Llywodraeth Cymru
Welsh Government

Yr Is-adran Gwyddoniaeth, Ymchwil a Thystiolaeth
Science Research Evidence Division
Y Grŵp Iechyd, Gofal ac Atal
Health, Care and Prevention Group

Weekly Surveillance Report

06 November 2026



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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 44 2026, up to 01 November 2026)

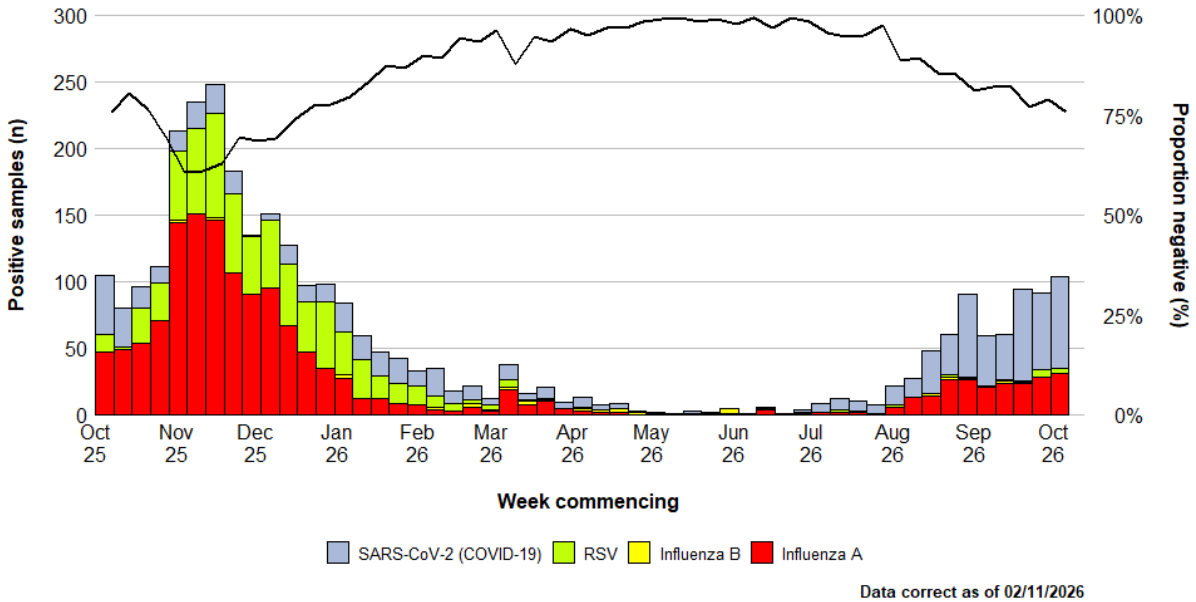
- COVID-19 confirmed case admissions to hospital have **increased** and in-patient cases have **increased** in the most recent week.
- Influenza (flu) confirmed case admissions to hospital have **increased** and in-patient cases have **increased** in the most recent week.
- Respiratory Syncytial Virus (RSV) admissions to hospital have **increased** and in-patient cases have **increased** in the most recent week.
- Respiratory Syncytial Virus (RSV) incidence in children under 5 years has **decreased** in the most recent week.
- Scarlet Fever notifications have **decreased** in the most recent week.
- Norovirus confirmed cases have **increased** in the most recent week.

B. Acute Respiratory Infections Situation Update

B.1. COVID-19 Update

- At a national level, the weekly number of confirmed cases of community-acquired admissions to hospital **increased** and the number of cases who were inpatients **increased** in week 44 2026 (to 01 November 2026).
- As of 01 November 2026 (week 44), the number of confirmed cases of community acquired COVID-19 admitted to hospital **increased** to **43** (**34** in the previous week) and there were **279** in-patient cases of confirmed COVID-19, **1** of whom was in critical care compared to **242** and **2** in the previous week.
- Confirmed cases of positive tests remained stable at **10.9%** in hospital and non-sentinel GP practices in the most recent week (week 44).
- In the last six weeks, **Omicron TK.1*** is the most frequently detected Pango lineage group in Wales currently, accounting for **24.2%** of sequenced cases in the previous six weeks (reporting weeks 2026 W35 to 2026 W41).

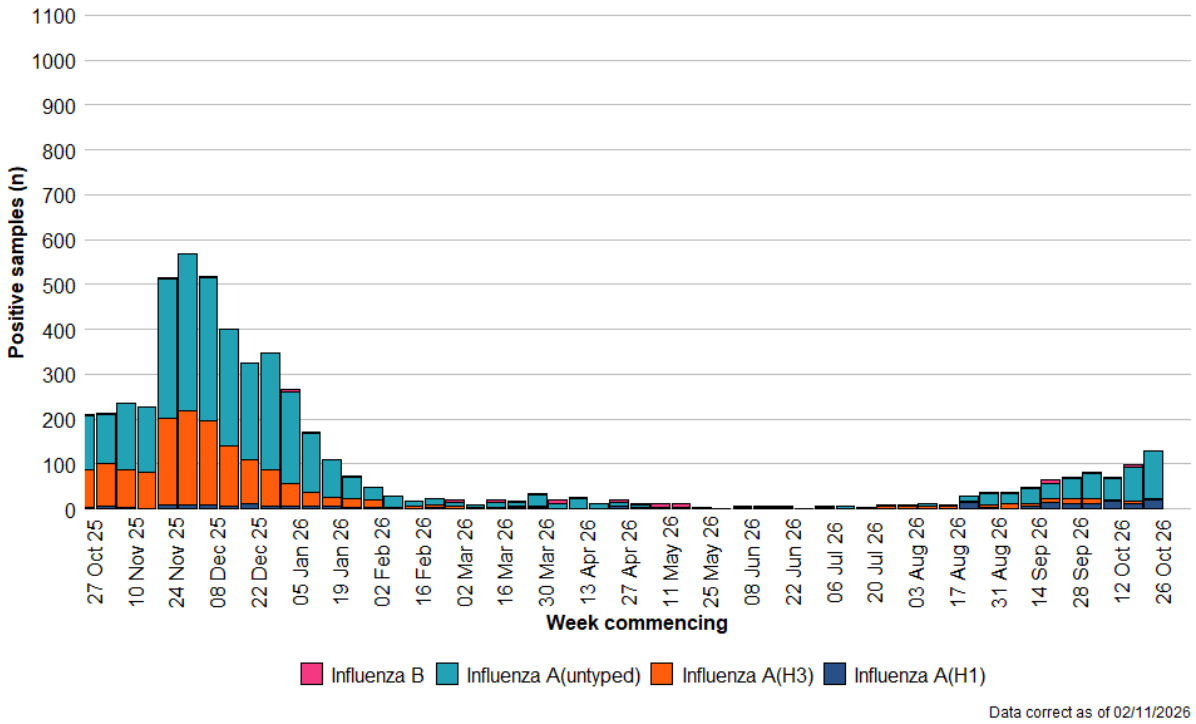
Figure 1: Samples from hospital patients submitted for COVID-19, influenza and Respiratory Syncytial Virus (RSV) testing only, by week of sample collection, week 44 2025 to week 44 2026 (source: PHW).



B.2 Influenza (flu) Update

- The influenza-like-illness GP consultation rate decreased in the most recent week, however confirmed cases of influenza in sentinel GPs have increased across Wales. This suggests that influenza is now circulating.
- The overall proportion of samples testing positive in hospital and non-sentinel patients **increased** in the most recent week to **8.6%.**
- Consultations for influenza-like illness (ILI) with sentinel GPs **decreased** compared to the previous week and has now returned to baseline levels. **14** cases of influenza were confirmed from symptomatic sentinel GP network patients across Wales last week.
- The number of confirmed cases of community acquired influenza admitted to hospital increased to **46** in the most recent week (**32** in the previous week) and there were **79** in-patient cases of confirmed influenza, **4** of whom were in critical care compared to **48** and **6** in the previous week.
- In the most recent week (week 44) there were 3 influenza A(H3), 20 influenza A(H1N1), 105 influenza A untyped and 1 influenza B subtypes detected in Wales (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 44 2025 to week 44 2026 (source: PHW).

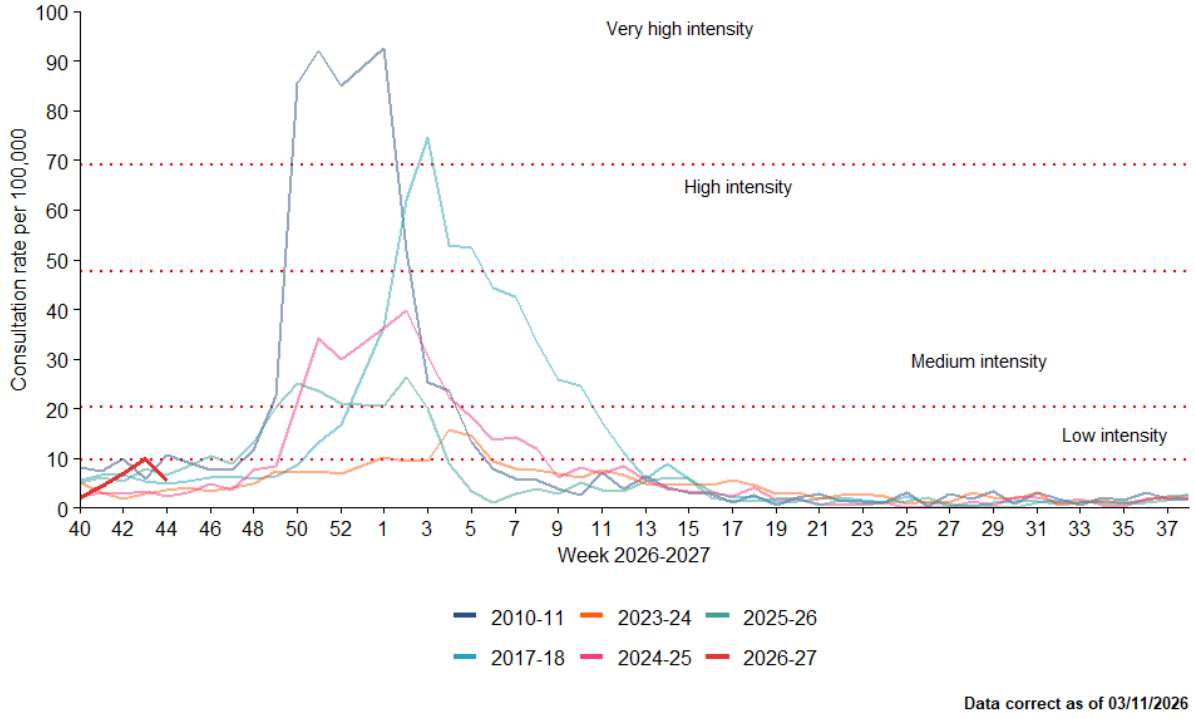


The sentinel GP consultation rate for influenza like illness (ILI) is at baseline and the three-week trend is variable.

There were **5.4** ILI consultations per 100,000 practice population in the most recent week, a **decrease** compared to the previous week (9.9 consultations per 100,000), see Figure 3.

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

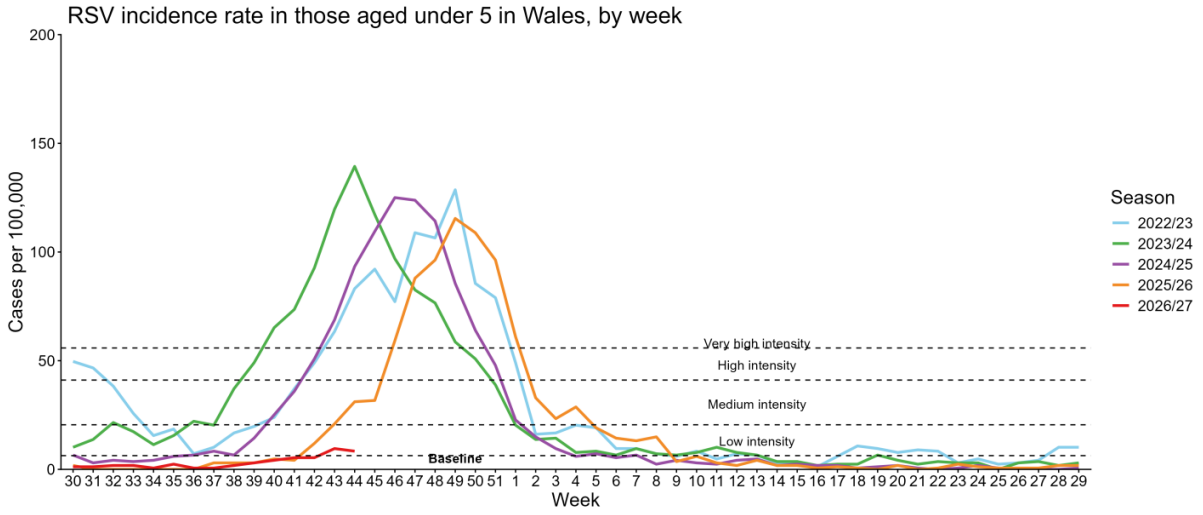
Figure 3: Sentinel GP network clinical consultation rate for ILI per 100,00 practice population (source: PHW).



B.3. Respiratory Syncytial Virus (RSV) Update

- The number of confirmed cases of community acquired RSV admitted to hospital increased to **15** (4 in previous week). There were **5** in-patient cases of confirmed RSV, none of whom were in critical care, compared to 3 and 0 in the previous week.
- RSV incidence per 100,000 in children aged up to 5 years is now at **low intensity** levels (8.4 per 100,000), see Figure 4.

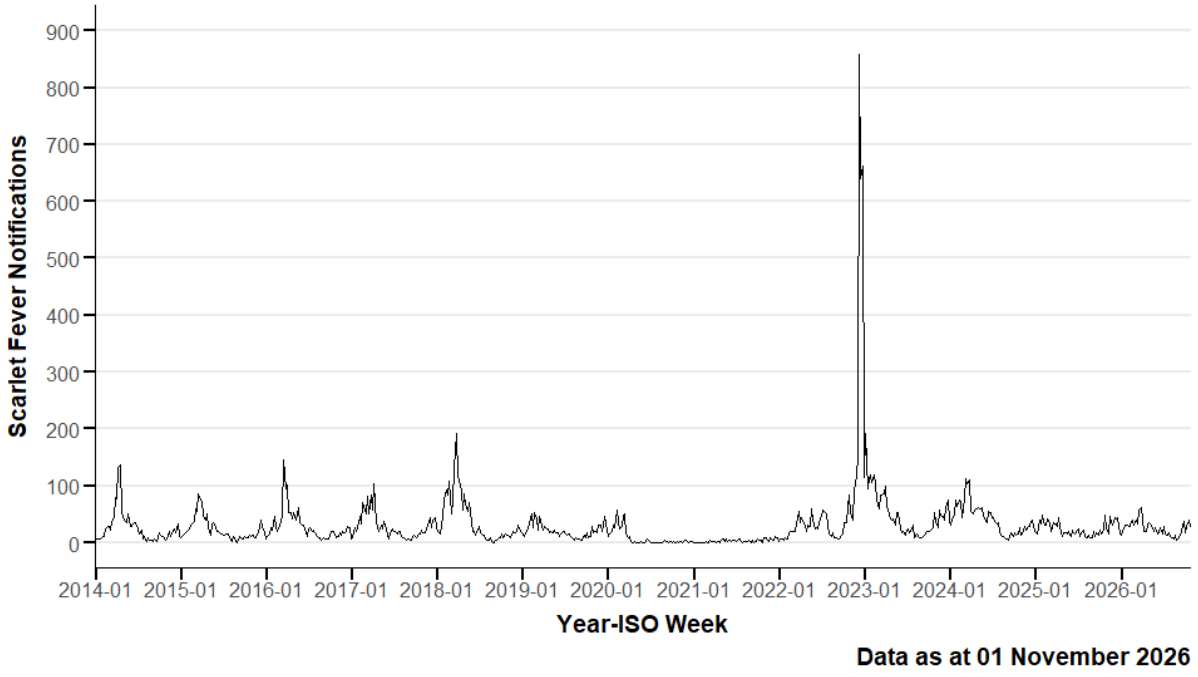
Figure 4: Respiratory Syncytial Virus (RSV) incidence rate per 100,000 population under 5 years, week 30 2022 to week 44 2026 (source: PHW).



B.4 iGAS and Scarlet Fever Update

The number of iGAS notifications are currently low, remaining at seasonally expected levels. Scarlet Fever notifications have further **decreased** in the most recent week (week 44, up to 01 November 2026), Figure 5.

Figure 5: Rolling 3-Week average Scarlet Fever notifications, 2014-2026, Wales (source: PHW).



B.5. Additional indicators

- The number of ambulance calls recorded referring to respiratory syndromic indicators **decreased** from 1,495 in the previous week to 1,472 in the latest reporting week (week 44).

- During Week 44, **1** ARI outbreak was reported to the Public Health Wales Health Protection Team. The incident was Acute Respiratory Infection and was in a Residential Home.

- 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

C.1 Short Term Projections

The Science Research Evidence (SRE) team at Welsh Government have produced short term projections (STPs) for COVID-19, influenza (flu) and Respiratory Syncytial Virus (RSV) at national and at Local Health Board level. STPs project 2 weeks forward using the most recent 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.

The STPs report the difference between the most recent observed data (7 day rolling sum) and the projected central estimate 2 weeks later. STP computations use admission data from PHW until **01 November 2026** to make short term projections two weeks forward **(to 15 November 2026)**. The dots in the charts represent the most recent observed data points (7 day rolling sum) while the white line is the central estimate from the most recent projection. The colour shadings represent the 95% confidence interval of the projections.

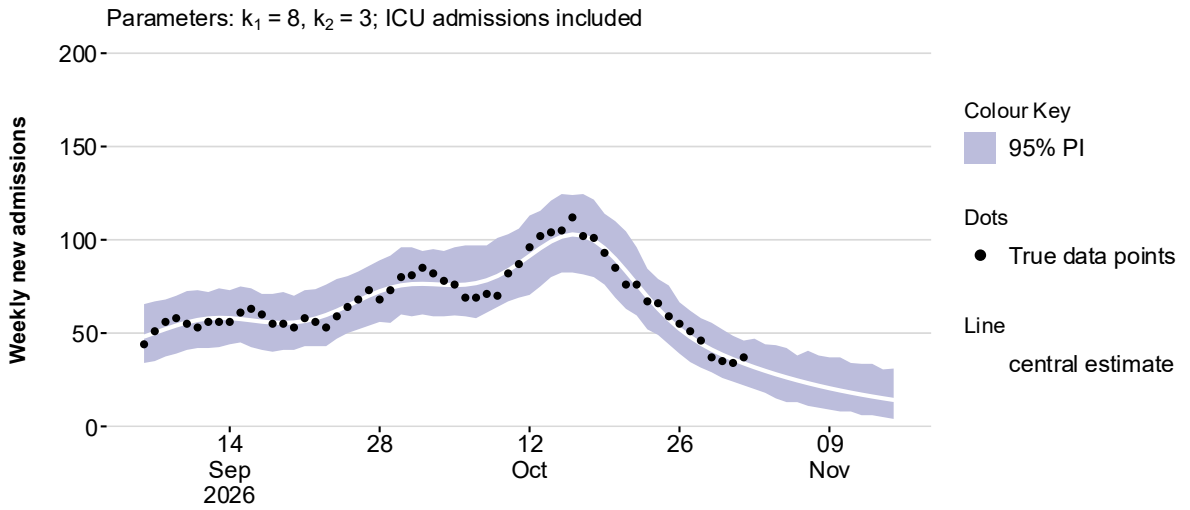
The STPs are produced nationally and at the provider health board level, not at resident health board level. Powys health board is not included in the analysis due to low numbers.

Note: Due to low levels of RSV circulating currently, only modelling for COVID-19 and influenza are presented this week.

C.1.1 COVID-19

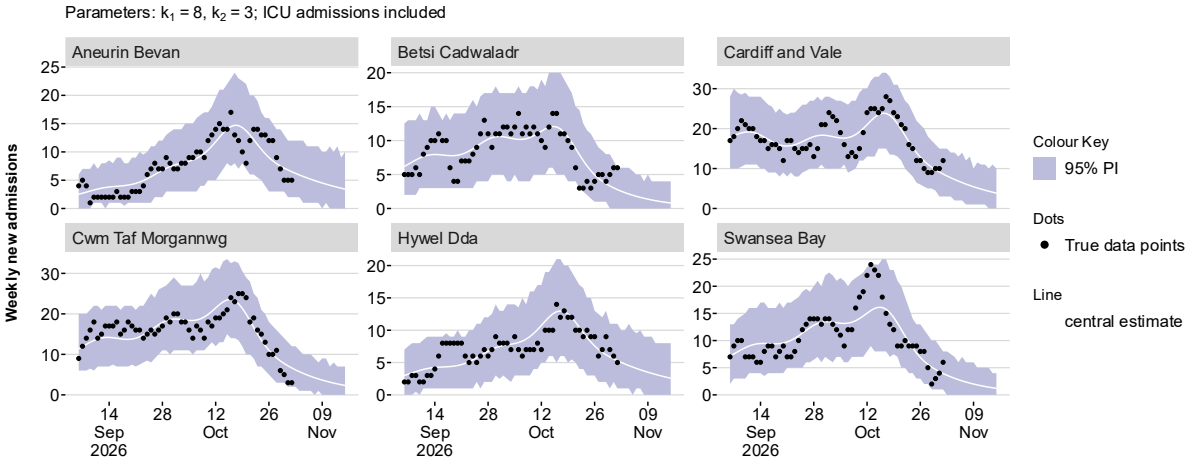
STPs for Wales show that COVID-19 admissions are projected to **decrease** over the next two-week period (to 15 November 2026), Figure 6.

Figure 6: Short term projections for COVID-19 hospital admissions in Wales (data to 01 November 2026, projection to 15 November 2026).



COVID-19 admissions are projected to **decrease** in all health boards over the next two-week period (to 15 November 2026), Figure 7.

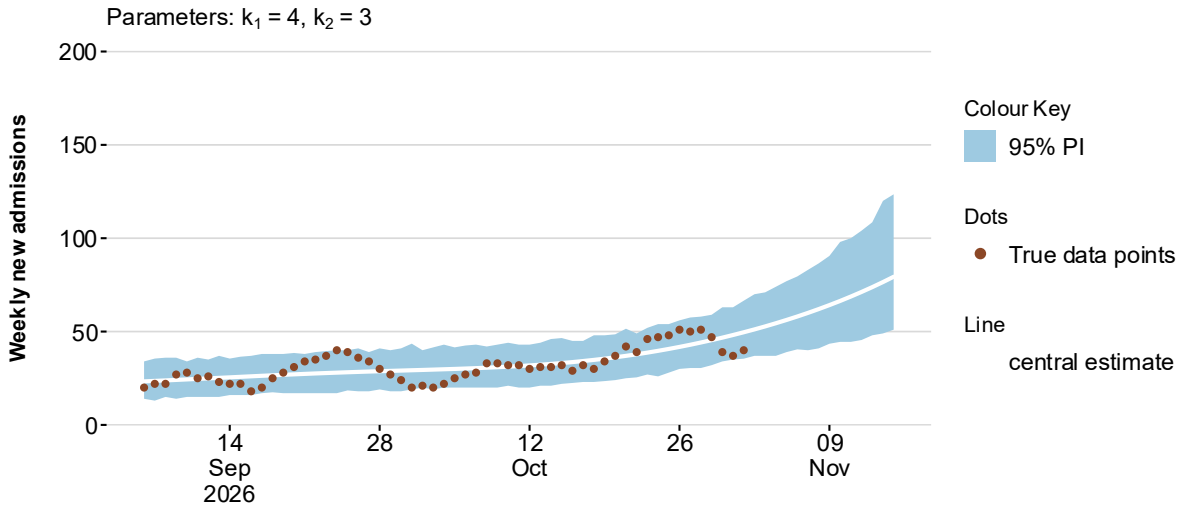
Figure 7: Short term projections for COVID-19 hospital admissions in Wales Health Boards (data to 01 November 2026, projection to 15 November 2026).



C.1.2 Influenza (flu)

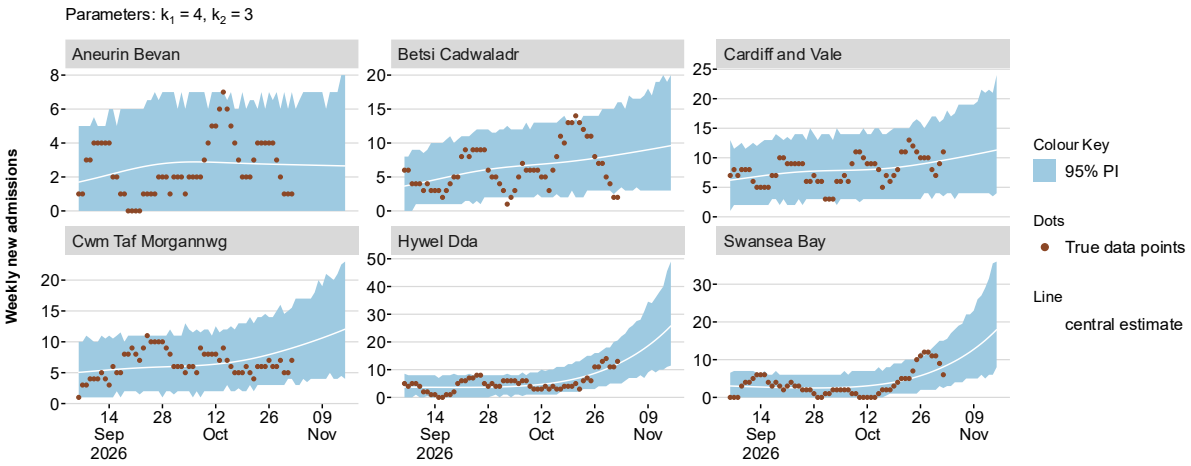
STPs for Wales show that influenza admissions are projected to **increase** over the next two-week period (to 15 November 2026), Figure 8.

Figure 8: Short term projections for influenza (flu) hospital admissions in Wales (data to 01 November 2026, projection to 15 November 2026).



Influenza admissions are projected to **increase** in all health boards in Wales over the next two-week period (to 15 November 2026), except for Cardiff and Vale where influenza admissions are projected to **remain stable**, Figure 9.

Figure 9: Short term projections for influenza (flu) hospital admissions in Wales Local Health Boards (data to **01 November 2026**, projection to **15 November 2026)**.



C.2 Winter Modelling 2026/27

The Science, Research and Evidence (SRE) team in Welsh Government have published modelled scenarios for COVID-19, influenza and Respiratory Syncytial Virus (RSV) for Winter 2026/27.

This uses analysis of historical data to estimate what we may see in winter 2026/2027 in terms of hospital admissions and hospital bed occupancy in Wales, contributing to winter planning for NHS Wales.

The figures that follow (Figures 10-11) show an estimate of hospital admissions occurring so far in winter 2026/2027 using actual data and are compared to our 2026/2027 winter modelling scenarios (see the technical notes at this section for details on how the 'actuals' were estimated).

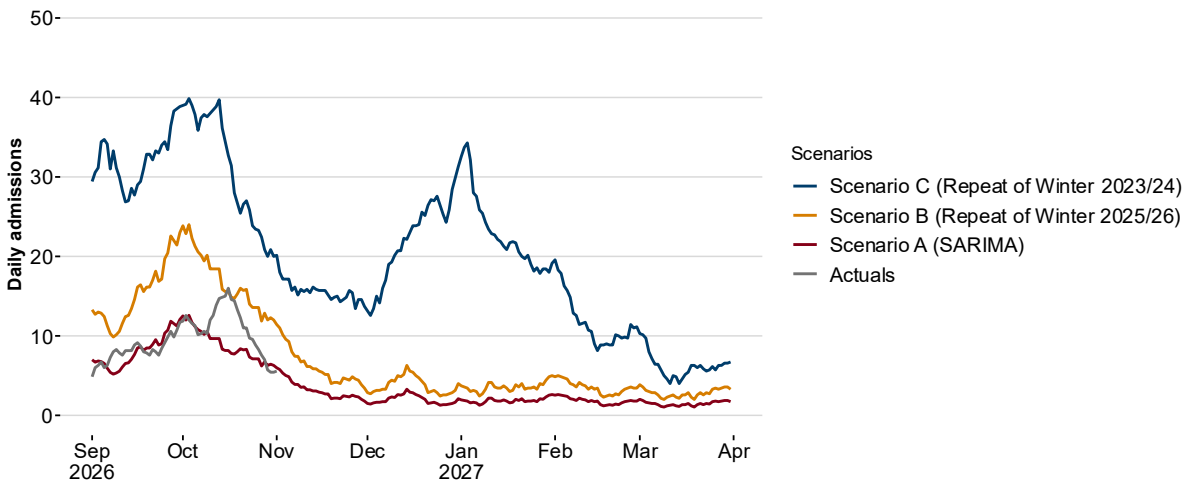
Modelling is an estimate of what may happen, not a prediction of what will happen.

Note: Due to low levels of RSV circulating currently, only modelling for COVID-19 and influenza are presented this week.

C.2.1 COVID-19

COVID-19 actuals are currently decreasing and below all scenarios, Figure 10.

Figure 10: Daily COVID-19 Winter 2026/2027 admissions scenarios, modelling to 31 March 2027 (actuals data until 01 November 2026).

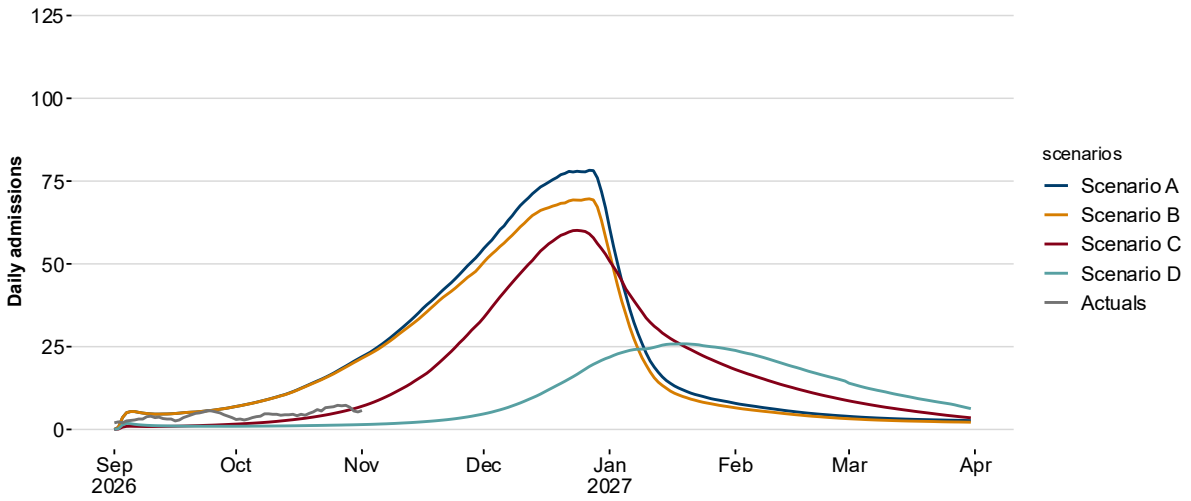


Source: Raw data to 31 March 2026 provided by DHCW, projected scenarios from 01 September 2026 to 31 March 2027 from SRE, actuals data until 01 November 2026 from PHW.

C.2.2 Influenza (flu)

Influenza actuals are tracking closely with Scenario C, Figure 11.

Figure 11: Daily influenza Winter 2026/2027 admissions scenarios, modelling to 31 March 2026 (actuals data until 01 November 2026).



Source: Raw data to 31 March 2026 provided by DHCW, projected scenarios from 01 September 2026 to 31 March 2027 from SRE, actuals data until 01 November 2026 from PHW.

C.2.2 Technical Notes

The winter modelling used hospital admissions data from the Patient Episode Data for Wales (PEDW) dataset provided by Digital Health and Care Wales (DHCW). However, due to a lag in clinical coding and receiving PEDW data from DHCW, the ICNET admissions data provided by Public Health Wales (PHW) were used for the actuals. The data sources differ for a few reasons: the influenza and RSV data from PHW includes lab-confirmed results only and includes inpatients only. The PEDW data from DHCW is based on International Classification of Diseases version 10 (ICD-10) codes.

Modelling Scenario Details:

COVID-19

- Data includes ICD-10 codes U07.1, U07.2, U09.9 and U10.9. Two scenarios repeat recent year's data from Digital Health and Care Wales, and one is calculated by applying a statistical technique.

Table 1: Descriptions for COVID-19 admission scenarios.

Scenario name	Scenario	Description
Scenario A (SARIMA)	SARIMA	Model fit to SARIMA modelling.
Scenario B (Repeat of Winter 2025/26)	Repeat of Winter 2025 to 2026	Model fit to 2025 to 2026 winter season.
Scenario C (Repeat of Winter 2023/24)	Repeat of Winter 2023 to 2024	Model fit to 2023 to 2024 winter season.

Influenza (flu)

- Data includes ICD-10 codes: J09.X, J10.0-J10.2, J10.0, J11.8, J11.1 and J11.2.

Table 2: Descriptions for influenza admission scenarios.

Scenario name	Scenario	Description
Scenario A	Repeat of 2022 to 2023 data, low vaccine coverage	2022 to 2023 winter season (when both H1N1 and H3N2 were dominant) with low vaccine uptake assumptions (20% lower than observed uptake).
Scenario B	Repeat of 2022 to 2023 data, baseline vaccine coverage	2022 to 2023 winter season (when both H1N1 and H3N2 were dominant) with baseline vaccine uptake assumptions (observed vaccine uptake).
Scenario C	Repeat of 2024 to 2025 data, baseline vaccine coverage	2024 to 2025 winter season (when H1N1 was dominant) with baseline vaccine uptake assumptions (observed vaccine uptake).
Scenario D	Repeat of 2023 to 2024 data, high vaccine coverage	2023 to 2024 winter season (when H1N1 was dominant) with high vaccine uptake assumptions (20% higher than observed vaccine uptake).

Respiratory Syncytial Virus (RSV)

- Data includes ICD-10 codes: J12.1, J20.5, J21.0 and B97.4.

Table 3: Descriptions for Respiratory Syncytial Virus (RSV) admission scenarios.

Scenario name	Scenario	Description
Scenario A (Low coverage)	Low vaccine coverage	Model fit to data between 1 April 2023 and 31 March 2026. Vaccine uptake rate assumed to be 20% lower than baseline vaccine coverage (note there was an error in the previous weeks report that stated this was 20% higher rather than lower – this has now been amended).
Scenario B (Baseline coverage)	Baseline vaccine coverage	Model fit to data between 1 April 2023 and 31 March 2026. Baseline vaccine coverage assumes a repeat of from the uptake rates during 2025/26.
Scenario C (High coverage)	High vaccine coverage	Model fit to data between 1 April 2023 and 31 March 2026. Vaccine uptake rate assumed to be 20% higher than baseline vaccine coverage.

D. Communicable Disease Situation Update (non-respiratory)

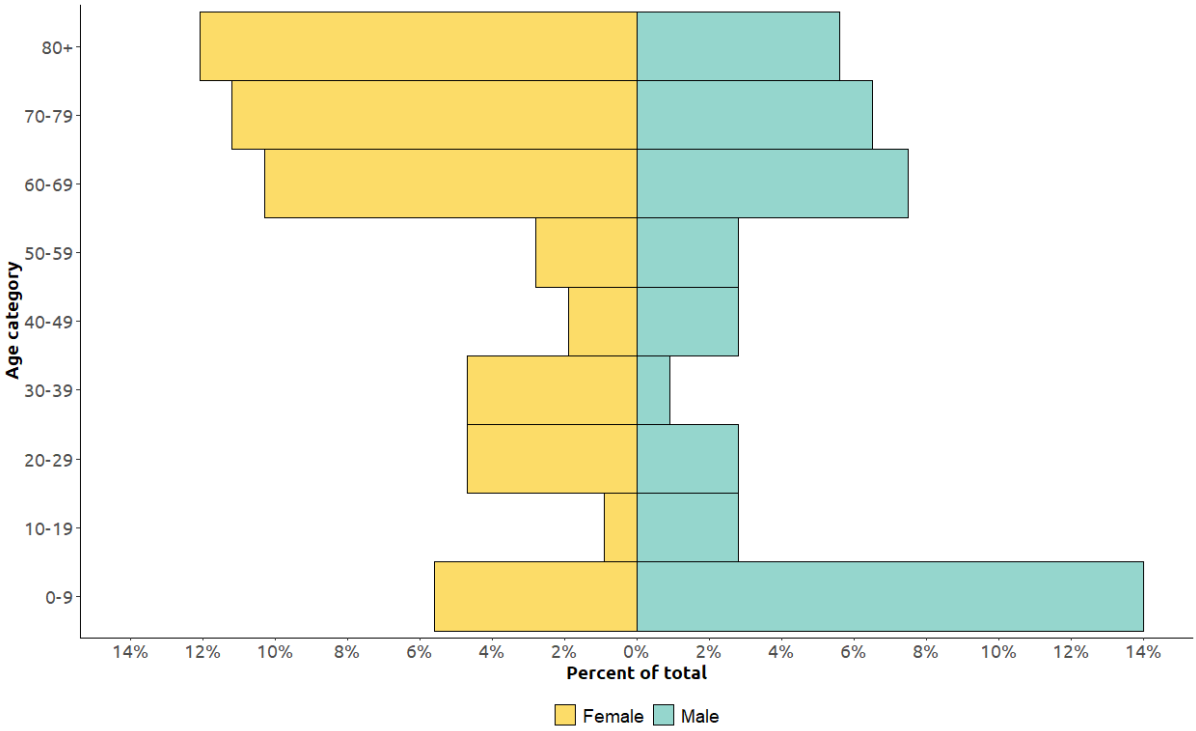
D.1. Norovirus Update

In the current reporting week (week 44 2026), a total of **11** Norovirus cases were reported in Welsh residents. This is an increase (**37.5%**) in reported cases compared to the previous reporting week (week 43 2026), when **8** Norovirus cases were reported.

In the last 12-week period (10/08/2026 to 01/11/2026) a total of **107** Norovirus cases were reported in Welsh residents. This is a decrease (**-26.7%)** in reported cases compared to the same 12-week period in the previous year (10/08/2025 to 01/11/2025) when **146** Norovirus cases were reported.

In the last 12 weeks (10/08/2026 to 01/11/2026) **58** (**54.2%**) Norovirus cases were female and **49** (**45.8%**) cases were male. The age groups with the most cases were the **0-9** years (**21 cases**) and **60-69 years** (**19 cases**) age groups (Figure 12).

Figure 12: Age and sex distribution of confirmed Norovirus cases in the last 12 weeks (10 August 2026 to 01 November 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 44, up to 01/11/2026). Under-ascertainment is a recognized 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. UKHSA Influenza update (8 October)

UKHSA report that early signs suggest that the flu season may be starting earlier this year. Flu activity throughout September has been higher than in the same period over the past 4 winters. While levels remain at baseline, the upward trend - if it continues in the coming weeks - suggests an early flu season. The rise so far has been driven largely by cases in the 18- to 24-year-old age group.

So far this season, there's a mix of 2 flu A subtypes, H1N1 and H3N2, circulating in England. The flu vaccine is designed to protect against all 3 main types of flu: influenza A(H1N1), A(H3N2) and influenza B.

Flu viruses are constantly changing through a natural process called antigenic drift. Each year, the World Health Organization monitors circulating strains globally and selects which ones should be targeted by that season's vaccine, but this decision has to be made months in advance, to give manufacturers time to produce enough doses. Sometimes the virus continues to change after that point, resulting in it no longer matching the vaccine strain as closely as originally predicted.

This year, it's the A(H1N1) subtype that has drifted from the strain used in the vaccine. It's still too early in the season to know for certain whether this drifted H1N1 will circulate widely in the UK, or how it will affect vaccine effectiveness. Last winter, a drifted strain of H3N2, known as subclade K, emerged after the vaccine composition for the Northern Hemisphere had already been finalised. Despite this, the vaccine was effective and even with an earlier start to the flu season, overall levels of activity and mortality were lower than the previous year.

E.2. UKHSA COVID-19 Variant update (8 October)

XFG - sometimes referred to in the media as the Stratus variant - remains the most common current COVID-19 variant. XFG has also been referred to as ‘American Covid’ in some media coverage, though it is not new and has been circulating in the UK and other countries for around a year. The name reflects where the strain was first sequenced and detected, rather than necessarily where it originated.

UK Health Security Agency (UKHSA) data shows that COVID-19 positive test rates rose to around 7% in September, with hospital admission rates increasing by approximately 50% over the same period. These increases have been observed consistently across England, Scotland, Wales and Northern Ireland, as well as across Europe and the United States, indicating this is not a localised trend.

Current data does not indicate that these variants lead to more severe illness than other variants in circulation. UKHSA monitors a range of surveillance systems, including GP appointments, A&E attendances and hospitalisations, alongside genomic sequencing, to track how variants are behaving. As increases in hospitalisations are rising in line with overall increases in COVID-19 circulation - rather than rising sharply on their own - this

suggests a general increase in COVID-19 activity rather than a variant causing more severe disease.

There are likely to be several factors behind the current rise. As we move into winter, colder and wetter weather means people spend more time indoors, which enables the spread of respiratory viruses. It has also been roughly a year since the last significant COVID-19 wave, so immunity from vaccination and previous infection may be waning in parts of the population, making people more susceptible.

There have been previous detections of BA.3.2, a highly divergent descendant of the Omicron BA.3 lineage that re-emerged in South Africa in late 2024. It has since been sporadically detected across multiple continents. BA.3.2 is sometimes called the 'Cicada' variant. The World Health Organization (WHO) has designated BA.3.2 a Variant Under Monitoring (VUM). WHO currently assesses the public health risk as low, as there is no evidence of increased severity, hospitalisation, or mortality, although available evidence remains limited.

E.3. Ebola disease outbreak caused by Bundibugyo virus – Democratic Republic of the Congo and Uganda – 2026 (4 November)

- As of 4 November 2026, the Democratic Republic of the Congo (DRC), where community transmission is ongoing, has reported a total of 10 668 confirmed cases, including 5 198 related deaths (from data up until 3 November). Since the beginning of the outbreak, eight provinces have been affected: Ituri, Nord-Kivu, Sud-Kivu, Tshopo, Haut-Uélé, Bas-Uélé, Sud Ubangi and Nord Ubangi.
- On 20 October 2026, an Ebola case was reported in Nigeria. The person has since been medically evacuated to Switzerland. The individual, who had a travel history to Uganda, developed symptoms on 7 October, sought medical care on 11 October, and tested positive on 20 October. As of 3 November, 62 contacts of the case had been identified and were under follow-up.
- As of 26 October 2026, a total of nine confirmed cases, including two deaths, have been reported in Kenya, all linked to the first case. The last case was reported on 20 October 2026 (a close contact of the first case) and the second death was reported on 23 October 2026.
- ECDC is monitoring the outbreak through its epidemic intelligence activities and actively liaising with partners to support the response.
- Since 26 October, three ECDC experts have been deployed to Nigeria to provide advice and technical support to the EU Delegation in Abuja. Support has also been offered to the Nigerian authorities in surveillance, contact tracing, IPC and preparedness and response.

E.4. Seasonal surveillance of West Nile Virus infections – 2026 (28 October)

Since the beginning of the 2026 transmission season, and as at 28 October, 234 areas affected by West Nile virus (WNV) have been identified in 20 countries across Europe.

These areas are located in Italy (70), France (31), Greece (25), Romania (24), the Netherlands (18), Serbia (11), Bulgaria (7), Croatia (7), Spain (7), Belgium (6), Germany (6), North Macedonia (5), Hungary (4), Kosovo* (4), Austria (3), Albania (2), Cyprus (1), Moldova (1), Slovakia (1) and Slovenia (1).

This week, five areas have been reported as affected for the first time this season.

The 20 countries have reported 2 009 locally acquired human cases of WNV infection: Italy (780 cases), Greece (463 cases of which 4 had an unknown place of infection), France (180 cases), Spain (149 cases), Romania (125 cases), the Netherlands (76 cases of which three had an unknown place of infection), North Macedonia (71 cases), Serbia (59 cases), Croatia (22 cases), Cyprus (21 cases), Belgium (15 cases), Austria (eight cases), Bulgaria (eight cases), Kosovo* (eight cases), Albania (seven cases), Germany (seven cases), Hungary (five cases), Slovenia (three cases), Moldova (one case) and Slovakia (one case).

WNV infection in humans is a notifiable disease at EU level and cases should be reported by national public health authorities through the EpiPulse Cases platform according to the EU case definition. According to Commission Directives 2004/33/EC and 2014/110/EU on blood safety, blood establishments in EU/EEA countries should apply temporary deferral criteria for donors of allogeneic blood donation for 28 days after they have left a risk area for locally acquired WNV, unless an individual nucleic acid test (NAT) is negative.

E.6. Seasonal surveillance of Crimean-Congo haemorrhagic fever – 2026 (21 October)

Since the beginning of 2026, and as at 21 October 2026, one country in Europe has reported locally acquired1 cases of Crimean-Congo haemorrhagic fever (CCHF): Spain (4 cases).

Of the four cases reported in 2026, three were notified in Salamanca, where cases have also been reported in previous years, and one in Ciudad Real, which reported its first locally acquired human case. In 2026, no healthcare-associated transmissions were reported, i.e. all individuals were infected through tick bites. The reported dates of symptom onset were between 11 June 2026 and 7 August 2026.

For the general population, the risk of contracting CCHF in the areas where the virus is known to be present in Spain is low. This risk increases for people undertaking outdoor activities that expose them to tick bites (e.g. hunting, forestry work, hiking, animal surveillance). As a general precaution against CCHF, but also against other tick-borne

diseases, people who may potentially be exposed to ticks should apply personal protective measures.

In Spain, CCHF virus is transmitted to humans mainly by ticks of the genus Hyalomma. While Hyalomma lusitanicum plays a key role in virus maintenance and transmission dynamics, Hyalomma marginatum is generally considered to be the principal species involved in transmission to humans. Hyalomma marginatum is widely present in southern and eastern Europe and Hyalomma lusitanicum is present in parts of southern Europe.

E.7. Seasonal surveillance of chikungunya virus disease (28 October)

Since the beginning of 2026, and as at 28 October 2026, two countries in Europe have reported locally acquired cases of chikungunya virus disease: France (204 cases) and Italy (one case).

Since last week's update, France has reported 22 new locally acquired chikungunya virus disease cases, bringing the total to 204 cases. These cases are distributed across 29 clusters, with seven new clusters identified: four in Gironde department, one in Var department, one in Val-de-Marne department and one in Seine-Saint-Denis department. Nineteen clusters are currently active, including the largest clusters in Prayssac (36 cases), Lot department, and Cavalaire-Sur-Mer (31 cases), in Var department. The cluster in Prignac-et-Marcamps (30 cases), in Gironde department, is now closed.

No new locally acquired chikungunya virus disease cases have been reported by Italy since last week's update. To date, Italy has reported one locally acquired chikungunya virus disease case in Rome. The associated cluster is closed.

Chikungunya is a mosquito-borne viral disease that is emerging in Europe, with locally acquired cases reported in several EU/EEA countries. In the light of this development, ECDC has implemented seasonal enhanced surveillance to monitor the occurrence of cases in the EU/EEA. The primary objective is to inform public health authorities and support the implementation of appropriate response measures. Chikungunya virus disease is a notifiable disease at the EU level and cases are reported in accordance with the EU case definition. Chikungunya virus disease cases – and their corresponding case numbers – have been reported to the European surveillance portal for infectious diseases (EpiPulse Cases). Please note that cases acquired in Portuguese and Spanish Outermost Regions are included. However, due to the distinct epidemiological situation and differences in surveillance systems, cases acquired in the French Outermost Regions are not included.

E.8. Seasonal surveillance of dengue in the EU/EEA (28 October)

Since the beginning of 2026 and as at 28 October 2026, two countries in Europe have reported locally acquired cases of dengue: Italy (76 cases) and France (eight cases).

Since last week's update, Italy has reported three new locally acquired dengue cases. The cumulative number of locally acquired cases in Italy is 76, distributed across seven clusters. No new clusters have been identified this week. Six of the clusters are currently active, and the cluster 'Garbagnate Milanese' in Milano region is now closed.

One new locally acquired case has been reported by France since last week's update. The cumulative number of locally acquired cases in France is eight, distributed across five clusters, one of which is active, in the municipality of La Farlède, Var department.

Dengue is a mosquito-borne viral disease that is increasingly emerging in Europe, with locally acquired cases reported in several EU/EEA countries. In light of this development, ECDC has implemented seasonal enhanced weekly surveillance to monitor the occurrence of cases in the EU/EEA. The primary objective is to inform public health authorities and support the implementation of appropriate response measures. This includes assessing the risk of dengue transmission through substances of human origin (SoHO).

Dengue is a notifiable disease at the EU level and cases are reported in accordance with the EU case definition. Dengue cases – and their corresponding case numbers – are reported to the European surveillance portal for infectious diseases (EpiPulse Cases).