

From the Chief Medical Officer
Professor Sir Michael McBride



HSS(MD)38/2026

FOR ACTION

Chief Executives, Public Health Agency/HSC
Trusts/NIAS
Chief Operating Officer, SPPG
GP Medical Advisers, SPPG
All General Practitioners and GP Locums (*for onward
distribution to practice staff*)
OOH Medical Managers (*for onward distribution to
staff*)

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Your Ref:
Our Ref: HSS(MD)38/2026
Date: 12 October 2026

Dear Colleague

CONFIRMED INFLUENZA IN NORTHERN IRELAND

ACTION REQUIRED

Chief Executives must ensure that this information is drawn to the attention of all staff involved in treating patients with suspected influenza.

SPPG must ensure that this information is cascaded to all General Practitioner Practices and Community Pharmacies immediately

Introduction

1. The purpose of this letter is to inform you that Public Health Agency (PHA) Health Protection Influenza surveillance data indicates that influenza is circulating in the community in Northern Ireland. GPs (and other prescribers) are reminded that early antiviral treatment, where clinically appropriate, reduces the risk of complications and improves clinical outcomes. Neuraminidase inhibitors (oseltamivir and zanamivir) are the mainstay of treatment and prophylaxis.
2. Baloxavir marboxil is also licensed in the UK for treatment and prophylaxis of influenza but has not undergone appraisal by the National Institute of Health and Care Excellence (NICE). Prescribers considering its use where there is a poor clinical response to treatment or where resistance to oseltamivir is suspected or confirmed should work with local pharmacy teams to assess availability and supply, including Trust formulary processes. Early treatment

of influenza is where the greatest benefit is seen, and so clinicians should start an alternative treatment option instead of delaying initiation of antiviral treatment due to supply.

3. Amendments to The Health and Personal Social Services (General Medical Services Contracts) (Prescription of Drugs Etc) Regulations (Northern Ireland) 2004 came into effect from 1st May 2026 which removed the previous restrictions on Health and Social Care (HSC) prescribing and dispensing of oseltamivir (Tamiflu®) and zanamivir (Relenza®) by standard HSC prescription processes outside the flu season. Please refer to [HSS\(MD\) 19/2026](#) for further information.
4. [UKHSA guidance](#) provides detailed advice on the use of antiviral agents for treatment and prophylaxis of influenza. Health professionals should refer to this guidance for current advice.
5. Clinicians should be aware of the regular updates on Influenza activity which are available on the Public Health Agency website at:
<https://www.publichealth.hscni.net/services-and-teams/public-health-services/health-protection/surveillance-data/respiratory-0>

Definitions

Non-severe influenza (illness)

6. Non-severe influenza illness is most commonly characterised by symptoms such as:
 - sudden onset cough
 - sore throat
 - rhinorrhoea (runny nose),
 - fever
 - headache
 - muscle and joint pain
 - severe malaise (feeling tired and unwell)
7. Most people recover from the fever and other symptoms within a week, without requiring medical attention. This was previously referred to as 'uncomplicated'. If antiviral treatment of non-severe infection is warranted, this can typically be done in the community.
8. Gastrointestinal (particularly in children) and less commonly ocular (eye) symptoms (photophobia, conjunctivitis, lacrimation and pain upon eye movement) have been described in association with influenza infection.

Severe influenza (illness)

9. Severe influenza illness is characterised by evidence of clinical complications directly resulting from influenza virus infection, such as pneumonia, sepsis, multi-organ-failure, encephalopathy or exacerbation of chronic disease, which warrant management in a hospital or critical care setting (such as a high dependency unit (HDU) or intensive care unit (ICU). However, not all patients who are hospitalised primarily for other reasons with an incidental finding of influenza detection have severe influenza and clinical judgement should be exercised.

Risk factors for severe influenza and hospitalisation

10. Certain patient groups are at increased risk of progression to severe influenza.

11. Patients considered at-risk include those with:

- chronic neurological, hepatic, renal, respiratory and cardiovascular diseases
- diabetes mellitus
- (potential) immunosuppression¹
- morbid obesity (BMI ≥40)
- age over 65 years
- current pregnancy (including up to 2 weeks post-partum)
- children under 6 months of age.

Severe immunosuppression

12. The risk of developing severe illness, and the risk of developing resistance to antivirals is higher in people with severe immunosuppression. This is a subset of patients with immunosuppression and a narrower definition than those used in assessment of whether a patient is 'at-risk' (see [UKHSA Guidance](#), 'Risk factors for severe influenza and hospitalisation' section). Degrees of immunosuppression are difficult to quantify, and individual variation exists, therefore this list is not comprehensive.

13. Examples of severe immunosuppression include:

- severe primary immunodeficiency
- current or recent (within 6 months) chemotherapy or radiotherapy for malignancy

¹ For oseltamivir and zanamivir treatment, NICE includes any who might be immunosuppressed within its at-risk criteria ([TA168](#)).

- solid organ transplant recipients on immunosuppressive therapy
- bone marrow transplant recipients currently receiving immunosuppressive treatment, or within 12 months of receiving immunosuppression
- patients with current graft-versus-host disease
- patients currently receiving high dose systemic corticosteroids (equivalent to ≥ 40 mg prednisolone per day for >1 week in an adult, or ≥ 2 mg/kg/day for ≥ 1 week in a child), and for at least 3 months after treatment has stopped
- people living with HIV with severe immunosuppression ($CD4 < 200/\mu l$ or $< 15\%$ of total lymphocytes in an adult or child over 5; $CD4 < 500/\mu l$ or $< 15\%$ of total lymphocytes in a child aged 1 to 5; expert clinical opinion in a child aged under 1)
- patients currently or recently (within 6 months) on other types of highly immunosuppressive therapy or where the patient's specialist regards them as severely immunosuppressed.

Clinical diagnosis and testing for influenza

14. The potential for co-circulation and similarity in clinical presentation of other respiratory viruses can make influenza diagnosis challenging on clinical-epidemiological grounds alone. Coinfection of a patient with influenza and other respiratory viruses is possible, more commonly in children, and may be associated with increased mortality.
15. Therefore, depending on the epidemiological picture, severity of illness, experience of the clinician, clinical setting and the infection prevention and control (IPC) requirements, an increased use of virological testing to guide case management and outbreak response may be warranted. UKHSA supports the use of validated point-of-care/near-patient influenza tests (POCTs) in patients presenting with acute respiratory infection symptoms to improve diagnostic certainty and support timely clinical management and IPC when influenza is suspected.
16. The UK Health Security Agency (UKHSA) has produced guidance on recommendations for testing, and information on clinical at-risk groups and patients eligible for treatment in primary care with either oseltamivir or zanamivir: [Influenza: treatment and prophylaxis using anti-viral agents - GOV.UK](#)

Prescribing antivirals in accordance with NICE guidance

17. NICE guidance on the use of antiviral drugs for the treatment of influenza is available at: <http://guidance.nice.org.uk/TA168>
18. NICE guidance on the use of antiviral drugs for the prophylaxis of influenza is available at: <http://guidance.nice.org.uk/TA158>
19. Oseltamivir and zanamivir are licensed for the treatment and prophylaxis of influenza. Refer to BNF section 5.6.5 for further details.

20. Treatment is most effective if taken within 48 hours of onset of symptoms. It is indicated for people in at risk groups (outlined above) that present with an influenza-like illness and can start treatment within 48 hours (or within 36 hours for zanamivir treatment in children) of the onset of symptoms.
21. Prophylaxis is indicated for people in at risk groups (outlined above) where a patient has been exposed to an influenza-like illness and is able to begin prophylaxis within the timescale specified in the marketing authorisations of the individual drugs (within 36 hours of contact with an index case for zanamivir and within 48 hours of contact with an index case for oseltamivir).
22. Given that antiviral treatment and prophylaxis are most effective when initiated promptly, prescribers should consider early liaison with community pharmacies, where appropriate, to facilitate timely access to antiviral medicines and minimise delays in treatment.

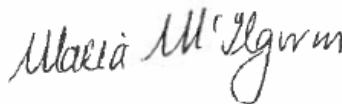
Supplying antivirals from community pharmacies

23. Community pharmacies should order antiviral medicines through their usual pharmaceutical wholesalers. GP Out-of-Hours services should also consider keeping a supply of antivirals as part of their stock medication.
24. It is important that pharmacists ensure antiviral medicines are issued to patients promptly, to avoid treatment delay. If unable to fulfil the whole prescription, they should consider how best they can assist patients to gain timely access.

Yours sincerely



Prof Sir Michael McBride
Chief Medical Officer



Prof Maria McIlgorm
Chief Nursing Officer



Prof Cathy Harrison
Chief Pharmaceutical
Officer

Circulation List

Director of Public Health/Medical Director, Public Health Agency (*for onward distribution to all relevant health protection staff*)

Assistant Director Public Health (Health Protection), Public Health Agency

Director of Nursing, Public Health Agency

Assistant Director of Pharmacy and Medicines Management, SPPG (*for onward distribution to SPPG Pharmacy and Medicines Management Team and community pharmacists*)

Directors of Pharmacy HSC Trusts

Director of Social Care and Children, SPPG

Family Practitioner Service Leads, SPPG *(for cascade to GP Out of Hours services)*

Medical Directors, HSC Trusts (for onward distribution to all Consultants, Occupational Health Physicians and School Medical Leads)

Nursing Directors, HSC Trusts (for onward distribution to all Community Nurses, and Midwives)

Directors of Children's Services, HSC Trusts

RQIA (for onward transmission to all independent providers including independent hospitals)

Regional Medicines Information Service, Belfast HSC Trust

Regional Pharmaceutical Procurement Service, Northern HSC Trust

Professor Kenda Crozier, Head of School of Nursing and Midwifery QUB

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Stephanie Foster, Open University

Professor Paul McCarron, Head of School of Pharmacy and Pharmaceutical Sciences, Ulster University

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This letter is available on the Department of Health website at

<https://www.health-ni.gov.uk/topics/professional-medical-and-environmental-health-advice/hssmd-letters-and-urgent-communications>

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