

03 Situation Report Series

Immunisations

SEPTEMBER 2026



The Situation Reports series provide an overview of the current situation of a topic of concern. The reports are purposely short and focused in order to provide timely updates allowing quicker response.

Outcomes could range from informing colleagues, taking action or triggering a deep dive into the topic.

The report is produced by Thurrock Public Health Intelligence Team, after reviewing available data.

Acknowledgements: This JSNA product has been developed with input from partner organisations represented through the JSNA Steering Group. The inclusion of partner logos recognises their contribution to the JSNA programme and does not necessarily indicate formal endorsement of the content of this document.

Look out for our upcoming reports on:



Excess weight in childhood



Tobacco in Thurrock



Oral Health in Thurrock



Respiratory Conditions in Thurrock

Background

Immunisation protects individuals against vaccine-preventable infectious diseases. Vaccination is the main method for immunisation: a safe medicine is given to stimulate the body's immune response and provide protection if someone goes on to be exposed to the disease. Across the whole population, vaccination uptake is an important indicator of vulnerability of the community to infectious disease outbreaks. Higher vaccine coverage generally reflects stronger community protection, while lower uptake indicates increased susceptibility to outbreaks.

Trend of Immunisation

Overall, childhood vaccination uptake rates in England declined between 2019 and 2023, falling below the WHO's recommended 95% target across five key vaccines. Within this broader trend, inequalities appear to be widening, with noticeable regional differences in uptake emerging across the country. The UK has consistently fallen short of the national target of ensuring 95% of children receive two doses of the MMR vaccine by the age of five. In 2023-24, 83.9% of children in England received two doses of the MMR vaccine by age five (NHS England, 2024). The impact of the COVID-19 pandemic and a growing anti-vaccination sentiment also contributed to a decline in childhood vaccination rates. Rising measles cases across the UK since 2023 reflect the consequences of declining immunisation rates (UK Health Security Agency, 2026).

Immunisation Focus

This report focuses on commonly recommended vaccines in the UK for children (aged 3-11), adolescents (aged 15-19), at-risk persons (6 months to 64 years), older people (aged 65+) and pregnant women. These include the following:

- Childhood vaccinations: 6-in-1 (DTaP/IPV/Hib/HepB), MenB, Rotavirus, Pneumococcal (PCV13)
- School age children: MMR and DTaP/IPV booster
- Adolescent vaccinations: HPV, MenACWY
- Person's at-risk: Influenza (Flu), PCV, COVID-19
- Older people vaccinations: Flu, PCV, shingles, COVID-19
- Pregnant women: Flu, Pertussis, RSV

Herd Immunity as Benchmark

Herd immunity occurs when a sufficiently large proportion of a population has become immune to an infectious disease, either through vaccination or prior infection. This reduces the likelihood of the disease transmission and provide indirectly protection to those who are not immune.

The threshold required to achieve herd immunity varies depending on the infectiousness of the disease. For highly contagious illnesses such as measles, around 95% of the population needs to be immune. Therefore, national targets recommend that at least 95% of children are immunised against vaccine-preventable diseases of the diseases targeted for elimination or control. In 2024/25, for the seventh consecutive year, none of the routine vaccinations in the UK met this benchmark (Nuffield Trust, 2026).

When childhood vaccine uptake falls below optimal levels, both individuals and wider populations become more susceptible to infection, raising the likelihood of infectious disease outbreaks.

Purpose of Booster Vaccine Doses:

Over time, antibody levels can naturally decrease, and the immunity created by some vaccines can fade. For some vaccines, a booster dose is needed to kickstart the immune response, tricking the immune system into thinking it's encountering the virus. In response, the body rebuilds immunity by increasing the quantity and quality of the antibodies it makes.

Data Sources

The data used in this report is from individual level data recorded on the SystmOne platform by primary care. GP-level coverage data is also collected by the NHS Digital strategic data collection service and used by Child Health Information Service (CHIS) providers.

Completeness of practices and data quality may vary, and so data quality checks were done at several points of reports and data extraction before data analysis was carried out. The approach used aligns with reports used by NHS digital to ensure that results are both reliable and comparable. Vaccination data for pregnant women were extracted for the full calendar year (January–December 2025) to capture all three vaccine dates across the course of pregnancy.

Data for at-risk populations were extracted from 1 April 2025, aligning with the current 2025/2026 reporting year.

Public Health Response

With existing awareness of the low vaccination levels in Thurrock and surveillance of outbreaks of vaccine preventable diseases in neighbouring areas of Thurrock, it is important that the system comes together to support communities to be able to take up the vaccinations offered..

This report will allow us to pinpoint geographical areas of highest risk as well as who is at risk to enable relevant partners and communities to reduce that risk and support the usual delivery model with enhanced targeting and tailored offers.

A co-ordinated drive to increase vaccination uptake through education, myth-busting and vaccinations directly in the communities identified as experiencing lower uptake is supported.



Headlines

Overall: Vaccination coverage falls below the 95% herd immunity threshold across all age groups. Gaps are observed across integrated neighbourhood team (INT), deprivation level and ethnicity. The Aveley, South Ockendon and Purfleet (ASOP) population generally have higher levels of missed vaccinations. Measles, Meningitis, and Pertussis pose a higher outbreak risk.

Younger children (age 3–5yrs) — Rotavirus, PCV, MenB: 14% to 15% of this age group are not vaccinated. Higher rates of missed vaccination are seen in children of Black or Mixed ethnicity. The highest proportion of children missing vaccinations are located around West Thurrock and South Stifford, Grays Thurrock, Tilbury Riverside and Thurrock Park.

Primary school-aged children (age 6–11yrs) — MMR, DTaP/IPV booster: Up to 16% are not fully vaccinated against MMR, leaving them with significant susceptibility to a Measles outbreak. DTaP/IPV uptake is 84%, raising Pertussis risk. Non-vaccination is more prevalent among children in most deprived areas and those of Black, Mixed, or Other ethnic backgrounds. Geographically, non-vaccination rates are highest in Grays Thurrock, Grays Riverside, West Thurrock and South Stifford.

Adolescents (age 15–19yrs) — HPV, MenACWY: 29% of females and 38% of males have not received the HPV vaccine. One-third have not received MenACWY, posing a higher meningitis risk as many in this age group start to mix more e.g. at college and university. Some inequalities in vaccine uptake by deprivation and ethnicity are observed in this group. Non-vaccination rates are highest in Grays Riverside, West Thurrock and South Stifford, Tilbury Riverside and Tilbury St Chads.

Older people (age 65+yrs) — Flu, PPV, Shingles, COVID: 27% have not received the flu vaccine, 31% have not received the PCV vaccine. Additionally, 56% have not received Shingles vaccine and only 7% have not received COVID vaccine. Higher non-vaccination rates are observed among those in more deprived areas and of Black or Mixed ethnicity.

At-risk population — Flu, PCV, COVID (“at risk” group): Among eligible at-risk persons, 53% remain unvaccinated for influenza, 63% for PCV, and 27% for COVID-19. Deprivation-related inequalities are minimal; however, Black and Mixed ethnicity groups show slightly higher non-vaccination rates compared to White and South Asian groups.

Pregnant Women — Flu, Pertussis, RSV: 74% are not vaccinated for influenza, 59% for RSV and 40% for Pertussis. Deprivation-related inequalities are minimal across deprivation levels and ethnicity.

Immunisations in Younger Children

Population vaccination coverage (Age 3 -5 yrs): Rotavirus, PCV, MenB booster.

Figure 1: Vaccine uptake for children aged 3 to 5 yrs in Thurrock

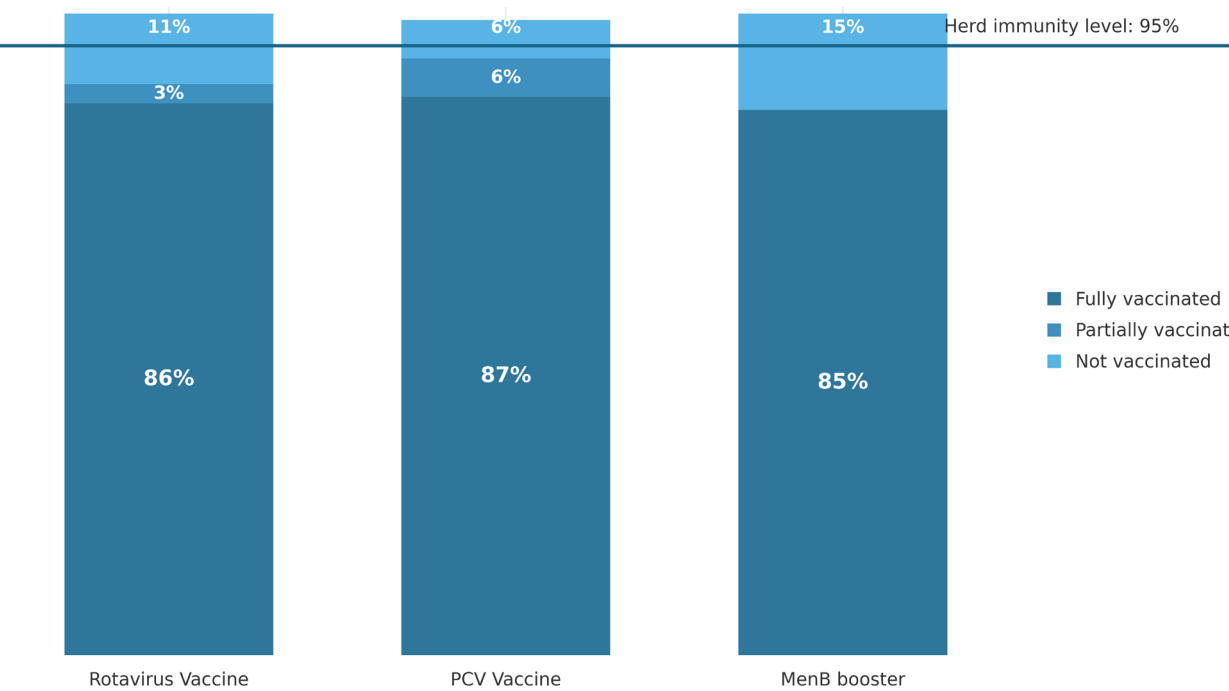
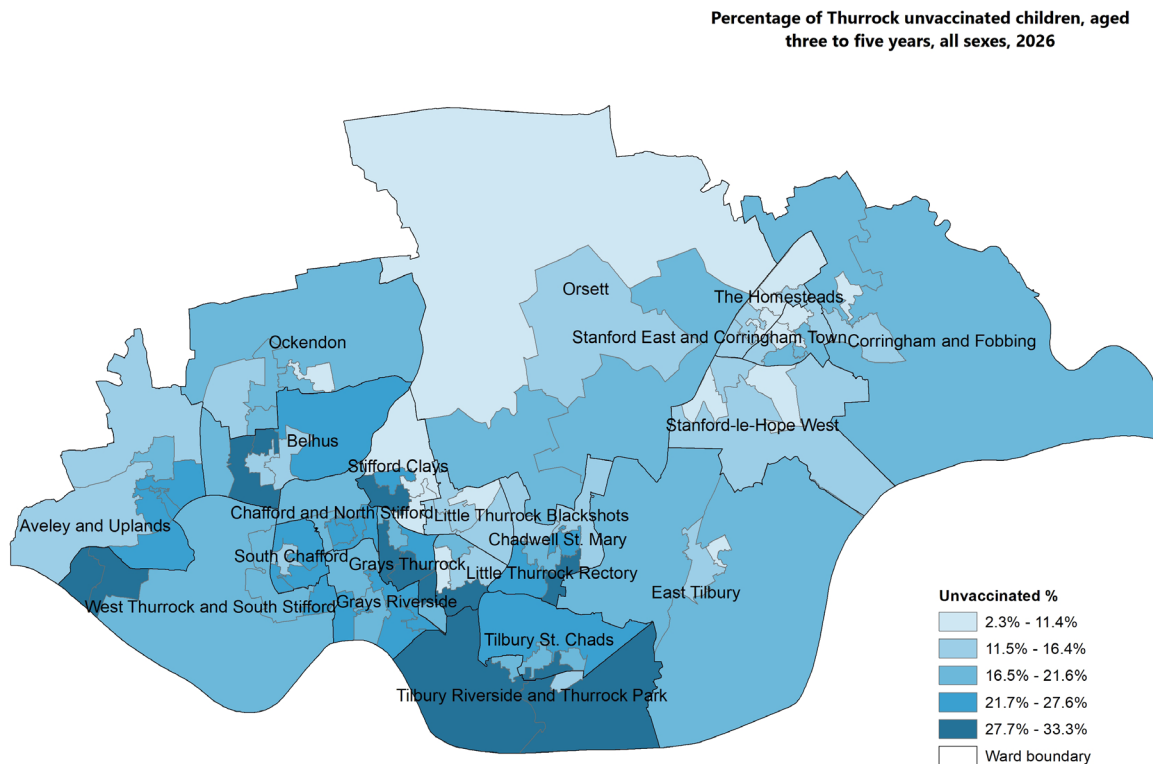


Figure 2: Geographic Distribution of Missing Vaccinations (Ages 3–5 yrs, Thurrock)



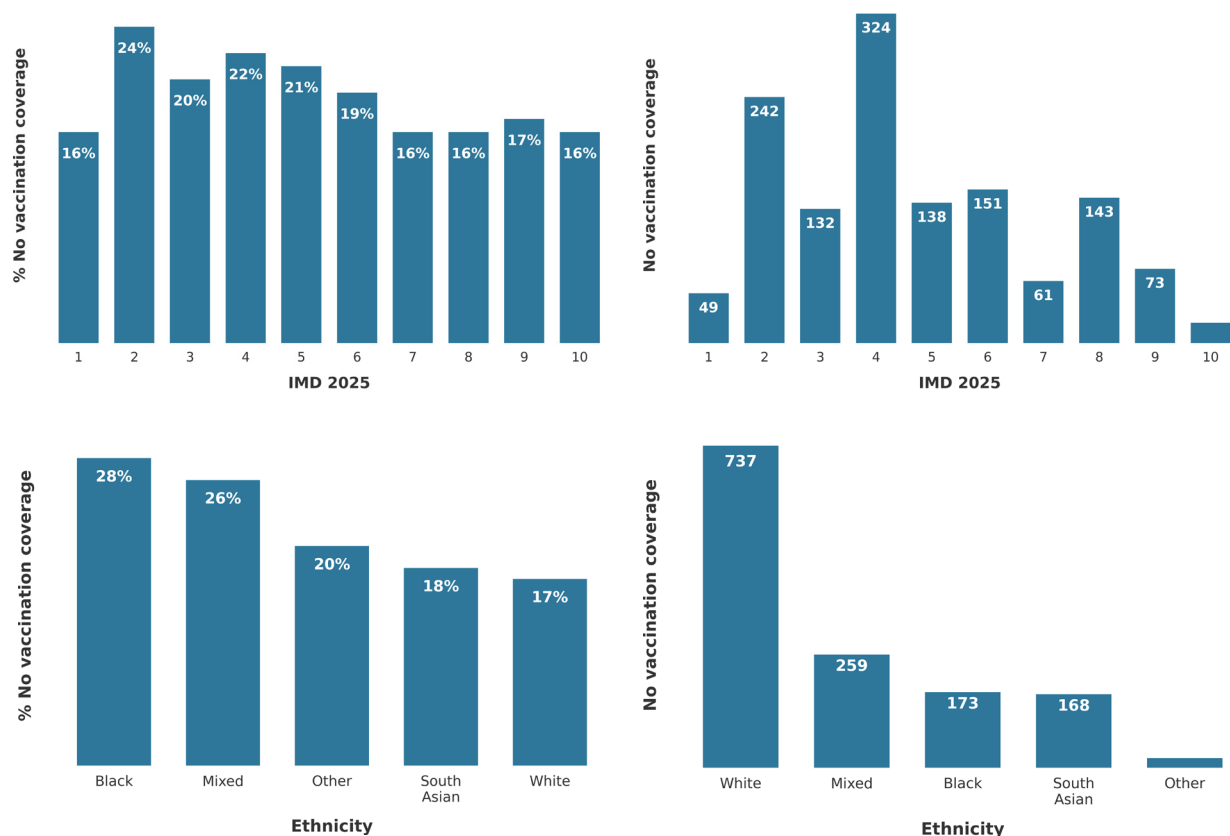
Among children aged 3 to 5 years in Thurrock

- **14% have not been fully vaccinated** against **Rotavirus**. This ranged from 9% in Tilbury and Chadwell to 16% in ASOP.
- **13% have not been fully vaccinated** against **Pneumococcal infection**. This ranged from 9% in Tilbury and Chadwell to 16% in ASOP.
- **15% have not been fully vaccinated** against **Meningitis B**. This ranged from 13% in Tilbury and Chadwell to 18% in ASOP.
- The highest levels of missing vaccination are located around West Thurrock and South Stifford, Grays Thurrock, Tilbury St Chads and Tilbury Riverside and Thurrock Park ward. (Fig. 4)

[See Appendix A for Integrated Neighbourhood Team level coverage figures and breakdown by Wards]

Inequality in Vaccine Uptake among 3 to 5 years

Figure 3: Missing Vaccinations by Deprivation and Ethnicity (Ages 3–5 yrs, Thurrock)



The association between deprivation and non-vaccination rates is unclear. While there are small differences between groups, it is generally those areas which have medium levels of deprivation where the highest rates are observed and decile 2 stands out as particularly high¹.

Disparities in vaccination uptake are observed between ethnic groups. Children from Black ethnic backgrounds had the lowest uptake with 28% not fully vaccinated. Similarly, children of Mixed ethnic heritage also demonstrated high non-vaccination rates with 26% not fully vaccinated. (Fig. 3).

In absolute terms, 737 White, 259 Mixed, 173 Black, and 168 South Asian children had not received their complete vaccinations (on the date data was extracted).

¹This pattern may be indicative of previous attempts to improve vaccination levels in our more deprived areas

Immunisation in Primary School-Aged Children (Age 6-11 years)

Figure 4: Vaccine uptake for children aged 6 to 11 years in Thurrock

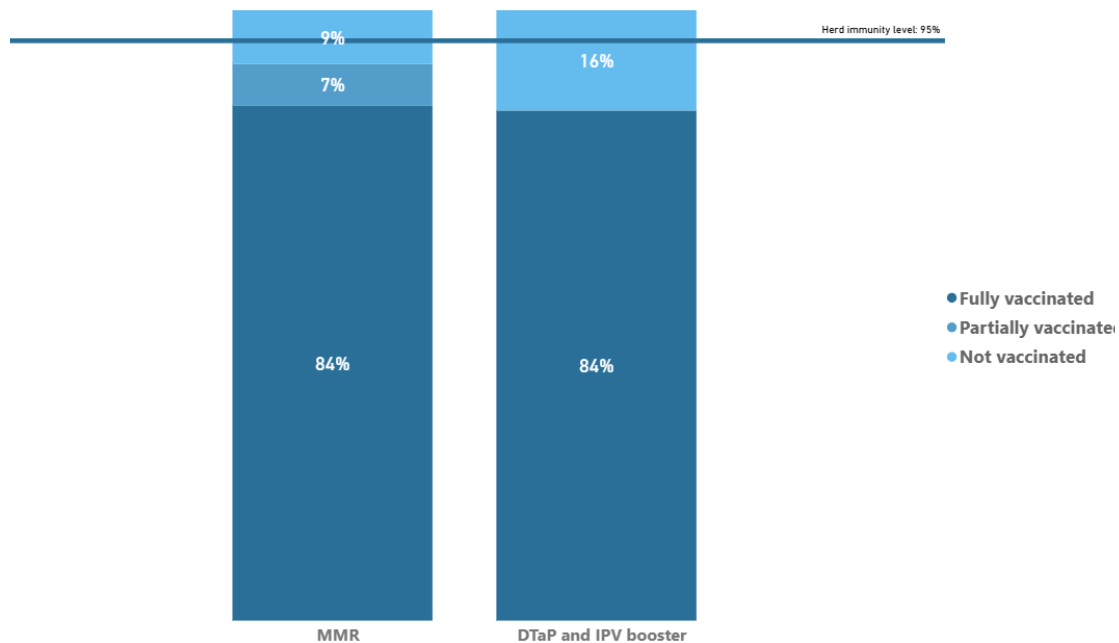
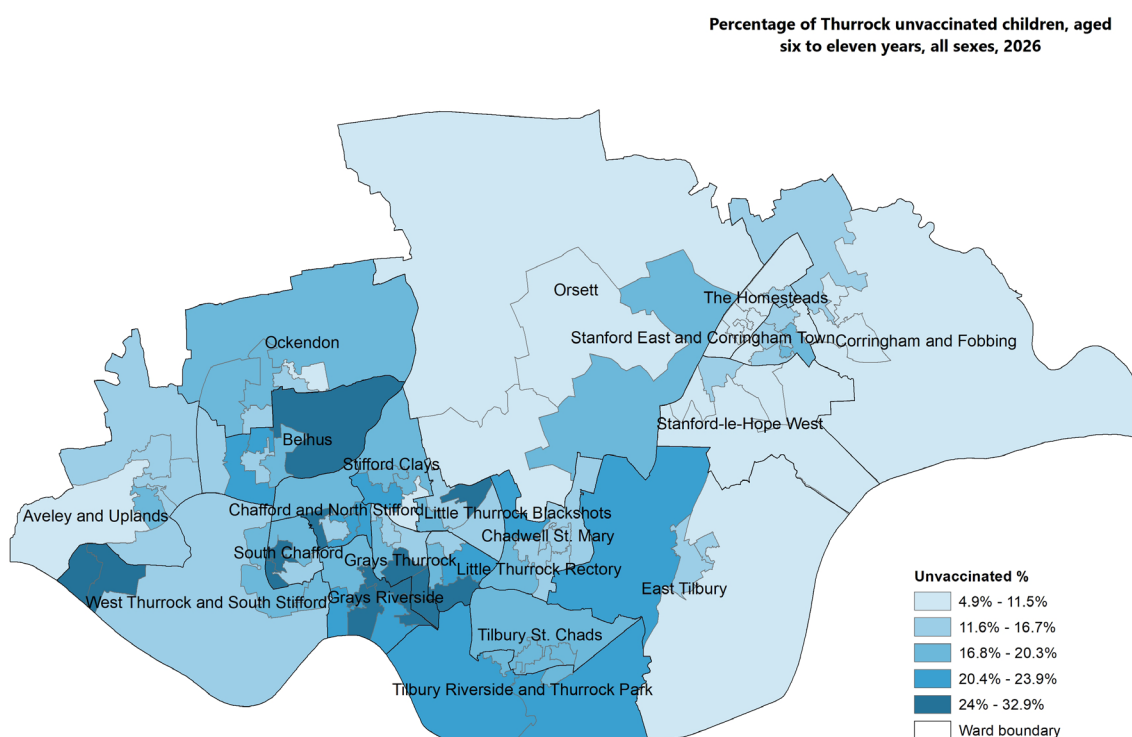


Figure 5: Geographic Distribution of Missing Vaccinations (Ages 6–11 yrs, Thurrock)

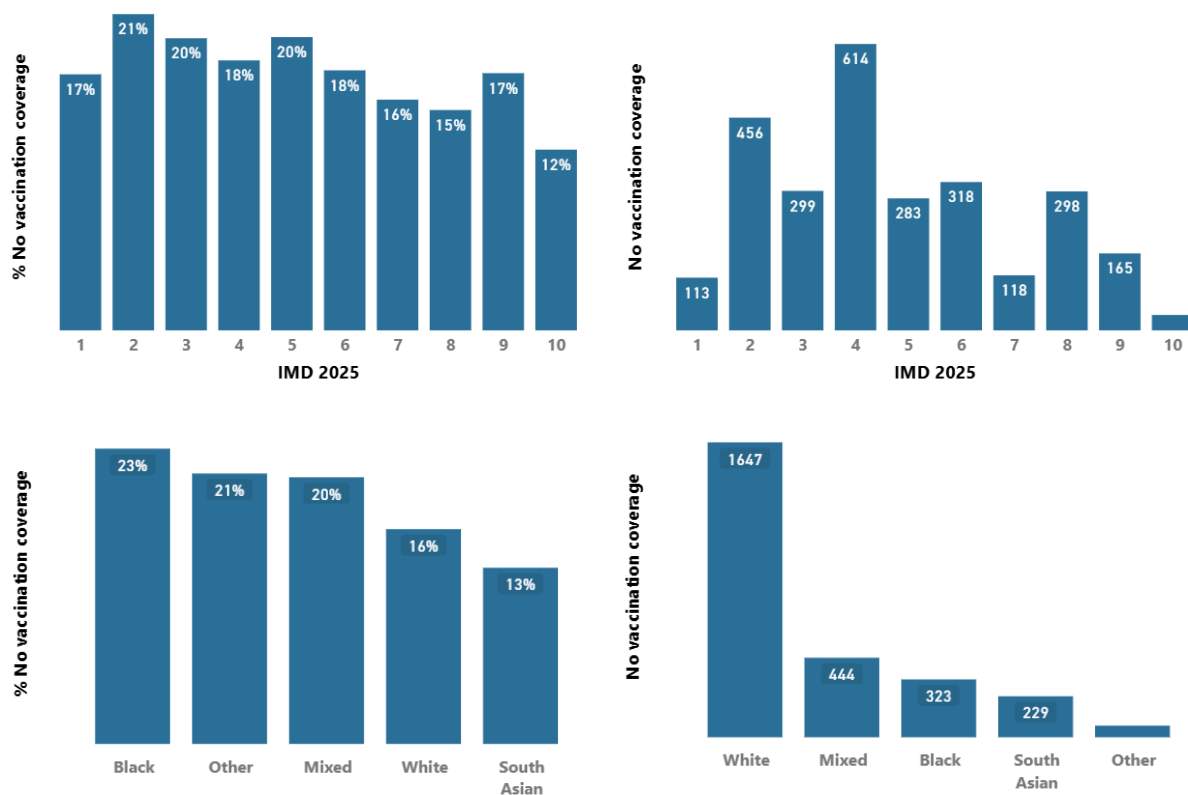


Among children aged 6 to 11 years in Thurrock

- **16% have not been fully vaccinated** against **Measles, Mumps and Rubella (MMR)**. This ranged from 9% in Stanford-Le-Hope to 18% in Grays.
- **16% have not been fully vaccinated** against **DTaP and Inactivated Poliovirus Vaccine (IPV)**. This ranges from 10% in Stanford-Le-Hope to 20% in Grays.
- The highest levels of non-vaccinated children in this age range are in the mid-areas of Thurrock, including the Orsett, The Homesteads and Grays Thurrock.

Inequality in vaccine uptake among primary school aged (6 to 11-year-old) children in Thurrock

Figure 6: Missing Vaccinations by Deprivation and Ethnicity (Ages 6–11 yrs, Thurrock)



School-age children residing in the most deprived areas show similar rates of non-vaccinations compared to those in less deprived areas. There are some disparities observed in vaccination uptake between ethnic groups. Children from Black, Other and Mixed ethnic groups had higher rates of missing vaccinations, compared with children who identified as White or South Asian ethnic group.

Immunisation in Adolescents (Age 15-19 yrs)

Figure 7: Vaccine uptake for adolescents aged 15 to 19 yrs in Thurrock

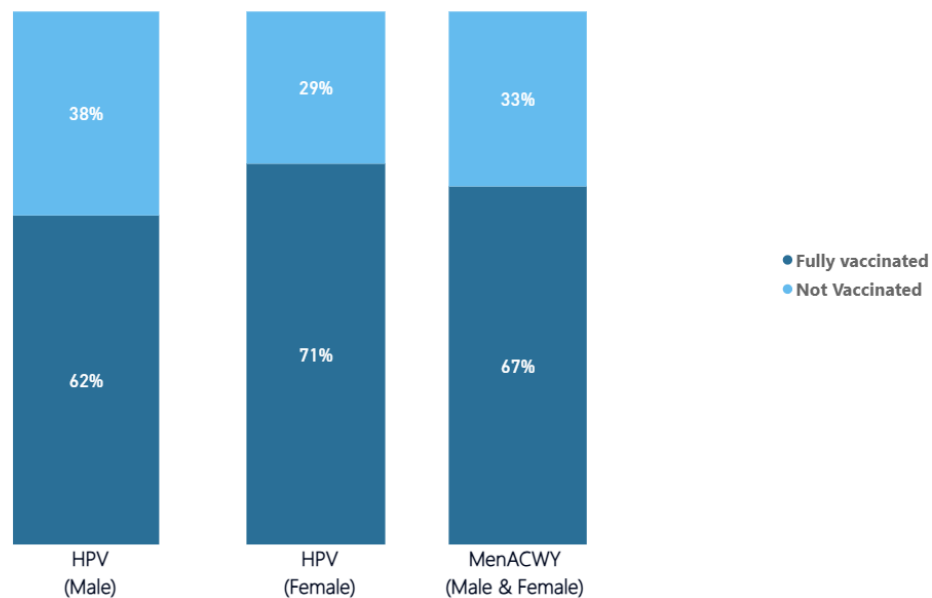
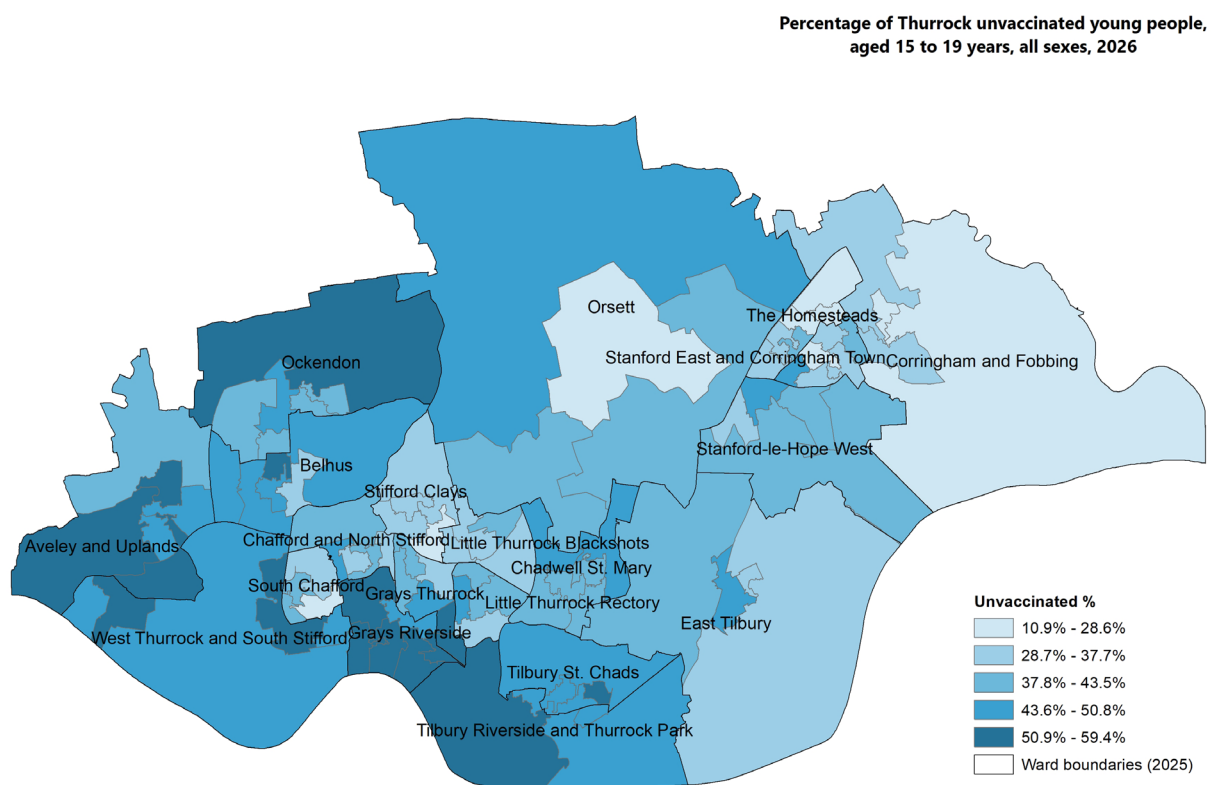


Figure 8: Geographic Distribution of Missing Vaccinations (Ages 15-19 yrs, Thurrock)

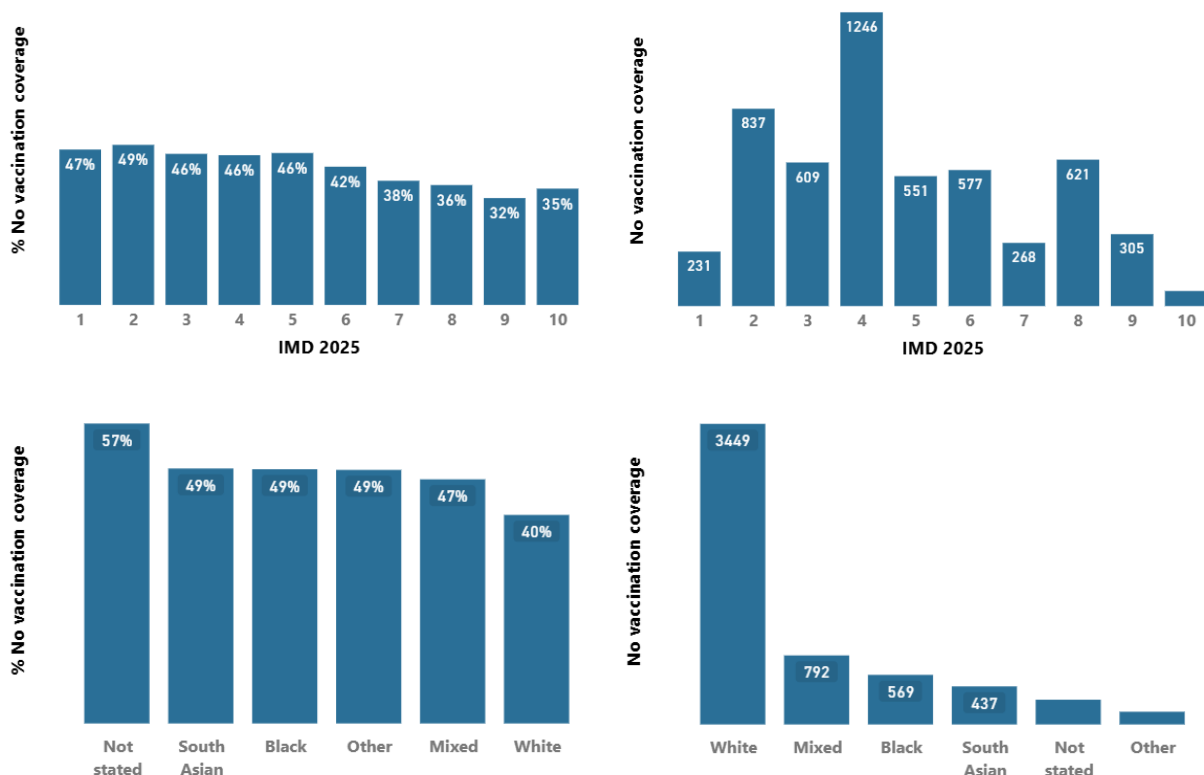


Among adolescents aged 15 to 19 years in Thurrock

- **29% of females and 38% of males have not been vaccinated** against **Human Papilloma Virus (HPV)**. For both sexes, it ranges from 25% in Stanford-Le-Hope to 39% in ASOP.
- **33% have not been vaccinated against MenACWY**. This ranges from 27% in Stanford-Le-Hope to 37% in ASOP.
- Areas such as Grays Riverside, West Thurrock and South Stifford, and Tilbury St Chads recorded particularly high levels of missed vaccination, with about 50% of adolescents in these areas not vaccinated.

Inequality in vaccine uptake among 15- to 19-year-old adolescents in Thurrock

Figure 9: Missing Vaccinations by Deprivation and Ethnicity (Ages 15–19 yrs, Thurrock)



The proportion of unvaccinated 15 to 19 years shows some variation of about 10% between highest and lowest deprivation levels and about 9% difference between White ethnic group and Other ethnic groups.

Immunisation in Older People

Figure 10: Vaccine uptake for older people aged 65 yrs and above in Thurrock

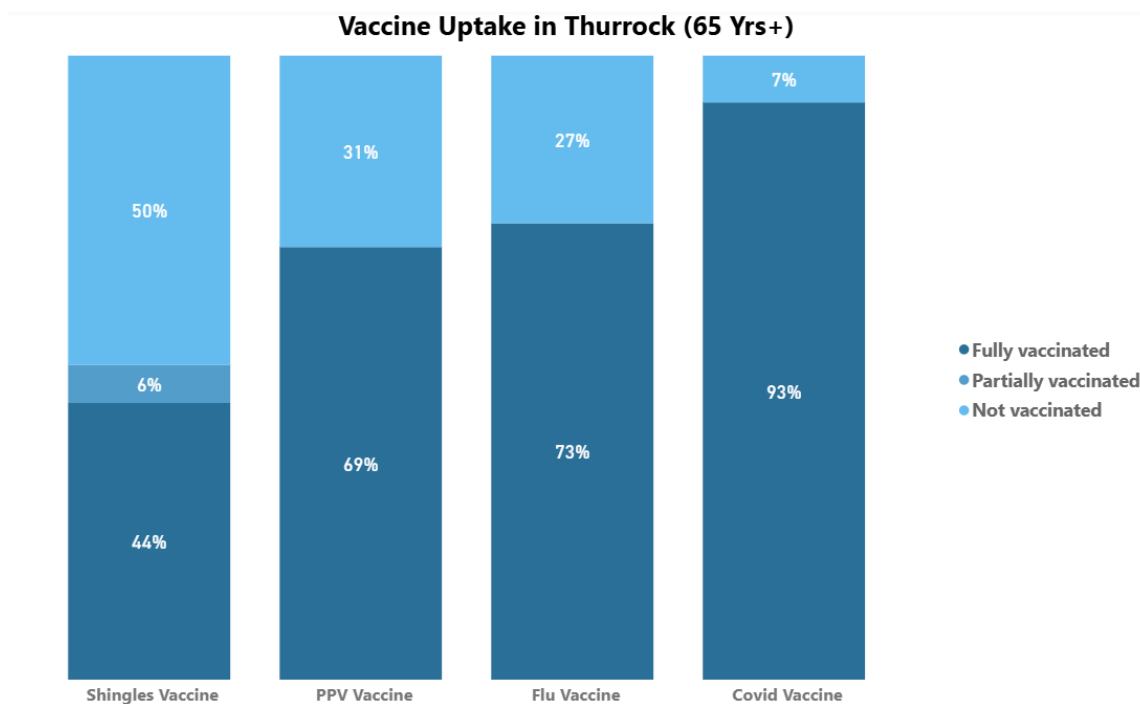
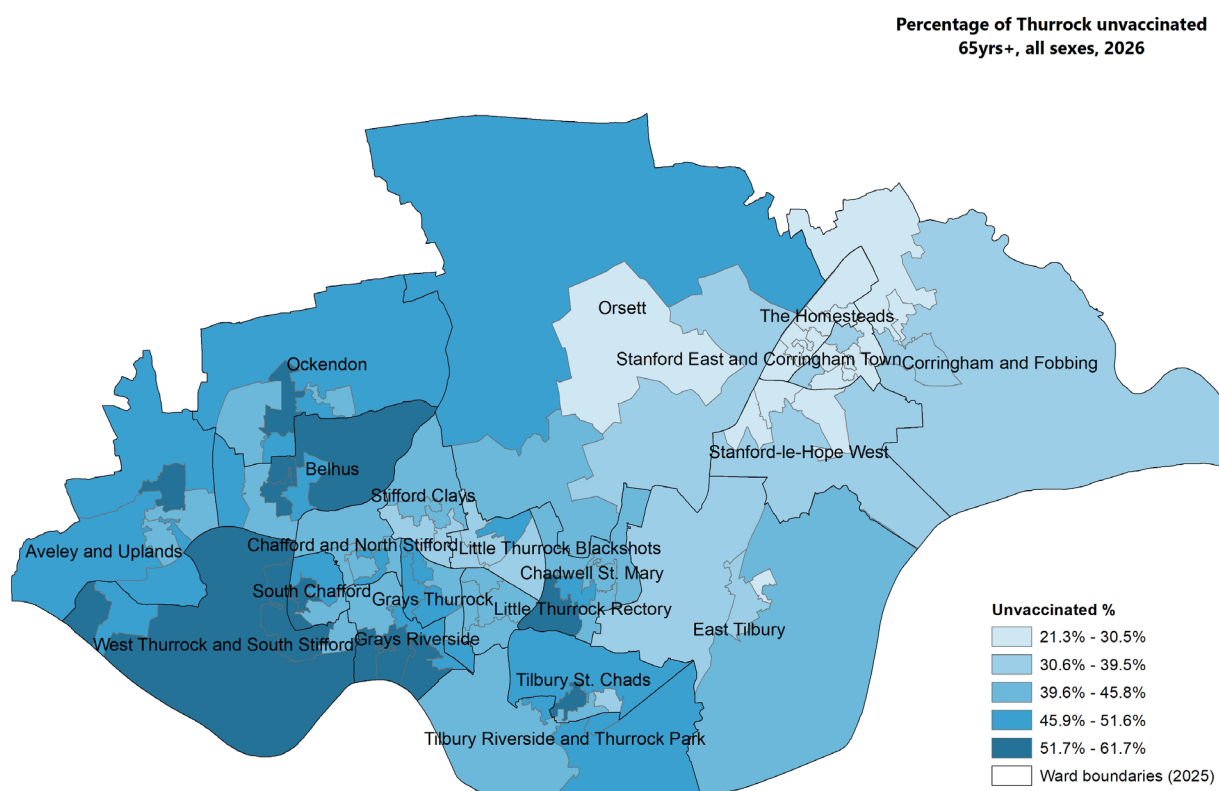


Figure 11: Geographic Distribution of Missing Vaccinations (Ages 65+ yrs, Thurrock)



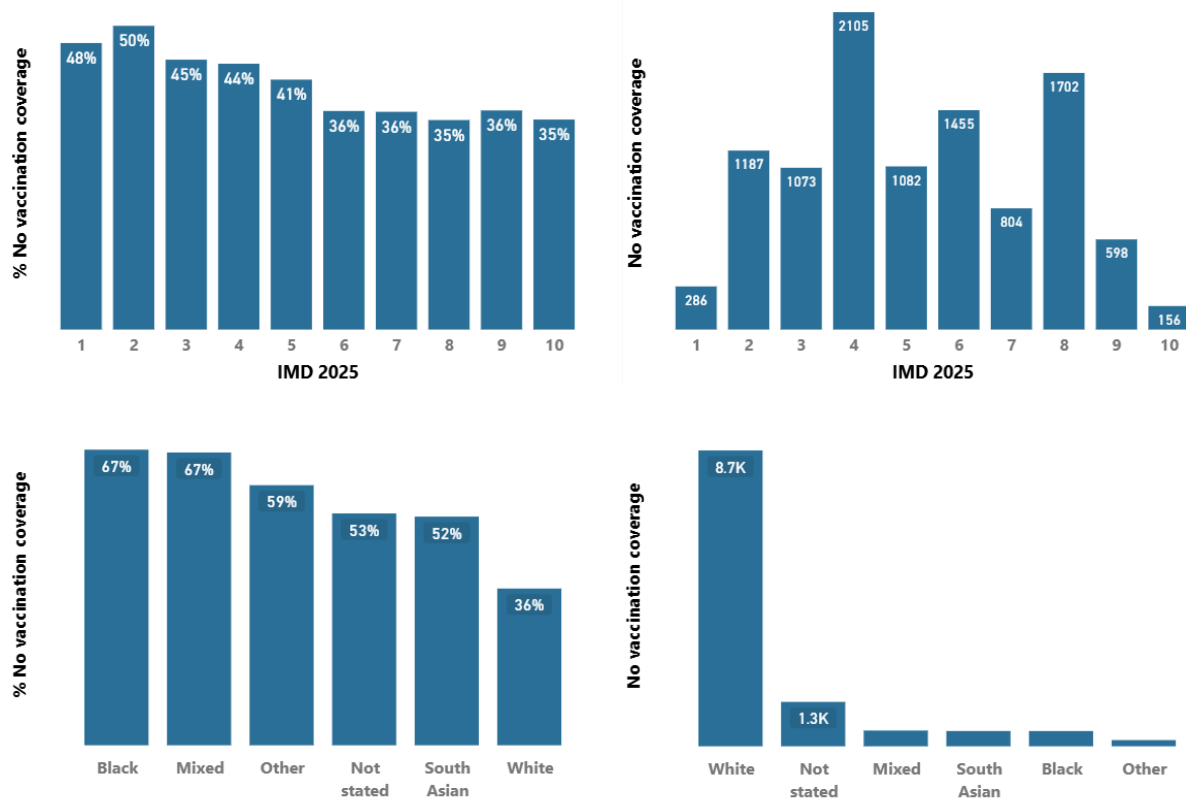
Among older residents aged 65 years and above in Thurrock

- **50% have not been fully vaccinated** against **shingles**. 6% are partially vaccinated (received only one dose of Shingrix).
- **31% have not been vaccinated** against **pneumococcal infections**. This ranges from 23% in Stanford-Le-Hope to 39% in ASOP.
- **27% have not been vaccinated** against **influenza infections**. This ranges from 19% in Stanford-Le-Hope to 35% in ASOP.
- **7% have not been vaccinated** against **COVID-19**. This ranges from 4% in Stanford-Le-Hope to 12% in ASOP.

Unvaccinated older residents are concentrated in West Thurrock and South Stifford, Belhus, South Chafford and Grays Riverside.

Inequality in vaccine uptake among older people in Thurrock

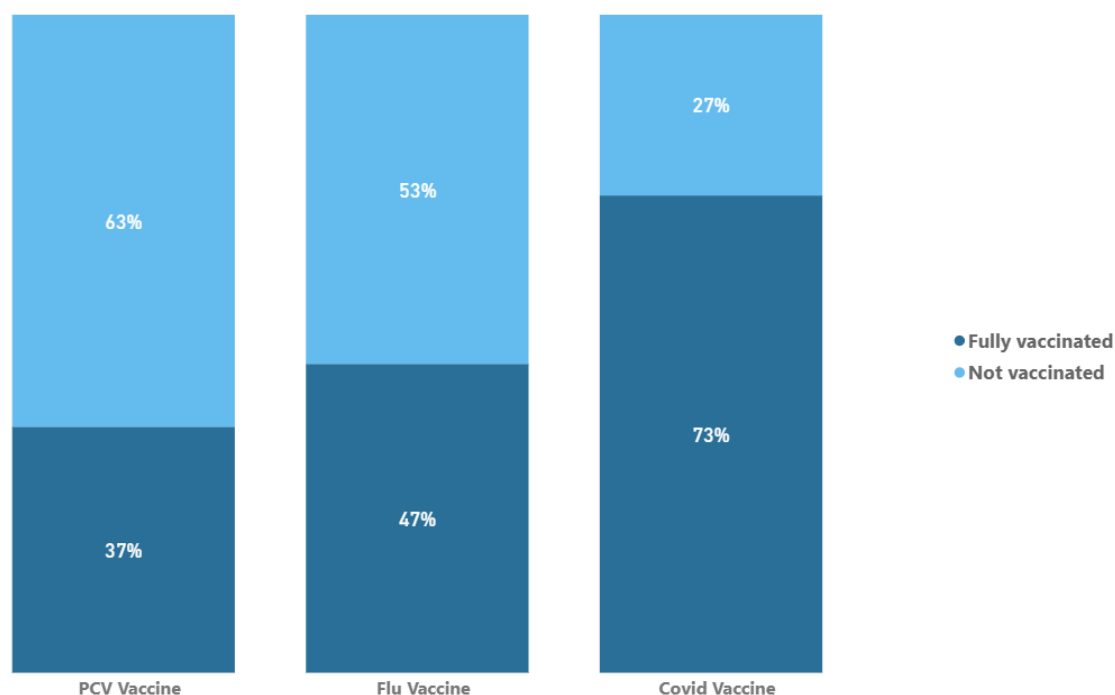
Figure 12: Missing Vaccinations by Deprivation and Ethnicity (Age 65+ yrs, Thurrock)



Persons aged 65 and above in the most deprived areas show higher rates of incomplete vaccination. Black and Mixed ethnic groups have higher rates of missed vaccinations than the White ethnic group.

Immunisation in 'At risk' Individuals

Figure 13: Vaccine uptake for 'at risk' population in Thurrock

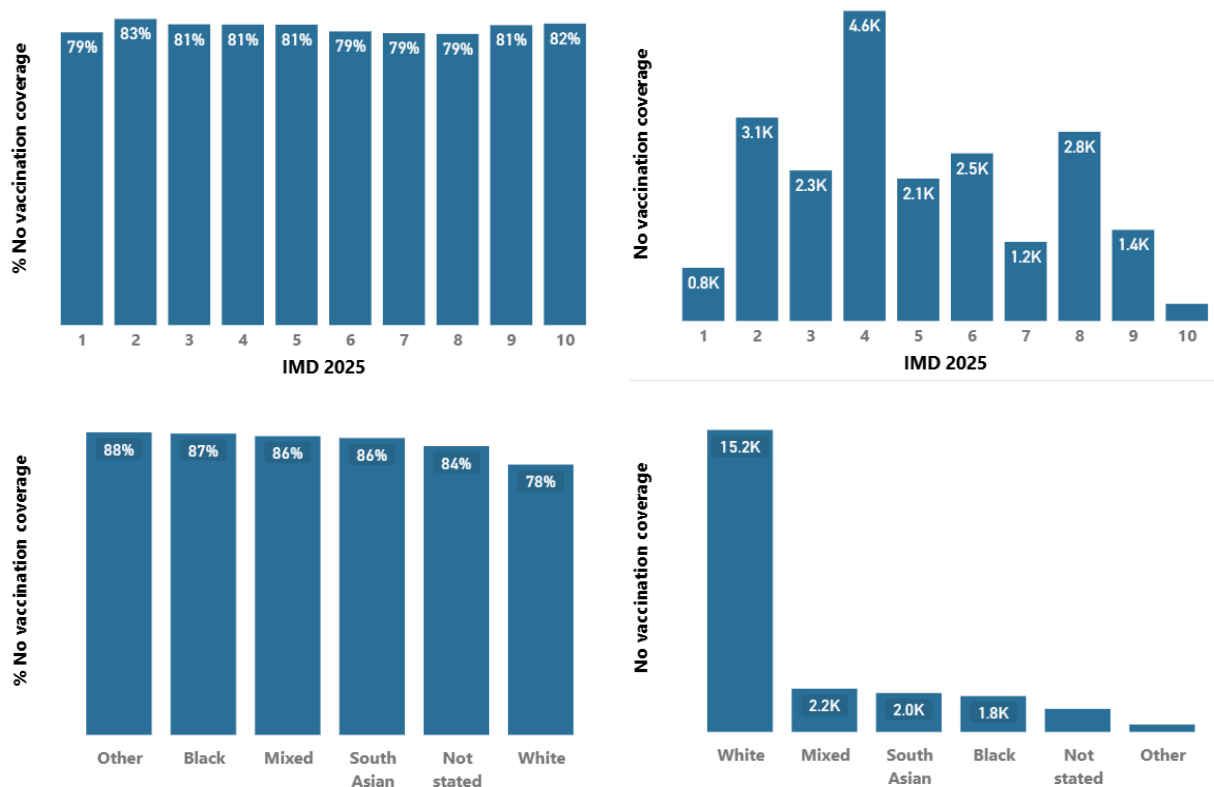


Among the under-65 "at risk" population in Thurrock eligible for PCV, influenza, and COVID-19 vaccination:

- **63% have not been fully vaccinated** against **pneumococcal infections**. This ranges from 61% in Stanford-le-Hope and Tilbury and Chadwell to 66% in ASOP.
- **53% have not been vaccinated** against **influenza**. This ranges from 43% in Stanford-le-Hope to 59% in ASOP.
- **27% have not been vaccinated** against **COVID-19**. This ranges from 22% in Stanford-le-Hope to 31% in ASOP.

Inequality in vaccine uptake among “at-risk” population in Thurrock

Figure 14: Missing Vaccinations by Deprivation and Ethnicity (At-Risk), Thurrock

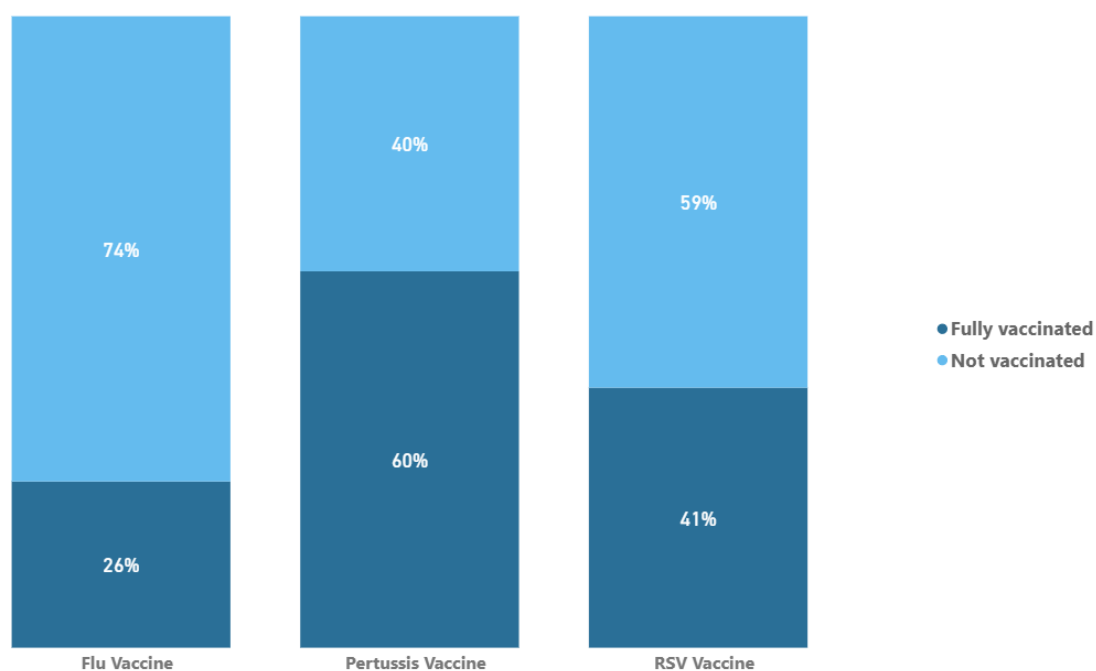


Non vaccination rates among at-risk persons shows relatively little variation across deprivation levels, with no substantial differences observed between the most and least deprived deciles.

Across ethnic groups, individuals of Black and Mixed ethnicity show slightly higher rates of non-vaccination compared to White and South Asian groups.

Immunisation in Pregnancy

Figure 15: Vaccine uptake during Pregnancy in Thurrock



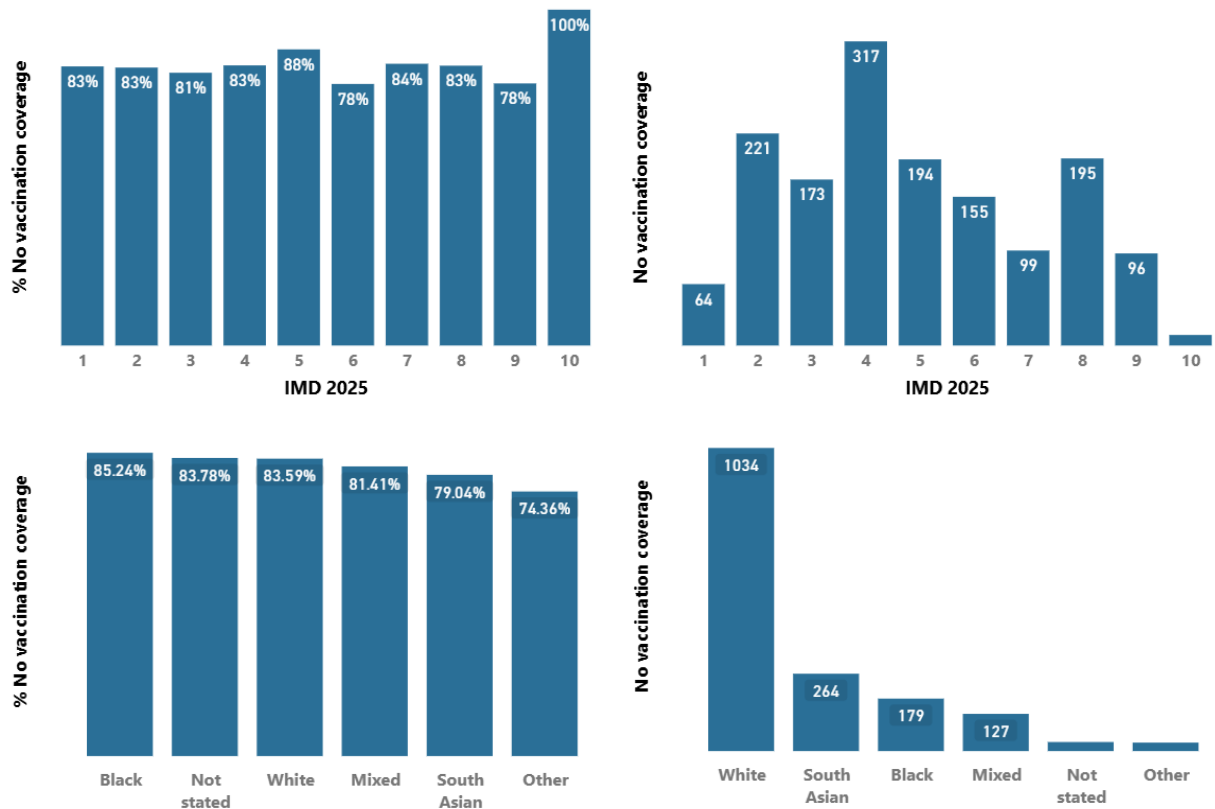
Among pregnant women in Thurrock in the last year:

- **74% have not been vaccinated** against **influenza**. This ranges from 68% in Stanford-le-Hope to 78% in ASOP.
- **40% have not been vaccinated** against **pertussis**. This ranges from 29% in Stanford-le-Hope to 46% in ASOP.
- **59% have not been vaccinated** against **RSV**. This ranges from 54% in Stanford-le-Hope to 66% in ASOP.



Inequality in vaccine uptake among pregnant women in Thurrock

Figure 16: Missing Vaccinations During Pregnancy by Deprivation and Ethnicity (Thurrock)



missing vaccination rates among pregnant women shows relatively little variation across deprivation levels and ethnicity. There were no substantial differences observed between the most and least deprived deciles, and between individuals from different ethnic background.

What is Happening in Thurrock?

Within Thurrock and extending across Southend and Essex colleagues there is a collaborative partnership with NHS England Immunisations and Screening team, the Community and School-Aged Immunisation Service provider (CSAIS), Primary Care and UKHSA as well as with local and regional colleagues in the delivery of initiatives to support increased access and uptake of immunisations locally.

- A monthly meeting with **action plan to improve childhood immunisations** with a number of actions around sharing communications and engaging with underserved populations. Supporting linkages with education and early years providers.
- A **mobile vaccination unit** owned by the CSAIS team is used to provide access for communities where reaching static clinics is difficult and to provide more options for people at weekends and in areas of high footfall such as supermarkets and sports centres. The team are also able to attend key public events to offer vaccinations.
- **Increasing access for Special Educational Needs and Disabilities** though dedicated clinics with attention to required adjustments, sensory needs and additional visits as well as with Learning Disability communities through commissioning projects with additional providers. Dedicated clinics are provided for home educated children and after school clinics for working parents regularly until 7pm as well as a domiciliary visit offer where this is required.
- **Targeted programmes** to support uptake of specific immunisations also exists driven by needs, for example a catch-up campaign related to the MMR vaccination in response to outbreaks of measles in parts of London.

The NHS England Screening and Immunisation team have a number of initiatives including:

- **East of England Immunisation Call and Recall service** - this innovative service identifies under-vaccinated pre-school children and invites them for vaccination. Parents will receive phone calls to have a tailored conversation to fully understand their needs, and potentially **resolve any barriers to vaccination. They will then be offered the opportunity to book a catch-up vaccination appointment.**
- **Direct Booking project with GP practices. This allows the East of England Immunisation Call and Recall service to book appointments** for parents directly in their GP Practice if that is the most convenient location or most trusted provider for them. This then reduces burden on the parent to contact their GP to book an appointment.

- **Developing an Adult Immunisation System** to support the effective delivery and monitoring of adult vaccinations in a similar way to the Child Health Information Service (CHIS) that has existed for a number of years, holding a digital record for immunisations, screening and development checks. Following a successful pilot, it highlighted that many older people were simply not vaccinated because they were not aware of their eligibility. When live, this system will be able invite patients by letter, text and email.
- **Maternity delivery actions** to support increased uptake within Basildon hospital maternity unit. There is a unique model for maternal RSV delivery where all pregnant mothers will be contacted personally by CSAIS and invited for vaccination in a range of locations. The East of England are also the first area in the country to pilot maternal vaccines being offered in community pharmacies. Once evaluated further rollout to more pharmacies will be possible.
- **Acute trust vaccination service** seeks to build on the maternal vaccination offer and gives Trusts the framework and funding to offer the full immunisation schedule to those eligible both in and outpatients. The service specification has been reviewed with discussions underway with Mid and South Essex Foundation Trust (MSEFT) to agree an implementation plan within acute sites.

Family Hubs provide an opportunity to improve immunisation uptake by offering a trusted, community based setting where families already access support. They can help normalise conversations about vaccination, address hesitancy, and reach families who may not engage with traditional health services. By working alongside health visitors and community providers, Family Hubs can support signposting, outreach and opportunistic vaccination, helping to improve access, reduce inequalities and increase overall uptake.

The introduction of the **MMRV vaccine** to the routine schedule in January 2026 (combined measles, mumps, rubella and varicella) presents an opportunity to improve uptake by combining protection against four infections into a single vaccination, it may help improve acceptance among parents and children and reduce missed opportunities. The addition of varicella (chicken pox) alongside MMR provides a prompt to re-engage families who may have delayed or missed MMR, creating an opportunity to catch up children who are not fully protected.

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Appendix A – Missing Vaccination by INT area and Ward

Table 1: INT Breakdown of Vaccination among Children Aged 3 to 5 yrs

3 to 5 Years a Vaccination			
INT	Ward	% Missing Vaccination *	Missing Vaccination Count*
ASOP	Aveley and Uplands	21%	85
ASOP	Belhus	23%	92
ASOP	Ockendon	16%	51
ASOP	West Thurrock and South Stifford	28%	123
Grays	Chafford and North Stifford	23%	67
Grays	Grays Riverside	23%	156
Grays	Grays Thurrock	26%	102
Grays	Little Thurrock Blackshots	15%	33
Grays	Little Thurrock Rectory	19%	42
Grays	South Chafford	23%	66
Grays	Stifford Clays	17%	35
Stanford-Le-Hope	Corringham and Fobbing	16%	26
Stanford-Le-Hope	Orsett	16%	31
Stanford-Le-Hope	Stanford East and Corringham Town	14%	42
Stanford-Le-Hope	Stanford-le-Hope West	12%	40
Stanford-Le-Hope	The Homesteads	12%	33
Tilbury and Chadwell	Chadwell St Mary	20%	86
Tilbury and Chadwell	East Tilbury	16%	50
Tilbury and Chadwell	Tilbury Riverside and Thurrock Park	24%	98
Tilbury and Chadwell	Tilbury St Chads	24%	72

* Any person who has not received at least one of the vaccines examined for the group is classified as missing vaccination

Table 2: INT Breakdown of Vaccination among Children Aged 6 to 11 yrs

6 to 11 Years Vaccination			
INT	Ward	% Missing Vaccination *	Missing Vaccination Count*
ASOP	Aveley and Uplands	15%	144
ASOP	Belhus	20%	198
ASOP	Ockendon	16%	120
ASOP	West Thurrock and South Stifford	22%	204
Grays	Chafford and North Stifford	21%	146
Grays	Grays Riverside	25%	314
Grays	Grays Thurrock	25%	214
Grays	Little Thurrock Blackshots	16%	95
Grays	Little Thurrock Rectory	21%	108
Grays	South Chafford	21%	150
Grays	Stifford Clays	17%	89
Stanford-Le-Hope	Corringham and Fobbing	9%	30
Stanford-Le-Hope	Orsett	11%	39
Stanford-Le-Hope	Stanford East and Corringham Town	13%	82
Stanford-Le-Hope	Stanford-le-Hope West	11%	82
Stanford-Le-Hope	The Homesteads	10%	59
Tilbury and Chadwell	Chadwell St Mary	16%	171
Tilbury and Chadwell	East Tilbury	16%	116
Tilbury and Chadwell	Tilbury Riverside and Thurrock Park	21%	197
Tilbury and Chadwell	Tilbury St Chads	19%	139

* Any person who has not received at least one of the vaccines examined for the group is classified as missing vaccination.

Table 3: INT Breakdown of Vaccination among Adolescents Aged 15 to 19 yrs

15 to 19 Years Vaccination			
INT	Ward	% Missing Vaccination *	Missing Vaccination Count*
ASOP	Aveley and Uplands	49%	393
ASOP	Belhus	47%	389
ASOP	Ockendon	44%	238
ASOP	West Thurrock and South Stifford	51%	363
Grays	Chafford and North Stifford	39%	238
Grays	Grays Riverside	53%	469
Grays	Grays Thurrock	46%	331
Grays	Little Thurrock Blackshots	35%	166
Grays	Little Thurrock Rectory	42%	172
Grays	South Chafford	35%	231
Grays	Stifford Clays	34%	191
Stanford-Le-Hope	Corringham and Fobbing	27%	95
Stanford-Le-Hope	Orsett	38%	138
Stanford-Le-Hope	Stanford East and Corringham Town	37%	227
Stanford-Le-Hope	Stanford-le-Hope West	41%	210
Stanford-Le-Hope	The Homesteads	31%	163
Tilbury and Chadwell	Chadwell St Mary	42%	365
Tilbury and Chadwell	East Tilbury	39%	230
Tilbury and Chadwell	Tilbury Riverside and Thurrock Park	50%	381
Tilbury and Chadwell	Tilbury St Chads	50%	319

* Any person who has not received at least one of the vaccines examined for the group is classified as missing vaccination

Table 4: INT Breakdown of Vaccination among Older Persons over 65 yrs

Over-65 Years Vaccination			
INT	Ward	% Missing Vaccination *	Missing Vaccination Count*
ASOP	Aveley and Uplands	47%	658
ASOP	Belhus	50%	743
ASOP	Ockendon	47%	612
ASOP	West Thurrock and South Stifford	53%	380
Grays	Chafford and North Stifford	45%	381
Grays	Grays Riverside	50%	593
Grays	Grays Thurrock	46%	760
Grays	Little Thurrock Blackshots	37%	521
Grays	Little Thurrock Rectory	43%	512
Grays	South Chafford	50%	244
Grays	Stifford Clays	39%	571
Stanford-Le-Hope	Corringham and Fobbing	29%	434
Stanford-Le-Hope	Orsett	39%	573
Stanford-Le-Hope	Stanford East and Corringham Town	29%	558
Stanford-Le-Hope	Stanford-le-Hope West	29%	353
Stanford-Le-Hope	The Homesteads	24%	475
Tilbury and Chadwell	Chadwell St Mary	43%	807
Tilbury and Chadwell	East Tilbury	39%	454
Tilbury and Chadwell	Tilbury Riverside and Thurrock Park	48%	443
Tilbury and Chadwell	Tilbury St Chads	47%	376

* Any person who has not received at least one of the vaccines examined for the group is classified as missing vaccination



Appendix B – About Vaccinations

- **The rotavirus vaccine** protects against gastroenteritis. The vaccine was introduced into the routine childhood immunisation programme in 2013 for babies at 8 and 12 weeks of age. Rotavirus vaccine is offered to children aged from 6 weeks up to 23 weeks as part of the childhood vaccination programme.
- **The PCV vaccine** protects against pneumococcal infections that can cause pneumonia, septicaemia or meningitis. The PCV vaccine is given to all children under two years old as part of the childhood vaccination programme.
- **The PPV vaccine** protects against pneumococcal infections. It is offered to adults aged 65 years and over, and to younger people with certain long-term health conditions who are at increased risk of developing pneumococcal disease.
- **The MenB vaccine** protects against invasive meningococcal disease capsule group B most commonly presenting as either septicaemia or meningitis, or a combination of both. The vaccine was introduced into the routine childhood immunisation programme in September 2015 for babies at 8 and 16 weeks of age, with a booster dose after the first birthday.
- **The Hib and MenC booster** increase the protection a child gets from the first course of Hib vaccine when they are 8, 12 and 16 weeks old, and the MenC vaccine when they are 12 and 16 weeks. This boosted immunity lasts into adulthood. The Hib vaccine protects against *Haemophilus influenzae* type b, a bacterium that causes life-threatening conditions like meningitis, pneumonia, and a severe throat swelling called epiglottitis, while the MenC vaccine protects against group C meningococcal bacteria, which are a major cause of bacterial meningitis and life-threatening blood poisoning (septicaemia). The routine Hib/MenC dose at 12–13 months has been discontinued from 1 July 2025.
- **The MMR vaccine** is the combined vaccine that protects against measles, mumps and rubella. These are highly infectious conditions that can have serious complications, including meningitis, swelling of the brain (encephalitis) and deafness. The MMR vaccine is routinely administered at around one year of age, with a booster dose given between three and five years, prior to school entry.
- **The DTaP and IPV booster** is routinely offered at approximately 3 years and 4 months of age, prior to school entry. The DTaP reinforces protection against diphtheria, tetanus, pertussis (whooping cough), while IPV booster protects against polio, reinforcing immunity established during the infant vaccination schedule.
- **The HPV vaccination** programme has been offered to Year 8 females (aged 12–13) since 2008, primarily to prevent cervical cancer. From September 2019, males of the same age became eligible.

- **The MenACWY vaccine** protects against four strains of meningococcal disease (A, C, W and Y), which can cause meningitis and septicaemia. Introduced into the national immunisation programme in 2015, it is routinely offered to young people in school Years 9 and 10 (aged 14–15). In addition to directly protecting those vaccinated, the vaccine also reduces carriage of the bacteria, providing indirect protection to the wider population.
- **Shingles Vaccine:** Shingles is a painful rash caused by reactivation of the varicella-zoster virus (VZV), the same virus responsible for chickenpox. It can lead to long-term nerve pain and serious complications, particularly in older adults. The shingles vaccine works by boosting pre-existing immunity to VZV, which cannot be acquired through natural exposure alone, making vaccination the primary means of protection. The programme aims to reduce both the incidence and severity of shingles among eligible groups.
- **Influenza Vaccine:** Influenza is a highly infectious viral illness transmitted via respiratory droplets. The flu vaccine is offered annually to individuals at greater risk of serious complications, including hospitalisation. It is one of the most effective tools available for preventing severe illness in vulnerable groups. Improving uptake among high-risk populations also helps reduce winter pressures on primary care and hospital services.
- **The seasonal flu vaccine** is offered to individuals at greater risk of serious complications from influenza. Eligible groups include those with chronic respiratory, cardiac, renal, hepatic conditions, and pregnant women. The programme runs from October through to the end of February each season. A higher uptake contributes to reducing the wider burden on primary care and hospital services during the winter period.
- **High Risk group for Flu Vaccination** include people with respiratory conditions such as asthma, COPD, or cystic fibrosis, heart conditions, chronic kidney disease, or liver disease. Neurological conditions such as Parkinson's disease, multiple sclerosis, or cerebral palsy, along with diabetes, Addison's disease. It also includes people with weakened immune system.
- **COVID-19 Vaccination:** The spring 2026 vaccination programme in England targets adults aged 75 years and over, residents of older adult care homes, and individuals aged 6 months and over who are immunosuppressed. The COVID-19 vaccine continues to be offered to those most vulnerable to severe illness and complications from COVID-19.
- **RSV Vaccine:** RSV (Respiratory Syncytial Virus) is a common and highly contagious respiratory virus that can cause severe illness in young infants. The RSV vaccine is offered to pregnant women — typically between 28 and 36 weeks of gestation — so that protective antibodies are passed to the baby before birth. It is one of the most effective tools available for reducing the risk of serious RSV-related illness in newborns in their first months of life. Improving uptake among pregnant women helps reduce the burden of infant hospitalisations and winter pressures on neonatal and paediatric services.

Appendix C – Immunisation Schedule

Age	Vaccines
8 weeks	6-in-1 (DTaP/IPV/Hib/HepB), MenB, Rotavirus
12 weeks	6-in-1 (2nd dose), MenB (2nd dose), Rotavirus (2nd dose)
16 weeks	6-in-1 (3rd dose), PCV
1 year	*MMRV (measles, mumps, rubella, varicella/chickenpox), MenB booster, PCV booster
18 months*	6-in-1 (4th dose), MMRV (2nd dose)
3 years 4 months	dTaP/IPV pre-school booster (4-in-1)
12–13 years	HPV vaccine
14 years old	Td/IPV, Meningococcal groups A,C,W and Y
Pregnancy	Pertussis-containing vaccine and seasonal influenza vaccine, RSV
65 years and over	Seasonal influenza, pneumococcal vaccine, shingles vaccine, RSV vaccine (eligible cohorts)
Seasonal programmes	Influenza and COVID-19 vaccines for eligible risk groups

* - MMRV replaces MMR in the routine childhood programme

Source – UKHSA (From Jan 2026)

Thurrock's health and wellbeing needs
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