



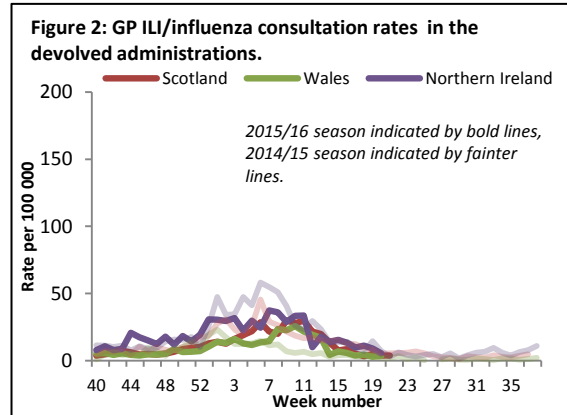
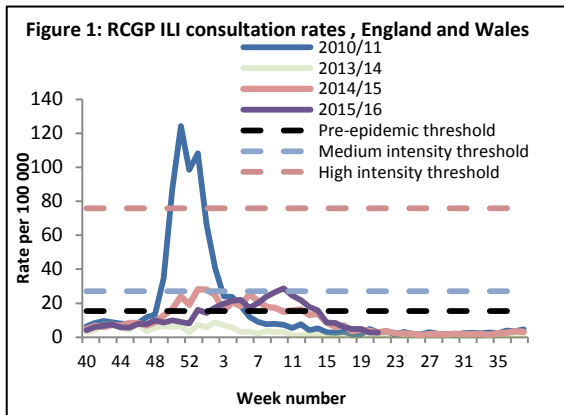
This report is published [online](#). A summary report is being published once a fortnight while influenza activity is low. For further information on the surveillance schemes mentioned in this report, please see information available [online](#).

In week 22 2016 (ending 05 June 2016), influenza activity continues to decrease and is below baseline levels across surveillance schemes. The national influenza report will now be published bi-weekly.

Community surveillance

- GP consultation rates for influenza-like illness remain low in all schemes in the UK (Figures 1 and 2).

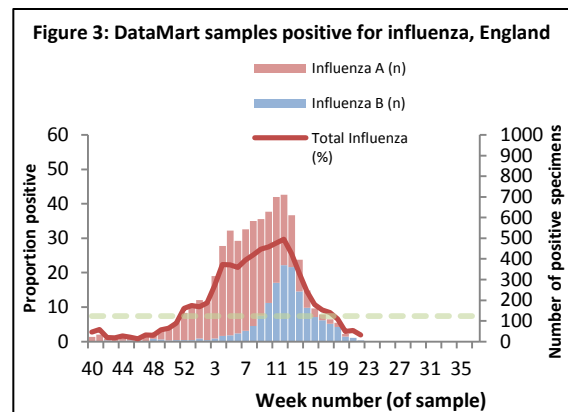
Scheme	GP ILI consultation rate per 100,000			Peak age group
	Week 21	Week 22		
England (RCGP)	2.8	2.7	↔	45-64yrs
Scotland	3.8	3.9	↔	65-74yrs
Northern Ireland	5.6	8.0	↑	65-74yrs
Wales	4.5	1.8	↓	65-74yrs



- Syndromic surveillance
 - Syndromic surveillance indicators for influenza remained low in weeks 22 2016.
 - For further information, please see the Syndromic surveillance [webpage](#).

Virological surveillance

- English Respiratory Data Mart system
 - In week 22 2016, 15 samples (1.9%) of the 774 respiratory specimens tested were positive for influenza (4 A(H1N1)pdm09, 4 A(H3N2), 1 A(untyped) and 6 B, Figure 3).
 - Rhinovirus positivity increased slightly from 15.0% in week 21 to 16.9% in week 22. RSV positivity increased slightly from 0.1% in week 21 to 0.9% in week 22. Positivity remained low for parainfluenza (9.1%) and increased slightly for hMPV (1.4%) and adenovirus (5.3%).
- UK GP-based sentinel schemes
 - Through the GP-based sentinel schemes across the UK, no samples were positive for influenza in week 22 2016.



Outbreak Reporting

- Five new acute respiratory outbreaks were reported in the past 7 days. Three were from hospitals where two tested positive for parainfluenza viruses and one for influenza B. Two were from care homes where one tested positive for influenza A(H3N2) and one for influenza B.
- Outbreaks should be reported to the local Health Protection Unit and Respscidsc@phe.gov.uk.

All-cause mortality surveillance

- In week 21 2016, an estimated 9,739 all-cause deaths were registered in England and Wales (source: [Office for National Statistics](#)). This is a decrease compared to the 9,953 estimated death registrations in week 20 2016, and is below the 95% upper limit of expected death registrations for the time of year as calculated by PHE (Figure 4). The drops in the number of deaths in week 53 and week 13 correspond to weeks where there were bank holidays and fewer days when deaths were registered. Therefore these decreases are likely to be artificial.
- In week 22 2016, no significant excess was reported overall, by age group or by region in England after correcting ONS disaggregate data for reporting delay with the standardised weekly EuroMOMO algorithm (Table 1). This data is provisional due to the time delay in registration and so numbers may vary from week to week.

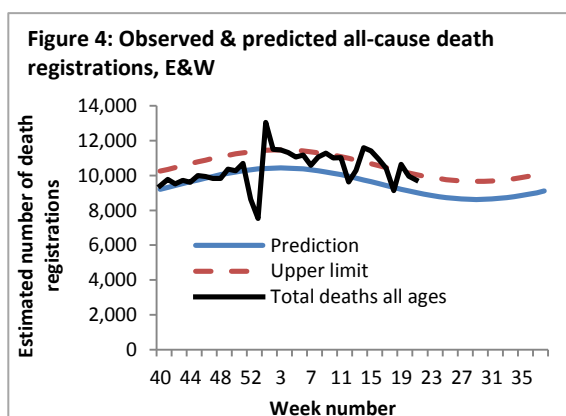


Table 1: Excess mortality by age group, England*

Age group (years)	Excess detected in week 22 2016?	Weeks with excess in 2015/16
<5	x	05,15,19
5-14	x	51
15-64	x	52-53, 03,05-07, 09-10,12,17
65+	x	NA

* Excess mortality is calculated as the observed minus the expected number of deaths in weeks above threshold

International Surveillance

- Influenza
 - Influenza activity in the northern hemisphere continued to decrease with a predominance of influenza B virus reported. In temperate countries in the southern hemisphere, influenza activity started to increase slightly in South America and South Africa, but remained low overall in most of Oceania.
 - In North America, influenza activity continued to decrease while the proportion of influenza B virus detections increased compared to previous reporting periods.
 - Influenza activity continued to decrease in Europe and temperate Asia with a predominance of influenza B virus activity.
 - The WHO GISRS laboratories tested more than 63813 specimens from 0 May 2016 to 15 May 2016. 6224 were positive for influenza viruses, of which 2104 (33.8%) were typed as influenza A and 4120 (66.2%) as influenza B. Of the sub-typed influenza A viruses, 938 (79%) were influenza A(H1N1)pdm09 and 249 (21%) were influenza A(H3N2). Of the characterized B viruses, 268 (25%) belonged to the B-Yamagata lineage and 804 (75%) to the B-Victoria lineage.
- MERS-CoV
 - Up to 01 June 2016, a total of four cases of Middle East respiratory syndrome coronavirus, MERS-CoV, (two imported and two linked cases) have been confirmed in the UK. On-going surveillance has identified 750 suspect cases in the UK that have been investigated for MERS-CoV and tested negative.
 - Globally, since September 2012, WHO has been notified of 1,728 laboratory-confirmed cases of infection with MERS-CoV, including at least 624 related deaths. Further information on management and guidance of possible cases is available [online](#). The latest ECDC MERS-CoV risk assessment can be found [here](#), where it is highlighted that risk of widespread transmission of MERS-CoV remains low.
- Influenza A(H7N9)
 - On **10 May 2016**, the National Health and Family Planning Commission (NHFPC) of China notified WHO of 11 additional laboratory-confirmed cases of human infection with avian influenza A(H7N9) virus, including 4 deaths.
 - A total of 770 laboratory-confirmed cases of human infection with avian influenza A(H7N9) viruses, including at least 306 deaths, have been reported to WHO.
 - For further updates please see the WHO website and for advice on clinical management please see information available [online](#).