



Childhood Vaccinations Committee

Corrected oral evidence

Monday 20 April 2026

3.20 pm

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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. 9

Heard in Public

Questions 97 – 103

Witnesses

I: Professor Helen Bedford, Professor of Children's Health, University College London; Dr Heather Bower, Head of Education, Royal College of Midwives.

USE OF THE TRANSCRIPT

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

Examination of witnesses

Professor Helen Bedford and Dr Heather Bower.

Q97 The Chair: Welcome back to today's meeting. This is the ninth oral evidence session as part of the committee's inquiry into childhood vaccination rates in England. Thank you to Professor Helen Bedford and Dr Heather Bower for attending today. The session is open to the public, is broadcast live and will subsequently be accessible on the parliamentary website. A verbatim transcript will be taken of the evidence and published on the parliamentary website. A few days after this session, it will be sent to our witnesses. If there are any small changes that you need to make, please send them as soon as you can. After this evidence session, if you wish to clarify anything or send us additional evidence, please do feel free to do so.

The first question is: how effective is nursing, health visiting and the midwifery workforce to support uptake of infant and pre-school vaccinations? How has this changed over recent years and how could the workforce be used more effectively?

Professor Helen Bedford: I am Professor of Children's Health at UCL Great Ormond Street Institute of Child Health and an Honorary Professor at the London School of Hygiene & Tropical Medicine. I am also speaking on behalf of Institute of Health Visiting as its expert adviser on immunisation.

In general practice, vaccination programmes are largely run by nurses in various formats. We have heard that general practice nurses are very involved in administering vaccination. Currently, health visitors are underused as a resource for health visiting, particularly in the talking to parents and answering their questions. However, as we will get to later, there is a pilot going on to train health visitors to give a supplementary offer—not universal administration but to offer vaccine to children who have missed out for various reasons.

However, as we have heard many times, the big problem is that there are not enough of these people able to take on the role. Only this morning, we heard in the news that the number of health visitors over the last decade has fallen by almost 50%, with huge case loads. It means that this bread-and-butter public health work goes by the board in favour of safeguarding issues. That is the big problem. They are very effective, but we just do not have enough of them.

Dr Heather Bower: I am a midwife. I have been an academic midwife for the last 20 or so years. I work for the Royal College of Midwives as the Head of Education. That is the capacity in which I am here today—to give evidence for the Royal College of Midwives.

As midwives, we have a limited role compared with some of the other health professionals in childhood vaccination. However, we give antenatal vaccinations, particularly for influenza, pertussis and, more recently, RSV.

I have been involved in the rollout of the RSV from a college perspective, so I can talk to that today. In terms of midwifery education, midwives will be educated about those vaccines. We will be administering them antenatally. However, on childhood vaccination, we will be giving advice, but it will be other professionals who give them in most instances.

The Chair: Thank you. We have heard that there is evidence that women who accept the vaccinations that are being offered antenatally are more likely to bring their babies to be vaccinated after the birth. Is that because they trust the information given by midwives? Do the midwives have enough information to answer questions about vaccinations other than the prenatal ones?

Dr Heather Bower: They certainly have the education about early childhood vaccination, so they would have the information to give to women. One of the big problems in midwifery at the moment, of which I am sure that you are all aware, is workforce issues and just having the time to give that information. Women's maternity journey has become more complex in recent years. There is a shortage of midwives to do those tasks. Community midwifery has particularly been squeezed. There is a lot more emphasis on midwifery in hospitals. As my previous colleague said, one of the things that has suffered in that is the continuity. In terms of trust, it is quite difficult to build up that relationship with women when community services are so thin and continuity of care is not as it used to be. That is one of the issues in terms of uptake, but if women are more inclined to have an antenatal vaccine, they are probably more trusting of vaccines generally and therefore more likely to go ahead with childhood vaccine.

Professor Helen Bedford: It is a very useful opportunity for parents if midwives can say that this is to protect your baby and that when your baby is born, there will be more vaccines being given directly to the baby. That is a very powerful message indeed.

Q98 **Baroness Cass:** My question is an expansion of what we have just discussed and what we heard in the last session; I know that Helen was sitting in for much of it. How effective do you feel the core offer for infants and pre-school vaccinations is in primary care? What would you do to improve that offer?

Professor Helen Bedford: It is a resource issue. It is about having the offer, with parents knowing where to go, what will be given and when. That is really important. However, the communication must start earlier than the first routine vaccine at eight weeks. That is absolutely critical, and it is a health-visiting issue. It is about talking to parents from when the baby is born—ideally, midwives talking to the parents when the woman is pregnant—so that they build on that relationship and the parents are aware of what is expected and when it is going to happen, and so that the parents have had all their questions and queries answered before they go into general practice for the vaccination.

Baroness Cass: Going back to the question I asked in the previous

session, on our pilot with health visitors, is there any way in which one could ring-fence health visitors into vaccination services? The urgent always trumps the important; therefore, if it is at the back end of somebody's workload, it is potentially not going to happen. I am just speculating.

Professor Helen Bedford: Unless we increase the numbers, I do not see how we can possibly do that. If people have case loads of 1,000 families, they simply cannot do that.

One thing I want to raise is that, in the Healthy Child programme, which is the public health programme for children and families, in the "nought to five" section, there are various high-impact factors and health priorities for children. Immunisation is not considered a high-impact factor on its own. There is breastfeeding, healthy weight and nutrition—all sorts of things—but immunisation is buried in another high-impact factor: the reduction of minor illness and health literacy. It is not flagged up. That is partly a commissioning issue but, unless it is brought to the fore, it may not always be seen as a high priority.

Baroness Cass: That is a very good point. Dr Bower, do you want to add anything to that? I have a more specific question for you about midwifery services and their impact.

Dr Heather Bower: Midwives have a very important public health role but, again, it is exactly as you said: the acute trumps primary health. There is so much emphasis on acute care in midwifery at the moment that it is superseding primary care needs and the whole-community strength, if you like, of midwifery practice.

As I said, that has also had an impact on the continuity of care that women get. Ideally, midwives should be introducing all sorts of primary health and public health topics antenatally, but, as my colleague Helen said, it is about time, resources and workforce.

Baroness Cass: The Chair has already alluded to how, if you get vaccinated in pregnancy, that is a good predictor of whether you are going to follow through with your baby. This is probably a really difficult question to answer, but what is the continuity with a midwife through pregnancy like now? Do we know whether that continuity is more likely to help with childhood vaccination? With the best will in the world, despite what we have heard from previous witnesses, we know that continuity in primary care is not what it was, but your midwife is somebody whom you may well see on a number of occasions.

Dr Heather Bower: Absolutely. I cannot quote the statistics on that but we can find them out for you.

Baroness Cass: It would be really interesting to have them, if they exist and if that would be possible.

Dr Heather Bower: There is so much evidence. Recently, in just the past couple of months, a paper has been published on the evidence for

continuity of care during pregnancy, labour and the postnatal period, including how outcomes are improved for mothers and babies. If there is good continuity of care, there is less intervention and the public health outcomes improve. So there is very strong evidence for continuity.

Over the past decade, particularly since Covid, continuity has been on the decrease rather than the increase. As I say, that is partly to do with the issues that we are facing in maternity services, but there is a lot of focus on that at the moment because we know that we have lost a lot of the continuity we used to have. Obviously, that is impacting outcomes in all sorts of ways, not just in vaccination uptake.

Baroness Cass: It would be really helpful if you could dig out some of that data for us.

Q99 **Baroness Andrews:** Mine is a question of context. Why do health visitors have such a big health load? Is it because they have been leaving the profession, or have we not been recruiting enough? Is there a plan to recruit more in the workforce plan? Do health visitors have something to look forward to? Can we all look forward to having more health visitors? Clearly, the pilot, which I would have thought would be successful, will create further demand for more intensive engagement for health visitors. What is the plan for health visitors?

Professor Helen Bedford: I hope that the plan is to get more, but that will require a lot of investment. Basically, it has been underinvested in. Funding has been taken away from it. Also, people are leaving the profession, and we have an ageing population.

Baroness Andrews: Has funding been taken away from training or professional development?

Professor Helen Bedford: No. It has been taken away from funding posts. The number of posts has been reduced. Like many nursing professions, it is an ageing profession. So it is about reinvestment.

We also have the NHS plan, which talks about a focus on community and on prevention. That is a really important opportunity to increase the health visiting workforce.

Baroness Andrews: Is that explicit in the plan?

Professor Helen Bedford: Yes. It is in the NHS health plan.

Baroness Andrews: Right. So there is a recognition that we need more health visitors and that they can play a bigger role, particularly in family support.

Professor Helen Bedford: I am not sure whether it actually mentions health visitors or whether it mentions community and prevention, but that is my interpretation because that is what they do.

Baroness Andrews: Is it possible for you to tell us how many posts have been lost? Perhaps you could write to us if not.

Professor Helen Bedford: I believe that the figures are something like this: there were more than 10,000 health visitors in 2016 but, now, there are something like 5,000.

Baroness Andrews: So it has gone down by half.

Professor Helen Bedford: Almost half, yes. It has gone down by something like 45%.

Baroness Cass: It is undervalued as well as underinvested in, I would say.

Professor Helen Bedford: Part of the problem for health visitors is demonstrating what they do, because they do so much. Let us look at particular outcomes; take vaccination as an example. There are so many people involved in vaccination. You cannot say, "Take away health visitors or put in more health visitors. That's totally the answer", because there are so many people involved. It is all integrated and everybody is working to that end.

Baroness Hodgson of Abinger: Has anybody identified why we have lost so many? What is happening on recruitment? Is it put over as an attractive, desirable job that will be valued?

Professor Helen Bedford: It is a question of underinvestment. Investment has been chopped, which is why there are fewer people. It is considered an attractive job to do, but not at the moment if you have a case load of 1,000 families. That, along with a lot of other problems in society, such as poverty, make it a very hard job.

The Chair: We are expecting the NHS health workforce plan in the spring. Spring is nearly over, so let us hope that we get something positive out of that plan when we eventually get it.

Q100 **Baroness Ritchie of Downpatrick:** I want to move on to outreach services for undervaccinated communities. You have already made reference to this subject, in terms of the content of the NHS plan on community and immunity. How effective and sustainable are outreach services for undervaccinated communities? What are the main challenges in developing effective, sustainable outreach services? What would be the best ways of overcoming those challenges?

Dr Heather Bower: We know that uptake is lower in the global majority population for antenatal vaccination. The Royal College has done quite a lot of work around decolonising education to try to help midwifery students, in particular, to look at the differences between populations. We know that there is some very good outreach work going on in some of our communities, but that is not consistent. So I think that consistency is the thing we need, in terms of outreach.

Also, on service development, we need to look at co-production. We need to look at trying to design services with the service users whom we are trying to target. There are some really good examples of that in

midwifery, which would include vaccination uptake as well, but, again, it is not consistent across the board. Co-production is really important in involving service users—particularly in maternity, because these women are not sick; they are having a baby. They want to be consulted. They want to have a say in their services and what they choose. It is really important to design those services with service users themselves, because that is going to help them buy into those services. Where that has been successful, co-production has been a really important element.

Professor Helen Bedford: Echoing what Heather said, we need a real understanding of local need—of what is required. First, what is the problem? Is it accessibility or is it hesitancy? Also, what is acceptable to the population? In a previous evidence session, you heard from Dr Hussain, who works in West Yorkshire. She has done a fantastic initiative, but she had to try different things to find out what was going to work in her area. It has been a tremendous success, but what happens if she moves on or the funding goes? That is the problem. Often, when you have successful initiatives, everybody says, “Great, we’ve done it. Now, we can move away and look at something else”. It then falls back again. It is about sustaining these sorts of initiatives and funding them appropriately.

Baroness Ritchie of Downpatrick: Further to that, Helen, what are the key opportunities and risks in the current pilot on vaccination delivery for health visitors? What outcomes would you like to see from this pilot?

Professor Helen Bedford: I would like to see health visitors being more involved in immunisation.

Baroness Ritchie of Downpatrick: And more health visitors?

Professor Helen Bedford: Yes. When I qualified as a health visitor many years ago—35 years ago, in fact—I was banging on about why health visitors were not doing more in the way of vaccination.

As you know, the focus of this pilot is on vulnerable families. It is not a universal offer. It is really important to remind ourselves of that. However, I think that it will have wider benefits because, if you are training health visitors to administer vaccines and talk to vulnerable families who have missed out, the training that they receive will equip them also to have conversations with all their families. So it will, I hope, have wider benefits.

As I have mentioned, this is core public health work. Immunisation is absolutely fundamental, so it should be bread-and-butter work for health visitors. From starting the pilot and talking to health visitors, we know that they are keen to be involved. Because of the strong relationships that they have with families, in particular, they feel that it will be successful—but only with proper resourcing and proper numbers of people involved. We know that parents value their conversations with health visitors and that they want this service to be available to them, but it is not always so at the moment.

As we have said a number of times, the big “but” is the number of health visitors who are available to do this sort of core work. In 2024, we conducted a survey in conjunction with UKHSA with around 300 midwives and 300 health visitors across the country. Around a third of the midwives were administering vaccines then, but only 4% of the health visitors were administering vaccines. So we have a long way to go in getting more health visitors involved in that.

- Q101 **Baroness Browning:** Can you say a bit more about the training of nurses, health visitors and midwives? How effective is that training in supporting them, including supporting them in communicating with families about childhood vaccines? What are the differentials between the types of training that those three groups— nurses, health visitors and midwives—get? What are the main barriers to effective communication?

Professor Helen Bedford: Perhaps Heather should start by talking about pregnancy.

Dr Heather Bower: Midwifery education programmes include vaccination. Student midwives will be taught about vaccination programmes that are relevant to a midwife. However, because the RSA vaccine, for instance, was brought in last summer, it is not included in midwives’ proficiencies yet. So vaccination is in there as a subject, but that vaccine is not identified in their proficiencies through the regulatory body because it is new; presumably, it will be included the next time those proficiencies are rewritten. I am not saying that students do not have the information, but it takes the regulatory bodies a while to catch up when things are introduced.

Baroness Browning: How long would that be?

Dr Heather Bower: There is no plan to review the proficiencies at the moment. As I say, the broad umbrella of vaccination is in there—that is fine—but there is probably no way of monitoring exactly what each individual university is doing.

Let us look at post-qualifying education because, obviously, that was really important when the RSA vaccine came in. Again, as one of my colleagues said in a previous session, the speed at which the vaccination programme was brought in for midwives to deliver was incredibly quick. The royal college did some work with UKHSA last year because we were part of the group that was looking at the implementation of that programme. The training materials for midwives who had already qualified came out in July last year, and the programme started in September. At the time, we raised our concerns at that being an incredibly quick turnaround.

Some trusts have individual specialist midwives who look at vaccination so, where they had a specialist midwife who was responsible for that education, it was probably rolled out more successfully—I can give you examples of where that was done successfully—but there were a lot of trusts that did not have a specialist role, so it was up to midwives or the

trust to dictate what individual midwives needed to do. That was an incredibly quick turnaround for midwives, who are going to be delivering it at scale, to upskill themselves with the knowledge. It is about not the technique of delivering an injection but the knowledge that is required to give women an informed choice because, obviously, informed choice is incredibly important.

Baroness Browning: What would be the best way of improving that communication?

Dr Heather Bower: It is about the timescale. Sometimes, we work to incredibly quick timescales that are probably really difficult for trusts to roll out. Because all midwives are employed by trusts, obviously, it falls to the trust to implement that education even though it might be coming from the ICB, the Government or wherever. A longer period of time is needed to educate midwives when things like that vaccine programme roll out.

Baroness Browning: How would you evaluate success in terms of whether you feel that somebody is suitably trained?

Dr Heather Bower: It is probably both quantitative and qualitative. Uptake is probably a measure of success, but so is the woman's individual experience. Getting qualitative feedback from women on how they felt the information was imparted would be an evaluation project in itself because, again, we are working to very tight timeframes. Say the information had to be imparted by the midwife through the booking interview when the woman is first pregnant. More and more is being squeezed into that booking interview, so there is less time to deliver everything. It is about time and resources, but it is strongly about education as well.

Baroness Browning: Do you think that it is because, according to the figures that we have been given, the public trust midwives more than any other person in the health service? Therefore, it seems that the obvious thing to say is, "Let's get midwives to do more in this area".

Dr Heather Bower: Yes, and it is an amazing public health opportunity. Most women are very excited to be pregnant. They want to do the best for their unborn child. That is why we have a unique opportunity to deliver public health. However, there has also been a lot of negative publicity about midwifery and maternity services in the last few years. We are seeing the impact of that on trust as well.

Baroness Browning: Helen, I am going back a long way now. Tell me if this has disappeared into the aether. When my children were young, in the early 1970s, the health visitor would measure milestones as they developed, pre-school. At about two, three or four years of age there would be a check on their milestones of development. Does that still take place? Is that an opportunity for vaccination to be part of a health visitor's remit?

Professor Helen Bedford: In England there are five mandated contacts at various stages, the first one in pregnancy and then new birth, six weeks and then a couple more, but there are far fewer than in Scotland, where they have 11 mandated contacts. In terms of milestones, it is not quite so systematic as that. There is a two-year review when various checks will be made, but otherwise it is a bit looser than that. It is not, "Is your child doing X, Y and Z at particular stages?", because they have fewer contacts.

Baroness Browning: I was thinking that this would be the opportunity at that point.

Professor Helen Bedford: Yes, because a lot of things are discussed at those contacts, not just child development but feeding, sleeping and all sorts of things relating to the wider family, not just to the child.

Baroness Browning: You have had a lot of experience in training. How easy is it to evaluate and know what can be done to improve things?

Professor Helen Bedford: The Royal College of Nursing has developed some core competencies for vaccination. The UKHSA has produced a core curriculum. Everybody involved in vaccination should undertake this training and have updates on an annual basis. The Royal College of Nursing has also produced core competencies, so for people undertaking that training there are things that they need to have done. They also have a mentor who will oversee administration—injection technique. Improving that means making it more available for people because a lot of people do not have access to the training because they cannot get time off work, there is not funding for it, or it is not available locally. That is part of the problem, making training more available.

Baroness Browning: Who would be responsible?

Professor Helen Bedford: That is the big question. Who is responsible for making sure—

Baroness Browning: In service training?

Professor Helen Bedford: Yes. It is not clear. The lines of responsibility about who is responsible for your health visitor practice nursing workforce are not always clear. Practice nurses are under GPs; health visitors are in a different system.

The Chair: You have talked a lot about initial training and the core competencies that need to be trained for and achieved. I want to ask you more about ongoing CPD and whether there is a system for passing on information that is interesting and important to the people whom you represent.

As a lay person, I was very interested over the weekend in a piece on BBC News on some recent evidence about how highly effective the RSV antenatal vaccination is in protecting babies from going into hospital because of respiratory problems at a very early age. Is there any way in

which that sort of ongoing, topical new information can be passed on, particularly to midwives who are giving the RSV antenatally?

Dr Heather Bower: All midwives have CPD; they have to meet a certain amount of CPD to stay on the Nursing and Midwifery Council register as a registrant. However, it is quite variable as to what they get. There is no mandated specific content. Most trusts prioritise emergency care in maternity. The RSV training would not be mandated necessarily.

If midwives are going to be giving RSV, they need some level of post-qualifying training, but it is going to be the emergency scenarios that take priority rather than the public health issues. The amount of continuing professional development that midwives get in different trusts will vary.

One of the asks of the Royal College of Midwives is that the Government mandate 52 hours of CPD per midwife per year, which is similar to what happens in Wales. That is one of our recent asks that we are talking to MPs about. Some trusts will comply with that; a lot of them will not; but that is the amount that we feel it needs to keep midwives up to date each year, based on the Welsh experience.

The Chair: Is it evaluated?

Dr Heather Bower: Some trusts will evaluate individually, but it is not evaluated nationwide—apart from the fact that midwives need to revalidate with their regulator.

The Chair: Thank you. We move on to Baroness Hodgson for the final question.

Q102 **Baroness Hodgson of Abinger:** I thank you both for giving us lots of valuable information, but we as a committee are going to have to make recommendations to the Government on how to improve the uptake of vaccinations and how to reduce disparities. Can you give us a rundown of what you think we should prioritise?

Dr Heather Bower: I will make three points that I think are really important.

The first thing is the workforce. We have to look at the workforce and the number of midwives we have, because midwives keep absorbing more roles. For instance, midwives now do the first examination of the newborn, which is not something that I did when I qualified as a midwife. We keep acquiring roles; it was one of our points when the RSV programme was rolled out that it is just another thing that midwives have to do in the same amount of time. We need to look at what midwives are doing for the workforce to match that.

The second thing concerns all antenatal vaccinations—this probably continues into late childhood—and the ethnicity differential. We need to think about how we can target those more vulnerable communities and the ones that are more vaccine hesitant.

The third thing is education. We need to start with our pre-registration education and make sure that our vaccination education is really strong in our pre-registration programme. However, again, pre-registration programmes are having to absorb more and more content in the same amount of time. It is about how that is rolled through to post-qualifying education, particularly when things such as the RSV are rolled out at speed. We understand the reason for that—obviously, it is about new evidence coming along and suggesting that that is going to protect the newborn, so that programme was rolled out for a good reason—but it was done at such speed that there was huge variation in how it was delivered across the country. We are only just catching up with now, probably, so education must be factored into anything that we are looking at.

Baroness Cass: May I ask Heather something? When I was a neonatal SHO, it was the neonatal SHOs who did the first check; that seemed a very good idea to me because it was an opportunity to examine lots of normal babies. What drove that change?

Dr Heather Bower: Partly, it was the lack of SHOs, or what they are now called.

Baroness Cass: I am sorry; I should not have used that term.

Dr Heather Bower: No, but you know what I mean. It was due to lots of things. It is also about the fact that the midwife then provides that continuity—which actually does not often roll out in practice, because some midwives who have expertise in that will run examination-of-newborn clinics; that does not provide continuity. However, that has now been absorbed into the pre-registration education proficiencies, so all graduating midwives will theoretically be able to examine the newborn. That is a big change; as you will very much appreciate, Baroness Cass, a huge increase in the content of the programme will obviously be needed to allow that to happen.

Professor Helen Bedford: For my wish list, I would implement NICE's 2022 guidance on improving vaccine uptake and make sure that people are doing the same; everything is in there. We need more staff who are trained to be confident and competent. Our data systems need improving, not only in terms of the quality of data but so that, in settings outside general practice, people can quickly determine a child's vaccine status and vaccinate them if it is appropriate and acceptable to do so. Training is also very important.

It is very difficult to say what is a priority because you need all these things, but having a vaccination lead in organisations is critical. It is about having somebody, often a clinician, who has ultimate responsibility and who can answer clinical questions—someone everybody knows who pulls all the strings together.

Q103 **The Chair:** I want to ask one further question. It has been suggested that the ICB level is the correct footprint for where the responsibility should lie. Do you think that it is the right footprint or, given that they

are all clustering together now, is it too big? We have heard from quite a lot of witnesses that you need to get down to the granularity of individual communities to find out what would work best for them.

Baroness Neuberger: As a supplementary to that, if we are going to have integrated health organisations on a local patch and providing services for a specific area—their footprint—is that prospect a better place to locate the responsibility for childhood vaccination? It is the same question about how it should work.

The Chair: Where should it be?

Professor Helen Bedford: It should be as local as possible because, even within a small area, things are very different. People have to have a real understanding of their population's needs.

The Chair: Thank you very much indeed for all the information that you have given us this afternoon and your patience with our supplementary questions. That marks the end of this session.