



CHILDHOOD VACCINATIONS COMMITTEE

NOTE OF COMMITTEE VISIT TO HACKNEY, TUESDAY 30 JUNE 2026

Introduction and tour of the practice

The delegation was welcomed to Spring Hill Practice, Hackney and given an introduction to childhood vaccinations in the area and given a tour of the practice.

The following representatives were in attendance.

Representatives

Agnieszka Polej, Deputy Practice Manager, Spring Hill Practice

Dr Tehseen Khan, Clinical Director, Springfield Park Primary Care Network

Anwara Begum, Practice Manager, Spring Hill Practice

Members of the Delegation

Baroness Walmsley (*Chair*)

Lord Dholakia

Baroness Ritchie of Downpatrick

Baroness Nye

Baroness Wyld

Introduction and tour of the practice

Dr Tehseen Khan began the session by welcoming the Committee, introducing the itinerary for the visit, and giving some information about the practice. The Committee and the participants then introduced themselves.

The Chair, Baroness Walmsley asked about whether there was an obligation for GPs to join a Primary Care Network (PCN) and whether they had any in the area not part of the PCN.

Dr Tehseen Khan responded that they do not have any GPs not in the PCN because of an established culture of working within PCNs in the area.

Baroness Walmsley then asked whether it would worry him if there were any that were not part of the PCN.

Dr Tehseen Khan stated that it would, as it could potentially lead to disparities and inequity for patients. Compared to 2019, they have 25 additional roles. When a practice is not engaged with a PCN they risk missing additional services, such as physiotherapy. It is advantageous to be part of a network.



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The Committee was then given a tour of the practice by Agnieszka Polej, the deputy practice manager, alongside other staff including Anwara Begum, the practice manager, and Dr Tehseen Khan. They stated that the practice was previously in a terraced house, subsequently merging with another practice and operating out of temporary buildings, until two years ago when the new practice building was built by the council.

Staffing at the practice was discussed, with the practice manager reporting 60 salaried staff and other additional healthcare workers who visit the practice. They explained functions of the different rooms in the practice, including a minor surgery room, and the different staff they had, including GPs, practice nurses, pharmacists, health visitors, and administrators, among others.

They also drew the Committee's attention to the work done at the practice by Volunteer Centre Hackney, who put on free events for the community throughout the week, including coffee mornings, walking groups, English learning groups, among others.¹ They showed the patient waiting area and the screens that have information on, telling the Committee that they would play an immunisation video co-produced with the local community. They highlighted that the health visitors hold baby clinics twice a week and they are always booked, with a doctor available to assist with any issues.

Upon conclusion of the tour, Dr Tehseen Khan and the Committee discussed how the architecture of the building helps instil a sense of calm on patients.

¹ [Together Better. Spring Hill Practice](#)



Roundtable

The delegation held a roundtable with representatives from Spring Hill Practice, Springfield Park PCN, community representatives, and North East London ICB.

The following representatives were in attendance.

Representatives

Dr Carolyn Sharp, Public Health Consultant, City and Hackney Public Health

Ratidzo Chinyuku, Senior Public Health Specialist, City and Hackney Public Health

Dr Tehseen Khan, Clinical Director, Springfield Park Primary Care Network

Gemma Evans, Lead Nurse, Immunisations Service, Springfield Park Primary Care Network

Samina Tarafder, Community Engagement Manager, Springfield Park Primary Care Network

Sarah Weiss, Public Health Lead and Policy & Compliance Officer, Interlink

Sarah Darcy, Strategic Lead for Children and Young People, NHS North East London

Mercedes O'garro, Operational and Digital Transformation Manager, Springfield Park Primary Care Network

Members of the Delegation

Baroness Walmsley (*Chair*)

Lord Dholakia

Baroness Ritchie of Downpatrick

Baroness Nye

Baroness Wyld

Discussion

Dr Tehseen Khan began the roundtable by giving the Committee some background information on childhood vaccinations in the Spring Hill Practice area. He stated that they have the core childhood vaccination offer but since the creation of the local GP confederation and given the extremely low uptake in North Hackney, they have had an enhanced offer. The Primary Care Trust (PCT) and Clinical Commissioning Group (CCG) always invested in childhood immunisation due to there being such low uptake in the area. In 2022 the GP



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confederation handed over the service to the PCN, hosted on behalf of 9 GP surgeries. Since the 2022 contract, they have worked closely with the community, with people like Samina Tarafder, the community engagement manager at Springfield Park PCN who was also present at the roundtable. They work with people like Sarah Weiss, Public Health Lead and Policy & Compliance Officer at Interlink, to ensure all communications are culturally sensitive. They offer clinics on Sundays instead of Saturdays to align the service with the prominent adherence to Sabbath in the local community and are the only PCN which have been granted special permission by NHS England to do this. They also run holistic health events, including one they did a few years ago where they had bouncy castles, which proved very successful as they were able to vaccinate about 200 children.

Baroness Walmsley (Chair) asked about how many patients they had and how this had changed.

Dr Tehseen Khan responded that patient numbers have grown steadily over the past decade. The Orthodox Jewish community doubles around every 15 years. There are around 1000 births a year across the three practices for a population of around 46,000. For most other practices, this birth rate is around 250. They have more baby check clinics here. These births present a challenge for GPs to keep up with. He also stated that the community is very reactive to outbreaks and will come forward for vaccination, but vaccination rates are difficult to sustain with an ever-growing population.

Baroness Ritchie asked what challenges they face with uptake.

Gemma Evans stated that they engage with the community to inform them of national communications. She emphasised that low uptake in the orthodox Jewish community is not caused by religion. Usually there is a concern about overloading the child's immune system. Having bespoke clinics in community settings and giving parents the chance to ask questions has been positive and is how you can combat these barriers. Everyone wants their children to be as safe as possible. Parents do not have a problem with the measles vaccination in this area. The area had experienced an outbreak recently, so it is in people's minds and has caused an increase in uptake.

Baroness Wyld asked if they have found that the change of the MMR vaccine to MMRV has had an impact.

Gemma Evans responded that they think that it has helped them. She stated that in large families, parents often do not want their children to get chicken pox and having it can cause lasting effects like scarring, so they have had quite a positive response to MMRV. A small number of parents have asked for just the MMR vaccine. Having the time to answer people's questions helps.

Baroness Walmsley (Chair) emphasised the importance of having time to answer parents' questions and asked how they have been able to allocate the additional time required.

Gemma Evans responded this has been facilitated by their access to the enhanced service and having additional money to attack the issue. This allows them to book the appropriate number



of nurses to cope with the demand, and without which they could not cope with the high birth rate.

Samina Tarafder added that many of the parents at the community clinic are vaccine hesitant and have questions about safety, such as whether it is safe to vaccinate a child at eight weeks. Most of the families do not vaccinate to schedule. It is important to have conversations and build a relationship with them so that it makes them want to come back for further vaccines.

Baroness Walmsley asked how important an opportunity the baby check clinics are not only to check that the baby is healthy but also discuss the vaccine schedule.

Dr Tehseen Khan responded that they are an important opportunity, and that they try to align the two by having the baby check at 8 weeks old.² Health visitors, GPs, and nurses work alongside each other to do the checks, and the nurse will try to provide an opportunity to vaccinate alongside the appointment. If they cannot fit the vaccination in, then they can return at the Sunday clinic.

Sarah Darcy corroborated the importance of the walk-in clinic. She stated that there was a lot of insight work done with the community and this helped them to understand that a lot of the reasons thought to be behind the low uptake were misconceptions. Understanding these misconceptions enabled them to understand previous low coverage. They first addressed this 10 years ago as they were concerned at the time about the risk of an outbreak and wanted to do something outside of their statutory commissioning responsibilities. The first service was mobilised by the GP confederation within 12 months of the first measles outbreak. They already had built up trust with the community prior to the measles outbreak, so they were able to deliver an outbreak response rapidly. It felt as if the service was part of the community. They know they must be in this for the long haul and that these issues are not going to be resolved overnight.

Lord Dholakia noted their work to build trust in the community and asked about how they reach to those who do not engage with the community and those who do not make use of these services.

Sarah Darcy responded that they have a good understanding of the Haredi community and that they are continually innovating with how to engage, educate, and communicate to them about the importance of vaccinations. She stated that they probably do not have the same level of understanding and reach with other communities and are aware of that. They have tried to respond where they believed the need was greatest but are aware that other communities need this kind of work as well. They have the City and Hackney strategic action plan and are working with partners to get more of the granular data needed to take forward tailored work with other communities.

² According to the vaccination schedule, children are due the 6-in-1, rotavirus, and MenB vaccine at eight weeks of age; UKHSA, [Routine childhood immunisation schedule](#) (1 December 2025)



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Baroness Walmsley noted that the practice clearly has a better understanding of their population than many practices do. She added that the Committee understands that challenges with data collection mean that there is often not enough information about patient ethnicity or cultural group. Knowing what community people belong to might make outreach easier. Nationally, this is not available, but she asked whether this data would be useful.

Mercedes O'garro stated that they undertook work a few years ago on Making Every Contact Count and would ask people about their background. Only 10% of the PCN population has not had that background research done. When anyone is overdue a vaccine, they are contacted and will continue to be contacted.

Baroness Walmsley asked whether this allows them to provide culturally sensitive services.

Dr Carolyn Sharpe responded that the work in the practice is very culturally sensitive. She stated that they are codeveloping solutions to cultural barriers but that they do not have good enough data at a local level to be able to quantify factors such as the proportional uptake in a specific group compared to the general population. Where they identify that a particular group may be facing challenges, they are unable to measure this or the impact that any interventions might have. She stated that she co-leads an immunisation network across London and this is a perennial issue that gets raised about public health, that they cannot understand or quantify the data or analyse their activity. These data challenges are a barrier to understanding the problem and evaluating any implemented solutions. They need a clear map of the data flows to identify where the problems are.

Baroness Walmsley stated that it is important for planning to know whether an intervention has worked or not.

Samina Tarafder stated that sometimes people in some communities are hesitant to identify their ethnicity. In the last census, they had the lowest uptake in the north of Hackney. She stated that she spoke to people and explained that it helps them to plan services accordingly and see what challenges families are facing. This increased census completion rates.

Baroness Walmsley asked whether people trust that their data will remain private.

Samina Tarafder responded that she and colleagues must often explain that it is to help the community and noted that people of a mixed heritage do not like ticking the 'other' box.

Baroness Walmsley stated that it is a question of dignity and privacy for patients.

Sarah Weiss stated that the Haredi community does not pick up information from the internet and social media. She emphasised the importance of paper-based information and advertisements to engage this community. Materials are given for free to local households. She then showed the Committee some of the communication materials as examples and pointed to one which addresses frequently asked questions that the Haredi community has about childhood vaccinations.



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Baroness Walmsley asked whether they have the resources to check how effective these tailored materials are. She stated that unless they can prove to those who have the money that an intervention works it is difficult. It matters because it will continue the funding.

Samina Tarafder stated that families are asked about how they heard about the clinics. 95% say that they heard about it from the adverts. Publications are also shared with local synagogues. An example of the importance of these publications is a news sheet targeted towards men in the community. Samina Tarafder noted that, when speaking to them at a community event, they highlighted that communication material which emphasised that pregnant women and children under the age of one are particularly vulnerable to MMR, as they cannot receive the vaccine, made the biggest difference in encouraging attendance at vaccination clinics. These materials were paid for by the PCN and are vital pieces of work for the community, especially for those are hesitant.

Dr Carolyn Sharp added that there are two elements of the enhanced vaccination service. One is adverts that go out periodically in local Jewish newspapers and publications, which they know the community engage with and on which they have data. The other is the provision of resilience in an outbreak scenario, which they see reasonably regularly, as they already have the infrastructure there to respond. She stated that they recently set up 50 clinics that delivered 2000 vaccinations across three months, which is unprecedented across London. The trust is there, the community knows that they are there, and that allows them to vaccinate a large amount of people very quickly in an outbreak.

Samina Tarafder added that during the recent outbreak they administered triple the number of vaccines compared to the typical monthly average.

Gemma Evans stated that during the outbreak they operated across all North Hackney with clinics set up to cover all areas. Within a couple of days, they had made a plan. They needed the enhanced service team in place to do this.

Baroness Nye asked if this non-recurrent funding stops, then does this work stop also.

Ratidzo Chinyuku stated that it is about building trust. Haredi schools are disengaged with the SAIS programme, and they have found reduced uptake in adolescents. They are piloting ways to increase engagement through areas including community engagement. They have found that these schools are receptive to the structure of the enhanced service, indicating that trust takes years to build and is not transactional. The enhanced service is not perceived as an external force trying to encourage vaccination in a coercive way.

Baroness Walmsley stated that she understands there are some schools that do not engage with SAIS and asked whether this is because of religious reasons.

Sarah Weiss emphasised that limited engagement with SAIS is not driven by religious or moral concerns.

Baroness Walmsley asked why local schools have limited engagement with SAIS.



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Sarah Weiss noted that it is necessary to understand the infrastructure of these schools to explain the disengagement. Many of them are overstretched in capacity and on non-ideal premises, with there also being challenges of identifying a suitable slot and space for vaccinations. She reiterated that it is not a religious reason or lack of perceiving vaccination as good. Those who are anti-vaccination are just the loudest and not the most prominent. It is not this group they seek to engage with but rather those who are hesitant.

Baroness Walmsley referenced the Committee's visit to Leicester and stated that the Committee had heard about the challenges of schools engaging with SAIS and the lack of flexibility they offer to schools, not getting enough notice of when they plan to visit with little consideration for factors such as exam season.

Baroness Wyld followed this up by asking if there was a way that SAIS could be more flexible.

Dr Carolyn Sharp responded that she agreed with the points raised and that one size does not fit all. The core offer works for most but not all, which is where the enhanced immunisation services are needed. A good example of the SAIS offer not working for all is in Haredi schools. There is a lack of trust, awareness, and understanding in these schools and no one has made the effort to explain school-aged vaccinations to them. It would only require £10,000–£20,000 of funding to bridge this gap and make iterative progress with schools. There is a lack of flexibility in funding for this, though, and it is a rigid offer. It works for many but there needs to be flexibility around the edges to address the inequalities that they are seeing.

Baroness Walmsley noted that the delegation understand this point, and that it is not the first time they have heard it. She then asked why HPV is not part of the offer in the school-aged vaccination catchup programme that they run for these schools.

Sarah Weiss said that in the days of the PCT, the HPV vaccine was presented as just addressing cervical cancer. They received culturally generic materials about HPV. It was then decided that it would be left out of the vaccination leaflets as it was at risk of alienating the rest of the schedule. There was then talk about HPV reducing risk of other cancers such as neck and throat and then believed it was time to reintroduce it. It is not presented as addressing a range of cancers.

Baroness Walmsley asked where the culturally generic information had come from.

Samina Tarafder said that it was communication materials from Vaccination UK.

Dr Carolyn Sharp stated that it comes from general information about the HPV vaccine protecting against a sexually transmitted disease that is not suitable for the Haredi community and needs to be reframed.

Ratidzo Chinyuku added that a lot of other communities have the same reservations about the HPV vaccine and perceptions that it may promote sexual promiscuity.

Gemma Evans said that it also about the time that you have to discuss the vaccination. She will discuss it with mothers when she is doing cervical screenings and if you tell them that is



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cuts cervical cancer risk to near 0% then people respond positively to that. You have to build it into normal conversations in a clinical setting.

Samina Tarafder stated that the letters sent to schools about HPV by Vaccination UK were completely inappropriate. In Barnet, she was consulted on the language used and changed some of the wording in the letters so that schools would accept the materials. There are around 22 primary and 18 secondary Haredi schools. She has spoken to headteachers, and they agree with the vaccination programme, but it is not just about them. Governors and Rabbis may see it as a GP rather than school responsibility, so they signpost parents there instead. In 2014, National Child Measurement Programme (NCMP) went into all schools to measure children in reception and year 6 for height, weight, hearing, and vision and they missed a quarter of the population in Hackney. Funding was given to commission two Haredi providers to be trained and go into all schools and were much more accepted; this is now an ongoing practice. With vaccinations, community input is important.

Baroness Walmsley asked whether anybody had tried to stop them adapting communications to be more locally culturally sensitive.

Samina Tarafder responded that they had seen an anti-vaccination advert that came from America.

Baroness Walmsley followed up by asking whether they had received any direction from UKHSA requiring them to use standardised materials.

Samina Tarafder replied that they had not and that they work very closely with UKHSA and which has been supportive of creating culturally appropriate communication materials.

Sarah Weiss said that there is no culturally appropriate fact sheet for HPV, but they do have letters, and that this is similar to the situation in Barnet.

Baroness Walmsley asked whether there were similar issues in other parts of the country such as Manchester.

Sarah Weiss stated that there was.

Baroness Wyld asked whether the hesitancy seen with the HPV vaccine are also seen with cervical screenings.

Dr Tehseen Khan responded that they have had very low uptake of cervical screening, particularly from the Haredi community, but a pilot of self-sampling that is happening in Stamford Hill will start to help. The incidence of cervical cancer in the Haredi community is very low. When managing priorities, focus is directed to more pressing issues like measles outbreaks. Sometimes HPV is given less priority as there is low incidence of infection in the Orthodox Jewish community.

Sarah Weiss added that they have done a small piece of work for NHS England regarding cervical screening and language and worked closely with community organisations and Rabbis. It is very much about using culturally sensitive language and addressing communications to



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married women; they have worked with Hatzola to facilitate this. There is very low incidence, but it is still important to not ignore it.

Baroness Wyld asked about the drop off in coverage for the second dose of the MMR vaccine and whether the decision to bring the appointment forward to 18 months will improve this.

Dr Carolyn Sharp replied that the intention behind moving it closer was that it offered earlier protection to children whilst giving families an additional opportunity for catch up at the original appointment at 3 years 4 months.

Baroness Wyld asked about uptake of the 27-month health visitor check.

Dr Carolyn Sharp responded that they have a lower uptake of health visitor checks in this community. It is usually higher for the first few children that a family has but after that it is lower.

Ratidzo Chinyuku added that the earlier delivery of the MMR vaccine was already being undertaken in other London boroughs with low vaccine uptake before being introduced in Hackney. There is lower vaccine uptake with increasing immunisation age. Uptake at 12 months is considerably higher than those offered at 24 months or 5 years. An earlier schedule offers increased opportunity to catch up.

Dr Tehseen Khan stated that they observe two main concerns, immune overload coming from too many vaccinations being given at once and a concern that the child is too young to be vaccinated. There is some evidence that you can catch them up when they are a bit older.

Sarah Weiss said that at a vaccine event they heard concerns and questions about how you can vaccinate a baby at eight weeks and Dr Tehseen Khan would inform them that babies are exposed to millions of germs every day.

Samina Tarafer stated that they work closely with the health visitor service who do the baby checks which helps.

Baroness Walmsley asked whether there was any outreach needed to reach other groups and communities.

Sarah Darcy responded that the plan is to fund each PCN to deliver one vaccine event per quarter, building on the model that has proved to work here in addressing the needs of communities.

Dr Tehseen Khan added that, in some ways, they have it easier as they know that they need to reach a specific population group, with 50%–60% of the population being Haredi. In other areas, this will not be the case, and the challenge will be much greater due to there being greater diversity. There is a need to think about each individual community and what the barriers are in each case. Concern over links between the MMR vaccine and autism are not present in this community but in others it is, which presents an additional challenge. These conversations tend to be difficult.



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Baroness Walmsley asked what the barriers are to the sharing of good practice between areas.

Samina Tarafder said that it is all transferable. For instance, they know that in Tower Hamlets they have used the stop smoking service to target the Ramadan period for the Muslim community. With immunisation, similar messaging could be placed on the Ramadan calendar. It could be possible to look at different holidays and celebrations in communities and use them to spread messaging. They have not had issues with language but in places like Enfield and Newham there are a greater number of different languages spoken. Most of the publications they do for this community are in English but some of the headings are translated into Yiddish. This is important for communities, so they know that the materials are for them.

Dr Carolyn Sharp added that they were asked about how they can replicate what they are doing elsewhere in a scrutiny meeting and highlighted that there are several challenges to doing this. It is resource intensive. Funding needs to be sustainable as it takes years to build the trust needed to be effective. You cannot “lift and shift” outreach easily between boroughs; it must be built up gradually. The neighbourhood working approach represents an opportunity to look at specific communities, working with family hubs, GPs, local authorities, and community groups. They hope that the devolution of responsibility to ICBs gives them the flexibility to respond to the unique needs of a population at a hyper-local level.

Sarah Darcy added that the flexibility of the workforce is also important. They are part of the NHS England-funded pathfinder health visitor pilot and are starting to agree what this model will look like with health visitors. They are looking at not having a standalone targeted immunisation offer but weaving it into the health visitor offer to families. This is a long-awaited return to commissioning vaccination delivery by health visitors, which stopped in 2014 alongside changes to the NHS. This could be revisited with the delegation to ICBs.

Baroness Walmsley stated that this is as long as the duties and parameters of ICBs are correct and leadership is correct. There is a gap between ICB board level and GP practice level. She then asked if there is anyone in between this that should have this responsibility to ensure that there is joined up top-to-bottom communication, especially considering ICB clustering and the increased footprint they will have as a result which may make a more local focus difficult.

Sarah Darcy responded that, from an ICB perspective in North East London, they are around two thirds of the way through the ICB restructure and currently in a state of change. As they move into the new structure, they will have named immunisation leads. They will continue to have place-based leads, such as the City and Hackney neighbourhood team. They hope that they will be able to build on and continue community partnership work with delegation. There are concerns surrounding the loss of 50% of the ICB workforce and the subsequent loss of clinical leadership. There are always losing a lot of clinical leadership, and this has a significant impact on the childhood immunisation agenda. The scale of the restructure means that it will take time to embed new ways of working. There will be an inevitable vacuum in decision making. Previously they were able to invest heavily through the CCG in childhood



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immunisation here as they were able to make decisions at a city level of City and Hackney but cannot do this as an ICB as there must be equity across the North East London ICB. There is a clear priority for childhood vaccinations but there is a risk of a lack of funding.

Dr Tehseen Khan added that they were lucky to have had such a great CCG and for commissioners to have recognised their needs. It is not the fault of the ICB [that previous arrangements cannot continue]. City and Hackney typically always had more funding than the other areas within the North East London ICB and now it is promised that other areas will be levelled up. Ultimately, there is not enough money to go around. For the past three years the PCN has had annual contracts, and they do not know whether they will have enough funding to continue their current staffing into the next year until December. This uncertainty affects planning and workforce morale. The neighbourhood agenda is a real opportunity, but it is very disease- and hospital-centred with a focus on reducing admissions, with broader prevention less of a priority. There is a worry about the immunisation agenda being limited by the fact that prevention requires money. It is necessary to think about how you create healthy communities rather than just looking at disease metrics. They do not know what funding will look like next year for prevention and this is causing some tension.

Baroness Walmsley stated that the funding is not following the national agenda of a move towards prevention. A debate in the House of Lords agreed that the balance of the funding was not correct. ICBs have a problem of making sure funding for outreach is sustainable. They have done well here, but it is not the case elsewhere.

Sarah Darcy said that this was not the ICBs responsibility.

Baroness Walmsley asked whether she thinks that it should be.

Sarah Darcy replied that you would hope with the delegation of commissioning responsibility to ICBs that funding would come with this. In an ideal world it is for ICB and local partners to agree where the needs are and how to meet them. What they would want is to commission a school-based vaccination offer that meets the needs of communities, which it currently does not. The immunisation programme should not be seen in isolation but rather as a whole offer to meet communities' needs. Commissioning is currently very complicated. Senior immunisation colleagues in the NHS told them that they were duplicating the core vaccination offer when funding the enhanced immunisation service, but they went ahead with it anyway. This was a while ago and things have changed. Outbreak funding was always difficult as NHS England would provide funding if an outbreak occurred in a specific setting but not if it occurred in communities, so the ICB is left to fund this outside of their standard responsibilities. There are barriers about what they can and cannot commission.

Baroness Walmsley asked whether they had evaluated the costs of commissioning outbreak response.

Dr Carolyn Sharp responded that they completed a light touch economic evaluation of outbreak response costs to make the case for the enhanced service. They voluntarily did this to see what it would cost to respond. They try to do this when they can.



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Baroness Walmsley stated that they asked about the cost-benefit of vaccinations at the start of the inquiry to a professor and he could not answer due to a lack of data.

Dr Carolyn Sharp said that this is because vaccination is so successful that there is no counterfactual data until recently, when outbreaks have started to happen.

Samina Tarafder added that Haredi families have an average of 7–8 children who attend different educational establishments as the schools in the community are gender divided. The risk of spread is therefore higher and is more difficult to contain due to children in the same family attending multiple schools.

Gemma Evans said that there is not a one size fits all approach when it comes to the schools.

Dr Carolyn Sharp stated that they are not talking about lots of money here. To undertake work with Haredi schools would cost around £10,000. Outreach work with the African and Caribbean community would cost approximately £20,000–£30,000 at most to undertake a significant piece of work. There is a lack of funding for this type of work. Community groups are really struggling financially as well, and you cannot ask them to work for free.

Baroness Nye asked whether the WHO 95% coverage target should be reinstated.

Dr Carolyn Sharp responded that this is not an arbitrary figure as it is based upon herd immunity. It should be aimed for but there is a question of how realistic this target is, and you cannot penalise people for not hitting it.

Dr Tehseen Khan stated that previously the Quality and Outcomes Framework (QOF) in the GP contract did not account for equity as practices in affluent areas do not have to undertake the additional work to make people come and be vaccinated as those located in more deprived areas do. The change in the QOF this year is positive.³ He said that he agrees with Dr Carolyn Sharp that the epidemiological reason for this 95% target is important.

Baroness Wyld stated that there is a consensus that access outweighs hesitancy and that, whilst UKHSA parent survey data suggests that there is high confidence in vaccinations, there needs to be very high confidence to reach this 95% target.

Dr Tehseen Khan said that they have discussed the extent to which access or confidence are barriers to vaccination and they believe there is an overlap. Being present in the community and creating easier access will increase confidence and trust. Unfortunately, because of the rise of social media, concerns can spread easily.

Baroness Wyld stated that she had assumed that the incorrect perception of a link between autism and the MMR vaccine, based on false claims, had been resolved. However, the Committee heard that this was still prevalent in some communities, such as the Somali community in Brent where targeted work is taking place. She then asked how much of an issue is this and whether it is growing.

³ The Quality and Outcomes Framework was recently changed to allow GP practices that show substantial improvement to be rewarded in the same way that those who reach the targets are.



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Samina Tarafder said that it is present across multiple communities. When she would sit in Haredi community meetings she used to hear these concerns, but this was a long time ago and she rarely hears it now.

Gemma Evans added that she has observed these concerns in other communities where she has vaccinated.

Samina Tarafder stated that sometimes where there are more children with special educational needs in a community then these concerns arise more, but it is about getting the message across that this is coincidental.

Dr Tehseen Khan said that, regarding communications, challenging the myths can be helpful. It was thought for a while that it would be counterproductive to address misinformation, but current evidence suggests that if it can work if done in the right way.

Dr Carolyn Sharp added that guidance states that it is more counterproductive to try and unpick the link between autism and MMR. There is a spectrum of hesitancy and people usually sit in the middle. It is usually a combination of what people have heard and being busy that causes vaccinations to be delayed or missed. Making vaccination easier and more accessible would be better. It is also important about where vaccine messaging comes from. GPs are trusted sources of information, but it is also important to use the wider workforce to make every contact count in supporting these messages.

Baroness Ritchie asked what they would like to see the Government doing and what the Committee might recommend.

Dr Tehseen Khan emphasised equitable and sustainable funding for areas with low uptake and not having to do year-to-year planning. Not having a service funded for a year and then having to scramble to get a business case together would be very helpful. Stability is important as it takes time to build trust and if you destabilise a service, it can quickly dispel trust, and people can take this as betrayal.

Baroness Walmsley asked why funding is allocated year-to-year.

Dr Tehseen Khan replied that the first five years of the PCN contract was set in 2019 and every year since then, for political reasons, funding has been allocated has been year-to-year. Single and multi-neighbourhood contracts are coming now. So far, they have been short-term with the view that there will imminently be a radical change in the way that the contracts are structured.

Sarah Darcy stated that the ICB never received funding for this type of work and used whatever non-recurrent funding they could, as it is not a statutory responsibility.

Gemma Evans stated that it is important to have a consistent service and make people aware of it. She wants to be able to have consistent clinics that people know and trust.



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Sarah Weiss emphasised the importance of cultural competence and using trusted community partners. Unfortunately, these are usually unfunded, and it is a struggle for voluntary organisations. Some of the work they do is funded by NHS England.

Samina Tarafder highlighted the importance of equity in vaccination services, giving an example of them realising that male children were not able to access their Sunday clinic service as they had school on Sundays, so they extended the clinic times to beyond the school day.

Dr Carolyn Sharp also emphasised flexible commissioning arrangements alongside the importance of granular data to understand and address inequalities.

Sarah Darcy added that she hoped that delegation of commissioning to ICBs would allow them to fund the local community and the connection with local community partners. She highlighted the importance of developing a workforce that meets the needs of the community.

Mercedes O'garro seconded the recommendations heard so far and that the year-to-year funding arrangements are difficult and causes anxiety amongst staff.

Baroness Walmsley stated that it must take a lot of time to bid for the funding, to which the participants agreed. She then moved on to discuss training and noted that the technical aspect of training is mandatory, but that she understands training to hold empathetic conversations about vaccination is not and asked what the participants views were on this.

Dr Tehseen Khan responded that they currently have quite a good approach to this. They have Make Every Contact Count training that some staff have been through which focuses on using motivational interviewing techniques to engage with patients. This allows the practice to frame appointments as an offer for a conversation rather than simply vaccination, which takes the pressure off people. Motivational interviewing and equipping staff to be able to have appropriate conversations with parents is important. They also train recallers and admin staff on this approach. There is more they could do with Make Every Contact Count, for instance with receptionists.

Baroness Walmsley asked whether there was a funding issue for this training.

Dr Tehseen Khan replied that reduced ICB funds and training hub funds are always an issue. Releasing staff to attend training is also difficult. Dedicated resources to do this would be helpful. It is important that non-clinical staff are informed as they will have conversations with patients.

Baroness Walmsley stated that it is important that parents have the opportunity to ask questions and receive information about vaccinations. She then asked when parents should be receiving this information.

Dr Carolyn Sharp responded that it should be taught in schools. Understanding vaccinations and how they work takes time to explain. A simple way to do this is through teaching. Having a population that is health literate would make a big difference. When young people leave school, they are able make informed decision about their and their children's health. They have an immunisation group that meets regularly with midwives, school nurses, health visitors,



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and the wider healthcare workforce to try and use every opportunity to have a non-pressurised conversation.

Samina Tarafder stated that young people in the Haredi community have been positive about learning about vaccinations in schools, with some indicating that they had engaged with the fact sheet and communication materials.

Baroness Walmsley asked whether midwives have the time to have these conversations with mothers, highlighting the link between maternal vaccination and increased child vaccination uptake.

Sarah Weiss stated that there were joint voluntary-NHS England communications on pregnancy and vaccination. Sometimes they will not put local authority branding on these communications as they do not want it to be seen as an arm of the local authority.

Baroness Nye then asked whether these communications were for this specific community or distributed nationally.

Dr Tehseen Khan stated that he believes it was shared across London. They have a good working relationship with midwives.

Gemma Evans added that, for RSV and Pertussis, mothers do know about the vaccinations.

Sarah Weiss said that NHS England asked them to do communications for the national Haredi community on the RSV vaccination when it was first offered. They had Rabbis on board with this and created letters that have gone to Haredi families and to schools that have been signed by Rabbis. All regions have their own. In other regions, such as Manchester, they have used community centres to set up clinics and have had strong engagement with this. In 2023 they did a piece of work engaging with community organisations, including the Jewish Maternity Programme that provides maternal support and answers questions from within the community as a helpline, passing on trusted public health messages. They had materials signed by doctors and Rabbis.

Samina Tarafder added that families will call Hatzola when there are suspected cases of diseases such as measles or meningitis.

Dr Tehseen Khan noted that Hatzola are a respected organisation that has universal buy-in from the community.

Samina Tarafder added that the recent communications included a quote from Dr Opat of Hatzola.

Baroness Walmsley asked about data and whether there are any issues or suggestions that they want to make.

Dr Tehseen Khan responded that the data environment is complex with a lot of stakeholders involved. There are lots of different systems. There is a move towards changing to a more universal data entry system. They have been supported by Queen Mary's Clinical Effectiveness Group (CEG) in creating timely data dashboards tailored to North East Hackney due to the



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low uptake there. They are still learning to use the new data on information of low uptake, but it will be useful in further understanding the issues. They know where the issues are and what to focus on, but the value of data is being able to evaluate interventions in real time. Vaccinations are very complicated and there will be more than one factor influencing uptake. There is value in tracking individual interventions to develop an understanding of efficacy of the outreach offer.

Baroness Walmsley asked whether the introduction of the Single Patient Record will help.

Samina Tarafder replied that it would be an issue digitising the red book, for this community.

Sarah Darcy stated that it will be helpful in making every contact count and data visibility.

Baroness Walmsley stated that currently there is a cat's cradle of data systems and asked whether this was useful or not.

Dr Carolyn Sharp responded that you would not design a system in the way that the current one is set up. During the COVID-19 pandemic, the data system was good as it was possible to design it from the ground up. It was possible to see data by ethnicity and geography and could undertake granular analysis. Childhood vaccinations are different as there are so many different databases involved, presenting different versions of the truth, which is unhelpful. There could be improvements to the process of recording a vaccination. For instance, there are variations in how vaccinations are recorded, with SAIS team's vaccination records not automatically updating a patient's GP record.

Gemma Evans added that health visitors, midwives, and nurses all record vaccinations on different systems. A digital vaccine passport attached to the GP record would be useful.

Baroness Wyld asked whether the introduction of the digital red book would do this.

Gemma Evans replied that she has not used one coming but was concerned that it would not be user friendly. She was worried that it will take too long to introduce and be too difficult to use in the limited amount of time that nurses have. If the physical red book was retained alongside a digital system, they would have to record a vaccination twice. She wants a universal, single version of the truth, which would also help with safeguarding.

Baroness Walmsley asked whether it would be helpful if the digital red book went up to age 18.

Gemma Evans replied that it would.

Dr Carolyn Sharp added that the digital red book might yet just be another version of the truth that is added to the current data system. There needs to be just one version of the truth that is shared with key people.

Samina Tarafder stated that, when it comes to adolescent vaccinations, some Haredi parents have become confused as they understood that childhood vaccinations had finished by this point. Questions arise to why these are not in the red book and it would be helpful to have this go up to the age of at least 16 so that it covers these vaccinations.



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Baroness Nye asked whether there would be any value in it being the school's responsibility to check children's vaccination status when they enter a school, on the condition that it is not required for entry.

Baroness Walmsley added that the NICE guidelines state that vaccination records should be checked at specific educational stages. It is best to do it in primary school as that is when parents are most engaged. It should be a nudge to parents, not a pressure. There also needs to be an opportunity for them to catch up if there is a vaccination missing.

Samina Tarafer stated that some of the nurseries in the area are very proactive in checking vaccination status and reminding parents. Some of the mothers have said that their children have been asked at nurseries.

Baroness Walmsley said that when this point was raised with headteachers during the Committee's visit to Leicester, they said that it is important that this would be done at the right time, for instance after they already had a place in the schools so that it would not be seen as a requirement for entry.

Dr Carolyn Sharp stated that it is a nice idea but that schools would need to be told by the Department for Education that they are accountable for this so that it actually happens. If you leave it as guidance rather than a requirement then the accountability gets lost and leaves rooms for variation where some schools do it and others do not. Governance is very complex; responsibility and accountability need to be clear.

Baroness Walmsley suggested that a check of a child's vaccination record could be completed at the same time as a school ask for a child's allergies. The roundtable was then closed by the Chair, who thanked the participants for their time and contributions.