NSF for children and young people in Wales

The National Service Framework (NSF) for children, young people, and maternity services in England has recently been published by the Department of Health. On 15 October the equivalent Welsh consultation document was launched by the Minister for Health and Social Services at the Welsh Assembly Government, Mrs Jane Hutt; the consultation document of the Welsh NSF differs from the English NSF in a number of ways.

First, the Welsh document has set standards not just for health and social care but also for the other agencies which have a strong influence on the health and wellbeing of children, such as education, housing, leisure, and transport. The document has been endorsed in a foreword signed by the First Minister, Rhodri Morgan, and all members of the Cabinet of the Welsh Assembly Government.

A second difference from the English NSF is that the Welsh document is written with 21 standards and 205 “key actions”, each of which is specific, written in the present tense, and can be measured. The third difference is that a web based self-assessment audit tool is being developed for use by all the agencies who will be involved in implementing the NSF in order to assess progress locally (in the 22 local government authorities throughout Wales). This measurement should prove invaluable in helping to determine local priorities for future service development.

As part of the process, the Welsh Assembly Government commissioned an extensive series of consultation events with children and other stakeholders, parents, and carers at a variety of venues around Wales, as well as through questionnaires sent out to schools. The final reports of these consultation exercises are available to view or download from the NSF website; the development of the key actions within the document have been driven by the results of these consultation exercises to ensure that children and their families have been placed at the heart of all service planning.

There is now a three month consultation period when we hope that all will have an opportunity to read and then comment on the draft document. The document is being made available on the website, but also has three different hard copy versions: a full version, including references (158 pages long); a shorter version containing the key actions (93 pages); and a young person’s version, including references (158 pages + 2 weeks) The following

The coordination of local services is the responsibility of Children and Young People’s Framework Partnerships which are partnership organisations made up of local authorities, health services, other statutory bodies such as the police, and voluntary organisations. Each partnership in Wales must involve children, young people, and families in preparing a framework plan which sets out the strategic priorities for services.

The key actions within the NSF will only be as good as our ability to implement them. We cannot know if we are being successful in our implementation unless we measure the extent to which they are being delivered, and the challenge has been to develop a methodology for measuring success that is compatible with the performance management framework already in existence. To try to meet this requirement, a web based self-assessment audit tool is being developed for publication at the same time as the final standards in the summer of 2005, which we hope will enable local measurement of progress in achieving the key actions. In addition, the standards and key actions will be subject to inspection processes by Health Inspectorate Wales (HIW) (working in conjunction with the Healthcare Commission), and we anticipate that there will be joint inspections carried out in Wales between HIW, Social Services Inspectorate Wales, Care Standards Inspectorate Wales, and the Inspectorate for Education and Training in Wales (ESTYWN).

It is clear that the profile of the children’s and young people health and wellbeing is higher than it ever has been on the political and planning agenda, in both England and Wales. We can learn from each other and we, in Wales, would be grateful to receive comments from all parts of the UK on our Welsh NSF, as part of the consultation process, before the final document is published in summer 2005. Please access the website www.wales.nhs.uk/nsf and let us have your comments.

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Risk of life threatening apnoea after immunisation

It is common practice in the UK to immunise babies with DTP (diphtheria, pertussis, tetanus), Hib (haemophilus influenza type b), meningitis C, and polio at 8 weeks following delivery, regardless of corrected gestational age. However, such recommendations may be inappropriate for premature babies who may be at increased risk of apnoea and bradycardia.²

Twenty seven week gestation twins underwent their first immunisations at 62 days of age (corrected age 46+2 weeks) The following morning (15–16 hours later) both twins went a pale, dusky colour and had a respiratory arrest requiring bag and mask ventilation with severe bradycardia. On examination both twins were bursting for air, tachycardia, and pyrexia. Intravenous antibiotics were started but stopped 48 hours later when full septic screens, viral cultures, and a nasopharyngeal aspirate returned negative. Cardiac and oxygen saturation monitoring showed several further episodes of desaturations, requiring facial oxygen and gentle stimulation. A full recovery to normal self-ventilation in air followed over four hours. Both babies remained pale, active, and with no respiratory distress despite elevated C reactive protein (twin 1: 27 mg/l; twin 2: 38 mg/l; normal <10 mg/l) and raised platelets in twin 1 (420×10⁹/l; normal 150–400). The reactions were reported to the UK Adverse Drug Reactions reporting scheme.

Four weeks later the second immunisation sets using acellular pertussis were administered while cardiorespiratory and oxygen monitoring was performed. Neither twin had any reaction to the second course of immunisations. Current evidence points to an increase in episodes of apnoea and bradycardia in preterm infants receiving their eight week immunisation,³ and the unit has decided to review its policy on the monitoring of such infants.

The episodes of apnoea and bradycardia in the twins following their immunisations were highly suggestive of a delayed type hypersensitivity reaction to a component of one of the vaccines. Studies have implicated the whole cell pertussis component of DTP with significantly more reactions and raised C reactive protein after immunisation with DTP than after separate diphtheria, Hib, and tetanus toxoid vaccines alone.⁴

Current opinion for immunisation of preterm infants suggests cardiorespiratory monitoring for up to 48 hours post-immunisation rather than postponement of immunisation;³ however, recommendations for future immunisations in infants who have had an episode of apnoea or bradycardia are unclear. Many suggest immunisation with acellular pertussis, as inpatients with 48 hour monitoring. However, the evidence from one Australian study implies that the risk of future reaction is very low.⁵

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Competing interests: none declared

References


3 Johnson CP, Fildes BG. Adverse events following pertussis and rubella vaccines. JAMA 1992;267:392–6.
Addressing child welfare concerns: a new approach

In a small proportion of childhood hospital attendances there are obvious child protection issues. In a much greater number there is concern about the child's welfare. Only if concerns are recognised, documented, and addressed at an earlier stage, can we hope to improve “safeguarding” children.

In Peterborough District Hospital a “Concern Sheet” has been in use since 1998 to address child protection concerns throughout the Trust. Use of the Concern Sheet has been mandatory two times. Despite this, many failures of documentation, reporting, and follow up were identified. To address these problems, a joint hospital/community “Children’s Liaison and Discharge Coordinator” was appointed in October 2002. She is a registered children’s nurse, with child protection experience.

Our aim was to see if these two measures improved identification, documentation, and follow up of child protection concerns. We prospectively analysed the Concern Sheet data collected for 2003 and noted a striking increase in child protection awareness in every hospital department where children are seen. The Coordinator has been very active in raising the profile of child welfare concerns, not just overt abuse, with all staff.

Table 2 shows the causes of concern for different age groups. It is interesting that 25% of reported concerns were about parents and their ability to care for their children. There is a potential risk to children cared for by adults with mental health problems, those who abuse drugs/alcohol, or when there are concerns regarding domestic violence. Hall has stressed that healthcare professionals must take the opportunity to prevent child abuse/neglect when faced with such situations.

We believed that we were addressing concerns which were less serious at an earlier stage, but it is noteworthy only 47 (9.6%) required no further action. Nearly half (230, 46.9%) of the concerns were serious enough to warrant a discussion with Social Services. The Coordinator liaised with health visitors in 229 (46.7%), school nurses in 214 (43.3%). Child and Adolescent Mental Health Services in 29 (5.9%), and police in 40 (8.2%) of the cases where Concern Sheets were completed.

Forty two children (18.2%) proceeded to an Initial Child Protection Conference, 14 (6%) had an early Review Conference, and 2 (0.8%) had an early Transfer-in Conference as a result of the concern reports. Of those subjected to an Initial Conference, 36 (86%) were registered.

From past enquiries into child deaths, the common reasons which have led to a failure to intervene early enough are poor training, documentation, information sharing, and follow up of concerns. Lord Laming has emphasised the importance of better training and introducing systems which allow quality monitoring. We have attempted to address these issues and conclude that “safeguarding children” may be improved by:

- Having a person other than the named and designated professionals in the role of a Coordinator
- Having a uniform way of recording child welfare concerns throughout a Trust.

Table 1

<table>
<thead>
<tr>
<th>Area</th>
<th>2002 (n = 153)</th>
<th>2003 (n = 490)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediatric assessment unit</td>
<td>68 (44.4%)</td>
<td>105 (21.4%)</td>
</tr>
<tr>
<td>Paediatric ward</td>
<td>43 (28.1%)</td>
<td>73 (14.8%)</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>32 (20.9%)</td>
<td>244 (49.7%)</td>
</tr>
<tr>
<td>Special care baby unit</td>
<td>3 (1.9%)</td>
<td>19 (3.8%)</td>
</tr>
<tr>
<td>Children’s outpatients</td>
<td>3 (1.9%)</td>
<td>11 (2.2%)</td>
</tr>
<tr>
<td>Community child health</td>
<td>0</td>
<td>5 (1.0%)</td>
</tr>
<tr>
<td>Maternity unit</td>
<td>0</td>
<td>15 (3.1%)</td>
</tr>
<tr>
<td>Others*</td>
<td>4 (2.6%)</td>
<td>18 (3.6%)</td>
</tr>
</tbody>
</table>

*As awareness increased, concerns were also received from surgical wards, therapists, and paramedics in 2003.

Table 2

<table>
<thead>
<tr>
<th>Category</th>
<th>0–4 years (n = 260)</th>
<th>5–10 years (n = 90)</th>
<th>11–16 years (n = 140)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neglect</td>
<td>102 (39.2%)</td>
<td>17 (18.9%)</td>
<td>15 (10.7%)</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>94 (36.1%)</td>
<td>30 (33.3%)</td>
<td>30 (21.4%)</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>3 (1.1%)</td>
<td>7 (7.8%)</td>
<td>4 (2.9%)</td>
</tr>
<tr>
<td>Emotional abuse</td>
<td>0</td>
<td>2 (2.2%)</td>
<td>37 (26.4%)</td>
</tr>
<tr>
<td>Mental health issues / self harm/overdose</td>
<td>0</td>
<td>2 (2.2%)</td>
<td>37 (26.4%)</td>
</tr>
<tr>
<td>Misuse of drugs/alcohol</td>
<td>0</td>
<td>0</td>
<td>23 (16.4%)</td>
</tr>
<tr>
<td>Parental mental health issues</td>
<td>20 (7.7%)</td>
<td>8 (9.9%)</td>
<td>10 (7.1%)</td>
</tr>
<tr>
<td>Parental misuse of drugs/alcohol</td>
<td>21 (8.1%)</td>
<td>10 (11.1%)</td>
<td>4 (2.9%)</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>17 (6.5%)</td>
<td>12 (13.3%)</td>
<td>8 (5.7%)</td>
</tr>
<tr>
<td>Others</td>
<td>3 (1.2%)</td>
<td>3 (3.3%)</td>
<td>9 (6.4%)</td>
</tr>
</tbody>
</table>

Each column adds up to 100%.

References


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Maternal vitamin D deficiency, refractory neonatal hypocalcaemia, and nutritional rickets

We read with interest the articles by Allgrove and Ladhani and colleagues which highlighted the re-emergence of vitamin D deficiency, neonatal hypocalcaemia, and nutritional rickets as a major public health problem in the UK, especially in the “at risk” ethnic minority groups.

We would like to present our experience from a single centre of maternal vitamin D deficiency, neonatal hypocalcaemia, and nutritional rickets. Leicester City has an estimated proportion of 28% South Asians (Census 2001) and an increasing number of other ethnic groups, including an estimated recently arrived 10 000 people of Somali origin. Studies in our centre have confirmed that significant numbers of south Asian mothers have vitamin D deficiency at the end of pregnancy, and substantial numbers of children have infantile and adolescent rickets, some of whom have extremely severe bone deformities. In addition there have been increasing numbers of late (5–10 days of age) and late-late (12–14 weeks of age) neonatal hypocalcaemia, presenting predominantly with seizures, which, despite intensive calcium and vitamin D treatment have been difficult to correct biochemically. All the mothers had vitamin D deficiency and were supplemented with oral vitamin D and calcium supplements. None of the mothers, despite being within high risk ethnic groups, had vitamin D supplementation in pregnancy despite the recommendation by COMA (Committee on Medical Aspects of Food Policy in UK) that all at-risk pregnant and lactating mothers should receive 10 µg (400 IU) of vitamin D daily. Furthermore, a local audit involving clinicians in antenatal care including general practitioners, midwives, and obstetricians showed that, while health professionals were aware of this issue, there was no clear policy followed.

At birth, the newborn’s vitamin D status is directly related to maternal vitamin D status and materno-fetal transfer of vitamin D and its metabolites in pregnancy. Babies whose mothers have a marked vitamin D deficiency will have a compromised vitamin D status, and this has important long term implications for the health of the offspring.

As noted by Allgrove there were national and local “stop rickets campaigns” in the 1970s, and in Leicester this appeared to reduce but not remove the spectre of nutritional rickets. In view of recent experiences confirming an increasing frequency and severity of neonatal vitamin D
Apnoeas in bronchiolitis: is there a role for caffeine?

Bronchiolitis is a common respiratory illness in infants in winter months. Recurrent apnoeas in high risk infants with severe bronchiolitis increases the need for respiratory support (nasal continuous positive airway pressure and ventilation) and transfer to the paediatric intensive care unit (PICU). During the winter of 2003–04 we had three babies presenting with apnoeas secondary to bronchiolitis. All three babies were ex-preterm infants under 3 months of age. All had deterioration in their respiratory status potentially needing further care in PICU. On advice of two PICU consultants these babies were treated with a loading dose of caffeine. All the children showed immediate improvement in their respiratory status and avoided being transferred out. Caffeine is a respiratory stimulant widely used in the treatment of bronchiolitis across 20 intensive care units in the UK. We made a thorough literature search to look at the evidence. Of the 20 questionnaires sent, only 10 replies were received. Opinion was divided between PICU consultants, with four stating that they would advise a trial of caffeine. This made a total of six, including the two who advised us previously. The evidence from literature is anecdotal.

We conclude that there is little evidence in literature to support the use of caffeine in bronchiolitis, and there is divided opinion in PICUs across the UK. We feel that caffeine is a relatively simple treatment option in a district general hospital for apnoeas in bronchiolitis and recommend a randomised controlled trial. We would welcome comments on similar experiences from readers.

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Competing interests: none declared

References

BOOK REVIEWS

Child public health


Since the heyday of public health in the late nineteenth century it has failed to raise the pulse of many clinicians, as they believe its work, at least in the developed world, is done. This book comes on the tide of renewed interest in the discipline. It outlines the current state of child public health, refreshes the contemporary image, and reinforces the premise that child public health is as relevant and important today as it has ever been. Aimed at paediatricians and public health practitioners, it will also appeal to all those who work in child health, whatever their professional background.

R Tomlinson, S Lenton

Reference

Epilepsy in children, 2nd edition

The clinical management of craniosynostosis


In the introduction of this text the editors have indicated their desire to produce a volume that does not constitute a specialised text for experts, but rather a resource of information for associated professionals who perform an essential role in the management of these complex cases, is only a relatively small/short phase of a coordinated multidisciplinary care pathway in these frequently complex cases.

The authors have acknowledged the fact that this text constitutes a single unit to philosophy, and as such is a distillation of the “home institution”. In this regard the book has been successful in its aim, and it is certainly refreshing to see a book of craniofacial surgery not concentrating on surgery for sutures.

In fact the contents of the book highlights the fact that surgical intervention, although a major factor in the treatment of these complex cases, is only a relatively small/short phase of a coordinated multidisciplinary care pathway in these frequently complex cases.

The clinical management of craniosynostosis (hardback), pp 304. ISBN 1 898 68336 0

In conclusion, this text represents a worth-while contribution to the craniofacial literature. It is generally a readable and accessible source of information, achieving the aims outlined by the editors, and all contributors should be congratulated on a book highlighting the fact that a coordinated multidisciplinary approach is essential in the treatment of all patients with craniosynostosis.

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www.archdischild.com

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