PHE Weekly National Influenza Report

Summary of UK surveillance of influenza and other seasonal respiratory illnesses

21 July 2016 – Week 29 report (up to week 28 data)

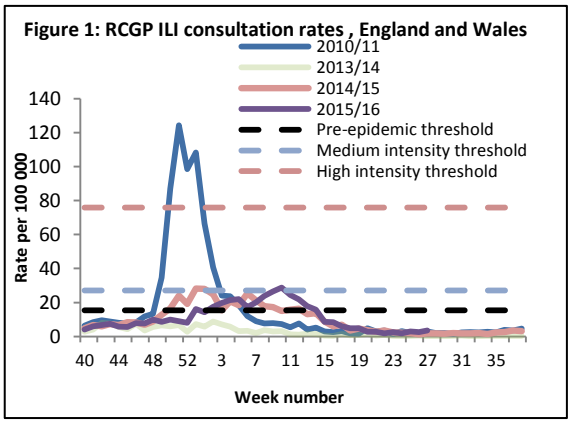
This report is published online. A summary report is being published once a fortnight while influenza activity is low. For further information on the surveillance schemes mentioned in this report, please see information available online.

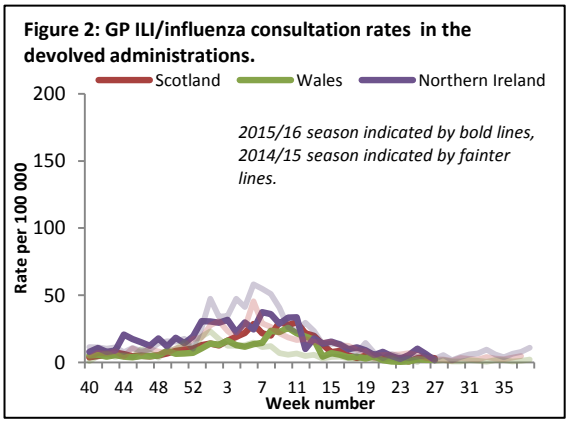
Indicators for influenza show very low levels of activity.

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 27	Week 28		
England (RCGP)	2.6	3.5	⇩	45-64yrs
Scotland	4.1	3.2	⇩	45-64yrs
Northern Ireland	6.2	1.6	⇩	15-44yrs
Wales	1.9	2.0	⇔	45-64yrs





- Syndromic surveillance
  - Syndromic surveillance indicators for influenza remained low in weeks 27 and 28 2016.
  - For further information, please see the Syndromic surveillance webpage.

Virological surveillance

- English Respiratory Data Mart system
  - In week 28 2016, 11 (1.4%) of the 774 respiratory specimens tested were positive for influenza.
  - Rhinovirus positivity increased from 21.8% in week 27 to 24.1% in week 28. Parainfluenza positivity decreased from 6.2% in week 27 to 5.2% in week 28. Positivity remained low for RSV (0.4%), hMPV (1.1%) and adenovirus (5.0%).
- UK GP-based sentinel schemes
  - Through the GP-based sentinel schemes across the UK, no samples were positive for influenza in week 28 2016.
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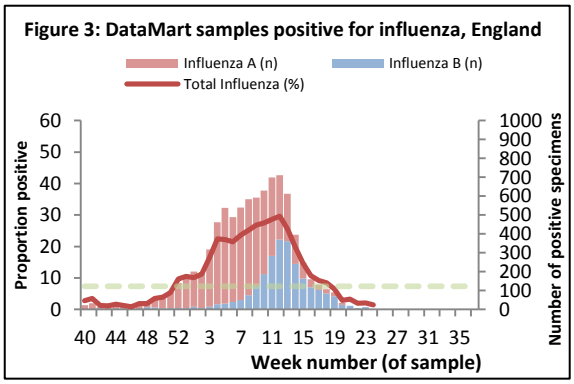

Outbreak Reporting

- Two new acute respiratory outbreaks were reported in the past 14 days. Both of the outbreaks were from care homes and tested positive for rhinovirus. Outbreaks should be reported to the local Health Protection Unit and Respscidsc@phe.gov.uk.

All-cause mortality surveillance

- In week 27 2016, an estimated 9,138 all-cause deaths were registered in England and Wales (source: Office for National Statistics). This is a decrease compared to the 9,228 estimated death registrations in week 26 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 28 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.

Figure 4: Observed & predicted all-cause death registrations, E&W

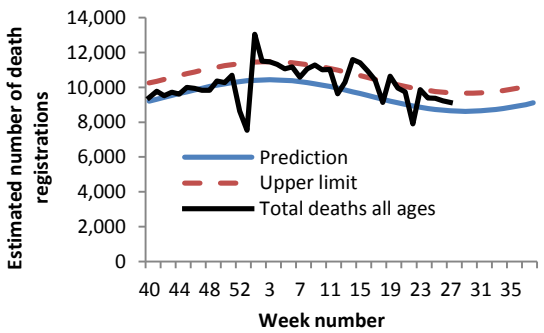

Table 1: Excess mortality by age group,England*

Age group (years)	Excess detected in week 28 2016?	Weeks with excess in 2015/16
<5	×	40,05,11,19
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
  - In temperate countries in the southern hemisphere, influenza activity increased steadily in the last few weeks in South America and 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. Of the respiratory viruses detected, respiratory syncytial virus (RSV) and influenza A(H1N1)pdm09 predominated.
  - In the temperate countries of Southern Africa, influenza detections continued to increase with predominantly influenza B viruses detected. In the northern temperate and central tropical regions of Africa, influenza activity was generally low with influenza A virus detections predominant in Western Africa and influenza B virus detections predominant in Eastern and Northern Africa.
  - In Oceania, influenza virus activity remained low. ILI activity in Australia remains low for this time of the year.
  - In the Caribbean countries, respiratory virus activity remained generally low with decreasing influenza B activity reported in many countries over the past few weeks, except in Jamaica, where slight increases in SARI and pneumonia activities were observed.
  - In Central America, detections of influenza A(H1N1)pdm09 decreased slightly while detections of non-influenza respiratory viruses increased. RSV activity continued in Costa Rica and Guatemala.
  - In tropical South America, respiratory virus activities varied. In Colombia and the Plurinational State of Bolivia, influenza A(H1N1)pdm09 activity increased and RSV activity decreased or remained low. ARI and SARI activities were elevated compared to previous years in Colombia. Influenza A(H1N1)pdm09 detections seemed to have peaked and the proportion of SARI-related hospitalizations decreased to expected levels in Ecuador. In Peru, influenza A(H1N1)pdm09 activity decreased while RSV activity increased slightly. In Brazil, influenza detections and SARI indicators seemed to have peaked already.
  - In tropical countries of South Asia, influenza activity was generally low with influenza A and B co-circulating in the region.
  - The WHO GISRS laboratories tested more than 50,149 specimens during that time period. 2,207 were positive for influenza viruses, of which 1,247 (56.5%) were typed as influenza A and 960 (43.5%) as influenza B. Of the sub-typed influenza A viruses, 808 (74.0%) were influenza A(H1N1)pdm09 and 284 (26.0%) were influenza A(H3N2). Of the characterized B viruses, 113 (25.7%) belonged to the B-Yamagata lineage and 327 (74.3%) to the B-Victoria lineage.
- MERS-CoV
  - Up to 20 July 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 775 suspected cases in the UK that have been investigated for MERS-CoV and tested negative.
  - Between 21 and 30 June 2016 the National IHR Focal Point of Saudi Arabia reported 13 additional cases of Middle East Respiratory Syndrome Coronavirus (MERS-CoV) including one death and on 16 June 2016, the National IHR Focal Point of United Arab Emirates (UAE) reported one additional case of MERS-CoV.
  - Globally, since September 2012, WHO has been notified of 1,782 laboratory-confirmed cases of infection with MERS-CoV, including at least 634 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 15 June 2016, the National Health and Family Planning Commission (NHFPC) of China notified WHO of 5 additional laboratory-confirmed cases of human infection with avian influenza A(H7N9) virus, including 1 death.
  - A total of 781 laboratory-confirmed cases of human infection with avian influenza A(H7N9) viruses, including at least 313 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.