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Independent report

JCVI statement on influenza vaccines for 2026 to 2027

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Contents

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Introduction

The Joint Committee on Vaccination and Immunisation (JCVI) reviewed the latest UK influenza immunisation programme data, including uptake, epidemiology and vaccine effectiveness for the 2024 to 2025 season at the influenza sub-committee meeting on 13 May 2025 and the JCVI meeting on 4 June 2025.

The 2024 to 2025 influenza season started in the second half of November 2024, with the peak of activity occurring just before the start of 2025. There was a relatively high burden of disease over the season, with influenza-attributable excess mortality higher than in the 2023 to 2024 season and with more paediatric deaths reported.

Following JCVI advice in 2023, the start of the adult influenza programme (except for pregnant women) was moved from September to October. This was based on evidence that vaccine effectiveness can wane over time in adults, and therefore if vaccination is given closer to the start of the influenza season, vaccine effectiveness will be higher during peak influenza activity. The timing of the programme did not change for pregnant women as vaccination needs to occur prior to delivery to protect the baby in the first few months of life, while also protecting the mother during peak season. The timing of the children's programme also did not change as protection from vaccination lasts longer in children.

Coverage was lower than the 2023 to 2024 season for adults, while it remained similar for children. The ongoing low or declining coverage, specifically in clinical risk groups, pregnant women and frontline healthcare workers, is concerning, especially given the impact vaccination has on preventing hospitalisation: recently published modelling estimates (https://www.gov.uk/government/statistics/influenza-in-the-uk-annual-epidemiological-report-winter-2024-to-2025) suggested that the influenza vaccination programme prevented approximately 100,000 hospitalisations in the 2024 to 2025 season.

Vaccine effectiveness is important in determining the vaccines used in the programme. Current vaccines provide moderate effectiveness, ranging from 30% to 70% depending on age, setting and vaccine type, with the highest effectiveness seen against hospitalisation.

Recent improvements in surveillance through the use of the national vaccine registry and the expansion of primary care sentinel surveillance have supported informative comparisons between vaccine types. Unpublished data from the UK Health Security Agency (UKHSA) for the live attenuated influenza vaccine (LAIV) used in the children's programme suggested that vaccine effectiveness against influenza A(H1N1) was lower than for the inactivated influenza cell-culture vaccine (IIVc) over the past 3 seasons combined, although the confidence intervals were overlapping.

While this reduction in effectiveness is of concern to JCVI, LAIV is still an effective vaccine that is preventing hospitalisations in children.

Unpublished analyses undertaken by UKHSA on vaccine effectiveness against hospitalisation for adults over 65 years showed overlapping confidence intervals for the 3 vaccines that were used in the 2024 to 2025 season: adjuvanted inactivated influenza vaccine (aIIV), IIVc and high-dose inactivated influenza vaccine (IIV-HD). Previous analyses have shown lower vaccine effectiveness for the inactivated influenza egg-culture vaccine (IIVe), which reinforces the current JCVI advice not to use this vaccine for adults aged 65 years and over.

In those groups where the use of IIVe remains an option, this should only be in circumstances where the preferred first-line influenza vaccines are not available and efforts should be made to use the best available influenza vaccines, particularly in clinical risk groups.

JCVI has previously advised that they would like to see more use of inactivated recombinant influenza vaccine (IIVr) in the programme to improve estimates of vaccine effectiveness and have data over multiple seasons on the performance of this vaccine, especially in older adults where there is strengthening evidence of additional benefit relative to other products. This advice remains.

The advice below represents JCVI's scientific view on the use of influenza vaccines in the UK for the 2026 to 2027 influenza season.

Summary of influenza vaccines for 2026 to 2027

Age or risk group	Vaccine preference	If the preferred vaccine is unavailable
Aged 65 years and over	aIIV, IIVc, IIV-HD or IIVr	Not applicable
Aged 18 to 64 years in a risk group	IIVc, IIVr or aIIV (in those aged 50 to 64 years) or IIV-HD (in those aged 60 to 64 years)	IIVe

Age or risk group	Vaccine preference	If the preferred vaccine is unavailable
Aged 2 to less than 18 years	LAIV	IIVc
Aged 2 to less than 18 years but unable to have LAIV	IIVc	IIVe
Aged 6 months to 2 years in a risk group	IIVc	IIVe

> Note: LAIV is the vaccine of choice for children aged 2 to 17 years.

Advice on influenza vaccination in 2026 to 2027

Adults aged 65 years and over

For vaccination of those aged 65 years and over, JCVI advises the use of the following vaccines:

- adjuvanted inactivated influenza vaccine (aIIV)
- inactivated influenza cell-culture vaccine (IIVc)
- high-dose inactivated influenza vaccine (IIV-HD)
- recombinant inactivated influenza vaccine (IIVr)

The inactivated influenza egg-culture vaccine (IIVe) is not advised for use in this age group.

Considerations
JCVI is of the view that there is enough supporting evidence for IIVc to now be considered equivalent to aIIV, IIV-HD and IIVr in those aged 65 years and older (JCVI meeting, 4 June 2025). This is based on unpublished UKHSA vaccine effectiveness data from the 2024 to 2025 season which

showed overlapping confidence intervals for aIIV, IIV-HD and IIVc (noting that IIVr was not used in the UK in this season). A meta-analysis of vaccine effectiveness against hospitalisation from the 2022 to 2023 and 2023 to 2024 seasons had also shown overlapping confidence intervals for these vaccines, suggesting that IIVc performs as well as aIIV and IIV-HD against hospitalisation for adults over 65 years.

The available evidence indicates additional benefit from the use of aIIV, IIVc, IIV-HD and IIVr in those aged 65 years and over, compared with standard dose IIVe. However, there is little available data to provide a preference between these 4 vaccines. The level of uncertainty in the available evidence, and lack of head-to-head studies, is considered too great to allow for a preferential recommendation between these vaccines at the current time.

JCVI strongly advises against the use of IIVe in adults over 65 years of age.

At-risk adults aged 18 to 64 years (including pregnant women)

For vaccination of adults aged 18 to 64 years in a clinical risk group, JCVI advises the use of the following influenza vaccines:

- inactivated influenza cell-culture vaccine (IIVc)
- inactivated recombinant influenza vaccine (IIVr)

As aIIV is licensed from the age of 50 years, it can also be considered for use in those aged 50 to 64 years alongside the above.

IIV-HD is licensed from the age of 60 years. Therefore, it can also be considered for use in those aged 60 to 64 years alongside the above.

IIVe can also be considered for use in this age group if all other options are unavailable.

Considerations
There is a potential advantage to using influenza vaccines which do not use eggs in the manufacturing process (cell-culture or recombinant) compared with egg-cultured influenza vaccines, due to the possible impact of ‘egg adaptation’ on the effectiveness of influenza vaccines, particularly against A(H3N2) strains. The evidence on additional benefit is available for only a few seasons but the issue of egg adaptation remains a real concern for the A(H3N2) virus which is a more virulent influenza subtype in terms of morbidity and mortality.

There is limited, but good, evidence that IIVr, which is also not affected by egg adaptation, is more effective than IIVe in adults under 65 years age. Therefore, IIVr is preferred over IIVe in adults under 65 years old.

Based on the available evidence, JCVI supports a clear preference for IIVc and IIVr over IIVe, and these are the vaccines of choice for this vulnerable group.

IIVe can also be considered for use in this group if all other options are unavailable because any impact of egg adaptation will likely be limited to seasons in which the influenza season is dominated by well-matched A(H3N2) strains.

Children aged 2 to less than 18 years of age

Children aged 2 to less than 18 years of age should be offered LAIV unless it is medically contraindicated or otherwise unsuitable. In those for whom LAIV is not suitable, JCVI advises the use of IIVc.

Therefore, JCVI advises these influenza vaccines in the following order of preference:

1. live attenuated influenza vaccine (LAIV)
2. inactivated influenza cell-culture vaccine (IIVc) (where LAIV is medically contraindicated or otherwise unsuitable)

As IIVc is egg-free, egg-allergic individuals can be safely vaccinated in any setting with this vaccine, including those who have required admission to intensive care for a previous severe anaphylaxis to egg.

The inactivated influenza egg-culture vaccine (IIVe) can also be considered for use in this age group if all other options are unavailable.

Considerations
LAIV was first advised for use in the children's programme in 2012 and remains the vaccine of choice given its acceptability and ease of administration, good safety profile and evidence of effectiveness, particularly against influenza A(H3N2) and influenza B.

Studies on the use of LAIV have also indicated that vaccination of primary school children is associated with protection in the children receiving the vaccine and also indirectly protects older adults (Sinnathamby, 2023; Kassianos, 2020; and Pebody 2015).

Although JCVI noted reduced vaccine effectiveness of LAIV against influenza A(H1N1) as compared with IIVc in the last few seasons, the

vaccine is still effective at preventing hospitalisations in children.

Children less than 2 years of age

For vaccination of children less than 2 years of age in an at-risk group, JCVI advises the use of the inactivated influenza cell-culture vaccine (IIVc).

The inactivated influenza egg-culture vaccine (IIVe) can also be considered for use in this age group, if all other options are unavailable.

Generating real-world evidence in the UK

Further comparative data is required, preferably from the same country over multiple seasons and with laboratory-confirmed influenza endpoints, to support consideration of the relative effectiveness of the influenza vaccines available in the UK across the different age and risk groups in which they are licensed. JCVI would like to see high-quality comparative data generated in the UK. Most of this data can potentially be generated from the monitoring and surveillance of vaccine effectiveness in primary and secondary care for those influenza vaccines delivered through the influenza vaccination programme.

Improvements in data systems since the COVID-19 pandemic have enabled better vaccine effectiveness estimates with hospitalisation as a clinical endpoint in the UK. JCVI would like to see continued enhancement of the existing influenza surveillance systems for generating adequately powered data on influenza vaccine effectiveness in primary and secondary care settings. Improvements have been made linking vaccination records with laboratory data and hospital admissions and work is ongoing to increase laboratory submissions of negative results. It is also important to maximise influenza A subtyping to support vaccine effectiveness evaluation. This data is important to inform future JCVI decisions which will benefit public health in the longer term and should form part of the longer-term planning for a first-class influenza programme as a whole.

Other research initiatives could also contribute to improving the evaluation of influenza vaccines in the UK. JCVI supports initiatives involving close working of industry, regulators, government and public-funded research in this regard.

JCVI would like to see all the available vaccines, which it has advised in preference to standard egg-based vaccines, used in the UK so they can be properly evaluated through the programme but understands that this is subject to NHS negotiations. There might be important differences in the products which could lead to a differential impact on winter pressures, and it would be difficult to evaluate the significance of this for the NHS unless all of the advised products are available in the programme.

Operational considerations

JCVI is mindful that factors other than purely scientific and clinical advice need to be considered from an operational perspective, including supply availability and affordability, and which will contribute to the decisions on which vaccines are purchased for the 2026 to 2027 season.

JCVI's advice outlines the preferred vaccines that should be made available, subject to vaccine availability. The aim of this advice is to provide a framework from which NHS England, the devolved governments and UKHSA can plan the ordering of vaccines and delivery of the influenza programme in 2026 to 2027 and communicate this clearly to providers and the public. A well-planned and orchestrated programme that results in the timely delivery of vaccination is important to ensure the eligible population is protected as early as possible before influenza activity starts to increase in the winter months.

Background to the current vaccines in the programme

Adjuvanted influenza vaccines were first advised for use in the UK programme in October 2017 and subsequently available in the 2018 to 2019 season.

In June and October 2018 JCVI discussed IIV-HD and IIVc, respectively. Both vaccines were advised for use in adults over 65 years of age in the 2019 to 2020 season. IIVc was also advised for use in adults aged less than 65 years who were in clinical risk groups and children who could not receive LAIV.

In October 2020, IIVr was considered by JCVI to be an acceptable alternative to aIIV and IIV-HD, alongside IIVc in adults aged 65 years and over. It was also considered suitable for use in adults aged less than 65 years who were in clinical risk groups.

Following the September 2021 influenza sub-committee, JCVI revised the use of IIVr and advised that it could be considered equivalent to aIIV and IIV-HD in those aged 65 years and over.

An influenza programme for children was advised by JCVI in April and June 2012, with LAIV as the preferred vaccine. From the start of the 2023 season, IIVc became the preferred vaccine for children less than 2 years of age, following JCVI advice in October 2022.

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