



update four

BETTER HEALTH,
BETTER CARE

update

on the *National Delivery Plan for Children and Young People's Specialist Services in Scotland*



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WELCOME

I'M VERY PLEASED TO HAVE BEEN
GIVEN THE OPPORTUNITY TO WRITE
IN THIS NEWSLETTER AND
INTRODUCE MYSELF.

I lead the Directorate within Scottish Government that plays a lead role in seeking to secure better outcomes for children, young people and families in Scotland. Given the breadth of that subject, we work directly to Education, Health and Justice Ministers and work with a wide range of partners within Scotland. We have recently taken on responsibility for child and maternal health within the Directorate, giving us the opportunity to reinforce further the links across Scottish Government in this important area.

By bringing together our work in this way I feel very confident that we can further enhance the huge amount of good work, including that in Specialist Children's Services being done across Scotland.

I very much welcome the work being carried out under the auspices of the *National Delivery Plan* – action that puts the child and young person at the centre and delivers the best possible service to meet their needs. Our aim is to improve outcomes for children and young people, many of whom are vulnerable and all of whom look to us to give them the support they need.

The *National Delivery Plan* will soon reach the end of its three-year implementation phase, and many of the recommendations contained in the original report have already been implemented. I would like to put on record my thanks to the members of the Implementation Group who have steered it so successfully, and particularly to the Chair, Caroline Selkirk.

I have been impressed by the range of actions and the scale of your work to improve the lives of children and young people and I hope soon to have the opportunity to see for myself some of the excellent work that you do. I look forward to working with you as we rise to meet the challenges and make the most of the opportunities that lie ahead to improve the lives of our children, young people and families.

With best wishes for an interesting and rewarding 2011.

SARAH SMITH
Director, Children and Families Directorate



LEADING THE WAY FOR CHILDREN AND YOUNG PEOPLE'S CLINICAL CARE

DR KATE MCKAY,
NATIONAL CLINICAL LEAD FOR CHILDREN AND YOUNG PEOPLE'S HEALTH IN SCOTLAND

IN SCOTLAND TODAY INCREASING NUMBERS OF CHILDREN AND FAMILIES FACE WORSENING POVERTY AS A RESULT OF THE ECONOMIC RECESSION AND ITS CONSEQUENCES IN TERMS OF UNEMPLOYMENT AND DECREASED PUBLIC SPENDING. HOWEVER, THE SCALE OF POVERTY IS OFTEN NOT ACKNOWLEDGED BY CHILD HEALTH SERVICES DESPITE THE FACT THAT WE KNOW THE POVERTY-HEALTH CYCLE CAN INCREASE THE RISK OF INFANT MORTALITY, PREMATURITY, ACCIDENTS, CHRONIC ILLNESS, AND DEVELOPMENTAL AND BEHAVIOURAL MORBIDITY. I BELIEVE ALL CHILDREN IN SCOTLAND HAVE THE SAME RIGHTS TO A HEALTHY FUTURE AND LIFE OUTCOMES, IRRESPECTIVE OF SOCIAL OR CULTURAL BACKGROUND.



For those children most at risk, all child health services – across primary, secondary and tertiary care – must move from reactive service provision to being proactive and delivering evidence-based early intervention. These interventions must be multi-agency to achieve the best possible life outcomes for the most vulnerable children and families. Recent and emerging policies such as *Equally Well*, *GIRFEC*, the *Early Years Framework* and, for health, *Health for All Children and Better Health, Better Care* all focus on early years services with the aspiration of improving outcomes. The *National Delivery Plan* has invested substantially in, amongst other things, acute-based children's services to provide national, regional and local networks for low volume, highly specialist services. However, I think to get the most out of this investment we should in future link specialist service provision into *GIRFEC* and the *Early Years Framework*, especially for those with complex care needs, to identify those most at risk of social exclusion and health inequalities and support them within their own communities. This would be more cost effective and improve outcomes. In addition, for children with complex care needs more emphasis on developing good discharge planning using the *GIRFEC* assessment processes may improve outcomes for the child's educational and social future, not just their health. This is especially true if these children are at risk from child protection issues due to poor parenting skills, parental addiction and mental health problems.

So, my role as National Clinical Lead is to direct the traffic two ways: one from the clinical body in paediatrics to the Civil Service and Scottish Government (as the Adviser to the Government) and the other to drive the implementation of the Scottish Government policies within the clinical community, helping to deliver those policies in innovative and joined up ways across the children's sector workforce. No mean task! So far, I have spent time getting to know how the Civil Service works and trying to find out where I am best able to achieve success. I have met all the main strategic bodies and am working with the RCPCH and other bodies to influence our biggest limiting factor: the present workforce challenges. And all this within a period of intense financial austerity. Interesting times!

DELIVERING GENERAL SURGERY OF CHILDHOOD IN THE NORTH OF SCOTLAND

KEN MITCHELL, PROGRAMME MANAGER, NORTH OF SCOTLAND REGIONAL PLANNING GROUP

THE UNIQUE SET OF PROBLEMS ASSOCIATED WITH DELIVERY OF GENERAL SURGERY OF CHILDHOOD (GSC) IN THE NORTH OF SCOTLAND HAS BEEN PREVIOUSLY DISCUSSED HERE. SMALL VOLUME DELIVERY IN A NUMBER OF REMOTE AND RURAL SITES AND A SPECIALIST CENTRE THAT IS NOT LOCATED CLOSE TO THE CENTRE OF THE GEOGRAPHICAL AREA SUPPORTED REMAINS A REAL CHALLENGE. THERE IS, HOWEVER, A COHORT OF DEDICATED ADULT GENERAL SURGEONS WHO ARE MOTIVATED TO CONTINUE DELIVERY OF THIS SERVICE LOCALLY.

The appointment of an Aberdeen-based paediatric surgeon as part of the *National Delivery Plan* has permitted a major change in the mechanism of delivery of the service. Outreach clinics delivering GSC are now running in Inverness, Elgin, Orkney and Shetland with a frequency dependent upon need. The general approach has been to enable the local teams to keep the work they feel comfortable doing while directing referrals previously made to Aberdeen into local specialist paediatric surgery clinics. Using this model local services delivering GSC are supported and enhanced, staff are

upskilled and, most importantly, patients get a safe and secure service as close to home as possible.

In addition to delivery of GSC, the use of an outreach service enabled by the NDP process has permitted the introduction of specialist clinics in Inverness, Dundee and Elgin. By redistributing consultant sessions there is now delivery of a regional paediatric urology service in all three centres, and in Inverness and Dundee this is a combined nephrourology service in conjunction with the Scottish Paediatric Renal Urology Network – a genuinely joined up service! Orkney and Shetland have a combined specialist and GSC clinic meaning only children who need urgent assessment need to travel off the island for a specialist surgical opinion.

In addition to clinics, in Inverness and Shetland we now have regular daycare operating sessions combined with the clinic day. These may be joint operating sessions with local surgeons as required. The aim is to facilitate maintenance and development of the surgical skills and attitudes required to work with children and to engage new appointees who will take the service forward.

Throughout the process we have made a point of discussing local needs and wishes before starting clinics to ensure there is no perceived threat to the local

service. We have also tried to give each centre a consistent point of contact to facilitate communication.

Future developments may be joint operating, development of regional protocols of care and utilising the specialist service as resource for continuous professional development for both surgical and nursing staff. Educational sessions have already been delivered in several centres.

Since starting this enhanced service over a thousand children have attended a locally delivered clinic and over a hundred have had their operation as a daycare in their local hospital. The savings in travelling time, transport costs, days of school or work missed and most importantly parental stress and anxiety have been significant.

This is a model of care that is time intensive for the visiting surgeon and would not have been possible without the additional appointment. For a relatively small investment, however, we are in a position to maintain general surgery of childhood as a locally delivered service in the North of Scotland and provide a significantly enhanced locally delivered specialist paediatric surgical service.



THE SPEG MCN HAS BEEN ESTABLISHED SINCE 2009. ITS ESTABLISHMENT WAS MADE POSSIBLE THROUGH NDP FUNDING FOR MANAGEMENT AND ADMINISTRATIVE SUPPORT. THE LEAD CLINICIAN FOR THE NETWORK SINCE 2009 HAS BEEN PROFESSOR CHRIS KELNAR, RHSC EDINBURGH AND THE MANAGER HAS BEEN MARIANNE HAYWARD, MCN OFFICE RHSC GLASGOW.

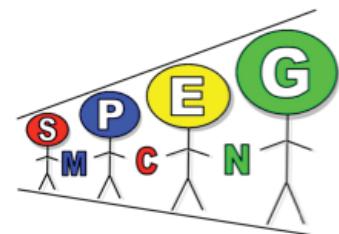
In addition to MCN organisation support, NDP funding has also allowed for the expansion of paediatric endocrine services in the West through additional dietetic and nursing staff. This has been important in developing local multi-disciplinary clinical expertise in paediatric endocrine conditions across district general hospitals in the West. There remains a challenge for dedicated time for this service in other areas in Scotland; however, the recent appointment of a nurse post in Fife has been a welcome development.

The SPEG MCN's aims are to deliver high standards of care, which is evidence-based, as locally as possible. Paediatric endocrine conditions are broad-ranging, making maintaining a clinical expertise across all clinical areas challenging. To address this paediatric endocrine teams in tertiary care centres from Edinburgh and Glasgow have provided shared care clinics in district general hospitals across Scotland for many years. As indicated above the additional NDP-funded posts have enhanced this support.

The network has completed a number of key pieces of work since its inception: sub-groups have been established to develop education, protocols and guidelines, quality indicators and patient information.

Education: The network has held several education events across the country on Growth and Maturation, Precocious Puberty and Thyroid. In addition there is an established multi-disciplinary teleconferenced meeting weekly, based in RHSC Glasgow. Metabolic, Endocrine Lectures in Yorkhill (MEDLY) have been very successful, attracting clinicians across the county to attend or video link.

SCOTTISH PAEDIATRIC ENDOCRINE GROUP MANAGED CLINICAL NETWORK (SPEG MCN)



MARIANNE HAYWARD, MCN Manager, RHSC Glasgow

Scottish Paediatric Endocrine Group Managed Clinical Network CONTINUED

In addition, the network has now established a community of practice page through the Managed Knowledge Network, where all education information is available.

Protocols and Guidelines: A key piece of work for the protocols and guidelines group was the standardisation of practice for dynamic function tests both from the biochemistry and clinical perspective. To achieve this the protocols and guidelines sub-group audited current practice from clinicians and biochemists across Scotland. The audit revealed a broad range in practice. To address this, the network has agreed standard practices and has developed a biochemistry/clinical handbook. This was launched in January 2011.

Congenital Hypothyroidism is one of the most common paediatric endocrine conditions. There are around twenty-five cases per year, identified by the new born screening programme. Time to treatment is important to avoid any mental deterioration, preferably within fourteen days. Although a pathway of care existed prior to the network, strengthening this pathway and revisiting the guidelines for CH care has led to an improvement on time to treat by one day.

Quality Indicators: The network has worked with Information Services Division to establish continuous quality indicators. These are now being implemented on Congenital Hypothyroidism patients and with patients on growth hormone, the results of which will be reported in March 2011.

Patient Information: Consultation with patients and nursing staff revealed a gap in the provision of patient information on thyroid conditions and precocious puberty as well as information for schools on adrenal insufficiency. Through the nurse group the network has developed patient information on these topics which will be launched at the end of January 2011.

These are a few of the key priorities which have been delivered by the SPEG MCN. There will be challenges with workforce planning in future years as specialists in paediatric endocrine care retire. Having the network allows for that future planning, ensuring a continued high standard of care which is evidence-based and locally provided.



THE INTRODUCTION OF A PAEDIATRIC EPILEPSY NURSE SPECIALIST (PENS) POST WITHIN NHS AYRSHIRE AND ARRAN

JOANNE PASCUAL, PENS, NHS AYRSHIRE & ARRAN

NHS AYRSHIRE & ARRAN WAS ONE OF THE FEW SCOTTISH HEALTH BOARDS WITHOUT AN EPILEPSY NURSE SPECIALIST. THIS SERVICE GAP WAS RECTIFIED WITH THE APPOINTMENT FROM YEAR 2 NDP FUNDING OF A PAEDIATRIC EPILEPSY NURSE SPECIALIST (PENS) AND, ONE YEAR ON, JOANNE PASCUAL DESCRIBES THE PROGRESS MADE SINCE HER APPOINTMENT IN RELATION TO IMPROVING SERVICES LOCALLY AND COMPLYING WITH THE SIGN GUIDELINE 81.

Services for patients

A telephone support service has been set up for families to be able to contact me for advice, support or information in relation to their child's epilepsy when they need it as opposed to having to wait until the next medical clinic appointment. This, and the associated database, has proved extremely successful as it allows the child's consultant to have ready access to data involving a call regarding a child/young person under their management. This has improved communication amongst professionals, allowing any queries and concerns from families to be dealt with more efficiently.

All families whose child has a diagnosis of epilepsy receive a letter which provides them with information regarding my role, the ways in which I can support the child and family and my contact details.

Families also receive an age-appropriate epilepsy information pack with vital information on paediatric epilepsy, i.e. seizure types, specific diagnosis (if known), specific treatment, age appropriate information (e.g. teenage information, driving, exams, employment), sport and leisure, safety issues, information for teachers and useful organisations, websites and support agencies.

To give the family the opportunity to 'get to grips' with the information discussed during the consultation and look through the information provided, they are contacted within two weeks of them receiving an information pack to discuss concerns or questions they may have. The families, of course, can contact me before this time for advice, support or information if needed. A home visit is offered at this time.

The Introduction of a PENS post within NHS Ayrshire and Arran

CONTINUED

Seizure Management Plans (SMPs) are now provided to all children and young people who attend nursery/school and are prescribed rescue medication. The SMP provides specific information about the individual's seizures and how best to manage them. SMPs are reviewed at each clinic visit (minimum annually). The introduction of SMPs has improved the standard of care delivered to children/young people who have a diagnosis of epilepsy as an accurate up-to-date plan provides parents and teachers with the confidence to manage the child/young person's seizure by themselves when possible. This minimises unnecessary hospital attendance/admissions for self-resolving seizures, thanks to successful administration of rescue medication in the community.



Staff Training and Education

Monthly in-house teaching sessions are provided to staff on different aspects on paediatric epilepsy. Teaching sessions are open to all who wish to attend. To date, paediatric staff nurses, school nurses, healthcare assistants, nursery nurses, nursing assistants, after school staff, football coaches, respite carers, pharmacists, psychologists, medical staff and education transport staff have attended.

All trained staff within the paediatric inpatient ward, assessment unit and paediatric clinics have been provided with Midazolam training sessions. These have enabled families to be provided with a more effective and efficient service as staff nurses now have the knowledge and skill needed to teach a family how to safely prepare and administer Midazolam as rescue medication when it is prescribed and not have to wait for the community nurses to provide such training at a later date.

If there are specific concerns raised by the child/family/nursery/school the nursery/school is offered an Epilepsy Education Session and is provided with a teachers' pack. The information provided within these packs specifically relates to education and learning, i.e. the child/young person's specific seizure type and epilepsy diagnosis, impact on learning, memory, exams, careers and how to manage a seizure if one were to occur in nursery/school. The education sessions and teachers' packs have proved popular and have been well received. On average I attend three nurseries/schools each month to provide training and support to education staff.

Paediatric Epilepsy Link Nurses and Epilepsy Information Folders are provided to all clinical areas throughout Ayrshire and Arran. It is anticipated that these folders, along with the introduction of PENS, will ensure that all members of staff within the paediatric wards and clinics will have direct access to up-to-date, accurate and approved information about epilepsy, thereby increasing staff insight and understanding of the condition and the numerous factors involved.

Information systems and related processes

Prior to October, 2009 there was no data available on the number of children or young people within Ayrshire and Arran who had been given a diagnosis of epilepsy. In the first year we have developed an electronic database and gathered data on almost 200 children and young people. We anticipate this figure will rise significantly as more children and young people are brought to my attention. Having an epilepsy database will enable the service to be improved in the future with services being tailored to the need of the families, e.g. clinics for teenagers, transition clinics etc.

An electronic information system involving seizure types, epilepsy syndromes, treatments, epilepsy documentation charts and reference sheets and information on the role of the PENS has been made available to all staff within Ayrshire and Arran. Having the information in this format enables ready access to such information whenever needed.

PENS from the West of Scotland are now able to work together to produce standard documentation and information on difficult aspects of epilepsy such as Sudden Unexplained Death in Epilepsy (SUDEP). Having the support and access to other PENS is vital to the success of the role within Ayrshire and Arran and provides a level of clinical governance, guidance, support and supervision that would be otherwise difficult to obtain. Without our regular monthly meetings such developments would take much longer to be finalised and then put into practice.

Links have been made between the paediatric epilepsy service, local paediatric neurology community service and respite centres throughout Ayrshire and Arran. It is important that families receive the optimum standard of care available to them therefore processes have been put in place to ensure families are provided with the same information no matter which establishment they attend and seek support from. I attend the local Neurology Specialist Centre once a month and provide training and updates to staff within the respite centres. Shared drives have been set up between these services and open communication with all the services involved is encouraged.

Future developments

It is anticipated that local Paediatric Epilepsy Clinics will be held every two months starting in March 2011 and the Paediatric Epilepsy Database will be further developed leading to research projects to improve standards and review current practice. Increased priority will be given to joint working with the Adult Epilepsy Teams to ensure that children have a smooth transition to the Adult Epilepsy Service.

The appointment of the Paediatric Epilepsy Nurse Specialist has been of benefit in that Ayrshire and Arran is now compliant with SIGN Guideline 81 in this respect. From a patient perspective, the addition of a PENS has resulted in ongoing improvements to the standard of care and in the quality of the advice, information and support which is now available to children/young people, their families and fellow health professionals in Ayrshire and Arran.

PROFILES OF THREE NDP-FUNDED CLINICIANS

A day in the life of . . .

LESLEY BLAIKIE, SENIOR CYSTIC FIBROSIS NURSE SPECIALIST, NHS HIGHLAND

Delivering care across the Highlands and Western Isles has challenges throughout the year, not only in terms of the geographical area (some 40% of the land mass of Scotland) but also in ensuring equity of service throughout the region. The *National Delivery Plan* money supports a now fully-funded multi-disciplinary team to sure quality, timely, efficient, effective, equitable, patient-centred and safe care throughout the Highlands and Western Isles. Today is my monthly trip to Lewis and Harris to review three of the patients living there. It is 6 a.m. and already I am on my way to the airport after a quick de-ice of the car!

After the short flight I arrive at the local hospital to collect the pool car and drive the one and a half hours down to visit the youngest patient (Baby A aged two months) who lives on the south eastern peninsular of Harris. New-born screening has identified eight children across Highland over the past seven years. Providing home support for families is a significant part of the role of a Cystic Fibrosis Nurse Specialist. It empowers families to work towards self-care and management of this chronic condition. This support also involves working in partnership with their local teams to provide ongoing care.



It has been agreed that during today's visit I would not only meet with the family but also go along to meet with the local GP and health visitor to discuss ongoing management of Baby A's Cystic Fibrosis. Baby A is thriving, she is weighed today and this is reassuring for the parents especially after the initial shock of the diagnosis and fear for their daughter's health and future well-being. A routine cough swab is taken for analysis, a review of her medications is carried out and dose adjustments are made according to her current weight.

The General Practitioner has never had any direct experience of the management of Cystic Fibrosis and the health visitor's last experience was a long time ago, so there was a need for an update on current practice and management. For example, population-based approaches to the management of common illness, such as a cough or a cold, are the opposite to the recommendations for the treatment of CF. The onset of a cough or a cold may be the first sign of a CF exacerbation and would require antibiotics.

Following the visit and meeting in Harris it is now time for the drive back to Lewis to visit a boy now aged three (Boy B), who has just started nursery. A protocol for the nursery has been written and the parents were emailed this prior to my visit, so any adjustments could be made to the plan prior to its implementation in the nursery. Boy B has recently been taught by the Cystic Fibrosis Physiotherapist how to do a cough swab and today he is proud to show off this new skill. A review of his medication is carried out and supplies of equipment are left for the family.

The final visit of the day is to see Girl C, a teenager, on her return home from school. Teenage years are perhaps one of the most challenging stages of childhood. Girl C had a portable, implantable venous access device fitted last year to facilitate intravenous antibiotics. Usually a local member of the healthcare team would access the port on a monthly basis but the management of this young girl has been challenging with poor relationships with healthcare team members. When arriving at the home of Girl C, it was discovered that she has been sent home from school as she had developed a cough and was feeling unwell. Hand-held spirometry revealed that her lung function was maintained at previous recordings and auscultation of her chest revealed no added sounds. As an independent nurse prescriber, with access to her most recent bacteriology results, a course of oral antibiotics was prescribed and a sputum sample was obtained for the lab. Her port was flushed and a date set for the next flush, which would be in Inverness as her annual review was due. An agreement with the Girl C and her mum was reached that, should she fail to respond to the oral antibiotic, liaison with the team would be required to establish whether a course of intravenous antibiotic may be necessary.

It is a quick dash then to return the pool car before catching the flight back to Inverness. It's now 7.30 p.m. and I arrive at Raigmore with the samples for the lab. Off home now as tomorrow we have a clinic in Inverness and an annual review to carry out in the morning.

PROFILES OF THREE NDP-FUNDED CLINICIANS CONTINUED

A day in the life of ...

JO STEWART, AN NDP-FUNDED PAEDIATRIC GI DIETITIAN, STIRLING ROYAL INFIRMARY

I start the day with a Paediatric Coeliac Clinic at the recently opened Forth Valley Royal Hospital in Larbert. The clinic has been set up to provide an annual review for children with coeliac disease. We have been aiming to provide this service for a long time and the NDP money has now enabled this clinic to be established. It has always been a priority to see those with a new diagnosis of coeliac disease within a week of referral, but we did not have any formal review service set up. As a result of the NDP funding for GI services we can now ensure that children with coeliac disease get a formal annual review by a dietitian in line with the British Society of Gastroenterology (2010) and NICE (2009) recommendations.

I then head back to Stirling Royal Infirmary for the GI team meeting which we hold every Wednesday between 1-2 p.m. The team consists of two Specialist Nurses, the Paediatrician and the Dietitian. At this meeting we discuss any new or ongoing patients. It gives us an opportunity to review

patient blood results and bring up any issues that patients may be having. Although we speak regularly on an informal basis, it is essential to have this dedicated time to ensure effective communication within the team.

In the afternoon the Specialist Nurse and I go to the Paediatric Assessment Unit to review a patient who has recently been diagnosed with Crohn's Disease. It is his half-way review on Modulen IBD. He is one of the first IBD patients we have been involved with since the NDP posts were established so we are keen to review his progress.

The patient's mum is particularly pleased that he could be seen at Stirling Royal Infirmary as it is so close to home and school. His mum comments: "The best thing about having a local service is that there is much less interference with family life as the hospital is only 10 minutes away. It also feels more normal to be seen at your local hospital, which is psychologically better for your child."

Although we have reviewed some of the IBD patients and used Modulen in the past, it is great to now have the back up of the Specialist GI team at RSCH, Yorkhill to discuss individual cases and seek advice. Part of the NDP funding is for the team at Yorkhill to provide training and support, and to attend four joint GI clinics a year in Forth Valley. I have gained a lot of experience from this already and it is great to have the opportunity to focus on gaining new knowledge and skills in a specialist area of dietetics.



A day in the life of . . .

DOROTHY CAMPBELL, CHILDREN AND YOUNG PEOPLE'S COMPLEX RESPIRATORY CARE NURSE, AYRSHIRE AND ARRAN

8.30 On my way to work I collect a saturation monitor from a patient's home. On arrival at my base, I download the monitor, check my e-mails and mail. I then review any children who are ward inpatients who have respiratory issues and meet with the consultant to discuss any patients where there are concerns.

09:30 -11:00 I undertake a home visit to a child who is oxygen dependent to monitor and assess their condition. The advantage of seeing children and young people within their home is that they are more relaxed in their own surroundings. For example, if a child has badly controlled asthma I can spend more time going over important points with them such as problems with their technique with inhaled medication. This is often the most common reason for poorly controlled asthma in children.



11:00 -12:30 I have a meeting with staff from a local nursery to discuss a child with complex respiratory needs who will be starting nursery very soon. An important and key element of my role is working with carers, nursery staff, school staff and any other staff or organisations who require training to enable the child to lead a full and active life in educational and other community settings.

12:30 -13:00 Lunch and informal catch up with colleagues.

13:00-13:30 I liaise with Yorkhill Hospital staff regarding a child's care plan to ensure, for example, that a complex respiratory appointment is not booked at Yorkhill Hospital one day and another similar appointment in Crosshouse Hospital the next day. This ensures that the child or young person's journey is smooth, coordinated and as close to home as possible.

13:30 -15:00 A further home visit to a child who has been discharged home on oxygen therapy. I monitor children closely at home and then report back to the relevant consultant, which avoids the child being admitted to hospital for oxygen monitoring. Care is also coordinated for children

A key rationale for NDP funding is the ability to provide specialist care closer to the patient's home, thereby reducing disruption to the life of the child and family as much as possible. Dorothy Campbell was appointed last year to the NDP-funded post of Children and Young People's Complex Respiratory Care Nurse for NHS Ayrshire and Arran.

who require long-term ventilation. Any investigation that can be safely carried out at home is done at home, saving the child and family unnecessary admissions to hospital. I also advise and liaise with health visitors and school nurses to ensure coordinated care.

15:00-15:30 I write up patients' notes, follow up calls and review tomorrow's work load.

15:30 – A home visit to a child with poorly controlled asthma (after school to ensure less disruption to the child's life and education). Then it is time to go home.

Expert nursing care delivered at home or close to home improves and enhances the experience and quality of life of children, young people and their families. By joint working and shared care with the specialist professionals in tertiary centres local teams can provide specialist respiratory care and treatment confidently and competently, supported by training and guidance from the Managed Clinical Network.

THE OTHER WAY: education to support AHPs in paediatric services

JANE REID AND PAULINE BEIRNE,
EDUCATION PROJECTS MANAGERS (AHPs), NHS EDUCATION SCOTLAND

NATIONAL DELIVERY PLAN MONIES FUNDED THE APPOINTMENT OF 1.0wte AHP EDUCATION PROJECTS MANAGER (EPM) FROM APRIL 2009 UNTIL DECEMBER 2010 TO DEVELOP A RANGE OF EDUCATIONAL SUPPORT FOR PAEDIATRIC AHPs.



Jane Reid (left) Pauline Beirne (right)

AHP CYP Educational Network

The network was launched in October 2009 and brought together for the first time AHP practitioners working with children and young people (CYP). This significant stakeholder event generated several work streams and focused on the educational and training needs of CYP AHPs, thus acting as a foundation for the EPM work streams. In addition to the event a virtual network has been established within the Managed Knowledge Network (MKN) and can be accessed via <http://www.knowledge.scot.nhs.uk/child-services/communities-of-practice/ahp-cyp-network.aspx>. Stakeholder feedback has been hugely positive and it would appear that it is filling a significant gap for AHPs for informal support and accessible information regarding educational opportunities. It is envisaged that, in time, the MKN will be used to provide "virtual mentoring". In order to keep the momentum going and the inter-professional collaboration it has been recommended that an annual event is held and monies are currently being sought to support this.

The Children's Chapter

With the increasing emphasis on the vital role of AHPs in ensuring effective and efficient care for children and young people and their families, it is imperative that AHPs have access to education that will facilitate a career pathway within CYP services.

In collaboration with an expert advisory stakeholder group, an educational framework has been developed by the NES child health team. *The Children's Chapter* was launched at the second AHP CYP Network event in Edinburgh on 1 October 2010.

This framework provides educational guidance and support to clinicians, managers and planners working within CYP Services and sets the strategic overview and educational objectives. The framework is underpinned by signposting to current and future educational resources. Individuals can access these via the AHP Community of Practice on the CYP Services

Managed Knowledge Network <http://www.knowledge.scot.nhs.uk/child-services/communities-of-practice/ahp-cyp-network/the-children's-chapter.aspx>

The framework's core element applies to all AHPs and enables individuals to recognise where they are competent, where they have learning needs and which elements are specialist or profession-specific. It also provides guidance to enable education providers to plan or develop current or future educational materials.

The Children's Chapter is a welcome and long overdue document. It provides clear educational direction for AHPs and support workers, and also for service managers when planning development and identifying learning needs of their staff. Underpinned by the principles of *Getting it Right for Every Child*, it ensures the developmental direction undertaken by the practitioner has the child and young person's needs at its core.

A 'Virtual' Solution to Core AHP Paediatric Education

A key component of *The Children's Chapter* is the need for core paediatric education for AHPs. A stakeholder consultation recognised the need for a core learning resource that could be included at induction for AHPs new to CYP services and indeed for students on a practice placement. The small numbers and geographical distribution of clinicians make the delivery of inter-professional learning challenging and the vulnerability of the patient group is problematic in delivering relevant learning opportunities. NES and the Physiotherapy Division at University of Nottingham entered into a collaborative venture to identify whether a contextualised, reusable e-tool (ReTool) developed for undergraduate physiotherapy education in paediatrics could be adapted for use as part of a 'virtual' paediatric induction programme for multi-professional AHPs.

Educational approaches for AHPs need to stimulate problem-solving skills essential to professional practice. AHPs entering practice in paediatrics seldom have the opportunity to develop problem-solving skills at an undergraduate

level. Therefore, at induction, AHPs require opportunities to consider their knowledge and experience with respect to current practice and policies.

The ReTool utilises a series of virtual case studies with embedded multimedia. Four separate learning tasks are delivered at weekly intervals to stimulate clinical reasoning and problem-solving in small group discussion. It was evaluated very highly by physiotherapy students for problem-solving and clinical reasoning skills. It was proposed that it would also do the same for AHPs new to paediatrics and become an integral part of the educational framework for AHP paediatric induction in Scotland. Twelve AHPs were recruited including physiotherapists, occupational therapists, speech and language therapists and dietitians from a variety of clinical settings across Scotland. The ReTool was delivered to the AHPs in their individual environments across the regional Scottish Health Boards.

Evaluation showed overall usability of ReTool to be generally positive and participants confirmed that it met the intended aims of the pilot, namely to:

- Develop knowledge and understanding of a specific paediatric pathology
- Develop clinically provoked problem-solving skills and confidence
- Develop clinical reasoning in regard to the management of a paediatric condition
- Gain knowledge about professionals and facilitate inter-professional learning



THE OTHER WAY: education to support AHPs in paediatric services

CONTINUED



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Any negative findings were related to inability to access the resource due to the NHS firewall at work and the need to contextualise some of the resources to meet policy requirements within NHSScotland.

It has been recommended that ReTool is incorporated into the induction component of the education framework for AHPs working with children and young people. Negotiations are currently in progress to purchase the licence, and the necessary amendments to meet the needs of AHPs working in NHSScotland will be completed by March 2011 with a view to roll-out three times a year from April 2011. The ReTool will support individuals to meet the standards set out in the Knowledge and Skills Framework as well as *Getting it Right for Every Child* and the *Quality Ambitions*.

Paediatric Advanced Practice

The Scottish Government's Advanced Practice Succession Planning Toolkit was modified to apply to the CYP workforce of both nurses and AHPs. NHS Boards have received funding from NES and to date three cohorts (fifteen AHPs) have commenced the Paediatric Advanced Practice Succession Planning Development Pathway.

To secure long-term sustainability, NES supported the development of three new paediatric advanced practice modules at Scottish Credit and Qualification Framework (SCQF) Level 11 (Masters).

- Pathophysiology for Advanced Child Health Practitioners (*Edinburgh Napier University*)
- Advanced Paediatric Practice for AHPs and Nurses (*Queen Margaret University*)
- Advanced Paediatric Decision Making (*University of the West of Scotland*)

Funds accessed via NDP have enabled thirty-five AHPs to date to access one or two of the above modules. Additionally, the advanced practitioners have access to their own virtual network on the MKN at <http://www.knowledge.scot.nhs.uk/child-services/communities-of-practice/scottish-paediatric-advanced-practice-network.aspx>

Health Care and Social Work AHP (CYP) Education

A pilot by Robert Gordon's University of an educational resource at levels 7 and 8 for support workers across health education and social care in early years has also included the involvement of AHP support workers in a variety of practice settings working with children and young people.

The importance of the availability of this paediatric specific learning for support workers in AHP services has been recognised by AHP managers and leads across Scotland and there is significant support for the ongoing availability of this education for AHP Health Care and Social Work.

Summary

The investment of NDP funds has made a significant difference to supporting the education of AHPs working in CYP services. However, these building blocks are only the start. The response from the AHP CYP practitioner community to the work of the Education Project Managers (EPM) has been consistently and overwhelmingly positive. The impact of the work undertaken in the EPM role has had a profound effect on this group of practitioners. The end of this secondment will undoubtedly represent a significant gap for educational support. Further investment is seen as an essential need for paediatric AHPs.

For further information please contact pauline.beirne@nes.scot.nhs.uk

BUILDING CAPACITY IN CHILD AND ADOLESCENT MENTAL HEALTH

THOMAS HOGG, POLICY MANAGER, SCOTTISH GOVERNMENT
PRIMARY AND COMMUNITY CARE DIRECTORATE

IN THE AUTUMN OF 2000, THE THEN SCOTTISH EXECUTIVE COMMISSIONED A NEEDS ASSESSMENT OF THE MENTAL HEALTH OF SCOTLAND'S CHILDREN AND YOUNG PEOPLE. THE RESULTING SCOTTISH NEEDS ASSESSMENT PROGRAMME (SNAP) REPORT ON CHILD AND ADOLESCENT MENTAL HEALTH WAS PUBLISHED IN 2003.

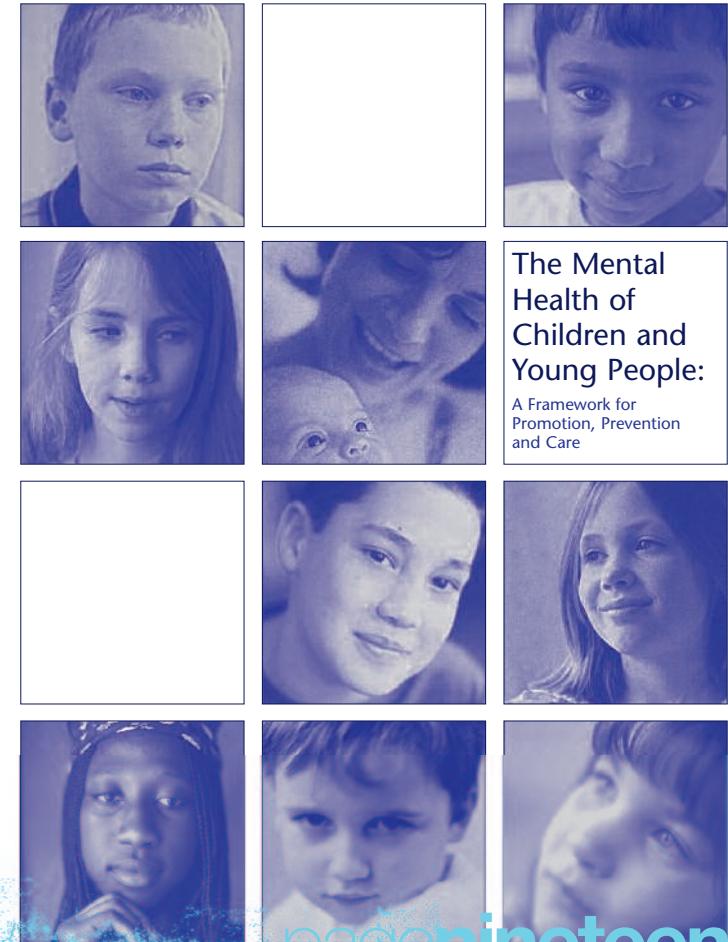
The report made ten broad recommendations, some of which had implications at a national level, some for local strategic planning and others for local practice. The report also stated that about 10% of children and young people 'have mental health problems which are so substantial that they had difficulties with their thoughts, their feelings, their behaviour, their learning, their relationships, on a day to day basis'.

In 2005 as a follow on from this report the Scottish Executive produced the *Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care* with a view to implementation by 2015. The main themes of the document were to promote equity of access throughout Scotland to services designed to ensure that the right care and treatment is available at the right place and at the right time. The 2005 Framework is founded on the idea that promoting and sustaining good mental health should be an underpinning principle for all who come into contact with children and young people. It also sets out an integrated and holistic approach to healthcare in all settings, including non-health settings, such as schools. Awareness of child and adolescent mental health in schools has been improved by, amongst other things, a Scottish Government commitment encouraging the establishment of explicit links between schools and child and adolescent mental health (CAMH) specialists as well as the development of a web-based toolkit (<http://www.handsontscotland.co.uk>) aimed at improving the confidence of teachers and others in responding to the mental health needs of children.

Our work with NHS Boards and their partners in implementing the framework highlighted a need for further expansion of the workforce capacity and we have begun to address this. We are allocating £6.5 million over three years to increase the number of psychologists working in specialist CAMHS, with £1 million having been allocated in 2009-10, £2 million being allocated in 2010-11 and £3.5 million being allocated in 2011-12. We are also making available £2 million, £1 million of which comes from NDP funding, each year to help NHS services enhance intensive community services (Tiers 3 and 4) and to help reduce the need for children and young people to be admitted to hospital. This investment will also support our referral to treatment waiting time target for specialist CAMHS, which means by March 2013 no one will wait longer than 26 weeks from referral to treatment.

This commitment to central government funding for NHS CAMHS workforce development is starting to be reflected in workforce growth of the specialist CAMHS workforce. The workforce has grown by 25% since September 2008.

We are aware that we have much more to do on CAMHS, but with the current focus on building capacity through broad policy implementation (main themes of integration, mainstreaming of mental health and a child-centred *GIRFEC* approach) along with other initiatives such as the development of benchmarking and performance measures (which will see a CAMHS balanced scorecard being used from early 2011 by NHS Boards), we will be able to deliver services which meet all our expectations for children and young people.



INTENSIVE TREATMENT SERVICES:

Supporting young people with mental health problems at home instead of in hospital

DAN ISAAC, REGIONAL CHILD AND ADOLESCENT HEALTH SERVICES
PROJECT MANAGER, SOUTH EAST AND TAYSIDE REGIONAL PLANNING GROUP

IN 2009/10, SCOTTISH GOVERNMENT FUNDING WAS MADE AVAILABLE TO DEVELOP SPECIALIST CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS) IN SCOTLAND. FOLLOWING A SUCCESSFUL PROPOSAL SUBMITTED ON BEHALF OF SEAT, NHS BORDERS, NHS FIFE AND NHS LoTHIAN RECEIVED RECURRENT FUNDING (PARTLY FROM NDM MONIES AND ON CONDITION THAT IT BE MATCH-FUNDED BY BOARDS) TO DEVELOP A MODEL OF CARE AS AN ALTERNATIVE TO INCREASING THE NUMBER OF INPATIENT BEDS IN THE ADOLESCENT INPATIENT UNIT (IPU) IN EDINBURGH.

The regional model established an Intensive Treatment Service (ITS) in Lothian and expanded existing services in Fife and Borders. Each ITS provides flexible, rapidly responsive community services for young people with a range of issues or mental health problems, including depression, eating disorders, psychosis, autistic spectrum disorders and suicidal or self-harming behaviours.

In NHS Borders, two nurses have been recruited to share responsibility with other CAMHS staff, to provide intensive treatment interventions alongside a generic caseload. NHS Fife appointments have included two nurse consultants, an occupational therapist and a clinical psychologist. Lee Cowie, Nurse Consultant (Acute Services) says: “*Additional staffing has allowed the service to expand its age range to 8-18 years and to offer this level of provision beyond the boundaries of diagnosis to young people who are significantly affected by mental health issues or who have complex presenting difficulties and may have previously fallen between services.*”

The new ITS in Lothian comprises a senior charge nurse, five community psychiatric nurses, a clinical psychologist, a psychiatrist, an occupational therapist and a dietitian. Gavin Cullen, Senior Charge Nurse, explains: “*The job of the service is to prevent a mental health crisis developing or, where it has occurred, to help the patient recover using the psychological, social and medical supports the multi-disciplinary team can offer. The ITS has already proved successful in supporting youngsters at home rather than in hospital.*”

As well as new investment, redesign work in the IPU has included redefining formulation and care planning meetings and improving links with referrers. In addition, a Regional CAMHS Consortium has been meeting every two months since June 2010 to drive the regional work. As Gilly Waite, CAMHS Manager, NHS Borders, explains: “*The Consortium brings together about a dozen CAMHS staff from across the region to work to improve processes and communication. This interaction has been invaluable in developing a regional approach to improving specialist CAMHS.*”

Although it's early days, indications are that the ITS model is having a positive impact by:

- freeing up capacity in the IPU, which, in turn, has reduced the need to admit young people to adult beds;
- reducing IPU lengths of stay (average length of stay in 2010 was 46 days compared to 109 days in 2008);
- providing the catalyst for refining processes and improving communication between CAMHS teams across the region.

Work is progressing to measure patient outcomes and ask young people what they think about services, which may provide the most valuable endorsement of all.



DELIVERING PAEDIATRIC SERVICES IN REMOTE AND RURAL AREAS

KEN MITCHELL, PROGRAMME MANAGER, NORTH OF SCOTLAND REGIONAL PLANNING GROUP

CHILDREN AND YOUNG PEOPLE IN SCOTLAND, REGARDLESS OF WHERE THEY LIVE, REQUIRE THE SAME ACCESS TO HEALTHCARE. THIS CAN BE CHALLENGING IN REMOTE AND RURAL COMMUNITIES, WITH MANY FAMILIES HAVING TO TRAVEL SIGNIFICANT DISTANCES TO ACCESS SPECIALIST SERVICES. THE *NATIONAL DELIVERY PLAN* RECOGNISED THAT THE DELIVERY OF SUSTAINABLE SERVICES IN REMOTE AND RURAL AREAS FOR CHILDREN WAS CRUCIAL AND NEEDED TO BE PROGRESSED IN PARTNERSHIP. TO ADDRESS THIS THE REMOTE AND RURAL IMPLEMENTATION GROUP (RRIG) WAS ESTABLISHED.

More than one in five Scots lives in a remote or rural area, with some parts of Scotland being significantly more remote than others. Each of the regional planning groups has some remote areas, although the majority are in the North. As part of the NDP process, each of the regional planning groups has sought to improve services within their own area through the three-year investment programme. They have also worked with RRIG to support the implementation of *Delivering for Remote and Rural Healthcare*¹.

RRIG has overseen the development of the implementation programme and has identified a number of actions where work is ongoing and a number of recommendations for the future to be delivered by NHS Boards. These include:

- The need for a safe system of emergency care, including decision-making support for acute requirements;
- The continued requirement for children's services to be established as Obligate Networks.

¹ (2008) "Delivering for Remote and Rural Healthcare" May 2008, Scottish Government, Edinburgh.

North of Scotland NDP Investment

Across the three-year investment programme, the North of Scotland has started to address the needs of remote and rural communities through the development of a number of networks which have gone beyond the traditional Managed Clinical Networks to provide a range of outreach services. A key aspect of these is building capacity among local staff which includes education and peer support.

These developments have focused on progressing the development of networks in neurology, gastroenterology, respiratory and general surgery of childhood. The networks have developed a range of services to support the provision of care in remote and rural settings. Examples include:

Neurology Network

NHS Orkney & NHS Shetland Outreach clinics have been established and supplemented by telemedicine links for both Orkney and Shetland. Not only will there be fewer requirements for children and their families to travel to the mainland, but this will also allow for improvements in quality of care through the links that the network provides.

West Morayshire A tertiary consultant is supporting paediatricians in Elgin to provide joint epilepsy clinics; this has significantly reduced travel time for families.



Gastroenterology Network

Telemedicine The *National Delivery Plan* has allowed investments in generic videoconferencing services. Linking in with the already well-established videoconferencing facilities in remote and rural areas of Highland and within the North Isles, this has allowed video consultations to be carried out for children in Orkney, Shetland and Western Isles. Videoconferencing also plays a critical role in supporting the educational needs of staff and is being used for teaching, peer support and meetings by medical, dietetic, nursing and psychology staff.

Respiratory Network

NDP investment has allowed NHS Tayside to appoint a consultant in Paediatric Respiratory Medicine. This NDP funded appointment has helped the creation of a regional respiratory network between Tayside Children's Hospital, Dundee, the Royal Aberdeen Children's Hospital, Aberdeen and Raigmore Hospital in Inverness. This has led to CF and specialist respiratory clinics with joint working between visiting respiratory consultants and local paediatricians in Inverness being progressed on a quarterly basis.

These clinics have enabled the review of patients from areas remote to Inverness including the Islands and Caithness and provided an educational component for Raigmore staff.

General Surgery Network

The network to deliver general surgery of childhood and specialist paediatric surgery to the North of Scotland is working effectively.

Outreach clinics have been established in Inverness and Elgin monthly. In Inverness the service has started operating sessions and there is a plan for joint operating sessions with a local adult general surgeon who has taken on the paediatric lead.

Shetland Specialist Paediatric Surgery Clinics are taking place three times per year. Plans are also being progressed regarding the provision of joint operating, for CPD purposes. Work is also ongoing to enhance nursing and anaesthetic CPD arrangements to develop skills and confidence in providing additional services.

Scottish Centre for Telehealth (SCT)

SCT has ensured that there has been significant investment in telehealth infrastructure as part of the NDP investment. There are particular challenges in providing unscheduled paediatric care and a system built around critical decision-making support within rural general hospitals, particularly as most do not have the benefit of locally-based paediatricians or paediatric nurses.

Providing healthcare in remote and rural areas is a challenge, but through NDP investment and the Remote and Rural Implementation Group, solutions are being found to ensure that children, young people and families have access to specialist children's services.

USING PARENTS' AND CHILDREN'S EXPERIENCE TO EVALUATE OUR NEUROLOGY NETWORK

NOELLE O'NEILL,
PUBLIC HEALTH SCIENTIST, NHS HIGHLAND

TO QUOTE WALT DISNEY, "*OUR GREATEST NATURAL RESOURCE IS THE MINDS OF CHILDREN*". UTILISING THIS RESOURCE AND CAPTURING A CHILD'S VIEW ALLOWS A PICTURE TO BE PAINTED OF HOW SPECIALIST SERVICES REALLY ARE FOR CHILDREN AND THEIR FAMILIES AND IF THEY SEE THE SERVICE CHANGING OVER TIME. IT PROVIDES THE OPPORTUNITY TO BUILD A TRULY CHILD-CENTRED PLATFORM ON WHICH TO INTELLIGENTLY INFORM THE FUTURE DEVELOPMENT OF CHILDREN AND YOUNG PEOPLE'S SPECIALIST SERVICES ACROSS THE NORTH OF SCOTLAND.

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Recognising this opportunity, the North and East Scotland Child & Adolescent Neurology Network (NESCANN) is in the process of developing a pragmatic, qualitative methodology which will support clinical staff to gain a unique insight into service delivery through the eyes and ears of those potentially most impacted by changing times and changing services, i.e. the children, young people and families who are cared for by NESCANN.

The methodology is being developed by NESCANN for NESCANN. Taking account of the particular patient population of interest and bearing in mind that paediatric neurological conditions are often complex and chronic by nature, an informal discussion/patient story-type approach is considered to be the most appropriate, realistic and achievable method of

capturing their views and sharing their experience of, and aspirations for, the service. Familiarity with, and having trust and confidence in, clinical staff members were considered to be essential elements of this approach and as such those working with children and their families on a day-to-day basis, for example Epilepsy Liaison Nurses, will undertake this project. This type of approach will aim to encourage engagement and participation. Guidance is being developed to support staff in the process and will include an introductory letter to share with children and families which will provide brief details of the project and an interview template to assist staff members with this qualitative, open-question approach. Further information on this approach can be obtained from Noelle O'Neill at noelle.oneill@nhs.net

Linked to this regional piece of work is the “Epilepsy 12” UK national audit. This audit is beginning in 2011 and it will provide a “snapshot” of a year of clinical care of almost every child with newly-diagnosed epilepsy in the UK. The North of Scotland is one of three “early adopter sites” for this audit. Part of the “Epilepsy 12” audit involves a questionnaire enquiring about the parents’ and children’s experience of their epilepsy service. This questionnaire has been developed and piloted in NESCAN working with colleagues in the University of Dundee and will be rolled out across the whole of the UK. Further information on this audit can be found on: <http://www.rcpch.ac.uk/Research/ce/Clinical-Audit/National-Epilepsy-Audit>.

TO REITERATE LORD DARZI'S VIEW:

"IF QUALITY IS TO BE AT THE HEART OF EVERYTHING WE DO, IT MUST BE UNDERSTOOD FROM THE PERSPECTIVE OF THE PATIENT"² .

² Darzi A. *High Quality Care for All: NHS Next Stage Review—Final Report*. Department of Health London (2008) http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085828.pdf



INTEGRATED CANCER CARE: The benefits of pharmacy and nursing investment for all-round patient care in Grampian

JENNY MOSLEY, PAEDIATRIC PHARMACIST, ROYAL ABERDEEN CHILDREN'S HOSPITAL

THE APPOINTMENTS OF NURSING AND PHARMACY STAFF TO NDP POSTS IN ABERDEEN HAS HAD A POSITIVE INFLUENCE ON THE SUSTAINABILITY OF CURRENT PAEDIATRIC ONCOLOGY SERVICES IN GRAMPIAN. TAKING FORWARD THE AIMS OF THE NDP, THE FOCUS HAS BEEN ON MAINTAINING AND IMPROVING THE PROVISION OF SAFE, HIGH QUALITY, PATIENT-CENTRED SERVICES WITHIN THE ONCOLOGY DEPARTMENT.

There is now specialist nurse cover five days a week expanding on the previous four-day service, and the addition of a second, part-time, pharmacist has provided cover for the existing pharmacist and allowed some service developments.

A pharmacist attends the multi-disciplinary team weekly meetings and the daily morning ward rounds, where a lot of decisions regarding patient treatments are made. The implementation of pharmacy care plans for all haematology/oncology patients has improved consistency in prescribing for patients at each cycle of chemotherapy and acts as an efficient communication tool to ensure staff are aware of any changes to patient treatments.

The increased pharmacy service has increased the opportunity for counselling of patients on their medicines and gives families more opportunities to ask medicine-related questions. Improved medication information and dosing sheets have been produced to allow improved compliance and increased safety. The nurses have set up an information stand at clinic which has been welcomed by patients and parents.



"I THINK THAT THE INFORMATION STAND IS A REALLY GOOD INITIATIVE. THERE IS ALWAYS SOMETHING NEW THERE TO READ AND IT ENCOURAGED ME TO ASK THE DOCTORS QUESTIONS AT THE CLINIC. IT IS PARTICULARLY GOOD FOR TEENAGERS WHO ARE TOO EMBARRASSED TO ASK THE QUESTIONS. ALL IN ALL VERY INFORMATIVE."

[quote from parent]

Increased communication with nurses following patient home visits has identified patients struggling to comply with medications and has allowed us to introduce measures to help these patients.

Increased pharmacist support has contributed to the release of more chemotherapy protocols on the electronic prescribing system, which allows safer management of patients throughout their chemotherapy. Prescriptions for all of our current patients are managed and authorised through this system.

To improve safety on the wards a formal system of written and practical training has been introduced involving the specialist nurses and pharmacists to ensure that ward nurses involved in the administration of chemotherapy regularly demonstrate competence in this area.

With more specialist nursing cover, extra patient home visits can be provided. The aim is to make the visits flexible to suit the patient and their family.

Building on the system that was already in place, the nurses are able to provide extra support in schools and nurseries so that the children and young people can get to school as often as possible in whatever form that may take. The negative and devastating impact of cancer treatment on family life and that of the siblings is well documented and all of this is aimed at reducing that impact and giving the family the chance of as much normality as possible.

These improvements in service delivery allow Aberdeen to continue to play a major role in the national network for delivery of care to children with cancer in Grampian and the Islands. The delivery of as much care as possible close to home is in keeping with the plans of the Scottish Government.



The Scottish
Government

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APS Group Scotland
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www.specialchildrensservices.scot.nhs.uk/