



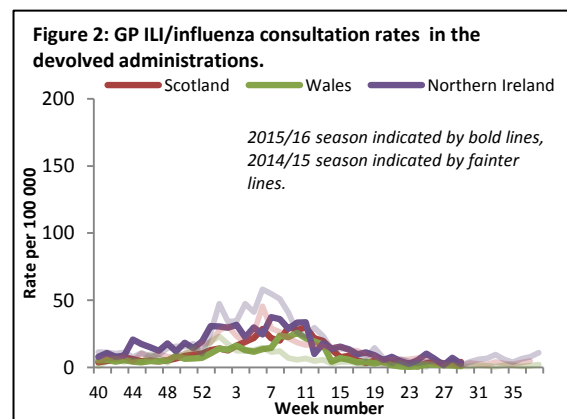
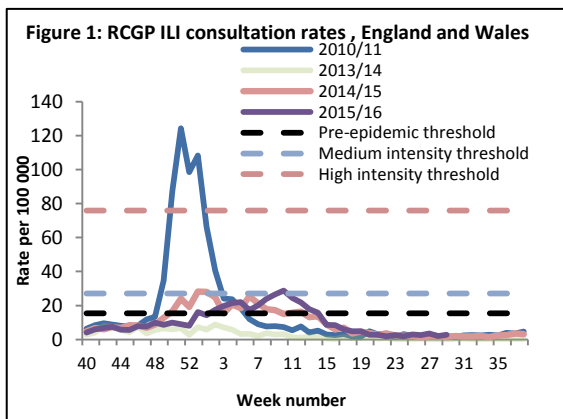
This report is published [online](#). A summary report is being published once a fortnight while influenza activity is low. For further information on the surveillance schemes mentioned in this report, please see information available [online](#).

## Indicators for influenza show very low levels of activity.

### Community surveillance

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

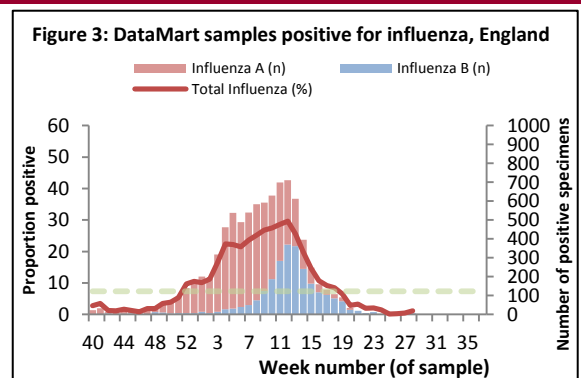
Scheme	GP ILI consultation rate per 100,000			Peak age group
	Week 29	Week 30		
England (RCGP)	2.0	2.7	↔	45-64yrs
Scotland	2.0	4.2	↑	75+ yrs
Northern Ireland	7.1	2.8	↓	75+ yrs
Wales	1.6	0.9	↔	45-64yrs



- Syndromic surveillance
  - Syndromic surveillance indicators for influenza remained low in weeks 29 and 30 2016.
  - For further information, please see the Syndromic surveillance [webpage](#).

### Virological surveillance

- English Respiratory Data Mart system
  - In week 30 2016, 1 (0.1%) of the 833 respiratory specimens tested were positive for influenza (influenza A(H3)).
  - Rhinovirus positivity decreased from 19.4% in week 29 to 14.7% in week 30. Parainfluenza positivity remained stable at 5.8% in week 30. Positivity remained low for RSV (1.3%) and hMPV (1.7%), however positivity for adenovirus increased from 4.5% in week 29 to 6.2% in week 30.
- UK GP-based sentinel schemes
  - Through the GP-based sentinel schemes across the UK, no samples were positive for influenza in week 30 2016.



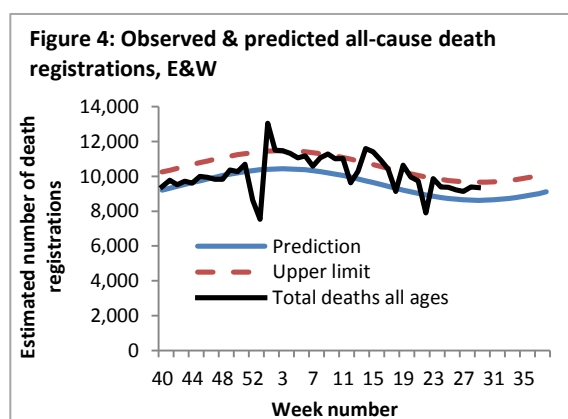
### Outbreak Reporting

- One new acute respiratory outbreak was reported in the past 14 days. This outbreak was from a care home and tested positive for rhinovirus. Outbreaks should be reported to the local Health Protection Unit and [Respscidsc@phe.gov.uk](mailto:Respscidsc@phe.gov.uk).

### All-cause mortality surveillance

- In week 29 2016, an estimated 9,350 all-cause deaths were registered in England and Wales (source: [Office for National Statistics](#)). This is a decrease compared to the 9,388 estimated death registrations in week 28 2016, and is below the 95% upper limit of expected death registrations for the time of year as calculated by PHE (Figure 1). The drops in the number of deaths in weeks 53, 13, 18 and 22 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 29 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 29 2016?	Weeks with excess in 2015/16
<5	×	40,05,19
5-14	×	NA
15-64	×	52-53, 03,05-07, 09-10
65+	×	NA

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

## International Surveillance

- Influenza**
  - Influenza activity varied in countries of temperate South America and increased steadily in the last few weeks in South Africa, but remained low overall in most of Oceania. Influenza activity in the temperate zone of the northern hemisphere was at inter-seasonal levels.
  - In temperate South America, influenza-like illness (ILI), acute respiratory infection (ARI) and severe acute respiratory infection (SARI) cases continued to increase, with influenza A(H1N1)pdm09 predominating and co-circulating with influenza B viruses in some countries. Respiratory syncytial virus (RSV) remained elevated in this region.
  - In the temperate countries of Southern Africa, influenza detections continued to increase among ILI consultations with predominantly influenza B viruses detected, followed by A(H3N2) viruses. In the northern temperate and central tropical regions of Africa, influenza activity was generally low with influenza A(H3N2) virus detections predominant in Western Africa and influenza B virus detections predominant in Eastern and Northern Africa.
  - In Oceania, influenza virus activity slightly increased but remained low. ILI activity in Australia and New Zealand remained low for this time of the year.
  - In the Caribbean countries, respiratory virus activity remained generally low. SARI cases and hospitalisations increased slightly in several countries and influenza B continued to circulate at low levels especially in Cuba.
  - In Central America, detections of influenza A(H1N1)pdm09 continued in a decreasing trend while detections of non-influenza respiratory viruses increased.
  - In tropical South America, respiratory virus activities generally decreased in recent weeks or remained low, with influenza A(H1N1)pdm09 predominant. In Colombia and the Plurinational State of Bolivia, influenza A(H1N1)pdm09 activity seemed to have peaked in the past few weeks at levels higher than peaks in the previous few years. ARI and SARI activities decreased but remained elevated compared to the same period last year in Colombia. Influenza A(H1N1)pdm09 detections continued to decrease in Ecuador. In Brazil and Peru, influenza A(H1N1)pdm09 activity remained low and SARI indicators continued to decrease in Brazil.
  - In tropical countries of South Asia, influenza activity was generally low with influenza A and B co-circulating in the region. Influenza activity was low in temperate Asia with influenza B virus predominant.
  - The WHO GISRS laboratories tested more than 44,063 specimens between 27 June 2016 and 10 July 2016. 2,366 were positive for influenza viruses, of which 1,571 (66.4%) were typed as influenza A and 795 (33.6%) as influenza B. Of the sub-typed influenza A viruses, 601 (57.2%) were influenza A(H1N1)pdm09 and 450 (42.8%) were influenza A(H3N2). Of the characterized B viruses, 105 (34.0%) belonged to the B-Yamagata lineage and 204 (66.0%) to the B-Victoria lineage.
- MERS-CoV**
  - Up to 03 August 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 787 suspected cases in the UK that have been investigated for MERS-CoV and tested negative.
  - Between [2 and 14 July 2016](#) the National IHR Focal Point of Saudi Arabia reported 9 additional cases of Middle East Respiratory Syndrome Coronavirus (MERS-CoV) including 2 deaths.
  - Globally, since September 2012, WHO has been notified of 1,791 laboratory-confirmed cases of infection with MERS-CoV, including at least 640 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 [12 July 2016](#), the National Health and Family Planning Commission (NHFPC) of China notified WHO of 7 additional laboratory-confirmed cases of human infection with avian influenza A(H7N9) virus, including 4 deaths.
  - A total of 793 laboratory-confirmed cases of human infection with avian influenza A(H7N9) viruses, including at least 319 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](#).