



CHILDHOOD VACCINATIONS COMMITTEE

UKHSA RESPONSES TO CHILDHOOD VACCINATIONS COMMITTEE FOLLOW UP QUESTIONS

Further to the exchange with Baroness Cass at Q218, please briefly outline the scope of work on the framework for action for immunisation training and give an indication of when outputs are expected to be published.

1. UKHSA are leading a group which has brought together experts from DHSC, NHSE (Clinical, Workforce, Public Health, Primary Care representation), academia and those leading on training from the devolved administrations to review and develop options for improving the delivery, accreditation and assurance of high-quality immunisation training.
2. The purpose of this group is to:
 - a. provide strategic leadership and governance for the development and implementation of training resources for the national immunisation programmes and for health professionals at all levels who are involved in the provision of these services;
 - b. revise/refresh the minimum training standards to ensure robust arrangements for immunisation training going forward (these were updated and republished in July 2025);
 - c. clarify the roles and responsibilities for training provision and access to training;
 - d. identify gaps in the understanding of training resources, capacity, and implementation which would benefit from further research;
 - e. support the development of training pathways, competency frameworks and ongoing developmental programmes for clinical / public health specialist immunisation roles and for providers across the full immunisation pathway – the Framework for Action on Training has been developed to take this forward;
 - f. develop a resource or toolkit for Integrated Care Boards (ICBs) to support them in their role as commissioner as they take on their delegated roles and responsibilities. This is ongoing.
3. The Minimum standards and Core Curriculum for Immunisation Training (2025) provide the 'what' in relation to the knowledge and skills that all immunisers must achieve to be signed off as competent to practice in this role. The evidence reviewed by the group indicated that whilst these standards are clear, there are no equivalent standards to guide the 'how' in relation to the delivery and assurance of immunisation training in England. Training in England is provided by a range of providers from in house, or via Primary Care or Trust training hubs, or most commonly via small external independent commercial providers. There is currently no standardised accreditation process for individuals completing training and no accreditation or assurance of the training being provided. Whilst this does not in itself mean that the training is not of high quality this lack of oversight means that it is not possible to say for certainty that it is. Given that having

knowledgeable, confident and competent and confident staff is evidenced to be essential to the integrity of the programmes and underpins public trust, the group have been developing a Framework for Action on Immunisation Training to agree and then progress options to establish an optimal approach to delivering and assuring training.

Please see copy of the Framework and actions being taken forward by the working groups attached.

- a. The first document provides an early framework for how vaccination training could be approached, and identifies key areas where decisions are required.
- b. The overall purpose is to determine the work needed to produce an action plan, including costs, to present to ministers.
- c. The framework is organised around five themes and does not propose changes to national minimum standards. The focus is on how training is delivered, assessed, and quality-assured, not on what vaccinators need to know.

4. Theme 1 – Training Model (Central vs Local)

- a. Options of models ranging from fully centralised training (e.g., UKHSA-designed and delivered) to fully local models (e.g., GP practices/employers designing/delivering training).
- b. Not recommending a particular model but reviewing all possible options with their advantages and disadvantages.
- c. Each theme has associated actions needed to reach decisions.
- d. A working group will refine this into a smaller set of preferred options.
- e. Some options may require ministerial guidance due to financial implications.

5. Theme 2 – Needs Based Approach to Immunisation Training

- a. Examines the current vaccination workforce, acknowledging varied professional backgrounds, competencies, and registration status.
- b. Everyone must meet national minimum standards, but some roles (e.g., supervisors, those signing off competences) need additional skills.
- c. Recognises people involved in the vaccination pathway who do not administer vaccines (e.g., teachers, volunteers, outreach workers) but still require training.
- d. A simple vaccine pathway has been developed to identify where training needs exist beyond traditional vaccination roles.
- e. Includes exploring models for accrediting and assuring those who deliver vaccinations.

6. Theme 3 – Accreditation and Assurance of Training Providers

- a. Expects training to be delivered through a hybrid model, rather than solely through central or local mechanisms.
- b. Questions to address:

- i. Who is providing training?
- ii. What training is being delivered?
- iii. How is quality ensured?
- c. Explores potential accreditation or assurance systems for training providers.
- d. Further work and costings will depend on decisions from Themes 1 and 2.

7. Theme 4 – Innovative and Tailored Vaccination Training

- a. Looks at new training approaches, including the use of technologies such as AI.
- b. Emphasises reviewing evidence and testing new methods.
- c. Highlights the continued value of face-to-face training and warns against defaulting too heavily to remote or online methods.
- d. Considers whether in-person training should have a stronger local component.

8. Theme 5 – Role of Public Health in Vaccination

- a. Recognises significant system change, loss or reduction of certain roles, and increasing complexity in the vaccination landscape.
 - b. Seeks clarity on where public health expertise fits within the vaccination programme.
 - c. Covers the full spectrum from local authority public health teams to national public health functions.
 - d. Intends to define roles, responsibilities, and workforce needs across the system
9. Work is in progress to develop costed options for the first two themes as these are critical dependencies for the remaining themes, particularly Themes 3 and 4. This has included producing a survey which has been sent out to immunisers, and those who commission or procure immunisation training, to establish a baseline in relation to the current provision of training. This survey is due to close on 16 August and will inform the options appraisal for the Training Model and the Needs based approach to training.

10. Key actions for the task and finish groups working on Themes 1 and 2 are as follows:

11. Theme 1:

- a. Map current training providers and how training is delivered across regions.
- b. Identify data sources that demonstrate effectiveness of existing training models.
- c. Engage with the **UK National Screening Committee sponsor** to understand training and training governance arrangements for screening and how these compare to immunisation.
- d. Engage with devolved administrations to understand the detail and practicalities of their systems.
- e. Develop a shortlist of feasible training delivery models and assess economic and staffing implications.

- f. Engage key system stakeholders to understand their role in potential models.
- g. A proposed list of stakeholders for the working group was shared (UKHSA and NHS partners).

12. **Theme 2:**

- a. Determine learning needs for different staff groups delivering vaccinations (e.g., pharmacists, health visitors).
 - b. Identify what level and type of training is required.
 - c. Engage with Royal Colleges and other professional bodies.
13. These groups are established and recommended options are being developed which will be presented to minister in September. Once preferred options are agreed these will then be consulted on with key stakeholders including the Royal Colleges. Work will then rapidly progress on developing and appraising options for delivering robust but workable accreditation and assurance arrangements to underpin the model and approach. The timescales for producing the Action Plan to guide the full development of the Training Model is April 2027, with implementation to take place during 2027/28 (noting that the complexity of the assurance process will be dependent on the final option agreed for the model e.g. if a centralised model was preferred, assurance is simple as only one provider; if the preferred model is a hybrid, hub and spoke, or distributed then assurance is much more complex and may need to involve the commissioning of, for example, an academic or other body to provide and administer that assurance arrangement). A **clinical advisory group** is being established to support this project and will include staff who would ultimately receive training (e.g., school immunisation nurses, pharmacists, HCAs, non-vaccinating staff such as teachers or receptionists) to enable sense checking and acceptability prior to delivering the final options.
14. Progress has also been made in relation to Theme 5 which related to Specialist Public Health Training following the development of a Special Interest Group (SIG) for Immunisation within the Faculty of Public Health. The purpose of the SIG is to bring together Faculty members with an interest in immunisation to drive forward a programme of work, which includes pathways for specialist training and the development of clear competency standards.
15. Finally, a **motivational interviewing** and **empathetic refutational interviewing** task and finish group has been convened and has been reviewing the various approaches to delivering training on motivational interviewing skills, alongside evidence of the effectiveness of those approaches. Whilst of considerable interest, this forms only one part of the wider training work and will be incorporated into the overarching framework. The task and finish group has recently produced a document summarising the findings which is pending publication.

In [correspondence](#) to the Committee, the President of the Faculty of Public Health suggested consideration of a system of standing consent for vaccinations, established at the beginning of a child's school journey and maintained throughout their time in education. What is your assessment of the merits and drawbacks of this proposal?

16. It is unclear what is meant by a system of standing consent, however, if this means a single consent obtained when the child commences school which then acts as the evidence of consent for all vaccinations throughout the child's time in school, then this has been considered extensively.
17. It is a general legal and ethical principle that valid consent must be obtained from an individual before starting a treatment or physical intervention. For consent to be valid it must be given voluntarily by an appropriately informed person who has the capacity to consent to the intervention in question.
18. Consent is a fundamental principle of good health care and professional practice. It is a process rather than a one-off event. The exchange of information between the healthcare provider and the individual, or someone with parental responsibility, is key to ensuring informed consent. Where feasible, healthcare professionals seeking consent for immunisation should find out what matters to individuals so that they can share relevant information about the benefits and risks of immunisation, including the risks of not proceeding with immunisation. The information provided should enable individuals to make fully informed decisions about immunisation and be given sufficient time and support to understand that information.
19. The current consent model for school-age immunisations requires parental consent to be obtained close to the point of vaccine administration in schools. Challenges in obtaining consent for school-based adolescent vaccination programmes have been identified as a barrier to vaccine coverage. These include the non-return of written parental consent forms, limited capacity to undertake follow-up telephone calls with parents, and low levels of school engagement with adolescent vaccination programmes.
20. Current consent practices vary nationally, relying on mixed e-consent platforms, alongside paper and verbal consent, with information disseminated via letters, emails, texts and phone calls.
21. The consent process has recently been made more convenient for some parents through the national roll-out of a NHSE owned digital platform (MAVIS) that manages the end-to-end consent process from School Age Immunisation Service (SAIS) team to parent. While the reminder process is robust, it is still possible for parents to miss the message or forget that action is required even if they want their child to be vaccinated. Further information is available on MAVIS if required.
22. We are currently working with colleagues in NHSE, DHSC and with our legal teams to look at whether we could further simplify the consent process, to preserve the purpose of consent, but to make it easier for busy parents to respond as required, this review includes consideration of the benefits and challenges of using single consent processes.
23. Whilst the potential benefits may be reduced administrative burden on immunisation service providers and parents, there are several important challenges. These include:

- a. Potential risk that those who decline may fail to be re-offered the opportunity to change their mind and consent in subsequent years. Any process would need to ensure non-responders and decliners were reoffered the opportunity ahead of the following year.
- b. Low-uptake cohorts and vulnerable groups may be most at risk of loss to follow-up. A single consent model would need robust joined-up data systems to consistently and correctly identify non-responders to ensure confidence that parents and children do not miss out on future opportunities to consent.
- c. The approach may not meet the clinical safety standards for consent (see UKHSA legal view below) because:
 - i. it is not timely – if taken a year or more in advance, some people may view this as too far in advance;
 - ii. whilst it may reduce some of the current administrative burden by reducing the number of times consent is sought, it may also create some new administrative burdens, such as managing tracking of consent, follow-up in subsequent years of non-responders/active decliners. There would need to be a mechanism to share information for pupils who change schools between years or to re-ask those parents if they have consented.
- d. As the SAIS teams do not have access to an individuals' medical record, the consent form also acts as a means of gathering information about the child's health status. Health status can change, sometimes rapidly, meaning that a clinical contraindication to receive a vaccine which was not present in previous years may be present in the current year. It is therefore still necessary to gather this information from the parents (or Gillick competent young person), before each vaccine, including flu, is offered
- e. Indemnity and professional risk: A single-consent model for recurrent (annual) flu vaccination may fall outside established legal and professional standards which require consent to be informed and time-specific. Flu vaccination is considered clinically to be a single episode of care. This means that each year the administration of the flu vaccine is a new episode of care rather than continuation of a course of preventive treatment or an additional / booster dose. Where adverse events or disputes arise, clinicians could therefore face increased exposure to clinical negligence claims on the basis that consent was not valid at the point of administration. This may place pressure on indemnity arrangements (e.g. NHS Resolution schemes), with potential consequences including personal professional scrutiny, regulatory referral (GMC/NMC), and challenges in defending claims, where contemporaneous, procedure specific consent cannot be evidenced.
- f. There is very limited evidence available that assesses the impact of a single flu consent model on vaccine coverage.
- g. The approach risks eroding trust with parents and schools if consent is not clear and proximate to vaccination, particularly where decisions may have changed either in

favour or to decline vaccination. In this model potentially 5 years may have passed since consent was given. This could be counterproductive for vaccine hesitant groups: as there may be a perceived lack of consent at the time of vaccination. Conversely parents who change their mind and who may now accept vaccination would not have a prompt to reflect this in the consent held on file for their child.

- h. A successful legal challenge or media coverage of any adverse events arising from inadequate consent would potentially result in reduction in confidence in the national programme.

24. The legal position on consent, from UKHSA legal team is as follows:

- a. There is an important distinction between vaccinations that are delivered as multi-dose courses and those delivered as annual/seasonal programmes. For vaccinations delivered as a defined multidose course, a single consent can ordinarily cover the entire course, provided that:
 - i. No material clinical changes arise between doses that would alter the information on which consent was originally based; and
 - ii. The young person or parent/carer remains willing to proceed at each appointment.
- b. While there is no legal requirement to obtain new written consent for each dose, it remains best practice to reconfirm the individual's willingness to proceed before administering each dose. This is in line with NHS standards, which require that consent is voluntary, informed, and remains valid throughout the course of treatment.
- c. For annual/seasonal vaccination programmes (such as the school flu vaccine), a new consent must be obtained each year. Consent cannot be presumed or rolled over from previous years. This is because lawful consent must be:
 - i. **Informed:** reflecting the current year's vaccine formulation, eligibility criteria, risks and benefits.
 - ii. **Treatment specific:** tied to the particular vaccination being offered that season.
 - iii. **Time specific:** valid for the specific point in time when the vaccine is administered.
- d. This position is consistent with UKHSA's own guidance, NHS consent principles and CQC guidance.

Please provide the Committee with a (simplified as necessary) diagram of data controllers, inputs, flows and outputs for childhood vaccinations.

25. Please see attached a document produced by Colin Campbell which provides a diagram of the information as required above. This has been developed in collaboration with colleagues in the NHS England Vaccine Digital Services team

Response to the evidence provided by South Tees

26. Why does UKHSA (not the NHS) draft the patient leaflets?

27. Extracts from “Immunisation Against infectious Disease”, chapter 2 “Consent”

It is a legal and ethical principle that valid consent must be obtained before starting personal care, treatment or investigations. This reflects the rights of individuals to decide what happens to their own bodies and consent is a fundamental principle of good healthcare and professional practice.

People have the right to be involved in decisions relating to their treatment and care. The exchange of information between the healthcare provider and the individual is key to ensuring informed consent.

28. As part of the informed consent process, UKHSA aims to ensure that accurate information is available on the benefits and risks of vaccination, where possible tailored to the individual’s specific circumstances, for example their age group and/or clinical status. Research suggests that different individuals will want different amounts of information depending on their prior beliefs and concerns. No single product will therefore address this need for all vaccine recipients. People should therefore be able to access information before, at the time of, and after a vaccination appointment. They should also be able to ask further questions from a registered health professional. All these information sources need to be consistent.
29. UKHSA provides a huge amount of the evidence that is reviewed by JCVI when developing advice and recommendations. UKHSA also provide secretariat function for JCVI that formulates and publishes the committee’s advice that then goes to ministers and will lead to a vaccine policy decision. The UKHSA teams are therefore well placed to understand and accurately describe the benefits and risks of that vaccine, both overall and for specific populations.
30. UKHSA uses this expertise and knowledge to produce an extensive amount of guidance and support for health care workers, for example on the indications and contraindications to vaccination, and to provide accurate and up to date information on the effectiveness and safety of the vaccines. The definitive advice is contained in the relevant chapter of UKHSA’s “Immunisation Against infectious Disease”, and consistent information will be contained in online training resources, guidance to support medicines prescribing, and a set of frequently asked questions (which include less common questions on specific patient circumstances). This suite of resources ensures that Health Care Professionals (HCPs)

can help to advise the public on the benefits and risk of vaccination for them (on an individual basis), and to answer questions that they may have.

31. UKHSA also develops public facing resources including leaflets, flyers, and posters. These are developed and overseen by the same highly experienced clinical team to ensure consistency with the policy and with information provided to health care professionals. The scope of the information contained in these public resources will be similar to the parallel information for professionals but will use more appropriate language. The reading age that the core materials are developed for is 7-11 years in line with standard national requirements, however the amount of detail within the full range of resources varies as appropriate to the format. All resources are kept under review and are updated regularly as new information arises. In addition, translations and other accessible formats are produced.
32. The fact that UKHSA leads this end-to-end process should help to result in informed consent consistent with the expert recommendations and the national policy decision. UKHSA does not prevent other groups, such as those in the NHS or people working with community groups, from developing their own materials. UKHSA, however, does believe it is important that this information is cross checked to ensure consistency with authoritative clinical advice, and to ensure the legal basis of consent.
33. UKHSA also believes that it is more efficient for UKHSA to produce a single national set of resources, which avoids the risks of local products becoming out-of-date and therefore inaccurate or misleading. UKHSA is also happy to receive feedback on any specific concerns about content of the national resources and to update them as required based on that feedback. We, will also, wherever possible produce bespoke customised material to meet a particularly public health need where required, for example, during an outbreak in a specific community, or where a local team identifies a need for a resource in a format or language that is not currently available.
34. The NHS website is fully aligned with, and provides direct links to, all the national resources produced by UKHSA.
35. **In relation to the specific issues referred to by South Tees**, UKHSA were contacted by colleagues from Stockton on Tees council who requested that UKHSA review some resources that they had been developing.
36. They advised that:

This work initially came about from some local insights work that was conducted here in Stockton-on-Tees. It revealed that young people and their parents lacked knowledge, and accessible resources to acquire knowledge, regarding the vaccines offered to teenagers within a school setting. It also revealed that the NHS was considered more trustworthy than local authorities which has led us to pursue use of the NHS logo.

The creation of the leaflets was initially commissioned to an easy read provider who co-produced the resources with young people with learning disabilities. This company sadly went bust so we continued the project with another provider. Despite creating easy read documents,

we made the conscious decision to not include references to easy read on the cover or elsewhere on the document. This was largely due to wanting to appeal to those with a lower reading age as well as those with learning disabilities or accessibility requirements while attempting to remove any stigma.

Would you be able to advise whether the messaging is consistent with UKHSA guidance and whether it would withstand potential legal scrutiny?

Additionally, would you advise whether you feel they meet easy read requirements?

37. We carefully reviewed the two leaflets provided and advised the council that unfortunately they did not meet the required accessibility / Easy read standards and would therefore not stand up to legal challenge. In addition, it was advised that the national immunisation programme leaflets were free with free delivery to any stakeholder, vaccine provider, LA, school, college or educational setting and that it is important not to duplicate resources already available and that using those may enable better use of local funds for local community specific needs that the national programme is unable to meet.
38. UKHSA willingly provides advice to local teams on any materials they are developing if requested, but it does not require local areas to seek their approval when producing those localised materials. What we can do is to provide the artwork and files of the any of the national resources to local teams to enable them to adapt these materials to meet local needs if this is required. If the materials are significantly changed from the original, then the liability for any legal challenges arising, however, transfers to that local agency. We also advise that they will need to ensure that the materials be continually updated in line with any programme changes that occur in future. Given that the projects are often financed using one off or short-term funding, or as in this case are being produced by small local entities that may not be able to provide an ongoing service, these requirements are often not able to be met. This situation then risks those areas having materials that are not developed in line with accessibility standards and / or which are accurate, and with inconsistent or out of date materials then circulating for many years with both legal and clinical potential impact.
39. Where a local area shares an idea or requirement for a project or resource that has potential wider application or benefit, UKHSA will work with that team to develop the resource, including potentially funding the development, and will then make it available nationally with UKHSA endorsement.
40. Recent examples of this include:
 - a. **The shingles eligibility calculator:** developed by the Southwest Vaccination and Screening team and then professionally produced and published on Gov.uk and the NHS website.
 - b. **The Childhood changes / MMRV eligibility calculator:** as above
 - c. **JANAMAP app:** this is an app primarily aimed at Southeast Asian women-developed by a consultant obstetrician from the University of Leicester Hospitals Trust. UKHSA provided a small amount of funding to support the completion of two videos (on RSV

and flu for pregnant women), developed in collaboration with the consultant and then refined by UKHSA to a standard that was able to be endorsed.

- d. **Resources for the Gypsy Roma Traveller community:** developed at the request of local teams following measles outbreaks and in collaboration with Families Friends and Travellers, a national group which represents and advocates for this population group
 - e. **SEND resources:** again, identified as a need by areas responding to outbreaks of measles, then developed and published nationally to support parents and schools in supporting improving uptake for children with SEND
 - f. **Great Ormond Street:** working with the Specialist Nurse for Immunisation to ensure resources meet the needs of children with complex needs in secondary care settings
 - g. **NHS London maternity units:** these had a built-in translation function available on their website and was hoping to embed some patient information leaflets so that their patients can read in their preferred language with just one click (rather than uploading multiple versions of the leaflet in different languages). NHS colleagues asked if word/similar text-based versions of resources could be shared to enable this. Fully supported and provided HTML versions which were able to be used, and the system was able to be implemented in those units
41. **In relation to Stockton on Tees**, we provided the council with links to all the relevant accessible resources produced by UKHSA, as the resource that had been referred to was the very detailed, and much longer, combined leaflet which covers information on all the teenage vaccination programmes, and which is most often provided to parents who are seeking more comprehensive information. The team had not been aware of the full range of materials available, including that there were already national resources produced in EasyRead; in more than 30 languages and in other accessible formats, including Braille and BSL video etc
42. We recommended using the national programme resources for school aged immunisation consent and advised that there were also free stickers and posters for the programmes.
43. Links to the full range of resources provided to Stockton on Tees Council were as follows:

HPV:

<https://www.gov.uk/government/publications/hpv-vaccine-vaccination-guide-leaflet>

This provides essential information on the programme so that parents can give informed consent for their children to have their HPV vaccination. [Order copies in English here.](#)

There are 33 different language versions available to order and download: [Albanian](#), [Arabic](#), [Bengali](#), [Brazilian Portuguese](#), [Bulgarian](#), [Chinese \(Simplified\)](#), [Chinese \(Traditional\)](#), [Spanish](#), [Estonian](#), [Farsi](#), [Fijian](#), [Greek](#), [Gujarati](#), [Hindi](#), [Kurdish Sorani](#),

[Latvian](#), [Lithuanian](#), [Nepali](#), [Panjabi](#), [Pashto](#), [Polish](#), [Romany](#), [Romanian](#), [Russian](#), [Somali](#), [Tagalog](#), [Turkish](#), [Twi](#), [Tigrinya](#), [Ukrainian](#), [Urdu](#), [Yiddish](#), and [Yoruba](#).

Accessible versions are also available to order and download: [audio](#), [BSL](#), [Braille](#), [easy read](#) and [large print](#).

[Your guide to HPV vaccination for all - British Sign Language version](#), this version also has subtitles and a spoken audio track.

Teenage Booster:

<https://www.gov.uk/government/publications/a-guide-to-the-3-in-1-teenage-booster-tdipv>

Paper copies of the leaflet are [available to order](#) for free.

This leaflet is also available in 33 languages, both as paper copies and digital downloads.

[Albanian](#), [Arabic](#), [Bengali](#), [Brazilian Portuguese](#), [Bulgarian](#), [Chinese \(simplified\)](#), [Chinese \(traditional\)](#), [Estonian](#), [Farsi](#), [Gujarati](#), [Hindi](#), [Hungarian](#), [Kurdish Sorani](#), [Latvian](#), [Lithuanian](#), [Nepali](#), [Panjabi](#), [Pashto](#), [Polish](#), [Romanian](#), [Romany](#), [Russian](#), [Slovak](#), [Somali](#), [Spanish](#), [Tagalog](#), [Tigrinya](#), [Turkish](#), [Twi](#), [Ukrainian](#), [Urdu](#), [Yiddish](#) and [Yoruba](#).

MenACWY:

<https://www.gov.uk/government/publications/menacwy-vaccine-information-for-young-people>

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Or the **combined** **leaflet**
<https://www.gov.uk/government/publications/immunisations-for-young-people>

You can view, download, or order printed copies of this leaflet for free from [Find Public Health Resources](#) using the product code: [24YPGIEN](#).

44. It is highly likely that the improvement in uptake quoted resulted from a number of changes made as part of this project rather than being solely due to changing the resources, not least the additional engagement and dialogue with schools, parents, pupils and communities that was involved to enable the project to progress. We have advised that these are activities that can and should continue regardless of any decisions in relation

to local vs national materials. We remain in contact with the local team and are continuing to support with advice and guidance, however the decision to develop or use any alternative local resources rather than to use this wider range of accessible national assets and resources that we have provided, remains with that local authority.

30 July 2026