GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales

Weekly Acute Respiratory Infection Report

Public Health Wales

Communicable Disease Surveillance Centre

Report week: 14 (ending 05 April 2026)

Weekly acute respiratory infection summary

Headline

- Influenza circulation is at out of season levels.
- Respiratory Syncytial Virus (RSV) is at baseline (out of season) levels
- COVID-19 case numbers have remained broadly stable in recent weeks.
- GP consultations for acute respiratory infections decreased during week 14 compared to the previous week.
- According to EuroMoMo method, 'no excess' of all-cause mortality has been reported in the most recent week.
- As influenza and RSV circulation has returned to out of season levels, there will be a pause in the short-term forecasts of hospital admissions with acute respiratory infections. The forecasts will commence next season 2026-27.
- This report covers the week ending 5th April, which included one Bank Holiday, where in hours GP services would not have been available. We therefore suggest caution in interpretating trends in GP consultation rates covering this week.s

Foreword

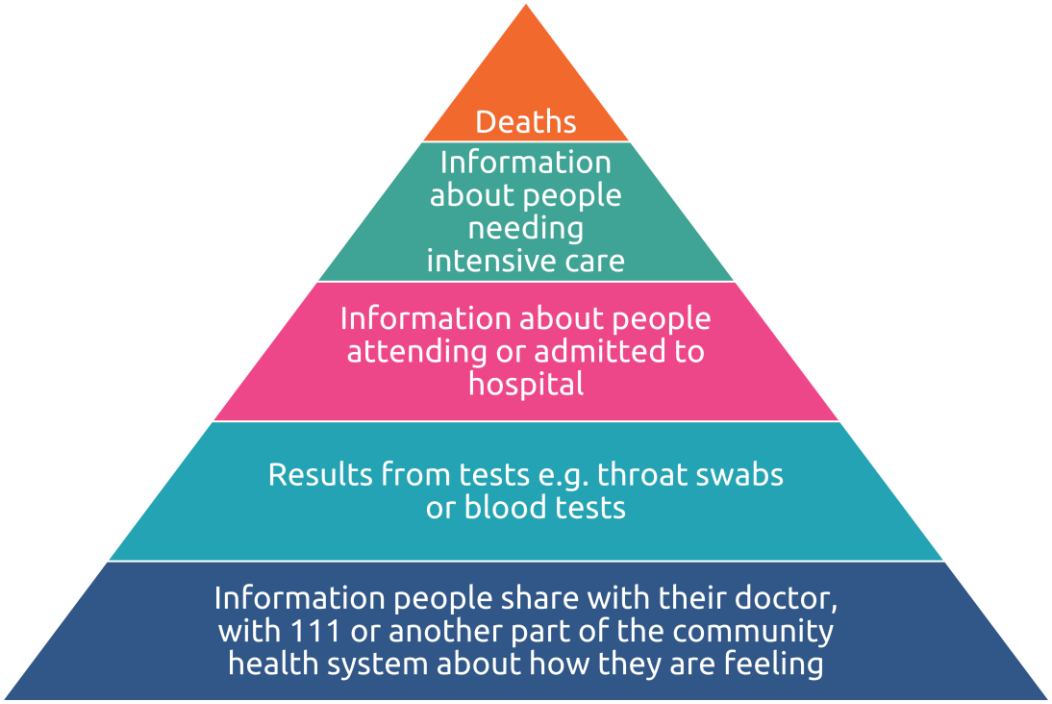
This report replaces the previously separate weekly reports on COVID-19, influenza and other respiratory infections. It is published on a weekly basis between Week 40 (October) and 20 (May) of the following year, and on a fortnightly basis during the summer period.

This report summarises the latest available information from several Public Health Wales surveillance schemes, reports on Acute Respiratory Infections (ARI) and information from other sources.

Additional information is available from the links below.

- Weekly ARI Hospital Admissions Dashboard
- EuroMOMO European mortality monitoring
- Public Health Wales Respiratory Infection Mortality updates
- COVID-19 variant summary

The structure of this report is based on the surveillance pyramid (from mild to severe infection outcomes), illustrated below. Icons alongside chapter headings indicate the types of information included in the chapter.



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High Level Summary Points

	Community infection indicators	Severe infection indicators
Overall Acute Respiratory Infection (ARI)	Consultations with Sentinel and non-sentinel GP's for acute respiratory infection (ARI) decreased compared to the previous week.	Admissions in patients testing positive for COVID-19 or RSV decreased, but increased slightly for influenza during week ending 05/04/2026 (1% of total admissions).
Influenza	**Overall, influenza activity is at baseline intensity levels.** The overall proportion of samples testing positive in hospital and non-sentinel patients remained stable in the most recent week at 2.0%. Consultations for influenza-like illness (ILI) with sentinel GPs are at **baseline** intensity levels and slightly increased compared to previous week. One case of influenza was confirmed in a symptomatic sentinel GP network patient last week.	The number of confirmed cases of community acquired influenza admitted to hospital increased to 13. There were 18 in-patient cases of confirmed influenza, one of whom was in critical care.
Influenza type breakdown	***Since 2025 Week 40**: 4,764 total influenza cases confirmed (1,548 influenza A(H3N2), 127 influenza A(H1N1)pdm09, 3,042 influenza A untyped and 47 influenza B).* ***In the most recent week**: One influenza A(H3), three influenza A(H1N1), 27 influenza A untyped and three influenza B.*	
COVID-19	The overall proportion of samples testing positive decreased to 2.0 % in hospital and non-sentinel GP practices. Consultations with Sentinel GPs and Pharmacies for COVID-19 increased in recent weeks.	The number of confirmed cases of community acquired COVID-19 admitted to hospital decreased to 16. There were 67 in-patient cases of confirmed COVID-19, three of whom were in critical care.
RSV	RSV incidence in children aged up to 5y was 1.8 per 100,000 (baseline intensity levels), This is an increase from the previous week.	The number of confirmed cases of community acquired RSV admitted to hospital decreased to 7. There were 16 in-patient cases of confirmed RSV, one of whom was in critical care.
Other respiratory pathogens	SARS-CoV-3 and C. pneumoniae are the most frequently detected other cause of ARI. Enterovirus and adenovirus cases have increased in recent weeks.	

1. Community surveillance indicators

GP Consultations

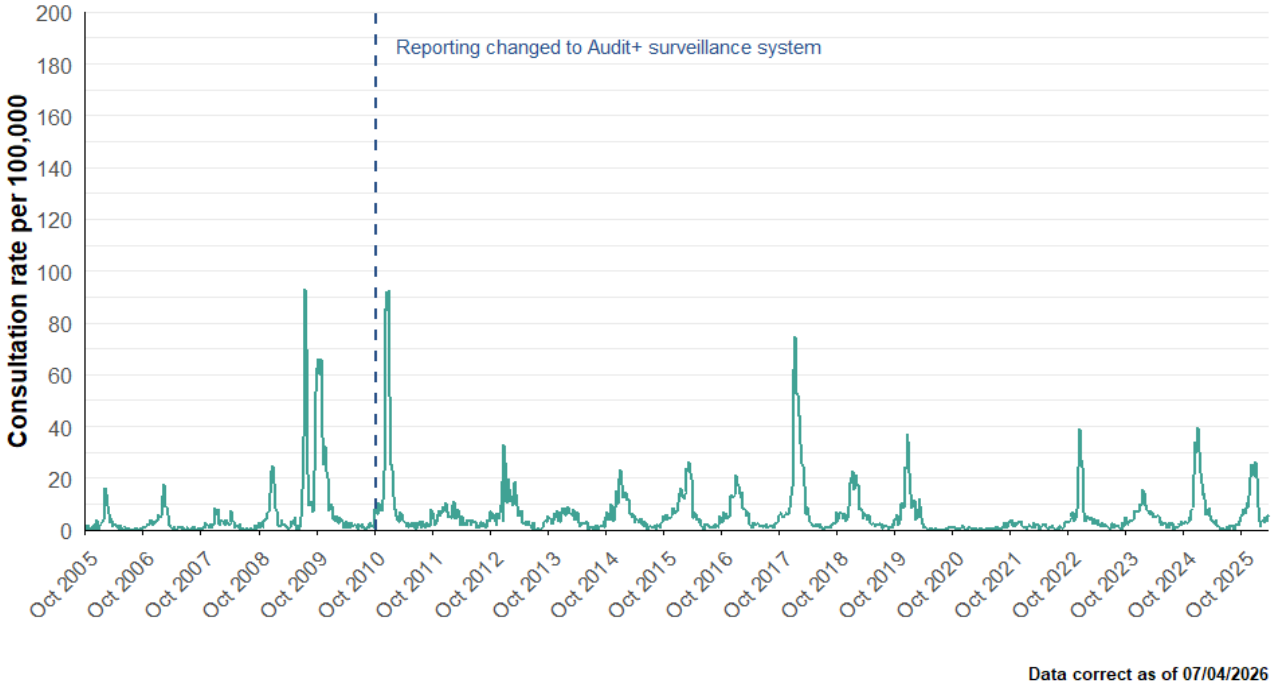
- The sentinel GP consultation rate for influenza-like illness (ILI) is at baseline levels, the three-week trend has increased but remains low (Figures 1.1, 1.2).
- There were 6.1 ILI consultations per 100,000 practice population in the most recent week, an increase compared to the previous week (5.5 consultations per 100,000).
- In the most recent week, using all available data from general practices, there were 11.2 ARI consultations per 100,000 practice population, an increase from 8.7 in the previous week (Table 1.1). The highest rates were found in people aged under 1 year (948.2) followed by people aged 1 to 4 (896.4) and people aged 5 to 14 (210.9) (Figure 1.3).
- Surveillance indicators for acute respiratory infections in GP consultation data in Wales are decreasing in people aged under 5 years (Figure 1.3).

Ambulance Calls

- The number of ambulance calls recorded referring to syndromic indicators decreased from 1,554 in the previous week to 1,490 in the latest reporting week (Figure 1.5, Table 1.2).
- Calls for cardiac or respiratory arrest increased compared to the previous week. Calls for chest pain, difficulty breathing were stable or decreased compared to the previous week (Figure 1.5, Table 1.2).

GP consultations – Sentinel Network

Figure 1.1. Sentinel GP network clinical consultation rate for ILI per 100,000 practice population (Week 40, 2004 - Week 14, 2026).



Data correct as of 07/04/2026

Figure 1.2. Sentinel GP network clinical consultation rate for ILI per 100,000 practice population.

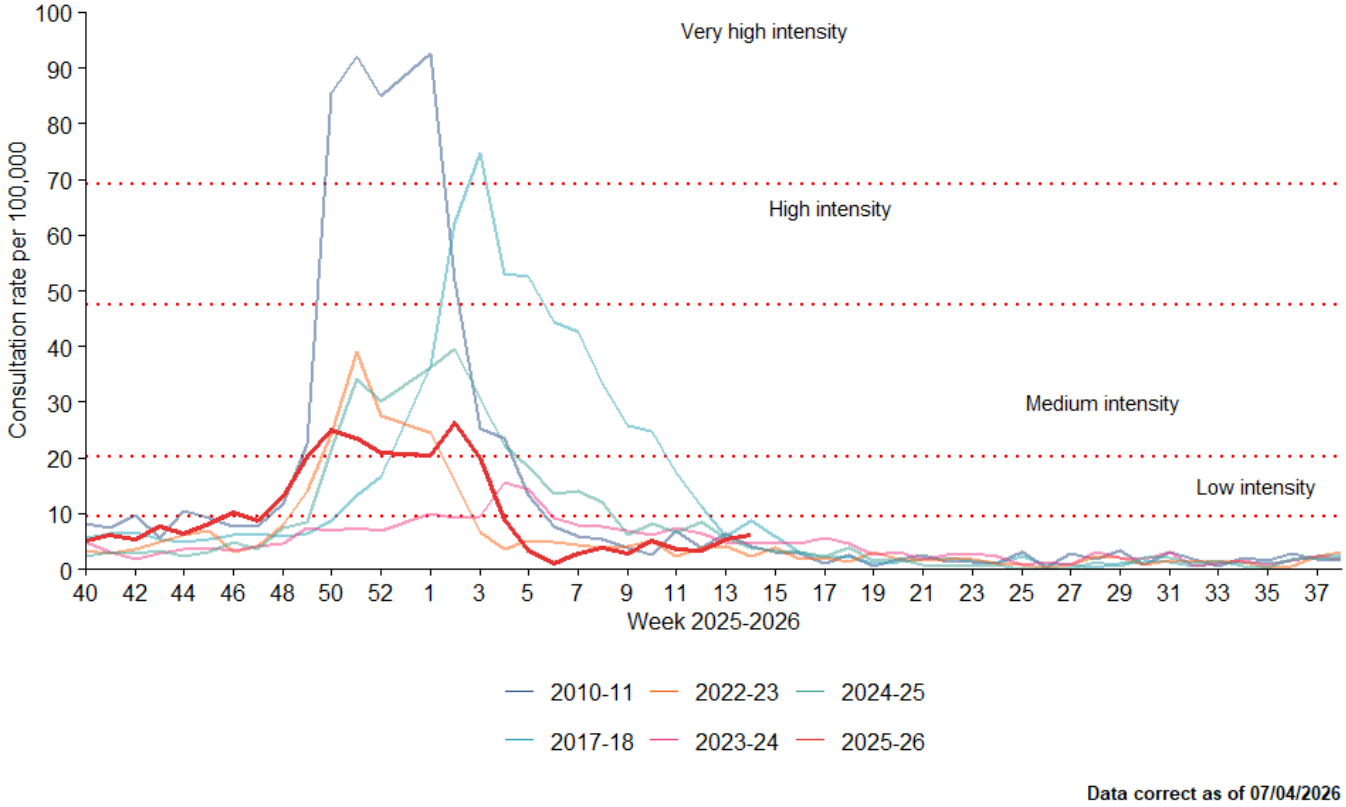
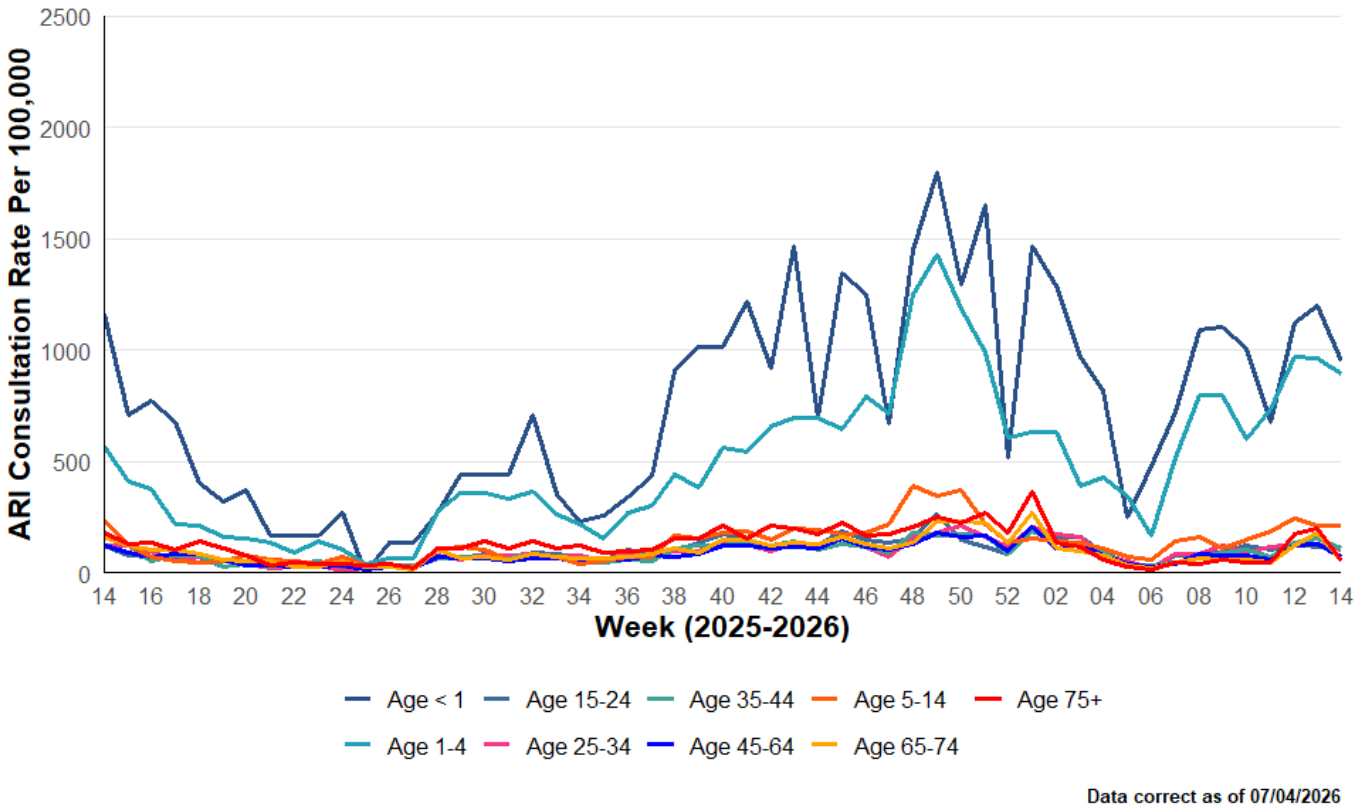


Figure 1.3. All Wales clinical consultation rates for Acute Respiratory Infection (ARI) per 100,000 practice population, by age bands.



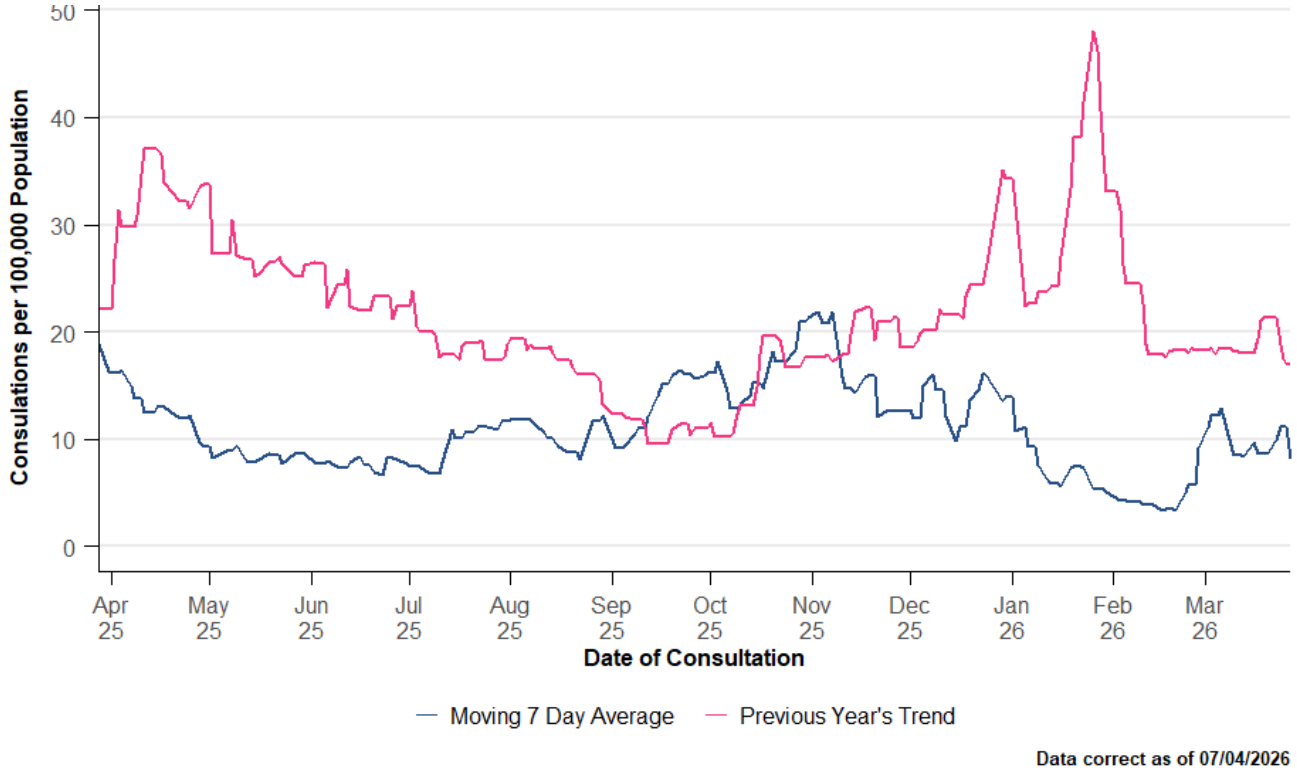
GP Consultations - All Wales

Table 1.1. Summary of GP consultations per 100,000 practice population in Wales, by indicator, for Week 14, 2026. This table uses all available GP surveillance data (from sentinel and non-sentinel practices).

Indicator	Current Reporting Week	Preceding Week	Equivalent Period Last Year
ARI	11.18	8.68	20.23
COVID-19	0.02	0.03	0.19
LRTI	4.23	3.15	7.27
Pneumonia	0.04	0.05	0.06
Severe asthma	0.16	0.14	0.72
URTI	6.94	5.55	12.99
Total	22.57	17.60	41.46

NB: "Current reporting week" refers to the average daily rate in the current reporting week. "Preceding week" refers to the average daily rate in the preceding week. "Equivalent period last year" refers to the average daily rate in the equivalent period last year.

Figure 1.4. Sentinel GP network consultation rates per 100,000 practice population for Acute Respiratory Infection (ARI).



Ambulance Calls

Figure 1.5. Rolling seven-day average for ambulance calls for both current and the previous year, by symptom. This summary analysis uses data provided by the Welsh Ambulance Service NHS Trust.

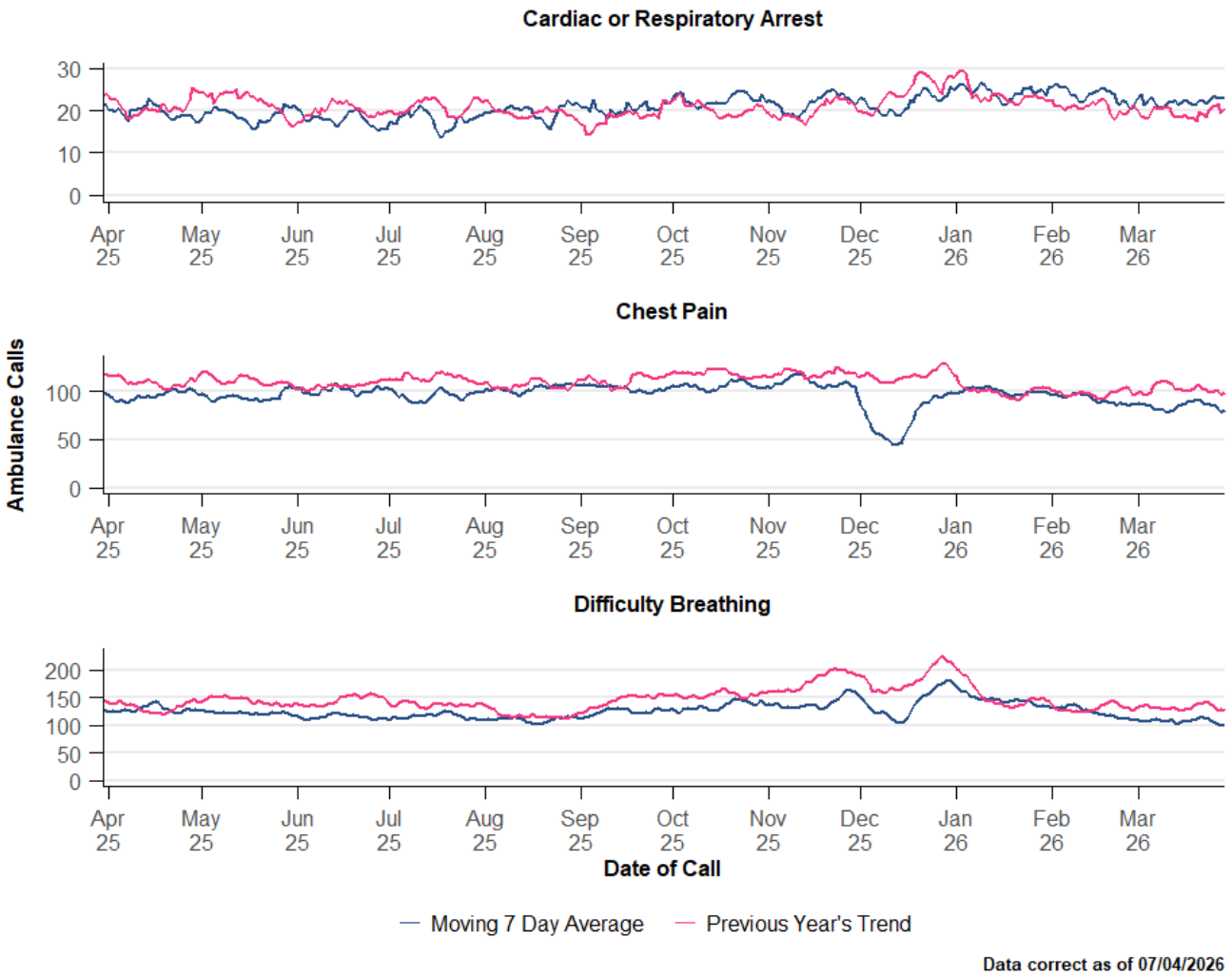


Table 1.2. Summary of weekly number of Ambulance calls, by symptom in Wales, for Week 13, 2026. This summary analysis uses data provided by the Welsh Ambulance Service NHS Trust.

Indicator	Current Reporting Week	Preceding Week	Equivalent Period Last Year
Cardiac or Respiratory Arrest	163	148	130
Chest Pain	591	633	719
Difficulty Breathing	736	773	945
Total	1,490	1,554	1,794

NB: "Current reporting week" refers to the total number of calls in in the current reporting week. "Preceding week" refers to the total number of calls in in the preceding week. "Equivalent period last year" refers to the total number of calls in in the equivalent period last year.

2. Virological Surveillance

Wales Sentinel GP and Sentinel Community Pharmacy Network

- There were 62 surveillance samples from patients with ILI symptoms collected by sentinel GPs and community pharmacies during Week 14, 2026, as at 08/04/2026 (Table 2.1, Figure 2.1).
- The most commonly detected pathogens were rhinovirus (7) followed by human metapneumovirus (4) and coronaviruses (2). Of the 62 tests, 66.1% were negative for all respiratory pathogens (Table 2.1, Figure 2.1).

All Wales Datastore Respiratory Infection Testing

- There were 935 samples receiving multiplex respiratory panel testing, collected from patients attending hospitals and non-sentinel GPs during Week 14 (Table 2.2, Figure 2.2).
- The most commonly detected pathogens were rhinovirus (109) followed by adenovirus (82) and human metapneumovirus (66). Of the 935 tests, 65.5% were negative for all respiratory pathogens (Table 2.2, Figure 2.2).

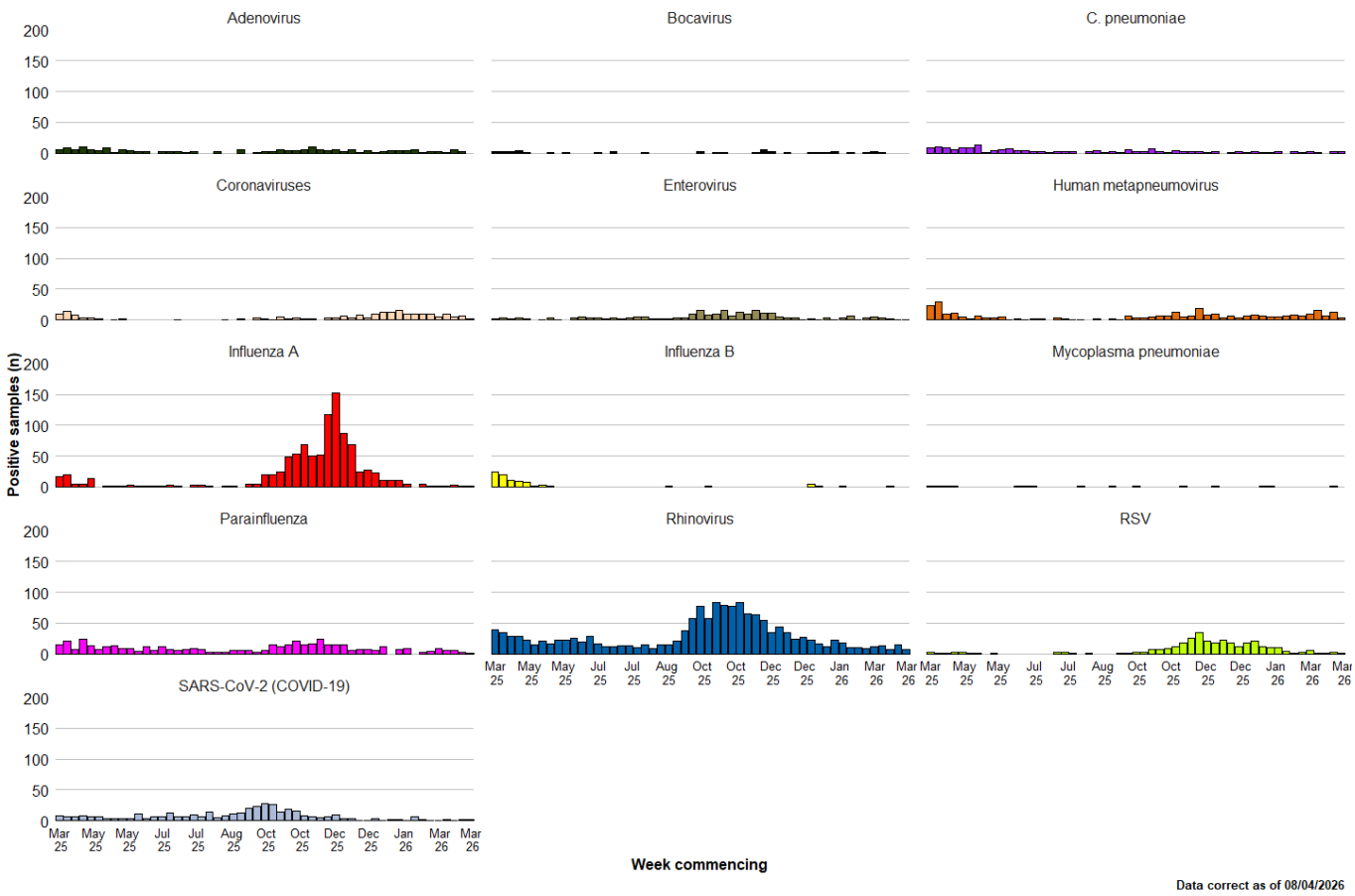
Additionally, during Week 14, 319 samples from patients were tested for influenza, RSV and SARS-CoV-2 only (Figure 2.3). Of these the following tested positive:

- 22 for influenza (20 for influenza A, two for influenza B)
- 12 for SARS-CoV-2 (COVID-19)
- 5 for RSV

Table 2.1: Pathogens detected, and sample positivity for samples from symptomatic patients from the Wales Sentinel GP and Sentinel Pharmacy networks, Week 14, 2026.

Pathogens Detected	Count (n)	Positivity (current week)	Positivity (previous week)	Trend
Rhinovirus	7	11.3%	15.2%	Decreasing
Human metapneumovirus	4	6.5%	12.1%	Decreasing
Coronaviruses	2	3.2%	6.1%	Decreasing
SARS-CoV-2 (COVID-19)	2	3.2%	2.0%	Increasing
C. pneumoniae	2	3.2%	2.0%	Increasing
Influenza A	1	1.6%	2.0%	Stable
RSV	1	1.6%	3.0%	Decreasing
Parainfluenza	1	1.6%	2.0%	Stable
Enterovirus	1	1.6%	1.0%	Stable
Influenza B	0	0.0%	0.0%	Stable
Adenovirus	0	0.0%	2.0%	Decreasing
Mycoplasma pneumoniae	0	0.0%	1.0%	Decreasing
Bocavirus	0	0.0%	0.0%	Stable

Figure 2.1. Pathogens detected in samples from symptomatic patients from the Wales Sentinel GP and Sentinel Pharmacy networks, by week of sample collection, Week 14, 2025 to Week 14, 2026.



All Wales Datastore Respiratory Infection Testing

Table 2.2: Pathogens detected and sample positivity for samples collected from hospital and non-Sentinel GP patients, Week 14, 2026.

Pathogens Detected	Count (n)	Positivity (current week)	Positivity (previous week)	Trend
Rhinovirus	109	11.7%	11.3%	Stable
Adenovirus	82	8.8%	11.3%	Decreasing
Human metapneumovirus	66	7.1%	6.1%	Stable
Parainfluenza	49	5.2%	3.8%	Increasing
Enterovirus	25	2.7%	4.5%	Decreasing
Seasonal coronaviruses	20	2.1%	1.6%	Stable
SARS-CoV-2 (COVID-19)	19	2.0%	4.1%	Decreasing
Influenza A	10	1.1%	1.0%	Stable
RSV	5	0.5%	1.4%	Stable
Influenza B	1	0.1%	0.3%	Stable
Mycoplasma pneumoniae	0	0.0%	0.0%	Stable
Bocavirus	0	0.0%	0.0%	Stable
C. pneumoniae	0	0.0%	0.0%	Stable

Figure 2.2. Pathogens detected in samples collected from hospital and non-Sentinel GP patients, by week of sample collection, Week 14, 2025 to Week 14, 2026.

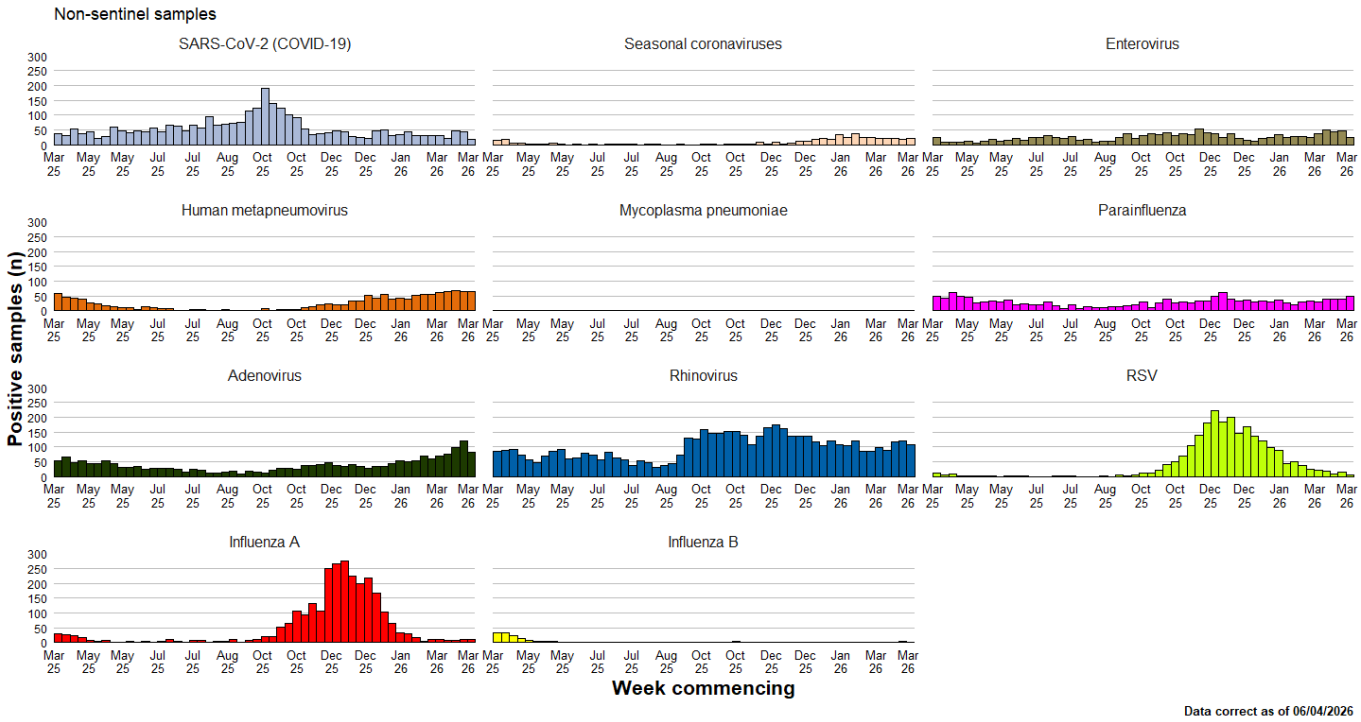
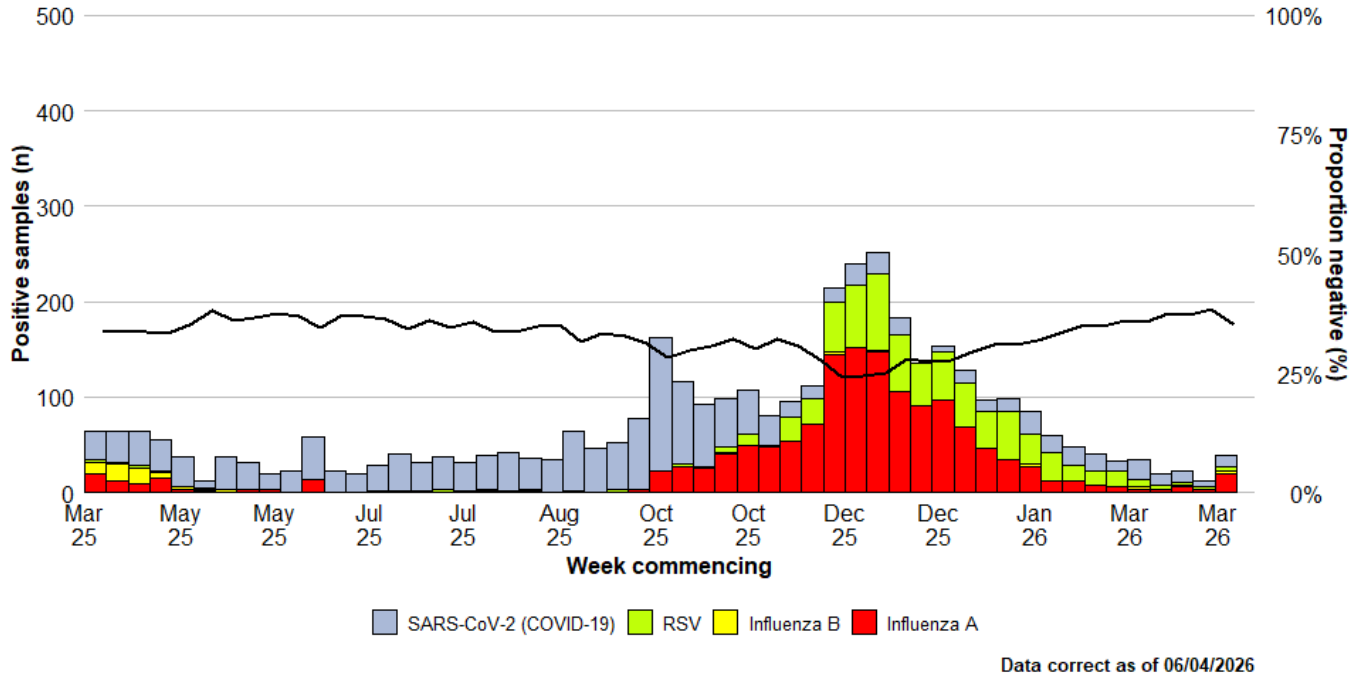


Figure 2.3. Samples from hospital patients submitted for RSV, Influenza and SARS-CoV-2 testing only, by week of sample collection, Week 14, 2025 to Week 14, 2026.



3. Severe Acute Respiratory Infection (SARI) and surveillance in hospitals

Sentinel SARI in emergency departments

- During the previous four weeks there were 54 surveillance samples taken from SARI surveillance sentinel emergency departments. The most common pathogen identified from these samples was Rhinovirus/Enterovirus(15) followed by Adenovirus(11) and Human metapneumovirus(2). Of the 54 samples collected, 50.0% were negative for all respiratory pathogens (Table 3.1).

- During this time, the proportions of symptomatic patients attending sentinel emergency departments due to acute respiratory symptoms testing positive were 2% for influenza, 4% for SARS-CoV-2 and 0% for RSV.

Hospital in-patients

- During week ending 05/04/2026 there were 36 patients admitted to hospital with confirmed COVID-19, RSV or influenza, (1 less than the previous week), equating to 1% of all hospital admissions in that reporting week.

- At 23:59 on 05/04/2026, there were 101 patients in hospital with confirmed COVID-19, RSV or influenza, 11 less than the previous Sunday. This equates to 1% of all hospital in-patients (IPs) at that time. Of whom 59% (60) were hospital acquired (HA).

Critical-care

- During week ending 05/04/2026 there were 4 ARI critical care (CC) admissions (1 more than the previous week), equating to 2% of all CC admissions in that reporting week.

- At 23:59 on 05/04/2026, there were 5 patients in CC with confirmed COVID-19, RSV or influenza, 1 more than the previous Sunday. This equates to 3% of all CC in-patients at that time. Of whom 0% (0) were hospital acquired (HA).

Virological surveillance in ICU

- During Week 14, 2026, 42 respiratory samples were tested from patients in intensive care units (ICU). Of these: two tested positive for SARS-CoV-2 (COVID-19), zero tested positive for Influenza and zero tested positive for RSV (Figure 3.4).

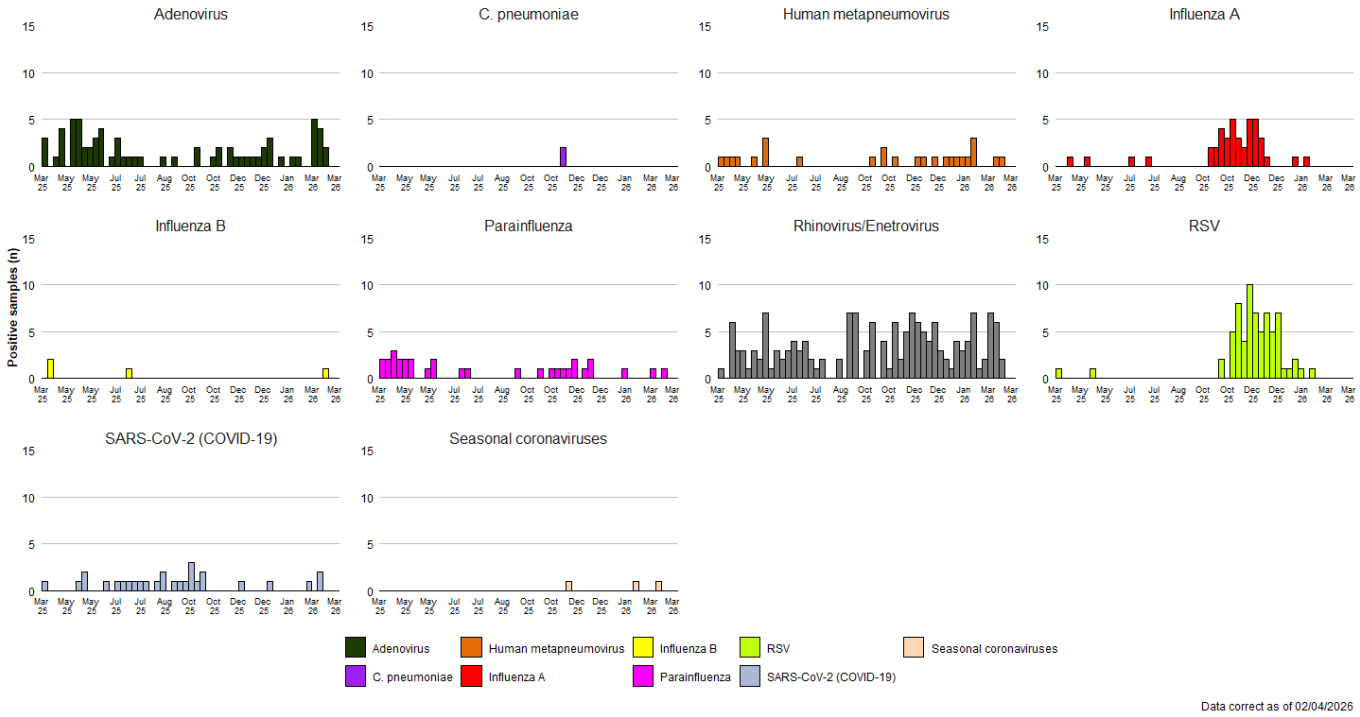
For detailed reports on surveillance of ARI in hospitals, including breakdowns by health board and age-group see: Hospital admissions dashboard

Wales Sentinel SARI Emergency Department Network

Table 3.1 Pathogens detected and sample positivity for samples collected from symptomatic patients presenting at participating SARI surveillance sentinel emergency departments, for Week 12, 2026.

	Meeting SARI case definition in the last 4 weeks		Meeting SARI case definition in the last 12 months	
Pathogens Detected	**n**	**%**	**n**	**%**
Adenovirus	11	20.4%	70	9.3%
C. pneumoniae	0	0.0%	2	0.3%
Human metapneumovirus	2	3.7%	26	3.5%
Influenza A	0	0.0%	51	6.8%
Influenza B	1	1.9%	4	0.5%
Mycoplasma pneumoniae	0	0.0%	0	0.0%
Parainfluenza	2	3.7%	32	4.3%
Pertussis	0	0.0%	0	0.0%
RSV	0	0.0%	68	9.1%
Rhinovirus/Enterovirus	15	27.8%	164	21.9%
SARS-CoV-2 (COVID-19)	2	3.7%	28	3.7%
Seasonal coronaviruses	1	1.9%	3	0.4%
Negative	27	50.0%	372	49.7%
Total	**54**	**100%**	**760**	**100%**

Figure 3.1 Pathogens detected in samples collected from symptomatic patients presenting at participating SARI surveillance sentinel emergency departments, for Week 12, 2026 and previous 12 months.

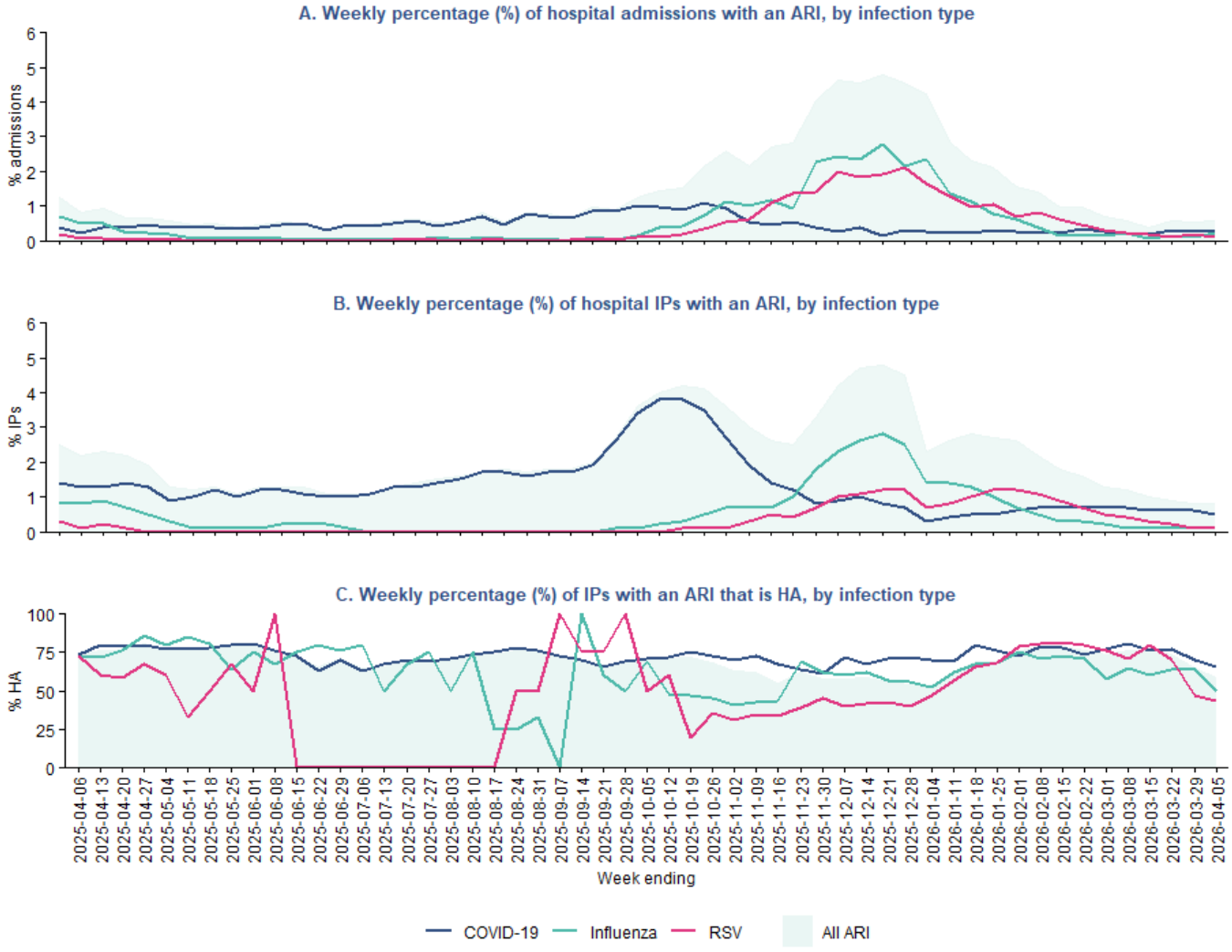


Acute Respiratory Infection Surveillance in Hospital In-Patients

Table 3.2. Hospital admissions in patients confirmed ***with*** COVID-19, influenza and RSV (acute respiratory infection may not necessarily be the primary cause of admission).

Infection	Hospital admissions		Hospital In-patients		
	Count	% of all admissions	Count	% of all IPs	% HA (n)
COVID-19	16	<1%	67	0%	66% (44)
Influenza	13	<1%	18	0%	50% (9)
RSV	7	<1%	16	0%	44% (7)
ARI total	**36**	**1%**	**101**	**1%**	**59% (60)**

Figure 3.2. (A) Weekly percentage of hospital admissions where influenza, COVID-19 or RSV was confirmed. (B) Weekly percentage of total in-patients where influenza, COVID-19 or RSV was confirmed. (C) Weekly percentage of total number of in-patients with confirmed COVID-19, influenza or RSV where the infection was healthcare acquired.



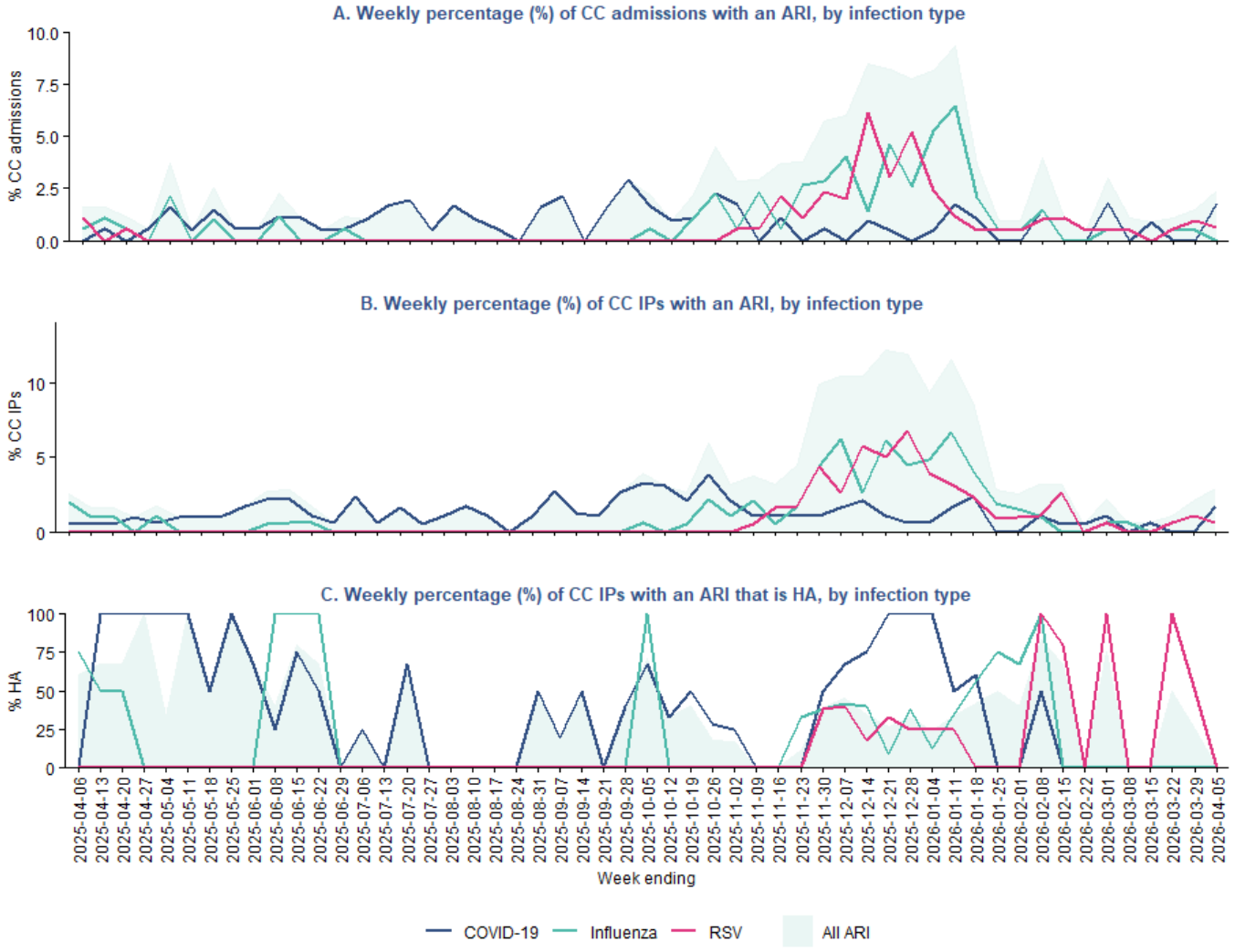
Data as of: 08-04-2026

Acute Respiratory Infection Surveillance in Critical-Care In-Patients

Table 3.3. Critical care (CC) admissions in patients confirmed with COVID-19, influenza and RSV (acute respiratory infection may not necessarily be the primary cause of admission).

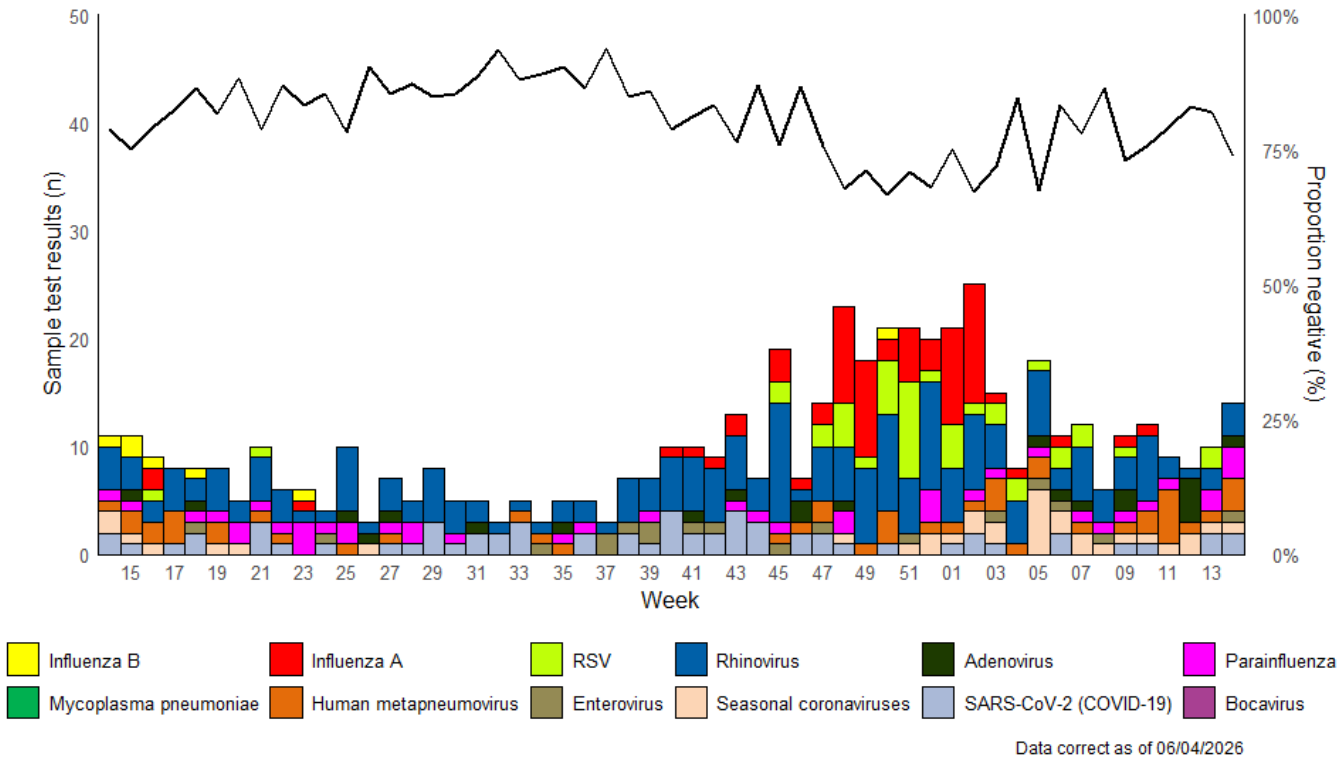
Infection	CC admissions		CC In-patients		
	Count	% of all CC admissions	Count	% of all CC In-patients	% HA (n)
COVID-19	3	2%	3	2%	0% (0)
Influenza	0	0%	1	1%	0% (0)
RSV	1	1%	1	1%	0% (0)
ARI total	**4**	**2%**	**5**	**3%**	**0% (0)**

Figure 3.3. (A) Weekly percentage of critical-care admissions where influenza, COVID-19 or RSV was confirmed. (B) Weekly percentage of total critical-care inpatients where influenza, COVID-19 or RSV was confirmed. (C) Weekly percentage of total number of critical-care inpatients with confirmed COVID-19, influenza or RSV where the infection was healthcare acquired.



Data as of: 08-04-2026

Figure 3.4. Samples submitted for virological testing from ICU patients, by week of sample collection, Week 14, 2025 to Week 14, 2026. The black line indicates the percentage of samples which tested negative for any of the pathogens listed.



4. Settings-based surveillance and outbreaks

Acute Respiratory Infection Outbreaks Reported to Public Health Wales Health Protection Team

During Week 14, 2026, 1 ARI and 1 influenza outbreak were reported to the Public Health Wales Health Protection Team.

Of these:

- The incidents were Rhinovirus, Influenza A
- The incidents were in Residential/ Care Homes

Figure 4.1. ARI outbreaks and incidents reported to Public Health Wales Health Protection Team, by setting and week of report. Completeness of reporting for outbreaks and incidents from schools/ nurseries and other community settings is unknown.

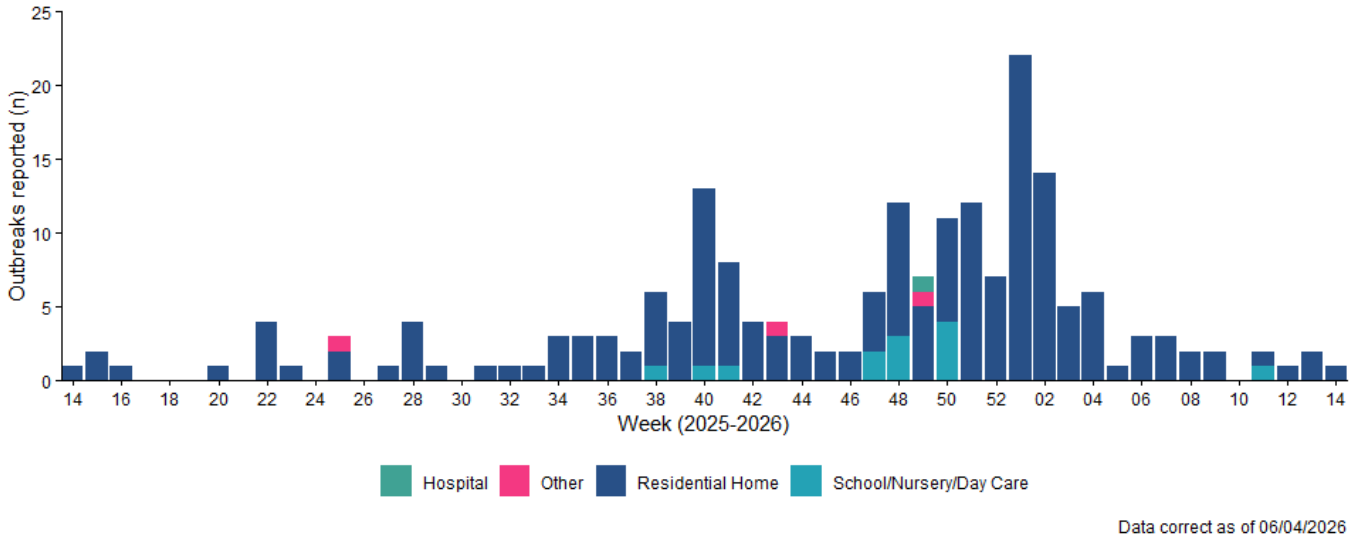
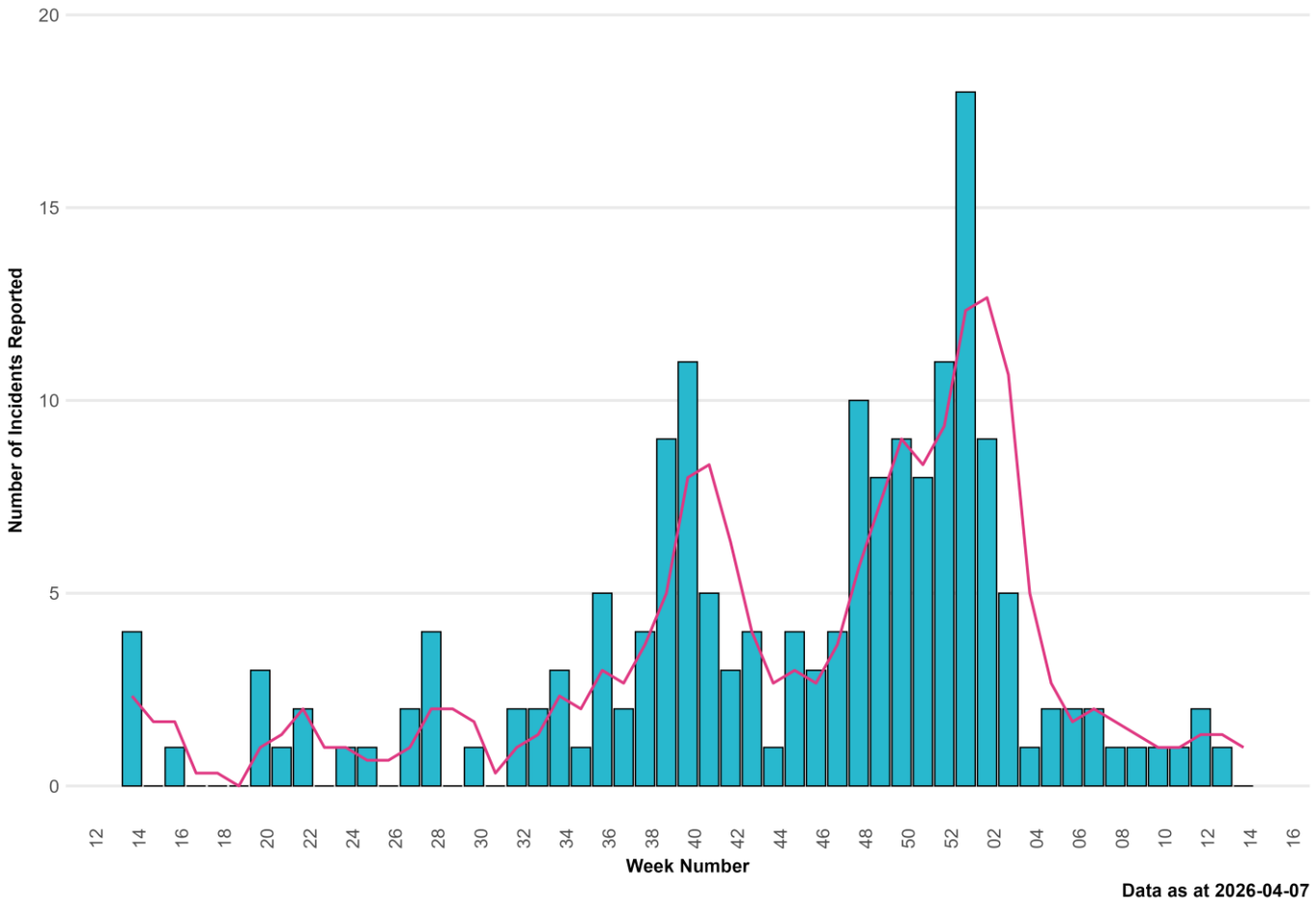


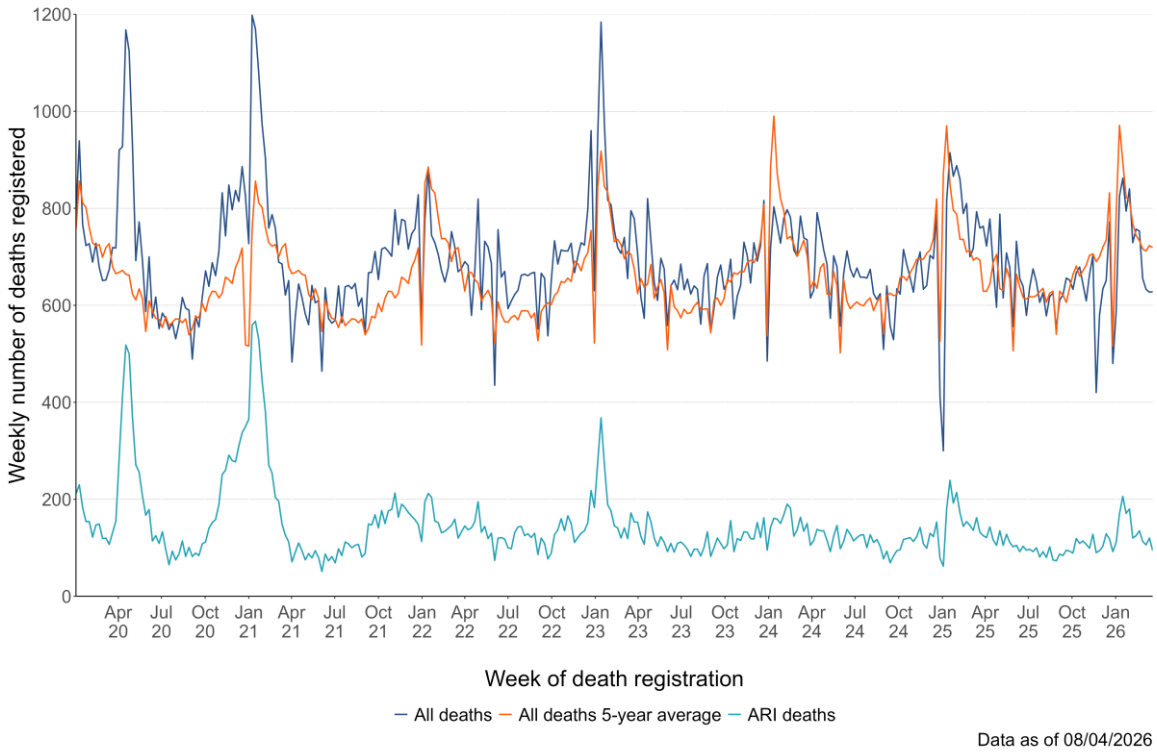
Figure 4.2. ARI outbreaks and incidents reported to Public Health Wales Health Protection Team, from residential care home settings, by week of onset of first case. The three-week rolling average is shown in pink.



5. Mortality surveillance

- According to European Mortality Monitoring (EuroMoMo) methods, no excess has been reported in the weekly number of deaths from all causes in Wales.
- Breakdowns of all-cause and ARI specific mortality, according to data from deaths registrations provided by the Office for National Statistics are summarised by week, age-group, setting of death and deprivation quintile of residence in Figures 5.1 to 5.4. Data for the most recent weeks in these summaries should be interpreted with caution due to potential reporting delays.
- Deaths relating to ARI have been defined using the following ICD10 codes: (J09-J22, J80, U07.1, U07.2 and J04)

Figure 5.1. Number of deaths registered (any cause), 5-year average (any cause) and deaths relating to ARI, by week of death registration.



Data as of 08/04/2026

Figure 5.2 Numbers of ARI related deaths by age-group and week of death registration.

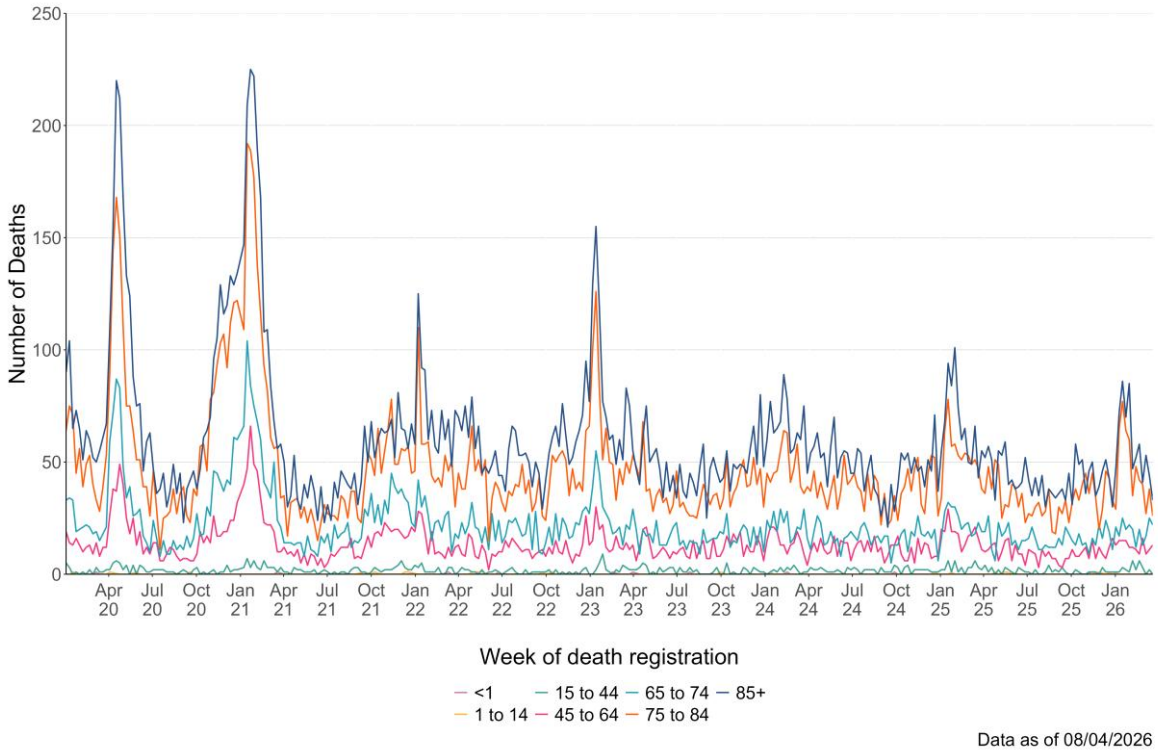


Figure 5.3. Numbers of deaths due to ARI, by place of death and week of death registration.

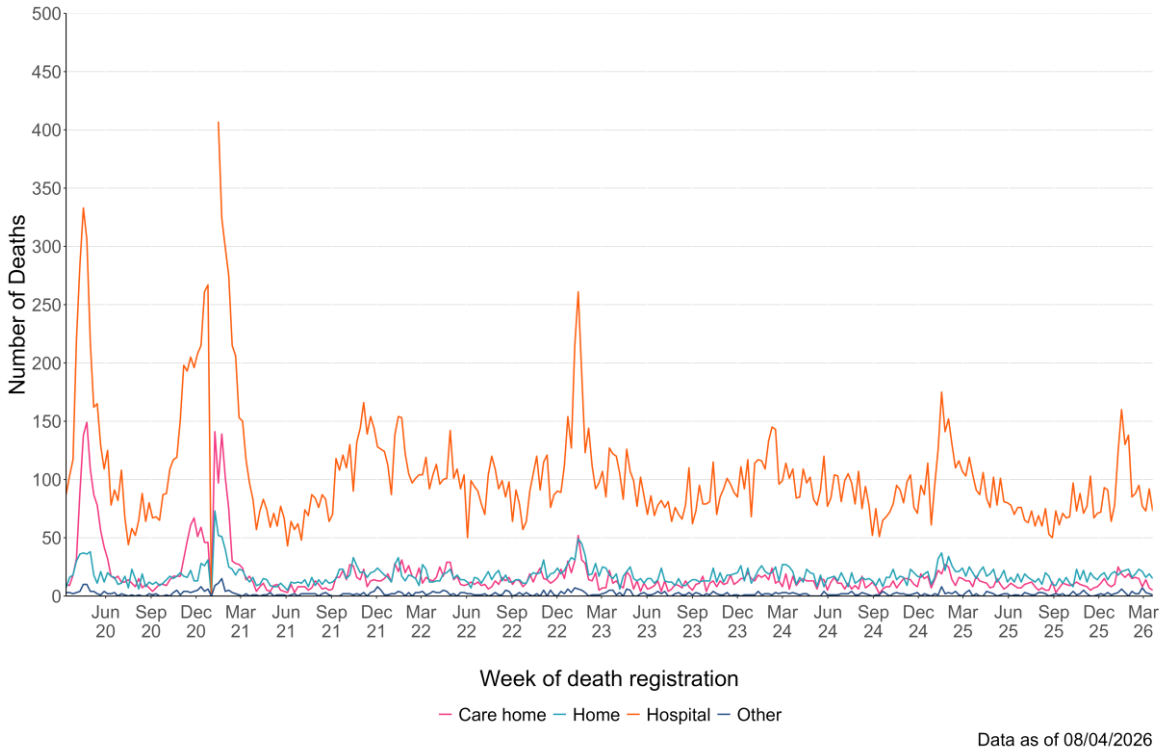
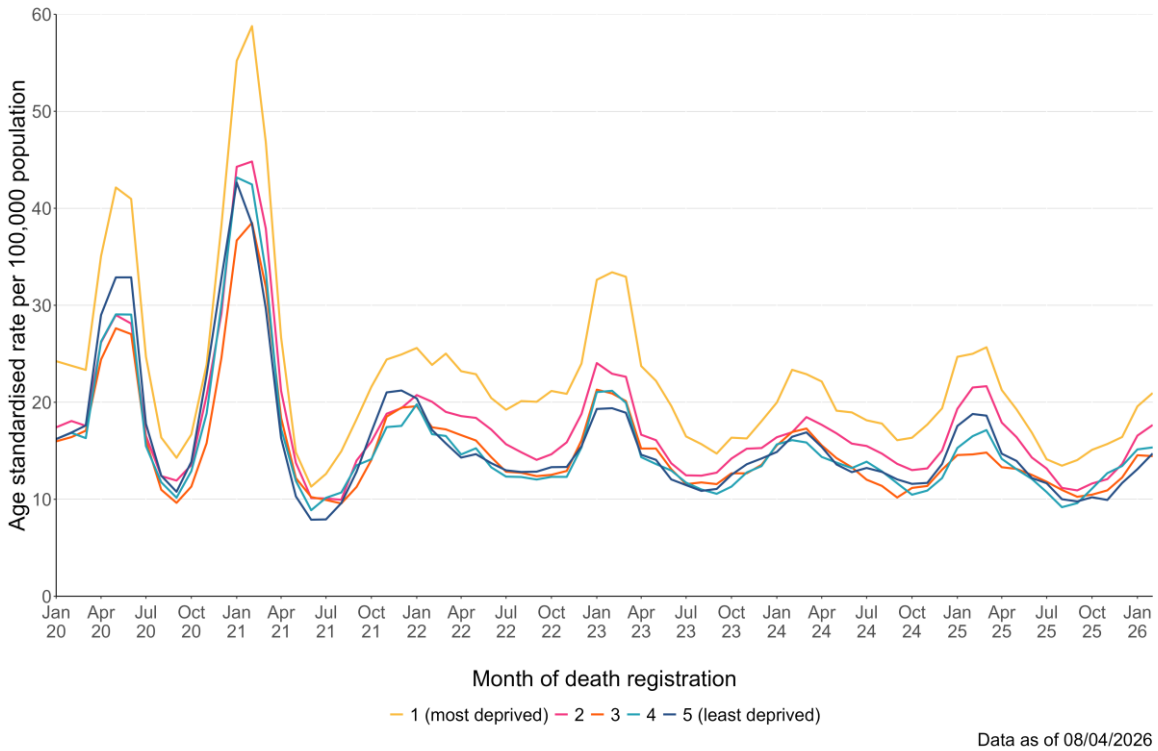


Figure 5.4. Numbers of ARI deaths, by quintile of deprivation of area of residence (based on the Welsh Index of Multiple Deprivation rankings of Lower Super Output Areas) and week of death registration.



For interactive versions of these data, including health board specific breakdowns, see: [ONS mortality dashboard]

6. Pathogen-specific surveillance

Influenza

- influenza A(H3N2) is the most commonly detected influenza subtype in Wales since Week 40 2025 (1,548 confirmed cases), followed by influenza A(H1N1) (127 confirmed cases) and influenza B (47 confirmed cases). Additionally, there have been 3042 untyped influenza A cases.

Figure 6.1a. Influenza subtypes based on samples submitted for virological testing by Sentinel GPs and community pharmacies, hospital patients, and non-Sentinel GPs, by week of sample collection, Week 14, 2025 to Week 14, 2026.

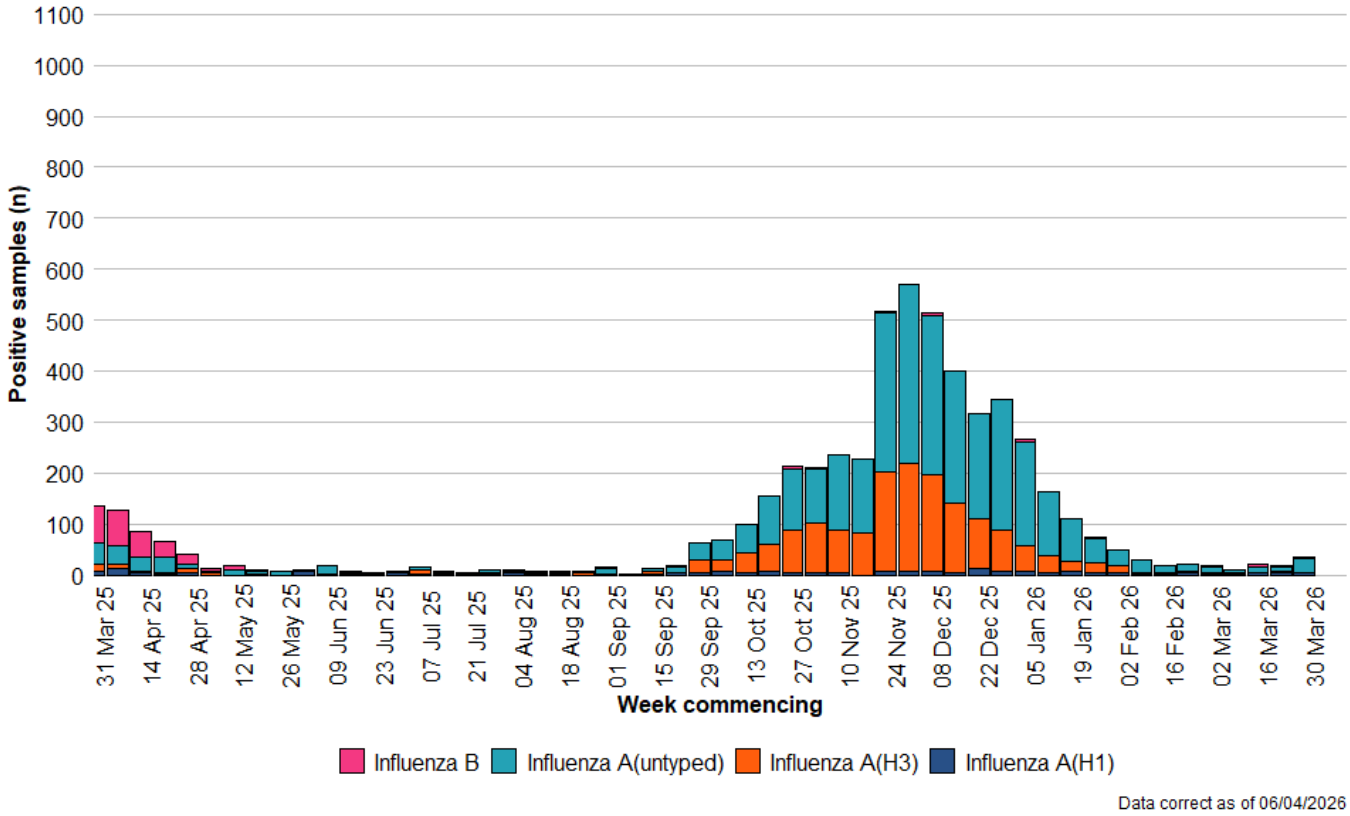
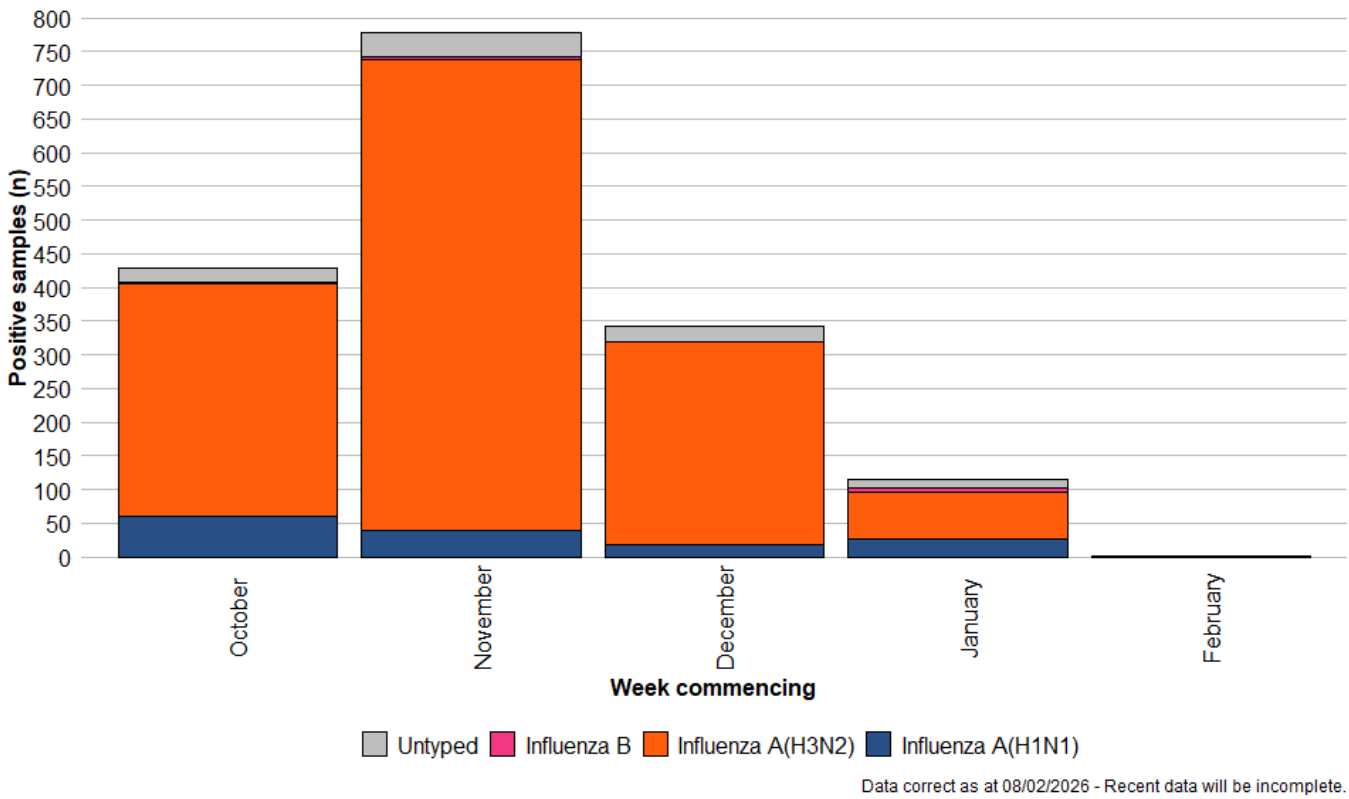


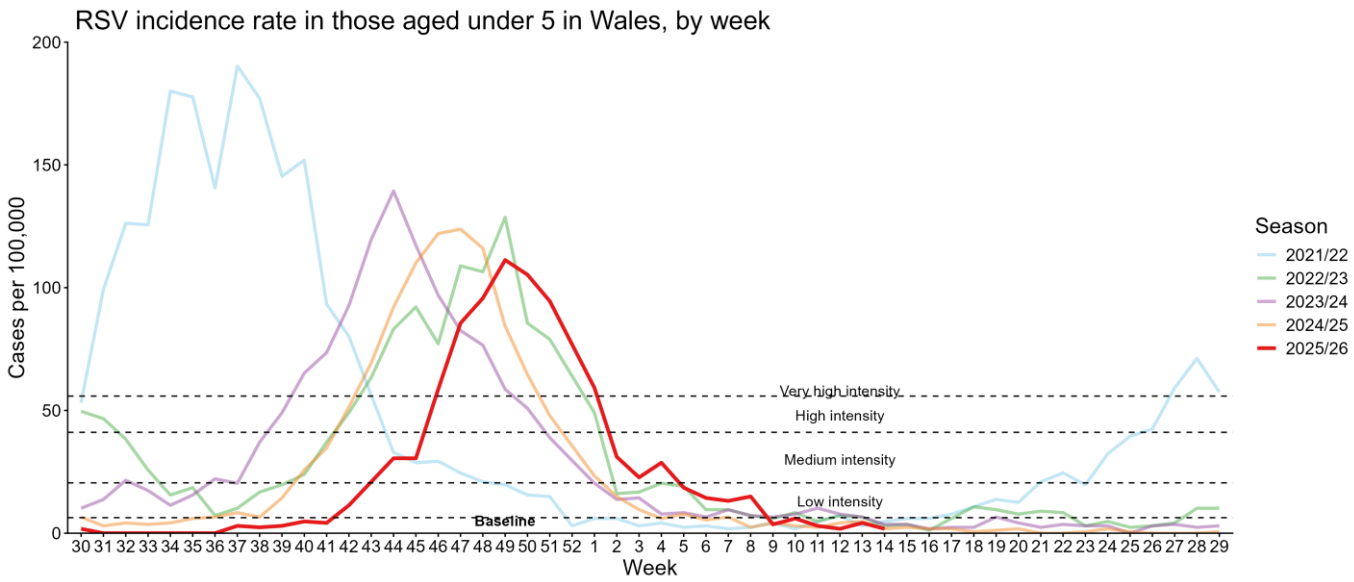
Figure 6.1b. Influenza subtypes based on samples referred to the Wales National Influenza Centre for typing, by week of sample collection, Week 40, 2025 to Week 5 2026.



Respiratory Syncytial Virus (RSV)

- RSV incidence per 100,000 population in children aged under five years is currently at baseline (1.8) intensity levels per 100,000 population during Week 14 2026 .

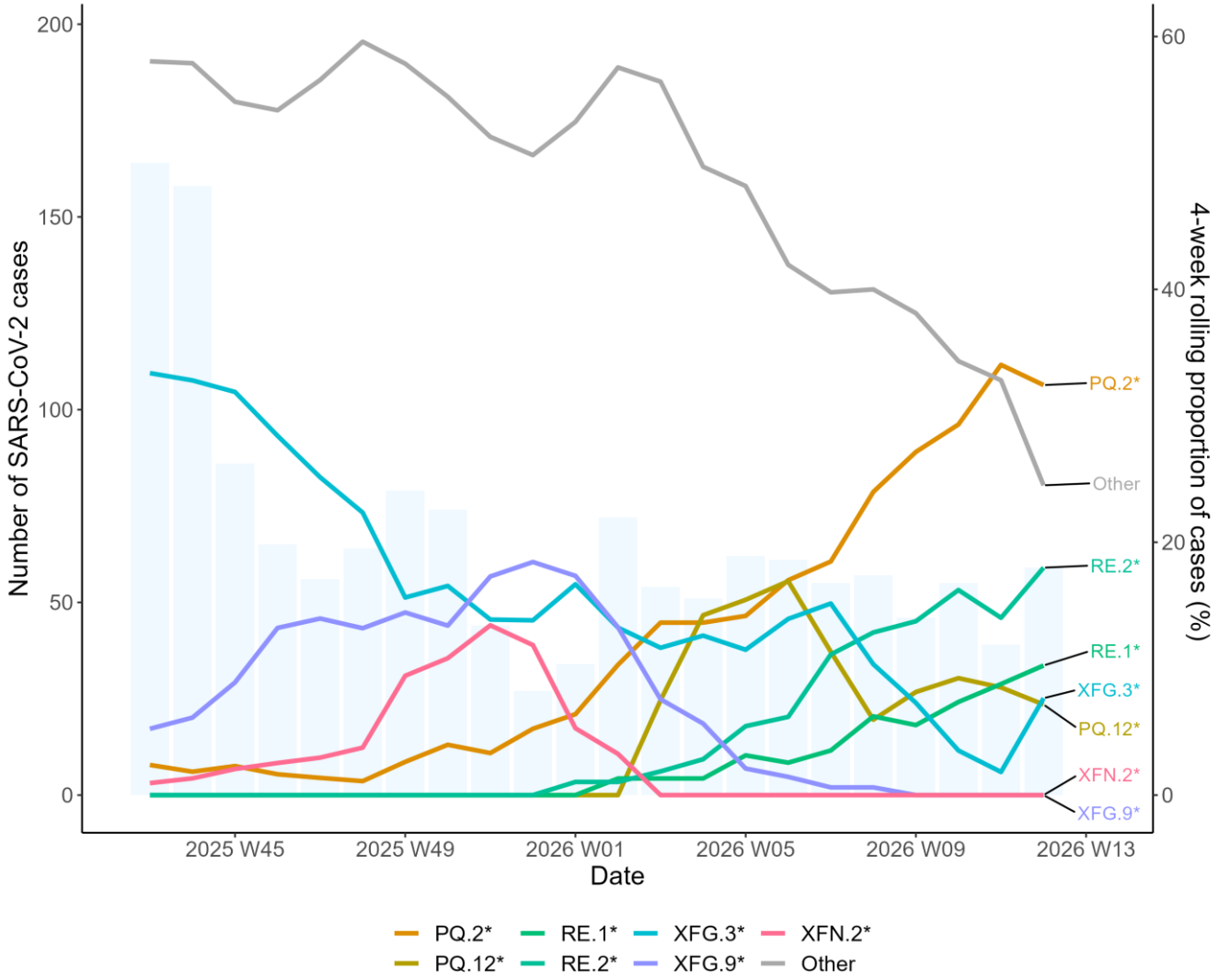
Figure 6.2. RSV incidence rate per 100,000 population aged under five years, Week 30, 2020 to Week 14 2026.



SARS-CoV-2 Variant surveillance

- Pango group PQ.2* is the most frequently detected Pango lineage group in Wales currently, accounting for 21.5% of sequenced cases in the previous six weeks.

Figure 6.3. Weekly number of SARS-CoV-2 cases (bars) and the 4-week rolling average proportion of sequenced cases attributed to each Pango lineage group (lines) from residents in Wales for the past six months (2025 W38 to 2026 W10).



For detailed information on genomic surveillance of SARS-CoV-2 in Wales, please see: https://public.tableau.com/app/profile/public.health.wales.health.protection/viz/COVID-19genomicsurveillance/Summary

7. Influenza vaccination uptake

The 2025/26 influenza vaccination programme is underway. Information on the groups who are eligible for a free NHS Wales influenza vaccine is available from: https://phw.nhs.wales/topics/immunisation-and-vaccines/winter-vaccinations/

Current uptake figures in eligible groups are presented in Table 8.1, these are updated on a weekly basis. Data on influenza vaccination coverage come from the Welsh Immunisation System (WIS). This is the first year that WIS has been used as the source of influenza vaccination data in Wales, and therefore caution should be used when comparing figures to previous years. Data in Table 8.1 were extracted on 31/03/26 and include vaccinations given and recorded in WIS up to the end of 30/03/26. Not all data for vaccinations given will have been entered into WIS at this time, therefore the figures presented here may not be a complete for vaccinations given up to 30/03/26. Vaccination uptake figures for school-aged children are based on a combination of data from WIS in five health boards and from a Public Health Wales survey in two health boards.

Table 8.1. Uptake of influenza vaccination in Wales 2025/26 (as of 31/03/26)

Influenza immunisation uptake in the 2025/26 season	
65 years and older	71.7%
16y to 64y in a clinical risk group	42.7%
Children aged 2 & 3 years	46.1%
Primary school aged children (4 to 10 years)*	57.6%
Secondary school aged children (11-15 years)*	45.4%

*Methods for calculating uptake in school aged children has changed for the 2025/26 season. Caution should be used when comparing estimated uptake to previous years, especially while school vaccination sessions are ongoing.

8. Early estimates of 2025/26 influenza vaccine effectiveness in the UK

- A combined study of influenza vaccine effectiveness has been conducted in Wales, Scotland and Northern Ireland. The study used a test negative case control approach to estimate the effectiveness of the current influenza vaccines at preventing hospital admissions with confirmed influenza A infections. The study included 1,379 cases of influenza and 12,364 controls, sampled from week 40 to week 47.

- The study included patients aged 2 to 17 years and patients aged 65 years and older. Limitations of early available data meant that estimation of effectiveness in adults aged 18 to 64 years was not possible at this point, but will be carried out in the coming months.

- Significant vaccine effectiveness was seen in both children and in older adults. Vaccine effectiveness was:

- 71.8% (95% CI: 58.8%–80.7%) in children and adolescents aged 2 to 17 years

- 33.5% (95% CI: 22.4%–43.1%) in adults aged 65 years and older

- Full details of this analysis, led by Public Health Scotland, are available from: https://publichealthscotland.scot/publications/show-all-releases?id=102486

- This study confirms the findings of an earlier test negative case control study carried out in England by UKHSA, where vaccine effectiveness against hospitalisation with confirmed influenza A was calculated as:

- 73.8% (95% CI: 62.8%-82.1%) for 2 to 17 year olds

- 32.5% (95%CI: 9.6%- 50.4%) for adults aged 18 to 64 years

- 39.0% (95% CI: 26.4%-49.7%) for adults aged 65 years and older

- Full details of this study are available from: https://www.eurosurveillance.org/content/10.2807/1560-7917.ES.2025.30.46.2500854

9. International Summary

Influenza activity – UK and international summary

- GP ILI consultations remained stable at 3.8 per 100,000 in England, slightly increased to 5.0 per 100,000 in Northern Ireland, and to 3.1 per 100,000 in Scotland in Week 12, 2026.
- During Week 13, 5,072 sentinel samples tested for influenza were reported in England of which 57 were positive for influenza (43 influenza A (not subtyped), 2 influenza A (H3N2),5 influenza A (H1N1)pdm09, and 7 influenza B).
- Overall, influenza positivity decreased to 1.1% in England, increased slightly to 1.7% in Northern Ireland and to 1.2% in Scotland, in Week 13, 2026.
- UK summary data are available from the UKHSA Influenza and COVID-19 Surveillance Report, Respiratory surveillance report | HSC Public Health Agency and COVID-19 & Respiratory Surveillance (shinyapps.io)

- The WHO and the European Centre for Disease Prevention and Control (ECDC) reported that influenza remained below the 10% positivity epidemic threshold at 5% in Week 12.
- There were 107 confirmed influenza virus infection detections reported from sentinel primary care, mainly influenza type A (92%).
- Of the 29 countries and areas reporting on influenza intensity, two reported medium intensity or higher.
- Of the 27 countries and areas reporting on geographic spread of influenza viruses within a country or area, 14 reported widespread or regional distribution.
- **Source:** European Respiratory Virus Surveillance Summary (ERVISS): https://erviss.org/

- **Globally**, influenza detections continued to decline in week 12. Influenza B viruses were predominant among influenza detections.
- **Northern hemisphere:** Influenza percent positivity was elevated (>10%) in North America, Western Africa, and Southern East Asia. Percent positivity exceeded 30% in countries in Central America and the Caribbean, Europe and South-East and Eastern Asia. Increases in activity occurred in a few countries in Central America and the Caribbean and in single countries in Western and Africa, Western and Southern Asia.
- **Southern hemisphere:** Influenza activity remained low overall. Elevated percent positivity (>10%) was reported in a few countries in Tropical South America and in single countries in Temperate South America and South-East Asia. A small increase in activity were observed in a single country in Tropical South America.
- **Virus predominance:** In zones with elevated positivity, A(H3N2) was predominant in most regions. Exceptions included Central America and the Caribbean, South West Europe and Southern Asia, where A(H1N1)pdm09 and A(H3N2) were codominant; Western Africa, where influenza B was dominant; and North America where A(H3N2) and B were codominant.
- **Source**: WHO influenza update: https://www.who.int/teams/global-influenza-programme/surveillance-and-monitoring/influenza-updates/current-influenza-update

- Based on the WHO influenza laboratory surveillance information reporting (as of 01/04/2026) during Week 11 globally there were 296 A(H1N1), 1,455 A(H3), 3,746 A(not subtyped), 1,894 influenza B (Victoria) and 7,341 influenza B(lineage not determined) **Source:** Flu Net: https://worldhealthorg.shinyapps.io/flunetchart/

Update on influenza activity in North America

- The USA Centers for Disease Control and Prevention (CDC) report that influenza activity remains elevated during Week 12 (ending 28/03/2026). Nationally, 5,675 (9.8%) out of 57,669 specimens have tested positive for influenza in Week 12 in clinical laboratories nationwide, of these positive samples, 894(15.8%) were influenza A and 4,781 (84.2%) were influenza B. Further characterisation has been carried out on 802 specimens by public health laboratories, and 194 samples tested positive for influenza A; 59 influenza A(H1N1)pdm09, 112 influenza A(H3N2), and 226 samples tested positive for influenza B. **Source:** CDC Weekly US Influenza Surveillance Report: FluView | FluView | CDC

- The Public Health Agency of Canada reported that during Week 12, indicators of influenza activity remained stable. Laboratory-confirmed detections of influenza were: 1,580 (221 influenza A and 1,359 influenza B). Source: https://health-infobase.canada.ca/respiratory-virus-surveillance/

Respiratory syncytial virus (RSV) in North America

The USA CDC reported that the RSV positivity rate decreased in Week 12, 2026.
Source: CDC RSV national trends: National Respiratory and Enteric Virus Surveillance System | CDC

Middle East respiratory syndrome coronavirus (MERS-CoV) – latest update from WHO and ECDC

- As of 21 December 2025, Saudi Arabia reported 19 MERS-CoV cases from 01 January 2025 to 21 December 2025, including 4 deaths. WHO Global Alert and Response website: https://www.who.int/emergencies/disease-outbreak-news
- Rapid risk assessments of the situation from ECDC, which contain epidemiological updates and advice for travellers and healthcare workers, are available from: https://ecdc.europa.eu/en/middle-east-respiratory-syndrome-coronavirus
- Further updates and advice for healthcare workers and travellers are available from WHO: http://www.who.int/emergencies/mers-cov/en/ and from NaTHNaC: https://travelhealthpro.org.uk/news/237/mers-cov-update-travelhealthpro-country-pages

Human infection with avian influenza A

- The WHO has published an updated assessment of recent influenza A(H5N1) virus events in animals and people. Currently, the global public health risk of influenza A(H5N1) viruses to be low, while the risk of infection for occupationally exposed persons is low to moderate, depending on the risk mitigation measures in place. Transmission between animals continues to occur and, to date, a growing yet still limited number of human infections are being reported. 05 July 2025:

Other updates on zoonotic influenza infections and risks to humans are available from the WHO Global Alert & Response website: https://www.who.int/emergencies/disease-outbreak-news

10. Notes on interpretation

Virological surveillance This report does not include results from Point of Care Tests (POCTs). Use of POCTs varies across Wales and so numbers and trends of respiratory pathogens should be interpreted with caution, particularly when comparing between health boards. We are working to incorporate these result into the report.

Hospital/critical care (CC) admission: A hospital/CC admission that involves a minimum of 1 overnight stay. N.B. Transfers to another hospitals within the same health board (HB) are counted as the same continuous inpatient stay.

ARI hospital/CC admission: A hospital/CC admission where the patient tested positive for an ARI infection in the community within 28 days prior to the admission date or in hospital up to 2 days after admission (where the date of admission is day 1).

Hospital/CC inpatient (IP): A patient admitted to hospital/CC on or before the specified date, with a minimum of 1 overnight stay who had not been discharged from hospital/CC by 23:59 of the specified date.

ARI hospital/CC IP: A hospital/CC IP who tested positive for an ARI in hospital or in the community within the previous 28 days. Hospital acquired (HA): An IP whose first positive ARI test was taken in hospital more than 7 days after admission for COVID-19 or more than 3 days after admission for Influenza and RSV.

ARI outbreaks and incidents in a care home setting (fig 4.2): Information about incidents and outbreaks is taken from the case management system used by Public Health Wales. An incident in this context refers to the way that information is recorded and organised on the case management system. Not all acute respiratory infections affecting two or more care home residents with a common exposure (an outbreak*) will be recorded as incidents and captured in this graph. This may be because there was not a need for ongoing public health advice and therefore a different type of record was created. As a result, certain infections (e.g. influenza) may be captured more than others and the actual number of ARI outbreaks is likely to be underestimated. Figure 4.2 is therefore most useful for telling us about trends in the number of incidents over time, although trends may be affected both by changes in testing policy and by changes in how the incident management system is used. We will continue to review the impact of such changes and update our methodology or caveats as appropriate. Note that this definition is one of the traditional or epidemiological definitions of an outbreak, not all outbreaks will result in formally activating The Communicable Disease Outbreak Plan for Wales https://phw.nhs.wales/topics/the-communicable-disease-outbreak-plan-for-wales

11. Statement of voluntary application of the Code of Practice for Statistics

The Communicable Disease Surveillance Centre in Public Health Wales publishes a weekly integrated respiratory infection summary. This report highlights the latest available information from a number of Public Health Wales surveillance schemes, reports and other sources on Acute Respiratory Infections (ARI) in Wales.

Our publications are categorised as management information and this statement outlines the steps taken towards voluntary adoption of the Code of Practice for Statistics to ensure that our publications are high quality, useful for supporting decisions and well-respected. The code is built around 3 pillars:

- **Trustworthiness:** confidence in the people and organisations that produce statistics and data
- **Quality:** data and methods that produce assured statistics
- **Value:** publishing statistics that support society's needs for information

Trustworthiness

This report (and the underlying analysis) has been developed by a team of epidemiologists and analysts under the guidance of senior scientists and consultants. We work as part of a wider integrated respiratory surveillance group, which brings together expertise in virology, epidemiology, genomics and surveillance. Key information summarised in this surveillance report is routinely shared with UK Health Security Agency (UKHSA), World Health Organisation (WHO) and other international networks to enable international surveillance and epidemiological studies. Appropriate disclosure control methods have been considered and applied.

The report is published on a weekly basis during winter period between week 40 (October) and 20 (May) of the following year and on a fortnightly basis during the summer period. Where there are interruptions to data flows, or other technical issues affecting the production of elements of the report, we highlight in the text as appropriate. Where there are unplanned delays to publication we inform our stakeholders. We highlight key changes in the report when necessary.

Quality

We are continuously seeking to improve the quality of our surveillance. Where possible, ARI surveillance schemes in Wales follow, or are working towards following, good practice recommendations and international guidance (e.g. the WHO MOSAIC framework, using professional judgement. The surveillance team routinely consults with other UK teams and international specialists. Where there are limitations in data or interpreting data, we try to specify and continue work to address them.

Value

This information contributes to many areas, including response to health threats, public health interventions, healthcare planning and research. There are also society benefits from making this information available, supporting transparency and providing timely access for the scientific community, public health specialists and the public. This in turn reduces the onus on our stakeholders to request information, releasing capacity or further development of our outputs. We aim to present epidemiological and virological data in meaningful and accessible ways to help meet the needs of different audiences. However, we aspire to improve in this, with improved understanding of user-needs. We have also included links to other related reports and resources to avoid duplication of data presentation.

12. Links to surveillance reports from other countries

Public Health Wales influenza surveillance webpage: https://phw.nhs.wales/topics/immunisation-and-vaccines/fluvaccine/weekly-influenza-and-acute-respiratory-infection-report/

Public Health Wales COVID-19 data dashboard: https://phw.nhs.wales/topics/latest-information-on-novel-coronavirus-covid-19/

Public Health Wales interactive report on hospitalisations in influenza and RSV cases: https://public.tableau.com/app/profile/public.health.wales.health.protection/viz/ARI-Hospitaladmissionsdashboard/ARIhospitaladmissionsdashboard?publish=yes

NICE influenza antiviral usage guidance: http://www.nice.org.uk/Guidance/TA158

England influenza and COVID-19 surveillance: National flu and COVID-19 surveillance reports: 2025 to 2026 season - GOV.UK (www.gov.uk)

Scotland seasonal respiratory surveillance: Publications - Public Health Scotland

Northern Ireland influenza surveillance: https://www.publichealth.hscni.net/directorate-public-health/health-protection/seasonal-influenza

European Centre for Communicable Disease: http://ecdc.europa.eu/

European influenza information: http://flunewseurope.org/

Advice on influenza immunisation https://phw.nhs.wales/topics/immunisation-and-vaccines/fluvaccine/

Advice on influenza immunisation (for intranet users) Influenza (sharepoint.com)

For further information on this report, please email Public Health Wales using: surveillance.requests@wales.nhs.uk