

Headlines

BRITISH ASSOCIATION
OF
NEURO-SCIENCE NURSES

British Association of
Neuroscience Nurses

Volume 1, Issue 2

October 2004

STRATEGIC REVIEW OF NEUROSCIENCE SERVICES

In Scotland, Health Minister Malcolm Chisholm has appointed an expert group to take a hard look at how the NHS can plan and deliver better health care services in Scotland for the longer term.

The Advisory Group on Service Change in NHS Scotland is chaired by David Kerr, Rhodes Professor of Cancer Therapeutics and Clinical Pharmacology at Oxford University. It will develop a national framework for service change in line with the aims of White Paper *Partnership for Change* to develop sustainable specialist services along with more local services delivered in community settings. Two sub groups are focusing on neuroscience services and paediatric services, so there is a degree of overlap here. The neuroscience group will build on several previous reports on acute and specialist services in Scotland:

The Acute Services Review which reported in June 1998 had neurology/neurosurgery multidisciplinary sub-groups. The neurosurgical element of this work was subsequently taken forward in a further Group chaired by the then CMO, Sir David Carter.

Following subsequent discussions between the neurosurgical community and Scottish Executive Health Department, the current CMO asked Professor Graham Teasdale to take forward further work in the area of adult neurosurgery. A Group under the aegis of Professor George Youngson's Scottish Colleges Committee on Children's Surgical Services has examined the issues around paediatric neurosurgical service delivery.

Professor Teasdale's report covers the various current drivers for change relevant to all areas of clinical service delivery, with which National Services Planning Group members are very familiar eg junior doctors' hours, EWTD, new consultant contract, increasing subspecialisation etc. It highlights manpower shortages in "support specialties" eg neuroanaesthesia, neuroradiology etc, which are specific to the specialty and particularly pressing.

The report covers potential responses to these drivers, in particular the development of Managed Clinical Networks (MCN), role replacement and reconfiguration of services. The report concludes that there is only a limited place for

role replacement in the area of adult neurosurgery. However, there is increasing recognition that service reconfiguration is inevitable. There is currently divergence of opinion about future service configuration and the remit of this new group is to move that agenda forward.

There is however a strong majority view that the present arrangements for provision of adult neurosurgical services in Scotland are not an appropriate basis for future planning. This represents a radical change in opinion in the neurosurgical community over the past 3-4 years. The group will not decide on current or imminent major service reviews by Health Boards, however, its work will complement future planning by Boards by giving a strategic national focus for the reconfiguration and redesign of services.

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The BANN has also been asked by the Health Commission Wales (Specialist Services) to nominate representatives attend workshops in South Wales on 9 November & 24 November and in North Wales on 8 November and 23 November.

The aim of the first workshop is to develop and objective for neuroscience services in Wales along with benefit criteria and the second workshop will score the proposed options. These nominations will be made in due course.

If you have any questions about these projects, please do not hesitate to contact me at elizabeth.preston@luht.scot.nhs.uk

Elizabeth Preston
President BANN

Cath Waterhouse reports on Neuroscience Benchmarking

There can be very few nurses practicing in the U.K who hasn't heard or has been actively involved in the process of benchmarking, be it organisational benchmarking, National 'specialist' benchmarking or the 'local' implementation of the Department of Health's "Essence of Care" (2001). The term 'benchmarking' has been defined as a 'structured comparison and sharing to bring about realistic development', (Judith Ellis 2000), it allows and encourages nurses to reflect, compare and share aspects of best practice (Mullaly, 2001). No other National or local initiatives have previously motivated nurses to generate such a wealth of clinical guidelines based on the best evidence and consensus agreement.

The National benchmarking group, representing the interests of the British Association of Neuroscience nurses, has recently undergone a period of renewed vigour and we have agreed standards, developed policies and guidelines and teaching packages for over ten benchmarks:

- External Ventricular drains
- Respiratory management (including tracheostomy and tracheal suctioning).

- Restraint
- Angiography
- Lumbar Puncture
- Cervical collars and traction
- Inotropes
- Immunoglobulin therapy
- Neurological assessment
- Transnasal Hypophysectomy.

With the advent of the 'Essence of Care' standards we have managed to redefine and focus our efforts by transferring some of our generic work to the National Initiative, for example mouth care and pain management, although they may highlight particular problems related to neuroscience, they are not exclusive to the speciality.

There are undisputable benefits to being involved in the benchmarking process - specifically networking with other Trusts and departments, sharing evidence and information, contributing to best practice guidelines. Our individual Trusts will similarly benefit from our work, through direct improvements in patient care, the potential bonus of positive CHI reviews and beneficial grades in the balanced score cards.

Looking closer to home, the time is probably right to begin to systematically, improve the way we presently disseminate

our work to other areas of nursing. For example, in the majority of large teaching hospitals, Neuroscience has been divided into separate adult and paediatric branches. Each has their own benchmarking association and until very recently, neither group were aware of the others existence, each one having developed virtually identical guidelines for such things as ICP monitoring, EVD'S etc.

Similarly, general critical care units often have to manage patients with head-injuries, subarachnoid haemorrhage and other neurological conditions. Many of these units readily insert external ventricular drains and intracranial bolts for the measurement and control of raised intracranial pressure. Within their own critical care network they have recognised the need to develop guidelines for specific neuro-care pathways. In this age of high clinical activity and when time is at a premium, the principles of benchmarking have to be made easier and more readily available for those people who need it, and the Neuroscience specialists ought to be the clinical 'experts' who set those standards.

"benchmarking has been defined as a structured comparison and sharing to bring about realistic development"
(Ellis 2000)

But what about the flip side – is there a downside to the process. I would argue that the basic principle and ideal is still sound. However, there is still considerable duplication and repetition of our efforts - how many units have researched and developed guidelines for EVD management, lumbar puncture or teaching packages for ICP monitoring. Multiplied by every Trust across the country, immense work is still being generated. It is obviously necessary and appropriate to 'shake-up' the way that we approach our work, re-visit, and re-evaluate many of our familiar working practices to incorporate new evidence, improved technologies, as well as Clinical Governance and risk management issues. But equally, we must be wary of overloading clinical staff who are already complaining of feeling saturated by the continuous change and re-evaluation of their working practice. And where will it all end? 'Essence of Care' will be launching further benchmarks in the future, and within

neurosciences we are impatient to start developing and writing standards for the administration of Botulinum toxin, coiling and embolisation, to mention just a few suggested topics.

We need to ensure that there is recognition of the work that is happening through specialist benchmarking groups. We may need to rethink and re-organise the way in which we develop, advertise and publicise our work. Whilst working in a geographical area has many benefits in terms of peer support and regular meetings, it limits our opportunities to 'brain storm' issues on the National agenda. In comparison to the British Association of Critical care nurses, we are a very small organisation and specialty but if we really wish to improve our professional status both Nationally and locally and be of value to other specialist areas of practice, we must identify ourselves as a credible, valuable source of information, issuing our own 'specialist mission statements' to guide

good practice finally publicise our work.

Recommendations for future practice.

1. Publish or work through the National Journals.
2. Call on the skills and knowledge of specialist nurses or nurses with 'specialist interests' to form working groups to identify 'best practice' and collect evidence from which we can produce bench further benchmarks.
3. Improve multi-disciplinary working when working towards new benchmarks.

References

Department of Health 1999 Making a difference: Strengthening the nursing, midwifery and health visiting contribution to health and health care. Department of Health: London

Department of Health 2001 The Essence of Care. Department of Health. London

Ellis J M. (1995). Using benchmarking to improve practice. Nursing Standard 9, 25-28

Stop Press
BANN CONFERENCE—LONDON
15-17 OCTOBER 2004

BANN' annual conference is to be hosted by the National Hospital for Neurology & Neurosurgery. The venue is the Holiday Inn, Bloomsbury.

Topics include;

- Agenda for change
- Developments in Genetics
- Euthanasia

- Brain Tumours
- EVD's & ICP's
- National Service Framework
- Conversion disorder
- Nursing research
- Deep brain stimulation
- Skull base and spinal

care

A full report will be available in the next newsletter.

For further information contact Anoushka Singh, Douglas Cheyne or Catherine Best
 020 7837 3611 Ext 3670, 3261 and 8704



*Holiday Inn
 Bloomsbury
 London
 15th—17th October 2005*

THE GLASGOW COMA SCALE

Cath Waterhouse

Earlier this year the RCN Neuroscience Forum was approached to write an article for the Nursing Standard on Glasgow Coma Scale Observations. On behalf of the BANN, benchmarking group, I attempted to put pen to paper and I have to say, it wasn't a completely painless exercise. If it weren't for the excellent papers written by Woodrow, Frawley, Crawford and Cosgrove, I wouldn't have managed to write any further than the title! Hopefully, we should be in print early next year but I would just like to share this alternative GCS guideline with you. I happened to ask one of our Neurosurgeons to proof read my original article and he invited me to attend one of his tutorials to the medical students – it went something like this:

THE GLASGOW COMA PUB SCORE

EYE OPENING

- | | |
|---------------|---|
| • Spontaneous | 4 |
| • To speech | 3 |
| • To pain | 2 |
| • Nil | 1 |

VERBAL RESPONSE

(As demonstrated by Rab C Nesbitt)

- | | |
|---|---|
| • Orientated (goes to the bar and remembers everyone's order correctly) | 5 |
| • Confused (goes to the bar again and returns with 6 pints of lager instead of the gin and tonics that you sent him for). | 4 |
| • Words only (!!! Off!) | 3 |
| • Sounds (difficult to distinguish from Govan speech) | 2 |
| • Nil | 1 |

MOTOR RESPONSE

- | | |
|--|---|
| • Obeys Commands (goes to bar and buys you a packet of crisps) | 6 |
| • Localises to Pain (puts his finger in your eye) | 5 |
| • Flexes to Pain (needs a kick to remind him to go to the bar) | 4 |
| • Abnormal Flexion (attempts to kiss you, but misses) | 3 |
| • Extends to Pain (arches his back in disgust) | 2 |
| • Nil (lies still under the table) | 1 |



Rab C Nesbitt

Reproduced with kind permission of Mr David Jellinek
Consultant Neurosurgeon
Sheffield

“The Scientist- the Doctor- The Patient” UK Brain Tumour Society Conference 2004

UK Brain Tumour Society, established 7 years ago, is a national charity that works to conquer brain tumours through Research, Education and Support.

In July, UKBTS hosted their 4th Residential Educational Conference, “The Scientist-The Doctor- The Patient”, at Nottingham University.

This event has become a notable date in the UK Brain Tumour Community’s diary, attracting over 70 patients, families, representatives from other brain tumour charities and scientific, medical and health professionals. The conference provides a forum for both formal presentations and informal discussions and was experienced very positively.

A mother whose son has a brain tumour had this to say:

“The conference far exceeded all my hopeful expectations. I thought the speakers were fascinating and extremely informative- I picked up a huge amount of information that probably would have otherwise taken me months to find and compile. I felt able to ask questions and address all concerns in a forum which was relaxed, informal and inspiring”

Presentations included:

A Focus on Treatment: Current Surgical Practice and the Role of Radiotherapy and Chemotherapy in

the treatment of brain tumours.

An Inspirational Story of a Charity’s Development from the States:

The Peter Best Memorial Lecture was delivered by Mike Traynor, the President of the Pediatric Brain Tumor Foundation of the United States who demonstrated how passion, sheer faith and determination can move mountains. The PBTF was established in 1984 and now is the largest non governmental funding agency in the US for childhood brain tumor research. Its current research/family support commitment is \$6.5 million with investment in over 30 translational and clinical grants.

A Celebration of Achievements in the field of research in the UK:

Neil and Angela Dickson founded the Samantha Dickson Research Trust in 1996 in memory of their daughter Samantha who died from a brain tumour aged 16.

In seven years, the SDRT has become the largest funder of laboratory based brain tumour research in the UK, having invested over £3 million. The couple are so determined to help raise awareness and funding for research, they invited us to share in a celebration of their charity’s achievements and have just launched, in partnership with five other charities such as UKBTS, the largest research initiative the UK has

ever seen.

Angela is one of only two members representing the patient’s point of view on the NICE Guidance Development Committee for brain and spinal tumours. This is an independent body set up by the Government to set national guidelines for the NHS.

Living with a Brain Tumour:

A comprehensive introduction was given by Shanne McNamara, Chair of ANON and Vice-president of BANN. This was followed by remarkable and intensely moving personal accounts from 4 people whose lives had been deeply touched by brain tumours. These stories shone with courage and hope.

Feedback tells us that participants came away from the conference with renewed hope and new friends and associations with professionals, patients and carers who are like minded and facing the same daunting task of beating brain tumours.

UK Brain Tumour Society is committed to hosting this conference annually, in July, at Nottingham. The event provides a rich opportunity for all members of the brain tumour community to come together, share knowledge and experience, find strength from each other and explore new ways of tackling brain tumours.

Zoe Hoppe UKBTS



UKBTS extends a warm invitation to any reader who is interested in joining us at our 2005 conference or who wants to find out more about our charity.

Please contact Jane on 0845 4500 386 or email info@ukbts.org.uk

Integrated Care Pathways (ICPs)



My name is Julie Collins. I'm the Integrated Care Pathways Co-ordinator for the Edinburgh Cancer Centre at the Western General Hospital. I would be really interested in hearing from anyone who is either in the process of or considering developing an Integrated Care Pathway in any Oncology area. My contact details are listed below.

Within the Edinburgh Cancer Centre the following ICP projects are being conducted:

- An **Oncology Complicated Discharge ICP** has been drafted & is currently being piloted,
- An ICP has been developed for patients with **Small Cell or Non-Small Cell Lung Cancer** who are receiving in-patient chemotherapy. A pilot is due to be carried out at the end of October at the WGH and is already underway at the RIE.
- A multidisciplinary group has formed aimed at developing a **Unitary Patient Record in Oncology**. The document is currently in draft format.
- A multidisciplinary group has recently formed aimed at standardising the care and **management of patients with Malignant Epidural Cord Compression**. This project is in its early stages but it is hoped that an ICP will be produced aimed at optimising the process of care for these patients.
- A **Prostate Brachytherapy ICP** is in implementation and is currently undergoing a third audit.
- An **ICP is currently being developed for Prostate Biopsy**.

Julie Collins
Integrated Care Pathway Co-ordinator
(for the Edinburgh Cancer Centre)
Tel: 0131 537 2657 or,
E-mail: jcollin2@staffmail.ed.ac.uk



Neuroscience Network and Care Bundles

Kate McArdle

Following on from the successes of the implementation of Ventilator care Bundles, a meeting of the national neuroscience network was held to discuss the possibilities of agreeing a 'Neuro' Care Bundle. As a result the Neurosciences Intensive Care Unit in Oxford and Milton Keynes hospital have volunteered to pilot the outline bundle agreed at this national meeting.

In July Tom Cadoux-Hudson a Consultant Neu-

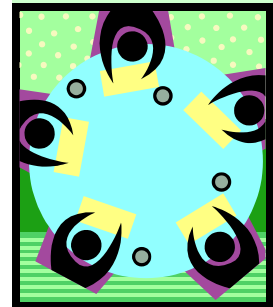
rosurgeon, Chris Kearns and Mhairi Speirs both Consultant Anaesthetists, Jill Titchell, Senior Staff Nurse, Kate McArdle, Head Nurse and Gill Leaver from the Thames Valley Critical Care Network met to discuss the care bundle components identified at the national meeting. We discussed relevant evidence, which could be utilised and deliberated parameters based on this, which would be used as guidance for implemen-

tation of the bundle.

We agreed that Emergency Department to Neuro ICU would be the best place to start and after drafting our discussions to clarify definitions and parameters we will devise an audit tool. After piloting this we plan to make adjustments for the bundle to be widened to include patients within the ICU.

The next national meeting will be at Milton Keynes on September 24th 2004 where we can all discuss

The next national meeting will be at Milton Keynes on September 24th 2004 where we can all discuss our progress.



Kate McArdle
Head Nurse
Neuro ICU
Radcliffe Infirmary Oxford

Neuroscience Educators Forum—Jayne Christopher

Jayne Christopher is Senior Staff Nurse Neurosurgery University Hospital of Wales Cardiff

The second meeting of the Neuroscience Educators Forum took place in Cardiff on the 29th of April 2004. Those present were nurses already in educational posts and ward based nurses with a special interest in education for post registration neuro nurses.

A mission statement summing up the groups intent was drafted:

"The Neuroscience Education Forum will be concerned with the sharing of educational ideas and practices occurring across Neuroscience units and will endeavour to deliver agreed best practice when educating and supporting all staff caring for neuroscience patients."

We discussed the educational / developmental programmes that are currently being used in our units and it was evident that these varied greatly. We

discussed the pros and cons of each others programmes and I believe we all came out of the meeting with some new ideas of how to improve our own programmes - which is indeed what the forum is all about.

Induction programmes seemed to be up and running in most units and in some offered accredited CAT points. It was generally felt that the more experienced nurses often missed out on any formal development, especially if they were not keen to undertake a diploma or degree level course. It was agreed that there should be more developmental study days / sessions available for them.

Other topics discussed included supernumerary periods for new staff, which again varied greatly between units (2 days to 4 weeks!); University links - which some found invaluable, others could live without! and "Adaptation" nurses and how best to induct them.

It is clear that neuroscience units vary greatly around the country depending on how big they are, where they sit geographically and how large a population they serve. It is also clear that neuro patients everywhere require nurses that are knowledgeable, highly skilled and above all motivated to provide the best care that they can. The sharing of educational ideas and practices between units can only improve the support, education and encouragement that we can give our staff. This in turn will ensure that our patients are receiving the best possible care available to them.

The next Neuro Educators meeting will take place at the BANN Conference in London. Anyone interested can attend. Details to be confirmed.

Jayne Christopher



Education and knowledge

Forthcoming conferences and events

The Primary Care Neurology Society

(PCNS) is a new network organisation supporting primary care professionals with an interest in neurology.

They are currently planning their first conference which will be held on 14th April 2005 in Church House, Westminster. For more information contact::

Neil Bindeman General
Secretary PCNS Tel 020
748 5311

www.p-cns.org.uk

The 9th World Federation of Neuroscience Nurses Congress

is being held at the Autonomous University of Barcelona (UBA) Campus Convention Centre, Spain from the 8th—12th May 2005.

The deadline for abstract submission is 24th October 2004.

Early registration 1st February 2005.

The official language will be English.

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The Department of Clinical
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Western General Hospital
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Gugenheim museum



Action On Neurology National Conference

Tuesday 9 November 2004

New Connaught Rooms, London



With a focus on long term conditions in the Government's NHS Improvement Plan, and the forthcoming publication of the National Service Framework for Long Term Conditions, this one day conference provides an ideal opportunity to hear how the *Action On* pilot sites are developing new ways of working to improve the way services are delivered to people with neurological conditions, as well as an update on the NSF.

The *Action On* Neurology team are delighted to invite you to this conference which will not only demonstrate the impact of the changes being made by the pilot sites, but will also show how health and social care services for people with long term conditions cannot be looked at in isolation.

The conference is aimed at clinicians, professionals and managers from both health and social care organisations as well as the voluntary sector.

The main theme will be the presentations from the *Action On* Neurology Pilot Sites covering the following topics:

- ◆ Re-designing services

for people with epilepsy and headaches

- ◆ Developing services for people with acquired brain injury
- ◆ Redesigning access pathways for people with Parkinson's Disease and Multiple Sclerosis
- ◆ Developing the role of the GP with Special Interest (GPwSI)
- ◆ The use of telemedicine in a rural community

There will be plenty of opportunity to ask members of the pilot site teams about their projects.

The other main topic is an update on the forthcoming National Service Framework for Long Term Conditions by a member of the NSF Team.

For further information contact:

Sue Barrow, Associate Director
Action On Neurology on 07810 880281

or

email

susan.barrow@npat.nhs.uk

or

Debbie Ingleby, Programme Manager, *Action On* Neurology on 07909 991472

or

email DINGLEBY@aol.com

If you would like to register for this event, please contact Helen Cullinan on:

0116 222 5186 or
email
helen.cullinan@npat.nhs.uk

COMPLEMENTARY THERAPY AND CHRONIC PAIN

Fiona MacPhearson

Chronic non-malignant pain is a significant problem in the United Kingdom and is one of the most common reasons patients visit their General Practitioner.

Chronic pain has been described as:

Pain that either persists beyond the point at which healing would be expected to be complete or that occurs in disease processes in which healing does not take place. Chronic pain may be accompanied by severe psychological and social disturbance. Chronic pain can be experienced by those who do not have evidence of tissue damage.

(Clinical Standards Advisory Group. CSAG 1999)

A World Health Organization study of 25,916 patients aged 18 to 65 years attending primary care, found that the mean occurrence of persistent pain was 21.5%, with a range of 5 - 33%. The study had defined chronic pain as lasting for at least six months, severe enough to merit consulting a doctor, requiring medication or interfering with the activities of daily living. Pain was consistently associated with emotional distress and impairment in work and social roles. (Gureje. *et al.*1998)

Similarly a study by Smith *et al.*(2001) used a sample drawn from the general population in the Grampian region of Scotland. The results showed that 14.1% reported 'significant' chronic pain (based on the reported need for treatment and professional advice), and 6.3% reported 'severe' chronic pain (based on reported intensity and pain related disability). The presence of significant and severe chronic pain also had marked interference with activities of daily living and general health.

Buckle (2002) also suggests that pain is one of the most common symptoms in clinical settings and one of the main reasons why patients seek complementary

therapies.

A study by Astin (1998) looked at complementary therapy use within the previous year, from a sample of 1,035 individuals. The most frequently cited problems treated with complementary therapies were chronic pain.

Additionally a study by Thomas *et al.*(2001) estimated that over thirty one million visits were made to eight established complementary therapies in 1998. Six million of these were for Aromatherapy.

Buckle (1999) states that Aromatherapy is the therapeutic use of essential oils, whether absorbed via the skin or olfactory system or taken internally.

Generally it appears that health care is in the process of change; and increasingly, as already discussed, the general public are using both conventional and complementary medicine

in the search for health.

Featherstone and Forsyth (1997) have suggested that this can lead to a fragmentation of care that does not lend itself to the highest quality of health care.

To avoid these divisions' health care professionals either from the conventional or complementary setting must be prepared to present evidence for the effectiveness and limitations of their therapy. Evidence of effectiveness is also a requirement in order that the integration of therapies can be justified, (Richardson 2000).

In summary pain has been shown to disrupt the life of chronic pain sufferers and prove costly in terms of medical attendance, loss of function, medicine intake and search for relief.

Dobson (2000) suggests that successful management of pain relies on determining how the

factors of physiology, psychology, emotional, and social issues impact on the personal experience of pain.

A study by the author aimed to examine the impact of aromatherapy massage and plain massage on pain and quality of life in chronic pain patients.

Method:

The subjects were randomly assigned to one of two treatment groups with a third control group taken from the waiting list. This was a convenience sample of patients attending a chronic pain clinic at the Western General Hospital in Edinburgh.

The subjects received either an aromatherapy massage or plain massage weekly for four weeks.

Quality of life was assessed using the WHOQOL-BREF quality of life questionnaire; subjects completed the questionnaire prior to treatment one and

then again after treatment four. The control group were posted the questionnaire and supplied with a return envelope four weeks apart.

Pain intensity scores and percentage of relief were assessed using the Numerical Rating Scale (NRS). Subjects completed the NRS before and after each treatment.

Results:

The results were analysed using repeated measure ANOVA and paired sample t-tests for changes over time.

There was no difference to the individual question of perception of quality of life, or satisfaction with health, however there proved to be a significant difference to the overall domain scores relating to physical health, psychological health and environment after receiving aromatherapy massage as compared to no treatment, and a significant difference to environment after plain

massage.

This suggests that both treatments are beneficial, but aromatherapy massage gained an advantage overall.

Pain intensity was reduced after both treatments.

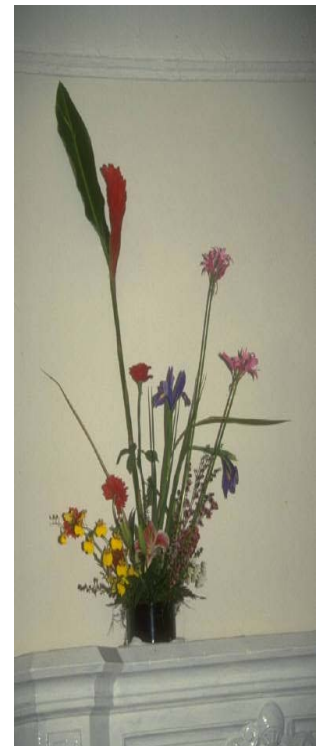
Conclusion:

There is an improvement in the perception of the facets that make up quality of life and a reduction in pain intensity after aromatherapy massage and plain massage.

These findings are similar to other studies in the field and agree with possible pain reduction due to the closure of the 'pain gate' and improvement in quality of life related to increased mood.

Further study would be beneficial to understand if the effect was maintained over a longer period of time.

• **Fiona is Clinical Nurse Specialist for Chronic Pain at the Western General hospital Edinburgh**



Fiona has been awarded £25 for her contribution to Headlines

**British Association of
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CONFIDENTIALITY

Please be advised that all membership records are held on computer. This computer does not link with any other network and so confidentiality is preserved. Names and addresses will not be disclosed to firms, companies, publishers, etc without the consent of individuals.

Information with regard to seeking assistance with nursing research projects or to patient support groups is facilitated through your unit link member at his or her hospital address.

BANN Executive Board

22nd November 1999

Updated April 2004

USEFUL ADDRESSES AND CONTACT

For full list see www.bann.org.uk

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Letter from the Editor

I hope you have enjoyed reading the second edition of the 'new style' Headlines.

I hope to see some of you at the annual conference in October. As you will have seen, there may still be time to register for this year.

Details of other events are also reported in this issue.

Once again a wide range of topics have been addressed. However what may be an improvement for future editions is more communication between BANN members. Let us know what is happening in your area.

The BANN Board has agreed that authors contributing articles published in Headlines will be paid for their contributions.

"Every little helps" as someone quite famous said!!

The next issue is to be published in April 2005. Articles, letters and news items to be forwarded to the editor by the end of February 2005.

BANN Membership Form

FULL MEMBERSHIP £20 PER YEAR

SURNAME.....

FORENAME.....

ADDRESS.....

.....

TEL: HOME.....
WORK.....

E-MAIL.....

PLACE OF WORK.....

RETURN TO: Cath Waterhouse 22 Camm Street Sheffield S6 8TR

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