Conclusion Acknowledgment of report alerts by referring clinicians may be increased through departmental educational meetings. Radiologists should not rely solely on email alerts however, since a considerable proportion continue to be unacknowledged by the recipient. Appropriate follow-up imaging was undertaken regardless in these cases, suggesting that radiologists continue to also rely on other alert methods despite the introduction of the email based system.

Patient safety, quality improvement, clinical practice

86 MAKING THE RIGHT CALL FOR FALLS' – EVALUATING THE EFFICACY OF A MULTI-FACETED TRUST WIDE APPROACH TO IMPROVING PATIENT SAFETY POST FALLS

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Introduction Inpatient falls are the most commonly reported patient safety incidents nationally, and carry a significant burden on resources, morbidity and mortality. Ensuring adequate post falls management of patients by staff is therefore paramount to maintaining patient safety especially in out of hours and resource stretched settings.
Aims This quality improvement project (QIP) aims to improve the current practice of falls management and patient safety at Guys and St Thomas Hospital. It also looks to increase junior doctors confidence in managing falls and their use of new intervention guidance protocols.Importantly it highlights the benefits of multi disciplinary collaboration with key stakeholders such as falls, radiology, QIPs and clinical medicine teams to achieve its intended impact.
Methods Interventions include:

1. The development of new trust guidelines.
2. The production and distribution of 2000 newly designed lanyard cards amongst ward staff that provide a concise management protocol.
3. Improved fall awareness trust wide through the use of trust media.
4. Implementation formal falls teaching at junior doctor induction.
5. Introduction of a new falls bleep to expedite key imaging.

Qualitative data analysis involved using an established incident database to retrospectively review clinical practice in 145 falls in 2016 pre-intervention as compared to 189 consecutive falls in 2017 post intervention. A separate serious harm database was used to analyse 50 falls from May 2015 to March 2018 to assess the interventions impact on delays to diagnosing serious harm.

Quantitative data analysis assessed junior doctors' confidence in managing falls, their awareness of the impact of falls and the utility of guidelines through pre and post intervention questionnaires.
Results The time from fall until harm was detected was statistically significantly lower ($p=0.044$) post intervention. The incidence of significant delays to detecting harm (>10 hours) also reduced post intervention. Rates of documentation, the time to clinical review and time to order and schedule X rays and Computer Tomography scans all improved in and out of hours. Results showed a statistically significant improvement in overall review time ($p=0.001$), ordering X rays ($p=0.046$) and scheduling CT scans ($p=0.029$) post intervention.

Questionnaire data demonstrated junior doctors' improved awareness of falls, clinical training, utility of guidelines and increased confidence.
Conclusions This quality improvement project has shown statistically significant improvements to fall management in a short period of time through a generalisable, multifaceted and multi-disciplinary team approach to a growing major national patient safety issue. Suggested next steps of this project include introducing trust wide fall specific induction sessions. This QIPs' ongoing work hopes to provide a template to help lessen the burden of falls on patients and trusts nationally.

Enhancing your leadership and management skills

87 FROM MEDICAL STUDENT TO PROJECT MANAGER: A LEADERSHIP IN HEALTHCARE EXPERIENCE

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As part of the 70th anniversary celebrations, a Student-led Health Commission was recruited by the Policy Institute at Kings College London. The group, commissioned by the NHS, was tasked to recommend radical changes to the UK National Health Service.The commission was challenged to identify young people's views of what our health and social care system should deliver and envision fundamental changes to healthcare over the next 15 years.

This project improved the commissioners' understanding of health policy process and allowed future health professionals to have hands on experience in health leadership and management, interacting with senior health management and organising an 'unconference'.

Due to varying personal and educational commitments outside of the project, coping mechanisms for time management strategies were developed by all members of the commission. Professionalism was another key learning point throughout the project. We were in continual contact with senior health management, clients and other stakeholders, and a professional attitude was essential.This experience highlights the importance of this type of project for students and alumni, equipping the interns with skills and knowledge that cannot be learned at university while making an impact on the population.

By managing two teams of commissioners, I was able to oversee several tasks informed by external stakeholders, for which we collected data using interviews and were advised by a team of Harvard interns. We engaged healthcare professionals and other young voices by circulating surveys to student networks and healthcare bodies. During our unconference, I presented recommendations to an audience of front-line staff, policymakers, senior managers and students, as well as live-interviewing a senior stakeholder on recommendations implementation.

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