

Health and Social Care Committee

Oral evidence: [The First 1,000 days: a renewed focus](#), HC 802

Wednesday 2 July 2025

Ordered by the House of Commons to be published on 2 July 2025.

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Members present: Paulette Hamilton (Chair); Danny Beales; Dr Beccy Cooper; Jen Craft; Andrew George; Alex McIntyre; Joe Robertson.

Questions 107 - 194

Witnesses

[I](#): Dr Doug Simkiss, Chair of the British Association for Community Paediatrics, Royal College of Paediatrics and Child Health; Dr Sally Payne, Professional Advisor, Royal College of Occupational Therapists; Dr Claire Fuller, Co-medical Director for Primary Care, NHS England; and Anna Bird, CEO, Contact.

[II](#): Janet Cooper, Expert Adviser, Royal College of Speech and Language Therapists; and Jane Harris, CEO at Speech and Language UK.

[III](#): Dr Amit Aggarwal, Medical Director, Association of the British Pharmaceutical Industry; Dr Helen Skirrow, Clinical Research Fellow, Department of Primary Care and Public Health, Imperial College London; and Dr Helen Stewart, Officer for Health Improvement, Royal College of Paediatrics and Child Health.

Examination of witnesses

Witnesses: Dr Doug Simkiss, Dr Sally Payne, Dr Claire Fuller and Anna Bird.

Q107 Chair: Welcome to our third evidence session of the Health and Social Care Committee inquiry into the first 1,000 days of life, focusing on the NHS. Today, we will hear from three panels. The first panel will look at community paediatrics and neighbourhood health services, the second will look at speech and language therapy, and the third will look at vaccinations. Could the first panel please introduce themselves?

Dr Simkiss: Hello, my name is Doug Simkiss. I am a community paediatrician by training. I worked in Birmingham and was the designated doctor for looked-after children, and ended up as the chief medical officer and deputy chief executive of Birmingham Community Healthcare NHS foundation trust. I am chair of BACCH, the British Association for Community Child Health, which is the professional group of community paediatricians. It sits within the Royal College of Paediatrics and Child Health, and I am representing the college today.

Dr Payne: I am Dr Sally Payne. I am a professional adviser at the Royal College of Occupational Therapists and a children's occupational therapist, which means that I help people take part in the daily activities and routines that occupy them and give purpose and meaning to their lives.

Dr Fuller: Hello, I am Claire Fuller. I am a GP and the co-national medical director at NHS England for primary care. Prior to that, I was the chief exec at NHS Surrey Heartlands.

Anna Bird: I am Anna Bird. I am chief executive of Contact. We are a charity that supports families with disabled children. We reached 400,000 families last year with a range of information and advice across health, social care, education and benefits, including providing community support for families with children in their very early years.

Q108 Jen Craft: Anna, I will start with you. What challenges do the families that you support most frequently come to you with, in terms of accessing paediatric services?

Anna Bird: The families we support might be families of children with complex health needs, who might have a lifelong physical disability or even life-limiting conditions. Those families can face unique challenges in the early years. We are talking about families who might feel very isolated, scared and fearful of what is ahead. They need access to good quality expertise, insight into their child's condition, and support that wraps around the family in those early years.

It is really common for families to experience long delays and backlogs in access to assessments, diagnosis and therapies. That can often lead to the child's needs escalating over time and complications with the child's health, but also huge stress for the family and a huge impact on the whole

family's mental health and wellbeing. It can also result in delays in access to important therapies that can help the child's development, access to equipment and aids such as postural seats, and feeding and communication support—all those things that can help the child to thrive.

We often see that some of our families find themselves reaching for private diagnosis or private treatment to get the support they know their children need. We spoke to about 4,000 families through our "Counting the Costs" survey last year, and a third had been accessing private treatment. The cost of that is obviously huge for a family; they were facing extra costs of about £805 a year because they were needing to draw on additional support.

To give a flavour of what that means for an individual family, we have been supporting a family whose son is now seven. They noticed that there were some issues with their son's development when he was about 18 months old, and they sought support from a community paediatrics team. They had to wait two years to see the community paediatrician. Clearly, in that time, there was all sorts of stuff going on for the family. They and the people around them—but particularly the family themselves—thought that if they played with their child more or helped a bit more with reading, or if they parented a bit better, perhaps their son would catch up. They were encouraged to think that perhaps he would catch up.

Eventually, they saw a paediatrician, and it took a further three years to get a diagnosis, which was of a genetic condition that included learning disabilities. That child was never going to catch up, and in that time, lots of support was missed. The family could not apply for DLA, as they did not have the medical evidence to do it, and when the child started school, the school was not prepared for his needs. Clearly, that is quite an extreme case, but actually that is often the case with the families we support. There are often horror stories, and there is often a lot of trauma and stress involved in that waiting.

Q109 Jen Craft: Thank you very much; that was really brilliant, clear scene-setting. Doug, what are the long-term impacts on families and children of the waits that Anna has set out so very well?

Dr Simkiss: Very negative. Early access is key to making progress through childhood. We cannot solve lots of problems, and with that particular child, there is not a tablet or operation that is going to make that better. However, we can change the environment, and that is a really important intervention.

Long waits have a big impact on individual children and their families, and they have a big impact on us economically. It is an issue of equity, because not everyone can afford to go the route that Anna is describing. It also has a negative impact on the staff, because no one comes into these jobs wanting to say, "I cannot see you for a long period of time." It is quite disheartening for people.

Q110 Jen Craft: Is there almost a cumulative cost? So if you intervene earlier,



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is there less of a cumulative cost from conditions worsening or interventions not being made more quickly?

Dr Simkiss: Yes. Michael Marmot will be known to you, and his “Fair Society, Healthy Lives” gave key policy interventions to reduce health inequity. The No. 1 policy intervention is to give every child the best start in life. That has a huge positive impact across the life course, and it has the biggest return on investment. If you compare this country with some Scandinavian countries, we invest a third of what they do. That is largely not about community paediatrics; that is often about children accessing nurseries, family hubs and that type of provision. Those are really key alongside health visiting, if you want to go into the NHS world—they are key practitioners.

Q111 Dr Cooper: Thank you for coming this morning. I want to ask you about the systems in which you work. Dr Fuller, this is primarily for you, but I am happy to hear from others as well. Obviously, we are in the era of integrated care systems, and perhaps we will touch on that in a minute, but I want to go straight to the Core20PLUS5 initiative. That is NHS England’s targeted initiative to reduce health inequalities, which Dr Simkiss just touched on. As I understand it, Core20PLUS5 came into being in 2021, so can you outline what it is specifically and what it has achieved or demonstrated from then to now?

Dr Fuller: Core20PLUS5 is really the work of Professor Bola Owolabi, who I know has been before this Committee a number of times, and there are three components to it. “Core20” refers to the 20% of the population who live in the greatest areas of deprivation, so its No. 1 focus is on that 20%.

The “PLUS” is locally determined. It is for local systems to look at and work through who, given the demographic, is most at risk. In my old job in Surrey, although we did not actually have that much deprivation, we had a large Gypsy, Roma and Traveller community and a high number of veterans and children in care. They were part of our “PLUS” population.

The “5” refers to specific conditions where our outcomes across England are not as good as they should be. We have “5” for adults, but for children it relates to asthma, mental health, epilepsy, diabetes and oral health. We started with just the adult version and then produced the children’s version. What that means is that we have then focused nationally on policy to support systems and implementing.

One of the ICSs’ statutory obligations is to reduce health inequalities and focus on population health. By giving the right guidance on what they should be looking at, we have started to reduce the admissions for asthma from children, and particularly the health inequalities around diabetes. With closed loop insulin pumps, we initially found that the uptake was much greater in affluent areas. Partha Kar, one of our specialists in NHS England, has been focused on making sure that there is equity across all areas.

Q112 Dr Cooper: Thank you. When our researchers were putting our briefing together, they looked for a dataset specifically related to Core20PLUS5.



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You have clearly outlined what it is targeting, but if I were looking for a dataset that demonstrated the outcomes achieved through this specific initiative, where would I look for these data?

Dr Fuller: At an ICS or place level. Many of these things have a shared outcome, so we talk about—

Q113 **Dr Cooper:** I appreciate that, but you are NHS England, so do you amalgamate these data? Could I go somewhere and see that Core20PLUS5 is meeting its objectives at an aggregate level?

Dr Fuller: As NHS England, we look at higher-level metrics. We have just refreshed our national oversight framework and have now included some metrics that relate to areas of deprivation and to some numbers within Core20PLUS5. Regions then look at their ICBs, and ICBs then look lower down, because there is a different aggregation on how you should look at it. Our national oversight framework has altered so that we are now much more clinically focused and are looking much more at outcomes. There is also a greater focus on children within the framework.

Q114 **Dr Cooper:** That is really clear. I know that Dr Simkiss wants to come in, but, Dr Fuller, could you just summarise what Core20PLUS5 has achieved from the data that you have seen, either at aggregate level or specifically at ICS level?

Dr Fuller: The No. 1 thing it has done is highlight the importance of health inequalities, and it has given people a tool that they can use locally to drive local improvements—

Q115 **Dr Cooper:** Forgive me, but do you think that health inequalities were not highlighted or understood previously, given all the work that Marmot has done and all the public health data that have been around for so long? Was that actually necessary?

Dr Fuller: For all my career, we have all been talking about health inequalities, prevention and how we really have to do something better about that. I do not think we have had the right datasets to enable us to target things locally. Previously we have put in blanket interventions that looked at metrics at too high a level. To make the improvements for Core20PLUS5, you have to target them locally. Although the data is getting better, it is not there. It is certainly not disaggregated so that we have early years versus children, but at least we are now starting to look at adult versus children.

Q116 **Dr Cooper:** To pursue the point, at a local level, you have public health teams that have been producing joint strategic needs assessments for a fair while, and that is quite local disaggregated data. Has the problem been that NHS colleagues have simply not been utilising the local data that have been available?

Dr Fuller: I do not think we have fully used the opportunity of the health and wellbeing boards to create shared outcomes and shared datasets at that level, which is where we should be looking at shared outcomes.

Q117 Dr Cooper: Thank you. Dr Simkiss, do you want to come in?

Dr Simkiss: I want to highlight to the Committee the work that Michael Marmot has been doing with three integrated care systems on promoting health equity for children and young people. Those are Cheshire and Merseyside, South Yorkshire, and Birmingham and Solihull.

Q118 Dr Cooper: How long has that programme been running?

Dr Simkiss: It has been running for two and a half years. It closes in the summer. The products will be launched at a King's Fund event on 25 November. It includes a co-produced framework on the social determinants of health involving 308 children from those three places, and it involves data analytics, which is why I wanted to raise it.

Data analysts have created algorithms to produce all key performance indicators out of the ICS, by index of multiple deprivation and by key protected characteristics, and then each ICS has done an intervention. The Birmingham and Solihull one has been about what the ICS can do as an anchor institution, using social value and corporate social responsibility on the upstream determinants of child health.

Q119 Dr Cooper: That is so helpful, Dr Simkiss. Given that ICBs have been asked to reduce their budgets by 50%, do you get the sense that this will still be a priority area for ICSs?

Dr Fuller: I will pick that one up. Yes, ICBs and NHS England are reducing headcounts, but there is real clarity in the shift from integrated care systems being asked to look after everything to ICBs being much more focused on being the strategic commissioner. It is much clearer that the role is around population health management, reducing health inequalities, working with local communities and building neighbourhood providers. That gives clarity by removing the requirement to do the provider oversight, which will now sit with the regions. The clarity will help.

Q120 Dr Cooper: Great. Going back to the "5" of Core20PLUS5, which for children and young people are asthma, diabetes, epilepsy, oral health and mental health—as you said, Dr Fuller—have we seen any significant improvements in these areas for our 20% most deprived children and young people since Core20PLUS5 came in? As a follow-up question, if there is regional variation, do we know where that is and why it is?

Dr Fuller: We can write to you with more detail on it, but I can give you an example from across the south-west. I was visiting there on Monday, and they have had a real focus on children and young people because they noticed that their outcomes were worse than in other regions. They have collectively worked with each of the ICBs and put in children's initiatives that relate to Core20PLUS5. They have specifically focused on driving down admissions and A&E attendances for asthma by doing winter preparation. That regional focus has been powerful for them.

Q121 Dr Cooper: As a Committee, we would very much appreciate the detail around that regional variation. As ICSs move forward, it will be good to see where the standard practice is and where the best practice is.



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I will move on briefly to the plans around reforming elective care for patients. Providers are expected to conduct quarterly reviews of local waiting list data, including of children and young people, to better understand areas of inequality—we have touched on how much is already understood about those areas of inequality. As I understand it, that has been in place since January 2025. Why was that initiative put in place, and what do you expect to result from it?

Dr Fuller: The elective reform plan was published before Christmas and, as you say, there is a requirement to publish disaggregated data, as well as a requirement on ICBs and providers to ensure that interventions stop disparities between populations. Yesterday, we had our first regional oversight and assurance meeting with the north-west, and the focus was different: yes, we talked about 18 weeks and elective, but we also talked about community waits. The dataset now has the adults versus the children that we are looking at, by provider and across the ICBs as well.

It is early days, but I am noticing the different focus. The dataset is still children; it is not early years versus all children, which would give us greater insights. The waits are unacceptable for anybody, but if you are four, the impact of waiting two years is greater than if you are 16.

Q122 Dr Cooper: I appreciate that data is subject to interpretation, but there have been many datasets and data collections over the years, and this is yet another iteration. Do we now have the right dataset to tell us what we need for this particular group of people? Will we be able to access the appropriate data, or will there need to be subsequent iterations?

Dr Fuller: It will continue to iterate, because it is about improving the quality of the data.

Dr Cooper: But do you think that we now have—

Dr Fuller: I think we are on our way. We will continue to improve the data as we interrogate it, but the fact that we are now looking at a dataset for not only community waits, but community waits for children will mean that we start to improve them and see where they happen.

Q123 Dr Cooper: Why did we not look at these datasets before?

Dr Fuller: I don't think the data was there. The other bit we have done that will have an impact is to combine our improvement functions within NHS England. We used to have getting it right first time, known as GIRFT, and the provider support regime. They have now all come together under Sarah-Jane Marsh. By bringing them together, we will be able to target the different appropriate interventions to support systems and trusts when they get into difficulty.

Q124 Dr Cooper: I suppose my concern is that, as you know, with constant iteration, we never get to the point where we are actually going "Great, we are receiving data", but I very much look forward to these data sets coming forward.



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Dr Simkiss: The college has been advocating for this for a period of time. We are meeting at this point in time, we met the Minister for Children in the last Government and there has been a blueprint for transforming child health services. Those services are not just about doctors; they are about all these other services, too. There was also the “Collaborative healthcare in England: Delivering the services children need in the community” report just a couple of months ago.

Following meeting the Minister, NHS England set up a clinical advisory group for transforming community children's services. We are both members of it; I co-chair it. It is on at 1:00 this afternoon. We commissioned NHS Benchmarking to look at the data around community child health services. We have got the report. It is embargoed at the moment, but we would be very happy to send it to the Committee.

Dr Cooper: Great.

Dr Simkiss: The data gap is because lots of the best quality data follow the financial streams. Primary care had a clear structure of tariffs and payment by results in hospitals. Community services generally did not have that, which led to the gap. That is what we need to resolve, and we need to put referral to treatment, which is a technical phrase, into all pathways in community health services, both medical and non-medical. We have got a dataset from 38 providers that we can go and look at, and we can then make recommendations to NHS England about this summer.

Q125 **Andrew George:** That raises a number of questions, and I just wonder whether it is possible, having looked at the granularity of the questions that Becky has raised, to helicopter out again and look at this over a longer timescale. Going back over the last couple of decades, is it the result of better intelligence that you now realise just how serious the problems are in terms of demand and waiting times for that demand and that need, or has it always been that way? As far as we are aware, 20 years ago there were not these waiting times. Is it simply because parents have become more aware and they are demanding more of your services, or is it that that the problem has actually been getting worse?

Dr Simkiss: I will let Sally come in as well in a minute. I have been a community paediatrician for 35 years; it wasn't always like this. It was a really enjoyable, rewarding career, and I have loved it.

Andrew George: But it's not now?

Dr Simkiss: Well, it is less so now, because people want to make things better and they are frustrated that they cannot. Some of that change has been because of the mechanisms that focused the system on increased demand—things like activity through a hospital door did not exist here. There were block contracts, so you need to see more and more children with the same money.

The support services that allow doctors like me to function—health visiting for older children, school nursing, allied health professional colleagues and colleagues in primary care—have withered somewhat on the vine,



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particularly health visiting. The public health grant has dropped in real terms, and that is very consequential because, for a lot of the things that families need, they do not necessarily need me. I would not be very good at those things, but a health visitor with time, energy and enthusiasm would be wonderful for lots of these people.

Then there has been a change in the work that comes towards community paediatrics. There has been an increase in ADHD and autism, which are beyond the first 1,000 days. That is two thirds of the waiting list. When I started, that was a relatively minor part of my work.

So there has been increased demand, a change in the types of problems coming towards us, and fragmentation of the team that is really important to support a child and their family. Those are my thoughts, but Sally might have others.

Dr Payne: Thank you, Doug. Like you said, it is really important to say that we have a wonderfully motivated occupational therapy workforce that really wants to make a difference to children, young people and families, but we are being really stretched by the system at the moment. We carried out a survey of our members earlier this year. Of those surveyed, 675 were children's occupational therapists, and 71% said that they had seen an increase in demand over the past 12 months, and 64% said that children were presenting with a greater number and greater complexity of need.

One of the challenges that we have as an occupational therapy service, or as a profession, is that our services are often commissioned on a traditional, refer-assess-treat model, which does not allow us to do early intervention and prevention work. It is reactive, and there is some value in that, but I think that is probably contributing to the waiting lists. We really need to think about the commissioning models and move away from the block contract. That would allow us to provide that early intervention and prevention, which would prevent some of those children from needing referral to services.

Q126 Andrew George: When it comes to waiting times for these services, for a child under one, a one-year wait is more than a lifetime. For someone of my age, waiting a year is less important. Why has there not been a big outcry about this? Why are we not hearing advocates' voices loudly enough?

Dr Simkiss: One of the criticisms of paediatricians is that they are relatively soft and cuddly. If we were surgeons, you might have heard about it. We have been trying to speak up for a long time, but the NHS is dominated by adults and by secondary care, so it is easy for children and services that are relatively invisible—there is no big building for what we provide—to go under the radar. We have been trying to be more visible to important decision makers like you. The fact that we are here is evidence that we are making some progress, but that is not the same as making it better for a child and their family in clinic tomorrow. There is still a way to go there.



Q127 Andrew George: A moment ago, Dr Fuller, you referred to Core20Plus5. One of those is oral health. You mentioned the south-west. My constituency includes Land's End and the Isles of Scilly, and the nearest paediatric dentist is 200 miles away. Who is advocating on that? Obviously, I am advocating for my constituents, but why have we got to a situation whereby that is one of the indicators we are looking for, in terms of failings for children—particularly those who are particularly vulnerable—and yet the nearest service is 200 miles away from my constituents? That simply is not good enough. How have we ended up with a situation like this?

Dr Fuller: It is particularly extreme in dentistry, but we often find that the areas that need the services most are the least well served. You find this with the general practice workforce too: our most deprived communities have fewer GPs than more affluent areas.

What is encouraging about the change in the 2025-26 planning and the oversight framework is that there are now metrics looking at the number of urgent dental appointments, and a renewed focus on dentistry. One of the bits that we need to think about is primary prevention in dentistry, such as the fluoridisation of water. Up in Merseyside—another area that has significant issues with oral health in children—I visited an early years setting where they are doing education for families and children. They do supervised toothbrushing, and every child gets a toothbrush. It is not enough, but you can see that there are some real pockets of excellent improvement that are starting to happen, so we need to spread that and put the focus on the areas of greatest inequality.

Dr Simkiss: Primary intervention is really important, but secondary prevention is important too. It is important in dentistry, or in tooth health, to recognise that both dental caries and gum disease are entirely preventable. Again, this comes back to family hubs, with a children's workforce outside of a clinical workforce, and health visiting. Next door to Paulette's constituency, the last time I looked, Ladywood had 50% of children aged five with dental caries. So those messages about how to look after teeth, beyond fluoridation—our water is fluoridated—are really important. We can make a significant change, but we need someone to give the message.

Q128 Andrew George: The Government have an upcoming workforce plan. What engagement are any of you having with the Government? Realistically, how do you think the workforce could be improved within the parameters of the future workforce plan and over what time period? Do you think you can get the workforce at a level that can actually get on top of the waiting lists that you have?

Dr Fuller: One of the things that we saw in the previous long-term workforce plan was a real focus on generalism versus specialism and actually looking at the skills that are transferable that work across multiple settings. So when you work in the community, rather than having three people visiting one person, what are the transferable skills that we might use? The long-term workforce plan looks at core skills and the additional



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bits we need to do, making sure our teams have the right skill mix so that you are not necessarily sending out individual specialists each time and waiting for people to see specialists.

Dr Payne: Last year the Royal College of Occupational Therapists published a workforce strategy. A big focus of that is moving therapists from hospitals to the community. We absolutely believe that community services is where children's occupational therapists generally should be positioned for maximum impact. I think that that reflects the policy direction, which is encouraging. We also need to see an investment in career progression pathways. We have a real opportunity to develop our enhanced, advanced and consultant-level allied health professional practitioners. We have the potential there not only to retain our experienced workforce, but to use some of their skills not just for direct clinical work, but to transform care pathways so that we are improving their efficiency and reducing duplication. We have real opportunities there.

Q129 **Andrew George:** Reducing duplication is the point that Dr Fuller mentioned. In terms of integration with other services, is that incorporated within your ask?

Dr Payne: Absolutely, and it is about collaboration between the acute services, community services and local authorities. As occupational therapists, we work across all of those sectors, making sure that we have that integration at a local level and strategically as well.

Dr Simkiss: We have more people who want to be community paediatricians than we can train at the moment, so we could do with expanding our training numbers.

Andrew George: That is good.

Dr Simkiss: Yes, it is good, but it needs to be seen within the comprehensive child health workforce strategy. I rely on health visitors, my allied health professional colleagues and colleagues in primary care. Investment that is ringfenced around a children's workforce would be really good, and then working out how that operates locally. The operating model that Dr Fuller described really well in the report she wrote two or three years ago is about working in a local place, and that brings people together. So much is done better relationally in a small team, in a local place, than it is with bits of paper or emails flying around.

Q130 **Alex McIntyre:** Thank you all for your answers so far. We have touched on some of the things that I was going to ask about. I have to declare an interest: I have a 20-month-old boy, and he of course falls firmly within the 1,001 days. I have been really interested to hear what you have had to say so far. One part of the conversation that we have not had yet—perhaps we will come on to it—is that the impact on a child's health is really important, but the impact on parents is absolutely massive.

Speaking as a parent of someone who is fortunately quite well but has had health issues, accessing health care has not only been difficult but incredibly stressful, particularly for my wife who, because of my job, now



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bears the brunt of it. Parents are being passed from pillar to post; they are being referred from one service to another without really getting the answers they need. We really need to reflect on that as we go forward.

You touched on community health provision in your last answer. What changes in training do we need to give to practitioners to ensure that we can deliver more paediatric care in the community rather than in a secondary setting?

Dr Fuller: That is a really interesting question, because some of the things that are stopping the care going on in the community do not necessarily relate to training. When you see somebody in a hospital versus when you see somebody in the community, your perception of risk can feel very different. Seeing somebody in their own home is very different than seeing somebody on a hospital ward. As a GP, you may feel more comfortable making certain decisions after seeing someone's home structure, the people who are around them and the people who are there to support them than you might do if you saw somebody in a hospital bed on a ward round.

Some of the training needs to include more exposures for clinicians working in non-hospital settings, because it is a completely different way of working, and you can make different assessments if you understand how close somebody is to hospital, the other services that are available and whether they have got phone access. It is a different way of working. For me, I would make a shift towards having more training placements in the community and in general practice.

Anna Bird: Contact provides various interventions for families either while they are waiting for treatment or in the community. We provide a service called Brighter Beginnings. It is a six-week course that includes all sorts of support for parents. It might include understanding toilet training. It might include sleep training. It might include understanding your child's condition—social communication, speech and language, all of those things. Those interventions can happen while a child is on a waiting list or alongside medical support. What we need is onward referrals, and we need the commissioning of those services, because they are important.

Often what we hear back from the families we support is that there is something important about who is delivering that support to the family. We provide support from parents who have lived experience, and that makes a huge difference. Suddenly you do not feel isolated. Suddenly you know that the person in front of you really gets it. That can make a years' long difference to your experience, and it can deal with some of the trauma that families face. There is a question about the training of medical professionals, certainly, but it is also about what other support is wrapped around families to deal with the stuff that medical professionals may not need to deal with.

Having said that, one of the things that we have heard from families is that sometimes the environments in which they are receiving medical support in the community are not appropriate. Going into a big,



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overwhelming hospital setting for an out-patient appointment can be really difficult for families with children who have neurodevelopmental conditions. The training of medical professionals to understand that and to create a sensory environment that is more appropriate and perhaps to have play professionals to de-escalate things is actually really valuable.

Dr Payne: We also need to think about where the workforce is positioned. It is about that as much as it is about the training. We need to be positioned in those community settings where families are comfortable and we can develop those trusted relationships. We have allied professionals who are working in the acute services and in neonatal care. When those babies come out of hospital, they receive medical follow-up, but there is not always that community follow-up from allied health professionals. If we are missing those critical developmental windows, then we are missing opportunities to develop the foundational skills that infants and babies need. We will also fail to build that relationship with the parents, as well as their confidence and capacity, their skills to care for their babies and nurture their development and their brain development, and to bond with their baby. We know how important that is not only for the baby's development, but for their parents.

Dr Simkiss: The only piece I would add is that there was an independent ADHD taskforce report published on 20 June—it is about 10 days old. It has got really sensible recommendations in it. It recommends a holistic, stepped, joined-up and generalist approach to that condition, and that it should be needs-led. We have got to decouple diagnosis from need. The heavy focus on diagnosis means that people are driven into a really small resource area. If we went back to need, which is what it was always supposed to be about, we could meet a lot of that need in a much wider workforce.

My second point is that community child health and mental health services ought to be joined up. There are community mental health providers and community physical health providers, but there ought to just be community providers for children. My third point is that advanced clinical practice is a really important adjunct to medical practice. That means that someone who has come out of Sally's background—like occupational therapy, speech-language therapy, physiotherapy or a nurse—can come into advanced clinical practice and support a broader workforce to address the challenges we are facing. We have appointed somebody on our exec committee to try and move that forward as an ACP.

Q131 **Alex McIntyre:** To change the subject slightly, on that point about need, one of the challenges that parents in my part of the world are facing is around allergies. We know that allergies are massively increasing, particularly among babies,. With things like eczema, the research shows that allergies are likely to be involved as well. Waiting times to see a dietician or anyone with a specialism in allergies and paediatrics is 18 months. It is a really challenging time when you are trying to wean a small child, but you do not know what they are allergic to and how to deal with that. Allergy UK are running a campaign about getting more dieticians and



nurses who are qualified to deal with that need in primary care, rather than with getting a diagnosis. This is probably a question for Claire: is that something that you think the NHS should look at, and how could we roll it out in primary care?

Dr Fuller: The shift to needs-based support for people has got to be the right way forward, rather than waiting two years for a diagnosis. As you said, when you are weaning a baby, it is a critical time. I am supportive of the way the additional roles reimbursement scheme has worked; we have brought a lot of different roles into practices and primary care networks. You can see that local networks have taken things on, depending on what their needs are. Some have put in place additional psychological support to start working on ADHD triage, and working on needs with local schools to see what they can help families with, rather than waiting for that diagnosis. It fits into that area; it is about looking for people who have got the right interest, where the need is local, and working with the local trusts where they have waiting times to think about how we could do it differently.

Anna Bird: We fully support a needs-led approach, and that would clearly help to reduce the waiting times and some of the long waits that families experience. It needs a whole-system adoption of that approach. What we see at the moment is the knock-on. If families do not have good, solid medical evidence, it can be really difficult to get the rest of the support that the family needs. In terms of applying for short breaks, you need some kind of medical recommendation for that; for access to social care, you need good solid medical evidence, as with access to DLA. We need to ensure that other parts of the system recognise need, not just a doctor's note, because otherwise families will lose out.

Q132 **Alex McIntyre:** We are in a really fortunate position in many ways, but we have been passed from pillar to post on this. We were told by a GP to go to the health visitor on it; the health visitor said that we need to go to a pharmacist; the pharmacist said no, we need to go back to the health visitor; they then said we need to phone 111, and we then end up in A&E. The advice we were given on allergies specifically, was that the best way to get seen on the NHS was to shove your child full of egg and take him to A&E with the reaction. Clearly, that is not right. We need to find a way of giving parents the answer the first time, so that whichever door they end up at, they get the support they need on a needs-led basis, rather than waiting for a diagnosis.

Chair: Alex, we'll have to be rounding up or we won't get the questions in.

Alex McIntyre: One final question to make sure I get it in. Claire, this is for you. How is the guidance on the neighbourhood multidisciplinary teams being implemented in practice?

Dr Fuller: Very good. Neighbourhood health and neighbourhood health teams are not a new concept. They have been around for a long time. As Doug said, I wrote a report a number of years ago that talked about integrated neighbourhood teams. I have been to visit each one of our systems, and each system can show an example of an integrated



neighbourhood team. Where they put their focus depends on what their population is like. Many people have focused initially on frail, older people, but a number of places with higher percentages of children and young people have developed integrated neighbourhood teams for young people.

The concept is simple, and your point highlighted it beautifully. It is about making sure that we organise our services to work for people rather than for organisations, to stop people being bounced around. The other side of the coin is that, as professionals trying to deliver services, we are often incredibly frustrated. The heart of neighbourhood healthcare is making sure that services work for people and for professionals.

From a patient point of view, your proactive care is based around the care plan that you have co-produced with professionals to make sure that it works for you. We have to make sure that care plan is accessible, and then if you become unwell, you know who to call, and when you call them, you are not bounced around, as you say. As ever with all these things, there are some brilliant examples around the country. I could go on all morning giving you examples, but I won't. We have an upcoming 10-year plan. It will be a good one to think about once that has been published.

Alex McIntyre: I will hand back to the Chair.

Chair: Thank you, Alex. We will go straight over to Danny.

Q133 **Danny Beales:** Taking advantage of the Chair's good will, I have a follow-up question. You mentioned the 10-year plan. We know that a shift to neighbourhood health will be a key component of that. Many of you have talked about the importance of community-based and multidisciplinary working. Do you have a view about where that should be based? Primary care and family hubs have been mentioned, and we envisage neighbourhood hubs will be set up as part of the 10-year plan.

Dr Payne: Perhaps I can kick off. We absolutely welcome that shift from acute services to community; that is where we need to be. Clearly, as Anna said, we need to be in the places where families feel comfortable and where we can develop that trust. One of our concerns about the current neighbourhood guidance for children's multidisciplinary teams is that there is a strong focus on medical and acute care, and allied health professionals are not represented within the guidance.

Occupational therapists, for instance, are mentioned once as professionals who might be included in the multidisciplinary team. Speech and language therapists are mentioned four times, nurses 22 times, paediatricians 30 times and GPs 103 times. You can see that the balance does not feel quite right if we are going to be thinking about the complexity of children's needs and looking across health, education and care.

Q134 **Danny Beales:** So the important thing is that an MDT is representative of all allied professions. It is not necessarily the location but the mix of skills that is the most important thing.

Dr Payne: Absolutely.



Q135 Danny Beales: Do you want to add anything, Doug, before I move on?

Dr Simkiss: The other point to make is that there is probably a team of MDTs. If you are a child with complicated asthma who is going to hospital quite a lot, you will need a multidisciplinary team focused on asthma. If you are a child with cerebral palsy, you will need a completely different team around you. So there is a team of multidisciplinary teams, depending on what your presentation is. There was a second point, but I have forgotten it.

Q136 Danny Beales: I was taking a liberty there with a follow-up question, so I will move on to data. Beccy talked about a macro-level analysis of data. Focusing back down on the child, the Children's Wellbeing and Schools Bill is piloting a single unique identifier for children. In the evidence we have heard so far, we have heard that one of the challenges is keeping track of children, and children being lost in the system and having multiple datasets. What engagement have any of you had with the proposed plans to pilot the single unique identifier for children? Has anyone been involved in those discussions about the emerging piloting?

Dr Fuller: I will kick off. I had a conversation last night with Ming Tang, our chief data and information officer, who was talking about how advanced the conversations are with the Department for Education. She said that they had reached agreement that the NHS number would be used as the unique identifier number, which is really positive.

Anna Bird: We certainly do not have involvement in piloting, but we would say that it is a really helpful thing. We hear all the time from families that they have to repeat their story endlessly to multiple professionals across health, social care, education and benefits. Anything that can reduce the burden on families of continuously telling that story and can share information better has to be a good thing. We fully support it. We are part of the health policy influencing group, which is advocating for this change. The test will be whether using the identifier speeds up access to professionals for families.

Q137 Danny Beales: What kind of challenges does Contact face at the moment in terms of the data issue? Do you have any considerations about where you sit in the system with the use of the NHS number and how the system might relate to you?

Anna Bird: We are an open-access charity. We do not have any gateway to our services. Parents come to us freely.; they do not have to have a diagnosis. We receive everyone who comes to us and provide information and advice so for us, it is not an issue, but it is an issue for the families who call us on the helpline deeply frustrated. They assume that their information will be shared across health and social care, but it does not happen, so they are at the point of information-sharing. They have to do that work, which could be done more easily. We hear that experience all the time.

Q138 Danny Beales: Sally, I suppose that, as an OT, you are not always considered in the MDT and a lot of the guidance. In terms of your access

to data at the moment, what do you think about an NHS number being the basis for the single identifier going forward?

Dr Payne: We absolutely support the single identifier. At the moment, as Anna just explained, information is really fragmented and disjointed, so it is really difficult to join up the services. We do not necessarily know whether a young person is receiving support from social services, social care or education, or what type of support they are receiving, so it would be hugely beneficial.

However, there are some issues. We need to think about the digital infrastructure for all our community therapists and about the safety of transporting systems information—not only the safety of the professional who is potentially carrying around equipment, but data security. So there are some things we need to think about, but we agree that it needs to be sorted.

Q139 Danny Beales: Dr Simkiss, the RCPCH suggested the NHS number being the unique identifier in evidence, so presumably you are happy with the emerging approach that has been mentioned.

Dr Simkiss: We are. Sweden had a unique single identifier in 1947. I work with Swedish researchers and they can produce huge amounts of valuable life course data. That helps us to understand associations over the life course, because they have been at it for 80 years.

Q140 Danny Beales: Something has to be picked, and there will be challenges with whatever is picked. Some children may not have an NHS number at present.

Dr Simkiss: Almost nobody does not, actually. I see a lot of unaccompanied asylum-seeking children in my practice. By the time I see them, which is a few days after they have arrived, they have an NHS number. It is given to everybody at birth, and people that arrive in childhood seem to get it very quickly, in my experience.

Q141 Danny Beales: It has been suggested to us that asylum seekers might be part of the group that is not covered by NHS numbers.

Dr Simkiss: They are at risk, but my experience is that they come along with their NHS number when I see them.

Q142 Danny Beales: So you do not envisage that there will be a group of children who would struggle?

Dr Simkiss: I would have thought that it is important to highlight those vulnerable groups in the planning, but my experience is that the processes seem to work already.

Q143 Danny Beales: Fantastic. Sally, you briefly touched on some of the logistical and practical challenges for professionals. Are there any other resources or tools that the workforce will need to successfully implement this new approach?

Dr Payne: I think there will be something around the confidence and competence to use the new systems and navigate them. We know that we have a workforce that perhaps has not had the opportunity to develop its confidence in those areas, so there is a training issue.

Danny Beales: Great. Thank you.

Q144 **Chair:** Thank you, Danny. I would now like to ask a question. In previous meetings, professionals have talked about the lack of a common outcomes framework for children across health, education and social care, which the Committee found really interesting. Do you support the calls for a shared outcomes framework for children's wellbeing? If so, what should the shared aims be, and what key metrics would you like included?

Dr Fuller: This is the core job of an integrated care system. There are many really good examples of people who are already working on shared outcomes frameworks. This goes back to the conversation I was having with Dr Cooper. This is something that good health and wellbeing boards have developed across their local authority, across all their NHS partners and across the voluntary sector.

The sentinel bit where you would have to start is reducing infant mortality and reducing perinatal and maternal mortality. You then need to break that down into who in which sector would have different responsibilities. There are things you would do as a trust, such as reducing maternal smoking, reducing neonatal mortality and reducing A&E attendances. There are things you would do in primary care that would relate to, for example, vaccine updates and making sure we have done long-acting reversible contraception. Then for local authorities, there are things we would want our health visitors to do.

It is about being really clear that, although it will be a common aim for a place or system, different sectors and different organisations will contribute in different ways, but they are all working towards the same goal.

Chair: Fantastic. Does anyone want to add anything?

Dr Simkiss: The Royal College would be really keen to be part of that. I would highlight Professor Chris Morris at Exeter University, who has done a lot of work on outcomes frameworks. He would be a good person to involve.

Anna Bird: We absolutely support the development of a national outcomes framework. Of course, it needs to properly span health, social care and education. Alongside all the health outcomes, we want a real focus on outcomes for children with complex needs, and that needs to be things like time taken to secure joint health and social care services, timely diagnosis and access to specialist care.

We also want to see some education outcomes. We want to see attendance and exclusion rates. We want to see wellbeing in school,



participation in school and access to therapies in school. Those things are really important.

Finally, it is really important that the family is part of this picture. That means looking at carers' quality of life, looking at parental confidence in navigating services—do they feel confident, or do they feel isolated?—and access to respite care. All those things need to be part of that mix.

Dr Payne: I would echo Anna's points. We need to be really clear that the indicators have to go beyond medical indicators, so that they cover that whole range of places and environments in which children and young people and their families live and the things that they want and need to do.

Q145 **Chair:** You said we need an integrated care system. My challenge back to you is this. We know it needs doing, but the professionals are telling us it has not been done. Has any organisation in NHSE, whether it be the ICBs or others, said, "We want this done and in place by a certain time," or are you expecting this to happen organically?

Dr Fuller: I can give you some examples. Birmingham has done this. North-central London has done this. We did this in Surrey. There are places that have done this, but it is something that NHS England needs to do in conjunction with local government and with the Department for Education, which is why I keep coming back to this being about the health and wellbeing board, because that the table all the partners are sitting around. It needs to be locally agreed, because it needs to be relevant to the local demography and the inequalities that people are facing, which will slightly skew where you put your shared outcomes framework.

Q146 **Chair:** This is my final question, because time is short. There is a shift at the moment, with changes to the way health and wellbeing boards will be run and the way ICBs will be run, and the fact that NHSE will not be there. Do you think that that will hold it back, or do you think the changes that are coming that we know about—we do not know about everything, because we do not know about the 10-year plan—will help to bring it forward a bit faster?

Dr Fuller: I think the shift to ICSs becoming strategic commissioners is really important. In my previous role, a lot of my time was taken up by managing providers and managing performance within providers, whereas the job of the ICS needs to go back to being strategic commissioning and being about population health management, dealing with health inequalities, ensuring that we have value for money and starting to promote social enterprise. I think that this brings greater clarity; I know that it feels disruptive at the moment, but the course and direction are much clearer.

Q147 **Chair:** Thank you. If no one else wishes to add anything, I will ask my famous last question. We are doing this inquiry, and you have highlighted how delighted you and Dr Simkiss were that we are doing it. If there were two things that you wanted to ensure were included in the inquiry, what would they be? I will start with Anna.



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Anna Bird: Oh no! *[Laughter.]* I will just give you one. For us, it is the value of wraparound support to families. It is such a hard time for families with children with complex health needs and with disabilities. It can be so difficult to navigate the systems of support, and the waits can be very long. We know that the big difference is when families get support. It is making sure that a part of the mix is voluntary and community organisations being able to provide wraparound support to the families, making that part of the commissioning of ICBs and others. That is really important for us.

Chair: I didn't mean to say inquiry; I meant report.

Dr Fuller: Of the two from me, No. 1 has to be the data—greater disaggregation of the data, not just for adults and children, but being really clear about the early years, because the impact is so much more significant. The second one would be the importance of co-production—when we are designing services and having conversations with people about their care plans, let us ensure that they are properly grounded in people's real life.

Dr Payne: Two from me. One would be the importance of strategic workforce planning for allied health professionals, particularly children's occupational therapists and our colleagues. The second thing would be about commissioning models that enable occupational therapists to be positioned where we can have the most impact, which is in those early intervention services, particularly the neonatal care follow-up.

Chair: Fantastic. Last, but by no means least, Dr Simkiss.

Dr Simkiss: Mine would be to highlight the fact that there is this NHS England clinical advisory group looking at transforming community children's services—it is looking at data, pathways, workforce and at outcomes—and to put your weight behind supporting it as a mechanism for making the changes. That is No. 1.

The second one would be—the point that I had forgotten—that as we are talking about moving to community services, we have community provision that is struggling to meet enormous demands, so it is about recognising that there needs to be some investment. Some of it can be transformation, but there needs to be investment, too, to ensure that services that are already struggling do not fall over as more services come their way.

Andrew George: What do you mean by community provision?

Dr Simkiss: I mean the bit that is not primary care or hospital provision. I mean the services that Sally delivers, health visiting, school nursing, my stuff.

Chair: Thank you all—this was a brilliant session. We will keep the film rolling, but if you could step back, we will ask the second panel to come forward.

Examination of witnesses

Witnesses: Janet Cooper and Jane Harris.

Q148 **Chair:** Our second panel will be concentrating on speech and language therapy. Welcome, both of you. May I ask you to introduce yourselves?

Jane Harris: I am Jane Harris, the chief executive of the children's charity Speech and Language UK. We supported over 320,000 children last year by providing tools and training to nurseries and schools across the UK, but also running our own two specialist schools, providing advice directly to families and doing public affairs work, like this today.

Janet Cooper: Good morning. I am Janet Cooper, a clinical lead speech and language therapist for Midlands Partnership Trust. I am representing the Royal College of Speech and Language Therapists today.

Q149 **Chair:** Thank you. What impact can the failure to provide adequate speech and language support during the first 1,000 days have in a child's later life?

Jane Harris: It is really hard to think of an area of a child's life that is not impacted by this. It can impact their learning. We know that a child who has poor language skills at age five is six times more likely to be behind in English at age 11, but 11 times more likely to be behind in maths at age 11.

It also affects their mental health. Some 45% of children referred to children and young people's mental health services have a speech and language challenge as well, so almost half the children presenting for that mental health support will also have speech and language problems. That makes sense, because we need language to help us understand our emotions: we need to be able to say to ourselves, "I'm sad" or "I'm happy" or "I'm scared." We need language to do self-talk—to think to ourselves, "Actually, don't worry about that," or "I'll think about that later," and so on. Also, we need language to engage in talking therapies, if that is what the NHS offers us.

We know that about two thirds of young offenders have a speech and language problem, but that often is not identified until they are in trouble with the criminal justice system. We also know that when children become young adults, they are far more likely to end up in unemployment. That is not because some of these children are employed and some are not, but because they move in and out of the labour force: they get a job, it seems like they can do it, and they fall out of it three, six or nine months later.

Q150 **Chair:** How does it compare with the cost of putting that intervention in?

Jane Harris: As well as representing Speech and Language UK, I am one of the co-chairs of the Speech, Language and Communication Alliance. We are working at the moment with a disabled children's partnership on some research that is looking at how much money public services could save overall if we put this in place. That has not been published yet, but we will share it with the Committee as soon as we are ready to do so.



Chair: Do you want to add anything, Janet?

Janet Cooper: Just talking at the human level, really, about those under-twos. It is about the relationship with the family. We heard earlier about the strain on the parents and the ability to access local community groups. We talk to lots of parents whose child is not included because of the behaviour or the lack of ability to communicate, so a lot of those children are very isolated from a very young age. Lots of schools do not want those children in, because they are more challenging, and they do not always have the resources to support them, so that limits the access to education and certainly to educational attainment. There is a long-term impact, but immediately there is a family impact and a social impact for that child as well.

Q151 **Chair:** What interventions do you believe could support children with speech and language development in early years to prevent them from getting isolated, having challenging behaviours and doing all the things that you have just talked about, Janet?

Janet Cooper: Lots of NHS services can only pick these children up after two. Previously there were things like Sure Start; there was Every Child a Talker, which focused on a much younger age group. That enabled speech and language therapists to get involved at a much more universally targeted level. We have outcomes from that that prove that it made a massive difference. But NHS services are struggling so much with referrals and dealing at the specialist end that there is no capacity in the system at the moment to work at that lower level. So I would say much more preventative, much more universal work and much more targeting on those very, very little children.

Q152 **Chair:** Brilliant. Jane, how can parents be supported to create a positive learning environment for these children?

Jane Harris: We know that about 25% of a child's development in this area comes from the home learning environment, so it is really important. The Department for Education knows that, because it was its own study that showed that. What we really need is to see more of a joined-up strategy to give parents information about how to boost children's development. Parents just do not get that information at the moment. If you think about the information that parents get on things like vaccines or healthy eating, that is huge compared with what they get on speech and language development.

I don't know whether to call what we have at the moment haphazard or a hodgepodge, but we just have a mess of different initiatives. The Government do a campaign called Start for Life. We have not seen any evaluation of that yet. There were two interim evaluations, but they have not been made public. There is one coming next year; that piece of work is going on. The BBC runs a campaign called Tiny Happy People, which is great for the people who like the BBC, but we know that the BBC brand is a barrier for people in socioeconomic classes D and E in engaging with that content. Even if the BBC creates great content, just the fact that it says



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"BBC" unfortunately turns those groups of people off. Some local authorities are doing campaigns in this area. We at Speech and Language UK work with them, and we independently do our own digital information for families.

We have a mess. What we need is a really strategic approach, because one in five children now has a speech and language challenge. That is a huge social problem, and you cannot deal with a social problem of that scale with this haphazard, unjoined-up approach. One thing we would really like to see is a national strategy that says, "Here are the people who really need this information. How are we going to get it to them?"

Q153 Chair: What are the barriers to having that national strategy?

Jane Harris: I think that at the moment it is just not thought of enough as a strategic issue, in either the NHS or the DFE, to be perfectly honest. It is that classic issue that falls into the cracks: it falls between the NHS and Education, and everybody else thinks that the other people are leading on it, so it just does not get prioritised.

Q154 Chair: My final question is to Janet. We have talked about the barriers, but how do you feel they could be addressed?

Janet Cooper: One of the biggest things that we are a victim of at the moment is the lack of public health nursing and the reduction in contact with families. The thing that works for families is trusted relationships. Historically, health visitors had a much more prominent role in which they knew families. It was a named person. Families could ask them anything and they had some follow-through with the same person.

The hub model does not work. It might for some families, but it relies on families speaking to somebody they do not know. It may be a different person the next time they ring up. It is disjointed. What families really need, particularly in areas of deprivation, is some continuity and trusted advisers who have a qualification that really does have all the answers. Again, that will be a workforce we can work with to train and pass on a lot of the skills.

Chair: We will be talking about workforce later, so I will hand over to Joe, because I think this is a good point at which to go into the next bit.

Q155 Joe Robertson: Hello. I want to explore how well speech and language services are integrated into wider service provision. What are your experiences delivering speech and language services through family hubs? What factors contribute to how well speech and language support is delivered in this setting? How can we replicate these conditions more widely?

Jane Harris: We have had some positive experiences. We have worked in Halton, in Coventry and in Telford and Wrekin, and we have provided early information to families about how to support babies to develop communication skills. But that is a bit—I am going to use the same word again—haphazard. It just depends on whether there are people in those family hubs who see this as a priority.



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We are really pleased that the Government changed the guidance earlier this year to allow family hubs to intervene on speech and language from the age of two, because previously it was the age of three. That is really helpful, but actually we could be doing this from before birth, because children's speech and language development starts in the womb. We could do some really innovative things. For example, when somebody goes for an ultrasound scan, they are often lying there for quite a long time, waiting while the person is looking at the machine. You could at that point be giving somebody an iPad with a video about children's speech and language development. That is why I am saying that we need an integrated strategy right from the beginning. At the moment, family hubs are prevented from doing that earlier on.

Janet Cooper: Could I add to that? Previously, I ran a program called Stoke Speaks Out, which was hugely successful and had all those elements to it. It was locally funded. We met parents on antenatal wards, where they had time; they were just sitting waiting for appointments, vaccines and all sorts of things. We had video loops and training. We met them on the wards when they did the ward visits. We went all the way up to five, but that is no longer funded. That was a local initiative but, again, there is no money in the system to secure some of the funding for things like that, and that had huge outcomes.

Q156 **Joe Robertson:** Janet, I think you said in your submission that the current guidance on family hubs does not allow early language and home learning environment funding to be used to target parents of children younger than two. Jane, you have just referred to going back to the womb. What activity does that prevent hubs from undertaking? What impact on service quality would extending the current funding to a larger cohort have?

Janet Cooper: The thing with family hubs is that the models are variable and the funding is not enough to focus on speech and language. What that prevents is more activity at that younger age group, as you said about antenatal and that first part of life.

Q157 **Joe Robertson:** What sort of activities could we see if that funding could be used for a lower-age cohort?

Jane Harris: You would basically be doing universal information provision. Language and communication are variable before age two. You cannot at that point think that you are going to target this specifically, because you do not know at that point. We need to ensure that every single family has the skills to know how to support their child's development at that point. Lots of those interventions are very cheap because they are information provision.

We have worked with some family hubs that have done things like giving out top tip cards to parents. We have run webinars that they have broadcast in family hubs. That is family hubs doing more than what the guidance says, if you see what I mean, rather than it being embedded into the structure of every family hub.



There is a clear model in speech and language support that you provide universal services and then targeted services to those who have not responded to the universal approaches. Then you provide specialist services to those who have not responded to the targeted programmes. It is like the stepped care model in the NHS. If we do that, we will save money overall, because you avoid people going up to the specialists.

Q158 Joe Robertson: More broadly, what practical steps could be taken to improve integration in commissioning of speech and language services in early years?

Janet Cooper: I see a lot of the measures coming in through education. That is things like end of foundation stage results, but they do not always join up with the public health results in the things that are captured. They do not link in with health services like my own. You will have people working in silos on those measures, but not looking at them as joint ownership. To go back to the Sure Start model, everybody had the same aims. It was the collective ownership of all those things, and we were measured together as a group. Owning it as a collective would be useful.

Jane Harris: The previous discussion about an outcomes framework is probably the most important thing, and ensuring that that outcomes framework does not just focus on acute needs. The responses that you got from the previous panel were interesting, because so many were about acute needs. Speech and language is a long-term condition for 10% of children. It is a preventable issue, but it will go on for children who do not get the support. The NHS is so focused on that acute need, but we almost need an outcomes framework that deviates the other way, because the culture pushes everybody towards acute need.

Q159 Joe Robertson: Janet, you have argued for a strategic lead for speech and language and communication in every ICS. How do you see that role working?

Janet Cooper: There is an example in Greater Manchester, where they have somebody who leads on that who is a speech and language therapist. That ensures that speech and language is on everybody's agenda, and that it is thought of at every level from pre-birth all the way through. She is in a role that joins up education, health and so on. It is a tried and tested model that could definitely be replicated elsewhere.

Joe Robertson: That is very interesting. Thanks very much.

Q160 Alex McIntyre: The workforce plan has set a target to increase training places for speech and language therapists at just under 1,200 this year. Will that meet the workforce demands the sector is facing?

Janet Cooper: No, probably not. It needs to be much more ambitious than that. There is a massive recruitment issue in speech and language therapy, because the demand has tripled since 2019 in most services but the workforce has not tripled with it. We welcome things like apprenticeships, but all those students also need supervision, and they need placements.



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There is a strain on the system at the moment. There is definitely a need for more. I think people are recognising that a speech therapist's role is not just about taking one child at a time into a clinic room and doing something to them. They are recognising the wider usefulness of therapists, and that adds to the demand. I think you are going to need far more than that.

Q161 Alex McIntyre: You touched on the focus being on NHS and healthcare settings. What can we do to see it differently in the future, so that we are focusing on other areas, too? In terms of the workforce, what would you like to see?

Janet Cooper: You need to consider the speech and language therapy workforce linking much better with education. Again, there are examples of that across the country, but it is not across the whole country. Education commissions some of the work as well. In the preventive agenda, for family hubs, it needs to be a must-do, not a "You might do it if you fancy it along the way." That preventive side is part of it as well.

The problem is—a bit like the previous panel said—that services are so stretched and strained at the moment that people are just firefighting with numbers. Children are not getting the outcomes they should because they are not seen as frequently as they should be. We are stuck in this spinning wheel where we need to stop and have a really clear plan of where that workforce needs to sit, and where the usefulness of speech and language therapies lies, and commission and develop the training places accordingly to go with the model.

Jane Harris: On the point about the join-up with education, it is really important to recognise that it is not just speech and language therapists who can impact children's speech and language development; it is a much, much wider workforce.

One of our real concerns is this. There was a really good programme called the Early Years Professional Development Programme, which was training the workforce in early years settings. It trained them in language and communication, personal, social and emotional development and maths. Maths is probably less of a concern for this Committee, but on the first two, it had really outstanding results. People participated in that programme from every single local authority in the country, but it stopped in March. An independent evaluation of it was published last week, which showed that 93% of the participants said it improved their confidence in supporting children's language and communication development. There was also a massive, measurable difference in participants' confidence in supporting children with long-term developmental or language delays, moving from 63% to 89%. That is really important.

It does not make any sense that the Government have stopped that programme. For a Government who are really committed to early years, it is really important that we bring back that kind of programme, which supports the early years workforce, because that will prevent some of those children then needing the specialist support, which is so strained.

Q162 Jen Craft: I was interested in what you said about workforce challenges. What role do you see early years providers and early years settings playing? You talked about having more trained specialist early years staff. Are there some light-touch interventions that require a small amount of training but do not require a speech and language therapist and that massive amount of input?

Jane Harris: There are two things that early years staff can do. First, they can make sure that every day is a speech and language day. They can do things like design their setting so that it prompts children to talk more. They can make sure their staff are skilled up in basic interactions. For example, if you really want to support a child's speech, you would not keep asking them questions. You ask a question, and then you might count for 10 seconds and wait for them to respond. It is those basic things that we really need every single early years educator to know. It was interesting in the evaluation of this programme that quite a lot of the participants said, "I didn't realise such small things could make such a difference." There is something about that everyday interaction.

There is a second piece of work they can do, which is more targeted interventions. We have a targeted intervention called Tots Talking, which is for children who are at higher risk of speech and language challenges. We deliver that to parents, and we train up staff to deliver that to parents. It only takes half a day to learn to use one of those programmes, because it is so highly structured that you do not have to train to be a speech and language therapist to do it. You just get a manual that says, "Here's your hour's slot for this week. This is what you do." Parents similarly say, "I didn't realise I could make such small changes and they would have such a huge impact on my child." They talk about impacts not just on things like speech and language, but on things like behaviour, because obviously if a child finds it easier to communicate their needs, behaviour will improve.

Jen Craft: Behaviour is communication.

Jane Harris: Yes, to coin a phrase.

Janet Cooper: On the focus on the nought to twos, the less experienced staff quite often get put in the baby rooms, and they often feel that they are just there changing nappies. There is definitely a need to focus on the education of that group of people, and to acknowledge that it is a really tricky job. You are taking somebody's most precious gift—it is quite often the first time they have been left—so there is a need for some qualifications around that, and a recognition that that is an enhanced role. We could perhaps award them something for being in that enhanced role, or encourage nurseries to put more experienced staff into those roles.

Q163 Chair: Before we swap panels, I am going to do what I always do, so I am sure you are all prepared. If there were two things in your area of expertise that you wanted to be highlighted in this report, what would they be? I will start with you, Jane.



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Jane Harris: The first thing is a national strategy to get information to parents. We need a national campaign on a similar scale to those done in the past around, for example, smoking or mental health, where small amounts of Government money created total changes in social attitudes. We need a similar thing about speech and language, directed at parents, kinship carers and foster parents—all those groups. That would be the first thing.

We have not seen an evaluation of the current Government campaign, so I don't have any official figures, but I checked last night on YouTube: the main video that is part of that campaign has been watched 4,700 times. That does not suggest that the campaign is getting national reach. I would love to see some official figures, so I could be sure, but that concerns me. It is just not getting to the people it needs to get to. That is the first thing: a national strategy, with good-quality information, to reach all families. Otherwise, they are just at the mercy of Google. They will find good information or bad information, and that is too risky for the next generation of children.

The second thing is training up the early years workforce. Especially when we have the expansion of childcare back to nine months, we need to make sure that the staff know what they are doing. We have higher staff ratios—1:5—in the baby rooms. That is a real risk to the children. We can start to mitigate that if the staff are high-quality.

Chair: Janet, you have the last word.

Janet Cooper: I would like to see more focus on the pre-birth to two agenda, not just starting once children get to school. There has been a lot of focus on reception-age children. That is too late; it needs to start much earlier. I would also like to see much more joined-up thinking across the different sectors. Speech and language is a thread that goes across every agenda, so we need a lot more joined-up thinking, and joined-up funding to go with it.

Chair: Thank you both so much. That was enlightening.

Examination of witnesses

Witnesses: Dr Amit Aggarwal, Dr Helen Skirrow and Dr Helen Stewart.

Q164 **Chair:** We now move to our third panel, which relates to vaccination. Can I ask that you introduce yourselves, starting with Dr Helen Skirrow?

Dr Skirrow: My name is Dr Helen Skirrow. I am a public health medicine doctor by background—still a trainee—but I am speaking on behalf of my role at Imperial College London, where I am clinical research fellow in the child health unit in the school of public health. I spent the last few years researching maternal—pregnancy—vaccine uptake and childhood vaccine uptake, with a particular focus on hearing from communities with historically low childhood vaccine uptake and co-production research.



Dr Stewart: My name is Helen Stewart. I am a consultant in paediatric emergency medicine in Sheffield. I am here from the Royal College of Paediatrics and Child Health, where I am the officer for health improvement.

Dr Aggarwal: My name is Amit Aggarwal, and I am the executive director for medical affairs and strategic partnerships at the Association of the British Pharmaceutical Industry. I am a medic by background. Very briefly, the ABPI is a trade association, and we represent innovative, R&D-focused pharmaceutical companies that develop and manufacture medicines and vaccines. We are active across all policy areas, everything from research and development through to access and uptake, including topics such as vaccination coverage.

Q165 **Danny Beales:** I will start quite generally about the challenge. Despite attempts to increase vaccination rates, rates have broadly and consistently fallen in terms of coverage since 2012, and the WHO target of 95% coverage was not met in 2023-24, before the target was abandoned in planning guidance for NHS England. What is your assessment of why we have got to this situation and why rates have continued to fall? I am happy for anyone to start.

Dr Stewart: The Royal College of Paediatrics published a report yesterday on access to immunisations. The results of the study showed three main areas. One was access to vaccinations. Families find that there are quite a lot of structural barriers to accessing vaccinations, such as convenient appointments, being able to afford to take time off work, looking after other children, convenient places to have those appointments, and just the flexibility of the system. There is another area around data and information; a lot of parents find it difficult to check what vaccines their children have had, and what they are still missing. You only get one letter in the post, and if you forget about it or miss it, it is easy for it to get pushed to the bottom of the pile. The third thing is around accessible information. We know that primary carers are overwhelmed, and parents feel that they have not had the opportunity to build a trusting relationship with a healthcare professional, be that a practice nurse or a health visitor. They don't see the same GP each time. Health visiting services have become overstretched and reduced, so they don't feel there is someone they can trust to go and ask questions about vaccines. Obviously, there is a lot of information out there and they want someone they can talk to. They don't feel that they have that at the moment, and they find it hard to find reliable information in the public arena.

Dr Skirrow: My research echoes what the Royal College of Paediatrics and Child Health report said, but with a particular focus on looking at a community in a low-uptake area, which is a more diverse and very deprived area with an ethnically diverse population. We also found the same findings. There was a variation in just being reminded about a vaccine: some people got a text message, some got a letter, and some did not get it. Convenience of appointments was brought out time and again, in both the survey and qualitative research. Information was key, and parents remembered conversations with health visitors or midwives, and



that was seen as a positive thing on their choice to get their child vaccinated. They did not want the information delivered in a leaflet or via a website; they wanted that conversation with someone who they trusted and felt was knowledgeable to answer their vaccine questions. We found really similar findings with the targeted recruitment in that area.

Dr Aggarwal: As you say, coverage has been declining gradually since 2012 and 2013—that has been a slow and steady decline, which accelerated a little bit during the pandemic. That is different from drop-offs in the past, which have been due to particular events or scares. It has been highlighted by both Helens that those longer-term declines are indicative of challenges with NHS delivery of vaccines. NICE has done some interesting work on this that it published in 2022, so it notes—broadly bucketed—challenges around parents having questions about vaccine effectiveness and safety, but moreover, the inflexibility of access, such as clinic times and locations, and the important issue of staff training, so that staff have the training and time to discuss any concerns about vaccinations with parents. Those last two have undoubtedly become more of a factor in recent years, given the pressures on the NHS.

Q166 **Danny Beales:** That is a really helpful summary. We have seen that trend since 2012. Is it your sense that all those barriers—in terms of access points such as convenience, time off work and so on, which are understandable barriers—have become more acute? What is your sense of why there has been a worsening of availability of appointments or conversations? Do you have a sense of why that might have changed and led to the decline since 2012?

Dr Stewart: We know that there are real inequalities in vaccine access. Those living in deprivation, with lower financial resources, are much more likely to struggle. Obviously, we have seen an increase in the level of poverty over that time, and we think there is a link there.

Dr Skirrow: I also think the pandemic had an impact on vaccine uptake and shone a light on the inequalities that were already there, and widened them. Research has demonstrated that inequalities in vaccine uptake have got worse in the last few years, and I think that is part of it. During the pandemic, my research found that all the issues we talked about, such as access, were exacerbated. If you were isolating or having to take time off, or your child had been off nursery or school, that made a vaccination appointment slip down the agenda—"I can't take time off school," or, "I can't take time off work for a vaccination." I think it is both the increase in deprivation and the huge impact of the pandemic.

Q167 **Danny Beales:** There are quite wide regional variations: 22 local authorities meet the 95% target, but 44 are below 90% and 12 are below 85%. Hackney is as low as 60-something per cent—approximately 63%—which is an almost 30% difference between the lowest and highest coverage in local authorities. What is your feeling about why that might be? Are some places meeting the challenges and overcoming the barriers, and some not?



Dr Skirrow: In my research, when I looked at the national data, the biggest predictor was deprivation. Even once you adjust for deprivation, when you look at ethnicity or other factors in the population, deprivation was the biggest predictor of whether a population was going to be vaccinated. The regional variations, where we see there is low vaccine uptake, track to deprivation levels. That would be my response: it seems to be related to those families finding it harder to access vaccine services in those areas.

Dr Aggarwal: Again, NICE has done some good work on this and has categorised certain groups that are supposed to be at high risk of low uptake. As Helen has already highlighted, deprivation is absolutely a major factor, but other groups are children from some minority ethnic backgrounds or certain religious communities, younger children in larger families, those with chronic illness and so on. For local authorities where there are challenges, that might partly reflect the population within that local authority.

In London specifically, population mobility is also a factor. As people move frequently, they change or lose contact with their GP, or they are not registered, so they are more likely to miss a call for vaccination. That is certainly a factor as well.

Q168 **Danny Beales:** The point has been mentioned that many families receive one letter. You also just mentioned population mobility and losing contact. What is your sense of where the system is working well in tracking those who have missed appointments? Are there places where that has been solved—perhaps through a more complex system of follow-ups and targeted interventions with multiple contact points? Or is it just a system challenge that if you can navigate the system, you do, and if you can't, you don't?

Dr Stewart: When we did our parent survey, it was across a wide variety of areas, so we could not pinpoint it. The feedback was also generally consistent across all those respondents, so I could not comment on individual places doing well.

We know there are specific challenges for specific communities. For instance, as well as deprivation and inequalities, there are migrant groups where English is not the first language, so they face language barriers on top of all the other barriers. Unfortunately, specific examples of good practice did not come out in our report.

Dr Skirrow: I can only speak for my research. Parents did talk about, "Oh, actually, I did get my child vaccinated in the end because they were doing a pilot where they were offering it in a children's centre. I didn't want it the first time I spoke to them at the children's centre. I had a chat with them, went away, thought about it, and then came back and did that." But that has not been evaluated in any way that I have seen. Those practices are happening, but I do not think we have the evidence base yet on whether they have actually improved uptake among those particular communities.



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Q169 Danny Beales: In terms of the impacts, there have been a number of outbreaks recorded: measles outbreaks in Birmingham and London, I think, and increasing cases of whooping cough and other things. Do you have any broader sense of what the implications might be for the health system? Are you aware of any kind of modelling on declining vaccination rates and what that might mean for the outcomes for children and families, including admissions to hospital?

Dr Stewart: I am not aware of any system evaluations of that, but I can speak from my experience in an emergency department. We had a few cases of measles during the recent outbreak, and it does create a significant impact in terms of infection control and cohorting patients, and just in terms of numbers, as well, because it often comes at the same time as other infectious diseases are breaking out. There was an awful lot of managerial time input into how to manage the outbreak. Measles is one of the most infectious diseases, so, in terms of contact tracing, it was a huge burden on clinical staff.

When these things break out, we report them to the Health Protection Agency, and they do contact tracing. We know that that can leave parents economically inactive for a few weeks, because, if they have several children, the infection gets passed around. That has a really big impact on the wider family as well when they experience these infectious diseases—not to mention the stress of seeing their child incredibly unwell. They can be in intensive care for days; unfortunately, I think 11 children died of pertussis in the outbreak last year, so there is a significant mortality and morbidity impact as well.

Dr Skirrow: There has been work showing that an increased proportion of the children living in more deprived communities are at an increased risk of getting measles outbreaks. In terms of pertussis and the tragic infant deaths last year, it has now been published that we have increased pertussis vaccine uptake among pregnant women. It was around 53% last year and that has gone up this year, I think, to 70%; they have just reported the figures.

It should not have got to that point, with tragic deaths, but there was a huge impetus to improve maternal vaccine uptake for whooping cough last year, and that has borne fruit. We have seen the figures starting to recover, but obviously we should not have got to the situation where babies were dying of a preventable disease in the first place.

Q170 Danny Beales: Thank you so much; I completely agree. Finally, for a number of the interventions that you have suggested might be needed, the barriers could be the required resources. But are you aware of any analysis of extra admissions or bed days by NHS England, at the national or regional level, that might show that “business as usual” declining rates are having a significant resource implication on the system?

Dr Stewart: Not that we have seen, no, but it might be a little soon for all the data to filter through, so it might be coming.

Q171 Dr Cooper: Thank you all for coming this morning. I just want to pick up



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where my colleague left off and move us on to the NHS England vaccination strategy, which I understand came about in December 2023. Could I ask you all, in turn, to briefly tell us how much progress you think has been made on implementing this strategy in your respective areas. Dr Aggarwal, perhaps we will start with you.

Dr Aggarwal: Yes, you are quite right. The NHS published the vaccination strategy in December 2023, partly as a recognition of the issues with vaccination coverage. For most children, with that long-standing approach to vaccination via the GP—where the GP contacts the parents to invite them to make an appointment, the family attends and child is vaccinated—achieving consistent operational excellence with that core offering is really important. But the strategy also recognised, I think, that that core offering is perhaps not working for all families, and that something more was needed.

Q172 Dr Cooper: Dr Aggarwal, when you say it is not working for all families, can we be explicit that there is probably a certain demographic that it is not working for, which would be more deprived areas?

Dr Aggarwal: Exactly. Those populations are at higher risk of missing out on coverage. It is not working for those particular families. The establishment of ICBs provides an opportunity to have more locally developed and delivered outreach for those under-vaccinated communities. ICBs will take accountability for that from April next year, and will be able to offer a tailored vaccination service, in addition to that core offering—

Q173 Dr Cooper: Sorry to interrupt, but the strategy came into place in December 2023, but we are only going to see this particular initiative start when, sorry? Next year?

Dr Aggarwal: After the formal delegation to ICBs, their formal responsibility will start from April 2026. In the meantime, as part of the vaccination strategy, demonstrator sites have been happening. Particular ICBs were essentially piloting those outreach approaches and taking learnings from them to see how they work.

Coming back to your original question about how the implementation has gone so far, it is progressing well, to our understanding. There is obviously a lot more to do, because the vaccination landscape is really complex. The coverage took a long time to fall—over 12 or 13 years—so it is not going to be back to where it needs to be overnight.

Q174 Dr Cooper: Just to be clear, the ICB roll-out from next year is happening because previously, immunisation was managed by what is called a tripartite arrangement, which is always interesting, from the Department of Health and Social Care, the UK Health Security Agency—previously the Health Protection Agency—and NHS England. It was deemed that that tripartite arrangement may not be optimal, and we are now delegating devolving resource down to the integrated care boards.

Dr Aggarwal: The tripartite arrangement had been in place for a number of years, since about 2012 or 2013. It was a complex arrangement, and it



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was felt that the formation of the ICBs was an opportunity to supplement the core offer with additional bespoke outreach to those communities who need it.

Q175 Dr Cooper: Do you agree with that? Do you think it is the right way forward?

Dr Aggarwal: Yes, very much so. I am very supportive of the vaccination strategy. Last year, the focus was really on stabilising, improving data quality, evaluating outreach approaches such as demonstrator sites and testing those new ideas. This year, there will be more of a focus on commissioning and contracting frameworks and outcomes frameworks, and looking at expanded roles for community pharmacy and health visitors, as well as—

Q176 Dr Cooper: We will come on to health visitors when my colleague picks up on that in a minute. Dr Stewart, is there anything you would like to add?

Dr Stewart: As was mentioned, it is obviously going to take time, but so far there has been no halting of the decline in uptake of vaccinations, which suggests—

Q177 Dr Cooper: So since the NHS strategy came into place in December 2023, we have not seen a halt in the decline of vaccination rates. Are you able to comment on why you think that is?

Dr Stewart: It is difficult, because obviously, it is early, but my understanding is that the vaccine strategy was supposed to be implemented in a cost-neutral way, and—

Dr Cooper: Can you explain what that means for people watching?

Dr Stewart: It does not cost any more money, basically, to implement it.

Q178 Dr Cooper: Do you think that is a reasonable thing?

Dr Stewart: I do not think it is all about money, but part of the solution is increasing the capacity of the vaccine delivery service.

Dr Cooper: As a resource?

Dr Stewart: As a resource, and the workforce needed to deliver that service is also a resource. Ultimately, we feel that more financial resource will be needed to make a significant impact.

Q179 Dr Cooper: I just want to push you a bit on that resource, compared with the significant investment in secondary and tertiary care in NHS services—the £20-odd billion. Presumably, we are not looking at that sort of figure for this resource to deliver a return on investment.

Dr Stewart: No, it should not be at all. It should be quite small numbers comparative to the NHS budget.

Q180 Dr Cooper: And the return on investment would be substantive to get those vaccination rates up?



Dr Stewart: Yes—massive.

Q181 **Dr Cooper:** Thank you—it is good to have that on the record. Dr Skirrow, is there anything you would like to add?

Dr Skirrow: I echo what my fellow panellists have said. I think it is too early to say that the national vaccine strategy has done anything to halt the decline in childhood vaccine uptake.

Q182 **Dr Cooper:** Which is fine, Dr Skirrow, but bear in mind that people watching are going, “Hang on, it started in December 2023 and it is now July 2025. When are we going to be able to say, ‘Okay, this vaccination strategy is the right way forward?’”

Dr Skirrow: I think it is the right way forward. It contains all the right elements, but to pick up on Dr Stewart’s point, to improve the inequalities we see in vaccine uptake will require greater resource. It needs a tailored approach and training of staff, and it will require some resource, but we probably do not need much more modelling about the impact of a measles outbreak on the healthcare system, because vaccination is one of the single most cost-effective interventions we have in healthcare. It is a low hanging fruit as to how to save the healthcare—

Q183 **Dr Cooper:** Excellent. That is really helpful, Dr Skirrow. Basically, what we are saying is that we have enough evidence and data to show that this is demonstrably an excellent initiative to invest in, and therefore all three of you, presumably, would advocate for additional resource into this initiative. But at the moment, the advice is that it is to be cost neutral.

Dr Skirrow indicated assent.

Dr Stewart indicated assent.

Dr Cooper: Before I hand over, I want to mention a particular initiative that relates to vaccination delivery in convenient local places. I think it was mentioned in relation to community pharmacies. Again, I read that we are in—the NHS loves it—the pilot phase. We have 36 community pharmacies in the east of England offering RSV—respiratory syncytial virus—vaccinations, and there are similar initiatives in north-west England for the measles, mumps and rubella vaccine. Can I get your thoughts on the role of community pharmacies in increasing vaccinations in those harder-to-reach areas? What are your thoughts on how long we should pilot this before we look at some serious commissioning?

Dr Skirrow: I asked parents about alternative locations, and two thirds of the more than 500 parents I surveyed said that they might consider taking their child to an alternative location. The key thing is that they wanted it to be someone who they trusted and who could answer their questions. I think it is quite location dependent because a community pharmacy in one location might be somewhere where parents do feel very comfortable going to discuss their health problems, whereas another location that they do not normally go to might feel completely alien compared with a GP practice. Whether they feel comfortable is quite context-specific.



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For adults, it is slightly different. That is a different population, because adults might be more used to going to pharmacies for their vaccinations. However, for parents at the vulnerable stage of having newborn babies, it is a very different thing. A lot of the parents talked about their experience of the covid-19 pandemic: "Oh, I wouldn't want to take my baby to some random location and for them to be vaccinated by someone random."

That trusted relationship with a healthcare professional is key. That is not to do down the role of community pharmacies, which is huge, but I think it really needs to be understood that it needs to be a trusted community pharmacy in that particular area to make sure that it actually addresses those groups that are less likely to be vaccinated. If not, you are potentially going to vaccinate the people who are already going to go to the GP to get vaccinated, and you are not going to improve uptake; you are just going to shift people going from one location to another.

Q184 Dr Cooper: Excellent; that is very clear. Dr Stewart, do you have anything to add?

Dr Stewart: I would just echo what Helen said: while they have a huge role in general community health, they do not address the need for that trusted person. I think they definitely have a role in an expanded vaccine service. I missed the email about my daughter's flu jab at school.

Q185 Dr Cooper: Me too, actually. I felt awful—I was like, "God, I am a public health consultant, and I missed it!". I had to phone them up and go, "I'm so sorry."

Dr Stewart: I missed it, so she could not have it, but I could not then find somewhere to get her a flu vaccine. It would have been amazing if I could have gone to the Boots down the road to say, "Can she have it?", but that option was not there. It is definitely part of a wider strategy, but I do not think it would address the main barriers, unfortunately.

Q186 Dr Cooper: So there are some gaps. Dr Aggarwal, any final words?

Dr Aggarwal: I think it has been really well covered already. It is an experience: a childhood flu jab missed because of a school trip on the same day and no way of catching up.

Dr Cooper: I can't believe I just said that publicly; that is terrible!

Dr Aggarwal: As NICE identified in a review a few years ago, the ability to have a conversation with a trusted healthcare professional is really key. In terms of expanded roles, whether it is for pharmacy or for health visitors, the question is going to be: do those roles have that relationship? Where there are difficult-to-convert scenarios, you need to have contact not once, not twice but maybe several times. That is time and labour intensive, so we need to concentrate on delivering the roles that will achieve that most effectively.

Q187 Danny Beales: On the role of health visitors, home visits have in many ways been shown to improve outcomes. You talked about the need to have discussions and trusted relationships. That would suggest that the



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role of health visitors could and should be an important one. The Government committed to pilot health visitors giving the vaccine. How much of a role do you think health visitors can play in closing the vaccine gap?

Dr Stewart: They have the potential to be hugely important in closing that gap. If a health visitor is able to build a relationship with a family, that creates a trusted person that they can go to discuss things. If they then have a future appointment, they may be happy to let that person vaccinate their child.

We have to be careful about what we put on health visitors; they are a very limited resource with limited time. They have been relevant in all the panels this morning, and they could potentially do a huge amount for families. A reduction in health visiting is also linked to an increase in under-ones visiting emergency departments. They have huge potential, but they need to be resourced, staffed and trained.

Health visitors' training is devolved down to their local authorities, so it is very hit and miss whether they feel comfortable and confident to talk about vaccinations with families, where they feel they have the skills to make that contact count and persuade them. There would need to be a big package of support in place to make that they are properly staffed, properly resourced and properly trained, because it is about not just giving the vaccine, but making sure it is safely stored, safely transported—there is a lot involved. So in principle, yes, fantastic, but it needs to be carefully thought through.

Dr Skirrow: I fully support the health visitor pilot and echo exactly what Dr Stewart said. I do think we need to look beyond just health visitors at who else comes into contact with families in the key early years. I would say that we also need to focus on midwives as a staff group. They would not necessarily deliver vaccines, although some midwives do deliver pregnancy vaccines in antenatal settings.

In my research, I found a clear relationship: women who took up the pertussis vaccine during pregnancy were 40% more likely to have a child vaccinated with the MMR vaccine. We need to make sure that we upskill all the people who talk to families across their journey from conceiving and first speaking to health visitors. I would include midwives in that as a staff group. We need to make sure that they are confident to talk to parents about vaccinations.

Q188 **Danny Beales:** The pilots that you have said you support seem incredibly slow in their roll-out, from what we have heard. There are just a handful of pilots, before we move on to a significant scale roll-out. Have you got any view about the pace of those? Are we going far enough quickly enough?

Dr Stewart: It is a difficult balance. We would love to see it happen more quickly, but we want to make sure that it is effective. We do not want to roll out a financial cost that will not work. Rather than speed, it is important to make sure it is done properly.



Dr Skirrow: The role of health visitors in all of early years health is so important that we probably do not have too long to spend rolling it out. Across all the panels this morning, the role of health visitors and multidisciplinary teams has been highlighted as crucial—not just for vaccination updates, but for all areas of child health.

Q189 Danny Beales: We have seen these declining rates since 2012, which is more than 10 years ago. A colleague earlier talked about the strategy development. Do you think the system has failed in moving at adequate pace to address the problem?

Dr Skirrow: A huge number of people—any healthcare provider you speak to, any UKHSA person—want to see vaccine uptake increase. There is nobody who is not aware of this as an issue. I just think that the complexity of the system, with the covid-19 pandemic widening—

Q190 Danny Beales: Has the system become more complex?

Dr Skirrow: In terms of vaccination, the move to ICBs and away from the tripartite should hopefully be a positive thing to make it simpler.

Q191 Danny Beales: All the issues you mentioned about disproportionate take-up of vaccines were known about during covid. There were a lot of efforts to do many of the things you talked about, such as roll-out vans, culturally targeted messengers and messages, and conversations in communities. It does not feel like there are issues with vaccines that we did not know about. I am trying to think what is novel that has suddenly developed. Is it not the case that the system has taken its eye off the ball and has not done enough to address the barriers to healthcare access for families?

Dr Stewart: It took a really long time for the health system to appreciate inequalities, and the wider determinants of what keeps people healthy and what helps them to access healthcare. It took a long time to accept that it was not just about telling a parent that they needed to vaccinate their child, and that parent then goes and vaccinates their child. We did not look carefully at why they were not doing what they were being paternalistically told to do. That took time, and that then needs to translate into the system taking it on and being proactive in combating some of those things. Quite a big mind shift was needed to start working on this properly.

Q192 Danny Beales: Hopefully it will be quick—quicker than a decade. Lastly, you touched on midwives and the important role they play. In their evidence to us, representatives of the RCM talked about the importance of a care navigation role around vaccination. Have you any views about that suggestion from the RCM? Do you agree with it? Do you think midwives should play that role? We talked a bit about a greater role for them pre-birth.

Dr Skirrow: A lot of the time, the recommendation is to make an appointment to see your GP to get the vaccination. All the evidence shows that it is access, so that we can close the loop for the families. Can the midwife, who identifies that somebody needs a vaccine, book an appointment for that person to get the vaccine, as opposed to saying



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contact the GP, giving the parent another job on a busy day? Can we ensure that we address not just the conversation and the availability of information at that point of contact but ensure that they can book the appointment as well?

Dr Stewart: I agree with that. If people can discuss whether they can give the vaccine there and then, it saves the family having to make another appointment. Midwives should 100% be considered as part of the wider vaccination workforce, because they have such an important role in giving those vaccinations during pregnancy.

That also means that they need proper training and education. One comment we got back in our survey that is in the report was from a mother who said she was told by her midwife not to have the RSV vaccine because it was new and experimental. She went away, did her own research and did finally get the vaccine, though she had been told by that frontline trusted healthcare professional not to get it. They definitely need to be considered as part of the group that needs training and education on this topic.

Q193 **Chair:** Thank you, Danny. Before we finish, you know what is coming. It is my little class act. We will start with Dr Aggarwal. What two things would you like to see in the report, given your discussions?

Dr Aggarwal: We touched on how cost-effective vaccines are. More than that, the majority of childhood immunisations are cost savings. Far from being a cost, they actually save money for the NHS. Ensuring delivery of the childhood immunisation programme is vital.

One point we haven't touched on is the NHS England-Department of Health and Social Care merger. As primary legislation goes through to underpin that merger, it needs to set out clearly roles and accountability for different aspects of vaccination policy and delivery: who is accountable in Department systems, UKHSA, and ensuring that operational expertise is retained at national level, which is really important.

Lastly, the Department of Health and Social Care tracking and monitoring immunisation expenditure, especially after delegation to ICBs happens, to ensure that investment is sufficient. We talked about cost neutrality, and whether that is good enough. Ensuring that investment is sufficient is key.

Q194 **Chair:** I need it to be succinct. Dr Stewart.

Dr Stewart: I would like to see a comprehensive expansion of the vaccination provision service to span primary care, with flexibility to make it more convenient for families and parents, which includes health visiting. I would also like expansion of the digital services around vaccination, so digitisation of the red book, to allow parents to check easily, and all health professionals to be able to see vaccination records, not just in primary care.

Dr Skirrow: First, a reminder that the majority—over 90%—of parents in the UK want to vaccinate their child; we just need to make it easy for



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them to do so. Secondly, a life course approach to vaccinations. From the moment when parents conceive, we work with them to ensure that pregnancy and childhood vaccines and, indeed, life course vaccinations are prioritised for all families.

Chair: Absolutely brilliant. Thank you all for coming this morning.