Public Health South Tees – Written Evidence (CVX0041)

About the author

I am an Advanced Public Health Practitioner working within a joint local authority public health service in the North-East of England, with specific responsibility for improving childhood immunisation uptake and reducing inequalities. I also Chair the Tees Valley Local Immunisation Steering Group and attend the NENC ICS Immunisation & Strategy Partnership Group. My submission reflects a professional, practice-based perspective grounded in local system leadership, experience of service delivery, work with schools and communities, and direct experience of the barriers facing underserved populations. This evidence is contextualised and strengthened by findings from the *Tees Valley Childhood Immunisation Engagement and Co-Production Project* commissioned by Middlesbrough Council (Eberhardt *et al.*, 2025).

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1. **What is the evidence on childhood vaccination coverage in England, disparities in coverage, and how coverage and disparities have changed over time?**

   From a local authority public health perspective, our ability to understand coverage and inequalities is limited by delayed and insufficiently granular data. COVER and ImmForm data have a significant time lag and do not routinely allow meaningful analysis by postcode, ethnicity, language, deprivation, or care status. These details are essential if local authorities are to target community interventions effectively.

   Local experience, reinforced by the Tees Valley Childhood Immunisation Engagement Project, suggests that headline vaccination coverage figures mask significant inequality, missed opportunities, and uneven access across communities. In particular, under-vaccination is closely linked to instability, mobility, poor record continuity, and weak recall systems rather than active refusal. Care leavers, migrant families with limited English, and Gypsy, Roma and Traveller (GRT) families frequently report not knowing which vaccines are due or how to check vaccination history, which represents a hidden but significant inequality.

2. **Why has childhood vaccination coverage been declining in England, and why are there disparities in coverage? What is the relative importance of different factors (such as access to healthcare and attitudes to vaccination) and how is this changing over time?**

   Locally, declining uptake reflects a complex interaction of structural, systemic, and social factors rather than a single cause. However, shortcomings in service delivery and local contextual understanding are significant contributors to low uptake.

   Demographic change is a major factor. In Middlesbrough, the proportion of residents from ethnic minority backgrounds has significantly increased and

GP practices collectively report **over 49 different languages spoken**. Many parents have limited English literacy, and some are unable to read in their first language. Existing vaccination systems are not designed for this level of linguistic and cultural diversity.

School-based immunisation highlights several of these challenges. Schools report **extensive use of digital consent systems** and text reminders, yet consent return remains low in highly diverse settings. Even where schools proactively support engagement — through parent evenings, phone calls, translated information routes, and collaboration with providers — immunisation teams often struggle with follow-up capacity, inconsistent contact, and system constraints. As a result, genuine willingness does not reliably translate into completed vaccination.

These challenges risk being amplified by the planned introduction of the **national Managing Vaccinations in Schools (MAVIS) system.** As currently understood, MAVIS will reduce or remove the facilitative role of schools in the vaccination pathway and replace locally tailored engagement with a standardised national invitation letter. Based on local experience of national screening and vaccination communications, there is a significant concern that such letters will not incorporate proven behavioural science techniques known to support engagement with consent and will be less effective for families with limited English, low health literacy, or low trust in statutory systems. Removing school-based mediation and local adaptation risks further disengaging the very groups already experiencing the lowest uptake.

Deprivation and the ongoing cost-of-living crisis further shift parental priorities. Families experiencing financial stress, insecure employment, housing instability, or caring responsibilities may deprioritise preventive health, even when broadly supportive of vaccination emphasising the importance of a service offer that makes taking up the vaccine as easy and understandable as possible.

The COVID-19 pandemic has negatively affected vaccine confidence for some communities, contributing to confusion, mistrust, and heightened concern about side effects. This is compounded by national information materials that are often too long, technically complex, and written at a reading level or cognitive demand that does not meet the needs of many families.

System pressures also play a role. GP practices face competing demands, limited time, and weak financial incentives to prioritise childhood immunisations, particularly in practices serving highly mobile or deprived populations where Quality and Outcomes Framework targets may feel unachievable. There is wide variation in how and whether families are invited or recalled for 0–5 vaccinations.

3. **What would be the best ways to improve childhood vaccination coverage and reduce disparities?**

Improvement requires genuine implementation of existing national commitments, combined with a shift towards behavioural science, equity, and lived-experience perspectives.

Information provision must be radically simplified. Families need short, clear, behavioural science informed materials — ideally a single A4 overview — explaining what the vaccines are, when they are due, why they matter, and what to expect. These should link clearly to more detailed optional content. Materials must be available in multiple languages and formats, set to an appropriate reading age, and the NHS should be the visible and trusted messenger – not UKHSA.

A national invitation and booking system with a single NHS front door — fully accessible in multiple languages — would significantly reduce friction and confusion. People should not need to navigate fragmented local pathways to protect their children. Such a system should prioritise early and meaningful **parental engagement and informed consent**, using behavioural science informed design and clear, accessible communication. Effective parental engagement upstream would reduce reliance on **Gillick competence assessments** during school-based delivery, which are currently used as a **mitigation for system failures in consent processes** rather than as a planned or desirable route. Over-reliance on Gillick competence places avoidable pressure on schools and immunisation teams, disrupts education settings, and can create tension with parents and communities. Designing systems that maximise parental understanding and consent in advance would support higher uptake, reduce operational disruption, and strengthen trust across families, schools, and vaccination services, particularly in diverse communities, where consent processes are already most fragile.

Service design must reflect how people actually live. Flexible delivery models — including walk-in clinics, evening and weekend appointments, mobile provision, community venues, and school-linked delivery — are essential to reduce inequalities. The evidence from Tees Valley strongly supports this approach.

4. **What are the strengths and weaknesses of the evidence base on childhood vaccination coverage; the drivers of the decline in coverage; and how to improve coverage and reduce disparities?**

A key weakness in the evidence base is the lack of timely, shareable, actionable data at local level. For adolescent vaccines in particular, local authorities often have no access to accurate, up-to-date data on school-level uptake, clinic delivery schedules, or consent patterns from School Aged Immunisation Services (SAIS). This makes targeted, preventative work extremely difficult.

Local behavioural insights work has demonstrated that consent materials and letters were previously of very poor quality, yet locally developed, evidence-based materials produced using inequalities funding are now being restricted by a UKHSA approval process. An initial trial achieved an increased uptake of 24.7% in one school, this was successfully replicated across other North East schools, and culminated in an invitation letter, text message reminders, leaflets for Y7, Y8, and Y9 pupils that includes regionally produced videos (with NHSE and SAIS involvement) of a school and clinic walkthrough (the school walkthrough has proven very popular with pupils, schools, and parents) these are now being halted by UKHSA who insist

national leaflets (20+ pages long that go unread) are used. This significantly undermines the ability to respond adaptively to local need and consequently risks wasting considerable time, effort, and government funding.

The Government's approach

5. **Who is responsible and accountable for reversing the decline in childhood vaccination coverage and reducing disparities at national, regional, and local level in England?**

   In practice, accountability is unclear and fragmented. Responsibility is spread across UKHSA, NHS England/Integrated Care Boards, local authorities, acute trusts, GP practices, SAIS providers, pharmacies, midwifery and CHIS. No single body is clearly accountable for declining coverage, creating a system where risks, failures, and gaps persist without ownership. Lines of responsibility are not clear at national, regional, or local level. Targets and expectations are poorly aligned with local population realities, particularly in deprived and diverse areas.

6. **Has the Government identified the right priorities for reversing the decline in childhood vaccination coverage and reducing disparities (including in the 2023 NHS vaccination strategy and the NHS 10-Year Plan)? If not, what should the Government prioritise instead?**

7. **How effective has the Government been delivering the commitments in the 2023 NHS vaccination strategy? Why has delivery been effective or ineffective?**

   There is currently little evidence locally that the commitments set out in the 2023 NHS Vaccination Strategy have been meaningfully implemented. Despite significant investment and partnership working, local systems still lack access to the high-quality data and national infrastructure needed to deliver sustained improvement.

Overcoming barriers

8. **How accessible are childhood vaccination services, both for the general population and for people in under-vaccinated groups? What are the main barriers to making childhood vaccination services more accessible for all, and how could those barriers be overcome?**

   Services exist, but they are not consistently accessible. Barriers for childhood vaccines include inconvenient appointment times, poor transport links, lack of childcare, inconsistent reminders, language barriers, and difficulty understanding eligibility and schedules. For teenage vaccines barriers include the reliance on digital consent (which is a problem for those with limited access) and having a consent process only available in English. These barriers must be addressed with more emphasis placed on relational, trust-based communication rather than reliance on written systems (lengthy booklets) alone.

9. **What is the influence of public attitudes on childhood vaccination coverage? What are the key barriers to strengthening public trust and confidence in childhood vaccination, and how could those barriers be overcome?**

10. **What is the influence of system leadership and commissioning on childhood vaccination coverage? How could system leadership and commissioning be made more effective?**

    a. **How effectively and equitably are childhood vaccination services funded? How could funding arrangements be made more effective and equitable?**

11. **How effectively are core and outreach childhood vaccination services delivered, including delivery through different providers and in different settings? How could service delivery be made more effective to help improve coverage and reduce disparities?**

12. **What is the influence of data systems on childhood vaccination coverage (including for inviting families for vaccinations, sharing data about vaccinations, and monitoring coverage)? What are the main barriers to the development and deployment of effective data systems, and how could those barriers be overcome?**

    Data systems are a major structural weakness. School, local authority, CHIS, GP, and provider services data sit on separate systems and are poorly coordinated. This directly affects invitations, follow-up, record continuity, and monitoring of inequalities. From a user perspective, poor data systems translate into missed reminders, uncertainty about vaccination history, and lost opportunities to catch up. Improving interoperability, access to records, and continuity during transitions (such as moving home or leaving care) is essential.

13. **What is the influence of the vaccination workforce and the wider healthcare workforce on childhood vaccination coverage? How could the workforce be effectively trained and strengthened to help improve coverage and reduce disparities?**

    The vaccination workforce and the wider healthcare workforce play a critical role in shaping parental confidence, trust, and follow-through. Evidence from local practice suggests that many staff are not adequately trained or supported to have effective, confident, and non-judgemental conversations with parents who are uncertain, anxious, or mistrustful about vaccination, even when those parents are not actively opposed.

    As a result, opportunities for reassurance, clarification, and engagement are often missed, and interactions can unintentionally reinforce hesitancy or disengagement. This is particularly important for underserved groups, where trust is relational and shaped by previous experiences of services.

Workforce strengthening should therefore go beyond clinical knowledge alone. Training should include behavioural science, motivational interviewing, trauma-informed practice, cultural competence, and communication skills tailored to vaccine conversations. Staff also require time, organisational permission, and system support to have these conversations well, rather than being expected to deliver vaccination alongside high throughput and competing priorities.

Embedding this capability across the wider healthcare workforce — including midwives, health visitors, school nurses, practice staff, and community-facing professionals — would improve consistency of messaging, reduce inequities in experience, and support higher uptake through trust-based engagement rather than reliance on information provision alone.

14. **What is the influence of the wider public, community and voluntary sectors (including schools) on childhood vaccination coverage? How could the NHS work more effectively with the wider public, community and voluntary sectors (including schools) to help improve coverage and reduce disparities?**

Public health teams, schools, and VCSE organisations are uniquely placed to improve awareness, trust, and access, particularly for underserved groups. However, while funding may be provided, the essential enablers — usable data, partnership working, and appropriate resources — are often absent. Schools have a critical role but are not adequately supported. PHSE education does not consistently address vaccines at the most influential point (during the consent window), and schools are often asked to shoulder engagement work without system-level support. A coherent national model allowing individuals to drop in for *any* missed vaccine, with accurate real-time recording, would significantly strengthen both access and confidence.

15. **What is the influence of the media environment on childhood vaccination coverage? What would be the best ways to support confidence and to address misinformation and disinformation about childhood vaccination in the media environment?**

The media environment strongly shapes vaccination confidence. Local experience and national evidence show that young people primarily engage with short-form content on platforms such as TikTok and Snapchat, while many parents rely on Facebook and Instagram. Lengthy written materials are therefore ineffective; communication must be designed for the channels and formats people actually use.

16. **What other key barriers are there to improving childhood vaccination coverage and reducing disparities? What would be the best ways to address them?**

Under-vaccination is rarely about refusal. It is about friction, uncertainty, mistrust, and system design that assumes stability, confidence, and health literacy. Addressing this requires simpler systems, clearer accountability,

behavioural science informed communication, flexible delivery and sustained investment in local relational work. Without these changes, inequalities in childhood vaccination will persist despite goodwill and professional effort at local level.

UK and international comparisons

17. **To what extent does England face similar challenges with declining childhood vaccination coverage to Scotland, Wales, Northern Ireland, and/or other comparable countries?**

18. **What can the UK Government learn about improving childhood vaccination coverage in England from Scotland, Wales, Northern Ireland, and/or other comparable countries?**

Reference

Eberhardt, J., et al. (2025). *Tees Valley Childhood Immunisation Co-Production and Engagement Project*. Unpublished project report.

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