Collaborating With Children and Young People: A New Model for Co-Production

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doi: 10.1192/bjo.2022.335

Aims. Childhood and adolescence is a time in which the patterns and foundations for future health are laid. The World Health Organisation advocate for providing opportunities for children and young people (CYP) to meaningfully participate in the design and delivery of services. Co-production, in which professionals and citizens collaborate together in an equal partnership, is recommended as an approach to achieve this and is linked to better community relations. Few co-production models exist that are specific to CYP and address the relevant practical and ethical challenges. We propose a new framework which can be used by organisations wishing to engage in meaningful collaboration with CYP.

To create a model for co-production with consideration of the specific needs of CYP.

Methods. The following methodology was used:

i) Identification of common themes from ten existing co-production frameworks
ii) Detailed analysis of three co-production frameworks with reference to CYP
iii) Identification of key issues from critique of the literature

Results. The key themes incorporated into the model using the above methodology were as follows: Purpose, Assets, Capabilities, Reciprocity, Networks and Relationships, Power, Catalysts, Diversity and Inclusion and Safety and Protection. This co-production framework can be used by organisations that wish to meaningfully collaborate with CYP and assess the depth of co-production of their initiatives.

Conclusion. The new model takes into account the socio-cultural challenges that must be considered when co-producing with CYP including power relations, safety and diversity and inclusion. We advocate for the model being tested, validated and further developed ideally with the collaboration of CYP.

End of Life Care on a Neuropsychiatric Inpatient Ward for Patients with Huntington's Disease: An Overview of Issues and a Project to Optimise Care

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doi: 10.1192/bjo.2022.336

Aims. Mill Lodge is a 14-bed inpatient neuropsychiatric ward in Leicestershire, UK. The service primarily functions for patients with Huntington's Disease (HD), a disorder that significantly reduces life expectancy. End of Life (EoL) care is necessitated in the inpatient setting. This project therefore aims to optimise EoL care in our specialist HD unit. Specific objectives are to: establish the levels of staff confidence in dealing with EoL care; identify specific areas of EoL care that staff felt could be improved; and to introduce a series of initiatives to optimise EoL care for our patients using a QI framework.

Methods. We commenced involvement with the local QI team to develop the project. The first stage of intervention included the planning and delivery of a stakeholder event on EoL care specific to HD with the assistance of regional palliative care colleagues.

As well as our inpatient nursing and medical staff and the palliative care teams, local GPs, district nursing colleagues, speech and language therapists and psychologists attended. The session comprised an educational overview for all colleagues of HD itself and palliation was discussed at length.

The meeting also comprised an open forum where we were able to identify barriers and facilitators to optimal care from all aspects of the assembled MDT.

Results. To date our interactions have revealed that staff confidence in dealing with the different aspects of EoL care was low. This included issues with care-planning; medications; communication with patients and staff; and when to refer for specialist help.

Other processes identified as difficult included paperwork that was not consistent across teams; district nursing colleagues having to liaise with multiple medical team members to ensure continuity of care; and the doses of EoL medications required in this patient group to mitigate involuntary movements that were previously controlled with multiple high-dose oral medications.

Conclusion. Staff without specialist knowledge require support. The efforts made to improve collaboration with external colleagues broke down barriers that were preventing optimal care and allowed all parties to express their opinions and feelings. This allowed us to transparently appraise our current processes and provide guidance on this difficult area.

The journey of optimisation continues, with further practical educational interventions planned, such as syringe-driver training, and efforts to improve shared documentation and enhanced communication and collaborative working between different disciplines.

Optimal, collaborative EoL care from a confident staff-group is possible and a most important part of care for this unique patient group.

Is Attachment Theory the Answer to a Complex Healthcare System?

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doi: 10.1192/bjo.2022.337

Aims. This article proposes the need for a theoretical framework that can be applied to underpin the varied idiosyncratic mental health systems.

Methods. Bowlby's Attachment Theory defines a set of values that are required for a developing child to acquire a stable base which allow for healthy psychological development into adulthood. These values and behaviours may serve as a caring and holistic framework for people using mental health services.

Results. The outcomes in mental health remain unsatisfactory and services are overall fragmented and increasingly specialised. Ongoing recognition of the inter-related relationship between a person's immediate and social environment and their mental health are frequently overlooked as services become ever stretched in terms of finances, capacity and limited resources including support for staff. The emphasis of treatment is on illness instead of the multifactorial humanity of the individuals using the services. A key outcome of mental health provision is recovery but instead, recovery is compromised by a reductive approach to care that may paradoxically compromise rights, autonomy, confidence and self-belief when people are at their most vulnerable. This creates

https://doi.org/10.1192/bjo.2022.337 Published online by Cambridge University Press

feelings of mistrust, uncertainty and a limited sense of safety toward services.

Attachment theory takes into account the individual, their experiences, their social world and the significant people in their lives. The principles required for the developing child to develop a secure attachment from a stable base are similar to those required for people experiencing mental illness to facilitate recovery and develop resilience to help manage and reduce episodes of relapse.

Systems that work well, frequently exhibit values underlying models of care that include continuity, consistency, respect, safety, autonomy, human rights, freedom, supportive, trusting relationships and collaboration. The opposite of that seen in what presents as autocratic and risk-averse approaches of many mental health services.

The principles required to enable a child to develop into a psychologically well-adjusted adult are similar to those required when a person is at their most vulnerable. Episodes of mental illness can be a time for reflection and growth, with the right care and therapeutic intervention, illness can also be a time to learn and develop skills for greater resilience in future.

Conclusion. This paper outlines the implications and cultural changes that are required so that the principles of attachment theory can serve as a theoretical framework across mental health services to provide a stable base for people using the services and staff providing the care.

Moving From Peripheral Project to Integrated Governance: Developing System Sustainability in Excellence Reporting

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doi: 10.1192/bjo.2022.338

Aims. There has been increasing recognition that healthy cultures within NHS organisations are key to delivering high-quality, safe care (King's Fund). A focus towards developing systems which recognise and learn from excellence has been shown to improve services' safety and contribute to staff's morale (Kelly *et al.* 2016). In 2019 Secure Services at Devon Partnership NHS Trust (DPT) developed an Excellence reporting system. Once successfully piloted, the intention was to extend to other departments before expanding to the entire Trust. Our aims initially were SMART: for 13 reports per week in Secure services and 8 in Perinatal (a smaller team). As we expanded the aim became qualitative: for a system to be embedded so staff could as readily and instinctively report Excellence as they could an error.

Methods. We developed our Theory of Change using Deming's theory of profound knowledge, ran a series of PDSAs, and introduced an Excellence system. We engaged early adopters, sent hand-written cards and shared data widely.

Learning included understanding setting up the system, and the importance of a team rather than an individual holding the system. We took this forward to bring the system to Perinatal. We continued to run PDSAs, then ran monthly trust-wide meetings providing space to learn from other directorates.

Results. Staff were initially excited, reports submitted, feedback good, then a plateau and slump.

Something was stopping the system perpetuating. When staff received timely thanks, and others heard about it, staff would go on to promote excellence. However, this was not possible without sufficient admin resources.

In early 2021 we changed tact and approached the top: we presented data to Directors who recognised the value and agreed to support. We then set about publicising the system, and demonstrating at trust-wide meetings.

By July 2021 we saw 10 reports per week in the Specialist Directorate.

By early 2022 reports were being inputted from staff across all directorates and our monthly meetings began to focus on sharing the learning.

Conclusion. We recognised the system's potential impact on safety and staff morale but struggled to sustain the system and support dwindled when staff were stretched.

After approaching leaders, then allocated resources, it allowed for more success. However, it is not *yet* fully embedded in our Trust's culture.

A lot of our work happened during COVID-19 and despite challenges there has been a new-found flexibility to innovate, greater ease to negotiate, and instigate change.

Understanding the Psychological Impact of Lockdown: Combining Quantitative and Qualitative Analysis of Emergency Presentations

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doi: 10.1192/bjo.2022.339

Aims. The pandemic of the COVID-19 variant caused a near-global lockdown, and the psychological impact of the direct effects of the virus, along with the resulting lockdown periods cannot be overestimated. Referrals made to the Liaison Psychiatry service at Derriford hospital during the 2020 lockdown were audited to better understand effects on patients' mental health and resulting emergency presentations to services. These data were then used to identify areas for improvement, in order to tailor services to better support the population during recovery from the current lockdown, and for planning for future similar events.

Methods. Referrals to the Derriford Liaison Psychiatry service between the 1st and 12th of May 202 were audited, totalling 106 referrals and a subsequent 87 assessments. Quantitative data on patient demographics, presentation, and outcomes was extracted from assessments along with qualitative data on patients' subjective experiences from the initial lockdown period for thematic analysis. Routine data were used for comparator time periods from 2019, and during the second 2021 lockdown.

Results. Despite a lower number of presentations to ED during the first lockdown, the data demonstrate a higher acuity in presentations with more referrals for admission under section. The lockdown is shown to have particularly affected those with pre-existing psychiatric and physical comorbidity, along with specific patient groups. Thematic analysis confirms this, showing the diverse factors contributing to emergency presentations and demonstrating the increased stress of life in the home under lockdown. Comparisons between the qualitative and quantitative data confirm that patient experiences directly match both the routinely collected data and prior research. The project also revealed a reliance on private and third sector organisations for signposting on from assessments, and highlighted frequent changes to services during lockdown as a source of confusion for both patients and staff.

https://doi.org/10.1192/bjo.2022.337 Published online by Cambridge University Press