DBOT National event 20/10/20

Workshop 1: Managing AGPs in Education and Social Care settings (Janine Walker and Michelle Sherlock)

- Air circulation funding – not currently funded but there is agreement that this is highly important, conversation on-going
    - Air filtering product:
- Ventilated children with a Clear-Therm Mini HMEF device (code 1831000) filter can remain in the classroom, but any additional AGP will need to be conducted in a separate room
- Q: infrastructure of old buildings in schools limits options for AGP which appropriate/ close enough to make use of
    - A: looked into temporary outside structures (Steve Berry?) if mainstream schools were not sufficient/ appropriate
    - A: making use of mechanical devices to support and accelerate speed of air change in rooms
- Q: are you considering oral suction as an AGP?
    - No,
- Q: Did you have to consider flooring?
    - Yes, in some cases carpeting has been removed to allow for cleaning
- Q: did you apply the Health care in the Build Environment Guidance to the school rooms?
    - A: Can't confirm for sure, but very likely. Building Regulations very involved in early conversations
- Q: Usage of NTSP guidance?
    - A: Told by NHSE to disregard as it hasn't been through a governance process
    - Confirmed by Deborah Ward
- Q: Use of pop up safe spaces? Some special schools have put in screens around open window
    - A: Ruled out within a classroom setting due to materials, doesn't solve the problem as air change is going to go near other children
- Q: Need written confirmation that oral suction isn't AGP
    - A: There isn't any clear guidance, but multi-agency meetings examined various policies and guidance, trying to align across multiple settings. Local guidance is clear that this is a local interim solution until there is further guidance, signed off by Trust.
    - Q: Can we escalate this work to push for national guidance?
        - A: It's been escalated
- Q: Families have pushed back against disregarding NTSP, concerns that children will be discriminated against/ stand out by being escorted out in PPE
    - A: Had conversations with family and developed discrete approaches and expectations on when PPE will be put on etc.
    - Q: Similarly concerns about not being able to respond quickly enough and putting the child at risk during to need to change rooms
- Q: Is there any research going on to clarify what the risk of a child with a trache is to be infectious with covid if they are asymptomatic as this would help?
    - A: Weekly testing would be the only way to confirm that a child was clear of Covid, this was discussed but it was decided that this wasn't ethical bearing in mind that children have been shielding. Agreement was to treat all children as asymptomatic.

    - A: Awareness that CYP may not be able to communicate symptoms such as loss of taste and smell
- Q: Do children need to remain in their wheelchairs all day? Hoisting to another area would take longer
    - A: No, children generally using normal mobility aids

<u>Workshop 2: Managing AGPs in Education and Social Care settings (David Widdas)</u>

- Q: Lack of agreement over PHE list of AGPs, e.g. RC Physiotherapists – although cough assist has been removed from NERVTAG list, evidence suggests it should still be on it and RCPT has kept it there
    - A: It's clear that individual risk assessments are still needed, led by skilled practitioners – some oral suctions are still being treated as AGPs, for example with productive coughs
    - Q: Wolverhampton working well and have come to a good consensus, but other areas may be less clear
- Q: BSW – if I deviate from the guidance than I am liable; some colleagues have undertaken risk assessments to reduce PPE, but concerned that there hasn't been enough consultation for deviating from the guidance
    - A: Decision in W'hm was come to working with Public Health and schools – we're not in a hospital context with regular testing and screening
    - Q: Remember that AGPs occur in other contexts, if we're deviating in schools then what does it mean in other contexts e.g. dentists
    - A: Different approaches taken in different
- Q: In the process of developing guidance, the guidance from Tracheostomy Association is at odds with Public Health guidance, families are challenging this
    - A: Working groups have met and commented on proposed draft, but not finalised yet – **Can we get an update out with the notes**
- Q: Is anyone doing regular testing? Could be sputum samples, possibly saliva, less invasive than swabs
    - A: PW shared previous discussion
- Q: Would need to seek the consent of other parents for children with AGPs to have this carried out – concerns about discrimination
    - A: We don't ask for consent for spitters
- Q: What about transport for CYP requiring suction in transport? Passenger assistant has to be in PPE, but what about the driver?
    - A: Individual risk assessments, offered temporary personal budgets which were well received – depends on both the child and the vehicle (partitions in black cabs, predictability of procedures)
    - Q: If suctioning occurs on the minibus it has to pull over and either remove the child to be suctioned or all the other children, very dangerous
    - A: Let's not forget at looking at risk overall, not just Covid
- Q: Struggling with space for separate rooms in special schools, sightly easier in mainstream as there are fewer CYP affected
- Q from David: anyone struggling to get their CYP back in schools?

- A: Struggling with 24 hour trahcy ventilated children, majority of others are back – parents want them back int the classroom, not a separate room
- A Jane Stellar: Most children back, looking at joint funded support worker to help with this
- A: Challenges with parents being so networked,
- A Sally Beckley: Child receiving remote learning 2 days a week, and 2:1 support 3 days a week for learning in the home, but Track & Trace app has been problematic as trained supporters are having to self-isolate