Llywodraeth Cymru
Welsh Government

Yr Is-adran Gwyddoniaeth, Ymchwil a Thystiolaeth
Science Research Evidence Division
Y Grŵp Iechyd, Gofal Cymdeithasol a'r Blynyddoedd Cynnar
Health, Social Care and Early Years Group

Weekly Surveillance Report

13th March 2026

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This report is produced by the Science Research Evidence Division (SRE) (previously Science Evidence Advice Division (SEA))

Science Research Evidence: Weekly Surveillance Report

A. Top Line Summary (as at week 10 2026, up to 08 March 2026)

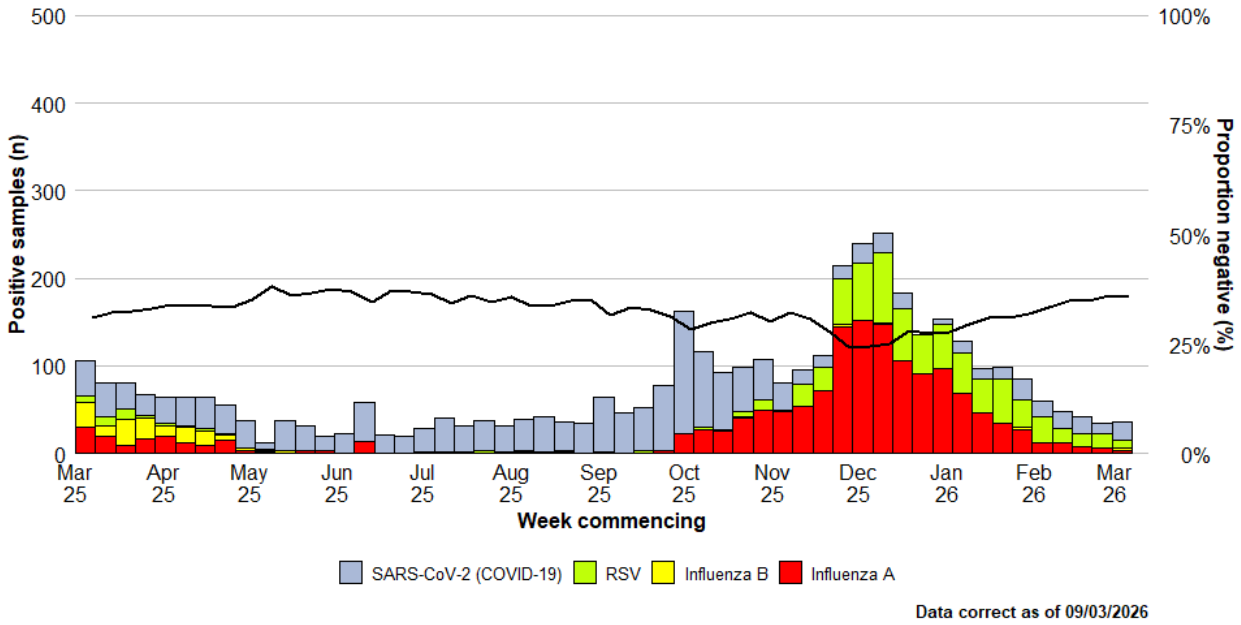
- COVID-19 confirmed case admissions to hospital **decreased**.
- COVID-19 cases who are inpatients have **remained the same**.
- RSV activity in children under 5 years has **increased** slightly.
- Influenza in-patient cases and admissions have **remained stable** in the latest week.
- Norovirus confirmed cases have **decreased** in the most recent week (week 10).
- Whooping Cough notifications have **increased** in week 9 (the most recent reporting week).
- Scarlet Fever notifications **increased** in the most recent week, (week 10).

B. Acute Respiratory Infections Situation Update

B1. COVID-19 Situation Update

- At a national level, the weekly number of confirmed cases of community-acquired admissions to hospital **decreased** and the number of cases who were inpatients **remained stable** in week 10 2026 (to 08 March 2026).
- As of 08 March 2026 (week 10), the number of confirmed cases of community acquired COVID-19 admitted to hospital **decreased** to 12 (14 in the previous week) and there were **95** in-patient cases of confirmed COVID-19, none of whom were in critical care compared to 95 and 2 in the previous week.
- Confirmed cases of positive tests remained stable at 3.4% in hospital and non-sentinel GP practices in the most recent week. Consultations with Sentinel GPs for COVID-19 have decreased.
- In the last six weeks, Omicron PQ.2* is the most frequently detected Pango lineage group in Wales currently, accounting for **21.5%** of sequenced cases.

Figure 1: Samples from hospital patients submitted for RSV, Influenza and SARS-CoV2 testing only, by week of sample collection, week 10, 2025 to Week 10, 2026. (source: PHW)



COVID-19, Respiratory Syncytial Virus (RSV) and Influenza Short Term Projections

The Science Research Evidence (SRE) team at Welsh Government have produced short term projections (STPs) for COVID-19, RSV and Influenza at national and Local Health Board levels. RSV STPs are also produced by age groups nationally. STPs project 2 weeks forward using current data covering the previous 8 weeks, and do not explicitly factor in properties of the infectious disease, policy changes, changes in testing, changes in behaviour, emergence of new variants or rapid changes in vaccinations.

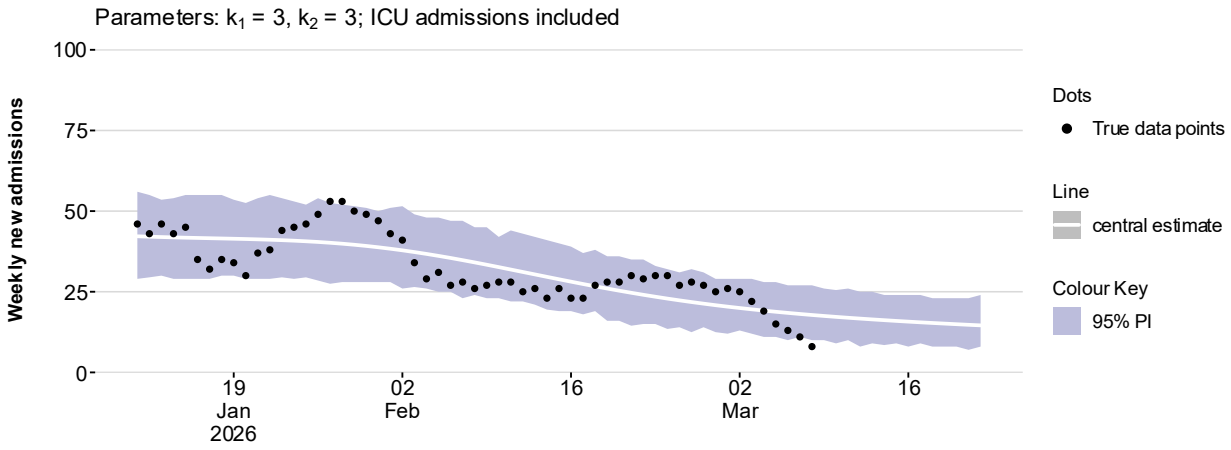
SRE previously reported on the trends of the central estimates. From December 2025, in line with PHW, the difference between the most recent observed data (7 day rolling sum) and the projected central estimate 2 weeks later is reported on.

STP computations uses admissions data from PHW until **08 March 2026** to make short term projections for COVID-19 two weeks forward **(to 22 March 2026)**. The black or brown dots in the charts represent the most recent observed data (7 day rolling sum) points while the white line is the central estimate from the most recent projection. The colour shadings represent the 95% confidence interval of the projections.

Please note: The STPs are produced nationally and at the provider health board level, not at resident health board level. Powys health board is not included in the analysis due to low numbers.

The STPs for Wales show that COVID-19 admissions are projected to plateau over the next two-week period (Figure 2).

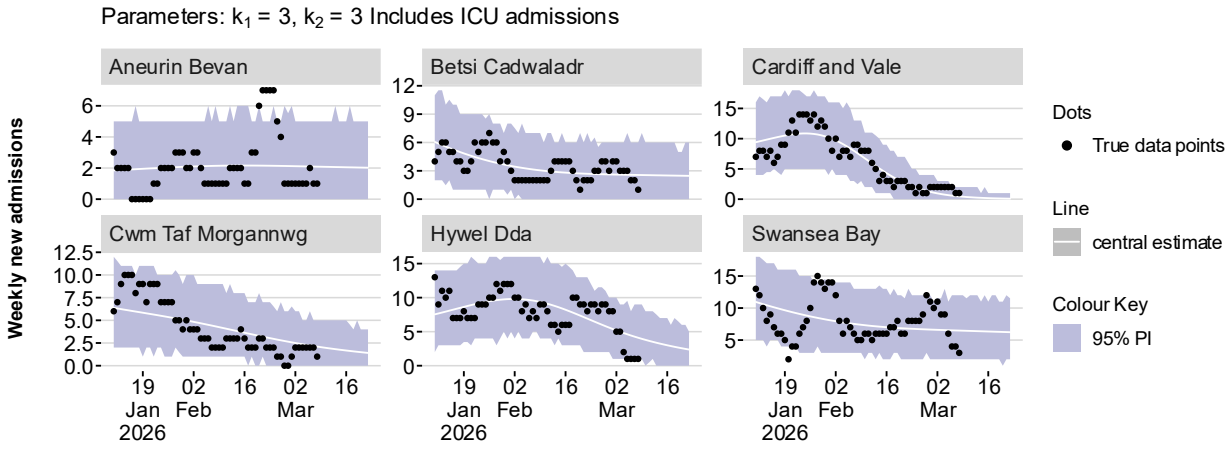
Figure 2: Short Term Projection for COVID-19 hospital admissions in Wales (data to 08 March 2026, projection to 22 March 2026)



Source: Public Health Wales

Figure 3 shows that COVID-19 admissions are projected to decrease or plateau in health boards in Wales over the next two weeks.

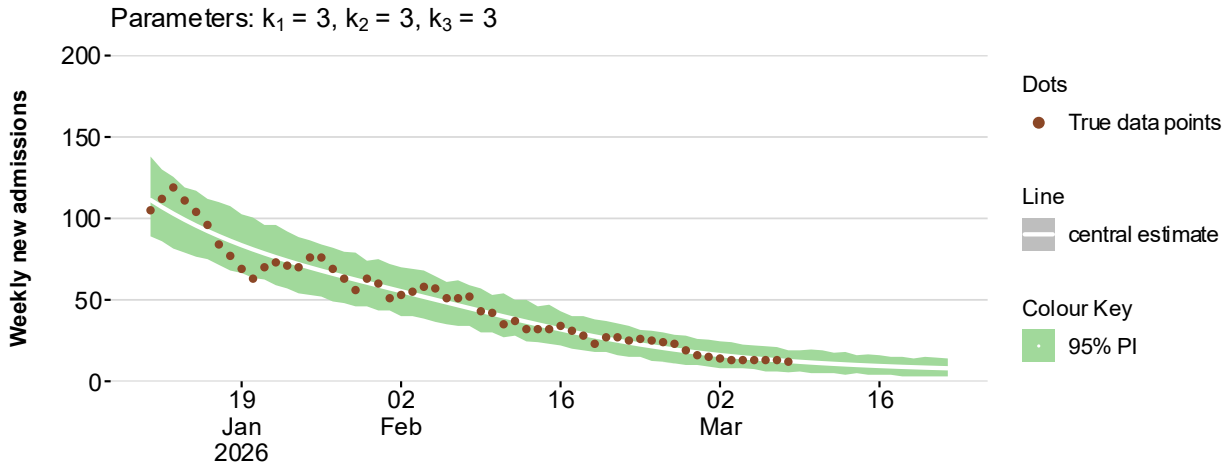
Figure 3: Short Term Projections for COVID-19 hospital admissions in Wales Health Boards (data to 08 March 2026, projection to 22 March 2026)



Source: Public Health Wales

The STPs for Wales show that RSV admissions are projected to plateau over the next two-week period (Figure 4).

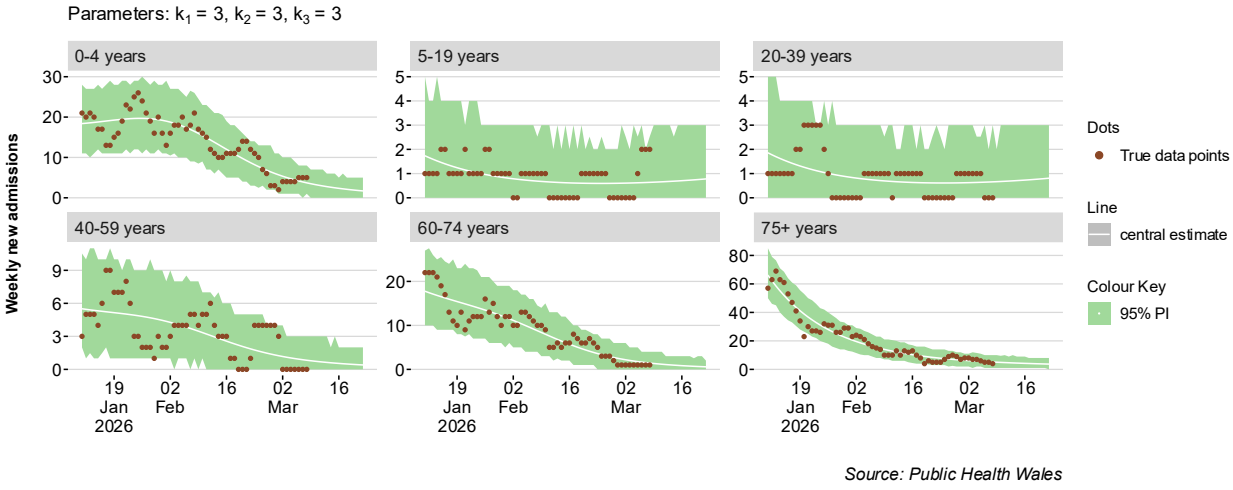
Figure 4: Short Term Projection for RSV hospital admissions in Wales (data to 08 March 2026, projection to 22 March 2026)



Source: Public Health Wales

Figure 5 shows that RSV admissions for all age groups are projected to decrease or plateau over the next two weeks **(to 22 March 2026)**.

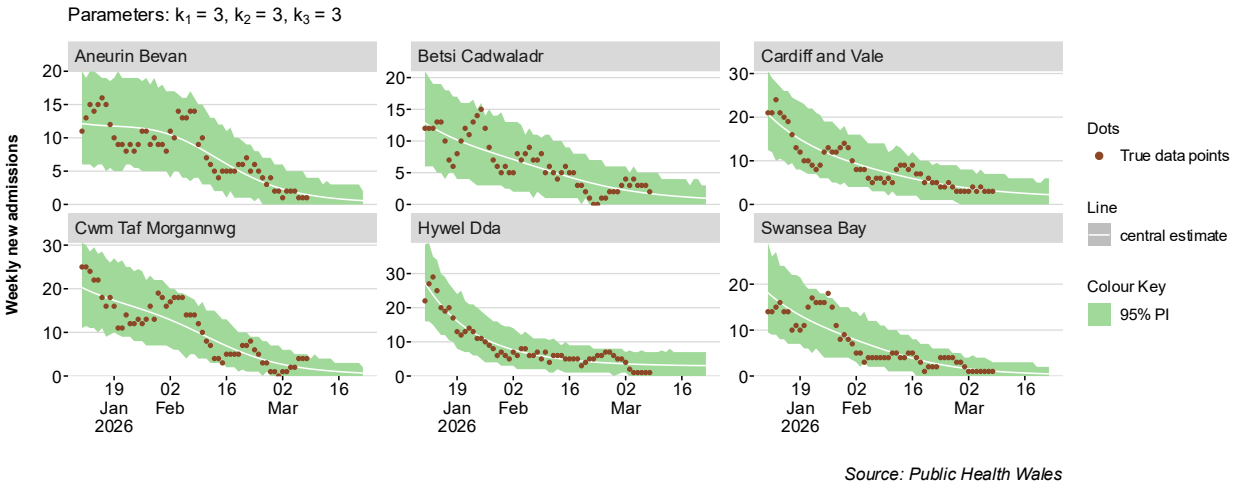
Figure 5: Short Term Projections for RSV hospital admissions in Wales by age groups (data to 08 March 2026, projection to 22 March 2026)



Source: Public Health Wales

Figure 6 shows that RSV admissions are projected to decrease or plateau over the next two weeks **(to 22 March 2026)**.

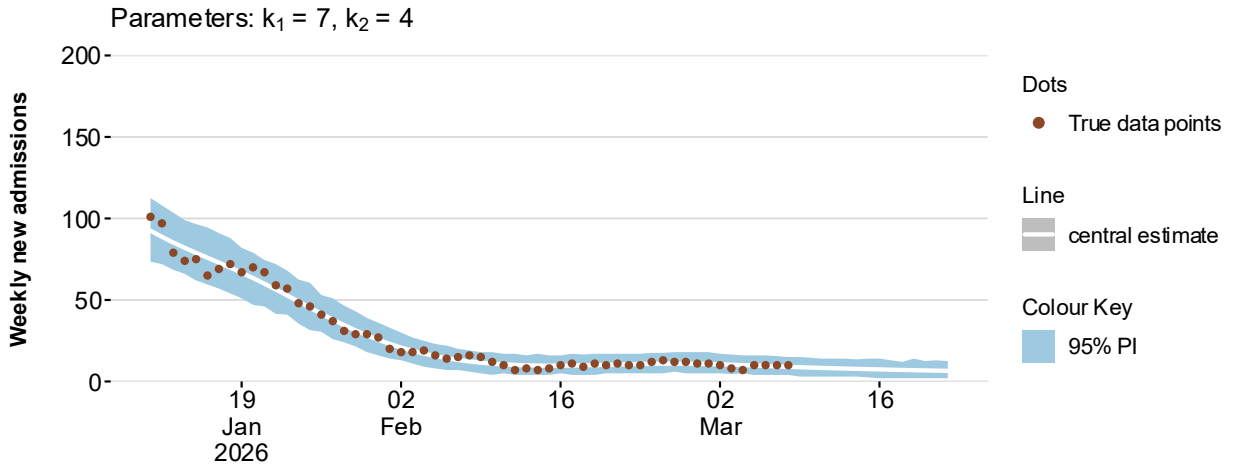
Figure 6: Short Term Projections for RSV hospital admissions in Wales Local Health Boards (data to 08 March 2026, projection to 22 March 2026)



Source: Public Health Wales

The STPs for Wales show that Influenza admissions are projected to plateau over the next two week period (Figure 7).

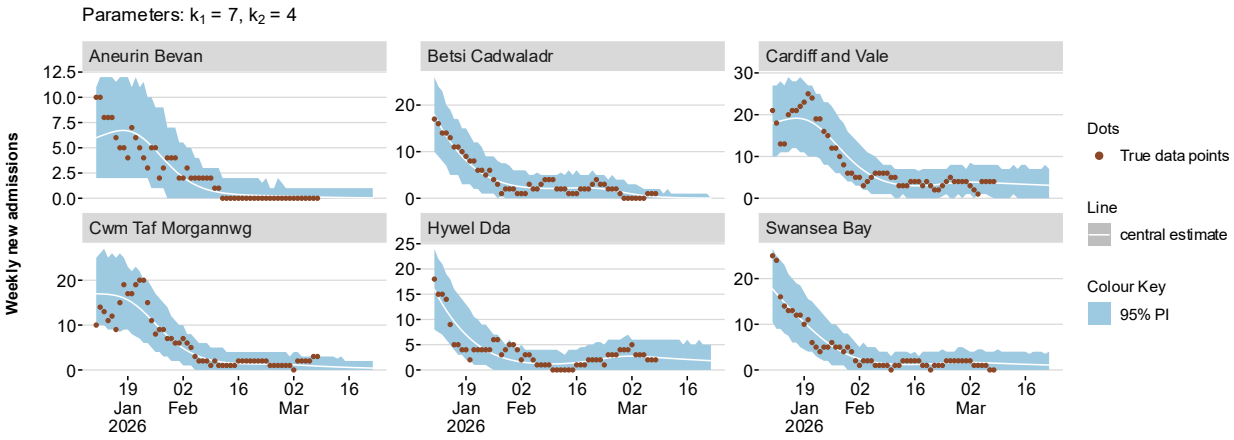
Figure 7: Short Term Projection for Influenza hospital admissions in Wales (data to 08 March 2026, projection to 22 March 2026)



Source: Public Health Wales

Figure 8 below shows that Influenza admissions are projected to plateau in health boards in Wales over the next two weeks.

Figure 8: Short Term Projections for Influenza hospital admissions in Wales Local Health Boards (data to 08 March 2026, projection to 22 March 2026)

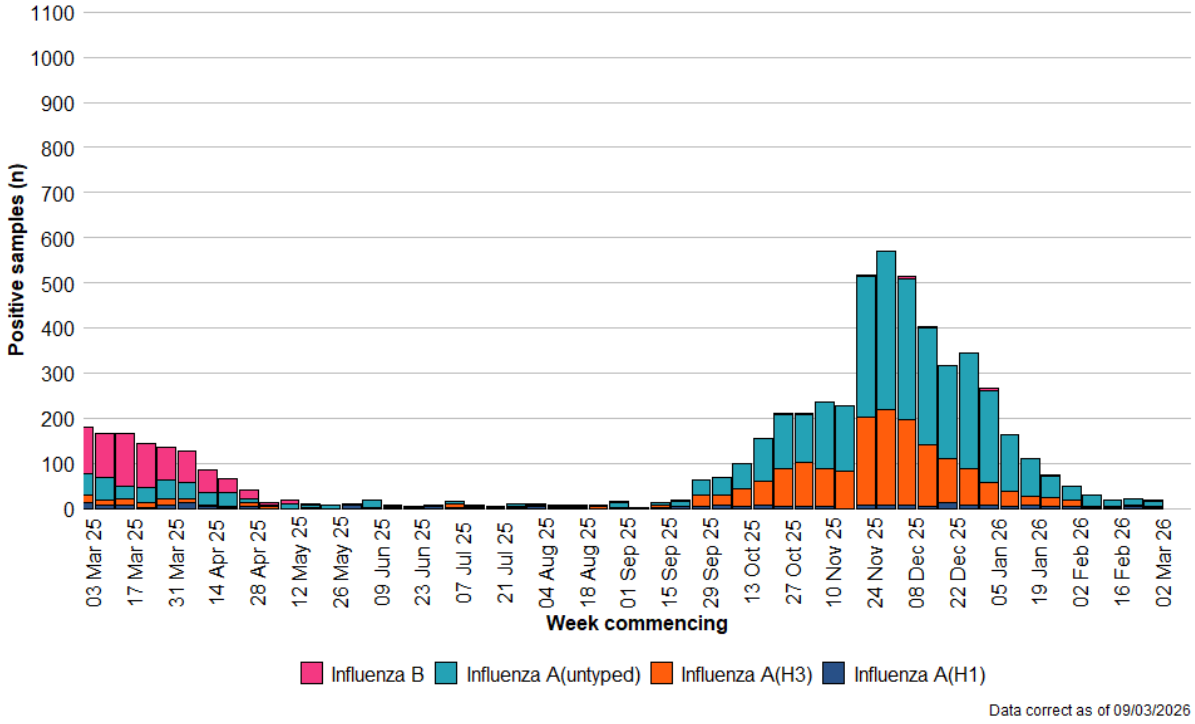


Source: Public Health Wales

B.2. Influenza Situation Update

- Overall, influenza activity is at baseline intensity levels. Test positivity remained stable and confirmed cases have decreased in the most recent week compared to last week. 1 case of influenza were confirmed from symptomatic sentinel GP network patients across Wales last week. Influenza A untyped is the most frequently detected influenza virus in Wales, accounting for the majority of cases.
- Confirmed cases of community acquired influenza admitted to hospital increased to **14** in the current week (**9** in the previous week). Test positivity remained stable at **1.2%**.
- There were **20** in-patient cases of confirmed influenza, **1** of whom was in critical care compared to **23** and **1** in the previous week.
- In week 10, 2026, there were 3 influenza A(H3), 2 influenza A(H1N1), 10 influenza A untyped and 4 influenza B (Figure 9).

Figure 9: 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 (source: PHW)



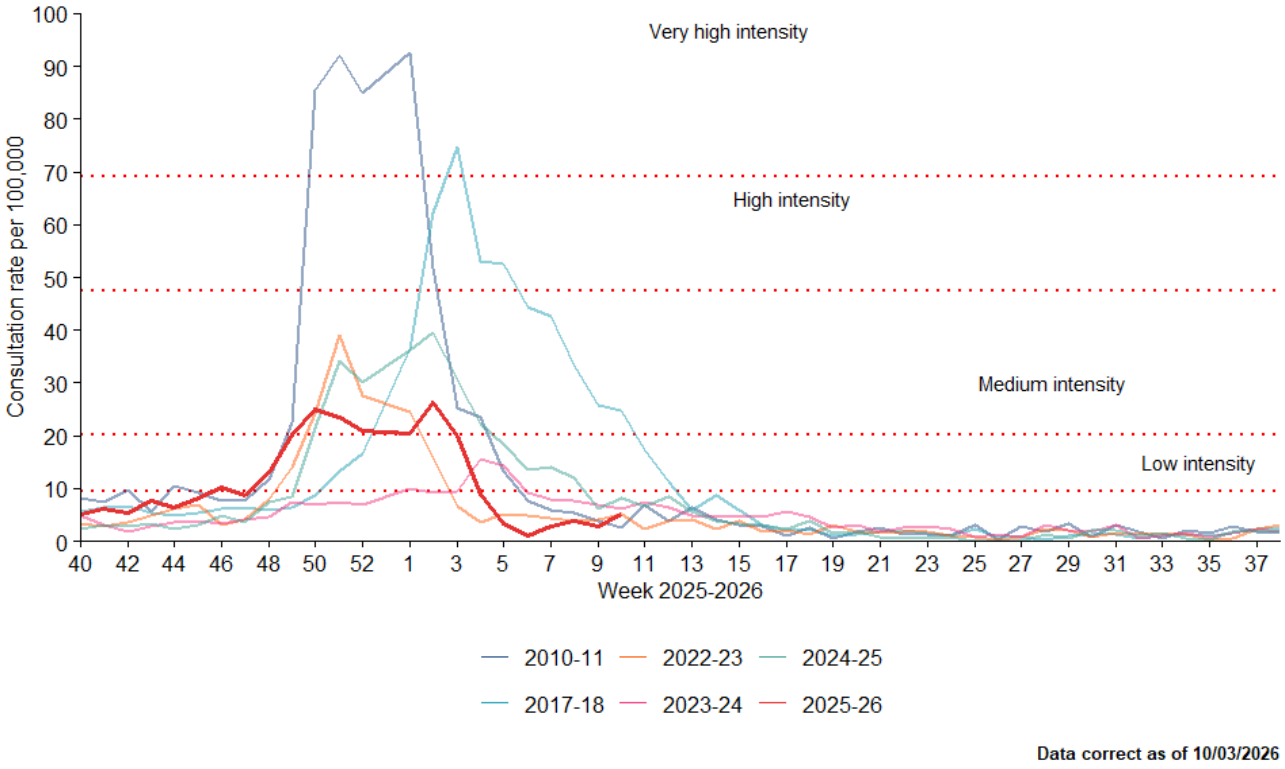
The sentinel GP consultation rate for influenza-like illness (ILI) is at baseline levels and the three-week trend is variable.

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. The highest rates were found in people aged under 1 year (1,008.3) followed by people aged 1 to 4 (598.1) and people aged 5 to 14 (147.6).

Surveillance indicators for acute respiratory infections in GP consultation data in Wales are decreasing in people aged under 5 years.

Figure 10: Clinical consultation rate for ILI per 100,000 practice population in Welsh sentinel practices (source: PHW)

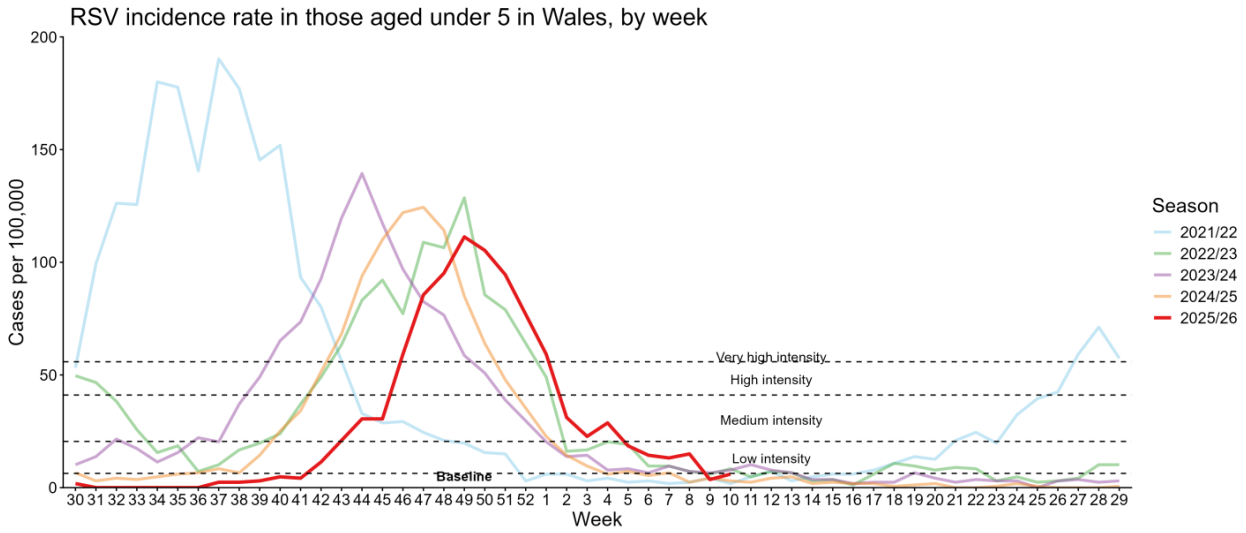


B.3. Respiratory Syncytial Virus (RSV) update

The number of confirmed cases of community acquired RSV admitted to hospital decreased to **12** during week 10.

RSV incidence per 100,000 in children aged up to 5 years **increased** to **15** in Week 10 (3.6 in the previous week) and is currently at Low intensity levels. During week 10 there were **51** in-patient cases of confirmed RSV, and **none** in critical care.

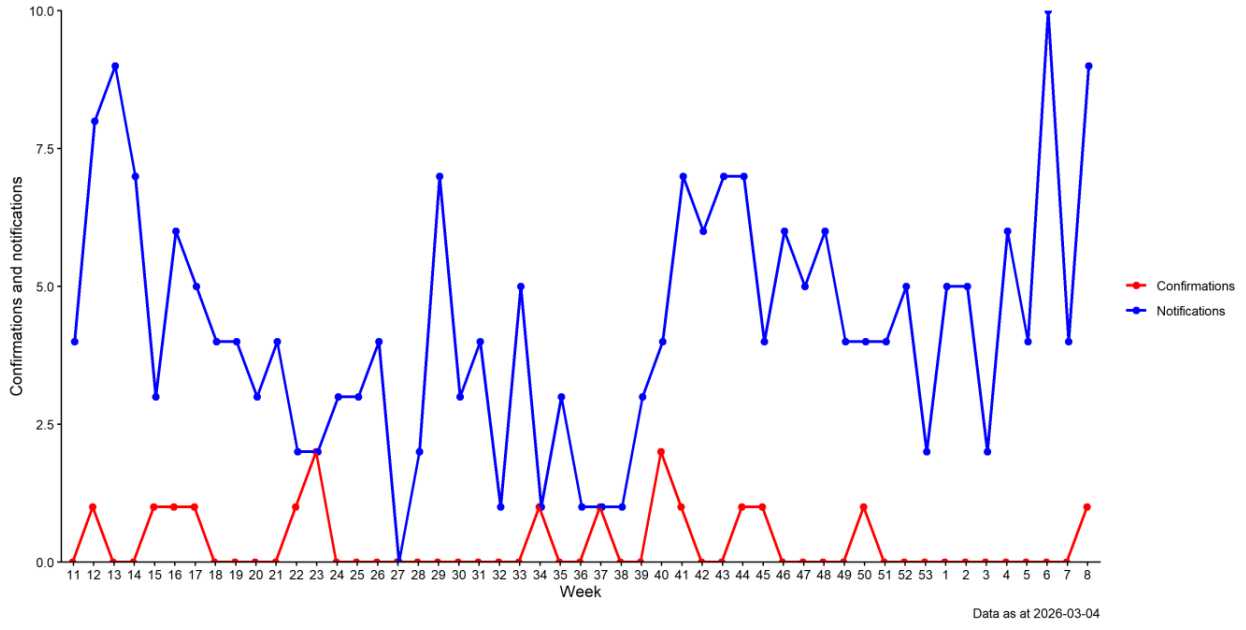
Figure 11: RSV Incidence Rate per 100,000 population under 5 years, weeks 30 2020 to Week 10 2026 (source: PHW)



B.4. Whooping Cough (Pertussis)

Figure 12 below shows that whooping cough notifications up to week ending 01/03/2026 ***increased***. Lab confirmations are at low levels (*Whooping cough is now reported on every two weeks*).

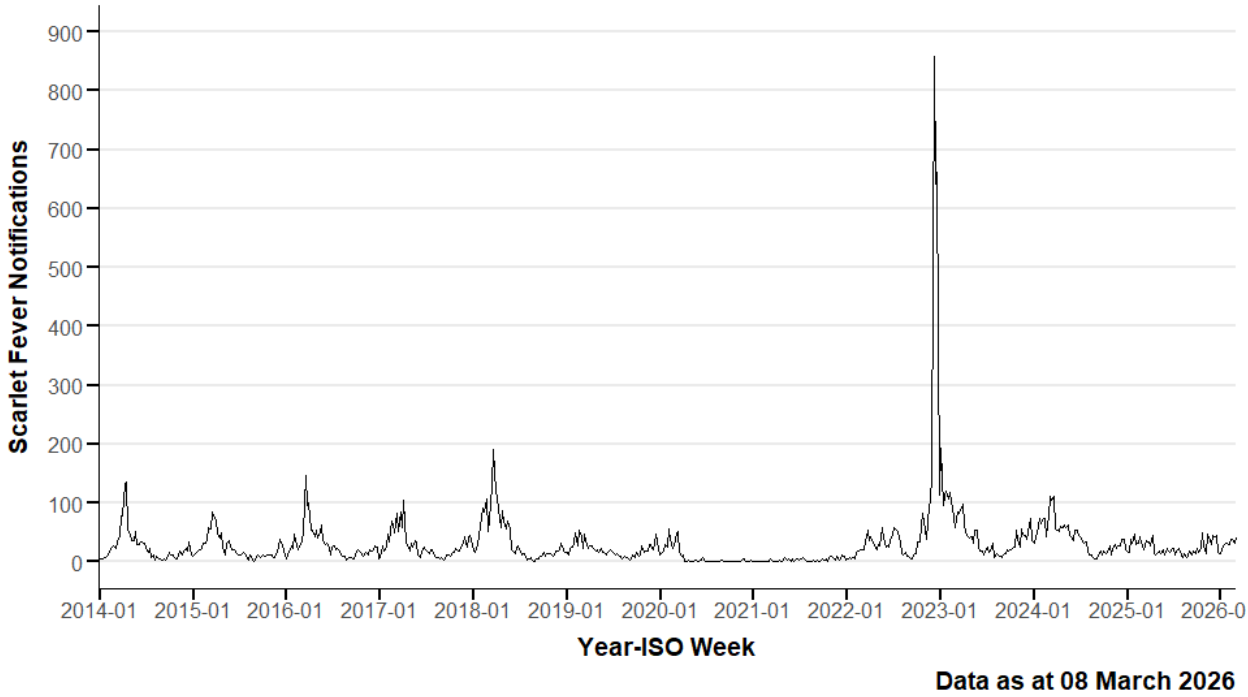
Figure 12: Weekly notifications and confirmations of Pertussis/Whooping Cough in Wales. (Source: PHW)



B.5 iGAS and Scarlet Fever

The number of iGAS notifications is currently low, remaining at seasonally expected levels. Scarlet Fever notifications have been **increasing**, though still remaining in a narrow range, in recent weeks as shown in the figure below.

Figure 13: Rolling 3 Week Average Scarlet Fever Notifications, 2014-2026, Wales (source: PHW)



B.6 Additional indicators

- The number of ambulance calls recorded referring to syndromic indicators decreased from **1,520** in the previous week to **1,519** in the latest reporting week.
- During Week 10, 2026, no ARI outbreaks were reported to the Public Health Wales Health Protection Team.
- Thus far this season, According to European Mortality Monitoring (EuroMoMo) methods, no excess has been reported in the weekly number of deaths from all causes in Wales.

C. Science, Research Evidence Winter Modelling

The Science Research Evidence (SRE) team in Welsh Government have published modelled scenarios for COVID-19, RSV and Influenza for winter 2025-26.

This uses analysis of historical data to estimate what we may see in winter 2025/26 in terms of hospital admissions and hospital bed occupancy in Wales, contributing to winter planning for NHS Wales.

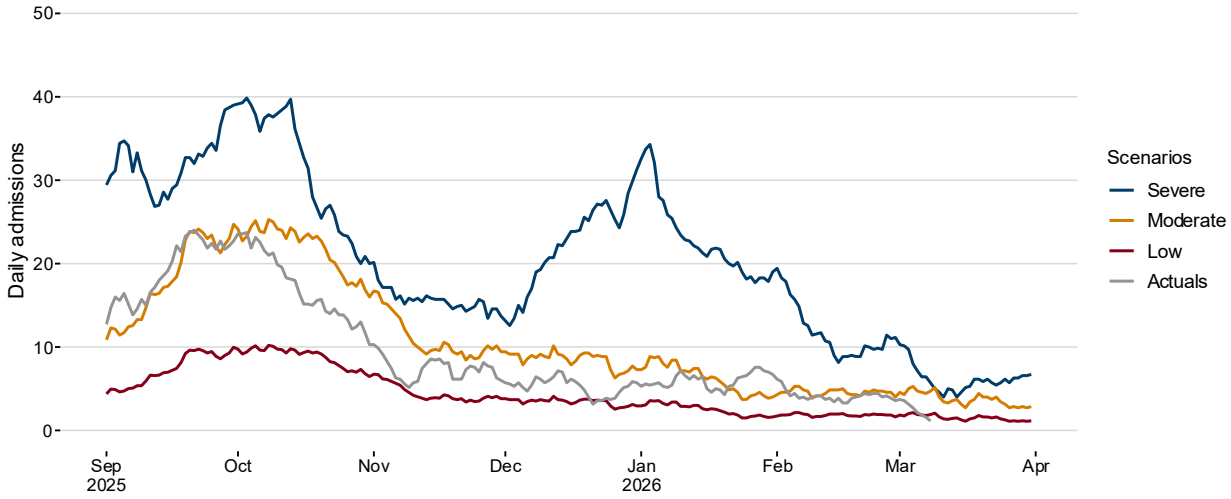
The charts that follow (Figures 14-16) show estimates of hospital admissions occurring so far in winter 2025/26 using actual data and these are compared to our 2025/26 winter modelling scenarios. (See the technical notes at the end of section **C. Science Research Evidence Winter Modelling** for details on how the 'actuals' were estimated).

Note that modelling is an estimate of what may happen, not a prediction of what will happen.

COVID-19

COVID-19 admissions are decreasing and are currently tracking around the Low scenario.

Figure 14 Daily COVID-19 Winter 2025-26 admissions scenarios, modelling to 31 March 2026 (most recent observed data (7 day rolling sum) until 08 March 2026)



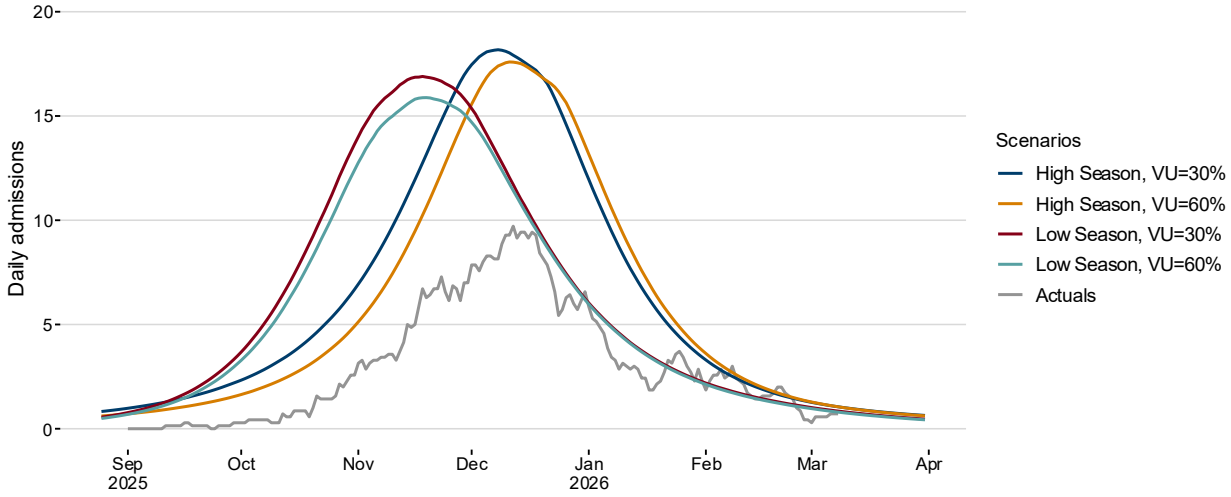
Source: historical data to 31 March 2025 provided by DHCW, projected scenarios from 1 September 2025 to 31 March 2026 from SRE, most recent observed data (7 day rolling sum) until 8 March 2026 from PHW.

Notes: Scenarios repeat previous year's data from Digital Health and Care Wales. Includes ICD-10 codes U071, U072, U099, U109.

RSV

RSV admissions (ages 0-4 years) actuals are increasing and track with all scenarios (since all scenarios have now converged).

Figure 15: Daily RSV Winter 2025-26 paediatric (ages 0-4) admissions scenarios, modelling to 31 March 2026 (most recently observed data (7 day rolling sum) data until 08 March 2026)

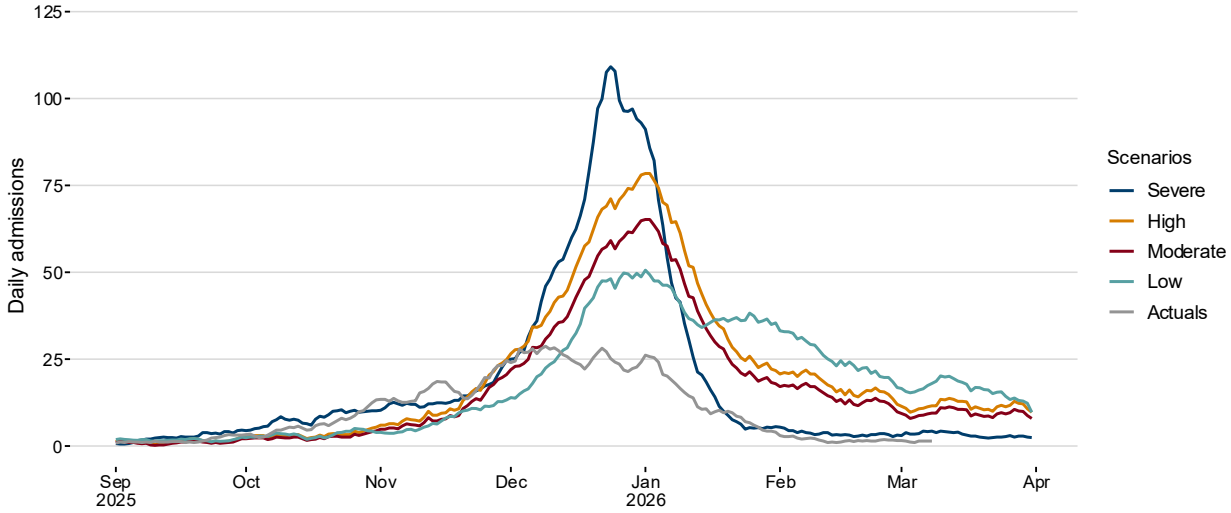


Source: historical data to 31 March 2025 provided by DHCW, projected scenarios from 1 September 2025 to 31 March 2026 from SRE, most recent observed data (7 day rolling sum) until 8 March 2026 from PHW.

Influenza

Influenza (flu) admissions actuals are approximately flat and are currently tracking below all scenarios.

Figure 16: Daily flu and pneumonia Winter 2025-5 admissions scenarios, modelling to 31 March 2026 (most recently observed data (7 day rolling sum) until 08 March 2026)



Source: historical data to 31 March 2025 provided by DHCW, projected scenarios from 1 September 2025 to 31 March 2026 from SRE, most recent observed data (7 day rolling sum) until 8 March 2026 from PHW.

Technical Notes

The winter modelling used hospital admissions data from the Patient Episode Data for Wales (PEDW) dataset provided by Digital Health and Care Wales (DHCW). However, due to a lag in clinical coding and receiving

PEDW data from DHCW, the ICNET admissions data provided by Public Health Wales (PHW) were used for the actuals. The data sources differ for a few reasons: the flu and RSV data from PHW includes lab-confirmed results only and includes inpatients only. The PEDW data from DHCW is based on International Classification of Diseases version 10 (ICD-10) codes.

Modelling scenario details:

- **COVID-19**: Data includes ICD-10 codes U071, U072, U099, U109. Two scenarios repeat recent year's data from Digital Health and Care Wales, and one is calculated by applying a statistical technique.

Names of COVID-19 scenarios and the statistical model applied

Scenario name	Technique
Severe	Repeat of 2023/2024 data
Moderate	Repeat of 2024/2025 data
Low	SARIMA

- **RSV**: Data includes ICD-10 codes J121, J205, J210, B974.

Names of RSV scenarios, model assumptions

Scenario name	Reference Season	Vaccine uptake (VU)
High season, VU= 30%	2022/23 winter	30%
High season, VU= 60%	2022/23 winter	60%
Low season, VU= 30%	2023/24 winter	30%
Low season, VU= 60%	2023/24 winter	60%

- **Flu**: Data includes ICD-10 codes J09X, J100 to J102, J110, J108, J111, J112, J118.

Names of influenza scenarios and the statistical models applied

Scenario name	Technique
Severe	Repeat of 2022/23 data
High	Repeat of 2024/25 data
Moderate	SARIMA
Low	ETS

D. Communicable Disease Situation Update (non-respiratory)

D.1 Norovirus

In the current reporting week (week 10 2026), a total of **56** Norovirus cases were reported in Welsh residents. This is a *decrease* **(-17.6%**) in reported cases compared to the previous reporting week (week 9 2026), when **68** Norovirus cases were reported.

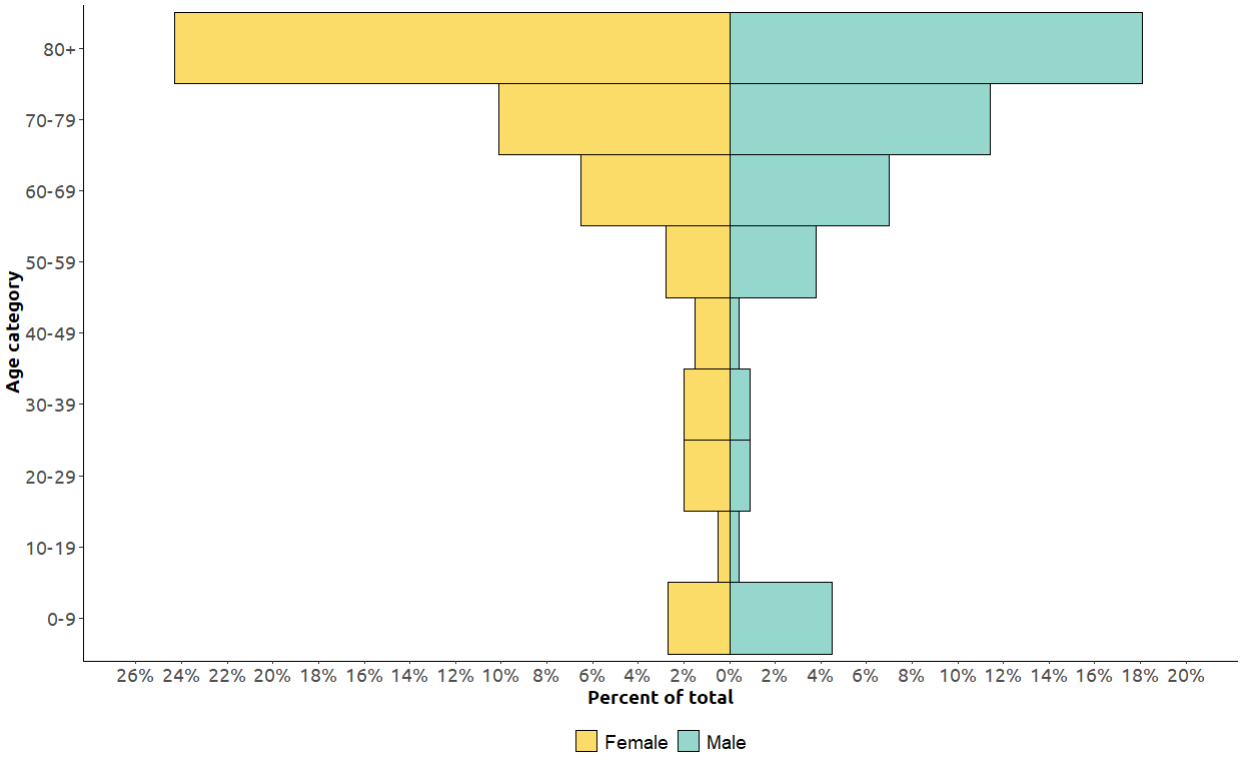
In the last 12-week period (15/12/2025 to 08/03/2026) a total of **740** Norovirus cases were reported in Welsh residents. This is an ***increase*** (60.5%) in reported cases compared to the

same 12-week period in the previous year (15/12/2024 to 08/03/2025) when **461** Norovirus cases were reported.

Taken from Norovirus page 7, initially was on page 6

In the last 12 weeks (15/12/2025 to 08/03/2026) **389** (52.6%) Norovirus cases were female and **351** (47.4%) cases were male. The age groups with the most cases were the **80+** (**314** cases) and 70-79 (**159** cases) age groups.

Figure 17: Age and sex distribution of confirmed Norovirus cases in the last 12 weeks (15/12/2025 to 08 March 2026)



Notes: This data from PHW only includes locally-confirmed PCR positive cases of Norovirus in Wales within the 12-week period up until the end of the current reporting week, week 10 2026 (15/12/2025 to 08/03/2026). Under-ascertainment is a recognised challenge in norovirus surveillance with sampling, testing and reporting known to vary by health board. In addition, only a small proportion of community cases are confirmed microbiologically.

E. UK and International Surveillance Update

E.1 Updates on Avian Influenza in the UK (up to 11th March 2026)

11 March 2026

Following successful completion of disease control activity and surveillance in the zone around a premises near Mundford, Breckland, Norfolk (AIV 2026/07) the 1km Low Pathogenic Avian Influenza Restricted Zone has been revoked.

5 March 2026

Following successful completion of disease control activities and surveillance in the zone around a premises near Needham Market, Mid Suffolk, Suffolk (AIV 2026/12), the 10km surveillance zone has been revoked.

3 March 2026

Highly pathogenic avian influenza (HPAI) H5N1 was confirmed at a premises near Pickering, Thirsk and Malton, Yorkshire on 3 March 2026.

A 3km protection zone and 10km surveillance zone were declared. All birds on the premises will be humanely culled.

2 March 2026

Following successful completion of disease control activities and surveillance in the zone around a premises near Newington, Swale, Kent (AIV 2025/71), the 3km Captive Bird (Monitoring) Controlled Zone has been revoked.

28 February 2026

Following successful completion of disease control activities and surveillance in the zone around a second premises near Bacton, Mid Suffolk, Suffolk (AIV2026/10), the 3km protections zone and 10km surveillance zones have been revoked.

Following successful completion of disease control activities and surveillance in the zone around a premises near Bacton, Mid Suffolk, Suffolk (AIV 2026/09), the captive bird (monitoring) controlled zone has been revoked.

27 February 2026

Following successful completion of disease control activities and surveillance in the zone around the following premises, the 10km surveillance zones have been revoked around:

- a second premises near York, York, North Yorkshire (AIV2026/05)
- a third premises near York, York, North Yorkshire (AIV 2026/08)

26 February 2026

Following successful completion of disease control activities and surveillance in the zone around a premises near Needham Market, Mid Suffolk, Suffolk (AIV 2026/12), the 3km protection zone has ended and the area that formed it, becomes part of the surveillance zone.

E.2. Mpox clade Ib and clade IIb recombinant strain (14 February)

On 14 February 2026, WHO published a Disease Outbreak News (DON) Item summarising two cases of mpox infected by a clade Ib and clade IIb recombinant strain of monkeypox virus (MPXV) (WHO Disease Outbreak News "Mpox: recombinant virus with genomic elements of clades Ib and IIb – Global situation", 14 February 2026). The cases were reported by the United Kingdom and India in December 2025 and January 2026, respectively. Both cases had travel history albeit to different areas. The case reported by the UK had travel history to the Asia Pacific region in October 2025 and was reported by the UKHSA in December 2025 (New mpox strain identified in England - GOV.UK, 8 December 2025). The case reported by India had travel history to the Arabian Peninsula in and presented symptoms in September 2025. The cases had clinical presentation that was consisted with clade I and clade II (non-recombinant infections). The virus from the patient from India was reclassified as the recombinant when comparison with the UK recombinant strain was possible. Phylogenetic analysis showed >99.9% similarity between the recombinant strain from India and the recombinant strain from the UK.

According to WHO, the case in India is the earliest detection of the recombinant strain that has been reported so far. The DON notes that given the current transmission of clade I and clade II across sexual networks in many countries and settings, co-infection can be expected as well as that the origin of the recombinant virus remains unknown and the transmission of the recombinant virus already involves at least four countries in three WHO regions. Other conclusions about transmissibility or clinical characterisation of mpox due to recombinant virus cannot be currently made.

E.3. SARS-CoV-2 variant classification (8 March)

Since the last update on 30 January 2026, and as of 27 February 2026, no changes have been made to ECDC variant classifications for variants of concern (VOC), variants of interest (VOI), variants under monitoring (VUM) or De-escalated variants. An increase in detections of BA.3.2 has been observed in two EU/EEA countries in recent weeks, with the variant circulating at a proportion greater than 40% in Germany and the Netherlands in week 1, 2026. However, estimates are subject to considerable uncertainty due to low levels of SARS-CoV-2 circulation and low numbers of sequence submissions, with no recent submissions belonging to BA.3.2 for weeks 6–7 2026.

Low SARS-CoV-2 transmission, reduced reporting and low testing volumes in sentinel systems all have an impact on ECDC's ability to accurately assess the epidemiological situation, including variant circulation.

The EU/EEA population overall has a significant level of hybrid immunity (prior infection plus vaccination/boosters), conferring protection against severe disease. The variants currently circulating that are classified as VOI or VUM are unlikely to be associated with any increase in infection severity compared with previously circulating variants, or a reduction in vaccine effectiveness against severe disease. However, older adults (aged 65 years old and above), those with underlying conditions, and people who have previously not been infected could develop severe symptoms if infected. Vaccination continues to be protective, with stronger protection against more severe disease, although this protective effect wanes over time. Vaccination of people at high risk of severe outcomes (e.g. older adults) remains important.

E.4. Avian influenza A(H9N2) – Multi-country (World) – Monitoring human cases (10 February)

According to the Hong Kong Centre for Health Protection's Avian Influenza Report from 10 February 2026, two human infections with avian influenza A(H9N2) were reported in China. The first case was in a 73-year-old woman from Guangdong Province who developed symptoms on 17 January 2026. The second case was in a two-year-old boy from Hunan Province with symptom onset on 29 December 2025. No further epidemiological information was provided for either case.

Background:

Overall, 195 human cases of avian influenza A(H9N2), including two deaths, have been reported since 1998 from 10 countries. Since 2015, China has reported 154 human cases of avian influenza A(H9N2) virus infection to the World Health Organization (WHO), including two deaths (case fatality rate (CFR): 1%)

E.5. Human cases of influenza virus A(H1N1) variant of swine origin – Multi-country Overview (27 February)

In February, authorities in Spain reported a confirmed human case of swine influenza A(H1N1)v. The case, reported from the autonomous region of Catalonia, was confirmed positive for swine influenza by PCR and sequencing. According to the latest available information, the case has no known history of exposure to pigs or a contaminated environment.

Cases of swine influenza have been sporadically reported in Spain and in other countries, the last case being from the autonomous region of Catalonia reported in 2024 (onset of symptoms in 2023).

In Spain, a total of four human cases of swine influenza A(H1N1) have been reported in the last 17 years, and no human to human transmission has been identified to date. A sample taken as part of the acute respiratory infections surveillance system tested positive for influenza A. Subsequent testing was positive for swine influenza A(H1N1)v at the reference laboratory of the autonomous region of Catalonia. The case remains asymptomatic, while epidemiological investigations are still ongoing.

E.6. Middle East respiratory syndrome coronavirus (MERS-CoV) (2 March)

Update:

Since the previous update on 3 February 2026, and as of 2 March 2026, no new MERS cases have been reported by the World Health Organization (WHO) or national health authorities.

Summary:

Since the beginning of 2026, and as of 2 March 2026, no MERS cases have been reported by WHO or national health authorities.

Since April 2012, and as of 2 March 2026, a total of 2 647 MERS cases, including 959 deaths, have been reported by health authorities worldwide.

Human MERS cases continue to be reported in the Arabian Peninsula. However, the number of new cases detected and reported through surveillance has dropped to the lowest level since 2014. The probability of sustained human-to-human transmission among the general population in Europe remains very low and the impact of the disease in the general population is considered low. The current MERS-CoV situation poses a low risk to the EU/EEA, as stated in the Rapid Risk Assessment published by ECDC on 29 August 2018.

E.7. Nipah virus disease – India and Bangladesh – 2026 (6 February)

Update: Bangladesh: On 6 February 2026, WHO posted a Disease Outbreak News (DON) item about a confirmed death due to NiV infection that occurred in Rajshahi Division, northwestern Bangladesh. The patient was a woman in her forties residing in Naogaon District, Rajshahi Division. She developed symptoms compatible with NiV infection on 21 January, beginning with fever, headache, muscle cramps, anorexia, weakness and vomiting, which progressed to hypersalivation, disorientation and convulsions. She became unconscious on 27 January and was referred to a tertiary hospital, where she was admitted on 28 January; samples were collected on admission and she died later the same day.

The patient had repeatedly consumed raw date palm sap between 5–20 January, considered the likely exposure source. An outbreak investigation involving One Health partners began on 30 January. Investigators identified 35 contacts, and six symptomatic contacts were sampled; all tested negative for NiV by PCR and IgM ELISA. As of 3 February, no additional cases have been detected, and all contacts remain under monitoring.

Summary: India: According to the National IHR Focal Point for India reporting to the World Health Organization (WHO) on 26 January 2026, there have been two confirmed cases of NiV reported in the state of West Bengal, India. A total of 196 contacts of the confirmed cases were identified and tested negative for NiV. No additional cases have been reported as of 27 January 2026, according to the Indian Ministry of Health. Several media outlets, quoting India's health authorities, have reported five NiV disease cases in the same outbreak in healthcare workers at the same hospital, in the district of North 24 Parganas, in the West Bengal State, India. Both individuals are between the ages of 20 and 30 years old, one male and one female, working as nurses at the same private hospital in Barasat, located in North 24 Parganas district, West Bengal State. Both of them developed symptoms typical of severe NiV infection in late December 2025 and were admitted to hospital in early January 2026. As of 21 January 2026, the second individual showed clinical improvement, while the first remained under critical care.

E.8. Travel-associated chikungunya virus disease in EU/EEA countries imported from Seychelles (27 February)

Overview:

Since November 2025, more than 70 travel-related cases of chikungunya virus disease have been reported by 10 European countries among travellers returning from Seychelles. This represents a marked increase compared with the earlier months of 2025, and no cases have been reported in preceding years. The emergence of chikungunya virus disease in Seychelles aligns with a broader regional spread throughout the Indian Ocean. Notably, Réunion Island (France) experienced a major outbreak in 2025. According to local health authorities, chikungunya virus has become more prevalent in Seychelles compared with other circulating arboviruses. For global epidemiological updates, see ECDC's dedicated chikungunya webpage.

ECDC assessment:

The current likelihood of chikungunya virus infection for travellers to Seychelles is high. Given that the peak travel period to Seychelles occurs between February and April, it is important to strengthen communication to travellers and travel medicine clinics regarding the ongoing outbreak and the need for reinforced preventive measures. Vaccination of travellers may be considered, based on national recommendations. The likelihood of onward transmission of chikungunya virus in mainland Europe following introduction by a viraemic traveller is currently considered unlikely, as environmental conditions are not favourable for Aedes mosquito activity at this time of year.