Royal College of General Practitioners – Written Evidence (CVX0042)

1. Childhood immunisation in the UK is fundamentally a success story of general practice, but one that is now under increasing strain.

2. The Royal College of General Practitioners (RCGP) welcomes the opportunity to contribute to the Committee's inquiry into childhood vaccinations. Rather than addressing each question individually, our submission focuses on several key points based on the experience of general practitioners and the role of general practice in delivering childhood vaccinations.

How the current system works in general practice

3. General practice plays a central role in childhood vaccination, delivering vaccines in a cost-effective way that supports the long-term health benefits of families.

4. The current financial incentives within the GP Contract help practices achieve good vaccination coverage . However, these incentives do not adequately fund the additional time and resource required to reach children and families experiencing barriers to engagement.

5. Delivering childhood vaccines is part of the contractual responsibilities of general practice. GP practices are expected to operate call-and-recall systems to invite children for vaccination when they become eligible and to follow up children who miss appointments.[1] This population-based approach is supported by the registered patient list system in general practice, which enables practices to track vaccination status and invite families accordingly.

6. It is also supported by NHS South, Central and West Child Health Information Service (SCW CHIS), which is an NHS-commissioned service that is responsible for collating immunisation and screening data from healthcare professionals for children aged 0-19 in a specified area, into a single child health record.[2]

7. Practices receive a payment of around £12 per dose from NHSE for every vaccine administered as part of the routine childhood

immunisation schedule. These payments are intended to support the organisation of vaccination clinics and ensure practices are able to deliver routine immunisation services to their registered populations.[3]

8. In addition to activity payments, GP practices can receive financial support through the Quality and Outcomes Framework (QOF), the national performance incentive scheme for general practice. Practices earn points based on the proportion of eligible children in their population who have received recommended immunisations by specified ages. Payments increase as practices achieve higher levels of coverage, with thresholds typically starting at around 81% and rising to higher levels for maximum payment.[4]

General practice has a strong track record in delivering vaccination programmes

9. General practice has historically played a central role in ensuring that children receive the vaccinations they need. The long-standing model of vaccinations delivered through registered GP practices supports high coverage because practices hold comprehensive patient lists, have established relationships with families, and are able to integrate vaccination with other elements of routine and opportunistic child healthcare.

10. Historically, this system has performed very well. Through the late 2000s and early 2010s, the GP-led model achieved, or came close to, the 95% coverage target for several routine childhood vaccines, particularly within the primary series.

11. That level of coverage reflects the effectiveness of a system built on continuity of care, comprehensive records, and trusted relationships with families.

12. Continuity of care, seeing the same GP over time, has been associated with improved long-term health outcomes, including reduced hospital admissions and increased life expectancy. This trusted relationship is particularly important in supporting conversations with families about vaccination and maintaining confidence in the programme.

13. Evidence from the COVID-19 vaccination programme further demonstrates the capacity, efficiency and value for money of GP-led delivery at scale. . During the pandemic, GP-led services delivered a very large proportion of vaccines at pace and scale. The National Audit Office found that the COVID-19 vaccination programme exceeded initial expectations for uptake and represented value for money, delivering high vaccination coverage and doing so at lower wastage and efficient deployment costs.[5]

System pressures are weakening general practice's ability to sustain childhood vaccine uptake

14. Despite the strong track record for achieving strong coverage for childhood vaccinations in general practice, performance is now under increasing pressure. Recent data show that coverage across the routine childhood vaccination schedule has fallen below the 95% target, with particularly low uptake for second-dose MMR and the preschool booster.

15. This represents a sustained decline over recent years. It is important to emphasise that this is not a failure of the underlying model, but rather the result of growing system pressures, including workforce constraints and widening health inequalities.

Current incentives enable good coverage but do not fund outreach to harder-to-reach groups

16. A key challenge is that the current financial incentives within the GP Contract help practices achieve good vaccination coverage among the majority of the population. However, these incentives are not designed to adequately fund the additional time and work required to reach children and families experiencing barriers to engagement.

17. Improving uptake among these groups often requires proactive outreach, repeated follow-up, engagement with families who may have concerns about vaccines, and coordination with community services. Many GP practices undertake this work because of their commitment to their local populations and their expertise in identifying invisible barriers, digital exclusion,

navigating the system, and because the level of trust they are given in their communities.

18. Time and workforce capacity are critical constraints. The average FTE fully qualified GP now cares for approximately 16% more patients than in 2015, with pressures most acute in socio-economically deprived areas.[6] This leads to shorter appointments. RCGP's 2025 GP voice survey found that 75% of GPs said they do not have enough time to offer health advice for preventive care (e.g. vaccination advice, self-care, health education, lifestyle advice).[7] Much of GP's outreach work is therefore done outside contracted hours with the GMC recently reporting that 80% of GPs across the UK work beyond their rostered hours at least once a week.[8]

19. There is also a clear mismatch between need and resource. Practices in the most deprived areas have around 14.4% more patients per GP but receive about 7% less funding, and they receive around 29% less in QOF incentive payments. These are the same communities where vaccination uptake is lowest, so the system risks reinforcing inequalities.[9] This mismatch between need and resource risks entrenching and widening existing health inequalities, as areas with the lowest uptake have the least capacity to respond.

20. Recent changes to the GP Contract, including updates to QOF and the Investment and Impact Fund, introduce improvement-based incentives for vaccination, which is a positive step. These allow practices to be rewarded for incremental progress rather than fixed thresholds, better reflecting the realities in underserved populations.

21. However, structural challenges persist. Practices in deprived areas often have larger patient lists, fewer GPs per capita, and greater clinical complexity, limiting their ability to deliver proactive care such as vaccination and outreach. While incentive reform is helpful, more equitable funding and targeted workforce distribution are needed to address these underlying disparities.

22. If policymakers wish to improve vaccination coverage among populations facing the greatest barriers, the system will need to recognise the additional resource required to support this work.

The need to improve data sharing

23. Current data and call/recall systems do not consistently enable optimal childhood vaccination uptake. A key limitation is the lack of easy, integrated access to children's health records across services. This means opportunities for catch-up vaccination are often missed when children present for other care, undermining the principle of maximising every contact and limiting engagement with families about immunisation.

24. Fragmented systems also make it harder to identify and follow up under-vaccinated children, particularly in more mobile or disadvantaged populations.

25. Improvements should focus on better data integration and transparency. The introduction of a Single Unique Identifier, as proposed by the Royal College of Paediatrics and Child Health, would support consistent tracking of vaccination status across services. In addition, greater integration of digital child health records with call/recall systems is needed.

26. There is also a clear opportunity to improve transparency and engagement for parents. Providing accessible, real-time information on a child's vaccination status and upcoming appointments through tools such as the NHS App could empower families, improve timely uptake, and support more proactive participation in vaccination programmes.

Health visitors and schools can play an important complementary role in improving uptake

27. The RCGP supports efforts to strengthen vaccination uptake through wider multidisciplinary collaboration.

28. Adolescent vaccination programmes are largely delivered by school nurses with general practice providing essential catch-up and supportive access.

29 . Health visitors can also play a valuable role in supporting vaccination uptake through engagement, education and follow-up with families. Health visitors often have trusted relationships with parents of young children and may be well placed to identify families who face barriers to accessing vaccination services.

30 . Health visitor involvement can therefore complement existing vaccination services by supporting families with information, addressing concerns, and helping to ensure children attend appointments. This may be particularly important for families experiencing social, language, or access barriers. However, this support should work alongside established vaccination delivery services rather than replace them.

Conclusion

31 .Any changes to how childhood vaccinations are organised should build on the strengths of the current system rather than fragment it. GP practices provide continuity of care, maintain complete patient records, and already deliver the majority of routine childhood immunisations. Moving childhood vaccination delivery away from general practice risks undermining the integrated model of care that has historically supported high coverage rates. The priority is not to redesign the model, but to ensure it is adequately supported to meet current and future demand.

32 . Recommended actions: Increase workforce capacity and core funding in general practice Provide targeted investment for practices serving deprived populations
Reform incentives to better support outreach to under-vaccinated groups
Improve data integration and interoperability, including consideration of a single unique child identifier. With the right support, the existing GP-led model can continue to deliver high vaccination coverage and equitable outcomes for all children.

29 April 2026

[1] Childhood vaccination invitation letter templates - GOV.UK
[2] Child Health Information Services (CHIS) - NHS SCW Support and Transformation for Health and Care
[3] NHS England, *Vaccination and Immunisation Services: Standards and Core Contractual Requirements*; NHS England, *Changes to the GP Contract 2025/26*
[4] NHS England » Quality and Outcomes Framework guidance for 2026/27 chapter 4.3
[5] National Audit Office, *The rollout of the COVID-19 vaccination programme in England* (HC 1106, Session 2021–22, 25 February 2022), paras **3.5, 3.22–3.28 and 1.5–1.8**.
[6] RCGP Key general practice statistics and insights https://www.rcgp.org.uk/representing-you/key-statistics-insights (accessed April 2026
[7] RCGP's 2025 GP voice survey
[8] General Medical Council (2025) *The state of medical education and practice in the UK: Workplace experiences 2024*. London: GMC. (Part 2, Chapter 4)
[9] RCGP Breaking the inverse care law in UK general practice (2025) https://www.rcgp.org.uk/getmedia/815fd4c7-2a57-4b08-b8c9-0ac9e8ddcf95/parliamentary-briefing-breaking-inverse-care-law-uk-general-practice.pdf