Meeting: **Health and Communities Overview and Scrutiny Committee**

Date/Time: **Wednesday, 3 June 2026 at 2.00 pm**

Location: **Sparkenhoe Committee Room, County Hall, Glenfield**

Contact: **Euan Walters (Tel. 0116 305 2583)**

Email: **Euan.walters@leics.gov.uk**

Membership

Mr. M. Durrani CC	Mr. M. T. Mullaney CC
Dr. S. Hill CC	Dr. D. North CC
Mr. P. King CC	Mr. D. Page CC
Mrs. K. Knight CC	Mr. B. Piper CC
Mr. J. McDonald CC	Mr J. Poland CC
Mr. J. Miah CC	Mr. C. Whitford CC
Mr. P. Morris CC	

Please note: this meeting will be filmed for live or subsequent broadcast via the Council's web site at http://www.leicestershire.gov.uk

AGENDA

Item		Report by
1.	Appointment of Chairman. To note that Dr. S. Hill CC has been appointed Chairman of the Health and Communities Overview and Scrutiny Committee in accordance with Rule 6(a) of the Overview and Scrutiny Procedure Rule (Part 4E of the County Council's Constitution).	
2.	Election of Vice Chairman.	
3.	Minutes of the meeting held on 4 March 2026.	(Pages 5 - 10)
4.	Question Time.	
5.	Questions asked by members under Standing Order 32(1).	

6.	To advise of any other items which the Chairman has decided to take as urgent elsewhere on the agenda.		
7.	Declarations of interest.		
8.	Declarations of the Party Whip in accordance with Overview and Scrutiny Procedure Rule 16.		
9.	Presentation of Petitions under Standing Order 33.		
10.	Healthwatch Leicestershire report - Improving Hospital Discharge.	Healthwatch	(Pages 11 - 16)
11.	Learning Disability Annual Health Check - Progress Update	Leicestershire Partnership NHS Trust	(Pages 17 - 24)
12.	Vaccines and Immunisations.	Integrated Care Board	(Pages 25 - 56)
13.	Date of next meeting. The next meeting of the Committee is scheduled to take place on Wednesday 9 September 2026 at 2.00pm.		
14.	Any other items which the Chairman has decided to take as urgent.		

QUESTIONING BY MEMBERS OF OVERVIEW AND SCRUTINY

The ability to ask good, pertinent questions lies at the heart of successful and effective scrutiny. To support members with this, a range of resources, including guides to questioning, are available via the Centre for Governance and Scrutiny website www.cfgs.org.uk. The following questions have been agreed by Scrutiny members as a good starting point for developing questions:

- Who was consulted and what were they consulted on? What is the process for and quality of the consultation?
- How have the voices of local people and frontline staff been heard?
- What does success look like?
- What is the history of the service and what will be different this time?
- What happens once the money is spent?
- If the service model is changing, has the previous service model been evaluated?
- What evaluation arrangements are in place – will there be an annual review?

Members are reminded that, to ensure questioning during meetings remains appropriately focused that:

(a) they can use the officer contact details at the bottom of each report to ask questions of clarification or raise any related patch issues which might not be best addressed through the formal meeting;

(b) they must speak only as a County Councillor and not on behalf of any other local authority when considering matters which also affect district or parish/town councils (see Articles 2.03(b) of the Council's Constitution).

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Agenda Item 3

Minutes of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Glenfield on Wednesday, 4 March 2026.

PRESENT

Dr. S. Hill CC (in the Chair)

Mrs. L. Danks CC	Mr. P. Morris CC
Mr. P. King CC	Mr. D. Page CC
Mrs. K. Knight CC	Mr. B. Piper CC
Mr. J. McDonald CC	Mr J. Poland CC
Mr. J. Miah CC	Mr. K. Robinson CC

In attendance

Fiona Barber – Healthwatch Leicestershire
Jean Knight - Managing Director, Leicestershire Partnership NHS Trust (minute 58 refers)
Saskya Falope - DMH Head of Nursing, Leicestershire Partnership NHS Trust (minute 58 refers).
Siobhan Favier - Director of Planned Care, University Hospitals of Leicester NHS Trust (minute 59 refers)
Suzanne Nancarrow - Deputy Chief Operating Officer - Planned Care, University Hospitals of Leicester NHS Trust (minute 59 refers)
Kelly Lambert - Associate Medical Director for Cancer, University Hospitals of Leicester NHS Trust (minute 59 refers).

51. Minutes of the previous meeting.

The minutes of the meeting held on 14 January 2026 were taken as read, confirmed and signed, subject to the addition of Fiona Barber (Healthwatch Leicestershire) to the attendance list.

52. Question Time.

The Chief Executive reported that no questions had been received under Standing Order 32.

53. Questions asked by members.

The Chief Executive reported that no questions had been received under Standing Order 7.

54. Urgent items.

The Committee noted an urgent statement provided by the Integrated Care Board regarding Out of Hours medical appointments which had been produced in response to

concerns raised in the Market Harborough area over the previous 24 hours. A copy of the statement is filed with these minutes.

55. Declarations of interest.

The Chairman invited members who wished to do so to declare any interest in respect of items on the agenda for the meeting.

Mr. J. Poland CC declared a registerable interest in agenda item 8: LPT CQC Inspection as he was a Trustee of the Loughborough Wellbeing Centre.

The Cabinet Lead Member for Health Mr. M. Squires CC declared an interest in all substantive agenda items due to his employment with a partner organisation.

56. Declarations of the Party Whip.

There were no declarations of the party whip in accordance with Overview and Scrutiny Procedure Rule 16.

57. Presentation of Petitions.

The Chief Executive reported that no petitions had been received under Standing Order 33.

58. CQC Inspection Update: LPT Adults Community Mental Health Services

The Committee considered a report of Leicestershire Partnership NHS Trust (LPT) regarding the Care Quality Commission (CQC) inspection of the Trust's adult community mental health services. A copy of the report, marked 'Agenda Item 8', is filed with these minutes.

The Committee welcomed to the meeting for this item Jean Knight, Managing Director, LPT and Saskya Falope, DMH Head of Nursing, LPT.

Arising from discussions the following points were noted:

(i) In response to a query about the exact scope of the CQC inspection, it was explained that this was set out in the CQC report, a link to which was provided in the covering report to the Committee. The voluntary sector, who played a significant role in LPT services, had not been part of the CQC inspection. The delivery of mental health services was complex and it was not possible to cover it all in the report.

(ii) In November 2020 LPT's adult community mental health services were receiving approximately 200 referrals a month, whereas in November 2025 the service received around 700 referrals. In response to a question as to why there had been such a significant increase in demand, it was suggested that isolation during the Covid-19 pandemic was a big factor, but it could also be due to socio-economic/cost of living factors. In addition, the introduction of the Central Access Point made it easier for people to refer themselves into LPT, whereas before they had to be

referred from their GP. Whilst this was a positive, it had resulted in an increase in demand on LPT services.

(iii) In response to concerns raised by members about waiting times and patients failing to attend appointments, it was explained that a person's mental health could fluctuate and may have improved between the time the appointment was booked and the actual date of the appointment. There were also trends with regards to missed appointments for example Mondays and Thursdays were the days of the week on which the most Did Not Attends (DNAs) occurred. Some patients struggled with appointments earlier in the day. Text messages were sent out to remind patients of appointments. Reassurance was given that there was a robust process in place for managing DNAs and assessing whether immediate action needed to be taken, such as contacting relatives.

(iv) In response to further questions about LPT activity and performance trends it was agreed that more detailed information would be provided after the meeting.

(v) A member raised concerns that people having a mental health crisis might feel overwhelmed by the amount of services, websites and phone numbers available. In response it was explained that the Central Access Point was there to simplify the whole process from a patient perspective and all a patient had to do was call NHS 111 and then select Option 2 in order to be directed to the appropriate place for them.

(vi) The Community Connector was a new role within LPT Mental Health Planned Care Services designed to help support people to achieve better mental health and wellbeing and link them in with a wider integrated team of voluntary sector, local authority, and primary care staff.

(vii) LPT was making use of technology to help patients, such as with the Joy mobile phone app which connected people with local community services and wellbeing groups.

(viii) One of the areas the CQC had identified for improvement was unfilled vacancies and reliance on long-term temporary staffing. This was partly a result of mental health services expanding quickly in a short space of time. However, since the inspection had taken place in May 2025 improvements had been made and there were now less vacancies and more qualified staff available for recruitment.

(ix) A member raised concerns that the adult community mental health services were not the only services provided by LPT that CQC rated as 'requires improvement' and queried whether there was a more systemic problem in LPT. In response it was submitted by LPT that overall the CQC ratings for LPT had improved, and also pointed out that some of the CQC inspections for other LPT services had been several years ago so the CQC ratings could be out of date. The approach of the CQC had evolved over the years and it was difficult for Trusts to know what the inspection criteria was and what actions would result in a good inspection report. In response, the member noted that some of LPT's failures related to government regulations which the Trust was in breach of and stated that LPT should have been clearly aware what those regulations were.

(x) It was queried how LPT compared with other Trusts and whether the complexity of the services provided by LPT made it difficult to improve performance. In response

it was explained that when compared with other Trusts LPT was about average. In addition to the CQC there were other mechanisms for measuring performance such as the National Oversight Framework.

RESOLVED:

That the contents of the report be noted with some concern.

59. Elective Care, diagnostics and cancer performance.

The Committee considered a report of University Hospitals of Leicester NHS Trust (UHL) which provided an update on elective care, diagnostics and cancer operations plus work being carried out to reduce waits for patients. A copy of the report, marked 'Agenda Item 9', is filed with these minutes.

The Committee welcomed to the meeting for this item Siobhan Favier, Director of Planned Care, UHL, Suzanne Nancarrow, Deputy Chief Operating Officer - Planned Care, UHL, and Kelly Lambert, Associate Medical Director for Cancer, UHL.

In presenting the report it was emphasized that UHL was not content with the performance for elective care, diagnostics and cancer, and the impact on patients due to delays in receiving care was acknowledged.

Arising from discussions the following points were noted:

(i) Members raised strong concerns about the length of the waiting lists and a lack of overall progress with performance over recent years. In response UHL argued that there had been improvements particularly with regards to the numbers of patients waiting the longest. In response to a request for more detail on the actions being taken by UHL to tackle performance issues, including the dates that the actions would be completed, it was agreed that the improvement plan would be shared with the Committee after the meeting.

(ii) The industrial action being taken by resident doctors did have an impact as activity needed to be reduced during strike periods as the staff was not available to cover it.

(iii) UHL was the NHS Trust most badly affected by the Covid-19 pandemic therefore it was taking longer to recover from the pandemic.

(iv) Whilst UHL was not meeting the NHS standards for cancer with regards to timescales, other NHS Trusts nationally were in a similar position. UHL was the largest NHS trust in the East Midlands for cancer referrals and it had a good reputation for cancer treatment therefore continued to receive more referrals than other Trusts. Whilst on a waiting list cancer patients were assessed and prioritised based on a mixture of need and risk but also the length of time they had been waiting. Administrative staff regularly tracked the patients on the waiting list.

(v) Whilst campaigns which had taken place over the years regarding stopping smoking had a positive effect on the amount of patients presenting with cancer, this was balanced out by the ageing of the population and the greater likelihood of cancer in the older population.

(vi) East Midlands Planned Care Centre based at the General Hospital was designed to reduce the number of patients waiting for appointments and treatment. Hinckley Community Diagnostics Centre which had recently opened would also have an impact. Members raised concerns that plans for a same-day surgery unit in Hinckley had been cancelled and therefore the Community Diagnostics Centre would stand in isolation in Hinckley. In response reassurance was given that the cancellation of the same-day surgery unit would not have a significant impact on the planned care waiting lists.

(vii) UHL was working with the Getting It Right First Time (GIRFT) programme which was a national NHS England programme designed to improve the treatment and care of patients. The GIRFT programme was helping UHL improve productivity, throughput and patient follow-ups.

(viii) Going forward technology would play an increasingly important role in diagnostics and treatment. Artificial Intelligence (AI) could be used for assessing scans, though humans would still play a role in viewing scans as well. AI could also be used to summarise consultations and dictate letters. The NHS app was gaining greater functionality particularly with regards to primary care. The use of robotics for surgical procedures was becoming more prevalent and UHL had recently received its third surgical robot.

(ix) Currently a patient's full medical record could not be viewed throughout all parts of the NHS; only the summary care record could be viewed. A balance needed to be struck with sharing the right level of detail about a patient's history. A new Patient Administration System known as 'Nervecentre' was being implemented in UHL which would enable better sharing of information across the NHS and management of patients.

RESOLVED:

That the update on elective care, diagnostics and cancer operations be noted with concern.

60. Issues arising from Health Performance report that merit more detailed scrutiny.

The Committee considered a joint report of the Director of Public Health, Law and Governance and the ICS Performance Service which provided an update on public health and health system performance in Leicestershire and Rutland based on the available data in January 2026. A copy of the report, marked 'Agenda Item 10' is filed with these minutes.

Members were asked whether there were any areas identified in the report that they felt required more detailed scrutiny at a future meeting but no suggestions were made. Members were advised they could submit any suggestions after the meeting.

RESOLVED:

That public health and health system performance in Leicestershire be noted.

61. Date of next meeting.

RESOLVED:

That the next meeting of the Committee be held on Wednesday 3 June 2026 at 2.00pm.

2.00 - 3.45 pm
04 March 2026

CHAIRMAN

Agenda Item 10

healthwatch Leicester and Leicestershire

HEALTH AND COMMUNITIES OVERVIEW AND SCRUTINY COMMITTEE: 3 JUNE 2026

REPORT OF HEALTHWATCH LEICESTER AND LEICESTERSHIRE

IMPROVING HOSPITAL DISCHARGE - WHAT PATIENTS AND CARERS TOLD US

Purpose of report

1. The purpose of this report is to present Healthwatch Leicester and Leicestershire's findings from two pieces of work on hospital discharge:
   - Improving hospital discharge: what patients and carers told us report, capturing patient and carer experiences of recent discharge;
   - An Enter & View report following visits to community hospital discharge wards.

2. The report provides independent insight into what is working well and where further improvement is needed and sets out recommendations to support ongoing discharge and flow improvement across the system.

3. Hospital discharge remains a key system issue affecting patient experience, flow and health inequalities. The Health Overview and Scrutiny Committee is asked to maintain oversight of this work, noting the findings and supporting system partners to use the learning to inform ongoing improvement activity.

Recommendation

4. The Health Overview and Scrutiny Committee is asked to:
   - Note the findings and recommendations from Healthwatch Leicester and Leicestershire's hospital discharge work;
   - Support system partners to consider how the learning can inform ongoing discharge improvement, patient experience and inequality-reduction work;
   - Note that Healthwatch Leicester and Leicestershire will continue to gather patient and carer feedback to help assess progress over time.

Policy Framework and Previous Decision

5. The Health and Social Care Act 2012 introduced statutory duties on local authorities to deliver effective local Healthwatch services.

6. The main statutory functions of HWLL are set out below:

a. Gather and share the views of members of the public who use health and social care services.
b. Influence the planning, commissioning, delivery, re-design and scrutiny of health and social care services.
c. Assess the standard of local health and care provision and make recommendations for improvement based on the views of service users.
d. Help people access and make choices about health and care services.
e. Is representative of local people, representing the diversity of the community it serves and different users of services in the way in which it exercises its functions.
f. Has powers to request information from commissioners and providers of health and social care and to enter health and social care premises, known as “Enter & View” visits.
g. Has a seat on Leicester City and Leicestershire County Health & Wellbeing Boards (HWBB).
h. Signposts people to information about local health and care services and how to access them.
i. Is able to alert Healthwatch England (HWE), or the Care Quality Commission (CQC) where appropriate, to specific care providers, health or social care matters.
j. Has a duty to produce an annual report on their activities and finance and send a copy of their annual reports to NHS England, relevant Integrated Care Systems (ICS) and HWE, among others specified in previous legislation.

7. These statutory functions underpin Healthwatch Leicester and Leicestershire’s role in gathering patient and carer insight on hospital discharge and presenting independent findings to system partners.

Background

8. HWLL undertook a research project on hospital discharge in October 2020 to follow up on visits to the discharge lounges at local hospitals in July 2019. There were interviews with 23 people between 29 October and 9 November 2020 to understand how the discharge process worked.

9. In 2025, Leicestershire County Council approached HWLL to look at gathering independent insights from patients and carers. The project was designed with the following objectives in mind:
   - Evaluate progress since 2020: Assess whether the key issues identified in the previous report have improved.
   - Collect qualitative and quantitative data from patients and carers about their recent hospital discharge experiences.
   - Include the voices of patients, carers and family members to ensure comprehensive insights.

- Present the patient's views of the discharge process and highlight areas for improvement.
- Provide actionable, evidence-based recommendations to health and social care providers.

Consultation/Patient and Public Involvement

Improving Hospital Discharge what patients and carers told us

10. This work involved consultation with patients and carers who had recent experience of hospital discharge. Engagement took place between March and August 2025 through surveys and direct discussions, ensuring patient and carer voices were central to the work.

11. In addition, Enter & View visits were conducted in four community hospital discharge wards in October – December 2025, involving conversations with patients and observations of ward environments and discharge processes.

12. The feedback gathered has directly informed the findings and recommendations in the published Healthwatch reports.

Key findings

13. The key findings are as follows:
    - 58% of respondents felt involved in discussions about their discharge.
    - 38% said they did not receive clear information about follow-up care, medication or support after leaving hospital.
    - 71% received a copy of their discharge summary, though some reported inaccuracies.
    - 60% were discharged within the timeframe they expected; medication delays were the most common cause of frustration.
    - Only 16% of carers were informed of their right to a Carers' Assessment.
    - Three-quarters (76%) of respondents felt ready to go home, though some described feeling unsupported once home.

What are the outcomes?

14. The consultation identified a range of positive experiences, particularly within community hospital discharge wards, including calm environments, strong multidisciplinary working and good patient satisfaction.

15. It also highlighted ongoing challenges, including communication gaps, medication delays, limited carer involvement and uncertainty about aftercare once home.

Next Steps

16. The findings and recommendations have been shared with Leicester Hospitals, Leicestershire Partnership NHS Trust, Local Authorities and relevant system partners to support ongoing discharge and flow improvement work.

17. Healthwatch Leicester and Leicestershire will continue to gather independent patient and carer feedback on hospital discharge, using future engagement activity and Enter & View visits where appropriate to assess whether improvements are being felt in practice and to identify any emerging issues.

Appendices

Improving hospital discharge | Healthwatch Leicester and Leicestershire
Discharge Wards Enter and View | Healthwatch Leicester and Leicestershire

Officer to contact

Hardip Kaur Chohan

Director of Operations and Services

0116 257 5050

Hardip.c@valonline.org.uk

Relevant Impact Assessments

Equality Implications

18. VAL is committed to promoting equality and welcomes diversity in all aspects of its service delivery. We operate in a diverse community and our aim is to harness the talent within the community to help improve our service provision further. We understand that our services have to be delivered in a different way to meet the legitimate needs of different communities.

19. We are committed to preventing and eliminating discrimination, harassment and victimisation of any form, fostering good relations between all our people, advancing equality of opportunity for all and welcoming diversity.

20. We operate an Equality and Diversity Policy in service delivery and employment. VAL aims to provide appropriate service delivery to very diverse communities. VAL aims to recruit a staff and volunteer(s) team that reflects and is understanding of that diversity. This means that services have to be delivered in a different way to meet the legitimate needs of different communities. VAL

will ensure it will recruit to each project/post staff with the appropriate understanding and specific skills needed.

21. In pursuit of this diversity VAL will ensure that no job applicant, volunteer, employee, user of services or member is discriminated against directly, indirectly, by association or perception because of disability, gender (including gender reassignment), race, colour, nationality, ethnic or national origin, marital status or civil partnerships, responsibility for dependents, sexuality, pregnancy or maternity, age, trade union activity, political or religious, agnostic or atheist beliefs and (unrelated to the post) criminal convictions.

22. We will not tolerate any form of harassment or victimisation.

Human Rights Implications

23. There are no human rights implications arising from the recommendations in this report.

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Agenda Item 11

Leicestershire Partnership NHS Trust

HEALTH AND COMMUNITIES OVERVIEW AND SCRUTINY COMMITTEE: 3 JUNE 2026

REPORT OF LEICESTERSHIRE PARTNERSHIP NHS TRUST

LEARNING DISABILITY ANNUAL HEALTH CHECK – PROGRESS UPDATE

Purpose of report

1. This report provides an update on the work carried out by the Leicester, Leicestershire and Rutland (LLR) Learning Disability and Autism (LDA) Collaborative to increase the number of people with a learning disability (LD), aged 14+, receiving an Annual Health Check (AHC) from their primary care provider.

Background

2. People with a learning disability experience significantly poorer health outcomes and a higher rate of avoidable deaths compared with the general population. AHCs play a vital role in identifying unmet health needs early, ensuring timely and appropriate treatment, improving health promotion, and reducing inequalities. The LDA Collaborative seeks to ensure that every eligible person receives a high-quality, timely AHC and a Health Action Plan (HAP), supported by accurate registers, effective primary care relationships, and a strong focus on reducing inequalities across all LLR communities.

3. Where other Integrated Care Systems have centralised this activity to non-registered staff to increase coverage, the LDA Collaborative has a resolute commitment to ensure people with a learning disability are able to access this opportunity through their own GP. We believe this strengthens the relationship between both parties, ensuring the best possible opportunity for a holistic assessment of needs and proactive health intervention on these occasions and in future, and additionally provides a level of access that is in keeping with the risks experienced by this community. The LDA Collaborative commissions three LD Primary Care Liaison Nurses from LPT to provide expert support to primary care colleagues.

4. The LD AHC was introduced in 2009, under the Primary Medical Services Directed Enhanced Service (DES) contract, with a nationally mandated target of 75% of people aged 14+ on the LD Register.

5. The national target was removed by NHS England (NHSE) from April 2025 with encouragement for local systems to maintain focus on this important area of practice, continued performance reporting (see point 8 below) and incentivised funding for GP practices to maintain accurate LD registers. The LDA Collaborative's Board agreed a

local target of 80% and reiterated a firm commitment to increase the number of people on the LD Register, year on year.

6. The LDA Collaborative works with partners to identify people for inclusion in the LD Register; during 2025/26 increasing the number by a further 250 (4.9%). Table 1 below provides data from the NHSE national team and the final confirmed position for 2025/26. Whilst this demonstrates a slight reduction in percentage coverage there was again a further increase in the number of local people receiving an AHC (96 or 2.1%).

7. The number of people receiving an AHC in LLR has increased every year since the LDA Collaborative was established in 2021; exceeding the national target since 2022 and the performance of the majority of other ICS areas.

Number of Annual Health Checks carried out for persons aged 14 years and over on the QOF Learning Disability Register														Expected prevalence as per planning round	% Health checks against prevalence
LLR ICB	April	May	June	July	August	September	October	November	December	January	February	March	Total		
2021/22	59	131	193	155	188	212	288	375	316	394	542	729	3582	5451	65.7%
2022/23	77	105	216	245	344	330	267	355	284	434	583	651	3891	4993	77.9%
2023/24	104	180	258	275	349	366	336	472	325	511	611	541	4328	4999	86.6%
2024/25	154	221	309	348	290	335	388	506	314	504	627	493	4489	5097	88.1%
2025/26	140	215	329	394	346	439	390	408	396	583	477	468	4585	5347	85.7%

*Table 1: Number of Annual Health Checks carried out for persons aged 14 years and over on the QOF Learning Disability Register (*N.B. During 2021 there was a national issue with people being incorrectly added to the LD Register by NHSE, which is reflected in the higher prevalence number for that year).

8. The NHSE national planning metric related to AHCs for 2026/27 has been revised and now includes: *Percentage of people aged 14+ on the QOF Learning Disability Register with an annual health check and a health action plan (HAP).* LLR has recorded the number of HAPs completed as part of the AHC process in previous years and has consistently achieved high performance in this area (2025/26 – 99.7%). This will continue to be included as part of our regular performance reporting for this financial year.

9. Due to the high performance of the LLR system the LDA Collaborative was selected as one of two national pilot sites (alongside Northeast London ICB) to participate in a 12-month proof of concept pilot to develop and test the feasibility of combining the established health checks for severe mental illness (SMI) and learning disabilities (LD) with a new check for autistic people, into one combined health check. In January 2026 NHSE committed to the delivery of an autism health check across England.

10. The learning from project work to increase the quality and uptake of LD AHCs and the National Combined AHC work are informing LLR plans currently being implemented within the LDA Collaborative's well-established annual Health Equity Programme. Details of this work are included in this report.

LDA Collaborative Projects and Initiatives:

Increasing the number of people receiving an AHC: all ages

11. The LD Primary Care Liaison Nursing (PCLN) team in LPT works to support improved process and practice in primary care through education, quality improvement projects and practical clinical advice and support. The team is supported by the Clinical Lead GP within the Collaborative, Health Informatics staff and Collaborative leads.

12. During 2025/26 the PCLNs focused on reducing variation across practices by supporting GP practices to validate and expand LD registers to enable early identification of need, by undertaking targeted reviews, and by reducing barriers to access; with a specific focus on people living in the most deprived communities. This has included increased use of population health data to help practices prioritise individuals most at risk or living in the most deprived 20% of areas.

13. This work has also included regular engagement sessions with Primary Care Networks (PCNs), GP practices and ICB colleagues to review progress and address variation. A significant feature of this work is to encourage practices to complete a larger proportion of AHCs earlier in the year to stabilise activity and ensure those individuals who are the most vulnerable during winter months have proactive care plans in place. The impact of this work can be seen in Table 2 below.

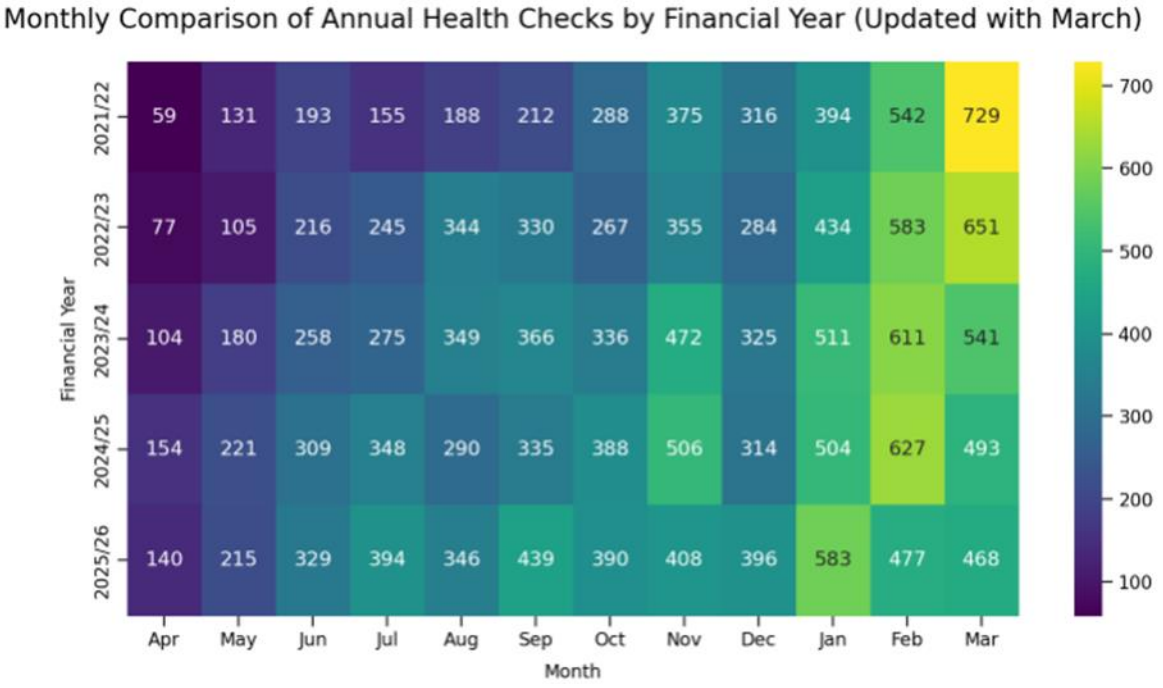

Table 2: Table showing change in AHC activity to earlier in the financial year to support timely clinical intervention and service stabilisation.

14. The work of the PCLNs is enhanced by a developing GP Ambassador network, increasing communication and support to primary care colleagues, their regular practice visits and a collaborative troubleshooting approach. The PCLNs have also led the GP LD Friendly Practice Award to recognise and communicate good practice in improving access and reducing barriers for people with a learning disability.

Strengthened DNA and Decline Monitoring

15. In 2025/26, enhanced monitoring of Did Not Attend (or Was Not Brought) data, and incidences of AHC appointments being declined, has enabled targeted support to practices and individuals; improving systems and processes and ensuring risks to individuals are assessed and addressed. In 2025/26 over 100 DNA/WNBs were recorded and a similar number of declined appointments.

Improving the Quality of AHCs and HAPs

16. NHS England's Learning Disability and Autism Programme (2025) and NICE indicator IND266 (2023) on learning disability health checks and action plans, both highlight the importance of the quality and consistency of care delivered in primary care settings. In 2025/26 practices have been supported to improve the quality and completion rate of HAPs, with the programme expectation that every AHC should be accompanied by a meaningful HAP.

17. Ensuring local targets are stretching, but remain achievable, has allowed increased focus on the quality of AHCs and HAPs in 2025/26, through the interventions of the PCLN team and the Lead GP. Quality-improvement work and evaluation of the enhanced AHC template showed disparities in practice that directly affected the experience and outcomes of people with a learning disability and the team continue to address these. A particular focus being the creation of actionable HAPs to support continuity of care and improved health outcomes.

18. This work continues in 2026/27 with a project to refine and improve the local HAP template, using experiences and insights from both patient and clinician engagement activities. This improvement work directly reflects national guidance on personalised, co-produced action planning as one approach for tackling longstanding health inequalities among people with a learning disability (NHSE and LeDeR).

Increasing uptake of annual health checks: 14–19

19. Attendance at AHCs among people aged 14-19 was identified as being significantly lower to other age groups; therefore a project was initiated during 2025/26 to establish a process that ensured more children and young people (CYP) with a LD were accurately identified on GP LD Registers and consistently invited to attend their LD AHC.

20. The project involved a multi-agency working group across education, health and social care and utilised insights from collaborative discussions to understand where improvements could be made. The main outputs from this project were:

    - Improving clinical coding pathways: implementing changes to the Community Paediatric SystmOne template to enable services to directly add a young person to the LD Register using the appropriate SNOMED codes;

    - Updating the CAMHS SystmOne template (increasing functionality) to ensure young people were identified and coded consistently;

- Creating a LD Screening Tool for young people to support consistent identification of those who should be added to the GP LD Register;

- Promoting LD AHCs to young people, their parents and carers and education professionals to ensure they understand the purpose, benefits and process.

21. Overall, the project has delivered practical system improvements, enhanced coding pathways, strengthened data quality and tools that support earlier and more accurate identification. These changes contribute to improved access to AHCs, better preparation for adulthood and reduced health inequalities for CYP with learning disabilities across LLR.

Focus on Reducing Inequalities

22. In 2025/26 greater attention was given to supporting individuals from the most deprived communities. Work led through the GP LD Friendly Practice Award and work on accessible environments have helped reduce barriers to attendance.

23. This work has been complimented by actions to identify people who have declined, did not attend or were not brought either for their AHC or other appointments.

24. The work will continue in 2026/27 with the team embedding the GP LD Friendly Practice Award across all practices, further enhancing relationships with primary care, improving communication and engagement with families and carers, and providing targeted support to practices with persistent performance challenges.

The National Combined Health Check Pilot

25. Due to our high performance, the LLR system was selected as one of two national pilot sites (alongside Northeast London ICB) to participate in a 12-month proof of concept pilot to develop and test the feasibility of combining the established health checks for severe mental illness (SMI) and learning disabilities (LD) with a new health check for autistic people into one combined health check.

26. The purpose of the pilot was to establish if people with a SMI, LD and autistic people, as well as clinicians and practice staff, derive the anticipated benefits from reduced duplication and greater personalisation of the annual health check process. Many people are eligible for more than one of these three health checks.

27. The pilot included people aged 14 years or over who are registered with an NHS practice; increasing the inclusion for SMI health checks. Work included commissioning of an independent evaluation partner, creating new contracting arrangements, clinical template and related IT developments for national use, GP practice selection, developing training packages for the different staff groups involved, pathway development, creation of multimedia accessible information resources, curation of resources for future implementation leads, and delivery of over 500 health checks using this approach.

28. The final evaluation will be published in quarter 1 of 2026/27 and will address the tolerability of the combined check for all parties, barriers to success, planning lessons, cost analysis and recommendations for policy implementation.

29. Health checks for autistic people in the pilot resulted in safeguarding, audiology, continence, contraception and mental health referrals, cervical, bowel and breast cancer screening referrals, carer assessments, and significant use of social prescribers, home visits, specialist dentistry support, and increased use of respect and advanced end of life care documentation.

30. The impact of health checks for autistic people with more acute needs in the pilot has been significant. To support the implementation of the Mental Health Act reforms, and the related need for improved community support for autistic people, the LDA Collaborative will be commissioning a targeted autism health check pilot in 2026/27 for the most vulnerable.

Learning from 2025/26:

31. The learning from 2025/26 is as follows:

- Early and consistent engagement with PCNs has driven better performance in primary care in terms of both quality and activity;
- A combined approach of nursing and medical clinical leadership has provided effective and thorough oversight of AHC progress;
- Effective project management and data analysis has enabled accurate tracking of activity and adjustment of plans to best target quality improvement interventions;
- Practices need clear guidance and support on what high-quality AHCs and HAPs look like;
- Coding of DNAs/WNBs and declines is inconsistent across practices and requires standardisation;
- Performance remains variable across PCNs, indicating the need for targeted and ongoing support;
- Following feedback from practices the GP LD Friendly Practice Award self-assessment tool was reviewed and streamlined to further increase engagement. Good practice is evident across LLR with 9 practices awarded Gold or Silver in the GP LD Friendly Practice Award, with interest or partial completion in other practices and commitments from both PCN's and Practices going into 2026/27.

Plans for quality improvement work in 2026/7

32. Further deep-dive work is needed into high-DNA/WNB practices to identify barriers and develop tailored improvements alongside the Collaborative's second year of work focused on improving the quality and consistency of HAPs.

33. The team will be striving to sustain register validation to capture newly eligible individuals and improve accuracy of data and will be providing focused support to PCNs and practices with persistent performance variation.

34. The PCLN team and GP Lead will be embedding the GP LD Friendly Practice Award across all practices and further strengthening the network of LD GP Ambassadors;

strengthening positive relationships to enhance further quality monitoring and improvement for HAPs.

35. The objective of the Collaborative is to slightly increase the coverage rate (to 82%), providing opportunity for further work on quality improvement and timely targeting of those at greatest risk; improving consistency in coding of DNA/WNB and incidences of appointments being declined. The team are already working to sustain early-year momentum to avoid end-of-year pressure distorting relationships and improvement activities.

Conclusions

36. This report sets out the need for continued support to ensure people in LLR with a learning disability have access to a high-quality AHC. It describes the context in which this work is being undertaken, the detailed project planning, data analysis, professional and operational leadership and collaboration underway to achieve this.

37. The report also notes the sustained high performance of the LDA Collaborative's work; combining rigorous and impactful project management together with mature systemwide relationships, and the opportunities locally and nationally for learning that this has presented.

38. Finally it sets out the balance being sought between stretching targets and developmental and high-quality intervention for those most at risk within the resources available.

39. The scrutiny committee's comments on the activities, progress and plans of the LDA Collaborative in enabling partners to provide high quality and timely annual health checks for people with a learning disability are welcomed.

Circulation under the Local Issues Alert Procedure

40. None.

Equality Implications

41. There are no equality implications arising from this report.

Human Rights Implications

42. There are no human rights implications arising from this report.

Other Relevant Impact Assessments

43. Not applicable

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Leicester, Leicestershire and Rutland

HEALTH AND COMMUNITIES OVERVIEW AND SCRUTINY COMMITTEE: 3 JUNE 2026

JOINT REPORT OF THE NHS LLR ICB VACCINATION & IMMUNISATION & THE DIRECTOR OF PUBLIC HEALTH

VACCINATION & IMMUNISATION

Purpose of report

1. The purpose of this report is to provide an overview of life-course vaccination delivery across Leicestershire, outlining current arrangements, recent activity, areas of challenge and improvement, and the direction of travel for vaccination services. The report invites the Health Overview Scrutiny Committee to note progress, understand pressures and provide views on how vaccination access and uptake can continue to be improved, with a particular focus on reducing persistent inequalities. This paper focuses on Leicestershire performance and delivery, within the wider Leicester, Leicestershire and Rutland (LLR) system governance and support arrangements.

Policy Framework and Previous Decisions

2. Vaccination and immunisation services are commissioned and delivered in line with national NHS policy and guidance, including the UK immunisation schedule and advice from the UK Health Security Agency (UKHSA). Locally, delivery is overseen by the NHS Leicester, Leicestershire and Rutland (LLR) ICB through established immunisation governance arrangements.

3. In addition to core programme delivery, NHS England has issued 2026/27 guidance on improving access and reducing inequalities across vaccination programmes. This guidance reinforces that targeted approaches should be data-driven, focused on underserved communities and areas with low uptake, and delivered using flexible engagement and outreach models. It also places emphasis on linking outreach activity to wider prevention support through a Making Every Contact Count approach and on capturing evidence of impact through routine reporting and evaluation, so that learning can inform future campaign planning and commissioning.

4. The Committee has previously received updates on childhood and seasonal vaccination programmes on 06 March 2024, including work to address variation in uptake and respond to outbreaks, such as measles. This report builds on that earlier discussion by taking a life-course view, from birth through to older age.

Executive Summary

Current Position

5. The current position is as follows:

- Early years programmes show high uptake, though MMR two-dose coverage remains below the 95% threshold, increasing outbreak risk.
- Adolescent programmes (HPV, MenACWY) show greater variability, particularly where individuals miss school-based delivery.
- Adult and seasonal programmes demonstrate good uptake in older adults, but lower coverage in under 65 at-risk groups, pregnant women and some workforce groups.
- Across all programmes, headline averages mask significant variation between communities, GP practices and PCNs.

Key Issues

6. The key issues are as follows:

- Inequalities in uptake persist and are widening in some cohorts.
- Drop-off in coverage occurs at transition points beyond structured delivery (e.g. boosters, adolescence).
- Variation in delivery and engagement across providers contributes to uneven access.
- Sub-optimal coverage in some groups creates ongoing risk of outbreaks, particularly for measles.

System Response and Direction of Travel

7. Vaccination delivery uses a targeted, data-driven approach, including:

- Expansion of flexible delivery models (e.g. outreach clinics, roving healthcare unit, FE settings).
- Strengthening primary care recall and additional workforce support.
- Working with Voluntary, Community and Social Enterprise (VCSE) partners to improve engagement and trust.
- Using local intelligence and Joint Strategic Needs Assessment (JSNA) insights to target areas of lowest uptake.

Conclusion of Executive Summary

8. Vaccination remains a cornerstone of public health protection in LLR. While progress has been made, improving equitable uptake is critical to reducing inequalities and preventing outbreaks. The next phase will focus on embedding a coordinated,

year-round life-course model, improving data quality, and closing the inequality gap across all cohorts.

Background

9. Life-course vaccination refers to the full range of NHS-recommended vaccinations delivered at different stages of a person's life, including:

- pregnancy and early years;
- childhood and adolescence;
- young adults;
- working-age adults;
- older people.

10. This approach recognises that vaccination is not a one-off intervention but an important part of preventing illness, reducing health inequalities and protecting population health over time.

11. Engagement has taken place with GP practices/Primary Care Networks, Leicestershire public health team, community providers, voluntary sector partners and the general public. Feedback has helped shape delivery models, particularly around outreach, access, and communication with young people and underserved communities.

Pregnancy and Early Years

12. Vaccinations offered during pregnancy (such as whooping cough and RSV) and in early childhood (including MMR, polio, diphtheria and others) are delivered through a combination of primary care, maternity services and the School Age Immunisation Service (SAIS). Uptake is generally strong in many areas; however, variation remains, with lower uptake seen in more deprived communities. Targeted work is underway to:

    - support expectant parents with clear information;
    - improve data quality between maternity and GP systems;
    - offer flexible access through community and outreach settings.

Children and Young People

13. Routine childhood and adolescent vaccinations, including MMR and HPV, are mainly delivered via:
    - GP practices.

- The School Age Immunisation Service.
- Targeted catch-up activity.

14. While coverage has improved in some cohorts, HPV and older childhood boosters remain priority areas, particularly where children and young people have missed earlier vaccination opportunities. Innovative approaches have been introduced, such as:
    - opportunistic vaccination through outreach services;
    - vaccination at further education colleges;
    - GP call/ recall supported by additional workforce.

Young and Working-age Adults

15. Young adults are less likely to engage with routine healthcare, which can result in missed vaccinations, including HPV catch-up and MMR. To address this, Leicestershire has expanded:
    - community-based and walk-in offers;
    - use of mobile vaccination services;
    - close working with colleges, employers and community organisations.
16. For working-age adults, vaccination remains especially important for those with long-term health conditions or weakened immune systems.

Older Adults

17. Vaccinations for older people, including flu, COVID-19, pneumococcal and shingles vaccines, are delivered through GP practices, pharmacies and community services.
18. Recent campaigns have achieved **strong uptake**, including high coverage in care homes, although variation still exists by place and population group.
19. The ICB will continue to strengthen a life-course vaccination model by:
    - maintaining a universal vaccination offer;
    - targeting additional support where uptake is lowest;
    - expanding flexible and outreach-based delivery;
    - strengthening GP call/ recall and data reconciliation;
    - improve ethnicity and deprivation data quality;
    - improving coordination between services across age groups.

20. This includes the effective use of mobile services and additional vaccinators to support GP practices, Primary Care Networks (PCNs), other providers and within community settings.

Cross-cutting themes

21. The Health Equity Audit for the National Immunisation Programme[1] clearly evidences inequity across immunisation programmes, which has implications for public health protection and public confidence in the vaccination offer.

Deprivation

22. National evidence shows a strong socioeconomic gradient in vaccination uptake: lower uptake is consistently correlated with higher deprivation, and the gap between the most and least deprived groups has widened in several programmes over time. The national audit also highlights persistent lower uptake in several minority ethnic groups for some programmes, and notes that data completeness and granularity are still insufficient for some communities, limiting how precisely the system can target and evaluate interventions.

23. For Leicestershire, seemingly strong headline averages can mask pockets of lower coverage. Routine data shows material variation by place (e.g. PCN/ GP Practice) and by life-course transition points (boosters and adolescence).

24. Middle Super Output Areas (MSOAs) identified within JSNAs as more deprived include:

- Charnwood: Loughborough Lemyngton and Hastings; Storer and Queens Park; Shelthorpe
- North West Leicestershire: Agar Nook, Coalville
- Oadby and Wigston: South Wigston

25. The JSNA sets out operating principles to apply across services, which includes positioning services to be accessible. The mobile provision of vaccinations offered by the roving health unit supports access in these areas.

26. Published vaccination coverage reports provide robust assurance at local authority and service geographies (e.g., PCN/ practice), but do not consistently publish neighbourhood-level uptake by deprivation decile for all programmes, and the availability of routine outputs by level of deprivation is not uniform across datasets. To ensure we still act on inequity, partners use internal intelligence (including child health information that highlights under-immunisation in higher-deprivation

[1] https://assets.publishing.service.gov.uk/media/60183a8de90e07128e743b85/immnstn-equity_AUDIT_v11.pdf

neighbourhoods) to identify pockets of low uptake, triangulate with operational insight (access barriers, missed opportunities, mobility) and trigger targeted interventions.

27. Actions that follow this intelligence include deploying flexible capacity (such as the outreach vaccination offer and additional vaccinator support, working with communities, faith leaders and the voluntary sector) and focusing improvement effort where uptake is lowest, aligned with JSNA-identified MSOAs and populations of concern. A deprivation map of Leicestershire is given in the Appendix.

28. National flu uptake data demonstrates the impact of socioeconomic deprivation on vaccination uptake, persisting across age groups. The national data is contained within Appendix A.

Rurality

29. Rurality can influence vaccination uptake in ways that are distinct from deprivation. In rural and semi-rural areas, practical access barriers (for example, travel distance, limited public transport, fewer local venues delivering vaccination, and constraints on appointment availability) can make it harder for some residents to attend routine or follow-up appointments. These barriers are particularly relevant at “transition points” in the life-course pathway, where delivery is less structured and people may need to access catch-up vaccination through primary care rather than receiving it through a routine service contact. NHS England’s 2026/27 guidance on improving access and reducing inequalities explicitly includes rural areas among the underserved communities that may require targeted approaches, alongside data-driven outreach, flexible delivery models and evaluation of impact. Local partners ensure rurality and access are considered when targeting outreach and flexible delivery capacity (including mobile provision).

Ethnicity

30. Leicestershire has a diverse population profile, with a greater ethnic diversity among younger age groups. This is significant for vaccination programmes as these groups represent a significant proportion of the population eligible for routine childhood immunisations. The National Immunisation Programme Health Equity Audit (2025) identifies that vaccination uptake is consistently lower in some ethnic minority groups, and that these inequalities have persisted over time and, in some cases, widened. A number of factors drive these differences, including place barriers, cultural and linguistic differences and confidence and trust in vaccination services. Patterns of ethnic diversity often overlap with areas of greater deprivation and geographical variation, meaning that some communities experience multiple, reinforcing barriers to vaccination uptake. An overview of ethnicity in Leicestershire is given in Appendix B.

31. In line with national evidence and expectations, local vaccination programmes use population data and service intelligence to identify communities where uptake is lower and take targeted, culturally responsive action, including working with trusted community organisations and leaders, tailoring communication and engagement approaches and providing flexible outreach vaccination delivery, encouraging services to respond to the diverse needs of communities.

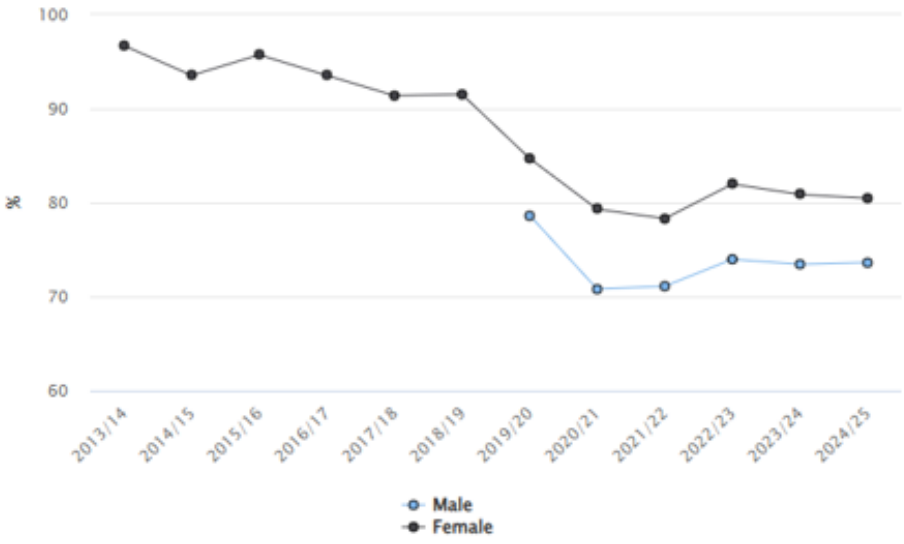
32. Addressing variation in uptake is important not only for equity, but for overall health protection resilience. Lower vaccination coverage in specific communities increases the risk of outbreaks of vaccine-preventable diseases, sustained transmission within under-protected groups and widening inequalities.

HPV Vaccination Programme

33. HPV (human papillomavirus) is a widespread virus. Most infections are harmless, but persistent high-risk HPV can cause several cancers, including cervical, vulvar, vaginal, penile, anal, and some head and neck cancers. The programme aims to protect young people before exposure. High coverage also reduces vaccine-type HPV in the community, leading to herd protection and fewer cases even among unvaccinated individuals.

34. The routine HPV vaccine is mainly offered by the School-Aged Immunisation Service (SAIS) in Year 8 schools (age 12–13), with follow-up opportunities for those who miss the first session. From September 2023, most young people receive a single-dose schedule, though some clinical groups have different schedules, simplifying delivery while ensuring protection. In Leicestershire, SAIS provides vaccinations in schools and community clinics, including options for home-educated students, reserving home visits for those with health needs and offering multiple opportunities throughout the school year to reduce missed cases.

35. Uptake remains higher among girls than boys, with 2024/25 coverage at 80.5% for girls and 73.6% for boys. Despite the single-dose schedule easing logistics, the main challenge is reaching students who miss school sessions due to absence, consent issues, changing schools, or being outside mainstream education. This reinforces the need to expand post-school catch-up and improve consent and attendance pathways.



	Male	Female
2013/14	-	96.7%
2014/15	-	93.5%
2015/16	-	95.7%
2016/17	-	93.5%
2017/18	-	91.4%
2018/19	-	91.5%
2019/20	78.7%	84.7%
2020/21	70.8%	79.3%
2021/22	71.1%	78.3%
2022/23	74.0%	82.0%
2023/24	73.4%	80.9%
2024/25	73.6%	80.5%

: UK Health Security Agency

Figure 1- Gender differences in HPV Vaccine Uptake

36. HPV vaccination rates are tracked using routine coverage reports, usually published for groups like year group and sex, or larger geographic areas. This reporting makes it easy to see differences between genders, but it is not as effective at consistently measuring other inequalities – such as those involving ethnicity, deprivation, or neighbourhoods – from the same data. Therefore, this section focuses on disparities clearly shown in regularly published coverage data. In addition, service planning uses operational details, such as patterns of missed sessions, consent returns, and catch-up uptake, to guide improvement efforts and decrease unnecessary variation.

37. A system-wide improvement approach has been adopted that extends beyond the routine school session. NHS South, Central & West supported the project group to co-design and facilitate a collaborative workshop with commissioning and delivery partners, producing a unified strategy and agreed actions to improve HPV uptake and sustainability. Alongside this strategic work, SAIS has expanded practical catch-up arrangements through community-based clinics, including holiday-period catch-up clinics for young people.

38. Efforts to improve post-school HPV vaccination include a 2025/26 NHS campaign targeting unvaccinated 16–24-year-olds and encouraging opportunistic offers for eligible individuals starting at age 14. Practices must ensure GP records accurately reflect vaccinations from schools or clinics before sending invitations, aiming to reach those who missed school doses and prevent gaps between services. Activity has also been extended into secondary sixth forms and further education (FE) colleges, including targeted communications and the deployment of the roving healthcare units offering HPV and other vaccinations to eligible young people who may have missed vaccination offers through school-based routes.

39. LLR supports informed choices with accessible information and myth-busting on the ICB website and has enhanced guidance via a local walk-in immunisation finder/portal covering HPV, making catch-up routes easier to navigate for young people and families.

40. The next phase of the programme will focus on consolidating the progress made to date and moving from a series of targeted initiatives to a data-driven, system-wide model, with a focus on closing the inequality gap and improving uptake across all eligible cohorts.

Measles, Mumps and Rubella (MMR)

41. MMR vaccination protects against measles, mumps and rubella, infections that spread easily and can cause serious complications. Measles can lead to serious complications, with higher risks in young infants, immunosuppressed people and pregnant women.

42. The most effective way to control measles is achieving high uptake of two doses of an MMR-containing vaccine, with the World Health Organization recommending coverage greater than 95% to interrupt transmission. Routine MMR vaccination is delivered primarily through general practice in early childhood, with catch-up vaccination offered for anyone who is not fully immunised. In LLR, the School-Aged Immunisation Service (SAIS) supports school-age vaccination programmes and

includes an invitation-based offer of MMR catch-up for under-immunised young people, with delivery via schools and community clinics where required.

43. Nationally, measles activity has risen sharply in recent years. UKHSA reported 2,911 laboratory-confirmed measles cases in England in 2024 and 959 cases in 2025. The UKHSA measles dashboard reports 542 laboratory-confirmed cases in England between 1 January and 11 May 2026, with the majority reported in London and the West Midlands, though all regions have recorded cases.

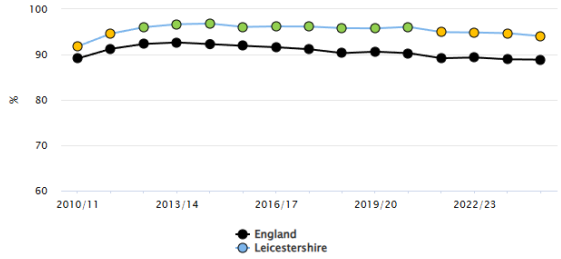
44. Based on the latest Leicestershire vaccination coverage, performance for the first dose (MMR1) at age 2 is 94.1%, and increases to 96.2% by age 5. However, two-dose coverage (MMR2) is 91.0%, below the 95% threshold required to prevent outbreaks.

Population vaccination coverage: MMR for one dose (2 years old)

Proportion - %

Show confidence intervals Show 99.8% CI values

▶ More options



Recent trend: ⬇ Decreasing & getting worse

Benchmarking against goal: <90% | 90% to 95% | ≥95%

Period		Leicestershire Count	Value	95% Lower CI	95% Upper CI	England
2010/11	🟡	6,722	91.8%*	91.2%	92.4%	89.1%*
2011/12	🟡	6,893	94.6%*	94.0%	95.1%	91.2%*
2012/13	🟢	7,251	96.0%*	95.5%	96.4%	92.3%*
2013/14	🟢	7,381	96.7%*	96.2%	97.1%	92.7%*
2014/15	🟢	7,293	96.8%*	96.4%	97.2%	92.3%
2015/16	🟢	7,109	96.1%*	95.6%	96.5%	91.9%
2016/17	🟢	7,289	96.2%*	95.7%	96.6%	91.6%
2017/18	🟢	7,098	96.2%	95.7%	96.6%	91.2%
2018/19	🟢	6,987	95.8%	95.3%	96.3%	90.3%
2019/20	🟢	7,024	95.8%*	95.3%	96.2%	90.6%
2020/21	🟢	7,120	96.1%*	95.6%	96.5%	90.3%
2021/22	🟡	6,982	94.9%*	94.4%	95.4%	89.2%
2022/23	🟡	6,799	94.9%*	94.3%	95.3%	89.3%
2023/24	🟡	7,106	94.7%*	94.2%	95.2%	88.9%
2024/25	🟡	6,782	94.1%*	93.5%	94.6%	88.9%*

Source: UK Health Security Agency, Coverage of Vaccinations Evaluated Rapidly Programme

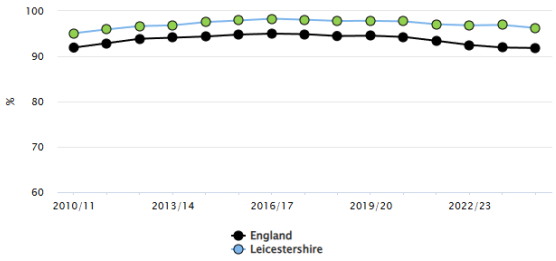
Indicator Definitions and Supporting Information

Population vaccination coverage: MMR for one dose (5 years old)

Proportion - %

Show confidence intervals Show 99.8% CI values

▶ More options



Recent trend: ⬇ Decreasing & getting worse

Benchmarking against goal: <90% | 90% to 95% | ≥95%

Period		Leicestershire Count	Value	95% Lower CI	95% Upper CI	England
2010/11	●	6,806	95.1%*	94.6%	95.6%	91.9%*
2011/12	●	7,093	95.9%*	95.5%	96.4%	92.9%*
2012/13	●	7,390	96.7%*	96.3%	97.1%	93.9%*
2013/14	●	7,400	96.8%*	96.4%	97.2%	94.1%*
2014/15	●	7,493	97.6%*	97.2%	97.9%	94.4%
2015/16	●	8,007	97.9%	97.5%	98.2%	94.8%
2016/17	●	8,104	98.3%*	97.9%	98.5%	95.0%
2017/18	●	7,719	98.1%	97.8%	98.4%	94.9%
2018/19	●	7,339	97.8%	97.4%	98.1%	94.5%
2019/20	●	7,780	97.8%*	97.5%	98.1%	94.5%
2020/21	●	8,072	97.7%*	97.4%	98.0%	94.3%
2021/22	●	7,946	97.1%*	96.7%	97.4%	93.4%
2022/23	●	7,917	96.8%*	96.4%	97.2%	92.5%
2023/24	●	7,854	96.9%*	96.5%	97.3%	91.9%
2024/25	●	7,662	96.2%*	95.8%	96.6%	91.8%*

Source: UK Health Security Agency, Coverage of Vaccinations Evaluated Rapidly Programme

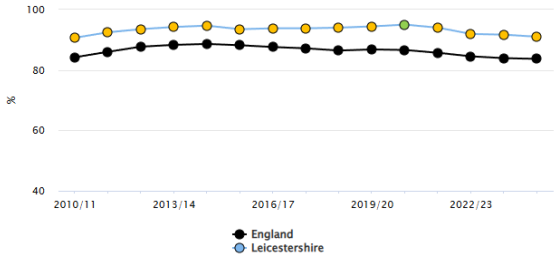
Indicator Definitions and Supporting Information

Population vaccination coverage: MMR for two doses (5 years old)

Proportion - %

Show confidence intervals Show 99.8% CI values

▶ More options



Recent trend: ⬇ Decreasing & getting worse

Benchmarking against goal: <90% | 90% to 95% | ≥95%

Period		Leicestershire Count	Value	95% Lower CI	95% Upper CI	England
2010/11	●	6,490	90.7%*	90.0%	91.3%	84.2%*
2011/12	●	6,836	92.5%*	91.8%	93.0%	86.0%*
2012/13	●	7,149	93.5%*	93.0%	94.1%	87.7%*
2013/14	●	7,202	94.2%*	93.7%	94.7%	88.3%*
2014/15	●	7,271	94.7%*	94.1%	95.2%	88.6%
2015/16	●	7,650	93.5%	93.0%	94.0%	88.2%
2016/17	●	7,735	93.8%*	93.2%	94.3%	87.6%
2017/18	●	7,382	93.8%	93.2%	94.3%	87.2%
2018/19	●	7,055	94.0%	93.5%	94.5%	86.4%
2019/20	●	7,510	94.4%*	93.9%	94.9%	86.8%
2020/21	●	7,850	95.0%*	94.5%	95.5%	86.6%
2021/22	●	7,695	94.0%*	93.5%	94.5%	85.7%
2022/23	●	7,516	91.9%*	91.3%	92.5%	84.5%
2023/24	●	7,430	91.7%*	91.1%	92.3%	83.9%
2024/25	●	7,245	91.0%*	90.4%	91.6%	83.7%*

Source: UK Health Security Agency, Coverage of Vaccinations Evaluated Rapidly Programme

Figure 2- Leicestershire performance MMR vaccination coverage

45. The overall Leicestershire figures mask important inequalities in protection. At Primary Care Network level within Leicestershire, routine coverage data shows a clear spread: MMR1 by 18 months ranges from 85.8% to 96.7%, and the “fully protected by age 5” proxy ranges from 82.8% to 95.7%.

PCN Area	Children who received at least 1 dose of MMR vaccine between the ages of 1 & 1.5 years (2024/25)	Children aged 5 years, who received a reinforcing dose of DtaP/IPV & at least 2 doses of MMR between the ages of 1 & 5 years (2024/25)
Beacon (Charnwood)	96.7%	91.0%
Bosworth	92.7%	91.3%
Carillion	87.4%	82.8%
Fosseway	95.6%	93.4%
Hinckley Central	92.7%	92.3%
North West Leicestershire	94.8%	88.7%
Soar Valley	94.5%	91.5%
Watermead	85.8%	87.3%
Cross Counties	95.3%	95.7%
G3	89.9%	89.5%
Market Harborough & Bosworth	91.5%	85.2%
Melton, Syston & Vale	93.6%	89.9%
North Blaby	91.5%	89.2%
Oadby & Wigston	89.4%	85.8%
South Blaby & Lutterworth	95.0%	90.4%

46. The Annual GP MMR Catch-up Collection adds a second inequality lens: cohort effects and pockets of under-immunisation across registered practice populations, due to missed opportunities (appointments, mobility); vaccine confidence issues, data recording gaps (overseas vaccines). It shows a strong gradient by age cohort- by age 5, 91.4% have 2 recorded doses and 3.9% have no recorded doses, but by age 30, only 70.1% have 2 recorded doses and 23.0% have no recorded doses. The same GP return also demonstrates variation between practice populations, with recorded “zero dose” ranging from 2.4% to 50.1% and two-dose coverage ranging from 44.3% to 92.8%. There is also a known cohort effect nationally: MMR uptake fell in the late 1990s and early 2000s following highly publicised (and subsequently disproven) claims of a link between MMR and autism/ Crohn’s disease, sometimes referred to as the ‘Wakefield cohort’. This legacy of misinformation can contribute to lower vaccination in some older age bands and reinforces the importance of opportunistic catch-up and record reconciliation.

47. Interpretation of the GP catch-up dataset requires caution. “Zero dose” reflects no *recorded* dose, which can include incomplete coding (for example vaccines given elsewhere) as well as true non-vaccination, and it reflects GP-registered populations

only. For these reasons, this section focuses on the inequalities that are directly evidenced by the routine outputs, while operational planning also draws on local intelligence and incident/ outbreak learning to target action to communities and settings at highest risk.

48. Interpretation should be cautious in three ways:

    a) the GP catch-up return reflects GP-registered populations only, so it may under-represent people who are not currently registered or who move frequently between services

    b) “zero dose” in this dataset means no recorded dose and may include people vaccinated elsewhere (including outside England) or where historic vaccination events are not coded correctly; improving record reconciliation is therefore important for targeting and monitoring

    c) the datasets used here provide limited routine visibility of neighbourhood-level and ethnicity-specific inequalities for MMR.

49. Therefore, this section focuses on what is directly evidenced (cohort effects and variation between PCNs/practice populations), while operational planning draws on local intelligence and outbreak management principles to target action to settings and groups at highest risk. Current MMR vaccine uptake creates a material outbreak risk, particularly where two-dose coverage remains below 95%

Meningococcal Group B (MenB) Vaccination

50. Meningococcal disease is a rare but rapidly progressive bacterial infection caused by *Neisseria meningitidis*, most commonly presenting as meningitis and/or septicaemia. Although uncommon, invasive meningococcal disease can lead to death within 24 hours of symptom onset and is associated with a case fatality rate of around 5–10%, with survivors at risk of severe long-term complications.

51. In England, infants under one year of age have the highest incidence, with a secondary peak in teenagers and young adults. Transmission occurs through close and prolonged respiratory contact, with higher risk in closed or crowded settings such as student accommodation. Around 300 to 400 cases of meningococcal disease are diagnosed in England every year.

52. Vaccination programmes have led to substantial reductions in disease over the past two decades. However, more recent UKHSA data indicate rising case numbers following the pandemic period, combined with declining vaccination uptake in both infant and adolescent cohorts, increasing population susceptibility. Recent national incidents, including meningococcal group B (MenB) outbreaks in 2026, have demonstrated that where immunity is uneven, infection can spread within high-contact populations such as young adults, requiring rapid public health response, including targeted vaccination and antibiotic prophylaxis. These events reinforce the importance of maintaining high and equitable vaccination coverage.

53. Within this national context, Leicestershire continues to perform relatively well overall, particularly for the infant MenB programme. Coverage at two years of age has consistently remained above the England average. However, the local trend shows a gradual decline over recent years (Figure 1): Coverage was 95.1% in 2020/21,

however has since reduced to 93.1% in 2024/25. While this remains within the national target range (90-95%), it remains below the 95% level required for optimal population protection and shows a downward trajectory (now classified as decreasing and getting worse).

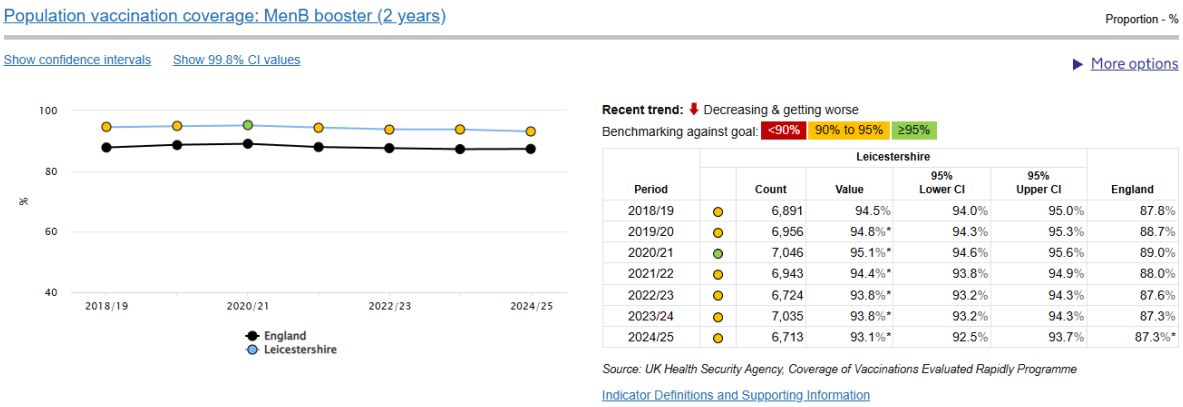


Figure 3 – MenB booster uptake (Leicestershire)

54. Local GP data reinforces his pattern, with 52-week uptake being 95.5% for dose 1 and 93.5% for dose 2, which then reduces to 87.6% for the booster (at 78 weeks). The adolescent programme that vaccinates against other strains of meningitis (MenACWY) shows a more marked decline over time. Uptake previously exceeded 90% locally in the years prior to the pandemic but dropped significantly during this period and has not fully recovered. In 2024/25, coverage stands at 84.6%, reflecting partial recovery but remaining below historic levels. Wider GP (from 2023/2024) data suggest lower uptake across some eligible cohorts, at approximately 77.2% across multiple age bands, particularly with lower coverage in older adolescents and young adults reliant on catch-up through primary care.

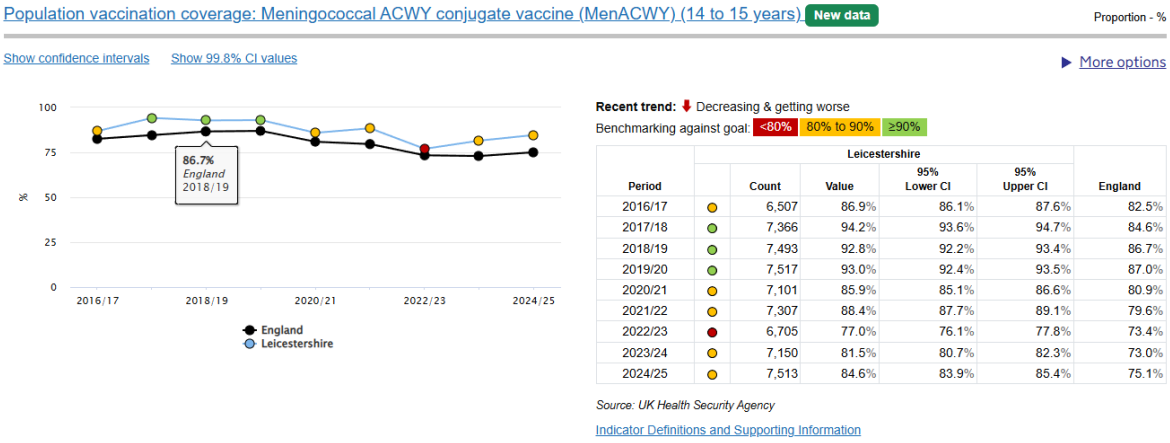


Figure 4- MenACWY Uptake (Leicestershire)

55. Taken together, these data demonstrate that while Leicestershire performs well on headline indicators, overall figures mask important and persistent inequalities in

vaccination coverage. Aggregate averages obscure variation between local areas, between population groups and across different stages of the vaccination pathway. High overall coverage can coexist with pockets of significantly lower uptake, where susceptibility to infection is higher and where transmission can be sustained.

56. These inequalities are most clearly seen across the age pathway. Uptake is highest during infancy, when vaccination is delivered through routine and structured contacts with health services, but declines at the booster stage and falls further in adolescence, particularly where individuals miss school-based delivery and must rely on opportunistic or catch-up vaccination. These transition points represent key moments where engagement is lost and inequalities widen.

57. There is also considerable variation between GP practices, reflecting differing local population characteristics, deprivation, mobility and access to services, as well as differences in recall systems and service delivery. This variation means that individuals living in certain areas are at greater risk, despite the apparent strength of system-wide averages. Differences are also evident across ethnic groups. While uptake among White British populations is consistently high, data indicate lower or more variable uptake among some minority ethnic groups, although interpretation is constrained by small numbers and incomplete ethnicity recording. In contrast, differences by gender are minimal, with similarly high uptake observed among males and females, indicating that gender is not a primary driver of inequality within this programme.

58. These findings have important implications for local preparedness. The uneven distribution of immunity within the population creates conditions in which outbreaks can occur, particularly in groups with close social contact such as adolescents and young adults. The Green Book highlights that these groups play a key role in the transmission of meningococcal bacteria due to higher carriage rates. Local preparedness arrangements therefore need to account not only for overall coverage levels but for the distribution of that coverage across the population. In response, local systems continue to maintain robust outbreak response capability, including close working with UKHSA, rapid identification and management of cases and contacts, and the ability to deliver targeted vaccination where required. This sits alongside ongoing work to strengthen routine vaccination uptake and reduce inequalities, recognising that prevention through equitable coverage is the most effective means of reducing risk.

59. There has been recent national attention on MenB outbreaks in parts of England, reinforcing the importance of maintaining high coverage. There are no outbreaks or cases linked to outbreaks identified in Leicestershire.

Seasonal Vaccinations: COVID-19 & Flu

60. Seasonal influenza remains a significant cause of morbidity and mortality each winter, particularly among older people, individuals with underlying health conditions, and pregnant women. Vaccination is the most effective way to reduce serious illness, hospitalisation and deaths associated with influenza.

61. The seasonal flu vaccination programme targets a range of eligible groups, including adults aged 65 years and over, individuals aged 6 months to under 65 years in clinical risk groups, pregnant women, and children aged 2–15 years. The programme

is delivered through general practice and community pharmacy for adults, and through a combination of general practice and school-based delivery for children.

62. Local data for the 2025/26 season show that uptake in those aged 65 years and over reached approximately 78.2%, broadly consistent with national levels. However, uptake was considerably lower in some eligible cohorts, with individuals aged under 65 years in a clinical risk group experiencing uptake of 43.7%. For pregnant women, uptake was 43.9%. These figures demonstrate a persistent gap in coverage between older adults and other at-risk groups, despite the latter often experiencing a higher relative risk of severe complications from influenza.

63. Local GP collection shows that among pregnant women uptake is around 43.9%. Vaccination delivery is spread across settings, with a substantial proportion delivered through GP practices, with notable contributions from maternity services and community pharmacy. While access points exist across the system, overall uptake remains constrained by a combination of engagement and acceptance.

64. Uptake among older adults increased during the COVID-19 pandemic period, peaking at over 80%. Recent years have seen a decline to 78.6% in 2024/25. For younger children aged 2–3 years, the decline has been more marked, with uptake falling from 68.9% in 2020/21 to 48.1% in 2024/25, indicating a sustained downward trend. Maintaining engagement with vaccination programmes has become more challenging in recent years, particularly in cohorts reliant on general practice delivery.

65. There is significant variation in uptake between general practices locally, with coverage for those aged 65 years and over ranging from the mid-60% range to over 80%, with similar variation observed across other eligible groups. This variation is also evident in workforce groups: uptake among health and social care workers aged under 65 (not at risk) was only 28.8% overall, with wide variation between practices, including some reporting uptake below 20%. This highlights inconsistent delivery and engagement across providers and settings.

66. In children, uptake continues to vary by age and delivery model. Local data suggest that uptake among pre-school children aged 2–3 years is around 50%, whereas uptake among school-age children is in the range of 60–65%. This reflects the impact of delivery approach, with school-based immunisation programmes achieving higher and more consistent coverage compared to reliance on general practice for younger children.

67. Inequalities in uptake are also evident. National data demonstrate a clear gradient by deprivation, particularly among younger children, where uptake in the most deprived communities is around 30% compared to approximately 53% in the least deprived groups. Additional local analysis shows variation by ethnicity across multiple cohorts, with some groups consistently showing lower uptake than the population average, including among adults aged under 65 and pregnant women. These patterns indicate that lower uptake is not evenly distributed but is associated with socioeconomic and demographic factors.

68. The programme performs relatively well for older adults, though there are ongoing challenges in achieving equitable and consistently high uptake across all eligible groups. Lower coverage among under 65 clinical risk groups, pregnant women and health and social care workers, coupled with declining trends in some cohorts and clear socioeconomic and demographic inequalities, highlight the need for continued

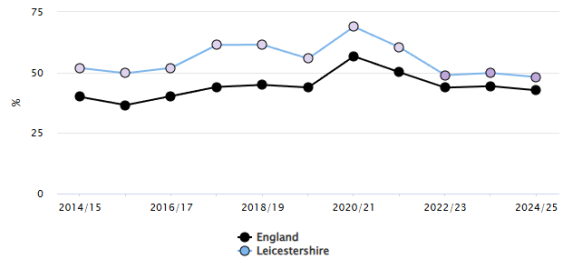
focus on access, engagement and tailored delivery approaches to improve vaccination uptake.

Population vaccination coverage: Flu (2 to 3 years old)

Proportion - %

Show confidence intervals Show 99.8% CI values

▶ More options



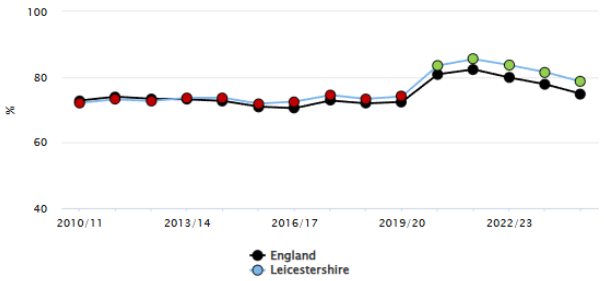
Recent trend: ⬇ Decreasing & getting worse

Period		Leicestershire Count	Value	95% Lower CI	95% Upper CI	England
2014/15		8,563	51.9%*	51.1%	52.6%	39.9%
2015/16		7,741	49.7%*	48.9%	50.5%	36.6%
2016/17		8,049	51.9%*	51.1%	52.7%	40.2%
2017/18		9,677	61.4%*	60.6%	62.1%	44.0%
2018/19		9,448	61.5%*	60.7%	62.2%	44.9%
2019/20		8,870	55.7%*	55.0%	56.5%	43.8%
2020/21		10,649	68.9%*	68.1%	69.6%	56.7%*
2021/22		8,951	60.4%	59.6%	61.2%	50.1%
2022/23		7,496	48.9%*	48.1%	49.7%	43.7%
2023/24		7,405	49.8%*	49.0%	50.6%	44.4%
2024/25		7,288	48.1%*	47.3%	48.9%	42.6%*

Source: NHS England

Indicator Definitions and Supporting Information

Figure 5- Pre-school flu vaccination performance (Leicestershire)



Recent trend: ⬇ Decreasing & getting worse

Benchmarking against goal: <75% ≥75%

Period		Leicestershire Count	Value	95% Lower CI	95% Upper CI	England
2010/11		86,538	72.2%*	71.9%	72.4%	72.8%*
2011/12		92,088	73.2%*	73.0%	73.5%	74.0%*
2012/13		94,794	72.7%*	72.5%	72.9%	73.4%*
2013/14		101,863	73.7%*	73.4%	73.9%	73.2%
2014/15		104,719	73.7%*	73.5%	73.9%	72.7%
2015/16		102,863	71.9%*	71.7%	72.1%	71.0%
2016/17		107,109	72.5%*	72.3%	72.7%	70.5%
2017/18		105,386	74.5%*	74.3%	74.7%	72.9%
2018/19		107,304	73.4%*	73.1%	73.6%	72.0%
2019/20		116,274	74.1%*	73.9%	74.3%	72.4%
2020/21		131,503	83.5%*	83.5%	83.9%	80.9%*
2021/22		129,048	85.5%	85.4%	85.7%	82.3%
2022/23		134,481	83.7%*	83.5%	83.8%	79.9%
2023/24		136,893	81.5%*	81.3%	81.7%	77.8%
2024/25		131,997	78.6%*	78.4%	78.8%	74.9%*

Source: NHS England

Figure 6- Population flu vaccination performance (65+ cohort)

COVID-19

69. COVID-19 vaccination continues to play an important role in protecting those at highest risk of severe illness, particularly older adults and individuals with underlying health conditions. Since the transition from mass vaccination to a more targeted seasonal approach, the programme has focused on seasonal boosters for older and clinically vulnerable populations.

70. Local data for the 2024-25 autumn booster programme shows variation in uptake by age. Uptake was 53.9% among those aged 65–69 years, increasing to 63.7% in those aged 70–74 years, 70.6% in those aged 75–79 years, and 73.0% in those aged 80 years and over. This demonstrates a consistent gradient, with higher uptake

in older age groups.

71. The vaccination timeline shows that uptake increased rapidly early in the campaign demonstrating effectiveness at reaching individuals who are already engaged and motivated early in the rollout. However, there is a clear challenge in sustaining uptake beyond this initial period and in reaching those who do not access vaccination promptly.

72. Analysis by ethnicity highlights significant inequalities in uptake. While overall coverage among those aged 65 years and over is moderate, uptake varies markedly between ethnic groups. Some communities, including Bangladeshi and Black African populations, show particularly low uptake, in some cases in the low-teens or single digits, even among those identified as clinically at risk. In contrast, uptake is higher in White British and some other groups, with many vaccinations delivered to these populations. The data also highlight challenges in data completeness, with a notable proportion of patients recorded as having unknown or unspecified ethnicity. This limits the ability to fully understand and address inequalities and suggests a need for improved recording and use of demographic data within primary care systems.

73. This inequality is longstanding, and the system has moved from describing variation to embedding action and accountability. In line with NHS England's 2026/27 guidance on improving access and reducing inequalities, targeted outreach and engagement is planned around where uptake is lowest and which groups face the greatest barriers, with delivery models linked to wider prevention support through a Making Every Contact Count approach. In parallel, improvement work includes strengthening how practices use and record demographic information and ensuring that evaluation and reporting capture not only headline uptake but also whether interventions are reaching underserved groups and converting engagement into booked and completed vaccination.

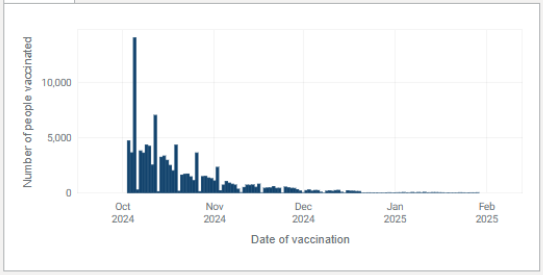
Vaccinations ›

People aged 65 and over who have had autumn booster vaccinations, by vaccination date (Leicestershire)

The number of people aged 65 and over who have had an autumn booster COVID-19 vaccination. Data is shown by date of vaccination.

Up to and including 29 Jan 2025

Chart | Tabular data | Download

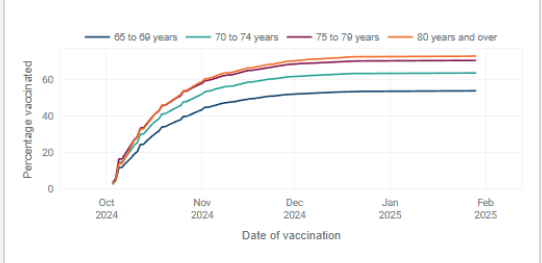


Autumn booster vaccination uptake (65+), by vaccination date (Leicestershire)

The percentage of people aged 65 and over who have had an autumn booster COVID-19 vaccination.

Up to and including 29 Jan 2025

Chart | Tabular data | Download



74. Across delivery partners, the system's 2025/26 post-programme debrief identified persistent unwarranted variation at practice and community level, including a small number of GP practices with consistently low uptake and evidence of inequalities linked to deprivation and certain ethnic minority groups. Recommendations for

improvement will form part of the planning process for the 2026/27 seasonal vaccination campaign.

Capacity Enhancing Support

Roving Healthcare Unit (RHU)

75. Significant work has been undertaken across LLR to expand the capability and reach of the roving healthcare unit (RHU), to enable it to deliver a broader vaccination offer, aligned to the life course approach. The RHU has been developed into a flexible, multi-purpose vaccination unit, capable of delivering the vaccines typically offered in primary care. This supports a shift from a campaign-based programme (eg COVID and flu), to a year-round, life course vaccination offer, thereby improving access and supporting the system's health inequalities objectives.

76. The RHU operates to the same standards as fixed clinical settings: robust clinical governance and cold chain processes, with access to patient records to support eligibility checks and safe delivery. Operating three days per week, all year-round, across LLR, the unit has been fully integrated into the wider vaccination delivery model, providing opportunistic vaccination, mop-up activity and targeted outreach, particularly in areas of low uptake and deprivation.

77. Over the past 12 months (April 2025 to March 2026), the RHU has delivered 277 vaccinations (includes 138 COVID-19 and 120 flu vaccinations) and 468 Making Every Contact Count (MECC) activities, across the county.

Supervaccinator Workforce

78. The supervaccinator workforce provides a flexible, deployable clinical resource supporting GP practices, community providers and outreach activity. The team is used to increase delivery capacity, run additional clinics, and support targeted interventions, particularly where there are workforce gaps or where additional effort is needed to improve uptake.

79. Over the past 12 months (April 2025 to March 2026), the team has delivered 616 vaccinations across 15 different county-based clinics.

Improving Immunisation Uptake Team (IIUT)

80. The IIUT provides targeted administrative training and ongoing support to general practice staff, aimed at strengthening immunisation processes and improving vaccination uptake. Their support includes delivery of structured, virtual training sessions covering vaccination schedules and decline management, and provision of practical resources and support packs.

81. Over the past 12 months (April 2025 to March 2026), IIUT the team has only needed to support two GP practices.

Recent Projects

82. The Local Immunisation Street Team (LIST) project was a targeted vaccination inequalities initiative that worked with VCSE partners to understand and address barriers to vaccination uptake in communities experiencing inequality. In Leicestershire, partnership working with Leicestershire GATE focussed on communities through local inequality intelligence including Traveller communities. The model centred on community-based engagement using vaccination ambassadors to build relationships, facilitate discussions, identify barriers, and link residents into vaccination opportunities, supported by flexible delivery capacity such as the Roving Healthcare Unit (RHU) and collaboration with GP practices.

83. The LIST approach was explicitly built around establishing relationships through community partners and ambassadors, reflecting the practical reality that trust is often a prerequisite for uptake in underserved groups. The project found that working with a community must move beyond data but to include local insight to ensure partners have a shared understanding of priority groups and places and recommended empowering training for VCSEs. Success in this type of work is not measured by an improvement in headline uptake figures, but whether the lowest-uptake pockets are given an opportunity to make an informed decision about the vaccination offer. This was evidenced through improved trust with the community enabling access to other prevention interventions such as screening. This reinforces an equity approach based on targeted effort where barriers are greatest.

Figure 7- Community Engagement with the Roving Health Unit during the LIST project

Public Health Investment Fund (PHIF)

84. The PHIF immunisation programme is an NHS England-funded initiative designed to reduce inequalities in vaccination uptake across Leicester, Leicestershire and Rutland by working with VCSE partners and system teams to understand and address barriers to access, confidence and service navigation for Section 7A vaccination programmes. The programme targets populations and places where uptake is persistently lower and inequalities are greatest, including communities experiencing socioeconomic deprivation and Gypsy, Roma and Traveller communities, using community-led engagement and navigation, with outreach clinics where appropriate and a “Making Every Contact Count” approach where possible.

85. Delivery remains ongoing and is expected to conclude in the Summer. The programme was explicitly designed to build on learning from the LIST project, carrying forward the core recommendations that improvement requires a community-centred approach built on trust, integrated delivery linking community engagement to primary care pathways, earlier and clearer evaluation with baseline indicators, practical VCSE onboarding and data capture support, and a broader prevention offer where that improves engagement and access.

Figure 8- VCSE organisations come together to consider inequalities in vaccination (and screening)

Resource Implications

86. Most routine vaccination programmes are commissioned by NHS England as Section 7A public health functions. Delivery is provided through a mix of providers (including GP practices, community pharmacy, maternity services and the School Age Immunisation Service (SAIS)), with local system governance and performance oversight provided through established immunisation governance arrangements.

87. Additional resources, such as mobile clinics and supervaccinator support, are deployed strategically to address gaps in access and workforce capacity. Financial, workforce and contractual implications are routinely reviewed through ICB governance processes.

Timetable for Decisions

88. Views and feedback from the Health Overview Scrutiny Committee will be considered as part of ongoing planning for:

- the 2026/27 vaccination delivery period;
- future seasonal campaigns;
- and continued development of life-course vaccination approaches.

Conclusions

89. Vaccination across the life course remains a core public health intervention in Leicestershire. While good progress has been made, challenges persist in ensuring equitable access and uptake for all communities. The Committee is invited to **note the progress described in this report and provide comments** on how life-course vaccination delivery can continue to improve.

Background papers

- HPV Vaccination Programme
- Childhood Immunisations: MMR
- Meningococcal Group B (MenB) Vaccination
- Seasonal Vaccinations: COVID-19 and Flu
- Capacity Enhancing Support.

Equality Implications

90. Improving vaccination uptake across the life course has a positive impact on reducing health inequalities. Targeted action focuses on groups and communities

with historically lower uptake. An Equality Impact Assessment supports this work and informs mitigations where needed.

Human Rights Implications

91. There are no adverse human rights implications arising from this report. Access to vaccination supports the protection of life and health.

Other Relevant Impact Assessments

Not applicable

Appendices

Appendix A: Deprivation
Appendix B: Demographics
Appendix C: NHS Immunisation Schedule & Guidance
Appendix D: UK Health Security Agency Vaccination Guidance

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APPENDIX A

Deprivation

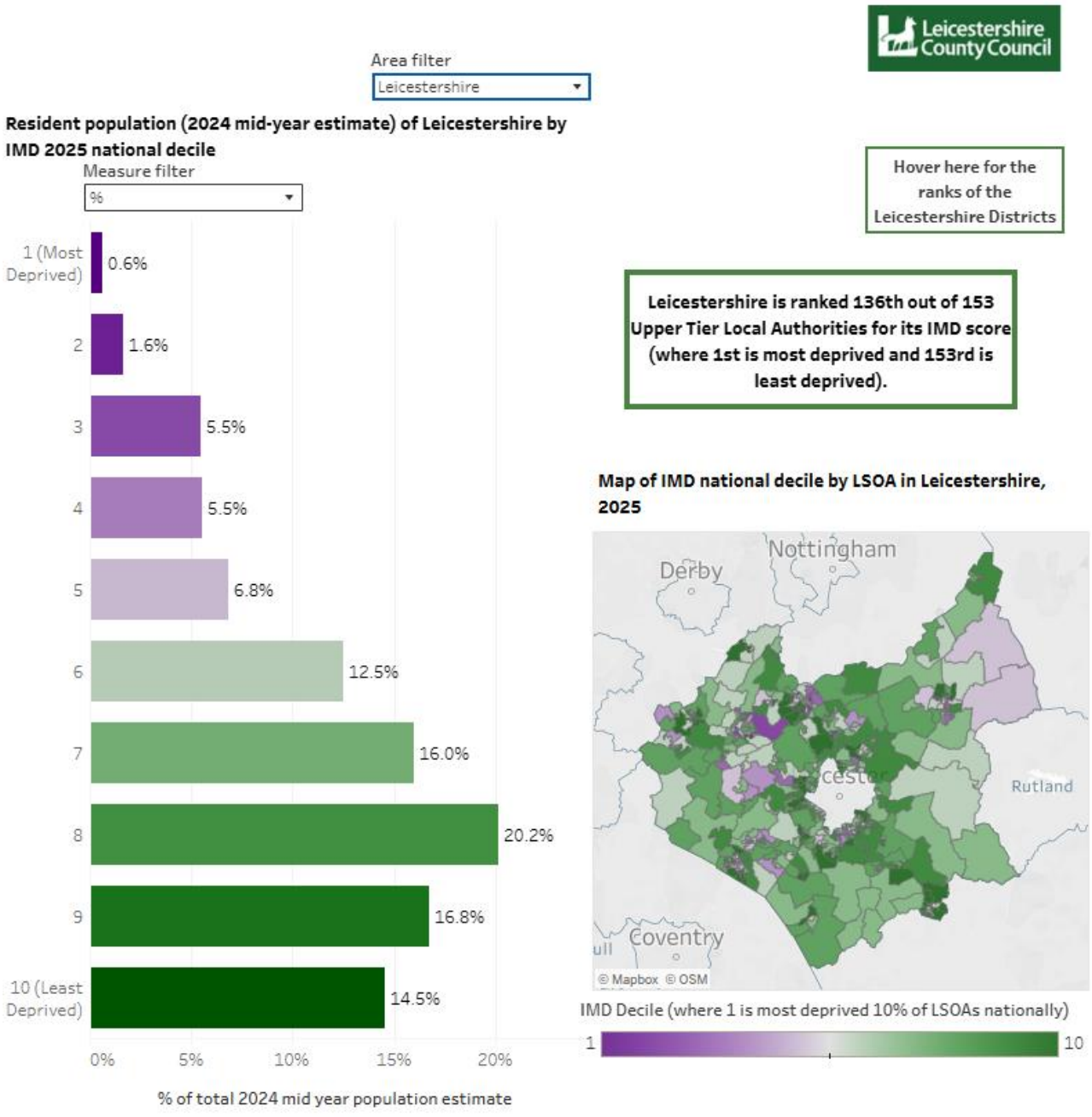
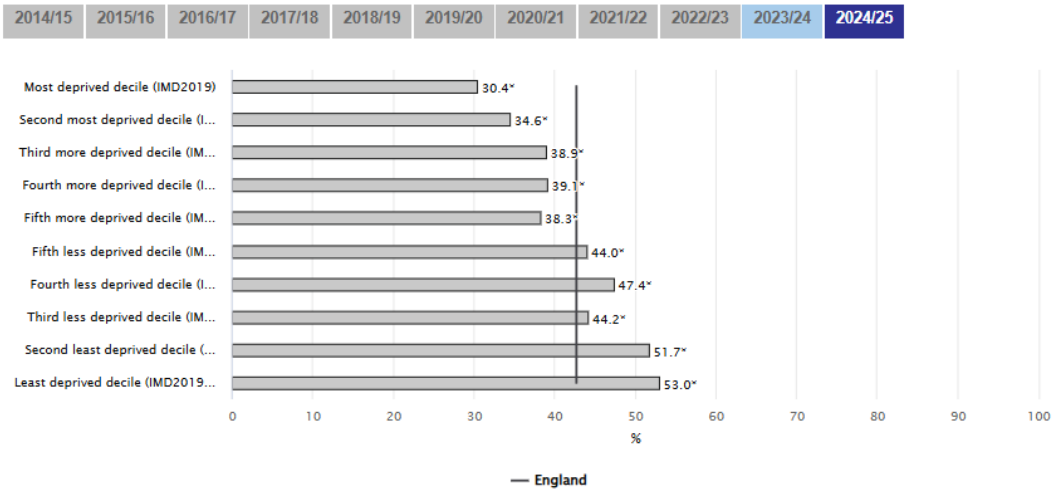
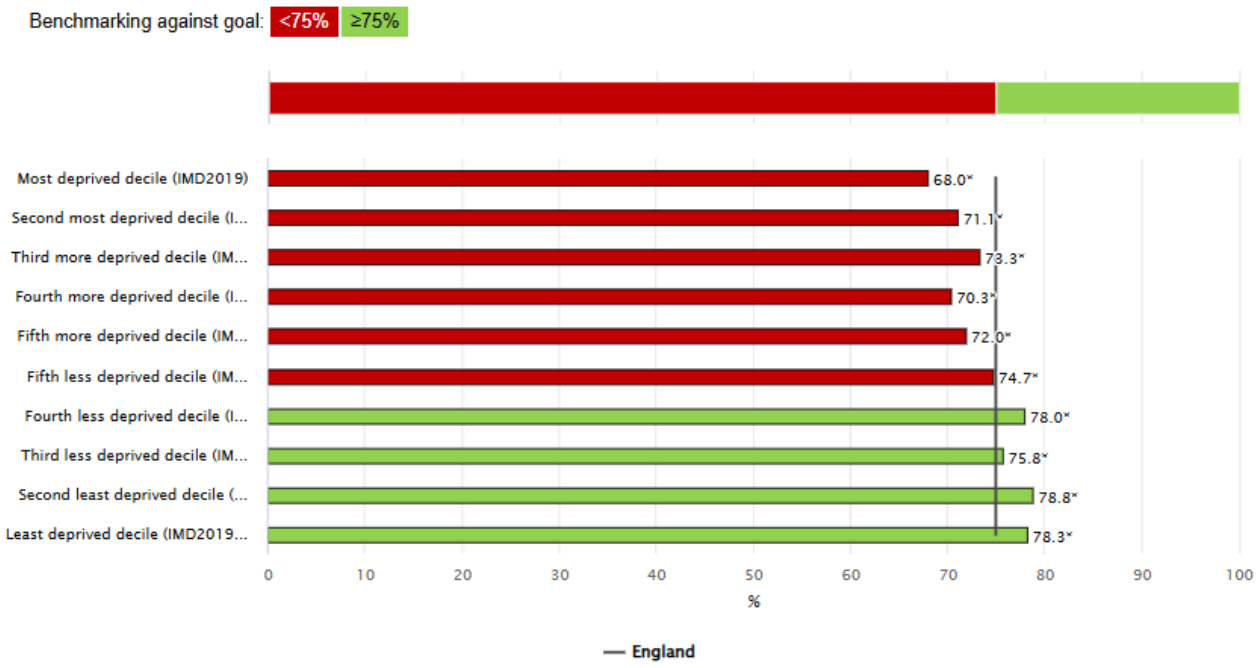


Figure 1: Deprivation across Leicestershire



	Count	Value	95% Lower CI	95% Upper CI
England	525,707	42.6*	42.6	42.7
Most deprived decile (IMD2019)	41,852	30.4*	30.1	30.6
Second most deprived decile (IMD2019)	29,339	34.6*	34.2	34.9
Third more deprived decile (IMD2019)	41,593	38.9*	38.6	39.2
Fourth more deprived decile (IMD2019)	42,630	39.1*	38.8	39.4
Fifth more deprived decile (IMD2019)	44,885	38.3*	38.0	38.5
Fifth less deprived decile (IMD2019)	44,188	44.0*	43.7	44.3
Fourth less deprived decile (IMD2019)	76,365	47.4*	47.1	47.6
Third less deprived decile (IMD2019)	66,307	44.2*	44.0	44.5
Second least deprived decile (IMD2019)	88,966	51.7*	51.5	52.0
Least deprived decile (IMD2019)	49,582	53.0*	52.7	53.3

Figure 2- Inequalities in population (England) vaccination coverage: flu (2 to 3 years old)



	Count	Value	95% Lower CI	95% Upper CI
England	8,494,489	74.9*	74.9	74.9
Most deprived decile (IMD2019)	591,429	68.0*	67.9	68.1
Second most deprived decile (IMD2019)	462,678	71.1*	70.9	71.2
Third more deprived decile (IMD2019)	611,730	73.3*	73.2	73.4
Fourth more deprived decile (IMD2019)	563,313	70.3*	70.2	70.4
Fifth more deprived decile (IMD2019)	752,008	72.0*	71.9	72.1
Fifth less deprived decile (IMD2019)	830,446	74.7*	74.6	74.8
Fourth less deprived decile (IMD2019)	1,368,468	78.0*	77.9	78.1
Third less deprived decile (IMD2019)	1,172,124	75.8*	75.7	75.9
Second least deprived decile (IMD2019)	1,459,124	78.8*	78.7	78.8
Least deprived decile (IMD2019)	683,169	78.3*	78.2	78.4

Figure 3- Inequalities in population (England) vaccination coverage: Flu (Aged 65 and over)

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APPENDIX B

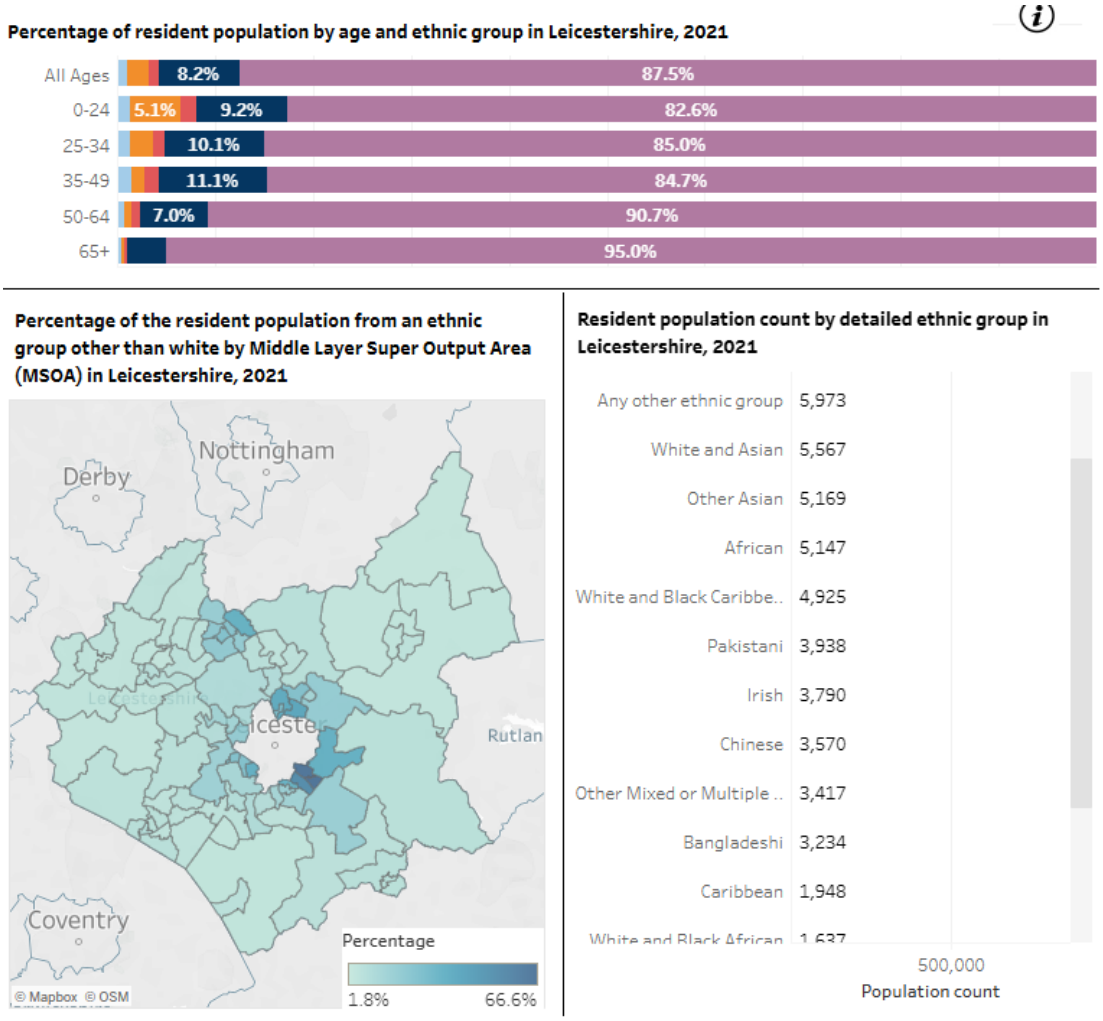

Figure 1- Ethnicity variation across Leicestershire

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APPENDIX C

NHS Immunisation Schedule and Guidance

Vaccines for babies under 1 year	
Age	**Vaccines**
8 weeks	6-in-1 vaccine (1st dose) Rotavirus vaccine (1st dose) MenB vaccine (1st dose)
12 weeks	6-in-1 vaccine (2nd dose) MenB vaccine (2nd dose) Rotavirus vaccine (2nd dose)
16 weeks	6-in-1 vaccine (3rd dose) Pneumococcal vaccine (1st dose)
Vaccines for children aged 1 to 15 years	
Age	**Vaccines**
1 year	MMRV vaccine (1st dose for children born on or after 01/01/2025) Pneumococcal vaccine (2nd dose) MenB vaccine (3rd dose)
1 year & 6 months (18 months)	6-in-1 vaccine (4th dose for children born on or after 01/07/2024) MMRV vaccine (1st or 2nd dose for children born on or after 01/07/2024)
2 to 15 years	Children's flu vaccine (every year until children finish Year 11 of secondary school)
3 years & 4 months	4-in-1 pre-school booster vaccine MMRV vaccine (1st or 2nd dose for children born between 01/09/2022 & 31/12/2024)
12 to 13 years	HPV vaccine
14 years	Td/IPV vaccine (3-in-1 teenage booster) MenACWY vaccine
Vaccines for adults	
Age	**Vaccines**
65 years	Flu vaccine (given every year after turning 65) Pneumococcal vaccine Shingles vaccine (if you turned 65 on or after 02/09/2023)
70 to 79 years	Shingles vaccine
75 years & over	RSV vaccine COVID-19 vaccine (usually given in spring & winter)
Vaccines for pregnant women	
When it is offered	**Vaccines**
During flu season	Flu vaccine in pregnancy
Around 20 weeks pregnant	Whooping cough (pertussis) vaccine
From 28 weeks pregnant	RSV vaccine

(Source: NHS vaccinations and when to have them - NHS)

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APPENDIX D

UK Health Security Agency Vaccination Guidance

Vaccine programmes

Information for immunisation practitioners and other health professionals

- Annual flu vaccination programme
- Bacillus Calmette–Guérin (BCG) vaccination programme
- COVID-19 vaccination programme
- Diphtheria vaccination and treatment resources
- Hepatitis A infection: prevention and control guidance
- Hepatitis B routine and selective vaccination programmes
- Human papillomavirus (HPV) universal vaccination programme
- Human papillomavirus (HPV) vaccination for men who have sex with men (MSM) programme
- Measles, mumps, rubella and varicella (MMRV) vaccination programme
- MMR catch-up programme 2013, measles, mumps and rubella vaccination
- Meningococcal ACWY (MenACWY) vaccination programme
- Meningococcal B (MenB) vaccination programme
- Meningococcal B (MenB) vaccination programme against gonorrhoea
- Meningococcal C (MenC) vaccination programme
- Mpox (monkeypox) vaccination programme
- Pneumococcal vaccination programmes for infants and adults
- Polio vaccination campaign
- Respiratory syncytial virus (RSV) vaccination programme
- Rotavirus vaccination programme
- Shingles vaccination programme

(Source: Immunisation - GOV.UK)

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