Public Health England

NHS England and NHS Improvement

North Thames Paediatric Network
Connecting paediatric services

South Thames Paediatric Network
Transforming Healthcare for Children and Young People

Pan Thames Paediatric Specialist Networks
Guidance for infection prevention & control - and inter hospital transfers.
(Updated 20.10.22 for all viral respiratory tract infections)

The North and South Thames Networks aim to:

- Improve clinical care and experience for sick children and their families
- Facilitate transfers to and from critical care units as rapidly as possible

We must avoid unnecessary delays, including those related to infection prevention and control (IPC) concerns. Referrals or repatriations must not be refused because of colonisation/ infection, appropriate IPC precautions and prioritisation should be in place to facilitate patient flow.

For all staff and carers, good hand hygiene practice and appropriate use of PPE remain key to infection prevention and control.

Screening swab results
Previously paediatric transfers have been delayed, when hospital Trusts did not accept results of screening swabs (e.g. for MRSA / CRO / VRE / ESBL*) from other Trusts. Screening swabs taken in other hospitals should always be accepted, including SARS CoV-2, and documentary evidence of recent results should be provided by the referring unit. There is no requirement for discharge screening before transfer.

Pre-transfer multi-disciplinary teleconference
A small number of children being transferred may have complex conditions with protracted admissions. A pre-discharge multi-disciplinary teleconference may help to cover issues other than just infection prevention, ensuring support to families during the transition.

Appropriate use of cubicles / side rooms
Routine isolation of children in cubicles when transferred from one hospital to another is unnecessary. Some children will always require a cubicle, but others, depending on availability and staffing, can be safely cared for in a ward area.

In the case of infections spread by airborne route (e.g. measles, VZV, TB etc) it may be necessary to care for children in cubicles/ side rooms to prevent spread to other patients.

During periods of high prevalence of respiratory viruses, cubicles should be considered to reduce the risk of transmission of all viruses to the most clinically vulnerable, including children with:

1. Uncorrected haemodynamically significant, acyanotic congenital heart disease, up to 2 years of age, or children with uncorrected cyanotic or acyanotic congenital heart disease with significant respiratory comorbidities, up to 2 years of age.
2. Chronic lung disease (bronchopulmonary dysplasia) or other lower respiratory tract pathologies necessitating home oxygen or long term ventilation, up to 2 years of age.
3. Upper airways pathologies requiring ventilatory support, up to 2 years of age.
4. Severe neuromuscular conditions (i.e. SMA type 1) requiring night-time ventilatory support or regular use of airway clearance technologies (up to school age).
5. Significant immunosuppression e.g. - severe combined immunodeficiency (until immune reconstituted), post BMT: 1st 6 months post allogeneic BMT or 1st 3 months post autologous BMT, post solid organ transplantation: in the 1st 6 weeks following transplant.
6. Newly diagnosed leukaemia during induction (1st month) or relapsed leukaemia (case by case decision based on intensity of treatment for relapse).

In addition in some circumstances cubicles or side rooms are required for specific reason such as end of life care, or other complex psychological / social or family concerns.

Children with the following conditions may be cared for in an open ward / bay / cohorted area, with careful IPC measures, and depending on a local risk assessment:

1. Infants aged <3 months if immunised / or <6 month if not immunised
2. CRO (but not CPE) / MRSA / VRE / ESBL* positive on screening swabs or clinical samples

*MRSA – *Methicillin resistant Staphylococcus aureus*; CRO – *Carbapenem resistant organisms*; VRE – *Vancomycin resistant Enterococci;* ESBL – extended-spectrum –β-lactamase producing Enterobacteriaceae.

Managing children with bronchiolitis or viral induced wheeze.
Respiratory infections in infants drive significant seasonal pressure on all paediatric beds. Nosocomial spread occurs due to direct contact with the patient or patient environment**. Thus, appropriate infection prevention and control precautions negate the need for a cubicle in every case. Refer to the updated RCPCH guidance National guidance for the management of children in hospital with viral respiratory tract infections (2022) | RCPCH. The flow chart for managing children is included at the end of this letter.

- Rapid molecular tests should be used for **SARS CoV-2**, **RSV, FLU A / B** prior to ward admission so that children can be admitted to a cubicle / cohorted as appropriate.
- **IPC precautions** must be undertaken at all times by parents and staff, all carers must wear face masks if in a bay. Clinical staff must wear appropriate PPE.
- **Admission without virology results** – infants with unidentified respiratory illnesses should be admitted to a cubicle. However, ***where cubicles are limited,*** to maintain patient flow and after a local risk assessment, it may be necessary to admit the child to a "respiratory cohort bay". Consider setting up age appropriate, "bronchiolitis and / or "viral wheeze" bays.
- **Admission with virology results** – if cubicles are scarce, infants may be cohorted in a bay according to the relevant viral infection (e.g. RSV, FLU etc.).
- **Resident Carers** – present more risk of spreading **respiratory viruses** than infants. Manage carers presence on the unit according to local policy, any carer with COVID symptoms should be asked to go home.

**https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(07)70310-9/fulltext
**https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2805593/

Please report delays in inter- hospital transfers related to IPC issues
Please inform us of any transfers delayed for IPC reasons which do not adhere to the guidance. We will support you if needed in local negotiations and review all such cases at our clinical governance meetings, with feedback to Trusts. Delays or any incidents of concern should be reported to:

- North Thames Paediatric Network: england.ntpn@nhs.net
- South Thames Paediatric Network: england.stpn@nhs.net

We hope you will find this guidance useful to streamline clinical care for children, please do feedback any comments or concerns.

Hermione Lyall and Mamta Vaidya
Joint Clinical Directors
North Thames Paediatric Network

Hermione.lyall@nhs.net
Mamta. vaidya1@nhs.net

Marilyn McDougall
Clinical Director
South Thames Paediatric Network

Marilyn.McDougall@gstt.nhs.uk

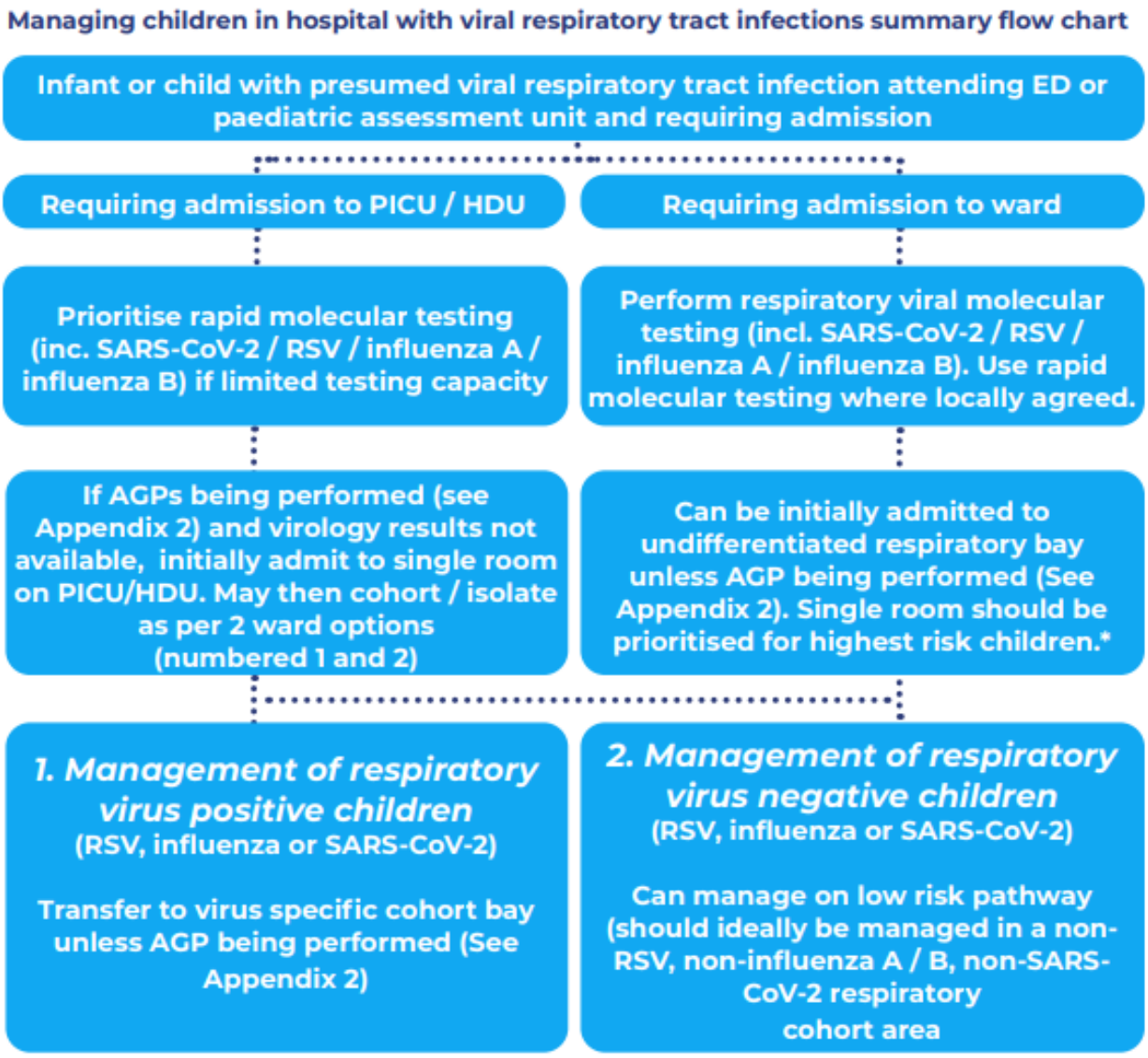
This document has been agreed and ratified by:

- The North and South Thames Specialist Paediatric Network Boards
- The London PIC Forum

It has also been approved on behalf of NHS England and NHS Improvement London by the London Clinical Advisory Group

Jane Clegg
Co-Chair of the London Clinical Advisory Group
Regional Joint Chief Nurse

RCPCH - managing children with viral respiratory tract infections, updated October 2022



* During periods of high prevalence of respiratory viruses, cubicles should be prioritised for the most clinically vulnerable children for protective isolation. This includes children with uncorrected haemodynamically significant, acyanotic congenital heart disease, up to 2 years of age, or children with uncorrected cyanotic or acyanotic congenital heart disease with significant respiratory co-morbidities, up to 2 years of age; children with chronic lung disease (bronchopulmonary dysplasia) or other lower respiratory tract pathologies necessitating home oxygen or long term ventilation, up to 2 years of age; children with significant upper airways pathologies requiring ventilatory support, up to 2 years of age; children with severe neuromuscular conditions (i.e. SMA type 1) requiring night-time ventilatory support or regular use of airway clearance technologies such as a cough assist machine/vest (up to school age) and children with significant immunosuppression such as severe combined immunodeficiency (until they are immune reconstituted), post BMT: 1st 6 months post allogeneic BMT or 1st 3 months post autologous BMT, post solid organ transplantation: in the 1st 6 weeks following solid organ transplants; children with newly diagnosed leukaemia during induction (1st month) or children with relapsed leukaemia (case by case decision based on intensity of treatment for relapse). If admitted with a viral respiratory tract infection, a risk assessment should be performed to decide if they can be managed in a virus specific cohort bay.

ips Infection Prevention Society

RCPCH Royal College of Paediatrics and Child Health
Leading the way in Children's Health