Title	Childhood Immunisations in Hackney
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Executive Summary

After clean water, vaccination is one of the most effective public health interventions for saving lives and promoting good health. Globally, vaccination is estimated to prevent 3.5-5 million deaths each year and has contributed to major reductions in vaccine-preventable diseases (VPDs) such as polio and some cancers, while also reducing pressure on health and care systems.

Childhood immunisation coverage has declined across England over the past decade. The rate of decline has been more pronounced in London, consistently reporting lower coverage than the national average and remaining below the 95% herd immunity target required to prevent vaccine-preventable disease (VPD) outbreaks, including measles. The

Childhood immunisation uptake in City and Hackney also continues to decline across routine childhood immunisation programmes. The average childhood immunisation coverage in Hackney across the 12-month, 24-month and 5-year cohorts was approximately 72% in 2024/25. This is significantly lower than both the London average (80%) and England average (90%). However, compared with previous years, the rate of decline slowed in 2024/25 for some vaccination programmes (at 12 months), and there have been modest improvements in some school-based programmes. This likely reflects the impact of sustained partnership working and targeted system-wide interventions, including progress against the City and Hackney Immunisation Strategic Action Plan (2024-27), of which at least 50% of objectives have been delivered.

Despite the recent improvements in uptake, Hackney remains vulnerable to VPD outbreaks due to low coverage and persistent inequalities, as demonstrated by the 2025 measles outbreak which disproportionately affected the Charedi Jewish community in North Hackney.

Inequalities in immunisation uptake, for example by ethnicity, socio-economic status, and geography, are a product of wider structural and community determinants of health - including poverty, living conditions, institutional harms and structural racism. They are not a matter of individual choice. The local response is therefore positioned as part of the Council and partnership's broader anti-poverty, health inequalities and anti-racism work, and is delivered through trusted, community-led and culturally responsive approaches (see Sections 1 and 7).

The outbreak demonstrated the value of established local partnerships and immunisation infrastructure. Agencies including the UK Health Security Agency (UKHSA), Springfield Park Primary Care Network (PCN), Public Health, National Health Service (NHS) England London, the North East London Integrated Care Board (NEL ICB), Communications, and Haringey counterparts mounted a coordinated multi-agency response, at a substantial pace and scale, mitigating further public health impacts and wider-system pressures.

Importantly, the ICB-commissioned Enhanced Immunisation Service, operating through Springfield Park PCN to improve uptake in North Hackney and within the Charedi community, provided an established delivery platform that enabled the rapid outbreak response and supported the vaccination of approximately 1,540 children, with over 2,000 vaccination doses delivered between May and August 2025. This highlights both the ongoing

risks associated with low coverage, and the importance of sustained investment in targeted, community-informed immunisation infrastructure and interventions.

Significant risks and challenges remain:

- The most significant risk is the absence of a sustained funding pipeline to maintain the Enhanced Immunisation Service in North East Hackney that sits outside statutory commissioning responsibilities. Since c. 2016, the NEL ICB has prioritised significant non-recurrent funding to sustain this tailored model, which enabled the immediate responses to both measles outbreaks. Funding has always been provided on a non-recurrent basis. Continuing this targeted activity, alongside tailored provision beyond North East Hackney, will require a shared, system-wide funding solution. The associated risk is to the continuity of the trusted relationships, community intelligence, and operational infrastructure that have supported both routine immunisation improvement and outbreak management.

- In line with national ICB restructuring requirements (including wider system efficiency and operating model changes affecting vaccination and screening programmes), the ICB has experienced a reduction in vaccination leadership (in particular clinical leadership), coordination, and workforce capacity.

- There also remains ongoing ambiguity regarding future delegated commissioning arrangements of immunisations from NHS England to ICBs (delayed from April 2025) and system responsibilities for immunisation delivery and oversight.

- Progress on the development of a NEL-wide immunisation dashboard had previously stalled. This has recently resumed, with the ICB Insights Team exploring the use of primary care data to support its development and enable the proactive and routine identification and mitigation of population-level inequalities in uptake, as well as targeted evaluation.

The system continues to manage these risks collaboratively. The ICB and local partners have a long-standing, close working relationship and remain jointly committed to ensuring that future commissioning and service delivery models remain responsive to the needs of the local population. This continued partnership working across the system (see Appendix 2) provides a degree of mitigation and resilience within the evolving immunisation landscape. This includes ongoing oversight and escalation of immunisation challenges through local and regional governance structures and fora, alongside the continued role of system partners in supporting equitable access and service responsiveness.

In parallel, system partners continue to progress delivery of the City and Hackney Immunisation Strategic Action Plan (2024-27) and associated system-wide interventions aimed at improving immunisation coverage, reducing inequalities, and mitigating strategic and operational risks. This ongoing work has also received national recognition, including within the Chief Medical Officer's Annual Report 2025 focused on Infections (page 148), which highlighted Hackney's partnership approach to addressing barriers to vaccine uptake.

1. Introduction

1.1. Vaccination is universally recognised as one of the most effective public health interventions available, saving millions of lives globally each year and significantly reducing the burden of vaccine-preventable diseases (VPDs) on health and care systems.

1.2. Vaccination is also highly cost-effective; for example around one in five children with measles require hospital care, with overnight admissions alone estimated at approximately £500 per night (excluding wider operational response costs), while a single measles vaccination costs only a small fraction of the required treatment.

1.3. Although the UK offers a comprehensive vaccination programme across the lifecourse (Appendix 1), uptake across programmes has declined nationwide, regionally and locally over the last decade, alongside widening inequalities. For most immunisation programmes, coverage remains below the 95% target required for herd immunity.

1.4. The decline in coverage has been particularly pronounced across London, where uptake remains significantly below the national average and below the 95% herd immunity[1] threshold for most programmes. This places London, including Hackney, at continued risk of VPD outbreaks including measles.

1.5. To exemplify the above, across England the uptake of the hexavalent Diphtheria, Tetanus, acellular Pertussis and Inactivated Polio (DTaP/IPV/Hib/HepB) vaccine at 12 months was 94% in 2014/15 compared to 91% in 2024/25. For London, the uptake was 90% in 2014/15 and 86% in 2024/25. For Hackney, the uptake was 86% in 2014/15 and 62% in 2024/25[2].

1.6. The risk for VPDs is further amplified by London's high levels of international travel and population movement, increasing the likelihood of importation and spread from countries where VPDs, such as measles, remain endemic.

1.7. As with the national and London profile, lower immunisation uptake in Hackney is associated with higher deprivation, certain geographical areas (such as urban centres), inclusion health status, barriers to GP registration and some ethnic minority populations. These inequalities reflect broader social determinants of health, including poverty and deprivation, housing insecurity and structural barriers experienced by some communities.

1.8. These patterns reflect the downstream consequence of the wider political, social and community determinants of health. A strong and growing evidence base shows structural and institutional racism as a fundamental cause of

[1]Herd immunity is when enough people in an area have immunity to (protection from) a disease that it no longer spreads easily.
[2] OHID Fingertips. Health Protection Data Profile. Accessed 5 June 2026.

ethnic inequities in vaccine uptake, shaping the conditions - socioeconomic position, area-level deprivation, overcrowded housing, experiences of discrimination, and the degree of trust between communities and institutions - long before any individual decision about vaccination is made (see the Runnymede Trust and Centre on the Dynamics of Ethnicity briefing on the role of racism in vaccine hesitancy).

1.9. Nationally, the greatest declines in coverage have been observed among more deprived groups, while uptake among the least deprived has remained comparatively more stable.

1.10. Vaccine hesitancy is a behaviour, influenced by a number of factors including issues of confidence (do not trust vaccine or provider), complacency (do not perceive a need for a vaccine, do not value the vaccine), and convenience (access)[3].

1.11. Additional barriers to uptake in Hackney are multifactorial and include confidence (such as concerns about side effects, unmet information needs, exposure to misinformation and institutional mistrust), complacency (such as preferences for delayed or alternative vaccination schedules) and convenience-related barriers (such as perceived difficulties related to arranging vaccination for larger family sizes and competing priorities). Religious objections have also been reported, although these appear limited to a small minority.

1.12. Notwithstanding these challenges, there is a strong evidence-base and growing local system intelligence regarding interventions that can and do improve uptake. These barriers are being addressed through multi-agency and cross-system partnership working as part of the City and Hackney Immunisation Strategic Action Plan (2024–27). Much of the activity within the Plan seeks to address barriers experienced by underserved communities through community engagement, culturally responsive approaches, service accessibility and partnership working. Early impact is beginning to emerge, with evidence of incremental improvement across some routine childhood and adolescent immunisation programmes.

2. System-wide Roles and Responsibilities

2.1. NHS England has the responsibility for the commissioning of national routine immunisation programmes under the terms of the Section 7A agreement of the Health and Social Care Act 2012.

2.2. NHS England commissions a range of providers to deliver routine, targeted and seasonal vaccinations. Providers include GPs, community pharmacies, sexual health services, and school-age immunisation services (SAIS).

[3] SAGE Vaccine Hesitancy Working Group, What influences vaccine acceptance: A model of determinants of vaccine hesitancy, 2013.

2.3. The NEL Integrated Care Board (NEL ICB) is not a statutory commissioner for immunisation programmes but plays a key role in supporting primary care engagement and performance improvement. NEL ICB has been the commissioner and funder of the Enhanced Immunisation Service delivered through Springfield Park PCN in North East Hackney since c. 2016. The ICB has also funded dedicated immunisation leadership and programme roles supporting strategy development and delivery across City and Hackney. This represents significant non-recurrent investment, prioritised outside the ICB's statutory responsibilities, in recognition of local need and risk.

2.4. The local authority public health team does not hold any commissioning responsibility for immunisation programmes, but plays a key system leadership and coordination role. This includes supporting uptake and addressing inequalities through engagement with local communities, partners, and services.

3. Data Context

3.1. Progress on plans to develop a NEL-wide immunisation dashboard had stalled, although recently resumed through discussions with the NEL ICB's Insights Team. The ICB previously noted that data available to local authorities is largely provided in aggregated form by registered GP practice, rather than by borough of residence, reflecting national data structures. This was felt to limit the additional value of a dashboard based on existing published datasets.

3.2. However, the Insights Team is now proposing development of a population-level dashboard using alternative data sources held within the ICB, although this remains subject to assessment of data validity, quality and completeness.

3.3. Wider system partners, including Public Health, maintain that access to more granular and population-based intelligence is necessary to provide important insights into vaccine coverage by geography (e.g. ward or neighbourhood), ethnicity, age and other population characteristics. This capability is necessary to enable the identification and mitigation of inequalities, and further support hyperlocal responses and evaluation activity.

4. Changes to the routine immunisation programme

4.1. The NHS offers a comprehensive and free routine immunisation schedule (Appendix 1). The age at which vaccinations are given is determined by the best available evidence for protecting children and young people when they are most vulnerable to infection.

4.2. There have been significant changes to the routine childhood immunisation schedule and to the selective hepatitis B (HepB) programme from 1 July 2025

and 1 January 2026 (Appendix 1). These include the introduction of a new routine vaccination appointment at 18 months of age.

4.3. From 1 July 2025:

- The Haemophilus influenzae type b/Meningococcal group C (Hib/MenC) programme offered at 12 months was discontinued following the cessation of manufacturing of the Menitorix vaccine.
- The first dose of the pneumococcal conjugate vaccine (PCV13) dose was moved from 12 weeks to 16 weeks of age.
- The second dose of the Meningococcal group B (MenB) vaccine was brought forward from 16 weeks to 12 weeks, based on evidence that earlier scheduling provides earlier protection against serious and potentially fatal infections.

4.4. As of 1 January 2026:

- A fourth dose of the hexavalent DTaP/IPV/Hib/HepB vaccine was introduced at a new routine appointment at 18 months to provide longer term protection against Hib infection.
- A varicella (chickenpox) component was also added to the routine measles, mumps and rubella (MMR) vaccine schedule, so that a measles, mumps, rubella, varicella (MMRV) vaccine is now given.
- The MMRV (previously MMR) schedule has changed so that the second dose is given at the new 18-month appointment to improve uptake and provide earlier protection. Previously this was given at 3 years 4 months. The primary MMRV dose is still given at 12 months.

4.5. Early qualitative feedback from primary care and community partners suggests that the introduction of the varicella vaccine has been well accepted by families, potentially reflecting greater familiarity and/or risk perception of chickenpox compared with diseases such as polio or diphtheria.

5. Spotlight on Measles

5.1. Measles remains a significant and immediate concern due to comparatively lower vaccine coverage, its high transmissibility, and several recent outbreaks. Notwithstanding, declining immunisation coverage increases vulnerability to other VPDs as evidenced by recent meningococcal outbreaks in the UK, detections of poliovirus in wastewater in North and East London in 2022, and an outbreak of pertussis in Hackney's Charedi Jewish community in 2024. This risk is further increased where infections are imported from countries where such diseases remain endemic or more prevalent.

5.2. The UK lost its measles elimination status in January 2026, following ongoing disease circulation since late 2023. Measles is one of the most highly

infectious VPDs, with up to 9 in 10 unvaccinated individuals becoming infected following exposure.

5.3. Nationally, approximately 40% of measles cases require hospitalisation, with the burden of disease disproportionately affecting children under 10 years of age. Increased transmission has also been observed nationally following the COVID-19 pandemic, reflecting further declines in immunisation coverage, and growing mistrust of and disengagement with health services.

5.4. While vaccination remains highly cost-effective, the cost of a single measles case or outbreak can be substantial, including contact tracing, healthcare utilisation (including GP consultations and hospitalisation), workforce pressures, parental caring responsibilities, and missed education.

5.5. Measles cases, driven by both importation and local community transmission, have been high in London and across the country since late 2023 (Table 1), with the highest case numbers in 2024 (2,911). Between 1 January 2025 to 31 December 2025, there were 959 laboratory confirmed measles cases reported in England, with outbreaks particularly affecting London and the North West of England.

5.6. During 2025, Hackney reported the highest number of laboratory-confirmed cases (133) of any local authority, driven by an outbreak that disproportionately affected the Charedi Jewish community in North Hackney.

5.7. A multi-agency response led by the UK Health Security Agency (UKHSA) was initiated at the start of the outbreak to limit transmission and protect vulnerable populations. As a result, between May and July 2025, 51 vaccination clinics were delivered, administering 2,600 vaccinations to 1,500 children, including 1,300 non-MMR catch-up vaccinations. The scale and pace of the response prevented further severe outcomes and limited onward spread beyond Hackney.

5.8. While a formal economic evaluation of the outbreak is planned, the estimated total cost of the outbreak response and associated hospitalisations is approximately £51,000-£82,000. This includes around £36,000 in direct response costs and an estimated £15,000-£46,000 in hospitalisation costs, depending on the extent of underreporting. This further highlights the importance of continued investment in targeted and outreach-focused vaccination approaches.

5.9. Between 1 January and 27 April 2026, there have been 477 laboratory confirmed measles cases reported in England. Measles activity has mostly been driven by an outbreak in North London and Birmingham. There have been 11 laboratory confirmed cases of measles in Hackney between 1 January and 27 April 2026.

Table 1. Confirmed cases of measles by local authority: 2026

Source: UKHSA, Measles epidemiology 2023 to 2026, 2026.

	2023	2024	2025	2026
Laboratory confirmed cases	367	2,911	959	477 (between 1 January and 27 April)
% in London	34%	45%	51%	66%
Areas with the highest numbers of cases	London (Hillingdon and Tower Hamlets); West Midlands (Birmingham); Yorkshire and the Humber	London (Lambeth and Wandsworth); West Midlands (Birmingham); East of England	London (Hackney); Midlands (Birmingham) ; Bristol; North West; East of England	London (Enfield, Islington, Haringey); West Midlands (Birmingham)

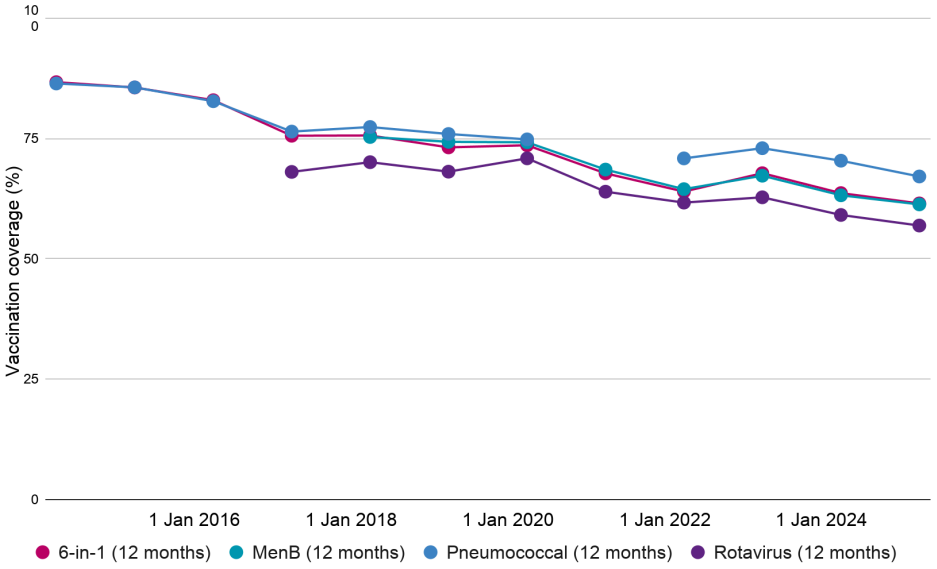
6. Coverage: Trends and Performance (2024/25) in Hackney

6.1. Childhood vaccination coverage statistics for Hackney are available from the Public Health Profile. A data review was also conducted in 2024 as part of the City and Hackney Strategic Immunisation Action Plan (2024-27). Access to more granular and population-based intelligence (e.g., immunisation uptake by ethnicity, age and other population characteristics) is hoped to be attained through the development of the NEL-wide dashboard.

6.2. Childhood immunisation uptake in City and Hackney continues to decline overall across routine childhood immunisation programmes. However, compared with previous years, the rate of decline slowed in 2024/25 for some vaccination programmes (at 12 months), including the 6-in-1, MenB and rotavirus programmes, suggesting possible early stabilisation (Fig. 1).

6.3. The trend in declining vaccination coverage has been broadly consistent across childhood immunisation programmes between 2013/14 and 2024/25 (Fig. 1). Over this period, the 6-in-1 vaccine demonstrated the largest absolute decline in uptake, followed by pneumococcal vaccination (Fig. 1).

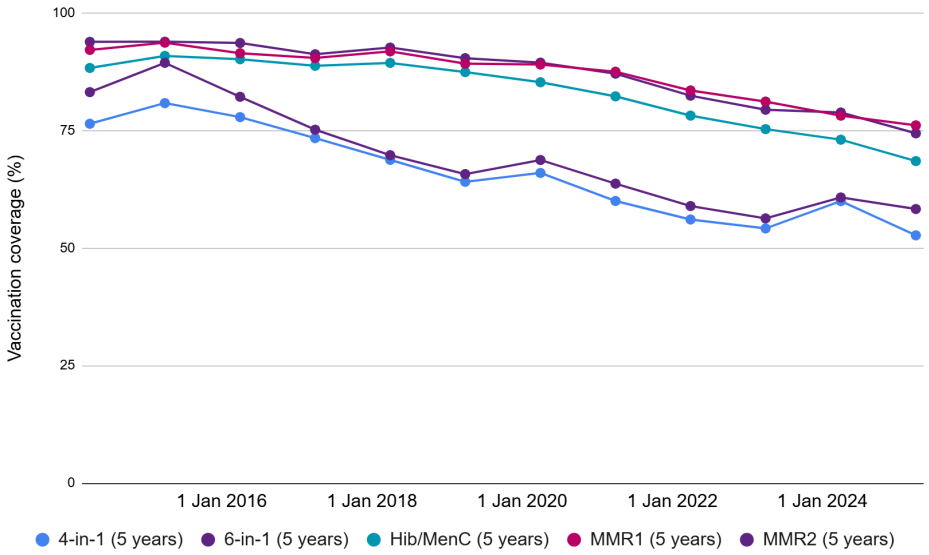
Figure 1. Vaccination coverage by year between 2013 - 2025 (Hackney) (12 months)



Source: UKHSA, data dashboard, 2026.

6.4. For some immunisation programmes, coverage at 5 years is substantially lower than at 12 months and 24 months for both London and Hackney. This decline is primarily driven by lower uptake of the pre-school dTaP/IPV booster (4-in-1) and MMR2, both of which show the steepest decline over time and the lowest overall coverage by 2024/25 (Fig. 2). In contrast, MMR1 and Hib/MenC coverage remain comparatively higher, although they have also declined over the period.

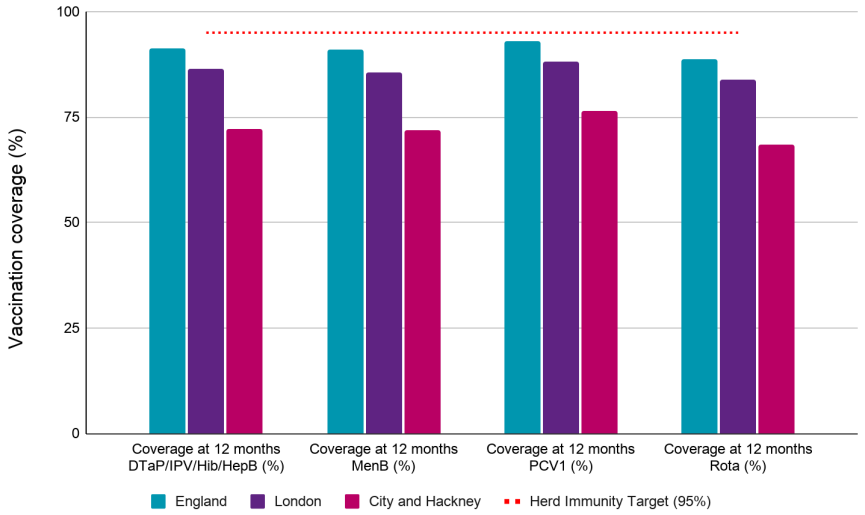
Figure 2. Vaccination coverage by year between 2013 - 2025 (Hackney) (5 years)



Source: UKHSA, data dashboard, 2026.

6.5. Over 2024/25 in City and Hackney, immunisation programmes in children aged 12 months demonstrated an average coverage of 72%. This is significantly lower than both the London average (86%) and England average (91%) (Fig. 3).

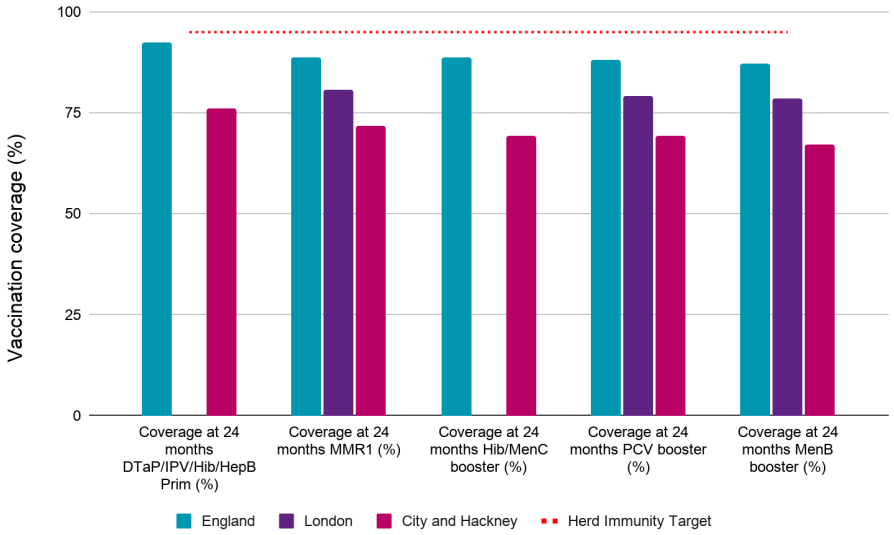
Figure 3. Completed immunisations in children aged 12 months (2024/25)



Source: UKHSA, Vaccination coverage statistics for children aged up to 5 years, April 2024 to March 2025, 2026.

6.6. Immunisation programmes in children aged 24 months in City and Hackney demonstrated an average coverage of 71% (2024/25). This is significantly lower than both the London average (80%) and England average (89%) (Fig. 4).

Figure 4. Completed immunisations in children aged 24 months (2024/25)



Source: UKHSA, Vaccination coverage statistics for children aged up to 5 years, April 2024 to March 2025, 2026.

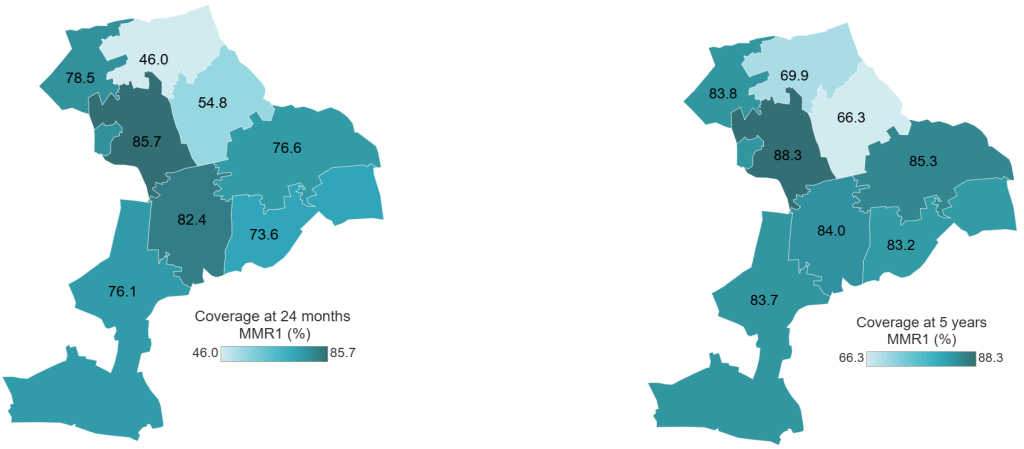
6.7. Immunisation programmes in children aged 5 years in City and Hackney demonstrated an average coverage of 72% (2024/25). This is similar to London (75%) but lower than the England average (89%) (Fig. 5).

Figure 5. Completed immunisations in children aged 12 months (2024/25).

Source: UKHSA, Vaccination coverage statistics for children aged up to 5 years, April 2024 to March 2025, 2026.

6.8. Coverage varies markedly within the borough. The lowest uptake is consistently in Springfield Park and Hackney Downs PCNs in the north east, which serve much of the Charedi community. The highest is in Clissold Park PCN (Fig. 6).

Figure 6. Percentage of children receiving MMR at 24 months (left) and 5 years (right) by City and Hackney PCNs 2024/25.



Source: UKHSA, Vaccination coverage statistics for children aged up to 5 years, April 2024 to March 2025, 2026. Prepared by the City and Hackney Public Health Intelligence team, 2026.

6.9. Adolescent vaccination uptake in Hackney and NEL is showing early signs of recovery following several years of decline. As of 2024/25, performance within the school-age immunisation programme improved across a number of programmes compared with the previous year, with evidence of stabilisation or reversal of previous downward trends for some cohorts:

- Primary school-aged flu: 8.1% **increase** from 33.1%to 41.2%.
- Human papillomavirus (HPV) (12-13 years males): 6.0% **increase** from 49.5% to 55.5%.
- HPV (12-13 years females): 1.4% **increase** from 55.5% to 56.9%.
- Meningococcal groups A, C, W, and Y (MenACWY) (14-15 years): 7.4% **reduction** from 64.1% to 56.7%.

6.10. Overall, while immunisation coverage remains below national targets, there is evidence of incremental improvement across several programmes, including within the adolescent/school-based immunisation programmes and through targeted community-based initiatives, such as the local measles outbreak response, during which approximately 1,540 children were immunised between May and July 2025.

6.11. Maternity and prenatal immunisation coverage has also improved across both Hackney and London. Following the introduction of the maternal respiratory syncytial virus (RSV) vaccination programme in September 2024, uptake increased alongside continued improvements in maternal pertussis vaccination coverage. In Hackney, pertussis vaccination uptake increased from 36.2% in December 2024 to 52.0% in December 2025.

7. Actions to Address Inequalities and Improve Coverage in Hackney

7.1. Progress against the City and Hackney Immunisation Strategic Action Plan (2024-27) is ongoing. A summary of the Plan (on a page) is highlighted in Appendix 2. The plan aims to safeguard all communities from VPDs by increasing and addressing inequalities in immunisation coverage through community-, data- and system-led insights.

7.2. The plan sets five priorities: reducing inequalities in inclusion and high-risk groups; community engagement and co-production; data enhancement; service optimisation; and Making Every Contact Count (MECC).

7.3. While not framed explicitly in the language of anti-racism, these priorities are consistent with the structural and community-determinants approach described in Section 1. In practice, the Plan seeks to shift effort “upstream” to address the institutional and community-level conditions that drive lower uptake (such as barriers to GP registration, accessibility, trust and the cultural responsiveness of services) rather than attributing low coverage to individual communities. As a health systems partnership, we will also ensure we connect with and act upon our systems' wider place-based anti-racism and anti-poverty strategies.

7.4. In developing the strategy, views were sought from a wide range of stakeholders, including commissioners, providers and organisations supporting vaccination programme delivery, engagement and outreach (Appendix 2). Particular emphasis was placed on engaging stakeholders with a strong community focus, as well as those directly interfacing with eligible residents. This approach supported ambitions to raise awareness of vaccination through MECC and build trust within communities. These partnerships continue to play an important role in the successful delivery of the Plan.

7.5. A review of actions delivered in Year 1 of the plan was conducted in January 2026. At least 50% of the plan's objectives have been achieved to date, reflecting strong collaborative working across system partners. The delivery of targeted outreach, community engagement and communications is likely contributing to the observed stabilisation and improvement in uptake trends across some immunisation programmes.

7.6. Example actions delivered against the Plan include:

- Production of an early years-focused podcast to build confidence in discussing routine childhood immunisation among early years practitioners.
- Delivery of immunisation and peer-support training to Community Health Champions (CHCs), and routine involvement of CHCs in the co-design of or feedback of resources.
- Children and Young People (CYP) making every contact count (MECC) training programme developed and operational, with immunisations embedded as a core priority.
- Development and socialisation of an immunisation best practice toolkit for GP practices.
- Development and implementation of a health protection and CYP communications calendar.

8. Risks and Challenges

8.1. The risks set out below are system-wide and are shared across partners, including NHS England, the NEL ICB, the local authority and providers. They reflect a changing national operating environment. The most significant risk is the absence of a sustained, system-wide funding solution to maintain tailored immunisation activity beyond the current arrangements. Addressing these risks will require continued joint working and a shared commitment across the system, building on the long-standing partnership and investment that has supported immunisation improvement and outbreak response to date.

Vaccination leadership, workforce and operational restructuring across the ICB

8.2. In line with national requirements, the NEL ICB is undergoing significant cost-saving measures and organisational restructuring. The ICB has, over a

sustained period and outside its statutory responsibilities, invested significantly in local immunisation activity, including funding the Enhanced Immunisation Service in North East Hackney and dedicated programme and leadership roles. The current restructuring has nonetheless led to the loss of several key clinical and vaccination leadership roles across the system, and vaccination committees that focused on the primary care delivery of these programmes have either been scaled down or ceased operation.

8.3. This reduction in workforce and system leadership presents a risk to the oversight, clinical expertise, coordination, troubleshooting and support for immunisation programmes at both place and practice-based levels.

8.4. Notwithstanding, as per the national requirements, there is expected to be a change in how clinical leadership and vaccination programmes are supported. The operating model will address oversight and governance of immunisations and primary care services as required by the statutory functions, as well as how the ICB interfaces with other stakeholders involved in delivering immunisation programmes. At NEL-level, the new organisational structure will include a Deputy Director for Neighborhood Development, and clinical leads working closely with local authority teams to support neighborhood development.

8.5. The restructuring also delayed the release of funding intended for borough-based immunisation coordinators across NEL (a programme funded and commissioned by NHS England) as the ICB was unable to accept the funding. However, following escalation of the matter by City and Hackney Public Health to the ICB's Chief Medical Officer, the ICB has now confirmed (in April 2026) that measures are in place to release the necessary funding and procure the service through the North East London Foundation Trust (NELFT).

8.6. The funding release will secure the continuity of the immunisation coordinator workforce for the 2026/27 financial year although the operational delivery model remains unconfirmed. This includes how the coordinators will be deployed through NELFT (e.g., whether posts will operate on a borough basis or as a shared resource across NEL), alongside the scope and function of the roles.

Delegated commissioning arrangements from NHS England to ICBs

8.7. The planned transfer of immunisation commissioning from NHS England to ICBs, originally planned for April 2025, has been postponed again. This delegation remains dependent on legislative changes. Currently, NHS England retains the statutory accountability for commissioning these services. However, it is working closely with ICBs through existing system oversight and delivery structures. A formal transition programme would be put in place to manage the implementation and changes to local responsibilities should the delegation ultimately go ahead.

8.8. The Enhanced Immunisation Service, commissioned and funded by the NEL ICB and operating in the North East of the borough where immunisation uptake is lowest, has always been supported on a non-recurrent basis. The absence of a confirmed, sustained system-wide funding pipeline beyond the current arrangements places at risk the trusted relationships, community intelligence, and operational infrastructure that have been instrumental to both routine immunisation improvement and outbreak management.

Recurrent funding stream to enable continued delivery of the Enhanced Immunisation Service based in North Hackney

8.9. Funding from NEL ICB has been identified to enable service delivery to the end of the 2026/27 financial year. The lack of a future funding pipeline reflects the long-standing non-recurrent nature of the arrangement and is not a consequence of the ICB restructure. Securing the continuation of this tailored activity, and of tailored provision for other Hackney communities beyond North East Hackney, will require a shared, system-wide funding solution.

Flexibility within commissioning models to meet the needs of local populations across NEL

8.10. There is currently limited flexibility within existing commissioning and contractual arrangements to deliver services tailored to borough-specific needs; delegated commissioning could help address this. However, given the limited clarity on how delegated commissioning arrangements will be implemented across NEL, there is a risk that approaches may not sufficiently address existing geographical inequalities and the unique challenges across individual boroughs in NEL. The ICB and local partners have worked closely together over many years, and are jointly committed to continuing this close partnership working to address health inequalities across NEL, including through any future commissioning arrangements should delegation proceed.

NEL-wide population-level immunisation dashboard to enable the identification and mitigation of inequalities in uptake

8.11. As further detailed in Section 3 (data context), progress on the development of a NEL-wide immunisation dashboard had previously stalled. This has recently resumed, with the ICB Insights Team exploring the use of primary care data to support its development. This work is necessary to enable the proactive and routine identification and mitigation of population-level inequalities in uptake, as well as targeted evaluation.

9. Mitigations and Achievements

9.1. Active collaborative system-wide work is progressing despite the communicated challenges. Evidence of this progress includes the successful Year 1 review of the City and Hackney Immunisation Strategic Action Plan (2024-27), where over 50% of objectives were achieved, alongside the

modest but encouraging reduction in the declining trend of vaccination coverage.

9.2. System-wide oversight and coordination is also ongoing through:

- The City and Hackney Children and Young People's (CYP) Immunisations Forum: The Forum, chaired by Public Health, convenes a wide range of partners including health visiting, maternity, Interlink, school nurses, early years, healthy schools coordinator, and education. The Forum supports the identification and mitigation of risks, facilitates the cascading of guidance, and coordinates campaign delivery.

- Regular meetings with primary care and remaining ICB personnel for oversight, coordination and troubleshooting are ongoing.

- The Charedi Working Group: Established in January 2026 as a legacy of the measles outbreak response, the Group ensures continued strategic focus, oversight, and coordination to improve vaccination uptake and prevent VPDs within the Charedi community. The work of the Group includes the monitoring of vaccination coverage and community insights, the sharing and escalation of emerging issues, and the development and delivery of initiatives (including communication and outreach campaigns) to increase vaccination coverage.

9.3. Non-recurrent funding has been secured for the Enhanced Immunisation Service until the end of the current financial year (2026/27).

9.4. Lessons learned are routinely shared via local and regional fora, including:

- The City and Hackney Health Protection Forum
- The Faculty of Public Health's Health Protection Special Interest Group (HP SIG)
- The Health Protection Assurance Framework meeting
- London Immunisations Board

9.5. The challenges and improvement work undertaken in Hackney have also received national recognition. A formal response was submitted to the UK Parliament Committee inquiry on immunisation, and Dr Tehseen Khan, Clinical Director for Springfield Park PCN and the Enhanced Immunisation Service, was invited to provide evidence at the March 2026 parliamentary evidence session. The evidential hearing focused on the experiences of delivering childhood vaccination programmes, including the operational challenges faced and wider barriers contributing to declining childhood vaccination uptake.

9.6. Finally, the collaborative partnership achievements, notably reflected in the Chief Medical Officer's Annual Infections Report 2025[4], stand as a testament to the extensive and impactful work being delivered in Hackney in this critical public health space, despite ongoing challenges.

[4] [1] Chief Medical Officer. *Chief Medical Officer's Annual Report 2025: Infections and the Health of the Nation*. London: Department of Health and Social Care; 2025. Case study 2: *Addressing barriers to vaccine uptake in Hackney*, p.148.

Appendix 1. Complete Routine Immunisation Schedule as of 1 January 2026

Age due	Diseases protected against		Vaccine given and trade name		Usual site[1]
Eight weeks old	Diphtheria, tetanus, pertussis (whooping cough), polio, *Haemophilus influenzae* type b (Hib) and hepatitis B		DTaP/IPV/Hib/HepB	Infanrix hexa or Vaxelis	Thigh
	Meningococcal group B (MenB)		MenB	Bexsero	Thigh
	Rotavirus gastroenteritis		Rotavirus[2]	Rotarix[2]	By mouth
Twelve weeks old	Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B		DTaP/IPV/Hib/HepB	Infanrix hexa or Vaxelis	Thigh
	MenB		MenB	Bexsero	Thigh
	Rotavirus		Rotavirus[2]	Rotarix[2]	By mouth
Sixteen weeks old	Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B		DTaP/IPV/Hib/HepB	Infanrix hexa or Vaxelis	Thigh
	Pneumococcal (13 serotypes)		PCV	Prevenar 13	Thigh
One year old (on or after the child's first birthday)	Pneumococcal MenB Measles, mumps, rubella, varicella		PCV MenB MMRV	Prevenar 13 Bexsero ProQuad or Priorix Tetra	Upper arm or thigh
Eighteen months old	**Born on or after 1 July 2024** Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B Measles, mumps, rubella, varicella	**Born on or before 30 June 2024** No appointment	DTaP/IPV/Hib/HepB MMRV	Infanrix hexa or Vaxelis ProQuad or Priorix Tetra	Upper arm or thigh
Three years four months old or soon after	**Born on or after 1 January 2025** Diphtheria, tetanus, pertussis and polio	**Born on or before 31 December 2024** Diphtheria, tetanus, pertussis and polio Measles, mumps, rubella, varicella	dTaP/IPV MMRV	REPEVAX ProQuad or Priorix Tetra	Upper arm
Boys and girls aged twelve to thirteen years	Cancers and genital warts caused by specific human papillomavirus (HPV) types		HPV	Gardasil 9	Upper arm
Fourteen years old (school Year 9)	Tetanus, diphtheria and polio		Td/IPV (check MMR status)	REVAXIS	Upper arm
	Meningococcal groups A, C, W and Y		MenACWY	MenQuadfi	Upper arm
65 years old	Pneumococcal (23 or 20 serotypes)		Pneumococcal polysaccharide vaccine (PPV23) or Pneumococcal conjugate vaccine (PCV20) once PPV23 stock exhausted	Pneumovax 23 Prevenar 20	Upper arm
65 years of age and older	Influenza (each year from September)		Inactivated influenza vaccine	Multiple	Upper arm
Individuals turning 65 from 1 Sept each year (commencing 1 Sept 2023 onwards)	Shingles		Shingles vaccine	Shingrix	Upper arm
70 to 79 years of age (and those severely immunosuppressed over 18 years of age)	Shingles		Shingles vaccine	Shingrix	Upper arm
75 years of age	Respiratory syncytial virus (RSV)		RSV vaccine	Abrysvo	Upper arm

Appendix 2. City and Hackney Immunisations Strategic Plan (2024-27) on a Page

VISION

Our vision is to safeguard all communities from vaccine-preventable diseases by increasing and addressing inequalities in immunisation coverage through action of community-, data- and system-led insights.

STRATEGIC PRIORITIES

- Reduced inequalities in inclusion & high-risk groups
- Community engagement and co-production
- Enhanced data systems to drive quality improvement
- Optimised service delivery and resource planning
- Guidance, Training and Making Every Contact Count

OUTCOMES

Enhanced outreach offer	Comprehensive stakeholder mapping	Improved data quality and accessibility	Strengthened quality improvement	Vaccination advocacy in commissioned services
Targeted channels for engagement	Strengthened partnership working	Data and intelligence led activity	Best practice call and recall	Training for clinical and non-clinical staff
Targeted campaigns	Co-produced resources and initiatives	Campaign monitoring and evaluation	Alternative vaccination sites and delivery	Opportunistic awareness raising and engagement

PARTNERS