



Public Health  
England

Protecting and improving the nation's health

# **Weekly national Influenza and COVID-19 surveillance report**

Week 18 report (up to week 17 data)  
6 May 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 17 (between 26 and 02 May 2021) and for some indicators daily data up to 04 May 2021.

Data in this week's report may be subject to delays due to the Early May Bank Holiday and should be interpreted with caution.

Surveillance indicators suggest that at a national level COVID-19 activity decreased in week 17 of 2021. There is currently limited testing for other respiratory viruses, however, laboratory indicators suggest that influenza activity is low.

Overall case rates continued to decrease in week 17. Decreases in case rates were observed in the majority of age groups, ethnic groups and regions. Overall Pillar 1 and Pillar 2 positivity decreased slightly compared to the previous week.

The number of reported acute respiratory incidents in the past week increased slightly compared to the previous week. SARS-CoV-2 was identified in the majority of these. In week 17, there was an increase in the number of outbreaks in educational settings.

COVID-19 hospitalisations decreased further in week 17 and have been decreasing since week 2. Deaths with COVID-19 decreased further in week 17 and have 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 46.7% for dose 1 at the end of week 17, 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 21.0% for dose 2 at the end of week 17.

The impact of the vaccination programme is particularly notable in the seroprevalence data which indicates that around 67.4% of the population have antibodies to SARS-CoV-2 from either infection or vaccination, compared to 16.6% from infection alone. Differences in seropositivity for vaccination or infection versus infection alone are most notable in the older age groups. There have been sharp increases in seropositivity for vaccination or infection in 60 to 69 and 50 to 59 year age groups, following vaccination rollout.

Through Respiratory Datamart, there were no influenza positive samples detected in week 17. Other indicators for influenza such as hospital admissions and GP influenza-like illness consultation rates remain low. Slight increases in rhinovirus activity were noted this week.

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# Laboratory surveillance

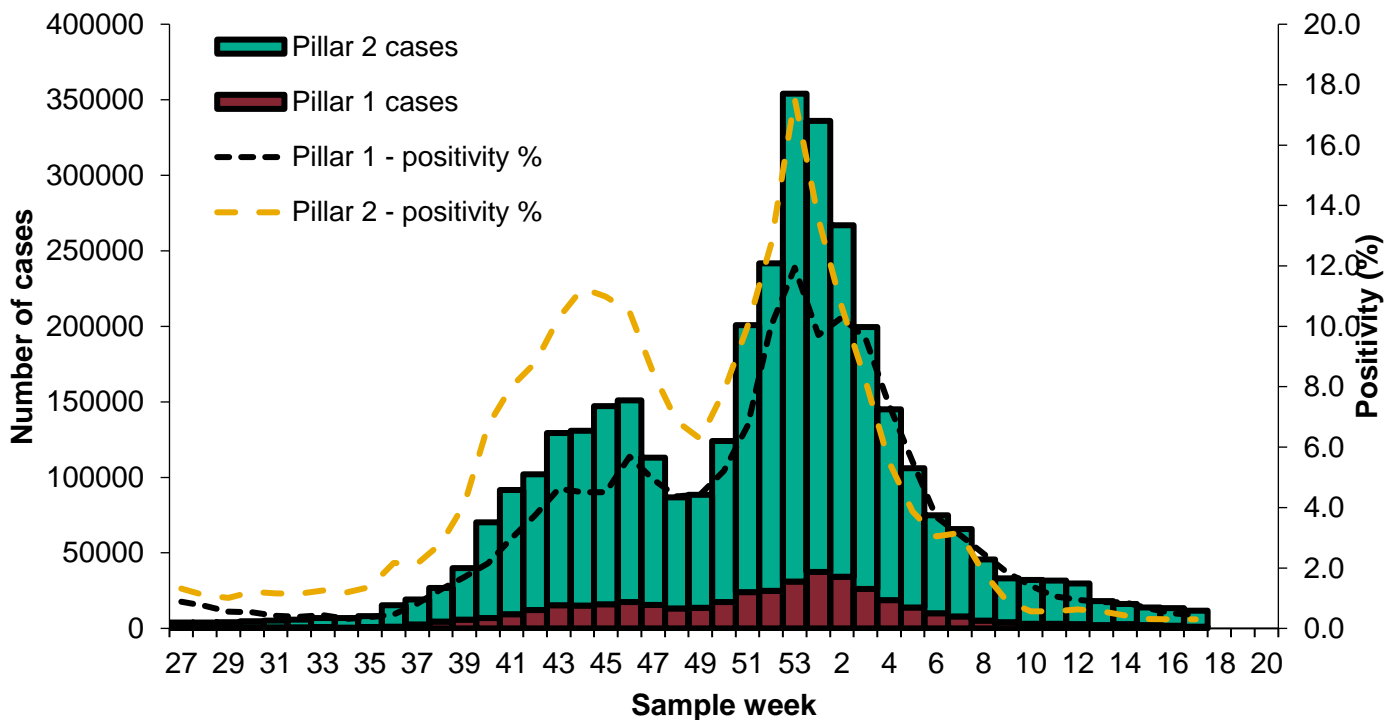
## Confirmed COVID-19 cases (England)

As of 09:00 on 04 May 2021, a total of 3,865,013 have been confirmed positive for COVID-19 in England under Pillars 1 and 2.

Overall case rates continued to decrease in week 17. Decreases in case rates were observed in the majority of age groups, ethnic groups and regions. Overall Pillar 1 and Pillar 2 positivity decreased slightly compared to the previous week.

Data on variants of concern or under investigation are available [here](#) and [here](#).

**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 (%)**

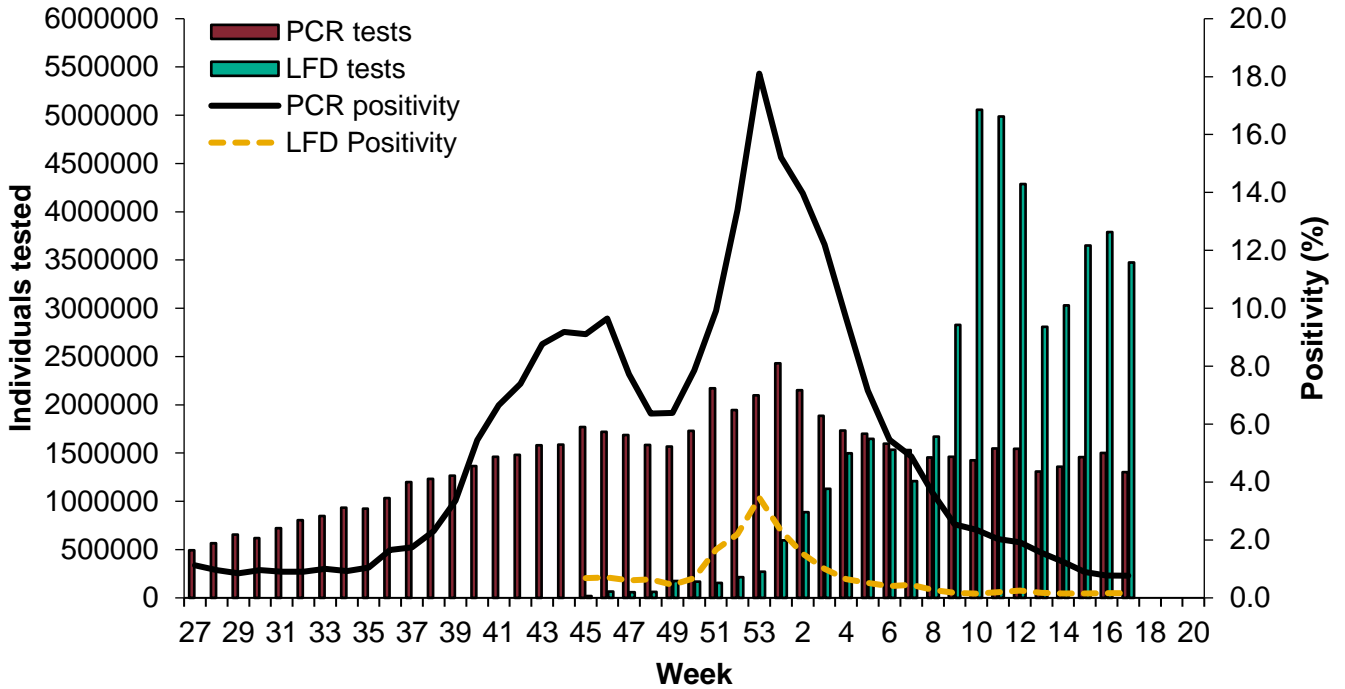


\*The data are shown by the week the specimen was taken from the person being tested. This gives the most accurate analysis of this time progression, however, for the most recent week results for more samples are expected therefore this should be interpreted with caution.

\* 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. Both PCR and lateral flow device (LFD) testing are included.

\*Cases that have been identified through a positive rapid LFD test will be removed if the individual took PCR tests within 3 days that were all negative.

**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)**



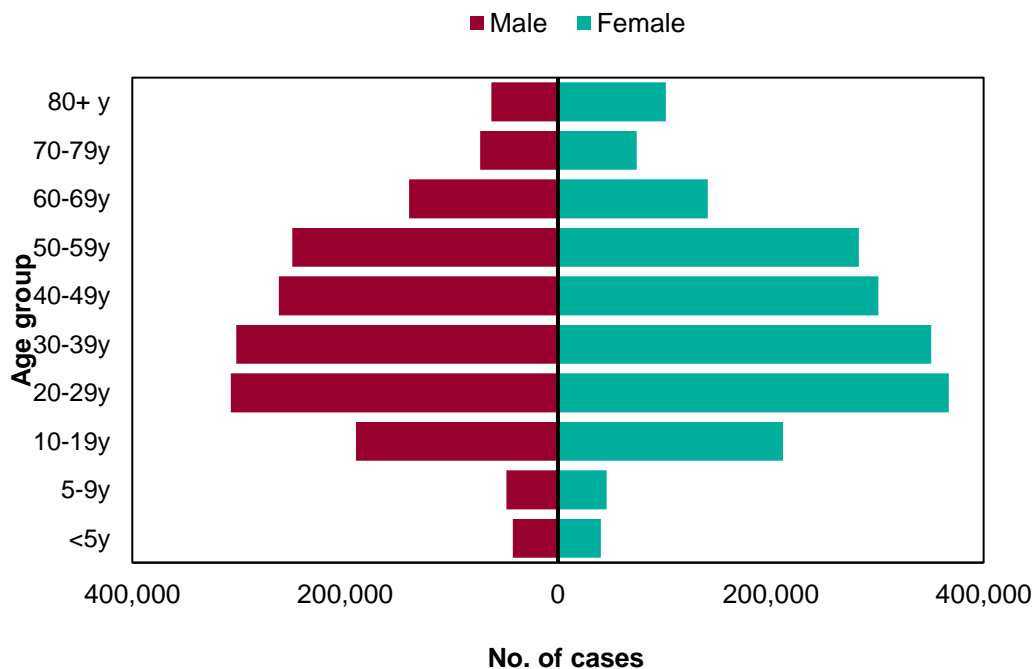
\*For Figure 2 positivity is calculated as the number of individuals testing positive using a specific test type during the week, divided by the number of individuals tested using that specific test type during the week.

\*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.

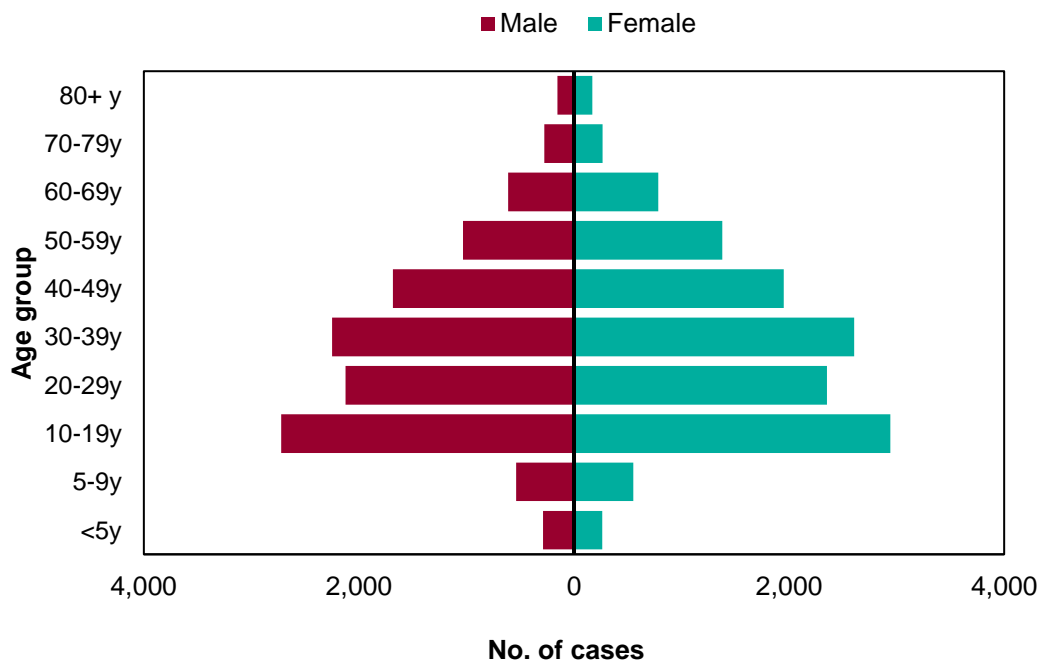
## Age and sex

**Figure 3: Age/sex pyramids for confirmed COVID-19 cases tested under Pillars 1 and 2 (a) cumulative number since week 27 (n=3,593,399), and (b) in weeks 16 and 17 (n=24,942)**

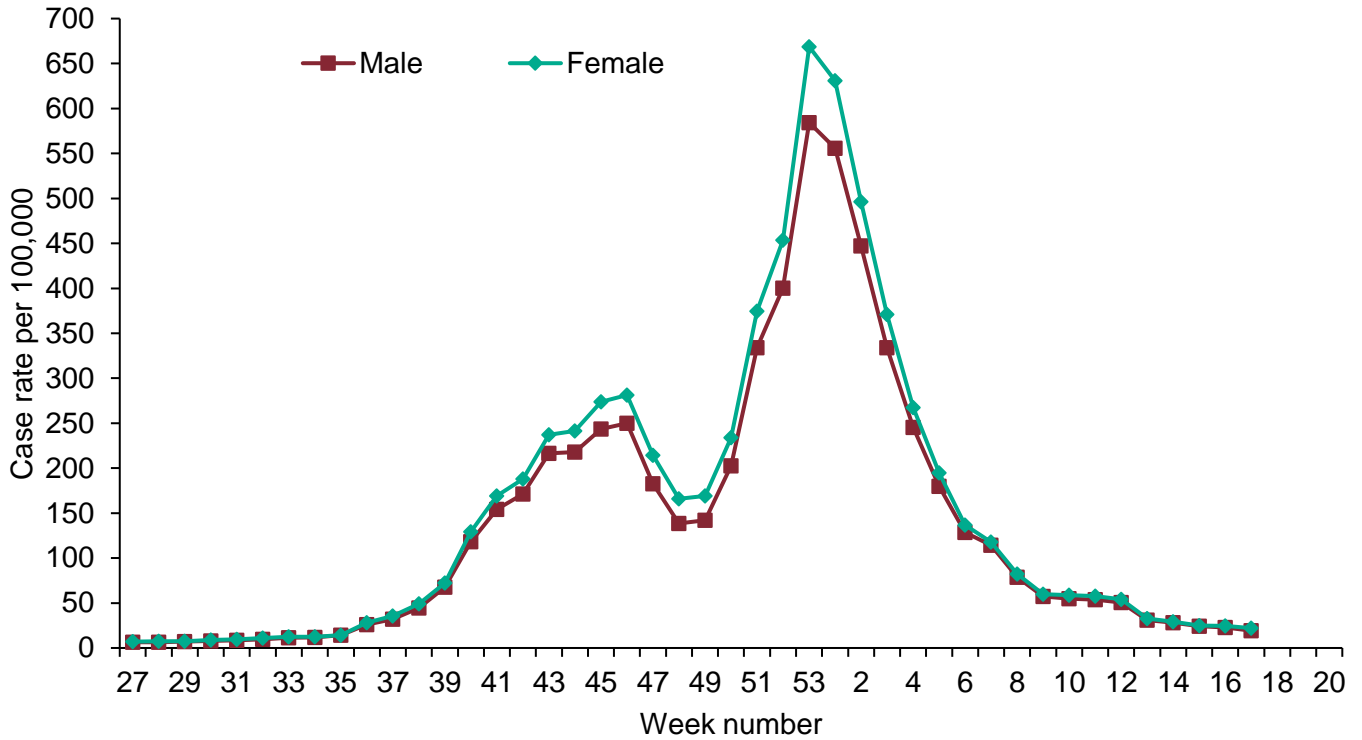
(a)



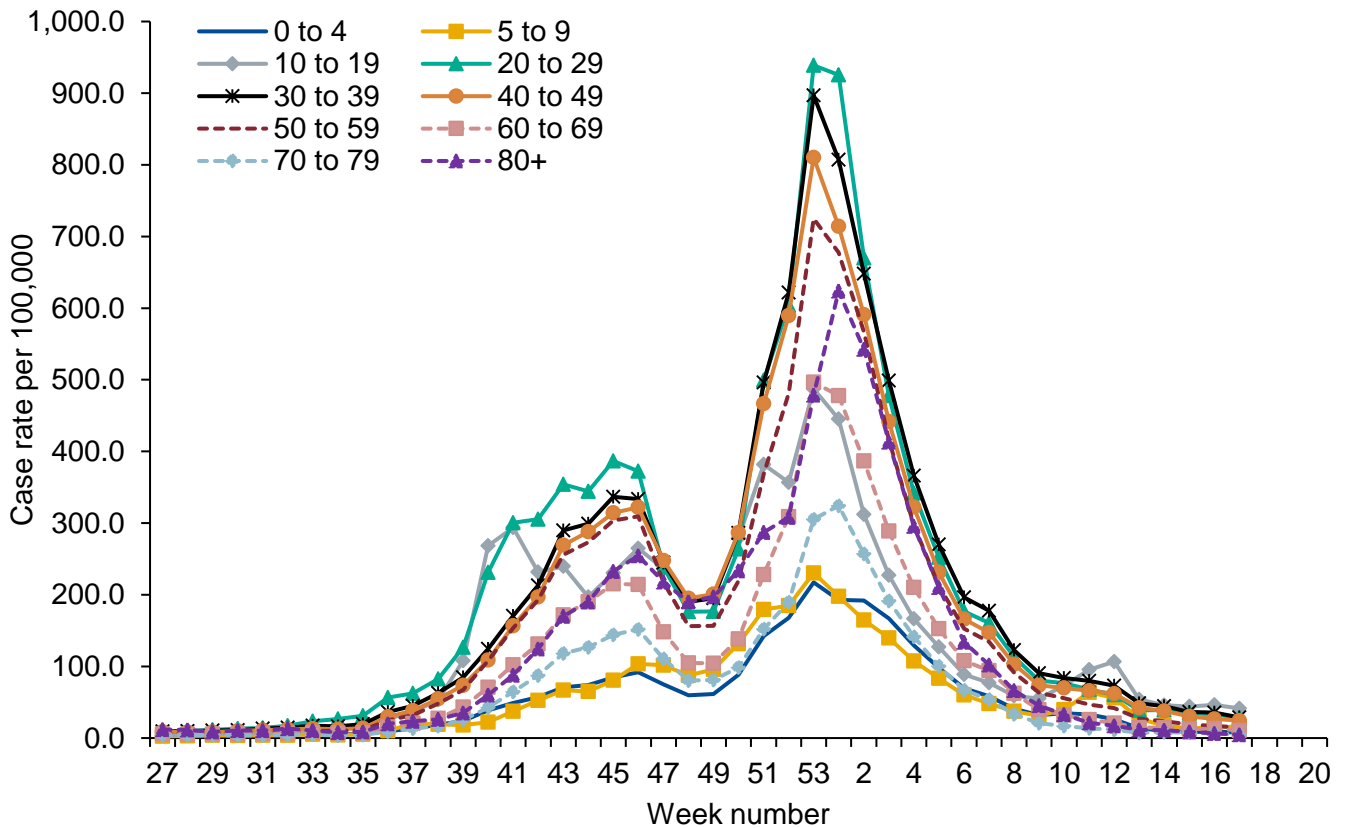
(b)



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



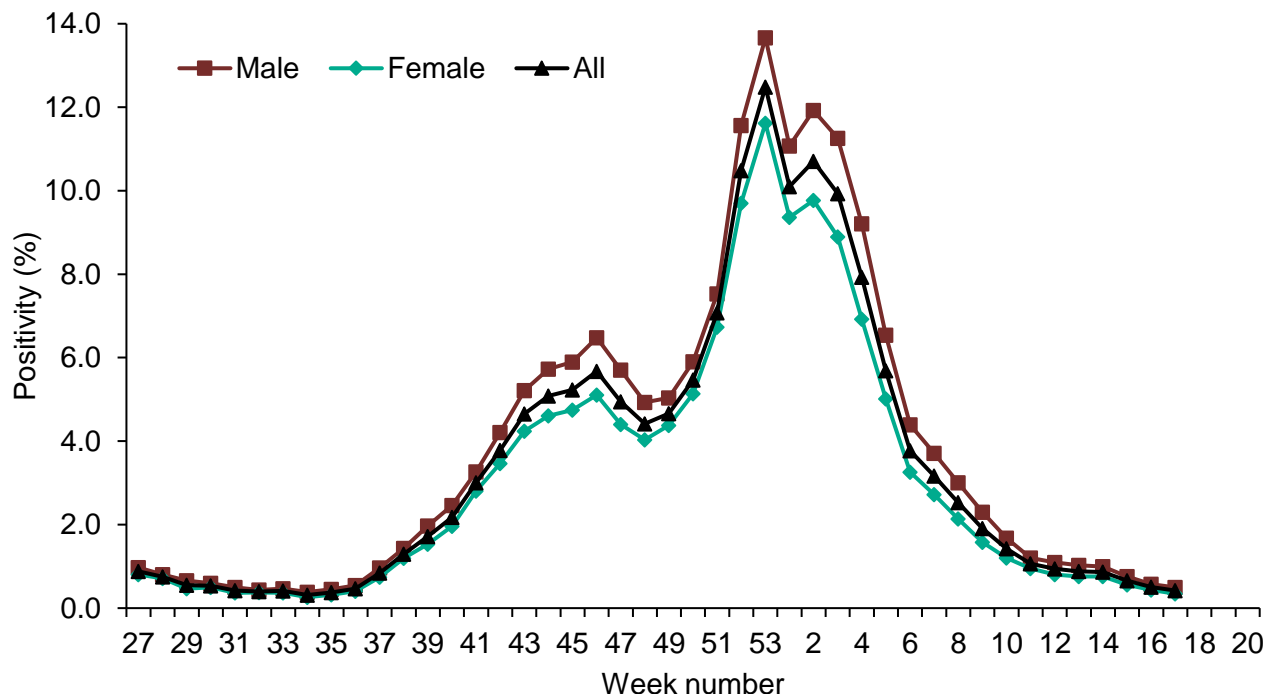
**Figure 5: Weekly confirmed COVID-19 case rates per 100,000, tested under Pillar 1 and Pillar 2, by age group**



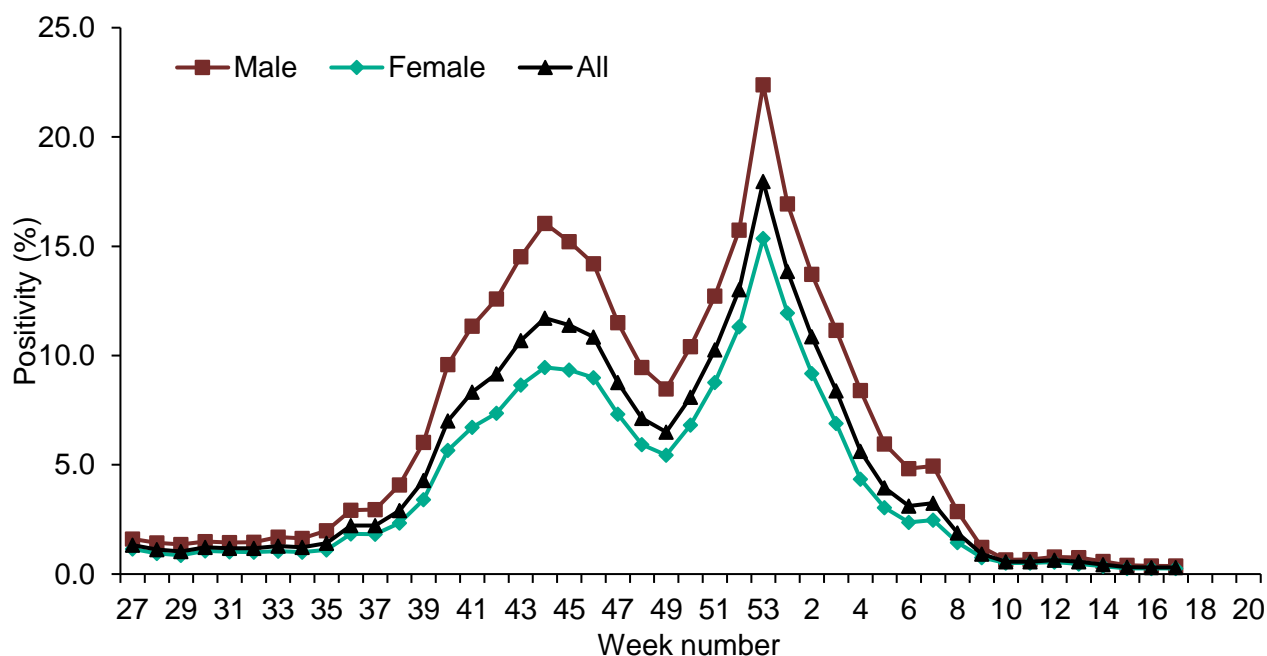


**Figure 6: Weekly positivity (%) of confirmed COVID-19 cases tested overall and by sex under (a) Pillar 1 and (b) Pillar 2, (SGSS and Respiratory DataMart)**

(a)

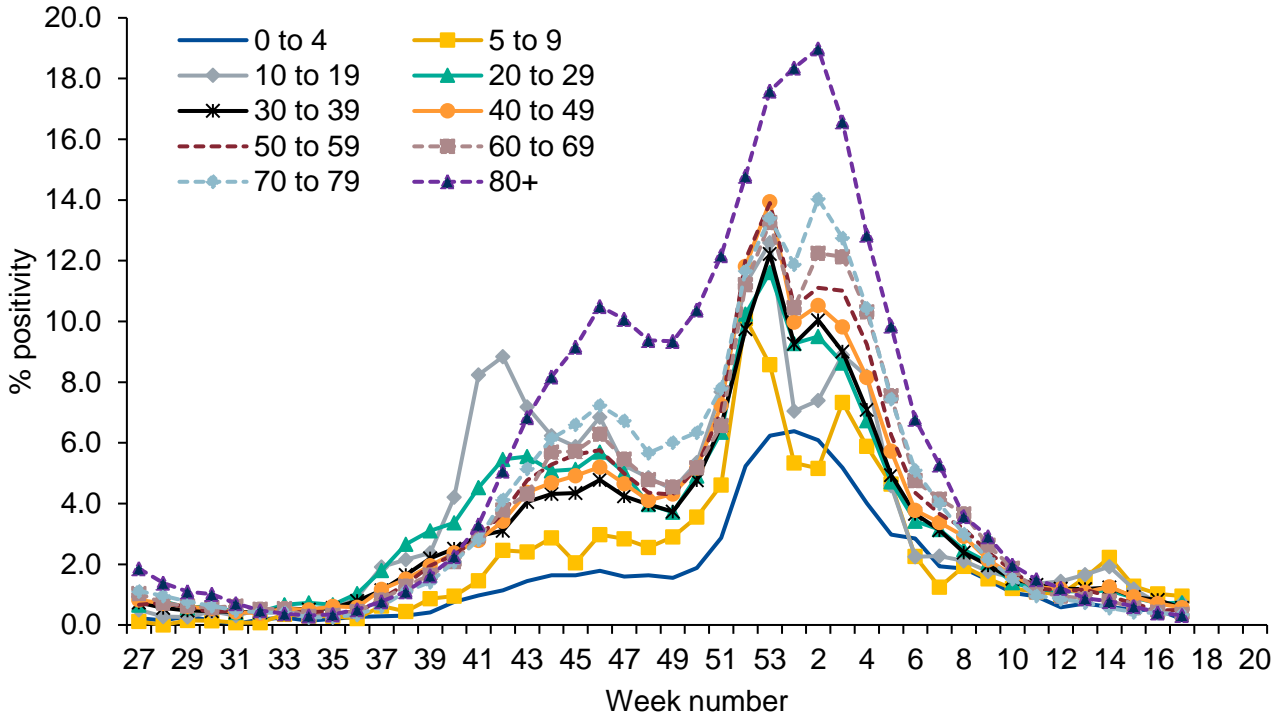


(b)

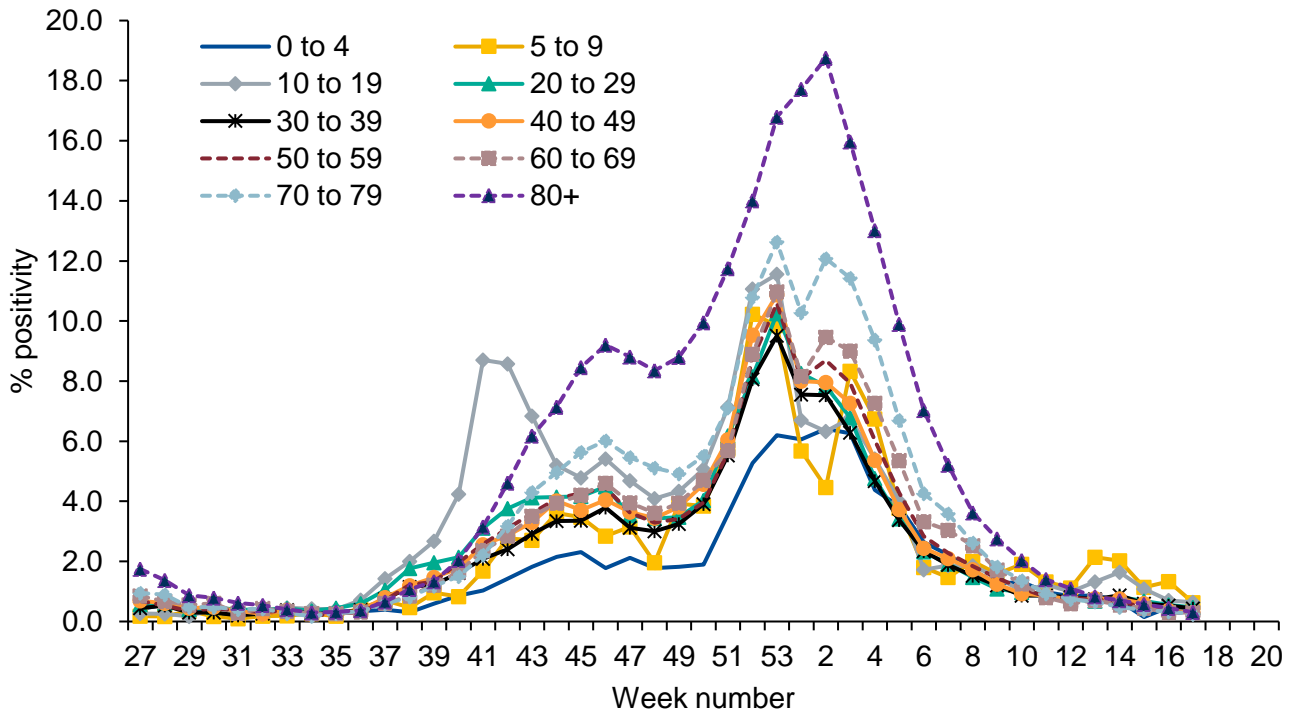


**Figure 7: Weekly positivity (%) of confirmed COVID-19 cases tested under Pillar 1, (a) by male and age group and (b) by female and age group and; under Pillar 2, (c) by male and age group and (d) by female and age group, (SGSS and Respiratory DataMart)**

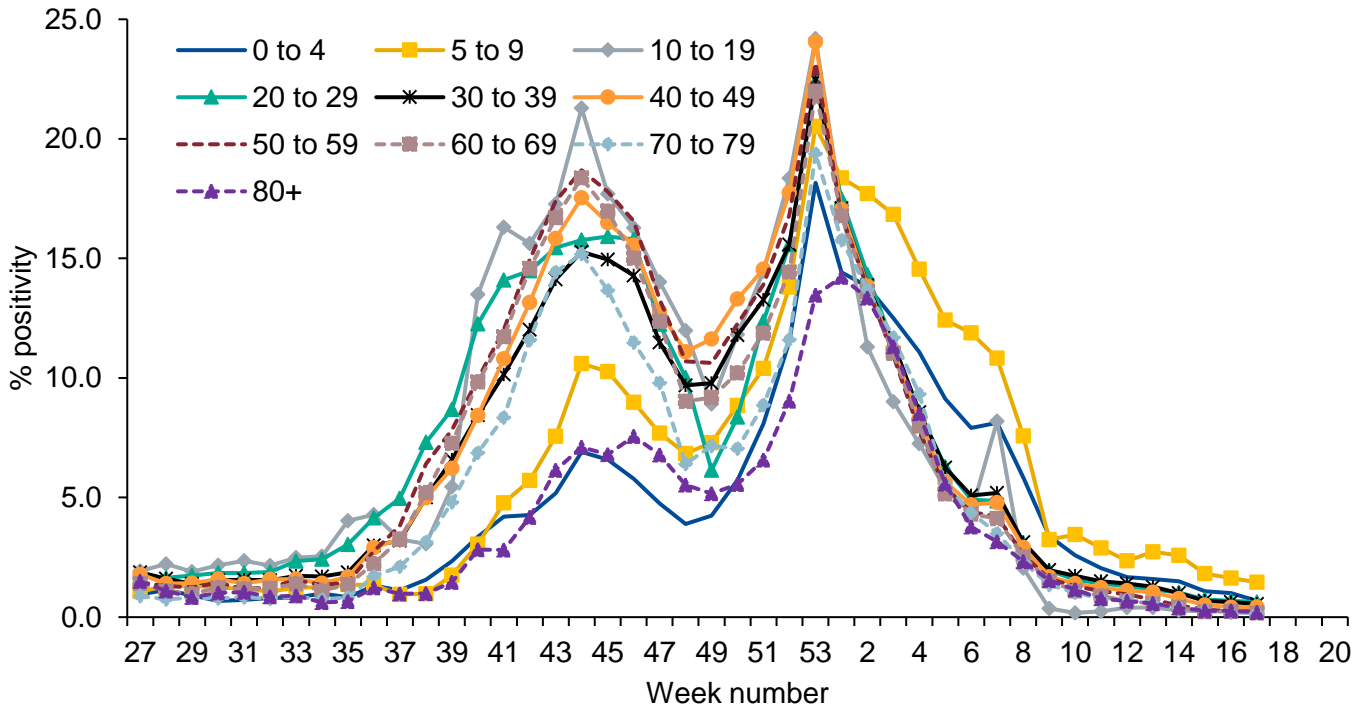
(a) Pillar 1 - Male



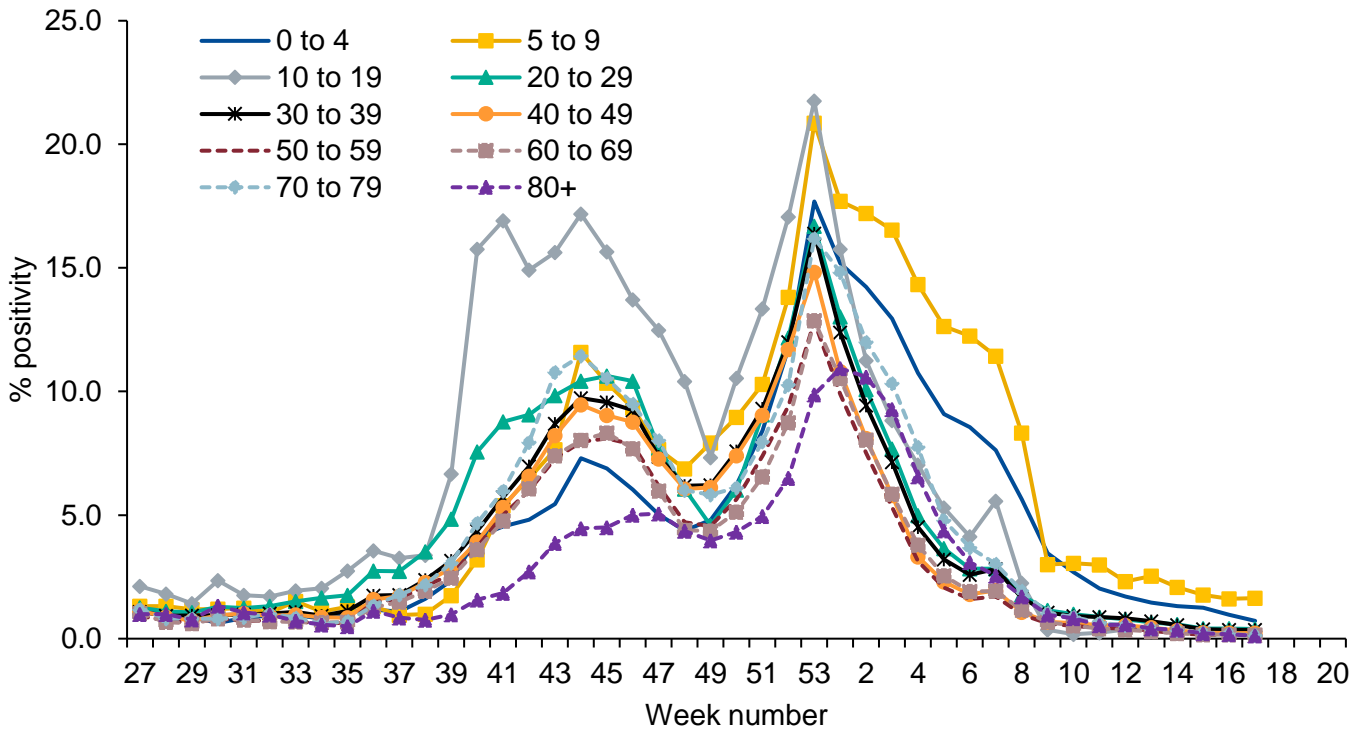
(b) Pillar 1 - Female



(c) Pillar 2 - Male



(d) Pillar 2 - Female

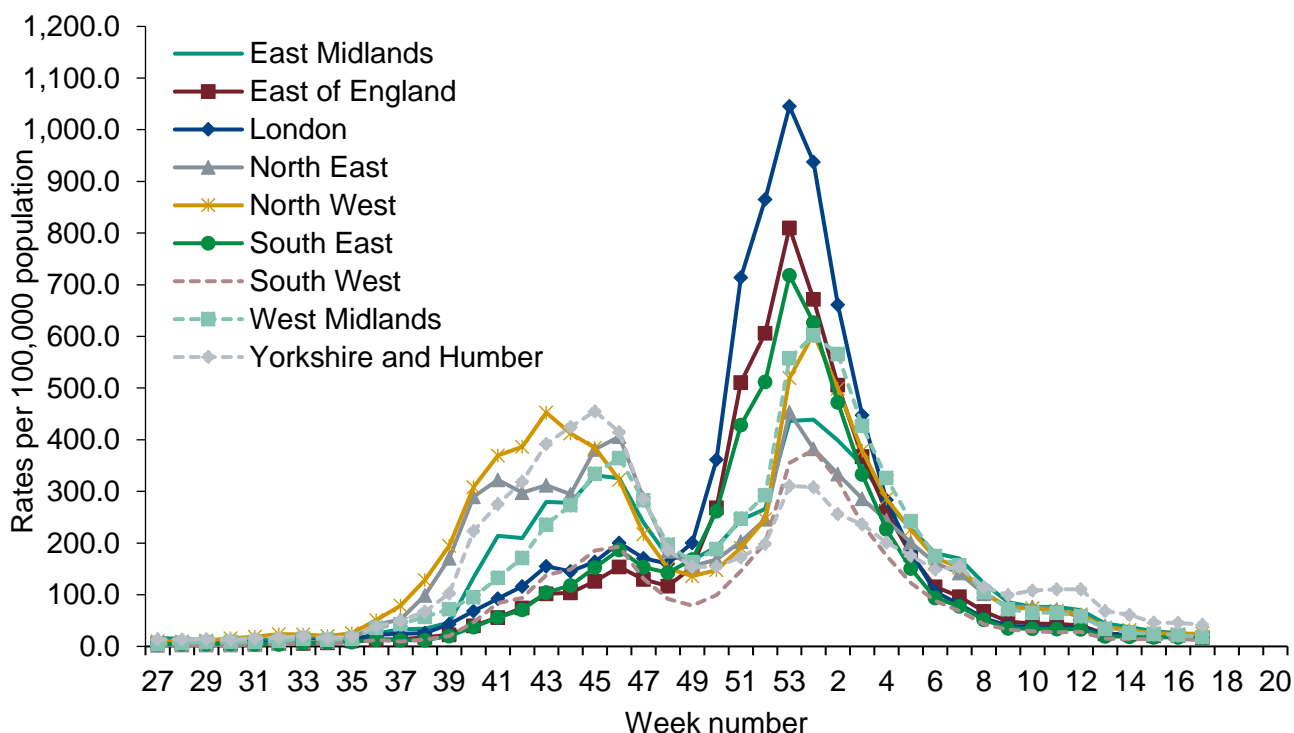


## Geography

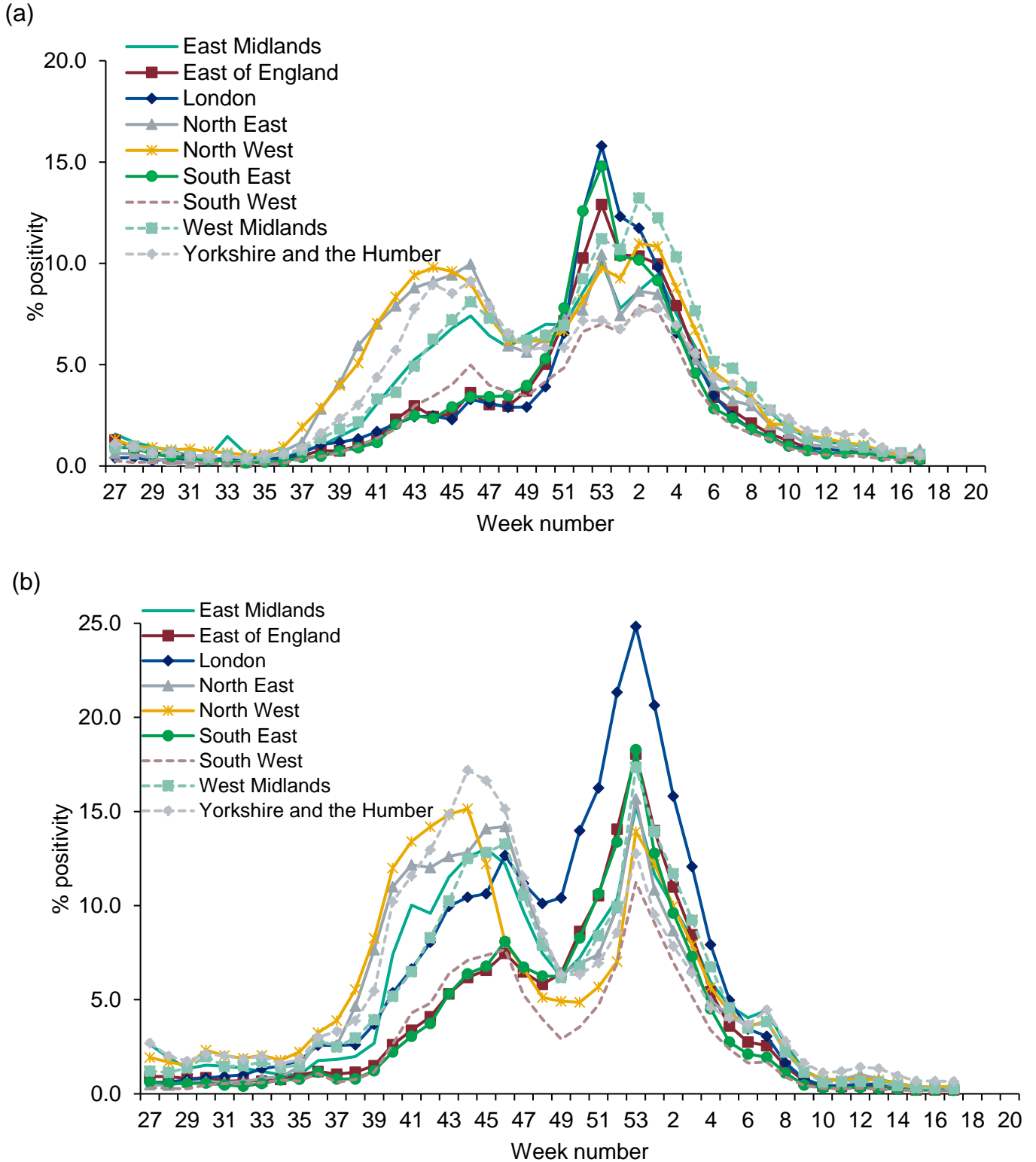
**Table 1: Cumulative number of cases under Pillars 1 and 2 (n=3,828,229) and cumulative number of cases since week 27 under Pillar 1 and 2 (3,593,410)**

PHE Centres	Cumulative Pillar 1 + 2 cases	Cumulative since week 27, Pillar 1 + 2 cases
North East	193,503	178,502
North West	607,935	565,678
Yorkshire and Humber	394,888	366,213
West Midlands	430,343	405,195
East Midlands	329,591	308,947
East of England	409,606	385,482
London	720,326	686,725
South East	520,614	487,922
South West	221,423	208,746

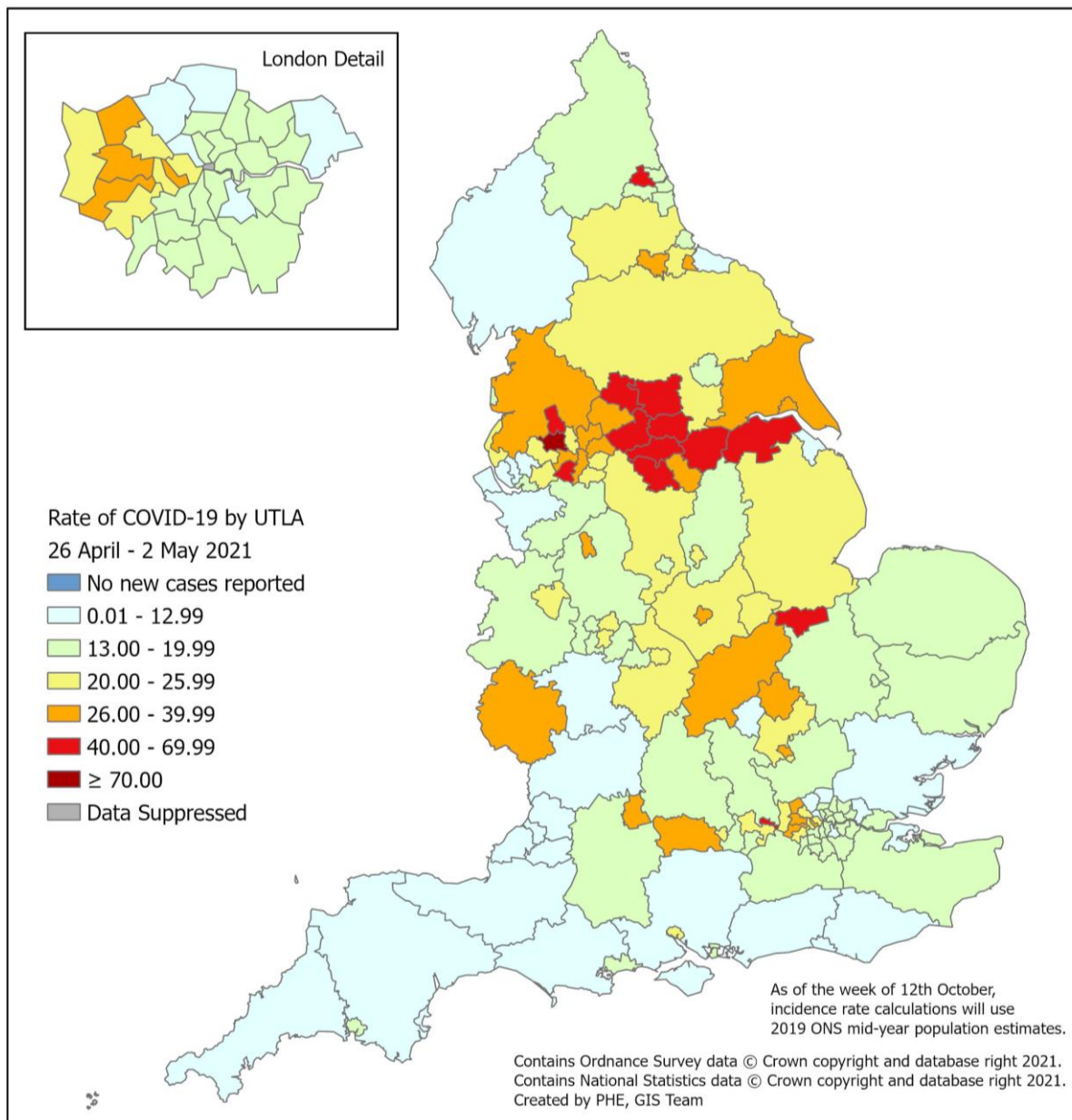
**Figure 8: Weekly confirmed COVID-19 case rates per 100,000 population (Pillar 1 and Pillar 2), by PHE Centres and sample week**



**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)**

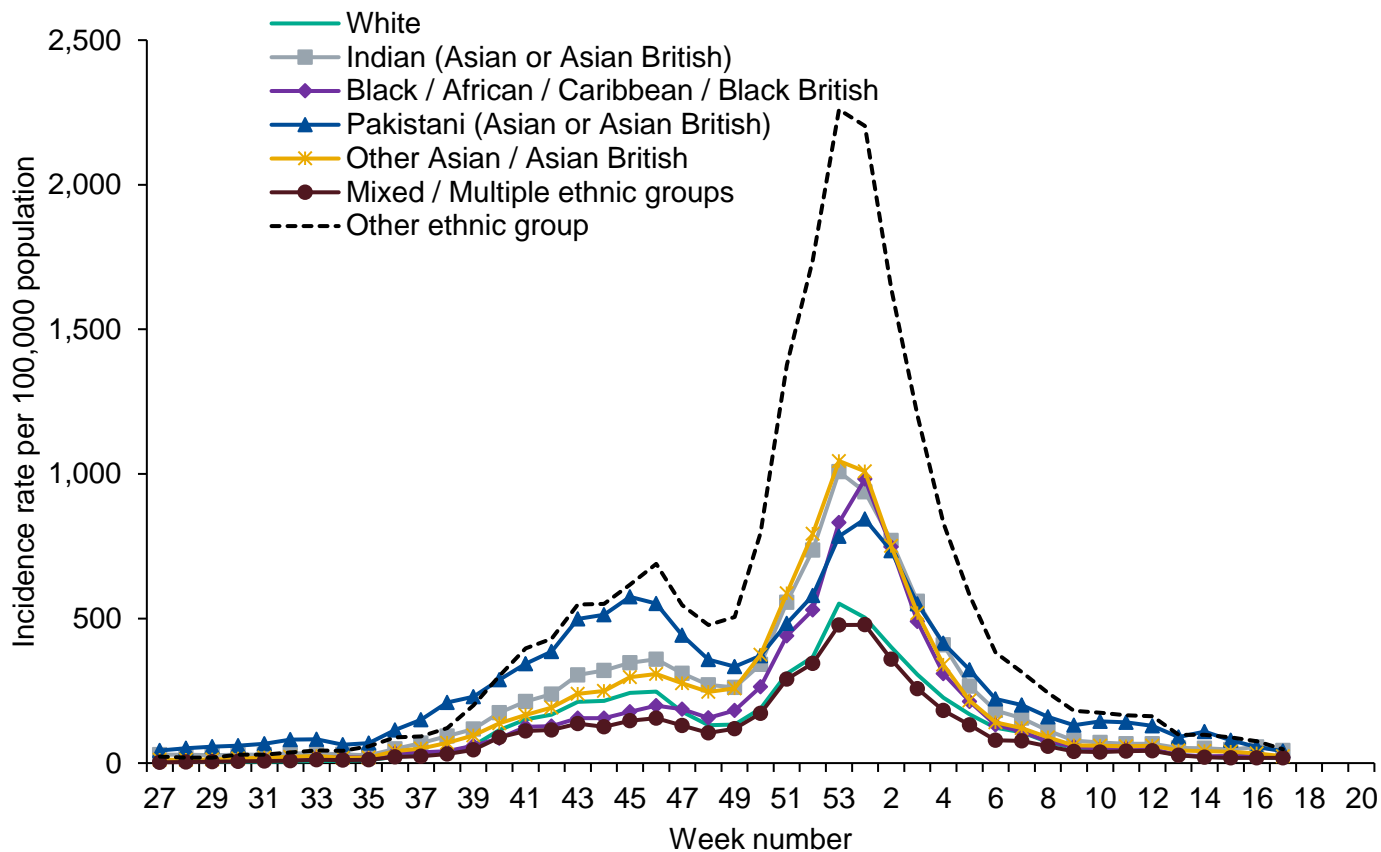


**Figure 10: Weekly rate of COVID-19 cases per 100,000 population (Pillar 1 and 2), by upper-tier local authority, England (box shows enlarged map of London area)**



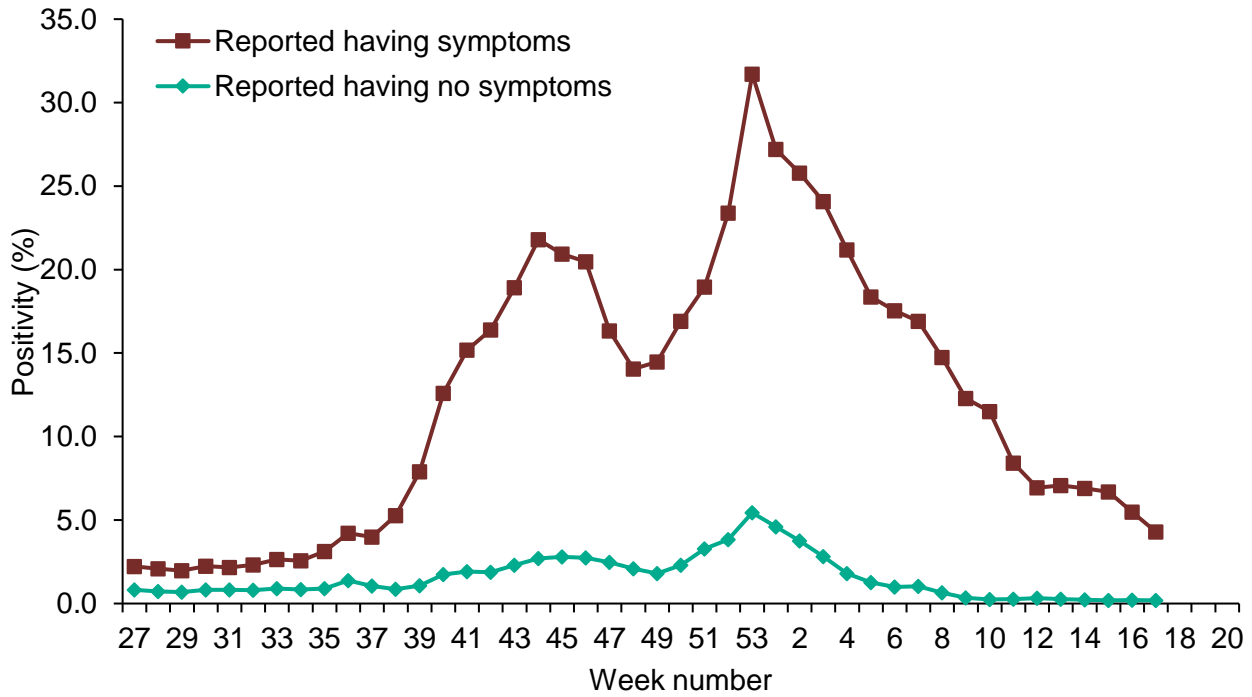
## Ethnicity

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)**





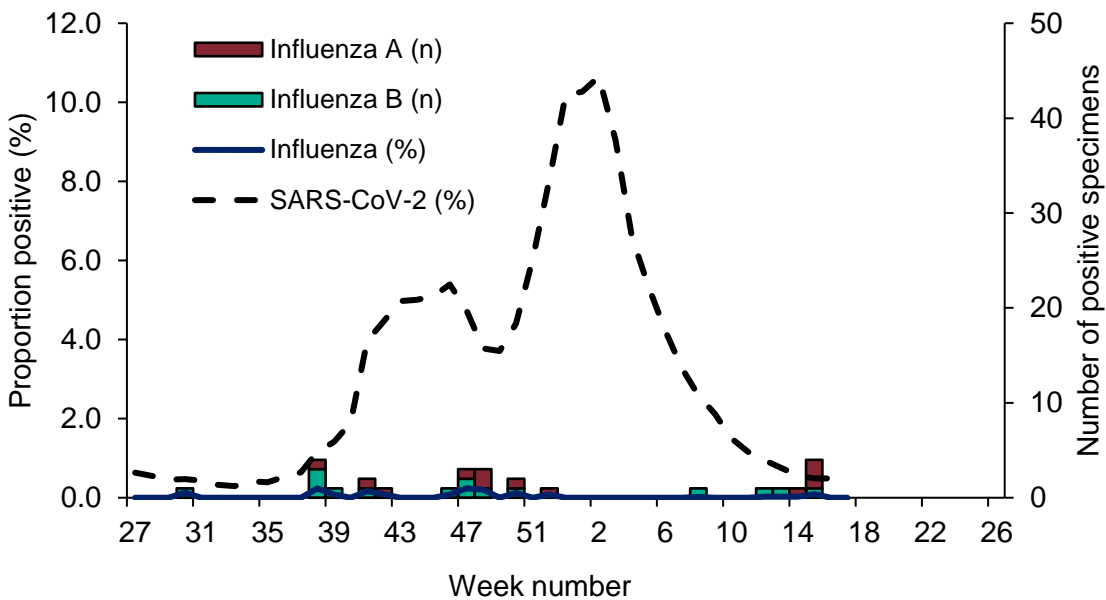
## Respiratory DataMart system (England)

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. Sixteen 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.

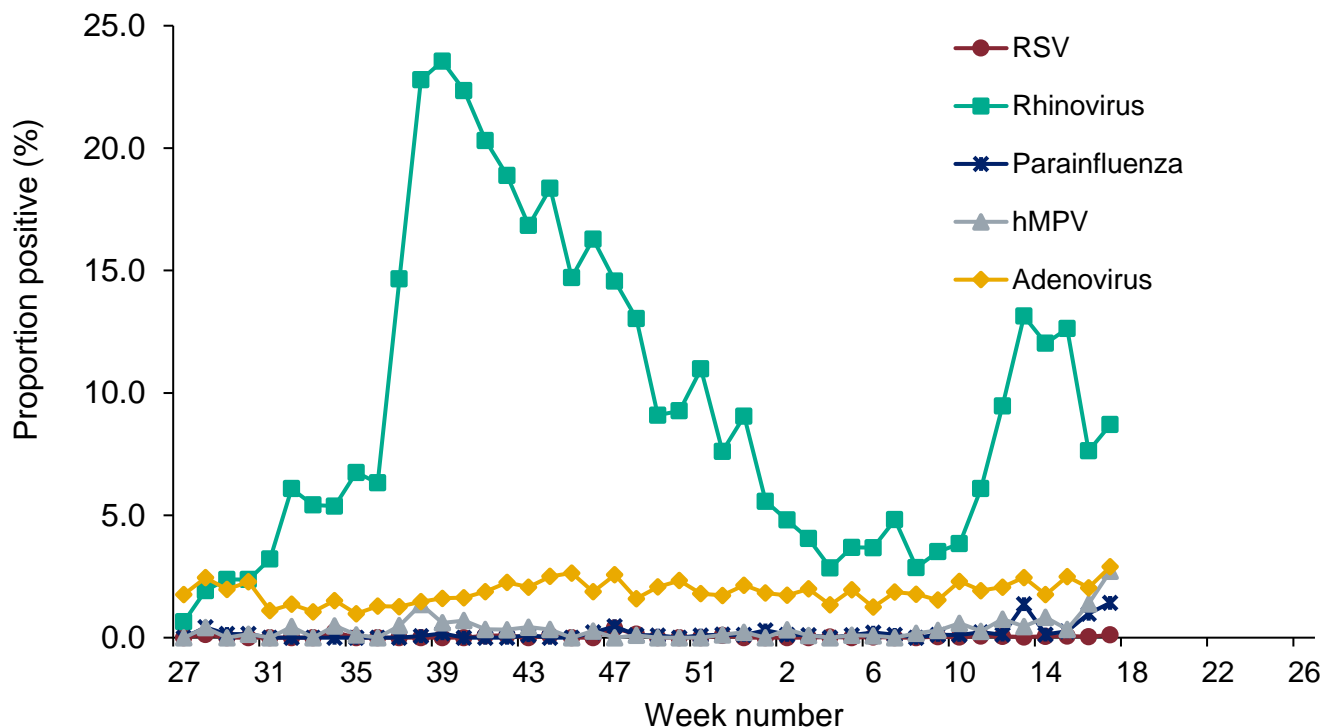
In week 17 2021, out of the 106,535 respiratory specimens reported through the Respiratory DataMart System (based on data received from 15 out of 16 laboratories), 633 samples were positive for SARS-CoV-2 with an overall positivity of 0.6%. The highest positivity was noted in the 15 to 44 year olds at 0.8% in week 17. The overall influenza positivity remained very low at 0.0% in week 17, with none of the 4,540 samples testing positive for flu.

Rhinovirus positivity increased slightly from 7.6% in week 16 to 8.7% in week 17. Respiratory syncytial virus (RSV), adenovirus, parainfluenza and human metapneumovirus (hMPV) positivity all remained low at 0.1%, 2.9%, 1.4% and 2.7% respectively in week 17 (Figure 14).

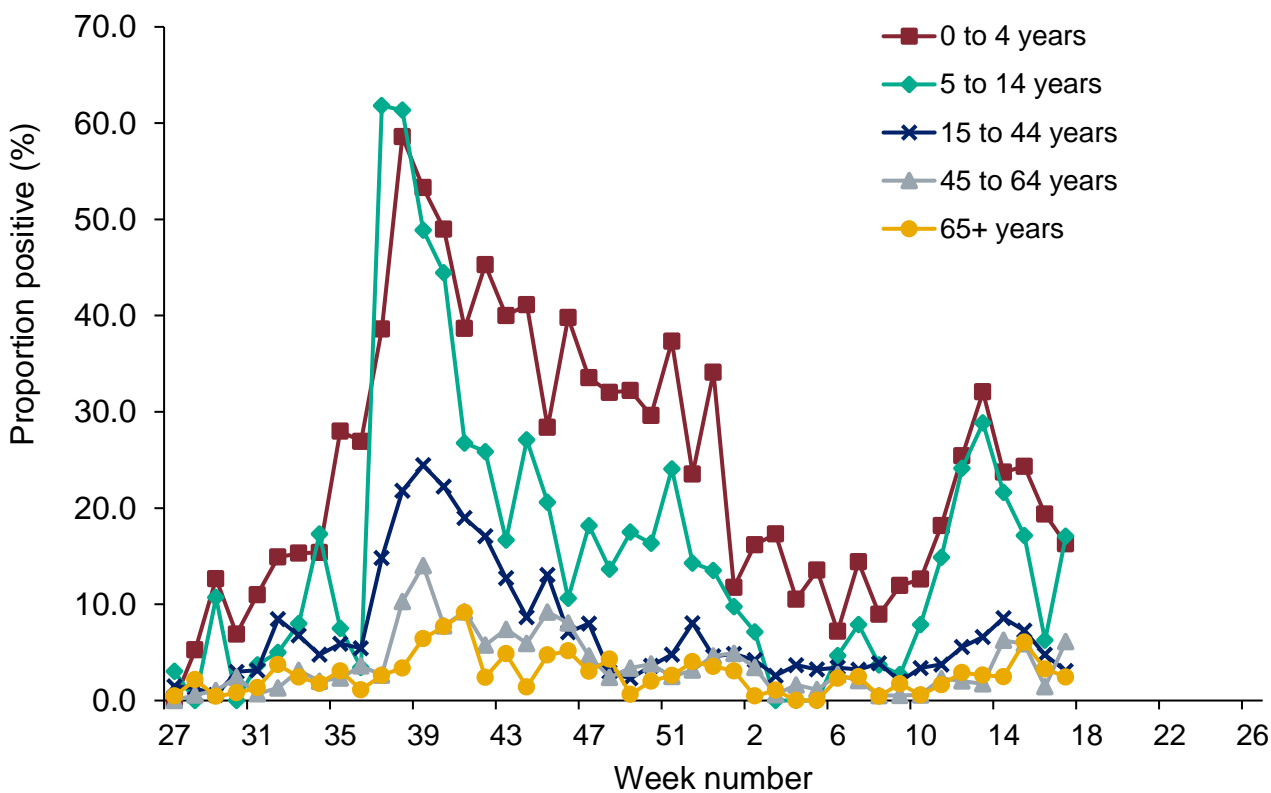
**Figure 13: DataMart samples positive for influenza and weekly positivity (%) for influenza and SARS-CoV-2, England**



**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, that is where 2 or more laboratory confirmed cases (SARS-CoV-2, influenza or other respiratory pathogens) are linked to a particular setting. Incidents where suspected cases test negative for 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.

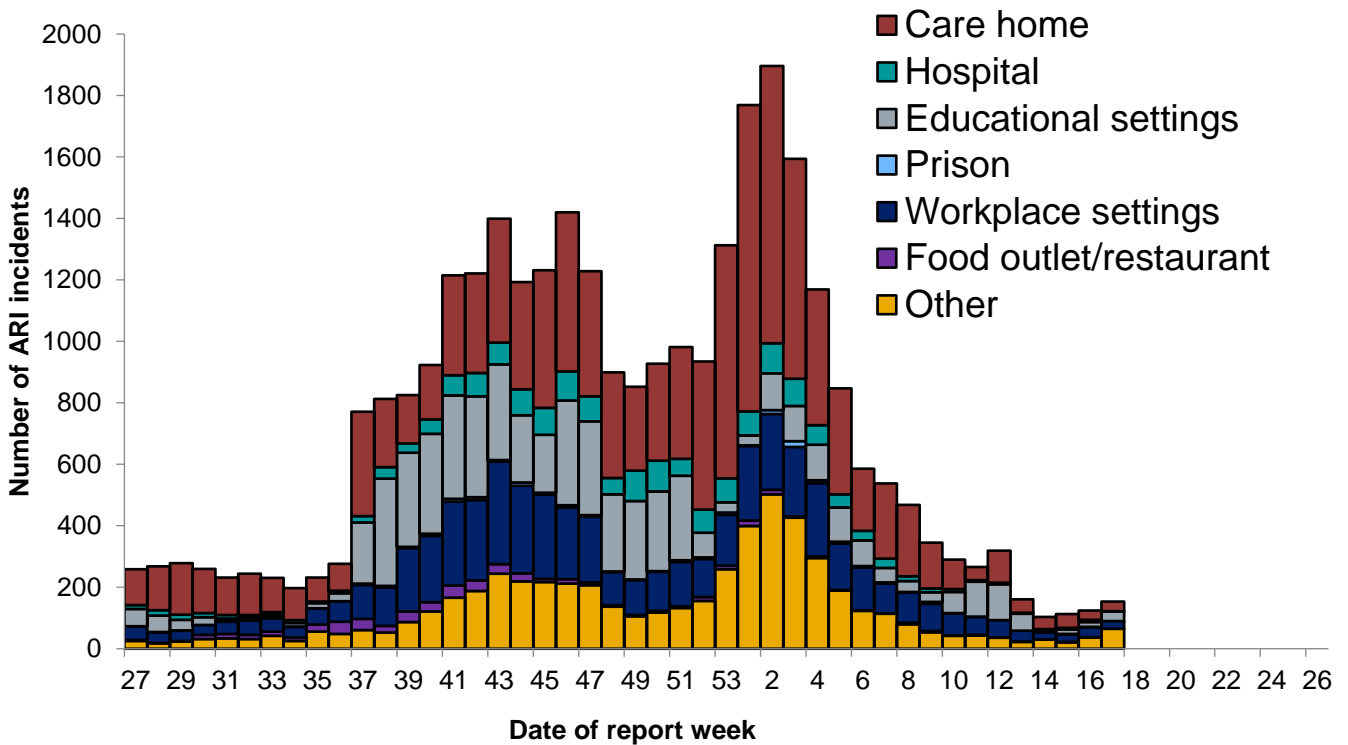
It should be noted that the denominator for the different settings will vary significantly. For example, there are fewer hospitals than workplaces. In addition, the propensity to report incidents to PHE also varies significantly by setting. This needs to be taken into account when interpreting the weekly 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.

156 new ARI incidents have been reported in week 17 in the UK (Figure 16):

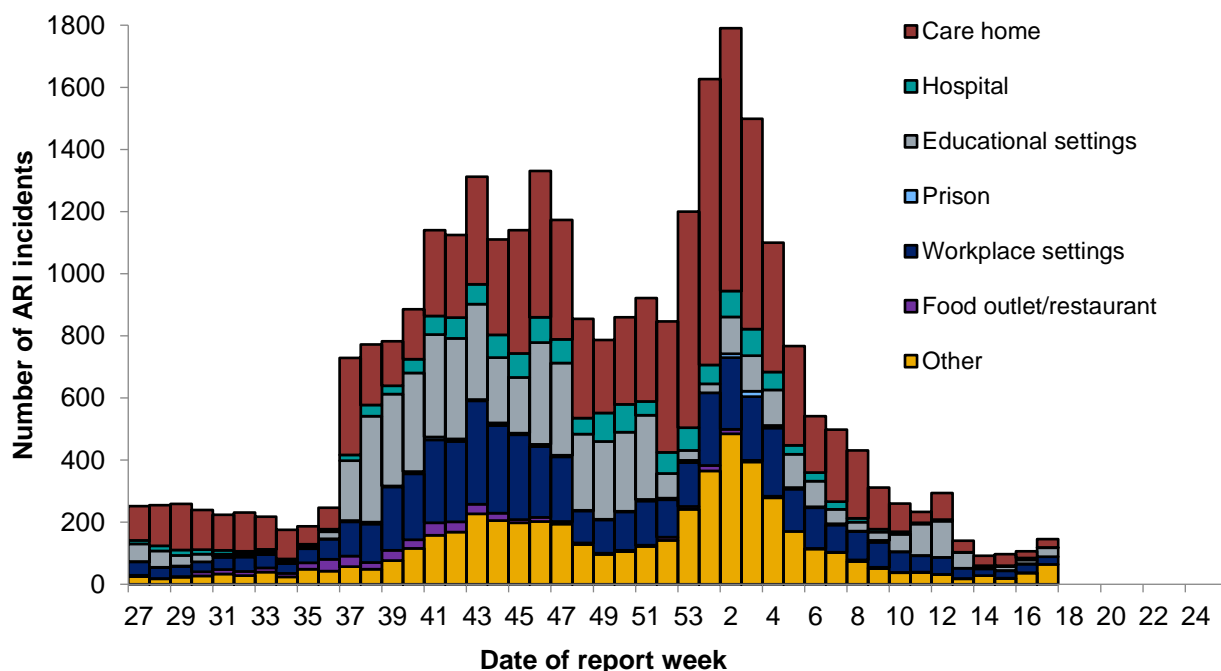
- 32 incidents were from care homes where 26 had at least one linked case that tested positive for SARS-CoV-2 where test results were available
- 31 incidents were from educational settings where 23 had at least one linked case that tested positive for SARS-CoV-2
- 1 incident was from a hospital, which had at least one linked case that tested positive for SARS-CoV-2
- 25 incidents were from workplace settings where 20 had at least one linked case that tested positive for SARS-CoV-2
- 67 incidents were from other settings where 48 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**

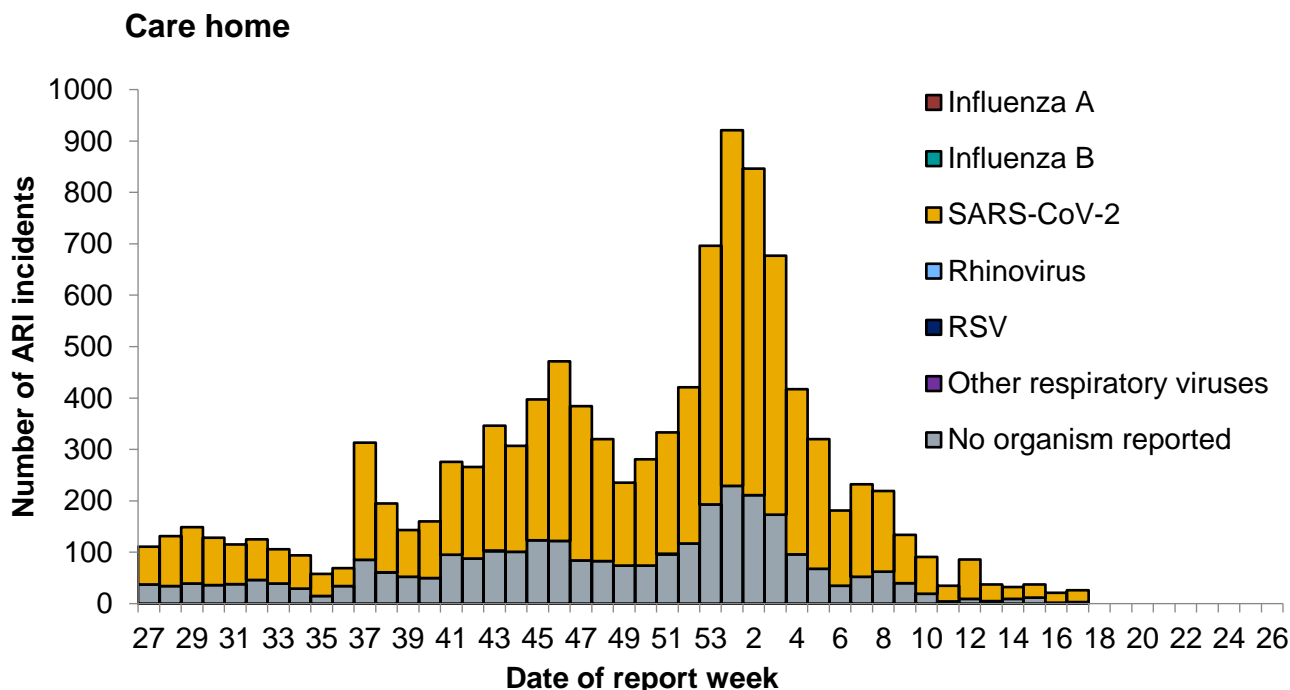


\*excludes data from Wales

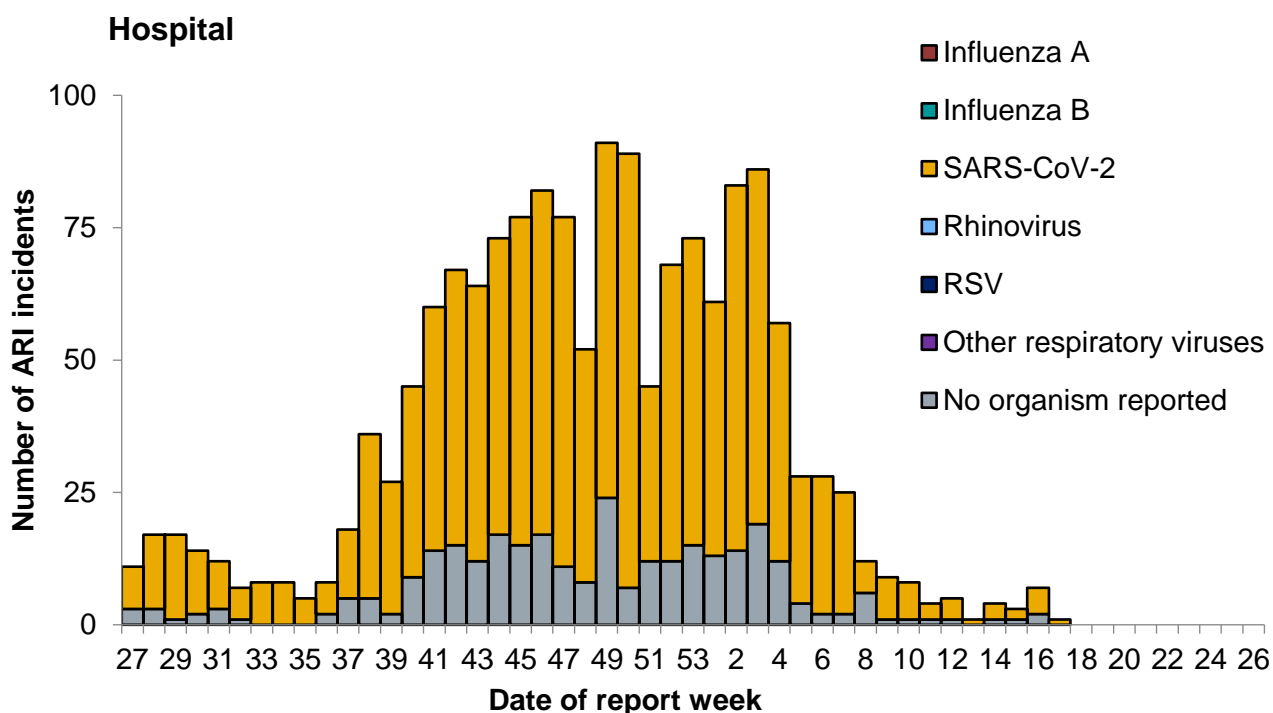
**Figure 17: Number of acute respiratory infection (ARI) incidents by setting, England**



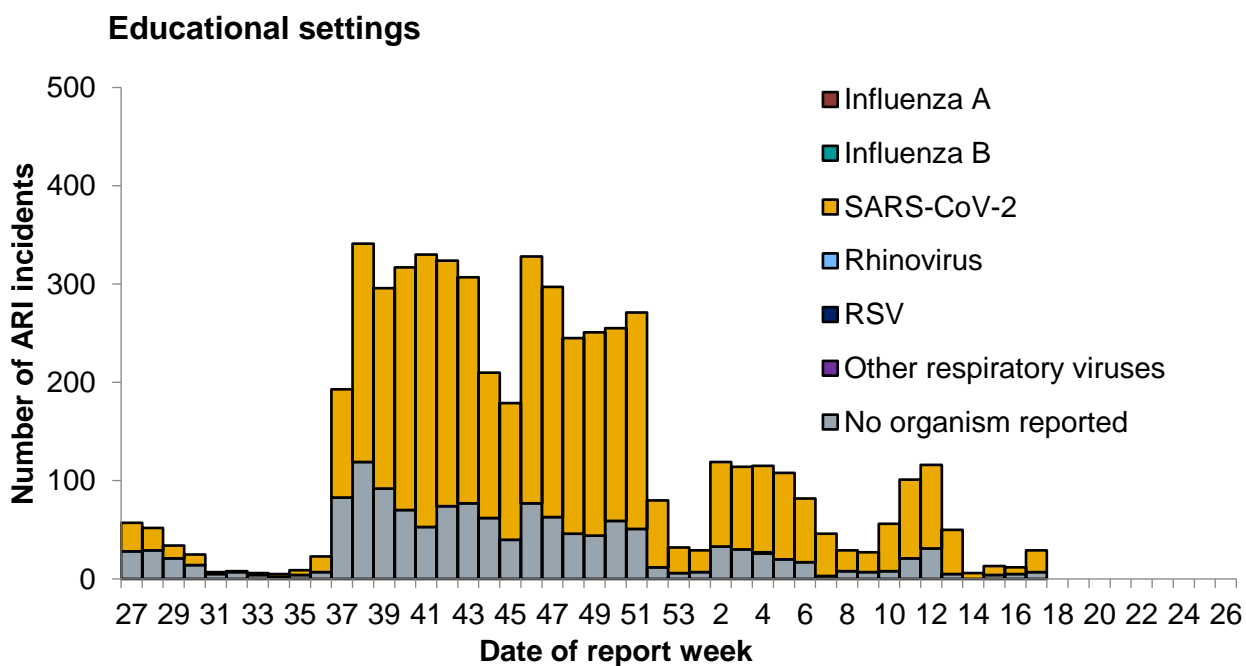
**Figure 18: Number of acute respiratory infection (ARI) incidents in care homes by virus type from week 27, England**



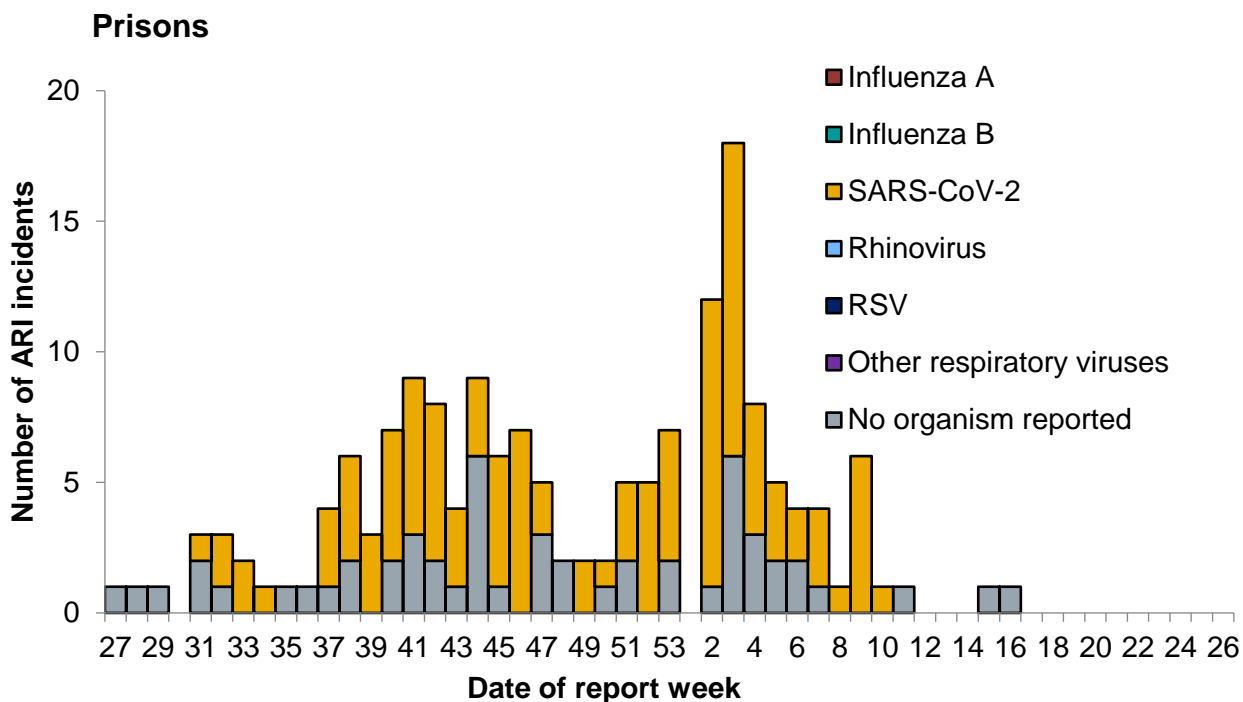
**Figure 19: Number of acute respiratory infection (ARI) incidents in hospitals by virus type from week 27, England**



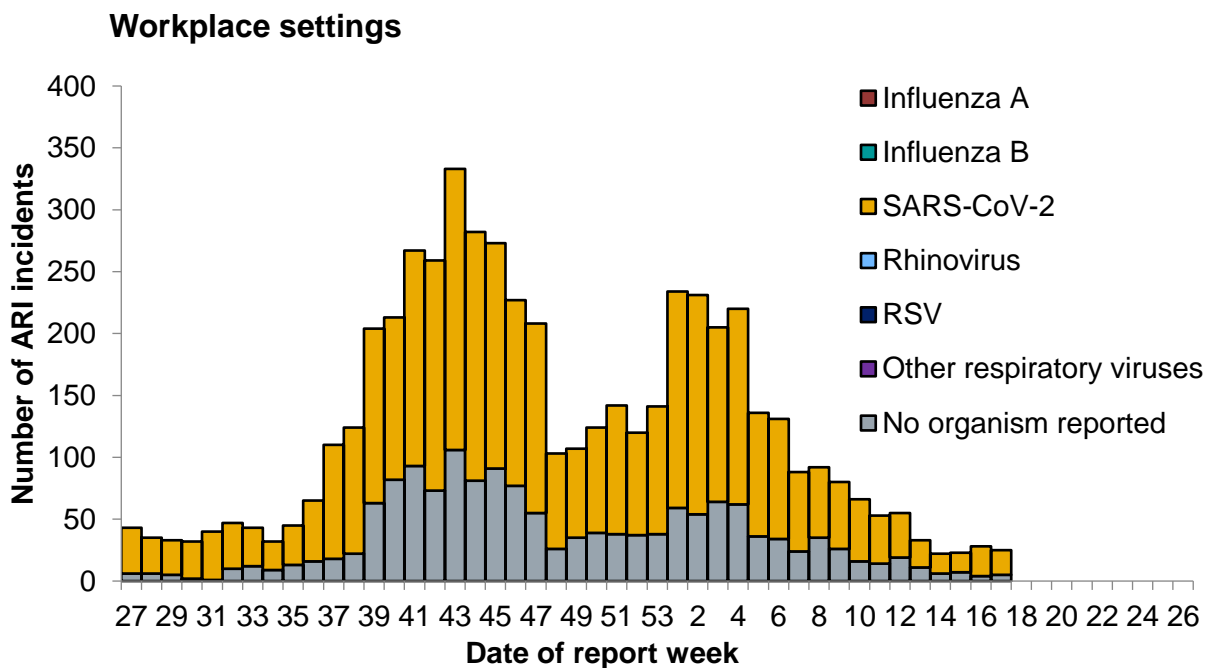
**Figure 20: Number of acute respiratory infection (ARI) incidents in educational settings by virus type from week 27, England**



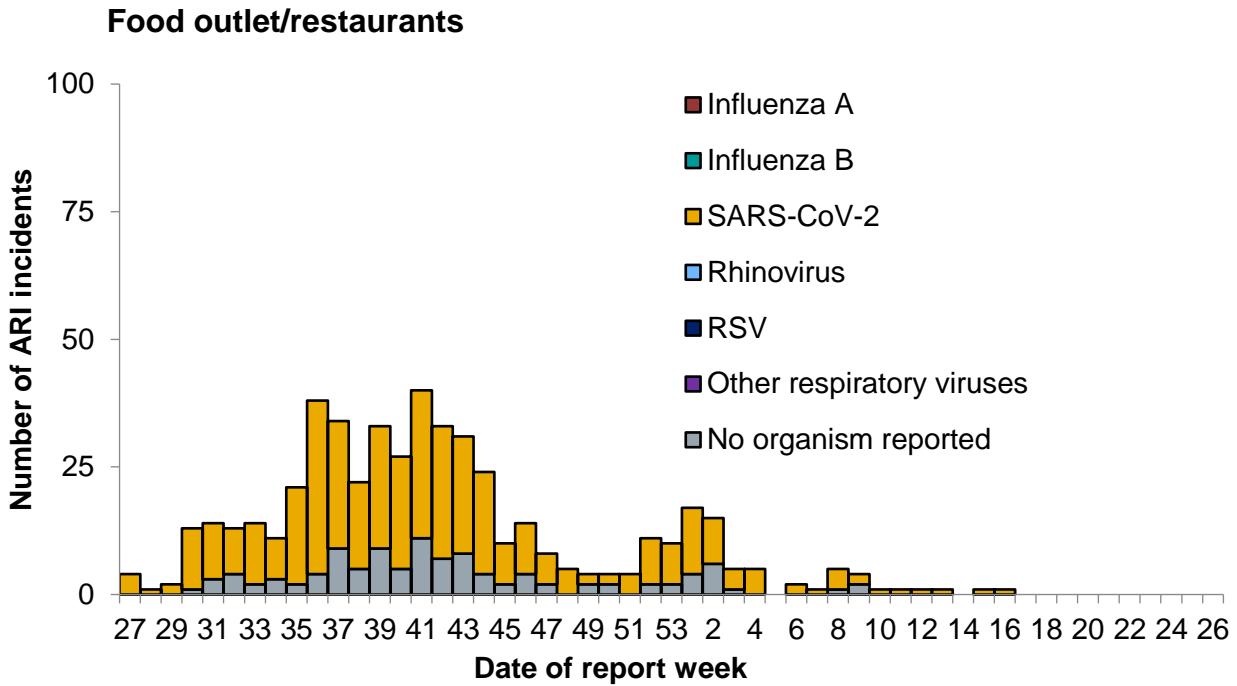
**Figure 21: Number of acute respiratory infection (ARI) incidents in prisons by virus type from week 27, England**



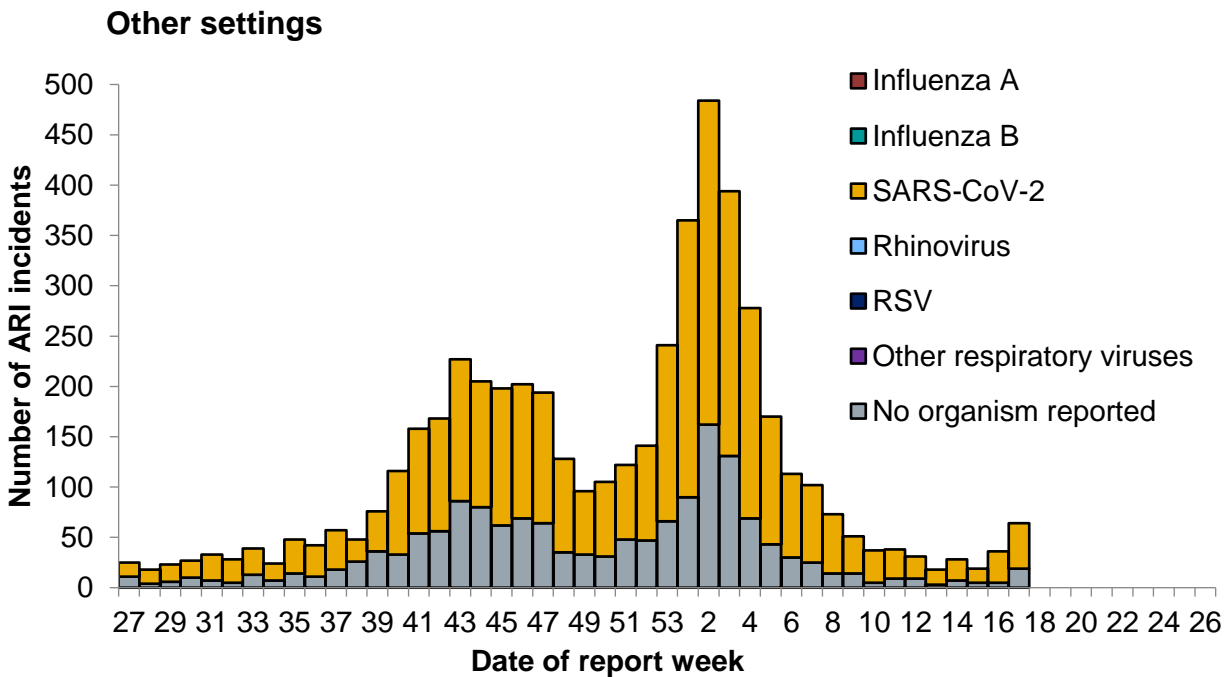
**Figure 22: Number of acute respiratory infection (ARI) incidents in workplace settings by virus type from week 27, England**



**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 4 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	14(4)	2(0)	2(2)	1(0)	6(2)	0(0)	8(3)	33(12)
East Midlands	7(0)	1(1)	10(3)	0(0)	18(3)	0(0)	6(5)	42(11)
London	9(1)	2(0)	6(4)	1(0)	3(1)	0(0)	27(11)	48(17)
North East	6(1)	0(0)	1(0)	0(0)	0(0)	0(0)	5(3)	12(4)
North West	6(0)	1(0)	6(2)	0(0)	11(4)	0(0)	11(6)	35(12)
South East	18(2)	0(0)	9(6)	0(0)	10(2)	0(0)	29(20)	66(30)
South West	19(3)	1(0)	2(2)	0(0)	4(1)	0(0)	25(7)	51(13)
West Midlands	26(12)	4(0)	7(2)	0(0)	13(3)	0(0)	11(4)	61(21)
Yorkshire and Humber	11(3)	4(0)	17(8)	0(0)	33(9)	2(0)	25(5)	92(25)
<b>Total</b>	116(26)	15(1)	60(29)	2(0)	98(25)	2(0)	147(64)	440(145)

## 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 17, 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	Week 12	Week 13	Week 14	Week 15	Week 16	Week 17
Residential dwelling (including houses, flats, sheltered accommodation)	94.1	92.8	92.0	91.2	92.2	92.6
Undetermined	2.6	3.4	4.2	4.6	4.0	3.5
Care/Nursing home	0.8	0.8	1.0	0.9	0.6	0.6
Residential institution (including residential education)	0.2	0.2	0.4	0.6	0.5	0.5
Other property classifications	0.6	0.8	0.9	1.2	1.4	1.1
House in multiple occupancy (HMO)	0.5	0.6	0.7	0.6	0.4	0.7
Medical facilities (including hospitals and hospices, and mental health)	0.3	0.9	0.6	0.7	0.7	0.7
Prisons, detention centres, secure units	0.8	0.4	0.2	0.2	0.2	0.3
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) and 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 2021 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 0.00 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 5.76 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 available since week 50.

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

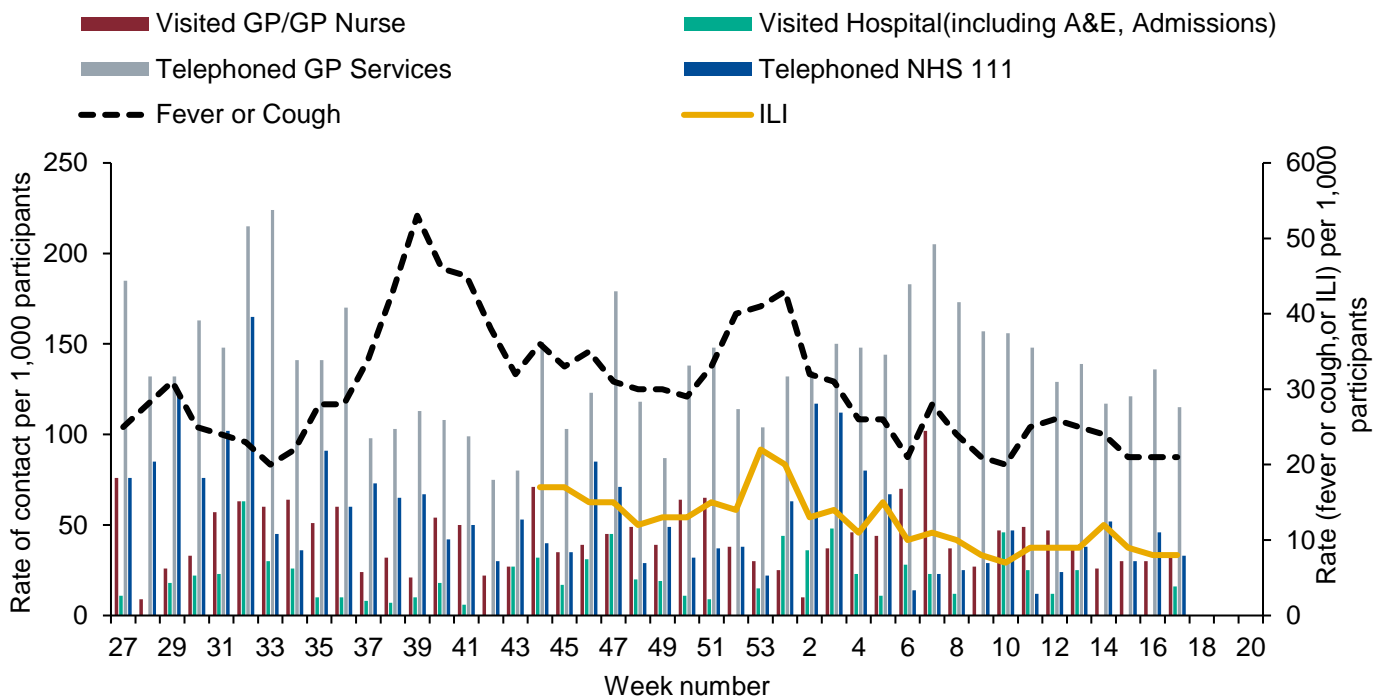
# FluSurvey

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 2,865 participants completed the weekly surveillance survey in week 17, of which 61 (2.1%) reported fever or cough and 24 (0.8%) 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**



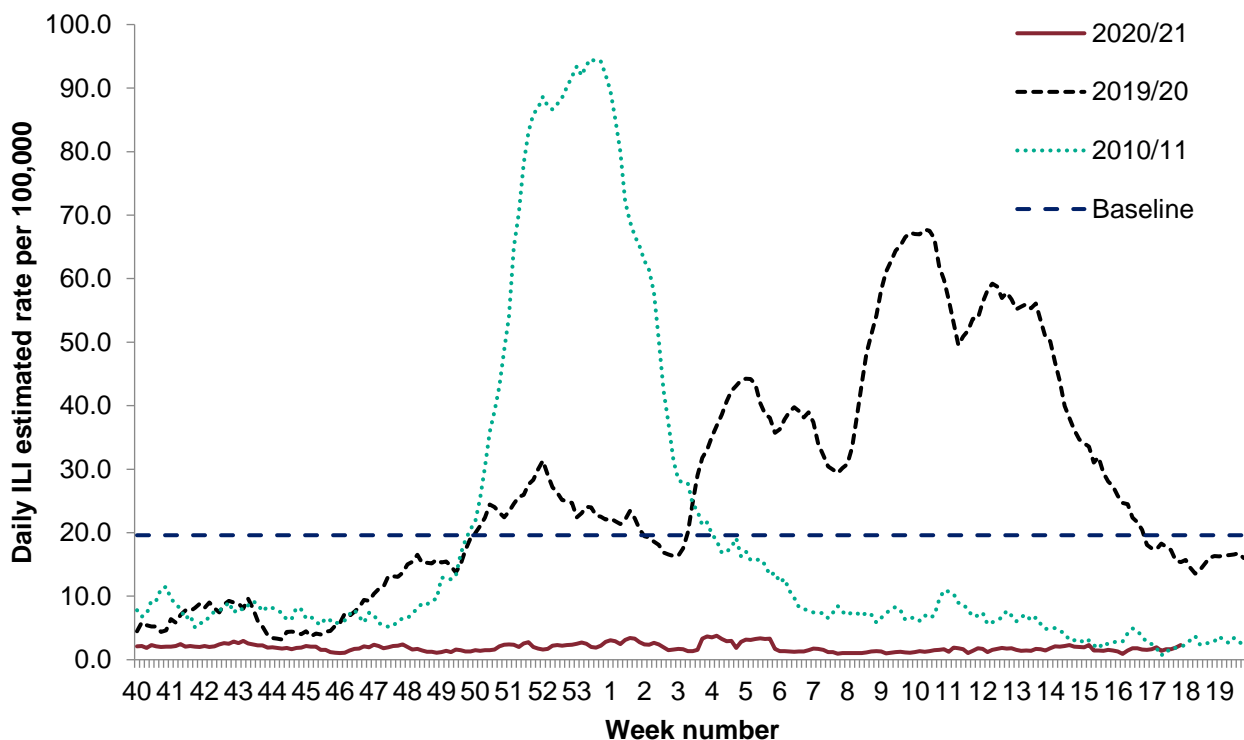
## FluDetector

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 6 days before it).

For week 17, 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**

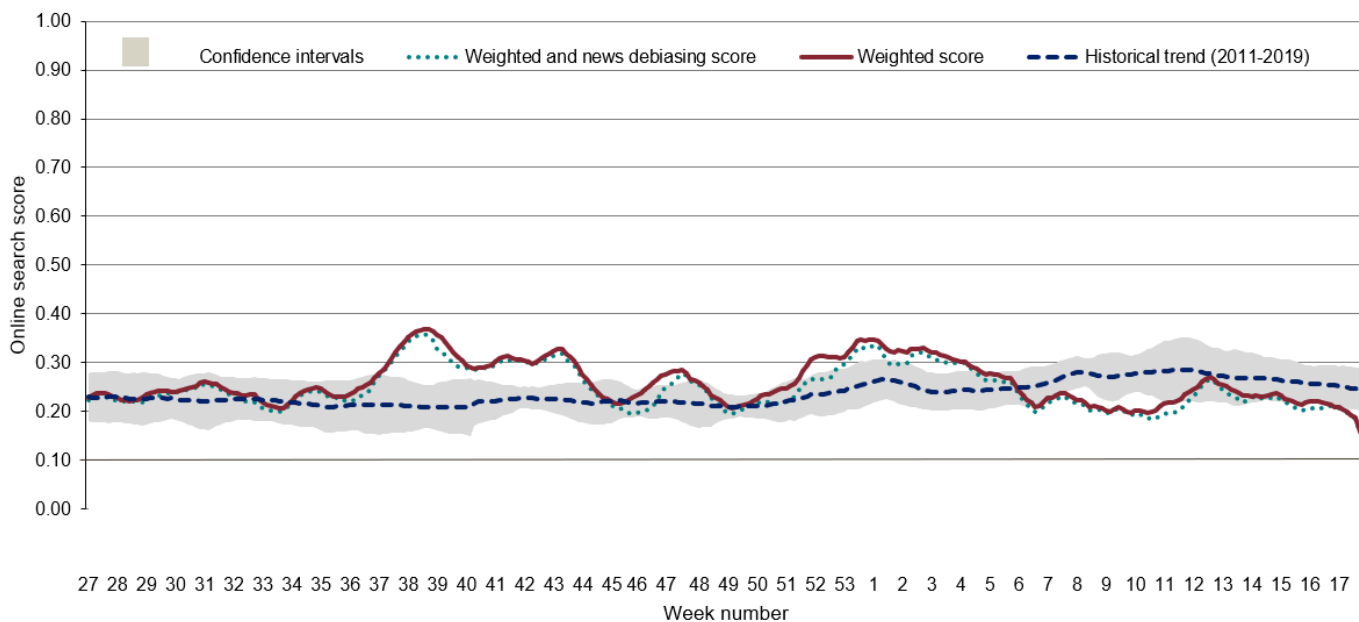


## Google search queries

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” (for example, “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 17, the overall and media-debiasing weighted Google search scores decreased slightly (Figure 27).

**Figure 27: Normalised Google search score for COVID-19 symptoms, with weighted score for media-debiasing and historical trend, England**



# NHS 111

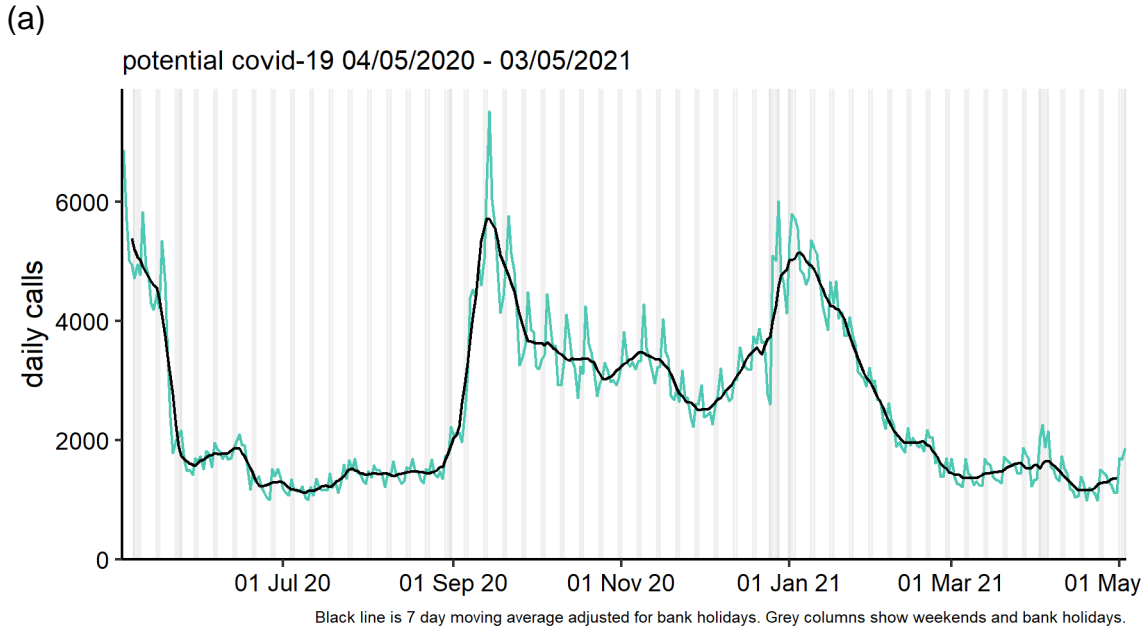
The NHS 111 service monitors daily trends in phone calls made to the service in England, to capture trends in infectious diseases such as influenza and norovirus.

Up to 3 May, NHS 111 calls for cold/flu and potential COVID-19 increased, while calls for loss of taste or smell remained stable. Online assessments for cold/flu, potential COVID-19 and loss of taste or smell remained stable (Figure 28 and 29).

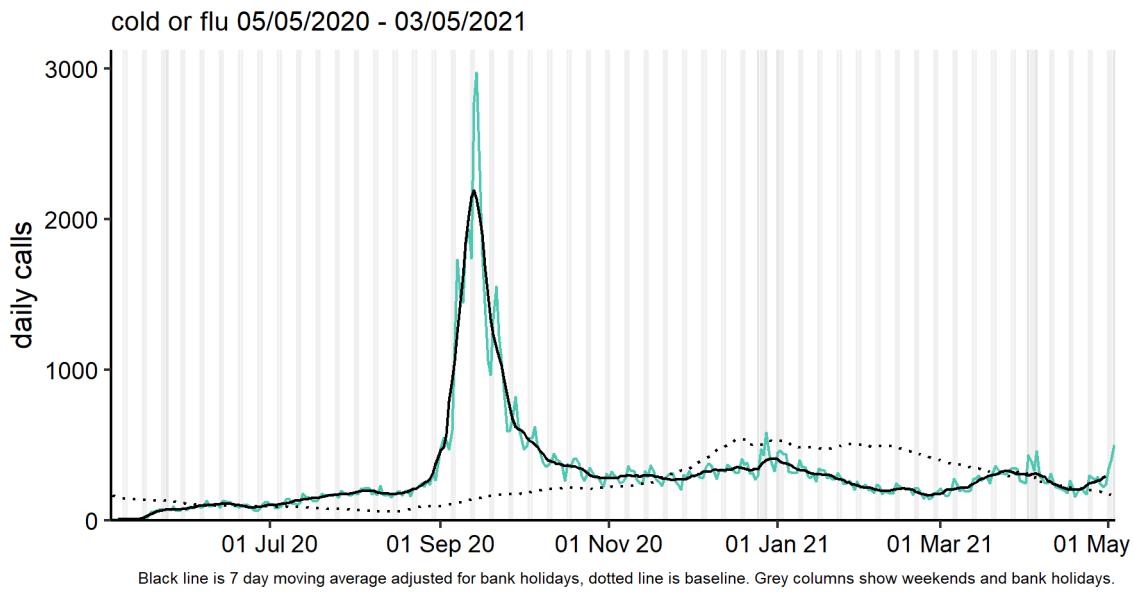
Please note that NHS 111 callers (from 11 May 2020) and NHS 111 online users (from 11 June 2020), who are assessed as having probable COVID-19 symptoms are now triaged using symptom specific pathways, for example cold/flu, which are included in routine syndromic indicators.

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

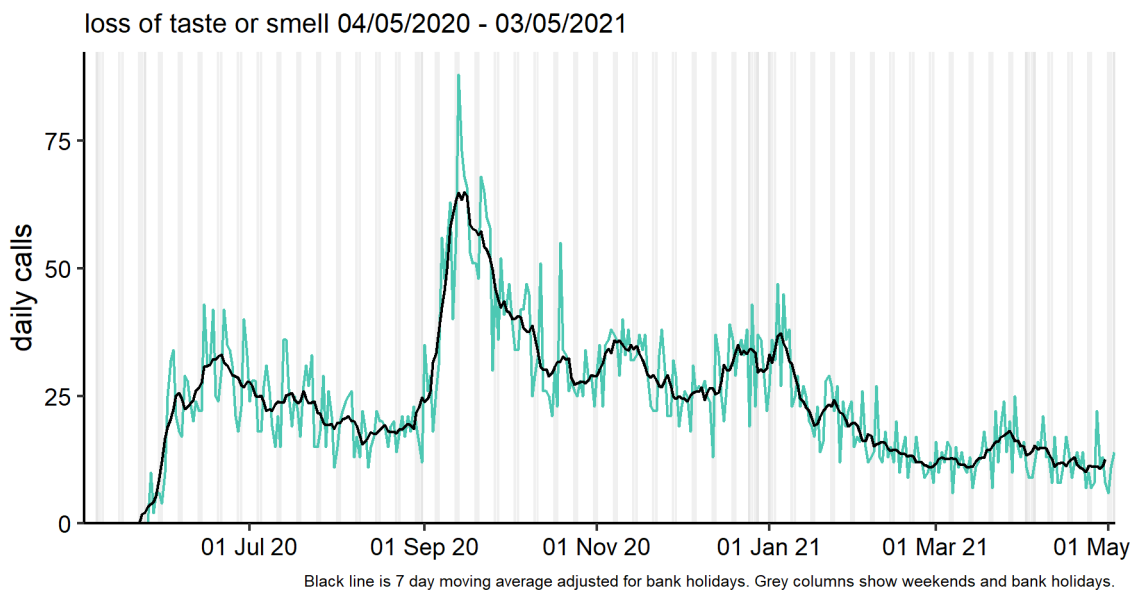
**Figure 28: NHS 111 telephony indicators (and 7-day moving average) for (a) daily potential COVID-19 calls, (b) daily cold/flu calls and (c) daily loss of taste or smell calls, as a percentage of total calls for all ages, England**



(b)

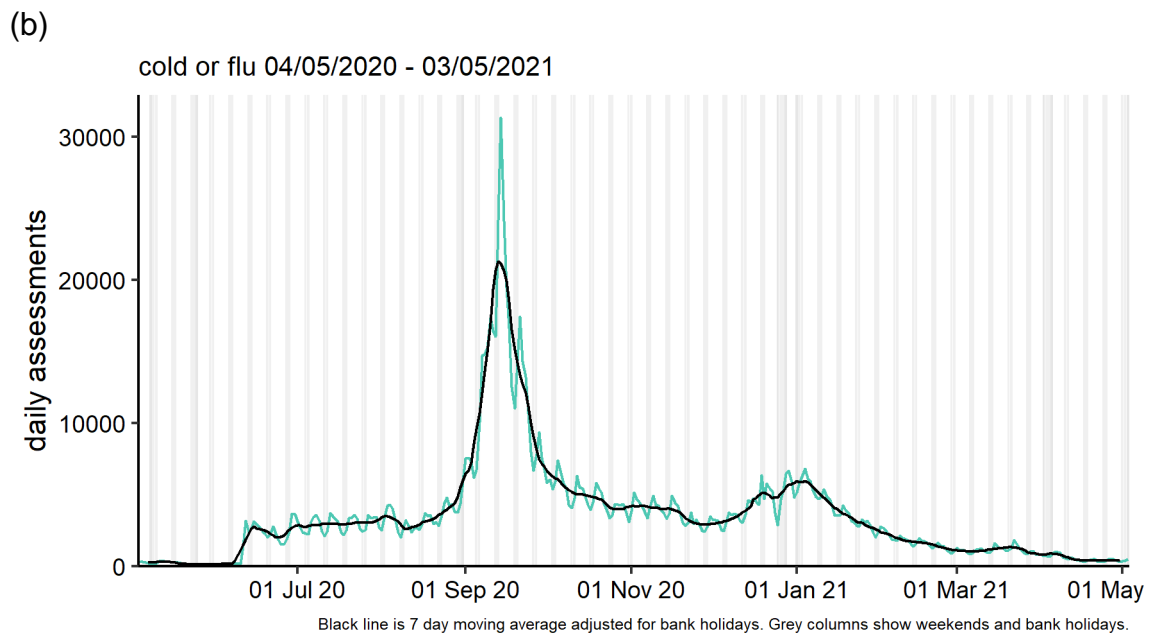
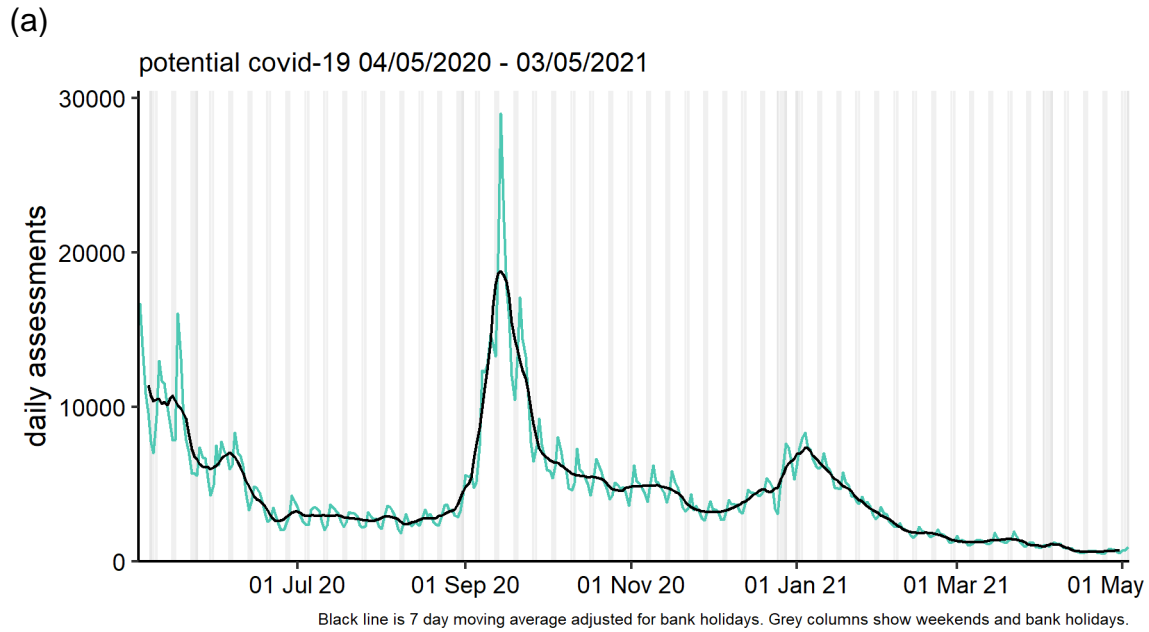


(c)

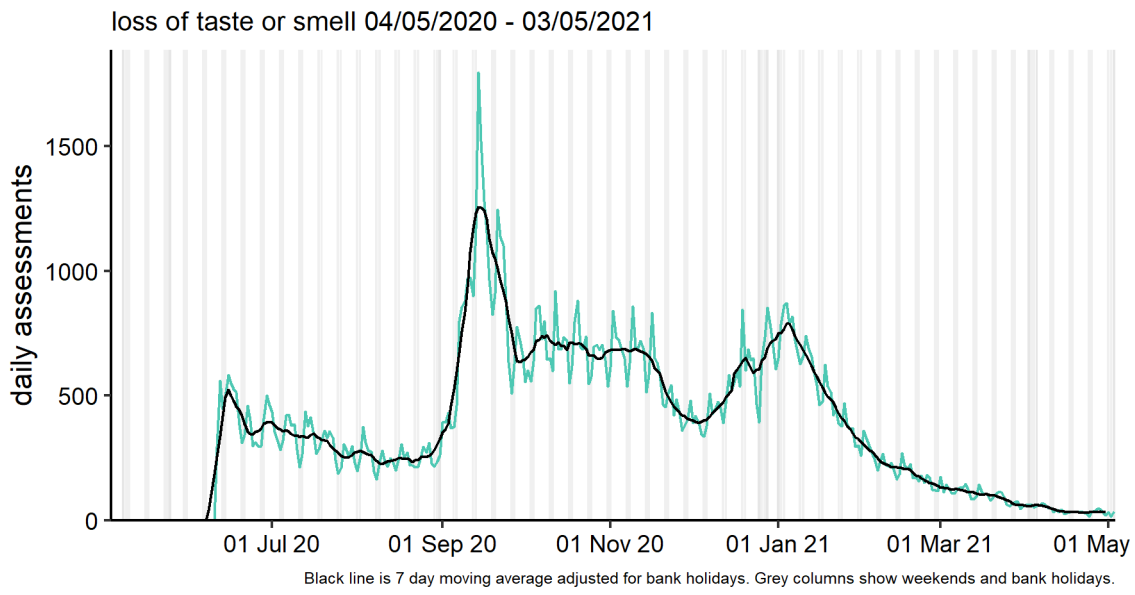




**Figure 29: NHS 111 completed online assessments (and 7-day moving average) for (a) daily potential COVID-19 online assessments, (b) daily cold/flu online assessments and (c) daily loss of taste or smell online assessments, as the number of completed online assessments for all ages, England**



(c)

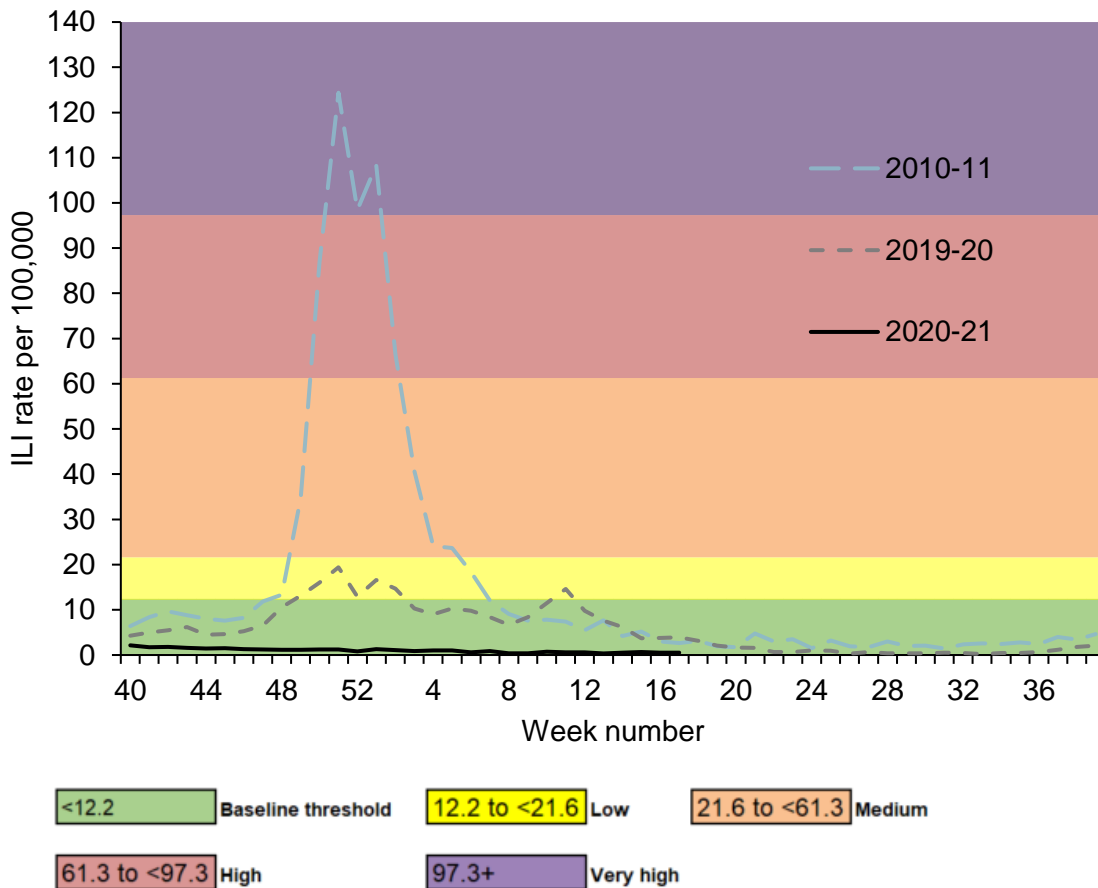


# Primary care surveillance

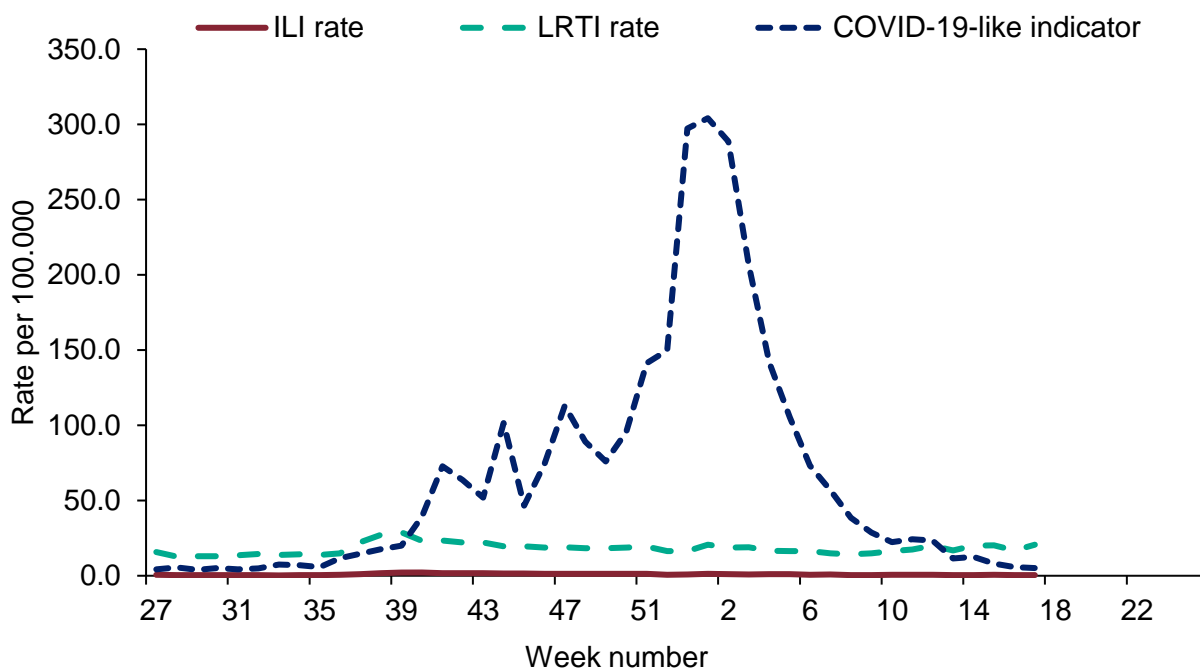
## RCGP (England)

The weekly ILI consultation rate through the RCGP surveillance was 0.5 per 100,000 registered population in participating GP practices in week 17 compared to 0.5 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 1 to 4 year olds (1.6 per 100,000). The Lower Respiratory Tract Infections (LRTI) consultation rate was at 20.7 per 100,000 in week 17, compared to the rate of 16.8 per 100,000 from the previous week. The COVID-19-like indicator consultation rate was at 5.2 per 100,000 in week 17 compared to a rate of 5.7 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 (0.6 per 100,000) and the 15 to 44 year olds in Northern Ireland (1.2 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																			
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
England (RCGP)	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	0.6	0.5	0.5			
Wales	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	0.5	0.0				
Scotland	0.5	0.6	0.5	0.5	0.5	0.4	0.5	0.5	0.3	0.2	0.3	0.4	0.4	0.3	0.3	0.2	0.2			
Northern Ireland	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	0.8	0.4	0.7			

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

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

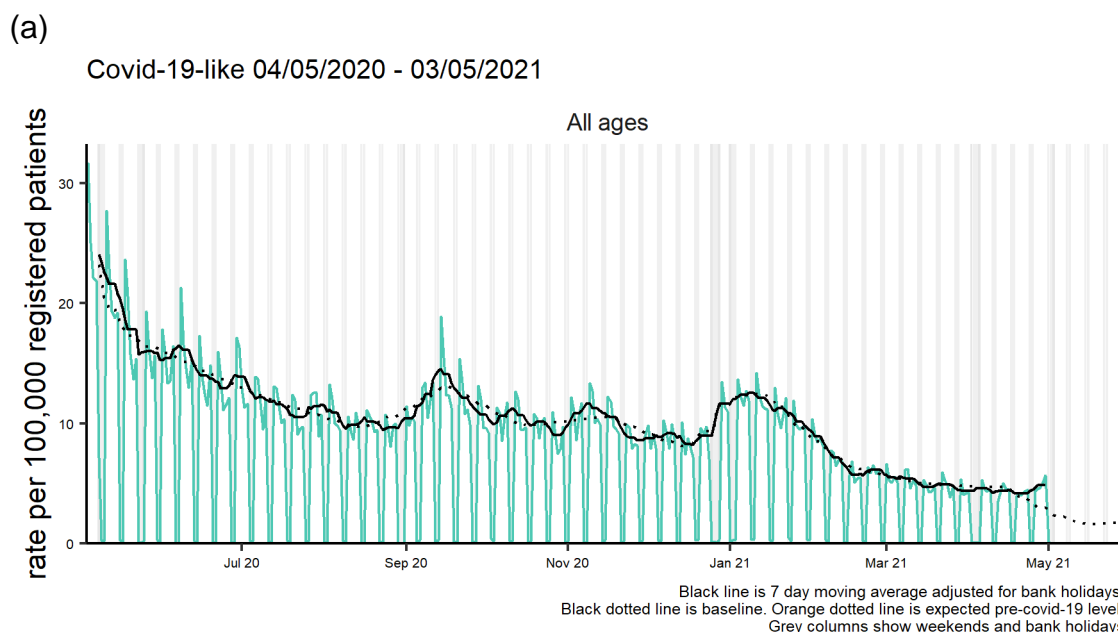
## GP In Hours, Syndromic Surveillance

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

Up to 3 May GP in-hours consultations for potential COVID-19 increased, while consultations for influenza-like-illness remained similar to baseline levels (Figure 32).

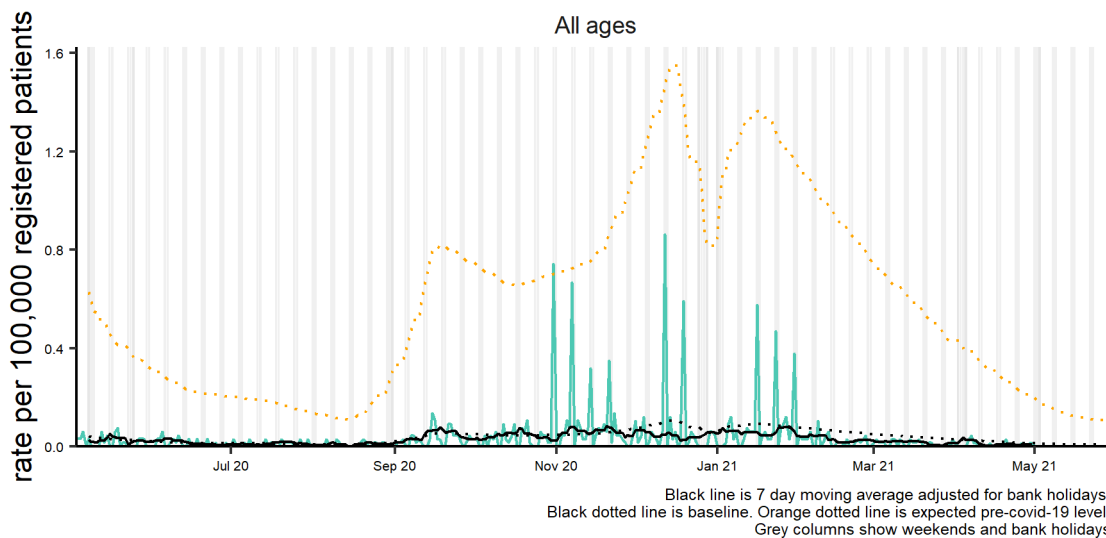
Further information about caveats is available from the [PHE GP In Hours Syndromic Surveillance bulletin](#).

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



(b)

Influenza-like illness 04/05/2020 - 03/05/2021



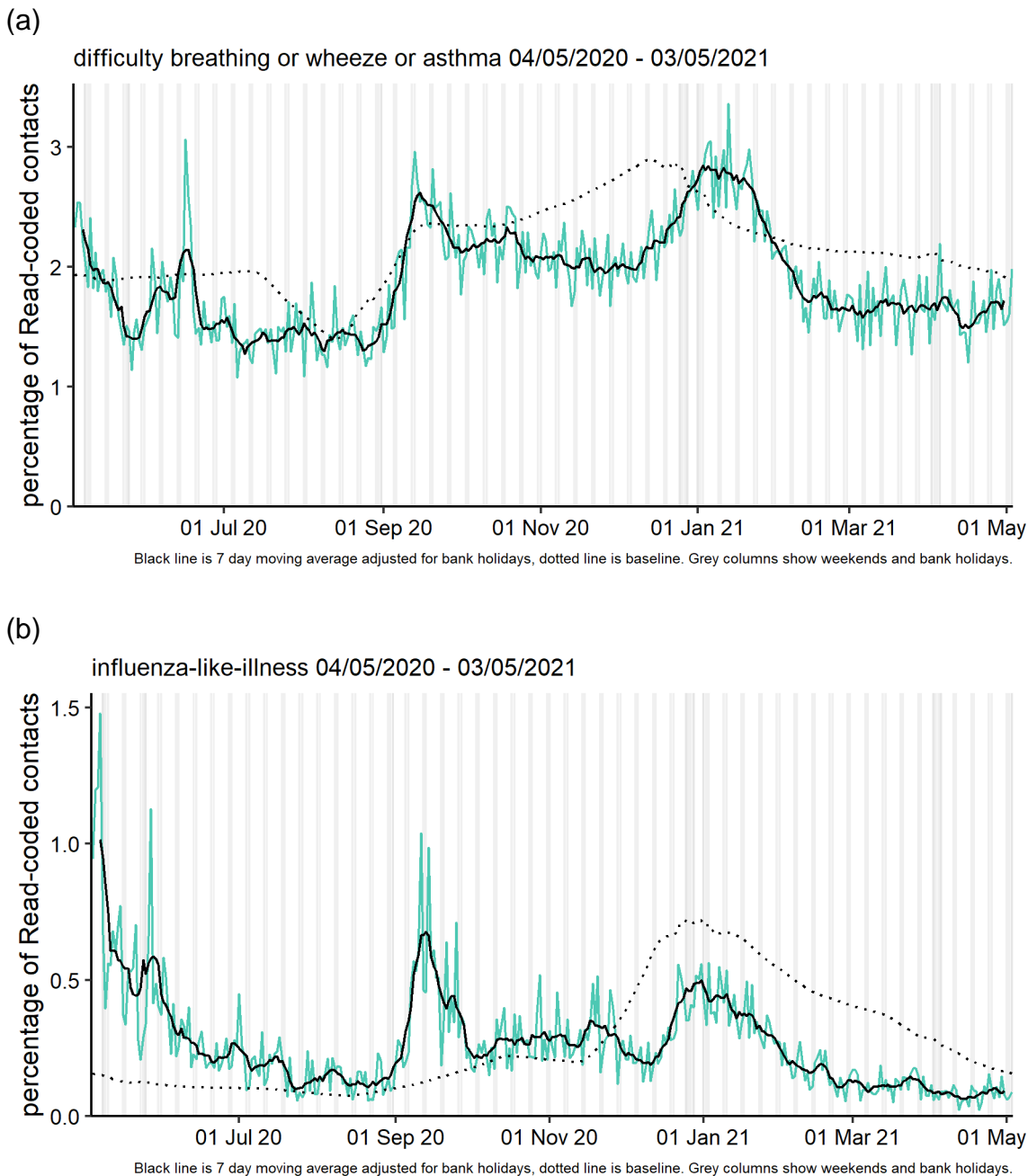
GPIH Baselines are modelled from historical data to give current seasonally expected levels. GP consultations rates decreased during 2020 due to changes in guidance on accessing health care, therefore separate modelled estimates are provided to show seasonally expected levels pre-COVID-19.

## GP Out of Hours, Syndromic Surveillance

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

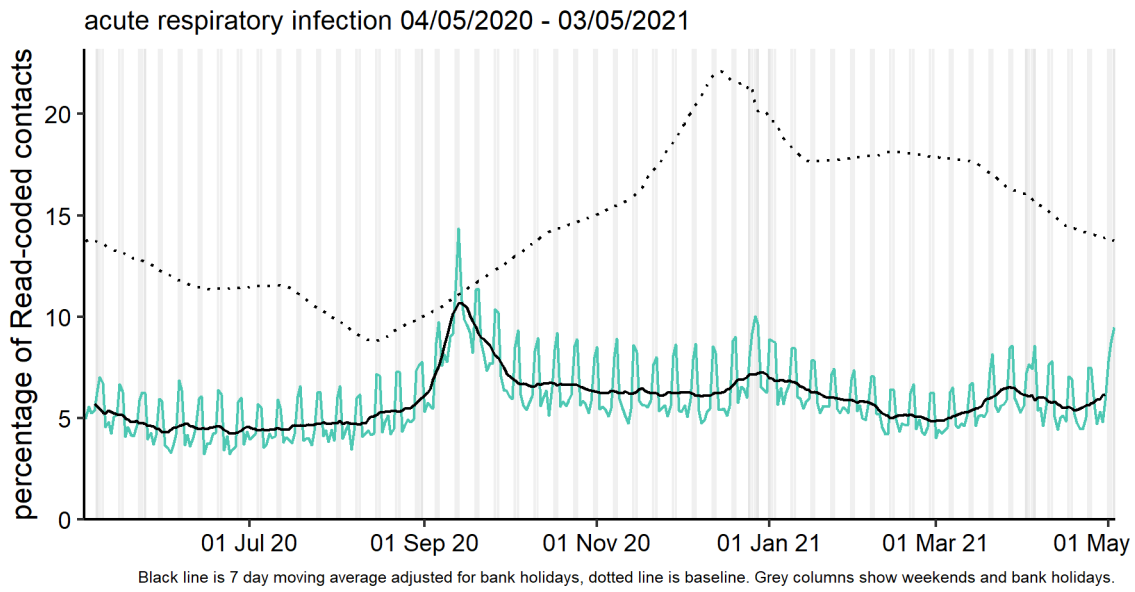
Up to 3 May, GP out-of-hours and unscheduled care consultations for difficulty breathing/asthma/wheeze and influenza-like illness remained stable, while consultations for acute respiratory infections increased (Figure 33).

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





(c)

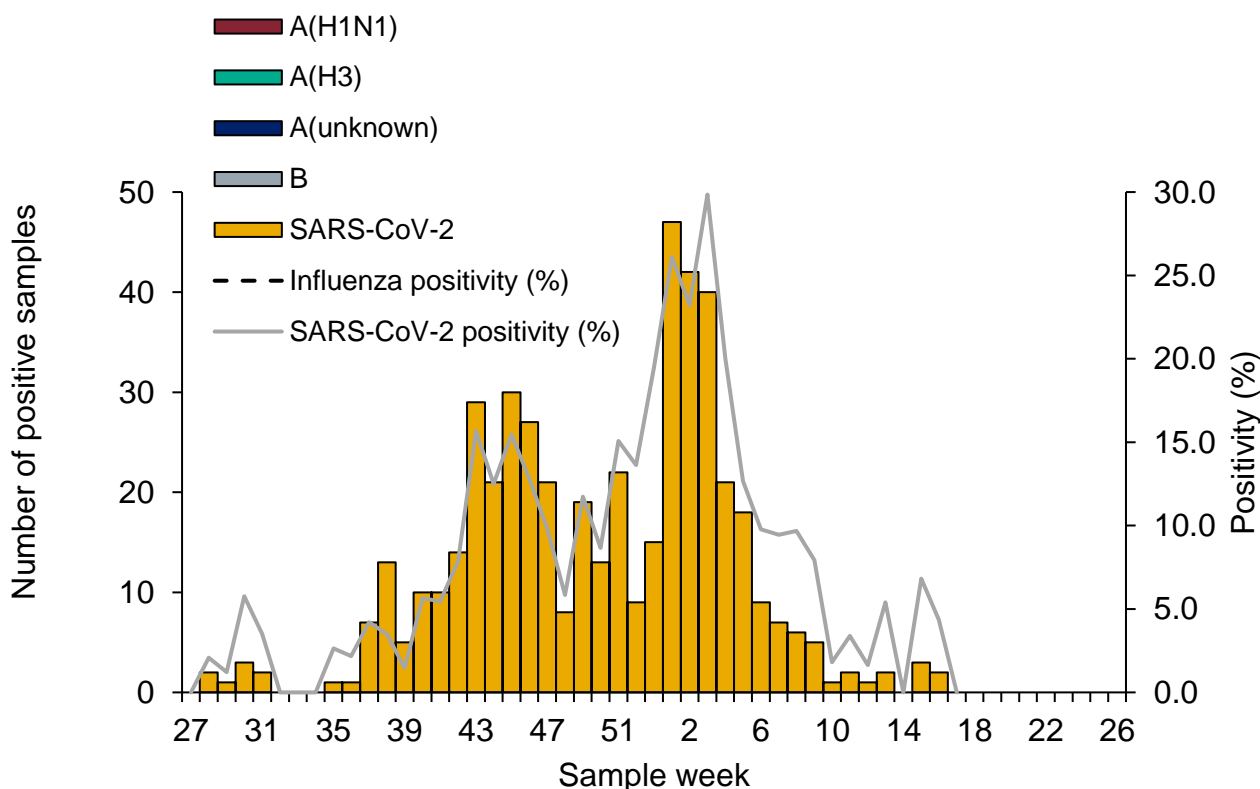


## Sentinel swabbing scheme in the UK

In week 17 2021, no samples tested positive for SARS-CoV-2 with an overall positivity of 0.0% (0/29) compared to 4.7% (2/43) 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.

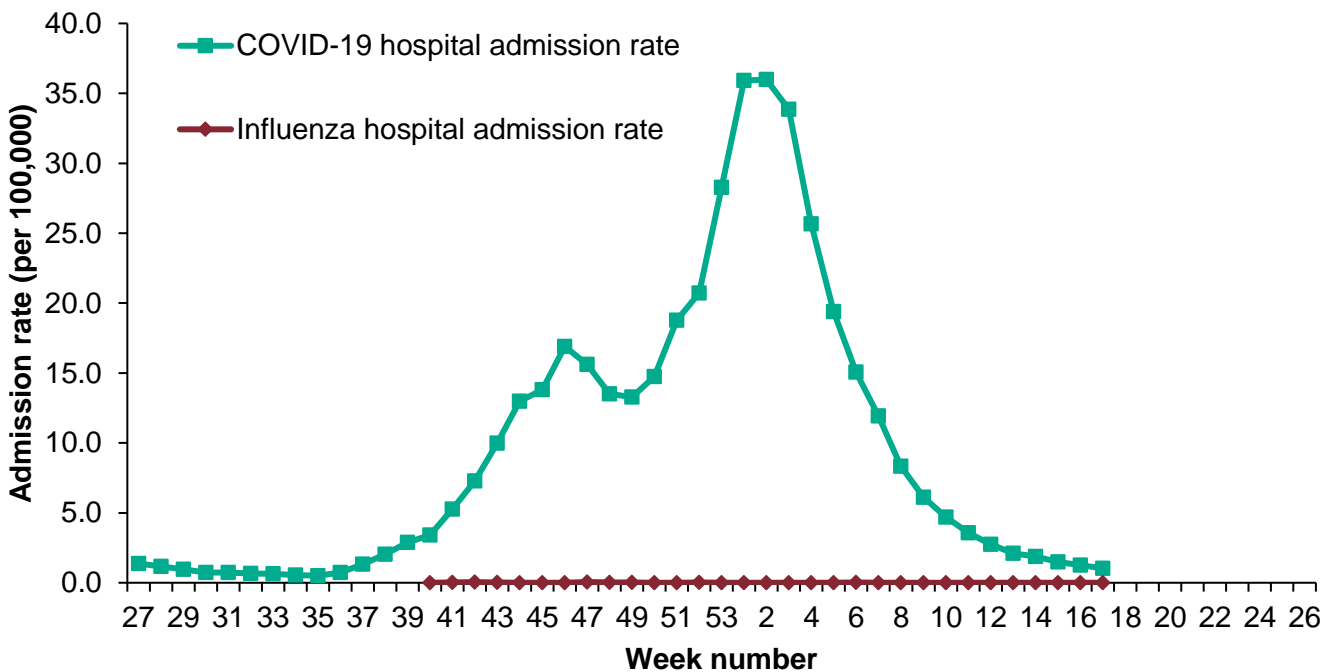
## Hospitalisations, SARI Watch

In week 17, the overall weekly hospital admission rate for COVID-19 continued to decrease. There were no new hospital admissions for influenza in week 17.

The hospitalisation rate for COVID-19 was at 1.04 per 100,000 in week 17 compared to 1.27 per 100,000 in the previous week.

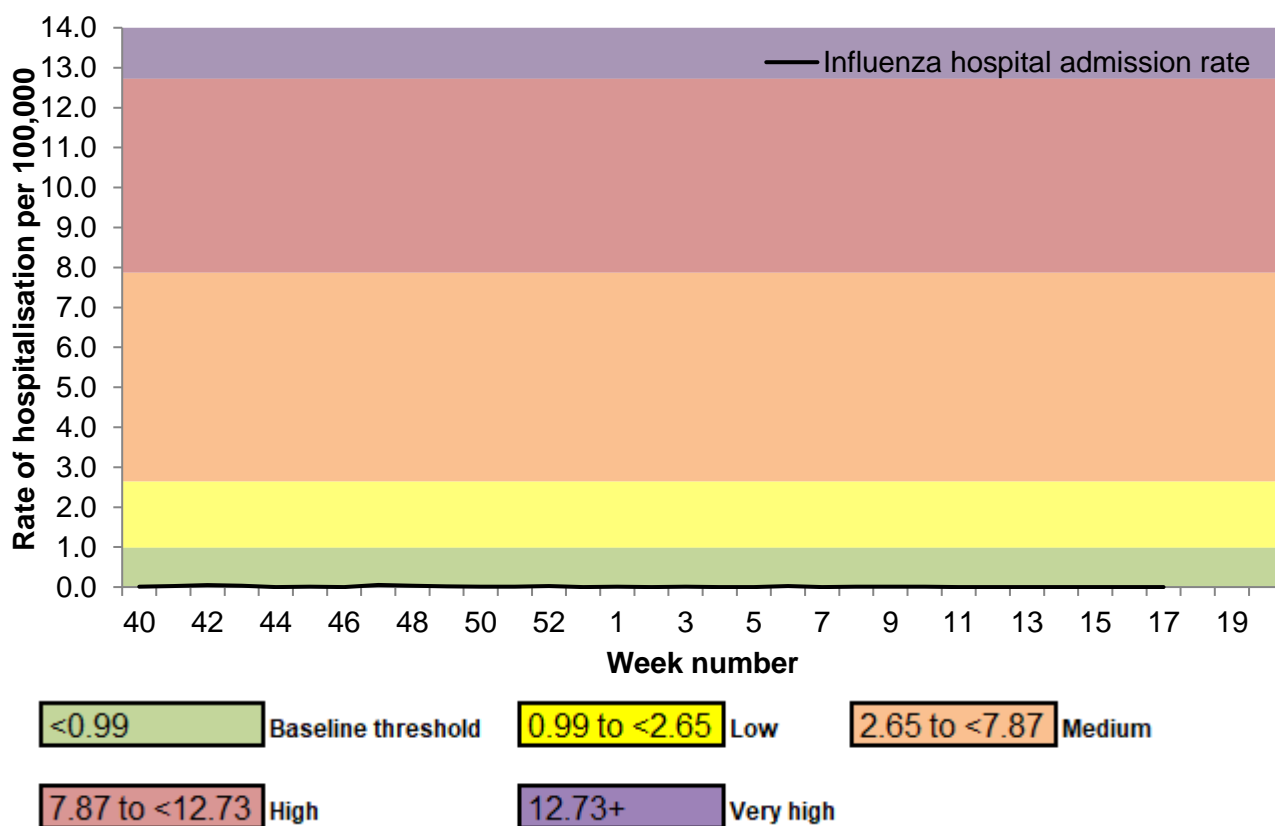
By PHE centre, the highest hospital admission rate for COVID-19 was observed in the West Midlands. By age groups, the highest hospital admission rate for confirmed COVID-19 was in the 85+ year olds.

**Figure 35: Weekly overall hospital admission rates per 100,000 of new COVID-19 and influenza positive cases reported through SARI Watch, England**



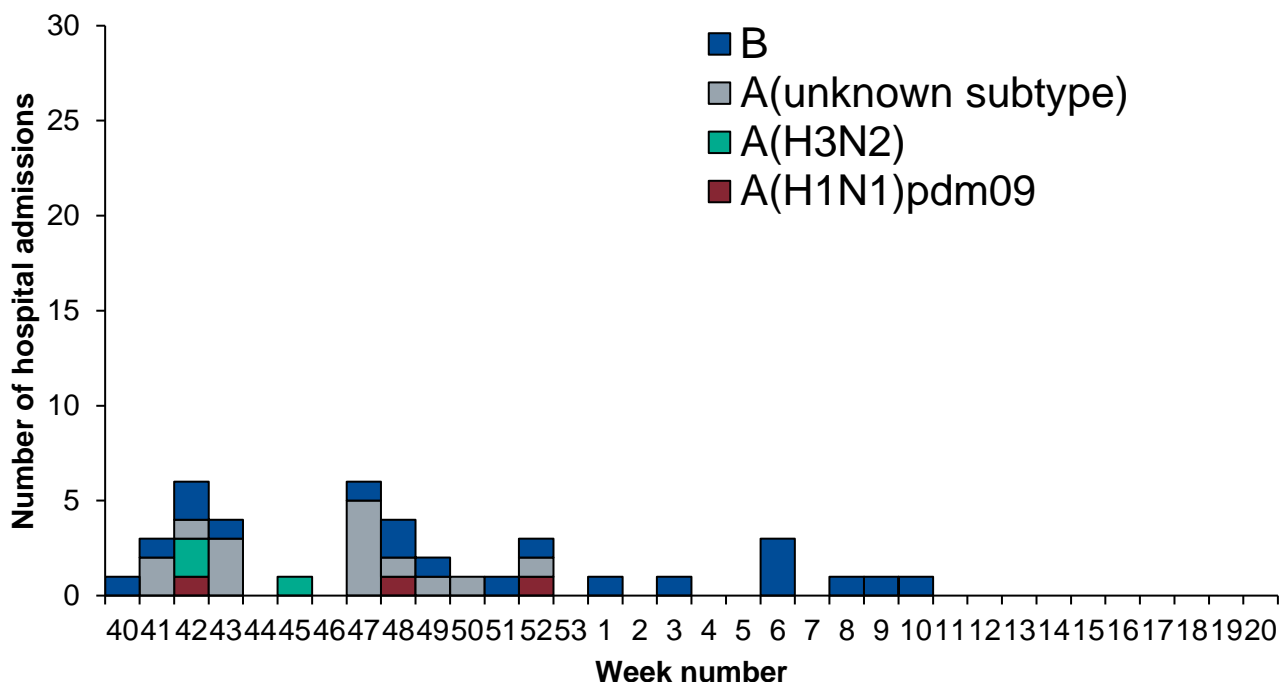
- \* influenza hospital admission rate is reported from week 40 2020 onwards
- \* influenza hospital admission rate based on 23 sentinel NHS trusts for week 17
- \* COVID-19 hospital admission rate based on 114 NHS trusts for week 17
- \* SARI Watch data are provisional.

**Figure 36: Weekly overall influenza hospital admission rates per 100,000 trust catchment population with MEM thresholds, SARI Watch, England**

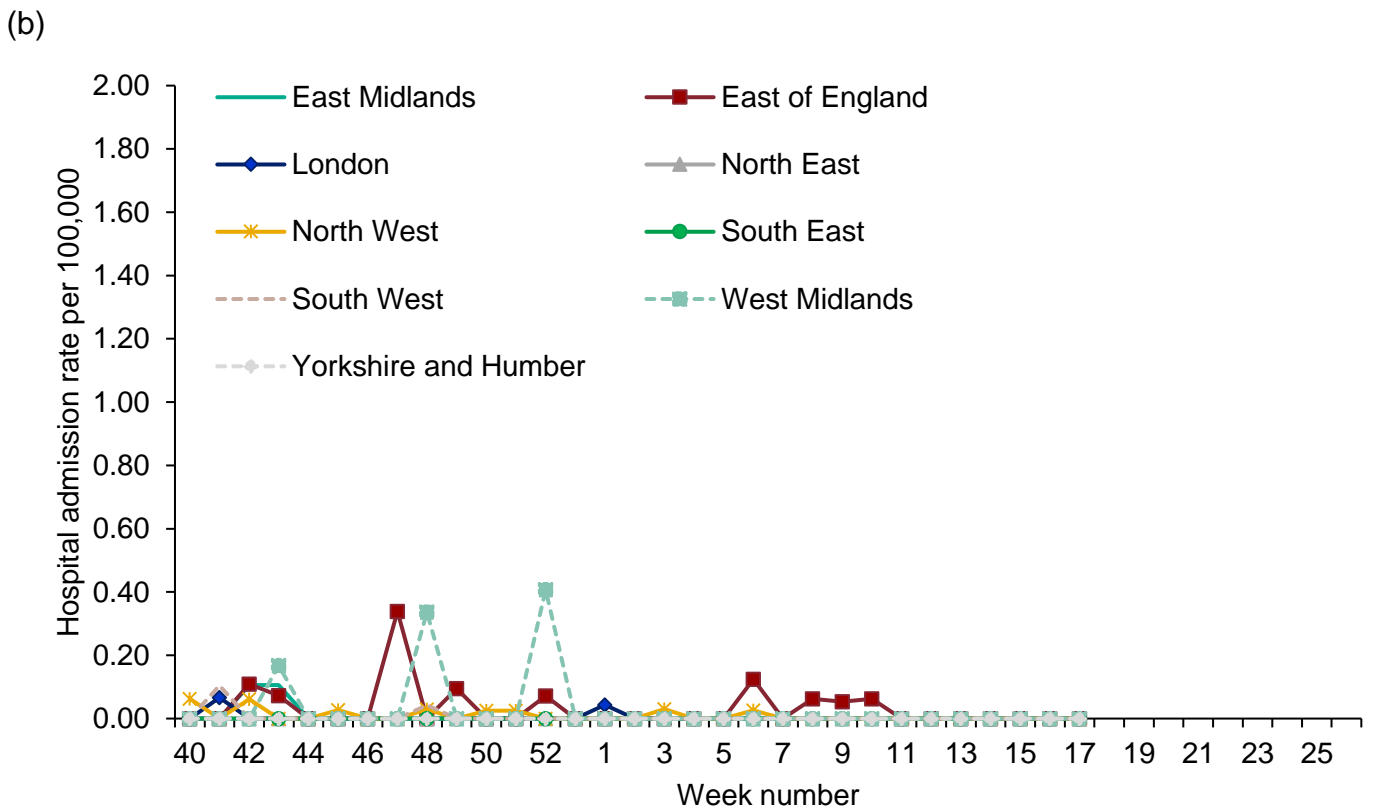
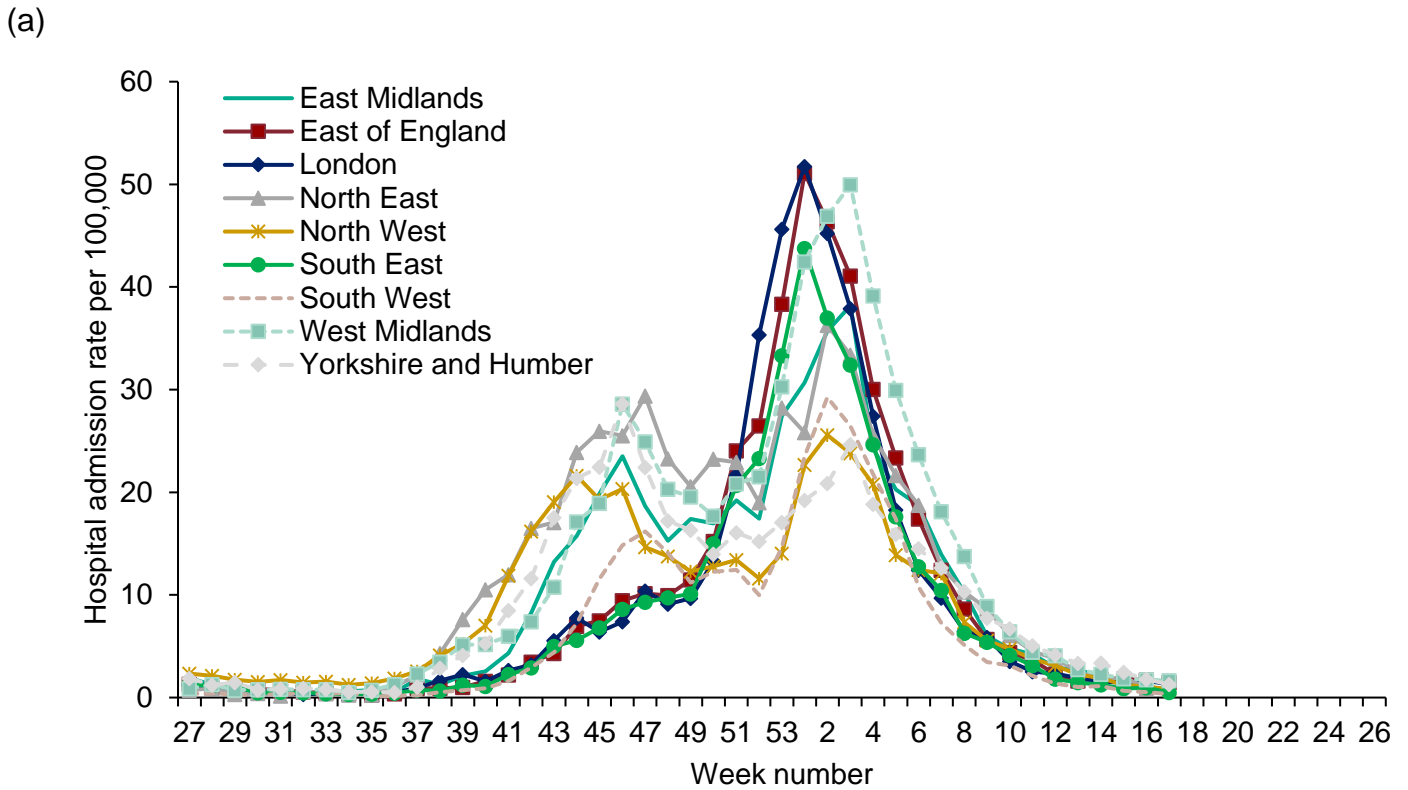


\* the MEM thresholds used are those from the 2019/20 season due to the pandemic

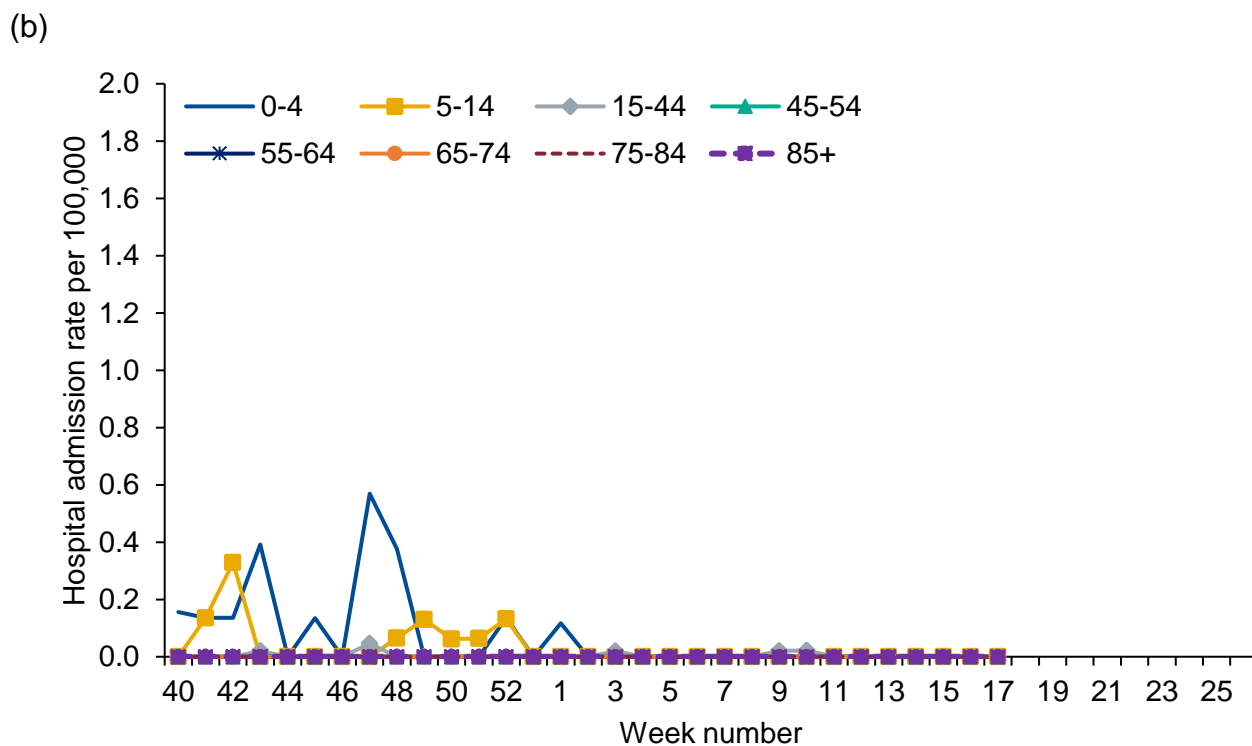
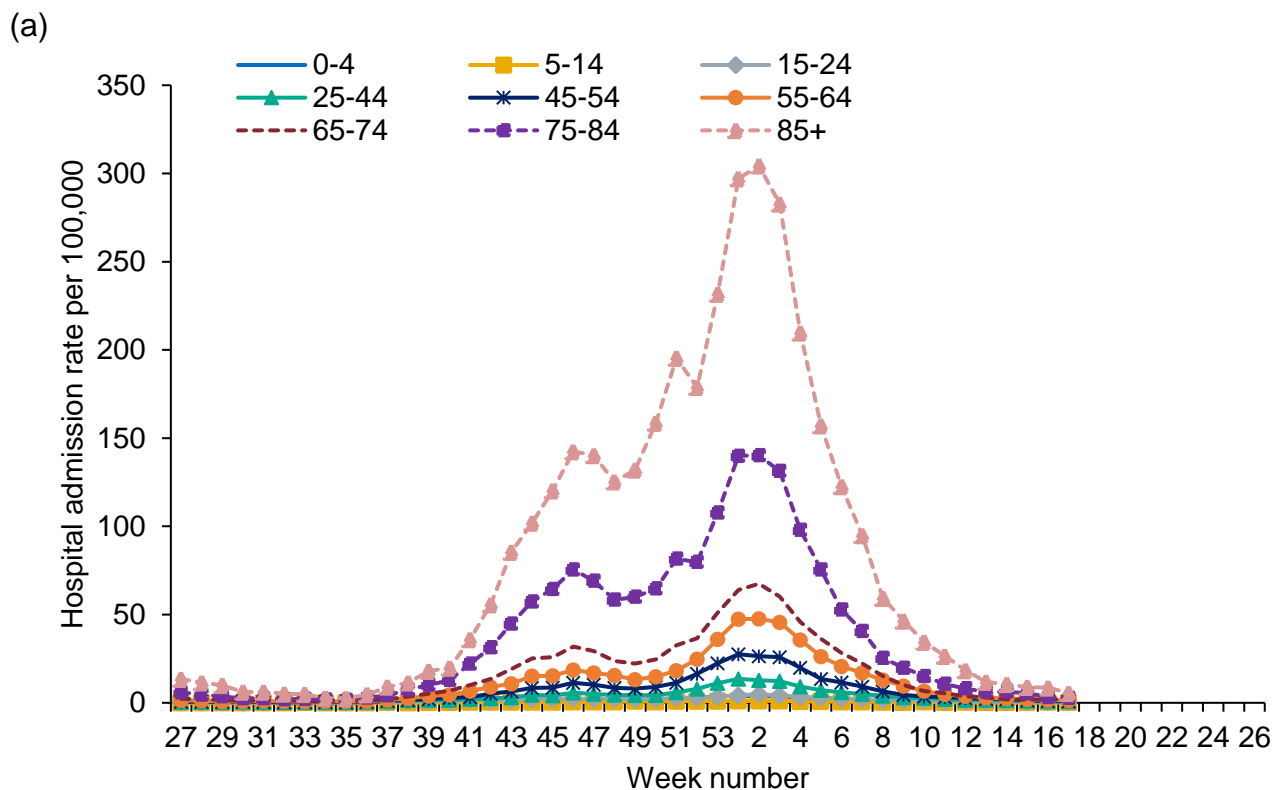
**Figure 37: Weekly influenza hospital admissions by influenza type, SARI Watch, England**



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



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



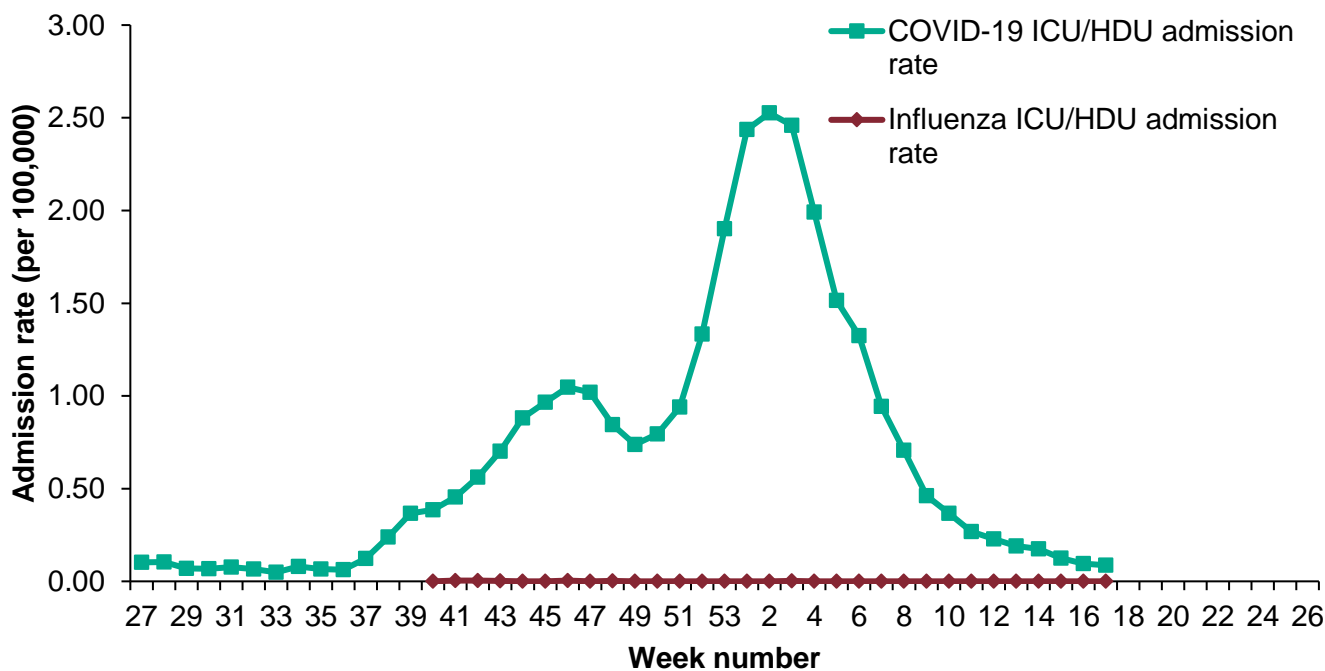
## ICU/HDU admissions, SARI Watch

In week 17, the weekly ICU/HDU admission rates for COVID-19 remained stable. There were no new ICU/HDU admissions for influenza in week 17.

The ICU/HDU rate for COVID-19 was at 0.09 per 100,000 in week 17 compared to 0.10 per 100,000 in the previous week.

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

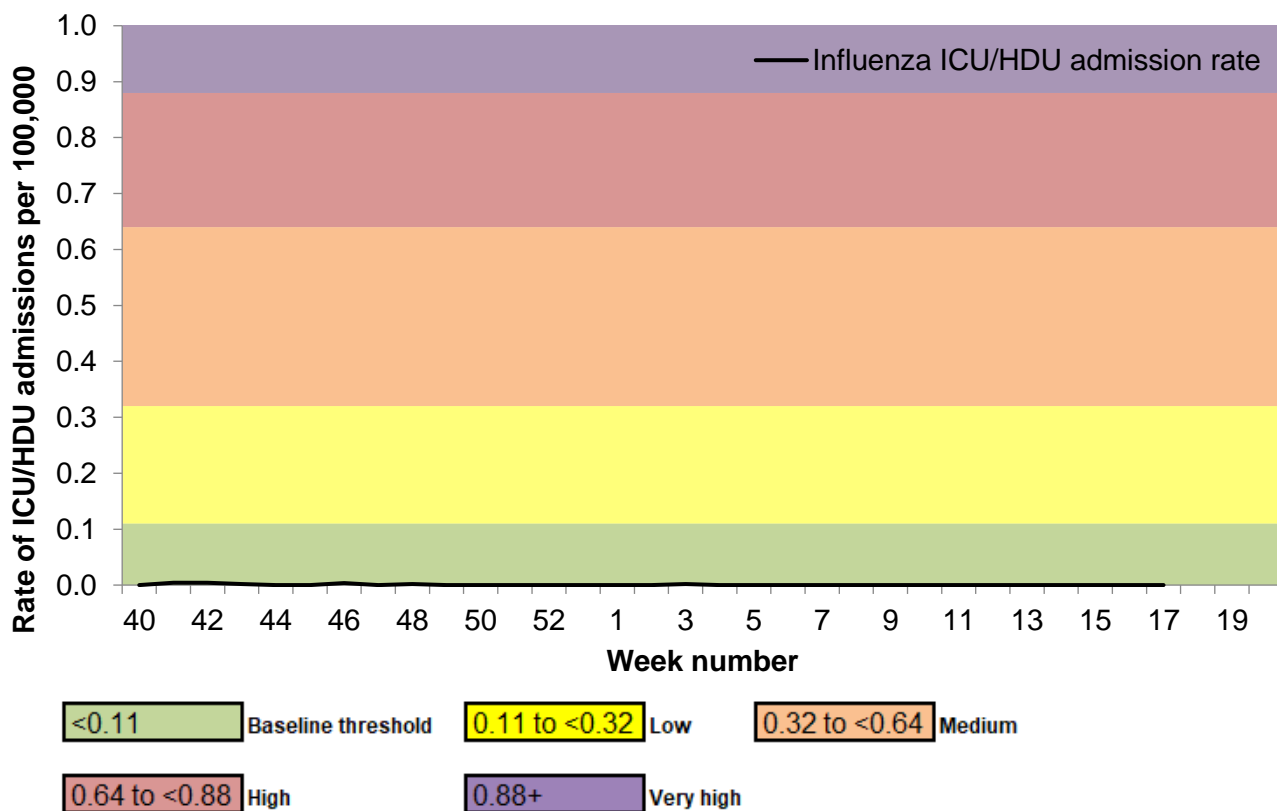
**Figure 40: Weekly overall ICU/HDU admission rates per 100,000 of new COVID-19 and influenza positive cases reported through SARI Watch, England**



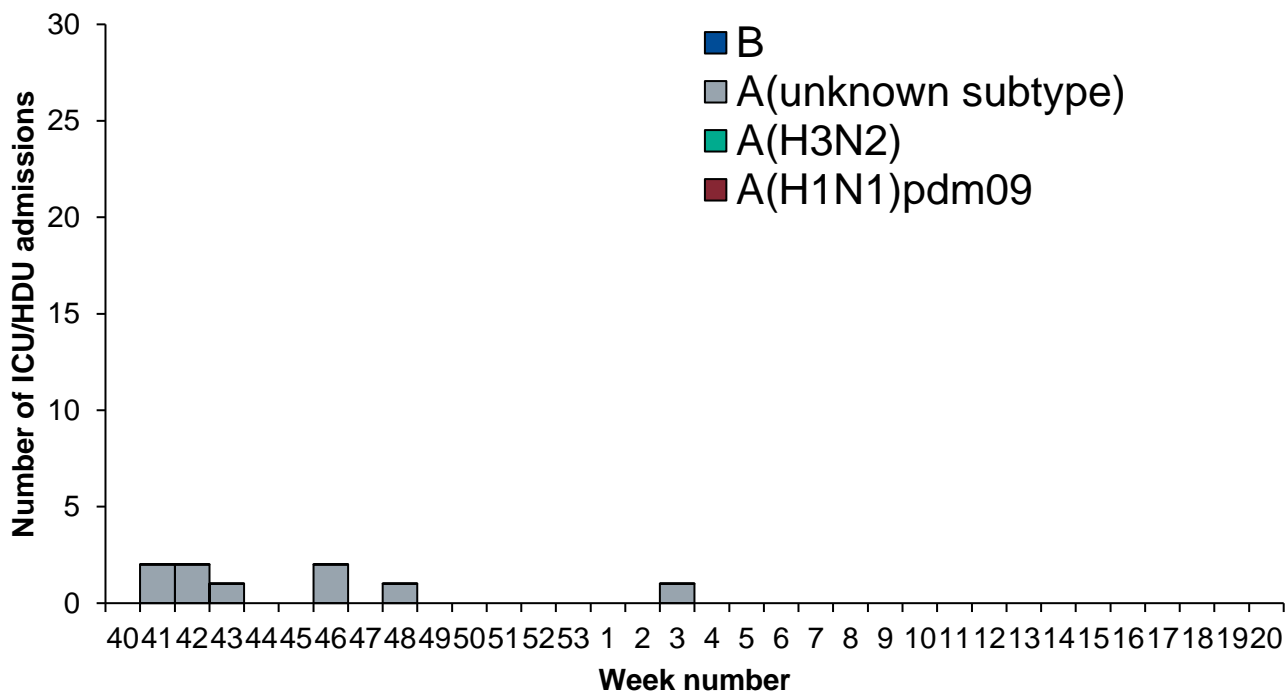
- \* influenza ICU/HDU admission rate is reported from week 40 2020 onwards
- \* influenza ICU/HDU admission rate based on 98 NHS trusts for week 17
- \* COVID-19 ICU/HDU admission rate based on 109 NHS trusts for week 17
- \* SARI Watch data are provisional.



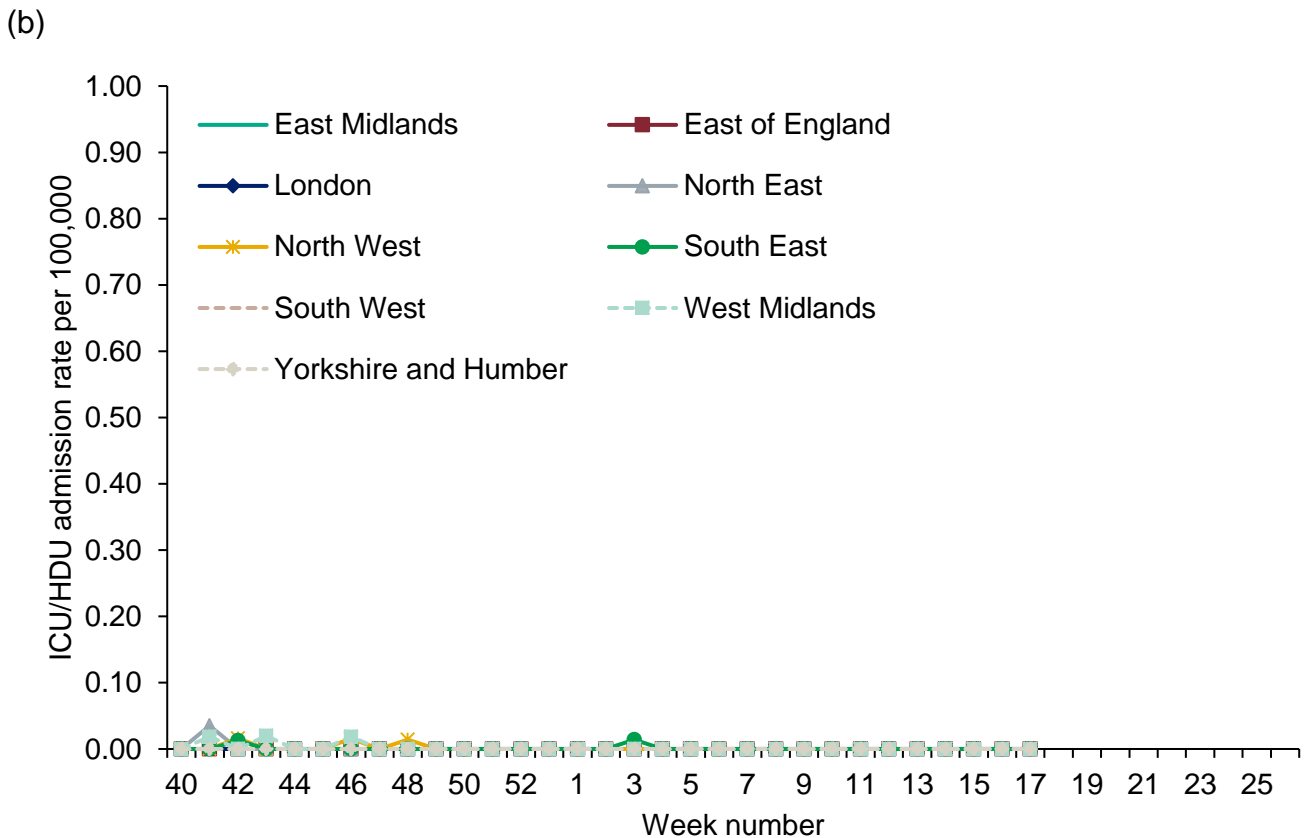
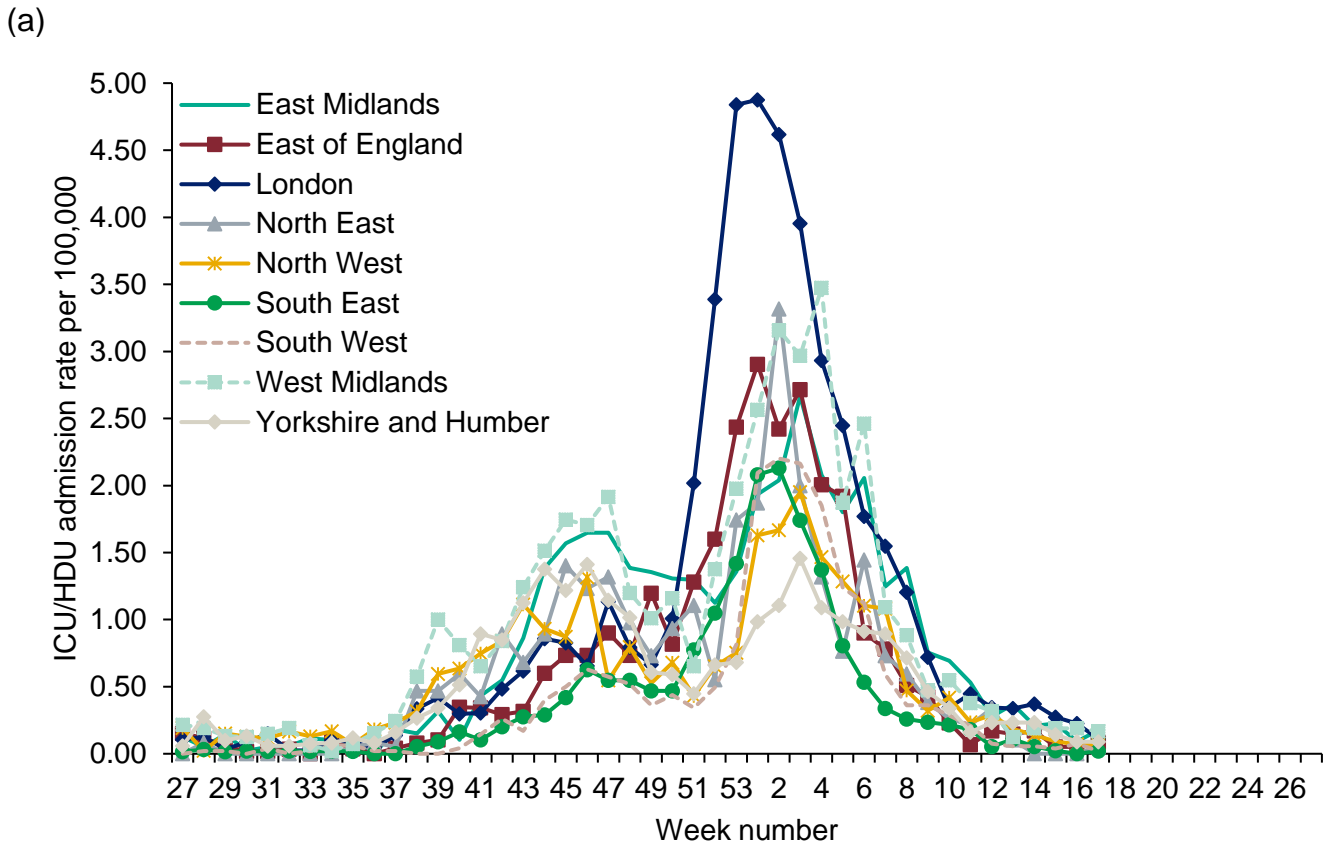
**Figure 41: Weekly overall influenza ICU/HDU admission rates per 100,000 trust catchment population with MEM thresholds, SARI Watch, England**



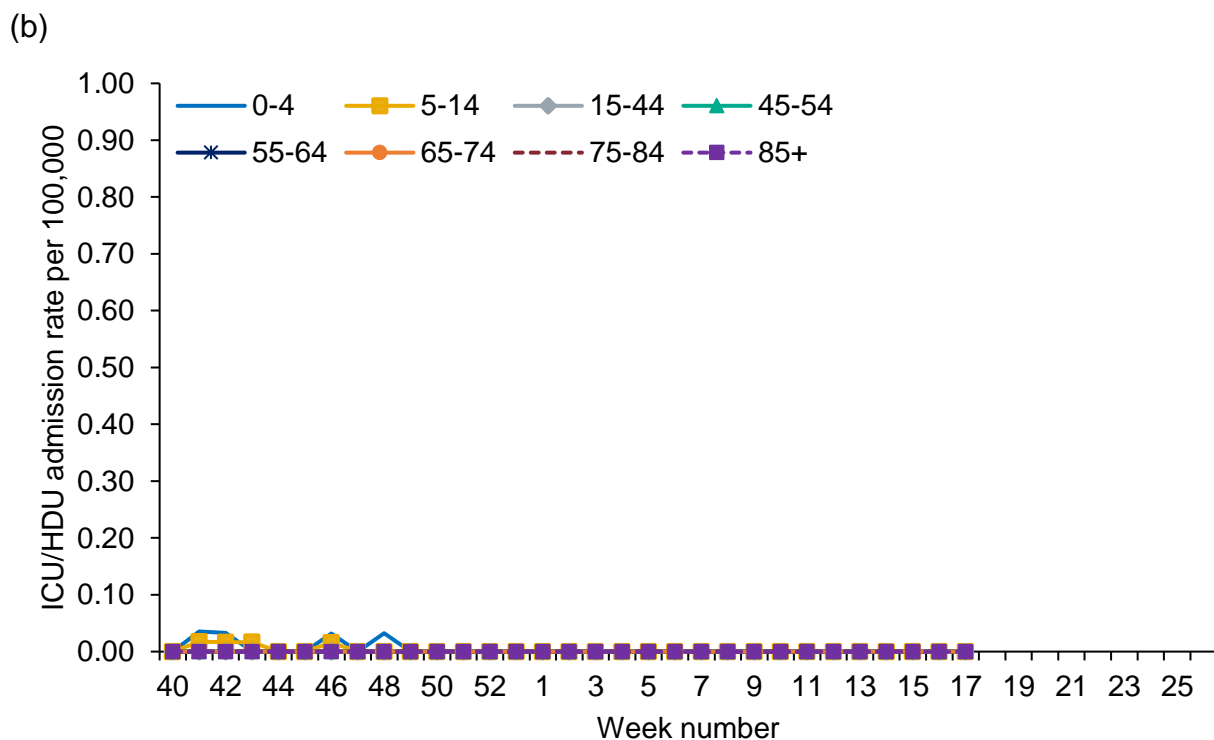
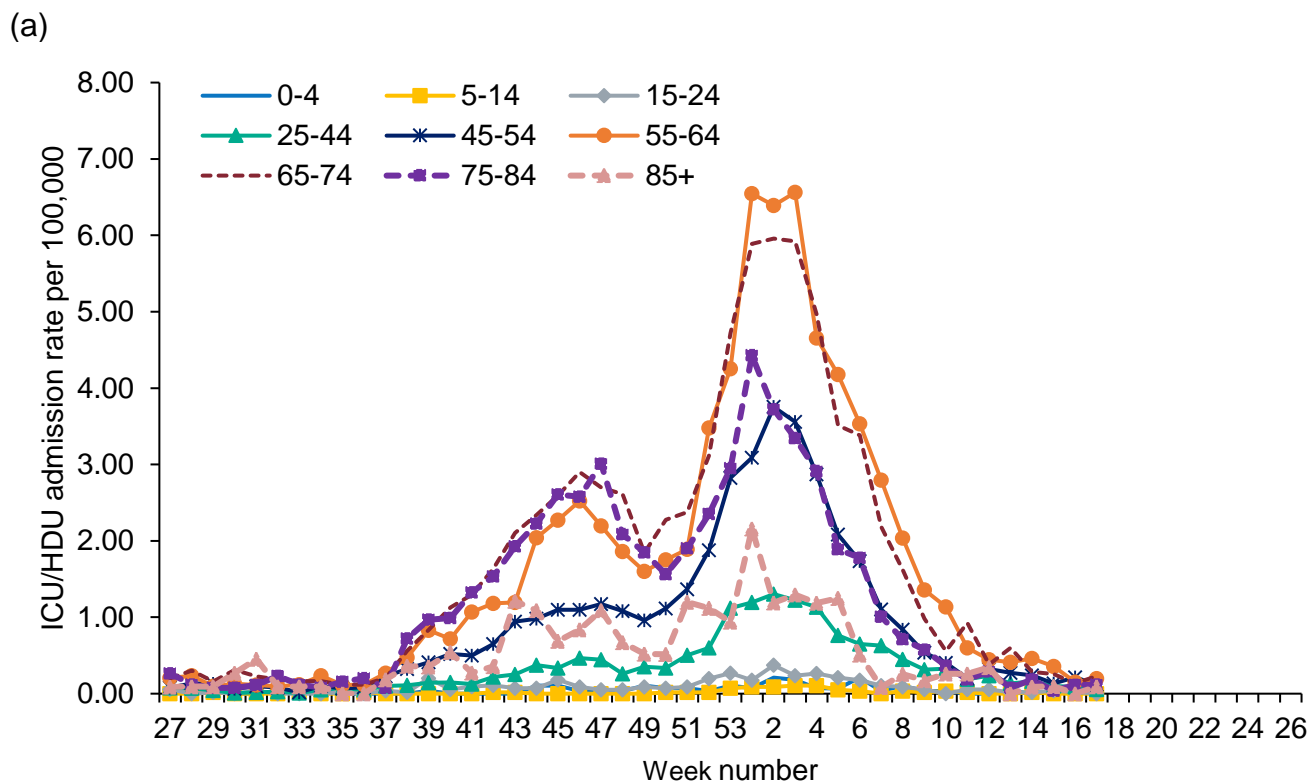
**Figure 42: Weekly influenza ICU/HDU admissions by influenza type, SARI Watch, England**



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



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



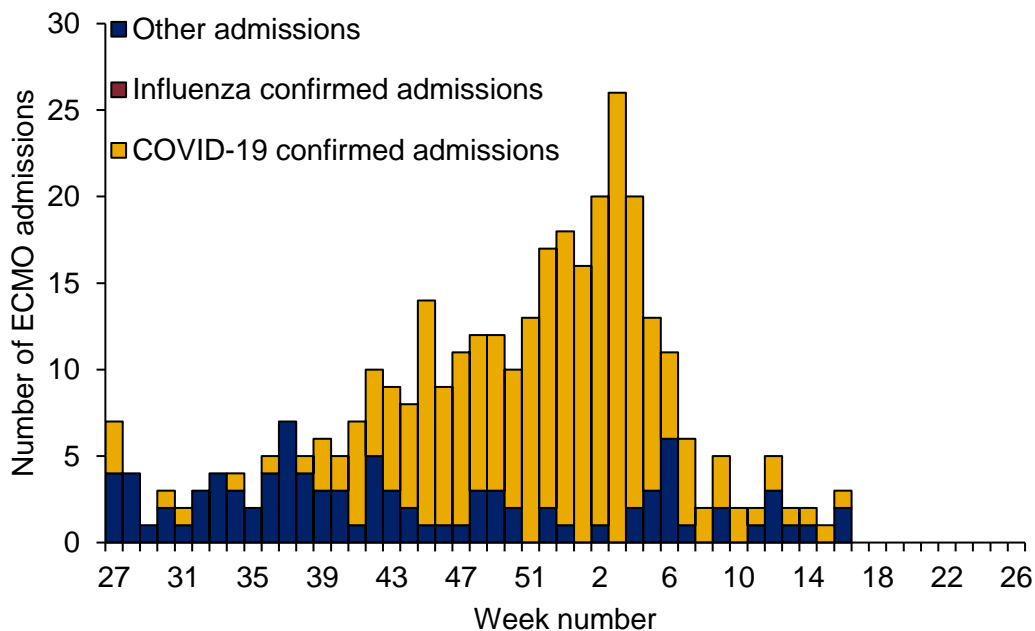
## ECMO, SARI Watch

From week 27 2020, a total of 251 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 17 (Figure 45).

Please note that in the week 18 report, retrospective data was submitted from an ECMO centre therefore there is a slight increase in ECMO admissions in previous weeks data.

**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

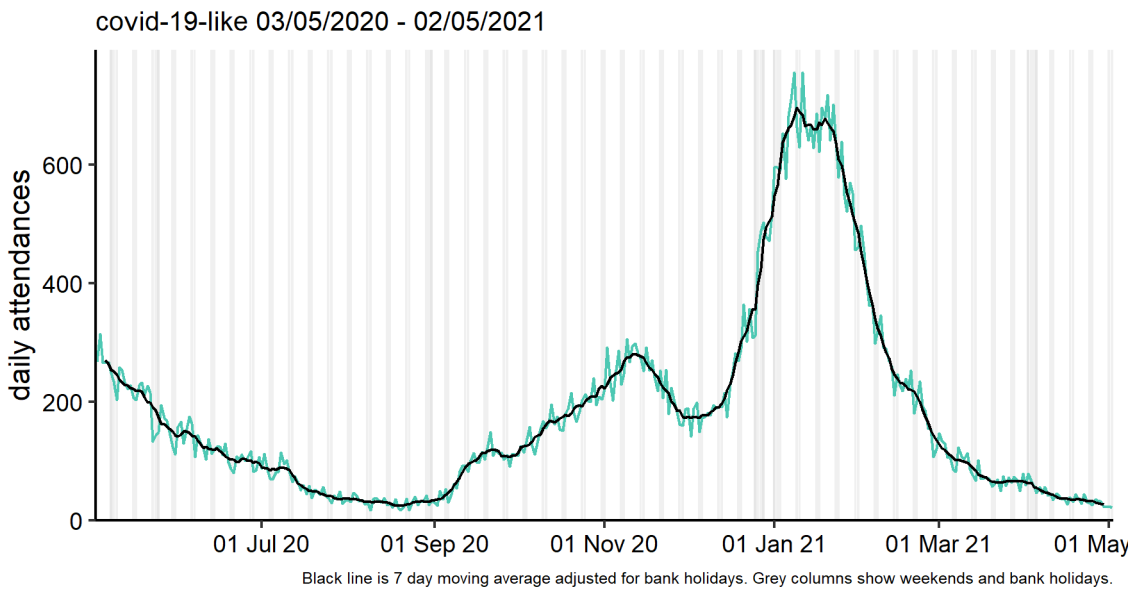
The Emergency Department Syndromic Surveillance System (EDSSS) monitors the daily visits in a network of emergency departments across England.

Up to 3 May 2021, the daily number of emergency department (ED) attendances for all ages as reported by 91 EDs for COVID-19-like infection decreased slightly (Figure 46).

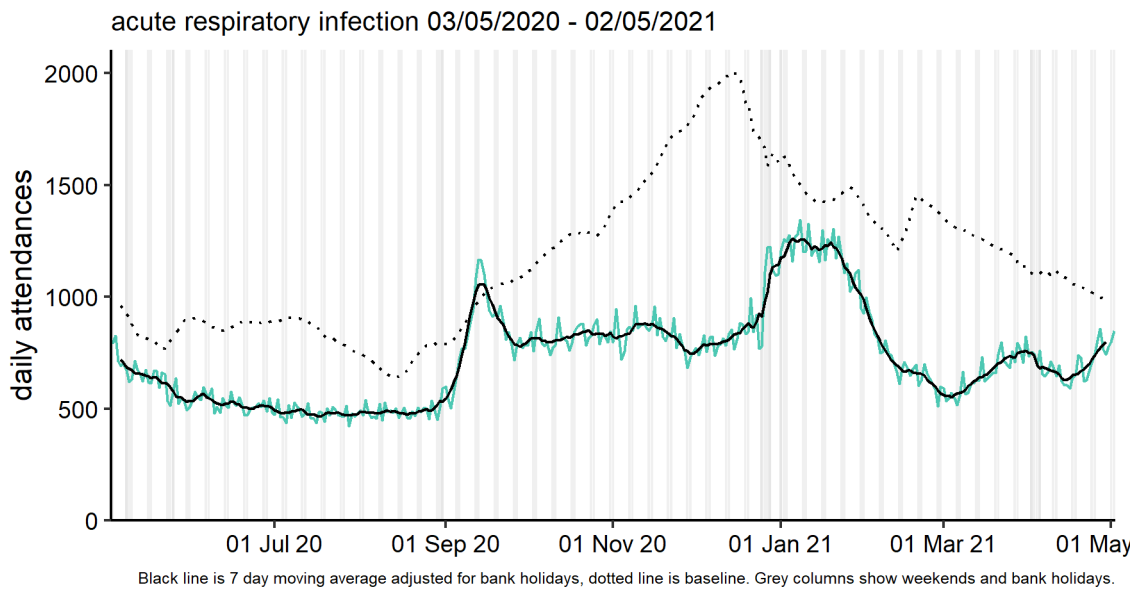
Please note: the COVID-19-like ED indicator is an underestimation of the number of COVID-19 attendances as it only includes attendances with a COVID-19-like diagnosis as their primary diagnosis. The EDSSS COVID-19-like indicator should therefore be used to monitor trends in ED attendances and not to 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)



# Mortality surveillance

## Cumulative COVID-19 deaths

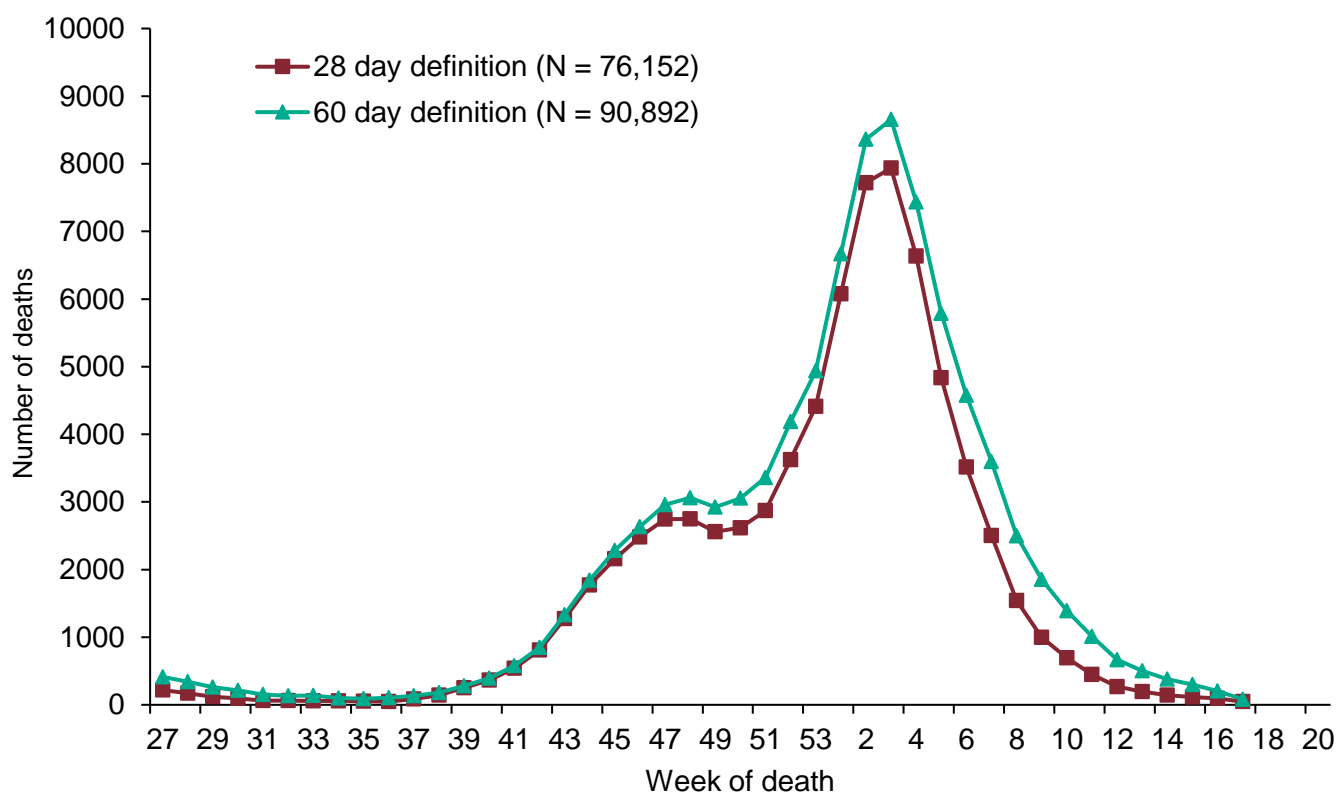
Changes to the definitions of COVID-19 related deaths in England are described in more detail in an accompanying PHE technical summary.

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

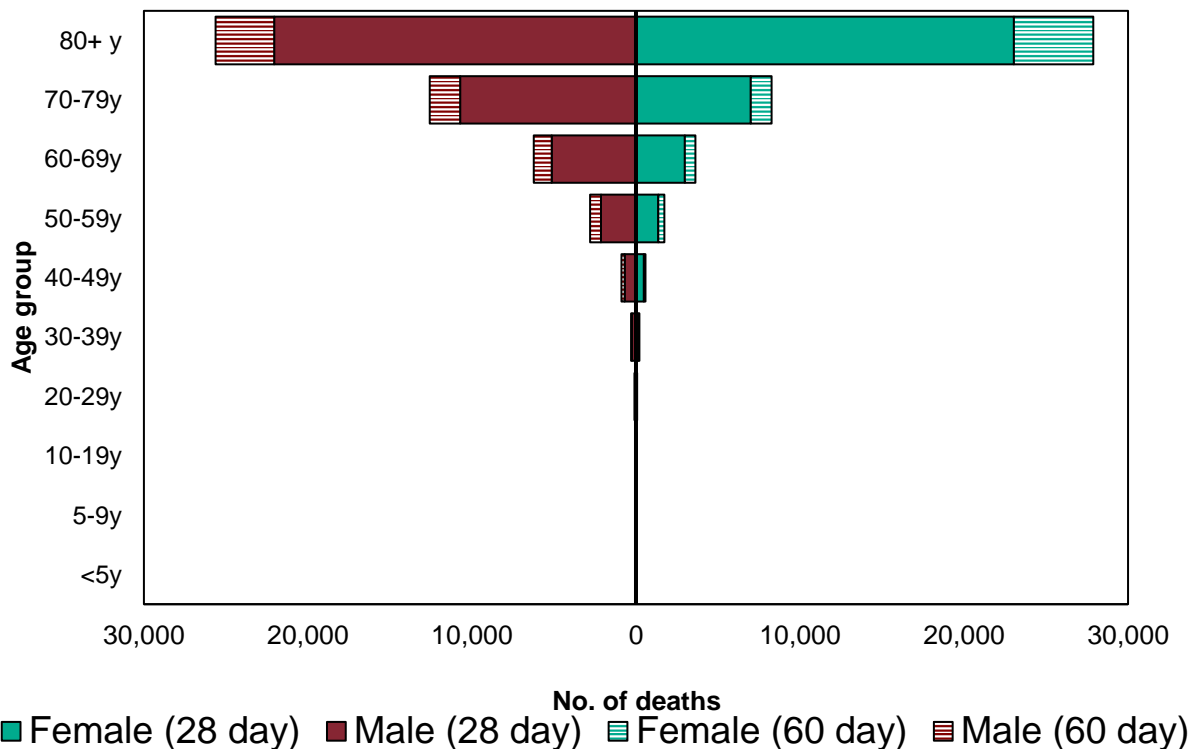
The introduction of these definitions will affect the numbers which have been presented in past reports and therefore Figure 47 represents these differences by definition.

**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	88.5	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

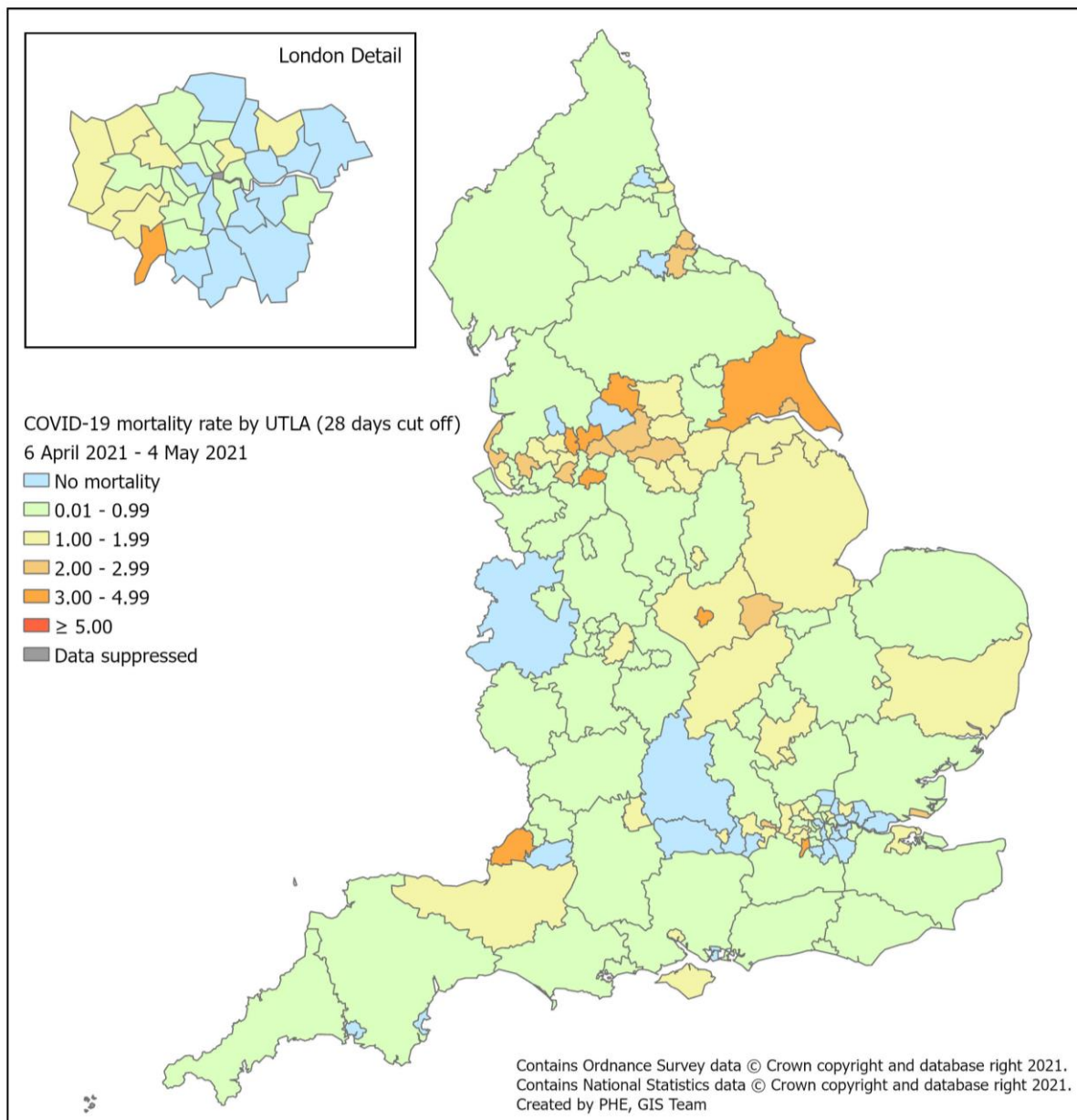


**Table 6: Cumulative number of COVID-19 deaths since week 27 and time since laboratory confirmation of COVID-19 by PHE Centres**

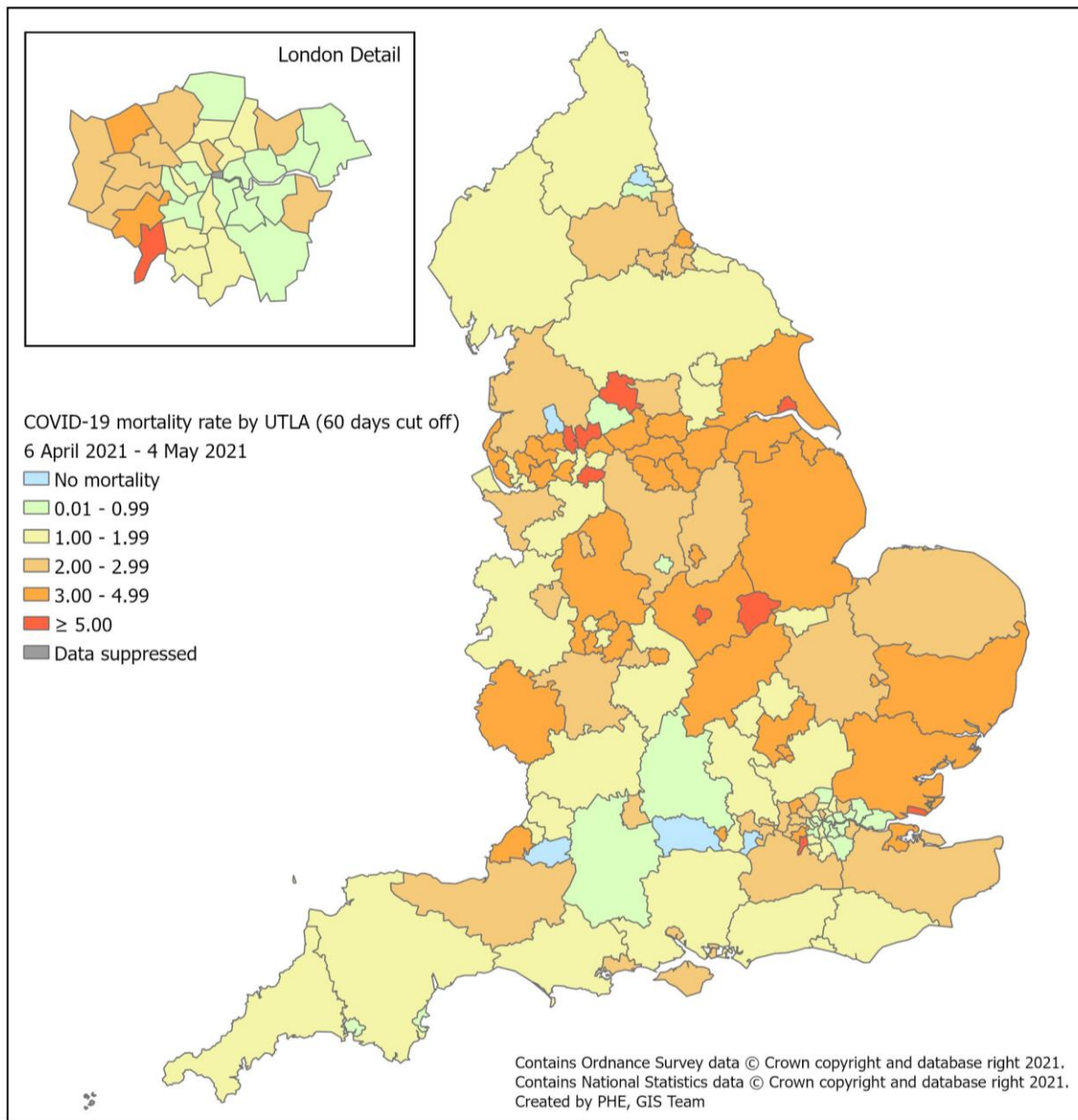
<b>PHE Centres</b>	<b>28 day definition</b>	<b>60 day definition</b>
North East	3,850	4,607
North West	11,920	14,297
Yorkshire & Humber	7,459	8,912
West Midlands	9,004	10,818
East Midlands	7,262	8,669
East of England	9,757	11,575
London	9,355	11,275
South East	12,158	14,488
South West	4,949	5,788

**Figure 49: Cumulative mortality rate of COVID-19 cases per 100,000 population tested under Pillars 1 and 2 for the past 4 weeks by (a) 28 day definition and (b) 60 day definition**

(a)



(b)



## Daily excess all-cause mortality (England)

Deaths occurring from 1 January to 27 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.

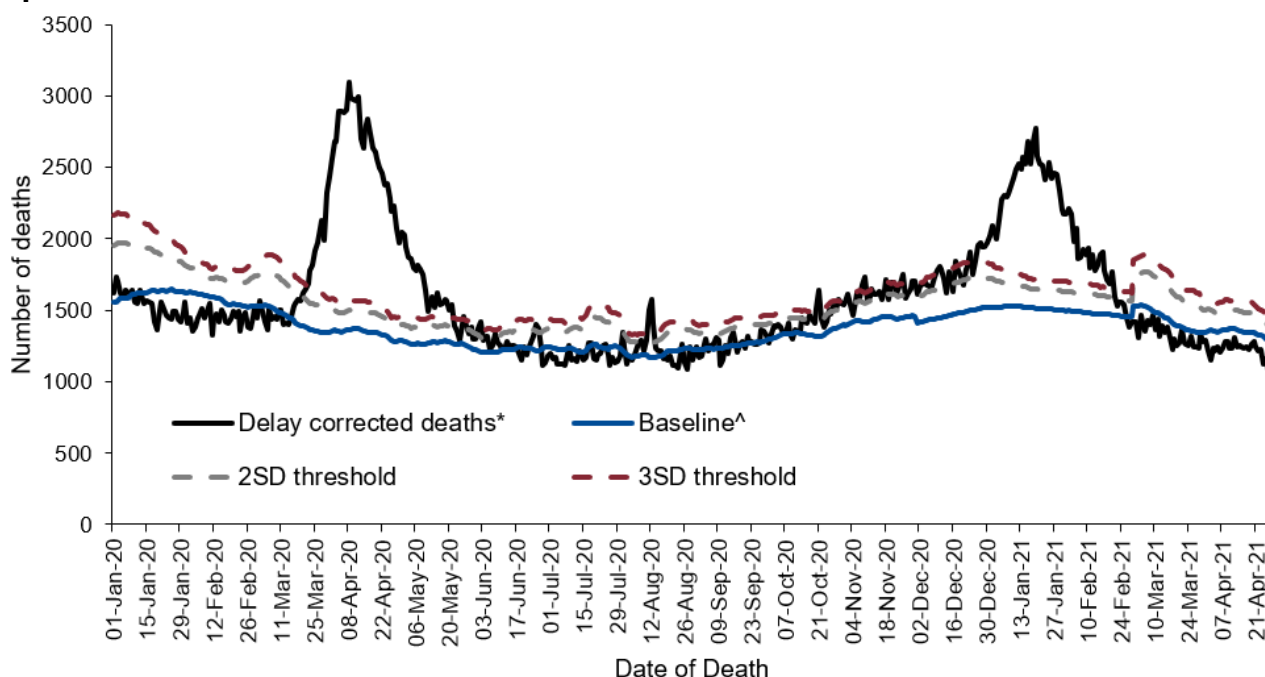
**Note:** that as these data are by date of death with delay corrections, numbers are subject to change each week, particularly for more recent days.

**Please note that due to longer delay to registration over the bank holiday the corrected observed deaths are likely to be low for the most recent 2 weeks shown. Estimates next week should be less affected by these longer delays.**

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

No significant excess all-cause mortality was observed in week 16 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 27 April 2021**



^Baseline calculation:

January to November 2020: same day in previous 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**

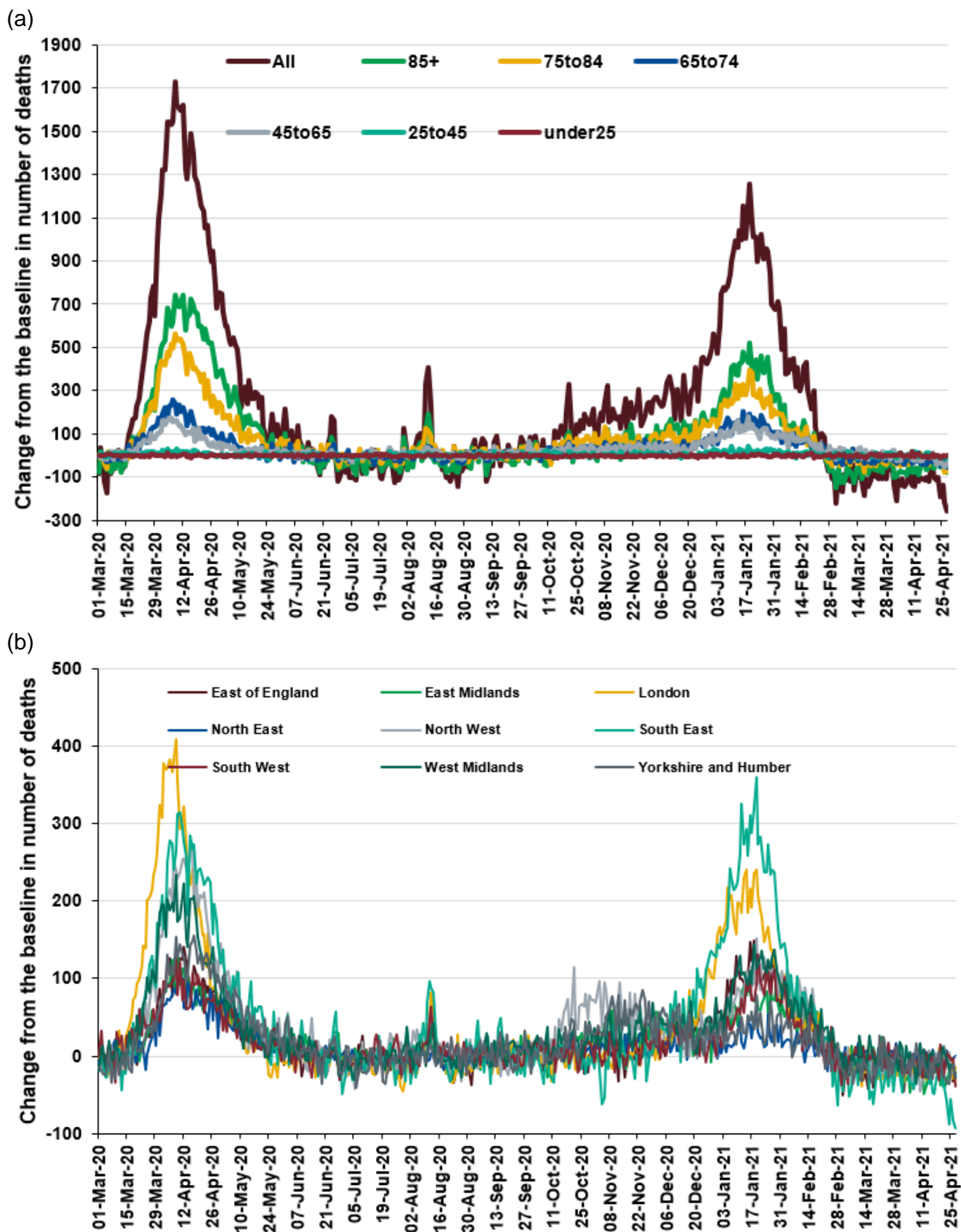
(a)

Age Group	Excess detected in week 16 2021?	Weeks in excess from week 10 to 53 2020	Weeks in excess from week 01 to 16 2021
All	x	13 to 21, 33, 43, 45, 47 to 48, 50, 52 to 53	01 to 07
under 25	x	None	None
25 to 44	x	14 to 16	02 to 04
45 to 64	x	12 to 19, 46 to 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 16 2021?	Weeks in excess from week 10 to 53 2020	Weeks in excess from week 01 to 16 2021
East of England	x	14 to 19, 52 to 53	01 to 07
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 07
West Midlands	x	13 to 20, 45, 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 27 April 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 17, 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 17, no influenza viruses were tested for antiviral susceptibility.

## Antimicrobial susceptibility

Table 8 shows in the 12 weeks up to week 17 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	1,027	82
	Macrolides	1,118	76
	Tetracycline	1,091	78
<i>H. influenzae</i>	Amoxicillin/ampicillin	4,416	58
	Co-amoxiclav	4,781	67
	Macrolides	1,315	10
	Tetracycline	4,819	98
<i>S. aureus</i>	Methicillin	4,890	93
	Macrolides	5,618	71
MRSA	Clindamycin	243	42
	Tetracycline	287	71
MSSA	Clindamycin	3,480	78
	Tetracycline	4,350	93

\* Macrolides = erythromycin, azithromycin and clarithromycin

Data source: PHE's SGSS AMR module, please note that this is different to the data source used in the reports published between weeks 41 2020 to 05 2021 inclusive of the 2020/21 influenza season when the SGSS CDR module was used instead due to a PHE SGSS AMR data infrastructure issue which has now been resolved. Therefore, the above results are not directly comparable to the results reported between weeks 41 2020 and 05 2021. The AMR module of SGSS was used during the 2019/20 influenza season. 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 15 2021 are summarised. This programme has previously involved testing approximately 1000 donor samples from 2 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 2 to 3 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 16.6% (95% CI 15.7% - 17.5%) using the Roche N assay and 67.4% (95% CI 66.4% - 68.3%) using the Roche S assay for the period 29th March – 25th April (weeks 13-16 2021)). 1182/7264 were Roche N positive and 4915/7297 samples were Roche S positive. This compares with 14.5% (95% CI 13.7% - 15.4%) Roche N seropositivity and 50.6% (95% CI 49.5% - 51.6%) Roche S seropositivity for the period of 1<sup>st</sup> March 2021 – 27<sup>th</sup> March 2021 (weeks 9-12 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 53). Seropositivity estimates are plotted weekly using the mid-point of a rolling 4-weekly period.

In London, the 4-weekly rolling seropositivity increased from 22.1% (95% CI 19.6% - 24.9%) in weeks 9-12 2021 to 25.6% (95% CI 22.9% - 28.4%) in weeks 13-16 2021.

Data from the North West show that seropositivity has remained stable at 16.1% (95% CI 13.9% - 18.7%) in weeks 9-12 2021 and 16.4% (95% CI 14.0% - 19.0%) in weeks 13-16 2021.

In the East of England seropositivity increased from 10.2% (95% CI 8.5% - 12.2%) in weeks 9-12 2021 to 12.7% (95% CI 10.4% - 15.5%) in weeks 13-16 2021.

Seropositivity increased slightly in the South East region from 13.2% (95% CI 10.9% - 15.9%) for weeks 9-12 2021 to 13.9% (95% CI 12.1% - 16.0%) in weeks 13-16 2021.

In the South West region, seropositivity has shown a very modest increase from 8.0% (95% CI 6.4% - 10.0%) in weeks 9-12 2021 to 8.9% (95% CI 7.2% - 10.9%) in weeks 13-16 2021.

Seropositivity in the North East and Yorkshire NHS region increased slightly from 14.9% (95% CI 12.8% - 17.2%) in weeks 9-12 2021 to 15.5% (95% CI 13.2% - 18.1%) in weeks 13-16 2021.

Data from the Midlands show the proportion seropositive increased from 14.0% (95% CI 12.1% - 16.0%) in weeks 9-12 2021 to 18.7% (95% CI 16.4% - 21.2%) in weeks 13-16 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. This is particularly evident in the Midlands and London regions where an increase in seropositivity has been observed recently. This in part due to ongoing higher levels of transmission observed around urban centres and there has been a proportionally greater number of samples from these locations in the region recently.

### Prevalence by age group

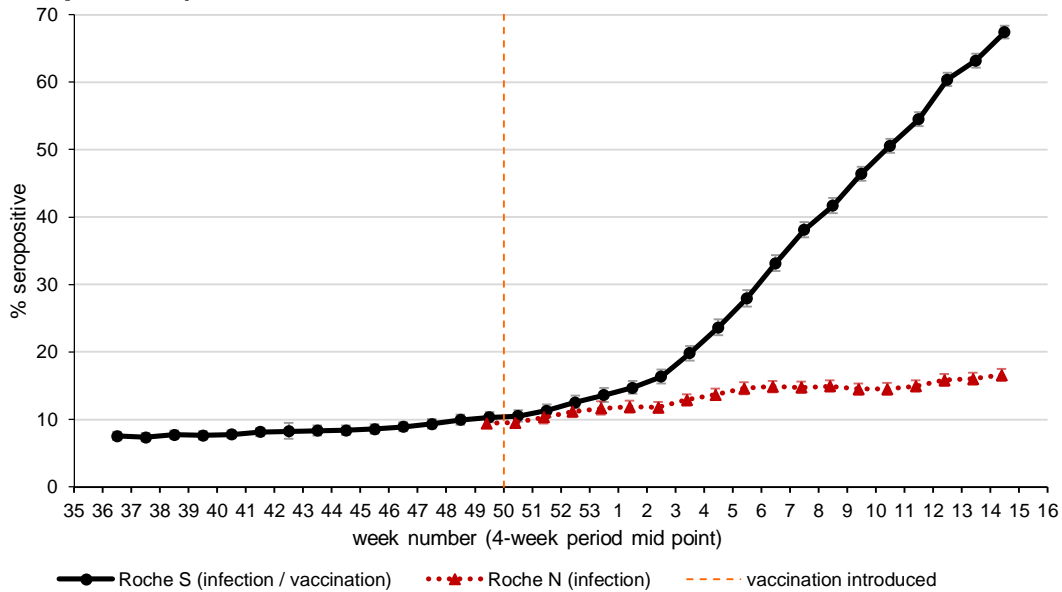
Seropositivity estimates by age group using the Roche N and Roche S assays are presented below. Prevalence for all age groups for weeks 41-44 has been excluded due to a change in sampling strategy from week 44 which resulted in a small number of samples from older age groups in some regions which makes interpretation of trends for this period difficult.

Based on testing samples using the Roche N assay (Figure 54) 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 was 20.9% (95% CI 18.4% - 23.5%) in weeks 9-12 2021 and 23.4% (95% CI 20.9% - 26.1%) in weeks 13-16 2021. Roche N seropositivity has similarly plateaued in recent weeks across most age groups but this was seen earliest in the 70-84 age group. Seropositivity in those aged 70-84 showed a slight increase from 4.9% (95% CI 3.1% - 7.5%) in weeks 9-12 to 6.7% (95% CI 4.5% - 9.9%) in weeks 13-16 2021. This increase is in line with variability in N seropositivity observed previously within this age group and is not expected to reflect increases in infection. 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.

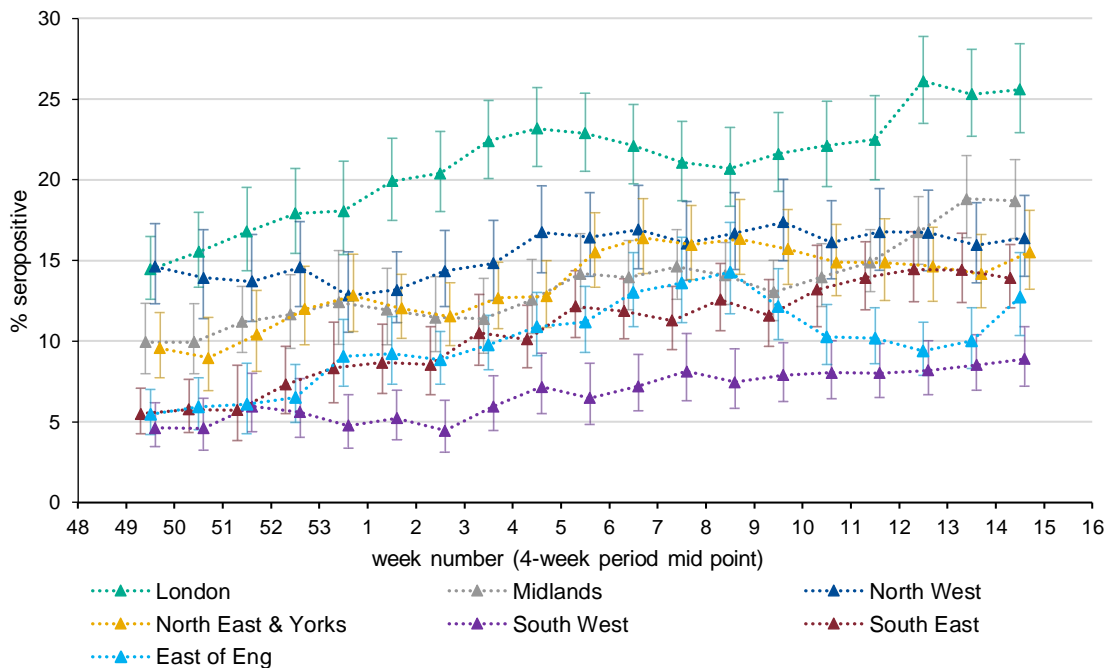
The increase in vaccination especially in the older age groups is seen by the sharp increase in seropositivity using the Roche S assay (Figure 54). Whilst prevalence in those aged 17-29 has increased from 39.0% (95% CI 36.1% - 42.0%) in weeks 9-12 2021 to 45.2% (95% CI 42.2% - 48.2%) in weeks 13-16 2021, this compares with larger increases in older age groups. Roche S seropositivity has shown an increase in those aged 70-84 reaching 99.3% (95% CI 98.2% - 99.7%) in weeks 13-16 2021. A dramatic increase has been observed in those aged 60-69 from 73.0% (95% CI 70.3% - 75.5%) in weeks 9-12 2021 to 97.4% (95% CI 96.2% - 98.2%) in weeks 13-16 2021. A notable increase in Roche S seropositivity has also been observed in those aged 50-59 from 43.9% (95% CI 41.5% - 46.4%) in weeks 9-12 2021 to 86.5% (95% CI 84.8% - 88.0%) in weeks 13-16 2021.

Vaccination is making an important contribution to the overall Roche S increases observed since the roll out of the vaccination programme, particularly individuals aged 50 years and above who have been prioritised for vaccination as part of the phase 1 programme. 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 older age groups is likely to reflect vaccine impact.

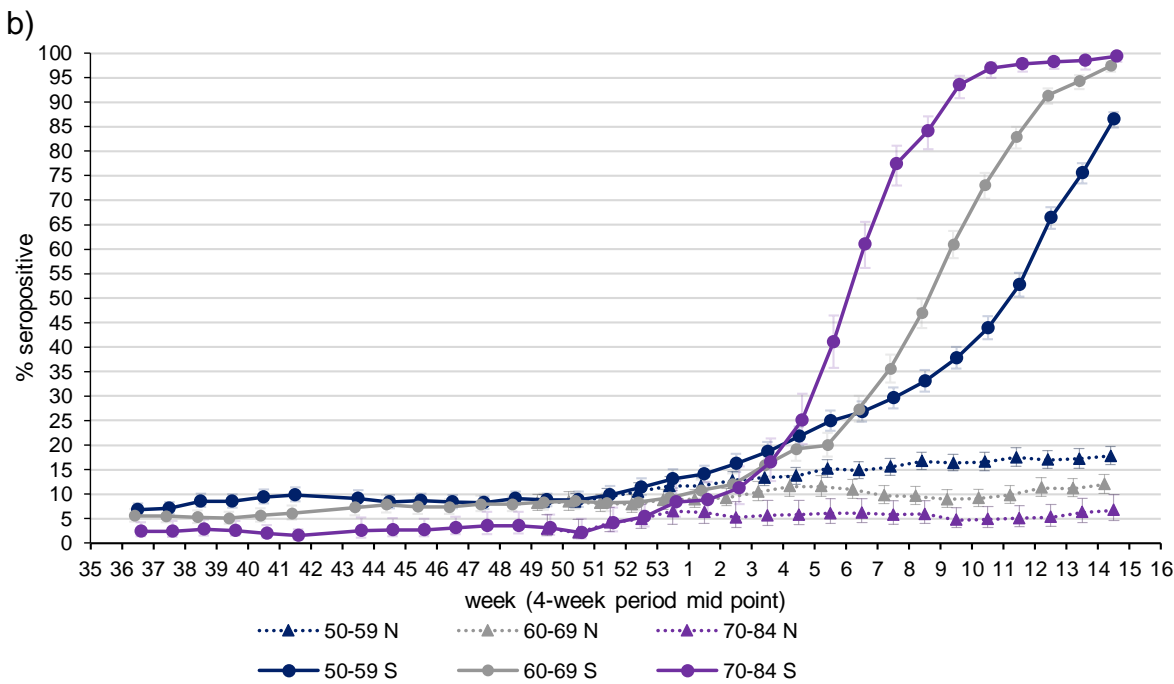
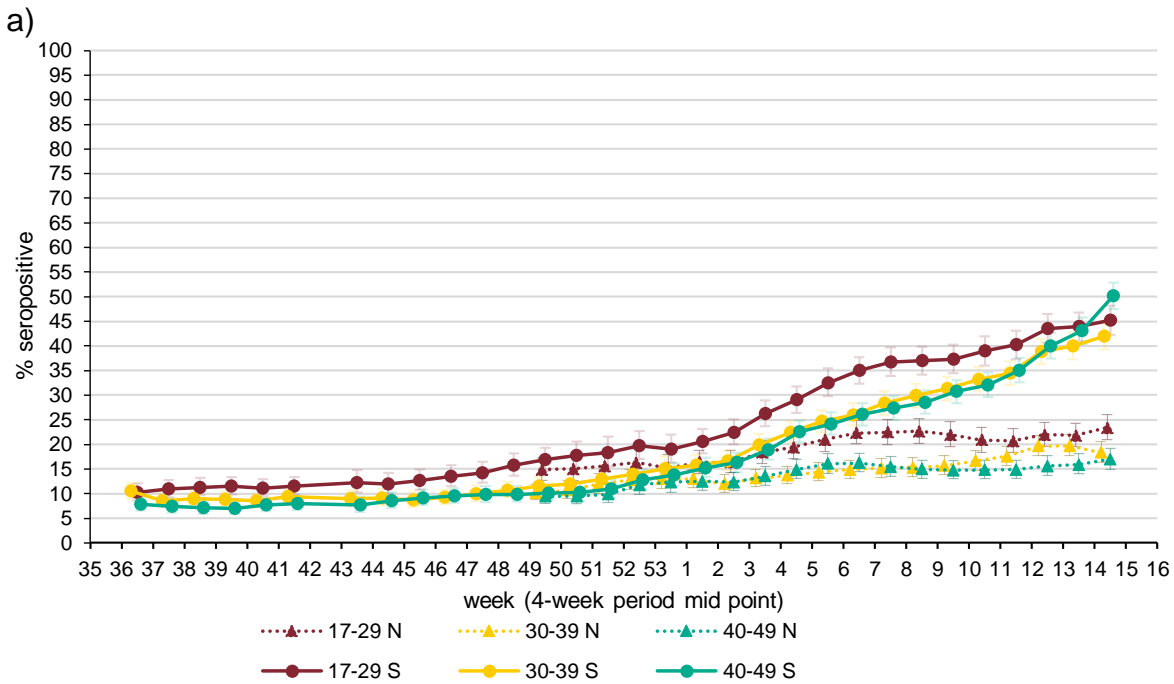
**Figure 52: Overall 4-weekly rolling SARS-CoV-2 antibody seroprevalence (% seropositive) in blood donors**



**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**



# Influenza vaccination

## Influenza vaccine uptake in GP patients

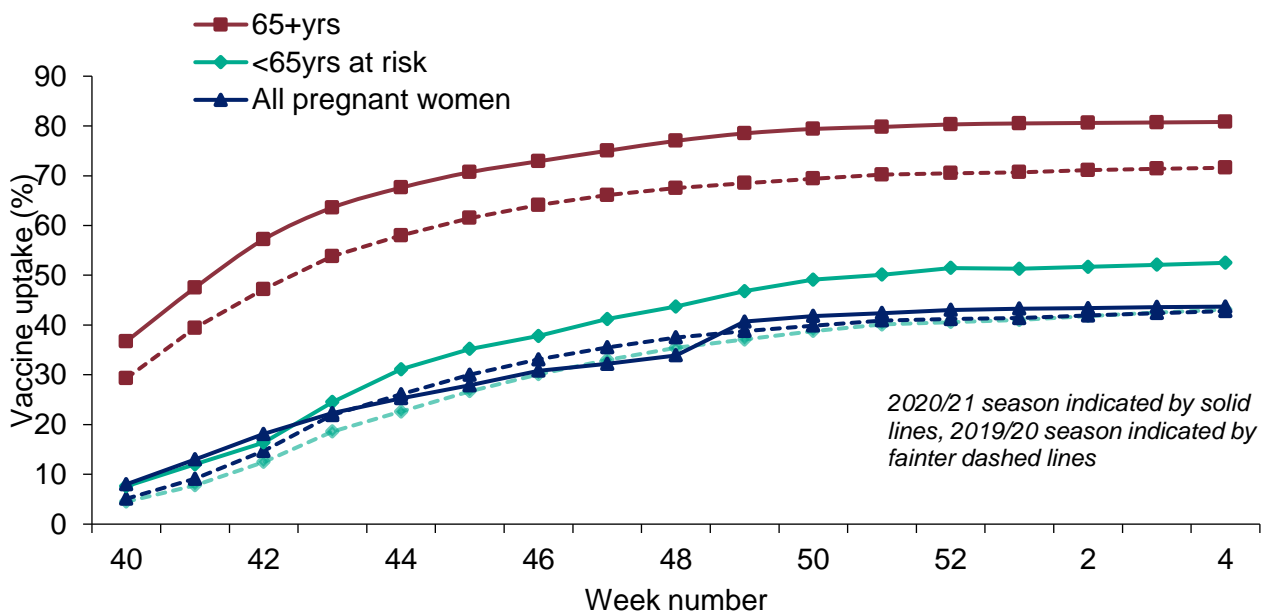
Up to week 4 2021 in 94.7% of GP practices reporting weekly to Immform for the main collection, the provisional proportion of people in England who had received the 2020/21 influenza vaccine in targeted groups was as follows (Figure 55):

- 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

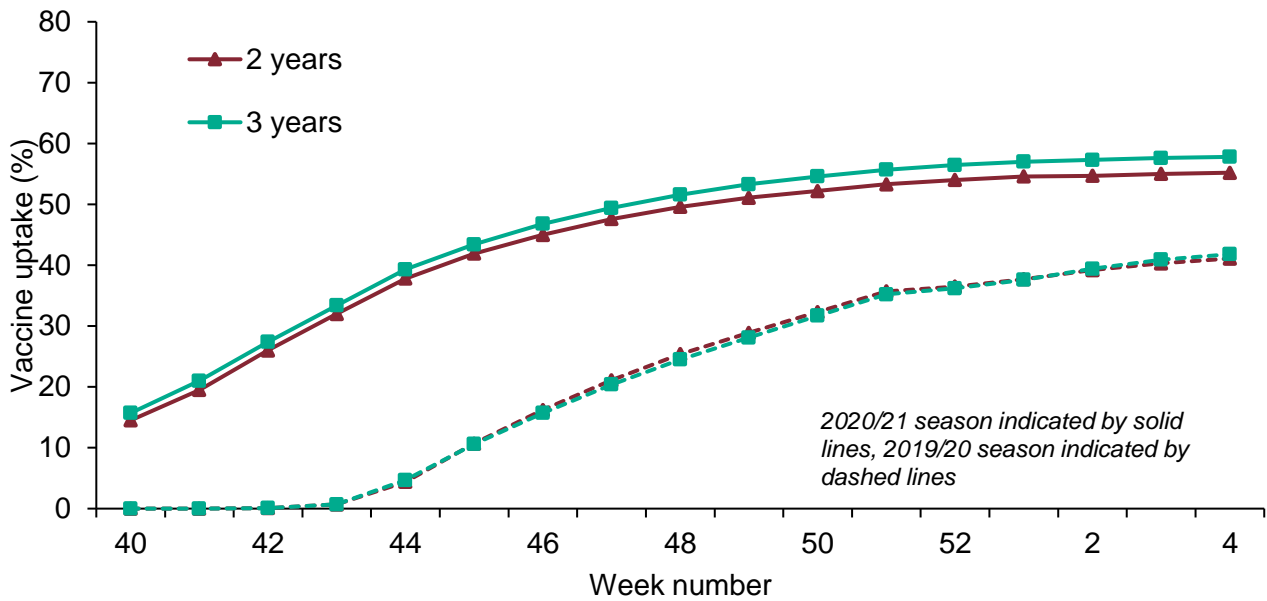
**Figure 55: Cumulative weekly influenza vaccine uptake by target group in England**



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

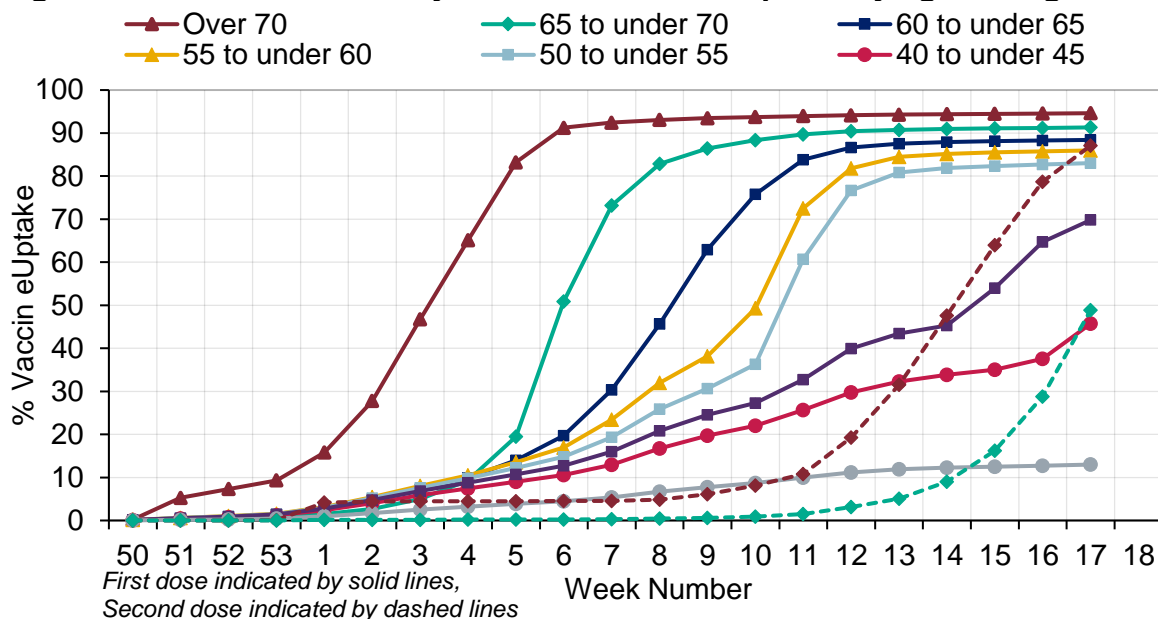
COVID-19 vaccinations began in England on 8 December 2020 during week 50 2020 (week ending 13 December 2020). Cumulative data up to week 17 2021 (week ending 2 May 2021) was extracted from the National Immunisation Management Service (NIMS). The data presented this week is the provisional proportion of people in England who had received one dose and 2 doses of a COVID-19 vaccination by age group. The overall vaccine uptake in the population for dose 1 was 46.7% and 21.0% for dose 2. The breakdown by sex showed vaccine uptake in males was 43.1% and 50.2% in females for dose 1. For dose 2 total uptake was 17.4% in males and 24.6% in females.

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

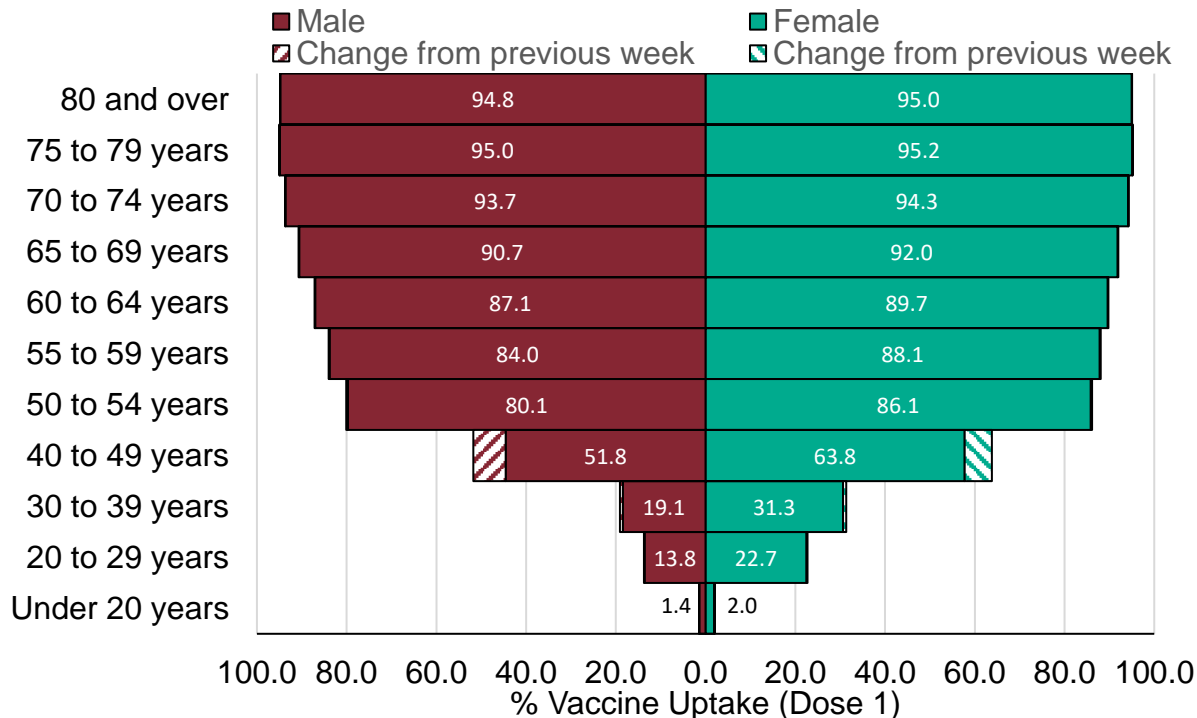
Age group	Vaccinated with at least 1 dose			Vaccinated with 2 doses		
	People in NIMS cohort	Number vaccinated	% vaccine uptake	People in NIMS cohort	Number vaccinated	% vaccine uptake
<b>80 years and over</b>	2,839,985	2,695,893	94.9	2,839,985	2,525,517	88.9
<b>75 to under 80 years</b>	2,088,170	1,985,387	95.1	2,088,170	1,866,381	89.4
<b>70 to under 75 years</b>	2,878,687	2,705,504	94.0	2,878,687	2,407,181	83.6
<b>65 to under 70 years</b>	2,891,606	2,640,825	91.3	2,891,606	1,413,456	48.9
<b>60 to under 65 years</b>	3,447,363	3,048,044	88.4	3,447,363	811,424	23.5
<b>55 to under 60 years</b>	4,069,178	3,498,593	86.0	4,069,178	793,795	19.5
<b>50 to under 55 years</b>	4,212,560	3,497,499	83.0	4,212,560	697,597	16.6
<b>45 to under 50 years</b>	3,978,068	2,777,020	69.8	3,978,068	545,492	13.7
<b>40 to under 45 years</b>	4,094,219	1,871,601	45.7	4,094,219	457,468	11.2
<b>Under 40 years</b>	31,090,397	4,039,398	13.0	31,090,397	1,423,738	4.6
<b>Total</b>	61,590,233	28,760,055	46.7	61,590,233	12,942,168	21.0

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

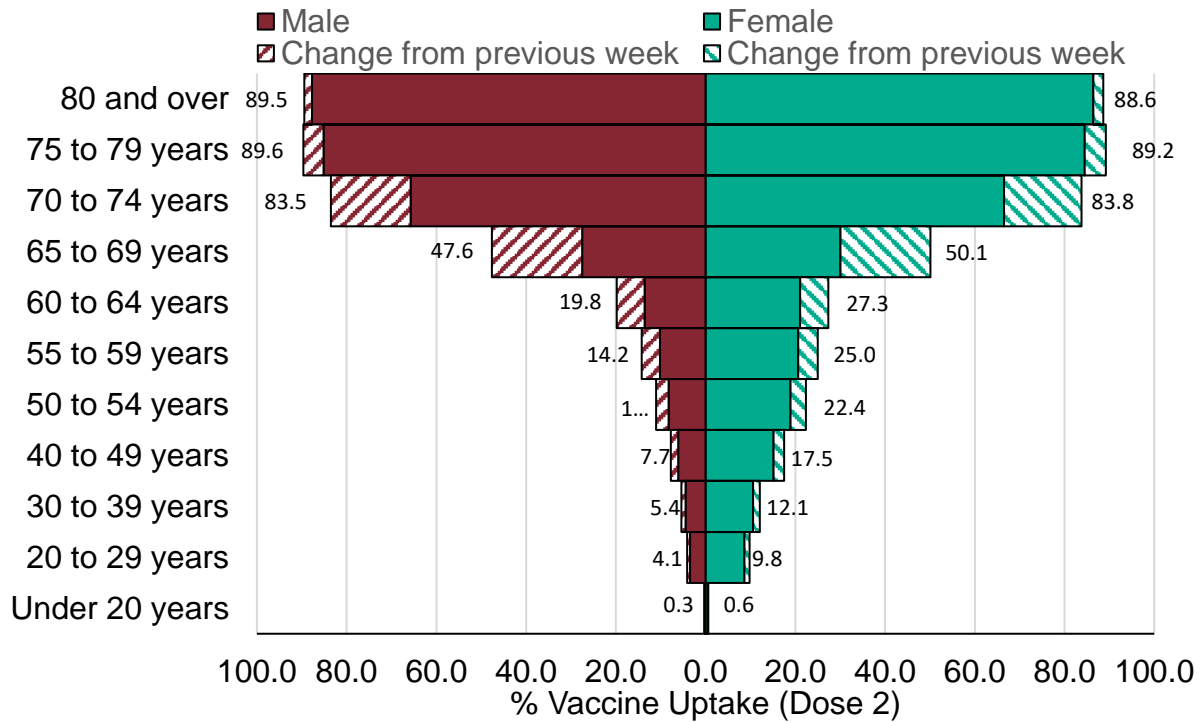
**Figure 57: Cumulative weekly COVID-19 vaccine uptake by age in England**



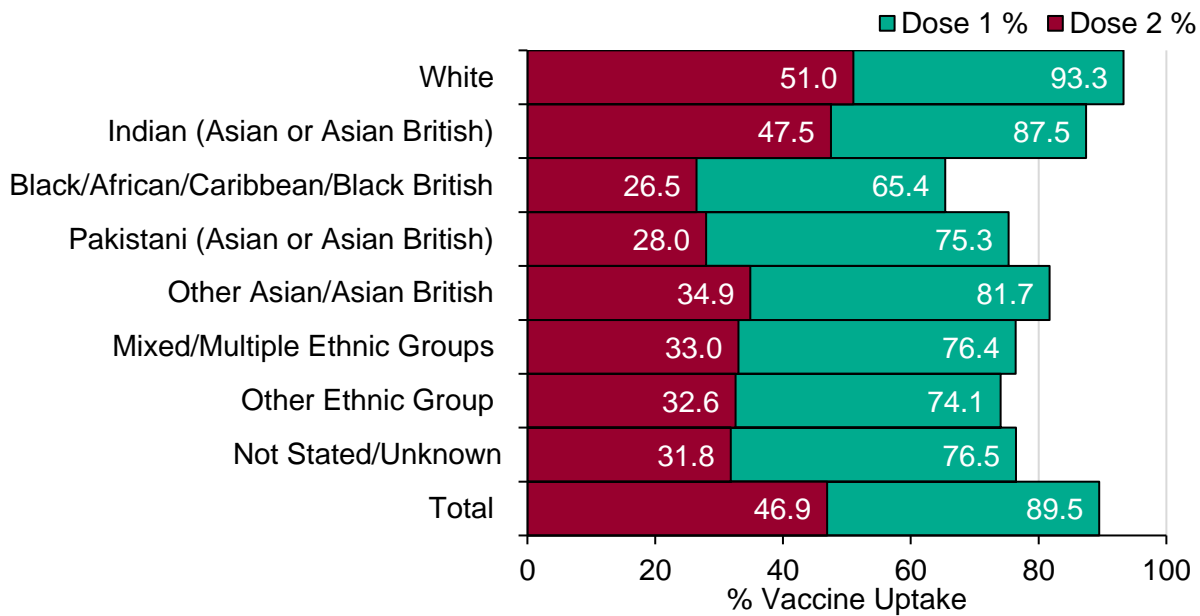
**Figure 58: Age/Sex pyramid for COVID-19 vaccine uptake by age in England for Dose 1**



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



**Figure 60: Cumulative weekly COVID-19 vaccine uptake by ethnicity in England in those aged 50 and over**



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/>

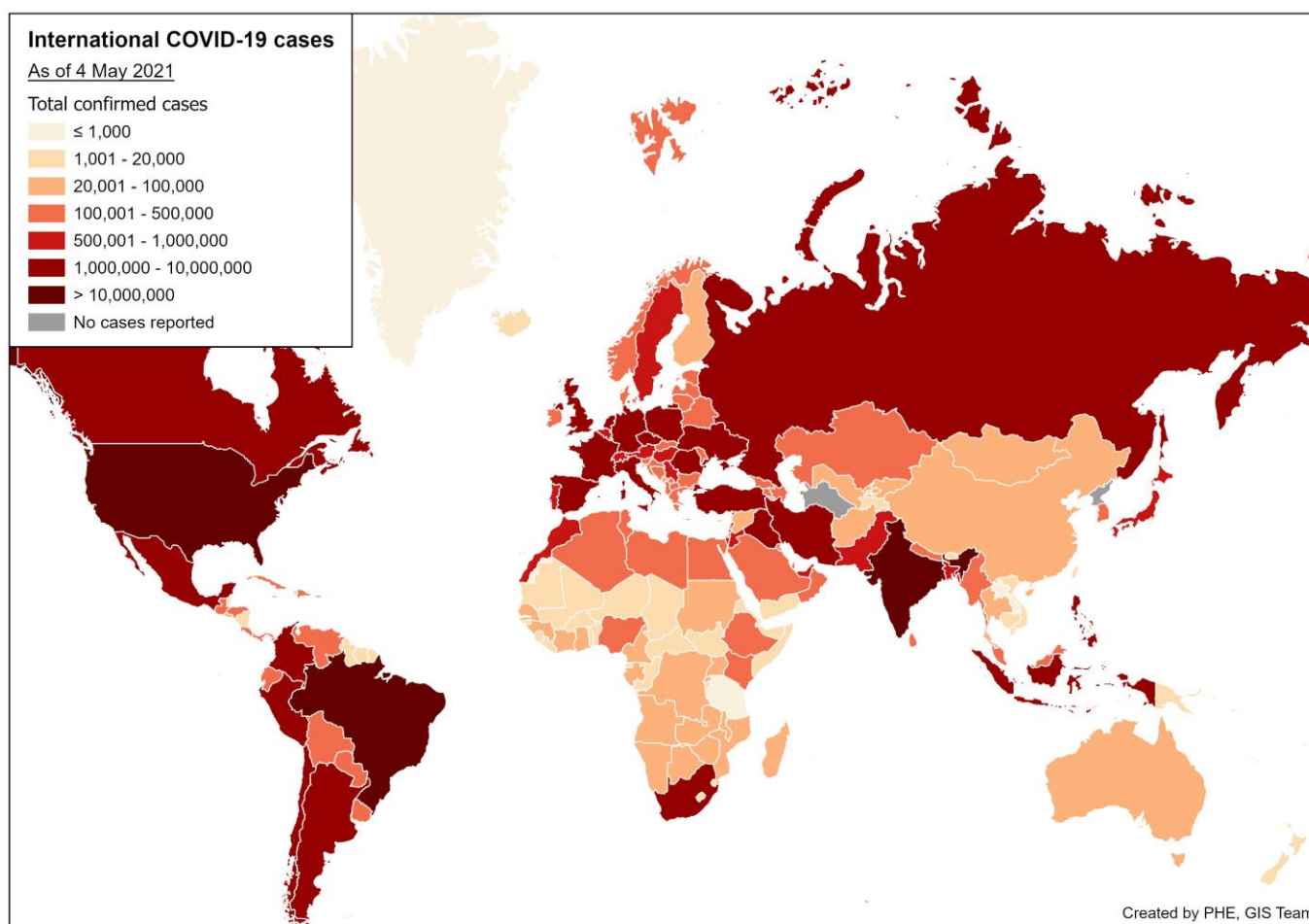
# International update

## Global COVID-19 update

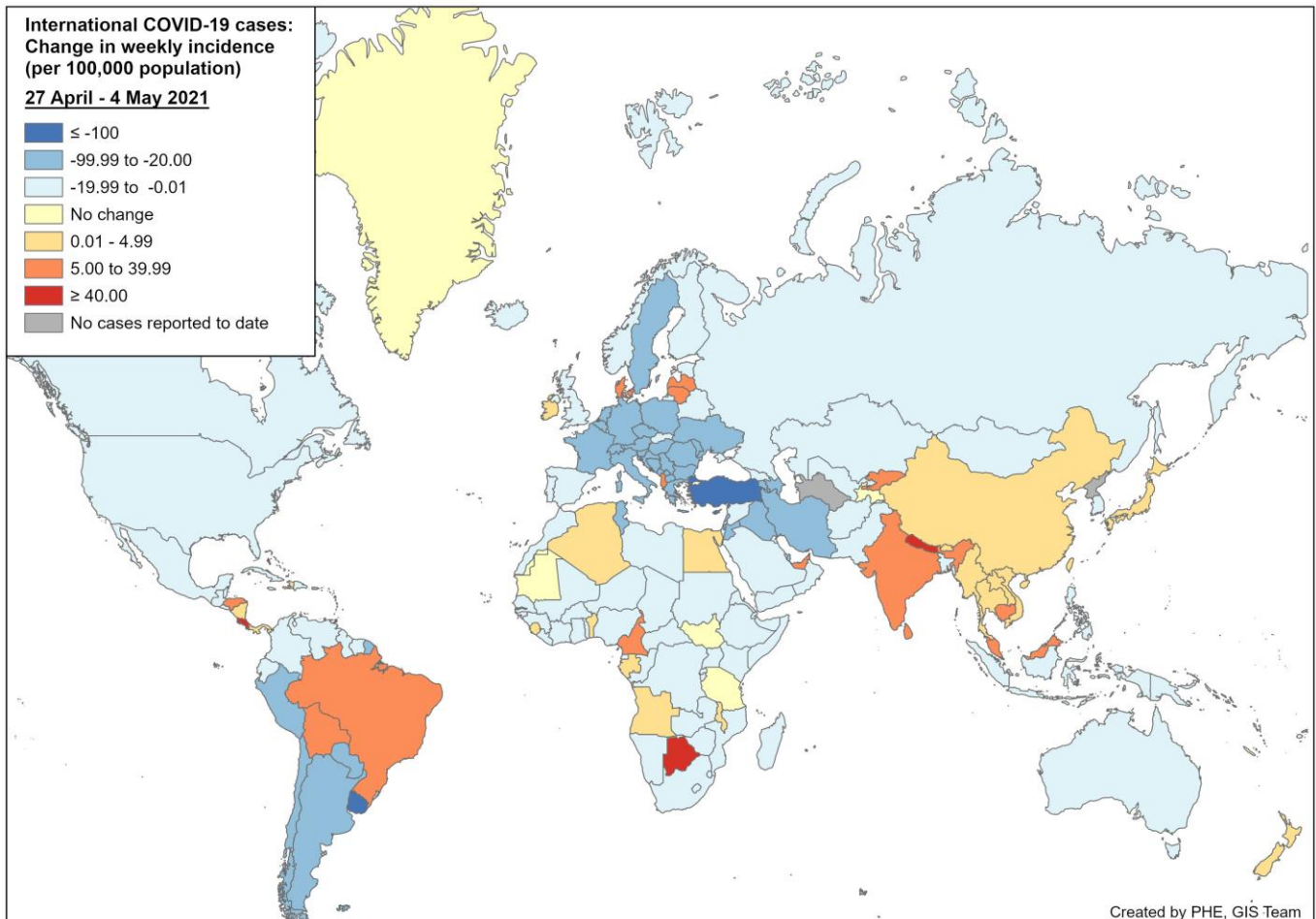
Globally, up to 04 May 2021, 153,276,539 cases of COVID-19 infection have been reported worldwide, including 3,215,346 COVID-19 related deaths.

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

**Figure 61: Global map of cumulative COVID-19 cases**



**Figure 62: 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 26 April 2021 (based on data up to 11 April 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 Caribbean and Central American countries, sporadic detections of influenza A and B were reported in Mexico.

In the tropical countries of South America, no influenza detections were reported for this period. Few RSV detections were reported in Brazil, Colombia, Ecuador and Peru. SARI activity increased to high levels in Ecuador

In tropical Africa, influenza detections were reported in some countries in Western, Middle and Eastern Africa.

In Southern Asia, influenza activity continued to be reported at low levels in India and Nepal.

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

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. Qatar reported detections of influenza B viruses since the end of February. ILI continued to increase slightly in Turkey. SARI activity in Armenia increased in recent weeks.

In East Asia, influenza illness indicators and influenza activity remained low.

The WHO GISRS laboratories tested more than 310129 specimens during that time period. A total of 588 specimens were positive for influenza viruses, of which 102 (17.3%) were typed as influenza A and 486 (82.7%) as influenza B. Of the sub-typed influenza A viruses, 9 (16.1%) were influenza A(H1N1)pdm09 and 47 (83.9%) were influenza A(H3N2). Of the characterized B viruses, 1 (0.2%) belonged to the B-Yamagata lineage and 437 (99.8%) to the B-Victoria lineage.

## Influenza in Europe

Updated on 4 May 2021 ([Joint ECDC-WHO Europe Influenza weekly update](#))

For week 16 2021, influenza activity remained at or below inter-seasonal levels throughout Europe.

For week 16 2021, of 996 sentinel specimens tested for influenza viruses, none were positive. Since the start of the season, of 37,639 sentinel-source specimens tested for influenza viruses, 41 were positive (28 type A and 13 type B viruses).

## 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 27 April 2021 ([WHO website](#))

Since the previous update on 29 January 2021, 2 human infections with avian influenza A(H5N6) viruses, 7 human infections with avian influenza A(H5N8) viruses, 3 human infections with avian influenza A(H5) viruses, 10 human infections with avian influenza A(H9N2) viruses and one human infection with an influenza A(H3N2) variant virus were reported officially.

Influenza A(H5) viruses:

Between 30 January 2021 and 15 April 2020, 2 new laboratory-confirmed human cases of influenza A(H5N6) virus infection were reported to WHO; one from China and one from Lao People's Democratic Republic (LPDR). On 18 February 2021, the Russian Federation notified WHO of the detection of avian influenza A(H5N8) virus in 7 human clinical specimens in December 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 3 February and 15 April 2021, China notified WHO of the detection of 9 human cases of infection with influenza A(H9N2).

### Middle East respiratory syndrome coronavirus (MERS-CoV)

Latest update on 20 April 2021 ([WHO website](#))

Up to 20 April 2021, a total of 5 cases of Middle East respiratory syndrome coronavirus, MERS-CoV, (3 imported and 2 linked cases) have been confirmed in the UK through the on-going surveillance since September 2012.

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

Between 1 January 2021 and 11 March 2021, the National IHR Focal Point of Saudi Arabia reported 7 additional cases of Middle East respiratory syndrome (MERS-CoV) infection, including 3 associated deaths ([WHO website](#)).

From 2012 through 11 March 2021, a total of 2,574 laboratory-confirmed cases of MERS-CoV and 886 associated deaths were reported globally to WHO under the International Health regulations (IHR 2005).

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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