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

24th April 2026

gov.wales

This report was 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 16 2026, up to 19 April 2026)

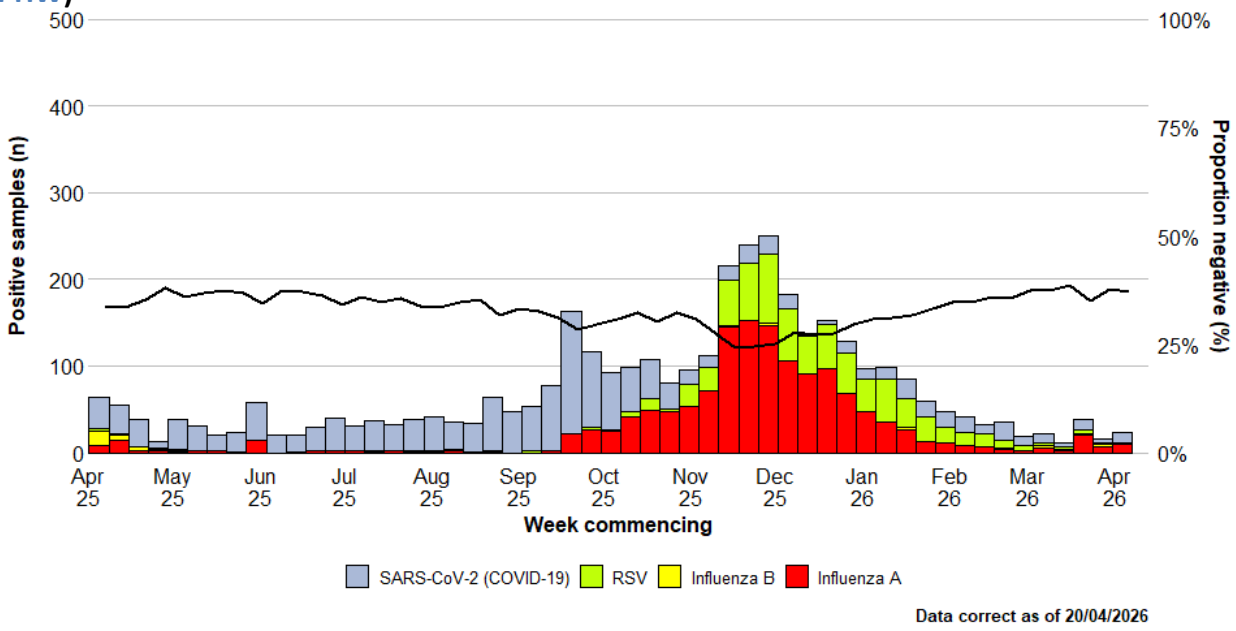
- COVID-19 confirmed case admissions to hospital **decreased**.
- COVID-19 cases who are inpatients have **decreased**.
- RSV activity in children under 5 years has **decreased**.
- Influenza confirmed case admissions to hospital have **decreased** and inpatients have **remained stable** in the latest week.
- Norovirus confirmed cases have **decreased** in the most recent week (week 16).
- Whooping Cough notifications were **unchanged** (data to 15/04/2026).
- Scarlet Fever notifications **decreased**.

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 **decreased** in week 16 2026 (to 19 April 2026).
- As of 19 April 2026 (week 16), the number of confirmed cases of community acquired COVID-19 admitted to hospital **decreased** to 10 (14 in the previous week) and there were **50** in-patient cases of confirmed COVID-19, **none** of whom were in critical care compared to 55 and none in the previous week.
- Confirmed cases of positive tests remained stable at 2.0 % in hospital and non-sentinel GP practices in the most recent week. Consultations with Sentinel GPs and Pharmacies for COVID-19 have increased.
- In the last six weeks, Omicron PQ.2* is the most frequently detected Pango lineage group in Wales, accounting for **33%** of sequenced cases.

Figure 1: Samples from hospital patients submitted for RSV, Influenza and SARS-CoV2 testing only, by week of sample collection, week 16, 2025 to Week 16, 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.

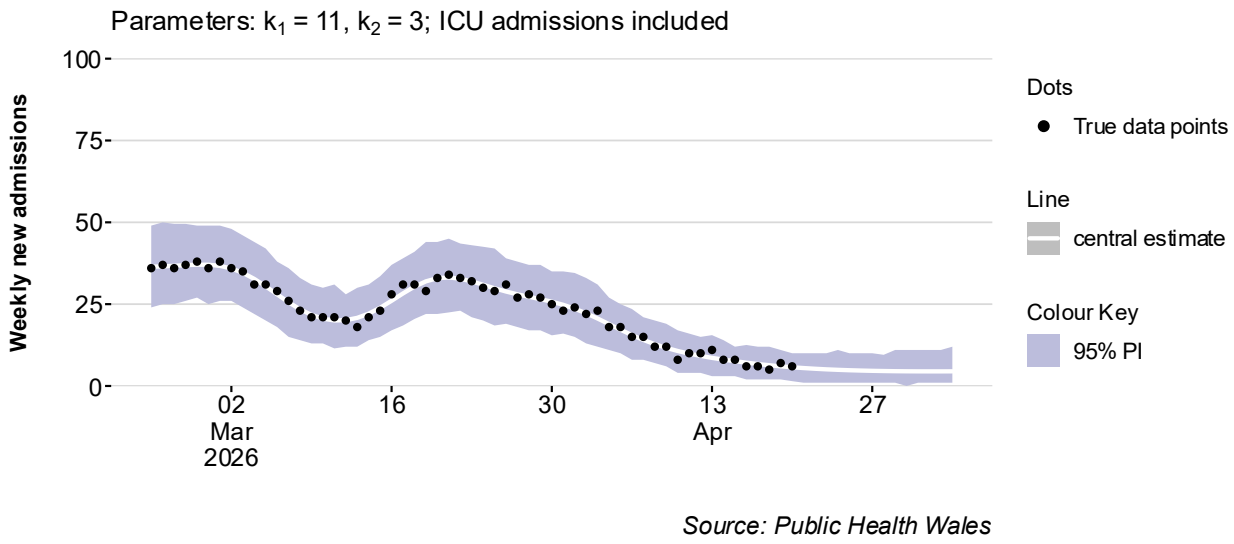
SRE previously reported on the trends of the central estimates. From December 2025, in line with PHW, the difference between the most recent observed data (7 day rolling sum) and the projected central estimate 2 weeks later is reported on.

STP computations uses admissions data from PHW until **19 April 2026** to make short term projections for COVID-19 two weeks forward **(to 03 May 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 remain stable over the next two-week period (Figure 2).

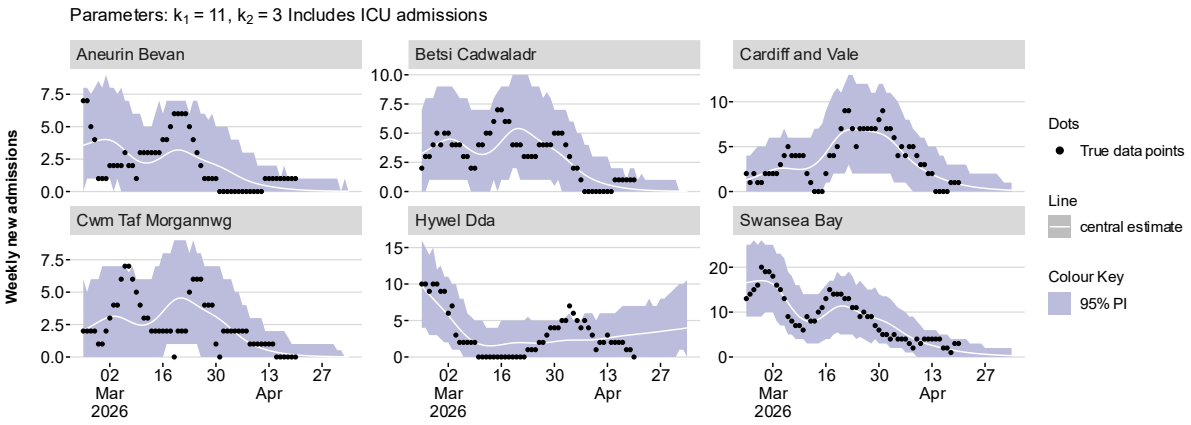
Figure 2: Short Term Projection for COVID-19 hospital admissions in Wales (data to 19 April 2026, projection to 03 May 2026)



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 except Hywel Dda which estimates an increase over the next fortnight.

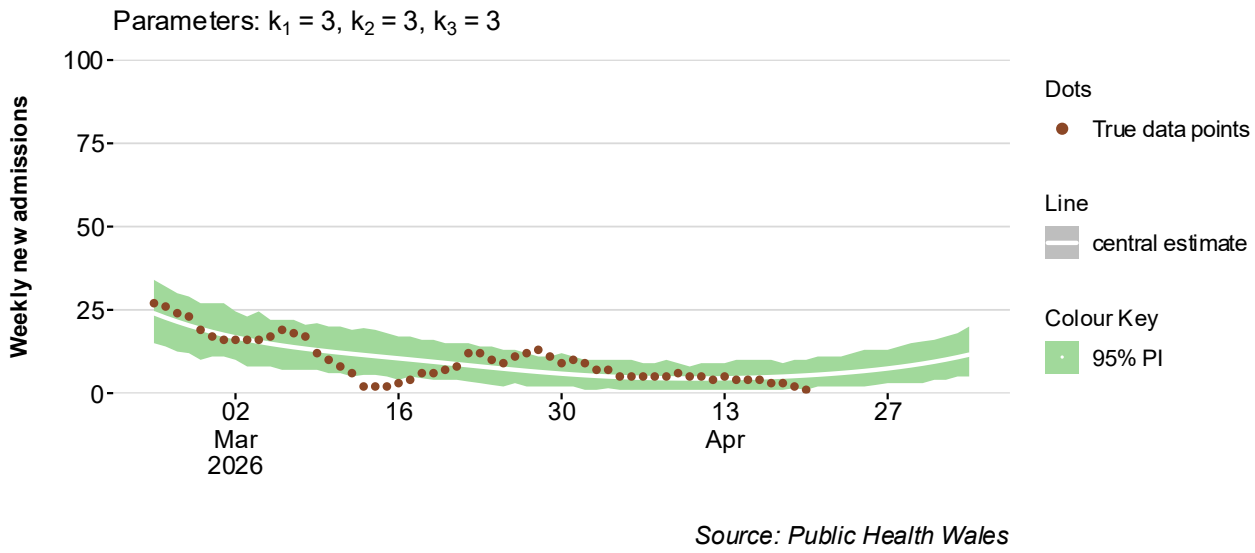
Figure 3: Short Term Projections for COVID-19 hospital admissions in Wales Health Boards (data to 19 April 2026, projection to 03 May 2026)



Source: Public Health Wales

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

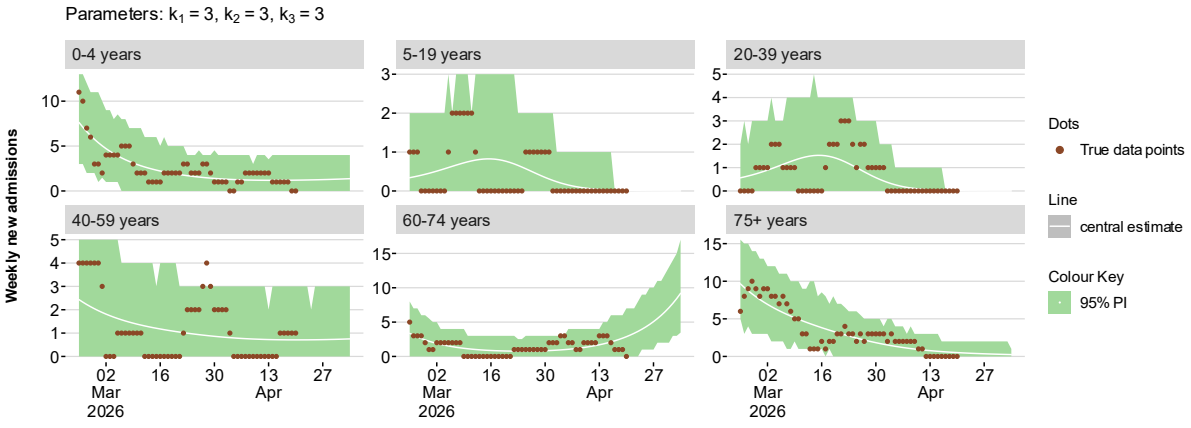
Figure 4: Short Term Projection for RSV hospital admissions in Wales (data to 19 April 2026, projection to 03 May 2026)



Source: Public Health Wales

Figure 5 shows that all age groups are stable in RSV admissions projections except for 0-4 years and 60-74 years which estimates increases in RSV admissions over the next fortnight **(to 03 May 2026)**.

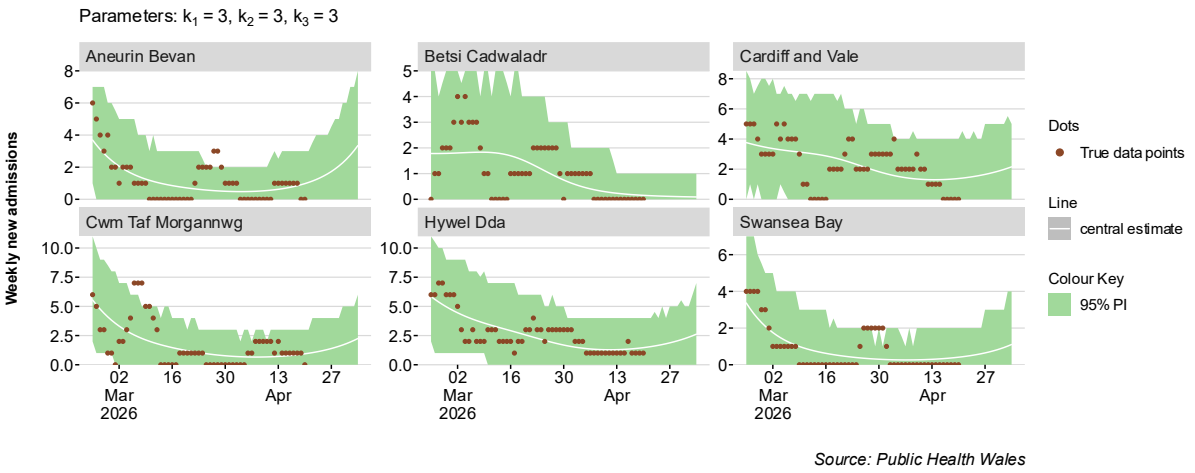
Figure 5: Short Term Projections for RSV hospital admissions in Wales by age groups (data to 19 April 2026, projection to 03 May 2026)



Source: Public Health Wales

Figure 6 show an increase in RSV admissions projections over the next fortnight (except Betsi Cadwaladr which estimates admissions will remain stable) **(to 03 May 2026)**.

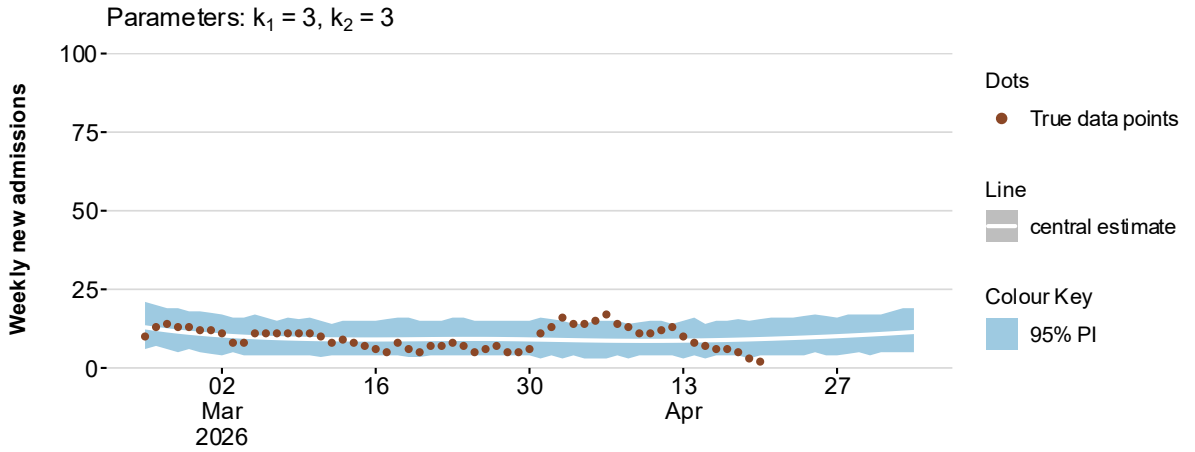
Figure 6: Short Term Projections for RSV hospital admissions in Wales Local Health Boards (data to 19 April 2026, projection to 03 May 2026)



Source: Public Health Wales

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

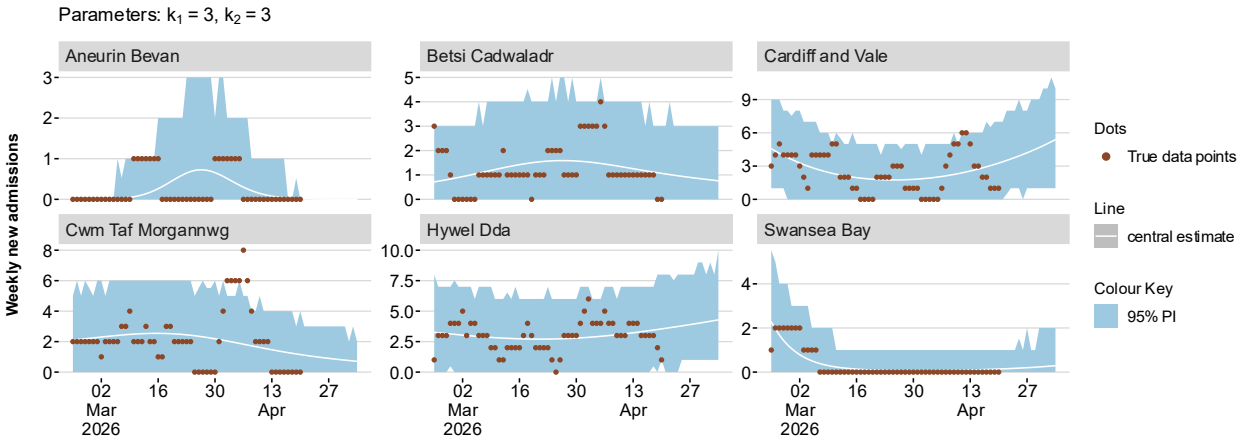
Figure 7: Short Term Projection for Influenza hospital admissions in Wales (data to 19 April 2026, projection to 03 May 2026)



Source: Public Health Wales

Figure 8 below shows all LHB show an increase in influenza admissions projections over the next 2 weeks (except Swansea Bay and Aneurin Bevan where admissions are estimated to remain stable).

Figure 8: Short Term Projections for Influenza hospital admissions in Wales Local Health Boards (data to 19 April 2026, projection to 03 May 2026)

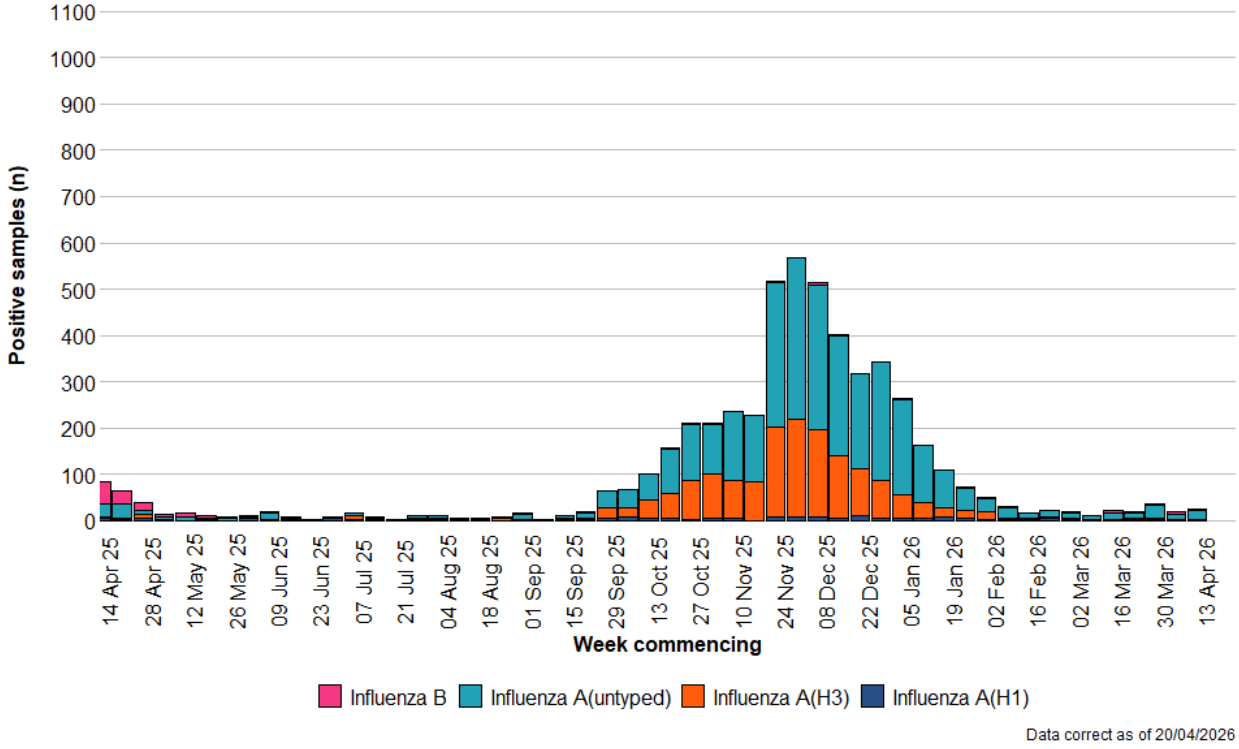


Source: Public Health Wales

B.2. Influenza Situation Update

- Overall, influenza is not currently circulating in Wales. Test positivity remained stable and confirmed cases have decreased in the most recent week compared to last week. No cases 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 decreased to **2** in the current week (**10** in the previous week). Test positivity remained stable at **1.5%**.
- There were **19** in-patient cases of confirmed influenza, **none** of whom were in critical care compared to **16** and **none** in the previous week.
- In week 16 2026, there were 0 influenza A(H3), 1 influenza A(H1N1), 22 influenza A untyped and 2 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 16, 2025 to Week 16, 2026 (source: PHW)



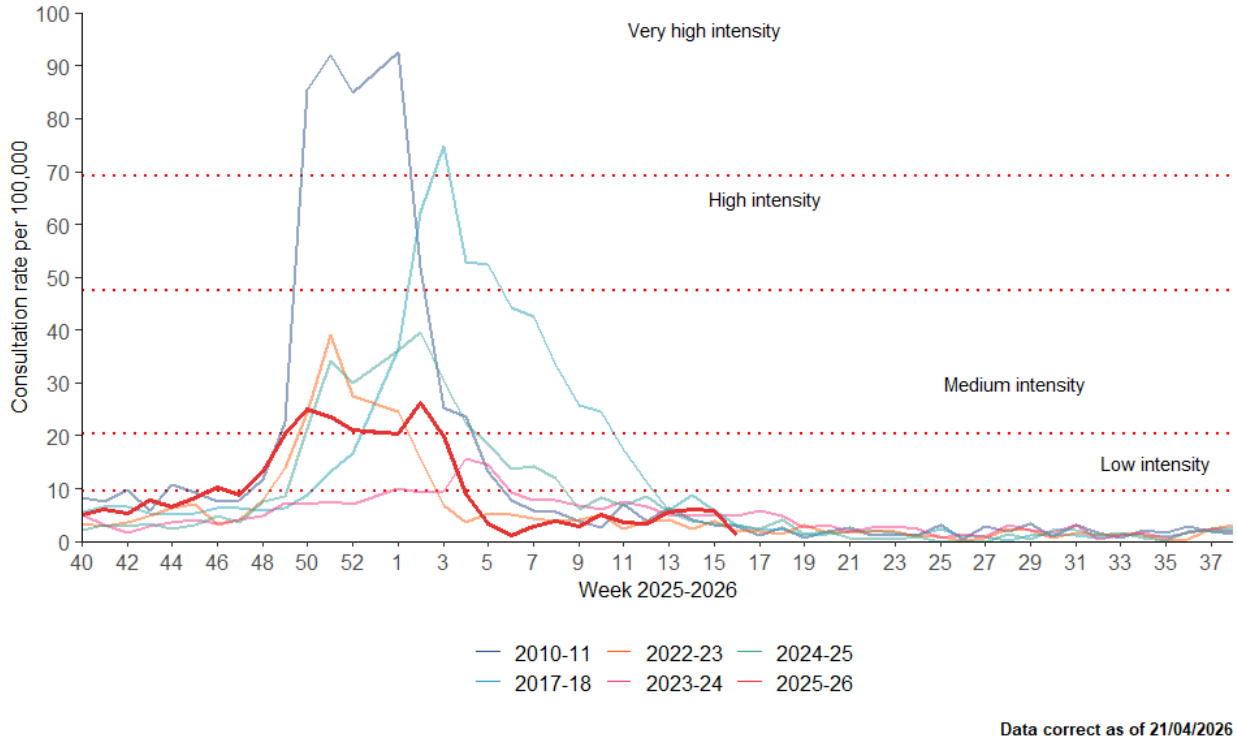
The sentinel GP consultation rate for influenza-like illness (ILI) is at baseline levels and the three-week trend is decreasing.

There were 1.2 ILI consultations per 100,000 practice population in the most recent week, a decrease compared to the previous week (5.8 consultations per 100,000).

In the most recent week, using all available data from general practices, there were 8.8 ARI consultations per 100,000 practice population, a decrease from 10.1 in the previous week. The highest rates were found in people aged under 1 year (1,153.3) followed by people aged 1 to 4 (554.3) and people aged 75+ (152).

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

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

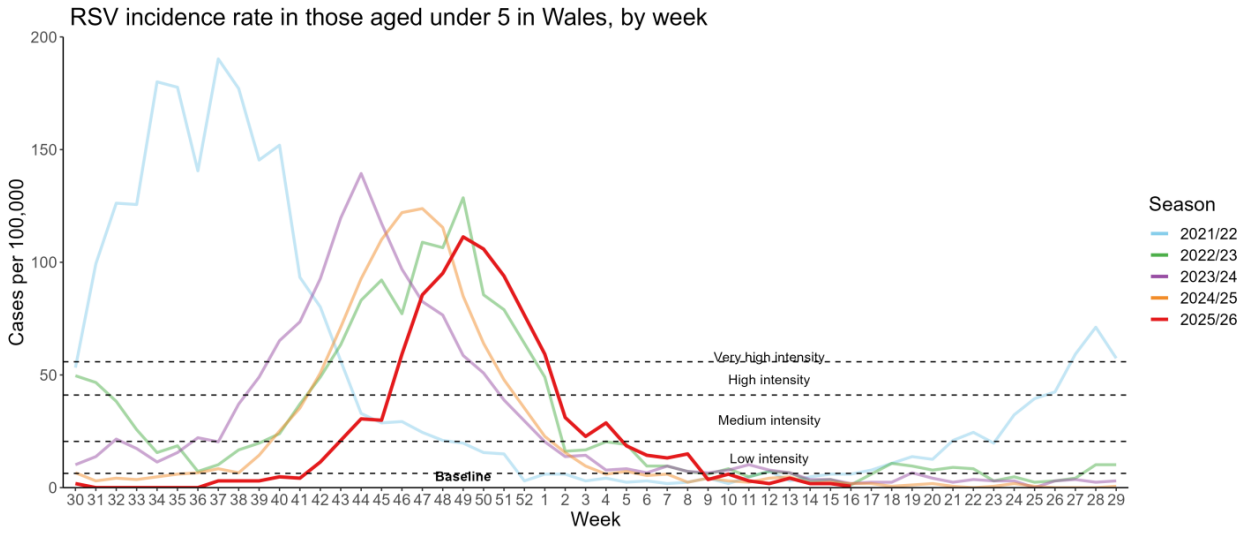


B.3. Respiratory Syncytial Virus (RSV) update

The number of confirmed cases of community acquired RSV admitted to hospital decreased to **2** during week 16.

RSV incidence per 100,000 in children aged up to 5 years **decreased** to **0.6**. in week 16. This is a decrease from the previous week (1.8) and is currently at baseline intensity levels. During week 16 there were **8** in-patient cases of confirmed RSV, **none** of whom were in critical care.

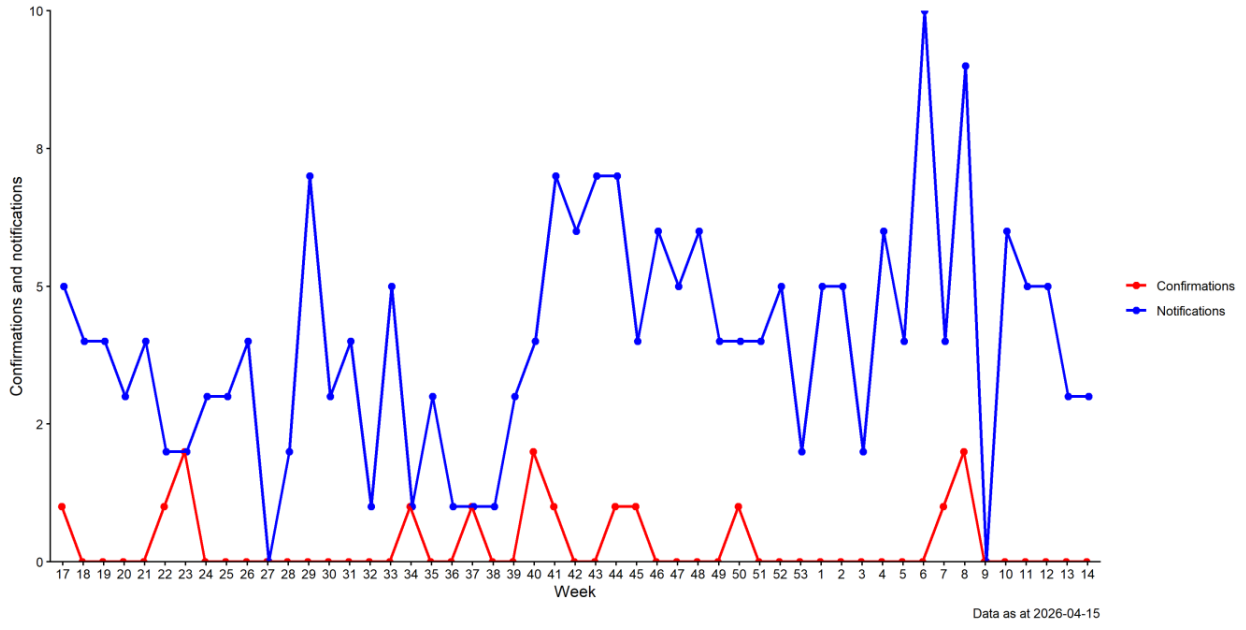
Figure 11: RSV Incidence Rate per 100,000 population under 5 years, weeks 30 2020 to Week 16 2026 (source: PHW)



B.4. Whooping Cough (Pertussis)

Figure 12 below shows that whooping cough notifications (data as at 15/04/2026) ***were unchanged***. Lab confirmations continue to be at very low levels (*Whooping cough is now reported on every two weeks*).

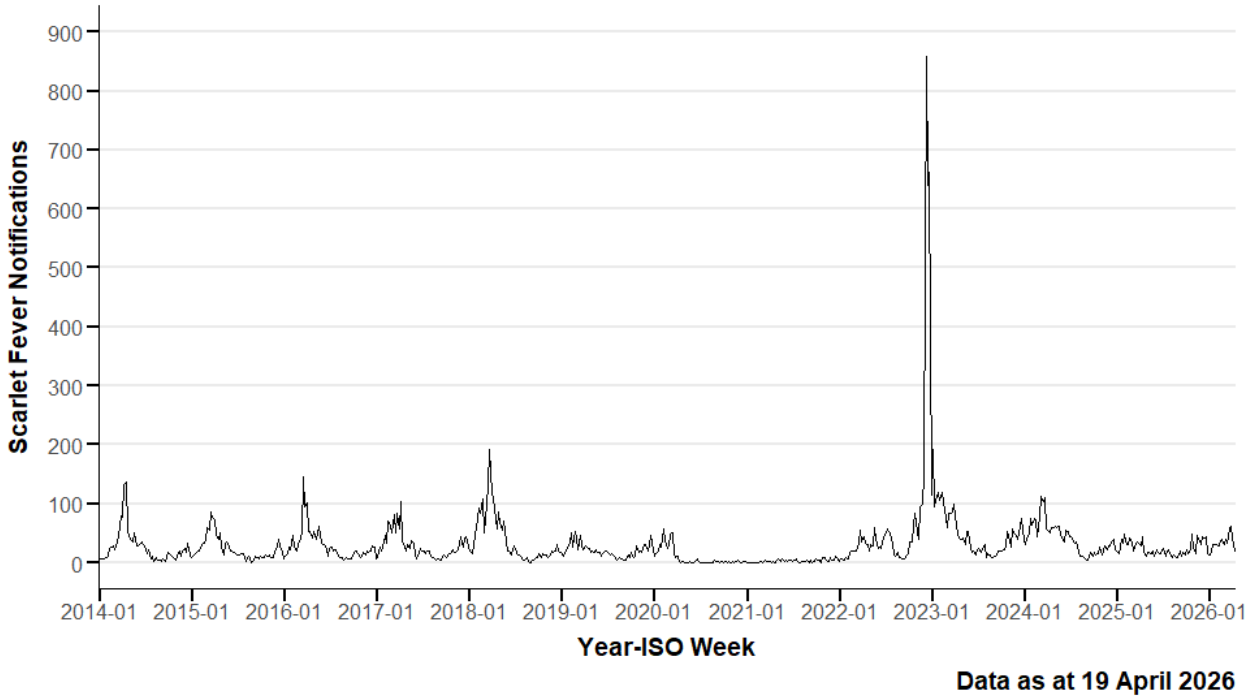
Figure 12: Weekly notifications and confirmations of Pertussis/Whooping Cough in Wales. (Source: PHW)



B.5 iGAS and Scarlet Fever

The number of iGAS notifications is currently low, remaining at seasonally expected levels. Scarlet Fever notifications have **decreased** in the most recent 3-week average 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 **1,584** in the previous week to **1,554** in the latest reporting week.
- During Week 16, 2026, 0 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 published modelled scenarios for COVID-19, RSV and Influenza for Winter 2025-26. This used analysis of historical data and projected forward to estimate hospital demand throughout winter 2025/26, which contributed to winter planning for NHS Wales.

The modelled scenarios were produced from September 2025 until end of March 2026 and these can be found in previous surveillance reports along with the technical notes, Science Research Evidence: communicable disease surveillance reports | GOV.WALES.

Note that the modelling was an estimate of what may happen not a prediction of what would happen.

D. Communicable Disease Situation Update (non-respiratory)

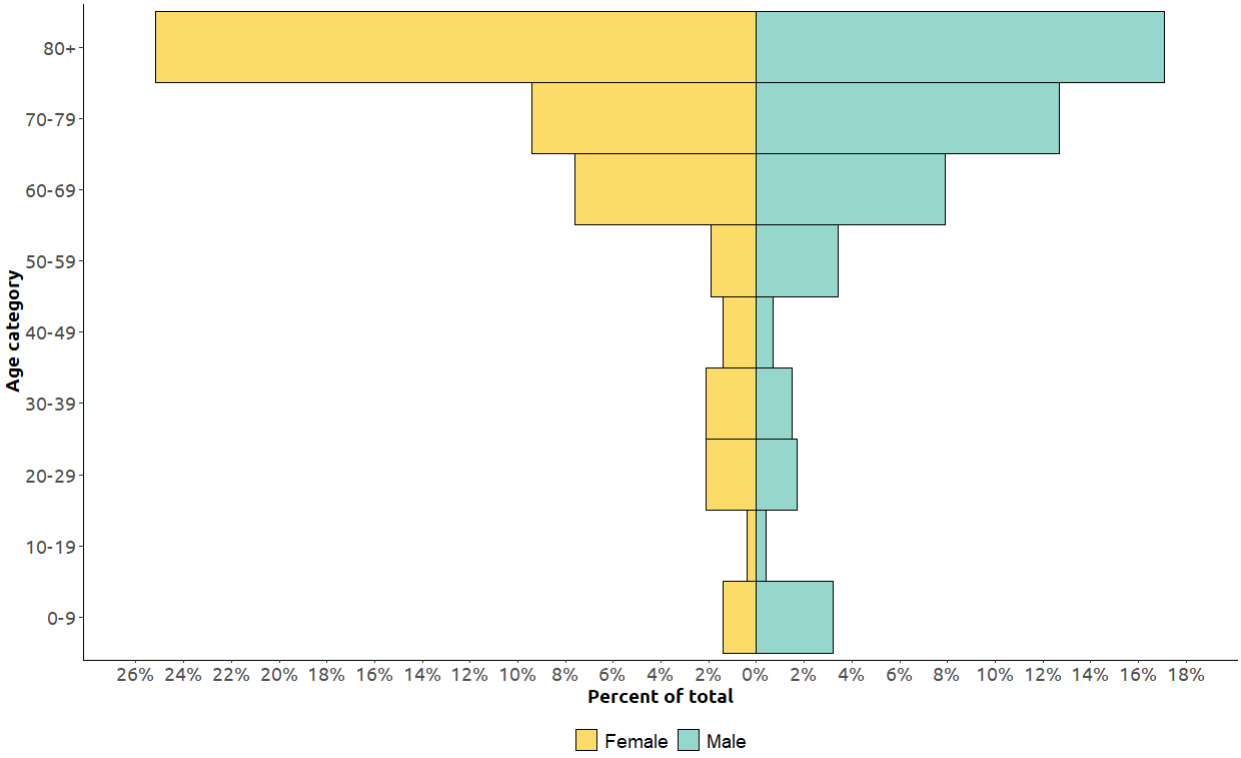
D.1 Norovirus

In the current reporting week (week 16 2026), a total of **42** Norovirus cases were reported in Welsh residents. This is a ***decrease*** (-12.5%) in reported cases compared to the previous reporting week (week 15 2026), when **48** Norovirus cases were reported.

In the last 12-week period (26/01/2026 to 19/04/2026) a total of **725** Norovirus cases were reported in Welsh residents. This is an ***increase*** (14.5%) in reported cases compared to the same 12-week period in the previous year (26/01/2025 to 19/04/2025) when **633** Norovirus cases were reported.

In the last 12 weeks (26/01/2026 to 19/04/2026) **373** (51.4%) Norovirus cases were female and **352** (48.6%) cases were male. The age groups with the most cases were the **80+** (**307** cases) and **70-79** years (**160** cases) age groups.

Figure 14: Age and sex distribution of confirmed Norovirus cases in the last 12 weeks (26/01/2026 to 19/04/2026)



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 16 2026 (26/01/2026 to 19/04/2026). 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 17 April 2026)

17 April 2026

Highly pathogenic avian influenza (HPAI) H5N1 was confirmed in a fifth large commercial poultry unit near Gainsborough, West Lindsey, Lincolnshire.

A 3km protection zone and 10km surveillance zone has been declared around the premises.

14 April 2026

Highly pathogenic avian influenza (HPAI) H5N1 was confirmed in commercial poultry:

- at a third premises near Gainsborough, West Lindsey, Lincolnshire
- near Great Shelford, South Cambridgeshire, Cambridgeshire

A 3km protection zone and 10km surveillance zone has been declared around each of the premises. All poultry on the premises will be humanely culled.

11 April 2026

Highly pathogenic avian influenza (HPAI) H5N1 was confirmed in commercial poultry near Market Rasen, West Lindsey, Lincolnshire.

A 3km protection zone and 10km surveillance zone has been declared around the premises. All poultry on the premises will be humanely culled.

9 April 2026: further update

Following successful completion of disease control activities and surveillance in zone around a premises near Pickering, Thirsk and Malton, Yorkshire (AIV 2026/15) the 10km surveillance zone has been revoked.

9 April 2026: AIPZ housing measures lifted

You can now let your birds outside again unless you're in a protection zone or captive bird (monitoring) controlled zone. Check what zone you're in.

You must continue to follow the mandatory biosecurity measures.

All bird flu cases and disease control zones

The first case of HPAI H5N1 of the 2025 to 2026 outbreak season was confirmed in:

England on 11 October 2025

Scotland on 12 November 2025

Wales on 25 October 2025

Northern Ireland on 9 October 2025

In line with World Organisation for Animal Health (WOAH) rules, the UK is no longer free from highly pathogenic avian influenza (bird flu).

Find details of all bird flu cases and disease zones in England.

2025 to 2026: summary of confirmed cases in the UK

	HPAI H5N1 cases	LPAI cases
England	79	1
Scotland	9	0
Wales	7	0
Northern Ireland	5	0
Total	100	1

2 April 2026: prepare to let birds outside again from 9 April

Mandatory housing measures for poultry and other captive birds will be lifted in England and Wales from 00:01am on Thursday 9 April 2026.

As birds may have been housed for several months, there is a 7 day notice period to give keepers time to prepare. Keepers should follow the guidance on preparing to let birds outside again, including cleansing and disinfecting hard surfaces, fencing off ponds or standing water and reintroducing wild bird deterrents.

Birds must still be housed if you are in a protection zone or captive bird (monitoring) controlled zone. All keepers must continue to follow strict biosecurity measures to prevent bird flu and stop it spreading.

The housing measures are being lifted because bird flu risk levels have reduced.

Mandatory biosecurity measures remain in place in England, Scotland and Wales.

E.2. Dengue epidemic in New Caledonia (10 April)

New Caledonia is currently facing its first outbreak of dengue since 2019, with over 640 cases (probable and confirmed) reported since the beginning of the year. The main vector of transmission is Aedes aegypti. In New Caledonia, dengue virus transmission is typically higher during the warm and wet months, with peaks often observed in late austral summer to early autumn (around March–April). With the rainy season, pools of water can support high mosquito population density, favouring transmission of the virus.

In addition, the ongoing school holidays (4-19 April) may favour movement of people and the spreading of the virus.

In 2019, New Caledonia launched a project with the release of Wolbachia carrying mosquitoes, and by 2024, 86% of the mosquitoes tested in the Greater Nouméa region were carrying the bacteria. According to the authorities and the media, the zones where Wolbachia-bacteria-carrying mosquitoes were released are currently experiencing less intense transmission than in other areas of New Caledonia.

The current likelihood of dengue virus infection for travellers to New Caledonia is moderate, especially when travelling outside of the Greater Nouméa region, where virus circulation is more intense.

The likelihood of transmission of dengue virus in mainland Europe following introduction by a viraemic traveller is currently considered very low, as environmental conditions are not favourable for Aedes mosquito activity at this time of year.

E.3. Influenza A(H5N1) – Multi-country (3 April)

On 31 March 2026, the Cambodian Ministry of Health reported a new human case of avian influenza A(H5N1) virus infection in a boy under five years old from Banteay Ampil District in Oddar Meanchey province. The child is currently isolated in hospital and is receiving treatment. Epidemiological investigations revealed that the patient had played with poultry and that there had been sick and dead poultry both in the household and in the village. On 29 March 2026, the National Institute of Public Health confirmed infection with avian influenza A(H5N1). No additional information is available at this time.

National and local authorities are actively investigating the event and implementing response measures. As part of the response, close contacts of the case have received antiviral prophylaxis (oseltamivir), and health education campaigns are ongoing in the affected villages. This is the third human case reported in Cambodia this year. The previous case (in a woman) was reported on 15 March 2026. Information about the virus clade has not been reported for the recent cases. Clade 2.3.2.1e has been circulating among birds in Cambodia and has been detected in infected humans in the recent past. Overall, since 2003, Cambodia has reported 93 cases, including 52 deaths (CFR: 56%)

E.4. Human case of avian influenza A(H7N7) Taiwan – 2026 (10 April)

On 3 April 2026, Taiwan CDC reported a human case of avian influenza A(H7N7) virus infection in a man in his 70s in Taiwan (Press Release: Influenza A(H7) detection update, Taiwan CDC, 3 April 2026). The patient, who has chronic diseases, developed symptoms on 20 March 2026 (rhinorrhea, myalgia, cough). On 22 March, due to worsening symptoms and fever, he was admitted to hospital and diagnosed with pneumonia. The patient had had exposure to domestic birds prior to the onset of symptoms. The patient received antiviral treatment and, following clinical improvement, was discharged on 3 April 2026.

Avian influenza A(H7N7) was confirmed through gene sequencing from the patient's sputum samples taken on 27 March 2026. There were no detections of mutations related to enhanced avian-to-human transmission. No drug resistant mutations were found, and the virus remains sensitive to antiviral drugs. According to Taiwan CDC, the genomic analysis showed that the influenza A(H7) belongs to the Eurasian lineage, similar to those strains circulating in Taiwan in wild animals (mainly geese and ducks).

As of 2 April 2026, 33 contacts of the case had been identified and were being monitored (Press Release: Influenza A(H7), Taiwan CDC, 2 April 2026), three of whom had received prophylactic treatment; tests taken from six family members were negative for avian influenza.

This is the first case of A(H7N7) reported in Taiwan. In the EU/EEA, 92 human cases with A(H7N7) infection were reported in the Netherlands in 2003 (n=89) and in Italy in 2013 (n=3) and no cases have been reported since (Epidemiological update: Highly pathogenic influenza A(H7N7) in poultry and transmission to three human poultry workers in Emilia-Romagna, Italy, September 2013). In both events, most patients had had occupational exposure to poultry. Most cases had mild symptoms, including influenza-like symptoms and/or conjunctivitis. One fatal case was reported in a patient with pneumonia in combination with acute respiratory distress syndrome (ECDC-EFSA Scientific Opinion Preparedness, prevention and control related to zoonotic avian influenza, 2024).

E.5. Measles – Multi-country (World) Monitoring European outbreaks (17 April)

In February 2026, 26 countries reported measles data. Eleven countries reported 139 cases and 15 countries reported zero cases. Overall, case numbers decreased compared with the previous month, however this may be subject to change in the event of a future retrospective update. The highest case counts were reported by Italy (63), Spain (36), France (16) and Poland (five).

Between 1 March 2025 to 28 February 2026, 30 EU/EEA Member States reported a total of 4 623 cases of measles, 3 860 (83.5%) of which were laboratory confirmed. Of the 4 623 cases with known age, 1 536 (33.2%) were in children under five years; 1 956 (42.3%) cases were in those aged 15 years or above. The highest notification rates were observed among

infants under one year of age (124.0 cases per million) and children aged 1-4 years (65.3 cases per million). Of 4 013 individuals (86.8% of all cases) with a known age and vaccination status, 3 206 (79.9%) were unvaccinated, 378 (9.4%) were vaccinated with one dose of a measles-containing vaccine, 386 (9.6%) were vaccinated with two or more doses, and 34 (0.8%) were vaccinated with an unknown number of doses.

During the 12-month period, six deaths (case fatality rate (CFR): 0.130 %) attributable to measles were reported to ECDC by France (four), Netherlands (one) and Romania (one). Detailed data are available in ECDC's Surveillance Atlas of Infectious Diseases.

Complementary epidemic intelligence surveillance was performed on 15 and 16 April 2026. An outbreak has been reported in Bulgaria. Sporadic cases and clusters were reported in several EU/EEA countries. Updates are provided for several countries and regions outside the EU/EEA. Outside the EU/EEA, updates have been provided England, Bangladesh, Ukraine, Africa CDC,the World Health Organization Pan American Health Organization (WHO PAHO), Canada, US, Mexico, Indonesia and Japan.

England reported 371 laboratory confirmed cases and no deaths, between 1 January and 6 April 2026. The majority of cases – 69% - involve children under 10 years of age and 26% were young people and adults 15 years or older. Geographically, 57% of the cases have been reported in London, followed by 24% in West Midlands and 7% in North West.

E.6. Chikungunya virus disease – French Guiana, France – 2026 (17 April)

Currently, there is ongoing chikungunya virus circulation in French Guiana. Since January 2026, over 85 confirmed autochthonous cases were identified, with eight cases in week 14-2026, 11 cases in week 13-2026 and 12 cases in week 12-2026. Most cases (n=75, 87%) were detected in Littoral Ouest sector, located in the western side of French Guiana, near the border with Suriname. This sector is currently in the outbreak cluster phase, indicating active viral circulation throughout the sector.

The Maroni, Savanes, and Ile de Cayenne sectors are in a phase of sporadic transmission, whereas the Intérieur, Intérieur Est, and Oyapock sectors remain in a surveillance phase, with no cases identified to date. All cases were confirmed by RT-PCR and the identified strain in French Guiana belongs to the ECSA genotype but lacks the E1-A226V mutation. It shows a close genetic relationship with recent sequences from Cuba and Brazil. Suriname, which shares a border with western French Guiana, reported 2 579 cases between 1 January and mid March 2026.

The last chikungunya virus disease outbreak in French Guiana occurred in 2014. During the 2014-2015 outbreak in French Guiana, more than 16 000 suspected cases and 500 hospitalisations were reported, resulting in an estimated chikungunya virus disease seroprevalence of 20% in 2017.

E.7. Transmission of integrase inhibitor resistant HIV-1 – Multi country – 2026 (3 April)

Overview: On 4 March 2026, the Netherlands reported two patients with baseline resistance to all currently available integrase strand transfer inhibitors (INSTIs). Both individuals were diagnosed with HIV-1 subtype B in autumn 2025 and had no history of pre-exposure prophylaxis (PrEP) or antiretroviral treatment (ART).

The first patient was a heterosexual man from the Netherlands, who reported no sexual partners since 2022. No resistance mutations were detected in the reverse transcriptase or protease genes; however, mutations associated with INSTI resistance (G140S and Q148H) were identified in the integrase gene.

As of March 2026, 33 treatment-naive patients without PrEP history were reported by Belgium, Denmark, France, Greece, Hungary, Lithuania, Luxembourg and the Netherlands with viruses carrying high-level or major INSTI resistance and varying NNRTI and NRTI resistance. Additional persons with low-level resistance were reported. Findings of resistance in treatment-naive patients are evidence of transmission of INSTI-resistant HIV, which has been historically rare.

Although the number of reported cases remains small, and there is currently no evidence of widespread transmission of INSTI-resistant viruses across the EU/EEA, the absence of epidemiological or molecular linkage between cases reported by countries suggests that these are likely isolated transmission events rather than large transmission clusters. Nevertheless, HIV transmitted drug resistance in the EU/EEA remains an important public health concern, particularly in the context of expanding ART options and the increasing use of INSTIs.