PHE National Influenza Report

Summary of UK surveillance of influenza and other seasonal respiratory illnesses

06 July 2017 – Week 27 report (up to week 26 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 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 25	Week 26		
England (RCGP)	0.9	1.7	⇧	15-44years
Scotland	5.2	1.8	⇩	45-64years
Northern Ireland	4.0	0.6	⇩	15-44years
Wales	1.1	1.3	⇔	75+years

Figure 1: RCGP ILI consultation rates , England and Wales

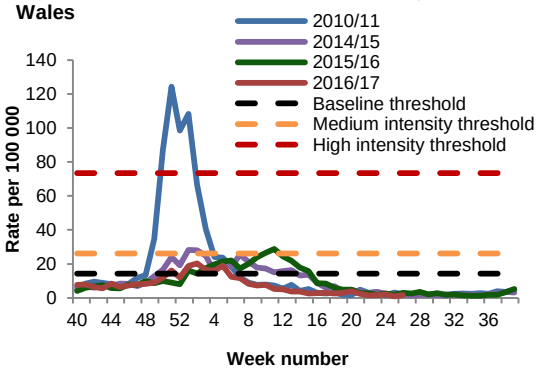
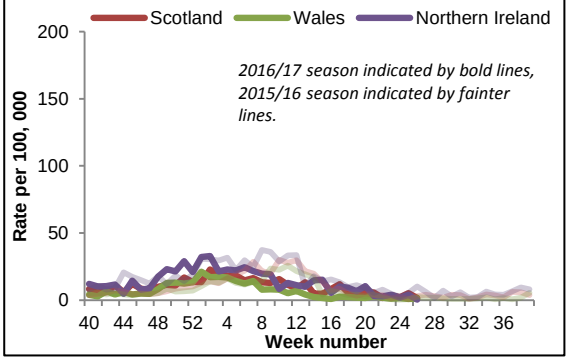


Figure 2: GP ILI/influenza consultation rates in the devolved administrations.

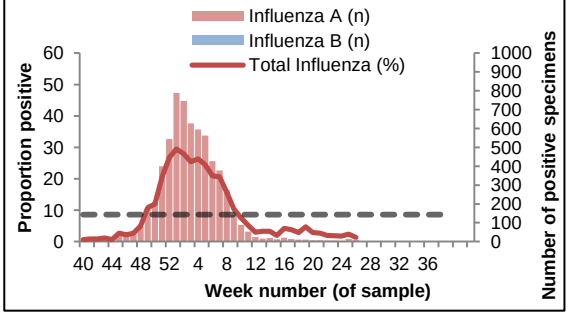


- Syndromic surveillance
  - Syndromic surveillance indicators for influenza were low in weeks 25 and 26 2017.
  - For further information, please see the Syndromic surveillance webpage.

Virological surveillance

- English Respiratory Data Mart system
  - In week 26 2017, 10 (1.3%) of the 766 respiratory specimens tested were positive for influenza (5 influenza A(H3), 2 influenza A(not subtyped), 1 influenza A(H1N1)pdm09 and 2 influenza B).
  - RSV positivity remained low in week 26. Rhinovirus positivity increased from 13.2% in week 25 to 15.5% in week 26. Adenovirus positivity decreased from 5.7% in week 25 to 5.2% in week 26. Parainfluenza positivity increased from 2.7% in week 25 to 4.9% in week 26. Human metapneumovirus (hMPV) remained low at 0.6% in week 26.
- UK GP-based sentinel schemes
  - Through the GP-based sentinel schemes across the UK, no samples were positive for influenza in week 26 2017.

Figure 3: DataMart samples positive for influenza, England



Outbreak Reporting

- One new acute respiratory outbreak has been reported in the past 14 days. The outbreak was from a hospital 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 26 2017, 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.

Figure 4: Excess mortality in all ages by week of death, EuroMOMO, England

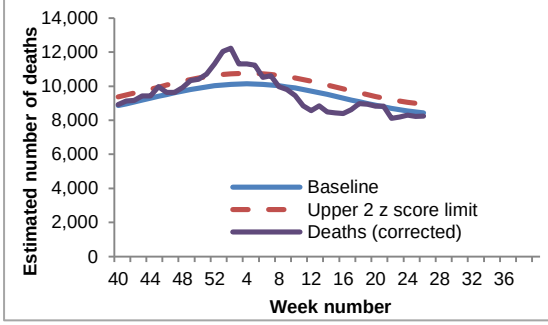


Table 1: Excess mortality by age group,England*

Age group (years)	Excess detected in week 26 2017?	Weeks with excess in 2016/17
<5	×	-
5-14	×	02
15-64	×	52-01
65+	×	45, 51-05,07

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

International Surveillance

- Influenza updated on 26 June 2017
  - In the temperate zone of the southern hemisphere, influenza activity continued to increase. Influenza activity in the temperate zone of the northern hemisphere continued to decrease. Worldwide, influenza A(H3N2) and B viruses co-circulated.
  - In temperate South America, influenza like illness (ILI) levels remains above the seasonal threshold in some countries, with influenza A(H3N2) viruses predominant. In tropical South America, influenza activity remained low in most of the region, with influenza A(H3N2) and B viruses predominating.
  - In Southern Africa, influenza activity is increasing, with influenza A(H3N2) being the most detected subtype.
  - In Oceania, influenza activity in Australia and New Zealand increased from baseline to inter-seasonal levels, with both influenza A and B co-circulating.
  - In Western Africa, few influenza detections were reported and in Eastern Africa, increased influenza activity was reported with influenza A(H3N2) predominant.
  - In Southern Asia, low levels of influenza activity continue to be reported, with influenza B virus most frequently detected. In India, influenza A(H1N1)pdm09 virus detections continued to decrease.
  - In South East Asia, influenza activity increased with influenza A(H3N2) and B viruses being predominant and in some parts (Viet Nam) influenza A(H1N1)pdm09 and B viruses was predominant. In Western Asia, influenza activity increased slightly, with influenza A(H1N1)pdm09 and B viruses being the most detected subtypes.
  - In East Asia, influenza activity was low in general, except in Southern China, influenza activity continued to decrease with A(H1N1)pdm09 and B Victoria lineage viruses predominant. In Northern China, low influenza A(H1N1)pdm09 virus detections were reported.
  - In the northern hemisphere influenza activity was low with a small number of influenza B virus detections reported.
  - The WHO GISRS laboratories tested more than 61275 specimens between 29 May to 11 June 2017. 4815 were positive for influenza viruses, of which 3286 (68.2%) were typed as influenza A and 1529 (31.8%) as influenza B. Of the sub-typed influenza A viruses, 757 (31.5%) were influenza A(H1N1)pdm09 and 1648 (68.5%) were influenza A(H3N2). Of the characterized B viruses, 134 (37.1%) belonged to the B-Yamagata lineage and 227 (62.9%) to the B-Victoria lineage.
- MERS-CoV updated on 4 July 2017
  - Up to 05 July 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 979 suspected cases in the UK that have been investigated for MERS-CoV and tested negative.
  - Between 16 and 23 June 2017, the national IHR Focal Point of Saudi Arabia reported seven additional cases of Middle East Respiratory Syndrome Coronavirus (MERS-CoV) infection, including two deaths, and four deaths among previously reported cases. On 19 June 2017, the national IHR focal point of Lebanon reported one additional case of MERS-CoV infection.
  - Globally, since September 2012, WHO has been notified of 2,037 laboratory-confirmed cases of infection with MERS-CoV, including at least 710 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) updated on 15 June 2017
  - Between 17 May and 15 June 2017, 47 laboratory-confirmed humans cases of influenza A(H7N9) virus infection were reported to WHO from China. A total of 1,533 laboratory-confirmed human infections with avian influenza A(H7N9) virus, including at least 592 deaths, have been reported to WHO as of 15 June 2017.
  - For further updates please see the WHO website and for advice on clinical management please see information available online.