GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales

Weekly Acute Respiratory Infection Report

Public Health Wales

Communicable Disease Surveillance Centre

Report week: 10 (ending 08 March 2026)

Weekly acute respiratory infection summary

Headline

- Influenza activity is at low levels. Confirmed case numbers have decreased in the current week, test positivity remains stable. As at week 9 GP consultations for influenza-like illness remained at low levels.
- Respiratory Syncytial Virus (RSV) is currently at baseline intensity levels.
- COVID-19 case numbers have remained broadly stable in recent weeks.
- GP consultations for acute respiratory infections increased during week 10 compared to the previous week.
- According to EuroMoMo method, 'no excess' of all-cause mortality has been reported in the most recent week.

Foreword

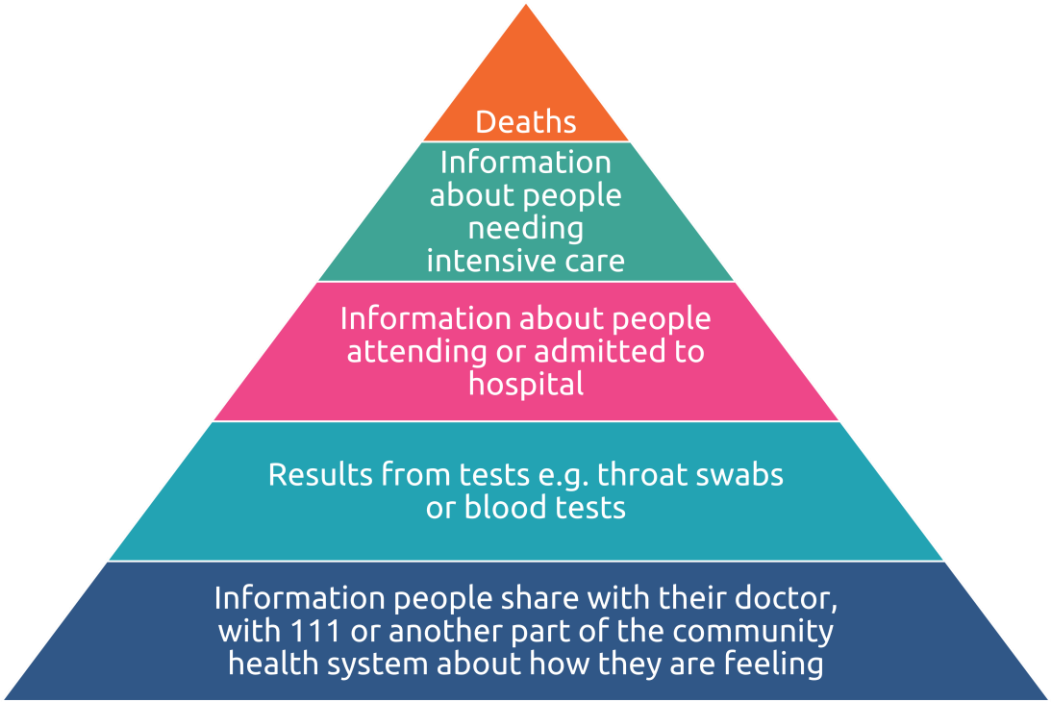
This report replaces the previously separate weekly reports on COVID-19, influenza and other respiratory infections. It is published on a weekly basis between Week 40 (October) and 20 (May) of the following year, and on a fortnightly basis during the summer period.

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 GPs for acute respiratory infection (ARI) increased compared to last week.	Admissions in patients testing positive for influenza, COVID-19 or RSV decreased during week ending 08/03/2026 (1% of total admissions).
Influenza	**Overall, influenza activity is at <u>low intensity levels.</u>** The overall proportion of samples testing positive in hospital and non-sentinel patients remained stable in the most recent week at 1.2%. Consultations for influenza-like illness (ILI) with sentinel GPs increased but still are at **baseline** intensity levels. 1 case of influenza was confirmed from symptomatic sentinel GP network patients across Wales last week.	The number of confirmed cases of community acquired influenza admitted to hospital increased to 14. There were 20 in-patient cases of confirmed influenza, one of whom was in critical care.
Influenza type breakdown	***Since 2025 Week 40**: 4,683 total influenza cases confirmed (1,544 influenza A(H3N2), 116 influenza A(H1N1)pdm09, 2,987 influenza A untyped and 36 influenza B).* ***In the most recent week**: three influenza A(H3), two influenza A(H1N1), 10 influenza A untyped and four influenza B.*	
COVID-19	The overall proportion of samples testing positive remained stable at 3.4 % in hospital and non-sentinel GP practices. Consultations with Sentinel GPs and Pharmacies for COVID-19 decreased in recent weeks.	The number of confirmed cases of community acquired COVID-19 admitted to hospital decreased to 12. There were 95 in-patient cases of confirmed COVID-19, none of whom were in critical care.
RSV	RSV incidence per 100,000 in children aged up to 5y increased to 15 but remains at baseline intensity levels.	The number of confirmed cases of community acquired RSV admitted to hospital decreased to 12. There were 51 in-patient cases of confirmed RSV, and none of whom were in critical care.
Other respiratory pathogens	Rhinovirus and seasonal coronaviruses are the most frequently detected other cause of ARI. Enterovirus and adenovirus have increased in recent weeks.	

1. Community surveillance indicators

GP Consultations

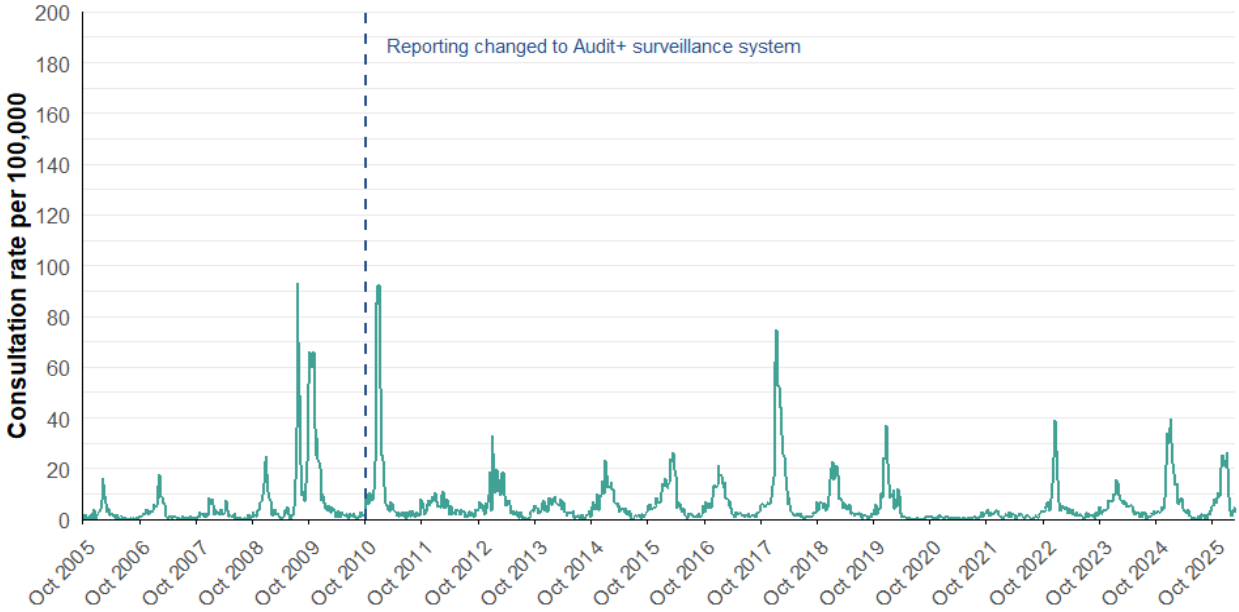
- The sentinel GP consultation rate for influenza-like illness (ILI) is at baseline and the three-week trend is variable (Figures 1.1, 1.2).
- There were 5.1 ILI consultations per 100,000 practice population in the most recent week, an increase compared to the previous week (2.7 consultations per 100,000).
- In the most recent week, using all available data from general practices, there were 12.2 ARI consultations per 100,000 practice population, an increase from 5.7 in the previous week (Table 1.1). The highest rates were found in people aged under 1 year (1008.3) followed by people aged 1 to 4 (598.1) and people aged 5 to 14 (147.6) (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 with respiratory syndromic indicators, decreased from 1,520 in the previous week to 1,519 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).

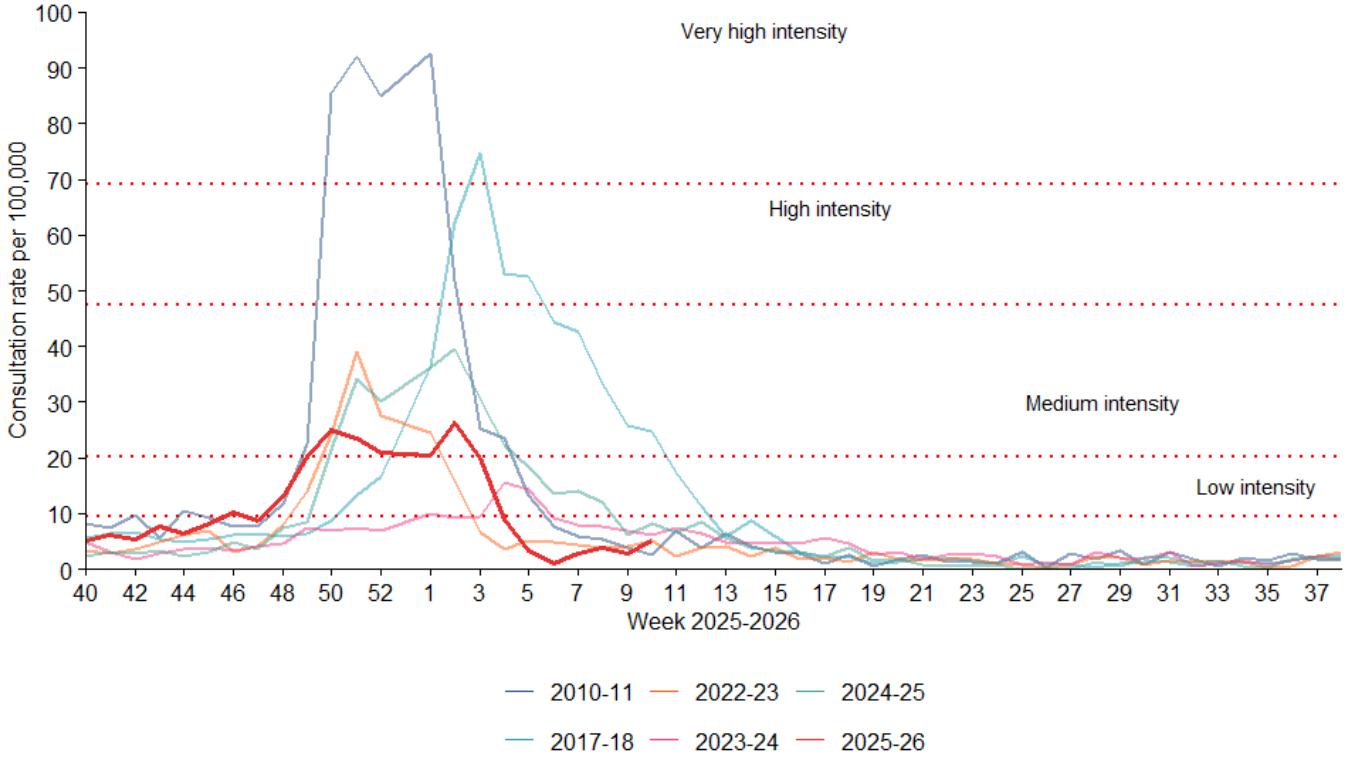
GP consultations – Sentinel Network

Figure 1.1. Sentinel GP network clinical consultation rate for ILI per 100,000 practice population (Week 40, 2004 - Week 10, 2026).



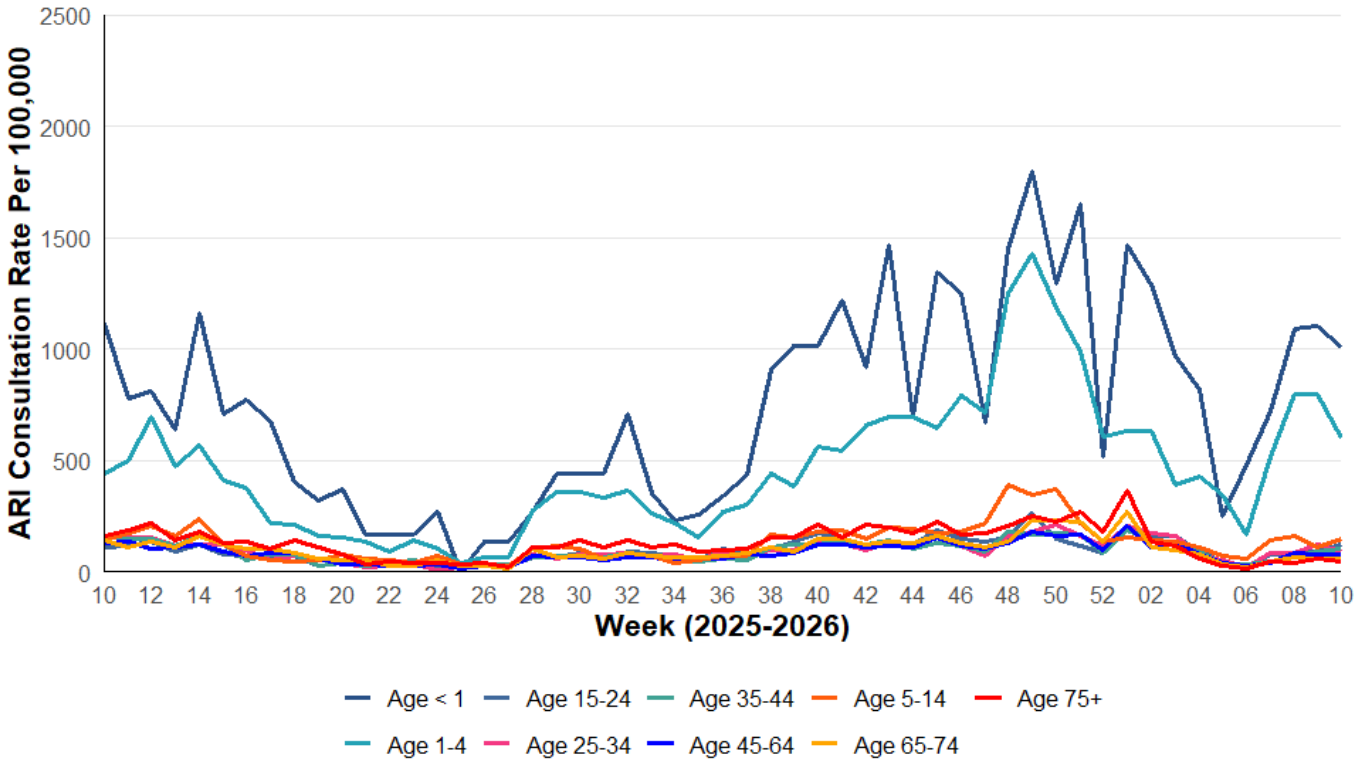
Data correct as of 10/03/2026

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



Data correct as of 10/03/2026

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



Data correct as of 10/03/2026

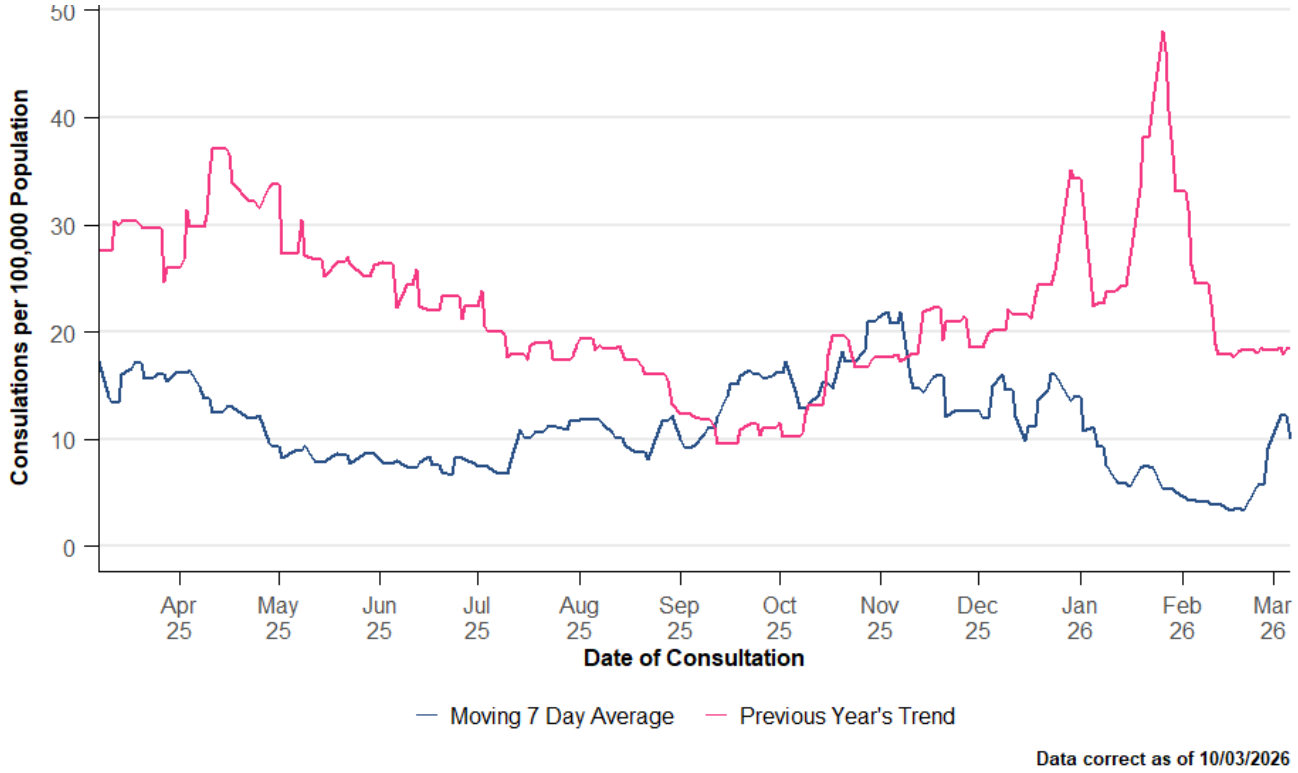
GP Consultations - All Wales

Table 1.1. Summary of GP consultations per 100,000 practice population in Wales, by indicator, for Week 10, 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	12.19	5.66	18.29
COVID-19	0.04	0.04	0.24
LRTI	4.73	1.96	6.58
Pneumonia	0.02	0.01	0.04
Severe asthma	0.21	0.17	0.78
URTI	7.47	3.72	11.76
Total	24.66	11.56	37.69

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.

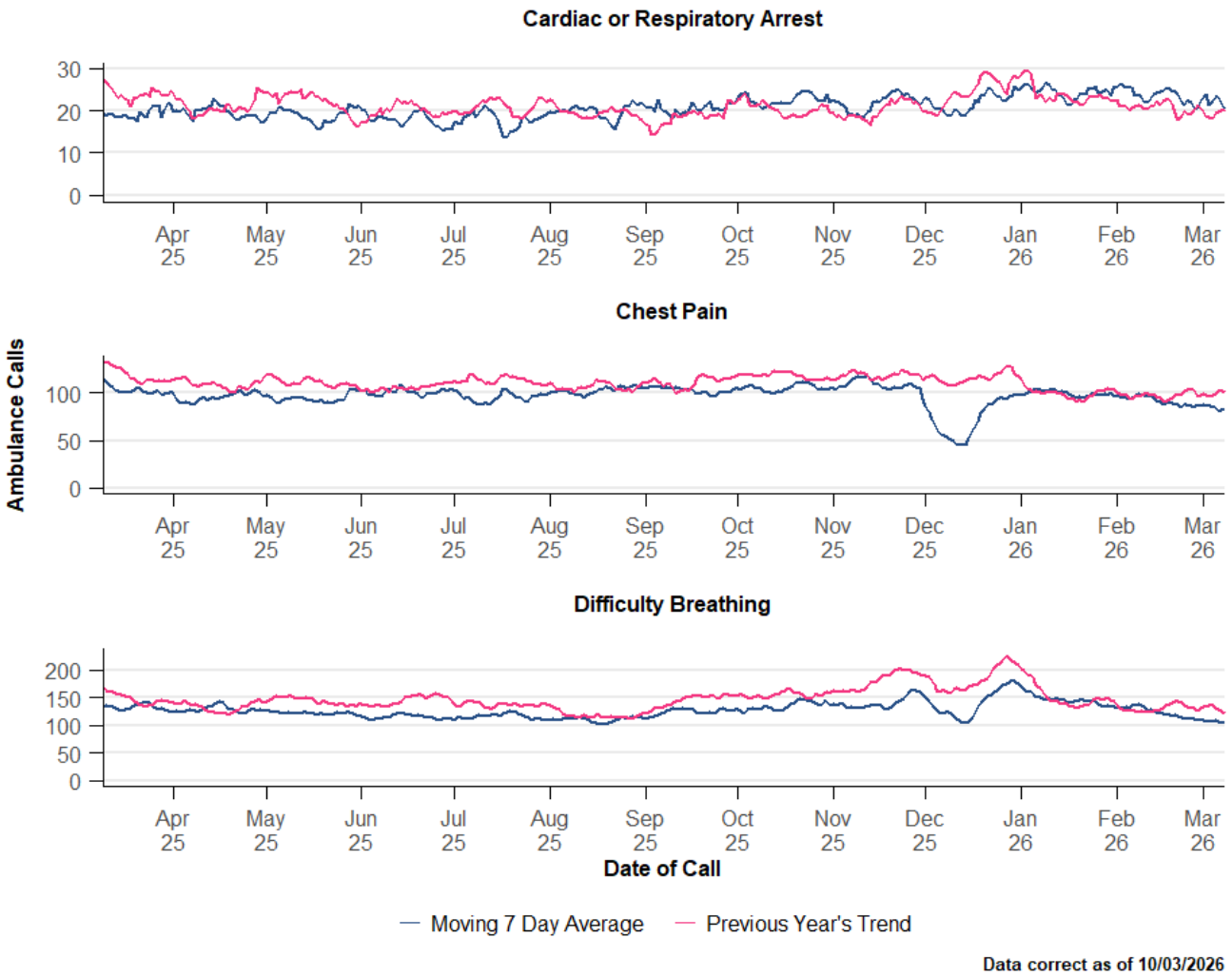


Table 1.2. Summary of weekly number of Ambulance calls, by symptom in Wales, for Week 10, 2026. This summary analysis uses data provided by the Welsh Ambulance Service NHS Trust.

Indicator	Current Reporting Week	Preceding Week	Equivalent Period Last Year
Cardiac or Respiratory Arrest	162	144	140
Chest Pain	593	595	706
Difficulty Breathing	764	781	926
Total	1,519	1,520	1,772

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 103 surveillance samples from patients with ILI symptoms collected by sentinel GPs and community pharmacies during Week 10, 2026, as at 11/03/2026 (Table 2.1, Figure 2.1).
- The most commonly detected pathogens were rhinovirus (10) followed by human metapneumovirus (8) and parainfluenza (7). Of the 103 tests, 55.3% were negative for all respiratory pathogens (Table 2.1, Figure 2.1).

All Wales Datastore Respiratory Infection Testing

- There were 946 samples receiving multiplex respiratory panel testing, collected from patients attending hospitals and non-sentinel GPs during Week 10 (Table 2.2, Figure 2.2).
- The most commonly detected pathogens were rhinovirus (111) followed by adenovirus (70) and human metapneumovirus (58). Of the 946 tests, 66.2% were negative for all respiratory pathogens (Table 2.2, Figure 2.2).

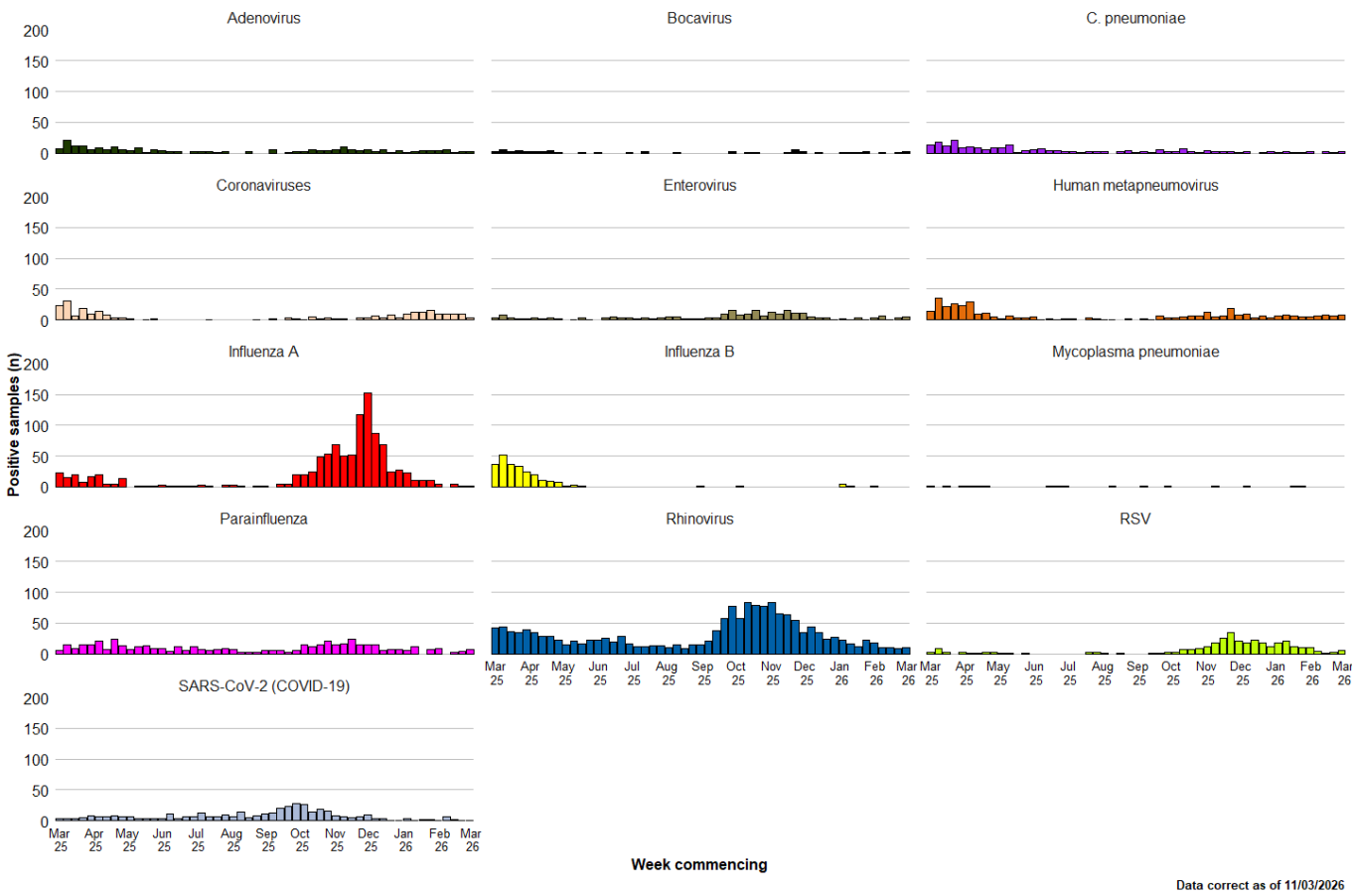
Additionally, during Week 10, 340 samples from patients were tested for influenza, RSV and SARS-CoV-2 only (Figure 2.3). Of these the following tested positive:

- 7 for influenza (four for influenza A, three for influenza B)
- 21 for SARS-CoV-2 (COVID-19)
- 8 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 10, 2026.

Pathogens Detected	Count (n)	Positivity (current week)	Positivity (previous week)	Trend
Rhinovirus	10	9.7%	8.2%	Increasing
Human metapneumovirus	8	7.8%	6.4%	Increasing
Parainfluenza	7	6.8%	3.6%	Increasing
RSV	5	4.9%	1.8%	Increasing
Enterovirus	5	4.9%	2.7%	Increasing
Coronaviruses	4	3.9%	9.1%	Decreasing
Adenovirus	3	2.9%	1.8%	Increasing
C. pneumoniae	3	2.9%	0.9%	Increasing
Bocavirus	2	1.9%	0.9%	Increasing
Influenza A	1	1.0%	1.8%	Stable
SARS-CoV-2 (COVID-19)	1	1.0%	0.9%	Stable
Influenza B	0	0.0%	0.0%	Stable
Mycoplasma pneumoniae	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 10, 2025 to Week 10, 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 10, 2026.

Pathogens Detected	Count (n)	Positivity (current week)	Positivity (previous week)	Trend
Rhinovirus	111	11.7%	8.3%	Increasing
Adenovirus	70	7.4%	6.1%	Increasing
Human metapneumovirus	58	6.1%	5.7%	Stable
SARS-CoV-2 (COVID-19)	32	3.4%	3.1%	Stable
Parainfluenza	31	3.3%	3.2%	Stable
Enterovirus	24	2.5%	2.6%	Stable
Seasonal coronaviruses	22	2.3%	2.6%	Stable
RSV	21	2.2%	2.5%	Stable
Influenza A	10	1.1%	1.2%	Stable
Influenza B	1	0.1%	0.1%	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 10, 2025 to Week 10, 2026.

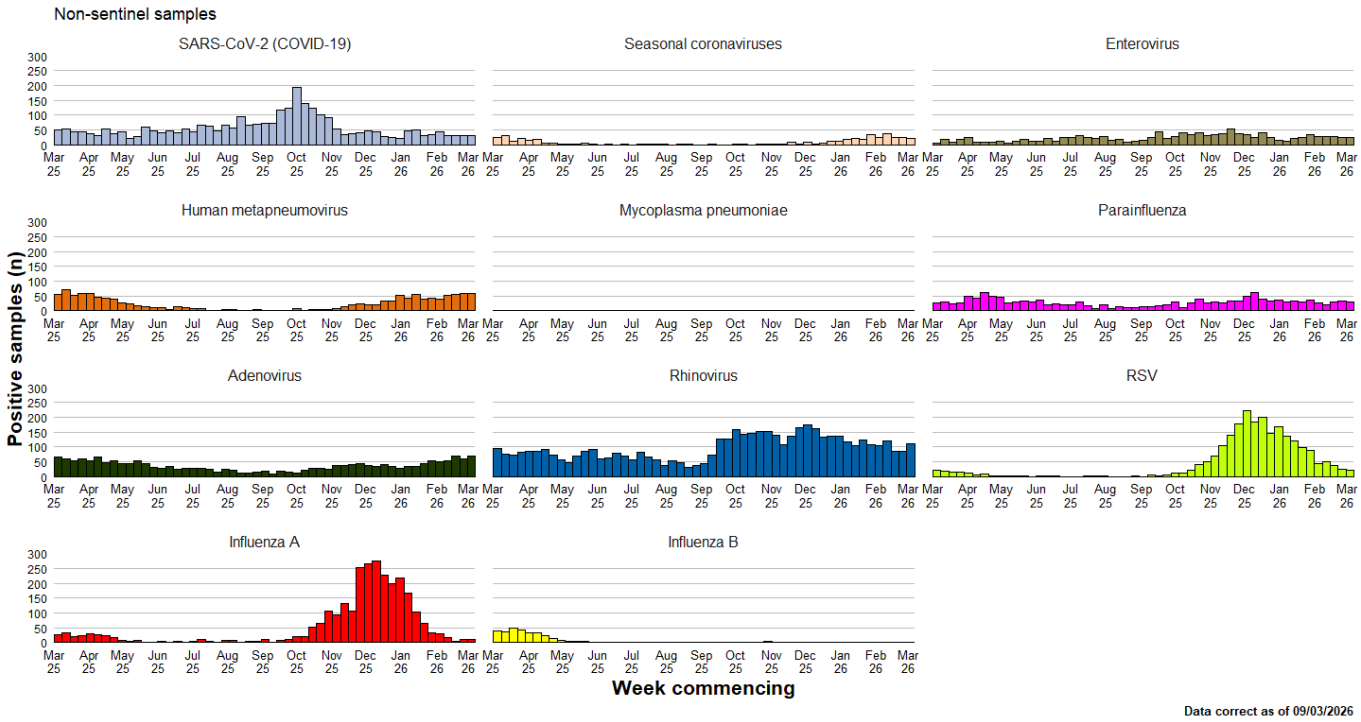
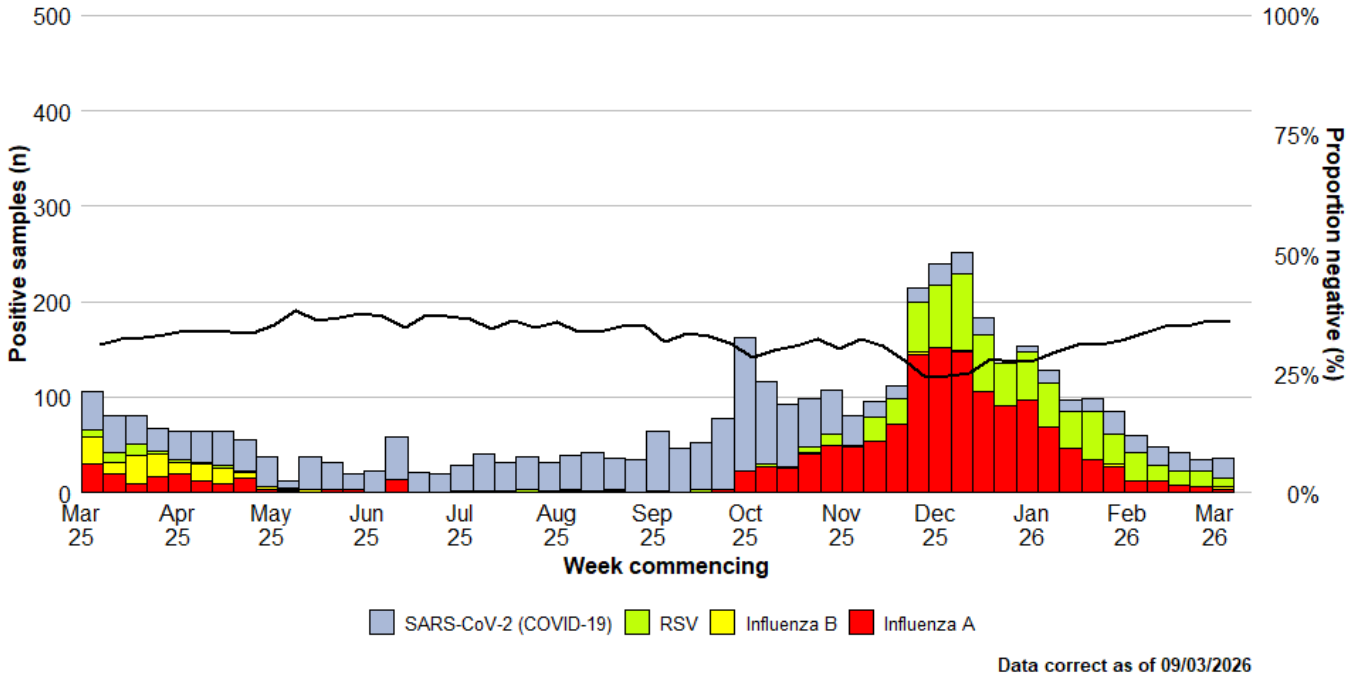


Figure 2.3. Samples from hospital patients submitted for RSV, Influenza and SARS-CoV-2 testing only, by week of sample collection, Week 10, 2025 to Week 10, 2026.



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

Sentinel SARI in emergency departments

- During the previous four weeks there were 41 surveillance samples taken from SARI surveillance sentinel emergency departments. The most common pathogen identified from these samples was Rhinovirus/Enterovirus(14) followed by Human metapneumovirus(4) and Adenovirus(2). Of the 41 samples collected, 53.7% 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, 2% for SARS-CoV-2 and 2% for RSV.

Hospital in-patients

- During week ending 08/03/2026 there were 38 patients admitted to hospital with confirmed COVID-19, RSV or influenza, (7 less than the previous week), equating to 1% of all hospital admissions in that reporting week.

- At 23:59 on 08/03/2026, there were 166 patients in hospital with confirmed COVID-19, RSV or influenza, 22 less than the previous Sunday. This equates to 1% of all hospital in-patients (IPs) at that time. Of whom 77% (128) were hospital acquired (HA).

Critical-care

- During week ending 08/03/2026 there were 2 ARI critical care (CC) admissions (3 less than the previous week), equating to 1% of all CC admissions in that reporting week.

- At 23:59 on 08/03/2026, there were 1 patients in CC with confirmed COVID-19, RSV or influenza, 3 less than the previous Sunday. This equates to 1% of all CC in-patients at that time. Of whom 0% (0) were hospital acquired (HA).

Virological surveillance in ICU

- During Week 10, 2026, 46 respiratory samples were tested from patients in intensive care units (ICU). Of these: one tested positive for Influenza, one tested positive for SARS-CoV-2 (COVID-19) and zero tested positive for RSV (Figure 3.4).

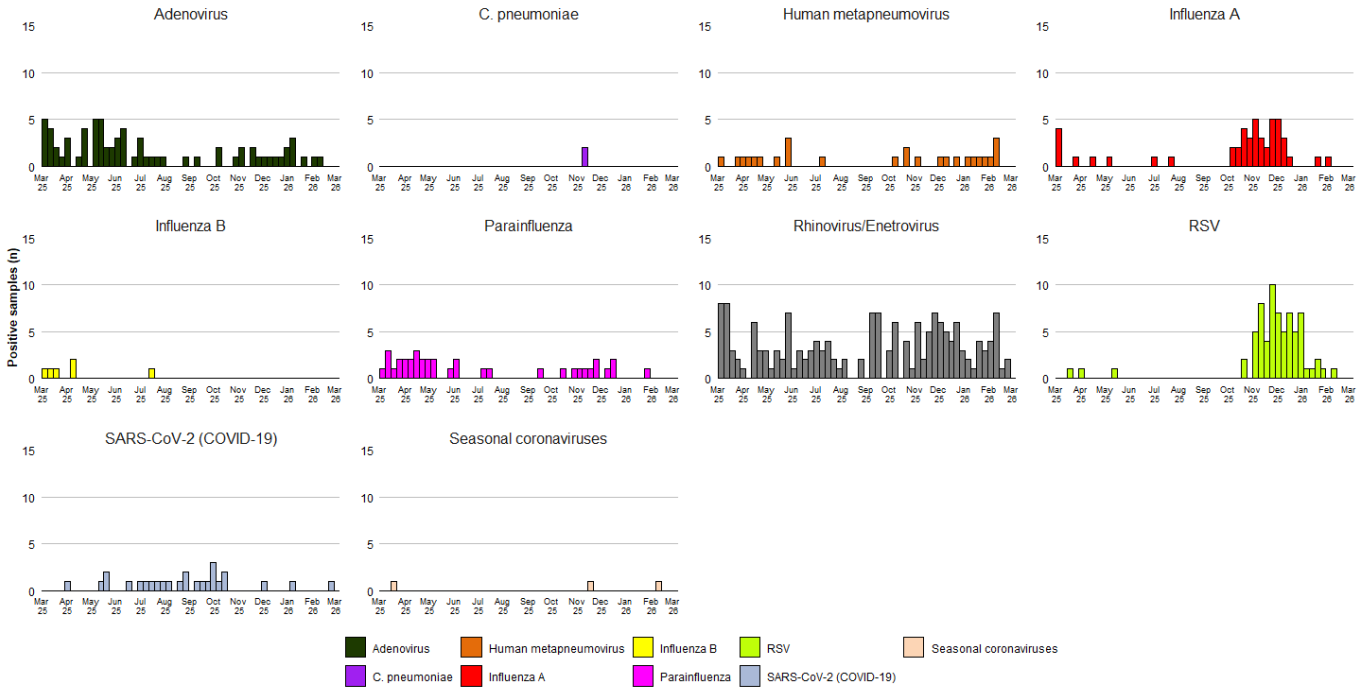
For detailed reports on surveillance of ARI in hospitals, including breakdowns by health board and age-group see: Hospital admissions dashboard

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 9, 2026.

	Meeting SARI case definition in the last 4 weeks		Meeting SARI case definition in the last 12 months	
Pathogens Detected	**n**	**%**	**n**	**%**
Adenovirus	2	4.9%	71	9.2%
C. pneumoniae	0	0.0%	2	0.3%
Human metapneumovirus	4	9.8%	26	3.4%
Influenza A	1	2.4%	56	7.3%
Influenza B	0	0.0%	6	0.8%
Mycoplasma pneumoniae	0	0.0%	0	0.0%
Parainfluenza	0	0.0%	37	4.8%
Pertussis	0	0.0%	0	0.0%
RSV	1	2.4%	69	8.9%
Rhinovirus/Enterovirus	14	34.1%	170	22.0%
SARS-CoV-2 (COVID-19)	1	2.4%	26	3.4%
Seasonal coronaviruses	1	2.4%	3	0.4%
Negative	22	53.7%	377	48.9%
Total	**41**	**100%**	**783**	**100%**

Figure 3.1 Pathogens detected in samples collected from symptomatic patients presenting at participating SARI surveillance sentinel emergency departments, for Week 9, 2026 and previous 12 months.



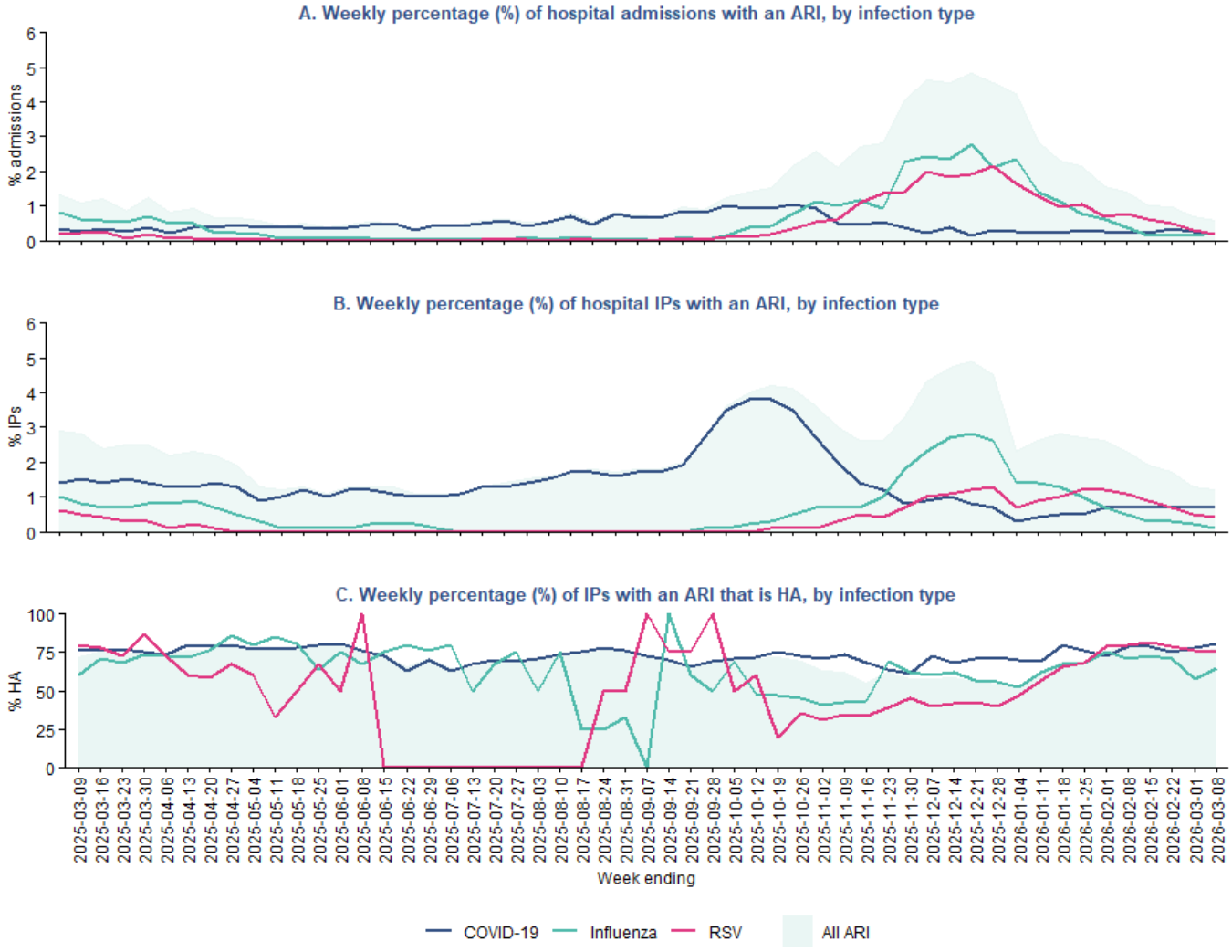
Data correct as of 05/03/2026

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	12	<1%	95	1%	81% (77)
Influenza	14	<1%	20	0%	65% (13)
RSV	12	<1%	51	0%	75% (38)
ARI total	**38**	**1%**	**166**	**1%**	**77% (128)**

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.



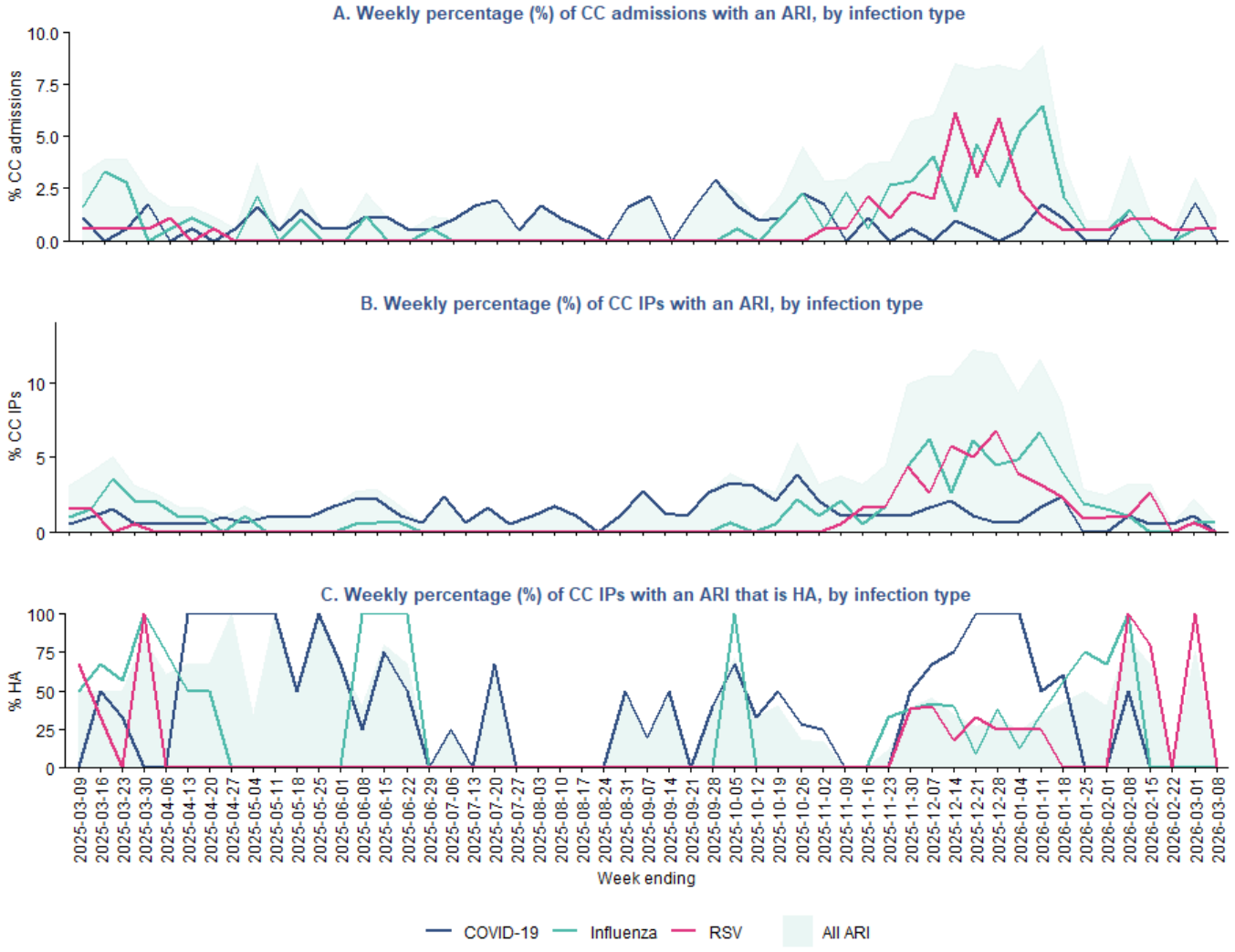
Data as of: 11-03-2026

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).

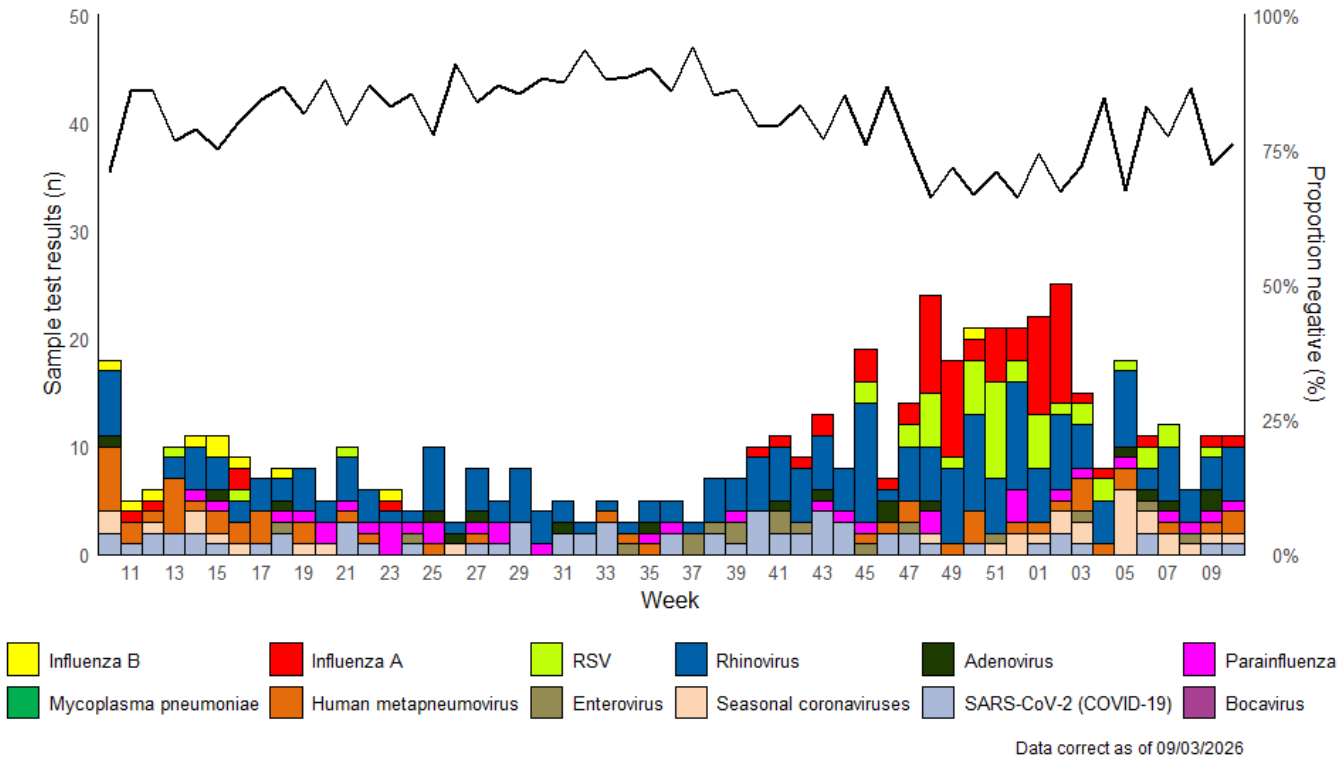
Infection	CC admissions		CC In-patients		
	Count	% of all CC admissions	Count	% of all CC In-patients	% HA (n)
COVID-19	0	0%	0	0%	0% (0)
Influenza	1	1%	1	1%	0% (0)
RSV	1	1%	0	0%	0% (0)
ARI total	**2**	**1%**	**1**	**1%**	**0% (0)**

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: 11-03-2026

Figure 3.4. Samples submitted for virological testing from ICU patients, by week of sample collection, Week 10, 2025 to Week 10, 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 10, 2026, there were no ARI outbreaks were reported to the Public Health Wales Health Protection Team.

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.

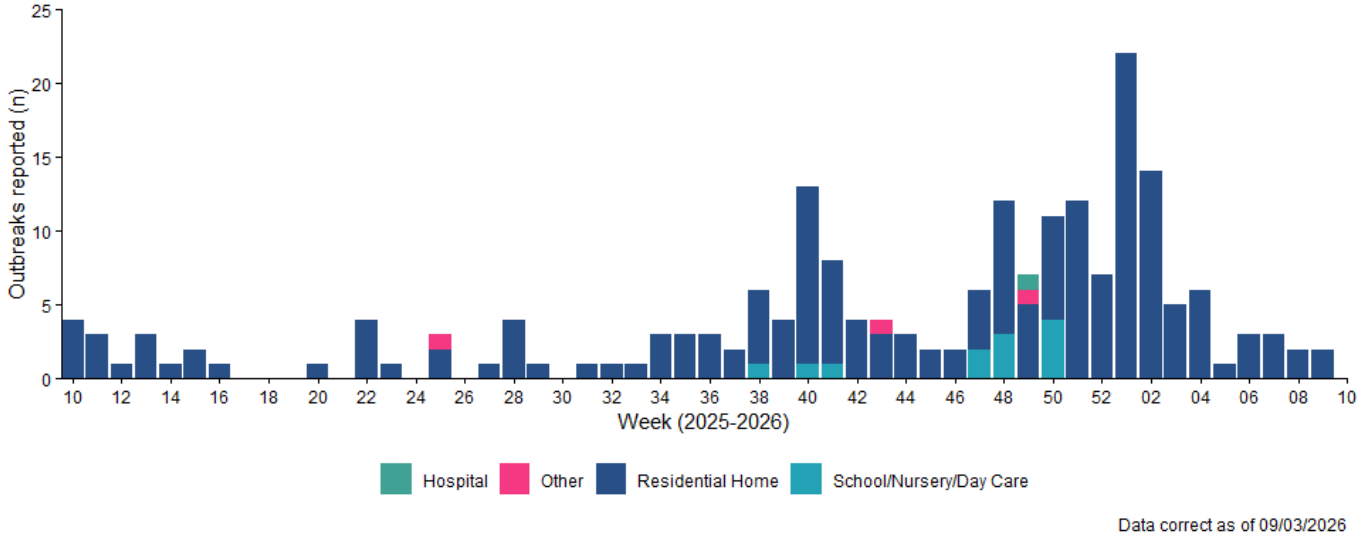
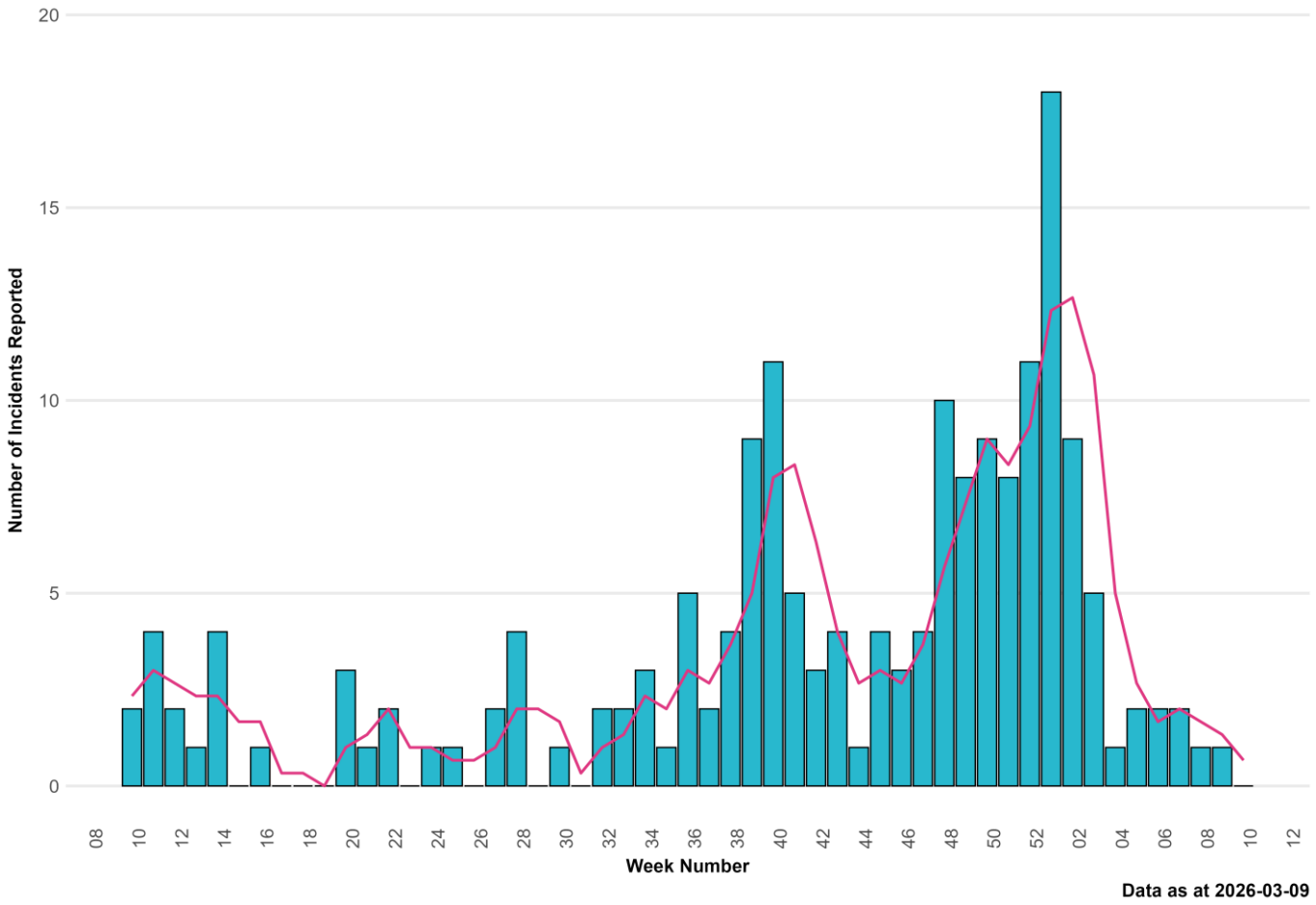


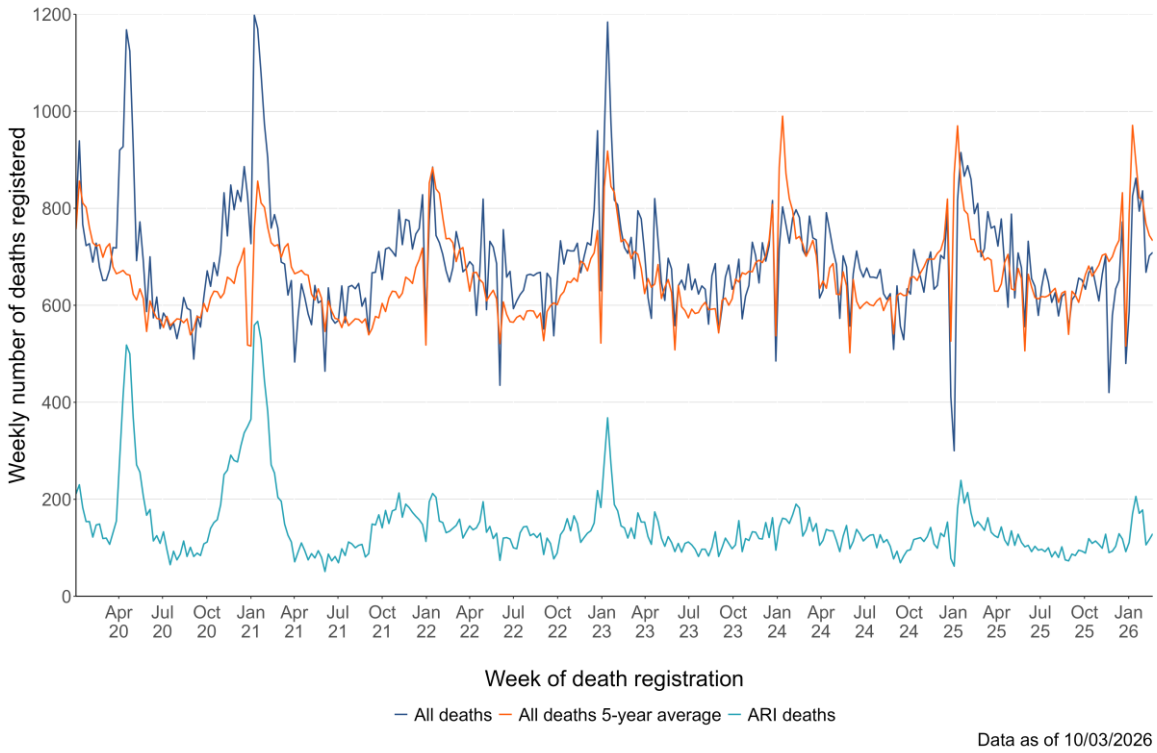
Figure 4.2. ARI outbreaks and incidents reported to Public Health Wales Health Protection Team, from residential care home settings, by week of onset of first case. The three-week rolling average is shown in pink.



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 5.2 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 10/03/2026

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

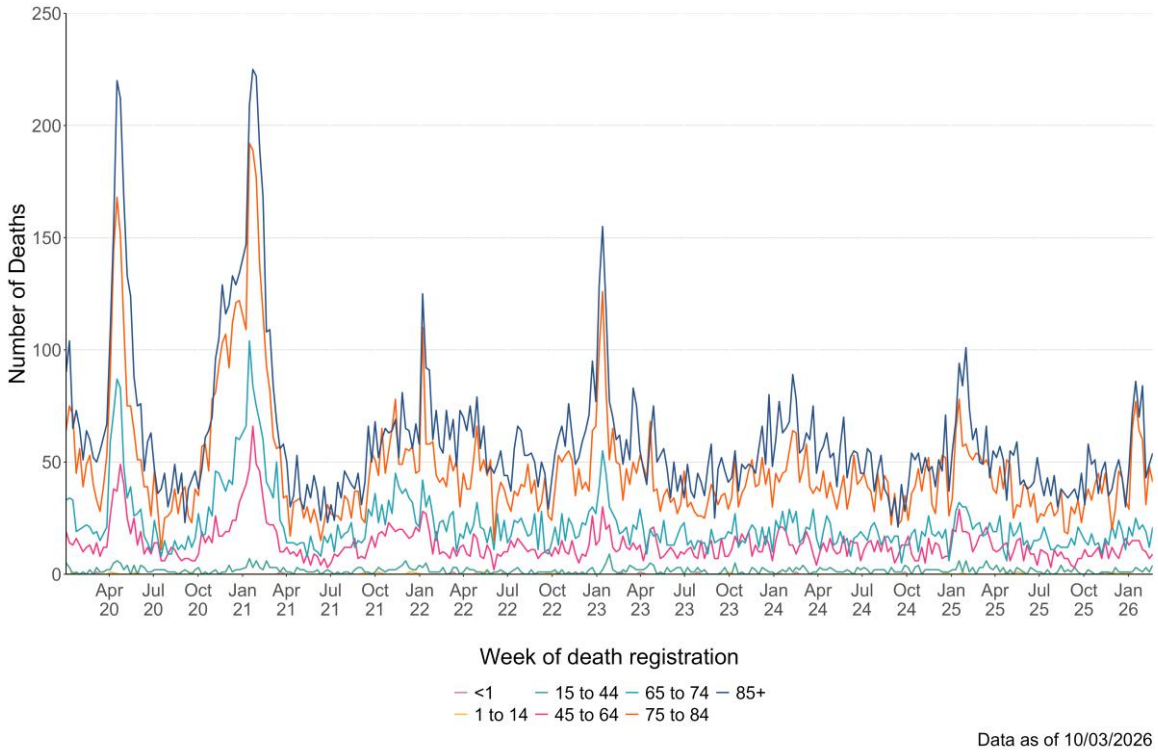


Figure 5.3. Numbers of deaths due to ARI, by place of death and week of death registration.

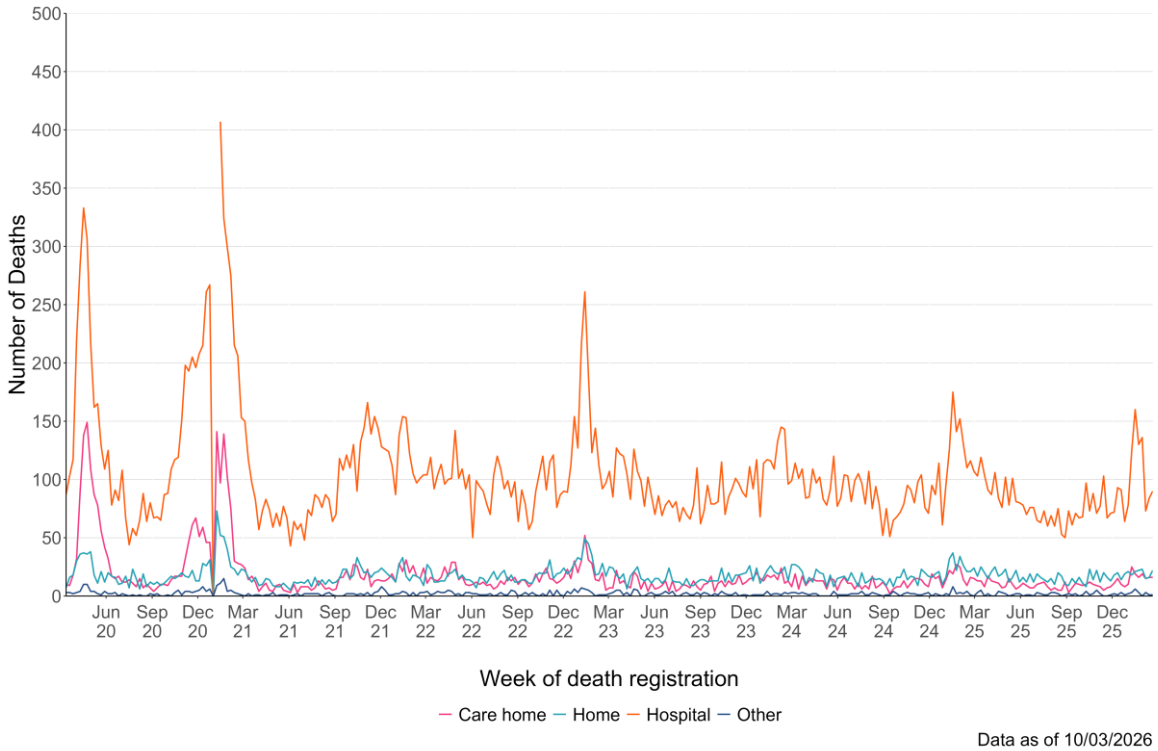
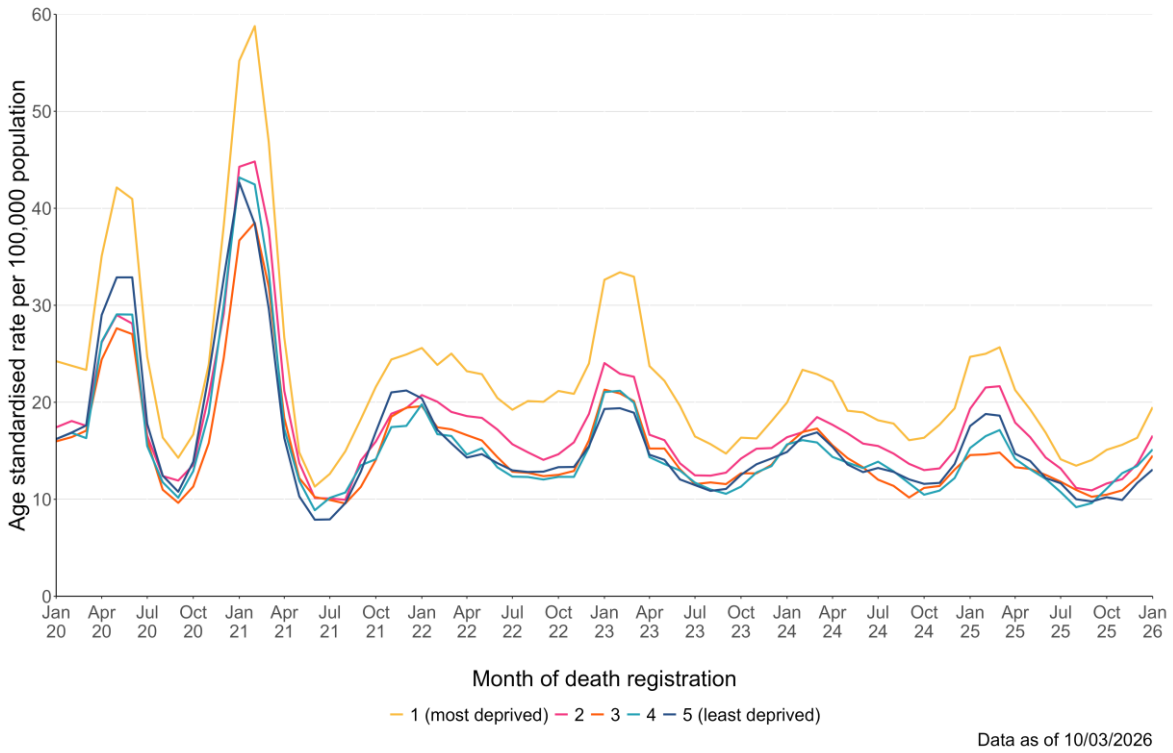


Figure 5.4. Numbers of ARI deaths, by quintile of deprivation of area of residence (based on the Welsh Index of Multiple Deprivation rankings of Lower Super Output Areas) and week of death registration.



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 (1,544 confirmed cases), followed by influenza A(H1N1) (116 confirmed cases) and influenza B (36 confirmed cases). Additionally, there have been 2987 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 10, 2025 to Week 10, 2026.

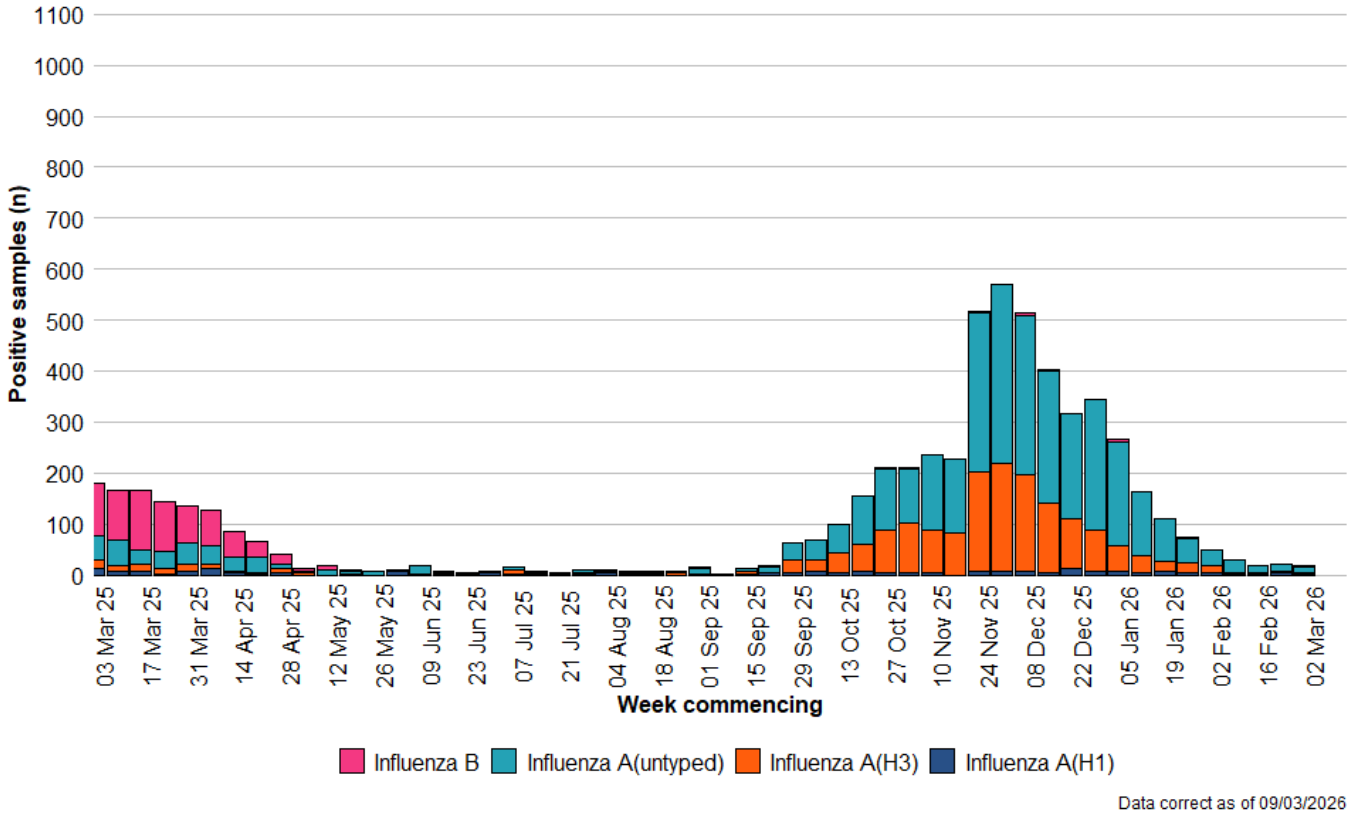
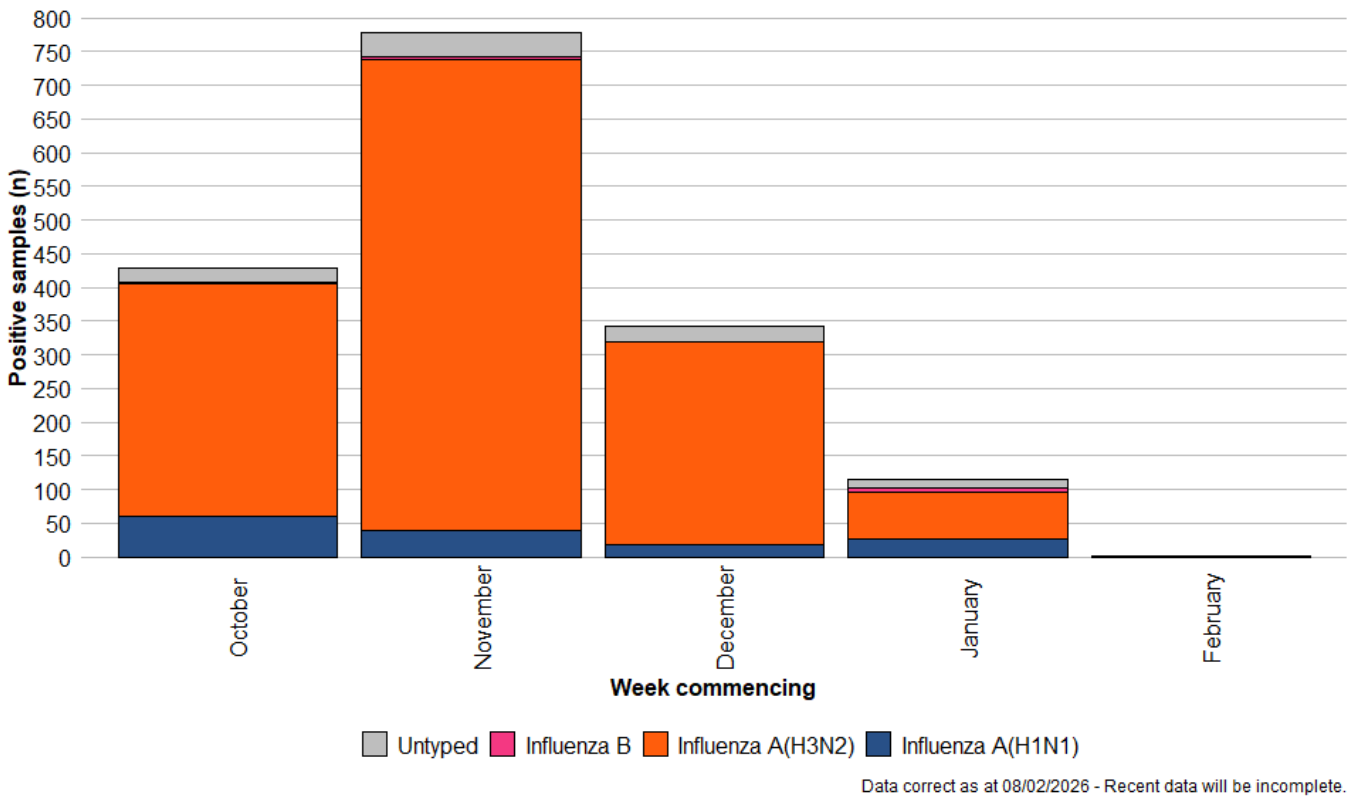


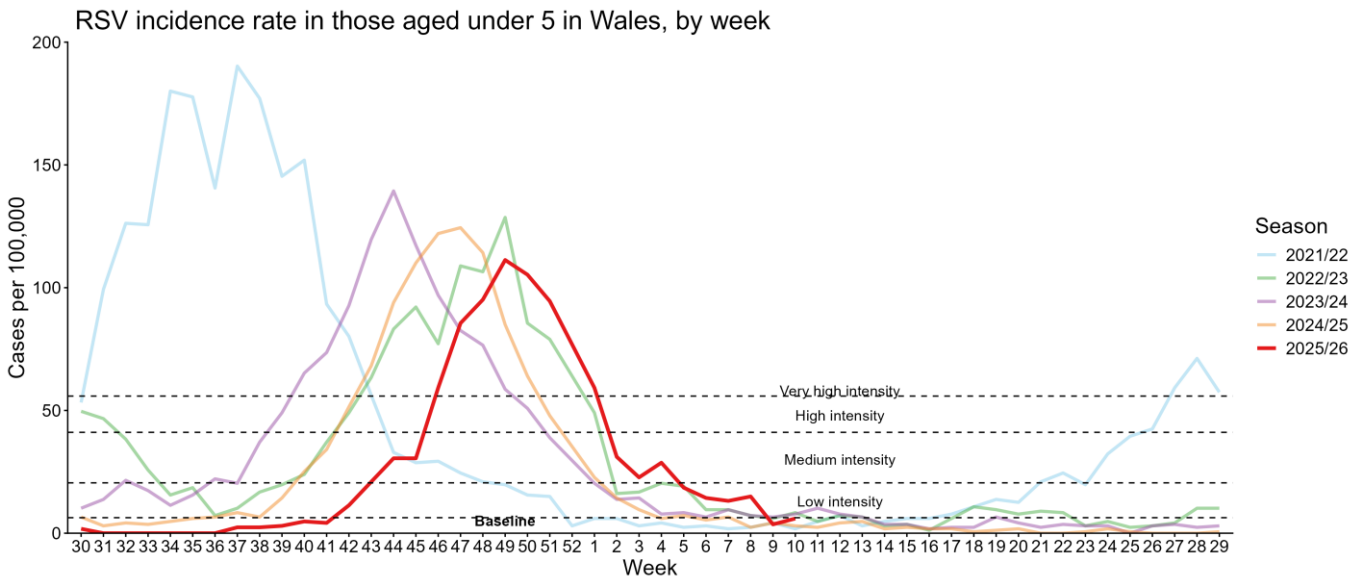
Figure 6.1b. Influenza subtypes based on samples referred to the Wales National Influenza Centre for typing, by week of sample collection, October 2025 to February 2026.



Respiratory Syncytial Virus (RSV)

- RSV incidence per 100,000 population in children aged under five years is currently at baseline (6.0) intensity levels per 100,000 population during Week 10 2026 .

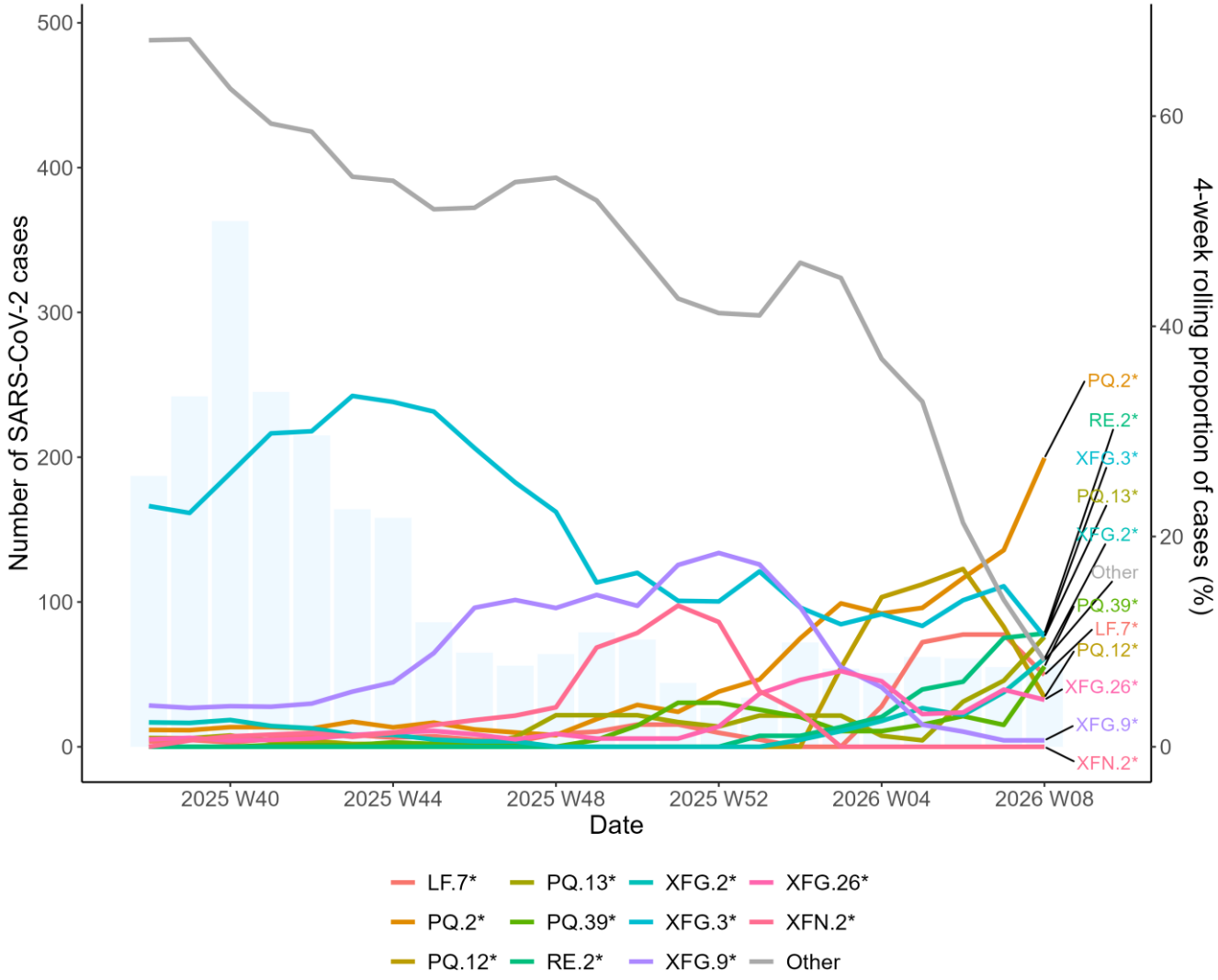
Figure 6.2. RSV incidence rate per 100,000 population aged under five years, Week 30, 2020 to Week 10 2026.



SARS-CoV-2 Variant surveillance

- Pango group PQ.2* is the most frequently detected Pango lineage group in Wales currently, accounting for 14.4% 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 W34 to 2026 W06).



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. Weekly winter forecasting of hospital admissions with acute respiratory infections in Wales - Week starting 09/03/2026

Introduction

- Short-term forecasts use a modelling approach to suggest possible future trends in hospital admissions in patients with COVID-19, influenza and RSV across Wales for this and next week.
- The trends suggested in this analysis draw on recent hospital admissions and other surveillance indicators. The forecasts are designed to support planning and situational awareness during the winter season.
- All forecasts carry uncertainty, particularly when the season progresses rapidly or during holiday periods when health seeking behaviours may vary; estimates should be used alongside other sources of surveillance information in this weekly report.
- The models used to suggest these future trends are under development. Exact methods may change and are subject to an evaluation and assurance process.

Headlines

- Estimates from our forecasts suggest that, over the next two weeks, combined admissions with COVID-19, influenza or RSV will **remain stable** (confidence level: likely).
- For the week commencing **09/03/2026**, our forecasts estimate that between **26** and **49** hospital admissions with either COVID-19, RSV or influenza (median: **37**) may occur across Wales. Roughly **53%** will be for COVID-19, **26%** for influenza and **21%** for RSV. For the following week, between **23** and **49** admissions are estimated by the model.

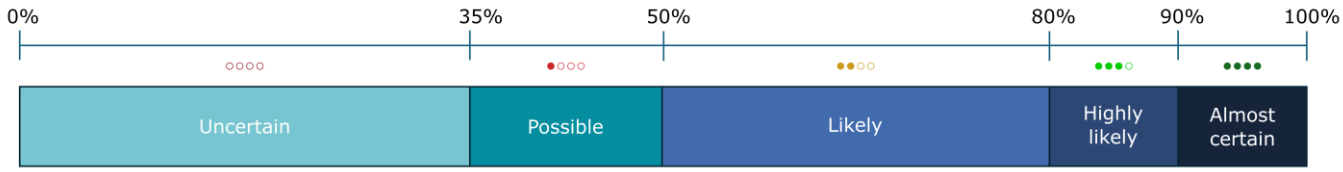
Table 7.1. Forecasted hospital admissions with COVID-19, influenza and RSV.

Infection	Observed	Admissions range (median)		Suggested two-week trend	
	Admissions last week (n)[1]	Week starting 09/03/2026	Week starting 16/03/2026	Trend[2]	Confidence[3]
COVID-19	12	9 – 26 (18)	9 – 27 (18)	Stable →	Likely ●●○○
Influenza	14	5 – 16 (10)	3 – 17 (9)	Stable →	Likely ●●○○
RSV	12	5 – 15 (10)	3 – 14 (7)	Stable →	Almost certain ●●●●
Total	38	26 – 49 (37)	23 – 49 (35)	Stable →	Likely ●●○○

[1]Admissions are defined as individuals admitted to a hospital in Wales who tested positive for SARS-CoV-2 (COVID-19), influenza, or RSV via PCR test within 28 days before or two days after admission.

[2]Trend interpretation: The suggested trend is derived from the middle scenario of all possible changes indicated by our forecast. It is calculated by comparing the previous weeks total admissions with the estimated admissions in the second week of our forecast. A stable trend is defined as a change of less than 20% or a difference of fewer than 10 admissions.

[3]Confidence interpretation: Confidence in the suggested trend is based on the proportion of model predictions which agree with the middle forecast scenario. See image below for confidence bands.



COVID-19

- Estimates from our short-term forecasts suggest that, over the next two weeks, COVID-19 admissions will **remain stable** (confidence level: likely).
- For the week commencing **09/03/2026**, our forecasts estimate that between **9** and **26** hospital admissions with COVID-19 (median: **18**) may occur across Wales. For the following week (commencing 16/03/2026), between **9** and **27** admissions are estimated.
- Forecasted COVID-19 admissions are suggested to be **similar** compared to the same 14-day period in the previous year (Figure 7.1).

Influenza

- Estimates from our short-term forecasts suggest that, over the next two weeks, influenza admissions will **remain stable** (confidence level: likely).
- For the week commencing **09/03/2026**, our forecasts estimate that between **5** and **16** hospital admissions with influenza (median: **10**) may occur across Wales. For the following week (commencing 16/03/2026), between **3** and **17** admissions are estimated.
- Forecasted influenza admissions are suggested to be **lower** compared to the same 14-day period in the previous year (Figure 7.2).

RSV

- Estimates from our short-term forecasts suggest that, over the next two weeks, RSV admissions will **remain stable** (confidence level: almost certain).
- For the week commencing **09/03/2026**, our forecasts estimate that between **5** and **15** hospital admissions with RSV (median: **10**) may occur across Wales. For the following week (commencing 16/03/2026), between **3** and **14** admissions are estimated.
- Forecasted RSV admissions are suggested to be **lower** compared to the same 14-day period in the previous year (Figure 7.3).

Figure 7.1. Estimates from short-term forecasts of hospital admissions with COVID-19 (7-day rolling sum) across Wales compared with reported admissions for the same date in previous years.

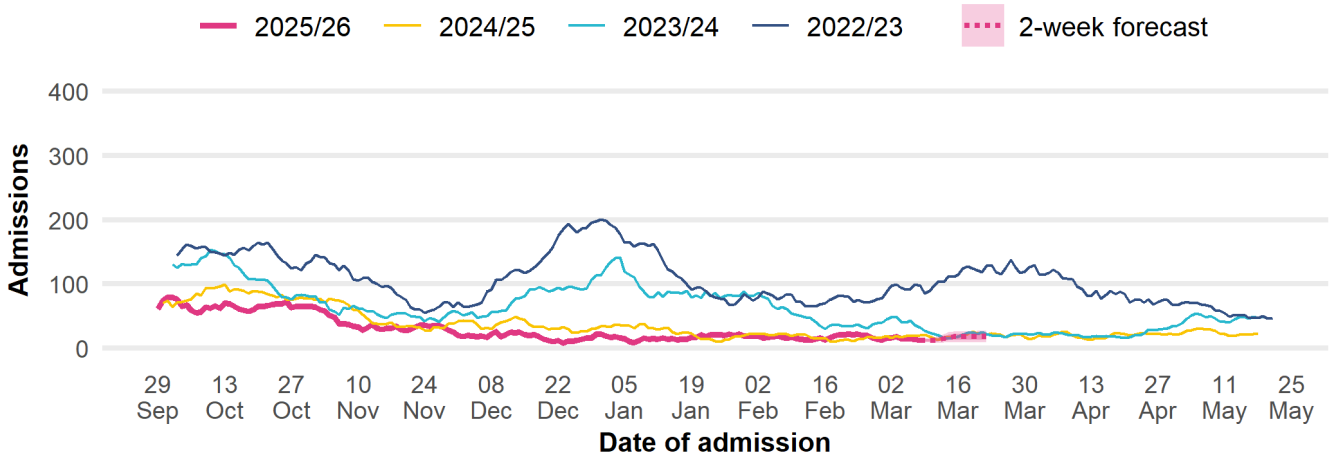


Figure 7.2. Estimates from short-term forecasts of hospital admissions with influenza (7-day rolling sum) across Wales compared with reported admissions for the same date in previous years.

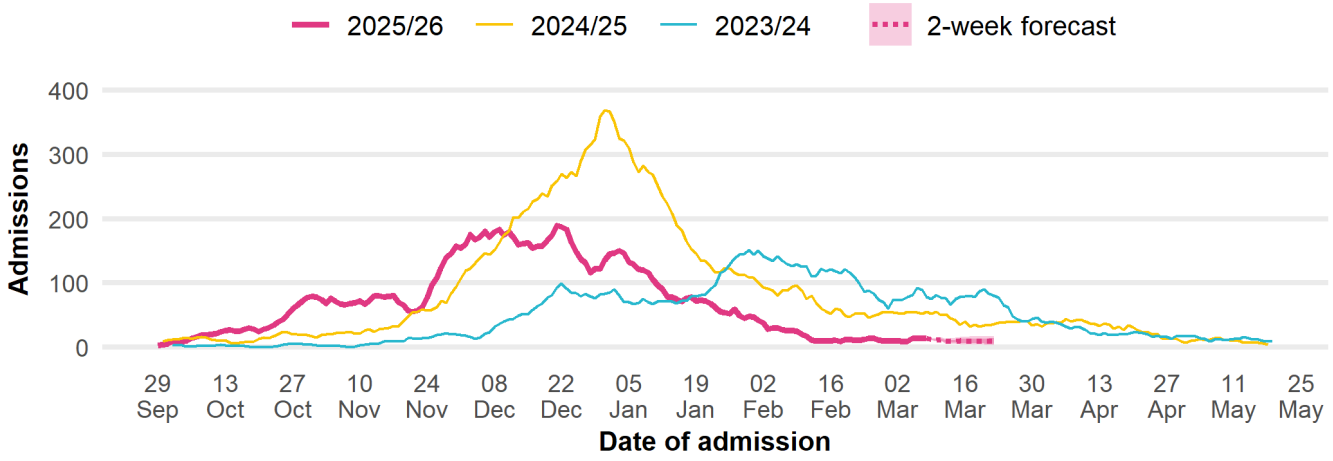
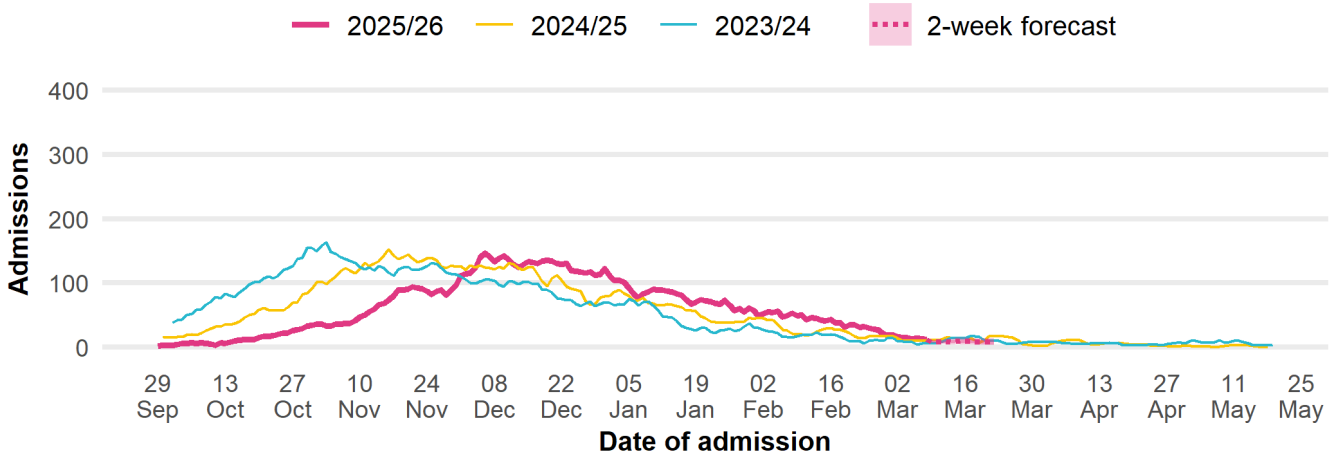


Figure 7.3. Estimates from short-term forecasts of hospital admissions with RSV (7-day rolling sum) across Wales compared with reported admissions for the same date in previous years.



Methodology and caveats

- **Interpretation of ranges and figures:** Any ranges reported here refer to the 80% prediction intervals (10th to 90th percentiles). The shaded pink area in the figures represents the forecast range; the lighter shade indicates the 80% prediction interval, and the darker shade indicates the 50% prediction interval. The solid lines in the figures represent reported admissions and the dashed lines represent the median forecasted admissions.

- **Methodology:** The forecasts are produced from an ensemble model which combines results from several models. Each model captures different aspects of how hospitalisations may change over time. By combining them, the ensemble approach helps balance the strengths and weaknesses of each model to provide more stable and reliable forecasts.

- **Limitations:** The forecasts may not accurately capture inflection points. Predictions further into the future are associated with higher levels of uncertainty. Variations in testing practices across health boards may lead to underestimation of true admission numbers.

NB: Welsh Government produce short-term projections of hospital admissions associated with ARI (including both community and hospital-acquired infections). See Communicable disease surveillance reports: 2026.

8. 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 03/03/26 and include vaccinations given and recorded in WIS up to the end of 02/03/26. 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 02/03/26. 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 03/03/26)

Influenza immunisation uptake in the 2025/26 season	
65 years and older	71.7%
16y to 64y in a clinical risk group	42.2%
Children aged 2 & 3 years	46.1%
Primary school aged children (4 to 10 years)*	57.6%
Secondary school aged children (11-15 years)*	46.1%

*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.

9. 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

10. International Summary

Influenza activity – UK and international summary

- GP ILI consultations decreased to 4.3 per 100,000 in England, to 4.6 per 100,000 in Northern Ireland, and to 2.7 per 100,000 in Scotland in Week 9, 2026.
- During Week 9, 5,101 sentinel samples tested for influenza were reported in England of which 103 were positive for influenza (81 influenza A (not subtyped), 9 influenza A (H3N2), 7 influenza A (H1N1)pdm09, and six influenza B).
- Overall, influenza positivity decreased to 2.4% in England, slightly increased to 2.1% in Northern Ireland and decreased to 1.6% in Scotland, in Week 9, 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 above the 10% positivity epidemic threshold at 16% in Week 9.
- Of the 37 countries and areas reporting on influenza intensity, nine reported medium intensity or higher.
- Of the 35 countries and areas reporting on geographic spread of influenza viruses within a country or area, 26 reported widespread or regional distribution.
- There were 454 confirmed influenza virus infection detections reported from sentinel primary care, mainly influenza type A (98%). **Source:** European Respiratory Virus Surveillance Summary (ERVISS): https://erviss.org/

- **Globally**, influenza detections continued to decline in week 8. Influenza A viruses were predominant among influenza detections, with a slight increase in the proportion of influenza B virus detections in recent weeks.
- In the northern hemisphere, influenza percent positivity was elevated (>10%) in countries in North America, Western and Northern Africa, Western, Southern and South-East Asia. Percent positivity was over 30% in countries in Central America and the Caribbean, Tropical South America, Europe and Eastern Asia. Increases in activity were observed in single countries in Central America and the Caribbean, South West and Eastern Europe, Western and Eastern Asia.
- In the southern hemisphere, influenza activity remained low overall although elevated positivity (>10%) was reported in two countries in Tropical South America and in single countries in Temperate South America and Eastern Africa.
- In the zones with elevated positivity, influenza A(H3N2) was predominant in most of the zones except Central America and the Caribbean where influenza A(H1N1) was most prevalent, while A(H3N2) and A(H1N1) were most prevalent in Western Asia. In countries of West Africa and South-East Asia, influenza A and B detections were predominant.
- **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 04/03/2026) during Week 7 (latest data available) globally there were 719 A(H1N1), 1,134 A(H3), 16,691 A(not subtyped), 1,181 influenza B (Victoria) and 9,495 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 8 (ending 28/02/2026). Nationally, 12,374 (15.8%) out of 78,361 specimens have tested positive for influenza in Week 8 in clinical laboratories nationwide, of these positive samples, 4,477(36.2%) were influenza A and 7,897 (63.8%) were influenza B. Further characterisation has been carried out on 1,259 specimens by public health laboratories, and 510 samples tested positive for influenza A; 73 influenza A(H1N1)pdm09, 287 influenza A(H3N2), and 222 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 8, indicators of influenza activity remained stable. Laboratory-confirmed detections of influenza were: 1,479 (811 influenza A and 668 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 increased in Week 8, 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

11. 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

12. 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.

13. 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