

- Learning from the findings of the Going Digital Study, which highlighted key health inequalities that may lead to inequities
- The collection and analysis of accurate, up-to-date data to determine the hospital's current health inequality priorities, for example, 'Was not brought' and digital exclusion data, and the development of a health inequalities data dashboard
- Collaboration across clinical services to understand and implement changes to reduce inequities in access, experience and outcomes for defined cohorts of patients/families most at risk of experiencing health inequalities
- Collaboration with Integrated Care Boards, the Children's Hospital Alliance, partner organisations, and policy makers to address health inequalities, and to implement changes to improve outcomes in population health and healthcare
- Developing awareness, accountability, and insight on the impact of health inequalities as an organisation through the delivery of health inequalities workforce education
- Advocating for change and improvement on a national scale.

Conclusion The impact of health inequalities on families is high on the Trust's agenda. Through a strategic, collaborative approach, steps are being taken to address these inequalities and resulting inequities.

101 ANGIOGRAM AND RENAL ANGIOPLASTY IN A PATIENT WITH WILLIAMS SYNDROME

David Cunningham, Maryam Zaky. *Great Ormond Street Hospital for Children NHS Foundation Trust, UK*

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Background Williams Syndrome is a genetic condition occurring in approximately 1 in 10,000 live births. The deletion of genes in chromosome 7 affects tropoelastin, a protein involved in vascular wall formation. This results in a multisystem disorder predominantly affecting connective tissue, the central nervous system, and the cardiovascular system. Some surgical interventions can exacerbate haemodynamic changes and pose challenges for the anaesthetist when a patient with Williams Syndrome requires a general anaesthetic.

Case Report We present the case of a 7-year-old girl with Williams Syndrome undergoing angiography and angioplasty to her only kidney and explore the perioperative challenges for the anaesthetist. Prior to her transfer to Great Ormond Street Hospital, she had a prolonged hospital admission for control of hypertension and underwent neurosurgical intervention following an intracranial haemorrhage. Blood pressure was being controlled with seven antihypertensive medications. Echocardiogram showed left ventricular hypertrophy, severe left atrial dilatation, mitral stenosis and pulmonary hypertension. A cardio-stable induction was achieved with ketamine and total intravenous anaesthesia with propofol. An arterial line was sited in the right radial artery to monitor beat-to-beat changes in systemic blood pressure and non-invasive blood pressure monitoring sited on the leg. Blood pressure was optimised throughout the procedure using phenylephrine. Following a short recovery period, she was transferred back to the ward and was discharged two days after the procedure.

Conclusion Patients with Williams Syndrome undergoing general anaesthesia offer challenges to the anaesthetist. Careful consideration should be given to the cardiovascular implications of such cases and the approach to minimising changes in blood pressure.

103 ATTACHMENT AND TRAUMA: A CASE STUDY ON THE CHALLENGES OF IMPLEMENTING FAMILY CENTRED AND TRAUMA INFORMED CARE ON A PAEDIATRIC PATIENT

Orla Friel. *Great Ormond Street Hospital for Children NHS Foundation Trust, UK*

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Background 'Mother is the whole world' was an article written in 1952 by attachment theory pioneer, John Bowlby. How are we, as healthcare providers in 2023, influenced by the theory of attachment? How do we support one another and families in providing care that supports the emotional needs of the child, in particular children who have experienced trauma? Such questions are pertinent to the care of our Paediatric population, their families and our colleagues, post-pandemic.

Methods A qualitative case study of a patient exhibiting high levels of psychological distress within the hospital environment during the pre-operative phase was compiled. The case-specific factors analysed were: patient background and attachment style, their response to the hospital environment, concerns voiced by parents, supports utilised by the family, outstanding supports available and staff approach to care. The themes included in the research process were: attachment, family centred care, trauma informed care, principles and practical approaches, challenges in practice and staff engagement. This cross-sectional analysis was then summarised into a presentation, aiming to deepen the understanding of the practical approaches and challenges faced across a multidisciplinary team.

Results This study showed that family centred care is considered a practical and preferred approach to promoting bonding within the contemporary family unit. Furthermore, the study revealed an array of challenges to providing trauma informed care such as: a lack of education concerning attachment and trauma, breakdowns within the multidisciplinary team's approach to care which aggravate these problems, an increase in adult professional anxiety and reduced resources.

Conclusion In conclusion, to rise to the challenges of implementing family centred and trauma informed care there is a need for targeted improvements in education, systemic approaches and the availability of key resources in order to adequately support our paediatric population, their families and our colleagues, post-pandemic.

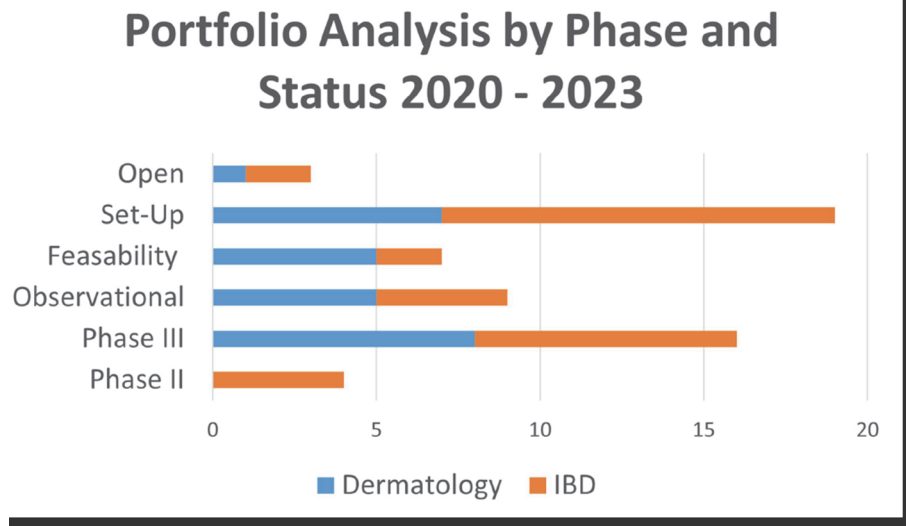
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104 HOW THE CRF SUPPORTED SATELLITE RESEARCH TEAMS TO DRIVE OUR RESEARCH HOSPITAL VISION

¹Hamza Meghari, ²Grant Nicholson. ¹*Great Ormond Street Hospital for Children NHS Foundation Trust and University College London, UK;* ²*Great Ormond Street Hospital for Children NHS Foundation Trust, UK*

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GOSH hospital has a strategic vision to become a research hospital and build on our position as a key Paediatric partner for research industry by fully integrating research into clinical services. Our vision is in line with the UK 10-year vision for



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the future of clinical research delivery, particularly the themes on embedding and streamlining research in the NHS. This necessitates facilitating collaborations to strengthen and develop new research portfolios and ensure equitable access to all types of research across all specialties.

The NIHR GOSH Clinical Research Facility (CRF) has established a model to support the clinical teams to grow their research portfolios throughout the hospital utilising satellite teams. We analysed two research portfolios as tangible examples of this action plan. Data were extracted and collected from different sources including portfolio trackers. We reviewed the increase in the number of studies overtime, the potential delivery in clinical service, and clinical teams' perspectives on the support received from the CRF.

Our analysis showed a considerable expanding number of research studies across the two specialties in a relatively short period of time since the start of the model implementation

(figure 1). A total of 29 studies were identified. The majority were later phase studies at 55%, followed by observational studies at 31%, and early phase studies at ~ 14%. A number of these studies were at a stage where minimum or no CRF support was required and could fully or partially run in the clinical service. This relieved substantial pressure on the CRF capacity and enabled the CRF team to support early phase studies.

This model has proven successful in accelerating quality research set-up and delivery across different specialties at GOSH. We continue to replicate this model within other specialties to empower their research activities in their clinical departments.

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