Barnsley Clinical Commissioning Group

Children's Services Review

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1. Executive Summary

The purpose of this review was to address the following questions in relation to children's services at Barnsley Hospital NHS Foundation Trust (BHNFT):

- Are the services provided of good quality?
- Are the services provided efficient and effective?
- What are the flows between the services?
- Are these working in an effective way for children?

Defining quality, efficiency and effectiveness is complex in its own right and even more so when applied to a varied array of services. For this exercise, we have interpreted these terms as meaning - is the main provider delivering the right care, at the right time, in the right place by the right people. We then explored whether patients and parents were happy with the care they received.

The quality of clinical decision making and treatment pathways has not been assessed as part of this review.

Key Findings - Markers of Good Practice

- As with all good Paediatric services, Barnsley paediatric services operate on a system-wide basis across the region to deliver good care.
- The service operates, and the workforce is utilised, in a similar way as many other paediatric units, apart from the diabetes service which has a unique offer.
- There is active input from the executive team and there is a senior management team in place with the right knowledge and skills to lead to service.
- There is a comprehensive work plan that appears to cover all the aspects of service development that are required as well as participation in national and local audit programmes.
- The ward team are using an acuity tool which is both effective and safe.
- The Friends and Family Test feedback is good and PICKER feedback showed satisfactory as patient experience.
- There have not been any Strategic Executive Information System (STEIS) events in the last 36 months.
- The paediatricians support children regardless of where they are in the organisation, which would include surgery and the Emergency Department (ED).
- There is an 'open access' arrangement for children with long term conditions.

Other Key Findings

- In the main, children are cared for in the right place but not always at the right time – an example would be the outpatients department (OPD), due to the length of time they may wait for follow up appointments. Additionally, some mental health and CED patients may not be seen by the right people, due to shortages of children's nursing.

- The Children's Emergency Department (CED) and children's ward have a high vacancy rate in children's nursing.
- The conversion rate of CED attendance to ward admissions is high and the reasons require further exploration.
- The team should describe and document more clearly the pathway from GP advice, guidance and referral to the Children's Assessment Unit (CAU)
- The community nursing team and the neonatal community team should write an annual report covering demand, capacity and quality metrics. This would demonstrate the impact the service has and identify areas for improvement and opportunities to develop.
- Children's Community Nurses (CCNs) should adopt an acuity tool and other caseload activity metrics that enables them to scrutinise patients on the caseload.
- The children's OPD has a lack of capacity with some children having a long wait for follow up. Nurse-led clinics may hold some part of the solution to this problem.
- The service action plan is far-reaching, but the team needs to identify areas of high priority and areas of highest risk.
- The 'open access' arrangements for children with long term conditions requires active management to ensure patients are clearly informed and demand managed.
- The CCG and trust could consider adopting a GP advice and guidance service arrangement which will help to reduce attendances at CED and CAU.
- Relationships and pathways for mental health patients aged 18 and under require further work between Child and Adolescent Mental Health services (CAMHS) and ED and the paediatrics department.
- The safeguarding action plan requires updating to ensure that all the actions remain completed.

Conclusions

- There is much to commend about this unit and this is evident in the structure and processes of the services and throughout the many pieces of evidence submitted for the review.
- In the main the service appears effective and efficient but there are some outstanding areas of practice that require attention and organisation. Key concerns are all recognised as shown in the service action plan and the management team is clear about their future work programme.
- There are some engrained staffing problems which will need creative solutions to resolve but the new build CAU will offer an opportunity to increase the attractiveness of the organisation and use the medical and nursing staff differently.
- Future service design should include more pathway work across the Sustainability and Transformation Partnership (STP) / Integrated Care System (ICS).

2. Purpose of the Review

The purpose of this review was to answer the following questions in relation to children's services at BHNFT:

- Are the services provided of good quality?
- Are the services provided efficient and effective?

The following services were reviewed in more detail:

- Children's Ward
- Children's Assessment Unit (CAU)
- Community Children's Nursing Team including Neonatal Outreach

For these services, in addition to the above, the aim was to establish:

- What are the flows between the services?
- Are these working in an effective way for children?

The Terms of Reference for this review have been included at Appendix 1.

3. Approach to the Project

In order to fulfil the review brief, Dorothy Bean (DB, Registered Nurse) and Geoff Bick (GB, Civil Eyes Research (CER)) designed a project that would fulfil the review requirements. A total of six days were allocated.

The project combined a quantitative analysis of Hospital Episode Statistics (HES) data by benchmarking against other services with similar demography alongside a qualitative work strand that included an on-site visit in order to understand how the pathways worked, to assess the strengths and weakness of service design and also a review of softer provider information.

The project was carried out via the following steps:

- A pre-meet (May 2019) between GB and DB to design a project that met the brief
- A meeting between DB and GB to review the first cut of the HES data (June 2019)
- Trust visit by DB to talk to key clinical and operational staff members to understand the metrics used by the organisation and strengths and challenges (July 2019). Appendix 2 contains the schedule of meetings.
- Draft reports written by DB and GB
- Meeting between DB and GB to discuss qualitative and quantitative data findings
- Co-ordination of the joint report and presentation by DB and GB
- Attendance at presentation meeting by DB and GB as arranged for 31st July 2019

4. Findings from the Hospital Episode Data Analysis

The full detail of this analysis is available in a separate PowerPoint file.

CER undertook a benchmarking analysis of children's services using HES data. The period covered was, in the main, the 2017/18 financial year. The analysis covered admitted care (inpatient and day case), outpatient and ED activity.

CER are experienced users and analysts of HES data and have undertaken numerous studies and analyses covering myriad settings across the UK. Within this, CER has operated a benchmarking programme with 20 specialist children's hospitals across the UK for the past twelve years.

The main findings from the HES analysis were as follows:

- Hospital admissions for children from Barnsley CCG had a similar age profile as the selected peer group, but a higher level of deprivation.
- Children from Barnsley had a relatively low rate of access to elective admitted care activity as calculated per 1,000 head of population.
- The rate of new outpatient activity was relatively high compared with peer CCGs at 311 attendances per 1,000 head of population on a deprivation adjusted basis.
- The outpatient follow-up rate was below the peer average at 1.8 follow-up attendances per first attendance while the average outpatient wait for a new appointment was in line with the peer mean.
- The rate of ED activity per 1,000 population was below average but the proportion admited to hospital was high.
- The average time spent in the department for patients not admitted was relatively high; for those admitted, the mean duration in the department was similar to the peer avarage.

Methodology

HES data were selected for patients aged 0 – 18 inclusive and also where treatment function codes or specialty related to paediatric or children's specialties.

CER applied criteria of similar geographical area, population deprivation and service configuration in order to identify an appropriate peer group with which to conduct the HES analysis. CER sought to identify CCGs where acute provision was mainly from a district general hospital alongside reasonable geographical proximity to a specialist children's hospital.

The following peer group was identified:

- Airedale, Wharfedale & Craven
- East Staffordshire
- Hartlepool & Stockton-on-Tees
- Mansfield & Ashfield
- Nene
- Newcastle Gateshead
- Warwickshire North
- North Derbyshire
- Rotherham
- South Tyneside
- Southern Derbyshire
- Tameside & Glossop
- Walsall

Figures 1 to 3 below show the benchmarked population and deprivation values.

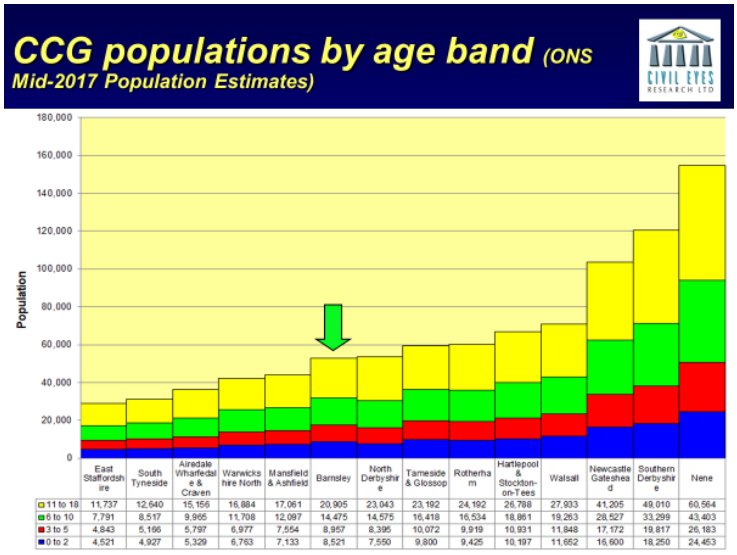

Figure 1 – Population by CCG

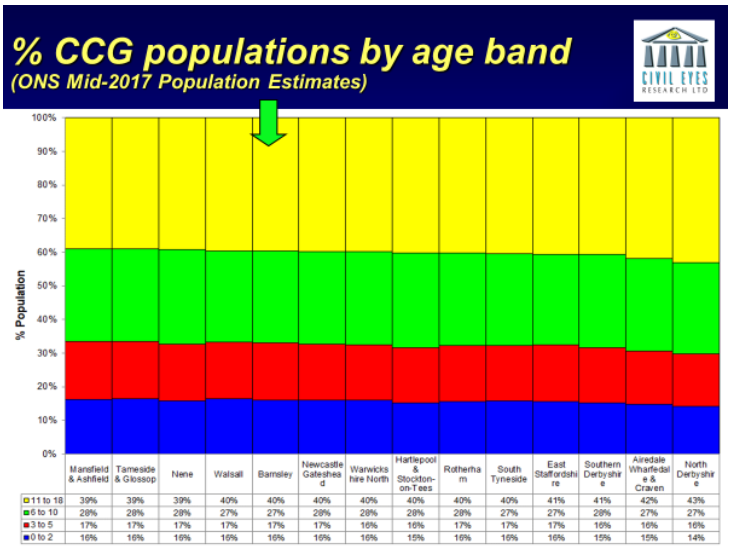

Figure 2 – % Population by CCG by Age Band

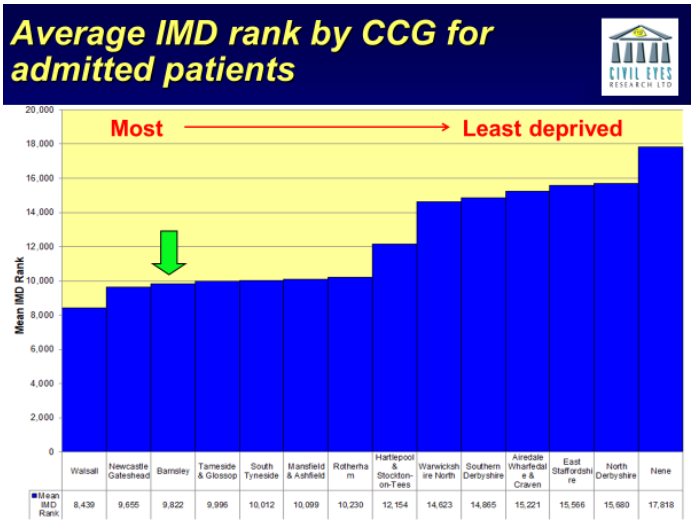

Figure 3 – Mean Deprivation by CCG (based on the Index of Multiple Deprivation)

CER derived a weighted population measure in order to look at activity in relation to the quantum of population in a manner that took deprivation into account. CER has found this approach to be useful in other settings. The weighted population was derived by indexing the mean deprivation value for admitted care activity for each CCG (for this group of CCGs) and applying this index to each CCG's population. The Figure below demonstrates the effect of this approach.

For example, for Nene CCG, with a comparatively low level of deprivation, the weighted population reduced relative to the unadjusted population, whereas for Newcastle Gatehead CCG, with a relatively more deprived population, the weighted population increased. For Barnsley CCG, the effect was to increase the weighted population due to the relatively high level of deprivation.

Within the HES analysis, rates of access were calculated on both an unadjusted and a deprivation adjusted basis.

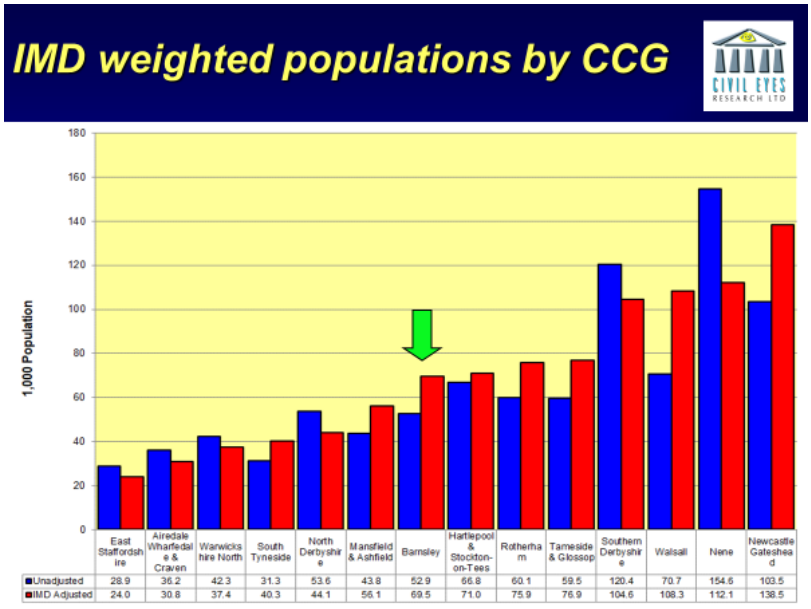

Figure 5 - Deprivation Weighted Populations by CCG

Admitted Care Activity

The HES analysis found that 61% of all admitted care activity for patients aged 0 – 18 from Barnsley CCG were treated at BHNFT, with a further 25% admitted to Sheffield Children's hospital. Over half the admissions at Barnsley were to the paediatrics specialty. There was also a high volume of admissions to oral surgery for multiple teeth extraction.

The most common activities at Sheffield Children's hospital related to chemotherapy, urology, sleep studies and gastroenterology.

The HES analysis considered elective and unplanned admitted care activity separately. It found that children from Barnsley had a relatively low rate of access to elective activity as calculated per 1,000 head of population. The weighted rate of access was 53 spells per 1,000 population against a mean of 59. Some CCGs had rates of over 70 spells per 1,000 adjusted population.

The rates of elective access were low for the following specialties – ENT, paediatrics, gynaecology and ophthalmology. The rate of elective bed days per head of population for

mental health (MH) was low, but this may in part reflect differences in data recording and service configuration.

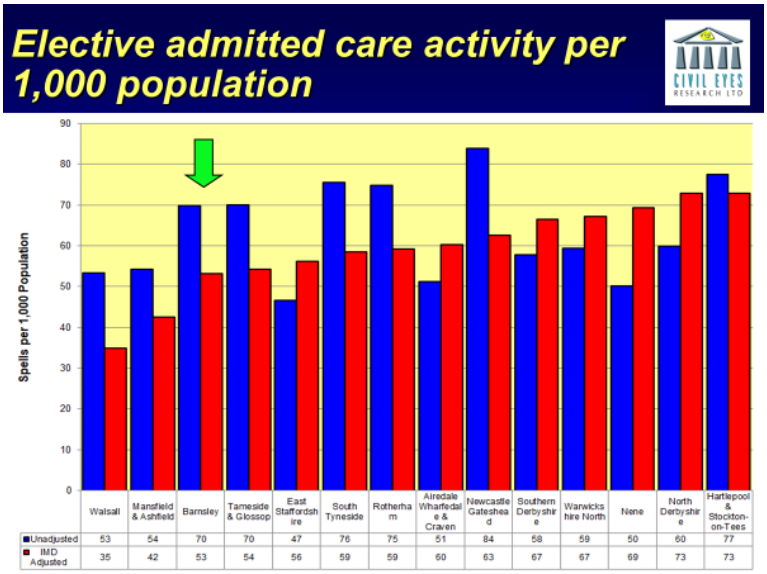

Figure 6 – Elective Admitted Care Activity per 1,000 Population

The mean elective wait for admission, based on HES data, was in line with the average of the peer group but was particularly high for ophthalmology. Waits were relatively low for plastics, rheumatology and orthopaedics.

Looking at efficiency, the proportion of elective actvity managed on a day case basis was similar to the majority of the peer CCGs, and day case rates were high for the dental, ophthalmology, oral surgery and paediatric surgery & urology specialties. However day case rates were low for the gastroenterology, general surgery, gynaecology, haematology & oncology, orthopaedics and paediatrics specialties.

The readmission rate following elective activity was relatively high, the most common condition being children undergoing chemotherapy.

The rate of non-elective activity per 1,000 population was in line with the peer average on both a spell and a bed day basis. Within this, the rate for non-elective ENT admissions was comparatively high.

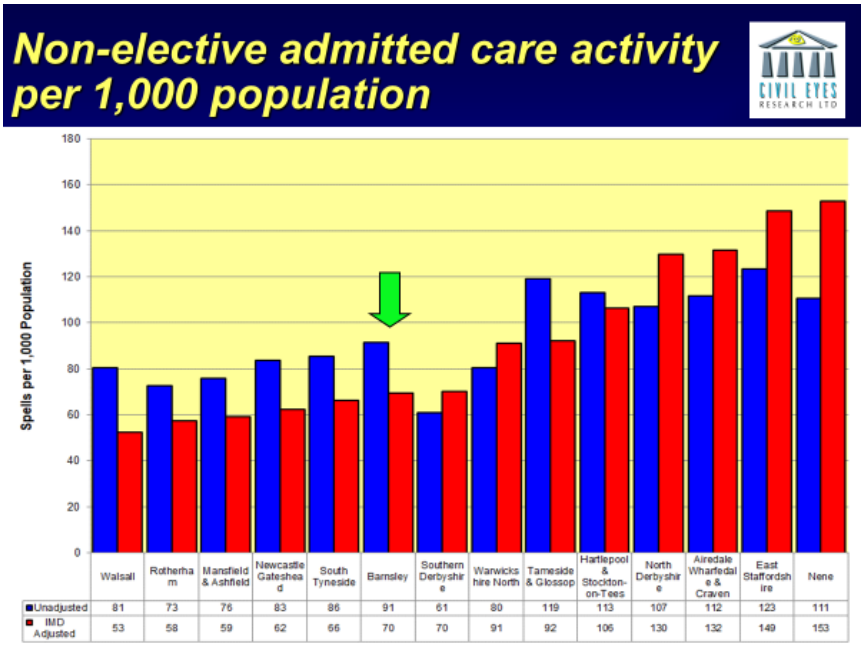

Figure 7 - Non-Elective Admitted Care Activity per 1,000 Population

The high rate of readmissions following non-elective activity was driven by neonatology activity but this is an area that is often recorded inconsistently across different health economies within HES data.

Outpatient Activity

The HES analysis found that 67% of all outpatient activity for patients aged 0 – 18 from Barnsley CCG were treated at BHNFT, with a further 16% at Sheffield Children's hospital. The most common treatment specialties at Sheffield Children's hospital were paediatric surgery & urology and trauma & orthopaedics.

The rate of new outpatient activity was relatively high compared with peer CCGs at 311 attendances per 1,000 head of population on a deprivation adjusted basis.

The rate of new outpatient activity per 1,000 head of population was high for the paediatrics, ophthalmology, paediatric surgery & urology, cardiology, gynaecology and respiratory medicine specialties, but low for ENT, mental health and haematology & oncology.

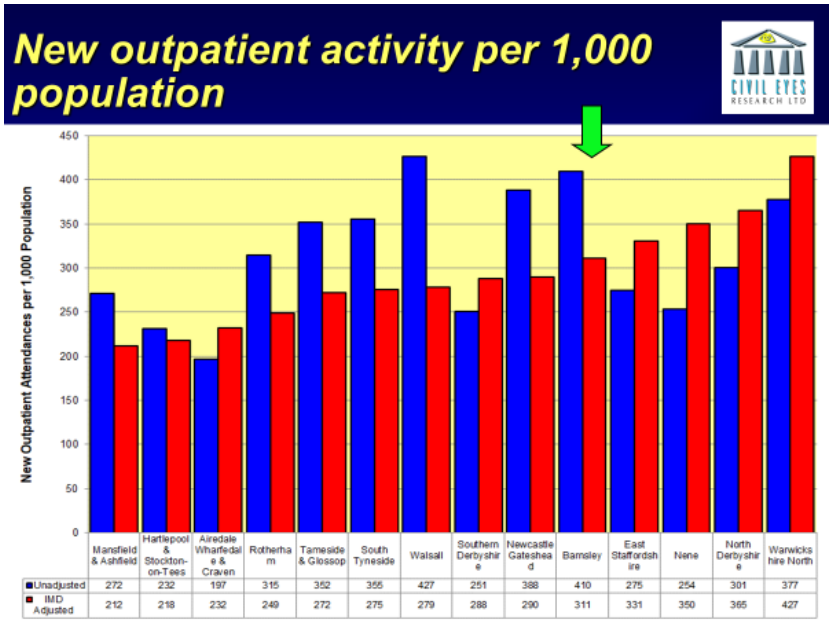

Figure 8 – Rate of New Outpatient Activity per 1,000 Population

The outpatient follow-up rate was below the peer average at 1.8 follow-up attendances per first attendance.

The average outpatient wait for new appointment was in line with the peer mean. The only specialty that benchmarked with a relatively long wait for a new appointment was dermatology.

Overall, the level of outpatient did not attends (DNAs) / was not brought (WNB) was in line with the peer, but the rates were high for the cardiology, dental, dermatology, ENT, ophthalmology, paediatric surgery & urology specialties.

Emergency Department Activity

83% of all emergency department activity for patients aged 0 – 18 from Barnsley CCG were treated at BHNFT.

The rate of ED activity per 1,000 population was below average.

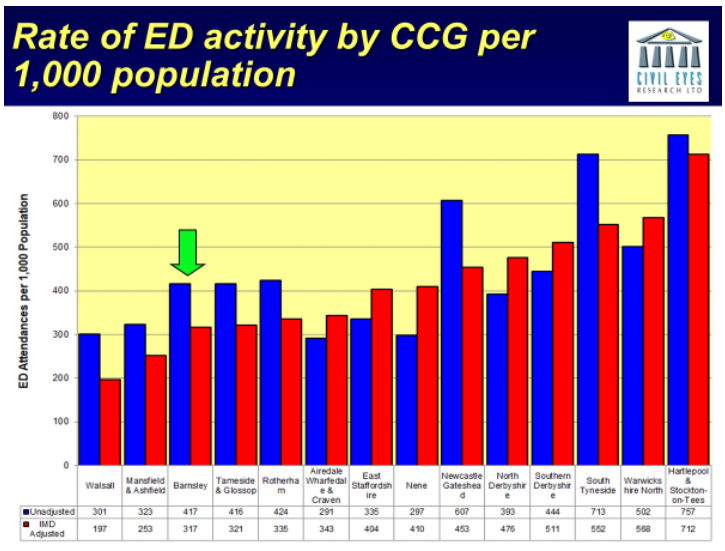

Figure 9 - Rate of ED Activity by CCG per 1,000 Population

The rate of reattendance at ED was in line with the peer average, but the proportion of ED activity admitted to hospital was relatively high. Examination of the HES data found that BHNFT did not record its admission or assessment unit activity as a spell, unlike some other hospitals.

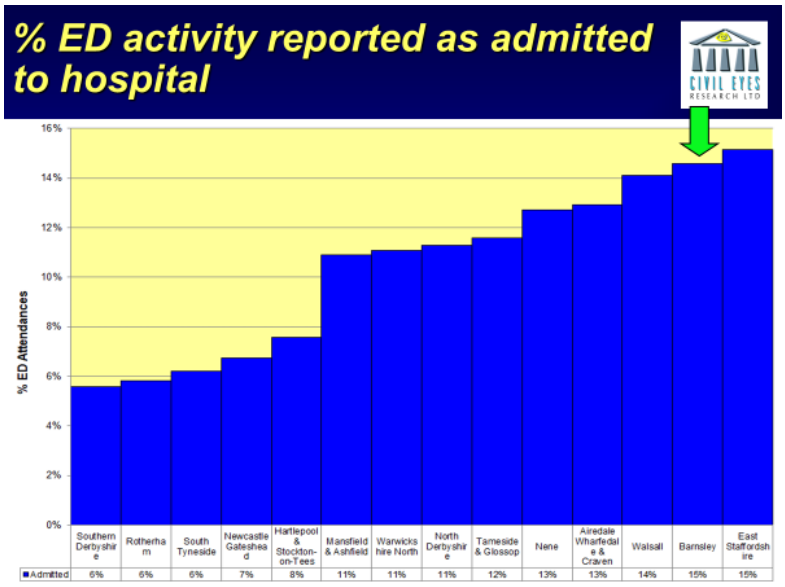

Figure 10 - % ED Activity Reported as Admitted to Hospital

The average time spent in the department for patients not admitted was relatively high; for those admitted, the mean duration in the department was similar to the peer average.

5. Findings from the On-site Visit

Interview number 1 was conducted with Alison Cowie the new Paediatric Manager; key findings have been noted below.

The paediatric unit works with the Integrated Care System (ICS) which includes Barnsley, Bassetlaw, Doncaster, Sheffield and Rotherham.

The Sustainability and Transformation Partnership (STP) / ICS had identified, from a hospital services review, that the priority areas for a deep dive would be emergency care, gastroenterology, maternity services, paediatric services and stroke. The subsequent workstreams reported back but did not make any recommendations about children's bed capacity at BHNFT. Its only recommendation was to explore hospital at home services in paediatrics.

There appears to be a high number of sudden infant deaths in the area. There is a child death overview panel (CDOP). Alison was unaware of any specific findings, actions (and outside the scope of this review) or implications to Public Health or CDOP. The CCG will want to know that any actions recommended by CDOP or the coroner have been acted upon.

The creation of a hosted regional children's services network is currently being established. Decisions are underway to agree the model for this. It is perceived that the agenda will be driven by workforce and financial challenges in the region.

There is a managed clinical network in the region which is trying to embed the standardisation of the five high volume paediatric conditions across the system. Such projects have been replicated in many regions of the UK with mixed success, and without digital systems to

support, few manage to sustain measurable improvements. Newcastle is one such service who have been able to embed good respiratory pathways across primary, secondary and tertiary care services to children across the health economy.

The service uses a Paediatric Early Warning Score (PEWS) system which is an adapted version from Sheffield. It is situated on their 'Vital Pac' digital record system. This system requires manual escalation of concerns i.e. it does not automatically contact a doctor when a PEWS score is over a chosen threshold.

The team have not yet started to analyse data from vital pack yet.

Key Findings - Markers of Good Practice

- That the paediatric team are working well with their ICS, Managed Clinical Network and developing Hosted Network, are markers of good practice. This is because paediatrics operates on a system-wide basis across a region to deliver good care and ensure they keep up to date. That these relationships are built by clinical practitioners and managers shows that all parts of the team are engaged in cross-system working.
- The use of a PEWS system shows the implementation of best practice guidance. The ward is using acuity data to assess dependency and model staffing requirements.
- The service has an experienced senior children's nurse to lead children's nursing and a senior lead consultant.

Other Key Findings and recommendations

- The ICS's recommendation to explore 'hospital at home services' in paediatrics should be explored to affect a reduction in hospital attendances, admissions, or length of stay. As 85% of parents bring children directly to ED, any GP related scheme to reduce attendances will have limited impact. The Luton model of acute community nursing is held in high esteem by providers and commissioners alike and may be a useful point of reference. https://www.cambscommunityservices.nhs.uk/what-we-do/luton-adults-childrens-services---april-2015/childrens-continuing-care-and-community-nursing-services/children's-rapid-response-service
- The paediatric team should analyse data from Vital Pac in the coming months to ensure they learn from it and better understand timeliness of observations and acuity which may help increase the effectiveness of bed utilisation in summer months.
- The CCG will want assurance that any actions recommended by CDOP have been acted upon. The Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK data may be a good source of comparator information.

Interview number 2 was conducted with the medical leadership team; key findings have been noted below.

There are eight full time consultants in this acute unit. They all work on the 'hot week on-call rota' which suggests all are competent in all areas of paediatric practice. They work a 1:8 on-call which run from Friday to Friday. This is a popular model for on-call arrangements in organisations this size. They do not cover clinics when on-call. Each also covers an on-call for neonatal services and when they do, are present in the neonatal unit from 09-00 to 13-00. The service action plan suggests a review of this arrangement is needed.

Medical staff undertake handover three times per day which is a common model used to ensure that junior doctors are well supported, mentored and have enough contact time with senior consultants. A senior registrar level doctor is on site overnight, but consultants frequently remain on site when on-call until 22-30.

It was reported there were 5.5 community consultants. It was not evident through this review how they collaborated to influence local service configuration. However, the enuresis service was given as an example of service which required better cross-system planning and sounded fragmented leading to poor patient experience and poor clinical outcomes.

There are five ED consultants who have a paediatric qualification, which is high compared to many trusts. ED paediatric patients needing resuscitation are managed in a children's bay in the ED resuscitation area and include consultant anaesthetists and paediatricians when needed. They are managed in resus until collection by the regional children's transport service - EMBRACE. Only ward children who require resuscitation will go to adult ITU / recovery area for stabilisation whilst waiting for EMBRACE. The team submitted data and an action plan to show recent benchmarking against a national paediatric critical care review.

Paediatricians from the children's unit will be called to any paediatric patients across the trust requiring resuscitation, safeguarding advice or are post-operative and unwell. They give advice and guidance to GPs as required (typically one to two cases per day) but there is no contracted GP hotline arrangement.

Consultant paediatricians respond to advice and guidance requests in choose and book and triage OPD referrals to ensure children are seen in a timely way. They cover the named doctor responsibility in the trust and follow up child sexual abuse cases requiring local follow up. These processes are an effective way to operate.

Outpatient Clinics

Consultants will do between two to three clinics per week depending on their job plan. Clinics are run as new patient clinics and follow up clinics, but any slots that come empty are filled with other patients where known cancellations occur. Follow-ups sound like they are hard to fit in, with many waiting six to nine months. Some clinics were over-booked in order to see patients in a timely way, especially newly discharged patients or neonates that cannot be slotted into the four CAU slots and need short term follow up. New patients are allocated 30 minutes with 15 minutes for follow ups. Some specialty clinics require 45 minutes for new patients although the trust will not be paid for appointments over 30 minutes. These timings are typical.

Ward attenders come to the ward / CAU as the OPD team often cannot find clinic slots to see patients in the desired time frame. The efficiency of this system is reflected in both the OPD data and the DNA / WNB rate (see slide pack). Clinics are described as busy. This may be an outcome of being short of the recommended 10 consultants and shortage of space. The OPD does not feature in the service action plan which should be checked.

If the consultant workforce is under establishment, other areas of practice - for example clinical governance, quality management, self-development, improvements in care pathways and consistent attendance at essential meetings - may be neglected due to clinical capacity limitations. We noted that the parts of the service action plan allocated to medical staff are all in red and attention to this is needed.

Visiting consultants are mainly from Sheffield Children's Hospital. These cover cardiology, asthma, gastroenterology, endocrine, neurology and paediatric surgery. It is reported to be is a challenge to fit these into the OPD footprint.

We know that children are seen by other trust doctors outside paediatric services such as ophthalmology, orthopaedics and dermatology. If they are seen outside the children's OPD,

the systems, processes and quality of those services should be reviewed along with the set up of children's day surgery.

The medical staff suggest that some Cystic Fibrosis (CF), allergy and jaundice clinics could be undertaken by a specialist nurse which, was later echoed by the sister in the OPD.

Junior Doctors

The current rota arrangement was described as being populated with 10 WTE tier one and 10 WTE tier two doctors. One is covered by a headcount of 15 doctors. All tier two doctors are ST4 - 8 grades of which three are trust grade staff. This is strong at present but was described as not always being so.

Surgical Pathway

The medical team was not able to describe the surgical pathways completely clearly. ENT and orthopaedic surgeons appeared more likely to undertake procedures in children aged under two. There was an observation that new surgical consultants were much less likely to undertake procedures on small children than their predecessors due to changes in national guidance. Most paediatric emergency surgery on children under the age of eight was believed to be done in Sheffield and less well differentiated conditions like abdominal pain were more likely referred to paediatricians in the first instance. From a quality perspective, this is usual practice.

The day surgical unit try to operate as a one stop shop with the majority undertaking the whole pathway in the day surgery unit. This is good practice and seen as being the most efficient model. If surgical patients are admitted to the ward, either because they require an inpatient facility or are a failure to recover in time for day surgery closure, the paediatricians would often cover any care requirements where nurses have concerns for patients. This is usual practice for units of this type and size and indeed many larger units. Surgical teams undertake the planned activity around the pathway but, if children become clinically unwell, paediatricians participate and advise when required to do so to ensure patient safety.

Paediatricians and midwives contribute to the new-born screening programme and undertake the Newborn and Infant Physical Examination (NIPE) screening. There is reportedly a smooth pathway for any babies whose hips are raised as a concern (which is one of the areas where there is most discrepancy in practice nationally).

The local pathway for the screening programme gives clear narrative about the processes involved. Having looked at the very comprehensive 2017/18 Antenatal and New-born Screening Programme Annual Report - the trust shows high levels of compliance to all measures. The raw data suggest that all babies were accounted for.

Key Findings - Markers of Good Practice

- The model of medical management used by the service is in line with that delivered in many similar paediatric units.
- The NIPE screening appears well managed based on the report and the pathway is clear and shows responsiveness is built into the system.
- There are five ED consultants who have a paediatric qualification which is an asset for the trust in terms of managing safely especially if the increase in paediatric patients continues.
- The paediatricians give advice and guidance to local GPs.
- The children's OPD appears to operate efficiently – see slide pack.

- If any surgical paediatric patients are admitted to the ward, either because they require inpatient care or fail to recover adequately, the paediatricians will cover overall care.
- The trust's paediatric anaesthesia and surgery guidelines (2019) are helpful in setting out the trust's position and arrangements.
- The trust has recently undertaken a comprehensive self-assessment for the 'Children's Surgery and Anaesthesia Managed Clinical Network' with only paediatric pharmacy and low APLS / EPLS rates outstanding.
- The children's ward and surgical day unit should ensure they always have a member of staff on duty who have an APLS / EPLS qualification. Not currently the case.
- Paediatricians from the children's unit will be called to any paediatric patients across the trust and act as a trust-wide resource for any paediatric matters.
- Medical staff undertake handover three times per day which is a common pattern to ensure support of junior medical staff.
- Clinic slots that come empty due to cancellations are filled immediately.

Other Key Findings and recommendations

- National recommendations state that a minimum of ten WTE consultants are required. Consideration should be given to the level of staffing for the consultant body to ensure they are able to respond to any fluctuations in middle grades doctors, the lack of capacity in children's OPD, and the lack of progress on the service action plan.
- The enuresis service was given as an example of a service which required cross-system planning. It appears fragmented and leading to poor patient experience.
- In the NIPE report, greater clarity on any babies who missed the 72 hour hip screen and their outcome would be helpful to assure the service that no babies slipped through the net.
- The COPD does not feature in the service action plan although it appears under pressure. Some clinics could be undertaken by a specialist nurse and there is a likely shortage of clinic slots.
- There is no formal contracted GP advice and guidance service which could both support GPs and reduce CED attendances and thus admissions. Access to CAU through this pathway, although mapped, should be clearer to ensure clarity and continuity of responsibilities.
- The service action plan for medical on-call for neonatal services suggests a review of this arrangement is needed.
- If children are seen by other trust doctors outside paediatric services such as in ophthalmology, orthopaedics and dermatology services and outside children's outpatient systems, the processes and quality of those services should be reviewed along with the setup of children's day surgery.
- The COPD and CED Friends and Family Test data appears to have low collection while other areas appear to score well.

Interview number 3 with Children's Community Nursing (CCN); key findings have been noted below.

The community nursing team combines generic and specialist nurses who work in the community with patients who have specific or generic conditions. Therefore, the team has a suite of skills to draw upon. The service has the following resources:

- Generic community nurses - 3.4 WTEs
- Specialist diabetes nurses - 3.1 WTEs
- Specialist respiratory nurse - 0.8 WTEs

- Specialist neonatal nurses - 1.3 WTEs
- Specialist continuing care nurse - 0.6 WTEs

They are based in the COPD and services are open from 08-30 to 17-00 Monday to Friday apart from the diabetes service.

Diabetes Nurses

The diabetes nurses are a highly qualified group of specialist nurses who have all undertaken additional education programmes and are non-medical prescribers. They cover on-call at weekends and evenings on a hot week arrangement. This is in line with best practice tariff (BPT) requirements. They have a relatively high on-call volume as they do not share a rota with any other service (as Mid Yorkshire do, for example).

They are currently in the process of recruiting a part time psychologist (0.8 WTE at band 8A) having received an improvement notice to do so. Such a post is an essential metric to receive BPT funding, but posts are sometimes difficult to fill. The main problems reported is dealing with anxiety related to the condition.

The nurses note a high level of safeguarding concerns due to inadequate parenting and engagement, DNAs / WNB and non-compliance to treatment.

The service is currently supporting 187 children and young people and support young people between the ages of 19 - 22 years (for which BPT is not received).

Considering the recommendations within the long-term plan for children's and young people's (CYP) services to extend, in some circumstances, to cover patients up to 24 years old, this is an insightful development. The model includes young people's transition clinics which are staffed by a combination of adult consultants, paediatrics diabetic consultant and CYP diabetes specialist / community nurse. These do not include the attendance of adult diabetes nurses possibly due to workforce pressures in the adult service.

When talking with the ED medical staff about how the pathway works for 16 year olds and beyond, they were unaware that this service went up to the age of 22. This should be clarified.

Respiratory services within the CCN team

The respiratory service has 0.8 WTE nurses. A second post ceased some time ago. The service works with patients who have difficult asthma (stage three and above) and other diseases such as CF, whose care they share with Sheffield Children's Hospital. Referral demand is high from consultants at BHNFT. They are participating in the national asthma audit as at June 2019.

The respiratory nurse is unaware of the number of asthmatic children who have an asthma plan in the Barnsley locality and / or come through the ED. More under fives appear to attend the trust with increasing frequency as practice nurses are unable to undertake their annual review of since they do not feel competent to do so.

Asthma guidelines are in place and were included with the review data pack. It is reportedly difficult to undertake spirometry tests in a timely way (echoed by the COPD sister) due to their being only one spirometer. We understand that another is on order.

The CF patients who require regular antibiotics in two-week blocks have their intravenous antibiotics at home. In terms of disruption to patients and family this is good practice – although some CF specialists insist long term outcomes are improved if antibiotics are administered in hospital. CF patients are transitioned to Northern General Hospital in

Sheffield after they undertake their GCSEs showing efficiency of service. The nurse undertakes school visits due to either safeguarding concerns or where medication is being given by schools. This service is reactive in this regard.

Safeguarding

The team have six monthly safeguarding supervision meetings with access to the Named Nurse in between.

Neonatal Nurses

Neonatal Nurses were not available to meet on the day of the site visit. There was a referral criterion available but not service description or annual report.

Generic CCN team

The team cover a geographical area with a 20 mile radius and describe working in a way that tries to be as economical as possible in terms of travel. All CCNs have laptops, so can work remotely when internet access is available. They work with a range of tertiary centres including Sheffield and Nottingham.

If newly diagnosed child is being discharged with complex medical needs, they will visit accompanied by a member of the senior medical team to ensure they receive training and detailed handover. This is good practice and helps to build relationships with the tertiary centres.

Palliative care patients are difficult to manage due to the variable lengths of the terminal phase of illness and the lack of seven day per week cover.

The CCNs articulate a clear teamwork centred daily routine. The caseload size is unknown but contains both live and dormant patients i.e. those who will need care again at soon. A patient acuity scoring tool has not been used on the caseload in order to understand the needs of patients as a whole.

Key Findings - Markers of Good Practice

- The diabetes nurses have undertaken the required additional education to ensure they are working at the top of their competence.
- The CCN and consultant teams visit tertiary centres when accepting complex children to assess the child's needs, the training, identify equipment and get clear handover. This is safe and effective practice.
- Parents of children with CF are undertaking the two week intravenous antibiotics regime at home. In terms of disruption to patients and family lives, this is good practice.
- The CCNs have laptops and mobile phones to enable mobile working.
- The CCNs receive six monthly safeguarding supervision.

Other Key Findings and recommendations

- The pathway for newly diagnosed 16 year old diabetics, and for diabetic patients aged 16 - 22 going through ED or adult wards, should be reviewed with the ED and possibly adult ward teams to achieve continuity of care.
- Recruitment of a part time psychologist (0.8 WTE at band 8A) is underway.
- Cross-system / ICS work on the children's asthma pathway could help reduce the total number of children attending ED and COPD (Newcastle have implemented a system across the system that is worth review.)

- The CCN team should have a service description that makes clear how the service is operationally run and shows how it meets the service specification of the CCG if one is in place.
- The CCN service could adopt a patient acuity scoring tool on the caseload in order to ensure they systematically review care needs, admission and discharges, analyse activity and productivity. Leicester district nursing team have an excellent model.
- This should also be done by the neonatal unit service who have referral criteria but no service description. A service description and annual report would give an opportunity to review the year's activity and audit cycle and to assess demand, dependency and quality.
- The CCN service is not able to respond to the needs of paediatric patients with palliative care needs due to limited capacity; however, there are very few children and most use Bluebell Wood hospice.
- The diabetes CCNs have a high on-call rate. This function could be shared with another team to increase efficiency.

Interview number 4 with the Senior Management Team; key findings have been noted below.

The interview with the children's senior leadership team was intended to examine how the service responded to the last Care Quality Commission (CQC) report and their plans to improve the effectiveness of the service.

There is a substantial and detailed Delivery Action Plan (2019) which has had support from the trust Project Management Office and describes the actions the service intends to undertake. The plan covers pathway design, education, governance, leadership, quality and the workforce issues.

The clinical effectiveness team are due to audit changes the completion of the mental health risk assessment.

There is nothing in the plan about patient experience, little regarding the quality or efficiency of pathways and nothing about the ICS agenda. It is difficult to tease out the priorities, areas of highest risk and they are at risk of trying to do everything at once.

The action plan is overseen by a steering group which is chaired by the Deputy Director of Operations. Items that require escalating do so via the governance or briefing papers to board. There is a vast amount of work involved in the completion.

There is a post CQC, Safeguarding Action Plan (2018) in which all domains are complete, and progress has been made. However, all actions should be checked to ensure they remain embedded. The safeguarding action plan states that the CAMHS care plan was in place in 2018 but the ward sister explained that the care plan outstanding at the current time. Many actions in the delivery plan centre on safeguarding. Two guidelines were out of date. Safeguarding level three training rates were low.

There is more work to do on their CAMHS pathways including building the relationship with the MH team. The team noted that 13 staff are to undertake MH first aid training by end of august 2019.

There remains more work to do in implementing the sepsis 6 bundle.

Underpinning high quality of care, is the knowledge of how to use the research on human factors, and models for quality improvement including PDSA cycles and total quality management. The team acknowledge that such skills are not yet developed in this team.

Skilled improvement support to help lead their quality improvement work with the sepsis 6, mental health improvements and safety huddles would help them progress at pace.

There was no calculation about the time or skills required to deliver all the objectives in their plans. Many were assigned to the nursing and medical teams and we noted all actions for the medical actions were mainly in red.

The team worries about capacity in the safeguarding team and the named doctor only has 1.5 PAs for this role. The recommendation being 2 - 2.5 PAs.

The team state they have good input from the executive team who have met with many members of the unit team.

The effectiveness of some relationships between staff in the children's unit, between different departments or with external partners was of some concern.

The capacity within the leadership infrastructure to complete the work programme was also a concern and that they were not compliant with national standards, such as staffing.

Positives raised were about the new Clinical Director and her positive impact on the team and all enthused over the lead paediatrician who was described as follows:

"Dr Kerrin always does the right thing and the patient is always at the centre of everything he does". This reflects well and is vital for the effective leadership of the service.

Key Findings - Markers of Good Practice

- There is input by the executive that is meaningful and constructive.
- The new Clinical Director and lead paediatrician are reported as highly effective leaders.
- There is a substantial and detailed action plan with input from the trust Project Management Office responding to the required work programme.

Other Key Findings and recommendations

- The named doctor has only 1.5 PAs for safeguarding which is below standard. The named midwife is only 0.5 WTE which is limited. The capacity and effectiveness of the safeguarding systems should be reviewed.
- Concerns were raised about staffing levels in the children's department and lack of capacity for education.
- The team may benefit from a quality improvement specialist who can help them develop implement Plan, Do, Study and Act cycles and application of human factors approaches to help them manage clinical aspects of low compliance.
- The service plan should include patient experience, efficiency of pathways goals and the wider ICS agenda and identify the priorities.

Interview number 5 with the ward sister and matron; key findings have been noted below.

The ward has 20 beds open 24/7 and two beds in a spacious high dependency (HD) bay. The CAU is open 10-00 – 21-00 five days per week and 09-00 to 13-00 at weekends.

Open access arrangements for children operates on an informal basis. Children on the open access list have long term conditions and need swift access into the children's department. Open access is organised via a paper record being held on the ward which includes the last clinic letter and name of consultants. It is unknown how many children are on open access and there does not appear to be clear arrangements around its management. There was not

organisation around children being added to or removed from the list. This is most likely to affect staff trying to manage beds especially in winter.

The CAU has a range of functions including short term follow up of patients, review of ward attenders who need intravenous antibiotics, replacement of nasogastric tubes at weekends (when CCNs are not working), patients with prolonged jaundice, short term review post-discharge patients or those who needs rapid review from e-referral. Rapid access clinics were noted to have stopped.

The ward team described having a good relationship with consultants now and that executive team buy in had helped to facilitate cultural change. It was noted in the report by the Nottingham team (November 2018) that relationships between nurses and medical staff were strained thus this reflects a positive change. Relationships were noted to be improving due to ongoing workstream meetings, improving communication and better listening.

No healthy babies or ex-pre-term babies return to the neonatal unit apart from those who need an exchange transfusion. This is usual practice.

The CAMHS patient pathway was raised as an area of concern. CAMHS workers will see patients when they are medically fit for discharge, which is common practice and see patients in ED if it can be achieved within the four-hour target.

Presently CAMHS patients admitted at weekends may not be seen until Monday due to lack of availability of the CAMHS team. Changes from September will result in children and young people (of any age) being seen by the on-site mental health liaison team in the hope this will reduce the number of children being admitted.

The ward team have produced a mental health risk assessment (now in use), but there is reportedly no care plan. The team state they feel vulnerable re this pathway which was echoed by the ED team.

The team were not aware of any performance dashboards for safeguarding service.

The HDU is a spacious dedicated facility but the team were concerned this was not funded so cannot be staffed as they would like. It has monitoring capability and piped air so they can deliver continuous positive airway pressure (CPAP) and high flow of which training rates are now 85% following network critical care educator delivering training.

The team are now confident with high flow but not CPAP due to infrequency of use. They are competent at using peripheral and long lines and but there is limited resource in accessing portacaths. Bespoke training is planned via skills and drills days.

Affecting only about eight children locally, paediatric tracheostomy patients are not managed on the ward due to their infrequency. The adult respiratory team at BHNFT reportedly will not support the paediatric service. The CCN team are competent with tracheostomies as are the three trainee ANPs. The children go to Sheffield Children's hospital if they have any health problems be it serious or minor.

Other physicians, surgery, ophthalmology and ENT are supported by the paediatricians who will prescribe medication and fluids. This arrangement is described in very positive terms as to how the medical team manage such requests from nursing staff.

The team has a critical care skills passport and good relationships with the critical care outreach team who deliver critical care skills days. There is planned level one simulation training sessions for October 2019.

The ward has no educator and this is reported to have an impact on learning, students and clinical policy.

Our assessment of the nurse staffing requirement is as follows:

Staffing requirement for CAU and ward 37 if 20 beds open	**Registered Nurses**	**Registered Nurses**
Ward and CAU actual budgeted	27.66 WTEs	
Ward requirement based on acuity and 20 beds	27.5 WTEs	
Ward requirement based on under 2s and poor visibility due to layout		35.75 WTEs
CAU requirements based on current opening hours (11 hrs x 5, 4 hrs x 2)	4.12 WTEs	4.12 WTEs
Sister 0.6 WTE	0.6 WTEs	0.6 WTEs
Total to be RCN compliant	**32.22 WTEs**	**40.47 WTEs**

The acuity data suggest the requirement is from 25.45 WTEs to 38.76 WTEs over the nine month period while the acuity data mean was 32.48 WTEs.

Reference – RCN (2013) Defining staffing levels for children and young people's services.

Key Findings - Markers of Good Practice

- That children with long term conditions have an open access arrangement.
- The CAU has a range of functions that ensures the overall clinical pathways work.
- The ward team described having good relationship with consultants leading to an improved safety culture.
- Team members have a critical care skills passport and good relationships with the regional critical care team who undertake critical care skills days and there is now 85% compliance of staff having high flow training.
- The development of the on-site mental health liaison team will be useful if it achieves its goal of safely reducing CAMHS admissions and should improve the CAMHS pathway.

Other Key Findings and Recommendations

- The report by the Nottingham Hospitals team shows an increase in the nursing workforce is required.
- The ward layout could be revised during the summer months when occupancy declines as the split between genders is not mandated in children's services.
- It is unknown how many children are on the 'open access' arrangement so the ward team should create a mechanism by which they review, at least annually, the patients using this facility to ensure its good management.
- If not already in place, an operating policy for CAU would be helpful to manage length of stay and criteria for admission with clarity especially for 16 and 17 year olds.
- The pathway from GP advice through to paediatrics should be clearly agreed.
- There is no clinical ward educator for the children's unit.

- The presence of a nurse with APLS or EPLS on each shift and a band 6 on each shift is recommended in RCN guidelines.
- Both the PICKER survey (2016) and PLACE (2019) survey identified torn furniture should be replaced.
- The unit requires a staffing review. The ward layout and the number of children under two must be considered as part of this.

Interview number 6 with the Emergency Department leadership team; key findings have been noted below.

The service is in the top ten in the country against the four hour target and proud of sepsis time to one hour antibiotic achievement.

The unit has increased its medical workforce by expanding junior grades and consultant workforce, now having 14 WTE consultants with a headcount of 18. There is a high percentage of consultants who have undertaken the paediatric emergency medicine (PEM) accreditation.

They have a junior nursing workforce having 100 WTE nurses in department, but only three band seven nurses and a clinical nurse manager at band 8A.

They are very short of registered children's nurses and have six vacancies out of 11.5 WTEs. This is clearly of concern as it was raised as an issue in the CQC report when the department was better off than is currently the case. The department deploys a children's nurse in the children's ED with a highly experienced ED nurse as a way of mitigating the risk. Adult nurses have undergone bespoke paediatric centred two-day study sessions - all band 6s will do the training by the beginning of September.

Asked about paediatric resus cases, they explained that their relationship with EMBRACE is good. They have feedback sessions to ensure learning from cases and paediatric resuscitation is described as well managed. The newly expanded resus room enables better capacity management so paediatric patients will be treated in a paediatric bay in ED (this is not the case in all trusts). It was stated that a paediatric nurse will always work in the resus area if there is a collapsed child and support will be received from the ward from if needed.

A specialty training 3 grade doctor will be delegated to children's ED and always has a consultant available to give advice across whole department.

It was described that GP referrals who had been directed into paediatrics via the on-call paediatrician, did not seem to go direct to CAU. They perceived that this was due to having a low threshold for direct admission to CAU. The consequence of this is to divert most GP referrals to ED first even when the PEWS score was low.

This suggested that the two teams need to develop a policy to give clarity about this pathway, in order that it be managed consistently and so both teams know what to expect. In many services this arrangement exists i.e. where children enter the system via a referral from a GP to a paediatrician. The reason for this arrangement is to increase the safety of the transfer with a visual triage taking place in the ED, with observations taken if required, and then the transfer being made. Even where formal contracted arrangements have been put in place for paediatricians to offer a hotline to GPs, the pathway remains through ED for a minimum triage.

The ED team have concerns about 16 and 17 year olds who may be placed in the adult clinical decision unit sometimes for several days. The teams are fearful that they cannot protect young people in this setting and consider the MH service for adults to be better. There is a monthly meeting with police.

Key Findings - Markers of Good Practice

- There is a high percentage of consultants who have undertaken the paediatric emergency medicine (PEM) programme.
- That there is always a doctor present in the CED.
- The four hour target is met, one of the few hospitals in the country to do so.
- There are clear pathways in regards resuscitation and input from EMBRACE service.
- Children requiring resuscitation are always cared for in the correct resus bay.
- There is a monthly meeting with police.

Other Key Findings and Recommendations

- The shortage of children's nurses in ED is of great concern to the service team. It is compounded by a shortage of children's nurses in the ward who they wish to draw upon if needed. The services together should look at the career structure for children's nurses to ensure there are promotion and development opportunities if they stay.
- Considering the paucity of children's nurses in the department and the high admission rate, the team should consider using a more senior clinician in CED at peak periods
- The re-attendance rate should be reviewed
- The pathway from GP to CAU requires clarification
- The department may want to consider benchmarking themselves against the Standards for children in emergency care settings (2018) (available at:

https://www.rcpch.ac.uk/sites/default/files/2018-06/FTFEC%20Digital%20updated%20final.pdf)

6. References

The following references are commended for further information:

- RCN (2013) Defining staffing levels for children and young people's services, 2013 https://www.rcn.org.uk/professional-development/publications/pub-002172

- RCPCH (2018) Facing the Future: Standards for children in emergency care settings https://www.rcpch.ac.uk/sites/default/files/2018-06/FTFEC%20Digital%20updated%20final.pdf

Appendix 1

Children's Services Review Terms of Reference

1. INTRODUCTION

1.1 Context

NHS Barnsley Clinical Commissioning Group (CCG) included as part of the 2019/20 Contracting Intentions a commitment to review Barnsley Hospital NHS Foundation Trust (BHNFT) Children's Services. These Terms of Reference set out the scope and arrangements of the review and associated working group.

1.2 Definitions

For the purposes of the review children are defined as patients aged 0 to 18 years old. Data and services provided to children outside the children's department will not be included in the review. The review will cover all Children's Services provided by BHNFT (inpatient, outpatient and community) excluding inpatient neonatal services. The services provided are:

Children's Emergency Department

There is a children's area within the A&E department at BHNFT.

Inpatient Care

- There is a 20 bedded in patient children's ward.
- There is a Children's Assessment Unit (CAU) collocated on the children's ward, children and young people are initially admitted to CAU (during opening hours) and then transferred to the children's inpatient ward should they require on-going care, referrals come from GP surgeries, the Emergency Department and from community practitioners.
- Children and young people are cared for in a 20-bedded ward.
- There is also a Children's Assessment Unit (CAU) where children are referred to from the Emergency Department, GP surgeries, Community Midwives and Health Visitors.
- The Children's Ward takes inpatients and cares for children aged 0 to 16 years from a range of specialties that include:
    - Paediatric medicine
    - Emergency
    - Dermatology
    - ENT
    - Ophthalmology
    - Orthopaedics
    - Surgery
- There is a high dependency cubicle on the ward with two level 2 critical care beds for children/young people who need more intensive medical and nursing care. Children who require more specialised treatment are generally referred to regional tertiary centres e.g. Sheffield Children's Hospital or Leeds.
- The Children's Play Specialist support children/young people whilst they are being cared for in the hospital environment.

Outpatient Care

Children with all different medical and surgical conditions are seen in the children's outpatient department.

There are also speciality clinics with visiting consultants from Sheffield and Leeds including:

- Cardiology
- Endocrinology
- Genetics

- Metabolic Medicine
- Neurology
- Orthopaedics
- Surgery

Children's Community Nursing Team

Care and support for children from birth to 16 years old in their own homes, working in collaboration with both general practitioners and hospital staff. The team consists of a number or specialist nurses and supports children/young people and their families with a wide range of conditions and includes:

- Allergies
- Asthma
- Cancer
- Cystic Fibrosis
- Diabetes
- Ear-nose and throat conditions
- Neonates
- Oxygen dependent babies
- Palliative care needs
- Some children who have had surgery
- Children with special needs who need specialist support
- Nurse-led clinics for children with diabetes and asthma

The review will not include acute neonatal services as this is commissioned by NHS England. The Neonatal Outreach Team work is paid for by the CCG and as such will be included within the review.

2. PURPOSE

2.1 Purpose of Review

The purpose of this review is to answer the following questions in relation to Children's Services:

- Do the services provide improved outcomes for patients?
- Are the services provided of quality?
- Are the services provided efficient and effective?

It should be noted that, as this is a high level review, improved outcomes will be inferred. To fully review outcomes patient records would need to be accessed to ensure that the correct pathways and procedures have been untaken in a timely way and any deviations and variation from pathway explained. There is not time within this high-level review to undertake this level of detail. We will make recommendations should any information come to light that indicates particular pathways require further clinical enquiry.

The following services will be reviewed in more detail:

- Children's Ward
- Children's Assessment Unit (CAU)
- Community Children's Nursing Team including Neonatal Outreach

Of these services, in addition to the above, the aim is to establish:

- What are the flows between the services?
- Are these working in an effective way for children?

2.2 Independent Reviewer

The review will be led by independent children's specialist clinician, Dorothy Bean, an experienced children's nurse with 14 years' experience of managing children's nursing and services. The review will be supported by Civil Eyes Research, a data analysis and benchmarking organisation.

2.3 Timescales

- The final report is due by 31 July 2019.
- The review will report formally to the CCG's Governing Body.
- Data is expected to be shared in a timely manner between parties in order to keep to timescales.
- The Independent Reviewer will undertake a site visit to BHNFT during June/July 2019.
- Internal governance arrangements are responsibility of the individual organisations.

3. SCOPE

In relation to the services being reviewed, the scope of the review will consider where relevant and without limitation:

3.1 Governance

- The latest BHNFT CQC report.
- Any peer reviews, external reviews or audit reports about Children's or Neonatal services undertaken in the last 3 years e.g. Diabetes, Epilepsy, Children's Surgery, NICU by the neonatal network.
- Outcomes of safeguarding reviews undertaken by Ofsted and/or the CCG.
- Outcomes of Section 11 visits undertaken by any other organisation such as external auditors.
- Any other external reviews or reports that have been undertaken in the last 3 years e.g. the recent review undertaken by nurses from Nottingham Children's Hospital.
- Any high level reports on overall self-assessment against compliance with NICE guidelines.
- Numbers of policies and guidelines in date and out of date.
- Any information received by the CCG relating to incidents triggering Duty of Candour events of moderate and above.
- Any Strategic Executive Information System (STEIS) events or any Never Events that have been reported in the last 3 years (2016-2019).

3.2 Contracting

- Service specifications.
- Key performance indicators (KPIs) and/or targets.
- Outcomes and quality metrics.
- Underpinning modelling assumptions.

3.3 Investment

- Value for money versus patients treated.
- Spend per capita.

3.4 Activity (including patient flows and pathways)

- National and local data e.g. HES/SUS/SLAM.
- Data on total Children's Emergency Department attendances for 2016-2019 broken down by year.
- Paediatric 4 hour target compliance for 2018/2019 broken down by month.
- Bed and cot occupancy data by month for 2018/2019.

3.5 Workforce and Staffing

- Workforce data on nurses, medical staff and Allied Health Professionals (AHPs) broken down by WTE funded, unfunded, vacant and filled.
- Staff mix and models.
- Any ward metric reports on Royal College of Nursing (RCN) Paediatric Staffing.
- Royal College of Paediatrics and Child Health (RCPCH) Facing the Future - Standards for Acute General Paediatric Services.
- RCPCH Standards for Short-Stay Paediatric Assessment Units.
- Any other ward dashboards; ward accreditation reviews and any reports/reviews from the RCPCH in the last 3 years (2016-2019).

3.6 Service User Views

- Patient experience data e.g. Picker in-patient survey report, Picker outpatients report and Picker Children's Emergency Department.
- Staff experience reports if they have been split by department. If staff experience can't be split to extrapolate Children's Services then this is not required.
- Rates of staff sickness and maternity leave.
- Compliance against mandatory training 2018/2019.

3.7 Benchmarking

- Civil Eyes, an independent benchmarking organisation, will support the review.
- The service will be benchmarked in relation to all aspects of the review against comparable CCGs and/or Trusts as appropriate.
- Rotherham (CCG and acute Trust) have been agreed, but not limited to, as appropriate to benchmark against based on proximity and population.

4. WORKING GROUP

4.1 Remit

The main responsibilities of the working group are:

- To meet regularly to support this work with appropriate clinical input.
- To ensure work relating to the review is put through appropriate internal governance procedures.
- The group will share information and where necessary work through issues.
- To ensure all parties working on various elements of the review are kept up to date on the latest position.
- To receive the outcomes of the review and establish a forum to deliver any necessary improvements to Children's Services.

4.1 CCG Membership

- Chief Finance Officer
- Head of Commissioning (Mental Health, Children's and Maternity and Specialised Services)
- Contract and Commissioning Support Manager
- Invitation to GP Governing Body Leads for Children's Services and Acute Trust

4.2 BHNFT Membership

- Head of Midwifery/Associate Director of Nursing
- Contract Manager
- Finance Manager

4.3 Independent Reviewer

It may be appropriate for the Independent Review Team to attend, Dorothy Bean and/or representatives from Civil Eyes Research, a data analysis and benchmarking organisation.

Partners may invite additional representatives as required for discussion of specific issues to support the review.

4.4 Quoracy

The meeting will be quorate if there are at least two members of the group from each organisation.

4.5 Meeting Arrangements

Meetings will be chaired by the Head of Commissioning (Mental Health, Children's and Maternity and Specialised Services) or a designated deputy.

Barnsley CCG will be responsible for providing the necessary secretarial and administrative resources to support the arrangement of meetings, including:

- Meeting venues
- Producing and distributing agendas
- Minute taking and distribution.

4.6 Frequency

The working group will meet on a regular basis for the duration of the review.

5 REVIEW

As the review is expected to be undertaken during Quarter 1 2019/20 these Terms of Reference will be reviewed and agreed by all parties at the earliest possible convenience.

Appendix 2

CCG Service Specification Review

Arranged visit, Friday 5th July 2019

Time	Department
9.00 am	Alison Cowie to meet Dorothy Bean in main Reception of Barnsley Hospital NHS Foundation Trust
9.30 am – 10.30 am	Medical Leads – Jo Butterworth (Clinical Lead) / Dr P Sharma (Lead for CAU)
10.30 am – 11.30 am	Children's Ambulatory Care – Alison Outhwaite (Generic Team Leader)/Samantha Norris (Diabetes) / Zeena Thomas (Respiratory Nurse)
11.30 am – 12.00 pm	Children's Ambulatory Care Visit – in department
12.00 pm – 12.30 pm	Lunch
12.30 pm – 1.30 pm	Management Team – Laura Rumsey (ADON) /Alison Cowie (DADON) / James Townsend (DADO) / Deena Goodhead (Service Manager)
1.30 pm – 2.30 pm	Paediatric Ward – Ben Dockerill (Matron) / Lizzie Robson (Team Leader)
2.30 pm – 3.00 pm	Paediatric Ward Visit
3.00 pm – 4.00 pm	Emergency Department – Mark Railton (DADO) / David Walker (ED Clinical Lead) / Val Parkin (Clinical Nurse Manager)
4.00 pm – 4.30 pm	Emergency Department Visit
4.30 pm – 5.00 pm	Management Team/ Initial feedback