

Activity: The MELISSA project team works with multiple organisations supporting various workstreams in alignment with the FPS strategy. The scope of work includes on location training for multidisciplinary NHS staff, social care, non-professional carers [1], clinical delivery such as COVID-19 vaccination programme work [2], health and welfare checks for the homeless, healthcare conferences, career events and public engagement events supporting organisations such as Diabetes UK, Citizens Advice, and Healthworks.

Results: From 2021 to June 2022, MELISSA supported more than 120 events, engaged with more than 15 organisations inclusive of Care Commissioning Groups, Foundation Trusts, Colleges, Councils, and Housing Associations. It facilitated delivery of 23 clinical training events and achieved over 600 clinical competency sign-offs, 10 public engagement events with 172 members of the public in attendance and providing support around health and wellbeing. The homeless welfare checks involved serious blood borne illness screening and subsequent referral to services for those individuals involved. During the pandemic, whilst training was restricted, MELISSA flexed her role to provide 68 clinics delivering over 13,750 vaccinations, including vulnerable patient groups. The flexibility of locations that MELISSA has visited included rural and remote medical centres, community hospitals, care homes, schools [3], town centres, and supermarket car parks.

Conclusion: Through the initial waves of the COVID-19 pandemic, MELISSA provided a significant role in the delivery of the vaccination programme, particularly to areas in the North East with reduced uptake. With restrictions easing, the number of face-to-face clinical training sessions has quadrupled and reach within our region dramatically widened. MELISSA is a well utilised resource within the region with patient safety and public wellbeing being a priority.

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RESTARTING FOUNDATION SIMULATION TEACHING IN THE WAKE OF THE COVID-19 PANDEMIC: ADDRESSING A SIGNIFICANT DROP IN ATTENDANCE

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Background: With reducing rates of COVID-19 transmission, Health Education England (HEE) recognises the importance of re-establishing simulation-based education programmes that halted during the early phase of the COVID-19 pandemic [1]. After a 17-month hiatus, the Foundation Doctor's simulation programme is one of several to re-start in a face-to-face format at the Royal Cornwall Hospital (RCH). However, during the first four months since restarting, attendance rates amongst doctors were noted to be significantly reduced

at 19% (9 of 48) compared with 77% in the four months prior to the pandemic (34 of 44). The authors sought to establish any logistical or cultural changes that explained this.

Methods: A four-month period of attendance to foundation simulation teaching was reviewed retrospectively. For every absence noted, a survey was sent to the absentee requesting an explanation for this. After subsequent implementation of a new online system for self-booking onto sessions, comparison of attendance rates was made for a further four-month period.

Results: Over 6 teaching sessions delivered during the initial four-month period, there were 39 absences, for which 27 survey responses were received. In explanation of a given absence: 7 (25.9%) reported having been on a scheduled off-day or post-night rest-day, 4 (14.8%) had been working a night shift, 1 (3.7%) had been on annual leave, 11 (40.7%) had been unable to leave their clinical area due to poor staffing levels or high clinical workload, 1 (3.7%) had an alternate teaching commitment, and 3 (11.1%) had been unaware the teaching was taking place. None had attributed their absence to feelings of anxiety, concern over the transmission of COVID-19, or perceived lack of benefit in the teaching. After subsequent implementation of the new self-booking system, attendance rates improved to 69% (18 of 26).

Conclusion: Poor planning and failure to coordinate with working rotas provides an explanation for a large proportion of absences initially seen. The newly implemented system enables doctors to self-allocate sessions at short notice to work around their rotas. Although this has improved overall attendance rates, the absolute number of attendees still remains relatively low compared to pre-pandemic levels. Concern remains around the 40.7% of absences that arose as a result of doctors feeling unable to leave their clinical areas to attend teaching. Ongoing efforts are therefore being made to improve local cultures in relation to releasing staff for mandatory training and ensuring staffing levels are bolstered to account for this.

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THE POWER AND INFLUENCE OF THE THEATRE ON IMMERSIVE 360° VIDEOS

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Background: Three hundred and sixty-degree (360°) videos are becoming increasingly popular [1], allowing for an immersive viewing experience with high levels of fidelity, accessible via a range of devices. This is important for ease of use for training NHS staff. The videos often utilise a camera as a character of its own, the viewers seeing the narrative in first person rather than a passive third person perspective [2]. 360° video, in many ways, resembles a technological take on theatre in the round with its design being similarly based on audio amplification and the feeling of having nowhere to hide [3].

Methods: Viewers can choose which character to follow through a scenario. When paired with debriefing or training, users can observe alternative outlooks on the exact same

scenario by multiple characters. The scenario also unravels around the participant and allows, in some cases, actors to speak or appeal directly to the viewer. Maudsley Learning's work with Kings College London on the Tackling Inequalities and Discrimination Experiences in health Services (TIDES) videos implements these ideas. The role of the debriefing is comparable to the role of a theatre audience where powerful experiences shown allow you to process, before giving space to replay and re-examine from other viewpoints as we leave the theatre. Themes of Race inequality were shown through the TIDES 360° videos followed by debriefing to enhance the learners' experience.

Results: Users reported being unable to take a step back from the action, which can be applied as bystander training when paired with content around themes such as discrimination and equality. Users reported being left with a feeling of helplessness or desire to intervene. When discussed, participants described feeling exposed, at the centre of the action happening around them. In a real-life scenario, a person would re-position themselves to where they feel more comfortable but are unable to do so with a 360° video.

This, along with the use of ambisonic sound, resembles the theatre in the round, where actors, have their backs to audience members, creating a more intimate and realistic dynamic for staging.

Conclusion: 360° video is an innovative tool that replicates the principles of theatre in the round to immerse learners in scenarios with a range of benefits. Producers encourage users to autonomously choose to follow a path from multiple available storylines, which creates rich debriefing discussions that enhance the learning value.

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EMBEDDING INTERDISCIPLINARY IN-SITU SIMULATION IN CRITICAL CARE: ONSITE INNOVATION, CHALLENGES, AND SOLUTIONS

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Background: Over the last decade, research has demonstrated the positive impact of providing clinical simulation-based training (SBT) to both undergraduate students and clinical staff [1]. In-situ SBT is useful for skills improvement and team development [1]. We deliver SBT within our Intensive Care Unit (ICU) during clinical shifts. However, there are challenges to providing this education in the busy NHS environment [2]. Our aim was to address these and find solutions.

Methods: An interdisciplinary team was formed to explore clinical simulation within a 20 bedded ICU. Our ICU is within a large inner-city teaching hospital, employing over 100 nurses and 14 consultants.

We deliver scenario-based simulation during clinical shifts with members of the interprofessional team. Scenarios include: unplanned extubation and major haemorrhage [3].

Evaluation of sessions is undertaken through anonymous questionnaires of those involved in the SBT. PDSA (Plan, Do, Study, Act) cycles have been adopted to test the change and improve delivery.

Results: To date, 16 sessions have been carried out (from July 2018) involving a total of 51 members of the interprofessional team. Evaluation response rates are 100% (n= 51). These sessions have proven popular with staff, with feedback such as: 'Learning under stress has helped me focus more, especially as it is a safe environment.' Staff welcomed the opportunity to undertake this training in the 'real' clinical environment.

Challenges included risk of delay in care to our patients, increased unit workload, and establishing and maintaining a circle of trust. However, senior team 'buy in' has enabled sessions, consequently demonstrating the value placed in SBT. The COVID-19 pandemic created significant critical care skills gap. In-situ SBT addressed this by bringing teams together to explore cross-discipline working within the real clinical environment.

Conclusion: We have demonstrated that the delivery of this type of education is safe and effective, and staff found it useful and accessible. Feedback suggests the impact of SBT alongside traditional competency-based teaching is beneficial in achieving different educational goals. In-situ simulation ideally enables a team of experts to become an expert team. Having a simulation champion to promote in-situ within the unit and demonstrate a return in investment to senior managers and participants of effort and time against clear educational goals for critical care.

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MAJOR INCIDENT SIMULATION FOR NURSING STUDENTS: REFLECTIONS ON TEAMWORK, LEADERSHIP SKILLS, AND RISK MANAGEMENT

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Background: COVID-19 enforced change in ways universities design and deliver undergraduate nursing programmes. Students who trained throughout the initial outbreak of COVID-19 had to embrace a different learning experience both in practice and during their theory block [1]. As the UK was reducing their restrictions on COVID-19, universities reviewed their regulatory procedures by allowing students (limited numbers per session) to return face to face on campus. A group of lecturers took this opportunity to design an interactive simulated crisis (major incident) based in secondary care.

Methods: Lecturers created a 'snapshot' of a major incident and created a table top interactive activity. Students had the opportunity to work as a team and take on leadership roles to solve problems and manage risk in prioritising patient