

Weekly Acute Respiratory Infection Report

Public Health Wales

Communicable Disease Surveillance Centre

Report week: 37 (ending 13 September 2026)



Headline

- Influenza circulation is at out of season levels.
- Respiratory Syncytial Virus (RSV) has decreased and is at baseline intensity levels
- COVID-19 case numbers have remained broadly stable in recent weeks.
- GP consultations for acute respiratory infections decreased during Week 37 compared to the previous week.
- 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.

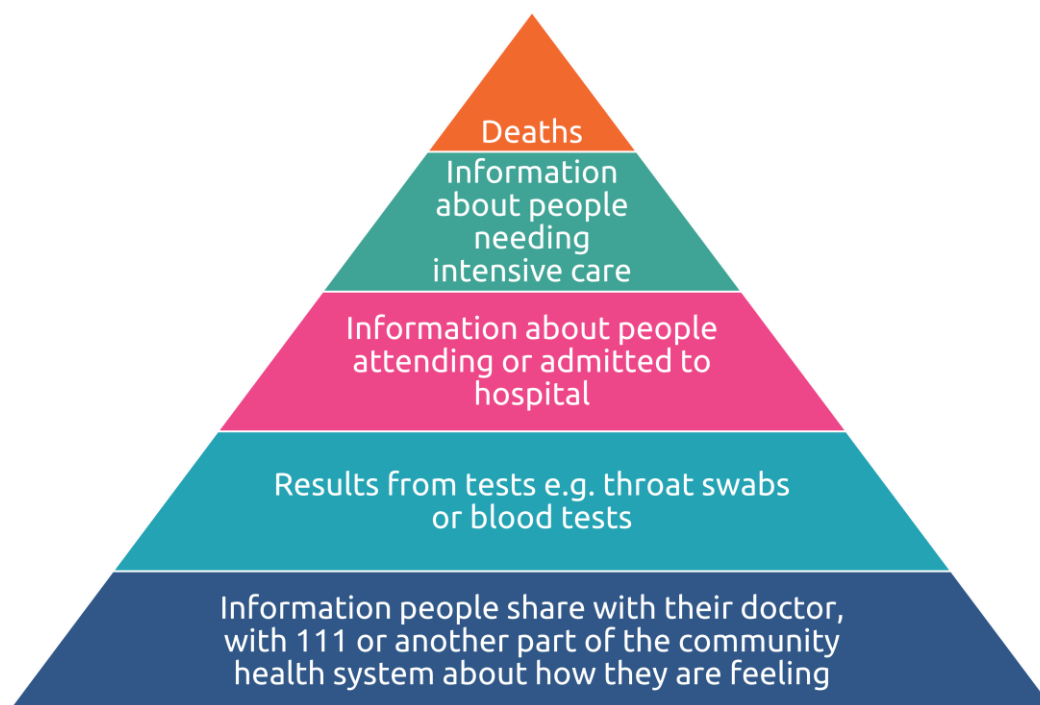


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High Level Summary Points

	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 (data as at 19 th August).	Admissions in patients testing positive for COVID-19, RSV and Influenza decreased during week ending 13/09/2026 (<1% of total admissions).
Influenza	Overall, influenza is not currently circulating in Wales. The overall proportion of samples testing positive in hospital and non-sentinel patients decreased in the most recent week to 3.4%. Consultations for influenza-like illness (ILI) with sentinel GPs are at baseline intensity levels and increased compared to the previous week. Three 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 remained stable at 13 in the most recent week. There were 40 in-patient cases of confirmed influenza, two of whom were in critical care.
Influenza type breakdown	Since 2025 Week 40: 5,067 total influenza cases confirmed (1,587 influenza A(H3N2), 171 influenza A(H1N1)pdm09, 3,208 influenza A untyped and 101 influenza B). In the most recent week: 8 influenza A(H3), 4 influenza A(H1N1), 25 influenza A untyped and 3 influenza B.	
COVID-19	The overall proportion of samples testing increased to 6.5% in hospital and non-sentinel GP practices. Consultations with Sentinel GPs for COVID-19 decreased in recent weeks.	The number of confirmed cases of community acquired COVID-19 admitted to hospital decreased to one. There were four in-patient cases of confirmed COVID-19, none of whom were in critical care.
RSV	RSV incidence per 100,000 in children aged up to 5y is at baseline intensity levels. This remained stable compared to the previous week.	The number of confirmed cases of community acquired RSV admitted to hospital decreased to zero. There were no in-patient cases of confirmed RSV.
Other respiratory pathogens	Rhinovirus and parainfluenza are the most frequently detected other cause of ARI.	



1. Community surveillance indicators

GP Consultations

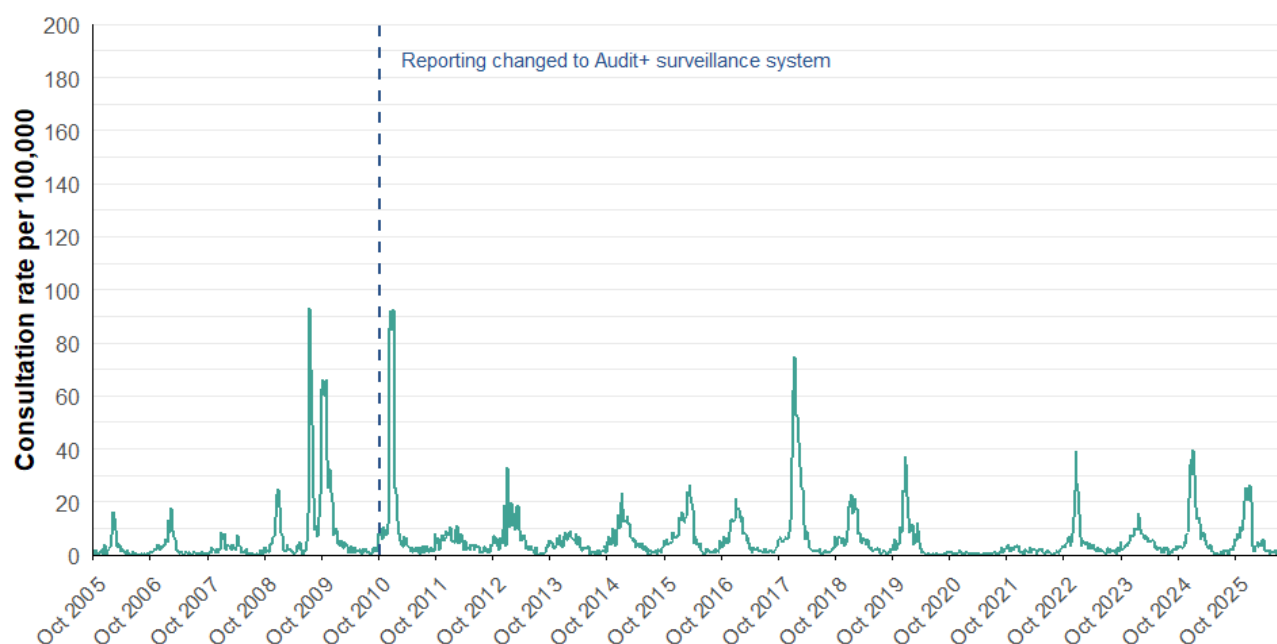
- The sentinel GP consultation rate for influenza-like illness (ILI) is at baseline and the three-week trend is increasing (Figures 1.1, 1.2).
- There were 1.5 ILI consultations per 100,000 practice population in the most recent week, an increase compared to the previous week (1 consultations per 100,000).
- In Week 33, using all available data from general practices, there were 2.1 ARI consultations per 100,000 practice population, an increase from 1.7 in the previous week (Table 1.1; latest data available). The highest rates were found in people aged under 1 year (371.2) followed by people aged 1 to 4 (319.8) and people aged 75+ (103.3) (Figure 1.3).

Ambulance Calls

- The number of ambulance calls recorded referring to respiratory syndromic indicators increased from 1,411 in the previous week to 1,505 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).

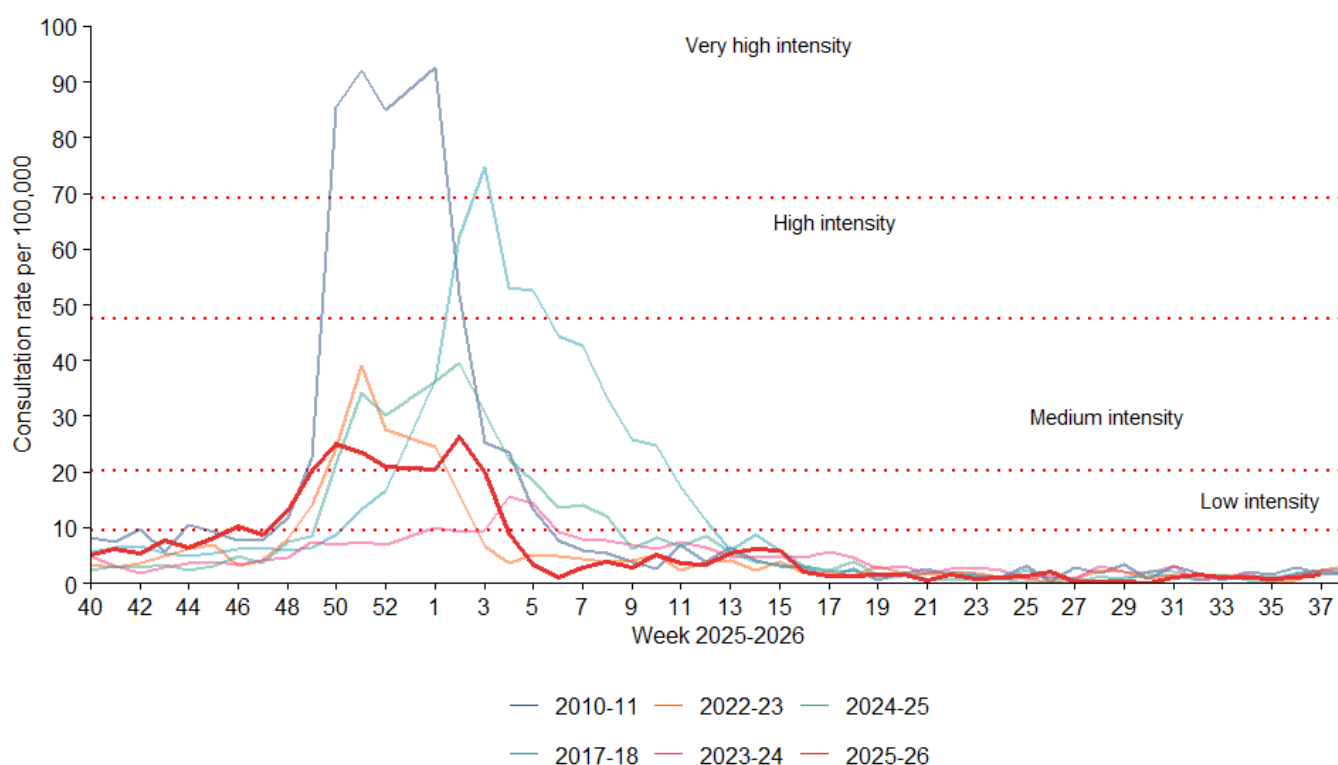
GP consultations – Sentinel Network

Figure 1.1. Sentinel GP network clinical consultation rate for ILI per 100,000 practice population (Week 40, 2004 - Week 37, 2026).



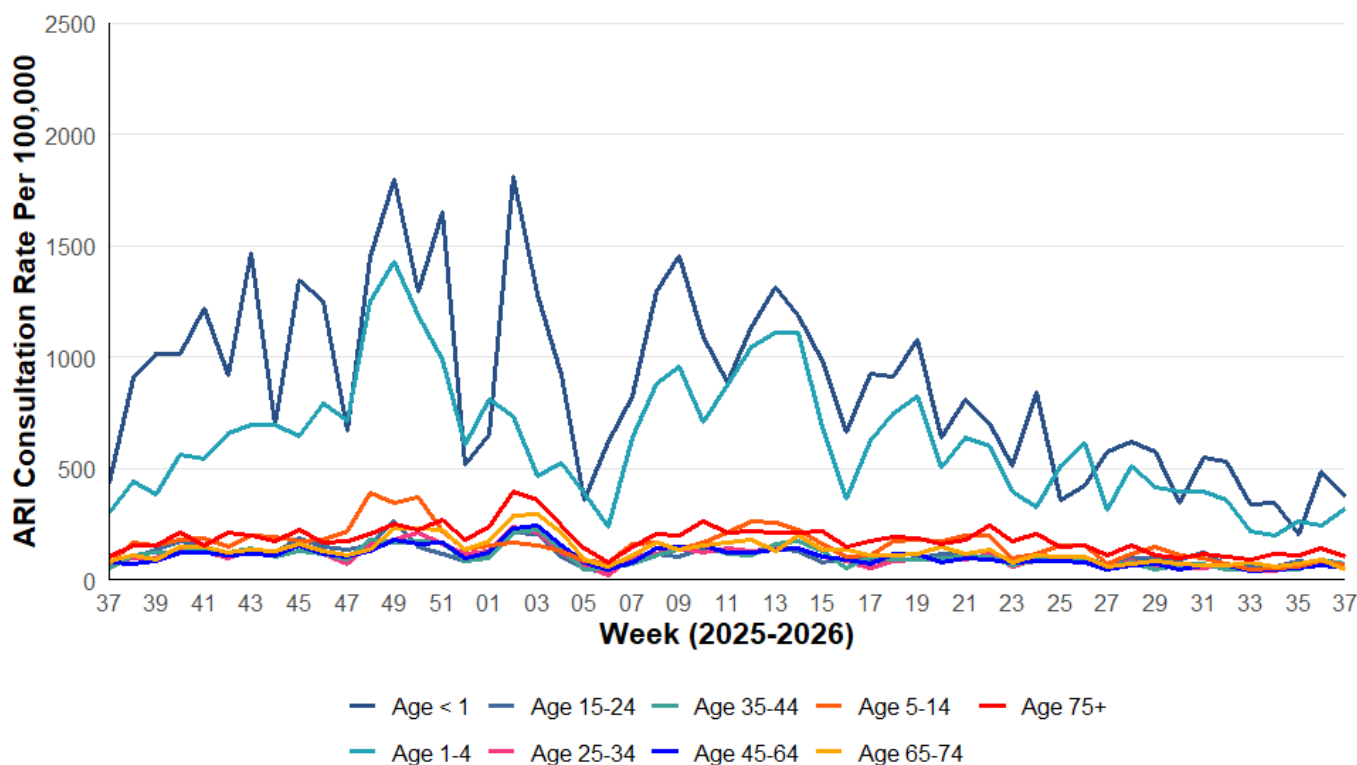
Data correct as of 15/09/2026

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



Data correct as of 15/09/2026

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



Data correct as of 15/09/2026

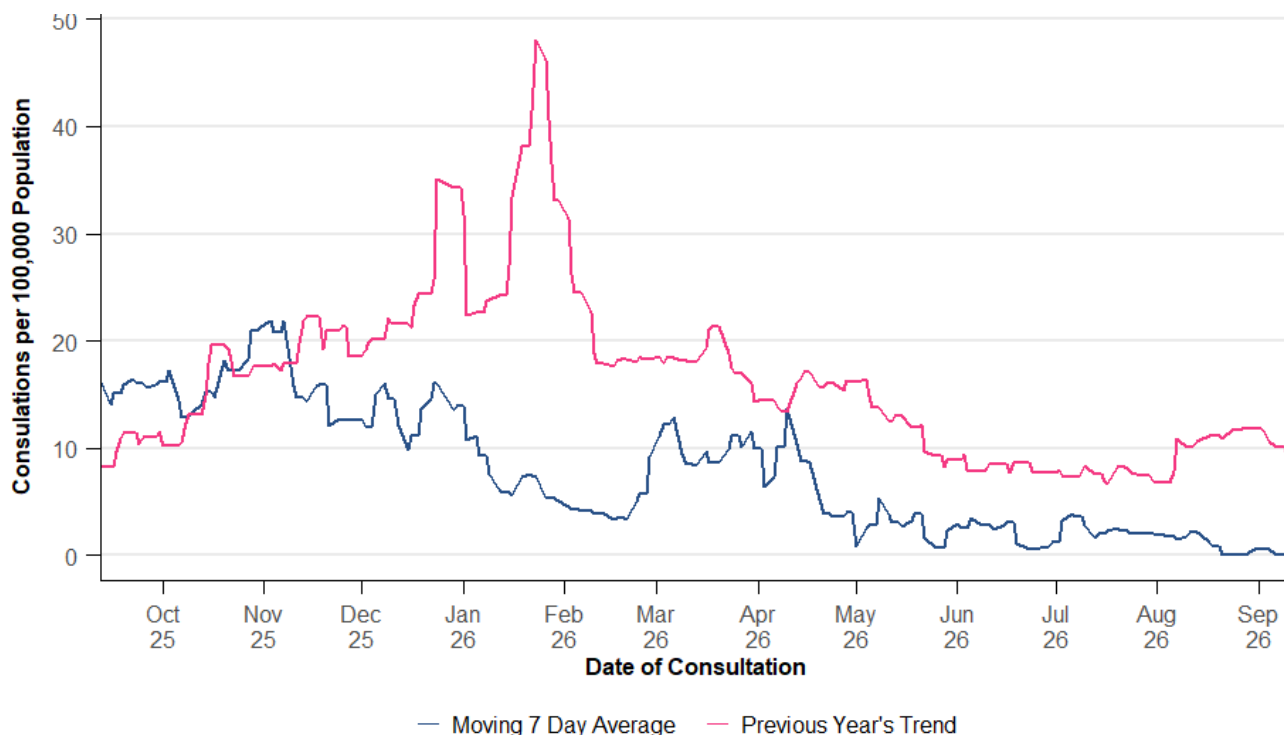
GP Consultations - All Wales

Table 1.1. Summary of GP consultations per 100,000 practice population in Wales, by indicator, for Week 37, 2026. This table uses all available GP surveillance data (from sentinel and non-sentinel practices; latest data available).

Indicator	Current Reporting Week	Preceding Week	Equivalent Period Last Year
ARI	2.12	1.68	7.00
COVID-19	0.00	0.00	0.05
LRTI	1.02	0.25	2.17
Pneumonia	0.01	0.01	0.03
Severe asthma	0.04	0.04	0.35
URTI	1.09	0.94	4.85
Total	4.28	3.4	14.45

NB: "Current reporting week" refers to the average daily rate in the current reporting week. "Preceding week" refers to the average daily rate in the preceding week. "Equivalent period last year" refers to the average daily rate in the equivalent period last year.

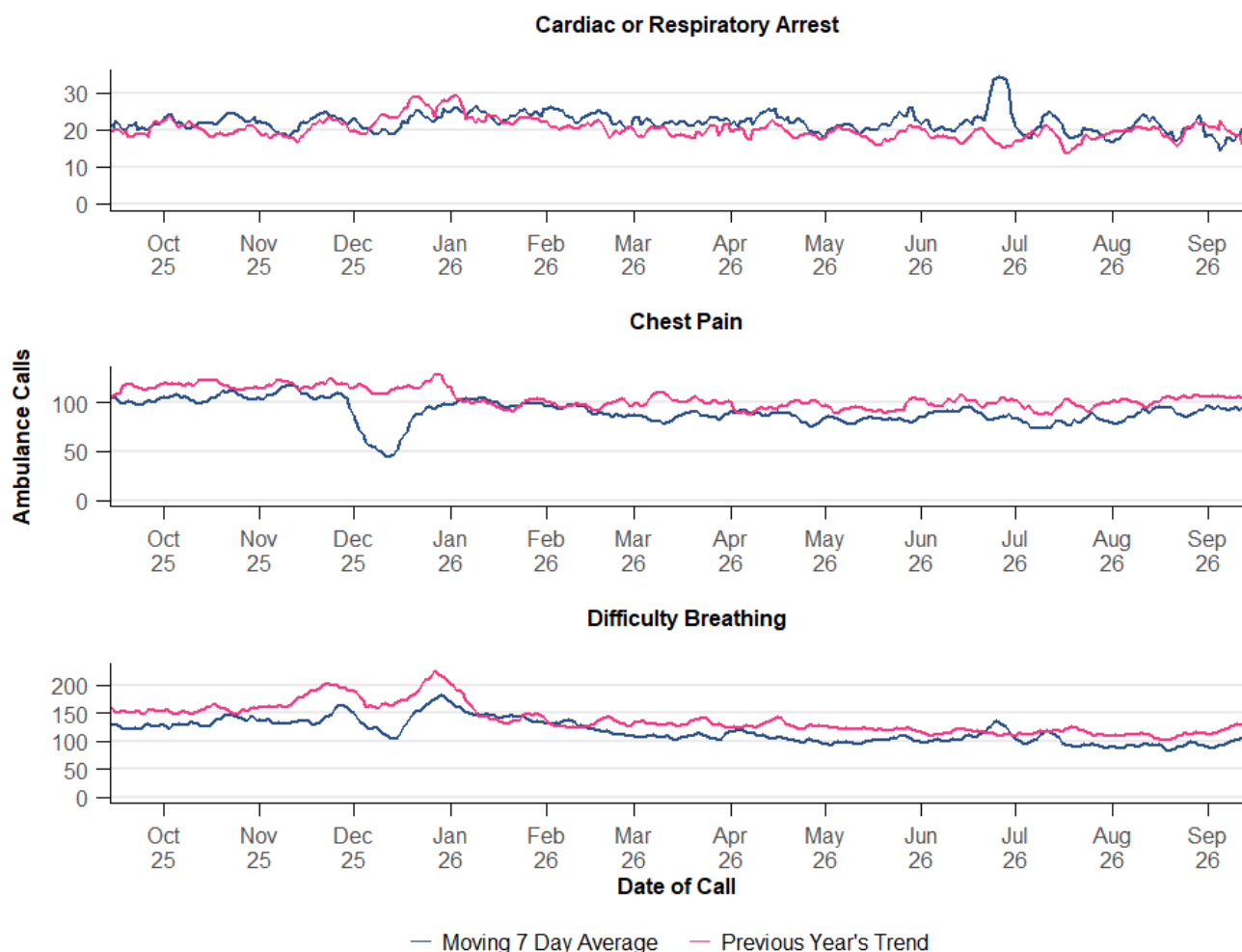
Figure 1.4. Sentinel GP network consultation rates per 100,000 practice population for Acute Respiratory Infection (ARI).



Data correct as of 15/09/2026

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.



Data correct as of 15/09/2026

Table 1.2. Summary of weekly number of Ambulance calls, by symptom in Wales, for Week 37, 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	129	122	147
Chest Pain	660	654	743
Difficulty Breathing	716	635	810
Total	1,505	1,411	1,700

NB: "Current reporting week" refers to the total number of calls in the current reporting week. "Preceding week" refers to the total number of calls in the preceding week. "Equivalent period last year" refers to the total number of calls in the equivalent period last year.



2. Virological Surveillance

Wales Sentinel GP and Sentinel Community Pharmacy Network

- There were 52 surveillance samples from patients with ILI symptoms collected by sentinel GPs and community pharmacies during Week 37, 2026, as at 16/09/2026 (Table 2.1, Figure 2.1).
- The most commonly detected pathogens were rhinovirus (12) followed by SARS-CoV-2 (COVID-19) (7) and influenza A (3). Of the 52 tests, 51.9% were negative for all respiratory pathogens (Table 2.1, Figure 2.1).

All Wales Datastore Respiratory Infection Testing

- There were 601 samples receiving multiplex respiratory panel testing, collected from patients attending hospitals and non-sentinel GPs during Week 37 (Table 2.2, Figure 2.2).
- The most commonly detected pathogens were rhinovirus (76) followed by SARS-CoV-2 (COVID-19) (39) and parainfluenza (25). Of the 601 tests, 70.9% were negative for all respiratory pathogens (Table 2.2, Figure 2.2).

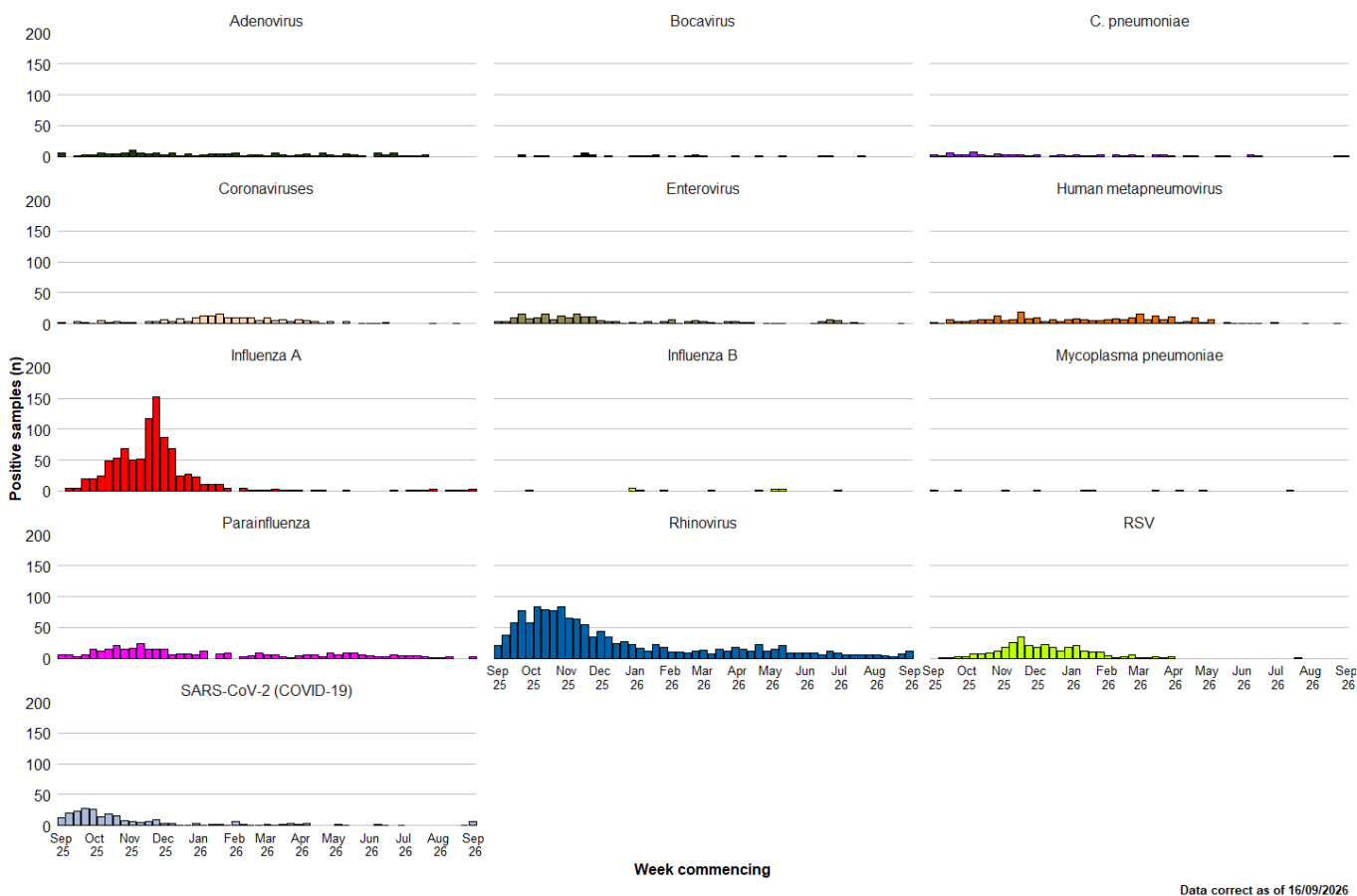
Additionally, during Week 37, 356 samples from patients were tested for influenza, RSV and SARS-CoV-2 only (Figure 2.3). Of these the following tested positive:

- 17 for influenza (15 for influenza A, two for influenza B)
- 34 for SARS-CoV-2 (COVID-19)
- 0 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 37, 2026.

Pathogens Detected	Count (n)	Positivity (current week)	Positivity (previous week)	Trend
Rhinovirus	12	23.1%	21.2%	Increasing
SARS-CoV-2 (COVID-19)	7	13.5%	3.0%	Increasing
Influenza A	3	5.8%	3.0%	Increasing
Parainfluenza	2	3.8%	0.0%	Increasing
C. pneumoniae	1	1.9%	3.0%	Decreasing
Influenza B	0	0.0%	0.0%	Stable
RSV	0	0.0%	0.0%	Stable
Adenovirus	0	0.0%	0.0%	Stable
Mycoplasma pneumoniae	0	0.0%	0.0%	Stable
Human metapneumovirus	0	0.0%	3.0%	Decreasing
Enterovirus	0	0.0%	3.0%	Decreasing
Bocavirus	0	0.0%	0.0%	Stable
Coronaviruses	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 37, 2025 to Week 37, 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 37, 2026.

Pathogens Detected	Count (n)	Positivity (current week)	Positivity (previous week)	Trend
Rhinovirus	76	12.6%	6.8%	Increasing
SARS-CoV-2 (COVID-19)	39	6.5%	4.1%	Increasing
Parainfluenza	25	4.2%	2.3%	Increasing
Influenza A	19	3.2%	3.9%	Stable
Enterovirus	13	2.2%	1.8%	Stable
Adenovirus	10	1.7%	2.1%	Stable
Seasonal coronaviruses	2	0.3%	0.4%	Stable
Influenza B	1	0.2%	0.4%	Stable
RSV	1	0.2%	0.2%	Stable
Human metapneumovirus	1	0.2%	0.2%	Stable
Mycoplasma pneumoniae	0	0.0%	0.0%	Stable
Bocavirus	0	0.0%	0.0%	Stable
C. pneumoniae	0	0.0%	0.2%	Stable

Figure 2.2. Pathogens detected in samples collected from hospital and non-Sentinel GP patients, by week of sample collection, Week 37, 2025 to Week 37, 2026.

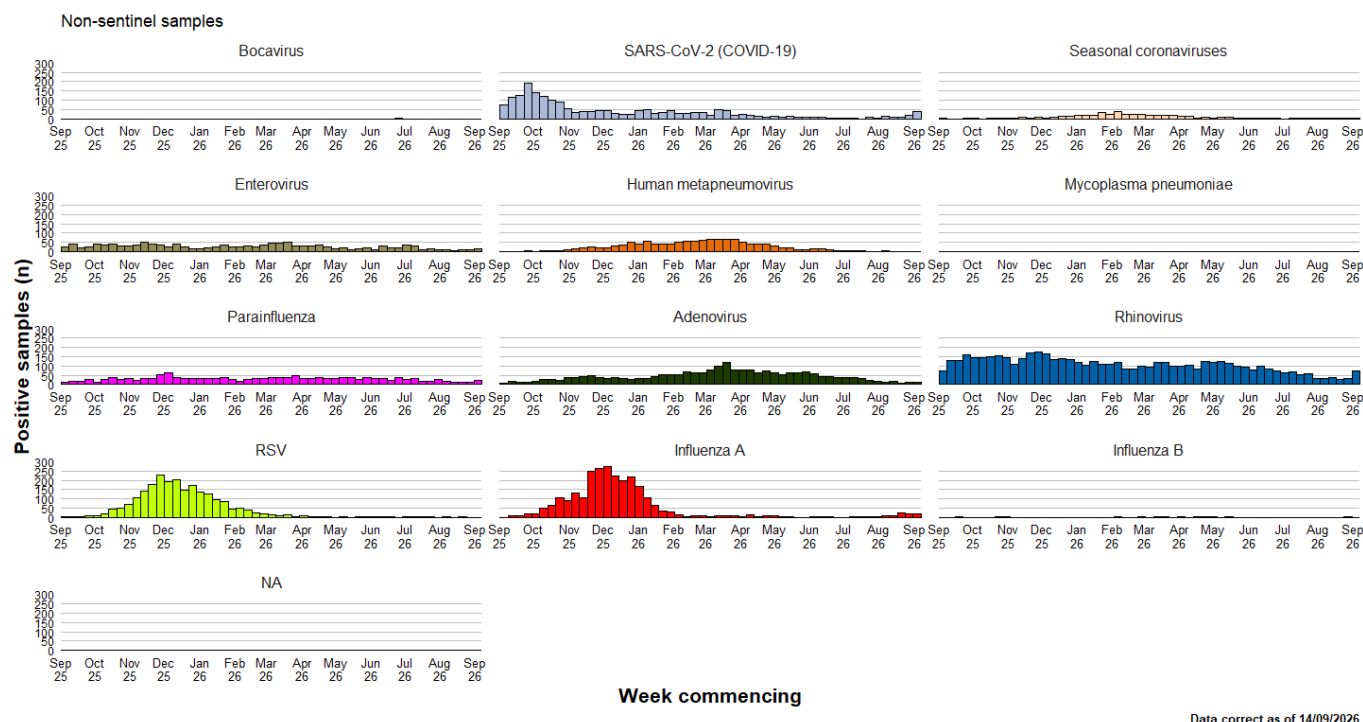
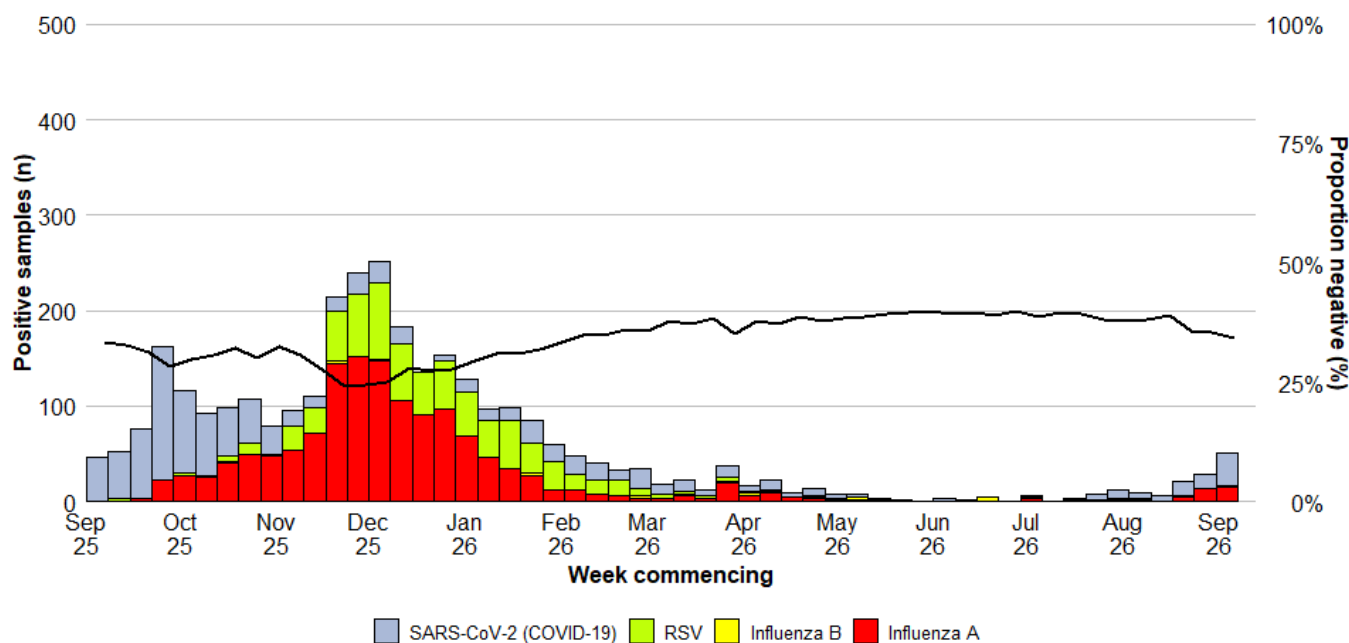


Figure 2.3. Samples from hospital patients submitted for RSV, Influenza and SARS-CoV-2 testing only, by week of sample collection, Week 37, 2025 to Week 37, 2026.





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

Sentinel SARI in emergency departments

- During the previous four weeks there were 22 surveillance samples taken from SARI surveillance sentinel emergency departments. The most common pathogen identified from these samples was Rhinovirus/Enterovirus(6) followed by Parainfluenza(1) and SARS-CoV-2 (COVID-19)(1). Of the 22 samples collected, 63.6% 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 0% for influenza, 5% for SARS-CoV-2 and 0% for RSV.

Hospital in-patients

- During week ending 13/09/2026 there were 14 patients admitted to hospital with confirmed COVID-19, RSV or influenza, (4 less than the previous week), equating to 0% of all hospital admissions in that reporting week.
- At 23:59 on 13/09/2026, there were 44 patients in hospital with confirmed COVID-19, RSV or influenza, 1 less than the previous Sunday. This equates to 0% of all hospital in-patients (IPs) at that time. Of whom 80% (35) were hospital acquired (HA).

Critical-care

- During week ending 13/09/2026 there were 3 ARI critical care (CC) admissions (2 more than the previous week), equating to 2% of all CC admissions in that reporting week.
- At 23:59 on 13/09/2026, there were 2 patients in CC with confirmed COVID-19, RSV or influenza, 1 more than the previous Sunday. This equates to 1% of all CC in-patients at that time. Of whom 100% (2) were hospital acquired (HA).

Virological surveillance in ICU

- During Week 37, 2026, 40 respiratory samples were tested from patients in intensive care units (ICU). Of these: two tested positive for Influenza, one tested positive for SARS-CoV-2 (COVID-19) and zero tested positive for RSV (Figure 3.4).

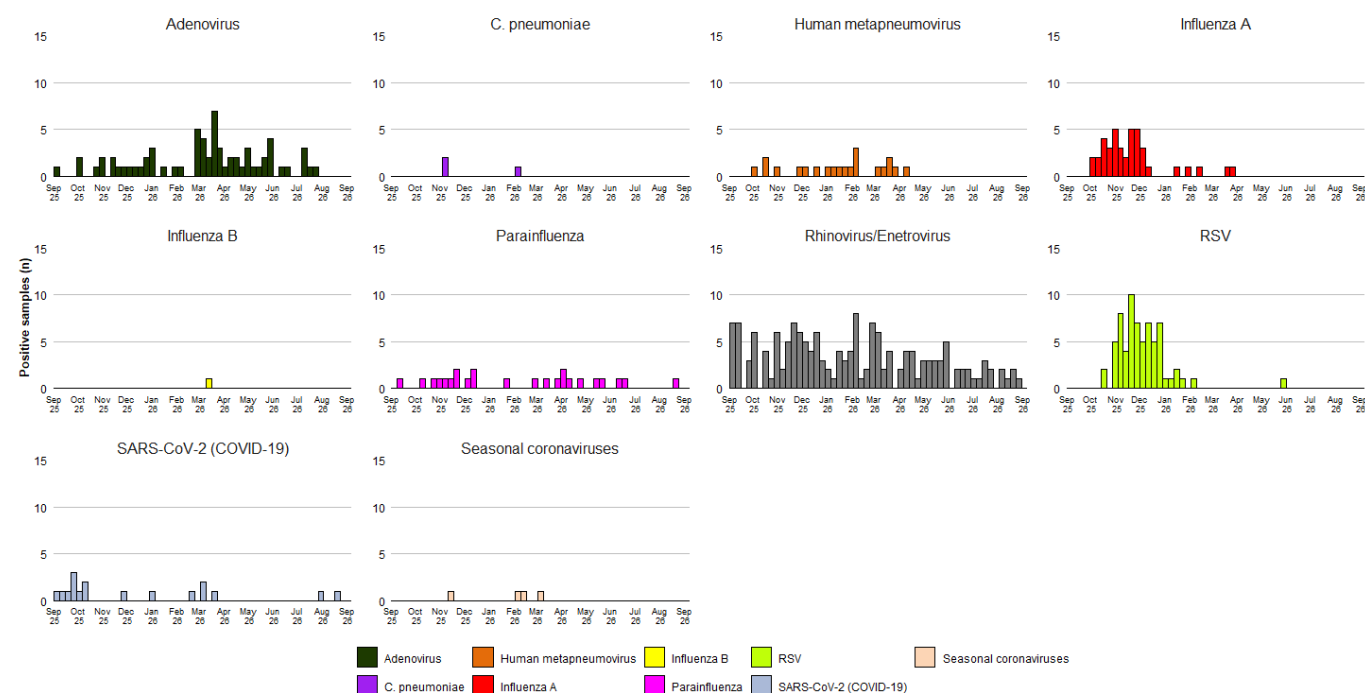
For detailed reports on surveillance of ARI in hospitals, including breakdowns by health board and age-group see: [Hospital admissions dashboard](#)

Wales Sentinel SARI Emergency Department Network

Table 3.1 Pathogens detected and sample positivity for samples collected from symptomatic patients presenting at participating SARI surveillance sentinel emergency departments, for Week 36, 2026.

Pathogens Detected	Meeting SARI case definition in the last 4 weeks		Meeting SARI case definition in the last 12 months	
	n	%	n	%
Adenovirus	0	0.0%	66	10.8%
C. pneumoniae	0	0.0%	3	0.5%
Human metapneumovirus	0	0.0%	21	3.4%
Influenza A	0	0.0%	48	7.9%
Influenza B	0	0.0%	1	0.2%
Mycoplasma pneumoniae	0	0.0%	0	0.0%
Parainfluenza	1	4.5%	24	3.9%
Pertussis	0	0.0%	0	0.0%
RSV	0	0.0%	67	11.0%
Rhinovirus/Enterovirus	6	27.3%	163	26.7%
SARS-CoV-2 (COVID-19)	1	4.5%	17	2.8%
Seasonal coronaviruses	0	0.0%	4	0.7%
Negative	14	63.6%	265	43.4%
Total	22	100%	614	100%

Figure 3.1 Pathogens detected in samples collected from symptomatic patients presenting at participating SARI surveillance sentinel emergency departments, for Week 36, 2026 and previous 12 months.



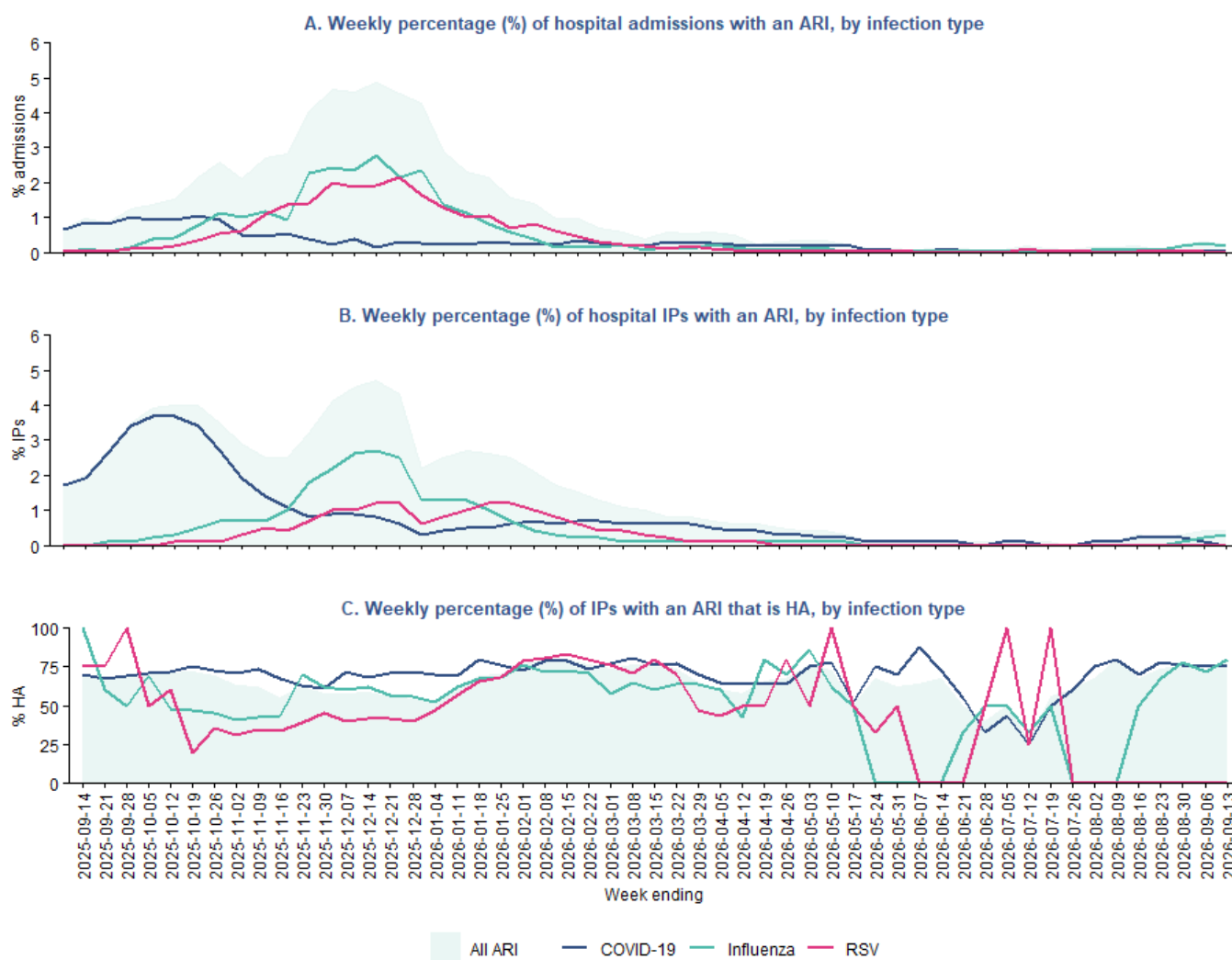
Data correct as of 10/09/2026

Acute Respiratory Infection Surveillance in Hospital In-Patients

Table 3.2. Hospital admissions in patients confirmed **with** COVID-19, influenza and RSV (acute respiratory infection may not necessarily be the primary cause of admission).

Infection	Hospital admissions		Hospital In-patients		
	Count	% of all admissions	Count	% of all IPs	% HA (n)
COVID-19	1	<1%	4	<1%	75% (3)
Influenza	13	<1%	40	0%	80% (32)
RSV	0	0%	0	0%	0% (0)
ARI total	14	<1%	44	0%	80% (35)

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: 16-09-2026

Acute Respiratory Infection Surveillance in Critical-Care In-Patients

Table 3.3. Critical care (CC) admissions in patients confirmed with COVID-19, influenza and RSV (acute respiratory infection may not necessarily be the primary cause of admission).

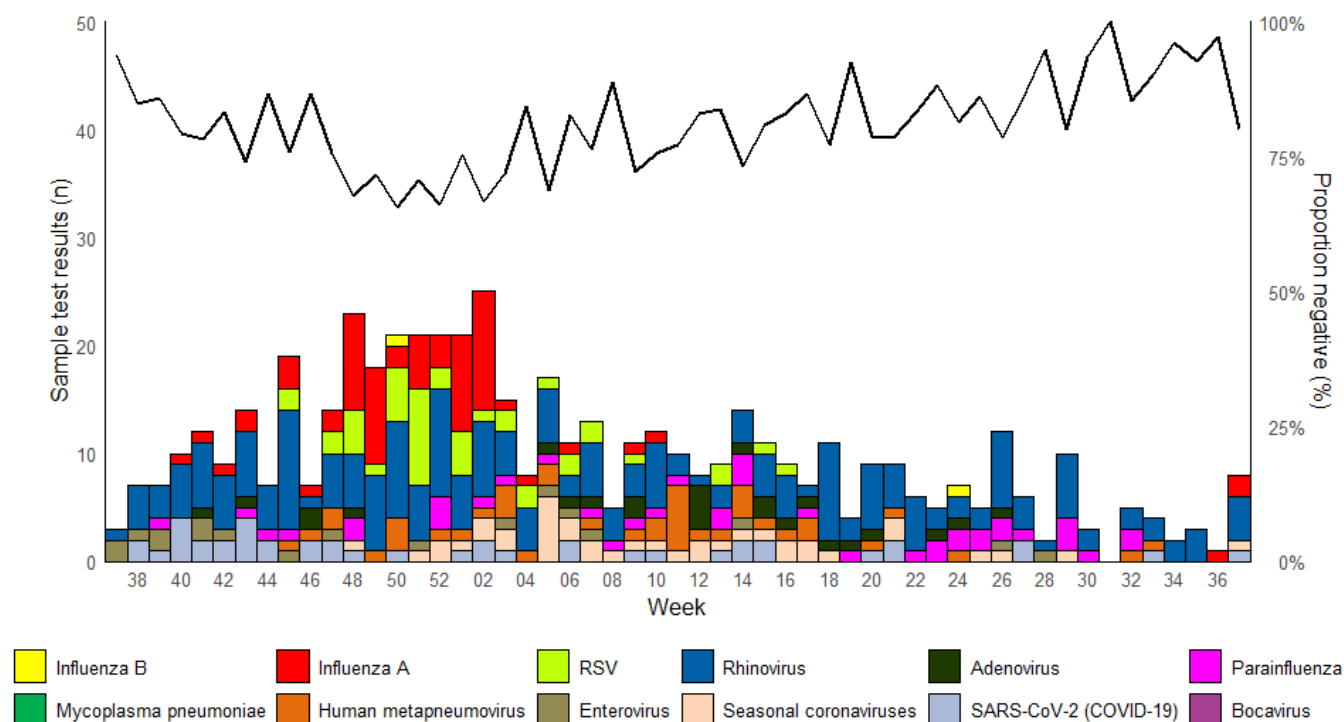
Infection	CC admissions		CC In-patients		
	Count	% of all CC admissions	Count	% of all CC In-patients	% HA (n)
COVID-19	0	0%	0	0%	0% (0)
Influenza	3	2%	2	1%	100% (2)
RSV	0	0%	0	0%	0% (0)
ARI total	3	2%	2	1%	100% (2)

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: 16-09-2026

Figure 3.4. Samples submitted for virological testing from ICU patients, by week of sample collection, Week 37, 2025 to Week 37, 2026. The black line indicates the percentage of samples which tested negative for any of the pathogens listed.



4. Settings-based surveillance and outbreaks

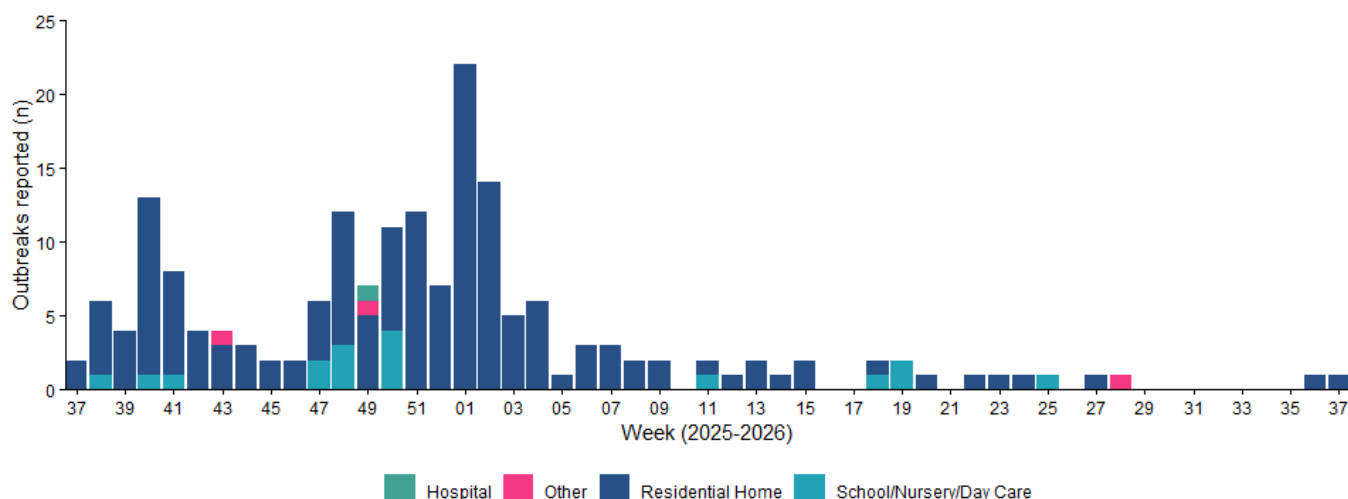
Acute Respiratory Infection Outbreaks Reported to Public Health Wales Health Protection Team

During Week 37, 2026, 1 ARI outbreak was reported to the Public Health Wales Health Protection Team.

Of these:

- The incident was COVID-19
- The incident was in a Residential Home

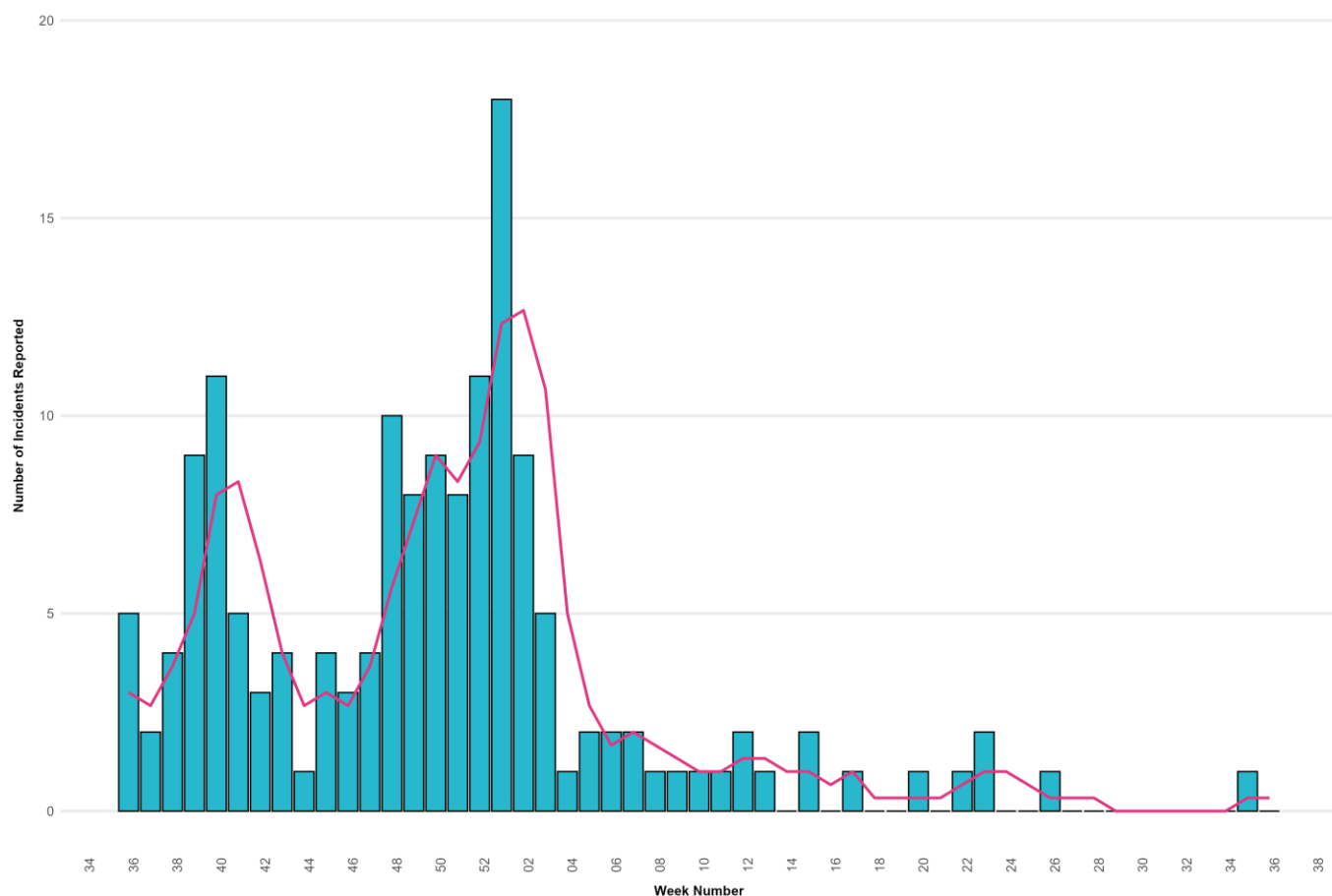
Figure 4.1. ARI outbreaks and incidents reported to Public Health Wales Health Protection Team, by setting and week of report.



Data correct as of 14/09/2026

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.



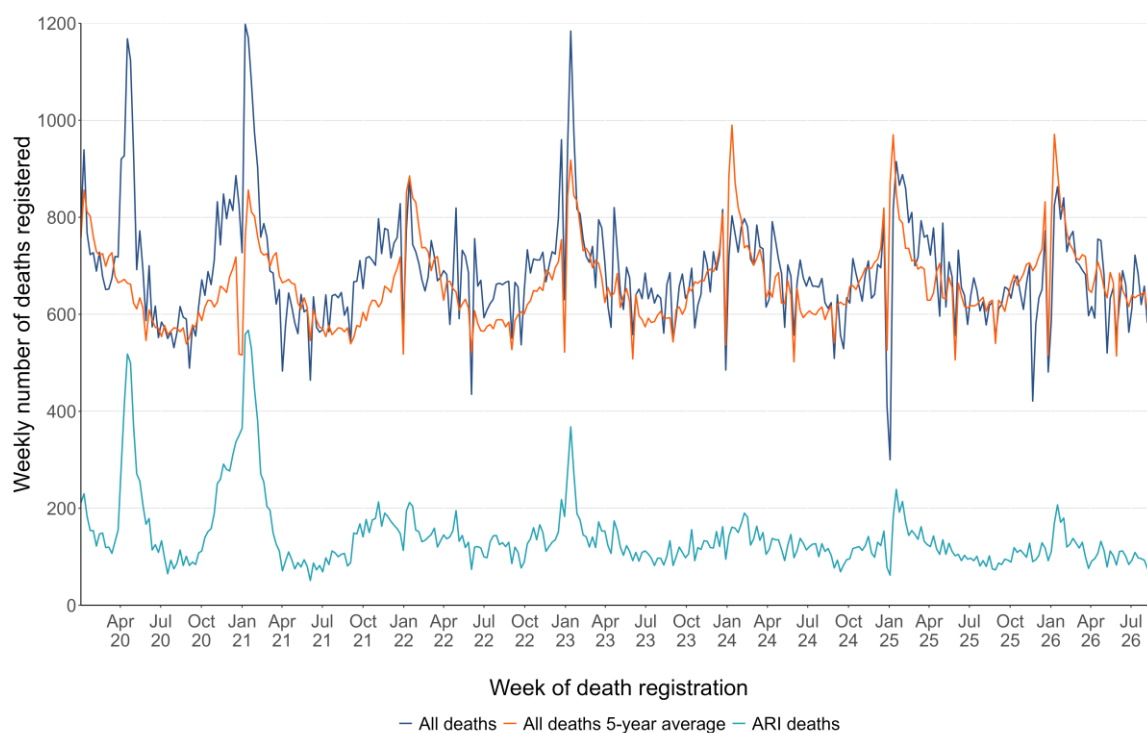
Data as at 2026-09-08



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.



Data as of 15/09/2026

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

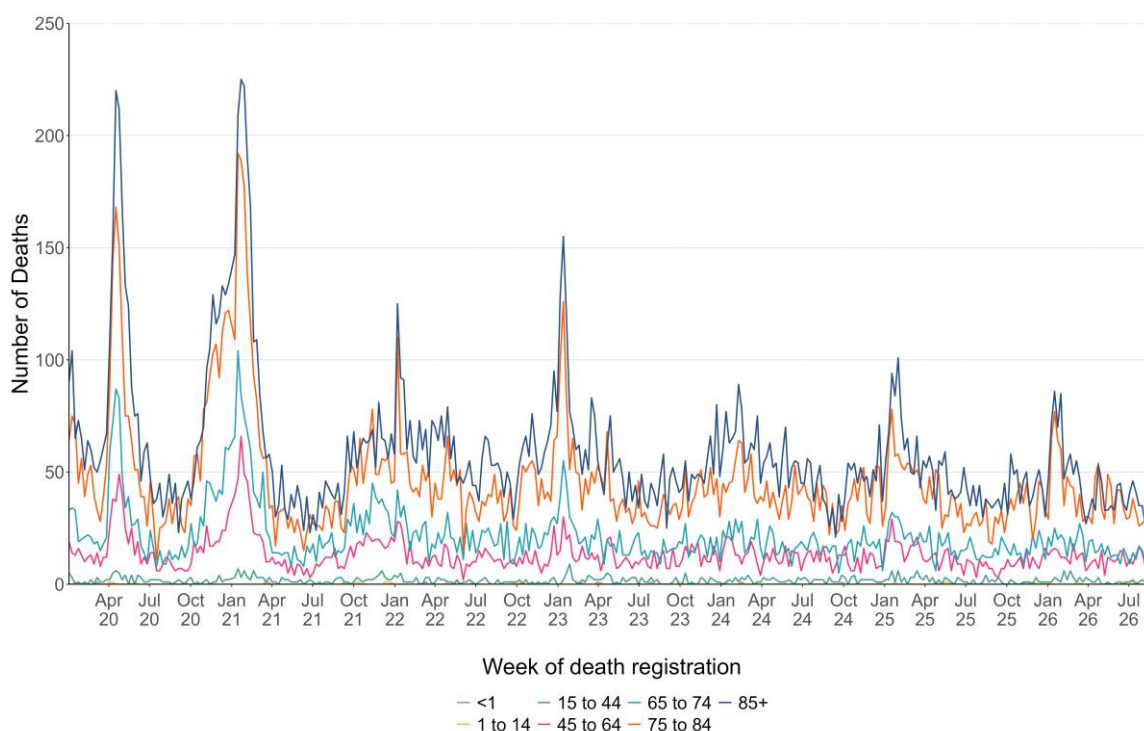


Figure 5.3. Numbers of deaths due to ARI, by place of death and week of death registration.

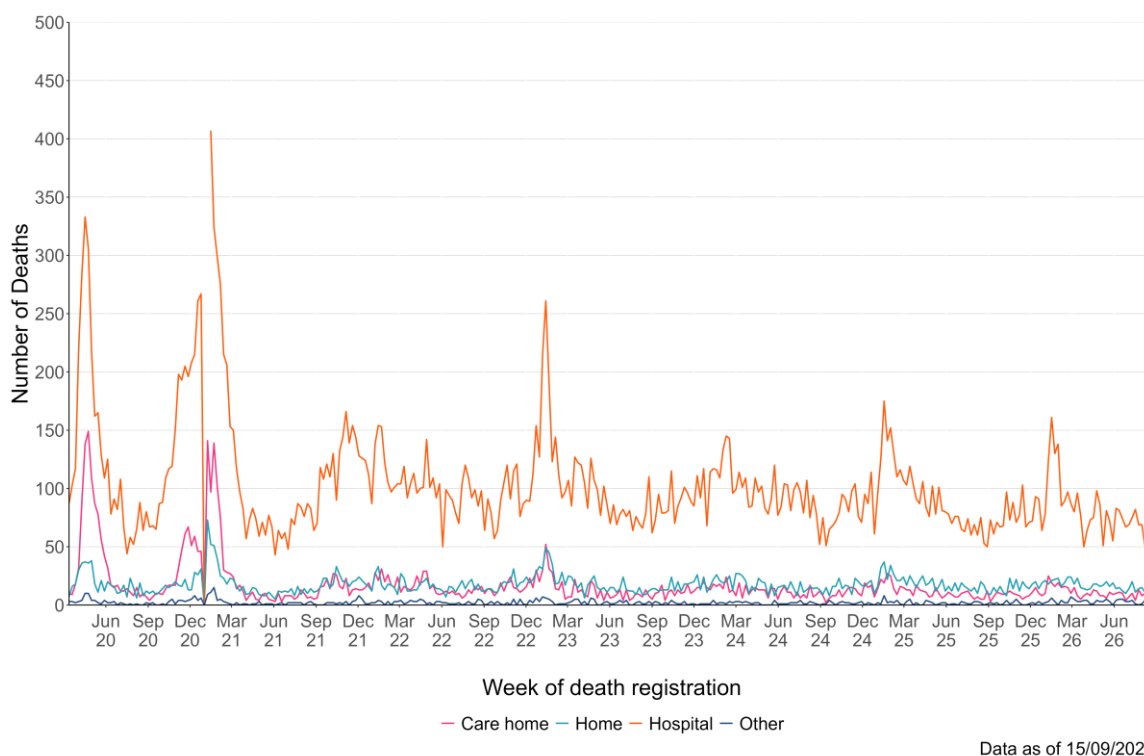
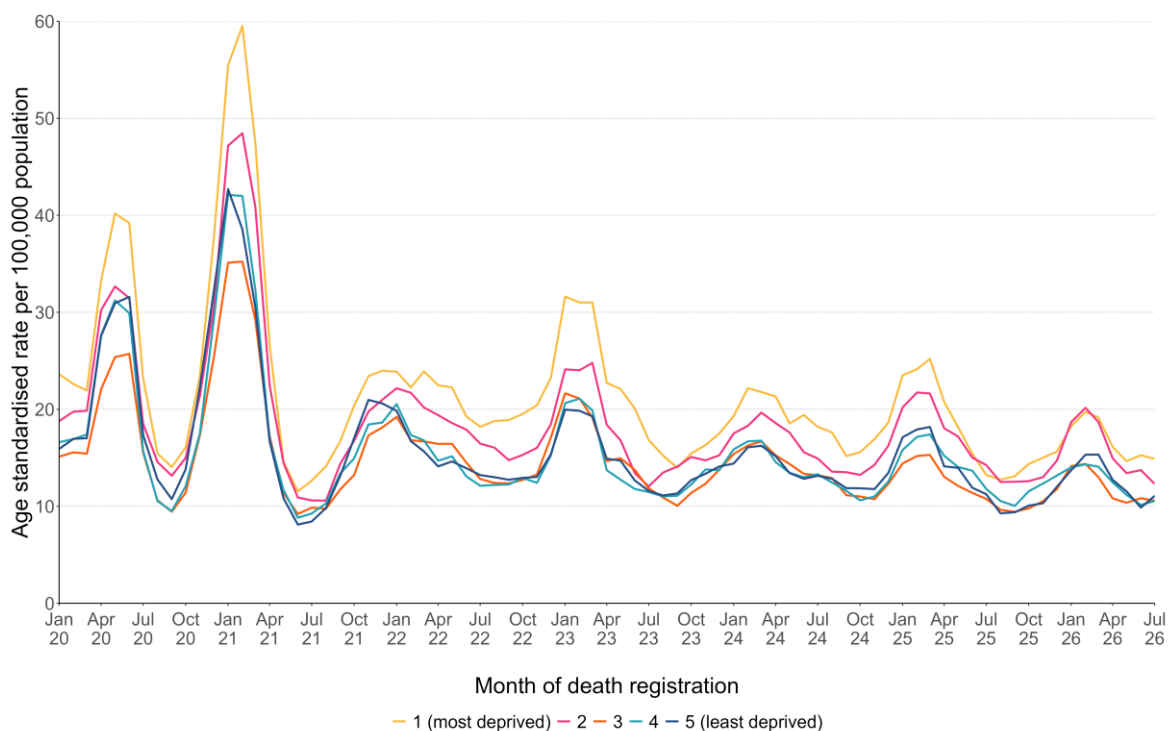


Figure 5.4. Numbers of ARI deaths, by quintile of deprivation of area of residence (based on the Welsh Index of Multiple Deprivation rankings of Lower Super Output Areas) and week of death registration.



Data as of 15/09/2026

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

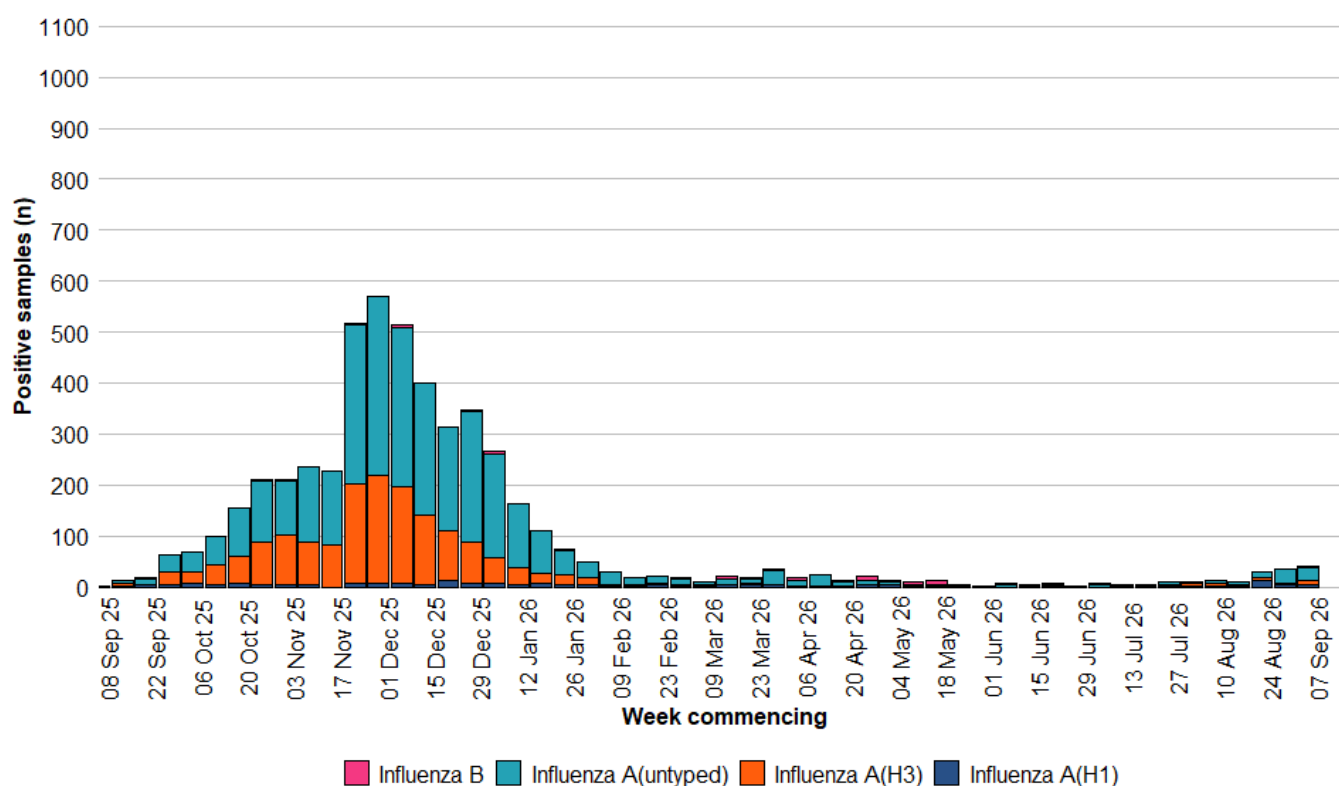


6. Pathogen-specific surveillance

Influenza

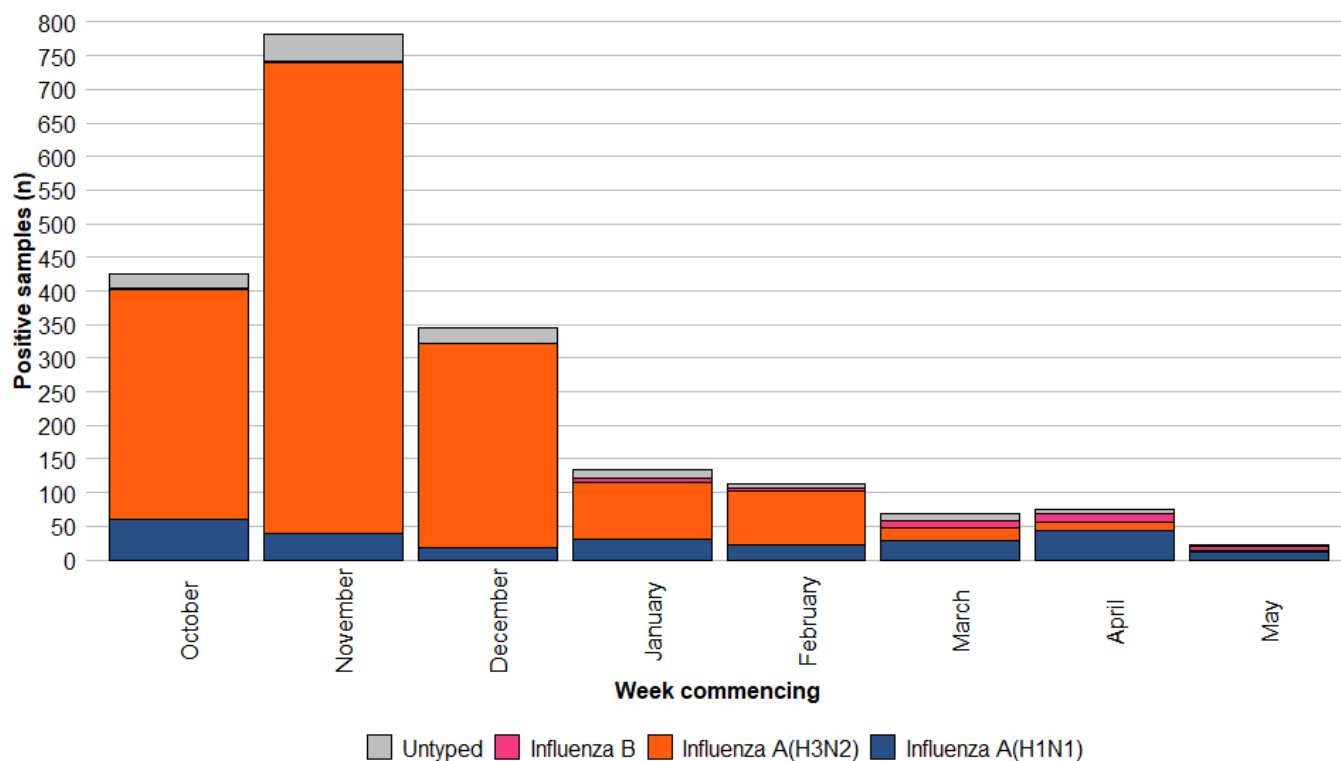
- influenza A(H3N2) is the most commonly detected influenza subtype in Wales since Week 40 2025 (1,587 confirmed cases), followed by influenza A(H1N1) (171 confirmed cases) and influenza B (101 confirmed cases). Additionally, there have been 3208 untyped influenza A cases.

Figure 6.1a. Influenza subtypes based on samples submitted for virological testing by Sentinel GPs and community pharmacies, hospital patients, and non-Sentinel GPs, by week of sample collection, Week 37, 2025 to Week 37, 2026.



Data correct as of 14/09/2026

Figure 6.1b. Influenza subtypes based on samples referred to the Wales National Influenza Centre for typing, by week of sample collection, Week 40, 2025 to Week 5, 2026.

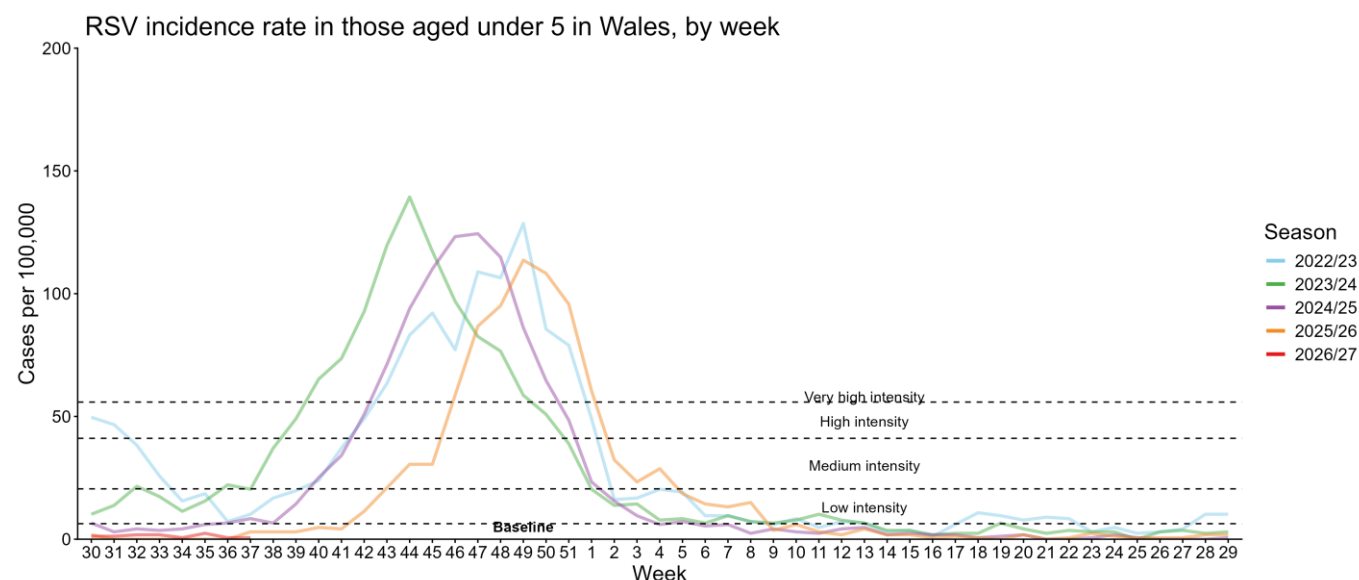


Data correct as at 01/06/2026

Respiratory Syncytial Virus (RSV)

- RSV incidence per 100,000 population in children aged under five years is currently at baseline (0.6) intensity levels per 100,000 population during Week 37, 2026 .

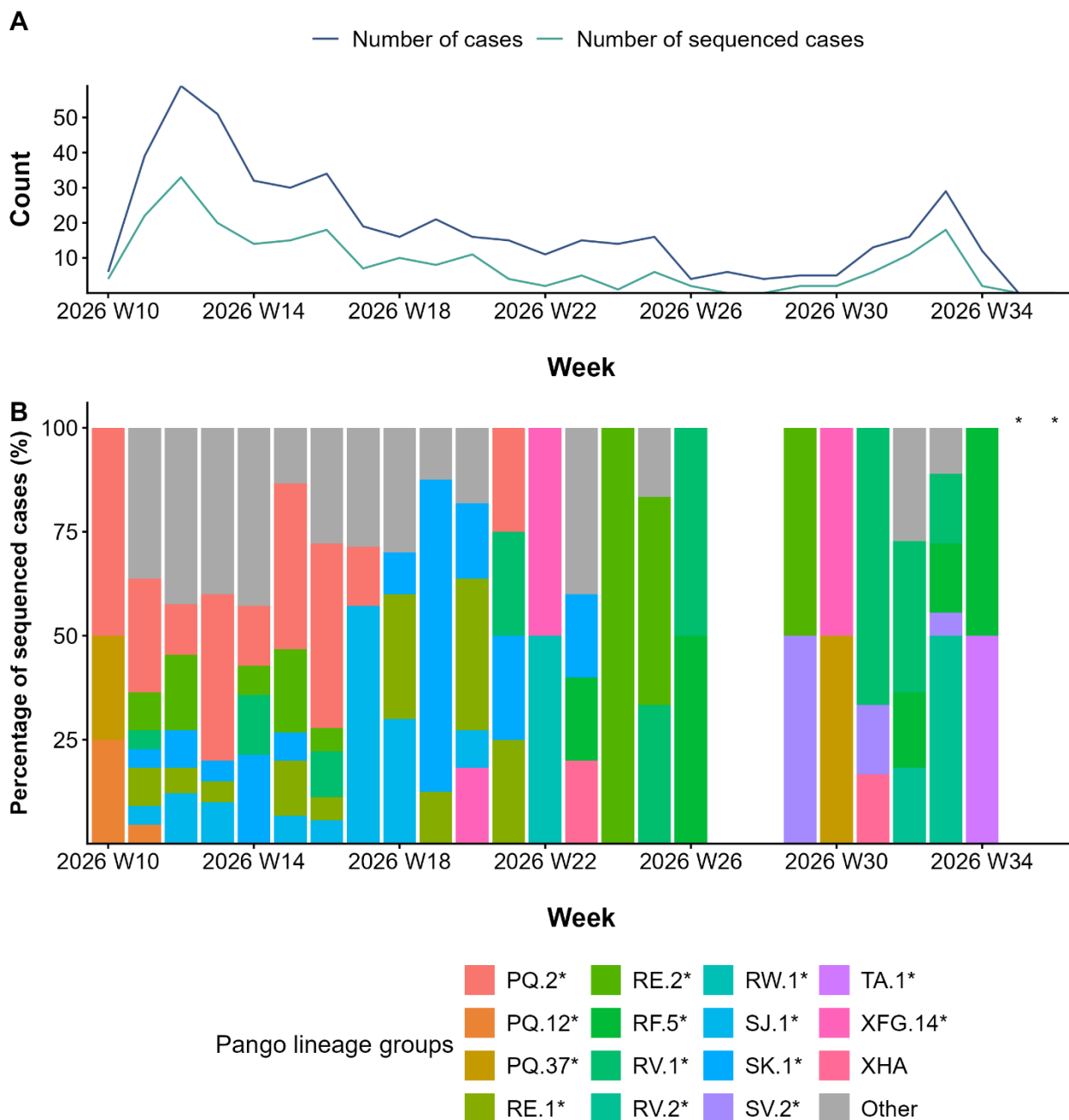
Figure 6.2. RSV incidence rate per 100,000 population aged under five years, Week 30, 2022 to Week 37, 2026.



SARS-CoV-2 Variant surveillance

- Pango group RF.5* is the most frequently detected Pango lineage group in Wales currently, accounting for 16.2% of sequenced cases in the previous six weeks.

Figure 6.3. Weekly number of SARS-CoV-2 cases (bars) and the 4-week rolling average proportion of sequenced cases attributed to each Pango lineage group (lines) from residents in Wales for the past six months (2025 W06 to 2026 W26).



* 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. Influenza vaccination uptake

The 2026/27 influenza vaccination programme began on 1st September; reporting of uptake for this season will begin at the end of September.

The 2025/26 influenza vaccination programme is complete. Information on the groups who are eligible for a free NHS Wales influenza vaccine is available from: <https://phw.nhs.wales/topics/immunisation-and-vaccines/winter-vaccinations/>

End of season uptake figures in eligible groups are presented in Table 7.1, these are final uptake figures for the 2025/26 influenza vaccination campaign. Data on influenza vaccination coverage come from the Welsh Immunisation System (WIS). This is the first year that WIS has been used as the source of influenza vaccination data in Wales, and therefore caution should be used when comparing figures to previous years. Data in Table 7.1 were extracted on 31/03/2026 and include vaccinations given and recorded in WIS up to the end of 30/03/2026. Vaccination uptake figures for school-aged children are based on a combination of data from WIS in five health boards and from a Public Health Wales survey in two health boards.

Table 7.1. Uptake of influenza vaccination in Wales 2025/26 (as of 30/03/2026)

Influenza immunisation uptake in the 2025/26 season	
65 years and older	71.7%
16y to 64y in a clinical risk group	42.7%
Children aged 2 & 3 years	46.1%
Primary school aged children (4 to 10 years)*	57.6%
Secondary school aged children (11-15 years)*	45.4%

*Methods for calculating uptake in school aged children has changed for the 2025/26 season. Caution should be used when comparing estimated uptake to previous years, especially while school vaccination sessions are ongoing.

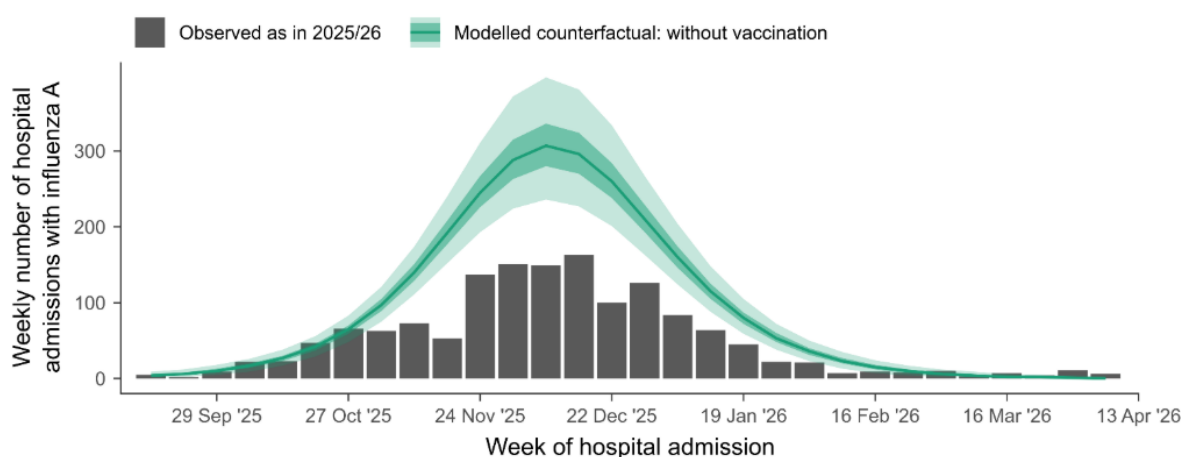
8. Vaccine impact and effectiveness

Estimates of hospital admissions averted due to vaccination in 2025/26

To estimate the number of influenza-related hospital admissions averted due to routine influenza vaccination in Wales in 2025/26, we adapted the mathematical model developed by [van Leeuwen et al. \(2025\)](#) to a Welsh context and data. The model describes influenza transmission, vaccination, and progression to hospital admission, incorporating observed vaccine uptake rates in Wales, vaccine effectiveness against hospitalisation and age-specific social mixing rates. The model was fitted to surveillance data routinely collected in primary and secondary care between 15 September 2025 (week 38, 2025) and 12 April 2026 (week 15, 2026). Data included consultation rates and virological surveillance data from the sentinel GP network, and hospital admissions with recent laboratory confirmed influenza¹.

A counterfactual scenario was then simulated in which routine vaccination was removed from the model, while keeping all other aspects of the model unchanged. By comparing this counterfactual scenario with the modelled 2025/26 vaccination scenario, we estimated that routine influenza vaccination averted 1,226 (95% prediction interval: 817–1,748) hospital admissions with influenza² during the 2025/26 season. This corresponds to an estimated 45% (95% prediction interval: 35–54%) reduction in hospital admissions with influenza due to routine vaccination across the season (see Figure 8.1 below). These reductions reflect both the direct protection conferred to vaccinated individuals and the indirect benefits arising from reduced transmission of influenza within the wider population.

Figure 8.1. Weekly number of hospital admissions with influenza during 2025/26 which were observed (bars) and estimated (ribbon) in the absence of routine influenza vaccination by the model. The estimates shown represent the median (line), 50% (dark shaded area) and 95% prediction interval (light shaded area).



¹ A hospital admission with influenza was defined as those admitted to hospital who tested positive via PCR test for influenza within 28 days prior to admission or up to day 2 of an inpatient stay (where admission date is day 1).

² Only hospital admissions with influenza A (H3N2 and H1N1) were analysed due to low numbers of admissions with influenza B and insufficient data on vaccine effectiveness estimates against influenza B.

Vaccine 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>

9. International Summary

Influenza activity – UK and international summary

- GP ILI consultations were last reported as 2.1 per 100,000 in England in Week 20 (latest data available). GP ILI consultations increased at 1.7 per 100,000 in Northern Ireland and increased to 1.9 per 100,000 in Scotland in Week 36.
- During Week 36, 1,705 sentinel samples tested for influenza were reported in England of which 42 were positive for influenza (23 influenza A (not subtyped), 10 influenza A (H3N2), 7 influenza A (H1N1)pdm09, and 2 influenza B).
- Overall, influenza positivity remained stable at 2.5% in England, decreased to 3.8% Scotland in Week 36 and increased to 2.0% in Northern Ireland in Week 36.
- 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 4% in Week 36.
- There were 30 confirmed influenza virus infection detections reported from sentinel primary care, all influenza type A viruses; and among those subtyped there was a mix of A(H3) and A(H1)pdm09.
- Of the 14 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 35, with influenza A viruses detections predominant.
- In the southern hemisphere, influenza percent positivity was elevated (>10%) in single countries in Tropical and Temperate South America and South-East Asia. Percent positivity was over 30% in one country in Oceania where a small increase in activity was observed.
- In the northern hemisphere, influenza percent positivity was elevated (>10%) in some countries in Western Africa, Northern Europe, Western, Southern and South-East Asia and in single countries in Central America and the Caribbean, Eastern and Middle Africa, and Eastern Asia. Percent positivity was over 30% in single countries in Western Africa and South-East Asia and two countries in Southern Asia. Small increases in activity were observed in some countries in Southern Asia and in single countries in Central America and the Caribbean, Eastern Europe, Western, Northern and Eastern Africa, and South-East and Eastern Asia.
- In the zones with elevated positivity, influenza A(H3N2) was predominant in Eastern Asia and Oceania; influenza A(H1N1)pdm09 was predominant in Western, Southern and South-East Asia and influenza B was predominant in Tropical and Temperate South America. Influenza A and B were codominant in Central America and the Caribbean, Western and Eastern Africa, and influenza A(H1N1)pdm09 and influenza A(H3N2) were codominant in 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 of 09/09/2026) during Week 35 globally there were 1,233 A(H1N1), 2,369 A(H3), 1,298 A(not subtyped), 1,303 influenza B (Victoria) and 659 influenza B(lineage not determined) **Source:** Flu Net: <https://worldhealthorg.shinyapps.io/flunetchart/>

Update on influenza activity in Australia and New Zealand

- In New Zealand, during the week ending 06/09/2026, influenza-like illness activity (ILI) activity in the community decreased. Through seasonal sentinel community influenza surveillance, 47 influenza cases were identified at sentinel practices during the week ending 30/08/2025.
Source: Institute of Environmental Science & Research, New Zealand
<https://www.phfscience.nz/digital-library/respiratory-illness-dashboard/>
- In Australia, according to the latest available update (fortnight ending 06/09/2026), influenza-like illness (ILI) activity in the community increased. To date, most nationally reported laboratory-confirmed influenza cases were influenza A(H3N2).
Source: [Australian Centre for Disease Control](#)

Respiratory syncytial virus (RSV) in North America

The USA CDC reported that the RSV positivity rate increased in Week 34, 2026.

Source: CDC RSV national trends: [National Respiratory and Enteric Virus Surveillance System | CDC](#)

Middle East respiratory syndrome coronavirus (MERS-CoV) – latest update from WHO and ECDC

- As of 21 December 2025, Saudi Arabia reported 19 MERS-CoV cases from 01 January 2025 to 21 December 2025, including 4 deaths. WHO Global Alert and Response website: <https://www.who.int/emergencies/disease-outbreak-news>
- Rapid risk assessments of the situation from ECDC, which contain epidemiological updates and advice for travellers and healthcare workers, are available from: <https://ecdc.europa.eu/en/middle-east-respiratory-syndrome-coronavirus>
- Further updates and advice for healthcare workers and travellers are available from WHO: <http://www.who.int/emergencies/mers-cov/en/> and from NaTHNaC: <https://travelhealthpro.org.uk/news/237/mers-cov-update-travelhealthpro-country-pages>

Human infection with avian influenza A

- The WHO has published an updated assessment of recent influenza A(H5N1) virus events in animals and people. Currently, the global public health risk of influenza A(H5N1) viruses to be low, while the risk of infection for occupationally exposed persons is low to moderate, depending on the risk mitigation measures in place. Transmission between animals continues to occur and, to date, a growing yet still limited number of human infections are being reported. 05 July 2025: Other updates on zoonotic influenza infections and risks to humans are available from the WHO Global Alert & Response website: <https://www.who.int/emergencies/disease-outbreak-news>

10. 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>

11. 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.

12. Links to surveillance reports from other countries

Public Health Wales influenza surveillance webpage: <https://phw.nhs.wales/topics/immunisation-and-vaccines/flu vaccine/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/flu vaccine/>

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