Results: 44% had prior experience of clinical simulation and only 9% had previous experience working as a doctor in the NHS. On further analysis, 50% felt either quite unconfident, or neither confident or unconfident working in the NHS. A minority felt confident dealing with medical emergencies (18%) and surgical emergencies (13%) and with their communication (32%) and leadership skills (23%). In the post-simulation feedback, 100% reported that simulation was a useful method to help doctors transition into working in the NHS and felt it improved their confidence in the workplace. Furthermore, 100% stated that the simulation sessions had changed their clinical practice and addressed their learning needs. The participants reported that the sessions had improved their stepwise approach to emergencies (100%), communication (95%), teamwork (100%), leadership (70%), and decision-making skills (95%).
Conclusion: This project demonstrated that simulation is a popular and useful educational resource in helping improve international doctors' confidence when transitioning into working in the NHS. Given that 100% of our participants wanted further simulation sessions, our Trust plans to employ a dedicated MSW simulation fellow to support further cohorts.

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REFLECTIONS ON OUR EXPERIENCES OF DELIVERING A SIMULATION-BASED EDUCATION PROGRAMME FOR MEDICAL SUPPORT WORKERS

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Background: International Medical graduates (IMGs) contribute significantly to the NHS medical workforce, but often face unique challenges which are not always catered for within medical education [1]. The Medical Support Worker (MSW) role was created in response to the COVID-19 pandemic, providing an opportunity for doctors seeking GMC registration to gain clinical experience within a supervised NHS placement [2]. Our Trust's Postgraduate Medical Education department was asked to deliver a teaching programme to the Trust's first cohort of 29 MSW's, 28 of whom are from Myanmar. The aims of this programme were to provide support for the MSW role and preparation for working as an NHS doctor.
Methods: Based on a scoping questionnaire of the MSWs' perceived learning needs and our prior experiences of working clinically with IMGs, we developed an innovative tailored programme, consisting of three days covering frequently-encountered clinical scenarios, non-technical, procedural and communication skills.
Results: Throughout the teaching programme, several themes unique to MSWs became apparent. These learners' previous experiences of medical education were predominantly behaviourist, consisting of didactic teaching in which learner contribution was not encouraged. Their only prior experience of simulation was for assessment. It was therefore vital that we ensured a psychologically safe environment in which they felt confident and were encouraged to participate in near-peer learning. We achieved this by explicit conversations about different styles of medical education and modelling these behaviours consistently. A particular challenge we encountered was introducing the learners to the hidden curriculum of the NHS [3]. This refers to the behaviours and values that form an acceptable professional identity and may differ between international healthcare systems. It became apparent during simulation that dedicated human factors training would be valuable. This was integrated via two half-day sessions focussing on non-technical skills and communication-based simulation. Cultural differences, especially in communication styles, became apparent. This included: a doctor-centred versus patient-centred agenda; challenges inherent to communicating in a second language; and different cultural values and legal frameworks. We endeavoured to expose our learners to scenarios that provoked discussions around these issues, for example communicating with a teenager requesting contraception.
Conclusion: IMGs face unique challenges when entering the NHS workforce and it is inherent upon medical educationalists to consider and meet these needs. We have identified three major themes (different educational models; the hidden curriculum of the NHS; and cultural differences) that must be addressed to ensure high quality care and patient safety.

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A PILOT STUDY EXPLORING HOW FACILITATORS SUPPORT HEALTHCARE LEARNERS DURING SIMULATION-BASED SCENARIOS TO ACHIEVE THE LEARNING OUTCOMES

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Background: A significant body of work has been surrounding simulation design, pre-briefing, debriefing, and evaluation within healthcare simulation that has informed several frameworks and national guidelines [1]. The 2021 INACSL Standards of Best Practice Facilitation direct the facilitator to deliver cues to redirect learners during the scenario to achieve the learning outcomes within the scenario [1]. Cue is the term used to describe additional information provided by the facilitator to the learners about the patient to achieve the learning outcomes [1]. Cueing examples include providing additional blood results or changing a vital sign [1]. The facilitator chooses cues based on their learners' perception within the scenario [1]. There is no guidance on the types of cues used or when and how to use them. Interestingly no other strategies are suggested to support learners. This research is exploring how simulation facilitators working with undergraduate nursing students can support learning through simulation at a university in England using a descriptive case study [2]. A case study will reveal current practices from the perspectives of facilitators and learners within a scenario. The research questions (RQ) to be addressed are: How do facilitators support student nurses in simulation-based scenarios? What support do student nurses require from facilitators in simulation-based scenarios to aid their learning?