

Serial number: BN2025/042

Date: 05/11/2025

Event: Influenza A(H3N2) early season activity in England: implications for clinical practice and laboratory referral

Sent on behalf of:

Thomas Waite, Deputy Chief Medical Officer for England, Department of Health and Social Care

Shona Arora, Interim Chief Medical Advisor, UK Health Security Agency (UKHSA)

Notified by:

Jamie Lopez Bernal, Consultant Epidemiologist, Immunisation and Vaccine-preventable Diseases Division, UKHSA

Anika Singanayagam, Consultant Virologist, Respiratory Virus Unit, UKHSA

Authorised by:

Mary Ramsay - Director of public health infection programmes, UKHSA

Richard Pebody - Director of epidemic and emerging infections, UKHSA

Renu Bindra - Strategic Response Director On-call, UKHSA

Derren Ready - Deputy Director, Reference Microbiology, UKHSA

David Pearce - Regional Deputy Director, UKHSA

Shaun Whelan - Senior Communications Manager, UKHSA

Contact:

UKHSA Regional teams <https://www.gov.uk/guidance/contacts-phe-health-protection-teams>

IRP Level: N/A

Instructions for Cascade

Please note, notes are routinely cascaded to the below groups:

- UKHSA Private Office Groups who cascade onwards within Groups
- UKHSA Health Protection in Regions:
 - UKHSA Field Services
 - UKHSA Health Protection Teams including UKHSA Regional Deputy Directors
 - Deputy Directors in Regions Directorate
- UKHSA Lab Management Teams
- UKHSA Regional Communications
- Generic inbox for each of the Devolved Administrations
- Inboxes for each of the Crown Dependencies
- DHSC Chief Medical Officer (CMO)
- NHSE Chief Pharmaceutical Officer (CPhO)
- OHID Regional Directors of Public Health
- National NHSE EPRR
- NHSE National Operations Centre



UK Health Security Agency

- **Devolved Administrations** For information to CMOs, CPhOs and respiratory virus surveillance leads
 - **Crown Dependencies** for information to CMOs, CPhOs and respiratory virus surveillance leads
 - **Regional Deputy Directors** to cascade to Directors of Public Health
 - **UKHSA microbiologists** to cascade to non-UKHSA labs (NHS labs and private)
 - **UKHSA microbiologists** to cascade to NHS Trust infection leads
 - **NHS labs/NHS infection leads/NHS microbiologists/NHS infectious disease specialists** to cascade to general/acute/emergency medicine including respiratory and elderly care, paediatrics, obstetrics, critical care and other relevant specialties
 - **NHSE National Operations Centre** to cascade to GPs, community pharmacists and hospital pharmacists
-
- Royal College of General Practitioners
 - Royal College of Emergency Medicine
 - Faculty of Intensive Care Medicine
 - Royal College of Obstetricians and Gynaecologists
 - Faculty of Occupational Medicine
 - Royal College of Paediatrics and Child Health
 - Royal College of Pathologists
 - Royal Pharmaceutical Society
 - Royal College of Physicians
 - Faculty of Public Health
 - Healthcare Infection Society (HIS)
 - Infection Prevention Society (IPS)

Summary:

- Influenza is now circulating in the community with earlier than usual onset of activity in the 2025 to 2026 season, and with an A(H3N2) drifted strain (K, also known as J.2.4.1) predominating
- A(H3N2) predominance is associated with higher morbidity and mortality, particularly in the elderly, than when A(H1N1) predominates
- All eligible groups should be encouraged to get vaccinated with the 2025 to 2026 seasonal influenza vaccine as soon as possible
- Prompt antiviral post exposure prophylaxis and treatment for seasonal influenza should be offered to eligible groups
- Antivirals [guidance for treatment and prophylaxis of seasonal influenza](#) has been updated – health professionals should familiarise themselves with the key updates which simplify first line recommendations, strengthen advice to support empirical treatment with neuraminidase inhibitors and diagnostic testing, and advise on the use of baloxavir marboxil.
- Laboratory [specimen referral guidance](#) has been updated for 2025 to 2026; in-season influenza referral practices now apply
- Infection prevention and control (IPC) [measures](#) such as wearing of masks, ventilation, hand hygiene, and prompt clinical isolation/cohorting should be used in healthcare settings as appropriate.



Background and Interpretation:

Early influenza epidemiology in the 2025/26 season

The latest UKHSA [surveillance data](#) shows influenza activity is now above baseline levels following an early start to influenza circulation in children and young adults. We anticipate that circulation will continue to increase and spread in these and in other age groups.

Recent influenza signals (data to 26 Oct, [published](#) 30 Oct) include:

- Overall positivity now at 8.2% (7 day moving average) in NHS and public health laboratories and over 30% in 5-14 year olds
- Positivity among primary care presentations with acute respiratory infection has reached 10.2%
- Emergency department influenza-like illness attendances are well above baseline for the time of year
- Hospitalisation rates and ICU admission rates for influenza are now above baseline, with the highest admission rates in those age 85 years and over
- There has been an increase in influenza outbreaks reported to Health Protection Teams

Early influenza virology in the 2025/26 season

The latest UKHSA [virological surveillance data](#) shows that the majority of influenza detections with subtyping information in both primary and secondary care are A(H3N2). Available whole genome sequencing from the UKHSA Respiratory Virus reference Unit (RVU) has identified that current circulating A(H3N2) viruses are genetically diverse; early data shows that many belong to genetic subclade J.2.4.1 (now known as K), which has rapidly grown in prevalence globally.

Viruses from the K subclade have antigenically drifted from the A(H3N2) strains which have circulated in recent years and the A(H3N2) strain used in the 25/26 vaccines. The impact on vaccine effectiveness is unclear.

A(H1N1)pdm09 and influenza B viruses continue to be detected. These are similar to strains detected over the summer which were shown to be antigenically similar to the 2025/26 vaccine viruses.

Importance of influenza vaccination

Vaccines typically provide protection against severe clinical disease even when drifted strains are seen. The UK programme uses technologically advanced vaccine types optimised for each patient group. Influenza vaccination remains the best protection against influenza and is expected to continue to offer protection, including against the two other influenza types/subtypes that are likely to circulate this season.

Guidance on the use of antiviral agents for the treatment and prophylaxis of seasonal influenza

On 1 October 2025 the regulations governing prescribing of neuraminidase inhibitors (NAI) in the community were updated to remove restrictions on prescribing outside of the influenza season (see UKHSA briefing note BN2025/037 issued 3/10/2025 or the [Drug Tariff](#) Part XVIII B).



UKHSA guidance on the use of antiviral agents for the prompt treatment and prophylaxis of seasonal influenza have been updated for the 2025/26 season and are available [here](#). Key changes include:

- Simplification of treatment and prophylaxis guidance to standardise the choice of first line antiviral regardless of the dominant circulating strain
- Strengthening of advice to support empirical NAI treatment and diagnostic testing
- Description and advice on use of new antiviral baloxavir marboxil

As per NICE [TA158](#), **following relevant exposure, antiviral prophylaxis should be offered to eligible people in at-risk groups irrespective of vaccination status in light of the evidence outlined above of a drifted strain**. At risk groups include those age 65 years and over, under 6 months of age, pregnant women and anyone in a clinical risk group (see Green Book [influenza chapter](#)).

Infection prevention and control advice

Guidance on [measures to prevent and control](#) respiratory virus infections should be followed including appropriate ventilation, hand hygiene and the use of personal protective equipment in health care settings.

Advice on testing for influenza

Clinicians should have a low index of suspicion for testing for influenza in patients presenting to healthcare with acute respiratory infection symptoms. Testing should not delay initiation of antiviral treatment in suspected cases. If rapid RT-PCR or validated POCTs for respiratory viruses are unavailable, prompt antiviral initiation prior to virological testing is recommended. Early initiation of therapy is associated with clinical benefit.

Sample referral instructions for laboratories

UKHSA has updated [laboratory guidance for referral of influenza samples](#) for winter 2025/26. Clinical diagnostic laboratories are asked to:

1. Ensure that subtyping (for H1/H3) is attempted on **all severe influenza A** cases (ITU/HDU/fatal), either locally or in a UKHSA laboratory.
2. Arrange for a proportion of influenza A positive material to be subtyped - either using validated subtyping assays locally and reporting to SGSS, OR by referring a locally-agreed proportion to a UKHSA Clinical Network Laboratory or Collaborating NHS Laboratory for surveillance purposes.
3. Forward influenza A positive samples for which subtyping attempts have failed (**unsubtypeable samples**) to the UKHSA RVU Colindale using the [E3 form](#).

Recent [international reports](#) have identified H3 subtyping assay failures due to recent evolution in circulating viruses. Laboratories should be alert to potential assay performance issues this winter season. Concerns with commercial diagnostic assay performance should be reported by the laboratory using the assay via the [MHRA Yellow Card scheme](#).

Implications & Recommendations for UKHSA Regions:



Health protection teams should use the updated epidemiological and virological information, and antiviral guidance in managing suspected seasonal influenza outbreaks in care homes and other institutional settings.

Implications & Recommendations for UKHSA sites and services:

UKHSA Clinical Network Laboratories (Birmingham, Bristol, Cambridge, and Manchester) should note that in-season influenza sample referral practices now apply.

- **Select up to 25 samples per week to refer to RVU Colindale** on which subtyping has been performed. Prioritise unsubtypeable influenza A, severe or fatal influenza, samples associated with outbreaks or with suspected antiviral resistance, as in the [Sample Referral Guidelines](#).

Implications & Recommendations for NHS:

Healthcare professionals

- Should continue to strongly advocate for and, where contracted, provide seasonal influenza vaccination to eligible groups.
- Should use the updated epidemiological and virological information, and antiviral guidance in managing suspected and confirmed seasonal influenza case-patients and at-risk patients exposed to suspected and confirmed cases.
- Should apply respiratory IPC measures applicable to their clinical setting.

Laboratory health professionals

In-season influenza sample referral practices now apply.

NHS Collaborating Laboratories (Leeds, Newcastle, Southampton) should:

- **Select up to 10 samples per week to refer to RVU Colindale**, on which subtyping has been performed. Prioritise unsubtypeable influenza A, severe or fatal influenza, samples associated with outbreaks or with suspected antiviral resistance, as in the [Sample Referral Guidelines](#).

Other NHS clinical diagnostic laboratories should:

- If subtyping is not performed in-house, refer a locally-agreed portion of routine samples to a UKHSA Clinical Network Laboratory or Collaborating NHS Laboratory for surveillance purposes.
- If performing subtyping in-house, report to SGSS and refer up to 5 subtyped samples per week to RVU Colindale, following [Sample Referral Guidelines](#), noting instructions for referral of unsubtypeable influenza A.

Laboratory informatics specialists are reminded that influenza negative, indeterminate and void results are required in the Health Protection Regulations to be reported to UKHSA alongside positive results.



Implications and recommendations for Local Authorities:

The briefing is circulated for information to local authority public health teams to make them aware that influenza is circulating in the community. There are no specific changes to existing local arrangements for seasonal flu response.

References/ Sources of information:

Weekly national respiratory virus surveillance reports,
gov.uk/government/collections/weekly-national-flu-reports

Guidance on use of antiviral agents for the treatment and prophylaxis of seasonal influenza, November 2025 gov.uk/government/publications/influenza-treatment-and-prophylaxis-using-anti-viral-agents

Referral of influenza samples to RVU, UKHSA Colindale, 2025 to 2026
gov.uk/government/publications/referring-influenza-samples-to-respiratory-virus-unit-phe-colindale

CMO Letter: <https://www.cas.mhra.gov.uk/SearchAlerts.aspx>

NICE guidance on antiviral prophylaxis for influenza: nice.org.uk/Guidance/TA158

NICE guidance on antiviral treatment of influenza: nice.org.uk/Guidance/TA168

UKHSA guidelines on the management of outbreaks of influenza-like illness (ILI) in care homes gov.uk/government/publications/acute-respiratory-disease-managing-outbreaks-in-care-homes

NHS England: National infection prevention and control manual (NIPCM) for England
england.nhs.uk/national-infection-prevention-and-control-manual-nipcm-for-england/
