UK Health Security Agency

Immunisation Equity Strategy

Commitments for 2025 to 2030

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Forewords

The COVID-19 pandemic underscored the many ways in which infectious disease threats can mirror and often worsen existing health inequalities, but also the crucial role of timely vaccination in providing protection across populations. Inequities in outcome for vaccine-preventable diseases (VPDs) have complex and long-standing causes and effective action to address these inequities requires sustained action on vaccination uptake, public health surveillance and a range of wider healthcare and public health measures. Importantly, we need to ensure both that vaccine uptake is high overall, but also that it is maximised within those communities who are less likely to be able to access vaccination.

The UK Health Security Agency (UKHSA) has a long-standing track record in development, implementation and evaluation of immunisation programmes to monitor vaccine effectiveness and to assess factors that could affect trust in vaccination for different populations. This work is supported by the development of resources and guidance that are designed to be culturally competent and available in different languages and media. It is also supported by our joint working with other government partners and with the voluntary and community sector during and since the pandemic to ensure vaccination programmes are accessible to people in inclusion health groups.

This refreshed Immunisation Equity Strategy arrives at a time of significant change in the immunisation system and in wider healthcare system structures in England. In 2023, the NHS published its national vaccination strategy and in April 2026, the commissioning of immunisation programmes are due to be delegated from the NHS National Immunisations Directorate to NHS integrated care boards (ICBs). Our Strategy outlines a series of action areas in which the UKHSA and its national partners will work to support ICB colleagues to navigate these changes, through support to the commissioning and delivery of immunisation programmes. It forms part of a broader programme of work to support high quality, safe immunisation service delivery. UKHSA is committed to working collaboratively in partnership with underserved communities to remove barriers to prevention, diagnosis and treatment for all VPDs and will review the strategy after its first year to ensure it continues to support new structures and systems as they arise.

Dr Mary Ramsay CBE

Director of Public Health Programmes, UKHSA

Professor of Vaccine Policy,
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Immunisation has contributed to major advancements in health over many decades, helping us to live longer and healthier lives. However, in recent years, uptake for many vaccinations in England has fallen. We know that these effects are not evenly distributed – they are most pronounced in areas of deprivation and amongst some of our most vulnerable communities. Immunisation inequities are avoidable disparities in access to and/or uptake of immunisation which lead to some population groups remaining unprotected or under-protected from VPDs.

The updated UKHSA Immunisation Equity Strategy highlights the importance of taking a 'people and place' based approach, recognising that the barriers that can stand in the way of people receiving the right protection from VPDs at the right time, in a place that is appropriate and accessible, are varied and complex. Integrated Care Systems (ICS) in England have been established to improve access, experience and outcomes of services for all, reduce health inequalities, and improve the health of the populations they serve in a way that maximises the benefit of the money that we receive from the public. Work to address immunisation inequities must be built around partnerships, reflect local realities and (re) build levels of trust with communities.

Importantly it depends on acknowledging the inequities by strengthening the availability of data on uptake and outcomes in different populations and using the latest and best evidence to develop tailored approaches to vaccination alongside routine offers.

Taken together, this work will help us reach all sections of our communities and ensure that immunisation, a basic right of everyone as enshrined in the NHS charter, becomes a reality for everyone. So, I welcome the focus on 'people and place' based approaches to realising equitable healthcare for all, and encourage colleagues in England's ICBs to work with local leaders and partners to make an even bigger difference to the people they serve.

Dame Marie Gabriel

Chair, North East London ICB

Chair, NHS Race Observatory

Executive summary

This document sets out actions to be taken by the UK Health Security Agency (UKHSA) alongside our partners to support local actors in addressing immunisation inequities in the period 2025 to 2030. The Strategy refreshes the Immunisation Inequalities Strategy first published by Public Health England in 2021 and should be read alongside the NHS Vaccination Strategy. It has been produced to provide additional support to colleagues in Integrated Care Boards (ICBs) and their local partners navigating the planned delegation of commissioning responsibilities for immunisation from NHS England to ICBs by April 2026.

The immunisation system is concerned with all the actions that help reduce the spread of vaccine-preventable diseases (VPDs) – including vaccination but also action on infectious disease cases and outbreaks, public health monitoring, and many other public health functions. Immunisation equity is about reducing unfair and avoidable differences in outcomes from immunisation.

Data show that immunisation outcomes vary in complex ways by vaccine and by factors including age, ethnicity, and socioeconomic status. Addressing immunisation inequity will help ensure that everyone is able to receive the immunisations which support them in leading a healthy life, no matter where they live or who they are.

While uptake of vaccinations in England remains high overall, there have been gradual declines across most vaccine programmes in recent years. There are also important variations in uptake by population group, although the detailed picture varies by vaccine, geography and other factors.

Against this context, our vision is to ensure that everyone has the opportunity to be protected by full immunisation, and that everyone can make an informed choice about whether to take up vaccination based on reliable information about the vaccines that they are offered, irrespective of where they live, their age, socioeconomic status, or gender-related or other factors. The Strategy supports the central ambition of the NHS Vaccination Strategy to increase vaccination uptake and coverage across all populations.

To achieve our vision, we will work with our partners over the next 5 years to ensure that: there is more accountable system leadership on immunisation inequities; access to timely, high-quality data on immunisation is improved for all relevant stakeholders to enhance policy, strategy and delivery activities; practitioners and policymakers are better able to generate, share and use evidence to promote immunisation equity; and people and place based approaches to communication and engagement around immunisation with different communities and professional groups are embedded in ways of working at all levels.

The updated Strategy outlines a series of actions for UKHSA and our partners for the period 2025 to 2030, to help achieve these outcomes. Actions under the Strategy will be collated in an implementation plan which will include key performance indicators

to support progress monitoring against our commitments. We will report on our progress internally to UKHSA's Vaccines Board. Externally, we will report to the Equity Subgroup of the Immunisation Programmes Implementation Group (IPIG). The subgroup reports in turn to IPIG, which brings UKHSA and its national partners together to oversee the implementation and delivery of all the individual immunisation programmes in England. The updated Strategy will continue to be monitored to ensure it aligns with, and is effective within, any new developing health system structures as they arise.

1. Background

Why immunisation equity matters

The immunisation system is concerned with all the actions that help reduce the spread of vaccine-preventable diseases (VPDs). Ensuring that people receive vaccines against these diseases in a timely way is one of the most important contributors to effective immunisation. However, there are many other activities that determine whether people become ill – or even sadly die – from VPDs. These include, among many others: effective public health surveillance systems; identifying and acting promptly on VPD cases and outbreaks in the community; getting the right treatment at the right time to people who have developed a VPD; and the actions we all take every day to help stop these and other infections spreading.

We know that vaccination is one of the most effective public health interventions available. Vaccinations have saved over 150 million lives globally since the introduction of the Expanded Programme on Immunisation (EPI) for children in 1974, the vast majority in young infants. They have contributed to large reductions in mortality and morbidity in England since the 1950s.

We also know that effective immunisation has significant economic benefits for society as a whole. Evidence shows that routine childhood and adult vaccination greatly reduce the burden of treatment and hospitalisation costs on health systems and services. The returns on investment on adult immunisation programmes in general are considerable and many adult immunisation programmes demonstrate a high benefit to cost ratio.

While national immunisation programmes have achieved high coverage rates overall, uptake for many vaccines has gradually declined in recent years, a decline accelerated by disruptions during the COVID-19 pandemic. Overall trends mask a complex picture of inequities in immunisation (where equity is defined as the absence of unfair and avoidable differences in immunisation outcomes) between populations and societal groups, by geography, and by other factors.

Positively improving immunisation equity is central to achieving UKHSA's strategic priority on improving health outcomes through vaccines and our efforts to reduce the gap in healthy life expectancy between populations. It is also a key focus for the World Health Organisation globally.

Vaccination benefits us all by:

- helping to protect those who are vaccinated from the harmful effects of VPDs, and reducing harmful impacts on schooling and work
- reducing the risk of VPDs among the groups and individuals who are most vulnerable to severe disease (including those living with certain long-term health conditions) and even death
- protecting those who aren't vaccinated by helping to reduce the spread of some diseases overall
- helping to reduce reliance on treatment of infection using antimicrobials, and therefore helping reduce risks from antimicrobial resistance

Addressing immunisation inequity will help ensure that everyone has the same opportunities to lead a healthy life, no matter where they live or who they are.

Immunisation inequities in England

A Health Equity Audit (HEA) conducted for the national immunisation programmes in England in 2019 found evidence of significant variations in vaccination coverage and timeliness of vaccination by age group, geography, socioeconomic status, ethnicity, religion, and according to other factors including the presence of pre-existing health conditions, membership of underserved groups (for example prisoners, migrants, people living with disabilities including autistic people and those with a learning disability) and household characteristics. The pattern of inequity varies in important ways by vaccine programme. Findings from the audit also showed that inequalities exist not just for overall coverage, but also for timing of vaccines and completion of vaccine schedules.

Since 2019, academic and practice evidence has continued to highlight significant inequalities in coverage by ethnicity, consistently lower coverage among socioeconomically deprived groups, and lower coverage in specific geographical areas (notably London) by comparison with the rest of the country. In addition, important new evidence has been published concerning approaches that work in improving uptake across populations and from which this Strategy draws (see Box 1).

Although broad themes regarding the picture of inequities across communities are consistent, taking stock of the detailed picture for immunisation inequities and how and why they occur, is challenging. There are many reasons for this, including the evolution of the national programmes and the occurrence of clinically significant changes at least once a year (for example changes in scheduled ages or use of updated vaccine products).

Box 1: Evolving evidence and guidance to improve vaccine uptake across populations

In May 2022, the National Institute for Health and Care Excellence (NICE) published a new guideline on Vaccine uptake in the general population. The guideline includes recommendations on service organisation; identifying eligibility, giving vaccinations, and recording vaccination status; and invitations, reminders and escalation of contact. These recommendations can be applied locally to increase the uptake of all vaccines provided on the routine immunisation schedule and reduce inequalities.

The NICE guideline was underpinned by a systematic review of published evidence on vaccine uptake, including barriers to and facilitators for vaccine uptake by different population groups and immunisation programmes. As part of this review, several additional groups at risk of immunisation inequalities were identified including people experiencing homelessness, people from non-English-speaking families, and people not registered with a GP. The evidence also further highlighted the need for tailored approaches that meet the needs of specific populations and sub-populations. For example, young people who aren't attending school, due to long-term illness or home-schooling, or for other reasons, will need a different setting for vaccination and may not be covered by existing school-based programmes.

NICE has published a baseline assessment tool to help commissioners and providers to benchmark their activity against the national guidelines and identify priority areas for improvement within and across immunisation programmes. For example, the NHS England South West Vaccination and Screening Team used the baseline assessment tool to refresh their MMR uptake action plan and identify where alternative provision of immunisation services was required for underserved or unregistered communities, and those who find accessing immunisations challenging.

The context for the Strategy

Action on health inequities

The Government's Plan for Change includes an explicit commitment to address the underlying drivers of ill-health and to tackle persistent inequalities in health, building on findings from Lord Darzi's Independent Investigation of the National Health Service in England. Action on immunisation inequities will make a key contribution to building an NHS fit for the future by helping to reduce the burden of VPDs on health services especially during periods of seasonal pressure, and keeping the health and care workforce healthy. It will break down barriers to opportunity by helping to ensure that all children are given the best possible protection against VPDs and improving attainment at school. And it will support foundations for economic growth by reducing the impact on economic productivity of work days lost to VPDs each year in England, and by improving the health of all people across the life course.

The Equality Act 2010 requires all public sector bodies to address inequalities related to the nine protected characteristics – age, disability, gender reassignment, marriage and civil partnership, race, religion or belief, sex, and sexual orientation. It also sets out provisions to reduce the risk of discrimination – for example, through a requirement to put in place reasonable adjustments to ensure services are appropriate and accessible, physically and otherwise, to meet the needs of all. The Health and Social Care Act of 2012 goes further by introducing duties on a range of NHS bodies to have 'due regard' to reducing health inequalities in exercising their functions.

Health equity is a cross-cutting goal in the UK Health Security Agency (UKHSA) Strategic Plan, a strategic priority for the UKHSA through the Health Equity for Health Security Strategy, and an important commitment for the National Health Service in England (NHSE) through its National Framework on Inclusion Health, the Core 20Plus5 approach and the NHS Vaccination Strategy published in December 2023. To help inform our work on health equity, we have adopted the NHSE Core20PLUS framework to outline the populations we will consider through our work. These include:

- the most deprived 20% of the population as defined by the Index of Multiple Deprivation
- people who are clinically vulnerable
- people with protected characteristics covered by the Equality Duty as outlined above
- inclusion health groups
- coastal communities, where there may be areas of high deprivation
- young people who are themselves carers, are care leavers, or are in contact with the justice system

UKHSA is mandated, through our Remit Letter, to support action to ensure that all members of the community are protected equitably from exposure to, and the consequences of, health protection threats, and more particularly to reduce disparities in vaccination coverage that may put specific regions and communities at higher risk from VPDs.

The evolving vaccination delivery landscape

National immunisation programmes are currently overseen by a Tripartite collaboration between the Department of Health and Social Care (DHSC), UKHSA and NHSE. This document addresses immunisation activities both within and outside Section 7a, a national agreement that sets out arrangements for commissioning and delivery for many vaccination programmes.

The landscape for vaccination delivery in England has changed in important ways since 2021 and further significant change is on the horizon. The NHS Vaccination Strategy was published in December 2023 to define the NHS's future approach, working across the current tripartite and partners, to increase vaccination uptake and coverage and thereby reduce morbidity and mortality from VPDs. In addition, the Health and Social Care Act 2022 established Integrated Care Boards (ICBs) with activities determined through partnership with relevant Local Authorities and supported by local Directors of Public Health (DsPH). From April 2026, responsibility for commissioning vaccination services will be delegated to ICBs across England.

This Immunisation Equity Strategy has been refreshed to provide additional support to ICBs and their local partners to help them navigate this transition – from local commissioners and providers of healthcare services, including local authorities and their directors of public health, through to UKHSA regional teams engaged in the prevention and control of VPD cases and outbreaks. It complements the NHS Vaccination Strategy by setting out a series of action areas to help address inequities in vaccination coverage between and across populations and strengthen the immunisation system in the round.

Case study boxes have been included throughout the document to provide real-world examples illustrating how, through specific interventions or improved ways of working, action on immunisation equity can be strengthened.

2. Vision, aim and expected outcomes for 2025 to 2030

The Immunisation Equity Strategy has been updated following a multi-stage consultation process with stakeholders across the health system in England, combining participatory workshops, interviews and document analysis. This section sets out its vision, aim and expected outcomes for 2025 to 2030, as well as the key actions we plan to take over the next 5 years.

Principles for action on immunisation equity

Achieving equitable immunisation outcomes depends on integrated and inter-related action across a range of areas including: effective VPD surveillance; timely identification of, and action on, cases and outbreaks of VPDs; and effective and efficient vaccination delivery.

The approach outlined in this document is based on a set of principles for action:

Getting the basics right: ensuring effective vaccination delivery, uptake and evaluation through core programme offers (for example the childhood immunisation programme) is central to the attainment of high uptake across all population groups. By improving vaccine coverage overall, under-served populations will potentially benefit through reduced risk of exposure to agents that cause VPDs, and other mechanisms. This is central to achieving UKHSA's strategic priority to improve health outcomes through vaccines and is strategic priority number 1 in the WHO's Immunization Agenda 2030. It is also a central aim of the NHS Vaccination Strategy.

Working collaboratively: collaboration and partnership with relevant stakeholders at all levels of the immunisation system is essential to ensuring equity outcomes can be met, and for drawing in relevant local knowledge and contextual understanding of the factors contributing to immunisation inequities noted above. This will require clarity on the roles and responsibilities of different actors in the immunisation system and collective agreement on how we will measure progress in improving equity.

Ensuring timely access to high-quality, granular data: data flows are complex and function in different ways across the country and for different vaccination programmes. Information needs to be available at a level of granularity and quality that is sufficient to support tailored, local action to address immunisation inequities. Data must also be of appropriate consistency and quality to support national surveillance requirements. UKHSA has statutory functions, as set out in our Remit Letter, in generating, collating and distributing data.

Supporting expertise at all levels of the system: for vaccination delivery and uptake to operate well, tangible, coordinated and interdependent action is needed at local, regional and national levels, drawing on the best available evidence. Importantly, local commissioners and providers of healthcare services and community groups are best placed to understand needs in their communities. Appropriate support and training will be needed at all levels to ensure that systematic approaches are applied to understanding the needs of different populations in relation to immunisation, and to allow for the planning and delivery of effective and equitable services.

Focusing on people and place: supporting approaches that address health hazards for the population groups, places and settings that experience health inequalities is a key focus of UKHSA's Health Equity for Health Security Strategy. We know that successfully addressing immunisation inequity requires tailoring of approaches, and that some groups affected by immunisation inequities may also be less able to access other health services in a timely way. We will encourage the use or adaptation of existing tools such as the WHO's Tailoring Immunisation Programmes (TIP) to ensure that we draw on the expertise and contributions of those with lived experience, and to think in an integrated way about how to improve service access, rather than focusing on immunisation in isolation.

Our vision and aim

Our **vision** is to ensure that everyone has the opportunity to be protected by full immunisation, and that everyone can make an informed choice about whether to take up vaccination based on reliable information about the vaccines that they are offered, irrespective of where they live, their socioeconomic status, and other factors such as age or ethnicity.

Our **aim** is to maximise vaccination uptake overall while closing the gap between different communities and across different vaccine-preventable disease programmes in line with the duties contained in The Health and Social Care Act of 2012 and using the Core20PLUS approach.

Expected outcomes and key actions for 2025 to 2030

We will work with our partners across the immunisation system to ensure that, by 2030:

1. There is more accountable system leadership across the key stakeholders in the immunisation system to improve immunisation equity

Fostering partnership between stakeholders at all levels of the vaccination delivery system is essential to addressing immunisation inequities over the life cycle of the Strategy. Action on immunisation equity under the 2021 Immunisation Inequalities Strategy has been overseen by the Immunisation Programme Implementation Group (IPIG), a group that ultimately reports to the UKHSA Vaccines Board and to the Department of Health and Social Care. We will strengthen system leadership over the next 5 years by:

1.1 Refreshing the Immunisation Equity sub-group to the Immunisation Programme Implementation Group (IPIG) to respond to system changes and support national level, collaborative action on equity across the immunisation system;

1.2 Updating the Health Equity Audit for the National Immunisation Programme to provide a baseline against which progress can be assessed, with a further update in 2030 to assess progress;

1.3 Developing an integrated action plan which will include key performance indicators against which we will monitor progress in implementing the commitments outlined in this document;

1.4 Co-developing a framework outlining the roles and responsibilities of each actor in the immunisation system in improving immunisation equity;

1.5 Establishing a refreshed monitoring and reporting mechanism to the Immunisation Equity Subgroup of the IPIG, drawing on existing data collection tools.

There are many examples showcasing the impact that effective local system leadership can have in improving ways of working at different levels, in support of immunisation equity – see for example **Box 2**.

Box 2: Strengthening local system leadership and accountability through Maximising Immunisation Uptake Groups, Southwest England

In 2022, the NHS England Southwest Vaccination and Screening Team (VST) spearheaded the formation of Maximising Immunisation Uptake Groups (MIUGs) to bring together local stakeholders to develop coordinated plans to tackle disparities in immunisation coverage aimed at improving vaccine uptake and reducing inequalities.

MIUGs had 4 aims: (1) create a community of practice and foster learning; (2) use local intelligence to address inequalities across all immunisation programmes; (3) work with under-served communities to remove barriers to access to vaccination services; and (4) use relationships and insight into the needs of the local population to deliver acceptable immunisations.

Each MIUG developed its own evidence-based action plan. Based on local knowledge, the MIUG set its core priorities, with clear roles, responsibilities, and reporting mechanisms for each of the partners. This structure promoted accountability and coordination, avoiding duplication of efforts while ensuring alignment towards shared outcomes. The Southwest VST provided coordination and support, connecting MIUGs with broader regional inequalities work and facilitating the sharing of lessons and good practices across the wider health system.

MIUGs have proven successful at improving coordination and reducing overlap at regional and local levels. Stronger system leadership not only improved opportunities for input from community groups but led to greater understanding of how to improve uptake and reduce barriers. By putting a focus on shared leadership, accountability, and evaluation, and with the support of the regional team, they have been able to reach deeper into communities to understand and address complex inequalities in access and uptake.

2. Access to timely, high-quality data is improved for all relevant stakeholders to guide policy, strategy and delivery activities at national, regional and local levels

We will continue to promote a data-driven approach to developing and implementing actions to address immunisation inequities over the next 5 years by:

2.1 Securing strategic level agreements with relevant partners to enable UKHSA's access to all disaggregated immunisation datasets, ensuring continued improvement in monitoring of immunisation inequities;

2.2 Advocating for, and guiding, the integration of public health considerations into the formulation and implementation of new data collections across all health partners from inception to enable better monitoring and evaluation for public health purposes;

2.3 Making data on annual and quarterly childhood vaccination coverage available through a UKHSA-produced data dashboard, providing – in a single platform – uptake figures broken down by region and local authority to support local level action by ICBs and other actors;

2.4 Revising and updating UKHSA's Data and Information Sources document on immunisation inequalities to provide more detailed operational information on how different data sources can be used to support local level analysis;

2.5 Modernising the systems UKHSA uses to collate and analyse data on immunisation to ensure better inclusion of inequity and under-served communities;

2.6 Expanding the number of routine vaccine coverage collections for which ethnicity data are gathered, to help inform surveillance and public health action.

A considerable amount of work is underway currently, led by NHSE, to improve data flows and accessibility relating to vaccination. In addition, the NHS Vaccination Strategy includes a commitment to creating a national vaccination data record to improve availability of timely, accurate data across all vaccination programmes. Drawing on work from the response to rising measles case numbers in England in 2023-24, **Box 3** illustrates some of the benefits that can be gained from improved data disaggregation to support monitoring and evaluation where strategic-level agreement and appropriately disaggregated data flows have been secured at national and local level.

Box 3: Data disaggregation to support action to improve the response to the national measles incident in England, 2023 to 2024

In 2023, NHSE and UKHSA established a new real-time dataflow comprising individual-level data on measles, mumps and rubella (MMR) vaccination from GP records, through the Immunisation Information System (IIS). Enabling secure access to these data allowed for more frequent and more detailed analysis of who received MMR vaccination than had been possible previously, including by the recipient's ethnicity, where they live, and by deprivation status. Access to these data also enabled comparisons of vaccine coverage over time (such as before and after a catch-up campaign).

Using these data, a national evaluation of catch-up vaccination delivery activities designed to improve MMR uptake was carried out, showing an improvement in uptake for the first and second doses of the vaccine across all population groups assessed, and particularly large increases among the most deprived children, and those from some ethnic groups among in whom uptake has historically been lower. Secondly, access to patient-level data helped UKHSA's regional Health Protection Teams (HPTs) focus public health actions and support work with relevant local authorities and other stakeholders and reduce the number of calls to General Practices to confirm vaccine status.

Successfully strengthening action on immunisation inequities for the future will depend on broadening access to disaggregated data across all the vaccination programmes, as well as ensuring people's vaccination histories are recorded in a complete and consistent way in their medical records.

3. Practitioners and policymakers are better able to generate, share and use evidence to guide action in improving immunisation equity

Targeted use of high-quality evidence, tailored to local context, is vital in informing effective action on immunisation equity (see **Box 4**). UKHSA has a central role in generating, collating and distributing evidence on immunisation inequities and what works in addressing these. We will work with our partners to help provide stakeholders at all levels of the immunisation system with the evidence they need to act on immunisation inequities by:

3.1 Identifying key knowledge gaps that can help address immunisation inequities, why they occur, and cost-effective approaches to addressing them, and then developing and co-leading research to address these, working with academic partners and NHSE;

3.2 Agreeing a sustainable mechanism for sharing materials across all stakeholders to improve access to actionable evidence to support practice and policy in improving immunisation equity for stakeholders working nationally, regionally and locally;

3.3 Advocating for the collation and dissemination of better practice examples in reducing inequities in immunisation by supporting the use of standardised templates for case studies in platforms such as FutureNHS, including information on costs and operational processes;

3.4 Scaling up the distribution of information on better practice examples through existing routes such as UKHSA's Vaccine Update, the National Immunisation Network and FutureNHS Inequalities Hub; and monitoring uptake and use through the IPIG sub-group;

3.5 Supporting the scale up of training and capacity-building for colleagues in the immunisation system to improve knowledge, understanding and practise of integrating inequity into immunisation research and practice;

3.6 Supporting the integration of research activities across the Health Protection Research Units (HPRU) that UKHSA are partnered with to ensure a multi-pathogen approach and that both the direct and indirect benefits of immunisation are captured.

Box 4: Increasing uptake of vaccinations in schools through nuanced communication and collaboration with multi-disciplinary teams in the West Midlands

In November 2023, a national catch-up campaign for MMR was launched by NHS England. The West Midlands supplemented this with a multi-pronged approach to increase vaccine outreach and uptake using tailored communications with under-served communities. They focused on outreach into selected schools in Birmingham, Coventry, Sandwell and Wolverhampton at both primary and secondary levels. Healthcare teams undertook mixed methods qualitative research that included: circulation of a data collection form to School Age Immunisation Services; observation of MMR school sessions; and focus groups and semi structured interviews with stakeholders. Findings were then used to tailor communication materials and shape methodologies for reaching out to local populations.

As a result of the intervention, vaccine uptake among those eligible and unvaccinated in participating primary schools was 15.4% (range 0.9-46.5%) and 11.2% in secondary schools (range 0-25%). These are important gains when set against changes observed for those eligible and unvaccinated during previous campaigns. In the 2013 MMR catch-up campaign in England, for example, an increase of 10.8% in uptake among previously unvaccinated children was seen compared to baseline, although this campaign focused on those aged 10-16 only and methodological differences preclude detailed, direct comparison. Stakeholders reported a number of factors contributing to improved MMR uptake in participating schools in the West Midlands: clear and established stakeholder roles and responsibilities, coproduction and multistakeholder working; educators promoting the session within their school drawing on their trusted position; tailored communications (stakeholder and promotional communications); and widening the offer of vaccination to parents/guardians and school staff. They also noted challenges including short timescales for initial scoping work to delivery for the intervention, and around data quality.

A 2024 evaluation of the impact of national and regional measles catch-up activity on MMR vaccine coverage in England demonstrated that the Midlands had been one of the most successful regions at increasing vaccine uptake across different age groups (see table 3 in the evaluation report). It also demonstrated the largest gains were seen in the most deprived populations and among ethnic groups with lower baseline coverage of MMR vaccination (e.g., individuals from Other Black, African, and Arab ethnic backgrounds).

4. People and place-based approaches to communications and engagement are embedded in ways of working at all levels, to improve immunisation equity

UKHSA and its partners have engaged in extensive work to develop tailored communication approaches to support work with and for different population groups over many years. We will work with our partners across the immunisation system to embed people and place-based approaches over the next 5 years by:

4.1 Continuously improving existing communications materials to incorporate evidence on reaching under-served populations, for use in local, regional and national settings;

4.2 Developing and implementing approaches to monitoring and evaluating the effectiveness of communications approaches and materials for different population groups, giving consideration to cost effectiveness and efficiency;

4.3 Advocating for regular review of existing training materials for different healthcare professional groups, to raise awareness of immunisation inequities and effective interventions across populations, and enable these professionals to effectively deliver, and advocate for, equity in immunisation services;

4.4 Establishing a network across UKHSA and with communities and relevant health professional groups, drawing on tools such as the WHO TIP approach, to support the co-design and implementation of communications resources and engagement strategies.

In embedding people and place-based approaches, we will harness our existing behavioural insights and attitudinal research work. **Box 5** outlines one example of how work using WHO TIP has shaped the communication and engagement approaches applied in addressing immunisation inequities at local area level.

Box 5: Putting People and Place into practice – applying the WHO TIP approach to improve uptake of vaccinations among the Charedi community in North London

The Charedi (strictly observant, orthodox Jews) community has lower than average rates of vaccination uptake leading to increased risk of VPD cases and outbreaks. Reasons for variations in vaccination uptake are varied and can include problems in accessing services (for example – inconvenient opening times, long waits), concerns about vaccine safety, lack of trust in health authorities and other factors. The Tailoring Immunisation Programmes (TIP) approach was developed by the WHO's European Office to help decision-makers and health service providers understand what might be driving lower-than-expected uptake in some communities. This allows policy makers and service providers the opportunity to tailor interventions aimed at specific communities.

The TIP approach sets out some principles about how to work with affected communities, a theoretical model to help design interventions, and an outline of the steps needed to help improve engagement. The TIP principles are that all actions should be: equity focused; people-centred; participatory; evidence-based; comprehensive across all potential barriers to and drivers of vaccine uptake behaviour; and focused on reaching specific health goals.

UKHSA worked with Charedi community leaders, the local hospital trust, third sector organisations and WHO Europe representatives, among others, to help identify reasons for, and make recommendations to address, sub-optimal immunisation coverage using the TIP approach. Work in North London before the COVID-19 pandemic showed that the principal barriers concerned accessibility of immunisation services especially in families with many children to vaccinate. General Practice services were unable to meet demand. Cultural and/or religious factors were not found to influence sub-optimal coverage. More recent work on COVID-19 vaccination delivery to the same community showed that flexibility in commissioning models and delivery arrangements helped reduce barriers to uptake, but also highlighted continuing information needs to help inform patients' decisions around whether or not to take up the offer of a vaccine.

These pieces of work illustrate how approaches such as TIP can be applied to help better understand specific barriers and facilitators to uptake for different communities, and to supporting appropriate tailoring of intervention design.

3. Governance and progress monitoring

Progress against the commitments outlined in this document will continue to be reviewed by the Immunisation Equity technical sub-group of the IPIG, and through annual reporting to IPIG itself. Within UKHSA, progress against the commitments in the Strategy will be reported to UKHSA's Vaccines Board and ultimately to the Department of Health and Social Care.

In consultation with our partners, we will develop a plan that will include key performance indicators against which we will monitor progress in implementing the Strategy. We have also set out above our intention to repeat the Health Equity Audit on a 5-yearly cycle. Ongoing development of routine reports and indicators will help us to monitor trends in vaccination coverage inequalities at national, regional and local level and in immunisation outcomes such as VPD case rates.

In addition, we will continue to engage formally and informally with local teams to communicate about the Strategy, and to help evaluate its usefulness, during National Immunisation Network events, team visits, through regular Vaccine Update publications and via other means.

Annexe: progress since 2021 – how we have delivered on our commitments

The 2021 Immunisation Inequalities Strategy set out 2 objectives:

1. To provide those responsible for the delivery and commissioning of immunisations with the evidence and tools that they need to reduce inequalities in immunisation.

2. To provide system leadership to tackle inequalities in immunisation by communicating the need for action, providing evidence and guidance to inform commissioning and policy, and by working with partners to build the evidence base about what works.

This section summarises what has been achieved since 2021 against the 4 workstreams under these objectives, working in collaboration with our partners in central government, the NHS, in local authorities and elsewhere. At the end of the section, we also summarise key activities in improving communication and engagement with different populations in recent years.

Developing locally relevant data and resources to support needs assessment

A template Local Action Plan was published alongside the 2021 Strategy to support local partners in developing approaches to reducing inequalities in uptake for their populations, building on the World Health Organisation's TIP model and on recommendations from the UK's Measles and Rubella Elimination Strategy, published in 2019. We have since provided additional guidance to local partners to help them identify relevant material to support needs assessment and ongoing monitoring, through a Data and Information Sources document, published in 2023. The Data and Information sources document covers general vaccine information, vaccine coverage data, general health data, population characteristics and case studies on people using the data to support monitoring and improving uptake. It is designed for those working at local level and includes information about the level of data handling and interpretation skills required for each area.

Sharing new practice and evaluation findings between stakeholders to develop the evidence base

UKHSA has a key role in promoting the generation of robust evidence, synthesising findings on what works in improving vaccination uptake across populations and helping to disseminate this material to those at the front line. We continue to build academic partnerships to generate original evidence on immunisation inequities, and on the effectiveness of different approaches to addressing them. We have done so through our work as part of the NIHR Health Protection Research Unit (HPRU) in Vaccines and Immunisation working with the London School of Hygiene and Tropical Medicine (LSHTM), and with partners elsewhere including the University of Bristol. We are also contributing to multi-year projects with European organisations on approaches to enhancing vaccination uptake among ethnic, religious and cultural minorities, and on vaccination uptake in prisons and other custodial settings. Some of this work has made important contributions in influencing immunisation policy and practice (see for example **Box 6**).

As part of our work during the first cycle of the Strategy, an evaluation framework was produced to help design and implement immunisation and vaccination interventions, in partnership with researchers at LSHTM. The framework was developed in response to an ask from local service providers and commissioners during the consultation process for the 2021 Immunisation Inequalities Strategy. The framework applies the capability, opportunity, motivation, behaviour (COM-B) model from behavioural science to help identify drivers and barriers to immunisation uptake to feed into intervention design. It helps users focus on modifiable factors to address immunisation inequities. The Framework is designed to be accessible to those with, and without, experience in evaluation, and training materials have been developed to guide users in applying it. It has been applied in a number of local areas is currently being used to support evaluation of work in demonstrator systems leading implementation of the NHS Vaccination Strategy.

Finally, we continue to highlight case studies of good practice. This is achieved through channels such as the 'How we did it' section of the Vaccine Update circular that is issued by UKHSA to in excess of 77,000 stakeholders on a monthly basis, and indexed separately; and by collating and distributing good practice evidence through the FutureNHS platform. NHSE insights work and evaluations continue to be used alongside research from UKHSA and other partners to build the body of evidence to help address immunisation inequities.

Box 6: Understanding Health and Social Care workers experience of vaccination to devise the most effective vaccination policies and delivery approaches

Work since the last iteration of the Strategy has considered approaches to strengthening vaccination confidence and uptake among health and social care professionals. For example, in 2021, the HPRU on Vaccines and Immunisation led a project on vaccination beliefs, attitudes and behaviours among health and social care workers in England. This work took place while new legislation to introduce COVID-19 vaccination as a condition of deployment for all frontline health and social care workers was under consideration. A total of 1,656 healthcare workers and 261 social care workers were surveyed and 20 took part in an interview. Although COVID-19 vaccine uptake was high (93.9% of healthcare workers and 90.0% of social care workers) at the time of the survey (Jan/Feb 2021), the project identified several factors contributing to variations in vaccination uptake and access.

Firstly, social care workers faced challenges in accessing vaccination because of fragmentation in the provider landscape. Black African or Mixed Black African participants were offered COVID-19 vaccination at a lower rate than White British and White Irish participants. Secondly, workplace culture and features of different health and social care organisations played an important role in the likelihood of getting vaccinated. Interviews suggested that pressuring staff to vaccinate may increase their intention to refuse the vaccine.

Results from the survey showed that Black African or Mixed Black African participants were significantly more likely to decline vaccination than those of White British or White Irish ethnicity, when offered. Lack of trust in the vaccine, in providers and/or policy makers appeared to be important factors in this, but the factors influencing vaccination decisions were complex and showed a careful weighing up of perceived risks and benefits. Some participants highlighted what they felt was a lack of safety information or research evidence, and a lack of trust in institutions.

Recent insights work from NHSE has built on findings from this study to identify approaches to increasing vaccination confidence and uptake through, for example: provision of clearer information to healthcare workers, approaches to communication that emphasise the role of staff vaccination in protecting others and improving the accessibility of vaccination in the workplace – among other approaches.

Contributing to system leadership on immunisation inequities

The IPIG is responsible for bringing together partners from across the tripartite to oversee the implementation and delivery of all the individual immunisation programmes in England. The IPIG Inequalities Subgroup has been meeting on a quarterly basis since 2022 and alongside its oversight role has provided important opportunities to share evidence on emerging practice in addressing immunisation inequities across the Tripartite. It has included representation from UKHSA, DHSC, NHSE national team, NHSE Screening and Immunisation Teams, immunisation providers, Local Authorities, and the NIHR HPRU in Vaccines and Immunisation.

A Four Nations Forum (the UK Forum on Inequalities and Declining Coverage across the Routine Immunisation Programmes, bringing together representatives from England, Northern Ireland, Scotland and Wales) has also been established following a discussion at the Joint Committee on Vaccination and Immunisation (JCVI), to help identify any lessons, commonalities, gaps, quick wins or action points that each country can implement to increase uptake. The forum provides a space to share good practice across the nations and has so far considered topics including: data and data collection systems, attitudinal work, service delivery models for vaccination, system leadership and coordination, uptake of maternal vaccinations, and coverage through secondary school programmes – among other topics. In addition, two topic-specific groups have been formed under the Forum – one on data, and one on attitudinal research – to take forward more detailed review and action planning in these areas.

Using existing data sources to support monitoring and reduction of inequalities in routine vaccination coverage

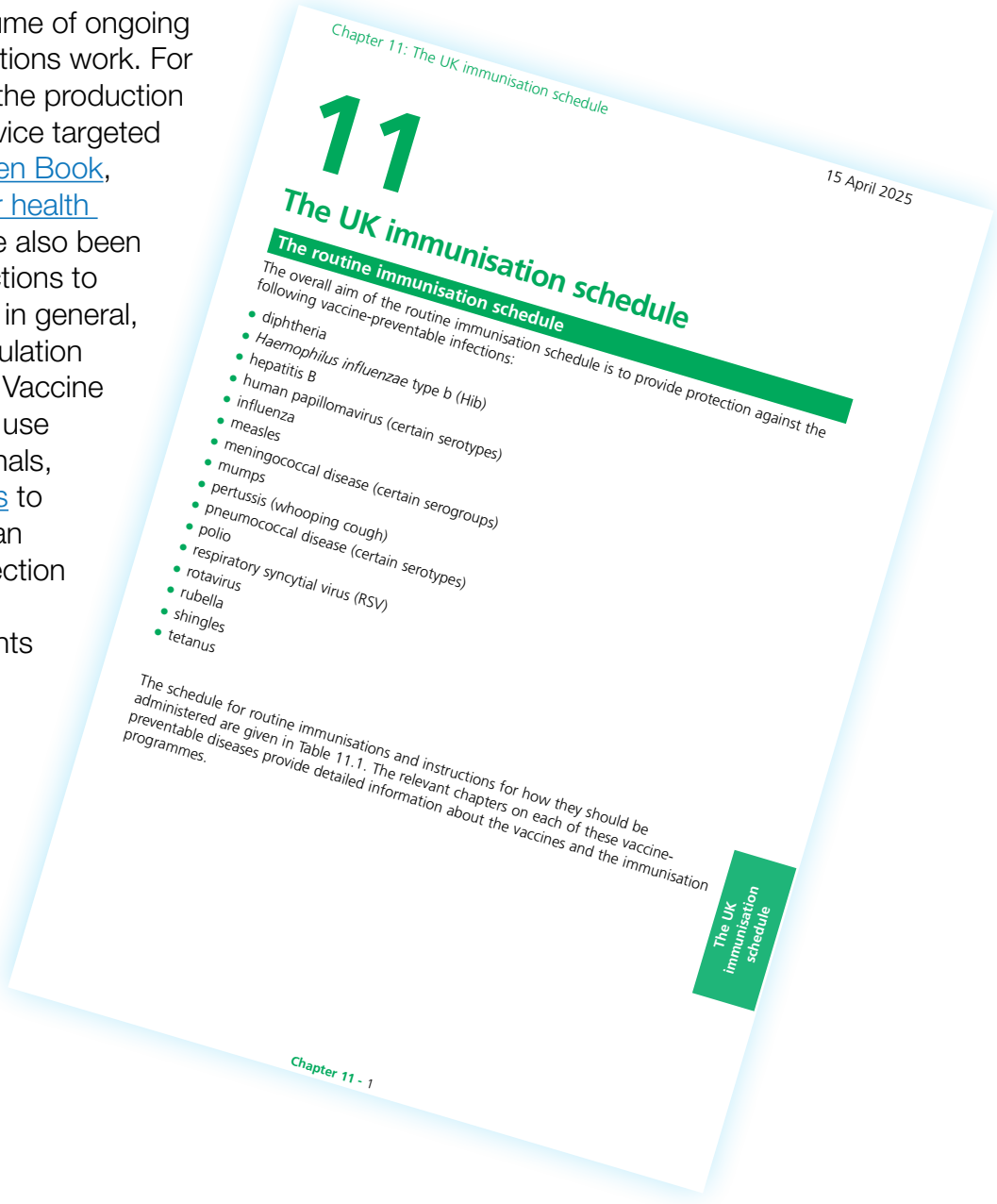
We continue to collect, analyse and regularly report vaccine coverage and uptake data across England for all routine programmes, with intermittent enhanced collections. These draw on NHS operational data but also on dedicated data gathering through mechanisms such as ImmForm – a platform that is used to collect data on vaccine uptake for immunisation programmes and to provide vaccine ordering facilities for the national immunisation programme. Coverage data are used to estimate susceptibility to vaccine-preventable diseases, inform disease control, and support vaccine delivery efforts. These supplement data by locality available via the Public Health Outcomes Framework and childhood vaccination coverage statistics currently published by NHSE. Provision of these data continues to have measurable impacts on immunisation programme delivery. For example, analysis of coverage in London boroughs giving the second dose of MMR vaccination early showed higher coverage in these areas after taking account of potentially contributing factors such as socioeconomic deprivation, and underpinned recent advice from the JCVI to bring forward the second dose to 18 months within the childhood programme for all areas. More recently, individual-level data have been used to inform an evaluation of catch-up activities in response to an increase in measles cases in England.

UKHSA also continues to commission behavioural and attitudinal work including an annual survey of teenager and parental attitudes to vaccination to help identify any divergent attitudes among different population groups. The surveys have been run consistently using standardised questions for some time (since 1990 for parents of infants; since 2017 for teenagers and parents of teenagers) and allow a view of long-term attitudinal trends. Discrete pieces of work have also been conducted previously to explore attitudes to vaccination among pregnant women and healthcare workers among others. Findings from regular surveys continue to show high levels of public trust in UK programmes overall and contribute to the design and implementation of UKHSA's communications and engagement work.

Strengthening communication and engagement approaches with different populations

Although the 2021 Strategy did not include a specific objective around communication and engagement, UKHSA and its partners have engaged in extensive work to develop tailored communication approaches to support work with and for different population groups over many years. Many key materials for current vaccine-preventable disease priorities are held on platforms such as the Campaign Resource Centre. This work also includes translation of information and guidance materials into over 30 languages; into accessible formats including braille, audio, large print, Easy Read and British Sign Language; and dedicated products for target population groups for individual vaccine programmes including for school aged-children, and gay, bisexual and men who have sex with men (GBMSM). These materials are publicly accessible and many have been co-produced with members of relevant communities. They are intended to support local level action, with tailoring to context as appropriate.

There is also a large volume of ongoing professional communications work. For example, UKHSA leads the production and dissemination of advice targeted by population in the Green Book, and training materials for health professionals. Tools have also been developed to support actions to build trust in vaccination in general, and among specific population groups. These include a Vaccine Confidence package for use by health care professionals, and EDUCATE resources to raise awareness of human papillomavirus (HPV) infection and its effects among secondary school students to support the delivery of the HPV vaccination programme.


Chapter 11: The UK immunisation schedule

11

15 April 2025

The UK immunisation schedule

The routine immunisation schedule

The overall aim of the routine immunisation schedule is to provide protection against the following vaccine-preventable infections:

- diphtheria
- *Haemophilus influenzae* type b (Hib)
- hepatitis B
- human papillomavirus (certain serotypes)
- influenza
- measles
- meningococcal disease (certain serogroups)
- mumps
- pertussis (whooping cough)
- pneumococcal disease (certain serotypes)
- polio
- respiratory syncytial virus (RSV)
- rotavirus
- rubella
- shingles
- tetanus

The schedule for routine immunisations and instructions for how they should be administered are given in Table 11.1. The relevant chapters on each of these vaccine-preventable diseases provide detailed information about the vaccines and the immunisation programmes.

The UK immunisation schedule

Chapter 11 - 1

About the UK Health Security Agency

UK Health Security Agency (UKHSA) prevents, prepares for and responds to infectious diseases and environmental, radiological and chemical hazards, to keep all our communities safe, save lives and protect livelihoods.

We provide scientific and operational leadership, working with local, national and international partners to protect the public's health and build the nation's health security capability.

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