

Health and Social Care Committee

Oral evidence: Prevention in health and social care, HC 965

Tuesday 23 May 2023

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Members present: Steve Brine (Chair); Paul Blomfield; Martyn Day; Chris Green; Dr Caroline Johnson; Rachael Maskell; James Morris.

Questions 111 - 158

Witnesses

I: Maria Caulfield MP, Parliamentary Under-Secretary of State, Department of Health and Social Care; and Dr Nikki Kanani, Director of Clinical Integration and Deputy Senior Responsible Officer, NHS Covid-19 Vaccination Programme, NHS England.

Examination of witnesses

Witnesses: Maria Caulfield MP and Dr Nikki Kanani.

Q111 Chair: Good morning. This is the Health and Social Care Committee, live from the House of Commons in Westminster. Today we are talking about vaccination. Vaccination is a separate workstream in our major inquiry into prevention in health and social care. These are very short, focused workstreams within the broader prevention inquiry. As I said, today it is the vaccination workstream.

We will hear from the Minister, Maria Caulfield, Parliamentary Under-Secretary of State in the Department, and Dr Nikki Kanani, who is director of clinical integration and deputy SRO of the NHS covid-19 vaccination programme at NHS England. Thanks very much for joining us. As you can see, members are all here, chomping at the bit to ask questions about vaccination, which, arguably, is the greatest public health intervention and prevention mechanism that this species has found so far—so, well done us.

Of course, it is no good just developing them; we have to get them out and get them into people. We have had quite a lot of written evidence on this subject. We have just agreed today to publish some more evidence from the ABPI. One of the threads that comes through is that there is a real opportunity, with the advent of integrated care systems, for a system-wide perspective to speed up the time it takes from a vaccination getting approval to getting it into bodies. That said, we have declining rates of vaccine coverage. We have heard from UKHSA about that. How concerned are you, as the Minister responsible, about declining rates?

Maria Caulfield: Obviously, you need a certain threshold for any vaccination programme to be effective, so declining rates are a concern. To reassure the Committee, across all our vaccination programmes, we still have one of the most extensive immunisation programmes in the world and our vaccine confidence and uptake rates are among the highest globally. We have some challenges, but we are pretty well placed to deal with many of those.

In our vaccination programmes, there are three main strands to try to keep uptake as high as possible. The first is having really good data—almost live data—so that you can see where a vaccination programme is working or where it is struggling. Covid was a really good example of that. We were able to identify quite quickly populations where we needed vaccination rates to be higher and we were able to put in some specific interventions to try to improve that. For example, during covid there was obviously disruption to the HPV vaccination programme in schools. We have had to put in some interventions for the years that did not get their vaccines. We have almost caught up in that regard. Having that data, and having it as live as possible, is really helpful.



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The second strand is improving access, making it as easy as possible for people to get a vaccination. Again, we are doing well on that. We have vaccination programmes in schools and care homes. We have opened it up to pharmacies so that people can access a chemist when they are out shopping and pop in for their vaccination. There is also the issue of who can do vaccines. Again, covid was a game changer. Traditionally, it was either the GP or a practice nurse. Now we have pharmacists and community vaccinators, who were never around before. Making it as easy as possible for people helps with uptake.

Then there is our improvement programme. Where there are problems with a vaccination programme, either because of vaccine hesitancy or because particular groups of the population are not coming forward, we are putting in interventions and making it as easy as possible. We are always conscious of uptake rates, but we are in a good place compared with many countries and we have strands of work where, should there be a problem with a vaccination programme, we can step in.

Q112 Chair: Dr Mary Ramsay from the UKHSA, whom you know, spoke to us. Similarly to you, she said that, despite the decline, we should not panic—we should never panic; it is never a good thing. She also spoke about some of the existing vaccine programmes and said, “There are vaccines we are still not using as much as we should. We have not yet rolled out the full childhood flu programme to the whole school age, for example. We have not yet adopted the varicella vaccine”—the chickenpox vaccine—“in this country. It is something that we have been looking at for a while.” What gets in the way of, say, the childhood flu programme being rolled out to the whole school-age population? Is it data, access or a failing in the improvement programme?

Maria Caulfield: As Ministers, we take advice from the JCVI. Without giving too much away, I think that the flu programme this coming winter will probably be for a different population from the one last winter. We are guided by the JCVI on the clinical indications of that.

As Ministers, we have been very responsive to recommendations on the clinical aspects of who should be vaccinated, as well as the timings, which are often key. With the flu vaccine, if you vaccinate too early, you might miss the strain for that winter. If you vaccinate too late, you might already have people who have developed flu and are acutely unwell. There is a range of factors other than just who you vaccinate. It is about the timing and the type of vaccine that you give. Those are all indicators on which we get clinical advice from the JCVI and UKHSA.

Q113 Chair: I have touched on integrated care systems, and the evidence from ABPI talked about that opportunity. It noted that in Scotland’s vaccine transformation programme they have moved responsibility for immunisation from GPs to the health boards. Are there learnings in that for the ICS approach as far as we are concerned in England?



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Maria Caulfield: The ICSs played a big part in the covid roll-out. My own ICB in Sussex opened up different avenues for vaccination routes. It took vaccination programmes into care homes, for example. With the spring roll-out for the over-75s, the ICBs in the various regions were able to get care homes vaccinated. About half were vaccinated within the first three weeks of the roll-out. Getting that local intelligence is crucial.

ICBs are taking on a much bigger role when a vaccination programme is happening. They are much more involved now. If a particular part of the country is struggling, they often bring together GPs, pharmacists and community vaccinators to step in. The integrated care boards are taking a lead on local provision, but it is still important that, overall, vaccination programmes are managed nationally. You must have a central database of who is coming forward where, and who has been vaccinated and when, so that you are not contacting several times people who have already been vaccinated. There needs to be national oversight, but the ICBs are definitely playing a bigger role than perhaps the old CCGs did traditionally.

Q114 **Chair:** National oversight, but with local roll-out.

Maria Caulfield: Yes. There are local factors. For example, Cornwall is a much harder geography to vaccinate than an urban city centre, simply because of the distance that people often have to travel to get a vaccination. The solutions in Cornwall will be very different from solutions in London. ICBs are best placed to make those decisions.

Q115 **Chair:** I agree. Dr Kanani, can I bring you in? The Minister mentioned pharmacy. That wider workforce is important here, right? Are ICBs up to the task of challenging often traditionally very powerful GP partners who enjoy doing vaccinations because there is a reward in doing that? Are they up to the job of spreading the work across their ICB primary care workforce and allowing the GPs, who, as we know, are very pressed, to focus on other work—older people with long-term conditions and comorbidities, for instance?

Dr Kanani: Thank you for having us. I think they absolutely are. As with anything, you will see a spectrum of systems needing different types of support, but the narrative that the Minister set out is exactly the direction of travel.

We have seen it come to life. A really good example is in Bolton, on Chris Green's patch. Helen, Linda and Zahida put together a really integrated offer to make sure that your local residents not only got their vaccinations from a range of members of the workforce, but that GPs stepped back, because what was important for your community was having a Mela, health checks and healthy eating advice. The opportunity to work together is very much at the heart of ICSs. The GPs I speak too, as well as community pharmacists and the wider health service, really value that. I work in a practice as well. I like giving vaccinations, because



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it is nice to see families, but the reality is that we have a lot of other things to do. Getting that balance and blend in place is important.

Chair: We will explore those points in more detail. Do you want to come in on this, Paul?

Q116 **Paul Blomfield:** Specifically on that one, I fully appreciate the Minister's point about the need for co-ordination nationally. I met our CCG weekly throughout the pandemic. The complaint there was not about their having the capacity to undertake a vaccination programme in the way we were talking about a moment ago; it was about the command and control mentality from NHS England. How is that changing to liberate ICBs to be more flexible on the ground?

Dr Kanani: As you can imagine, when we were going through the pandemic and setting up the vaccine programme, we needed to have an element of what you rightly describe as command and control. We had a very precious vaccine. We described it as liquid gold. We would not waste a drop. We had to target it to the right people at the right time, so making sure that we had that supply and getting it to the right people was important. We have seen that loosen already. We now allocate supply four weeks in advance. We support systems to look at and interrogate their data, and to get the right mix of supply that they need for the population. Part of the success of the speedy spring care home roll-out and uptake was that the right vaccine was available for teams to get into care homes early.

The learning and evaluation piece is absolutely key. We are constantly iterating our systems to make sure that, as we build our organisation and our relationship with systems, we devolve as much as possible. That has to be the way forward, but when we were in the middle of a pandemic, and people were not leaving their houses and were terrified, we took the right steps to make sure that we got the vaccine out and we got to sit in rooms like this again.

Chair: Interesting. Thanks for following up on that, Paul. The aforementioned Bolton is coming in now.

Q117 **Chris Green:** Minister, when it comes to uptake, confidence is absolutely important, to make sure that you reach as many people as possible and get herd immunity. Pre-covid, we were already dipping down in uptake of vaccinations. What do you think that was caused by? What were the main issues for people declining a vaccination before covid?

Maria Caulfield: Obviously, we had issues around certain types of vaccination. A few years ago, the MMR had issues around some concerns about that. Those were dismissed, and it has taken time to restore confidence, but a survey of parents only last year showed that parents have 95% confidence in vaccines, which is good.

It is not just about the vaccine itself. People have to feel a number of things to take part in a vaccination programme. They have to feel that



there is a risk if they do not—a risk from the illness itself. If they do not feel that they are at risk, they are less likely to come forward for a vaccination. They have to feel confidence in the vaccine as well. They must also have ease of access. In some communities—for example, poorer communities—where we see that uptake is lower, very often people are on zero-hour contracts or low pay. Taking time off to go for vaccination or to take parents or grandparents to a vaccination is not easy. Sometimes it is about practical aspects as well.

That is why communication is key. That is why the data is key. There are certain communities where, no matter what the vaccine programme is, whether it is flu or covid, people will always come if they are invited, but there are certain groups that will almost never go. That is where we need to do the work. Some of the work that we did during covid was quite groundbreaking. We looked at communities that had a higher risk of becoming unwell if they developed covid—for example, the black and Asian communities. Black Afro-Caribbean groups were 20% less likely to come forward for their vaccination than white counterparts, and it was crucial that they were vaccinated. It is things like taking the vaccine into communities and places of worship, working with faith and community leaders, and having vaccination buses—making it as easy as possible. Those are the lessons that we have learnt from covid that we are now rolling out across vaccine programmes.

We have certain thresholds to meet, and if we do not meet them, the whole programme is at risk. We are meeting those in most cases. It is about communication. It is about sending out the message to people, “This is why you need to have it done. These are the risks. These are the benefits of the vaccine. This is how you can access the vaccine.”

Q118 Chris Green: Some of the hard to reach groups in society often have quite unstable backgrounds in terms of housing. They are moving from place to place to place. If the younger children do not have a good relationship with the GP or the local school, they may not be caught in the programme at that stage. Once they are through that period, they do not get checked up on afterwards. Do we have a comprehensive national register of people who have been vaccinated, and the ability, therefore, to chase up afterwards to make sure that those people who, for whatever reason, have slipped through the net can be communicated with?

Maria Caulfield: The spring roll-out of the covid vaccine for the over-75s and the immunocompromised is a great example. GPs have a register of—

Q119 Chris Green: I was thinking more of younger children, as opposed to that group.

Maria Caulfield: Again, HPV is a good example. We knew that there were a couple of school years that did not get both vaccines for HPV. It is so important that they do; we are already seeing that the roll-out of that programme is reducing the risk of cervical cancer by about 80%. We



hope that we can eradicate cervical cancer with that programme eventually. We knew that there were cohorts of two years that missed out, and there has been some really targeted work to turn that around, because we know who did and did not get the vaccine. I think that we have almost caught up on that programme.

Dr Kanani: Absolutely. Covid taught us so much about data. In my practice, we were able to see where there was lower uptake in particular communities, as Maria mentioned. We did not quite understand why, so we walked the streets, found a community centre, went in and said, "Can we come and vaccinate here?" Quite rightly, the community centre said, "Actually, we would really like to talk about prostate cancer. We have had more men coming forward to talk about it, but we don't really know enough to advise them." We set up clinics to talk about prostate cancer and we then went and gave vaccines. Then we went and did blood pressure checks. Our ability to work with communities who are traditionally under-served is now so much stronger. We can apply that across other programmes and into our wider health services. It is a real benefit for the communities who most need us to be creative and innovative.

Q120 **Chris Green:** I have a follow-up on a point that was made earlier. The health service is going through a bit of a change at the moment, with the integrated care systems and boards. I have concerns about the representation of primary health care on the board, but there are certain advantages in the link between the integrated care system and local government. How do you see the challenges that the system faces in reaching the whole community with vaccinations? Do you think that some kind of challenge or pressure needs to be put on the ICBs to make sure that they have the representation, and to make sure that the chemists are included in an effective way in the roll-out, as opposed to the voice being focused more on the GPs at the ICB?

Dr Kanani: It is a great question. We have put out guidance to ICBs and meet them regularly. We are meeting them again this afternoon. The guidance talks very much about the clinical and care professional voice, because that is the connection into the community. I grew up in community pharmacy, so I am very aware that community pharmacy is often the place someone comes to when they do not want to go to their local GP. That trust—that relationship—is key.

On the wider relationship, in Winchester, our homeless outreach service was across sectors. It was phenomenal. The uptake that we saw was phenomenal in finding people who were homeless or asylum seekers, registering them, giving them health checks and then making sure that they had local authority support, as well as the health intervention, which was a covid vaccine and a flu vaccine, because they were saying, "Actually, we want both of them. Please give it to us. We are really worried about it."



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Our ability to mainstream that going forward is key. We all get tired of reorganisations. I very much recognise that—and feel it—but if it means that the care we offer is much closer to an individual in the community and reflects what they actually need, that is what I am driving for.

Q121 Chris Green: There is very high confidence in vaccinations in the United Kingdom. Some countries have compulsory vaccination. Would you be concerned about that being introduced in the United Kingdom? Do you think that there is any need for it at any stage?

Maria Caulfield: I do not think that there is a need for it at the moment. We have very high uptakes for most vaccine programmes. Our preference is to give people the choice, to give them the information and then to make it as easy as possible.

Q122 Chris Green: I am a bit concerned by your “at the moment”.

Maria Caulfield: I will be very clear: there are no plans to bring in compulsory vaccination at all. We have a successful vaccination programme. There are 12 national immunisation programmes: seven for children; two for the elderly; and three adolescent programmes. Across all of those, we have very high uptakes. We do not see the need for that at the moment.

Q123 Chris Green: The foundation is relationships, communication and the confidence that the current system gives, which perhaps is more effective than other countries with compulsory vaccination. The current system is more effective.

Dr Kanani: Yes, absolutely. We have decades of experience doing this. Forget the covid vaccine. Even before that our flu uptake rates were phenomenal, and they have continued to be record-breaking every year. That comes from really good knowledge of what works in deployment. It is the WHO three Cs: confidence, convenience and complacency. We work to address each of those. We have iterated our programmes, but that is absolutely what we need to do.

Our relationship with the black Afro-Caribbean community has changed completely. In Sheffield, in Paul Blomfield’s constituency, we have done pop-ups in a way that we had never done before. I have relationships with faith leaders from across society and communities. They have been built up with trust, because we have had multi-professional teams—local authority and health teams—going into houses and saying, “Let’s offer a covid vaccine.” Quite rightly, families have said, “Why should I take that? What about the mould on my wall or the fact that my boiler doesn’t work?” You say, “Okay, let’s work on that first.” Then you keep going back. Eventually, we have families saying, “Okay, I can take this vaccine now. I trust you.”

That is what has to be primary in this. The biggest resource and skill that we have is the individuals who work with our communities. That has intergenerational effects. If a mum and dad say that they are going to



take the vaccine then odds on, in my experience as a GP, their kids, grandkids and great-grandkids will take the vaccine, too.

Chair: That is great. I want to pick up on the trust point. When Jenny Harries spoke to us, she said that, in general, “the NHS...is a trusted brand”, but she totally recognised that we need other sources that may be more trusted for reaching different groups. Thank you for mentioning Winchester; I believe you were referring to Trinity Winchester. That is a trusted brand with members of a certain community, and it was very successful. Thank you for referencing that. You have done your homework on all of us, which is exactly right.

Q124 **James Morris:** The development of the covid vaccine is seen around the world as an exemplar of collaboration between industry, Government and whatever. It was seen as very successful, but we have evidence from witnesses that we have lost our edge a little in relation to clinical trials and so on, and our ability to scan the horizon for emerging threats. What are the Government doing to make sure that we learn the lessons from how we dealt with the covid vaccine and do not fall behind in relation to our ability to innovate and to conduct clinical trials?

Maria Caulfield: Lord O’Shaughnessy is doing a review at the moment, which will be published soon, on how we can improve our research capability in this country. I worked in clinical research before I came to this place. There are a number of issues. There are some red-tape issues. It takes such a long time in this country to start up a clinical trial. The MHRA is doing work around that to help those who want to set up clinical trials to do that in a more—

Q125 **James Morris:** I am sorry to interrupt. After we showed incredible innovation with the covid vaccine and showed what could be done, do you think that we are reverting to a status quo position where the MHRA is not as well-resourced as it should be, there is a reassertion of bureaucratic inertia and so on? Do you think that we are reverting, rather than learning the lessons about how to innovate?

Maria Caulfield: No. The partnership that we have just made with Moderna is a 10-year strategic partnership that is looking at developing mRNA capability. Obviously, we have covid, but there are some exciting developments around the use of mRNA in cancer vaccines, potentially. We are working with industry to develop not just technology but capacity. If a development in a vaccine is made, how do we get that up and running as quickly as possible and learn the lessons from covid? We are working with industry in a way that was not happening pre-covid.

There are also some routes to developing clinical trials outside that which we need to tackle. That is why the MHRA is working at pace to try to speed up that process; there are multi-centre global trials that the UK is able to take part in before the trial closes globally. For years, we have been slow on that. That is what we want to change.



Q126 **James Morris:** The Government announced that they were awarding £10 million of additional funding to the MHRA to “help bring innovative new medicines and medical technologies to UK patients more quickly.” That seems to me to be quite a small amount of money.

Maria Caulfield: That is only part of the work. We have funding with the NIHR—the National Institute for Health and Care Research. One of the key things we find is that often we do not have research bids coming forward. There is a combination of factors. There is funding available for research grants, but we do not have the research coming forward. We often do not have research in the right groups; for example, women and people from certain ethnic groups are not participating in research in the way we would like.

There are a number of workstreams going forward. Capacity in the MHRA is one of the issues, but sometimes that is not necessarily the stumbling block. The MHRA will often turn round an application pretty quickly. Getting that application in in the first place is often the barrier. There are multiple pieces of work. Our Moderna partnership is pretty exciting in terms of building our capacity and using new technology to develop the new types of vaccines going forward.

Q127 **James Morris:** Can I ask about the JCVI and its role? Obviously, its role became very prominent during covid. Ben Lucas from the ABPI said that it is now “time to look at the terms of reference of JCVI and the resourcing” in order to future-proof the system to be ready for future innovations. What do you see as the future role of the JCVI and how it might develop?

Maria Caulfield: The JCVI is independent, and we take its advice. I have taken advice in the last few months on both the flu roll-out and the spring covid roll-out. As a Minister, I find its advice invaluable. It is pretty on the ball as regards the vaccination programmes. The timing of the advice is done well so that we are able to get vaccine programmes stepped up. I am always happy to look at suggestions, but my experience of the JCVI has been—

Q128 **James Morris:** The evidence that we have had is that the JCVI did a good job and, as you say, is independent, but it has only a limited amount of capacity. It needs more capacity to be able to do future modelling, research and so on. I wonder whether that is—

Maria Caulfield: I would see that more as a role for UKHSA, which looks at future variants and future pandemic preparedness all the time. It is always giving advice on future threats and the direction of travel with vaccination. The JCVI is not the only body working in that space. I see the JCVI as giving us up-to-date advice on current programmes that we need to be rolling out, whereas UKHSA is future-proofing the direction of travel for the next five to 10 years.

Q129 **James Morris:** This is my final question. Other evidence that we got, and the sense that we got from one of the sessions, is that there is a



perception that when we were dealing with covid we had a very integrated approach, with everybody working together and collaborating, and it was delivered. There is a sense, which has come out a little in our exchange, that the current system feels a bit fragmented. There are various bodies around. Industry wants better data sharing and better access for clinical trials, and the system has fragmented again. What would you say to that?

Maria Caulfield: Nikki, you are—

Dr Kanani: From a very practical point of view, on the vaccine side, we are still working very closely with our counterparts in industry. I still speak to Jenny, Mary, Stuart and others all the time—relatively more than I do to many of my family members. We spend a lot of time together because we learn so much from one another. We do the same with our UK SROs as well, to make sure that we really understand what is happening in different parts of the UK. That helps us to understand how to evolve how we deliver vaccines, screening and the wider prevention agenda in systems in a way that is as hands off as possible.

To your point on clinical trials, it is so important that we have diversity of researchers and communities who take part, from a gender-equality point of view as well, otherwise we will continue to be in a space where not just vaccines, but medications, are tested and tried on one group but not on many others. I had a funny moment yesterday. I was picking up my daughter from school and a bus went past, and there was May Parsons on the bus holding a vaccine; it was the first vaccine in the midlands, in your patch. I thought, “Oh, are we advertising May or something?” Actually, it was about everything that the Filipino community has given us in supporting the vaccine programme, and how we can encourage more people from Filipino backgrounds into health and into communities. I think that is incredible because it is going to help people to join the NHS as well, to take part in research trials and to do the joined-up piece that you have described.

Q130 **Rachael Maskell:** Thank you so much for coming in this morning. Obviously, a lot of learning has taken place over the last few years. In 2022, it was determined that there would be a development of the vaccine and immunisation programme. Where is it up to at the moment?

Dr Kanani: From the strategic point of view?

Rachael Maskell: Yes.

Dr Kanani: I think it was in the Treasury minute. We described a vaccine strategy, which is a good opportunity to set out everything that we have learnt and think is important, not just from the pandemic but from the decades that we have had setting up and rolling out programmes, and learning from areas where we need to do better or differently.

We are still on track, working with our DH partners, and other partners that you have had here round the table before, to make sure that it is



really reflective of not just what we have seen nationally but what the wider market has seen as well. We have done market testing exercises and worked with citizens to understand what vaccination needs to look like in the medium-term future. We are on track to publish that, as described in the Treasury minute.

Q131 **Rachael Maskell:** When are you expecting it to be published?

Dr Kanani: It will be this year, as we have committed to. We have tried to make it practical as well. Hopefully, when colleagues see it, you will see really good examples of what makes a difference in vaccination and why we are building it into the strategy.

Q132 **Rachael Maskell:** From an HSE perspective, what are the driving principles that you are hoping to achieve, and who is going to deliver those?

Dr Kanani: First of all, the driving principles are things that we have learnt from our communities, but that we recognise as valuable ourselves. The first is simple and convenient access. Making it difficult to get a vaccine means that people will not go and get a vaccine. It sounds really barn door, but it is about making sure that we are using our national booking service to be as creative as possible. Being able to use our app more creatively means that we can then create more support to have more outreach. The second element is the outreach ability, which is our ability to get into communities, to do pop-ups and to do outreach, and to have both a consistent offer and then a diversified offer that supports communities to feel confident in vaccinations and wider health checks as well.

The third part, on who is delivering, is using the integrated, multidisciplinary workforce. I have loved having a range of people working in our practice, not just delivering vaccines but volunteering, supporting and looking out for each other and caring about the local community. A big theme will be a range of providers who are able to give the vaccine in a way that works for the local community.

Q133 **Rachael Maskell:** The questioning this morning is trying to establish who is the controlling mind and how that operates over the different bodies. We have quite a lot of fragmentation across the NHS, with UKHSA, OHID and different people overseeing different elements of this. Who has the controlling mind and at what levels, particularly around delivery?

Dr Kanani: For delivery, for deployment, it is NHS England, but we work closely in partnership. We have to work closely together because we learn so much from each other and we need that support in deployment. We work through our systems. The whole principle around the strategy and around the conversations we have had today is, yes, we can co-ordinate and set a direction for supply, data and aspiration, but local systems should be in the controlling seat. They know their communities and



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population. They have the relationships to be trusted. That is the paradigm shift that we need to see.

Maria Caulfield: I do not think you can have one body that is the kingmaker in this because it will not work. If, in the Department, we say, "This is the flu vaccine for this winter," and we have not engaged with NHSE or the local integrated care boards or with the JCVI and we are doing something completely different from their recommendation, it is not going to work. It goes back to James's point. It needs to be more co-ordinated. That is why the strategy is all the bodies together setting out lessons learnt, best practice and how we go forward over the next few years. If you are just looking to one body or organisation to dictate to the others, it will not work.

Q134 **Rachael Maskell:** What we learnt in York, where we had a really good delivery programme, is that, first of all, the funding and giving additional headroom is important, as is involving our local public health director. I think that talked about how to drill into the difficult areas. I would very much want to see directors of public health being at the top table at a local delivery area level because they may not sit on the ICBs. As a result of that I think their inclusion is really important.

Moving forward and looking at how the responsibilities roll out, this does not of course just impact on health. It crosses over into the new Department for Science, Innovation and Technology as well. How are you collaborating there around future development of vaccines, in particular?

Maria Caulfield: The Moderna collaboration that I talked of is cross-government. It is not just Health and Social Care leading with that partnership; we are working with the Cabinet Office and other Departments too, because we recognise that this is not just a health issue. The investment, research and innovation behind much of it needs to be cross-government. The Cabinet Office is leading on that rather than Health, although it is a Health partnership.

We absolutely fully recognise that, which is why the Government have put so much investment into it. We want to retain much of the tech and development that we saw during covid. It is not just about the vaccine itself; it is how you roll it out. Things like the NHS app, which came through via covid, mean that people can book their appointments more quickly. They can change their appointments. GPs are now able to see more easily which patients have come forward for vaccination and which have not. The tech and the science behind it is not just about the vaccine itself: it is about the whole system. In a way, covid was an opportunity to fast-track much of that; it would not have been in place for probably another 10 years had covid not happened.

Q135 **Rachael Maskell:** I have a final question. Has there been any talk or consideration of a national immunisation board as a way of bringing about that co-ordination? One of the things that has not come up in any of the conversations today, where we are looking at the UK perspective,



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is how that feeds into the international opportunity, particularly if you are looking at developing countries and their access to vaccines as well. What we do here is critical, so I am just wondering if there has been any discussion around a national immunisation board for the UK and about the international perspective?

Maria Caulfield: I have seen a number of reports suggesting that as a way forward, but much of it overlaps with current provision. In section 7A, on governance, under the NHS public health functions, the Department delegates responsibility for delivering immunisations to NHSE. We have governance arrangements that have ministerial oversight over that. Minister O'Brien, who took the lead on it, held the last board on 11 May, which gives oversight and scrutiny of how the various vaccination programmes exist. It is not our intention to create a whole new board that virtually mirrors what is happening now.

Dr Kanani: On the international piece, we have worked closely with DH to find international exemplars and places where they have done it differently from the way that we have, so that we can build that into the vaccine strategy. I think we already have those global relationships. I have certainly spoken to many countries about our reflections, and learnt from others as well, most recently Canada. Our ability to have those relationships internationally is already there. Although the Policy Exchange report described a national immunisation board, I think there is a lot more worth in having the relationships that Maria has described because that is the way that we can deliver strong work, rather than something over there. It is all of our business.

Q136 **Chair:** You mentioned the NHS app in that exchange with Rachael. Could I ask you a bit about where you see that working on vaccination and driving vaccinations? What conversations do you have with the team at NHS Digital in driving that through? Speeches are made all the time about the NHS app—there was one yesterday by the Leader of the Opposition—but let's be clear. It is not an app. It is a web app. It is not a proper app like we have on our iPhones. It needs serious work to be an app that is comparable to the other apps. What conversations do you have with NHS Digital?

Dr Kanani: First of all, my son is 14 and his relationship with his health service is through the NHS app. He can see when he needs to repeat order his medication. He does it himself and then he will go and pick it up. He tries to get me to, but usually I manage to swerve that. I think the app has a huge amount of capability.

NHS Digital is now part of our organisation and part of the work that I do. It is brilliant because now we are a new NHS England that is driven by tech, with a massive transformation directorate, and by our workforce—our people and our digital capability. That is exactly right because it is joined up for the first time in a really long time. Some reorganisations are welcome. We talk regularly to our colleagues in the transformation directorate about the app. We have a set of digital goals in the



organisation for systems and for people. What is critical in the people piece and the access piece that you describe is less the tech of the app—it does what it needs to do at the moment, although I am sure that there is more we can do; it is about the digital literacy piece. That is the bit that I want our teams to focus on, both nationally and locally.

It is great having an app, and it might be able to do a million things, but if our communities do not know about it and they do not know how to use it we are missing a trick. It is back to why ICSs are good because we can work with local authorities. In our patch, in the local council library they have a tech and talk session. They talk about the health apps that individuals and communities can use. My dad still refuses to go there, but I think there is a real opportunity to build digital infrastructure into our communities. That releases capacity for others who will not find it a useful endeavour, and they are able to access health services differently.

Q137 Paul Blomfield: I want to follow up on one or two of the points that have been covered so far. First, in relation to Rachael's question, Minister, one of the lessons of the pandemic was the effectiveness of actually having a single Minister responsible for vaccines. We are not in a pandemic any more, but vaccine coverage is moving in the wrong direction. We have exciting new developments in the potential of vaccines to tackle disease. Do you not think that there is some merit in looking again at the idea of having a single Minister driving vaccine strategy and co-ordinating across Departments?

Maria Caulfield: I think it depends on the vaccine. We work really closely as a team. For example, in the cancer space I think it is right and proper that the cancer Minister oversees that. That is a very different programme from, say, childhood vaccinations. Just to see vaccines as one specialty would be a mistake. Childhood vaccinations are a very different beast from flu and covid. It is about each Minister taking responsibility for their own particular sphere and then doing specific work on that.

For example, on the flu vaccine, which will be rolled out later this year, we will be taking advice from the JCVI about the different populations and the different drivers in terms of what is holding back vaccine rates there. That will be very different from the issues in schools with HPV uptake, where working with DFE and schools and colleges is key in that sense. To see vaccination as just one big piece would have disadvantages.

Q138 Paul Blomfield: You mentioned the flu vaccine. We talked earlier about the contribution that pharmacies made on that, and obviously during the pandemic as well. Nikki, perhaps you could develop your comments about the potential that you see for the role of pharmacy in developing vaccine programmes.

Dr Kanani: I am really glad that you asked that. Can I place on record my thanks to our teams who delivered that programme? They were



phenomenal. Whatever profession they were from, people came together and delivered that life-changing programme.

Community pharmacies, in particular, have a huge role to play in the future of vaccine delivery. They are trusted. As I said, they are a space that people go when they will not go somewhere else. They are often found in the most deprived boroughs and high streets, and have popped up there quite organically. They are able to offer other health advice as well, as they already do. Obviously, if you have somebody coming for a vaccine, your ability to say, "Well, have you had your blood pressure checked?", or whatever, is great because you have just jabbed them. They are in your hands, so to speak.

We have worked with pharmacy representatives to think about the right model. As we said, ICSs will design their model to make sure that there is access for their communities, but I see a strong role for pharmacies in that. They are one of our great assets. Their ability to connect with a population is huge, as is their understanding of medicines and wider health issues. We have already started to talk about the wider role that community pharmacies can play, not only because of their skillset but because of the great pressures that general practice is facing.

Q139 Paul Blomfield: I want to return to the discussion we were having earlier about command and control. I didn't want to follow it up at that stage. I understand what you were saying about the precious vaccine that we had during covid, although there was sometimes frustration locally that the rigid guidance and control that was set by NHS England meant that the vaccine did not necessarily reach people or that its use was optimised. We have been looking at this whole issue in relation to the way that integrated care systems are operating. How do we get balance between achieving national targets and giving local ICBs flexibility? How do you see that working in relation to vaccination?

Dr Kanani: One of the things that Amanda Pritchard talks about quite clearly is the concept of earned autonomy, which means the more the system can reflect the needs of its healthcare professionals and its communities and can stand on its own two feet, recognising that we have had a really tough few years, the more it will be able to focus on the outcomes that we want all of our systems to focus on. Our ability to be there when a system needs it but not to overstep it is important, and we are learning that. It is a very different way of working and one that I firmly believe in. This is the time for distributed and collaborative leadership.

We are testing as we go. The more we can put into communities and systems, the better. I firmly believe that with the pandemic we did the right thing at the right time. Operational robustness was the key. It meant that people did not get left behind. It meant that we got the uptake that we did. It meant that we used a very precious supply in a way that we could never have expected to. That vaccine programme has set up more sites than any supermarket roll-out ever, and most of us



were not supermarket professionals. We had great help from people who were, and from the military and others, but we had to work in the way that we did, taking that learning. Now, we are keen and clear that we want to make sure it goes back into the community and that we get the right balance between performance management and performance improvement.

Q140 **Paul Blomfield:** Where are the learning points from the pandemic? If you were faced with that again—let's hope we are not—

Dr Kanani: I could do with not.

Q141 **Paul Blomfield:** What would you do differently?

Dr Kanani: That is a great question. First of all, I think that we did everything we could with all the resource and support that we had. I remember my first care home vaccination. I spent four hours vaccinating people, mainly in beds. It was mainly a nursing home. A lady from Ghana was going round with me. For four hours she kept saying, "I'm not having it. I'm not having it." I kept talking about it. I wasn't pushing it, but just talking about why I thought it was important and talking about it with each resident as we went round. At the end we had one dose left. I thought, "Oh, I might have it now." I wanted it but, because it was so precious, I was waiting to see if anyone else wanted it. At the very last moment she came forward and said, "Actually, I will have it."

I wish I could have had that time with more people. I think it is the same for all of my colleagues. We were not just delivering vaccines. We were trying to deliver a health service that was safe. We were worried about our own families being safe. My dad was shielding. My mum was working in a community pharmacy. The door was open constantly. My practice was running a hot clinic. We were all trying to do a million things. I was trying to home-school my kids and trying not to have to do the actual home-schooling because I am terrible at it. I am thankful for our teachers.

Time is the thing that we cannot do differently, but if we can take the learning from that really difficult time and take the innovation, upend what we do collectively for society and address health inequalities in a way that can shift the dial because we know what works, then we have done the best we can.

Maria Caulfield: Can I follow up on that in terms of command and control? The covid vaccine roll-out is very different from most of the vaccination programme. In most of the vaccination programme there is complete flexibility in local decision making. When you have to vaccinate the whole population in a short space of time in two doses, you need a slightly different command and control system. In routine vaccination programmes, there is very little top-down management of the process. We have absolutely gold-standard champions in local communities delivering those programmes on a daily basis. Covid absolutely was not the norm.



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Paul Blomfield: I pick up from my local ICB, with which I still meet monthly, not weekly any more, that the balance still is not quite right between NHS England and the autonomy they have to address challenges, but we will come back to that issue.

Q142 **Chair:** It is remarkable, listening to you talking about vaccinating the vast majority of the population, to think that we did that. I know it is fashionable to say that the NHS is broken and on its knees but actually we did something remarkable.

Dr Kanani: We did something incredible. There are 148 million doses now and over 3 million in the spring campaign, so it is still going great guns. If you remember the first few days, we were getting the elderly out of their cars into our vaccine hub to vaccinate them. We were seeing the individual numbers tick up. Suddenly there were a million in a month and then 20 million in two months.

Q143 **Chair:** Of course, a lot of older people already have regular interaction with the health service, whereas when I volunteered—I am sure my colleagues did as well—at vaccination centres I saw people who said, “I haven’t been here for a very long time.” What a shame that that interaction with health services was not able to be something more. A simple blood pressure check with a spot of them would have picked up—

Dr Kanani: We started to do that, making every contact count as people felt safer, and all of us felt safer, but at that point it was very much: be protected, get people in and get them vaccinated.

Q144 **Chair:** Jab and go.

Dr Kanani: That was the safest thing to do. Now, we have teams doing all sorts of multidisciplinary offers which centre around education and mental wellbeing, particularly for our children. How incredible is that?

Chair: It is incredible. On the subject of incredible, Martyn Day.

Q145 **Martyn Day:** Thank you very much. What a build-up. I hope that the short questions I have are not a let-down after that. I have a few smash areas, some of which have been touched on and others which have not. To start with one that has, we have mentioned a bit about clinical trials already. The point I want to make is, how do we get more people from the immunocompromised and from ethnic minorities to participate in those trials? Those are the two bits that we are missing out on. I do not know the answer myself, so I am not criticising. What more can we do?

Maria Caulfield: On the immunocompromised, I might leave that to Nikki because I think there are some clinical issues. Simply the condition they have that makes them immunocompromised excludes them from a lot of clinical trials. It is a clinical issue rather than a policy-making decision. There are more trials coming forward, whichever condition they have that makes them immunocompromised, but it is more difficult, if you have pre-existing comorbidities, to take part in clinical trials. You want a standard population to test new drugs on. If you have an existing



illness and are on other medication, it often prevents you from taking part.

We are looking at people from different ethnic minority groups in the work we are doing with the equality unit and Inclusive Britain, for example. We recognise—Nikki is quite right—that the majority of our participants in clinical trials come from a certain background. When you are looking for side-effect profiles and effectiveness, and you are testing on just one group of the population, you are not picking up other side effects from different groups or how effective a medication is. More and more in clinical trials now, they look at the patient experience of being on a drug. It is not just about whether drug A works better than drug B; it is, “What is the quality of life for that person?” If you are not doing clinical research on a certain group you will miss out on lots of those factors.

There is work being done. There is work around covid, building those relationships. I was at St George’s recently. At the front entrance the clinical research team was there, grabbing people as they came in: “Why are you here? Do we have a clinical trial for you?” It is making it as easy and as accessible as possible, in the same way as the vaccine programmes, in order to give people a reason to go into a clinical trial. Very often you get access to drugs that are not available on the NHS. They may be new drugs for whatever medical condition you have. You get really good one-to-one care. I was a research nurse. I had a group of people for whom I was solely responsible because they were in a clinical trial. We know that outcomes for patients in clinical trials are better than if you do not take part in clinical trials.

There are some really good reasons to take part in research. We need to be much more on the front foot in selling those positive points to all patients. It is about making every contact count. For example, if someone has diabetes, we do not expect them to walk into a clinic and say, “What clinical trials have you got and how can I take part?” We know that certain ethnic groups have a higher rate of diabetes than others. It is about getting into those communities and saying, “Oh, you’re diabetic. Have you thought about going into this clinical trial?” That is the mindset. They need to have confidence in their healthcare system too.

I do work on maternal disparities, for example, where outcomes for black, Asian and ethnic minority women are poorer. They have very often had a poor experience of the health service in the past. That is why they are not coming forward for pre-conception care. It is why they are not coming forward when they are struggling through their pregnancy or have concerns about the birth. When they have done so in the past it has not been a great experience. There are some fundamental things that we need to change and improve. It is not just the clinical trial itself.

Dr Kanani: Absolutely. For the immunocompromised, Maria is spot on clinically. We need to make sure that people get the right trial. If they are



more at risk from a particular vaccine or medication because their immune system is suppressed, that could be risky. We have much better data now. The other thing that covid has given us is lists of people at practice level that you can reach out to. There are many practices that are involved in research and are now able to say, "We need somebody who has had this particular condition and this type of treatment in the past. Let's at least talk to them about the opportunity of joining a trial," in the way that Maria described.

The other thing about ethnic minority communities in particular is role modelling—the ability for somebody to say, "You know what, I've been on a trial and I was okay." I was looking at the picture as we were talking. Role modelling is really stark, isn't it. It gives people the opportunity to take part in all sorts of things, including clinical trials. The more we can do that, the better it has to be for our society. Hopefully, we can talk about it more when we go into communities that trust us now. We can talk about the opportunities that we can also offer those communities, but from a basis of trust.

Q146 Martyn Day: That leads me to my next point. We do not want to focus on the anti-vaxxers who have hijacked other issues. One of the areas that concerns me is the vaccine compensation scheme. The rate has not increased in a decade. While we do not want anyone to go into it thinking, "At least I'll get compensated," it would give people a bit more surety of mind. Are we looking at increasing the rate?

Dr Kanani: The vaccine damage payment scheme has a fixed rate of £120,000, which is paid out no matter what the vaccine is. It is not meant to be a compensation scheme. It is in addition to any other payouts that are made from a legal perspective.

What we are doing is improving the speed of the scheme. It was traditionally always rolled out by DWP. It has now come to us in the Department with the NHS. There are simple things like getting consent immediately on an application. We can go to GPs and NHS trusts and get patient information about what has happened through the process and the vaccine that has caused the issue. Previously, we had to get consents for every single institution, and we struggled to get notes. We are improving the turnaround times dramatically as a result of what we have learnt from covid, but there is no discussion at the moment about the amount that is paid out.

I am meeting the APPG the week after recess. I will be meeting concerned colleagues, patients who have been through the process themselves and relatives. It is an ongoing discussion. What we are likely to change is the process, to speed it up and make it much more user-friendly. At the moment there are no discussions around changing the payment amount.

Q147 Martyn Day: The last point I want to raise is the million-dollar question. Are we ready for the next pandemic? What prompted me to ask that are



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the press comments I saw from Professor Adrian Hill regarding the loss of the Vaccines Manufacturing and Innovation Centre. Do we have the flexible manufacturing capability to respond? That is the concern I have now, and I hope you can put my mind at ease today.

Maria Caulfield: We are working with industry. In the Moderna partnership that we have signed, they are building new capacity and work has started on that already, and that is about working with industry. If we need to fast-track and scale up manufacturing, we have the capacity here in the UK.

It is also about surveillance monitoring—for example, in the work of UKHSA on horizon-scanning globally and threats. Although there is no vaccine for it, we did work around strep A over the last winter period. I know there were some pressures on antibiotics, but considering it was an outbreak that was not usual for that time of year and it was affecting young people and older people quite considerably in terms of morbidity, the way we were able to scale up the vaccine we could give for that, and the way we were able to get that information through directors of public health and local communities where there were outbreaks, show that we are much more nimble than we were four or five years ago. We were able to horizon-scan that this was happening in a number of European countries. It was clearly happening in some parts of the country. The Christmas break helped to dampen down the outbreak, but we were able to achieve that. There was a huge demand for antibiotics for strep A for all the age groups affected, but we were able to cope with that. That is just one example of how we are much more nimble now and how we have learnt lessons from covid.

Dr Kanani: We have. Even in the midst of another big covid vaccine roll-out, we set up and rolled out monkeypox vaccine phenomenally fast. We have done polio boosters in London and MMR catch-up programmes. The amount that colleagues, partners and health services are trying to deliver is phenomenal. It is very much based on what we have learnt about keeping the capacity to deploy rapidly.

To Rachael's question about the vaccination strategy, one of the other elements is the outbreak function—the ability at local level to have a resilience function. The ability to step up services if we need to is much stronger. Although we have it now, it is great to have it standardised across systems so that we can respond to things as they come out.

Q148 **Dr Johnson:** I have a couple of questions about pre-school vaccines. We know that the number of children getting their pre-school vaccines has drifted. That is probably the fairest way of describing it. It has gone down very gradually over time. The most recent figures on gov.uk that I could find today show that 83.4% of children going into school are fully vaccinated. What are you doing to address that?

Dr Kanani: This is one of the areas that we are most focused on. It is certainly one of the areas that we worry most about. As you know really



well, there is a multitude of factors that sit behind it. It is about families who have been disengaged for so many reasons from society and community in the last few years. Parents, quite understandably, are nervous and anxious about the wider pre-school immunisation profile even though they are much better than we were eating polio off sugar cubes—or maybe not.

Although we have great innovation, we also have a set of families and communities that are really worried. Building on Maria's point, our ability to have flexible deployment models is important. The general practice is the key relationship with the family, particularly when it is young. If you are going to a community clinic, seeing a health visitor for another child or even going into school because you have an older child in the school, our ability to diversify the offer so that you are not just getting one vaccine by one provider in one place is key. We have seen lots of that, particularly for MMR catch-up. The more important that is, the more we will build it in, going forward.

Maria Caulfield: The data is key as well. We know, for example, that that might be the figure nationally, but if you look at Hackney, their polio vaccine coverage at 12 months is 64% where the national average is 91%. That is an important issue for Hackney and we can do some targeted interventions with those families to try to get that up. But if you are dropping to that point, it puts the rest of the population at risk. If you are not getting optimum coverage, all of a sudden you get outbreaks.

The data is crucial to find out where the gaps are. The work that we are doing around family hubs, for example—we have 75 being rolled out in some of the most deprived parts of the country at the moment—is, as Nikki said, about a holistic approach to family life. A young mum might be coming in because she is struggling with breastfeeding, for example. That is a great opportunity to talk about childhood vaccinations as well. It is around trying to make every contact count, so that you look at people as a whole and building relationships. They will feel, "Yes, I got some help with my breastfeeding, and I'm much more likely to allow my children to be vaccinated." The data is key. It is knowing who is not coming forward for vaccination and how we can reach out to them to try to encourage that. It is not just about their vaccination safety: it is about the general population as well.

Q149 **Dr Johnson:** I should mention, Chair, that last autumn I was briefly in the role of Minister responsible for vaccines. I also volunteered at our local vaccine centre for just under a year and I am a children's doctor.

That sounds great, Minister, but in practice there isn't any obvious effect. It is not making huge amounts of difference so far at the moment, certainly in the overall national figures. Do you believe that people are not coming forward for the pre-school vaccines particularly because they do not wish to have them, for whatever misconceived or genuine reason, or do they not know that they need them then?



When you have those very early vaccines, you are often having regular contact with your clinicians or health visitor. By the time they get to three and a half, it is less common. What work do you do with nurseries and pre-schools? Is there a pre-school checklist from the council, for example, saying, "You're going to go to school next year. Which school do you want to go to? By the way, before you go you should have these vaccines," just to make sure that parents know they are there to have? My experience tells me that some parents do not realise when they are supposed to have them or what they are supposed to have. Even between children—I have three children—the vaccine schedule is not the same now as it was, and it was not the same for any of the three. Ensuring that people know things is very important.

Dr Kanani: Access to data and information is critical. It sits at the heart of how well we perform as a health system and a society more generally. Thames Valley did a really good piece of outreach with a nursery, specifically. They increased their pre-school booster immunisation rates dramatically. A really targeted approach, as Maria says, is key.

The national data hides massive variation. There is a bit of a time lag as well, so we have to drill under it. It is much better at regional level, but we have pockets of areas where there is real risk. It needs to be both the trusted messenger piece and different settings, because people move in different parts of society in different ways. It is both about awareness raising, as you say, and making sure that people can get it easily, whether it is in a hub or a community centre. We have a local community centre for people seeking advice from the citizens advice bureau. They are getting in there and offering the vaccine as well—the pre-school immunisation scheme—so we need to build in all that learning and keep going. We are not going to finish this one. As our communities and society change, the relationship with healthcare will change. We need to keep evolving how we deliver our offer. As a health service we are 75 this year. We have kept evolving in quite an incredible way. We have to keep doing that for the changes that we see in our communities.

Maria Caulfield: Tech also has a role to play in that. The work that Andrea Leadsom is doing as the adviser on children and with OHID is around digitising the red book, for example, so that it is not lost down the back of a sofa. There are notifications coming forward to parents to say, at 12 months, "Have you booked a vaccination for your children?" They can check quite easily which vaccinations have and have not been done. Up until now it has not been easy for parents to remember which vaccination they have had done because the records are held with the GP. It is not always user-friendly for parents. Using technology to remind people what is due when will also encourage parents who may not be sure that vaccinations are due for their children to have that more user-friendly information.

Q150 **Dr Johnson:** Apparently there is an 83.4% uptake. On the basis of all of the things you are planning to put into place, if we were to look back in



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four or five years' time, what sort of percentage uptake would you consider a success at that point?

Dr Kanani: I think that depends on the vaccinations.

Q151 **Dr Johnson:** The pre-school booster.

Dr Kanani: We are looking at this through a range of different lenses. We would want to be hitting key targets, but the reality is that we will do everything we can to get maximum uptake across maximum coverage.

Q152 **Dr Johnson:** Minister?

Maria Caulfield: We have a target coverage. It is supposed to be around 95% for childhood programmes. That is what we are working towards. I can't remember whether it was James or Chris who said that there were problems before covid in terms of a downturn. Covid has massively impacted it. The disruption to children's schools and the routines that people had meant that childhood vaccinations were not necessarily front and centre of people's minds. That is now changing. There will be a return to a laser-like focus on all the vaccination programmes.

We have not touched on HPV, for example. That was significantly disrupted for schoolchildren who would normally have had that vaccination. We are now on catch-up. Even so, for children who are in the routine programme for HPV, it is still lower than we would like, given the significant success, if we could get all children vaccinated with both doses, in eradicating cervical cancer. They are things that we were not able to concentrate on in the last two years because covid was the priority. There are laser-like focuses now returning to those programmes to get those figures up.

Q153 **Dr Johnson:** To listen to you, you would think that everything was going well and then along came covid and things went dramatically down, and then back up again. That is not the graph that gov.uk is showing for the pre-school boosters. It suggests that there has been a gradual drift over time.

Maria Caulfield: GPs, for example, who would probably have been meeting mum and two kids for a cough or a cold, tonsillitis or whatever, and then saying, "I notice that they haven't had their boosters," have not had the capacity to have that conversation.

Q154 **Dr Johnson:** They weren't great before covid, and they haven't been great after covid. Pre-school boosters, according to the graphs, have not shown a particularly dramatic result. Saying it is all about covid is—

Maria Caulfield: I am not saying it is all about covid. We also had issues around MMR, where there was misinformation and disinformation for parents. As Nikki said in a previous answer, if your parents did not give you those boosters, the chances of you then getting them done for your children are slightly less.



There is also trust. We know from the surveys that were done last year that there is 95% confidence from parents in childhood vaccination programmes. There is confidence, but it is about getting routine vaccines back into people's minds. There was a lot of damage done around MMR and that has had a knock-on effect on vaccination rates for childhood vaccines as well.

Q155 Chair: Nikki, you might be able to answer this. With respect to children who have the HPV vaccine in school who have deep anxieties—of course we know how much that has increased for our young people—and cannot face having the vaccine in school, what is the route for those children? Is that then covered? Is there a cost issue for parents whose child cannot have it in school?

Dr Kanani: No. We still have a catch-up programme that has a back-up offer. It is, as you say, primarily in school, but we always commission an alternative, for children who are home-schooled, for example. It would be that home-school offer, which is usually a community offer, that somebody would be able to tap into. If a child is in school, usually the school can advise who that is. If they are out of school and they have not been able to tap into that, it would be their local health service general practice team who would be able to direct them to it.

Q156 Chair: I ask because the number of home-schooled children has risen, so we are told, and I wanted to make sure that that route was open. Minister, when do you think the vaccination strategy will be out?

Maria Caulfield: I don't have a date in mind, but I think it is supposed to be later this year. We don't have a specific date for it, but it will be this year.

Q157 Chair: But not before summer? Would that be your working assumption?

Dr Kanani: It would be great to be able to inform our autumn planning. We have done the due diligence, as you said, and we have committed to getting it out as quickly as possible. It was a massive market engagement exercise, and we will get it out as quickly as possible. It will be very tangible, practical and actionable—

Q158 Chair: That is helpful to know. For the future, scientific progress means that there is an incredible number of innovative new vaccines that are coming our way, yet we have heard that it takes more than six years in the UK at the moment for a vaccine to go for assessment by the JCVI to programme roll-out. Taking that, I know that there is already a vaccine for shingles which is a programme for the over-70s. I understand—we discussed this with Jenny Harries—that there is one coming for the over-50s. Is that true?

What is next? What is coming up? What is in the exciting future box? We have heard about a vaccine around cardiovascular disease and COPD, for instance. What should we be looking at on the horizon?



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Dr Kanani: There are two parts to that. In terms of shingles specifically and the roll-out, as we have previously discussed, that will be JCVI. If JCVI gives that guidance—the independent clinical advice—that is what we will do. I expect to see it quite rapidly deployed because we already have a model that we offer shingles through. It is quite joined up and locally integrated, so that works for me.

What I want to see in the next few years—I think Mary referred to this as well—is our ability to horizon-scan better. I would like to say that in a local area, where we see a particular increase in a particular condition or disease, personalised medicine means that we will start to be able to change our relationship with industry and pharma to talk about vaccines that are coming. What is exciting, and we touched on it, are personalised cancer vaccines. There is a whole range of other things. We have to do both. We need to look forward and be able to deliver something huge and exciting, and recognise that we have an NHS going through rapid change and growth. We need to make sure that we have uptake in coverage in the basic 20 vaccines at the same time, so it is both/and.

Chair: That concludes our session. Thank you very much, Dr Nikki Kanani. Minister Maria Caulfield, as always it is a pleasure to see you. Thanks for coming in.