

**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<sup>1</sup> 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

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<sup>1</sup> [https://assets.publishing.service.gov.uk/media/60183a8de90e07128e743b85/immnstn-equity\\_AUDIT\\_v11.pdf](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).

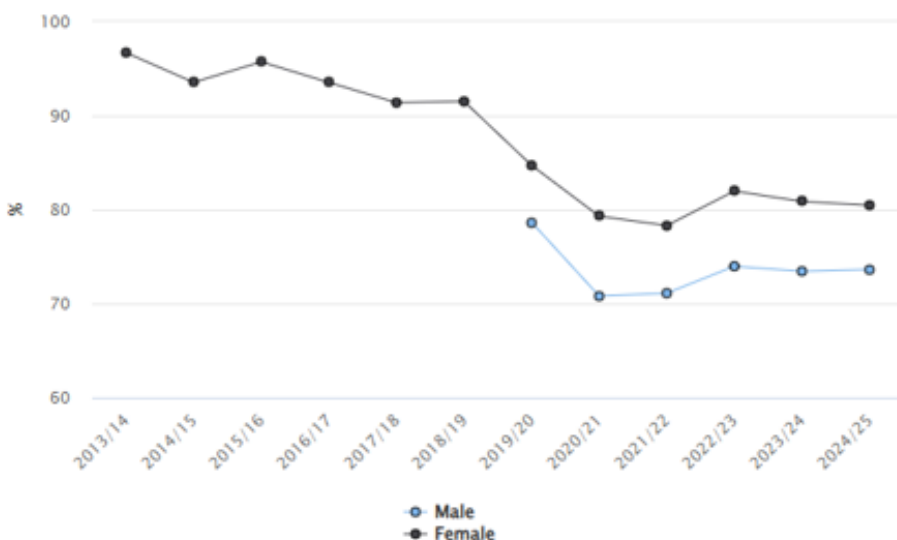
### Ethnicity

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.

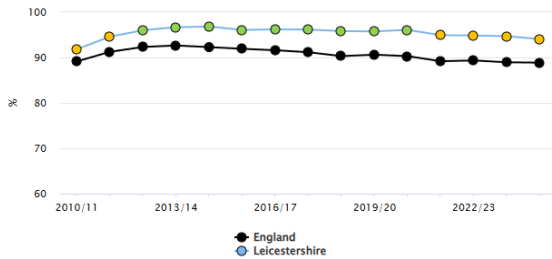
- 43. Nationally, measles activity has risen sharply in recent years. UKHSA reported 2,911 laboratory-confirmed measles cases in England in 2024 and 959 cases in 2025. The UKHSA measles dashboard reports 542 laboratory-confirmed cases in England between 1 January and 11 May 2026, with the majority reported 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	Count	Value	Leicestershire		England
			95% Lower CI	95% Upper CI	
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

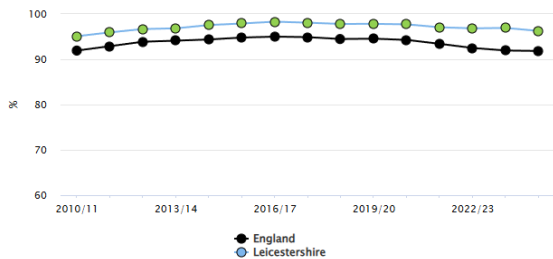
[Indicator Definitions and Supporting Information](#)

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	Count	Value	Leicestershire		England
			95% Lower CI	95% Upper CI	
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%	94.4%
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

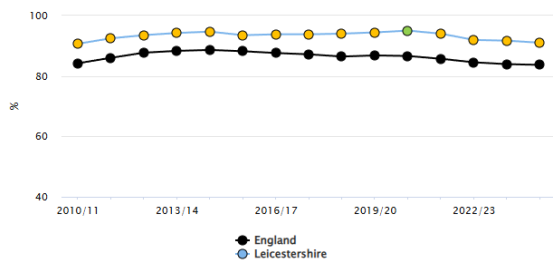
[Indicator Definitions and Supporting Information](#)

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	Count	Value	Leicestershire		England
			95% Lower CI	95% Upper CI	
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

- 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).

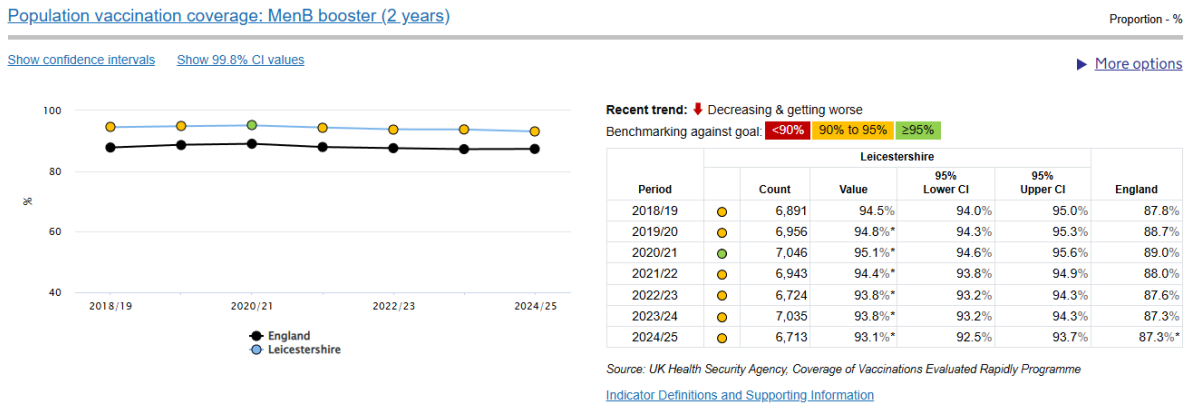


Figure 3 – MenB booster uptake (Leicestershire)

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.

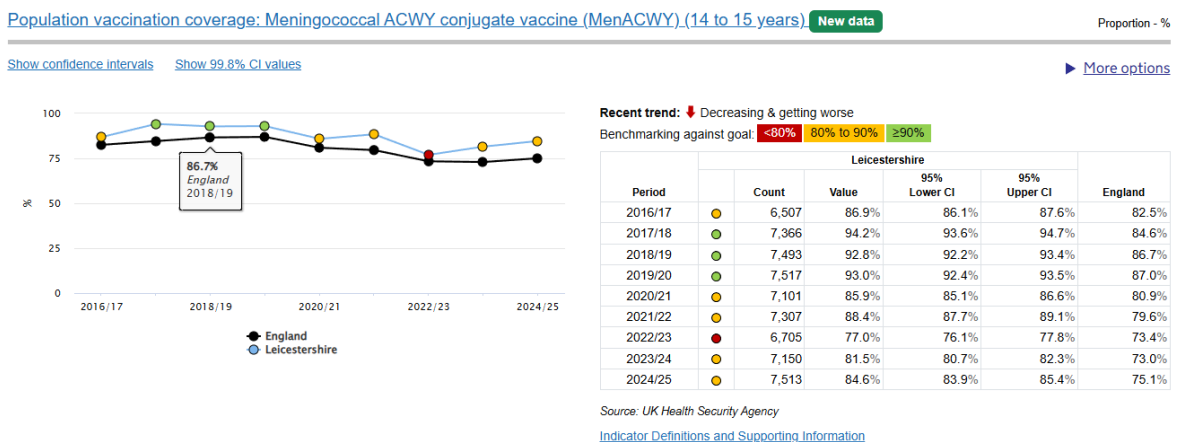


Figure 4- MenACWY Uptake (Leicestershire)

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

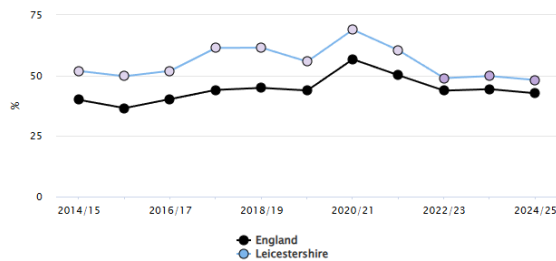
focus on access, engagement and tailored delivery approaches to improve vaccination uptake.

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

Proportion - %

Show confidence intervals Show 99.8% CI values

More options



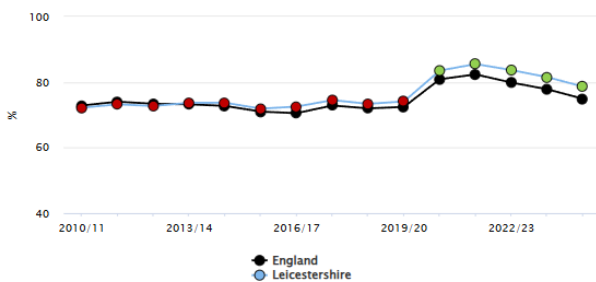
Recent trend: Decreasing & getting worse

Period	Count	Value	Leicestershire		England
			95% Lower CI	95% Upper CI	
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	Count	Value	Leicestershire		England
			95% Lower CI	95% Upper CI	
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)

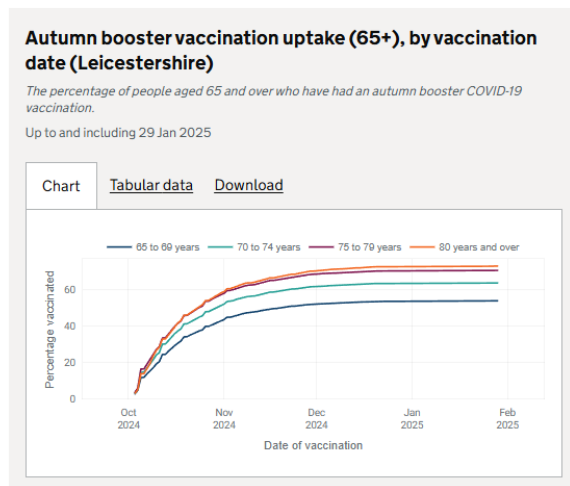
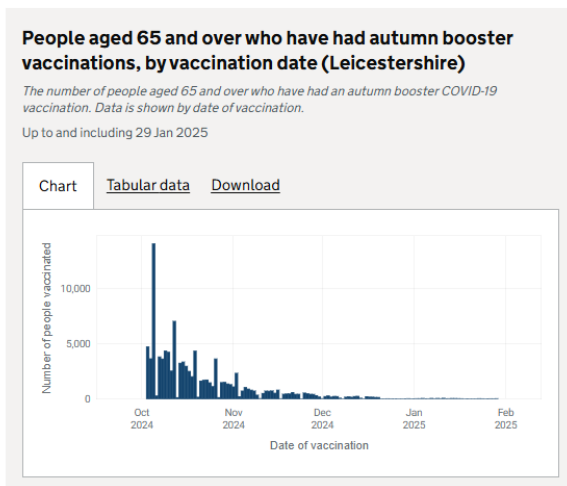
COVID-19

- 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 >



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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