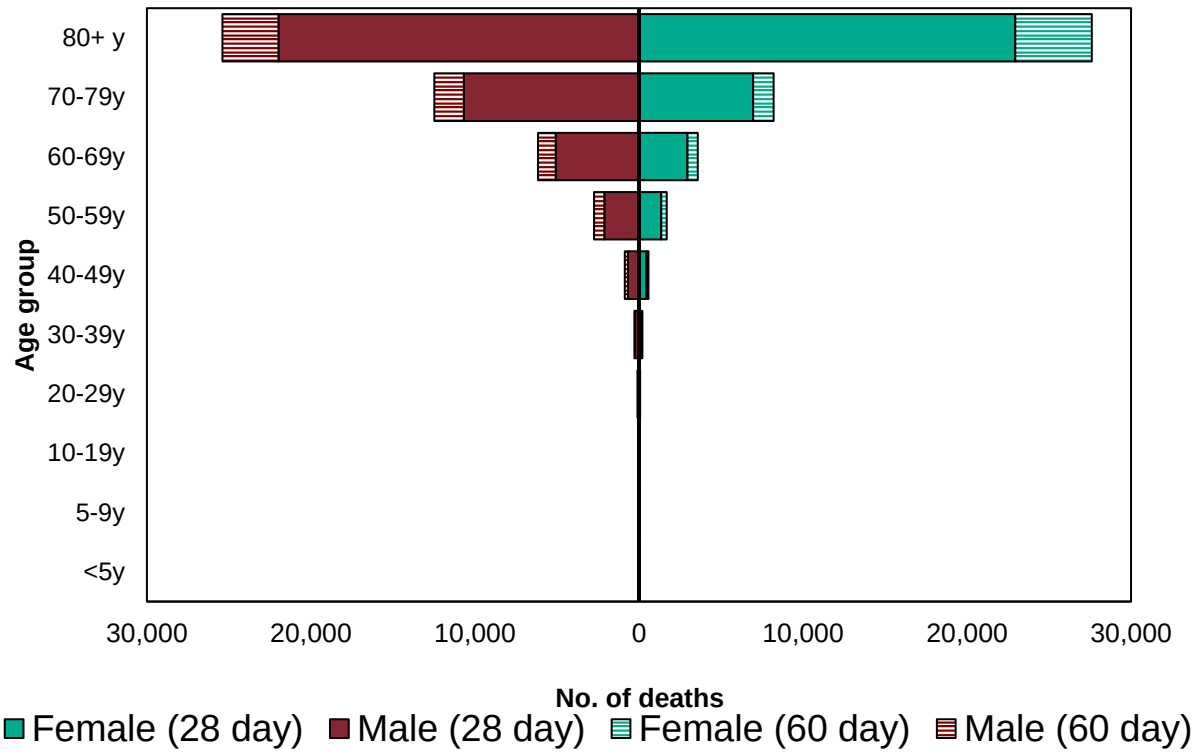


Table 5: Ethnic group (%) of COVID-19 deaths and time since laboratory confirmation of COVID-19, England

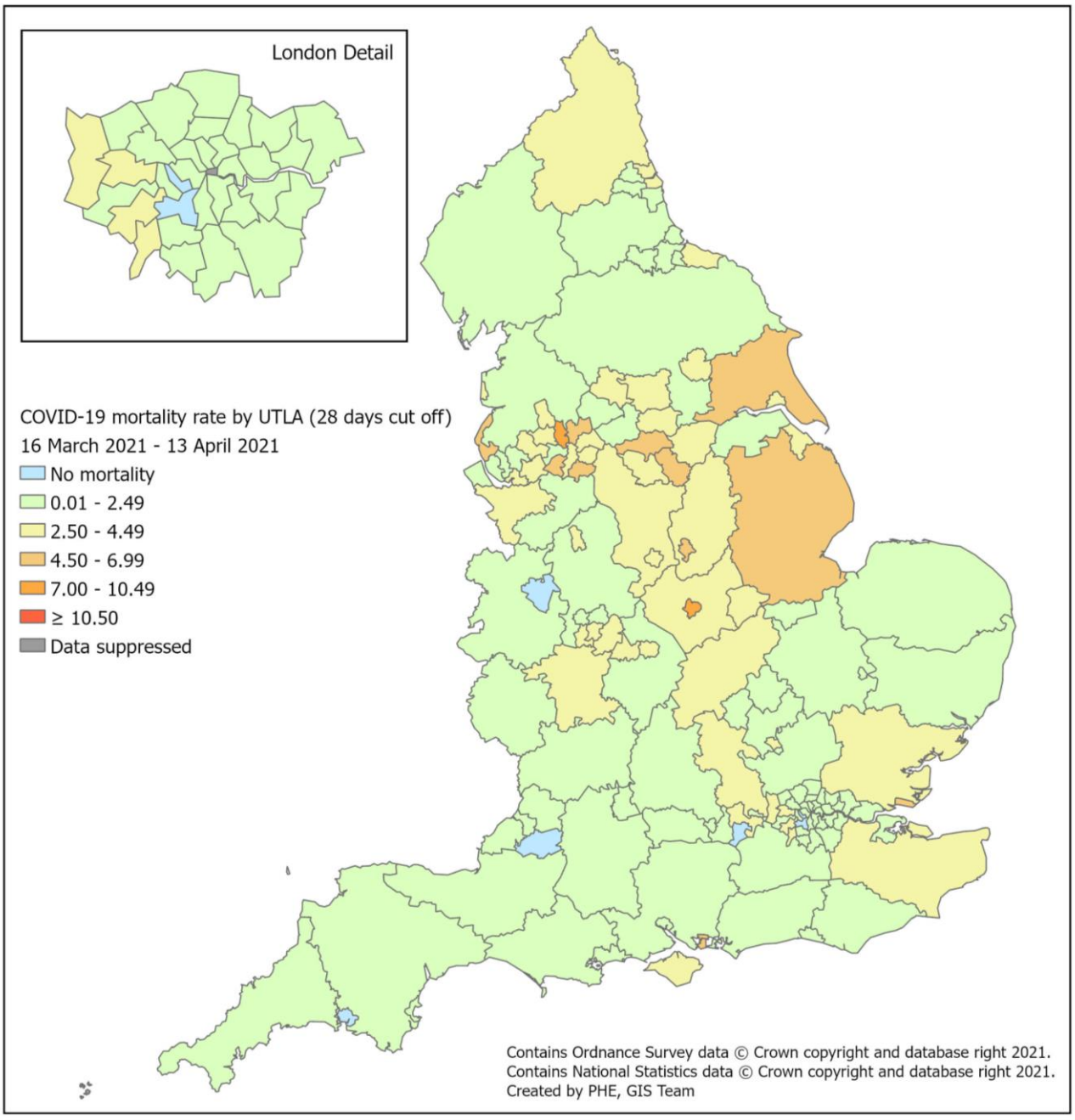
Ethnicity	28 day definition	60 day definition
White	88.6	88.6
Asian / Asian British	6.9	6.8
Black / African / Caribbean / Black British	2.5	2.5
Mixed / Multiple ethnic groups	0.5	0.5
Other ethnic group	1.6	1.6

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

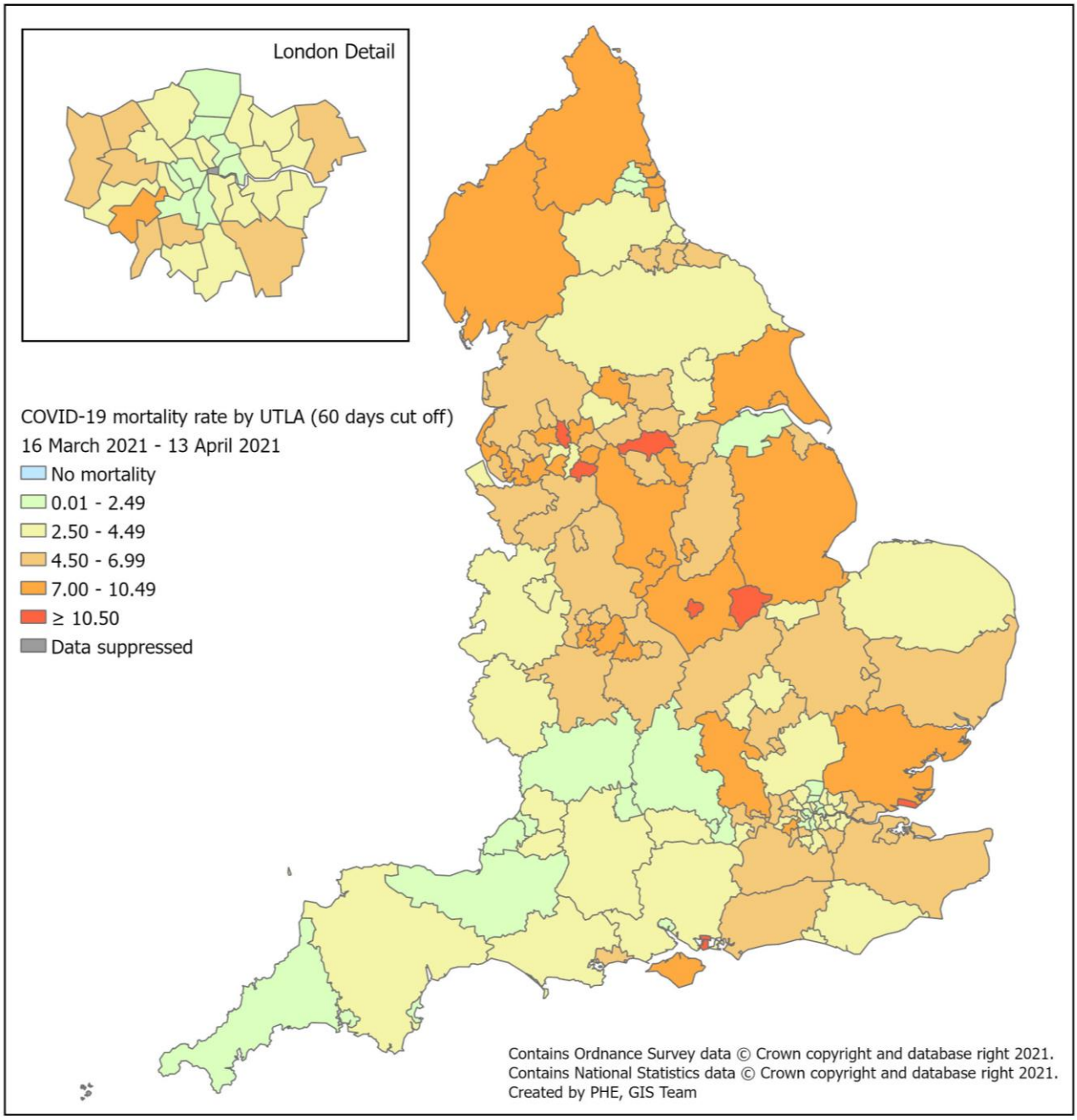
PHE Centres	28 day definition	60 day definition
North East	3,838	4,581
North West	11,861	14,164
Yorkshire & Humber	7,381	8,785
West Midlands	8,970	10,693
East Midlands	7,228	8,573
East of England	9,723	11,457
London	9,312	11,155
South East	12,122	14,366
South West	4,917	5,724

Figure 49: 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)


London Detail
COVID-19 mortality rate by UTLA (60 days cut off)
16 March 2021 - 13 April 2021
No mortality
0.01 - 2.49
2.50 - 4.49
4.50 - 6.99
7.00 - 10.49
≥ 10.50
Data suppressed
Contains Ordnance Survey data © Crown copyright and database right 2021.
Contains National Statistics data © Crown copyright and database right 2021.
Created by PHE, GIS Team

Daily excess all-cause mortality (England)

Deaths occurring from 1 January to 7 April 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 50).

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 50.

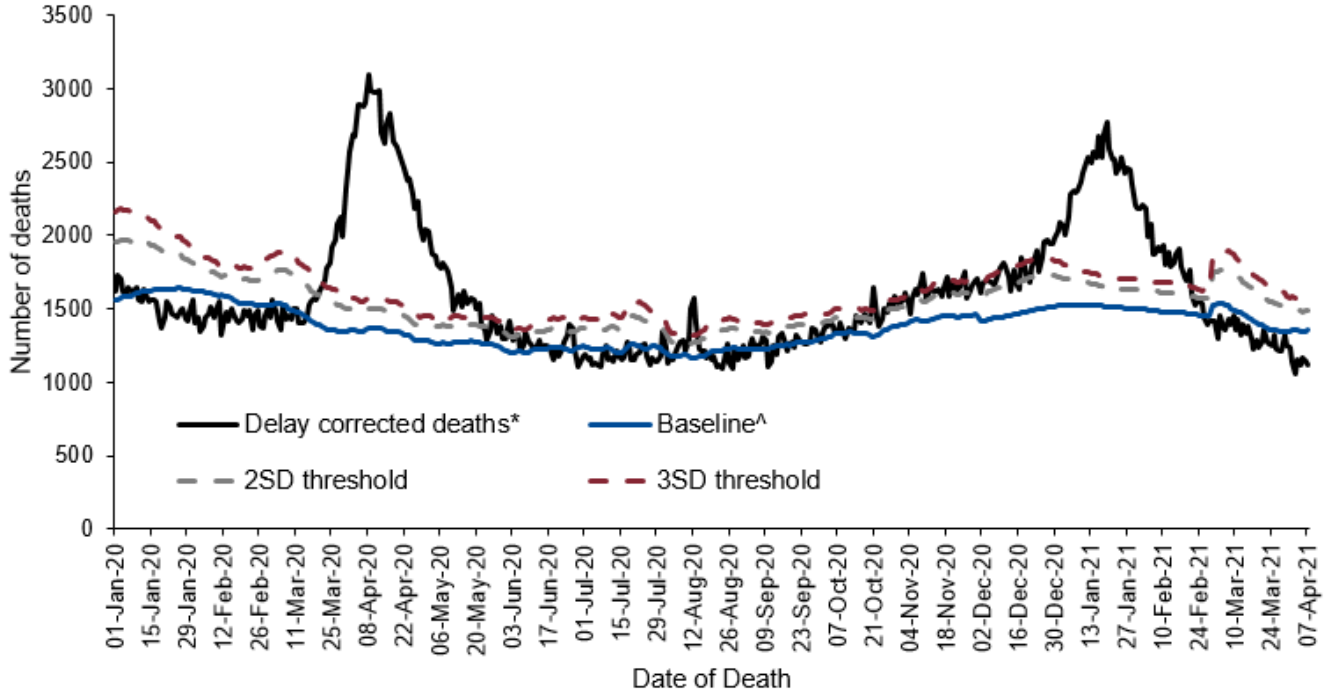
Note that as these data are by date of death with delay corrections, numbers are subject to change each week, particularly for more recent days.

Please note that there may still be slight delays to registration due to the Easter bank holidays.

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

No significant excess all-cause mortality was observed in week 13 overall, by age or sub-nationally. The excess noted in week 33 coincides with a heat wave (Figure 50, 51 and Table 7).

Figure 50: Daily excess all-cause deaths in all ages, England, 1 January 2020 to 7 April 2021



^Baseline calculation:
January to November 2020: same day in previuos 5 years +/- 1 week with a linear trend.
December 2020 to February 2021: past 3 low flu years +/- 2 weeks, no trend.
March 2021 onwards: same baseline as 2020
* corrected for delay to registration from death

Other measures of excess mortality published by 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)

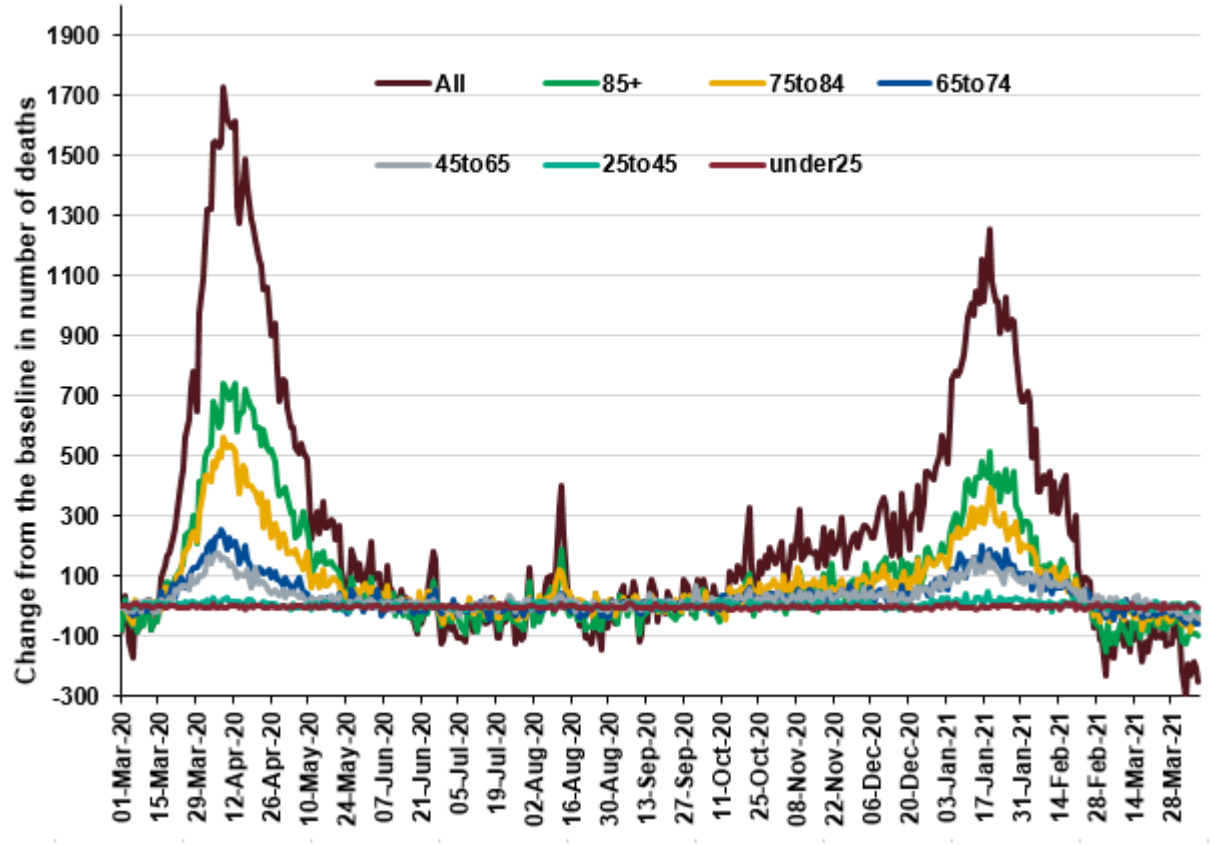
Age Group	Excess detected in week 13 2021?	Weeks in excess from week 10 to 53 2020	Weeks in excess from week 01 to 13 2021
All	x	13 to 21, 33, 43, 45 to 48, 50, 52 to 53	01 to 07
under 25	x	None	None
25 to 44	x	14 to 16, 53	02 to 04, 07
45 to 64	x	12 to 19, 44, 47, 49 to 50, 52 to 53	01 to 08
65 to 74	x	13 to 19, 46, 52 to 53	01 to 07
75 to 84	x	13 to 21, 33, 45, 50, 52 to 53	01 to 07
85+	x	13 to 21, 33, 53	01 to 07

(b)

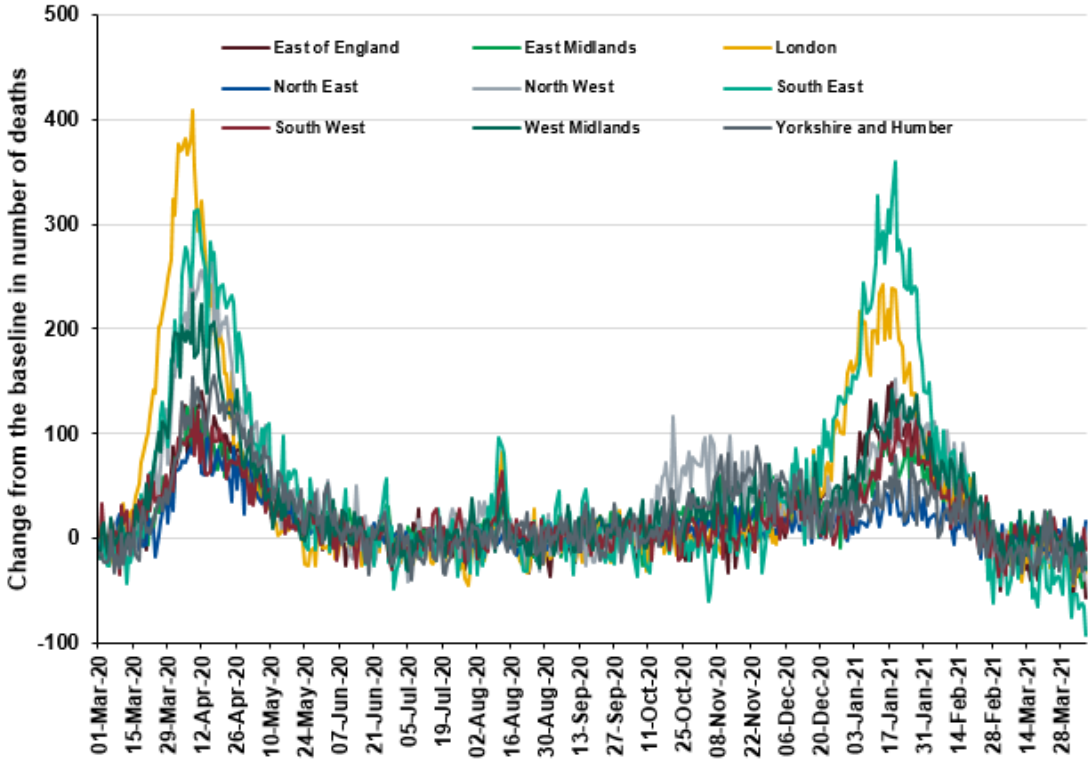
PHE Centres	Excess detected in week 13 2021?	Weeks in excess from week 10 to 53 2020	Weeks in excess from week 01 to 13 2021
East of England	x	14 to 19, 52 to 53	01 to 06
East Midlands	x	13 to 19, 48	01 to 07
London	x	12 to 19, 33, 51 to 53	01 to 07
North East	x	14 to 21	02 to 04
North West	x	13 to 19, 33, 42 to 47	01 to 07
South East	x	13 to 21, 33, 50 to 53	01 to 07
South West	x	13 to 19, 33	02 to 05, 07
West Midlands	x	13 to 20, 45 to 46, 48, 53	01 to 07
Yorkshire and Humber	x	14 to 21, 23, 43 to 50	02 to 05

Figure 51: Daily excess all-cause deaths by (a) age group and (b) PHE centres, England, 1 March 2020 to 7 April 2021

(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 14, 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 14, no influenza viruses were tested for antiviral susceptibility.

Antimicrobial susceptibility

Table 8 shows in the 12 weeks up to week 14 2021, the proportion of all lower respiratory tract isolates of Streptococcus pneumoniae, Haemophilus influenza, 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 (%)
S. pneumoniae	Penicillin	842	81
	Macrolides	923	72
	Tetracycline	904	75
H. influenzae	Amoxicillin/ampicillin	4,143	58
	Co-amoxiclav	4,459	67
	Macrolides	1,134	11
	Tetracycline	4,518	97
S. aureus	Methicillin	4,922	92
	Macrolides	5,622	71
MRSA	Clindamycin	282	47
	Tetracycline	342	73
MSSA	Clindamycin	3,470	77
	Tetracycline	4,355	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 35 2020 and week 13 2021 are summarised. This programme has previously involved testing approximately 1000 donor samples from two different NHS regions each week. As of week 44 2020, approximately 250 samples from each geographic NHS region are tested each week. The COVID-19 vaccination campaign began on the 8th December 2020 (week 50) with a phased roll out by age and risk group.

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

The results presented here are based on testing blood donor samples with Roche nucleoprotein (N) and Roche spike (S) antibody assays.

Nucleoprotein (Roche N) assays only detect post-infection antibodies, whereas spike (Roche S) assays will detect both post-infection antibodies and vaccine-induced antibodies. Thus, changes in seropositivity for the Roche N assay will reflect the effect of natural infection. Increases in seropositivity as measured by S antibody will reflect both infection and vaccination. Antibody responses to both targets will reflect infection/vaccination occurring at least two to three weeks previously given the time taken to generate a COVID-19 antibody response. Donors have been asked to defer donations for 7 days post vaccination.

This report presents Roche N and Roche S seropositivity estimates on the same set of samples, 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.

National prevalence

Overall population weighted (by age group, sex and NHS region) antibody prevalence among blood donors aged 17 years and older in England was 15.0% (95% CI 14.1% - 15.9%) using the Roche N assay and 53.7% (95% CI 52.6% - 54.8%) using the Roche S assay for the period 8th March – 1st April (weeks 10-13 2021). 1086/7265 were Roche N positive and 3524/6982 samples were Roche S positive. This compares with 14.7% (95% CI 13.9% - 15.6%) Roche N seropositivity and 38.1% (95% CI 37.0% - 39.2%) Roche S seropositivity for the period of 8th February 2021 – 7th March 2021 (weeks 6-9 2021).

Seropositivity (weighted by region, age group and sex) varies over time. Figure 52 shows the overall 4-weekly rolling proportion seropositive over time for the Roche N and Roche S assays. Seropositivity estimates are plotted weekly using the mid-point of a rolling 4-weekly period.

Regional prevalence of infection over time

Seropositivity (weighted by age group and sex) using the Roche N assay which detects infection only, varies by region (Figure 2). Seropositivity estimates are plotted weekly using the mid-point of a rolling 4-weekly period.

In London, the 4-weekly rolling seropositivity increased from 21.1% (95% CI 18.7% - 23.6%) in weeks 6-9 2021 to 22.5% (95% CI 20.0% - 25.2%) in weeks 10-13 2021.

Data from the North West show that seropositivity has remained stable between 16.1% (95% CI 13.8% - 18.6%) in weeks 6-9 2021 and 16.7% (95% CI 14.2% - 19.5%) in weeks 10-13 2021.

In the East of England seropositivity decreased from 13.6% (95% CI 11.2% - 16.5%) in weeks 6-9 2021 to 10.2% (95% CI 8.6% - 12.1%) in weeks 10-13 2021.

Seropositivity increased in the South East region from 11.3% (95% CI 9.5% - 13.4%) for weeks 6-9 2021 to 14.3% (95% CI 12.0% - 16.9%) in weeks 10-13 2021.

In the South West region, seropositivity has plateaued at 8.1% (95% CI 6.3% - 10.5%) in weeks 6-9 2021 and 8.0% (95% CI 6.4% - 10.0%) in weeks 10-13 2021.

Seropositivity in the North East and Yorkshire NHS region decreased from 16.0% (95% CI 13.8% - 18.4%) in weeks 6-9 2021 to 14.9% (95% CI 12.5% - 17.6%) in weeks 10-13 2021.

Data from the Midlands show the proportion seropositive has remained stable at 14.6% (95% CI 12.6% - 16.9%) in weeks 6-9 2021 compared to 15.0% (95% CI 13.1% - 17.0%) in weeks 10-13 2021.

The recent fluctuations observed across some regions based on testing using the Roche N assay are likely to reflect ongoing transmission occurring 2-3 weeks before sampling or variation in precise locations of sampling within a region.

Prevalence by age group

Seropositivity estimates by age group using the Roche N and Roche S assays are presented below. 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.

Based on testing samples using the Roche N assay (Figure 53) as a marker of infection, the highest seropositivity has consistently been observed in those aged 17-29 and the lowest in those aged 70-84. Prevalence in individuals aged 17-29 has decreased from 22.4% (95% CI 20.0% - 25.1%) in weeks 6-9 2021 to 20.9% (95% CI 18.4% - 23.5%) in weeks 10-13 2021. Roche N seropositivity has started to plateau in recent weeks across most age groups but this was seen earliest in the 70-84 age group. Seropositivity in those aged 70-84 decreased from 5.8% (95% CI 3.9% - 8.6%) in weeks 6-9 to 4.8%

(95% CI 3.1% - 7.3%) in weeks 9-13 2021. The earlier plateauing of Roche N seropositivity in the older age groups likely reflects the additional role vaccination is having in reducing viral infection ahead of reduction seen from national restrictions alone in younger age groups.

The increase in vaccination especially in the older age groups is seen by the sharp increase in seropositivity using the Roche S assay (Figure 54). Whilst prevalence in those aged 17-29 has increased from 36.7% (95% CI 33.9% - 39.7%) in weeks 6-9 2021 to 39.6% (95% CI 36.5% - 42.7%) in weeks 10-13 2021, this compares with a dramatic increase in those aged 70-84 from 77.3% (95% CI 73.1%-81.1%) in weeks 6-9 2021 to 97.7% (95% CI 96.0% - 98.7%) in weeks 10-13 2021. A noticeable increase has also been observed in those aged 60-69 from 35.6% (95% CI 32.8% - 38.5%) in weeks 6-9 2021 to 81.1% (95% CI 78.5% - 83.5%) in weeks 10-13 2021. An increase in Roche S seropositivity has been observed in those aged 50-59 from 29.6% (95% CI 27.5% - 31.8%) in weeks 6-9 2021 to 50.2% (95% CI 47.7% - 52.8%) in weeks 9-13 2021.

Vaccination is likely to be making an important contribution to the overall Roche S increases observed since the roll out of the vaccination programme, particularly in older age groups who were the first groups prioritised for vaccination. Rises in Roche S above Roche N seropositivity in younger age groups suggest that health and social care workers are likely to be over-represented among donors. The absence of a recent increase of seropositivity, using the Roche N assay, in the oldest age group is likely to reflect vaccine impact.

Figure 52: Overall 4-weekly rolling SARS-CoV-2 antibody seroprevalence (% seropositive) in blood donors

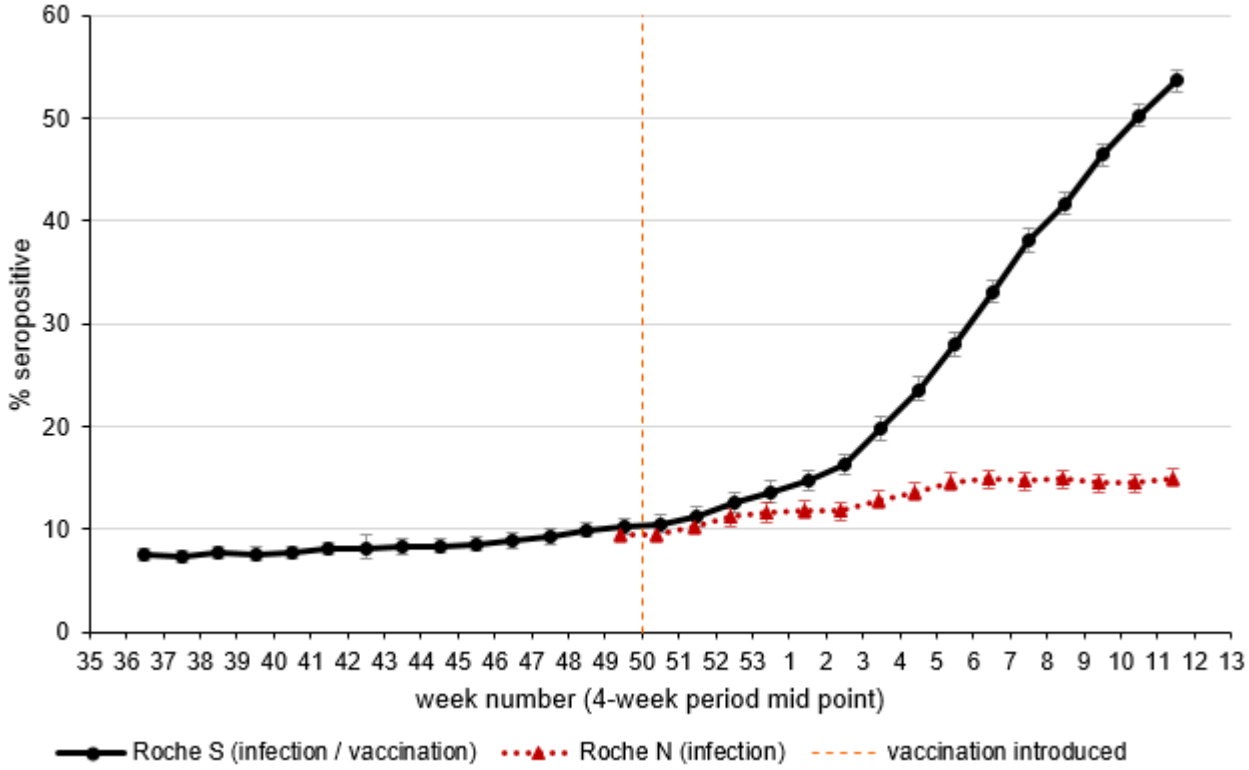


Figure 53: 4-weekly rolling SARS-CoV-2 antibody seroprevalence (% seropositive) in blood donors by region, using Roche N test; error bars show 95% confidence intervals

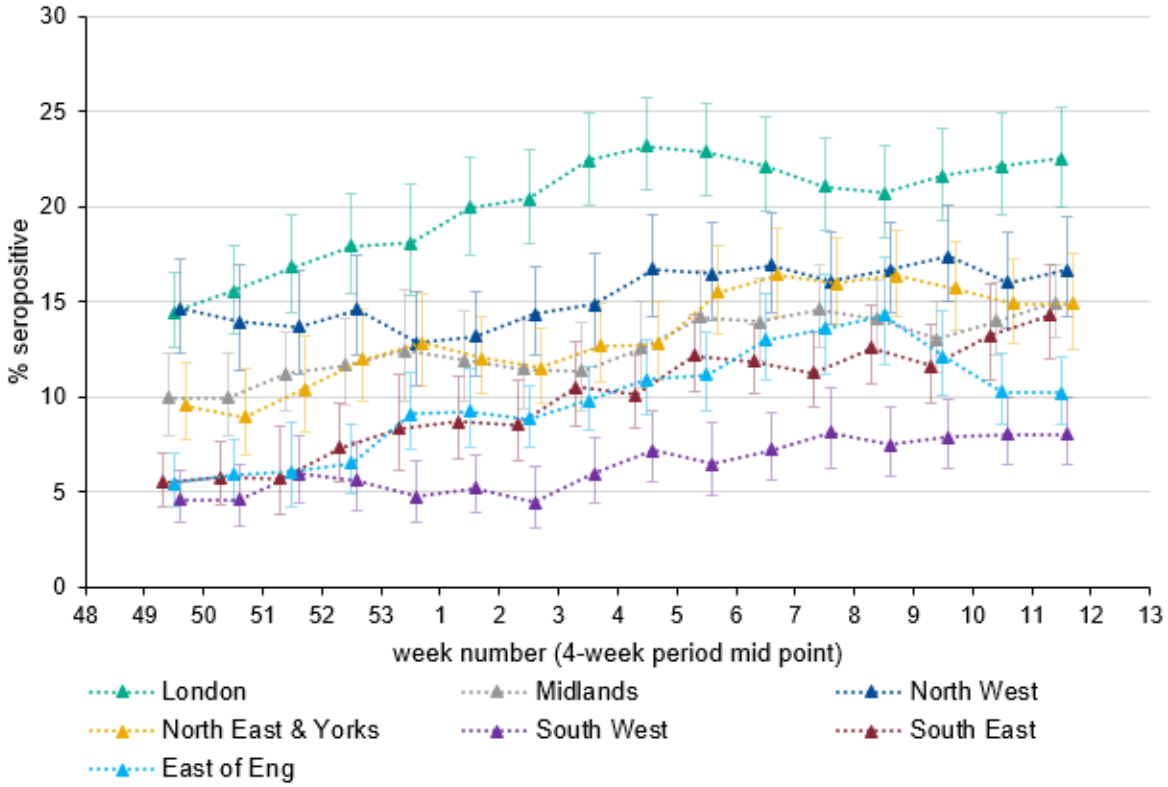
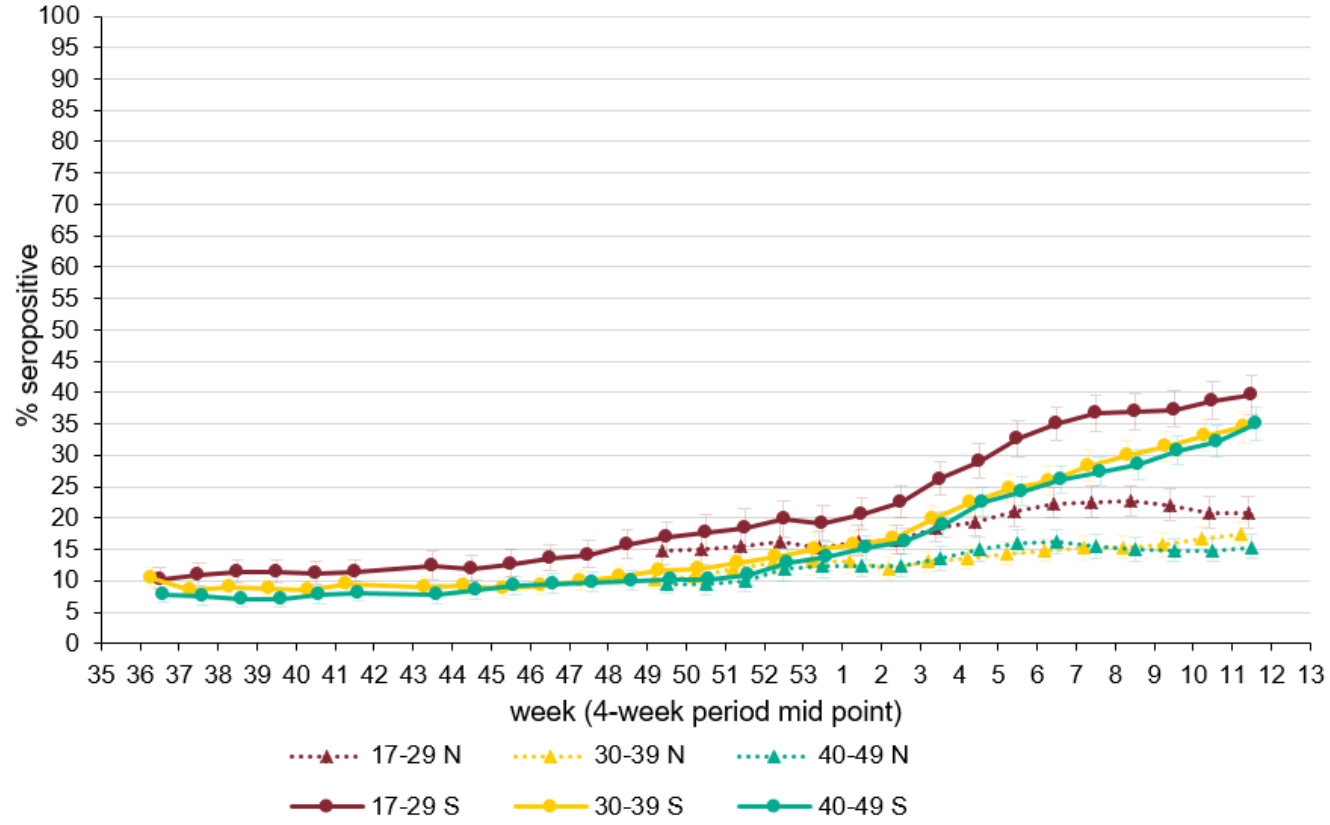
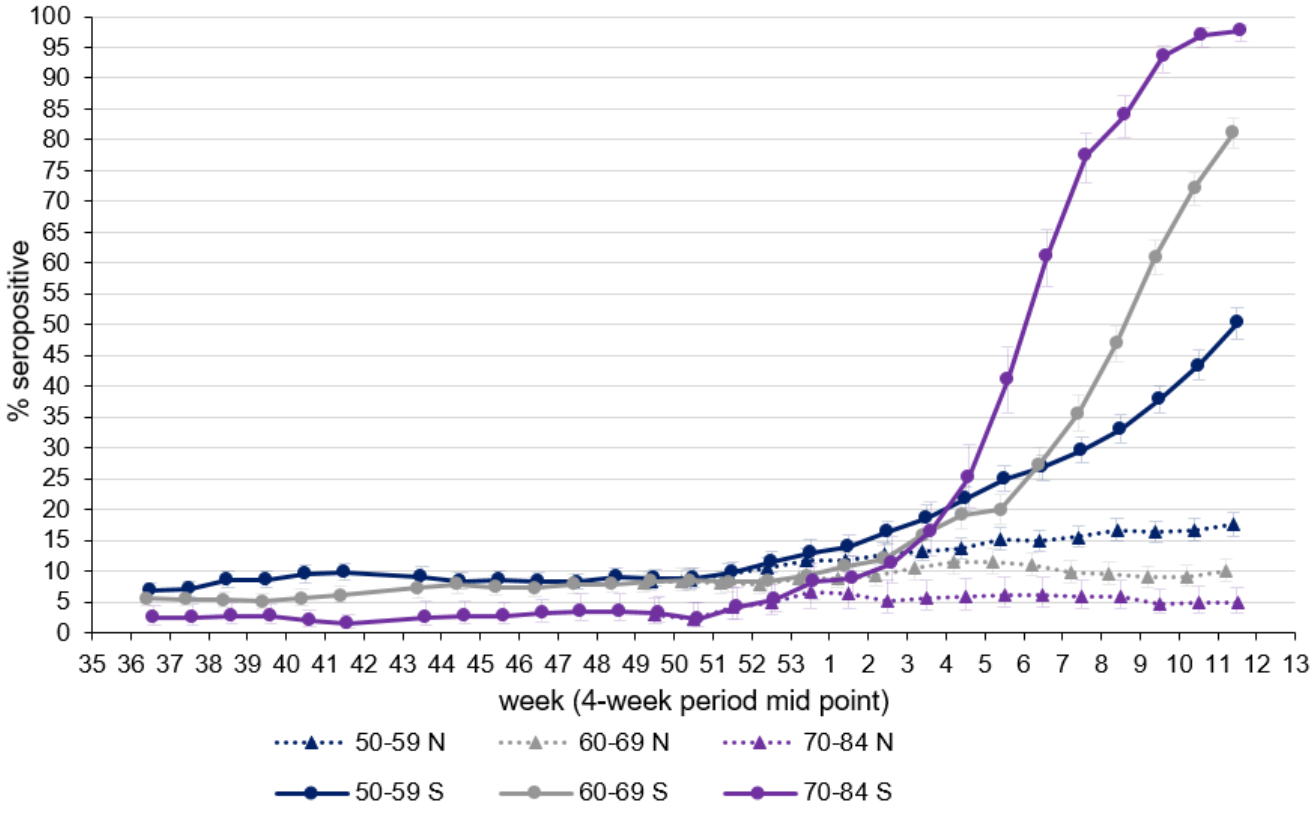


Figure 54: Population weighted 4-weekly rolling SARS-CoV-2 antibody seroprevalence (% seropositive) in blood donors from the Roche S and Roche N assays by a) age groups 17-29, 30-39 and 40-49, b) age group 50-59, 60-69 70-84

a)



b)



Influenza vaccination

Influenza vaccine uptake in GP patients

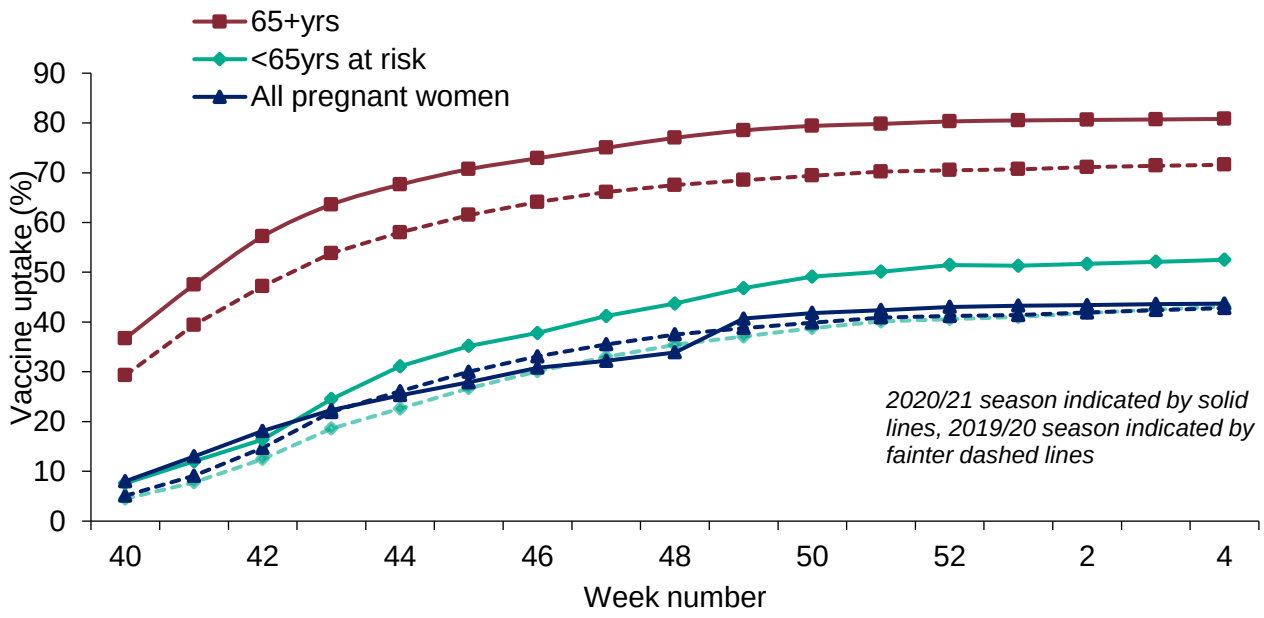
Up to week 4 2021 in 94.7% of GP practices reporting weekly to Immform for the main collection, the provisional proportion of people in England who had received the 2020/21 influenza vaccine in targeted groups was as follows (Figure 55):

- 52.5% in under 65 years in a clinical risk group
- 43.7% in pregnant women
- 80.8% in 65+ year olds
- 34.1% in those aged 50-64 who are not in a clinical risk group

Weekly vaccine coverage data are provisional. Week 4 was the last publication of the weekly data for this season.

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

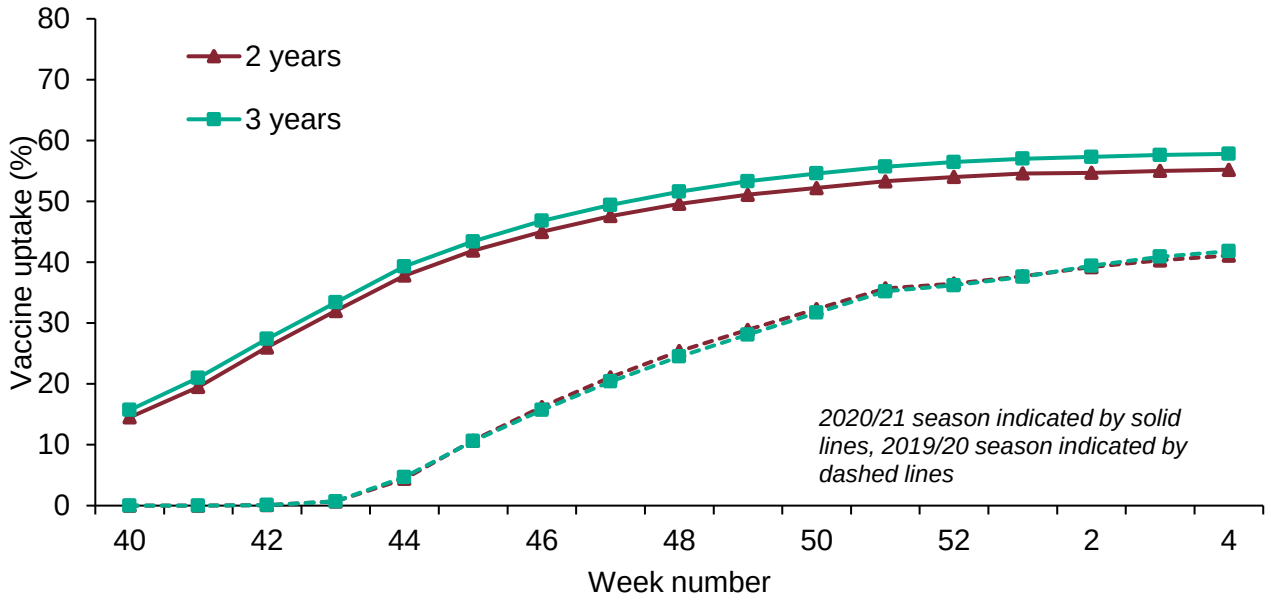
Figure 55: Cumulative weekly influenza vaccine uptake by target group in England



In 2020/21, all 2 and 3 year olds continue to be eligible for influenza vaccination through their GPs. Up to week 4 2021, in 93.6% 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 56):

- 55.2% in 2 year olds
- 57.8% in 3 year olds

Figure 56: Cumulative weekly influenza vaccine uptake in 2 and 3 year olds, in England



On the 25 March 2021 routine monthly reports that evaluate influenza vaccinations given between 1 September and 31 February 2021 to health care workers and eligible GP patients were published here:
https://www.gov.uk/government/statistics/seasonal-flu-vaccine-uptake-in-healthcare-workers-monthly-data-2020-to-2021
https://www.gov.uk/government/statistics/seasonal-flu-vaccine-uptake-in-gp-patients-monthly-data-2020-to-2021

Vaccine coverage data is also presented by different ethnic groups for the clinical at-risk cohorts and pregnant women. The highest vaccine uptake in at risk groups aged 16 to under 65 years was observed among Asian or Asian British Bangladeshi (59.8%), White British ethnic groups, and Asian or Asian British -Indian ethnic groups; whereas the lowest uptake was observed in Black or Black British (Caribbean (32.4%) ethnic groups, Black or Black British (Any other Black background) ethnic groups and the Mixed White and Black Caribbean ethnic group. In pregnant women the highest vaccine uptake was observed in the Chinese (50.4%), White British and Asian or Asian British - Indian ethnic groups and the lowest uptake was observed in Black or Black British Caribbean (16.9%), Black or Black British (Any other Black background) and Mixed – White and Black Caribbean ethnic groups.

Influenza vaccine uptake in school age children

Provisional data from the fourth monthly collection of influenza vaccine uptake for children of school years Reception to Year 7 (from a sample of 96.7% 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 31 January 2021 in targeted groups in Table 9.

Table 9: Provisional cumulative influenza vaccine uptake in children in school years Reception to Year 7, up to 31 January 2021 and 2020, England

School Year	% Vaccine uptake (up to 31 January)	
	2020/21	2019/20
Reception (4-5 years)	63.5	64.2
Year 1 (5-6 years)	63.9	63.5
Year 2 (6-7 years)	63.2	62.6
Year 3 (7-8 years)	62.6	60.6
Year 4 (8-9 years)	61.2	59.6
Year 5 (9-10 years)	60.5	57.2
Year 6 (10-11 years)	58.5	55.1
Year 7 (11-12 years)	55.5	-

Influenza vaccine uptake in healthcare workers

Provisional data from the fifth monthly collection of the influenza vaccine uptake by frontline healthcare workers show 76.8% were vaccinated by 28 February 2021 from 97.7% of all organisations, compared to 74.3% vaccinated in the previous season by 29 February 2020. The report provides uptake at national, NHS region, Sustainability and Transformation Partnerships (STP) and Trust-level.

COVID-19 vaccination

COVID-19 vaccine uptake in England

COVID-19 vaccinations began in England on 8 December 2020 during week 50 2020 (week ending 13 December 2020). Cumulative data up to week 14 2021 (week ending 11 April 2021) was extracted from the National Immunisation Management Service (NIMS). The data presented this week is the provisional proportion of people in England who had received one dose and two doses of a COVID-19 vaccination by age group. The overall vaccine uptake in the population for dose 1 was 43.8% and 10.5% for dose 2. The breakdown by sex showed vaccine uptake in males was 40.0% and 47.6% in females for dose 1. For dose 2 total uptake was 5.3% in males and 9.1% in females.

Table 10: Provisional cumulative COVID-19 vaccine uptake by age in England

Age group	Vaccinated with at least 1 dose			Vaccinated with 2 doses		
	People in NIMS cohort	Number vaccinated	% vaccine uptake	People in NIMS cohort	Number vaccinated	% vaccine uptake
80 years and over	2,854,271	2,701,895	94.7	2,854,271	2,127,543	74.5
75 to under 80 years	2,090,980	1,981,985	94.8	2,090,980	1,007,773	48.2
70 to under 75 years	2,880,205	2,696,966	93.6	2,880,205	621,388	21.6
65 to under 70 years	2,891,665	2,628,460	90.9	2,891,665	263,270	9.1
60 to under 65 years	3,445,830	3,030,133	87.9	3,445,830	309,854	9.0
55 to under 60 years	4,066,032	3,465,855	85.2	4,066,032	374,570	9.2
50 to under 55 years	4,207,066	3,447,624	81.9	4,207,066	356,689	8.5
Under 50 years	39,044,523	6,988,042	17.9	39,044,523	1,382,671	3.5
Total	61,481,516	26,941,229	43.8	61,481,516	6,443,823	10.5

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

Figure 57: Cumulative weekly COVID-19 vaccine uptake by age in England

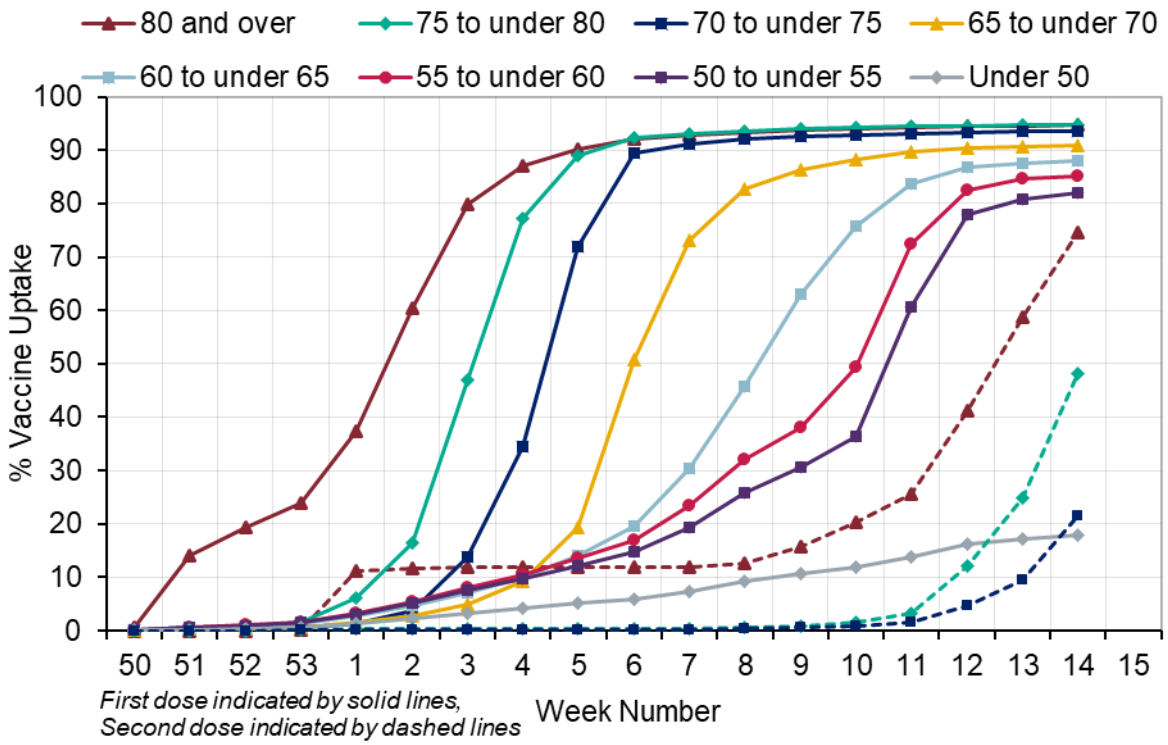


Figure 58: Age/Sex pyramid for COVID-19 vaccine uptake by age in England for Dose 1

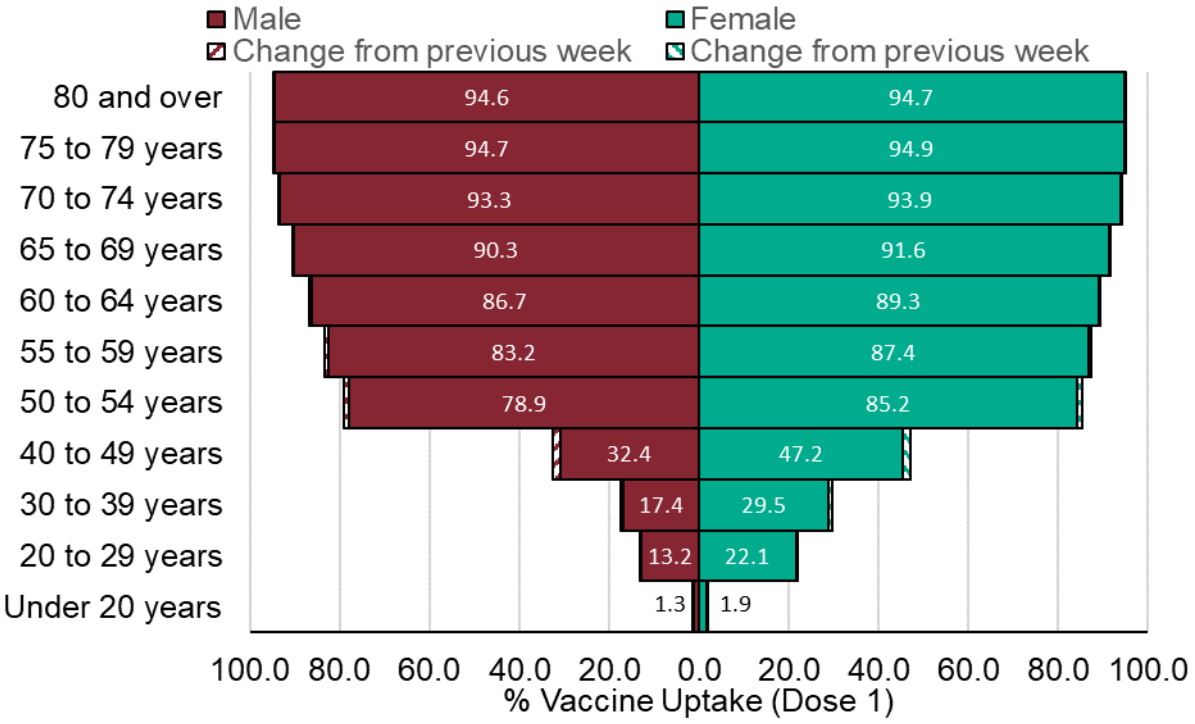
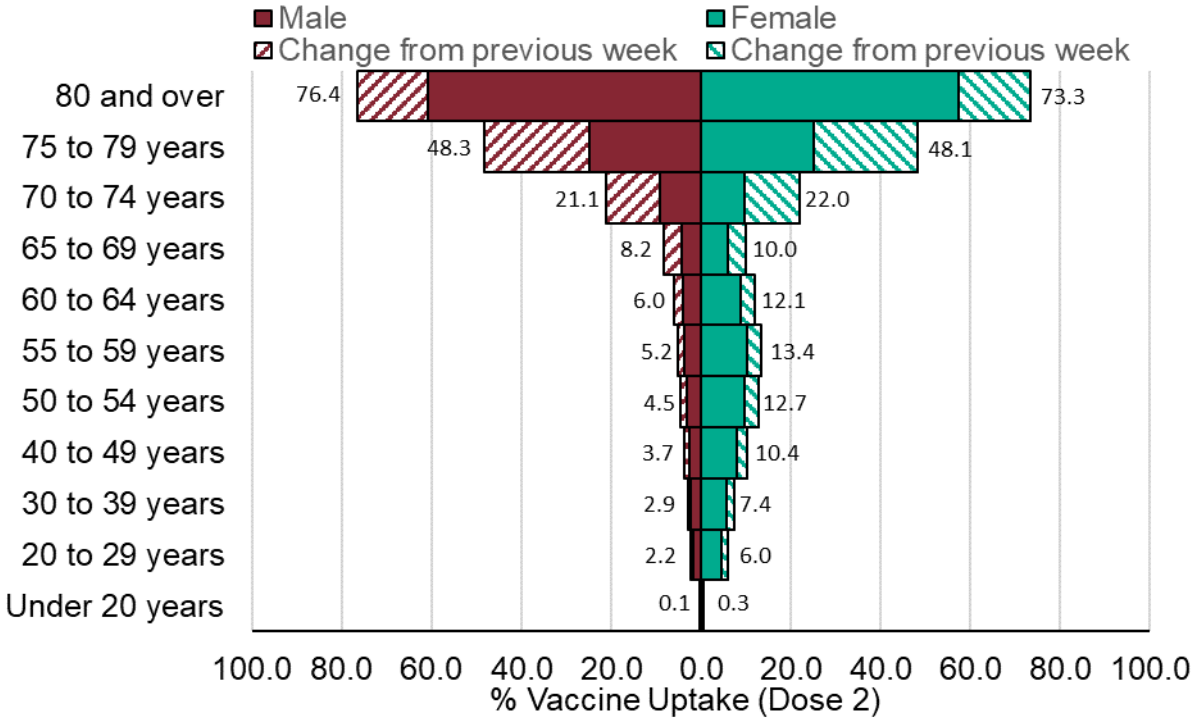


Figure 59: Age/Sex pyramid for COVID-19 vaccine uptake by age in England for Dose 2



From the 6 January 2021 (week 1 2021), the JCVI advises initially prioritising delivery of the first vaccine dose to maximise the public health impact in the short term and reduce the number of preventable deaths from COVID-19: https://www.gov.uk/government/publications/prioritising-the-first-covid-19-vaccine-dose-jcvi-statement/optimising-the-covid-19-vaccination-programme-for-maximum-short-term-impact

For UK COVID-19 daily counts of vaccinations, please see the Vaccinations' section of the UK COVID-19 dashboard here: https://coronavirus.data.gov.uk/

For COVID-19 management information on the number of COVID-19 vaccinations provided by the NHS in England. Please see here: https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-vaccinations/

International update

Global COVID-19 update

Globally, up to 13 April 2021, 136,257,695 cases of COVID-19 infection have been reported worldwide, including 2,947,162 COVID-19 related deaths.

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

Figure 60: Global map of cumulative COVID-19 cases

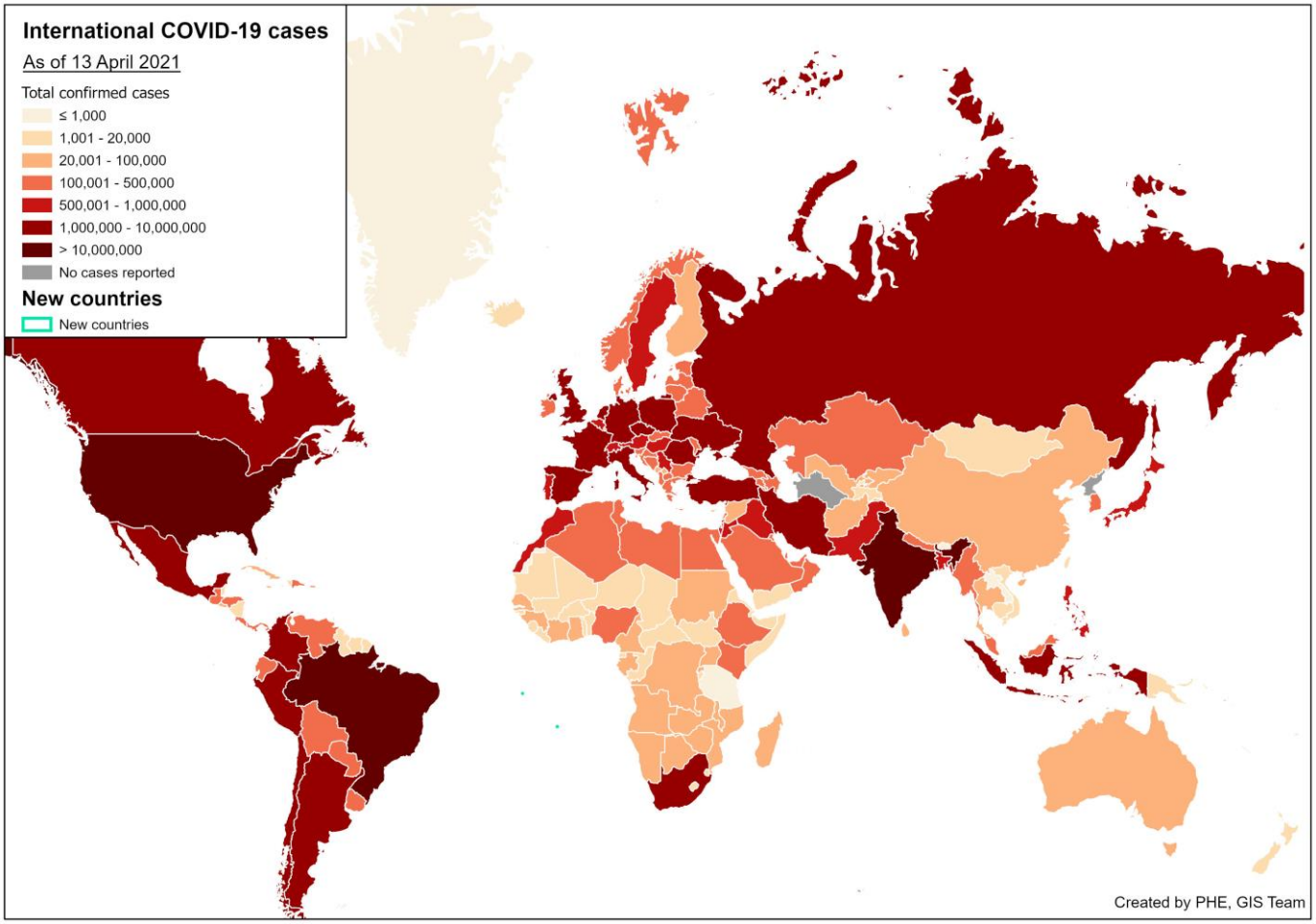
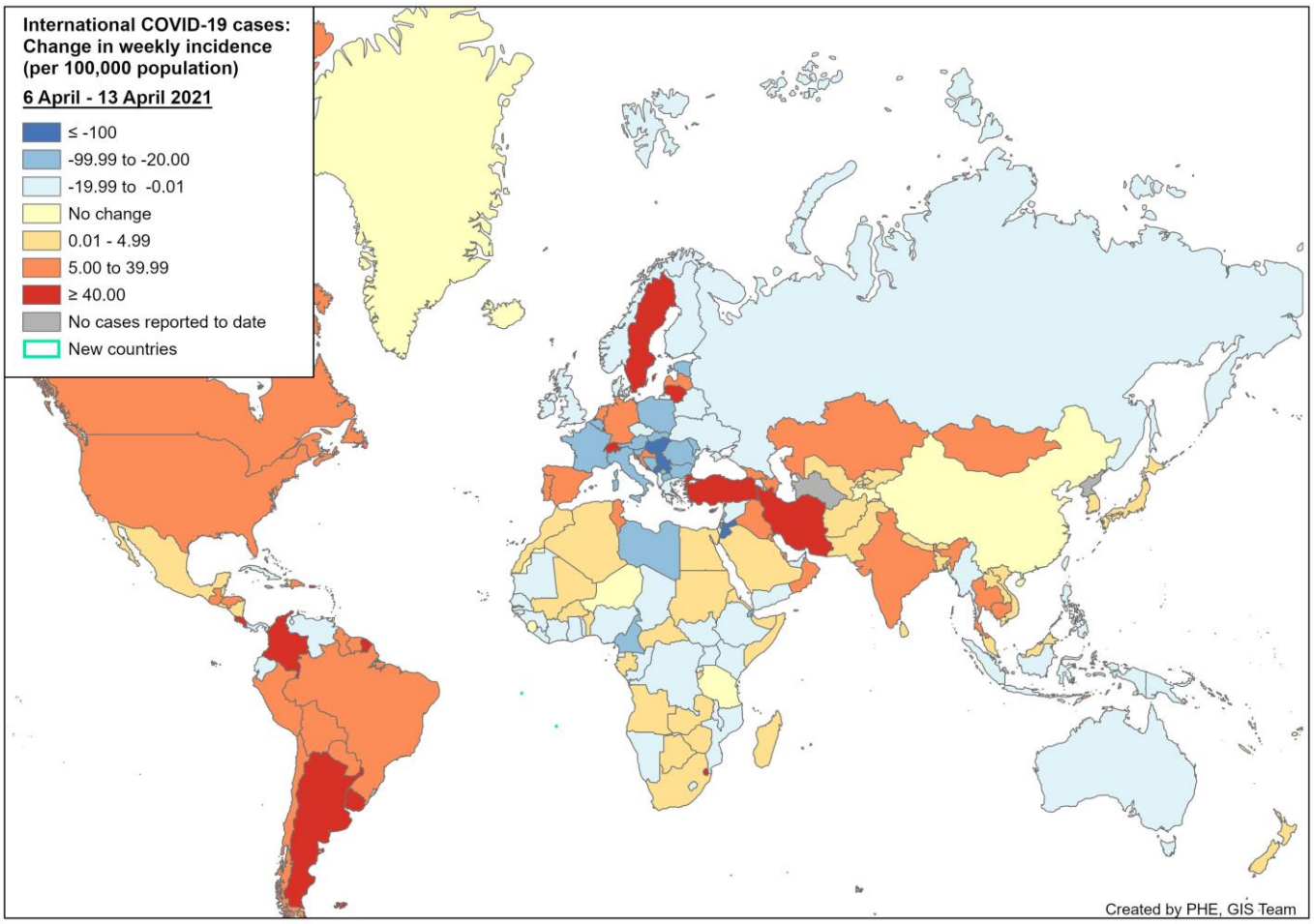


Figure 61: Global map of change in weekly COVID-19 case incidence rate per 100,000 population compared to the previous week



Global influenza update

Updated on 29 March 2021 (based on data up to 14 March 2021) (WHO website).

In the temperate zone of the northern hemisphere, influenza activity remained below baseline, though sporadic detections of influenza A and B viruses continued to be reported in some countries. In the temperate zone of the southern hemisphere, influenza activity was reported at inter-seasonal 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, despite testing at usual or increased levels.

In Europe, influenza activity was at very low level with sporadic detections of influenza A and B viruses reported in some countries.

In Central Asia, no influenza detections were reported across reporting countries.

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

In Western Asia, influenza and ILI activity remained low overall with sporadic detections of influenza B viruses in Iraq, Saudi Arabia and the United Arab Emirates (UAE). The UAE also reported sporadic detections of influenza A(H3N2) during this period.

In East Asia, influenza illness indicators and influenza activity remained low or below baseline in reporting countries.

In the Caribbean and Central American countries, no influenza detections were reported for this period.

In tropical South America, no influenza but low levels of detection of other respiratory viruses (ORVs) were reported in some countries.

In tropical Africa, influenza activity was reported in some reporting countries in Western and Eastern Africa in recent weeks.

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

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

The WHO GISRS laboratories tested more than 291,427 specimens between 1 March 2021 and 14 March 2021. A total of 375 specimens were positive for influenza viruses, of which 132 (35.2%) were typed as influenza A and 243 (64.8%) as influenza B. Of the sub-typed influenza A viruses, 5 (6.1%) were influenza A(H1N1)pdm09 and 77 (93.9%) were influenza A(H3N2). Of the characterized B viruses, 0 (0%) belonged to the B-Yamagata lineage and 188 (100%) to the B-Victoria lineage.

Influenza in Europe

Updated on 12 April 2021 (Joint ECDC-WHO Europe Influenza weekly update)

For week 13 2021, influenza activity remained at inter-seasonal levels throughout Europe.

Of 37 countries and areas reporting on intensity of activity, 33 reported baseline (across the region) and 4 (Azerbaijan, Estonia, Slovakia and Ukraine) reported low intensity for week 13 2021. Of 38 countries and areas that reported on geographic spread, 34 reported no activity and 4 (Azerbaijan, Luxembourg, Portugal, United Kingdom (Scotland)) reported sporadic spread for week 13 2021.

For week 13 2021, of 1,019 sentinel specimens tested for influenza viruses one was positive. Since the start of the season, of 32 556 sentinel-source specimens tested for influenza viruses, 38 were positive (22 type A and 16 type B viruses).

No hospitalized laboratory-confirmed influenza cases in ICUs were reported for week 13 2021. Since the start of the season, there have been 11 hospitalized laboratory-confirmed influenza cases in ICUs.

There was no new laboratory-confirmed influenza case in wards outside ICUs reported for week 12 2021. Since the start of the season, there have been 10 laboratory-confirmed influenza cases (all were infected with type A viruses) in wards outside ICUs.

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 29 January 2021 (WHO website)

Influenza A(H5) viruses:
Between 9 December 2020 and 29 January 2021, four new laboratory-confirmed human cases of influenza A(H5N6) virus infection were reported from China to WHO.

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 9 December 2020 and 29 January 2021, eight laboratory-confirmed human cases of influenza A(H9N2) virus infection were reported from China to WHO.

On 18 February 2021, the National IHR Focal Point for the Russian Federation notified WHO of detection of avian influenza A(H5N8) in seven human clinical specimens (WHO website).

Middle East respiratory syndrome coronavirus (MERS-CoV)

Latest update on 6 April 2021 (WHO website)

Up to 8 March 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.

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

From 2012 through 28 February 2021, a total of 2,567 laboratory-confirmed cases of MERS-CoV and 882 associated deaths were reported globally to WHO under the International Health regulations (IHR 2005), including one new case this month. 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.

About Public Health England

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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