



PHE National Influenza Report

Summary of UK surveillance of influenza and other seasonal respiratory illnesses

15 September 2016 – Week 37 report (up to week 36 data)

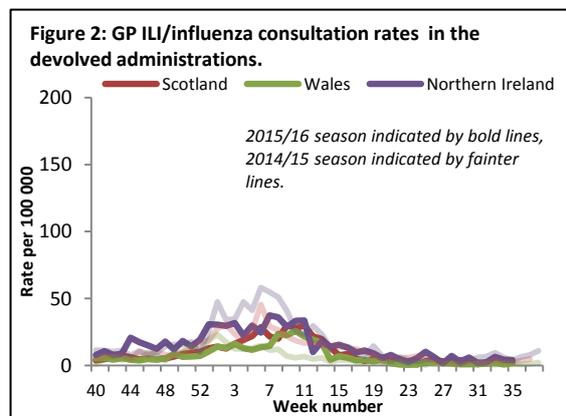
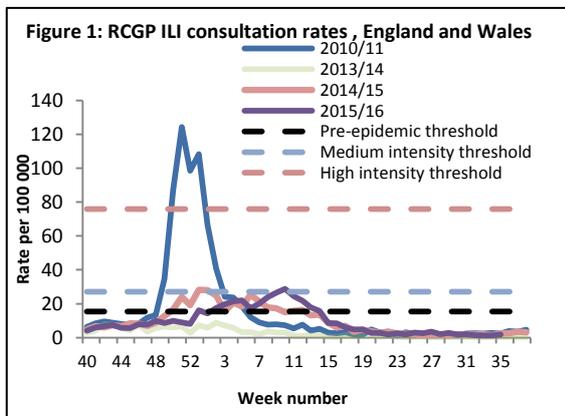
This report is published [online](#). A summary report is being published once a fortnight while influenza activity is low. For further information on the surveillance schemes mentioned in this report, please see information available [online](#).

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).

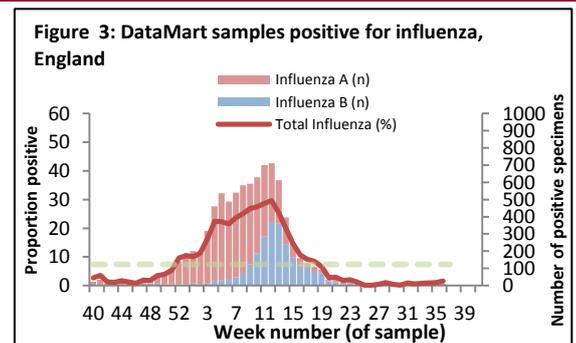
Scheme	GP ILI consultation rate per 100,000			Peak age group
	Week 35	Week 36		
England (RCGP)	1.3	1.9	↔	45-64yrs
Scotland	3.7	2.3	↓	75+yrs
Northern Ireland	4.4	4.2	↔	65-74yrs
Wales	0.8	1.7	↔	75+yrs



- Syndromic surveillance
 - Syndromic surveillance indicators for influenza remained low in weeks 35 and 36 2016.
 - For further information, please see the Syndromic surveillance [webpage](#).

Virological surveillance

- English Respiratory Data Mart system
 - In week 36 2016, 12 (1.6%) of the 766 respiratory specimens tested were positive for influenza (3 influenza A(H1N1)pdm09, 3 influenza A(H3), 2 influenza A(not subtyped) and 4 influenza B).
 - RSV positivity increased slightly from 1.6% in week 35 to 2.4% in week 36. Rhinovirus positivity remained similar to last week at 10.9% in week 36. Positivity remained low for parainfluenza (1.3%), adenovirus (3.5%) and hMPV (1.0%) in week 36.
- UK GP-based sentinel schemes
 - Through the GP-based sentinel schemes across the UK, no samples were positive for influenza in week 36 2016.



Outbreak Reporting

- Three new acute respiratory outbreaks from care homes have been reported in the past 14 days with no test results available. Outbreaks should be reported to the local Health Protection Team and Respscidsc@phe.gov.uk.

All-cause mortality surveillance

- In week 35 2016, an estimated 7,923 all-cause deaths were registered in England and Wales (source: [Office for National Statistics](#)). This is a decrease compared to the 9,319 estimated death registrations in week 34 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 weeks 53, 13, 18, 22 and 35 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 36 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.

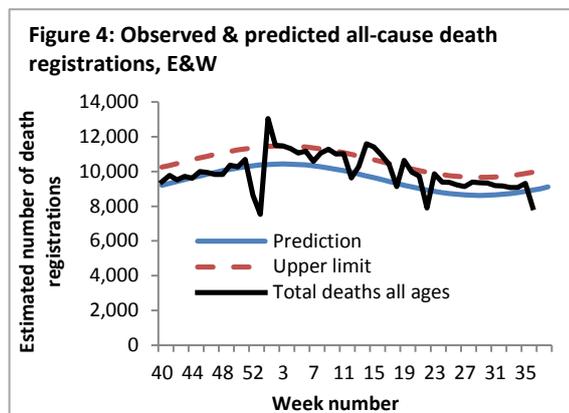


Table 1: Excess mortality by age group, England*

Age group (years)	Excess detected in week 36 2016?	Weeks with excess in 2015/16
<5	x	40,05,19
5-14	x	NA
15-64	x	52-53, 02-03,05-07, 09-10
65+	x	29

* 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 and Oceania. Influenza activity in the temperate zone of the northern hemisphere was at inter-seasonal levels.
 - In temperate South America, there was a decreasing trend in influenza and respiratory syncytial virus (RSV) activity levels throughout most of the sub-region. 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, among the few countries reporting data during this period.
 - In the temperate countries of Southern Africa, influenza detections among ILI patients continued to rise, with a recent shift from influenza B to predominantly influenza A virus circulating.
 - In Oceania, influenza virus activity increased over the last weeks with influenza A(H3N2) being the dominant circulating influenza virus.
 - In the Caribbean countries, influenza virus activity remained low.
 - In Central America, influenza virus activity remained low but in most of the countries, detections of non-influenza respiratory viruses stayed elevated with RSV predominating.
 - In tropical South America, influenza A(H1N1)pdm09 and RSV virus detections generally decreased in recent weeks or remained low in most of the countries.
 - In tropical countries of South Asia, influenza activity was generally low with seasonal influenza A and B viruses co-circulating in the region.
 - Influenza activity was generally low in temperate Asia. In South East Asia, there has been an increase in influenza detection in recent weeks, with seasonal influenza A and B co-circulating.
 - The WHO GISRS laboratories tested more than 36,019 specimens between 08 August 2016 and 21 August 2016. 2,173 were positive for influenza viruses, of which 1,524 (70.1%) were typed as influenza A and 649 (29.9%) as influenza B. Of the sub-typed influenza A viruses, 390 (30.7%) were influenza A(H1N1)pdm09 and 880 (69.3%) were influenza A(H3N2). Of the characterized B viruses, 39 (23.2%) belonged to the B-Yamagata lineage and 129 (76.8%) to the B-Victoria lineage.
- MERS-CoV
 - Up to 14 September 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 808 suspected cases in the UK that have been investigated for MERS-CoV and tested negative.
 - On [30 July 2016](#), the Ministry of Public Health, Thailand, announced a laboratory confirmed case of Middle East Respiratory Syndrome (MERS-CoV) in an 18-year-old Kuwaiti man who arrived in Thailand on 25 July with his family.
 - Globally, since September 2012, WHO has been notified of 1,800 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 [11 August 2016](#), the National Health and Family Planning Commission of China notified WHO of five additional cases of laboratory-confirmed human infection with avian influenza A(H7N9) virus, including one death.
 - A total of 798 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](#).