PostScript

LETTERS

Pneumococcal and influenza vaccines: a survey of knowledge and practice among UK paediatricians

Since January 2002 the Chief Medical Officer (CMO) in the UK has issued newsletters recommending limited use of the heptavalent pneumococcal conjugate vaccine (PCV) in children under 2 years old considered to be at high risk of pneumococcal infection.¹ In September 2006, the PCV was incorporated into the universal national immunisation schedule in the UK.²

A survey of paediatricians in the North East of England was conducted to determine their knowledge and practice in respect of the CMO's recommendations. Fifty paediatricians working in 10 district general hospitals (n = 41), five community centres (n = 7) or both (n = 2) completed self-administered questionnaires. The overall response rate was 67%. Forty seven paediatricians (94%) claimed to be aware of the CMO's recommendations for high-risk children requiring pneumococcal and yearly influenza vaccines.

The highest rates of appropriate vaccine recommendations were for children with chronic lung disease (76%), cystic fibrosis (74%), neuromuscular diseases (66%), congenital heart disease (64%), asplenia or severe splenic dysfunction (63%), chronic heart failure (54%), nephrotic syndrome (58%) and chronic renal failure (50%).

The lowest rates of appropriate vaccine recommendations were for children with chronic liver diseases such as cirrhosis (34%), biliary atresia and chronic hepatitis (33%), and for influenza vaccines for children previously admitted for asthma (17%) or with a lower respiratory tract disease (15%).

There were no significant differences between the average rates of recommendation of the pneumococcal (50%) or influenza vaccines (47%), or between the paediatricians working in the community or in district general hospitals ($\chi^2 = 0.73$, $p = 0.693$).

Influenza vaccine was incorrectly recommended for children with cochlear implants (18%) or CSF shunts (16%), and for children with a previous invasive pneumococcal disease under the age of 5 (28%). Pneumococcal vaccine was incorrectly recommended for children previously admitted for asthma (12%) or with a lower respiratory tract disease (14%).

Forty three respondents (86%) recommended the vaccines by clinical letters to the GPs and 40 (80%) by verbal advice to the parents/carers, while 28 respondents (56%) recommended the vaccines via letters to the parents/carers.

The generally poor rate of correct responses that were in accordance with the CMO's recommendations reflects a lack of familiarity with the recommended guidelines on the vaccinations of high-risk children. However, this could be partly explained by the fact that

some of the paediatricians do not regularly see some categories of the patients in the community or in the district general hospitals, because the patients are being exclusively followed up by the tertiary hospital paediatricians. It is also possible that some paediatricians are not convinced that either or both vaccines are useful in some categories of high-risk children as recommended by the CMO.

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References

- 1 **Department of Health.** Extending meningitis C vaccine to 20-24 year olds: pneumococcal vaccine for at-risk 2 year olds, 2002. PL/CMO/2002/1: 1-4, <http://www.dh.gov.uk/assetRoot/04/01/34/85/04013485.pdf> [accessed 25 May 2007].
- 2 **Department of Health.** Important changes to the childhood immunisation programme, 2006. PL/CMO/2006/1: 1-16, <http://www.immunisation.nhs.uk/files/CMO-CNO-CPHOLetterchangestoscheduleJuly2006.pdf> [accessed 25 May 2007].

Response: How can the UK National Health Service be broke?

Professor Stephenson raises many important issues with his rhetorical question, "is the NHS still something to be proud of?",¹ pointing out that children are among a number of vulnerable groups likely to find specialist services increasingly difficult to come by. Payment by results seems poised to bankrupt children's hospitals, and in my own Trust, from having been a net "earner" the paediatric department is now likely to produce a £16 million annual deficit. Needless to say, plans for the long awaited Children's Hospital for Leeds have (once again) been shelved. The popular view fostered by New Labour politicians, parliamentary committees and much of the media is that greedy doctors (large pay rises) and poor financial management go a long way to explaining why record investment seems to have achieved so little. As Professor Stephenson shows, this is not the whole story. The fact that the NHS is being quite deliberately dismantled through the process of "patchwork privatisation", eloquently argued by Alex Nunn for the "Keep our NHS Public" campaign (www.keepournhspublic.com), is seldom mentioned. The prospect of a health service opened up to private companies beholden only to their shareholders is not what inspired many of us to become paediatricians. We can look forwards to a wasteful American-style system of healthcare for those who can afford to pay. A broad and popular movement in defence of the principles on which the NHS

was founded is the only way we might yet avoid being left to reflect dismally on the days of a comprehensive and equitable service as a vanished golden age. As Nye Bevan said of the NHS, "it will last as long as there are folk left with the faith to fight for it". Professor Stephenson has thrown down the gauntlet.

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Reference

- 1 **Stephenson T.** How can the UK National Health Service be broke? *Arch Dis Child* 2007;92:189-90.

Training on the NHS is also broke

We read Professor Stephenson's excellent perspective on the state of the NHS with interest.¹ This is a very comprehensive account of the NHS budget, NHS reform and implications for children's services. We would like to add a few points specific to the impact of the new NHS on the care of children, both current and in the future, due its effect on the training of new paediatricians.

Towards the end of the article, the important point is made that patient choice and plurality of providers may well not be the best solution for children with multiple coexisting long-term problems. We would like to add that there is also a real danger that the system by offering more patient choice may lead to delayed flagging up of child protection issues. One of the strengths of the old NHS was that it encouraged clinical networks and tertiary specialists were generally enthusiastic about giving informal telephone advice to generalist paediatricians. Many paediatricians will be worried that the Payment by Results scheme will demotivate the formation of such networks and financial implications may get in the way of professional relationships. Finally, while it is important to ensure paediatric services are efficient and to emphasise the importance of discharging children back to primary care, it is arguable if measuring outcomes such as new to follow-up ratios and dissuading consultant-to-consultant referrals are in the best interests of the child.

The NHS has always been about both service provision and medical training. The patient has been put in the centre of the equation, but what about the trainee? We believe that financially motivated changes in the way we work without understanding how this will impact on training are short-sighted. Many changes have revolved around providing the most activity with minimum staff and ensuring that service needs are met without doctors working over the number of hours allowed by European Work Time Directives. This has meant that trainees are often stretched by service commitments, demoralised and demotivated so that they do not derive full benefit from the many learning opportunities that clinical care offers.

While educational supervision and regular appraisal of trainees do take place, we believe it