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

29th May 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 21 2026, up to 24 May 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 **increased** and inpatients have **decreased**.
- Norovirus confirmed cases have **decreased** in the most recent week (week 21).
- Whooping Cough notifications have **decreased** in week 21 (the most recent reporting week).
- Scarlet Fever notifications **decreased** in the most recent week.

Please note, from the 29th of April 2026 the SEA weekly surveillance report is now produced fortnightly until September 2026 and this is in line with Public Health Wales reporting.

B. Acute Respiratory Infections Situation Update

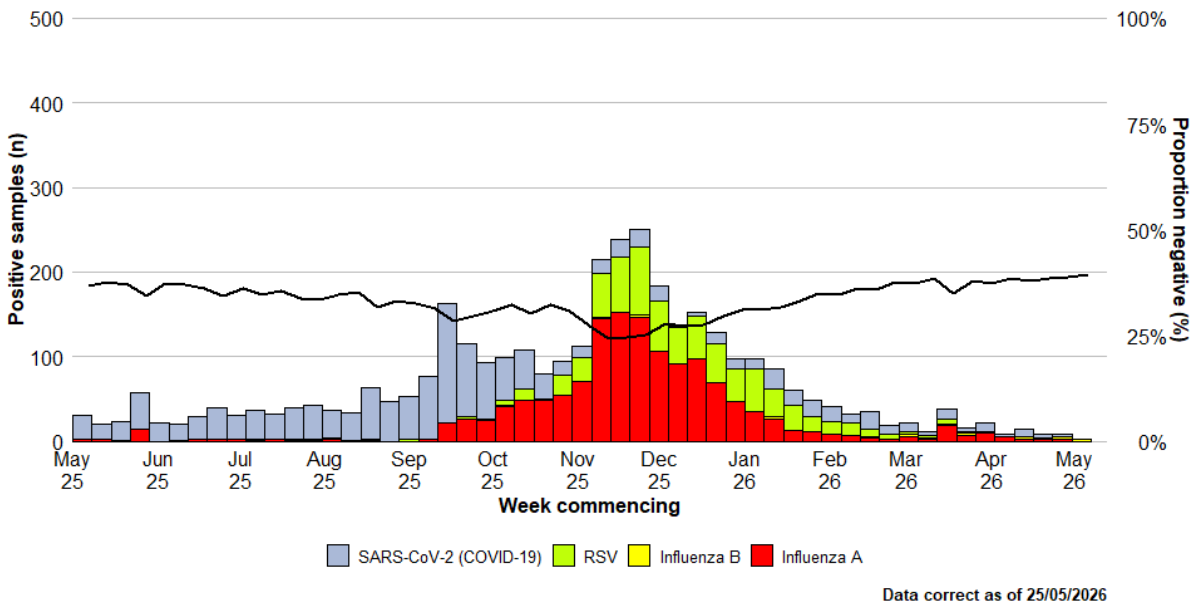
B1. COVID-19 Situation Update

- 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 21 2026 (to 24 May 2026).
- As of 24 May 2026 (week 21), the number of confirmed cases of community acquired COVID-19 admitted to hospital **decreased** to 4 (11 two weeks ago) and there were **13** in-patient cases of confirmed COVID-19, **none** of whom was in critical care compared to 32 and none two weeks ago.

- Confirmed cases of positive tests remained stable at 1.4% in hospital and non-sentinel GP practices in the most recent week. Consultations with Sentinel GPs and Pharmacies for COVID-19 remained stable in recent weeks.

- In the last six weeks, Omicron PQ.2* is the most frequently detected Pango lineage group in Wales, accounting for **36.8%** of sequenced cases.

Figure 1: Samples from hospital patients submitted for RSV, Influenza and SARS-CoV2 testing only, by week of sample collection, week 21, 2025 to Week 21, 2026. (source: PHW)



Short Term Projections (STPs)

STPs will not be produced for RSV and Influenza during the summer period.

STPs will not be published for COVID-19 during the summer period unless we see an increase in infections.

B.2. Influenza Situation Update

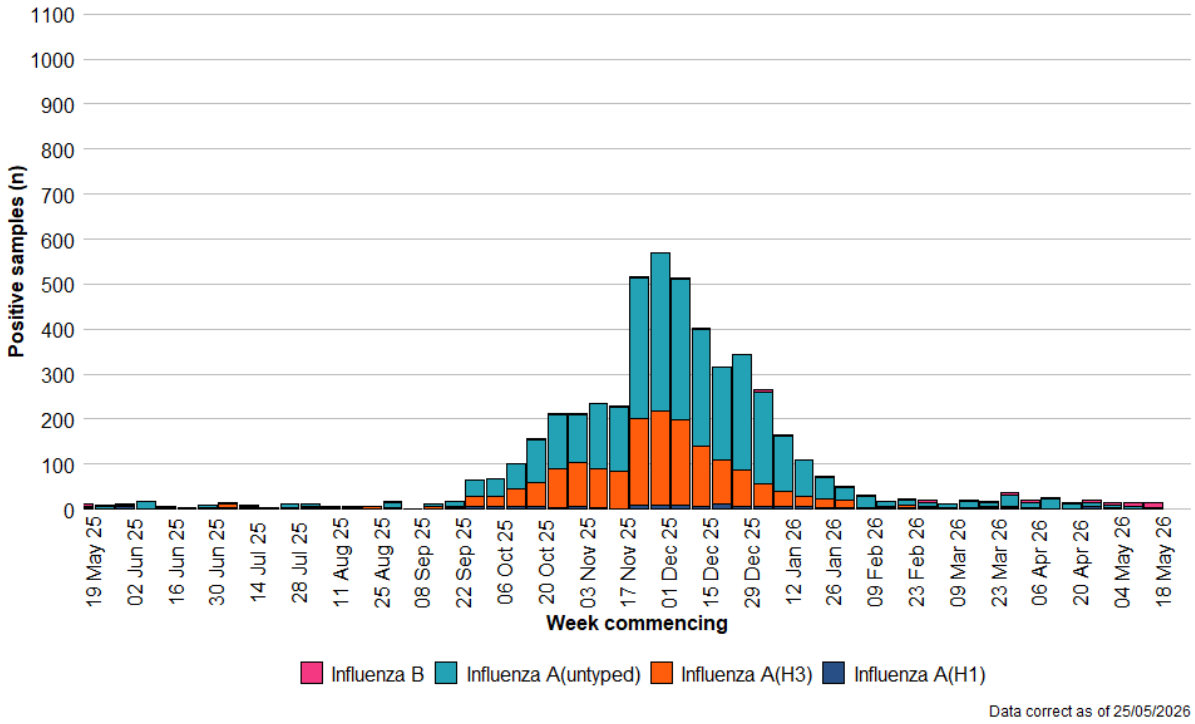
- Overall, influenza is not currently circulating in Wales. Test positivity remained stable but confirmed cases have increased in the most recent week compared to two weeks ago. No cases of influenza were confirmed from symptomatic sentinel GP network patients across Wales last week. Influenza A untyped is the most frequently detected influenza virus in Wales.

- Confirmed cases of community acquired influenza admitted to hospital increased to **1** in the current week (**10** two weeks ago). Test positivity remained stable at **0.9%**.

- There was **1** in-patient case of confirmed influenza, **none** of whom was in critical care compared to **16** and **one** two weeks ago.

- In week 21 2026, there were 2 influenza A(H3), 1 influenza A(H1N1), 0 influenza A untyped and 10 influenza B. (Figure 2).

Figure 2: 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 21, 2025 to Week 21, 2026 (source: PHW)



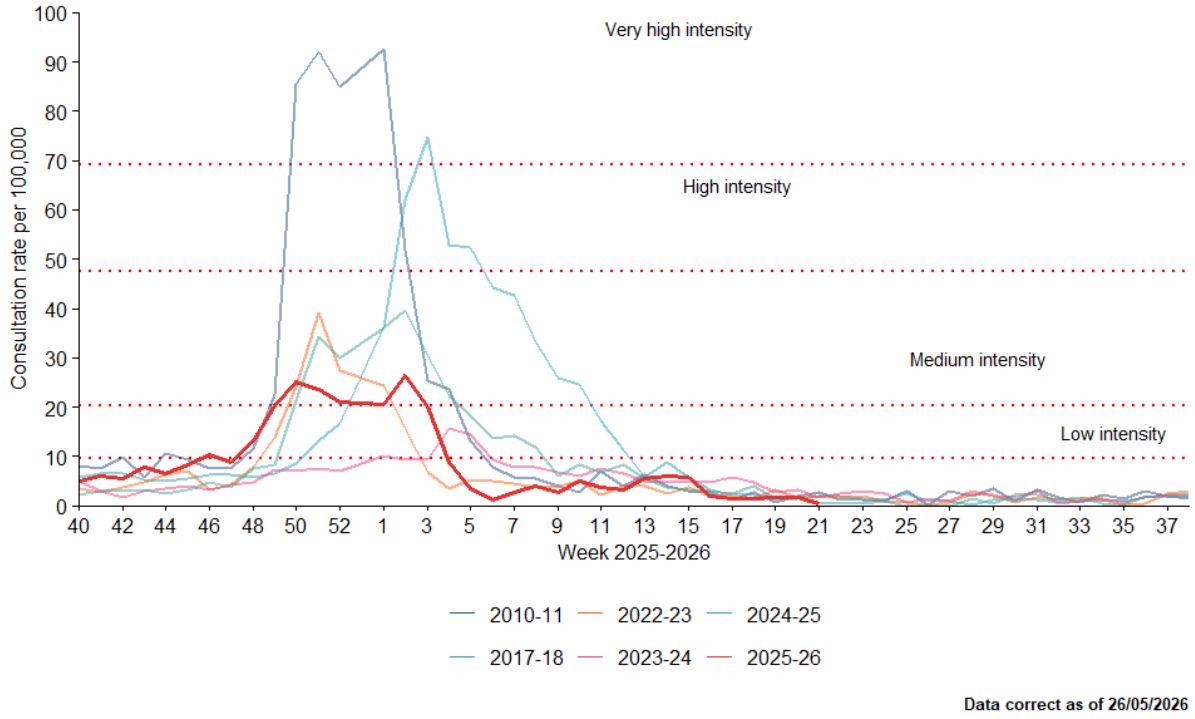
The sentinel GP consultation rate for influenza-like illness (ILI) is at baseline and the three-week trend is variable.

There were 0.5 ILI consultations per 100,000 practice population in the most recent week, an decrease compared to the previous week (1.7 consultations per 100,000).

In the most recent week, using all available data from general practices, there were 2.7 ARI consultations per 100,000 practice population, a decrease from 4 in the previous week. The highest rates were found in people aged under 1 year (813.6) followed by people aged 1 to 4 (640.6) and people aged 5 to 14 (196.5).

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

Figure 3: Clinical consultation rate for ILI per 100,000 practice population in Welsh sentinel practices (source: PHW)

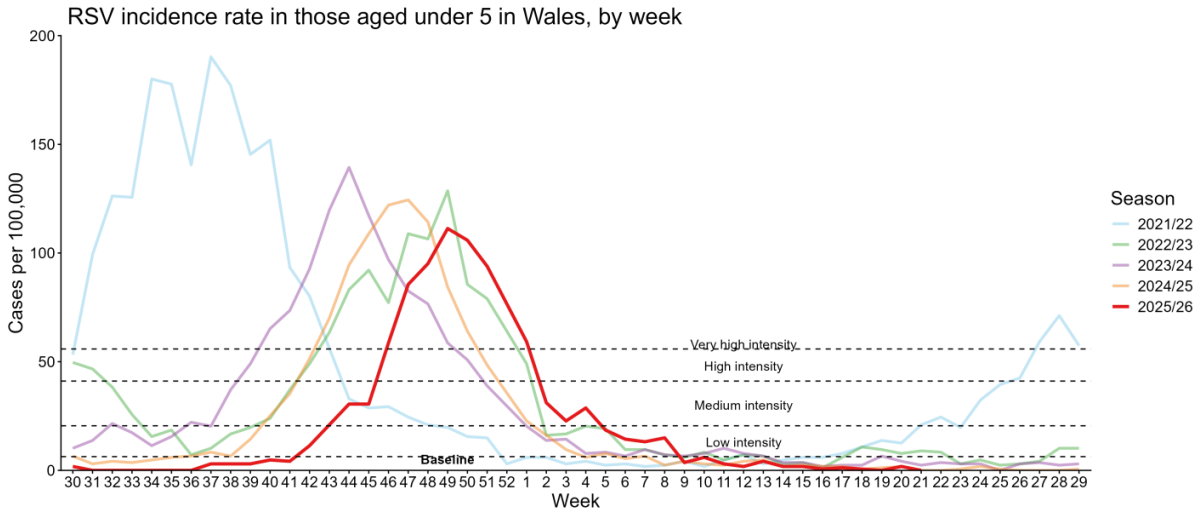


B.3. Respiratory Syncytial Virus (RSV) update

The number of confirmed cases of community acquired RSV admitted to hospital remained stable at 1 during week 21.

RSV incidence per 100,000 in children aged up to 5y is at baseline intensity levels and has decreased to 0 from 1.2 two weeks ago. . During week 21 there was **3** in-patient cases of confirmed RSV, and none were in critical care.

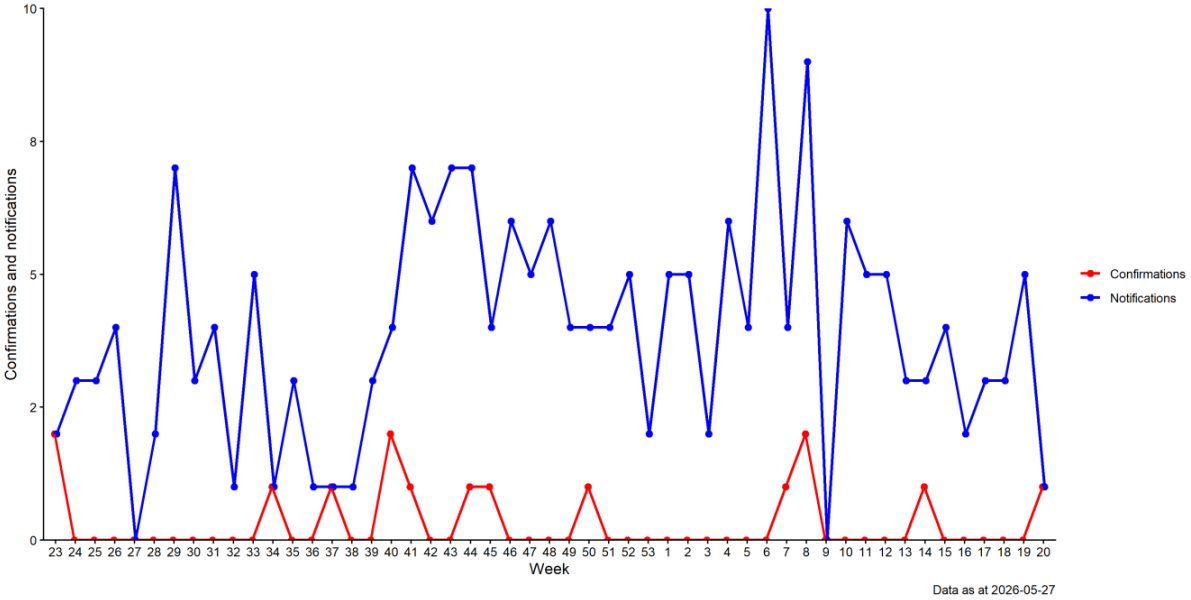
Figure 4: RSV Incidence Rate per 100,000 population under 5 years, weeks 30 2020 to Week 2121 2026 (source: PHW)



B.4. Whooping Cough (Pertussis)

Figure 5 below shows that whooping cough notifications (data as at 27/05/2026) ***decreased***. Lab confirmations continue to be at very low levels (*Whooping cough is now reported on every two weeks*).

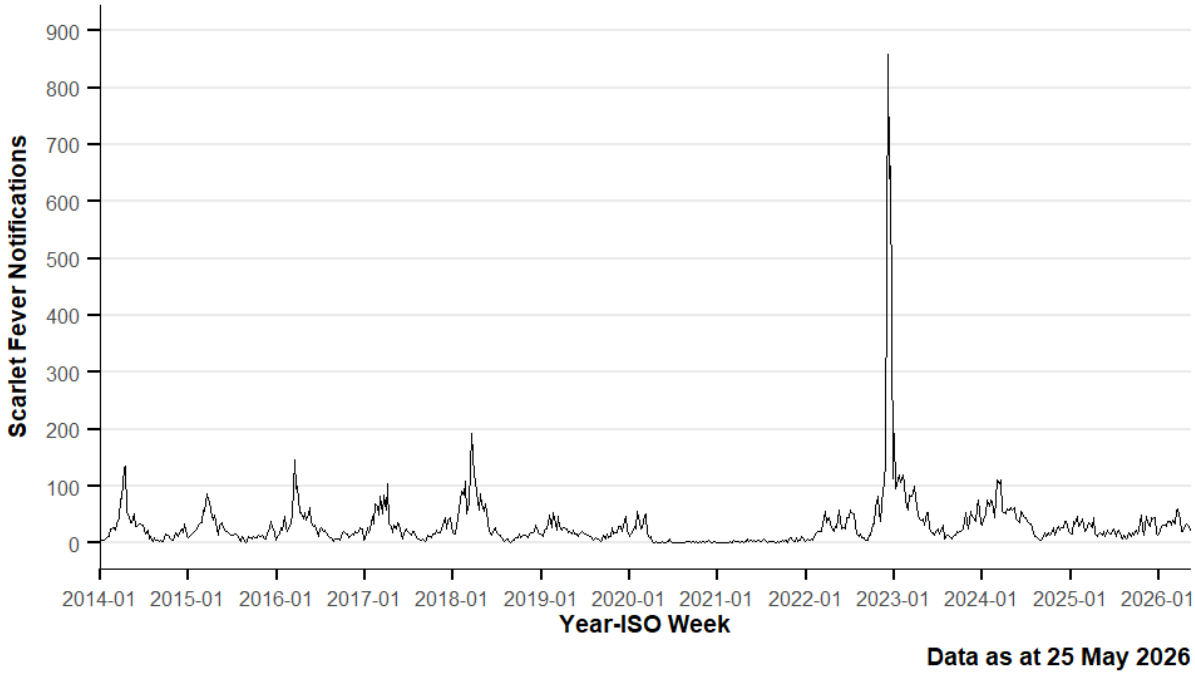
Figure 5: Weekly notifications and confirmations of Pertussis/Whooping Cough in Wales. (Source: PHW)



B.5 iGAS and Scarlet Fever

The number of iGAS notifications is currently low, remaining at seasonally expected levels. Scarlet Fever notifications decreased in the most recent 3-week average as shown in the figure below.

Figure 6: 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 increased from **1,382** in the previous week to **1,401** in the latest reporting week.
- During Week 21, 2026, no ARI outbreak was 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)

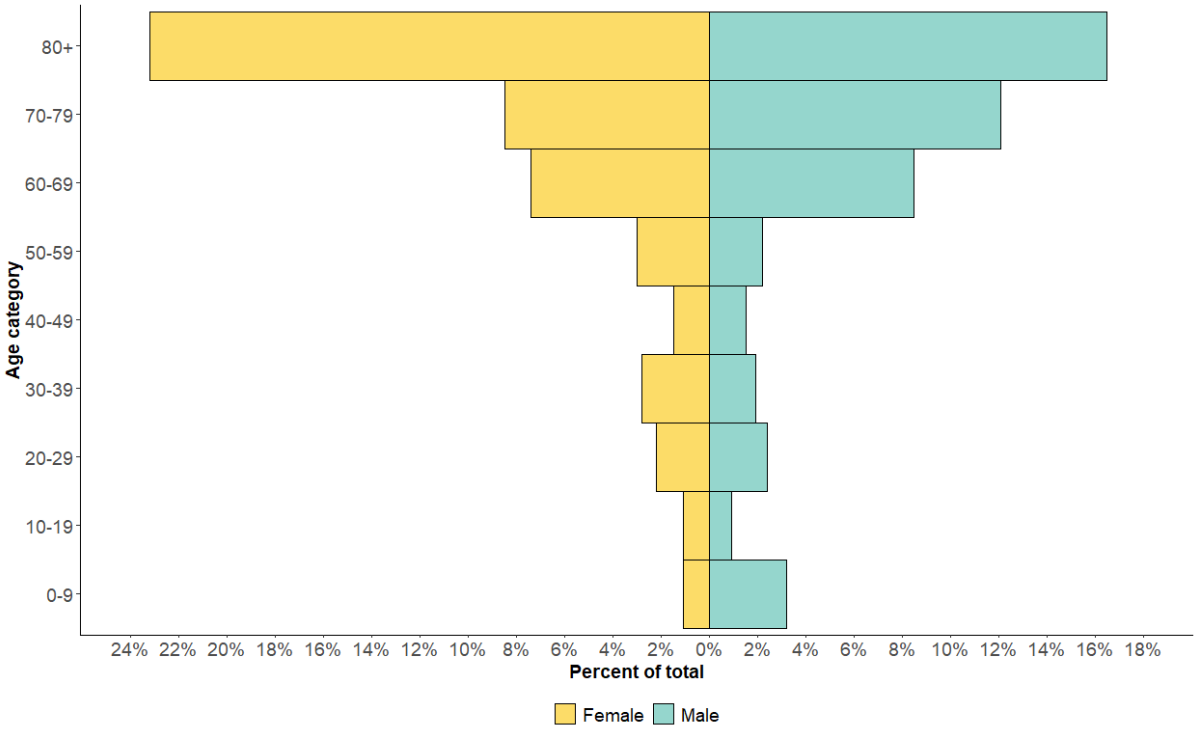
D.1 Norovirus

In the current reporting week (week 21 2026), a total of **27** Norovirus cases were reported in Welsh residents. This is a **decrease** (-18.2%) in reported cases compared to the previous reporting week (week 20 2026), when **33** Norovirus cases were reported.

In the last 12week period (02/03/2026 to 24/05/2026) a total of **540** Norovirus cases were reported in Welsh residents. This is a **decrease** (-13.7%) in reported cases compared to the same 12-week period in the previous year (02/03/2025 to 24/05/2025) when **626** Norovirus cases were reported.

In the last 12 weeks (02/03/2026 to 24/05/2026) 274 (50.7%) Norovirus cases were female and 265 (49.1%) cases were male. The age groups with the most cases were the 80+ (214 cases) and 70-79 (111 cases) age groups. Age data were not available for 1 case and sex data were not available for 1 case.

Figure 7: Age and sex distribution of confirmed Norovirus cases in the last 12 weeks (02/03/2026 to 24/05/2026)



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 2121 2026 (02/03/2026 to 24/05/2026). 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 20 May 2026)

20 May 2026

Following successful completion of disease control activities and surveillance in the zone around:

- a fourth premises near Gainsborough, West Lindsey, Lincolnshire (AIV 2026/17)
- a fifth premises near Gainsborough, West Lindsey, Lincolnshire (AIV 2026/19)

The 10km surveillance zone around each premises has been revoked.

19 May 2026

Following successful completion of disease control activities and surveillance in the zone around a second premises near Great Shelford, South Cambridgeshire, Cambridgeshire (AIV 2026/18) the 3km protection zone has ended and the 10km surveillance zone has been revoked.

15 May 2026

Following successful completion of disease control activities and surveillance in the zone around a second premises near Market Rasen, West Lindsey, Lincolnshire (AIV 2026/16) the surveillance zone has been revoked.

8 May 2026

Following successful completion of disease control activities and surveillance in the zone around a second premises near Market Rasen, West Lindsey, Lincolnshire (AIV 2026/16) the 3km protection zone has ended and the area that formed it becomes part of the surveillance zone.

All poultry on the premises have been humanely culled.

E.2. Ebola disease outbreak caused by Bundibugyo virus – Democratic Republic of the Congo and Uganda – 2026 (28 May)

According to the Ministry of Health of the Democratic Republic of the Congo (DRC), 13 confirmed Ebola cases have been reported since 19 May 2026. The new confirmed cases have been reported from Ituri (12 cases) and North Kivu (1). Over 1 000 contacts are being followed up in Ituri. Overall, according to the Ministry of Health of DRC, there are over 650 suspected cases, including 160 deaths. Sixty-four confirmed cases have been reported in DRC, including six deaths.The confirmed cases have been reported from Ituri (60 confirmed cases; four deaths) and from North Kivu (four confirmed cases; two deaths). Cases have been reported in the capitals of Ituri (Bunia) and North Kivu (Goma). Media have reported

that a case has been confirmed in South Kivu Province in a person that had traveled from Tsopo Province (BBC Ebola outbreak in DR Congo, 21 May 2026).

On 15 May 2026, Africa CDC reported an outbreak of Ebola disease in Ituri Province, DRC (Africa CDC Calls Urgent Regional Coordination Meeting Following Ebola Virus Disease Outbreak in Ituri, 15 May 2026, Africa CDC Special Briefing on Ebola Virus Disease Outbreak Status, 16 May 2026). Laboratory analysis at the Institut National de Recherche Biomedicale of DRC identified Bundibugyo virus (Democratic Republic of the Congo confirms new Ebola outbreak, WHO scales up support | WHO AFRO, 15 May 2026).

According to the World Health Organization (WHO), as of 20 May 2026, approximately 600 suspected cases had been reported, including 139 deaths among suspected cases. Overall, 51 confirmed cases have been reported in DRC and two imported cases in Uganda. In DRC, cases have been reported in both Bunia and Goma, the capital cities of Ituri and North Kivu, respectively (WHO Director-General's opening remarks at the media briefing on Ebola outbreak in DRC and Uganda 20 May 2026).

Based on provisional data published by WHO as of 18 May 2026, a total of 516 suspected cases have been reported from DRC, including 131 suspected deaths. Most suspected cases have been reported in the Mongbwalu (302 suspected cases, 74 deaths) and Rwampara (136 suspected cases, 38 deaths) in Ituri Province. As of 18 May 2026, 35 cases have been confirmed, 33 in DRC and two in Uganda, including five deaths (four in DRC and one in Uganda). The confirmed cases from DRC have been reported from four health zones in Ituri Province ((Rwampara (19), Bunia (6), Nyankunde (4) and Mongbwalu (1)) and from three health zones in North Kivu (Butembo (1), Goma (1) and Katwa (1)). Over 500 contacts are being followed up in DRC and over 100 contacts are being followed up in Uganda (WHO AFRO: Ebola Bundibugyo virus disease outbreak, DRC and Uganda, data as of 18 May 2026).

Clusters of community deaths have been reported, including deaths among healthcare workers in DRC (Epidemic of Ebola Disease caused by Bundibugyo virus in the Democratic Republic of the Congo and Uganda determined a public health emergency of international concern, 17 May 2026, Ebola disease caused by Bundibugyo virus, Democratic Republic of the Congo (The) & Uganda)

E.3. Hantavirus disease outbreak on cruise ship - South Atlantic (13 May)

On 2 May 2026, the Netherlands informed ECDC about an outbreak of unknown aetiology on a cruise liner under the Dutch flag, the MV Hondius. The ship had been on a cruise in the Southern Atlantic after departing from Argentina on 1 April and was en route to Cabo Verde. The cruise followed an itinerary including stops on mainland Antarctica, South Georgia, Nightingale Island, Tristan da Cunha, St Helena, and Ascension Island with Cabo Verde as the next port of call.

As of 13 May 2026, no new cases or deaths have been reported. A repatriated asymptomatic passenger from the United States had inconclusive test results and has been

reclassified as such pending additional laboratory tests. A second US citizen was reported who developed mild symptoms during evacuation and tested negative for the Andes virus.

The cruise ship MV Hondius arrived at the port of Granadilla, Tenerife on Sunday 24 May. Disembarkation of passengers and part of the crew was carried out and completed on 11 May. The passengers and crew members were transported to the airport and repatriated via evacuation flights throughout 10 and 11 May.

Evacuation was carried out from Tenerife to the following countries: Spain (14), France (5), Canada (4), the Netherlands (26), UK (22), Ireland (2), Turkey (3), and the US (17).

Preliminary analysis of genome sequences from some of the positive cases confirmed a high level of genetic similarity between isolates, likely indicating an initial zoonotic spillover event followed by human-to-human transmission. Further results from genomic sequences are pending.

Since the start of the outbreak and as of 12 May 2026, 11 cases (eight confirmed, two probable and one inconclusive) have been reported. Of these, three have passed away. Infection prevention measures, including use of personal protective equipment, isolation of symptomatic individuals and social distancing, have been recommended. Further investigations are ongoing to identify a potential source of exposure.

Even if transmission of ANDV were to happen from passengers evacuated from the ship, ANDV does not transmit easily so it is unlikely that it would cause many cases or a widespread outbreak in the community, if infection prevention and control measures are applied. In addition, the natural reservoir for ANDV is not present in Europe, so introduction to the rodent population and potential rodent-to-human transmission in Europe is not expected. The risk to the general population in the EU/EEA from ANDV spreading from this cruise ship outbreak is very low.

E.4. Influenza A(H5N1) – Multi-country (1 May)

On 29 April 2026, WHO reported a fatal human case of avian influenza A(H5N1) virus infection in a child from Chattogram Division, Bangladesh. The child developed symptoms on 21 January 2026, was hospitalised on 28 January and admitted to intensive care on 31 January, and died on 1 February 2026. The patient had no known comorbidities.

A nasopharyngeal swab collected on 29 January 2026 through the hospital-based influenza surveillance platform tested positive for influenza A(H5) by real-time RT-PCR at the National Influenza Centre (IEDCR) on 7 February 2026. Whole genome sequencing at the International Centre for Diarrhoeal Disease Research, Bangladesh (icddr,b) identified A(H5N1) clade 2.3.2.1a (Gs/GD lineage), consistent with strains circulating in poultry in Bangladesh since 2011. Sequence data are available in GISAID (EPI_ISL_20367262; submitted 19 February 2026; IEDCR). Epidemiological investigation identified exposure to household poultry; two ducks and one chicken reportedly died shortly before illness onset. Animal and environmental investigations by icddr,b found influenza A(H5) by RT-PCR in two duck samples from the community and in two chicken meat samples from

the household freezer; serology was also performed. Samples from symptomatic close human contacts tested negative for influenza A(H5).

This is the first confirmed human A(H5) case in Bangladesh in 2026. In 2025, four cases were reported in Bangladesh.

E.5. Avian influenza A(H5N6) Multi-Country (13 May)

On 8 May 2026, one human case of human infection with avian influenza A(H5N6) virus was reported by WHO in the Avian Influenza Weekly Update Number 1044 (WHO Avian Influenza Weekly Update). The case was a female in her fifties from Chongqing Municipality, China. The person developed symptoms on 16 April. She was hospitalised on 23 April, after developing severe pneumonia, and died on 3 May. The case had exposure to live poultry, which she purchased, slaughtered and consumed prior symptoms onset. Samples collected from the cutting board were positive for A(H5) virus. None of the close contacts developed symptoms and all tested negative for influenza virus.

Since 2014, and as of 8 May 2026, a total of 94 laboratory-confirmed human cases of avian influenza A(H5N6), including 58 deaths (case fatality rate: 62.4%), have been reported from China (93) and Laos (1) to WHO. The majority of cases (>90%) reported exposure to domestic poultry.

E.6. 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.7. Chikungunya virus disease – French Guiana, France – 2026 (1 May)

There is ongoing chikungunya virus circulation in French Guiana. Since January 2026, 143 confirmed autochthonous cases have been identified, with 33 cases in week 16 2026, compared with 15 cases the previous week. Most cases (n=115; 80%) were detected in Littoral ouest sector, located on the western side of French Guiana, near the border with Suriname. This sector has now entered the outbreak epidemic phase, the highest level, a level higher than the isolated clusters phase.

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.

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.8. Human cases of swine influenza A(H1N2) variant virus infection (13 May)

On 8 May 2026, one new human infection with swine influenza A(H1N2) variant (v) virus was reported in the Weekly US Influenza Surveillance Report for week 17 (Weekly US Influenza Surveillance Report | CDC). The case was in a person under 18 years old who developed respiratory illness during the week ending on 4 April 2026. After their symptoms worsened, the person sought medical help during the week ending on 18 April 2026, but was not hospitalised, and has since recovered. Investigation by public health authorities did not find any direct or indirect contact with pigs. A close contact developed mild respiratory illness on the same day as the case, but there was no other human cases of A(H1N2)v infection associated with this event. This is the first case of A(H1N2)v infection reported in the US this year, and the second associated with the 2025-2026 season.

Overall, 34 cases of human A(H1N2)v infection have been reported globally since 2019, four of which were reported in the EU/EEA: Austria (2021), Denmark (2019), France (2021), and the Netherlands (2022). Outside the EU/EEA, cases have been reported in Brazil (3), Canada (3), Taiwan (3), the United Kingdom (1), the US (19), and mainland China (1).