



# PHE Weekly National Influenza Report

## Summary of UK surveillance of influenza and other seasonal respiratory illnesses

09 February 2017 – Week 06 report (up to week 05 data)

This report is published weekly on the [PHE website](#). For further information on the surveillance schemes mentioned in this report, please see the [PHE website](#) and the [related links](#) at the end of this document.

| [Summary](#) | [Community surveillance](#) | [GP consultation rates](#) | [Hospitalisations](#) | [All-cause mortality](#) | [Microbiological surveillance](#) | [Vaccination](#) | [International](#) | [Acknowledgements](#) | [Related links](#) |

### Summary

During week 05 (ending 05 February 2017), influenza activity continues across all indicators The Department of Health has issued an [alert](#) on the prescription of antiviral medicines by GPs.

- [Community influenza surveillance](#)
  - Through the GP In Hours Syndromic Surveillance system, there were further slight increases in GP consultations for influenza like illness (ILI) in the over 45 years age group in week 05.
  - 78 new acute respiratory outbreaks have been reported in the past 7 days. 51 outbreaks were from care homes, where 18 tested positive for influenza (18 influenza A(not subtyped)). 15 outbreaks were from hospitals where 11 tested positive for influenza (10 influenza A (not subtyped) and 1 influenza A(H3N2)) and two were mixed infections with influenza A and other respiratory viruses. Nine outbreaks were from schools, where two tested positive for influenza (2 influenza A(not subtyped)). The remaining three outbreaks were from the Other settings category (two households and a prison), where all three tested positive for influenza A (not subtyped).
- [Overall weekly influenza GP consultation rates across the UK](#)
  - In week 05, the overall weekly influenza-like illness (ILI) GP consultation rate was 18.9 per 100,000 in England compared to 15.9 per 100,000 in the previous week. This is above the baseline threshold of 14.3 per 100,000 for this season, consistent with influenza circulating in the community. In the devolved administrations, ILI rates have remained similar or decreased compared to the previous week.
- [Influenza-confirmed hospitalisations](#)
  - In week 05, there were 81 admissions to ICU/HDU with confirmed influenza (50 influenza A(unknown subtype), 25 influenza A(H3N2), four influenza A(H1N1)pdm09 and two influenza B) were reported across the UK (137/156 Trusts in England) through the USSS mandatory ICU scheme with a rate of 0.16 per 100,000 compared to 0.16 per 100,000 in the previous week.
  - In week 05, there were 106 hospitalised confirmed influenza cases (53 influenza A(H3N2), 47 influenza A(not subtyped), one influenza A(H1N1)pdm09 and five influenza B) reported through the USSS sentinel hospital network (15 NHS Trusts across England), with a rate of 2.06 per 100,000, compared to 1.93 per 100,000 in the previous week.
  - No confirmed influenza admissions have been reported from the six Severe Respiratory Failure centres in the UK in week 05.
- [All-cause mortality data](#)
  - In week 05 2017, statistically significant excess all-cause mortality by week of death was seen through the EuroMOMO algorithm in England overall and by age group, in the 15-64 year olds and 65+ year olds.
- [Microbiological surveillance](#)
  - 31 samples tested positive for influenza (19 influenza A(H3N2), 9 influenza A(unknown subtype) and 3 influenza B) through GP sentinel schemes across the UK, with an overall positivity of 34.4% in week 05 compared to 35.4% in week 04.
  - 474 influenza positive detections were recorded through the DataMart scheme (413 influenza A(H3N2), 56 influenza A(unknown subtype) and 5 influenza B) in week 05. The overall positivity was at 23.1% in week 05 compared to 26.0% in week 04, which remains above the threshold for 2016/17 season of 8.6%.The highest age-specific positivities were seen in the 65+ year olds (29.4%).
- [Vaccination](#)
  - Up to week 04 2017, in 85.0% of GP practices reporting weekly to Immform, the provisional proportion of people in England who had received the 2016/17 influenza vaccine in targeted groups was as follows: 48.5% in under 65 years in a clinical risk group, 44.9% in pregnant women and 70.5% in 65+ year olds. In 88.1% of GP practices reporting to Immform, the provisional proportion of children in England who had received the 2016/17 influenza vaccine was as follows: 39.0% in all 2 year olds, 41.6% in all 3 year olds and 33.8% in all 4 year olds.
  - Provisional data from the third monthly collection of influenza vaccine uptake in GP patients up to 31 December 2016 has been published. The [report](#) provides uptake at national, Area Team (AT), Clinical Commissioning Group (CCG) and by Local Authority (LA) levels.
  - Provisional data from the third monthly collection of influenza vaccine uptake by frontline healthcare workers show 61.8% were vaccinated by 31 December 2016, compared to 47.6% vaccinated in the previous season by 31 December 2015. The [report](#) provides uptake at Trust level.
  - Provisional [data](#) from the third monthly collection of influenza vaccine uptake for children of school years 1, 2 and 3 age show the provisional proportion of children in England who received the 2016/17 influenza vaccine via school, pharmacy or GP practice by 31 December 2016 in targeted groups was as follows: 56.6% in children of school Year 1 age (5-6 years); 54.4% in children of school Year 2 age (6-7 years); 52.4% in children of school Year 3 age (7-8 years).
- [International situation](#)
  - Globally, influenza activity in the temperate zone of the northern hemisphere continued to increase, with many countries especially in Europe and East Asia passing their seasonal threshold early in comparison with previous years. Worldwide, influenza A(H3N2) virus was predominant.

Through the GP In Hours Syndromic Surveillance system, there were further slight increases in GP consultations for influenza like illness (ILI) in the over 45 years age group in week 05. 78 new acute respiratory outbreaks were reported in the past 7 days.

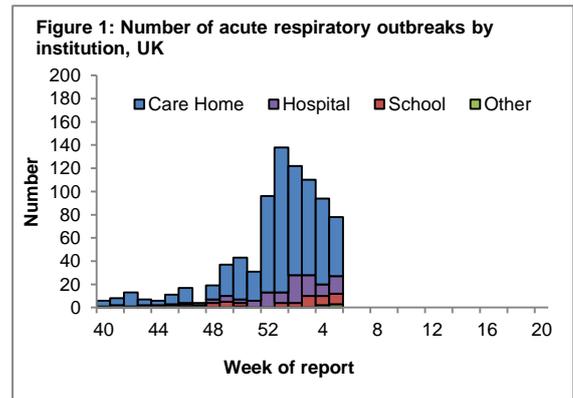
- PHE Real-time Syndromic Surveillance

- During week 05, contacts for respiratory conditions remained at seasonally expected levels across all syndromic surveillance systems. There were further slight increases in GP consultations for ILI in adults aged 45 years and over.
- For further information, please see the syndromic surveillance [webpage](#).

- Acute respiratory disease outbreaks

- 78 new acute respiratory outbreaks have been reported in the past 7 days. 51 outbreaks were from care homes, where 18 tested positive for influenza (18 influenza A(not subtyped) ), two were positive for human metapneumovirus (hMPV) and one tested positive for RSV. 15 outbreaks were in hospitals where 11 tested positive for influenza (10 influenza A(not subtyped) and 1 influenza A(H3N2)) and two tested positive for mixed infections of influenza A and other respiratory viruses. Nine outbreaks were from schools, where two tested positive for influenza (2 influenza A(not subtyped)). The remaining three outbreaks were from the Other settings category (two households and a prison), where all tested positive for influenza A(not subtyped).

-Outbreaks should be recorded on HPZone and reported to the local Health Protection Teams and [Respscidsc@phe.gov.uk](mailto:Respscidsc@phe.gov.uk) .

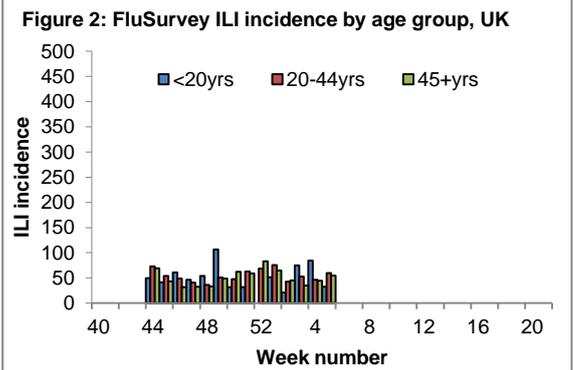


- FluSurvey

- Internet-based surveillance of influenza-like illness in the general population is undertaken through the FluSurvey. A project run jointly by PHE and the London School of Hygiene and Tropical Medicine.

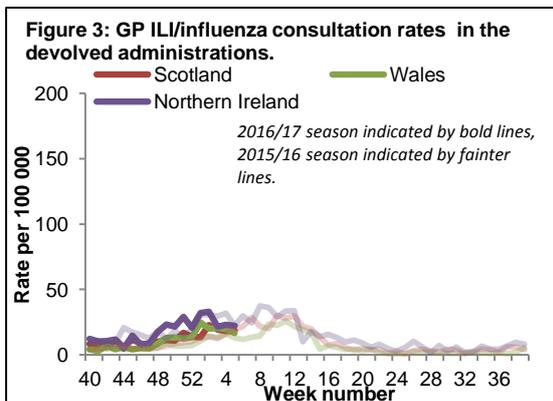
- The overall ILI rate (all age groups) for week 05 was 54.9 per 1,000 (108/1,967 people reported at least 1 ILI), with the 20-44 years age group reporting a higher rate of 59.5 per 1,000.

- If you would like to become a participant of the FluSurvey project please do so by visiting the <https://flusurvey.org.uk/en/accounts/register/> website for more information.



In week 05, the overall weekly influenza-like illness GP consultation rate has increased and remains above the baseline threshold in England. In the devolved administrations, ILI rates have remained similar or decreased compared to the previous week.

- Influenza/Influenza-Like-Illness (ILI)



Northern Ireland

-The Northern Ireland ILI rate remained similar to the previous week at 22.3 per 100,000 in week 05 compared to 23.0 per 100,000 in week 04 (Figure 3). This remains below the baseline threshold (47.9 per 100,000).

-The highest rates were seen in the 75+ year olds (44.5 per 100,000) and 45-64 year olds (33.4 per 100,000).

### Wales

-The Welsh ILI rate has decreased at 16.7 per 100,000 in week 05 compared to 19.9 per 100,000 in week 04 (Figure 3). This remains above the baseline threshold (10.3 per 100,000).

- The highest rates were seen in the 5-14 year olds (26.9 per 100,000) and 45-64 year olds (23.3 per 100,000).

### Scotland

-The Scottish ILI rate remained similar to the previous week at 18.7 per 100,000 in week 05 compared to 18.0 per 100,000 in week 04 (Figure 3). This remains below the baseline threshold (36.1 per 100,000).

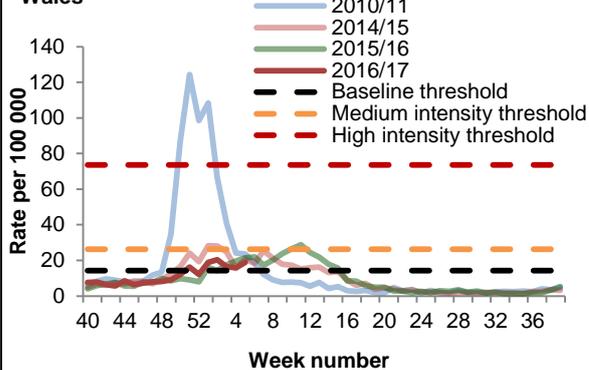
-The highest rates were seen in 75+ year olds (27.3 per 100,000) and 45-64 year olds (25.3 per 100,000).

### RCGP (England and Wales)

- The weekly ILI consultation rate through the RCGP surveillance is at 18.9 per 100,000 in week 05 compared to 15.9 per 100,000 in week 04. This is above the baseline threshold (14.3 per 100,000), consistent with influenza circulating in the community (Figure 4\*). By age group, the highest rates were seen in 75+ year olds (28.2 per 100,000) and 45-64 year olds (21.5 per 100,000).

*\*The Moving Epidemic Method 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 in a standardised approach across Europe.*

**Figure 4: RCGP ILI consultation rates , England and Wales**



### GP In Hours Syndromic Surveillance System (England)

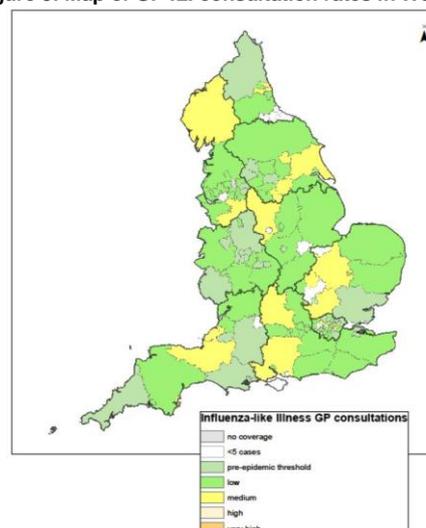
-The weekly ILI consultation rate through the GP In Hours Syndromic Surveillance system is at 13.6 per 100,000 in week 05 (Figure 5).

Figure 5 represents a map of GP ILI consultation rates in Week 05 across England by Local Authorities, using influenza-like illness surveillance thresholds.

*Thresholds are calculated using a standard methodology for setting ILI thresholds across Europe (the "Moving Epidemic Method" (MEM)) and are based on six previous influenza seasons (excluding the 2009/10 H1N1 pandemic)*

-For further information, please see the syndromic surveillance [webpage](#).

**Figure 5: Map of GP ILI consultation rates in Week 05**



## **Influenza confirmed hospitalisations**

[| Back to top |](#)

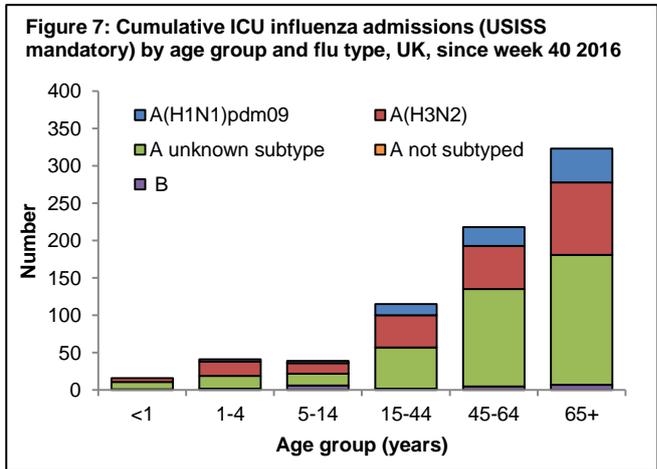
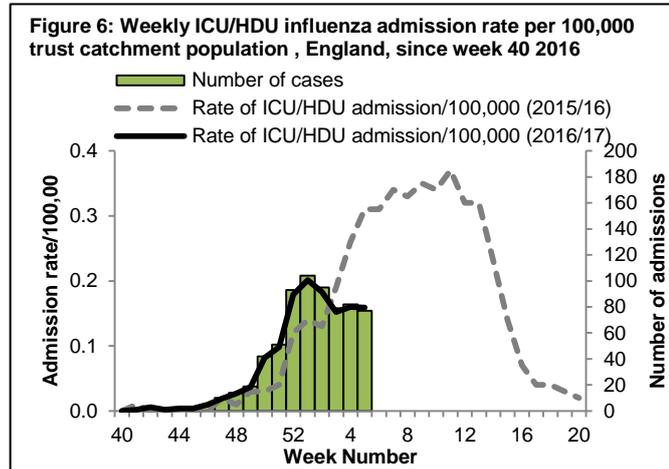
**In week 05, there were 81 admissions to ICU/HDU with confirmed influenza (50 influenza A(unknown subtype), 25 influenza A(H3N2), four influenza A(H1N1)pdm09 and two influenza B) reported through the USISS mandatory ICU/HDU surveillance scheme across the UK (137 Trusts). 106 hospitalised confirmed influenza cases (53 influenza A(H3N2), 47 influenza A(not subtyped), five influenza B and one influenza A(H1N1)pdm09) were reported through the USISS sentinel hospital network across England (15 Trusts).**

A national mandatory collection (USISS mandatory ICU scheme) is operating in cooperation with the Department of Health to report the number of confirmed influenza cases admitted to Intensive Care Units (ICU) and High Dependency Units (HDU) and number of confirmed influenza deaths in ICU/HDU across the UK. A confirmed case is defined as an individual with a laboratory confirmed influenza infection admitted to ICU/HDU. In addition a sentinel network (USISS sentinel hospital network) of acute NHS trusts is established in England to report weekly laboratory confirmed hospital admissions. Further information on these systems is available through the [website](#). Please note data in previously reported weeks are updated and so may vary by week of reporting

- Number of new admissions and fatal confirmed influenza cases in ICU/HDU (USISS mandatory ICU scheme), UK (week 05)

- In week 05, there were 81 admissions to ICU/HDU with confirmed influenza (50 influenza A(unknown subtype), 25 influenza A(H3N2), four influenza A(H1N1)pdm09 and two influenza B) reported across the UK (137/156 Trusts in England) through the USISS mandatory ICU scheme, with a rate of 0.16 per 100,000 compared to a rate of 0.16 per 100,000 in week 04 (Figures 6 and 7). Nine deaths were reported to have occurred in week 05.

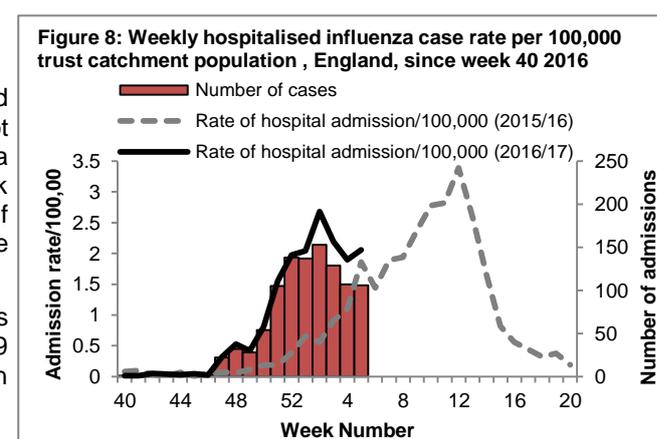
A total of 752 admissions (402 influenza A(unknown subtype), 236 influenza A(H3N2), 91 influenza A(H1N1)pdm09 and 23 influenza B) and 85 confirmed deaths have been reported since week 40 2016.



- USISS sentinel weekly hospitalised confirmed influenza cases, England (week 05)

- In week 05, there were 106 hospitalised confirmed influenza cases (53 influenza A(H3N2), 47 influenza A(not subtyped), one influenza A(H1N1)pdm09 and five influenza B) reported through the USISS sentinel hospital network from 15 NHS Trusts across England (Figure 8), a rate of 2.06 per 100,000 compared to 1.93 per 100,000 in the previous week.

A total of 1,046 hospitalised confirmed influenza admissions (669 influenza A(H3N2), 342 influenza A(not subtyped), 29 influenza B and six influenza A(H1N1)pdm09)) have been reported since week 40 2016.



- USISS Severe Respiratory Failure Centre confirmed influenza admissions, UK (week 05)

- In week 05, there were no confirmed influenza admissions reported from the six Severe Respiratory Failure (SRF) centres in the UK. There have been four confirmed influenza admissions (one influenza A(H3N2) and three influenza A(unknown subtype)) reported since week 40 2016.

### All-cause mortality data

[| Back to top |](#)

**In week 05 2017 in England, statistically significant excess all-cause mortality by week of death was seen through the EuroMOMO algorithm in England overall, in 15-64 year olds and 65+ year olds. In the devolved administrations, significant excess all-cause mortality was observed in Scotland in week 05.**

Seasonal mortality is seen each year in the UK, with a higher number of deaths in winter months compared to the summer. Additionally, peaks of mortality above this expected higher level typically occur in winter, most commonly the result of factors such as cold snaps and increased circulation of respiratory viruses, in particular influenza. Weekly mortality surveillance presented here aims to detect and report acute significant weekly excess mortality above normal seasonal levels in a timely fashion. Excess mortality is defined as a

significant number of deaths reported over that expected for a given point in the year, allowing for weekly variation in the number of deaths. The aim is not to assess general mortality trends or precisely estimate the excess attributable to different factors, although some end-of-winter estimates and more in-depth analyses (by age, geography etc.) are undertaken.

- Excess overall all-cause mortality, England and Wales

- In 04 2017, an estimated 12,877 all-cause deaths were registered in England and Wales (source: [Office for National Statistics](#)). This is a decrease compared to the 13,610 estimated death registrations in week 03 2017.

- Excess all-cause mortality by age group, England, Wales, Scotland and Northern Ireland

-In week 05 2017 in England, excess mortality by week of death above the upper 2 z-score threshold was seen in all ages, 15-64 year olds and 65+ year olds England after correcting ONS disaggregate data for reporting delay with the standardised [EuroMoMo](#) algorithm (Table 1). No significant excess was seen in the other age groups. Subnationally, excess mortality was seen in the London, North West, South East & West, East & West Midlands, East of England and Yorkshire and Humber regions. This data is provisional due to the time delay in registration; numbers may vary from week to week.

- In the devolved administrations, significant excess mortality above the threshold was observed in Scotland but not in Wales in week 05 (Table 2). Data was not available for Northern Ireland.

**Table 2: Excess mortality by UK country, for all ages\***

Country	Excess detected in week 05 2017?	Weeks with excess in 2016/17
England	✓	51-05
Wales	×	52,03
Scotland	✓	46,50,51,01,05
Northern Ireland	-	-

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

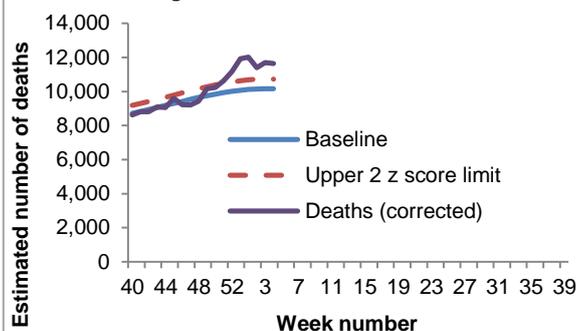
NB. Separate total and age-specific models are run for England which may lead to discrepancies between Tables 1 + 2

**Table 1: Excess mortality by age group, England\***

Age group (years)	Excess detected in week 05 2017?	Weeks with excess in 2016/17
<5	×	44,48
5-14	×	-
15-64	✓	51-02,04,05
65+	✓	51-05

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

**Figure 9: Excess mortality in all ages by week of death, EuroMOMO, England**



## Microbiological surveillance

[Back to top](#)

In week 05 2017, 31 samples tested positive for influenza (19 influenza A(H3N2), 9 influenza A(unknown subtype) and 3 influenza B) through the UK GP sentinel schemes with an overall positivity of 34.4%. 474 positive detections were recorded through the DataMart scheme (413 influenza A(H3N2), 56 influenza A(not subtyped) and 5 influenza B) with a positivity of 23.1% in week 05.

- Sentinel swabbing schemes in England (RCGP) and the Devolved Administrations

-In week 05, 31 samples tested positive for influenza (19 influenza A(H3N2), 9 influenza A(unknown subtype) and 3 influenza B) through the UK GP sentinel swabbing schemes, with an overall positivity of 34.4% compared to 35.4% in week 04 (Table 3).

Since week 40 2016, 643 samples (558 influenza A(H3N2), 41 influenza A(unknown subtype), 3 influenza A(H1N1)pdm09 and 41 influenza B) have tested positive for influenza through this scheme.

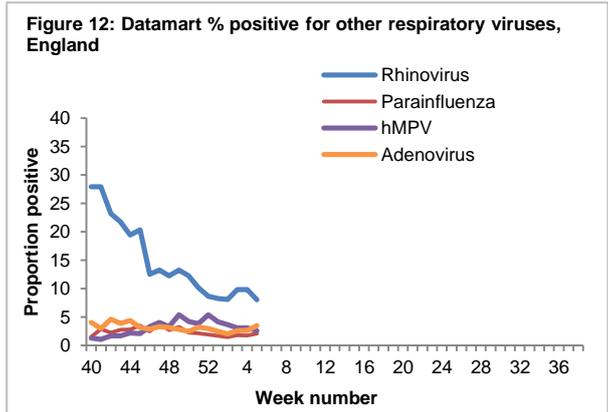
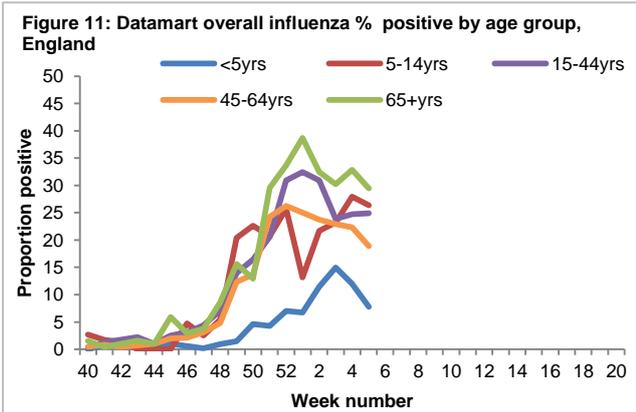
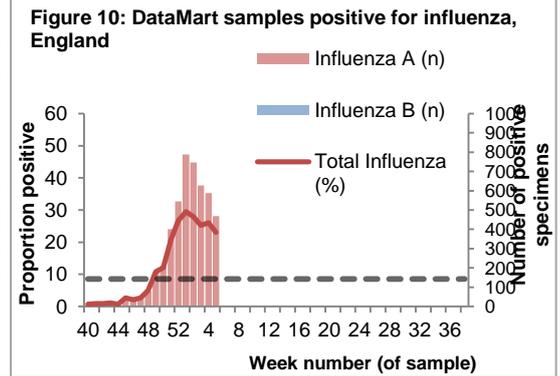
**Table 3: Sentinel influenza surveillance in the UK**

Week	England	Scotland	Northern Ireland	Wales
01	51/135 (37.8%)	19/56 (33.9%)	8/13 (61.5%)	5/12 (41.7%)
02	52/126 (41.3%)	31/103 (30.1%)	3/13 (23.1%)	9/15 (60%)
03	52/126 (41.3%)	31/85 (36.5%)	3/12 (25%)	4/12 (33.3%)
04	29/98 (29.6%)	27/71 (38%)	6/12 (50%)	8/17 (47.1%)
05	7/13 (53.8%)	21/67 (31.3%)	0/4 (-)	3/6 (-)

NB. Proportion positive omitted when fewer than 10 specimens tested

- Respiratory DataMart System (England)

In week 05 2017, out of the 2,055 respiratory specimens reported through the Respiratory DataMart System, 474 samples (23.1%) were positive for influenza (413 influenza A(H3N2), 56 influenza A(not subtyped) and 5 influenza B) (Figure 10), which is above the MEM threshold for this season of 8.6%. The highest positivity by age group was seen in the 65+ year olds (29.4%)(Figure 11). The overall positivity for RSV decreased at 3.0% in week 05. The highest positivity was noted in the <5 year olds at 5.4% in week 05. Positivity for rhinovirus decreased slightly from 9.9% in week 04 to 8.0% in week 05. Positivity for adenovirus increased slightly from 2.7% in week 04 to 3.5% in week 05. Positivities for parainfluenza and human metapneumovirus (hMPV) remained at low levels at 2.1% and 2.6% respectively in week 05.



\*The Moving Epidemic Method 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 in a standardised approach across Europe. The threshold to indicate a likelihood of influenza community circulation for Datamart % positive as calculated through the Moving Epidemic Method is 8.6% in 2016/17.

- Virus characterisation

PHE characterises the properties of influenza viruses through one or more tests, including genome sequencing (genetic analysis) and haemagglutination inhibition (HI) assays (antigenic analysis). These data are used to compare how similar the currently circulating influenza viruses are to the strains included in seasonal influenza vaccines, and to monitor for changes in circulating influenza viruses. The interpretation of genetic and antigenic data sources is complex due to a number of factors, for example, not all viruses can be cultivated in sufficient quantity for antigenic characterisation, so that viruses with sequence information may not be able to be antigenically characterised as well. Occasionally, this can lead to a biased view of the properties of circulating viruses, as the viruses which can be recovered and analysed antigenically, may not be fully representative of majority variants, and genetic characterisation data does not always predict the antigenic characterisation.

Since the start of the 2016/17 winter influenza season in week 40 2016, the PHE Respiratory Virus Unit has characterised two A(H1N1)pdm09 influenza viruses: one genetically and one antigenically. The A(H1N1)pdm09 virus genetically characterised belongs in the genetic subgroup 6B.1, which was the predominant genetic subgroup in the 2015/16 season. The virus antigenically analysed is similar to the A/California/7/2009 Northern Hemisphere 2016/17 (H1N1)pdm09 vaccine strain. Genetic characterisation of 254 A(H3N2) influenza viruses since week 40 showed that they all belong to genetic subclade 3C.2a, with 135 belonging to a cluster within this genetic subclade designated as 3C.2a1. The Northern Hemisphere 2016/17 influenza A(H3N2) vaccine strain A/HongKong/4801/2014 belongs in genetic subclade 3C.2a. This seasons A(H3N2) viruses are difficult to cultivate, and only 15 influenza A(H3N2) viruses have been isolated and antigenically characterised since week 40 2016, representing a minority of the detections, indicating the bias in antigenic data. The viruses antigenically analysed are similar to the A/HongKong/4801/2014 Northern Hemisphere 2016/17 A(H3N2) vaccine strain. Of the 15 antigenically characterised viruses, three early isolates have also been genetically characterised, with all belonging in genetic group 3C.2a, and two belonging in the recently emerged 3C.2a1 cluster. Ten influenza B viruses have been analysed genetically since week 40/2015; eight have been characterised as belonging to the B/Yamagata/16/88-lineage and 2 belonging to the B/Victoria/2/1987-lineage. Eleven influenza B viruses have been isolated and antigenically characterised since week 40 2016. Eight viruses were characterised as belonging to the B/Yamagata/16/88-lineage and were antigenically similar to B/Phuket/3073/2013, the influenza B/Yamagata-lineage component of 2016/17 Northern Hemisphere quadrivalent vaccine. Three viruses were characterised as belonging to the B/Victoria/2/87-lineage and were antigenically similar to B/Brisbane/60/2008, the influenza B/Victoria-lineage component of 2016/17 Northern Hemisphere trivalent and quadrivalent vaccines.

- Antiviral susceptibility

Influenza positive samples are screened for mutations in the virus neuraminidase gene known to confer oseltamivir and/or zanamivir resistance. Additionally, testing of influenza A (H1N1)pdm09, A(H3N2), and influenza B virus isolates for neuraminidase inhibitor susceptibility (oseltamivir and zanamivir) is performed at PHE-RVU using a functional assay. The data summarized below combine the results of both testing methods. The samples tested are routinely obtained for surveillance purposes, but diagnostic testing of patients suspected to be infected with neuraminidase inhibitor-resistant virus is also performed.

Since week 40 2016, 181 influenza A(H3N2) have been tested for oseltamivir susceptibility; 177 are fully susceptible. 151 of the 181 were also tested for zanamivir susceptibility with 148 being fully susceptible. Three A(H3N2) viruses have been detected with an R292K amino acid substitution, which causes resistance to oseltamivir and a reduction in susceptibility to zanamivir, and one A(H3N2) virus with an E119V amino acid substitution was detected, causing resistance to oseltamivir but not affecting zanamivir susceptibility. All three R292K cases and the E119V case have been identified in patients with underlying medical conditions with some exposure to oseltamivir. Two influenza A(H1N1)pdm09 and 10 influenza B (Yamagata) viruses have been tested for oseltamivir susceptibility and all were fully susceptible. One of the two influenza A(H1N1)pdm09 virus and 9 out of the 10 influenza B (Yamagata) virus have been tested for zanamivir susceptibility and all were fully susceptible.

- Antimicrobial susceptibility

-Table 4 shows in the 12 weeks up to 05 February 2017, 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 4: Antimicrobial susceptibility surveillance in lower respiratory tract isolates, 12 weeks up to 05 February 2017, E&W**

Organism	Antibiotic	Specimens tested (N)	Specimens susceptible (%)
<i>S. pneumoniae</i>	Penicillin	3,855	91
	Macrolides	4,367	82
	Tetracycline	4,182	84
<i>H. influenzae</i>	Amoxicillin/ampicillin	16,628	69
	Co-amoxiclav	17,287	88
	Macrolides	6,198	12
	Tetracycline	16,903	98
<i>S. aureus</i>	Methicillin	6,436	90
	Macrolides	6,957	67
MRSA	Clindamycin	382	41
	Tetracycline	581	81
MSSA	Clindamycin	3,482	77
	Tetracycline	5,358	92

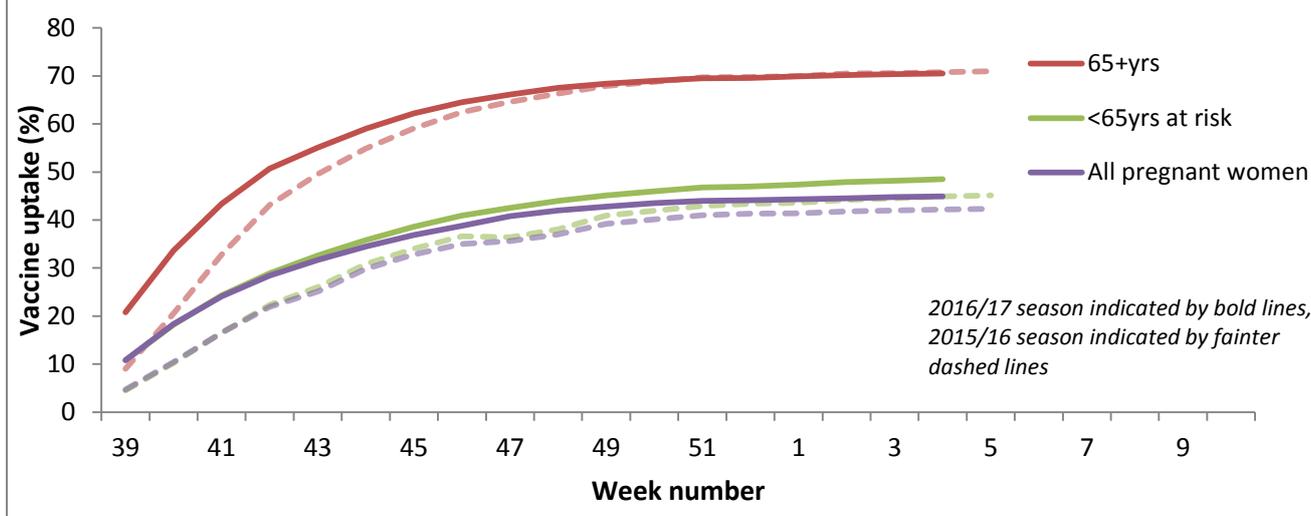
\*Macrolides = erythromycin, azithromycin and clarithromycin

## Vaccination

[| Back to top |](#)

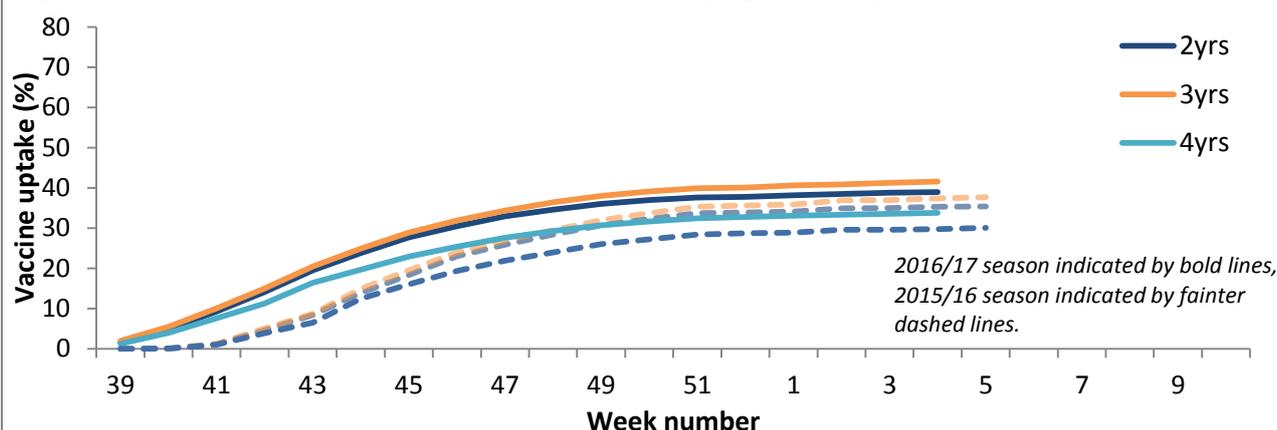
- Up to week 04 2017 in 85.0% of GP practices reporting weekly to Immform, the provisional proportion of people in England who had received the 2016/17 influenza vaccine in targeted groups was as follows, with vaccination activity starting earlier than last season (Figure 13):
  - 48.5% in under 65 years in a clinical risk group
  - 44.9% in pregnant women
  - 70.5% in 65+ year olds

**Figure 13: Cumulative weekly influenza vaccine uptake by target group in England**



- In 2016/17, all two-, three- and four-year-olds continue to be eligible for flu vaccination. In addition, the programme has been extended to children of school years 1, 2 and 3 age. Up to week 04 2017 in 88.1% of GP practices reporting weekly to Immform, the provisional proportion of children in England who had received the 2016/17 influenza vaccine in targeted groups was as follows (Figure 14):
  - 39.0% in all 2 year olds
  - 41.6% in all 3 year olds
  - 33.8% in all 4 year olds

Figure 14: Cumulative weekly influenza vaccine uptake by target group in England



- Provisional data from the third monthly collection of influenza vaccine uptake in GP patients up to 31 December 2016 show that in 95.4% of all GP practices in England responding to the main GP survey, the proportion of people in England who received the 2016/17 influenza vaccine was as follows:
  - 46.9% in under 65 years in a clinical risk group
  - 44.1% in pregnant women
  - 69.6% in 65+ year olds
- Provisional data from the third monthly collection of influenza vaccine uptake in GP patients up to 31 December 2016 show that in 96.2% of all GP practices in England responding to the child GP survey, the proportion of people in England who received the 2016/17 influenza vaccine was as follows:
  - 37.8% in all 2 year olds
  - 40.1% in all 3 year olds
  - 33.1% in all 4 year olds
- Provisional data from the third monthly collection of influenza vaccine uptake by frontline healthcare workers show 61.8% were vaccinated by 31 December 2016 from 97.7% of Trusts, compared to 47.6% vaccinated in the previous season by 31 December 2015. The report provides uptake at Trust level.
- Provisional data from the third monthly collection of influenza vaccine uptake for children of school years 1, 2 and 3 age (from a sample of 100% of all Local Authorities in England) show the proportion of children in England who received the 2016/17 influenza vaccine via school, pharmacy or GP practice by 31 December 2016 in targeted groups was as follows:
  - 56.6% in children of school Year 1 age (5-6 years)
  - 54.4% in children of school Year 2 age (6-7 years)
  - 52.4% in children of school Year 3 age (7-8 years)

## International Situation

[Back to top](#)

**Influenza activity in the temperate zone of the northern hemisphere remained widespread especially in Europe and East Asia passing their seasonal threshold early in comparison with previous years. Worldwide, influenza A(H3N2) virus was predominant.**

- [Europe](#) updated on 03 February 2017 (Joint ECDC-WHO Influenza weekly update)

In week 04/2017, influenza activity remained elevated across Europe with 28 of 43 countries reporting increased activity.

In week 04/2017, 1,612 of 3,176 (51%) sentinel specimens tested positive for influenza viruses. Of these, 95% were type A and 5% were type B. The great majority (97%) of subtyped influenza A viruses were A(H3N2). The lineage of 36 influenza B viruses was determined of which 18 fell in B/Yamagata and 18 in B/Victoria lineages. Of 34 countries across the region that each tested at least 10 sentinel specimens, 26 reported proportions of influenza virus detections above 30% (median 54%, range 33% to 77%).

For week 04/2017, of the 15 countries that conduct sentinel surveillance on severe acute respiratory infection (SARI), 10 reported data and 7 of the 9 countries that conduct surveillance on hospitalized laboratory-confirmed influenza cases reported data.

Of 1,107 SARI cases reported, 179 were tested for influenza virus and 54 (30%) were positive: 46 A(H3N2), 1 type A not subtyped and 7 type B viruses. Since week 40/2016, 20 766 SARI cases have been reported from 15 countries with 5,256 tested for influenza virus, of which 1,973 (38%) were positive: 1,707 (87%) were type A and 266 (13%) type B viruses. Of the influenza A viruses, 1,614 (94.5%) were A(H3N2), 1 (0.1%) was A(H1N1)pdm09 and 92 (5.4%) were not subtyped.

For week 04/2017, 8,056 specimens from non-sentinel sources (such as hospitals, schools, non-sentinel primary care facilities, nursing homes and other institutions) tested positive for influenza viruses. Of these, 95% were type A (with 99% of the subtyped viruses being A(H3N2)), and 5% type B.

Many participating countries across the European region continue to see a marked increase in all-cause excess mortality among the elderly aged 65 years and above. A substantial increase has similarly been observed in the 15-64 years age group. Most likely, this is mainly due to the circulation of influenza A(H3N2) virus.

- [United States of America](#) updated on 03 February 2017 (Centre for Disease Control report)

During week 04, influenza activity increased in the United States.

The most frequently identified influenza virus subtype reported by public health laboratories during week 04 was influenza A (H3). The percentage of respiratory specimens testing positive for influenza in clinical laboratories increased.

A cumulative rate for the season of 20.3 laboratory-confirmed influenza-associated hospitalizations per 100,000 population was reported.

Nationwide during week 04, the proportion of outpatient visits for influenza-like illness (ILI) was 3.9%, which is above the national baseline of 2.2%.

- [Canada](#) updated on 03 February 2017 (Public Health Agency report)

For week 04, influenza activity continues to be reported across Canada and a few regions are reporting widespread influenza activity. All indicators (laboratory detections, influenza-like illness, outbreaks and hospitalizations) have either decreased or remained similar to the previous week.

In week 04, 51 outbreaks were reported, the majority in long-term care facilities and due to influenza A.

A(H3N2) continues to be the most common type of influenza affecting Canadians.

Nationally in week 04, 2,586 positive influenza tests were reported, down from 2,667 tests reported in week 03. The majority of laboratory detections, hospitalizations and deaths have been among adults aged 65+ years.

- [Global influenza update](#) updated on 06 February 2017 (WHO website)

Influenza activity in the temperate zone of the northern hemisphere continued to increase, with many countries especially in East Asia and Europe having passed their seasonal threshold early in comparison with previous years. Worldwide, influenza A(H3N2) virus was predominant. The majority of influenza viruses characterized so far were similar antigenically to the reference viruses contained in vaccines for use in the 2016-2017 northern hemisphere influenza season. All tested viruses collected recently for antiviral sensitivity were susceptible to the neuraminidase inhibitor antiviral medications.

In North America, influenza activity with A(H3N2) virus predominating continued to increase in the United States of America, whereas in Canada and Mexico, influenza activity decreased.

In Europe, influenza activity remained high, and has peaked already in some countries, with influenza A (H3N2) virus being the most prominent subtype. Persons aged over 65 years were most frequently associated with severe disease from influenza infection.

In East Asia, high influenza activity continued to be reported with influenza A(H3N2) viruses predominant.

In Western Asia, influenza and ILI activity appeared to be decreasing in Armenia, Georgia, Israel and Iraq. Influenza A(H3N2) was the most frequently detected virus, followed by influenza B virus.

In Southern Asia influenza activity remained low in most of the countries, with influenza A (H3N2) virus predominant, and low levels of influenza A(H1N1) and influenza B viruses present. In South East Asia, influenza activity remained low, with influenza A(H3N2) virus and influenza B predominating in the region.

In Northern Africa, influenza activity was reported in Algeria and Morocco with influenza A(H3N2) and influenza B virus detections. In West Africa, influenza B continued to be detected in Ghana.

In the Caribbean countries and Central America, influenza and other respiratory virus activity remained low in general. Puerto Rico and Costa Rica however reported an increase of ILI and influenza activity, respectively.

In tropical South America, influenza and other respiratory viruses activity remained low.

In temperate South America, influenza and RSV activity remained low in most of the countries. In Paraguay, ILI activity increased above expected levels but no influenza activity was reported.

In the temperate zone of the Southern Hemisphere, influenza activity was at inter-seasonal levels.

Based on FluNet reporting, the WHO GISRS laboratories tested more than 159,276 specimens between 09 January 2017 and 22 January 2017. 40,570 were positive for influenza viruses, of which 38,581 (95.1%) were typed as influenza A and 1,989 (4.9%) as influenza B. Of the sub-typed influenza A viruses, 294 (1.8%) were influenza A(H1N1)pdm09 and 16,121 (98.2%) were influenza A(H3N2). Of the characterized B viruses, 186 (60.4%) belonged to the B-Yamagata lineage and 122 (39.6%) to the B-Victoria lineage.

- [Avian Influenza](#) latest update on 16 January 2017 (WHO website)

### **Influenza A(H5) viruses**

On [07 December 2016](#), two new laboratory-confirmed human case of influenza A(H5N6) virus infection was reported to WHO from the National Health and Family Planning Commission (NHFPC) of China.

Since 2003, a total of 856 laboratory-confirmed cases of human infection with avian influenza A(H5N1) virus, including 452 deaths, have been reported to WHO from 16 countries.

Although other influenza A(H5) subtype viruses have the potential to cause disease in humans, no human cases, other than those with influenza A(H5N1) and A(H5N6), have been reported so far. According to reports received by the World Organisation for Animal Health (OIE), various influenza A(H5) subtypes continue to be detected in birds in West Africa, Europe and Asia. There have also been numerous detections of influenza A(H5N8) viruses in wild birds and domestic poultry in several countries in Asia and Europe since June 2016.

### **Influenza A(H7N9)**

On [11 January 2017](#), the Department of Health, China, Hong Kong Special Administrative Region (SAR) notified WHO of a laboratory-confirmed human infection with avian influenza A(H7N9) virus and on 12 January 2017, the Health Bureau, China, Macao SAR notified WHO of an additional laboratory-confirmed case of human infection with avian influenza A(H7N9) virus.

On [5 January 2017](#), the Department of Health, Hong Kong Special Administrative Region (SAR) notified WHO of a case of laboratory-confirmed human infection with avian influenza A(H7N9) virus and on 9 January 2017, the National Health and Family Planning Commission of China (NHFPC) notified WHO of 106 additional laboratory-confirmed cases of human infection with avian influenza A(H7N9) virus.

A total of 918 laboratory-confirmed human infections with avian influenza A (H7N9) virus, including 359 deaths have been reported through IHR notification since early 2013.

### **Influenza A(H7N2)**

Between [20 December 2016 and 16 January 2017](#), the United States of America (USA) reported one laboratory confirmed human case of influenza A(H7N2) virus infection to WHO. The likely source of infection in the human was through close contact with ill cats infected with an A(H7N2) virus. More information on influenza in cats, influenza A(H7N2), and the human infection with A(H7N2) can be found [here](#).

### **Influenza A(H9N2)**

Between [20 December 2016 and 16 January 2017](#), One new laboratory-confirmed human case of A(H9N2) virus infection was reported to WHO from China in a seven-month-old girl from Guangdong province. Avian influenza A(H9N2) viruses are enzootic in poultry in China.

- [Middle East respiratory syndrome coronavirus \(MERS-CoV\)](#) latest update on 08 February 2017

Between [02 and 07 January 2017](#) the National IHR Focal Point of Saudi Arabia reported nine (9) additional cases of Middle East Respiratory Syndrome (MERS) including two (2) fatal cases. Two (2) deaths among previously reported MERS cases (cases no. 7 and 8 in the Disease Outbreak News (DON) published on 17 January 2017) were also reported.

Up to 08 February 2017, 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 933 suspect cases in the UK that have been investigated for MERS-CoV and tested negative.

Globally, since September 2012, WHO has been notified of 1,879 laboratory-confirmed cases of infection with MERS-CoV, including at least 666 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.

## Acknowledgements

[| Back to top |](#)

This report was prepared by the Influenza section, Respiratory Diseases Department, Centre for Infectious Disease Surveillance and Control, Public Health England. We are grateful to all who provided data for this report including the RCGP Research and Surveillance Centre, the PHE Real-time Syndromic Surveillance team, the PHE Respiratory Virus Unit, the PHE Modelling and Statistics unit, the PHE Dept. of Healthcare Associated Infection & Antimicrobial Resistance, PHE regional microbiology laboratories, Office for National Statistics, the Department of Health, Health Protection Scotland, National Public Health Service (Wales), the Public Health Agency Northern Ireland, the Northern Ireland Statistics and Research Agency, QSurveillance<sup>®</sup> and EMIS and EMIS practices contributing to the QSurveillance<sup>®</sup> database.

## Related links

[| Back to top |](#)

### Weekly consultation rates in national sentinel schemes

- [Sentinel schemes operating across the UK](#)
- [RCGP scheme](#)
- Northern Ireland surveillance ([Public Health Agency](#))
- Scotland surveillance ([Health Protection Scotland](#))
- Wales surveillance ([Public Health Wales](#))
- [Real time syndromic surveillance](#)
- MEM threshold [methodology paper](#) and [UK pilot paper](#)

### Community surveillance

- [Outbreak reporting](#)
- [FluSurvey](#)
- [MOSA](#)

### Disease severity and mortality data

- [USISS](#) system
- [EuroMOMO](#) mortality project

### Vaccination

- Seasonal influenza vaccine programme ([Department of Health Book](#))
- Childhood flu programme information for healthcare practitioners ([Public Health England](#))
- 2016/17 Northern Hemisphere seasonal influenza vaccine recommendations ([WHO](#))