Implementing an ACP led immunisation clinic for unaccompanied asylum-seeking children (UASC) .

A Quality Improvement Project

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NHS
Royal Cornwall Hospitals
NHS Trust

Outstanding
Care for One+All

Who are we referring to?

‘Someone seeking international safety by requesting complementary protection or refugee status, necessitated by fear of persecution, war and human rights violations in their home country’ (UNHCR, 2025)

UASC

CYPSAR

Unaccompanied minor

SCSA

‘CYP under 18 years of age who have travelled from their home, for fear of safety, and have arrived in a host country **without parents or carers**’
(Coyle, Bennett and Coyle, 2016).

Common health challenges

- Skin, respiratory and intestinal infections,
- Dental caries,
- Nutritional deficiencies,
- Physical injuries,
- Mental health problems such as PTSD and depression
- **Poor or no immunisation status**

‘Catch-up’ immunisations

UK Health Security Agency

Vaccination of individuals with uncertain or incomplete immunisation status

For online Green Book, see www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book • For other countries' schedules, see immunizationdata.who.int/global?topic=Vaccination-schedule&location=

Infants from eight weeks of age up to first birthday

DTaP/IPV/Hib/HepB[a,ff] + MenB[b] + rotavirus[c]
Four week gap
DTaP/IPV/Hib/HepB + MenB[b] + rotavirus[c]
Four week gap
DTaP/IPV/Hib/HepB + PCV13[b,d]

[a] A child who has already received 1 or more doses of primary diphtheria, tetanus, inactivated polio, pertussis and Hib should complete the 3 dose course with DTaP/IPV/Hib/HepB. Where a child is only missing any doses of HepB, these can be given as monovalent HepB at 4 week intervals
[b] Children require 2 doses of MenB (at least 4 weeks apart) and 1 dose of PCV13 in first year of life
[c] First dose of rotavirus vaccine to be given **only** if child is more than **6** weeks and under **15** weeks. Second dose to be given **only** if child is less than **24** weeks old
[d] Children who are aged 16 weeks or over when starting their primary schedule can be given their single infant priming dose of PCV13 with their first set of primary immunisations. If a child has received PCV10 vaccine abroad, they should be offered 1 dose of PCV13 (at least 4 weeks after PCV10 was given and once they are 16 weeks of age). A dose of PCV13, PCV15 or PCV20 given abroad from 12 weeks of age counts as a valid dose

Subsequent vaccination

As per UK schedule ensuring a minimum 4 week interval between the MenB and PCV13 priming and booster doses

General principles

- unless there is a documented or reliable verbal vaccine history, individuals should be assumed to be unimmunised and a full course of immunisations planned
- individuals coming to UK part way through their immunisation schedule should be transferred onto the UK schedule and immunised as appropriate for age
- If a course of vaccines has been started but not completed, resume the course – no need to repeat doses or restart course
- plan catch-up immunisation schedule with minimum number of visits and within a minimum possible timescale – aim to protect individual in shortest time possible

[f] If an individual has received any oral polio vaccine (OPV) in another country since April 2016, these doses should be discounted as it is unlikely that they will protect against all 3 polio types.

Most countries who still use OPV have a mixed OPV and IPV schedule so if sufficient IPV doses have been received for age, no additional IPV doses are needed. See Green Book Polio chapter for individuals who have received fractional doses of IPV (fIPV).

Individuals who are pregnant, at high risk or with specific underlying medical conditions may require additional vaccinations. Refer to individual Green Book chapters.

Children from first up to second birthday

DTaP/IPV/Hib/HepB[b, ††,g] + PCV13[†††] + MenB[††††] + MMR[†††††]
Four week gap
DTaP/IPV/Hib/HepB[†] + MenB[††††]
Four week gap
DTaP/IPV/Hib/HepB[†]

[†] Children born from 01/08/17 who received primary vaccines without HepB should be opportunistically offered a 3 dose course of monovalent HepB vaccine. If they are in a high-risk group or are exposed to hepatitis B, they should be proactively offered a hepatitis B vaccine course
[††] **All children require a dose of Hib over the age of 1 year.** If they have received all 3 primary doses of hexavalent vaccine in their first year of life but no dose of a Hib-containing vaccine over 1 year of age, and were born:
- **on or before 30/06/24,** they should be offered the combined Hib/MenC vaccine now (or hexavalent if Hib/MenC vaccine not available) ensuring a minimum 4 week interval between this and the primary DTaP/IPV/Hib/HepB doses given in their first year of life
- **on or after 01/07/24,** they should be offered the hexavalent vaccine at 18 months (or now if older than 18 months)

If they have received at least one of their primary doses of hexavalent vaccine over 1 year of age, the Hib/MenC or additional hexavalent dose offered at 18 months is not needed
[†††] All children require a dose of PCV over the age of 1 year. If a child has received PCV10 vaccine abroad, they should be offered 1 dose of PCV13 (at least 4 weeks after PCV10 was given). PCV15 or PCV20 given abroad over 1 year of age counts as a valid dose
[††††] All children require a dose of MenB over the age of 1 year. However, children who received less than 2 doses of MenB in their first year of life should receive 2 doses of MenB in their second year of life (given 4 weeks apart)
[†††††] See MMR box below regarding timing of 2nd dose

Subsequent vaccination

- all children require a dose of Hib over 1 year (see [††] above)
- dTaP/IPV vaccine should be offered from 3 years 4 months (and at least one year after last dose of DTaP/IPV/Hib/HepB vaccine)
- MMR vaccine should be offered as described below

Children from second up to tenth birthday

DTaP/IPV/Hib/HepB[b, **,g] + MMR
Four week gap
DTaP/IPV/Hib/HepB[†] + MMR
Four week gap
DTaP/IPV/Hib/HepB[†]

[†] DTaP/IPV/Hib/HepB is the only suitable vaccine containing high dose tetanus, diphtheria and pertussis antigen for priming children of this age. Children born from 01/08/17 who received primary vaccines without HepB should be opportunistically offered a 3 dose course of monovalent HepB vaccine. If they are in a high-risk group or are exposed to hepatitis B, they should be proactively offered a HepB vaccine course
[**] **All children require a dose of Hib over the age of 1 year.** If they received all 3 primary doses of hexavalent vaccine in their first year of life but no dose of a Hib-containing vaccine over 1 year of age, they should be offered the combined Hib/MenC vaccine now (or hexavalent if Hib/MenC vaccine not available). If the hexavalent vaccine is given, there should be a 12-month interval before the dTaP/IPV booster is administered

Subsequent vaccination

- if child is 3 years 4 months or older, their dTaP/IPV booster can be given as early as 1 year following completion of primary course to re-establish on routine schedule. If a Hib-containing vaccine has not been received over 1 year of age, replace dTaP/IPV with DTaP/IPV/Hib/HepB
- additional doses of DTaP-containing vaccines given under 3 years of age do not replace the need to give the dose of dTaP/IPV vaccine from 3 years 4 months
- subsequent vaccination – as per UK schedule

From tenth birthday onwards

Td/IPV[e] + MenACWY[*] + MMR
Four week gap
Td/IPV + MMR
Four week gap
Td/IPV

[*] MenACWY is offered routinely around 14 years of age. There is no requirement to give it earlier than this unless particular indication (e.g. travel, post exposure). Individuals who have not received it at this age remain eligible until their 25th birthday. Doses of MenACWY vaccine already received from 10 years of age count as valid doses and do not need to be repeated

Subsequent vaccination

First booster of Td/IPV: Preferably 5 years following completion of primary course
Second booster of Td/IPV: Ideally 10 years (minimum 5 years) following first booster

MMR vaccine – from first birthday onwards

- doses of measles-containing vaccine given prior to 12 months of age should not be counted
- 2 doses of MMR should be given irrespective of history of measles, mumps or rubella infection and/or age
- a minimum of 4 weeks should be left between 1st and 2nd dose MMR
- give 2nd MMR from 18 months of age if born on/after 01/07/2024. If born on/before 30/06/2024, to remain on previous schedule with 2nd MMR dose due from 3 years 4 months (unless particular reason to give earlier)
- 2nd dose of MMR should not be given <18 months of age except where protection against measles is urgently required

Flu vaccine (during flu season)

- those aged 65 years and older although recommendations may change annually so always check Annual Flu Letter
- children eligible for the current season's childhood influenza programme (see Annual Flu Letter for date of birth range)
- those aged 6 months and older in the defined clinical risk groups (see Green Book Influenza chapter)

Respiratory syncytial virus (RSV) vaccine

- routinely from 75th birthday (eligible until 80th birthday)
- one-off catch-up campaign for those already aged 75 to 79 on 01/09/24. See RSV vaccination programme

Pneumococcal polysaccharide vaccine (PPV)

- those aged 65 years and older
- those aged 2 years and older in the defined clinical risk groups (see Green Book Pneumococcal chapter)

HPV vaccine

- all females (born on/after 01/09/91) and males (born on/after 01/09/06) remain eligible for HPV vaccine up to their 25th birthday on the adolescent programme
- eligible immunocompetent individuals aged 11 to 25 years only require a single dose of HPV vaccine
- eligible individuals who are HIV positive or immunosuppressed should be offered a 3 dose schedule at 0, 1, 4-6 months
- for details of GBMSM HPV vaccination programme, please see Green Book HPV chapter
- any dose of Cervarix, Gardasil or Gardasil 9 given from 9 years of age would be considered valid if previously vaccinated or vaccinated abroad

Shingles vaccine

- **severely immunosuppressed individuals** from 50 years of age (eligibility as defined in the Green Book, Shingles chapter 28a): 2 doses of Shingrix vaccine 8 weeks to 6 months apart; no upper age limit to start or complete the course
- **immunocompetent individuals** from their 65th or 70th birthday (see Shingles: guidance and vaccination programme on GOV.UK website for eligibility): 2 doses of Shingrix vaccine 6 months to 12 months apart
- **all individuals** between 70 and 79 years of age are eligible for shingles vaccination if they have not received it
- once individuals become eligible, they remain eligible until their 80th birthday. The second dose of Shingrix vaccine can be given up to 81st birthday to those who have commenced but not completed the course

Effective from 1 July 2025
UK Health Security Agency gateway number: 2025014

UKHSA, 2025

The National Picture

Are you satisfied with the vaccination status of UASC in your area?

How are UASC accessing vaccines in your area?

تحديد المشكلة

- 57% لم يتلقوا أي لقاحات
- 7% تلقوا الجرعات الأولى فقط
- 14% تلقوا الجرعتين الأولى والثانية
- 21% أكملوا برنامج التعويض

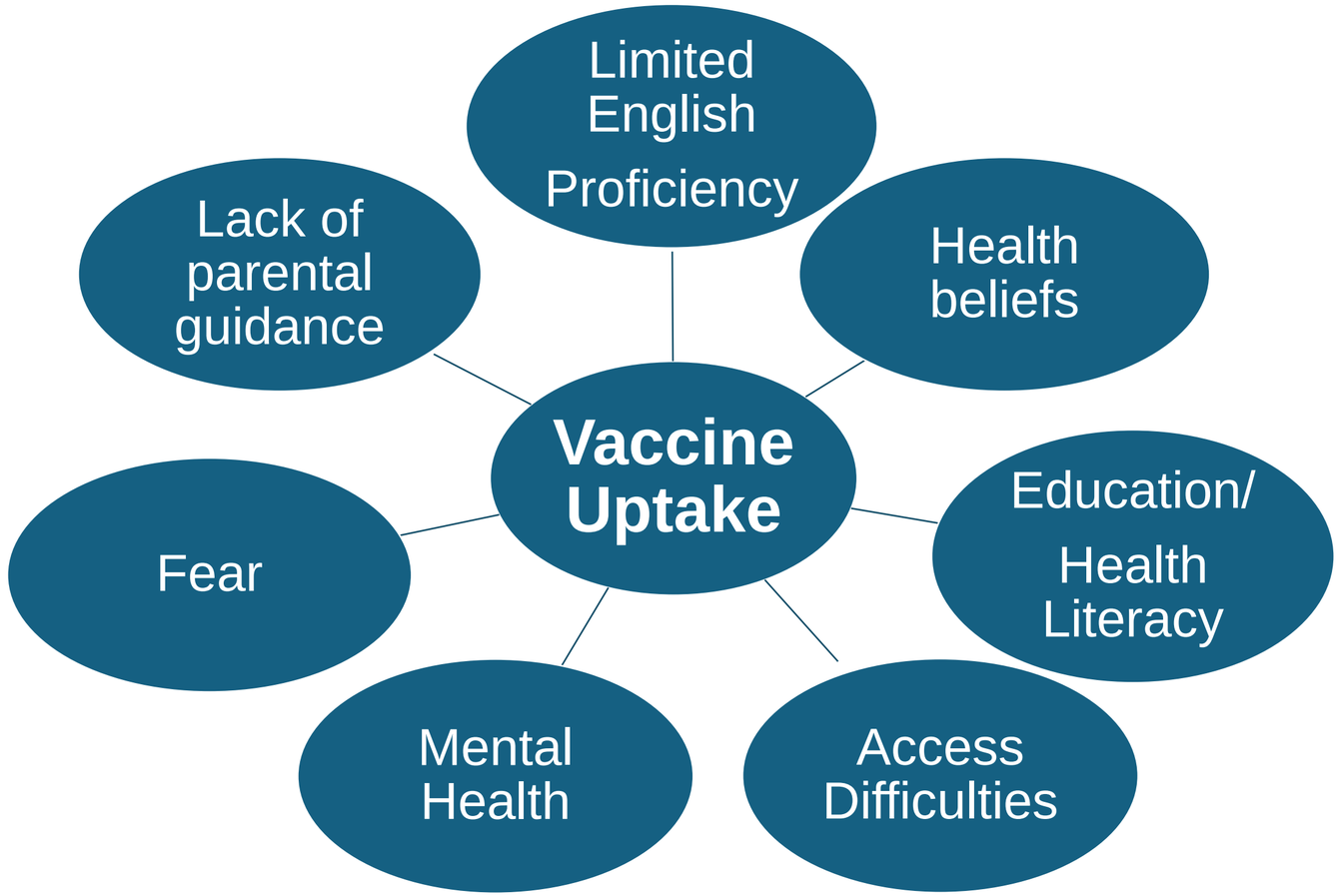
Identifying the problem

- 57% had not received any vaccines
- 7% had received **only** the first doses
- 14% had received the first and second doses
- 21 % completed the catch-up program

Local audit Cornwall CIC Health Team, August 2024

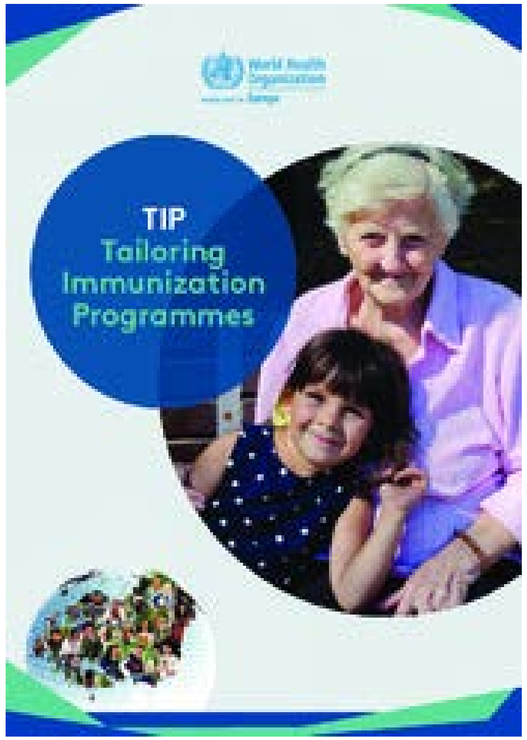
Why or (why not)?

Potential reasons for inadequate local UASC vaccination uptake



Global context

‘Leave no one behind’



‘Millions of children at risk as global vaccine rates fall, study finds’ The Guardian, 24 June 2025

National Immunisation Programme: health equity audit

A small test of change (PDSA)

Aim:

To increase uptake of immunisations among UASC within 4 months of their entering local authority care, or by the time they turn 18

BY

Removing barriers & providing equitable access to vaccines

Improving vaccination accessibility by utilising statutory health appointments

Objectives

Provide accessible information to UASC & their Workers about the ‘catch-up’ schedule and vaccines included.

Arrange three vaccination appointments for UASC

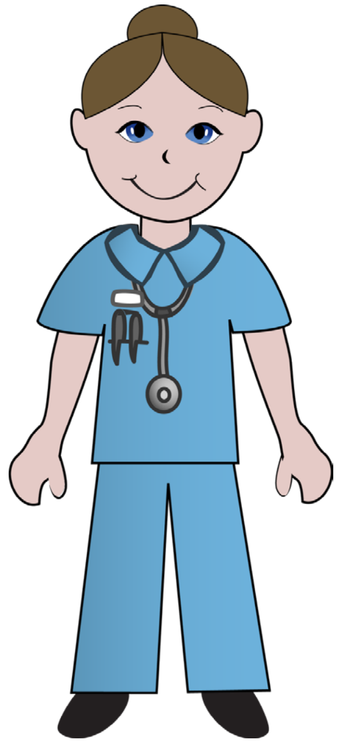
Create a trauma-informed and culturally aware clinic environment.

Enable sustained co-production

How?

The emerging Advanced Nurse Practitioner role

Pillars of Advanced Practice	Actions demonstrating the pillars of Advanced Practice
Clinical Practice	Prescribing vaccines & vaccine administration Conducting complex health consultations and physical assessments
Leadership & Management	Clinic planning and organisation for effective, safe & reliable clinic service delivery. Sourcing, ordering & stocking vaccines/ medication
Education	Vaccine training planning & support Providing accessible patient/carer vaccine information
Research	Acquiring relevant literature and resources to guide the project Evidencing the test of change. Audit & evaluation.



Demonstrating the four pillars of advanced practice
(Health Education England, HEE, 2017):

Existing ‘One Stop Shop’ model

F2F IHA & screening with Paediatrician & recommending vaccines with GP

F2F RHA at 3 months with Specialist CIC Nurse (varying Practitioners & venues)

Screening results reviewed by paediatrician & sent by letter to GP, SW & YP

Extended One Stop Shop Model

F2F IHA with Paediatrician & Trainee ANP. Screening (BBV,TB, baseline bloods, sexual health)

1st Vaccine doses: Td/IPV, MMR, Men ACWY

BY 12 weeks, catch-up immunisation is complete

Empirical Albendazole prescribed & dispensed at IHA

Praziquantel & Vitamin D prescribed & dispensed at 2nd/ 3rd appointments.

t 4 weeks (post IHA) health review, screening results
eatment discussed/initiated with Trainee ANP/Dr

2nd Vaccine doses: Td/IPV, MMR

At 8-12 weeks post IHA F2F RHA/health update with Trainee ANP

3rd Vaccine doses: Td/IPV, HPV

JBI Key components/ PDSA

Context analysis	Facilitation	Evaluation
Identifying the problem Exploring wider context Establishing the aim **Engaging with stakeholders** Planning and Gantt chart HRA tool	**Vaccine training** **Vaccine stock and storage** **Vaccine prescribing** **Clinic resources** **Make appointments** **Utilise Interpreters** **Administer vaccines using SW toolkit – establish, code, identify, plan**	Vaccine uptake log Young person survey Worker survey Collaborative feedback with professionals Trial Groups 1,2,& 3

Holistic and individual approach

Immunisation process (adapted from ICARS, 2024)

Did the enhanced service improve vaccine outcomes for UASC?

Outcome and Process measures – Evaluation

- Quantifying any increase in the number of vaccines obtained by UASC during the test of change period.

- How the process of delivering vaccines to UASC was received by those involved.

16 UASC commenced vaccination doses during the project = 100% uptake = project aim achieved

Full immunisation status: all vaccines recommended in the ‘catch-up’ algorithm received (UKHSA, 2025),

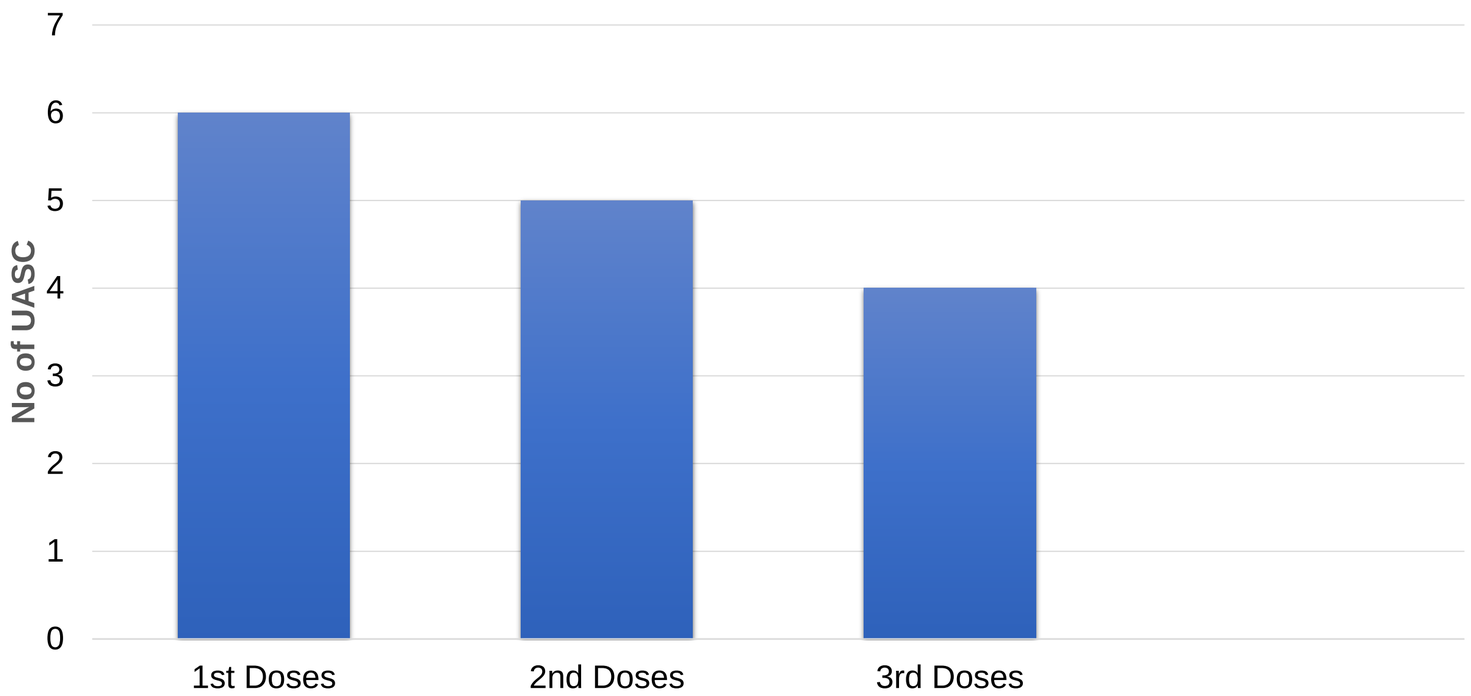
Completing all doses of a multiple-dose vaccine course is advised for complete disease prevention (WHO, 2025).

- **Pilot Groups** 1,2 & 3 (6)

- **Additional Vaccines**: Offered to UASC attending IHA and RHA appointments, not in the small test of change (10)

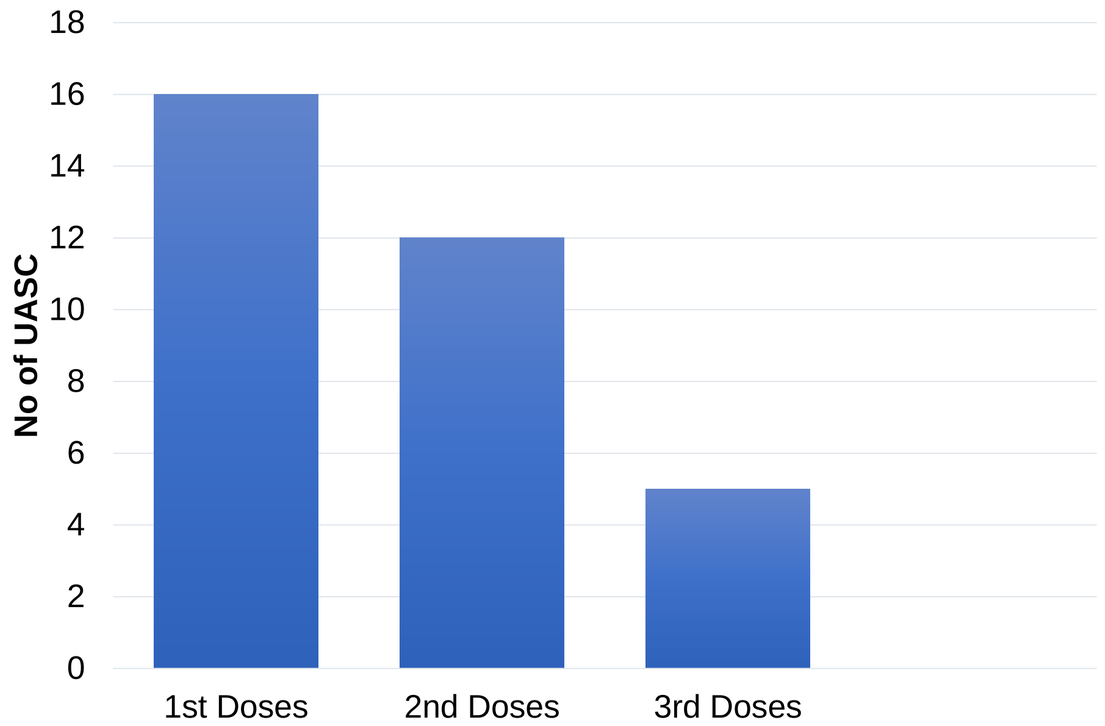
Vaccine uptake among pilot groups 1,2, and 3 (6 in total)

Number of doses received by pilot group UASC



Vaccine uptake among UASC offered during the project

Number of doses received by all 16 UASC



Survey Results 1

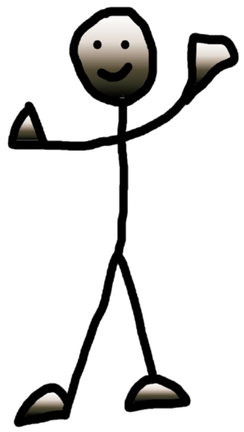
UASC comments

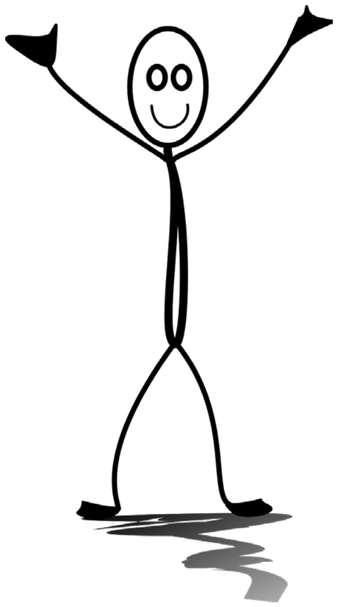
Went very well. I'm happy. The doctors are very good with us

Everything is fine, thank you for help

Nurse was very kind

It was nice and easy





Survey Results 2

Worker comments

Excellent service and care.

Long appointments but very human & child-centred.

Having information in different languages

YP was nervous but treated with best care and understanding

Side effects explained in his language

YP helped to understand information in his language

YP had a good understanding of what was happening

Remind workers to explain the vaccinations before the appointment

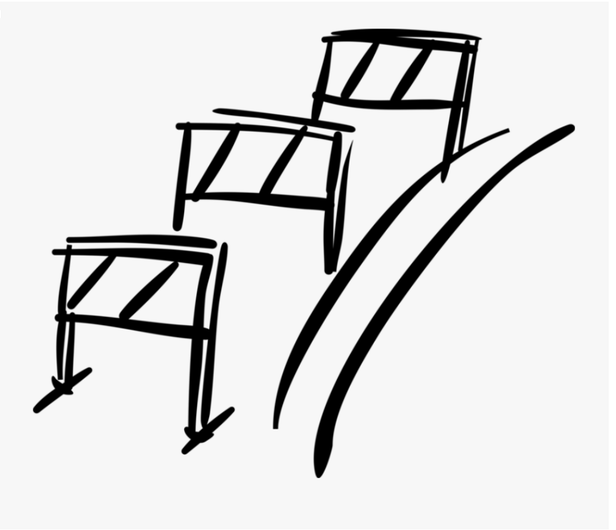
Fantastic service & needed

So what?

- **Individualistic** and time-generous approach
- **Bespoke** packages - Ramadan
- **Relationship** model
- Modelling service to improve access to universal services
- Informed consent
- **Time** to explore barriers to vaccination – HBM, language
- Leaving care supportive process
- Transitioning YP – without parental guidance and support

Challenges

Rural location, Team priorities, Service demands.



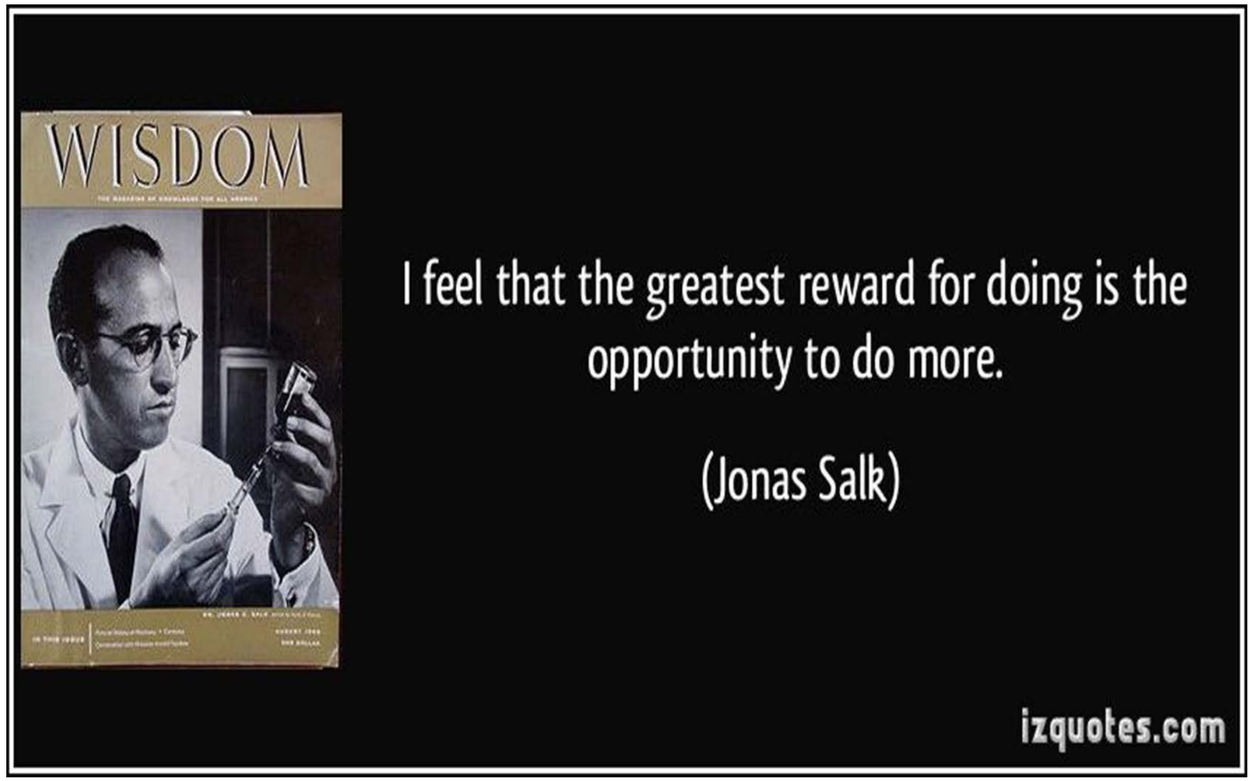
- Location
- Interpreter limitations
- QuantiFERON Bloods (TB) – Blood Bikes
- Commissioning
- Encompassing the broader context of the consultation.
- Additional staff for sustainability

What next? (ACT)

- Continue…..
- National replication to improve vaccine outcomes for **ALL UASC**, not just Cornish
- Ensuring sustainability
- Increased public health approach
- **Building the ANP role within**

Any Questions?

This is just the beginning……



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Thank you

Our values

Respect

Compassion

Honesty

Teamwork

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Outstanding
Care for **One+All**