

SHORT REPORT

Does providing social services with information and advice on immunisation status of "looked after children" improve uptake?

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Arch Dis Child 2003;**88**:299–301

We prospectively assessed whether providing social services with information on the immunisation status for a cohort of looked after children in the care of an urban unitary authority in England improved uptake rates. The provision of such information did not improve immunisation coverage in these children.

The health of children looked after by local authorities has come under close scrutiny following recent high profile cases of neglect and abuse.¹ There is growing evidence that physical and mental health outcomes in this group of individuals are worse than in the general population, and may actually worsen while in local authority care.^{1,2} Immunisation uptake rates have been shown to be poor in these children.^{3,4} One of the Quality Protects performance indicators for children looked after for more than 12 months is the percentage whose routine immunisations are up to date. We assessed whether providing social services with detailed immunisation histories for every child looked after by a single urban unitary authority in England, including instructions for those immunisations needed to bring them up to date, led to improved uptake.

SUBJECTS, METHODS, AND RESULTS

The study was based in a single urban unitary authority area with a total population of just over 190 000, with over 46 600 (24.5%) aged 0–18 years. Deprivation as measured by the Child Poverty Index varied between wards, with ward scores ranging from 10.5 to 79.6. Sixty one per cent of looked after children were male, 4.7% had their ethnicity classified as other than white, and 71% were subjects of care orders. Children looked after by the unitary authority on 31 March 1999 had their age appropriate immunisation status assessed, as defined by the Department of Health schedule,⁵ using community child health immunisation records. These records were used because they included data on immunisations given in primary care that formed the basis of general practitioner (GP) payments for immunisation coverage in children prior to school age, and also included information on subsequent immunisations given by the school health services. The immunisation records were assessed for each child against the Department of Health schedule, appropriate for the age of the child. The reliability of the records was not specifically evaluated. Only 90.1% of the names of looked after children supplied for 1999 (227 of 252) were matched to child health records despite searching both electronically and manually using known aliases, previous addresses, and previous names. Because of the way data were collected and recorded in 1999 it is not possible to say which children were looked after out of area, as placements were not categorised by area. However, by

using school attended as a proxy for where they lived, 16 children were identified as living out of area (a figure that closely matches subsequent snapshots where area of placement has been included). It is likely that these account for 16 of the 25 children where child health records were not present. This still leaves nine children whose child health notes could not be identified. Overall 53.3% of looked after children had received all their age appropriate immunisations compared with over 90% for the district as a whole. Immunisation coverage for individual courses is given in table 1, and shows that looked after children had poorer completion rates for all immunisations compared with the child population as a whole, and that this became more marked once they reached the age for pre-school boosters and beyond. The data also revealed that for 19 of the 93 girls looked after (age range 14–18 years), there was no record of them having received rubella immunisation, either as single dose vaccine or as part of MMR. Meningitis C immunisation uptake rates were not included because this immunisation programme was introduced midway through the period of study.

A detailed immunisation history was prepared and provided to social services for every looked after child where the immunisation status was assessed. This included a record of all immunisations that had been recorded as received and detailed those immunisations that needed to be given to ensure that each child had received all their age appropriate immunisations. This information was provided to the senior social services manager in the unitary authority who had managerial responsibility for looked after children.

The impact of providing this information was assessed by reviewing the immunisation status of children looked after by the unitary authority on 31 March in both 1999 and 2000. A total of 136 children were identified as being looked after continuously during this period (age range 16 months to 17 years 2

Table 1 Completed age appropriate immunisation courses (%) in looked after children (LAC) in a single unitary authority compared with overall district rates, 1999

Immunisation	Scheduled age for giving	Completed courses (%)	
		LAC	Whole district
Primary DTP	2, 3, and 4 months	85	95
Primary polio	2, 3, and 4 months	85	95
Primary Hib	2, 3, and 4 months	95	95
Primary MMR	15 months	87	90
Preschool boosters	4 years	72	90
MMR2 (booster)	4 years	70	87
BCG*	13 years	9	95
School leaver boosters	15 years	26	72

*BCG unavailability from winter 1998 onwards taken into account.

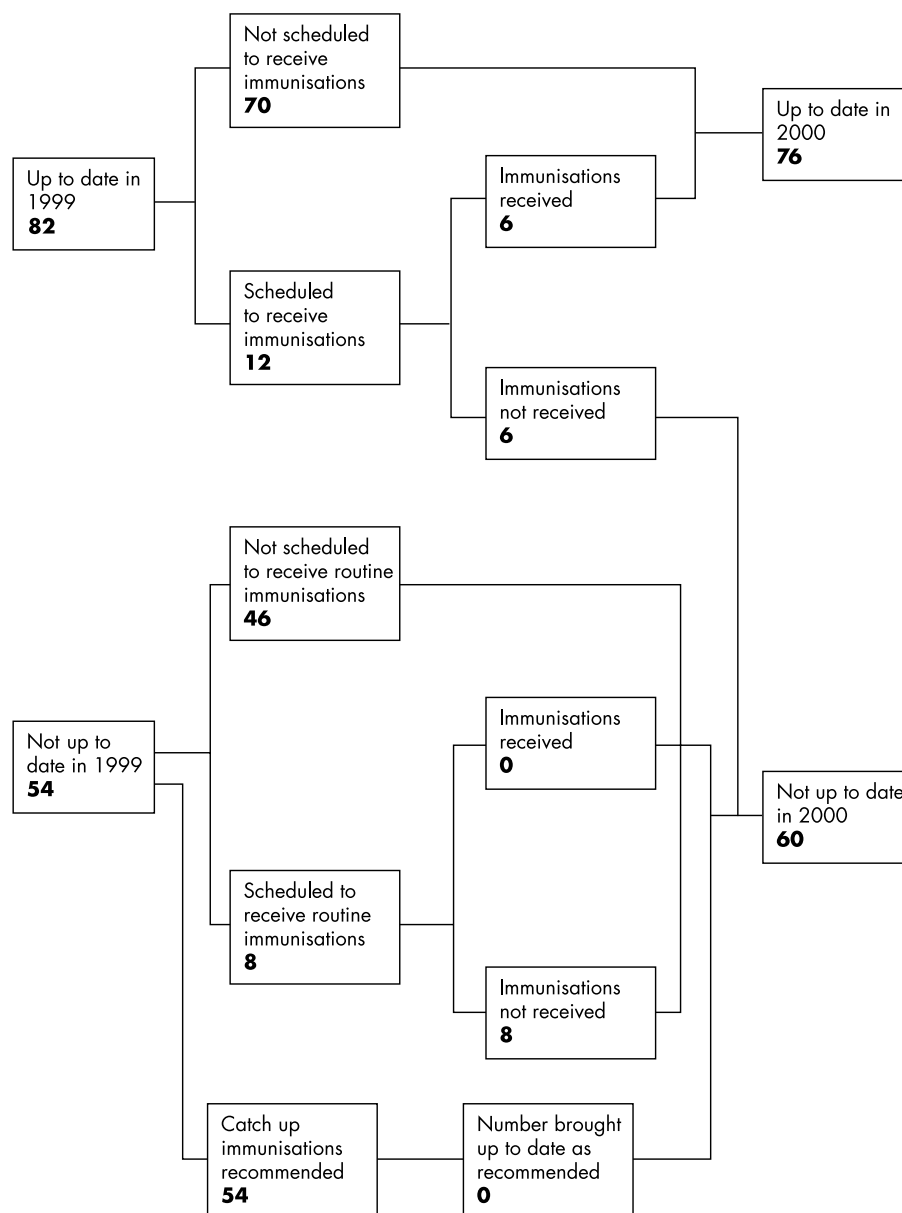


Figure 1 Changes in immunisation status of children looked after on 31 March in both 1999 and 2000 (number of children given in bold).

months). Eighty two of these children (60.3%) were up to date with their immunisations in 1999. Figure 1 shows the change in immunisation status of this cohort of 136 children looked after between 1999 and 2000. None of the 54 children requiring catch up immunisations was brought up to date as a result of this initiative. Twenty of the 136 children (14.7%) were scheduled to receive immunisations during the period 1999–2000. Only six of the 20 (30%) received them. By the end of the two periods immunisations were up to date in 76 children (55.9%). The difference between 1999 and 2000 of 4.4% (95% confidence interval 7.6% to 16.4%) is not statistically significant.

DISCUSSION

These findings show that the immunisation uptake rates in looked after children are worse than in non-looked after children, and is consistent with findings from other published studies.^{3,4} The figure of 53.3% of looked after children having received all their age appropriate immunisations in this unitary authority is lower than the figure of 69% for all looked after children in England overall.⁶ Providing social services with detailed information on each child's immunisation

status, with advice on what immunisations were needed to bring them up to date, did not lead to any child being brought up to date with their immunisations who was looked after by the unitary authority continuously for the period of study (1999–2000). Although not statistically significant, these findings show that the immunisation status of the 136 children looked after by social services continuously in this unitary authority actually worsened over a 12 month period between 1999 and 2000. It is possible that some children might have received immunisations from local GPs that were not recorded on the child health records. However, because GPs only give those immunisations scheduled prior to school age, and this information is used to calculate the practice's level of payment based on set targets, it is unlikely that these numbers are significant. No studies were identified that assessed the value of providing social services with information on the immunisation status of individual children. Our study shows that identifying a health need in these children (poor immunisation uptake) and providing social services, the corporate parents of these children, with the information to correct this did not lead to improvement.

Providing healthcare to looked after children faces many challenges that result from placement moves, discontinuity of primary medical care provision, discontinuity of schooling, and changes in social worker, all of which will contribute to the lack of success in this initiative. Older children also have the right to refuse immunisations that once again will serve to lessen the impact of this process. The Department of Health has recognised that the key to improving the health of looked after children is to identify their health needs so that they can be addressed.⁷ Our study shows that identification of health needs alone is not sufficient to bring about improvements in health. National policy is needed to clarify where responsibility lies for ensuring that the assessed health needs of looked after children are met. We would suggest that as corporate parents local authorities are responsible for ensuring that the identified health needs of children in their care are addressed. They will, however, require advice and support from the local health service community, and will clearly have to take into account the wishes and rights of looked after children.

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Accepted 23 September 2002

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