HOUSE OF LORDS

Childhood Vaccinations Committee

Corrected oral evidence

Monday 23 March 2026

2.15 pm

Watch the meeting

Members present: Baroness Walmsley (The Chair); Baroness Andrews; Baroness Browning; Lord Dholakia; Baroness Freeman of Steventon; Baroness Hodgson of Abinger; Baroness Neuberger; Lord Randall of Uxbridge; Baroness Ritchie of Downpatrick; Baroness Wyld.

Evidence Session No. 4 Heard in Public Questions 41 – 53

Witnesses

I: James Roach, Director of Primary Care and Local Care, NHS Hampshire and Isle of Wight; Dudu Sher-Arami, Director of Public Health, Enfield; Will Huxter, Regional Director of Commissioning, London Region, NHS England.

USE OF THE TRANSCRIPT

1. This is a corrected transcript of evidence taken in public and webcast on www.parliamentlive.tv.

Examination of witnesses

James Roach, Dudu Sher-Arami and Will Huxter.

Q41 **The Chair:** Good afternoon and welcome to today's meeting. This is the fourth oral evidence session as part of the committee's inquiry into childhood vaccine rates in England. Thank you to Will Huxter, James Roach and Dudu Sher-Arami for attending.

The session is open to the public, and it is broadcast live. It will subsequently be accessible via the parliamentary website. A verbatim transcript will be taken of the evidence, and it will be published on the parliamentary website in due course. A few days after this session, we will send our witnesses a copy of the transcript to check for accuracy. If there are any small changes, do let us know as soon as you can. If after this evidence session, you would like to send us more evidence, correct or amplify anything, or send us more information, you would be very welcome to submit written evidence to us.

If a Division is called in the Chamber during our session this afternoon, I will have to pause the meeting to allow members to vote, and we will resume about 15 minutes later once members have voted. This is more likely to happen later this afternoon, but it could happen at any time.

If everybody is ready, perhaps I could ask the first question and remind you to introduce yourselves at the beginning of your answer. What are the trends and disparities in childhood vaccination coverage in your area, and what are the main reasons for those trends and disparities? While you are answering, could you tell us a bit about the relative importance of the different factors in influencing childhood vaccination coverage in your area, including access and attitudes to vaccination and how and whether those factors interact?

We have heard that there may be some overlap between income and ethnic minorities, and we have not really heard any research about that, so you may be able to enlighten us. Dudu, would you like to go first?

Dudu Sher-Arami: To start us off on this, I will tell you a bit about Enfield, which is the borough in which I am Director of Public Health. Enfield is a large north London borough. We are the ninth-largest borough in London. We have nearly 330,000 individuals in our population. We are the ninth-most deprived London borough as well, and that is measured by the indices of multiple deprivation, which is a composite score that looks at income, employment and the well-being outcomes of children, older people, housing and services. It encompasses a lot.

We can see that vaccination uptake very much mirrors the pattern that deprivation has within our borough. That is an association that is relevant to many other London boroughs and probably most other urban areas as well—vaccine uptake and high deprivation overlap.

In Enfield, we have a large young people's population. A greater proportion of our population are under 17 than the average for London, and we have a higher density of young people living in our areas of highest deprivation as well, which is an important factor to be aware of. We have around 90 languages spoken among young people. Enfield is very ethnically diverse. It is very mobile, with people coming in and out of the borough all the time. We have got a high proportion of people living in temporary accommodation.

While that is a reasonably good description of Enfield, I do not feel that it makes Enfield special when we compare it with many other similar areas in London. When we look at vaccination coverage and think about that correlation and association between deprivation and vaccine uptake, we know, thinking about access, that there is an unknown number of individuals who are not registered with GPs, so they will not have that routine "call and recall" and all the great provision that is provided through primary care.

We know that sometimes there is an issue with people's health literacy about what the system can offer them for their well-being. I am thinking particularly about preventive healthcare measures like vaccination that we are talking about here today. There is an issue around trust as well; trust of state apparatus and organisations and where people can get that trusted, accurate information from. The fact that often in areas of high deprivation communities are highly mobile, moving in and out of an area all the time, means there are issues around service continuity and understanding who is actually here in the borough and who is not, even if they have got a record within our datasets. All those issues create an environment in which it is much more challenging to offer and to achieve high vaccine uptake.

The Chair: Before we move on, Dudu, would it also be true to say that there is a difficulty in recording which vaccinations people have had in a sustainable way?

Dudu Sher-Arami: That is absolutely correct. There are a number of systems in which vaccinations are recorded, but they do not easily speak to each other—that is not a technical term—so there are lots of challenges in understanding who is in the borough, what vaccinations they can receive, whether or not they have had them and, particularly in urban communities with high deprivation, there are people moving in and out who have often had their immunisations abroad.

For example, I live in Enfield. I did not have my vaccinations as a child in the borough. There is no vaccination record for me, and I am a typical example of an Enfield resident. There are lots of challenges there for residents and for people providing their care in understanding.

Q42 **The Chair:** Will Huxter, you also have responsibility for London.

Will Huxter: Yes. I am the Regional Director of Commissioning for NHS England in London. Within my remit is included the various immunisation

programmes which we commission, though they are delivered overwhelmingly by primary care and other providers locally. I very much agree with the themes that Dudu set out. If you look across London, there is a very similar pattern of variation. It differs depending on population, including turnover of population.

One of the factors that makes accurate records complicated is that we have got a 20% to 30% turnover in people registered with GPs in a given year. We rely quite heavily on a GP call and recall system, but people are in temporary accommodation and change address and so on. We have got some systems which are set up for a more stable population than we probably have now.

The other issue that I would really highlight is the point about trust. It is trust in the people giving advice and encouragement about immunisations, but there is a broader issue about trust in statutory services. It may not just be about immunisations; it may be about other aspects of NHS provision and local authority provision. We have got various levels of deprivation and disadvantage and simply being able to say there are appointments available is not adequate, and there is much more we need to do with community engagement, which I think we will probably talk about a bit more later on. Trust and community engagement are really fundamental to how we tackle some of these long-standing issues.

Q43 **The Chair:** We move on to James Roach from Hampshire.

James Roach: It is a slightly different environment but with very similar challenges. I would just like to pick up on the point that Will made about trust. Trust is critical but, to make this point early on, we are seeing increasing confidence in relation to the way we provide vaccines and the way we support patients. In terms of disparities, what we have found is that on the trust issue it is often about who gives the message and how, particularly regarding certain ethnic groups.

Hampshire is broadly rural with big urban places like Winchester and Basingstoke. Southampton and Portsmouth are cities. We have the Isle of Wight as well. Picking up on Dudu and Will's points, if you take Southampton, there is a lot of alignment in trust issues. There is vaccine hesitancy; there are cultural issues impacting on trust and confidence; people living in more deprived communities; people who are not registered with GPs; and people who have long-standing issues with accessing core services.

We did some work on this in Southampton, and one particular area we focused on accounted for 20% of the most deprived population when compared with the UK average. We had low levels of general literacy and very low levels of health literacy, and lots of different nationalities within the one area as well. What made it really difficult was that often people who have moved here assumed they had had a full vaccination schedule in the country which they came from.

Patients not being aware of immunisation and vaccination is a key issue. As Dudu said, there are some concerns around what is in the product, such as a toxin for particular ethnic groups. There are concerns about pork products being in particular vaccines as well. Low levels of literacy make it really difficult to provide impactful communication. Often these are people who are not registered with a GP, and I am sure we will touch on later the importance of community pharmacy and other community programmes in making that connection.

We found with these particular groups that being really flexible with our service offer was key, being really-community focused with how we provide services and really buying into the need to provide support for the family and not just the individual receiving the vaccination. We very much leant into a family hub approach and really looked at different ways in which we could engage the population as well. So, in Hampshire and the Isle of Wight, there is lots of diversity and there are lots of challenges, but we have found some key principles that have driven improvement in our more challenging areas.

The Chair: Have you been able to fund the outreach programmes that you have just mentioned sustainably, or do they happen for six months and then the funding stops? How does it work?

James Roach: You have articulated the challenge, because often we identify the problem and we commission a solution for a short period of time, and then we get back into a funding cycle and do not sustain the investment. I am sure we will come on to recommendations later, but outreach in particular needs a coherent long-term commissioning strategy.

Q44 **Baroness Andrews:** I have two questions. They are a bit different, because I am just picking up now on what James has said. Hampshire's population is very diverse, is it not? You have that coastal strip with tremendous complexity and poverty, and then you have some quite affluent rural areas. What is the strategy for diving into those communities where there is clustering of the hard-to-reach and where you need more flexibility to be very local at a neighbourhood level?

My second question, which is more general, is: how serious was Covid in affecting trust? Could we say with any confidence that if it had not been for Covid, you might have actually been in a position where people would maintain a reliable relationship, in so far as anyone can, in the populations that you have described?

James Roach: We have a lot of diversity. We also have an island community, and that stretch of water makes a big difference in access to services and ongoing sustainability.

Your point around clustering is well made. We have tended to identify a cohort and deal with it in a siloed way with a single pathway or a single scheme. If you really layered the data—I am sure Will and Dudu will add to this—often it is the same group that have challenges accessing CVD

treatment, or cannot register with a GP, or have ongoing healthcare issues.

We found that when we did some focused work around CVD screening, women's health initiatives, and even when we tried to do work around frailty as well, it is often the same social groups in the same communities with the same characteristics. We need to almost see vaccinations as a catalyst by which we can identify our highest risk populations and provide a more co-ordinated neighbourhood health approach. That aligns with national policy, of course.

Baroness Andrews: That is very interesting. What about the Covid point?

Dudu Sher-Arami: I have a mixed view on the implications of trust and Covid. On the one hand, there have been a number of issues around how we communicate about health issues over some years, and Covid was one of those. However, Covid also provided lots of opportunities for us to work more closely with communities, and I can think of lots of relationships with communities that were developed during that period. That was partly because there was additional resource to do that work, and there was a very focused priority in the work that was happening in those communities, given that we could see they were being impacted by Covid in a more dramatic way not only by the health outcomes but the economic aspects and the challenges to households.

There are a number of ways in which we changed our engagement work through Covid that we have now extended beyond the Covid period, and we really learnt from that how engagement works with communities. There may well have been negative aspects, but there were also some positive ones as well.

Baroness Andrews: Does that include the fact that you are using paramedics and nurses—more familiar and less authoritative people—to deliver in the community?

Dudu Sher-Arami: We worked very closely with our faith forum in the council. We ensured that the faith leaders had the right information to provide to their communities and were advocates for health and well-being within their various communities.

Q45 **Baroness Neuberger:** I want to come back to a point that James made. It is now government policy to take, if you like, more seriously the left shift and look more at communities. But we have been bedevilled in the NHS—I chair a couple of hospitals—with initiative-itis, and so it is always relatively short-term.

I know we are going to come on to recommendations later but is there a way that, if we made some of these campaigns much more mainstream and not initiative-funded, they would likely be more successful, given what we know—we do not know everything—than they are at the moment? That is a really important point for us.

James Roach: Without wishing to reference pilots after pilots, the pilots demonstrate, even in a very focused way, that there is opportunity and benefit.

Baroness Neuberger: Yes, they do.

James Roach: I think as ICBs become strategic commissioners, that requires us to think on a multi-year basis. It requires us to be really clear on the funding mechanism for more than one year, give certainty to providers and not focus on one particular healthcare professional, and be really broad in terms of that integrated workforce response and be stronger on the case for change.

At the moment, when we talk about vaccinations, we are chasing numbers. We are not necessarily focusing on opportunities lost. I do not think we are engaging our public enough on the personal, social and structural costs associated with not partaking in the vaccination campaign.

You referenced Covid. We got there towards the end of Covid with some really positive, innovative, direct public messaging. I am not suggesting we need to be as direct for childhood vaccinations, but we need to be really clear as to why, who and where and what everyone's responsibility is in that.

Baroness Neuberger: Would you say we need to be almost as direct for measles?

James Roach: That is my view, but we would need to be really lateral in the way we communicate. My final point on this is that we are missing a huge opportunity in relation to digital solutions. A culture shift is possible. In October, all GPs provided online consultations 10 hours a day, Monday to Friday. That happened. We can do it on a bigger scale for these sorts of things more routinely.

Will Huxter: There is also something about how we make sure that our messages are relevant at different times. We have a cycle about when we offer vaccinations and when we pursue them, but that may not be the right time for a family to be making that decision. There is that year-round approach, which is not just about immunisations but is everything from welfare benefits and advice to housing advice and support so that, at the right time, people feel confident to come forward and take up other offers of vaccination or other services. That context is a really important part of what we do.

Q46 **Baroness Neuberger:** A declaration of interest: I am still, until next week, on the North Central London ICB that is merging with West London, as you know. So, to Dudu particularly, how have services responded to the measles outbreak in Enfield? Can you talk a bit about what the costs are? That is the financial costs and the social costs compared with the costs of routine vaccination locally in Enfield.

Dudu Sher-Arami: Absolutely. I will try to make it brief. There has been a huge amount of really positive work. But it is also important to identify that we have a very significant level of business-as-usual work that has been working to improve vaccination uptake for many years, because we recognised that this was an issue. In a sense, I am a little bit surprised that it has taken so long for Enfield to have a measles outbreak, unfortunately. We have not had a huge level of success in our immunisation uptake work. We continue to try different things.

You will be aware that UKHSA, the UK Health Security Agency, is the lead organisation for the management of outbreaks. When the outbreak was initially identified at the end of January, it was very quick off the mark to identify cases and close contacts and to engage with the settings, such as schools, where cases had been during the infectious period. One of the great things that came out of Covid was the good and strong lasting relationship that the public health team and the local authority have with schools. We quickly stood up a webinar for schools all across the borough to inform them about the outbreak, for them to understand what measles was all about and to inform them about how to respond appropriately and quickly. That has been useful because schools operated extremely professionally and appropriately all the way through.

The level of provision that has been stood up in terms of vaccination has been phenomenal. Across Enfield the primary care system stood up additional call recall, so many practices were contacting families who had previously declined but were due or overdue their vaccinations. That was through text, letters and phone calls. Where there were a significant number of cases within a particular primary school, all the families of children who were undervaccinated were contacted and offered vaccination by the school-age immunisation service.

The level of additional capacity within the system has been significant. As of the week before last, 26 additional clinics had been provided, which resulted in 118 additional hours of vaccine capacity within primary care. We have had six or seven catch-up clinics provided by our school-age immunisation team. Some of those have been at schools; others have been in GP practices that are in the south-east of our borough, where the outbreak has been occurring. A huge level of communication and engagement has been taking place through our family hubs, schools, leisure centres, libraries and voluntary sector organisations, and lots of communities have invited us to come and speak to them. There has been a significant organised level of work to try to raise awareness about what measles is and of course to encourage people to be immunised.

Baroness Neuberger: In that particular endeavour, with all the extra capacity that you have provided, how was the take-up? What did it look like? Did people come forward to get the immunisation, or was that still very difficult?

Dudu Sher-Arami: It is still difficult, there is no doubt about it, but the good news is that we have had an increase in our MMR take-up. More MMRs were given in February than in any one month since 2018, though

there still have not been the queues of people that I would have liked to have seen. There is a larger number of those people for whom it is MMR2, the second dose of MMR. Those are people who are accepting of vaccination but might have forgotten about it or it has been delayed for a reason. None the less, we have seen also a large uptick in MMR1s, as well as vaccination of people who are over five and some over-25 as well—people who have entirely missed the routine schedule for MMR vaccination. So, while there is some good news, we know that there are still many children and adults in the borough who do not have MMR vaccination.

Baroness Neuberger: I do not know if it is possible for you to give us some of that data but, if it were, that would be useful. It would only be an example, but it would be useful to see, if you add the capacity, who comes forward and roughly what they come forward for. That would be useful to frame things for us.

Dudu Sher-Arami: I am sure that Will and I can work on something.

Q47 **Baroness Neuberger:** That would be great. If it could be London-wide then that would be even more wonderful, but I do not know whether that is possible. I have a much more general question for all three of you, and this gives you the chance to lay out your pitch. What are the main barriers to developing effective core and outreach childhood vaccination services, and what would be the best ways of overcoming those barriers? I think that gives you a chance to say what needs to happen.

James Roach: The obvious part is always capacity and funding. That is because often we lose the battle around prioritisation. We need to be clear that we need to address these issues more routinely. The example just given from an Enfield perspective—being really flexible about the time and location where you can have a vaccination, and it does not have to be that particular GP but could be a GP within the primary care network because those GPs work together—is really important. Convenience, time and choice are key factors now, so that has been really helpful.

We should be a bit more innovative about information provision and going outside the box. We looked at how we engage with our whole supply chain to provide expertise and assets. Within our region, we have worked with existing suppliers of vaccinations to provide particular information online or in print to look at innovative ways by which we can reach people. Reach is challenging, and people have a lot of public information that they have to transmit. The barriers have been traditional delivery structures, capacity and funding, and not being as innovative as we need to in getting that message out there. We have tried to address that by being flexible and using all our assets and means to do that. The key thing for vaccinations is that the assets are there in the community, but we have to be a lot more agile in using every one of those assets to improve uptake, collect information and support families and children.

Baroness Neuberger: Will, would you say something about schools as

well? I would love at least one of you to talk about schools.

Will Huxter: I agree with all that. We have quite rigid structures about how we do things, and the way in which we contract with general practice sets up some rules about how things work that are not as flexible as what we would want to be able to do here. However, we do not have discretion to vary locally. We have talked about making sure that things are ongoing rather than stop-start. I have lost count of the number of times that feedback from communities has been, "You're coming to us because you want us to get vaccinated. You need to come to us when it's not about vaccination but is about other things as well".

We have touched a bit on people not being registered with GPs and not being connected with statutory services. One way forward is to put immunisation much more fairly and squarely in the context of neighbourhood health in the round. We are thinking about the homeless population from that particular standpoint, right the way through to other communities. The bit about flexibility is important.

Schools are another area that has traditionally been quite cumbersome, even just at the consent level. Letters go out to parents, and then have we got the letters back? The staff are trying to run a busy school. Also, it is not just one vaccination programme; next term it will be HPV, and so on. There is a lot to deal with.

In London we have re-procured our providers—the whole of north London is one provider and the whole of south London is another—in order to drive good systematic approaches to working with schools. Some schools or groups of schools have been resistant to having services brought in, and that is a difficult barrier because the route is not directly to the children; it is through the school. That is a particular challenge.

I still think that schools are a great setting, though we also have to remember home schooling and kids who are not in school on the day that the vaccination team is in. There is a lot of mop-up that needs to be done.

Dudu Sher-Arami: While the majority of schools are very supportive of vaccination—I would say that most head teachers recognise that a well-vaccinated school community is going to have less absence, and that will contribute towards attainment, and that is what they are there to do, to provide education—I very much support what Will has said.

There are occasions when head teachers have been criticised by parents for providing their data to the school-age vaccination teams—which is absolutely right and above board with regard to GDPR—and that has created for some a reticence and resistance to doing that, which means that the vaccination opportunities for those children are much reduced. The school-age immunisation teams, even if they might be coming in to provide flu in a particular session, will also review the vaccination status of each of the children, if they have the names in advance, and offer to

the parents anything else that is missing for the child. When it works well, it is great.

One thing I have been very cognisant of during this whole episode is that for the majority of people our standard offer within primary care and schools works well but that there is a significant proportion of the population for whom that does not work, for all the reasons that we are talking about here today. This is the bit that we really need to get in order to achieve nationally high vaccination status—how do we flex our system to enable it to provide a service outside of the standard at the moment? That is the million-dollar question that we all have.

The Chair: At the beginning when you all talked about your very mobile communities in your areas and so many people not being registered with a GP, with the vaccination system so heavily focused on service from GPs, I thought: how on earth do you reach those people? Will, you particularly talked about that. Is there anything else that can be done? Is it through the communities? Or is it by widening the places where people can get vaccinations, as you mentioned earlier? Or is it both?

Will Huxter: It is both. James mentioned community pharmacies. That is another point of access for people to use. Obviously this is a different population, but in London more Covid vaccinations were delivered in community pharmacies than outside of community pharmacies. They became a very popular and easily accessible way, without having to make appointments.

There is a perception, which is not always true, that it is very hard to get an appointment with your GP to get vaccination. If that is the perception and sometimes the reality, there may be a particular time that you are ready to do it that does not work. But going back to my point about flexibility and joined-up data, I would like the position to be that every hospital that provides services to children has access to their child health record and can see whether they have been vaccinated, so that when they come for their out-patient appointment the hospital can say, "You're not up to date for your MMR. We could do that for you now". There are things such as that, where we have to take people where they are rather than assuming that they will make a particular effort to go for something else.

The Chair: That is very much emerging during the evidence that we are hearing. But the problem, as you have just highlighted, is joining up the data so that the patient's record is complete wherever they have their vaccination.

Baroness Neuberger: And changing the way that we operate, because we operate in a way that is convenient for the service, not the punters.

Q48 **Baroness Browning:** You have had a lot of structural change in the way that vaccines are delivered in the past, and the committee is aware that you have yet more changes to come and that you are in the middle of them now with changes to the ICBs and so on. In the evidence that we

have taken so far, we have struggled at times to understand the structure of accountability. Can I start by asking you, Will, who is responsible and accountable in your whole-of-London region for improving childhood vaccination coverage and reducing disparities? When you have identified that person, body or job title, how effective is leadership and co-ordination?

Will Huxter: As things stand, the statutory responsibility for that is with the regional office of NHS England. I am the Regional Director of Commissioning and it sits in my portfolio. We have a Regional Director of Public Health and regional director overall, but it sits within my responsibility. It is then discharged by the organisations that we commission services from. Dudu and I were both at a meeting last week of the immunisations board that is across London, which has ICB colleagues, local authority colleagues, UKHSA and others, because part of the importance of our role is to make sure that the structural change does not affect what is delivered and we try to make sure that we are working to a common strategy for what we want to do. As responsibilities get passed on, that will change.

It is shared leadership, but the ultimate accountability sits with us. Certainly, we do not have the levels of uptake that I would like to see, and that is a constant focus of what we want to do. We talked about this last week but, again, we need to reorientate from thinking about people who find it easy to come through—as per James's point about counting numbers—and think: how do we reach people who have never had any vaccination and no child in their household has ever had a vaccination? How do we tackle that? Other members of the population will come forward regardless. We try to need more root and branch on the equity side of things.

Baroness Browning: From what you see coming down the track—I know that it is not yet exact as to what the changes to the ICBs will be—how much flexibility will you have to put into practice those ideas when they are disagreed or decided?

Will Huxter: There are two aspects to that. There is strategic agreement that that is what we want to do. ICB chief executives and their teams, local authority colleagues and we have agreed on that. In the future, the team that I currently have working on immunisations in NHS England will become a team working on behalf of the ICBs in London. From the point of view of subject matter expertise, contact with communities and understanding of arrangements, that should be relatively smooth.

I would not, of course, dispute that reorganisation always causes some disruption, but the programmes are good schemes that work well. What we need to make sure we are still doing is focusing on those communities that we are at the moment not reaching as well as we should do.

Baroness Browning: I will put it this way: will the buck still stop with you?

Will Huxter: No. The buck will stop with the ICBs. From the time of the legislation passing, it will formally become the responsibility of the ICBs. The regional office will hold the ICBs to account for what they do but the buck will stop with the ICBs.

Baroness Browning: I see, thank you. James, in relation to Hampshire and the Isle of Wight moving forward and this change to the ICBs and the wider NHS reforms, I do not know whether this is correct or not but there are question marks about existing ICBs being amalgamated. They may well get bigger, in the same way that we are going to see bigger police forces. What if your area, Hampshire and the Isle of Wight, which I know very well as I live on the Dorset coast and look out at the Isle of Wight, was joined together with Dorset and became one Dorset and Hampshire ICB? What sort of challenges would that pose?

James Roach: You are right to note the reorganisation. We will stand alone as an ICB moving forward. There are no planned mergers. In the instances that we have seen in other parts of our region where ICBs have merged, you are seeing more scale and easier alignment of that regional approach. But the risk, as always, is: can you get the balance right on the push at regional level and what you need to do locally on the pull?

My experience in Hampshire is that we work really well with the NHS England public health immunisations and vaccinations team. We work together on local strategy. Similarly to London but on a smaller scale, we have a single point of co-ordination that will include those teams—the ICB and local authorities as well. It is really important to have that local authority/public health interface at place level. Where it is working well is that we are able to bring that commissioning expertise together. I talked about push and pull earlier—we almost have the push in the national policy, framework and strategy. The benefit of aligning it with local commissioners is that you can start to pull through solutions at a local level. Having that commissioning expertise in the conversation enables you to think about pathways and to think differently about how you can increase access and bring some of the services that were traditionally seen as national and regional into that local space.

Baroness Browning: It would give you a clearer view, would it not, if you had more local overview? Does that apply to Enfield as well?

Dudu Sher-Arami: While directors of public health do not have commissioning responsibilities, they have a statutory duty for assurance of things such as immunisation uptake and screening uptake. What that means in practice is probably slightly different in each area, but certainly it is about the role of public health in facilitating system-wide improvement and development of the system, and being able to use some of the public health expertise in understanding communities and their needs to feed into the commissioning and the provision of immunisation services.

There may be something to consider about how that is strengthened, and how the role of director of public health is strengthened, in the

relationship with the ICB. More often than not, directors of public health are a single appointment with the local authority rather than a dual appointment with the ICB as well, but there may be something to consider about strengthening the assurance role.

Baroness Browning: In practice, is there much competition between delivering the screening services as far as resources are concerned and vaccination services, as they seem to be in the same circle? When there is a government initiative, for good reasons—for some new screening, or for a new age block for screening—is it vaccination that very often loses out, or am I getting that wrong?

Dudu Sher-Arami: No, I do not think so. There are many similarities when we look at our intelligence about low vaccine uptake and low cancer screening uptake. There is a divergence there. I could have said everything that I said at the start about local deprivation and uptake about screening as well. There are many similarities. We have talked about how to further develop and sustain our engagement work, and something like that would also benefit other health issues and preventative health issues like screening as well.

The Chair: I fear that we have less than 15 minutes left but we have four questions to ask. We can perhaps go on till about 3.20 pm and give about five minutes to each question, so we are going to have to be very disciplined.

Q49 **Lord Dholakia:** I want to ask about the influence of the healthcare system on childhood vaccination coverage. I have two particular issues in mind. One is the funding arrangements, and the second one is data systems. You must have different systems in Enfield and Hampshire. How could you use the influence of funding arrangements to be used to help to improve coverage and reduce disparities in those areas? Secondly, what are the barriers to data collection and how could they be improved?

Dudu Sher-Arami: There are lots of opportunities to look at how the whole spectrum of the health service or indeed the public sector service supports vaccination and immunisation uptake. Will spoke earlier about the situation of a child coming into an out-patient clinic. There are lots of children, and that is a routine opportunity to check that child's immunisation status and offering vaccination if they are missing anything, but we do not maximise those opportunities throughout the system. There are some good reasons why that does not happen—everyone is very busy and there are real constraints in time—but there are also potentially issues around people's confidence in addressing those sometimes difficult vaccine-related questions. It is important to think about how we ensure that there is robust training for all healthcare service staff who have contact with children and families.

The Chair: Do you think that would save money?

Dudu Sher-Arami: It could possibly increase our vaccination uptake, which would prevent outbreaks. While I have not been able to do a cost

analysis of what the outbreak in Enfield has looked like, if I had a hat then I would eat it if that was not the most expensive way of doing things.

James Roach: On funding mechanisms, you will remember that GPs and pharmacists broadly are independent businesses and contractors, so fiscally it needs to make sense. We often commission on a unit price. There are examples of where we try to incentivise GPs or healthcare professionals to act more proactively in deprived areas. This year in the GP contract we have a quality and outcomes framework, where there appears to be more incentive and more investment in vaccinating hard-to-reach communities. Another key issue with the money is not just what you get this year; it is about making sure that you get the same amount of money year on year so you can plan your business. Lastly, we hear a lot that it is not just about the delivery of the vaccine; there needs to be enough headroom for training, follow-up and connection into other healthcare services. So we have a really good foundation in funding, but we need to be a lot more flexible in how those funds can be used, how we incentivise long-standing problems and how we bring other contractors into the mix.

Will Huxter: We make our current systems quite complicated. As James has said, we have over 1,000 GP practices in London, and each of them is having to do the stuff around claiming the money for the system under which we pay for immunisations. We need to get to a better state where we commission a range of services for which there is a sum of money, and there is a focus on, as James is highlighting, higher levels of uptake among the more deprived communities. Without that, we are not going to have the population health gain that we need.

Another thing I will say about costs is that the only thing more expensive than an outbreak is children getting unwell and being hospitalised as a result of not having been immunised. That has a broader impact on education as well as the time spent, sadly, in hospital for some individuals.

The Chair: It is very difficult to cost all that, is it not?

Q50 **Baroness Freeman of Steventon:** Each of you has mentioned the importance of data systems and the difficulties of them talking to each other and being useful. What are the main barriers for the development and deployment of more effective data systems, and how could we overcome them?

Will Huxter: One of the main challenges is that there are lots of different systems, so there is terrible interoperability. The ability of different systems to talk to one another, as Dudu mentioned earlier, is really problematic. Whenever we do bits of work looking in detail at particular populations, we find inaccuracies, whether that is a slight misspelling of a name or the fact that a child may have had some vaccinations abroad. There is a range of things that play into that. I have been really clear about the information that is required: from a technical point of view, it is

just about making sure that all our systems are able to flow between one another. There is a consent issue as much as a technical issue with that about the perception of who owns the data, but it is the patient's data and there should be the right for that to flow around the system.

Certainly, in my experience of talking to patients, they often assume that everything is joined up already and are a bit surprised that their secondary care consultant cannot see the information their GP has, or vice versa. There is almost a cultural philosophical piece, and then there is making sure that immunisations, not just things like out-patient appointments, are visible across the comprehensive record.

Dudu Sher-Arami: It would be useful to consider a single vaccination record for each child. We have spoken a lot about flexibility in how payments happen. Primary care is paid to provide vaccinations but, in those communities where lots of people have their vaccinations abroad, the primary care professionals are not paid to update the vaccination record with a complicated vaccine history of their patients, sometimes requiring translation, for vaccinations that they have had abroad. If we do not account for the vaccinations that occur then we cannot understand what our population's immunity level is, which is so important from a public health perspective.

James Roach: We have to link that to payment mechanisms as well. There has to be a correlation between what goes in and then how people are remunerated, to drive accuracy.

My final point is about the NHS app. I am conscious that not everyone uses it, but even if we can get to 70:30 or 80:20 then that is a step in the right direction, with patients contributing their own data so that we can get accuracy.

The Chair: And indeed a digital red book, at long last, would be good too.

Dudu Sher-Arami: Can I add something?

The Chair: It will have to be very quick.

Dudu Sher-Arami: One sentence. We know that each vaccination within an area of higher deprivation needs a much greater degree of effort to be put in, and that needs to be very well reflected within our payment systems.

The Chair: Something has already been said about the training of the healthcare workforce, but Lord Randall is going to give you all an opportunity to say more about that.

Q51 **Lord Randall of Uxbridge:** Obviously healthcare professionals have an important role. I am wondering how much training they have and whether there is an opportunity for more public-facing workers generally to have that. How do we make sure they are giving out the right message?

Will Huxter: It is clear what the right messages are. There is good evidence about the efficacy and effectiveness of vaccination, but we do not always recognise the extent that staff are juggling a whole number of different things or what the particular focus is of their interaction with a patient at a particular time.

We introduced a new vaccination programme, RSV, for respiratory illness in newborns, pregnant mothers and the elderly. The uptake of that has been really positive, and lot of that is about the trusted professional who you are having the interaction with. That is a range of people, whether it is health visitors, midwives or others who interact at different points. We likewise have really good uptake for antenatal and newborn screening programmes, which again is a point of particular trust. So it is predominantly about trust in the healthcare or other professionals who patients are interacting with.

I am less worried about the information being available. Sometimes it is about how you give the message and how you can tell whether the person in front of you is ready to hear that message, as well as using faith and other community leaders to work with us on particular things. So there is a background context.

Q52 **Baroness Hodgson of Abinger:** Have you done any qualitative and quantitative studies on people who have not taken vaccinations and things? Have you dug into reasons why they have not?

Will Huxter: We have the quantitative data. In terms of qualitative, there has been a range of surveys. The UKHSA does a survey on attitudes to vaccination and we get a range of answers, access being one of them, but another is scepticism about the need for and effectiveness of vaccines in the context of some messaging, which is that vaccines can be harmful or that they do not have the desired impact. So there are a lot of different factors that people take into account, but access is probably highlighted more often than downright scepticism about the value of vaccination.

James Roach: To add to Will's point, we try to offer an extensive programme free of charge to all staff working in health and social care so that we can start to make it a bit more everyone's business and get people equipped at every point of contact. As you know, these healthcare professionals are time-pressed and under pressure, so you have to demonstrate the benefit of training. We should promote it as a key part of someone's continuing professional development, a key part of how we want to develop services. Digital training is a lot more effective because people can deliver that in line with their professional obligations, so we need to be flexible in how we offer training. We should focus not only on the clinical parts of that team but on the non-clinical too. Social prescribing in primary care is a key issue. How do we equip our connectors and community contacts to better identify outreach groups and get messages out as well? There has to be a balance around administration, but training people to get out there, communicate and engage is just as important.

Dudu Sher-Arami: There are also opportunities to look at the rest of the public sector in terms of vaccination. Obviously clinical conversations need to happen in healthcare settings, but family hubs, schools and early years settings all provide opportunities to engage with families about health issues, including vaccination. The Government's Best Start in Life programmes and focus on readiness for school fit very well into that sort of frame of work.

The Chair: That is a point very well made.

Q53 **Baroness Andrews:** This is a tough question because you have covered so many different aspects, both very good and a bit worrying, but can you each choose one thing that you think is imperative that we as a committee recommend in our report?

Will Huxter: There are a lot of things to pick from. The way in which we think about the population we are trying to reach needs to change. Baroness Neuberger made the point earlier on about trying to take longer-term views on things and lots of change. A focus on neighbourhood health is an absolute priority in the 10-year plan for what is happening within the NHS.

We need to think about the health needs of the population in the round. Making sure that there is partnership between secondary care, primary care, the voluntary, community and faith sector and the local population is the way in which we need to deliver more and more stuff that is relevant to, and well accessed by, our population. Isolating immunisation separate from the rest of health is not helpful. It needs to be in the round of what is being provided to that population.

Baroness Andrews: We need to make sure that our structures reflect that.

James Roach: I support that. To lift a bit from Will's proposal—this may be easy to suggest but it is not clear that it is the case—does this need to be more of a pan-government endeavour? Health, economy, science, communities and employment are all factors that have worked well previously. I wonder whether we need a clearer pan-governmental department statement and partnership-working approach in relation to the delivery of vaccines. That would ensure that the neighbourhood health approach that Will is promoting had a much clearer steer locally than pushing this agenda. It is not just about health; it is about all those agencies working differently in partnership.

Baroness Andrews: Bigger message, louder voice.

Dudu Sher-Arami: Mine is probably resourcing to enable more focused work in areas of higher deprivation, which is more costly; resourcing for training and making sure that it covers the healthcare workforce who are the vaccinators, as well as the workforce in other public sector organisations as well; and resourcing for engagement because, while there is no silver bullet of an answer to this question and engagement is

certainly not a silver bullet, it is very important for those communities that are furthest from our system.

The Chair: I thank all three of you for your patience with us and all our questions this afternoon. We have learned a great deal from you. With that, I am going to close this evidence session.