Leicester
City Council

Minutes of the Meeting of the
PUBLIC HEALTH AND HEALTH INTEGRATION SCRUTINY COMMISSION

Held: TUESDAY, 28 APRIL 2026 at 5:30 pm

P R E S E N T :

Councillor Pickering (Chair)
Councillor Agath (Vice-Chair)

Councillor Clarke
Councillor Haq
Councillor March
Councillor Sahu

Councillor Singh Patel

In Attendance:
Councillor Dempster, Assistant City Mayor - Health, Culture, Libraries and Community Centres

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26. WELCOME AND APOLOGIES FOR ABSENCE

The Chair led on introductions and welcomed everyone to the meeting.

Apologies were received from Cllr Singh Johal and Cllr Westley. Cllr Singh Patel was present as substitute.

27. DECLARATIONS OF INTERESTS

There were no declarations of interest.

28. MINUTES OF THE PREVIOUS MEETING

AGREED:

The minutes of the previous meeting held on 24th March 2026 were confirmed as a correct record.

29. CHAIRS ANNOUNCEMENTS

The Chair announced that the Care Quality Commission (CQC) had published a report on Leicestershire Partnership NHS Trust's mental health crisis services and health-based places of safety, rating them as 'Good' following an inspection in May 2025.

30. QUESTIONS, REPRESENTATIONS AND STATEMENTS OF CASE

It was confirmed than none had been received.

31. PETITIONS

It was confirmed than none had been received.

32. HEALTH PROTECTION

The Director of Public Health provided the Commission with a verbal update. Slides were presented as attached. Additional points to note were as follows:

- Public Investment Funds funded voluntary schemes for screening and vaccination. This could be brought back to scrutiny.
- There had been no meningitis outbreaks seen in Leicester since the last update.
- Healthy Life Expectancy (the number of years an individual can expect to live in good health) was declining. It was unusual to see such a decline.
- Flu was at low levels, but vaccination rates in Leicester were lower than the national rate. It was hoped that improvement may be seen once more up-to-date statistics were released. It was a similar pattern for Covid.
- There had been no change on TB since the last update.
- There had been no new cases of Measles, but more vaccinations were needed to reach the herd-immunity rate of 95% uptake. The uptake was higher in the early years and then dropped off after five years old, this was used as a rationale to administer the second dose after 18 months.
- Statistics were presented on Childhood Immunisation in the period 2022-24 as outlined on the slide. It was noted that whilst this was lower than hoped, each level had increased slightly.
- There was an evidence base for the HPV vaccine in reducing cervical cancer and it was hoped that with a higher vaccination rate the beginning of the elimination of cervical cancer could start to be seen.

In response to member questions and discussions, the following was noted:

- With regard to healthy life expectancy, poor health was defined as people declaring that they had chronic conditions or illness that affected quality of life. As to whether or not this was a measure of good preventative healthcare, it was noted that awareness could make a difference, but more of a factor was whether or not people had a chronic condition or illness.

There had been significant disinvestment in public health and Local Authority Services from 2013, so this would affect people in poverty and deprivation more than others

AGREED:

1. That the update be noted.
2. That comments made by members of this commission to be taken into account.

33. RHEUMATOLOGY

The University Hospitals Leicester (UHL) Provided a verbal presentation into Rheumatology Services across Leicester. The following was noted:

- An apology was provided on behalf of UHL for the late submission of the report, with paper copies circulated at the meeting. It was noted that this was not common practice and that learning had been taken from the issue.
- The service overview highlighted that Rheumatology covered more complex conditions such as rheumatoid arthritis and lupus, requiring ongoing care rather than discharge.
- Services were delivered across Leicester Royal Infirmary and Leicester General Hospital, with 12 consultants and specialist nurses supporting adult and paediatric clinics, treatment and follow up care. This included DMARDs, biologics, physiotherapy, pain management, an advice line and joint procedures.
- Activity levels had increased significantly, with 2,670 referrals in 2025 to 2026, representing a 34% rise. This was linked to chronic conditions and an ageing population.
- Around 17,000 follow up appointments had been delivered. The DNA rate was 3.2%, which was in line with the national average.
- Performance against the 18 week referral to treatment standard remained challenged due to increased demand, with 42% of patients treated within 18 weeks.
- It was noted that longer waits were influenced by the prioritisation of urgent cohorts, particularly within early inflammatory arthritis pathways.
- The early inflammatory arthritis clinic was highlighted as a key area of strong performance, with earlier treatment leading to improved patient outcomes and remission rates. Performance had improved from around 50% to 56% 3 years ago to 96% of patients now treated within 6 weeks with a DMARD, making the service one of the best performing nationally.
- The British Society for Rheumatology was undertaking a case study on the service due to its high performance, which exceeded other trusts both regionally and nationally.
- It was noted that the service had previously been a poor performer but had significantly improved by 2025 to 2026.
- Work was taking place to support referral to treatment recovery included

moving towards a single point of access model to provide early guidance and reduce demand on the service.
- Increased use of patient initiated follow up had been introduced, enabling patients to re access the service when required.
- A need to expand the clinical workforce was identified, with a business case being developed to secure additional funding.

In discussion with Members the following was noted:

- Concern was raised regarding risks to patients alongside a 20% year on year increase in referrals, with continued growth expected. It was queried whether moving towards advice and guidance models could create additional risks by delaying early intervention, and what the current position and capacity was for 2026 to 2027. It was explained that demand had increased significantly, with a historic backlog and capacity pressures, although earlier diagnosis had improved from around 10 years to 2 years for some conditions, particularly inflammatory arthritis.
- Referral to treatment performance had remained largely static over the past 2 years, with ongoing challenges in managing both new and long term patients. It was explained that many conditions required lifelong management, limiting discharge rates and placing sustained pressure on the service.
- With 12 consultants and around 53% unmet demand, equating to over 3,500 patients, concern was raised that current workforce plans did not match the scale of need. Additional consultants were required, with at least 2 to 3 posts identified to improve capacity.
- Increased referrals since COVID 19 reflected a national trend, particularly for rheumatoid arthritis, and that patients were rarely discharged due to the chronic nature of conditions. It was queried whether some patients could be safely managed differently, including earlier stage management outside of acute settings. It was confirmed that a longer term workforce and neighbourhood model approach was being developed to support this.
- Recruitment remained challenging due to consultant vacancies and retention pressures, although there were opportunities to recruit candidates with local ties. Specialist nurses were also highlighted as a key part of the workforce, supporting clinics and patient care.
- While improvements in early treatment were welcomed, concern remained about overall capacity given population need and a 27% increase in referrals. Delays in diagnosis were linked to referral quality and pathways, and while no specific figures were available, potential cases of harm had been identified and reviewed through governance processes.
- It was questioned why additional funding had not been secured. Previous business cases had been submitted, however financial constraints required prioritisation across services. International recruitment was being explored to support workforce expansion.
- A workforce plan was in development and could be brought back to the Commission, including a 2 year outlook. Same day emergency care and

on call rheumatology advice were in place to support urgent cases.

- Queries were raised about where business cases had been submitted and whether trainee retention was an issue. Recruitment had been impacted by a freeze, although strong training and specialist clinics supported retention.
- Shared care arrangements were not operating as effectively as intended, increasing pressure on hospital services. Closer joint working between UHL, the ICB and GPs was identified as key, including expanding specialist nurse roles within primary care.
- The rise in referrals reflected a combination of factors, including improved awareness, more treatment options and limited time within primary care consultations. A triage decline rate of around 15% was noted.
- Patient safety incidents were monitored through trust governance processes, including weekly reviews of cases involving moderate harm with senior clinical oversight.
- Concerns were raised about the quality and appropriateness of referrals, with some GPs lacking confidence in diagnosis. Diagnoses required clinical assessment, with detailed management plans provided following specialist review. Work was underway to improve referral quality through guidance, streamlined forms and exploration of AI tools.
- Some conditions, including fibromyalgia and ME, did not require rheumatology input and should be managed in primary care or pain services, supported by existing guidance.
- Early inflammatory arthritis clinics operated a 3 week wait, although not all referrals were appropriate, reinforcing the need for improved referral quality and education.
- The importance of delivering care closer to home was emphasised, including through shared care, neighbourhood working and stronger collaboration with GPs and the ICB. A dedicated forum with primary care partners was suggested.
- System wide resource constraints continued to impact delivery, particularly access to biologic treatments.
- Concern was raised about the wider impact of capacity pressures, with a recommendation that the ICB review business cases and funding approaches in light of patient care needs. This was seconded.

AGREED:

1. That Members note the verbal presentation.
2. That the item would be added to the work programme for an update in the new municipal year.

34. LLR CHILD DEATH OVERVIEW PANEL ANNUAL REPORT 2024/25

Due to the similarity in the items, the LLR Child Death Overview Panel Annual Report and the report on Reducing Infant Mortality were taken together.

The Director of Public Health, Leicester City Council and the LLR Designated Doctor for Child Deaths, Leicestershire Partnership Trust outlined the work of

the Child Death Overview Panel (CDOP) and presented the findings of the CDOP annual report to the Commission.

Slides were presented as attached with the agenda pack. Additional key points to note were as follows:

- This was a very challenging area, but the team supported families.
- A report had been produced to collate the narratives and to prevent future deaths.
- The data was based on child deaths notified to the service.
- A key issue was support for the family. The team acted as a key worker for families. Families were supported to participate in the review process and feedback.
- Once a child dies, there was a period of decision making. Following this there was an investigation and information gathering. This could take the form of anything form a criminal investigation to a post-mortem. Once this was concluded, staff were brought in for review and analysis was begun to look at what may have contributed to the death in order to capture learning. This was reviewed at a panel for final independent scrutiny.
- All data went into the national database.
- Infant mortality in Leicester was higher than in England and in the county of Leicestershire. Work was being undertaken to understand what was driving this.
- In terms of wider context, it was key to note that deprivation was strongly associated with child mortality. Babies in the most deprived fifth percentile of the population had twice the deathrate of the least deprived.
- The first dataset reviewed were the notifications as there was a statutory duty to notify of a death. There had been 92 notifications in total, a quarter of which required a joint-agency response.
- Over half of notifications were death after birth, but while the baby was still in hospital. Many of these were pre-viable gestation.
- 20% died at home. Some of these had died suddenly, but others had planned end-of-life care.
- Prolonged information gathering could cause reviews to take a long time to complete. The majority of cases were complete within 12-18 months.
- Nationally, most deaths were perinatal or neonatal, the second biggest category were chromosome or congenital anomalies and the third were malignancy or unexplained issues.
- Contributory factors were factors that could have contributed to the death, often in terms of family, social and environmental factors, and social services received. A modifiable factor was a factor that, if it had been different, might have led to a different outcome.
- Early warning scores could help to catch risks early but did not always work.
- When safety mechanisms needed to interact but worked in different systems, this could be a risk.
- Information gathering was carried out, and interpretations were made before a decision was made. Therefore, it was necessary to have access to people with the expertise to analyse and interpret.
- The quality of referrals could make a difference.

- A clear evidence base policy and guidance were need. Information sharing to identify the emergence of risks could be useful.
- A model put decision making into context of interpersonal interaction. The quality of interaction could affect what was done with decisions.
- Wider organisational and system processes were present. This risk assessment and interaction occurred in this context. It was necessary to have available and effective resources to tackle risks.
- It was noted where things had gone well. This was captured through a free-text box and put into a word-cloud as set out on the slide.
- In terms of thematic learning, every year, cases were looked at to consider themes and recommendations.
- Learning was done at a national level and a commissioner level and shared with LLR.

The Acting Consultant in Public Health submits a report to update the Commission on the Infant Mortality Rate in Leicester.

Slides were presented as attached with the agenda pack. Additional key points to note were as follows:

- Infant mortality referred to death in the first year of life. It was a complex issue and not all of the answers were available. However, a lot of good work was being undertaken.
- Leicester had the second-highest rate of infant mortality in England.
- Infant mortality rates were higher for BAME babies.
- Due to the high rate, it was necessary to understand what was happening in the city and to make changes.
- Key stakeholders were being worked with and asked why they thought the rate was so high, what could be done differently and what was going well. This feedback was analysed and taken to a conference with other stakeholders where themes were presented in a logic model to look at how to get to solutions. Comments were analysed to come up with an account plan and delivery. There was a system-wide steering group. Actions were complex and system wide.
- The action plan was in the first draft. Possible solutions included a multi-disciplinary approach, better equipping people to have a healthy pregnancy
- Care navigation included more support for fathers, streamlining the process, the delivery of the bumps-to-babies antenatal sessions, and advice on breast feeding.
- The charity Baby Basics were worked with to ensure that there was no waiting list for safe sleep spaces (moses baskets and cots) for babies.
- There was lots of work to be done, it was challenging, but the service were committed.

In response to member questions and comments, the following was noted:

- Support was expressed for taking the reports together. Concern was raised about the high proportion of deaths in the neonatal period and the

correlation with low birth weight and higher mortality rates among Black mothers and babies. It was queried what measures were currently in place, including whether care passports were effective in preventing information loss. It was outlined that many neonatal deaths related to extremely premature births, with very low survival rates at earlier gestations, and that robust pathways were in place to optimise care and outcomes. Care passports aimed to improve communication and reduce the need for families to repeat their experiences.

- It was highlighted that disparities in outcomes for Black mothers and babies persisted even when deprivation was accounted for. It was noted that while no single consistent theme had been identified, cases were reviewed individually, with learning logged and action taken where required.
- It was noted that wider work was being undertaken across the system to address inequalities linked to poverty, housing and ethnicity, including consideration of the experiences of looked after children and care experienced parents. It was outlined that data relating to care experience was collected and considered, although local numbers were small and national data sharing remained complex.
- The strong link between deprivation and infant mortality was emphasised, with significantly higher death rates in the most deprived areas. Concern was raised about the impact of wider societal factors, including housing conditions, reduced public health resources and increasing inequalities. It was suggested that both local and national action was required, including raising concerns with government and national bodies
- Many of the recommendations were longstanding, raising questions about whether key messages were effectively reaching communities. It was queried whether outcomes differed for new arrivals and what data was available to understand this. It was explained that data collection was being strengthened, and that safe sleeping remained a key area of focus. It was also noted that changing parenting contexts, including reduced family support and the impact of COVID 19, had influenced risk factors.
- It was acknowledged that consistent public health messaging remained important, with a need to consider how messages could be delivered differently to improve impact.
- Emerging trends were highlighted, including a small number of cases linked to IVF treatment abroad, where higher risk practices may be used. It was noted that increasing awareness of these risks would be important.
- Strong concern was expressed regarding Leicester having one of the highest infant mortality rates nationally. Pressures on maternity services, including estate capacity and increasing demand, were highlighted, alongside challenges in accessing local perinatal services. It was suggested that more targeted action was needed in areas of highest deprivation. It was queried how system partners, including the ICB, would support addressing these issues.
- System wide resource pressures were acknowledged, alongside the importance of early intervention and wider social determinants of health. It was noted that outcomes would likely be worse without existing services and education.
- It was queried whether there was national best practice that Leicester

could adopt, particularly in relation to housing, indoor air quality and smoke free environments. It was outlined that work was evidence based and tailored to Leicester's needs, with links to housing and enforcement of standards such as damp and mould. Opportunities to strengthen partnerships with housing providers were identified.

- The impact of smoking and indoor air quality was discussed, including the risks to infants returning to home environments following hospital care. It was noted that further work with landlords and tenants could support smoke free homes.
- The role of vaping was discussed, including its use as a smoking cessation tool and concerns regarding uptake among young people. It was emphasised that vaping should support quitting smoking rather than act as a gateway behaviour.
- Concerns were raised regarding access to and availability of products such as shisha and vaping products within communities.

AGREED:

1. That the report be noted and the recommendations to Scrutiny be supported.
2. That comments made by members of this commission to be taken into account.
3. That a further update be brought back to the Commission on progress, including delivery against the action plan and any measurable impact on outcomes.

35. REDUCING INFANT MORTALITY IN LEICESTER

Due to the similarity of the items, the LLR Child Death Overview Panel Annual Report and the report on Reducing Infant Mortality were taken together. The discussion and minutes are recorded under the previous agenda item.

36. WORK PROGRAMME

The Chair reminded Members that any suggested items for inclusion in the work programme should be shared with the Chair and the Senior Governance Officer.

It was suggested that a item would be added to the work programme for GP Health Referrals for Children.

37. ANY OTHER URGENT BUSINESS

With there being no further business, the meeting closed at 8:11pm.

Health protection

An overview of health protection issues in Leicester including Flu, RSV and COVID-19

Minute Item 32

SOURCES:
UK Health Security Agency: Notifiable diseases
OHID Fingertips

Last updated 22/04/26
For presentation on: 28/04/2026

Prepared by:
Public Health Division, Leicester City Council

Leicester City Council

Health Protection Update Headlines

- **Changes to the childhood vaccination schedule from Jan 1st 2026:** Children born on or after 1 July 2024 will now receive an additional 4 in 1 vaccine at 18 months alongside their second MMR vaccination also at 18 months (previously at 3 years 4 months). This is expected to increase update of the 2nd MMR vaccination.
- **Flu and covid vaccination ongoing** but early indicators are that this season uptake has increased (official figures not yet available).
- **ICB moving to LNR** including with immunisation and screening programmes (due to be delegated from NHS England in April 2027).
- **Two public health investment funds (PHIF) ongoing**. Ten VCSE organisations are currently working to increase screening and vaccination with their own communities. All work is being evaluated with an overall evaluation framework and individual frameworks for each organisation.
- **A further small outbreak of meningitis** in Dorset was limited to three young people who are all recovering. Antibiotics and vaccination has been offered to a large group of young people in the affected area.
- **LLR plans for any potential outbreak** fully worked up.

Healthy life expectancy shows the years a person can expect to live in good health (rather than in poor health).

Similar to the national trend, healthy life expectancy in Leicester has fallen over the past 10 years.

Over this period, healthy life expectancy in Leicester peaked at around 60 years in 2014–16, but has since declined to 58 years in 2022–24.

The latest data shows that males in Leicester can expect to live 58 years in good health, followed by a further 19 years in poor health. This compares with the national average of 61 healthy years and 19 years in poor health.

Females in Leicester can expect to live 58 years in good health, followed by a further 23 years in poor health. By comparison, the national average is 63 healthy years and 20 years in poor health.

There are further inequalities between our most and least deprived residents.

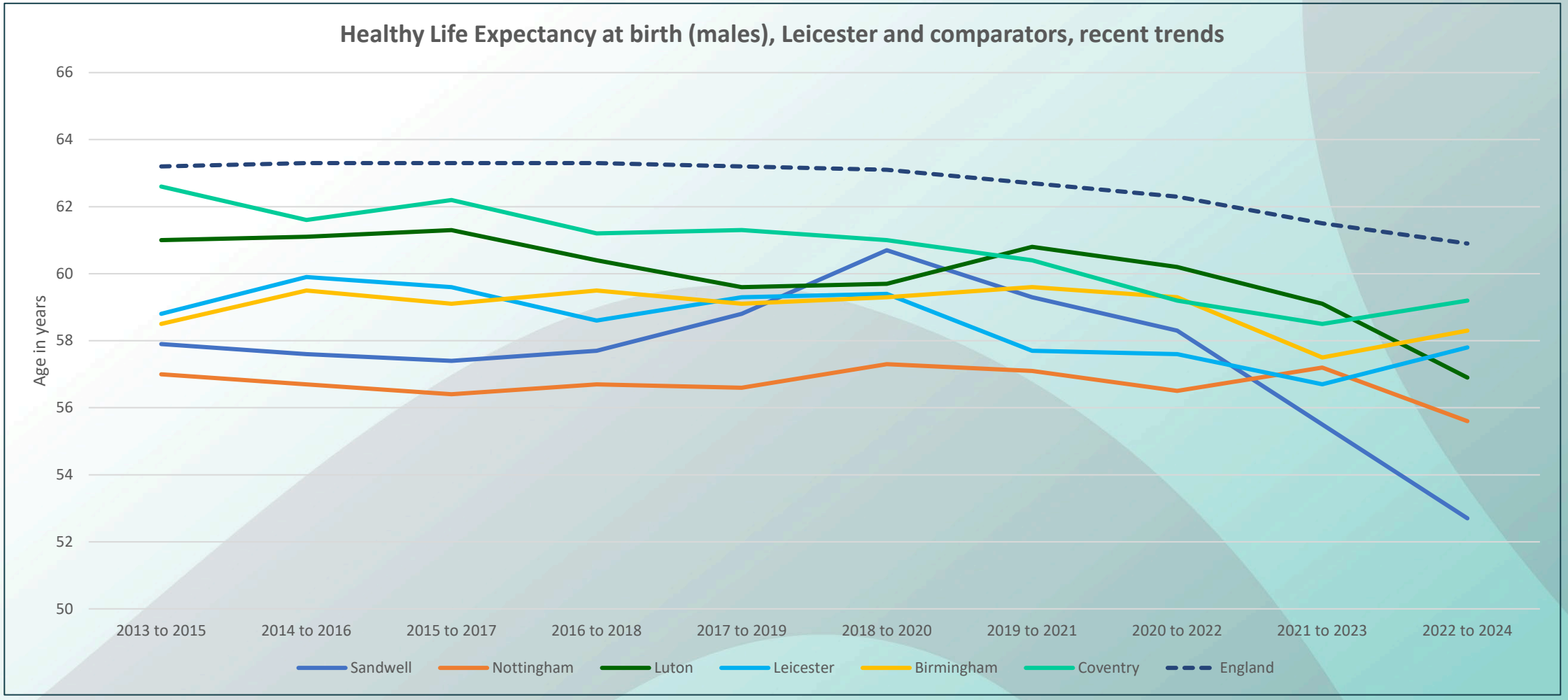
UK healthy life expectancy falls by two years in past decade

Hugh Pym, Health editor and **Nick Triggle**, Health correspondent

27 April 2026, 05:55 BST · 274 Comments

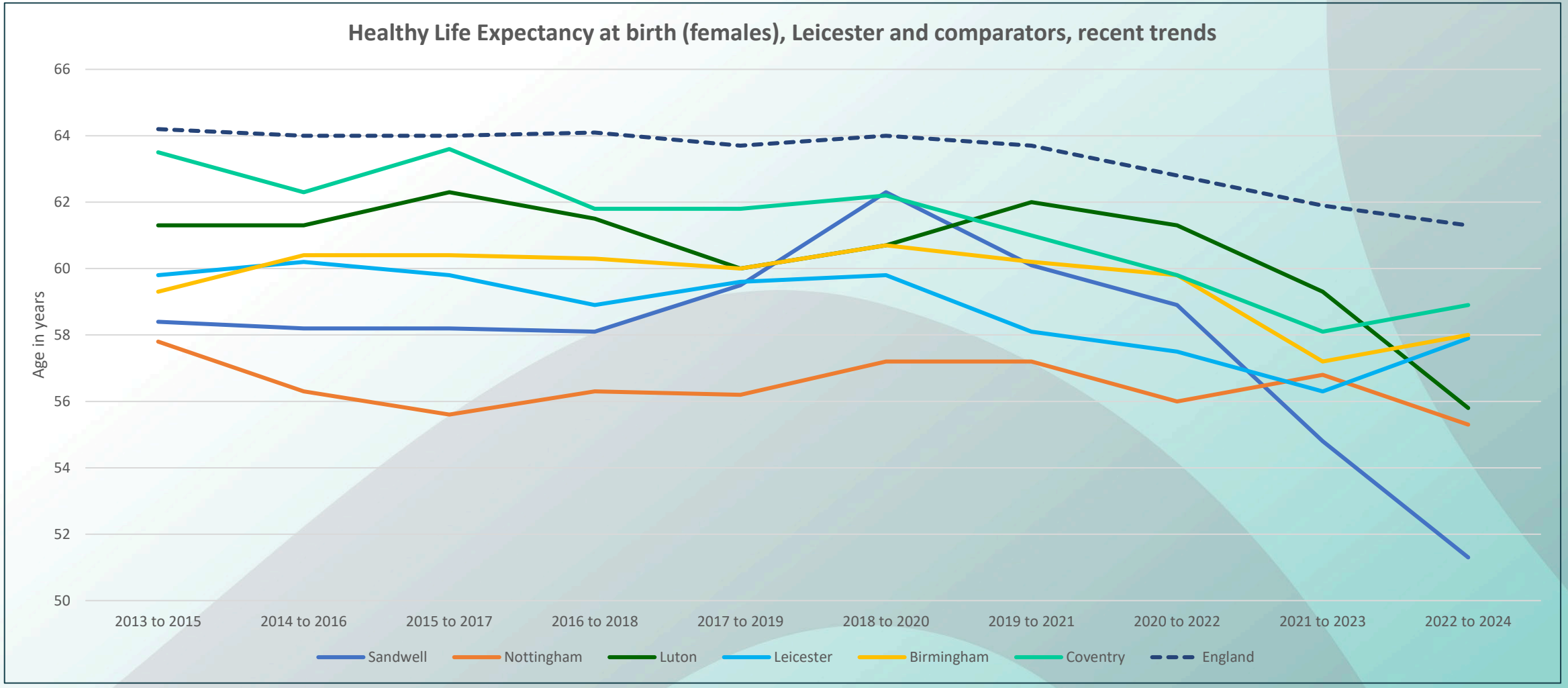
[UK healthy life expectancy falls by two years in past decade - BBC News]

Topic	Product	Source
6. Healthy Life Expectancy: 2022-24	The number of years males are expected to spend in “good” general health	Healthy life expectancy, UK: between 2011 to 2013 and 2022 to 2024 - Office for National Statistics



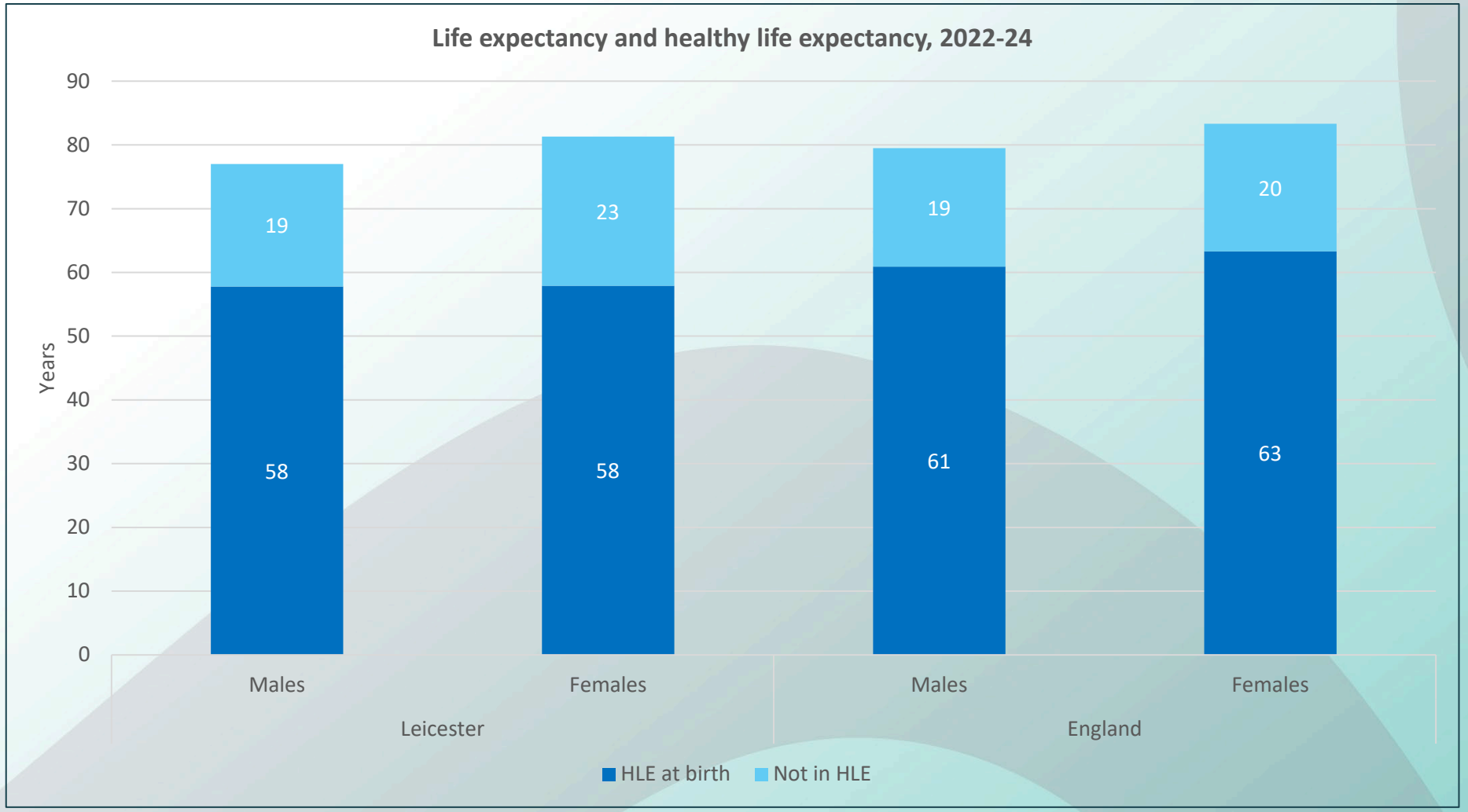
Data: ONS

Topic	Product	Source
6. Healthy Life Expectancy: 2022-24	The number of years females are expected to spend in “good” general health	Healthy life expectancy, UK: between 2011 to 2013 and 2022 to 2024 - Office for National Statistics



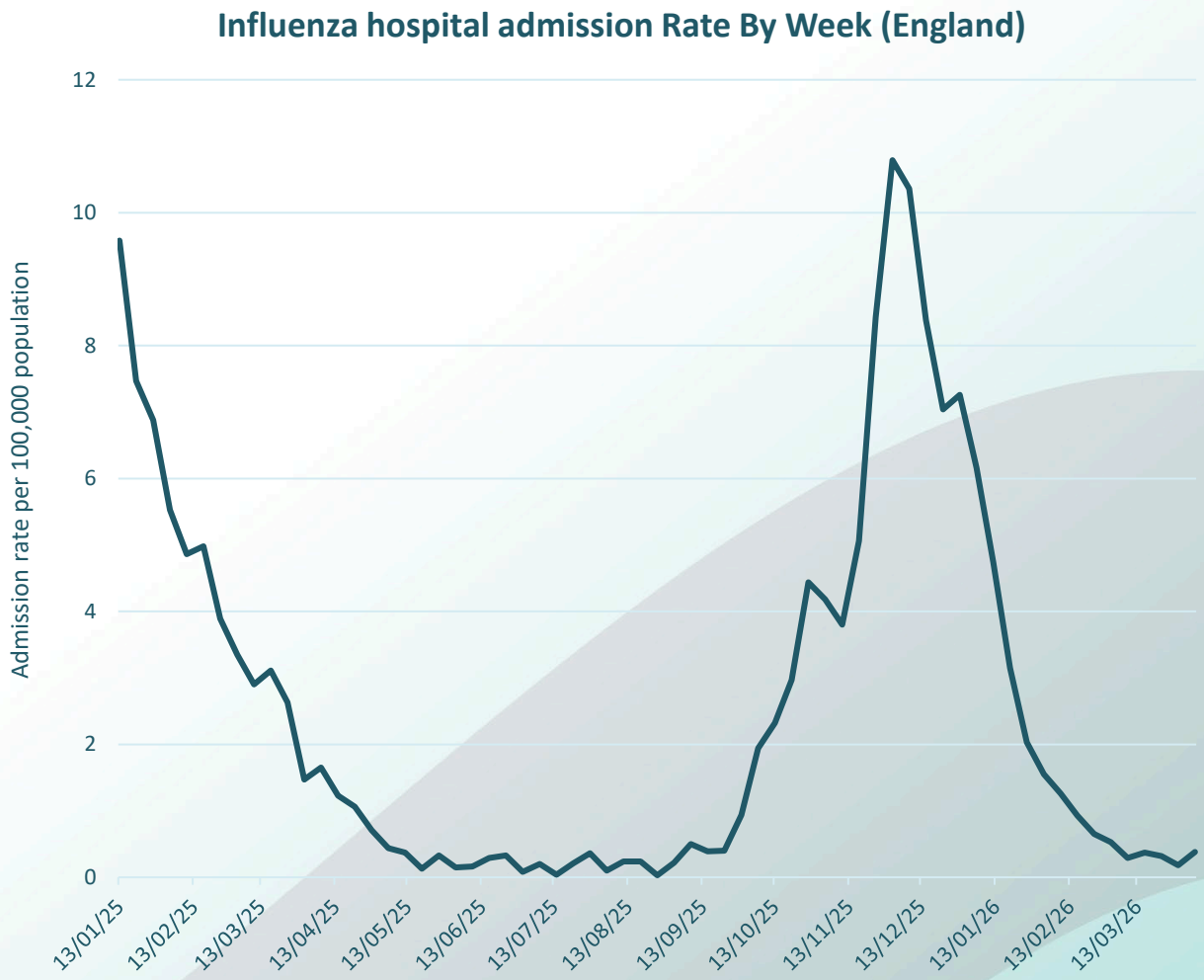
Data: ONS

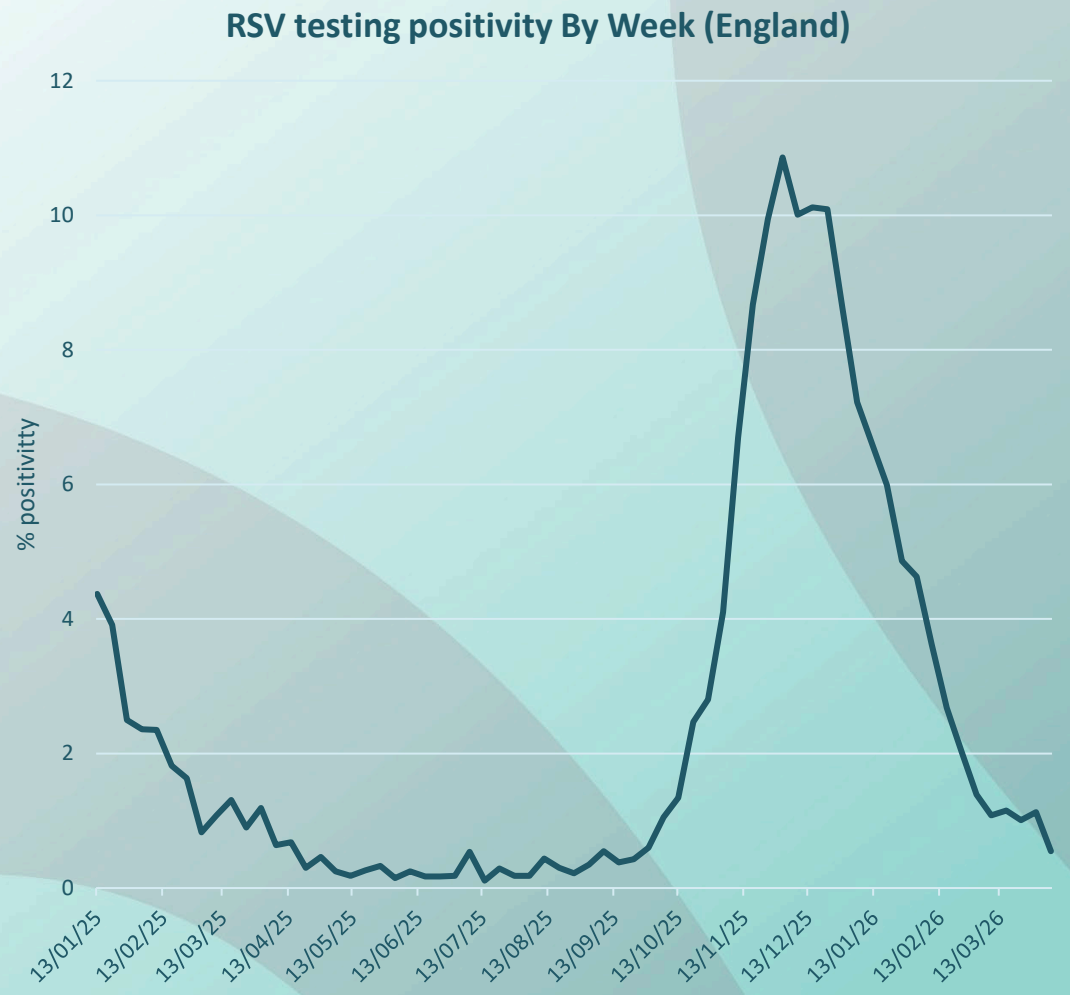
Topic	Product	Source
6. Life and Healthy Life Expectancy: 2022-24	The number of years people are expected to spend in “good” general health and ill health	Healthy life expectancy, UK: between 2011 to 2013 and 2022 to 2024 - Office for National Statistics



Data: ONS and OHID Fingertips

National flu and RSV surveilance: Influenza (commonly known as flu) is a respiratory infection and is currently stable and circulating at baseline levels. Respiratory syncytial virus (RSV) is one of the common viruses that cause coughs and colds in winter. RSV causes mild symptoms, but can be serious for some infants, older adults and people with chronic medical conditions. RSV has decreased and is circulating at baseline levels.





Weekly national flu reports - GOV.UK

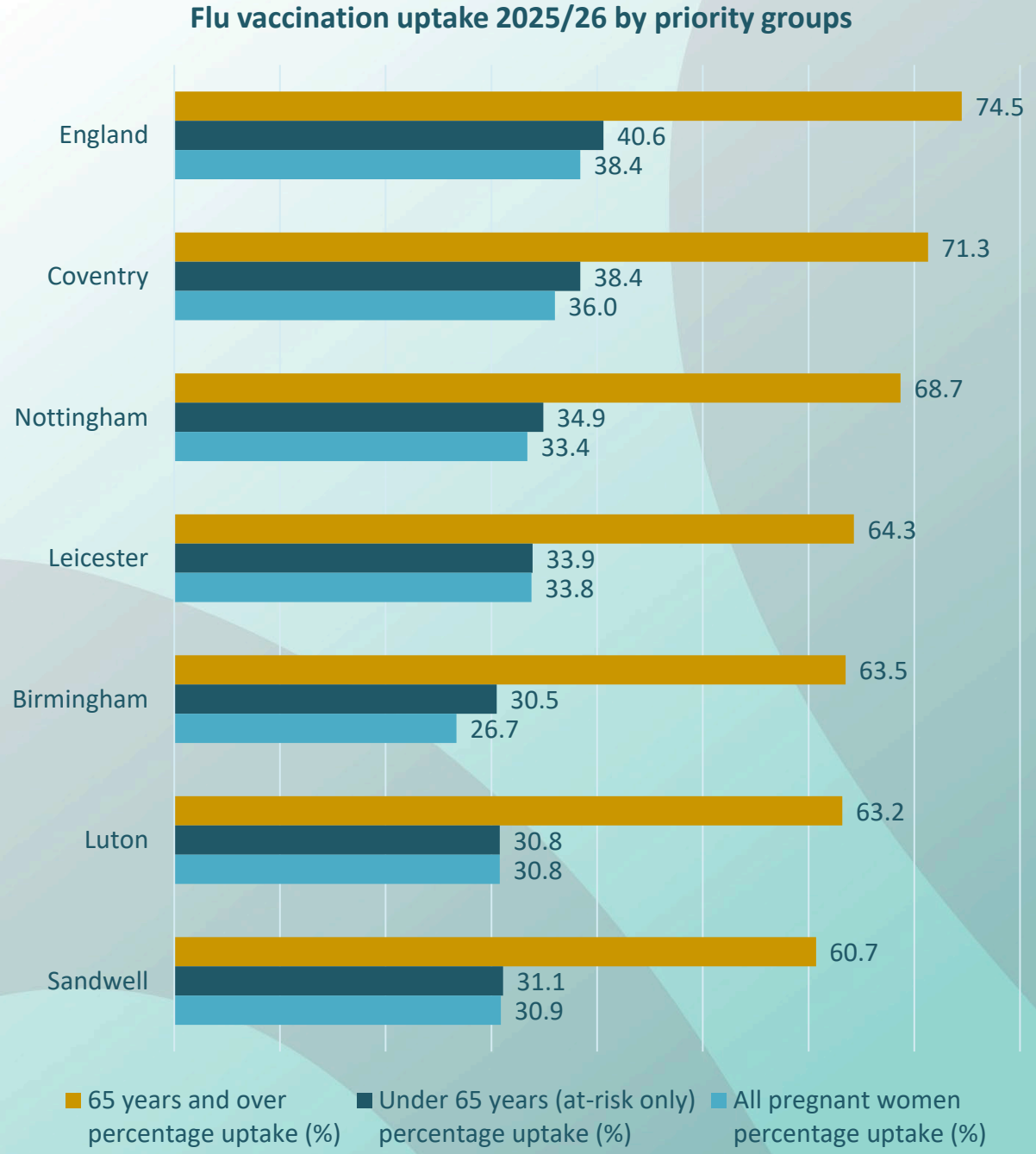
Flu vaccination uptake in priority groups

Influenza (also known as Flu) is a highly infections viral illness spread by droplet infection. The flu vaccination is offered to people who are at greater risk of developing serious complications if they catch flu.

65 year olds and over: 64% of Leicester 65+ year olds were vaccinated against flu. This is below the national average, but similar to our comparators. The goal of 75% has not been achieved in Leicester since 2021/22. In the 2024/25 campaign Leicester achieved 65%.

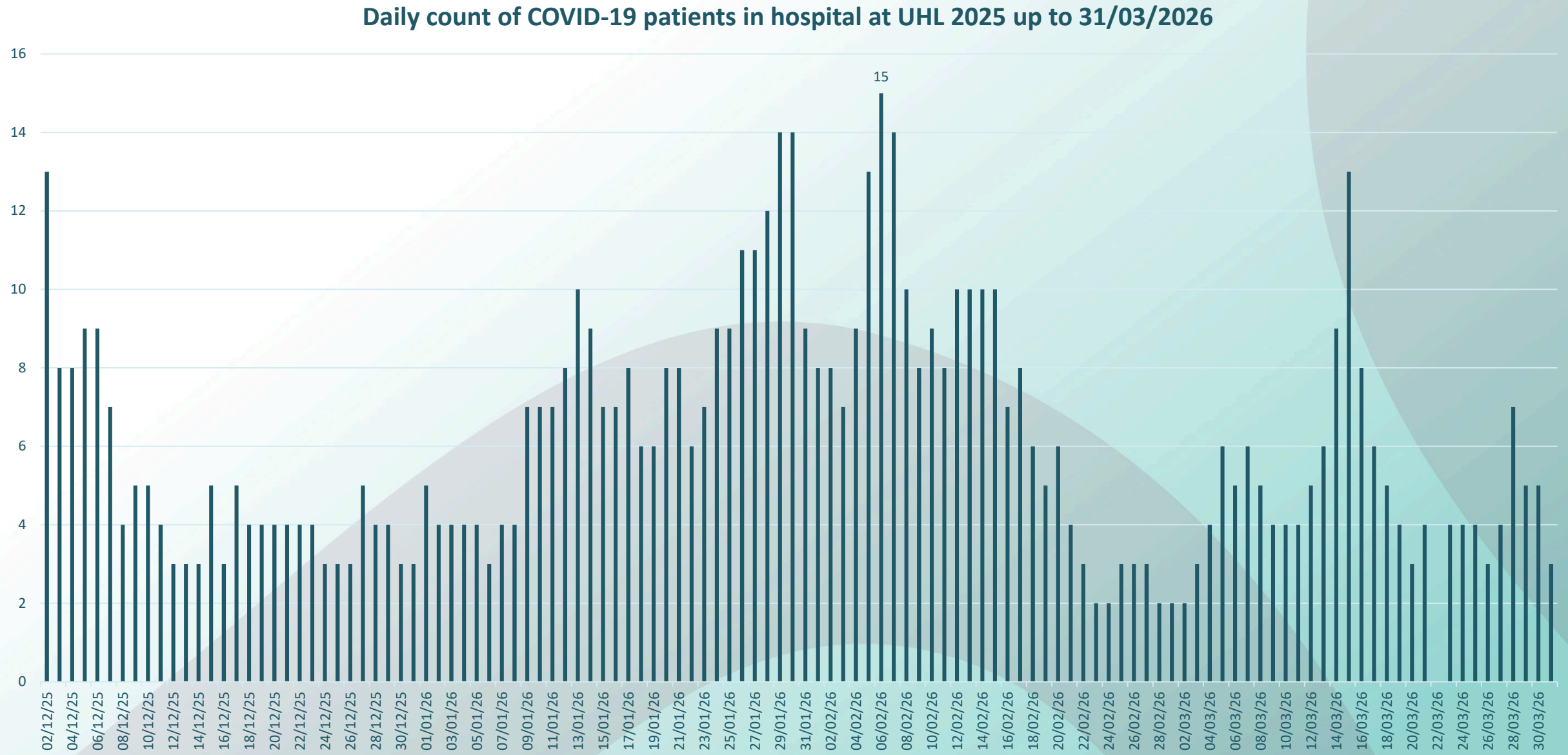
Under 65 (at risk population): About a third (33.9%) of the under 65 at risk population have had the vaccination compared to 40% for the national average. Last year we achieved 32.3%.

Pregnant women: Less than a third (33.8%) of the pregnant population have had the vaccination compared to 35% for the national average. Last year we achieved 30.3%.

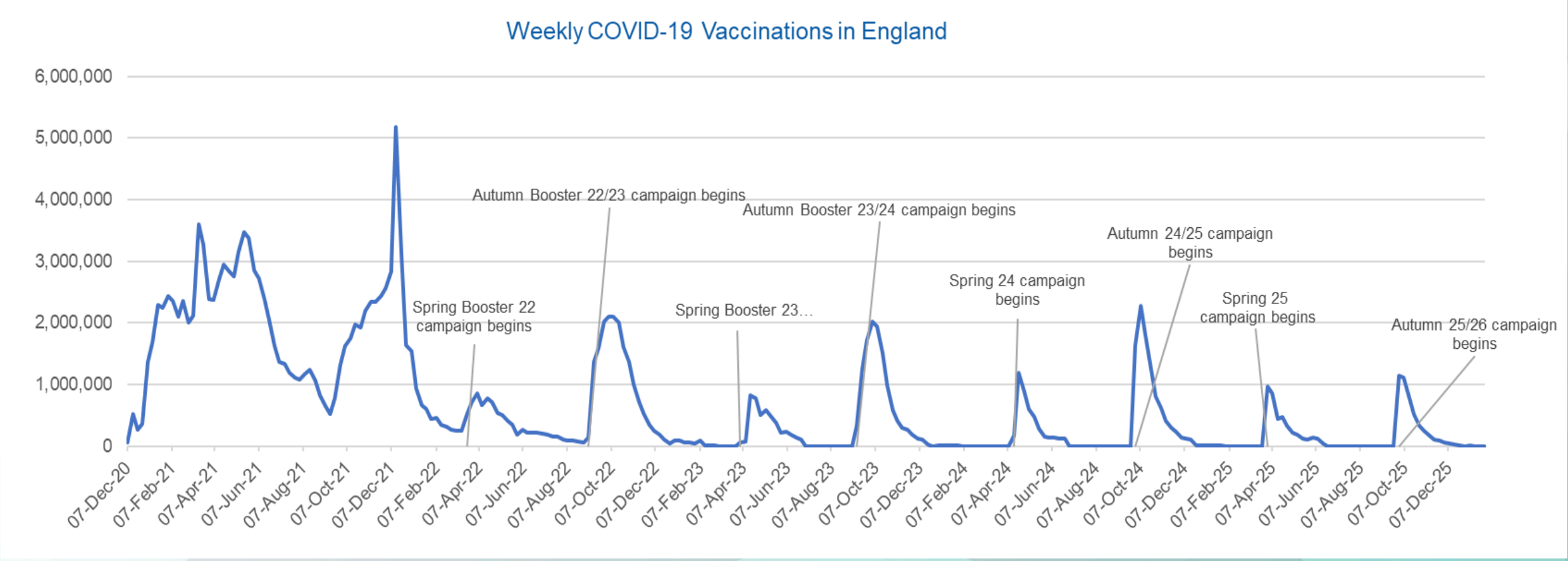


Source: *UKHSA national influenza vaccinations in GP patients in England 2025 to 2026*

COVID 19 in Leicester (UHL): COVID-19 activity remained stable and is circulating at baseline levels nationally. There are currently less than five COVID-19 patients at UHL. The peak in 2026 was 15 in February.



COVID 19 vaccination Autumn Winter Uptake: There continues to be autumn and spring booster campaigns but numbers continue to fall year on year. There has been a pattern of lower uptake in Leicester compared to the national and Leicestershire county for consecutive autumn and spring booster campaigns. Last



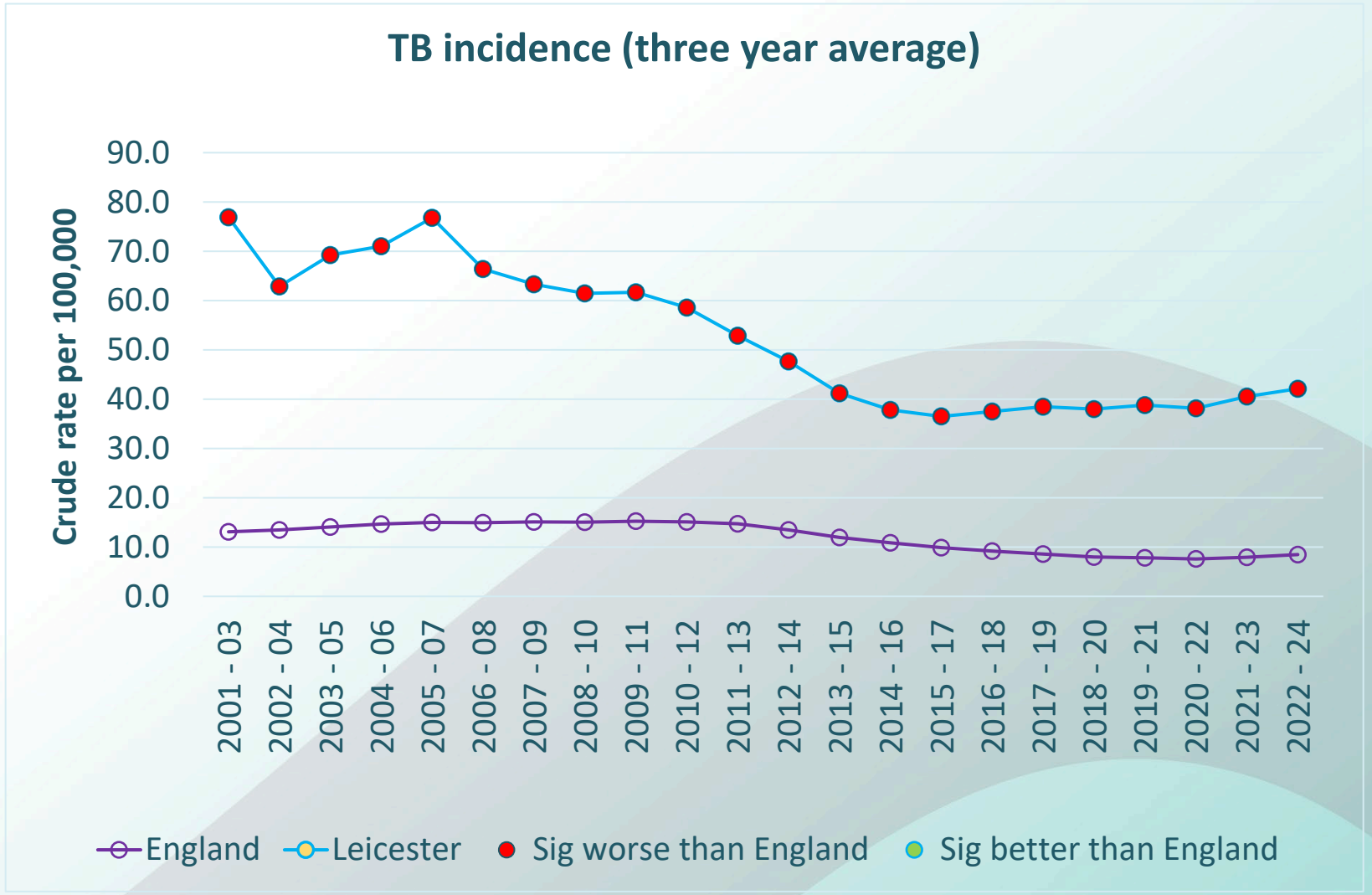
Tuberculosis in England 2024 report

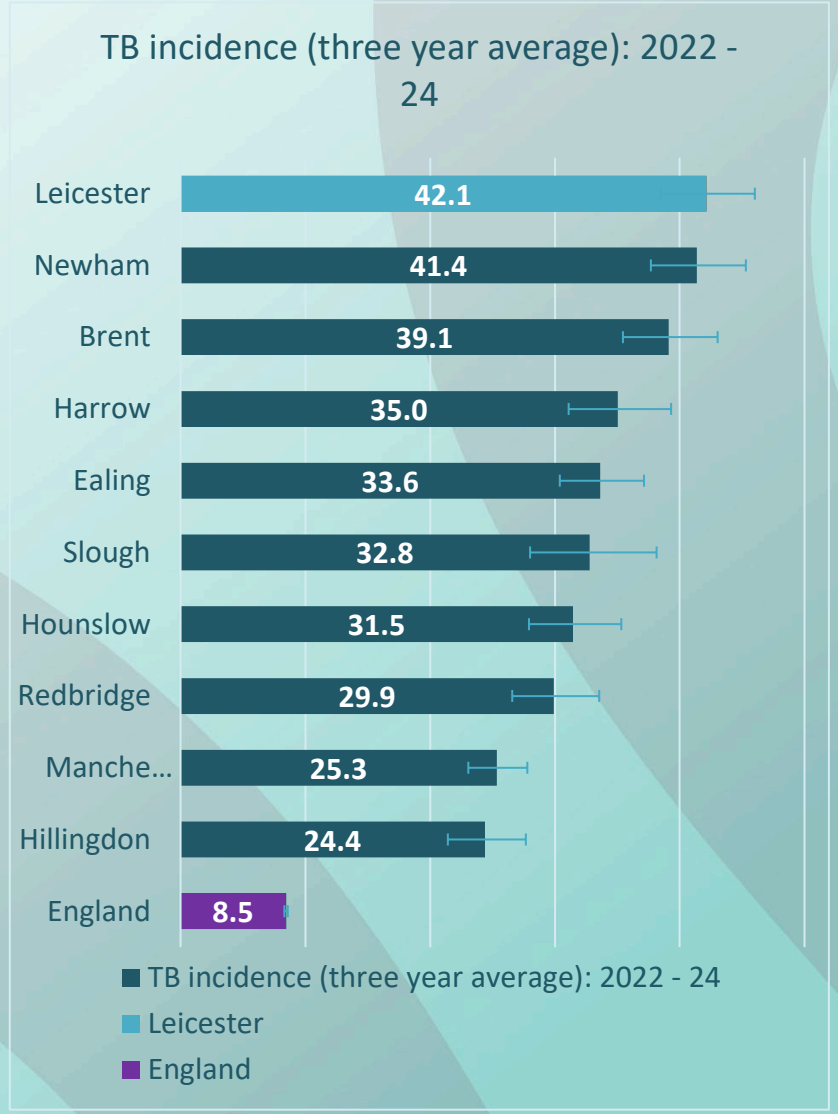
In the calendar year 2024 data shows that:

- In 2024, the steep upward trajectory of TB notifications seen in 2023 continued, with an increase of 13.6% - the largest annual increase since national surveillance began.).
- England remains just under the World Health Organization (WHO) threshold of 10 notifications per 100,000 (9.4) but at current rates of increase England will pass this threshold by the end of 2025.
- TB rates remain highest in urban areas. Rates continue to be highest in London and the Midlands and in those living in the most deprived areas of England.
- 81.9% of notifications were in people born outside the UK, similar to 2023 (80.0%).
- Rates increased in people born in the UK by 5.0% in 2024, only the second year-on-year increase since enhanced surveillance started in 2012.
- Tuberculosis continues to be strongly associated with inequalities. 1 in 7 TB notifications reported one or more social risk factors with the most common being homelessness, asylum seeker status and drug use.
- **In 2024, the same 2 local authority districts as in 2023 had a 3-year average notification rate above 40 per 100,000. These were Leicester City (East Midlands) at 42.1 per 100,000 and Newham (London) at 41.4 per 100,000.**

1. Tuberculosis incidence and epidemiology, England, 2024 - GOV.UK (published 2025)

Tuberculosis in Leicester and England: The three year average TB incidence rate shows Leicester has had a significantly higher rate compared to England for many years. The rate in the city has fallen but in recent years has seen a small increase to about 42 per 100,000 population (an average of 161 notifications a year). Leicester's TB incidence is significantly higher than our comparators, and latest data shows we are currently highest in country with London boroughs Newham, Brent, Harrow, and Ealing also in the top five.





Source: OHID Fingertips

Measles in England: In 2025 there were 959 laboratory-confirmed measles cases reported in England, this was considerably lower than the high of nearly 3,000 in 2024. Promotional material has been circulated to all schools and nurseries in the city reminding parents of where and how they can get their children vaccinated and why this is important.

In 2025 the majority (68%) of these cases were in children aged 10 years and under, and 25% were in young people and adults aged 15 years and over.

51% of these cases were in London, 14% in the North West, and 8% each in the East of England and the West Midlands.

Leicester did not feature amongst the list of authorities with the most cases in 2025.

Since 1 January 2026, there have been 407 laboratory confirmed measles cases reported in England.

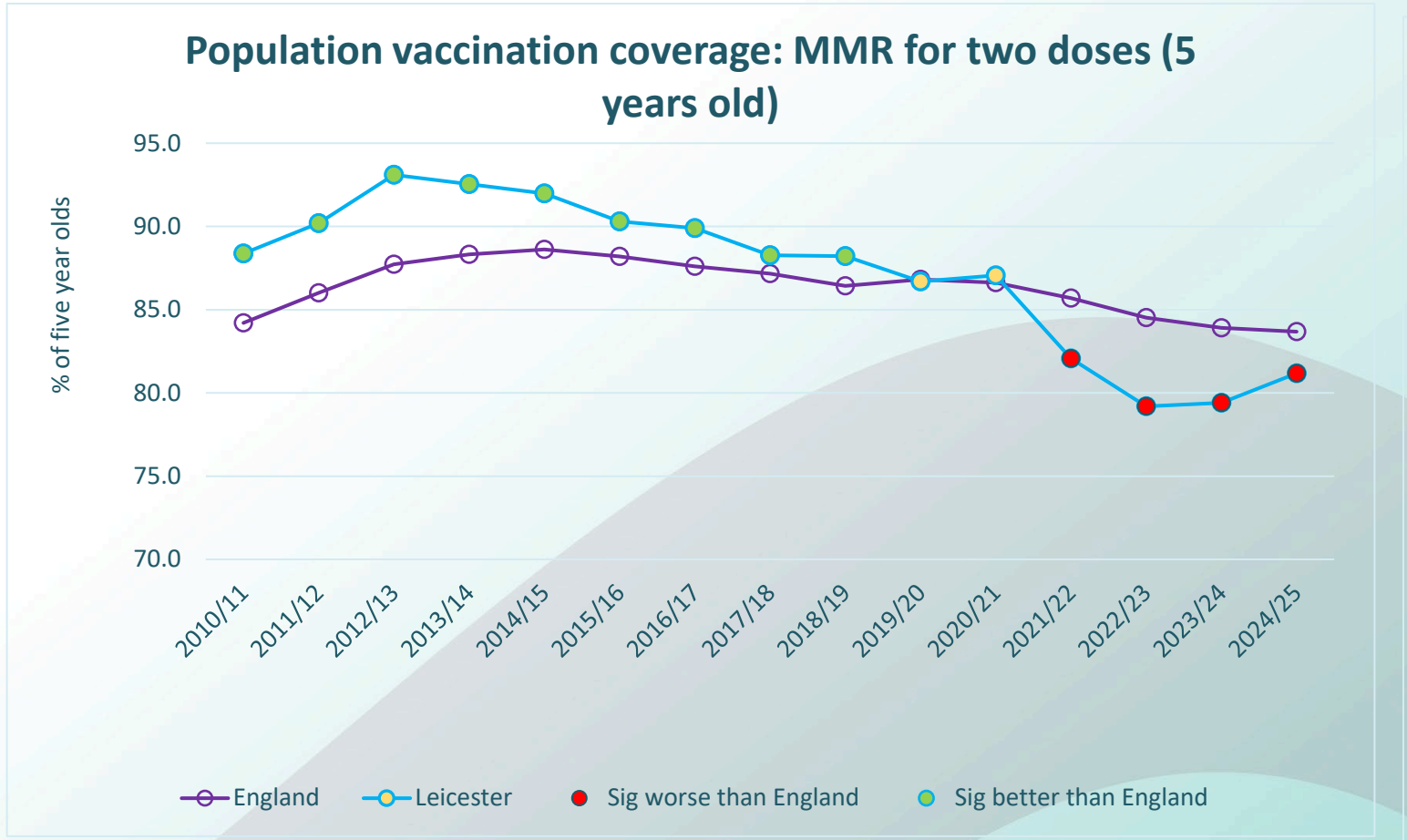
56% of these cases have been in London, 25% in the West Midlands, and 7% in the North West. However, all regions have reported at least one confirmed case.

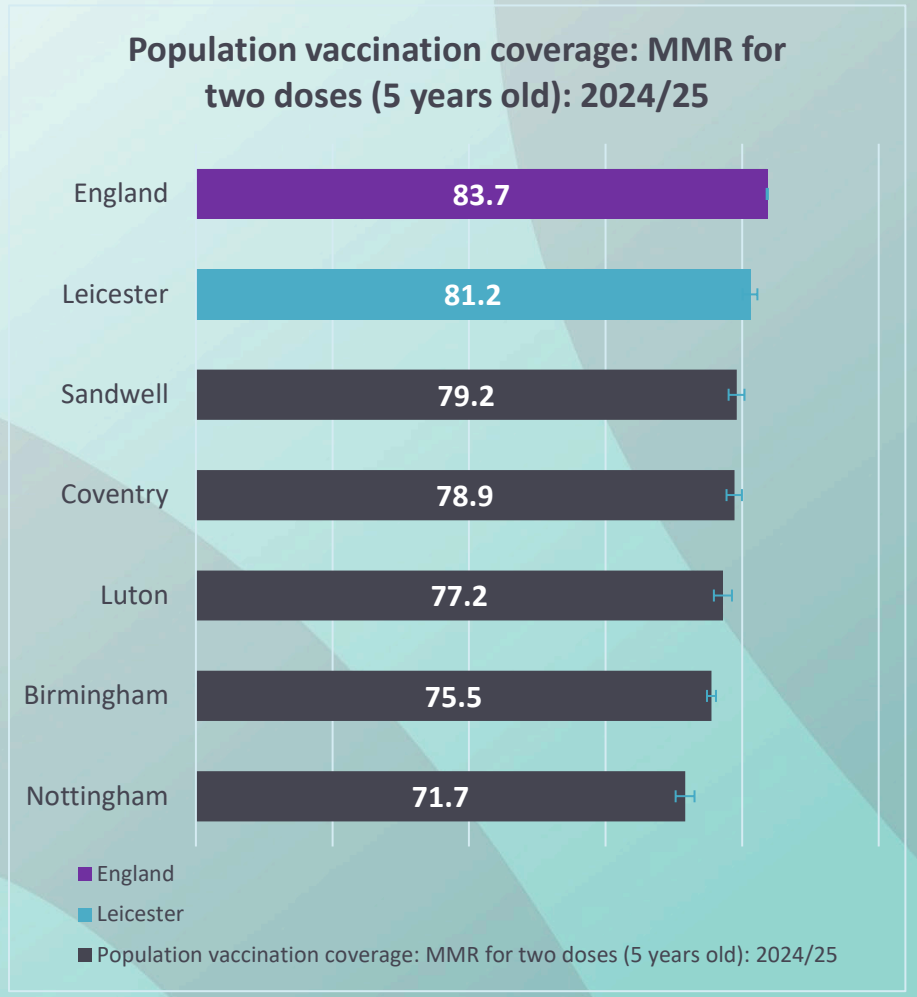
Leicester does not feature amongst the list of authorities with the highest number of cases during 2026 .

Measles | UKHSA data dashboard

Confirmed cases of measles in England by month, age, region and upper-tier local authority: 2025 - GOV.UK

MMR (2 doses) Vaccination in Leicester and England for 5 year olds: The picture of MMR vaccination coverage in our five year old children has changed from a picture of significantly better than the national to one significantly worse. In recent years Leicester has seen improvement in coverage and is better than our comparators.
From 1st January 2026 the 2nd dose of MMR will be given at 18 months rather than 3 years 4 months.





Source: OHID Fingertips
Note: UK Health Security Agency (UKHSA) recommend achieving 95% coverage for two doses of the MMR vaccine.

MMR Vaccination delivery in Leicester quarterly data for 2025/26: The quarterly picture for Leicester also shows improvement across the quarters for MMR delivery. The latest for MMR dose 2 delivery at 5 years old is 85.9%, this is higher than the national average at 83.8%.

Vaccination	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26
MMR Dose 1 at 24 months	88.0%	88.6%	87.7%	
MMR Dose 1 at 5 years	92.5%	92.7%	93.5%	
MMR Dose 2 at 5 years	82.7%	83.1%	85.9%	

Cover of vaccination evaluated rapidly (COVER) programme 2025 to 2026: quarterly data - GOV.UK

Childhood Immunisations: Leicester has experienced falling vaccination coverage for a range of childhood immunisations over the last 10 years. The city has often moved from a position of above vaccination target to below the target over this last 10 year period.

Population vaccination coverage	Leicester 2014/15	Leicester 2019/20	Leicester 2024/25
Dtap IPV Hib HepB (1 year old)	**96.1%**	92.3 %	91.4%
Hib and MenC booster (2 years old)	94.4%	90.8%	***88.1%***
PCV booster (2 years old)	94.5%	90.8%	***86.2%***
MMR for one dose (2 years old)	94.8%	91.2%	***88.4%***
MMR for two doses (5 years old)	92.0%	***86.7%***	***81.2%***

Benchmark against goals: *The World Health Organisation (WHO) has set vaccination coverage targets which have been adopted by the Department of Health at national and local levels. The 95 percent target for vaccination coverage is required nationally to ensure control of vaccine preventable diseases within the UK routine childhood vaccination programmes, with at least 90 percent coverage in each geo political unit.*

Above 95% target	90% to 95% acceptable range	***Below 90%***

Childhood Immunisations: Leicester, Leicestershire and Rutland has also experienced falling vaccination coverage for a range of childhood immunisations over the last 10 years.

Population vaccination coverage	LLR 2012/13	LLR 2014/15	LLR 2019/20	LLR 2024/25
Dtap IPV Hib HepB (1 year old)	**97.6%**	**96.9%**	94.8%	93.5%
Hib and MenC booster (2 years old)	**96.5%**	**95.9%**	93.8%	91.7%
PCV booster (2 years old)	**96.4%**	**96.0%**	93.8%	90.8%
MMR for one dose (2 years old)	**95.9%**	**96.0%**	93.9%	91.9%
MMR for two doses (5 years old)	93.4%	93.6%	91.3%	***87.1%***

Benchmark against goals: *The World Health Organisation (WHO) has set vaccination coverage targets which have been adopted by the Department of Health at national and local levels. The 95 percent target for vaccination coverage is required nationally to ensure control of vaccine preventable diseases within the UK routine childhood vaccination programmes, with at least 90 percent coverage in each geo political unit.*

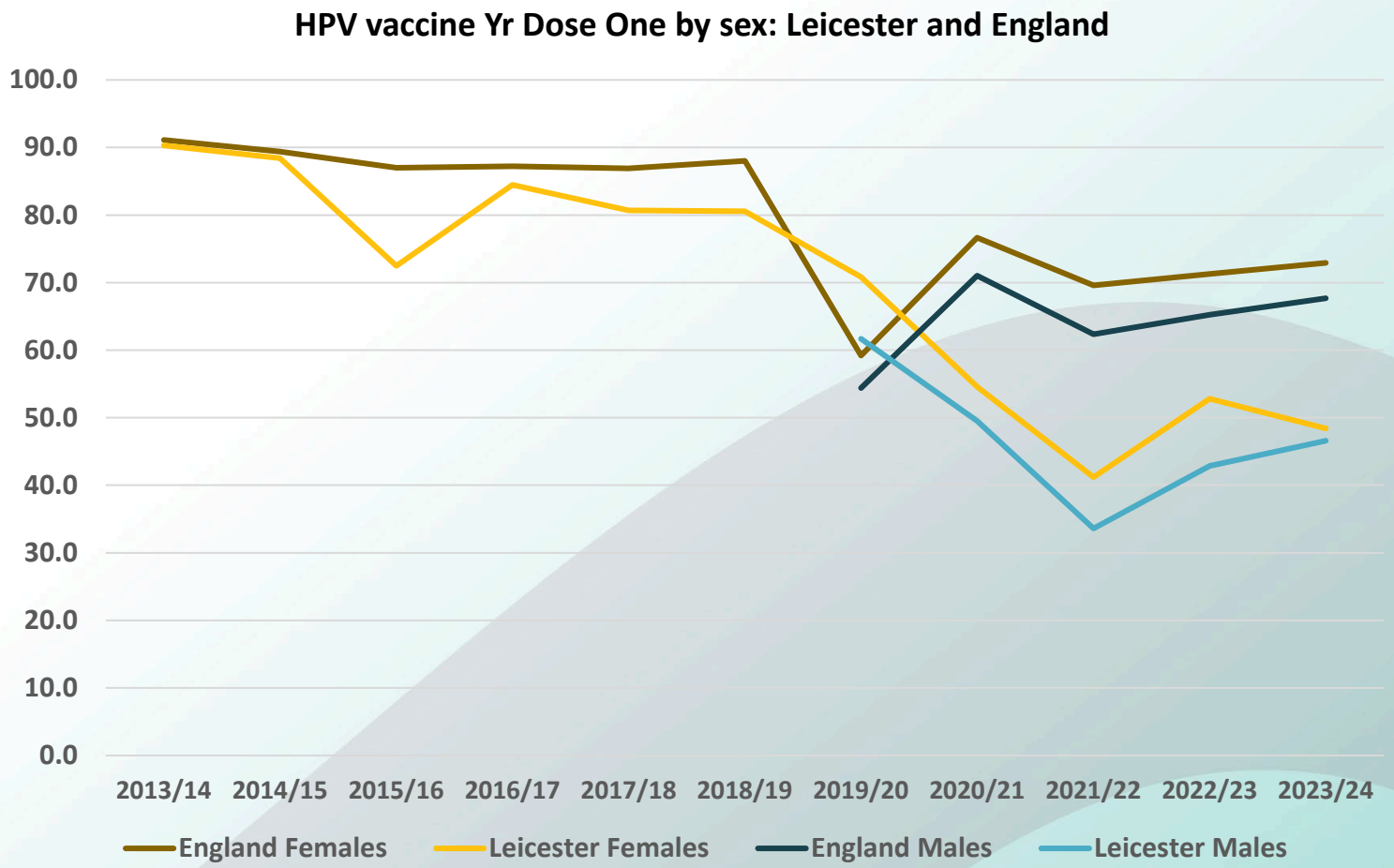
Above 95% target	90% to 95% acceptable range	***Below 90%***

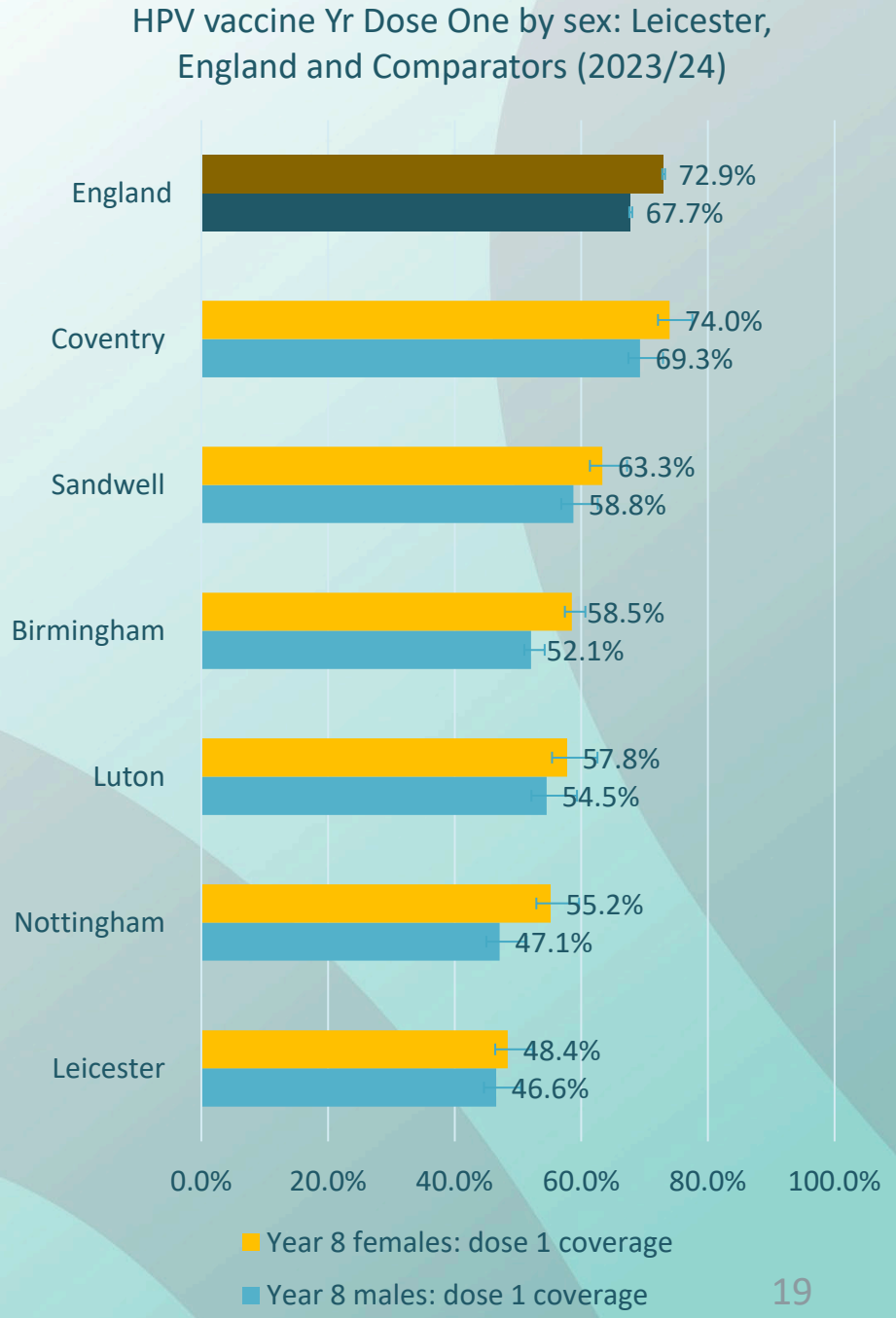
Childhood Immunisations change in the last year: Leicester has seen some small improvement across a range of childhood immunisations in the last year, and placing our coverage closer to the national average for many.

	Leicester 2023/24	Leicester 2024/25	England 2024/25
Population vaccination coverage: Dtap IPV Hib HepB (1 year old)	91.1%	91.4%	**91.3%**
Population vaccination coverage: MenB (1 year)	89.0%	90.2%	**91.0%**
Population vaccination coverage: Rotavirus (Rota) (1 year)	85.5%	85.5%	**88.8%**
Population vaccination coverage: PCV	93.6%	93.8%	**93.1%**
Population vaccination coverage: Dtap IPV Hib HepB (2 years old)	92.6%	93.0%	**92.5%**
Population vaccination coverage: MenB booster (2 years)	84.3%	86.0%	**87.3%**
Population vaccination coverage: MMR for one dose (2 years old)	87.7%	88.4%	**88.9%**
Population vaccination coverage: PCV booster	85.5%	86.2%	**88.0%**
Population vaccination coverage: Hib and MenC booster (2 years old)	87.0%	88.1%	**88.6%**
Population vaccination coverage: DTaP and IPV booster (5 years)	75.9%	77.8%	**81.3%**
Population vaccination coverage: MMR for one dose (5 years old)	91.2%	91.5%	**91.8%**
Population vaccination coverage: MMR for two doses (5 years old)	79.4%	81.2%	**83.7%**

Health Protection - Data | Fingertips | Department of Health and Social Care

HPV Uptake Trend: This data relates to vaccine coverage for the routine school-aged HPV immunisation programme in England for the 2023 to 2024 academic year. In recent years, there has been a decline in HPV vaccine coverage nationally and at the local authority level. Leicester has seen some improvement in recent years, however the HPV vaccination rate in the city remains below national and many of our comparators





Data source: and link [Human papillomavirus (HPV) vaccine coverage estimates in England: 2023 to 2024 - GOV.UK]

Vaccination against HPV reduces cervical cancer risk up to 18 years later with no signs of waning protection, research has shown.

A Swedish analysis of nationwide data of almost a million girls and women between 2006 and 2023 found a ‘consistently low incidence of invasive cervical cancer’ the follow up period after the introduction of the quadrivalent vaccine.

It extends previous long-term research by six years and with protection particularly strong for those vaccinated before the age of 17 years.

Writing in the BMJ, they concluded that the results ‘further support global strategies aimed at cervical cancer elimination through high vaccine coverage, particularly in younger populations’.
Their analysis was based on 926,362 girls and women born between 1985 and 2001 with no previous HPV vaccination or diagnosis of invasive cervical cancer at the start of follow-up in 2006.
Participants were followed up to a maximum age of 38 years, with those vaccinated before age 17 followed up to a maximum age of 34, they reported.
The researchers also took into account age, county of residence, mother’s country of birth and history of high-grade cervical lesions and non-cervical cancers, parental education and income.
Overall, 365,502 (40%) of participants had received at least one dose of the quadrivalent HPV vaccine.
The data showed 930 cases of invasive cervical cancer – 97 in vaccinated and 833 in unvaccinated individuals.
Those vaccinated before age 17 had a 79% lower risk of cervical cancer compared with the unvaccinated group, with sustained protection (77% lower risk) for 13 to15 years after vaccination, the team reported.
In those vaccinated at age 17 or older, the analysis showed a 37% lower risk of invasive cervical cancer compared with the unvaccinated group, with a 46% lower risk 10 to 12 years after vaccination and a 77% lower risk 13 to 15 years after they were vaccinated.
The figures also showed a population level decline in cervical cancer cases over time, progressively falling as more girls and women were vaccinated.
‘This risk reduction was observed regardless of age at vaccination initiation, with no indication of waning or attenuation over time,’ they said.
‘To our knowledge, this is the first study to assess how the risk reduction varies by time since HPV vaccination based on the longest follow-up.’
Last year GPs were told to focus on HPV vaccination as part of the national immunisation campaign.
It followed changes to cervical cancer screening intervals from three to five years for women aged 25 to 49 years who have a negative HPV test in England.
Uptake of HPV vaccination had declined in the pandemic but has since shown signs of recovery.