difficulty in assessing risk at admission and difficulty in prioritising workload. The aim of the project was to first assess pre-intervention rates of handover for inpatient admissions. Then with these data, look for interventions. The final aim was to re-asses post-intervention, analysing if interventions improved rates of handover.
Methods. Pre-intervention quantitative data were gathered over a three week period in April 2022, with Junior Doctors noting for admissions to Woodland View Psychiatric Hospital whether handover had been received, or if the Duty Doctor had been alerted at all to the admission prior to patient's arrival on the ward.

Qualitative data were also gathered, specifically asking what factors admitting clinicians found impacted ability to handover.

Data were presented at the monthly division of psychiatry meeting, and subsequently interventions were discussed in a meeting with Hospital bed managers, Hospital co-coordinators and the clinical director for inpatient care. The outcome resulted in change to the local hospital admission protocol, with bed managers prompting the importance of handover, and transferring admitting clinician's phone calls to the duty doctor at the time admissions are accepted by bed managers.

Post-Intervention, the same criteria assessed in April 2022 was reassessed in January 2023.
Results. Pre-intervention, of 25 admissions, a handover was provided for 32% of patients. Duty doctor was alerted to 52% of admissions prior to the patient's arrival on the ward. Post-intervention, this increased to 71% and 82% respectively for 17 patients admitted in January 2023.

Qualitative themes thought to impact ability of handover were admitting clinicians feeling there was already a number of calls made when admitting, and one with duty doctor could be neglected. Secondly the clinicians thought another member of the team would alert duty doctor of admissions.
Conclusion. The project met its aims, showing pre-intervention rates of handover as low, and post-intervention rates rising after the admission process was changed, taking on the feedback from admitting clinicians. Given rates remain still significantly below 100%, there is still further work to be done. Results are due to be shared again with bed managers and at division to discuss further interventions.

Evaluating a Pilot 'Hearing Voices Group' for People With Learning Disabilities

Dr Kirsty Bates*

Avon & Wiltshire Partnership NHS Trust, Bristol, United Kingdom
*Corresponding author.

doi: 10.1192/bjo.2023.255

Aims. Adults with learning disabilities have traditionally been excluded from psychosis research studies and intervention trials because of their learning disabilities. There is a distinct lack of knowledge about adults with learning disabilities and their lived experience of psychosis including specific symptoms such as voice hearing. Interventions such as Hearing Voices Groups (HVG) have been developed without thorough understanding of what these experiences mean for this population, I found one pilot study ran by South London and Maudsley (SLAM) in 2018 (1)

- Understand more about voice hearing experiences in people with a learning disability
- Evaluate whether an adapted HVG is acceptable and affective in this patient group
- To obtain feedback in order to improve the group for future practice

Methods. We set up a hearing voices group for people under the Bristol Community Learning Disability Team (CLDT) who experience hearing voices which causes them distress. The sessions for the group were inspired by ideas from the book "People with Intellectual Disabilities Hear Voices too" published by Psychologist Dr John Cheetham, which we adapted into accessible session plans. The group consisted of 6 service users and was facilitated by me and 3 mental health nurses and ran for 8 weeks on a weekly basis for 1 hour 30 mins. Each participant worked through an accessible handout which we then collated at the end to create a take home workbook of all the material covered throughout the group, as well as individual feedback from the group facilitators.

We used CORE-LD 30 and World Health Organisation Quality of Life (WHOQOL-8) tool pre-group and post-group which are both validated tools for use in people with a learning disability. We also conducted an adapted Maastricht's interview with each service user to understand more about their voice hearing experiences and a post group feedback questionnaire.
Results. All participants had a reduction in their CORE-LD score with lower scores indicating fewer distressing symptoms and lower risk to self, with an average reduction in score of 39%. Themes of why they thought they heard voices included: bereavement, bad neighbours, doing something bad in the past. When asked what the voices say, they were mostly negative insults towards the service user or telling them to harm themselves. Feedback post group included: more sessions/more time, learnt ways of coping with voices, helped to speak about the voices, felt safe and less alone, enjoyed sharing experiences, understand voices.
Conclusion. The NICE Guidelines 2017 Quality statement 4 states that we should be tailoring psychological interventions for people with learning disabilities. Previously there were specific interventions for people with a learning disability within the LD service. The evaluation of this group helps to support the effectiveness in adapting a well-established intervention and the value of offering this on a continued basis in the Bristol CLDT.

References

1. **"You hear voices too?":** A hearing voices group for people with learning disabilities in a community mental health setting-- Aisling Roche-Morris, John Cheetham 2018.

Use of an Information Pack to Improve Relative", Friend" and Carer" Satisfaction With the Admission Process in an Older Adult Inpatient Service: A Quality Improvement Project

Dr Luke Baxter* and Dr Tharun Zacharia

South London and Maudsley NHS Foundation Trust, London, United Kingdom
*Corresponding author.

doi: 10.1192/bjo.2023.256

Aims. We performed a Quality Improvement Project in an inpatient Old Age Adult ward to increase patients' relatives, friends and carers' (RFCs') knowledge about important aspects of hospital admission, through the provision of an information

pack. By increasing this knowledge, we aimed to improve RFC satisfaction surrounding the admission process. Previously published evidence has shown that increasing the perception of involvement of RFCs in a patient's admission promotes greater satisfaction within this group. Adequate information provision is regarded as an important part of promoting perceived involvement; conversely, a lack of information provision and communication has been associated with dissatisfaction with hospital admissions among RFCs.
Methods. Using a survey directed towards members (n=9) of the ward MDT, we identified several topics relating to hospital admission that were regarded as high priority for inclusion in an information pack. MDT members were also asked about their perception of RFC satisfaction in the admission process. RFCs (n=8) were asked how well-informed they felt about these topics with a separate survey, and their level of satisfaction with the admission process. An information pack was created based on the results of these surveys and distributed to RFCs. The RFC survey was then repeated to assess improvements in RFC knowledge and satisfaction.
Results. Perceived RFC satisfaction among staff members prior to the publication of the information pack was lower than actual RFC satisfaction. RFC satisfaction with and knowledge about the admission process increased following the distribution of the care pack.
Conclusion. Admission information packs can be used on inpatient old age wards to improve patient family, friend and carer knowledge and satisfaction.

Lifestyle Factors and the Physical Health of Patients on Depot Antipsychotics in the Haywards Heath Catchment Area, Linwood ATS (Phase1, 2022)

Dr Mihaela Bucur*, Dr Naoko McCabe, Dr Emily Ross-Skinner and Dr Hannah Kazmierow

Sussex Partnership NHS Foundation Trust, Haywards Heath, United Kingdom
*Corresponding author.

doi: 10.1192/bjo.2023.257

Aims/Context. Patients with severe mental illness have reduced life expectancy, representing one of the most significant health disparities. Although the cause is multifactorial, cardiovascular disease & other comorbid chronic conditions play an essential role. Individuals with mental illness often face considerable barriers to accomplishing their health and well-being goals. As a result, there is a growing interest nationally and internationally and research evidence for the role of lifestyle interventions in managing mental health conditions. NICE guidelines now reflect this, recognizing the impact of physical health comorbidity and recommending monitoring of metabolic status and cardiovascular risk (using the Q-RISK3 tool) in the management of schizophrenia & bipolar. *AIMS:* -Phase 1: to identify & analyse lifestyle parameters contributing to patient'' health & leading to excessive disease burden and the QRISK3 calculations for patients in the Haywards Health catchment area on depot antipsychotics. -Phase 2: make recommendations focused on lifestyle factors interventions in addition to standard care-Phase 3: to re-assess following the recommendations from phase 2.
Methods. *Phase 1 Steps*:

- Identifying all patients on depot antipsychotics living in the defined catchment area.
- Data Collection from the electronic clinical record: diagnoses, gender, physical activity, alcohol intake, smoking, lipids, employment, BMI, blood pressure, QRISK3.
- Analyse results.
- Make Phase 1 Recommendations

Phase 2: Implement phase 1 recommendations
Phase 3: Use the electronic records to conduct a second analysis assessing the offer of intervention to patients, reassessing the lifestyle parameters and QRISK3 calculation
Results. *Phase 1* Results: All patients identified (6) had a detailed overview of the lifestyle parameters assessed. None of the patients had the QRISK®3 calculation in phase 1.
Conclusion. A series of recommendations were made at the end of *Phase 1* in view of initial results.

- Disseminate results locally, including in primary care
- Ascertain up-to-date information regarding physical health and lifestyle parameters in the OPC reviews; include in the letters to GP updates on the category of lifestyle parameters included in this project.
- Discussion with patients on the impact of lifestyle factors in the OPC reviews
- Signpost patients to resources they can use to support implementing positive lifestyle choices
- QRISK®3 measurement
- 1:1 psychoeducational session focusing on improving lifestyle choices.
- Engage patients to engage in co-producing psychoeducational sessions aimed at improving lifestyle choices.

Phase 2: implement phase 1 recommendations (October 2022-September 2023)
Phase 3: re-assess in October 2023

Unspoken: Verbal Sexual Harassment by Patients in Psychiatry

Dr Jo Butler-Laurence* and Dr Xiaofei Fiona Huang

South London and the Maudsley NHS Foundation Trust, London, United Kingdom
*Corresponding author.

doi: 10.1192/bjo.2023.258

Aims. Patient-initiated verbal sexual harassment (PIVSH) is common in the healthcare workplace, however institutes often neglect to address it. Objectives: (1) Define extent of PIVSH among staff at South London and the Maudsley Trust (sLaM), (2) Characterise the impact of PIVSH on staff, (3) Understand barriers to reporting PIVSH, (4) Inform policy and training to support staff.
Methods. A questionnaire from Scruggs et al. (2020) was adapted with types of PIVSH on a standardised scale of severity from 'most' to 'least' harassing. The anonymous, retrospective, online survey was disseminated to sLaM staff via Trust-wide communications, staff networks and Whatsapp groups. Descriptive statistics were used to analyse quantitative data (PIVSH frequency, confidence to respond to PIVSH, reporting practices). Respondents used free text to describe the impact of PIVSH,