Child Development Team
South Aberdeen
Integrated Evaluation Report

September 2009
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FOREWORD

This report summarises the programme of audits set up pro-actively with the inception of the Child Development Team in South Aberdeen.

I am indebted to the parents of children on the caseload of this team for participating in the audits and for giving their valuable suggestions to improve the service. Professional colleagues from all three major disciplines of Health, Education and Social Work have encouraged us through these first two years and I wish to record my gratitude for their tolerance and support.

It would not have been possible to carry out this programme of audits without the unreserved enthusiasm, professionalism and dedication of all my colleagues in the Child Development Team who rose to the challenges encountered over the past two years.

The audits and the compilation of reports have been completed with the assistance of the Clinical Effectiveness Team, NHS Grampian. All documents related to the audits referred to in this report are available through this department. They are also available on the NHS Grampian Intranet via the Document Information Silo (DIS) (http://intranet.grampian.scot.nhs.uk/ccc_nhsg/foi_search.jsp)

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September 2009
1. **INTRODUCTION**

Specialist Child Development Services in Grampian for the assessment and management of children with complex neuro-disability are provided through a number of different venues. In Aberdeen City, the community based pre-school specialist services are provided through the Department of Community Child Health. Clinics are scattered around the city e.g. Denburn Health Centre, Garthdee Medical Practice, Kincorth Medical Practice, Mastrick Medical Practice, Tillydrone Health Centre, Bridge of Don Health Centre, and Bucksburn Medical Practice. In addition, clinics are also held in some family centres and pre-school nurseries.

Children requiring multi-disciplinary assessments are seen at the Raeden Centre, which is a regional pre-school multi-agency Child Development Centre, where there is provision for multi-disciplinary assessments, a developmental nursery school for children aged 3-5 years and a day nursery for children up to 3 years old.

School age children with complex neuro-disability receive Community Child Health Services in the same way as for pre-school children, however specialist clinics are held in the special schools and bigger Additional Support for learning bases attached to mainstream schools. The Department of Community Child Health and the Therapy Services are based in the Royal Aberdeen Children’s Hospital (RACH). In Aberdeenshire, four multi-agency and multi-disciplinary Child Development Teams covering different geographic areas provide birth to school leaving specialist services.

Recent reviews\(^1\) of services for children with special needs have recommended re-designing the existing services. Recommendations include “The current service for children with special needs is re-designed and re-focused to provide a more equitable service across Aberdeen City. These services are developed within community settings.”\(^2\) The main elements of the model of future service provision for Aberdeen City for children with special needs are:

- A community-based multi-disciplinary, multi-agency service.
- The majority of children will attend mainstream placements with appropriate support.

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\(^1\) Review of pre-school services in Aberdeen City for children with special needs. Karen Foster and Eleanor Spalding, February 2004.


• Facilities will be developed for children with severe and profound needs which cannot be met within mainstream settings.

• The service should be designed to offer support to children and young people from 0-19 years whose special needs require on-going multi-disciplinary assessment and management.

This recommendation was made primarily to address inequalities in service for all children. The recommendations go on to specify that “the specialist service should consist of three child development teams based in each of the Aberdeen neighbourhoods areas (North, Central and South)”.

The implementation of the Additional Support for Learning Act (Scotland) 2004 presented an opportunity to pursue this model in one neighbourhood of Aberdeen city. Funding applications were sought for development of services which would support the implementation of this act. This convergence of goals of the service reviews and the ASL act helped to galvanise support for children with complex neuro-disability in the context of multi-agency and multidisciplinary working. An application for funding a Child Development Team³ in a neighbourhood of Aberdeen as a pilot was thus successfully made in August 2005. On approval of the application, the process of employing team members, securing premises, and agreeing working practices was started. The south neighbourhood of Aberdeen represented a suitable geographic area for the team’s coverage because of its higher deprivation indices, and because it was not included in the Aberdeen city councils “3Rs” project which focused on developments in the Central and North neighbourhoods. The core team was in place by late 2006, and a temporary base for the team was approved by Aberdeen City Council at Tullos Primary School in Torry. Geographic boundaries for the CDT are co-terminus with those used by Departments of Education and Social Work.

The Core Team consists of a Consultant in Community Paediatrics and two Staff Grade Paediatricians, two Physiotherapists (1.0 WTE), an Occupational Therapist (1.0 WTE), a Speech and Language Therapist (0.5 WTE) a Therapy Support Assistant (0.5 WTE), a Nursery Nurse (1.0 WTE), and a Medical Secretary (0.5 WTE). Associated professionals give dedicated time to the team. These include the Educational Psychologists covering the south neighbourhood, Social Worker from the Social Work Disabilities team, Clinical Psychologist from the Department of Clinical Psychology, RACH. A Parent representative gives of her valuable time and brings the essential parent perspective to the proceedings of the team.

By April 2007, a caseload of 26 children with enduring and complex needs and multiple therapy needs was taken on. By 2009 this had increased to 39 children. Children move in and out of the case load as their geographic location changes or when they are transferred to Adult Services.
2. EVALUATION

An Evaluation Strategy was approved by the NHS Grampian-led Complex Needs group in August 2008 which included a systematic programme of audit with assistance from the Clinical Effectiveness Team, NHS Grampian.

The strategy involved carrying out the following activities:

1: Perform two parent/carer satisfaction audits: an initial audit to assess parents’ views of existing services prior to the introduction of the CDT, and a second audit after the children had been supported by the Child Development Team over a two year period.

2: Stakeholder interviews involving professionals and parents in direct contact with the CDT. (December 2008)

It was planned that these two generic surveys/audits would be supplemented by the following more specific smaller audits:

3: Parental views on their perception of community-based Multi-disciplinary Assessments.

4: Review of the CDT’s Involvement and Support in the Additional Support for Learning process.

5: Quantitative review of Referral and Medical assessment data using the Patient Administrative System (PAS) to determine change in the trends in community-based paediatric neuro-developmental assessments. Review of case notes to analyse demographic, administrative and clinical information.

The salient findings of these activities are discussed below.

2.1 User Surveys/Audits:

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Methodology:
Two audits were carried out. The first was conducted in April 2007 to canvas parental views of existing services before their child was taken on to the CDT caseload; and the second was carried out in April 2009, when the team had been operational for two years. Both audits
involved inviting parents to participate in an anonymous questionnaire-based survey. The response rates were 60% and 53% respectively, and were considered to be representative of the larger caseload.

**Results:**

**Caseload** – Since the first audit two years ago there has been an increase in the number of children on the case load of the Child Development Team, South Aberdeen. Cases have nearly doubled and the age range distribution is much wider. This compares well to the age distribution of the total current caseload which is illustrated in Fig 1. As caseload increases and younger children are taken on, the Team need to ensure that the needs of all children continue to be met.

*Fig 1*

![Child Development Team Caseload Age Range August 2009](image-url)
Involvement of Professionals – Both surveys recorded involvement of all professionals. Fig 2 shows the actual caseload broken down by age bands, with involvement of the CDT therapists and the nursery nurse.

Fig 2

![Age Range and Therapy Access](image)

Appointments – A wide range of appointment sites continue to be used by the therapists to see the children. These include schools in the majority of cases, followed by home and RACH. A significantly smaller percentage of hospital appointments (32% as compared to 53%) in the second audit, suggests a trend towards using non-hospital based sites. This model of service delivery is likely to develop further, particularly when more suitable community-based premises for the Child Development Team are available. This trend mirrors the increasing utilisation of community-based sites for medical consultations as demonstrated in the quantitative analysis of data from Patient Administration System (PAS) (see section 2.5). Consistently high affirmative responses are given to aspects such as “ease of use”, “suitability of appointment time” and “child friendliness”. 26% as compared to 13% in the previous survey report that appointment times are “always suitable”, demonstrating the therapists’ willingness to adjust timings to suit parents’ preferences. In 2009, only 5% report that their child is seen in a non-child friendly environment as compared to 20% in the first survey. It is acknowledged that some parents report difficulty in attending appointments when they are working fulltime, particularly during school hours. They also comment about the difficulty of finding disabled car parking facilities at RACH. Staff are reported to be friendly and helpful universally. This is echoed in the Stakeholders Feedback as well (see section 2.2). Parents appreciate receiving handouts and therapy sessions to focus on specific therapeutic input.
Team Work and Care Co-ordination – Parents’ positive perception of team work and care coordination is evidenced in these audits. This could, however, be improved further by undertaking more multi-disciplinary therapy sessions and regular review case conferences. This approach though is likely to be more labour intensive, and may take time away from other activities within the CDT. A higher percentage in 2009, (80% as compared to 74%) report being involved “always or mostly in planning the child’s care. This, again, supports more collaborative working with parents in developing Joint Care Plans for children. However, Care Plans are often in the context of Individual Education Plans (IEP) or Coordinated Support Plans (CSP) which are multi-agency and require the collaborative planning amongst Health, Education and Social Work. It is envisaged that the CDT therapists will move towards providing single, integrated, Joint Therapy Plans.

There continues to be a high proportion of parental involvement when changes are made to their child’s care. Similarly a high percentage continues to report that they feel that they are listened to. 85% as compared to 67% in the previous survey report that “useful changes” have always or mostly been made to meet the changing needs of the child. Confidentiality ratings as perceived by the respondents have increased from 27% in 2007 to 53% (2009) in the “always” category, implying that there is continued commitment to maintain confidentiality within the multi-disciplinary multi-agency setting.

Communication

Following the first audit it was decided that a Family Communication Folder be provided to families on the caseload. The folder was developed by the CDT South Aberdeen and on the whole appears to have been a successful intervention. 75% of the respondents have found the folder to be useful, but some have not. Those not finding it useful report not having enough time to keep it up. Others have just stated that they do not use it. Those using the folder store Child Development Team and other related information including Disability Living Allowance forms, correspondence from the various professionals who see their child and information about play therapy and exercises. We have to acknowledge, though, that not all parents will have the time or inclination to use it. It remains, nevertheless, a useful resource for those parents who wish to use it.

A majority of parents continue to state that they are told about decisions affecting their child’s care, with a higher percentage stating the affirmative view as compared to the First User Survey. Consistently high percentages of respondents report that they receive verbal and written information about their child’s progress.

The Team need to be more consistent about providing both verbal and written information. It is likely that the provision of both verbal and
written information will need to be revised to make this more meaningful. Most respondents continue to report that they are told quickly enough about their child’s progress, with higher percentages being reported in the second audit as compared to the first. Most continue to find reports useful and easy to understand. 32% as compared to 7% report that they “mostly” had a member of staff go through the written report with them to facilitate their understanding of technical terminology. However, 32% as compared to 20% state that they never needed such help, suggesting that reports are better written and parents are able to understand them easily.

It appears that reports are well-written and by and large easily understood, and if required, staff members are very willing to explain the technical aspects of the report. Only 11% as compared to 33% in the previous audit report that only “occasionally” did they require staff to go over the report. A majority 63% as compared to 60%, in the last audit, report that they had never received conflicting information. The perception of conflicting information is a problem and regular written multi-disciplinary reports could reduce the risk of this and would be an important goal to work towards. Parents comment on preferences for written reports, consistently good communication amongst all of the team members and the use of simple language in explaining technical issues.

Problem Solving – 63% of the respondents in the second audit as compared to 33% in the first audit, report that they “always” knew who to contact if they had a problem. This is a significant increase since the last audit and suggests much better information about the team members than the previous survey. The vast majority continue to report that their concerns are dealt with. The perception of concerns being addressed remains high, despite the nature of disabilities in most of the children and the relatively limited scope for making life changing interventions.

The Team is seen to be actively listening to parents, is sensitive to emerging problems and in trying to find workable solutions.

**Conclusion:**

These two audits canvassed parents’ views over a period of two years of the Child Development Team service. The length of time parents would have had support from the Team at the time of the Second User Survey ranged from 3 months to 2 years. While the overall feedback from the respondents is positive, there are some areas that clearly need attention. Parents seem to be asking for more multidisciplinary reviews, regular written feedback, consistency of information provision, improved communication amongst all team members and with parents and continued flexibility in providing appointments and therapy times.
However, one must keep in mind that the team has been evolving over two years and these two user surveys only provide a snapshot of the perception of parents who have responded to the surveys. The views of and reasons for those not participating in these two surveys (40% in 2007 and 47% in 2009) remain unknown. A number of Action Points have been agreed by the CDT to address the issues which have surfaced as a result of these surveys. These are:

- Provide Joint Therapy Reports annually as part of the Annual School Review process
- Engage in Annual multi-disciplinary reviews of all pre-school children on the case load of the CDT
- Provide written information to parents when and where appropriate
- Visits are targeted to therapy, followed by provision of relevant written information
- Carry out a third Parent/Carer satisfaction audit in 2012

### 2.2 Stakeholder Feedback

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**Methodology:**

Two groups of Stakeholders were identified. The first and most important being the children and their parents who were on the caseload and second, the various professionals who have been in contact with the CDT. In the case of the first group, only parents were interviewed, some directly and others by telephone. Children were not interviewed. In the second group, all professionals were interviewed directly. The salient findings from both groups of stakeholders are presented below:

**Results:**

**Parents**

Parents don’t necessarily differentiate between the CDT service and other health services, for example, from RACH and their feedback reflects this. There is also evidence of a lack of clarity and understanding as to who is responsible for delivering each service as parents see “health, education and care as interdependent”.

Parents would ideally like a holistic service i.e. health, education, care and emotional needs met by a multi-agency, multi–disciplinary team and the CDT is working towards achieving this. The joint clinics the
Team has set up with other agencies and disciplines are particularly valued. This model is likely to be further improved by the introduction of the Single Plan as part of the GIRFEC (Getting It Right For Every Child) Agenda and Key Working in the near future.

Parents have described the CDT as “responsive, polite, friendly, visible and accessible”. Most feel involved in making decisions about their child’s health needs and consider themselves as “partners in care”. Parents like to be involved and were pleased to have this opportunity to comment on the services they receive.

For many parents the transition to the CDT was easier as they were already receiving a service from staff who became Team members. Perhaps because of this, there was less of a more formal introduction to the CDT which parents would have appreciated. However, parents report that when their child has been involved in other transitions such as moving to another school, this has been supported by the CDT, with improved co-ordination and communication.

Parents appreciate the Team operating in the local community with appointments mainly held in the child’s school or in the home. Particularly valued is the regular input from therapists, with parents reporting good working relationships and the key role of the school doctor. Some parents would like therapy to continue during the school holidays, particularly in the summer, and for there to be contingency plans when there is a problem in delivering a particular service due to staff illness.

Communication with parents and school staff seems to work better if the child attends a school specifically for children with complex needs. Parents like to know if the child has been seen in school and would welcome more regular written feedback.

Professionals

Feedback from colleagues who have a significant working relationship with the CDT in South Aberdeen, indicates a fairly high level of satisfaction with this model and the practice of service delivery, despite the newness of the service. The Team has been operational for only two years and it takes time to develop systems to deliver a multi disciplinary, multi agency service in a community setting.

The joint clinics set up by the Team with community partners seem to be particularly valued. There also seems to be a better attendance rate for appointments, as it is easier and perhaps, for some parents, less threatening, to attend an appointment in the school. This leads to a more holistic “joined up” service to the family and appropriate information sharing by community partners. The adage of “once a Team child, always a Team child” is appreciated and viewed as the
best model of service delivery. This is most useful at times of transition when partners state that the Team are usually involved earlier and there is a better co-ordination of services. However, this can be problematic in the transition from child to adult services, not only for the CDT but for other service providers. An unexpected benefit is the shared use of an interpreter at joint appointments for some families which results in less repetition of the child’s details for the family.

There seems to be improved communication emerging as working relationships improve with more opportunities for informal encounters. The Team are developing more knowledge of local resources and a greater understanding of the role and remit of community partners. Education staff, in particular state that they are more involved in assessment, and as the Team develops more knowledge of the educational settings, more detailed information as to how best to manage the child’s needs can be offered. Some colleagues still seem unclear about the role and remit of the Team and further dissemination of information would be helpful.

An added challenge is the co-existence of the CDT and the Raeden Service. This is not envisaged in the delivery of services by either model and is a transitional phase as the CDT model is piloted in the City. This has led to a duplication of services for the 0 – 5 year old population, with the resources available being inequitable, and has resulted in missed opportunities to fully develop a 0 – 18 years service with fewer transitions for children and families.

It would seem that staff who have significant contact with the CDT view the service positively, and note improvements over the last year as new systems and ways of working become embedded in practice.

2.3 Multidisciplinary Assessments

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Method:

Pre-school children were assessed by the multi-disciplinary team in the community. Parents opted for a community- based assessment as children were already attending local nursery schools. The assessment involved a Paediatric medical assessment, observation and assessment by the Nursery Nurse and by nursery school staff to prepare a developmental profile of the child, specialist assessments including Clinical Psychology, Educational Psychology, Social Work,
Speech and Language Therapy, Occupational Therapy, and Physiotherapy depending upon the child’s presentation, in order to identify areas of need. At the conclusion of the assessments a multi-disciplinary meeting was held to bring all the information together, to agree a developmental profile, explore a diagnosis where appropriate, identify specific areas of need and agree plans to support the child. The responsibility for follow-up and implementation of the agreed management plan was with the Medical Coordinator and the agreed therapy professionals.

Feedback from parents was sought about their experience of this assessment. Five out of seven parents returned the completed questionnaires. The results are given below.

**Results:**

All strongly agreed that they understood the reasons for the multi-disciplinary assessment, and that the meeting was held at an appropriate time and place. All agreed that there was a clear presentation of their child’s abilities, difficulties, diagnosis and a Management Plan formulated.

**Figure 1 – Level of agreement**

![Bar chart showing level of agreement](chart.png)

Clear & accurate presentation of child’s....

The comments of one parent given below seem to capture the essence of the feedback received from all the respondents:

“I would like to say thank you to the team for all their help with my son and would recommend to anyone this process. Quality of family time we have together is so much better and my son interacts with his peers and enjoys nursery.”
Conclusion:

This small sample of parents was clearly satisfied with the process. Although no formal audit was performed to seek the perspective of the professionals involved, their opinions of the process were equally well-received. The effort of coordination required to carry out community-based multi-disciplinary assessment is offset by the better quality of observations achieved in the child’s own nursery and at home and the ownership of the outcomes being shared between professionals from different agencies. Amongst the assessments carried out there was an instance where all observations were carried out in the community but the meeting was held at the Raeden Centre.

The exercise demonstrates very clearly that these complex assessments can be carried out successfully in community settings.

One of the outcomes following these assessments is whether a child may benefit from coming into the Raeden Centre Developmental Nursery School for 3-5 year olds or the Day Nursery for younger children. Similar provision is not available in Aberdeen city so there were children who attended Raeden Centre nursery after the community-based assessment process. If community-based assessments are to be pursued and the emphasis of providing specialist services in the local neighbourhood is to remain a priority, then Developmental Nursery provision in the locality must be provided.

2.4 Support for the Additional Support for Learning (ASL) Act (Scotland) 2004

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Method:

This small initial audit into the involvement of the Child Development Team South Aberdeen in the ASL process took the form of extracting information from clinical notes made by individual CDT professionals, with respect to 10 out of a total of 36 children on its caseload. The same structured questionnaire was used by all professionals.
Results:

Coordinated Support Plan (CSP).

Notification of the CSP is recorded in varying degrees. While the Occupational Therapists have received notification in 70% of cases, the Community Paediatricians and the Educational Psychologists record this in 50% of the cases and the Physiotherapists record this in 40% of cases. While it is conceivable that some children may have more involvement of one therapist as compared to the other, depending on their respective active needs, it is surprising to find the lower instances of notification to professionals where their involvement is more generic, such as Paediatricians and Educational Psychologists.

Assessment of the child for the purposes of the CSP is recorded in 60% of the cases by the Occupational Therapist and in 50% of cases by the Community Paediatricians and the Educational Psychologists. This suggests that Community Paediatricians and Educational Psychologists have assessed the child in all instances where they were notified. The Physiotherapist records this in only 20% of cases even though notification was received in 40%. This suggests that new assessments have not been required as the ongoing involvement is sufficient to provide an updated report. Attendance at the meeting is also consistently high for the Occupational Therapists and in all cases where notification is received by the Community Paediatricians and Educational Psychologists but is only 10% for the Physiotherapists. A report is submitted in 70% of cases by the Occupational Therapists, 50% by the Educational Psychologists and 40% each in case of the Community Paediatrician and the Physiotherapist. There is high concordance between notification received and report submitted. It follows, therefore, that Notification of the CSP process must be made consistently to all members of the CDT if their involvement is to be assured.

Presence at the Review Meeting is recorded in a very high percentage (50%) by the Community Paediatricians when notification is also 50%; 40% by the Educational Psychologists, 20% by Occupational Therapists and 10% by the Physiotherapist. It is possible that the priority of attendance at Review Meetings is adjusted according to the overall need of the child – delivering therapy itself perhaps taking precedence over attendance at the meeting.

Individual Educational Plan (IEP).

Involvement in the IEP process is recorded only for Occupational Therapists and Physiotherapists. Occupational Therapists record a bigger percentage (60%) for Target and Report compilation, and attendance at the meeting. Submission of report is recorded in 50% of
cases by the Occupational Therapists with a 10% attendance at the Review meeting. Occupational Therapist involvement is significant in the IEP process for those children accessing the CDT service.

School Review Meeting:

Notification of involvement in the School Review is recorded in 60% of cases by the Educational Psychologist and in 40% of cases by the Community Paediatrician, with 30% recorded by Occupational Therapist and Physiotherapist. Report compilation by the Occupational Therapist and Educational Psychologist is 30% i.e. as much as notification, with the Physiotherapist reporting 20%. Surprisingly the attendance at meetings for School Review is recorded in 80% of cases by the Occupational Therapist and Educational Psychologist even though notification is much lower. This suggests that the higher percentage of attendance at meetings by Educational Psychologists and Occupational Therapists is irrespective of notification which may represent a strong informal network of sharing information. Report submission is a conservative 30% by the Occupational Therapist and Educational Psychologist with 20% reported by the Physiotherapist.

Transitional Arrangements:

Occupational Therapists are prominent in their involvement in the multi-disciplinary planning.

Capacity Building:

Capacity building in the form of assessment of need, sourcing equipment and aids, and training of professionals is reported in 70% of the cases by the Occupational Therapists, with Physiotherapists, reporting assessment of need in 50% cases, sourcing equipment in 40% cases and training of staff in 40% cases. The high percentage of Occupational Therapist and Physiotherapist involvement demonstrates their involvement in finding practical solutions by way of assessing need and sourcing equipment. The emphasis on training is more at school than with parents. This is not surprising for school age children where a combined posture and mobility programme may be in place with both Occupational Therapists and Physiotherapists working together to achieve the same goals.

Conclusion:

This limited audit highlights the variable involvement of members of the CDT in the ASL process. Notifications to individual members of the CDT about the various stages in the process play a key role in predicting further involvement in the ASL process. This has to be standardised in the case of all children to ensure a more consistent input into their management in the context of the ASL process.
2.5 Trends in Clinic selection for medical consultation

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Children whose parents are resident in Aberdeen city and who may have neuro-developmental problems are seen at a variety of different sites. Pre-school children may be seen in any one of many community based clinics for an initial assessment. Those suspected of having complex disorders often require multi-disciplinary assessments, undertaken at the Raeden Centre. With the establishment of the Child Development Team in 2007, it became possible for pre-school children from the South Neighbourhood of Aberdeen to have Community Based Multidisciplinary Assessments. School aged children with neuro-developmental disorders are seen either in School clinics or in Community- based child health clinics.

Method:
All clinic appointments are recorded on the Patient Administration System (PAS) employed by NHS Grampian. The PAS system was interrogated by a system analyst of the Health Intelligence Unit in a systematic manner to determine any change in the trend of children under 5 years old being offered community-based clinic appointments. The Data relates to annual Consultant Clinic attendances from 2006, 2007 and 2008.

Results:
Jan – Dec 2006

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<th>CCH</th>
<th>RAEDEN</th>
<th>TOTAL</th>
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<tr>
<td>TOTAL</td>
<td>175 (58%)</td>
<td>129 (42%)</td>
<td>304</td>
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<tr>
<td>UNDER FIVES</td>
<td>88 (45%)</td>
<td>107 (55%)</td>
<td>195</td>
</tr>
<tr>
<td>SOUTH NEIGHBOURHOOD</td>
<td>22 (47%)</td>
<td>25 (53%)</td>
<td>47</td>
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The trend over the three years indicates the following:

1: The total number of children seen in the consultant clinic has stabilised to 385 per annum.

2: The proportion of under-fives has reduced from 64% in 2006 to 38% in 2008, implying a more selective system of seeing children in the more specialist clinics.

3: The overall proportion of children being seen in CCH clinics has increased from 58% in 2006 to 71% in 2007 and 2008, implying that more are being seen in CCH clinics but a third are still seen at the Raeden Centre.

4: The proportion of under-fives being seen at CCH clinics remains stable at 55% throughout the three years of monitoring.

5: The proportion of children under five years old from the south Aberdeen neighbourhood being seen in the community clinics has increased from 47% in 2006 to 71% in 2008. This implies a significant shift in the way the caseload is seen for specialist medical consultations and would indicate that this change represents the impact of the Child Development Team in the south neighbourhood.
3. CONCLUSION

1: In the two years since the pilot CDT has been operational it has successfully taken on and managed a caseload of children with complex and enduring neuro-developmental problems.

2: The perception of parents as evidenced by two parent/carer satisfaction audits and the stakeholder interviews is very positive and over time demonstrates increased positive perceptions in the key areas of appointments, team work and coordination of care, communication and problem solving. Parents wish to see more evidence of multi-disciplinary team work for all of the children on the caseload, regular written feedback charting the progress of their child, good communication between all team members and themselves and continued flexibility in appointment setting to suit the particular circumstances of the child and parents. They point towards a preference for community-based appointments rather than in the hospital because of difficulties in finding disabled parking bays near the appointment site. They like the Joint Clinics which have been set up in the community e.g. the Posture and Mobility Clinics involving the CDT professionals, parents, children and professionals from the Mobility and Rehabilitation Service.

3: Professionals who have had contact with the Team appreciate the holistic approach and the improved communication and input into the existing processes. There is confusion about parallels between the services offered at the Raeden Centre and those offered by the CDT. Collaborative working with professionals working in the Centre and the Child Development Team would enhance the understanding of each others’ specific roles and remits.

4: Pre-school multi-disciplinary assessments have been carried out very successfully in the community using a model similar to that employed at the Raeden Centre. Opportunities for children to attend developmental nursery provision in the community and provision of placements for daycare for the under-three year olds would add strength to the model of providing local specialist services to children with complex neuro-developmental problems. Enhanced communication between professionals will undoubtedly make the transition from nursery to primary education smoother.

5: Although members of the CDT are engaged in supporting the children in the ASL process, there needs to be consistent notification to all members of the team for meaningful engagement in terms of provision of up-to-date information relating to assessment and management. Within the CDT service it is envisaged that all pre-school children will receive an annual multi-disciplinary review. Joint therapy reports will be circulated beforehand. The school annual review dates for all children on the
caseload need to be shared with the team well in advance so that reports can be prepared and circulated in time.

6: The trend of increasing medical assessments in the community mirrors the parents’ desire for appointments to be in community-based settings. The provision of appropriate community-based settings for therapists to work with children will enhance their ability to provide a more accessible service to children and their families.
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3:  Child Development Team in Support of the Education (ASL) (Scotland) act 2004. 5th August 2005. Dr J Crum, Dr S Daud, Dr AD Kindley

4:  Child Development Team South Aberdeen Evaluation Strategy. Dr S Daud 18/7/2008


8:  Child Development Team South Aberdeen, Support for the ASL Act (Scotland) 2004. Dr S Daud, Brenda Lurie, Blair Watt