

Scottish Government and Public Health Scotland Response to House of Lords Childhood Vaccinations Committee

1. What are the key trends and disparities in childhood vaccination coverage in Scotland? What are the drivers of those trends and disparities?

Key trends in childhood immunisation uptake in Scotland

Scotland's routine childhood immunisation schedule aligns with WHO recommendations and includes additional vaccines as recommended by JCVI and outlined in the [Department of Health's Immunisation against Infectious Diseases, commonly known as the 'Green Book'](#). Children in Scotland are routinely vaccinated against more than ten infectious diseases, all of which carry risks of severe illness, long-term health problems, or even death.

The general trend across Scottish childhood immunisations is one of long-term modest declines. Despite this, Scotland's uptake has remained relatively high.

Figures 1, 2 and 3 show quarterly immunisation uptake in Scotland, from March 2016 to December 2025, for immunisations by 12 months, 24 months, and five years, respectively. Key dates denoted are the first COVID-19 lockdown (March 2020) and the four-year period known as the vaccination transformation programme (VTP) where immunisation delivery transitioned from a primarily GP-led delivery model to NHS board-led delivery.

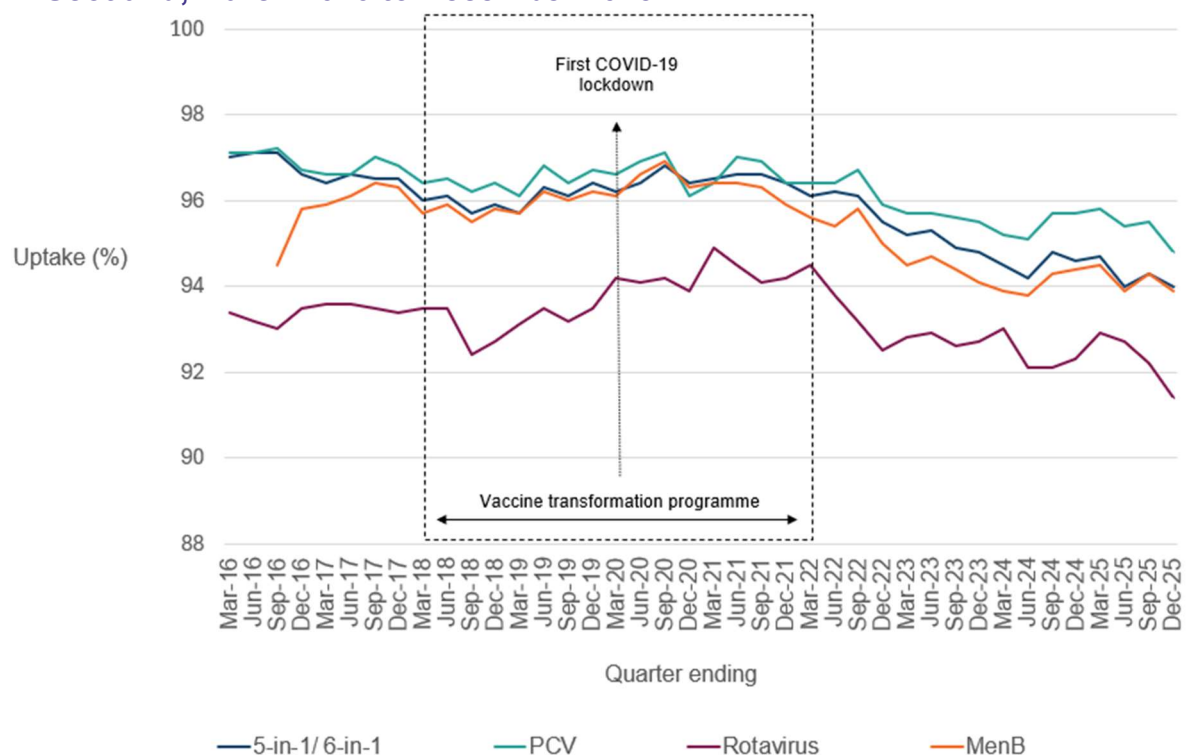
Prior to VTP, modest declines were observed across many childhood immunisations. During the initial phases of VTP, national declines slowed, stabilised, and reversed. By the first COVID-19 lockdown in March 2020, national uptake rates were improving and continued to do so until mid-2022 when quarter-on-quarter declines were observed. Declines were also seen across the rest of the UK and Europe.

From mid-2024, declining trends in immunisations by 12 months showed some stabilisation, and quarterly data in 2025 showed some modest variation for PCV, 6-in-1 and MenB. As such, when comparing annual trends at 12 months (Table 1) between 2024 and 2025, there was no change in PCV (95.1%) or rotavirus uptake (92.2%), and small differences for 6-in-1 (decreased 0.2 percentage points to 94.2%), and MenB (increased 0.2 percentage points to 93.9%).

Rotavirus vaccine uptake tends to be lower than that of other infant immunisations due to the strict age requirements for delivery (first dose by 15 weeks, second dose by 24 weeks). If the first dose is delayed for any reason, it may not be possible to complete both doses.

Therefore, rotavirus trends can serve as a proxy for timeliness of immunisation. Rotavirus vaccine uptake by 12 months declined quarter-on-quarter in 2025.

Figure 1: Quarterly trends in childhood immunisation uptake (%) by 12 months in Scotland, March 2016 to December 2025



Note: the y-axis (vertical axis) has been restricted to improve readability.

Table 1: Comparison of annual childhood immunisation uptake (%) in Scotland, 2021 to 2025

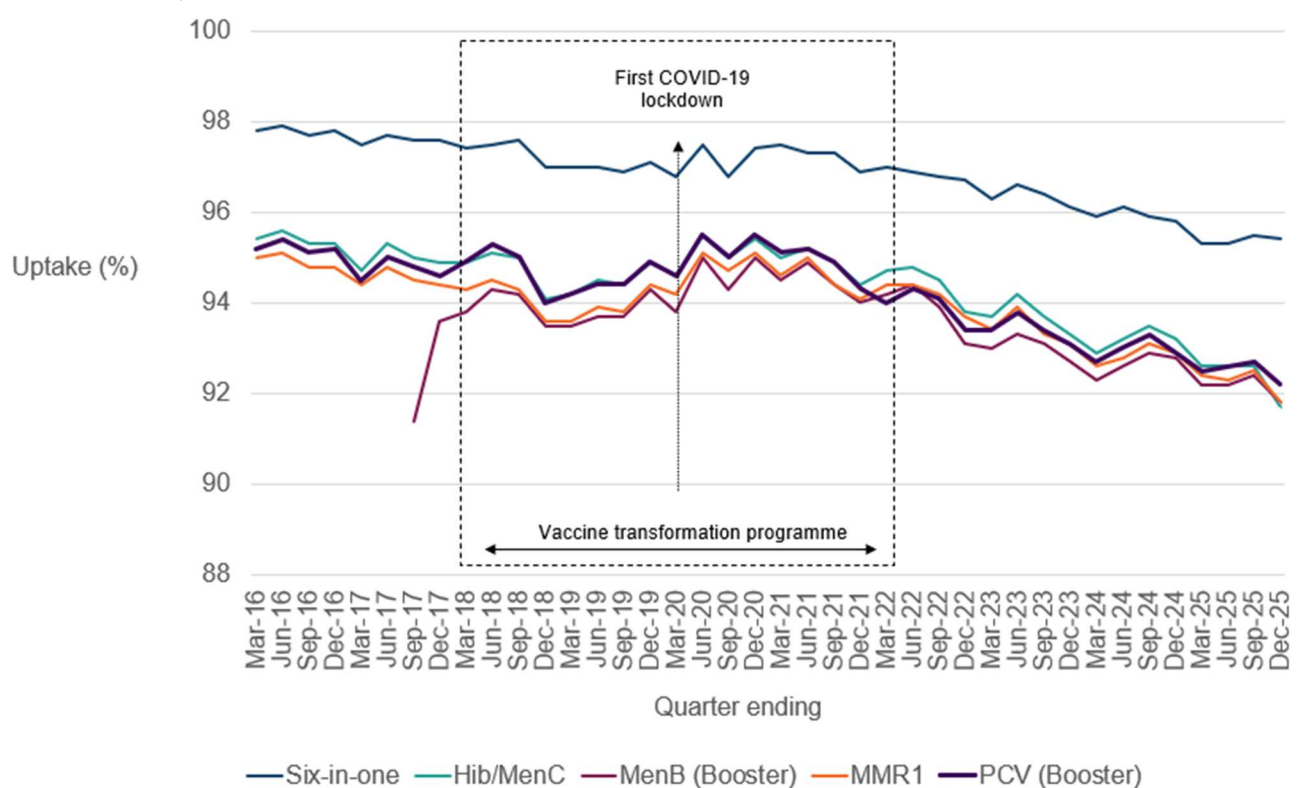
Age*	Immunisation ^{&}	Year ending 31 Dec 2021	Year ending 31 Dec 2022	Year ending 31 Dec 2023	Year ending 31 Dec 2024	Year ending 31 Dec 2025	Change from 2024 to 2025 ^{\$}
12 m	6-in-1 primary course	96.4	95.7	95.0	94.4	94.2	↓ (-0.2)
	PCV primary course	96.5	95.8	95.2	95.1	95.1	↔ (0.0)
	Rotavirus primary course	94.2	93.1	92.5	92.2	92.2	↔ (0.0)
	MenB primary course	95.9	94.7	93.8	93.7	93.9	↑ (0.2)
24 m	6-in-1 primary course	97.1	96.6	96.2	95.9	95.3	↓ (-0.6)
	MMR1 ²	94.4	93.9	93.0	92.8	92.1	↓ (-0.7)
	Hib/MenC	94.4	93.7	93.0	92.9	92.1	↓ (-0.8)
	PCV Booster	94.6	93.4	92.9	92.7	92.3	↓ (-0.4)
	MenB Booster	94.0	93.2	92.3	92.3	91.8	↓ (-0.5)
5 y	MMR1	97.4	95.2	95.2	95.1	95.4	↑ (0.3)
	Hib/MenC	96.1	94.5	94.5	94.3	94.7	↑ (0.4)
	4-in-1 (Booster)	95.7	91.1	89.6	89.3	90.1	↑ (0.8)
	MMR2	92.1	90.5	89.1	88.7	89.7	↑ (1.0)

*12 m = Uptake by 12 months of age; 24 m = Uptake by 24 months of age; 5 y = Uptake by five years of age; [&]MMR1: first dose of MMR; MMR2: second dose of MMR. ^{\$}Percentage points change i.e. uptake rate in the latest year minus in the previous year.

For quarterly uptake by 24 months in 2025, the trends were largely stable until the last quarter when declines were observed across all immunisations (Figure 2). As such, the annual uptake in 2025 by 24 months was lower than annual uptake in 2024 for 6-in-1 (decreased 0.6 percentage points to 95.3%), MMR1 (decreased 0.7 percentage points to 92.1%), Hib/MenC (decreased 0.8 percentage points to 92.1%), PCV booster (decreased 0.4 percentage points to 92.3%), and MenB booster (decreased 0.5 percentage points to 91.8%), (Table 1).

Uptake of the first dose of the MMR vaccine was 92.4%, 92.3%, 92.5%, and 91.8% for each of the quarters in 2025, declining from the previous year. As measles virus is a highly infectious pathogen, achieving high uptake ($\geq 95\%$) remains a priority.

Figure 2: Quarterly trends in childhood immunisation uptake (%) by 24 months in Scotland, March 2016 to December 2025



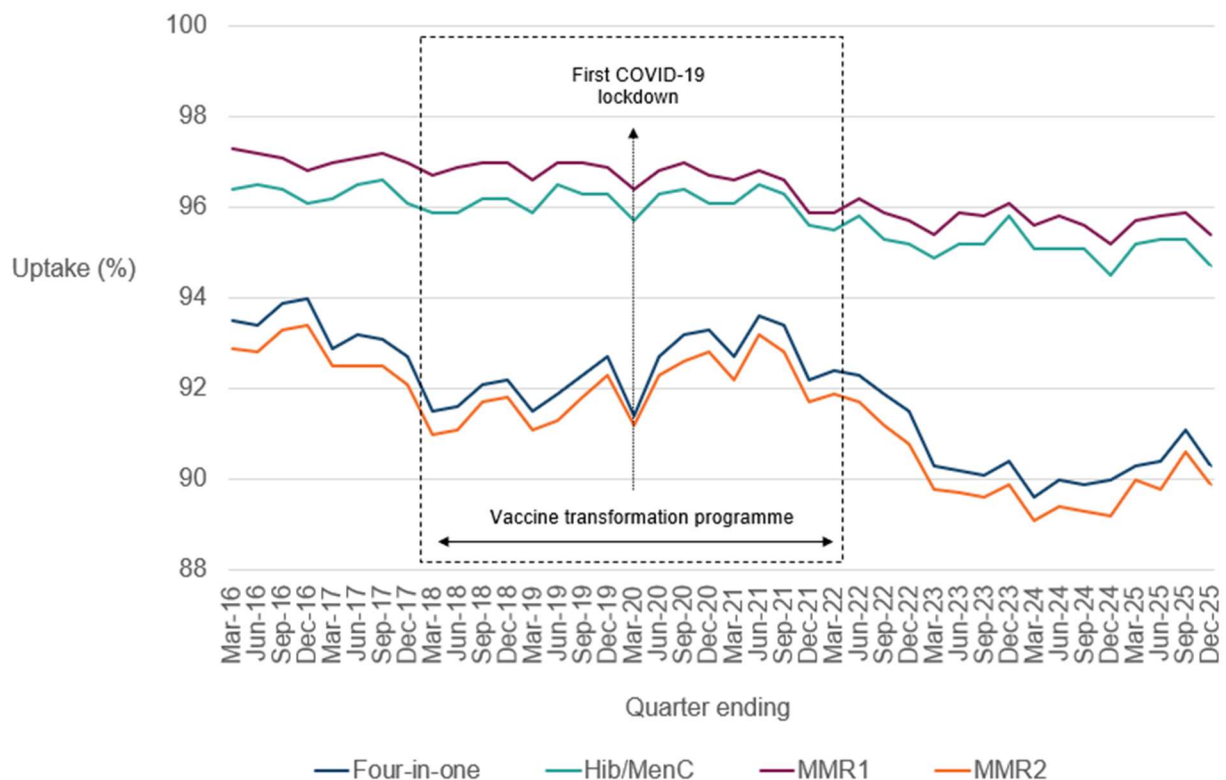
Note: the y-axis (vertical axis) has been restricted to improve readability.

Quarterly trends of uptake by five years in 2025 were largely stable for MMR1 and Hib/MenC, with some improvements for MMR2 and 4-in-1, until the last quarter when declines were observed across all MMR1, MMR2, Hib/MenC, and 4-in-1 immunisations (Figure 3).

There were increases in annual uptake in 2025 by five years when comparing with 2024; MMR1 (increased 0.3 percentage points to 95.4%), Hib/MenC (increased 0.4 percentage points to 94.7%), 4-in-1 (increased 0.8 percentage points to 90.1%), and MMR2 (increased 1.0 percentage points to 89.7%), (Table 1).

Uptake of MMR1 by five years has remained on or above 95.0% for each quarter since March 2016. Uptake of MMR2 by five years fell below 90.0% for the first time in the quarter ending March 2023, and for the quarters in 2025 it ranged from 89.8% to 90.6% (Figure 3).

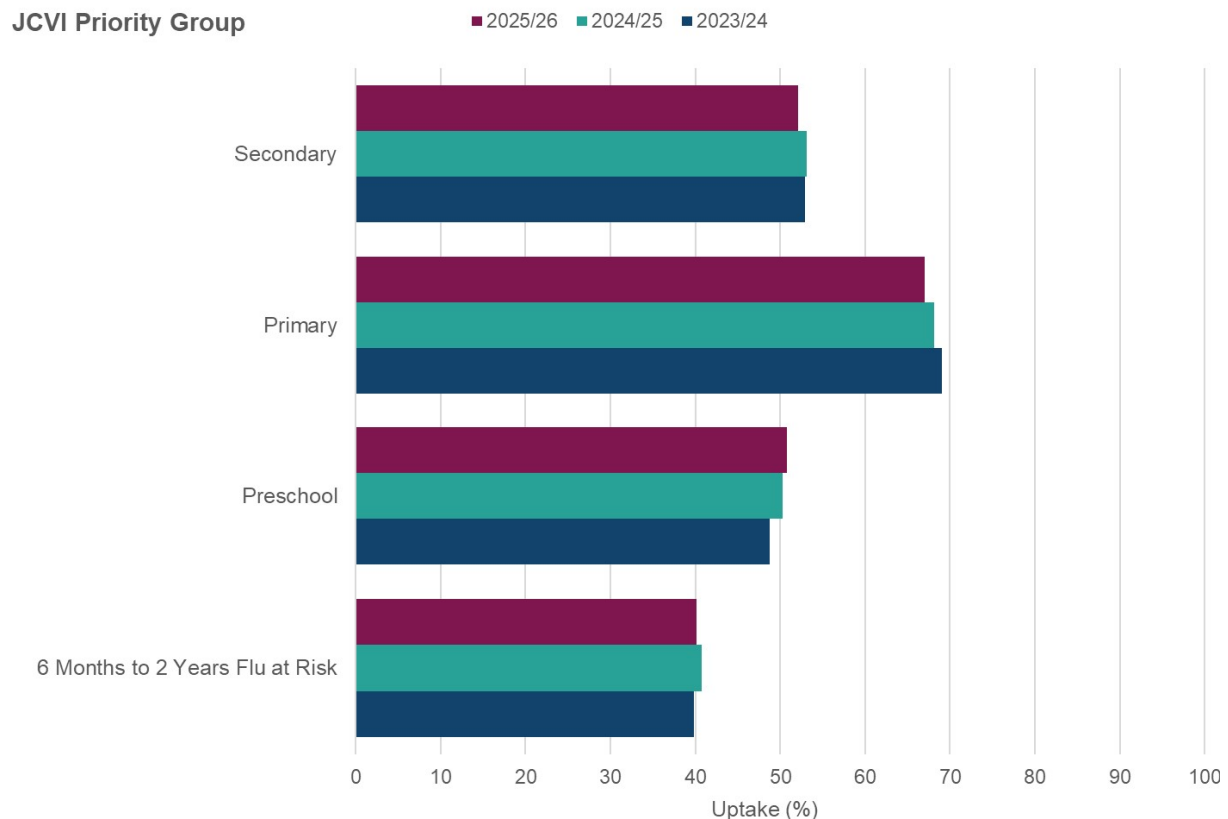
Figure 3: Quarterly trends in childhood immunisation uptake (%) by five years in Scotland, March 2016 to December 2025



Note: the y-axis (vertical axis) has been restricted to improve readability.

A total of 524,722 children aged six months to 17 years received an influenza vaccine as part of the winter 2025/26 vaccination programme, representing 58.3% of the total eligible child / young person population. Comparing the winter 2025/26 influenza immunisation programme in children aged six months to 17 years with the previous season (2024/25), decreases were observed for primary schools (decreased by 1.1 percentage points, from 68.1% to 67.0%), secondary schools (decreased 1.0 percentage point, from 53.1% to 52.1%), and at-risk children aged six months to two years (decreased 0.6 percentage points, from 40.7% to 40.1%). However, there was a slight increase in uptake for pre-school children (increased 0.5 percentage points, from 50.3% to 50.8%), (Figure 4).

Figure 4: Comparison of vaccine uptake for the influenza (children six months to 17 years) immunisation programme, winter seasons 2023/24 to 2025/26*, by eligible group**



*Winter 2025/26 vaccination is defined as a vaccine administered from 15 September 2025. Vaccination surveillance is based on the current, living population of Scotland. Those who have died or have moved from Scotland since vaccination are not included in uptake figures.

**JCVI priority groups are not mutually exclusive. Individuals can appear in more than one group.

Inequalities in childhood immunisation uptake

Children living in the most deprived areas have lower vaccine uptake than those in the least deprived areas. This deprivation gradient is seen across all immunisations.

In 2025, vaccine uptake by 12 months of age in those living in the most deprived areas was 92.0% for 6-in-1, 94.0% for PCV, 89.8% for rotavirus, and 92.1% for MenB. This compares to those living in the least deprived areas where uptake for the same immunisations was 97.0%, 96.6%, 94.7%, and 96.1%, respectively (Table 2).

Therefore, the gap in vaccine uptake by 12 months of age between those living in the most and least deprived areas for 6-in-1, PCV, rotavirus and MenB was 5.0, 2.6, 4.9, and 4.0 percentage points, respectively.

For children reaching 24 months of age in 2025, the gap in vaccine uptake between those living in the most and least deprived areas for MMR1, Hib/MenC, PCVB, and MenB (Booster) was 6.6, 6.3, 6.2, and 6.7 percentage points, respectively.

For children reaching five years of age in 2025, the gap in vaccine uptake between those living in the most and least deprived areas for MMR1, MMR2, and the 4-in-1 booster was 3.5, 8.9, and 8.3 percentage points, respectively.

When comparing the gap in uptake between those living in the most and least deprived areas between 2024 and 2025, the gap narrowed for vaccine uptake by 12 months and five years, notably for MenB by 12 months with the gap narrowing by 1.0 percentage point, and for MMR2 and 4-in-1 by five years where the gap narrowed by 1.4 and 1.3 percentage points, respectively (Table 2). There was a widening in the gap, or no change, in uptake between those living in the most and least deprived areas between 2024 and 2025 by 24 months. The aim is to narrow this gap by maintaining or improving uptake in the least deprived quintile, while simultaneously improving uptake in the most deprived quintile.

Table 2: Comparison of primary uptake rates (%) by 12 months, 24 months, and five years of age, for selected immunisations in 2024 and 2025 in Scotland, by most and least deprived quintile

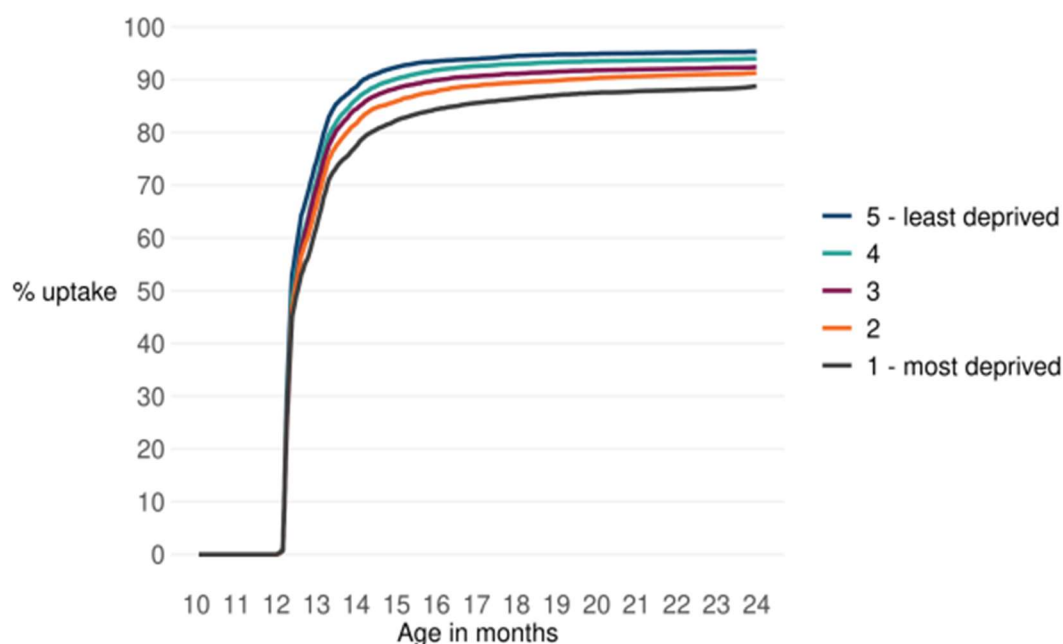
Age*	Immunisation ^{&}	2024 SIMD 1 (most deprived)	2024 SIMD 5 (least deprived)	2024 percentage point difference	2025 SIMD 1 (most deprived)	2025 SIMD 5 (least deprived)	2025 percentage point difference	Change in gap from 2024 to 2025 ^{\$}
12 m	Six-in-one	91.8	97.0	5.2	92.0	97.0	5.0	↓ (-0.2)
	MenB	91.2	96.2	5.0	92.1	96.1	4.0	↓ (-1.0)
	PCV	93.6	96.7	3.1	94.0	96.6	2.6	↓ (-0.5)
	Rotavirus	89.3	95.1	5.8	89.8	94.7	4.9	↓ (-0.9)
24 m	Six-in-one	94.3	97.8	3.5	93.3	97.4	4.1	↑ (0.6)
	Hib/MenC	89.8	95.8	6.0	88.8	95.1	6.3	↑ (0.3)
	MenB (Booster)	89.0	95.6	6.6	88.2	94.9	6.7	↑ (0.1)
	MMR1	89.6	96.1	6.5	88.7	95.3	6.6	↑ (0.1)
	PCV (Booster)	89.7	95.9	6.2	89.1	95.3	6.2	↔ (0.0)
5 y	MMR1	93.4	97.4	4.0	93.7	97.2	3.5	↓ (-0.5)
	MMR2	83.5	93.8	10.3	85.1	94.0	8.9	↓ (-1.4)
	Four-in-one	84.4	94.0	9.6	85.8	94.1	8.3	↓ (-1.3)

*12 m = Uptake by 12 months of age; 24 m = Uptake by 24 months of age; 5 y = Uptake by five years of age; [&]MMR1: first dose of MMR; MMR2: second dose of MMR. ^{\$}Percentage points change i.e. difference in uptake gap (between SIMD 1 and 5) between latest year minus in the previous year.

Further to having lower overall uptake, those living in the most deprived areas receive their immunisations later than those living in least deprived areas. The first dose of MMR is universally offered at 12-13 months of age, and 88.7% of children living in the least deprived areas were immunised by 14 months in 2025. This compares to 77.5% of children living in the most deprived areas being immunised by 14 months in 2025, a difference of 11.2 percentage points (Figure 4).

Similarly, for children reaching 12 months in 2025 and living in the most deprived areas, 85.1% had received their first dose of 6-in-1 by six months. This compares to 94.1% living in the least deprived areas, a difference of 9.0 percentage points.

Figure 4: Uptake of first dose of MMR (MMR1) as of 31 December 2025, by age in months and deprivation

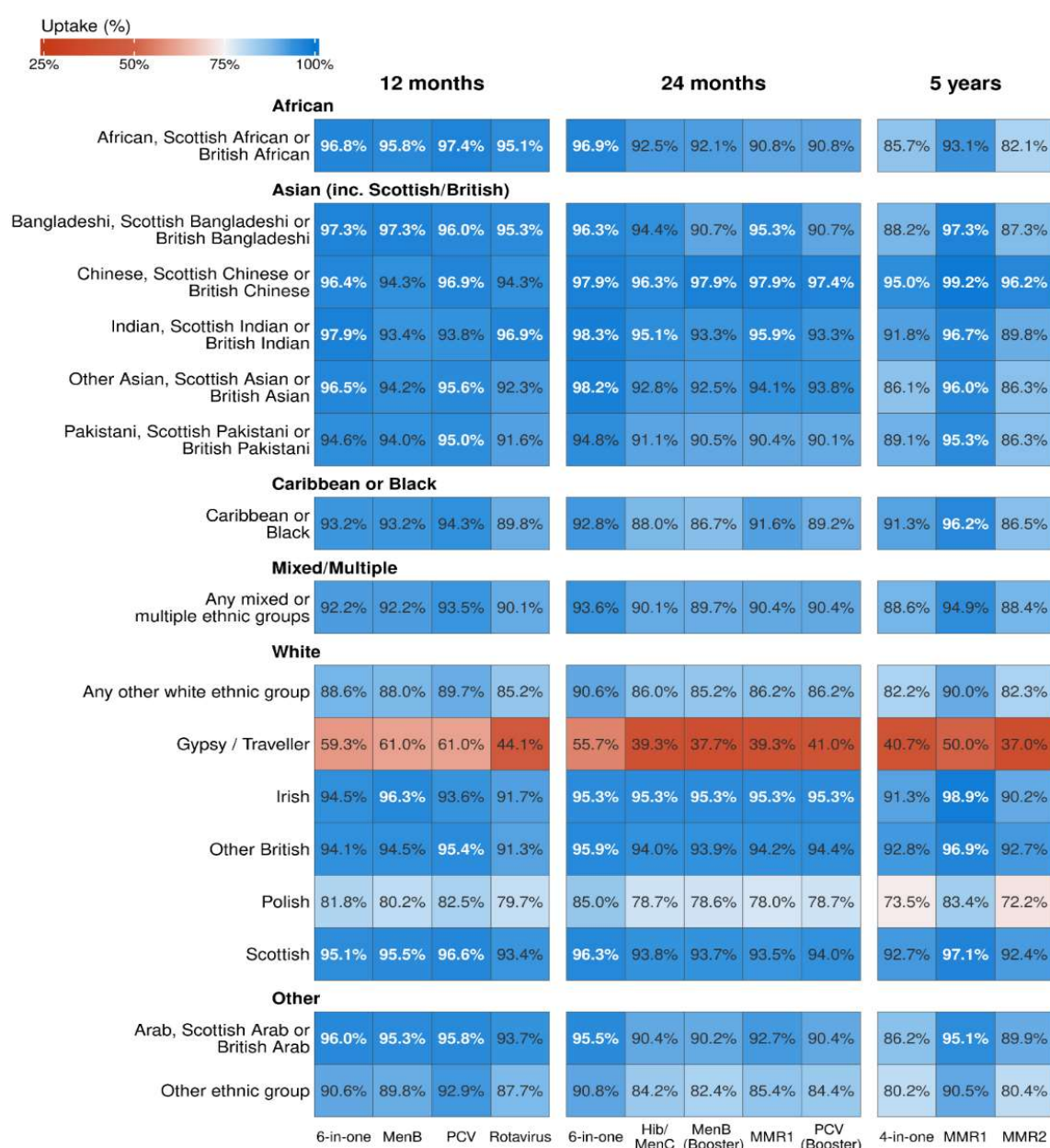


In addition to having lower overall uptake and receiving doses later, children living in the most deprived areas are also more likely to be partially immunised and to not receive all the doses required to complete the course. As of November 2025, 14.0% of children aged 4 to 11 years and living in the most deprived areas (SIMD1) were missing at least one dose of diphtheria, tetanus and polio, while 7.4% of children aged 4 to 11 years and living in the least deprived areas (SIMD5) were missing at least one dose. Similarly, 14.2% of children (4 to 11 years) living in the most deprived areas (SIMD1) were missing a dose of MMR, while 7.4% of children living in the least deprived areas (SIMD5) were missing a dose. Furthermore, 13.0% of children (4 to 11 years) living in the most deprived areas (SIMD1) were missing at least one dose of diphtheria, tetanus and polio AND missing a dose of MMR, while 6.6% of children living in the least deprived areas (SIMD5) were missing at least one dose of diphtheria, tetanus and polio by AND missing a dose of MMR.

Describing vaccine uptake by ethnicity provides opportunity to identify and address health inequalities, ensure equitable access to vaccines, and understand disparities in outcomes across different groups at a population level. This allows for targeted interventions to promote immunisation and improve the health of all communities.

In 2025, uptake for rotavirus by 12 months ranged from 44.1% for children recorded as Gypsy/Traveller to 96.9% for children recorded as Indian, Scottish Indian or British Indian, a difference of 52.8 percentage points (Figure 5). Similarly, uptake for MMR1 by 24 months ranged from 39.3% for children recorded as Gypsy/Traveller to 97.9% for children recorded as Chinese, Scottish Chinese or British Chinese, a difference of 58.6 percentage points. Uptake was also consistently low for children recorded as Polish. Denominator sizes vary considerably by ethnicity and should be considered when interpreting these figures. Further work is needed to understand why these disparities occur and to develop strategies to improve vaccine uptake among all ethnic groups.

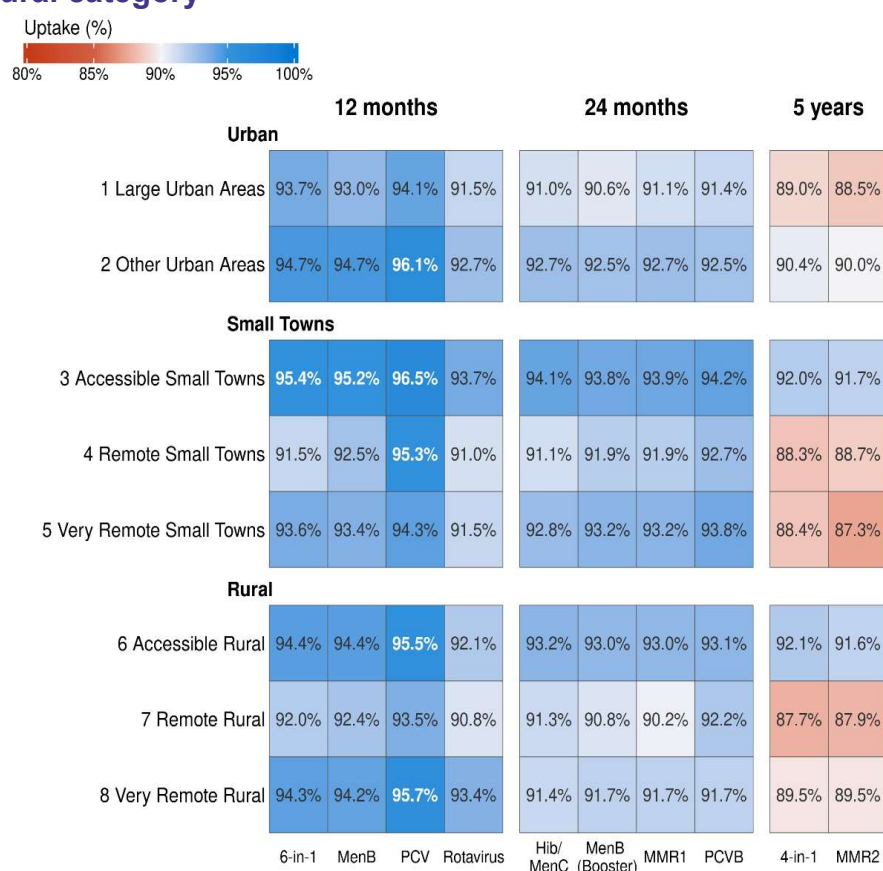
Figure 5: Comparison of primary uptake rates (%) by 12 months, 24 months, and five years of age, for selected immunisations in 2025 in Scotland, by ethnic group and ethnicity



Note: Text in white shows uptake greater than or equal to 95.0%.

There are eight geographical urban/rural categories in Scotland. Describing vaccine uptake by urban/rural category can identify areas of lower uptake that may reflect access to services as well as the populations within these areas. In general, the highest uptake across childhood immunisations in 2025 was in accessible small towns, followed by accessible rural areas (Figure 6). For immunisations by 12 months, 6-in-1, rotavirus, MenB and PCV, uptake was consistently lowest in remote small towns and remote rural areas. For immunisations by 24 months, uptake tended to be lower in large urban areas, remote small towns, remote rural areas, and very remote rural areas. For MMR2 by five years of age, uptake was lowest in very remote small towns and remote rural areas.

Figure 6: Comparison of primary uptake rates (%) by 12 months, 24 months, and five years of age, for selected immunisations in 2025 in Scotland, by urban rural category



Note: Text in white shows uptake greater than or equal to 95.0%.

Teenage immunisation coverage rates

Four vaccines are routinely offered to young people of secondary school age primarily through school-based programmes. HPV vaccine is first offered in the first year of secondary school (S1) to protect against cancers caused by HPV including cervical, anogenital, head and neck cancers. In the third year of secondary school (S3), young people are offered the 3-in-1 teenage booster (Td/IPV), which provides further protection against diphtheria, tetanus, and polio, along with the MenACWY vaccine, which protects against invasive disease including meningitis and septicaemia caused by meningococcal bacteria serogroups A, C, W, and Y. Each winter, the influenza vaccine is offered to all young people at secondary school, as well as to younger children. A status check for the MMR vaccine also takes place in secondary school and there is an offer to catch up on any missed doses.

Prior to the COVID-19 pandemic, teenage immunisation uptake and coverage rates were maintained at high levels although had been gradually declining over time.

In school year 2019/20, sharp declines were observed. HPV coverage in S1 females, MenACWY and Td/IPV in S3 fell below 80.0% for the first time. This was due to disruption in immunisation delivery during the COVID-19 pandemic, school closures during lockdown periods, and high absenteeism due to sickness and isolation policies. Coverage rates subsequently recovered from school year 2021/22 onwards but not to pre-pandemic levels. Coverage rates in 2024/25 were similar to the previous year.

For the school year 2024/25, HPV vaccine coverage was 72.6%, up from 71.5% in 2023/24, but not reaching post-pandemic rates of 73.5% in 2021/22 (Table 3). The annual trend for HPV vaccine coverage in females in S1 has declined over time, from 89.0% in 2014/15 (first dose, representing 11 of 14 NHS health boards), falling below 80.0% for the first time in 2019/20 (61.0%), to 75.7% in 2024/25. Males were first offered HPV vaccine in 2019/20 (55.1%), and annual coverage rates have always remained below 70.0%, reaching 69.7% in 2024/25.

Coverage of Td/IPV in S3 pupils has declined from a high of 83.7% in 2011/12, falling below 80.0% for the first time in 2019/20 (71.4%), to 70.1% in 2024/25. Coverage in S4 pupils peaked in 2014/15 at 88.1%, before falling to 74.4% in 2024/25. Similarly, MenACWY coverage rates have declined from above 80.0% pre-pandemic, to 70.2% and 74.4% in S3 and S4 pupils in 2024/25, respectively.

Table 3: Comparison of teenage coverage rates (%) from 2019/20 to 2024/25 in Scotland, by immunisation and school year

Immunisation	School year	2019/20*	2020/21*	2021/22	2022/23	2023/24	2024/25	Change from 2023/24 to 2024/25 ^{\$}
HPV	S1	58.0	52.1	73.5	72.9	71.5	72.6	1.1 ↑
	S2	88.5	80.5	83.6	79.5	79.0	77.5	1.5 ↓
	S3	90.5	90.5	87.2	85.2	81.6	81.1	0.6 ↓
	S4	91.9	91.2	91.5	87.9	86.3	82.9	3.4 ↓
Td/IPV	S3	71.4	39.8	71.6	68.6	68.9	70.1	1.2 ↑
	S4	86.7	80.3	74.9	77.3	75.5	74.4	1.1 ↓
MenACWY	S3	71.6	39.6	71.7	68.7	68.9	70.2	1.3 ↑
	S4	86.8	80.4	73.8	77.4	75.6	74.4	1.2 ↓

^{\$}Percentage points change i.e. difference in uptake from 2023/24 to 2024/25. *HPV coverage includes female uptake only for these years.

During winter 2025/26, influenza vaccine uptake was 52.1% among secondary school pupils, 1.0 percentage point lower than the previous winter season (2024/25, 53.1%), and 0.8 percentage points lower than winter 2023/24 (see Figure 4).

Teenage immunisation rates by inequalities groups

Since the HPV vaccine was first offered to males in 2019/20, coverage has been lower than in females, and coverage in S1 males has remained below 70%. In 2024/25, the difference in S1 coverage between males and females was 6.0 percentage points (female coverage was 75.7%, male coverage was 69.7%), and the difference in S4 coverage was 5.4 percentage points (female coverage was 85.7%, male coverage was 80.3%).

There is also a difference (albeit smaller) between females and males in Td/IPV and MenACWY coverage with coverage in males being consistently lower (S3 difference 2.9 and 3.0 percentage points, respectively, and S4 difference was 3.3 percentage points for both vaccines).

There is a deprivation gradient in teenage immunisation coverage which has existed since the beginning of the programmes, but the gap has widened since the COVID-19 pandemic, with trends largely driven by declines in the most deprived quintiles.

For HPV vaccine, coverage in 2024/25 for S1 pupils living in the most and least deprived quintiles was 62.0% and 83.4%, respectively (21.4 percentage points difference) (Table 4). By the end of S4, HPV coverage was 74.6% and 90.7% for pupils living in the most and least deprived areas, respectively (16.1 percentage points difference). This gap in S4 coverage in

HPV vaccine has widened considerably since 2019/20 when the difference was 3.1 percentage points (91.1% and 94.2% for the most and least deprived quintiles).

In S3 in 2024/25, 56.7% and 56.6% of pupils living in the most deprived areas received Td/IPV and MenACWY vaccines, respectively, compared with 82.6% and 82.7% of pupils living in the least deprived areas, respectively. The gap in coverage was 25.9 and 26.1 percentage points for Td/IPV and MenACWY, respectively.

In 2015/16, the difference between the least and most deprived quintiles in S4 for Td/IPV was 10.2 percentage points (82.4% and 92.6% for the most and least deprived quintiles), however in 2024/25, there was a difference of 24.0 percentage points (62.1% and 86.1% for the most and least deprived quintiles).

When comparing the change in the gap in coverage between those living in the most and least deprived areas between 2023/24 and 2024/25, the gap narrowed for HPV vaccine coverage in S1 by 0.8 percentage points, from 22.2 percentage points difference in 2023/24, to 21.4 percentage points difference in 2024/25. This gap increased between 2023/24 and 2024/25 for S2, S3 and S4 (Table 4).

With more opportunities for immunisation, since it is first offered in S1 with catch up offered in subsequent years, HPV coverage by S4 is higher than that for Td/IPV and MenACWY, which are first offered in S3. Offering Td/IPV and MenACWY vaccines earlier would provide additional opportunities for immunisation and could potentially reduce the deprivation gap, but vaccination service capacity is a barrier to implementing this change. Absenteeism and leaving school early likely contribute to lower coverage of Td/IPV and MenACWY, intensified in areas of higher deprivation.

Table 4: Comparison of teenage coverage rates (%) in 2023/24 and 2024/25 in Scotland, by most and least deprived quintile

Immunisation	School year	2023/24 SIMD 1 (most deprived)	2023/24 SIMD 5 (least deprived)	2023/24 SIMD difference	2024/25 SIMD 1 (most deprived)	2024/25 SIMD 5 (least deprived)	2024/25 SIMD difference	Change in gap 2023/24 to 2024/25 [§]
HPV	S1	59.9	82.1	22.2	62.0	83.4	21.4	↓ (-0.8)
	S2	69.8	87.7	17.9	67.1	87.1	20.0	↑ (2.1)
	S3	72.8	89.7	16.9	72.2	89.7	17.5	↑ (0.6)
	S4	79.9	92.6	12.7	74.6	90.7	16.1	↑ (3.4)
Td/IPV	S3	56.8	81.5	24.7	56.7	82.6	25.9	↑ (1.2)
	S4	64.9	86.5	21.6	62.1	86.1	24.0	↑ (2.4)
MenACWY	S3	56.8	81.6	24.8	56.6	82.7	26.1	↑ (1.3)
	S4	64.9	86.8	21.9	62.0	86.0	24.0	↑ (2.1)

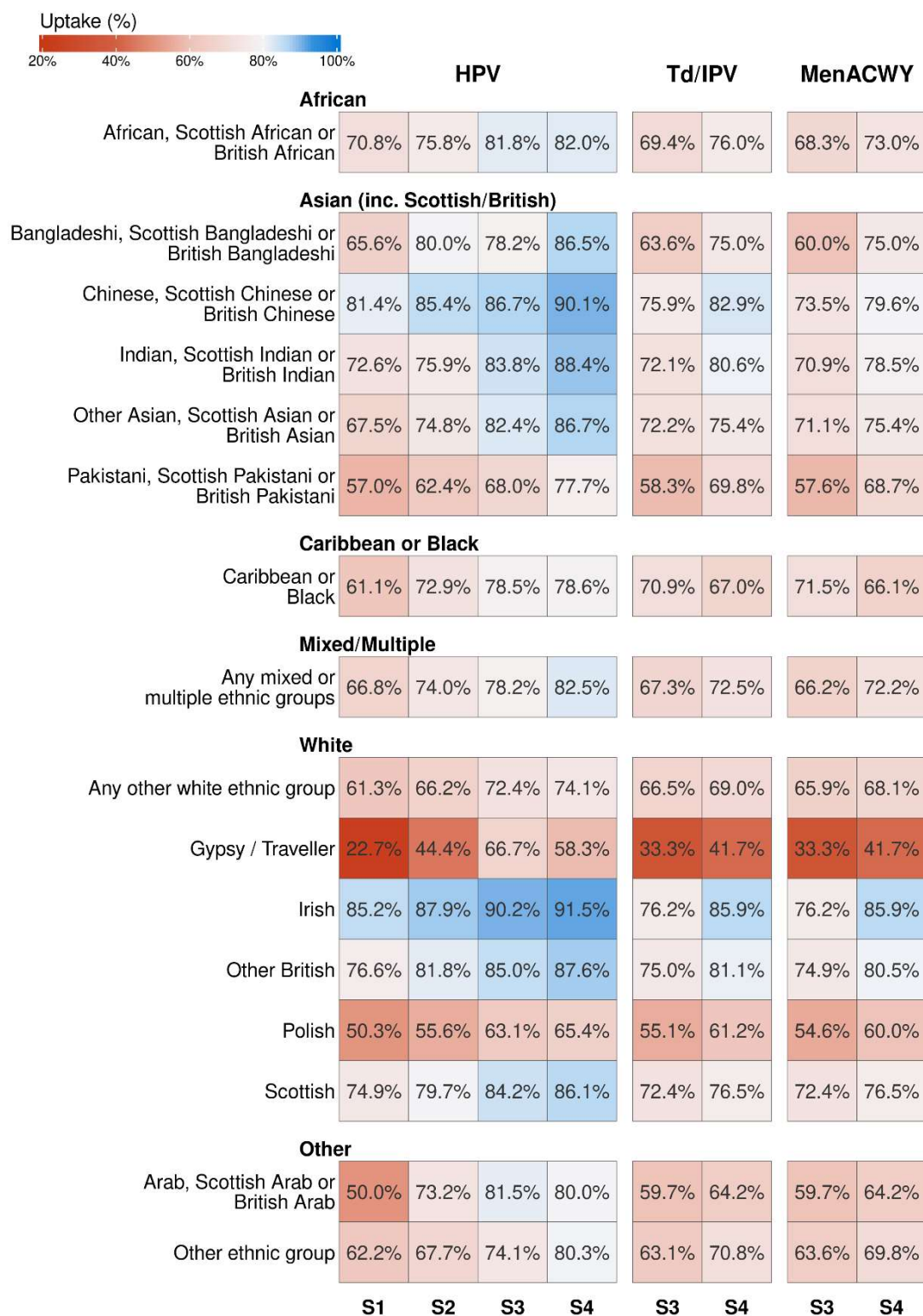
[§]Percentage points change i.e. difference in uptake gap (between SIMD1 and 5) between the latest year and the previous year.

There is variation in teenage immunisation coverage by ethnicity. In 2024/25, coverage of teenage immunisations of HPV in all school years was highest in young people with Irish ethnicity recorded with 85.2%, 87.9%, 90.2% and 91.5% for S1, S2, S3 and S4, respectively (Figure 7). Coverage was also high for HPV across S1 to S4 in young people with Chinese, Scottish Chinese or British Chinese ethnicity recorded with 81.4% coverage in S1 to 90.1% coverage in S4.

HPV coverage was lowest in young people with Gypsy/Traveller ethnicity recorded for all academic years with 22.7% coverage in S1. HPV coverage in S1 was also low for young people with ethnicity recorded as Arab, Scottish Arab or British Arab (50.0%); Polish (50.3%); Pakistani, Scottish Pakistani or British Pakistani (57.0%); and Caribbean or Black (61.1%).

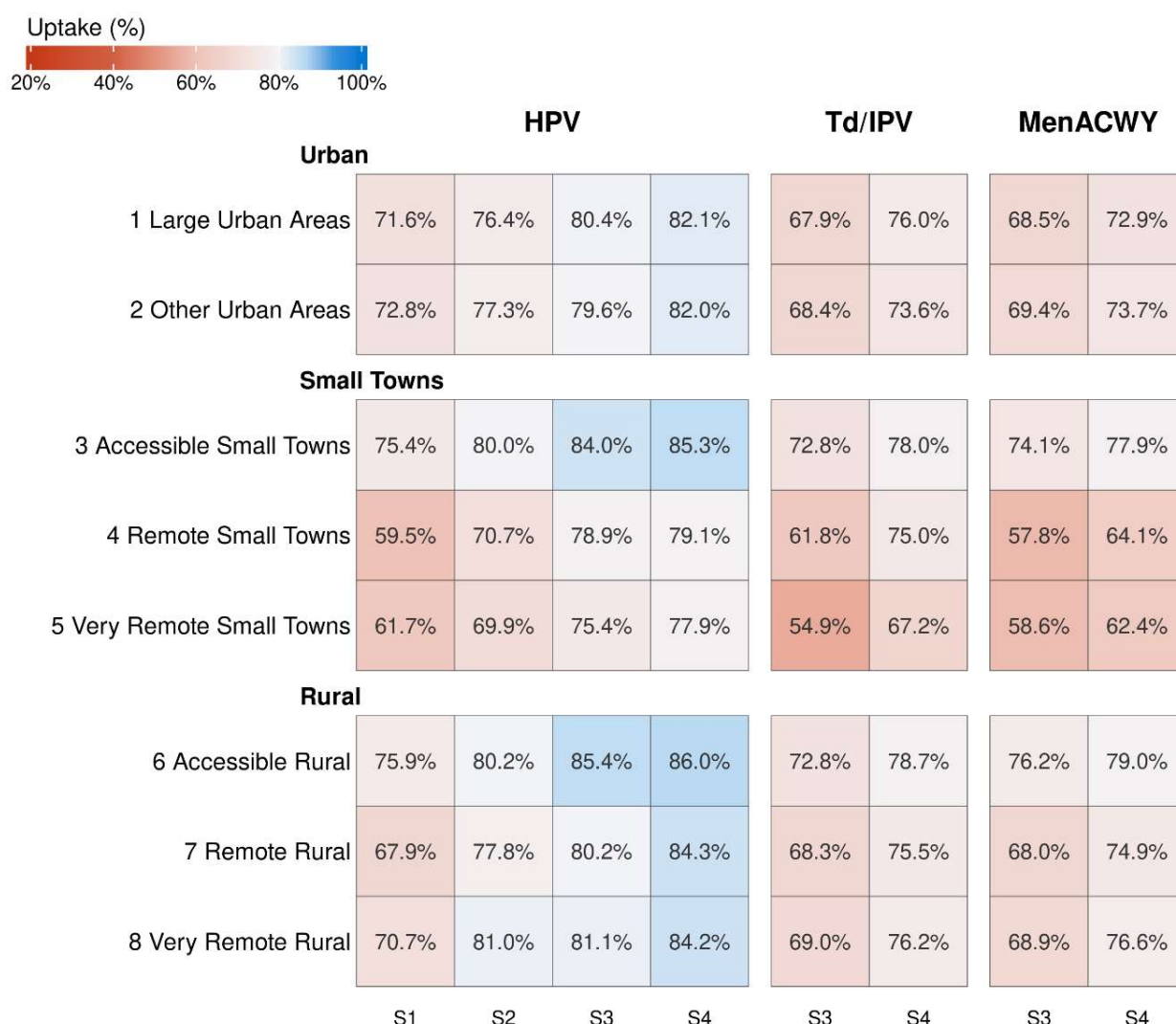
For MenACWY and Td/IPV coverage was highest in young people with Irish ethnicity recorded (76.2% for both vaccines in S3, and 85.9% for both vaccines in S4). MenACWY coverage in S3 was lowest in young people with Gypsy/Traveller ethnicity recorded (33.3%), followed by Polish (54.6%), Pakistani, Scottish Pakistani or British Pakistani (57.6%), and Arab, Scottish Arab or British Arab (59.7%).

Figure 7: Comparison of teenage uptake rates (%) by school year 2025 in Scotland, by ethnicity



Teenage immunisation coverage tends to be highest in accessible small towns and accessible rural areas, and lowest in remote small towns and very remote small towns (Figure 8). For HPV in S1, coverage was highest in accessible rural areas (75.9%) and lowest in remote small towns (59.5%). Since immunisations are primarily delivered through schools, this variation is perhaps unexpected. These coverage figures do not account for other factors, such as deprivation and ethnicity, which vary across urban-rural areas.

Figure 8: Teenage coverage rates (%) by school year 2024/5 in Scotland, by urban rural category



Uptake figures and further details can be found on [PHS Vaccination Surveillance](#), in quarterly surveillance reports [Childhood immunisation statistics Scotland - quarter and year ending 31 March 2026 - Childhood immunisation statistics Scotland - Publications - Public Health Scotland](#), and in the annual report [Protecting the population of Scotland from vaccine preventable diseases: Vaccination and Immunisation Report in 2025 - Publications - Public Health Scotland](#).

Drivers of trends and disparities

Longer term declining childhood immunisation trends have been described across the UK nations and internationally, but with steeper declines particularly since the COVID-19 pandemic. The reasons are likely multifactorial, with UNICEF suggesting that confidence in vaccines is a significant issue when parents and carers are considering vaccinations, and that vaccine confidence has dropped since the start of the pandemic, with people under 35 years having lower confidence than those over 65 years.

Public Health Scotland (PHS) undertook a qualitative study with Immunisation Coordinators (ICs) in all 14 territorial NHS Board areas to identify factors believed to be influencing trends and inequalities. The analysis identified a wide range of factors, several of which are reflective of wider socioeconomic conditions and NHS and system pressures and resources. These included: behavioural factors (opportunity, motivation and capability to be vaccinated), delivery models (how and where people were invited for vaccinations and how accessible these were), system related factors (data and digital systems blockers and drivers) and contextual factors (e.g. VTP and the COVID-19 pandemic). It is likely that these factors contribute to inequalities in uptake. The report included recommendations relating to workforce, marketing and communications and systems and process which are being progressed by the Scottish Vaccination and Immunisation Programme (SVIP). See the report here: [Understanding and Addressing Declines in Childhood Immunisations - Publications - Public Health Scotland](#).

Colleagues from Public Health Scotland, Scottish Government and NHS Boards contributed to a UK four nations forum (with England, Northern Ireland, and Wales) on declining coverage and increasing inequalities across the routine immunisation programmes. This work had been requested by JCVI and focused on several different topic areas over 10 deep dive sessions. The report of the UK Forum on declining coverage and increasing inequalities across the routine immunisation programmes 2023-2025 was published with the minutes of the meeting of the JCVI held on 1 October 2025. The overall consensus was that declines were multifactorial, and that a range of actions are required to make improvements in relation to the key drivers affecting all four nations:

- **Specialist public health system leadership**, local and national, is critically important for ensuring effective coordination of clinically safe and robust services
- **Improving data recording and flow** – alongside reinforcing processes for regular data cleansing as routine practice, new digital infrastructure and data systems were needed to improve data quality and accessibility, including the creation of a single vaccination record for patients and health bodies; and systems to check the immunisation status of children and young people and to provide catch-up vaccination at every appropriate opportunity
- **Improving access to vaccinations** – there is more to do to ensure that existing core providers get the basics right as a priority to improve access and service effectiveness; to ensure that there is an effective system to invite those who are eligible for vaccines and to remind/recall those who do not attend, as well as establishing the evidence base for tailored approaches for particular populations with low or partial uptake to ensure timely immunisation across a range of settings.

- **Delivery of school age vaccination programmes** – performance of school age immunisation services (SAIS) should be further supported and improved with obstacles to delivery in schools addressed as an agreed key priority.
- **Addressing complacency and improving confidence** – it is highly likely that uptake can be improved by ensuring healthcare staff throughout the NHS are appropriately trained and are both knowledgeable and confident to discuss vaccination; by making optimal use of national communication channels; and by ensuring that patient communications are sufficiently accessible, of a high standard, and produced in the correct formats to support patients and parents/carers to make an informed decision. This also includes using understanding of approaches to addressing false health information to reduce its impact on vaccination uptake.

With funding from the Scottish Government, PHS commissioned YouthLink Scotland to undertake research with young people who are missing from vaccine services in Scotland. This comprised eight focus groups (six with young people and two with parents) led by youth workers, and a national online survey. Findings suggest that there are fears and anxiety about having vaccines, particularly in relation to needles and side effects, and that young people are looking for trustworthy, relatable information and reassurance about vaccine benefits and safety. This research has resulted in the development of a positive relationship with YouthLink Scotland, with innovative practice involving youth workers leading the focus groups and undertaking thematic analysis of the findings. The findings are available on the YouthLink Scotland website [Young people missing from vaccine services research | YouthLink Scotland](#).

Insights from this research will be used to inform improvements to health information materials and marketing and comms campaigns, including producing videos and social media content aiming to address and allay some of the key concerns expressed by young people. The findings have also been shared with Immunisation Coordinators and NHS board service leads to support them in widening and enhancing the range of settings in which they offer vaccinations for young people, including more tailored clinic and small community vaccination sessions for those whom school-based vaccination is less suitable.

Hesitancy and mis/dis information

The Scottish Government and NHS partners have recognised that misinformation and disinformation are increasingly impactful determinants of vaccine confidence and uptake.

Through its Scottish Health Information Integrity Strategy ([Scottish Health Information Integrity Strategy - gov.scot](#)), Scottish Government is taking a structured, evidence-informed approach to understanding and mitigating the impact of false and misleading health information on population outcomes, drawing on WHO infodemic management principles and contemporary academic evidence.

This strategy notes that the qualitative research reported on by PHS in *Understanding and Addressing Declines in Childhood Immunisations* (link above) found that false health information is often cited by parents and families when explaining why they do not want their children to be vaccinated. The 2025 survey of parental attitudes to vaccination in the UK ([Childhood vaccines: parental attitudes survey 2025 findings - GOV.UK](#)) found that overall parental trust in vaccination remains relatively high. However, the Strategy also highlights the finding of surveys by conducted YouGov which have shown an alarming increase in the belief that the side effects of vaccination are being covered up, particularly

amongst young adults ([Do Brits think vaccines have harmful effects which are not being disclosed? 2019-2026](#)).

Taking these insights into account, Public Health Scotland is leading the delivery of key elements of the Scottish Health Information Integrity Strategy across vaccination programmes, including strengthening audience-tailored communications, enhancing surveillance of misinformation dynamics, and supporting the workforce to respond confidently to vaccine queries through training and education resources and activities.

The NHS Inform website's immunisation pages ([Immunisation | NHS inform](#)) and all supporting immunisation materials are routinely reviewed and updated by Public Health Scotland and partners to ensure accuracy, accessibility and consistency with current clinical guidance.

The multiagency Scottish Vaccination and Immunisation Programme (SVIP) is also currently developing a Tackling False Health Information Action Plan to ensure a coordinated approach is taken to providing leadership, building citizen resilience, and ensuring appropriate rapid responses are in place to combat false health information in relation to vaccination. This work is integral to maintaining trust, improving vaccine literacy, and improving equitable uptake.

2. What is the Scottish Government's strategy to increase uptake of childhood vaccinations?

a. What is the Scottish Government's strategy for ensuring equitable access to childhood vaccinations and reducing disparities, including by deprivation, ethnicity, and primary language spoken?

Scotland's strategy for improving childhood vaccination, including equity of access and coverage, is set out in our 5-year Vaccination and Immunisation Framework and Delivery Plan (See: [Scotland's 5-year Vaccination and Immunisation Framework and Delivery Plan - Publications - Public Health Scotland](#)). This was developed in a participative and collaborative process involving all key stakeholders, including Scottish Government, Public Health Scotland, national and territorial NHS boards, Health and Social Care Partnerships (HSCPs), and third sector organisations.

The Framework and Delivery Plan's overarching goals are to:

- **Improve vaccine uptake:** reach population uptake thresholds across all age groups in all communities.
- **Reduce inequalities:** ensure immunisation services meet the needs of everyone, no matter where they live or who they are.
- **Avert illness:** reduce and prevent morbidity and mortality from vaccine-preventable diseases to improve population health.

Four priority areas are identified to achieve these goals, with a particular emphasis on ensuring equitable access and uptake – recognising that inclusivity is not a choice but a necessity for population health:

- **ensuring everyone has timely and equitable access** – especially where uptake is lower than expected and there is a significant variation across different communities that reflect wider health inequalities.
- **making every contact and interaction count and optimising patient/public experience and engagement**
- **strengthening capacity and capability** of the multi-disciplinary vaccination workforce, embedding flexibility to meet changing demands
- **adopting a system-wide** approach to deliver safe, effective, sustainable and patient-centred immunisation services across all settings.

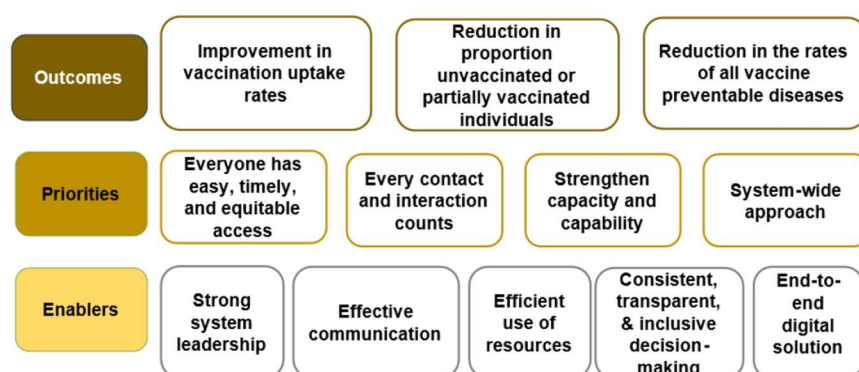
Achieving these ambitions will require effective use of resources and strong system enablers, including within leadership, communication, governance and digital systems. Partners will need to work together to integrate all elements of the vaccination programme, ensuring appropriate workforce resources, and data, evidence and technology infrastructures are in place, with the ability to be flexible and innovative in response to challenges such as changes and additions to vaccination schedules, and the evolving epidemiology of vaccine-preventable diseases.

Progress in achieving the Framework and Delivery Plan's aims is overseen by the Strategy and Planning Group of the Scottish Vaccination and Immunisation Programme (SVIP), led by Public Health Scotland and sponsored by Scottish Government's Director of Population Health (please see under Question 3 for further details).

In support of the delivery plan's priorities, SVIP aims to implement five key enabling actions and activities:

- Develop an **end-to-end digital solution** that provides a single, accessible vaccination record for Scottish citizens.
- Develop an **effective communication strategy** with clear marketing and engagement approaches.
- **Use available resources efficiently** to continue to deliver a sustainable vaccination and immunisation service, improve NHS boards' ability to plan and use resources flexibly, and improve the interaction between different health programmes and systems.
- Establish systems and processes within SVIP governance arrangements that support **consistent, transparent and inclusive decision-making processes**.
- Establish **strong system leadership** across all vaccination and immunisation programmes by developing a framework for clarifying roles and responsibilities of the different partner organisations.

Summary of Delivery Plan outcomes, priorities and enablers



At the core of all the actions and objectives set out in the delivery plan is the collective aspiration to tackle ongoing declines in vaccination uptake and to mitigate existing health inequalities across Scotland.

This same ambition, and the vital role of the 5 Year Vaccination and Immunisation Framework and Delivery Plan in preventing disease and improving population health more widely, are embedded in Public Health Scotland's 10-year strategy ([Together we can: our 10-year strategy to 2035 - Publications - Public Health Scotland](#)). This sets out a prevention-focused system and equitable access to health and care as being core drivers for action; ensuring that people are able and confident to get vaccines – thereby attaining vaccination uptake rates that meet or exceed population protection thresholds – is listed as a key objective.

The delivery plan for the provision of safe, effective and sustainable immunisation services across Scotland also sits in the context of wider reform of health and social care being undertaken by the Scottish Government and partners through the Population Health Framework ([Scotland's Population Health Framework - gov.scot](#)). Among the initial

actions that this Framework specifies are delivering on the 5 Year Framework and Delivery Plan. This will include:

- building on SVIP's work to increase confidence and uptake, especially in under-served communities
- responding to Joint Committee on Vaccination and Immunisation (JCVI) advice regarding changes to current vaccination programmes and the introduction of new vaccination programmes
- developing Standards for vaccination services, with indicators to assess improvement of these services.

Underneath its overarching goals and objectives, the 5 Year Vaccination and Immunisation Framework and Delivery Plan details a comprehensive set of specific actions and workstreams, many of which focus on driving up coverage and improving equity across vaccination programmes. These make clear that protected characteristics, and wider drivers of low uptake such as poverty, should be central to national and operational level service design and development. Programme planning should draw on Health Impact Assessment methodology and on established international evidence and guidance on effective tailoring of services for under-vaccinated groups in order to achieve equitable uptake, and should ensure that resources are committed to inclusion activities to address the Inverse Care Law.

Practical examples include undertaking targeted engagement, and bespoke and outreach clinic provision, in settings such as faith and community centres, or via mobile vaccination units, for people who face difficulties in accessing services due to language, cultural, transport, or other barriers. Other initiatives include adapting clinic times to accommodate parents and families for whom employment, childcare or other commitments may act as barriers, and offering home- or specialised community-based appointments for young people for whom vaccination in a school or traditional healthcare environment is unsuitable.

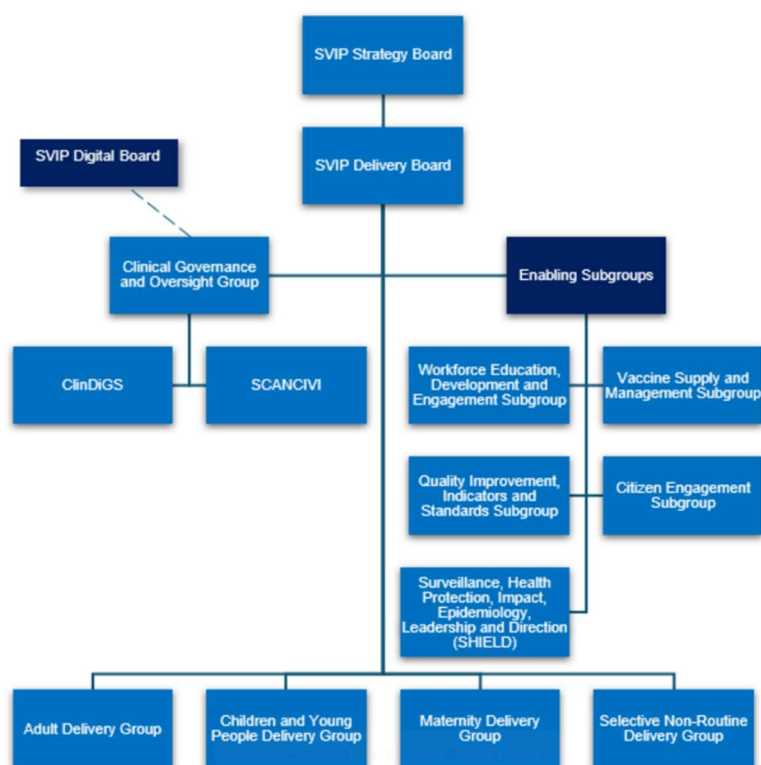
SVIP partners at all levels will also build and expand their engagement and support for both healthcare and other professionals, and trusted voices and leaders of different communities, to build trust and confidence, to create opportunities to share appropriate information about vaccination to tackle concerns and misperceptions, and facilitate community members and service users to make informed decisions about immunisation.

3. Who is responsible and accountable for sustaining and improving childhood vaccination coverage in Scotland at the local, regional, and national levels?

The Scottish Vaccination and Immunisation Programme (SVIP) is responsible for all aspects of immunisation programme delivery in Scotland. SVIP operates through strong partnerships between Public Health Scotland (PHS), territorial and national NHS boards, the Scottish Government (SG), Health and Social Care Partnerships (HSCPs), and third sector organisations. PHS is the lead organisation in SVIP; its activities are coordinated through its Vaccination and Immunisation Division (VAID) within the Clinical and Protecting Health (CPH) directorate.

An updated SVIP governance structure was implemented in January 2026 to streamline decision-making processes, improve oversight of immunisation programmes, and support progress toward [Scotland's 5-year Vaccination and Immunisation Framework and Delivery Plan](#). The planning and preparation for these changes spanned several months during 2025, to ensure a thorough and considered approach. The current SVIP governance structure incorporates a multidisciplinary, multiagency Delivery Board. Reporting into it are four Delivery Groups providing dedicated forums for operational planning and detailed discussion on maternity, children and young people, adult, and selective and non-routine programmes. The Delivery Groups are supported by facilitatory Subgroups responsible for leading on cross-cutting themes including patient and public engagement, communications and marketing, workforce development, vaccine supply, digital development, and quality improvement and standards.

SVIP Governance Structure (last updated: 24/04/2026)



NB *ClinDiGS* is the Clinical Digital Governance Subgroup; *SCANCI/M* is the Scottish Clinical Advisory Network on Cohort Identification for Vaccination and Immunisation

National - Scottish Government: Ultimately Ministers and Officials are responsible for vaccination coverage in Scotland, as they set the policy and the strategy (including the Population Health Framework and the shift to making the NHS a preventative health organisation), and are responsible for the financing of programmes. Scottish Government also has the role of formally performance managing individual NHS boards in instances where delivery and uptake has dropped to a critical point, and formal intervention is required. To underpin this responsibility, development of a set of high-level performance indicators is underway. These will link to SVIP standards, and will support NHS boards to integrate vaccination delivery and improvement with their overarching delivery plans, in line with the [NHS Scotland Operational Improvement Plan](#) and the [Health and Social Care Service Renewal Framework](#).

National - Public Health Scotland: PHS is responsible for turning national vaccination policy into delivery, and holds the role of Senior Responsible Officer (SRO) for the vaccination programme in Scotland. PHS is responsible for overseeing and assuring that programmes are being implemented in line with national policy, and that they are being run in a way that supports the key aims and objectives of the 5 Year Framework and Delivery Plan. This is carried out via SVIP, in collaboration with Scottish Government, other national agencies, NHS boards, and key third sector partners.

NHS boards and national agencies are supported by PHS to continuously identify, share and implement learning about best practice, through both facilitated peer-to-peer engagement, and applying international evidence and expertise to the Scottish context. PHS leadership of monitoring and evaluation of delivery against meaningful and impactful targets and standards, including in relation to inequalities in uptake and their determinants, helps to drive improvement at all levels.

Regional / local - 14 Territorial Health Boards: Scotland is split into 14 different regions each with their own individual NHS Board responsible for planning and delivering acute elective and unscheduled secondary care for their populations.

Local - 31 Health & Social Care Partnerships: Scotland has 31 Health and Social Care Partnerships (HSCPs). These are statutory bodies which integrate community-based health and social care. Each HSCP is jointly managed by the NHS board and the local authority for its area, and is responsible for delivering primary health care and adult social care services within the local authority's boundaries.

Immunisation service models

NHS Boards and HSCPs are responsible for configuring and managing local vaccination services within their wider operational structures, based on the needs of their populations. There is a variety of models: services may be managed, and their staff directly employed, by either the NHS board or the HSCP, or split between them for different functions or programmes.

Some NHS boards and HSCPs operate a single integrated vaccination service delivering routine and selective childhood and school-based immunisations alongside all adult routine, selective and seasonal programmes, as well as unscheduled / non-routine, travel and other vaccinations. In other areas, separate teams – sometimes managed within different organisational divisions or directorates – may have specific responsibility for certain programmes or patient groups, such as childhood/pre-school, school-based, and adult. There are also some examples of general practices taking responsibility for delivery of vaccinations for certain programmes or patient groups, or within specific geographies – particularly in more rural and remote communities. These may be practices that the NHS

board or HSCP directly manages, and/or independent NHS providers with which the NHS board / HSCP has contracted locally for the delivery of defined vaccination services.

The role of the Immunisation Coordinator

The safe and effective delivery of the immunisation programme is dependent on the existence of a sustainable, confident, and competent workforce. In Scotland, a key cohort of staff members involved in this delivery is Immunisation Coordinators. They provide strong professional specialist clinical and public health leadership and oversight for all services delivering vaccinations within their area – a function which has been well established for over 25 years. There is one Immunisation Co-ordinator within each of the 14 local geographically defined NHS boards.

Immunisation Coordinators operate within NHS board and HSCP multidisciplinary governance and coordination structures. The role encompasses clinical leadership and performance management, professional leadership, and educational and professional development, and can be summarised as:

- Providing expert clinical advice in relation to immunisation to patients, carers, and other healthcare professionals and providers
- Overseeing the delivery, quality and effectiveness of immunisation programmes for the population of their NHS board, being directly accountable to the Director of Public Health for this work, and providing subject matter expertise as part of a wider multidisciplinary team
- Leading formal processes for planning, implementation and coordination of the delivery of immunisation programmes within their NHS board area, and contributing to the leadership of equivalent processes nationally. Where the Immunisation Coordinator has direct managerial responsibility for delivery of immunisation services, they will also be responsible for operational management
- Ensuring arrangements for effective monitoring of uptake and identifying inequalities in vaccination are in place, and supporting services to improve uptake and develop effective methods to target underserved people.

While the remit within Immunisation Coordinator roles is extensive, a vital function is to provide liaison between local and national structures, providing local service delivery expertise within the national Scottish Vaccination and Immunisation Programme governance structure. Immunisation Coordinators have their own peer-to-peer network where they provide support to each other as well as the network providing an opportunity for governmental and external agencies to seek their collective opinion on national initiatives before they go live.

Suggested knowledge and skills required by individuals undertaking this role are outlined in a Knowledge and Skills Framework co-produced by NHS Education for Scotland (now part of NHS Public Services Delivery Scotland), Public Health Scotland and Immunisation Coordinators. There is an ambition to specify the functions and associated required knowledge and skills of the Immunisation Coordinator role, and support these with associated learning tools as required. While different areas may use different staffing models, appointments to Immunisation Coordinator posts are generally at Public Health Specialist Consultant level.

4. How are routine pre-school and school-aged vaccination programmes in Scotland commissioned, funded, and delivered? What are the strengths and weaknesses of this model?

Commissioning

At a national level, delivery of all vaccination programmes, and of particular programme elements, is commissioned by Scottish Government. The 14 territorial NHS boards are commissioned by Scottish Government to deliver vaccination programmes. Scottish Government also commission Special / National Health Boards to deliver national infrastructure and support services, such as:

- PHS to deliver and manage SVIP
- Scottish Ambulance Service to provide a mobile outreach vaccination service
- NHS Public Service Delivery Scotland (PSDS) to deliver vaccination digital services, the national vaccination helpline, and national vaccine procurement

Territorial NHS boards may in turn commission local partners including general practices and community pharmacies to provide vaccine related services. For most programmes and in most areas, the NHS board and/or HSCPs directly manager and deliver vaccinations services within their own organisations.

Funding

Ultimately, Scottish Government funds all vaccination programmes via its funding of territorial and special / national NHS boards and of HSCPs. The funding landscape is complex, with some funding already in the baseline allocations for these providers, and some elements being funded via in-year financial allocations to Boards.

Part of the landscape is the annual Primary Care Improvement Fund allocation to HSCPs to support implementation of the 2018 Scottish GMS Contract. HSCPs are responsible in turn for allocating these monies within their areas to support implementation of the Primary Care Improvement Programme, one element of which is delivery of vaccination programmes that general practices were formerly primarily responsible for delivering.

At a local/regional level, where NHS boards choose to commission local providers such as community pharmacies or general practices to deliver specific service elements, they manage that funding locally from their own organisational budgets.

Delivery

SVIP supports delivery of national programmes, but ultimate responsibility lies largely with the 14 territorial Health Boards, coordinated via SVIP and led by PHS.

a. To what extent have alternate delivery models been piloted, evaluated, and scaled up?

During the implementation of Scotland's vaccination transformation programme (VTP – see below), the potential to evaluate the programme, including models for delivery that were being planned and implemented within each of the territorial NHS boards, was scoped. It was noted that the impact of the VTP would be difficult to evaluate due to a number of complexities:

- Some NHS boards were already using a mixed model of delivery involving both general practices and directly managed services at the outset of the transformation programme.

- Implementation of the transformation programme occurred over a four-year period, with the transition from general practice delivery to other models occurring at different times for different vaccination programmes and in different NHS boards.
- The transformation of delivery coincided with the COVID-19 pandemic and the emergency response to it, including rapid development and deployment of new vaccination delivery teams and supporting physical, logistics, digital and management infrastructures, all of which influenced the subsequent design and development of BAU services to take over responsibility for vaccination service delivery from general practice, making interpretation very difficult.
- Lack of availability of comparable data (pre- and post-implementation) due to system changes – e.g. introduction of centralised identification of eligible individuals based on age and clinical coding data extracted from primary, secondary and prescribing patient datasets.

NHS Health Scotland (one of Public Health Scotland's precursors) undertook a survey of NHS board Business Change Managers for the transformation programme in 2020. This identified a set of enablers and barriers to implementation for transitioning vaccination delivery from general practice to new services. These included availability and retention of suitably qualified staff, provision of workforce training and education, availability and cost of healthcare and non-healthcare clinic premises, and development nationally of integrated call/recall, cohort identification, and recording and reporting systems. These are all core themes and workstreams within SVIP today.

As noted, there is considerable variation in the specifics of operational and management models for vaccination service delivery across Scotland's 14 territorial NHS boards.

Immunisation Coordinators and service leads within the boards and HSCPs are encouraged and supported to identify gaps and opportunities for improvement within their own footprints, to develop and implement plans locally to address these (in line with the 5 Year Framework and Delivery Plan's aims and priorities), and to evaluate and share learning on effective approaches with each other to drive embedding of best practice throughout the country.

The recent establishment of an SVIP Quality, Improvement, Indicators and Standards (QIIS) subgroup provides a national locus for enabling and coordinating the process of evaluating and synthesising insights into effective vaccination service developments and innovations across Scotland. This is further supported by plans to implement a structured programme of regular peer review of services and arrangements between NHS boards, which will again be led and coordinated by PHS via SVIP.

b. Why was responsibility for routine vaccinations transferred from GPs to health boards in Scotland? What is the evidence of the impact of this change on vaccination coverage?

The programme for Scottish vaccination delivery has undergone a significant transformation in recent years. In 2017, the Scottish Government and the Scottish General Practitioners Committee (SGPC) jointly decided to shift from the conventional GP delivery model to a system centred around NHS Board / Health and Social Care Partnership (HSCP) delivery facilitated by specialised teams. This was part of a wider transfer of community treatment and care, urgent care, pharmacotherapy, and other healthcare activity from general practices to alternative service models.

The initiation of the Vaccination Transformation Programme (VTP) took place on April 1, 2018. It was established to support the review and transformation of vaccination delivery in

Scotland (See: [NHS Scotland - Publications](#)). Transferring the delivery of vaccinations from a GP-centred model to one based on delivery in community settings through NHS boards was completed in April 2022. The anticipated outcome was that, by the conclusion of the transition period, all programmes would have undergone the transformation within Health and Social Care Partnerships (HSCPs) and NHS boards, including the programmes for children aged 0-5 years.

Completion was originally scheduled for April 2021, but extended by one year to April 2022, due to the COVID-19 pandemic. There were differing approaches to VTP adopted within and between Boards, with delivery of vaccinations transitioning away from GPs at different times over the four-year transition period, and some Boards operating mixed models for some time. Additionally, there were boards that had already moved away from GP responsibility for delivery of children's vaccinations prior to VTP being introduced. In some Boards, some GP premises are still being used as vaccination venues by agreement with their owners/operators, albeit the vaccinations themselves not being delivered by GPs or their staff.

Key outcomes of Scotland's Vaccination Transformation Programme (VTP) were to:

- Make vaccination, and information about vaccines, more easily accessible with more efficient delivery models tailored to the needs of local people.
- Reduce variation through improving consistency in the delivery system and address health inequalities.
- Ensure greater flexibility in delivery mechanisms in a joined-up way by integrated teams working across the system and organisations, to improve patient experience, deliver value for money, and safeguard long-term financial sustainability.
- Establish partnerships with trusted intermediaries within the community and voluntary sector, to build vaccine confidence and equitable programmes.
- Strengthen collaboration between national and local NHS boards.
- Strengthen clinical governance at local and national level
- Develop effective digital services, with non-digital pathways, to ensure inclusion.
- Support resilience and being prepared for future infectious disease threats.

As shown in Figures 1, 2, and 3 (see under question 1), during the initial phases of VTP, when the model of vaccination delivery was transitioning from being led by general practices to NHS Boards, national declines in uptake slowed, stabilised and reversed. By the first COVID-19 lockdown in March 2020, national uptake across immunisations was already increasing and continued to increase, before the more recent declines from mid-2022. It is not possible to disentangle the relative contributions of GP-based delivery before services transitioned and of NHS board and HSCP managed delivery following transition, as well as of pandemic related factors and other variables – including service improvement, communications, resource allocation and other local and national level interventions distinct from VTP – to these trends.

In the qualitative analyses described in [Understanding and Addressing Declines in Childhood Immunisations - Publications - Public Health Scotland](#), it was reported that for childhood immunisations, VTP aimed to create a more standardised, resilient and flexible service, with less reliance on individual GP practices, and greater ability to manage appointments, venues and missed vaccinations consistently.

Some NHS board areas reported that benefits of VTP included improved equity through more consistent delivery across geographical areas, reduced dependence on individual GP practices or administrative staff, and greater resilience when local staff were unavailable.

VTP also supported wider use of standardised scheduling systems, such as SIRS, helping Boards maintain better oversight of appointment queues, and follow-up for children who did not attend. In some areas, the new model for delivery increased flexibility for families by allowing appointments at a wider range of times and venues, rather than tying children to their own GP practice. It also enabled NHS boards and Child Health teams to take a more coordinated approach to planning, managing capacity, responding to local needs, and developing strategies to improve uptake.

Reported drawbacks of the transition away from general practice led provision of childhood immunisations included the loss of some opportunistic vaccination opportunities within GP practices, where vaccinations could previously be discussed or delivered during other routine contacts. For some families, VTP also created a need for separate vaccination appointments and additional travel, particularly where services moved from local GP practices to more centralised community venues. This was seen as a potential barrier for families in more deprived areas or those with limited transport options. The shift in responsibility away from GPs also appeared to create some confusion about roles and signposting, with concerns that families may not always know who to contact about immunisation or be directed promptly to Child Health services. In addition, some parents/carers were reported to have concerns about the safety, familiarity or acceptability of non-GP vaccination venues, which may affect confidence or willingness to attend.

At present there is an ongoing review of the model of immunisation service delivery across NHS Highland. The intention is to develop a collaborative hybrid model with vaccine delivery undertaken by both general practices and NHS Highland vaccination teams. This provides a unique opportunity to build on the strong foundations that exist within general practice and NHS Highland vaccination teams. Both childhood and adult immunisation programmes are currently being considered for the collaborative hybrid delivery model across NHS Highland, and the development process is expected to be completed before the end of the year.

5. How is childhood vaccination integrated with the wider preventative health offer for infants and children in Scotland, including health visiting and school nursing services? a. What evidence is there on the influence of the higher number of mandatory health visits in Scotland compared to England on child health and vaccination uptake?

Within each NHS board, local governance and management structures should ensure there is effective partnership working and coordination between services which deliver vaccinations and wider preventative healthcare for infants and children. The principle of making every contact count which is embedded in Scotland's 5 Year Vaccination and Immunisation Framework and Delivery Plan should be applied to ensure the Health Visitors and School Nurses provide timely information, signposting, and support for children to take up the offer of vaccinations in accordance with UK schedules.

Scotland's **Universal Health Visiting Pathway** recognises that health professionals, particularly Health Visitors, have a vital role to play in supporting children and families in the first few years of a child's life. Building on the collaborative working of several national groups and lessons learned from other relevant activities such as Family Nurse Partnership (FNP), the Pathway provides a consistent approach to Health Visiting roles and services across Scotland, supporting and underpinning Health Visitors' proactive interactions with families on all health topics, including vaccination.

The Universal Health Visiting Pathway links in turn to core advice, policy and legislation including Health for All Children 4, Getting it right for every child (GIRFEC), and the Children and Young People (Scotland) Act 2014, all of which should guide and direct all members of the primary care and wider Child Health support team (including General Practitioners, Staff Nurses and Early Years Support Workers) to prioritise supporting and encouraging parents and carers to take up the offers of childhood vaccinations.

Within the Pathway, guidance for the delivery of Health Visitors' Public Health role emphasises the impact of poverty and associated risk factors on children's health and social outcomes, and specifies immunisation as one of the core issues that should be covered, and recorded, at every visit. These provisions are mirrored in Scotland's priorities and pathways for specialist school nursing.

Health Visiting and School Nursing leads are expected to work closely with vaccination teams and Immunisation Coordinators to ensure that information on children who have not attended for scheduled vaccinations is shared timeously, and that parents and families receive the individual advice and support they need to facilitate them accessing vaccinations at clinics or in other settings as appropriate.

6. How are supplementary and outreach vaccination childhood services in Scotland commissioned, funded, and delivered, including in partnership with communities with lower vaccination uptake?

Outreach and tailored vaccination services supporting children and young people who are members of underserved communities and/or who have additional support needs are planned, commissioned, and delivered directly by the core providers of wider vaccination services within the Scottish programme model – i.e. territorial NHS Boards and HSCPs. Service leads are expected to embed these activities as part of their core BAU service delivery arrangements and budgets, applying learning and insights from counterparts across Scotland, and working through networks and inclusion structures within and between the NHS, other public sector and third sector partners with their areas.

These initiatives are supported by PHS and national partners via SVIP and its constituent Delivery Groups and Subgroups, through applying the principles and objectives set out in Scotland's 5 Year Vaccination and Immunisation Framework and Delivery Plan. The specific form and balance of supplementary and outreach activities varies across Scotland based on local need, resources and capacity. PHS supports these activities at a national level by developing communications and marketing toolkits and informed consent materials which are shared with a wide range of stakeholders who are trusted voices for their communities.

PHS have an accessible information policy ([Accessible information policy - Publications - Public Health Scotland](#)) to improve equity of access to information. Its informed consent materials are produced in a number of additional formats and languages as standard. These include: Polish, Chinese (Traditional and Simplified), Arabic, audio, BSL, easy read and large print. Other formats and languages are available on request.

7. How does the NHS in Scotland work with the wider public, community and voluntary sectors (including schools) to help improve childhood vaccination coverage and reduce disparities?

PHS works with a range of stakeholders to support confidence in vaccination. Where possible, all informed consent resources are coproduced with relevant stakeholders.

Insights from research, data, marketing campaign evaluations and lessons learned activity are collated and used to inform improvements in national resources and campaign materials, to address barriers raised by young people and parents. The recent Children's campaign 'One less thing to worry about' has evaluated very successfully.

PHS is working on an SVIP stakeholder map and engagement plan to ensure services are communicating with as wide an audience as possible to make every contact count. In addition to information for the public in printed informed consent leaflets and on NHS inform webpages, PHS produces information for professional audiences including healthcare professionals, third sector stakeholders and schools. These include information sheets, marketing campaigns, social media toolkits, and posters. PHS has hosted an annual SVIP conference for the last two years which has been an excellent opportunity for all partners to share best practice and make new connections.

These national level efforts support vaccination service leads and practitioners within NHS boards and HSCPs to establish and strengthen relationships, build networks and lead working groups to achieve effective engagement with underserved communities of all kinds. This in turn supports continual service improvement and the refinement of core and outreach provision and communications to widen engagement and access at local level.

8. How do call and recall, and consent processes support childhood vaccination in Scotland? What are the Scottish Government and Public Health Scotland doing to improve call and recall, and consent processes?

9. How do data systems in Scotland support childhood vaccination programmes, including data quality, data flows across systems, and monitoring of coverage and disparities? What are the Scottish Government and Public Health Scotland doing to improve childhood vaccination data systems?

NB the following information responds to both question 8 and question 9

Until May 2026, childhood immunisation appointments in Scotland were scheduled (call and recall) using the Scottish Immunisation Call and Recall System (SIRS). All completed vaccinations (immunisation events) were also recorded on SIRS by the NHS services delivering the childhood programmes. This enabled SIRS to constitute a single comprehensive record of vaccination history and status for all children in Scotland, linked to their unique national patient identifier (CHI number), with each child's DOB and status used by the system to trigger vaccination appointments for them at the appropriate ages throughout childhood. SIRS and related Child Health recording and scheduling systems were managed by specialist Child Health administrators within NHS boards, supported by national NHS system management services.

In May 2026, a new Child Health system which had been in development for NHS Scotland over a number of years was deployed across all NHS boards. This system replaces the full set of roles and functions of SIRS as described above (as well as supporting various childhood screening and health checks), and is managed and used by the same clinical and administrative teams in NHS boards as SIRS. All of the records held in SIRS have been migrated into the new system in order to ensure continuity of data and care.

While SIRS operated, PHS received quarterly data extracts from it, primarily to produce national intelligence on immunisation uptake across child and school immunisation programmes. As part of this process, validation and quality assurance checks are undertaken to ensure the data are robust for reporting and analysis. These systems and processes are being adapted with the introduction of the new Child Health system, with the intention to ensure continuity of existing reporting formats and frequency, while improving monitoring/surveillance and strengthening their utility for service delivery and responsiveness by enabling more real-time data availability. Reports and analyses of uptake, incorporating geographical and demographic variables including Scottish Index of Multiple Deprivation (SIMD) and ethnicity, are published via PHS webpages, public-facing dashboards, and NHS service management platforms.

In addition to being recorded on SIRS, childhood influenza immunisation events are recorded separately via the Vaccine Management Tool (VMT), with data accessed nationally through the National Clinical Data Store (NCDS). These systems were developed for the COVID-19 vaccination programme and have since been extended to routine adult and selected other vaccinations. A national programme of digital vaccination system development has been initiated via SVIP and SG to improve integration and data sharing between the various separate platforms on which vaccination records are currently held (Child Health, VMT/NCDS, GP and Maternity records systems).

Teenage immunisations are primarily delivered in schools at scheduled times during the academic year and recorded on SIRS / the new Child Health system, with denominator data

obtained from the Child Health Surveillance Programme for School (CHSP School) system. Influenza immunisations are also recorded using the VMT and data accessed via the NCDS. Consent for vaccinations delivered in school is routinely obtained prior to immunisation using a paper based process, and there is currently no national digital system to capture and manage consent. A move towards digital consent is currently being progressed via SVIP in order to reduce barriers to vaccination and provide flexibility for service users.

Following some sharing of local best practice around consent at a national School Immunisation Peer Network meeting, national partners have co-produced a number of outputs to support local teams. Workforce education colleagues in PSD Scotland ran an online webinar on consent in young people. This included speakers from PHS, PSD Scotland and the NHS Central Legal Office, and raised awareness about the legalities relating to self-consent by young people and national resources available to support this ([Immunisation consent for young people | NHS inform](#)). PHS have also produced a self-consent checklist to support vaccinators delivering school-based programmes across Scotland.

PHS publishes childhood immunisation uptake statistics on a quarterly and annual basis both on the PHS Vaccination Surveillance dashboard and accompanying PHS reports with national, health board and local authority trends, and breakdowns by deprivation, ethnicity, and urban-rurality. Similarly, teenage coverage statistics are published annually, and influenza uptake statistics published at regular intervals through the winter season.

Bimonthly online liaison calls between individual territorial NHS boards and the PHS team provide regular opportunities to focus on different topic areas and discuss local data and operational issues, as well as further strengthening relationships. The annual SVIP conference also provides an opportunity to reflect on national trends and inequalities in vaccine preventable disease epidemiology and vaccine uptake / coverage statistics across the life course.

More granular data are made available to NHS boards via Discovery, a secure platform, to support local situational awareness and service improvement. Improvements and developments to this system are ongoing, e.g. expanding the suite of equalities breakdowns in addition to ethnicity, deprivation, age, sex, urban-rurality, and exploring other protected characteristics and inequality areas such as learning disabilities, and uptake in different settings and populations such as prisons and homelessness.

Work is currently being undertaken to develop a data and intelligence framework that will outline current and future SVIP requirements, aligning with [Scotland's 5-year Vaccination and Immunisation Framework and Delivery Plan - Publications - Public Health Scotland](#). In addition, indicators are being developed so that progress towards the ambitions set out in the 5 Year Framework can be monitored.

10. How are the vaccination workforce and the wider healthcare workforce in Scotland trained and supported to answer patients' questions about vaccination and to build trust? What are the Scottish Government and Public Health Scotland doing to improve training and support?

NHS Education for Scotland (NES) recently merged with NHS National Services Scotland to form Public Services Delivery (PSD) Scotland. They work with Public Health Scotland to jointly develop, distribute, and review vaccination workforce education resources and educational development opportunities with the objective of maintaining a skilled and knowledgeable workforce able to implement vaccination programmes. These resources are made freely available to all health and social care staff on the PSD Scotland learning platform [Turas Learn](#), and include eLearning, slides for independent or facilitated learning, animations, and posters. They cover core generic learning, vaccine specific learning, and supporting resources.

The '[Promoting Effective Immunisation Practice](#)' programme comprises 12 units aligned to the UKHSA national minimum standards and core curriculum for immunisation training. Tailored programmes are available for both registered healthcare professionals and healthcare support workers. Participants are supported by a mentor during the programme and produce a portfolio which is assessed.

Vaccine specific learning resources are available for the majority of vaccines offered on the UK national schedule, and some non-routine vaccines e.g. those delivered in sexual health services. Supporting resources include vaccine administration techniques, vaccination in pregnancy, and vaccinating children and young people including those with additional needs. A vaccinator career development framework to support the education, development, and progression of the vaccination workforce across Scotland is in development.

As a core member of SVIP, PSD Scotland shares the commitment to increase levels of vaccine uptake, following declines in recent years, and to address inequitable coverage. Ongoing renewal of training and education materials is supported by a dedicated SVIP Workforce Education, Development and Training Subgroup.

These provisions demonstrate recognition of the important role that healthcare workers can play in building trust in vaccination programmes. Healthcare workers in vaccination services and throughout the NHS need to be confident in their responses to questions and concerns raised by service users, informed by evidence-backed research and information, and provide appropriate encouragement and signposting to support those who are eligible to take up the offer of immunisation. In support of this, Vaccination Conversations Workforce Education Development resources have been developed with the objective of supporting healthcare workers in having these conversations with members of the public.

11. How do the Scottish Government and Public Health Scotland work with the UK and other devolved governments and public health agencies to improve childhood vaccination rates and reduce disparities? How could collaboration be strengthened?

The Scottish Government's vaccination policy leads and Chief Medical Officer, and SVIP's Senior Responsible Officer, regularly meet their UK counterparts via standing meetings and forums to share updates and to coordinate planning of vaccination programme strategy and delivery across the four nations. PHS vaccination specialists also maintain close professional relationships and dialogue with colleagues at the UKHSA and their equivalents in Northern Ireland and Wales in order to support effective UK-level coordination and development.

Additionally, senior PHS staff participated in the Forum of UK public health agencies convened by UKHSA in December 2023 following a request from the Joint Committee on Vaccination and Immunisation (JCVI) to explore factors that may be contributing to the continuing declining trends in immunisation uptake together with increasing inequalities over the last decade. This Forum provided the opportunity for the respective public health agencies UK to consider the factors which impact on immunisation programme delivery and uptake and enabled consensus to be developed on the main challenges (see above).

While individual actions within each nation are tailored to their individual systems and governance structures, a range of activity covering national and UK-wide deliverables congruent with wider actions and/or implementation plans within individual nations, was captured by the UK Forum. Activities to implement deliverables set out in the Forum's final report commenced in 2024, including through a small number of working groups (attitudinal and data) which have been established to continue the four nations collaboration and sharing of good practice in these high priority areas of work. In Scotland, SVIP is responsible for building on this work to consider and incorporate UK-level deliverables within its implementation, monitoring and improvement arrangements as appropriate, aligned to the 5 Year Vaccination and Immunisation Framework and Delivery Plan, and to associated NHS and population health plans.

Conclusion

There is widespread recognition within the Scottish Vaccination and Immunisation Programme (SVIP) and its constituent partners, including Scottish Government and NHS Scotland, that long-term declines and widening inequalities in childhood vaccination uptake represent a significant challenge to population health and to Scotland's renewed preventative health agenda. These trends are observed across the UK and internationally, and reflect a complex array of factors including the global proliferation of false health information, growing health service demand and resource pressures, and wider socioeconomic conditions.

The establishment and updating of national vaccination programmes governance and leadership arrangements formed by SVIP, together with development of core national strategic plans – specifically the 5 Year Vaccination and Immunisation Framework and Delivery Plan, and the linked wider NHS reform programme – provide a strong foundation for the work necessary to apply learning from the UK Forum and other evidence to further stabilise and begin to reverse prevailing trends. Scottish Government, PHS, NHS boards and wider partners are committed to building and sustaining the energetic whole-system leadership which will be crucial to realising this shared ambition and vision.