estimate staff engagement and facilitate ideas for next planning phase.

Results The initial survey (1 st phase) was analysed to obtain a needs analysis based on response. 44 NCHD's (excluding interns) responded to the survey showing 100% of respondents willing to engage in proposed interview skills sessions.

It was very evident that we successfully identified a gap in our NCHD's career development that we can fill and use as a point of contact to engage our NCHD cohort. With only 4.55% (n=2) NCHD reporting that some form of interview skills was provided by their department and only 2.27% (n=1) reporting that their affiliated training body has provided them with this a skill base.

Post survey analysis 3 interview sessions were organized for St. James's NCHD's to attend based on a first come first served bases and 2 sessions for Intern group. Funding was negotiated for and generously provided by St. James's HR and Trinity College Dublin.

Separate interview sessions were organized for the intern group to address different interview skills needs based on planned interview types.

A total of 47 attended with 10 doctors per session lasting 2 hours duration each.

Post event survey was conducted to estimate the relevance and content of the training in NCHD's opinion. 96% (n=45) of NCHD's strongly agreed that the content covered and time allocated to the sessions was relevant. 96% of NCHD's also strongly agreed that it was a worthwhile event to continue as part of NCHD engagement and training.

Phase 3: A staff engagement survey was conducted several weeks post event date to request feedback for future events and comments on any developments that should be taken into view for the incoming year.

Conclusion In conclusion we can see that the success and over subscription to our events was a combination of early planning, effective communication and an enthusiastic group of receptive NCHD's.

Enhancing your leadership skills

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BRINGING CLINICAL MEDICAL EDUCATION ON A PAPERLESS JOURNEY: MAKING EVERY PATIENT CONTACT COUNT

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10.1136/leader-2018-FMLM.80

Introduction Hospital based medical education is the pivotal point of knowledge and skills transfer to our medical students, who, not before long will join us as colleagues on the wards. St. James's hospital in Dublin 8 is the biggest teaching university hospital in Dublin and home to 1,010 acute patient hospital beds.^{1 2}

Early and effective contact to the clinical world is important in motivating and stimulating medical student interest in clinical work, which is why having access to difficult patient cases of interest is so important in ensuring knowledge acquisition at an early stage in clinical teaching.³

Making every patient contact count towards education regardless of where they are seen within the hospital system using electronic patient record (EPR) is vital for a more holistic approach to clinical teaching.⁴

Aims

1. To make every patient contact count as a valuable teaching resource.
2. To give NCHD's the opportunity to identify patient cases with interesting signs in any clinical setting and make it easily available to the lecturing staff.

Current practice Teaching staff and NCHD's flag patients with interesting signs on wards for teaching purposes using patient lists and waiting lists. This is very time consuming and can be facilitated by creating a better electronic function that all staff can use.

Planned future practice and design Electronic patient record (EPR) is the current system being used to capture patient information in St. James's hospital and is being used in all specialties in different levels.

Design encompassed an easily accessible tab for physicians to comment on the reason for patient case inclusion, the sign and symptoms of interest, what kind of contact is the patient was willing to facilitate and if the patient is willing to take part in clinical exams.

Outcomes anticipated

1. A higher yield of specific patient cases can be accumulated to facilitate teaching in a more organised fashion.
2. Lecturing staff will have easy access to specific patient cases that can augment their teaching and learning outcomes for specific teaching seminars without looking through numerous patient lists.

Next step forward Ensure all NCHD's are aware of the new medical education electronic function built into EPR at induction in July.

Monitor number of NCHD's contributing to it and feedback during ground rounds on the type of cases and numbers that have been submitted, to allow teams to see progression in case load contribution.

Audit lecturers experience with new system.

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Developing effective leaders

83

HOW DO MEDICAL STUDENTS VIEW LEADERSHIP? A NATIONAL CURRICULUM ANALYSIS AND SURVEY

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This project, conducted by the FMLM Medical Student Group, was the first national analysis of UK medical students' access to medical leadership and management (MLM) teaching, within the undergraduate curriculum, and their opinions regarding this.

Timetables (2014/15) from 16 Medicine (A100) courses were analysed to identify data surrounding MLM sessions.

This included: duration, format, title, and year of study, of any MLM components in the timetable. We also launched an anonymous online survey for medical students to determine their perceptions of MLM teaching in the curriculum.

Across the timetables, 892 (range, 8–141) MLM teaching sessions were identified. Of these, 64.9% took place during clinical years. 644 medical students from 30 universities completed our survey. 88.3% agreed that MLM skills are important for junior doctors and 87.4% agreed that MLM is relevant to their education. Despite 57.5% agreeing that there should be specific standards set for graduating medical students, only 8.9% were aware of the Medical Leadership Competency Framework, and 17.1% felt that MLM is taught effectively in their curriculum. Students' preferences for teaching and assessment of MLM were not in line with the distribution of teaching sessions identified in our analysis, indicating that there are future challenges in matching student's expectations towards developing leadership capabilities with formalised undergraduate curricula.

Medical students' teaching experience varies widely between universities, but the majority recognise the importance of MLM in their education and their future roles as junior doctors. This research provides novel insight into the national delivery of MLM within undergraduate medical schools, alongside important commentary on students' preferences for curriculum delivery. We anticipate that this research will be used to enhance teaching delivery and hope that this data is useful in supporting the leadership development of future doctors.

Reducing waste

84 REDUCING WASTE AND IMPROVING PATIENT SAFETY: INTRODUCTION OF THE ON-CALL DOCTOR'S BAG

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We introduced an on-call doctors bag for the Foundation Year One (FY1) doctor's on-call medical ward cover at Wexham Park Hospital. These on-call shifts are extremely busy with the FY1 covering 14 different wards. Time is wasted locating essential equipment on unfamiliar wards. Literature over the last 5 years has calculated that junior doctors spend on average 29 hours accessing treatment room and approximately 4 working days collecting equipment over a year.¹ These delays can compromise patient safety in emergencies as well as contributing to daily inefficiency and lower job satisfaction.

A pre-intervention questionnaire using a 5-point Likert Scale identified 90% of FY1 respondents (n=22) at felt that significant time was wasted looking for equipment on unfamiliar wards.

A paramedic sling-bag (£90) was purchased as an on-call doctors bag. The bag was stocked with the relevant equipment and was made available to all FY1s for their medical on-call. The bag was restocked by the ward manager at the end of each shift.

A post-intervention questionnaire was distributed to FY1 doctors. 100% of respondents (n=20) agreed the on-call bag helped them to be more efficient. 100% of respondents

agreed less time was spent collecting equipment on the wards with the bag. 95% of respondents stated that they will continue to use the on-call bag.

10 simulated trials were performed comparing the time taken to collect equipment on 8 different wards. 6 volunteer final year medical students unfamiliar with the hospital environment were asked to collect equipment for four common on-call tasks (ABGs, cannulas, phlebotomy and blood cultures) on 8 different wards with and without the on-call bag. In every trial performed, the student with the on-call bag obtained the equipment faster than the student without the bag. The median time saved across all procedures and wards was 3 min 26 s (range 57 s – 7 min 29 s).

The on-call doctor's bag is invaluable in reducing waste and increasing the number of on-call jobs that can be completed per shift. It reduces the time wasted in collecting essential equipment when treating the unwell or deteriorating patient.

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Radiology report alert systems

85 RADIOLOGY REPORT ALERTS! ARE EMAIL 'FAIL-SAFE' ALERTS ACKNOWLEDGED AND ACTED UPON?

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10.1136/leader-2018-FMLM.83

Background After identifying failure to act on radiology reports as a cause of patient safety incidents, The Royal College of Radiologists and National Patient Safety Agency released guidelines stipulating that it is incumbent on radiology departments to use 'fail-safe alert' systems to communicate critical and significant unexpected results. Electronic systems are preferred, to reduce errors, increase workflow efficiency and improve auditability. A paucity of evidence exists on the effectiveness of such systems.

Aim To assess i) acknowledgment of email radiology report alerts by clinical referrers and ii) where indicated, whether follow-up imaging was performed.

Methods and Materials A full-cycle audit conducted at a tertiary referral centre in London, which uses the email-based 'RadAlert' system (Rivendale Systems, UK). All cases on the RadAlert database between 5th February 2017 and 31st July 2017 were audited in cycle 1 and, following departmental educational meetings, the first 100 cases during Sept 2017 in cycle 2. The target compliance for acknowledgment of alerts was 100%.

Results In cycle 1, 39% (154/390) alerts were 'accepted', 55% (213/390) 'abandoned', 5% (21/390) 'declined' and 1% (2/390) 'cancelled'. In a sample of 'abandoned' alerts, follow-up imaging (where deemed indicated based on the report) was still performed for 76% (19/25).

In cycle 2, 56% (56/100) alerts were 'accepted', 37% (37/100) 'abandoned', 4% (4/100) a 'duplicate record' on the database and 3% (3/100) 'declined'. Of all 'abandoned' alerts, follow-up imaging (where deemed indicated) was still performed for 76% (22/29).