



Public Health  
England

Protecting and improving the nation's health

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

Week 30 report (up to week 29 data)  
29 July 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 29 (between 19 July and 25 July 2021) and for some indicators daily data up to 27 July 2021.

Surveillance indicators suggest that at a national level COVID-19 activity has been decreasing in some indicators in week 29 of 2021, while in other indicators activity continues to increase. Laboratory indicators suggest that influenza activity is low.

Overall case rates decreased in week 29. Case rates decreased in most age groups, and in all regions and ethnic groups. 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 decreased compared to the previous week. SARS-CoV-2 was identified in the majority of these. Large decreases were seen in the numbers of incidents reported in educational settings, coinciding with the school holidays, while increases were observed in care homes.

COVID-19 hospitalisations increased in week 29. Deaths with COVID-19 increased slightly in the most recent week.

COVID-19 vaccine coverage was 62.7% for dose 1 at the end of week 29. COVID-19 vaccine coverage was 50.0% for dose 2 at the end of week 29, reaching over 90% in all cohorts over the age of 60 years and over 80% in all cohorts over 50 years.

Seroprevalence data indicates that approximately 95.5% of blood donors aged 17 and over have antibodies to SARS-CoV-2 from either infection or vaccination, compared to 17.1% from infection alone. Increases in seropositivity continue to be observed in those aged 30 to 39 and 17 to 29, following vaccination rollout.

Through Respiratory Datamart, there was one influenza positive samples detected in week 29, an influenza B. Other indicators for influenza such as hospital admissions and GP influenza-like illness consultation rates remain low. Respiratory syncytial virus (RSV) positivity increased from 9.0% to 12.9%, while parainfluenza positivity decreased to 4.1% in week 28. Rhinovirus activity remained stable at 11.4% in week 29. Adenovirus and human metapneumovirus (hMPV) positivity remained low at 1.4% and 1.3% respectively.

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# Laboratory surveillance

## Confirmed COVID-19 cases (England)

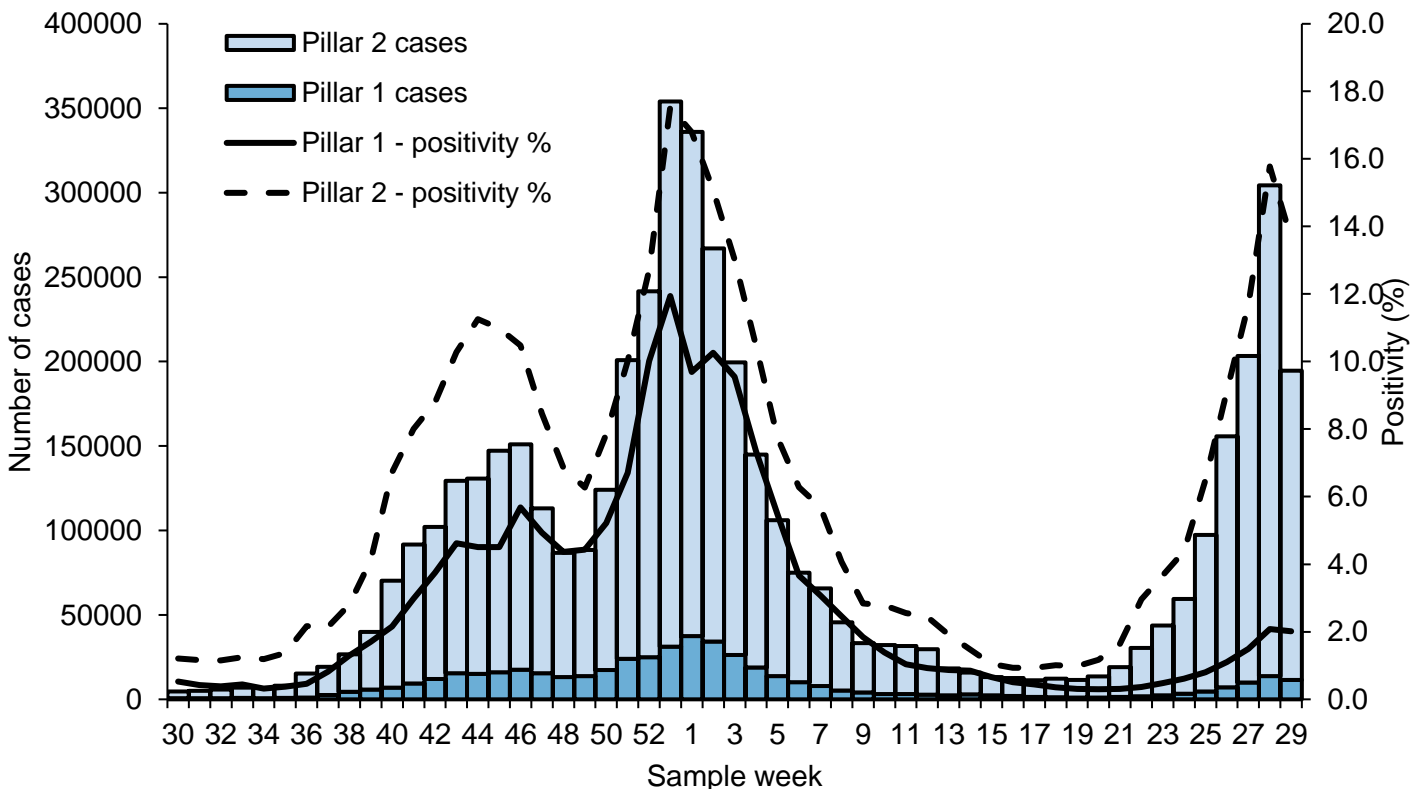
As of 9am on 27 July 2021, a total of 5,013,664 first positive cases have been confirmed for COVID-19 in England under Pillars 1 and 2, since the beginning of the pandemic.

Overall case rates decreased in week 29. Case rates decreased in most age groups, and in all regions and ethnic groups. Overall Pillar 1 and Pillar 2 positivity decreased slightly compared to the previous week.

Please note that positivity is presented as positivity by Polymerase Chain Reaction (PCR) testing only, unless otherwise stated (for example figure 2). This differs to in previous weeks where positivity by PCR and Lateral Flow Device (LFD) testing was presented. This change was introduced to improve comparability across population groups that may have different rates of asymptomatic LFD testing.

Changes to testing policies over time may impact on positivity rates.

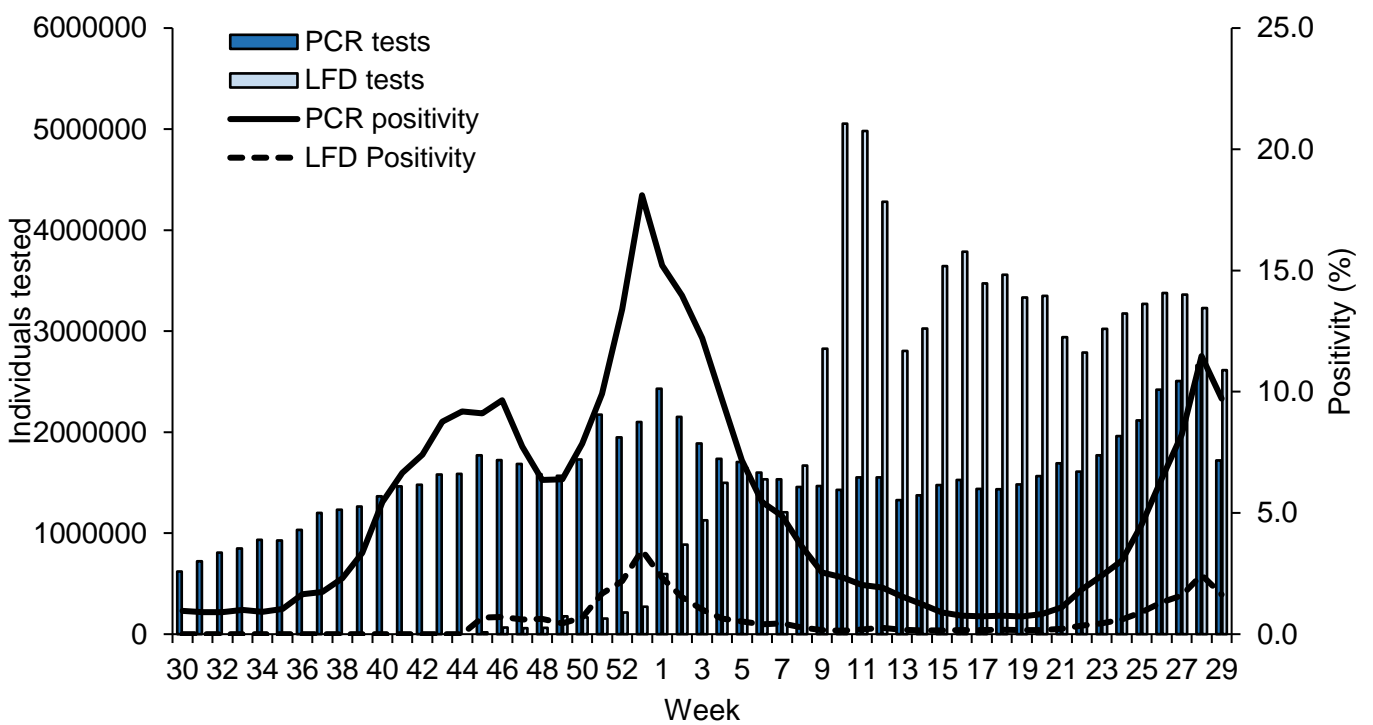
**Figure 1: Confirmed COVID-19 cases tested under Pillar 1 and Pillar 2, based on sample week with overall weekly PCR positivity for Pillars 1 and 2 (%)**



\* 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 through Polymerase Chain Reaction (PCR) testing. Please note that this differs to in previous reporting weeks, where both PCR and lateral flow device (LFD) tests were included.

**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)**

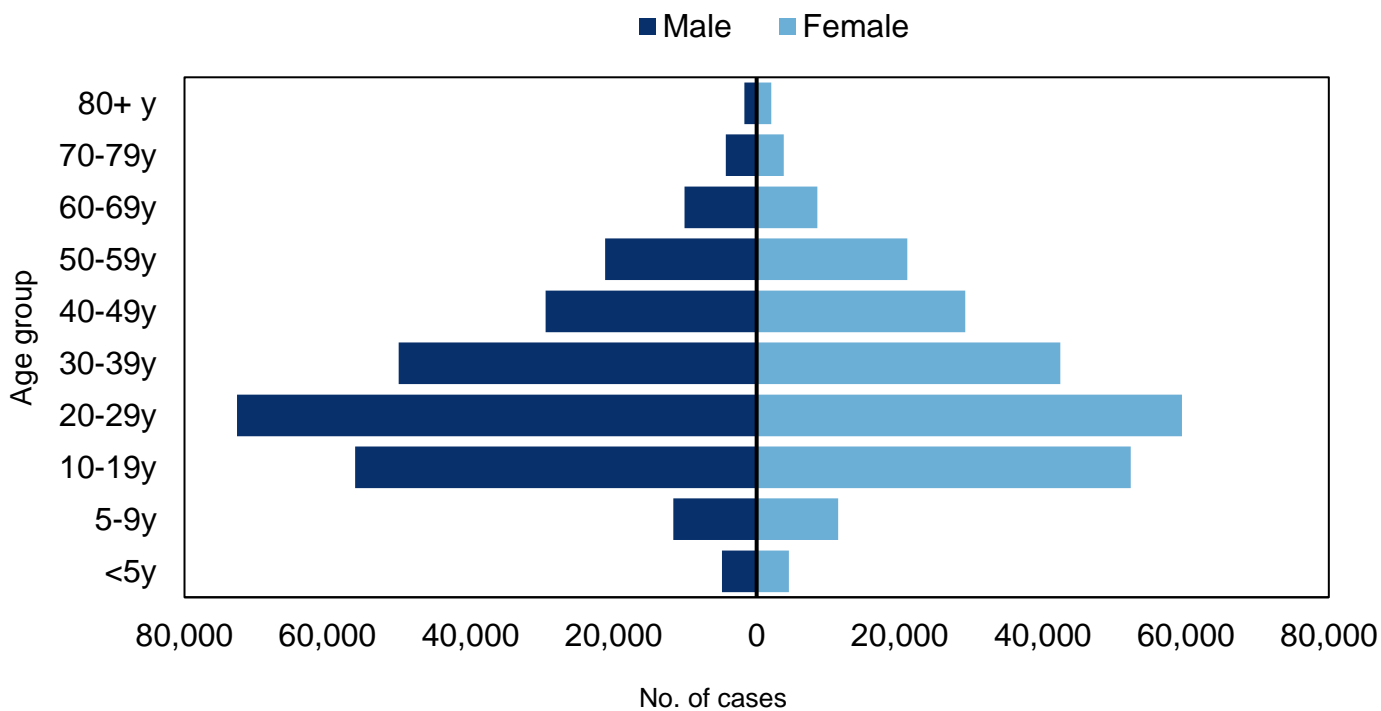


\*For Figure 2 positivity is calculated as the number of individuals testing positive using a specific test type during the week, divided by the number of individuals tested using that specific test type during the week.

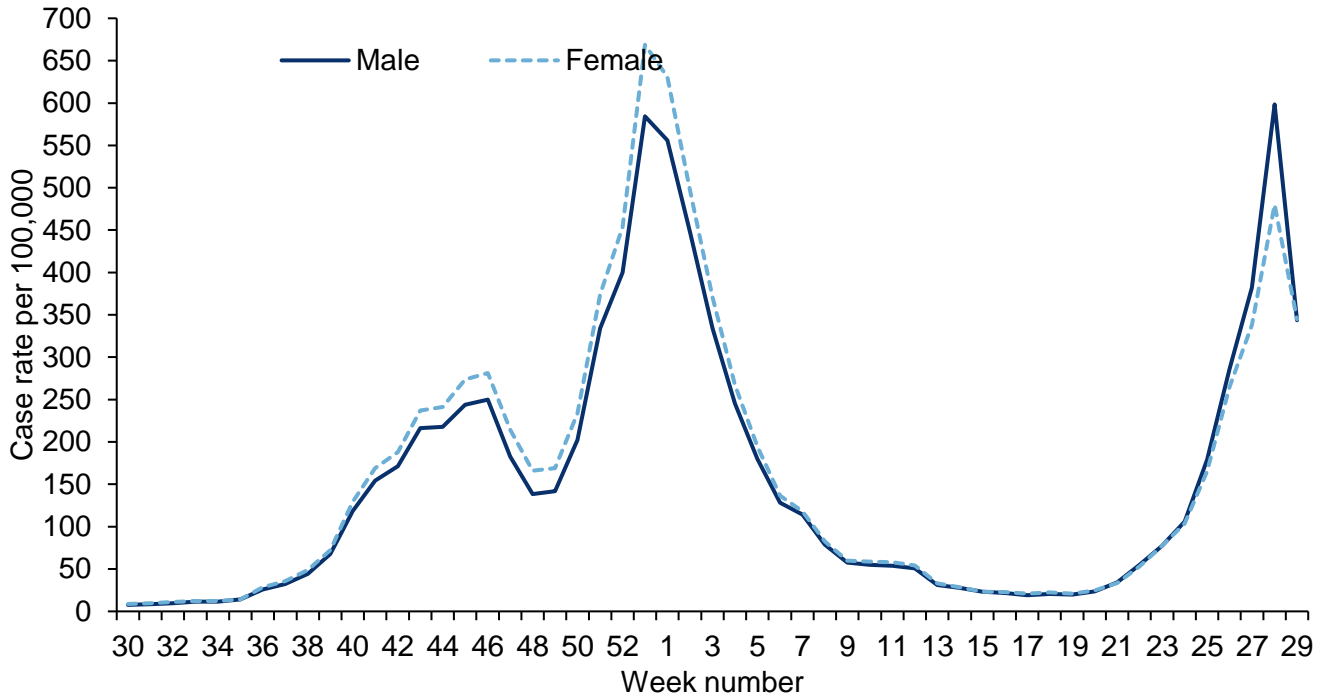
\*Please note that an individual may appear under both PCR and LFD tests if they have been tested using both test types in a given week.

## Age and sex

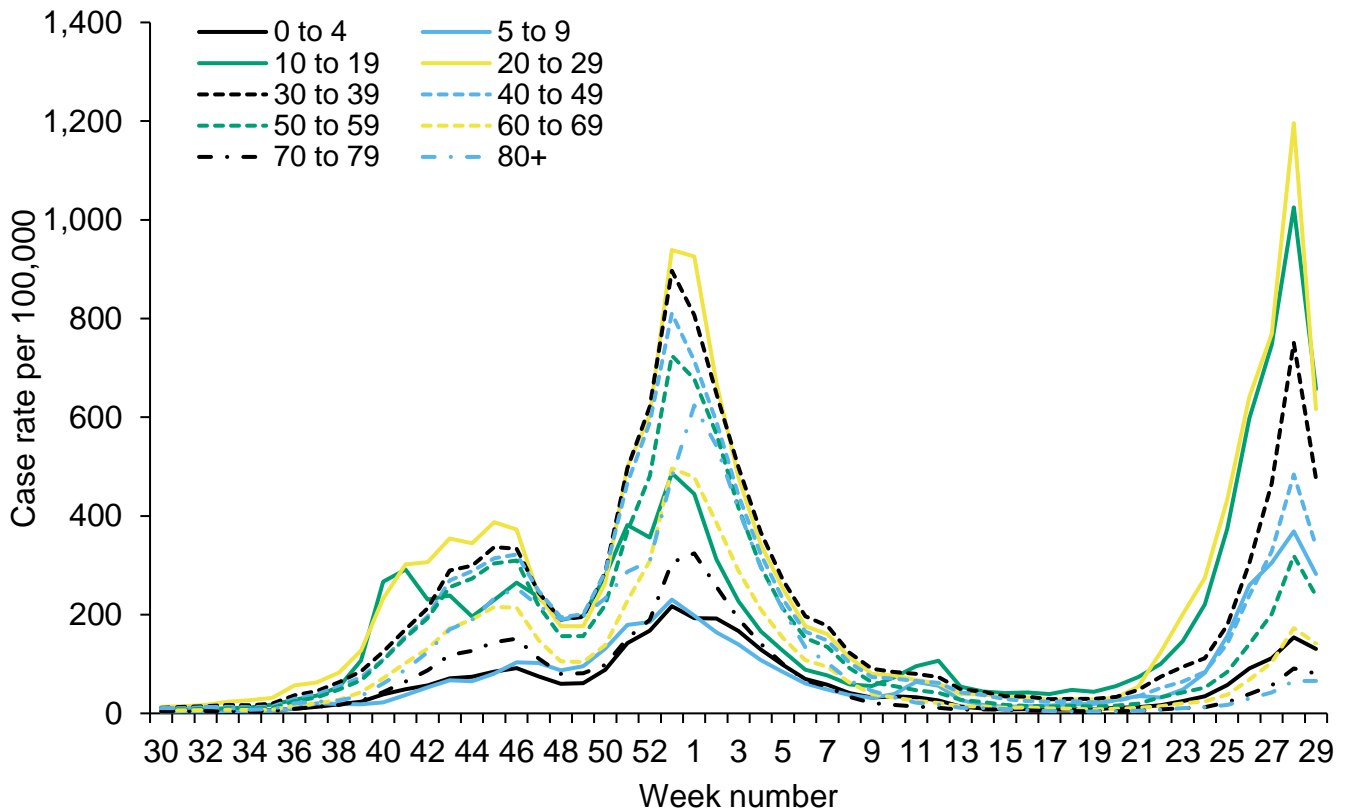
**Figure 3: Age-sex pyramids for confirmed COVID-19 cases tested under Pillars 1 and 2 in weeks 28 and 29 (n=496,813)**



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

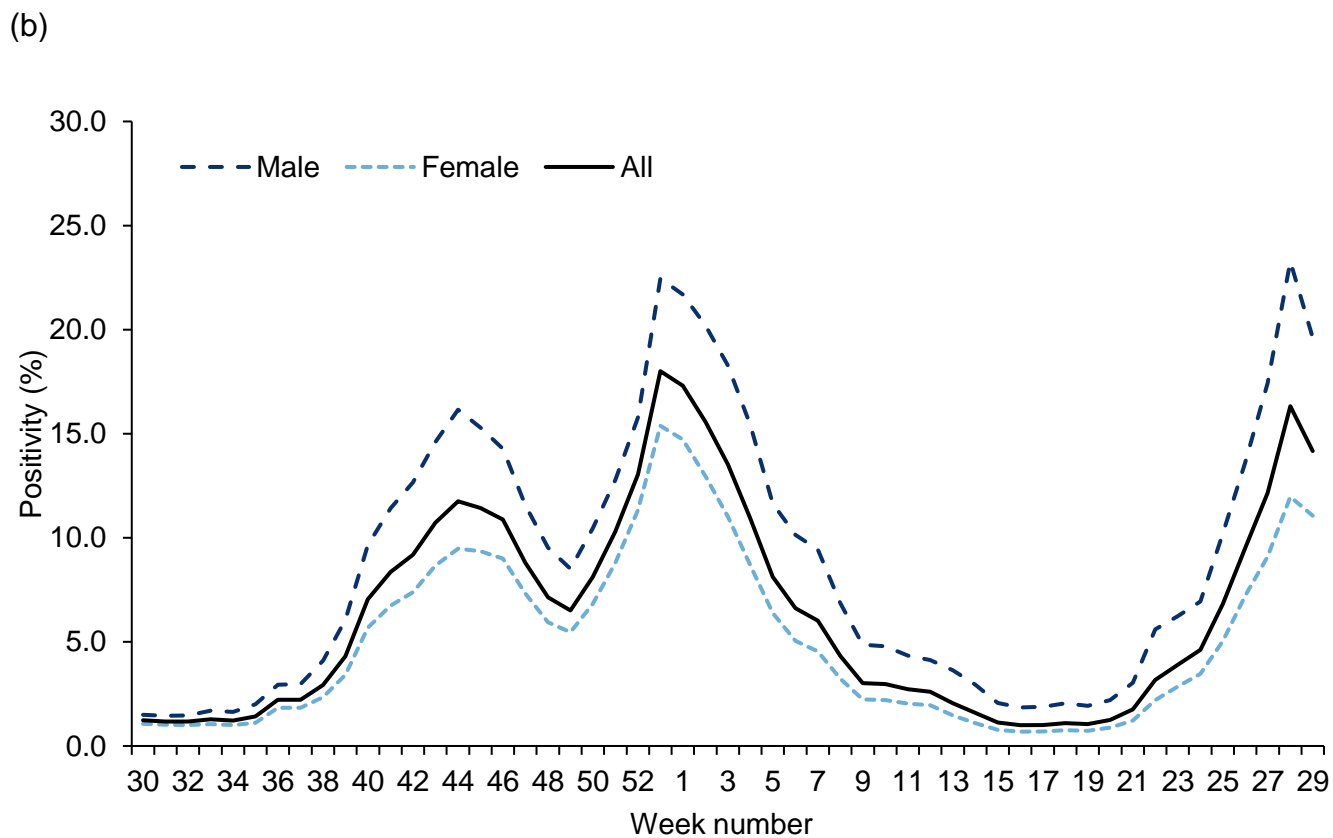
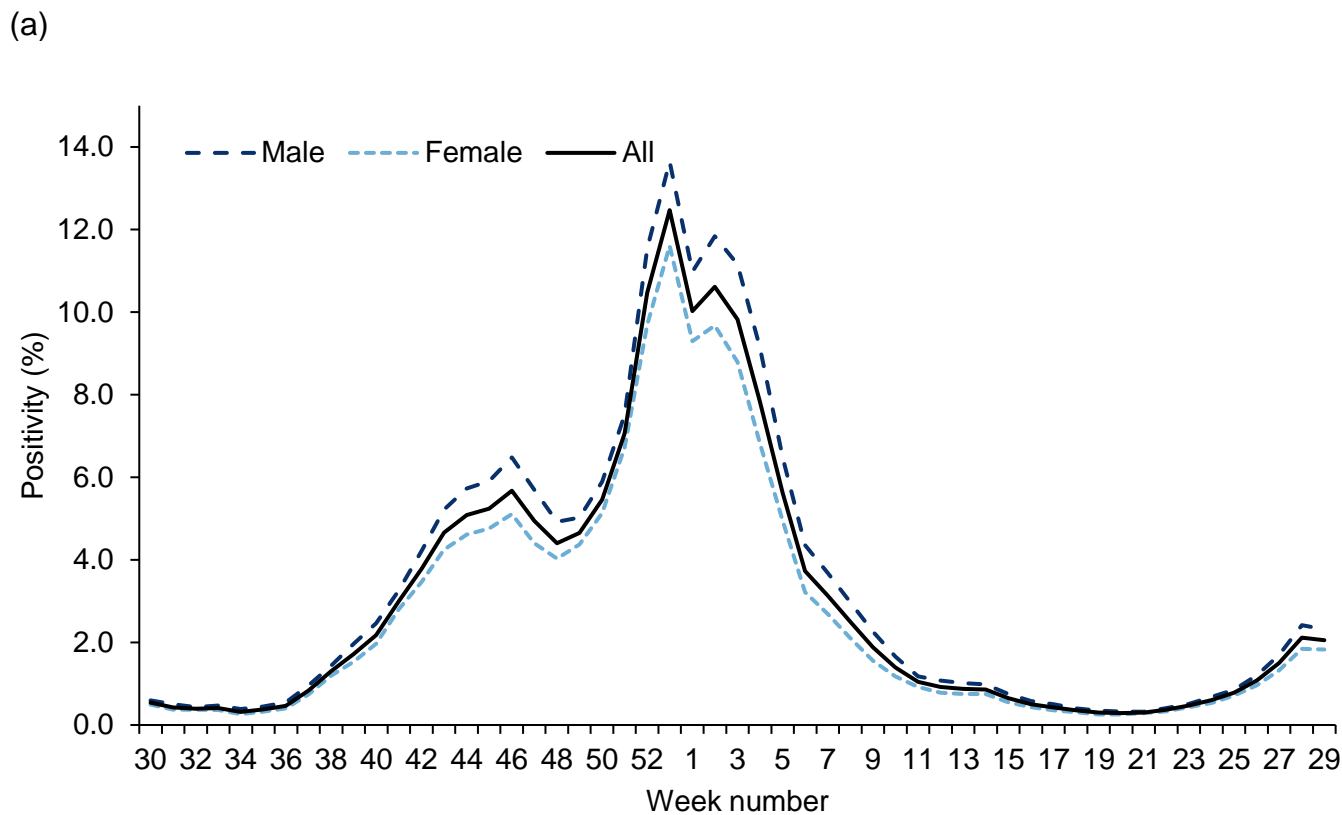


**Figure 5: Weekly confirmed COVID-19 case rates per 100,000, tested under Pillar 1 and Pillar 2, by age group**



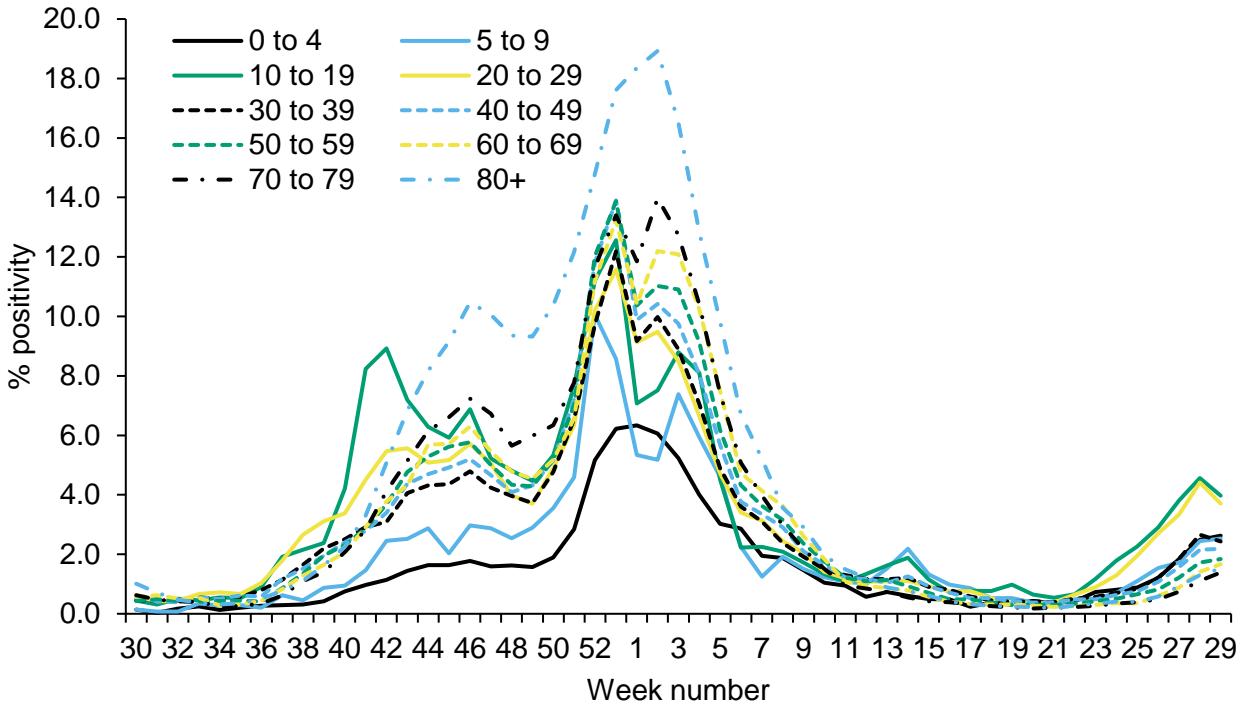


**Figure 6: Weekly PCR positivity (%) of confirmed COVID-19 cases tested overall and by sex under (a) Pillar 1 and (b) Pillar 2, (SGSS and Respiratory DataMart)**

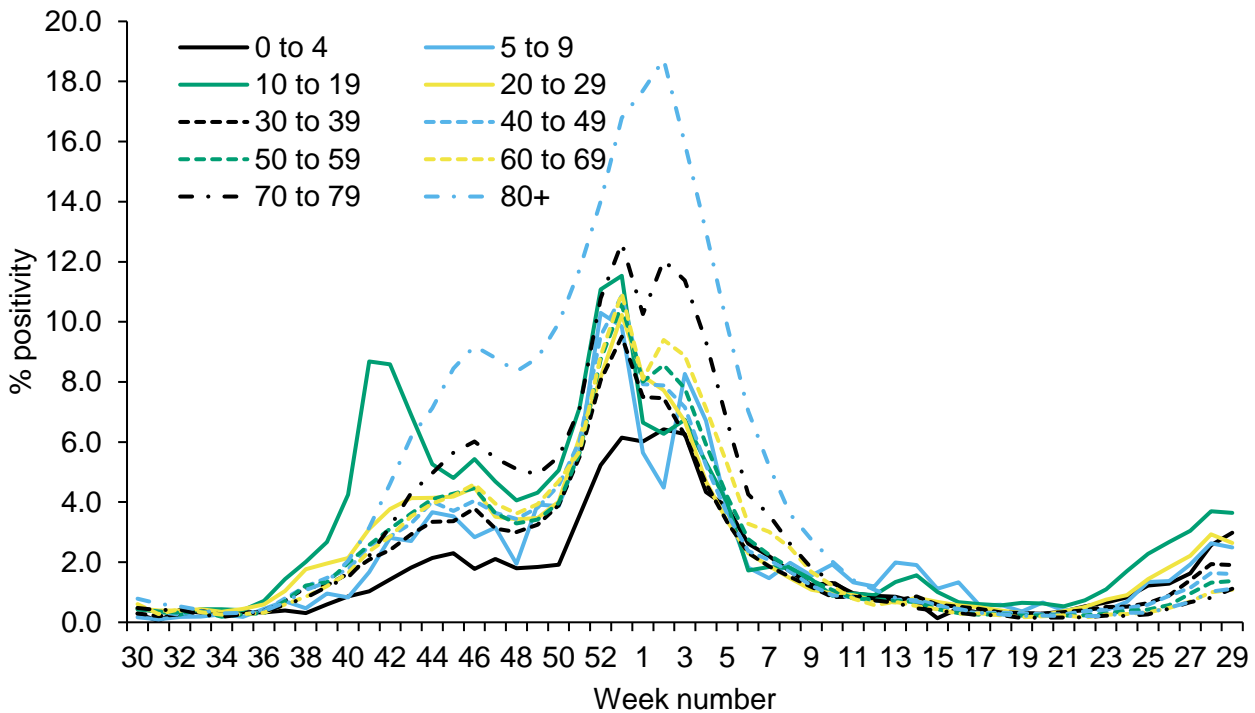


**Figure 7: Weekly PCR positivity (%) of confirmed COVID-19 cases tested under Pillar 1, (a) by male and age group and (b) by female and age group and; under Pillar 2, (c) by male and age group and (d) by female and age group, (SGSS and Respiratory DataMart)**

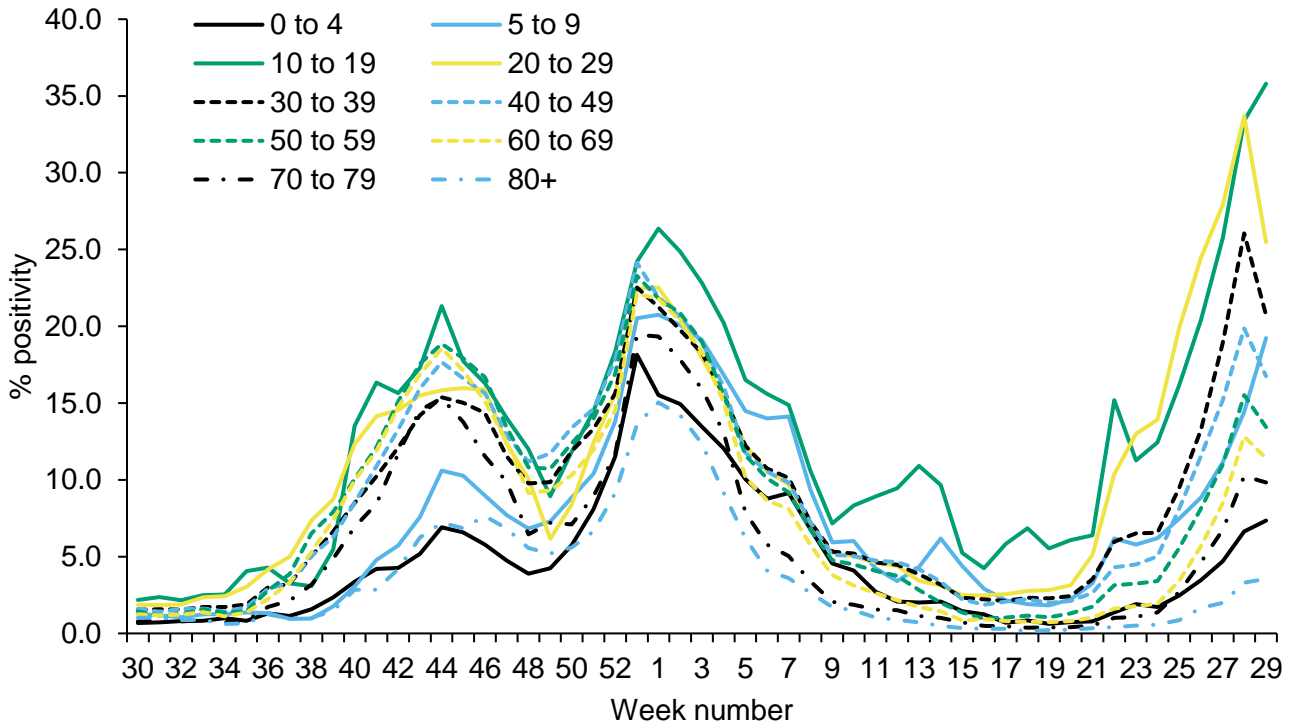
(a) Pillar 1 - Male



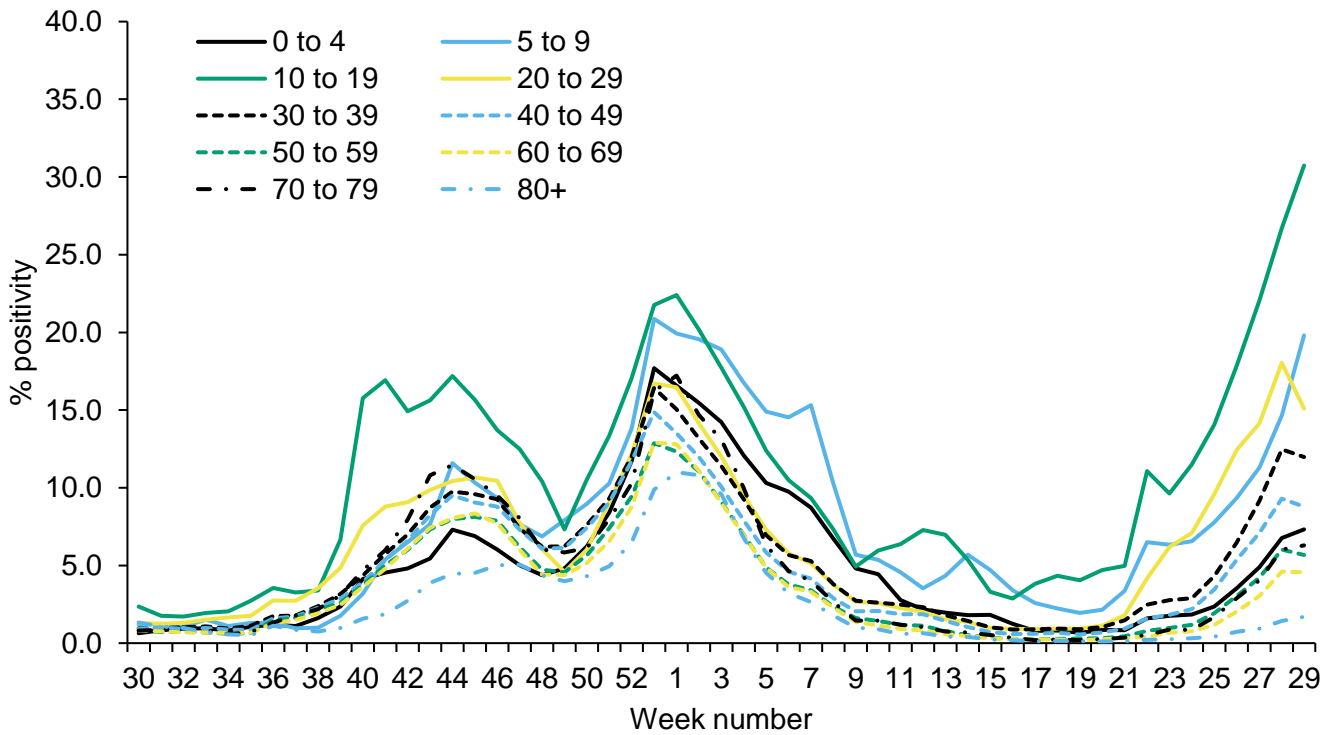
(b) Pillar 1 - Female



(c) Pillar 2 – Male

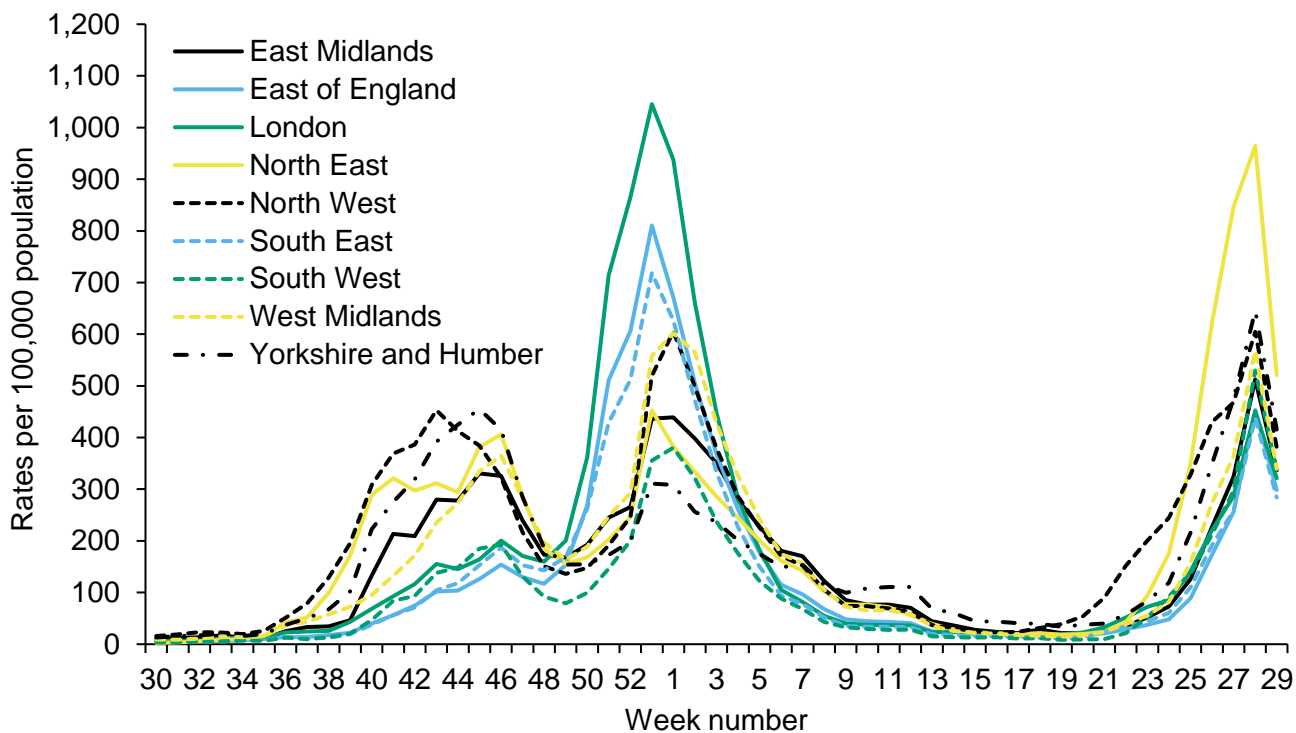


(d) Pillar 2 – Female

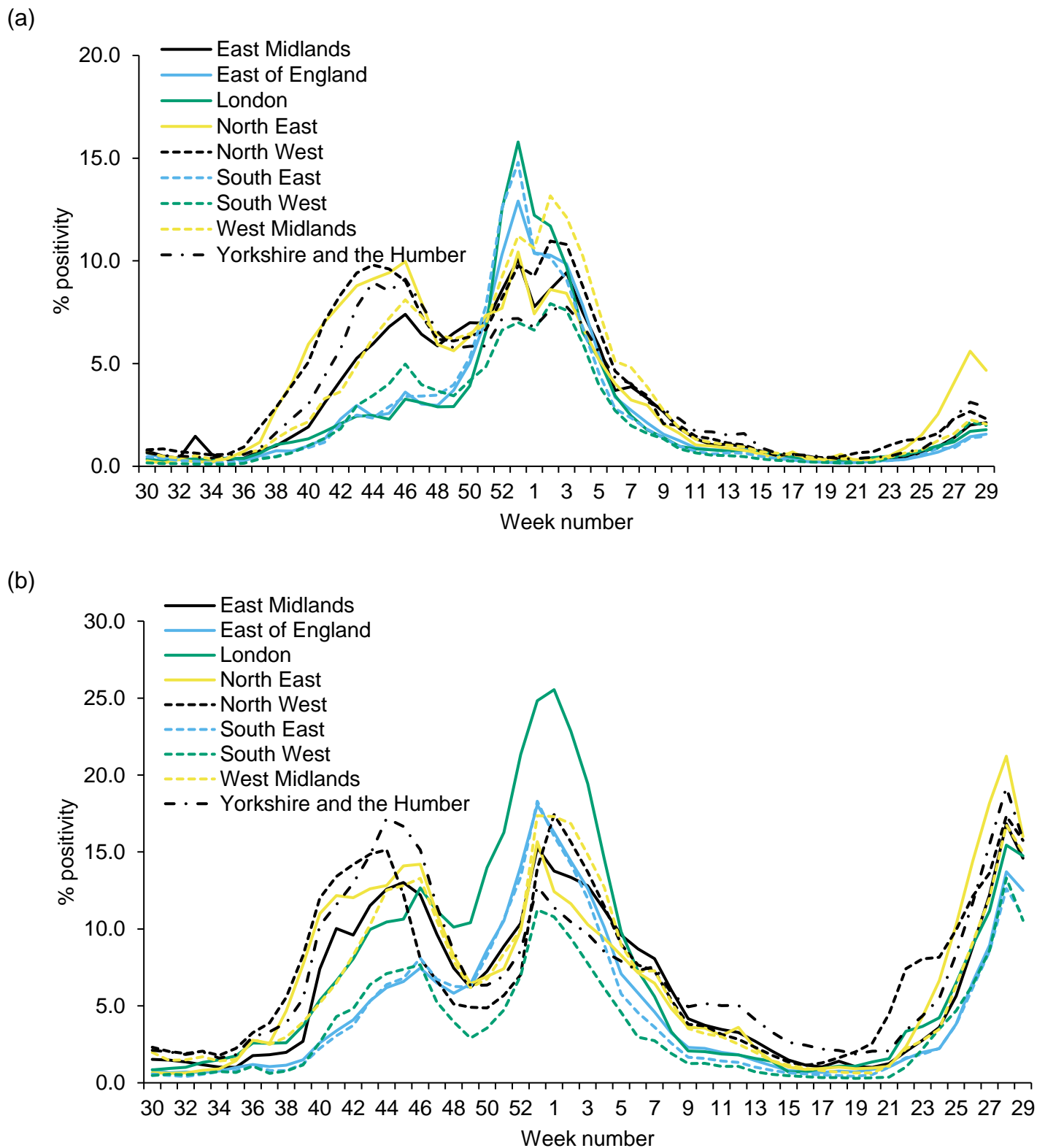


## Geography

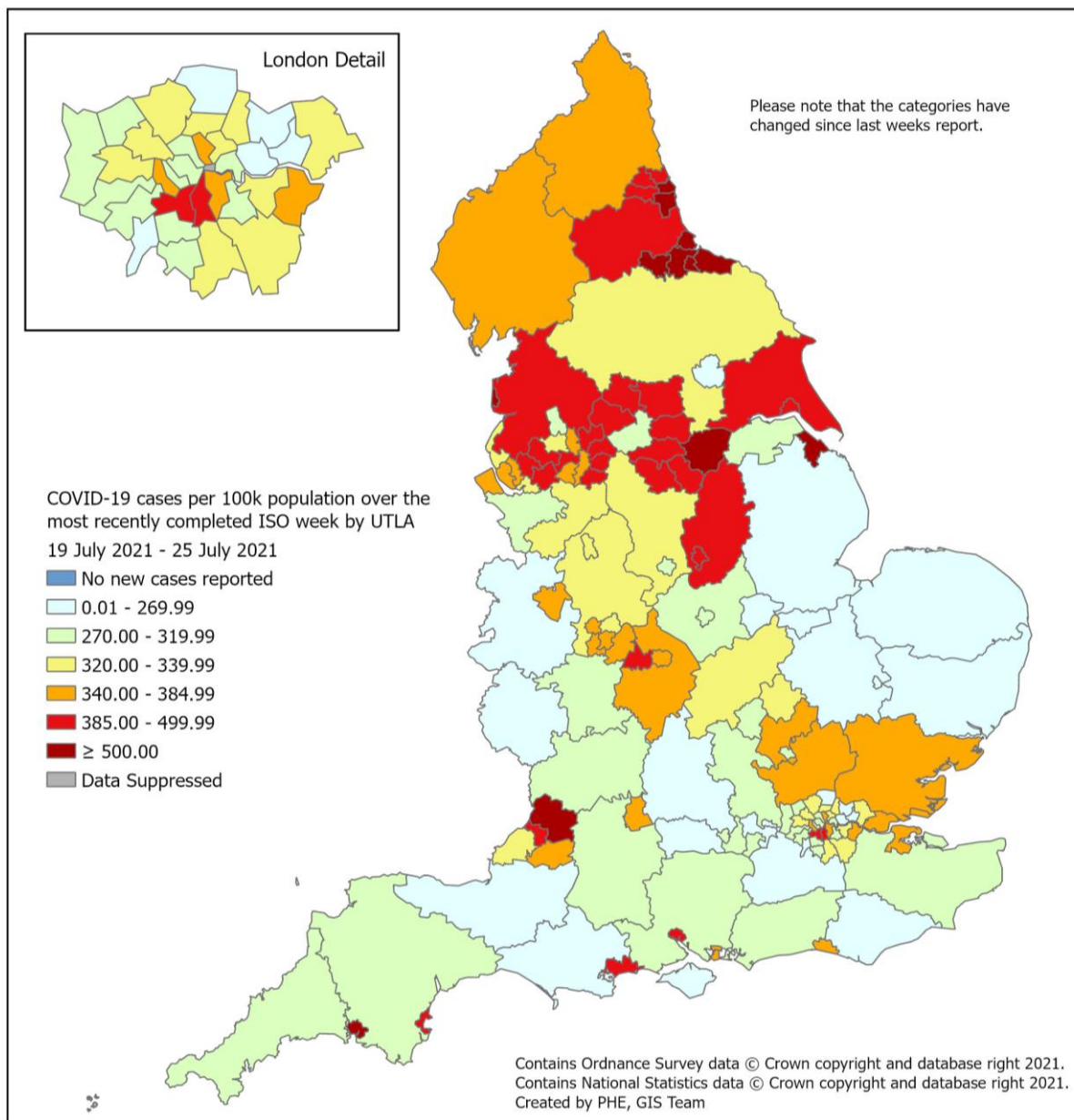
**Figure 8: Weekly confirmed COVID-19 case rates per 100,000 population (Pillar 1 and Pillar 2), by PHE Centres and sample week**



**Figure 9: Weekly PCR 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)**

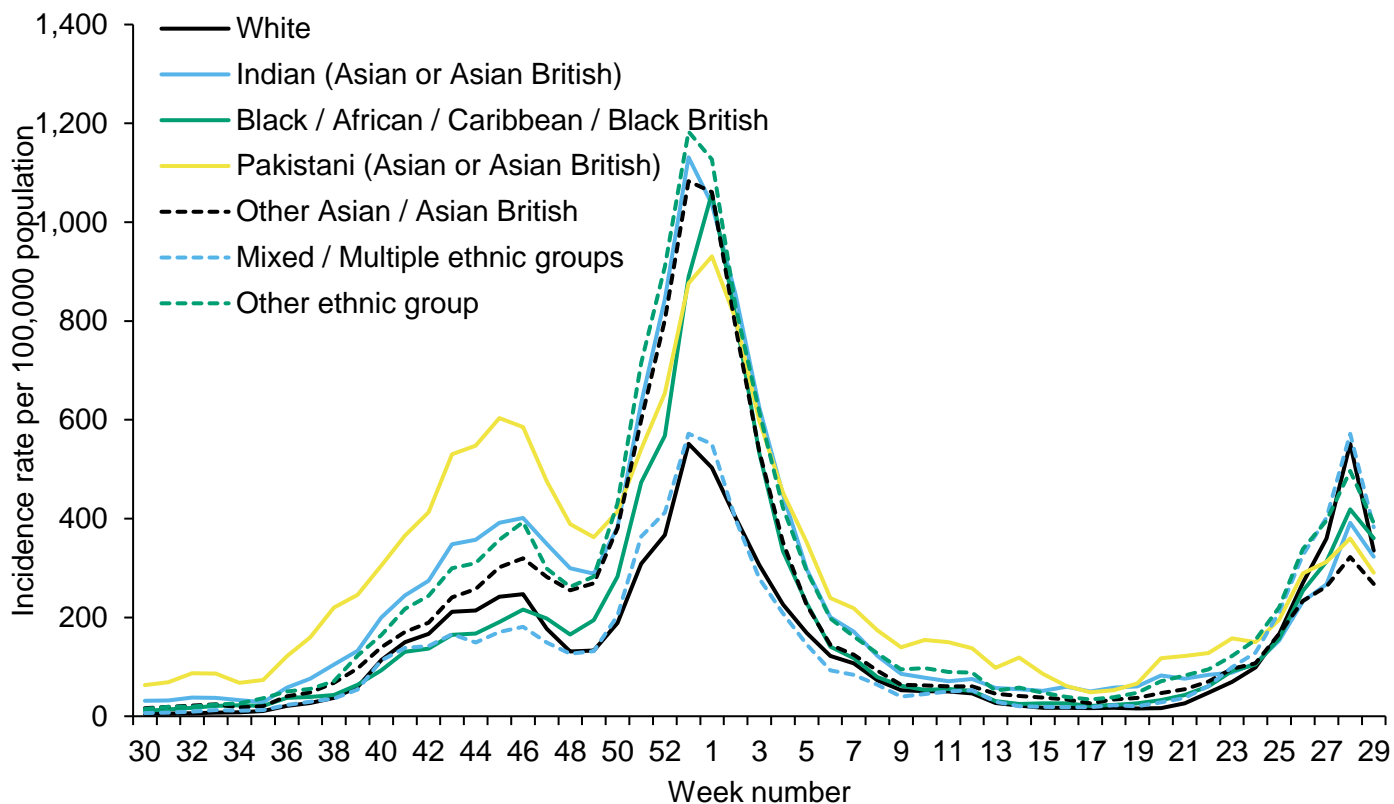


**Figure 10: Weekly rate of COVID-19 cases per 100,000 population (Pillar 1 and 2), by upper-tier local authority, England (box shows enlarged map of London area)**



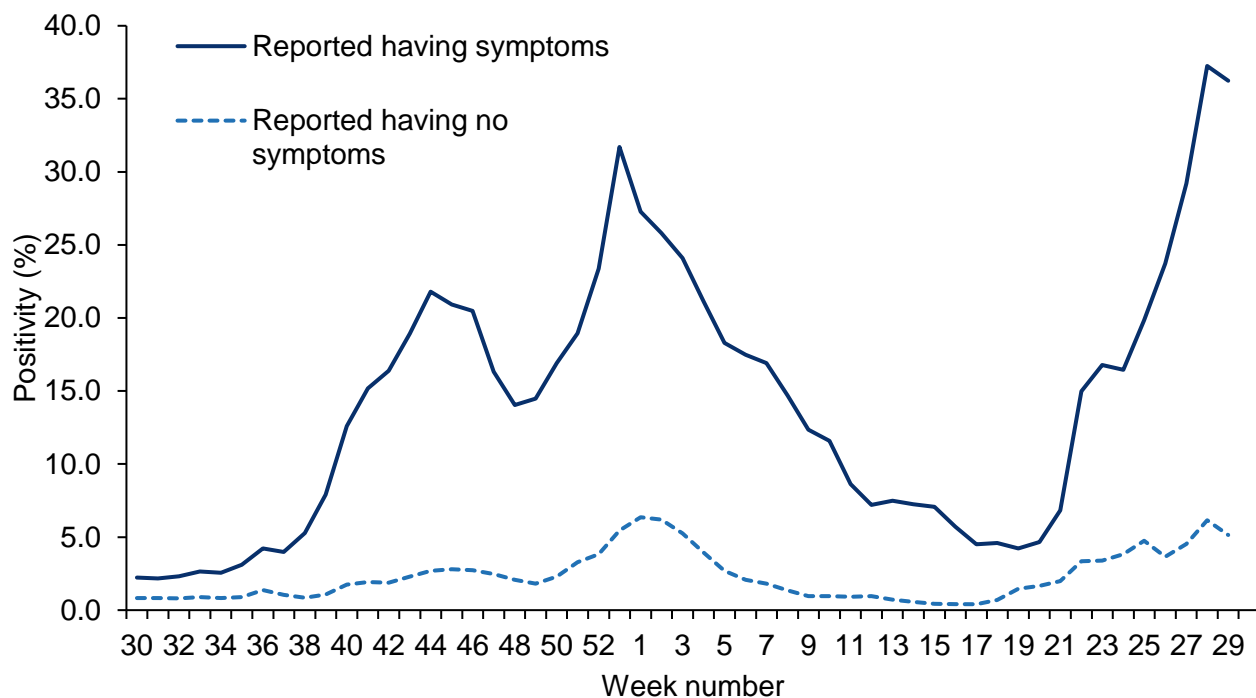
## Ethnicity

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



## Positivity by symptoms

**Figure 12: Weekly PCR positivity (%) of confirmed COVID-19 cases by symptoms reported on Pillar 2 test request, (SGSS and Respiratory DataMart)**





## Possible SARS-CoV-2 reinfection in England

Please note that this section will be updated monthly. Last update was published 15 July 2021.

The following figures present population data based on the first time that individuals tested positive for SARS-CoV-2 through PCR and/or lateral flow device testing in England together with those who have tested positive for SARS-CoV-2 through PCR and/or lateral flow testing with an interval of at least 90 days between two consecutive positive tests. To the end of week 27 in 2021 (to 4 July 2021) 23,105 possible reinfections have been identified, of which 66 have been confirmed by identification of genetically distinct specimens from each illness episode (see Table 1).

For a possible reinfection to be categorised as confirmed it requires sequencing of a specimen at each episode and for the later specimen to be genetically distinct from that sequenced from the earlier episode. Availability of such dual sequencing is currently very low for several reasons; sequencing was not widely undertaken early in the pandemic; LFD test results do not allow sequencing and some PCR samples have a low viral load where sequencing cannot be undertaken. To meet the definition of a probable reinfection requires sequencing at the later episode that identifies a variant that was not circulating at the time of the earlier episode. Further details on the methodology, as well as additional data on reinfections are available in the graph set published alongside this report.

It is important to consider reinfections in the context of first infections and there is a 90-day delay before people with a first infection can become eligible for reinfection.

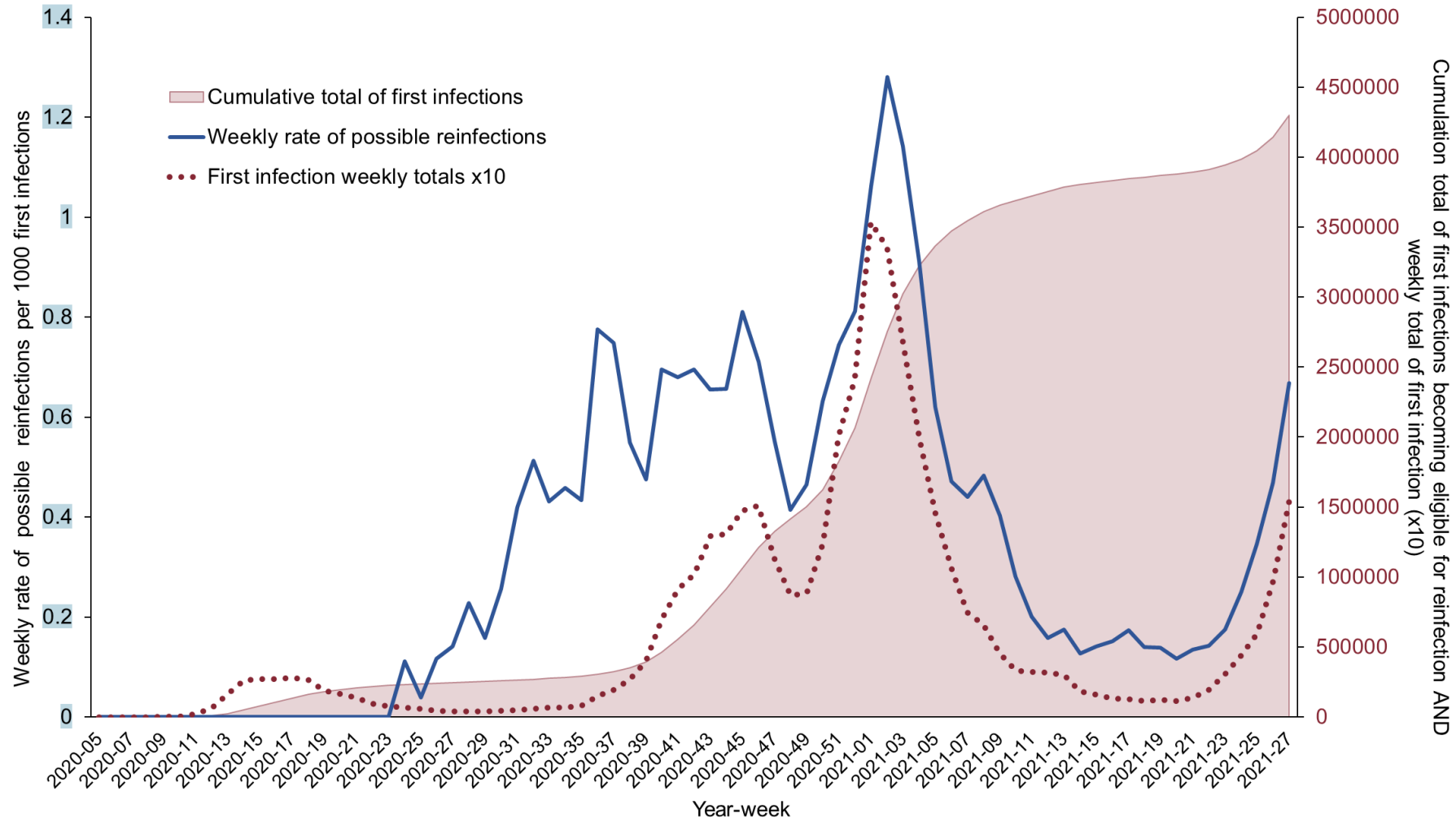
Table 1 summarises the definitions of different categories of COVID-19 infection accompanied by totals generated to 4 July 2021 (end week 27 2021) and review of 1424 possible reinfections with sequencing data available. These data are skewed by the limited availability of sequencing data, particularly in the early months of the pandemic. More recently, widespread routine testing of asymptomatic individuals has taken place and this, together with surge testing, will lead to an increased number of asymptomatic reinfections being identified.

Figure 13 shows the weekly rates of possible reinfections per 1000 first infections based on a cumulative denominator derived from total individuals with a first SARS-CoV-2 positive test result at a point 13 weeks (91 days) before the second positive test result together with the cumulative total of first infections (secondary Y-axis) and total first infections (secondary Y-axis) by week of onset.

**Table 1: Different categories of COVID-19 infection with current totals generated by ongoing analysis in England to 04 July 2021 (end week 27 2021)**

<b>Infection type</b>	<b>Definition</b>	<b>Current totals</b>
<b>Primary infection/ first positive</b>	the first positive PCR/ LFD test result for an individual	<b>4.3 million first positives</b>
<b>Possible reinfection</b>	identified based on two sequential positive test results (PCR or LFD) at least 90 days apart	<b>23,105 possible reinfections</b>
<b>Probable reinfection</b>	where only reinfection sample is available, and this is congruent with contemporaneous phylogeny OR the second event identifies a variant which was not in circulation at the time of first infection	<b>839 classified as probable*</b>
<b>Confirmed reinfection</b>	sequencing of a specimen at each episode of a possible reinfection with the later specimen genetically distinct from that sequenced at first episode	<b>66 confirmed reinfections*</b>
<b>Persistent infection</b>	<i>Nominally repeat test positives at between 14 and &lt;90 day intervals (likely associated with immunosuppression)</i>	Unquantified

**Figure 13: The weekly rate of possible COVID-19 reinfections with cumulation of first infections becoming eligible for reinfection and weekly total of first infection\* (England only to week 27 2021)**



\*These data have been derived independently based on Pillar 1 and Pillar 2 datasets and may therefore differ to previously published data

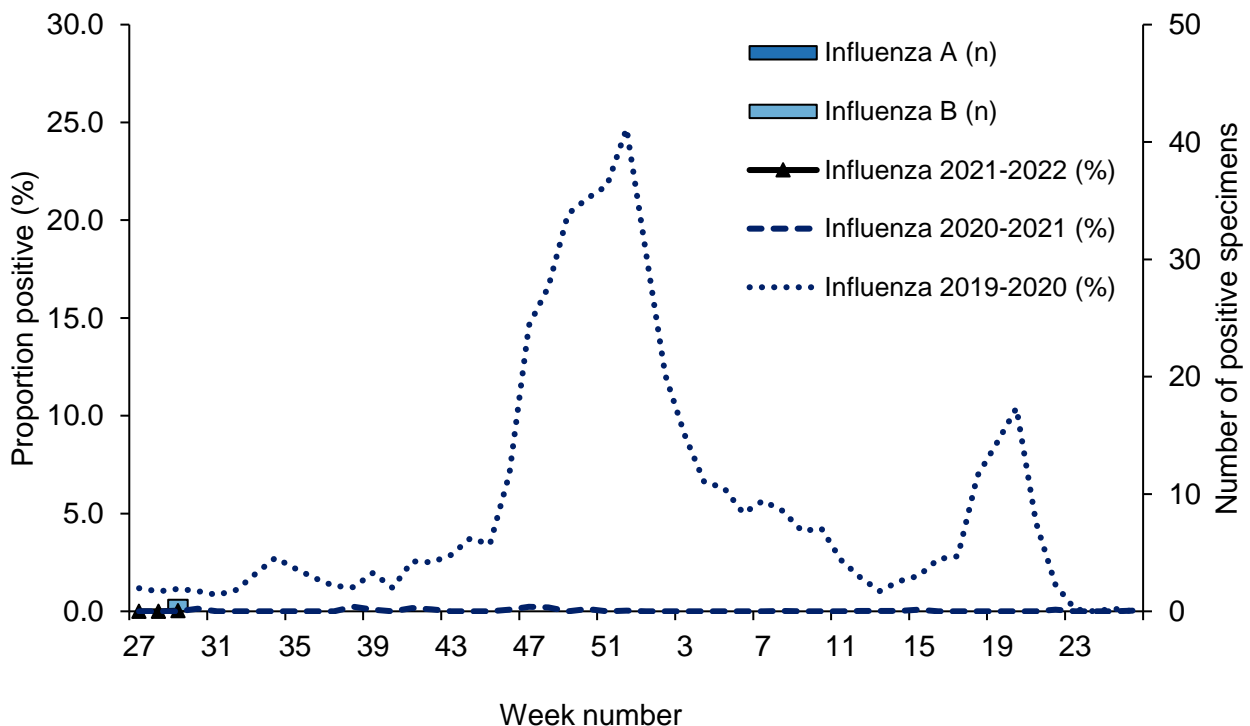
## Respiratory DataMart system (England)

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.

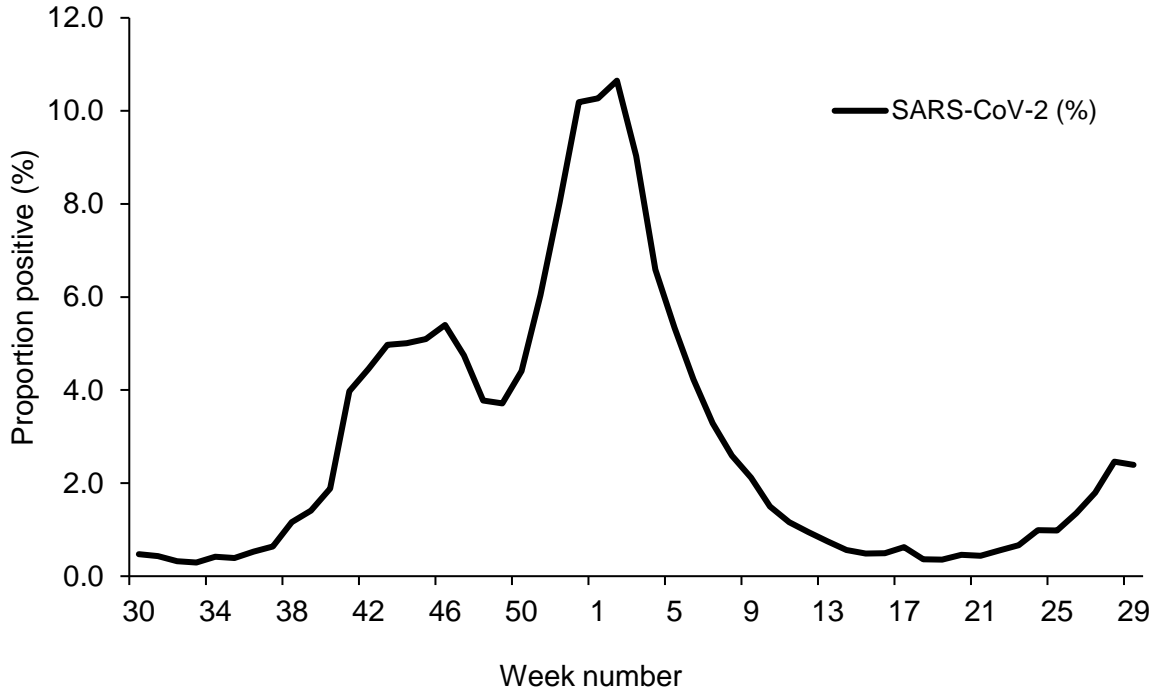
In week 29 2021, out of the 106,817 respiratory specimens reported through the Respiratory DataMart System (based on data received from 15 out of 16 laboratories), 2553 samples were positive for SARS-CoV-2 with an overall positivity of 2.4%. The highest positivity was noted in the 5 to 14-year olds at 4.9% in week 29. The overall influenza positivity remained very low at 0.0% in week 29, with one of the 2,982 samples testing positive for influenza (1 influenza B).

Respiratory syncytial virus (RSV) positivity increased from 9.0% in week 28 to 12.9% in week 29. Rhinovirus positivity remained stable at 11.4% in week 29. Parainfluenza positivity decreased from 6.5% in week 28 to 4.1% in week 29. Adenovirus and human metapneumovirus (hMPV) positivity remained low at 1.4% and 1.3% respectively in week 29 (Figure 16).

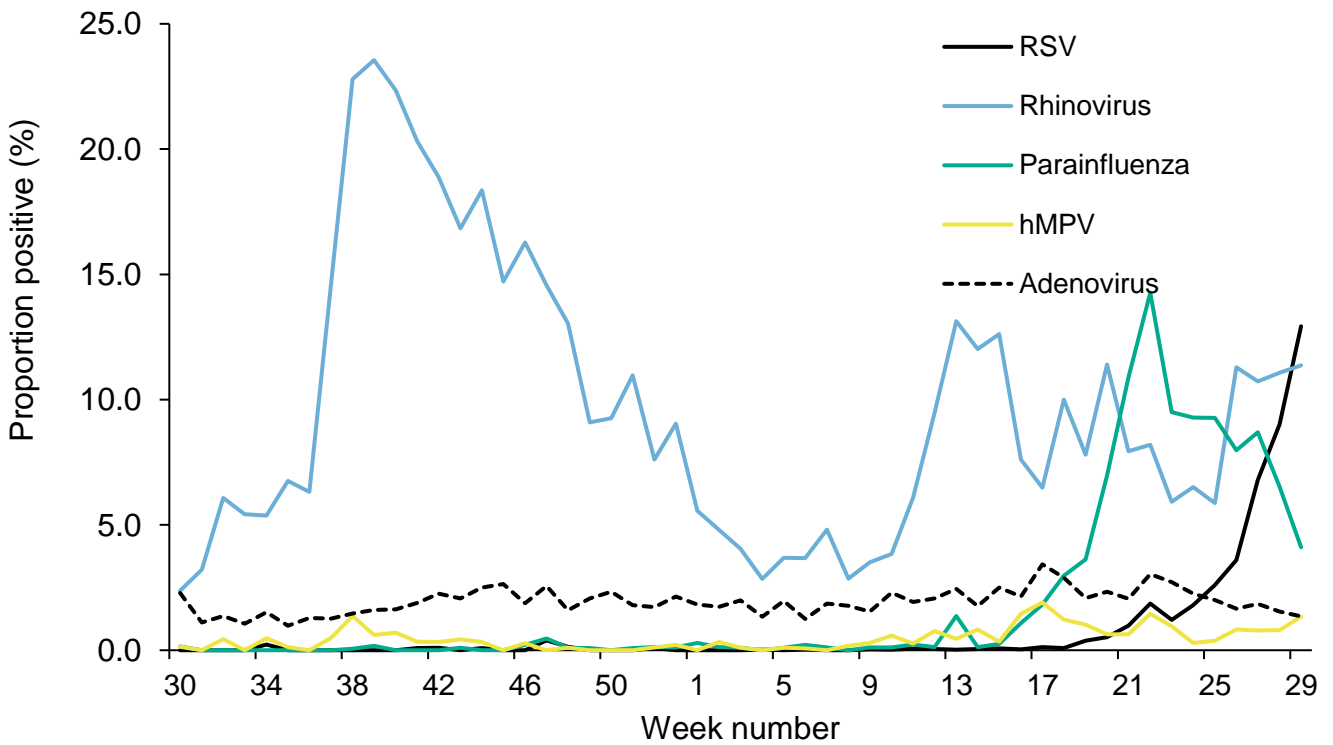
**Figure 14: DataMart samples positive for influenza and weekly positivity (%) for influenza, England**



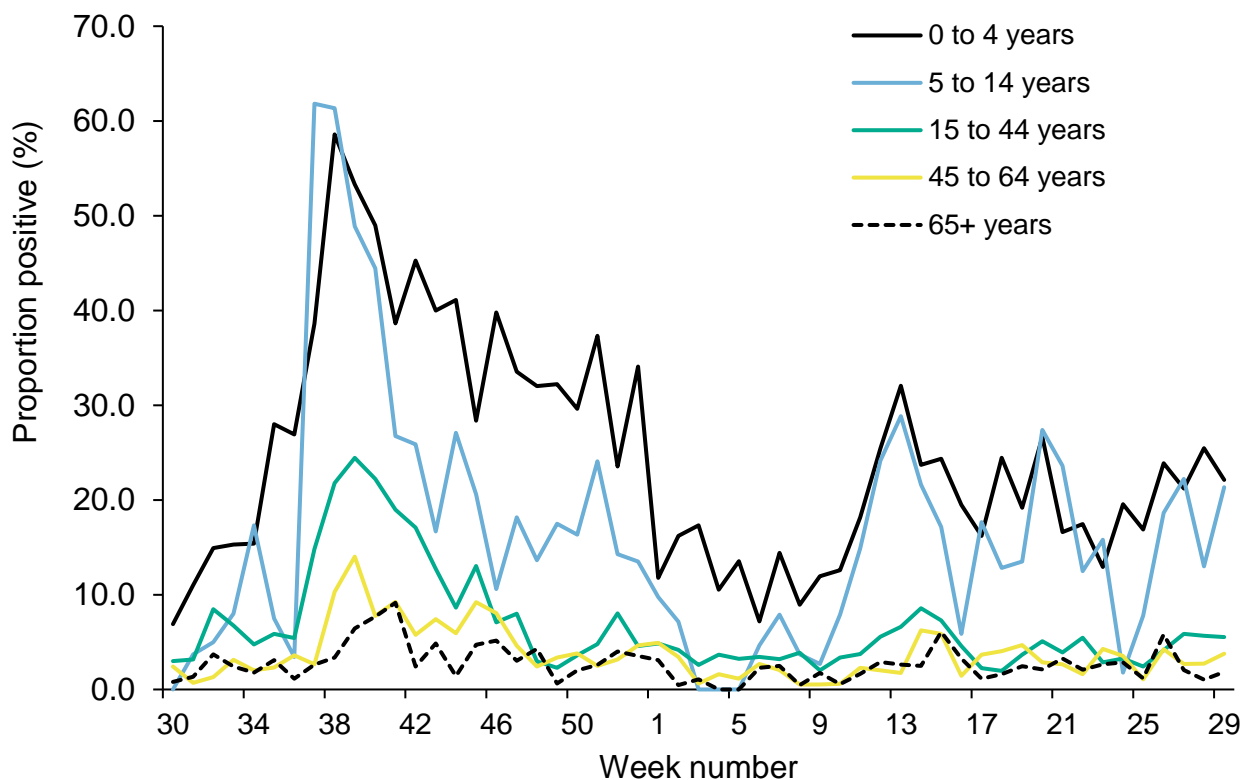
**Figure 15: DataMart weekly positivity (%) for SARS-CoV-2, England**



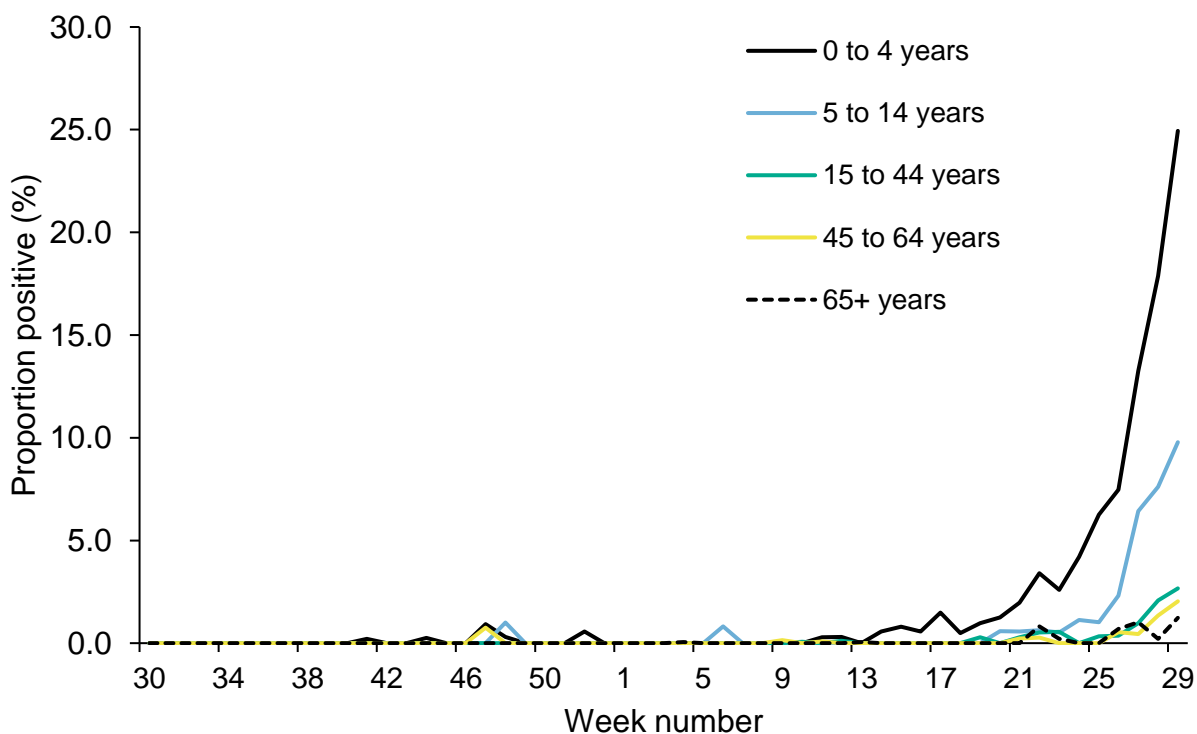
**Figure 16: DataMart weekly positivity (%) for other respiratory viruses, England**



**Figure 17: DataMart weekly positivity (%) for rhinovirus by age, England**



**Figure 18: DataMart weekly positivity (%) for RSV 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 COVID-19 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 COVID-19 (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.

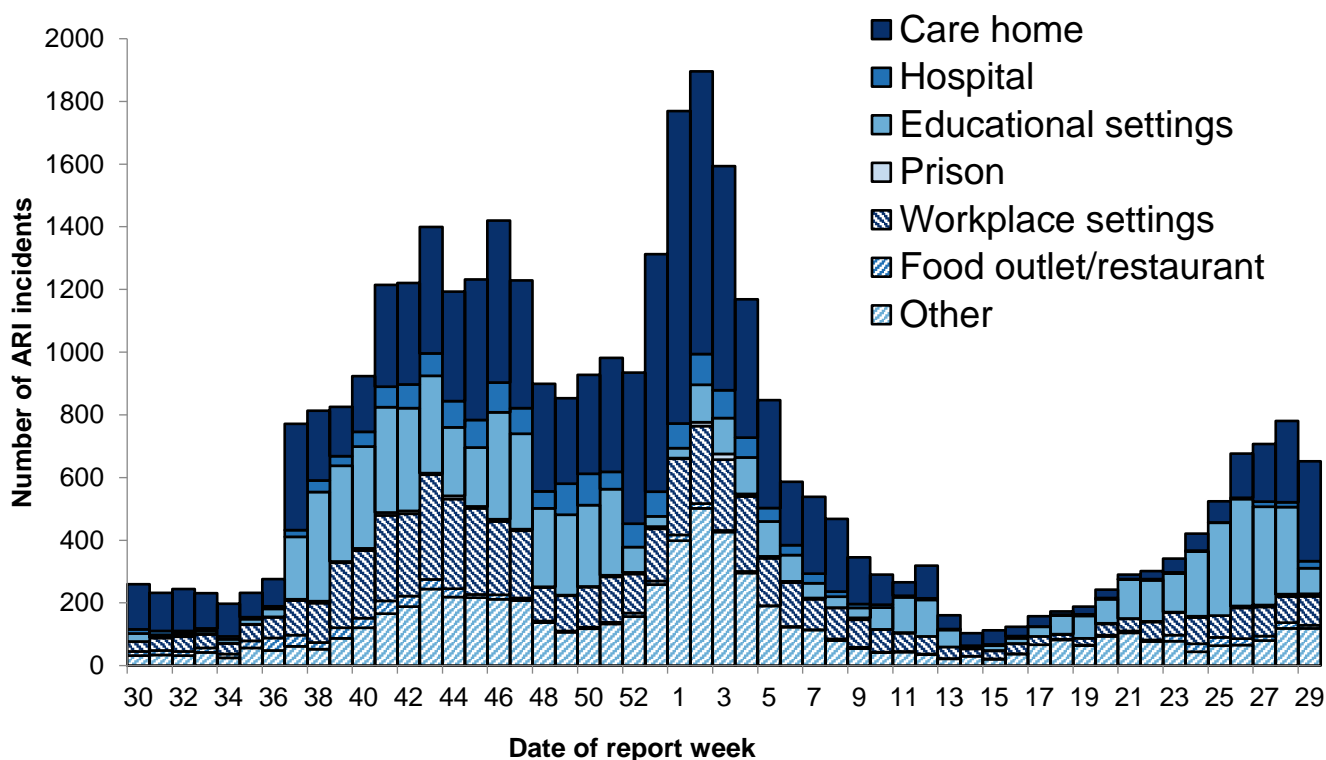
### Data caveats:

1. 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.
2. 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 or outbreaks being reported to HPTs in these settings.
3. 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.
4. In light of the above, comparisons between Regions and settings are not advised as they may be misleading.

652 new ARI incidents have been reported in week 29 in the UK (Figure 19):

- 319 incidents were from care homes where 243 had at least one linked case that tested positive for SARS-CoV-2 where test results were available
- 82 incidents were from educational settings where 51 had at least one linked case that tested positive for SARS-CoV-2
- 22 incidents were from hospitals, where 14 had at least one linked case that tested positive for SARS-CoV-2
- 8 incidents were from prisons, with 6 testing positive for SARS-CoV-2
- 96 incidents were from workplace settings where 56 had at least one linked case that tested positive for SARS-CoV-2
- 10 incidents were from food outlets or restaurants where 7 had at least one linked case testing positive for SARS-CoV-2
- 119 incidents were from other settings where 79 had at least one linked case that tested positive for SARS-CoV-2

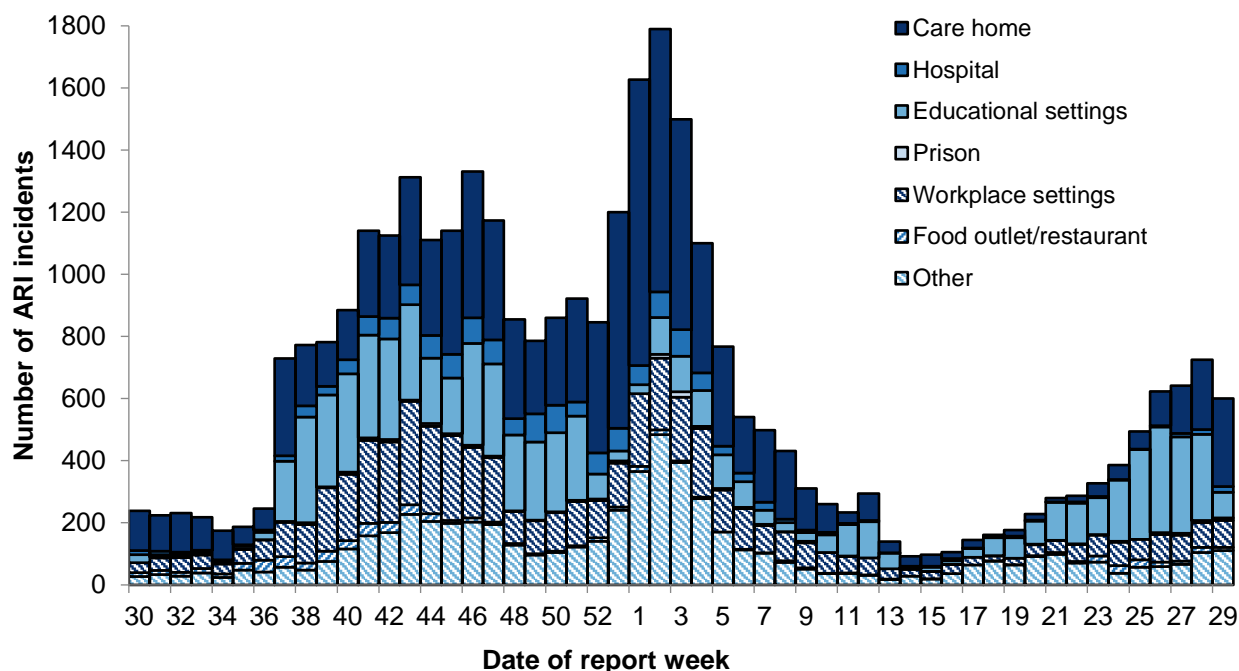
**Figure 19: Number of acute respiratory infection (ARI) incidents by setting, UK**



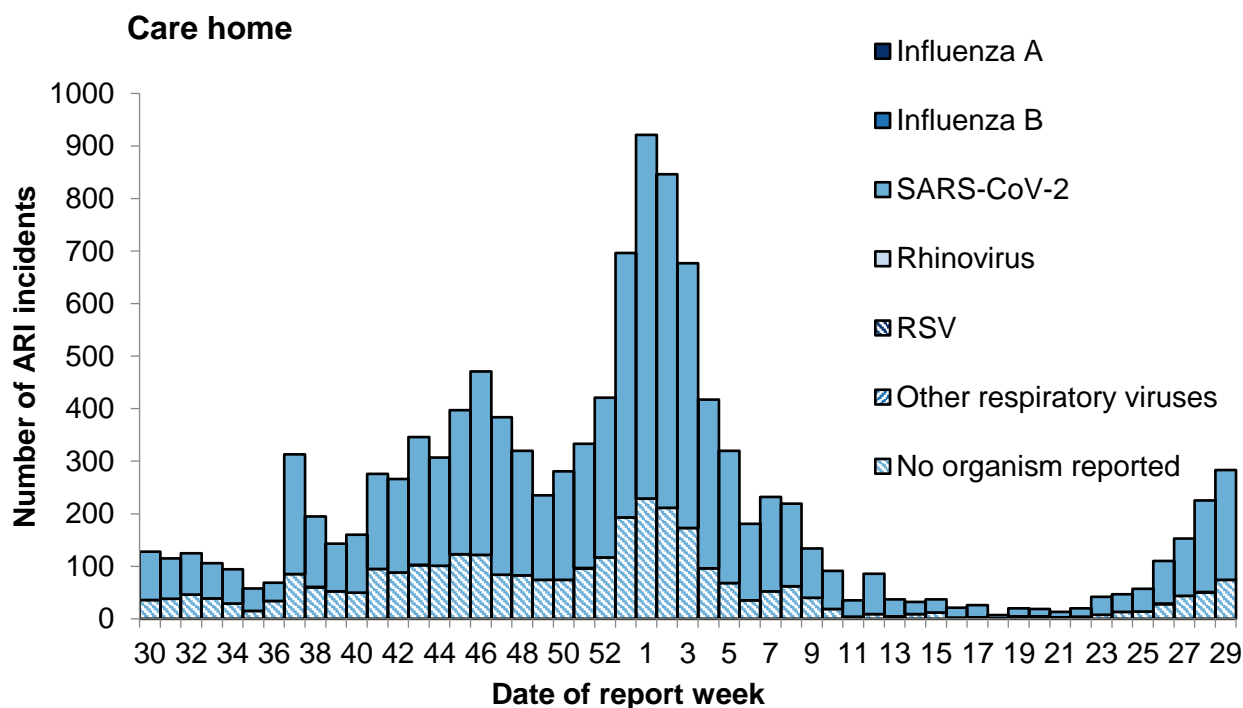
\*excludes data from Wales



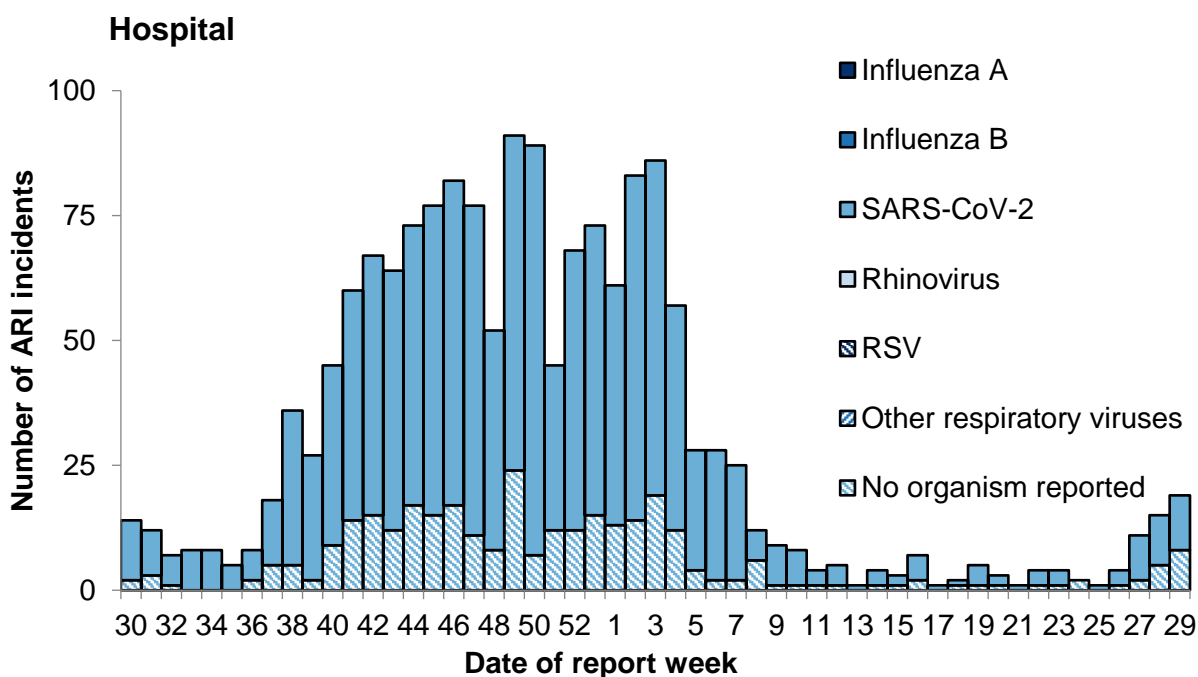
**Figure 20: Number of acute respiratory infection (ARI) incidents by setting, England**



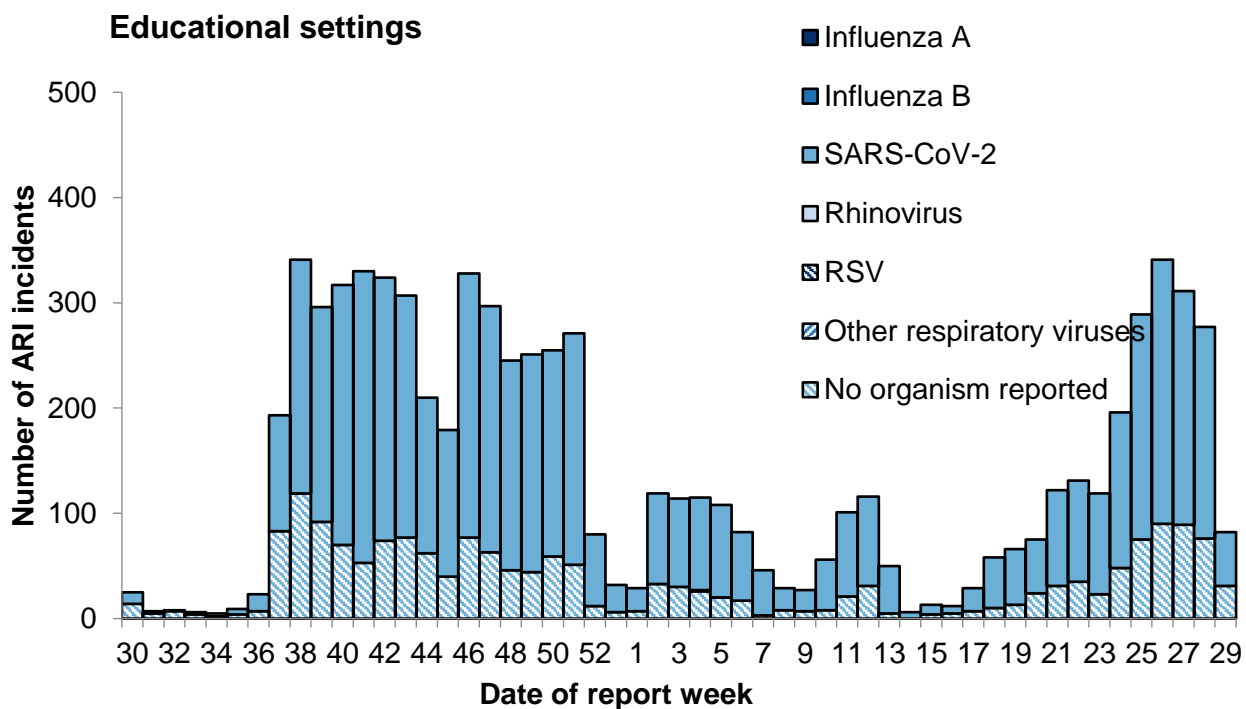
**Figure 21: Number of acute respiratory infection (ARI) incidents in care homes by virus type, England**



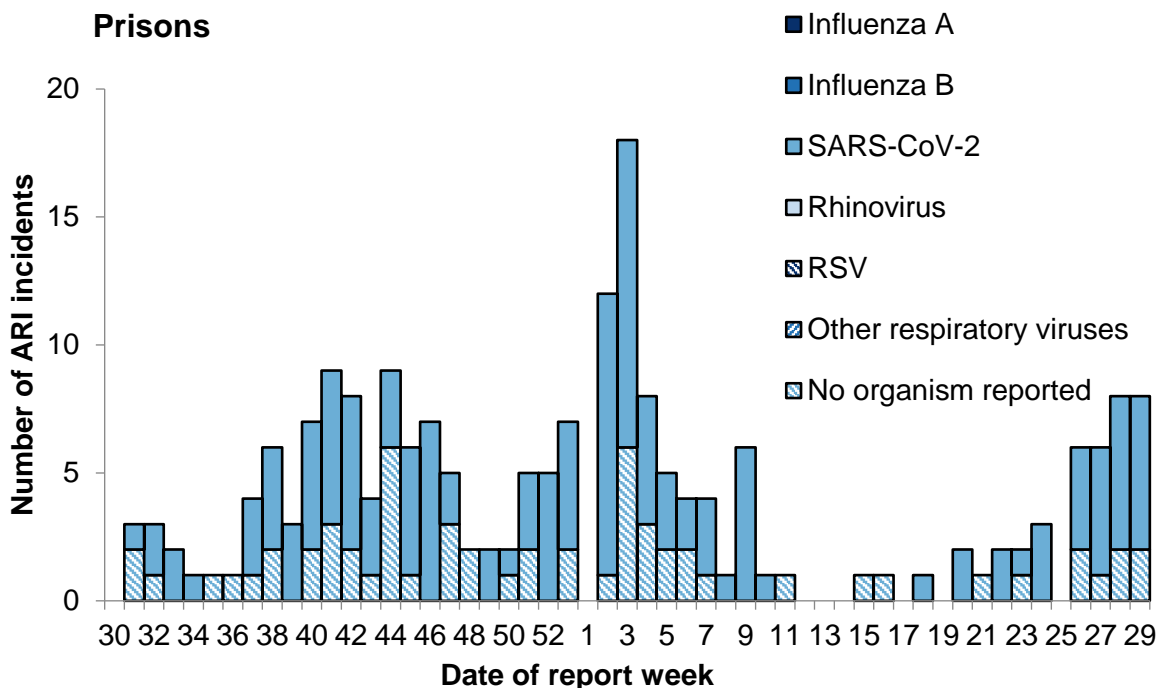
**Figure 22: Number of acute respiratory infection (ARI) incidents in hospitals by virus type, England**



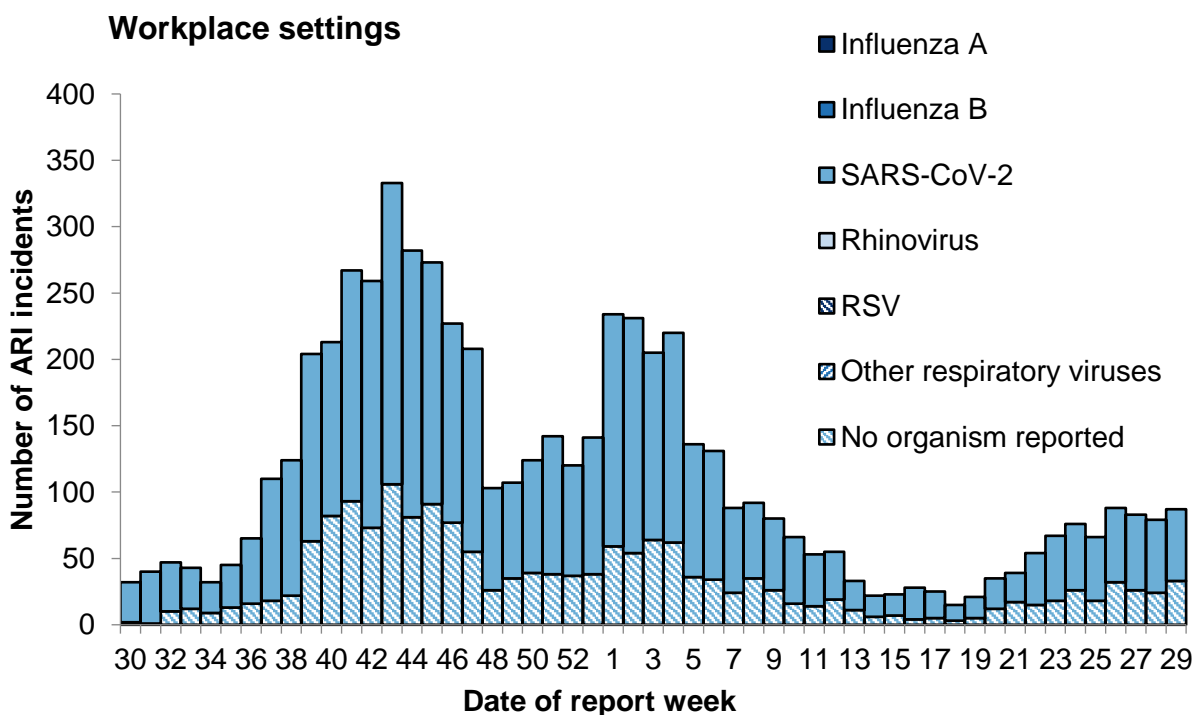
**Figure 23: Number of acute respiratory infection (ARI) incidents in educational settings by virus type, England**



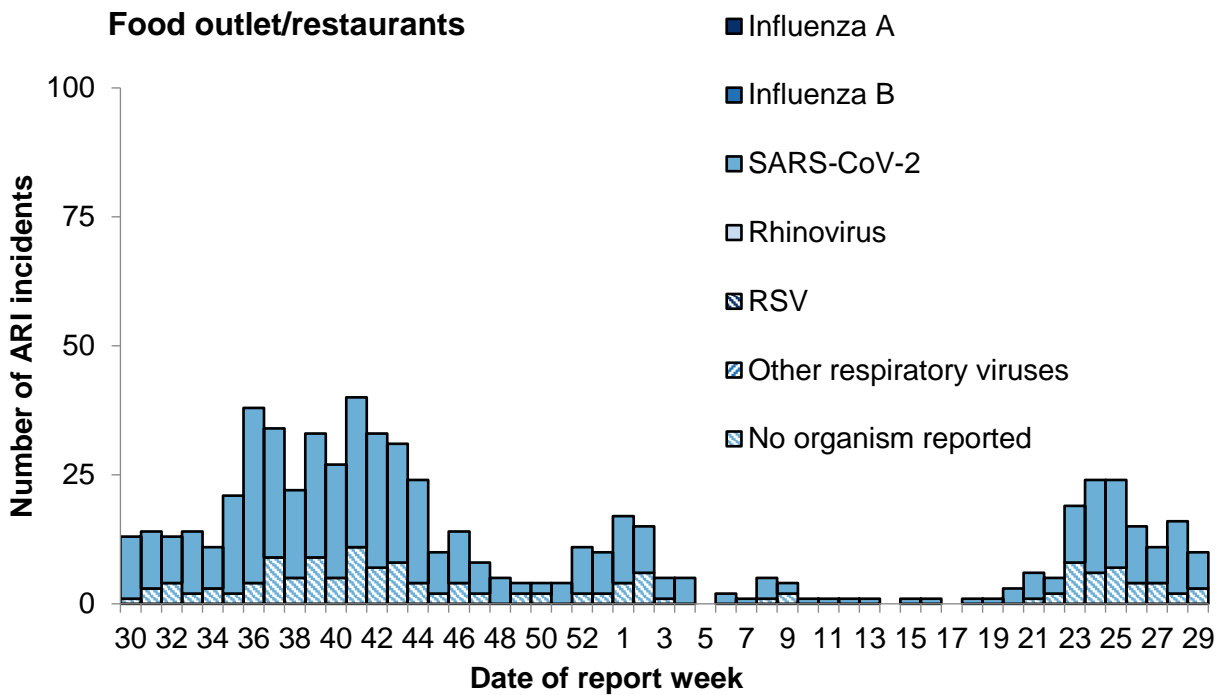
**Figure 24: Number of acute respiratory infection (ARI) incidents in prisons by virus type, England**



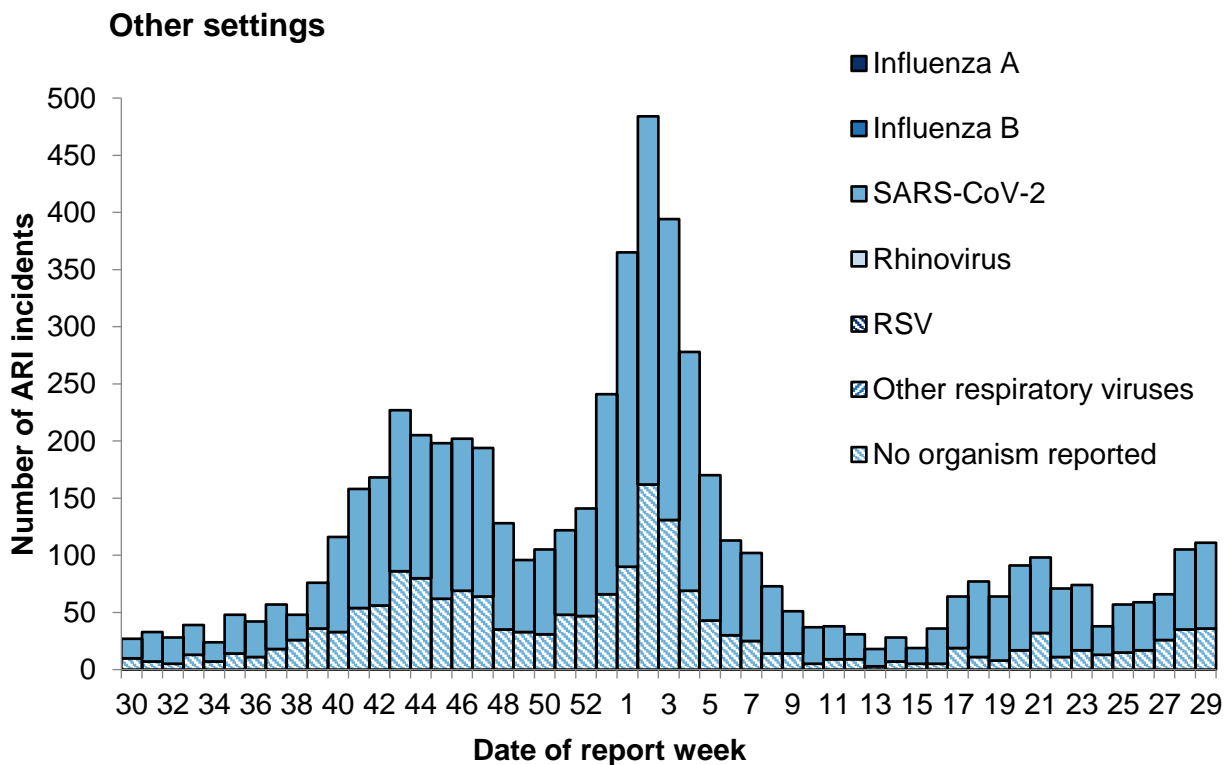
**Figure 25: Number of acute respiratory infection (ARI) incidents in workplace settings by virus type, England**



**Figure 26: Number of acute respiratory infection (ARI) incidents in food outlet or restaurant settings by virus type, England**



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



**Table 2: Total number of situations and 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	48(22)	7(4)	22(1)	3(2)	8(1)	0(0)	29(15)	117(45)
East Midlands	57(24)	7(1)	65(8)	3(2)	24(6)	3(1)	28(7)	187(49)
London	41(17)	13(5)	253(25)	2(0)	23(6)	4(1)	34(12)	370(66)
North East	141(47)	0(0)	0(0)	3(1)	0(0)	0(0)	26(8)	170(56)
North West	52(16)	4(1)	44(4)	0(0)	167(62)	17(3)	63(24)	347(110)
South East	97(38)	4(2)	274(6)	6(0)	26(4)	12(5)	41(12)	460(87)
South West	209(76)	0(0)	147(4)	0(0)	31(1)	4(0)	45(13)	436(94)
West Midlands	33(11)	9(3)	70(3)	7(3)	27(5)	8(0)	29(7)	183(32)
Yorkshire and Humber	93(32)	5(3)	136(11)	4(0)	31(2)	4(0)	46(13)	319(61)
<b>Total</b>	<b>771(283)</b>	<b>49(19)</b>	<b>1011(82)</b>	<b>28(8)</b>	<b>337(87)</b>	<b>52(10)</b>	<b>341(111)</b>	<b>2589(600)</b>

## 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 29, the highest percentage of confirmed COVID-19 cases by type of residence was seen in residential dwellings (Table 3).

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

Type of residence	Week 24	Week 25	Week 26	Week 27	Week 28	Week 29
Residential dwelling (including houses, flats, sheltered accommodation)	91.0	91.7	92.5	93.4	93.3	93.3
Undetermined	2.9	2.6	2.4	2.2	2.9	3.0
Care/Nursing home	0.3	0.2	0.3	0.3	0.2	0.3
Residential institution (including residential education)	1.5	1.2	0.9	0.4	0.3	0.2
Other property classifications	1.0	1.0	0.8	0.8	0.7	0.6
House in multiple occupancy (HMO)	1.8	1.6	1.0	0.6	0.4	0.5
Medical facilities (including hospitals and hospices, and mental health)	1.5	1.7	2.0	2.3	2.2	2.0
Prisons, detention centres, secure units	0.1	0.0	0.1	0.1	0.1	0.1
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

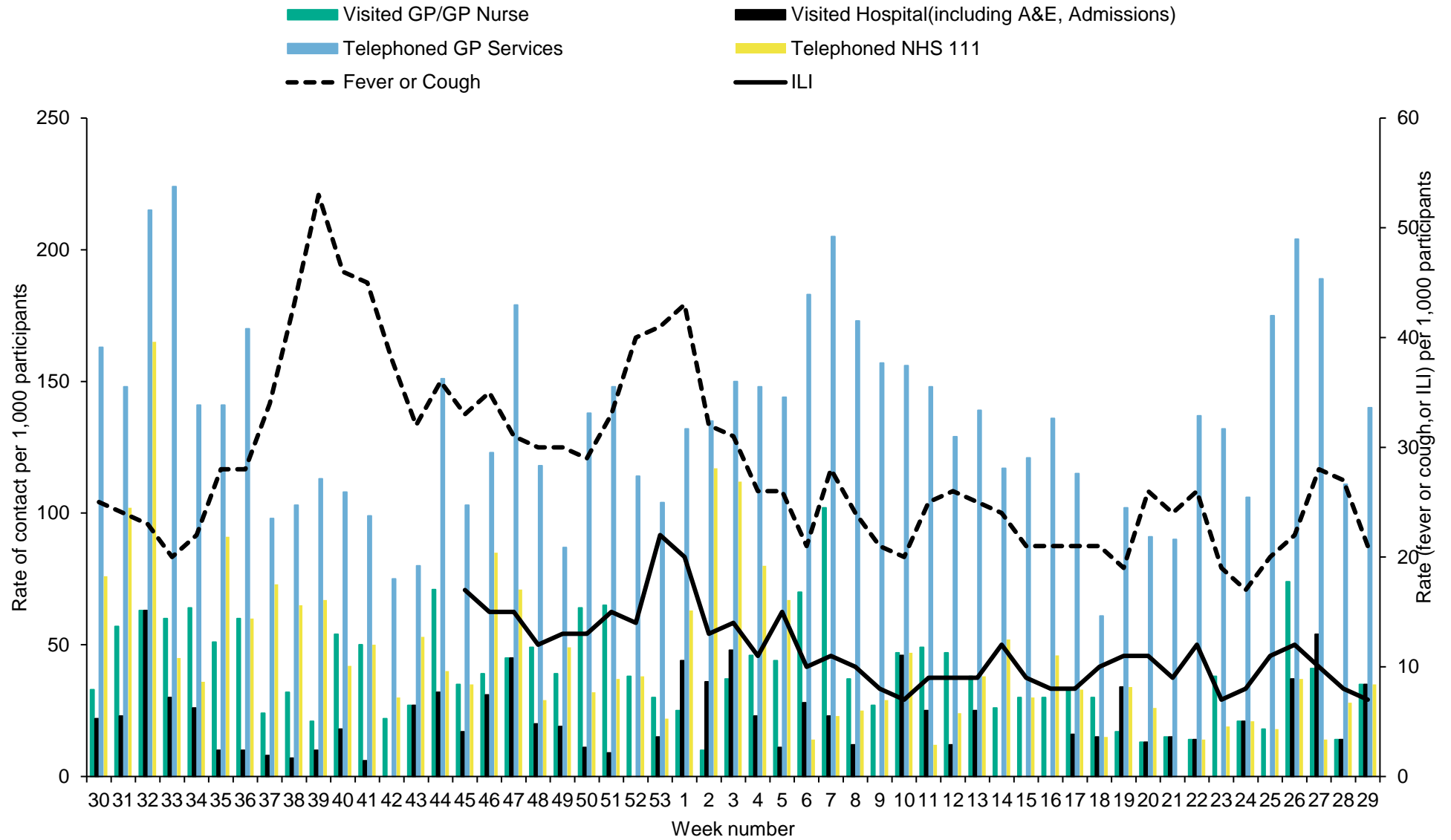
## FluSurvey

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 2,775 participants completed the weekly surveillance survey in week 29, of which 57 (2.1%) reported fever or cough and 19 (0.7%) reported influenza-like illness (ILI). The most commonly used healthcare services reported by respondents remains telephoning a GP practice (Figure 28).

**Figure 28: FluSurvey participants self-reporting fever or cough and ILI symptoms, and trends in healthcare seeking behaviour among these participants, England**



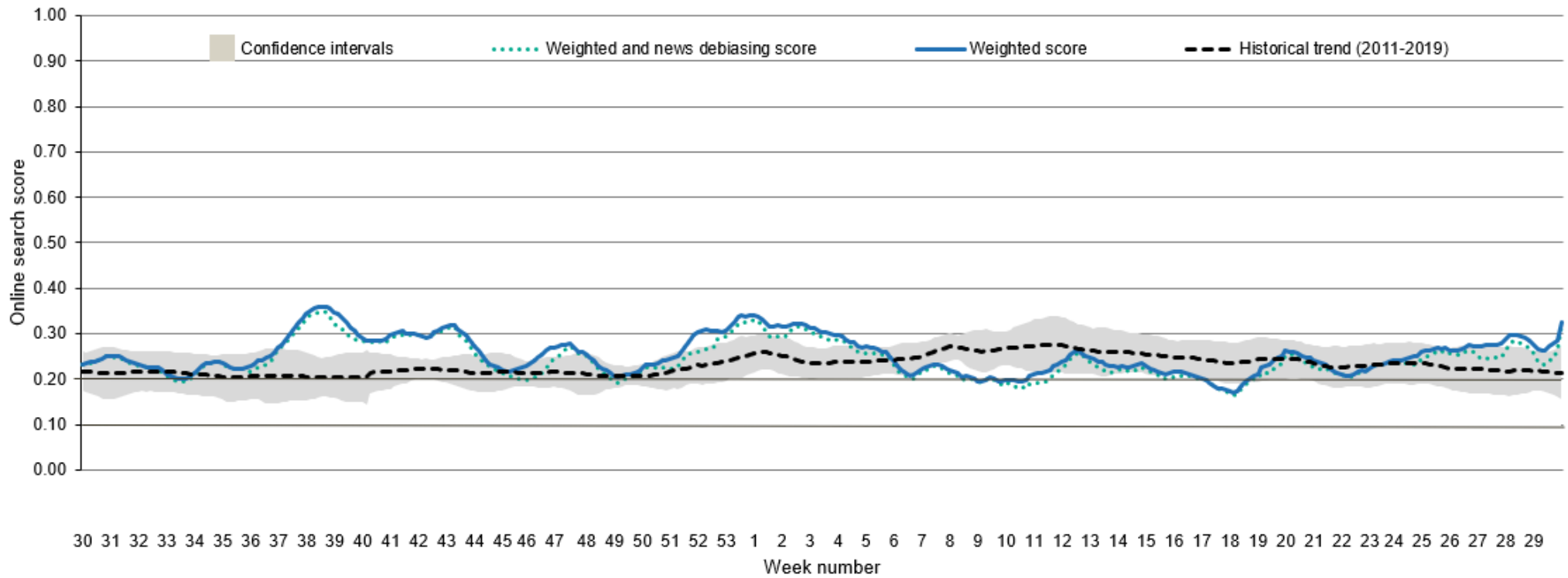


## Google search queries

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](#).

During week 29, the overall and media-debiasing weighted Google search scores increased (Figure 29).

**Figure 29: Normalised Google search score for COVID-19 symptoms, with weighted score for media-debiasing and historical trend, England**



## NHS 111

Please note that different syndromic surveillance indicators (NHS 111, GP in hours, GP out of hours and emergency department attendances) are presented here than have been included in previous versions of this report. All indicators previously presented will continue to be published in the [PHE Syndromic Surveillance bulletins](#).

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 25 July, NHS 111 calls for cold/flu decreased, and calls for cough remained stable although above seasonally expected levels (Figure 30 and 31).

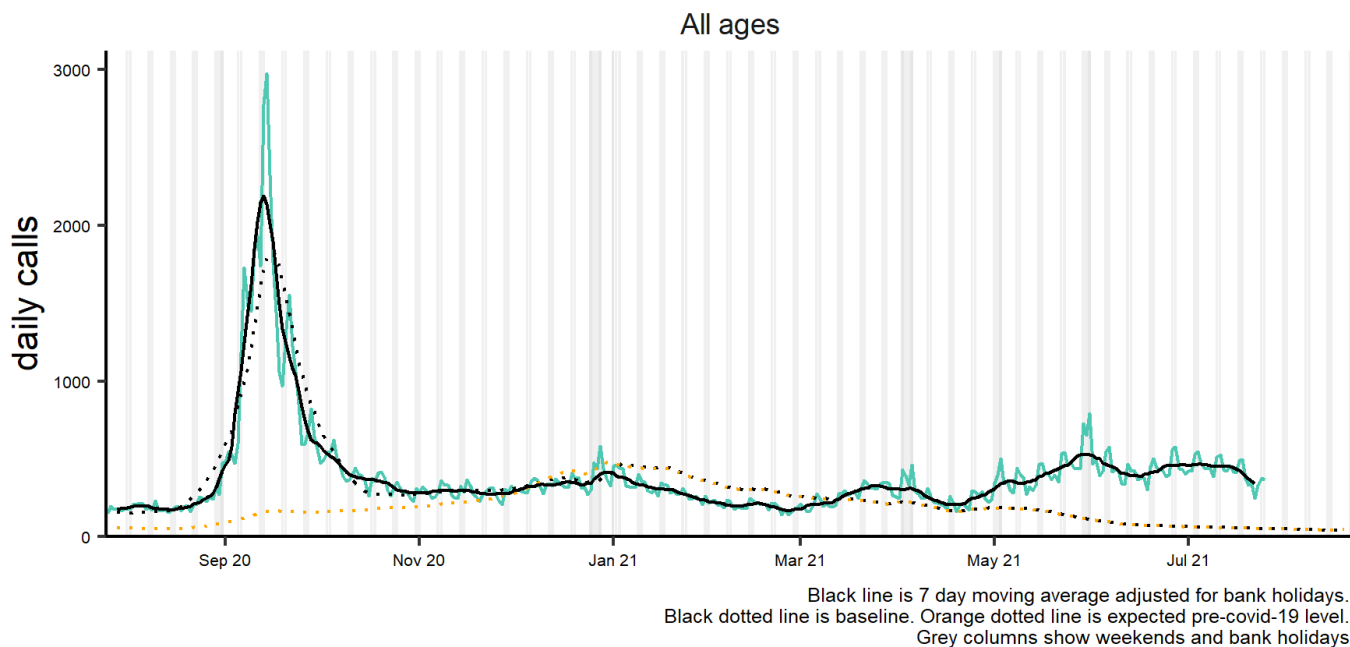
Please note that NHS 111 callers (from 11 May 2020) who are assessed as having probable COVID-19 symptoms are now triaged using symptom specific pathways such as cold or flu, which are included in routine syndromic indicators.

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

**Figure 30: NHS 111 telephony indicators (and 7-day moving average) for number of daily cold/flu calls, England (a) nationally and (b) by age group**

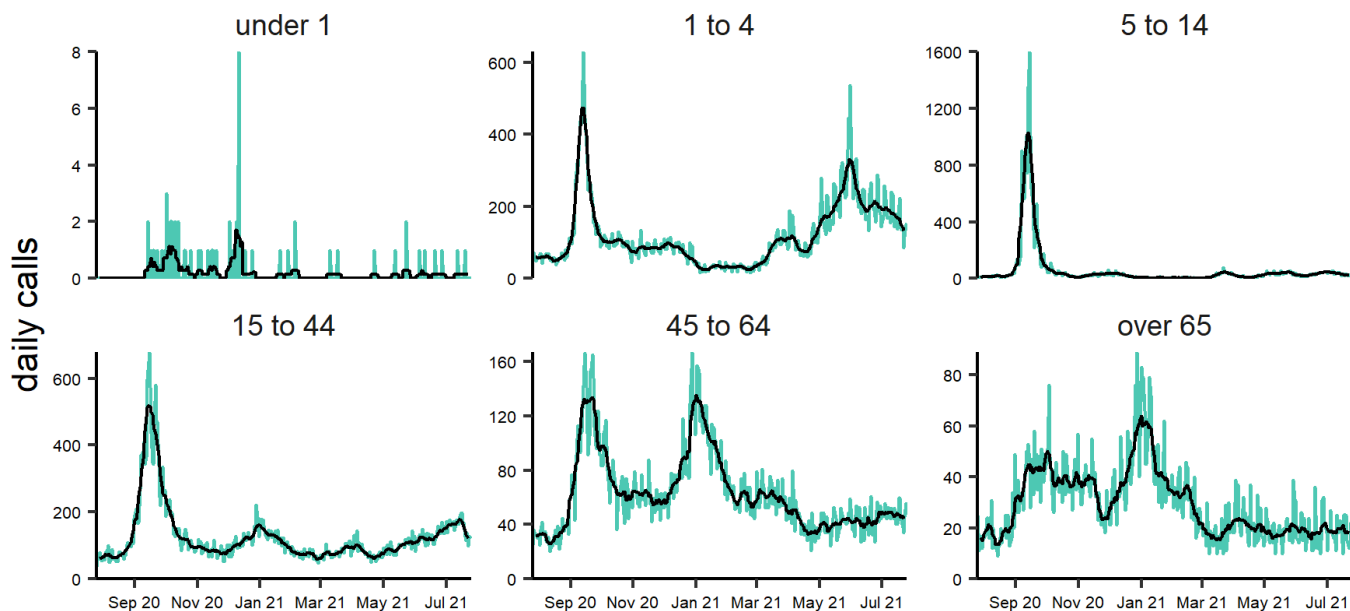
(a)

Cold or flu 26/07/2020 - 25/07/2021



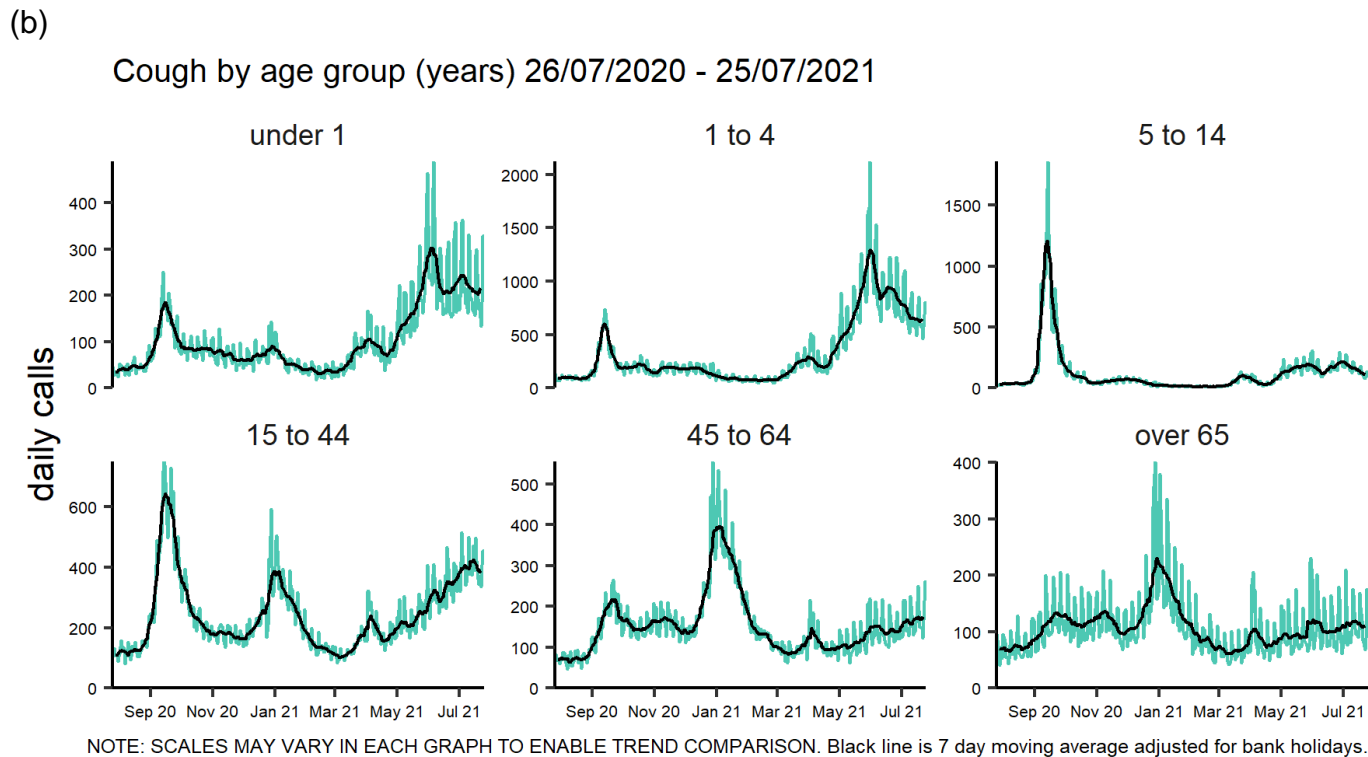
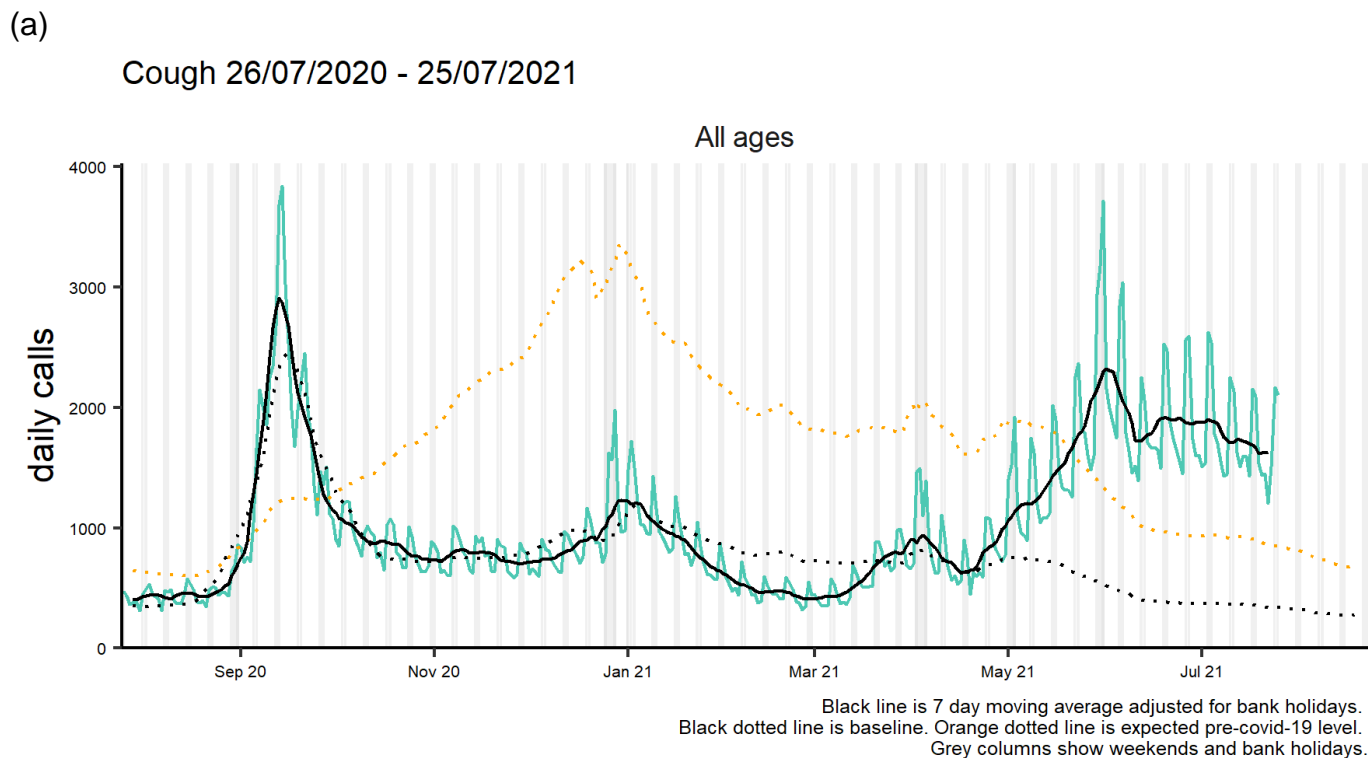
(b)

Cold or flu by age group (years) 26/07/2020 - 25/07/2021



NOTE: SCALES MAY VARY IN EACH GRAPH TO ENABLE TREND COMPARISON. Black line is 7 day moving average adjusted for bank holidays.

**Figure 31: NHS 111 telephony indicators (and 7-day moving average) for number of daily cough calls, England (a) nationally and (b) by age group**

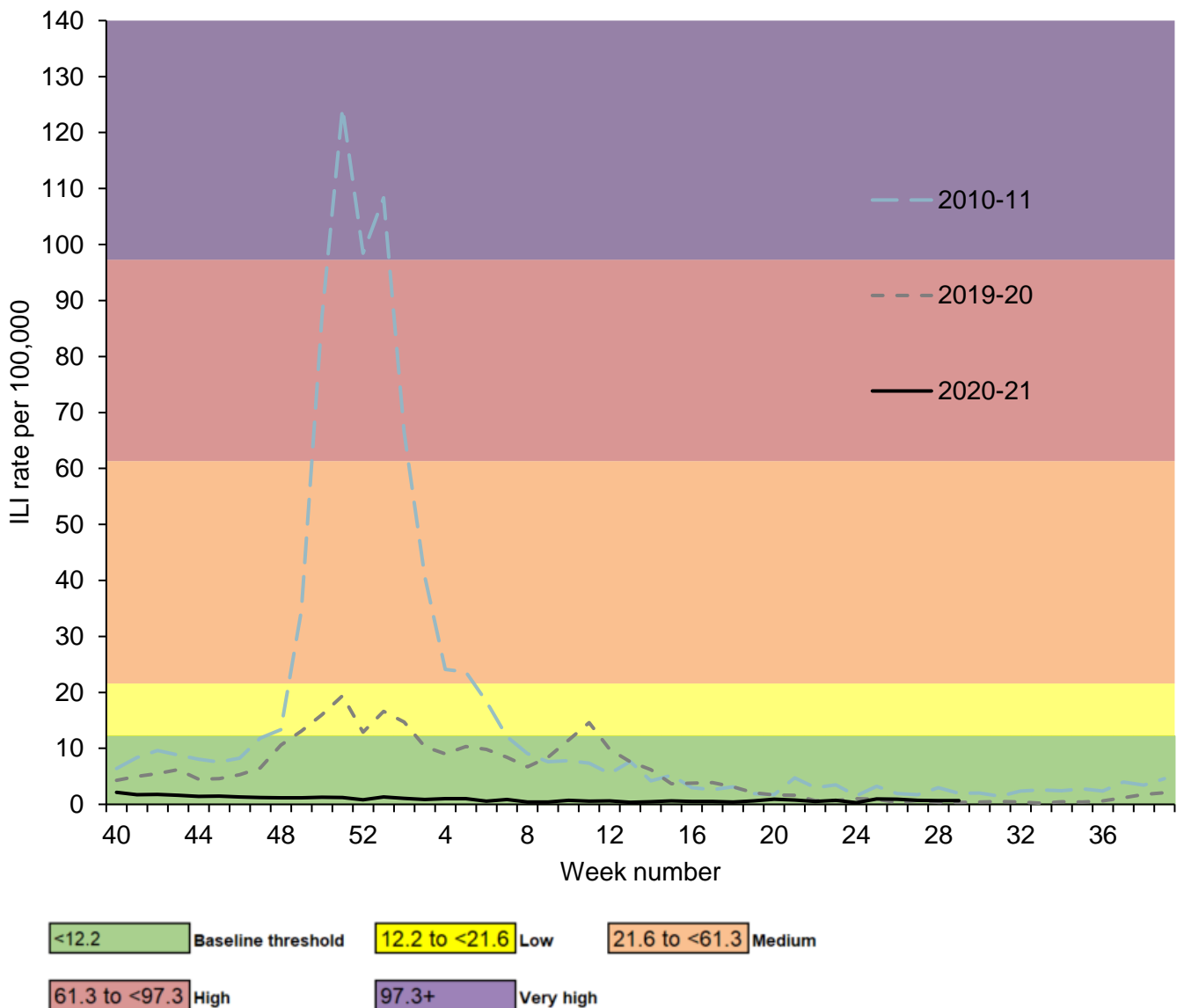


# Primary care surveillance

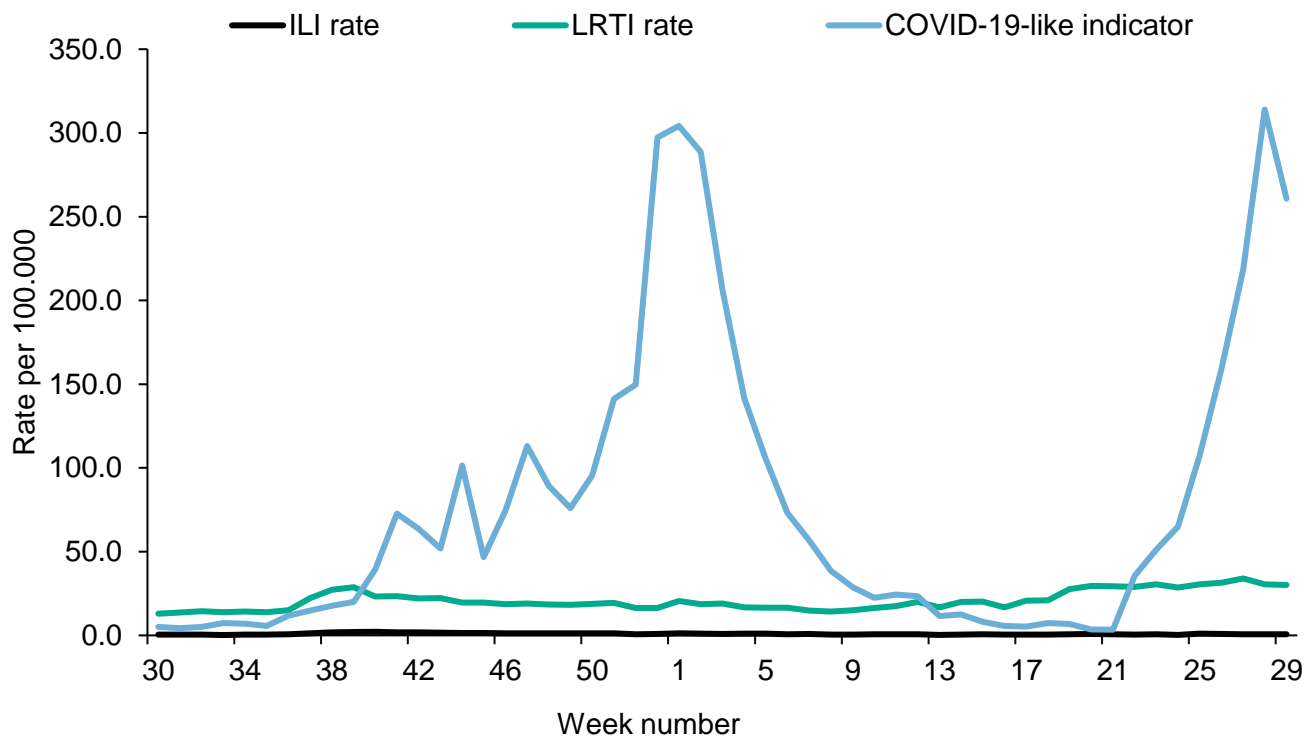
## RCGP (England)

The weekly ILI consultation rate through the RCGP surveillance was 0.7 per 100,000 registered population in participating GP practices in week 29 compared to 0.7 per 100,000 in the previous week. This is below the baseline threshold (12.2 per 100,000) (Figure 32). By age group, the highest rates were seen in the 1 to 4-year olds (1.3 per 100,000). The Lower Respiratory Tract Infections (LRTI) consultation rate was at 30.1 per 100,000 in week 29, compared to the rate of 30.5 per 100,000 in the previous week. The COVID-19-like indicator consultation rate was at 260.9 per 100,000 in week 29 compared to a rate of 313.9 per 100,000 in the previous week (Figure 33).

**Figure 32: RCGP ILI consultation rates, all ages, England**



**Figure 33: RCGP ILI, LRTI and COVID-19-like indicator consultation rates, England**



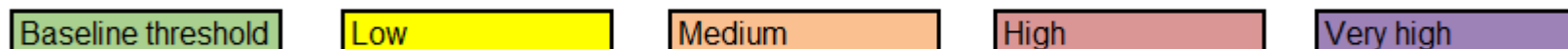
## UK

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 15 to 44 and 45 to 64-year olds in Northern Ireland (1.2 per 100,000), the 75 years and over in Wales (2.9 per 100,000) and the 65 to 74-year olds in Scotland (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																			
	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29
England (RCGP)	0.7	0.6	0.6	0.3	0.5	0.6	0.5	0.5	0.4	0.6	0.9	0.7	0.5	0.7	0.3	1.0	0.9	0.7	0.7	0.7
Wales	0.5	0.0	1.0	0.5	0.5	0.5	0.0	0.0	0.3	0.8	0.5	0.0	0.5	0.7	0.3	0.3	0.3	0.5	1.5	0.9
Scotland	0.2	0.3	0.4	0.4	0.3	0.3	0.2	0.2	0.2	0.3	0.2	0.2	0.3	0.2	0.5	0.4	0.5	0.4	0.3	0.5
Northern Ireland	0.7	0.6	0.6	0.4	0.3	0.8	0.4	0.7	0.1	0.5	0.5	0.4	0.4	0.6	0.6	0.6	1.0	0.9	0.9	0.8



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 to 2010), in a standardised approach across Europe. For MEM threshold values for each country, please visit the PHE webpage [Sources of UK flu data: influenza surveillance in the UK](#).



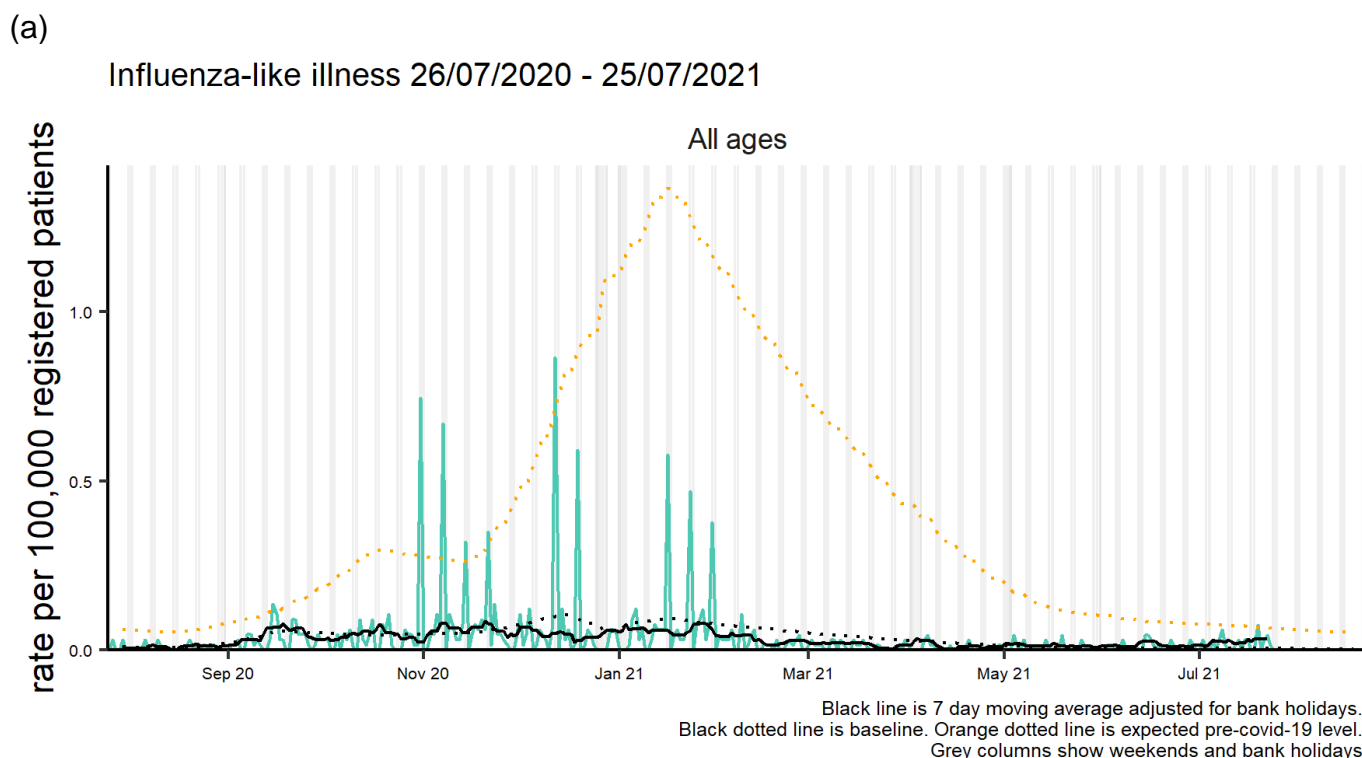
## GP In Hours, Syndromic Surveillance

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

Up to 25 July GP in-hours consultations for influenza-like illness remained stable (Figure 34).

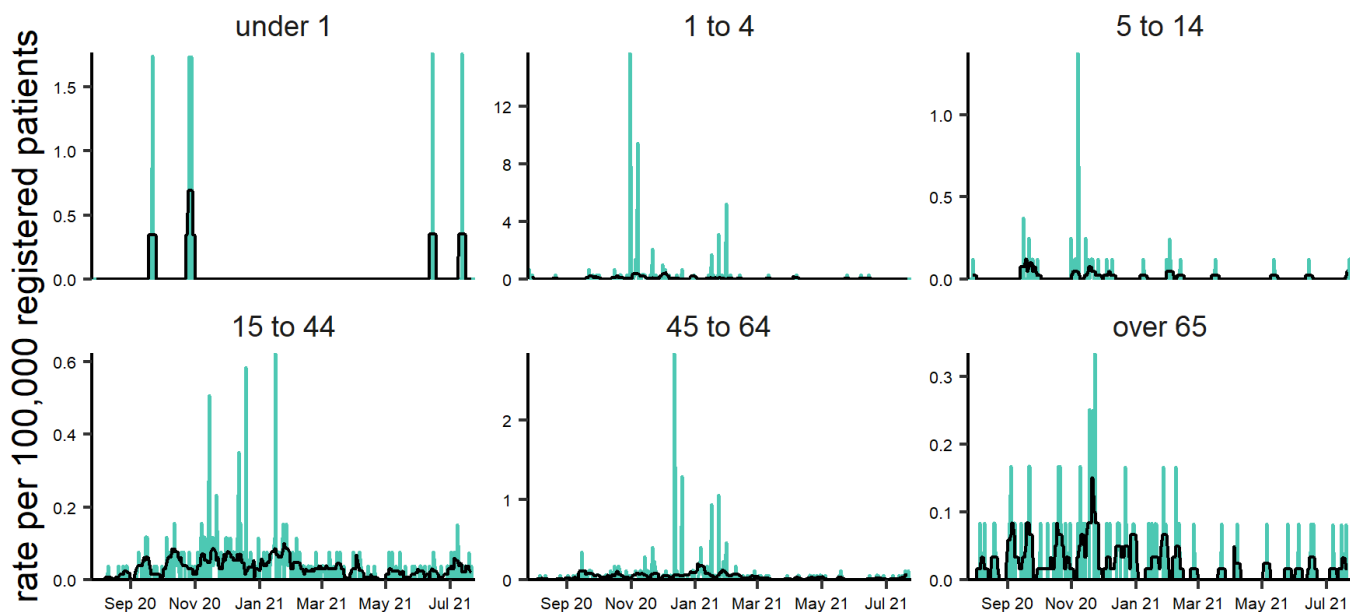
Further indicators and information about caveats are available from the [PHE GP In Hours Syndromic Surveillance bulletin](#).

**Figure 34: GPIH clinical indicators for influenza-like illness GP consultations, England (a) nationally, (b) by age group and (c) by PHE Centre**



(b)

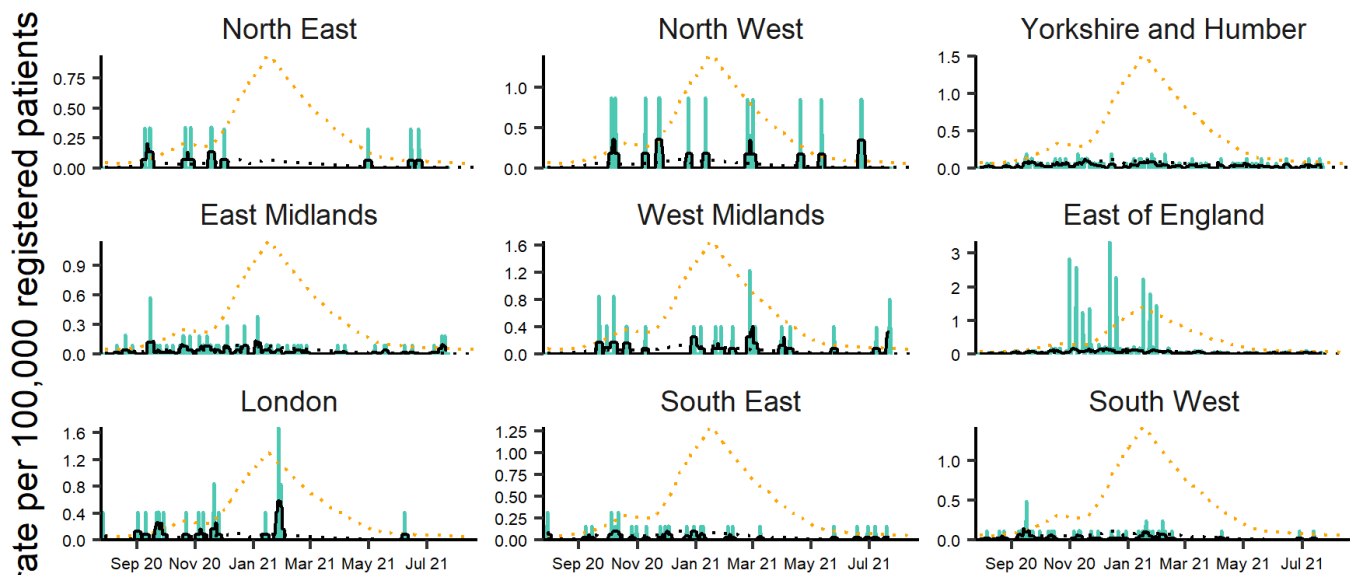
Influenza-like illness by age group (years) 26/07/2020 - 25/07/2021



NOTE: SCALES MAY VARY IN EACH GRAPH TO ENABLE TREND COMPARISON. Black line is 7 day moving average adjusted for bank holidays.

(c)

Influenza-like illness by PHE centre 26/07/2020 - 25/07/2021



NOTE: SCALES MAY VARY IN EACH GRAPH TO ENABLE TREND COMPARISON. Black line is 7 day moving average adjusted for bank holidays. Black dotted line is baseline. Orange dotted line is expected pre-covid-19 level.

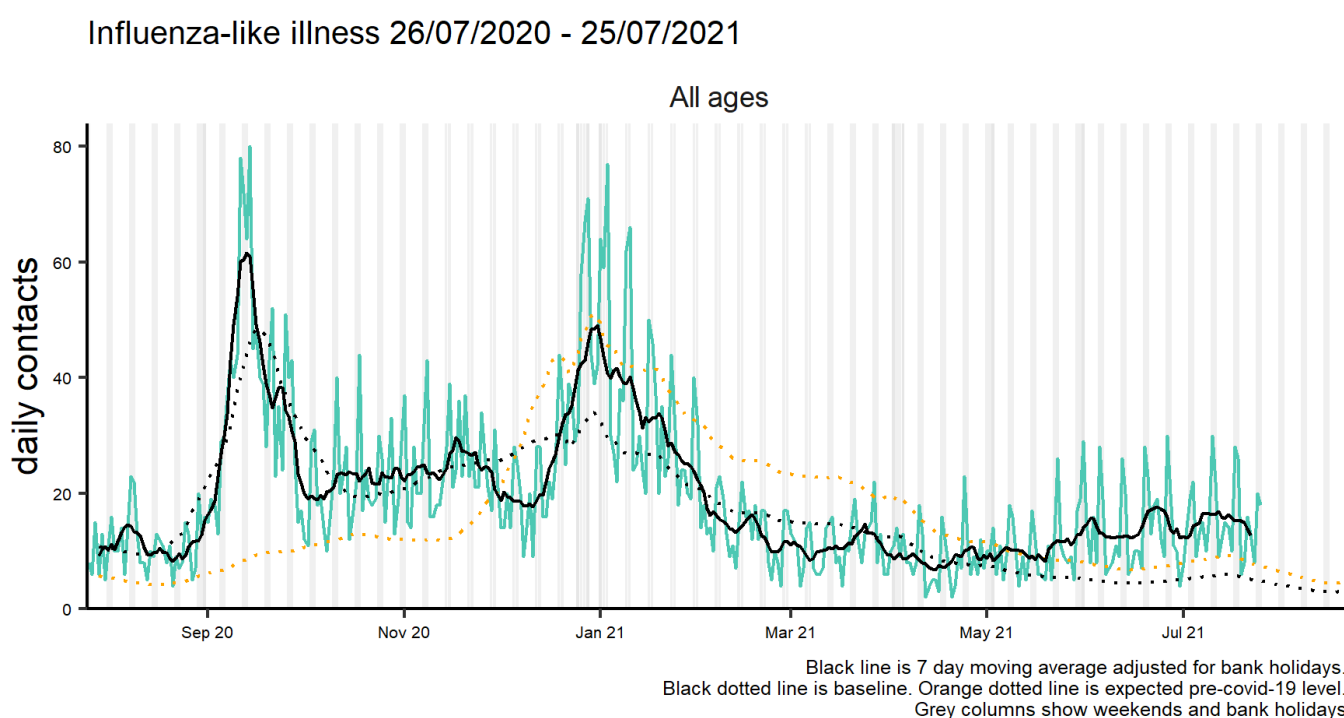
GPIH Baselines are modelled from historical data to give current seasonally expected levels. GP consultations rates decreased during 2020 due to changes in guidance on accessing health care, therefore separate modelled estimates are provided to show seasonally expected levels pre-covid-19.

## GP Out of Hours, Syndromic Surveillance

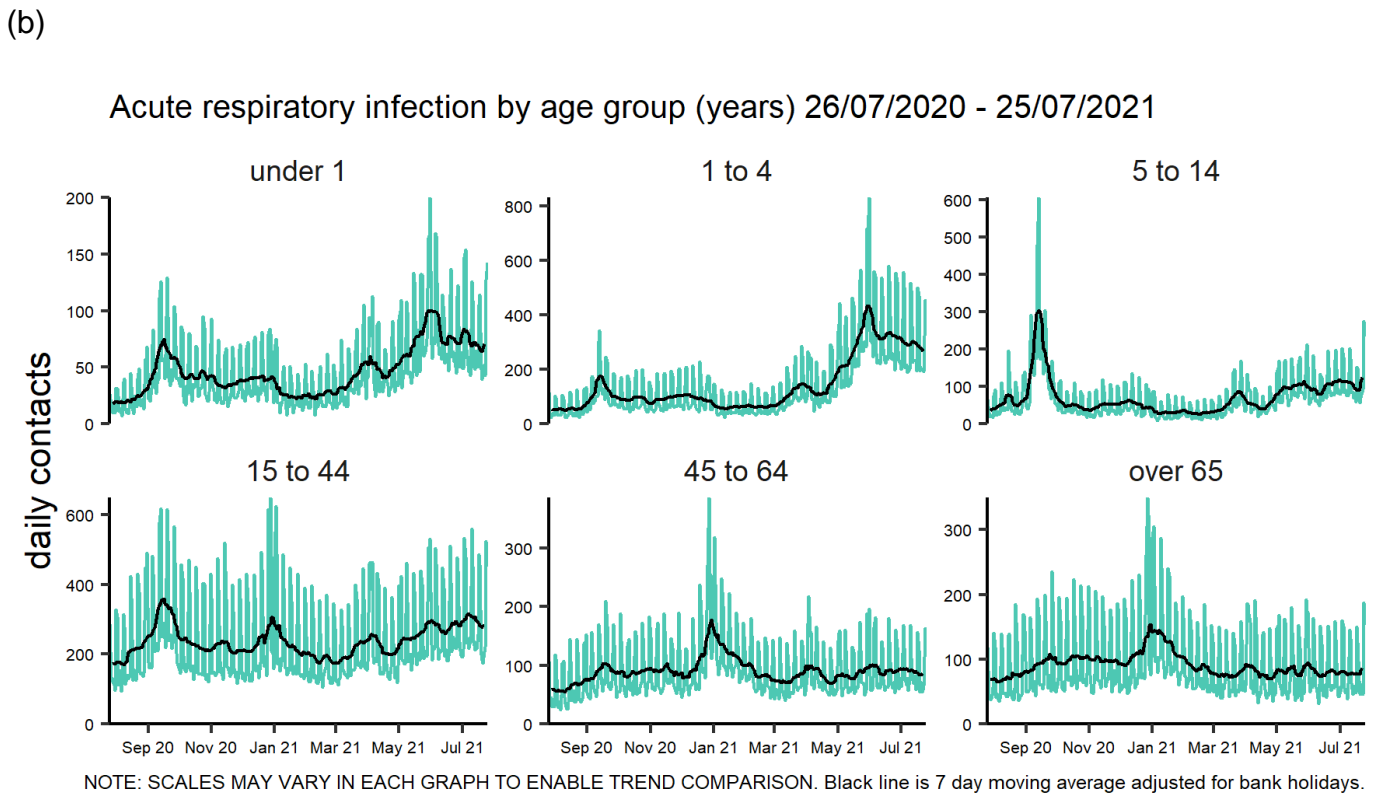
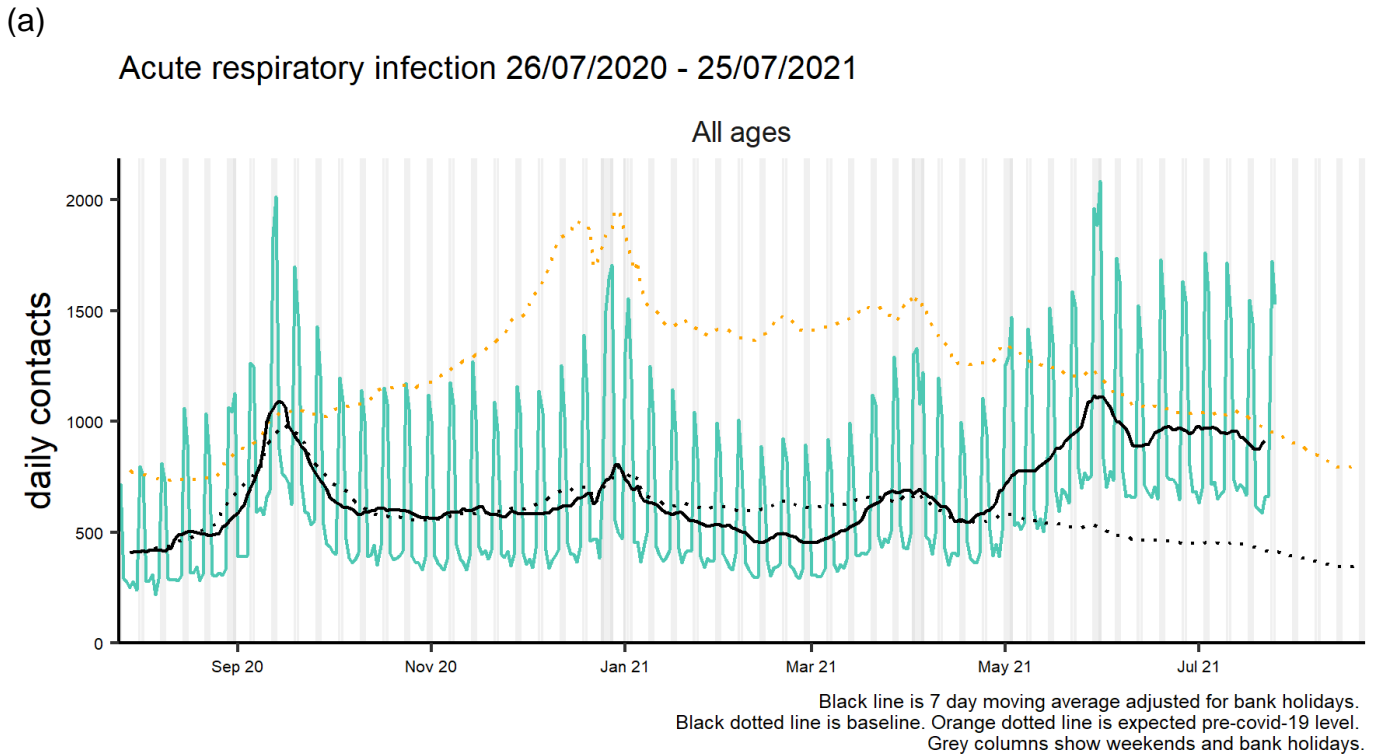
The GP Out of Hours (GPOOH) syndromic surveillance system monitors the numbers of daily unscheduled visits and calls to GPs during evenings, overnight, on weekends and on public holidays. This system covers around 55% of England's out of hour activity.

Up to 25 July, GP out-of-hours and unscheduled care consultations for acute respiratory infections remained stable, and for influenza-like illness decreased (Figure 35 and 36).

**Figure 35: GPOOH number of daily contacts for all ages for influenza-like illness, England**



**Figure 36: GPOH number of daily contacts for acute respiratory infections, England (a) nationally and (b) by age group**

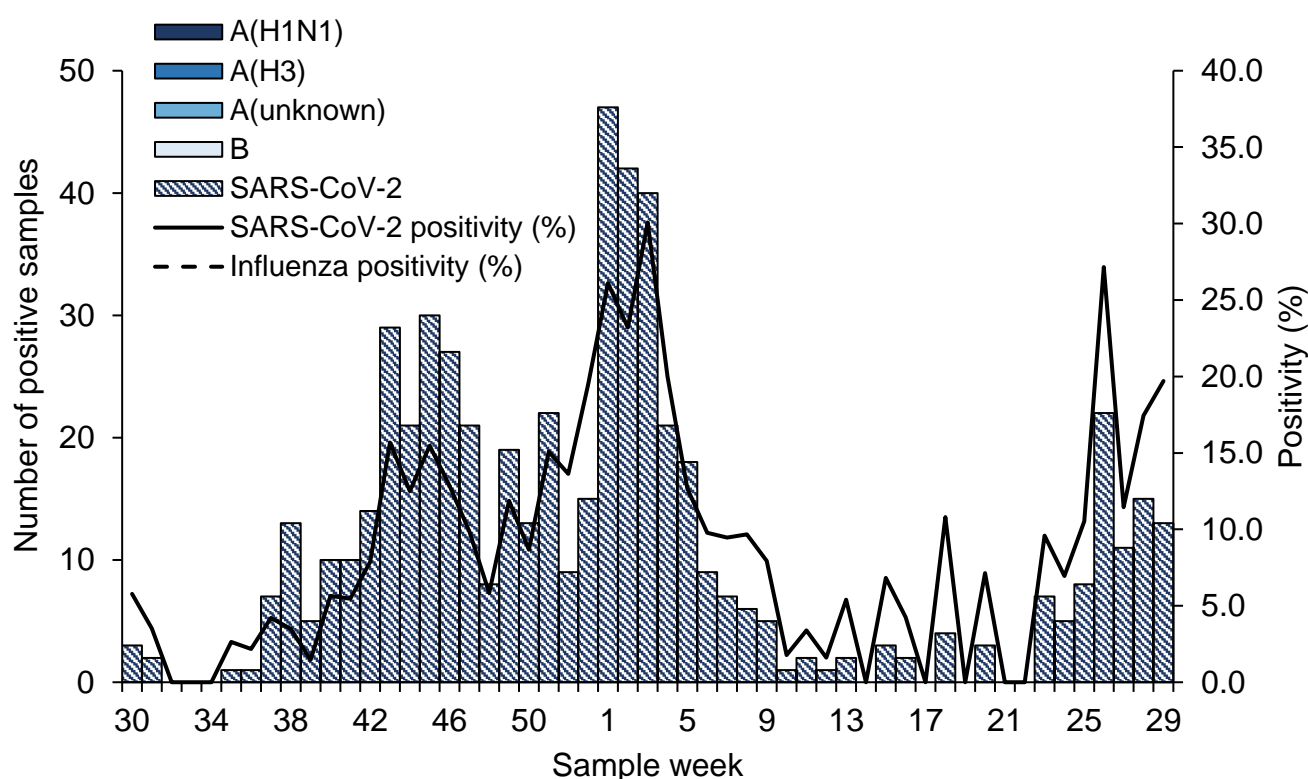


## Sentinel swabbing scheme in the UK

In week 29 2021, 13 samples tested positive for SARS-CoV-2 with an overall positivity of 19.7% (13 out of 66) compared to 17.4% (15 out of 86) in the previous week, through the UK GP sentinel swabbing schemes (Figure 37).

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

**Figure 37: 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 37 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 and 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, influenza and RSV 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.

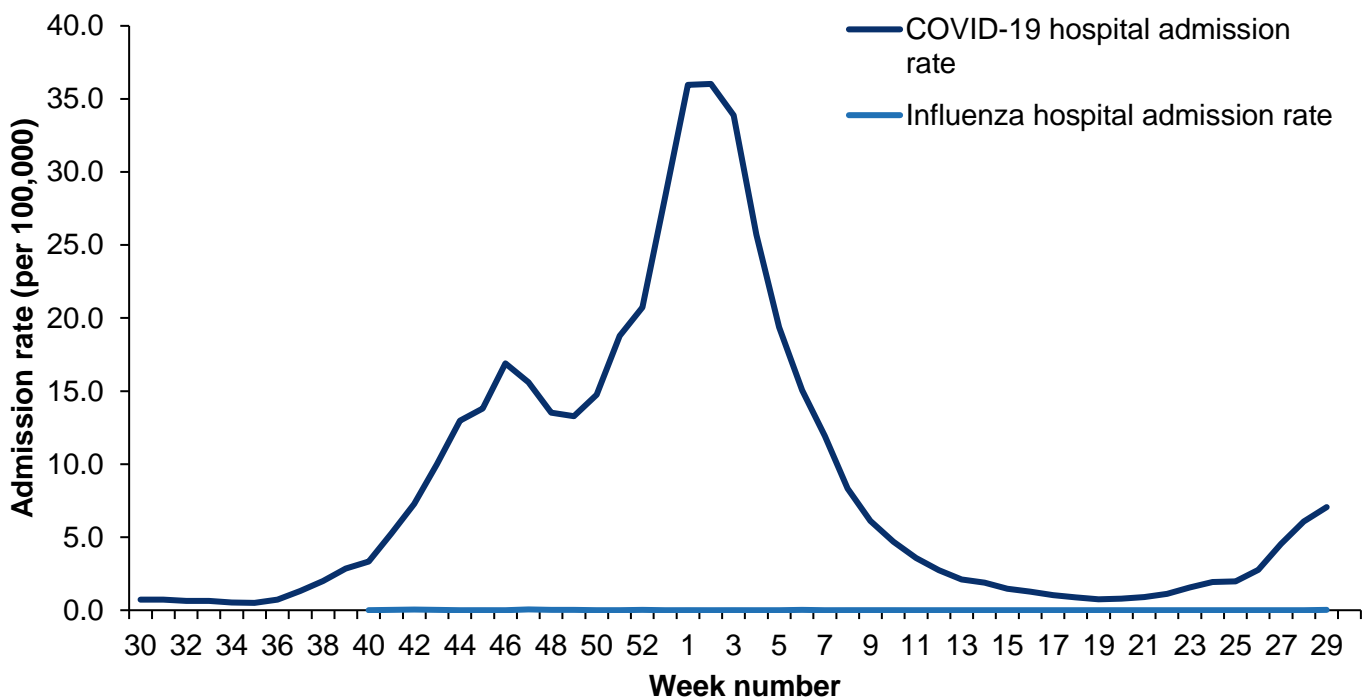
## Hospitalisations, SARI Watch

In week 29, the overall weekly hospital admission rate for COVID-19 increased. There was 1 new hospital admission for influenza in week 29, an influenza A(H1N1)pdm09.

The hospitalisation rate for COVID-19 was at 7.06 per 100,000 in week 29 compared to 6.06 per 100,000 in the previous week.

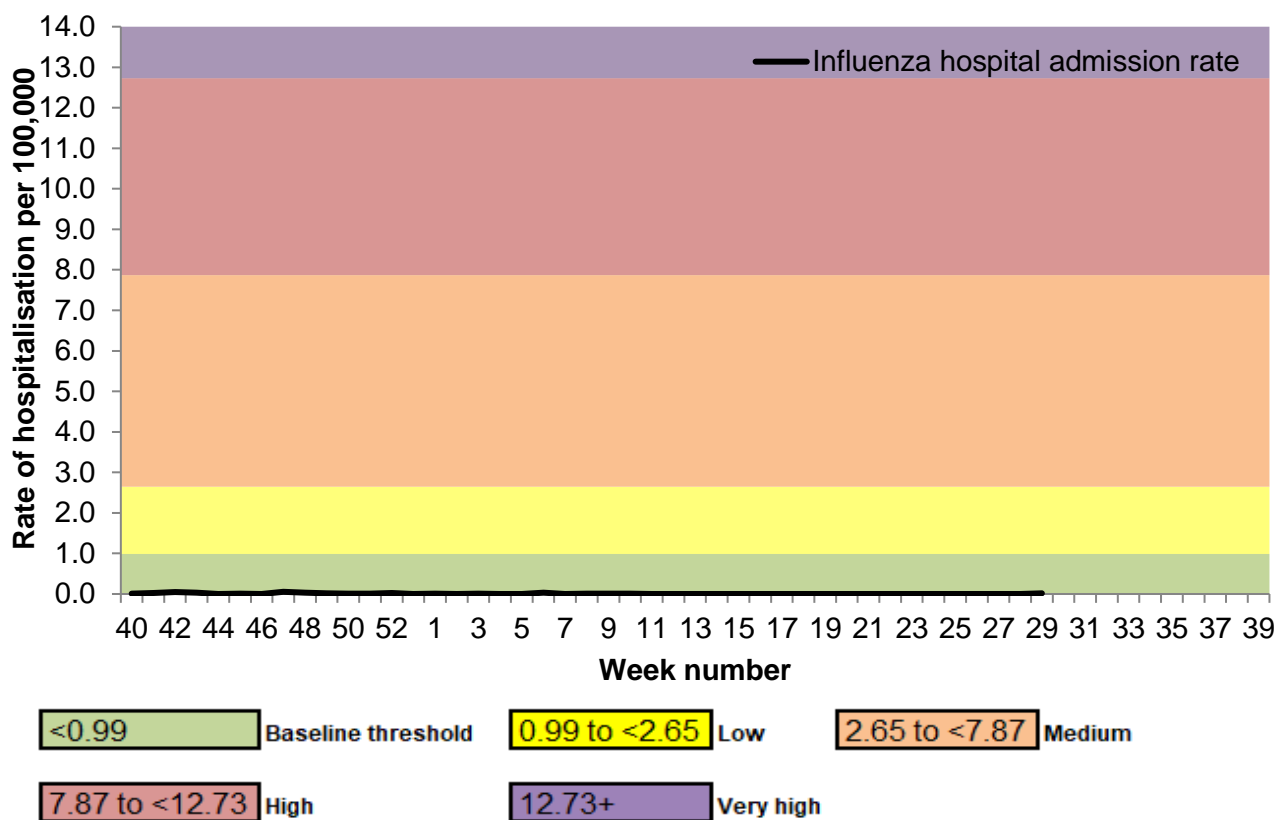
By PHE centre, the highest hospital admission rate for COVID-19 was observed in the North East. By age groups, the highest hospital admission rate for confirmed COVID-19 was in the 85-year olds and over.

**Figure 38: Weekly overall hospital admission rates per 100,000 of new COVID-19 and influenza positive cases reported through SARI Watch, England**



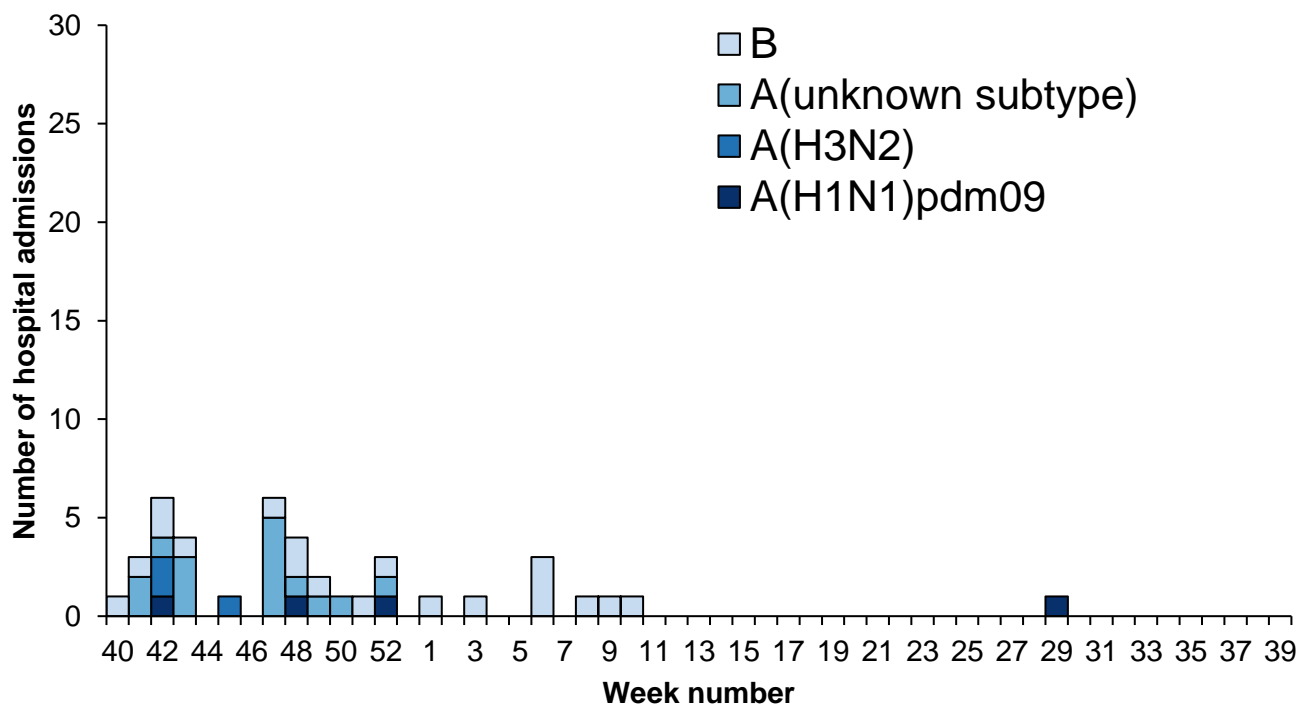
- \* influenza hospital admission rate is reported from week 40 2020 onwards
- \* influenza hospital admission rate based on 19 sentinel NHS trusts for week 29
- \* COVID-19 hospital admission rate based on 117 NHS trusts for week 29
- \* SARI Watch data are provisional.

**Figure 39: Weekly overall influenza hospital admission rates per 100,000 trust catchment population with MEM thresholds, SARI Watch, England**



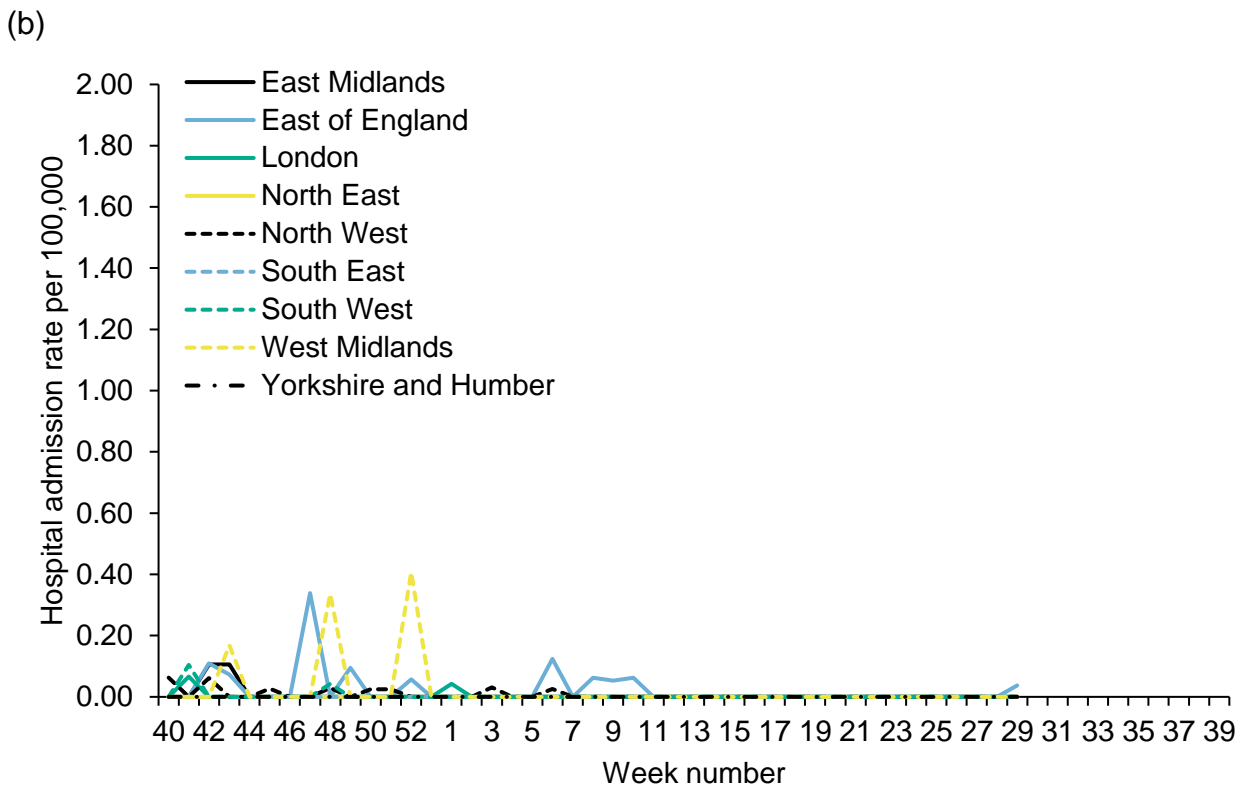
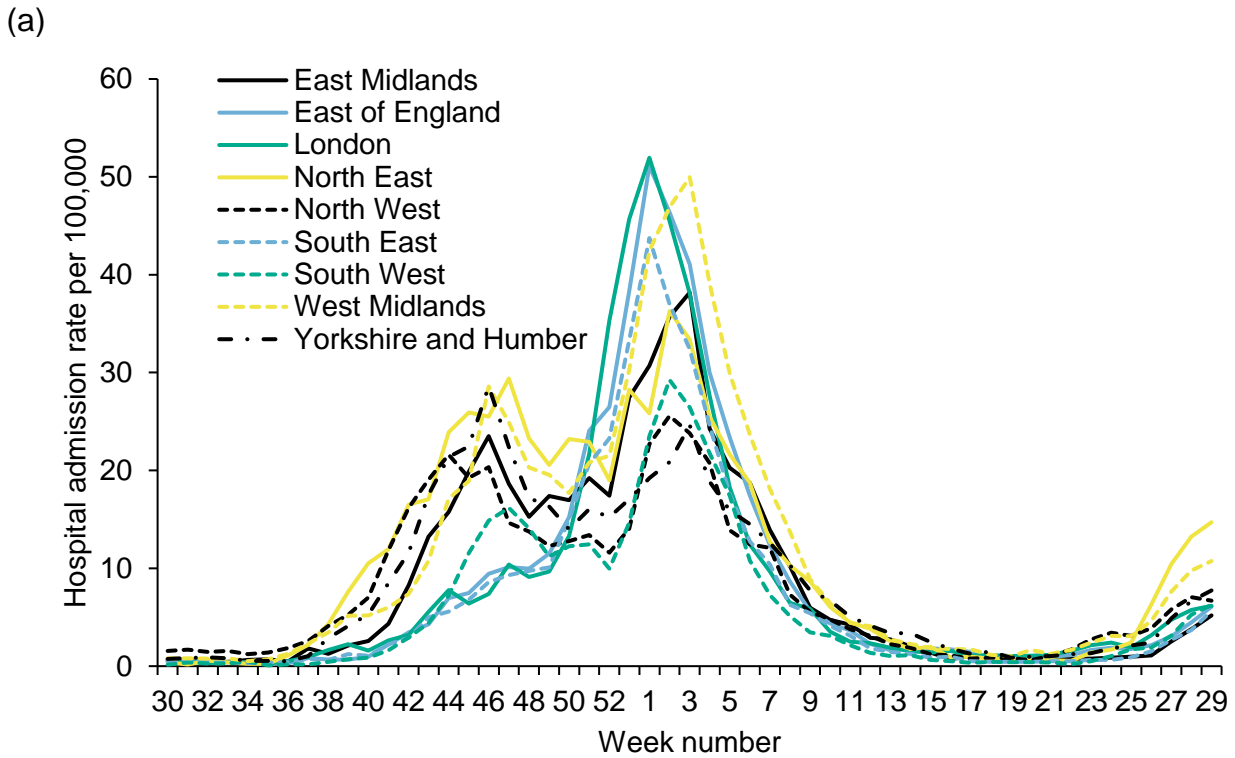
\* the MEM thresholds used are those from the 2019 to 2020 season due to the pandemic

**Figure 40: Weekly influenza hospital admissions by influenza type, SARI Watch, England**

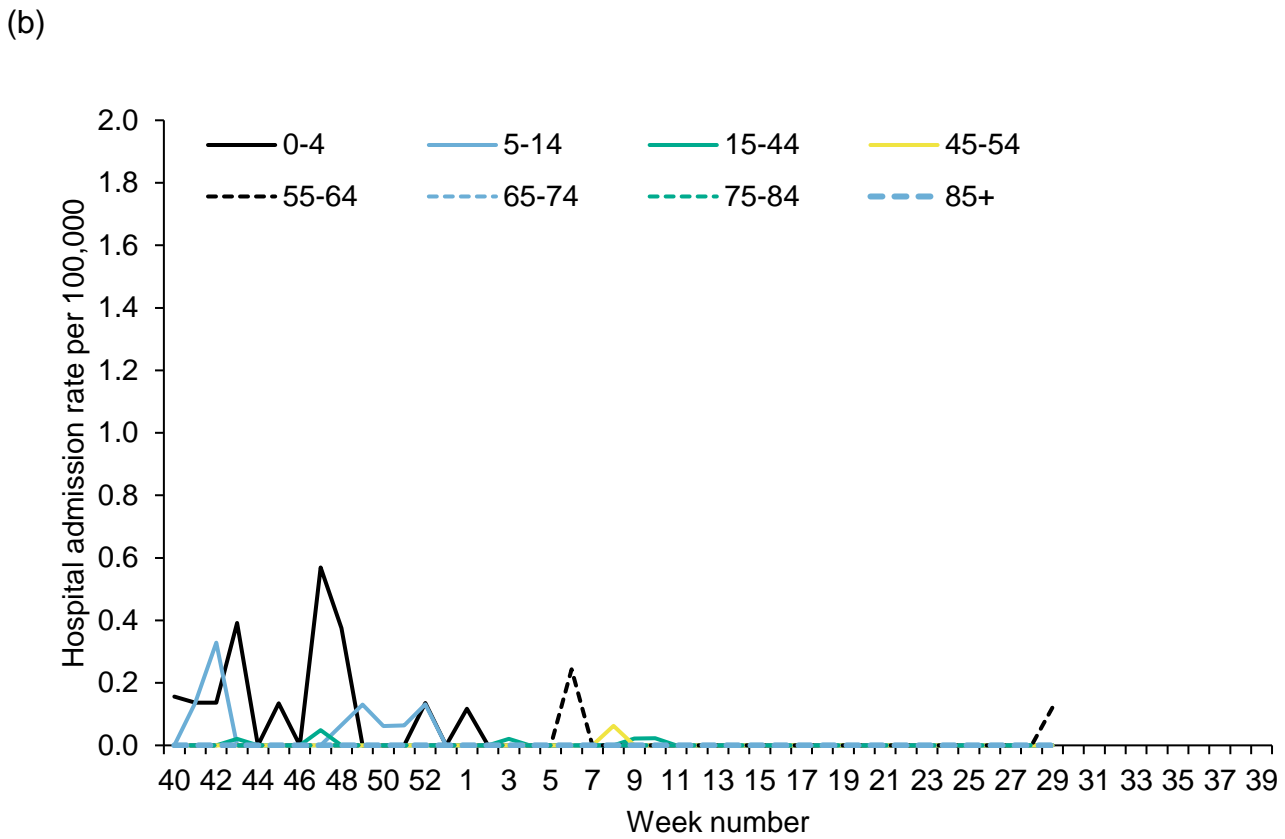
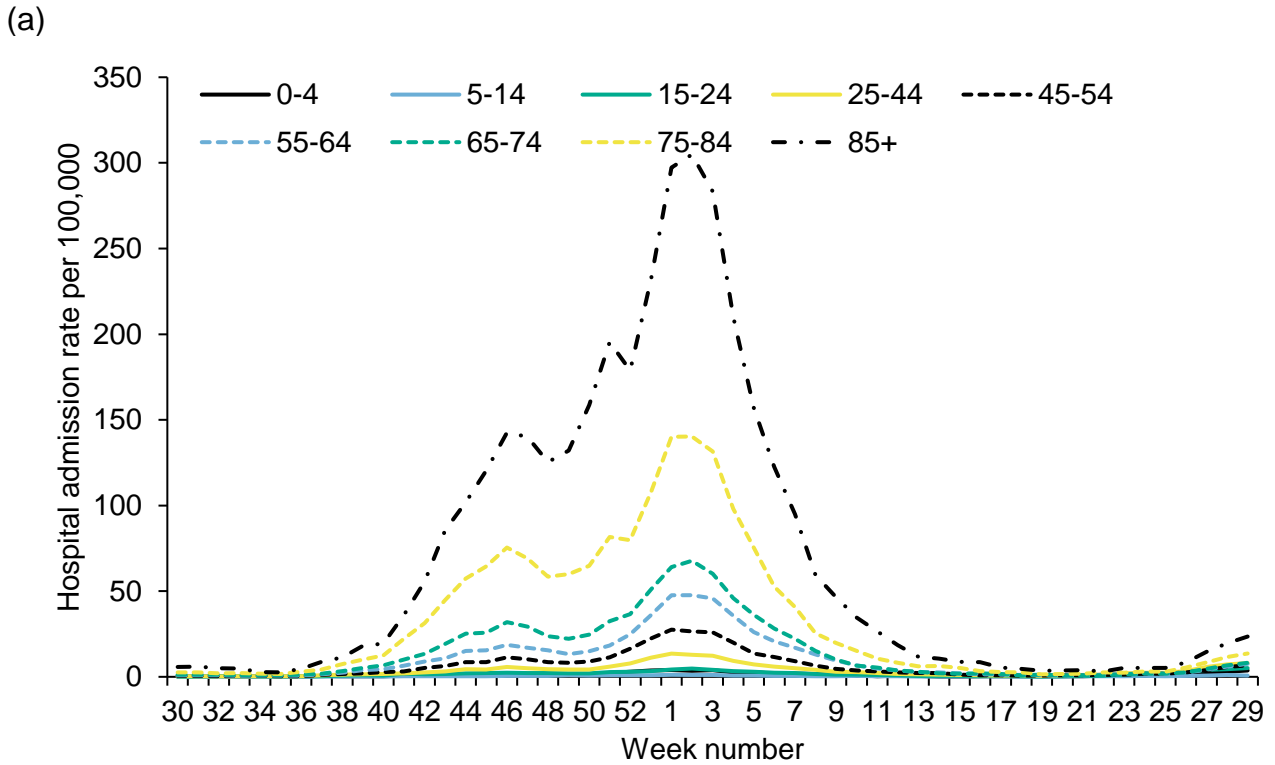




**Figure 41: Weekly hospital admission rate by PHE Centre for new (a) COVID-19 positive cases and (b) influenza reported through SARI Watch**



**Figure 42: Weekly hospital admission rate by age group for new (a) COVID-19 positive cases and (b) influenza reported through SARI Watch**



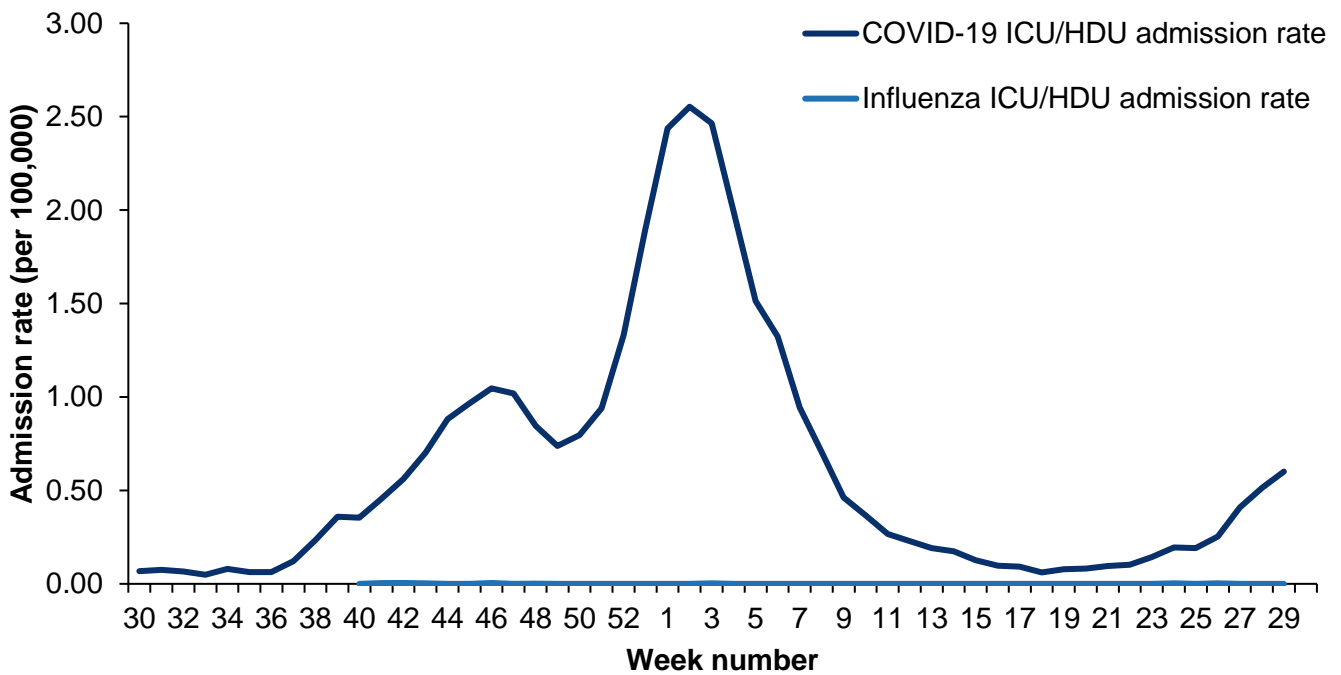
## ICU or HDU admissions, SARI Watch

In week 29, the overall weekly ICU or HDU admission rates for COVID-19 increased slightly. There were no new ICU or HDU admission for influenza in week 29.

The ICU or HDU rate for COVID-19 was at 0.60 per 100,000 in week 29 compared to 0.51 per 100,000 in the previous week.

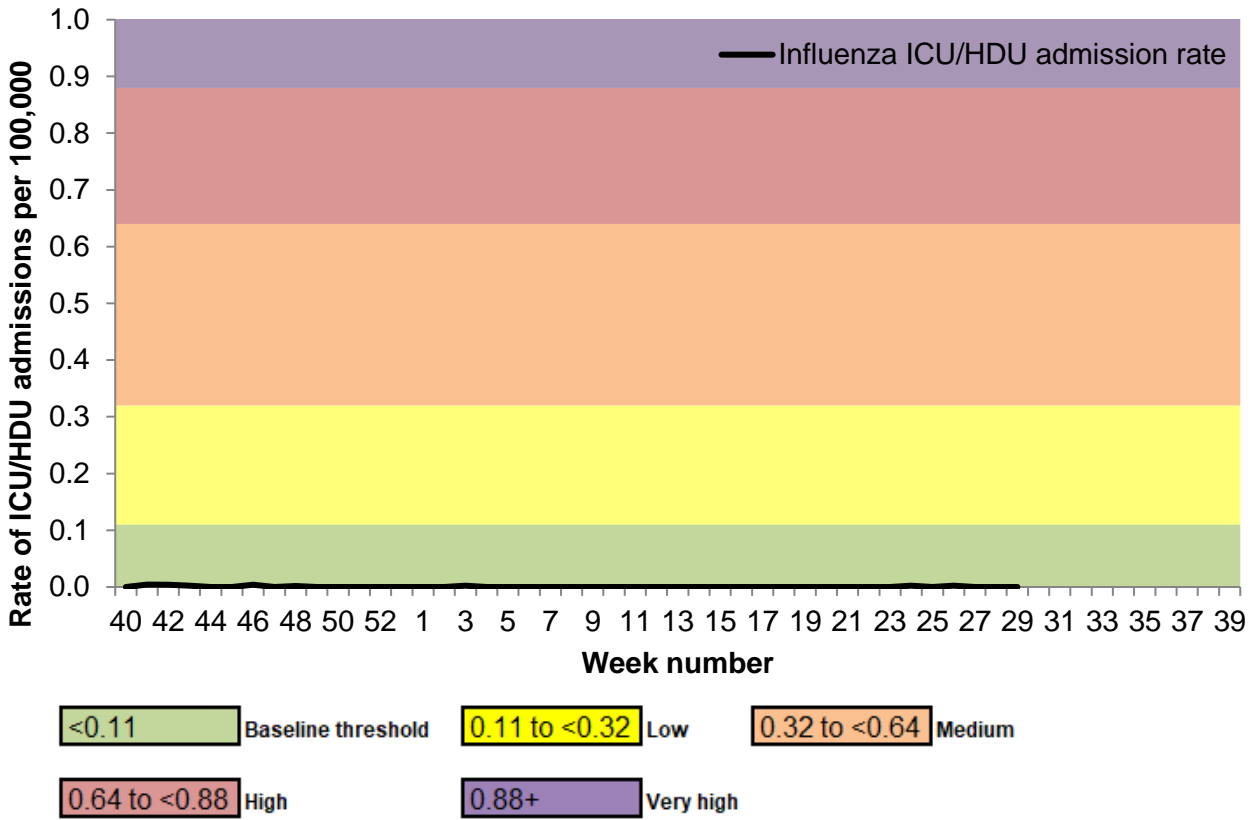
By PHE Centre, the highest ICU or HDU admission rates for COVID-19 were observed in the North East. By age groups, the highest ICU or HDU admission rates for COVID-19 were observed in the 55 to 64-year olds.

**Figure 43: Weekly overall ICU or HDU admission rates per 100,000 of (a) new COVID-19 and influenza positive cases reported through SARI Watch, England**

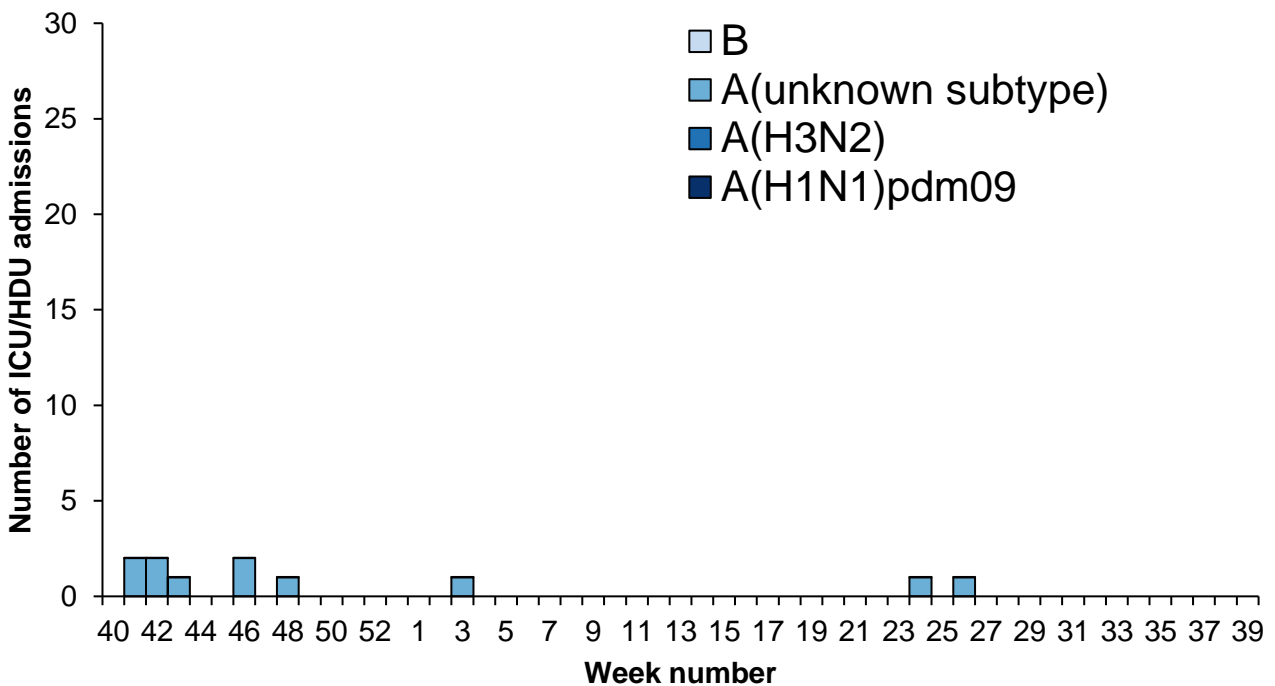


- \* influenza ICU or HDU admission rate is reported from week 40 2020 onwards
- \* influenza ICU or HDU admission rate based on 87 NHS trusts for week 29
- \* COVID-19 ICU or HDU admission rate based on 110 NHS trusts for week 29
- \* SARI Watch data are provisional.

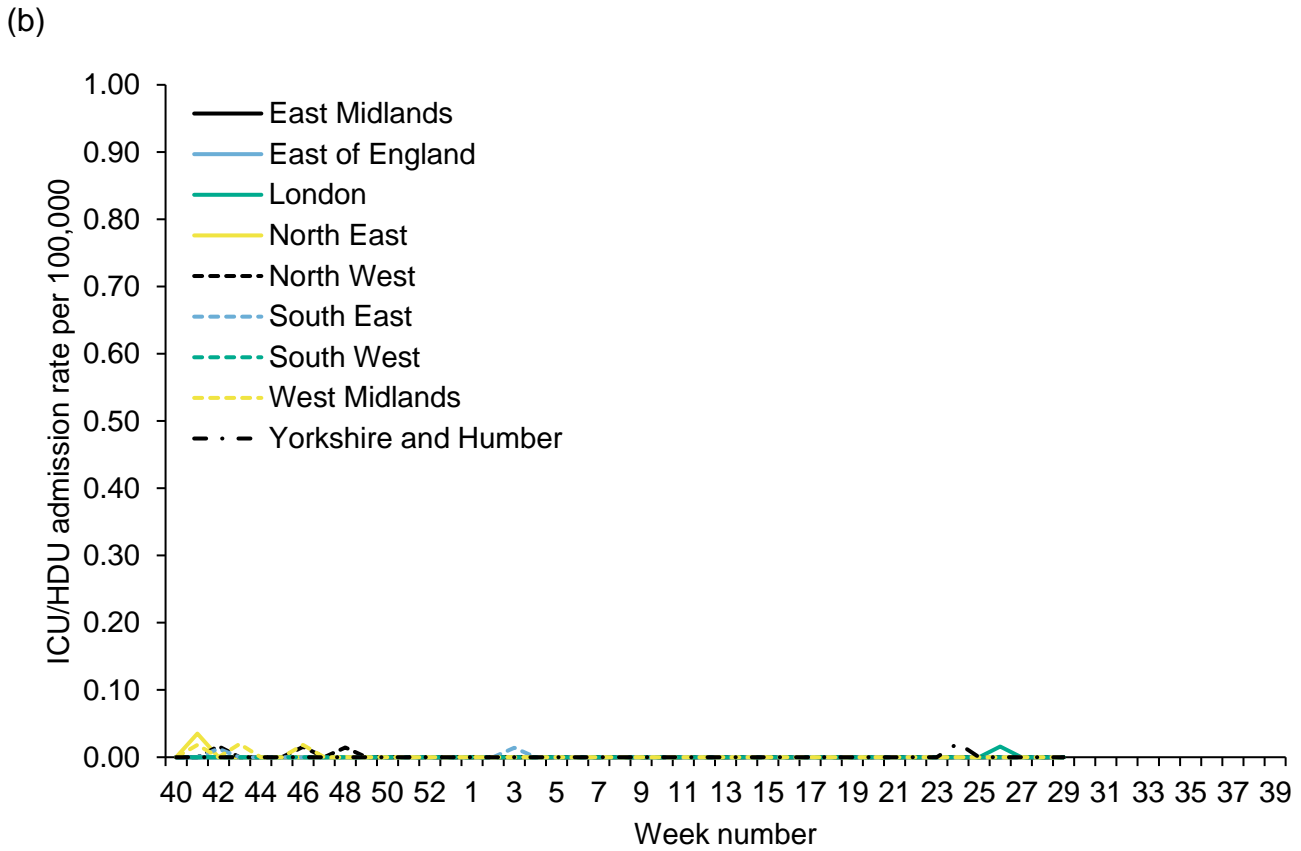
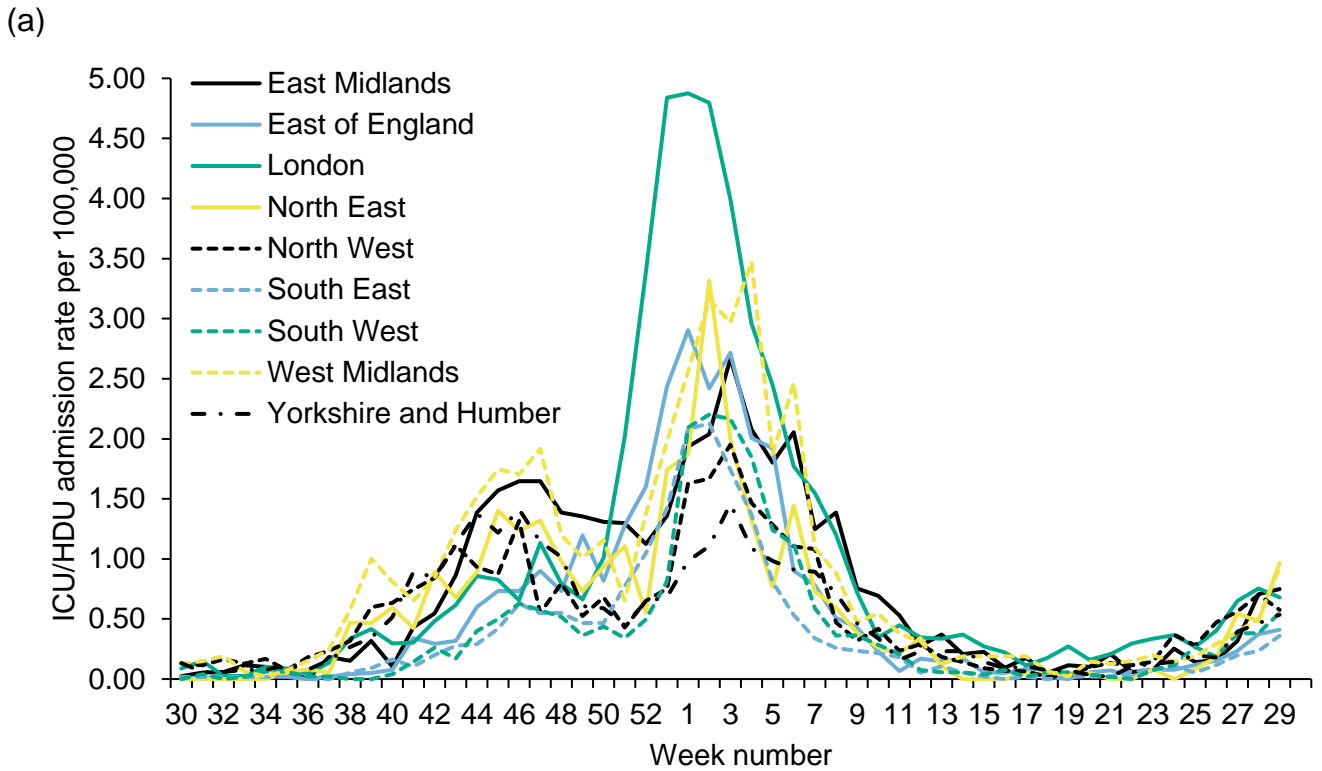
**Figure 44: Weekly overall influenza ICU or HDU admission rates per 100,000 trust catchment population with MEM thresholds, SARI Watch, England**



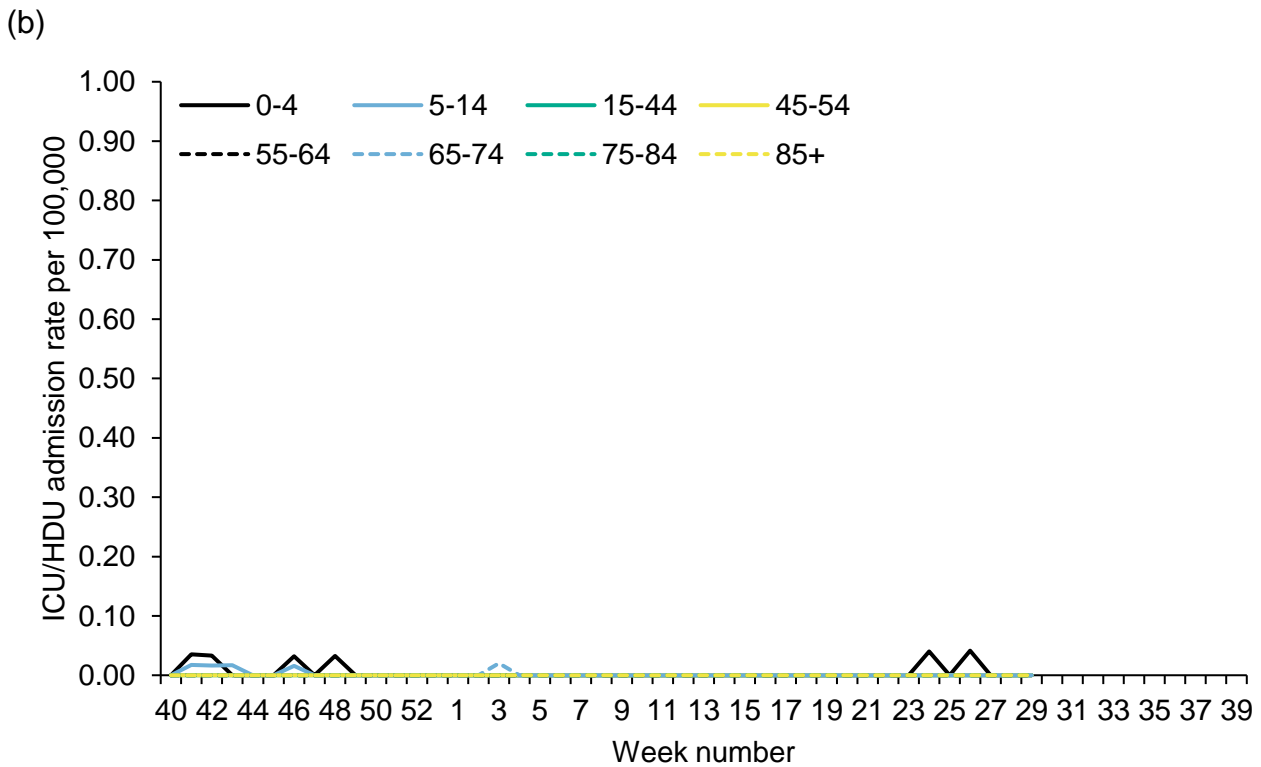
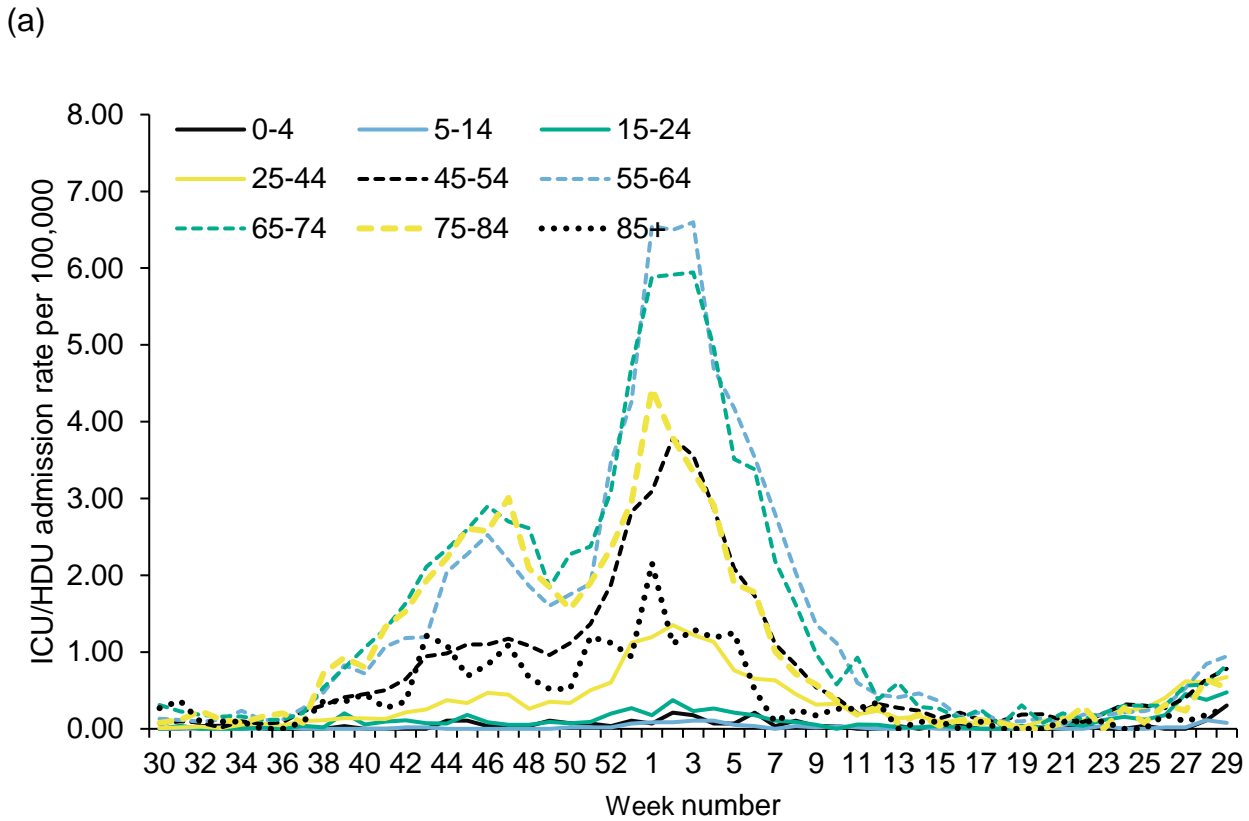
**Figure 45: Weekly influenza ICU or HDU admissions by influenza type, SARI Watch, England**



**Figure 46: Weekly ICU or HDU admission rate by PHE Centre for new (a) COVID-19 positive cases and (b) influenza, reported through SARI Watch**



**Figure 47: Weekly ICU or HDU admission rate by age group for new (a) COVID-19 positive cases and (b) influenza, reported through SARI Watch**

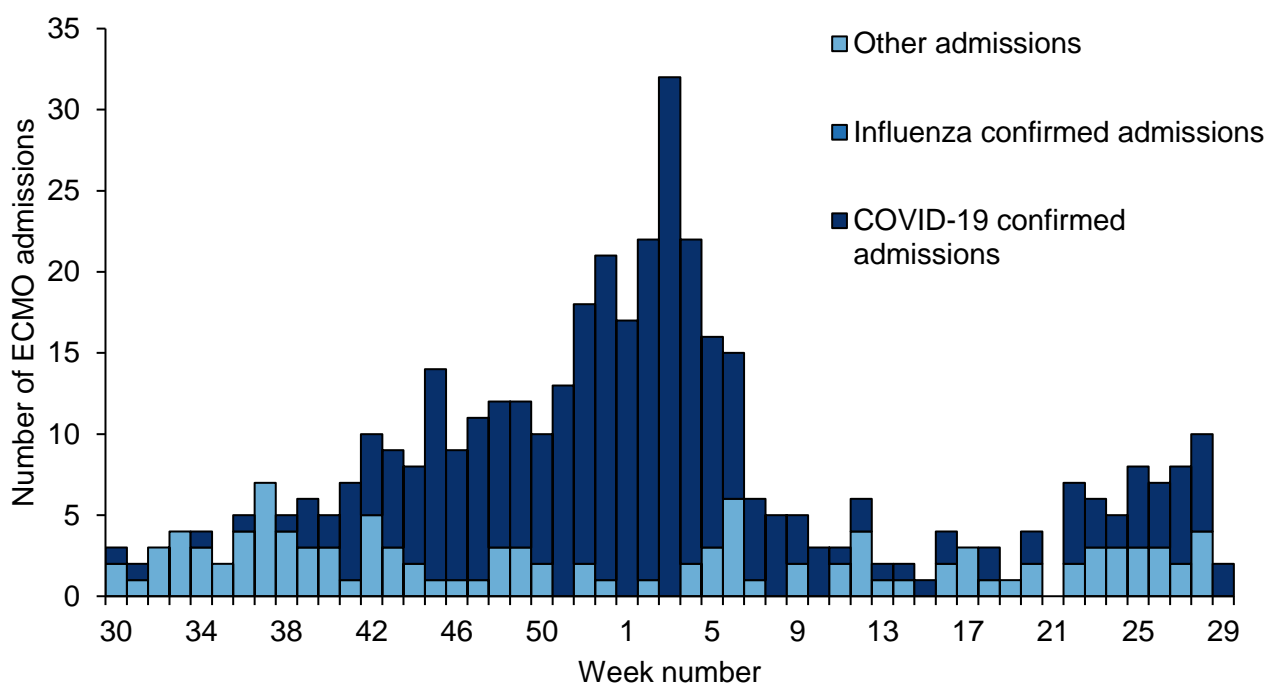


## ECMO, SARI Watch

From week 30 2020, a total of 312 laboratory confirmed COVID-19 admissions have been reported from the 6 Severe Respiratory Failure (SRF) centres in the UK.

There were 2 new laboratory confirmed COVID-19 admission reported in week 29 (Figure 48).

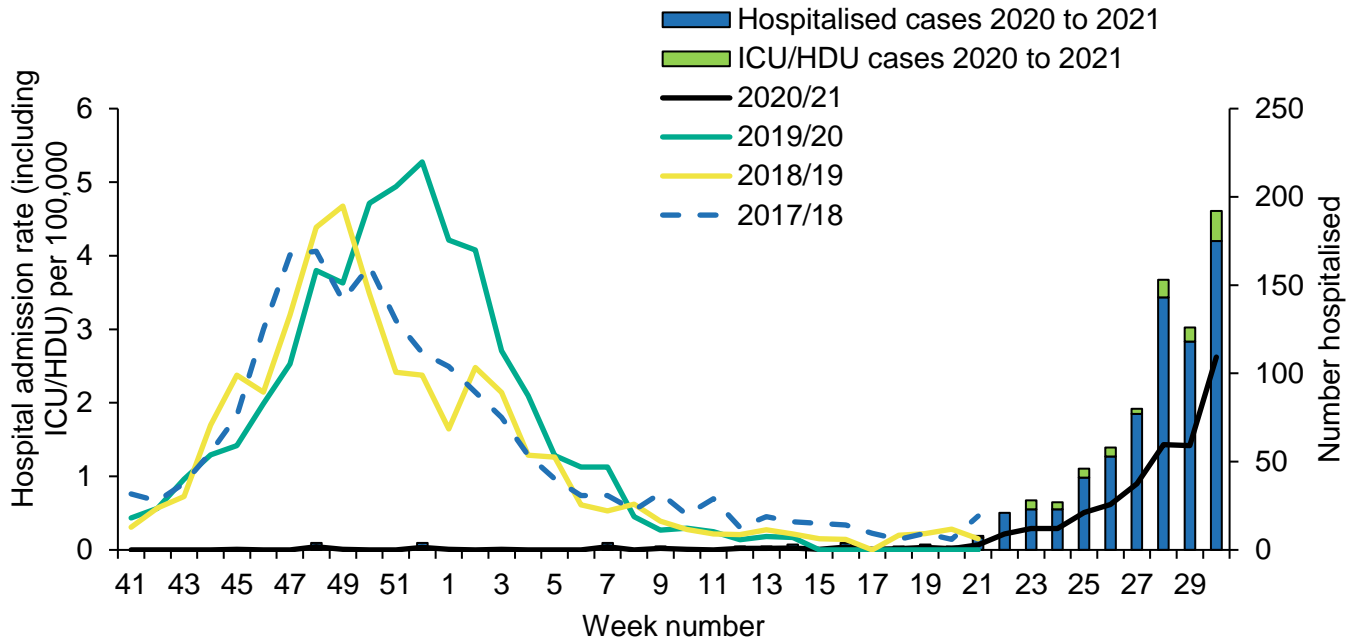
**Figure 48: Laboratory confirmed ECMO admissions (COVID-19, influenza and non-COVID-19 confirmed) to Severe Respiratory Failure centres in the UK**



## RSV admissions, SARI Watch

Data on hospitalisations, including ICU/HDU admissions, with Respiratory Syncytial Virus (RSV) are shown below.

**Figure 49: Weekly overall hospitalisation (including ICU/HDU) admission rates per 100,000 of RSV positive cases reported through SARI Watch, England**

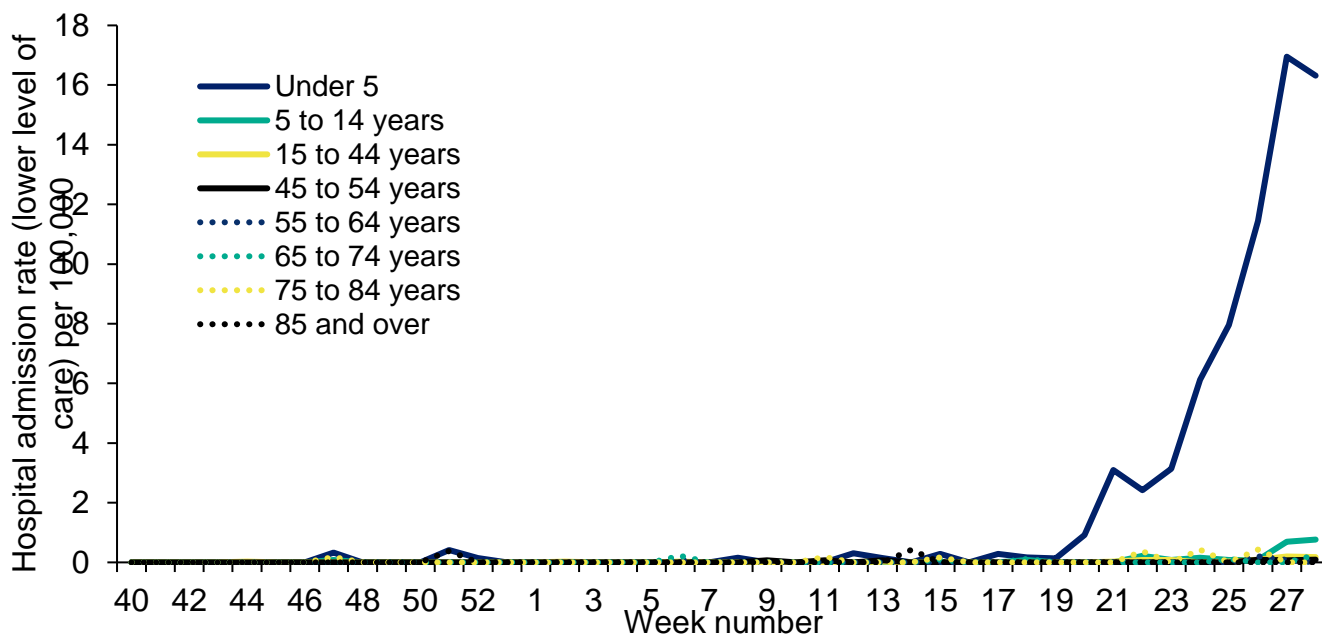


\* Please note that in previous seasons, RSV SARI Watch surveillance has run from week 40 to week 20. In the 2020 to 2021 season this was extended to run throughout the year, to allow for surveillance of out-of-season trends



**Figure 50: Weekly hospitalisation admission rates by age group for new RSV cases reported through SARI Watch in 2020 to 2021, England**

Please note that this week, data on ICU/HDU admissions was unavailable therefore the rates presented represent those hospitalised at a lower level of care only.



\* Please note that rates are based on the number of hospitalised cases divided by the Trust catchment population, multiplied by 100,000

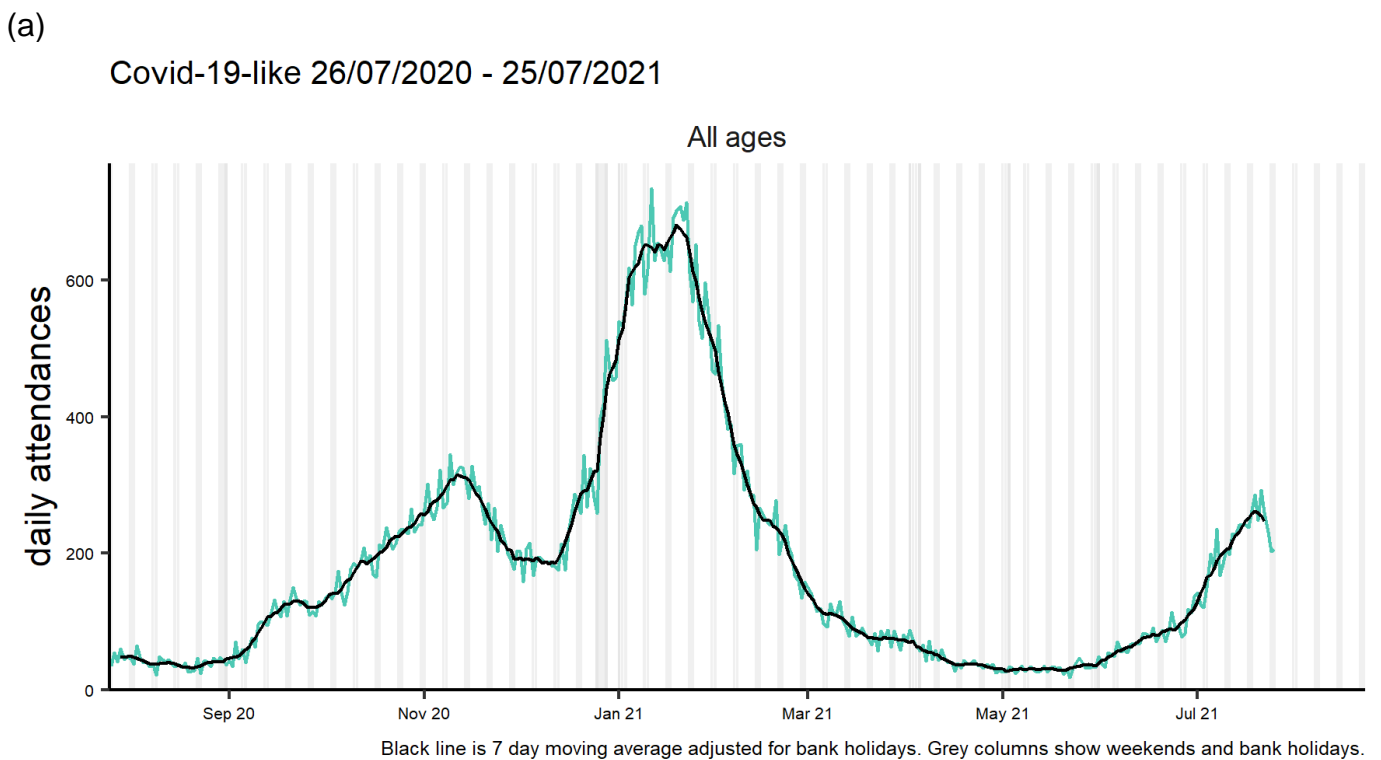
# Emergency Department attendances, Syndromic surveillance

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

Up to 25 July 2021, the daily number of ED attendances as reported by 97 EDs for COVID-19-like infection decreased, except from in the South West (Figure 51).

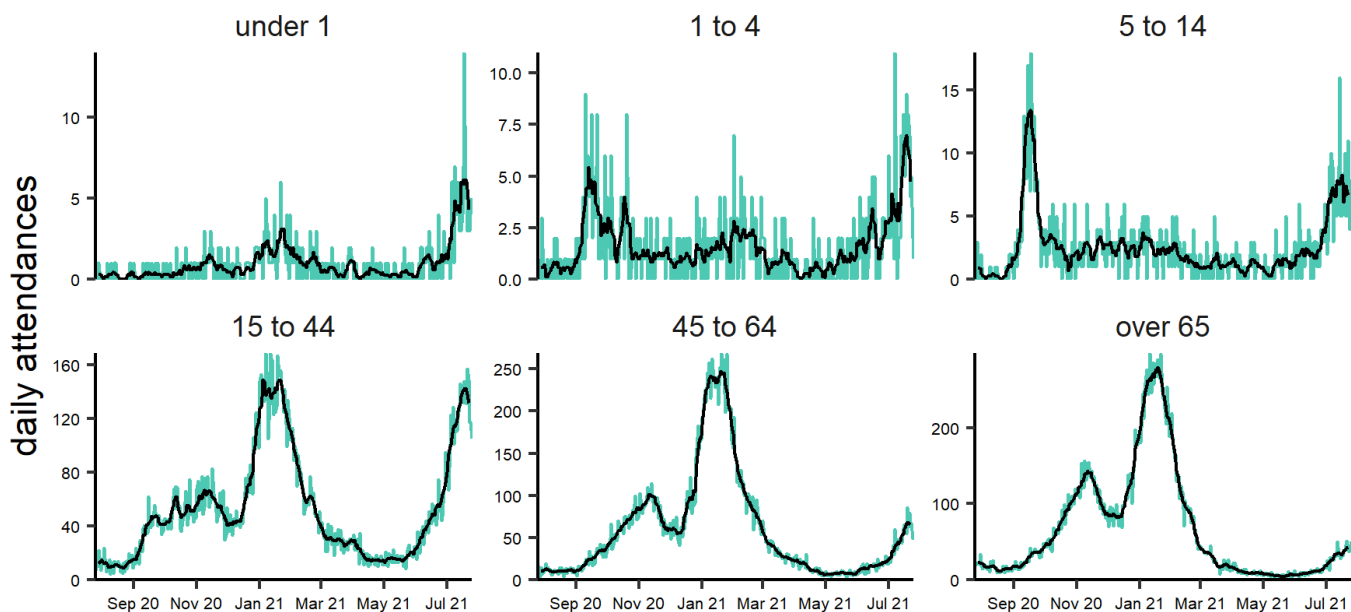
Please note: the COVID-19-like ED indicator is an underestimation of the number of COVID-19 attendances as it only includes attendances with a COVID-19-like diagnosis as their primary diagnosis. The EDSSS COVID-19-like indicator should therefore be used to monitor trends in ED attendances and not to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

**Figure 51: Daily ED attendances for COVID-19-like infections, England (a) nationally, (b) by age group and (c) by PHE Centre**



(b)

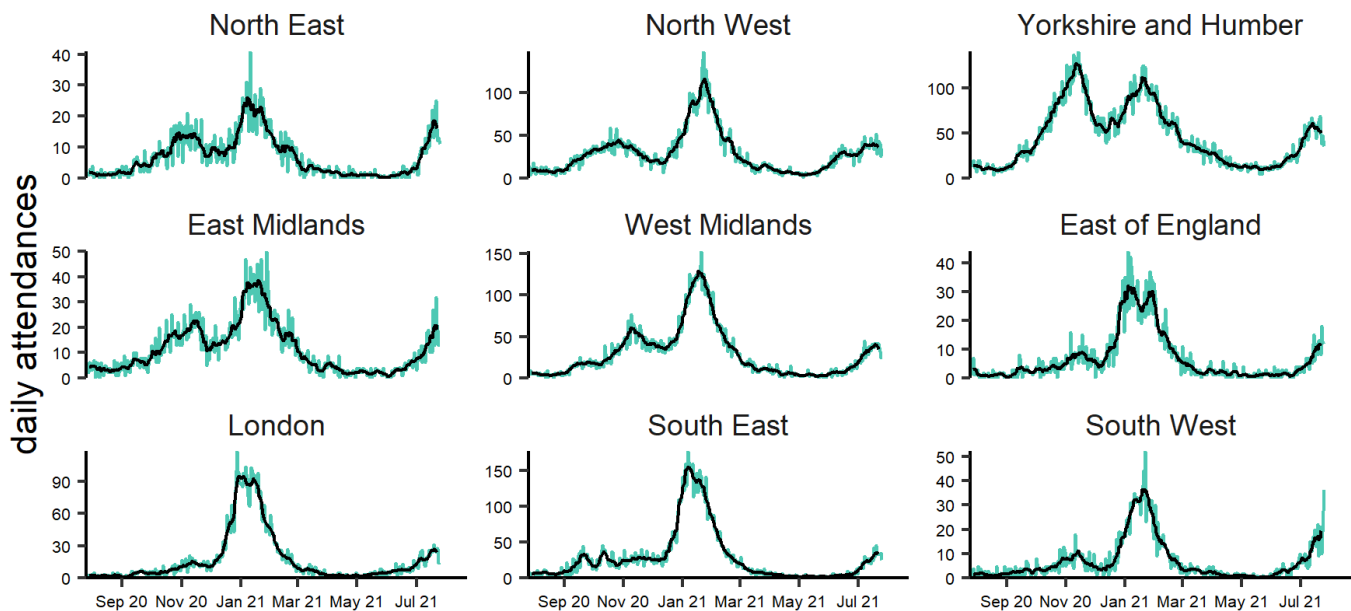
Covid-19-like by age group (years) 26/07/2020 - 25/07/2021



NOTE: SCALES MAY VARY IN EACH GRAPH TO ENABLE TREND COMPARISON. Black line is 7 day moving average adjusted for bank holidays.

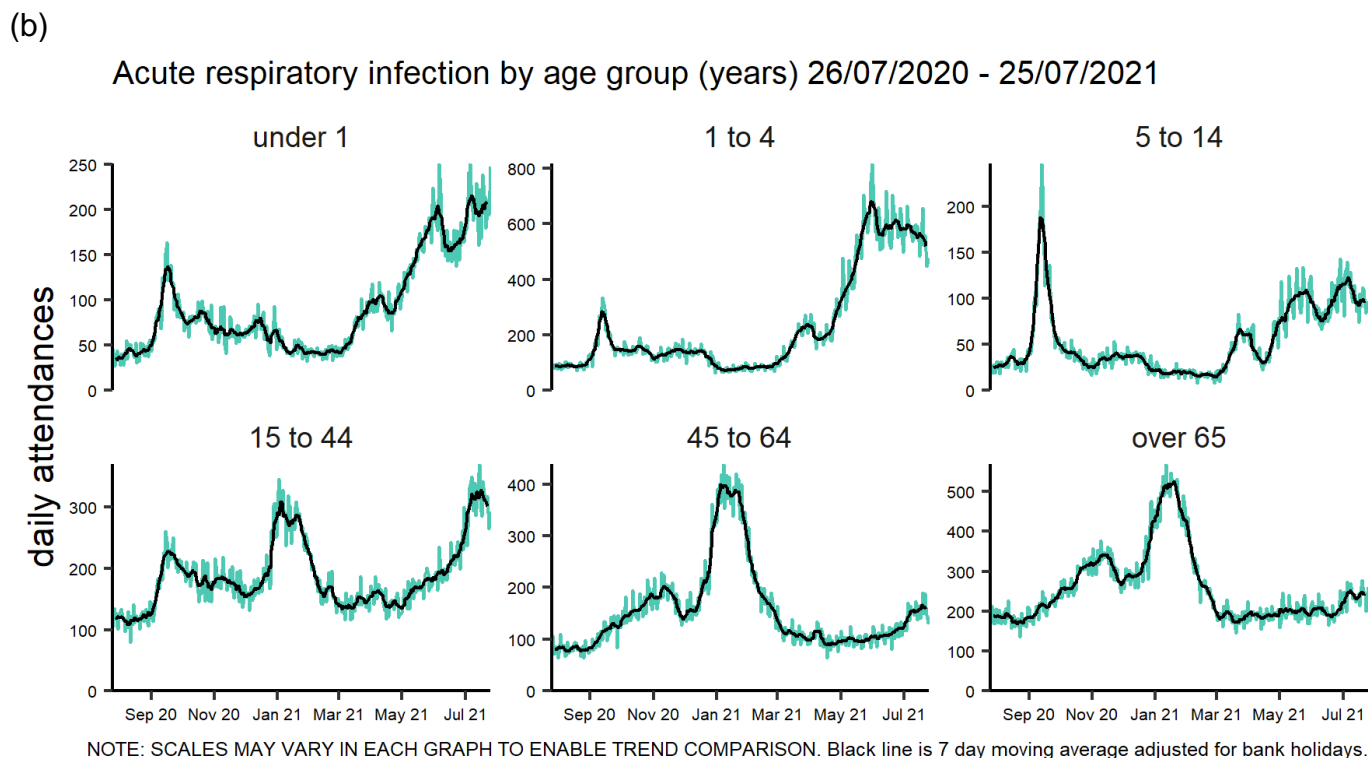
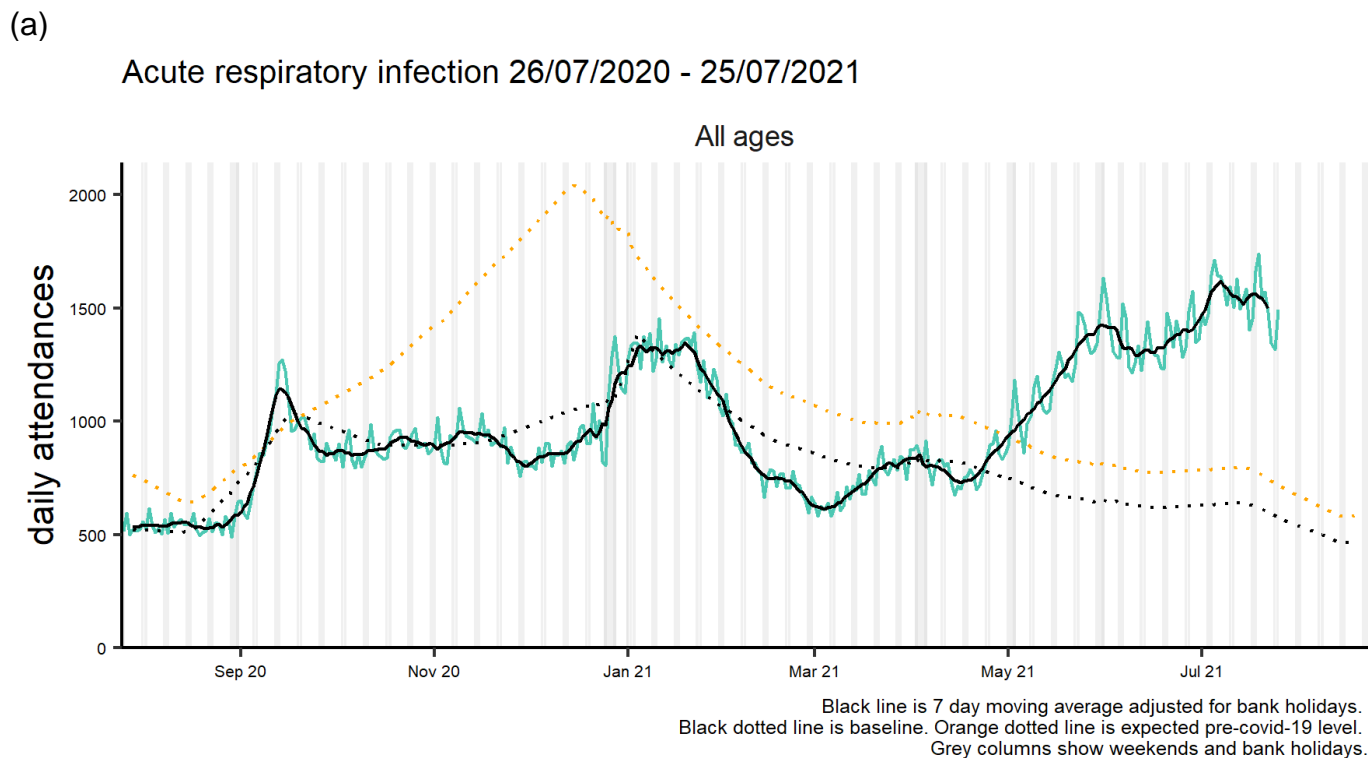
(c)

Covid-19-like by PHE centre 26/07/2020 - 25/07/2021



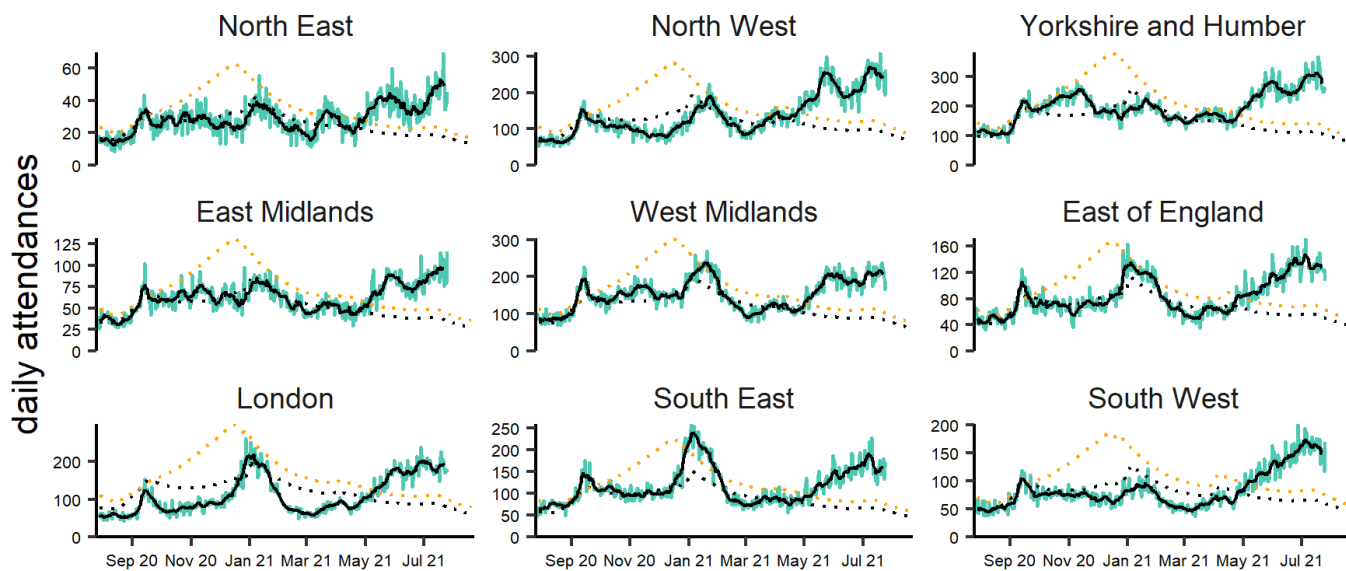
NOTE: SCALES MAY VARY IN EACH GRAPH TO ENABLE TREND COMPARISON. Black line is 7 day moving average adjusted for bank holidays.

**Figure 52: Daily ED attendances for acute respiratory infections, England (a) nationally, (b) by age group and (c) by PHE Centre**



(c)

### Acute respiratory infection by PHE centre 26/07/2020 - 25/07/2021



NOTE: SCALES MAY VARY IN EACH GRAPH TO ENABLE TREND COMPARISON. Black line is 7 day moving average adjusted for bank holidays. Black dotted line is baseline. Orange dotted line is expected pre-covid-19 level.

# Mortality surveillance

## Cumulative COVID-19 deaths

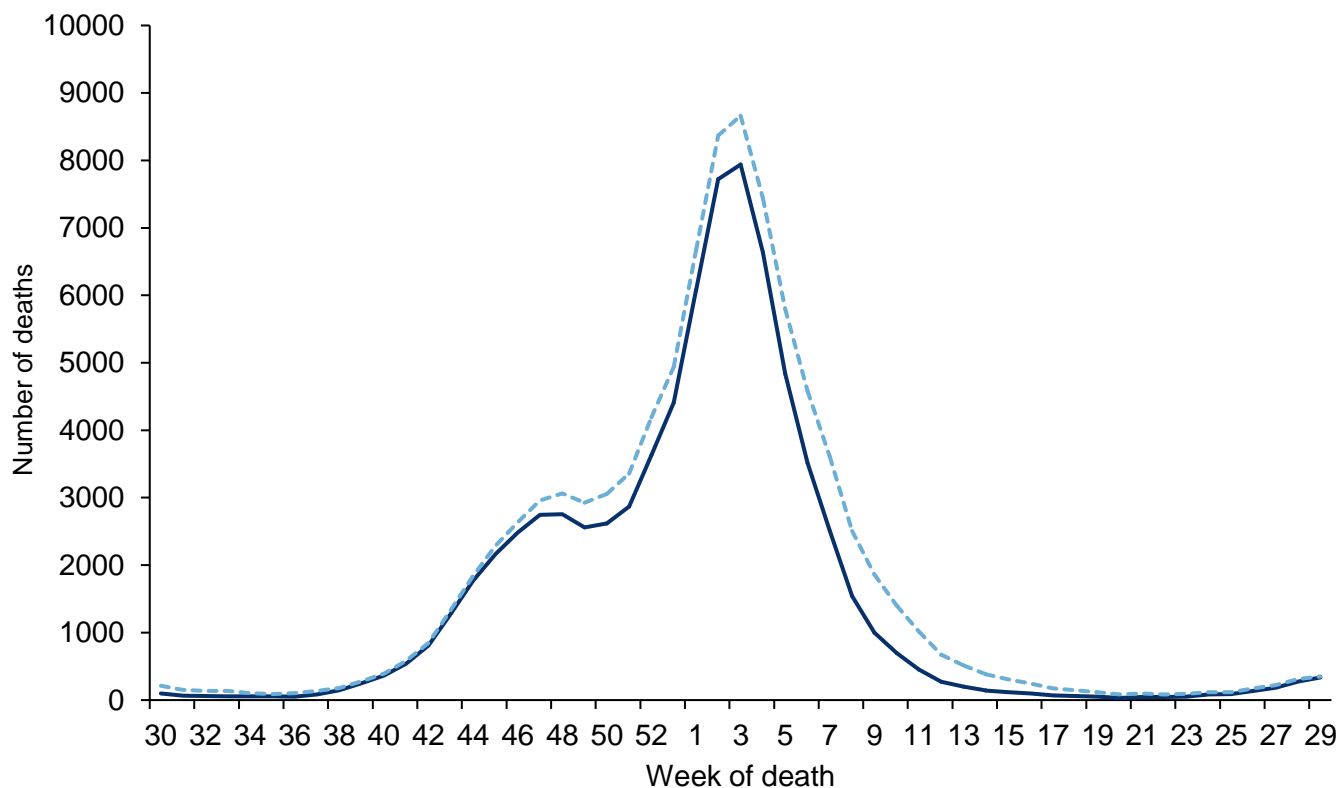
Changes to the definitions of COVID-19 related deaths in England are described in more detail in an accompanying PHE technical summary.

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

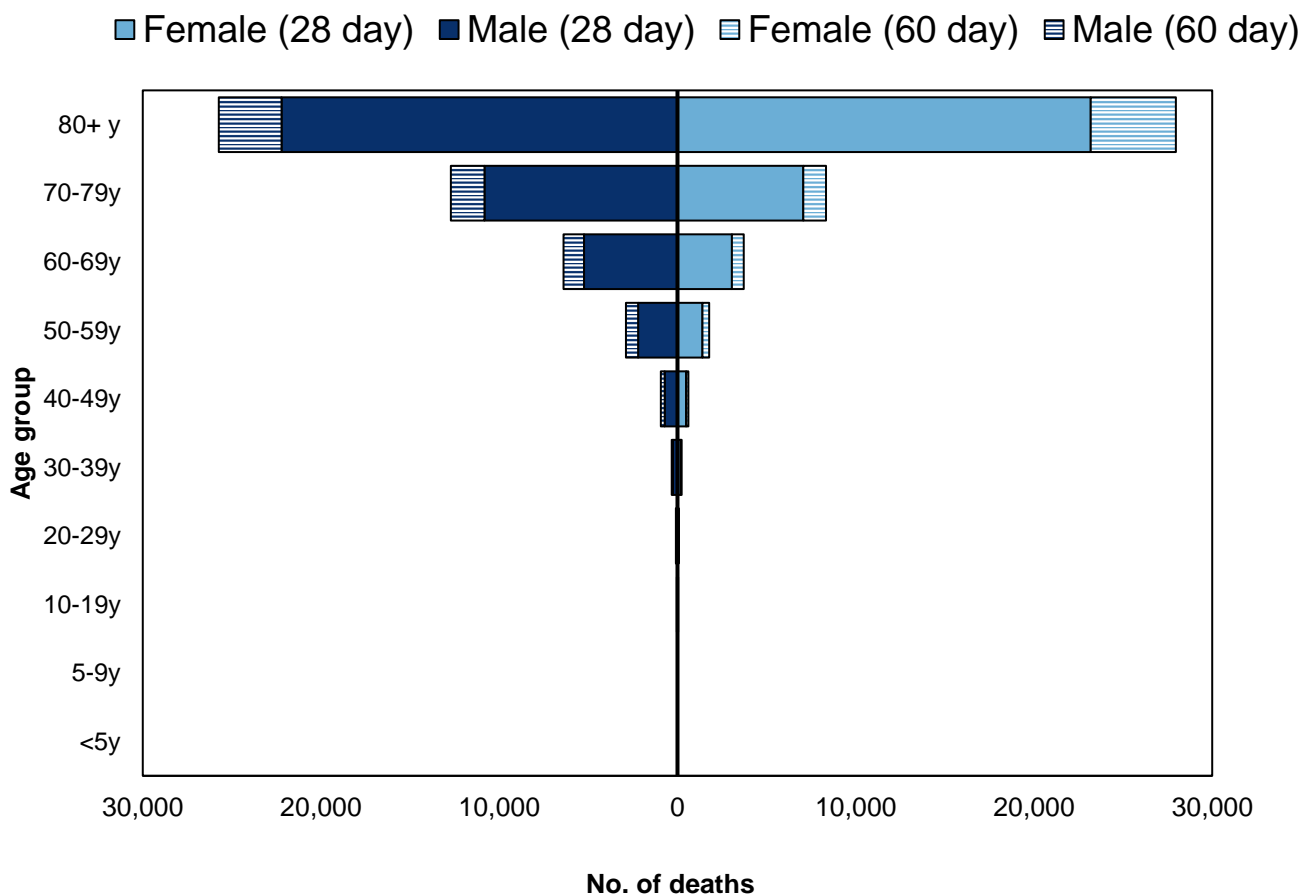
The introduction of these definitions will affect the numbers which have been presented in past reports and therefore Figure 53 represents these differences by definition.

**Figure 53: Number of deaths since 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 54: Age-sex pyramid of laboratory confirmed COVID-19 deaths, for the past year**



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

Ethnicity	28 day definition	60 day definition
White	88.9	88.9
Asian / Asian British	7.4	7.3
Black / African / Caribbean / Black British	2.7	2.7
Mixed / Multiple ethnic groups	0.5	0.5
Other ethnic group	0.5	0.5

\*Due to a misclassification of two subgroups within the Asian/Asian British and Black/Black British ethnic categories, the proportions of deaths for these ethnic categories in reports published between week 37 2020 and week 29 2021 were incorrect.

In comparison to last week's report (week 29), the rolling (by year) proportion of deaths with an Asian/Asian British ethnic background has decreased from 8.6% to 7.4% and 8.5% to 7.3% for 28- and 60-day definitions respectively for this week. Additionally, in comparison to last week's report (week 29), the rolling (by year) proportion of deaths with a Black/Black British ethnic background has increased from 1.5% to 2.7% and 1.6% to 2.7% for 28- and 60-day definition respectively.

The impact of the correction will specifically affect the proportion of deaths with an Asian/Asian British and/or Black/Black British ethnic category. The total number of deaths reported is unaffected. Other ethnicity data included in the report are also not affected by this issue.

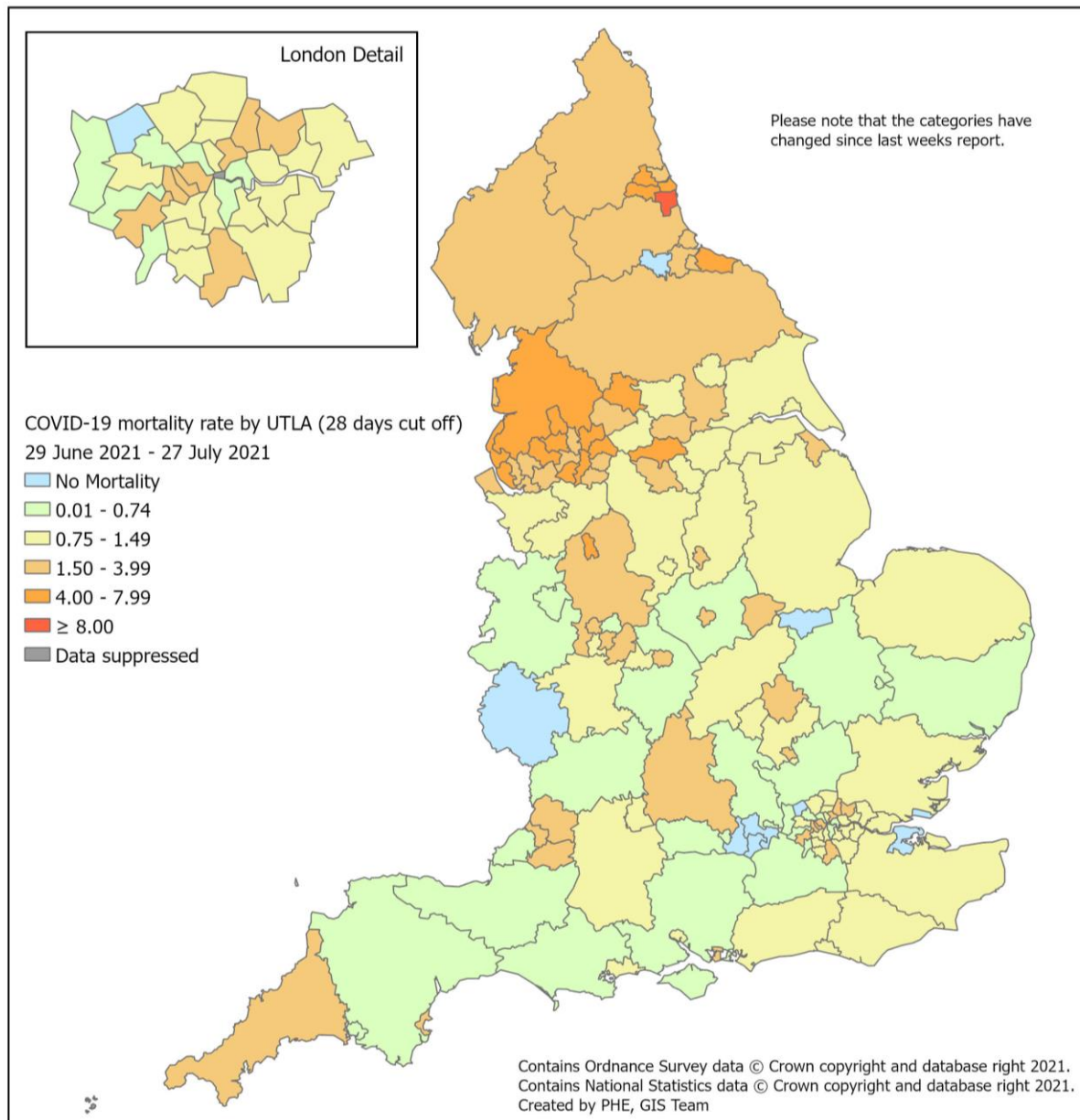
**Table 6: Cumulative number of COVID-19 deaths since and time since laboratory confirmation of COVID-19 by PHE Centres, for the past year**

PHE Centres	28 day definition	60 day definition
North East	3,973	4,737
North West	12,244	14,605
Yorkshire and Humber	7,569	9,010
West Midlands	9,111	10,943
East Midlands	7,306	8,704
East of England	9,738	11,577
London	9,549	11,537
South East	12,101	14,422
South West	5,009	5,868

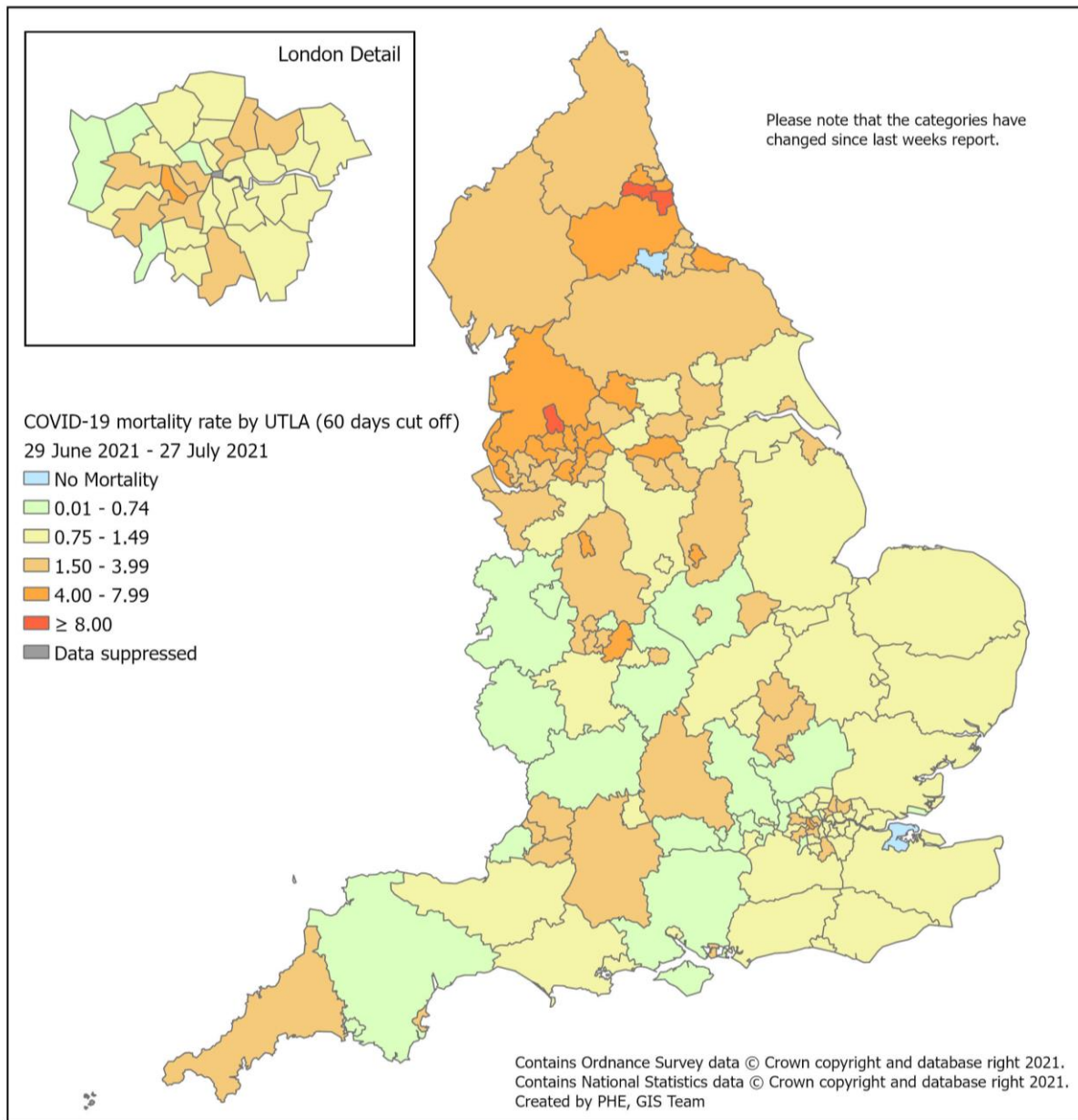


**Figure 55: Cumulative mortality rate of COVID-19 cases per 100,000 population tested under Pillars 1 and 2 for the past 4 weeks by (a) 28 day definition and (b) 60 day definition**

(a)



(b)



## Daily excess all-cause mortality (England)

Deaths occurring from 01 January 2020 to 21 July 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 plus or minus 7 days with an extrapolated time trend, and with 2 and 3 standard deviation (SD) limits shown (Figure 56).

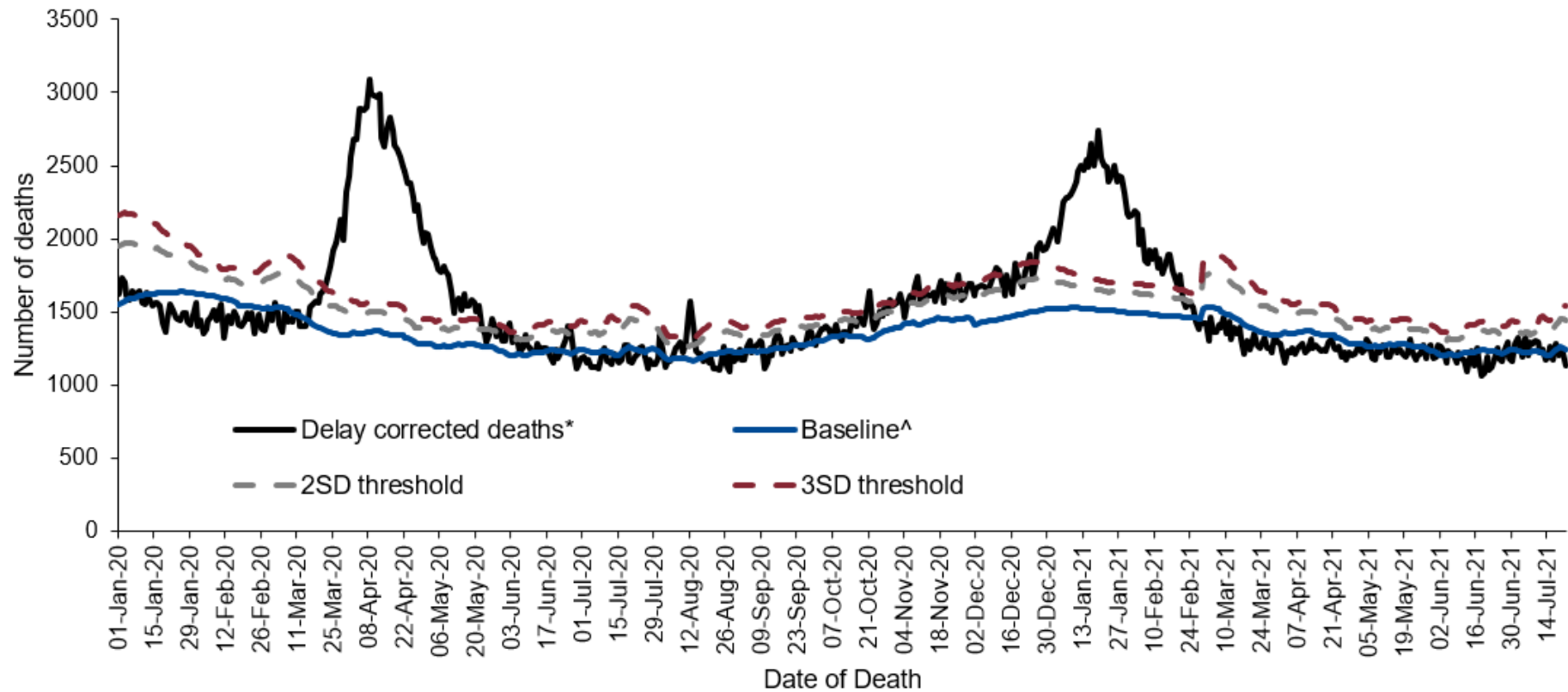
Weeks in which at least 2 days exceeded the 3SD threshold are shown in Table 7 and the daily difference from the baseline by age and region is given in Figure 56.

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.

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

No significant excess all-cause mortality was observed in week 28 overall, by age or sub-nationally. The excess noted in week 33 coincides with a heat wave (Figure 56, 57 and Table 7).

**Figure 56: Daily excess all-cause deaths in all ages, England, 01 January 2020 to 21 July 2021**



^Baseline calculation:

January to November 2020: same day in previous 5 years plus or minus 1 week with a linear trend.

December 2020 to February 2021: past 3 low flu years plus or minus 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**

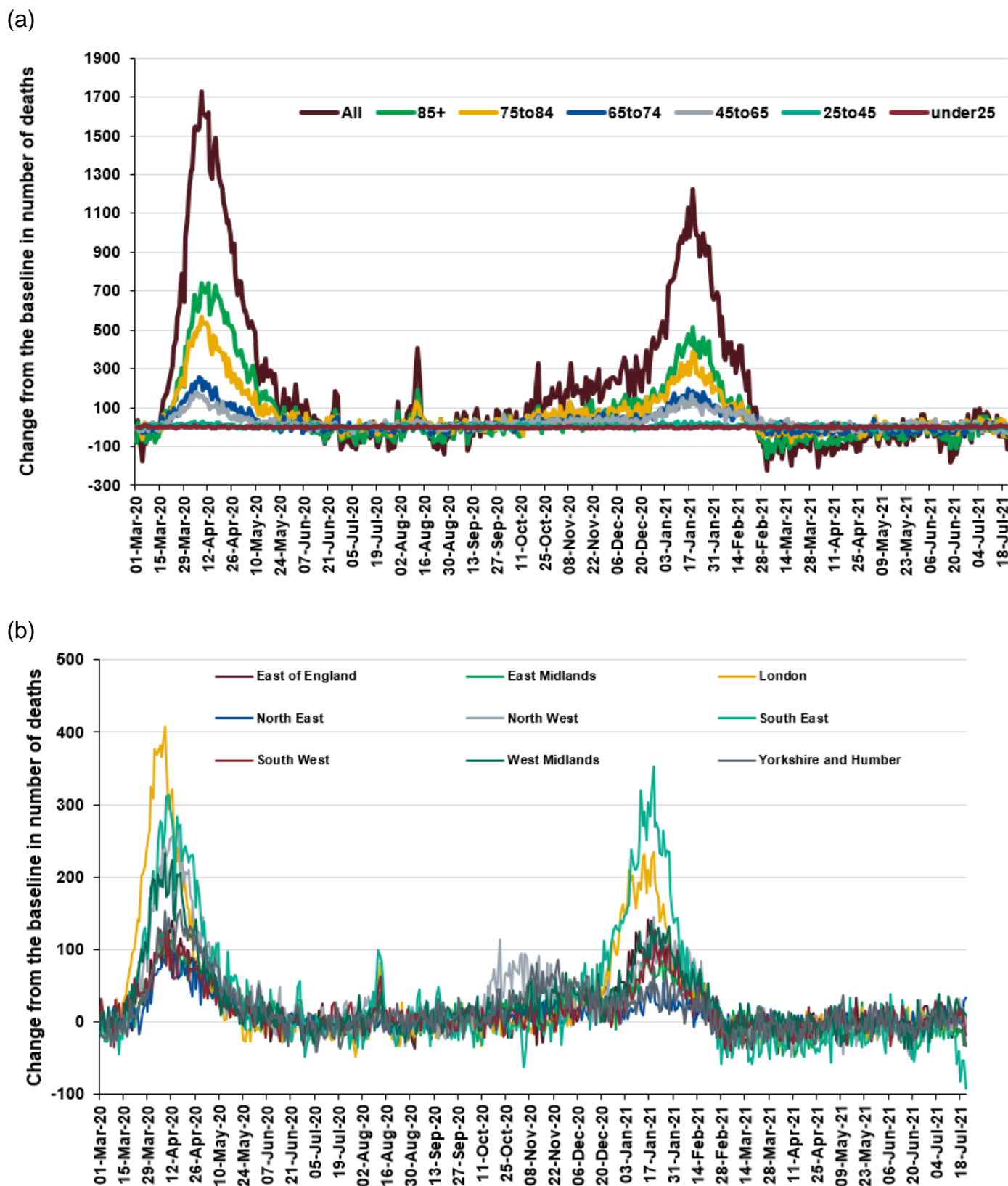
(a)

Age Group	Excess detected in week 28 2021?	Weeks in excess from week 10 to 53 2020	Weeks in excess from week 01 to 28 2021
All	x	13 to 21, 33, 43, 45, 50, 52 to 53	01 to 07
under 25	x	None	None
25 to 44	x	14 to 16	None
45 to 64	x	12 to 19, 44, 49 to 50, 52 to 53	01 to 08
65 to 74	x	13 to 19, 46, 48, 53	01 to 07
75 to 84	x	13 to 21, 33, 45, 49, 52 to 53	01 to 07
85+	x	13 to 21, 33, 53	01 to 07

(b)

PHE Centres	Excess detected in week 28 2021?	Weeks in excess from week 10 to 53 2020	Weeks in excess from week 01 to 28 2021
East of England	x	14 to 19, 52, 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	01 to 07
West Midlands	x	13 to 20, 45, 48, 53	01 to 07
Yorkshire and Humber	x	14 to 21, 23, 43, 45 to 50	02 to 04

**Figure 57: Daily excess all-cause deaths by (a) age group and (b) PHE centres, England, 01 March 2020 to 21 July 2021**



# Microbiological surveillance

## SARS-CoV-2 variants

PHE conducts surveillance of SARS-CoV-2 variants. Further information including an overview of variants, information on new variants and detailed surveillance of particular variants of concern can be found [here](#), and in the latest technical briefing [here](#).

## Antimicrobial susceptibility

Table 8 shows in the 12 weeks up to week 29 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	1,472	84
	Macrolides	1,646	80
	Tetracycline	1,634	82
<i>H. influenzae</i>	Amoxicillin/ampicillin	5,555	59
	Co-amoxiclav	6,078	66
	Macrolides	1,674	7
	Tetracycline	6,092	98
<i>S. aureus</i>	Methicillin	4,771	93
	Macrolides	5,345	71
MRSA	Clindamycin	257	48
	Tetracycline	319	72
MSSA	Clindamycin	3,388	78
	Tetracycline	4,163	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 to 2021 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 to 2020 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 28 2021 are summarised. This programme has previously involved testing approximately 1,000 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 8 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 or 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 age group estimates and a 12-week rolling prevalence for 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 17.1% (95% CI 16.2% - 18.1%) using the Roche N assay and 95.5% (95% CI 94.9% - 96.0%) using the Roche S assay for the period 21 June – 16 July (weeks 25-28 2021). 1,216 /7,397 were Roche N positive and 7,126/7,397 samples were Roche S positive. This compares with 14.9% (95% CI 14.1% - 15.8%) Roche N seropositivity and 84.2% (95% CI 83.3% - 85.0%) Roche S seropositivity for the period of 24 May 2021 – 20 June 2021 (weeks 21-24 2021).

Seropositivity (weighted by region, age group and sex) varies over time. Figure 58 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 59).

Regional seropositivity estimates are plotted using the mid-point of a 12-weekly rolling period that reduces to 8 weekly in the most recent weeks to allow for a more representative current estimate of seropositivity. Previously, regional Roche N seropositivity was reported using a 4-week rolling period; however, this was recently changed due to the difficulty interpreting regional trends when using a 4-weekly window, given the fluctuation in sampling locations each week for some regions.

In London, the 12-weekly rolling seropositivity increased from 23.0% (95% CI 21.4% - 24.6%) in weeks 9-20 2021 to 24.8% (95% CI 23.0% - 26.8%) in weeks 21-28 2021.

Data from the Midlands show the proportion seropositive remained the same at 16.0% (95% CI 14.8% - 17.2%) in weeks 9-20 2021 and 15.9% (95% CI 14.4% - 17.5%) in weeks 21-28 2021.

Seropositivity in the North East and Yorkshire region showed a decrease from 15.5% (95% CI 14.2% - 16.9%) in weeks 9-20 2021 to 13.9% (95% CI 12.3% - 15.7%) in weeks 21-28 2021.

Data from the North West show that seropositivity has increased from 17.3% (95% CI 15.9% - 18.8%) in weeks 9-20 2021 to 21.1% (95% CI 19.1% - 23.2%) in weeks 21-28 2021.

Seropositivity has remained stable in the South East region at 12.3% (95% CI 11.1% - 13.5%) in weeks 9-20 2021 and 12.5% (95% CI 11.1% - 14.1%) in weeks 21-28 2021.

In the South West region, seropositivity has remained stable at 8.8% (95% CI 7.8% - 9.9%) in weeks 9-20 2021 and 9.0% (95% CI 7.7% - 10.4%) in weeks 21-28 2021.

In the East of England, seropositivity has also remained stable at 12.7% (95% CI 11.5% - 14.0%) in weeks 9-20 2021 and 12.9% (95% CI 11.6% - 14.4%) in weeks 21-28 2021.

London has consistently seen the highest Roche N seropositivity with the lowest observed in the South West.

## 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 60) 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 increased in recent weeks from 20.9% (95% CI 18.4% - 23.7%) in weeks 21-24 2021 to 24.4% (95% CI 21.8% - 27.3%) in weeks 25-28 2021. There has also been an increase in seropositivity in those aged 70-84, from 5.2% (95% CI 3.6% - 7.5%) in weeks 21 to 24 to 9.2% (95% CI 6.9% - 12.1%). Similar fluctuations in seropositivity have been observed in this age group previously and given the small numbers of samples within this age group, estimates are prone to variation.

Roche N seropositivity has continued to plateau across most other age groups. The recent small increases in Roche N seropositivity seen in the 17-29 year olds is consistent with recent increases of transmission seen from other surveillance data. The absence of Roche N increases across most of the other groups likely reflects the additional role vaccination is having in reducing viral infection in those already vaccinated.

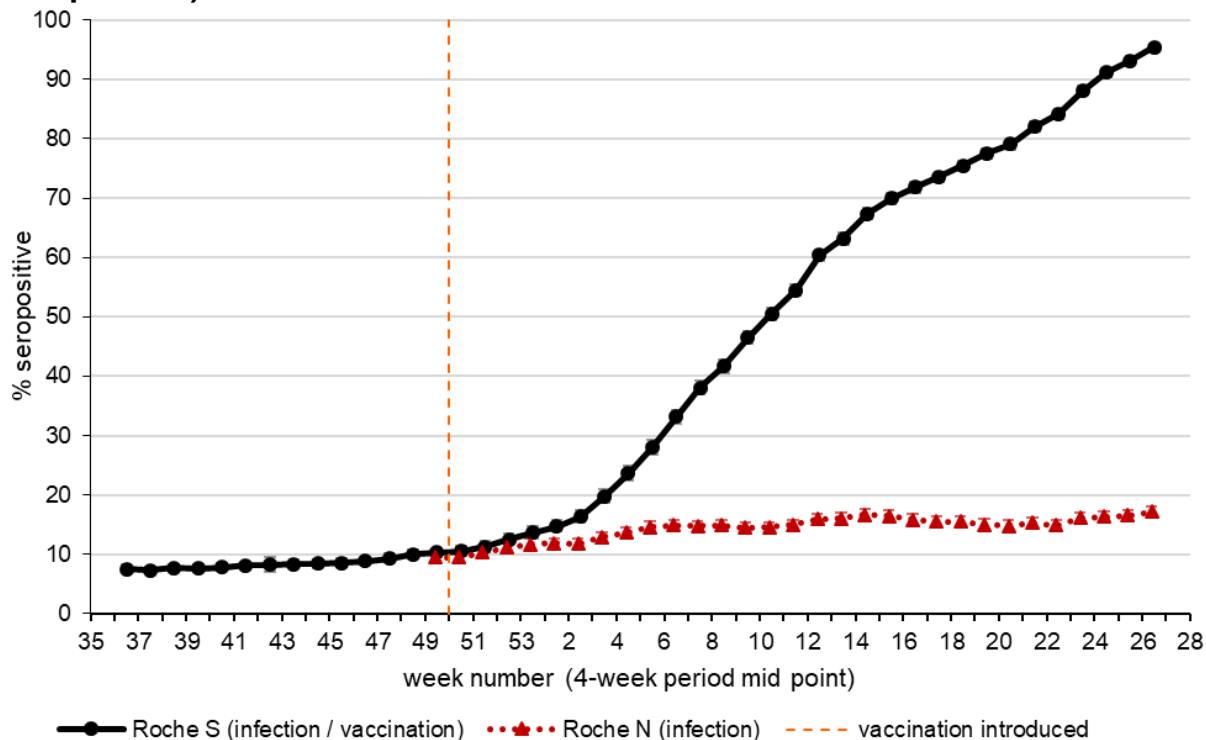
The sharp increases in seropositivity across all age groups using the Roche S assay reflect the presence of antibodies induced by vaccination (Figure 60).

Roche S seropositivity increased earliest in those aged 70-84 and since week 13 plateaued, reaching 99.4% (95% CI 98.3% - 99.8%) in weeks 25-28 2021. Seropositivity in those aged 60-69 has also plateaued since week 16 reaching 99.2% (95% CI 98.6% - 99.6%) in weeks 25-28 2021. A plateauing in Roche S seropositivity since week 19 has been observed in those aged 50-59 reaching 98.3% (95% CI 97.5% - 98.9%) in weeks 25-28 2021. A plateauing in seropositivity has recently been observed in the 40-49 year olds reaching 96.5% (95% CI 95.2% - 97.4%) in weeks 25-28. Large increases continue to be seen in the 30-39 year olds, from 76.5% (95% CI 74.2% - 78.7%) in weeks 21-24 to 95.2% (95% CI 93.9% - 96.2%) in weeks 25-28. Currently the greatest increase observed is in those aged 17-29, increasing from 51.0% (95% CI 47.8% - 54.2%) in weeks 21-24 2021 to 87.4% (95% CI 85.1% - 89.4%) in weeks 25-28 2021.

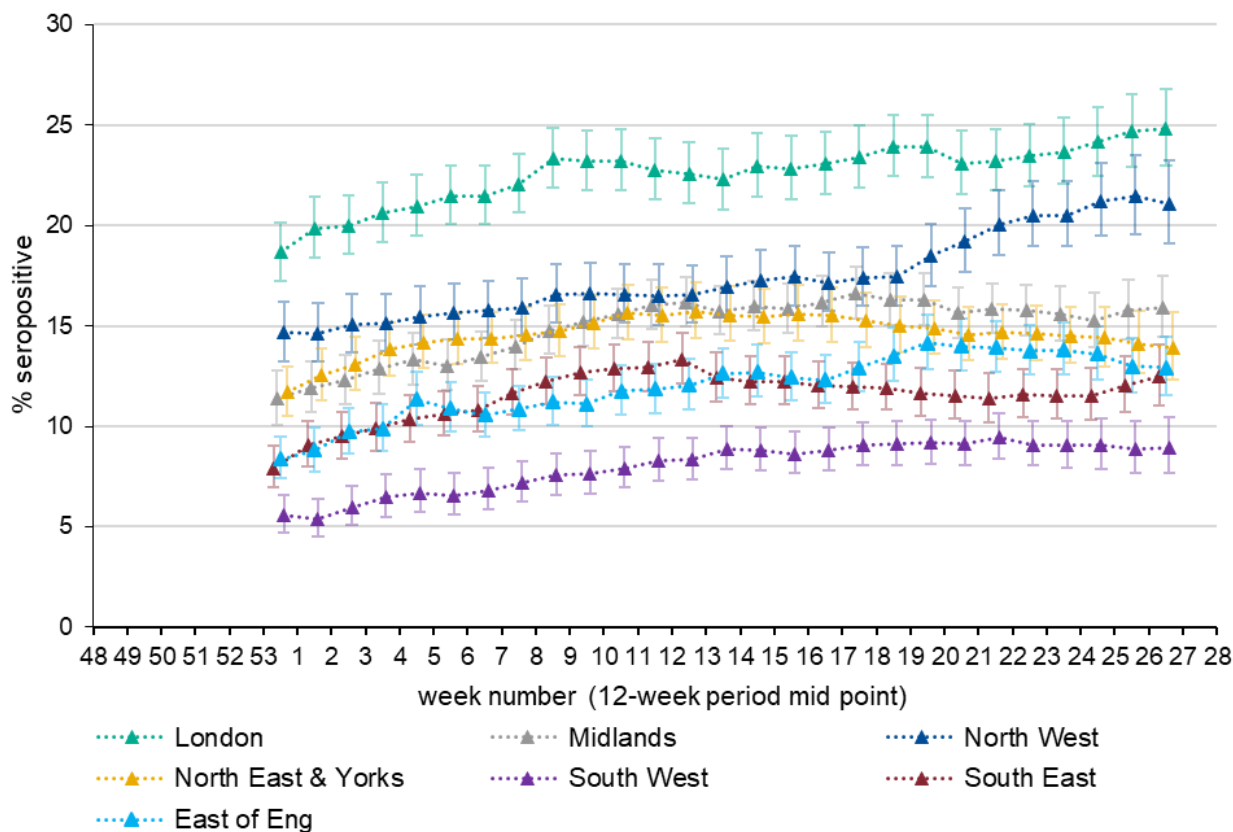
Vaccination is making an important contribution to the overall Roche S increases observed since the roll out of the vaccination programme, initially amongst individuals aged 50 years and above who were prioritised for vaccination as part of the phase 1

programme and more recently in those aged 49 and below as part of phase 2 of the vaccination programme. The continued plateauing of seropositivity, using the Roche N assay, in most age groups is likely to reflect vaccine impact.

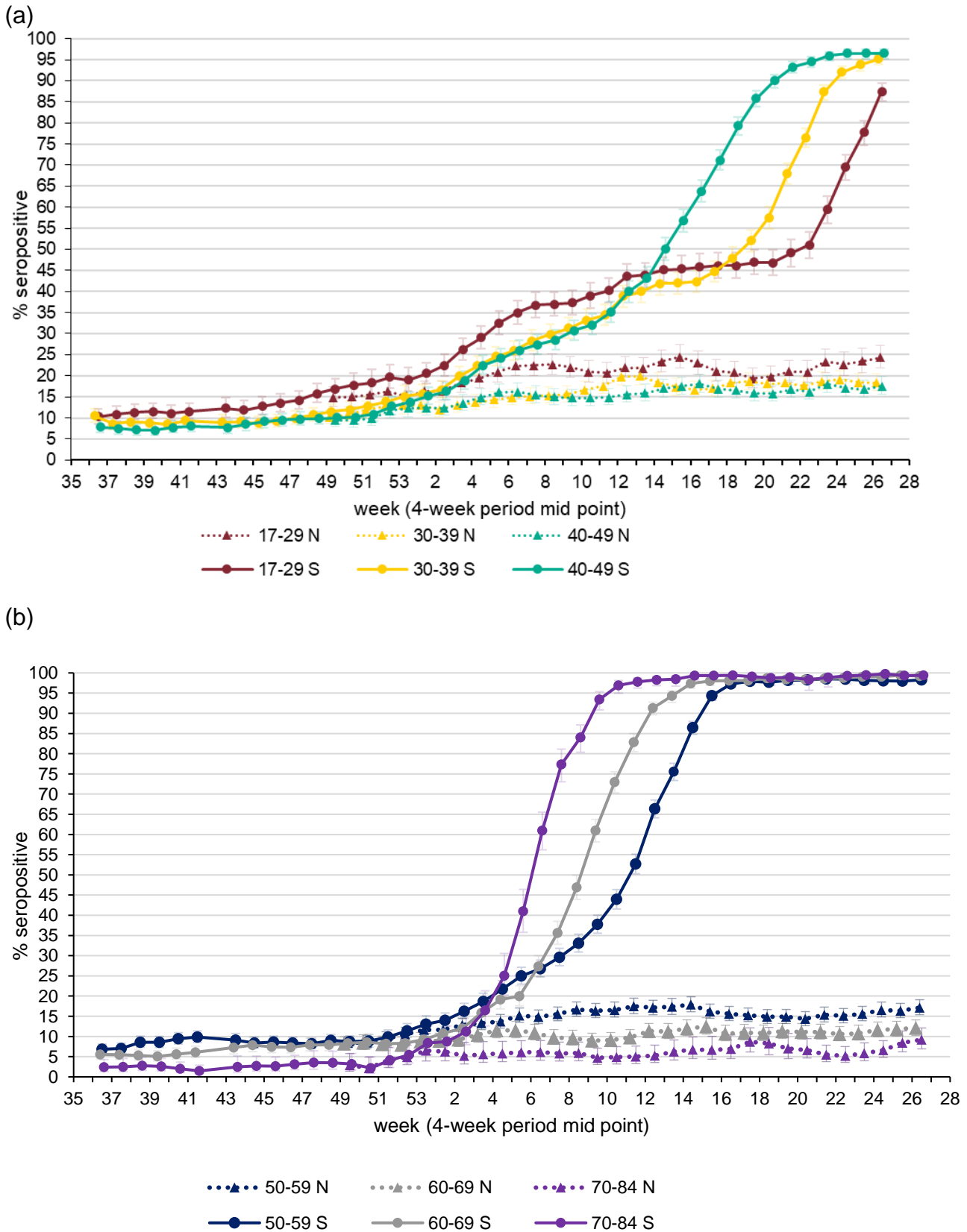
**Figure 58: Overall 4-weekly rolling SARS-CoV-2 antibody seroprevalence (% seropositive) in blood donors**



**Figure 59: 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 60: 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 to 29, 30 to 39 and 40 to 49, b) age group 50 to 59, 60 to 69 and 70 to 84**



# 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 29 2021 (week ending 25 July 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 62.7% and 50.0% for dose 2. The breakdown by sex showed vaccine uptake in males was 60.2% and 65.0% in females for dose 1. For dose 2 total uptake was 46.8% in males and 53.4% in females. The vaccine uptake rate in adults aged 18 and over was 78.2% (38,666,085/49,466,994) for dose 1 and 62.6% (30,962,282/49,466,994) for dose 2.

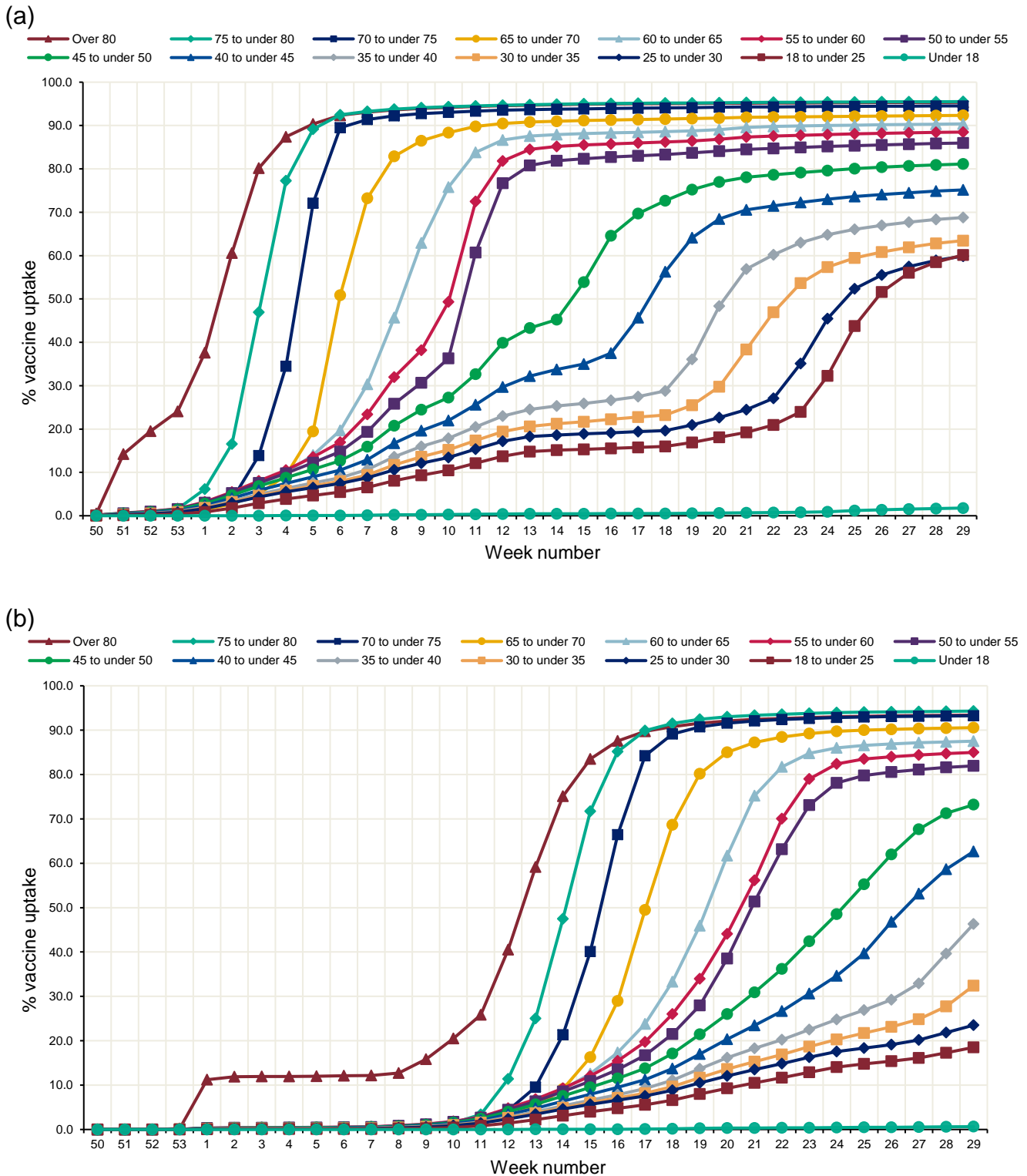
**Table 9: Provisional cumulative COVID-19 vaccine uptake by age in England**

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
Over 80	2,784,245	2,654,459	95.3	2,784,245	2,600,002	93.4
75 to under 80	2,075,790	1,982,723	95.5	2,075,790	1,957,448	94.3
70 to under 75	2,870,648	2,713,380	94.5	2,870,648	2,676,622	93.2
65 to under 70	2,889,866	2,668,360	92.3	2,889,866	2,617,133	90.6
60 to under 65	3,450,296	3,118,564	90.4	3,450,296	3,019,587	87.5
55 to under 60	4,077,234	3,607,771	88.5	4,077,234	3,464,665	85.0
50 to under 55	4,226,620	3,633,105	86.0	4,226,620	3,463,556	81.9
45 to under 50	4,000,723	3,245,530	81.1	4,000,723	2,928,167	73.2
40 to under 45	4,126,390	3,100,854	75.1	4,126,390	2,585,723	62.7
35 to under 40	4,512,699	3,103,805	68.8	4,512,699	2,089,752	46.3
30 to under 35	4,754,766	3,017,230	63.5	4,754,766	1,541,814	32.4
25 to under 30	4,451,501	2,665,479	59.9	4,451,501	1,046,599	23.5
18 to under 25	5,246,216	3,154,825	60.1	5,246,216	971,214	18.5
Under 18	12,580,644	223,755	1.8	12,580,644	79,616	0.6
Total*	62,047,638	38,890,375	62.7	62,047,638	31,042,190	50.0

\*Caution should be exercised when summing the regional or age figures as the sum of the regions will not equal the England total. This is due to individuals vaccinated in England who have a registered address in Scotland or Wales or where their address is unknown. There were also vaccinations where the individual had an unknown region and age group.

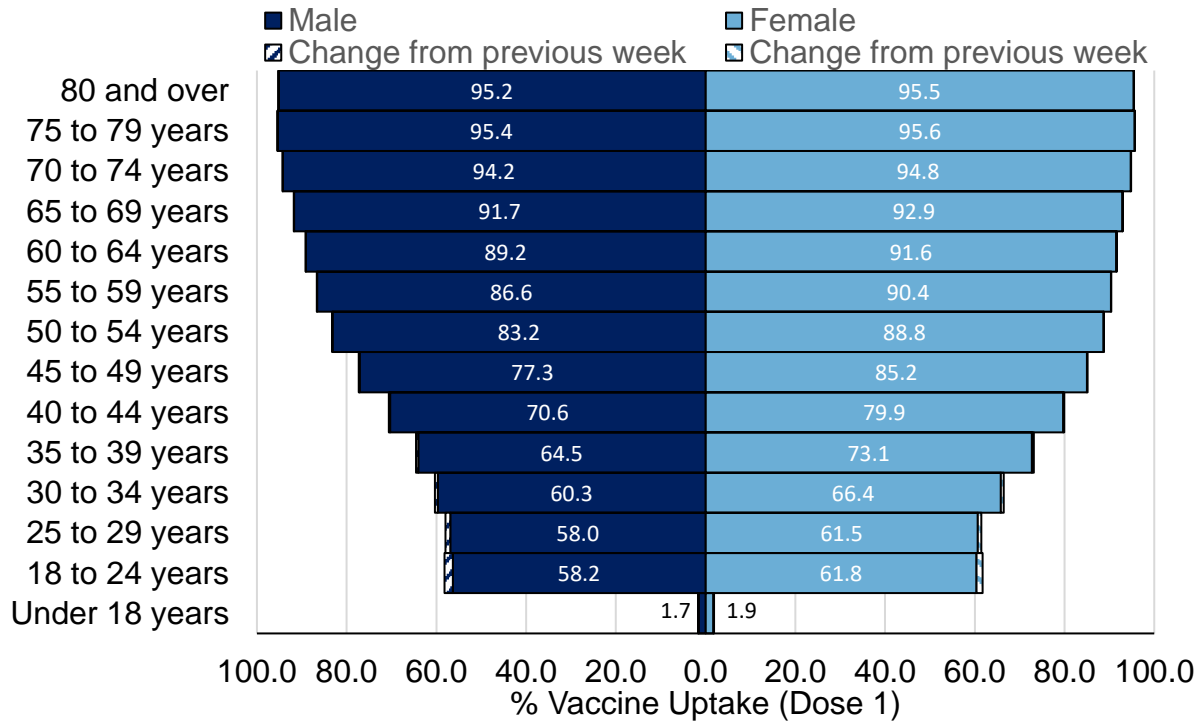
Data are provisional and subject to change following further validation checks. Any changes to historic figures will be reflected in the most recent publication. Please note that numbers published by PHE are for public health surveillance purposes only.

**Figure 61: Cumulative weekly COVID-19 vaccine uptake by age in England for (a) Dose 1 and (b) Dose 2**

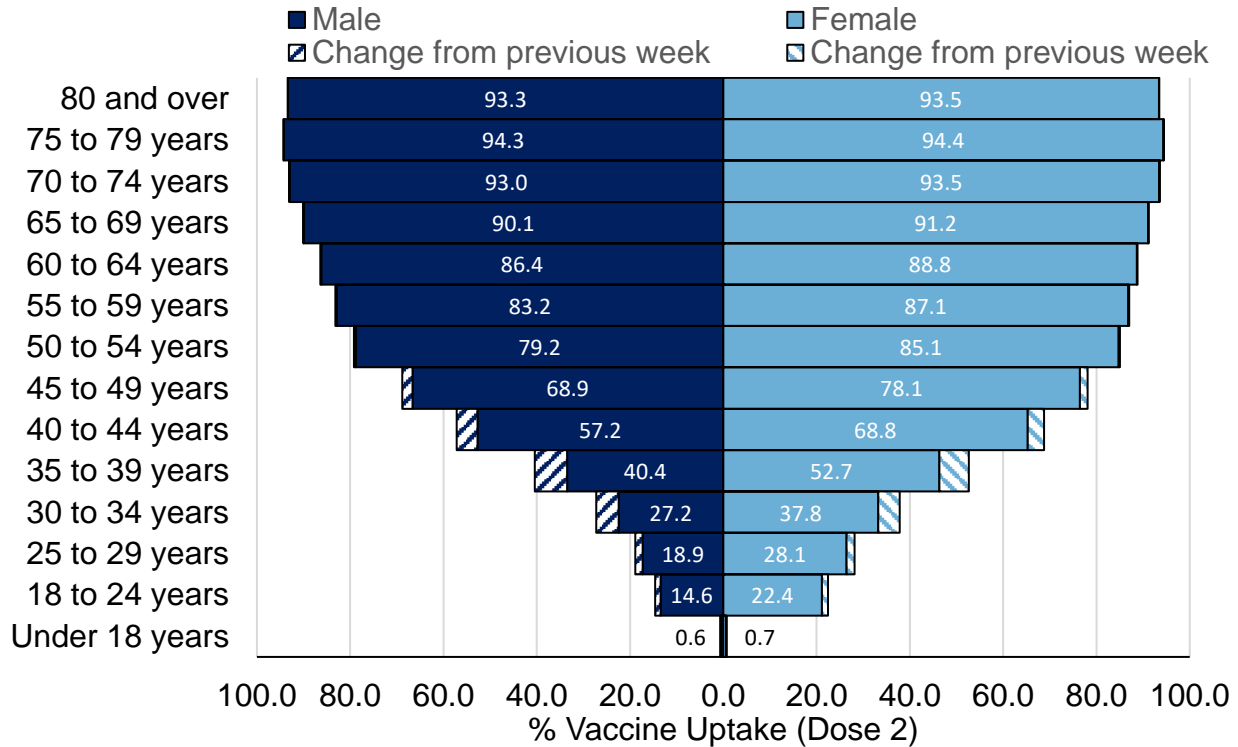




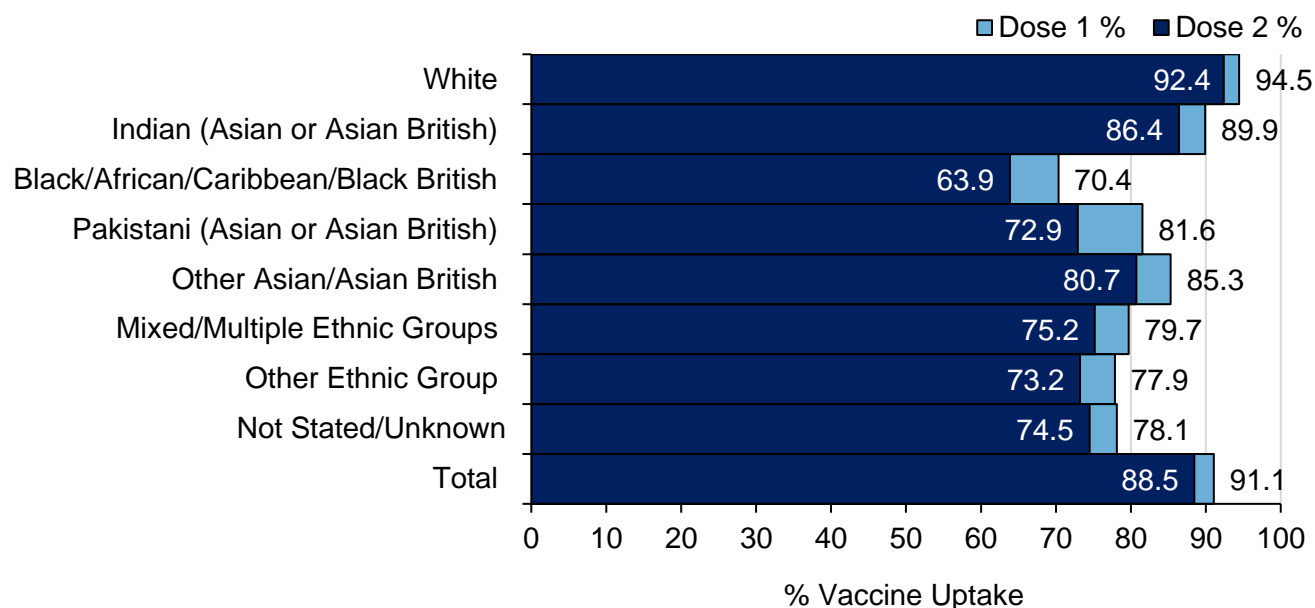
**Figure 62: Age-Sex pyramid for COVID-19 vaccine uptake by age in England for Dose 1**



**Figure 63: Age-Sex pyramid for COVID-19 vaccine uptake by age in England for Dose 2**



**Figure 64: 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. The statement can be accessed [here](#)

For UK COVID-19 daily counts of vaccinations, please see the [Vaccinations' section of the UK COVID-19 dashboard](#).

For COVID-19 management information on the number of COVID-19 vaccinations provided by the NHS in England, please see the [COVID-19 vaccinations](#) webpage.

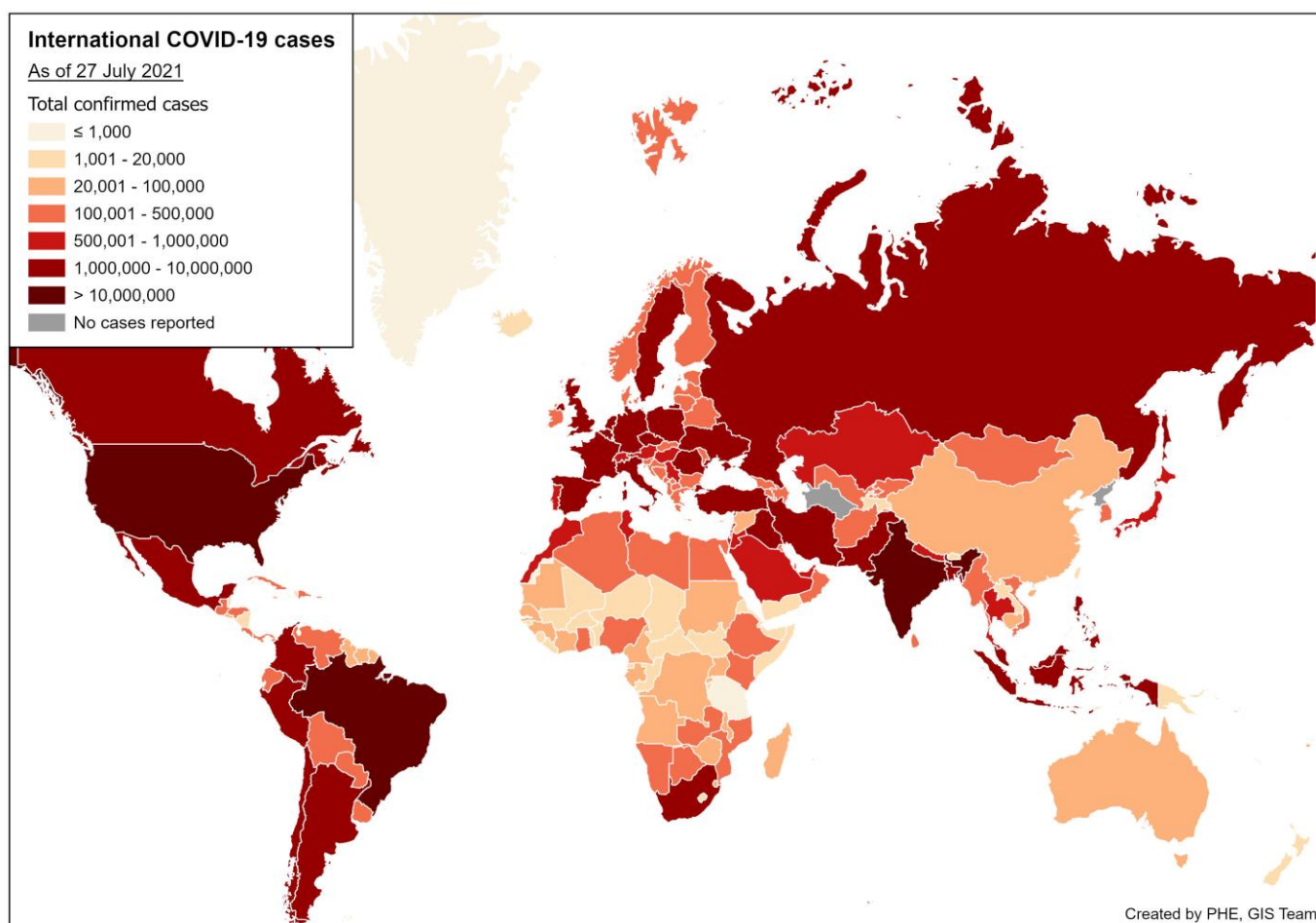
# International update

## Global COVID-19 update

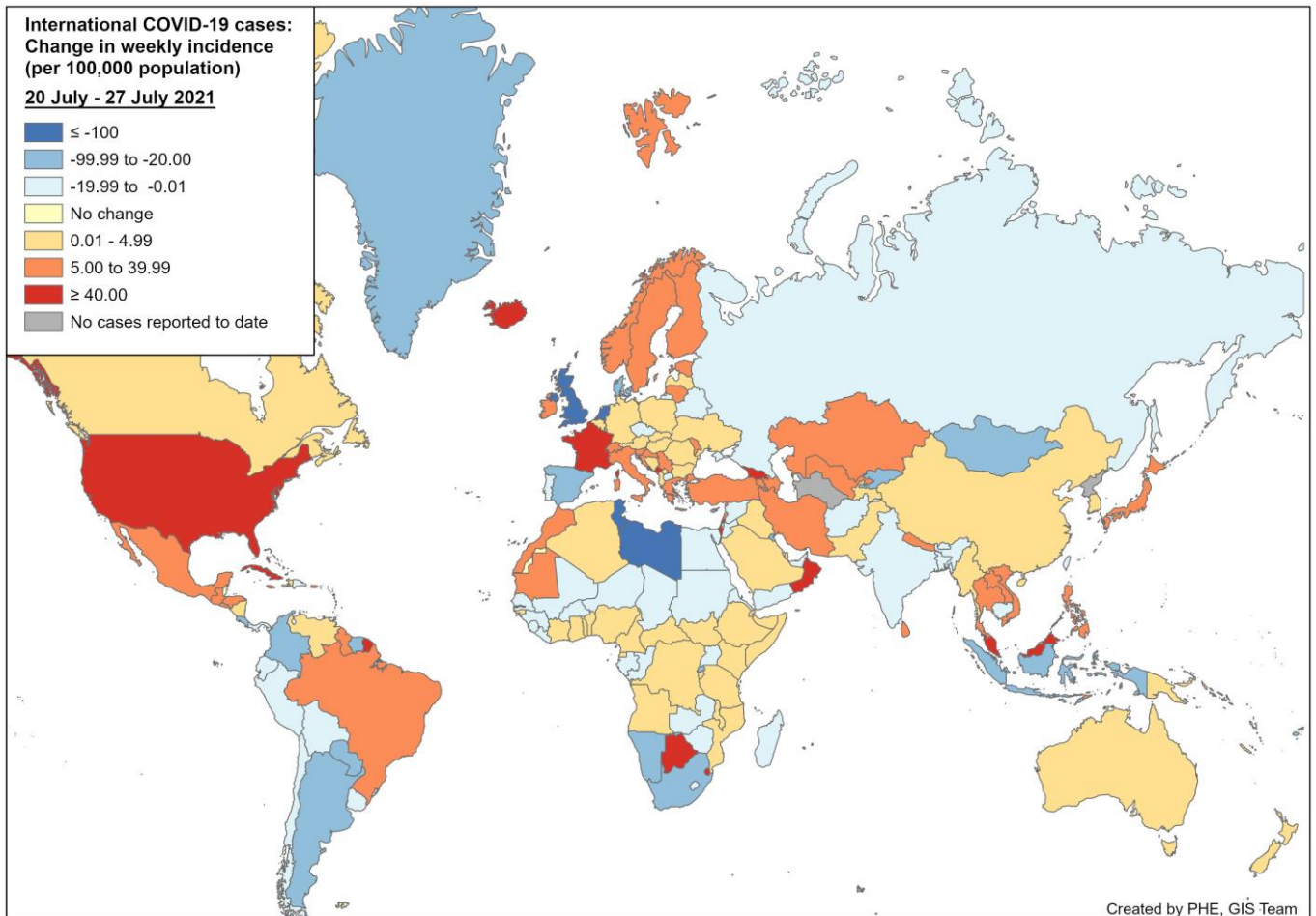
Globally, up to 27 July 2021, 194,646,599 cases of COVID-19 infection have been reported worldwide, including 4,175,138 COVID-19 related deaths.

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

**Figure 65: Global map of cumulative COVID-19 cases**



**Figure 66: 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 19 July 2021 (based on data up to 04 July 2021) ([WHO website](#)).

In the temperate zones of the northern hemisphere, influenza activity remained below baseline overall. In the temperate zone of the southern hemisphere, influenza activity was reported at inter-seasonal levels. Worldwide, influenza B detections accounted for the majority of the very low numbers of detections reported.

In the Caribbean and Central American countries, no influenza was reported across reporting countries.

In the tropical countries of South America, one influenza detection was reported for this period from Colombia.

In Western Africa, detections of influenza A(H1N1)pdm09 continued to be reported from Côte d'Ivoire and Ghana.

In Middle Africa, no detections were reported.

In Eastern Africa, Kenya reported some influenza B virus detections, while Tanzania reported detections of influenza A(H1N1)pdm09, A(H3N2) and influenza B viruses. Ethiopia reported detections of influenza A(H3N2) viruses.

In Southern Asia, detections of influenza A(H3N2) continued to be reported in India, as well as in Nepal and Pakistan. A small number of influenza A(H1N1)pdm09 virus detections were reported from India, and influenza B virus detections from Pakistan.

In South East Asia, influenza A(H3N2) and B detections were reported from the Philippines.

In the countries of North America, influenza activity indicators, including the percent of tests positive for influenza and influenza like illness (ILI) activity, were at very low levels.

In Europe, influenza activity remained at inter-seasonal levels 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, Egypt reported updated data showing continued detections of predominantly influenza A(H3N2) viruses and some influenza B virus detections since April 2021.

In Western Asia, influenza and ILI activity remained low overall. Qatar, Oman and Saudi Arabia reported detections of influenza B viruses.

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

In East Asia, influenza illness indicators and influenza activity remained low. Decreased detections of influenza B-Victoria lineage virus were reported from northern and southern China and remain low compared to previous years.

The WHO GISRS laboratories tested more than 156,034 specimens during the period 21 June to 04 July 2021. A total of 631 specimens were positive for influenza viruses, of which 143 (22.7%) were typed as influenza A and 488 (77.3%) as influenza B. Of the sub-typed influenza A viruses, 74 (59.2%) were influenza A(H1N1)pdm09 and 51 (40.8%) were influenza A(H3N2). Of the characterized B viruses, 2 (0.5%) belonged to the B-Yamagata lineage and 402 (99.5%) to the B-Victoria lineage.

## Influenza in Europe

Updated on 27 July 2021 ([Joint ECDC-WHO Europe Influenza weekly update](#))

For weeks 25 to 28 of 2021, influenza activity remained at inter-seasonal levels throughout Europe.

For week 28 2021, of 395 sentinel specimens tested for influenza viruses, none were positive. Since the start of the 2020 to 2021 season, of 45,513 sentinel-source specimens tested for influenza viruses, 46 were positive.

## 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 22 June 2021 ([WHO website](#))

Since the previous update on 21 May 2021, one human case of infection with an influenza A(H5N6) virus, two cases of human infection with influenza A(H9N2) viruses, one human infection with an influenza A(H10N3) virus, two human cases of infection with influenza A(H1N2) variant viruses and one human case of infection with an influenza A(H3N2) variant virus were reported officially. One additional human case of infection with an influenza A(H1N1) virus was detected.

Influenza A(H5) viruses:

According to reports received by the World Organisation for Animal Health (OIE), various influenza A(H5) subtypes continue to be detected in birds in Africa, Europe and Asia.

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. Overall, the risk assessments have not changed.

Influenza A(H9N2) viruses:

Since the last risk assessment on 21 May 2021, two human cases of infection with influenza A(H9N2) viruses were reported from China on 9 June 2021.

### 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, (three 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](#)

[COVID-19 vaccine surveillance reports](#)

[PHE monitoring of the effectiveness of COVID-19 vaccination](#)

[Investigation of SARS-CoV-2 variants of concern: technical briefings](#)

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

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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