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.

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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.

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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