

Vaccination

Annual Report

2024-25



Table of Contents

1. EXECUTIVE SUMMARY	8
2. INTRODUCTION	10
3. WHY VACCINATION IS IMPORTANT AS PART OF POPULATION HEALTH .	13
4. NATIONAL AND LOCAL CONTEXT – IMMUNISATION PROGRAMMES	15
4.1. NATIONAL	15
4.2. LOCAL	16
4.3. FINANCE	16
4.3.1 SVIP	17
4.3.2 PCIF	17
4.3.3 HEALTH BOARD BASELINE/CORE BUDGET	19
4.3.4 VACCINE SUPPLY COSTS	19
4.3.5 OTHER CONSIDERATIONS	19
5. VACCINE PREVENTABLE DISEASES	21
5.1. CHOLERA.....	21
5.2. COVID-19.....	21
5.3. DIPHTHERIA	24
5.4. GONORRHOEA.....	24
5.5. HAEMOPHILUS INFLUENZA TYPE B (HIB)	24
5.6. HEPATITIS A	25
5.7. HEPATITIS B	25
5.8. HUMAN PAPILLOMA VIRUS (HPV)	26
5.9. INFLUENZA	27
5.10. MEASLES.....	28
5.11. MENINGOCOCCAL DISEASE (MEN B).....	29
5.12. MPOX	31
5.13. MUMPS	32
5.14. PERTUSSIS (WHOOPING COUGH).....	32
5.15. PNEUMOCOCCAL DISEASE.....	33
5.16. POLIO.....	34
5.17. RABIES.....	34
5.18. RESPIRATORY SYNCYTIAL VIRUS (RSV).....	35
5.19. ROTAVIRUS.....	35
5.20. RUBELLA	36
5.21. SHINGLES.....	37

5.22.	TETANUS	37
5.23.	TUBERCULOSIS	38
5.24.	TYPHOID	39
5.25.	VARICELLA	39
6.	VACCINE UPTAKE	40
6.1.	PREGNANCY	41
6.1.1	PERTUSSIS	41
6.1.2	FLU AND COVID-19 PROGRAMME	42
6.1.3	RSV	42
6.2	CHILDHOOD ROUTINE IMMUNISATIONS.....	44
6.2.1	IMMUNISATIONS UP TO 12 MONTHS OF AGE	44
6.2.2	IMMUNISATIONS UP TO 24 MONTHS OF AGE	46
6.2.3	IMMUNISATIONS UP TO FIVE YEARS OF AGE	47
6.2.4	IMMUNISATIONS UP TO SIX YEARS OF AGE	49
6.3	UPTAKE AND COVERAGE OF SCHOOL-BASED IMMUNISATION PROGRAMMES.....	51
6.3.1	HUMAN PAPILLOMA VIRUS (HPV)	51
6.3.2	VACCINATION WITH TD, IPV AND MEN ACWY	52
6.4	UPTAKE AND COVERAGE IN ADULT IMMUNISATION PROGRAMMES	53
6.4.1	SHINGLES	53
6.4.2	PNEUMOCOCCAL.....	55
6.4.3	OLDER ADULT RSV	57
6.5	UPTAKE AND COVERAGE IN SEASONAL IMMUNISATION PROGRAMMES.....	59
6.5.1	AUTUMN WINTER 2024 / 25	59
6.5.2	SPRING 2025.....	69
6.6	UPTAKE AND DELIVERY OF OTHER SELECTIVE AND NON- ROUTINE VACCINES.....	72
6.7	POST EXPOSURE TREATMENT OF INFECTIOUS DISEASE.....	73
6.8	BABIES BORN TO MOTHERS WITH HEPATITIS B.....	73
6.9	BCG FOR NEWBORNS AT RISK OF TUBERCULOSIS	74
6.10	VACCINATIONS DELIVERED IN SEXUAL HEALTH CLINICS	74
6.11	VACCINATIONS DELIVERED IN OCCUPATIONAL HEALTH SERVICES	75
6.12	TRAVEL HEALTH.....	76
7	EQUITY IN GRAMPIAN.....	78

7.1	HOME SCHOOLED CHILDREN	78
7.2	EQUITY AUDIT	80
7.3	OTHER EQUITY WORK	81
7.3.1	Moray.....	81
7.3.2	Aberdeenshire	82
7.3.3	Aberdeen City	82
8	QUALITY IMPROVEMENT AND SAFETY IN VACCINATION	85
8.1	PRIORITIES FOR IMPROVEMENT NOT MENTIONED ELSEWHERE	85
8.1.1	DIGITAL IMPROVEMENTS TO NON-ROUTINE PATHWAY/ TETANUS POST EXPOSURE PATHWAY	85
8.1.2	DETAILED RISK ASSESSMENT AND MITIGATIONS OF LOCAL MANUAL APPOINTMENT SYSTEMS.....	85
8.1.3	HSCP BIENNIAL REPORTS TO VACCINATION PROGRAMME BOARD	85
8.1.4	REVIEW OF VACCINATION SCHEDULING STRATEGY ACROSS GRAMPIAN.....	86
8.1.5	EVALUATION OF STAFF FLU VACCINATION OFFER	86
8.1.6	MEDICAL STUDENTS ON VACCINATION PLACEMENTS	86
8.2	RISK MONITORING	87
9	SPOTLIGHTS	88
9.1	SPOTLIGHT SCHOOLS	88
9.1.1	ABERDEEN CITY PILOT.....	88
9.1.2	PARTNERSHIP WORKING IN MORAY	88
9.2	SPOTLIGHT TRAVEL HEALTH.....	89
9.3	SPOTLIGHT: GREENING OF VACCINATION SERVICES	93
10	PLANNED CHANGES AND HORIZON SCANNING FOR PROGRAMME.....	95
11	GENERAL PRACTICE DELIVERY.....	97
11.1	WHY GENERAL PRACTICES DON'T DELIVER VACCINES ANYMORE 97	
11.2	THE ROLE OF GENERAL PRACTICE IN VACCINATIONS IN 2026	97
12	CONCLUSIONS	100
13	ACKNOWLEDGEMENTS.....	101
14	FEEDBACK	102
15	REFERENCES.....	103
16	APPENDICES	105
16.1	APPENDIX A – COHORT BREAKDOWNS	105

16.2 APPENDIX B - DIRECTIONS COVER LETTER..... 106

Abbreviations

ADP	Annual Delivery Plan
AMR	Antimicrobial resistance
CMO	Chief Medical Officer (for Scotland)
DPH	Director of Public Health
FVCV	Flu Vaccine and Covid-19 Vaccine
GBMSM	Gay, Bisexual and Men who have sex with Men
GREC	Grampian Regional Equality Council
GVIP	Grampian Vaccination and Immunisation Programme
HSCP	Health and Social Care Partnership
HV	Health Visitor
IJB	Integrated Joint Board
JCVI	Joint Committee on Vaccinations and Immunisation
MSM	Men who have Sex with Men
NHSG	NHS Grampian
PAG	Preliminary Assessment Group
PHS	Public Health Scotland
SG	Scottish Government
SIMD	Scottish Index of Multiple Deprivation
SIRS	Scottish Immunisation & Recall System
SLWG	Short Life Working Group
SVIP	Scottish Vaccination and Immunisation Programme
VMT	Vaccination Management Tool
VTP	Vaccination Transformation Programme
WHO	World Health Organisation

Vaccine and disease abbreviations

BCG	Bacillus Calmette-Guerin
DTP	Diphtheria, tetanus, polio
FVCV	Influenza vaccine (Flu) and COVID-19 Vaccine
Hep A	Hepatitis A
Hep B	Hepatitis B
Hib	Haemophilus influenzae type B
HPV	Human Papilloma Virus
IPD	Invasive pneumococcal disease
IPV	Inactivated Polio Virus
MenACWY	Meningococcal groups A, C, W and Y
MenC	Meningitis C
MMR	Measles, Mumps and Rubella
MMRV	Measles, Mumps, Rubella and Varicella
Mpox	Mpox (Previously Monkeypox)
PCIF	Primary Care Improvement Funding
PHF	Population Health Framework
PPV	Pneumococcal Polysaccharide Vaccine
RSV	Respiratory Syncytial Virus
TB	Tuberculosis
Td	Tetanus and Diphtheria vaccine

1. EXECUTIVE SUMMARY

2024–25 was a year of significant progress and sustained pressure for vaccination and immunisation services across NHS Grampian. Despite operating during a period of financial constraint, service redesign, and increasing programme complexity, NHS Grampian continued to deliver high- quality, equitable vaccination services and consistently achieved uptake levels at or above the Scottish average across most programmes.

The introduction of major national changes—including the new RSV programmes for pregnant people and older adults, ongoing enhancements to the childhood schedule, and refinements to COVID- 19 and influenza eligibility—required rapid operational adaptation. NHS Grampian implemented these changes effectively, achieving strong RSV uptake (approximately 10% above national averages) and maintaining high coverage across key childhood vaccines. Pertussis in pregnancy remained particularly strong, and uptake for primary doses at 12 and 24 months remained high across all HSCPs.

Seasonal vaccination delivery remained robust. Uptake among older adults and care home residents continued to exceed national rates, although lower uptake persisted among younger risk groups and certain workforce cohorts, reflecting national trends. Targeted approaches, such as Priority Intervention Hubs and community- based clinics, contributed to improved access for underserved populations.

A new Once- for- Grampian Travel Health service was successfully launched, modernising access, improving consistency of advice, and delivering high levels of user engagement. Significant progress was also made in developing digital referral pathways for non- routine and post- exposure vaccination requests, strengthening clinical governance and standardisation.

The report highlights increasing pressures on the system. Programme expansion without additional national funding, continued reliance on temporary premises—particularly in Moray—ongoing workforce constraints, and the absence of a national integrated vaccination information system all represent material operational risks. Epidemiological pressures also persisted, including an exceptional pertussis surge in 2024, growing TB notifications in early 2025, and rising national measles activity requiring heightened vigilance and continued focus on MMR uptake.

Equity remains a central theme of the programme. Although NHS Grampian performs strongly overall, gaps remain for some ethnic communities, home- schooled children, and residents in areas of greater deprivation and large urban settings. Work continues to strengthen community relationships, improve accessibility, and deliver targeted interventions aligned with the Scottish Vaccination and Immunisation Programme’s 5- Year Strategic Framework.

Despite challenges, NHS Grampian’s vaccination teams have demonstrated resilience, innovation and strong partnership working across the system. The achievements set out in this report reflect a committed workforce and a

well- functioning, adaptable vaccination system that continues to protect the health of people across Aberdeen City, Aberdeenshire and Moray.

2. INTRODUCTION

This is the third Annual Vaccination and Immunisation Report for NHS Grampian. Its purpose is to provide an annual monitoring report of vaccine preventable disease surveillance data, along with uptake data for each vaccine. A commentary is provided to give context for greater understanding of the data and the challenges and quality improvement measures associated with the programme

2024-25 has been another busy year in the vaccination world. The NHS Grampian Vaccination and Immunisation Programme (GVIP) continues to offer a good service and overall exceeds the Scottish average for most populations for most vaccination programmes.

In the Executive summary to Scotland's newly published Population Health Framework¹ 2025-35 we find the following paragraph:

We are under no illusion of the financial pressures we currently face across the public sector and society as a whole, some of which affect the resources available to support individuals and services. We also recognise, however, that unless we make this shift to prevention, the demands on support and services will only increase.

This resonates strongly in NHS Grampian as we find ourselves escalated to Level Four of the NHS Scotland Support and Intervention framework whilst at the same time trying to meet the increasing requirements of the Scottish Vaccination and Immunisation Programme (SVIP) vaccination programme at a time of static funding following baselining.

The Population Health Framework's vision and aim is to live longer, healthier and fulfilling lives whilst improving life expectancy and reducing the life expectancy gap between the most deprived 20% of local areas and the national average. One of the two initial priorities is Embedding prevention in our system and a high-quality comprehensive vaccination programme is at the forefront of the delivery on this priority.

Our contribution to the Population Health Framework is implementation of the 5-year Strategic Framework². This puts equity at the heart of our programme – not as an extra, but in fulfilment of our aim to leave no-one behind³. Because a proportion of our population doesn't come forward for vaccination, we have to put more resource into reaching those individuals, providing more opportunities for explanation and vaccination. Sometimes, that means being available in the right places to talk without an immediate benefit. All of this takes time and resource. It is not enough to make the offer; have it rejected and move on. This will not narrow the life expectancy gap.

¹ [Scotland's Population Health Framework - gov.scot](https://www.gov.scot/publications/population-health-framework-2025-35/pages/1-introduction.aspx)

² [Scotland's 5-year plan - Scottish Vaccination and Immunisation Programme \(SVIP\) - Immunisation, vaccine and preventable disease - Health protection - Population health - Public Health Scotland](https://www.health.scot.nhs.uk/our-work/5-year-plan-scottish-vaccination-and-immunisation-programme-svip-immunisation-vaccine-and-preventable-disease-health-protection-population-health-public-health-scotland)

³ Plan for the Future NHS Grampian [Plan For The Future](#) Accessed 03/12/2025

Like many population based primary prevention interventions, vaccination is excellent value for money. The Population Health Framework cites a return on investment of £34 for every £1 spent. In NHS Grampian, our overall vaccination rates for most programmes are good. However, throughout the region we have pockets where uptake is less good. These may be related to deprivation or particular ethnic communities or transport links.

In August 2024 Scotland commenced delivery on the Respiratory syncytial virus (RSV) vaccination programme, which provided protection to older adults and to infants via a maternal vaccination programme. Despite being brought in very rapidly with little time for familiarisation within the population, national evaluation of these programmes have already shown success in reducing hospitalisations due to RSV infections by 62% in adults⁴ and 80% in children under 1⁵. These results are excellent and will provide relief to the system during the Autumn- Winter period. Of note, the decision by SG to implement RSV vaccination as a campaign rather than a year long programme linked to birth dates (the English model) is part of the reason behind the success of the programme and also the existence of the rapid evaluation. Following these excellent results the RSV programme will be expanded for 2026 to include those aged over 80 years. Vaccination works, and the more we improve our uptake rates, the greater the benefit to individuals and to our health care system.

2024-25 was the year that the SVIP budget was baselined. Unfortunately, it also became the first year that no additional funding was available for new vaccination programmes. In practice this means that costs for delivery of the new RSV vaccination were absorbed by the programme and that changes to the child health programme for 2025-26 which require an additional 18 month appointment will also have to be absorbed by Health Boards as well as the proposed Measles, Mumps, Rubella, Varicella (MMRV) catch up programme. Funding for vaccination programmes is complex and there is a new section in this year's report to explain this further.

Early in 2025 the new travel health service was launched as a once for Grampian initiative. It is an innovative model aimed to signpost individuals to the service they need. More information can be found in the Travel health section later in the report. Travel health diseases are now included in the vaccine preventable disease section for the first time.

2024-25 was also the year that Moray vaccination service was forced to move premises again. They took over the Southfield site in June 2024 and left again in April 2025 when a lease renewal did not complete at short notice. Moray Council offered a temporary home at Beechbrae Education Centre, for which we thank them. At the time

⁴ PHS Early evidence of population impact of RSV vaccinations on hospitalisations among older adults in Scotland [2025-02-early-evidence-population-impact-rsv-vaccination-hospitalisations-older-adults-scotland-v1.docx](#) accessed 03/12/2025

⁵ PHS Our Blog 01/12/2025 [How the new maternal RSV vaccination prevents serious illness in Scotland: 219 babies and counting - Our blog - Public Health Scotland](#) Accessed on 03/12/2025

of writing the vaccination service does not have a permanent location, although a great deal of work is going into finding a new home.

The Moray vaccination service staff deserve our thanks for their resilience at this time. The opportunity has been taken to better align vaccination clinics with population centres using an “expanded hub and spoke model”. This has moved a greater number of vaccination appointments closer to the eligible populations place of residence and early feedback has found this popular with the population with fewer DNA’d appointments and positive comments to staff about the new locations making it easier to attend. We have a new partner in Forres Mechanics Football Club and thank them for hosting us for the Autumn-Winter vaccination programme.

Finally, the first SVIP vaccination conference was held in June 2025 and NHS Grampian co-hosted an extremely well received workshop about Making Every Opportunity Count (MEOC) in vaccination services.

3. WHY VACCINATION IS IMPORTANT AS PART OF POPULATION HEALTH

The World Health Organisation (WHO) describes vaccines as one of the two public health interventions that have the greatest impact on the world’s health, the other being clean water. It is also considered as one of the most impactful and cost-effective public health interventions available to communities and populations across the world. Vaccination can prevent or reduce the severity of disease, minimise disability and save lives, often in many of the most disadvantaged people in society. It offers excellent value for money by reducing current and future public expenditure on health and social care provision. The European Region of the World Health Organisation (WHO) recommend coverage of 95% in a population is required to control or eliminate disease.

Effective control of vaccine preventable disease requires action across the whole health and care system, and this aligns with the drive to improve outcomes and reduce inequalities.

Surveillance data demonstrate low incidence rates of vaccine preventable disease during 2024 in Grampian apart from a surge in pertussis (whooping cough). These periodic surges occur regularly in this disease, and more details can be found in section 5.14. Many of the vaccine preventable diseases are also notifiable diseases because of their potential to cause harm to public health. The information in table 1 was taken from disease notifications to Public Health Protection Team in 2023.

Antimicrobial resistance (AMR) has been highlighted as a global threat to health as pathogens evolve and become more successful at evading antibiotics causing morbidity and mortality. As vaccines are used prophylactically, they decrease the number of infectious disease cases and reduce antibiotic use and the emergence and spread of AMR⁶. It is expected that the new RSV programme will have a significant effect on antibiotic prescribing.

Table 1: Notifiable organism/ disease controllable by vaccination in Grampian Calendar Year 2023 and 2024

Notifiable Organism / Diseases Controlled by Vaccination in Grampian (2023-2024)		
Infectious Disease	2023	2024
Pertussis	19	1076
Mumps	≤5	12
Rubella	0	0
Measles	0	0
Meningococcal	≤5	≤5
Hepatitis B (Chronic + acute)	58	80
Tuberculosis (active)	28	18
C. diphtheria	0	0
Hepatitis A	≤5	≤5

Source: HP Zone – 10/09/25

⁶ Micoli, F., Bagnoli, F., Rappuoli, R. et al. The role of vaccines in combatting antimicrobial resistance. Nat Rev Microbiol 19, 287–302 (2021). <https://doi.org/10.1038/s41579-020-00506-3>

Apart from Pertussis, Hepatitis B and Tuberculosis (TB) have numerically the highest number of notified cases. There has been a fall in TB and a rise in Hepatitis B cases in 2024. This is likely to be due case finding activities and increased testing. Tuberculosis vaccination is a targeted, risk-based programme, not a population-based vaccination programme. Infection rates are low regionally in comparison to international incidence. Hepatitis B became a population-based programme in October 2017 as part of the childhood programme, and we would predict these numbers to fall as the children grow to adulthood. More information on both programmes is given below.

4. NATIONAL AND LOCAL CONTEXT – IMMUNISATION PROGRAMMES

4.1. NATIONAL

Immunisation policy in Scotland is set by the Scottish Government Health Directorate who take advice from the UK Joint Committee on Vaccinations and Immunisation (JCVI). JCVI provide advice on immunisations for the prevention of infections and/or disease following consideration of evidence on the burden of disease, vaccine safety and efficacy, and on the impact and cost effectiveness of immunisation strategies ⁷. The UK immunisation schedule is continually reviewed and updated.⁸ Immunisation against infectious disease (commonly known as the Green Book)⁹ reflects the current policies and procedures as advised by the JCVI and provides essential guidance on vaccines and vaccination procedures for all vaccine preventable diseases that may occur in the UK.

Scottish Vaccination and Immunisation Programme (SVIP) took over formal responsibility for all aspects of vaccination programmes from 2023. SVIP is a partnership of Scottish Government (SG), Public Health Scotland (PHS) and the fourteen territorial health boards. SVIP incorporates a public health and clinically led, person-centred approach to the programme based on strong collaboration across the system.

It builds on the learning and experience developed from the previous PHS-led Scottish Immunisation Programme (SIP), the previous SG-led Flu and Covid-19 (FVCV Programme) and the Vaccination Transformation Programme (VTP).

Since the adoption of the 2018 GMS contract primary care staff do not deliver vaccinations. Recent SG directions confirm that primary care can only deliver vaccinations at the request of the Health Board in “exceptional circumstances”. However, recent CMO letters in 2024 and 2025 state the ongoing important role of General Practice staff in recording vaccinations into GP records where no data link is possible, promoting and advising on vaccinations; responding to vaccination status enquiries including vaccination histories; and signposting and referring to Immunisation Teams in Health Boards for vaccine delivery.^{10 11}

⁷ [1] Joint Committee on Vaccination and Immunisation Code of Practice, June

⁸ Complete schedule (children & adults) available here: <https://www.gov.uk/government/publications/the-complete-routine-immunisation-schedule>

⁹ Immunisation Against Infectious Disease, Immunisation against infectious disease - GOV.UK (www.gov.uk)

¹⁰ Non-routine vaccination update SGHD/CMO(2024)13 4th July 2024

[Non-routine vaccination update](#)

¹¹

Averting the resurgence of measles in Scotland SGHD/CMO(2023)13 , 2023 16th August 2023

4.2. LOCAL

The Director for Public Health has the accountability and governance oversight for vaccination and immunisation at NHS Grampian Board Level and undertakes the role of executive lead.

Since 2022, NHS Grampian has been responsible for the design and delivery of vaccination services for citizens living in its boundary. The vaccination programme team coordinate vaccination programmes on behalf of the Board and are active participants within the SVIP structure.

The Grampian Vaccination and Immunisation (GVIP) Programme Board (VPB) is chaired by the Director of Public Health with the 3 HSCP Chief Officers, Finance, Primary Care, Nursing and Pharmacy colleagues as members. The Vaccination Programme Board has oversight of the whole vaccination programme, oversees progress, and ensures the nationally agreed outcomes are delivered within Grampian, taking decisions on a Grampian wide basis on complex issues that are common to Grampian or issues which are escalated.

Reporting into the GVIP Programme Board, the GVIP Clinical and Care Governance Group meets monthly to be assured that all appropriate governance arrangements are in place, to identify actions where required and to provide support and advice and share learning across NHS Grampian. This group reviews quality of service delivery, complaints and feedback, adverse events along with the review of the vaccination programme risk register.

Our three Health and Social Care Partnerships (HSCPs) in Aberdeen City, Aberdeenshire, and Moray deliver vaccinations on behalf of the Board. HSCP Chief Officers are accountable to their respective Integrated Joint Boards (IJBs) for their services and are members of the Grampian wide GVIP Programme Board as above.

It is recognised that some functions are better organised once on the bigger NHSG footprint rather than three times on the smaller HSCP footprints. This Once for Grampian approach can be seen in the successful move to a single call centre model and the integrated travel health service.

This has meant local changes in how members of the public access services. In Grampian, vaccinations are administered in a range of settings.

4.3. FINANCE

The funding arrangements for service delivery and vaccine supply are complex and are likely to evolve over time. The funding to support the delivery currently comes from several sources including SVIP, Primary Care Improvement Fund (PCI)F and board baseline budgets. These funding streams are largely historic.

4.3.1 SVIP

This budget was originally given during the expansion of services to meet the challenges of the Covid pandemic and provides the approximately 70% of operating budget. Corporate costs are top-sliced and then the remaining budget is allocated to partnerships each year on a population basis. Each year the allocation is approved at Vaccination Programme Board.

The SVIP budget provided for the new Covid programme and also the expansion in the flu programme. Since then, it has also paid for the MPox vaccination programme, RSV programme and changes to the Shingles programme resulting in a doubling of delivery activity. It has supported the premises costs for vaccination centres, refit of those centres as necessary and utility bills. It has also paid for a number of corporate costs such as transport and distribution, pharmacy staff, infection prevention and control team costs, public health staff and HR and recruitment staff.

The SVIP budget therefore supplies the deficiencies of the PCIF allocation and is a net contributor to the PCIF budget.

Scottish Government is undertaking a review of current funding arrangements with the aim of future streamlining the funding approach across immunisation programmes and providing greater transparency of how vaccination programmes are funded. The SVIP budget is already baselined for 2024-25 and processes have commenced to baseline the PCIF funding.

It is anticipated that this move will help facilitate the flexibilities available and will ease the reporting burden across funding streams. It will continue to engage with Boards via Directors of Finance, Directors of Public Health and Immunisation Coordinators over the course of this financial year to support the transition to greater baselining of funding.

4.3.2 PCIF

As part of the 2018 GMS primary care contract, PCIF funding was awarded to establish the multidisciplinary teams designed to take activity away from primary care so practices could focus on developing specialist generalist services. Vaccination was one of these multidisciplinary teams. Each HSCP provided plans to SG and was awarded an allocation according to their plans. For this reason, there is variation in the amounts each partnership receives for vaccination from this source. This funding was to support the vaccination programmes delivered by primary care at the time of the 2018 contract.

PCIF funding pays a contribution towards vaccination staff. It does not pay for any other business costs of running a service such as premises costs, pharmacy, distribution or corporate services such as programme management, recruitment and HR.

A further source of funding is delivered directly to primary care from SG to pay for the residual functions described in Section 4.1 which are carried out in general practice.

4.3.3 HEALTH BOARD BASELINE/CORE BUDGET

The core budget within NHS Grampian provides funding to HSCP's to support the delivery components of the school aged vaccination programme. In addition, the baseline budget covers the supply of vaccine

4.3.4 VACCINE SUPPLY COSTS

Vaccine cost recharges within NHS Grampian refer to the process of allocating and recovering the expenses associated with vaccine procurement.

There are currently several mechanisms in place to manage these costs due to pricing confidentiality with vaccine manufacturers.

In Grampian, vaccine supply costs are currently managed via board baseline budget, in year allocations from SG based on administration, financial performance returns (FPR's) and invoicing directly to SG from UKHSA.

4.3.5 OTHER CONSIDERATIONS

Management of budgets for delivery of vaccinations sits within the HSCPs. However, the HSCPs deliver on behalf of NHS Grampian, and their chief officers sit of the VPB which agrees strategic direction for the vaccination programmes.

There is more to the delivery of a vaccination programme than needles in arms. Preventative services require more than simply making an offer and then moving on if an individual doesn't take up the offer at the first time of asking. There is the outreach work with vulnerable populations to encourage them to come forward for vaccination. Building trust in communities takes time. Putting on bespoke clinics for underserved populations takes resource and may mean that staff see few residents in those sessions at first. The approach in the 5-year strategic framework incorporated in the Population Health Framework expects this kind of work to be business as usual, not an optional extra or the marker of a platinum service.

Throughout 2024 it has become more apparent that not all the budget allocated to HSCPs for vaccination has been spent on vaccination activity. Staff paid for from vaccination budget lines have been used to deliver CTAC services whilst vaccination budgets have become overspent. Restructuring of staff teams is recommended to align to current and future business needs.

As vaccination programmes continue to expand without additional SVIP funding to support this expansion this situation becomes a risk. Currently, the SVIP budget is used to support those services historically delivered in General Practice and paid for out of the PCIF. If expansion continues without additional funding, it may be necessary for the Health Board and HSCPs to consider how to pay for business expenses previously paid for out of SVIP funding. In the worst-case scenario, it might be

necessary for the Health Board to decide which elements of the vaccination programme it can no longer support.

5. VACCINE PREVENTABLE DISEASES

Data for vaccine preventable diseases are summarised at both a national and Grampian level where data are available. The following section contains background information about the agents, diseases, and vaccinations for reference. Graphs showing Scottish data illustrate the effect of vaccination on vaccine preventable diseases.

5.1. CHOLERA

Cholera is a severe acute gastrointestinal infection caused by the pathogen vibrio cholerae which is found in contaminated or undertreated water. Cholera causes severe watery diarrhoea which can lead to dehydration and death within hours. While cholera has a high attack rate, only around 5% of people will become seriously ill. Children under 5 are at highest risk of developing severe symptoms. As cholera is spread faecal orally it mainly affects areas with little sanitation and water treatment facilities, or in areas of humanitarian or climate crisis (Source: BMJ Best Practice (2024). Cholera; Green book)

The current seventh global cholera pandemic started in 1961, and cholera remains endemic in many countries. In 2022 there were 472,697 cases of cholera across 24 countries and over 2000 reported deaths. In countries with established sanitation and water supplies cases of cholera are extremely rare. In the UK there were 20 cases reported in 2022, all of which were contracted from abroad. There are two oral cholera vaccines licensed in the UK however they are only recommended to the following groups:

- Humanitarian aid workers
- Persons going to areas of cholera outbreak who have limited access to safe water and medical care
- Other travellers to cholera risk areas who are at risk of exposure or serious infection

5.2. COVID-19

COVID-19 is an acute respiratory viral infection caused by SARS-Cov-2 and spread primarily through respiratory droplets and aerosol. The 2020 COVID-19 pandemic resulted in a significant increase in mortality both worldwide and in the United Kingdom, particularly in people aged over 75, and led to several lockdowns and accelerated vaccine development.

Initial national programmes in the UK aimed to offer primary vaccination prioritised by risk category as capacity allowed.

From 2024 JCVI no longer advised COVID 19 vaccination for health and social care workers or care home staff, however they suggested an occupational offer for these groups, which the Scottish Government accepted.

During the recovery phase of the pandemic, a non-standard method of vaccine cost analysis was used in determining eligibility to reflect ongoing uncertainty. This resulted in a wide cohort being offered vaccination. However, post pandemic as the virus has changed, more people have protection following vaccination or infection and we understand more about the benefits of vaccination (e.g. reducing severe disease and hospitalisation, but having limited effect on onward transmission), JCVI has moved to a more business as usual approach, and cost effectiveness analysis is now following the standard model. This has resulted in a reduction in eligible cohorts from 2025/26. The data section in this report therefore includes the at-risk groups in Tables 3 and 4 from the Covid-19 Chapter of the Green Book. Next year's report will reflect these changes and report the smaller cohorts.

For autumn 2024/25 the following groups are eligible:

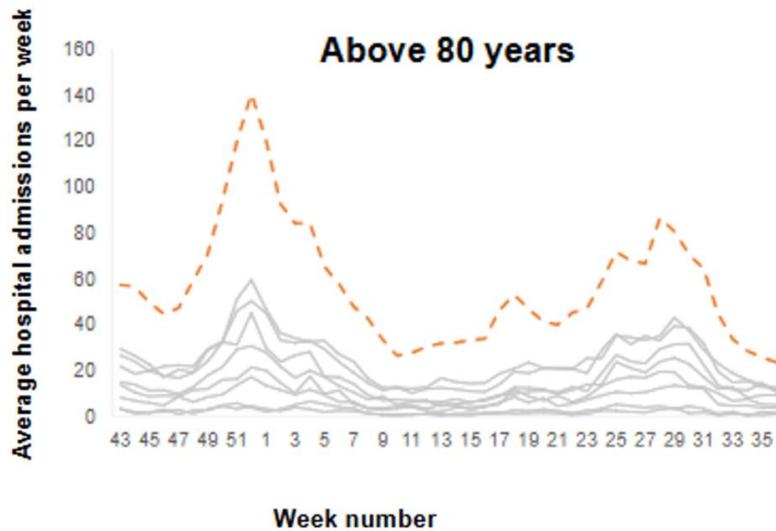
- Residents in a care home for older adults
- All adults aged 65 years and over
- Persons aged 6 months to 64 years in a clinical risk group as defined in Tables 3 and 4 of the Covid-19 Chapter in the Green Book.

For autumn 2025 and spring 2026 the following groups will be offered the vaccine:

- Adults aged 75 and over
- Residents in a care home for older adults
- Individuals ages 6 months and over who are immunosuppressed

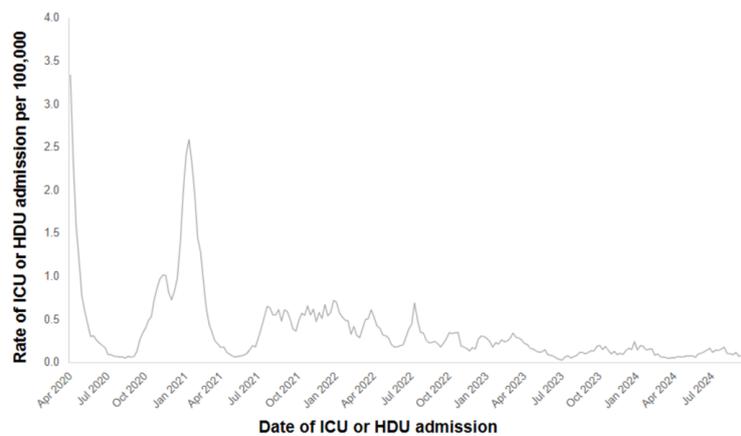
The age at which the vaccine is recommended has increased to 75 and reflects available data, figure 1, which demonstrates that those aged over 80 (orange dotted line), are much more likely to experience hospitalisation than all other age group, grey lines (Source: JCVI statement on COVID-19 vaccination in 2025 and spring 2026 - GOV.UK)

Figure 1: Smoothed-out weekly average of COVID-19 hospital admissions in those aged over 80 in England (October 2023 to September 2024). Grey lines represent all other age groups



Intensive care and high dependency admission rates due to COVID-19 have shown no large seasonal peaks and very low baseline rates since 2023, figure 2. This contrasts to influenza data where there are large seasonal peaks in winter.

Figure 2: Weekly overall COVID-19 ICU or HDU admission rate per 100,000 trust catchment population reported between April 2020 and September 2024 through SARI-Watch mandatory surveillance (England)



5.3. DIPHTHERIA

Diphtheria is caused by *Corynebacterium diphtheriae* and closely related bacteria and classically presents with swollen neck glands and a pseudo membrane in the throat which obstructs the airways or sore throat or pharyngitis in unimmunised or partially immunised individuals. It is now rare in Scotland following the vaccination programme which began in 1941/2. In 1940 there were nearly 16,000 cases in Scotland with 675 deaths.

5.4. GONORRHOEA

Gonorrhoea is caused by the bacteria *Neisseria Gonorrhoeae* and is one of the most common sexually transmitted infections worldwide. It can affect the throat, rectum, urethra and endocervix, and may be asymptomatic or cause purulent discharge and pain when urinating. If left untreated, it can lead to infertility and pelvic inflammatory disease. The immune system is not effective at clearing gonorrhoea and therefore protective immunity does not occur after infection, making re-infection common. Gonorrhoea cases have risen globally, with increasing resistance to antibiotics. Therefore, from August 2025, a targeted opportunistic vaccination campaign has been introduced primarily for gay and bisexual men who have sex with men (GBMSM) diagnosed in sexual health clinic or who report high risk sexual activity. GBMSM have a diagnostic rate 24 times higher than heterosexual men attending sexual health clinics. The vaccine used in this campaign is for *Neisseria Meningitidis*, 4CMenB, which is given as part of the routine childhood immunisation schedule to protect against meningitis. Due to the similarity between the two bacteria, the vaccine can provide some cross cover to protect against gonorrhoea. The vaccine will be offered to high-risk groups and requires two doses at least 4 weeks apart (Source: Green Book).

5.5. HAEMOPHILUS INFLUENZA TYPE B (HIB)

Haemophilus influenzae can cause serious invasive disease, especially in young children. There are six subtypes but prior to vaccination Type B was the dominant subtype. The usual presentation of invasive disease was meningitis with around 10% of children having long term complications of the disease. Cases from Hib have fallen dramatically since the introduction of vaccination. Protection is achieved from 4 doses given in multivalent preparations as part of the childhood programme. (A multivalent preparation is one which provides protection against multiple strains of a disease, or protection against multiple diseases in the same vaccine preparation.)

The Hib/MenC vaccine for infants turning one was discontinued in July 2025. The evidence now suggests that MenC vaccination is no longer necessary and to provide additional coverage for Hib a further dose of the 6 in 1 vaccine will be added to the schedule from 1st January 2026 (Source: CMO Letter).

5.6. HEPATITIS A

Hepatitis A is caused by the Hepatitis A virus and spread through the faecal-oral route. Hepatitis A infection tends to be mild and does not result in chronic infection or liver impairment, though can lead to significant morbidity or mortality in older people and those with hepatic co-morbidities. Given its faecal-oral spread, Hepatitis A is comparatively rare in high-income countries with adequate standards of sanitation and vaccination. At-risk categories include individuals travelling to Hepatitis A-endemic areas; patients with chronic liver disease; patients with haemophilia; men who have sex with men (MSM); people who inject drugs, and individuals with occupational exposure. Several Hepatitis A vaccinations are available – both monovalent and combined with Hepatitis B or Typhoid vaccinations – and these are given either IM or subcutaneously (in the case of haemophilic patients) in two or three doses.

5.7. HEPATITIS B

Hepatitis B is caused by the Hepatitis B virus and spread through exposure to infected blood or bodily fluids. Hepatitis B causes an acute flu-like illness with jaundice and may sometimes lead to complete liver failure. While infection resolves in most patients following the acute illness, chronic infection persists in a proportion of cases. Risk of chronic infection is increased in young people and immunocompromised individuals, and chronic infection can lead to cirrhosis and hepatocellular carcinoma.

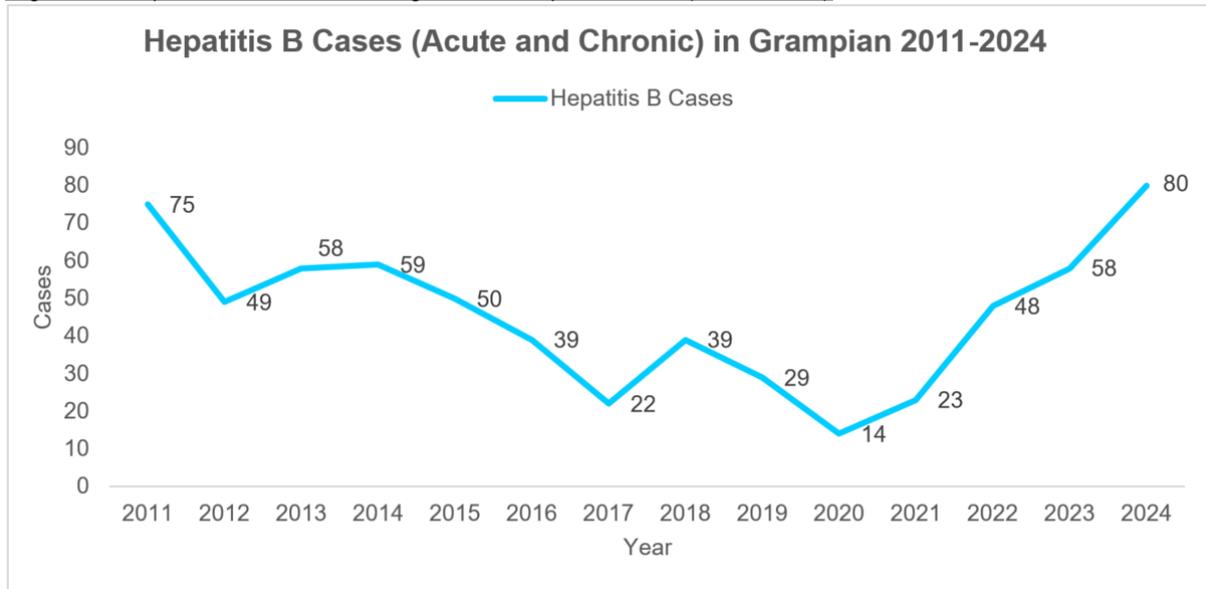
Hepatitis B vaccination is included in the routine childhood immunisation programme.

As of 1st January 2026, an additional 6 in 1 vaccination will be offered at 18 months and will provide an additional dose of the hepatitis B vaccine for all infants. This will reduce the need for infants at increased risk to attend at 1 year (Source: CMO Letter).

At risk categories include neonates with maternal Hepatitis B exposure; travellers to endemic countries; people who inject drugs; MSM; sex 12 workers; close family contacts of individuals with chronic Hepatitis B infection; individuals living in custodial institutions or residential accommodation; individuals with certain renal or hepatic comorbidities, and those at risk of occupational exposure.

Cases of Hepatitis B can be seen in figure 3, reaching a high of 80 during 2024. This likely reflects increased testing for blood borne viruses.

Figure 3: Hepatitis B Cases Throughout Grampian Trend (2011-2024)



Source: HP Zone – 10/09/25

5.8. HUMAN PAPILLOMA VIRUS (HPV)

Vaccination against HPV is part of WHO's global Cervical Cancer Elimination Initiative. There is a causal pathway from infection with particular high risk HPV subtypes and development of squamous cell carcinomas of the cervix, anus, vulva, vagina, penis and head and neck cancers. By vaccinating young people and older people at higher risk, this pathway can be disrupted.

A joint paper¹² from PHS and the Universities of Strathclyde and Edinburgh published online in January 2024 showed that following vaccination, reductions in incidence of cervical cancer are seen for those aged under 18 at the time of vaccination. A great success is that no cervical cancer cases have been detected in fully vaccinated women following HPV immunisation at age 12 and 13 since the programme started in Scotland in 2008. Australian data has shown a similar success with no cancers diagnosed in women aged <25 years in 2021¹³.

5.14. From 1 January 2023, following a review of evidence by JCVI showing one dose conferred similar levels of immunity to two doses, the HPV vaccine moved to a one-dose schedule for immunocompetent individuals before their 25th birthday. 2 doses are required for citizens aged 25 – 45 years in the MSM programme and 3 doses for those who are immunosuppressed or known to be HIV positive.

While the vaccination programme is proving highly successful, the NHS strongly encourages everyone with a cervix to attend cervical screening when they are called, irrespective of vaccination status (Source: Green Book)

¹² Palmer et al [Invasive cervical cancer incidence following bivalent human papillomavirus vaccination: a population-based observational study of age at immunization, dose, and deprivation - PubMed](#) J Natl Cancer Inst 2024 June 7 Accessed 3/12/25

¹³ 2025 Cervical cancer elimination progress report [2025 Cervical Cancer Elimination Progress Report | C4](#) Accessed 03/12/2025

5.9. INFLUENZA

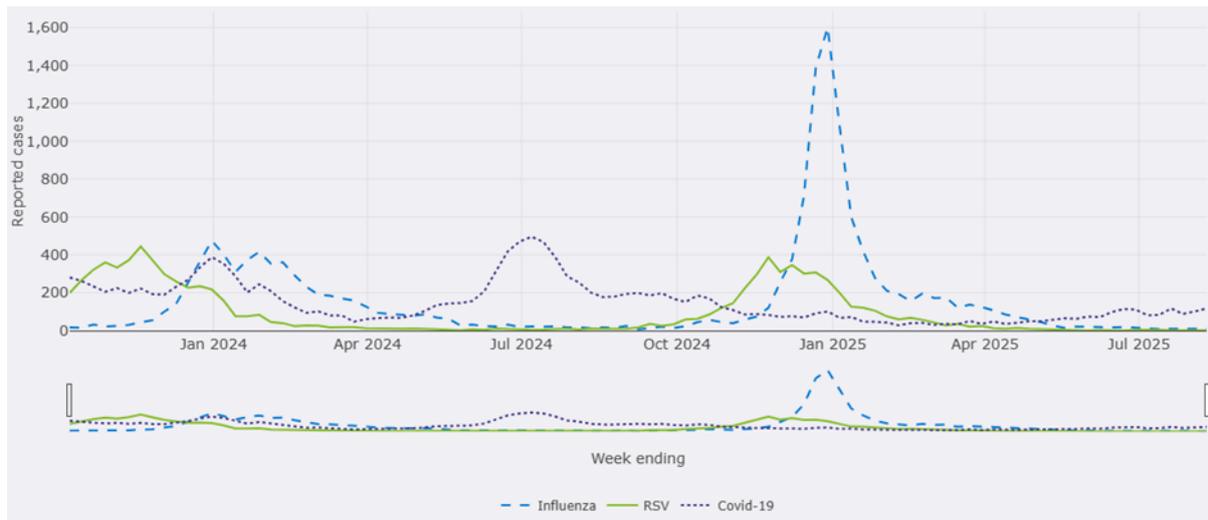
Influenza is an acute viral respiratory infection caused by influenza A, B or C – symptoms include fever, myalgia, malaise, headache and coryzal (common cold) symptoms. Influenza is normally self-limiting in otherwise healthy patients but can lead to significant morbidity in young children, older people, immunocompromised individuals, those with respiratory or cardiac co-morbidities and pregnant women. Influenza is highly seasonal, and a vaccination programme has been in place in the United Kingdom since the late 1960s. Periodic antigenic drift in the virus means that individuals frequently lose immunity between influenza seasons, necessitating at-risk individuals being re-vaccinated each year against likely dominant strains.

The nasal flu vaccine is used in the children's programme because of its superior effectiveness in children leading to reduced cases in children and the community when compared to injectable vaccines.

Bird flu or Avian Influenza is an infectious type of influenza that spreads between birds and occasionally infects humans who have directly handled infected birds alive or dead. It isn't spread easily from human to human. There is a risk that a new strain of flu could be created if an individual is infected with both a strain of bird flu and human flu at the same time and elements from each combine to produce a new strain. If this resulted in a new, more infectious and harmful type of flu there could be an increase in morbidity and mortality. For this reason, poultry workers are advised to be vaccinated against human flu as they are the most likely to be at risk in this circumstance. In a further development, evidence of infection with avian influenza has been found in dairy cattle in the US. The impact of this on bovine (cattle) and human health is under investigation nationally and internationally.

Influenza shows large seasonal variation as seen in figure 4 where cases greatly increase during the winter months. Data from last winter shows a large spike in influenza hospital admissions, especially compared to other respiratory infections (Source: COVID-19 & Respiratory Surveillance).

Figure 4: Number of acute hospital admissions due to COVID-19, influenza and RSV in Scotland



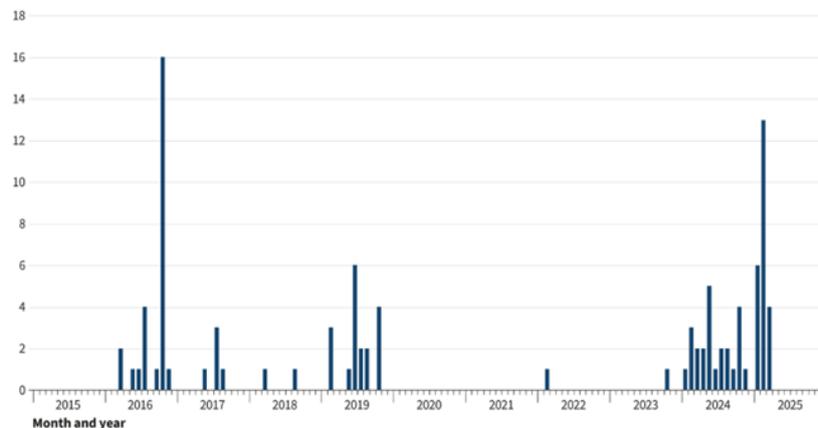
Source:PHS Viral respiratory diseases (including influenza and Covid 19) surveillance in Scotland

5.10. MEASLES

Measles is one of the most transmissible infectious diseases. It can lead to serious and potentially life-threatening complications even years after the original infection. Catching measles when pregnant can result in complications for baby. However, the MMR vaccine, which also provides protection against mumps and rubella, is highly effective - after two doses around 99% of people will be protected against measles.

In last year's annual report, the measles outbreak in England was ongoing. Although cases are now decreasing there were over 2,900 cases of measles in 2024. As of 13th August, there have been 28 laboratory-confirmed measles cases in Scotland compared to 24 in 2024. None of these have occurred in Grampian. See figure 5. In the first quarter of 2025 there were three primary cases of measles, two of which were imported from out with the UK and resulted in a further 12 cases, and five cases not associated with chains of transmission, two of which were associated with foreign travel. Individuals who are not fully immunised are therefore advised to complete a course prior to travel.

Figure 5: Number of laboratory-confirmed cases of measles in Scotland by month and year, 2015 to March 2025



Source: Disease surveillance - Data and surveillance - Measles - Infectious diseases - Health protection - Population health - Public Health Scotland

These increases are consistent with the rest of Europe where 26,222 cases of measles were reported to the European Centre for Disease Prevention and Control between March 2024 and March 2025. Importation of measles from out with the UK and subsequent transmission within unvaccinated groups is a concern and highlights the need for good vaccine coverage. While rare, some fully vaccinated individuals can develop measles however their symptoms are usually milder, and individuals are less infectious. Childhood MMR vaccination rates are generally high in Scotland however uptake has shown some recent decline and within certain population groups these rates are much lower.

In Scotland, measles remains a mainly imported infection however vaccinations rates need to remain consistent in all population groups to prevent transmission.

In line with other changes to the childhood immunisation schedule, the second MMR vaccine has been moved from 3 years 4 months to the new 18-month appointment. (Source: CMO letter)

5.11. MENINGOCOCCAL DISEASE (MEN B)

Meningococcal disease is caused by *Neisseria meningitidis* and has many different groups including B, C, W and Y which are the most common. It is transmitted through air droplets often requiring a prolonged period of contact with an infected individual. Invasive disease can cause meningitis and sepsis with infants under the age of one being most at risk.

Meningococcal B vaccination is given as 3 doses in the first year of life. From July 2025, the second dose of 4CMenB moved from 16 to 12 weeks to provide earlier protection.

The Meningococcal groups A, C, W and Y (Men ACWY) vaccine protects against meningococcal disease caused by four groups of meningococcal bacteria. The Men ACWY vaccine is offered to all young people in S3 at school. Young people in S4 to S6 who missed the opportunity to be immunised the previous year are offered vaccination at subsequent visits.

The Hib/MenC vaccine was previously given to children at 12 months however this was removed from the schedule in July 2025 due to low rates of Men C across all age groups, primary due to the success of the MenACWY vaccination programmes. There have been no deaths in Scotland due to Men C since 2017, figure 6.

Figure 6: Meningococcal Deaths by Serotype reported in Scotland 2005 to 2025 (week 13)

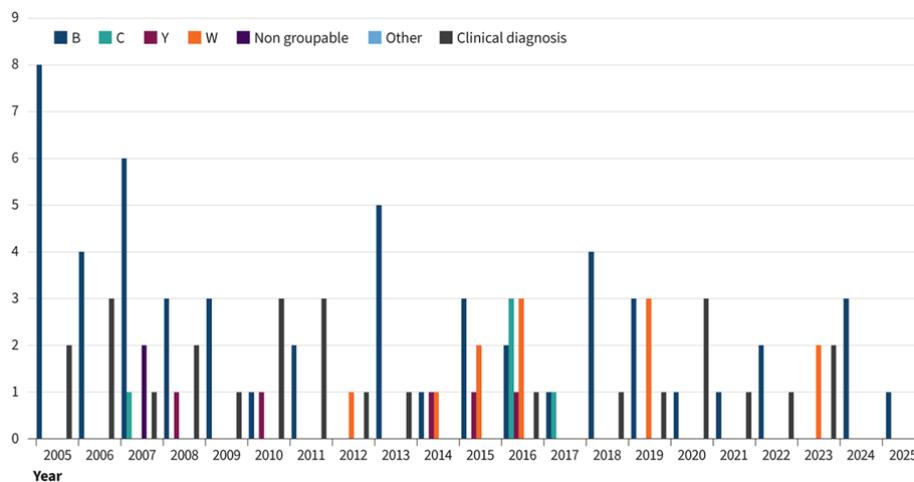


Figure 7: Meningococcal serogroup W by age group reported in Scotland 2009 to 2025 (week 13)

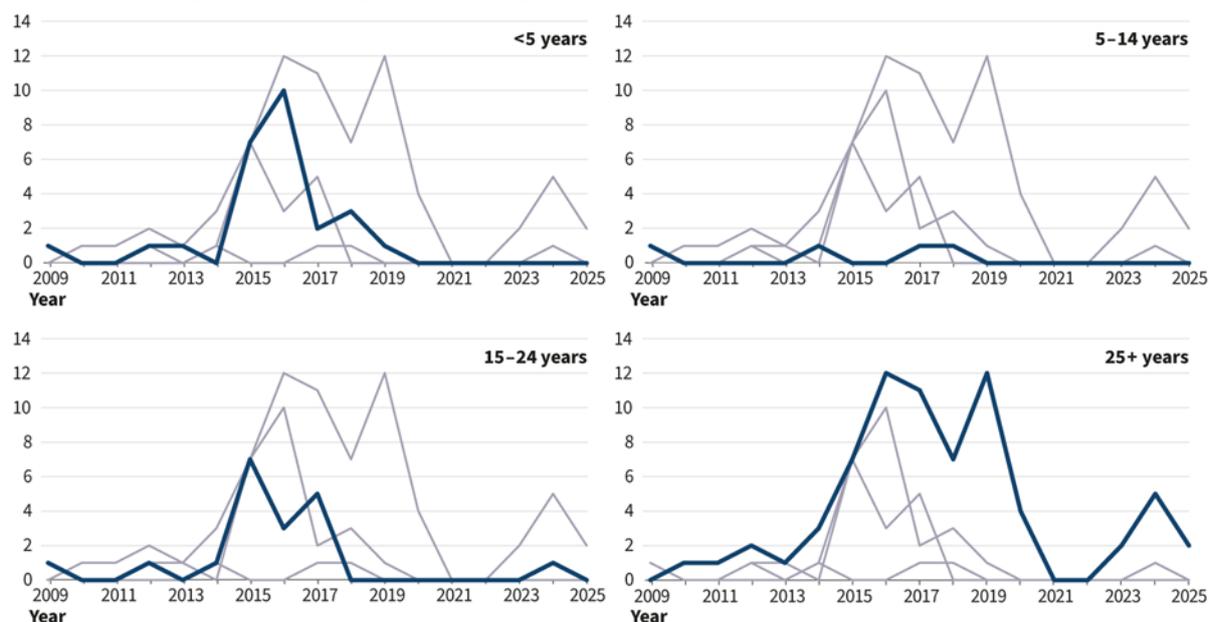


Table 2: Meningococcal cases in Grampian 2012 – 2024

Meningococcal Cases in Grampian 2012-2024												
2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
5	7	6	11	11	7	8	5	≤5	0	≤5	≤5	≤5

Source: HP Zone – 10/09/25

5.12. MPOX

Mpox (previously known as Monkeypox) is a rare viral infection related to Smallpox. It is usually associated with travel to West Africa and has only, until recently, rarely been reported out with this region. Two forms of Mpox are found Clade I (Central African) and Clade II (West African) and Clade 1 was considered a high consequence infectious disease.

While still considered a serious infection for some individuals, following an assessment by the advisory Committee on Dangerous Pathogens (ACDP) clade 1 mpox is no longer classified as a high consequence infectious disease. As outlined by the WHO European Region, national elimination is a country defined as detecting only import related cases and no local animal reservoir. Therefore, the UK's strategic goal is to eliminate person-to-person transmission of mpox.

The Mpox virus is similar to the smallpox virus and the smallpox vaccine gives effective protection against Mpox. The vaccine is given in two doses a minimum of 28 days apart.

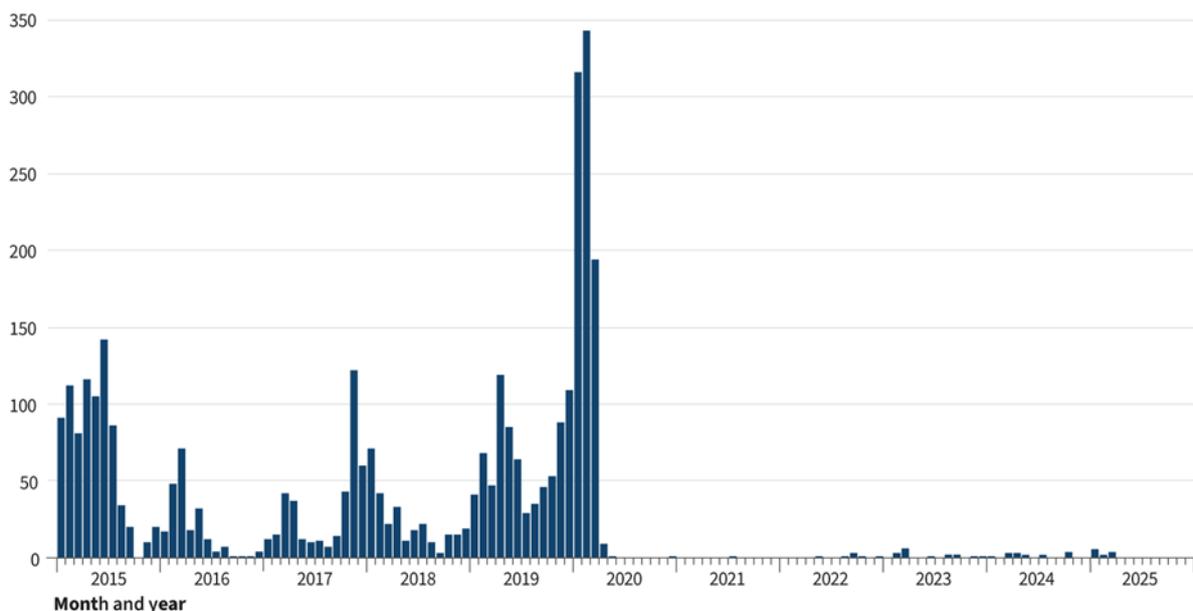
The Mpox vaccine continues to be offered opportunistically to high-risk groups in Grampian. Health and social care workers are at very low risk of exposure to mpox and therefore do not require pre-exposure vaccination (Sources: Current situation - Overview - Mpox - Infectious diseases - Health protection - Population health - Public Health Scotland; Green book – vaccine eligibility).

5.13. MUMPS

Mumps, caused by paramyxovirus, is spread by airborne or droplet transmission and classically causes bilateral parotid swelling, fever, and myalgia. In addition, mumps can cause a variety of significant complications such as meningitis, encephalitis, orchiditis, oophoritis and pancreatitis. These complications, if developed, may be associated with sensorineural hearing loss and subfertility. Vaccination against mumps in the United Kingdom commenced with the introduction of the MMR vaccine in 1988, leading to a significant decrease in the prevalence of mumps in the years following due to high levels of uptake.

The COVID-19 pandemic lockdowns significantly reduced the transmission of mumps, see figure 9. Last year in Grampian there were 12 cases of mumps (Source: Mumps - Results and commentary - Immunisation and vaccine-preventable diseases quarterly report - January to March 2025 (Q1) - Immunisation and vaccine-preventable diseases quarterly report - Publications - Public Health Scotland).

Figure 8: Mumps Transmission (2015-2025)



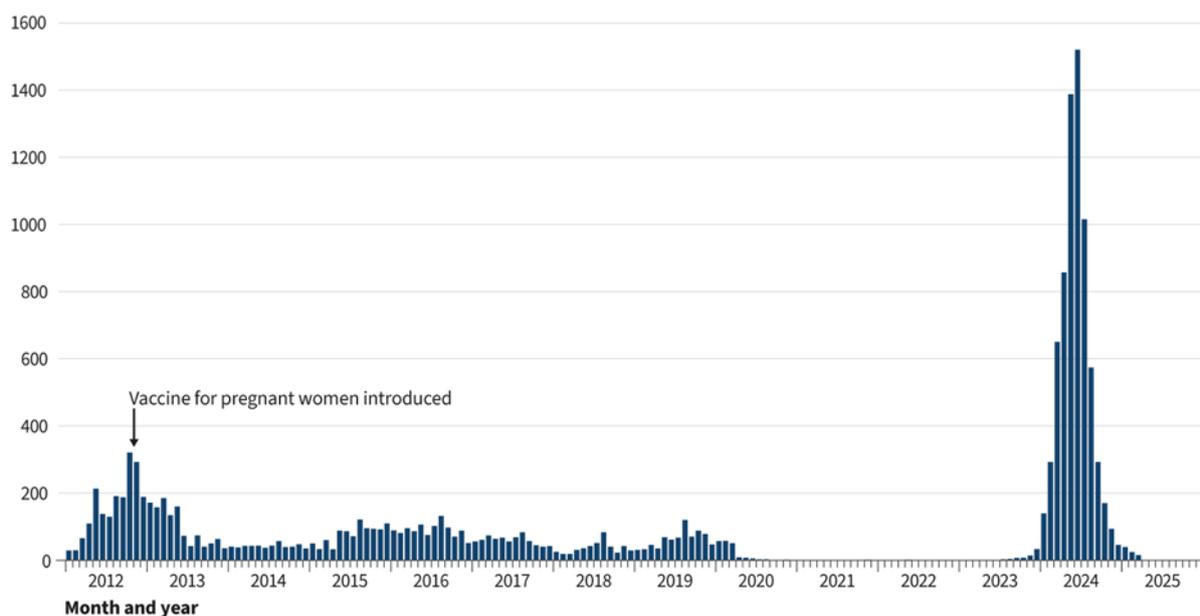
5.14. PERTUSSIS (WHOOPIING COUGH)

Pertussis, or whooping cough, is a highly, infectious bacterial disease affecting the respiratory system. Infants and young children are particularly at risk of severe disease and/or death.

Protection against disease is conferred via vaccination in childhood. From October 2012, pregnant women in Scotland have been offered a pertussis vaccine typically between 16- and 32-weeks' gestation. This is to protect infants in their first eight weeks of life who are too young to receive their routine immunisations and are most at risk of complications from the infection.

As figure 9 shows, last year there was a huge surge in pertussis cases in Scotland, and Grampian reported 1,076 cases. This increase has now settled with a marked 10-fold decrease in Scottish cases in the first quarter of 2025 compared to the same period in 2024. There is annual variation in the number of pertussis cases, and this spike was thought to be a combination of annual variation and decreased natural immunity following isolation during the pandemic (Pertussis - Results and commentary - Immunisation and vaccine-preventable diseases quarterly report - January to March 2025 (Q1) - Immunisation and vaccine-preventable diseases quarterly report - Publications - Public Health Scotland).

Figure 9: Number of Laboratory-confirmed Bordetella Pertussis Cases in Scotland, by month 2012 to March 2025



5.15. PNEUMOCOCCAL DISEASE

Pneumococcal disease can present as non-invasive or invasive infections caused by the bacterium *Streptococcus pneumoniae* (also called pneumococcus). Non-invasive disease includes middle ear infections (otitis media), sinusitis and bronchitis, whilst invasive pneumococcal disease includes septicaemia, pneumonia, and meningitis.

Young children, the elderly and people in a clinical risk group are most at risk of severe pneumococcal disease, and so all these groups are currently offered a pneumococcal immunisation.

People aged 65 or over only need a single dose of the vaccine. However, those with certain underlying health conditions require additional doses every 5 years. Children with health conditions may require additional doses.

The pneumococcal conjugate vaccine covering 20 types of pneumococcus will replace the existing vaccine for adults over 65 in 2026. It was found to reduce mortality and hospital admissions and be more cost effective (Source: Green book; Cost-

effectiveness of using a 20-valent pneumococcal conjugate vaccine to directly protect adults in England at elevated risk of pneumococcal disease – PubMed).

5.16. POLIO

Poliomyelitis is now rare in the UK following national vaccination programmes. It is an acute illness caused by the poliovirus entering the body through the gut and giving rise to a range of symptoms from gastrointestinal disturbance, fever and paralysis. During UK epidemics in the 1950s up to 8000 notifications of paralytic polio were received in a year. 4 doses via the 6 in 1 vaccine are offered during the childhood programme, with a booster dose delivered at age 14 (S3). Pre-travel vaccination assessment is advised for high risk areas.

5.17. RABIES

Rabies is a virus caused by the rabies virus genotype 1 or less commonly by rabies related lyssaviruses. Rabies leads to acute infection of the central nervous system called encephalomyelitis. It causes headache, fever and laterally hallucinations and coma. Rabies is almost always fatal. Infection usually occurs following a bite or scratch from an infected animal, most commonly a dog or bat. It can also occur if mucous membranes are in contact with infected saliva, such as an infected animal licking a wound or mouth.

In Asia, Africa, Central and South America, rabies is endemic in feral, and less frequently domestic, dogs. Global mortality from rabies is estimated to be around 59,000 people each year, mainly in Asia and Africa. Although the UK is rabies free, certain bat species still carry the infection.

Prior to travel to a rabies endemic country, it is recommended to seek advice from a travel clinic about receiving the rabies vaccination. Pre-exposure immunisation is given in three doses on days 0, 7, and 28. If you plan to travel sooner an accelerated course can be given.

Non travellers, including animal control workers and veterinary staff, with occupational exposure to rabies enzootic areas are also recommended to receive pre-exposure vaccination. This will be offered on the NHS to volunteer bat handlers.

It is important that if exposure does occur, a further risk assessment is carried out without delay as the vaccine does not offer full protection. The exposed site should be washed out with soap and water and further post exposure vaccination and immunoglobulins may be required depending on the exposure (Source: Green Book).

Sadly, it was reported this year that a returned traveller died in the UK from rabies infection following contact with a stray dog in Morocco. Cases of rabies in the UK are extremely rare; between 2000 and 2024 there were 6 cases of human rabies associated with animal exposures abroad. Prior to travel it is important to seek advice regarding rabies vaccination and if exposed a prompt course of rabies treatment is extremely effective at preventing the disease (Source: Rabies case confirmed following contact with animal abroad - GOV.UK).

5.18. RESPIRATORY SYNCYTIAL VIRUS (RSV)

RSV is one of the common respiratory viruses circulating every autumn in the UK. Globally up to 90% of children are infected by the age of 2. RSV epidemics tend to start in October and go on for 4-5 months, peaking in December. The time between contact with an infected person and developing symptoms is 3-5 days. RSV is spread via coughs and sneezes in large droplets and secretions and can live on surfaces for around 4-7 hours.

For most people RSV is a mild respiratory illness. Sneezing, runny nose, cough and fever are common symptoms with a smaller number of children having ear infections and croup. Infants under the age of one and older adults are at greater risk of more severe disease including wheezing and breathing difficulties. RSV is the most common cause of bronchiolitis in babies and older adults can suffer from pneumonia. Severe cases may require hospitalisation and RSV infection can lead to deaths.

Two highly successful vaccination programmes for RSV commenced in August 2024 in time to protect for the Autumn; one for pregnant women given at 28 weeks' gestation onwards to protect infants and one for older adults aged 75-79. Despite being brought in very rapidly with little time for familiarisation within the population, national evaluation of these programmes have already shown success in reducing hospitalisations due to RSV infections by 62% in adults¹⁴ and 80% in children under 1¹⁵

For very and extremely preterm infants (born before 32 week) the JCVI advises immunoglobulin during or immediately prior to their first RSV season. This is because they are unlikely to be protected by maternal vaccination. This is given by paediatric staff.

5.19. ROTAVIRUS

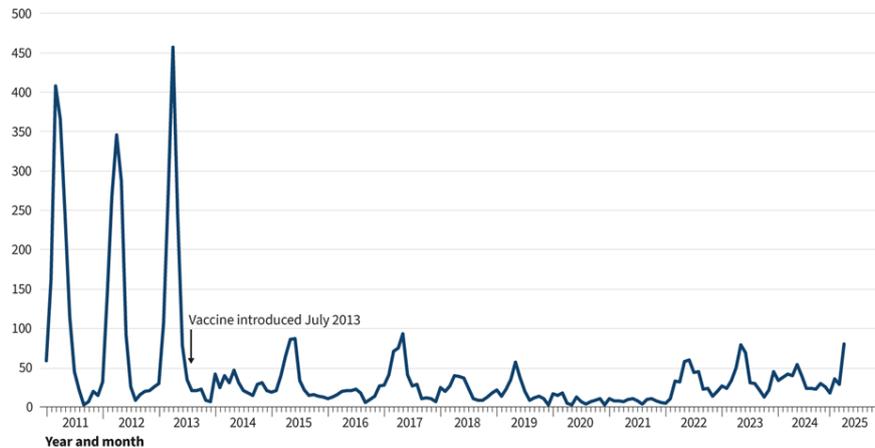
Rotavirus is an extremely infectious cause of gastroenteritis through both the faecal-oral and occasionally respiratory route and can require hospitalisation in severe cases due to dehydration. Incidence follows a seasonal pattern, with most cases in winter and early spring, and most symptomatic cases are in young children. A national infant rotavirus vaccination programme was commenced in Scotland in 2013, leading to a significant reduction in both overall cases and peak incidence in winter. Rotarix, the licensed vaccine for rotavirus, is given orally in two doses at 8 and 12 weeks (Source: Rotavirus - Results and commentary - Immunisation and vaccine-preventable

¹⁴ PHS Early evidence of population impact of RSV vaccinations on hospitalisations among older adults in Scotland [2025-02-early-evidence-population-impact-rsv-vaccination-hospitalisations-older-adults-scotland-v1.docx](#) accessed 03/12/2025

¹⁵ PHS Our Blog 01/12/2025 [How the new maternal RSV vaccination prevents serious illness in Scotland: 219 babies and counting - Our blog - Public Health Scotland](#) Accessed on 03/12/2025

diseases quarterly report - January to March 2025 (Q1) - Immunisation and vaccine-preventable diseases quarterly report - Publications - Public Health Scotland).

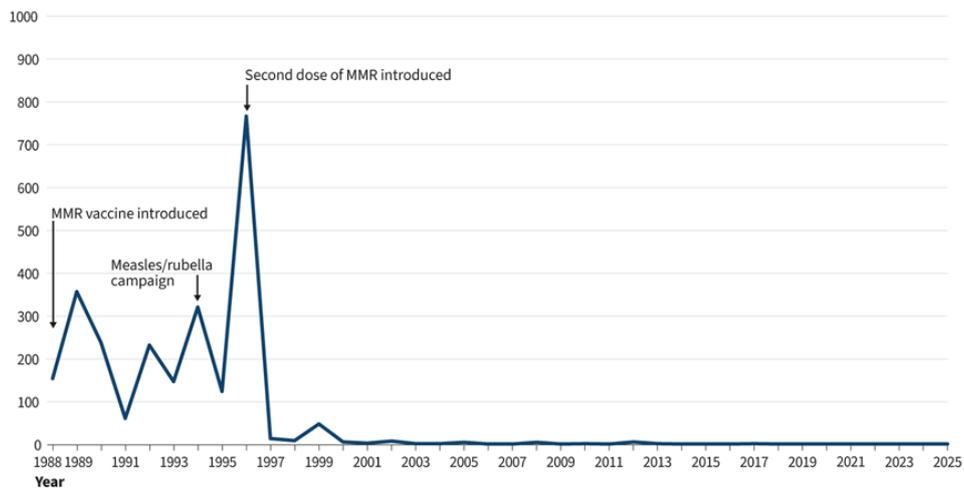
Figure 10: Laboratory reports of rotavirus in Scotland from 2011 to end of March 2025 (week 13)



5.20. RUBELLA

Rubella is a viral illness caused by togavirus and spread by droplet transmission. The symptoms of acute rubella infection tend to be mild and include fever, coryzal symptoms, malaise and rash – though it may be associated with more serious complications such as post-infectious encephalitis and thrombocytopenia. The primary concern regarding rubella is the potential for foetal loss and birth defects in cases of maternal infection in pregnancy. Up to 90% of infants exposed to rubella at 8 to 10 weeks' gestation will develop congenital rubella syndrome. As such, the primary aim of vaccination programmes is to reduce exposure of pregnant women to rubella. Targeted vaccination began in the UK in 1970, and universal vaccination began in 1988 with the introduction of MMR leading to significant decreases in rates of rubella. This is delivered during the childhood programme via the MMR vaccine (Source: Rubella - Results and commentary - Immunisation and vaccine-preventable diseases quarterly report - January to March 2025 (Q1) - Immunisation and vaccine-preventable diseases quarterly report - Publications - Public Health Scotland).

Figure 11: Number of laboratory-confirmed cases of rubella in Scotland by year, 1988 to March 2025 (week 13)



5.21. SHINGLES

Shingles (Herpes zoster) is caused by the reactivation of a latent varicella zoster virus infection, sometimes decades after initial infection. Shingles can occur at any age, with the highest incidence seen in older people. The severity of shingles generally increases with age and can lead to Post Herpetic Neuralgia that may require hospitalisation.

The shingles vaccine programme for older adults was introduced in Scotland in September 2013 following recommendation by JCVI in 2009 and SG policy. From 1st September 2023 the vaccine offered has changed from Zostavax to the non-live vaccine Shingrix requiring a switch from a 1-dose to a 2-dose schedule.

The eligible age for immunocompetent individuals has changed from 70 to 60 years of age for the routine cohort in a phased implementation over a 10-year period. Eligibility also expanded to all those who are severely immunosuppressed aged 50 years and over, with no upper age limit. Further expansions will take place in 2026.

5.22. TETANUS

Tetanus is caused by the release of tetanus toxin during infection with *Clostridium tetani*. It causes symptoms such as fever, muscle spasms, lockjaw, difficulty breathing and swallowing problems. Bacterial spores are commonly present in the environment, including soil. This vaccine is currently given as part of the childhood schedule at 8, 12, 16 weeks and 3 years 4 months.

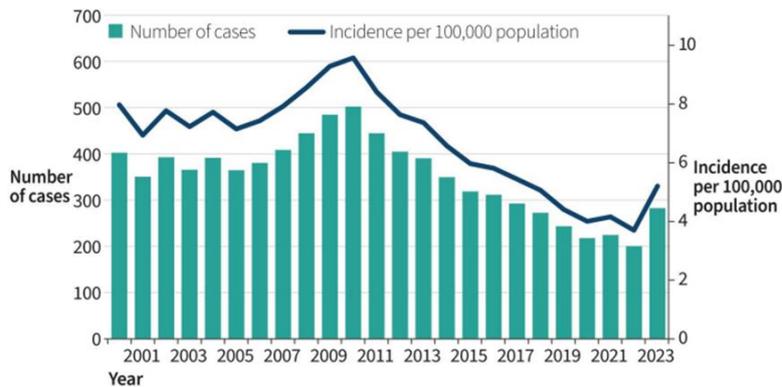
From January 1st 2026, as part of the changes to the children’s schedule an additional dose of 6-in-1 vaccine that includes diphtheria, hepatitis B, polio, tetanus, haemophilus influenzae type B, and pertussis will be given at 18 months (Source: CMO Letter).

5.23. TUBERCULOSIS

BCG immunisation programme was introduced into the UK in 1953 to protect against Tuberculosis (TB), a serious bacterial disease which affects the lungs and other parts of the body including brain, bones, kidneys, and joints. The programme has undergone changes in response to changing trends in TB epidemiology. Following a continued decline in TB incidence in the UK-born population, the universal school-based programme for adolescents was stopped in 2005. The BCG immunisation programme is now risk-based; the key part being a neonatal programme targeted at those children most at risk of exposure to TB, to protect them from the more serious childhood forms of the disease. Babies are offered the vaccine if they or their parents or others close to the baby have lived in an area with high levels of tuberculosis.

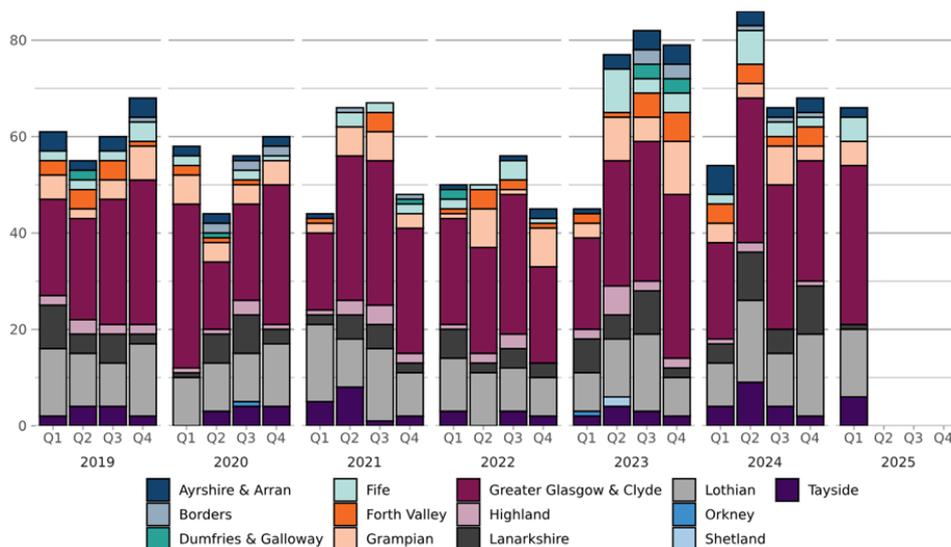
In 2023 the rate of tuberculosis increased in Scotland, mostly in persons born outside of the UK. However, as figure 12 shows there has been a general decline in tuberculosis numbers since 2010. (PHS, 2024)

Figure 12: Number of tuberculosis cases and incidence per 100,000 population in Scotland, 2003-2023



2024 saw a decrease in numbers of TB from 2023 number but cases were still higher than the previous years which showed a decline in cases. In Grampian the number of cases of TB dropped in 2024 to 18 which is a return to the mean for the number of cases between 2019-2022. (HP zone data). The first part of 2025 has seen numbers increase in Scotland when compared to the start of 2024, including within Grampian, figure 13.

Figure 13: Number of TB notifications in Scotland by NHS boards by quarter, January to March 2025



5.24. TYPHOID

Typhoid fever is caused by *Salmonella enterica typhi* and is spread through the faecal-oral route. Typhoid fever varies significantly in severity from isolated gastrointestinal symptoms and fever to multi-organ failure and has a mortality rate of up to 20% if untreated.

Given its faecal-oral spread, typhoid fever is comparatively rare in high-income countries with adequate standards of sanitation. In England, Wales and Northern Ireland there were 645 cases of typhoid in 2023, 97% of these were associated with travel abroad. Pre-travel assessment and vaccination is advised for higher risk areas.

5.25. VARICELLA

Varicella or chickenpox is caused by the virus varicella zoster. It causes a characteristic rash and will affect most people at some point in their lifetime. In most cases the virus affects children under ten and causes mild disease. However, in some groups the infection can be more serious; pregnant women and those who smoke are at the greatest risk. There is no universal varicella vaccine programme in the UK as 90% of adults raised in the UK are immune, having had mild disease as a child.

From January 2026 a new MMRV vaccine will be introduced into the childhood schedule with two doses at 12 months and 18 months. Details for a limited catch up of older children are not available at the time of writing.

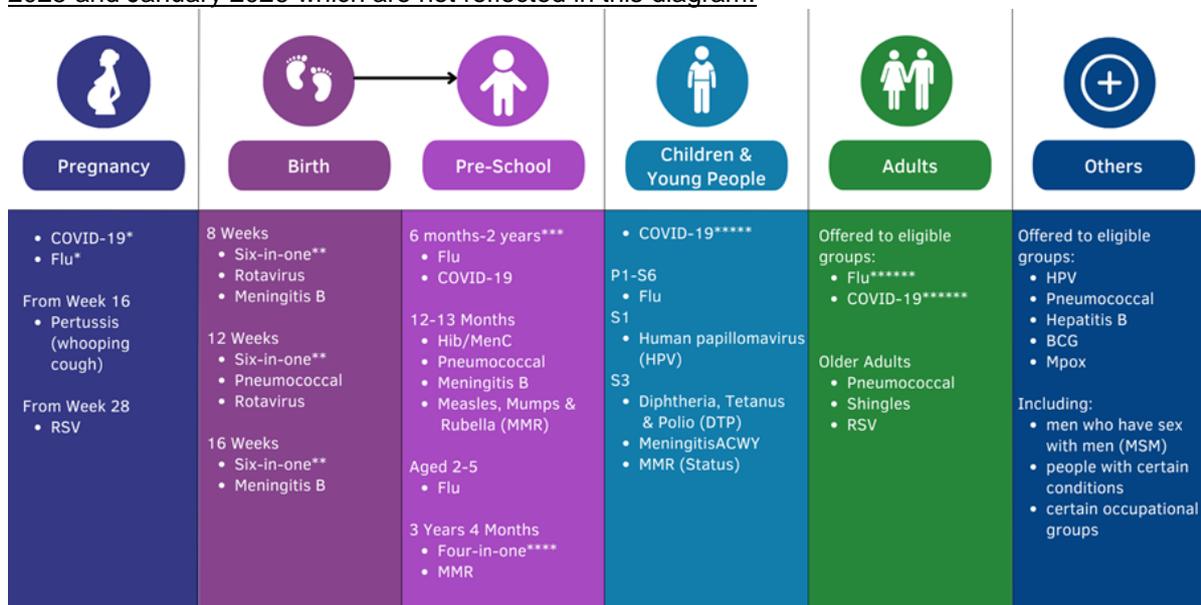
Non-immune individuals with occupational exposure, most commonly healthcare workers, and healthy household contacts of immunocompromised persons are also eligible. Post exposure prophylaxis with VZIG has largely been superseded by post exposure treatment with antiviral agents such as aciclovir except for neonates at high risk because of maternal infection 7 days prior to and after delivery.

6. VACCINE UPTAKE

Vaccination coverage is the percentage of people from the target population who have received a specific vaccine. For very infectious communicable diseases a universal vaccination approach is taken. The risk to public health increases if immunisation rates for these diseases fall below herd immunity levels as this makes the possibility of communicable disease transmission more likely. Less transmissible diseases or those affecting a particular cohort in the population are better suited to a targeted approach.

The Grampian Vaccination and Immunisation Programme is organised into the following work streams, largely mirroring the structure in figure 15 below. Reporting in this chapter follows the order below in Table 3. (Please note this is the schedule prior to the changes made to birth and pre-school schedules in July 25 and January 26.)

Figure 14: Vaccination and Immunisation Work streams: Please note changes to programme in July 2025 and January 2026 which are not reflected in this diagram.



*offered in Winter season **diphtheria, tetanus, pertussis, polio, haemophilus influenzae type b, hepatitis B ***those with an eligible condition offered in Winter season

****diphtheria, tetanus, pertussis, polio *****those with an eligible condition offered in Winter and/or Spring seasons *****eligible adults offered in Winter and/or Spring seasons

Table 3: Reporting Periods

Cohort	Reporting Period
Pregnancy Routine	April 2024 - March 2025
Childhood Routine	July 2024 - June 2025
Teenage Routine	School Year 2023 - 2024 (2024 - 2025 will be realised during November 2025)
Adult Routine	April 2024 - March 2025 & September 2024 - August 2025
Flu and COVID-19	September 2024 - March 2025
Travel Health	September 2024 - August 2025

6.1. PREGNANCY

6.1.1 PERTUSSIS

Across Grampian the pertussis vaccine in pregnancy programme is delivered from 16 weeks' gestation. Midwives have an important role in promoting the vaccine, ensuring pregnant women are informed and administering the vaccine.

During 2024/25, coverage in Grampian from locally held data was 87.2%, shown in Table 4. The data is reported according to NHS Board of delivery and therefore excludes those who chose to receive their maternity care in other Board areas.

Because of different approaches to recording data across Scotland, it is difficult to make a direct comparison with the rest of Scotland, which has an average of 83.3%.

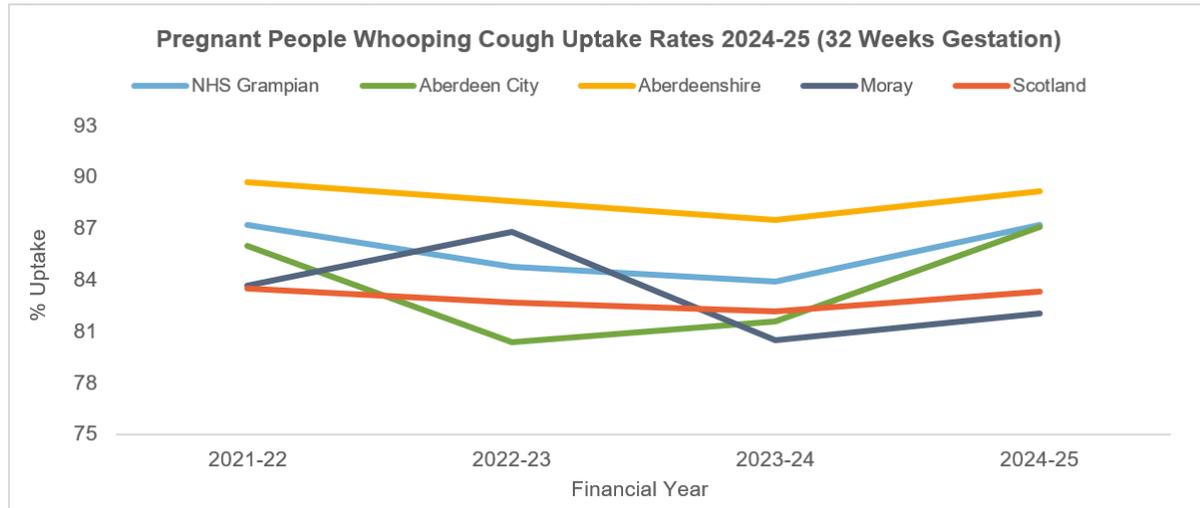
Table 4: Whooping Cough in Pregnancy Uptake Rates in NHS Grampian between April 2024 – March 2025

Pregnant People Whooping Cough Uptake Rates 2024-25			
Location	Population	Vaccinated	Uptake %
NHS Grampian	4,424	3,857	87.2
Aberdeen City	1,886	1,643	87.1
Aberdeenshire	1,841	1,642	89.2
Moray	697	572	82.1
Scotland	44,572	37,130	83.3

Source: Badgernet - 12th September 2025

Figure 15 displays the trend for Pertussis vaccination since 2021-22 and demonstrates high uptake. Since 2021-22, there has been a decline in vaccine uptake throughout Scotland, but uptake significantly improved in the most recent year. This is especially evident in Aberdeen City's increase from 81.6% to 87.1%. Moray has dipped slightly under the Scotland average since 2023-24 but the partnership has begun to produce local communications to improve uptake.

Figure 15: NHS Grampian Pregnant People Whooping Cough Uptake by Financial Year



Data Source: Discovery (2025)

6.1.2 FLU AND COVID-19 PROGRAMME

Pregnant people remained eligible for both Flu and COVID-19 vaccinations up to and including the 2024-25 season, but uptake remained low. NHS Grampian records 6,418 pregnant people during Autumn Winter 2024-25 that were eligible for vaccination (EDD 280 days before 01-09-2024 and 280 days after 31-03-2025). Of the eligible population, 576 (9.0%) individuals came forward for COVID-19 vaccination and 953 (14.8%) had the influenza vaccination.

In NHS Grampian, Influenza and COVID-19 vaccines in pregnancy are given by the vaccination service, not by community midwives as part of antenatal care. These vaccines are part of a seasonal programme and there is insufficient capacity to deliver in maternity services. Pregnant people are given a fast-track pass to drop in to vaccination services as a priority for flu and COVID-19 vaccination

During the summer of 2023, a study was undertaken in Grampian to understand vaccine hesitancy in pregnant women. Several recommendations were identified and implemented including better access to vaccination information for both patients and staff and a fast-track pass to vaccination hubs. Feedback shows midwives feel more supported in their vaccination roles and some barriers to vaccination were reduced. Feedback about the fast-track pass has resulted in changes to the pass itself to make it look more “official”.

In 2024, we worked with midwifery colleagues and a behavioural scientist from University of Aberdeen to try to boost autumn and winter vaccination rates among maternity staff and pregnant people.

6.1.3 RSV

RSV is a common virus which can cause a lung infection called bronchiolitis. In small babies this condition can make it hard to breathe and to feed. Pregnant people throughout Scotland are invited for an RSV vaccine at their 28-week antenatal

appointment as of 1st August 2024. Having the RSV vaccine allows the parent to build a good level of antibodies to pass on to their baby before birth, giving them the best protection. As of 31st July 2025, NHS Grampian’s cohort comprised 4,613 eligible pregnant people (4,084 have since delivered and 529 with ongoing pregnancies), of which 2,772 had the RSV vaccination as shown in table 5.

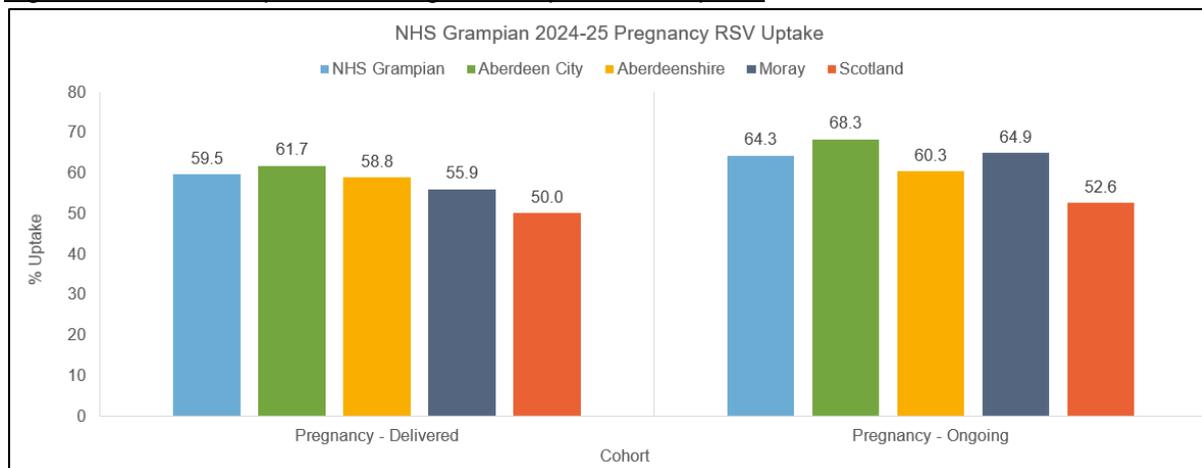
Table 5: NHS Grampian RSV Pregnant People Cohort

Cohort	Population	Vaccinations	NHS Grampian
Pregnancy - Delivered	4,084	2,432	59.5
Pregnancy - Ongoing	529	340	64.3

Data Source: Discovery (2025)

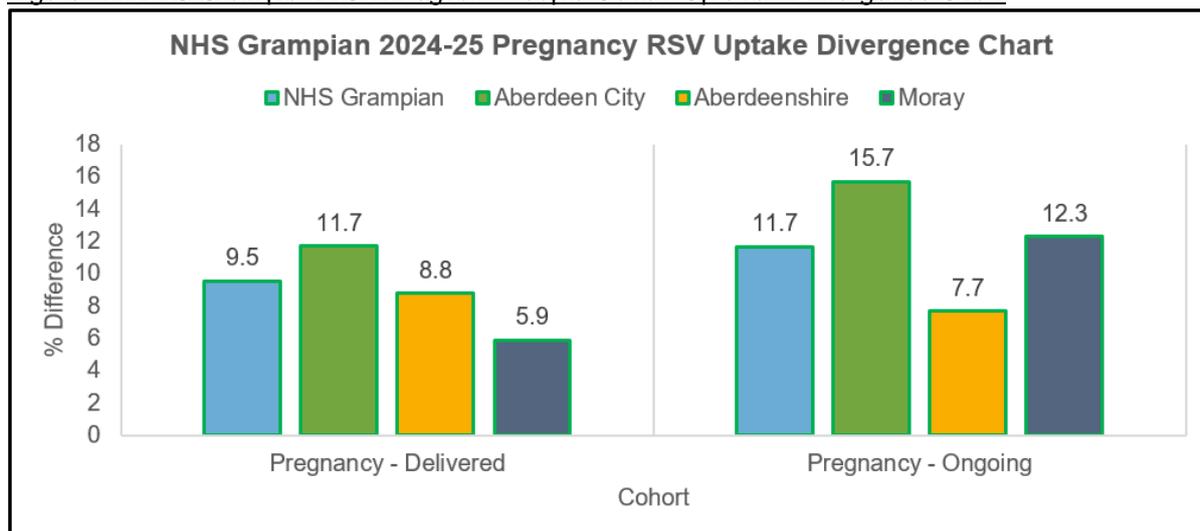
NHS Grampian achieved significantly higher uptake rates across all HSCPs compared to the Scottish average (59.5% versus 50% and 64.3% versus 52.6%) as shown in figure 16 which is approximately 10% above the average. The divergence chart in figure 17 illustrates these differences from the Scottish baseline (0). The data suggests that women throughout Grampian were well-informed about the benefits of the RSV vaccination during pregnancy which increased uptake, highlighting the successful campaign.

Figure 16: NHS Grampian RSV Pregnant People Cohort Uptake



Data Source: Discovery (2025)

Figure 17: NHS Grampian RSV Pregnant People Cohort Uptake – Divergence Chart



Data Source: Discovery (2025)

6.2 CHILDHOOD ROUTINE IMMUNISATIONS

Over the past ten years, there has been a gradual decline in the uptake of childhood immunisations across the UK and globally. While Scotland’s uptake has continued to perform well by comparison with the other UK nations, this trend is observed in Grampian also. The reporting ages for childhood vaccine completion rates in the UK are 12 months, 24 months, five years and six years of age.

There are time lags between when a vaccination is first offered within the routine childhood schedule and when uptake is evaluated, for example MMR2 appointments are scheduled from 3 years 4 months but uptake is evaluated based on the cohort of children who reach 5 years. Therefore, uptake data in a particular reporting year reflect delivery practices over a longer period.

Changes are taking place to the childhood schedule in July 2025 and January 2026.

6.2.1 IMMUNISATIONS UP TO 12 MONTHS OF AGE

Analysis of vaccine uptake at 12 months shows strong overall coverage across Grampian displayed in figure 18, with most vaccines achieving or approaching WHO benchmark and national targets, though some variation remains by geography.

Uptake of the 6- in- 1 vaccine remains consistently high across all areas, generally staying above 95% in Aberdeenshire and Moray. Aberdeen City maintains strong coverage, with a brief dip below 95% in Q3 2023–2024 followed by recovery in subsequent quarters.

Pneumococcal (PCV) uptake is stable across throughout Grampian, with rates consistently above 90% and minimal variation over time.

Rotavirus uptake demonstrates more quarterly variability across Grampian, with all HSCP areas experiencing some fluctuation. Aberdeen City shows the most pronounced variation, with coverage dropping in Q2 2023–24 and Q1 2024–25,

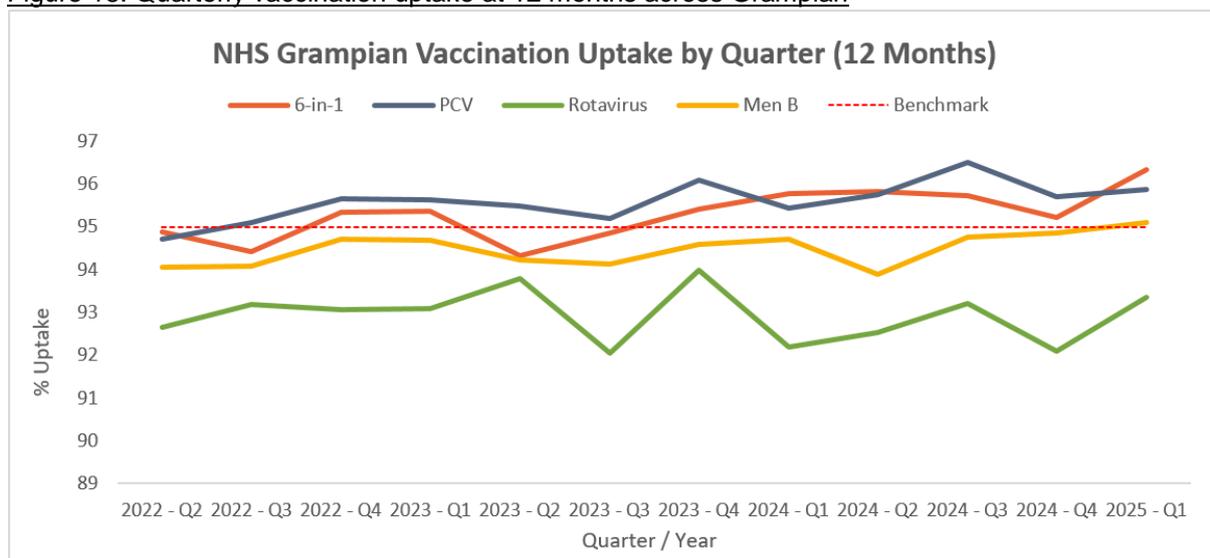
though rates have subsequently improved. These patterns may reflect the challenges of maintaining consistent coverage in a larger, more diverse urban population.

Meningococcal B (MenB) coverage remains robust across all areas. Aberdeen City shows a wider range of uptake compared to Aberdeenshire and Moray, with rates occasionally reaching the high 80s, though still maintaining strong overall protection.

Analysis of numerator and denominator trends confirms that fluctuations are unlikely to be due solely to small cohort sizes as shown in figure 19. Aberdeen City consistently has the largest eligible population, which may present different operational challenges compared to the smaller cohorts in Aberdeenshire and Moray. Previous work has also shown that faster population turnover in Aberdeen City can result in children appearing as eligible after they have moved address or left the Board area.

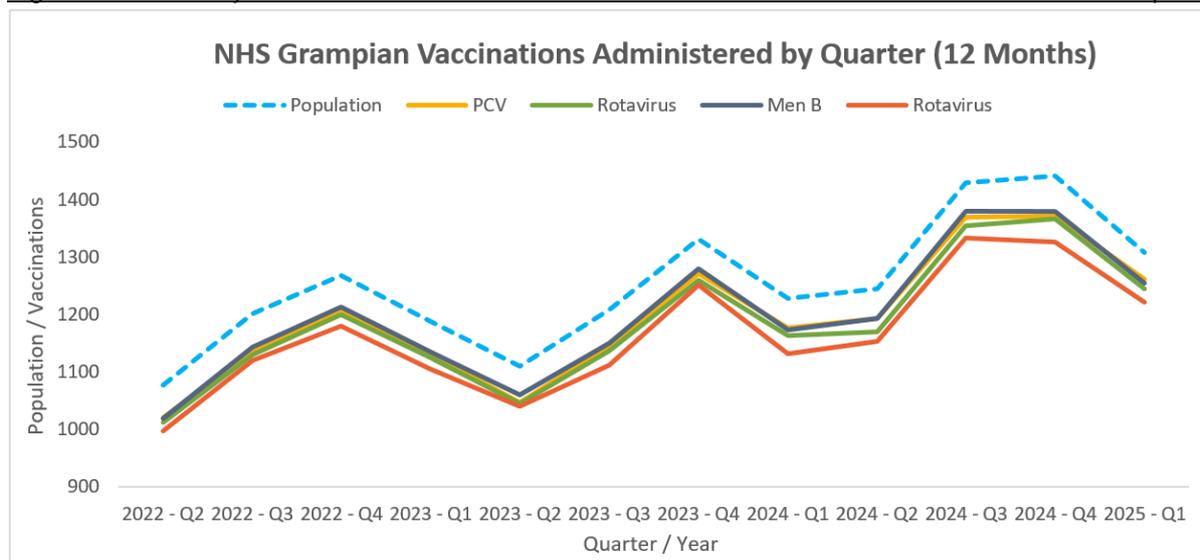
Overall, Grampian achieves high vaccine coverage at age 12 months vaccination. The greater variability observed in Aberdeen City, particularly for Rotavirus and MenB, likely reflects the complexities of delivering services to a larger, urban population.

Figure 18: Quarterly vaccination uptake at 12 months across Grampian



Data Source: Discovery (2025)

Figure 19: Quarterly numerator and denominator trends for 12- month vaccinations across Grampian



Data Source: Discovery (2025)

6.2.2 IMMUNISATIONS UP TO 24 MONTHS OF AGE

At 24 months, vaccination uptake remains strong overall across Grampian, though booster doses and MMR1 show greater variation than primary schedule vaccines, as shown in Figure 20.

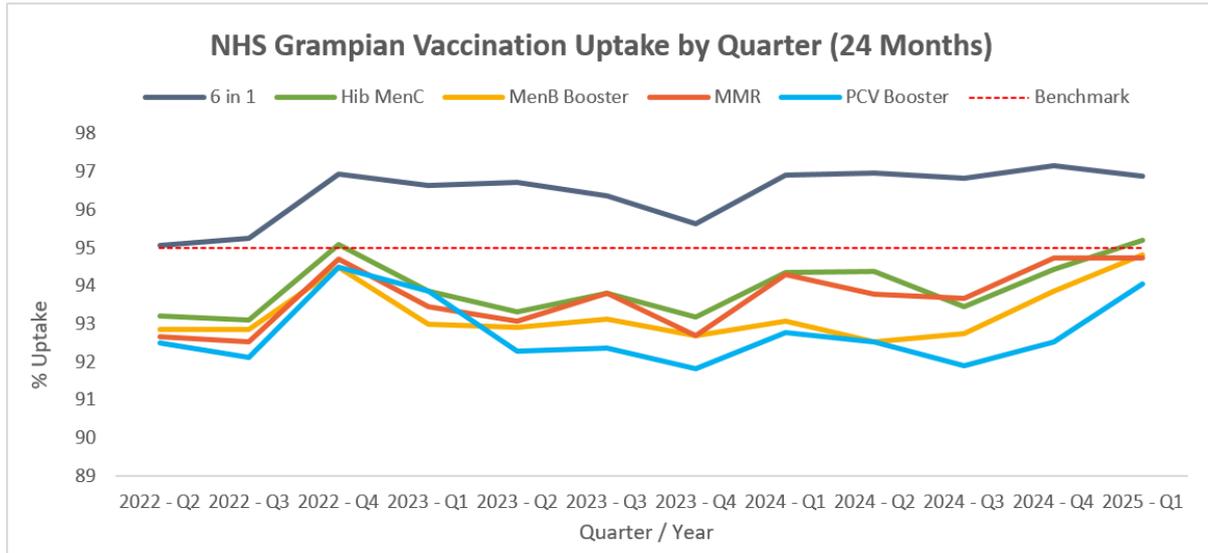
The 6- in- 1 and Hib/MenC vaccines maintain high coverage above 90% across all areas, with Aberdeenshire and Moray consistently exceeding 95%. MenB booster and PCV booster uptake also remains strong, though modestly lower than primary doses, with all areas maintaining coverage above 85%.

MMR1 uptake ranges from the mid- 80s to low- 90s across HSCPs, reflecting the national trend of declining MMR coverage. While below the WHO 95% target, Moray and Aberdeenshire achieve rates in the low 90s in most quarters, providing a solid foundation for targeted catch- up activities.

Analysis of numerator and denominator trends (Figure 21) confirms stable cohort sizes across all areas, with Aberdeen City serving the largest eligible population.

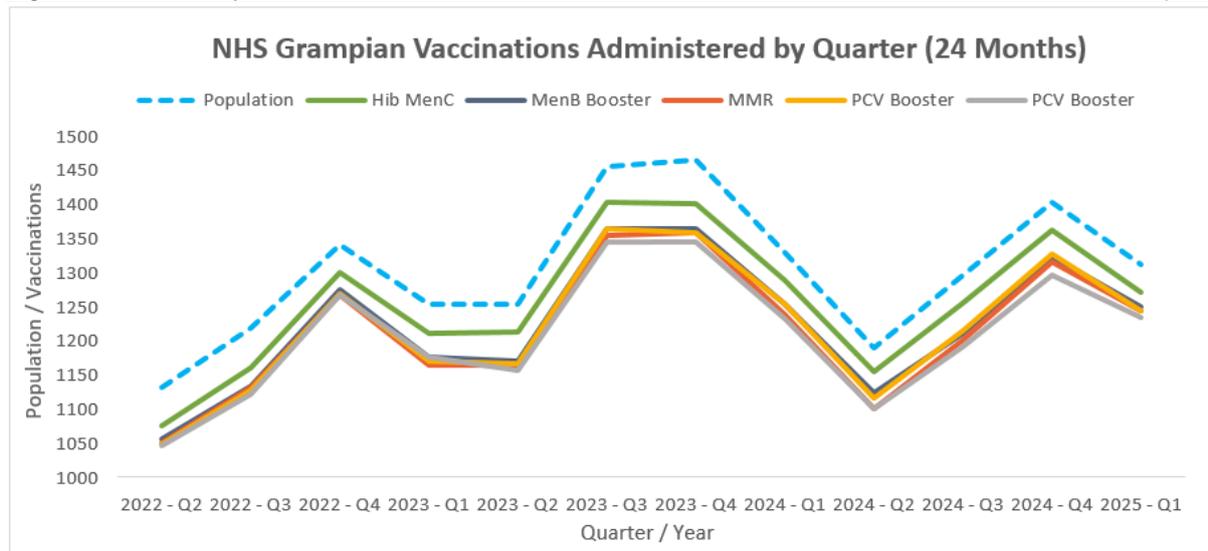
Overall, Grampian maintains strong coverage for primary schedule vaccines at 24 months. The lower uptake for booster doses and MMR1 aligns with national challenges and highlights the need for ongoing opportunities for focused engagement to strengthen baseline coverage.

Figure 20: Quarterly vaccination uptake at 24 months across Grampian



Data Source: Discovery (2025)

Figure 21: Quarterly numerator and denominator trends for 24- month vaccinations across Grampian



Data Source: Discovery (2025)

6.2.3 IMMUNISATIONS UP TO FIVE YEARS OF AGE

Across NHS Grampian (figure 22), vaccine uptake by age 5 remains strong, with the 6- in- 1 vaccine consistently achieving the 95% WHO benchmark. MMR1 and Hib/MenC also attain high coverage in the low- to- mid 90s, approaching the target threshold.

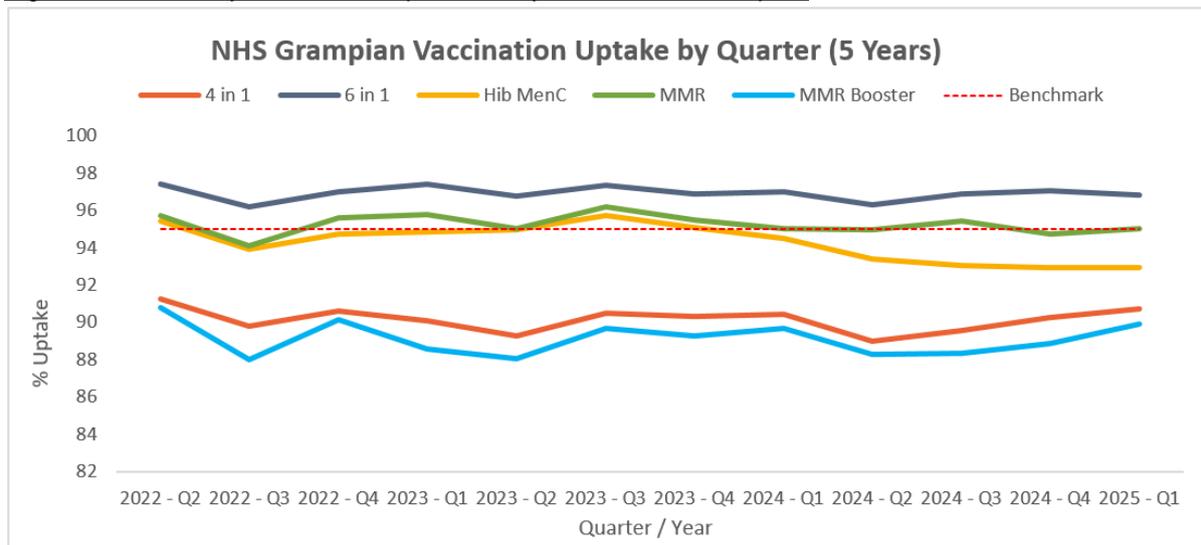
Booster doses show modestly lower completion rates. The 4- in- 1 preschool booster and MMR2 typically reach the high 80s to around 90% across Grampian, falling short of the 95% target needed for optimal community protection against measles and pertussis.

Geographic variation reflects different population contexts. Aberdeenshire consistently achieves the highest coverage, meeting or exceeding 95% for most vaccines across recent quarters. Moray maintains strong uptake in the mid- 90s for primary vaccinations, with boosters around 90%. Aberdeen City shows lower coverage, with primary vaccines in the low- to- mid 90s and boosters in the mid- 80s, likely reflecting the challenges of delivering services to a larger, more diverse urban population.

Analysis of numerator and denominator trends (Figure 23) confirms stable cohort sizes across all areas.

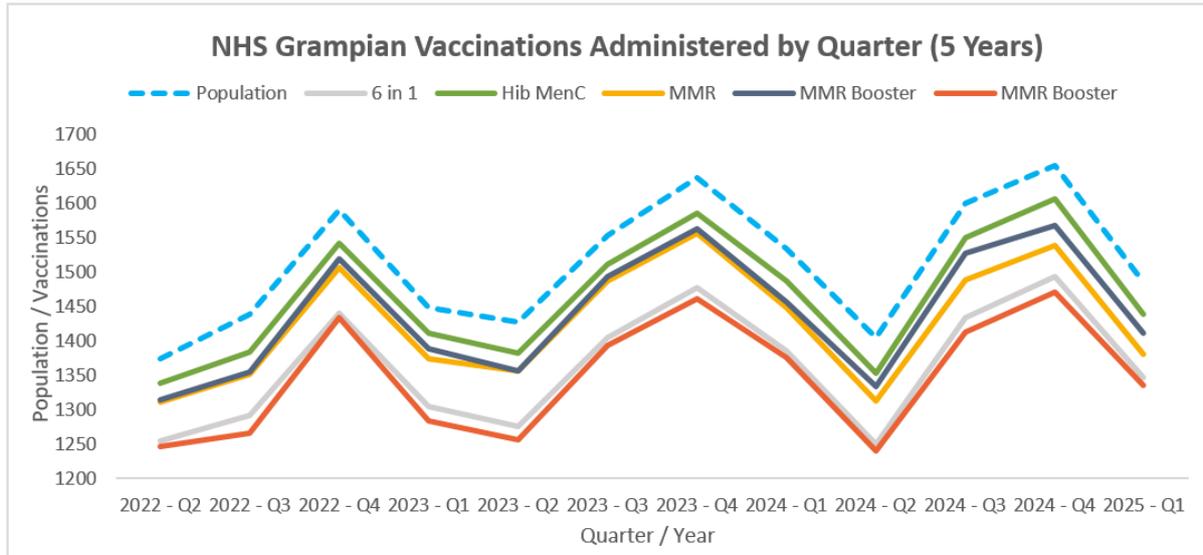
Overall, Grampian demonstrates solid vaccination coverage by age 5, with primary schedule vaccines performing particularly well. The gap in booster uptake, especially in Aberdeen City, presents an opportunity for targeted interventions to strengthen second- dose completion and maintain community protection as measles activity increases nationally. MMR completion is likely to improve with the move to an 18- month appointment in January 2026.

Figure 22: Quarterly vaccination uptake at 5 years across Grampian



Data Source: Discovery (2025)

Figure 23: Quarterly numerator and denominator trends for 5- year vaccinations across Grampian



Data Source: Discovery (2025)

6.2.4 IMMUNISATIONS UP TO SIX YEARS OF AGE

By 6 years of age, vaccination uptake in NHS Grampian remains below the 95% target for preschool immunisations, with notable geographic variation, as shown in Figure 24.

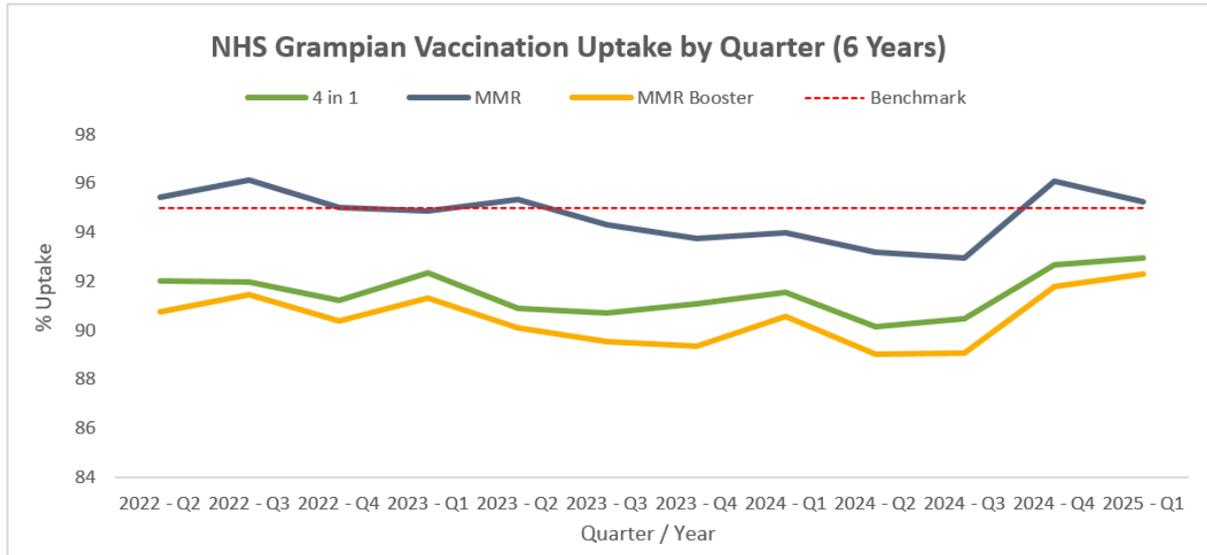
Aberdeenshire and Moray achieve strong coverage, approaching 95% for MMR1 and reaching approximately 93–94% for the 4- in- 1 and MMR2 boosters. Aberdeen City shows lower uptake, with around 90% coverage for MMR1 and mid- 80s for booster doses, reflecting the ongoing challenges of urban vaccine delivery.

The overall Grampian average sits at approximately 93% for MMR1 and 89% for MMR2, slightly below the Scottish national average. Coverage has largely plateaued across all areas in recent quarters, with modest improvements from age 5 to age 6 due to catch- up programmes, though not sufficient to reach the 95% threshold.

Analysis of numerator and denominator trends (Figure 25) shows minor cohort fluctuations but confirms that coverage gaps persist across all areas.

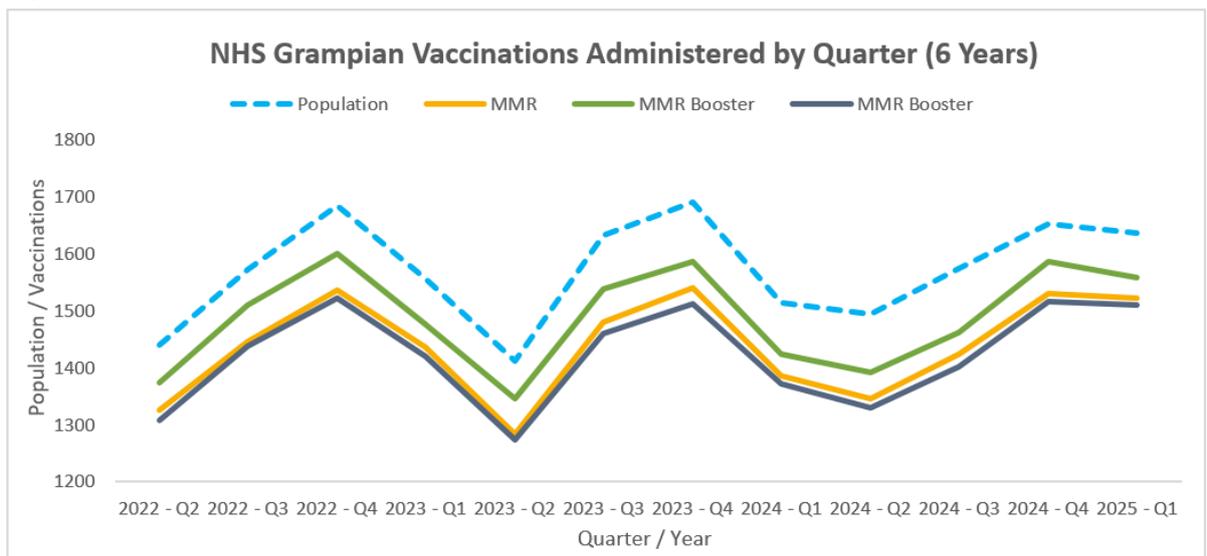
Overall, Grampian demonstrates solid primary vaccine coverage by age 6, though booster completion remains an area for improvement. The plateau in recent uptake trends highlights the need for HSCPs to continue to resource sustained engagement and targeted catch- up efforts, particularly in urban settings, to achieve optimal community protection as children enter school.

Figure 24: Quarterly vaccination uptake at 6 years across Grampian



Data Source: Discovery (2025)

Figure 25: Quarterly numerator and denominator trends for 6- year vaccinations across Grampian



Data Source: Discovery (2025)

6.3 UPTAKE AND COVERAGE OF SCHOOL-BASED IMMUNISATION PROGRAMMES

6.3.1 HUMAN PAPILLOMA VIRUS (HPV)

HPV uptake in 2023/24 increased steadily from S1 to S4 in both Grampian and Scotland. In 2024/25, a similar trend was observed, with rates rising by approximately 1–5% from S1 to S6 in Grampian (see Table 6). Coverage consistently improved with each school year, highlighting the importance of offering catch-up vaccination opportunities annually.

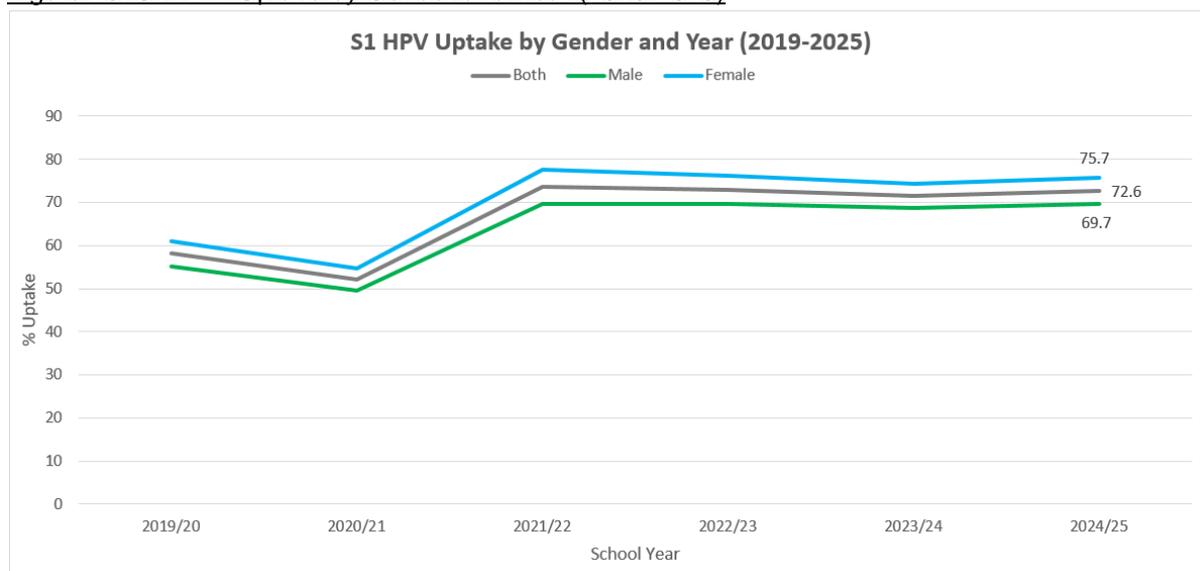
A process has been developed to ensure that any child who leaves school without receiving routine vaccinations is contacted and offered vaccination.

Table 6 – NHS Grampian HPV Uptake Between 2024-25

HPV Grampian Uptake			
School year	Population	Vaccinated	%Uptake
S1	6,668	5,016	75.2
S2	6,508	5,269	81.0
S3	6,454	5,418	83.9
S4	6,531	5,531	84.7
S5	5,806	5,206	89.7
S6	5,007	4,547	90.8
Grand Total	36,974	30,987	83.8

When examining HPV uptake by gender in S1, female uptake was consistently higher by around 5% across the years (see Figure 26). In 2024/25, uptake for both females and males increased steadily from S1 to S6, with coverage improving across all school years.

Figure 26: S1 HPV Uptake by Gender and Year (2019-2025)



6.3.2 VACCINATION WITH TD, IPV AND MEN ACWY

Uptake for Td/IPV throughout NHS Grampian increased by approximately 5% across school years (S3–S6), as shown in Table 7—again highlighting the importance of annual catch-up opportunities. Uptake for Td/IPV in 2023/24 increased from S3 to S4 in both Grampian and Scotland; however, Grampian uptake exceeded the Scotland average.

Table 7 – NHS Grampian Td/IPV Uptake Between 2024-25

Td/IPV Grampian Uptake			
School year	Population	Vaccinated	% Uptake
S3	6,454	4,860	75.3
S4	6,531	5,219	79.9
S5	5,806	4,957	85.4
S6	5,007	4,507	90.0
Grand Total	23,798	19,543	82.1

Similarly, uptake for MenACWY in 2024/25 in Grampian increased by an average of 5% from S3 to S6 (see Table 8). The 2023/24 trend for MenACWY mirrored that of Td/IPV.

Table 8 – NHS Grampian MenACWY Uptake Between 2024-25

MenACWY Grampian Uptake			
School year	Population	Vaccinated	% Uptake
S3	6,454	4,849	75.1
S4	6,531	5,198	79.6
S5	5,806	4,944	85.2
S6	5,007	4,509	90.1
Grand Total	23,798	19,500	81.9

6.4 UPTAKE AND COVERAGE IN ADULT IMMUNISATION PROGRAMMES

6.4.1 SHINGLES

During 2023/24 the shingles programme moved to the 2-dose Shingrix schedule. In December 2024, invitations were sent to eligible groups, with vaccinations commencing in January 2025. This represents the second year of the programme. The eligible routine groups were those who are aged 50 years old and over with a severely weakened immune system and individuals aged 65 and 70 (predefined age eligibility cut offs). A catch-up offer was also made to individuals aged 66 or between 71-79 years.

In 2024/25, 23,907 shingles vaccines were administered covering the routine and catch-up cohorts as displayed in Table 9. This led to an uptake rate of 41.7% for dose one. Of those who received dose one, 81% went forward to receive the second dose, which was 6% higher than the national average. The highest uptake was observed within the new cohorts (Age 65 and Age 70).

Table 9: Shingles Cohort Population and Vaccinations Administered

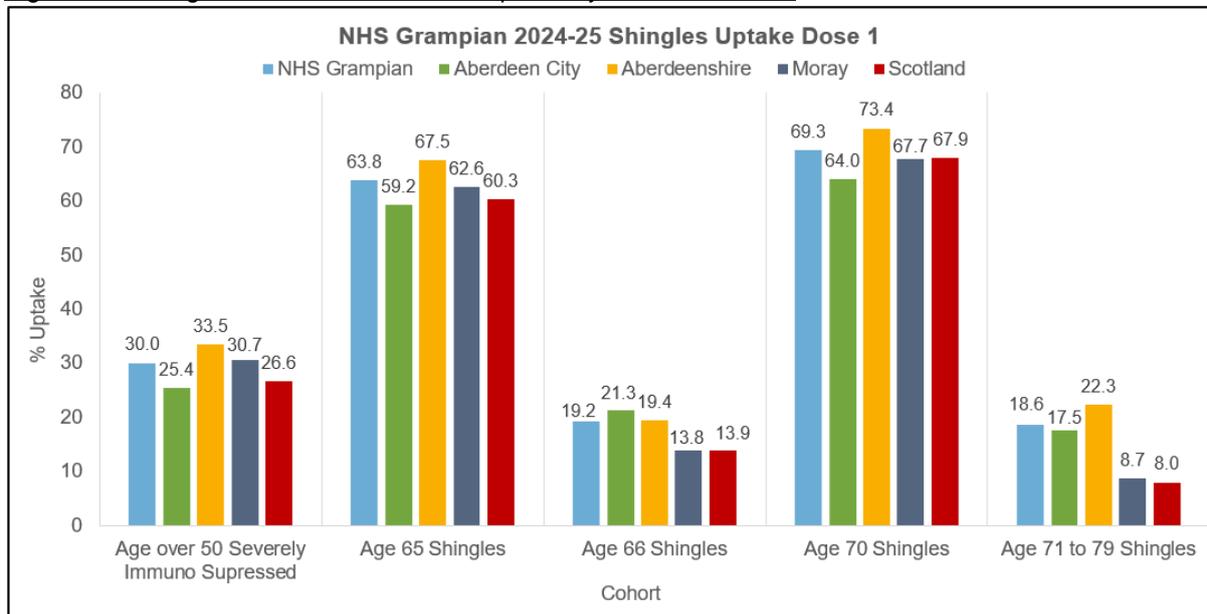
Cohort	Dose 1			Dose 2		
	Population	Vaccinated	Uptake %	Population	Vaccinated	Uptake %
Age over 50 Severely Immuno Supressed	4,120	1,237	30.0	1,636	1,158	70.8
Age 65 Shingles	7,436	4,741	63.8	4,766	4,068	85.4
Age 66 Shingles	2,291	441	19.2	1,001	585	58.4
Age 70 Shingles	6,149	4,264	69.3	4,291	3,878	90.4
Age 71 to 79 Shingles	10,622	1,978	18.6	2,902	2,095	72.2
Total	29,757	12,398	41.7	14,210	11,509	81.0

Data Source: Discovery (2025)

The high dose 2 completion rate of 81% demonstrates strong adherence to the two-dose schedule among those who initiated vaccination as seen in figure 27 and 28. Uptake experiences seasonal fluctuations as the programme is delivered between the spring and autumn/winter COVID/flu campaigns.

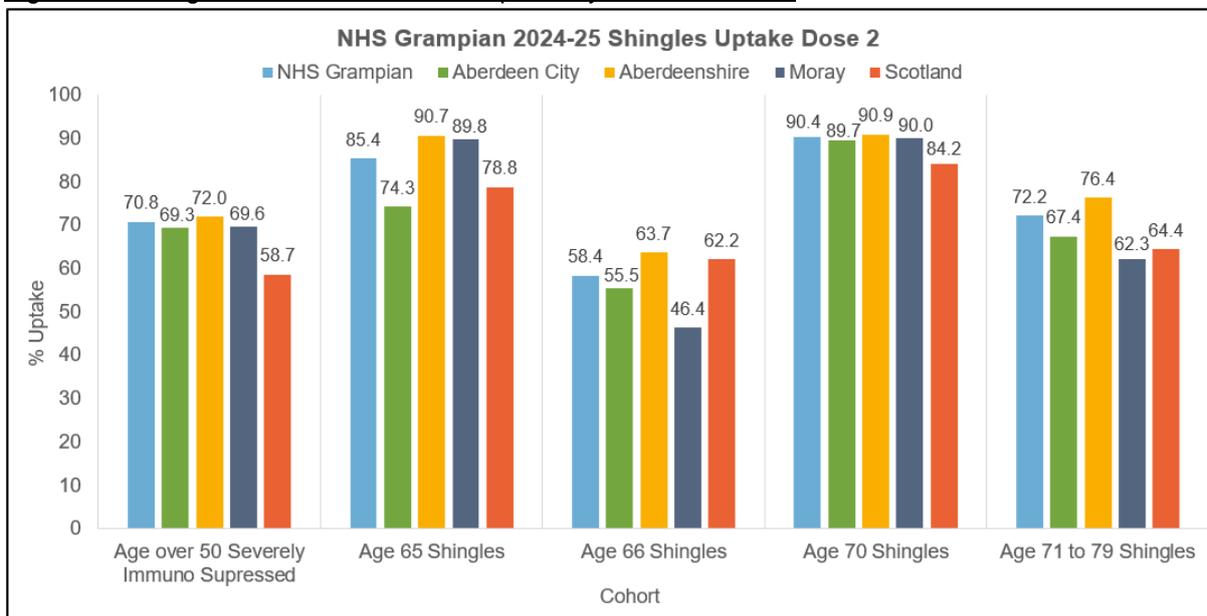
When reviewing the total coverage for the shingles vaccination throughout NHS Grampian as of 31st August 2025, we can see that the total population is 75,957 of which 55,879 have been fully vaccinated (73.6%). This is higher than the Scottish average coverage of 69.4%.

Figure 27: Shingles Dose 1 Vaccination Uptake by Cohort 2024-25



Data Source: Discovery (2025)

Figure 28: Shingles Dose 2 Vaccination Uptake by Cohort 2024-25



Data Source: Discovery (2025)

6.4.2 PNEUMOCOCCAL

Pneumococcal is a one-off vaccine offered to those aged 65 and over and those under 65 with underlying conditions, that protects against 23 serotypes of pneumococcal disease. A small cohort require repeat vaccination every 5 years.

NHS Grampian has an effective delivery strategy that focuses on inviting and administering the vaccine when seasonal vaccinations are not being carried out, typically between June-July and January-March. This approach reduces operational pressure and aligns with the delivery of shingles.

Table 10 demonstrates the cohort sizes for NHS Grampian between 2023-2024 which has increased by 27.1% - influenced by the aging demographic throughout Scotland and Grampian.

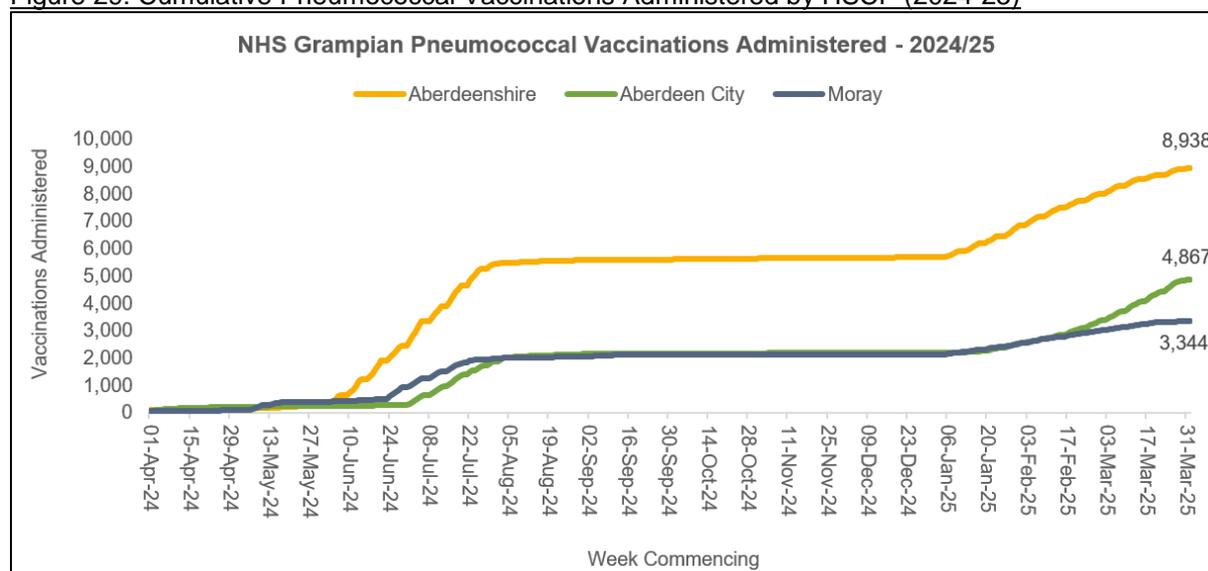
The cumulative line graph in figure 29 displays how many vaccinations were administered by the HSCPs during 2024/25. Aberdeenshire administered 8,938, Aberdeen City administered 4,867 and Moray administered 3,344 totalling 17,149 throughout Grampian.

Table 10: Pneumococcal Cohort Population and Changes

NHS Grampian Pneumococcal Population 2023-2024			
Cohort	Population		
	2023	2024	% Difference
2 to 64 Pneumococcal At Risk	19,424	24,407	25.7
Aged 65+	21,910	28,678	30.9
Pneumococcal every 5 years	3,586	4,451	24.1
Total	41,336	52,532	27.1

Data Source: Discovery (2025)

Figure 29: Cumulative Pneumococcal Vaccinations Administered by HSCP (2024-25)

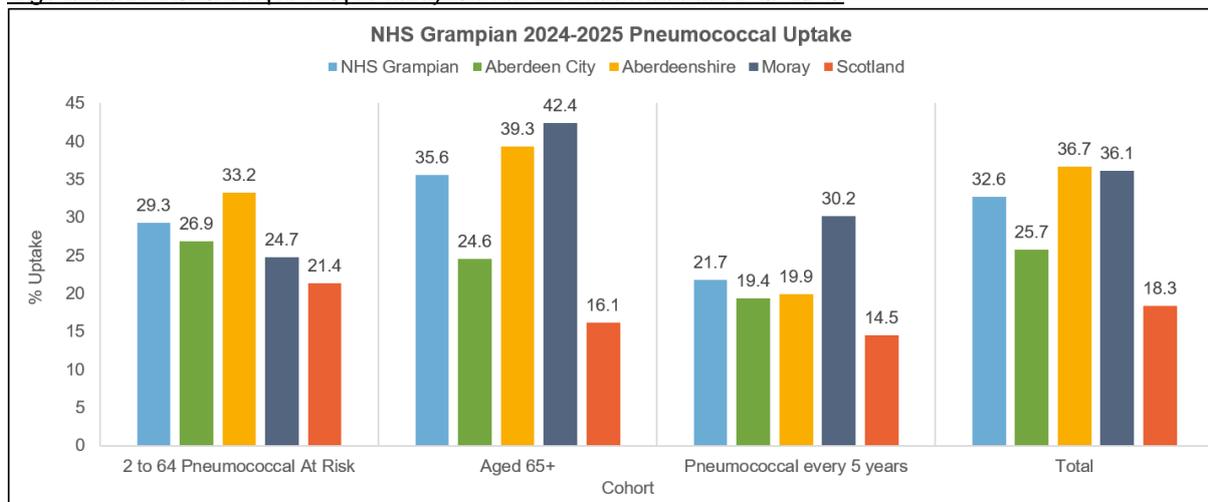


Data Source: Discovery (2025)

NHS Grampian's uptake was above the Scottish average for 2024-25 which can be seen in Figure 30. Moray achieved the second highest uptake throughout Scotland for aged 65+ (42.4%) and every 5 years (35.6%). A detailed cohort breakdown can be seen in the Appendix.

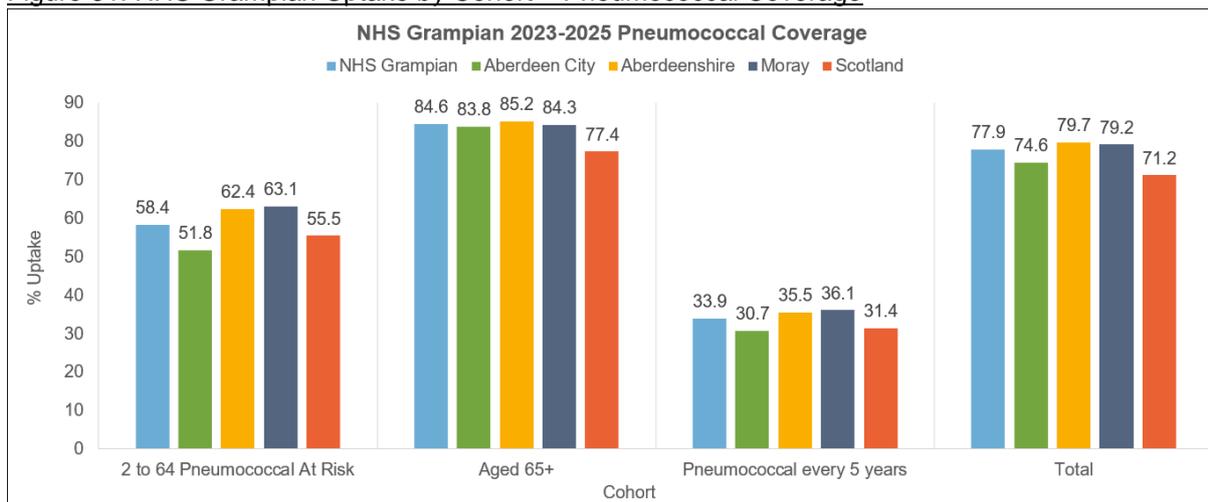
The total coverage methodology (including previously vaccinated individuals), figure 31, demonstrates that the vast majority of individuals aged 65+ are protected at 84.6% (101,976 vaccinations). Uptake drops for the aged 2 to 64 at risk (58.4%) and further drops again for every 5 years cohort (33.9%)

Figure 30: NHS Grampian Uptake by Cohort – Pneumococcal 2024/25



Data Source: Discovery (2025)

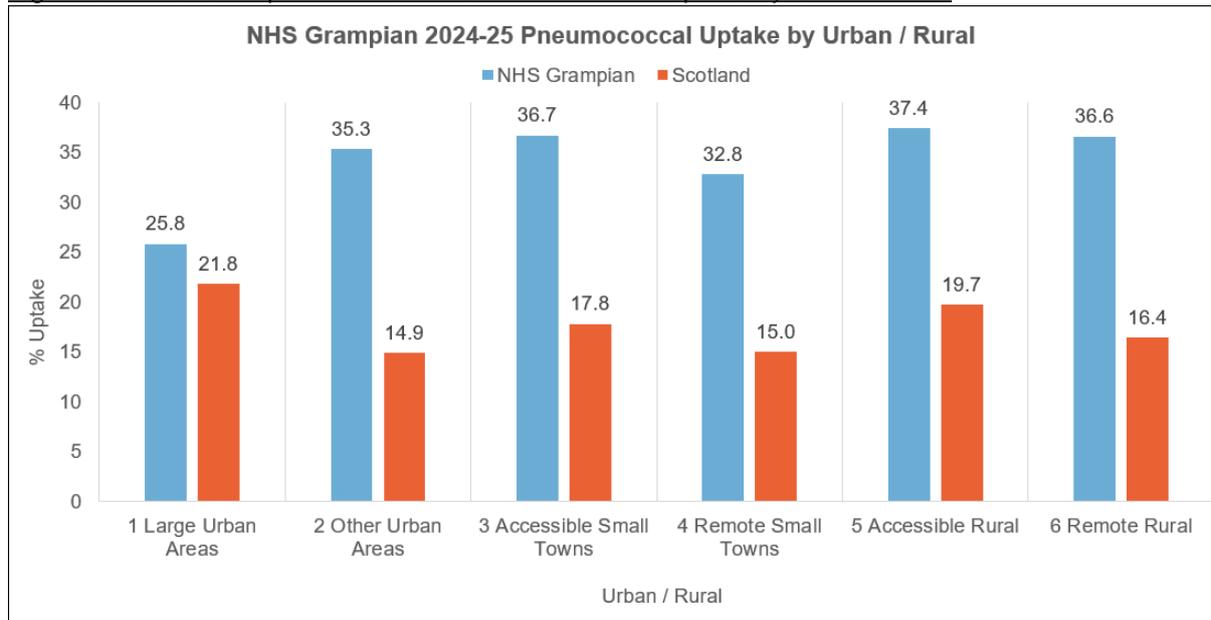
Figure 31: NHS Grampian Uptake by Cohort – Pneumococcal Coverage



Data Source: Discovery (2025)

NHS Grampian achieves good uptake throughout all Urban / Rural criteria seen in figure 32. However, Large Urban Areas are 7-12% under the other classifications and much closer to the Scottish average.

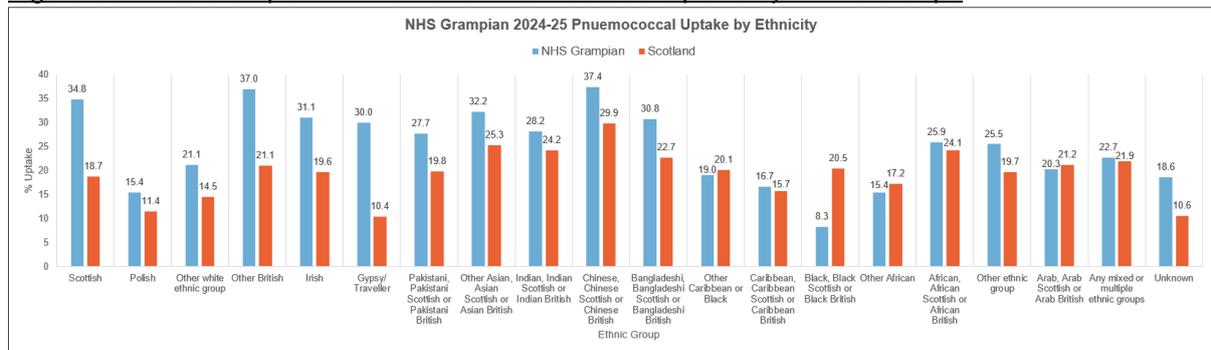
Figure 32: NHS Grampian AW 2024/25 Pneumococcal Uptake by Urban / Rural



Data Source: Discovery (2025)

Pneumococcal vaccine uptake by ethnic group is mostly above the Scottish average (figure 33). Uptake is slightly lower among Other Caribbean or Black (1.1%) Other African (1.8%) and Arab, Arab Scottish or Arab British (0.9%) populations. Most notable, uptake among Black, Black Scottish or Black British is 12.1% below the Scottish average.

Figure 33: NHS Grampian AW 2024/25 Pneumococcal Uptake by Ethnic Groups



Data Source: Discovery (2025)

6.4.3 OLDER ADULT RSV

The first successful year of the older adult RSV programme launched on 1st August 2024, targeting 30,536 individuals aged 75-79 and those turning 75 in Grampian (table 11). Uptake was 21,639 (70.8%), marginally above Scottish averages. Aberdeenshire exceeded national averages by 1.1-1.9%, while Aberdeen City was 0.7-1.9% below average (Figure 34 and 35). Most areas achieved over 70% uptake, except those turning 75 in Aberdeen City (68.1%) and Moray (69.6%), indicating opportunities for targeted improvements.

Table 11: NHS Grampian RSV Cohort Population and Number Vaccinated

Cohort	Population	Vaccinations	% Uptake
Age 75 to 79	25,027	17,782	71.1
Turning Age 75	5,509	3,857	70.0

Data Source: Discovery (2025)

Figure 34: NHS Grampian vs Scottish Benchmark – RSV 2024/25

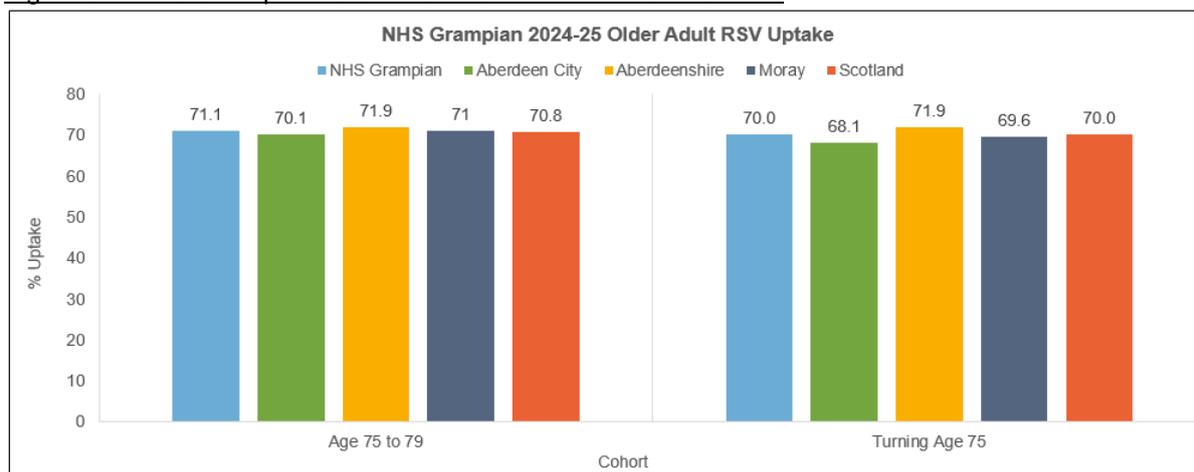
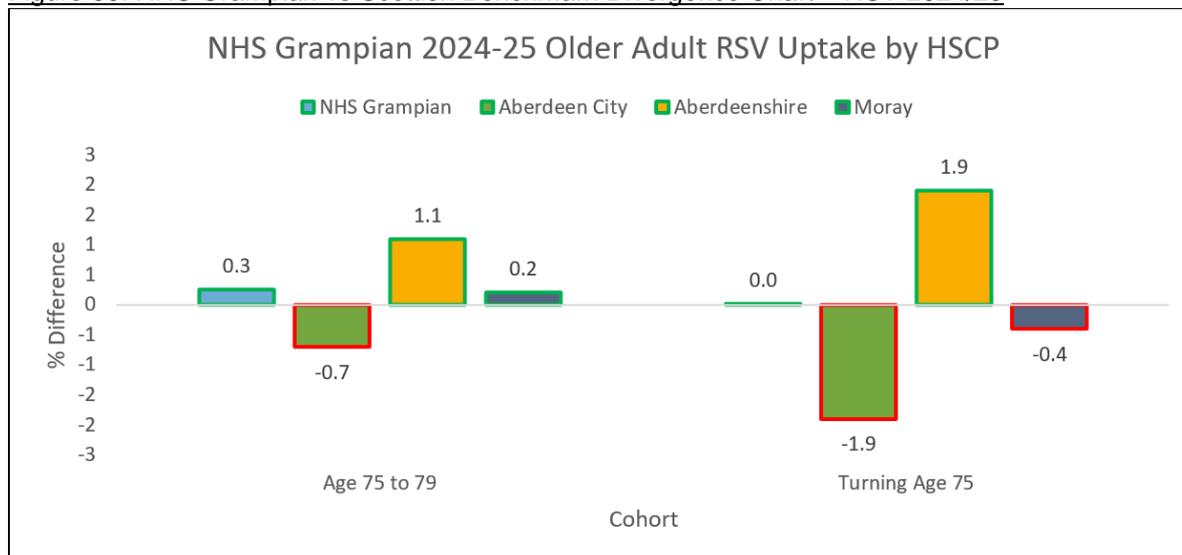


Figure 35: NHS Grampian vs Scottish Benchmark Divergence Chart – RSV 2024/25

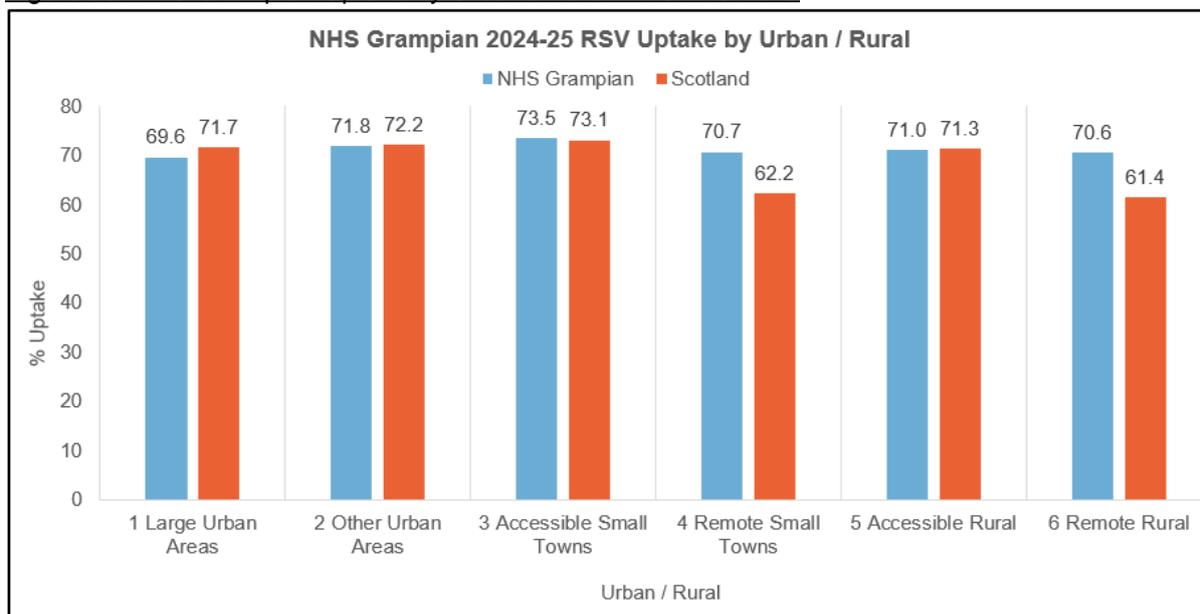


Data Source: Discovery (2025)

Like other vaccination programmes, figure 36 demonstrates that the lowest uptake in the Urban / Rural criteria is within Large urban areas at 69.6%, but this is only a slight difference from the Scottish average of 71.7%. However, remote small towns and remote rural areas exceeded averages by 8.5% and 19.2% respectively, demonstrating NHS Grampian provides equitable access regardless of rurality.

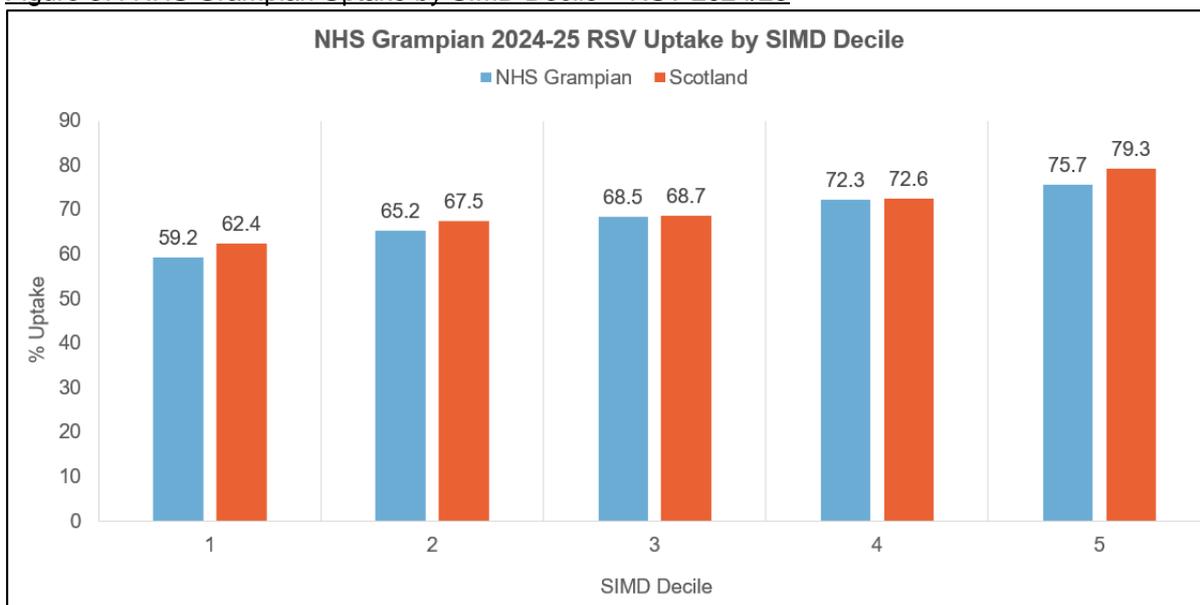
NHS Grampian is under the averages for all SIMD deciles shown in figure 37 but the gap between SIMD 1 and 5 is slightly narrower by 0.5%.

Figure 36: NHS Grampian Uptake by Urban / Rural – RSV 2024/25



Data Source: Discovery (2025)

Figure 37: NHS Grampian Uptake by SIMD Decile – RSV 2024/25



Data Source: Discovery (2025)

6.5 UPTAKE AND COVERAGE IN SEASONAL IMMUNISATION PROGRAMMES

6.5.1 AUTUMN WINTER 2024 / 25

Autumn Winter 2024/25 Campaign ran from 1st September 2024 to 31st March 2025 and introduced changes to vaccination timeframes and eligibility criteria. COVID-19 administrations ended in January 2025. Adults aged 50-64 were no longer automatically eligible unless "At Risk" or having a "Weakened Immune System".

Cohort sizes and % differences for COVID-19 and/or Influenza can be found in Table 12. The CMO's recommendation was to offer an appointment to 85% of the population, on a date prior to the 8th December 2024.

Grampian's cohort population was 229,436 for COVID-19 and 234,642 for influenza. Eligibility changes reduced the adult influenza cohort by 74,089 (24%), while the weakened immune system cohort increased by 7,290 (61.8%). This large increase is due to the weakened immune system cohort being refreshed.

Table 12: Autumn Winter 2024-25 Eligibility Criteria and Population Changes

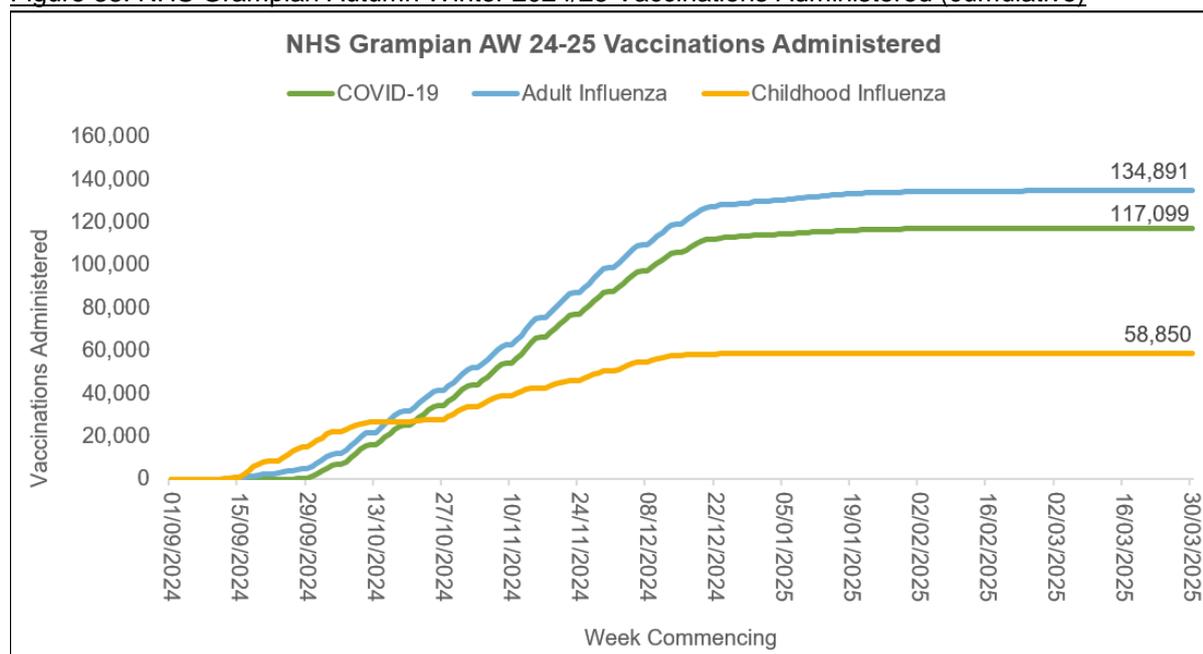
COVID-19				Adult Influenza			
Cohort	Population		% Difference	Cohort	Population		% Difference
	2023	2024			2023	2024	
Older people care home residents	2,910	3,026	4.0	Older people care home residents	2,910	2,917	0.2
Aged 75+	55,283	57,491	4.0	Aged 75+	55,283	57,072	3.2
Age 65 to 74	65,635	66,939	2.0	Age 65 to 74	65,635	66,796	1.8
Weakened immune system	11,996	14,877	24.0	Age 50 to 64	126,141	Not Eligible	N/A
At risk age 12 to 64	78,653	78,638	0.0	Weakened immune system	11,802	19,092	61.8
At risk age 5 to 11	3,190	3,422	7.3	At risk age 18 to 64	88,823	85,274	-4.0
At risk age 6 months to 4 years	787	790	0.4	All health care workers	17,218	17,854	3.7
Frontline health care workers	10,571	11,201	6.0	All social care workers	17,164	17,947	4.6
All social care workers	17,245	18,050	4.7	Distinct Total	308,731	234,642	-24.0
Distinct Total	224,418	229,436	2.2				

Data Source: Discovery (2025)

Following the reduction of cohort population, there was a corresponding reduction in the number of vaccinations administered by 14.8%, from 365,041 (AW 2023/24) to 310,841 (AW 2024/25), with reductions across COVID-19 (131,329 to 117,099), influenza (174,702 to 134,891), and childhood influenza (59,010 to 58,850). These patterns mirrored Scotland-wide trends.

The line graph (figure 38) shows peak administrations in November despite compressed COVID-19 timelines, with sharp December drops consistent with previous years. This suggests NHS Grampian successfully adapted by frontloading the campaign, with the main difference being a steeper end-of-December decline demonstrating success against the CMO's target date.

Figure 38: NHS Grampian Autumn Winter 2024/25 Vaccinations Administered (cumulative)



Data Source: Discovery (2025)

Vaccination uptake analysis figures 39 and 40 show highest uptake rates in older adult cohorts during Autumn Winter 2024/25. Care homes exceeded 80% for both vaccines, followed by Age 75+ (77.3% COVID-19, 81.4% influenza). Uptake declined significantly in younger cohorts: at-risk ages 5-11 achieved 9.3% and ages 6 months - 4 years reached 12%. Calls to family reminding them of their appointment, revealed parents were unaware their children were “at risk” and did not feel they required vaccinations.

The divergence graphs (figures 41 and 42) show NHS Grampian performed well overall, with most cohorts above Scottish averages. Aberdeenshire consistently delivered the highest uptake rates across all cohorts for both diseases, while Moray and City also achieved excellent rates throughout most cohorts.

Some improvement areas were identified. Uptake for social care workers fell 0.5-0.6% below national averages, while healthcare workers were 2.2% below average for influenza.

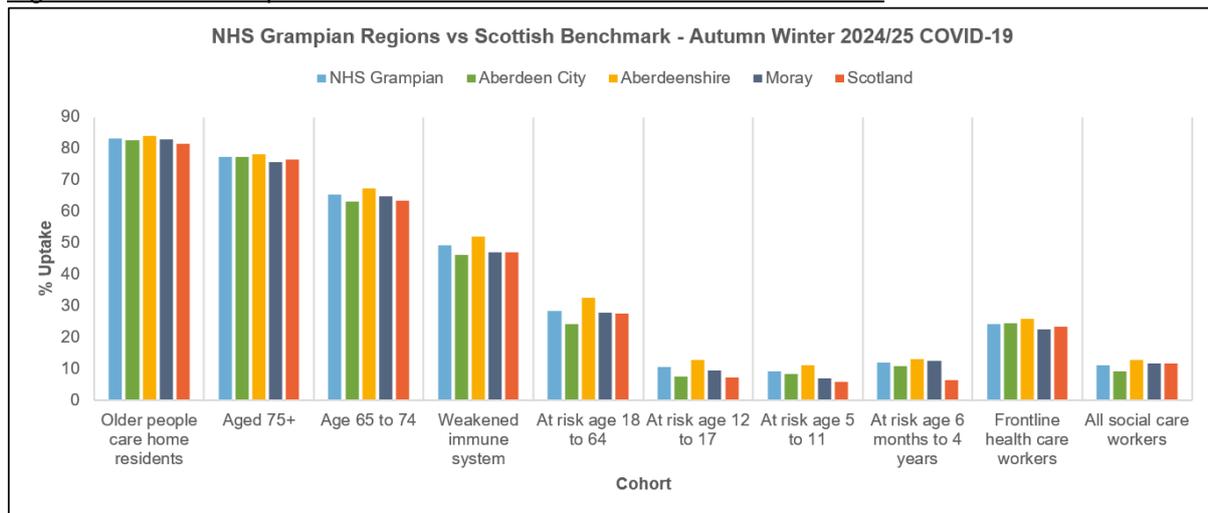
A local survey of care home staff conducted by colleagues in Health Protection showed 471/786 respondents had been vaccinated in previous years. Only 224 respondents said they had been vaccinated this season, 5 had not answered and 557 respondents had said they had not been vaccinated this season. This represents the most striking result as a significant shift from those who had accepted vaccination in previous years to not having accepted this season. This shift saw 260 individuals who had previously accepted vaccination not accepting it this season.

Various reasons were given for not accepting vaccinations this year. These were then categorised into broader themes. The themes that were most common were “did not want vaccination” (31%), “vaccine apathy” (16%), “health illiteracy” (14%), and

“concerned about side effects” (14%). These categories were similar for both groups who had and hadn’t had a previous vaccination.

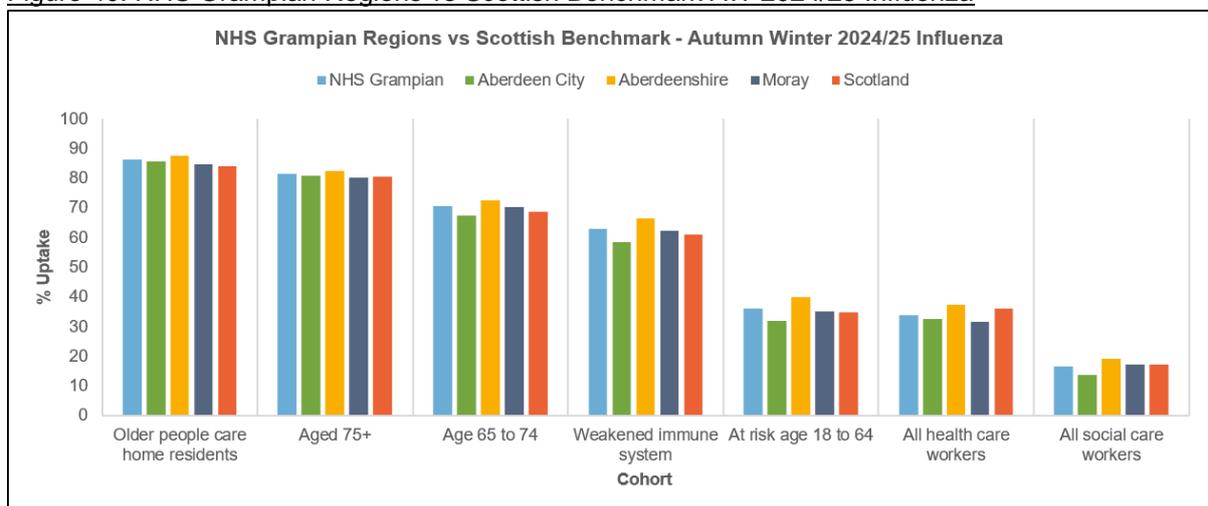
Aberdeen City showed the greatest variation, with uptake lower than the Scottish average across four COVID-19 and five influenza cohorts, particularly among at-risk individuals aged 18–64. However, compared with 2023/24, uptake in Aberdeen City increased by 4.6% for children aged 6 months–4 years and by 2.3% for those aged 5–11. Detailed breakdowns are provided in the appendix.

Figure 39: NHS Grampian vs Scottish Benchmark AW 2024/25 COVID-19



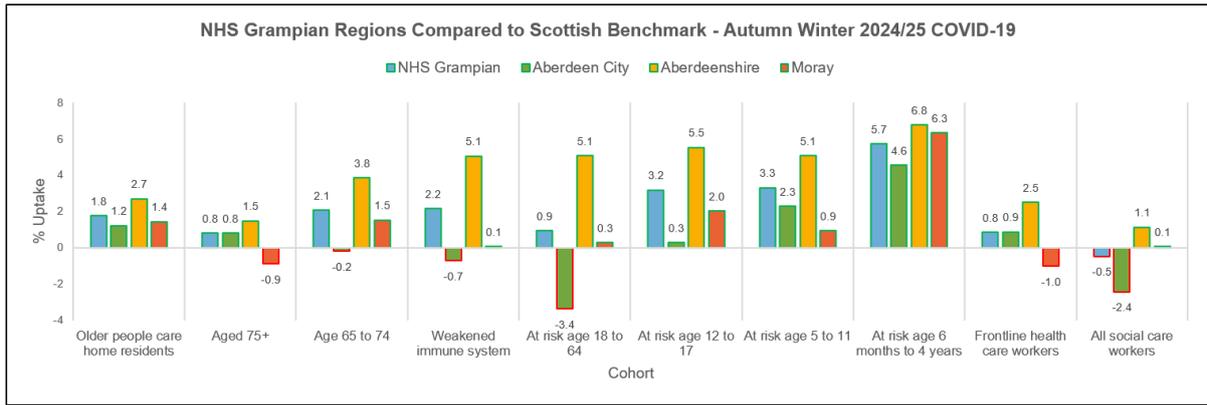
Data Source: Discovery (2025)

Figure 40: NHS Grampian Regions vs Scottish Benchmark AW 2024/25 Influenza



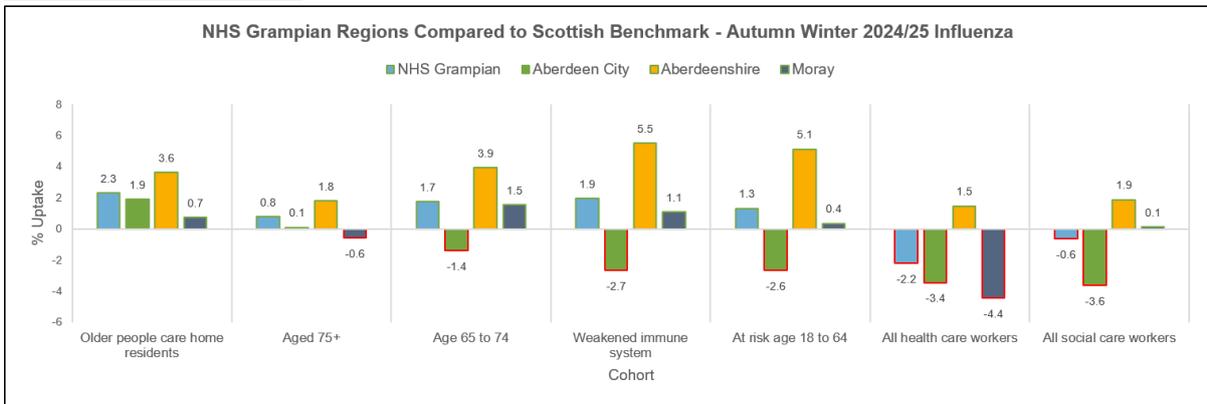
Data Source: Discovery (2025)

Figure 41: NHS Grampian Difference compared to Scottish Benchmark Divergence Chart – Autumn Winter 2024/25 COVID-19



Data Source: Discovery (2025)

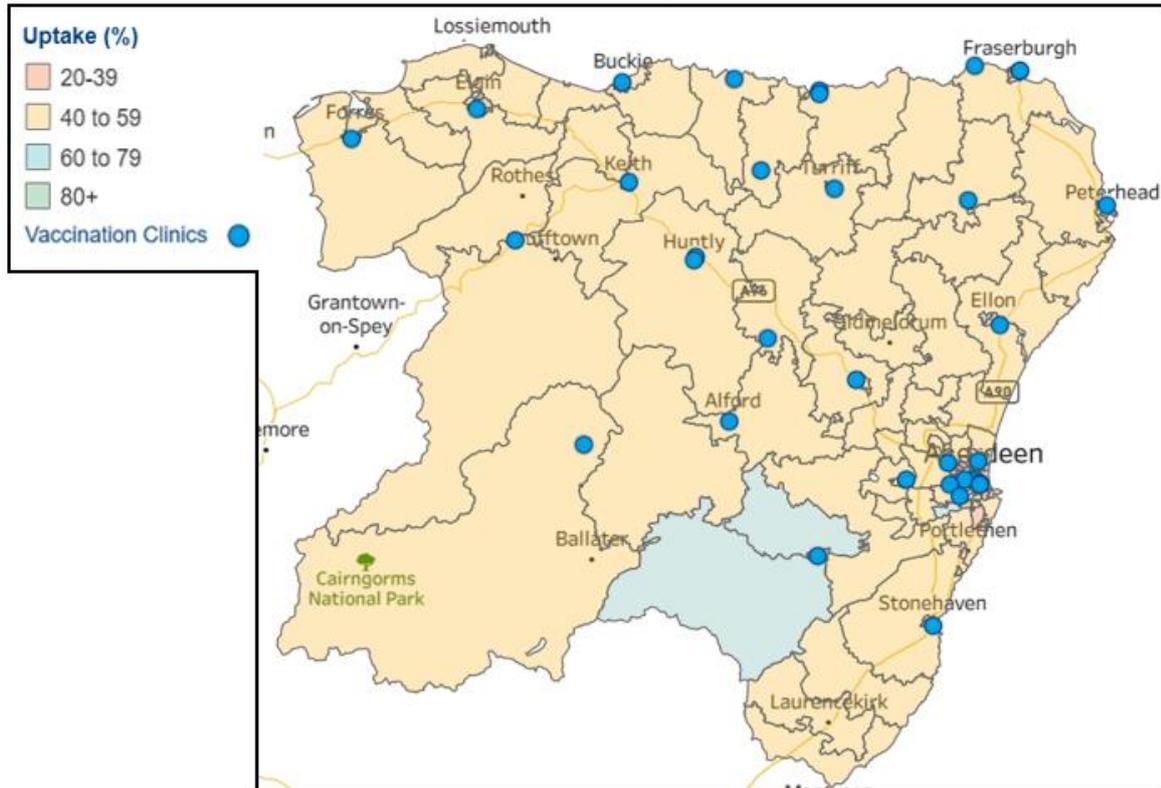
Figure 42: NHS Grampian Difference compared to Scottish Benchmark Divergence Chart – Autumn Winter 2024/25 Influenza



Data Source: Discovery (2025)

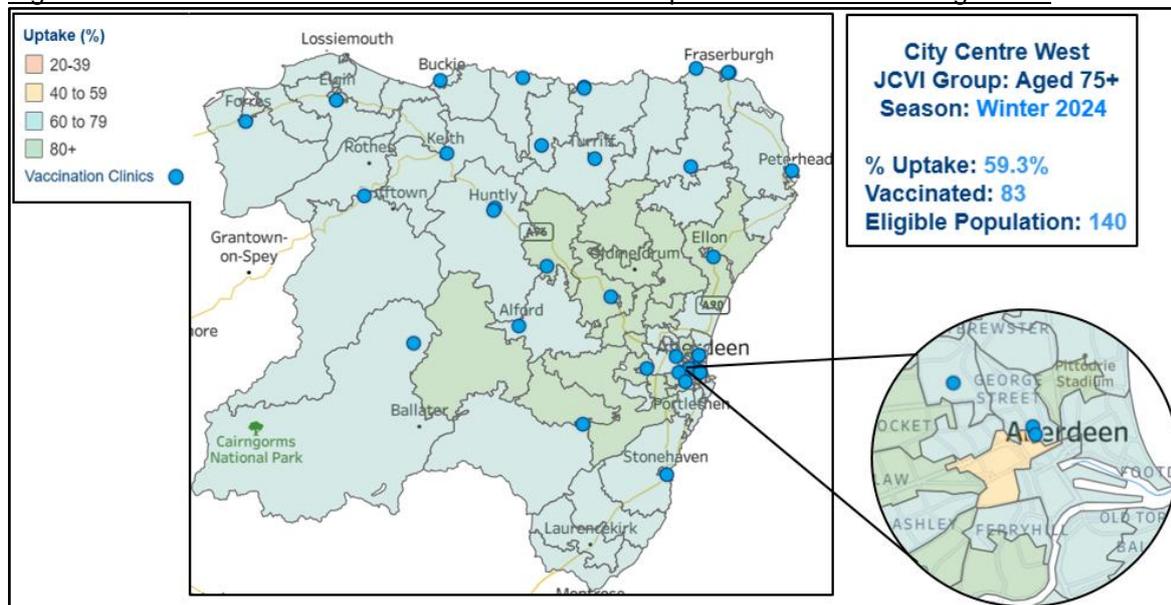
Intermediate zone maps were used to identify areas of low uptake. Figure 43 displays COVID-19 uptake across all cohorts and most intermediate zones throughout NHS Grampian were between 40-59% uptake (amber). This reflects the lower uptake rates throughout the WIS and at-risk cohorts. When filtered to only display the 75+ cohort (figure 44), the map changes sharply to uptake rates of 60% and over (green). City Centre west is one of the only intermediate zones that has less than 60% uptake.

Figure 43: Autumn Winter 2024/25 Intermediate Zone Uptake for COVID-19 - All Cohorts



Data Source: Discovery (2025)

Figure 44: Autumn Winter 2024/25 Intermediate Zone Uptake for COVID-19 – Aged 75+

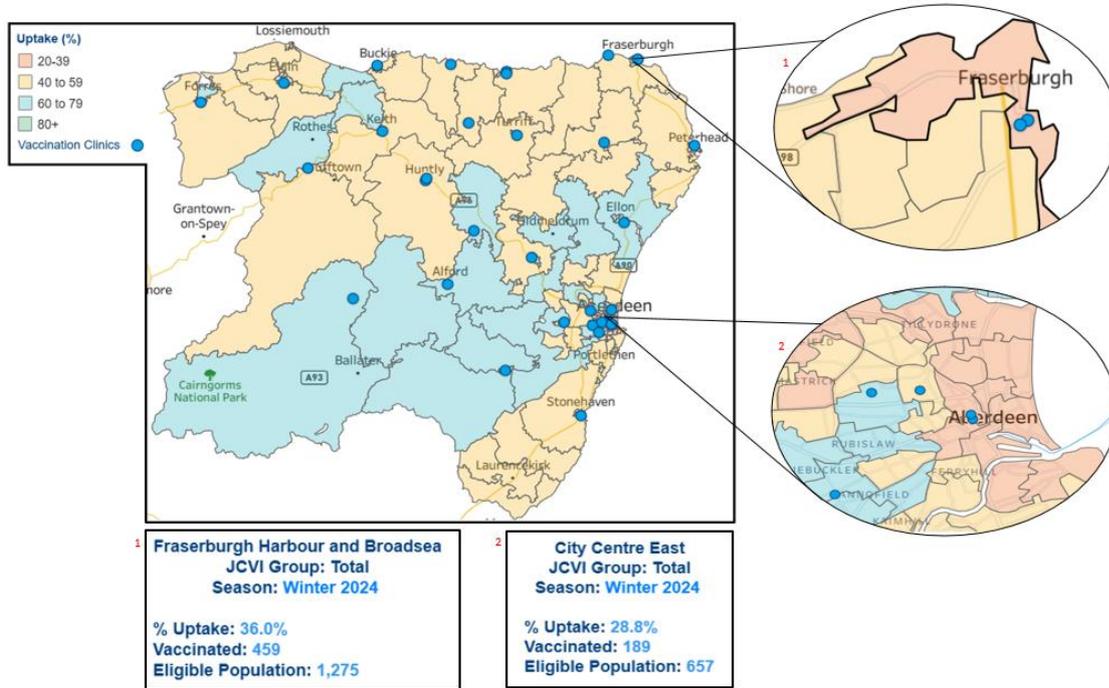


Data Source: Discovery (2025)

Similar intermediate zone analysis for influenza demonstrated noticeable differences from COVID-19 maps. Higher uptake occurred throughout all zones, though some areas fell below 40% (Figure 45) due to the lower younger cohort uptake rates. When filtered to 75+ only (Figure 46), most areas exceeded 80% uptake. The maps were

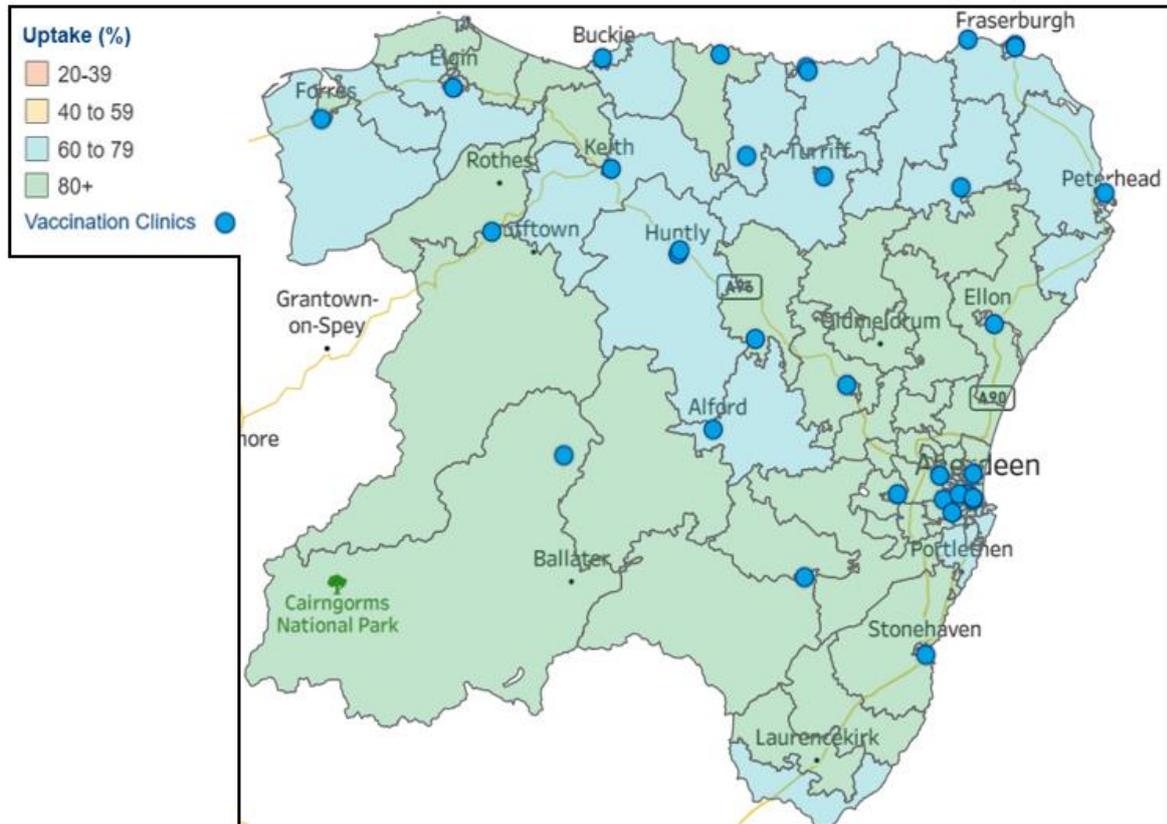
presented to HSCP teams which allowed for targeted interventions in the lowest uptake areas.

Figure 45: Autumn Winter 2024/25 Intermediate Zone Uptake for Influenza - All Cohorts



Data Source: Discovery (2025)

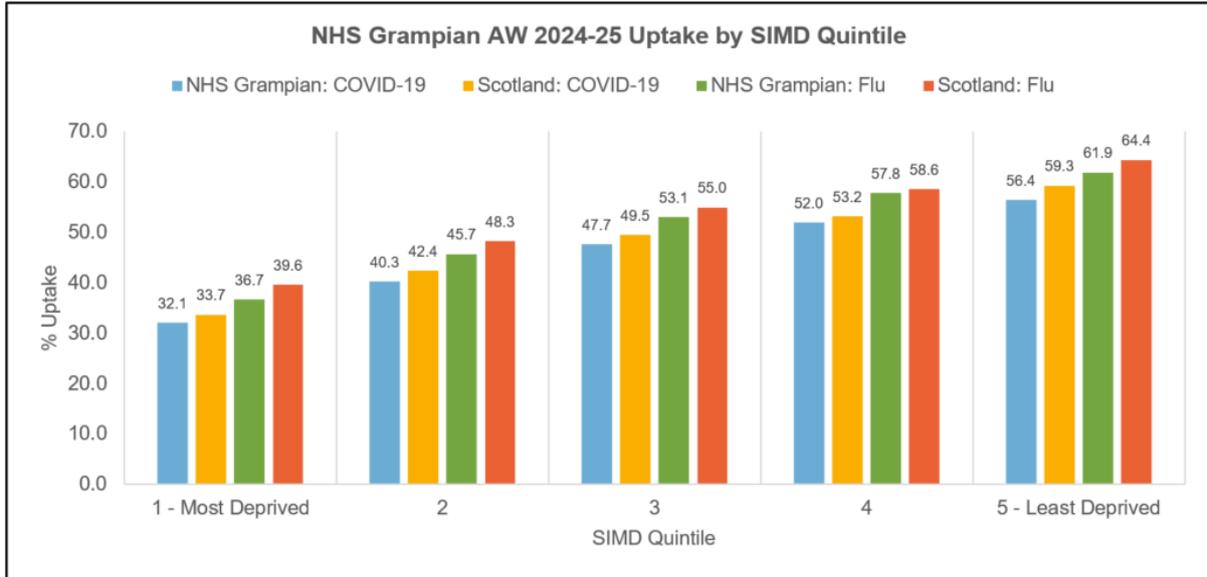
Figure 46: Autumn Winter 2024/25 Intermediate Zone Uptake for Influenza – Aged 75+



Data Source: Discovery (2025)

NHS Grampian's vaccine uptake by deprivation level (figure 47) is slightly below the Scottish average, following the typical pattern where uptake decreases by approximately 6% per SIMD quintile. Between the most deprived (SIMD 1) and least deprived (SIMD 5) areas, there's a 24.3% uptake difference for COVID-19 (Scotland: 25.6%) and 25.2% for Influenza (Scotland: 24.8%). The COVID-19 uptake gap between least and most deprived is slightly narrower compared to Winter 2023 whereas influenza is slightly wider (1%).

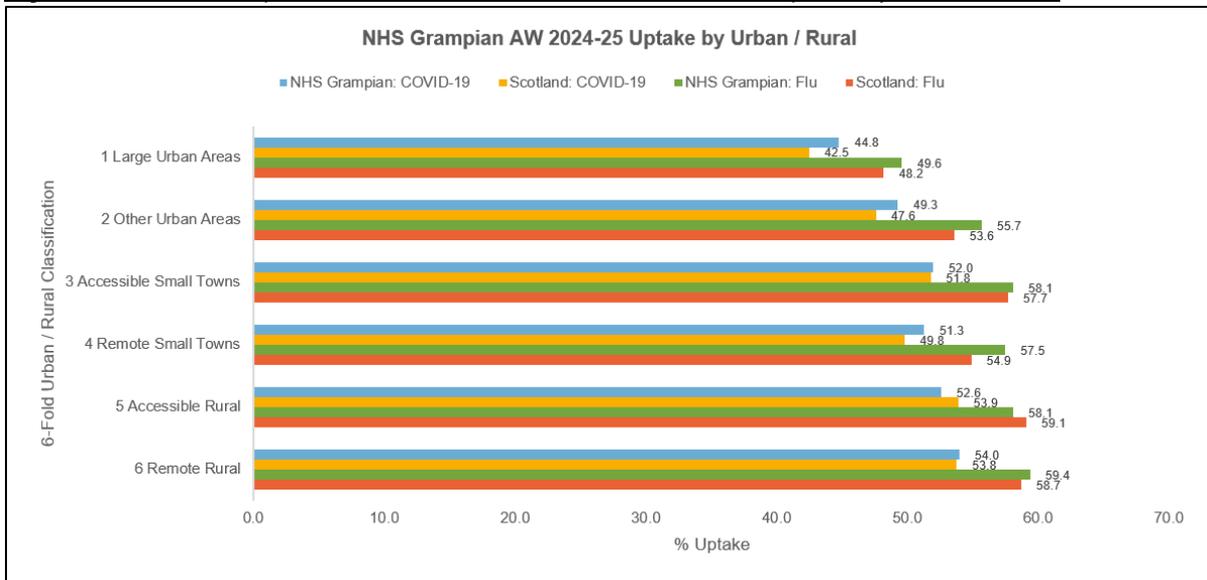
Figure 47: NHS Grampian AW 2024/25 COVID-19 and Influenza uptake by SIMD Quintile



Data Source: Discovery (2025)

NHS Grampian's uptake by 6-fold urban/rural classification (based on population and accessibility, displayed in figure 48) exceeds the national average in all areas except accessible rural, consistent with previous years. Remote rural areas showed the highest uptake for influenza (59.4%) and COVID-19 (54%), indicating vaccination services successfully reach all Grampian communities without accessibility barriers.

Figure 48: NHS Grampian AW 2024/25 COVID-19 and Influenza uptake by Urban / Rural



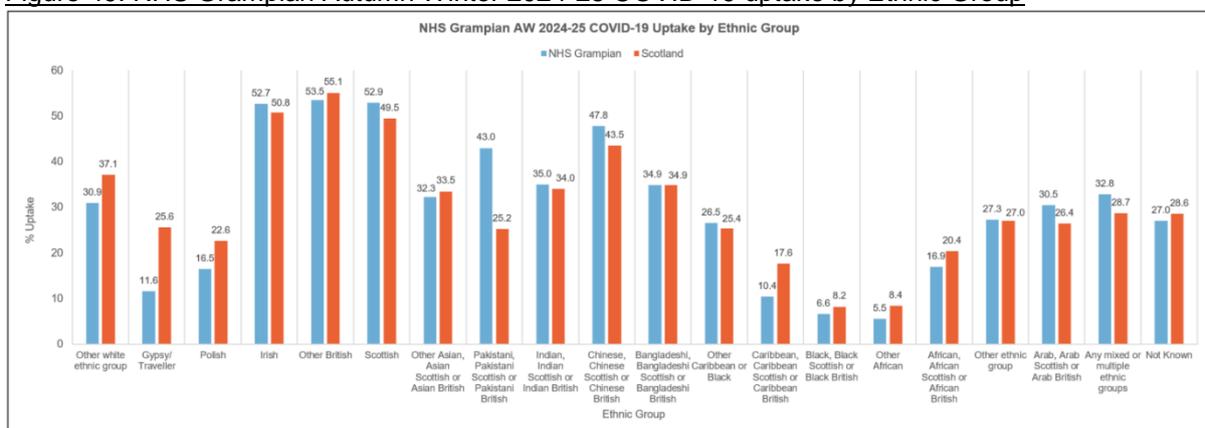
Data Source: Discovery (2025)

NHS Grampian's vaccination data shows ethnic inequalities across both COVID-19 and influenza programmes shown in figure 49 and 50, with persistent 45-50% gap between White populations (highest uptake) and African communities (lowest uptake), similar to previous years. These communities also have lower uptake than the Scottish

averages. Although influenza coverage is higher, the same groups face barriers to both vaccines, indicating the need for targeted interventions in African, Caribbean, Black and Gypsy/Traveller populations to address systematic vaccination inequities.

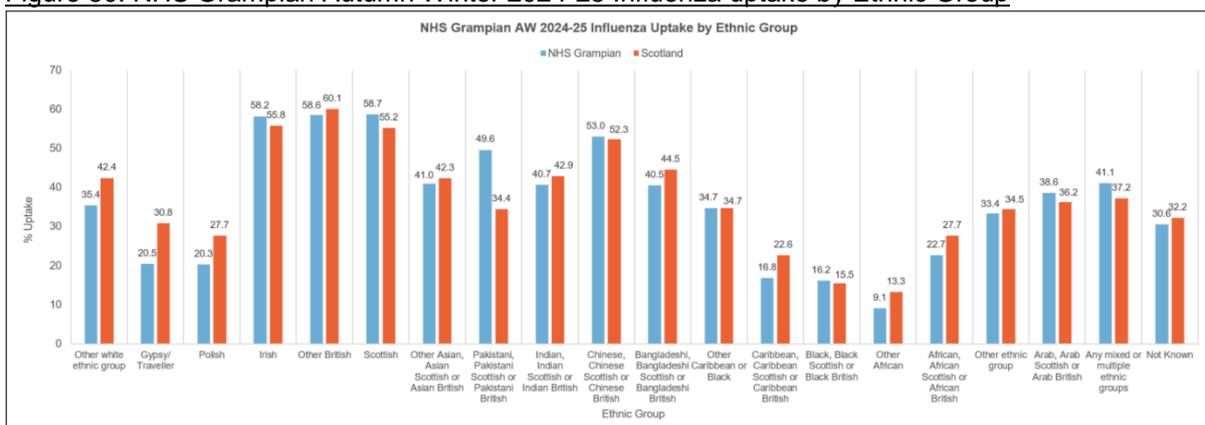
During 2024/25, Aberdeen City implemented targeted strategies to reduce vaccination inequalities among priority groups, including African, Caribbean, Black, and Gypsy/Traveller populations. Interventions focused on high-deprivation areas, with Priority Intervention Hubs, pop-up clinics, and strong community partnerships improving access. These hubs provided vaccinations and health promotion in non-medicalised environments, reducing barriers to care. These efforts demonstrate a sustained commitment to tackling health inequalities and improving vaccine coverage across all communities.

Figure 49: NHS Grampian Autumn Winter 2024-25 COVID-19 uptake by Ethnic Group



Data Source: Discovery (2025)

Figure 50: NHS Grampian Autumn Winter 2024-25 Influenza uptake by Ethnic Group



Data Source: Discovery (2025)

6.5.2 SPRING 2025

Similar to Spring 2024, the Spring 2025 campaign ran from 1st April until 30th June 2025. During this period, eligibility criteria remained the same as 2024 – individuals were eligible for a COVID-19 vaccination if they were part of the cohorts in Table 13.

Table 13: Spring 2025 Eligibility Criteria and Population Changes

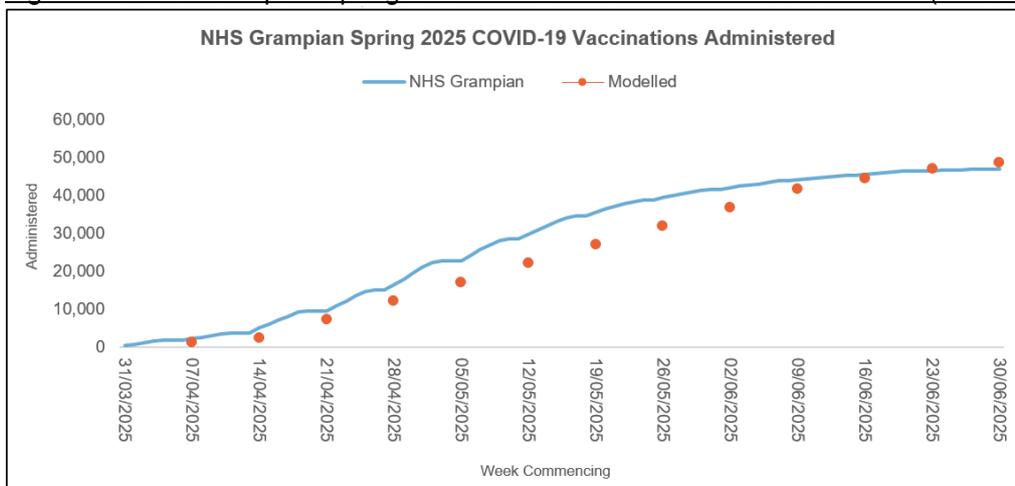
Cohort	Population		% Difference
	2024	2025	
Older people care home residents	2,911	3,055	4.9
Aged 75+	53,286	55,125	3.5
Weakened immune system	14,526	15,083	3.8
<i>Age 18 to 74 weakened immune system</i>	14,086	14,661	4.1
<i>Age 12 to 17 weakened immune system</i>	261	276	5.7
<i>Age 5 to 11 weakened immune system</i>	151	139	-7.9
<i>Age 6 months to 4 years weakened immune system</i>	27	26	-3.7
Distinct Total	70,723	73,263	3.6

Data Source: Discovery (2025)

Grampian's eligible population increased to 73,263 (+3.6% from 70,723 in 2024), and vaccinations administered decreased to 46,602 from 48,546. This resulted in 63.6% uptake versus 68.6% in 2024 (-5%), requiring 3,656 additional vaccinations to match previous performance. Scotland showed similar decline (-4.6%).

The 13-week campaign averaged 3,618 weekly administrations, peaking 28th April-12th May with 20,211 vaccines (43.3% of total) as seen in figure 51. NHS Grampian's vaccinations fell below the national model (based on previous years) by 3.7% towards the end of the campaign, while Scotland on average dropped by approximately 8%. The spring 2025 programme protected our vulnerable citizens earlier than previous campaigns.

Figure 51: NHS Grampian Spring 2025 COVID-19 Vaccinations Administered (cumulative)

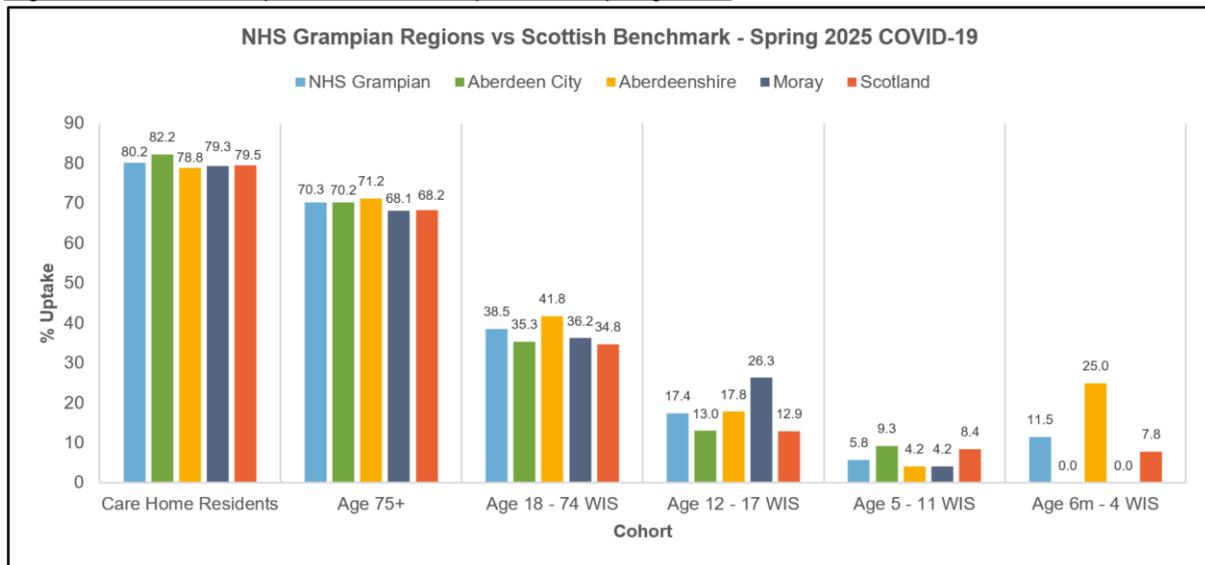


Data Source: Discovery (2025)

NHS Grampian achieved 3% above the Scottish average for Spring 2025 vaccine uptake. The cohort summary charts below show performance across different groups, with detailed breakdowns available in the Appendix (page X).

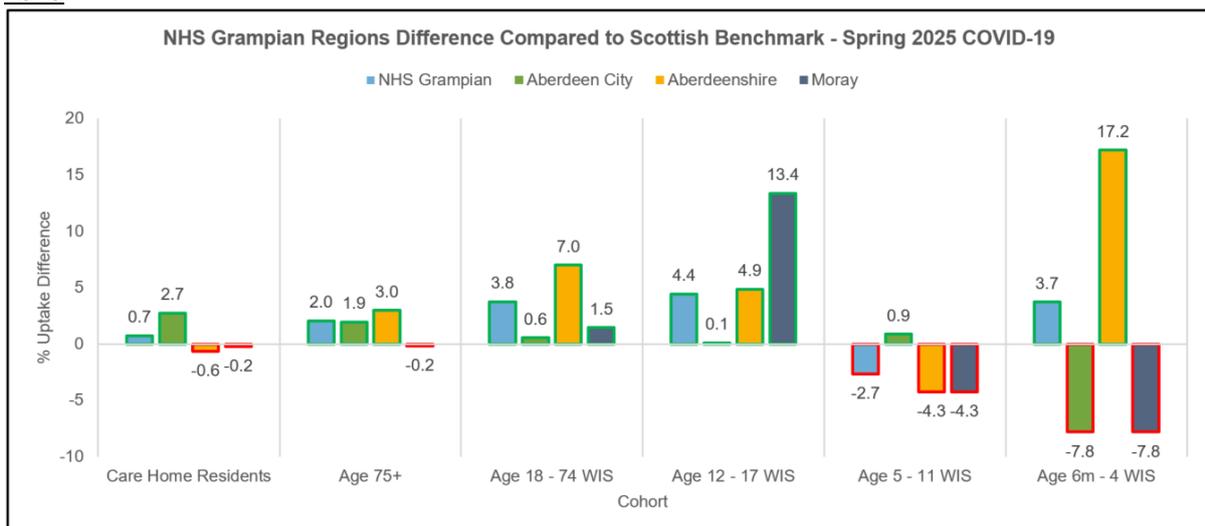
The first chart (52) compares uptake rates for NHS Grampian and the three HSCPs against the Scottish average. While most cohorts had strong uptake, children aged 5-11 with weakened immune systems fell 2.7% below the national average. The second chart (53) displays these differences with Scotland average set at zero.

Figure 52: NHS Grampian and HSCP Uptake for Spring 2025



Data Source: Discovery (2025)

Figure 53: NHS Grampian Difference Compared to Scottish Benchmark Divergence Chart – Spring 2025

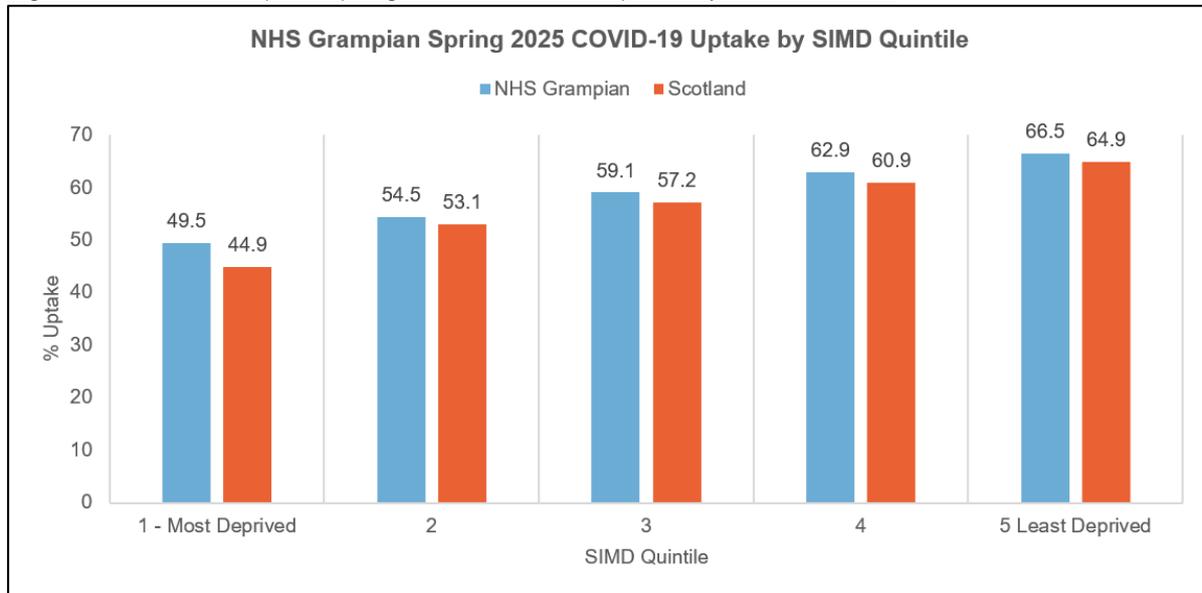


Data Source: Discovery (2025)

Uptake by SIMD Quintile for NHS Grampian is above the Scottish average throughout all quintiles. However, all boards follow the same pattern whereby the most deprived

areas have lower uptake, consistent with other vaccination programmes. In figure 54 below, we can see that the most deprived uptake was 49.5% compared to the least deprived at 66.5%. There is a narrower gap (17%) between most and least deprived compared to Scotland (20%) however the gap for Grampian increased by 1.6% compared to Spring 2024 (15.4%).

Figure 54: NHS Grampian Spring 2025 COVID-19 uptake by SIMD Quintile

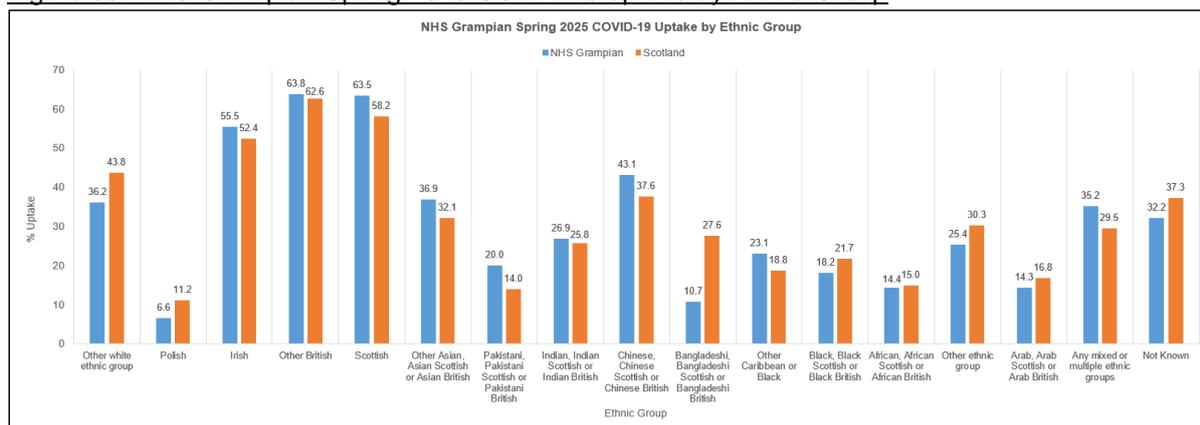


Data Source: Discovery (2025)

The Spring 2025 campaign achieved strong uptake rates across most cohorts: 80.2% for care home residents, 70.3% for individuals aged 75 and over, and 45.6% for those with weakened immune systems - all surpassing national averages. However, younger children with weakened immune systems showed lower uptake, indicating a need for ongoing work. Future efforts will focus on improving identification of eligible children through enhanced clinical record reviews to ensure accurate eligibility determination, and we want to work closely with healthcare teams to make sure all children eligible are supported to access the service. The aim is to make access simpler and more accessible, strengthening partnerships with specialities so we can reach and engage with families more effectively.

Spring 2025 vaccinations by ethnic group (Figure 55) show NHS Grampian performing well in several populations, including Scottish (63.5%), Irish (55.5%), and Other British (63.8%) groups. However, uptake falls below the national average in certain communities: Bangladeshi populations show the largest gap at 16.9% below the Scottish average, while Polish and Pakistani communities also demonstrate lower uptake. These disparities indicate a need to investigate potential barriers such as communication preferences, language access, or differing information needs within these communities. Understanding these factors will inform the development of culturally appropriate vaccination strategies for future campaigns.

Figure 55: NHS Grampian Spring 2025 COVID-19 uptake by Ethnic Group



Data Source: Discovery (2025)

6.6 UPTAKE AND DELIVERY OF OTHER SELECTIVE AND NON-ROUTINE VACCINES

Non routine vaccinations cover a range of situations where citizens require vaccination out with the usual population vaccination schedules. These include those identified as at clinical risk as defined in the Green Book, post exposure prophylaxis, individuals recently treated for cancer or who have had a stem cell transplant and require their full course of vaccinations again; bat handlers or travellers who have been scratched or bitten by rabid animals; new residents in Scotland requiring catch up vaccinations.

Non routine does not include occupational, sexual health risk-based vaccinations or travel vaccinations.

With no national scheduling, call or recall system for non-routine vaccinations, Boards have been working to put in place processes which support the delivery of these vaccines. NHSG has processes by which services may refer a citizen for vaccinations that are required out with normal vaccination schedules. There remain outstanding operational and clinical questions to be worked through, and we are collaborating with specialist services on a local and national level to achieve clarity and strong clinical governance in this most flexible of programmes. A local working group has been established to improve and further develop a system-wide approach to non-routine vaccinations in NHSG with the aim to protect the health of the local population and reduce inequalities. There is also a recently established national “Selective Vaccinations” group with this remit and NHSG representation.

A CMO letter clarifying the place of non-routine vaccinations was issued in July 2024¹⁶.

A digital referral pathway has successfully been established in NHS Grampian for primary care using SCI Gateway in April 2024 and a further digital pathway for secondary care utilising order comms was implemented in November 2025.

The first form was received via SCI gateway on 8th April 2024 and since then there has been 921 forms submitted as of 30th September 2025. Of this total, 182 (19.7%)

¹⁶ [Non-routine vaccination update](#)

were returned to the sender for further clarification, and 89 (9.6%) were cancelled due to not being eligible for vaccination or duplicated requests. Further evaluation will be carried out. The remaining 650 went on to receive vaccination, 270 were administered in Aberdeen City, 291 in Aberdeenshire and 89 in Moray. Unfortunately, the type of administered vaccination is not currently available on the Business Object reports.

6.7 POST EXPOSURE TREATMENT OF INFECTIOUS DISEASE

Health protection investigations regularly identify persons who have been exposed to infectious disease. Post-exposure treatment with vaccines is recommended in some cases including Diphtheria, Hepatitis A and B, Measles, Meningococcus, MPox and Pertussis. Immunoglobulin may also be indicated for some infections. Health and Social Care Partnerships (HSCP) arrange and administer vaccinations, with referrals made in line with the non-routine vaccine pathway. Out of hours arrangements are under local discussion as vaccination is not funded for an out of hours service. This service gap has come under national discussion in response to discussions about MPox preparedness.

A new post exposure pathway for measles has been developed with clear referral processes in place.

A tetanus pathway is in progress to streamline the referral process for subsequent vaccination following clinical review and initial treatment.

A pathway for rabies is also in development, in collaboration with relevant stakeholders.

6.8 BABIES BORN TO MOTHERS WITH HEPATITIS B

The risk of developing chronic hepatitis B (Hep B) infection depends on the age at which infection is acquired. Chronic infection occurs in 90% of those infected perinatally but is less frequent in those infected as children (e.g. 20%-50% in children between one and five years of age). Post-exposure immunisation is provided to infants born to Hep B infected mothers, identified through antenatal screening, to prevent mother to child transmission at or around the time of birth.

Immunisation of the infant starts as soon as possible after birth, and no later than 24 hours, and is followed by additional doses at four weeks and one year. These doses are in addition to the routine schedule at 8, 12 and 16 weeks. An updated vaccination schedule is due to be implemented in January 2026, which substitutes the monovalent Hep B dose offered at one year of age, with the addition of a dose of hexavalent vaccine at 18 months as part of the main schedule.

During 2024/25, a total of 15 babies were born to mothers' resident in Grampian infected with Hep B (Table 14). Because of the small numbers involved the breakdown of the data is not provided.

Ongoing audit and analysis of vaccinations is discussed at the appropriate Grampian Newborn Screening overview meetings.

Table 14: Hepatitis B Screening Status of All Mothers Delivering in Grampian during the Period April 2024 – March 2025

Hep B Screening Status of all mothers delivering in Grampian during the period April 2024 - March 2025				
Health Board	Hep B Screening Result: Negative	Hep B Screening Result: Positive	No Screening results	Total
Grampian	4,554	15	46	4,615

6.9 BCG FOR NEWBORNS AT RISK OF TUBERCULOSIS

In 2024, 870 babies in Grampian were identified as meeting the national eligibility criteria for BCG vaccination. Of these 721 (82.9%) received the vaccine within the first 12 months of life (table 15). This puts us 3rd highest in Scotland behind only Shetland and Orkney.

The BCG uptake levels in at risk infants in Grampian is slightly under the 2018 Scottish TB Framework Key Performance Indicator level (set at 85% uptake level) by 2.1%.

Table 15: Uptake Levels of BCG for Eligible Infants During the Period 2017 – 2024

Year Turning 12 Months	Cohort Size	At Risk		Immunised		
		n	% of Cohort	n	% of SIRS Cohort	% of At Risk
2017	6,254	952	15.2	696	11.1	73.1
2018	5,922	852	14.4	645	10.9	75.7
2019	5,846	811	13.9	598	10.2	73.7
2020	5,467	707	12.9	541	9.9	76.5
2021	5,165	710	13.7	561	10.9	79.0
2022	5,374	846	15.7	658	12.2	77.8
2023	5,024	887	17.7	766	15.2	86.4
2024	4,793	870	18.2	721	15.0	82.9

Source: PHS Childhood Immunisations Publication 2025

6.10 VACCINATIONS DELIVERED IN SEXUAL HEALTH CLINICS

A small number of vaccinations (including HPV, Hep A, Hep B, Prevenar and MpoX) are carried out in sexual health clinics as part of their specialist assessment and treatment.

Since the MpoX outbreak in 2022/23 NHS Grampian sexual health clinics vaccinated 833 individuals, with all those eligible having been offered an appointment to attend for 1st and 2nd doses. Opportunistic vaccinations continue. A further breakdown is detailed below in Table 16.

Table 15: Vaccinations Delivered Within Sexual Health Clinics

Vaccinations Delivered in Sexual Health Clinics						
Financial Year	HPV	Hep A	Hep B	Hep A & B	Prevenar	MPX
2021-22	362	84	97	271	14	
2022-23	376	57	118	335	29	
2023-24	284	48	128	250	35	
2024-25	277	39	173	271	21	202

Source: NaSH – 21st October 2025

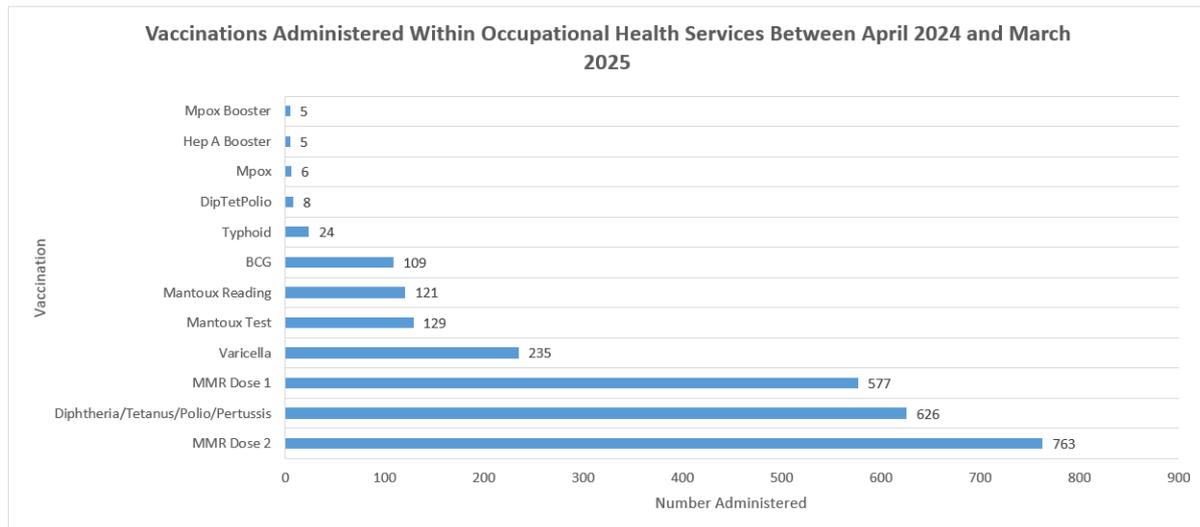
6.11 VACCINATIONS DELIVERED IN OCCUPATIONAL HEALTH SERVICES

Occupational Health Services (OHS) provides professional, confidential and impartial specialist advice to support employees in the workplace about their health.

The OHS runs clinics for staff in the Aberdeen and Elgin sites offering Hep A, Hep B, DTP, DtaP, Typhoid, MMR, Pertussis and Varicella vaccines. The team also offer Mantoux testing and Mpox vaccine to eligible staff. External clinics at RGU support the student cohorts as well as maternity staff. The draft staff Immunisation policy is currently being reviewed by the Equality and Diversity team.

Between April 2024 and March 2025, a total of 6,633 vaccinations were administered within the occupational health services. 4,019 (60.6%) of these vaccines were Hep B vaccinations. A breakdown of the remaining 2,614 vaccinations is displayed in the below figure 56. Of note, numbers of first and second MMR vaccinations were considerably higher in 24/25 than 23/24. 1st dose is 577 compared to 359 the preceding year and an amazing 763 individuals have completed their MMR course compared to 466 the previous year.

Figure 56: Vaccinations Administered Within Occupational Health Services Between April 2024 and March 2025



6.12 TRAVEL HEALTH

The delivery of a travel health service was part of the GMS contract and is therefore currently funded via the PCIF. There is a requirement to deliver the function in all health board areas as detailed in the Chief Medical Officer letter [SGHD/CMO\(2021\)13](#) issued on the 31st March 2022.

NHS Grampian have delivered travel health services via a community pharmacy model since October 2021. Due to budget tracking, a highlighted potential overspend in August 2024 prompted the decision to develop and implement a once for Grampian approach to an in-house, capacity led delivery model, which projected a cost saving. Following agreement to implement the new delivery model, a soft launch took place in January 2025, with a full implementation in February 2025. The service is delivered from 3 sites across Grampian.

The new model of delivery is designed to make full use of the existing national digital offer to direct and assist traveller to self-care and make their own initial risk assessment prior to approaching the travel health service with a completed self-assessment form, which is then reviewed by the travel team. Individuals are asked to source their current vaccination history from their own records, or by requesting this from their GP (as the holder of the complete record.) A comprehensive risk management review is undertaken, with consultations offered online via Near Me Consultation where individuals are offered and sign posted to appropriate health and safety advice relevant to their destination, along with guidance on managing existing health conditions. Due to the capacity of the team, those who submit an assessment less than 8 weeks before their intended travel date are signposted to a private provider to access their health advise and vaccinations privately.

The service continues to offer the 4 vaccinations available free on the NHS (Polio, given as a combined diphtheria/ tetanus/ polio; Typhoid; Hepatitis A and Cholera). For individuals who require further vaccination and malarial medication, they are signposted to community pharmacy to arrange these privately. Travellers who are

identified as requiring further routine vaccinations to ensure the routine schedule is completed (e.g. MMR/ Diphtheria/tetanus/polio) are referred to the vaccination team via the non-routine route, for administration as required.

Up until the end of September 2025, there have been 1,127 travel health assessments received and of these, 56.7% (639) were female and 43.3% (488) were male. The citizens that submitted the forms resided throughout Aberdeen City (43.5%), Aberdeenshire (47.2%) and Moray (9.4%).

Further information on the service can be found in the Spotlights section 9.

7 EQUITY IN GRAMPIAN

7.1 HOME SCHOOLED CHILDREN

A number of vaccination programmes for children are delivered in partnership with schools. Schools distribute our information packs and provide practical assistance with delivering vaccination on site. This is extremely convenient for children and parents alike. However, if a child is not on a school roll for any reason, they are unable to benefit from this convenience. Children who are off roll and/or home schooled are entitled to an equivalent offer of healthcare and these rights are enshrined in the United Nations Convention on the Rights of a Child (UNCRC). Current arrangements are generally sending information to education departments for dissemination on to the parents of those children identified on their registers. The parents are requested to phone in and book a vaccination appointment for their children.

However, although local authorities have a responsibility to keep a register of home-schooled children, parents are not compelled to let the local authorities know of home schooling. This population of children is therefore difficult to identify. Children's vaccinations and health screening are administered through the SIRS system and is given an annual data uplift from education sources.

Home-schooled children in the UK are believed to have lower vaccine uptake than their mainstream school peers. The absence of a national dataset makes it difficult to confirm and address this disparity. For this reason, we decided to test whether there was an inequity between vaccination uptake for the off roll/home schooled population and the general population.

NHS Grampian's Child Health Team identified 2,746 children coded as 'HOME TUITION- C/S 0,1,3' or 'No School' which are broken down into their relative cohorts in table 17. Their vaccination histories were analysed, focusing on four key vaccines: HPV (first dose), MenACWY, Td/IPV, and MMR. The first three are given in secondary school. MMR is given as a preschool vaccine but was included both as a vaccine which is offered in secondary school as a catch up and is a marker for preschool vaccinations.

Across Grampian, while general uptake rates for Td/IPV (76.5%), MenACWY (76.2%), HPV (82.2%), and MMR (95.4% first dose, 90.8% booster) exceed national averages, uptake among home-schooled children is markedly lower as seen in Figures 57 and 58.

Gender disparities are also evident, with females generally showing higher uptake especially with HPV, though Aberdeenshire reports higher male rates for MenACWY.

These findings highlight the urgent need for targeted outreach and a unified strategy to ensure equitable vaccine access for all children, regardless of educational setting.

Table 17: Children Flagged as Home School or Have No School Attachment

HPV	Aberdeen City	Aberdeenshire	Moray
HOME TUITION- C/S 0,1,3	25	120	10
No School	464	252	511

MenACWY	Aberdeen City	Aberdeenshire	Moray
HOME TUITION- C/S 0,1,3	16	85	< 10
No School	374	215	467

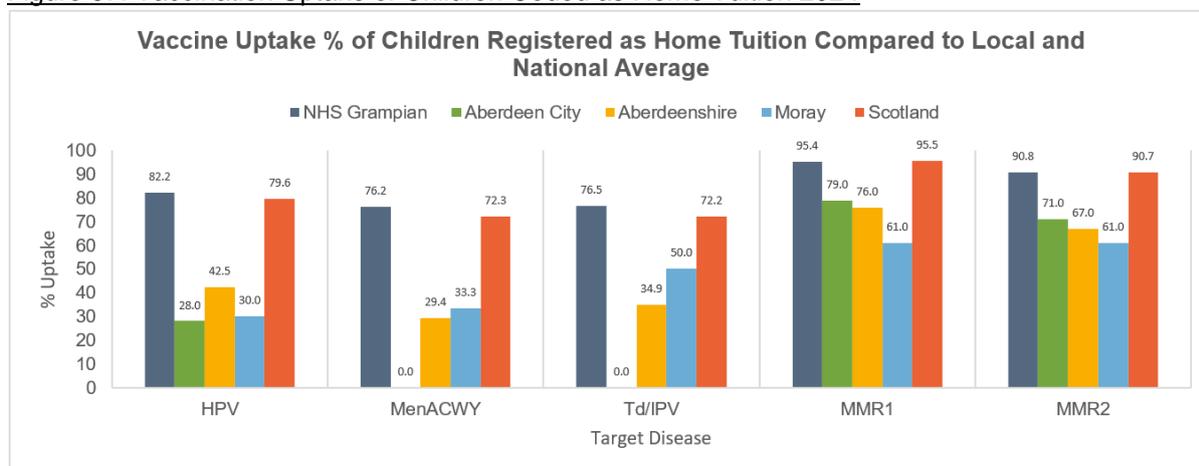
Td/IPV	Aberdeen City	Aberdeenshire	Moray
HOME TUITION- C/S 0,1,3	< 10	43	< 10
No School	203	141	430

MMR1	Aberdeen City	Aberdeenshire	Moray
HOME TUITION- C/S 0,1,3	86	314	36
No School	1,022	465	823

MMR2	Aberdeen City	Aberdeenshire	Moray
HOME TUITION- C/S 0,1,3	86	314	36
No School	1,022	465	823

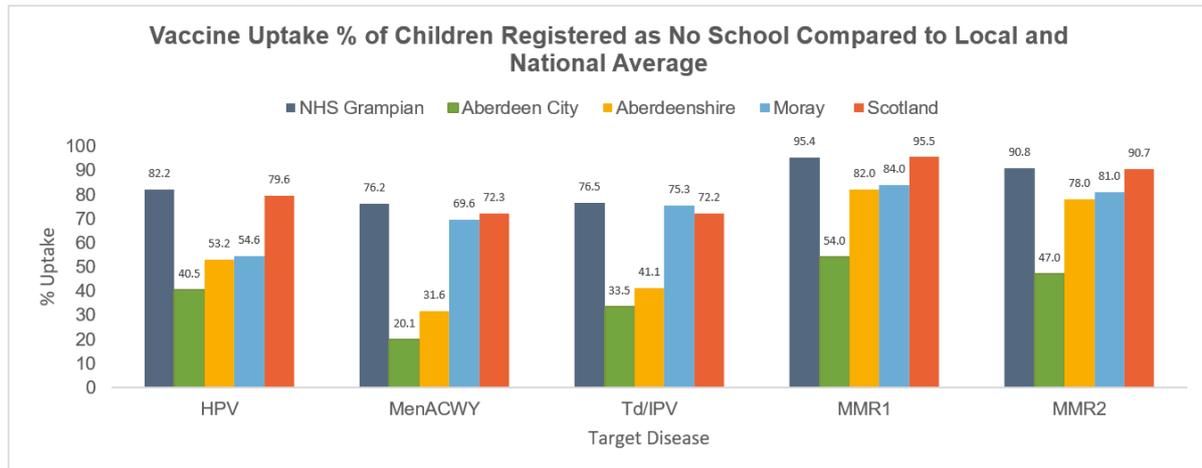
Source: SIRS – 21st October 2025

Figure 57: Vaccination Uptake of Children Coded as Home Tuition 2024



Source: SIRS – 21st October 2025

Figure 58: Vaccination Uptake of Children Coded as No School 2024



Source: SIRS – 21st October 2025

Following the home-schooled vaccination deep dive, letters were sent to households confirming eligibility for the autumn/winter vaccination programme. At the same time these letters also advised families to come forward for other routine childhood vaccines. Evaluation of this measure will be used to make decisions/ further inform about further interventions for this group.

7.2 EQUITY AUDIT

PHS's 5-year Vaccination and Immunisation Framework and Delivery Plan 2024 (5YSF), identifies barriers alongside recommendations to improve uptake for under-served populations which include: young people/older people, LBGTQIA+ people, minority ethnic people, people who are unmarried, married or in a civil partnership, people who are pregnant/new parents, disabled people, people in rural locations, people in poverty, people in the criminal justice system, gypsy & traveller groups, homeless people, asylum seekers & refugees, carers and staff.

We have been:

- Establishing the size of populations of under-served groups in each of the partnership areas.
- Monitoring uptake data for intermediate zone, ethnicity, urban / rural and by SIMD produced by PHS (Discovery).
- Auditing NHS Grampian vaccination and immunisation service practice for under-served populations, against the PHS 5YSF recommendations.

Findings:

- NHS Grampian vaccination centres have paper copies of PHS leaflets explaining the vaccination schedule, vaccine safety and side effects. PHS leaflets provide links to alternative formats and alternative languages. PHS also provide specific resources aimed at younger people, older people, minority ethnic communities, pregnancy/maternity, people in the criminal justice system and asylum seekers & refugees.

- NHS Grampian local vaccination contact centre provides a phone number and email address to discuss changes to appointments if the time or location is not suitable.
- NHS Grampian vaccination appointments can provide arrangements for language line, BSL interpreters, wheelchair access, portable hearing loops and quiet spaces/rooms.
- NHS Grampian vaccination clinics are available outside of working hours and across NHS Grampian localities including via the Scottish Ambulance Service mobile vaccination bus and the Moray mobile vaccination van.
- NHS Grampian staff flu vaccinations 2025 are available via appointment at permanent vaccination centres, via peer-to-peer scheme in primary and secondary care, at workplace clinics in NHS premises with/without an appointment in September and December, but without priority at Aberdeen City, Aberdeenshire and Moray vaccination centres.
- NHS Grampian have established relationships with a variety of stakeholders including schools, Grampian Regional Equity Council (GREC), drug and alcohol partnerships, services for homeless people, mosques, gypsy & traveller groups and other third sector organisations.

Identified Gaps

- Mechanisms for capturing language, communication, accessibility requirements and location preferences.
 - This may be possible once a single digital solution for the vaccination services is developed.
- Explore arrangements for co-ordinating appointments with partner or a household member.
 - Although it can be difficult to book coordinating appointments online, this can be done by phoning the national helpline in the case of flu and covid vaccinations and the local helpline in the case of other vaccinations.
- Reducing the uptake gap between underserved groups and the general population
 - As the Public Health directorate plan is to work with similar underserved groups, we have contributed to the joint plan this year by identifying and mapping Trusted voices in the North Aberdeenshire area as a first step towards a coordinated approach of reaching into communities with a combined targeted preventative healthcare offer.

7.3 OTHER EQUITY WORK

This is a compilation from the mid-year reports to Vaccination Programme Board for April 2025 – October 2025

7.3.1 Moray

There has been a change in service delivery to the population with Learning Disabilities. Last year some residents opted not to visit the centre. Working with the

Learning Disabilities service, we are vaccinating residents for autumn winter 2025 in their residential facilities and hope to improve the vaccination rates for this cohort.

The Drug and Alcohol service agreed to give their clients fast track appointment cards (similar to those provided to maternity services). These appointment cards mean that service users can come to the centre for vaccination without an appointment. In addition, clinics were organized in the Drug and Alcohol services premises in an attempt to improve uptake of vaccination.

A similar arrangement has been reached with the Moray Council team which supports homeless clients in the Moray area. They also have a supply of fast track appointment cards and outreach clinics in their Elgin facility and Buckie facilities were planned for the autumn winter season.

Targeted clinics for these populations will run from 16.30 – 19.00 in response to service providers advice.

7.3.2 Aberdeenshire

Aberdeenshire has largely focused on rural communities and have prioritised local delivery to reduce travel barriers and improve uptake.

Aberdeenshire have prioritised local delivery to reduce travel barriers and improve uptake:

- Vaccination Centres: Long-term centres established in local towns- Macduff, Fraserburgh, Peterhead, Huntly, Inverurie, Stonehaven, and Banchory.
- Pop-up Clinics in Fire Stations: Partnerships with the Scottish Fire & Rescue Service have enabled clinics in Aboyne, Ballater, Laurencekirk, and Alford, bringing vaccines closer to rural communities.
- SAS: Deploying SAS vaccinators to low uptake and rural areas to improve uptake.
- Hub and Spoke Model- Spoke outreach to rural communities and areas with challenging transport links to ensure high uptake across all of Aberdeenshire.

Aberdeenshire is taking steps to target hard to reach communities-

- Drop-in Clinics: Available across Aberdeenshire for spring boosters, especially targeting older adults.
- Public Campaigns: MSPs and health leaders encouraged residents to get vaccinated, highlighting the importance of protection and reducing NHS pressure. Maximizing local and board level social media.
- Targeted Outreach: Focused efforts to reach vulnerable groups, including care home residents, pregnant women, and those with chronic conditions.

7.3.3 Aberdeen City

Aberdeen City has implemented a range of targeted strategies to ensure equity of vaccination uptake, particularly in line with Standard 4: ensuring good quality data on under-represented groups and taking steps to reduce inequalities. These include:

Priority Intervention Hub Model

- Aberdeen City has expanded the Vaccination Centre into a Priority Intervention Hub offering tailored services to underserved communities. A similar scaled model has been expanded to Get Active @ Northfield, Tillydrone Community Campus and Countesswell Health & Wellbeing Centre.
- The main hub in the City Centre provides same-day access to vaccination, health promotion, and community support in non medicalised environments, helping reduce barriers to access.

Data Driven Targeting

- The Vaccination & Immunisation Annual Report 2024 highlights the use of SIMD (Scottish Index of Multiple Deprivation) and ethnicity-based data to identify gaps in uptake. This enables targeted outreach to harder to reach groups including:
 - People in areas of high deprivation
 - Ethnic minority communities
 - Individuals with low health literacy or digital exclusion

Outreach and Mobile Clinics

- Based on the information above, Aberdeen City has arranged pop up clinics in areas of lower uptake and lower deprivation to support
 - Areas of Low uptake (Tillydrone, Northfield, Mastrick, King Street, Torry etc)
 - Homeless population (Timmermarket)
 - Refugees and asylum seekers (Language Café & Hotels hosting asylum seekers)
 - Substance Misuse (ADA)

Expansion of Pre-school Clinics in Local Communities.

- During 2024/25 the service expanded availability of pre-school clinics in lower uptake areas including:
 - Tillydrone Community Campus
 - Bucksburn Medical Practice
 - Torry Medical Practice
 - Countesswells Health & Wellbeing Centre
- Drop in Access for Pre-school Vaccinations or Vaccine Histories at the Aberdeen Vaccination & Wellbeing Hub.

Community Engagement

- The Aberdeen City Team have attended several community centres and events over the past 6 months to promote vaccinations in underserved areas.

The Aberdeen City Team have attended all Community Appointment Days in the City to promote vaccinations and undertake opportunistic vaccinations where possible.

Impact

- **Childhood Vaccinations** in Aberdeen City have shown year on year improvement with uptake for Rotavirus and MenB exceeding 90% approaching the World Health Organisation target of 95%
- Pneumococcal vaccination uptake among older adults and at risk groups has increased sharply since 2020/21, now exceeding the Scottish Average in most cohorts.
- Shingles vaccination uptake has been particularly strong with 70% uptake and 80% of those recipients completing the two dose course.
- A satisfaction survey was also carried out in regards to expanding our Pre-school Vaccination Clinics in Tillydrone, Bucksburn, Torry and Countesswells and opening up walk ins at the Vaccination & Wellbeing Hub.
- Walk in Access to pre-school immunisation nurses at the Hub on Tuesdays and Thursdays) has been well received by parents especially those with unpredictable schedules or limited transport.
- Parents appreciated the flexibility to speak directly with nurses about their children's vaccine schedule without needing a formal appointment.
- The Central location in the Bon Accord Centre was praised for being non clinical, welcoming, and easy to access, particularly for families with young children.
- Parents have welcomed the availability of clinics closer to their home locations providing easier access.

Community Appointment Days: The rollout of Community Appointment Days demonstrates a proactive and integrated approach to public health, aligning vaccination delivery with broader preventative care and wellbeing services. These initiatives are embedded within the Aberdeen City Health & Social Care Partnership & NHS Grampian Strategic commitment to health equality, early intervention and patient centred care offering accessible, non-clinical environments that reduce barriers to uptake. Crucially, they are underpinned by strong partnership working across sectors, bringing together vaccination teams, Community Treatment & Care, Health Visitors and third sector organisations to co-design and deliver services that meet the needs of underserved populations. This collaborative model not only enhances service reach and trust but also supports wider prevention goals by addressing social determinants of health and promoting holistic wellbeing within local communities.

8 QUALITY IMPROVEMENT AND SAFETY IN VACCINATION

8.1 PRIORITIES FOR IMPROVEMENT NOT MENTIONED ELSEWHERE

8.1.1 DIGITAL IMPROVEMENTS TO NON-ROUTINE PATHWAY/ TETANUS POST EXPOSURE PATHWAY

Pre-populated primary care referral form has been successfully used for a year via SCI Gateway.

Pre-populated secondary care referral form via order comms, has been trialled and went live in Trakcare in late November 2025.

Work on the multidisciplinary tetanus post exposure pathway is nearing completion. This piece of work clarifies the pathway and establishes the principle that the clinicians responsible for the primary assessment and treatment of the tetanus prone wound are also responsible for the first tetanus treatment with antitoxin. If subsequent tetanus injections are required these can be given in vaccination clinics following referral and prescription. With the implementation of the Trakcare form this will be more straightforward for clinicians.

8.1.2 DETAILED RISK ASSESSMENT AND MITIGATIONS OF LOCAL MANUAL APPOINTMENT SYSTEMS.

This was a local Grampian piece of work initiated following incidents in two of our HSCPs involving manual appointment systems involving excel spreadsheets. The process is now complete and the short life working group is disbanded. Thanks to John Reid, who led the process to help us identify our risks, what we had control over and what we couldn't control. Changes have been made to mitigate our risks, and no further incidents have occurred. This remains a temporary fix until the SVIP programme receives its integrated data solution.

8.1.3 HSCP BIENNIAL REPORTS TO VACCINATION PROGRAMME BOARD

A formal biennial reporting process has been instituted this year supported by a template to be completed by HSCPs. The template covers the following areas:

- Activity levels: delivery and uptake of programmes
- Staffing and establishment: Staffing levels, recruitment, training, and workforce planning.
- Finance: Budget utilisation, cost efficiency, and financial sustainability.
- National Vaccination Standards: Compliance with Scottish Government standards and quality benchmarks

Delivery teams have completed this process once at the half year mark and we are reviewing how useful each element is compared to the time taken to complete the template

It is anticipated that the information in this document will be used as the basis for all enquiries about operational delivery of the services by the HSCPs. We hope it will reduce the need for additional reporting in response to all enquiries from inside and outside Grampian.

8.1.4 REVIEW OF VACCINATION SCHEDULING STRATEGY ACROSS GRAMPIAN

A strategic review of the current scheduling framework for vaccination appointments across NHS Grampian is planned for the first half of 2026 with the aim of improving accessibility, equity and efficiency by prioritising proximity to vaccination centres over adherence to local authority boundaries.

A mapping exercise of all adult cohorts will be carried out broken down by intermediate/data zones similar to that done in Moray as part of the needs assessment for a new vaccination site in Elgin. The impact of current scheduling arrangements on travel times, appointment availability and vaccination uptake will be assessed and alternative models assessed which prioritise proximity to a vaccination centre. Barriers to new models will be assessed and stakeholders involved before developing a revised scheduling framework that enhances accessibility and equity across the Grampian region.

8.1.5 EVALUATION OF STAFF FLU VACCINATION OFFER

An evaluation of the 2025/26 staff flu offer is planned for January to March 2026. A senior public health registrar has been identified to carry out the work and will produce an options appraisal for the 2026/27 campaign.

8.1.6 MEDICAL STUDENTS ON VACCINATION PLACEMENTS

This autumn – winter period we have had our first cohorts of 4th year medical students from the University of Aberdeen on placement with vaccination teams as part of the Specialty Preferences block.

Once students completed the basic vaccinator training, they were working alongside staff delivering vaccinations and brief opportunistic interventions as well as learning about prevention, equity and equality and wider public health issues. Evaluation of this pilot is underway.

8.2 RISK MONITORING

Risk within the vaccination programme in Grampian is managed through a structured and proactive approach, ensuring patient safety, operational continuity and compliance with national vaccination standards.

A key element of this process is the maintenance of our risk register on Datix, which provides a centralised platform for recording, reviewing and monitoring risks.

Typical risks include the introduction of new and expanded vaccination programme being introduced at short notice, vaccine supply disruptions, cold chain failures, workforce shortages, data quality issues, adverse weather impact clinic operations as well as digital system to support the safe and effective delivery of vaccination programmes.

9 SPOTLIGHTS

9.1 SPOTLIGHT SCHOOLS

9.1.1 ABERDEEN CITY PILOT

In 2025, Aberdeen City undertook a quality improvement pilot aimed at streamlining the school immunisation programme and improving vaccine uptake. The pilot was implemented across three schools - Hazlehead Academy, Lochside Academy, and St Margaret's, and consolidated multiple immunisation sessions into a single visit for HPV, DTP/MenACWY, and MMR catch-up, rather than the traditional three separate visits. This approach minimised disruption to schools, improved efficiency, and created more opportunities for vaccine promotion and engagement with pupils.

A key feature of the pilot was extended time within schools, which allowed pupils who were initially hesitant or absent to return later in the week, supporting informed decision making and reducing vaccine hesitancy. Dedicated staff, including vaccinators and healthcare support workers, were available to provide reassurance and address concerns.

The results were highly positive: HPV uptake increased by an average of 10.7% across the three schools, with individual improvements ranging from +6.8% to +15.9%, and DTP/MenACWY uptake rose by an average of 4.5%. Staff feedback was overwhelmingly positive, with 82% of vaccination staff and 100% of school staff recommending wider rollout.

Based on these outcomes, the model will be expanded to seven additional schools in 2025, with further rollout planned for 2026–27.

9.1.2 PARTNERSHIP WORKING IN MORAY

In August 2025, Moray Council instituted a new mobile phone in schools' policy to align with Scottish Government guidelines from 2024. The new policy requires that staff, including visitors such as school inspectors and healthcare staff keep mobile phones out of sight and are generally discrete with their use of phones.

Vaccination staff use mobile phones regularly in schools for a number of reasons including checking medical information with parents, taking consent from parents and to use as mobile data hotspots when coverage fails for the mobile devices we use for recording vaccinations in schools. (Staff cannot access school wifi for this purpose). Mobile phones would also be used to call for help in the event of any health emergency.

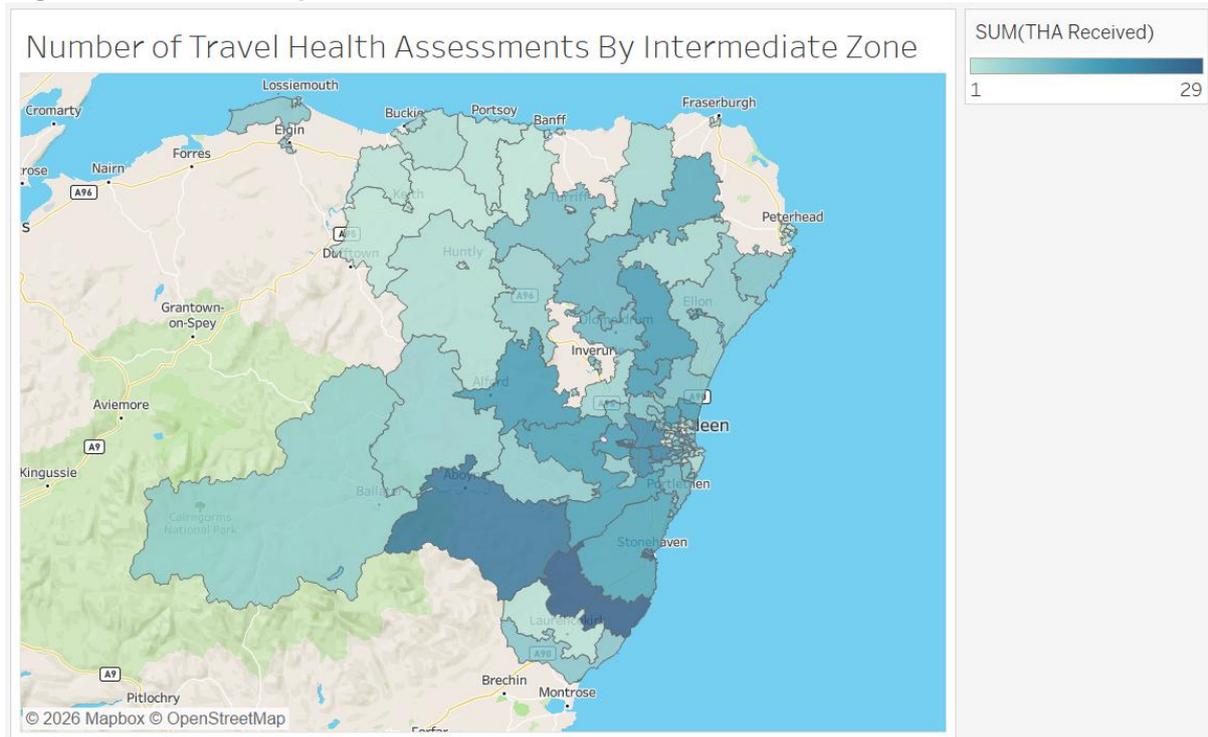
Following discussions with the Education team, mitigations have been put in place including the provision of landlines for staff use in areas where vaccination sessions are taking place, where areas where no landline is available a mobile phone can be used as a landline discretely and in the event of a medical emergency, mobiles can be used freely, especially when someone cannot be left to call for help.

9.2 SPOTLIGHT TRAVEL HEALTH

Travel health is a vital component of public health, as it helps to protect individuals from preventable illnesses and infectious diseases that may be prevalent in their destination/s. Since inception in late January 2025, the Travel Health Team has developed, implemented and continually reviewed robust processes, in line with national guidance, to ensure that all travellers receive the highest standards of care and advice. The travel health team reviews risk assessment forms submitted by citizens prior to travel. Review of the travel risk assessment ensure the travel health practitioner can identify risk, provide advice and recommend appropriate preventative measures required to support safe travel. By providing tailored guidance and vaccinations, we not only safeguard the health of travellers but also reduce the risk of importing infections into our communities. This proactive approach ensures that journeys are safe and enjoyable, whilst supporting global health security.

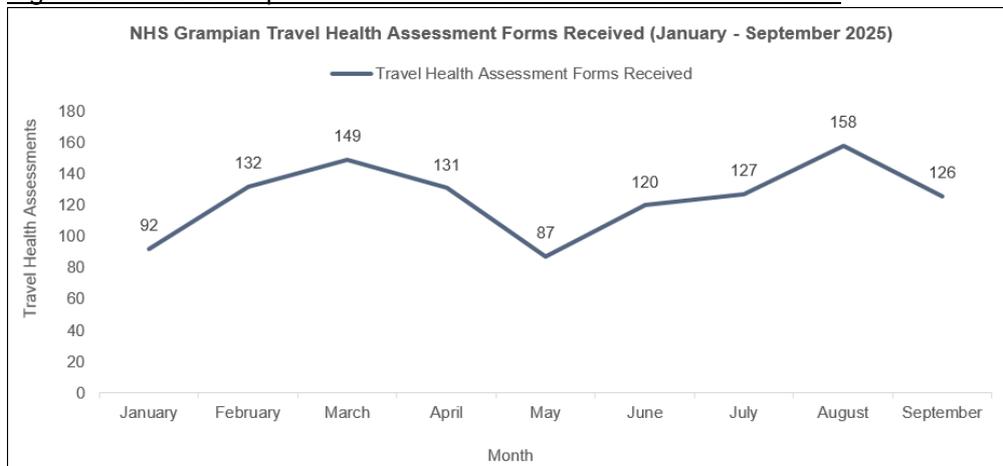
Between January and September 2025, NHS Grampian's travel health service received 1,127 referrals, averaging approximately 125 per month from individuals located throughout all three HSCPs as seen in Figure 59. Referrals peaked in August (158) and March (149), as shown in Figure 60, likely reflecting pre-summer and spring holiday planning patterns. A breakdown of the forms received by age band can be found in figure 661 which suggests the travel health services assists individuals of all ages but particularly those aged between 10-29 and 50-69. Notably, 94.6% of individuals (1,066) accessed the travel health website prior to submitting their form, demonstrating that it serves as an accessible and valued resource for citizens.

Figure 5: NHS Grampian Travel Health Assessment Forms Received



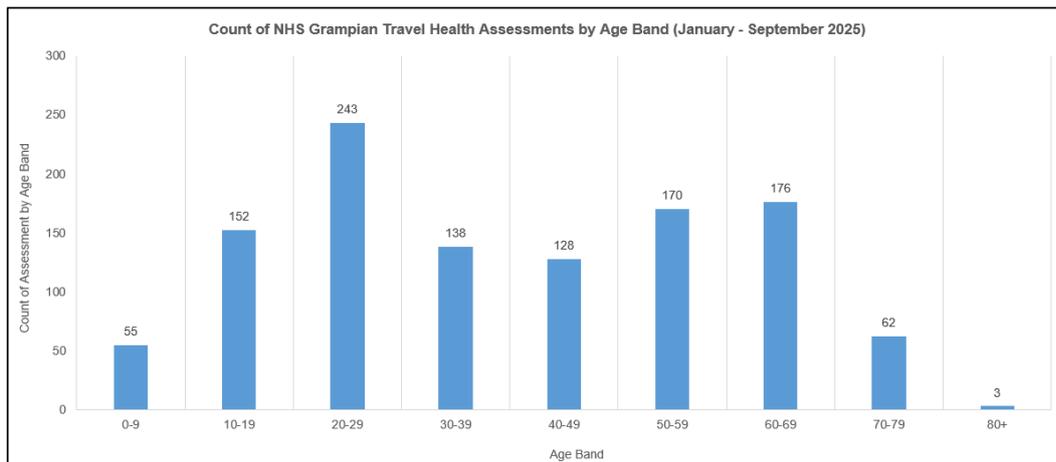
Source: Travel Health Team – 1st October 2025

Figure 60: NHS Grampian Travel Health Assessment Forms Received



Source: Travel Health Team – 1st October 2025

Figure 61: NHS Grampian Travel Health Assessment Forms Received by Age Band

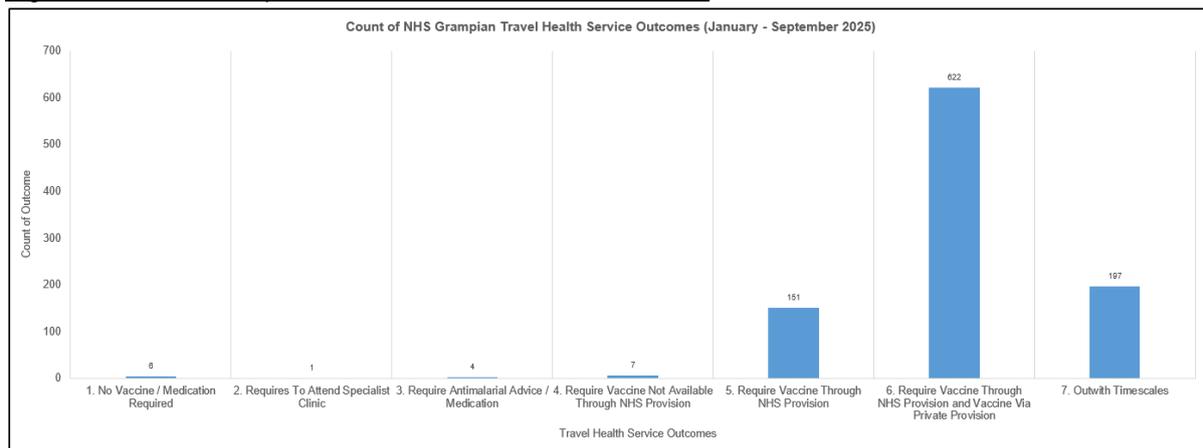


Source: Travel Health Team – 1st October 2025

As of 30th September 2025, 97.2% of forms (1,095) had been completed, with 27 (2.3%) in progress and 6 (0.5%) recalled for a later date, indicating efficient processing and turnaround times.

Reviewing the travel health assessment outcomes of the 1,127 submitted forms (figure 62) revealed that 622 (55.2%) required vaccinations via both NHS and private provision whereas 151 (13.4%) required vaccination through NHS provision only. This indicates that over two-thirds of travellers required some form of vaccination, underscoring the service's critical role in disease prevention

Figure 62: NHS Grampian Travel Health Service Outcomes

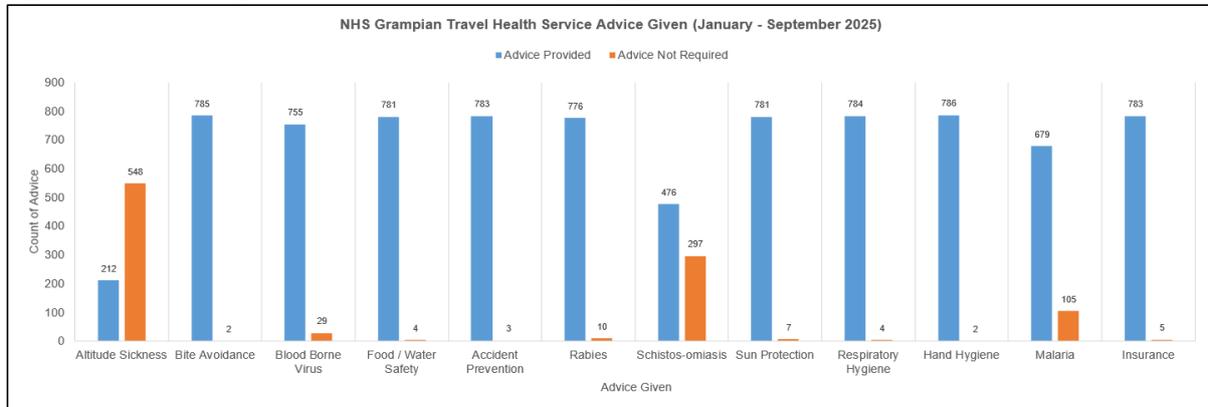


Source: Travel Health Team – 1st October 2025

Figure 63 illustrates the range of advice offered to travellers. Core travel health topics including sun protection, hand hygiene, malaria prevention, food and water safety, and insect bite prevention were discussed with approximately 800 individuals each, reflecting their universal relevance. Specialist advice on altitude sickness and

Schistosomiasis was provided less frequently, tailored to specific destinations and itineraries.

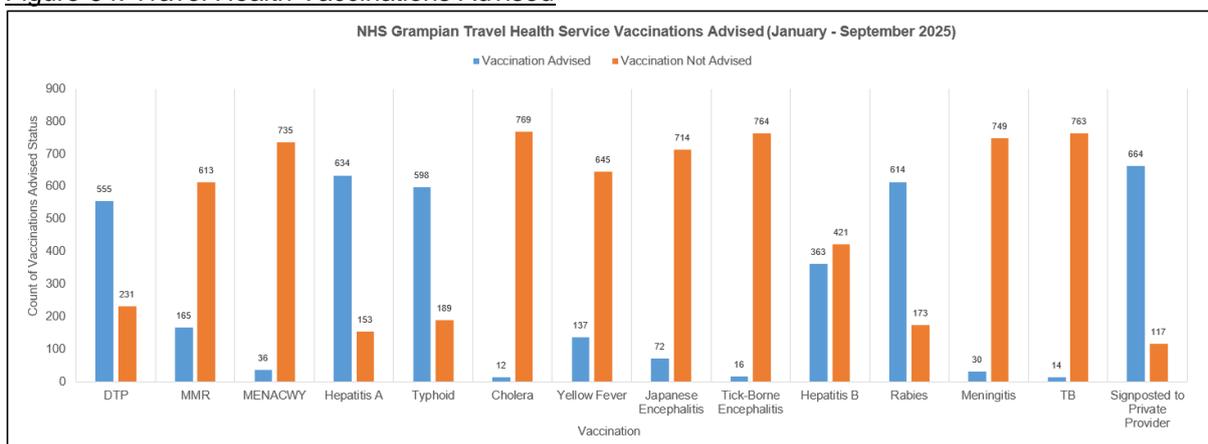
Figure 63: NHS Grampian Travel Health Service Advice Types



Source: Travel Health Team – 1st October 2025

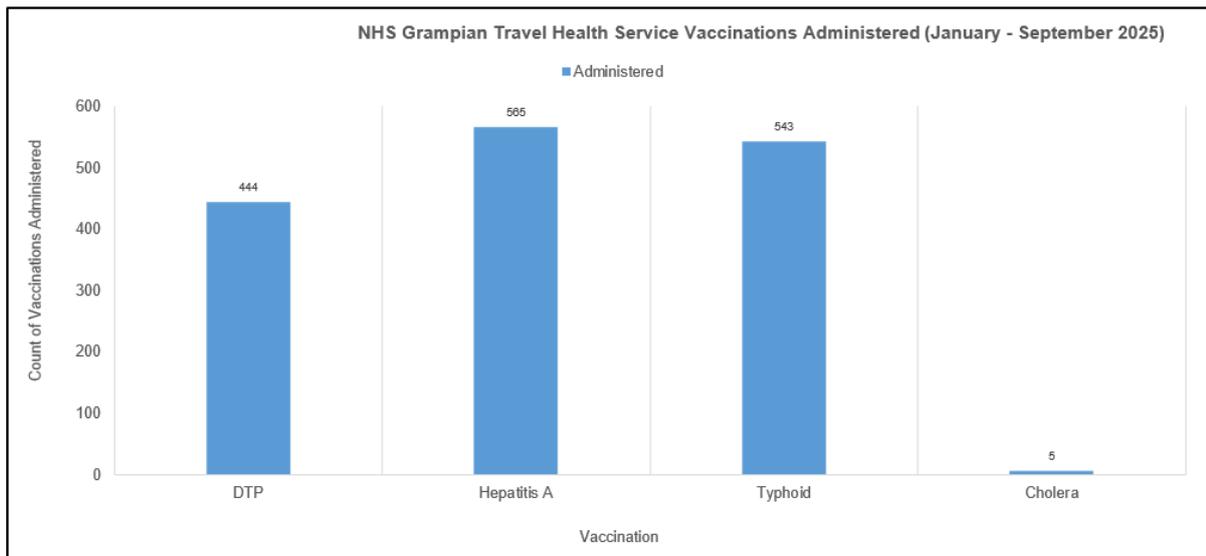
The travel service advised 3,246 vaccinations across all travellers (figure 64) which led to 1,557 NHS vaccinations being administered as of 30th September 2025 (figure 65), approximately 178 vaccinations each month. 664 individuals were signposted to private providers for non-NHS vaccinations, and 45 catchup vaccinations were identified for MMR and MENACWY, and referred, representing an important opportunistic public health intervention.

Figure 64: Travel Health Vaccinations Advised



Source: Travel Health Team – 1st October 2025

Figure 65: Travel Health Vaccinations Administered



Source: Travel Health Team – 1st October 2025

9.3 SPOTLIGHT: GREENING OF VACCINATION SERVICES

Grampian Vaccination and Immunisation Programme (GVIP) are working to reduce emissions and adapt to climate change.

PHS's 5-year Vaccination and Immunisation Framework and Delivery Plan 2024 identifies the need for a climate informed immunisation strategy to meet the NHS Climate Emergency & Sustainability target of net zero emissions by 2040.

We are working in partnership with PHS to see what this might look like in practice and developing methods to measure our environmental impact. Vaccination has many benefits as discussed in this document, but there is also the risk of negative environmental impacts. In Grampian, we aim to balance the two where we can. We have identified carbon emissions across our patient pathways and are looking for ways both to reduce our negative impact and to find ways to make an environmental approach business as usual.

We have been:

- Establishing pathways from vaccination storage at the Aberdeen Royal Infirmary to vaccination delivery at the vaccination centres and satellites across Aberdeen City, Aberdeenshire and Moray.
- Establishing lists of site: name, type, location, postcode, ownership, delivery and programmes across Aberdeen City, Aberdeenshire and Moray.
- Auditing GVIP use and emissions for fleet travel, business travel, electricity, gas, water use and waste in relation to these sites.
- Auditing GVIP use of green space, active travel and reporting of overheating and flooding.

- Designing a questionnaire for visitors to vaccination centres to capture how far and how long they are travelling to vaccination sites; their preferred transport options and preferences about the use of green space on the NHS estate.

Auditing NHS Grampian vaccination and immunisation service has shown that:

- Use and emissions vary across NHS Grampian vaccination centres for fleet travel, gas use and waste. We await further data on business travel, electricity and water use.
- Green space varies across NHS Grampian vaccination centres. We await further data on active travel and reporting of overheating and flooding.

Recommendations so far:

- To disseminate the results of the audit throughout vaccination services
- To create a strategy that will tackle the development of sustainable ways to share and embed good practice within vaccination services
- Explore the development of sustainable, routine monitoring across a range of areas including fleet, business and active travel, utilities, waste, reporting of overheating and flooding and use of green space.

10 PLANNED CHANGES AND HORIZON SCANNING FOR PROGRAMME

The below table provides a summary of planned and proposed schedule changes during 2025, 2026 and beyond, which will require teams to adapt delivery models.

Programme	Changes (Planned / Approved)
<p style="text-align: center;">Childhood</p>	<ul style="list-style-type: none"> • The following JCVI recommended changes are due to come into effect as follows <ul style="list-style-type: none"> ○ From 1st July, 2025, children will be offered the 2nd dose of Men B vaccine at 12 weeks instead of the current 16 weeks ○ From 1st July, 2025, children will be offered the PCV13 vaccination against pneumococcal disease at 16 weeks instead of the current 12 weeks ○ From 1st July 2025, the offer of the combined Hib/MenC is removed. ○ To replace the Hib dose previously administered through Hib/MenC, the 4th 6 in 1 vaccine will be offered at the new additional 18 month scheduled appointment. ○ From the 1st January, 2026, children will be offered an MMRV vaccine at one year and eighteen months of age which will protect against measles, mumps, rubella (German measles) and varicella (chickenpox). The second MMR dose is being moved forward in the schedule to provide earlier protection and help to improve uptake. ○ An MMRV catch-up programme will also be offered to those aged 3 years 4 months to under 6 years between November 2026 and August 2028 • Implementation date for the new Child Health System to replace Scottish Immunisation Recall Systems (SIRS) is now first quarter of 2026.
<p style="text-align: center;">Adult</p>	<ul style="list-style-type: none"> • The following additional JCVI recommendations are due to come into effect as follows <ul style="list-style-type: none"> ○ From 1st September 2025, people aged 18 and over with severe immunosuppression are eligible for vaccination against Shingles ○ From 1st September 2026, people aged 80 and over are eligible for vaccination against Shingles ○ From 1st April 2026 the RSV programme will be extended to include those over the age of 80, and all residents in a care home for older adults. <p>Further expansion of the RSV programme is being considered by JCVI and is to be confirmed.</p>

Seasonal	Flu – Poultry workers and bird handlers were added to the adult flu eligibility criteria for 2025/26. A final ministerial decision on the inclusion of at-risk cattle and swine workers for the seasonal programme for winter 2026/27 is awaited at the time of writing.
Epidemic Planning	<p>The Scottish Government vaccines' team has been working with PHS to finalise a deployment plan for the H5 pre-pandemic avian influenza vaccine. While JCVI has not yet advised deployment, boards were asked to note the plan and consider local readiness to support rapid implementation if required.</p> <p>During September – November 2025 a Tier 1 national pandemic exercise led by the UK Government's Department of Health and Social Care and the UK Health Security Agency, with participation from the Scottish Government and other Devolved Governments. This exercise was designed to rigorously test the UK's response to a future pandemic caused by a novel infectious disease. Exercise Pegasus will be a 'live play' scenario, involving real-time decision-making and coordination across all UK Government departments, Devolved Governments and thousands of participants from across the nations and regions of the UK.</p>

COVID-19 & flu cohort changes – discussed in section 5

11 GENERAL PRACTICE DELIVERY

11.1 WHY GENERAL PRACTICES DON'T DELIVER VACCINES ANYMORE

As mentioned above in 2018 a new contract was negotiated for General Practice by its leaders and voted on by its membership. The majority of Scottish GPs agreed with the changes and the new GMS contract was implemented.

The Scottish Government said the new contract proposed a “refocusing of the GP role as expert medical generalists. This role builds on the core strengths and values of general practice – expertise in holistic, person-centred care – and involves a focus on undifferentiated presentation, complex care and whole system quality improvement and leadership.”

To allow for this refocusing to take place some of the tasks previously carried out in General Practice were moved into separately funded multidisciplinary teams. GPs were not financially disadvantaged during this restructuring. The Scottish Government acknowledged the need for financial stability under the new arrangements and GPs kept the funding they had previously received for vaccinations. This historic funding to GP continues.

In Grampian, our 3 HSCPs planned and costed 5 workstreams. Funding for the plans were approved by Scottish Government, the HSCPs received separate funding and the workstreams were implemented. One of these workstreams was vaccination, called VTP, the Vaccination Transformation Project, which created an integrated, cradle to grave, specialist vaccination service. Implementation of this new service was overtaken by the start of the pandemic and the usual kind of communication with stakeholders and the public to explain this new service did not take place.

From 2020 onwards vaccination needs rapidly multiplied under the weight of the pandemic when new programmes were implemented at pace and existing programmes extended. VTP was fully implemented and ended in 2023. The Scottish Immunisation Programme, Scottish Government led Flu and Covid-19 programme and VTP structures handed over responsibility for governance to SVIP in April 2024. Vaccination services are a success story of the 2018 GMS contract arrangements.

GPs in Scotland have not routinely delivered vaccinations since the implementation of the 2018 contract.

11.2 THE ROLE OF GENERAL PRACTICE IN VACCINATIONS IN 2026

The CMO for Scotland in 2024 and 2025 as well as the Directions 2025 (Appendix B) have described the supportive role of General Practice in vaccinations.

GPs' expertise and trusted relationships with their patients make them crucial in enhancing vaccine uptake and safeguarding public health. Some specific roles of General Practice will include taking responsibility for:

- promoting and advising individuals about vaccinations, and providing clear answers to individual queries, in line with a patient's specific medical history;
- providing trusted vaccination and immunisation information to their patients to ensure their patients make informed decisions about vaccinations, and to provide accurate information on safety and improve confidence and trust in vaccination;
- providing advice, and signposting their patients to trusted evidence sources, information and resources such as posters and screen displays for all vaccinations;
- ensuring their patients have equitable and timely access to the vaccines they are entitled to receive;
- making every contact and interaction count and optimising their patient's experience and engagement;
- providing information on immunisation status of their patients as and when requested.
- The General Practice with which the patient is registered should continue to enter vaccination events within the practice's electronic medical records system. This activity continues to be resourced through the payments practices receive for their historic role in vaccination delivery. This will continue until national digital solutions are in place.

In order to deliver these functions on behalf of the System, General Practices are recompensed through the historic funding arrangements described above.

We quite often get questions about why General Practice no longer delivers vaccinations and under what circumstances General Practice could begin to deliver vaccinations again. These questions have become more frequent following the announcement of a hybrid service including General Practice from April 2026 in NHS Highland. NHS Grampian are operating under different circumstances to NHS Highland and have no plans for GP delivery of population level vaccination programmes.

There are a number of reasons for this that mainly relate to the opportunity costs to the Health Board for GP delivery. Opportunity costs ask us to think about the next best alternative way that the Health Board can use resources. Put another way, "What else could primary care teams be doing in the time it would need to organise and administer vaccinations according to the demands of the Scottish vaccination and immunisation programme".

These demands are greater than in 2018. There is the Covid-19 programme, the extensions to the Flu programme, extended shingles programme which moved from a one to two appointments, a new RSV programme for older adults which again is extending following the successes of the first year and multiple changes to the childhood schedule requiring all children to have an additional appointment.

There are additional quality demands - eligibility and uptake in programmes is more closely monitored than before. There are new national quality standards to achieve as well as fulfilling the requirements of the 5 year strategic framework, and the Scottish Government's 2025 Population Health Framework, in which vaccination is a key programme.

Furthermore, as vaccination budgets become baselined and new vaccination programmes no longer attract new funding for staff and only limited funding for the costs of vaccinations, the Health Board has to absorb these costs. NHS Grampian is in Level 4 of the SGs Escalation and Support Framework and has been advised to introduce zero-based budgeting to ensure realistic costings. Although GPs would only be able to claim a fee for service for vaccination, the Board would have to take into account the resource costs to both the Board and GP practices to establish the real costs of any vaccination model to avoid destabilising primary care or the Board. We are developing a template for zero-based budgeting for GVIP from 2026.

We asked Scottish Government policy colleagues for their help in clarifying the SG position on GP delivery of vaccinations and received the following response from Michael Taylor from the Primary Care policy team:

For the delivery of vaccinations by local GP practices there has to be a determination whether it is necessary for one or more local GP practices to deliver that service. The health board is responsible for decisions about design and delivery of vaccination services (Directions 2025) and in NHS Grampian the multidisciplinary Vaccination Programme Board, chaired by the SRO makes these decisions.

We are contracting with GP practices nationally on the basis that they will be focusing on delivering (and improving) those GP essential services which only GP practices provide. Vaccinations should only be provided by GP practices by exception.

For it to be necessary for General Practice to deliver vaccinations this means they would not only have to be the best option, but the only available option. Any change in vaccine delivery will mean an opportunity cost to General Practice in NHS Grampian. Therefore, NHS Grampian will continue to follow SG policy in this area.

12 CONCLUSIONS

The vaccination programme has still not achieved its steady state with the introduction of new programmes and significant expansion to existing programmes. Implementation of some of these changes will continue to work through over the next few years.

Overall NHS Grampian provides a good vaccination service; we exceed average Scottish uptake for most programmes; we play our role nationally in SVIP structures; we lead.

Locally our most significant gaps are around vaccination and specific ethnic communities and adults and children who are part of our weakened immune systems cohorts.

Our successes are continuing to exceed expectations around our ability to bring in new programmes; our situational awareness and risk identification on a national scale; our “make it happen” attitude which has brought in our innovative travel health service, our work with secondary care teams and also tests of change to improve the service.

We have worked to be more transparent around governance and have a plan of work with HSCP partners to provide data against national standards and local requirements to anticipate information requests from partners and reduce duplications. In addition, working with our partners in 2026 we will look at cross boundary arrangements and move towards zero-based budgeting in line with KPMG recommendations. Changes are coming in the Human Medicine Regulations which will allow delivery teams re-examine the skill mix of their teams and how staff are deployed throughout the year.

Finance is mentioned in a number of sections because of the baselining of the SVIP budget, the work towards baselining of the PCIF, and the expansion of programmes without additional funding.

Work will continue maximising our uptake in an environment of vaccine hesitancy and mis and disinformation. We count on your active support.

13 ACKNOWLEDGEMENTS

The NHS Grampian public health directorate would like to thank everyone who works so hard across the Grampian system to ensure the population is protected against vaccine preventable disease by working to ensure we maintain a high vaccine coverage.

14 FEEDBACK

The team is always happy to receive feedback about the annual report. Please contact gram.vaccineenquiries@nhs.scot to leave your comments.

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16 APPENDICIES

16.1 APPENDIX A – COHORT BREAKDOWNS

Appendix – Pneumococcal 2024-25 Cohort Breakdown (Detailed)

Cohort	NHS Grampian			Aberdeen City			Aberdeenshire			Moray			Scotland		
	Population	Vaccinated	% Uptake	Population	Vaccinated	% Uptake	Population	Vaccinated	% Uptake	Population	Vaccinated	% Uptake	Population	Vaccinated	% Uptake
2 to 64 Pneumococcal At Risk	24,407	7,153	29.3	10,644	2863	26.9	10,445	3,468	33.2	3,324	822	24.7	252,272	53,916	21.4
Aged 65+	28,678	10,205	35.6	8,526	2096	24.6	14,153	5,562	39.3	6,002	2,547	42.4	6,002	49,246	16.1
Pneumococcal every 5 years	4,451	968	21.7	1,633	316	19.4	1,945	388	19.9	874	264	30.2	43,937	6,358	14.5
Total	52,532	17,149	32.6	18,928	4867	25.7	24,351	8,938	36.7	9,262	3,344	36.1	551,132	101,113	18.3

Appendix – Spring 2025 Cohort Breakdown (Detailed)

Cohort	NHS Grampian			Aberdeen City			Aberdeenshire			Moray			Scotland		
	Population	Vaccinated	% Uptake	Population	Vaccinated	% Uptake	Population	Vaccinated	% Uptake	Population	Vaccinated	% Uptake	Population	Vaccinated	% Uptake
Older people care home residents	3,055	2,451	80.2	1,182	972	82.2	1,342	1,058	78.8	531	421	79.3	30,064	23,897	79.5
Aged 75+	57,764	40,599	70.3	19,028	13,354	70.2	27,914	19,878	71.2	10,822	7,367	68.1	542,151	369,933	68.2
Weakened immune system	19,837	9,055	45.6	6,747	2,847	42.2	9,573	4,653	48.6	3,516	1,555	44.2	201,353	84,531	42.0
Age 18 to 74 weakened immune system	14,661	5,648	38.5	5,192	1,834	35.3	6,930	2,894	41.8	2,539	920	36.2	153,382	53,330	34.8
Age 12 to 17 weakened immune system	276	48	17.4	92	12	13.0	146	26	17.8	38	10	26.3	2,510	325	12.9
Age 5 to 11 weakened immune system	139	8	5.8	43	4	9.3	72	3	4.2	24	1	4.2	1,200	101	8.4
Age 6 months to 4 years weakened immune system	26	3	11.5	< 10	0	0.0	12	3	25.0	< 10	0	0.0	269	21	7.8
Distinct Total	73,263	46,602	63.6	24,540	15,339	62.5	35,229	22,920	65.1	13,493	8,343	61.8	703,866	426,805	60.6

Appendix – AW 2024-25 Cohort Breakdown – COVID-19 (Detailed)

Cohort	NHS Grampian			Aberdeen City			Aberdeenshire			Moray			Scotland		
	Population	Vaccinated	% Uptake	Population	Vaccinated	% Uptake	Population	Vaccinated	% Uptake	Population	Vaccinated	% Uptake	Population	Vaccinated	% Uptake
Older people care home residents	3,026	2,519	83.2	1,098	908	82.7	1,435	1,208	84.2	486	403	82.9	29,509	24,043	81.5
Aged 75+	57,491	44,534	77.5	18,953	14,681	77.5	27,781	21,702	78.1	10,761	8,151	75.7	541,204	414,775	76.6
Age 65 to 74	66,939	43,850	65.5	22,417	14,179	63.3	32,391	21,790	67.3	12,133	7,881	65.0	634,291	402,304	63.4
Weakened immune system	14,877	7,308	49.1	5,258	2,432	46.3	7,104	3,696	52.0	2,508	1,180	47.0	155,406	72,997	47.0
At risk age 18 to 64	75,040	21,393	28.5	29,443	7,129	24.2	33,056	10,751	32.6	12,470	3,472	27.8	764,494	210,789	27.6
At risk age 12 to 17	3,598	379	10.5	1,203	92	7.6	1,770	228	12.9	630	59	9.4	36,827	2,692	7.3
At risk age 5 to 11	3,422	318	9.3	1,318	109	8.3	1,555	172	11.1	535	37	6.9	36,083	2,157	5.9
At risk age 6 months to 4 years	790	95	12.0	304	33	10.9	367	48	13.1	111	14	12.6	7,615	479	6.3
Frontline health care workers	11,201	2,724	24.3	5,211	1,269	24.4	4,327	1,125	26.0	1,468	330	22.5	111,986	26,296	23.5
All social care workers	18,050	2,020	11.2	7,225	667	9.2	7,791	997	12.8	3,033	356	11.7	170,447	19,879	11.7
Total	229,436	113,159	49.3	83,362	37,389	44.9	105,883	55,822	52.7	39,919	19,947	50.0	2,232,526	1,058,774	47.4

Appendix – AW 2024-25 Cohort Breakdown – Adult Influenza (Detailed)

Cohort	NHS Grampian			Aberdeen City			Aberdeenshire			Moray			Scotland		
	Population	Vaccinated	% Uptake	Population	Vaccinated	% Uptake	Population	Vaccinated	% Uptake	Population	Vaccinated	% Uptake	Population	Vaccinated	% Uptake
Older people care home residents	2,917	2,513	86.2	1,044	895	85.7	1,393	1,218	87.4	473	400	84.6	28,370	23,781	83.8
Aged 75+	57,072	46,449	81.4	18,791	15,163	80.7	27,584	22,730	82.4	10,690	8,556	80.0	537,098	432,892	80.6
Age 65 to 74	66,796	47,025	70.4	22,368	15,052	67.3	32,330	23,476	72.6	12,101	8,497	70.2	632,906	434,620	68.7
Weakened immune system	19,092	12,014	62.9	6,516	3,801	58.3	9,254	6,155	66.5	3,315	2,058	62.1	195,614	119,306	61.0
At risk age 18 to 64	85,274	30,660	36.0	32,525	10,405	32.0	38,314	15,236	39.8	14,337	5,017	35.0	888,761	307,849	34.6
All health care workers	17,854	6,013	33.7	9,200	2,985	32.4	6,239	2,331	37.4	2,215	697	31.5	183,655	65,922	35.9
All social care workers	17,947	2,966	16.5	7,192	973	13.5	7,741	1,473	19.0	3,013	520	17.3	169,873	29,138	17.2
Total	234,642	128,816	54.9	85,748	42,815	49.9	107,936	63,373	58.7	40,677	22,626	55.6	2,305,037	1,225,407	53.2

Appendix – AW 2024-25 Cohort Breakdown – Childhood Influenza (Detailed)

Cohort	NHS Grampian			Scotland		
	Population	Vaccinated	% Uptake	Population	Vaccinated	% Uptake
Secondary school	38,283	20,741	54.2	364,938	193,694	53.1
Primary school	37,193	25,993	69.9	388,877	264,846	68.1
Pre-school	20,304	11,091	54.6	136,437	68,582	50.3
At risk age 6 months to 2 years	222	59	26.6	1,861	757	40.7
Total	95,956	57,862	60.3	891,608	527,605	59.2

16.2 APPENDIX B - DIRECTIONS COVER LETTER

Population Health Directorate Simon Cuthbert-Kerr
Deputy Director for Public Health Capabilities Division E: immunisationpolicy@gov.scot

17th November 2025

Dear Colleague

I am writing to advise you of the National Health Service (Vaccination and Immunisation) (Scotland) Directions 2025 which set out duties of territorial Health Boards in delivering vaccination and immunisation programmes in Scotland. This follows the 2017 Vaccination Transformation Programme (VTP) and establishment of the Scottish Vaccination and Immunisation Programme (SVIP).

In 2017, the Scottish Government (SG) and the Scottish General Practitioners Committee (SGPC) agreed vaccinations would move away from a model based on GP delivery to one based on Health Board/Health and Social Care Partnership (HSCP) delivery through dedicated teams. This was called the Vaccination Transformation Programme. This would allow GPs to focus on delivering services that only they can deliver, as expert medical generalists.

In March 2022, a Chief Medical Officer ([CMO](#)) letter was issued setting out details and timescales for the rollout of VTP. In August 2022, a [Primary Care Administration](#) circular was issued setting out the framework for bringing General Practice role in delivering vaccinations to an end. All Health and Social Care Partnerships (HSCPs) and Health Boards transitioned delivery by April 2023.

The VTP covered all NHS vaccinations that are delivered in Scotland. Each Health Board is now responsible for both designing and delivering vaccination services within their area in a way that is best suited to local populations, geography, and resources.

SVIP came into effect in January 2024, bringing existing governance structures together, such as the Flu and Covid Vaccine Programme (FVCV) and Scottish Immunisation Programme (SIP). It is a partnership between territorial and National Health Boards, Public Health Scotland (PHS) and Scottish Government, with PHS holding the Senior Responsible Officer (SRO) role.

As set out in these Directions, Health Boards hold the responsibility to deliver vaccinations, including the use of General Practice in exceptional circumstances. The fees and associated details for this are set out here at [pca2022-m-07.pdf](#). Other locally negotiated services, such as pharmacy, optometry, and dentistry may be used to deliver vaccinations depending on local needs.

While the Directions instruct Health Boards on the delivery of vaccinations, General Practice, even if not contracted to deliver vaccines, retains some responsibility in regard to good clinical care as set out in [Non-routine vaccination update](#) and [Shingles vaccination programme 2024/25](#)

GPs expertise and trusted relationships with their patients make them crucial in enhancing vaccine uptake and safeguarding public health. Through their on-going involvement in vaccination and immunisation programmes, their advocacy for

vaccination helps to strengthen public confidence. This contributes to the overarching goal of SVIP - reducing morbidity and mortality from vaccine preventable diseases. GPs active involvement and engagement in vaccination and immunisation is therefore essential for the success of the programme, and some specific roles of General Practice will include taking responsibility for:

- Promoting and advising individuals about vaccinations, and providing clear answers to;
- Individual queries, in line with a patient's specific medical history;
- Providing trusted vaccination and immunisation information to their patients to ensure their patients make informed decisions about vaccinations, and to provide accurate information on safety and improve confidence and trust in vaccination;
- Providing advice, and signposting their patients to trusted evidence sources, information and resources such as posters and screen displays for all vaccinations;
- Ensuring their patients have equitable and timely access to the vaccines they are entitled to receive;
- Making every contact and interaction count and optimising their patient's experience and engagement; and
- Providing information on immunisation status of their patients as and when requested. To support GPs engagement, Health Boards should ensure information about local services is available to GP practices and provide all relevant communications materials such as leaflets. [1](#)
- General Practice and other relevant primary and secondary care clinicians retain responsibility for referral to Health Board and HSCP-led vaccination teams should a patient be identified as requiring vaccination. The referral is usually made via the local immunisation team, details of which can be found on NHS Inform.

It is recognised that vaccination programmes can change. Where there are any changes in existing programmes such as eligibility or doses, a revised CMO letter will be issued. This will also be the case should a new programme be introduced. The latest CMO letters are listed at Annex A and can also be found [here](#).

Patient accessibility is an important aspect of vaccination services. Health Boards should explore together with GP practices how to best use the general practice estate with agreed reimbursement where appropriate.

Health Boards should ensure that resources are in place to meet their Public Sector Equality Duty and Fairer Scotland Duty to consider and address lower vaccination uptake in underserved groups.

Vaccination Record Management

Accurate recording of vaccination events remains essential to ensure patient safety and continuity of care. All Health Boards should be using the Vaccination Management Tool (VMT) and National Clinical Data Store (NCDS) to record vaccination events if

the recording of those vaccinations is supported by these systems. This includes the recording of vaccinations delivered during pregnancy. If specific vaccines are not yet supported by these systems – existing arrangements for updating patient records should continue. We note that this most prominently affects children’s vaccination.

Where vaccinations are administered by Health Board or HSCP-led immunisation teams and cannot yet be recorded through VMT/NCDS, the General Practice with which the patient is registered should continue to enter the vaccination event within the practice’s electronic medical records system. This activity continues to be resourced through the [payments](#) practices receive for their historic role in vaccination delivery. General Practices are also expected to provide individuals with their vaccination data in a timely manner. In some areas, Health Boards have established data-sharing arrangements that enable vaccination teams to update patient records directly, reducing the need for manual input by General Practice. Where feasible, Health Boards and practices are encouraged to explore such local arrangements.

The SG and SGPC agreed that the VTP was substantially complete in 2022, and that GP practice teams would continue this data-entry function until national digital solutions were in place. Although the delivery of these developments has taken longer than originally anticipated, the SG continues to prioritise and invest in this digital transformation as part of its ongoing commitment to improving vaccination services. Integrations between GP-IT systems and NCDS are now being developed as part of the initial phase of the vaccination digital transformation programme. These developments form part of wider NHS Scotland digital transformation, and must align with forthcoming GP-IT system updates. We will continue to provide updates as the digital programme moves forward.

Funding

Delivery of our vaccination programmes is funded through the Primary Care Improvement Fund (PCIF) and has been supplemented through the seasonal flu and COVID-19 vaccine (FVCV) allocation since 2020. This latter allocation was introduced at the start of our COVID-19 programme to support the national efforts required to deliver our largest ever vaccination programme.

In line with the reduction in the size and scope of the COVID-19 vaccination programme since the height of the pandemic, FVCV costs have reduced over time. Since 2023/24, with the shift to business as usual for the COVID-19 vaccination programme, these funds can be used to support the local delivery across our full range of programmes. This facilitates workforce resilience and sustainability while maximising efficient use of venues. The FVCV funding has been baselined from 2025/26.

We acknowledge that we have asked Boards to accommodate new programmes within existing FVCV funding, such as the introduction of the new RSV older adults and maternal programmes in 2024. We also understand that there are competing financial priorities at Board level, such as investment in efforts to maintain and improve vaccination uptake, and improve equity of access via expanded outreach and targeted inclusivity activity. In future, new immunisation programmes being introduced, or step

changes to the vaccination system in Scotland, will be carefully assessed as to the feasibility, clinical impact and financial implication for health boards, with the potential for any additional funding considered to support this activity, as set out in the 5 year SVIP Framework.

The PCIF allocation funds the delivery costs of the vaccinations formerly delivered by GP practices. There is no ring-fenced allocation for vaccination activity within the PCIF. Fees for GP practices which are continuing to vaccinate are also met from the PCIF allocation.

The payments GP practices receive for their historic role in delivering vaccinations are met from the Primary Medical Services (Revenue) allocation. These payments cover some residual GP practice activity including updating practice records and providing vaccination records where necessary.

Vaccine costs are covered through a variety of mechanisms based on procurement routes and contracts. These include: costs being met from the Health Boards' baseline allocation, in-year allocations provided by the Scottish Government to Health Boards based on recorded expenditure on utilised vaccines, and the Scottish Government paying UK Health Security Agency (UKHSA) directly due to pricing confidentiality.

I would like to thank you for your support in promoting and delivering vaccination programmes in Scotland.

Yours sincerely



Simon Cuthbert-Kerr

Deputy Director for Public Health Capabilities

¹ Vaccine communication material can be ordered from PHS.