Minutes of the Yorkshire and Humber Paediatric Critical Care Operational Delivery Network Executive Group Meeting

Tuesday 14 July 2020, 10am -12 noon, Via Microsoft Teams

Present	Apologies Received
• Emma Andrews, Network Manager, SIC ODN • Helen Brown, Y&H ODN Director (Chair) • Vanessa Brown, Matron, Hull • Sian Cooper, Clinical Lead, ODN • Kathryn Davison, Consultant Paediatrician, Mid Yorks • Emma Green, Service Specialist, NHS England • Karen Perring, Network Manager & Lead Nurse, PCC ODN • Clair Scaife, Matron – Paediatrics, Rotherham • Rum Thomas, Clinical Lead/Consultant, ODN/PICU SCH • Murray Wheeler, Consultant Paediatrician, York • Stephen Hancock, Consultant, Embrace • Samantha Maher, Deputy Divisional Manager, SCH • Anna Clack, Network Manager CSA and CAIC MCN, SYB ICS • Helen Berry, Locum Consultant Paediatrician, Bradford • Vijaya Hebbar, Consultant Paediatrician, NLAG • Julie Walker, Matron, Harrogate • Andrea Bliss, Associate Director of Nursing, DBTH • Helen Moore, Consultant Paediatrician, Chesterfield • TracyAnn Taylor, Barnsley • Angela Hughes, Lead Nurse PCCU, Sheffield Children's • Matt Timms, Matron, DBTH • Naveen Naganna, Consultant Paediatrician, Rotherham • Andrew Sinclair, Business Manager, Leeds • Karen Bartholomew, Consultant Anaesthetist, Calderdale and Huddersfield • Ezzedin Gouta, Clinical Lead Paediatrics, Barnsley • Shoma Ganguly, Consultant Paediatrician, DBTH • Kirsty Randell, Matron, Airedale • Chris Medd, Consultant Anaesthetist, Chesterfield	• Fatemah Rajah, Embrace • Alison Cowie, Rotherham • Alison Conchie, Network General Manager Yorkshire and Humber Congenital Heart Disease Network • Sue Langworth, Head of Children's Nursing, Mid Yorks • Donna Webb, Matron for CC and Cardiology, Leeds • Vicky Lister, Ward Manager, Harrogate

ITEM		ACTIONS
1.	**Apologies, welcome and introductions** • It was noted that the meeting was quorate. • There were no conflicts of interest.	
2.	**Minutes of the previous meeting held 30 January 2020** The minutes from the previous meeting were accepted as a true and accurate record.	
3.	**Paediatric Critical Care and Surgery in Children ODN** • HB informed the group that PCC and SIC ODN is commissioned as one single network. It has been agreed that it makes more sense to have 2 distinct arms to the network- one for PCC and one for SIC. Both will still work closely together. Timings of future meetings have not been decided as yet however, we will keep the existing exec in October in diaries in order to keep everyone involved and in the loop. • Changes have been made to the support structure for the networks. As of 1st July 2020, KP will have a hybrid role of Manager/Lead Nurse for the PCC ODN and EA will concentrate on SIC ODN as Network Manager for SIC. AD will act as Project lead for both networks providing admin support. HB will continue to oversee both networks however her key role will be around the Neonatal ODN and implementing the National recommendations for Neonatal transformation. • Still proposing having some Clinical leadership and HB shared that SC and RT have been doing a sterling job for PCC. Still unsure who will undertake clinical leadership for the SIC network, expressions of interest will be going out in due course. Looking at the gap in educator posts and whether additional nurses/AHP input will be needed. Please email HB with any questions.	
4.	**Work Programme- post COVID work plans** • **Service Evaluation Update** KP informed the group that during COVID the PCCODN held 2 weekly Q&A meetings via Teams. This helped to maintain communication around the region. This has meant that most people are up to date with plans. There are 4 Service evaluations left to do, these will be done virtually. All remaining Trusts have agreed for this and will start late September. A summary report will be given at the October exec. • **HDU** Reports went out week beginning 10th July to the DGH's. Leeds and Sheffield are still outstanding.. Audit ran identical time period from last year. The data collection form separated the NIV support into CPAP and mask ventilation. 100% participation and KP thanked everyone. 658 forms were included in the audit from the DGH's. Numbers are a little down from last year. There were 2134 Level 1 bed days and 227 Level 2 bed days which equates to 2.5 Level 2 bed days per day. The Leeds and Sheffield HDU reports will be completed over the next two weeks and sent to the Trusts. For Level 1 interventions overall there has been a similar picture from last year. HB queried the data for Scunthorpe. KP advised that Scunthorpe had done more LTV work and had verbally reported that activity had been increased however there was no one representing Scunthorpe on the call to comment. SH queried Rotherham data- is this data collection issue. KP advised that numbers are always relatively low with what hits the data criteria. Some units don't trigger	

the criteria. CS and NN will review the Rotherham report and provide feedback. 9 out of the 14 units gave L2 respiratory support. There were 44 tracheostomy ventilated bed days over 5 sites. CPAP numbers have gone down from last year as high flow increases. KP asked the group their thoughts on repeating the HDU audit this winter over the same time period. The comparison data has shown what has changed in the region over the last two winters and it was suggested that it would be useful to inform future work to compare this winter especially due to the Covid pandemic. There was consensus amongst those on the call that it should be repeated. KP will email staff with details nearer the time. The proposed dates for this year will be Monday 2nd November 2020 to Sunday 31st January 2021 inclusive.

- **LTV**

  SC updated the group. The LTV working group started early 2019 and has had a 3 month pause due to COVID. The next meeting will be in September and this is via Microsoft Teams. The LTV working group has achieved a lot during the 1st year. Currently working on an Acute Pathway for LTV patients who are acutely unwell or injured. 1st draft has been written and will be reviewed at the meeting in September. Also work has been ongoing around an Online FAQ list for parents and also Embrace. The group realised that commissioning is an important part of LTV and a much wider than PCC. Task and finish work streams have been linking in with our group. These include:

  1. Acute Pathway
  2. Prevention of admissions to hospital
  3. Discharge planning and step down
  4. Honorary contracts
  5. Some LTV specific core areas

  SC has just finished writing a letter to parents who have provided feedback and this summarises what the group has done and thanks them. The Terms of reference has also been updated. MW added that the LTV work is a huge achievement and well done!

- **Next steps**

  HB discussed outstanding workstreams and the need for wider buy in from commissioners. EG was asked for feedback ad added that COVID has paused things but need to now move forward. EG and HB to catch up to discuss plans to move forward. KP added that there has been a conversation through the PCC CRG and the National ODN group. KP has also been involved in a number of meetings in her PCC CRG role around LTV and the Children and Young Person's Transformation Board are interested in what's happening following the NCEPOD 'Balancing the pressure's' report. There has also been discussion around where the ODN sits with regard to LTV. HB/SC/KP

  KP told the group that the LTV Clinical forum was very successful and a lot of shared learning took place with delegate emails being shared to link up and share best practice going forward. Considering doing the same thing again to pick up momentum. HB commented that more work needs to be done around the stakeholder analysis. KP, SC and HB to pick this up.

- **COVID-19 data collection**

  KP thanked everyone for participating in the weekly data collection which ran over 10 weeks. It provided an overview of service provision during COVID. The

data collection was agreed by the group and covered the service as a whole not just PCC. The results showed that all units adapted very well. Children were redirected from A&E to the ward, numbers were low and some units accepted 16-18 year olds to relieve the pressure from adult services. Emergency surgery was carried out across the region. There did prove to be an increase in CAMHS patients in particularly eating disorder and this has been fed back to the National Team. Any delayed presentations were reported as there were concerns at the beginning of covid around this. The data collection combined with the 2 weekly calls worked well for the region.

NIC to PCC transition

- HB updated the group. At the last meeting the need for a formal transition pathway from Neonatal Intensive Care to paediatric Critical Care was agreed. This is mentioned in the National Neonatal Critical Care recommendations and long term plan. As EG updated earlier all transformation work was paused during COVID but are now looking at restoration and recovery plans and this will form part of that.

5.

- **PICU/Embrace updates:**

  Embrace- SH gave update and activity graphs were shared with the group. They show a drop in the numbers due to COVID. Activity has started to return to normal. COVID response to COVID included secondment of staff to Harrogate Nightingale Hospital, a 4th acute team during the day and a movement of people of non-clinical activity to clinical shifts. This maximised the amount of critical care transport and availability to support adults if needed. The team also saw a significant amount of cleaning and have identified probable risk to meet winter needs. Transferred 14 PIMS-TS patients to Leeds. Rotas have been successfully managed and have weekly rota meetings. Some staff have been shielding and shifts have been covered . Working towards winter rota as of 21st September. Are working closely with PCC and Neonatal ODN around winter planning. SH thanked the management of the ODN's. Consultant rota-employed 2 locum consultants making 1.5 WTE. Electronic referral is on the website, is much quicker and works well. Website is being revamped. Embrace drug card -review is still underway – SH will follow this up.

- **Leeds**- DW gave apologies and had provided a written update. In 2019 there were 747 admissions and in January to June there have been 337 suggesting similar numbers. There have been 149 cardiac surgery patients which again is similar to last year. There have been 16 refusals all of which went to SCH. Mean length of stay is 5.1 bed days. 8 WTE consultants but currently working 1:6 due to 2 x consultants off currently. Nurses: 98 WTE - looks like considerable increase since last report but due to the amalgamation of PICU and HDU nursing staff on to one roster to allow greater flexibility for beds between both units. 12 WTE student nurses working as Band 4s since March 2020, all have successfully gained posts on PCCU - been working Supernumery and due to extra education and training will be ready to go in numbers in Sept/Oct rather than usual Dec/Jan ensuring that we should be able to remain at least 13 beds this winter. Plans being put in place to allow early pregnancy staff to remain to the workplace following risk assessments, awaiting guidance on shielding staff. 11 WTE trainees (LST and 8 HST) and 4 WTE ACP's and 1 in training. There has been no change in Consultant reduction in

	PA's since last report. Target of 500 cardia cases reached for 2019/2020. Acute cardiac work has continued during pandemic, lists starting to return to normal numbers. Waiting lists for adult congenital remain a concern. Other Quality parameters- Unplanned extubation rate is low and there has been a sustained reduction. There was a recent spike in unplanned extubations which is being audited and may be as a result of a change from IV to enteral sedation. 48 hour readmission rate is low. Crude mortality rate is around 3% for 2019 and is lower than our previous average. ECMO survival rates are 65-75% which is comparable to National and International outcomes, plan going forward is to work towards a nurse led service. Nursing staff currently delivering 40% of shifts of ecmo runs. Plan to train further nursing staff once face to face course available in Birmingham. Average yearly CRBSI rate is between 1 and 2/1000 catheter days • **SCH**- AH and RT updated the group. Lots of planning for surge, activity remained low. 6 staff have been shielding and they should return to work in August. New normal is now increasing and has been 3 uplifts in care to Leeds. No refusals. ICU activity is getting busier. 75 staff in post which equated to 7 beds. 13 vacancies. Challenges going forward are with infection, prevention control. Full house of juniors. 1 locum post coming to an end but will hopefully be able to advertise for a 10 PA post. RT advised the group of a piece of work with Jessop wing to improve the transfer of information and the care for the family and the baby when moved from neonatal services to paediatric services. Another piece of work is around making the unit more ASD/ADHD and LD friendly. SC advised this would be good for the whole network not just South Yorkshire. RT to bring this through the network and the Neonatal ODN.	
6.	• **Winter** **Surge and escalation planning**- KP has been leading on this work from an ODN perspective. Have been requested to have plans ready by the end of July/ middle of August. KP and SH have been involved with the Adult Critical Care Cell. Clear message there is no ask if there is a second surge of COVID for PICU units to support adult services. KP sent out a mapping document to the 2 tertiary centres, this describes what they can offer re baseline beds going into winter, what they could deliver now, what they can deliver with a slight surge and what they can deliver with a high level of surge. KP is still in the process of looking at the returned documents. NHSE have requested that each region plans to maintain surge in their region as far as possible to avoid out of region transfers. . This may require working as a supra region with the North East and North West. We have asked for the units to risk assess and try to work on trigger points for when staff ratios would be affected. Work is ongoing. Looking at how we can use our 2 PICU's more effectively so that specialist services can be maintained. Progress will be updated to the group. A mapping document has also been circulated to the DGH's to identify any challenges facing services in managing critically ill children in a surge period. **High flow**- data shows that we do a lot of high flow, we need to make sure that high flow can still be delivered to that level and we recognise that during COVID it requires more PPE and this can be challenging. KP asked the group to flag if they felt that the units would not be able to deliver the same amount of high flow as been done over the previous few years.	**KP/all**
7.	**Education and training** • KP advised the group that education and training has stopped due to COVID.	

	This is still the case. An education scoping survey was sent out recently which showed that the educator post is needed and is important to the region. Work is ongoing regarding the educator post. KP gave an overview of the survey results. There is training ongoing on site in some hospitals and there are some intermediate life support courses/ simulation work being carried out. Concerns going forward mainly that they felt compromised regarding education at this time and some staff groups in particularly adult trained ED nurses felt vulnerable. Some of the nurses Skills passport competency work has been suspended locally. KP hopes this will be picked up on the mapping tool to show this. Training needs identified were stabilisation skills, Embrace procedures, ED staff and recognition of the sick child, difficult airway management. Online training was recognised as a useful way of training at this time however nothing replaces face to face training. RT and SC both advised that there may be some online training and recommended training can be shared and signposted. • **Clinical Forum-** SC discussed the next Clinical Forum which is scheduled for 15th September on Metabolic Emergencies. This will be held via Microsoft Teams. Speakers have been booked and the agenda will be sent out once finalised. It will run for approximately 90 minutes. MS teams details for those who have booked on will be sent out in due course. LTV proved popular so plan is to run that topic again next year.	
8.	**Feedback:** • **CRG representation** KP advised the next CRG meeting has been arranged virtually. Considering doing some work with respiratory medicine CRG about LTV service specification. Work programme has not been signed off yet due to COVID. Asking for some clarity around the GIRFT programme.	
	• **Update SYB ICS Workstreams** AC (SYB ICS) described the temporary approval to transfer all non-time critical paediatric surgery (under 16 years) to SCH from Doncaster, Bassetlaw, Barnsley, Chesterfield and Rotherham hospitals. This started at end of March and was stepped down at the end of June largely. 164 patients transferred. DBTH still receiving some ongoing support. Care of the acutely ill child network- SYB healthier together website has been approved for funding. Looking at all the clinical information that needs to go on there. Based on a website developed in Hampshire. Clinical guidelines are being developed and working on the governance.	
	• **SIC ODN Update** Work has been ongoing with the tertiary units and Embrace around a pathway to be able to transfer patients between SCH, Leeds and Hull as we were aware that some units would come under pressure and not be able to provide surgery during COVID. An engagement group has started to look at how the ODN can be involved to support the delivery of elective surgery. Main piece of work is data collection to be able to understand the backlog and the mapping of recovery of services to develop a picture of the shortfall of the demand against the capacity available. The SIC ODN has been asked by the Children's Partnership Board to give a level of assurance that no child would be disadvantaged due to COVID. Working on the structure of the network and going out for expressions of interest for Clinical leadership.	

9.	**Parent Engagement update** Nothing to feedback	
10.	**AOB** • HB happy to chair but asked the group if they felt that the chair needed to be a NHSE rep as usually best to have an external chair. HB asked for feedback via email. Some comments on chat asked for external chair. • SC added that a document has been added to the website this is an internal document for Leeds Children's Hospital. The aim is to clarify the patient pathway for time critical transfers in terms of principles, process and destination and to avoid delays in treatment. Please note this only applies to West Yorkshire hospitals that feed into Leeds. This can be found on the via the link below https://www.networks.nhs.uk/nhs-networks/yorkshire-humber-paediatric-critical-care-odn/guidelines/time-critical-transfers-non-trauma-into-leeds-childrens-hospital-sop/view	**HB/all** **SC**
11.	**Dates and times for PCC Executive Group 2020 meeting** . • Tuesday 13 October 2020, 10am – 12noon, via Microsoft teams **PCC ODN Clinical Forum – Metabolic Emergencies:** • Tuesday 15th September 2020, 10am – 12pm, via Microsoft Teams	