HOUSE OF LORDS

Childhood Vaccinations Committee

Corrected oral evidence

Monday 20 April 2026

2.10 pm

Watch the meeting

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

Evidence Session No. 8 Heard in Public Questions 84 – 96

Witnesses

I: Dr Katie Bramall, Chair, General Practitioners Committee, British Medical Association; Kim Ball, Professional Lead Primary Care, Royal College of Nursing; Professor Victoria Tzortziou Brown, Chair, Royal College of General Practitioners.

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 Katie Bramall, Kim Ball and Professor Victoria Tzortziou Brown.

Q84 **The Chair:** Welcome to today's meeting. This is the eighth oral evidence session as part of the committee's inquiry into childhood vaccination rates in England. Thank you to Professor Victoria Tzortziou Brown and Dr Katie Bramall, who are joining us in person, and Kim Ball, for attending online. The session is open to the public. It is broadcast live and subsequently will be accessible on the parliamentary website. A verbatim transcript will be taken of the evidence. It will be published on the website. A few days after the session we will send it to our witnesses. If you have any small changes that you need to make, please advise us of that. If, after this session, there is anything further that you would like to tell us—any further evidence or to amplify a point that you have made, please feel free to do that.

I will ask the first question. How effectively do GP practices deliver core childhood vaccination services, and how has it changed over recent years? What are the main challenges for effective support and delivery of these programmes? What would be the best way to overcome the challenges?

Dr Katie Bramall: Thank you very much. I trained at University College, London, qualifying in 2003. I then undertook obstetrics and gynaecology and general practice training in London, qualifying as a GP in 2008. I subsequently worked in Haringey and Hackney before relocating to Hertfordshire. I am the Chair of the British Medical Association's General Practitioners Committee England and General Practitioners Committee UK.

On how effectively general practice delivers childhood vaccination services and how it has changed, the answer is very effectively with regard to the paucity of investment, but it could and should be so much better. Practices are reimbursed via an item of service arrangement. That £12.06 covers the jab. It does not cover the job. General practice is the backbone, but it is being asked to carry the whole system. A routine childhood vaccination is absolutely bread-and-butter general practice. It works best when general practice is properly resourced to do what we are designed to do—continuity of care, trust, systematic follow-up.

At present we are relying on that backbone while progressively weakening it. We remain the most trusted source for parents. We know that coverage declines with system strain. It is not a sudden loss of confidence. We know that we are not going to fix coverage without stabilising general practice capacity. It is not primarily a hesitancy problem but an access and follow-up problem. Most parents are not anti-vaccine. They are busy, they are mobile, they are navigating an NHS system that too often fails to pull them back in.

For example, the drop-off between dose 1 and dose 2 in MMR is a system failure. Missed appointments are not chased consistently any more.

Families fall out of system during house moves, deprivation—very challenging, chaotic lives. The bottom line is that if you make it easy and persistent, most people will vaccinate. That is how we can see the damage to continuity of care. The damage to investment has seen that fall off in terms of successful vaccination campaigns.

We cannot keep adding expectations, be it outreach, follow-up or data cleaning, without adding capacity. Our practice nurses are already stretched. Administrative time for recall and chasing is underestimated. Recruitment and retention matter here just as much as they matter in hospitals. It is not that we do not want to do it. It is not that we do not want to prioritise it. It is a fundamental basis of general practice and health promotion and prevention in the community. That is one of the most important things that we do. Yet NHS England's vaccination strategy since November 2023 has been to fragment vaccination and prioritise delivery at a community pharmacy level. In England, we need to reflect on the learning from Scotland and their 2018 general practice contract, which took vaccination away from practices and gave it to health boards to deliver differently. It has failed. Ever since 2019, they have been trying to put it back into general practice. We need to learn and reflect on that in England.

The Chair: Thank you. We will look into all those issues a little further as we go along.

Professor Victoria Tzortziou Brown: I am a GP in Tower Hamlets, east London, President of the Royal College of General Practitioners and a Professor in Primary Care and Health Policy at Queen Mary University of London.

I agree that general practice is the backbone of childhood vaccination delivery in the UK. Delivering routine immunisations within general practice is supported by the registered patient list system, which enables us to systematically track children, identify those due or overdue vaccinations and run proactive call and recall systems. This population-based approach is a major strength of the model, allowing for organised, equitable and cost-effective delivery at scale.

Historically, this system has performed very well. In the late 2000s and early 2010s, the GP-led model came very close to achieving the 95% coverage target for several routine childhood vaccines. That level of coverage reflects the effectiveness of a system built on continuity of care, comprehensive records and trusted relationships with families.

Another example of very high performance was during the Covid-19 pandemic, where the National Audit Office found that GP-led and community services delivered around 71% of the Covid-19 vaccinations, which significantly exceeded the 56% which was initially planned. That programme showed very good value for money and was delivered efficiently with low levels of wastage.

However, performance is now under increasing pressure. Recent data shows that coverage across the routine childhood vaccination schedule has fallen below the 95% target. We have particularly low uptake for second doses of MMR and the pre-school booster. This represents a sustained decline over recent years. It is important to emphasise that this is not a failure of the underlying model but rather the result of the growing system pressures—including the workforce constraints and the widening health inequalities.

In summary, the GP-led model for childhood vaccinations is fundamentally strong with a proven track record of high performance. The challenge is not redesigning that model but ensuring that it is adequately supported to meet current demands and reverse the recent decline in uptake.

Kim Ball: I am the UK Professional Lead for Primary Care at the Royal College of Nursing, and I am a general practice nurse by background. I also hold other roles, including Director of Nursing at Avon Local Medical Committee, and I am an immunisation trainer as well.

I agree with lots of the points that have been raised already. It is pivotal that the workforce is at the heart of immunisation delivery, and our general practice nurse workforce is absolutely critical to immunisation delivery success. We know that parents, as Katie has mentioned, favour general practice. In fact, in a parental attitudes survey undertaken by the UK Health Security Agency, 81% of parents agreed that general practice had the right facilities to deliver it. Moreover, what is more important is that 67% of parents said that they would prefer to take their children to general practice as opposed to another healthcare setting. We have to realise that, as Katie has mentioned, this is much more than a jab—it is a conversation; it is continuity of care. As a general practice nurse myself in the past, I have built long-standing relationships. Every conversation matters.

Some of the challenges we have in primary care are capacity and access. It is really challenging to have meaningful conversations about immunisation, how vaccines work, what is included in the vaccination, trying to alleviate any parental concern, and trying to offer reassurance and safety netting with small appointment times and competing priorities within general practice. Our general practice nurses are not solely focused on immunisation. Like GPs, we see anything and everything across the whole of the life course. Although immunisation is big part of our role and we are experts within it, we need to appreciate that those competing priorities can be really challenging.

With our workforce in general practice, we are really struggling at the moment. We are not included in the GP contract. Therefore, unlike in areas such as secondary care, many general practice nurses will not have access to equitable pay terms and conditions. That is really key, because we want nurses to work in general practice and to become expert in immunisation. However, if we cannot retain them because general practice is not receiving sufficient funding to meet the same offers that

are being offered in other health areas, how are we expected to retain that workforce? There is an absolute desire for that workforce to stay. However, the survey data completed by Nursing in Practice recently has shown that a large number of general practice nurses intend to leave. It is a retiring workforce, and many young people do not consider it as a first-stage career. We need to really focus on the workforce if we are ever going to have a successful vaccination programme.

Q85 **The Chair:** Thank you very much. I am glad that you mentioned training; we will have a question about that from Lord Randall a little later. A couple of you have already mentioned, which we have heard before, that the most trusted person for information on vaccines is the GP. Yet GPs do not often deliver the vaccines themselves—it is done by the GP practice nurse or somebody else. Could you just say whether many people will actually ask for an appointment with the GP to ask questions? If so, is the GP able to give that time?

Dr Katie Bramall: I am happy to come in here. Capacity is enormously stretched. We see in England the equivalent of one in two of the population every single month, so 33.5 million appointments took place last month, and it was very similar for every previous month. Our demand has risen extraordinarily post pandemic, and this Government have put in a contract with unlimited uncapped online requests, as well as telephone. We are now therefore having to deploy GP face-to-face appointment time away from patients and to triaging hundreds of online requests. One example I got last week was, "I'm at a pub quiz—how many bones are there in the human body?", and we are contracted to respond.

The capacity of the conversations that we want to have is under a lot more strain than we would like it to be. Nevertheless, when we see patients—predominantly it will be GPs who see acute illness in under-fives—very often it is a great opportunity to connect with parents, to explore their ideas, concerns and expectations, to reassure them about mild respiratory viruses, for example, and to have that conversation: "I notice that you are overdue the vaccination. Is there anything you are worried about there?" There might be lots of experiences.

For example, pregnant women, as we have seen and learned from the Covid inquiry, are not involved in trials of novel medications and novel vaccinations, for very good reason. However, that sometimes puts into the public consciousness that "this is not going to be safe in pregnancy so how is it safe for my child?" There is a huge amount of disinformation that is in the public domain now that we are not rebutting strongly enough as the NHS. There is a responsibility on us to do that and to have much more public messaging.

When we do see patients, we can have that possibility. It will normally be one of a number of questions in a consultation, but we recognise its importance. For example, the recent meningitis outbreak in Kent saw a huge, rapidly deployed vaccination programme across the practices. We might not be delivering the vaccination—we leave that to our wonderful

practice nurses—but, for example, with seasonal vaccinations such as Covid and influenza, we are very much focused on delivering the flu vaccine to many thousands.

The point here is the value of continuity of care. The Health Select Committee's report on the future of general practice was published in September 2022. Sadly, this was about a day before Her Majesty passed away, so it got lost in the media. It had some wonderful analysis around how to better equip the country for vaccination uptake, how to do call and recall better, how to rely on general practice and to see what has been peeled away in years of commissioning. It is not rocket science. We got it right. We just need to go back to where we were.

The Chair: It sounds as if we ought to read that.

Dr Katie Bramall: I would highly recommend it.

Professor Victoria Tzortziou Brown: It is very much opportunistic conversations that we have with parents, but it is the GP who does the baby checks. Those times present a fantastic opportunity to discuss vaccinations. However, I agree that it is all about capacity and the time to have these conversations about proactive preventative care.

Q86 **Baroness Andrews:** My general question picks up on what Katie said about the increase in demand—not the triaging and the online systems but the increase in demand post Covid. Has there been post-Covid awareness of RSV infections, or has something else been happening as a result of the general anxiety that Covid created? I am just wondering whether there is something to be unpicked from that. My second question is about the nature of the conversation. You are quite right; it must be very frustrating for GPs and general practice nurses not to have the time to have that conversation about the child's care as a whole and where vaccination fits in. However, it can be more than opportunistic. When they do turn up for their first booster, are parents told that it will be the first of a series? Do they internalise that one vaccination is insufficient—that it must be a series of consistent effects?

Professor Victoria Tzortziou Brown: Regarding whether there is increased anxiety post Covid, mental health issues such as anxiety have increased since Covid but there is a lot of complexity. There are multiple reasons why demand and need have increased. Partly it is because we have an ageing population, increasing complexity and multi-morbidity to deal with.

On whether these conversations can be more than opportunistic, the baby checks offer a consistent opportunity to have these conversations. When parents attend for the first vaccination, they are usually told that there will be a follow-up vaccination. Sometimes they are given the date for the next vaccination date as well, because it is easy to predict when this is coming up. Yes, we are having these conversations. Our practice nurses are also very well trained to have these conversations with parents.

Baroness Andrews: But the follow-up date would not be automatically given in each case?

Professor Victoria Tzortziou Brown: It depends on the date. If it is relatively soon, it can be planned.

Dr Katie Bramall: In many cases, there are months of interval between the vaccination schedules. Appointment rotas may not be on, because we might not be able to predict who is going to be around that week, for example. We are quite small organisations. We are not able to do that. We have been relying on SMS and other online messages but unfortunately, so many ICBs are now cutting SMS funding. If practices wish to continue with text messages, they are much more valuable because a lot of families do not have affordability for smartphones. They may not speak English as a first language. People forget this. A text message is a helpful, simple message. We have got to look at that 10% to 15% who do not come back.

On what you mentioned about the complexity in demand, that is a point that is very well made and, as Victoria said, is multifactorial. However, we must also recognise that there are still 7 million patients on hospital waiting lists. Their throughput has not increased. Every patient that is waiting to see secondary care keeps coming back to their GP. We keep trying to manage the deterioration in their symptoms with medication and with other investigations. Sometimes there is nothing that we can do but hold their hand, metaphorically. That is a huge demand. That is the iceberg under the waves that we are managing. It probably is the case with many of the roles in this room that 80% of your caseload is probably 20% of your cohort. You are trying so hard with some extremely complex cases or complex families with immense need to do the very best you can to keep them out of hospital, to keep children out of harm. That takes up a disproportionate amount. We are made to feel that we must ration care.

When it comes to vaccination, we have got a fork in the road around the 2026 commissioning changes. We have got delegation to ICBs now. That could improve local ownership or make variation worse. It is the variation in deprived communities that worries me. The risks are around fragmentation, loss of national consistency, and weakened public health input. The opportunities are place-based targeting, better integration with general practice and better local accountability. However, it is only going to work if your national standards, your data systems, your accountability is watertight. We are not going to reverse the decline in childhood vaccination by messaging alone. We are going to reverse it by rebuilding a system that reliably identifies every child, repeatedly invites them, makes vaccination easy and takes responsibility when it is missed. General practice is central to that, but we cannot do it without proper resourcing, integrated outreach and clear system accountability. We cannot simply absorb the work any more. In the past we did via good will, but that headroom no longer exists.

The Chair: I am getting anxious about getting all the questions in. We

will come to some of these issues.

Q87 **Baroness Hodgson of Abinger:** I want to ask about health visitor coverage in many GP practices and the role that they can play or do play. They can be very useful in conversations and building trust. Do most practices have a health visitor who would engage with small children?

Dr Katie Bramall: I am sure that Victoria feels the same. When I first qualified as a GP, we had our health visitor, we knew her by name; we might even have had two. We saw her every Monday. She would drop in. Now we are lucky if we see them once every couple of months. They have been decimated in terms of workforce. There is a report out there this morning that their case load is over 1,000 families. They are stretched so thin. There is hardly any support outside of acute hospitals. If you look at the pie chart of funding in the NHS, about 95% of it goes into hospitals. Compared with five, 10 or 15 years ago, a tiny proportion now goes into community and primary care structures. That is a really good example of the importance of outreach into particular families. But yes: when we have them, we are primarily focused on the safeguarding cases of children in immense neglect and at risk of severe harm.

The Chair: Thank you. I saw Kim nodding vigorously. Would you like to add anything in answer to Baroness Hodgson's question?

Kim Ball: I was going to mention the point that Katie made. General practice nurses have relationships with health visitors and speak to them, but it is often when there is a more complex case. As we see in the report in the news today, the case load of health visitors is immense. They cannot visit every child and have these conversations with every single child because they need to prioritise those who are most vulnerable, but they absolutely play a vital role in educating parents on vaccination and having those discussions.

The Chair: Thank you. Before we move on, do you have anything to add, Victoria?

Professor Victoria Tzortziou Brown: I agree that they are a very valuable part of our workforce. They would be able to have these conversations with families but, again, it comes down to capacity.

The Chair: Baroness Nye is going to ask about outreach.

Q88 **Baroness Nye:** I am. Thank you for mentioning integrated outreach in your previous answer. In sessions before this we heard about undervaccinated communities. How effectively and sustainably do you think GP practices support and deliver outreach to those communities? Has this changed in recent years? What are the challenges and the best ways of overcoming the problems?

Dr Katie Bramall: We do not get equity without funding the extra work with those populations that require outreach. Vaccinating the last 10% to 15% is not the same job as vaccinating the first 80%. For reasons of deprivation, language and housing instability, you need more contacts.

Current funding is flat and transactional, and no serious system can expect equity without weighted resource. But those areas with the lowest coverage need more staff time, not just the same payment per jab.

The last 10% to 15% cost disproportionately more, but the current funding model assumes that all vaccinations cost the same to deliver, which is simply not true. You have to have multiple contacts, longer appointments and more administration. You will have more cases of "did not attend". Practices in deprived areas with high population turnover and representing diverse communities are doing significantly more work for the same payment, and that creates structural inequality.

We are asking the practices serving the most complex populations to do the most work with the least funding. The consequences of that are widening coverage gaps, burnout in high-need practices, and perverse disincentives to invest time in hard-to-reach families. Outreach works and is needed but only when it is integrated with general practice—exactly as you said, Baroness. Pop-up clinics and community outreach are really effective, but only if they are connected to the patient's GP record and there is a recall system and follow-up pathway. Fragmented delivery means that you lose data and have no continuity. Stand-alone outreach means that you have short-term gains but no sustained coverage. GP and community teams working together gives you that durable improvement. There is an awful lot of work that we could happily and easily point to in our written follow-up submission.

Professor Victoria Tzortziou Brown: I want to highlight the challenges that we face in general practice. At the moment, the average GP cares for around 16% more patients than in 2015—so about 10 years ago. On top of that, the average GP in deprived areas has 14% more patients than the average GP in non-deprived areas. At the same time, GP practices in deprived areas receive 7% less funding. We are asking people who already have a lot to deal with, and a lot more need, to receive less funding and undertake more work. I have seen, especially in areas like east London where I work, that GPs care about their population. They go over and above. They undertake this work in their own time and often in an unfunded or grossly underfunded way. This has implications for their morale. According to the GMC, about 80% of GPs across the UK work well beyond their rostered hours at least once a week. So this has implications for retention.

Kim Ball: In my local area, I am part of a group that is doing a project on HPV. We are going into schools and colleges and having conversations with young people in order to try to empower them to become health-literate and have a better awareness of their health. We do not want to be waiting for people to get to their adolescent years to catch up on vaccination; health literacy is really important from day one.

However, the outreach tends to be very short-term. There tends to be limited funding, and there tends to be a real focus on national priorities. Think about during Covid: there was a lot of outreach activity. For measles, there has also been a lot of outreach activity. We get things put

in place, increase vaccine uptake and have great successes, but then the funding stops or runs out or it is not seen as such a big priority. We need to be thinking proactively about long-term sustainability and key plans that enable general practice to release staff from their clinical, day-to-day duties so that they can go out to patients, have those conversations and build relationships in their communities and with groups.

We see lots of innovation. I volunteer at a community centre that hosts a pre-school. We brought in vaccinators during flu season to offer the vaccine to parents dropping off their children at pre-school. General practice would love to be doing more of those things, but it cannot do that without sustainable funding.

Q89 **Baroness Cass:** I want to ask a quick supplementary question. Given what has been said about the constraints on health visitors and today's news, the money invested in the Government's pilots in this area is presumably paying for overtime because you cannot knit extra health visitors. Is it your view that it is not likely to become a sustainable solution, given the numbers and the safeguarding pressures? I do not know who might want to pick that up.

Dr Katie Bramall: That is a really good point. Just looking at increasing the flat funding model is not going to be enough. We need to be smarter and not just have a flat approach, because a flat approach does not solve inequality, workload variation or the outreach gap. You could look at core funding for routine delivery, with a simple and scalable system, but you could also have weighted funding for complex cases—for example, higher payments for deprived populations, high mobility areas or areas with low baseline coverage.

It is also about funding call and recall, specifically with follow-up. You could have explicit payments for multiple contact attempts, data cleaning, non-responder tracking and incentives linked to outcomes, with rewards for improving coverage or narrowing inequality gaps and not just for activity volume.

The bottom line is the current "item of service" model. It pays practices to vaccinate the children who attend, but it does not adequately pay them to find and vaccinate the children who do not. That is precisely where the problem lies. We are not going to close that coverage gap with a payment model designed for throughput. The challenge now is around persistence, which, of course, costs time, workforce and money.

Our call and recall systems have quietly degraded, which is lethal for coverage. The single most powerful intervention in vaccination is a functioning call and recall system, but ours is now inconsistent, fragmented and underresourced. CHIS, GP records and mobility do not align clearly. Practices do not have the staff or the time to follow up repeatedly. No one is accountable for a child not being vaccinated. Who owns that? We need to fix one thing: call and recall with real accountability. Who is the one named and accountable system lead for coverage and inequality reduction in an ICS, for example?

The Chair: What about the newly announced change in the way in which GPs are funded in areas where coverage is low, with an extra payment for increasing the proportion of patients who are vaccinated? Do you think that that might help?

Dr Katie Bramall: I do not think it goes anywhere near enough. It is a few pence for extremely challenging populations, and you will get it only if you manage to make quite a significant uplift, which will take that resource that I alluded to. We are still paying for the vaccinations delivered; we are not paying for the children protected.

Where are the incentives for closing the gaps, for improving the second MMR, for reducing deprivation gradients? It is short-termism. We know that is in the contract this year but short-term funding pots, rather than sustained investment, do not do very much. Commissioning needs to reward coverage and equity, not just the throughput. Unfortunately, this year's imposed contract changes reward the throughput, and the access is designed around the system, not around families. If services are hard to book or open only in working hours or require multiple steps, uptake will fail, especially when you have working, busy, deprived households; your first language is not English, you might not be digitally literate. Parents want simple booking—text reminders; local, familiar settings that they can walk to without having to rely on public transport—so that is why GP surgeries are still preferred. Even small degrees of friction will lead to quite large-scale missed vaccinations.

The Chair: We are moving on to funding now with Baroness Neuberger's question.

Baroness Neuberger: To a large extent you have actually answered the question—

The Chair: Oh, Baroness Andrews, did you want another question?

Baroness Andrews: Very briefly, is there a tension between wanting to increase the capacity of a GP service and doing what the Government are planning to do in their neighbourhood health framework? We heard from the DHSC and NHS England that it is in development and these ancillary services such as pharmacies are part of that, but they said they wanted to make sure that those supplementary models do not undermine the core offer in the GP contract or reduce clarity of roles. That may be a way to increase capacity, but does it impact on your ambitions for seeing a better-funded, more resilient GP offer for vaccination?

Dr Katie Bramall: It goes back to trying to create new solutions to a problem we already have the answer to. How much will that cost? These neighbourhood health centres are meant to be funded through public/private investment. Where is the workforce? How will the contracts work? One of my jobs is being responsible for negotiating the general practice contract across England. We have seen a lot of similar slide shows that are being shown at the moment around neighbourhood health. We saw them in 2011. We saw them in 1993. They are promised

periodically and cyclically, and I am seeing them for the second time in my career—the third time in my more experienced colleagues' careers.

What is actually going to change for people? We know there is not enough funding to uplift the NHS by more than 2.7% within the comprehensive spending review terms until the end of 2027. An awful lot of this is unknown, uncosted and uncontracted, and at the moment it is a bit of a pipe dream. I am very concerned about the patients here and now who have profound need, who we are simply not addressing. I am sorry to be so blunt but I am a little frustrated, Lady Andrews.

The Chair: We will move on to Baroness Neuberger.

Q90 **Baroness Neuberger:** To some extent you have already answered the question, which was: how could commissioning and funding arrangements be made more effective and more equitable? Presumably you think that the present system, with the payment in three parts, is just ludicrous. You have said quite a bit about that. I would like to take you specifically to what you said about the ICS and how you could make that bit of it work—how you could make the commissioning work when you know that there are not going to be huge amounts more money.

Dr Katie Bramall: The beauty of having it more local is that the ICB should be much more familiar with the needs of the population it serves. For example, let us look at the Covid vaccination programme and how we used faith centres and communities more creatively, and a volunteer taskforce. An awful lot more could be done on cross-community links, using the voluntary and care sector and charities, where we would have quite a profound impact.

Again, a lot of this comes down to the registered patient list and the GP record. There needs to be better data sharing between the various organisations. It is no good for me as a GP opening up my patient's record if they have received vaccinations from a community pharmacy or a community trust but that is not actually in front of me. I am the custodian of keeping that cradle-to-grave record. There are plenty of opportunities but I also completely appreciate that ICB colleagues are under huge financial pressures and they have just had to lose a third to a half of their workforce. We are not having any of our contracts uplifted, even by CPI—they are all frozen across my patch—so I think we have an extremely invidious challenge ahead of us.

Baroness Neuberger: You made the point that the ICBs or the ICSs are closer to the population, but the ICBs themselves are quite often being merged and they are becoming quite large, so there is a question about how close they are to the population. Victoria, did you want to add to that at all?

Professor Victoria Tzortziou Brown: I agree that ICBs could have opportunities to target funding where there is more need. It is not just about funding; I would say that it is about targeted workforce distribution too. As we know, and as we said before, in practices serving more

deprived populations we have fewer GPs and fewer numbers of other members of staff who can be very valuable for the delivery of the vaccination programme.

Kim Ball: Within ICBs there is opportunity, although, as Katie alluded to, the amount of staff who have been lost within ICBs has been really significant. Within ICBs as well, what we are seeing across the country is a real depletion in general practice nursing leadership. If we think about the people that would be in these discussions, advocating for things such as immunisation services, as an example, they are not going to be in the room, which may lead to a slight power imbalance within ICBs and what conversations are taking place. We need to make sure that in ICBs there is adequate representation across all different healthcare settings, so that everyone has a fair opportunity to represent their workforce and patient population and their needs.

Baroness Nye: In your opening I think you mentioned something briefly about SMS funding being withdrawn. That seems quite a radical thing to do, given that it is it is one of those effective ways of recalling a patient. Could you just say a little bit more about what is happening on SMS funding?

Dr Katie Bramall: Because the delegation of contracts has gone down to ICBs, and ICBs have such a paucity of funding, they are making decisions to unilaterally cease reimbursements of SMS messaging. This has not been explicitly shared with us, but reports are coming through from increasing numbers of ICBs across the country, so that, as Baroness Neuberger said, perhaps we had 42 ICBs and now we have 26. So they have clustered and they have much larger populations. That is a real barrier, and I think it particularly impacts those who may not speak English as a first language and who may not have access to a smartphone. I think people sometimes live in their own bubble and do not realise how the majority of the population communicate, live and work and how chaotic their lives are. We have got to tailor our offer to the vast majority of the population, who may not be signed up to the NHS app or may not be able to do all of these whiz-bang, lovely things that are often put out on headlines.

There is also that point about communication. With ICBs, for example, how much would it really cost to have public health messages put in local papers or in local playgroups, which would be in a host of languages and settings? Now we have access to so many digital tools to help create really high-quality communication, messaging and so on. Again, through SMS, it is that reminder—that nudge. It works with voting and with so many things. We are busy; we forget; lives are chaotic, especially if you are balancing small children and lots of other things, so it is very important.

The Chair: SMS is obviously in danger, unfortunately. Can we move to Baroness Freeman's question?

Q91 **Baroness Freeman of Steventon:** We have already touched a little on

data and the call and recall systems. I wondered what you all thought were the best ways to improve those systems to better support vaccination uptake, and what are the current strengths and weaknesses of the systems? Also, while you are talking about data, I would be very interested to hear your thoughts on what the quality of the data we have on childhood vaccination really is, because I know that you keep children on your records for as long as possible in case they fall through cracks. But does that mean that we are overestimating or double counting, or that the data is not necessarily that good on what proportion of children on the record are being vaccinated?

Professor Victoria Tzortziou Brown: There is a need for integrated access to children's health records across services because, at the moment, there are missed opportunities potentially for catch-up vaccination when children present in other services and there is no clear and transparent record of their vaccinations. We would support better integration and transparency as well as the introduction of a single unique identifier, as proposed by the Royal College of Paediatrics and Child Health.

There is a clear opportunity for more transparent engagement with parents, through sources such as the NHS app, so that there is increased awareness of where vaccinations are recorded and where they may have been missed. That would empower parents to take some responsibility for this too. But I absolutely agree that there is a need for better data integration across the system.

Dr Katie Bramall: While general practice holds the patient record, we rely on all parts of the health service—health visitors, occupational health services and school nurses—to ensure that the record is up to date. Information does not routinely flow to GP clinical records, but actually that is vital to facilitate the call and recall GP IT service and allow opportunistic vaccine opportunities to be effective. So, from the BMA perspective, we would love to see consistency in ensuring that IT systems in general practice flag patients with outstanding vaccinations and are configured with the call and recall service.

As Victoria alluded to, the NHS app in England should be configured to give electronic prompts and updated to record full immunisation status. Too often, we find discrepancies and disparities with CHIS services and so on, which is a real problem. Generally, we do not lose the GP record until the next practice has grabbed it, if that makes sense, so there is no duplication for general practice, certainly.

Baroness Freeman of Steventon: We heard from a previous witness that they had a GP system that did talk to secondary care systems, so it seems like these great mythical beasts do exist. Who is in charge of commissioning the GP practices' software, and who makes the decision over which one to use?

Dr Katie Bramall: Ultimately, the GP systems of choice are determined by NHS England, in collaboration with the Department of Health and

Social Care. It is largely a duopoly: there are two main providers, and they are pretty good. There is a third small one and there are two others in development. But, across hospitals and community trusts, there are dozens, and they are different within the same system. So we cannot even get hospitals to talk to each other, let alone to speak to us. That is a big challenge.

At the moment, we are falling into the trap of trying to make it work for everything all the time and all at once. Actually, if we focused on the really important things, such as current medications, vaccination history and any documented drug allergies—a bit like the summary care record—we would be in a much smarter place.

Kim Ball: At the moment, in my local area, when a child is vaccinated in school, that school immunisation team reports that vaccine to the Child Health Information Service, which then relays that information back to the GP. During flu season, this can be particularly challenging. If we are considering a child who may be in a clinical at-risk group, there is responsibility for the school nurses to vaccinate children in school and for the GP practice to vaccinate children who are in clinical at-risk groups. So we both invite the patient.

If that delay is significant enough, there is a risk that that child becomes double vaccinated or that they become missed completely because one assumes responsibility over the other. It is really important that we maintain trust in immunisation, and this is a really good example of where the systems are delayed, they are fragmented, and we need something robust to be able to ensure that children are not missed—but, as well as that, that they are not double vaccinated, because that may lead to reduction in trust.

Q92 **Baroness Browning:** I just wondered something. How good are parents at maintaining a record? I would have thought that today there could be an app on a mobile phone to keep a record of childhood vaccines. In my day, we had those old-fashioned cards, which I think I still have for my children, even though they are in their 50s. I do not know why but I am rather fond of them, and they were very useful for parents to know who had what. Is there any evidence that that is one area which might work?

Dr Katie Bramall: I am sure that it does. We went on to the red book; with a newborn, you were given a red book for many years—that is now being withdrawn as well—but it depends on the parents not losing it or misplacing it. That probably falls into the 80% category who are probably going to be okay. It perhaps is not going to be of enormous benefit to the 15% who are going to be a real challenge to bring in or to try and rebuild trust, or who might have hesitancy and concerns around it. They may perceive a state document in a very different way, depending upon their life experience and what they have gone through. It is all about trying to make it as friendly and approachable as possible, hence why I like the phone buzzing—"do not forget".

There is something around learning from these awful outbreaks that we have seen in the West Midlands and in Kent. It does give us an opportunity to say to teenagers who perhaps have grown up in households where there has been profound institutional distrust of authority or vaccination, "It is up to you now. How about we protect you against measles, mumps and rubella too, because this is also potentially life-threatening and it could make a massive difference, especially before you go off to university or go out into the wider world?" There is a real importance in capitalising on some of these awful occurrences to try and make the best of them, in terms of increasing that public consciousness of responsibility to get yourself vaccinated, if that is what you want, because it is definitely the right thing to do.

The Chair: That takes us nicely to Lord Randall's question about communication and training.

Q93 **Lord Randall of Uxbridge:** You have very effectively told us about the increased pressures on GPs and practice nurses. I was wondering how much training and support is given to GPs and practice nurses in how they can effectively communicate about childhood vaccination to families, particularly those who, for whatever reasons, have got concerns. Then I was going to ask, supplementary to that: are we sure that all healthcare workers and, to some extent, practice nurses are convinced of the merits of childhood vaccinations?

Professor Victoria Tzortziou Brown: I can go first. Effective communication and also specific knowledge on vaccinations is part of the core training for GPs, and practice nurses too. Certainly, as the Royal College of GPs, we provide resources, training and support to clinicians to empower them to have these conversations with parents. Actually, the evidence does show that parents trust the GPs and our teams to have these conversations. In fact, the UKHSA parental attitude survey in 2025 found that the GPs were the most trusted individual source, with 67% of parents ranking them in their top three most-trusted sources. This demonstrates that both GPs and our practice nurses are well equipped to have these conversations. They can communicate well with parents, but this is not so much a matter of training or having the knowledge to do it. It is a more a matter of applying it in practice, and therefore it becomes a matter of capacity and the time to have these conversations when we are inundated with so many other demands.

Dr Katie Bramall: I am happy to pick up your question around the confidence of the staff. It is a good question. We saw a little bit of this in the conditions of vaccination and deployment in the pandemic that the then Health Secretary, Sajid Javid, revoked when the vaccine efficacy was starting to wane in 2022 after there had been several cycles.

An example I often give is that I am in the "Star Wars" generation—born between 1977 and 1982—and in those years we did not offer a mumps vaccine to any of the population. I caught mumps from a patient in 2010 and that led to me developing multiple sclerosis three weeks later. I say

to all my patients, "If there is one thing I could do to turn back the clock, it would be to have that vaccination".

That is where continuity works. Because if that patient has seen you looking after their parents or grandparents and you have been there during profound moments of grief or joy within the family—that whole cradle-to-grave ethos of general practice—that imbues trust. Continuity of care delivers trust. You cannot put a value on it. That is not just GPs, it is our practice nurses, our health visitors and our healthcare assistants. They are so vital to the confidence the population have in their local health service.

We are of a generation that does not remember a number of classmates passing away but for my grandmother that was absolutely the norm, with diphtheria, pertussis, and so on. When I was pregnant, having my pertussis booster, I would say, "Damn right I'm having my whooping cough booster. I do not want a child having a cough for 100 days". I have seen chicken pox pneumonitis admissions; I am delighted that we finally have a chicken pox vaccination. France, America, Canada and Australia have had it for years; why have we not? If we sent the message—"If you were paying for this privately it would cost this much but here is your voucher: you get it free on the NHS"—I think we would start to value it a little more. We sometimes do not realise how lucky we are.

Lord Randall of Uxbridge: I agree with you. We have noticed that with those who do not have the experience, as you have, and probably a generation older than you, of knowing about these diseases, there will be a wave of younger GPs coming in who do not have this collective memory. Is this able to be communicated to them?

Dr Katie Bramall: The generation of GPs coming through are much smarter that my generation.

Lord Randall of Uxbridge: I doubt that.

Dr Katie Bramall: They have had much harder exams to pass and there is far more competition. They are still excellent students of the sciences and statistical analysis. They can see the burden of proof in the literature. I would echo what Victoria said, and she is the academic here, not me. There is no question: we are all fervent advocates of vaccination. If there are pockets—which you will always get—of people who have challenging sets of healthcare beliefs, it can be very challenging, as you say, but we are looking at an extreme minority, so confidence intervals rather than the bell curve.

Professor Victoria Tzortziou Brown: I agree. Apart from specific training on immunisation and its importance, we have training on interpreting the research evidence available, and that speaks for itself.

Kim Ball: I agree that there is training out there which meets all the requirements, but access to that training can sometimes be limited. Another big challenge with immunisation is, if a new-to-practice nurse

joins a general practice, they do not have the same background that a GP would have coming into general practice. They may never have set foot in that practice setting before. They will undertake their immunisation training. We have had varying new-to-practice programmes, newly qualified support programmes and preceptorship programmes that have been able to support that newly qualified, newly registered or new-to-practice nurse throughout their training to develop their skills and knowledge in that area and bring them to a point where they become a competent, autonomous practitioner. But that does not come without resource, and it can be a big challenge. In some areas funding is provided for immunisation training; in other areas it is not. Many areas may default to things such as e-learning for health, which is a great resource. However, we know that not everybody can learn via an e-learning platform. We need to be thinking about meeting the learners' needs and having a diverse range of resources available to them.

In terms of the diseases within my own training, I make sure that the nurses are aware of all these diseases, because you are not going to see these day to day. You may see one once in your whole nursing career or not at all, but we cannot become complacent about those things that we do not see. If we stop vaccinating, we will see the resurgence of those—as we have done with measles.

Q94 **Baroness Hodgson of Abinger:** Dr Bramall, I am hearing from you the incredible importance of the relationship between GP and patient. Do you think that in recent years this has loosened? What can we do to restore that? A survey from Norway shows that if a GP knows a patient and there has been continuity of care for a number of years, they are less likely to be hospitalised, less likely to die and all the rest of it. What has happened to slightly break this and how can we resume what was such a wonderful service?

Dr Katie Bramall: That is an excellent question. I am so glad that you have asked it. If continuity of care was a drug, NICE would be mandating its use four times a day. There is no question. It not only reduces your admissions but your mortality if you know your GP and your GP knows you. It has been fragmented through deliberate commissioning decisions from 2010 onwards. We have lost one in four GP surgeries in England. We are now just about coming up to the level of GPs that we had back in 2015 and already that is so much lower per 1,000 patients that it should be. As Victoria alluded to, the average GP had perhaps 1,800 patients when I qualified. It is now 2,500 and they are consulting far more regularly. You mentioned earlier a question about demand. If you do not know who you are going to see, you do not have that sense of trust, you have not built up that credit in the bank. We like to try people out. We are human. A lot of politicians think that things can be reduced to AI, an app or a virtual assistant, but we are human. We are not programmed like computers.

I had a gentleman last Monday who came to see me about some gout in his toe. He actually wanted to talk about a much more sensitive personal problem, but he wanted to try me out first, to see if I was kosher, if I was

the sort of chap that he would be happy to drop his trousers to. Thankfully I passed the test. If you are seeing someone for the first time, that social connection is lost. Deliberate commissioning decisions over a number of years have reduced the proportion of investment and funding in general practice. We are still years away from turning that around. It is multifactorial. The BMA's GP Committee published its vision, *Patients First: Why General Practice is Broken & How We can Fix It*. I am the primary author of that document and am very happy to append it to our submission.

Q95 **Lord Dholakia:** I want to ask about barriers to communication from GPs and practice nurses. Do you feel more objections from ethnic minorities, diverse communities, Travellers and asylum seekers, in terms of inoculations?

Dr Katie Bramall: Absolutely. If you are a refugee arriving in Britain and somebody from the state wants to inject you with a needle, you might have very good reason to want to know exactly what that is for. If you are subjected to a chest X-ray, you might not fully appreciate that we are looking for signs of potential pulmonary tuberculosis. We are working with some extremely frightened populations.

Likewise, we must look at the institutional structures of so many organisations and how they have treated populations over the decades and be much better at providing information in their native languages from their own community leaders and working in a much more integrated manner with those populations.

Q96 **Baroness Andrews:** Thank you so much for your evidence so far. It is extraordinarily useful. We have to make recommendations. This is a really difficult question. There is context, because the House of Commons Health and Social Care Committee had a go at this as well. It came out with these top recommendations: clear responsibility and accountability, including targets for improvement of vaccination coverage; a plan to mitigate the risks of transferring responsibility for commissioning ICBs; sustainable funding, which we have talked a lot about, to support outreach and reduce disparities; better training and development; and better data access. Those were the top lines.

Is there anything there that you would disagree with or prioritise? Within that, what do you think we should be saying in relation to the two populations you have identified, the great mass of people and those who are hard to reach? "Hard to reach" is such a cliche, but I cannot think of another way of putting it. You have emphasised families with children and how difficult it is for the most organised families to get the recall right and turn up at the right time. With this systemic problem, what can we say that would make a difference?

Professor Victoria Tzortziou Brown: There is no single silver bullet. Improvement needs to come from strengthening the existing model because we know that it can work. We need to prioritise increasing capacity within general practice so that clinicians have the time to engage

with patients, particularly in deprived areas; have targeted support for practices in deprivation, including increased funding there; strengthen trusted communication, including what we have not talked about today, which is face-to-face consultations, which are sometimes going down instead of going up; collaboration with community leaders, as Katie has mentioned, to counter misinformation where it exists; and better data integration.

Kim Ball: I agree with all those points. One of the challenges is how the UK Health Security Agency and NHS England communicate with their staff. Patients may be watching BBC News in the morning and ask the practice nurse a question because they have an appointment. Information is often not embargoed and is released, but it is not getting down to the people on the ground. There is something about how messages are communicated from departments down to front-line staff. These people often do not have access to email, so we need to think strategically about how these messages are getting across and that we are equipping our healthcare professionals with the information that they need before the patients see it on the news and are asking questions that we may not have the answers to at that time.

Dr Katie Bramall: Fundamentally, our decline in vaccination coverage in childhood is now a service and system performance problem as much as a communications problem. National coverage remains below target and inequalities are entrenched by deprivation, geography and ethnicity. Reversal will require a strong, GP-led universal offer, funded outreach for undervaccinated groups, better call, recall and data linkage, simpler booking, more flexible access, one named accountable lead in every ICB, working with directors of public health and school nursing teams and funding, and assurance tied to coverage improvement and narrowing inequalities.

An important nuance for the inquiry is that this month's delegation of vaccination commissioning to ICBs gives you an opportunity but also a risk. It could improve local flexibility in population health ownership, but we have to have those national standards, CHIS functionality, regional assurance, public health expertise and transparent accountability. Otherwise, the reform will move ambiguity around the system. Accessibility is so important.

We have covered so much this afternoon. The questions have demonstrated your profound level of understanding of so many of the challenges. I would also encourage the inquiry to look at the UKHSA recommendations, because they vary markedly from NHS England. For example, NHS England talks about digital interfaces and apps and UKHSA talks about parents wanting GP-led SMS messages or plain email. A lot of answers are already out there. We do not need to find new solutions to this very old-established situation.

Baroness Andrews: You identified the ICB lead as important.

Dr Katie Bramall: I personally would. Accountability is missing. So often it falls between the gaps in the system architecture. That could easily be remedied.

Baroness Andrews: Is that completely compatible with what you say about the existing system in relation to the role of the GP?

Dr Katie Bramall: Absolutely.

Baroness Andrews: You also said to make it easy. Is that the strongest message?

Dr Katie Bramall: Make it easy for patients, make it easy for GPs and the rest will fall into place.

The Chair: Thank you very much indeed. Let us hope that it does as we wrangle with all the information that you have given us today. Thank you all very much indeed. That is the end of this afternoon's session.