confidence in IMTs to carry out remote consultations in the post-pandemic era as well as equip them with clinical and non-clinical skills to manage a specialty clinic. Expanding this course design to other specialties will go a long way in improving confidence and skills of IMT trainees in managing online clinics as well as bridge gaps in opportunities to mandatory SBE in the region.

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ADDRESSING OUR BLINDSPOTS: A MIXED METHODS STUDY LOOKING AT MEDICAL STUDENTS' VIEWS AND EXPERIENCES OF SIMULATION-BASED EDUCATION TO SUPPORT THEIR RECOGNITION OF IMPLICIT BIAS

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Background: Outcomes for Graduates mandates that newly qualified doctors should be able to recognise and manage their own Implicit Biases and the impact it has on individuals/groups [1]. Implicit bias (IB) refers to attitudes unconsciously affecting our understanding, actions, and decisions. Implicit Bias Recognition and Management (IBRM) strategies have included using online tests, lectures/workshops, and more recently simulation-based education (SBE) [2]. Literature suggests that SBE offers an approach that will lead to a change in perspectives for IB but more evidence is needed to ascertain whether SBE is an acceptable and effective method for medical students [3]. This study aims to firstly compare SBE to workshop-based teaching and secondly to explore medical students' views and experiences of an SBE session aimed to support their recognition of implicit bias.

Methods: This mixed method study is a pilot head-to-head trial of the two IBRM strategies followed by qualitative analysis of SBE. Following voluntary recruitment and consent of fourth- and fifth-year medical students (n=18), covariate adaptive randomization is used to assign them to a group. Both the SBE scenario (simulated ward round) and the interactive workshop were designed using learning objectives and constructive alignment theory. During the simulated ward round, a series of events demonstrating escalating IB were witnessed, and student experience and recognition were explored during the debriefing. The 1-hour interactive workshop covered theory (definitions, impact of IB and microaggressions, and challenges to confronting) followed by two case-based discussions. Post-session participant questionnaires (5-point Likert scale and free-text questions) are collected and analysed quantitatively using averages and Mann-Whitney U test. Following interviews, free-text responses and transcripts are coded by independent researchers into transformative learning framework using template analysis via Qualitative software NVivo. Ethical approval has been sought (SERB/2021/12/2236).

Results: The preliminary results from this pilot (n=6) suggest that the workshop is better than SBE at raising awareness (4.3 Vs 2.7). Qualitative feedback suggests that SBE provided a powerful experience (Table 1).

Table 1: An extract sample of results to date, exploring medical students' view on participating in simulation-based education to explore recognition of IB

Sub-theme	Quotation
Validating experience	Respondent 1: 'As a future BAME doctor myself, it was validating for [Implicit Bias comment] to be flagged up as explicitly inappropriate rather than brushed under a carpet.'
SBE facilitates a transformative learning experience	Interviewee 1: 'It definitely challenged me to think a bit more deeply about the impact of the things we say about patients… I find myself also guilty of doing this from time to time, making jokes at the patients' expense, when they're not there. I think that medicine is quite (pause) well, I wouldn't know yet, but from my placement experience, I do know that it can get quite overwhelming at times, and I guess, you know, sense of humour is what people usually resort to. To try to lighten the atmosphere, to try to cope with the stress.'
Incorporating implicit bias into simulations	Respondent 2: 'I did not recognise the [*Implicit bias example*] comment till the debriefing, as it was mentioned by the facilitator. But this is more of a reflection on my own implicit bias than the design of the sim' Respondent 3: 'I liked that the session was only titled 'Professionalism' so you had no idea what the simulation would involve. It was a very realistic way to facilitate.'
Challenges of confronting and dealing with microaggressions	Interviewee 1: 'But I guess that kind of shows that this is how I've always, you know, dealt with these sorts of incidents. Whether it's big or small, whether it's just a passing comment or whether it's a full-on confrontation, I've always. I've always been just not quite sure of how I should react to it, because there's, there's never *(pause)*… There's no code of conduct. There's no phrase I can say that, you know, like, just rip up my book and just say, OK, [they] are telling me this and I, my, response should be this and this.'

Conclusion: At present, participant numbers from the pilot are too small to make meaningful conclusions. Ongoing recruitment and post-session semi-structured interviews with students will help to inform which method is better at short-term awareness raising, however further follow-up will be required to identify longer-term impact. This will guide instruction on IBRM for medical students and whether witnessing IB events can be embedded in their current simulation curriculum.

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ADVANCING SIMULATION DEBRIEFING – A ONE-DAY COURSE

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Background: Debriefing is a form of "reflective practice" and provides a means of reflection-on-action in the process of continuous learning [1]. Debriefing and feedback have been recognized as the most important aspects of healthcare simulation [2]. It is necessary for simulation, and educators have reported that debriefing increases learners' knowledge, skill performance, satisfaction, and self-reflection [3]. The 'Advancing simulation debriefing' course was delivered in April 2022. The participants were healthcare professionals who had experience in debriefing.
Methods: The full-day course included reviewing the facilitators' experience and knowledge of debriefing frameworks and skills, and how these can be adapted and built upon to facilitate more demanding debriefings. During this engaging and interactive course, the attendees were invited to reflect on their own experiences and challenges, and build on active involvement in practising these skills live via tailored exercises. Participants were asked to complete a pre-course and post-course questionnaire rating their knowledge, confidence, and attitudes towards debriefing skills. The learning objectives covered a range of skills, such as learning different strategies for uncovering biases within debriefings and how to address these, how to maintain core psychological safety through challenging debriefings, and how psychologically informed debriefing principles, can enhance debriefing practice, for scenarios with a mental health focus as well as many others. Ethical approval was given by the Psychiatry Nursing and Midwifery Research Ethics Subcommittee at King's College London (PNM 13/14–179).
Results: Paired samples t-tests were conducted to analyze the difference in ratings between the pre-and post-course questionnaires. Of the 18 participants within the course, 11 provided eligible responses. They were healthcare professionals who were regularly involved in simulation-based education and debriefing. Results demonstrated a significant difference in the scores for all course-specific questions between pre- and post-score answers (pre-course MD=70.81, SD=9.24, post-course MD=96.82, SD=6.35) t(10) test=-7.41, $p<0.0001$, with an average increase of 37% in the total score. Open-text responses reflected improved confidence in the usage of different debriefing models, considering emotional factors, and taking the lead while debriefing.
Conclusion: The course had an impact on improving debriefing skills, especially by improving the facilitators' confidence in debriefing skills, ability to debrief, and understanding of how debriefing is related to simulation-based learning. These results demonstrate a profound benefit of the use of advanced debriefing skills as a better way to standardize participant experience across different sites to improve healthcare practice.

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SEQUENTIAL SIMULATION AROUND ONCOLOGICAL EMERGENCIES AND COMPASSIONATE CONVERSATIONS IN CANCER CARE FOR PRIMARY CARE HEALTH CARE PROFESSIONALS (HCPS)

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Background: Between 2016–2018, 375,400 people were diagnosed with cancer and between 2017–2019 167,142 people died from cancer in the United Kingdom [1]. 64% of patients with a cancer diagnosis express a wish to die at home although currently only 30% manage to do so [2]. The Primary Care team who look after a person with cancer remains the same unless they move or change practice. Their household will also, in most circumstances, be looked after by the same team. It is therefore vital for healthcare practitioners (HCP) in primary care to be able to recognise different stages in a patient's disease trajectory and be able to manage this effectively. Integral to this is a need for exemplary communication with the person and their household, in order that a therapeutic relationship with all is maintained [3].
Methods: We worked with the local Macmillan team to develop four different scenarios involving the same 44-year-old woman with a diagnosis of breast cancer. The scenarios were: neutropenic sepsis during chemotherapy, agitation caused by metastatic disease, conversations around completing a ReSPECT form and preferred place of death, and lastly end of life care and recognition of dying. Before each scenario participants were told how much time had elapsed since the patient had last been 'seen.' The simulation suite was set up as a consulting room for the first two scenarios and the patient's home for the remaining two. We used an experienced Simulated Patient with the patient's wife being played by one of the faculty.
The session was delivered to an interprofessional group of eight participants and comprised of four different HCP roles. It was jointly facilitated by the author and a member of the Macmillan team.
Results: 87.5% of attendees felt that their awareness of oncological emergencies and how they can present in primary care had increased because of the training, with 100% feeling it was relevant to their developmental needs and that it met the learning objectives for the day. There was appreciation of the value of being able to simulate breaking bad news and that the sequential nature of the day made it feel realistic to participants.
Conclusion: Sequential style simulations work well for primary care HCPs who recognise the value of simulation that replicates their own practice. We recommend exploration of further scenarios around end-of-life care and communication.

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PREPARATION FOR PRACTICE: 'WE DON'T PRACTICE IN ISOLATION, SO LET'S TRAIN TOGETHER'

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Background: Historically, simulation-based education (SBE) has been delivered to uniprofessional groups by uniprofessional faculty. This does not reflect the way we