



Childhood Vaccinations Committee

Corrected oral evidence

Monday 23 March 2026

3.20 pm

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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. 5

Heard in Public

Questions 54 – 62

Witnesses

I: Dr Tehseen Khan, Clinical Lead, City and Hackney Integrated Primary Care; Dr Zoyah Hussain, Childhood Immunisation Lead, Modality Partnership AWC Division, West Yorkshire.

USE OF THE TRANSCRIPT

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

Examination of witnesses

Dr Tehseen Khan and Dr Zoyah Hussain.

Q54 **The Chair:** Good afternoon, and welcome back to today's meeting. This is the fifth oral evidence session as part of the committee's inquiry into childhood vaccination rates in England. I thank Dr Tehseen Khan and Dr Zoyah Hussain for attending today.

This session is open to the public and is being broadcast live; it will subsequently be put on the parliamentary website and will be accessible to all. A verbatim transcript of the session will be taken and published on the parliamentary website. A few days afterwards, our witnesses will be sent a copy, so, if you need to make any small changes or corrections, please advise us as soon as you can so that we can get it up on the internet. If, after this evidence session, you wish to clarify something or make any further points that are relevant to what you have been asked about today, please send us further written evidence; that will be very welcome.

I am going to ask the first questions. I remind you to introduce yourselves when you answer. What are the key trends and disparities in childhood vaccination coverage in your area, and what are the main reasons for those trends and disparities? When you answer, perhaps you could tell us about whether the different factors that influence childhood vaccination coverage in your area interact, and which ones are the major ones. Where families do not take up the vaccination offer, what reasons do they give when you manage to speak to them? Are there, for example, concerns around the vaccine or problems with accessing services?

Dr Zoyah Hussain: Thank you very much. I am a salaried GP in the north of England; I work in Keighley, West Yorkshire, which is a subdivision of the Bradford district. I work for Modality's Airedale, Wharfedale & Craven division. We are a group of 11 practices that work together as one PCN, and we cover just over 85,000 patients.

Low uptake is consistently seen in deprived, low socioeconomic groups, similar to the population we serve. The main issues are access and engagement. We have addressed this through our pop-up children's clinics and baby well-being clinics. Since 2023, we have been providing these outreach clinics in the shopping centre, where there is easy access—there is a bus stop literally outside the door and there are car-parking facilities. It is also all flat, so those with disabilities or prams can access us.

One key point of what we offer is our walk-in capacity. We offer walk-in facilities, which are great for those young mums who might find access—or trying to commit to a 10-minute appointment at the surgery with a child who might not be as predictable as we would expect—difficult. Having that walk-in facility, taking away that pressure of a time-constrained appointment, has been really pivotal to our success.

Our rates have gone up, whereas, regionally and nationally, rates have gone down.

The Chair: You get to see more patients that way, perhaps, but do you manage to hear from the patients who do not turn up? What are the reasons for that in your area? What is the main reason, and are there any subsidiary ones?

Dr Zoyah Hussain: In the service we offer, we have a team of nurse care co-ordinators who make initial contact with families and parents. If they have any questions or hesitations, they are then directed to me, as the child immunisation lead, so I can make contact with the family. That is often through a phone call, so I can offer that personalised, individualised answer to their questions. If they would like to come along to a clinic, there is no obligation to come with an appointment; they can come to our monthly clinics and ask the questions if they want to ask them face to face.

As for the environment, we offer vaccinations in open cubicle bays, with privacy for immunisation. There are no doors being shut. There is no time constraint. There are experienced practice nurses there to answer any practicality questions, but I am also consistently there as the GP who can answer any questions or hesitations that they might have.

Q55 **Baroness Hodgson of Abinger:** That sounds very innovative. Obviously, it is great for a lot of young mums not to have the time pressure of coming, but do they then have to wait for hours to be seen sometimes?

Dr Zoyah Hussain: No. We offer a three-hour window, so you drop in as soon as you can. We have nurses with available appointments, so it is pretty much instant. We run it out of a hub, within which we have connections with community workers. We are able to offer free baby weighing, so, if they are waiting, they can weigh their child. There is a small play area for children as well, but you typically would not be waiting for longer than 10 minutes.

Dr Tehseen Khan: I am a GP in north Hackney. I am also the clinical director of the primary care network there, which serves around 45,000 residents and encompasses three surgeries.

In City and Hackney, we have one of the lowest vaccination uptake rates in the whole country. A lot of that is due to the north of Hackney, where our MMR uptake, measured at five years, is around 55% to 60%; that is much lower than the national average. If I am honest, a lot of that is because of the north of Hackney skewing the average figure. It can be as low as 30% in terms of timely MMR vaccinations, as well as other childhood vaccinations.

This has been sustained for generations, and there are multiple reasons for that. There has been a WHO study in north Hackney—in particular, in Stamford Hill, where, as you might know, there is a large Haredi Orthodox Jewish community. It is predominately, though not exclusively,

among that community where vaccination uptake has traditionally been low. There are multiple reasons for this. The community is very reliant on itself rather than on statutory services. It has its own faith schools, which generally do not allow access to vaccination services; Will mentioned this in the previous session. That is one of the issues.

Also, health literacy is really poor. They do not have access to smartphones, the internet or traditional media. Therefore, we have to work much harder with that community than with the general population—that is, the non-Haredi community—in trying to get messaging, along with basic health education, across.

We do that by having vaccination co-ordinators. We are very well embedded within the local community and we have the community, the voluntary sector and religious leaders as part of our collective. We coproduce solutions with our community.

The specific issues that mainly mothers come with are that they worry that their child is too young to have the vaccinations at that specific point. Also, they feel that we might be overloading their immune system with too many vaccines. A lot of our approach in north Hackney is, "Let us have a conversation, rather than push you to have a vaccination", because often it is about hearing the concerns and allyship with the parent: "You want the best for your child and that is why you are concerned about vaccination; we also want the best for your child and we may be different in our approaches". As soon as you establish that, it often goes some way to relieving their fears. Then you explain that you are not overloading the immune system, that your child could pick up a toy and put their hand in their mouth and be exposed to millions of germs, and a couple of dead viruses in a vaccine will not harm them.

One of the other cautions is that we often think that a lot of people are hardline anti-vaxxers when in fact a lot of people have perhaps some hesitancy that they want to talk to someone about—hence that offer of a vaccination conversation rather than an actual vaccination. As we mentioned in the last session, that builds trust. A lot of this boils down to trust and relationships between how we as a health and care system are agile enough to meet communities where they want to be met rather than saying, "This is the service and, in order for the service to function, you need to come to us".

We do a regular Thursday community clinic in a Jewish community centre. We also have Sunday clinics as a mainstream business-as-usual. We even go on home visits where there are more than two children. Our lead nurse will go out and vaccinate some children. On average, particularly in the Haredi community, there are eight children per household. Sometimes it can just be the logistics of getting to a vaccination site. We are trying to make it as accessible as possible to try to reduce that barrier. I like the three Cs framework of competency, confidence and convenience. We are trying to make it as convenient as possible for people to come forward and have their vaccines.

The Chair: When you get the opportunity to have those conversations, do you find that quite a lot of parents then say, "Thank you, you've set my mind at rest. I'll go ahead and have the vaccination"? What are the main barriers to having those conversations?

Dr Tehseen Khan: It is interesting. Some of the other GPs and nurses that we have spoken to have said that it might take a couple of conversations. You might speak to them once, the imms co-ordinator might speak to them again, and then on the third time they will come forward and have their child vaccine. I have had very worried parents whom, at the end of the consultation, I have managed to take to the nurse's room and have their children vaccinated. So it works but the barriers are that it takes a lot of time. It is resource intensive. These are not quick conversations. To address someone's concerns does not take five or 10 minutes; it takes multiple appointments to be able to have those conversations.

We talked about the QOF changes. Until recently, QOF locked in inequalities. You can achieve the maximum uptake for a GP practice with minimal effort if you were in a middle-class leafy area where children are bought to have their vaccinations on time versus a really low-uptake area where you cannot just send a text message to the parents. We often have to make multiple calls, which means a bigger team. Resourcing that has always been an issue. Until recently, we have been very lucky with some enhanced funding, which I can talk about, but it certainly takes a lot of time and effort.

The Chair: That leads nicely on to the next question, from Baroness Wyld.

Q56 **Baroness Wyld:** It is just as well that you are so conscientious. You have already started to answer my question, which is focused on core and outreach vaccination services and how you have responded to local needs. I wonder if there is anything you want to elaborate on. Dr Hussain, specifically picking up on some of the things you said, it sounds like it is all working pretty well where you are. Where do you see the gaps? What challenges are you still facing?

To both of you, as a starting point, you have touched on these conversations and how resource-intensive they are but how do you get confidence that the whole team you are working with feels confident enough to have those conversations, particularly when there is a change such as MMRV coming in January and people have to go out and explain that to parents? I would be really interested in your reflections on that within your teams.

Dr Zoyah Hussain: We work in a relatively small team. We have nurse care co-ordinators who are, as I said, guiding patients so that those who want to use the outreach service are able to and those who are happy to come to the practice as standard are also catered for. If they have any questions or queries, they know that they can come to me as the GP and named lead. It is really important for them to have that flexibility, those

options and that openness to be able to reach a set doctor and not wait for somebody who might be on leave or in the middle of a clinic. I have a reasonably fast turnaround.

The fact that we have the monthly clinics means that there is always a go-to. We release the dates for the clinics three months at a time, so that if you cannot make one, there is the next one. We use social media, advertising, posters in our practices and Facebook to highlight our events. We have also been into schools and spoken to parents so that they are aware of the service we run. If there are any questions or queries at the time, we are able to address them. Having a team who are committed and knowing who to turn to are helpful and key.

Dr Tehseen Khan: I agree with all of that. We have multiple enablers in north Hackney. Because we traditionally have additional funding from the ICB, because of our extremely low uptake, it enables us to have a comms and engagement lead who is embedded within the community. One reflection is that when we do community engagement in healthcare, it is often very one-sided: "Let's give some messaging". But what has worked really well with the community engagement manager is the two-way dialogue. What are the insights? What are the parents saying in the communities? What are the prevailing myths that are going around that we can use to adapt our comms?

MMRV is a good example of that. We did a panel where we asked about views and whether people would be more willing to have vaccinations or not. Some of the mothers decided that covering for chickenpox was a good thing. As it happens, that has not affected people so much in north Hackney but it was important to know because, if there was some hesitancy around that, we could have addressed it in our comms to that particular community. Again, it is about knowing the specific channels, as Dr Hussain mentioned, and whether to use a Facebook channel or *Our Haredi Community*, which is a news sheet that comes out every Friday in which we have a regular advertisement that profiles our clinics. We have done Q and As about vaccinations and the myths that might be talked about in the community that we can address. We have also done face-to-face events with the community, which around 100 mothers have attended.

It was highlighted in the past that if you go to a community to talk about vaccinations, people are not necessarily interested, but if you ask people what matters to them, they might tell you that they are worried about mental health or maternity services. We have a very high birth rate. In north Hackney, at any given time, around 12% of the population is pregnant, compared to about 3% for the rest of Hackney. Lots of babies are being born. Are we addressing some of those needs? Then you put in some messaging around vaccinations. We have health fairs at which we will have physiotherapy services, bouncy castles and a bike doctor who repairs children's bikes, but then we will also have a nurse who will talk about vaccines and deliver vaccinations where possible.

That has been the approach that we have taken over the past few years in the north Hackney model and it served us well in the recent outbreak last year when around 200 children had measles, because we had those established relationships. The other thing to mention is what that close, collaborative relationship between primary care, public health, UKHSA, the community and the voluntary sector enabled. When we heard about the first measles case last May, we heard about it on the Friday and, by the Monday, we had set up daily clinics. By the Sunday, we had seven nurses running a full-on Covid-style vaccination centre. Between May and July last year, we managed to deliver 2,500 vaccines to the community as part of that outbreak, which no doubt blunted the number of cases of measles.

So, again, this goes back to trust and relationships—not only relationships between team members, healthcare and social care but relationships with the communities that are, and have traditionally been, underserved in our neighbourhoods.

Baroness Wylde: Thank you; that is helpful. I was going to ask you about your response to the measles outbreak and the lessons you have learned but, obviously, you have touched on that. The big question, I suppose, is: how do you get sustainable rates of vaccination? It sounds as though you responded very effectively, and there are lots of different programmes within that, but, equally, you have touched on all the challenges that you face. Do you feel that you are getting closer to making progress?

Dr Tehseen Khan: It is really difficult. We know that community approaches vary. In Enfield, the response was slightly different, but, in the community in north Hackney, although people may be reticent to come forward for vaccines at the right time, as soon as there is an outbreak, they come forward and reactively get vaccinated.

When I first started working in Hackney in 2018, we had a measles outbreak then as well. The challenge is: how do you shift the mindset from being reactive to being proactive? The community, the voluntary sector, resident groups and religious groups can unlock the answer, I think. The closer we work with them, the more effective our comms are—as are our health literacy and health education for families and parents.

It will take time—it will take a generation rather than happening overnight—but I am always an optimist. I think about the conversations that I am having despite our data going up and down. Since Covid, our vaccination rate had gone down, but, because of the outbreak, we managed to increase it again. I remain optimistic. At the moment, we have the right structures, the right kind of people and the right training being given to people such as our recallers and our nurses so that they can have these conversations.

Obviously, there are concerns around the sustainability of all that, because we have been relying on annual funding cycles, and things are being cut at the moment. So we are not sure whether that service will continue. If it did not, I would be worried about what will happen to the

vaccination rate in north Hackney and what will happen in potential outbreaks, which are not, as you know, confined within borders; they would spread across London and across the country.

Baroness Wyld: Do you agree, Dr Hussain? Are you optimistic that rates can improve?

Dr Zoyah Hussain: I am optimistic. Our rates have been improving. In 2023, uptake of the first MMR was at 78% by the end of the year; according to the data from February and March, it is now at 88% in 2026. It was at 84% in 2023 and we are now at 87%. Although that percentage increase may not sound significant, the amount of work is. It is evidencing the fact that this outreach is not just community-focused: we are working with our community partners, but we also have a communication, innovation and development lead who is making those connections in communities with local maternity circles, which are a family service, as well as with charities, the voluntary sector and the care sector.

Every year, we all come together during National Baby Week and do a big event; we have dressed-up characters, and we really make it family-friendly. We also have dieticians and health visitors there, offering a one-stop service for mums and parents. That has been really key, because it is not about just one component. It is not about general practice just delivering immunisations; we are looking at child health holistically. We are providing free baby-weighing—that is, providing the device and the service so that people can just come and walk in. We have had up to 12 walk-ins for immunisations, and that is not including for advice at our clinics.

The fact that our rates have been going up consistently over the past three years shows that this method of delivering community-based healthcare, which is what the neighbourhood plan wants, works.

The Chair: Are you aware of any ways of disseminating that best practice across the country?

Dr Zoyah Hussain: I hope that this channel is one of them. We have been working locally with the Born in Bradford team to try to increase uptake regionally as well. I would be grateful for any other opportunities that come forward to take this on to a more national level.

Q57 **Baroness Ritchie of Downpatrick:** Dr Khan, your primary care network in Springfield Park has developed a range of outreach services for the local community, including walk-in vaccination clinics on Sundays, a community clinic on Thursdays, a domiciliary offer, community events, culturally tailored communications, the recruitment of a recaller from the Orthodox Jewish community and an additional full-time nurse. Having done that work, what do you think were the main barriers to developing effective core outreach childhood vaccination services? What would be the best way, considering your experience, of overcoming these barriers?

Dr Tehseen Khan: It is about having a long-term vision for the service. When we first start doing pop-ups—I remember this from the Covid response in particular—a couple of people will turn up when you do the first one, then five people might turn up when you do the second one. However, this goes back to the point about trust and relationships. Being there on a Sunday and having the practice—or a couple of practices, as in our case—open addresses the confidence issue. So I do not see a dichotomy between access and confidence. If you make things more accessible, you improve confidence in vaccinations as well.

It is about having a long-term vision and being patient around outcomes; looking at how we measure success is also important. As I said, it may take multiple conversations to convert someone to having their children vaccinated. If we measure only vaccination uptake, that will do a disservice to low-uptake areas such as mine, because we probably will not get to 90% for a very long time; I remain hopeful that we will do so one day, but it will take a long time because of the figures I told you about.

Also, when we talk about commissioning, in particular the commissioning of services, it would be really helpful to have a longer-term, multi-year contract—QOF is going some way to addressing that now—where there is payment as a result of increases in vaccinations, rather than the overall uptake. We know that QOF is not enough, though, particularly for very low-uptake areas; that is why we have had additional funding from the ICB. It is about having a longer-term, multi-year contract in which a whole host of metrics are measured—including conversations and vaccine readiness rather than just, ultimately, having a vaccination.

We are doing a study with Dr Kasstan-Dabush from the London School of Hygiene & Tropical Medicine; he gave evidence to you last week. He is doing a study in multiple areas, including Stamford Hill; it is one of the things we are looking at on how we can improve further. Having that academic partner is really helpful in trying to make things even better in future and, going back to the last question, in cascading this learning further than just Stamford Hill and north Hackney.

Baroness Ritchie of Downpatrick: Dr Hussain, both in your recent article and today, you have referred to the fact that you run the Modality children's clinic, where you offer both drop-ins and pre-booked child immunisation appointments. In your opinion, what would be the best way of developing core outreach childhood vaccination services and overcoming the barriers?

Dr Zoyah Hussain: It is about engaging the target audience and how we can do that. Is the language appropriate to the demographic? Is it simple to read? Do they know where they are going? Is it somewhere they are familiar with? It is about making sure that we look at the crucial elements of engagement. Why is there poor engagement? Is it because we are just not advertising in the right areas, or is it because they do not consistently see a familiar face with a consistent message?

Is that message evidence-based? That is what we are doing as health professionals, but are they relying on anecdotal information from friends and family who might not be medically trained, or looking at social media, TikTok or YouTube videos that encourage vaccine refusal? The information we are giving, and how we are delivering it, is important. It is great to have national incentives, but we have found that looking at what the local community want, listening to their voice and taking the time to hear their needs really helps to alleviate any barriers that become apparent.

Baroness Neuberger: I have a quick follow-up. What you have both said is fascinating. You have talked about faith leaders in communities being important. What about actual health professionals from within those communities? We have not talked much about that. For instance, in the Haredi community in Stamford Hill, where you have those ultra-orthodox doctors, does that help? Is there a way of making an alliance with them? I am wondering how you navigate that.

Dr Tehseen Khan: It is helpful that Dr Opat, in one of the three practices in Stamford Hill, is from the community and is very strong with his messaging. It is interesting; he takes quite a hard-line approach with some of the messaging; for example, in their waiting room there is a quote saying, "You can't vaccinate a dead child". For some communities you can have soft messaging, but, for some communities and some people, that hard-hitting fact can help. A lot of people think measles is a very mild illness from which they will recover and it is just a bit of a rash, not knowing that one in 20 people will have potentially life-changing complications. Again, exactly as Dr Hussain said, it is about tailoring the message. Who are the group in front of you? That is where insight gathering is really important, so that you can then tailor that message.

On healthcare professionals coming from within the community, it always helps to have people who look like you delivering that message and being part of that broader coalition. Our comms often have Dr Spitzer or Dr Opat signing them off to potentially get more buy-in, as well as the director of public health and myself as the PCN clinical director.

Baroness Hodgson of Abinger: If you have patients who are hesitant or concerned, would you split some of the vaccines that are delivered for multiple conditions? Would you offer patients to come two or three times instead of having the vaccines all at once?

Dr Zoyah Hussain: It is important to have that conversation. For some parents, splitting the MMR—typically the one that there are concerns about—is enough to incentivise having the vaccination.¹ For others, it helps when you reframe it: "Do you want to bring your child three times? Do you want them to be grumbly during each interval between visits?" It is about education and understanding what a vaccination actually is. Just providing that baseline medical information is enough to explain why we

¹ Note by the witness: This refers to offering the Measles, Mumps, and Rubella vaccinations separately which typically would be over three appointments.

have the schedule—why it is this way and why multiple vaccinations are given at the same time. Education is the key point to address that. If indeed they need three separate appointments then we are able to offer that with our walk-in service, but we also offer them appointments at the surgery. If they want to come to the walk-in to get their queries answered and then attend a nurse appointment at the practice, we are able to facilitate that and provide that appointment there and then. There is no “I’ll get back to you”.

Q58 **Baroness Hodgson of Abinger:** This question is about who is responsible and accountable in your area for improving childhood vaccination coverage and reducing disparities. How effective is the leadership and co-ordination? Thinking about the wider NHS reforms, what are the key opportunities and risks in the delegation of responsibilities for commissioning vaccine services in the ICBs? How should opportunities be realised and risks mitigated?

Dr Tehseen Khan: Will mentioned that NHS England has overall responsibility, but we in north Hackney have a very collaborative approach to our service. As I mentioned, I am the overall clinical director for the North Hackney Enhanced Immunisation Service, but we have good relationships with the public health consultant, Dr Carolyn Sharpe, and, through her, the director of public health, as well as then linking in with the UK Health Security Agency. Because of the unfortunately frequent vaccine-preventable disease outbreaks, we have quite close relationships with the UKHSA as well. We also have Interlink, the main umbrella community voluntary sector organisation from the Orthodox Jewish community, which is part of that leadership group at neighbourhood level. It is very much a collaborative approach.

The vaccination landscape is really complicated. Different parts of it are delivered by many different players. We have not even mentioned the schools-based service, which is another complexity to add in. In the past, without that collaborative approach, we have failed in addressing our response. For vaccinations, having that close relationship between primary care, public health, the community and voluntary sector and school-based services is really core.

On ICB commissioning opportunities and the ICBs changing to a strategic commissioner, we are hopeful that there will be more equity across the system and tailoring to local needs. However, that is a bit of a double-edged sword. Previously, for example, when we were the City and Hackney Place-based Partnership, we had autonomy, and we were always able to fund the additional contract for childhood immunisations because of the low uptake. However, when we became an ICB, we inherited debt from all across the system—from the seven places within the ICB—and suddenly our financial situation was completely different. City and Hackney does not have the autonomy to be able to continue the service; it has to be the ICB, which of course is looking at lots of hotspots of low uptake, so there is a finite amount of money. I can see the rationale from their perspective—they have to think about Tower Hamlets, Newham and Redbridge as well as City and Hackney. So there are concerns. Although,

being a strategic commissioner, they will have an oversight of some of the hotspots, we know that the funding situation is limited, and that finite money will unfortunately be stretched thinner.

On opportunities in future, we are at a new point with NHS England being combined with the Department of Health and Social Care, as well as the cuts to the ICBs. We have mentioned it a few times, but the neighbourhood model is the real vehicle into the future about how we deliver services. That makes sense because neighbourhoods are small enough to tailor to local needs but big enough to scale up actual interventions. It must be collaborative. That is kind of what we have been doing—it is not necessarily an innovation for City and Hackney because we have been working in a neighbourhood model since 2018—but I am hoping that the funding will be protected via the neighbourhood model. If we are talking about large footprints, we should think about levelling up to those areas that have traditionally had more funding because of low uptake, rather than levelling down because the funding is not there.

Dr Zoyah Hussain: You have put that really comprehensively. In my opinion, the responsibility is shared across GP practices, the ICBs and the public health teams. Primary care is delivering the service but the collective responsibility and accountability are across all areas. Clear local ownership and having a shared focus and a common vision or goal are really important so there are clear frameworks for what we are trying to achieve. Accountability with strong leadership is key as well. Those would be my salient points.

Q59 Lord Dholakia: Dr Khan and Dr Hussain, you both come from areas of very high settlement of diverse communities, Hackney and Keighley. How would you use the funding arrangements to reduce the disparity in childcare vaccinations?

Dr Zoyah Hussain: I work at Modality Airedale, Wharfedale and Craven, and we cover Skipton in North Yorkshire, which is relatively affluent—it is often in the news about being a nice, or even the happiest, place to live—and Keighley, which is just around the corner but has a completely different patient population profile and uptake. It is important to target your audience correctly and use the correct terminology, language and outreach methods. We have variability in our populations within a small area of just a few miles, and the key is being really targeted in who you are trying to reach and what message you are trying to deliver. Across the two towns there are very different messages. How you portray that message is important, and that has been the key to our success in bringing up our rates in Keighley. We are able to focus on what the community needs, and we listen and adapt to what they are saying. Over the last three years we have changed our message and our text invites, and we are responding to the feedback we are getting. That has been essential to our work.

Dr Tehseen Khan: I agree with everything that Dr Hussain has said. We have mentioned sustainability of funding and long-termism. I cannot remember the last time we had a contract that was longer than a year in

the NHS, whether for primary care networks or the enhanced funding that I am talking about. I have had emails for the last few weeks from our EMS co-ordinator asking me whether she will have a job at the end of this financial year, because we do not know whether the funding is going to be there. You cannot really run a service like that. Particularly where you have built relationships and trust, it is really destabilising to have to go through that cycle every single year, so much resource is spent in trying to build up business cases. Of course we need to know that the service is working—evaluation is important, and I am not saying it is not—but having a longer cycle, perhaps three years or even five, would be really helpful. That would be great. Ring-fencing that funding is important for equity.

We have to look at particular health inclusion groups where we know there is really low uptake: particular religious groups or Traveller communities, for example, or geographical areas where there is particularly low uptake. We have to be equitable with the funding and say, “There’s a higher need here because of the increased recall”—we mentioned the number of conversations we have to have—whereas in other areas you do not even necessarily have to try. So having a look at how we can be fairer with the funding would be helpful.

I mentioned incentive payments, which QOF is trying to address, slightly. We are rewarding GP surgeries that improve their uptake rather than looking at an absolute 90% or 95% uptake. Of course that is where we would all like to be, but that does not necessarily reward good behaviour within health systems.

Q60 The Chair: What are the barriers to the development and deployment of effective data systems? How do you think those barriers could be overcome?

Dr Zoyah Hussain: I think my message has been quite consistent throughout: it is about a community-based approach where you are addressing online misinformation that parents have come across, and the message is consistent, clear and at the right level. We must try to address historic distrust among communities, looking at and using the learning from Covid to see why there is hesitancy. What is the underlying reason? If you are able to address the question of why, you will be able to implement positive change. That has been crucial. Another way in which we have dealt with barriers is by using local clinicians and trying to make it a really local service so that we have a consistent face with a consistent message. That has been key to maintaining trust.

The Chair: In the services that you deliver, whether in a supermarket or a clinic, presumably the information that the patient has been vaccinated goes on to your system. That is not a problem. What about the hospitals in your area—A&E departments or the paediatric department? Do you have any difficulty in getting that information from them? If they do a vaccination, can you get it on to your system?

Dr Zoyah Hussain: We all use SystmOne. We are able to see the same information, so they should be able to see the vaccination record whether you are at the GP practice or sat in A&E. There is a consistent approach there. We use it to make sure the red books are up to date. If a parent turns up without a red book, we are all able to retrospectively update that so they have that information with them. All of us using the same system has been really key. There are no concerns about missing information.

The Chair: It sounds as though you are lucky in your area. We are hearing that in some areas there are systems that do not talk to each other. What happens for you, Dr Khan?

Dr Tehseen Khan: GP surgeries have the same record system—ours is EMIS—so within GP surgeries it is not so much of a problem. However, where you have schools-based providers, the data does not always flow in a timely way. As we have mentioned, London has a very transient population, with people coming from abroad. How do you convert that data into a GP record, and who is it viewable to?

Things are improving all the time. We now use HIE, which allows us to look at secondary care data, while secondary care services can look at primary care data. That is definitely better than it was five to eight years ago. There are also innovations, such as population health management tools that extract data from lots of different services such as primary care, secondary care and even social care. So it is an area that is improving, but is it perfect? Definitely not.

There is also the issue of list cleansing when people move away. It works slightly differently for children because we always err on the side of caution of keeping them registered until we know they have definitely moved away, because obviously we would not want any child not to have GP registration, but then that might affect uptake levels as well. So there is an issue with data accuracy. I went to the London Immunisation Board for a presentation by one of my colleagues about some of the improvements that are happening and planned around this. Then there is a separate information system, CHIS, which writes to the GP surgery. There is a complex network of different data systems that could probably have better linkages and interoperability, which could then potentially improve our uptake without us even doing much. If we had cleaner data then it might show that our uptake was better actually than it seemed.

The Chair: When you know where your patients are moving to, are you able to transfer the information to their new GP without difficulty?

Dr Tehseen Khan: Yes. That works.

Q61 **Lord Randall of Uxbridge:** What are the main barriers to sustaining public trust in childhood vaccinations, and what would be the best ways to overcome them? We have heard about the importance and influence of healthcare workers. Could more be done on training and so forth? I have another question. There is information nationally—I have just been

seeing some TV adverts—but how effective is it with those hard-to-reach communities? Do you get people coming into your GP surgery saying, “Well, I wasn’t thinking about it, but I’ve just seen an advert and I think I’d better get my kid immunised”?

Dr Zoyah Hussain: Putting the thought in parents’ heads is really important, and if that is through national campaigns in the media, then great. If they come and ask that question then we can use that opportunity to provide a personalised or individualised answer. We found that it is more vaccine hesitancy, and having the chance to ask their questions turns that hesitancy into a successful immunisation. Differentiating between vaccine refusal and hesitancy is important. Not marking a child as refusing all immunisations but giving the opportunity to have that conversation when it is next due, and revisiting it, is crucial.

Then how do you deliver that information? If your population cannot read English then providing resources in English is not helpful, but using different languages can be helpful. We should use simple English. The average reading age in the UK is around age 10 or 11. If we are using complicated words that they are not able to understand then we are not delivering the right message. Being adaptable is really important.

Lord Randall of Uxbridge: Is there anything one can do about misinformation now that things have changed, including social media? Is there anything that you can see that could be done on that?

Dr Zoyah Hussain: Yes: using health professionals, or guiding parents to health professionals, to get their information. There might be health professionals on social media, but look at who you are listening to. What are their credentials? Do they have the training and the appropriate degrees or qualifications to give you that information? Or is it opinion? Deciphering the difference between personal opinion and anecdotal evidence versus evidence-based medicine and years of research is important. Once people can identify the difference, they will go to the right channels.

Lord Randall of Uxbridge: Do you think the rise of social media is an increasing factor in hesitancy or refusal?

Dr Zoyah Hussain: It gives misinformation a platform, but at the same time health professionals and doctors are on social media advertising the right message. So it can be a double-edged sword, and how you want to use it is at your local discretion. We use social media to advertise our services through Twitter and Facebook, and it has been really helpful. There is scope for opportunity there.

Dr Tehseen Khan: Again, I agree. Social media gives a platform to fringe ideas that previously would not have seen the light of day, so it is challenging. There is definitely a role for health professionals, particularly in how we address vaccine hesitancy and low vaccine confidence for underserved communities.

We should think about motivational interviewing, using Making Every Contact Count and making sure that it goes beyond just clinicians. It is even about the receptionist seeing a parent bringing in their child and seeing that flag. Are they confident enough to have that conversation as a clinician? Are we providing that training as a health service for our wider team beyond clinicians? That would definitely help.

There is also something around cultural competence, knowing who the different communities are within your neighbourhood and what works for them. I keep coming back to this, but we need the insights from those communities about their main motivating factors and their barriers. We should also be mindful, when we talk about the Orthodox Jewish community or the Black community, that no one community is a monolith. There is so much diversity within communities that, while our approach needs to have awareness of that particular community, it needs to be tailored to the person in front of us.

Beyond that, what is even more effective is using community champions and people from within the community to be influencers. Some great work has been done on the London level with pastors talking to their congregation, particularly for the Black African churches, about the Covid and flu vaccines. An authority figure like that has much more sway over someone than I ever will as a GP, as much as I would like to have more sway. Identifying who those community influencers are and equipping them to have those conversations will spread that message and go some way to helping us to counter some of the threat from social media.

Baroness Wyld: I would like to understand a bit better how this works in practice. When you are working with community champions and leaders, would you equip them, for example, with a knowledge of why it is safe to have an MMRV so that they would have the confidence to put that message out if asked?

Dr Tehseen Khan: Yes. We have done things like motivational interviewing training. Obviously there is a limit to what information non-clinical people can give you.

Baroness Wyld: Yes, that was kind of my point.

Dr Tehseen Khan: But that is where the tiered service comes in, as Dr Hussain said. Certain questions can be handled by them, such as, "What are the common side-effects from vaccinations?" It does not necessarily need a clinician to answer that question. However, when someone asks, "What are the ingredients of the vaccine and how will they affect my child?", that goes on to tier 2, which is a clinical conversation with a nurse or a GP. So we have that established way of doing it, which we also do routinely with our recallers who are non-clinicians. They will escalate any clinical questions to our nurses or GPs.

Baroness Wyld: That is really helpful for understanding how the process works.

Dr Zoyah Hussain: It is more of an advocacy role rather than a clinical information role.

Baroness Wylde: So they will give a basic overview and be able to refer—well, not clinically refer, but say, “Speak to the GP”.

Dr Zoyah Hussain: When we do our outreach events at a community centre, mosque or local school, the clinician goes along, and that clinician is me. Having the community workers or the person who runs the centre advocating vaccinations, and then I am there to give the actual clinical medical opinion, works really well. That is how we have run our service, and it has been effective.

The Chair: When you are answering questions, is it more about safety, is it about effectiveness—“Does it really give protection?”—or is it about necessity: “Why do we need this? We don’t have whooping cough or polio around here”? What are the main areas where people are asking questions?

Dr Zoyah Hussain: It is about understanding the immunisation schedule and what the conditions are that they might never have heard of. When you mention chicken pox, there is a bit more awareness—parents have seen or heard about it—but if you mention diphtheria then some people might have never come across it and do not even know what it is. I find that it is about basic education about what these conditions are and what a vaccination is—a weakened or dead form of a virus. Explaining that in layman’s terms has been pivotal.

The Chair: Do you agree, Dr Khan?

Dr Tehseen Khan: Definitely. It is about having a broad-based education around how vaccinations work, but also about being balanced. People do not like it when you just talk about how amazing vaccinations are. We also have to say, “You know what? Your child will probably be cranky for a few days or get a fever. They might be under the weather. You might not like it as a parent. They might be up at night”. Having balanced information is important for parents.

Q62 **Baroness Browning:** You heard us ask the previous panel this question. Could you both please give us your priority that you would suggest we recommend to Government when we produce our report?

Dr Zoyah Hussain: Investing in outreach, not just core services, and trying to deliver the community aspect of the neighbourhood plan would be my key salient points, along with trying to improve recall systems, improving data quality and usability and trying to support local community-based initiatives rather than one national campaign.

Dr Tehseen Khan: I have similar themes. As we have mentioned, protected recurrent funding for a longer cycle would be really valuable to maintain services to help to secure staff and to help with training. We have talked about better data; interoperability between the different services would be really valuable.

Then there is community engagement and community trust. People from the community voluntary sector, when they come into meetings, often say that they are forgotten about when it comes to health and social care, yet they are the people who are closest to our community. They need to be funded properly to be able to give us insights but also to disseminate our information, because we cannot really do it without them. We should prioritise the role of the community and voluntary sector.

Agility and flexibility of approach are also important. We know that “one size fits all” does not work across an ICB. It is important that we look at those pockets and use the insights to tailor our approach to that particular hyperlocal area in addressing low uptake generally, as well as the question of what might work in a community, such as in north Hackney, if there is an outbreak. Local flexibility would be really important.

The Chair: Thank you, Dr Khan and Dr Hussain. We have heard about a lot of challenges but a lot of very good practice too, and we thank you both for that. That brings us to the end of the session.