GIG CYMRU NHS WALES
Iechyd Cyhoeddus Cymru
Public Health Wales

Weekly Acute Respiratory Infection Report

Public Health Wales

Communicable Disease Surveillance Centre

Report week: 47 (ending 22 November 2026)

Headline

- Influenza is now circulating in Wales, with positivity increasing to 17.5% in the most recent week. Influenza A (H1N1) is the most frequently detected influenza virus in Wales.
- Respiratory Syncytial Virus (RSV) has continued to increase and is at high intensity levels.
- COVID-19 case numbers have stabilised in recent weeks but remain elevated.
- According to EuroMoMo method, 'no excess' of all-cause mortality has been reported in the most recent week.
- Using a mathematical model previously applied in England, routine influenza vaccination in Wales during the 2025/26 season was estimated to have averted 1,226 hospital admissions with influenza, representing a 45% reduction in admissions with influenza.

Foreword

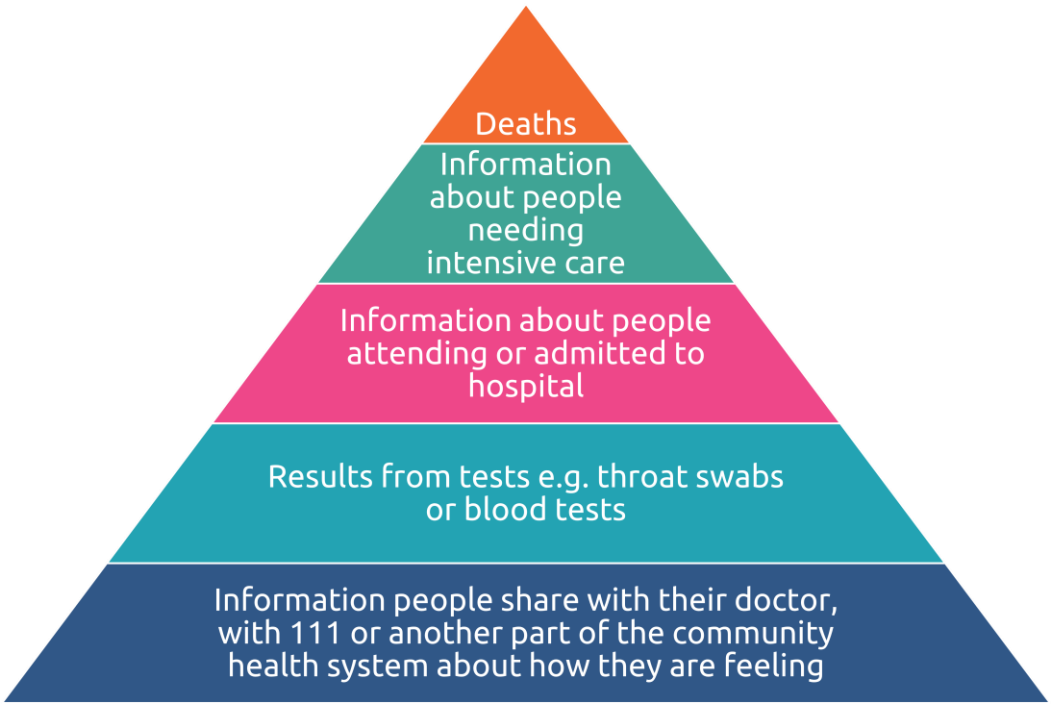
This report replaces the previously separate weekly reports on COVID-19, influenza and other respiratory infections. It is published on a weekly basis between Week 40 (October) and 20 (May) of the following year, and on a fortnightly basis during the summer period.

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) increased compared to the previous week.	Admissions in patients testing positive for COVID-19, RSV and Influenza increased during week ending 22/11/2026 (3% of total admissions).
Influenza	**Influenza is now circulating in Wales.** The overall proportion of samples testing positive in hospital and non-sentinel patients increased in the most recent week to 17.5%. Consultations for influenza-like illness (ILI) with sentinel GPs increased compared to the previous week and are at **low** intensity levels. 31 cases of influenza were 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 125 in the most recent week. There were 244 in-patient cases of confirmed influenza, four of whom were in critical care.
Influenza type breakdown	***Since Week 40 2026**: 1,197 total influenza cases confirmed (43 influenza A(H3N2), 209 influenza A(H1N1) pdm09, 922 influenza A untyped and 23 influenza B).* ***In the most recent week**: 2 influenza A(H3), 78 influenza A(H1N1), 314 influenza A untyped and 5 influenza B.*	
COVID-19	The overall proportion of samples testing positive was stable at 8.5% in hospitals and non-sentinel GP practices. Consultations with Sentinel GPs for COVID-19 are stable.	The number of confirmed cases of community acquired COVID-19 admitted to hospital decreased to 43. There were 357 in-patient cases of confirmed COVID-19, four of whom were in critical care.
RSV	RSV incidence per 100,000 in children aged up to 5y continued to increase and is at high intensity levels (46.1).	The number of confirmed cases of community acquired RSV admitted to hospital increased to 52. There were 30 in-patient cases of confirmed RSV, one of whom was in critical care.
Other respiratory pathogens	Rhinovirus and parainfluenza are the most frequently detected other cause of ARI.	

1. Community surveillance indicators

GP Consultations

- The sentinel GP consultation rate for influenza-like illness (ILI) is at low lwvels and the three-week trend is variable (Figures 1.1, 1.2).
- There were 9.6 ILI consultations per 100,000 practice population in the most recent week, an increase compared to the previous week (7.1 consultations per 100,000).
- In the 7-day period of the most recent week, using all available data from general practices, there were 216.5 ARI consultations per 100,000 practice population, an increase from 177.5 in the previous week (Table 1.1). The highest rates were found in people aged under 1 year (1492) followed by people aged 1 to 4 (1039.1) and people aged 75+ (228.6) (Figure 1.3).
- Surveillance indicators for acute respiratory infections in GP consultation data in Wales are increasing in people aged under 5 years (Figure 1.3).

Ambulance Calls

- The number of ambulance calls recorded referring to respiratory syndromic indicators increased from 1,588 in the previous week to 1,785 in the latest reporting week (Figure 1.5, Table 1.2).
- Calls for difficulty breathing increased compared to the previous week. Calls for cardiac or respiratory arrest, chest pain 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 47, 2026).

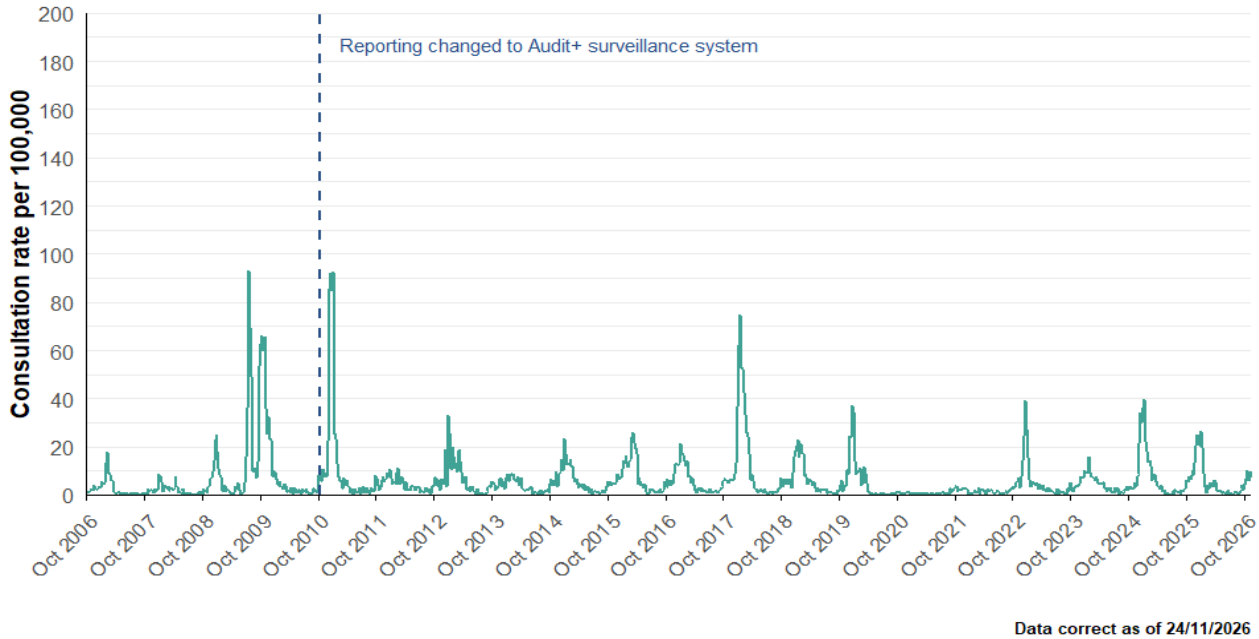


Figure 1.2. Sentinel GP network clinical consultation rate for ILI per 100,000 practice population.

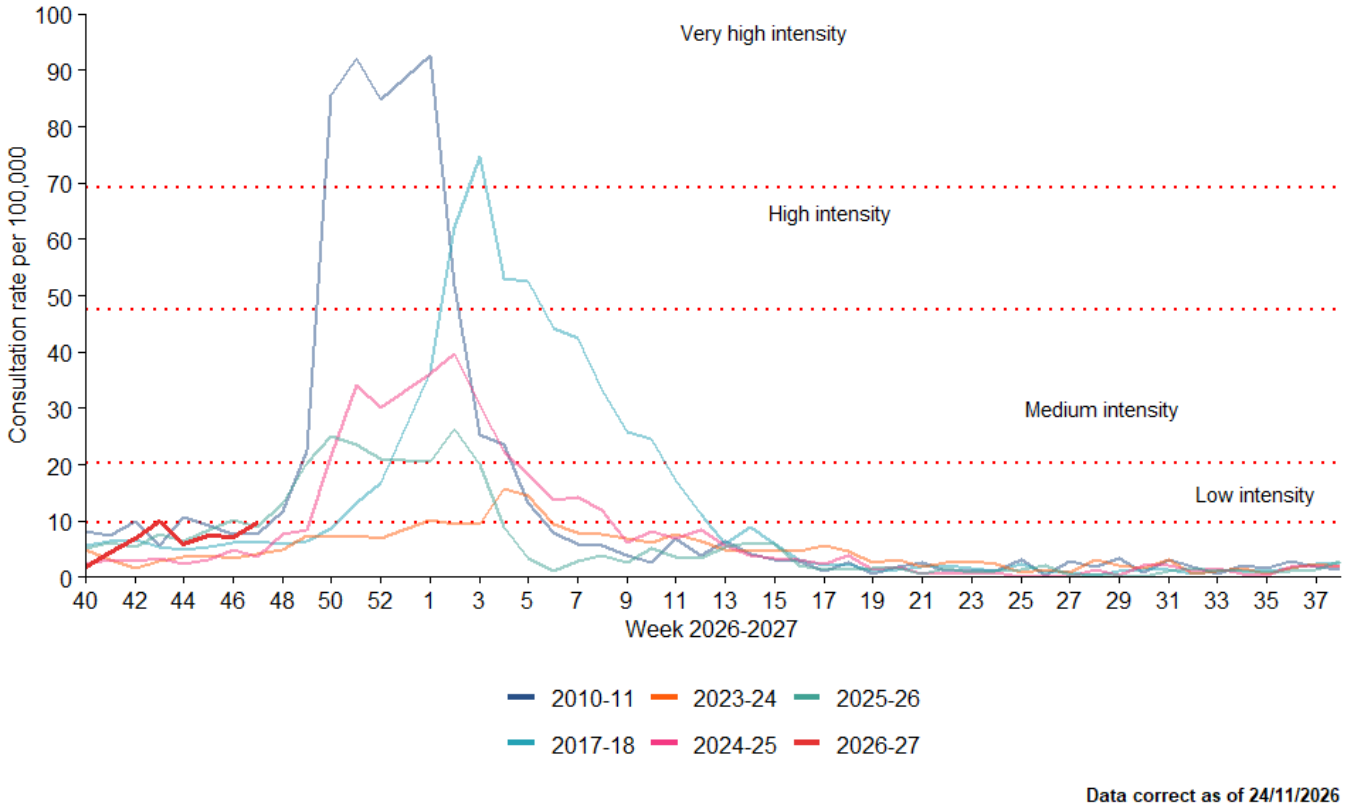
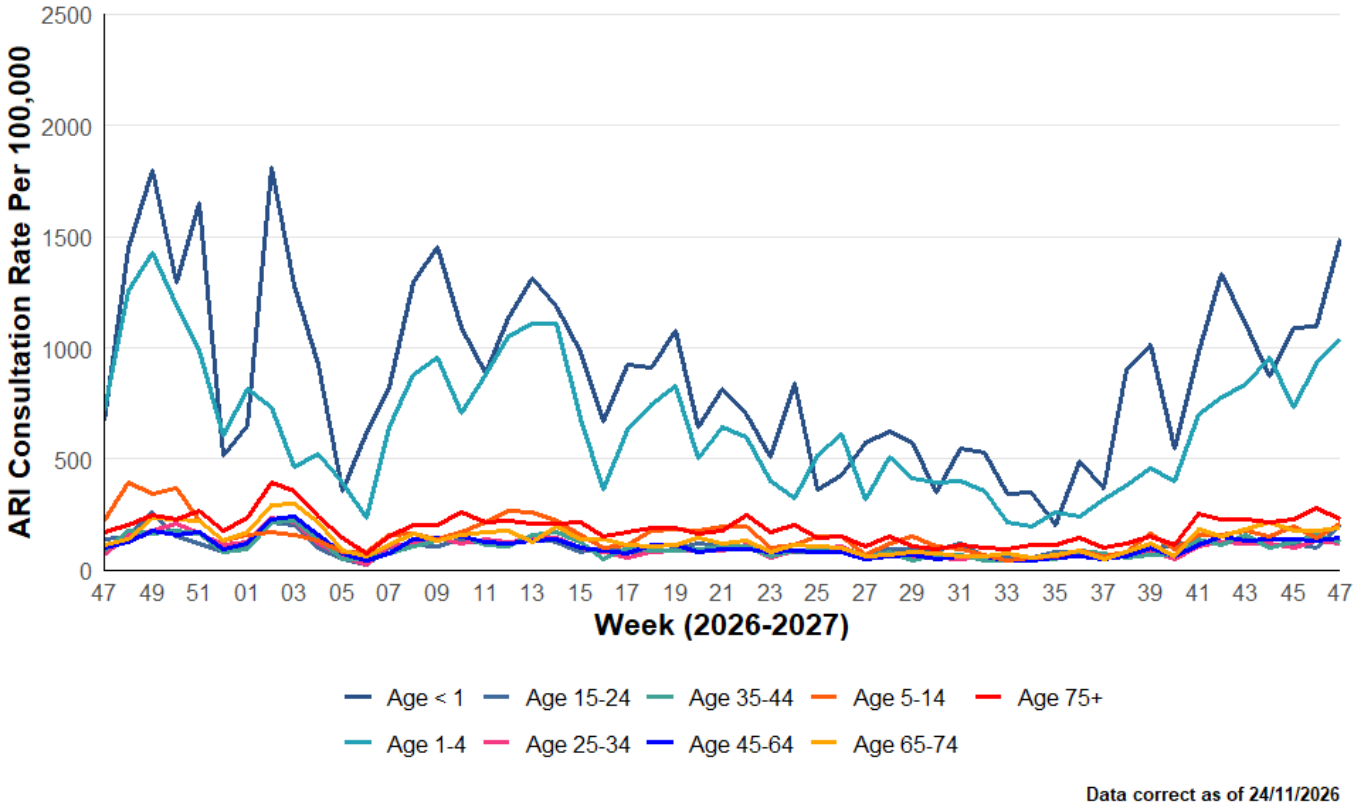


Figure 1.3. All Wales clinical consultation rates for Acute Respiratory Infection (ARI) per 100,000 practice population, by age bands.



GP Consultations - All Wales

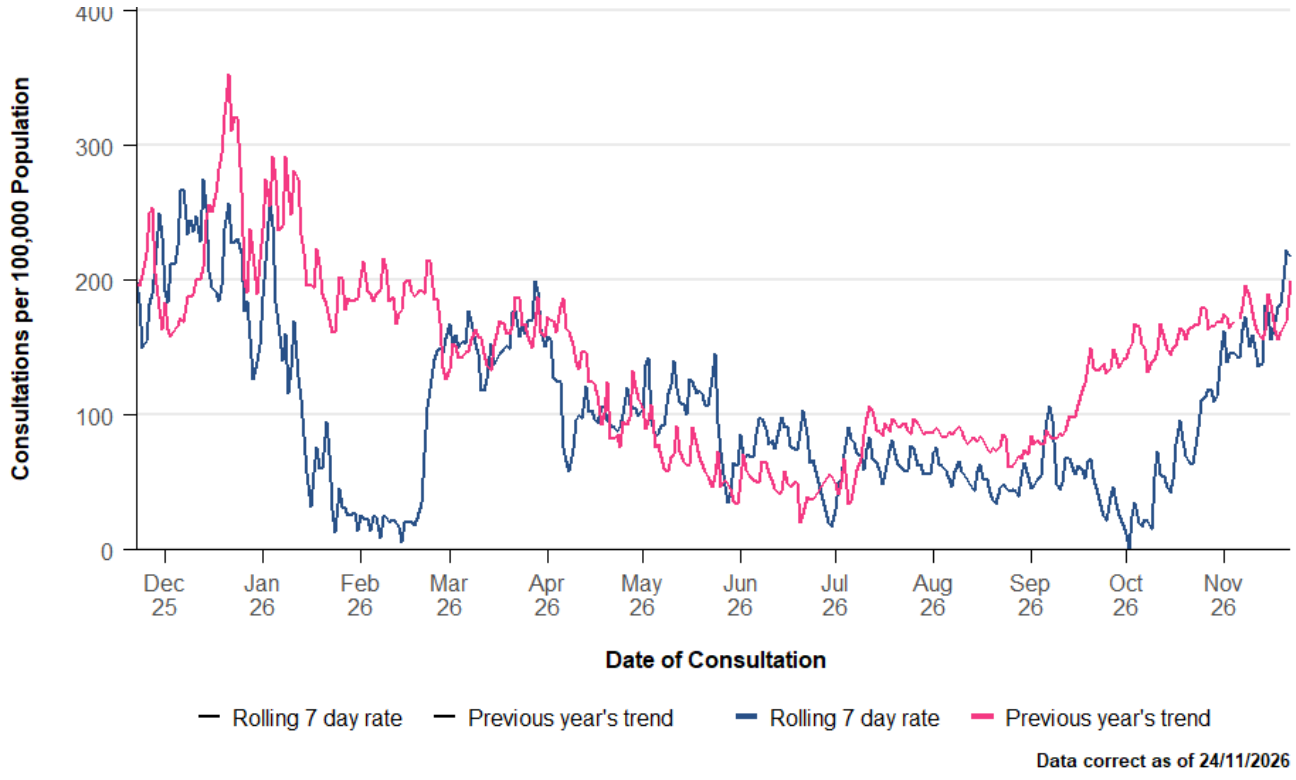
From 28th October 2026, the rates presented here are based on consultations occurring within a 7-day period, replacing the previously published rolling 7-day average rates.

Table 1.1. Summary of GP consultations per 100,000 practice population in Wales, by indicator, for Week 47, 2026, 2026. This table uses all available GP surveillance data (from sentinel and non-sentinel practices)

Indicator	Current reporting week	Preceding reporting week	Equivalent period last year
ARI	216.5	177.5	198.8
COVID-19	0.3	0.1	1.8
LRTI	85.6	68.9	74.5
Pneumonia	0.4	0.4	0.3
Severe asthma	2.7	2.6	3.7
URTI	132.2	109.4	125.6

NB: Rates are based on consultations occurring in a 7-day period and are presented per 100,000 practice population. "Current reporting period" refers to the 7-day period of the current reporting week, "Preceding reporting period" refers to the 7-day period of the previous reporting week, and "Equivalent period last year" refers to the corresponding 7-day period last year.

Figure 1.4. Rolling 7-day GP consultation rate 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.

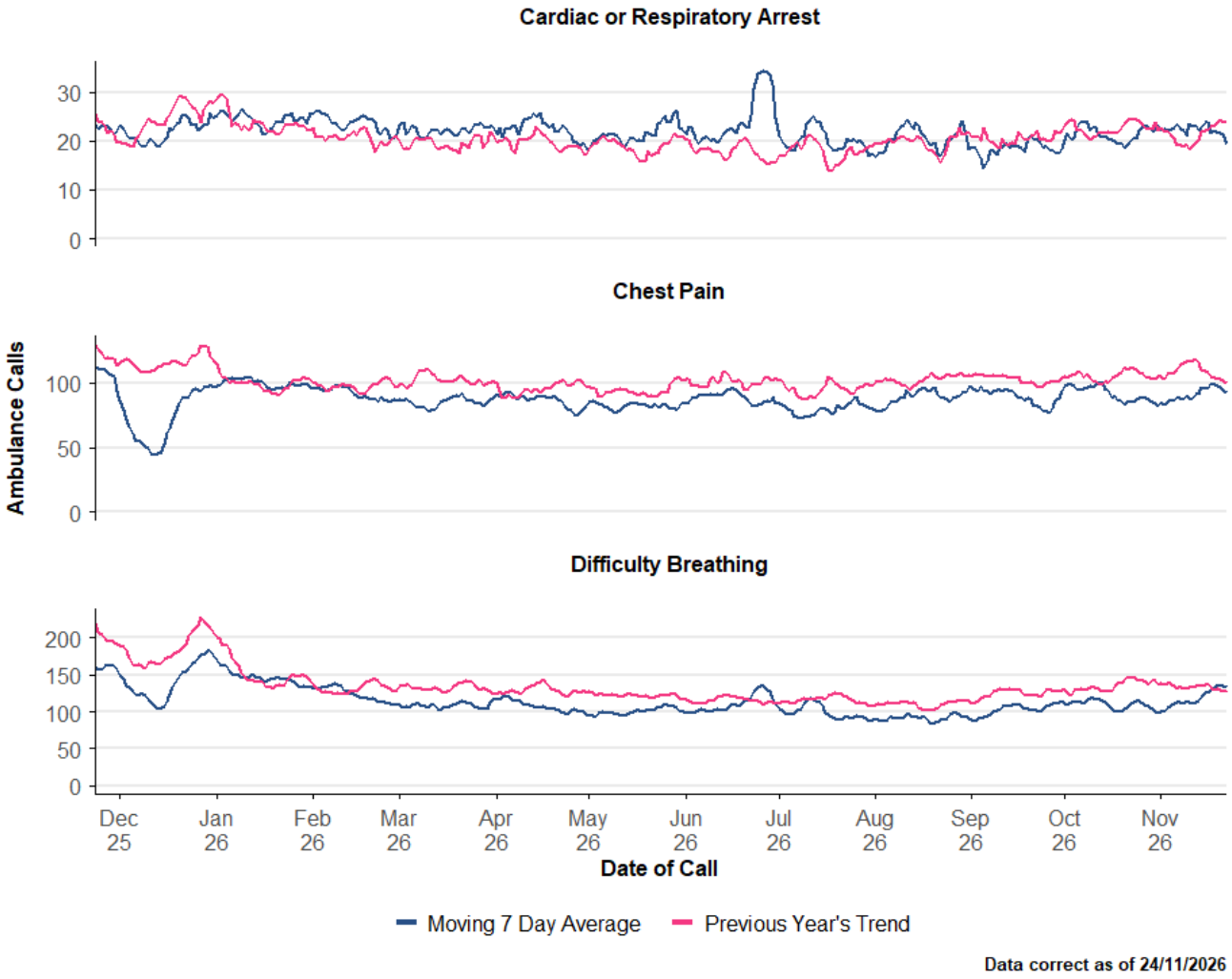


Table 1.2. Summary of weekly number of Ambulance calls, by symptom in Wales, for Week 47, 2026. This summary analysis uses data provided by the Welsh Ambulance Service NHS Trust.

Indicator	Current Reporting Week	Preceding Week	Equivalent Period Last Year
Cardiac or Respiratory Arrest	151	163	140
Chest Pain	682	640	803
Difficulty Breathing	952	785	938
Total	1,785	1,588	1,881

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 155 surveillance samples from patients with ILI symptoms collected by sentinel GPs and community pharmacies during Week 47, 2026, as at 25/11/2026 (Table 2.1, Figure 2.1).
- The most commonly detected pathogens were Influenza A (31), Rhinovirus (14), SARS-CoV-2 (COVID-19) (11). Of the 155 tests, 47.1% were negative for all respiratory pathogens (Table 2.1, Figure 2.1).

All Wales Datastore Respiratory Infection Testing

- There were 1,362 samples receiving multiplex respiratory panel testing, collected from patients attending hospitals and non-sentinel GPs during Week 47 (Table 2.2, Figure 2.2).
- The most commonly detected pathogens were Influenza A (236) followed by Rhinovirus (120) and SARS-CoV-2 (COVID-19) (116). Of the 1362 tests, 55.0% were negative for all respiratory pathogens (Table 2.2, Figure 2.2).

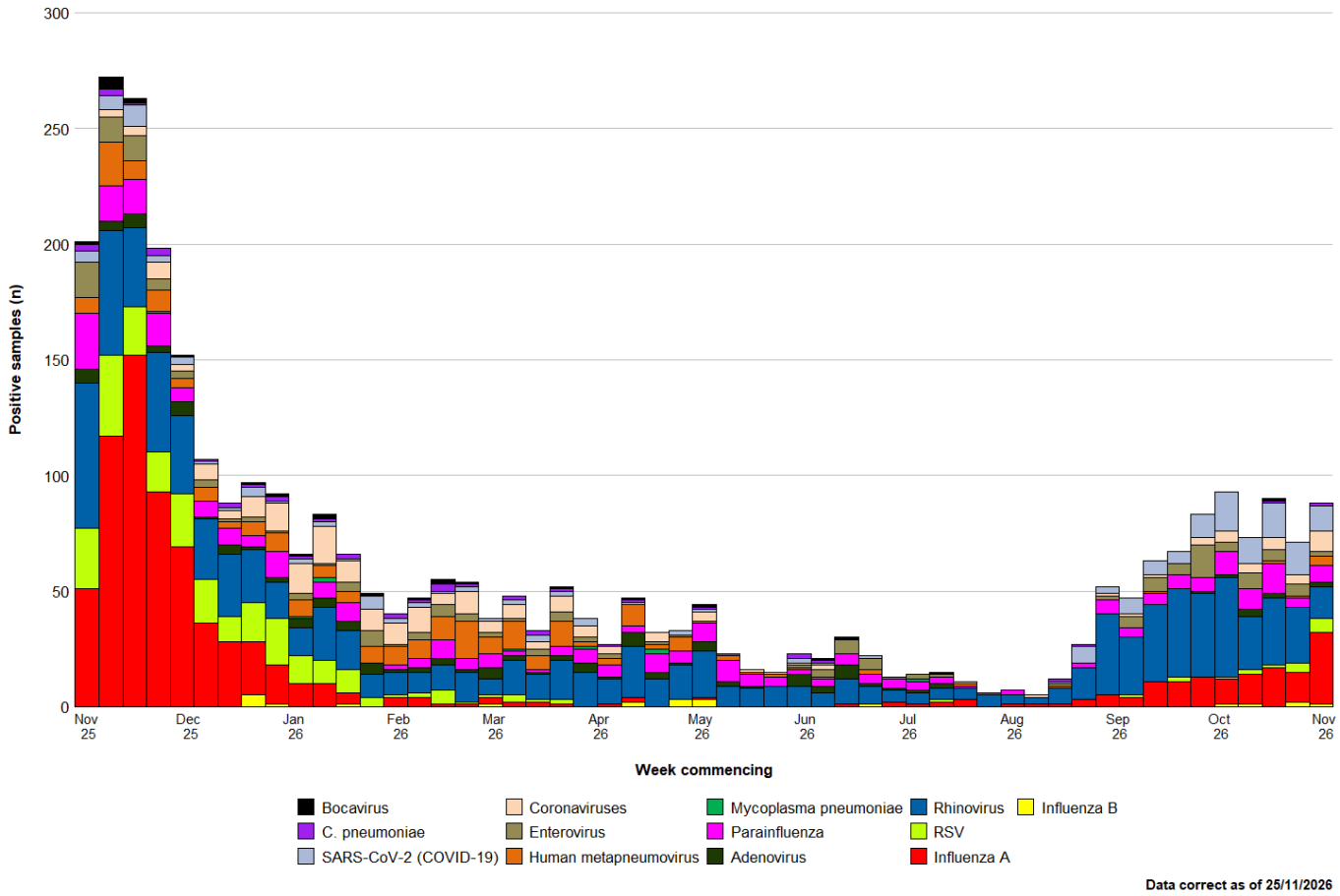
Additionally, during Week 47, 621 samples from patients were tested for influenza, RSV and SARS-CoV-2 only (Figure 2.3). Of these the following tested positive:

- 129 for influenza (127 for influenza A, two for influenza B)
- 87 for SARS-CoV-2 (COVID-19)
- 27 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 47, 2026.

Pathogens Detected	Count (n)	Positivity (current week)	Positivity (previous week)	Trend
Influenza A	31	20.0%	8.6%	Increasing
Rhinovirus	14	9.0%	15.8%	Decreasing
SARS-CoV-2 (COVID-19)	11	7.1%	9.2%	Decreasing
Coronaviruses	9	5.8%	2.6%	Increasing
Parainfluenza	7	4.5%	2.6%	Increasing
RSV	6	3.9%	2.6%	Increasing
Human metapneumovirus	4	2.6%	0.7%	Increasing
Adenovirus	2	1.3%	0.0%	Increasing
Enterovirus	2	1.3%	3.3%	Decreasing
Influenza B	1	0.6%	1.3%	Stable
C. pneumoniae	1	0.6%	0.0%	Stable
Mycoplasma pneumoniae	0	0.0%	0.0%	Stable
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 47, 2025 to Week 47, 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 47, 2026.

Pathogens Detected	Count (n)	Positivity (current week)	Positivity (previous week)	Trend
Influenza A	236	17.3%	11.4%	Increasing
Rhinovirus	120	8.8%	10.6%	Decreasing
SARS-CoV-2 (COVID-19)	116	8.5%	8.8%	Stable
RSV	65	4.8%	3.9%	Stable
Parainfluenza	45	3.3%	3.7%	Stable
Adenovirus	38	2.8%	2.4%	Stable
Enterovirus	30	2.2%	3.3%	Decreasing
Seasonal coronaviruses	25	1.8%	0.8%	Increasing
Human metapneumovirus	20	1.5%	0.5%	Stable
Influenza B	2	0.1%	0.2%	Stable
Mycoplasma pneumoniae	0	0.0%	0.0%	Stable
Bocavirus	0	0.0%	0.0%	Stable
C. pneumoniae	0	0.0%	0.1%	Stable

Figure 2.2. Pathogens detected in samples collected from hospital and non-Sentinel GP patients, by week of sample collection, Week 47, 2025 to Week 47, 2026.

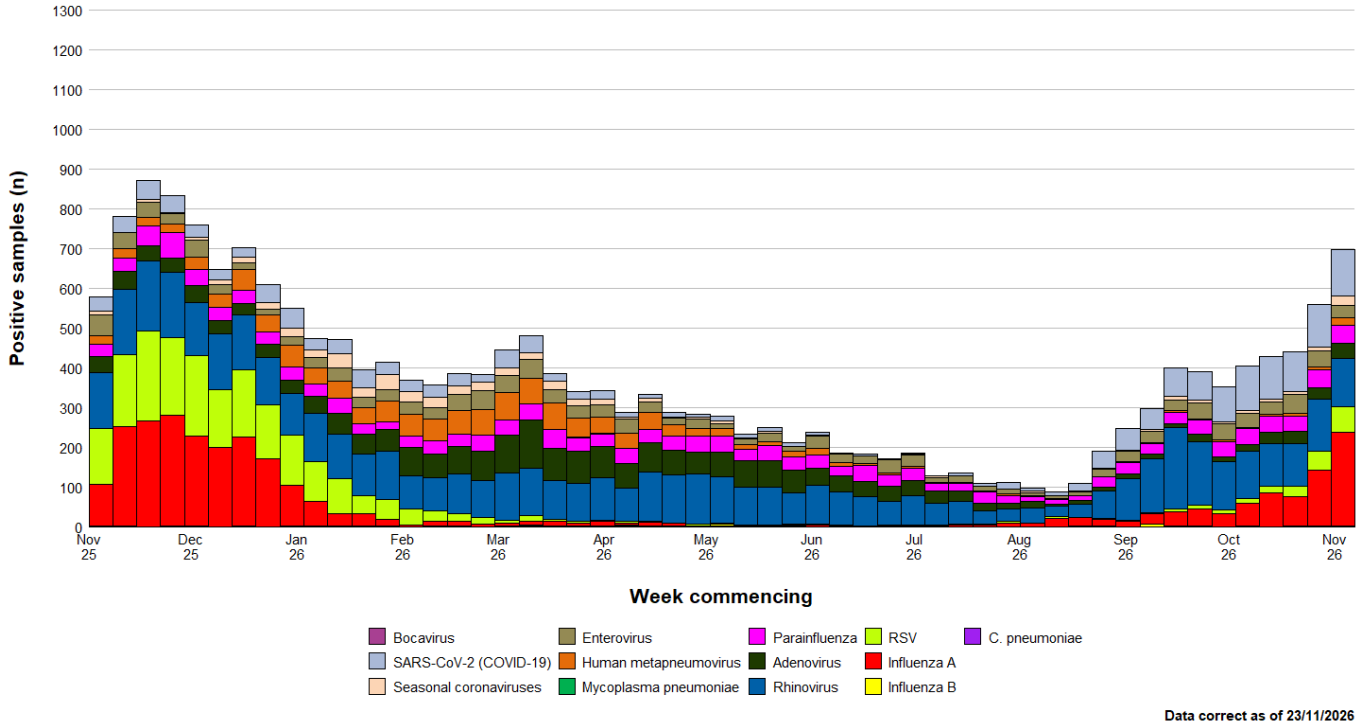
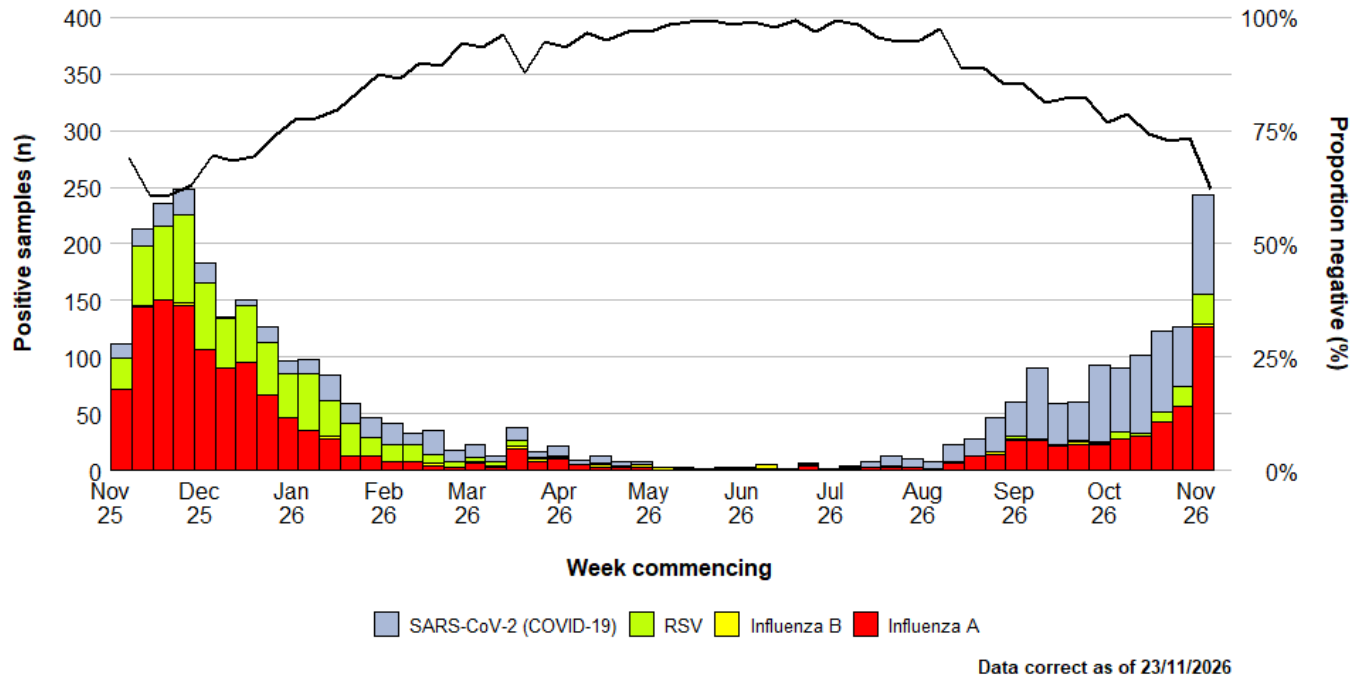


Figure 2.3. Samples from hospital patients submitted for RSV, Influenza and SARS-CoV-2 testing only, by week of sample collection, Week 47, 2025 to Week 47, 2026.





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

Sentinel SARI in emergency departments

- During the previous four weeks there were 60 surveillance samples taken from SARI surveillance sentinel emergency departments. The most common pathogen identified from these samples was Rhinovirus/Enterovirus(9) followed by Adenovirus(5) and SARS-CoV-2 (COVID-19)(5). Of the 60 samples collected, 56.7% 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 7% for influenza, 8% for SARS-CoV-2 and 5% for RSV.

Hospital in-patients

- During week ending 22/11/2026 there were 220 patients admitted to hospital with confirmed COVID-19, RSV or influenza, (41 more than the previous week), equating to 3% of all hospital admissions in that reporting week.

- At 23:59 on 22/11/2026, there were 631 patients in hospital with confirmed COVID-19, RSV or influenza, 119 more than the previous Sunday. This equates to 6% of all hospital in-patients (IPs) at that time. Of whom 71% (447) were hospital acquired (HA).

Critical-care

- During week ending 22/11/2026 there were 13 ARI critical care (CC) admissions (8 more than the previous week), equating to 7% of all CC admissions in that reporting week.

- At 23:59 on 22/11/2026, there were 9 patients in CC with confirmed COVID-19, RSV or influenza, 1 more than the previous Sunday. This equates to 5% of all CC in-patients at that time. Of whom 11% (1) were hospital acquired (HA).

Virological surveillance in ICU

- During Week 47, 2026, 56 respiratory samples were tested from patients in intensive care units (ICU). Of these: three tested positive for Influenza, two tested positive for SARS-CoV-2 (COVID-19) and zero tested positive for RSV (Figure 3.4).

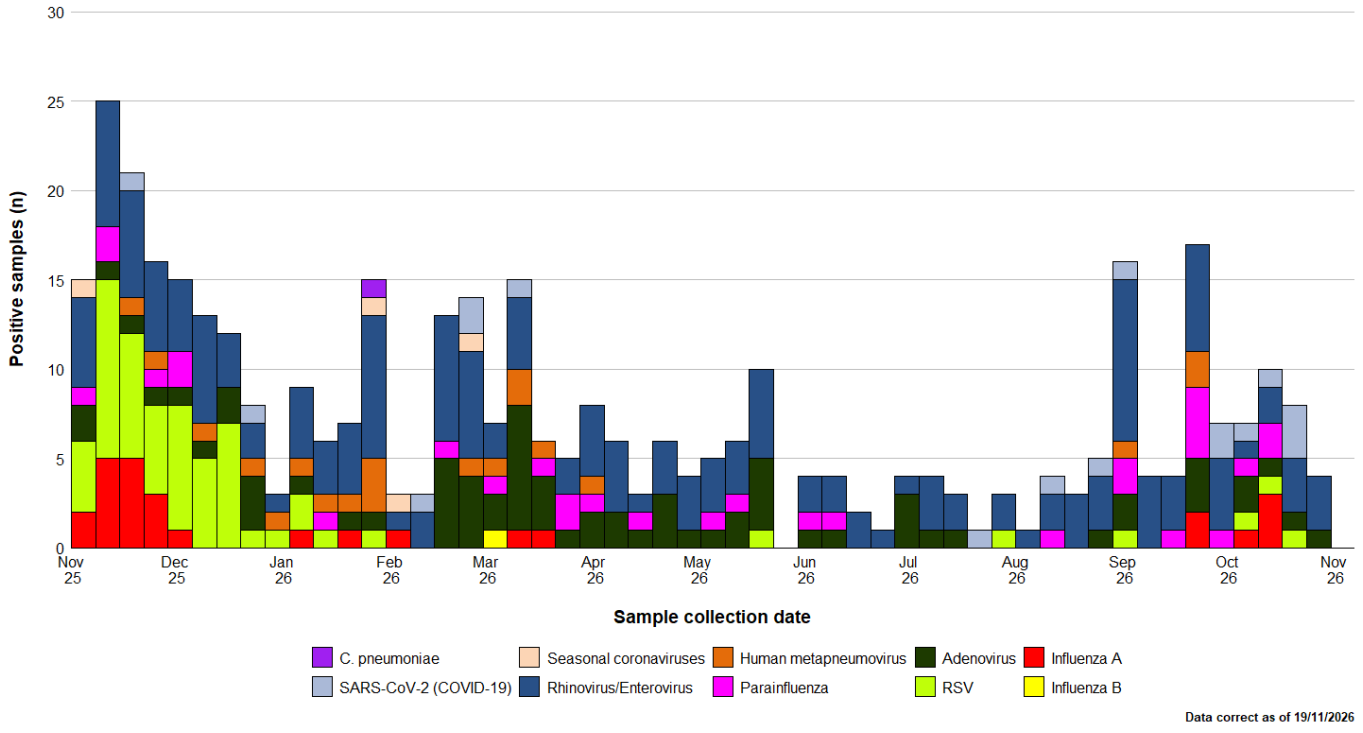
For detailed reports on surveillance of ARI in hospitals, including breakdowns by health board and age-group see: Hospital admissions dashboard

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 46, 2026.

	Meeting SARI case definition in the last 4 weeks		Meeting SARI case definition in the last 12 months	
Pathogens Detected	**n**	**%**	**n**	**%**
Adenovirus	5	8.3%	71	11.2%
C. pneumoniae	0	0.0%	1	0.2%
Human metapneumovirus	0	0.0%	20	3.2%
Influenza A	4	6.7%	35	5.5%
Influenza B	0	0.0%	1	0.2%
Mycoplasma pneumoniae	0	0.0%	0	0.0%
Parainfluenza	3	5.0%	30	4.7%
Pertussis	0	0.0%	0	0.0%
RSV	3	5.0%	57	9.0%
Rhinovirus/Enterovirus	9	15.0%	167	26.4%
SARS-CoV-2 (COVID-19)	5	8.3%	17	2.7%
Seasonal coronaviruses	0	0.0%	4	0.6%
Negative	34	56.7%	296	46.8%
Total	**60**	**100%**	**652**	**100%**

Figure 3.1 Pathogens detected in samples collected from symptomatic patients presenting at participating SARI surveillance sentinel emergency departments, for Week 46, 2026 and previous 12 months.

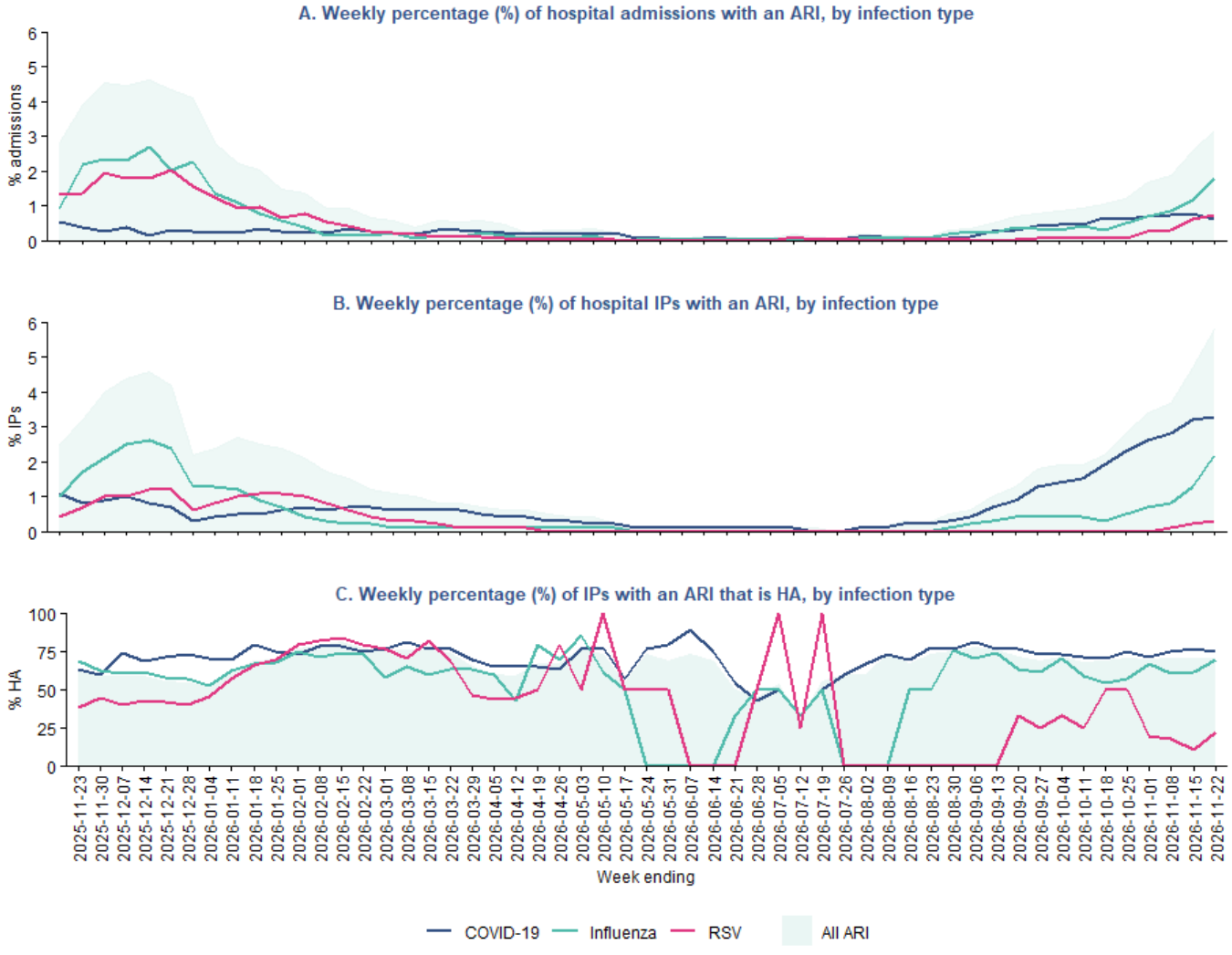


Acute Respiratory Infection Surveillance in Hospital In-Patients

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	43	1%	357	3%	75% (269)
Influenza	125	2%	244	2%	70% (171)
RSV	52	1%	30	0%	23% (7)
ARI total	**220**	**3%**	**631**	**6%**	**71% (447)**

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.



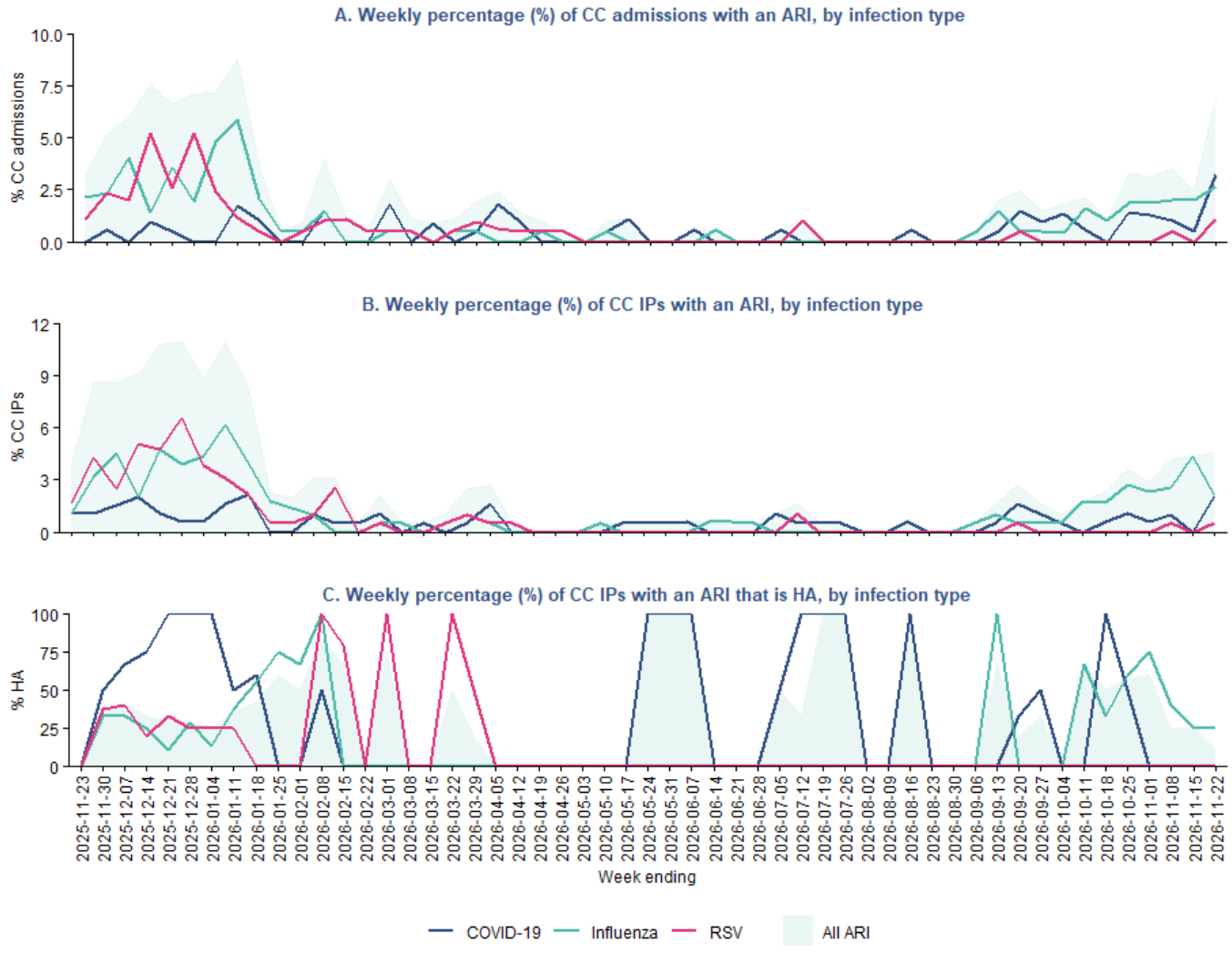
Data as of: 25-11-2026

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).

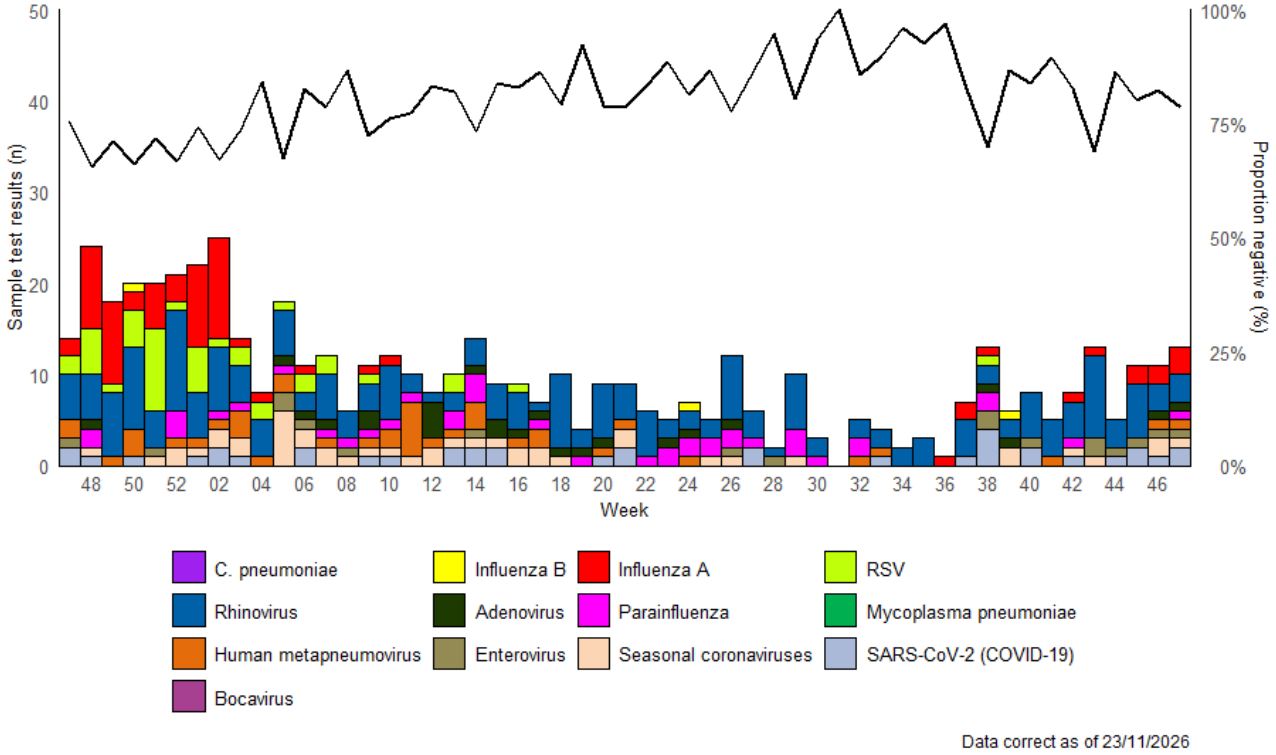
Infection	CC admissions		CC In-patients		
	Count	% of all CC admissions	Count	% of all CC In-patients	% HA (n)
COVID-19	6	3%	4	2%	0% (0)
Influenza	5	3%	4	2%	25% (1)
RSV	2	1%	1	0%	0% (0)
ARI total	**13**	**7%**	**9**	**5%**	**11% (1)**

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: 25-11-2026

Figure 3.4. Samples submitted for virological testing from ICU patients, by week of sample collection, Week 47, 2025 to Week 47, 2026. The black line indicates the percentage of samples which tested negative for any of the pathogens listed.



4. Settings-based surveillance and outbreaks

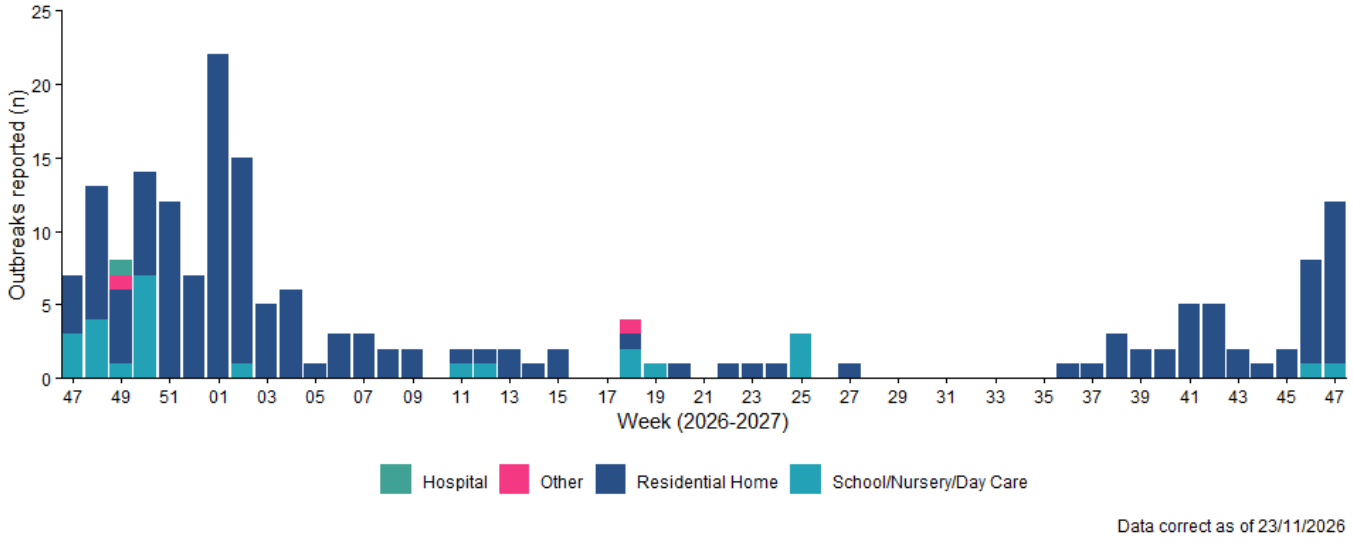
Acute Respiratory Infection Outbreaks Reported to Public Health Wales Health Protection Team

During Week 47, 2026, 11 ARI outbreaks were reported to the Public Health Wales Health Protection Team.

Of these:

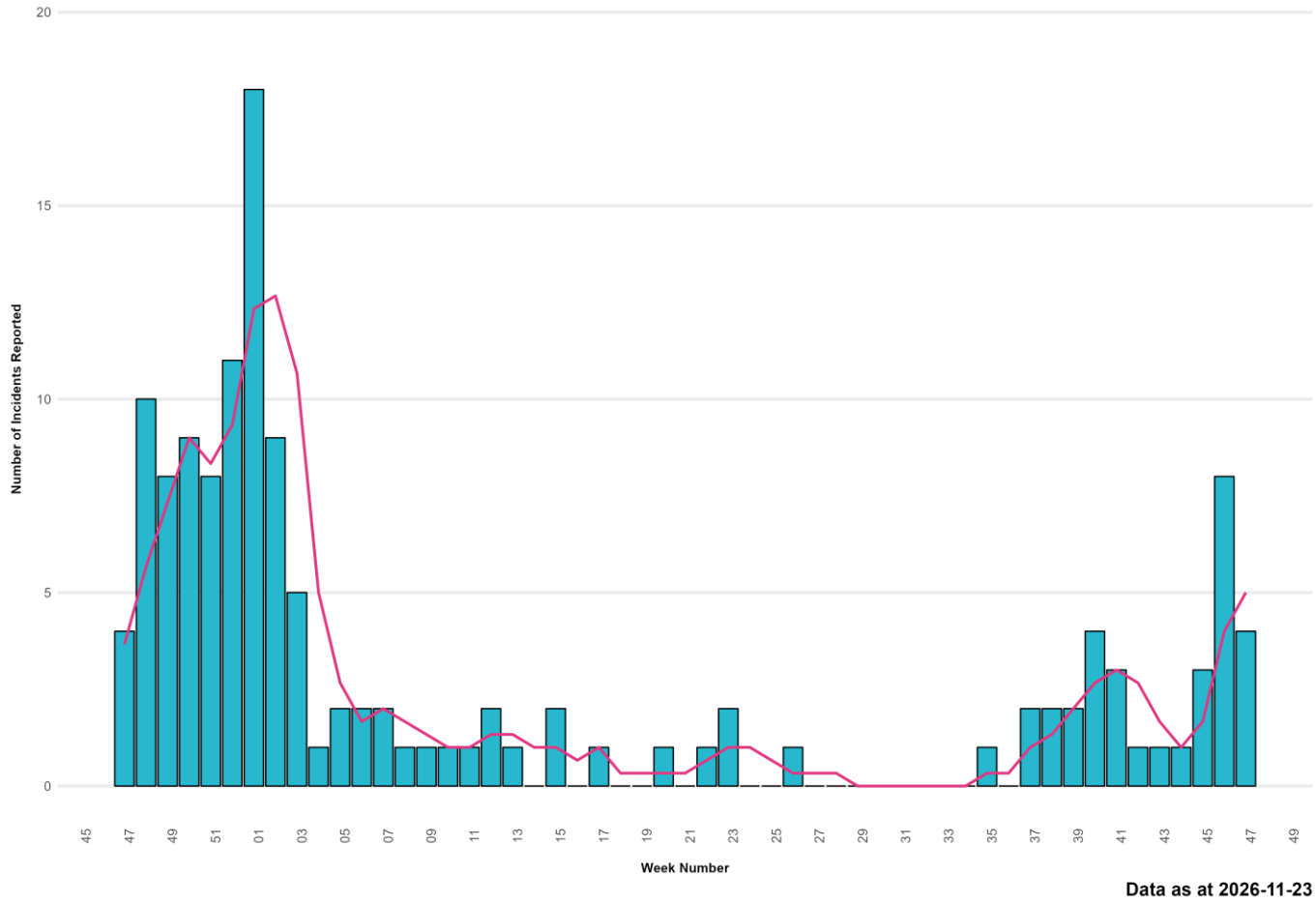
- Six were influenza (two of which had co-circulating pathogens); and give were other acute respiratory infections.
- Ten were in a residential home, and one was in a School/Nursery/Day Care setting

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 hospitals, 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.

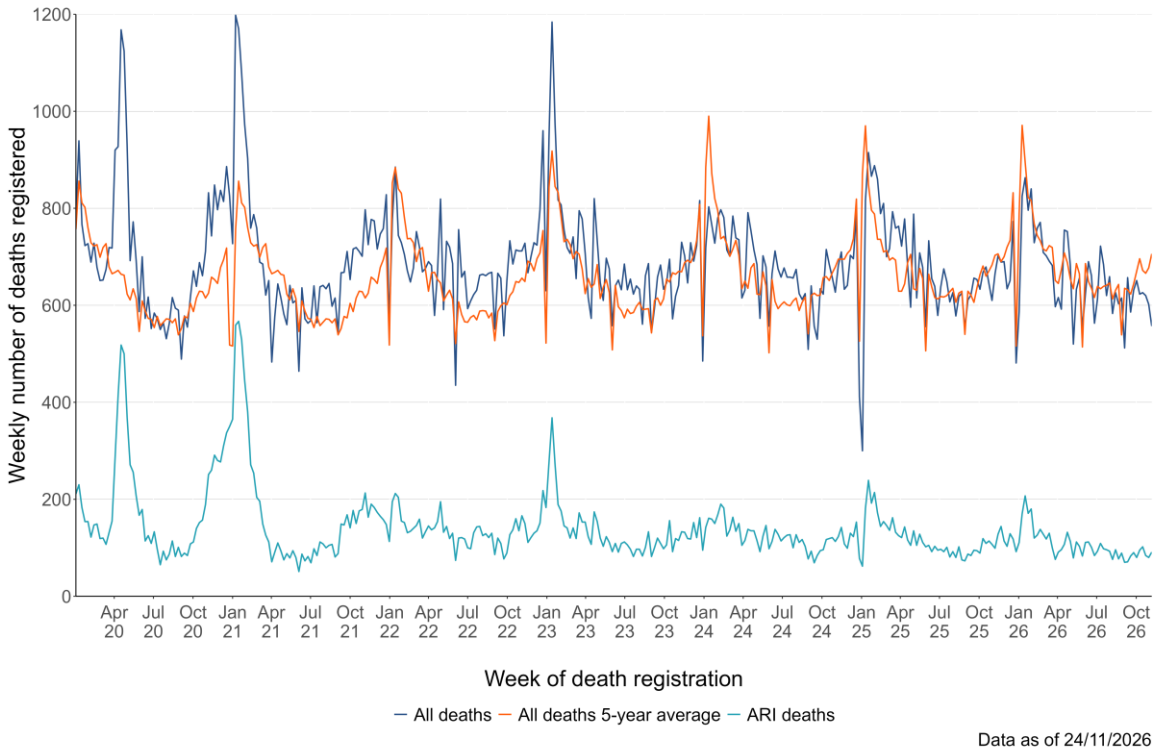


Figure 5.2 Numbers of ARI related deaths by age-group and week of death registration.

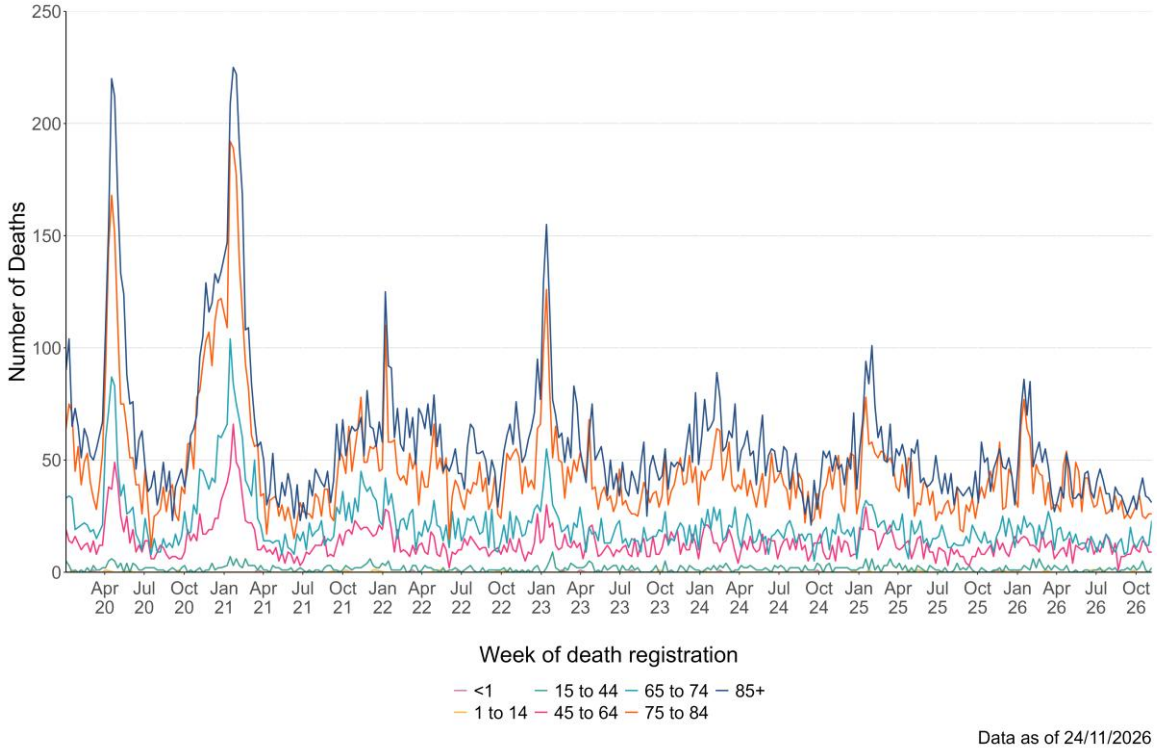


Figure 5.3. Numbers of deaths due to ARI, by place of death and week of death registration.

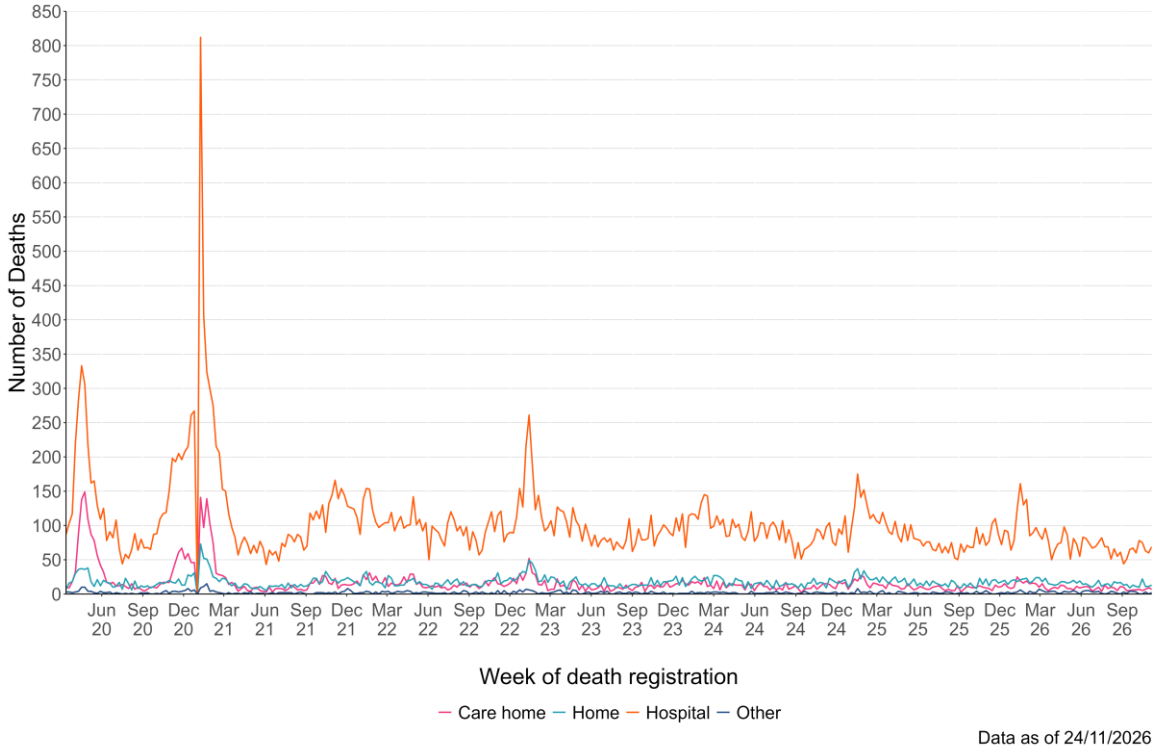
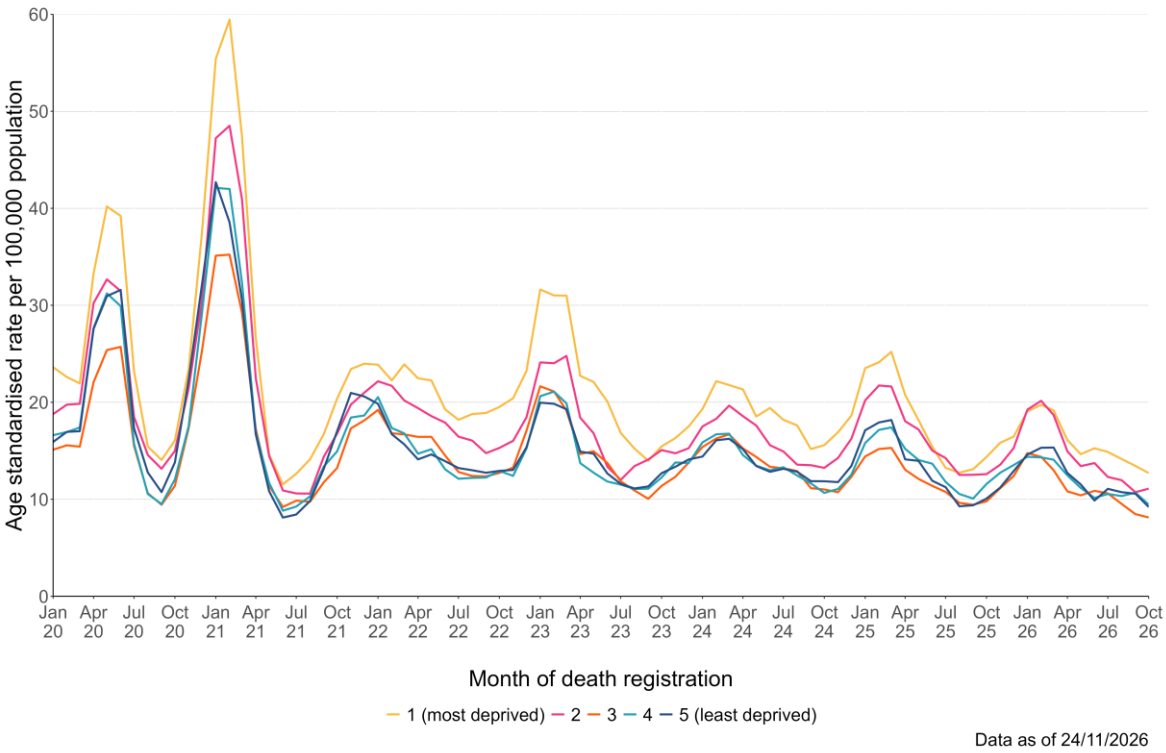


Figure 5.4. Numbers of ARI deaths, by quintile of deprivation of area of residence (based on the Welsh Index of Multiple Deprivation rankings of Lower Super Output Areas) and week of death registration.



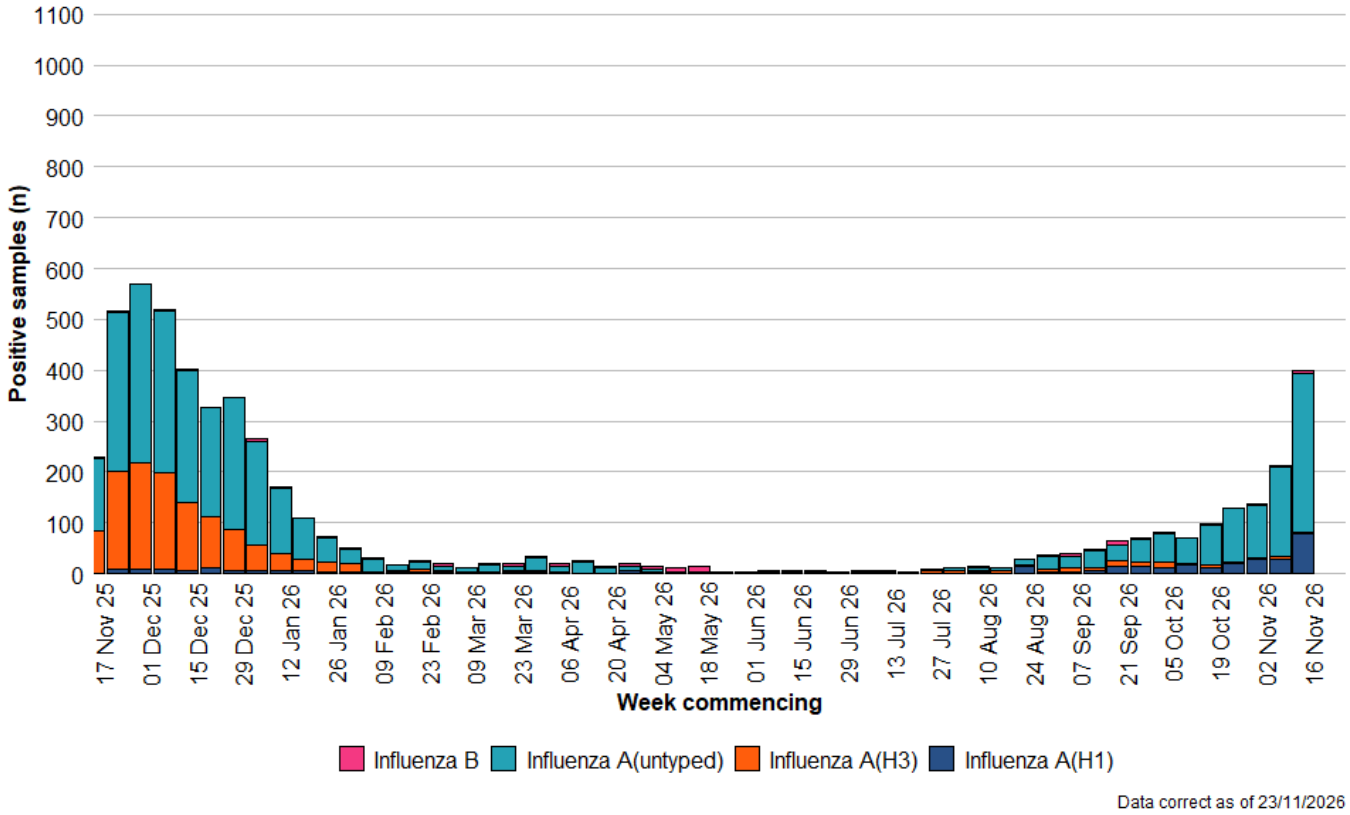
For interactive versions of these data, including health board specific breakdowns, see: [ONS mortality dashboard]

6. Pathogen-specific surveillance

Influenza

- influenza A(H1N1) is the most commonly detected influenza subtype in Wales since Week 40 2026 (209 confirmed cases), followed by influenza A(H3N2) (43 confirmed cases) and influenza B (23 confirmed cases). Additionally, there have been 922 untyped influenza A cases.

Figure 6.1. 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 47, 2025 to Week 47, 2026.

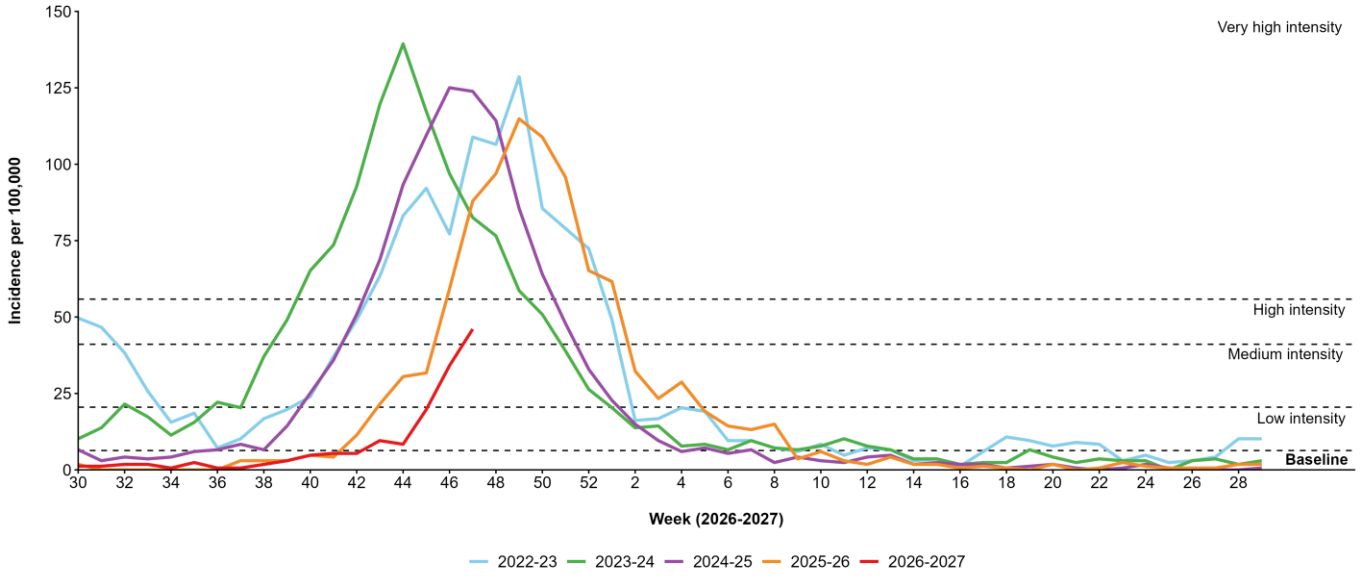


Data correct as of 23/11/2026

Respiratory Syncytial Virus (RSV)

- RSV incidence per 100,000 population in children aged under five years is currently at high (46.1) intensity levels per 100,000 population during Week 47 2026.

Figure 6.2. RSV incidence rate per 100,000 population aged under five years, Week 30, 2022 to Week 46 2026.



SARS-CoV-2 Variant surveillance

Data as at: 11/11/26

- Pango group TA.1 is the most frequently detected Pango lineage group in Wales currently, accounting for 21.5% of sequenced cases in the previous six weeks (reporting weeks 2026 W39 to 2026 W45).

Figure 6.3. Prevalence of sequenced cases assigned to each Pango lineage group in Wales in the past six months (2026 W21 to 2026 W45) A: Weekly total positive SARS-CoV-2 cases and sequenced cases B: Percentage of weekly cases attributed to each Pango lineage group



* The most recent 2 weeks of data should be interpreted with caution due to the sequencing lag

Note: Due to the high number of currently circulating Pango lineage groups, lineage groups which do not fulfill either of the following criteria are collapsed into the category 'Other': 1) Exceed a weekly prevalence of 10% within the last 6 weeks OR 2) Exceed a weekly prevalence of 25% within the last 6 months.

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. Estimates from short-term forecasts of hospital admissions with community-acquired ARI

Introduction

- Short-term forecasts use a modelling approach to suggest possible future trends in hospital admissions associated with community-acquired COVID-19, influenza and RSV infections 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 **increase** (confidence level: likely).
- For the week commencing **23/11/2026**, our forecasts estimate that between **230** and **328** hospital admissions with either COVID-19, RSV or influenza (median: **276**) may occur across Wales. Roughly **27%** will be for COVID-19, **49%** for influenza and **24%** for RSV. For the following week, between **224** and **457** admissions are estimated by the model.

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

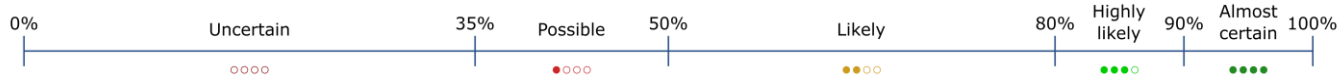
Infection	Observed	Forecasted admissions range (median)[2]		Suggested two-week trend	
	Admissions last week (n)[1]	Week starting 23/11/2026	Week starting 30/11/2026	Trend[3]	Confidence[4]
COVID-19	43	29 – 64 (45)	25 – 67 (45)	Stable →	Possible ●○○○
Influenza	125	120 – 194 (156)	111 – 294 (170)	Increase ↑	Likely ●●○○
RSV	52	52 – 99 (72)	47 – 163 (83)	Increase ↑	Likely ●●○○
Total	220	230 – 328 (276)	224 – 457 (315)	Increase ↑	Likely ●●○○

[1]Admissions with community-acquired infections are individuals admitted to hospitals in Wales who tested PCR test positive for COVID-19, influenza, or RSV within 28 days before or 2 days after admission.

[2]The total admissions forecast is calculated by combining the full forecasts of all individual infections. Therefore, the medians (middle scenario) of the individual infection forecasts may not always add up to the median of the total forecast.

[3]The suggested trend is based on the change between the previous week's admissions and the middle scenario for the second week. A stable trend is a change of less than 20% or a change of less than 10 admissions for forecasts of individual infections or 20 for forecasts of total admissions.

[4]The confidence in the suggested trend reflects the proportion of model predictions which agree with the middle 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: possible).
- For the week commencing **23/11/2026**, our forecasts estimate that between **29** and **64** hospital admissions with COVID-19 (median: **45**) may occur across Wales. For the following week (commencing 30/11/2026), between **25** and **67** admissions are estimated.
- Forecasted COVID-19 admissions are suggested to be **higher** 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 **increase** (confidence level: likely).
- For the week commencing **23/11/2026**, our forecasts estimate that between **120** and **194** hospital admissions with influenza (median: **156**) may occur across Wales. For the following week (commencing 30/11/2026), between **111** and **294** admissions are estimated.
- Forecasted influenza admissions are suggested to be **similar** 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 **increase** (confidence level: likely).
- For the week commencing **23/11/2026**, our forecasts estimate that between **52** and **99** hospital admissions with RSV (median: **72**) may occur across Wales. For the following week (commencing 30/11/2026), between **47** and **163** 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.

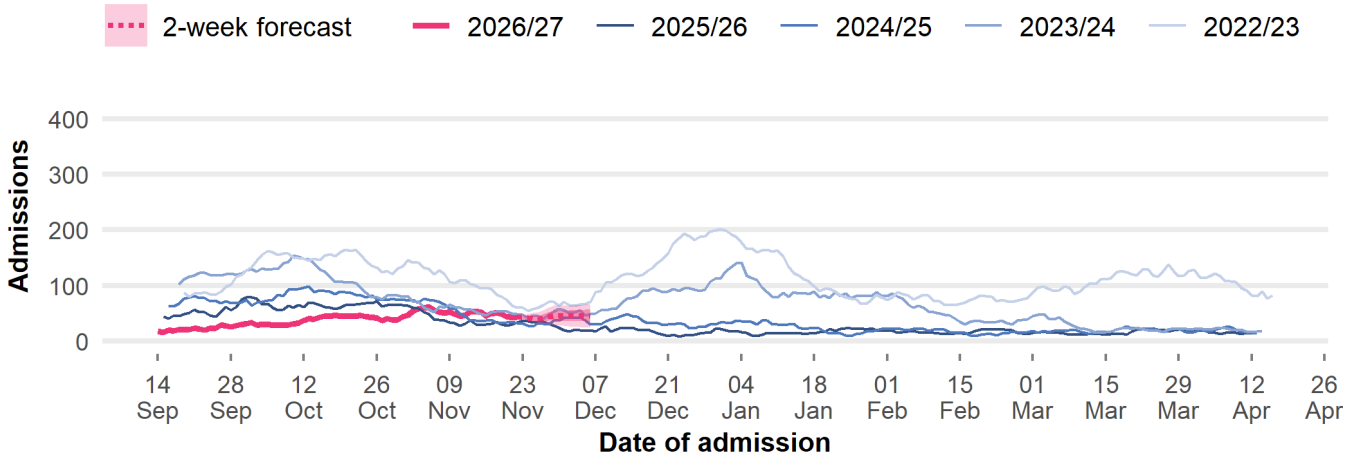


Figure 7.2. Estimates from short-term forecasts of hospital admissions with influenza (7-day rolling sum) across Wales compared with reported admissions for the same date in previous years.

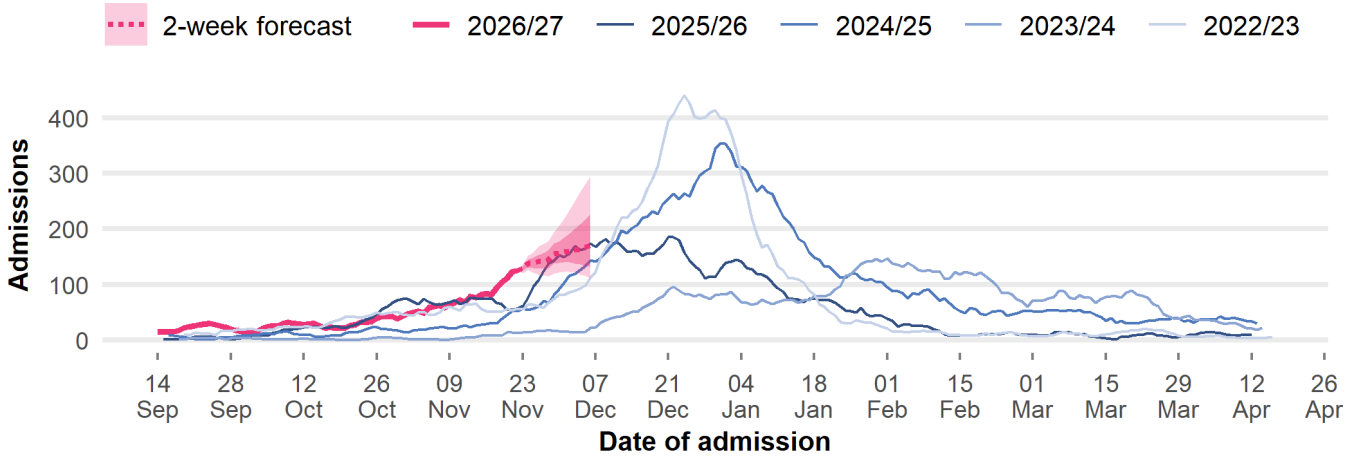
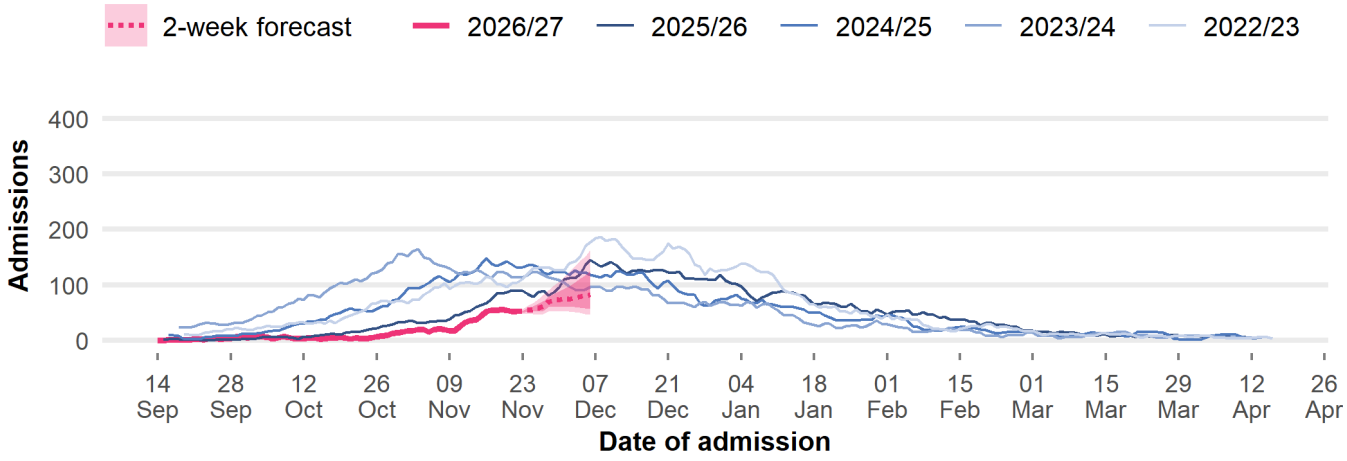


Figure 7.3. Estimates from short-term forecasts of hospital admissions with RSV (7-day rolling sum) across Wales compared with reported admissions for the same date in previous years.



Methodology and caveats

- **Hospital admissions with acute respiratory infections:** 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. This definition intends to capture community-acquired infections and exclude hospital-acquired infections.

- **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.

- **Methodology update:** The absolute threshold used to classify a suggested stable trend of the total admissions has been revised from a change of less than 20% or 10 total admissions in response to user feedback and continuous evaluation. From the week commencing 09/11/2026, the revised threshold is used.

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

8. Influenza vaccination uptake

Data on influenza vaccination coverage come from the Welsh Immunisation System (WIS). Data in Table 8.1 were extracted on 2026-11-24 and include vaccinations given and recorded in WIS up to the end of 2026-11-23.

Table 8.1. Uptake of influenza vaccination in Wales 2026/27 (as of 2026-11-23)

Influenza immunisation uptake in the 2026/27 season	
65 years and older	59.7%
6m to 64y in a clinical risk group	29.1%
Children aged 2 & 3 years	38.2%
Primary school aged children (4 to 10 years)*	45.1%
Secondary school aged children (11-15 years)*	14.8%

*Methods for calculating uptake in school aged children has changed for the 2026/27 season. Caution should be used when comparing estimated uptake to previous years, especially while school vaccination sessions are ongoing.

9. Estimates of 2025/26 influenza vaccine impact and effectiveness.

End of season estimates of influenza vaccine effectiveness against laboratory confirmed influenza were estimated using a test-negative design in those presenting to GP practices across England, Scotland, Wales and Northern Ireland. Estimated overall adjusted vaccine effectiveness for the 2025/26 season was 21.4% (95% CI 4.8% to 35.2%) in those aged 65 years and above, 32.2% (95% CI 22.3% to 40.9%) in those aged 18 to 64 years and 51.6% (95% CI 43.3% to 58.7%) in two- to 17-year-olds.

The effectiveness of vaccination in the 18-to-64-year age group against hospitalisation in England was 21.7% (95% CI 16.5% to 26.7%). In those aged two to 17 years of age effectiveness was 67.9% (95% CI: 64.6% to 71.0%). The overall effectiveness in the 65 years and over age group was 29.1% (95% CI: 25.9% to 32.2%)

https://www.gov.uk/government/statistics/influenza-in-the-uk-annual-epidemiological-report-winter-2025-to-2026/influenza-in-the-uk-annual-epidemiological-report-winter-2025-to-2026#vaccination

10. International Summary

Influenza activity – UK and international summary

- GP ILI consultations increased to 9.0 per 100,000 in England, to 13.3 per 100,000 in Northern Ireland and to 5.1 per 100,000 in Scotland in Week 46.
- During Week 46, 5,156 sentinel samples tested for influenza were reported in England of which 588 were positive for influenza (397 influenza A (not subtyped), 7 influenza A (H3N2), 166 influenza A (H1N1)pdm09, and 20 influenza B).
- Overall, influenza increased to 11.4% in England, and to 13.8% in Northern Ireland, and to 13.8 % in Scotland in Week 46.
- 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 11% in Week 46.
- There were 301 confirmed influenza virus infection detections reported from sentinel primary care, all influenza type A viruses; and among those subtyped the majority was A(H1N1)pdm09 (94%).
- Of the 16 countries and areas reporting on influenza intensity, none reported medium intensity or higher.
- Source: European Respiratory Virus Surveillance Summary (ERVISS): https://erviss.org/

- **Globally**, influenza detections remained low in week 44 with influenza A virus detections predominant.
- In the northern hemisphere, influenza percent positivity was elevated (>10%) in some countries in Central America and the Caribbean, Northern Europe and Southern and Eastern Asia and in a single countries in Eastern Europe and Western, Middle and Eastern Africa. Percent positivity was over 30% in some countries in Central America and the Caribbean, Western, Southern and South-East Asia and in single countries in Western and Eastern Africa. Increases in activity were observed in some countries in Central America and the Caribbean, South West Europe and Southern Asia and in single countries in Northern Europe, Middle Africa and Eastern Asia.
- In the southern hemisphere, influenza percent positivity was elevated (>10%) in some countries in Tropical South America and Oceania and in single countries in Temperate South America and Eastern Africa. Percent positivity was over 30% in a single country in South-East Asia. An increase in activity was observed in one country in Tropical South America.
- In the zones with elevated positivity, influenza A(H1N1)pdm09 was predominant in Northern Europe, Eastern Africa, Western and South-East Asia, and Oceania and influenza A(H1N1)pdm09 and A(H3N2) were codominant in Eastern Asia. Influenza A and B were codominant in Central America and the Caribbean, Temperate South America and Southern Asia and influenza B was predominant in Tropical South America, Western and Middle Africa.
- 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 at 25/11/2026) during Week 45 globally there were 4,971 A(H1N1), 241 A(H3), 16,152 A(not subtyped), 1 A9H5), 1,297 influenza B(not determined), 303 influenza B(Victoria) **Source:** WHO Virus detections by subtype reported to FluNet: Microsoft Power BI

Update on influenza activity in North America

- The USA Centers for Disease Control and Prevention (CDC) report that influenza activity levels were low but increasing in many parts of the country during Week 45 (ending 14/11/2026). Nationally, 7,269 (11.8%) out of 61,838 specimens have tested positive for influenza in Week 45 in clinical laboratories nationwide, of these positive samples, 7,209 (99.2%) were influenza A and 4760 (0.8%) were influenza B. Further characterisation has been carried out on 1,240 specimens by public health laboratories, and 613 samples tested positive for influenza; 352 influenza A(H1N1)pdm09, 12 influenza A(H3N2), 365 influenza A(not subtyped), 1 A(H5) and 12 influenza B. **Source:** CDC Weekly US Influenza Surveillance Report: FluView | FluView | CDC

- The Public Health Agency of Canada reported that during Week 45 2026 (ending 14/11/2026), influenza activity has increased in recent weeks. During Week 45 2026, 4769 (14.5% positivity) influenza detections were reported: 4,716 influenza A and 53 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 44, 2026 (latest data available). **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 15th October 2026, Saudi Arabia reported 8 MERS-CoV cases from 01 January 2026 to 05 October 2026, including 1 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