



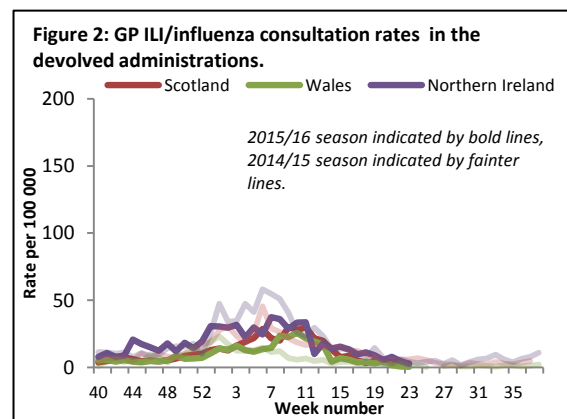
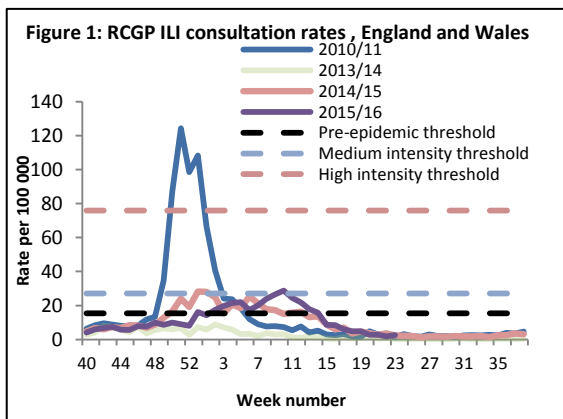
This report is published [online](#). A summary report is being published once a fortnight while influenza activity is low. For further information on the surveillance schemes mentioned in this report, please see information available [online](#).

**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).

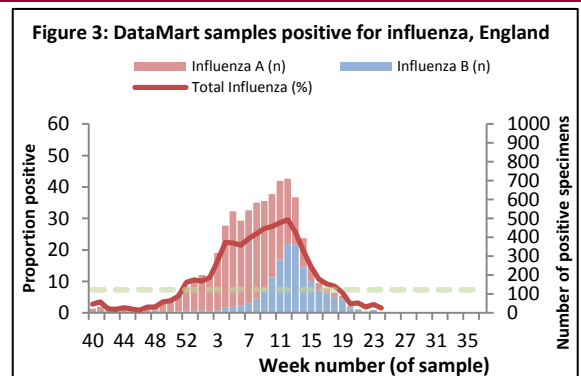
Scheme	GP ILI consultation rate per 100,000			Peak age group
	Week 23	Week 24		
England (RCGP)	1.9	2.6	↔	<1yrs
Scotland	1.3	2.8	↑	45-64yrs
Northern Ireland	4.7	2.6	↓	65-74yrs
Wales	0.9	0.6	↔	45-64yrs



- Syndromic surveillance
  - Increases have been seen in asthma/wheeze/difficulty breathing consultations, particularly in children aged 5-14 years, but levels remain within seasonally expected levels.
  - For further information, please see the Syndromic surveillance [webpage](#).

**Virological surveillance**

- English Respiratory Data Mart system
  - In week 24 2016, 12 samples (1.5%) of the 779 respiratory specimens tested were positive for influenza (10 A(H3N2) and 2 A(untyped) ), Figure 3).
  - Rhinovirus positivity increased from 16.1% in week 23 to 18.8% in week 24. RSV positivity remained low (0.7% in week 23 and 0.5% in week 24). Positivity decreased slightly for parainfluenza from 9.9% in week 23 to 8.9% in week 24, and remained low for hMPV (2.0% in week 23 and 1.6% in week 24). Positivity for adenovirus slightly decreased from 5.3% in week 23 to 5.0% in week 24.
- UK GP-based sentinel schemes
  - Through the GP-based sentinel schemes across the UK, no samples were positive for influenza in week 24 2016.



**Outbreak Reporting**

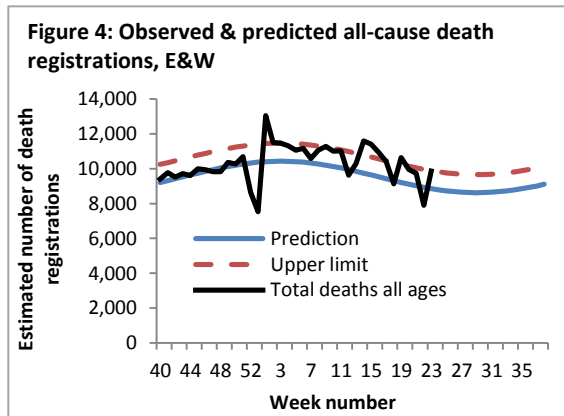
- Five new acute respiratory outbreaks were reported in the past 14 days. Three were from care homes with no test results available. One was from a hospital with no test results available and one outbreak was from the other settings category which tested positive for influenza A(untyped). Outbreaks should be reported to the local Health Protection Unit and [Respscids@phe.gov.uk](mailto:Respscids@phe.gov.uk).

**All-cause mortality surveillance**

- In week 23 2016, an estimated 9,873 all-cause deaths were registered in England and Wales (source: [Office for National Statistics](#)). This is an increase compared to the 7,909 estimated death registrations in week 20 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 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 24 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 24 2016?	Weeks with excess in 2015/16
<5	x	40,05,15,19
5-14	x	NA
15-64	x	52-53, 03,05-07, 09-10,12,17
65+	x	NA

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

## International Surveillance

- Influenza
  - Influenza activity in the temperate zone of the northern hemisphere continued to decrease to inter-seasonal levels. In temperate countries in the southern hemisphere, influenza activity started to increase in South America and South Africa, but remained low overall in most of Oceania.
  - In North America, influenza activity is below seasonal thresholds.
  - Influenza activity continues to decrease in Europe and temperate Asia with influenza B virus activity.
  - In the northern temperate and central tropical regions of Africa, influenza activity was generally low with influenza A virus detections reported in Western Africa and influenza A and B virus detections reported in Eastern Africa.
  - In Central America and the Caribbean countries, influenza and other respiratory virus activities remained generally low. El Salvador and Panama however reported increased influenza activity with influenza A(H1N1)pdm09 virus.
  - In tropical South America, influenza activity generally decreased or remained low except in Bolivia where influenza A(H1N1)pdm09 activity increased.
  - In tropical countries of South Asia, influenza activity was generally low with increased influenza B virus in some countries.
  - The influenza season began in temperate South America, with ILI and SARI activities increased above seasonal thresholds in Argentina, Chile and Paraguay. Respiratory virus detections were still low but increasing, with influenza A(H1N1)pdm09 predominant among influenza detections.
  - In the temperate countries of Southern Africa, the influenza season began with increasing influenza activity due to predominantly influenza B viruses.
  - The WHO GISRS laboratories tested more than 61285 specimens during that time period. 4320 were positive for influenza viruses, of which 1276 (29.5%) were typed as influenza A and 3044 (70.5%) as influenza B. Of the sub-typed influenza A viruses, 540 (71%) were influenza A(H1N1)pdm09 and 221 (29%) were influenza A(H3N2). Of the characterized B viruses, 221 (30.4%) belonged to the B-Yamagata lineage and 505 (69.6%) to the B-Victoria lineage.
- MERS-CoV
  - Up to 22 June 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 757 suspect cases in the UK that have been investigated for MERS-CoV and tested negative.
  - Between 19 and 20 June 2016 the National IHR Focal Point of Saudi Arabia reported six additional cases of Middle East Respiratory Syndrome Coronavirus (MERS-CoV) 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 1,768 laboratory-confirmed cases of infection with MERS-CoV, including at least 630 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 [10 May 2016](#), the National Health and Family Planning Commission (NHFPC) of China notified WHO of 11 additional laboratory-confirmed cases of human infection with avian influenza A(H7N9) virus, including 4 deaths.
  - A total of 770 laboratory-confirmed cases of human infection with avian influenza A(H7N9) viruses, including at least 306 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](#).