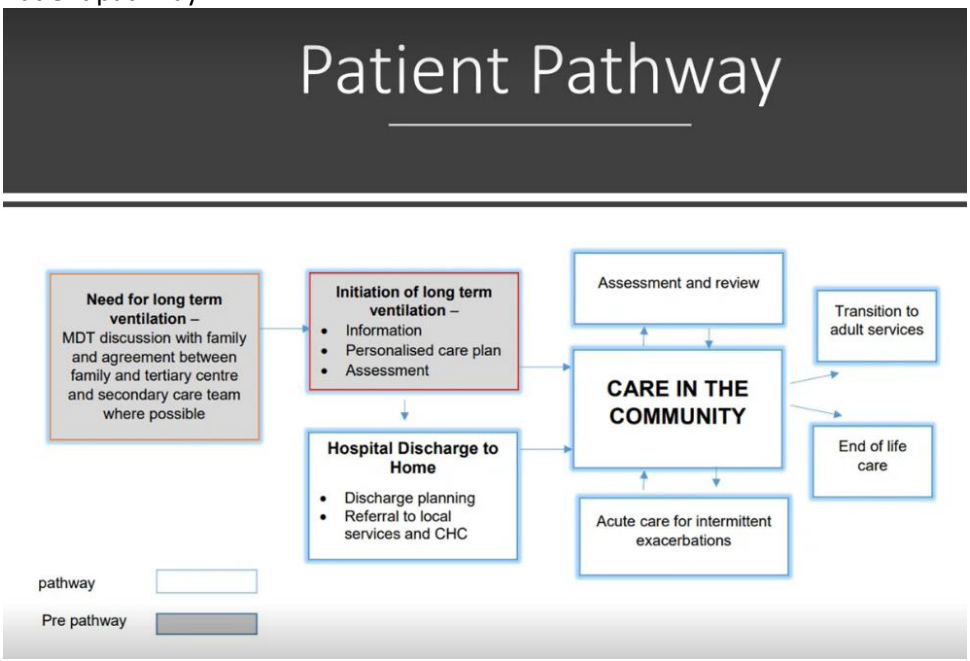
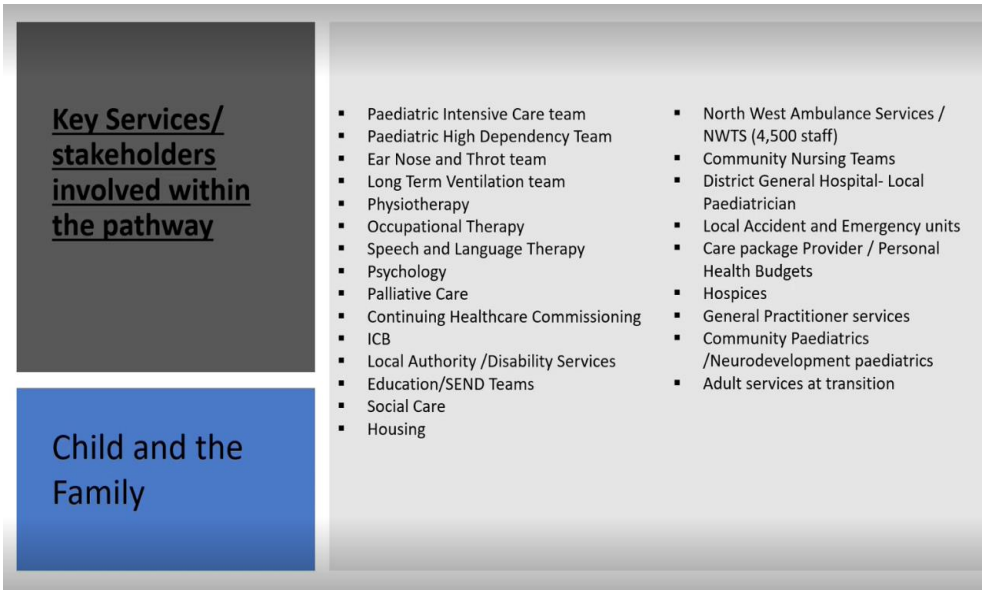
Minutes
LTV Education Scoping Meeting
15th July 2022 1.30pm via Teams

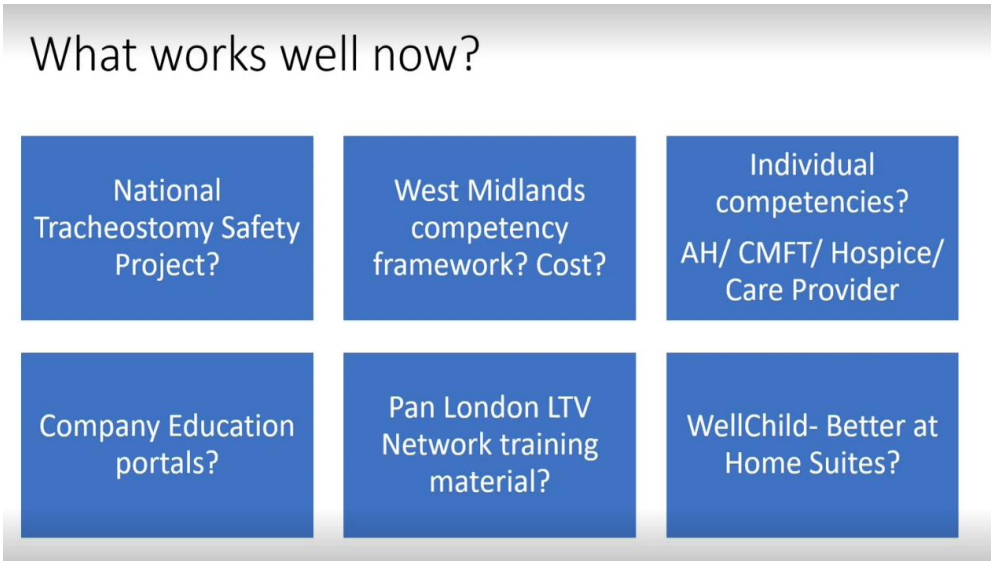
	Agenda Item	Action
1	**Welcome & Introduction** As Chair, Clare Halfhide opened the meeting and welcomed attendees. For attendance and apologies, please see Appendix 1.	
2	**Objectives** Presentation from Elaine O'Brien, regarding the purpose and background of the work: Presentation (EOB) - Education Scoping I	
3	**Discussion time** Patient pathway:  Anything/anyone missing?: - Voluntary sector e.g. Rainbows, who are providing direct care and have a vested interest	

- After school activities/providers
- Physiotherapy
- Parents and carers – opportunity for co-production of resources?

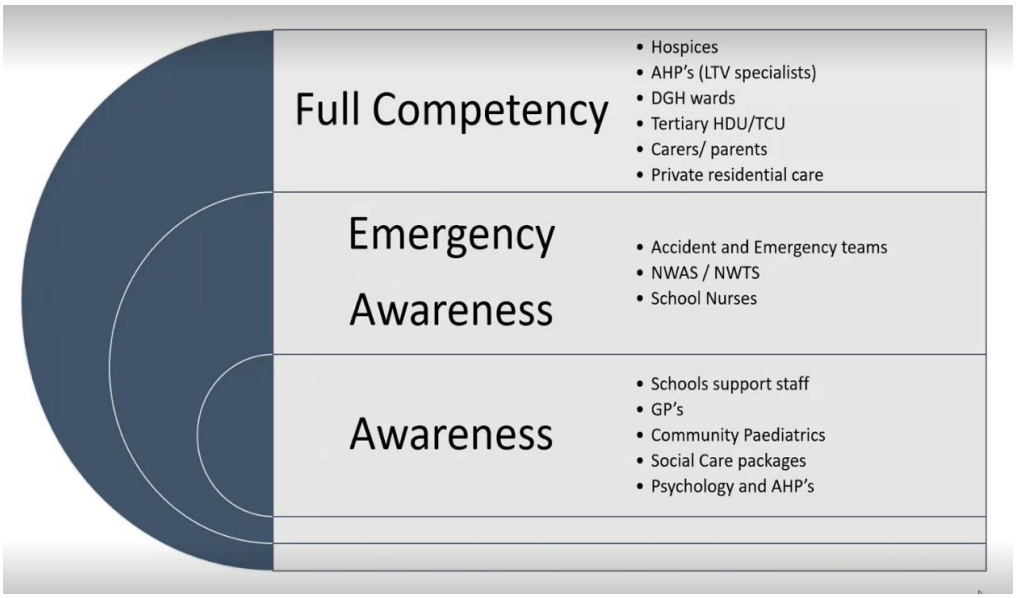
Stakeholders:



- Education around clinical skill set
- Also, wider awareness for ICBs etc e.g. what good support looks like, delays, patient stories etc
- Neonates could be involved for earlier part of pathway



- There is already a wealth of resources available (examples above) which we are keen to utilise where possible
- Kirsty explained Derian House have their own competency package. An issue is that there are so many resources online i.e. videos to backup face to face learning, that it is difficult to compile them. Would be useful for there to be agreed resources that are helpful and reliable.
- Esther explained that they mostly use the Alder Hey competencies, but they are looking to film some of their own videos for teaching. This has been done in the asthma service. Positive feedback has been received from families that they would find this useful, e.g. for alarm going off at 3am.

	- Angela stated that within the DGH they have no training as such. However, annual training is provided by the rep on the technicalities of the equipment. Concerned that it is difficult to keep up competencies for nursing the children. Annual face to face competency training would be useful. - Elaine stated that a training app produced by WellChild and Edge Hill could be worth revisiting. However, the training needs to have lots of different aspects to it to suit different learning styles. Simulation training could be very helpful for maintaining skill sets, e.g. trachy changes. Need to consider what we want to use from what is already out there. It is also acknowledged that AHCH and RMCH do some things very differently, so this needs to be looked at. - Initial and refresher training is needed, as well as trouble shooter training - Soraya explained from community perspective, they have their own competency framework for the staff they train, it is very in-depth, and based on the staff being lone workers in the patient's home. Also, ward 83 have a very robust practice educator team that they work with. All training is face to face. - Linda stated that she will speak to Professor Jane Coad and David Widders about e-learning training resources they have produced to see if they are still applicable and available. Clare commented that an information gathering exercise needs to be done to look at the resources out there. We also need to look at if we develop a package for training, how do we get this ratified in each of the stakeholders across the region.  Do we need to provide different training packages for different groups, or does that make it too complicated? - GPs for example, are going to have very limited time for training, and may just do the prescribing for the families, but they need a level of awareness and to be engaged in what the child's pathway should look like. They need to feel comfortable with reviewing the child and having them under their care. - For NWAS there are approximately 4500 staff, so to do full competency assessment with this staff group would be very difficult. - School nurses tend to cover quite a few different sites and change over quite frequently, so maintenance of skills is an issue. - A&E teams are very pressured, so fitting in time for training is difficult.	**LP**

	- NWAS have said they could potentially fit in an hour's training session. They also want to know what the parents and carers know, so they have an understanding of the different skill sets others involved possess. What do the plans look like and how do parents use the plans. - Emergency awareness training needs to include online videos/resources that staff can access. - Full competency training to those listed, including DGHs that would upskill to be spoke DGHs. - Capacity issues need to also be considered when building the hub and spoke model. DGHs need to be aware of the number of LTV patients in their area. - Another issue is the care teams being able to follow the patients into hospital, and being able to support with the ventilator, as there are cases of parents having to do this 24/7 when child in hospital. Spoke DGHs would need to allow care teams in. Commissioners need to be on board with this. If care teams can't go in, they get allocated to another child potentially, and then when the child is ready for discharge, their discharge is delayed whilst a new care package is established. - If training is standardised, then we would know what training the care teams have had, and it would strengthen the case for commissioners, for teams to then be allowed into hospital. - Who would have the responsibility for deeming someone competent? This would need to be addressed. This would need to be done timely to allow for discharge. The definition of competency would also need to be agreed.	

4	**Actions**
	• Literature review – Capture and review of what education/training resources are already out there.
	• What are the competencies we want to pull together?
	• What are the competencies required for each group; full competency, emergency awareness and awareness? What are the overlaps?
	• Need to agree structure for training. Training could be modular / in bundles.
	• Focus on full competency first, then pull out what is needed for the other two groups.
	• For full competency training, bespoke elements, such as resilience and end of life preparedness, also to be considered.
	• Staged approach for this work, what skills needs to be focussed on first?
	• A standard of care needs to be developed/agreed. Teams can opt to go over and above this if they wish.
	• Re: private care providers, commissioners need to agree that any private provider that can bid for a package must confirm that their carers meet the standard agreed by the ODN.
	• A working group to look at transition could also be included; development of resources for the young people themselves.
	• As a group we also need to define what success looks like for this work
	  ○ 90 day discharge
	  ○ Families being able to access more services, and feeling confident in these services
	• Group to share any competencies/resources they currently have
	• Any volunteers to be involved in the work are to contact louise.king@mft.nhs.uk
		All

	Volunteer nominations received so far: - Esther Bennington - Lisa Harvey - Anna Hughes - Joanne Hill - Linda Partridge	

Appendix 1

Attendees:

Clare Halfhide, AHCH/ODN
Stuart Wilkinson, RMCH/ODN
Elaine O'Brien, ODN
Joanna McBride, ODN
Helen Blakesley, ODN
Louise King, ODN
Sam Torkington, VAST/ODN
Soraya Begum, MFT
Charlotte Tindall, Derian House
Kirsty Blackburn, Derian House
Jane Enright, LSCFT
Anna Hughes, RMCH
Joanne Hill, Claire House
Louise Cain, St Helens & Halton
Angela Newby, ELHT
Alison O'Leary, AHCH
Rosemary Beckett, St Helens & Halton
Linda Partridge, Independent Member
Vicky Taylor, St Helens & Halton
Meg Ruecroft, AHCH
Mair Parry, Wales
Christopher Bedford, Warrington Hospital
Esther Bennington, BCUHB
Anna Sibley, ELHT
Lisa Harvey, BCUHB
Katie Ceraldi, ELHT

Apologies: Michele Brooks, Susie Holt