



Childhood Vaccinations Committee

Corrected oral evidence

Monday 15 June 2026

2.15 pm

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

Evidence Session No. 13

Heard in Public

Questions 150 – 158

Witnesses

I: Ruth Tennant, Director of Public Health, Solihull Metropolitan Borough Council, Representative, Association of Directors of Public Health; Baroness Clare Gerada, Member, House of Lords, former President, Royal College of GPs; Professor Andrew Furber, Regional Director of Public Health, NHS North West England.

USE OF THE TRANSCRIPT

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

Examination of witnesses

Ruth Tennant, Baroness Gerada and Professor Andrew Furber.

Q150 The Chair: Welcome to today's meeting. This is the 13th oral session as part of the committee's inquiry into childhood vaccination rates in England. I welcome our witnesses, Baroness Gerada, Ruth Tennant and Professor Andrew Furber, and thank them for attending today. The session is open to the public. It will be broadcast live, and it will be subsequently accessible via the parliamentary website. We will be taking a verbatim transcript of the evidence, and that will be published on the website. A few days after the session, our witnesses will be sent a copy of the transcript. If you come across any little mistakes, please let us know as quickly as you can, so that we can correct it and get it up on to the website. If, after this session, you wish to amplify or clarify anything that you have said or provide any additional material, you are very welcome to submit that to us, and we would be very grateful for that. I remind you to give a brief introduction about yourselves when you answer.

The first question is quite a general one: what are the strengths and weaknesses of the Government's approach to reversing the decline in childhood vaccination coverage and reducing inequalities? To what extent does the Government's approach to childhood vaccination form part of a coherent approach to public health and prevention?

Ruth Tennant: I am a Director of Public Health in Solihull in the West Midlands, and I also represent the Association of Directors of Public Health.

As far as the association's view goes, we have clearly had a national strategy around vaccination. There is a lot in there that we welcome in terms of setting an important and strategic framework for vaccination. There are a lot of key elements in there that are important in improving access to and take-up of vaccination. There are some elements, including, for example, extending use of the NHS app, making sure that people know how to access vaccinations, looking at how to deliver vaccination in convenient locations and being very clear that it needs a systems response, ICBs, directors of public health, all our partners in the NHS—particularly general practice and voluntary organisations—to work together to make this a success.

We particularly want to draw out the importance of inequalities. We know that there are certain groups that are particularly disproportionately affected that we need to get to. So, the focus on the inequalities dimension is to be welcomed. I know that there will be a question about data later on, but there are also some important measures about data in there.

In terms of what we need next—speaking as someone who has been working on the ground and dealing with quite significant measles outbreaks, including a very large one in the West Midlands a couple of years back—I want to see a sense of urgency and of quite how important

it is to get this right. We know that it will take quite a long time. This will not be a quick fix. We are probably talking about a good 10 years to get all the parts of the system working and to get some of those coverage levels up, particularly around MMR, where there has been a decline for a time. We need clear leadership. Who has the job card for holding the target in the public consciousness and in all our consciousnesses? We need to make sure that that is driven through.

Obviously, it was a disappointment when we lost our 95% uptake and the WHO status. That is an important goal to move towards. It will not be done overnight, but we need a strong, well-led and credible plan, with all the component parts to make it happen. I will stop at that point, but I am very happy to pick up details later.

Q151 The Chair: Thank you very much. I hope that the committee's report will play its part in that, and I am quite sure that the House of Commons report that we recently had will also play its part. Thank you for the association's written evidence, which was very helpful. I thank Baroness Gerada for the evidence she sent to us and the recommendations in that. Both were very helpful. Can I move to you, Baroness Gerada?

Baroness Gerada: By way of introduction, I spent 40 years, until very recently, as a GP in the same practice. The practice started as one practice on one site and is now made up of about 10 practices across 10 sites in London. It serves a population of around about 110,000 patients. I hope to bring to the committee my experience of the bad, the good and the not so good, and what I have learned throughout that time. I have also immersed my life in mental health, and there is an awful overlap.

I do not disagree at all with what Ruth said. One of the problems with the strategy is that the 95% target has been removed. I will state some of the positive things about the vaccine strategy. It is positive that it has expanded the number of vaccines that children are getting, including chicken pox, on the schedule. It is positive that we are looking at different ways of delivering care, including health visitor pilots. I will say something about that in a moment. On ICB devolution, it is positive, though as we go on with our evidence, that also has some problems associated with it. It is very positive that the 10-year plan talks about treatment to prevention. That is important.

Now for some of the problems: the strategy does not deal with the fundamental issues—deprivation, inequalities and poverty. The first thousand days have also stressed that. Dealing with vaccine in isolation completely misses the point. The strategy completely misses the issue around workforce—in particular, the first rung of public health, which is made up of GPs, health visitors and district nurses. While the district nurse pilots are good, we are just robbing Peter to pay Paul, because we know—and I am sure that you have heard—that we are about 5,000 health visitors short. To put that in context, that is nearly one health visitor per practice— if they were still attached to practices, which they are not. Though the strategy deals with deprivation, we are seeing inequalities widen. On many of the recommendations, including the issue

about using a digital solution, my patients cannot afford to have data. They might be able to use their phone as a phone, but they cannot use their phone unless they are connected to wifi for data. I think we forget the privileged positions that we are in—that we can just download the news at any time. We will talk about using a digital solution.

Finally, one of the issues is around the massive reorganisation. I know that Professor Andrew Furber will probably talk about that. While I think that it is good to devolve it to ICBs, we are at risk—and the strategy does not talk about it—of replicating some of the terrible consequences of the 2012 Act. A lot of my email traffic is goodbye emails from staff that I have known from working within the different health systems. We are losing, yet again, an enormous corporate memory. I will stop there.

The Chair: Are we losing skills as well?

Baroness Gerada: We are losing the soft intelligence and the names. Who do my staff ring up when there is a cold chain issue? This is vital. Who do we ring up when we cannot target the Bulgarian population? There is nobody. We are losing the soft intelligence.

The Chair: Professor Furber?

Professor Andrew Furber: I am the Regional Director of Public Health for the North-West of England. As regional directors of public health, we work across the Department of Health and Social Care, where we lead the department's health improvement and public health interests in our regions. We also have a role with NHS England. We oversee NHS England's prevention and inequalities programme, among other things. It is in the latter capacity that I am speaking to you today. I think you heard from colleagues in the department earlier in your inquiry, and you have our Minister coming in later to talk about the department's position.

I am really pleased that you are having this inquiry. The fact that UKHSA has reported two measles deaths this year is truly heartbreaking. I very much welcome the focus that you are bringing to this topic. That is one of the strengths, if you can call it that, of the current position: there is recognition that we are facing a major public health challenge, and your recommendations will be very important to that.

I agree with everything my colleagues said. The focus on inequalities will be fundamentally important. The unquestionable correlation between vaccine uptake and deprivation needs to be a core part of our thinking. The immunisation equity strategy is really helpful in framing some of that, but putting it into practice is clearly a challenge.

The three shifts in the 10-year plan give us hooks on which we can take some of this forward: the shift to prevention; the shift to neighbourhood health; and the increasing use of digital and the focus on data, which I am sure will come up later in our conversation.

This is about how we embed vaccination programmes within a broader portfolio of prevention work and our engagement with communities so

that they are not stand-alone programmes but integrated into a number of other activities that we have around early years, family hubs, maternity pathways and so on. That gives it more resilience.

The Chair: You represent the whole of the north-west region. How many ICBs will there be in your region?

Professor Andrew Furber: We have three ICBs—integrated care boards—in the north-west.

The Chair: Do we know whether they will cluster themselves when the changes come?

Professor Andrew Furber: No, they will remain as three.

The Chair: I see. Thank you.

Q152 **Baroness Nye:** You all mentioned the subject of my question in your opening statements. Witnesses have told us that the delegation of responsibility for commissioning to ICBs and the abolition of NHS England present both risks and opportunities. Baroness Gerada, you called it positive but said there was a risk of replicating. Ruth, you mentioned the job card and who will control it. In the context of these reforms, how could national, regional and local responsibility and accountability for childhood vaccination coverage be strengthened?

Professor Andrew Furber: We know that all change is disruptive and are mindful of the change that colleagues are going through at the moment, but, in principle, there are some real opportunities here. The role of regions, where I sit, will be increasingly powerful. We have seen this over recent months as we have held organisations to account for delivery on urgent and emergency care recovery and elective recovery. We have begun to see some progress on that. The challenge going forward is how we bring similar scrutiny on to the prevention agenda and, in the case of your inquiry today, the role of ICBs as strategic commissioners of immunisation services.

There is an opportunity for ICBs. In the north-west, their combined budget is in excess of £6 billion, so they have direction over a lot of public money. There is an opportunity to get them to think about how they can commission immunisation services within that quantum of resource, shifting resource towards neighbourhood health and communities and integrating vaccination services with other services that they commission. It needs national direction—standard setting and target setting at a national level—for us to then carry out our regulatory and assurance role around both ICBs, as strategic commissioners, and provider organisations, to ensure that delivery continues to improve.

Baroness Gerada: I agree with everything that has been said except for the caveat that, as I said at the start, we lost 10 years of work in 2012. While the NHS Confederation says that ICBs have the knowledge—it did a big survey—we have to be very careful about whether they are ready to take on these responsibilities. Strategic commissioning is very difficult.

We think of commissioning as just buying something, but it requires a tremendous amount of public health involvement and knowledge at the grass-roots level. So I agree, but I have a caveat.

There are clearly some advantages to the ICB. You can flex how you spend your money depending on the local population, and, much more importantly, you can integrate with your population health. But unless we have accountability at national level, with a national statutory body that is responsible for vaccination—that 95% target and all the other targets—we will just diversify responsibility, and when you diversify responsibility, you get no responsibility. At regional level we need some really skilled pan-regional commissioning, whether they are clusters of ICBs or whatever you call them, and, at local level, we have to have local vaccine co-ordinators, which I know is one of the issues that you have discussed. That has to be somebody who has a paid role that is not an add-on to the rest of their role, who is able to link in with the various parts of the system.

Ruth Tennant: I agree with everything my colleagues have said. One thing that we are all understanding as the new ICB structures come into play is how the very local interfaces with something that is working across a very big geographical footprint. Clearly, as colleagues have said, there are some benefits to that, but we know from our experience, when we have dealt with things like outbreaks, that you need very local knowledge and good connections with voluntary and community leaders who have credibility in local communities. You need the ability to get into very small parts of your community where there is an issue, and that will need really good local-to-ICB-level working. We are really keen to see how that plays out. There is a role for local directors of public health to work with their integrated care boards to say, “In my area, we really need to get to this pocket, where we know we have low uptake”, and to bring together the people who have credibility with that community. That is where we will get a really strong approach.

Baroness Nye: What is your view on the reintroduction of a local immunisation co-ordinator?

Baroness Gerada: Absolutely, yes. We need someone to bring in the local knowledge and help.

Ruth Tennant: It was in the primary care group; some of you may remember the primary care group days. That was a really important role and it was at quite a local level. We need someone who is able to really pull together the jigsaw, whose job card is to make sure that we increase uptake and that we are doing all the right things. We need to work out where that sits best: should it be within an integrated care board, but with good links to the local level? What is the right unit to deliver this? We really need people who have that as their job cards, who are clearly accountable, with the right level of seniority. We need it to be owned by boards: this target needs to be right up there in senior consciousness. It is about having a person with a job card, but also people taking that target really seriously at a very senior level.

Baroness Nye: Professor Furber, do you have anything on the idea of a local immunisation co-ordinator?

Professor Andrew Furber: The function is essential to effective delivery of vaccination programmes, but, rather as Ruth said, there are different ways to crack the nut. The function is really important; whether it needs a role depends on the local arrangements. One of the things that I hope we will come on to is the need for more innovation within the system, because what we have at the moment is one size fits all, and we know that, given the strong link to deprivation, we need some local innovation in order to tackle what inevitably is a local problem. The engagement of directors of public health is absolutely fundamental to doing that.

The Chair: At what level do you think that co-ordinator should be? Is it at director of public health level?

Baroness Gerada: I personally think it should be at PCN level, at a cluster, but it depends what their role is. You should have someone national, whose head rolls, who is accountable to the Secretary of State for Health or whoever takes responsibility, and someone at a regional level, but this has to be local—perhaps one per 100,000 population, which is essentially what a PCN is.

The Chair: Thank you. Could I have a little clarification? Professor Furber, you said that you have responsibility for holding the ICBs to account. What levers do you have to do that?

Professor Andrew Furber: NHS England has published an oversight and assurance framework that contains a number of metrics. One of those for ICBs is MMR uptake, so it is good that we see that. We have regular assurance meetings with the ICBs and we monitor their performance on these various metrics. If we are concerned that an ICB is not delivering, we can put directions on the organisation that require it to take certain actions to deliver improvement. So there is a kind of escalation that we can go through should we be concerned about the performance of a particular ICB.

Q153 **Baroness Andrews:** Good afternoon. I am sorry not to be with you in person. I want to ask Professor Furber about the idea of embedding vaccination. You spoke of a sense of urgency, which has been driven by outbreaks, and you mentioned a few possibilities—early years, family hubs and so on. Are there any other public health settings or avenues where there is a relatively captive audience that would allow vaccination to be driven in those directions and deeper into the communities with which you are obviously very concerned, in terms of deprivation?

Baroness Gerada: I do not mind picking this up first; it ties in with the next question. You were slightly muffled, but I understood your question as asking whether there are any other public health places where you can deliver vaccines. Yes, of course there are, but I want to back-pedal a little.

The problem we are trying to solve is that of strengthening the public health space that already exists and that did exist, which is primary care reaching out to its community. I think we are at risk, if I dare disagree with Professor Furber, of creating innovative, short-term, non-evidence-based solutions that then get dropped, which are not sustainable, which do not understand the local community and which do not use the voluntary sector. We must start to build on what we already have, rather than try to split it apart.

We talk about family centres, which of course sound like a good idea, but I provided them 15 years ago with bolt-on social workers, debt advisers and housing officers—knowing the family and their community, without just removing children and mothers. We will now have women’s hubs removing women and mental health hubs removing mental health patients. We will soon have men’s hubs. We are then left with a transactional space that is not a public health space, so my sense is that we are looking at this through the wrong lens.

We have to learn from Covid, when GPs were able to engage local communities, go to mosques, go to rabbis, start talking to people and go to local places—schools were not open—where the patients were. I still fundamentally say that we are trying to create solutions, rather than build on the solution that was the jewel in the crown of the NHS for decades.

Baroness Andrews: On that basis, Clare, how would your concept of a national statutory body link in with your absolutely understandable concern that public health is below the radar in different ways?

Baroness Gerada: I am not 100% sure that I understand. The requirement is for a national statutory vaccination lead that has a statutory responsibility. I would ask the experts how that sits in the NHS body, because I do not know.

Baroness Andrews: That is fine; I understand where you are coming from now. Professor Furber, do you have any other comments to add on that?

Professor Andrew Furber: I do not disagree with anything that Clare has said. The mainstay of childhood vaccination delivery is now and will always be through general practice. It is important that we make sure that that GP system is as strong as possible so that we continue to deliver as effectively as possible.

I go back to my point about inequalities. The data shows us that there is a small but significant proportion of the population for whom the GP system is not working, for whatever reason. We have a spectrum of general practice: the majority is very good, but a small proportion is perhaps less effective. There are also characteristics of local communities that perhaps mean that they do not engage with general practice in the way that the majority of the population does. In those circumstances, we need to think about the other touchpoints for these parts of our

population—as I said, they might be family hubs, health visiting or early years—where we need to think more creatively.

I was looking before I came at a number of good case studies, such as Bolton, Wigan and Trafford—just within the Greater Manchester area. I know that you have heard from Liverpool as well. However, I completely agree with Clare that the problem with these initiatives is that they are in response to cases of measles or an outbreak of some sort. They are very effective at increasing vaccination uptake in the short term, but they are not effective in the long term. We need to move from that to doing things that are sustainable and long term, and that engage communities in a more meaningful way, to make sure that we develop those relationships with community leaders and voices for the long term, not just for the short term, and that we deal with those things more sustainably.

- Q154 **Baroness Andrews:** My question is about GP services and their capacity. We have heard from many witnesses about how difficult it is for many families to access some of those services, because of capacity issues and sometimes the sheer inconvenience—having more than one child, trying to get to the surgery, follow-up notices and so on. My question is a very basic one, actually: do you have an idea of the best ways to build capacity in the core childhood vaccination services based in primary care? Clare has already raised the issue of workforce and so on, but where should we start?

Baroness Gerada: You have my evidence and I have read the evidence from your previous witnesses. I slightly disagree with some of their points. For example, one witness said that a young person came to the practice for a vaccine and was turned away. It is very unusual to do that; we would like to grab them in.

Let me start with some figures, which I have given you. We have had a 120% increase in the number of hospital consultants over the last decade and a -5% decrease in the number of GP principals—people like me. We have seen a fall in health visitors of 40%. We see now that about 80% of all nurses and doctors reside in hospitals, whereas, however you measure the activity, we know that 30 million contacts per month are in primary care. That 30 million is half the population of Britain every month, more or less. I know that that is probably not any of you, but this is an average.

We have also seen a formula for deprivation that is now 30 years old, which does not weight complexity but basically weights age and sex, with extremes of age. So someone in my practice at 55 has the same morbidity as an elderly person in Bournemouth. We get no deprivation because they are not 75 yet.

We have this downward spiral of general practice. Meanwhile, we have a removal of more of the workforce into these other spaces. We are also moving general practice from a relational activity—knowing the patient in the context of their family and community—to a transactional one of

giving repeat prescriptions and giving jabs, rather than knowing the whole person. That is decreasing.

I would argue that much of the evidence that you have had around access and hesitancy is not correct. You cannot argue that we have no access when we have 30 million contacts per month accessing us. You just cannot argue that. We have also always had hesitancy. I worked post Wakefield: if you want to see hesitancy, that was hesitancy. But we addressed that, and my partners are still addressing it—I spoke to one today. In order to bring in someone who is hesitant, you need two or three consultations. That is 30 minutes of time when we get £150 per patient per year. In order to do innovative solutions, we have to have time to consult the local community. My sense is that we want to do more, but our biggest constraint is time.

Baroness Andrews: You said that across your 12 practices you have good and bad. What would you define in terms of what you have just said?

Baroness Gerada: In terms of the practices that we serve, our range goes from 95% to just under 50%. I have looked at this, and my partners have looked at it, and it is deprivation. In the most deprived, we are lower, and we are higher in the more affluent. They are all in deprived communities because London itself is quite an unusual space that has about a 20% turnover rate. We basically we have the same staff, the same systems, the same ethos. I have given you evidence around the deep-end studies that show that if you are in the deep end, you have less money, more work, more turnover and more burnout. We range across those. You will find that London ranges across that, and I am sure my public health colleague will say that if you map deprivation and you see the thousand-day work, it is deprivation, housing, employment.

Of course, we have to factor in special communities, such as the Roma community. We have a large Bulgarian community who are very hard to vaccinate because they have historical reasons for why they mistrust vaccines. We find ways of doing it, and we find ways of engaging their elders, maybe to help them. We want to do this. We did it in the olden days. I and my partners would get on our bike, literally, and cycle to the patients who needed it. That requires time.

Baroness Andrews: I have one more question just for you. You mentioned that you are welcome. Do you think that the health visitor pilot is going to be able to be universalised because it will work more effectively than most strategies?

Baroness Gerada: Again, in the olden days, 15 years ago, we had three health visitors attached to our little group of practices who we saw every week. We would have corridor conversations. "I am very worried about Johnny". "Yes, I saw his father the other day. He smelled of alcohol." That does not happen any more. It is that soft intelligence—it is understanding the patient in the context of their illness, their family, their

environment and their lifespan. We have precious few health visitors now who are essentially carrying an enormous child protection caseload. Health visitors should give vaccines, but removing them into spaces just allows those who are going to get vaccinated anyway more choice. Bringing them back into the heart of primary care is the right way forward. If a recommendation from yourselves is that we need a real expansion of health visitors, school nurses and GPs, we would start to address some of the problems that we face now.

Q155 Baroness Andrews: May I just ask about capacity issues within GPs from your public health perspectives? Do you have anything that you would like to add to any of that? Can I start with you, Ruth?

Ruth Tennant: I think the Association of Directors of Public Health would completely agree with some of the points Clare has made about resourcing. We know the current formula does not help practices in areas of deprivation, and that has all the knock-on consequences that Clare has just described. I agree that general practice is absolutely the backstop of vaccination provision. There have been some good steps to nuance some of the payment mechanisms. Of course, it is not all about payment, but the quality outcomes framework has now been changed so it rewards improvement rather than hitting a very challenging target, which is incredibly difficult in a deprived area. Some steps are being taken.

I am certainly seeing, at a local level, positive developments around family hubs. There is clearly a way of looking at them. For example, where I work, we have family hubs in areas of deprivation. You have collocation of social workers, debt advice and domestic abuse advisers. Health visitors do certain clinics there, but not all. We have antenatal appointments now, and we are seeing successes through that model. That is absolutely not taking away vital connections with primary care, but what we are seeing is people who may come in with something completely different. They may be coming in because they can go to the free school uniform stand, where there is then an opportunity to engage in conversation, including about vaccinations. My view would be that we want all those contacts to be working because we know that some parents, as Clare said, need that conversation to say, "I am a little bit worried about vaccination. Can I talk it through?" and they want a trusted person to do that with. It is important that we mobilise all these resources to get us to the end result.

One thing as an association that we are interested in is call and recall. It is a bedrock, that ability to phone up people who have not been vaccinated and say, "We have noticed that you have not been in. What could we do to get you in?" We would be interested in looking at how we could develop that. It is very resource intensive. I know that when we have done it, it takes a lot of time, but people need those hard yards to build confidence and trust, and that is the sort of thing we really need to do to get into our more deprived communities.

Baroness Gerada: Can I just add a caveat to that, if that is all right? Again, for those of you who do not work in general practice, we have

data within a week—you can get it real time—on how we are driving. So we do blitzes on ringing patients up and texting them and ringing them again in order to do call and recall. The problem that we have yet again is the inverse care law. It costs a lot of money to do that. Remember that you are doing that in deprived communities because they tend to be the relevant ones. I do not want the committee to think that I am against family hubs; I am not against family hubs, but they have to be understood in the context of the resource that they have removed and the opportunity cost of doing that.

The Chair: Thank you. I can see that Baroness Ritchie has a supplementary question.

Baroness Ritchie of Downpatrick: Clare, you mentioned in making your submission that you chat with people about hesitancy. What were their reasons for hesitancy and what corrective measures could you put in place to deal with them?

Baroness Gerada: It varies from the sublime to the ridiculous—not to call my patients ridiculous. So, for example, a large amount of the hesitancy among the Muslim community may be because it contains pork. It does not contain pork, so we have conversations. Others are still hanging on to the remnants of Wakefield—that it is going to cause autism. We have seen an enormous increase in ADHD—“Well, it is clearly causing ADHD”. The hesitancy around Covid—I spent a lot of time talking to women about it—was that it caused infertility. It varies. Hesitancy is not fixed; it tends to be something you begin to understand and you start to frame it. There will always be 1% of people who absolutely think it is poison but, on the whole, surveys that have been done by UK JCVI, or whatever it is, have shown that hesitancy is not the major issue. The issue is around understanding their fears, hopes and beliefs.

The Chair: We need to move on. Actually, we have three more questions to get through and not enough time, so can I ask Baroness Neuberger to come in?

Q156 **Baroness Neuberger:** You have somewhat answered this, at least tangentially. I am going to say to Clare: let us assume for the moment that primary care is not going to be expanded massively quickly, because it takes quite a long time to do that. It is in that light that I want to ask this. The NHS and local authorities can and do work with undervaccinated communities, build trust and develop outreach services, but—you have been saying this—the initiatives are short-lived and really quite short-term. I want all three of you to answer this, if possible. What would you regard as the best way to develop effective and sustainable outreach services and outreach models? Obviously, primary care is one key way, but that is not going to happen quickly.

Baroness Gerada: I will be brief. It has got to be multiyear, ring-fenced funding, not just the lollipop lady giving out condoms on the zebra crossing, which did happen during HIV and did not work. You absolutely have to have the voluntary sector as co-partners. It is not the NHS. This

is just as it was during Covid. You absolutely have to bring back neighbourhood health workers—link workers, whatever you need to call them—and you absolutely need to address some of the data and some of the misinformation that is going on. I will give you a very brief example.

Baroness Neuberger: Sorry, I am going to stop you. You have to address it, but how would you address it?

Baroness Gerada: You address it by using your local knowledge. As I said, during Covid we learned that different communities had different reasons why they were not getting the Covid vaccine. I am not being dismissive of ICBs, but we asked for help to get through our Bulgarian community. We were told, “Well, why do not you text them?”—we tried that several times. It is about getting beneath that and finding out some of the reasons as to why they are not doing so. Is it because, “We are being spied on”? Is it, “They trying to put data into their system”?

Ruth Tennant: I agree with all that. It really comes down to local partnerships. I agree that we need to have a sustainable funding route to do this. We are very good at doing it when we get an outbreak, but we need to be doing this all the time. Local councils will have, for the most part, excellent relationships with the voluntary community and faith leaders. They will be engaging with them on all sorts of things all the time. There is something about how we really use those networks.

The data is crucial. We have to ask: where do we know we have low uptake and what would a solution look like in that area? To give a practical example, we had low uptake in one of our Roma Traveller sites. We talked to our local GP practice and our health visitor, both of whom are trusted, and we worked out a local plan to go in there. That needed local intelligence, local credibility and the right clinical teams at a very local level.

Baroness Neuberger: And extra money?

Ruth Tennant: That was less about the money and more about the relationships and working to a common plan. As I said, that was an outbreak situation—it is very easy, when you have an acute crisis, to pull¹ in—but this is about how we do that over the 10 years that, realistically, it will probably take. How do we get that into a sustained programme?

Baroness Neuberger: Professor Furber, can you comment from a regional perspective?

Professor Andrew Furber: I agree with all that. This is something that ICBs should look to commission over the longer term, particularly for areas where uptake is the worst, so that you have locally embedded outreach models. I completely agree with the point about these being co-designed with communities, VCSEs, faith groups and schools, while thinking about accessible settings. During Covid, we had some great examples of vaccines being delivered through mosques and really

¹ Note by witness: ‘pull resource and people in.

accessible venues. We need to be thinking about community champions that you equip for the longer term, so that you have a strong local voice.

The Chair: That moves us on to the issue of data.

Q157 **Lord Dholakia:** I have a question about the data required for childhood vaccination. We have been told by witnesses that this applies to the NHS, local government and patients. What could be done to alleviate this particular situation? What is the best way to improve these things?

Baroness Gerada: You are the data experts.

Ruth Tennant: I am happy to start, and Professor Furber may then want to come in.

I think there is consensus across the system that we need a national dataset for childhood vaccinations with live, real-time data. We have some good developments in training around the childhood programme. I do not know whether colleagues have heard about the Mavis programme, which is attempting to bring in a single system for schools. That is for school-age immunisations and vaccinations, but there are things like that that will be a real step forward if we can get there. At the moment, it is difficult to see live, real-time, accurate data, for a number of reasons that I am sure the committee has heard from other experts. To get to that granular detail—"Where do we have a problem and in which community?"—we need data to drive those bespoke solutions.

Also, for surveillance purposes, it is important that we can build confidence that things are getting better and that we can make a difference. Again, it is really important that we have good data in order to say that we are seeing the impacts of what we have done. That is where I think a national data solution is critical.

The right people need to be able to see that data. We have talked about how complex this system is. We need the ICBs and general practice. We need to have the right permissions, including local directors of public health who have teams that can analyse this data, to make sure that what we are doing is targeted and solutions-focused. It is an important part of the work you are doing to look at whether we are doing enough and what more we could do around that.

Professor Andrew Furber: When I talk to directors of public health in the north-west, this is their number one complaint. They always say that, if they had better data, it would empower them to do some of the local action that we have been talking about. It is a really important question and one that we get right.

I know you have already had evidence from others on how complex the system is. You have had other witnesses who have described some of the actions that are in place to try to improve the current situation and to provide more timely linked data, so I will not repeat all of that. The one point that I will make on new data arrangements is that it is important that we link it to deprivation in a better way—that we link it to ethnicity

and to geography—so that some of those inequalities that we have spoken about throughout the course of this conversation can be more effectively addressed through the data.

The Chair: Baroness Gerada, as a GP, what are the data issues that you encounter every day?

Baroness Gerada: There are lots of data issues. I wish that paediatricians could get the data as easily, so they could immunise. You had evidence from somebody whose child was immunised in Spain and that did not translate into the data.

You talk about ethnicity data. I am on the domestic violence group, and what we are learning is that ethnicity data is never granular enough. It might pick up the high level, but it certainly will not go down to tell you about the real pockets. It certainly would not tell you, for example, that the Bulgarian community in north London is not getting immunised, because they would just get mopped up into “white other”.

As a GP, ironically, we have very good data. We probably have the most accurate data of who is and is not being immunised across the whole system. It is just an issue of sharing that data with everybody else. We need to get over the fear of data sharing. I wish the new unique pupil record would include vaccination data, because it seems obvious that it should do so. That would be carried with the child wherever they went. For example, a paediatrician in a hospital would know that a child has not had their MMR vaccine; the paediatrician would then get it out of the fridge and give it to the child.

The Chair: Are you optimistic about the single patient record?

Baroness Gerada: Never. I am not optimistic at all about the improvements—but I am optimistic that there is a sea change in individuals’ in patients in wanting much more control over their own health and that of their children. Something has really shifted post Covid, so I am much more optimistic in that regard. We still have to address the inequalities. No, I am not optimistic.

The Chair: You mentioned earlier that a lot of data comes to the patient digitally, but a lot of patients are digitally excluded.

Baroness Gerada: It is not a lot, but it is a significant group. If we are looking at the deprivation, it is shocking when you see how people cannot afford data. We all look at our phones out there and think nothing of it—yet there is a group of patients, whom we all work with, who cannot afford that. That is the case when you are relying on a digital red book as opposed to a paper red book.

I also disagree that patients lose their red book. It is a bit like how they did not lose their maternity record. I still have both of my children’s red books; these are precious little objects. We have to be very careful about dealing with a deprivation strategy digitally. It is not always the right way forward.

Q158 Baroness Cass: We have to make recommendations to the Government on this complex array of issues. You have given us lots of thoughts on the way things should move forward, but I ask each of you to concentrate your minds to give me your top two recommendations that we should give to the Government.

Baroness Gerada: If they have chosen one of them, can we have another two?

Professor Andrew Furber: I have a long list here, but I will limit myself to two. From my perspective, the top one would be a clear accountability framework. We need national direction and standards, alongside regional assurance and local delivery. If we can get that value chain right, that would take us quite a long way.

The other is an explicit focus on inequalities. To be intentional about our commitment to address this through an inequalities lens would be important in addressing the gap that we currently have between the majority who take up the vaccine and the minority whom we have the greatest concern about.

Baroness Cass: You can send a whole list in afterwards.

The Chair: Baroness Gerada, let us hear your top two.

Baroness Gerada: Here are my top two. First, the figure of 95% should be not aspirational but the absolute, scientifically determined level of immunity that we need for herd immunity. We must restore the WHO's target of 95%, then find out.

The second thing is to rebuild the workforce, with health visitors, district nurses and general practice. If I am allowed to do so, I would also add a caveat: relook at the deprivation payment, which is called Carr-Hill, because, without that, we will get nowhere.

Ruth Tennant: The trouble with going third is that you have to agree. I agree completely with everything that my colleagues have said.

Baroness Cass: You can have two more, if you like.

Ruth Tennant: Okay. I would go back to tackling the main barriers to uptake—including access, limited awareness, confusion around eligibility, safety concerns and some of the practical challenges—and making sure that what we do comprehensively addresses those barriers, particularly through an inequalities lens. Having the 95% target is absolutely essential, as is being clear about who has the job cards to deliver it.

As a sideline, I think that we can be distracted by vaccine hesitancy being the thing. It has been very clear from the conversation today that that is not the case. There is something around recognising that, as Clare said, overall public confidence in vaccination remains really high. Let us send out a really positive message on vaccination, including the benefits and how you can do it.

Baroness Cass: That is brilliant; thank you so much.

The Chair: Thank you all very much indeed. This session has been very helpful and informative. It has been particularly useful for us to have your on-the-ground experience. I remind you that, if you want to send to us anything further, please do so. With that, I shall now close this public session.