burns, dehydration, prior IV chemotherapy, and IV drug use make peripheral veins difficult to identify and cannulate.

Critical time can be lost while attempting to obtain vascular access, potentially increasing patient morbidity and mortality. On the other hand, central venous access is time-consuming and poses complication risks like infections and pneumothorax.

In these instances, Intra-osseous (IO) contrast injections are beneficial to obtain good quality trauma scans for patients from the Emergency Department (ED).

Methods Multi-professional stakeholders (Radiologists, ED consultants, and Radiographers) met to identify the need for IO service in Aberdeen Royal Infirmary. This was followed by discussions at the CT user's group meeting. A need for developing a local protocol for IO contrast service was identified for patients with no IV access. A draft protocol was created and then modified to meet local needs.

Interventions Once the protocol was finalised, IO contrast service was introduced for trauma patients without IV access. The local protocol gives clear information about placement and checking of IO needle, local anaesthetic administration and the technique for contrast administration.

Results Since implementing the protocol, 3 successful trauma scans have been performed using IO access. The quality of images has been good with no recorded complications.

Conclusions IO contrast provides an effective and safe alternative to IV access. Good quality images can be obtained using established protocols.

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37 IS THERE A NEED TO CHANGE THE DELIVERY OF LEADERSHIP TRAINING TO OUR FUTURE DOCTORS?

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10.1136/leader-2021-FMLM.37

The General Medical Council (GMC) has advocated for wider leadership and management responsibilities for doctors and the Birmingham Medical Leadership Society (BMLS) aims to address ways in which students and doctors can be supported through this. Collecting data on this topic is pivotal to improving the way in which medical leadership is taught to prepare students to take on leadership roles.

The survey conducted addressed the importance of leadership training. After analysing 122 responses, the consensus is that medical leadership training is important with 61.5% of people rating it 5 on the Likert scale. Participants were given the opportunity to rate how they thought medical education would best be learned. 77.9% agreed an NHS paired learning scheme where students are paired up with a practising healthcare professional, would be a suitable method. Teaching from and shadowing of NHS managers proved popular, as did leadership workshops. The lack of representation of foundation doctors and those further on in their training has created a need for more data from doctors of different grades, to see if their views on medical leadership significantly differ.

Should leadership teaching be introduced earlier on in medical school through the methods

BMLS anticipates that earlier and better medical leadership education will make more confident doctors with capacity to take on leadership roles. Shifting the leaders of healthcare services towards those with clinical background prioritises patients at the centre of care.

Using student views to tailor medical education feels productive to producing the next generation of doctors who are better equipped with skills required to take on leadership roles. BMLS hopes medical schools will listen to these views and take action and that medical leadership training is emphasised in Good Medical Practice. This serves our healthcare service which in turn makes for better quality and safety of care.

38 LEADERSHIP IN THE MANAGEMENT OF PATIENTS WITH MULTIPLE CONDITIONS: AN IMPACT EVALUATION OF BMJ BEST PRACTICE COMORBIDITIES

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10.1136/leader-2021-FMLM.38

BMJ Best Practice Comorbidities has been created by the BMJ Knowledge Centre. This work was carried out by BMJ staff and was done in collaboration with healthcare professionals in training in the UK. One in three adults admitted to hospital in the UK have five or more conditions. People with comorbidities have poorer functional status, quality of life, and health outcomes, and are higher users of ambulatory and inpatient care than those without comorbidities. This poses a problem for patients, healthcare professionals, health leaders, and health systems. In light of this, BMJ Best Practice launched a new tool – BMJ Best Practice Comorbidities. This tool enables healthcare professionals to access detailed guidance on how to manage patients with multiple conditions and thus provide holistic care. In a pilot evaluation, we made this tool available to a group of healthcare professionals in training. We then asked them to fill in a simple questionnaire outlining what difference, if any, the tool made to their practice. We measured the effect of any improvement as a result of using the tool by means of a short questionnaire. We asked the healthcare professionals to describe the circumstances in which they had used the tool, whether the tool made any difference to their practice, and what impact this had on patient care. The evaluation showed that BMJ Best Practice Comorbidities is effective at helping healthcare professionals to improve the care that they provide to patients with multiple conditions (the resource helped users to improve practice in 70% of cases). When it doesn't change practice, it can still have an effect by reassuring users that their practice is correct (this occurred in 15% of cases). This evaluation showed impact in improving the practice of healthcare professionals in delivering high-quality and safe care for patients with comorbidities.

39 LOCAL TRAINING PROGRAMME FOR ANAESTHETISTS AND FUTURE LEADERS

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10.1136/leader-2021-FMLM.39

Primary issues - centralised training programme by HEE for anaesthetics, limited number of training posts compared to